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CMS Auditing Series: More Stringent Provider Penalties

The Office of Inspector General (OIG) recently announced newly expected recoveries of up to $3.4 billion from penalties tied to unlawful misconduct in the provision of federally funded healthcare programs from October 2010 and March 2011.[1] The OIG further estimated that approximately $222 million, more than 60 percent of the funds recovered, will likely be recouped from audits conducted by the Centers for Medicare and Medicaid Services (CMS).[2] These audits can result in various penalties beyond simple reconciliation, such as civil fines and criminal prosecution. The OIG may also opt to exclude individuals or entities from participating in federally funded healthcare programs as a result of misconduct.[3] In the fourth and final installment of the *CMS Auditing Series*, this article examines the provider penalties associated with CMS audits.

CMS Medicare and Medicaid audits identify fraudulent billing practices. Once uncovered, providers may be subject to repayment, regulatory sanctions, and civil fines. Fines are levied against providers or organizations when sufficient evidence shows false or fraudulent claims, negligence in patient care, anti-kickback statute or Stark Law violations, as well as other violations.[4] These regulatory penalties are typically coupled with the expectation that the sanctioned party will repay all falsely collected funds.[5]

Providers have the right to appeal accusations of fraud and abuse. To do so, the accused parties must request a hearing before an administrative law judge (ALJ) within the U.S. Department of Health and Human Services. If the ALJ finds against the provider, accused parties may appeal the ALJ's decision administratively and to a federal court. Most cases, however, are resolved through negotiation and settlement with the OIG before a hearing occurs.[6] While many violations result in monetary fines, governmental agencies are increasingly seeking criminal prosecution as well.

As CMS auditing gains momentum, the federal government is concurrently prosecuting more cases involving fraudulent billings and payments.[7] The OIG estimates that approximately $3.2 billion in expected recoveries will result from criminal and civil actions against individuals and entities suspected of healthcare-related fraud or other financial misconduct.[8] Criminal statutes addressing Medicare and Medicaid fraud include the False Claims Act, which holds providers liable for false or fictitious claims or demands made to the government, and the False Statements Act, which prohibits providers from hiding or falsifying statements, representations, or documentation related to Federal government correspondence. The Social Security Act, the Health Insurance Portability and Accountability Act, and the Federal Mail and Wire Fraud statutes also contain provisions that apply to healthcare providers.[9] For most statutes, the maximum criminal punishment is five years in prison and up to $500,000 in fines.[10] Although not generally enforced against healthcare providers, some court cases have expanded criminal sanctions for wire fraud (fraud accomplished through electronic communications) to 20 years in prison.[11]

The most egregious offenses under Medicare, Medicaid, SCHIP, or other state healthcare programs, result in a mandatory exclusion from federally funded healthcare programs. By law, OIG must exclude any individual or entity with a felony conviction of healthcare-related fraud, theft, or other financial misconduct. A direct relation between the conviction and a federal or state program is not necessary for a mandatory exclusion to apply. Convictions for patient abuse or neglect, as well as felonies associated with the illegal manufacturing, distributing, prescribing, or dispensing of controlled substances, may also result in the individual or entity being denied program participation.[12]

Permissive exclusions are left to the discretion of the OIG, which is generally utilized under the following circumstances: misdemeanor convictions of healthcare-related fraud or the illegal manufacturing, distributing, prescribing, or dispensing of controlled substances; fraud in any non-healthcare program funded by a government agency; or the suspension, revocation, or surrender of professional licensure related professional competence, professional performance, or financial integrity. Many additional factors may also affect OIG exclusion decisions, including the provision of unnecessary or substandard services; health education loan or scholarship obligation avoidance; acting as a sanctioned entity owner, officer, or managing employee; anti-kickback statute violations; or false or fraudulent claim submissions.[13]

Efforts to crack down on healthcare fraud are set to expand over the next decade, as additional funding, manpower, and legal provisions are dedicated to

(Continued on next page)

(Continued from previous page)

enforcement activities.[14] While providers may face numerous penalties some note, "*various Medicare and Medicaid auditing initiatives have sharply lowered erroneous excess payments under the programs over the past three years . . . and new initiatives will lower such mistaken spending further*."[15] The overall error rate in Medicare alone has fallen 1.6 percent in the past year, resulting in savings of approximately $12 billion.[16] System improvements protect both the integrity of federally funded healthcare programs and the welfare of these programs' beneficiaries.[17]

1 "Inspector General: Audits, Legal Actions May Net Up to $3.4 Billion" Office of Inspector General, June 1, 2011, http://oig.hhs.gov/newsroom/news-releases/2011/sar_release.asp (Accessed 11/18/2011).
2 Ibid.
3 "Exclusion of Certain Individuals and Entities from Participation in Medicare and State Health Care Programs" 42 U.S.C. 1320a–7, §1128 (January 7, 2011); Obligations of Health Care Practitioner and Providers of health Care Services; Sanctions and Penalties; Hearings and Review" U.S.C. 1320c-5, §1156 (January 7, 2011).
4 "Civil Monetary Penalties and Affirmative Exclusions" Office of Inspector General, http://oig.hhs.gov/fraud/enforcement/cmp/index.asp (Accessed 11/18/2011); "Criminal Prosecutions for Medicare and Medicaid Fraud" By Mark L. Bennett Jr., Bennett & Dillon L.L.P., Posted on Association of American Physicians and Surgeons (AAPS), http://www.aapsonline.org/fraud/fraud.htm (Accessed 11/18/2011).
5 OIG, "Civil Monetary Penalties and Affirmative Exclusions."
6 Ibid.
7 Bennett, "Criminal Prosecutions for Medicare and Medicaid Fraud."
8 OIG, "Inspector General: Audits, Legal Actions May Net Up to $3.4 Billion" 2011.
9 Bennett, "Criminal Prosecutions for Medicare and Medicaid Fraud."
10 False Claims Act, 18 U.S.C. § 287 (October 27, 1986); False Statements Act, 18 U.S.C. §1001 (July 27, 2006); Social Security Act: 42 U.S.C. § 132Oa-7 (January 7, 2011); Federal Mail and Wire Fraud: 18 U.S.C. §§1341, 1343 (January 7, 2008).
11 Skilling v U.S, 130 S.Ct. 2896 (June 24, 2010).
12 "Exclusions: Background Information" Office of Inspector General, http://oig.hhs.gov/exclusions/background.asp (Accessed 11/18/2011).
13 Ibid.
14 "Top 12 Uncertainties Hovering Over Healthcare" By Cheryl Clark, HealthLeaders (November 21, 2011), Accessed at http://www.healthleadersmedia.com/content/LED-273486/Top-12-Uncertainties-Hovering-Over-Healthcare.html (Accessed 11/28/2011).
15 "White House Cites Progress on Payment Errors" By Rich Daly, Modern Healthcare (November 15, 2011), Accessed at http://modernhealthcare.com/article/20111115/NEWS/311159964/?template=printp (Accessed 11/18/2011).
16 Ibid.
17 "Medicare Fraud & Abuse: Prevention, Detection, and Reporting" Centers for Medicare & Medicaid Services (October 2011), Accessed at https://www.cms.gov/MLNProducts/downloads/Fraud_and_Abuse.pdf (Accessed 11/21/2011).

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