2013 Already an Active Year in Health Care False Claims Act Settlements

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A False Claims Bulletin

Following a record-breaking year for False Claims Act (FCA) settlements and judgments in 2012 (see Bricker & Eckler's January 25, 2013 Bulletin), the first five weeks of 2013 show that we should expect more of the same this year, particularly in the health care arena. Of the more than $4.9 billion recovered by the government in 2012, more than $3 billion was from health care cases.[1] Already in 2013, the government has settled a diverse range of health care fraud cases involving a variety of allegations of lack of medical necessity, failure to follow other billing regulations and the payment of inducements for referrals.

Some Noteworthy Settlements So Far in 2013

Insufficient Physician Supervision. A collection of companies operating under the Open MRI name in Georgia have agreed to a settlement with the Justice Department of more than $1.2 million to settle allegations that the facilities performed hundreds of MRI procedures without the required physician supervision and billed various government payers for those procedures between 2007 and 2011.[2]

The Open MRI companies performed MRIs with contrast on numerous patients with only clerical staff and technicians onsite and no physician immediately available, in violation of Medicare supervision rules. Medicare, Georgia Medicaid, TRICARE, and the Federal Employees Health Benefit Program were then billed for these procedures. Even though there were no substantive allegations of insufficient medical necessity in these procedures (a common claim in alleged FCA violations), Open MRI still generated potential false claims by submitting bills for procedures for which it failed to meet the government's conditions of payment by providing insufficient supervision.

This case also serves as a reminder that FCA settlements and investigations in the health care field can involve claims submitted to a variety of government payers, not just Medicare. Here, as is typical, FCA settlements can have long-lasting consequences and administrative and financial burdens beyond the immediate dollar value of the settlement. In this case, besides the $1.2 million settlement, the government entered into a five-year corporate integrity agreement with Open MRI to prescribe its conduct and ensure future compliance.

Utilization of Excluded Providers. Burlington Health and Rehabilitation Center and St. Johnsbury Health and Rehabilitation Center, two nursing homes in Vermont operated by Revera Health Systems, entered into a nearly $250,000 settlement with the Justice Department for allegedly employing nurses excluded from participation in federal health care programs and using those nurses to provide patient services.[3] Medicare and other government payers will not reimburse providers for services provided by excluded persons.

Because the responsibility is on provider facilities to follow this rule, when employing or contracting with any type of health services personnel or company, providers should always consult the Department of Health and Human Services Office of Inspector General's on-line database of excluded persons and entities. This is a relatively simple step, but can avoid an investigation or potentially substantial settlement.

Disguised Payments to Induce Referrals. Cooper Health System (Cooper) of New Jersey entered into a $12.6 million settlement with the Justice Department and the State of New Jersey regarding financial arrangements Cooper had with physicians who served on the Cooper Heart Institute Advisory Board (Board).[4]

The government alleged that: 1) these payments were in excess of the fair market value for the services provided by the physicians, 2) that at least one purpose of the payments was to induce the physicians to refer federal health care business to Cooper, and 3) that the payments did in fact cause one or more of these physicians to refer business to Cooper.

The FCA action was brought by a whistleblower associated with Cooper – one of the physicians recruited to sit on the Board. Unlike in some cases where the whistleblower is a disgruntled physician excluded from an allegedly prohibited relationship, here the physician was offered a spot on the Board but declined and, feeling that the compensation arrangement was not appropriate, chose to become a whistleblower.

The Cooper settlement is a good reminder that even if an agreement is otherwise valid and for legitimate, needed services, the compensation paid must be fair market value and cannot be intended to influence referrals from the physicians to whom it is paid. The purpose of directing referrals does not need to be the sole purpose of the agreement, but merely one of the purposes of the agreement and the compensation. In order to safeguard against and minimize the risk of whistleblowers, providers should make sure their internal compliance policies are robust and that opportunities for employees to bring concerns to the attention of management within the organization are frequent and, where warranted, result in real compliance action by the organization.

Recommendations for 2013

The government has realized real financial gain from prosecuting health care fraud and will continue to aggressively pursue this area in 2013. To avoid such attention, organizations should continue to strengthen their internal compliance programs, cultivate good, open relationships within the organization, and foster a compliance culture where every member of the organization feels comfortable and listened to in internally reporting compliance issues. Organizations should also be proactive in searching out compliance issues internally and correcting them or, where an accepted protocol or mechanism is available, self-reporting such compliance issues to the government.

Footnotes

1. Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Justice Department Recovers Nearly $5 Billion in False Claims Act Cases in Fiscal Year 2012 (Dec. 4, 2012).
2. Press Release, United States Attorney's Office, So. Dist. of Georgia. Open MRI in Brunswick, Douglas, and Savannah Pays More than $1.2 Million for False Medicare Claims (January 11, 2013).
3. Press Release, United States Attorney's Office, District of Vermont. United States and State of Vermont Settle With Two Nursing Homes Over Employment of Banned Persons (January 24, 2013).
4. Press Release, United States Attorney's Office for the District of New Jersey, Major New Jersey Hospital Pays $12.5[sic] Million to Resolve Kickback Allegations (January 24, 2013).

Authors