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False Claims Act settlements to know from Q1 2023

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On February 7, the Department of Justice (DOJ)[1] issued a press release indicating that settlements and judgments under the False Claims Act (FCA) exceeded $2.2 billion in the fiscal year ending September 30, 2022. Of this total, over $1.7 billion came from claims involving the healthcare industry.

A medical device manufacturer agreed to pay $9.75 million to resolve allegations that it violated the FCA by paying kickbacks to an orthopedic surgeon over a nearly five-year period.

The DOJ has shown no signs of slowing down in 2023. Indeed, we have seen a number of noteworthy FCA settlements in the first quarter of the calendar year 2023. Several of these settlements top $20 million, with one coming in over $200 million. This post summarizes key settlements of interest.

Physicians and healthcare practices

- On January 9, a physician and her practice[2] agreed to pay $1.85 million to resolve allegations that she billed federal healthcare programs for testing and procedures performed on patients who were not qualified for the procedures or had been falsely diagnosed to justify the treatments. The procedures allegedly injured some patients. Additionally, some of the tests were allegedly performed using broken equipment or not interpreted in the medical record.
- On January 12, an orthopedic practice, its owner, and a subsidiary[3] agreed to pay more than $1.87 million to resolve FCA allegations that they billed Medicare and Medicaid for a brand-name product used in knee injections while instead using an inexpensive compounded agent for the injections.
- On February 2, a healthcare services provider[4] agreed to pay almost $26 million to resolve self-disclosed allegations that it misrepresented its income in financial reports submitted to the state, resulting in higher reimbursements from Medi-Cal.
- On February 27, a surgeon, a university hospital, and a physician group[5] agreed to pay $8.5 million to resolve allegations that the surgeon performed multiple surgeries simultaneously, resulting in Medicare being billed for procedures in which he did not fully participate. The surgeon's actions also allegedly caused unnecessary anesthesia services to be rendered. As part of the settlement, the surgeon will be subject to a Corrective Action Plan, and his Medicare billings will be audited by a third party for one year.

Hospitals

- On March 3, a regional medical center[6] agreed to pay $4 million to resolve allegations that it improperly made donations to the local government to help fund the state's share of Medicaid payments to the center. Federal law requires a share of a state's Medicaid payments to come from state or local government funds, and these funds cannot include "non-bona fide donations" from private healthcare providers. The government alleged that the hospital violated these rules for nearly a year by making donations to Polk County by assuming some of the county's financial obligations to other healthcare providers.
- On February 22, a long-term care hospital[7] and its operator agreed to pay more than $21.6 million to resolve FCA allegations that it submitted claims to Medicare for services that were: (1) provided by unqualified and unlicensed individuals; (2) provided while the treating physicians were out of the country; (3) not supported by the patient's medical records; and (4) not actually performed or performed inadequately.

Home health and skilled nursing

- On February 7, a home healthcare provider[8] and related entities agreed to pay $9 million to resolve allegations that they submitted false claims to the U.S. Department of Labor for services provided to beneficiaries of the Energy Employees Occupational Illness Compensation Program Act when the services were either not provided or were not medically necessary.
- On February 27, a skilled nursing facility[9] and related individuals and entities agreed to pay $7.168 million to resolve allegations that they billed Medicare for worthless services provided to residents, that the facility was understaffed and not physically maintained, and that residents were subject to unnecessary falls and pressure ulcers in addition to medication errors. The facility ceased to operate after the investigation. As

part of the settlement, several individuals and entities will be excluded from participation in federal healthcare programs for periods ranging from 10-20 years.

Pharmacies and PBMs

- On January 27, a pharmacy operator[10] agreed to pay $7 million to resolve allegations that a former pharmacist and store manager falsified the required prior authorization requests and clinical records for a hepatitis C medication. The pharmacy allegedly submitted reimbursement claims to the Tennessee Medicaid program for prescriptions dispensed based on the falsified records and then knowingly retained these overpayments after the issue was discovered.
- On January 31, a pharmacy benefits manager[11] agreed to pay more than $66 million to resolve allegations brought by the state of Indiana that it: (1) did not pass along discounts on pharmacy benefits and services to the state Medicaid program, and (2) inflated dispensing fees charged to the state Medicaid program. Then, on February 8, the same entity[12] agreed to pay more than $215 million to resolve similar allegations brought by the state of California.
- On February 7, an online pharmacy operator[13] agreed to pay $15 million to resolve allegations brought by the California Department of Justice that it billed Medi-Cal for counseling services that were not provided and for products that beneficiaries did not request.

Manufacturers and suppliers

- On January 20, a medical device manufacturer[14] agreed to pay $9.75 million to resolve allegations that it violated the FCA by paying kickbacks to an orthopedic surgeon over a nearly five-year period. The manufacturer allegedly gave the surgeon free spinal implants and tools to use in overseas surgeries to induce him to use the manufacturer's products in surgeries performed in the United States. Of the total settlement amount, approximately $7.23 million will be returned to the federal government, with the balance going to the state of Massachusetts for surgeries funded through Medicaid.
- On March 1, a DME supplier[15] agreed to pay $7 million to resolve allegations that it received inflated reimbursements from Medicaid programs in Kentucky, Missouri, and the District of Columbia for equipment provided to beneficiaries. When submitting the claims, the company allegedly failed to disclose the actual cost it paid to the equipment manufacturers or discounts it received, resulting in inflated reimbursements from the Medicaid programs at issue.

Notes

[1] http://bit.ly/414FWjg

[2] http://bit.ly/3KTYFs5

[3] http://bit.ly/3MC36cs

[4] http://bit.ly/3Kolwtq

[5] http://bit.ly/3GBPudv

[6] http://bit.ly/3o5Z4ik

[7] http://bit.ly/3KUpMDy

[8] http://bit.ly/3ZXMYFi

[9] http://bit.ly/3KS8B5s

[10] http://bit.ly/402SciY

[11] http://bit.ly/3Uxy4Ep

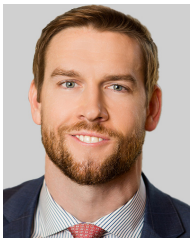
[12] http://bit.ly/43DWcts

[13] http://bit.ly/3KTodFN

[14] http://bit.ly/3KTZIbv

[15] http://bit.ly/3ZZFaCR

About the author



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