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Fraud and Abuse Investigations Should be Taken Very Seriously

By James A. Hoover February 2017

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According to the United States Government, fraud and abuse recovery has an excellent return for each investment dollar spent. According to the Health Care Fraud and Abuse Control (HCFAC) Program Report, released by the Department of Health and Human Services (HHS) and the Department of Justice (DOJ) on January 18, 2017, the federal government recovered more than $3.3 billion in fraudulent health care claims in Fiscal Year (FY) 2016. That means for the last three years for every one dollar invested into the Program it generated a five dollar return.

Established under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the HCFAC Program was designed to identify and prosecute health care fraud and abuse through the coordination of federal, state, and local law enforcement activities. Since its inception in 1997, the Program has returned close to $31 billion to the Medicare Trust Funds.

According to the Program Report, during FY 2016 the Federal Government won or negotiated over $2.5 billion in health care fraud judgments and settlements. Of the $3.3 billion, the Medicare Trust Funds received transfers of approximately $1.7 billion, and $235.2 million in Federal Medicaid money was similarly transferred to the Medicaid program. Over $17.9 billion has been returned by the Program to the Medicare Trust Funds for years 2009 through 2016 alone.

Other notable results of the Program include, the disclosure that for FY 2016 alone, the DOJ opened 975 new criminal health care fraud investigations that led Federal prosecutors to file criminal charges in 480 cases involving 802 defendants. A total of 658 defendants were convicted of health care fraud-related crimes during the year. On the civil front, in FY 2016 the DOJ opened 930 new civil health care fraud investigations and had 1,422 civil health care fraud matters pending at the end of the fiscal year.

HHS' Office of Inspector General (HHS-OIG) investigations conducted in 2016 resulted in 765 criminal actions against individuals or entities that allegedly engaged in crimes related to Medicare and Medicaid. There were 690 civil actions, which include false claims and unjust-enrichment lawsuits, civil monetary penalties (CMP) settlements, and administrative recoveries related to provider self-disclosures. HHS-OIG also excluded 3,635 individuals and entities from participation in Medicare, Medicaid, and other federal health care programs. Among these exclusions, some were based on criminal convictions for crimes related to Medicare and Medicaid (1,362) or to other health care programs (262), for patient abuse or neglect (299), or as a result of licensure revocations (1,448).

There were multiple highlighted cases involving physicians. In April 2016, a doctor in Maryland specializing in interventional pain management was sentenced to nine years and three months in prison, followed by three years of supervised release for one count of health care fraud, two counts

of making a false statement related to a health care program, one count of obstruction of justice, four counts of wire fraud, and one count of aggravated identity theft. The convictions were based on allegations the doctor submitted claims for nerve block injections when in fact the doctor did not own nor use imaging guidance which was necessary to administer nerve block injections. The doctor also falsely documented patient files to indicate that imaging guidance was used. Finally, when Medicare contractors visited the pain clinic and inquired about the imaging guidance machine, the doctor created a false lease document reflecting the fact that he had leased the machine.

In April 2016, a licensed physician pleaded guilty to health care fraud, admitting that he submitted false claims to Medicare for purported visits with Medicare beneficiaries, including on dates when he was out of the country, for beneficiaries who were deceased on the dates he purportedly treated them, and for services totaling more than 24 hours in one day. He agreed that he submitted approximately $2.4 million in fraudulent claims to Medicare for which he was paid approximately $1.2 million.

In July 2016, following a three-week trial in the Eastern District of New York, a physician was convicted of one count of health care fraud, three counts of making false statements in connection with health care matters, and two counts of money laundering. The evidence at trial showed the defendant, a general surgeon, billed the Medicare program for thousands of wound-debridement and incision-and-drainage surgical procedures that he did not in fact perform. The defendant billed Medicare over $7 million and was paid over $3 million in reimbursement by Medicare.

It is a safe bet to assume based on the above returns government investigations and qui tam/false claims lawsuits are here to stay no matter who is President. To read more about the 2016 results and upcoming initiatives, the Program Reports are located on the HHS-OIG website here.

Burr & Forman LLP is sharing this information as a partner with the Medical Association of the State of Alabama and would like physicians to understand that the federal government is being vigilant with all health care fraud and abuse investigations.

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