MOUNTING CONCERN FOR THE WAR ON HEALTH CARE "FRAUD"

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In the nearly 50 years since the government created national health insurance for the poor (Medicaid) and for the aged or disabled (Medicare), governmental expenditures for these programs have mushroomed.

A significant portion of this growth in governmental health expenditures is perceived as caused by health care fraud and abuse. Recent studies suggest that the annual loss due to health care fraud or abuse is "as high as 10 percent of our nation's annual health care expenditure." Accordingly, the government has launched a determined and expansive war against health care fraud and abuse.

Given a primary need to avoid an allegation of "fraud", it may be firstly helpful to understand how "fraud" is defined. One statute defines "fraud" as "an intentional deception or misrepresentation made by any person" ... "with the knowledge that the deception could result in some unauthorized benefit to that person or another person, including any act that constitutes fraud under applicable federal or state law." (emphasis supplied). On the other hand, provider practices are said to be "abusive" when they: (1) are "inconsistent" with sound fiscal, business or medical practices or (2) result in unnecessary costs to Medicaid, or (3) consist of services that are not medically necessary and/or (4) fail to meet professionally recognized standards for health care. (emphasis supplied). This term also includes recipient practices that result in unnecessary costs to Medicaid.

Since the 1970's we have experienced the multiplication of federal and state anti-fraud and anti-abuse statutes, of which the 2010 health reform law known as the Patient Protection and Affordable Care Act (ACA) is only the most recent.

This complex maze of laws and regulations impose ever more stringent compliance obligations on health care providers, their employees and agents.

The False Claims Act (FCA) was initially enacted during the Civil War era and has been amended several times. Most recently Congress has substantially expanded the FCA's reach in the Fraud Enforcement and Recovery Act of 2009 (FERA) and the Affordable Care Act of 2010 (ACA). Under the FCA, sanctions for filing a false claim include up to three times the program's actual losses plus penalties of $11,000 per claim. Moreover, if such a claim results from a kickback or payment for a referral and is false or fraudulent, federal law also makes relevant the Criminal FCA, which provides for imprisonment and fines. Fines include up to $50,000 per kickback plus 3 times the amount of remuneration, plus exclusion from participation in the federal health care programs.

The physician self-referral law, known as the Stark Law, basically prohibits a physician from referring patients to receive further health services, payable by Medicare or Medicaid, in which the physician or an immediate family member has a financial interest. As the Stark Law is a strict liability statute, proof of a specific intent to violate the law is not required.

Under the Civil Monetary Penalties Law (CMPL) the government may seek civil monetary penalties ranging from $10,000 to $50,000 per violation, and/or exclusion for a wide variety of conduct, including presenting a claim that a person knows or should know was false or fraudulent, or that the person knows or should know was for an item or service for which payment may not be made.

Sweeping changes to federal health care and abuse laws contained in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) include the creation of a criminal offense of "health care fraud". Prior to 1996 the criminal laws prohibited knowingly and willfully making or causing to be made any false statement or misrepresentation of material fact in any application for Medicare or Medicaid benefits. With HIPAA, criminal penalties for fraudulent billing activities were expanded to all claims involving any "federal health care programs". When the fraudulent activity is perpetrated by the provider of services the crime is considered a "felony" and the perpetrator may be fined up to $25,000 or imprisoned not more than five years, or both.

While federal enforcement efforts have focused on fraud against government health care programs, authorities have begun to use the new HIPAA "health care offense" to address fraud against private health insurance providers as well. Reportedly, for example, a New Jersey medical doctor was convicted of health care fraud for billing private insurers for electro-diagnostic testing of auto accident victims when such testing was not necessary and/or not even performed. The doctor was sentenced to three years in prison and ordered to pay $2,126,200 in restitution. And, the doctor was further required to surrender his licenses to practice medicine in New Jersey and New York and was excluded from participation in federal health care programs for a minimum of 25 years.

Additionally, New Jersey, and other states, have established state agencies to prosecute Medicaid fraud.

The Civil False Claims Act (FCA) can result in significant liabilities to health care providers who submit false Medicare or Medicaid claims. And, it has been stated that,

> "[t]he FCA's combination of treble damages and penalties of $5,000-$10,000 per claim, increased for inflation, easily leads to

> potential liability in individual cases that is many multiples of the government's loss. A representative example is United States v. Lorenzo, [768 F. Supp. 1127, E.D. Pa. 1991], where a dentist received $130,719 in Medicare reimbursement for upcoded claims, but the government's recovery in a FCA case against him totaled nearly $19 million ... Because of the size of potential liability, however, even FCA settlements regularly reach into the millions, tens of millions, and even hundreds of millions of dollars ..."[1]

Since the revision of the FCA in 1986, federal authorities have used it to reap growing recoveries against suspected fraudulent health care providers. In 2010 the government secured $3 billion in penalties for false claims. Two years later, in 2012, the federal authorities reportedly won $5 billion dollars in civil false claims recoveries. FCA claims against health care providers have risen dramatically and have resulted in staggering monetary penalties.

The extent of potential liability is striking, but it is not the whole story. The thoroughness and expansiveness of the government's war on health care fraud and abuse is further manifested by the surprising punishment of transgressions that merit particular attention.

In 2009 Congress amended the FCA in the Fraud Enforcement and Recovery Act of 2009 (FERA) to expand offenses. These FERA changes have targeted a provider's retention of overpayments. Section 6402(a) of the Affordable Care Act (ACA) of 2010 now requires the reporting and returning of overpayments the latter of either 60 days after the identification of an overpayment or the date any corresponding cost report is due. Significantly, the ACA clarifies that the return of the overpayment is an affirmative "obligation" for the purposes of establishing FCA liability. For the first time the return of an overpayment was referred to as a government recovery right. The ACA clarified the meaning of "obligations" by explicitly defining legal requirements regarding overpayments.

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[1] Health Care Fraud and Abuse Compliance Manual, Section 3-2c, page 2:45, by Christina W. Fleps, J.D., M.B.A., Wolters Kluwer Law & Business, Supplement #25, November 2011.

Medicare Parts A and B both contain provisions for deductibles and co-payments in connection with services provided. Absent a determination that the beneficiary faces substantial hardship or that cost-sharing amounts are uncollectible, a provider is not at liberty to waive these amounts. And, the provider must make a reasonable effort to collect such amounts before concluding that they are "uncollectible". The reasoning is that when such payments are waived, the actual charge becomes lower than the billed charge. The government's position is that it is being defrauded, because it is being caused to pay the full actual charge instead of the charge minus the deductible and co-payment. At one point the OIG explained as follows in a Special Fraud Alert:

> "A provider, practitioner, or supplier who routinely waives co-payments or deductibles is misstating its actual charge..."

In 2011 the government published a new compliance guidance document for physicians entitled "Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse" ("Roadmap"). Generally the Roadmap describes some of the following types of improper claims:

- Billing for services not actually rendered;
- Billing for services that were not medically necessary;
- Billing for services performed by an improperly supervised employee or unqualified person;
- Billing for services performed by someone who has been excluded from participation in the federal health care programs;
- Billing for services of such a low quality that they are virtually worthless;
- Billing separately for services that have already been included in a global fee; and
- Upcoding use of billing codes that reflect a more severe illness than actually existed or a more expensive treatment than was provided.

The Roadmap further advises physicians to maintain accurate and complete medical

records and documentation of services, and to ensure that claims they submit are supported by documentation. Perhaps opening up a new ground for alleging fraudulent billing, the Roadmap ominously warns that,

"[i]f you didn't document it, it's the same as if you didn't do it."

Another pitfall involves the area of "exclusion violations". For all providers, entering into relationships with individuals and entities who have been excluded from participation in governmental health programs presents an important - - but easily avoided - - risk. The government publishes a list of all exclusions on its website at http://www.oig.hhs.gov/fraud/exclusions/list of excluded.html. All health care providers should consult the list before entering into a new business relationship - - employment or contracting - - with another practitioner or provider. Even if one engages in no fraudulent or improper billing, if he/she is involved with or has employed an excluded practitioner, that alone could generate a substantial penalty.

By way of an illustration of this problem, in 2011 a national pharmacy chain agreed to pay $969,230 to resolve FCA allegations based on billing Medicare and Tri-Care for prescriptions dispensed by an excluded pharmacist at three stores in New York and New Jersey. The pharmacist had been excluded from federal programs in 2004 based on his criminal conviction in New York State, but the pharmacy had failed to investigate this circumstance.

The lesson is that one must remain alert to avoiding a risk of "fraud", which may not be blatant or a product of egregious dishonesty. By analogy it is similarly important to remain alert to the receipt of overpayments by the government and to timely return these. And, it is important to avoid doing business with an excluded practitioner. Finally, as noted above, remain alert to

careful documentation and the organization of records. One's innocent intent is not itself a complete defense to a charge of "fraud".