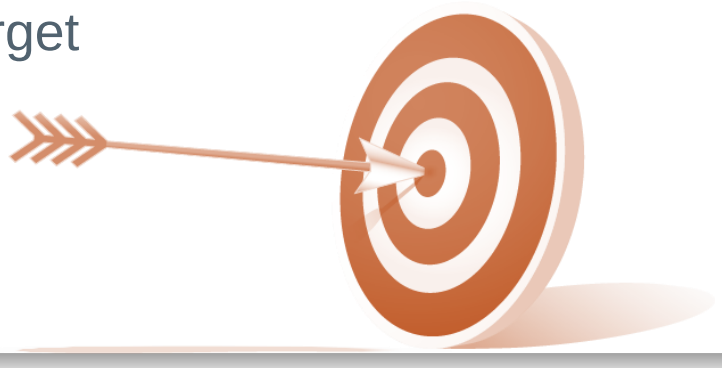
K&L GATES

The Biggest Health Care Scams in 2019 and How to Avoid Being a Target in 2020

Stephen Bittinger
Health Care Reimbursement Attorney
K&L Gates, LLP

GOALS FOR TODAY

- Learn Some of the Biggest Health Care Scams of 2019
  - The basic mechanics of how these scams worked and hurt many innocent providers
- Learn How to Identify Health Care Fraud Scams
  - The markings of a health care fraud scam and resources to validate/invalidate information available
- Learn From Others' Mistakes Through Compliance
  - The best way to learn how to improve your practice's revenue cycle performance without being the target



STRANGE BUT TRUE!

- Committing Crimes for Good Healthcare!
  - William Gallagher, a career criminal, robbed a bank in Wisconsin for the sole purpose of getting health treatment in their prison system.
  - While serving a 20 year sentence in New Jersey, he had heard that health care in Wisconsin prisons was superior to other institutions and better than the care offered through the U.S. Department of Veteran Affairs.
  - While demanding cash at the bank, he told the teller to call the police, sat down, and waited for the police to arrive.
  - He requested a 10 year sentence, but the judge instead ordered a presentence investigation.

Citation:

https://www.jsonline.com/story/news/crime/2019/01/29/real-life-shawshank-redemption-ex-con-robs-bank-go-back-prison/2704306002/

A. THE GLOBAL NUMBERS

- The False Claims Act (FCA) (qui tam/whistleblower) Remains the Main Weapon
- Department of Justice (DOJ) Recovers $3B+ in FY2019
  - $2.6B of the $3B recovered was from Health Care Industry
  - $2.1B from qui tam/whistleblower cases (someone inside); whistleblowers paid $265 million
  - Since FCA revised in 1986, more than $62B has been recovered in FCA cases.

Citation:
https://www.justice.gov/opa/pr/justice-department-recovers-over-3-billion-false-claims-act-cases-fiscal-year-2019

B. FRAUD SCAM 1: OPERATION BRACE YOURSELF

- $1B Durable Medical Equipment (DME) Fraud Scheme (2019)
  - An international telemarketing company lured hundreds of thousands of elderly and disabled patient into this criminal scheme.
  - DME companies were paying kickbacks to doctors and telemedicine companies for referrals for medically unnecessary braces (remember the TV adds about come get your “free brace”)
  - Telemarketer would get a Medicare patient on the phone, bring in a doctor on the call, ask just a few questions over a couple minutes, and tell the patient the brace was “in the mail.”
  - Many patients received braces (additional types) that they did not even ask for or know they were receiving.
  - 130 DME companies and individuals in six States were charged.

Citation:

https://www.nbcnews.com/politics/justice-department/feds-take-down-1-billion-fraud-scheme-operation-brace-yourself-n992481

B. FRAUD SCAM 2: OPERATION DOUBLE HELIX

- $2.1B Fraud Scheme for Genetic Testing for Cancer (2019)
  - Federal Health Care Fraud Task Force charges 35 individuals for $2.1B in losses to Medicare in a Single Day!
  - Telemedicine companies and cancer genetic testing laboratories in five states charged, including 10 providers
  - Marketers or physicians told patients that Medicare would pay for free genetic screening if the patients had any family history of cancer, but these services were not covered as medically necessary.
  - Many patients never received results or they were worthless to the doctors.

Citation:

https://www.justice.gov/opa/pr/federal-law-enforcement-action-involving-fraudulent-genetic-testing-results-charges-against

B. FRAUD SCAM 3: OPIOID SPRAY SCHEME

- The first case to hold an opioid maker and executives criminally liable! (All the rest have been civil cases so far)
  - Insys Theraputics paid bribes and perks to doctors to overprescribe Subsys, a fentanyl-based oral spray meant only for intense pain suffered by cancer patients.
  - Subsys cost payors up to $19,000 per month! Company reached a $225 million settlement with DOJ for both criminal and civil probes.
  - Company executives and marketers paid doctors to prescribe Subsys through lots of means, including lavish entertainment (exotic dancers included), travel, meals, and funds at times.

Citation:

https://www.latimes.com/world-nation/story/2020-01-12/former-drug-company-executives-to-be-sentenced-in-opioid-bribery-case

B. FRAUD SCAM 4: THE NURSING HOME PLAYBOY

- Philip Esformes, a Miami Beach health care mogul was sentenced to 20 years in Medicare fraud scheme and to repay $44 million.
  - Although the DOJ touted the losses to be in excess of $1B, the prosecution has mathematical difficulty showing a loss of this degree to Medicare.
  - Esformes bribed providers to “recycle” patients through his chain of assisted-living and skilled-nursing facilities where services of little to no clinical value were provided.
  - Esformes, who was born into a very wealthy family that owned health care operations in Chicago, lived one of the most extravagant lifestyles of known fraudsters, including a collection of exotic cars, numerous mansions with estates, and a multi-million dollar watch collection.

Citation:
https://www.miamiherald.com/news/local/article237583569.html

B. FRAUD SCAM 5: MARKETING AGREEMENTS AND THE TRAVEL ACT

- Forest Park Medical Center (FPMC) was a physician-owned hospital that maximized reimbursement by staying out of network (OON) and maximizing patient volume by paying kickbacks through marketing/education agreements.
  - FPMC stayed OON to set its own prices and misrepresented to covered patients that carriers would cover services at FPMC when FPMC would collect the higher OON rates and write off the balances.
  - FPMC paid a percentage of revenue generated ($40M) to referring providers for sham marketing and management agreements for "educational services."
  - Travel Act used to "federalize" state law crimes because FPMC has specifically avoided federal payors to circumvent federal restrictions.

Citation:
https://www.natlawreview.com/article/forest-park-medical-center-and-travel-act-different-road-same-destination

C. IDENTIFYING HEALTH CARE FRAUD AND WHO WAS HURT

- Scam 1: Operation Brace Yourself
- Why the Scam Worked:
  - Fraudsters figured out that the CMS adjudication system did not have a system edit to catch repetitious or unnecessary DME when specific ICDs were used
  - Abuse of new telemedicine policies that need revision to ensure integrity
- Innocent Victims:
  - Tax payers (obviously); Patients (no out of pocket but residual impact); Providers (many unknowing DME companies and providers caught in this – overpayments, fines, penalties, CMS suspension and/or termination, etc.)
- Red Flags:
  - Free – patients/consumers need more education; CMS does not give anything away that is not medically necessary
  - TeleDoc – patients/consumers need to understand rules of telemedicine

C. IDENTIFYING HEALTH CARE FRAUD AND WHO WAS HURT

- Scam 2: Operation Double Helix
- Why the Scam Worked:
  - Fraudsters figured out that the CMS adjudication system did not have a system edit to catch differences between services that did and did not require current diagnosis of cancer along with family history of cancer
  - Gray/Unclear guidance in LCDs versus NCDs per MAC jurisdiction
- Innocent Victims:
  - Tax payers (obviously); Patients (no out of pocket but residual impact); Providers (many unknowing labs and providers caught in this – overpayments, fines, penalties, CMS suspension and/or termination, etc.)
- Red Flags:
  - Volume – these services have existed for years; CMS did not turn on the faucet overnight
  - Screening – patients/consumers need to understand that CMS rarely pays for screening of potential health conditions

C. IDENTIFYING HEALTH CARE FRAUD AND WHO WAS HURT

- Scam 3: Opioid Spray Scheme
- Why the Scam Worked:
  - Fraudsters convinced providers of the wonders and benefits of spray versus oral version of medication; Fraudsters educated/mislead providers on the slight diagnosis difference needed for CMS to pay for medication 20 times more expensive
  - Old fashion greed and grease (wine and dine to excess); some direct kickbacks
- Innocent Victims:
  - Tax payers (obviously); Patients (addiction and deaths!); Providers in the same practices (many providers in the same practices were negative impacted by CMS sanctions of the group)
- Red Flags:
  - Cost – providers should know that CMS only pays big dollars for good reason (rare)
  - Fast and lose with the perks – any medical salesperson who overspends on entertainment should raise a flag for providers

C. IDENTIFYING HEALTH CARE FRAUD AND WHO WAS HURT

- Scam 4: The Nursing Home Playboy
- Why the Scam Worked:
  - Multiple NPIs (same owner) allowed claims through CMS without catching system edits
  - Steering from hospital to specific providers owned by fraudster
- Innocent Victims:
  - Tax payers (obviously); Patients (poor clinical care and outcomes; residual impact of unnecessary care); Providers (numerous innocent providers lost their jobs and fought off CMS sanction due to association with fraudulent practices
- Red Flags:
  - “Recycling” – many providers ignored unsound clinical decisions to continue treating patients

C. IDENTIFYING HEALTH CARE FRAUD AND WHO WAS HURT

- Scam 5: Marketing Agreements and Travel Act
- Why the Scam Worked:
  - Avoiding federal payors gave providers false security that they were not violating the law
  - Marketing/education agreements also gave providers false sense of security that they were being paid for something other than referrals
- Innocent Victims:
  - Private payors and plan beneficiaries (increased cost of premiums)
- Red Flags:
  - OON was not a problem for plan beneficiaries
  - Waiver of co-pays and deductibles

D. LEARNING FROM OTHERS' MISTAKES AND COMPLIANCE

- Scam 1: Operation Brace Yourself
  - Stopping Patient Victimization – The best advice for providers to give to their patients to prevent this type of telemedicine fraud is that they should not agree to anything without talking with their PCP first.
  - Telemedicine was designed for increased access to existing provider relationships.
  - Stopping Provider Victimization – Many providers that prescribed legitimate DME for the patients had payments recouped or other payor problems because their patient received duplicative DME within a prohibited time period (e.g. knee brace can only be replaced every five years).
  - Providers of DME must understand LCD/NCD limitations and check patient eligibility before prescribing expensive equipment.

D. LEARNING FROM OTHERS' MISTAKES AND COMPLIANCE

- Scam 2: Operation Double Helix
  - Stopping Patient Victimization – Patients must be educated that CMS only provides medically necessary services and does not pay for screening services unless there is a clear clinical purpose determined by a PCP or recommended specialist.
  - Telemedicine was designed for increased access to existing provider relationships.
  - Stopping Provider Victimization – Many reference laboratories unknowingly ran improper tests and billed for them because they did not understand the LCD/NCD position and relied on secondhand sources of interpretations.
  - Reference laboratories must be careful gatekeepers, because they will often be held responsible for referring providers' failures.

D. LEARNING FROM OTHERS' MISTAKES AND COMPLIANCE

- Scam 3: Opioid Spray Scheme
  - Stopping Patient Victimization – Broad, in-depth education of patients on the risks of opioid use is critical.
  - Providers – Do not give in to the "wine and dine" temptations! No matter how much marketers tell you they have "clearance" to provide perks, stick to your guns and focus on helping patients.
  - Provider Partnerships – You must police your own group! Many providers suffered tremendous losses because a partner in their practice participated in this scheme.
  - Provider Owners and Administrators – You must police your services and reimbursement. These claims should have been caught as unusually high reimbursement and rare services, but they were billed in huge volumes.

D. LEARNING FROM OTHERS' MISTAKES AND COMPLIANCE

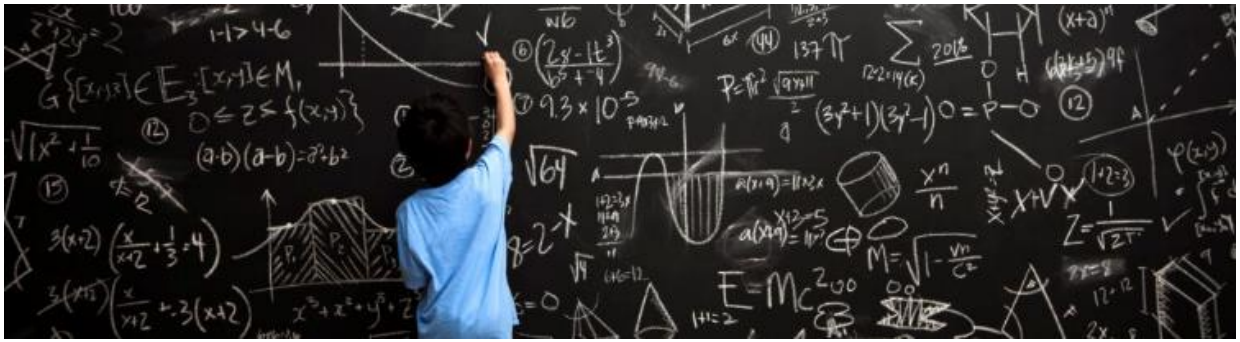
- Scam 4: Nursing Home Playboy
  - Stopping Patient Victimization – Patients and caregivers must not be afraid to question unusual or useless treatments and report treatment and providers that do not make sense.
  - Providers – Put the care of your patient above your employer's policies. Many providers ignored sound clinical guidance and just kept treating patient unnecessarily.
  - Providers and Administrators – Don't let the green-eyed monster get you! If financial gain is your primary goal, you shouldn't be in health care.
  - Overseers – A number of state overseers were paid off to make this scheme work. Do not always assume state approval equals compliance.

D. LEARNING FROM OTHERS' MISTAKES AND COMPLIANCE

- Scam 5: Marketing Agreements and Travel Act
  - Stopping Patient Victimization – Patients must be educated to understand that OON providers are the rare exception when the network does not have a specialist or services are provided in uncovered areas. They must also know that providers should never waive copays and deductibles.
  - Providers – Avoiding federal and state payors does not mean you avoid federal and state legal restraints! Almost all private payors require compliance with federal regulations. Most states have their own version of federal prohibitions (often more restrictive) that will be applied to even OON providers.
  - Providers – Don't fall for the "compliant kickback" (marketing, etc.)

SUMMARY

- As health care fraud is growing, oversight and prosecution are growing in sophistication and imposition.
- Patients are being victimized by the advances in technology that were designed to help provide them care.
- Innocent providers have more ways to innocently get into trouble then ever, which is why the level of education and compliance must increase to match the risk.
- Most, significant risks in health care can be avoided by common sense and regular education.



Stephen Bittinger, Esq.
Partner

www.klgates.com
Stephen.Bittinger@klgates.com
(o) 843.579.5694
(c) 440.823.0664