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Medicare and Medicaid False Claims: Prohibitions and Sanctions

*Timothy Stoltzfus Jost**

Federal and state laws forbid health care professionals and institutions from engaging in a wide range of activities generally referred to as Medicare and Medicaid fraud and abuse. Sections of these laws prohibit an assortment of rebates, discounts, incentives, joint ventures, and other profit-sharing arrangements, referred to as “bribes and kickbacks.”¹ Despite all of the attention that has been given to the issue of bribes and kickbacks, most Medicare and Medicaid fraud and abuse laws, criminal prosecutions, and administrative proceedings are brought under other sections of the statute that involve false claims. This article focuses on recent controversies and explores fraud and abuse law as it affects false claims.

The term “false claims” includes bills submitted for services that were not rendered, improperly coded, not provided by the person who claimed to have provided them, or provided unnecessarily. Some cases that have resulted in false claims sanctions have been quite bizarre. For example, a psychiatrist billed Medicaid for 4800 hours in one year, a physician billed Medicaid 48 separate times for performing two abortions within a month on the same patient, and a doctor billed Medicaid for treating a 22 year old college football player for diaper rash.² Most, however, have involved more prosaic manipulation of codes and padding of bills.

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1. A General Accounting Office briefing report analyzing 279 cases referred from the Office of the Inspector General to the Justice Department and closed during fiscal years 1984 and 1985 found that 89 percent of the cases involved submission of false claims. UNITED STATES GENERAL ACCOUNTING OFFICE, HEALTH CARE FRAUD: CHARACTERISTICS, SANCTIONS AND PREVENTION 2 (1987). A review of fraud and abuse civil money penalty cases reported during 1989 found that all but one were based on the false claims statute. Sanford V. Teplitzky & S. Craig Holden, 1989 *Developments in Medicare and Medicaid Fraud and Abuse*, in 1990 HEALTH LAW HANDBOOK 433 (Alice G. Gosfield ed., 1990).

2. See Paul Jesilow et al., *Fraud by Physicians Against Medicaid*, 266 J. AM. MED. ASS'N 3318 (1991).

With growing government concern over the rising cost of health care, the elimination of false claims has become an increasingly urgent priority of the federal and state governments. A recent Government Accounting Office report asserts that fraud and abuse may account for as much as 10 percent of the \$700 billion America spends on health care each year.³ The FBI has reassigned 150 agents to investigate health care fraud, which it identifies as one of its top three priorities in the area of white-collar crime for the 1990s.⁴ The Health Care Financing Administration (HCFA) is in the process of creating fraud and abuse units within companies that administer Medicare claims to strictly enforce Medicare billing requirements. The states are also continuing their efforts to prosecute Medicaid fraud and abuse. This article examines false claims law, focusing in particular on emerging issues and controversies.⁵

I. CRIMINAL PROHIBITIONS

Federal statutes define a "claim" as "[a]ny application for payments for items and services under" Medicare or Medicaid.⁶ Knowingly or willfully misstating a material fact in a claim for a benefit or payment under Medicare or Medicaid to determine eligibility for such a benefit or payment is a felony, punishable by up to five years imprisonment and a fine of up to \$25,000.⁷ It is also a felony to conceal knowledge of an event affecting a person's right to a Medicare or Medicaid benefit or payment if the event is concealed with the intent to secure the benefit or payment by fraud; to apply for and receive a Medicare or Medicaid benefit or payment intended for the use of another and

3. UNITED STATES GENERAL ACCOUNTING OFFICE, HEALTH INSURANCE, VULNERABLE PAYERS LOSE BILLIONS TO FRAUD AND ABUSE (1992).

4. Brian McCormic, *The Fraud Police*, AM. MED. ASS'N NEWS, Oct. 12, 1992, at 1. See also Joseph Ford, *Investigating a National Problem Through a Global Strategy*, FED. B.J., Jan. 1993, at 66.

5. This article does not discuss provider strategies for dealing with fraud investigations. For two articles on this topic, see Manatt, Phelps, Phillips, & Kantor, *When the Institutional Health Care Provider is the Target of Federal Fraud and Abuse Proceedings*, FED. B.J., Jan. 1993, at 52, and Alan Reider & Harvey Yampolsky, *Identifying and Coping with Health Care Fraud Investigations*, FED. B.J., Jan. 1993, at 62; see also Alice G. Gosfield, *Unintentional Part B False Claims: Pitfalls for the Unwary*, in 1993 HEALTH LAW HANDBOOK 205 (Alice G. Gosfield ed., 1993) (discussing in detail codes and procedures most likely to prompt fraud and abuse investigations).

6. 42 U.S.C. § 1320a-7a(i)(2) (1988). See also 42 C.F.R. § 1003.101 (1993).

7. 42 U.S.C. § 1320a-7b(a) (1988 & Supp. III 1991). The law also prohibits the filing of false claims under Title V (maternal and child health block grant) and Title XX (social services block grant) programs.

then steal it; or to bill for a physician's service knowing that the individual who provided the service was not a physician.⁸ Though criminal liability requires proof of intent—a “knowing” or “willing” violation of the law—intent may be proved by a conscious avoidance of an awareness of the falsity of claims or a reckless indifference to the falsity of claims.⁹ If the person who engages in one of these acts does not furnish medical items or services (for example, a billing clerk), he or she or the person is guilty of a misdemeanor, punishable by a fine of up to \$10,000 and by imprisonment of up to one year.¹⁰ The law also imposes criminal penalties for the knowing and willful violation of the terms of a physician or supplier participation agreement or the terms of a Medicare assignment of benefits agreement.¹¹ In addition, false claims may violate federal laws prohibiting mail fraud,¹² the presentation of false claims to government agencies,¹³ conspiracy to defraud the government,¹⁴ and racketeering,¹⁵ as well as state criminal laws.

While physicians, providers, and suppliers who violate these provisions typically do so by billing for services that they did not render, the statutes also prohibit upcoding services to receive a higher reimbursement rate than is appropriate and falsely certifying services as medically necessary. For example, in *United States v. Larm*,¹⁶ the court upheld the conviction of an allergist on seventeen counts of Medicaid fraud for billing nurse-administered allergy shots under CPT Code 90040,¹⁷ “brief examina-

8. 42 U.S.C. § 1320a-7b(a).

9. *United States v. Lennartz*, 948 F.2d 363 (7th Cir. 1991); *United States v. Evans*, 559 F.2d 224 (5th Cir. 1977). See Andrew Grosso, *Prosecuting Health Care Fraud: Tools of the Trade*, FED. B.J., Jan. 1993, at 22 (discussing government strategies for proving intent).

10. 42 U.S.C. § 1320a-7b(a).

11. *Id.* at § 1320a-7b(e).

12. 18 U.S.C. § 1341 (Supp. IV 1992).

13. 18 U.S.C. §§ 287, 1001 (1988).

14. 18 U.S.C. §§ 2, 286, 287, 371 (1988).

15. 18 U.S.C. § 1962 (1988). The Racketeer Influenced and Corrupt Organizations (RICO) statute permits, in addition to criminal penalties, forfeiture to the United States of property derived from racketeering activity. 18 U.S.C. § 1963 (1988 & Supp. IV 1992). The United States government used RICO to seize the clinics, home, automobiles, and yacht of a chiropractor convicted of mail fraud based on filing false Medicare and insurance claims. *United States v. Mayers*, 957 F.2d 858 (M.D. Fla. 1988), noted in Sanford V. Teplitzky & S. Craig Holden, *Medicare and Medicaid Fraud and Abuse*, in 1989 HEALTH LAW HANDBOOK 506 (Alice G. Gosfield ed., 1989).

16. 824 F.2d 780 (9th Cir. 1987), *cert. denied*, 484 U.S. 1078 (1988).

17. See AMERICAN MEDICAL ASSOCIATION, CURRENT PROCEDURAL TERMINOLOGY MANUAL (the basis for CPT billing codes).

tion, evaluation and/or treatment of same or new illness,” rather than CPT Code 90030, “minimal service: injections, minimal dressings, etc., not necessarily requiring the presence of a physician.” Other examples of fraudulent claims include bills submitted for office visits when in fact the physician only provided a telephone consultation;¹⁸ multiple bills submitted for services that should have been billed as a single office visit;¹⁹ services claimed as performed under the supervision of a physician that in fact were not;²⁰ services claimed that were not provided, even though in fact other services were provided;²¹ and bills submitted for in office services to a woman bedridden at home.²² Cases that are prosecuted generally involve multiple false claims, indicating a pattern of fraud and abuse.

False claims can be made either on paper or through electronic media. Currently about eighty percent of Medicare Part A claims and forty-five percent of Part B claims are filed electronically, as are up to ninety percent of Medicaid hospital claims and thirty-five percent of physician claims.²³ The Department of Health and Human Services and a variety of health care reform plans advocate the increased use of electronic media for processing claims and payments. There has been some concern that it may be difficult to prove that a false claim has been knowingly or willfully made if no piece of paper signed by the physician exists as a physical representation of the claim. However, computer-generated records, properly authenticated by a person who can explain how the data was created and maintained and how printouts or other representations of the data were generated, are generally admissible under the Federal Rules of Evidence and the evidentiary rules of most states.²⁴ In-

18. *United States v. Adler*, 623 F.2d 1287 (8th Cir. 1980).

19. *State v. Quinn*, 719 P.2d 936 (Wash. Ct. App. 1986).

20. *Peterson v. Weinberger*, 508 F.2d 45 (5th Cir. 1975), *cert. denied sub nom. Peterson v. Mathews*, 423 U.S. 830 (1975).

21. *Id.*; *People v. Gregory*, 266 Cal. Rptr. 527 (Cal. Ct. App.), *cert. denied*, 498 U.S. 1014 (1990).

22. *State v. Romero*, 574 S.2d 330 (La. 1990).

23. See WORKGROUP FOR ELECTRONIC DATA INTERCHANGE, REPORT TO THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES (1992).

24. See FED. R. EVID. 1001-1008; SYSTEMS POLICY STAFF, JUSTICE MANAGEMENT DIVISION, UNITED STATES DEPARTMENT OF JUSTICE, ADMISSIBILITY OF ELECTRONICALLY FILED FEDERAL RECORDS AS EVIDENCE (1991); ASSOCIATION FOR INFORMATION & IMAGE MANAGEMENT, PERFORMANCE GUIDELINE FOR THE LEGAL ACCEPTANCE OF RECORDS PRODUCED BY INFORMATION TECHNOLOGY SYSTEMS pt. 1 (1992).

deed, one of the earliest criminal cases in which computer-generated records were accepted involved false health insurance claims.²⁵ Establishing that a physician or provider actually submitted an electronic claim that he or she denies filing might be more problematic. In the analogous area of government contracting, the Comptroller General has issued an opinion recognizing the use of electronic signatures.²⁶ However, one state court has questioned the use of a presumption that a physician has knowledge of an electronic claim filed by his office based on the fact that he authorized in writing the filing of electronic claims.²⁷

II. CIVIL MONETARY PENALTIES

A person who submits false claims for payment under Medicare or Medicaid is also subject to civil sanctions, including monetary penalties and exclusion from federal programs. The Department of Justice enforces criminal fraud and abuse laws and general civil fraud laws, and the Office of the Inspector General (OIG) of the Department of Health and Human Services (HHS) enforces fraud and abuse civil penalties, and program exclusions specific to Medicare and Medicaid. In recent years the OIG has aggressively enforced the fraud and abuse laws with strong Congressional support. However, according to an understanding between HHS and the Justice Department, cases must first be referred to the Justice Department for criminal or civil action; the OIG pursues the claim only if the Justice Department declines prosecution.²⁸

Civil penalties for false claims can amount to \$2000 per item or service, plus assessments equaling twice the amount claimed.²⁹ A person is liable for civil penalties if he or she “knows or should know” that a claim is false or that the service was “not provided as claimed.” The “not provided as claimed” standard permits the imposition of penalties for miscoding as

25. *United States v. Russo*, 480 F.2d 1228 (6th Cir. 1973), *cert. denied*, 414 U.S. 1157 (1974).

26. COMPTROLLER GENERAL OF THE UNITED STATES, *MATTER OF NATIONAL INSTITUTE OF STANDARDS AND TECHNOLOGY—USE OF ELECTRONIC DATA INTERCHANGE TECHNOLOGY TO CREATE VALID OBLIGATIONS* (1991).

27. *People v. Freedland*, 444 N.W.2d 250 (Mich. Ct. App. 1988).

28. See Memorandum of Understanding Between the Department of Health and Human Services and the Department of Justice Regarding Implementation of Section 1128A of the Social Security Act (1988).

29. 42 U.S.C. § 1320a-7a(a)(1)(A) & (B) (1988). As with criminal sanctions, the provisions apply to state programs funded through Title V and Title XX.

well as for fictitious claims. The Eighth Circuit Court of Appeals upheld a \$258,000 penalty assessment against a physician group despite arguments that the physicians had merely “unartfully” described services rendered.³⁰ The court stated: “The standard of care imposed by this requirement is an exacting one, and an ‘unartful’ description of medical services in a Medicare claim is a description of services that were not provided as claimed.”³¹

The original civil sanctions statute, which imposed liability under a “knows or has reason to know standard,” created difficulties for the government when a physician asserted, as is common, that the false claim was the fault of a billing clerk. For this reason, Congress amended the statute in 1987 to create a “knows or should know” standard, which is based on an objective evaluation of what a reasonable medical provider has reason to know, not on what a particular provider admits to knowing in fact.³² Under this amended standard, a medical provider can be found liable for submitting false or improper claims if sufficient information came to the provider’s attention to place a reasonable provider on notice that the claims were questionable, or if a pre-existing duty required the provider to verify the truth, accuracy, and completeness of the claims.³³ The “should know” standard subsumes reckless disregard for the consequences of one’s actions, as well as negligence in preparing and submitting claims, whether done by the provider or someone under the provider’s supervision.³⁴ Congress also added a new subsection stating that, “a principal is liable under this section for the actions of the principal’s agent acting within the scope of the agency.”³⁵ This subsection clarifies that physicians, providers, and suppliers are liable for the acts of their employees. Thus, regardless of the amount of attention that physicians actually pay to claims processing, they will almost always be lia-

30. *Anesthesiologists Affiliated v. Sullivan*, 941 F.2d 678 (8th Cir. 1991).

31. *Id.* at 681.

32. Pub. L. No. 100-203, § 4118(e), 101 Stat. 1330-155 (1987).

33. *Inspector General v. Anesthesiologists Affiliated*, 1990 Medicare & Medicaid Guide (CCH) ¶ 38,554 (HHS Dept’l App. Board, Civ. Remedies Div. Feb. 5, 1990), *aff’d sub nom. Anesthesiologists Affiliated v. Sullivan*, 941 F.2d 678 (8th Cir. 1991); *Inspector General v. Kern*, 1990 Medicare & Medicaid Guide (CCH) ¶ 38,389 (HHS Dept’l App. Board, Civ. Remedies Div. Aug. 26, 1987).

34. 57 Fed. Reg. 3298, 3324 (1992). *See also* *Mayers v. United States Dept. Health & Human Servs.*, 806 F.2d 995 (11th Cir. 1986), *cert. denied*, 484 U.S. 822 (1987); *Anesthesiologists Affiliated*, 1990 Medicare & Medicaid Guide (CCH) ¶ 38,554.

35. 42 U.S.C. § 1320a-7a(l) (1988).

ble for civil sanctions if it is determined that their offices submitted false claims.

The civil monetary penalty statute gives the OIG considerable discretion in determining the amount of penalty to be assessed. The statute and regulations list a variety of mitigating or aggravating factors that the OIG may consider in determining the amount of the penalty, including the amount and number of false claims, the culpability of the person submitting the false claim, any history of prior offenses, and the financial condition of the person submitting the false claim.³⁶ For example, in an atypical case in which the OIG applied the maximum penalty, the doctor had established a sophisticated scheme that enabled him to submit bills for fictitious office visits and tests and to create fictitious patient records to support the claims.³⁷ In another case, the Eleventh Circuit Court of Appeals upheld an assessment of \$1,791,100, based on receipt of \$24,697.73, as justified because of aggravating circumstances, including the fact that the physician had submitted a large number of claims over a long period of time.³⁸

Absent mitigating factors, the amount assessed against one who files a false claim should equal at least twice the amount of damages and costs incurred by the United States government, including costs incurred in the investigation, prosecution, and administrative review of the case.³⁹ The imposition of a penalty substantially in excess of twice the amount of actual damages may result in a punitive sanction, raising constitutional double jeopardy problems in cases where a criminal penalty has already been imposed.⁴⁰

In addition to the civil penalties that can be imposed under the statute, civil penalties of \$5000 per false claim plus assessments of double the amount of the false claim can also be imposed under the federal Program Fraud Civil Remedies Act of 1986.⁴¹ Also, courts may impose penalties of between \$5000 and \$10,000 per claim, plus treble damages for false claims.⁴² Under

36. 42 U.S.C. § 1320a-7a(d) (1988); 42 C.F.R. § 1003.106 (1993).

37. *Inspector General v. Vo & Thieu Du*, 1989-2 Medicare & Medicaid Guide (CCH) ¶ 38,030 (HHS Dept'l App. Board, Civ. Remedies Div. Aug. 15, 1989).

38. *Mayers*, 806 F.2d 995. *See also Chapman v. United States Dept. of Health & Human Servs.*, 821 F.2d 523 (10th Cir. 1987) (civil penalties may exceed actual damages suffered by the government).

39. 42 C.F.R. § 1003.106(c)(3) & (d)(2).

40. *See United States v. Halper*, 490 U.S. 435 (1989).

41. 31 U.S.C. § 3802 (1988).

42. 31 U.S.C. § 3729 (1988).

the latter provision, a private citizen can bring a *qui tam* action, and receive a percentage of the recovery as a bounty as well as attorney's fees.⁴³

III. PROGRAM EXCLUSION

Exclusion from program participation, another remedy available to the OIG, will in many instances have a greater impact on physicians than will civil penalties. If an individual is "excluded," Medicare and Medicaid will not pay for services rendered by the excluded person or for services rendered by the order of, or under the supervision of, an excluded person, regardless of whether the claim in question is assigned or nonassigned.⁴⁴ Thus, a hospital that provides services to a patient who is admitted by an "excluded" physician cannot receive Medicare payment for the stay unless it can show that it did not know or have reason to know of the exclusion.⁴⁵ The hospital may even be liable for a civil penalty for submitting the claim.⁴⁶

While civil money penalties and exclusion are both available remedies for false claims, the purposes of the two types of sanction are different. Civil money penalties are imposed to make the wrongdoer reimburse the government for costs that the government incurred because of the misconduct. Exclusion, on the other hand, removes "untrustworthy" health care providers from the program.

43. 31 U.S.C. § 3730(b) & (d) (1988). See *United States ex rel. Stinson, Lyons, Gerlin & Bustamante, P.A. v. Provident Life & Accident Ins. Co.*, 721 F. Supp. 1247 (S.D. Fla. 1989) (permitting a *qui tam* action in a Medicare as secondary payor case).

44. 42 U.S.C. §§ 704(b)(6), 1395u(j)(2), 1395y(e), 1396b(i)(2), 1397d(a)(9) (1988 & Supp. III 1991); 42 C.F.R. § 1001.2 (1993). If a beneficiary submits a claim for services provided by an excluded person, HCFA will pay the first claim and immediately notify the beneficiary that the person is excluded. It will not pay for services provided more than fifteen days after the date of the notice. 42 C.F.R. § 1001.1901(c) (1993). Payment may also be made to patients admitted to a hospital before the exclusion or hospice or home health agency patients receiving care under a plan or care established before the exclusion for up to thirty days after an exclusion becomes effective unless the Secretary of Health and Human Services determines that the exclusion should take effect earlier. 42 U.S.C. § 1320a-7(c)(2)(B) (1988). Payments may also be made under limited circumstances for emergency services rendered by excluded persons. 42 C.F.R. § 1001.1901(c)(4). A physician or supplier who accepts an "assigned" claim bills Medicare directly, as an assignee of the Medicare beneficiary. A physician who accepts a Medicare patient on an "unassigned" basis, bills the patient, who in turn claims reimbursement from Medicare. See 42 U.S.C. § 1395u(b)(3)(B) (1988).

45. 42 U.S.C. § 1395y(e)(1)(B) (1988).

46. *Id.* at § 1320a-7a(a)(1)(D) (1988).

One of the most common grounds for exclusion is conviction of criminal Medicare or Medicaid fraud. Exclusion for at least five years (and longer if there are aggravating circumstances) is mandatory if a health care practitioner is convicted of a criminal offense related to the delivery of an item or service reimbursed under Medicare or a state health care program.⁴⁷ Criminal convictions on which exclusion may be based are defined to include not only guilty verdicts, but also guilty pleas, including nolo contendere pleas, in which the defendant pleads no contest but does not admit guilt, and Alford pleas, in which the defendant pleads guilty but maintains innocence.⁴⁸ The fact that a conviction has been expunged under state law does not hinder conviction-based exclusion under federal law. Once a conviction is entered, the defendant's guilt or innocence becomes irrelevant and cannot be relitigated at the exclusion hearing. Although physicians frequently argue in exclusion hearings that they pled guilty to the criminal charge merely to avoid the expense and hassle of a trial and in fact did nothing wrong, their earnest arguments are uniformly rejected and mandatory five-year exclusions are regularly imposed.

The exclusion provision also authorizes discretionary exclusions, which can be triggered by a variety of circumstances, including conviction of crimes involving fraud, theft, embezzlement, breach of fiduciary duty, or other financial misconduct, either in the delivery of health care in general or while participating in a governmental program.⁴⁹ The Secretary of HHS may also exclude providers who file Medicare or Medicaid claims that include charges or costs that substantially exceed the usual claims or costs⁵⁰ and providers who furnish health care to any patient (whether or not eligible for services under Medicare or a State health care program) that substantially exceeds the patient's needs.⁵¹

47. *Id.* at § 1320a-7(a)(1) (1988).

48. *Id.* at § 1320a-7(i) (1988). See *Hein v. Inspector General*, 1993 Medicare & Medicaid Guide (CCH) ¶ 41,366 (HHS Dept'l App. Board, Civ. Remedies Div. Feb. 26, 1993); James M. Becker et al., *Avoiding Multiple Sanctions and Collateral Consequences When Settling Fraud and Abuse Case*, in 1993 HEALTH LAW HANDBOOK 187 (Alice G. Gosfield ed., 1993) (discussing settlement issues generally).

49. 42 U.S.C. § 1320a-7(b)(1) (1988 & Supp. III 1991).

50. *Id.* at § 1320a-7(b)(6)(A) (1988 & Supp. III 1991). HHS declined to define "usual charges" or "substantially in excess" stating that it will analyze billing patterns on a case-by-case basis.

51. *Id.* at § 1320a-7(b)(6)(B) (1988 & Supp. III 1991).

Regulations list aggravating and mitigating facts that the OIG may consider in determining the length of the exclusion.⁵² However, they also attempt to cabin the OIG's discretion by establishing benchmarks for exclusion periods, which are binding unless mitigating or aggravating factors dictate an exclusion of a different length.⁵³ Although several administrative law judges (ALJs) have held that these benchmarks are not binding on ALJs reviewing OIG exclusion decisions,⁵⁴ HHS has recently amended its regulations to clarify that the benchmarks bind not only the OIG, but also ALJs, the Departmental Appeals Board, and the federal courts.⁵⁵ An alternative explanation for rejecting the application of the benchmark limits in ALJ hearings—that refusal to consider all mitigating factors would result in a punitive as opposed to a remedial sanction and thus violate the double jeopardy prohibition—was rejected by the Departmental Appeals Board in one of the *Hanlester* decisions. The Appeals Board noted that statutory violations are *prima facie* evidence of untrustworthiness, and that sanctions based on such conduct are by definition remedial, even though they might also serve incidental deterrent or punitive purposes.⁵⁶

If the OIG excludes an individual or entity from participating in the Medicare program, state Medicaid agencies must also exclude that individual or entity from participating in Medicaid for

52. Aggravating factors that may be considered include the amount Medicare and the state health care programs lost due to the claims or any other overbilling (with losses above \$1,500 considered aggravated); whether the acts or similar acts were committed over a period of one year or more; the severity of the adverse impact on the physical, mental, or financial welfare of program beneficiaries or others; and the existence of a prior record of criminal, civil, or administrative sanction. 42 C.F.R. § 1001.102(b) (1993). Mitigating factors that may be considered include a conviction of three or fewer misdemeanors, a financial loss to Medicare and the state health programs that is less than \$1,500; a mental, emotional, or physical condition that reduced the individual's culpability; or cooperation with federal or state officials that results in criminal conviction or civil penalties imposed against others for Medicare or Medicaid fraud. 42 C.F.R. § 1001.102(c) (1993).

53. See, e.g., 42 C.F.R. §§ 1001.201(b) (1993) (three years for criminal fraud conviction), 1001.501(b) (1993) (not less than the time of suspension or revocation for licensure actions).

54. See, e.g., *Herlick v. Inspector General*, 1992-2 Medicare & Medicaid Guide (CCH) ¶ 40,360 (HHS Dept'l App. Board, Civ. Remedies Div. May 11, 1992); *Baranco v. Inspector General*, 1992-2 Medicare & Medicaid Guide (CCH) ¶ 40,246 (HHS Dept'l App. Board, Civ. Remedies Div. Mar. 30, 1992).

55. 42 C.F.R. § 1001.1 (1993).

56. *In re Inspector General v. Hanlester Network*, Docket No. C-448, Decision No. 1347 (HHS Dept'l App. Board, App. Div. July 24, 1992), *aff'd*, *Hanlester v. Sullivan*, 1993-1 Medicare & Medicaid Guide (CCH) ¶ 41,076 (C.D. Cal. Feb. 10, 1993).

the same period of time.⁵⁷ However, states may request that an exclusion from state health programs be waived.⁵⁸ Also, states may, at their own initiative, exclude an individual or entity from participating in Medicaid for any of the reasons that the individual or entity could have been excluded from participating in Medicare under 42 U.S.C. § 1320a-7, or may impose exclusions for longer periods of time than those imposed by the OIG.⁵⁹ Under Executive Orders 12549 and 12689, Medicare exclusions are given government-wide effect: the excluded individual or entity is barred from participating in any other federal program.⁶⁰

In addition to the primary fraud and abuse civil penalty and exclusion provisions, the Medicare and Medicaid statutes are peppered with a large and growing number of other provisions authorizing civil sanctions or exclusions for various improper billing practices. These include violation of an assignment agreement, billing in excess of limiting charges by nonparticipating physicians, or failure to use the claim form for submitting claims.⁶¹ It is becoming increasingly common that a violation of Medicare or Medicaid administrative regulations renders a physician subject to administrative sanctions, though in most instances sanctions can only be imposed for knowing or willful, and perhaps even repeated, violations.

IV. STATE REMEDIES

Although the federal fraud and abuse laws have garnered much attention in recent years, the states have also been very active in prosecuting Medicaid fraud and abuse. Most states have statutes that specifically prohibit Medicaid fraud, though some states rely on more general statutes that prohibit fraud or theft by deception or false statements to public officials.⁶² Statutes prohibiting physicians or other medical providers from filing false claims or from obtaining payments through

57. 42 U.S.C. §§ 1320a-7(d), 1396a(a)(39) (1988).

58. *Id.* at § 1320a-7(d)(3)(B).

59. *Id.* at §§ 1320a-7(d)(3)(B)(ii), 1396a(p)(1) (1988).

60. 42 C.F.R. § 1001.1901 (1993).

61. Miscellaneous civil sanction authorities found in the Medicare and Medicaid laws related to billing practices include 42 U.S.C. §§ 1395l(h)(5)(D), (i)(6), (l)(5)(B), (p), (r)(3)(B), 1395m(b)(5)(C), 1395u(b)(12)(C), (j)(1), (k)(1), (l), (m), (n), (p), 1395w-4(b)(3), (g)(1), (g)(3), (g)(4) (1988 & Supp. III 1991).

62. *See, e.g.*, ME. REV. STAT. ANN. tit 17-A, § 354 (West 1964); N.Y. PENAL LAW § 175.35 (McKinney 1988).

misrepresentation are most common.⁶³ Some statutes closely track the federal law or some earlier version of it.⁶⁴ A number of states have prohibitions that supplement the federal law,⁶⁵ such as forbidding the provision of unnecessary care⁶⁶ or care of inadequate quality,⁶⁷ prohibiting providers and practitioners from charging Medicaid a fee that exceeds the lowest rate at which they bill to the general public,⁶⁸ authorizing civil penalties⁶⁹ or restitution⁷⁰ and suspension or termination from program participation,⁷¹ permitting penalties double or triple the amount falsely obtained,⁷² providing for forfeiture of profits or property attributable to the offense,⁷³ providing for the return of improperly obtained payments plus interest, but without additional penalties if no intent to defraud is shown,⁷⁴ and providing for assessments to cover the cost of the investigation in addition to any other penalties,⁷⁵ which must usually be imposed through

63. See, e.g., CONN. GEN. STAT. ANN. § 17-83k (West 1992); FLA. STAT. ANN. § 409.920 (West 1993); HAWAII REV. STAT. § 346-43.5 (1985); LA. REV. STAT. ANN. § 14:70.1 (West 1986); MICH. COMP. LAWS ANN. § 400.607 (West 1988); MISS. CODE ANN. § 43-13-13, -205, -213, -217 (1993); N.H. REV. STAT. ANN. ch. 167, §§ 17-b, 61-a (1990 & Supp. 1993); OHIO REV. CODE ANN. § 2913.40 (Anderson 1993).

64. See, e.g., 305 ILCS 5/8A-3 (Smith-Hurd 1993); MD. ANN. CODE art. 27, § 230B (1992); N.J. STAT. ANN. § 30:4D-17 (West 1981).

65. See, e.g., N.M. STAT. ANN. § 30-44-5 (Michie 1989) (failure to retain records documenting Medicaid claims for five years is a crime); R.I. GEN. LAWS § 40-8.203(a)(3) (1990) (submitting claim for which provider has already received or claimed reimbursement from another source is prohibited).

66. See, e.g., CONN. GEN. STAT. ANN. § 17-83k(a)(4) (West 1992) (performing services not needed or without prior authorization, where required); FLA. STAT. ANN. § 409.913(8)(i) (West 1993) (furnishing inappropriate, unnecessary, or harmful goods and services result in administrative sanctions only).

67. See, e.g., FLA. STAT. ANN. § 409.913 (inferior quality results in administrative sanctions only); 305 ILCS 5/12-4.25(A)(e) (Smith-Hurd 1993) (termination for care that is harmful or of "grossly inferior quality").

68. See, e.g., PA. STAT. ANN. tit. 62, § 1407(a)(8) (Supp. 1993).

69. See, e.g., ARK. CODE ANN. § 5-55-108 (Michie 1987); FLA. STAT. ANN. § 409.913 (West 1993); MISS. CODE ANN. § 43-13-225 (1993).

70. See, e.g., ARK. CODE ANN. § 5-55-107 (Michie 1987).

71. See, e.g., *id.* at § 5-55-110 (1987) (for up to one year); FLA. STAT. ANN. § 409.913(a) (West Supp. 1993) (suspension for up to one year, termination for one to twenty years); 305 ILCS 5/12-4.25 (Smith-Hurd 1993) (also authorizes withholding of payments while proceeding is pending).

72. See, e.g., 305 ILCS 5/8A-7(b) (Smith-Hurd 1993) (triple damages plus \$2000 per violation); OHIO REV. CODE ANN. § 5111.03 (Anderson 1993) (\$2000 per claim plus three times excess payments).

73. See, e.g., 305 ILCS 5/8A-3(d) (Smith-Hurd 1993).

74. See, e.g., N.J. STAT. ANN. § 30:4D-17(f) (West 1981); OHIO REV. CODE ANN. § 5111.03(D).

75. See, e.g., FLA. STAT. ANN. § 409.913(15); N.M. STAT. ANN. § 30-44-8(C) (Michie 1989); OHIO REV. CODE ANN. § 5111.03(B)(4); OKLA. STAT. ANN. tit. 56, 1007(A)(3) (West 1991).

judicial proceedings.⁷⁶ State statutes also permit revocation of professional licensure based on Medicaid or Medicare fraud convictions.⁷⁷

CONCLUSION

In most states Medicaid pays physicians at levels well below market rates. As the resource-based relative value scale⁷⁸ is implemented, it is likely that Medicare's reimbursement rate will decline below the private charges of many physicians, with "balance billing"⁷⁹ to the patient a very limited option. Under these circumstances physicians may be tempted to manipulate codes, submit multiple, fragmented bills for a single service, bill for services not rendered, or provide services not medically necessary.⁸⁰ The anonymity of electronic billing might make these practices even more attractive.

The false claims provisions of federal and state laws give the Office of the Inspector General, the Department of Justice, and state Medicaid Fraud Control Units an impressive arsenal of remedies for responding to such practices. Although most false claims probably go undetected, criminal convictions, civil monetary penalties, and exclusion from program participation are the consequences facing those who are caught. Pleas that improper practices were the result of oversight or the fault of an employee will seldom avail. Physicians convicted of Medicare and Medicaid fraud often serve little time in prison, but convictions are regularly followed by civil money penalties or exclusions, or even loss of licensure, which can have a devastating impact on the physician's practice.

Compliance with the law, or at least attempted compliance, renders the physician fairly secure from prosecution. Both criminal and civil penalties can only be based on willful or knowing violations of the law. Proof of intent or knowledge generally requires repeated violations. A physician or provider who can

76. See, e.g., ARK. STAT. ANN. § 5-55-108 (1987); 305 ILCS 5/8A-7(c) (Smith-Hurd 1988); N.H. REV. STAT. ANN. ch. 167, § 61 (1990). But see FLA. STAT. ANN. § 409.913(17) (authorizing administrative imposition of sanctions).

77. See, e.g., OHIO REV. CODE ANN. § 4731.22(B)(25)(Anderson Supp. 1992).

78. The resource-based relative value scale (RBRVS) is a method of paying physicians based on the value of their individual services rather than on their charges for those services. See 42 U.S.C. § 1395w-4 (Supp. II 1990).

79. A physician "balance bills" when he or she bills a patient a "balance" in excess of the Medicare payment rate. Balance billing is strictly limited under RBRVS payment. *Id.* at § 1395w-4(g).

80. See Gosfield, *supra* note 5, at 205 (discussing false claims under RBRVS).

demonstrate “due diligence” in attempting to code accurately and supervise billing personnel is unlikely to be sanctioned, even if a technical violation occurs.⁸¹ However, the physician or provider who either consciously cuts too close to the line or fails to pay attention to billing practice is courting disaster.

81. See Manatt, Phelps, Phillips, & Kantor, *supra* note 5 (discussing institutional compliance programs).