Drum Beat of Health Care False Claims Act Settlements Continued in February

March 19, 2013

A False Claims Bulletin

The United States Department of Justice announced a number of False Claims Act health care settlements in February. These settlements involved a wide array of allegations, including double-billing, improper physical therapy billing, accepting illegal kickbacks, and medically unnecessary admissions for short stays.

Double-Billing of Certain Psychiatric Services

St. Luke's-Roosevelt Hospital Center, Continuum Health Partners, Inc., and SLR Psychiatric Associates (collectively, St. Luke's) in New York agreed to a settlement with the Department of Justice in the amount of $2.325 million to settle allegations that St. Luke's double-billed for certain psychiatric services.[1]

The services were rendered at SLR, a St. Luke outpatient mental health clinic. The double-billing occurred in two ways: (1) the hospital received reimbursement for non-reimbursable costs relating to outpatient psychiatric visits conducted by SLR; and (2) the hospital billed out-patient psychiatric services to Medicaid as a rate-based service, which included the care provided by the physician and all other related costs. At the same time, SLR billed on a fee-for-service basis for the same care provided by the physician. Applicable regulations provide that "[t]he costs of routine physicians' services are included in facilities' rate or fee and shall not be billed separately."

Improper Billing for Physical and Aquatic Therapy Services

The Department of Justice announced a settlement with Todd Roberts of Old Saybrook, Connecticut, and his physical therapy practice, Roberts Physical and Aquatics Therapy (Roberts Therapy) in the amount of $328,828 to settle allegations of improper billing for physical and aquatic therapy services.[2] Medicare pays for outpatient therapy services if they are provided by physicians, licensed physical therapists, or licensed physical therapy assistants.

In addition, Medicare regulations state that therapeutic procedures require direct, one-on-one contact between the licensed therapist and the patient. The services must be thoroughly and accurately documented in the patient's chart. The government alleged that physical therapists and their assistants at Roberts Therapy routinely provided services to multiple patients at the same time. The services provided to each patient were billed as if the physical therapist or physical therapy assistant had provided direct, one-on-one care.

Moreover, Roberts Therapy routinely failed to document their services. Mr. Roberts was also sentenced to three years of probation for obstructing the federal audit. When Mr. Roberts learned that a Medicare contractor was auditing his practice, he instructed an employee to delay the audit by telling the contractor that medical records were stored at a nonexistent storage facility. He then rented a storage unit and used the delay to alter patient records.

Accepting Illegal Kickbacks from a Pathology Laboratory

The Department of Justice recently announced one of the largest settlements with an individual under the False Claims Act in United States history. Steven J. Wasserman, M.D., agreed to pay $26.1 million to settle allegations that he violated the False Claims Act by accepting illegal kickbacks from a pathology laboratory and by billing the Medicare program for medically unnecessary services.[3]

The government alleged that Dr. Wasserman entered into an illegal kickback arrangement with a clinical laboratory in an effort to increase the lab's referral business. Dr. Wasserman allegedly sent biopsy specimens for Medicare beneficiaries to the lab Tampa Pathology Laboratory (TPL) for testing and diagnosis. In return, the lab allegedly provided Dr. Wasserman a diagnosis on a pathology report that included a signature line for Dr. Wasserman to make it appear to Medicare that he had performed the diagnostic work that the lab had performed. The government alleged that Dr. Wasserman then billed the Medicare program for the lab's work, passing it off as his own, for which he received more than $6 million in Medicare payments. The government further alleged that Dr. Wasserman performed thousands of unnecessary skin surgeries known as adjacent tissue transfers on Medicare beneficiaries.

Medically Unnecessary Admissions for Short Stays

St. Joseph's Medical Center, a hospital located in Towson, Maryland, has agreed to a settlement with the Department of Justice of more than $4.9 million to settle the hospital's voluntary disclosure that it admitted patients unnecessarily from 2007 through 2009.[4] The hospital disclosed that it had admitted patients for short stays - typically one or two days - that were not necessary based upon the patients' medical conditions. As a result, a larger reimbursement than was proper was obtained for these patients. $4.75 million of the settlement will be paid to the United States, with the remainder going to the State of Maryland.

Recommendations

Health care fraud will continue to be aggressively pursued by the Department of Justice for the remainder of 2013 and in coming years. Organizations should continue to strengthen their internal compliance programs and foster a culture of compliance throughout every department. Employees should be encouraged to bring potential issues to the attention of management so that the issues can be investigated and, if warranted, corrected and self-reported to the government.

Footnotes

1. Press Release, Dept. of Justice, Southern Dist. of New York, *Manhattan U.S. Attorney Files and Simultaneously Settles Lawsuit Against St. Luke's-Roosevelt Hospital Center for Fraudulently Billing Medicare and Medicaid* (February 7, 2013).
2. Press Release, Dept. of Justice, Dist. of Connecticut, *Old Saybrook Physical Therapist is Sentenced, Agrees to Pay $328,828 to Resolve False Claims Act Liability* (February 25, 2013).
3. Press Release, Dept. of Justice, Middle Dist. of Florida, *Florida Physician to Pay $26.1 Million to Resolve False Claims Act Allegations* (February 11, 2013).
4. Press Release, Dept. of Justice, Dist. of Maryland, *St. Joseph's Medical Center Agrees to Pay $4.9 Million for Medically Unnecessary Hospital Admissions* (February 7, 2013).

Authors