Strike Force Hits Hard at Massive Medicare Fraud

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Last month, the Federal Medicare Strike Force charged 111 defendants in nine states for their alleged participation in fraud schemes that reportedly cost Medicare almost a quarter billion dollars. Last month's sweep resulted from the Justice Department's and Health and Human Services' work with the FBI, the HHS inspector general, and various state and local law enforcement officials. It represents the largest federal takedown to date of health-care fraud to date.

The schemes targeted by the Strike Force involved patient recruiters, who sought out Medicare beneficiaries who were willing to provide their Social Security Numbers and Medicare information. Recruiters allegedly induced beneficiaries to disclose their personal information with promises of free medical services or durable medical equipment. Recruiters were paid by health care professionals or health care facilities based on the amount of usable data they collected.

Healthcare professionals then used the data to bill for services or equipment that were not medically necessary or were never provided to the patient. The healthcare provider billed the bogus services to Medicare and pocketed the payments. In some cases, conspirators made tens of millions of dollars for unnecessary or undelivered medical care.

In 2007, the Justice Department, U.S. Attorney's Offices, FBI, Centers for Medicare and Medicaid, and HHS joined forces to investigate Medicare fraud in Miami. In 2008, the agencies expanded their work to Los Angeles and later to four other fraud hot spots: Houston, Detroit, Baton Rouge and Tampa.

Based on the early success of the Strike Forces in these six cities, DOJ and HHS established the Health Care Fraud Prevention and Enforcement Action Team, otherwise known as HEAT. Since then, Medicare Strike Forces have been deployed in Brooklyn, Chicago, and Dallas. Amounts of money siphoned from Medicare in each city ranged from a high of $90 million in Brooklyn to a low of $2.8 million in Dallas.

According to HHS Secretary Kathleen Sebelius, from 2008-2010, the government recovered an average of $6.80 for every dollar spent under the Health Care Fraud and Abuse Controls. The impressive return portends an increasing allocation of resources for the investigation and prosecution of Medicare Fraud, which suggests that Medicare Strike Forces are likely to expand first to bigger cities with greater potential for recovery and then to smaller locales.

Whatever the case, last month's arrests serve as a wake-up call. Healthcare providers can take a number of proactive steps to minimize their risk of criminal and civil liability under Medicare. First, Medicare providers should heed the results of Medicare overpayment audits andtake advantage of opportunities to work with the Medicare Safeguard Contractor to resolve disputed billing practices. Providers should also consider hiring a reputable independent consultant to audit and advise them on billing practices. Finally, if health care providers discover questionable or fraudulent billing practices within the organization, they should consider whether and how to disclose and correct the problems in order to minimize the organization's exposure to criminal or civil liability in the future.

Crime in the Suites is authored by the Ifrah Law Firm, a Washington DC-based law firm specializing in the defense of government investigations and litigation. Our client base spans many regulated industries, particularly e-business, e-commerce, government contracts, gaming and healthcare.
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