SANDBERG PHOENIX

PHYSICIAN LAW BLOG

Beware of Low Hanging Fruit - OIG Targets for Fraud and Abuse

AUTHOR: DENNIS HARMS

On June 18, 2015, the US Attorney announced two investigations resulting in a number of accusations of Medicare and Medicaid fraud and abuse. The “Home Alone IV” take-down and the largest national health care fraud take-down to date involving more than 200 subjects accused of defrauding Medicare and Medicaid of more than $700 Million in 14 states. Each of these takedown operations demonstrate just how seriously the Health Care Fraud Prevention and Enforcement Action Team (HEAT) is in its efforts to reduce fraud and abuse in healthcare operations. In particular, HEAT focuses on areas of potential abuse where the large increases in provider payments have occurred over the last several years. Providers are reminded that the services they provide will continue to be subject to investigations and scrutiny to ensure the services were provided and were medically necessary.

The Home Alone IV takedown involved allegations of fraud and abuse occurring in the Southern District of Illinois, where the US Attorney targeted personal assistants (PA) to Medicaid recipients. This takedown focused on medical services that were never performed but billed to the government along with medical services performed but that were medically unnecessary. Included among the 12 defendants were PAs claiming they provided services while the recipients were not in their homes; but were in jail, in hospitals or in nursing homes. One recipient of personal services was actually working as a teacher, while purportedly unable to drive a car to work. Another PA claimed payment for services provided in Illinois, at a time the PA was in Costa Rica. At the heart of these investigations was the fact that the program is intended to save federal and state tax money by providing assistance to recipients so they will not need to be hospitalized or go to a nursing home. By identifying fraud and abuse in the program, the OIG will ensure the integrity of the program is maintained.

The nationwide takedown involved Medicare Fraud Strike Force operations in 17 districts, resulting in charges against 243 individuals including 46 medical professionals, involving schemes including approximately $712 million in false billings. The takedown identified the OIG’s top priorities by focusing on fraud in three key areas: (1) Medicare Part D prescription drugs; (2) Medicaid Personal Care Services (PCS); and (3) Medicare home health benefits. The operation took place over a three day period over 14 states involving more than 325 federal agents and other professionals from the Office of the Inspector General (OIG).

Providers need to be aware of the priority areas under the OIG's watchful eye. The areas targeted are being reviewed through data analytics as well as field intelligence to identify fraud schemes. The Southern District of Illinois has been targeted as an area receiving significant investigative attention. Now is the time for providers to focus on proper documentation and management oversight to ensure that all healthcare services are provided as billed, and are medically reasonable and necessary. Since 2009, the Health Care Fraud Prevention and Enforcement Action Team (HEAT) has charged more than 2,097 defendants who collectively falsely billed over $6.5 billion. This latest takedown demonstrates how seriously HEAT and the OIG are to stop fraud and abuse. Providers need to be aware of the investigations and get their houses in order to ensure they won't be part of the low hanging fruit harvest.