Government Announces Record-Breaking Returns from Health Care Fraud Enforcement

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A False Claims Bulletin

Earlier this month, the U.S. Department of Justice and the Department of Health and Human Services released the Health Care Fraud and Abuse Control Program Annual Report for fiscal year 2012. The report touts that for every dollar spent investigating health care fraud cases during the last three years, the government recovered $7.90.

This is the highest average rate of return in the 16-year history of the Health Care Fraud and Abuse Program and is $2.50 higher than the average rate of return over the life of the program. In all, the government recovered $4.2 billion from health care providers in fiscal year 2012, which is also a record. With such a high rate of return, one can rest assured that the government will increase its health care fraud enforcement efforts during the coming years.

In addition to touting its success in combating health care fraud, the report also provides some specific examples of successful enforcement actions. The report reveals general categories of claims the government pursued against multiple hospitals that were more intricate than simply charging for services that were not rendered. These cases demonstrate that the government is applying the False Claims Act in more situations than simply those where the provider billed for services that were not rendered.

The first general category relates to "outlier payments." Medicare provides "outlier payments" to hospitals and other health care providers in cases where the cost of care is unusually high. In these cases, the government alleged that hospitals manipulated their charge structures to make it appear that the cost of treating certain patients was unusually high. For instance, it could be problematic if the charges for a procedure increase at a dramatically higher rate than the actual cost of providing the procedure, especially if the procedure at issue is disproportionately billed to Medicare patients.

In order to avoid such scrutiny, hospitals should ensure that all charge increases are justified based upon costs and other relevant factors without regard to the volume of Medicare patients that ordinarily receive the treatment at issue. Hospitals also should not consider the possibility of receiving increased "outlier payments" when establishing charges for procedures.

The second category of cases involves treating patients on an inpatient basis when those patients could have been treated as observation patients or on an outpatient basis. The government's focus on cases addressing the distinction between inpatient and outpatient procedures is not new. It is nonetheless advisable to regularly review these rules and ensure that this issue is always given due consideration. The government will continue to delve into these cases as they continue to find health care providers that treat patients in the improper setting. Hospitals can improve their compliance in this regard by adopting appropriate policies and procedures governing admissions, training employees and staff regarding those policies, and ensuring that staff properly documents all necessary information.

The success of the Health Care Fraud and Abuse Program, coupled with the new tools and resources provided by the Affordable Care Act, ensures that the government's enforcement activities in the health care sector will continue into the foreseeable future. The best way to combat the government's actions is to put a premium on compliance, recognize areas of potential concern, and manage those risks appropriately under the law.

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