Healthcare Fraud

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Point of View

- White-collar prosecutor for 25 years
- I sue people who commit fraud
  - Insurance company lawsuits
  - False Claims Act lawsuits
- I do not represent healthcare practitioners
Agenda

- Economic costs
- Social costs
- Legal Tools
- False Claims Act
Healthcare Fraud Affects Everyone

- Economic Costs
  - Americans spend $2.34 TRILLION on healthcare each year
  - 3% to 10% lost to fraud
  - $70 BILLION to $234 BILLION is stolen from healthcare payors every year
  - Who are healthcare payors?
    - YOU ARE!
Healthcare Fraud Affects Everyone

**Cost and Availability**
- Employers with less than 200 employees: 56% offer some health coverage
- Of those that do **not** offer coverage
  - 41% cite COST as primary reason for not offering coverage
- Percentage of small employers offering coverage has been declining for years
Figure 1
Percentage of Firms Offering Health Benefits, by Firm Size, 2000-2015

*Estimate is statistically different from estimate for the previous year shown (p<.05).

Note: Estimates presented in this exhibit are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits.

Figure 6
Average Annual Premiums for Covered Workers with Family Coverage, by Firm Size, 2000-2015

Healthcare Fraud Affects Everyone

- Fewer employers offering coverage
- Greater cost shifting
- Less generous coverage
- Higher Cost = Higher Cost
  - Individual Mandate
- Don’t forget auto insurance costs!
Healthcare Fraud Affects Everyone

- Fraud = Bad Medicine
In June 2010, a doctor and his wife were convicted of running a “pill mill” in a small town in Kansas. Posing as a pain management practice, the clinic run by the couple was open twelve hours a day and seven days a week and illegally dispensed controlled prescription drugs; meanwhile they collected more than $4 million from 93 different private health insurance and government health care programs. The doctor was found to be responsible for more than 100 overdoses and at least 68 deaths over a six-year period. The doctor and his wife were convicted, among other counts, of health care fraud resulting in death.
A California doctor was sentenced in 2008 to ten years in federal prison for performing more than 400 unnecessary surgeries as a scheme to defraud insurance companies. The doctor paid his patients hundreds of dollars to undergo colonoscopies and "sweaty palm surgeries" (to combat excessive perspiration), then billed insurance companies for the procedures. Prosecutors claimed that the doctor offered little pre-op consultation, no follow-up appointments for these patients, and in several cases risked puncturing his patients’ lungs. The doctor’s unnecessary surgeries accounted for 70 percent of his medical practice.
**POSITIONAL TESTS**

Normative values for positional tests are 0 - 3 degrees horizontal slow component velocity for all positions. Patient elicited the following values for the positional tests:

<table>
<thead>
<tr>
<th>Position</th>
<th>5 sec, Head C</th>
<th>5 sec, Head L</th>
<th>5 sec, Head R</th>
<th>Body C</th>
<th>Body L</th>
<th>Body R</th>
</tr>
</thead>
<tbody>
<tr>
<td>IL</td>
<td>11</td>
<td>11</td>
<td>21</td>
<td>21</td>
<td>21</td>
<td>21</td>
</tr>
<tr>
<td>LR</td>
<td>11</td>
<td>21</td>
<td>21</td>
<td>21</td>
<td>21</td>
<td>21</td>
</tr>
</tbody>
</table>

All tests are normal. No nystagmus was elicited.

**DIX / HALPIKE TEST**

Normative values for Dix-Hallpike tests are less than or equal to 3 degrees slow component velocity both horizontally and vertically. Patient has elicited 0 degrees horizontally and 0 degrees vertically on rightward testing and 11 degrees horizontally and 0 degrees vertically on leftward testing. These are normal findings. No nystagmus was elicited.

**CALORIC RESULTS**

Normative values for caloric testing are a combined slow component velocity less than or equal to 20 degrees/sec with a unilateral weakness of less than or equal to 25%. Patient has elicited the following results for caloric tests:

<table>
<thead>
<tr>
<th>Ear</th>
<th>Warm Left</th>
<th>Warm Right</th>
<th>Cool Left</th>
<th>Cool Right</th>
</tr>
</thead>
<tbody>
<tr>
<td>LR</td>
<td>21</td>
<td>11</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>RL</td>
<td>0</td>
<td>11</td>
<td>21</td>
<td>11</td>
</tr>
</tbody>
</table>

These were not adequately completed or recorded.

**IMPRESSIONS:**

Peripheral
- There is evidence of significant peripheral vestibular dysfunction.

Central
- There is evidence of significant central vestibular dysfunction. Definitive pursuit does not a CNS lesion. Bilateral or symmetric defective pursuit implies dysfunction of the cerebellum, brainstem, or brain. Asymmetry or reduced optokinetic nystagmus in the context of either abnormal pursuit or normal pursuit does not exclude central vestibular lesion. Adequate suppression of torsion does not exclude central vestibular dysfunction. VOR asymmetry suggests central dysfunction ipsilateral to the direction of asymmetry.

**RECOMMENDATIONS:**

- Balance rehabilitation is included targeting the above mentioned abnormalities.

[Physician Signature]
Metuchen dentist charged with falsifying dental records of 3 children, grandmother killed in South Plainfield fire

— Middlesex County officials today charged a Metuchen dentist with falsifying the dental records of three of the four children killed in the Feb. 23 South Plainfield fire that also took the life of the children's grandmother. The false records delayed identification of the fire victims, Prosecutor Bruce Kaplan said in a joint statement with South Plainfield police Chief James Parker . . . .
Definitions of Fraud

- NJ civil statutory definition:
  - A person violates the Act if he presents ... any written or oral statement as part of ... a claim for payment ... [under] an insurance policy ... knowing that the statement contains any false or misleading information ... material to the claim
A person violates the Act if he presents ... any written or oral **STATEMENT** as part of ... a claim for payment ... [under] an insurance policy ... knowing that the statement contains any false or misleading information ... material to the claim
Definitions of Fraud

- A person violates the Act if he presents ... any written or oral statement as part of ... a **CLAIM FOR PAYMENT** ... [under] an insurance policy ... knowing that the statement contains any false or misleading information ... material to the claim
A person violates the Act if he presents ... any written or oral statement as part of ... a claim for payment ... [under] an INSURANCE POLICY ... knowing that the statement contains any false or misleading information ... material to the claim
Definitions of Fraud

- A person violates the Act if he presents ... any written or oral statement as part of ... a claim for payment ... [under] an insurance policy ... KNOWING that the statement contains any false or misleading information ... material to the claim
Definitions of Fraud

- A person violates the Act if he presents ... any written or oral statement as part of ... a claim for payment ... [under] an insurance policy ... knowing that the statement contains any **FALSE OR MISLEADING INFORMATION** ... material to the claim
A person violates the Act if he presents ... any written or oral statement as part of ... a claim for payment ... [under] an insurance policy ... knowing that the statement contains any false or misleading information ... MATERIAL to the claim.
Definitions of Fraud

- KNOWING
- False or misleading statement
- Material to the claim
Definitions of Fraud

LIE + MATERIALITY = FRAUD
Billing for Services Not Rendered

- **Simple:** Bill for DOS when patient wasn’t treated
Fla. couple sentenced to prison in $40M Medicare fraud

Former home health care agency owner Jorge Lorenzo of Miami was sentenced Friday to serve 15 years and six months in prison for his role in a fraud scheme that cost the Medicare program over $40 million, while his wife and co-defendant, Yahima Prado, was sentenced to three years and six months. The couple admitted to submitting false claims for unprovided home health services from 2011 to 2015 and were also ordered to pay restitution of $40.3 million along with a third co-defendant.

(8/1/16)
Billing for Services Not Rendered

**More Complex:**
- Add procedure code to the bill
  - Acupuncture with stimulation
- Perform incomplete / worthless services
  - EMGs
Billing for Services Not Rendered

- **Even More Complex:**
- **Stolen / Purchased identities**
  - Completely fictitious claims
  - Fictitious providers
  - Speed game
Fla. clinic operators accused of $2.7M health insurance fraud

Florida residents Osmani Gonzalez, owner of ABC Therapy, and Osvaldo Garcia, owner of Universal Medical & Therapy Clinic, as well as two clinic office managers, were arrested on allegations of defrauding around $2.7 million from the Miami-Dade school district by falsely billing its health insurer. Gonzalez and Garcia are accused of conspiring with a recruiter to offer cash incentives to school employees in exchange for providing insurance and other personal information, then submitting fraudulent claims for unprovided health care services, authorities say.

(8/4/16)
According to a 2012 survey, among 807 patients who were affected by medical identity theft:

- 41% were terminated by a health plan or provider
- 30% had to spend significant time clearing up inaccuracies in their medical records
- 14% received incorrect treatments because of those inaccuracies, and
- 12% were diagnosed incorrectly as a result.

(Source: NHCAA 2016)
UMC Physicians, estate of late doctor resolve false claims allegations for $3.3M

UMC Physicians will pay $1.28 million to the federal and Texas state governments and the estate of late Lubbock, Texas, physician Kenneth Rice will pay $2 million to resolve health care fraud accusations. Rice, who died in a plane crash last year, was accused of submitting upcoded Medicare and Medicaid claims for evaluation and management services and services provided by non-physicians, according to authorities.
Kickbacks for Patient Referrals

- **Payments for:**
  - Referring a patient to another provider
  - Ordering a test
  - Prescribing medication or DME
- **Illegal to pay or receive kickbacks**
TRENTON – Acting Attorney General John J. Hoffman and the Office of the Insurance Fraud Prosecutor (OIFP) announced today that the ringleader of a major criminal enterprise and his wife pleaded guilty to charges that they bribed dozens of doctors in exchange for referrals, worth several million dollars, to the medical imaging centers they owned and operated. It was also announced that three other co-conspirators in the bribery scheme pleaded guilty to their roles.
Self-Referrals

- Unlawful for a practitioner to refer a patient
- To another healthcare entity
- In which that practitioner has a financial interest
- NJ exceptions
- Federal law more complicated
Unlawful Ownership Structure

- Only licensed healthcare professionals can have ownership interest in:
  - Medical
  - Chiropractic
  - Dental

- Ownership structure must allow appropriate supervision and QC
  - Lesser license cannot supervise greater license
    - Chiros & MDs
    - Dentists and dentists
New Jersey Allstate Recover Millions in PIP Insurance Fraud Case

July 28, 2016

New Jersey insurance officials said they have recovered $3.5 million in a personal injury insurance fraud case involving chiropractors, physicians, medical facilities, billing companies and others.

In a case connected to the same operation, Allstate Insurance recovered more than $20 million in damages, attorneys’ fees and costs from settlements, judgments and trial, according to officials.

Insurance Commissioner Richard J. Badolato said the $3.5 million in fines, penalties and attorneys’ fees came in a case against Gregorio Lajara of Perth Amboy and a host of individuals, health care practitioners and facilities who allegedly defrauded Allstate and other insurance companies through an “injury mill” that collected personal injury protection (PIP) benefits.

Lajara, who operated 10 chiropractic facilities through his firm, Medico Management, allegedly was the mastermind of the scheme that included physicians and chiropractors, medical imaging and pain management practices, medical equipment and billing companies, employees, owners and shareholders of those practices. It also included individuals who acted as “runners” who recruited individuals involved in motor vehicle accidents and referred them to doctors and lawyers in violation of the New Jersey Insurance Fraud Prevention Act, according to officials.

Once auto accident victims were recruited by “runners,” they were referred to Lajara’s chiropractic facilities for treatment and were then referred for mandatory MRI tests, acupuncture treatments, neurological and pain management testing and durable medical equipment orders, officials said.
Why is it so Prevalent?

- $70\ \text{BILLION to $234\ \text{BILLION}}$
  - Cost to consumers
  - Profit to fraudsters
Why is the Risk Low?

- **Fraud is Different from Other Crimes**
  - Fraud consists of convincing the victim they are *supposed* to pay you.

- **Limited Claims Examination**
  - Little human involvement
  - Business incentive to reduce claims handling costs
A businessman accused of orchestrating a $1 billion Medicare and Medicaid fraud scheme in South Florida will be staying in jail until his trial.

Court records show a Miami federal judge on Friday denied bail for 47-year-old Philip Esformes, finding he was a flight risk and might obstruct the ongoing investigation. Esformes faces a potential life prison sentence if convicted of multiple fraud, conspiracy and other charges.

Authorities say Esformes ran 30 nursing homes and assisted living facilities that used a network of corrupt doctors and hospitals to refer thousands of patients to the facilities even though they did not qualify for services. Esformes and others also allegedly got kickbacks for steering patients to other health centers.

The Justice Department says it's the largest health fraud case in U.S. history.
Why is the Risk Low?

- Fraud is Different from Other Crimes
  - Fraud consists of convincing the victim they are supposed to pay you.
- Limited Claims Examination
  - Little human involvement
  - Business incentive to reduce claims handling costs
- Much fraud never uncovered
Why is the Risk Low?

- Criminal prosecution
  - Limited resources (people and time)
- Civil enforcement
  - By the government
  - By insurance carriers
Criminal and Civil Tools

- Criminal prosecution
  - State and federal
    - NJ: OIFP and County Prosecutors
Doctor Pleads Guilty to Taking More Than $250,000 in Illegal Kickbacks for Referring Patients to Other Doctors and Healthcare Providers

He was charged in ongoing investigation by Attorney General’s new Commercial Bribery Task Force

TRENTON – Acting Attorney General Robert Lougy announced that a chiropractor from Morris County pleaded guilty today to taking more than $250,000 in illegal kickbacks from doctors and other individuals in return for referring patients to their practices, clinics and medical imaging centers.

Dr. Alexander Dimeo, 61, of Budd Lake, N.J., and Fort Myers, Fla., pleaded guilty today to two separate accusations before Superior Court Judge Michael A. Toto in Middlesex County. Dimeo retired last year, but he formerly operated Passaic Chiropractic & Therapy Center PC in Passaic. Dimeo pleaded guilty to an accusation charging him with second-degree conspiracy, second-degree money laundering, second-degree commercial bribery, three counts of third-degree commercial bribery, and third-degree failure to pay taxes.

Under the plea agreement, the state will recommend that Dimeo be sentenced to up to seven years in state prison. He must pay an anti-money laundering penalty of up to $250,000 and restitution to the state for any taxes he owes for kickbacks not reported on his tax returns. Sentencing is scheduled for August 22.
Criminal and Civil Tools

- **Civil Enforcement**
  - NJ DOBI: civil fines of up to $5,000 (1\textsuperscript{st} violation); $10,000 (2\textsuperscript{nd}); $15,000 (each additional)
  - Professional Licensing Boards
  - Debarment
    - Medicare & Medicaid

- **False Claims Act**
  - Civil suit against person filing false claim
  - Triple damages + Penalty
  - State and Federal FCA laws
False Claims Act

- Civil suit against a person submitting *false claim for payment* to the government
  - Lawsuit brought by state or federal government
  - Lawsuit brought by person/entity with knowledge of the fraud
    - “Relator”
False Claims Act

- Relator’s share
  - 15% to 30% of the amount recovered
  - Incentive for people to disclose fraud
  - Recognition that government cannot address fraud alone
False Claims Act

**Requirements**
- Fraud must be unknown to the government
- Fraud must be against a government program
  - Medicare / Medicaid / Tricare / FEHP / SHBP
  - FCA is **not** restricted to healthcare
- Fraud must involve a *knowing* false statement
False Claims Act

Process (in a nutshell)
- Relator gathers all information and seeks counsel
- Lawsuit filed under seal
- Material Disclosure Statement / Relator’s interview(s)
- Government intervenes or not
- Relator proceeds or not
- Lawsuit unsealed and served on defendants
False Claims Act

- Damages & Costs
  - Government intervenes: Relator’s share 15% to 25%
  - Government declines: Relator’s share 25% to 30%
  - Suit successful: Defendant pays Relator’s attorney’s fees and costs
    - Intent of the law is to give incentive to people to disclose frauds against the government
    - Costs shifted to person committing the fraud (theft)
Smith & Brink, P.C. (“Smith & Brink”) announces the resolution of claims brought against Millennium Health, LLC f/k/a Millennium Laboratories, Inc. (“Millennium”) pursuant to the federal False Claims Act in a settlement reached with the United States. Millennium is one of the largest urine drug testing laboratories in the country, and at the peak of its operation it was the largest recipient of Medicare drug-testing payments in the country. Smith & Brink filed a whistleblower lawsuit on behalf of Allstate Insurance Company and Lawrence K. Spitz, M.D. alleging that Millennium engaged in a wide-ranging and comprehensive scheme to defraud the United States of America by seeking payment from Medicare and other federal healthcare programs for services that were not actually provided and were medically unnecessary. The case is United States of America ex rel. Allstate Insurance Company and Lawrence K. Spitz, M.D. v. Millennium Laboratories, Inc., No. 14-cv-14276 (D. Mass). Specifically, the lawsuit alleged that Millennium improperly paid kickbacks to medical providers in order to induce the providers to refer patients for urine drug testing. Once Millennium secured the agreements for patient referrals, its sales representatives pressured the referring providers into using “custom profiles,” which are standing orders to perform the exact same range of tests regardless of the needs of individual patients. Smith & Brink’s lawsuit alleged that Millennium’s scheme relied on abusive practices to cause the performance of millions of urine drug tests that were medically unnecessary after screens did not reveal unexpected results.
Summary

- **LIE + MATERIALITY = FRAUD**
- Fraud is **BAD**
  - Increases costs
  - Decreases availability
  - Results in bad medicine that harms patients
- Fraud is difficult to detect
- Penalties must be stiff to offset low risk
- False Claims Act: financial incentive for individuals to take action against fraud
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