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Physician Persecution and the Prosecution of Health Care Fraud

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Picture this: your receptionist stands frozen in her tracks like a deer caught in the headlights as four strangers enter your office with guns on their hips. You and your staff are corralled onto chairs in a corner of your waiting room where you are instructed to sit silently, as patients are chased away. A man in a blue windbreaker with a second gun strapped to his ankle searches through every nook and cranny of your office. Three others rifle through your records, stowing your laptop in a box along with reams of patient and billing records.

Simultaneously, two others have taken your laptops and hard drives out the back door and placed them in a non-descript blue Ford van that is blocking your driveway.

While this might sound like a robbery in progress, it is nothing of the sort. It is the picture of modern law enforcement agents executing a warrant that grants them broad authority to search a suite of medical offices and seize records believed to evidence the commission of various health care crimes. It is an endeavor that could ruin your practice, destroy your reputation and deprive you of your liberty.

Almost overnight, the legislative landscape that governs the practice of medicine has undergone a hostile sea change. Business relationships that were once commonplace have been branded criminal and forbidden under penalty of imprisonment. Efforts to maximize profits in an era of dwindling reimbursement have been categorized as fraud. Indeed, it is with alarming frequency that federal, state and local officials first target and then descend upon health care practitioners in the fashion hauntingly similar to that described here. In some instances, these efforts are legitimate, in others physicians find themselves the victim of insurance companies that have the ear of law enforcement. Indeed, in the face of withering budget cuts, local prosecutors have accepted monetary grants from the insurance industry to fund insurance fraud investigations that would have otherwise fallen by the wayside as scarce resources are devoted to the prosecution of crimes of violence. While this has enabled prosecutors to continue investigating good faith allegations of fraud, it has also permitted insurance companies, in some circumstances, to use the specter of criminal prosecution to extract repayments and beef up their own ledgers by trying to balance their books on the backs of unsuspecting physicians who wanted to do little more than practice medicine and earn a decent living.

Even though seasoned criminal lawyers agonize over the subtleties and ambiguities of these laws, a simple understanding of the weapons employed by law enforcement and where their "guns" are trained will go a long way toward keeping you out of their scopes. While the criminal laws that affect your practice are legion, they are aimed, broadly speaking, at three major targets: business relationships, billing/coding practices and, of course, outright fraud.

Investigation and Prosecution of Classic Medical Fraud

To be sure, there are those who make their living defrauding both government and private health care insurers. Over the last ten years, state and local prosecutors, in concert with the insurance industry, have targeted dishonest practitioners who grind their grist in Medicaid, Medicare and No-Fault insurance "mills." Indeed, over the last ten years, these "mills" have become a multi-billion dollar cottage industry.

In law enforcement parlance a "mill" is a concern whose business is the mass generation of medical bills for treatment that was either not indicated or never rendered. They are concerns that are in the business, strictly speaking, of insurance fraud and outright theft.

Several years ago, prosecutors in Brooklyn, New York, shut down the prototypical no-fault in Brighton Beach. The clinic was operated by an enterprising Russian émigré with no medical expertise and little experience beyond that garnered driving a livery cab over the streets of Manhattan. Nonetheless, he conspired with a consortium of lawyers and doctors to recruit participants, most of whom were young recent immigrants, to participate in phony automobile collisions. The "patients" would receive \$1,000 for lending their names to an accident report and allowing phony records of treatment to be made at the clinic. Although treatment was virtually non-existent, patient records indicated that most received a comprehensive history and physical examination, physical therapy, chiropractic massage, psychotherapy, nerve conductivity testing (and, ultimately MRI's or CT scans at related facilities). The phony accident ring was penetrated by undercover officers and ultimately, the participants, at all levels, were tried and convicted of a variety of offenses ranging from grand larceny, insurance fraud, falsifying business records and practicing medicine without a license.

Similar criminal enterprises have increased at such an alarming rate that law enforcement that each of the District Attorney's Offices within the City of New York has opened insurance fraud units.

False and Fraudulent Claims

Seizing the opportunity created by these abuses, the insurance industry has also used the veil of “health care fraud” as a cloak to conceal a concerted effort to balance their books on the backs of honest physicians. Indeed, as the economy flattened and the stock market dropped, insurance companies began to pour more and more money into fraud and abuse investigations to balance their books. Both the federal government and private insurance companies have developed sophisticated software programs that identify those practitioners and target them for an audit of their medical records. In certain cases, they report their findings to state and federal prosecutors who may then target a physician for criminal investigation and prosecution.

To do so, they not only utilize search warrants to seize records and wiretap orders to record incriminating conversations, they also obtain, by way of grand jury subpoena, various banking, business and personal records. The most capable prosecutors will not rely solely upon “paper” to prove their cases. Instead, in exchange for promises of leniency, they will seek cooperation from others involved—people who are lower on the “food-chain” or whose guilt may be more easily proven. Additionally, they will interview present and former (preferably disgruntled) employees, even former spouses or lovers, to gain additional evidence or leverage that can be used to secure the physician’s cooperation or ensure a plea of guilty.

The investigation of fraud cases has branched out well beyond the kinds of medical mills described here. However, in order to bring a fraud case, prosecutors must nonetheless prove that the physician acted with the *intent* to commit a crime. Accordingly, they look for patterns that demonstrate such intent and mitigate against a defense of ignorance or mistake.

Recently, insurance investigators conducting a “utilization” review stumbled upon a physician who billed for a particular vaccination at a rate that far exceeded that of his peers. The matter was turned over to prosecutors who compared his billing records to purchase invoices and found that the physician had not purchased nearly enough serum to perform the procedures he had billed. The investigation revealed that both office records and billing records had been falsified in furtherance of this scheme.

Although local prosecutors targeted this physician, the same conduct would be punishable under federal law if it involved a federally funded program such as Medicaid or Medicare. Federal law prohibits one from knowingly presenting either a false claim or knowingly presenting false statements (or causing others to do so) in an application for any benefit or payment under a federal health care program (i.e., Medicaid or Medicare).ⁱ If a physician learns that a claim submitted by him (or on his behalf) is false, federal law saddles him with the responsibility of, to put it bluntly, “giving it up.” Indeed, the failure to make such a disclosure or return “ill gotten gains” is deemed an intentional concealment and is similarly punishable as a criminal offense under federal law.ⁱⁱ

There is no parallel state law requiring “self-report.” However, similar charges for submitting intentionally false claims for payment to private third-parties may be brought by state or local prosecutors for grand larceny, insurance fraud, falsifying business records and offering false instruments for filing.ⁱⁱⁱ Parenthetically, although the investigation and prosecution of private insurance fraud was once the province of local prosecutors, the federal mail fraud and wire fraud

statutes, in turn allow federal prosecutors to turn such state law violations into federal crimes merely by virtue of the fact that a physician (or someone acting on his behalf) may have used the U.S. mail, a telephone or facsimile transmission to present a false claim for payment. Unfortunately, the fact that billing was handled by others (or that a medical director of a “mill” did not actually see patients) is not necessarily a defense to health care fraud charges.

Both federal and state laws recognize that prosecutors may prove intent by presenting evidence of what is referred to as “conscious avoidance.” Simply stated, it means that criminal intent may be inferred from evidence demonstrating that the accused intentionally avoided confirming a particular fact (i.e., that treatment was billed for but not being rendered by employees, that billing was false or fictitious or that patients were not actually injured).^{iv}

Each violation of the federal laws relating to healthcare fraud is punishable by a \$25,000 fine and up to five years imprisonment. The likelihood of imprisonment increases in direct proportion to the amount of the financial loss. Under state law, penalties for crimes like grand larceny, insurance fraud, offering a false instrument for filing and/or falsifying business records are punishable by over one year in prison (depending upon the amount at issue and the degree of the crime charged) and/or a fine, restitution and community service.

Prohibited Business Relationships

In response to the spiraling costs of Medicaid and Medicare programs, the federal government attached substantial criminal penalties, including both the imposition of heavy fines and imprisonment the receipt or payment of “kickbacks” allegedly related to the referral of Medicaid or Medicare patients (and services).

The federal Anti-Kickback law was designed to target relationships fostered by such payments and prohibits (a) “the solicitation or receipt” and (b) “the offering or payment of remuneration” in return for referring a patient for any goods or services paid for by Medicaid or Medicare.^v At the most basic level, the law prohibits physicians from: (1) paying kickbacks to persons or entities that refer Medicaid/Medicare patients to them and (2) accepting kick-backs from entities to whom they refer Medicaid or Medicare patients for other services or goods to be paid for by either of these government subsidized programs.

The drafters recognized the existence of a variety of exceptions, characterized as “safe harbors.” However if the transaction comes under scrutiny, and if the physician wants to avoid prosecution, it is he who truly bears the burden of proving that the remuneration was not a kickback. As you will see, construction of this law often defies credulity and “safe harbors” should not be navigated alone. Indeed, criminal sanctions may attach to relatively benign conduct and it has become increasingly difficult to determine just what the government will characterize as an illegal kickback.

Classically, the “Anti-Kickback” statute was employed to ferret out frauds perpetrated by physicians who ran “Medicare mills” and received (or solicited) kickbacks or bribes from other providers, ambulette operators or purveyors of durable medical equipment (to whom patients were referred for equipment that was either medically unnecessary or never provided at all). Since then, it has been broadly interpreted to include *any inducement*. Accordingly, it prohibits conduct as disparate as the rental of office space by a physician to a clinical testing lab

for an amount that exceeds fair market value for the space to the waiver of a Medicare co-payment and the provision of free transportation for Medicare patients.^{vi} Moreover, since prosecution is not contingent upon an actual exchange of money (or receipt of some other kind or remuneration), it may be based upon a *simple offer expressing an ability and desire* to give something of value for the purpose of inducing a referral.^{vii} Courts have held that even when the relationship is clothed in a legitimate medical purpose, the referral may still violate the statute if “one purpose of the fee was to induce a referral.”^{viii}

In 1992, New York State enacted an identical statute thereby permitting its Attorney General to prosecute Medicaid kickbacks.^{ix} Despite the fact that there are no major substantive differences between the state and federal prohibitions, the same cannot be said for the attendant penalties. Violations of New York state law are considered misdemeanors, punishable by a fine not exceeding \$10,000 and/or up to one year in prison (unless over \$7,500 has been obtained, at which time the offense will be deemed a Class E felony). Once again, the penalties may be substantially greater if the felony charges such grand larceny, insurance fraud, offering a false instrument for filing and/or falsifying business records, all of which are punishable by over one year in prison, depending upon the amount at issue and the degree of the crime charged. While jail time is an option, New York State Supreme Court judges are vested with great discretion and normally reserve jail sentences for violent criminals, repeat offenders or pervasive fraudulent schemes involving large sums of money, multiple victims, or particularly vulnerable victims, such as senior citizens.

However, when the same conduct is prosecuted under federal law, dramatic and severe penalties loom large. Each violation of the federal Anti-Kickback statute is punishable by a \$25,000 fine and up to five years imprisonment and the likelihood of imprisonment increases in direct proportion to the amount of the financial loss. Unlike their counterparts in the state courts, the discretion vested in federal judges has been all but eliminated by the implementation of The Federal Sentencing Guidelines, which require an arithmetic computation whereby points are attached to specific offenses and offense characteristics. Furthermore, the Guidelines “punish” those who elect to go to trial by awarding defendants who plead guilty early on and/or cooperate against others by subtracting points from the calculus of their sentences.

Thus, defendants with identical levels of culpability may receive drastically different sentences simply by virtue of the fact that one has availed himself of his constitutional right to a trial by jury and the other has simply folded and pleads guilty. Additionally, in certain cases the federal government may argue that the crime falls outside the “heartland of the Guidelines” and request what is referred to as an “upward departure” from the sentencing guidelines that may expose the accused to a period of imprisonment that actually exceeds the statutory maximum. Appellate Courts have upheld this draconian calculus.^x Recently, the Supreme Court held that judges need not follow the guidelines. However, they must be considered and are, in reality, usually applied nonetheless.

The Stark Law

“The Ethics in Patient Referral Act,” commonly referred as the “Stark Law,” was enacted in December 1989 as a response to a small number of unethical physicians who established clinical laboratories (in their own names and those of family members) for the purpose of inflating their income by ordering (and profiting from) unnecessary laboratory testing.^{xi} The law

was amended in 1995 and now extends the original prohibition beyond clinical laboratories to include a variety of other services.

As it is presently written, the Stark Law *prohibits physicians from referring their Medicare or Medicaid patients to entities they own (or in which members of their immediate family have a financial relationship)* for clinical laboratory services, physical therapy, occupational therapy, radiological testing, radiation therapy, services and equipment, durable medical equipment and supplies, parenteral and enteral nutrients, equipment and supplies, prosthetics, orthotics, home health services, outpatient prescription drugs, inpatient as well as outpatient and inpatient hospital services. It also forecloses the possibility of using attenuated relationships and sophisticated financing as a means of “end-running” the law. Indeed, its definition of “*financial relationship*” encompasses any direct or indirect ownership interest, investment interest or compensation arrangement. In a similar vein, its definition of “*immediate family*” is prohibitively broad.^{xii}

While the Stark Law itself does not impose criminal penalties, the movement of money, falsification of records to conceal a relationship or false statements made to further the concealment may subject the complicit parties to criminal prosecution for falsifying records, conspiracy, money laundering, wire fraud or variety of other charges contained in the arsenal of the creative or ambitious prosecutor.

Protected Health Information

Of course, no modern discussion of health care law would be complete without some reference to the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). HIPAA limits the unauthorized disclosure or use of private health information (“PHI”) and establishes both civil and criminal penalties for proven violations. The intentional misuse of PHI is punishable by a fine up to \$50,000 and not more than one year in prison. The acquisition of PHI under false pretenses is punishable by a \$10,000 fine and a maximum sentence of five years in prison. Finally, the sale or attempted sale, transfer or use of PHI for pecuniary gain or for intentional harm is punishable by a maximum fine of \$250,000 and up to ten years in prison.

Avoiding and Defending Charges of Health Care Fraud

The best defense of all entails devising a plan that will keep you out of the government’s sights in the first place. Audit your own practice, become involved in your billing, review all correspondence from Medicare and be aware of the existence of claims that are routinely rejected and which may establish a pattern leading to an audit. Train your staff to bill properly (or hiring a reputable billing company, one that does not charge on a percentage basis) and institute a compliance plan. By doing so, you can demonstrate a lack of criminal intent by showing the existence of a vital, ongoing and professional effort to identify and report erroneous claim. If a serious problem comes to the fore, a capable attorney should conduct the investigation. By doing so, the results will be protected from disclosure by the attorney-client privilege and the information, therefore, cannot be obtained by prosecutors.

Have your business relationships and agreements reviewed by a knowledgeable attorney. Exit interviews of all outgoing employees should be conducted. They should be queried, albeit diplomatically, about their awareness of any unusual practices. By memorializing the interviewee’s remarks (which in most cases will be benign) that person’s

effectiveness as a potential government witness will be neutralized.

In the event that a physician learns that a government investigation is underway, time is of the essence. Retain a capable criminal lawyer with relevant experience. If you do not know one, contact your medical society and request a recommendation. All necessary steps must be taken to avoid indictment, while at the same time a defense must be undertaken. If overpayments can be identified, reported and repaid quickly, an indictment may be avoided. Efforts must also be undertaken to determine whom the government has targeted as a potential defendant and who may be cooperating with them. Speak to no one, for it is impossible to tell who is cooperating with the government and which phone is tapped.

Patient charts and billing records must be analyzed to determine the extent of exposure. All present and former employees must be interviewed and one may consider providing counsel to them where no conflict exists. The

investigation should be conducted by auditors and investigators hired by a capable criminal lawyer well versed in health care issues, not the physician or his staff. Once again, that will protect the results of the audit and all other aspects of the investigation from disclosure to the government.

Conclusions

Your office need not become the all-too-common disaster described in the beginning of this article. In the final analysis, the best defense lies with awareness and preparation. While counsel should review your business relationships, there is no substitute for intuition and good judgment. Avoid relationships with unscrupulous practitioners, management companies or billing companies. Read all the Medicare bulletins and be keenly attuned to potential kickback situations. A modicum of good judgment tempered with experienced counsel, an active compliance plan and your active participation can go a long way toward keeping you out of the government's "cross hairs."

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ⁱ 42 U.S.C. 1320a(1), (2)

ⁱⁱ 42 U.S.C. 1320a(3), (4)

ⁱⁱⁱ P.L. Articles 155, 176 and 175.

^{iv} Khan v. U.S. 53 F.3d 507 (2nd Cir. 1995); People v. Ohrenstein, 574 N.Y.SD.2d 616 (1991).

^v 42 U.S.C. 1320a-7(b)

^{vi} United States v. Lipkis, 770 F.2d 223 (9th Cir. 1981).

^{vii} United States v. Dur-Moz Diagnostic Laboratory, Inc., 650 F.2d 223 (9th Cir. 1981).

^{viii} United States v. Bay State Ambulance and Hospital Rental Inc., 874 F.2d 20 (1st Cir 1989).

^{ix} N.Y Soc. Services Law 366-d

^x Appendi v. New Jersey, 530 U.S.466 (2000).

^{xi} The "Stark Law", 42 U.S.C. 1395nn, was named after its principal sponsor, Rep. Fortney H. Stark.

^{xii} 42 C.F.R. 411.351.