Medicare Fraud Civil & Criminal Penalty: Pitfalls and Protections

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Efforts to control the escalating costs of government paid health care are increasingly putting physicians, clinics and hospitals in the crosshairs of both criminal and civil investigations into allegations of Medicare fraud. Physicians and practice administrators must not conclude that because there was no intentional billing misrepresentation, that there is nothing to fear from such investigations. There are proactive measures available that will provide protections from the potentially devastating criminal and civil penalties that are authorized under the law.

Experts estimate that Medicare fraud costs taxpayers from 60 to 100 billion dollars each year. The Government is responding to this fraud in several ways. First, it is implementing fraud programs, such as the Health Care Fraud Prevention and Enforcement Action Team, that treat Medicare fraud as a cabinet-level priority. Second, it is utilizing financial penalties ranging between $5,500 to $11,000 per claim that can cost providers millions of dollars. A Miami physician was sentenced to 235 months in prison and ordered to pay $11.7 million in restitution for participating in a $23 million Medicare fraud scheme. The largest health care system in New Jersey paid $265 million to settle allegations that it fraudulently increased charges to Medicare patients. Finally, the US Department of Health and Human Services ("HHS"), working with the Office of Inspector General ("OIG"), has released plans to conduct investigations into services rendered by non-physicians under Medicare's "incident-to" filing rules.

The first proactive step all providers must take is to review the adequacy of their Medicare and Medicaid billing compliance programs, and if no program is in place, providers need to immediately implement such programs after consulting with their attorneys. The compliance program is always requested in any investigation, and a properly implemented program is not only a defense, but the Attorney General's guidelines require favorable consideration if a compliance program is in place, and an unfavorable consideration when there is no such program. Also, if a physician is criminally prosecuted, the U.S. Sentencing Guidelines allow for a reduction in sentence if there was a compliance program used prior to the alleged criminal activity.

The False Claims Act, 31 U.S.C. § 3729, imposes civil liability on any person who "knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval." For example, a physician who charges for services not rendered or who "upcodes" a service (classifying a procedure as a more expensive one in an effort to obtain a larger reimbursement from Medicare), may be liable under the Act.

A civil action brought under § 3729 can be initiated either by the Attorney General or by private persons on behalf of the U.S. Government (a qui tam action). When a private persons (referred to as a whistleblowers or a relators) initiate an action, they must first serve on the Government a copy of the complaint and a written disclosure of all material evidence and information. Next, the complaint is filed with the court under seal, meaning the complaint is kept secret from the potential defendant. The time from the filing of the complaint to the Court issuing an order unsealing the relator's complaint so the provider can discover the allegations is no less than 60 days, but is more likely to be 18 to 24 months. Such actions require the Government to conduct investigations of the private citizen's allegations of health care fraud and determine whether it will intervene and proceed with the action on behalf of the private citizen. However, because this process takes place while the complaint is under seal, there is a distinct possibility that the Government investigation will begin before the providers are ever aware of the complaint.

Unfortunately, providers who are the subject of these investigations often unknowingly expose themselves to additional liabilities and penalties while attempting to comply with the Government's requests for information. It is important that providers be proactive in dealing with the Government's investigative process, educate themselves on the legal consequences associated with making a false claim, and involve their legal counsel at the beginning of the process.

If the Government decides to proceed with the action, it will begin an investigation using one of several government agencies (i.e., HHS or OIG) that issue subpoenas for simple pay disputes. The first indication that what is actually underway is a false claim investigation is a cover letter from the investigating U.S. Attorney. The letter includes Civil Investigation Demands ("CIDs") stating the government is seeking information related to an investigation of either fraud or false claims. Unfortunately, providers who respond to either the subpoena or the CID without consulting an attorney may inadvertently disclose privileged information or expose themselves to additional liability.

Mr. Brian Dickerson (left) and Mr. Robert Graziano (at podium) from Roetzel and Andress offered pointers on how physician can avoid problems that may arise under the False Claims Act at the AMCNO seminar.

Mr. R. Mark Jones, from Roetzel and Andress provides the opening comments at the seminar.

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) was pleased to co-sponsor a seminar with the law firm of Roetzel & Andress, LPA., covering the topic of the False Claims Act and how physicians can prepare for false claims enforcement. The seminar was moderated by Mr. Mark Jones with opening comments by the AMCNO president, Dr. Lawrence Kent. Presenters included Mr. Brian Dickerson, Esq., and Mr. Robert Graziano from Roetzel and Andress, LPA.

Attendees learned how to identify when they could be a target of an investigation and how to properly interact with the Department of Justice during their defense. The presenters provided an overview of the False Claims Act (FCA) and recent case decisions; the impact of recent settlements on criminal and investigative actions; new FCA enforcement initiatives in health care, and strategies in FCA cases and compliance techniques to reduce risks.

Please see the article on this page for more information on this important issue.

First, a provider may inadvertently reveal information protected by the attorney-client privilege. This privilege protects communications between clients and their attorney provided they are within the scope of representation. A provider who consults with an attorney after receiving a subpoena or CID is entitled to have those communications protected. However, those who fail to do so, and reveal information that would otherwise be protected, waive any future protection of those communications.

Second, a physician may inadvertently waive the Ohio physician-patient privilege when responding to a subpoena or CID. Under this privilege, a communication made to the physician by a patient, in relation to the physician's advice to the patient, is privileged and the physician cannot be compelled to testify about such communications. However, a physician who willingly submits this information in responding has waived the privilege and can be compelled to testify regarding the communications. Therefore, a physician must always consult with an attorney to determine how to respond in a way that complies with the Government's request and preserves the physician-patient privilege.

Third, providers may violate the Health Insurance Portability and Accountability Act ("HIPAA") if they provide the Government with protected health information. HIPAA makes it a violation for certain health entities to reveal protected health information to third parties without the patient's consent and imposes civil and criminal penalties. These penalties include fines up to $25,000 for multiple violations and fines up to $250,000 and/or imprisonment up to 10 years for knowing misuse of individually identifiable health information. Therefore, although providers may believe it is in their best interest to disclose as much information as possible to comply with a subpoena or CID, they may be harming themselves in the long run if the disclosed information is protected by HIPAA.

Also, physicians may face criminal sanctions if their responses to subpoenas or CIDs are false or misleading. Under Title 18 of the United States Code, a person who falsifies or covers up a material fact, or makes a false representation to the Government, with knowledge that the claim is false, is subject to imprisonment of up to five years. Additionally, an individual may face fines up to $250,000 for each offense that constitutes a felony and $100,000 for each misdemeanor. Organizations on the other hand may face fines up to $500,000 for each felony offense and $200,000 for each misdemeanor.

Finally, the Patient Protection and Affordable Care Act (PPACA) makes significant changes to the Medicare fraud provisions that will impact providers in the immediate future. To better understand these changes, providers should consult with an attorney to go over the new provisions and discuss strategies that providers can incorporate into their practices to deal with the new law.

As the Government continues its efforts to reduce the cost of Medicare fraud, providers need to take the appropriate steps to protect themselves from incurring any additional liabilities and penalties when dealing with these investigations. First, providers should consult an attorney and discuss strategies to proactively protect themselves from incurring additional penalties. Second, if ever presented with a CID or subpoena, a provider should seek counsel before responding in order to preserve any privileges and not incur criminal penalties. Finally, providers should contact an attorney to discuss the impact of the PPACA and determine which strategies need to be taken to better protect themselves from incurring liabilities. ■