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Health care fraud prosecutions reach new high

By: Alicia Gallegos, amednews staff

Federal prosecutions for health care fraud are skyrocketing, on track to rise by 85% by the end of the year, according to a report.

In the first eight months of 2011, the government launched 903 health care fraud prosecutions, according to an analysis of U.S. Dept. of Justice data by the Transactional Records Access Clearinghouse, or TRAC, a data gathering and research organization at Syracuse (N.Y.) University. In 2010, the number of health care fraud prosecutions totaled 731.

The high number stems from a series of large-scale investigations by the FBI and the Health Care Fraud Prevention and Enforcement Action Team. In Puerto Rico alone, 420 people were charged with health care fraud in 2011, TRAC research shows. Among the 50 states, Florida led the nation in fraud activity, accounting for one out of every nine health care fraud prosecutions.

David Burnham, TRAC's co-director, said it appears the government is making special efforts to combat health care fraud. Here are several of the government's recent efforts:

In August, a Government Accountability Office report showed that the Centers for Medicare & Medicaid Services expanded its anti-fraud efforts after receiving increased funding from Congress and reallocating money saved from Medicare contractor consolidations since 2006. The operations include more oversight of Medicare private insurers and drug plans.

In February, the Dept. of Health and Human Services Office of Inspector General launched a 10 most-wanted list featuring the nation's worst offenders to draw attention to the faces behind health care fraud crimes. The list is derived from a pool of more than 170 people accused of health fraud and includes mug shots, identification information and criminal profiles.

In January, HHS outlined renewed strategies aimed at combating fraud under the health system reform law. Those steps include tougher screenings of health care professionals who are planning to participate in Medicaid or Medicare, increased penalties for defendants and the withholding of payments to recipients under investigation.

James Quiggle, director of communications for the **Coalition Against Insurance Fraud**, said the heightened legal actions were part of a trend for the federal government.

"The feds are ratcheting up pressure on several fronts," he said. "New rules are beginning to focus more federal resources on shoring up the system's weak points. Strike forces are taking down large fraud rings in hard-hit regions, and mounting prosecutions are sweeping more swindlers off the streets. It's a frontal assault on an entrenched fraud binge that has freely looted Medicare and Medicaid for decades."

"It's a frontal assault on an entrenched fraud binge that has freely looted Medicare and Medicaid for decades," says James Quiggle, spokesman for the Coalition Against Insurance Fraud.

Coalition Against Insurance Fraud

Burnham pointed out, however, that a surge in health care fraud arrests and charges does not necessarily mean an increase in crime. "There is no way for the government to actually measure the extent of medical fraud in any city or the whole United States," he said in an email.

Meanwhile, federal agents in late August and early September charged 91 health professionals, including 11 doctors, with filing $295 million in false medical claims during a nationwide Medicare Fraud Strike Force operation.

In one case, a federal grand jury returned indictments against 13 people operating and working for the Biscayne Milieu Health Center in Miami. They were charged with conspiring to submit false claims for Medicare services that were medically unnecessary or never provided. The mental health center offered kickbacks to brokers who recruited patients for partial hospital program services, federal officials said.

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