Medical Practitioners Feel the HEAT in Largest Government Fraud Crackdown in History

False insurance billing is not a new plague on the healthcare industry. But yesterday marked a new chapter in its history with the announcement of the largest government crackdown in alleged healthc fraud the United States has ever seen. Unprecedented in size and scope, the national sweep names a total of 301 defendants criminal and civil charges, alleges the fraudulent use of approximately $900 million in federal funds, and involves several government agencies cooperating in the investigation and prosecution, including the FBI. The Department of Justice (DOJ) describes the landmark operation as "a coordinated takedown."

The takedown is possible because of the Healthcare Fraud Prevention and Enforcement Action Team (HEAT), a joint initiative between the DOJ and Health and Human Services (HHS) begun in 2009 with the goal of preventing fraud and enforcing anti-f legislation nationwide. The Medicare Fraud Strike Force probe into the medical practitioners charged (which include doctors, nurses, licensed medical professionals, and health care company owners) is carried out under HEAT's umbrella.

"The Medicare Fraud Strike Force is a model of 21st-Century data-driven law enforcement, and it has had a remarkable impa healthcare fraud across the country," said Assistant Attorney General Leslie R. Caldwell of the Justice Department's Criminal Division yesterday. "As the cases announced today demonstrate, the Strike Force's strategic approach keeps us a step ahead emerging fraud trends, including drug diversion, and fraud involving compounded medications and hospice care."

The fraud-related charges the 301 defendants face include bribery, identity theft, money laundering, kickback violations and conspiracy. The staggering $900 million loss that is the focus of this investigation was allegedly billed for medically unnecessa procedures, services, or medications, or services that were never performed.

Government ramps up fight against healthcare fraud

The Affordable Care Act (ACA) earmarks $350 million in federal funds to extinguish fraud in government healthcare programs addition to expanding financial and human resources in the war against healthcare fraud, the ACA calls for harsher sentences the case of criminal wrongdoing—the higher the monetary loss to the government (via fraudulently billed amounts), the longer perpetrator can expect to spend in prison.

"While DOJ has announced a grab-bag of healthcare fraud cases across the country, the charging of more than 60 physician other licensed healthcare professionals is noteworthy," said Mark Hardiman, partner at Nelson Hardiman, LLP. "Historically, licensed professionals have been more difficult to prosecute for healthcare fraud because they have significant leeway in prac medicine and also have the resources to aggressively defend themselves. Clearly, DOJ is sending a message that healthcare professionals who engage in fraud will be aggressively prosecuted."

Indeed, the tenor of the government's prosecutorial seriousness is made clear in this statement by Inspector General Daniel Levinson of the HHS Office of Inspector General (OIG): "While it is impossible to accurately pinpoint the true cost of fraud in f

healthcare programs, fraud is a significant threat to the programs' stability and endangers access to health care services for millions of Americans. As members of the joint Strike Force, OIG will continue to play a vital role in tracking down these crimin and seeing that justice is done."

Southern California doctors arrested in probe

Among the 22 California residents included in the crackdown, five physicians were arrested in Southern California: Samuel Al 81, of Laguna Beach; Sang Kim, 67, of Porter Ranch; Kain Kumar, 52, of Encino; David Michael Jensen, 65, of Whittier; and Donald Woo Lee, 50, with clinics in Temecula and Mira Loma. Lee is accused of performing medically unnecessary vein abla and submitting over $12 million in false bills to Medicare. And Jensen, owner of Valley View Drugs in La Mirada, was charged receiving illegal kickbacks. According to the indictment, insurers paid out more than $20 million in prescription drug claims to V View, of which the pharmacy paid approximately $10 million to companies associated with two marketers criminally charged a with Jensen.

"Patients were pawns in an alleged pay-for-play fraud scheme," California Insurance Commissioner Dave Jones said.

Military health care programs implicated in the alleged fraud

Medicare isn't the only government healthcare program impacted; TRICARE, the military's managed health care program, cla heavy losses as well. U.S. Atty. Eileen M. Decker said that fraudulent prescriptions were given to compounding pharmacies, usually for pain medications, and these came with sizable reimbursements, sometimes more than $15,000 per prescription. In many instances, the patients had not requested the medication and had not been seen by the prescribing physician. "TRICAR was the primary target of schemes involving the compounding pharmacies," Decker said. "Prescriptions were written for profit rather than to treat the patient."

The message the federal government sent yesterday to perpetrators or would-be perpetrators of healthcare fraud is unwaveri and undeniably clear. In terms of the sheer number of individuals charged, as well as the dollar amount of false billings, it is th most far-reaching and extensive enforcement action of its kind in U.S. History.

The National Healthcare Anti-Fraud Association (NHCAA) estimates that healthcare fraud is responsible for monetary losses tens of billions of dollars every year.

For more information/questions regarding any legal matters, please emailinfo@nelsonhardiman.com or call 310.203.2800.