A smorgasbord of false claims settlements to start off 2016

March 1, 2016

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This year has started off with a bang; we are seeing numerous interesting and noteworthy settlements of False Claims Act allegations. Below is a roundup of some interesting cases.

Oklahoma ENT doctor agrees to settle Medicaid false claims suit alleging medically unnecessary pediatric surgeries

On January 22, 2016, the United States Attorney's Office for the Eastern District of Oklahoma announced a $275,000 settlement with an otolaryngologist, Dr. Daniel Castro, to resolve allegations that Dr. Castro performed medically unnecessary surgeries on children and then billed the Oklahoma Medicaid program for those surgical procedures and related office services that were not performed as claimed and/or were not medically necessary. The government previously announced a $1.5 million settlement with the Medical Center of Southeastern Oklahoma (MCSO), where Dr. Castro practiced. (MCSO was originally owned by Healthcare Management Associates (HMA) until HMA was acquired by Community Health Systems in January 2014.) The government alleged that Dr. Castro submitted claims to the Medicaid program for surgical procedures called "functional endoscopic sinus surgeries" (FESS) that were not performed as claimed, as well as endoscopic debridement following a FESS that were also not performed as claimed. This case and the one against MCSO was brought to the government's attention by a whistleblower who had previously served as Dr. Castro's office manager and who claimed her employment was terminated, in part, due to raising concerns about Dr. Castro's false claims.

Texas ambulance company owners pay $245,000 to resolve kickback allegations

On January 27, 2016, the United States Attorney's Office for the Southern District of Texas announced settlements totaling $245,000 with two brothers who were the prior and successor owners of a Houston-area ambulance company called National Care EMS. The government alleged that the brothers and their ambulance provider companies paid kickbacks to nursing facilities and hospitals as part of a "swapping" arrangement whereby the EMS companies provided free and heavily-discounted ambulance transports to those nursing facilities and hospitals in exchange for the

right to those facilities' Medicare and Medicaid transport referrals. We have seen a number of settlements with ambulance providers and nursing facilities involving these types of swapping arrangements.

Florida urologist pays $1 million to resolve allegations of medically unnecessary lab tests

On January 29, 2016, the United States Attorney's Office for the Middle District of Florida announced a $1.05 million settlement with David Spellberg, M.D., a board-certified urologist employed by 21st Century Oncology, LLC, a national cancer care provider. According to the Department of Justice (DOJ) press release, Dr. Spellberg submitted claims to Medicare and TriCare for "fluorescence in situ hybridization (FISH) tests, which are lab tests performed on urine to detect genetic abnormalities associated with bladder cancer, that were not medically necessary. Medicare does not consider the FISH test to be medically necessary, unless (1) it is used to monitor for tumor reoccurrence in a patient previously diagnosed with bladder cancer, or (2) after performing a full urologic workup, the physician has reason to suspect that a patient with blood in the urine may have bladder cancer. The government alleged that Dr. Spellberg referred all of the FISH tests he ordered to a lab owned and operated by 21st Century and that he was paid, in part, based on the number of FISH tests he referred to that lab. This case was brought to the government's attention by a whistleblower who was a former medical assistant and had worked directly with Dr. Spellberg. Her share of the settlement with Dr. Spellberg is $199,500. In addition, she also received $3.25 million as her share of the government's $19.75 million settlement with 21st Oncology. The settlement with Dr. Spellberg may not be the only settlement with a physician to come from this case. According to an additional DOJ press release regarding the 21st Century Oncology settlement, there were three other physicians who were also billing for medically unnecessary FISH tests.

Florida radiology center to pay $8.71 million to resolve billing and kickback violations

On January 29, 2016, the United States Attorney's Office for the Middle District of Florida announced an $8.71 million settlement with Rose Radiology Centers, Inc. (Rose) to resolve allegations, brought to the government by two whistleblowers, that Rose billed federal health care programs for radiology procedures that were medically unnecessary and/or furnished in violation of federal law. Among the allegations resolved with this settlement are that Rose submitted false claims by (1) administering contrast dye during MRI scans without proper physician supervision; (2) billing Medicare for diagnostic tests ordered by chiropractors by indicating on the claim form that they were ordered by Rose physicians; (3) performing and billing for radiology procedures that were never ordered by the patients' treating providers, since IDTFs like Rose are not permitted to add any procedures without a written order from the treating physician; (4) billing Medicare for radiology services performed at locations not enrolled in Medicare as if they were performed at different locations that were properly enrolled; and (5) engaging in the practice of

paying kickbacks to referring physicians in the form of lunches, gift cards and tickets to concerts and sporting events in return for their radiology referrals. Rose entered into a five-year Corporate Integrity Agreement with the Office of Inspector General in order to avoid being excluded from participating in federal health care programs in addition to paying the $8.71 million settlement amount. The whistleblowers will share $1.7 million as their share of the settlement for bringing the allegations to the government's attention.

Two Florida compounding pharmacies and four physicians pay $10 million to resolve false claims allegations

On February 11, 2016, the United States Attorney's Office for the Middle District of Florida announced a $10 million settlement with two compounding pharmacies (WELLHealth and Topical Specialists) and four physicians. Topical Specialists was founded by a WELLHealth pharmacist and four physicians and was intended to be a standalone pharmacy. But since it had not been able to contract with government payors, Topical Specialists sent all of its prescriptions to WELLHealth to bill to federal payors. WELLHealth/Topical Specialists made certain compounded prescription creams that they billed federal payors thousands of dollars for, while the actual cost to compound the creams was often just 4-5 percent of the submitted cost. According to the DOJ press release, the four physician owners of Topical Specialists were responsible for 40 percent of the billings by WELLHealth and Topical Specialists, and the pharmacies were making up to 90 percent profit on the prescriptions for pain and scar creams filled by the two pharmacies, many of which the government alleged patients did not even need or use. The government also alleged that the four physician owners recruited other physicians to write prescriptions to be filled by WELLHealth/Topical Specialists by promising to share revenue with them – up to 40 percent of reimbursement, according to the government.

Adventist Health System to pay $2 million in connection with chemotherapy billing

On February 19, 2016, the United States Attorney's Office for the Middle District of Florida announced that Adventist Health System Sunbelt Healthcare Corporation (Adventist) had agreed to pay $2.09 million to resolve false claims allegations related to chemotherapy drug billing. Specifically, the government alleged that Adventist administered portions of single-dose vials of chemotherapy drugs that were left over from administration to prior patients in violation of rules that generally prohibit multiple uses of such single-use vials. The settlement also resolves allegations against Adventist that some platinum-based drugs were administered inappropriately, and that some infusion services were upcoded to reflect that infusions took longer than they really took. According to the settlement agreement and the DOJ press release, some patients had to be admitted for treatment as a result of the alleged conduct. Some of the allegations resolved by this settlement were brought to the government's attention by Adventist itself, while others were brought by a whistleblower who previously worked as an oncology nurse and who

will receive $376,452 as her share of the settlement.

This bulletin was composed by Shannon DeBra. For more information, contact any of Bricker's Compliance, Fraud & Abuse attorneys.