

Examples of Medical False Claims Act Violations That Will be Prosecuted

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The False Claims Act was enacted during President Abraham Lincoln's administration. The initial aim of the act was to help the government recoup false billings involving the Department of Defense. The scope of the Act has since been expanded to include many types of government claims – especially healthcare fraud claims. False Claims Act cases that affect the medical sector include:

- **Fraudulent medical claims.** False claims involving medical care, medical diagnosis, medical treatments, medications, medical supplies, and medical equipment
- **Violations of the Stark self-referral laws and the Anti-Kickback Statute.** These violations include improper payments for referrals and non-cash payments. Many types of acts may violate Stark or Anti-Kickback laws. There are exceptions and safe harbors to Stark and the Anti-Kickback Statute respectively that an experienced healthcare lawyer can explain.
 - Under Stark Law, physicians (and immediate family members) who have a financial relationship with an entity that provides “designated health services” can't refer patients to that entity and the entity can't bill Medicare or Medicaid – unless an exemption is allowed. Medicare and Medicaid rely on medical services being based on the legitimate needs of the patient and not the profit incentive of the physicians. Examples of Stark violations include interest-free loans, medical directorship pay that is more than the value of the medical advice provided, improper discounts, and other improper transactions.
 - The Anti-Kickback Statute is also aimed at making sure referrals are based on the needs of the patient and not the financial interests of the physicians making the referrals. The Statute makes bribes illegal. It also makes it illegal to offer inducements to obtain referrals for medical services and treatments that will be reimbursed by a federal health care program. Both the person encouraging the referral and the person making the referral can be held liable. Improper inducements include almost anything that encourages a referral based in return for some type of remuneration. There are safe harbors which define practices the Department of Health and Human Services allows – based on the idea that they won't affect the needs of the patient. Experienced health care lawyers can explain what safe harbors are available and what steps should be taken to meet the formal safe harbor definition. For example, a safe harbor applies to renting office space and equipment provided the lease agreements are in writing, reflect fair market value, and aren't based on the volume or the value of the referrals.
 - Doctors, hospitals, pharmacists, and other health providers generally must certify that they are in compliance with Stark Law and Anti-Kickback Statute before they can submit claims to Medicare, Medicaid, TRICARE, CHAMPVA, and other federal health programs.
 - The certification requirement means that bills submitted to federal health care programs where the health provider violated Stark or the Anti-Kickback Statute are deemed false claims under the False Claims Act.
 - Lots of types of fraud
- **Medicare fraud** which generally involves treatment of patients that are 65-years old and up and people with disabilities. It also includes Part D fraud.
- **Medicaid fraud** which generally involves people with federal health insurance because of low income.

The False Claims Act also applies to hospital fraud, pharmaceutical fraud, medical spa fraud, and other types of medical fraud

To prove a violation of the False Claims Act, the Department of Justice or an individual must generally show that the defendant knew he claim for payment was false and used false records or materially false statements.

Types of medically-related false claims acts in the healthcare sector include:

- False billing
- Billing for services never rendered
- Billing for services that weren't necessary
- Improper coding for services

Several cases show that the hospitals, doctors, and other health providers will be prosecuted if they provide medical services that are deemed medically unnecessary or if fraudulent claims are submitted.

Department of Justice Settles False Claims Act Charges for More Than \$15.6 Million Against 16 Hospitals

On May 7, 2015, the Justice Department announced that a settlement was reached in the Eastern District of Arkansas for charges that 16 hospitals submitted false claims for Medicare payments. The principal deputy assistant attorney general for the Civil Division of the Department of Justice said, when announcing the \$15.69 million settlement that:

Hospitals that participate in the Medicare program must ensure that the services they provide and bill for are based on the medical needs of patients rather than the desire to maximize profits. The Department of Justice is committed to ensuring that those who seek to abuse the Medicare program will be held accountable for their actions.

The lawsuit, which was brought by a whistleblower, involved claims for "Intensive Outpatient Psychotherapy." This therapy should be aimed at helping people with mental disorders after they have received ambulatory psychiatric services. Medicare does pay for IOP treatment provided the services are "reasonable and necessary for the diagnosis and treatment of the patient's condition."

The lawsuit claimed that the hospitals, between 2005 and 2013, knowingly submitted false claims. The claims were improper because:

- The patient's condition did not qualify for IOP;
- The patient's treatments were not provided pursuant to an individualized treatment plan designed to help the patient address specific mental health needs and reach achievable goals;
- The patient's progress was not being adequately tracked or documented;
- The patient received an inappropriate level of treatment;
- The therapy provided was primarily recreational or diversional in nature, and not therapeutic.

Allegiance Health Service, located in Shreveport, Louisiana, provided the IOP services on behalf of the providers. The providers who were the defendants in the False Claims Act lawsuit were Health Management Associates Inc. (HMA), and 14 hospitals that Health Management Associates, Inc. owned and operated. The 14 hospitals were located in Mississippi, Texas, North Carolina, Georgia, Florida, Oklahoma, and Arkansas. Another medical center based in Texas was also a defendant. Similar allegations against "LifePoint Hospitals Inc. and two of its subsidiaries, PHC-Minden L.P., doing business as Minden Medical Center, and PHC-Cleveland Inc., doing business as Bolivar Medical Center" were settled for \$4,672,469.80 in October 2013.

A representative of the US Department of Health and Human Services-Office of Inspector General added that

Our agency is dedicated to investigating health care fraud schemes such as this, which divert scarce taxpayer funds meant to provide for legitimate patient care, including services for the often underserved mentally ill population.

The whistleblower, more formally called a relator, was awarded \$2,667,300. Between January 2009 and the date of the press release, May 7, 2015, the Justice Department has used the False Claims Act to recover \$24 billion. **More than \$15.3 billion of that \$24 billion were recoveries that involved allegations of “fraud against federal health care programs.”**

24 Defendants Charged with Schemes Involving Distribution of Opioids and Dangerous Narcotics

The Department of Justice announced on July 13, 2017, that 24 defendants were charged, after the unsealing of three indictments, with schemes intended to divert pharmaceutical pills to the streets.

The unsealing of the indictments is part of a broad health care fraud enforcement action by the Medicare Fraud Strike Force that involves 412 charged defendants across 41 federal districts. The defendants include 115 doctors, nurses, and other licensed professionals. The fraud involves \$1.3 billion in false billing mostly for the roles of the defendants in prescribing and distributing opioids and other dangerous narcotics.

The Acting US Attorney for the Eastern District of Arkansas said that

The abuse of prescription medication, particularly opioids, is one of the largest health and crime problems Arkansas is facing, Harris said. This epidemic must be attacked on multiple fronts—by stopping the criminal doctors and medical professionals from writing medically unnecessary prescriptions, and by preventing the common drug dealers from diverting these pills to the hands of other addicts and dealers, either by writing fraudulent prescriptions or stealing dangerous drugs from pharmacies. The defendants in the cases announced by my office today illegally put hundreds of thousands of pills on the streets, and they must be stopped.

The three indictments were based on the following:

- **Indictment number one.** Four defendants were charged with conspiracy to break into a business premises registered with the DEA to dispense controlled substances. The DEA uncovered a string of related pharmacy burglaries.
- **Indictment number two.** A federal grand jury charged three defendants with conspiracy charges based on fabricating prescriptions to obtain oxycodone worth more than \$150,000.
- **Indictment number three.** A defendant was charged with creating fraudulent prescriptions using computer templates that were then filled at local pharmacies.

The press release stated that the charges were aimed at targeting schemes involving false claims with Medicaid, Medicare, and TRICARE. The opioid epidemic is continuing to take lives. The CDC data states that approximately 91 Americans die every day of an opioid related overdose.

Married Physicians Indicted for Healthcare Fraud

On April 2, 2014, the US Attorney for the Eastern District of Arkansas, announced that two married doctors were indicted by a federal grand jury for conspiring to commit healthcare fraud and for six acts of healthcare fraud. The male doctor was also charged with four acts of making false healthcare statements. The indictment asserts that the married doctors worked with a massage therapist who billed health insurers for physical therapy. The fees were then split between the therapist and the doctors. The male doctor was also charged with billing for therapeutic ultrasounds – even though that test was never conducted.

The false claims to Medicare and Arkansas’s Blue Cross and Blue Shield totaled more than \$1.2 million. The penalties could include up to 10 years in jail on each of the six healthcare fraud counts and another 10 for the conspiracy.

While settlements are not an admission of liability, the amounts of the payments are quite substantial. In addition to restitution

for improper payments.

Healthcare providers need to review with experienced lawyers the federal and state laws that regulate how bills and requests for payments are submitted. They need to understand what acts constitute violations of billing, self-referral, and kickback laws. Skilled healthcare lawyers can explain when exemption and safe harbors may apply. They can help craft a compliance program. Failure to comply with these can be quite severe:

- False Claims Act payments include civil fines and penalties. Federal penalties can amount to three times the amount of the claim. Additionally, health providers can be precluded from working with Medicare and Medicaid in the future.
- Stark Law violations can result in a restitution requirement, denial of the requested payment, and additional civil fines.
- Anti-Kickback Statute penalties include substantial fines and up to five years in prison for each violation.

WHAT HEALTHCARE COMPLIANCE PROGRAM POLICIES AND PROCEDURES SHOULD BE INCLUDED IN HEALTHCARE COMPLIANCE PROGRAM?

Health care governing boards can look to “Practical Guidance for Health Care Governing Boards on Compliance Oversight” for advice in designing a compliance program.

For a thorough review of the laws and regulations that affect your type of medical practice, speak with an experienced healthcare lawyer – one who has advised a broad range of clients. For help now, contact [Cohen Healthcare Law Group PC](#) at 310-844-3173 or fill out our [online contact form](#) to schedule an appointment.

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