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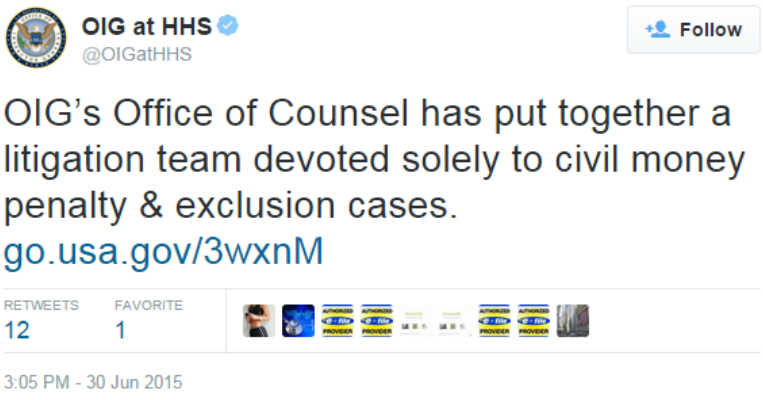
HHS New Litigation Group Focuses on Civil Monetary Penalties, Exclusions

On June 30th, 2015, the Department of Health and Human Services' (HHS) Office of the Inspector General (OIG) announced the creation of a new group of up to 10 attorneys entirely focused on seeking Civil Monetary Penalties (CMPs) and the exclusion from Medicare and Medicaid of health care providers convicted of kickbacks and overbilling. The OIG announced the new group at the annual conference of the American Health Lawyers Association in Washington, D.C., (link here at p.26) and on Twitter.



Purpose of the New Group

OIG created the new group to bring more enforcement actions for Medicare and Medicaid fraud, enforce OIG's industry guidance, and hold individuals accountable for compliance with applicable regulations. By entirely dedicating a team of attorneys to CMPs and the exclusion of fraudulent health care providers from Medicare and Medicaid, OIG officials predict "increased enforcement," and "a lot of kickback cases, both against the payor of the kickbacks…and the recipient of the kickbacks, which tend to be physicians," according to interviews with *Law360*.

Statutory Authority

The secretary of HHS is authorized to seek exclusions and CMPs under the Social Security Act, primarily 42 U.S.C. § 1320a-7a. The secretary of HHS has delegated most of this authority to the OIG. OIG can seek CMPs for several types of conduct, including: (1) presenting fraudulent medical claims for reimbursement by government programs (42 U.S.C. § 1320a-7a(a)(1)(A)-(B)); (2) violating the anti-kickback statute by paying to induce referrals, or getting paid for referrals of medical procedures covered by government programs (42 U.S.C. § 1320a-7a(b); 42 U.S.C. § 1320a-7a(a)(7)); (3) presenting claims that the physician knows she cannot be reimbursed for ("the Stark Law;" 42 U.S.C. § 1395nn(g)(3)); and (4) negligently failing to provide appropriate emergency medical services and treatment (42 U.S.C. § 1395dd(d)(1)(A)-(b)).

OIG has the authority to initiate its own enforcement actions, but also gets referrals of potentially fraudulent conduct from other groups within HHS, self-reported violations from health care providers, and reports from the public through OIG's online fraud reporting tool.

Example Actions

OIG official Robert M. Penezic cited, among other things, a 15-year exclusion and $1.5 million penalty for physical therapy fraud, and a $5 million settlement for urine-test fraud as examples of the types of actions that the new group will pursue.

The 15-year exclusion and $1.5 million penalty for physical therapy fraud resulted from a settlement agreement between OIG and New York/New Jersey Physician Dr. Joseph A. Raia, who also did not admit wrongdoing as part of the agreement. OIG sought CMPs against Dr. Raia because he submitted thousands of physical therapy claims for government reimbursement that either did not actually occur, or could not have occurred. One example included claims submitted for lengthy procedures on the same day that would have taken more than 24 hours if they were done consecutively. Finally, the $5 million settlement for urine-test fraud that Mr. Penezic mentioned was between OIG and Medicus Laboratories LLC, who also did not admit to any wrongdoing. OIG alleged that Medicus submitted claims for lab tests that Medicare does not cover and knowingly presented multiple claims for a single-patient encounter. OIG and Medicus also entered into a 5-year corporate integrity agreement as part of the deal.

Mr. Penezic also mentioned recent settlements with 12 individual physicians who entered into medical directorship and office staff arrangements that did not reflect the fair market value for the services performed, or where the services provided for in the agreements were not performed at all. OIG alleged that these 12 physicians violated the anti-kickback statute because the payments they were receiving reflected the number of referrals they were providing, but had no relationship to the work they were performing. In fact, OIG alleged that these physicians did no work—at all—to earn their referral fee. OIG further alleged that health care entities affiliated with some of the 12 physicians paid the salaries of the physician's front office staff. "Because these arrangements relieved the physicians of a financial burden they otherwise would have incurred, OIG alleged that the salaries paid under these arrangements constituted improper remuneration to the physicians. OIG determined that the physicians were an integral part of the scheme and subject to liability under the Civil Monetary Penalties Law."[1]

Predictions – What This Means for Health Care Providers

The creation of this new group presents a good opportunity for health care providers to revisit their billing procedures

[1] Department of Health and Human Services, Office of Inspector General, *Fraud Alert: Physician Compensation Arrangements May Result in Significant Liability* (June 9, 2015), http://oig.hhs.gov/compliance/alerts/guidance/Fraud_Alert_Physician_Compensation_06092015.pdf.

and their financial relationships with other health care providers to ensure compliance with applicable regulations. In response to the announcement of the new group, a former OIG official said he thought "physician compliance is behind the curve" and that physicians "need to ramp up their knowledge."[2] The dedicated focus of the attorneys in this new group likely means more enforcement, so now is a particularly good time to ensure compliance with the anti-kickback law and other applicable regulations.

Examples of the types of conduct prohibited by the applicable regulations that will likely be the target of the new enforcement group at OIG include: (1) presenting bills to Medicare or Medicaid for medical services that were never actually provided; (2) paying other medical providers to refer clients to you who are covered by Medicare or Medicaid; (3) attempting to get Medicare or Medicaid reimbursement for claims that you know Medicare or Medicaid does not cover; and (4) turning away or not providing adequate service to people in need of emergency medical care who are covered by Medicare or Medicaid.

OIG also recently issued an Alert warning about compensation arrangements like medical directorships. If those arrangements do not reflect fair market value for bona fide services the physicians actually provide, the physicians who have entered into them could be violating the anti-kickback statute, and OIG may come after them.

If you are a health care provider and have questions about the implications of this new group for your compliance policies and procedures, please contact Carolyn McNiven.

This *GT Alert* was prepared by **Carolyn McNiven, Michael J. Cherniga,** and **Thad Houston^**. Questions about this information can be directed to:

- Carolyn McNiven | +1 415.655.1270 | mcnivenc@gtlaw.com
- Michael J. Cherniga | +1 850.425.8505 | chernigam@gtlaw.com
- Or your Greenberg Traurig attorney

[2] James Swann, *HHS Adds New Legal Team Focusing on Monetary Penalties, Exclusions*, BNA HEALTH CARE FRAUD REPORT (July 8, 2015).

Albany
+1 518.689.1400

Amsterdam
+ 31 20 301 7300

Atlanta
+1 678.553.2100

Austin
+1 512.320.7200

Boca Raton
+1 561.955.7600

Boston
+1 617.310.6000

Chicago
+1 312.456.8400

Dallas
+1 214.665.3600

Delaware
+1 302.661.7000

Denver
+1 303.572.6500

Fort Lauderdale
+1 954.765.0500

Houston
+1 713.374.3500

Las Vegas
+1 702.792.3773

London*
+44 (0)203 349 8700

Los Angeles
+1 310.586.7700

Mexico City+
+52 55 5029.0000

Miami
+1 305.579.0500

New Jersey
+1 973.360.7900

New York
+1 212.801.9200

Northern Virginia
+1 703.749.1300

Orange County
+1 949.732.6500

Orlando
+1 407.420.1000

Philadelphia
+1 215.988.7800

Phoenix
+1 602.445.8000

Sacramento
+1 916.442.1111

San Francisco
+1 415.655.1300

Seoul∞
+1 82-2-369-1000

Shanghai
+86 21 6391 6633

Silicon Valley
+1 650.328.8500

Tallahassee
+1 850.222.6891

Tampa
+1 813.318.5700

Tel Aviv^
+03.636.6000

Tokyo¤
+81 (0)3 4510 2200

Warsaw~
+48 22 690 6100

Washington, D.C.
+1 202.331.3100

Westchester County
+1 914.286.2900

West Palm Beach
+1 561.650.7900

^Thad Houston is not admitted to practice law.