APRIL 19, 2019

OIG'S FRAUD RISK INDICATOR: STRATEGIC IMPLICATIONS FOR RESOLVING EXCLUSION LIABILITY

The Office of Inspector General for the U.S. Department of Health and Human Services (OIG) recently unveiled the use of a new tool called the Fraud Risk Indicator. OIG's stated purpose behind this new initiative is to provide more transparency to industry stakeholders (e.g., patients, family members, healthcare industry professionals) regarding OIG's risk assessment of a party to a False Claims Act (FCA) settlement and where that particular party falls on the OIG exclusion risk spectrum in cases where there is no corporate integrity agreement (CIA).

OIG has the authority to exclude any individual or entity from participation in the federal healthcare programs if they engage in certain healthcare fraud conduct. The government's primary tool for enforcing healthcare fraud violations is the FCA. Most FCA cases where the government alleges fraudulent conduct are resolved through settlement agreements in which the settling parties do not admit liability. OIG's permissive exclusion authority under section 1128(b)(7) of the Social Security Act is oftentimes implicated in the context of FCA healthcare fraud cases, because conduct that allegedly violates the FCA can also trigger exclusion liability. As a result, OIG is typically a party to FCA healthcare settlements in order to resolve its permissive exclusion authority. In determining whether it should exercise discretion under its exclusion authority, OIG evaluates future risk to the federal healthcare programs based on information gathered during the FCA case and applies certain factors and exclusion criteria to assess where a settling party falls on the OIG risk spectrum.

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