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Looking For Fraud in all The Wrong Places

By Gregory Naclerio

In the 1974 movie, *Return of the Pink Panther*, Inspector Jacques Clouseau interrogates a beggar playing an accordion in front of a bank. Clouseau informs the beggar that "City Ordinance 147-B prohibits the playing of any musical instrument in a public place for the purpose of commercial enterprise without a proper license." As the beggar and Clouseau debate whether the beggar and his "minkey" are engaged in a "commercial enterprise," four masked men in the background rob the bank. Many Medicaid providers believe the Office of Medicaid Inspector General (OMIG) is guilty of the same myopic view when it comes to finding fraud.

We are all aware of the state budget woes and the need for OMIG to meet federally set benchmarks to hold onto the $1.5 billion the federal government gave the state for health reform initiatives, also known as "F-Sharp." To date, OMIG has met its F-Sharp goals and is on track to surpass its September 30, 2010 goal of $429 million in recoveries. For that, OMIG is to be commended. But on closer inspection, is the OMIG *really* fighting fraud?

According to some, OMIG is making its "nut" not by combating fraud but by allegedly finding abuse. If a provider does not meet every single requirement of the Medicaid billing rules, OMIG declares that an "abuse" and seeks to collect not only the overpayment but multiples based upon its "95% confidence level." This nit-picking attitude is clearly illustrated by a recent OMIG Audit Report (posted online), which notes the OMIG auditor found a "58 cent" overpayment for a missing "signed written fiscal order." Yet, do such findings meet the definition of abuse? Pursuant to 18 NYCRR 515.1 (b) (1), abuse is defined as "…practices that are inconsistent with sound fiscal, business, medical or professional practices and which result in unnecessary costs to the medical assistance program, payments for services which are not medically necessary or payments for services which fail to meet recognized standards for health care."

Turning the tables on OMIG, a medical practice deemed to constitute Medicaid abuse must result in unnecessary costs to Medicaid, be for medically unnecessary services or for medical services that fall below recognized standards. Failing to dot every "i" and cross every "t" does not constitute "abuse." That is why in the pre-OMIG days, regulators who observed documentation problems demanded a Plan of Corrections or even imposed fines. Today, minute failure subjects honest providers to hundreds of thousands of dollars in claim overpayments, while real fraud goes unchallenged.

For instance, while OMIG is scrutinizing alleged abuse, on June 3, 2010, New York Attorney General Andrew Cuomo arrested four men connected to Dental Plaza who allegedly stole $5.7 million from Medicaid by illegally recruiting destitute patients from the street and subjecting them to questionable dental procedures. OMIG apparently does not have the investigators or ability to prosecute real fraud. Perhaps, it's time for state government to utilize the manpower and expertise of OMIG and merge it into an enhanced Medicaid Fraud Control Unit headed by Jim Sheehan so real fraud can be detected and prosecuted. All New Yorkers should be outraged by organized fraudsters stealing *their money* (income, sales and property tax dollars are all used to fund Medicaid). However, going after providers who fail to follow the billing rules, some of which the state rarely enforces, is not how you fight fraud.

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