The Centers for Medicare and Medicaid Services (CMS), the agency responsible for managing the billing of federal health care programs, has drawn criticism from many for what some politicians are calling an abysmal job of maintaining a healthcare system which reduces fraud. While CMS attempts to discover how to investigate fraud, the Department of Justice (DOJ) is not waiting and has committed itself to investigate and prosecute alleged fraudulent schemes, targeting fraud in overpayments to hospitals and other medical providers, such as physician practice groups. The DOJ has targeted large healthcare providers to small health care practice groups throughout the country including in northern Ohio.

On January 4, 2013, the United States Department of Justice intervened for purposes of effectuating the settlement of a qui tam action (filed under the federal False Claims Act or “FCA”) against a non-profit community hospital system, an independent physician group and two physicians who practiced in Northern Ohio. The suit was originally filed by a former manager of the hospital’s catheterization and electrophysiology laboratory. The complaint alleged that over a five year period the hospital and the physician group performed unnecessary cardiac procedures to Medicare patients. Specifically, the United States alleged that the hospital and the physician group over-prescribed angioplasty procedures, and improperly “unbundled” angioplasty and angiogram services, leading to the routine scheduling of “serial” angioplasties. The Medical Providers were also accused of performing angioplasty and stent services on individuals whose blood vessels were not sufficiently occluded to require such procedures.

The hospital and the physician group agreed to pay the United States approximately $4.4 million to settle the allegations that they submitted false claims to Medicare. As a result of the settlement, the whistleblower, will receive approximately $660,000 of the government’s recovery.

The word is out that the Department of Justice intends to focus its attention on hospital systems and other medical providers like physician practice groups, and the industry will be surprised by the number of whistleblower suits presently filed and awaiting a decision by the DOJ to intervene. Moreover, the industry is no longer looking at threats from low-level employees who are only aware of what they see in their small part of the company. As the above complaint reflects, managers, persons with a broader picture of the scope of wrongdoing and access to emails and other kinds of incriminating evidence, are more than willing to cooperate and are incentivized to make such claims.

Most FCA actions are settled before the complaint is unsealed. And in many instances, the settlement is for twice the amount of the overpayment. However, by statute, the government is entitled to recover treble damages plus a civil penalty of from $5,500 to $11,000 for each false claim submitted — an amount that could easily bankrupt a business.

Over the last four years, the United States has recovered over $13 billion dollars from fraudulent billing in Medicare. Because all stakeholders in the coming debate are going to be looking for ways to save money, more and more pressure will be placed on the DOJ to employ all the tools at its disposal, from civil actions under the False Claims Act to criminal prosecutions, in order to put an end to what the government believes is endemic fraud within the medical industry.

To assist healthcare companies in preventing the whistleblower cases and government action, each healthcare provider should implement an effective compliance program, which is designed to prevent fraudulent billing, illegal kickbacks, and activities which subject a provider to healthcare fraud and the False Claims Act. When DOJ is pursuing a civil healthcare fraud case, as with the False Claims Act, or when it believes that fraud is criminal, the United States Attorneys prosecuting the case, must follow the U.S. Attorney Handbook and Tile 9, “Principles of Federal Prosecution of Business Organizations”. Within this title, 9-28-800 sets the parameters which must be contained within a compliance program for the U.S. Attorneys to evaluate when a company has a compliance program and how the DOJ should analyze the compliance program to determine if it is effective and implemented properly. If the DOJ determines the compliance program has all of the necessary parameters as set forth in 9-28-800 and the act that is being investigated was not intentional or committed with reckless disregard (healthcare provider knew illegal billing or kickback was occurring and just ignored it or covered it up) then the healthcare provider can avoid substantial treble damages and criminal implications.

The parameters set forth within the U.S. Attorney Manual will have to be the cornerstone of any compliance programs of hospital administration and will become a necessary component of any medical practice that receives money from a federal government health program such as Medicare. Pursuant to the Patient Protection and Affordable Care Act (PPACA), the Secretary of Health and Human Services and the Office of the Inspector General are directed to establish core guidelines for such compliance programs for healthcare providers. Although Congress has mandated that these guidelines take into consideration the size of the practice being regulated, no one knows how complicated or expansive these regulations will be, once put in practice. Thus far the only compliance regime that has been mandated under the law applies to skilled nursing facilities and nursing homes. Although HHS has not yet issued regulations these providers, the statute requires these facilities to have an effective compliance program in place by March 23, 2013 and contain the core principles needed to create and implement such programs.

Section 6102 of the PPACA defines a “compliance and ethics program” as a program “reasonably designed, implemented, and enforced so that it generally will be effective in preventing and detecting criminal, civil, and administrative violations . . . and in promoting quality of care.” To that end, a compliance program must include the following elements:
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1. False Claims Act, 31 U.S.C. §§3729-33 (the “FCA” or the “Act”).
2. §3729(a)(1).