

ONLINE EXCLUSIVE



# New legislation adds teeth to healthcare investigations – and executives are fair game for prosecution

With a \$4-to-\$1 return on investment for healthcare fraud investigations, it's no surprise that the government is boosting its efforts to rein in fraud and hold responsible parties accountable. The question is what can you do to avoid investigations?

The words “fraud” and “abuse” have assumed new emphasis in today's healthcare environment, where industry professionals face a greater threat of civil and/or criminal prosecution for regulatory practices that violate federal and state laws on the organizational and individual level. And with changes in federal legislation, ignorance of the law and/or the lack of intent to commit a crime are no longer relevant factors in a legal defense.

To highlight the new focus on prosecuting healthcare fraud and abuse, Eric H. Holder Jr., U.S. attorney general, touted the fact that the Department of Justice (DOJ) pulled in \$4 billion in healthcare fraud recoveries and that it secured more than 700 criminal convictions against individuals involved in healthcare fraud schemes in 2010.

“And on the civil enforcement front, our healthcare fraud recoveries last year under the False Claims Act exceeded a stunning \$2.2 billion,” Holder added at a healthcare fraud prevention summit in Philadelphia this year.

Holder estimates that \$60 billion in public and private healthcare spending is lost annually to healthcare fraud. “That is a staggering amount of money,” he said at the summit. “It's half the entire economy of ... Kansas.”

The Department of Health and Human Services (HHS) and the DOJ are working with the Federal Bureau of Investigation (FBI) and Internal Revenue Service to combat Medicare fraud, and state agencies

are using a new arsenal of tools to identify and prosecute cases.

From a medical practice perspective, it's important to know the changes in these laws and how they can impact you. It is particularly important to:

- Update your compliance program and vigorously enforce it
- Scrutinize all financial relationships with potential referral sources
- Investigate employee whistle-blower complaints

The magnitude of penalties, even for noncompliance issues such as forgetting to sign a contract, can turn Stark or anti-kickback violations into False Claims Act violations that affect all Medicare/Medicaid services provided under the noncompliant arrangement. Add treble damage multipliers or per-claim penalties and you can have millions of dollars in civil and criminal penalties.

## New tools

The Patient Protection and Affordable Care Act provides \$350 million over the next 10 years to fight healthcare fraud through tougher sentencing, enhanced screening and enrollment requirements, improved data sharing among government agencies, expanded overpayment recovery efforts and improved oversight of private insurance abuses, according to the HHS.

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Last year, the HHS Office of Inspector General (OIG) increased incentives for recovery audit contractors (RACs)— entities that report instances of suspected fraud to the Centers for Medicare & Medicaid Services. State enforcement agencies, including the Medicaid Fraud Enforcement units, also have incentives to ramp up enforcement.

In addition to traditional criminal and civil enforcement, the OIG received expanded authority to exclude companies, officers and managing employees from participating in healthcare programs. The HHS/OIG can bar individuals who own or have a controlling interest in the company if they knew or should have known about the violations. While OIG representatives noted that its exclusionary authority had not been used, they emphasized their intent to employ it moving forward.

Most segments of the industry have been the subject of enforcement actions, including:

- A nurse and chief executive officer who allegedly billed Medicaid \$280,550 for private nursing services not provided
- A national dental management company that paid a \$24 million interest settlement over allegations that it submitted bills for medically unnecessary dental services performed on children in Medicaid programs
- A New Orleans orthopedic surgeon who was indicted for submitting claims totaling \$102,053 to the Department of Labor's Office of Workers' Compensation Program for services he claimed he provided but did not render
- A Louisiana interventional cardiologist who was convicted and sentenced to 10 years in prison on 51 counts of healthcare fraud in connection with claims that he performed medically unnecessary cardiovascular procedures
- A company that pleaded guilty and paid \$750 million in fines and penalties to resolve allegations that it illegally manufactured and distributed drugs at its Puerto Rico facility

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## Turning up the heat

The high rate of return on enforcement spending may be why the Obama administration requested a 23 percent increase in funding (\$60 million) for the DOJ's Criminal Division to enhance prosecution of economic crimes, which include healthcare fraud, in its 2011 fiscal year proposed budget.

And there is a joint initiative between the DOJ, HHS and the Health Care Fraud Prevention and Enforcement Action Team (HEAT). U.S. Attorneys' offices intend to use HEAT with state and local law enforcement to bring civil cases against corporations and individuals involved in kickback cases and unnecessary treatment. Most recently, HEAT was responsible for bringing criminal charges against 91 defendants, collectively accused of \$295 million in false billings, which represents the highest amount of false billings targeted by HEAT in a single takedown since its formation.

U.S. attorneys, who describe healthcare fraud as a top priority for their offices, announced a new focus on phony services, staged accidents and nonmedical necessity, upcoding and anti-kickback cases. They also said their offices may use the doctrine announced in the legal case *United States vs. Park*, which holds executives liable for violations of criminal law if they were in a position to prevent or correct the violation and did not do so. Unlike traditional crimes, there is no requirement to prove criminal intent to impose strict liability on officers and employees of corporations who violate federal law.

Congress expanded the reach of the False Claims Act through the healthcare reform legislation (Pub. L. No. 111-148, March 21, 2010) to enhance the government's ability to pursue fraud committed by entities that operate under government contracts. The changes make prosecution under the False Claims Act easier. For example, now the False Claims Act can be used against healthcare providers that knowingly retain overpayments and do not return them to the government during the prescribed time (60 days).

At a time when healthcare providers are under increased scrutiny for healthcare fraud, awareness of the laws and how they have changed has never been more important. 