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Client Alert

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Recent Government Actions Reflect Increased Focus on Physicians

Recent actions by the Department of Justice, including several criminal prosecutions and civil settlements, reflect an increased focus on physician activities. For example:

- On April 9, 2012, a North Caldwell, New Jersey, physician was sentenced to 24 months in prison for his role in defrauding Blue Cross Blue Shield of more than $725,000 by submitting false claims for services he never performed. In addition to the prison term, the physician was sentenced to three years of supervised release and ordered to forfeit $725,156.45 and pay restitution of $725,156.45. He also surrendered his medical license.

- On March 28, 2012, a Destin, Florida, physician was sentenced to 87 months in prison for a healthcare fraud scheme in which he submitted fraudulent claims and caused more than $1.8 million in payments to be paid by Medicare and 31 other health insurers. A federal jury convicted the physician of 150 counts of healthcare fraud, wire fraud and making false statements in healthcare matters. In addition to the prison term, the physician was required to pay restitution and fines over $1 million.

- On March 27, 2012, a Michigan physician was sentenced to one year in prison for a fraud scheme involving false billings to Medicare. In addition to his prison term, the physician was sentenced to three years of supervised release and ordered to pay $300,000 in restitution. According to the government, the physician billed Medicare and Blue Cross Blue Shield of Michigan for a procedure thousands of times from 2003 through 2006; however, he had not performed the procedures billed.

- On March 21, 2012, a dental clinic and physician, the former majority owner of the clinic, agreed to pay the federal government and State of Texas $1.2 million to resolve alleged violations of the civil False Claims Act and Texas Medicaid Fraud Prevention Act. The federal government and Texas contended that the physician and dental clinic caused "unbundled" and other improper claims to be submitted to the Texas Medicaid program for orthodontic-related items and services between 2004 and 2007. Although orthodontic services generally are reimburs-

able by the Texas Medicaid program as long as they are medically necessary, correctly coded and properly documented, the government contended that the defendants submitted improper Medicaid claims that failed to meet these requirements.

- On March 13, 2012, a Chicago physician was convicted of engaging in a healthcare fraud scheme between 2007 and July 2010. The physician, who operated a community clinic, was convicted of defrauding Medicare and Blue Cross Blue Shield of Illinois by submitting false insurance claims for medically unnecessary tests and using false diagnosis codes to justify the tests he had ordered. The evidence at trial showed that the physician ordered medically unnecessary tests, falsified patients' medical records and used false diagnosis codes on insurance claim forms for at least five patients. Additional evidence revealed that the physician administered echocardiograms, electrocardiograms, nerve conduction studies, and carotid Doppler and abdominal ultrasounds for an unusually high percentage of his Medicare and Blue Cross patients. When sentenced, the physician will face a maximum penalty of 10 years in prison on each count of healthcare fraud, five years in prison on each false statements count and a $250,000 fine on each count.

- On March 7, 2012, two physicians and four registered nurses were among 11 new defendants who were added to a federal indictment against a suburban Chicago man who operated two home healthcare businesses for allegedly swindling Medicare of at least $20 million over five years. The physicians were each charged with one count of healthcare fraud conspiracy and 31 counts of healthcare fraud between them. Healthcare fraud conspiracy and each count of healthcare fraud carries a maximum penalty of 10 years in prison and a maximum fine of $250,000, or an alternate fine totaling twice the loss or twice the gain, whichever is greater, as well as mandatory restitution.

- On March 1, 2012, an Alabama physician reached a settlement with the government to resolve allegations under the False Claims Act that he submitted more than $2.2 million in false or fraudulent claims to Medicare. The allegations include claims that the physician violated the False Claims Act by improperly billing Medicare for unnecessary pain injections administered by an unlicensed medical assistant. As a condition of the settlement, the physician admitted that he allowed the unlicensed medical assistant to administer at least 80 percent of the pain injections, and that the injections were unnecessary. Pursuant to the settlement, the physician will be excluded from payment from all federal healthcare programs for a period of seven years. The payment prohibition applies to the physician, anyone who employs or contracts with him, and any hospital or other provider for which he provides services. The physician was also required to immediately pay the government $5,000, as well as the proceeds from the sale of a second home.

These convictions and settlements serve as important reminders that the federal government and state authorities are not directing their fraud enforcement efforts toward healthcare entities alone—individual physicians are also at risk of investigation and prosecution. Furthermore, as evidenced by several of the set-

tlements, the federal government is focusing not only on allegations of billing for services not rendered, but it is also targeting physicians based on insufficient clinical support for procedures and the failure to properly document the need for such services. Taking immediate proactive steps to engage the federal government in connection with such allegations is vital to mounting a proper defense.

With a team of veteran litigators and former Department of Justice lawyers, Arnall Golden Gregory LLP brings significant knowledge and experience in representing physicians and other providers in reimbursement appeals, overpayments, and allegations of healthcare fraud, including False Claim Act matters. We have been able to obtain early dismissal or resolution of suits brought by qui tam plaintiffs and the federal government. By conducting credible internal investigations and negotiating with the federal and state government in matters involving overpayments, repayments and disclosure issues, we have also helped clients avoid criminal prosecution and accomplish appropriate civil resolutions of parallel criminal, civil, and administrative proceedings.