Phantom Billing, Fake Prescriptions, and the High Cost of Medicine

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INTRODUCTION

1. President Bush's 2008 budget provided $1.2 billion in mandatory funding and $183 million from a discretionary cap adjustment for the Health Care Fraud and Abuse Control Program for Medicare integrity activities. In 2008 the HHS Inspector General's Office collected $2.35 billion directly and $1.33 billion indirectly, and the OIG pursued about 2,100 cases stemming from 4,800 health care fraud and abuse complaints. During the same time frame, the Department of Justice recovered $1.12 billion from perpetrators of health care fraud, down from $1.53 billion the previous year.

For FY 2009, the OIG reported that 2,556 individuals and entities were excluded from federal health care programs and 671 criminal actions and 394 civil actions were taken. President Obama's proposed budget added $125 million in discretionary spending to the $1.5 billion that already funded the Health Care Fraud and Abuse Control Program. Total discretionary spending for the program in FY 2010 was projected to be $311 million. See Baumann 2007, 4; U.S. Department of Health and Human Services and U.S. Department of Justice 2007, 1; National Health Care Anti-Fraud Association, n.d.; Fierce Healthcare, Daily News for Health Care Executives 2009e; Fierce Healthcare, Daily News for Health Care Executives, 2008c; U.S. Department of Health and Human Services, Office of the Inspector General 2009; Kaisernetwork 2008a.

2. The degree of cooperation between federal and private agencies is extensive. According to the FBI's Financial Crimes Report to the Public, Fiscal Year 2006: "The FBI leverages its resources in both the private and public arenas through investigative partnerships with agencies such as the U.S. Department of Health and Human Services-Office of Inspector General (HHS-OIG), the Food and Drug Administration (FDA), Drug Enforcement Agency (DEA), Defense Criminal Investigative Service, Office of Personnel Management, Internal Revenue Service (IRS), and various state and local agencies. On the private side, the FBI is actively involved with national groups, such as the National Health Care Anti-Fraud Association (NHCAA), the National Insurance Crime Bureau (NICB), the Blue Cross and Blue Shield Association (BCBSA), the American Association of Retired Persons, and the Coalition Against Insurance Fraud, as well as many other professional and grass-roots efforts to expose and investigate fraud within the system.”

8. Because of the attention given to health care financing arrangements, the broader term “health care fraud” will be used in this book instead of the term “medical care fraud.” These terms, however, are often used interchangeably.
10. Ibid.
17. BrainyQuote n.d.
22. Defining the boundaries of the health care system can be a problem. Hospitals, physicians, and diagnostic laboratories are always regarded as part of any health care industry. Other health-promoting activities such as health foods, spas, gyms, and exercise equipment are usually excluded from an analysis of health care. This book focuses on the nine segments delineated by the Bureau of Labor Statistics, as well as both private and public sources of health care financing.
30. Freking 2008a.
32. Kaiser Family Foundation 2007; University of Maine, Bureau of Labor Education 2001, 1–8. It is also noteworthy that health care expenditures are not distributed uniformly. Eighty percent of U.S. health care expenditures are made by 20% of the population, primarily those suffering three serious chronic conditions simultaneously as well as by very ill persons who are in the last six months of their lives. See Bradley 2007, 135.
36. Joshi 2008. Citing a survey conducted by the foundation, the Washington Post reported: “More than two in five adults in the 19-to-64 age group reported problems paying medical bills or had accumulated medical debt in 2007, up from one in three in 2005. Their difficulties included not being able to afford medical attention when needed, running up medical debts, dealing with collection agencies about unpaid bills, or having to change their lifestyle to repay medical debts.” The Post described how people had exhausted their savings, incurred large amounts of credit card debt, and were unable to pay for basic necessities such as food, heat, or rent. Limited access to health care is especially devastating for infants and children, and a lack of insurance often forces adults to postpone seeking help until their medical conditions have become serious or even life threatening.
38. Families USA 2009.
sector: “The safety-net sector encompasses public and voluntary hospitals, community health centers, public health clinics, free clinics, and services donated by private physicians.” Brown goes on to say that these institutions often live on the financial edge and stay afloat with eleventh-hour infusions of money. But safety-net venues serve as a first line of defense for those without health insurance: “This fact is of paramount importance, for these providers also extend a safety net for the political legitimacy of the health care system as a whole.”

42. Chua 2006, 3.
43. The term “criminal” is used to describe anyone who commits a crime by violating a criminal statute or common law doctrine, regardless of whether their actions are detected or prosecuted. “Corruption” refers to an act in which a person uses his or her position of authority to commit a criminal or unethical act.
44. Beam and Warner 2009, 12.
45. Weisburd, Waring, and Chayet 2001, 51–90. These three authors coined the white-collar criminal terms “crisis responder,” “opportunity taker,” and “opportunity seeker.” The fourth category, “inadvertent offender,” is my categorization.
46. In some cases, a so-called crisis responder has committed other crimes that have gone either undetected or unreported.
47. 42 U.S.C., sec. 1395.
48. Some physicians may have become scapegoats in the prosecution of health care fraud and drug abuse cases. See Libby 2008.
52. Tenet Shareholder Committee, LLC 2008.
54. ITIM International n.d.
58. Wilemon 2010.
61. The term “non-self-revealing” has been used to describe health care fraud in Sparrow 1996, 20.

CHAPTER 1
2. This chapter provides an overview of the major laws and issues associated with health care fraud. Amendments to federal and state statutes, new court rulings, and changes in regulations and advisory opinions alter the interpretation of health care laws. The expertise and depth of knowledge required to prosecute or defend claims of health care fraud go well beyond the scope of this chapter. Litigants are directed to the Bureau of National Affairs’ treatises on health care fraud: Baumann 2007 (as well as the 2009 Cumulative Supplement); Loucks and Lam, 2001 and 2007. And they are encouraged to retain the services of an attorney who specializes in the complex area of health care fraud.
3. The terms “fraud” and “abuse” are often used interchangeably. Abuse, however, may occur in the absence of fraudulent intent. The Medicaid Program defines abuse as “provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized
standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program” (42 C.F.R., sec. 455.2, “Definitions”).


5. HealthGrades, Inc. 2006, 3. Minnesota, according to the survey, was the safest state, whereas New Jersey was the most dangerous state for medical errors and deaths.


7. Even in trials with a morass of evidence and conflicting testimony, proving intent to defraud often hinges on a simple, offhand statement by the perpetrator or an obscure document or e-mail message.


13. This case received nationwide attention and was later used as the basis for a television movie, The Babymaker: The Dr. Cecil Jacobson Story.


16. Loucks and Lam 2007, 464 and 506.


19. 18 U.S.C. sec. 371. “If two or more persons conspire either to commit any offense against the United States, or to defraud the United States, or any agency thereof in any manner or for any purpose, and one or more of such persons do any act to effect the object of the conspiracy, each shall be fined under this title or imprisoned not more than five years, or both.

If, however, the offense, the commission of which is the object of the conspiracy, is a misdemeanor only, the punishment for such conspiracy shall not exceed the maximum punishment provided for such misdemeanor.”


27. FindLaw for the Public 2008.

28. Section 1962(a) “makes it unlawful for a person to use an enterprise to launder money generated by a pattern of racketeering activity”; section 1962(b) “makes it unlawful for a person to acquire or maintain an interest in an enterprise through a pattern of racketeering activity”; and section 1962(c) “prohibits any defendant person from operating or managing an enterprise through a pattern of racketeering activity.”

Grell n.d.


38. Turkewitz 2008a and 2008b.
40. U.S. Code, Title 18, part 1, chap. 63, sec. 1347, Health Care Fraud: “Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice—
   (1) to defraud any health care benefit program; or
   (2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program, in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 10 years, or both. If the violation results in serious bodily injury (as defined in section 1365 of this title), such person shall be fined under this title or imprisoned not more than 20 years, or both; and if the violation results in death, such person shall be fined under this title, or imprisoned for any term of years or for life, or both.” With respect to wire fraud, section 1343 states: “Whoever, having devised or intending to devise any scheme or artifice to defraud, or for obtaining money or property by means of false or fraudulent pretenses, representations, or promises, transmits or causes to be transmitted by means of wire, radio, or television communication in interstate or foreign commerce, any writings, signs, signals, pictures, or sounds for the purpose of executing such scheme or artifice, shall be fined under this title or imprisoned not more than 20 years, or both. If the violation affects a financial institution, such person shall be fined not more than $1,000,000 or imprisoned not more than 30 years, or both.”
42. Grell n.d.
43. Ibid.
44. U.S. v. Jain, 93 F.3d 436 (8th Cir. 1996).
48. Many individuals and organizations withdraw or deposit large amounts of cash in the course of routine, legal business activities. Large withdrawals and deposits are not illegal, and the filing of a currency transaction report does not indicate criminal activity. The Tax Reform Act of 1986 requires organizations to file a report with the IRS when customers make cash purchases over $10,000. Criminals, for example, often pay cash for expensive items such as automobiles.
51. Tax evasion differs from tax avoidance. Tax evasion involves hiding income, claiming unauthorized exemptions, or taking illegal deductions. Tax avoidance involves taking full advantage of available deductions and exemptions and paying no more tax than necessary while complying fully with tax laws.
52. U.S. Department of the Treasury, Internal Revenue Service 2008c.
54. 18 U.S.C., sec. 1001. False statements include: “(1) falsifying or concealing a material fact by trick, scheme, or device; (2) making a false, fictitious, or fraudulent representation; and (3) making or using a false document or writing.”
55. 18 U.S.C., sec. 1621.
56. Garner 2000, 1233. The term “two-witness rule” is a misnomer because it is not necessary for two live witnesses to testify. Rather, one live witness plus corroborative evidence (the second “witness”) may be sufficient.
61. O’Connor 2006; U.S. v. Mikos 539 F.3d 706 (7th Cir. 2008).

CHAPTER 2
8. U.S. v. Hancock, 604 F.2d 999 (7th Cir. 1979).
23. 42 C.F.R., sec. 1001.952(v). In theory, safe harbors protect business practices when commercially reasonable items or services are exchanged at a fair market price. The obvious and safe choice is to comply fully with the detailed safe harbor rules. But partial compliance with a safe harbor rule does not necessarily violate the antikickback statute. Arrangements not adhering completely to safe harbor rules must be analyzed on a case-by-case basis. When parties are uncertain whether their arrangements qualify for safe harbor protection, they may request an advisory opinion from the U.S. Department of Health and Human Services, Office of Inspector General.

To help honest providers distinguish between what is and is not legal, the OIG periodically releases special fraud alerts and advisory bulletins pertaining to the antikickback statute. For example, a fraud alert on telemarketing activities by durable equipment...
manufacturers was released in March 2003. In case you ever wondered why wheelchair
and scooter providers are so fond of advertising on television, it is because this OIG alert
restricts unsolicited telephone calls by equipment companies to Medicare recipients.
Special fraud alerts and advisories do not carry the force of law, but they provide insight
into the concerns and views of the OIG. Baumann 2007, 32.

27. OANDP.com, O & P Edge n.d.
33. One critical aspect of FCA whistle-blower actions is whether the relator had infor-
mation already known by the government. Such cases involve the whistle-blower public
disclosure jurisdictional bar prohibiting lawsuits in cases where the relator was not the
original source of information surrounding the false claim. If the information was already
in the public domain, a whistle-blower suit is barred because, at that juncture, citizens
expect the government to intervene. The whistle-blower public disclosure jurisdictional
bar raises a number of issues, including the meaning of “public disclosure” and the point
where relevant information becomes public.

34. Ekstrand 2006; U.S. Government Accountability Office 2005. In the summer of
2008, the U.S. Department of Justice faced a backlog of more than five hundred health
care whistle-blower cases (out of a total of nine hundred backlogged cases). Since 2001
whistle-blowers have filed between three and four hundred cases a year, but the staff of
seventy—five attorneys assigned to these cases can handle only one hundred or so cases

37. The courts have also construed literal falsities under the FCA in conjunction with
violations of the antikickback and Stark laws.

1998). The nautical mile to statute mile conversion is 1 to 1.15.
43. Medicare Act, sec. 1320c–5(a) “(2) will be of quality which meets professionally
recognized standards of health care...” There may be a great deal of difference, however,
between procedures that are perfect versus those that are minimally compliant.

44. Covington v. Sisters of the Third Order of St. Dominic at Hanford, 61 F.3d 909 (9th
Cir. July 13, 1995).
v. U.S. ex rel. Wilson, U.S. Sup. Ct. No. 08–304 (March 30, 2010), the U.S. Supreme Court
held that whistle-blowers are barred from filing FCA lawsuits based on information ob-
tained through federal, state, or local reports. An FCA amendment that is part of the
Obama health care package, however, will permit such suits as long as the information
was not obtained by the whistle-blower from a federal source.
49. 18 U.S.C. sec. 1320a–7b. The HHS Office of Civil Rights enforces the privacy standards, and the Centers for Medicare and Medicaid Services enforces both the transaction and code set standards and the security standards.
53. History of the FDA n.d.
54. 21 U.S.C. 301 et seq.
56. According to 15 U.S. Code, sec. 55, “Additional Definitions”: “The term ‘drug’ means (A) articles recognized in the official United States Pharmacopoeia, official Homoeopathic Pharmacopoeia of the United States, or official National Formulary, or any supplement to any of them; and (B) articles intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animals; and (C) articles (other than food) intended to affect the structure or any function of the body of man or other animals; and (D) articles intended for use as a component of any article specified in clause (A), (B), or (C). The term “device” (except when used in paragraph (n) of this section and in sections 301(i), 403(f), 502(c), and 602(c)) means an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component, part, or accessory, which is—(1) recognized in the official National Formulary, or the United States Pharmacopoeia, or any supplement to them, (2) intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals, or (3) intended to affect the structure or any function of the body of man or other animals, and which does not achieve its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of its primary intended purposes.”
57. See U.S. Food and Drug Administration n.d.b. for a summary of the FDA approval process.
59. The discussion of the FDCA is based in part on Loucks and Lam 2001, 95–182.

CHAPTER 3
NOTES TO PAGES 65–72


18. U.S. Department of Labor, Office of Employment Disability Policy 2008. If the medical identity-theft victim has a record of a physical or mental impairment, protection against discrimination may be available under the Americans with Disabilities Act. Of course, forcing a victim of identity theft to endure unnecessary litigation is expensive, unfair, and discouraging.

19. Some imposters engage in “looping,” a practice in which the health insurance benefits for a family is exhausted one member at a time. Gellman and Dixon 2008, 11.


40. Fraud Guides n.d.

43. For a description of a DRG coding-process software used at the Louis A. Weiss Memorial Hospital, a teaching hospital affiliated with the University of Chicago Hospitals, see Kerwin 1995. According to medical economist J. D. Kleinke, “Indeed, the practices of upcoding, and optimizing [revenues] in particular, are so commonplace that they have spawned a cottage industry of software vendors and consulting firms that specialize in them.” Kleinke 1998, 21.
44. Phillips and Cohen, LLP n.d.
53. U.S. Department of Justice n.d.
55. Ibid.
58. U.S. Department of Justice n.d.
64. U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services n.d.a, 9-10.
68. Themedica 2009.
70. Abel 2009.
73. A complicating issue with respect to hospice patients is the uncertain course of their illness. Patients diagnosed with terminal illnesses, contrary to the standard textbook prognosis, sometimes survive indefinitely. This fortunate turn of events creates the impression the provider engaged in Medicare fraud.
74. Halper 2009.
76. U.S. Department of Justice n.d.
84. Freeman 2008.
86. Office of Applied Studies, Substance Abuse and Mental Health Services Administration 2010, 1.
90. Freeman 2008.
95. Clarkson n.d.
96. Cross and Bennett Attorneys 2007.
100. Mathias 2004.
103. Arkansas Division of Aging and Adult Services n.d., 1.
105. These cases were obtained from U. S. Department of Health and Human Services and Department of Justice 2007, 14–15.
111. Freking 2008b.
112. Ibid.
116. Ibid.
123. Gillam n.d.
CHAPTER 4

1. The physician revealed neither the patient's identity nor the name of the hospital where the treatment took place.


18. The historical sketch of HCA was based on their website at http://hcahealthcare.com/CustomPage.asp?guidCustomContentID=9612D4C4–07A9–4CD6-B271-87D3BF3225F0.

19. Funding Universe n.d.


27. Hoovers n.d.


32. But the $2.88 billion judgment against Scrushy will be paid directly to HealthSouth, and the shareholders will get approximately 40% of the settlement after legal and other expenses.


34. Esterl and Bauerlein 2009.


37. HealthSouth 2010.


42. Allen and Farragher 2009.

43. Allen and Bombardieri 2008a.

44. Ibid.

46. Allen and Bombardieri 2008b.
47. Ibid.
52. Kennedy 2009b; Chernoff and Steffen 2009.

CHAPTER 5

3. Rockoff and Kendall 2009; Winslow 2009; Pfizer n.d.; and O’Reilly 2009b. Note that doctors can prescribe drugs for off-label use, but drug manufacturers are forbidden from engaging in such promotions.
14. A Schedule I drug has a high potential for abuse, and it has no safe or accepted medical use in the United States. A Schedule II drug also has a high potential for abuse and it may lead to serious physical or psychological dependence by the user, but it does have a legitimate medical use (possibly with severe restrictions) in the United States. Schedules III, IV, and V all have acceptable medical uses with lower potential for abuse (with Schedule V being the least addictive). See Title 21 “Food and Drugs,” chap. 13 “Drug Abuse Prevention and Control,” subchap. I, “Control and Enforcement,” part B “Authority to Control”; Standards and Schedules, 21 U.S.C. Sec. 812 January 22, 2002, http://www.usdoj.gov/dea/pubs/csa/812.htm.
23. False Claims Act Legal Center n.d.
24. “Takeda Pharmaceuticals and TAP Pharmaceutical Products, Inc. Merge” 2008. Reference in this press release is made to TAP, the company’s name during the federal investigation and settlement, not to its current name of Takeda.
30. The quotes by McCallum, Sullivan, Thompson, and Bradley are from U.S.
Department of Justice 2001.
33. Murphy and Dembner 2004.
35. See, for example, Value Based Management.net n.d.
36. Both Serostim and the protease inhibitor drugs were introduced to the market
in 1996.
40. McGrath 2005, 14–16.
42. U.S. Department of Justice 2005.
43. Ibid.
44. Kerber 2007.
45. Purdue n.d.
47. Online Lawyer Source n.d. For an in-depth discussion of OxyContin, see Jayawant
49. Ibid, 859 (last full sentence of the text).
50. Roth et al. 2000. This quotation can be found in the Comment section of the ar-
ticle, 4th paragraph at the 4th and 5th sentences.
52. Ibid.
53. All quotes are from U.S. Attorney’s Office, Western District of Virginia 2007.
57. U.S. Department of Justice 2004c.
60. Harris 2004.
61. Ibid.
64. Armstrong and Weinstein 2009.
68. Periodic Table 2009.
71. Harris 2009.
74. Saul 2008.
75. Tabarrok 2000, 41–47.
78. O’Reilly 2009a.
84. Hood 2009, 52.
86. Burns 2008. Information on Zimmer Holdings, list of consultants, deferred prosecution agreement, and compliance hotline can be found at zimmer.com.
97. This information was derived from tables in Loucks and Lam 2007, appendix A: “Health Care Fraud Settlements of at Least $1 Million (1990–2007),” 519–640.
98. Settlement amounts for the eight-year period were taken from Loucks and Lam 2007, 513; the national health care expenditures were taken from U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services n.d.b.

CHAPTER 6

6. For a discussion of preventive methods, see Barber 2006 and the U.S. Securities Exchange Commission.
25. The proposed bill may be viewed at http://thomas.loc.gov/cgi-bin/bdquery/z?d110:H06898:@@@L&summ2=m&.
30. See Hyman 2001 for a discussion of the professional, social, and economic complications surrounding the control of health care fraud.
32. For an excellent analysis of the weakness of health insurance claims processing and fraud, see Sparrow 2000.
39. It appears that government prosecutors—from a cost-benefit standpoint—want to pursue potentially high-dollar settlements. In other instances the existence of whistle-blowers dictates which cases are prosecuted.
40. Basler 2008.
42. Hill 2007. Note the discussion in this chapter about the Inspector General’s investigation of the veracity of some fraud rates reported by CMS.
44. The description of the CMS pre- and postpayment claim-review programs are from U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services 2008d.
47. Clark 2009.
52. Li et al. 2008.
53. Obtaining documents or computer files may require a search warrant, but evidence pertaining to billings and reimbursements from Medicare, Medicaid, or other federal programs may be subject to seizure without a warrant.
55. Loucks and Lam 2007, 392.
56. To illustrate the confusing language of some Medicare regulations, see U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services 2004.
59. For an insider’s view of how federal prosecutors work, see Kroger 2008.

APPENDIX: A

2. Persons under the age of sixty-five who receive Social Security disability payments as well as dialysis patients, among others, may also be eligible for Medicare benefits.
5. Of this, 1.45% is contributed by the employee and 1.45% is contributed by the employer; those who are self-employed pay the entire 2.9%.
12. SCHIP had an initial ten-year authorization period.