

OIG's Latest Congressional Report Sees Continued Emphasis on Fraud and Abuse Enforcement

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In the final quarter of calendar year 2019, the Department of Health and Human Services Office of Inspector General ("OIG") released its Semiannual Report to Congress (the "Report"). The Report covers the six-month period from April 2019 through September 2019 and details for Congress the OIG's activities during that time and how the office uses its resources.

For the six-month period detailed throughout the Report, one thing is obvious: the OIG continued its aggressive approach in pursuing providers of all kinds for suspected fraud and abuse in HHS programs. The Report details how the OIG's investigative work, in conjunction with other federal and state agencies, led to \$2.74 billion in expected investigative recoveries, 388 criminal actions, 364 assessments of monetary penalties, and 1,347 exclusions of individuals and entities from Federal health care program. For comparison, for *entirety* of 2018, OIG reported expected recoveries of \$2.91 billion, criminal actions against 764 individuals or entities, and exclusion of 2,712 entities from federal healthcare programs. Thus, 2019 was a much more active year for the OIG.

Among other highlights included in the Report, the OIG reports an April 2019 investigation (known as Operation Brace Yourself) that dismantled a healthcare fraud scheme involving over \$1.2 billion in losses. In the alleged scheme,

medical professionals working with fraudulent telemedicine companies received illegal kickbacks and bribes from medical equipment companies. In exchange, the medical equipment companies obtained prescriptions for medically unnecessary orthotic braces and used them to fraudulently bill Medicare. The operation led to charges against

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twenty-four defendants across seventeen federal districts.

In the six-month period outlined in the Report, the OIG also netted the largest healthcare fraud scheme ever charged by federal authorities. The fraud scheme involved a record \$1.3 billion in claims. According to the investigation, the leader of the scheme bribed physicians to admit patients into care facilities he owned, and then cycled the patients through facilities in his network. In addition to billing Medicare and Medicaid for services and prescription drugs that were unnecessary or not provided, witnesses testified that the facilities were in poor condition and provided inadequate care—information that was concealed by bribing a state regulator for advance notice of surprise inspections. The leader of the scheme was sentenced to twenty years in prison, and his accomplice was sentenced to over six years in prison.

The Report also recounts the case of an inpatient rehabilitation company that settled allegations of submitting false patient diagnoses and admitting patients unnecessarily to bolster Medicare payments. The company allegedly provided false diagnoses on patient assessments to keep its facilities eligible for a special Medicare status that pays a higher rate. The company also allegedly admitted and billed for Medicare patients that did not need the care they were provided. The company ended up paying \$48 million to resolve the allegations.

What this means for you: the OIG's aggressive pursuit of providers for fraud and abuse related to federal and state healthcare programs continues to ramp up, with OIG reporting a \$5.4 billion in expected recoveries from FY 2019, which is a significant increase over 2018's \$2.91 billion. It's critical that providers ensure their operations, including all of their agreements, are up to date with the most current requirements under the law. Hospitals and health systems need to ensure their providers are educated on the fraud and abuse laws and remain diligent in the upcoming year. To paraphrase, according to Acting Inspector General Joanne M. Chiedi, 2020 will see the OIG continue its bold pursuit of those who attempt to cheat HHS programs or harm HHS beneficiaries and the agency will be resolute in catching and holding accountable perpetrators of fraud and identifying misspent funds.