No Rest for the Weary: The Feds Have Been Busy Fighting Health Care Fraud!

September 30, 2013

A False Claims Bulletin

On a monthly basis, we publish a roundup of some recent activity involving the False Claims Act and federal health care programs to highlight the types of conduct catching the attention of enforcement agencies and to help our clients avoid the pitfalls that could lead them to be target of future enforcement action. These updates do not contain a full listing of all enforcement actions during the month; rather, we select a few that we believe will be of interest to our clients and other readers. This month, we focus on three recent cases that, in total, resulted in more than $4.6 million dollars being returned to the Medicare program.

First is the government's September 12, 2013 announcement that it entered into a $258,000 settlement with Forest Park Medical Center (FPMC), a physician-owned hospital in north Texas. According to the press release from the United States Attorney's Office for the Northern District of Texas, FPMC did not participate in the Medicare and Medicaid programs, and believed that it did not accept federal funds and was not subject to the Anti-Kickback Statute. Thinking the Anti-Kickback Statute did not apply, FPMC representatives offered and paid excessive remuneration and other things of value to actual and potential referring physicians, including cash and gift cards/coupons for luxury items.

Unfortunately for FPMC, it did treat some patients whose care was paid for by a federal health care program — TRICARE, and the government alleged that the payments FPMC made to these referral sources were to obtain the referrals of the TRICARE patients. In addition to the civil settlement for $258,000, FPMC entered into a Non-Prosecution Agreement with the United States, acknowledging that the United States had sufficient evidence to seek an indictment for offering/paying illegal kickbacks in violation of federal law. As part of the Non-Prosecution Agreement, FPMC had to retain an independent monitor for 24 months to address any compliance issues and review and evaluate inpatient and outpatient claims submitted to all payors. The investigation related to the violations of the Anti-Kickback Statute continues, and no individuals were released from criminal or civil liability as part of the civil settlement and Non-Prosecution Agreement, so it is possible that we will see more enforcement actions related to this case.

Next is a settlement announced on September 13, 2013 involving radiology oncology providers in Pensacola, Florida. The defendants, Gulf Region Radiation Oncology Centers, Inc., Gulf Region Radiation Oncology MSO LLC, Sacred Heart Health System, Inc., West Florida Medical Center Clinic P.A., and Emerald Coast Radiology Center LLC as well as two physicians, Dr. Gerald Lowrey and Dr. Rod Krentel (Defendants), agreed to pay $3.5 million to resolve allegations that they billed the Medicare, Medicaid, and TRICARE programs for radiology oncology services that did not comply with program requirements since the services were provided without physician supervision.

According to the Department of Justice press release, the defendants regularly billed federal health care programs for radiation oncology services that were provided without physician supervision and when, in many cases, the defendant physicians were on vacation or working at another radiation oncology clinic. The government also alleged that the defendants billed for medical services not documented in patient medical records, billed twice for some services, and misrepresented the level of service provided to increase their reimbursement. The billing issues were brought to the attention of the government by a former

employee of Gulf Region Radiation Oncology Centers, who will receive $609,796 as his share of the recovery. Gulf Region Radiation Oncology Centers and the two individual physician defendants also entered into three-year Integrity Agreements with the Office of Inspector General (OIG) in order to monitor their future compliance with federal health care program requirements.

Last, but not least, is the September 17, 2013 announcement that the United States entered into a settlement agreement with Hutchinson Regional Medical Center (Hutchinson) in Kansas to resolve allegations that Hutchinson billed the Medicare program for medically unnecessary hyperbaric oxygen wound therapy services and for hyperbaric oxygen wound therapy services for which patient records lacked adequate documentation of medical necessity. The government also alleged that the Medicare claims for these services "resulted from kickback arrangements between the hospital, at least one of its physicians, and the company that supplied the [hyperbaric oxygen] chambers." While denying the allegations and admitting no wrongdoing, Hutchinson agreed to pay $853,651 to resolve its liability. Hutchinson also entered into a five-year Corporate Integrity Agreement with the OIG to monitor future compliance with federal health care program requirements.

Finally, a bonus case. In case you missed our bulletin earlier this month about the $26 million dollar settlement Shands Healthcare in Florida entered into with the United States, you can read our September 16, 2013 bulletin . The Shands Healthcare case is interesting because the whistleblower was the president of the consulting company that Shands Healthcare retained to help it review its billing for observation services and short inpatient stays. When the consultant did not feel that his client was responding appropriately to the billing issues identified in his company's audit, he filed a whistleblower action and will take home a share of the $26 million settlement as a result.

Authors