# OIG ANNOUNCES RECORD SETTING FINANCIAL RECOVERIES RELATED TO FY 2012 ENFORCEMENT ACTIVITIES

On November 27, 2012, the Department of Health and Human Services ("HHS") Office of Inspector General ("OIG") released its Fiscal Year ("FY") 2012 Semiannual Report to Congress ("Report") for the second half of FY 2012. The Report describes some of the OIG's major achievements related to the OIG's enforcement, audit, evaluation and compliance work during the second half of FY 2012, as well as provides a summary of the results of the OIG activities throughout FY 2012. This article summarizes some of the key highlights from the Report. For a copy of the complete Report, click here.

## SUMMARY OF OIG'S FY 2012 FINANCIAL RECOVERIES AND ENFORCEMENT ACTIVITIES

For FY 2012, the OIG reported expected recoveries of approximately $6.9 billion from the OIG's investigative and audit activities, including $6 billion in investigative receivables and $924 million in audit receivables. This is up from the OIG's expected audit and investigative recoveries of $5.2 billion in FY 2011, or an increase of more than 30%. In the Report, the OIG also identified approximately $8.5 billion of cost savings in FY 2012 as a result of legislative, regulatory or administrative actions that were supported by the OIG's recommendations.

The OIG also reported 3,131 exclusions of individuals or entities from participation in federal health care programs, 778 criminal actions against individuals or entities that committed crimes against HHS programs and 367 civil actions, which include false claims and unjust enrichment actions filed in various federal district courts, administrative recoveries related to provider self-disclosures and civil monetary penalties settlements.

## KEY OIG INVESTIGATIVE ACTIVITIES IN FY 2012

In the Report, the OIG summarizes some of the significant OIG investigations and settlements that occurred during FY 2012. Some of these investigations and settlements include the following:

- *Hospital Observation Services* - A hospital system agreed to pay $8.9 million to resolve allegations that it violated the False Claims Act. In this case, the government alleged that the hospital admitted patients who did not meet medical necessity criteria for inpatient admission and who only required observation and evaluation. As part of the settlement, the health system also entered into a five-year Corporate Integrity Agreement requiring independent reviews of the system's medical necessity decisions regarding inpatient admissions and lengths of inpatient stays.

- *Pharmaceutical Marketing Practices* - The OIG settled its largest criminal, civil and administrative case in history for $3 billion. Three different False Claims Act settlement agreements in the case resolved allegations that a certain pharmaceutical manufacturer participated in illegal marketing and promotion practices, including promoting several drugs for off-label use, paying kickbacks to induce providers to prescribe certain of the manufacturer's drugs, misleading the public about the safety of certain drugs and violating requirements of the Medicaid drug rebate program.

- *Nursing Home Quality of Care* - A Georgia nursing home operator was sentenced to 20 years in prison and ordered to pay $6.7 million in restitution for billing "worthless" services provided to nursing home residents. During the criminal trial, the government alleged that the services provided to residents were so deficient that the services were "worthless" and of no value to residents. This was the first time that a defendant was convicted in federal court for billing for "worthless" services.

## KEY OIG AUDIT ACTIVITIES IN FY 2012

In FY 2012, the OIG conducted several audits to identify improper Medicare payments resulting from Medicare's failure to effectively identify and reduce erroneous and inappropriate billings prior to payment. Some of the OIG's key audit activities in FY 2012 included the following:

- *DRG Payment Window* - The OIG reviewed outpatient billings associated with inpatient stays and discovered that hospital outpatient providers improperly submitted to Medicare claims for outpatient services provided within three days prior to or during the inpatient admission. The OIG found a 48% error rate, noting that many outpatient providers failed to have controls in place to prevent or detect

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incorrect outpatient billings related to inpatient admissions. The OIG recommended that CMS increase efforts to prevent payments for outpatient services that are already included in the DRG payment for inpatient services.

- *Physician E/M Services* - The OIG found that from 2001 to 2010 physicians increased their billing of higher level, more complex and expensive evaluation and management ("E/M") services and decreased their billing of lower level, lower cost E/M services. During this time period, Medicare payments for E/M services increased 48% compared to 43% for Part B goods and services generally. The OIG encouraged contractors to review physician billings for E/M services, including those physicians who regularly bill for higher level E/M services, and to take appropriate action.

- *Inpatient Rehabilitation Facilities* - In an audit of inpatient rehabilitation facility ("IRF") claims, the OIG found that over 80% of IRFs were overpaid. These overpayments occurred because the IRFs failed to transmit required patient assessment instruments ("PAIs") to CMS within the timeframe required, yet Medicare failed to impose the 25% payment reduction required for late PAI transmissions. The OIG estimated that this issue resulted in over $8.4 million in improper Medicare payments and encouraged CMS to support contractors' efforts to conduct periodic postpayment reviews of IRF claims.

**CONCLUSION AND PRACTICAL TAKEAWAYS**

The OIG's record number of financial recoveries in FY 2012 should signal to health care providers that enforcement of health care regulations is still on the rise. Although the OIG reported expected recoveries in FYI 2012 of approximately $6.9 billion, the OIG estimated that in FY 2011, there were $64 billion in improper payments from the Medicare and Medicaid programs. This suggests that the OIG is still only recovering about 10% of alleged improper Medicare and Medicaid payments. This gives the OIG a high incentive to continue its surge in enforcement activities and recover potential overpayments.

In light of the OIG's continued increase in health care enforcement activities, health care providers should continue taking steps to increase their compliance efforts and reduce potential liabilities. Providers should consider assessing the effectiveness of their compliance programs, conducting internal audits to identify potential high risks areas and developing appropriate corrective actions to minimize potential risk.

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