**False Claims Act – 2015 Update**

*By Seamus J. McMahon, Esq., Moscarino & Treu LLP*

The United States Supreme Court has held that the False Claims Act “was intended to reach all types of fraud, without qualification, that might result in financial loss to the Government.” *United States v. Neifert-White Company*, 390 U.S. 229, 233 (1968).

On its website, the Department of Justice boasts that, since January 2009, it recovered more than $23.9 billion through False Claims Act cases, with more than $15.2 billion of that amount coming from cases against physicians, hospitals, and others in the healthcare industry. In its press releases advising the public of settlements with healthcare providers, the Justice Department suggests that its ongoing efforts to enforce the FCA are based on three objectives — yielding a recovery for taxpayers, deterring future conduct, and making healthcare more affordable. Whatever the reason, as healthcare providers in different settings, including those with administrative responsibilities, our member physicians need to be cognizant of the FCA, its prohibitions, and the DOJ’s ongoing enforcement efforts. The DOJ is enforcing this law now more than ever and, as reflected below, they are willing to engage the offending providers in litigation to effectuate this enforcement.

The FCA provides, in pertinent part, that: Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government … a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government; (4) improperly pays any person, to induce that person … (b) For purposes of this section, the terms “knowingly” and “knowingly” mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required. 31 U.S.C. § 3729.

While the False Claims Act imposes liability only when the claimant acts “knowingly,” it does not require that the person submitting the claim have actual knowledge that the claim is false. A person who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information can also be liable under the Act. 31 U.S.C. § 3729(b). The following are several examples of settlements reached with the DOJ in the last several months as a result of their ongoing efforts of enforcement.

**Medically Unnecessary Services**

Federal health programs only reimburse for products and services that are medically necessary. Because all health care providers certify to Medicare that their billed services are medically necessary, billing for a medically unnecessary claim is a false certification. In April 2015, two cardiovascular disease testing laboratories agreed to resolve allegations that they violated the FCA by compensating physicians in exchange for patient referrals and billing federal health care programs for medically unnecessary testing. As alleged in the lawsuits, the labs induced physicians to refer patients to the labs for blood tests by paying them processing and handling fees per referral and by improperly waiving patient co-pays and deductibles. As a result, physicians allegedly referred patients to the labs for medically unnecessary tests, which were then billed to Medicare.

**Over-billing**

In March 2015, a heart monitoring company agreed to pay $6.4 Million for alleged overbilling for Mobile Cardiac Outpatient Telemetry (MCOT) services when those services were allegedly not reasonable or medically necessary. The government alleged that the company was aware that MCOT services were not eligible for Medicare reimbursement when those services were provided to patients who had experienced only mild or moderate heart palpitations because less expensive monitors could just as effectively collect the necessary data about those patients’ conditions. The government further alleged that, despite this, the company submitted claims to Medicare for those patients containing the billing code for the more expensive MCOT services along with an inaccurate diagnostic code that misrepresented the true condition of the patients and their need for MCOT services.

**Kickbacks**

In March 2015, an Ohio-based hospital system agreed to pay $10 million to settle claims that it violated the FCA by engaging in improper financial relationships with referring physicians. The settlement involved the hospital system’s financial relationships with a number of referring physicians that allegedly violated the FCA which restricts the financial relationships that hospitals may have with doctors who refer patients to them. The violating physicians allegedly failed to provide sufficiently legitimate management services to have justified the payments that they had received over the period of time reviewed by the DOJ. The hospital-system ultimately disclosed the issues to the government by way of self-reporting.

In February 2015, an Illinois physician pleaded guilty in federal court for receiving illegal kickbacks and benefits totaling nearly $600,000 from two pharmaceutical companies in exchange for regularly prescribing an anti-psychedelic drug — clozapine — to his mostly elderly patients. The physician also agreed to pay the United States and the state of Illinois $3.79 million to settle a parallel civil lawsuit which alleged that, by prescribing clozapine in exchange for kickbacks, he caused the submission of false claims to Medicare and Medicaid for the clozapine he prescribed for thousands of elderly and indigent patients in at least 30 Chicago-area nursing homes and other facilities. The government had alleged that the physician submitted to both Medicaid and Medicare claims for “pharmacologic management” of those patients for whom he prescribed clozapine. However, he allegedly did not engage in meaningful pharmacological management because his prescribing decisions for his clozapine patients were based primarily on the kickbacks he received and not his independent medical judgment or the needs of his patients.

**Inpatient vs. outpatient**

In October 2014, a hospital system with facilities in California, Nevada, and Arizona agreed to settle allegations that 13 of its hospitals submitted false claims to Medicare by admitting patients who could have been treated on a less costly, outpatient basis. The DOJ specifically alleged that those hospitals billed Medicare for inpatient care for patients who underwent elective cardiovascular procedures in scheduled surgeries when the claims should have been billed as outpatient surgeries and that they billed Medicare for patients undergoing elective kyphoplasty procedures that should have been performed and billed as outpatient procedures.

**“Unbundling” or upsoding**

Upcoding occurs when health care providers falsely represent that patients received a more complex or expensive service than what was actually provided. In March 2014, a North Carolina hospital system agreed to pay $1 million to settle allegations under the FCA that it made false claims by: (1) billing the government for services provided by physician (Continued on page 15)
assistants during coronary artery bypass surgeries when the PAs
were acting as surgical assistants which is not permitted under
government regulations and (2) increasing billing by unbundling
claims when the unbundling was not appropriate, specifically in
connection with cardiac and anesthesia services. The allegations
resolved by this settlement arose from a whistleblower lawsuit
filed by a former employee who identified irregularities in the
billing practices of the Hospital.

Although these examples may appear to be extreme, they
should continue to serve as reminder that, when it comes
to violating the FCA, the stakes are high, the government
continues to be vigilant, and the resulting related litigation
can be costly to all involved.