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False Claims Act settlements to know from Q2 2022

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The second quarter of 2022 brought a number of noteworthy False Claims Act (FCA) settlements, including several of $20 million or more. This post summarizes key settlements of interest to healthcare providers.

Hospitals

- On April 6, a health system and the operating entities for four hospitals[1] agreed to pay $20 million to resolve allegations that the health system made impermissible Medicaid donations. Under federal law, Florida's share of Medicaid payments must consist of state or local government funds and not "non-bona fide donations" from private healthcare providers. The health system was alleged to have violated this law by making non-bona fide cash donations to a juvenile welfare board, which transferred the funds to the Florida Medicaid program. These funds were then matched by federal government funds and paid out to the health system as reimbursements for claims the health system had submitted.
- On April 12, a healthcare system[2] agreed to pay almost $22.7 million to resolve allegations that it compensated two neurosurgeons based on a productivity system that incentivized them to perform higher numbers of complex procedures billed to Medicare, Medicaid, and other federal healthcare programs. The whistleblower and government alleged that as a result, some procedures were not medically necessary or performed adequately. As part of the resolution, the company entered into a Corporate Integrity Agreement (CIA) with HHS-OIG.

Physicians

- On April 6, a podiatrist[3] agreed to pay $865,000 to resolve upcoding allegations that she submitted claims to Medicare for the surgical implantation of neurostimulator electrodes, when the procedures she actually performed involved the non-surgical application of electro-acupuncture devices.
- On June 28, fifteen Texas doctors[4] agreed to pay a total of $2.83 million to resolve False Claims Act allegations involving illegal kickbacks in violation of the Anti-Kickback Statute and Stark Law. The doctors were alleged to have received thousands of dollars in remuneration from nine management service organizations (MSOs) in exchange for ordering laboratory tests from a hospital and two laboratories. The hospital allegedly funded the remuneration to the doctors in the form of volume-based commissions paid to independent contractor recruiters, who used the MSOs to pay the doctors for their referrals. The MSO payments to the doctors were allegedly disguised as investment returns, when they were in fact were based on and offered in exchange for the doctors' referrals.

Health care practices

- On April 12, a pain management practice, its founder, and its former chief medical officer[5] agreed to pay $24.5 million to resolve allegations that they violated the False Claims Act by:
  - (1) Submitting claims for urine drug tests that were not medically necessary.
  - (2) Compensating physicians a portion of the profits received from the unnecessary tests in violation of the Stark Law.
  - (3) Submitting claims for genetic and psychological tests performed before physician visits with patients, without regard for medical necessity.
  - (4) Requiring physicians to schedule evaluation and management appointments more frequently than typical monthly appointments and billing these visits using high-level procedure codes when the government suspended non-emergency medical procedures due to COVID-19.

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The practice also obtained a loan from the Paycheck Protection Program (PPP) after representing that it had not engaged in unlawful activity.

As part of the resolution, the company entered into a five-year CIA with HHG-OIG.

- On April 13, two physicians, the company they created, and 18 anesthesia practices owned and operated by the company[6]

agreed to pay $7.2 million to resolve allegations that they participated in an illegal kickback scheme that involved their obtaining agreements to provide anesthesia services to outpatient surgery centers by allowing physician owners of the centers to be partial owners of the companies that were created to provide the services. The company also allegedly subsidized the costs of drugs, supplies, and equipment used by the centers to persuade the physician owners to enter into the agreements.

Notes

[1] https://bit.ly/3QbNxXZ

[2] https://bit.ly/3QbujBD

[3] https://bit.ly/3SDOz0E

[4] https://bit.ly/3p9XcCx

[5] https://bit.ly/3QeVWd5

[6] https://bit.ly/3P6ps3z

About the author

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