Summer is Here and the HEAT is On! The Government's Health Care Fraud Prevention and Enforcement Action Team Has Been Busy!

June 6, 2013

A False Claims Bulletin

Once again, May was a busy month for False Claims Act activity. We saw many settlements and enforcement actions in late April and during the month of May, many of which were the result of the efforts of the Health Care Fraud Prevention and Enforcement Action Team (HEAT), a partnership between the Attorney General's Office and the Department of Health and Human Services to reduce and prevent Medicare and Medicaid financial fraud. This bulletin provides some highlights of these recent activities.

Dialysis Services: False Claims for Epogen "Overfill"

On May 21, 2013, the Department of Justice (DOJ) announced a $7.3 million settlement with U.S. Renal Care to resolve allegations that Dialysis Corporation of America (DCA), which U.S. Renal Care acquired in June 2010, had billed the Medicare program for more Epogen (a drug used to treat anemia) than had actually been administered to patients. The settlement relates to DCA's practice of billing for the Epogen "overfill" that is contained in each vial of the drug to compensate for medication that remains in the vial after extraction and in the syringe after administration. Due to the type of syringe DCA used, it apparently could not extract that "overfill" every time it administered Epogen to its patients, but DCA billed the Medicare for the Epogen as if it had in fact administered the overfill amount. The case originated as a whistleblower (*Qui Tam*) action filed by a registered nurse who had worked in one of DCA's dialysis centered and who had raised concerns internally about the billing practice and was allegedly ignored. The whistleblower will receive $1,314,000 as her share of the government's recovery. Read the DOJ press release on this settlement.

This case serves as a reminder to health care providers to ensure that that they are billing only for what they actually perform or provide. In this case, an employee raised the concern internally and was ignored, costing the company $7.2 million in addition to investigative and legal costs and the cost of implementing and complying with the terms of the corporate integrity agreement the OIG required as a condition of getting a release of the OIG's exclusion authority.

Hospice Services: False Claims for Hospice Crisis Care Services Not Necessary or Not Provided and Hospice Care for Patients who were not Terminally Ill

On May 2, 2013, the DOJ announced that it had filed a false claim lawsuit against Chemed Corporation and its hospice subsidiaries, including Vitas Hospice Services LLC and Vitas Healthcare Corporation (collectively, "Vitas"), the nation's largest for-profit hospice chain. In the lawsuit, the government alleges that Vitas submitted false claims to the Medicare program for crisis care services, which involve skilled nursing services being provided in the hospice patients' homes during a crisis to treat acute medical symptoms enable patients to remain at home. Crisis care services are reimbursed at the highest daily rate for hospice under the Medicare program. According to the government, Vitas billed Medicare for crisis care services not performed and/or that were not medically necessary.

The government alleges that Vitas used aggressive marketing tactics and pressured its staff to increase the number of crisis care days billed to Medicare and cites an example in its press release of a hospice billing for three days of crisis care for a hospice patient, during which time the patient apparently played bingo, calling into question whether the crisis care services were actually necessary (or provided). In addition, the government alleges that Vitas knowingly submitted or caused to be submitted hospice claims for patients who were not actually terminally ill, including one patient whose Vitas records described as "very healthy given her age." According to the government's lawsuit, Vitas paid bonuses to staff based on the number of patients enrolled and for patients admitted for longer lengths of stay and took adverse employment actions against marketing representatives who did not meet monthly admissions goals. This resulted in the admission of patients who did not qualify for hospice care. Read the DOJ press release announcing the lawsuit.

This is another case where the health care provider is alleged to have billed the Medicare program for services not provided. Providers should ensure that they have policies and procedures in place to help prevent and detect improper billing for services, and to encourage staff who suspect improper billing to report their concerns internally so that the provider has the opportunity to address billing issues before the government does.

Convictions for Paying and Receiving Kickbacks

On May 14, 2013, the U.S. Attorney's Office for the District of Massachusetts announced the conviction of Hunter A. Rigsby, a former territory manager for Orthofix, Inc., a company that sold bone growth stimulator medical devices, which are used by patients with broken bones or spinal fusions that are not healing properly. Medicare only pays for stimulators for long bone injuries when at least 90 days have elapsed without clinically significant healing, and only covers certain types of injuries. The territory manager pleaded guilty to health care fraud and paying kickbacks for forging patient medical records to make it appear the claim for the bone growth stimulator was covered by Medicare. For example, the territory manager would falsify the doctors' chart notes to make it appear that the 90-day rule had been satisfied and changing the notes to make it appear that the patient had injuries that were covered. He also forged physicians' signatures on prescriptions for the bone growth stimulator and Medicare Certificates of Medical Necessity and paid kickbacks to health care professionals to induce them to order Orthofix stimulators. While Mr. Rigsby hasn't been sentenced yet, the company itself and others involved in the scheme have been, including Orthofix , which was ordered to pay $42 million in criminal fines and penalties; the former vice president of sales for Orthofix, was sentenced to eight months in prison and ordered to pay $50,000 in fines and forfeiture for paying kickbacks; and a physician's assistant was sentenced to six months in prison and six months home confinement and ordered to forfeit $10,000 and pay a $3,000 fine for accepting kickbacks from Orthofix. Read the press release here.

This case is the poster child for what not to do — paying for referrals, falsifying records and forging signatures — all in the name of getting Medicare payments. We hope that this is an anomaly and that most individuals and corporations doing business in the health care industry in the United States know better.

Drug Company Kickbacks: Honorarium for Speaking at Educational Programs; Payments to Pharmacies in Exchange for Switching Transplant Patients to New Drug

On April 23, 2013, DOJ filed a false claims lawsuit against Novartis Pharmaceuticals Corp. (Novartis) alleging that Novartis paid kickbacks to health care providers in the form of fees paid to physicians and lavish meals for speaking at educational programs that the government alleges were often nothing more than social occasions for the physicians to induce them to write prescriptions for the Novartis drugs. According to the DOJ press release, many of the programs were held in locations that were virtually impossible for any kind of educational presentation, including one held on a fishing trip and another at a Hooters restaurant. In other cases, the physicians were paid even though the sessions were cancelled or where there were few to no attendees and others where no slides about the drugs were shown.

Particularly compelling to the government was the fact that Novartis tracked the rate of its return on investment in terms of the

additional prescriptions for its drugs written by the physicians who participated in the programs, both as speakers and attendees, and noted the highest rate of return was related to the "honorarium" paid to the physician speakers. In addition, DOJ notes in the press release that Novartis was already under a corporate integrity agreement following a 2010 false claims act settlement based, in part, on payments to physicians through speakers programs. This lawsuit stems from a whistleblower complaint filed by a former Novartis sales representative.

In addition to the lawsuit based on the speakers programs, the government filed a second lawsuit against Novartis on April 23, 2013. The second lawsuit alleges that Novartis paid kickbacks to pharmacies to get them to switch transplant patient to a Novartis drug. For more, read the DOJ press release.

The first Novartis case described above is an interesting one as we know that the speaker programs are not, per se, illegal. However, the way Novartis was allegedly conducting these programs calls into question the legitimacy of its program. That Novartis was internally tracking the rate of return on its investment in the speakers programs certainly supports the government's position that Novartis knew that the honoraria paid to physicians for speaking at its educational programs influenced physician prescribing patterns and intended to influence them with the speakers programs. This case, while far from over, should remind health care providers to use caution when tracking referrals to ensure that they are not linking any payments or benefits they provide to referral sources to that tracking.

Authors