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HEALTH CARE UPDATE

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53 Doctors, Health Care Executives & Beneficiaries Indicted For Involvement In A $50 Million Alleged False Billing Ring

Fifty-three people have been indicted for schemes to submit more than $50 million in false Medicare claims in the continuing operation of the Medicare Fraud Strike Force in Detroit, Attorney General Eric Holder, Department of Health and Human Services (HHS) Secretary Kathleen Sebelius, and FBI Director Robert Mueller announced today (June 24, 2009).

The charges were unsealed today against the 53 individuals who are accused of various Medicare fraud offenses, including conspiracy to defraud the Medicare program, criminal false claims and violations of the anti-kickback statutes. The indictments returned by a grand jury in Detroit resulted in arrests in Miami, New York City and Detroit.

According to the DOJ, federal agents from the FBI and the HHS Office of Inspector General (HHS-OIG) began executing arrest warrants and made arrests in Detroit, Miami and New York City earlier today as part of a concentrated effort targeting infusion therapy and physical/occupational therapy providers involved in schemes orchestrated to defraud the Medicare program.

Collectively, the indictment accuses the physicians, medical assistants, patients, company owners and executives charged in the indictments of conspiring to submit more than $50 million in false claims to the Medicare program. According to the indictments, the defendants participated in schemes to submit claims to Medicare for treatments that were in fact medically unnecessary and oftentimes, never provided. In many cases, indictments also allege that beneficiaries accepted cash kickbacks in return for allowing providers to submit forms saying they had received the unnecessary and not provided treatments. An indictment is merely an allegation, and defendants are presumed innocent until and unless proven guilty.

The investigation and enforcement action that lead to today's indictment was conducted as part of the continuing activities of the new interagency Health Care Fraud Prevention and Enforcement Action Team (HEAT) that DOJ and HHS jointly announced last month. On May 20, 2009, DOJ and HHS jointly announced they were combining forces to find and prosecute health care fraud through the HEAT and identified Detroit and Houston as cities targeted for Medicare Fraud Strike Force attention.

Before the May 20, 2009 HEAT announcement, Medicare Fraud Strike Forces operating demonstration projects in South Florida and Los Angeles already had produced a number of indictments. The Medicare Fraud Strike Force team operating in South Florida has already convicted 146 defendants and secured $186 million in criminal fines and civil recoveries. After the success of operations in South Florida, the Medicare Fraud Strike Force expanded in May 2008 to phase two in Los Angeles, where 37 defendants have been charged with criminal health care fraud offenses. To date in the Los Angeles cases, more than $55 million has been ordered in restitution to the Medicare program. The success of these demonstration projects lies behind the founding of the HEAT initiative.

The heightened emphasis on enforcement of federal health care fraud laws reflected in the HEAT program the enactment of recent amendments to the False Claims Act, 31 U.S.C. § 3729 (FCA) under the "Fraud Enforcement and Recovery Act of 2009"(FERA). The FERA amendments increase the likelihood both that whistleblowers will turn in health care providers and other individuals and organizations that file false claims in violation of the FCA and the liability that violators may incur for that misconduct.

The FERA amendments and the HEAT Team and Strike Force activities are part of a broader emphasis in the enforcement of federal health care fraud laws by both the Administration and Congress. President Obama's proposed Fiscal Year 2010 budget seeks to further increase funding for fraud prevention and enforcement by investing $311 million — a 50 percent increase from 2009 funding — to strengthen

program integrity activities within the Medicare and Medicaid programs. The Obama Administration anticipates that all combined, the anti-fraud efforts in the President's budget could save $2.7 billion over five years by improving oversight and stopping fraud in the Medicare and Medicaid programs, including the Medicare Advantage and Medicare prescription drug programs. Many state agencies also are stepping up their health care fraud investigations and enforcement.

In light of this new emphasis upon health care fraud detection and enforcement, health care providers now more than ever need to prepare to demonstrate the appropriateness and defensibility of their health care billing and other compliance efforts.

Solutions Law Press author and Curran Tomko and Tarski LLP Health Care Practice Chair Cynthia Marcotte Stamer has extensive experience advising and assisting health care practitioners and other businesses and business leaders to establish, administer, investigate and defend health care fraud and other compliance and internal control policies and practices to reduce risk under federal and state health care and other laws. 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 Cynthia Marcotte Stamer, CTT Health Care Practice Group Chair, at cstamer@cttlegal.com, 214.270.2402 or your other favorite Curran Tomko Tarski LLP attorney.

Other Helpful Resources & Other Information

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- HHS, Sesame Workshop, and the Ad Council Launch National Campaign to Protect Families from H1N1 (Swine Flu) Virus and Stay Healthy
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