Every year, hundreds of billions of tax dollars are spent to provide health care to our seniors, children, the poor and the disabled. Programs that are intended to provide benefits to beneficiaries and fair reimbursement to providers are also prime, and, at times, easy targets for the unscrupulous who seek to enrich themselves. Prosecuting health care fraud has been a decades-long emphasis of the United States Department of Justice and is presently one of its top priorities.

In 1997, Congress established the Health Care Fraud and Abuse Control program under the joint direction of the Attorney General and the Department of Health and Human Services, Office of Inspector General (HHS-OIG). Their joint mission is to coordinate federal, state and local law enforcement activities with respect to health care fraud and abuse. Since the inception of the program, the work of the two departments and their law enforcement partners has returned more than $15 billion to the federal government, including $13.1 billion which was returned to the Medicare Trust Fund. Federal prosecutors have also obtained more than 5,600 criminal convictions during that time period. In fiscal year 2010 alone, the United States recovered $2.5 billion in health care fraud judgments and settlements.

The nature and size of the cases run the gamut. For example, last year Pfizer Inc. and its subsidiary, Pharmacia & Upjohn Company, agreed to pay $2.3 billion to resolve criminal and civil allegations arising from the promotion of certain pharmaceutical products. In Texas, a hospital group agreed to pay the United States $27.5 million to settle claims that it paid illegal compensation to doctors in order to induce the doctors to refer patients to the group. In August of last year, a doctor in Michigan was convicted of health care fraud for receiving kickbacks and falsifying documents relating to the provision of home health care services that were never provided. He was sentenced to 168 months in prison and ordered to pay $9.5 million in restitution for his part in the five-year long scheme.

In December, the parent company of two New Jersey hospitals paid $7.9 million to resolve allegations that the hospitals wrongfully obtained excessive outlier payments. In March of 2010, a cancer center in Florida agreed to pay $12 million to resolve allegations that the center and one of its physicians improperly inflated claims by billing for services not rendered, services not supervised, duplicative and unnecessary services, and upcoded services. Finally, in Chicago, a medical center agreed to pay $1.5 million to resolve allegations that it had submitted false claims to Medicare and Medicaid by entering into an improper leasing arrangement for office space with certain physicians in violation of the Stark Law, which prohibits a hospital from profiting from patient referrals made by a physician with whom the hospital has an improper financial arrangement.

The goal of the task force is simple—to address fraud and abuse in a fair and comprehensive way.

In Rhode Island, Dr. Wallace Goncalves is presently serving a ten year prison sentence resulting from his convictions for diluting and adulterating vaccines, submitting false statements to the government relating to immigration medical exams that he falsely claimed he had performed, selling drug samples to Cameron's Pawtuxet Pharmacy and conspiring to commit health care fraud in relation to the drug samples which were dispensed by Cameron's Pharmacy. He was also ordered to pay $1.1 million in fines and restitution. The owner of Cameron's Pharmacy was sentenced to 37 months in prison for illegally diverting free drug samples for sale at the pharmacy and also forfeited $431,410.62 to the United States. Another doctor is presently a fugitive from charges that he committed approximately $2.9 million in health care fraud by upcoding billings for infusion drugs, billing for services not provided, and falsely prescribing drugs without medical justification. Although he is a fugitive, the government seized more than $2 million of his assets, including a house owned by the doctor and money from his bank accounts, in order to offset the false billings.

Such results are achieved through the cooperative work of the region's law enforcement personnel who work jointly in order to maximize the legal tools available to them. That work is generally coordinated though a health care fraud task force that meets regularly to discuss cases, share leads, and address on-going issues. It is comprised of members of various agencies, including the US Attorney's Office, the RI Attorney General's Medicaid Fraud Control Unit, the HHS-OIG, the Federal Bureau of Investigation, the US Food and Drug Administration, the Department of Labor, US Drug Enforcement Agency, the Department of Veteran's Affairs, the US Postal Service, the Internal Revenue Service and the RI State Police. In addition, representatives of private insurance companies regularly attend task force meetings so that law enforcement may maintain a continuing dialogue with them and address issues of fraud and abuse affecting private insurers. The task force also regularly exchanges information with the RI Department of Health on matters of mutual interest.

The goal of the task force is simple—to address fraud and abuse in a fair and comprehensive way. This may mean that, if the evidence is sufficient, a matter will be pursued criminally. That is, if the evidence shows that someone intentionally and knowingly defrauded a health care benefit program, such as Medicare or a

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private insurance company, then the matter may be presented to a grand jury for indictment and subsequent prosecution. In the criminal context, if a defendant is convicted, he may not only be facing a term of incarceration but the government will also seek restitution, since, after all, the purpose of these efforts is to protect taxpayer funds, and may seek forfeiture of the defendant’s assets if those assets constitute proceeds of the scheme.

However, criminal prosecution may not be the only option. Many health care fraud cases, as reflected in the aforementioned case studies, are pursued in the civil arena, including cases pursued under the False Claims Act (FCA). The FCA allows the government to sue a provider for “knowingly” submitting false claims to the government. In order to prove that a provider “knowingly” submitted false claims, the government must prove actual knowledge or a deliberate or reckless disregard for the truth, or falsity, of the claims. Hence, it is not a defense that a provider didn’t have actual knowledge as long as the evidence shows that he or she acted in a manner that would inevitably lead to the submission of false claims. Hence, it is not enough for one to stick his head in the sand in order to avoid civil liability. In addition, the government need not prove the matter “beyond reasonable doubt,” as in a criminal case, but must only establish its case by a preponderance of the evidence, which is a lower standard.

The penalties in the civil arena are strong. The provider may be liable for up to three times the amount of the false bills submitted to Medicare or Medicaid and may also be penalized between $5,500 to $11,000 for each, individual, false claim.2

Finally, the Department of Health and Human Services may also impose administrative penalties. For instance, if a provider is convicted of a health care offense, he or she may be subject to mandatory exclusion from the Medicare program. Other conduct, such as that captured by the False Claims Act, may be the subject of a permissive exclusion. Or, HHS may impose civil monetary penalties against providers who submit false claims, participate in illegal kickback schemes, fail to appropriately treat or refer patients who present at hospital emergency rooms, or engage in other activities prescribe by statute. In addition, HHS also conducts numerous audits and evaluations in order to determine whether improper bills have been submitted to Medicare or Medicaid. Such audits may lead to recoupment actions by HHS or, if the conduct is egregious, referral to investigative agencies. Interference with such audits, including the falsification of documents, may also lead to enforcement actions by the United States.

As can be seen, the Department of Justice and its law enforcement partners have not only embarked on a comprehensive approach to combating health care fraud but they also have many tools at their disposal. The purpose of these efforts is not to pursue providers who make honest mistakes. If a provider is receiving money for services that are provided and are medically necessary, law enforcement should not be interested. Indeed, the system has built in safeguards designed to address the honest mistakes, either through the audit process or the many educational offerings provided by the Centers for Medicare and Medicaid Services and the intermediaries who process the claims for Medicare and Medicaid.

However, it is also not enough for a provider to claim ignorance of the rules in order to avoid responsibility. It is not enough for a provider to claim that he left everything up to his biller or billing agency, if his conduct suggests that he knew of or created the circumstance for the false billing—such as ordering or providing services that were not medically necessary, creating records to establish that services were provided at a level higher than actually rendered, or which were based on improper financial relationships with other providers. In those cases, law enforcement will seek to address the wrongdoing and return the ill-gotten funds to the public fisc.

Notes
1. Data and national case studies contained herein were obtained from “The Department of Health and Human Services and The Department of Justice Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2010,” January 2011.
2. False Claims Act cases may be initiated by the United States, or they may be filed as “Qui Tam” lawsuits. A Qui Tam is a lawsuit that is filed by a citizen, referred to as a “relator,” who possesses knowledge of wrongdoing. When a Qui Tam lawsuit is initiated, the United States has the option of intervening and pursuing the lawsuit or declining to intervene. If the United States declines to intervene, the relator may pursue the lawsuit nonetheless. In either event, the relator may receive a share of the damages, typically between 15 and 25 percent, if the lawsuit is successful. The False Claims Act also contains provisions prohibiting retaliation against the relator by the defendant in the lawsuit.

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