

# FEDERAL LAW ENFORCEMENT HEALTHCARE FRAUD

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## INVESTIGATING HEALTH CARE FRAUD



### •Disclaimer

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- This presentation is not intended to waive the attorney client privilege, the work product privilege, or any other privilege.

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## HEALTHCARE FRAUD



“There is no kind of dishonesty into which otherwise good people are more easily and frequently fall than that of defrauding the government.”

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### HEALTH CARE FRAUD TASK FORCES

- **Health Care Fraud Task Force**
  - US Attorney's Office – Criminal Health Care Fraud and Affirmative Civil Enforcement Unit
  - Department of Health and Human Services Office of Inspector General (HHS-OIG)
  - Federal Bureau of Investigation (FBI)
  - Ohio Medicaid Fraud Control Unit (MFCU)
  - Internal Revenue Service
  - Drug Enforcement Administration – Tactical Diversion Squad
  - Ohio Department of Insurance
  - Licensing Boards (Ohio Medical Board, Ohio Nursing Board, Chiropractic Board)
  - Local Law Enforcement



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### HEALTH CARE FRAUD TASK FORCES

- **Elder Justice Task Force**
  - Department of Justice
  - MFCU
  - Ombudsman's Office
  - HHS-OIG
  - FBI
  - Licensing Boards
    - Ohio Medical Board
    - Ohio Nursing Board
    - Chiropractic Board



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### LAWS ENFORCED BY FEDERAL GOVERNMENT



- **Criminal:**
  - **18 USC 1035** – Health Care False Statements (0 – 5 years)
  - **18 USC 1347** – Health Care Fraud (Scheme) (0 – 10 years)
  - **18 USC 1349** – Conspiracy to Commit Health Care Fraud (0 – 20 years)
  - **18 USC 371** – Conspiracy to Commit Offense or to Defraud the U.S. (0 – 5 years)
  - **18 USC 1001** – Fraud or False Statements (0 – 5 years)
  - **18 USC 1028A** – Aggravated Identity Theft (2-year consecutive mandatory minimum)
  - **42 USC 1320a-7(b)** – Anti-Kickback Statute (0 – 5 years)

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# INVESTIGATING HEALTH CARE FRAUD

Health Care Fraud Scheme  
18 U.S.C. §1347



(a) 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, representations, or promises, any of the money or property owned by, or under the custody or control of, any **health care benefit program**.

in connection with the delivery of or payment for **health care benefits, items or services.**

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# LAWS ENFORCED BY FEDERAL GOVERNMENT

• **Civil/Administrative:**

- 13 USC 3729 – False Claims Act
- 42 USC 1395nn – Stark II (Prohibits physicians from making referrals to entity in which he/she has a financial interest)
- Civil Monetary Penalties

• **Laws Enforced by the State of Ohio**

1. Theft – R.C. § 2913.01
2. Medicaid Fraud – R.C. § 2913.40
3. Patient Abuse and Neglect – R.C. § 2901.34
4. Civil False Claims – R.C. § 5111.03



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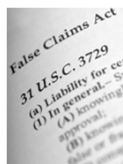
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# FALSE CLAIMS ACT (31 USC 3729, ET SEQ)

• Elements

- any **“person”**
- who submits or causes another person to submit
- a **“claim”** for payment or approval OR a record or statement
- that is **“false or fraudulent”**
- **“knowing”** that the claim/false record is false
- that is **“material”** to a false or fraudulent claim (having a **natural tendency to influence**, or be capable of influencing, the payment or receipt of money or property)



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### DAMAGES UNDER THE FALSE CLAIMS ACT

- Treble Damages: three times actual loss
- Penalty of \$5,500-\$11,000 per claim
- Amended to \$10,781 to \$21,563 for violations after 11/2/2015



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### ANTI-KICKBACK STATUTE (42 U.S.C. 1320A-7B) CRIMINAL AND CIVIL ASPECTS

- Prohibits asking for, soliciting or receiving any inducement ("remuneration") in exchange for referrals of federal health care program business
- Applies to payers and recipients of kickbacks
- Prohibited kickbacks include:
  - Cash for referrals
  - Free or reduced price rent for medical offices
  - Free clerical staff
  - Excessive compensation for medical directorships
  - Giving patients financial incentives to use your services



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### ANTI-KICKBACK STATUTE

- Affordable Care Act (2010) Amendments to AKS
  - Claims for services/items violating the AKS are false/fraudulent claims for purposes of the FCA
  - Standard for liability ("knowingly and willful") is knowing the conduct is wrongful, NOT actual knowledge of/specific intent to violate the AKS
- Penalties:
  - Prison sentences
  - Fines and penalties up to \$50,000 per kickback
  - Damages equal to three times the remuneration
  - Exclusion from federal health care programs



12

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### TYPES OF HEALTH CARE FRAUD

- Upcoding
- Rendering of medically unnecessary services or items
- Non-rendered services
- Kickbacks



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### PROVIDERS/SUPPLIERS INVESTIGATED

1. Hospitals
2. Physicians and physician practices
3. Home Health Agencies
4. Durable Medical Equipment (DME) Suppliers
5. Skilled Nursing Facilities (SNFs)
6. Long Term Acute Care Hospitals (LTACHs)
7. Pharmaceutical Companies
8. Pharmacies
9. Clinical Labs
10. Pain Clinics



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### DISCOVERING FRAUD

1. Complaints
  - a) Beneficiaries
  - b) Provider Employees
  - c) Anonymous (e.g., hotline complaints) – HHS/OIG and MFCU
2. Qui Tam Filings under the False Claims Act (parallel proceedings)
3. Self Disclosures
4. Data Mining (Unified Program Integrity Contractor – AdvanceMed, USAO/MFCU/Insurance Auditors)
  - a) Outlier billings – amount of billings/type of coding inconsistent with similar providers
  - b) Too many hours or servicing too many patients in a day
  - c) Billing for dead people or while person was in the hospital



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## HOME HEALTH CARE

MEDICALLY NECESSARY AIDE/NURSING SERVICES PROVIDED IN THE HOME

- Schemes to Defraud
  - Billing for services not rendered
  - Upcoding/splitting shifts
  - Billing while hospitalized
  - Unqualified aides
  - Falsification of records
  - Kickbacks



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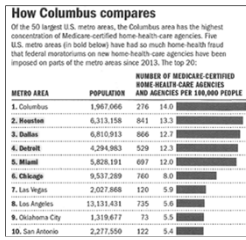
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## HOME CARE CRISIS

- “A nationwide shift away from nursing homes and institutions has fueled an industry that sends workers into the homes of ill, disabled and elderly Ohioans...”
- “[I]n the Columbus metro area, home health care isn’t merely expanding. It’s exploding.”
- <http://www.dispatch.com/content/stories/local/2014/12/14/home-care-crisis.html>



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## DURABLE MEDICAL EQUIPMENT (DME)

MEDICALLY NECESSARY EQUIPMENT OR SUPPLIES

- Schemes to Defraud
  - Billing for services not provided/not delivered
  - Upcoding
  - Kickbacks/referral
  - Shell companies: address is mail drop, but no supplies or actual business



18

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## LABS

- Schemes to Defraud
  - Kickbacks/incentives to doctors
  - Unbundling tests
  - Upcoding
  - Billing for excessive units/tests
  - Standing doctor's orders



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## TRANSPORTATION

TRANSPORTATION PROVIDED FOR NON-AMBULATORY MEDICAID COVERED SERVICES

- Schemes to Defraud
  - Billing for ambulatory recipients
  - Billing for extra attendant
  - Billing for trips not provided
  - Billing excess mileage
  - No Certificate of Medical Necessity



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## PAIN AND ADDICTION TREATMENT CLINICS – PILL MILLS

- A pill mill is a medical practitioner's office, clinic, or health care facility where the practitioner(s) routinely dispenses controlled substances without a legitimate medical purpose or outside the scope of a usual professional practice
- Hybrid offense involving illegal drug trafficking and health care fraud



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## SKILLED NURSING HOMES/HOSPICE

- Schemes to Defraud
  - Therapy upcoding
  - Service not rendered
  - Abuse/neglect
  - Kickbacks
  - Improper admissions/certifications (face to face)



22

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## INVESTIGATION TOOLS

- Criminal
  - Search warrant
  - Grand jury subpoena
  - HIPPA subpoena (18 USC § 3486)
  - Inspector General subpoena
- Civil
  - Civil investigative demand (FCA)
  - Inspector General subpoena
  - OIG



23

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## HEALTH OVERSIGHT AND LAW ENFORCEMENT EXCEPTION

▪ 45 CFR 164.512

(d) Standard: Uses and disclosures for **health oversight activities**

(1) **Permitted disclosures.** A covered entity may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight of:

- (i) The health care system;
- (ii) Government benefit programs for which health information is relevant to beneficiary eligibility
- (iii) Entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards; or
- (iv) Entities subject to civil rights laws for which health information is necessary for determining compliance

\*The Department of Justice qualifies as a Health oversight agency when performing health oversight functions – as does HHS-OIG and the FBI.

\*No subpoena is required for investigations involving Health oversight activities.

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## LAW ENFORCEMENT EXCEPTION

• 45 CFR 164.512

(f) **Standard: Disclosures for law enforcement purposes.** A covered entity may disclose protected health information for a law enforcement purpose to a law enforcement official if the conditions in paragraphs (f)(1) through (f)(6) of this section are met, as applicable.

(1) **Permitted disclosures: Pursuant to process and as otherwise required by law.** A covered entity may disclose protected health information:

- (i) As required by law including laws that require the reporting of certain types of wounds or other physical injuries, except for laws subject to paragraph (b)(1)(ii) or (c)(1)(i) of this section, or
- (ii) In compliance with and as limited by the relevant requirements of:
  - (A) A court order or court-ordered warrant, or a subpoena or summons issued by a judicial officer
  - (B) A grand jury subpoena, or
  - (C) An administrative request, including an administrative subpoena or summons, a civil or an authorized investigative demand, or similar process authorized under law, provided that:
    - (1) The information sought is relevant and material to a legitimate law enforcement inquiry;
    - (2) The request is specific and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought; and
    - (3) De-identified information could not reasonably be used.

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## PARALLEL PROCEEDINGS

### COORDINATING CRIMINAL AND CIVIL HEALTH CARE FRAUD INVESTIGATIONS AND PROSECUTIONS

- Investigative strategy and remedies
  - HIPAA subpoena
  - IG subpoena
  - CID
  - Search warrants
  - CJ – last resort – 6(e) order
- Witness interviews/obtaining testimony
  - Sharing of reports
  - Proffer sessions
  - Relator interviews
- Settlements
  - Generally negotiated separately
  - Exception: Global settlement – **must be initiated by defense counsel** (written request)
    - Criminal
    - Civil
    - Administrative (Corporate Integrity agreement)



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## PROSECUTION DECISIONS RELATING TO HEALTH CARE ORGANIZATIONS

- Considerations
  - Nature and seriousness of the violations (risk of harm)
  - Pervasiveness of wrongdoing (individual vs. systemic)
  - History of violations (prior criminal, civil, and administrative violations; pre-existing corporate compliance plan)
  - Collateral consequences (harm to shareholders or public by prosecution)
  - Deference (specific and general)
  - Obstruction of investigation
  - Cooperation

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### COOPERATING WITH THE GOVERNMENT

- Baer and Yates Memos
- Credit Eligibility
  - Voluntary disclosure (timely)
  - Provide all relevant facts about misconduct (does not include privileged information/ more information than legally obligated to disclosed)
  - Assistance with identifying responsible individuals
  - Speed of providing information
  - Remedial steps taken (corporate compliance program, proactive)



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### BENEFITS OF COOPERATION WITH THE GOVERNMENT

- Criminal
  - Non prosecution agreement
  - Deferred prosecution agreements
  - Credit for acceptance of xx guidelines
- Civil
  - Reduced multiplier (less than treble damages)
  - Reduced penalties
  - Corporate integrity agreement (claims/arrangement reviews)



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### ENFORCEMENT ACTION AND RECOVERIES

- 2016
  - 975 Health Care Fraud Investigations
  - 480 Criminal Health Care Fraud Charges Filed
  - 658 Defendants Convicted
  - 128 Health Care Fraud Criminal Enterprises Closed
- U.S. recovered \$4.7 billion in 2016
  - \$2.6 billion in health care fraud recoveries
  - 702 new qui tam cases filed
  - Recovered \$20 billion since 2009
  - \$14 billion involving fraud against federal health care programs
- Southern District of Ohio – Recovered over \$200 million since 2009



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