

The Medical Profession Beware: The False Claims Act - A Danger You Can't Ignore

The Dartmouth-Hitchcock Medical Center will pay over Two Million Dollars to settle a False Claim Act claim with the United States and the states of Vermont and New Hampshire. This case is yet another in a long line of cases in which the False Claims Act has been used to punish an assortment of billing and statutory violations by medical professionals and institutions. The Department of Justice says that since January 2009 some \$2.3 billion dollars has been recovered from health care professionals for violations of the False Claims Act. There is clearly more to come.

Doctors, hospitals and providers of medical services and equipment must be mindful of the federal government's increased enforcement and use of the False Claims Act. This treble damage act has snared medical entities, like Dartmouth and Rush University Medical Center and physician practices, for very large recoveries in recent years.

The Act prohibits making any false claim to the U.S. to obtain monies. Each Medicare reimbursement claim is accompanied by a representation that all federal laws and regulations have been followed by the provider seeking reimbursement. However, hospitals, doctors, medical associations, labs and equipment suppliers have often violated some regulation or law (often one of numerous requirements they must comply with) and thereby make all their Medicare reimbursements subject to False Claims Act violations. Because these violations are often discovered by whistleblowers, who receive substantial rewards for turning violators in, the potential for discovery is heightened.

In the Dartmouth case, a physician at the hospital filed a Whistleblower (Qui Tam) action, permitted by the Act, and the United States intervened and took over the case. The allegations were essentially that Dartmouth had billed for services performed by resident medical staff without sufficient supervision by physicians for a period of some five years. The physician who started the lawsuit will receive over \$300,000 of the settlement.

The Rush case settled for over \$1.5 million dollars. The violation alleged that the medical center leased office space to referring physicians for less than fair market value, thereby violating provisions of the Stark Act. That violation of Stark meant that all the physician Medicare reimbursements applied for by Rush violated the False Claims Act. The physician's reimbursements from Medicare were also claimed to be a violation of the False Claims Act. In addition, as in most cases, the government also claimed that Medicaid reimbursements from the States violated the various state false claims acts.

Recent federal case law appears to require physicians, hospitals and medical professionals to know the legal requirements for the valid submission and collection of claims for medical services. Medical professionals who simply chose not to educate themselves may be found to have acted in deliberate ignorance or with reckless disregard and may thereby be liable under the False Claims Act. The submission of a Medicare claim by a provider is a certification that the provider has complied with the Medicare Act's medical necessity definitions and complied with all relevant laws regarding submission of claims to the federal government.



To succeed on a False Claims Act case the government or the Qui Tam Plaintiff must prove: (1) a false or fraudulent claim; (2) which was presented or caused to be presented by the defendant to the United States for payment or approval; (3) with the knowledge that the claim was false. The damages assessed to the guilty defendant under the Act include liability for a civil penalty of not less than \$5,000 and not more than \$10,000, for each violation (claim) plus **3 times the amount of damages** which the Government sustains because of the violation. Since neither the Stark nor Anti-kickback statutes provide for rights of private action, violations of these acts are being brought under the False Claims Act.

Stark II prohibits doctors from referring patients to a hospital or medical care center or for certain health care services if the doctor has a financial relationship with that entity that does not fall into a specific and limited statutory exception. Violation of the Anti-kickback Statute (42 U.S.C.A. 1320 a-7b (b) (2) (2006)) can also trigger a False Claim Act charge. So, in the Rush case, it is alleged that the doctors got a below-market rental for office space and both the hospital and the doctors were faced with a False Claims Act case.

In the Dartmouth case, the hospital denied liability and implied they did not realize any improper billing was occurring. The requirement that false claim submissions undertaken knowingly do not require a specific pronounced intent to violate the law. However, medical professionals cannot simply disregard or attempt to remain ignorant of the dictates of healthcare law and the various requirements to be compensated for services rendered.

A physician or hospital negotiating for rental space, or compensation, or perks must be cautious to make sure that they can support that the arrangement meets the fair market standard. Doctors must be vigilant about their claims practices and should take every reasonable action to assure that they and their staffs are educated in the various health care law requirements.

In the False Claims Act cases we have handled, the initial punishment for the defendant medical professional is the cost, time and pressures brought on by a False Claims Act case. Usually thousands of documents and years of history are sought by the government for review. In states with false claims acts the matter of Medicaid reimbursement to the state comes into issue. If the federal investigators find that the violations involve criminal conduct then charges of conspiracy, mail and wire fraud, money laundering, and tax code violations can follow. For hospitals, expensive corrective action and/or corporate compliance programs may be required by the government to prevent future violations.

Admittedly the myriad of health care laws and regulations are a challenge to anyone. The busy healthcare professional would prefer to spend time improving their art and not plowing through laws and regulations. But the potential penalty for not taking care of reimbursement and regulatory issues is becoming too substantial to ignore. That's why we find the least costly legal help is prevention. As in medicine, if you can prevent the damage from occurring, the solution is always more cost effective.

This *Health Care Law Alert* was written by **Theodore Margolis**, who has prosecuted and defended a wide range of health care claims and **Sandra Jarva Weiss**, the Chair of our Health Care Group in our Pennsylvania office, who has extensive experience in health care regulations, both of Norris McLaughlin & Marcus, P.A. If you have any questions regarding the information in this alert or any other related matters, please feel free to contact the authors by email at tmargolis@nmmlaw.com and sjarvaweiss@thslaw.com, respectively.

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