FRAUD AND ABUSE, FROM 30,000 FEET

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Gregory Naclerio, Esq.

When the ball fell in Times Square on December 31st, more than 2007 was ushered in. This year will see the Federal and State governments putting a full court press on Medicare and Medicaid Fraud as well as thefts from private insurance carriers. This overview will give the new practitioner the basics of how health care fraud will be prosecuted. However, as with all fields of law, once the practitioner is familiar with the basics, a detailed course of study of the applicable regulations and case law is required to properly defend your client against allegations of Health Care Fraud.

The WHO: The Prosecution.

Fighting health care fraud is the priority of both federal and state prosecutors. The federal component is generally led by agents of the Health and Human Services, Office of the Inspector General ("OIG"). These agents are specialists in the investigation of health care fraud cases and are usually teamed-up with F.B.I. Agents or Postal Inspectors. The investigative findings of these law enforcement agents are presented to the United States Attorney's Office for prosecution. Each U.S. Attorney's Office has dedicated prosecutors – Health Care Fraud Criminal and Civil Coordinators – to evaluate and if appropriate, commence criminal and/or civil prosecutions.

The State's health care fraud prosecution is vested in the Attorney General's Medicaid Fraud Control Unit ("MFCU"). This office, consisting of auditors, investigators and prosecutors, utilizes the "team approach" in their prosecutions. With a compliment of fraud investigators located within their office, the MFCU commences its own investigations and is also responsible for prosecutions. A new state office, the Office of Medicaid Inspector General ("OMIG"), is primarily responsible for the audit of health care providers suspected of fraud and is obligated to refer potential criminal fraud to the

MFCU.

Recent public criticism of the MFCU coupled with the possibility of increased federal funds if the MFCU reaches certain recovery benchmarks, will usher more investigations and vigorous prosecutions in 2007.

The WHAT: Key Federal and State Health Care Fraud Statutes.
Federal: Private Plans

Prior to August 1996 the Federal government primarily used the Mail Fraud Statute (18 USC 1341) to prosecute thefts from private healthcare insurance carriers. However, as part of the Health Insurance Portability and Accountability Act ("HIPAA") new criminal statutes were passed to combat health insurance fraud in the private sector.

- Health Care Fraud (18 USC 1347)

  This statute is violated by whoever, knowingly and willfully, executes or attempts to execute a scheme or artifice to either *defraud any health care benefit program* or to obtain by means of false or fraudulent pretenses, representations, or promises any money or property from the health care benefit program in connection with the delivery of or payment for health care benefits, items, or services. Violation of this section is a felony punishable by imprisonment of not more than 10 years, a fine or both. If serious bodily injury results from the violation, the imprisonment may be increased to 20 years. If death results the penalty could be as high as life imprisonment.

  A "health care benefit program" is defined as any *public or private plan or contract,* affecting Commerce, under which any medical benefit, item or service is provided to any individual and includes any individual or entity who is providing a medical benefit, item or service for which payment may be made under the plan or contract (18 US §24(b)).

- False Statements Relating to Health Care Matters (18 USC §1035).

This section is violated by anyone, in any matter involving a health care benefit program, who, knowingly and willfully, (i) falsifies, conceals, or covers up by trick, scheme or device material fact or (ii) makes any materially false, fictitious, or fraudulent statements or representation, or makes or uses any materially false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry in connection with the delivery of or payment of health care benefits, items or services. Violation of §1035 results in a fine or imprisonment of not more than five years or both.

- Obstruction of Criminal Investigations of Health Care Offenses (18 USC §1518).

  Anyone who willfully prevents, obstructs, or misleads, delays or attempts to prevent, obstruct, mislead or delay the communication of information or records relating to a violation of a federal health care offense to a criminal investigator violates this section and is subject to a fine or imprisonment not more than five years or both.

  These sections along with the traditional prosecutors staples of conspiracy (18 USC §371), mail fraud (18 USC §1341) and money laundering (18 USC §1956) are among the weapons in the federal arsenal to prosecute commercial health insurance fraud.

Federal: Medicare/Medicaid.

Specifically addressing tools Federal prosecutors have to prosecute Medicare/Medicaid Fraud the following statutes are of note:

- False, Fictitious or Fraudulent Claims (18 USC 287).

  This section is violated by whoever makes or presents to any person or officer in this civil… service of the United States or to any department or agency thereof any claim upon or against the United States or any department or agency thereof knowing such claim to be false, fictitious or fraudulent. Violation of this section subjects a person to not more than five years imprisonment and a fine.

- Criminal Penalties for Acts involving Federal Health Care Programs (42 USC §1320a-7b (a)).
  This section addresses making or causing to be made false statements or representation. Specifically, *inter alia,* whoever (i) knowingly and willfully makes or causes to be made any false statement or representation of the material fact in any application for benefit or payment under a Federal Health Care Program or (ii) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment or (iii) presents or causes to be presented a claim for physician services for which payment may be made under a federal health care program and knows the individual furnished the service was not a licensed physician shall be guilty of a felony and, upon conviction thereof, fined not more than $25,000 or imprisoned for not more than five years or both.

- Medicare/Medicaid Anti-kickback Statute (42 USC §1320a-7b (b))

  Whoever knowingly and willfully *solicits or receives* any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a federal health care program or (b) in return for purchasing, leasing, ordering or arranging for or recommending purchasing, leasing or ordering any good, facility, service or item for which payment may be made in whole or in part under a federal health care program shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years or both.

  Similarly, whoever knowingly and willfully *offers or pays* any remuneration (including any kickback, bribe, or rebate), directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person – (a) to refer an individual to a person for the furnishing of any item or service which payment may be made in whole or in part under a federal health care program or (b) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which

payment may be made in whole or in part under a federal health care program shall be guilty of a felony and upon conviction thereof, shall be find not more than $25,000 or imprisoned more than five years or both.

The Medicare/Medicaid Anti-Kickback Statute ("AKS") was deemed to be so broad that Safe Harbor Regulations *(see infra.)* were promulgated to ensure those who come within the ambit of a Safe Harbor would not be prosecuted for violation of the AKS. Additionally, it should be noted that there are certain statutory exceptions to the AKS. They include (a) a discount or other reduction in price obtained by a provider of service or other entity under a federal health care program if the reduction in price is promptly disclosed and appropriately reflected in cost claimed or charges made by the provider; (b) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services; (c) any amount paid by a vendor of goods and services to a person authorized to act as a purchasing agent for a group and (d) waiver of any co-insurance under Part B of a Federally qualified health care center with respect to an individual who qualifies for subsidized services. (There are several other statutory exceptions to the anti-kickback statutes which should be examined as well.)

- Civil Monetary Penalties (42 USC 1320a-7a).

  The Federal government can also impose Civil Monetary Penalties (CMP's) against any person who knowingly presents or causes to be presented to any officer, employee, agent of the United States or any department thereof or any state agency a claim, *inter alia,* for other services that a person knows or should know was not provided as claimed, including or causing to be presented a claim for an item or service that is based upon a code that the person knows or should know would result in greater payment to the person then the code the person knows or should know is applicable to the item or service actually provided. CMP's are also available where the government is billed for an item or service that the person knows or should know is false or fraudulent or for pattern of medical or other items or services

that a persona knows or should know is not medically necessary.

In addition to any other penalties that are prescribed by law, CMP's provide for a penalty of not more than $10,000 for each item or service, plus an assessment of not more three times the amount claimed for such service may be imposed.

- Exclusion of Certain Individuals and Entities from Participation in Medicare and State Health Programs (42 USC 1320a-7).

  This section known as the "Professional Death Penalty" excludes affected individuals from participation in the Medicare and Medicaid Program for a *minimum* of five years. That period of exclusion can extend as long as 20 years in some egregious cases. Upon termination of the exclusion it is incumbent upon the excluded provider to reapply to the Medicare/Medicaid Program.

  Mandatory exclusion from Medicare or Medicaid can result from:

  - Conviction of program related crimes
  - Conviction related to patient abuse.
  - Felony conviction relating to health care fraud
  - Felony conviction related to controlled substances

In addition, the Secretary of Health and Human Services has the power to *permissively* exclude individuals for, *inter alia:*

- Any conviction relating to fraud
- Conviction related to obstruction of an investigation
- Misdemeanor conviction relating to control substances
- An individual whose license was revoked or suspended by a state agency
- Claims for excessive charges or unnecessary services and failure of certain organizations to furnish medically necessary services.
- Fraud kickbacks or other prohibited activities.
- Failure to grant immediate access to, *inter alia,* to the Inspector General of the Department of Health and Human Services for the purposes of reviewing documents or records or other data

necessary in the performance of statutory functions of the Inspector General or to the State Medicaid Fraud Control Unit.

Federal: The Anti-Kickback Statute: The Safe Harbors:

Health Care providers were becoming more and more concerned that practices they believed to be commercially reasonable could subject them to felony prosecution for violating the AKS. This concern was real as the AKS on its face was exceedingly broad in its scope. It took 15 years for the Providers to convince Congress to authorize HHS to promulgate "Safe Harbors" for "…certain commercial transactions which, while potentially prohibited by the law, would not be prosecuted."[1]

Today, there are Safe Harbors that range from arrangements for space rental to arrangements "between certain qualified managed care plans and their contractors and subcontractors." A full listing of Safe Harbors can be found at www.oig.hhs.gov and then click, Fraud Detection but the most popular Safe Harbors included:

Space Rentals	Sale of Physician Practice
Equipment Rentals	Small Entity Investments
Personal Service and Management Services	Discounts
Practitioner Recruitment	

While the rule is: If you are in a Safe Harbor you will not be prosecuted. However, the fact that you are not does not mean you violated the law. In short, being in a Safe Harbor means you meet *each and every element* of the Safe Harbor requirements and thereby qualify for a "We Will Not Prosecute You for a AKS Violation" card issued by the Government. But you can have a non-safe harbor agreement that still does not violate the AKS.

The safe harbor analogy is appropriate because if you stay in a safe harbor you're guaranteed you won't be captured by the pirates. If you venture out to sea the closer you get to dangerous areas the greater the chance you will get captured by the pirates. It depends on the skill of the Captain (i.e. you) to steer a safe course and avoid capture.

An illustration of a business arrangement will help understand the Safe Harbor concept.

Dr. Neuro, is a Board Certified Neurologist with a specialty in Neuro-Diagnostics. Dr. Neuro provides EMG's, NCV's, SEEP's to ascertain if the patient suffered nerve damage. She works as Chief of Neurology at St. Elsewhere Medical Center.

Dr. Family Medicine owns an office consisting of five treatment rooms and sees a lot of no-fault accident patients. Currently, Dr. Family sends his no-fault patients to Dr. Neuro testing at St. Elsewhere.
Dr. Family suggests Dr. Neuro start her own practice by renting space in his office and he will continue to send her the patients that he currently sends to St. Elsewhere. Dr. Neuro agrees and will rent two treatment rooms from Dr. Family on Tuesday and Wednesdays from 1:00 to 8:00 p.m.

Dr. Family and Dr. Neuro know that each neurological test performed on any patient referred by Dr. Family will let Dr. Neuro bill approximately $1,500. They figure the average referral will generate $3,000 to Dr. Neuro's PC. Dr. Family proposed that the rent for the two treatment rooms (total of 240 sq. ft.) be $7,500/month.

Does this violate the AKS?

No, the AKS only pertains to Medicine/Medicaid billings. Neuro is not a Medicare/Medicaid provider, so the AKS is not applicable.[2]

Now change the facts. Dr. Neuro is a Medicare provider and Dr. Family will send (Medicare Private-Commercial) to Neuro for testing. The rental is still $7,500 per month.

To ensure, this transaction will not be prosecuted as an AKS violation you want to come under a Safe Harbor – the Space Rental Safe Harbor seems to fit. To meet the safe harbor you must meet all five elements. Miss one and you're "Out!"

1. The lease agreement is set out in writing and signed by the parties.

- This could be a two page letter agreement
- A Blumberg Form, or
- Your 53 page standard lease agreement… with Rider.

2. The lease specifies the premises covered.

- Treatment room 3 and 4 consisting of 100 square feet each plus non-exclusive use of waiting room, reception desk, billing areas.

3. If the lease is intended to provide the lessee with access to the premises for periodic intervals of time, rather than on a full-time basis for the term of the lease, the lease specifies exactly the schedule of such intervals, their precise length, and the exact rent for such intervals.

- The space will be rented every Tuesday and Wednesday of each month between the hours of 1:00 p.m. and 8:00 p.m. The rental is $7,500 a month.

4. The lease is not less than one year.

"This lease is for one year," but you can have a no-cause termination clause as long as you do not enter into a new agreement between the parties for one year after termination of the agreement

5. The aggregate rental charge is set in advance, is consistent with "fair market value" in arms-length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare or a State health care program.

For purposes of paragraph (b) of this section, the term fair market value means the value of the rental property for general commercial purposes, but shall not be adjusted to reflect the additional value that one party (either the prospective lessee or lessor) would attribute to the property as a result of its proximity or convenience to sources of referrals or business otherwise generated for which payment may be made in whole or in part under Medicare or a State health care program.

- The rent is set in advance.
- Is it consistent with "Fair Market Value" (FMV) as defined above.

Fair Market Value is a key element in this five-prong test. Can you get a Certified Public Accounting Firm to give you an opinion that $7,500/month for 2 days is Fair Market Value? Is Neuro really paying for space or patients – "That is the Question". Fair Market Value is like Judge Stewart's response to whether he could define pornography "I know it when I see it." Nevertheless, I recommend getting a CPA Fair Market Value opinion letter.

The OIG also posted a Fraud Alerts on its website of particular note in connection with the example above (i.e. "Rental of Space" in Physician's Offices by an Entity or Person to which the Physician refers.)[3] The new health care practitioner would do well to review this alert and other guidance on the OIG website.

Advisory Opinions:

The OIG also accepts individual requests to review an existing or proposed transaction and will issue an Advisory Opinion indicating whether a given set of facts violates the AKS. The procedure to be followed in requesting an Advisory Opinion along with Advisory Opinions already issued appears on the OIG web site. While the opinions only affect the Requesting Parties, a review of past and current Advisory Opinions provide general guidance to all practitioners.

Federal: The Stark Law (42 USCA 1395mm)

"The Limitation on certain physician referrals" – commonly called the "Stark Law" after its sponsor Congressman Pete Stark simply states:

Except as provided in subsection(b) of this section, if a physician (or an immediate family member of such physician) has a financial relationship with an entity specified in paragraph (2), then.

A) the physician may not make a referral to the entity for the furnishing of designated health services for which payment otherwise may be made under this Chapter; and

B) the entity may not present or cause to be presented a claim under this subchapter or bill to any individual, third party payor, or other entity for designated health services furnished pursuant to referral prohibited under paragraph (A).

However, that is where the simplicity ends. Supplementing the Stark Law are the Stark Regulations I (Fed. Reg. Jan., 4, 2001 (Vol 66, No. 3 pp 855-904)) and Stark II Regulations (Fed. Reg. March 26, 2004 (Vol. 69, No. 59, pp16053-16146)) which take the simple premises of the Stark Law and expand its scope.[4] To fully understand the Stark Law you must read the Regulations. There is no getting around that daunting task. From "definitions" to "exceptions" the Stark Law, as explained by the Regulations, needs a lot of study. However, some of the easier concepts to emerge from Stark can be distilled as follows:

1. Stark only applies to "Designated Health Services that are paid for by Medicare/Medicaid. The Designated Health Services (commonly called DHS's) are:

a. Clinical lab services

b. Physical therapy services

c. Occupational therapy services

d. Radiology services, including MRI, CT and ultra sound

e. Radiation therapy services and supplies

f. Durable medical equipment and supplies

g. Parenteral and enternal nutrients, equipment and suppliers

h. Prosthetics, orthotics and prosthetic devices and supplies

i. Home health services

j. Outpatient prescription drugs

k. Inpatient and outpatient hospital services

To clarify these broad services the CPT Codes used to describe DHS's are in the Fed. Reg.[5] (Got to love health law alphabets soup!)

2. To meet a Stark Law exception you must meet each and every prong of the exception. Meeting 4 of the 5 tests for an exception will leave you in violation of the Stark Law.

3. Centers for Medicare and Medicaid Services will also issue Stark Law Advisory Opinions.[6]

Violations of the Stark Law will require refunding of payments received for a prohibited referral; a civil monetary penalty of not more than $15,000 for each service or a $100,000 civil monetary penalty for a "circumvention scheme." Also, exclusion from the Medicare/Medicaid programs can occur.

If you are not dealing with a service paid by Medicare/Medicaid, you still may need to examine the New York State Law for physician referral.

New York State: The Healthcare Practitioners Referral Act

New York State also believes that physicians who have a financial interest in certain ancillary services may engage in patterns of over utilization. Hence, New York passed the Health Care Practitioners Referral Act codified at 238 et seq. of the Public Health Law (PHL). Sometimes called the "State Stark" or "Mini-Stark," the PHL states that:

(a) a practitioner authorized to order clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services may not make a referral for such services to a health care provider authorized to provide such services where the practitioner or immediate family member of such practitioner has a financial relationship with such health care provider;

(b) a health care provider or a referring practitioner may not present or

cause to be presented any individual or third party payor or other entity a claim, bill, or other demand for payment for clinical laboratory services, pharmacy services, radiation services, physical therapy services, or x-ray or imaging services furnished pursuant to a prohibited referral.

Like Stark, there are exceptions to the above stated prohibitions. However, unlike Stark there are no regulations which have been promulgated pursuant to §238 to assist in clarifying the exceptions. Violations of §238 will make referring practitioners and the health care provider "jointly and severally" liable to the payor for any amounts collection. Violation of §238 can also be deemed a violation of P.H.L. §12(b) which is a misdemeanor as well as professional misconduct (Ed Law §6530. See, also, Ed Law Regs. 8 NYCRR 29.1 et seq.)

It should also be noted that Section 238-d of the PHL has a provision concerning practitioner disclosure requirements. Specifically, with respect to referrals not prohibited by Section 238 and subject to certain exceptions contained in that section, practitioner may not make a referral to a health care provider for the furnishing of any health or health related item or service where such practitioner or immediate family member of such practitioner has a financial relationship without disclosing to the patient ownership or investment interest with such health care provider or any compensation arrangement between physician and the health care provider which is in excess of fair market value or which provides for compensation that varies directly or indirectly based upon the volume or value of any referrals between the parties.

Fee Splitting

Corporate Practice

[1]See, Federal Anti-kickback Law and Regulatory Safe Harbors, Fact Sheet, Nov. 1999.

[2]The New York State Education Law regarding paying a referral fee may be implicated (Ed Law§ 6530 (18)).

[3]February 23, 2000 Fraud Alert, www.oig.hhs.gov/fraud/fraudalerts.html.

[4]See, www.cms.hhs.gov/physicianselfreferral.

[5]Id.

[6]Id.