

# Medical Fraud Under the False Claims Act

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## Medical Fraud

The Federal False Claims Act (FCA) was amended in 1986 to make it a more effective tool to fight fraud against the US Government. The major impetus for the 1986 Amendments was fraud by major defense contractors. But during the intervening years medical fraud has become a tremendous drain on the federal treasury. Nursing home fraud is an important part of this fraud on the Government.

**Medical fraud harms all of our citizens by diverting money needed for medical care into the pockets of corporate mobsters. Worse yet it results in substandard medical care for all. Especially heinous is the fraud perpetrated on Americans not able to care for themselves — seniors and poor people.**

The following lists major medical fraud FCA recoveries since 1986 and a careful reading will provide a virtual roadmap for discovering pervasive fraud in the medical industry:

## Types of Medical Fraud

Generally medical fraud involves reimbursement from the Medicaid or Medicare which is subject to strict regulation by the Government. The primary general types of medical fraud subject to FCA recovery include:

- ❑ **“Upcoding”** occurs when the Claimant uses a code to improperly describe a more complex medical procedure than that actually performed which will generate a higher recovery from the Government.
- ❑ **“Relabeling”** is where the Claimant improperly changes the label on a product to that of a more costly product resulting in a higher recovery from the Government. This might occur when a medical provider would change the label on an “expired” drug to make it current and illegally bill for the old drug.
- ❑ **“Overbilling”** results when the Claimant simply charges a higher rate or charges for more units of labor or goods that was provided resulting in an excess recovery from the Government. One example among many would be to charge for a lesser or unqualified person to perform a procedure at the rate allow for a higher or fully qualified person. Simply a Physicians Assistant might impermissibly charge at the rate authorized for a Medical Doctor.
- ❑ **“Bundling”** happens when the Claimant wrongly groups or bundles a number of procedures to obtain a higher reimbursement from the Government.
- ❑ **“Unbundling”** results when the Claimant improperly separates a number of medical procedures and individually bills for each to secure a greater reimbursement than permitted. For example a doctor during an office visit may perform a minor medical procedure to be able to bill for two procedures when he is legally permitted to charge only for one procedure — the office visit.
- ❑ **“Kickbacks”** include garden variety fraud where a Claimant improperly pays another person or entity to obtain Government business. This can include such things as a Doctor improperly referring patients to a medical laboratory he owns for tests. Other examples include drug companies paying doctors kickbacks disguised as teaching fees in exchange for the use of their overpriced drugs.
- ❑ Medical fraud at its simplest results when the Claimant charges for medical procedures that were not done or goods that were not necessary. This might also include charging for goods that do not meet Government standards like charging for medicine that has passed its expiration date.

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## Major Medical Fraud Recoveries

The following is a listing of the major FCA medical recoveries — all within the last ten years:

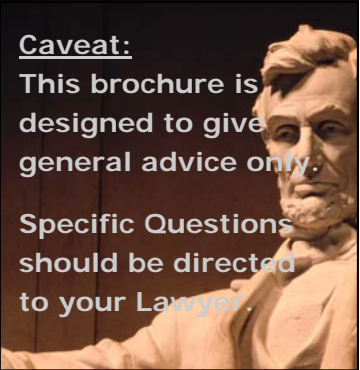
- ❑ [HCA — \\$731,400,000.](#) In December 2000, HCA The Healthcare Company (formerly known as Columbia HCA), the largest for-profit hospital chain in the United States, pled guilty to criminal conduct and agreed to pay more than \$840 million in criminal fines, civil penalties and damages for unlawful billing practices. Of this amount, \$731,400,000 was recovered under the False Claims Act. Under the settlement agreement, HCA's payment will resolve five allegations regarding the manner in which it bills the U.S. government and the states for health care costs. HCA's frauds on the taxpaying public included: billing for lab tests that were not medically necessary and not ordered by physicians, "**upcoding**" medical problems in order to get higher reimbursements for more serious medical issues, billing the government for advertising under the guise of "community education," and billing the government for non-reimbursable costs incurred in the purchase of home health agencies around the country.
- ❑ [HCA — \\$631,000,000.](#) In June 2003, HCA Inc. (formerly known as Columbia/HCA and HCA – The Healthcare Company) agreed to pay the United States \$631 million in civil penalties and damages arising from false claims submitted to Medicare and other federal health programs. This settlement resolves HCA's civil liability for false claims including cost report fraud and the payment of kickbacks to physicians. In a separate administrative settlement with the Centers for Medicare & Medicaid Services (CMS), HCA agreed to pay an additional \$250 million to resolve overpayment claims arising from its cost reporting practices. Combined with the December 2000 settlement, the government has recovered \$1.7 billion from HCA, by far the largest recovery ever reached by the government in a health care fraud investigation.
- ❑ [TAP \[Taketa-Abbott Pharmaceutical\] Pharmaceutical Products Inc. — \\$559,483,560.](#) In October 2001, TAP Pharmaceutical Products Inc. agreed to pay \$875 million to resolve criminal charges and civil liabilities in connection with fraudulent drug pricing and marketing of Lupron, a drug sold for the treatment of prostate cancer. Of this amount, \$559,483,560 was recovered under the False Claims Act. In addition, TAP pled guilty to a conspiracy to violate the Prescription Drug Marketing Act and paid a \$290 million criminal fine, the largest criminal fine ever in a health care fraud prosecution. Under the Lupron scheme, TAP gave doctors kickbacks by providing free samples with the knowledge that the physicians would bill Medicare and Medicaid \$500 per dose. At the time the Lupron fraud was discovered, Lupron accounted for 10% of the money spent on prescription drugs under Medicare Part-A.
- ❑ [Abbott Labs — \\$400,000,000.](#) In July of 2003, a unit of Abbott Laboratories, Inc. pled guilty to obstructing a criminal investigation and defrauding the Medicare and Medicaid programs and agreed to pay \$400 million to resolve civil claims. The Abbott/CG Nutritionals scam involved the sale of enteral products which pump special foods into the stomachs and digestive systems of patients who, because of disease or some other disorder, are not able to ingest meals in a normal manner.
- ❑ [Fresenius Medical Care of North America — \\$385,000,000.](#) In January of 2000, Fresenius Medical Care of North America, the world's largest provider of kidney dialysis products and services, agreed to pay the United States \$486 million to resolve a sweeping investigation of health care fraud at National Medical Care, Inc. (NMC), a kidney dialysis subsidiary owned by Fresenius. Of this amount, \$385,000,000 was recovered under the False Claims Act. Three NMC subsidiaries also pled guilty to three separate conspiracies and were levied fines of \$101 million. Fresenius has also entered into a corporate integrity agreement with the U.S. Department of Health and Human Services. The Fresenius/NMC scam involved fraudulent and fictitious blood testing claims by LifeChem, Inc., NMC's clinical blood testing laboratory, kickbacks to dialysis facilities to obtain blood testing contracts for LifeChem, and fraudulent claims submitted to Medicare for intradialytic parenteral nutrition (IDPN), a nutritional therapy provided to patients during their dialysis treatments.
- ❑ [SmithKline Beecham Clinical Laboratories Inc. d/b/a GlaxoSmith Kline — \\$325,000,000.](#) In March of 1997, SmithKline Beecham Clinical Laboratories Inc. (SBCL) was ordered to pay

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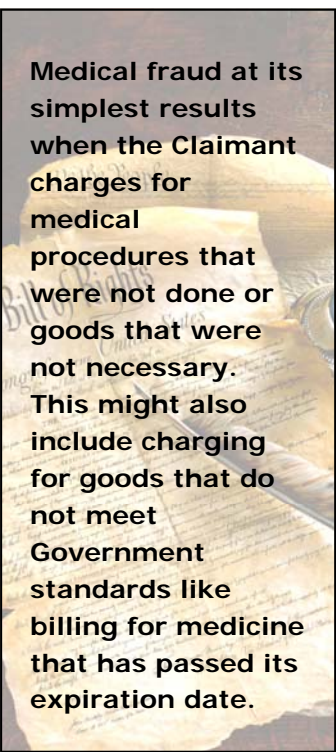
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\$325 million for filing of false claims relating to laboratory tests paid for in whole or in part by the federal government. The multiple scams involved adding on laboratory tests not requested by doctors and which were not medically necessary, billing for lab tests that were not actually performed, giving kickbacks to doctors in order to get their business, and billing Medicare for dialysis testing already paid for by kidney dialysis centers.

- ❑ **HealthSouth — \$325,000,000.** In December of 2004, HealthSouth Corporation, the nation's largest provider of rehabilitative medicine services, agreed to pay the United States \$325 million to settle allegations that the company systematically defrauded Medicare and other federal healthcare programs.
- ❑ **National Medical Enterprises — \$324,200,000.** In July 1994, National Medical Enterprises Inc. was ordered to pay \$379 million in criminal fines, civil damages, and penalties as part of a settlement in a case involving alleged Medicare and Medicaid fraud at psychiatric and substance abuse hospitals in over 30 states. The charges involved kickbacks to doctors for making referrals to the hospitals. Of the total \$379 million settlement, \$324,200,000 represented recoveries under the False Claims Act, and the rest represents criminal and civil fines.
- ❑ **Gambro Healthcare — 310,000,000.** In December 2004, Gambro Healthcare agreed to pay \$310.5 million to resolve civil liabilities stemming from alleged kickbacks paid to physicians, false statements made to procure payment for unnecessary tests and services, and payments made to Gambro Supply, a sham durable medical equipment company.
- ❑ **Schering-Plough — \$292,969,482.** In July 2004, Schering-Plough, a major pharmaceutical manufacturer, agreed to plead guilty to fraud in the pricing of Claritin sold to the Medicaid program. The settlement agreement included a criminal fine of \$52.5 million, \$117 million to settle state claims, and nearly \$176 million to settle federal False Claims Act claims.
- ❑ **AstraZeneca Pharmaceuticals — \$266,127,844.** In June 2003, AstraZeneca Pharmaceuticals LP, a major pharmaceutical manufacturer, pled guilty to health care fraud and agreed to pay \$355,000,000 to resolve criminal charges and civil liabilities in connection with its drug pricing and marketing practices with regard to Zoladex, a drug sold for the treatment of prostate cancer. Of this amount, \$266,127,844 was recovered under the False Claims Act, and the remainder was levied as criminal fines. AstraZeneca pled guilty to giving doctors kickbacks by providing free drug samples knowing that the doctors would then turn around and bill Medicare and Medicaid hundreds of dollars per sample.
- ❑ **Bayer Corporation — \$257,200,000.** In April 2003, Bayer Corp. paid \$257,200,000 to settle Medicaid fraud charges involving a "lick and stick" scheme in which Bayer sold re-labeled products to an HMO at deeply discounted prices, and then concealed this price discount in order to avoid paying additional rebates to the government. \$143 million of the Bayer settlement went to resolve a whistleblower's allegations that Bayer defrauded the Medicaid and Public Health Service programs by "**relabeling**" products sold to a health maintenance organization at deeply discounted rates and then concealing the discounts to avoid paying rebates, in violation of the Medicaid Rebate program.
- ❑ **First American Health Care of Georgia — \$225,000,000.** In October of 1996, a home health care organization and its purchaser agreed to reimburse the federal government \$255 million for "**overbilling**" and making fraudulent Medicare claims. Under the agreement, First American Health Care of Georgia, Inc., the nation's largest home health care provider, and its new owner, Integrated Health Services, Inc, agreed to reimburse the federal government for money stolen from Medicare through fraudulent billing practices. The alleged fraud was that First American billed Medicare for costs unrelated to the care of patients in their homes, including the personal expenses of First American's senior management, as well as for the company's marketing and lobbying expenses.
- ❑ **Laboratory Corporation of America — \$182,000,000.** In November 1996, Laboratory Corporation of America Holdings (LabCorp), agreed to pay \$182 million to resolve charges that it

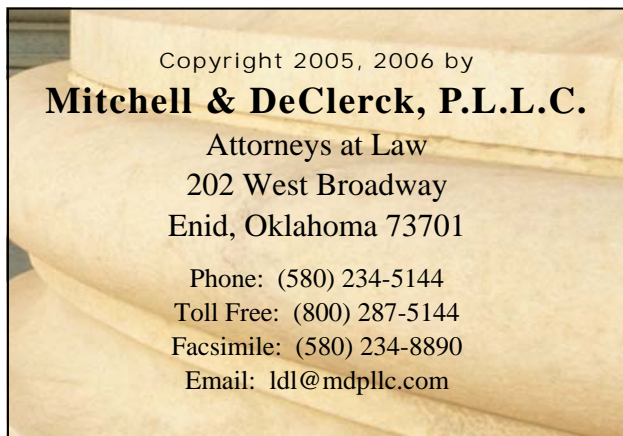


**Caveat:**  
This brochure is designed to give general advice only. Specific Questions should be directed to your Lawyer.



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## The Author

**Larry D. Lahman**, the author of this publication, was born in Carmen, Oklahoma. He attended Northwestern Oklahoma State University receiving a Bachelor of Science in Chemistry, Mathematics and Physics in 1965.

Lahman subsequently attended graduate school at OSU and later received a Juris Doctorate Degree from the OU Law School. He is admitted to practice before all state and local federal courts including the United States Supreme Court.

Lahman served as President of the Garfield County Bar Association and numerous other organizations.

**Lahman and our firm achieved the largest recovery in the state of Oklahoma in the 140 year history of the FCA in late 2004 — \$16 Million.**

He was a parachute officer with the U.S. Army Special Forces – the Green Berets – in Vietnam and retired as a Lieutenant Colonel in the U.S. Army Reserves.

## Our Law Firm

P.C. Simons, who served as Attorney General of Oklahoma Territory, organized the predecessor to **Mitchell & DeClerck** in 1907.

**The Firm has been in continuous existence for nearly a century and is the oldest law firm in Enid, Oklahoma, while also one of the oldest law firms in the state of Oklahoma.**

For decades the Firm has held the highest possible “A” rating by the Martindale-Hubbell Legal Directory. The Firm has long been listed in the “Bar Register” of preeminent law firms in the United States and “Best’s Directory of Recommended Insurance Attorneys.”

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submitted false claims for medically unnecessary laboratory tests to federal and state health care programs. The fraud involved bundled lab tests that were billed to Medicare as free-standing tests, resulting in an eight-fold increase in charges to Medicare.

- ❑ **Beverly Enterprises Inc. — \$170,000,000.** In February 2000, Beverly Enterprises Inc., the nation's largest nursing home chain, agreed to pay \$175 million to resolve civil and criminal charges that it defrauded Medicare. In addition to the \$170,000,000 collected under the False Claims Act, the company agreed to pay a \$5 million criminal fine and divest itself of ten nursing homes. The fraud involved nursing home workers charging Medicare for time not spent on Medicare patients. Instead of recording the true time spent on Medicare patients, Beverly-California fabricated records based on set formulas designed to maximize profits while avoiding detection by Medicare auditors. In addition to the guilty plea, the settlement requires Beverly to divest itself of 10 nursing homes and to submit to extensive monitoring by the Department of Health and Human Service's Office of Inspector General.
- ❑ **Pfizer/Warner-Lambert — \$152,000,000.** In May of 2004, Pfizer/Warner-Lambert agreed to pay \$430 million to resolve civil and criminal charges that it defrauded Medicaid by engaging in an aggressive and complex scheme to illegally promote Neurontin for at least 11 off-label uses. In addition, Warner-Lambert is alleged to have made kickbacks and payments to doctors in the form of trips to Puerto Rico, Florida, Hawaii and elsewhere as an inducement for them to give speeches promoting the off-label use of the drugs, as well as paying doctors to "author" medical journal articles that were actually written by a medical marketing firm. Of the total \$430 million payout, \$152 million will settle the False Claims Act aspects of the case, and an additional \$240 million represents criminal penalties.
- ❑ **Blue Cross Blue Shield Illinois — \$140,000,000.** In July 1998, Blue Cross Blue Shield of Illinois (also known as Health Care Service Corporation) pled guilty to eight felony counts and agreed to pay \$144 million. The nature of the fraud was that Blue Cross Blue Shield Illinois manipulated work samples and falsified reports to the Health Care Finance Administration in order to conceal evidence of its poor performance as a federally-contracted processor of Medicare claims.
- ❑ **Vencor, Inc./Ventas Inc. — \$104,500,000.** In March 2001, Vencor Inc., one of the nation's largest nursing home chains, and Ventas Inc., a related real estate investment trust, agreed to pay the United States \$104.5 million to resolve civil claims that Vencor knowingly submitted false claims against federal health care plans. Of the \$104.5 million settlement, more than \$20 million was accounted for by failure of Vencor to provide the promised quality of care to nursing home patients due to inadequate staffing, improper care of bedsores, and failure to meet resident's basic dietary needs. The remaining portions of the \$104.5 million settlement included a \$54 million civil fine for improper claims made on Vencor's hospital Medicare cost reports, and more than \$24 million for over-billing for respiratory care services and supplies.