HEAT Investigations of Health Care Fraud in South Texas

(January 6, 2011): Three Houston-area residents, one of whom is a physician, were sentenced to prison on January 4th for their roles in a multi-million dollar durable medical equipment (DME) Medicare fraud scheme. Each of the three defendants were also ordered to pay restitution to the Federal government, in amounts ranging from $29,052 to $1.4 million.

I. HEAT Investigations are Increasing:

According to DOJ, a Houston-area DME company improperly billed Medicare for power wheelchairs and orthotic devices, beginning in 2003 and continuing until late 2009. In addition to the three co-conspirators sentenced today, a total of eight other individuals were convicted for their participation in the fraudulent scheme. One of the eight included the owner of the DME company. At trial, Federal prosecutors were able to show that a variety of fraudulent actions had been taken by members of the group, ranging from the payment of illegal kickbacks to the prescription of medically unnecessary devices.

II. HEAT Investigations of Fraudulent Health Care Providers in South Texas are Increasing:

Notably, this was just the latest case investigated by members of the DOJ / HHS-OIG / MFCU *Health Care Fraud Prevention and Enforcement Action Team* (HEAT). This strike force is responsible for investigating and prosecuting cases throughout South Texas. As DOJ noted:

> ***"Since their inception in March 2007, Strike Force operations in seven districts have obtained indictments of more than 850 individuals who collectively have falsely billed the Medicare program for more than $2.1 billion. In addition, HHS's Centers for Medicare and Medicaid Services, working in conjunction with the HHS-OIG, are taking steps to increase accountability and decrease the presence of fraudulent providers."***

III. Steps You Can Take to Reduce the Likelihood of a HEAT Investigation:

Both Federal and State investigators are aggressively targeting non-compliant providers. South Texas providers who take the time to review and update their current Compliance Plan should also conduct a gap analysis to better ensure that their operational and billing practices fully comply with applicable statutory and regulatory requirements. When is the last time that you have reviewed your medical documentation to ensure that you are fully documenting a patient's medical need for care and treatment services? Are your documentation practices consistent with the 1995 or 1997 Evaluation & Management guidelines? Are any Local Coverage Determinations (LCDs) applicable to the claims you are reviewing? Have you properly coded and billed the claims to be submitted to Medicare for payment? If you cannot answer these questions in the affirmative, your claims are likely not ready to be audited!

Liles Parker attorneys have extensive experience representing health care providers in alleged Medicare overpayment and fraud cases. Should you have questions about our services, give us a call for a free consultation. We can be reached at 1 (800) 475-1906.