Part B Insider (Multispecialty) Coding Alert

Enforcement: OIG Targets False Claims in New Report

Don't underestimate the importance of proving medical necessity.

If you're waiting for the feds to lighten up their fraud-fighting efforts, you'll be waiting a long time. A new report highlights audits and investigations - and the numbers are staggering.

In its latest Semiannual Report to Congress, which covers HHS Office of Inspector General (OIG) activity for the reporting period that runs from Oct. 1, 2018 to March 31, 2019, the federal watchdog expects to recover $496 million from audits and $2.30 billion from investigations. Other numbers from this first part of the 2019 fiscal year include:

- **Civil actions:** OIG instigated civil actions against 331 individuals, including monetary penalties.
- **Criminal actions:** The feds initiated criminal charges against 421 individuals.
- **Exclusions:** 1,293 individuals found themselves excluded from federal healthcare programs.

"OIG is at the forefront of the Nation's efforts to fight fraud in HHS programs and hold wrongdoers accountable," says former Inspector General **Daniel R. Levinson** in the report's introduction. "During this reporting period, OIG continued to provide independent, objective oversight to identify key program vulnerabilities and recommend actions the Department can take to protect HHS beneficiaries from harm and ensure they receive high quality care."

In addition to looking at the agency's biggest takedowns, target areas, and commitment to protecting beneficiaries, the report also notes Levinson's departure as OIG's chief.

See the Major Target Areas

The OIG's Semiannual Report offers advice, insight, and cost-saving measures to HHS on ways to improve the various federal healthcare programs that fall under its umbrella, like CMS. However, a big chunk of the brief focuses on fraudsters who attempt to bunk Medicare and Medicaid. These investigations include cases that involve patient abuse; "billing for services not rendered, medically unnecessary services, or upcoded services;" the myriad of prescription drug offenses; and kickbacks and referral schemes, the report indicates.

False claims across the various subject areas were a hot topic during this timeline, the report shows. The following recoveries were among the OIG's reported triumphs over the six-month period, according to the report:

Medically unnecessary pacemakers: Over a four-year span, Kentucky physician, Anis Chalhoub, implanted 234 pacemakers, dozens of which were medically unnecessary under Medicare rules and were implanted after pressure he put on his patients to get them, according to the OIG. The feds sentenced him to more than three years in prison and $257,515 in restitution, the report adds.

Home health kickbacks and false claims: Two Detroit area-home health agency (HHA) owners, Hafiz and Tasneem Tahir, pled guilty to paying illegal kickbacks in exchange for the referral of Medicare beneficiaries to HHAs they owned. The defendants further admitted that between 2009 and 2017, they submitted false claims to Medicare for home health services that were never provided. They received 16 years in prison with Hafiz ordered to pay $9.6 million in restitution and Tasneem $4.4 million.

ED admissions fraud: Tennessee firm, Health Management Associates, Inc. (HMA) subsidiary, Carlisle HMA, LLC (Carlisle), conspired to defraud Medicare by increasing emergency department (ED) admissions in its hospitals and billing for "higher-paying inpatient care," the report suggests. Providers were pressured by HMA, even when ED admissions weren't medically necessary. The settlement of the case is complicated as HMA entered into a Non-Prosecution Agreement (NPA) with the feds and will pay $35 million in civil monetary penalties (CMPs), plus an additional $2.5 million

criminal fine. The HMA fraud also includes eight False Claims Act (FCA) cases with another civil resolution equaling $261 million to resolve violations.

Modifier 59 abuse: Philadelphia-based Coordinated Health Holding Company, LLC (Coordinated Health) founder and owner, Emil Dilorio, MD, settled with the feds for false orthopedic surgery claims that "were improperly unbundled using modifier 59" (Distinct procedural service) and submitted to Medicare and other federal programs, according to the OIG. Coordinated Health entered into a five-year Corporate Integrity Agreement, which includes monitoring of future billing practices, and will pay $11.25 million to alleviate the FCA allegations. Dr. Dilorio agreed to pay $1.25 million for his part in the scheme.

Here's How This Impacts Medicare Providers

Medicare providers who are concerned about navigating the choppy waters of compliance can learn a lot about the government's fraud and abuse targets from the federal watchdog's briefs. Moreover, the information you garner from perusing the daily actions, monthly work plans, semiannual reports, and annual reviews can help your practice devise a plan to steer clear of the OIG's spotlight.

"The OIG's semiannual reports indicate the current areas of concern for the OIG," explains Jackson, Mississippi-based attorney **Jonell B. Beeler,** with national firm Baker Donelson in its Health Law Alert blog. "Healthcare providers can utilize the insight offered by the report to review their own practices as they relate to the OIG's investigative focus issues and thereby ensure they are not on a path to becoming a statistic on the next report."

Read the Semiannual Report to Congress at https://oig.hhs.gov/reports-and-publications/archives/semiannual/2019/2019-spring-sar.pdf.