

Health Care Fraud Investigations

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This presentation provides general legal information and should not be construed as legal advice. Persons wishing such advice should seek legal counsel concerning specific fact situations that confront them. Opinions expressed herein or otherwise are those of the speaker and do not necessarily reflect the views of the United States Attorney's Office for the Northern District of Texas or the United States Department of Justice.

Outline of Presentation

- Overview of Government Enforcement Agencies and Activities
- Hypotheticals: Physician Upcoding and Wheelchair Fraud
- Applicable Health Care Fraud Statutes
- Available Investigative Tools
- Resolution of Hypotheticals
- Conclusion
- Questions

“[A] few dishonest individuals have hurt the reputations of many good and honest corporations and their executives. They've hurt workers who committed their lives to building the companies that hired them. They've hurt investors and retirees who placed their faith in the companies growth and integrity. For the sake of our free market, corporate criminals must pay.’ This statement applies equally to health care fraud committed against the taxpayers of this country. And that is why the Department of Justice, through the Civil and Criminal Divisions and through the U.S. Attorney's Offices, is fully committed to the fair and vigorous enforcement of the various laws at our disposal to deal with those companies and individuals that steal from the taxpayers.”

July 17, 2003, Statement before the House Committee on Ways and Means of William H. Jordan, Senior Counsel to the Assistant Attorney General for the Civil Division, Department of Justice

A Who's Who in Enforcement

- U.S. Department of Justice (DOJ)
 - Civil Division
 - Criminal Division
 - 93 United States Attorneys' Offices
 - Federal Bureau of Investigation
- U.S. Department of Health and Human Services (OIG)
 - Office of Inspector General
 - Centers for Medicare and Medicaid Services (CMS)
 - Program Safeguard Contractors
- U.S. Department of Defense
 - Tricare
 - Defense Criminal Investigative Service
 - Program Contractors

A Who's Who in Enforcement (continued)

- U.S. Postal Inspection Service
- U.S. Internal Revenue Service, Criminal Investigative Division
- Medicaid Fraud Control Units
- State and Federal Offices of Inspector Generals
 - Veterans Affairs
- State Oversight Agencies
 - Texas Health and Human Services Commission
- State Licensure Boards
 - Texas State Board of Medical Examiners
- Private Insurance Carriers

Health Care Fraud and DOJ

- Strategic Goal Continues to be Reduction of Fraudulent Practices in the Health Care Industry
- “Main” Justice is Located in Washington, DC
 - Pursue Separate and Joint Criminal and Civil Health Care Fraud Prosecutions
 - No Geographic Limitations on Jurisdiction
 - Organized into Distinct Components
 - Criminal Fraud Section - HIPAA
 - Civil Frauds Section of Commercial Litigation Branch - HCA
- United States Attorneys’ Offices
 - Located within 93 Separate Federal Judicial Districts
 - Conduct Criminal and Civil Prosecutions along with Debt Collection Activities
 - Limited Geographic Jurisdiction
 - Most Health Care Fraud Cases Resolved by U.S. Attorneys’ Offices

Role of the OIG in Health Care Fraud

- The OIG Reported Savings of \$21 Billion in Implemented Recommendations and Other Actions to Strengthen the Medicare and Medicaid Programs in FY 2003
- The OIG Obtained 533 Criminal Convictions in FY 2004
- The OIG Entered into 238 Civil Settlements in FY 2004
- The OIG Collected \$1.83 Billion in Fines and Recoveries in FY 2004
- The OIG Imposed 3,279 Program Exclusions Against Direct and Indirect Providers in FY 2004

Enforcement Related Information

- CMS/Program Safeguard Contractor Sponsored Education and Training
- Government Websites and Statistics
- Advisory Opinion Process
- Compliance Program Guidance
- OIG Work Plans and Audit Reports
- GAO Reports
- Published Corporate Integrity Agreements
- Comments to Proposed and Preambles to Final Anti-Kickback Safe Harbors
- Provider Self-Disclosure Protocol

Sources of Health Care Fraud Cases

- Qui tam Suits Filed under the Civil False Claims Act
- Referrals from Program Safeguard Contractors
 - CMS and the OIG
 - Federal Bureau of Investigation
 - U.S. Attorneys' Offices and/or Main Justice
- CMS Program Integrity Initiatives and Work Groups
- Defense Criminal Investigative Service
- Offices of Inspector Generals
- Anonymous and Hotline Complaints
- Competitor Complaints

Hypothetical #1 – Physician Upcoding

- Relator is a Former Staff Physician of a General Medicine Practice Group
- Relator Filed a Qui tam Alleging that the Practice Group and its Physician Majority Shareholder Upcoded Professional Services and Ordered Inflated and/or Unnecessary Services During Hospital Rounds and Office Visits
- Relator also Alleged that the Physician Owner Received Kickbacks from a Local Hospital under a Sham Medical Directorship Agreement
- Defendants are the Practice Group and Majority Physician Shareholder
- Relator is Seeking Damages from Defendants for Retaliation and Wrongful Termination

Upcoding of Items and Services

- Common Scheme
 - Medicare Paid \$19.3 Billion for E&M Services in FY 2004
 - Medicare Projected \$4.2 Billion in Improperly Paid E&M Services During Calendar Year 2003
 - Consider Medicare Reimbursement Rates for CPT Code 99211 (\$15) v. CPT Code 99213 (\$38)
- Coding Patterns
 - Focus on Aberrant or Suspect
 - Medical Review Plays Critical Role
 - Utility of Time Studies
- Knowledge
 - Actual Knowledge - Rejection of Contractor Guidance or Advice
 - Deliberate Ignorance/Reckless Disregard - Not Reviewing Billings or Receivables after Delegating Business Affairs

Government's Investigation

- Review Complaint
 - What are Allegations of Fraud?
 - Is DOJ Involvement Appropriate?
 - Contact Agency Representative
- Civil, Criminal, Administrative or Combination
 - Parallel Proceedings
 - Is there Harm to Federal or Private Health Care Programs?
 - Determine if Program/Agency has Issued Guidance/Instructions
- Scope and Nature of the Investigation
 - Involvement of Agent and AUSA
 - Federal and/or State
- Assemble Investigative Team
 - Agents and/or Auditors
 - Agency Counsel
 - Retain Litigation Consultant

2340. ALLOCATING NURSING SERVICE COSTS IN NURSING HOMES WITH DISTINCT-PART SKILLED NURSING FACILITY (FORMERLY EXTENDED CARE FACILITY)--GENERAL

One of the prerequisites for an institution to have a portion of its facility participate as an SNF (formerly ECF) is that it must have the record keeping capability to insure that it can adequately furnish the financial and statistical data required to separately determine costs applicable to the portion of the facility participating as an SNF and to other parts of the facility. The provider must be able to satisfy the intermediary that the system employed for recording and accumulated the number of hours of nursing services is capable of audit and equitably allocates the nursing service costs for Medicare reimbursement purposes. Nursing service costs refer only to gross salaries and wages of nursing and related personnel, such as registered nurses, LPN's, aides, etc.

2340.1 Methods of Allocating Nursing Service Costs for Cost Reporting Periods Starting After 1972.--For cost reporting periods starting after 1972, a nursing home that has only a portion of the facility certified as a distinct-part SNF shall allocate nursing service costs for Medicare reimbursement purposes under one of the following methods:

A. Actual Time Basis.--Under the actual time method, the number of hours of nursing service is the basis for allocation of nursing service costs to the distinct part of the facility participating as an SNF and to other parts of the facility. Various systems may be employed for recording and accumulated the hours of nursing services, e.g., payroll records, assignment schedules, etc. The preferred system is the use of time recorded which separately indicate the actual time spent in providing nursing care in the part of the facility certified as an SNF and in other parts of the facility. Regardless of the system or method used, the result should be an equitable allocation of the nursing service costs between the distinct and other parts of the facility based on records or notations made at the time the services were rendered.

Where a provider is located in a State having minimum State licensure requirements for nursing care, it is presumed that the provider allocated at least the minimum nursing time required in the noncertified parts of the facility. In those situations where the provider's records indicate that nursing time allocated to the noncertified parts of the facility is less than the minimum time required, an adjustment to the provider's cost report is necessary to decrease the nursing service cost allocated to the distinct-part SNF and to increase the nursing service cost allocated to the noncertified part so as to meet at least the minimum State licensure requirements. Where it becomes necessary to decrease nursing service costs allocated to the distinct-part SNF, appropriate on the basis of total accumulated costs which include nursing service costs.

B. Average Cost Per Diem Basis.--Under this method, the number of patient days is the basis for allocation of nursing service costs between the distinct part of the facility participating as an SNF and other parts of the facility. Total nursing service costs for the entire facility are divided by the total patient days for the entire facility to arrive at an average nursing service cost per diem. This average nursing service cost per diem is then multiplied by the number of patient days in the distinct-part SNF to determine the nursing service costs that may be allocated to the distinct-part SNF.

Under the following circumstances, it is necessary to allocate nursing service costs based on an average cost per diem basis:

1. The adjustments mentioned in subsection A above would result in less than minimum State licensure requirements for nursing services in the certified portion of the facility; or
2. The intermediary determines that adequate time records have not been maintained to support an equitable allocation of nursing costs; or
3. The intermediary determines that the allocation of nursing time results in an inequitable allocation of nursing service costs to the distinct-part SNF.

Where the intermediary requires the use of the average per diem method, the provider is not permitted to retroactively use estimates to allocate nursing costs under the actual time basis method described in subsection A above.

Where a provider is able to furnish sufficient documentation to satisfy the intermediary that the patient population in the noncertified part of the facility includes a substantial number of domiciliary patients requiring little or no nursing care, the intermediary may grant an exception to the average cost per diem method and apportion costs on the basis of the facts in that case.

Health Care Fraud Provisions

- Civil False Claims Act, 31 U.S.C. § 3729
- Health Care Fraud, 18 U.S.C. § 1347
- Stark Law, 42 U.S.C. § 1395nn
- The Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b)
- Civil Monetary Penalties Law, 42 U.S.C. § 1320a-7a
- Texas False Claims Acts, Tex. Hum. Res. Code Ann. § 36
- Mail Fraud, 18 U.S.C. § 1341
- Wire Fraud, 18 U.S.C. § 1343
- Fraud Injunction Statute, 18 U.S.C. § 1345

Health Care Enforcement Provisions

- HIPAA, 42 U.S.C. §§ 1320d-5 and 1320d-6
- Program Exclusions, 42 U.S.C. § 1320a-7
- Program Suspensions, 42 C.F.R. §§ 405.371-.377
- Quality Improvement Organizations, 42 U.S.C. § 1320c-5
- Sarbanes-Oxley, 15 U.S.C. § 7245; 17 C.F.R. Part 205
- Professional Licensure Statutes, Tex. Occupations Code Ann., Title III

Civil False Claims Act

- 31 U.S.C. § 3729 is the Primary Statute Used to Combat Health Care Fraud Against the United States
 - Majority of Cases are Qui tam Actions
 - Qui tams Resulted in Recoveries of \$1.3 Billion in FY 2003
- Generally, Persons who Knowingly Make or Present, or Cause to be Made or Presented, a False or Fraudulent Claim or Statement for Payment to the Government
 - Not Intended to Punish Mere Negligence
- “Knowingly” is Defined as:
 - Actual Knowledge
 - Acting in Deliberate Ignorance, or Reckless Disregard of the Truth or Falsity of the Information on the Claim
 - No Specific Intent to Defraud is Required
- Violators are Subject to Penalties of \$5,500 - \$11,000 per False Claim, Treble Damages, and Costs

The Anti-Kickback Statute and Stark Law

- Common Allegations in Health Care Fraud Investigations
 - Tainted Claims
 - Response to Position that Items/Services were Medically Necessary
 - Overutilization
 - Increased Program Costs
 - Improper Influence on Medical Decision-Making Process
 - Inappropriate Steering of Patients
 - Anti-Competitive
- The Anti-Kickback Statute
 - Remuneration can be Anything of Value
 - Fair Market Value is the Critical Inquiry in Several Safe Harbors
 - Generally, Compliance with Safe Harbor Means Less Risk
- The Stark Law
 - One Remedy is Disallowance of Improperly Paid Claims
 - Commercially Reasonable under Fair Market Value Exception Requires Arrangement to Further a Legitimate Business Interest

Administrative Remedies

- **OIG Authorities**
 - Specifically Applicable to Kickbacks and Failure of Care Cases
 - Penalties, Assessments, and Exclusion
 - Sanctions Imposed both Pre and Post Hearing
- **Suspension of Providers**
 - CMS or Contractor Initiated
 - Reliable Evidence of Fraud or Misrepresentation
 - No Notice Required if Harm to Trust Fund (or Fraud)
 - Extensions During Law Enforcement Investigations
- **Contractor Determinations**
 - Pre and Post Pay Review
 - Obligation to Repay Funds
 - Criminal Liability under 42 U.S.C. § 1320a-7b(a)(3)
 - Proposed CMS Regulation to Make Repayment Mandatory

Investigative Tools

- Search and Arrest Warrants
- Surveillance
- Subpoenas
 - Authorized Investigation Demand (HIPAA)
 - Inspector General
 - Grand Jury
 - Civil Investigative Demand
- Interviews
- Requests for Information
- Statistically Valid Random Samples
- Medical Reviews
- Consultants and Experts

Upcoding Investigation

- Request Claims History, Sample, and/or Medical Review
- Issue Subpoenas or Requests for Information
 - Evidence of Knowledge
 - Organization and Structure
 - Policies and Practices
 - Supporting Documents for Remuneration Paid to Providers
- Interviews
 - Former Employees
 - Hospital Fact Witnesses
- Review and Analyze Relevant Documents
 - Claims Data, Rules/Guidance, and Medical Records
 - Agreement or Contracts with Health Care Providers
 - Internal/External Correspondence and
 - Compliance and Educational Materials

Upcoding Investigation (continued)

- Develop Overpayment from Statistically Valid Random Claims Sample and/or Medical Review
 - Separate Sample and Review for Each Program Harmed
 - Claims Profile Shows Categories of Paid Items and Services
 - Damages do not Include Relator's Employment Claims
- Determine which Issues Should be Pursued
 - Every Issue may not be Substantiated
 - New Issues Arise During Investigation
 - Anti-Kickback Allegations are Difficult to Prove
 - Stark Law only Applies to Designated Health Services
- Approach Defendants to Discuss Settlement of Allegations
 - Opportunity for Rebuttal
 - Establish Dialogue to Exhaust Options Prior to Filing Suit and/or Taking Administrative Action

Resolution of Upcoding Investigation

- Settlement of Allegations
 - Negotiation of Settlement Agreement
 - Who and What are Released by Government
 - Administrative Remedies are not Released Without Agency Approval
 - No Confidentiality of Terms and Conditions
 - Relator's Employment Claims are not Addressed by Government
 - Negotiation of Integrity Obligations
 - Review and Assess Compliance Plan
 - Issue is not Whether Compliance Program Exists, but Whether it is Effective
 - Handled by Agency Counsel for the Program Harmed
 - HHS IG's 2001 Open Letter to Health Care Providers
- Intervene in Qui tam Suit
- Request Administrative Action

Hypothetical #2 – DME Fraud

- Allegations of Medicare Fraud Involving K0011 Power Wheelchairs and Accessories
- Allegations that DME Companies Delivered Nothing or Less Expensive Scooters
- Allegations that DME Companies were Trafficking in Certificates of Medical Necessity (CMN)
- Allegations that DME Companies and/or Employees Paid Recruiters Cash for Each Completed Medicare CMN
- Allegations that DME Companies and/or Employees Paid Physicians Cash for Every Signed CMN
- Allegations that Physicians and Recruiters were Paid only if the Medicare Claim “Hit”

K0011 Wheelchairs and Accessories

- Medicare Pays for a K0011 Wheelchair if:
 - Without Wheelchair Patient is Bed or Chair Confined;
 - Wheelchair is Medically Necessary and Patient is Unable to Operate a Manual Chair; and
 - Patient is Capable of Safely Operating Power Controls
- Patients Requiring K0011 Wheelchairs are:
 - Usually Totally Non-ambulatory; and
 - Possess Severe Weakness of Upper Extremities due to a Neurological or Muscular Condition
- Only Certain Physician Specialties may Order or Prescribe K0011 Wheelchairs
- Physician Must Sign CMN

CERTIFICATE OF MEDICAL NECESSITY

MOTORIZED WHEELCHAIRS		
SECTION A		Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___
PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER (____)____-____-____ HICN _____		SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER (____)____-____-____ NSC# _____
PLACE OF SERVICE _____ NAME and ADDRESS of FACILITY if applicable (See Reverse)	HCPCS CODES: _____ _____ _____	PT DOB ___/___/___; Sex (M/F); HT. (in.); WT. (lbs.) PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN NUMBER (____)____-____-____ UPIN# _____
SECTION B Information in This Section May Not Be Completed by the Supplier of the Items/Supplies.		
EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME)		DIAGNOSIS CODES (ICD-9): _____
ITEM ADDRESSED	ANSWERS	ANSWER QUESTIONS 1, 6 AND 7 FOR MOTORIZED WHEELCHAIR BASE, 1-5 FOR WHEELCHAIR OPTIONS/ACCESSORIES. (Circle Y for Yes, N for No, or D for Does Not Apply, unless otherwise noted.)
Motorized Whichr Base and All Accessories	Y N D	1. Does the patient require and use a wheelchair to move around in their residence?
Reclining Back	Y N D	2. Does the patient have quadriplegia, a fixed hip angle, a trunk cast or brace, excessive extensor tone of the trunk muscles or a need to rest in a recumbent position two or more times during the day?
Elevating Legrest	Y N D	3. Does the patient have a cast, brace or musculoskeletal condition, which prevents 90 degree flexion of the knee, or does the patient have significant edema of the lower extremities that requires an elevating legrest, or is a reclining back ordered?
Adjustable Height Armrest	Y N D	4. Does the patient have a need for arm height different than that available using non-adjustable arms?
Reclining Back; Adjustable Height Armrest	_____	5. How many hours per day does the patient usually spend in the wheelchair? (1-24) (Round up to the next hour)
Motorized Whichr Base	Y N D	6. Does the patient have severe weakness of the upper extremities due to a neurologic, muscular, or cardiopulmonary disease/condition?
Motorized Whichr Base	Y N D	7. Is the patient unable to operate any type of manual wheelchair?
NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print): NAME: _____ TITLE: _____ EMPLOYER: _____		
SECTION C Narrative Description of Equipment and Cost		
(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option. (See instructions on back.) If additional space is needed, list wheelchair base and most costly options/accessories on this page and continue on Form CMS-854.		
<input type="checkbox"/> CHECK HERE IF ADDITIONAL OPTIONS/ACCESSORIES ARE LISTED ON Form CMS-854		
SECTION D Physician Attestation and Signature/Date		
I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.		
PHYSICIAN'S SIGNATURE _____ DATE ___/___/___ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)		

K0011 CMN Requirements

- CMN is Basis for Claim and is Submitted to Medicare (Usually)
- CMNs Must Include:
 - Name and Address of Supplier
 - Medical Criteria for Wheelchair
 - Item(s) Ordered and the Charge(s)
 - Narrative Description of Accessories (if any)
- Every CMN Requires a Physician to Certify that he/she:
 - Was the Treating Physician Identified in Section A;
 - Received Sections A, B, and C (Including Charges for Items Ordered);
 - Certified the Medical Necessity Information was True, Accurate, and Complete; and
 - Acknowledged that any Falsification, Omission, or Concealment of Material Fact could Result in Civil and Criminal Liability
- Process for Prescription and Ordering of K0011 Wheelchairs and Accessories should be Arms Length

NAME and ADDRESS of FACILITY if applicable (See Reverse)

PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN NUMBER

(____)____-____-____ UPIN # _____

SECTION B Information in This Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME) DIAGNOSIS CODES (ICD-9): _____

ITEM ADDRESSED	ANSWERS	ANSWER QUESTIONS 1, 6 AND 7 FOR MOTORIZED WHEELCHAIR BASE, 1-5 FOR WHEELCHAIR OPTIONS/ACCESSORIES. (Circle Y for Yes, N for No, or D for Does Not Apply, unless otherwise noted.)
Motorized Whichr Base and <u>All Accessories</u>	Y N D	1. Does the patient require and use a wheelchair to move around in their residence?
Reclining Back	Y N D	2. Does the patient have quadriplegia, a fixed hip angle, a trunk cast or brace, excessive extensor tone of the trunk muscles or a need to rest in a recumbent position two or more times during the day?
Elevating Legrest	Y N D	3. Does the patient have a cast, brace or musculoskeletal condition, which prevents 90 degree flexion of the knee, or does the patient have significant edema of the lower extremities that requires an elevating legrest, or is a reclining back ordered?
Adjustable Height Armrest	Y N D	4. Does the patient have a need for arm height different than that available using non-adjustable arms?
Reclining Back; Adjustable Height Armrest	_____	5. How many hours per day does the patient usually spend in the wheelchair? (1-24) (Round up to the next hour)
Motorized Whichr Base	Y N D	6. Does the patient have severe weakness of the upper extremities due to a neurologic, muscular, or cardiopulmonary disease/condition?
Motorized Whichr Base	Y N D	7. Is the patient unable to operate any type of manual wheelchair?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
 NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C Narrative Description of Equipment and Cost

(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option. (See *instructions on back*.) If additional space is needed, list wheelchair base and most costly options/accessories on this page and continue on Form CMS-854.

CHECK HERE IF ADDITIONAL OPTIONS/ACCESSORIES ARE LISTED ON Form CMS-854

SECTION D Physician Attestation and Signature/Date

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE ____/____/____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

Government's Investigation

- Review Referral
 - What are Allegations of Fraud?
 - Is DOJ Involvement Appropriate?
 - Contact Agency Representative
- Civil, Criminal, Administrative or Combination
 - Parallel Proceedings
 - Is there Harm to Federal or Private Health Care Programs?
 - Determine if Program/Agency has Issued Guidance/Instructions
- Scope and Nature of the Investigation
 - Involvement of Agent and AUSA
 - Federal and/or State
- Assemble Investigative Team
 - Agents and/or Auditors
 - Agency Counsel
 - Retain Litigation Consultant

Goals of K0011 Fraud Investigation

- Joint Operation Between Law Enforcement Agencies
- Criminal Indictments of DME Owners, Recruiters, and Physicians
- Civil False Claims Act Recoveries
- Freeze Assets Belonging to Criminal Defendants
- Seize and Forfeit Proceeds of Health Care Fraud
- Suspend Target DME Companies and Physicians
- Exclude Criminal Targets from Participation in Medicare

Health Care Fraud Provisions

- Civil False Claims Act, 31 U.S.C. § 3729
- Health Care Fraud, 18 U.S.C. § 1347
- Stark Law, 42 U.S.C. § 1395nn
- The Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b)
- Civil Monetary Penalties Law, 42 U.S.C. § 1320a-7a
- Texas False Claims Acts, Tex. Hum. Res. Code Ann. § 36
- Mail Fraud, 18 U.S.C. § 1341
- Wire Fraud, 18 U.S.C. § 1343
- Fraud Injunction Statute, 18 U.S.C. § 1345

Health Care Enforcement Provisions

- HIPAA, 42 U.S.C. §§ 1320d-5 and 1320d-6
- Program Exclusions, 42 U.S.C. § 1320a-7
- Program Suspensions, 42 C.F.R. §§ 405.371-.377
- Quality Improvement Organizations, 42 U.S.C. § 1320c-5
- Sarbanes-Oxley, 15 U.S.C. § 7245; 17 C.F.R. Part 205
- Professional Licensure Statutes, Tex. Occupations Code Ann., Title III

Health Care Fraud Statute

- 18 U.S.C. § 1347 Commonly used to Prosecute Criminal Health Care Fraud
- Whoever Knowingly and Willfully Executes, or Attempts to Execute, a Scheme or Artifice-
 - (1) to Defraud any Health Care Benefit Program; or
 - (2) to Obtain, by Means of False or Fraudulent Pretenses, any of the Money or Property Owned by, or Under the Custody or Control of a Health Care Benefit Program, in Connection with the Delivery of or Payment for Health Care Benefits, Items, or Services
- Health Care Benefit Program Means:
 - Any Public or Private Plan or Contract, Affecting Commerce, Under Which any Medical Benefit, Item, or Service is Provided to any Individual, and Includes any Individual or Entity who is Providing a Medical Benefit, Item, or Service for Which Payment may be Made Under the Plan or Contract
- Violators Subject to Fine and up to 10 Years Imprisonment

Fraud Injunction Statute - Purpose

- Because the United States Believes Defendants will Likely Withdraw, Transfer or Otherwise Dispose of Assets Obtained from their Scheme to Defraud Medicare During the Pendency of the Criminal Case, the United States Seeks:
 - To Enjoin Defendants from Submitting, or Directing the Submission, of Additional Fraudulent Claims to any Federal Health Care Program
 - To Enjoin Defendants from Alienating or Dissipating Property or Assets Obtained by Fraud
 - To Obtain a Restraining Order Prohibiting Defendants, or any other Person from Withdrawing, Transferring, Removing, Dissipating, or Disposing of Assets Within Bank Accounts, or Property of Equivalent Value, until the Conclusion of the Criminal Case

Fraud Injunction Statute - Provisions

If a Person is—

(A) Violating or About to Violate this Chapter or Section 287, 371 (Insofar as such Violation Involves a Conspiracy to Defraud the United States or any Agency Thereof), or 1001 of this Title; or

(B) Committing or About to Commit a Banking Law Violation (as Defined in Section 3322(d) of this Title), or

(C) Committing or About to Commit a Federal Health Care Offense

The Attorney General may Commence a Civil Action in any Federal Court to Enjoin Such Violation.

Fraud Injunction Statute (continued)

If a Person is-

Alienating or Disposing of Property, or Intends to Alienate or Dispose of Property, Obtained as a Result of a Banking Law Violation (as Defined in Section 3322(d) of this Title) or a Federal Health Care Offense or Property Which is Traceable to Such Violation, the Attorney General may Commence a Civil Action in any Federal Court -

(A) to Enjoin Such Alienation of Disposition of Property; or

(B) for a Restraining Order to Prohibit any Person from Withdrawing, Transferring, Removing, Dissipating, or Disposing of any Such Property or Property of Equivalent Value.

Fraud Injunction Statute - Highlights

- Enjoins or Temporarily Restrains any Person from Disposing of Fraudulently Obtained Property
 - Limited to Certain Defined Offenses
 - Includes Family Members, Business Associates, Attorneys, and Agents
- Freezes Assets Derived from Fraud and/or Property of Equivalent Value
 - Tracing of Illegal Proceeds not Required (but Helps)
- Unlike Normal TROs or Preliminary Injunctions
 - Not Intended to Expire Within Certain Period of Time
 - Government Need not Prove Four Traditional Factors
- Must Show Defendants have Committed, are Committing, or about to Commit a Statutorily Specified Offense
 - No Need to Show that Government will Prevail in the Criminal Case
 - Civil Action - Burden of Proof is Between Probable Cause and Preponderance of the Evidence

Investigative Tools

- Search and Arrest Warrants
- Surveillance
- Subpoenas
 - Authorized Investigation Demand (HIPAA)
 - Inspector General
 - Grand Jury
 - Civil Investigative Demand
- Interviews
- Requests for Information
- Statistically Valid Random Samples
- Medical Reviews
- Consultants and Experts

K0011 Fraud – Investigative Steps

- Request Claims Histories of DME Company and Physician(s)
- Issue Grand Jury Subpoenas or Requests for Information
 - Financial Institutions
 - Lenders
 - Third Party Billing Companies
 - Non-Target Physicians who Signed CMNs for DME Companies
- Interviews
 - Former Employees
 - Medicare Beneficiaries
- Review and Analyze Relevant Documents
 - Claims Data
 - Rules and Guidance
 - CMNs/Medical Records
 - Financial Records

Resolution of K0011 Fraud

- Criminal Convictions
 - DME Owners
 - Recruiters
 - Physicians
- Froze, Seized, and Forfeited Health Care Fraud Proceeds
 - Luxury Cars
 - Cash
 - Bank Accounts
 - Homes
- Suspended DME Supplier Numbers
- Excluded Bad Actors
- Pending Criminal Cases

Conclusion

- Government's Approach to Enforcement is Focused on Egregious Conduct and Instances of Fraud and Abuse
- Government Relies on Sentinel Effect through Continued Criminal Convictions and Civil and Administrative Recoveries
- Still Encounter Physician Practices with no Compliance Plan
- Benefits of Compliance are Tangible
 - Helps Ensure that Provider is Properly Paid
 - Recognition of High Risk and/or Problem Areas
 - Demonstrated Commitment to Compliance may Help Mitigate Potential Criminal, Civil, and Administrative Liability
 - Effective Compliance Programs Likely Prevent and Deter Health Care Fraud and Abuse

Questions