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Medicare Fraud Strike Force Charges Against 91 Individuals For Falsely Billing $295 Million Latest Reminder Of Industry-Wide Enforcement Risk

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A nationwide takedown by Medicare Fraud Strike Force operations n eight cities resulted in the Department of Justice filing criminal charges against 91 defendants, including doctors, nurses, and other medical professionals, for their alleged participation in Medicare fraud schemes involving approximately $295 million in false billing, Attorney General Eric Holder and Health and Human Services (HHS) Secretary Kathleen Sebelius jointly announced the charges on September 7, 2011.

The charges are provide yet another powerful reminder to health care providers, leaders and organizations of the advisability of tightening compliance practices and taking other steps to guard against ever expanding health care fraud exposures. Already a lead federal enforcement priority for more than a decade, HHS recently established the Center for Program Integrity within the Centers for Medicare & Medicaid Services (CMS) to focus on identifying and stopping fraud and acting swiftly to protect beneficiaries.

Charges Announced September 7 Show Strike Force Targeting Fraud Industry Wide

In announcing the most sweeping joint action to date, HHS and Justice Department officials warned that the latest charges demonstrate the willingness and commitment of federal officials to find and prosecute health care fraud throughout the health care industry. The actions are the latest in a series of strong reminders to providers, leaders and others in the health care industry of the need to tighten compliance and risk management to minimize the risk of getting caught up in the Federal government's ever-tightening health care fraud investigation and enforcement net.

The charges made against the 91 defendants in the indictments announced cover nearly the entire spectrum of healthcare providers for a variety alleged fraudulent schemes. The defendants charged are accused of various health care fraud-related crimes, including conspiracy to defraud the Medicare program, health care fraud, violations of the anti-kickback statutes and money laundering. The charges are based on a variety of alleged fraud schemes involving various medical treatments and services such as home health care, physical and occupational therapy, mental health services, psychotherapy and durable medical equipment (DME). HHS and Justice Department Officials warned these latest sweeping charges clearly signal the resolve of the federal government to find and prosecute health care fraud throughout the industry.

According to the Justice Department and HHS, 70 individuals were charged by Strike Force prosecutors in indictments unsealed on September 6 and September 7, 2011 in six cities. The indictments allege a variety of Medicare fraud schemes involving approximately $263.6 million in false billings. As part of takedown operations last week, 18 additional defendants were charged in Detroit and one defendant was charged in Miami in cases unsealed on September 1, 2011, for their alleged roles in Medicare fraud schemes involving approximately $29.4 million in fraudulent claims. Additionally, two individuals are scheduled to appear in court on September 7, 2011 on charges filed on August. 24, 2011, for their roles in a separate $2 million health care fraud scheme. According to the September 7 announcement, this coordinated takedown involved the highest amount of false Medicare billings in a single takedown in Strike Force history.

According to court documents, the defendants allegedly participated in schemes to submit claims to Medicare for treatments that were medically unnecessary and oftentimes never provided. In many cases, indictments and complaints allege that patient recruiters, Medicare beneficiaries and other co-conspirators were paid cash kickbacks in return for supplying beneficiary information to providers, so that the providers could submit fraudulent billing to Medicare for services that were medically unnecessary or never provided. Collectively, the doctors, nurses, medical professionals, health care company owners and others charged in the indictments and complaints are accused of conspiring to submit a total of approximately $295 million in fraudulent billing.

In Miami, 45 defendants, including one doctor and one nurse, were charged September 6 and 7, 2011 for their participation in various fraud schemes involving a total of $159 million in false billings for home health care, mental health services, occupational and physical therapy, DME and HIV infusion. Another defendant in Miami was charged on Sept. 1, 2011, for a $1 million Medicare fraud scheme. In one case, 24 defendants are charged for participating in a community mental health center fraud scheme involving more than $50 million in fraudulent billing. According to court documents, the defendants allegedly paid patient recruiters to refer ineligible beneficiaries to the mental health center. In some instances, beneficiaries who were residents of halfway houses were allegedly threatened with eviction if they did not agree to attend the mental health center.

In Houston, two individuals were charged today with fraud schemes involving $62 million in false billings for home health care and DME. According to an indictment, one defendant allegedly sold beneficiary information to 100 different Houston-area home health care agencies in exchange for illegal payments. The indictment alleges that the home agencies then used the beneficiary information to bill Medicare for services that were unnecessary or never provided.

Ten defendants were charged in Baton Rouge, La., for participating in schemes involving more than $24 million related to false claims for home health care and DME. According to one indictment, a doctor, nurse and five other co-conspirators participated in a scheme to bill Medicare for more than $19 million in skilled nursing and other home health services that were medically unnecessary or never provided.

Six defendants, including two doctors, were charged in Los Angeles for their roles in schemes to defraud Medicare of more than $10.7 million. In Brooklyn, three defendants, including two doctors, were charged for a fraud scheme involving more than $3.4 million in false claims for medically unnecessary physical therapy. Two defendants, including a doctor, are making initial appearances today in U.S. federal court in Dallas after being charged for a scheme to defraud Medicare of approximately $2.1 million.

In Detroit, 18 defendants, including three doctors, were charged last week for schemes to defraud Medicare of more than $28 million. According to an indictment, 14 of the defendants participated in a home health care scheme that submitted more than $14 million in false claims to Medicare. Finally, four defendants including one doctor were charged in Chicago for their alleged roles in schemes to defraud Medicare of more than $4.4 million.

Charges Part of Ongoing National Anti-Health Care Fraud Campaign

The Medicare Fraud Strike Force operations are part of the Health Care Fraud Prevention & Enforcement Action Team (HEAT), a joint initiative between the Department of Justice and HHS to focus their efforts to prevent and deter fraud and enforce current anti-fraud laws around the country. The joint Department of Justice-HHS Medicare Fraud Strike Force is a multi-agency team of federal, state and local investigators designed to combat Medicare fraud through the use of Medicare data analysis techniques and an increased focus on community policing. Since its announcement, the Strike Force has used the combined resources of agents from the FBI, HHS-Office of Inspector General (HHS-OIG), multiple Medicaid Fraud Control Units, and other state and local law enforcement agencies to investigate and prosecute a rising number of organizations and individuals throughout the industry for alleged violations of Federal health care fraud prohibitions. In their September 7, 2011

announcement, HHS and DOJ credited Strike Force Operations in nine locations with resulting in charges against more than 1,140 defendants who the government charged collectively falsely billed the Medicare program for more than $2.9 billion.

In addition, the HHS Centers for Medicare and Medicaid Services, working in conjunction with the HHS-OIG, are using a wide range of new and old tools in their campaign against what they perceive as fraudulent providers and to deter other perceived aggressiveness by health care providers and organizations. See e.g., *U.S. to use software to crack down on Medicare, Medicaid, CHIP fraud; Health Care Fraud Enforcement Packs New Heat; OIG Shares Key Insights On When Owners, Officers & Managers Face OIG Program Exclusion Based On Health Care Entity Misconduct; OIG Launch of Health Care Fraud "Most Wanted" List Sign of Enforcement Risks; CMS Delegated Lead Responsibility For Development of New Affordable Care Act-Required Medicare Self-Referral Disclosure Protocol; HHS announces Rules Implementing Tools Added By Affordable Care Act to Prevent Federal Health Program Fraud.*

The effectiveness of these Federal efforts to deter, find and prosecute false claims and other perceived abuses of Federal health care law has been significantly strengthened since Congress passed the Patient Protection & Affordable Care Act (Affordable Care Act). Among other things, ACA empowered HHS to:

- Suspend payments to providers and suppliers based on credible allegations of fraud in Medicare and Medicaid;
- Impose a temporary moratorium on Medicare, Medicaid, and CHIP enrollment on providers and suppliers when necessary to help prevent or fight fraud, waste, and abuse without impeding beneficiaries' access to care.
- Strengthen and build on current provider enrollment and screening procedures to more accurately assure that fraudulent providers are not gaming the system and that only qualified health care providers and suppliers are allowed to enroll in and bill Medicare, Medicaid and CHIP;
- Terminate providers from Medicaid and CHIP when they have been terminated by Medicare or by another state Medicaid program or CHIP;
- Require provider compliance programs, now required under the Affordable Care Act, that will ensure providers are aware of and comply with CMS program requirements.

Act To Manage Risks

In response to the growing emphasis and effectiveness of Federal officials in investigating and taking action against health care providers and organizations, health care providers covered by federal false claims, referral, kickback and other health care fraud laws should consider auditing the adequacy of existing practices, tightening training, oversight and controls on billing and other regulated conduct, reaffirming their commitment to compliance to workforce members and constituents and taking other appropriate steps to help prevent, detect and timely redress health care fraud exposures within their organization and to position their organization to respond and defend against potential investigations or charges.

For More Information Or Assistance

If you need assistance reviewing or responding to these or other health care related risk management, compliance, enforcement or management concerns, the author of this update, attorney Cynthia Marcotte Stamer, may be able to help. Vice President of the North Texas Health Care Compliance Professionals Association, Past Chair of the ABA Health Law Section Managed Care & Insurance Section and the former Board Compliance Chair of the National Kidney Foundation of North Texas, Ms. Stamer has more than 23 years experience advising health industry clients about these and other matters. Ms. Stamer has extensive experience advising and assisting health care providers and other health industry clients to establish and administer compliance and risk management policies and to respond to DEA and other health care industry investigation, enforcement and other compliance,

public policy, regulatory, staffing, and other operations and risk management concerns. A popular lecturer and widely published author on health industry concerns, Ms. Stamer continuously advises health industry clients about compliance and internal controls, workforce and medical staff performance, quality, governance, reimbursement, and other risk management and operational matters. Ms. Stamer also publishes and speaks extensively on health and managed care industry regulatory, staffing and human resources, compensation and benefits, technology, public policy, reimbursement and other operations and risk management concerns including a number of programs and publications on OCR Civil Rights rules and enforcement actions. Her insights on these and other related matters appear in the Health Care Compliance Association, Atlantic Information Service, Bureau of National Affairs, World At Work, The Wall Street Journal, Business Insurance, the Dallas Morning News, Modern Health Care, Managed Healthcare, Health Leaders, and a many other national and local publications. You can get more information about her health industry experience **here**. If you need assistance with these or other compliance concerns, wish to inquire about arranging for compliance audit or training, or need legal representation on other matters please contact Ms. Stamer at (469) 767-8872 or via e-mail **here**.

If you or someone else you know would like to receive future updates about developments on these and other concerns, please be sure that we have your current contact information – including your preferred e-mail – by creating or updating your profile **here**. For important information concerning this communication click **here.** If you do not wish to receive these updates in the future, send an e-mail with the word "Remove" in the Subject to **here.**