Compliance with Health Care Fraud and Abuse Rules - An Overview

Although other federal and state rules may also apply, the biggest areas of concern relating to the health care industry for a physician are:

1. **Antikickback Statute** - The Big Issue: Knowing and Willful Payment for Referrals. This is a federal law (the Medicare Fraud and Abuse Amendments of 1977; 42 USC § 1320a-7b), but there are similar state laws, too, some of which may be more restrictive on certain matters; the state laws may relate directly to the medical profession or those who provided goods or services to the profession or patients (e.g., hearing aid sellers) or may be under general commercial bribery laws (or both). See, e.g., UCA § 26-20-4.

   a. **Prohibition and Consequences.** Prohibits knowing and willful payment or solicitation of remuneration to induce a referral of a patient for items or services for which payment may be made, in whole or in part, by Medicare or Medicaid. A person need not have actual knowledge of the law or specific intent to commit a violation of it. 42 USC § 1320a-7b (h).
      
      i. Violation is a felony (e.g., $25,000 or 5 years or both).
      
      ii. Civil penalties (e.g., $2,000 per item or service, 2 times amount claimed) as well as criminal sanctions apply.
      
      iii. Penalties include exclusion from Medicare and Medicaid, and may be obtained without a criminal conviction.
      
      iv. Violation includes offering or paying any remuneration (not limited to kickbacks, bribes, and rebates but includes anything of value) whether overt or covert, direct or indirect, in cash or in kind.
      
      v. Both parties to the agreement are liable.

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vi. Any payments to a physician to limit or reduce necessary services are also prohibited.

vii. Knowing and willful state of mind element broadly interpreted to apply if even one purpose is to induce referrals.

viii. Applies to any participating provider (i.e., not limited to physicians and their immediate family; thus unlike Stark Self Referral rules).

ix. No deduction as a business expense is allowable for income tax purposes with respect to illegal referral fees or other illegal referral remuneration.

b. Safe Harbors. Certain exceptions and safe harbors are provided. If the transaction fits a safe harbor, it is protected; if not, it still might not be a violation but will be scrutinized by regulators. Note the difference between a safe harbor and an exception to the rule: a safe harbor gives protection, but even if the safe harbor does not apply, the conduct may not be a violation; an exception means no violation, but where only exceptions apply (as in the Stark rules described below), outside the exception there is no salvation.

i. Regulations, fraud alerts, and advisory opinions are issued from time to time by the Office of Inspector General (“OIG”).

ii. The statute contains, as one of four exceptions, an exception for any amount paid by an employer to an employee who has a bona fide relationship with the employer for the provision of Medicare or Medicaid covered items or services.

iii. Safe harbor regulations have been adopted or proposed by the Office of Inspector General (“OIG”) in about 19 areas, including, for example, one for bona fide employment arrangements and one for recruitment incentives to attract physicians to rural areas. The employment safe harbor is tied to the tax definition of employee-employer relationship. Sham transaction or device rules have been adopted to preclude the use of safe harbors when the substance of the transaction or device is not accurately reflected by the form.

c. ERISA Violations. The Employee Retirement Income Security Act of 1974 covers not just pension and retirement plans but also many welfare benefit plans such as health plans. Federal law prohibits any person involved in administering such a plan from soliciting or receiving or agreeing to receive any kickback, loan, or anything of value with respect to such matters, and also prohibits anyone from offering promising or giving anything of value to such a person. 18 USC § 1954. U.S. v. Li, 55 F.3d 325 (7th Cir. 1995) (scheme between dentist and union fund official). See also, 18 USC § 664 (theft from plan).
d. **Theft and Bribery.** There are laws prohibiting theft and bribery of $5,000 or more in connection with federal assistance programs where an organization or state or local agency receives over $10,000 in any one year period. The receipt of Medicare funds through an intermediary qualifies for prosecution, as does solicitation or acceptance of bribes to influence such an organization or agency. 18 USC § 666(a)(1) Kickback schemes may be prosecuted under this provision. *U.S. v. Fischer*, 168 F.3d 1273 (11th Cir. 1999), *aff’d* 529 U.S. 667 (2000) (kickback to hospital CFO for loan from hospital).

2. **Stark I, II, and III Self-Referral Restrictions** - The Big Issue: Referrals to entity with which physician or family has financial arrangements. Similar state laws need to be consulted as well. Some state laws require disclosure of relationships between one make a referral and the one to whom the referral is made, even if Stark rules do not apply. See UCA § 58-67-801.

   a. **Prohibition and Consequences.** The Stark anti-self-referral law prohibits referrals for designated health services where the referring physician or the physician’s immediate family has ownership or investment interests or has compensation arrangements with the person or organization providing the services.

   i. Limited to referrals involving physicians and their immediate families. Physicians also “stand in the shoes” of their practice groups.

   ii. Unlike Antikickback law, there is no general intent or state of mind requirement (although “circumventing the law” may be heavily sanctioned).

   iii. Sanctions for violation include: no payment for the services (or required refund if paid), penalties up to $15,000 per service, $100,000 per arrangement with a principal purpose of circumventing law, $10,000 per day for reporting failures. Submitting claims triggers sanctions, not the referral itself (unless “circumventing the law” is involved).

   iv. The designated health services (DHS) include:

      1. clinical laboratory;

      2. physical therapy;

      3. occupational therapy, speech-language pathology services;

      4. radiology (X ray, MRI, CAT, ultrasound);

      5. radiation therapy and supplies;

      6. furnishing durable medical equipment;
(7) parenteral and enteral nutrients, equipment, and supplies;

(8) prosthetics, orthotics, and prosthetic devices;

(9) home health services;

(10) out-patient prescription drugs;

(11) inpatient and out patient hospital service.

v. Generally a physician’s own service is excepted from the prohibition, so referrals for services personally performed or personally supervised by a physician are not prohibited.

vi. Financial relationships covered by the rules include debt or equity interests in the entity providing services or in an entity that itself has such interests in the entity providing services.

vii. Compensation arrangements may be any payment of remuneration, direct or indirect, in cash or kind. This may, for example, include rent paid by a physician to an otherwise unrelated party. The direction of the compensation (to or from the physician) is of little consequence.

viii. Special antimarkup rules apply to limit or eliminate financial incentives to pass on marked-up prices for certain diagnostic tests (other than clinical diagnostic laboratory tests) ordered by a billing physician or other supplier (or a related party) and performed by a physician who does not share a practice with the billing physician or other supplier, whether the markup relates to the technical or professional component of the price. 42 USC § 1395u(n)(1); 42 CFR § 414.50. The antimarkup rules apply to all such diagnostic tests, not just those which are also subject to the Stark rules.

b. Statutory Exceptions. Exceptions have been provided for such areas as in-office ancillary services of group practices (there are requirements for same building and physician supervision and restrictions against compensation related to the volume or value of DHS), certain permitted ownership interests, and for certain compensation arrangements including office and equipment rentals with a term of over one year with rent at market rates without reference to referrals, certain minor remuneration, isolated transactions, and market payments by physicians for services furnished by the recipient, etc. Some of the exceptions relate only to ownership interests, some relate only to compensation arrangements, and some relate to both. The exceptions are generally the only way to avoid a violation for conduct otherwise covered. Some examples:

i. Incentives for the recruitment of physicians to relocate to become members of the hospital staff are excepted if, among other things, the physician
is not required to refer patients and the incentive is not tied directly or indirectly to the volume or value of any referrals.

ii. Bona fide employment arrangements will be excluded from the ban if:

   (1) the employee’s services are specified;
   (2) all compensation is reasonable even if there are no referrals;
   (3) compensation is determined without regard to the value or volume of referrals; productivity bonuses for services personally performed (e.g., hours worked, patients seen, gross billing for services personally rendered) are permitted; incentive payments for ancillary services ordered are very risky.

c. Responsible Officer Prosecution. Prosecution of officers of organizations might be possible under the responsible corporate officer doctrine which allows criminal prosecutions of persons who are in a position to but fail to prevent violations of public welfare laws, even where the officer lacks knowledge of or participation in the violation. See *United States v. Dotterweich*, 320 U.S. 277 (1943); *United States v. Park*, 421 U.S. 658 (1975) (both cases were under the federal Food, Drug, and Cosmetic Act (FDCA), 21 USC §§ 301 et seq. which contains a strict liability provision for misdemeanor misbranding and adulteration violations; note that the Stark law also is a strict liability law. 42 U.S.C. § 1393nn; 42 CFR § 411.351 et seq.)

3. False Claims Act and Related Laws. The Big Issue: knowingly presenting (or causing to be presented) a false claim to a federal health care program. Note: the government may try to use these rules where there is an antikickback or Stark violation under a theory of misrepresentation of compliance with those laws; this case law development has been codified as to Anti-Kickback violations by the Patient Protection and Affordable Care Act. 42 USC § 1320a-7b(g). There are also similar state laws which may apply. See UCA § 26-20-1 et seq. (Utah False Claims Act) and UCA § 76-10-1602(4)(d) (false claim violations are unlawful activities under the Utah pattern of unlawful activity, i.e., racketeering, law).

   a. False Claims Prohibition and Consequences. In addition to the submission of false claims, the False Claims Act (see 31 USC § 3729) prohibits knowingly making or using a false record or statement to get a false or fraudulent claim paid or approved by the Federal Government or its agents such as a carrier, claims processor, or state Medicaid program.

   i. A false claim is one for services or supplies not provided specifically as presented or for which the provider is not entitled to payment. For example,
(1) service or supply never provided or provided but poorly

(2) upcoding to obtain coverage not otherwise available

(3) upcoding to obtain additional reimbursement

(4) claim for services known not to be reasonable or necessary

(5) claim for services by unlicensed person.

ii. Knowingly presenting claim does not require intent to defraud the government; rather it means:

(1) actual knowledge claim is false,

(2) deliberate ignorance of truth or falsity of information, or

(3) reckless disregard of truth or falsity of information.

iii. Deliberate ignorance means deliberately disregarding truth or falsity of information even though provider knows or has notice the information may be false. For example, a violation may arise from ignoring provider update bulletins and not informing staff of changes in Medicare billing guidelines or updating billing system, then submitting a nonreimbursable claim.

iv. Reckless disregard means the provider pays no regard to whether information on a claim is true or false. For example, assigning an untrained office person to billing function without inquiry into the person’s knowledge and skill would qualify as reckless disregard.

v. The penalty is a minimum of $5,000 up to $10,000 for each false claim submitted. Also, the provider may be liable for three times the amount unlawfully claimed.

vi. Private persons may enforce the federal civil false claims act, including deemed violations arising from anti-kickback violations, by suing as qui tam relators on behalf of the government, and may personally receive significant awards for doing so. A number of states have their own qui tam statutes as well.

b. Civil Monetary Penalties Prohibition and Consequences. Also, the Civil Monetary Penalties law (see 42 USC § 1320a-7a) is closely related to the False Claims Act and the Anti-Kickback statute.
The Civil Monetary Penalties law prohibits presenting or causing to present a claim for services the provider “knows or should know” were

1. wrongly coded
2. not reasonable or necessary
3. furnished by unlicensed person or not properly supervised by a licensed person
4. furnished by licensed person who lied or cheated to obtain license
5. furnished by physician not certified in the specialty in which he or she claims certification, or
6. furnished by a physician excluded from participation in program to which claim is submitted.

Also, the Civil Monetary Penalties law is violated by

1. offering remuneration to a Medicare or Medicaid beneficiary where the person knows or should know it is likely to influence beneficiary to obtain benefits from a particular provider, or
2. contracting with individual or group where the person knows or should know the individual or group is excluded from participation.

For Civil Monetary Penalties Law, “know or should know” means to act in deliberate ignorance or in reckless disregard of the truth or falsity of the information.

The Civil Monetary Penalties Law may impose a variety of penalties, including up to $10,000 per item or service or $50,000 for each wrongful act or false statement, and up to three times the amount unlawfully claimed, and exclusion from participation in the federal program. The Office of Inspector General takes into account various aggravating and mitigating circumstances in deciding on program exclusion.

c. False Statements Relating to Health Care Matters. For knowingly and willfully falsifying or concealing a material fact or making any material false statement, or using any materially false writing or document (in connection with health care claims whether federal or not), fines, imprisonment for up to five years, or both, may be imposed. 18 USC § 1035. Any public or private plan or contract affecting commerce providing health benefits (for example, private health insurance) is covered by this federal criminal law. State law rules also apply. See UCA 26-20-3. ERISA covered
health plans are also subject to a prohibition on false statements and concealment in connection with plan documents. 18 USC § 1027.

d. Obstruction of Criminal Investigation of Health Care Offenses. Willfully preventing, obstructing, misleading, or delaying, the communication of information or records relating to a violation of a federal health care offense to a criminal investigator, or attempting to do any of these things (described above) may cause the imposition of fines, imprisonment for five years, or both. 18 USC § 1518. See U.S. v. Franklin-El, 554 F.3d 903 (10th Cir. 2009), cert. denied 129 S.Ct. 2813.

e. General Obstruction of Justice. There are state and federal laws punishing various forms of obstruction of justice. Among other statutes, the Sarbanes-Oxley (SOX) law applies obstruction of justice crimes to private as well as public companies. Under SOX, it is punishable by up to 20 years imprisonment to alter, destroy, conceal, cover up, falsify, or make a “false entry in any record, document . . . with the intent to . . . obstruct or influence the investigation . . . of any matter within the jurisdiction of any department or agency of the United States . . . or in relation to or contemplation of any such matter or case.” 18 USC § 1519. Also, hindering the communication to a law enforcement officer of information relating to a possible federal offense is punishable with up to 10 years imprisonment. State law obstruction of justice law may also apply. See UCA § 76-8-306.

f. Mail and Wire Fraud. Using mail, private courier, or wire service (e.g., phone, fax, e-mail) in scheme to defraud is a separate crime for each such use. Fines, imprisonment for five years, or both, may be imposed. This is also often used in connection with prosecuting insurance fraud schemes. See 18 USC § 1956. State communication fraud laws may apply as well. See UCA § 76-10-1801. The federal Hobbs Act provides for federal jurisdiction over interstate travel or the use of mail to violate or attempt to violate certain state laws, such as bribery which could include a kickback scheme. 18 USC § 1951.

g. False Statements in Representations. This is covered by the same criminal act covering Antikickback violations. The violation may, in addition to false statements, consist of

i. concealing any event affecting an individual’s initial or continued right to receive a benefit with intent to fraudulently receive the benefit or payment in excess of what is due or authorized;

ii. converting a benefit or payment for use or benefit other than for the person for whom it was intended;

iii. for a fee counseling an individual to dispose of assets in order to become eligible for medical assistance under a state health program (e.g., Medicaid), if disposition results in a period of ineligibility (not now being enforced against lawyers). These sorts of violations could cause fines up to $25,000,
imprisonment for five years, or both, and exclusion from the health care program (with the OIG taking into account aggravating and mitigating circumstances).

h. **General Criminal and Civil Fraud; Other Crimes.** Common law civil fraud and deceit (damage actions) and state criminal fraud law may apply to health care abuse. See, e.g., UCA 76-6-405 (theft by deception). Potential civil remedies could include damages based on equitable disgorgement, unjust enrichment, payment by mistake, and overpayment. Other potentially applicable federal criminal provisions include: 18 USC 669 (theft, embezzlement, misapplication of funds of health care benefit program); 18 USC 1347 (health care fraud); 18 USC 641 (theft, embezzlement, or knowing receipt of things of value of the U.S. or under contract to the U.S.; this can include overbilling Medicare, see U.S. v. O'Brien, 14 F.3d 703 (1st Cir. 1994) (overbilling for ambulance service)); 18 USC 2 (aiding and abetting violations); 18 USC 982(a)(6) and 21 USC 853(c) (criminal forfeiture of property used in a health care offense); 18 USC 371 (conspiracy); 18 USC 1345 (injunctions and asset freezes prior to indictment); 18 USC 1956(a)(1) and (2) (money laundering, conducting financial transactions with proceeds of unlawful activity; 18 USC 982 provides for asset forfeitures for money laundering). There is no lack of federal and state criminal statutes in this area.

i. **Racketeering.** Under 18 USC 1961-1968, the federal RICO or racketeering act, if there is a pattern (two or more incidents) of racketeering activity in which a person participated as a principal, there can be a racketeering conviction. There a number of predicate acts describing the unlawful activities, and they include health care offences. See U.S. v. Kahn, 53 F.3d 507 (2d Cir. 1995) (physician working for nine weeks with clinic convicted). The remedies under RICO are quite broad, providing for fines, imprisonment, asset forfeitures, and asset freezes and also providing for government or private causes of action for treble damages. For the Utah version see also UCA 76-10-1602(4)(d) (false claim and kickback violations are unlawful activities under the Utah pattern of unlawful activity, i.e., racketeering, law).

4. **Patient Privacy.** The Big Issue: Protection of a patient’s identifiable health care information against unauthorized disclosure. The major federal law is the Health Insurance Portability and Accountability Act of 1996, known as HIPAA, 42 USC 1320d et seq. State privacy law may apply as well. See, e.g., UCA 78B-5-618 (patient and third party access to medical records) and 26-45-104 (genetic testing privacy). There are, among other provisions under HIPAA, significant reporting requirements, patient consent requirements, and requirements to have agreements with business associates. HIPAA provides penalties of $100 per violation up to $25,000 (42 USC 1320d-5), but for knowing violations the penalties can be up to $50,000 with prison for up to a year, or if committed with false pretenses, $100,000 with prison up to 5 years, or if committed with intent to sell information, $250,000 with prison for up to 10 years (42 USC 1320d-6).
5. **Payment Reporting.** The Big Issue: Disclosing payments by manufacturers and others to physicians. Although the reporting requirements generally are on manufacturers and group purchasing organizations, the information reported will be of concern to affected physicians. Under the Physician Payments Sunshine Act which is part of the Patient Protection and Affordable Care Act of 2010 (the Affordable Care Act), the manufacturers of pharmaceuticals, devices, and other medical products, and group purchasing organizations need to report information about their financial ties to physicians and teaching hospitals to the Centers for Medicare & Medicaid Services (CMS). 42 U.S.C.A. § 1320a-7h(a)(1)(A). The agency will then publish the information on the Internet. The reports include payments by manufacturers of a covered drug, device, biological, or medical supply to physicians including such things as payments or transfers of value, for example in cash or stock, whether for consulting, food, or travel, and include ownership or investment interests by physicians in manufacturers and group purchasing organizations. Manufacturers and applicable GPOs are subject to civil monetary penalties for failing to comply. If a manufacturer or a GPO fails to submit the required information, then it will be subject to a civil monetary penalty of at least $1,000, but no more than $10,000, for each payment or other transfer of value, or ownership or investment interest not reported as required. The maximum total penalty with respect to each annual submission for failure to report is $150,000. For a knowing failure to submit required information in a timely manner, a penalty will apply of at least $10,000, but no more than $100,000, for each payment or other transfer of value, or ownership or investment interest not reported as required. The maximum total penalty with respect to each annual submission for a knowing failure to report is $1,000,000. These rules generally preempt state law, except where the state rules require reporting of information that the federal statute does not require or require reporting of information for public health purposes. 42 U.S.C.A. § 1320a-7h(d)(3)(B). Thus, state law still has a function here.

6. **Other Consequences.** Other unfortunate consequences beyond typical criminal responsibility and civil liability may attend a violation of applicable law.

   a. **Deportation.** At least some crimes (e.g., fraud) can lead to the deportation of foreign nationals under 8 USC § 1101(a)(43)(M)(i) and 8 USC § 1227(a)(2)(A)(iii).

   b. **No Indemnity.** A physician will not be fully covered by indemnity agreements or insurance against all areas of exposure. There are limits on such things as what sorts of claims or conduct is covered, when the coverage starts to pay, and when the coverage can be ended. Taking the Fifth Amendment privilege against self-incrimination could eliminate significant indemnity or insurance coverages. There is no indemnity allowed for reckless, willful, or criminal conduct (*Globus v. Law Research Serv., Inc.*, 418 F.2d 1276, 1288 (2d Cir. 1969)) and counterclaims for indemnification are barred under the False Claims Act (*Mortgages, Inc. v. U.S. District Court for District of Nevada*, 934 F.2d 209 (9th Cir. 1990)). See also corporate and other organizational codes such as 8 Del. C. §§ 145(a); *Hermelin v. K-V Pharm. Co.*, 54 A.3d 1093, 1094 (Del. Ch. 2012).
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(Delaware statute prohibits a corporation from indemnifying a corporate official who was not successful in the underlying criminal proceeding and has acted, essentially, in bad faith); UCA 16-10a-901 et seq. (corporations); UCA 48-2c-1801 et seq. (limited liability companies).

c. **Bankruptcy.** Liability of a company for fraud against the government may well not be dischargeable after a bankruptcy Chapter 11 plan is confirmed, and this includes False Claims Act liabilities to relators bringing *qui tam* actions under that Act. Bankruptcy Code 11 USC §§ 1141(d)(6)(A); 523(a)(2)(A) and (B). Nondischargeability may apply to settlements of such claims as well. See *U.S. v. Spicer*, 155 BR 795 (Bnkr. DDC 1993), *aff’d 57 F.3d 1152 (DC Cir.1994).* Fraud, fiduciary defalcation, and certain other kinds of misconduct liabilities are not dischargeable by individuals in bankruptcy. Bankruptcy Code 11 USC § 523.

d. **Licensing.** License revocations by state licensing officials may follow a fraud or abuse case or a criminal case. A license revocation in one jurisdiction can lead to reciprocal revocations in other jurisdictions.

e. **Injunctions and Asset Freezes.** Injunctions against violations and asset freezes may be sought by the government prior to indictment and the restraining order may be granted without bond. See 18 USC § 1345 (injunctions against fraud against the United States and to restrain disposition of property; aimed at banking and health care violations). The standard may not be as high as in other cases to obtain the order. See *U. S. v. Fang*, 937 F. Supp. 1186, 1197 (D. Md. 1996) (in case freezing half the assets of a physician, finding that “reasonable probability” standard of conventional preliminary injunction analysis equated with “probable cause” and that it applied in this health care fraud case). See also other fraud injunction provisions: 18 USC §§ 1341 to 1360; 18 USC § 287; 18 USC § 371; 18 USC § 1001.

f. **Tax Issues.** Violations of the health care laws can create tax issues, too.

i. Criminal fines or civil penalties imposed to enforce the law (as compared to those for other purposes, such as to obtain prompt compliance or provide a remedy for third party expense) are not tax deductible. 26 USC § 162(f); 26 CFR § 1.162-21; *Com‘r v. Heininger*, 320 US 467 (1943); *Southern Pacific Transp. Co. v. Com‘r*, 75 TC 497 (1980). The line between a nondeductible penalty and a deductible compensatory payment in a governmental settlement can be close, and can be affected by the structure of the settlement. See CCA 201308027.

ii. On the other hand, depending on circumstances, any indemnities that may be available might be taxable to the recipient (IRC § 61; at least to the extent the amounts reimbursed would not otherwise be deductible by the recipient) and deductible by the company paying them (IRC § 162). See also *Larchfield Corp. v. U.S.*, 373 F2d 159 (2d Cir. 1966) (payment to a director under a corporate indemnity was deductible to the corporation as a compensatory fringe benefit, even though director
could not have deducted all the defense cost payments individually if he had paid them; this implies potential taxability to the director of the portion the director could not otherwise deduct).

iii. Wrongfully received funds are no less taxable when received just because they are later recovered or must be repaid. Treas. Reg §1.61-14.

iv. Violating the Antikickback (42 USC § 1320(a)-7b(a) and (b)) or Stark Self-referral (42 USC § 1395nn) fraud and abuse rules or other unlawful conduct may destroy a nonprofit health care system’s tax exemption, as well as give rise to potentially massive penalties and disqualification from Medicare and Medicaid-type, federally-funded programs. GCM39862 (11/22/91).