



Health Care Fraud Report

Fiscal Year 1998

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EXECUTIVE SUMMARY

Since 1993, the Department of Justice (Department) has made fighting fraud and abuse in the health care industry one of the Department's top priorities. Health care fraud and abuse drains billions of dollars from Medicare and Medicaid, which provide essential health care services to millions of elderly, low income, and disabled Americans. The impact of health care fraud and abuse cannot be measured in terms of dollars alone. While health care fraud burdens our nation with enormous financial costs, it also threatens the quality of health care.

The Department has developed a balanced and responsible program to fight health care fraud and abuse. The first component of the Department's program focuses on enforcement efforts, including the use of criminal and civil tools. The second component emphasizes prevention and deterrence, through compliance initiatives for the health care industry and through public education to empower individual patients to be vigilant in identifying and reporting potential health care fraud schemes.

The Department's enforcement actions have proven results. In FY 1998, \$480 million was awarded or negotiated as a result of criminal fines, civil settlements, and judgments in health care fraud matters. Under the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), \$243 million was returned to the Medicare Trust Fund to support future beneficiary payments. Additionally, the Department reported that there were 326 defendants in 219 criminal cases that were convicted of health care fraud and abuse. At the same time the U.S. Department of Health and Human Services excluded more than 3000 individuals and businesses from participating in federal health programs, many due to criminal convictions.

The Department continues to prevent fraud and abuse in a number of ways: by encouraging providers to police their own activities through compliance programs; and by sponsoring consumer outreach initiatives, such as the consumer's fraud hotlines, to involve patients with first-hand knowledge in the detection of fraudulent practices. Settlement agreements with providers also emphasize future prevention efforts. Settlements in FY 1998 included 231 corporate integrity agreements, where providers agreed to change their operations so as to prevent fraud from recurring in the future.

The pace of legislative and industry change is altering the landscape of health care delivery and payment, presenting new challenges that must be planned for, both in prevention and enforcement efforts. The Department's continuing challenge in the future is to change the behavior of health care businesses so that they will take effective measures to prevent health care fraud schemes, while keeping enforcement efforts cognizant of the adverse impact of provider's conduct on the welfare of their patients.

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HEALTH CARE FRAUD: NATURE AND SCOPE OF THE PROBLEM

The Severity of the Problem

Health care fraud in the United States remains a serious problem that has an impact on all health care payers, and affects every person in this country. Health care fraud cheats taxpayers out of billions of dollars every year. Tax dollars alone do not show the full impact of health care fraud on the American people. Beneficiaries must pay the price for

health care fraud in their copayments and contributions. Fraudulent billing practices may also disguise inadequate or improper treatment for patients, posing a threat to the health and safety of countless Americans, including many of the most vulnerable members of our society.

Progress has been made in combating health care fraud as seen in the decline of Medicare overpayments. In FY 1998, Medicare overpayments were estimated at \$12.6 billion, or 7.1 percent, of Medicare's total fee-for-service spending, according to a comprehensive audit by the Office of Inspector General (OIG) for the U.S. Department of Health and Human Services (HHS). That compares with an estimated \$20.3 billion, or 11 percent, of Medicare spending, for FY 1997, and \$23.2 billion, or 14 percent, for FY 1996, the first year such an audit was conducted. This dramatic improvement is the result of stepped-up enforcement of Medicare regulations and laws by the Justice Department and HHS, additional funding for enforcement, and increased compliance by hospitals and other providers. In spite of this improvement, there is still more that needs to be accomplished in the health care fraud and abuse prevention effort.

Who Commits Health Care Fraud?

Fraudulent schemes are changing and becoming even more sophisticated. Unscrupulous persons and companies can be found in every health care profession and industry, and fraudulent schemes targeting health care patients, providers, and plans have occurred in every part of the country and involve a wide array of medical services and products.

Fraud has been perpetrated by individual physicians and large publicly traded companies, medical equipment dealers, contract carriers for Medicare and Medicaid, laboratories, hospitals, nursing homes, and home health care agencies. Individual scam artists who provide no health care at all prey upon the nation's health care programs, as well. Fraudulent schemes put billions of dollars in the pockets of individuals and providers who cheat the system, while we struggle to pay for lifesaving drugs to fight AIDS and provide more frequent screening to detect and prevent cancer as well as other life-threatening illnesses.

How Do Perpetrators Commit Health Care Fraud?

Health care fraud schemes are diverse and vary in complexity, with unscrupulous providers targeting both public and private health insurance plans. Such schemes include:

- Billing for services not rendered
- Billing for services not medically necessary
- Double billing for services provided
- Upcoding (e.g., billing for a more highly reimbursed service or product than the one provided)

- Unbundling (e.g., billing separately for groups of laboratory tests performed together in order to get a higher reimbursement)
- Fraudulent cost reporting by institutional providers

Kickbacks in return for referring patients or influencing the provision of health care are other common schemes. The anti-kickback statute prohibits the payment of kickbacks for the purpose of inducing the referral of services which are paid for by federal health care programs. Kickbacks corrupt the decision making of medical providers, placing profit above patient welfare. They can lead to grossly inappropriate medical care, including unnecessary hospitalization, surgery, tests, and equipment.

Other types of schemes include providing services by untrained personnel, failing to supervise unlicensed personnel, distributing unapproved devices or drugs, and creating phony health insurance companies or employee benefit plans.

Where Does Health Care Fraud Take Place?

Health care fraud schemes have been investigated and prosecuted in every part of the country, in urban and rural areas, and in rich and poor areas. As health care options and the reach of federal programs have expanded, so have the boundaries of health care fraud. New arenas for fraud are being seen in home health care and hospice services which have become eligible for reimbursement under federal programs. Strong control programs for reimbursement and vigilant enforcement efforts are required in these areas to prevent fraud from growing.

What Are the Consequences of Health Care Fraud?

Health care fraud exacts a price from everyone. For example, Tennessee clinics treated and discharged patients undergoing alcohol and drug rehabilitation without any physician involvement. In Georgia, one scheme involved enrolling impoverished children in after school programs, that were then portrayed as psychotherapy in billings to the state and Federal Government. In Minnesota, a university had been selling a non-FDA approved drug. Eliminating and deterring health care fraud schemes of all types are among the Department's highest priorities. The Department is committed to addressing the scope and variety of schemes in our efforts to successfully investigate and prosecute fraud.

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NATIONAL HEALTH CARE FRAUD PROGRAM

A Comprehensive Program Against Health Care Fraud and Abuse

The Department of Justice takes a balanced approach to combating health care fraud. The Department's strategy consists of two components: a strong civil and criminal enforcement program, strengthened under the Health Insurance Portability and Accountability Act of 1996 (HIPAA); and prevention efforts, which encourage providers to adopt compliance programs and accept responsibility for policing their own activities. In essence, preventing fraud where possible, but pursuing civil and criminal remedies when it is not. The Department is committed to tough but responsible enforcement of federal civil and criminal laws, as well as to strong partnerships with health care providers to promote compliance within the industry. The best way to strengthen the health care system in this country is by enforcing the laws and promoting compliance and prevention.

HIPAA required the Attorney General and the Secretary of HHS to establish a Health Care Fraud and Abuse Control Program (HCFAC), providing a coordinated national framework for federal, state, and local law enforcement agencies, the private sector, and the public to fight health care fraud. This focus coordinates the administrative approach, provides significant directed funding, and strengthens criminal laws and administrative powers related to health care fraud.

The Program seeks to achieve the following objectives:

- To punish wrongdoing
- To deter others from committing fraud and abuse
- To protect patients against abuse and neglect
- To protect the integrity of the Medicare Trust Fund, and other Federal health care programs
- To educate patients and providers about the need to prevent health care fraud and to foster compliance within the industry

HIPAA also strengthened enforcement authority under several new or revised provisions, which included:

- Creating a new criminal offense for health care fraud, theft or embezzlement in connection with a health care offense, false statements relating to health care offense, and obstruction of criminal investigations of health care offenses
- Adding a Federal health care offense to the money laundering statute
- Extending injunctive relief relating to health care offenses (includes freezing of assets)
- Providing the Attorney General with subpoena authority in criminal health care fraud investigations
- Establishing criminal forfeitures for Federal health care offenses
- Expanding anti-kickback statute to cover Federal health care programs, not just Medicare and State health care programs
- Strengthening exclusions for health care convictions

Each year, the Attorney General and the Secretary of HHS must determine and certify discretionary funding requirements, which were \$119.6 million in FY 1998. In addition, the Federal Bureau of Investigation (FBI), receives mandatory funding under HIPAA, which was \$56 million in FY 1998.

Enforcement Vehicles - Criminal and Civil

During FY 1998, federal prosecutors and attorneys filed 322 criminal health care fraud cases, had 3,471 civil health care fraud matters pending end of year, and filed 107 new civil fraud cases.

The use of civil laws is a critical component of our enforcement policy. Most civil health care fraud matters involve the False Claims Act (FCA), under which the Department may bring civil enforcement actions and seek damages and penalties against providers who knew that false or fraudulent bills were submitted to Medicare, Medicaid, or other federal health programs.⁽¹⁾

The Department has recovered \$2 billion in matters involving alleged fraud against HHS since 1986, when Congress amended the FCA to strengthen this important remedy, and noted in doing so that the Act is intended to address fraud against the Medicare and Medicaid programs. Congress intended for all providers to take responsibility for ensuring the accuracy of the bills they submit for reimbursement. Mere negligence, mistakes, and inadvertence, however, do not amount to false claims, and The Department does not and will not bring FCA actions against doctors and hospitals for honest billing errors. The purpose of the law is to single out those providers who recklessly or with deliberate indifference allow fraudulent billing practices to occur or continue.

In civil cases, the Department receives referrals from private whistleblowers bringing *qui tam* actions, other informants, and federal and state agencies. The Department carefully examines each referral to properly assess the liability of the health care provider and encourages providers to brief the responsible government attorney on any factors which may have bearing on a case. The Civil Division also maintains staff with expertise in health care fraud, and may work in conjunction with the United States Attorney's Office (USAO) or independently to handle large, national, or precedent-setting cases.

Qui tam, or whistle blower suits have dramatically increased detection of and monetary recoveries for health care fraud. Under the FCA, in certain circumstances private individuals can file an action on behalf of the United States, and obtain part of any recovery by the government in the action. The *qui tam* statute provides strong financial incentives to expose fraudulent activities. Over half of the \$480 million the Department was awarded in health care fraud cases in FY 1998, involved judgments or settlements related partially or completely to allegations in *qui tam* cases. More than one half of all *qui tam* suits involve allegations of fraud against HHS.

Qui tam suits are very important because they can serve to detect fraud that might otherwise go undetected. In a *qui tam* action, the government may choose to intervene and take over the case, or may decline yet collect part of any recovery in the case.

Qui tam plaintiffs often work with the Department to build a strong chain of evidence that can be used during settlement discussions or at trial.

Overall, the FCA has powerful and far reaching effects. First, it has been the vehicle for recovering hundreds of millions of dollars of fraudulently obtained funds each year. Second, the statute encourages providers to take responsibility for the accuracy of their claims - because they may be liable under FCA if they are reckless or deliberately ignorant of wrongdoing by employees. Finally, the statute helps to deter providers from committing fraud, because of its damage and penalty provisions. One recent study, "The 1986 False Claims Act Amendments: An Assessment of Economic Impact" by W. Stringer, estimates the deterrent effect of the FCA from 1987 to 1997 to be \$148 billion.

New tools and training are also being developed to aid litigation efforts:

In FY 1998, the Executive Office for the United States Attorney's (EOUSA) Office of Legal Education (OLE) conducted a number of both basic and advanced courses for Department attorneys, auditors, investigators and paralegals. Courses included:

- Affirmative Enforcement/Health Care Fraud Investigators Session
- Basic Health Care Fraud for Attorneys
- Basic Affirmative Civil Enforcement - included a health care fraud component
- Advanced Affirmative Civil Enforcement - included a health care fraud component
- Advanced Health Care Fraud for Attorneys
- Basics of Medicare for Attorneys and Paralegals

The funding made available through HIPAA also made it possible to have four Regional Training Conferences for FBI agents assigned to health care fraud investigations. These one-week training sessions sponsored by the Health Care Financing Administration (HCFA) provided in-depth training on the Medicare Program to almost 300 agents. Training was also provided on Pharmacy Diversion and Cost Report issues.

Civil Rights of Institutionalized Persons Act

In addition to the Department's civil and criminal health care fraud prosecutions, the Civil Rights Division has played an important role in protecting the rights of individuals in health care facilities and improving their conditions of confinement. During FY 1998, the Civil Rights Division continued its vigorous enforcement program under the Civil Rights of Institutionalized Persons Act (CRIPA) to remedy egregious conditions in public residential health care facilities. Under CRIPA, the Attorney General has authority to investigate conditions in public residential institutions, including nursing homes and

mental health and mental retardation facilities, and to take appropriate action where there is a pattern or practice of unlawful actions that deprive persons confined in the facilities of their constitutional or federal statutory rights. As a result of the Department's efforts since CRIPA was enacted in 1980, tens of thousands of institutionalized persons who were living in dire, often life-threatening, conditions now receive adequate care and services.

In FY 1998, the Department was active in CRIPA matters and cases involving 43 health care facilities in 20 states, the District of Columbia, the Commonwealth of Puerto Rico, and the Territory of Guam. The Department conducted CRIPA investigations of 27 health care facilities and monitored the implementation of consent decrees involving an additional 20 health care facilities. The Department's efforts in these facilities focused on protecting residents from abuse, neglect and undue restraint, providing adequate medical and nursing care and rehabilitation, and ensuring that residents are served in the most integrated setting appropriate to meet their needs as required by the Americans with Disabilities Act.

Of particular note, during August 1998, the Civil Rights Division settled a CRIPA case involving unlawful conditions of confinement in a Pennsylvania nursing home. This settlement represents the first case stemming from a joint investigation under CRIPA and the FCA. The settlement, which was a cooperative effort by the Special Litigation Section, the U.S. Attorney for the Eastern District of Pennsylvania, the Civil Division, and the Office of the Inspector General of the HHS, covered both the injunctive relief necessary to remedy deficiencies in the nursing home as well as monetary penalties to reimburse the federal government for fraudulent Medicare billings for inadequate care. The settlement required improvements in conditions at the Pennsylvania nursing home to ensure that its elderly and disabled residents were free from abuse and neglect and that they received adequate care and treatment. As a result of alleged false billing practices, the defendants agreed to pay civil monetary penalties to the federal government under the FCA and also to pay restitution to the residents by establishing a fund for a special project, authorized by the United States, that will improve the quality of life for residents at the nursing home. In addition, the settlement provides for a Federal monitor who will oversee compliance with the terms of the agreement.

National Projects

Increasingly health care fraud is becoming a widespread and sophisticated activity involving large computerized payment systems and a myriad of claims. Detecting fraudulent billing schemes often involves doing extensive computer analysis on claims. To provide for consistent treatment of fraudulent schemes, national projects have been initiated to address similar types of wrongdoing by a given class of providers.

For each national project, the Department establishes a working group to provide "best practices" guidance, and oversee compliance with Department policies, while simultaneously giving the United States Attorney's Office (USAOs) the flexibility they need to address each matter fairly and on an individual basis. The working groups are

comprised of Assistant United States Attorneys and Civil Division attorneys with particular expertise in health care fraud. For each project, the working group develops an appropriate, initial factual and legal predicate, a set of best practices on the investigative steps each district should take before proceeding against individual providers, sample contact letters, settlement agreements, and other pleadings. In addition, each working group is responsible for coordinating efforts with the investigative and program agencies. Working groups aim to ensure that the legal process and standards used are consistent across cases and afford proper notice to providers and provide an adequate opportunity to respond.

Prevention Efforts

Outreach efforts are crucial to winning the fight against health care fraud. The Department wants to encourage corporate citizenship and affirm the importance of strong compliance programs. This emphasis on compliance plans represents a fundamentally different approach from traditional law enforcement. Rather than the FBI and the Inspector General policing corporations, corporations would police themselves. Rather than an adversarial relationship between law enforcement and the private sector, there would be a relationship of cooperation and mutual support. Providers also benefit because a successful compliance program helps them to avoid potential civil and criminal liability.

Under a compliance program, providers become knowledgeable about when, where, and how fraud can occur, as well as about what the law and regulations require. They then develop control procedures and reporting for vulnerable aspects of their operations to prevent common types of fraud. They also develop reporting and audits that can detect fraud, and a way to deal with problems when they are found. If problems are found, they should be disclosed to the appropriate agencies and authorities to limit potential liability.

HHS and the Department are trying to encourage responsible provider action by providing model compliance guidance, and by providing interpretations of the law to guide providers in assessing their activities. In FY 1998, final regulations were issued for the advisory opinion process, through which HHS can provide guidance on whether specific transactions violate the anti-kickback or civil monetary penalty statute and fifteen advisory opinions were issued. Also, in FY 1998, HHS-OIG developed model compliance plans for home health agencies, hospitals, and recently third party medical billing companies. HHS-OIG will continue to develop these plans as well as voluntary disclosure programs. In addition, HHS is canvassing the industry for suggestions on where safe harbors under the anti-kickback statute and special fraud alerts are needed. One special fraud alert has been issued on financial relationships between hospices and nursing homes.

Outreach efforts will also focus on beneficiary populations, educating them on how to recognize and report suspected fraud and abuse. Consumers of health care should be the first line of defense against fraud. The Department places a high priority on this kind of outreach and intends to increase its efforts to enhance public awareness of health

care fraud.

During FY 1998, the Civil Rights Division also engaged in active outreach efforts to educate consumers, advocates, and the public about its CRIPA activities. The Division continued the activities of its Nursing Home Working Group, to coordinate and enhance its civil rights enforcement efforts in nursing homes. Finally, as required by CRIPA, where federal financial, technical, or other assistance was available to help state and local jurisdictions correct deficiencies, the Division advised responsible public officials of the availability of such aid and arranged for assistance, where appropriate.

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ENFORCEMENT ACCOMPLISHMENTS

A Record of Success

The USAOs, the Civil Division, the Criminal Division, the FBI, and the Justice Management Division (JMD) have utilized the increased resources provided by HIPAA, to prosecute and win record numbers of cases and recover larger amounts in fines and settlement payments than ever before. In FY 1998, enforcement efforts resulted in \$480 million in civil settlements and judgments won or negotiated. Statistical enforcement accomplishments in both civil and criminal cases are presented below, followed by synopses' of key cases. Descriptions of a variety of FY 1998 cases appear at the end of this report.

The Department collected \$264 million in FY 1998. Of the monies collected, \$239 million was returned to the Medicare Trust Fund, \$9 million was recovered as the federal share of Medicaid, \$12 million was restored to other Federal agencies, and \$4 million was paid to plaintiffs involved in *qui tam* suits.

Criminal and Civil Enforcement Statistics

Criminal matters investigated increased 23 percent in FY 1998, and prosecutions increased 14 percent. Criminal health care fraud cases are referred to USAOs by the FBI, HHS-OIG, or other enforcement agencies and opened as matters pending in individual districts. A case remains a "matter" until an indictment is filed or the case is declined for prosecution.

CRIMINAL HEALTH CARE FRAUD MATTERS (USAOs)

FISCAL YEAR	MATTERS	DEFENDANTS
1998	1,866	2,986

1997	1,517	2,479
1996	1,346	2,151

CRIMINAL HEALTH CARE FRAUD PROSECUTIONS FILED (USAOs)

FISCAL YEAR	CASES	DEFENDANTS
1998	322	439
1997	282	531
1996	246	450

CRIMINAL HEALTH CARE FRAUD CONVICTIONS (USAOs)

FISCAL YEAR	CASES	DEFENDANTS
1998	219	326
1997	217	363
1996	177	307

Civil health care fraud cases may be handled by a USAO itself or by the Civil Division in conjunction with a USAO. USAOs handle most matters in which the alleged single damages are less than \$1 million. Civil health care fraud matters are referred by federal or state investigative agencies or by private persons known as "relators." Relators file suits on behalf of the federal government under the 1986 *qui tam* amendments to the FCA, and may be entitled to share in the recoveries resulting from these lawsuits. When a case is referred to a USAO, it becomes a matter pending in the district. The United States may file a civil complaint or intervene in a *qui tam* complaint in U.S. District Court. Overall, the number of matters pending began to decrease in FY 1998, as activity on the DRG National Project began to wind down.

In addition to acting on referrals of fraud allegations, the Affirmative Civil Enforcement (ACE) program was initiated to encourage the USAOs to take a proactive approach to the use of available civil remedies to address health care and other fraud. The ACE program provides dedicated resources to supplement those of the various enforcement agencies on specific projects, and also to investigate potential fraudulent practices where no specific referral is involved.

CIVIL HEALTH CARE FRAUD MATTERS PENDING (USAOs)

FISCAL YEAR	MATTERS
1998	3,471
1997	4,010
1996	2,488

CIVIL HEALTH CARE FRAUD CASES FILED (USAOs)

FISCAL YEAR	CASES
1998	107
1997	89
1996	90

In conjunction with the USAO's, the Civil Division also pursues civil remedies in health care fraud matters, working closely with the FBI, HHS-OIG, and other federal law enforcement agencies. The Civil Division initiated a record number of 161 new health care fraud matters in FY 1998.

Civil Division judgments and settlements in health care fraud matters decreased from \$989.7 million in FY 1997 to \$300.4 million in FY 1998, a decrease of 33 percent. The decrease is due to the fact that 3 unusually large cases settled in FY 1997, Labcorp (\$187m), Smithkline (\$325m), and Damon (\$83.7m). *Qui tam* actions continue to provide support for a major portion of civil cases and judgments/settlements, as shown below.

QUI TAM* CASES AND RECOVERIES**	FY 1996	FY 1997***	FY 1998****
<i>Qui Tam</i> Cases Filed	346	546	469
<i>Qui Tam</i> Cases Filed Alleging Health Care Fraud	176	306	273
Health Care Fraud Judgments/Settlements in Matters with <i>Qui tam</i> Claims (millions)	\$66	\$608	\$261
Total Health Care Fraud Judgments/Settlements (millions)	\$136	\$961	\$300

* Cases personally handled by the Civil Division, cases worked in conjunction with the USAOs and cases delegated to the USAOs.

** Judgments/settlements in cases involving the Civil Division working alone or in conjunction with the USAOs; excludes monies from cases handled exclusively by the USAOs.

*** FY 1997 judgments/settlements include Smithkline Beecham at \$333.9 million (includes \$8.6 million interest and \$14.5 million in state recoveries).

**** FY 1998 judgments/settlements include \$.98 million in state recoveries.

Significant Cases

FY 1998 saw the conclusion of two major investigations involving allegations of fraud on the part of the contractors who process claims on behalf of the Medicare program. Health Care Services Corporation, the Medicare carrier for Illinois and Michigan, agreed to pay the government \$140 million in settlement of a *qui tam* suit alleging that it shredded claims, altered documents and otherwise manipulated data relied on by the HCFA to evaluate its contract performance. In addition to the civil settlement, the corporation agreed to plead guilty to obstructing a federal audit, conspiracy to obstruct a federal audit, and making false statements to HCFA which will result in a \$4 million

criminal fine. In order to guard against future misconduct, and to ensure that any potential lapses are detected early, the government and the corporation also entered into a strict corporate integrity agreement.

Pennsylvania Blue Shield, the Medicare carrier for several mid-Atlantic states, resolved a 2-year investigation by agreeing to pay \$38.5 million in settlement of allegations that it improperly processed Medicare secondary payor claims, neglected to recover overpayments, bypassed certain computer payment safeguards, and failed to implement required screens for certain lab tests, all of which resulted in false claims to the Medicare program. Again, the contractor agreed to undertake corporate integrity obligations, including training and external reviews of its performance.

In the area of psychiatry, an Atlanta businessman was sentenced to 3 years and 10 months and ordered to pay \$7 million in restitution for defrauding HHS, the State of Georgia Department of Medical Assistance, and certain Medicaid recipients, through a complex scheme involving billing Medicaid for individual and group psychotherapy allegedly provided to children. The scheme involved employees going door-to-door in impoverished areas to recruit children for after school programs, typically failing to inform parents that Medicaid would be billed for psychotherapy allegedly provided to their children. These services were not necessary and not actually provided to the children.

Smaller but significant settlements were reached in relation to defective pricing and pharmaceutical suppliers. Invacare Corporation agreed to pay \$2.6 million to the U.S. Department of Veterans Affairs to settle allegations of fraud in the sale of wheelchairs. The corporation failed to provide accurate and complete cost data during contract negotiations. An Illinois supplier of drugs and pharmaceutical products pleaded guilty to making false statements to the Illinois Department of Public Aid concerning fraudulent bills submitted to them, the Corporation also agreed to pay \$5.3 million to the U.S. Government and the State of Illinois. The defendant established a procedure in which medications that were returned to the pharmacy were placed back into inventory without crediting the Illinois Department of Public Aid, which had paid for the drugs.

The U.S. Court of Appeals for the Eighth Circuit reversed a lower court's ruling that the University of Minnesota could not be sued under the FCA. The court held that the United State's claim that the university misused federal grant money and made millions of dollars on an experimental drug that had not been approved by the Food and Drug Administration (FDA) could go forward. The Federal Government sued the University of Minnesota in 1995, claiming that it had misused grant money in an organ transplant research project. The government had also alleged that the University had submitted false Medicare claims, and that it received nearly \$2 million through illegal kickback arrangements.

The Department continues to make use of the new enforcement tools provided under HIPAA. In what may be the first use of 18 U.S.C. § 1035, enacted under HIPAA, which makes it a criminal offense to submit false statements relating to health care matters, two Florida men were indicted for allegedly defrauding 27 private insurance and self-

insured companies out of more than \$10 million by filing false medical claims, and with various acts of money laundering.

A manager working for the University of Mississippi pleaded guilty to embezzling nearly \$147,000. The violation to which the defendant pleaded guilty was 18 U.S.C. § 669, an embezzlement statute created by HIPAA. Section 669 of Title 18 makes it a crime to embezzle money or property from a health care benefit program or from an individual or entity providing health care services under a federal health care program such as Medicare.

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RESOURCES

In FY 1998, the Department received \$28.4 million of the \$119.6 million appropriation certified by the Secretary of HHS and the Attorney General, as necessary to execute the HCFAC Program. The funding breakdown within the Department is shown in the chart below. Separately, the FBI received \$56 million (\$47 million of which was base funding) for related enforcement activities.

Total departmental expenditures in FY 1998 were \$126 million, with \$77 million for the FBI and \$49 million for USAOs, Criminal, Civil Division, and Civil Rights Division.

Discretionary funding under HIPAA will increase by 15 percent annually until FY 2003, and FBI enforcement funding will reach \$114 million by FY 2003.

FY 1998 ALLOCATION OF DISCRETIONARY HCFAC APPROPRIATION (Dollars in thousands)

Department of Justice

United States Attorneys	\$23,856
Civil Division	3,803
Criminal Division	561
Justice Management Division	250
Total	\$28,470
Department of Health and Human Services	91,130
Total	\$119,600

In the last four years, Department staffing for health care fraud has grown rapidly. Department prosecutorial and FBI agent work years devoted to health care fraud matters

have tripled since FY 1993. Additionally, staff in the Civil and Criminal Divisions support the effort in litigating individual cases. The following chart shows the trend in attorney and agent work years devoted to health care fraud, a 22 percent growth in manpower (Department attorney and FBI agent work years) from FY 1997 to FY 1998. In FY 1998, the FBI received additional funding for 47 agent and 40 support positions.

EFFORT IN WORK YEARS DEVOTED TO HEALTH CARE FRAUD

Fiscal Year	USAO Attorneys	Civil Division Attorneys	Criminal Division Attorneys	Civil Rights Division Attorneys	FBI Agents	Total Atty./ Agents
1998	185	40	7	.25	442	672.25
1997	132	17	7	.2	395	551.2
1996	93	11	3	.2	256	363.2
1995	85	13	3	.1	261	362.1
1994	71	10	3	0	225	310
1993	43	6	3	0	147	200

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FUTURE CHALLENGES

The Department continues to reach out to consumers, providers, regulators, and the private bar in an effort to identify ways to improve enforcement efforts and policies. It is not sufficient that the Department collect dollars obtained through health care fraud schemes and cause penalties to be imposed on those who commit fraudulent acts. The Department's efforts in that regard have been quite successful. The Department's continuing challenge in the future is to change the behavior of health care businesses so that they will take effective measures to prevent health care fraud schemes.

To be sure, punishing those who commit health care fraud acts will deter those who might commit fraudulent acts in the future. However, changes in behavior, particularly corporate behavior, require changes in billing systems, education of providers and those who do their billing, and alteration of the attitudes of Boards of Directors, Chief Executive Officers, and facility Administrators. In essence, the Department wants health care businesses to alter the way they do business by placing a high priority on complying with applicable laws and regulations.

To this end, in a variety of forums, Departmental officials have encouraged corporate self-governance, urging businesses to assume responsibility for self-policing, rather than waiting for a whistleblower to alert the government to the fraud or for the government to detect it through other means. These changes in corporate attitudes are occurring, and

will continue to occur, as more and more health care businesses realize that it is "good business" to invest in their own future through fraud control systems and compliance programs.

The Department's reasons for encouraging good corporate citizenship are not limited to the need to protect public and private health care dollars which might otherwise be lost to fraud. The Department is concerned about the adverse effects on the quality of care which is rendered to patients as a result of fraudulent acts. In that regard, corporate compliance programs should not only prevent health care fraud, but should also result in greater compliance with standards of care, the violation of which can constitute violations of law.

The Department's future enforcement efforts will be especially cognizant of the adverse impact of provider's conduct on the welfare of their patients. A particular area of concern is protecting against fraud in managed care as the percentage of beneficiaries participating in federally-funded managed care plans continues to grow. In managed care arrangements, the fraud prevention and detection effort is primarily concerned with ensuring that the full quality of care and range of services that providers contract to provide are actually delivered. Proper contracting provisions, quality assurance mechanisms, and post care audits are required to ensure that providers comply with the care requirements and are accountable for their activities.

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SELECTED CASES

Ambulance Services

On February 27, 1998, in the Southern District of Mississippi, the owners of Gieger Transfer Services, an ambulance company, were sentenced to 80 months in prison and ordered to pay restitution of \$228,917 and a \$12,500 fine. The defendants billed Medicare \$400 per ambulance trip, claiming that patients taken on non-emergency ambulance trips were "bed confined" when, in fact, many could walk and had no need for ambulance transportation. A substantial portion of the money paid to the United States under the agreement is derived from the forced sale of beachfront properties purchased by the owners following the sale of their company in September 1997. The forced sale of the properties resulted from a \$2.25 million civil settlement with the owners and the company formerly owned by them.

Clinical Drug Trials Fraud

On September 15, 1998, in the Central District of California, the owner and President of

American Pharmaceutical Research (APR) were sentenced to 15 months in jail for conspiring to make false statements within the jurisdiction of the FDA. This case arose out of an FDA audit during which time it was learned that APR, which hired itself out to pharmaceutical companies to conduct clinical drug trial on human subjects, falsified drug study data that was being submitted to the FDA and failed to comply regularly with required drug testing and procedures.

Clinics

On February 20, 1998, in the Middle District of Florida, the owner/operator of the Tampa branch of the Florida Impotence Clinics, Inc., was sentenced to 27 months in prison and restitution of \$925,779. The defendant had pleaded guilty to having been engaged in a conspiracy to receive kickbacks for referrals to suppliers of diagnostic testing services. The owner received \$30 for any vacuum constrictor device used to treat impotence which was paid for by Medicare and sold by any clinic associated with the company.

On August 3, 1998, in the Northern District of Texas, a psychiatrist who was also an attorney and a member of MENSA, was convicted by a federal jury on 12 counts of mail fraud for overbilling insurance companies. The psychiatrist operated a clinic where he worked one day a week for approximately 7 hours when he would see patients. The majority of his patients would be billed for at least two medical procedures. One procedure would include a comprehensive medical service with a complete physical examination which should take at least 40 minutes. The other procedure was for an individual psychotherapy session of 45-50 minutes. Thus, for nearly every patient that was seen, they were billed for at least an hour and 25 minutes of care. In his seven-hour workday, the psychiatrist billed one hour and 25 minutes of work for 25-30 patients, billing from 35-40 hours in a single day. At the trial the psychiatrist's patients testified that they typically saw the doctor for about 10 minutes, and they were not aware that they received either the physical examinations or the psychotherapy that was billed.

On September 24, 1998, in the Western District of Washington, a doctor and his wife, operators of Seattle Acupuncture Center, pleaded guilty to a one-count information charging them with conspiracy to make false Medicare and Medicaid claims, and to commit mail fraud and health care fraud. Between 1992 through 1997, when acupuncture was not covered by Medicare, Medicaid and other insurers, the doctor and his wife falsely told Medicare and other insurers that patients received certain forms of physical therapy rather than the acupuncture actually provided. In some cases they submitted claims when no services were provided to the patients. The couple received \$375,000 to which they were not entitled. In addition to each pleading guilty to the criminal charge, they have jointly paid \$520,809 to the Federal Government as restitution and treble damages, and approximately \$117,000 in restitution to private insurance companies.

On August 14, 1998, in the District of Hawaii, a hospital paid \$2.4 million to the Federal Government and the state of Hawaii to settle allegations of wrongdoing concerning its billing and accounting procedures. The settlement concluded a multi year investigation

into the handling of Medicare credit balances, and unbundling of billings for outpatient laboratory services. As a Medicare provider, the hospital was required to submit quarterly reports identifying all excess Medicare payments, and then return the excess payments. As a result of the unbundling, the hospital obtained approximately \$238,494 in excess Medicare payments, and \$35,000 in excess Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) payments for 1992 through 1995. As part of the settlement, the hospital paid \$2.3 million to the Federal Government, and \$100,000 to the State of Hawaii. The hospital also agreed to a corporate integrity plan, which requires it to keep comprehensive accounting records, undergo periodic audits, and maintain a fraud and abuse reporting hotline.

Contractors

On July 16, 1998, in the Southern District of Illinois, Health Care Service Corporation (HCSC), the Medicare contractor for Illinois and Michigan, pleaded guilty to eight felony counts and agreed to pay a \$4 million criminal fine and \$140 million in settlement of its liability under the FCA. HCSC, also known as Blue Cross and Blue Shield of Illinois, pleaded guilty to six counts of making false statements to conceal evidence of its poor performance in processing Medicare claims from HCFA, and two counts of obstructing and conspiring to obstruct federal auditors. The civil settlement resolves allegations in a suit brought by a former employee of HCSC under the *qui tam* provisions of the FCA that the company falsified documents and manipulated samples used in government audits of the company's Medicare operations, failed to process claims in accordance with guidelines established by HCFA, and failed to handle beneficiary and physician inquiries in a timely manner. Prior to the corporate pleas, one former and one current manager at HCSC's Marion office pleaded guilty to charges of conspiracy, wire fraud and obstruction of a federal audit. On July 8, 1998, five other managers were indicted on similar charges. Through their submission of false information to HCFA concerning the performance of HCSC on its Medicare Part B contracts, HCSC had its contracts with HCFA renewed, received almost \$1.3 million in incentive payments from HCFA, and the five defendants received bonuses. In December 1997, HCSC agreed to withdraw from the Medicare program as of September 1, 1998. As part of the civil settlement, HCSC entered into a corporate integrity agreement.

On August 17, 1998, in the Middle District of Pennsylvania, Highmark, Inc., the parent company for Pennsylvania Blue Shield (PBS), agreed to pay the United States \$38.5 million to resolve claims relating to PBS's performance as a Medicare Part B carrier. PBS had contracted with HHS to process Medicare Part B claims for Pennsylvania, Delaware, New Jersey, and the District of Columbia. The United States alleged that PBS violated the FCA and other laws by: (1) failing to properly process Medicare Secondary Payor (MSP) claims, or failing to take appropriate action to recover mistaken MSP payments; (2) obstructing the Contractor Performance Evaluation Program (CPEP) by, among other actions, rigging samples for the HCFA audits; (3) failing to recover overpayments resulting from Series 700 errors and misrepresenting to HCFA the impact of those errors (4) failing to implement Medicare Carrier Manual requirements for the screening of End Stage Renal Disease lab claims; and (5) inappropriately using force

codes, following the adjustment of claims, to bypass electronic audits or edits. In a related development, a former corporate vice president at PBS was charged in a three count information with conspiring to submit false information to the HCFA and two counts of making false statements to HCFA in connection with CPEP audits. The former Vice President has pleaded guilty to these charges, which carry a maximum penalty of up to 3 years imprisonment and fines totaling \$300,000 and is awaiting sentencing.

Defective Pricing and Buy America Act Violations

On September 23, 1998, in the Southern District of Ohio, Invacare Corporation agreed to pay \$2.6 million to the U.S. Department of Veterans Affairs (DVA) to settle allegations of fraud in the sale of wheelchairs. Invacare allegedly failed to provide accurate and complete cost data during contract negotiations and violated the Buy America Act by supplying foreign-made wheelchairs. The United States had alleged that Invacare violated the FCA by providing DVA with inaccurate and incomplete data concerning discounts offered to other customers, and that these false statements caused the DVA to agree to a higher contract price than it would have otherwise.

Durable Medical Equipment Suppliers

On May 19, 1998, in the Eastern District of Pennsylvania, the head of MKM Healthcare Corp., a Pennsylvania medical supply company, pleaded guilty to a charge that he paid kickbacks to a surgeon, in return for ordering wound care supplies for his Medicare patients from MKM. On August 20, 1998, the surgeon's co-defendant also pleaded guilty to conspiracy to receive kickbacks. The kickbacks were disguised as fees for "educational services" supposedly provided by Wound Care Management Corp., a "front" company established by the surgeon to hide his receipt of kickbacks. Later the kickbacks were paid directly to the surgeon as compensation under a sham employment agreement as a supervising physician for MKM.

On October 2, 1998, in the Southern District of Ohio, the president of Major Health Services, Inc. (MMHS), pleaded guilty to two counts of mail fraud. Under the name MMHS, the president was paid approximately \$140,000 for false claims submitted to TRICARE and private insurance claims for Durable Medical Equipment (DME). MMHS billed for DME never received or DME other than what customers actually received. The president obtained a list of persons with handicapped licence plates from the motor vehicle's office, and directed employees in the Colorado office to use telemarketing techniques to sell scooters and adjustable beds, while offering DME as free with no co-share payment to people with physical handicaps. MMHS billed insurance companies for more sophisticated and expensive equipment, such as motorized wheelchairs and hospital beds, than actually provided.

Embezzlement

On May 1, 1998, in the Southern District of Mississippi, the office manager of a physician

group at the University of Mississippi Medical Center pleaded guilty to embezzling nearly \$147,000. The violation to which the defendant pleaded guilty was 18 U.S.C. § 669, an embezzlement statute created by HIPAA. Section 669 makes it a crime to embezzle money or property from a health care benefit program or from an individual or entity providing health care services under a federal health care program such as Medicare. An audit of the group's accounts and books revealed that the defendant wrote checks payable to himself from the group's account and attempted to conceal the location of the funds by altering the checks after they were cashed. The missing funds could exceed \$400,000. The physician group received funds from Medicare and Medicaid as reimbursement for services provided to beneficiaries of, or recipients from, these programs.

Group Homes

Between July 8, 1997, and February 18, 1998, in the District of Massachusetts, six men were sentenced to various jail terms and ordered to pay \$3.5 million in restitution for defrauding eight non-profit mental health care companies that provided services to de-institutionalized mentally retarded individuals in six states and Washington, D.C. The men formed a fictitious management company to provide contract services to group homes for the mentally ill. The men received payments from the Medicare and Medicaid programs for services not rendered.

Home Health Services

On January 30, 1998, in the Middle District of Tennessee, Medshares Home Care of Tennessee, Inc., doing business as Home Care of North Central Tennessee, Inc., agreed to pay the government \$1.2 million to settle allegations brought under the *qui tam* provisions of the FCA. The government alleged that Medshares submitted false claims to Medicare from July 1, 1994, through December 31, 1996, for skilled nursing visits, home health aide visits, medical social service visits, occupational therapy visits, physical therapy visits and medical supplies that were not "medically necessary," or were not for "homebound" beneficiaries eligible for the home health benefit. Through an audit of a random sampling of Medicare patient's records, the government determined that 17 percent of the company's patients were provided services that were not necessary.

On April 15, 1998, in the Northern District of Texas, the former president and administrator of the now defunct home health agency, Lubbock Care Associates, and the agency itself, pleaded guilty to mail fraud and engaging in monetary transactions in criminally derived property. The defendant submitted more than \$500,000 in fraudulent claims to Medicare for patients who did not qualify for home health services. The defendant falsified records to make it appear that patients were homebound when, in fact, they were not. The agency also submitted fraudulent promissory notes to Medicare to pay employees almost \$186,646 in unpaid salary. Medicare eventually reimbursed nearly \$500,000 to the home health agency. The investigation started when employees for the agency reported the problems to the FBI.

Hospitals

On September 10, 1998, in the Central District of California, Paracelsus Healthcare Corporation, a California corporation based in Houston, Texas, agreed to pay \$7.3 million to settle allegations that it defrauded Medicare at two Paracelsus facilities -- Orange County Community Hospital ("OCCH") and Bellwood General Hospital. The settlement resolves a *qui tam* suit brought by two former hospital administrators who will receive \$1,387,000 of the recovery. The settlement resolved allegations that Paracelsus: (a) made improper payments to "management companies," including Pride Institute at Solutions and Daybreak, Inc., in connection with psychiatric programs at OCCH; (b) submitted improper charges to Medicare for services to patients in the Pride and Daybreak programs; and (c) paid kickbacks to physicians and physician groups at Bellwood, an acute care facility. As part of the settlement, Paracelsus agreed to cost report audit adjustments valued at an estimated additional \$3,900,000 and entered a Corporate Integrity Agreement with HHS-OIG.

On December 16, 1997, in the Eastern District of Tennessee, Paracelsus Healthcare Corporation, a hospital company, was ordered to pay the United States and Tennessee a total of \$3 million to settle allegations that it billed and sought to defraud the Medicaid and Medicare programs for outpatient services that were not supervised by a physician and for inpatient rehabilitation care for which there was inadequate physician involvement. The suit claimed that the company violated Medicare and Medicaid regulations by admitting, treating and discharging outpatients undergoing alcohol and drug rehabilitation at the company's clinics in middle and eastern Tennessee without any physician involvement. The suit said that patients treated in the hospital's inpatient substance abuse rehabilitation unit failed to receive the number of physician visits required under Tennessee's Medicaid regulations. The settlement also resolves claims that the hospital deceived Tennessee regarding the frequency of inpatient physician visits being performed.

On June 4, 1998, in the District of Maryland, Levindale Geriatric Hospital paid \$800,000 to resolve allegations it violated the FCA by recoding and resubmitting denied charges for room and board. After the claims for room and board were denied by the Medicare Part A program, Levindale recoded the claims as supplies, laboratory work and other services, and submitted the claims for payment. In addition to paying a substantial penalty under the FCA, Levindale entered into a compliance agreement with HHS-OIG

Laboratory Services

On April 13, 1998, in the District of Maryland, Corning Life sciences, now known as Quest Diagnostics, paid \$6.8 million to resolve allegations that it billed the Medicare part B program for laboratory tests not ordered by a physician. Six Corning laboratories, including the Rockville and Baltimore, Maryland laboratories, engaged in the practice. The FCA recovery reflects 4.5 times the losses sustained by the Medicare Program. Corning is already subject to a compliance agreement in connection with a prior FCA

settlement and the HHS-OIG amended the existing compliance agreement to address the conduct involving billing for tests not ordered.

On October 31, 1997, in the Eastern District of California, Physician's Clinical Laboratory, Inc. (PCL) was ordered to pay the United States \$2 million to settle allegations that PCL had overbilled the United States under the Medicare and CHAMPUS programs with regard to blood and urine testing. The suit alleged that PCL overcharged the United States and the State of California in the Medicare and Medi-Cal programs. The suit alleged that PCL conducted urinalysis testing at one location, using particular technology, when in fact they performed the services at a different location using a procedure which called for a lower amount of reimbursement under the Medicare and CHAMPUS programs. The suit also alleged that PCL had improperly billed the United States for blood analysis, resulting in charging for tests which actually were not performed.

Lymphedema Pumps

On April 2, 1998, in the Central District of California, a federal grand jury returned an indictment charging the owner of the KP Medical Center in Los Angeles with conspiracy to defraud the United States, false statements, mail and wire fraud, and bankruptcy fraud. The owner allegedly submitted more than \$3 million in false claims to Tricare and other federal health care programs by signing certificates of medical necessity that falsely indicated that certain patients needed pumps for treatment of lymphedema, when the pumps were never needed or actually provided to the beneficiaries. The defendant also allegedly defrauded the Medicare and Medi-Cal programs, and submitted false statements to the programs, by billing under one name while actually operating under another name. The defendant allegedly conspired with two men who owned a home health agency to receive \$100 kickbacks for each Medicare beneficiary he referred to them in violation of the anti-kickback statute.

Medical Schools

On March 19, 1998, in the Western District of Pennsylvania, eighteen physician clinical practice plans associated with the University of Pittsburgh School of Medicine, the University of Pittsburgh Medical Center Health System, and the University of Pittsburgh agreed to pay \$14 million for false or improper billings to the Medicare program, and \$3 million for false or improper billings to the Pennsylvania State Medicaid Program. The settlement resolves allegations that the Clinical Practice Plans submitted claims in violation of established Medicare and Medicaid rules governing payment for physician services provided in the teaching setting. Attending physician's services which are furnished to beneficiaries in a teaching setting are covered under Medicare Part B and payment may be made only if the physician assumes and fulfills the same responsibilities for this patient as for other paying patients.

These responsibilities include the attending physician's personal examination of the

patient. Pursuant to established HCFA regulations, and directives from HCFA's contractors, the services of residents cannot be billed separately as services under Part B of Medicare. Services of residents and interns in approved teaching physician programs are explicitly excluded from the definition of "physician's services" and are not payable as such. These services are covered as hospital services under Medicare. Services provided by a resident or intern under the attending physician's personal and direct supervision, however, may be reimbursable under Medicare Part B. The Pennsylvania Medicaid rules allow payment only for services actually rendered by a provider.

The Clinical Practice Plans conducted an audit at their own expense. The audit found faulty or inaccurate billing practices where physicians billed for services actually rendered by residents, and some billing for evaluation and management services where the code levels selected were not supported by sufficient documentation in the medical records (upcoding.) The terms of the settlement also require specific compliance measures by the Clinical Practice Plans through a Corporate Integrity Agreement.

On September 8, 1998, in the District of Connecticut, a \$5.6 million settlement involving Yale University School of Medicine was reached regarding the school's maintenance, use and write-off of credit balances. A portion of the settlement calls for the school to pay the United States \$1,200,289 to settle a *qui tam* action. The rest of the settlement requires the school to pay \$1,888,525 to private insurance companies and \$2,511,298 to the State of Connecticut treasurer, pursuant to unclaimed property laws. The school did not match specific medical charges and posted them in their records as unidentified credit balances. Such credit balances represented amounts owed by the school to patients, health benefits program's and/or clinical departments within the school for the period January 1997 through September 1998. The government contended that the school improperly handled a significant number of credit balances. In the settlement, the school acknowledged that it failed to adequately manage and supervise the handling of certain credit balances. As part of a 4-year Corrective Action Plan, the school will establish a credit balance department, conduct biannual instruction programs for all individuals involved in the resolution of credit balances, and submit to annual audits.

Nursing Homes

On January 13, 1998, in the Eastern District of Pennsylvania, three Philadelphia-area nursing homes agreed to pay \$500,000 and implement a comprehensive corporate integrity program to settle allegations brought under a civil FCA complaint that they billed Medicare and Medicaid for inadequate care provided to nursing home residents from June 1995 to the present. The complaint specifically identifies 5 residents for whom the government was paying who were not adequately cared for by Chester Care Center, Bishop Nursing Home, and Manchester House Nursing and Convalescent Center. One resident of Chester Care Center died of injuries received when she was placed in a scalding tub of water by a nurse's aide, even though the nursing home was aware it had a malfunctioning boiler and had been cited by the state for improper water temperatures. Three other Chester residents died of receiving inadequate diabetes care, and another

resident of Bishop Nursing Home died of the nursing home's failure to respond in an appropriate and timely manner to the resident's progressive weight loss and failed to treat his resultant pressure sores properly.

On August 19, 1998, in the District of Connecticut, the operator of Pioneer Valley Geriatrics (PVG) was sentenced to 21 month's incarceration, three years of supervised release, a \$5,000 fine and \$5,198 in restitution for defrauding Medicare. The operator pleaded guilty on April 3, 1998, to a one-count information charging him with mail fraud in connection with claims he caused to be submitted to Medicare in relation to services provided by PVG at Chesthelm Nursing Home in Connecticut, where PVG had contracted to provide mental health services to patients. The operator caused the presentation by PVG of claims to Medicare totaling \$12,075 for 110 separate services of Chesthelm. These claims were represented as being performed by, or under the direct supervision of, a licensed medical doctor, but were not. Due to information that was discovered in an unrelated investigation months after the defendant was sentenced, the defendant filed a 2255 motion, seeking a resentencing related to whether he should have received an enhancement for obstruction of justice. The Government is consenting to the resentencing, at which time the court could impose the same sentence that was originally imposed.

On August 26, 1998, in the Eastern District of Michigan, an osteopath pleaded guilty to three counts of mail fraud and one count of accepting illegal kickbacks. The osteopath, who owned several Detroit area nursing homes, was charged with billing Medicare and Blue Cross/Blue Shield of Michigan for nursing home patient examinations that were either upcoded, or not performed at all. The osteopath was also charged with accepting more than \$25,000 in kickbacks from a local hospice in return for recommending the hospice to the staff of the osteopath's nursing homes. As part of the plea agreement, the osteopath agreed to pay in full at the time of sentencing, \$522,000 in restitution for the mail fraud violations and a \$200,000 fine. He also agreed to pay restitution for losses resulting from the kickback scheme, which may exceed \$700,000.

On August 13, 1998, in the Eastern District of Pennsylvania, a settlement was reached with the Department and HHS in which a Philadelphia nursing home will upgrade conditions to ensure that elderly and disabled residents are free from abuse and neglect and receive adequate treatment. The agreement, filed together with a lawsuit in the U.S. District Court in Philadelphia, stems from complaints about conditions at the Philadelphia Nursing Home (PNH) that were investigated by the Department. Under the agreement, the city of Philadelphia and Episcopal Long Term Care (ELTC), the city's contractor, will ensure that residents are free from mistreatment, abuse and neglect; provide adequate psychiatric, medical and nursing care, including daily activities that enable the residents to reach their highest practicable level of physical and mental well being; limit the use of restraints; work with a federal monitor to implement the agreed upon procedure; pay the Federal Government \$50,000 to resolve FCA violations; and create a \$15,000 fund for a special project, authorized by the United States, that will improve the quality of life for residents at PNH. A geriatric nurse practitioner appointed by the government at the nursing home's expense will visit the home at least monthly to monitor its compliance

with terms of the agreement.

Pharmaceuticals and Pharmaceutical Services

On June 12, 1998, in the Eastern District of Pennsylvania, a Philadelphia pharmacist was sentenced to four years in prison, and ordered to return the \$700,000 he obtained through filing false claims for prescription drugs with insurance companies. The defendant, and his brother, operated four pharmacies between 1985 and 1995. The defendant was ordered to forfeit \$700,000, and his brother was ordered to forfeit \$1.4 million, and both were charged in a criminal information with a 10-year fraud on prescription drug plans involving sham prescription reimbursement claims supported by phony prescriptions; fictitious prescriptions supplied by street dealers in return for a share of the expected reimbursement; the use of drug samples obtained from doctors in return for cash or goods; and an illegal drug diversion of Schedule II controlled substances including Percocet, Vicodin, Xanax and Promethazine with Codeine. This case was charged and the defendants pled to RICO conspiracy.

On April 16, 1998, in the Southern District of Illinois, Home Pharmacy Services, Inc., a wholly owned subsidiary of Omnicare, Inc., entered into a Settlement Agreement to resolve its liability under the FCA. Home Pharmacy Services, Inc., was an institutional pharmacy that served nursing homes throughout southern Illinois. Almost all of the patients serviced were on Medicaid, paid by the Illinois Department of Public Aid (IDPA). The pharmacy would receive returned medicines from the nursing homes because a patient died or the prescription changed. The pharmacy would repackage and resell the returned pharmaceuticals and not credit IDPA for the returns. Home Pharmacy agreed to pay \$5.3 million to settle the allegations of false claims. The former president of Home Pharmacy Services, Inc., pled guilty to felony false statements, and on September 21, 1998, was sentenced to 24 months imprisonment and ordered to pay \$500,000 in restitution and a \$250,000 fine. As part of the civil settlement, Home Pharmacy entered into a corporate integrity agreement.

On June 16, 1998, in the Southern District of Illinois, a Smithton resident pleaded guilty to making false statements to the Illinois Department of Public Aid concerning fraudulent bills submitted to that agency by Home Pharmacy Services (HPS), a Belleville, Illinois supplier of drugs and pharmaceutical products to nursing homes throughout southern Illinois. The defendant established a procedure in which medications which were returned to the pharmacy were placed back into inventory without crediting the Illinois Department of Public Aid which had paid for the drugs when first supplied to the nursing homes. The drugs were returned to HPS from the nursing home because the patients for whom they were prescribed had died. The drugs would be sent out a second time for other patients and Medicaid would be billed twice for the same medication. The defendant caused HPS to continue billing the agency even though he knew that HPS owed the agency in excess of \$2 million. On April 10, 1998, HP's parent company, Ohio-based Omnicare, agreed to pay \$5.3 million to settle *qui tam* allegations made by former employees of HPS.

Physicians and Other Practitioners

On December 9, 1997, in the Central District of California, an ophthalmologist agreed to pay the United States more than \$375,000 to settle a *qui tam* suit brought by a former office manager. The suit alleged that the doctor routinely billed Medicare for endothelial microscopy for every cataract patient he treated, even though it is a rarely used pre-cataract surgical procedure, and despite the fact that the doctor never performed the procedure. The doctor agreed to implement a five-year compliance program in which he will have to pay for an annual audit of his practice and permit office searches by federal investigators at any time.

On August 19, 1998, in the District of Nebraska, a man who had represented himself to patients as a surgeon, biochemist, and specialist in "ultramolecular medicine" who could cure cancer, AIDS, and other diseases, was sentenced to two and one-half years in prison, ordered to pay a \$5,000 fine, and \$80,000 in restitution to his victims. Patients spent more than \$1 million on the analysis, diagnosis, treatments and products, according to the indictment. The "surgeon" with only a high school degree and some unnamed "further educational undertakings" engaged in fraudulent behavior from 1989 through early 1996. The "surgeon" told patients he could diagnose ailments by examining hair and fingernail samples in what he claimed was a high tech lab. During the investigation the "surgeon" diagnosed a guinea pig hair as that of a person suffering from allergies and liver, kidney, and various organ problems. He told patients that he analyzed those samples through a NASA-provided laser, had 129,000 patients worldwide, and cured 400-500 AIDS patients and several thousand ovarian cancer patients.

On August 19, 1998, in the District of South Carolina, a man was sentenced to two months in prison and ordered to pay \$40,874 in restitution for mail fraud and for aiding and abetting a chiropractor who defrauded insurance companies by filing bills for unnecessary tests. The man aided the scheme of a doctor, the former owner and operator of the Plemmons Clinics. From 1992 to 1994, the doctor filed \$2 million in billings for unnecessary nerve and vascular tests that he performed on family, friends, and patients. For seven months in 1994, the man that aided the doctor signed the bills for unnecessary testing that the doctor sent to insurance companies. In June 1998, the doctor was sentenced to 46 months in prison and ordered to pay more than \$1 million in restitution for the actual payments he received from the insurance companies.

On September 21, 1998, in the Western District of Washington, a Tacoma chiropractor pleaded guilty to a felony charge of mail fraud. The chiropractor, doing business at ACTS Chiropractic Center, caused chiropractic records to be falsified to indicate that progress examinations were conducted on a different day from the date of an examination, so he could bill for two services which had actually occurred during a single office visit. During 1994 and 1995, when some of the falsely billed office visits were rejected, the chiropractor falsely billed for spinal manipulations on these dates when no services were provided. The fraudulent bills were processed by King County Medical, predecessor of Regence Blue Shield, while acting as a third party administrator of the Boeing Medical

Plan. The chiropractor will pay an agreed restitution of \$19,038 to Regence for the Boeing Plan.

On September 18, 1998, in the Eastern District of California, a podiatrist practicing in Stockton and Lodi, California was sentenced to 18 months in prison for defrauding the Medicare program. In addition, to settle the government's civil case against him, the podiatrist agreed to pay more than \$350,000 and to accept permanent exclusion from the Medicare program. From 1993 to 1997, the podiatrist regularly visited Medicare patients at nursing homes and performed routine foot care consisting of clipping patients' toe nails. Knowing that Medicare does not pay podiatrists for routine foot care, he claimed he performed surgical procedures and billed the federal health care program for surgeries. He then falsified his medical records to document performance of the procedures. In 1996, the HHS-OIG was alerted to the high number of foot surgeries the podiatrist had billed to the Medicare program. During a six-month period in which the podiatrist's billings were audited, the podiatrist submitted claims to Medicare for more than 1,750 surgeries, including more than 500 procedures in which he claimed to have removed foreign bodies from patients. Thereafter, federal agents conducted an undercover investigation in one nursing home, using audio and video surveillance. The video depicted the podiatrist only performing toe nail clippings. Nevertheless, he billed Medicare for performing foot surgery on those patients. The podiatrist pleaded guilty to one count of Medicare fraud, and entered into a stipulated judgement to settle the government's civil claims against him. To raise money to settle the civil case, he agreed to sell his house, his office building in Stockton, his car, and another vehicle.

On May 8, 1998, in the Northern District of Indiana, a doctor was sentenced to 37 months imprisonment, 3 years supervised release, and a \$40,000 fine for soliciting and receiving kickbacks in exchange for patient referrals to St. Joseph's Medical Center. The doctor's sentence was enhanced by the Court at the government's request for obstruction of justice because he committed perjury during the first part of his sentencing hearing, and before the grand jury that ultimately indicted him.

On August 3, 1998, in the Central District of California, a Beverly Hills, California dentist pleaded guilty to five felony mail fraud counts related to a fraudulent billing scheme in which insurance companies paid out tens of thousands of dollars for services that had not been rendered. On many of the claim forms submitted to the insurance companies, the dentist listed a "mail drop" that was purported to be the residence of the patient, when the mail drop was used in order to divert any correspondence from the insurance companies to an address under the dentist's control, which prevented patients from learning about the fraudulent billing. During the course of the scheme, the dentist received letters from insurance companies that sought verification from patients that certain services were not provided. On occasion, the dentist, or someone at the direction, completed these forms and returned them to the insurance companies. The verification forms falsely stated that all services in question had been performed, when in fact they were not.

On July 1, 1998, in the Eastern District of Michigan, a cardiologist was sentenced to

twelve months and one day on convictions of two counts of mail fraud. From 1993 through 1996, the cardiologist caused the submission of two reimbursement claims to Medicare and Blue Cross/Blue Shield of Michigan each time he performed a single echocardiogram or artery extremity study. As the result of these fraudulent billing practices, the cardiologist caused monetary losses of \$59,049 to Medicare and \$48,649 to Blue Cross/Blue Shield of Michigan. At the time of sentencing, the cardiologist made full restitution to both Medicare and Blue Cross/Blue Shield for the losses.

On August 4, 1998, in the Eastern District of California, a Fairfield dentist who pleaded guilty to a felony health care fraud charge was sentenced to a year in prison. The dentist was ordered to pay a fine of \$3,000, an assessment of \$100, and ordered to perform 300 hours of community service following his release from prison. The dentist, for nearly 30 years, provided pediatric dental care to the families of service men and women under the Active Duty Family Member Dental Plan ("FMDP"), a dental insurance plan sponsored by TRICARE, which was formerly known as CHAMPUS. A random audit by the plan administrator detected billing irregularities which led to the federal investigation. The dentist pleaded guilty to a single felony charge of health care fraud and in his plea agreement, the dentist admitted to submitting reimbursements for X-rays and dental procedures that were not medically necessary to the health insurance program for dependents of active duty military personnel. The dentist paid \$527,085 to settle a related civil suit brought by the federal government against him arising out of the same conduct and he will also be permanently excluded from the TRICARE program.

On September 16, 1998, in the Eastern District of Pennsylvania, a podiatrist, was indicted on charges of conspiracy, mail fraud, and making false claims to the United States government. The charges arise from the podiatrist's fraudulent billings to Medicare from 1988 through 1994 for podiatric services to patients in his office and at three nursing homes, services that neither he nor his staff had provided. Specifically, the indictment charged that although the podiatrist and his staff rendered routine foot care, which is not generally reimbursable by Medicare, he billed Medicare for such reimbursable services as avulsion (surgical removal of a toenail), incision and drainage of abscess, and arthrocentesis (the use of a needle to inject cortisone or remove fluid from a joint). The resulting loss to Medicare was more than \$300,000. In 1994, the podiatrist was convicted of mail fraud in connection with an insurance fraud scheme; he served 15 months in federal prison.

Private Insurers/Self-insured Companies

On January 28, 1998, in the Southern District of Florida, two South Florida men were indicted for allegedly defrauding 27 private insurance and self-insured companies out of more than \$10 million by filing false medical claims, and with various acts of money laundering. In what may be the first use of a provision enacted by HIPAA, the defendants were charged with violating 18 U.S.C. § 1035, which makes it a criminal offense to submit false statements or health care matters. Both men had prior federal convictions for securities fraud or drug trafficking. According to the indictment, the defendants allegedly set up 13 fictitious companies which posed as medical service providers,

submitted more than \$50 million in fraudulent claims to 27 companies, and received more than \$10 million. Once the defendants received this money, they deposited it into bank accounts they controlled under aliases.

On May 8, 1998, in the District of Maryland, an operator of Industrial Medical and Physical Therapy (Industrial), an "accident mill", in Baltimore, MD, was sentenced to twenty-seven months imprisonment to be followed by a three-year term of supervised release upon her plea to one count of mail fraud and one count of income tax evasion. The operator was ordered to pay \$300,000 in restitution to several different automobile accident insurance companies, including the Maryland Automobile Insurance Fund (MAIF). The insurance companies were defrauded as a result of the fraudulent schemes to which the operator pled guilty. Another operator was convicted of three counts of mail fraud and two counts of income tax evasion on March 13, 1998 after a three-week jury trial, and ordered to pay restitution to the Internal Revenue Service in the amount of \$17,834.00 and \$15,000 in restitution to various insurance companies who were defrauded by Industrial. Using "runners" to locate automobile accident victims, the operators of Industrial churned out inflated insurance claims by billing for physical therapy services that were not provided, double billing on x-rays, and billing for hard, plastic cervical collars when less expensive, soft foam cervical collars were provided.

Psychiatrists, Psychiatric Hospitals, and Mental Health Services

On January 26, 1998, in the Western District of Texas, two businessmen pleaded guilty to conspiracy and health care fraud for defrauding the Medicaid program out of more than \$2.8 million. The defendants submitted claims for chemical dependency treatment for juveniles who did not have drug or alcohol problems. In addition, the counseling they did receive was inappropriate, and in other cases no counseling was provided at all.

On May 4, 1998, in the District of Kansas, a psychiatrist was sentenced to five years in prison and ordered to pay \$927,000 in restitution for defrauding federal and private insurers of almost \$2 million. The defendant was convicted by a jury on November 26, 1997 of 13 counts of mail fraud, 21 counts of money laundering, and one count of using the mail to promote commercial bribery. Under a post-conviction agreement with the government, the psychiatrist agreed not to appeal the verdict in exchange for a government recommendation to the court to depart downward from the offense level. The defendant devised and executed a scheme to defraud Medicare, CHAMPUS and private insurers by submitting false claims for services he did not perform, services not rendered, submitting bills twice for the same services, and by upcoding and unbundling bills.

On June 8, 1998, in the Central District of California, a Beverly Hills doctor pleaded guilty to defrauding Medicare of more than \$216,000 by billing for treating patients who were either dead, in prison, or too distant from the doctor for him to have seen them on the dates in question. The indictment charged the defendant with 10 counts of mail fraud for carrying out the fraudulent Medicare billing scheme from January 1992 to May 1996, processing his claims through the Transamerica Corp. The doctor billed for services he

never provided and inflated claims for reimbursement from Medicare. A related civil FCA action against the defendant on similar charges, recovered \$1,500,000 in settlement. The settlement amount represented approximately five times the estimated loss to Medicare.

On September 30, 1998, in the Northern District of Georgia, an Atlanta businessman was sentenced to 3 years and 10 months and ordered to pay \$7 million in restitution. From January 1994 through July 1995, the defendant defrauded HHS, the State of Georgia Department of Medical Assistance and certain Medicaid recipients, through a complex scheme involving billing Medicaid for individual and group psychotherapy allegedly provided to children. The scheme involved employees going door-to-door in impoverished areas to recruit children for after school programs, typically failing to inform parents that Medicaid would be billed for psychotherapy allegedly provided to their children; billing for psychotherapy services that were not provided by a licensed psychologist or physician, which had no medical necessity and which had not actually been provided; billing Medicaid for the treatment of children in Atlanta for psychological services when, in fact, the billing physician, was out of the country, in places such as London, Paris, Bermuda, St. Croix, and Barbados. In the 14-month period of the scheme the defendant submitted approximately \$8.6 million in claims to Medicaid.

Staged Automobile Accidents/ Workers Compensation Fund

On October 6, 1997, in the District of Minnesota, three men pled guilty to money laundering charges. The men staged phony car accidents and scammed insurance companies for an estimated \$500,000 for their treatment of accident related injuries at fictitious medical clinics they set up in vacant office space. They established alias identities for themselves using false names, dates of birth, addresses and social security numbers, and used the aliases to obtain insurance policies, set up post office boxes for fictitious medical clinics, opened bank accounts, and submitted insurance claims.

Unapproved Drugs

On September 2, 1998, in the Eastern District of California, a manufacturer agreed to pay \$1 million to settle a whistleblower lawsuit. The lawsuit, originally filed by a former employee of the company, alleged the company sold "bone-growth stimulator" devices to Medicare and Medicaid beneficiaries, then knowingly billed the federal and state health care programs for the costs of the devices, even though the Food and Drug Administration (FDA) specifically advised the company that the use of the devices had not been approved by the FDA as safe and effective. The complaint against the manufacturer was filed in December 1996 by a Senior Appeals Specialist employed with the company from 1994 to 1996. This case may be the first time the FCA has been applied against a medical device manufacturer for submitting claims for reimbursement to the government based on the sale of medical devices not approved by the FDA. Under the terms of the settlement agreement, the manufacturer will pay \$1 million to be distributed to the Medicare and Tricare programs, and to Medicaid programs in states where the devices were sold.

On September 4, 1998, the U.S. Court of Appeals for the Eighth Circuit reversed a ruling of the U.S. District Court for the District of Minnesota that the University of Minnesota was not subject to the FCA because it is a state entity. The Federal Government sued the University of Minnesota in 1995, alleging that the University received \$50 million from the illegal sale of a drug used to suppress immune reactions in post-transplant patients; the drug was not approved by the Food and Drug Administration. The suit also alleged that the University misapplied approximately \$5 million in federal grants, submitted approximately \$1 million in false claims to Medicare, and received nearly \$2 million through an illegal kickback arrangement. The district court dismissed the suit's FCA counts, holding that the Act's language -- establishing liability against any person who knowingly presents a false claim for payment to the Federal Government -- did not clearly apply to state entities. The Court of Appeals reversed, holding that state entities like other recipients of federal funds, took those federal monies subject to the law, including the FCA. The lawsuit was remanded back to the U.S. District Court, where it recently settled for \$32 million.

1/Under the FCA, a person who knowingly submits a false claim to the United States may be liable for a civil penalty of between \$5,000 and \$10,000, plus up to three times the amount of damages sustained. The FCA defines "knowingly" to mean that the claimant (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or, (3) acts in reckless disregard of the truth or falsity of the information.

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