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HEALTHCARE LAW

Honest Healthcare Providers Need to Be Aware of New Federal Anti-Fraud and Abuse Weapons

Medicare pays approximately 1.5 million doctors, hospitals, and providers each year, approximately $750 billion in claims. By some estimates, $65 million of this is "fraudulent." The term "fraud" doesn't just mean activity which is *malum in se*, (bad in itself, like stealing.) It is also engaging in behavior which is *malum prohibitum* (bad because the government told you "don't do it," and you did it anyway). The Center for Medicare and Medicaid Services (CMS) and the Office of the Inspector General (OIG) have long been widely criticized for a system of "pay, then chase." Often, the worst abusers have been able to steal massive amounts of money, and are long gone before anyone finds out. Last year Peter Budetti, who oversees anti-fraud efforts at CMS, discussed the new anti-fraud tools available to the government under the Affordable Care Act (ACA). According to Budetti, "For a long time we were not in a position to keep up with the really sophisticated criminals ... They're not only smart, they're extremely well-funded. And, this is their full time job."

"We're able to now verify whether a person was being treated by two different physicians in two different states on the same day or a variety of other possibilities," he said. This permits the government to do what credit card issuers have done for years. The computer program crawls around the heaps of Medicare claims — some 4 million a day — to look for outliers: spikes in prosthetics in Miami or heart stents in Missoula, for example. And, for the first time, doctors and others who want to bill Medicare are being *assessed based on their risk to commit fraud*. Those who seem crooked are kept out.

How does all of this affect the average honest medical practice or provider? The case of *U.S. v. Krizek* is familiar to anyone who has read a health law textbook. The case resulted in three appellate decisions, six federal opinions in total, and one appeal to the U.S. Supreme Court. The texts report how a Washington, D.C.-based psychiatrist was sued for $82 million in penalties, though he barely earned $125,000 a year, ultimately suffering a judgment of $225,000. What you won't see is the back story of how Dr. Krizek got in trouble in the first place.

Dr. Krizek didn't understand CPT codes, and excessively used Code 90844. Code 90844 was the old code for a 50 minute face-to face therapy session. Krizek used it when his time spent working on a particular case reached one hour in the aggregate, not simply for face-to-face time. Krizek also did not realize, (which providers should) that excessive use of a particularly highly reimbursable CPT code is exactly what genuinely fraudulent criminals would do, if they wish to claim payment for treatment never given.

According to Mrs. Krizek, even though she could prove the patients were genuine, the government was on the scent, and would not give up. The moral of the story is this: now that the government has new tools for identifying excessive use of suspect codes, you must vigilantly keep abreast of what those codes are, lest you find the government in your lobby, asking for files.

If you receive either an external RAC audit letter from a Medicare contractor, or a private audit letter from a health insurance carrier, such as Cigna or Blue Cross Blue Shield of Texas, you should immediately call an experienced health lawyer, who will work with a coding expert to minimize your risk of an adverse assessment.

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INSIDE

Is Your Medical Office Lease Safe?

Since 1863, the False Claims Act has made it illegal to "lie" to the government in order to get paid for services which were clearly unnecessary, or never performed. But the FCA extends far beyond cases of actual fraud, or those in which the patient really didn't need the services provided. The FCA also looks into any irregularity in how the patient arrived in the doctor's office or hospital for treatment in the first place.

The AMA Code of Medical Ethics has long prohibited kickbacks in cash or in kind, (providers can't pay for referrals) and prohibits referrals where there exists a conflict of interest (such as referring a patient to a pharmacy the physician also owned.) See AMA Opinions 6.02-04 and 8.032. As federal spending on Medicare doubled, then tripled, over the decade between the 70s and 80s, the federal government took matters into their own hands and converted sections 6.02-04 and 8.032 of the AMA Code of ethics into *federal offenses* known as the Stark Law and the Anti-kickback Statute, which made ethics a federal offense enforceable under the False Claims Act.

Stark Law outlaws referrals, if a prohibited "relationship" exists; the Anti-kickback Statute outlaws kickbacks for referrals. Certainly the payment of money for referrals is always bad. The trouble comes with the concept of "in-kind" payments, (a term borrowed from the tax code.)

Office space leases are a prime example. Suppose, instead of giving you $5,000 to refer patients, a hospital were to give you free rent. Clearly this kind of "in-kind" payment is no different than writing you a check in the same amount. But what if the hospital charges you some amount for rent? How do you know the hospital is charging enough? That's where the "Safe Harbors" come into play. The Safe Harbors for "space rental" under the Anti-kickback Statute are located at 42 C.F.R. §1001.952 (b) which are identical to the safe harbor under Stark Law, 42 U.S.C. 1395nn. In addition to the requirement that an office lease be in writing, for a term of at least one year, at a rate set in advance, which does not take into account the value of referrals or the proximity of the space to the hospital, the provision which causes the most trouble is the requirement that the amount be at "Fair Market Value."

The problem lies in the fact that "Fair Market Value" is itself nothing more than an "opinion," or at least *mixed questions of "fact" and "opinion*." How do you know your lease is safe?

Recently, an opinion was handed down in *UNITED STATES OF AMERICA, ex rel., MARC OSHEROFF v. Tenent*, which should give every medical real estate professional and physician cause for concern. In *Osheroff*, Tenet's hospitals do in fact take patient referrals from physicians who lease space from Defendants. Some of these patients were Medicaid and Medicare patients, which implicates Stark Law and the Anti-kickback Statute. There is nothing wrong with this practice, as long as provisions of the Safe Harbor are met. (This is the very reason the Safe Harbor exists, to permit physicians to office very close to the hospital.)

Tenet hired a real estate firm to blast e-mails to 3,300 potential tenants, inviting them to visit the website, which advertised office lease rates. But here is where the matter gets messy. "Fair Market Value" for office space rental is not a "number;" it is a range of numbers which depends upon several factors: 1.) what are others charging? 2.) what is the finish-out allowance? and, 3.) what miscellaneous amenities are included?

The whistleblower's complaint in *Osheroff* detailed allegations of what he believed were below-market rental rates in two substantially similar buildings, understating the size of the premises, charging higher rental rates to non-referral tenants, and providing excessive tenant finish out allowances. Although the court dismissed the case on technical grounds, the court left open the possibility the whistleblower could have stated a case.

If the whistleblower was correct, everyone involved, *including all the physician tenants,* could be in big trouble. If the allegations of a knowing violation proved true, both the hospital and each physician involved could be liable for between $11,000 and $50,000 under the False Claims Act and the Civil Monetary Penalties Statute for each claim submitted.

The question remains: "How do you protect yourself?" While no attorney can guarantee a transaction will never draw criticism, you should involve a health lawyer experienced in Stark Law and the Anti-kickback Statute to assist you in the Fair Market Valuation process, which must be documented along with the remaining elements of the safe harbors. At Friedman & Feiger, we help healthcare clients in these matters.

Suspect Joint Ventures Under Stark Law and the Anti-kickback Statute

If it seems as though investment opportunities are flying from the woodwork these days, there's a reason. They are. Throughout most of the 20th century, physicians earned and enjoyed the highest level of respect from both patients and members of the business community. Sadly, as reimbursement rates drop, investment and business brokers are becoming more unscrupulous in sales tactics which offer "risk-free" investments in ancillary services providers, such as compounding pharmacies, diagnostic laboratories, or more traditional passive investments in medical office buildings, real estate ventures, hospital ownership, and a whole host of other investments.

The trouble lies in the fact that a physician's referral or signature is required for most any medical device, test, procedure, or service which is covered by governmental medical programs (Medicare, Medicaid, Tricare, Federal Employees Health Benefits, etc.) It would then make wise business sense to involve in the joint venture a physician who is in a position to make referrals (thereby guaranteeing the success of the venture). While this makes sense, it has the potential for disaster unless there is a 'safe harbor" or it is properly structured by an experienced healthcare lawyer. Sometimes, safe harbors will protect a joint venture, depending upon the structure.

Because it is sometimes difficult to tell, the OIG originally published a Special Fraud Bulletin in 1994 titled "Suspect Joint Ventures: What To Look For," updated in 2003 in a publication titled, "Contractual Joint Ventures." From the standpoint of the physician investor, the OIG warns physicians to be wary of the following:

• Investors are chosen because they are in a position to make referrals.

• Physicians who are expected to make a large number of referrals may be offered a greater investment opportunity in the joint venture than those anticipated to make fewer referrals.

• Physician investors may be actively encouraged to make referrals to the joint venture, and may been encouraged to divest their ownership interest if they fail to sustain an "acceptable" level of referrals.

• The joint venture tracks its sources of referrals, and distributes this information to the investors.

• Investors may be required to divest their ownership interest if they cease to practice in the service area, for example, if they move, become disabled, or retire.

After 25 years of helping physicians in health law transactions, I would add several other items to the list of suspicious sales pitches:

Pitch: "This is a LLC (limited liability company); the most you can lose is your $10,000 investment."

Reality: This is simply not true. The penalties and fines are for submitting a bill for payment when the referral was tainted by a conflict of interest or hidden kickback. The liability is determined by multiplying anywhere from $11,000 to $50,000 by the number of claims submitted to the government.

Pitch: "Don't worry, our legal department has looked at this and has given the deal the green light."

Reality: Never trust a salesman with your federal fraud and abuse liability. While the salesman may be correct, not all deals involving future referrals are unlawful. Make sure you obtain counsel from an experienced healthcare lawyer who understands your needs.

Pitch: "We have been doing this deal for years and never had any trouble."

Reality: This is exactly why the fines are so large. It is very easy to get away with Stark Law and Anti-kickback Statute violations for many years. But if you are caught, the damages are catastrophic.

Pitch: "We have 'carved out' Medicare business, so you do not have to worry."

Reality: Although Medicare referrals trigger liability under the Federal False Claims Act, many states have Anti-kickback statutes, Texas included, which apply to every kind of insurance, not just Medicare and Medicaid. The AMA Code of Ethics, particularly Opinion 8.0321, may also forbid physician self-referral.

Martin Merritt is a nationally recognized health lawyer and healthcare litigator, who writes a weekly column for PhysiciansPractice.com on the subject of state and federal health law, which is circulated to over 220,000 practicing physicians and their staff. Martin earned his first job in healthcare at age 15 as a messenger. In those days, Martin was known solely for his quickness hauling intravenous bags of D5NS up six flights of stairs. Thirty–five years later, with a degree in business administration and a degree in law, Martin performs a different service for hospitals, doctors, compounding pharmacies, dental practices and durable medical equipment manufacturers. Clients have come to rely upon Martin's experience in tailoring solutions in compliance with healthcare regulations. Martin can help, whether the matter involves Stark Law, the Anti-kickback Statute, FDA regulations, Texas Department of State Health Services inspections, RAC audits, insurance company audits, employment issues, medical director contracts, contract negotiations, real estate or office leases, equipment contracts, joint ventures, partnerships, ACOs or IPAs.

Martin is an experienced healthcare litigator as well as a former special prosecutor for the Texas Commission for Lawyer Discipline. This year, Martin was honored by The Federal Lawyer, the official magazine for the United States Federal Bar, when he was asked to write the definitive article on Pleadings and Motions to Dismiss False Claims Act cases in federal court. He was also honored by the American Bar Association, when Martin was asked to author the chapter on Stark Law and the Anti-kickback Statute for an upcoming book on ACO's. Martin has also contributed to national health magazines, such as Becker's Hospital Review and ASC Review.

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