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LEGAL ALERT

Federal Anti-Fraud Efforts Get Added Attention

By John C. Grady, Esq.

U.S. Attorney General Eric Holder followed up on President Obama's tough stance on health care fraud on the campaign trail with news of a new enforcement action in which 91 defendants – including doctors, nurses, and hospital officials – were charged in health care fraud schemes which presented more that $429 million in alleged false billings. Medical providers in Miami, Chicago, Dallas, Los Angeles, and across the country participated in alleged schemes to submit, and be paid for, claims that were for services that were not rendered or were not medically necessary.

As quoted in the *National Law Journal* on October 4, 2012, Attorney General Holder said, "Such activities not only siphon precious taxpayer resources, drive up health care costs, and jeopardize the strength of the Medicare program, they also disproportionately victimize the most vulnerable members of society, including elderly, disabled, and impoverished Americans. And, unfortunately, we allege that many of those charged today not only broke the law but also violated their professional obligations, and sacred oaths, as medical practitioners."

As anyone who has ever handled a health care claim fraud matter of any size knows – these matters require the commitment of time, investigative assets, and attention to detail - to identify, investigate and prosecute.

In November 2009, the President issued an Executive Order laying out a strategy to cut the Medicare fee-for-service improper payment rate in half by Fiscal Year 2012. The comprehensive plan that CMS adopted to achieve that goal identified key activities to reduce the improper payment rate:

- Increase and improve medical review by focusing on services or providers that are at high-risk for improper payments;
- Use predictive modeling and robust data analysis to review claims for medically unlikely events;
- Help providers analyze their administrative claims data or billing patterns through various reports;
- Allow Recovery Auditors to review additional provider types and closely monitor the decisions made by Recovery auditors; and
- Implement a series of demonstrations targeted at payment practices with historically high improper payment rates.

Source: Centers for Medicare & Medicaid Services Fiscal year 2013 Budget in Brief at p. 61.
http://www.hhs.gov/budget/budget-brief-fy2013.pdf

The Medicare Strike Force whose work Attorney General Holder was discussing is a partnership between HHS and DOJ in nine health care fraud hot spots across the country. The teams within the strike force use advanced data analysis techniques to identify high-billing levels in order to target emerging or migrating schemes and chronic fraud. There have been 663 guilty pleas and 74 convictions after jury trials. Convicted defendants are sentenced to an average of 42 months of incarceration. *Source: Centers for Medicare & Medicaid Services Fiscal year 2013 Budget in Brief at p. 61. http://www.hhs.gov/budget/budget-brief-fy2013.pdf*

Mr. Grady focuses his practice on insurance fraud, asset recovery, and insurance coverage and reimbursement issues and has developed a special concentration on the interpretation, application and enforcement of the Insurance Fraud Prevention Act, the standard of proof for an IFPA violation. He applies those precedents currently on behalf of insurance carrier clients and advocate for the continued evolution of the IFPA as an effective fraud fighting tool. Mr. Grady may be reached at (856) 795-2220 or via email at jgrady@kwclawyers.com.