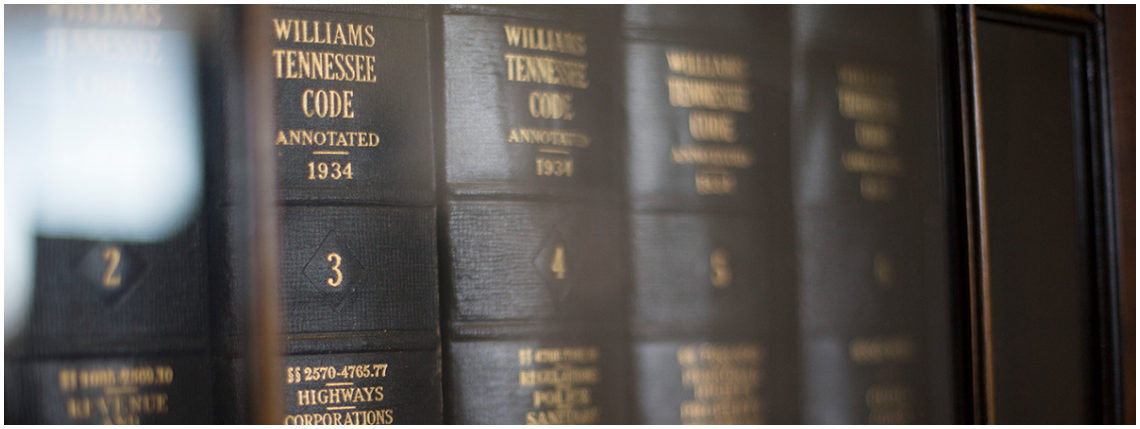
The False Claims Act



By Wendy Longmire, JD

The False Claims Act (FCA) is a federal law which imposes liability on any person or entity who knowingly presents false or fraudulent claims for payments to the United States government or the Armed Forces of the United States; knowingly makes, uses, or causes to be made a false record or statement to get a false or fraudulent claim paid for by the government; conspires to defraud the government by having a false or fraudulent claim paid or approved by the government; or knowingly makes, uses, or causes to be made a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money to the government.[1]

There are several penalties associated with the FCA, which, on the surface, do not appear to be that significant. The law maintains a civil penalty of no less than $5,000 and no more than $10,000 per violation.[2] However, the civil monetary penalties associated with a violation of the FCA adjust with inflation, which would make the penalties for a violation higher than the stated amount in the statute.[3] If a healthcare provider is submitting invoices and has essentially overbilled the federal government, each presentation of a bill is considered a violation. However, the crucial part of the law is that there is a penalty in addition to that for three times the amount of damages that the government sustained [4] - this is known as treble damages. Therefore, if a healthcare company were found to have overbilled Medicare for services that were not rendered, then that overage would be the amount of damages the government has suffered and would be subject to trebling. Finally, there is a Criminal False Claims Act [5], where healthcare providers can be criminally charged for submitting false healthcare claims.[6]

You may have noticed the term “knowingly makes” in the above-mentioned statute. Generally, one believes that those terms are aligned with intent to defraud. It is worth noting that the statute defines “knowingly” with respect to information as, “a person having actual knowledge of that information or one who acts in deliberate ignorance of the truth or falsity of that information or acts in reckless disregard of the truth or falsity of the information.” [7] Therefore, the law does not require specific intent to defraud.[8]

However, an entity does not violate the FCA by submitting a false claim, if, in fact, they do not have knowledge of the falsity pursuant to the aforementioned definition.[9]

Congress created the FCA in 1863, during the Civil War, out of concern that suppliers of goods to the Union were defrauding it.[10] Thus, the law was passed which provided that any person who knowingly submitted false claims to the government was liable for double the government’s damages, plus a penalty of $2,000 for each false claim.[11] In 1986, damages increased from double to treble damages and penalties raised from $2,000 to a range of $5,000-$10,000.[12] In the past 156 years, there have been only minimal modifications to this law.

Any healthcare provider who is billing Medicare or a state Medicaid program (such as Tenncare in Tennessee), should be concerned about both state and federal laws concerning false claims. In 2019 alone, there have been at least three substantial settlements in the state of Tennessee relating to FCA violations. There have been recent substantial settlements in Arkansas and Kentucky in the last two years.[13]

Vanguard Healthcare, a holding company that owns a chain of subsidiary skilled nursing facilities, was accused by the government of delivering worthless services to five residences and billing for the same. As a result, Vanguard Healthcare agreed to pay more than $18,000,000 to resolve the allegations against it. (See this link for more information).

In February 2019, Tennessee Health Management (THM) agreed to pay $9,764,107.98 to settle allegations that it had violated the FCA. Allegations contained in that federal lawsuit involved the submission of false claims to Tenncare for payment all the way to nursing facility services provided to Tenncare beneficiaries. It is worth noting that when false claims come to light, the offending company or organization should work with the government to immediately cooperate and resolve allegations and future risks. Doing so will minimize the amount of damages they will be forced to pay. THM, in this case, did work with the government to cooperate and resolve the allegations. (See this link for more information).

Wellbound of Memphis, a Memphis dialysis facility, was accused in a federal lawsuit of presenting false claims to Medicare, Tricare, and TennCare. The allegations against Wellbound included improper physician referral requirements in violation of the Anti-Kickback statute. (See this link for more information). In this article, Special Agent Derrick L. Jackson was quoted as saying, "When physicians receive financial incentives in exchange for patient referrals, it distorts medical decision-making and freezes out competition."

As a result of the qui tam (whistleblower) lawsuit brought initially by physician Dr. L. Darryl Quarles, and then joined by the United States government, Wellbound paid $3,246,000 to resolve the claims.

Pharmaceutical giant Walgreens recently agreed to pay a $269,000,000 settlement to the United States over allegations from two separate FCA whistleblower lawsuits. This payment will go to the United States and to multiple state governments in order to settle allegations involving the sale of insulin pens and alleged fraudulent acts related to the Walgreens Prescription Savings Club. Purportedly, Walgreens configured its computer system to prevent pharmacists from dispensing less than a full box of insulin pens, even in instances when dispensing a full box exceeded the dates of supply limit that could be dispensed and reimbursed under federal healthcare. In those instances, when the federal healthcare program denied a claim for the full box, it became Walgreens' practice to report days of supply to conform to the limit but still dispense and bill for the full box. As a result, Walgreens received reimbursements for millions of dollars for insulin pens that were not needed and potentially wasted. Additionally, Walgreens allegedly offered some of its customers a prescription savings club. Under Medicaid regulations, Walgreens should only seek reimbursement at the lowest price points of certain drugs, but instead they submitted claims at a higher, non-prescription savings club price. This resulted in multiple states overpaying Walgreens. (See this link for more information).

Walgreens, like THM and Vanguard, entered into a Corporate Integrity Agreement (CIA) with the Department of Health and Human Services and the Inspector General. A comprehensive CIA is generally three to five years in duration[14] and allows the government site reviews and broad oversight into the offenders' billing practices. This type of agreement is common when settlements are reached.

You might ask – how do these FCA lawsuits come to the attention of the United States government? Is there an auditing system? Generally, private individuals who formerly worked at these corporate entities often bring these types of lawsuits. These private parties are referred to as "qui tam relators". They may have an incentive to bring the wrongful actions to light because they may share in a percentage of the proceeds of any settlement. When the government actually intervenes in the lawsuit, a relator can receive between 15–25 percent of the proceeds of an FCA action. If the government does not intervene, the relator could receive as much as 25–30 percent of the funds received. The government intervenes in fewer than 25 percent of all false claim actions,[15] and if they do decline to intervene, the relator may prosecute the action on behalf of the United States. Candidly, if the Department of Justice declines intervention, the remaining plaintiff generally dismisses the case.[16] In addition, if the relator makes allegations and can prove they were discharged, demoted, suspended, threatened, or harassed because of their furtherance of an action under the FCA, there are additional remedies for that relator. These remedies may include reinstatement, double the amount of back pay, interest on back pay, and compensation for special damages (including litigation costs and reasonable attorney's fees). The FCA incentivizes those individuals to come forward when they are aware of wrongdoing.

Healthcare FCA claims are on the rise.

Notably, although there is a decrease in the number of total claims brought by the government under the FCA, government-initiated healthcare cases are increasing.[17] The uptick in these cases may be due to the creation of “Medicare Strike Force Teams”, which focus specifically on criminal and civil heath care fraud.[18] Further, healthcare-related false claims filings should increase in the next few years, as the government has increased the number of civil enforcement attorneys to initiate claims under the FCA, specifically in healthcare and government contracting.[19]

The FCA is the safeguard intended to protect the health and safety of Medicare patients and can certainly be a tremendous pitfall to any healthcare provider, large or small, who is not dutiful in abiding by the law as it relates to government reimbursements.

There are numerous steps that physicians or a practice group can take to develop a voluntary compliance program. First, groups should designate a compliance officer or contact responsible for monitoring compliance efforts and enforce practice standards throughout the group.[20] Second, physicians should conduct internal monitoring through the performance of periodic audits.[21] Further, practice groups should develop open lines of communication, such as discussions at staff meetings, regarding how to avoid erroneous or fraudulent conduct and update community bulletin boards to inform practice employees of compliance activities.[22] Finally, practice groups should enforce disciplinary standards through well-publicized guidelines that are readily available to all employees.[23] SVMIC is able to assist with compliance and program development. Please visit www.svmic.com for more information.

1. See 31 U.S.C. § 3729 (a)(1)

2. The False Claims Act: A Primer, United States Department of Justice, (April 22, 2011), https://www.justice.gov/sites/default/files/civil/legacy/2011/04/22/C-FRAUDS_FCA_Primer.pdf

3. See 31 U.S.C. § 3729 (a)(1)(G)

4. The False Claims Act: A Primer, United States Department of Justice, (April 22, 2011), https://www.justice.gov/sites/default/files/civil/legacy/2011/04/22/C-FRAUDS_FCA_Primer.pdf

5. See 31 USC §§3729; See 31 USC §§3730; See 31 USC §§3731: See 31 USC §§3732; See 31 USC §§3733

6. See 18 U.S.C. § 287; See also A Roadmap for New Physicians, Fraud & Abuse Laws, United States Office of the Inspector General, https://oig.hhs.gov/compliance/physician-education/01laws.asp.

7. The False Claims Act, Centers for Medicare & Medicaid Services, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Fast-Facts/False-Claims.html

8. See 31 U.S.C. § 3729 (b)(1)(B)

9. The False Claims Act: A Primer, United States Department of Justice, (April 22, 2011), https://www.justice.gov/sites/default/files/civil/legacy/2011/04/22/C-FRAUDS_FCA_Primer.pdf

10. The False Claims Act: A Primer, United States Department of Justice, (April 22, 2011), https://www.justice.gov/sites/default/files/civil/legacy/2011/04/22/C-FRAUDS_FCA_Primer.pdf

11. The False Claims Act: A Primer, United States Department of Justice, (April 22, 2011), https://www.justice.gov/sites/default/files/civil/legacy/2011/04/22/C-FRAUDS_FCA_Primer.pdf

12. The False Claims Act: A Primer, United States Department of Justice, (April 22, 2011), https://www.justice.gov/sites/default/files/civil/legacy/2011/04/22/C-FRAUDS_FCA_Primer.pdf

13. See *Signature HealthCARE to Pay More Than $30 Million to Resolve False Claims Act Allegations Related to Rehabilitation Therapy, United States Department of Justice*, https://www.justice.gov/opa/pr/signature-healthcare-pay-more-30-million-resolve-false-claims-act-allegations-related (June 8, 2018) (where Signature HealthCARE paid more than $30 million to resolve a false claims act related to rehab therapy); See also *Grenada Lake Medical Center to Pay More Than $1.1 Million to Resolve False Claims Act Allegations Involving Medically Unnecessary Psychotherapy Services, United States Department of Justice*, https://www.justice.gov/opa/pr/grenada-lake-medical-center-pay-more-11-million-resolve-false-claims-act-allegations (August 6, 2018) (where a medical center paid more than $1.1 million to settle claims regarding services that did not qualify for Medicare)

14. See *Corporate Integrity Agreements, United States Office of the Inspector General*, https://oig.hhs.gov/compliance/corporate-integrity-agreements/index.asp. For a list of current agreements, see *Corporate Integrity Agreement Documents, United States Office of the Inspector General*, https://oig.hhs.gov/compliance/corporate-integrity-agreements/index.asp

15. *False Claims Act Cases: Government Intervention in Qui Tam (Whistleblower) Suits, United States Department of Justice*, https://www.justice.gov/sites/default/files/usaoedpa/legacy/2012/06/13/InternetWhistleblower%20update.pdf

16. *False Claims Act Cases: Government Intervention in Qui Tam (Whistleblower) Suits, United States Department of Justice*,

https://www.justice.gov/sites/default/files/usaoedpa/legacy/2012/06/13/InternetWhistleblower%20update.pdf

17. *FRAUD STATISTICS – OVERVIEW, United States Department of Justice, December 21, 2018*, https://www.justice.gov/civil/page/file/1080696/download?utm_medium=email&utm_source=govdelivery

18. *See Megan Jeschke, Amy Fuentes, DOJ Releases 2018 False Claims Act Report and Statistics, Holland & Knight* (Jan. 17, 2019) https://www.hklaw.com/en/insights/publications/2019/01/doj-releases-2018-false-claims-act-report-and-stat

19. *See Megan Jeschke, Amy Fuentes, DOJ Releases 2018 False Claims Act Report and Statistics, Holland & Knight* (Jan. 17, 2019) https://www.hklaw.com/en/insights/publications/2019/01/doj-releases-2018-false-claims-act-report-and-stat

20. Department of Health and Human Services, Office of the Inspector General; OIG Compliance Program for Individual and Small Group Physician Practices, 65 Fed. Reg. 59434-59439 Thru. Oct. 5, 2000. See also *United States Office of the Inspector General, Compliance Guidelines*, https://oig.hhs.gov/compliance/compliance-guidance/index.asp.

21 *Id.*

22 *Id.*

23 *Id.*