Office of Inspector General Office of Investigations

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DHHS/OIG

Mission

PROTECT

- Integrity of DHHS Programs
- Health and Welfare of Program Beneficiaries

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Who We Are

- Established in 1976
- Forefront of the Nation's efforts to fight fraud, waste and abuse in Medicare, Medicaid and more than 300 other DHHS programs
- Largest Inspector General's Office in the Federal Government
- More than 1,600 employees dedicated to combating fraud, waste and abuse and improving the efficiency of DHHS programs

Who We Are

- Majority of OIG resources goes toward the oversight of the Medicare and Medicaid programs
- Oversight extends to programs under other DHHS institutions:
  - Centers for Disease Control and Prevention
  - National Institutes of Health
  - Food and Drug Administration

What We Do

6 Components

- Immediate Office (IO)
- Office of Audit Services (OAS)
- Office of Evaluations and Inspections (OEI)
- Office of Management and Policy (OMP)
- Office of Counsel to the IG (OCIG)
- Office of Investigations (OI)

OI- Nationwide

- 600 employees nationwide including over 450 criminal investigators
- Criminal Investigators are sworn Federal law enforcement officers and have the authority to carry weapons and execute search and arrest warrants
- OI consists of HQ, 10 Regional Offices, multiple Field Offices

OI - Chicago Region

- States: Illinois, Indiana, Michigan, Minnesota, Ohio and Wisconsin
- 46 Agents
- 8 non-agents (analysts, administrative support)

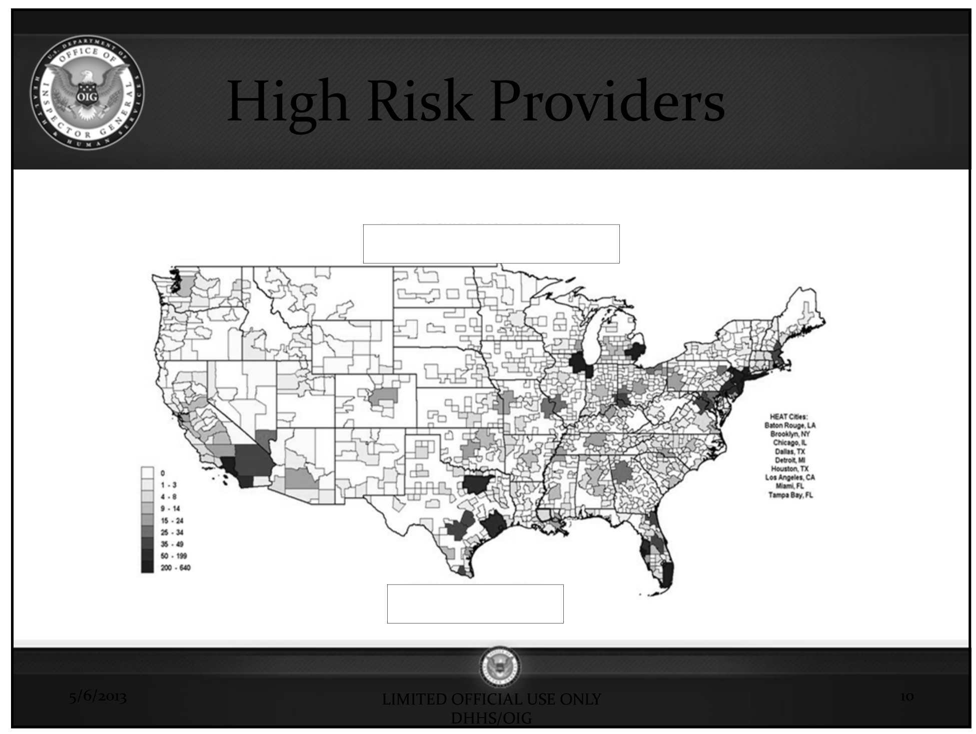
OI Ohio

- Two Offices in Cleveland and Columbus
- 4 Agents in Cleveland
- 4 Agents and 1 Analyst in Columbus

OI Ohio Partners

- Federal Bureau of Investigation, Health Care Squad
- Ohio Attorney Generals Office, Medicaid Fraud Control Unit
- DEA – Tactical Diversion Squad
- U.S. Attorneys Office
- Ohio Bureau of Workers Compensation
- Local Law Enforcement
- State Boards (Medical, Chiropractor, Pharmacy)
- Private Insurance companies
- Citizens – OIG Hotline (800-HHS-TIPS/ 800-447-8477)

High Risk Providers



Ohio Caseload

- 73% Criminal cases
- 27% Civil, CMPL, Administrative

- Almost all cases prosecuted through the U.S. Attorneys Office
  - Northern and Southern Districts of Ohio

Subjects

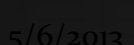
- Hospice providers
- Home Health providers
- Ambulance providers
- Labs
- Pharmacies
- Hospitals
- Hospital Network

Subjects

- Private Citizen
- Family Practice MD
- Internal Medicine MD
- Dermatologist MD
- Oncology MD
- Chiropractor
- Podiatrist

Subjects

- Durable Medical Equipment providers
- Day Care Center/Head Start
- Rehabilitation Clinics
- Pain Management
- Health Clinics



Allegations

- Unbundling
- Billing for services not rendered
- Upcoding
- Excluded provider billing Federal health care
- Unnecessary services
- Grant fraud
- Billing for unapproved drugs (imports)
- Drug diversion
- Lack of patient choice
- Identity theft

Allegations

- Kickbacks
  - knowingly and willfully
  - offered, paid, solicited, or received
  - remuneration (anything of value)
  - to induce, or exchange for, a referral of business payable by a Federal health care program

Allegations

- Self Referral/Stark
  - In general, if a physician , or an immediate family member of such physician, has a financial relationship with an entity, then
    - the physician may not make a referral to that entity
    - the entity may not present, or cause to be presented, a claim for Federal health care services

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Ohio - Health Care Fraud Trends

- Home Health
  - Independent providers
  - Conspiracy: HHC and MD
- Kickbacks
  - Hospital, nursing home, home health
- Grant Fraud
  - Embezzlement
- Drug Diversion
  - Pain management

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Recent Successes

- The leaders of an international ring that stole identities of doctors and patients in an effort to bill Medicare for more than $40 million worth of fraudulent charges were each sentenced to lengthy sentences (5/31/2012)
- Karen Chilyan, 26, of Burbank, CA was sentenced to 8 years in prison while Eduard Oganesyan, 35, of Glendale, CA was sentenced to 11 years in prison.
- Chilyan and Oganesyan unlawfully obtained personal identifiers of medical doctors and then leased commercial office space to establish false front practice locations for doctors or businesses purportedly employing the doctors whose identities were stolen.
- Provider applications submitted and bank accounts opened in the stolen doctors names. Then began billing Medicare using stolen beneficiary information*.
- 12 doctors, including 2 from Ohio had ID's stolen.
- 48 million billed. 13 million paid out.

Recent Successes

- John Heary, a Medina chiropractor pleaded guilty to 7 counts of Health Care Fraud after overbilling Medicare and insurance companies more than 1.8 million for medical equipment and treatment that were not medically necessary.
- Heary provided custom molded ankle foot orthotics, or "boots", to patients who did not need them and wrote false diagnosis to justify the billing. He billed anywhere from $2770 to $4300 for each pair of boots.
- He also routinely provided the most expensive back braces without any demonstration of medical necessity or any pursuit of a less costly alternative. He billed anywhere from $995 to $1250 for each back brace.
- Heary will be sentenced on 5/10/2013.

Recent Successes

- A man who lives in Orange, Ohio admitted to overbilling Medicare and Medicaid by more than 2.5 million. (4/14/2013)
- Divyesh "David" Patel, 39, pleaded guilty to 1 count of Conspiracy to commit Health Care Fraud and 4 counts of Health Care Fraud.
- Patel was the owner and president of Alpine Nursing care, a home health company.
- Patel employed Bush to prepare and submit billings even though Patel knew that Bush had been previously convicted of a health care-related felony that excluded Bush from being involved in Alpine's billings.
- Patel was aware that Bush falsified documents to bill for services which were never rendered.
- Bush is scheduled to be sentenced on May 28. Patel is scheduled for sentenced on July 18.

Recent Successes

- EMH Regional Medical Center and North Ohio Heart Center to Pay 4.4 million to resolve False Claims Act allegations. (1/4/2013)
- Between 2001 and 2006 EMH and NOHC performed unnecessary cardiac procedures on Medicare patients. Specifically, the U.S. alleged that EMH and NHOC performed angioplasty and stent placement procedures on patients who had heart disease, but whose blood vessels were not sufficiently occluded to require the particular procedures at issue.
- Whistleblower complaint filed under the false Claims Act. The whistleblower in this matter was the former manager of EMH's catheterization and electrophysiology laboratory. He received $660,859 of the settlement amount.
- Proof beyond a reasonable doubt vs. Perponderance of the evidence (more likely true than not)

Exclusions

- Implementing exclusions for over 30 years
- Over 3,100 individuals and entities excluded in FY 2012
- Over 54,000 individuals and entities currently excluded
- Exclusions based on convictions resulting from OIG investigations and referrals received from various sources, including USAOs, MFCUs, local prosecutors, Medicaid State Agencies and licensing boards

Exclusions

- Exclusion applies to the individual, not the profession
- Remedial in purpose -- Protect Federal health care programs and beneficiaries from
  - Improper payments
  - Improper/abusive practices
  - No further program remuneration
- Does NOT affect ability to receive benefits as a beneficiary

Exclusions

- No Federal health care program payment for any item or service furnished, ordered or prescribed in any capacity
- Prohibited from submitting claims or causing claims to be submitted
- No payment for administrative or management services
- No payment for salary, expenses or fringe benefits

Mandatory Exclusion

Program-Related Conviction

Related to the delivery of an item or service under the Medicare, Medicaid or State health care programs

Patient Neglect/Abuse Conviction

In connection with the delivery of a health care item or service meeting physical, mental or emotional needs or well-being of any patient

Felony conviction relating to a controlled substance

Unlawful manufacture, distribution, prescription or dispensing

Health Care Fraud Conviction

Permissive Exclusions

- Fraud
- Obstruction of Justice
- Controlled Substances
- Exclusion or Suspension from a Federal or State Health Care Program
- Excessive Claims, Unnecessary Items and Services, Failure to Provide Medically Necessary Items and Services
- False Claims, Fraud, Kickbacks, etc.

Permissive Exclusions

- Entities Controlled by Sanctioned Individual
- Failure to Disclose Required Information
- Failure to Supply Requested Information
- Failure to Supply Payment Information
- Failure to Grant Immediate Access
- Failure to Take Corrective Action

Permissive Exclusions

- Default on HEAL or Scholarship Obligations
- Individual Controlling a Sanctioned Entity
- Final license discipline
  - Any individual or entity whose license has been revoked, suspended, otherwise lost, or voluntarily surrendered.
  - For reasons bearing on professional competence, professional performance or financial integrity.

Exclusion Periods

- Mandatory Exclusion
  – 5 years, 1st conviction
  – 10 years, 2nd conviction
  – Permanent, 3rd conviction
- Permissive
  – 3 year benchmark
  – Can be increased or decreased based on aggravating or mitigating factors
- License Revocation
  – Indefinite
  – Eligible for reinstatement once license reinstated

Examples of Exclusion Violations

- Services performed by excluded pharmacists or other excluded individuals who input prescription information for pharmacy billing or who are involved in any way in filling prescriptions for drugs reimbursed, directly or indirectly, by any Federal health care program.
- Services performed by excluded nurses, technicians or other excluded individuals who work for a hospital, nursing home, home health agency or physician practice, where such services are related to administrative duties, preparation of surgical trays or review of treatment plans if such services are reimbursed directly or indirectly (such as through a PPS or a bundled payment) by a Federal health care program, even if the individuals do not furnish direct care to Federal program beneficiaries.

Examples of Exclusion Violations

- Services performed by excluded ambulance drivers, dispatchers and other employees involved in providing transportation reimbursed by a Federal health care program, to hospital patients or nursing home residents.
- Services performed for program beneficiaries by excluded individuals who sell, deliver or refill orders for medical devices or equipment being reimbursed by a Federal health care program.
- Items or equipment sold by an excluded manufacturer or supplier, used in the care or treatment of beneficiaries and reimbursed, directly or indirectly, by a Federal health care program.

Examples of Exclusion Violations

- Services performed by excluded social workers who are employed by health care entities to provide services to Federal program beneficiaries, and whose services are reimbursed, directly or indirectly, by a Federal health care program.

- Services performed by an excluded administrator, billing agent, accountant, claims processor or utilization reviewer that are related to and reimbursed, directly or indirectly, by a Federal health care program.

Employing an Excluded Subject

- Balanced Budget Act (BBA) authorizes the imposition of CMPs against health care providers and entities that employ or enter into contracts with excluded parties to provide items or services to Federal program beneficiaries (section 1128A(a)(6) of the Act; 42 CFR 1003.102(a)(2))

- Providers such as hospitals and nursing homes may face CMP exposure if they submit claims to a Federal health care program for health care items or services provided, directly or indirectly, by excluded parties

Civil Monetary Penalty Liability

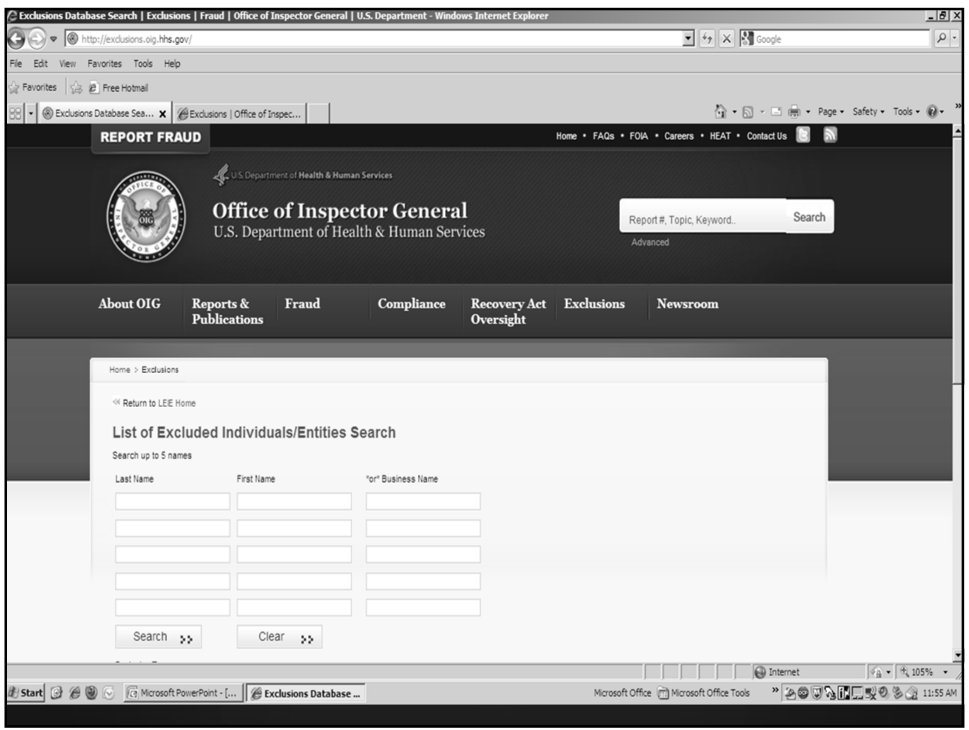
- CMPs of up to $10,000 for each item or service furnished by the excluded party and listed on a claim submitted for Federal program reimbursement may be imposed
- The excluded party may also be subject to treble damages for the amount claimed for each item or service
- Providers and contracting entities have an affirmative duty to check the program exclusion status of individuals and entities prior to entering into employment or contractual relationships

Exclusion

- Excluded individuals can:
  - Work in non-Federal health care program payment settings
  - Provide care to non-Federal health care program beneficiaries
  - Non patient care employment options such as facilities management or graphic design

Ohio Exclusion Case Example

- Matthew Nourse is a licensed pharmacist in in Ohio. Nourse was excluded from Federal health care programs for a 5 year period beginning on 2/20/2006. Nourse did not apply for reinstatement before obtaining work as a Pharmacist.
- Employed by Staker's Drugs East in Wheelersburg, Ohio from 2006 through 2010.
- Nourse was the lead pharmacist, whose duties included checking the exclusion status of Staker's employees. Previous lead pharmacist did not routinely check the exclusions database.
- In 2012, Nourse became aware of his exclusion and filed for reinstatement. Stated duties at Staker's Drug included "advertising, marketing and public relations consultant."
- On 5/11/2012 Nourse pled guilty in Federal Court to 1 count of False Statements Relating to Health Care Matters (18 U.S.C. 1035). Sentenced on 8/16/2012: 6 months home confinement, 3 years probation and $20,000 fine.
- On 5/18/2012 Staker's Drug signed a settlement agreement with the U.S. Department of Justice and OCIG for $110,000.



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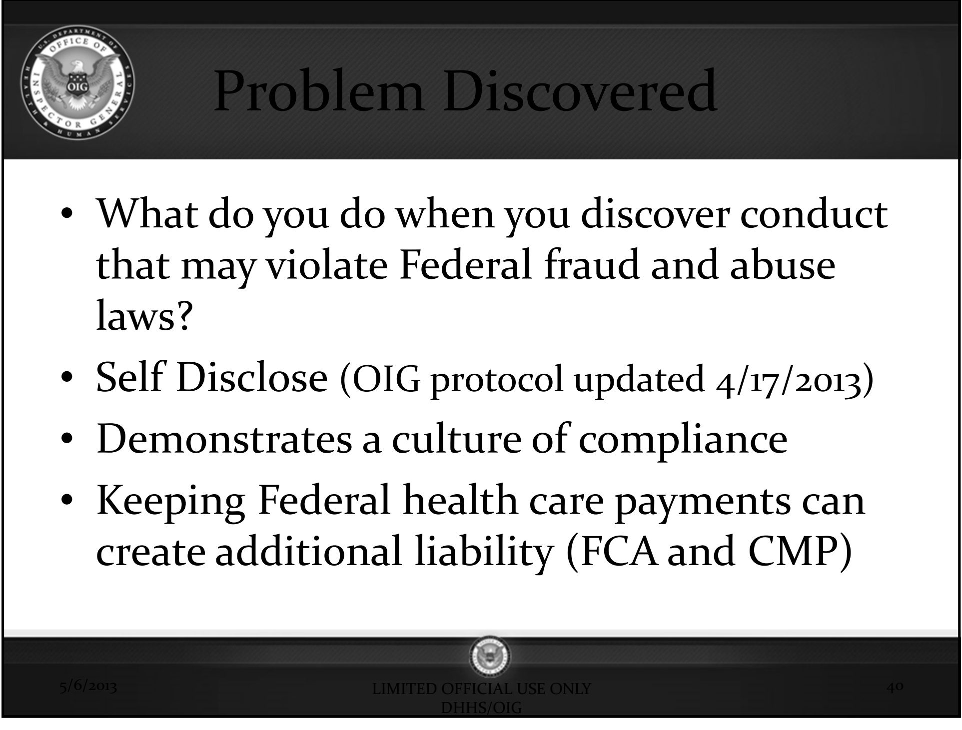

Problem Discovered
• What do you do when you discover conduct that may violate Federal fraud and abuse laws?
• Self Disclose (OIG protocol updated 4/17/2013)
• Demonstrates a culture of compliance
• Keeping Federal health care payments can create additional liability (FCA and CMP)
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Self Disclosure

- Providers now have an express duty to report and refund overpayments (within 60 days of identifying the overpayments – in most cases). Failure to do so constitutes an "obligation" under the FCA – a **reverse** false claim. PPACA §6402

Self Disclosure

Benefits of Self Disclosure:

1) Work collaboratively with the Government to reach a resolution
2) Pay a lower settlement amount (typically 1.5 times the actual damages)
3) Presumption against a Corporate Integrity Agreement when the provider has fully cooperated

Self Disclosure

What to do if you discover a problem:

1) Clarify the issue and confirm that it is a potential fraud issue
   - overpayments or innocent mistakes should be reported to Medicare contractors through the normal refund process

Self Disclosure

2) Consult with a health care attorney who has Federal health care program experience

3) Decide where to disclose:
   - U.S. Attorneys Office
   - CMS for Stark violations
   - OIG

Self Disclosure

Common Issues Providers Disclose:

- Billing for items or services furnished by excluded individuals
- Evaluations and management services and DRG up-coding
- Duplicate billing
- Alteration or falsification of records
- Kickbacks and Stark Law violations

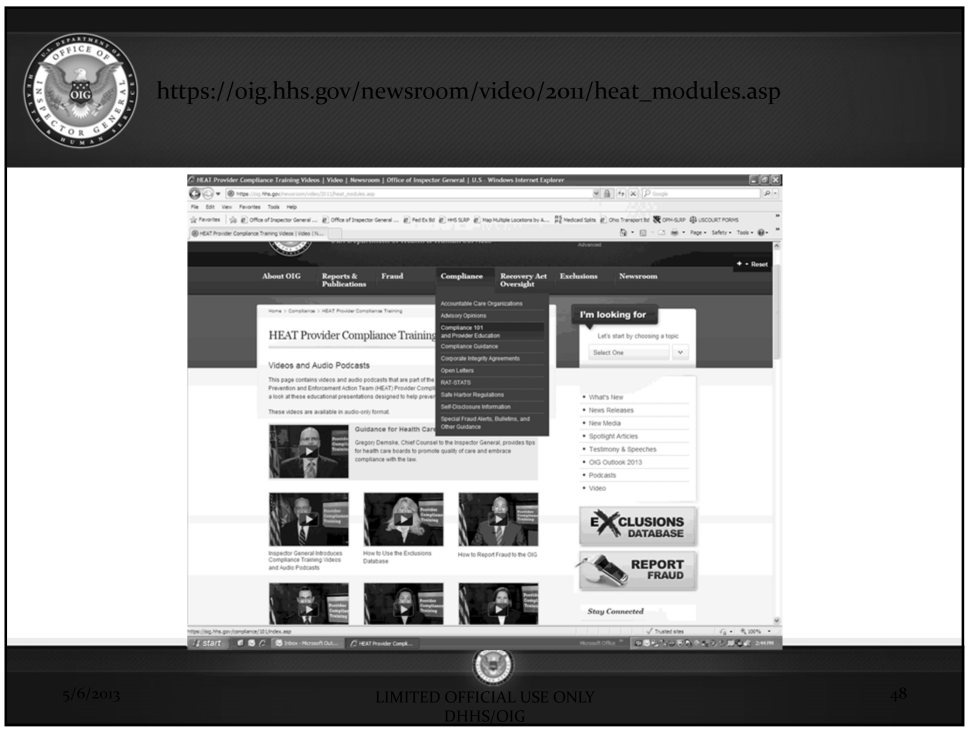
Self Disclosure – OCIG Advice

- Timing of disclosure: Your internal investigation and damages calculation needs to be finished or completed within 90 days of the initial disclosure.
- Full description of conduct: Incomplete submissions rejected. Cannot be a general reference to "federal laws and regulations."
- Respond promptly to requests for more information: Need and expect cooperation

Self Disclosure

- Expectation of a resolution through settlement:
  - Department of Justice and OIG = False Clams Act settlement
  - OIG = Civil Monetary Penalties Law settlement

https://oig.hhs.gov/newsroom/video/2011/heat_modules.asp



False Claims Act

- The False Claims Act provides that liability may be imposed:
  - » on any person who *knowingly* presents,
  - » or *causes* to be presented to the United States,
  - » a false or fraudulent claim for payment or approval.

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False Claims Act

- Intent to defraud not necessary.
- Burden of proof is by a preponderance of the evidence.
- FCA's penalty provision gives the Government leverage in negotiating settlements.

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FCA - Damages and Penalties

- Civil penalties between $5,500 and $11,000 for each false claim
  - Built-in inflationary adjustment mechanism – 28 CFR §85.3(9)
- Treble (3x) damages authorized in addition to penalties

False Claims Act – "Knowing" Standard

- A person knowingly submits a false claim when s/he:
  - » Actually knows the information contained in the claim is false; or
  - » Acts in deliberate ignorance of the truth; or
  - » Acts in reckless disregard of the truth or falsity of the information.

"Knowingly" Factors to Consider

- Notice to the provider
- Clarity of the rules or policy
- Pervasiveness and magnitude of the false claims
- Compliance Plans
- Past remedial efforts
- Guidance by the program agency or its agents
- Prior audits
- Any other information

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Contact the OIG

- OIG Hotline: 1-800-HHS-TIPS (1-800-447-8477)
- Exclusions database: https://oig.hhs.gov/exclusions/exclusions_list.asp
- Provider Compliance Training Videos: https://oig.hhs.gov/newsroom/video/2011/heat modules.asp

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