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HHS Inspector General Adds Enforcement Muscle to Catch Physician Fraud



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Law enforcement demonstrated this summer its coordinated approach to holding individual physicians accountable for fraudulent health-care claims.

In addition to record setting arrests, a special fraud alert and increasing use of data mining, the government now has hired a new task force of attorneys assigned to carry out enforcement activities against individual providers.

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According to the Centers for Medicare & Medicaid Services' deputy administrator and director of its Center for Program Integrity, waste accounts for 30 percent of overall health-care costs.

Over the years, it has become increasingly clear that the Department of Health and Human Services intends to reduce that percentage significantly by focusing on individual physicians as well as the organizations that pay them.

The 2015 Sweep

Fraud and abuse enforcement against individual physicians is not a new concept. The government has been pursuing individual physicians in a criminal context for years, particularly for accepting bribes and kickbacks or false billing (i.e., submitting claims for treatments that were medically unnecessary or never provided).

On June 18, however, the federal government announced its ''largest criminal health-care fraud takedown in the history of the Department of Justice'' after it charged 243 individuals with various health-care fraud-related crimes resulting in the submission of Medicare and Medicaid claims, estimating approximately $712 million.[1] Of the 243 individuals that were

[1] U.S. Dep't of Justice, Justice News, *National Medicare Fraud Takedown Results in Charges Against 243 Individuals for Approximately $712 Million in False Billing* (June 18, 2015), http://www.justice.gov/opa/pr/national-medicare-fraud-

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arrested, 46 were doctors, nurses, or licensed medical professionals.

Latest OIG Fraud Alert—Warning to All Physicians

On June 9, 2015, the HHS Office of Inspector General released a fraud alert warning physicians they could face liability under the anti-kickback statute unless their compensation arrangements, such as medical director agreements, reflect fair market value for bona fide services the physicians actually provide.

As part of the fraud alert, the OIG encouraged physicians ''to carefully consider the terms and conditions of medical directorships and other compensation arrangements before entering into them.''

Medical directorships will continue to be a focus because medical directors put individual physicians in a key position to generate business for the entity.

To underscore the seriousness of the issue, the OIG highlighted the fact that it has recently reached settlements with 12 individual physicians regarding questionable medical directorship and office staff arrangements.

Compliance issues under these agreements included compensation that reflected the volume or value of referrals, compensation that was not fair market value for services performed, and payment for services that were not actually performed.

This fraud alert in June, coupled with similar alerts released in 2013 and 2014, puts physicians on notice that they are squarely in the sights of law enforcement.

In one case, the OIG noted that the arrangement called for the affiliated health-care entity to pay the salaries of the physicians' front office staff, providing physicians an improper benefit by relieving them of that burden. This fraud alert, coupled with similar alerts released in 2013 and 2014, puts physicians on notice that they are squarely in the sights of law enforcement.

The OIG Adds Muscle to Its Flex

Also in June, a deputy director from the OIG announced at the American Health Lawyers' Association Annual Meeting conference that it will hire additional attorneys tasked with taking more administrative actions against physicians in their individual capacity.

The OIG clarified that the litigation team, said to be about 10 attorneys, will focus on levying civil monetary penalties (CMPs) and Medicaid and Medicare exclusions.

The creation of a new litigation team with a sole focus on CMPs and exclusions not only highlights the focus on individual physicians, but it also moves the OIG into a civil rather than criminal forum to do so.

This new team will lead to an increase in enforcement against physicians by targeting kickbacks, which ''taint medical decision-making, cause overutilization of services, and lead to increased taxpayer and patient costs.''[2] Since physicians are generally the payment recipients in any kickback scheme, they will be particularly vulnerable.

Expanding Use of Permissive Powers

The OIG has two ways to exclude physicians or entities from Federally funded health care programs: mandatory exclusion and permissive exclusion.

Under the Exclusion Statute (42 U.S.C. § 1320a-7), the OIG is legally required to exclude all individuals and entities convicted of criminal offenses related to the delivery of health care services under Medicare and Medicaid, such as Medicare or Medicaid fraud under the anti-kickback statute, False Claims Act, or Physician Self-Referral Law (''Stark law'').

Practice Tips for Physicians

1. Ensure medical director agreements—in fact, any financial arrangement, such as office staff arrangements—contain fair market value compensation for services that will actually be provided.

2. Make sure services provided under the financial agreement do not overlap with obligations under other agreements—this could be seen as double compensation.

3. Begin building evidentiary support (e.g., documenting time spent performing tasks under the agreement) in case the agreement is challenged. Documentation will be important in order to show that compensation was in fact based on the services provided rather than for a physician's past or future referrals.

4. Agreements that seem ''too good to be true'' should be viewed with suspicion.

5. Perform your own data analysis and be able to justify deviations in your statistics from the norm with objective criteria.

6. Increase emphasis on compliance because an ounce of prevention is worth a pound of cure.

This route works in combination with record breaking settlements, negotiated corporate integrity agreements, and criminal convictions. With that said, this mandatory exclusion path awaits the lengthy and expensive criminal process.

Under its permissive exclusion power, the OIG has the discretion to pursue physician conduct that may be otherwise criminal, even without obtaining a criminal

takedown-results-charges-against-243-individuals-approximately-712.

[2] *Cf.* U.S. Dep't of Justice, Justice News, *Biomet Companies to Pay Over $6 Million to Resolve False Claims Act Allegations Concerning Bone Growth Stimulators* (Oct. 29, 2014), http://www.justice.gov/opa/pr/biomet-companies-pay-over-6-million-resolve-false-claims-act-allegations-concerning-bone.

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conviction. The OIG also may pursue permissive exclusion for things like the revocation or suspension of a health care license or even the default on student loans.

CMPs may be assessed in accordance with the Civil Monetary Penalties Law (42 U.S.C. § 1320a-7a), in addition to other penalties prescribed by law, and include fines and assessments ranging from $2,000 to $100,000 per item, service, or scheme (depending on the misconduct), treble damages, and permissive exclusion from participation in all Federally funded health care programs.

The OIG may impose CMPs against physicians for an array of misconduct, such as a physician submitting a false claim or accepting a kickback, failing to report or return an overpayment, or not granting the OIG access to records upon request.

With its new attorney muscle, the OIG will likely seek imposition of severe penalties more rapidly, which may result in substantial penalties imposed on a larger number of individual physicians. Permissive exclusion and CMPs do not require utilizing the more rigorous and time-consuming criminal process.

Instead, the OIG pursues actions in the administrative realm before administrative law judges who specialize in health-care matters. No jury is involved, and the OIG needs to satisfy only the preponderance of the evidence standard rather than the criminal standard of evidence beyond a reasonable doubt.

The outcome can be equally catastrophic to physicians, however. For example, in 2014, the OIG initiated an administrative case against a New York and New Jersey licensed physiatrist for submitting false and fraudulent Medicare claims. To resolve the matter, Dr. Joseph Raia agreed to pay $1.5 million in assessments and penalties and was excluded from participation in all Federal health care programs for at least 15 years.[3]

Not surprisingly, program exclusion is referred to by many as the ''economic death penalty'' because the excluded physician cannot bill to a Federally funded health care program for any services provided.

[3] U.S. Dep't of Justice, Office of Inspector General, *Physician Agrees to $1.5 Million Payment and 15-Year Exclusion to Settle Civil Monetary Penalty Case* (March 14, 2014), https://oig.hhs.gov/newsroom/news-releases/2014/raia-cmp.asp.

Data Mining to Aid OIG in Its Enforcement against Physicians

In addition to increased staffing and resources to pursue administrative sanctions rather than criminal sanctions, the OIG has been utilizing sophisticated computer programs to identify fraud and abuse in the first place. This process, known as data mining, compares the billing patterns of physicians to identify an outlier.

Once the outlier is identified statistically, the OIG can focus on gathering proof that the statistical variation results from fraud. Data mining allows the government to spot fraudulent practices more easily and efficiently without relying on outside tips or expensive and time-consuming criminal investigations.

For example, in 2012, HHS investigators targeted Jacques Roy, a doctor in Texas, and five owners of home health agencies after analyzing Medicare billing data and finding that Roy certified over 5,000 home health claims compared to the average doctor's 104 certifications.[4]

This increased use of technology will allow the OIG to use a physician's own data to target ''suspicious billing spikes'' for further investigation. Although being an outlier in the data pool does will not necessarily lead to sanctions, it definitely grabs the attention of the OIG's new team of attorneys.

Conclusion

Over the years, the OIG has been warning physicians and the health care community of its intent to decrease health care costs by reducing fraud and abuse. By hiring additional attorneys, creating a litigation team dedicated to CMPs and exclusions, and using technology to analyze Medicare billing data, the federal government has an easier way to identify fraud and abuse and increased resources to enforce the laws more efficiently. Physicians need to protect themselves from this increased scrutiny.

[4] U.S. Dep't of Justice, Office of Public Affairs, *Dallas Doctor Arrested for Alleged Role in Nearly $375 Million Health Care Fraud Scheme* (Feb. 28, 2012).