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Healthcare Regulatory Liability

Regulatory Loss Scenarios

- A group of physicians at a Texas physician group billed for services performed while they were out of the country or at medical conventions. They also billed for services performed by unlicensed therapy personnel as licensed therapists. They agreed to pay a total of $2.3M to settle charges of submitting false claims for Medicare reimbursement.

- A diagnostics company defrauded Medicare by improperly submitting claims to a Medicare claims carrier in another state, which was outside its jurisdiction, in order to receive reimbursements at the higher states rates. This false certification that the claims were for services rendered in a false state resulted in a settlement of $938K.

- A California hospital chain agreed to pay a settlement of $2.9M because it knowingly kept overpayments made by Medicare and did not return those payments in a timely manner. The hospital knew of the overpayments but remained silent and even filed f lse cost reports that did not reflect the verpayments.

- A Pennsylvania hospital was billing for hospital outpatient procedures using codes reserved for physician's office visits instead of an outpatient procedure performed at the hospital. Medicare pays a higher rate for physician's office visits o reflect the cost of thei overhead. Hospitals receive a separate facilities fee to cover overhead and, as a result the correct reimbursement rates for hospital outpatient services are at a lower rate. The hospital agreed to a settlement of $7.5M.

- A Utah hospital paid a $3.3M settlement for overcharging state and federally funded health care programs for outpatient clinical laboratory services by double billing and unbundling. The hospital used two or more billing codes in lieu of the single billing code for the variety of lab tests that were performed as a single group of tests.

- A Rhode Island hospital gave free office s ace to a psychiatric services management company and infla ed management and director fees to induce it to funnel patients to the hospital. This kickback scheme violated the Stark Law and resulted in a $5.3M settlement paid by the hospital.

- A nursing home filed over 7,000 in fraudulent Medicare claims. A government audit and investigation revealed that they had billed Medicare for nonexistent medical supplies for the nursing home and filed cost reports with false expenses. He attempted to conceal the scheme by submitting false cost reports to Medicare supported by falsified medical records and fabricated invoices. The nursing home was ordered to pay fines, restitution and special assessments totalling more than $3.5M.

- The parent corporation of a Massachusetts health care provider of inpatient and outpatient services agreed to pay $3M in settlement of liability for violating the Medicare anti-kickback statute. The company made income guarantees and office-rent subsidies to physicians, granted low-interest or no – interest loans, forgave repayment of loans, provided staff support for a physician's private practice and entered "directorship" contracts in which physicians performed little or no services, to induce them to make referrals to the company.

- A not for profit nu sing home chain agreed to pay $150M for a variety of falsifications, including falsification o nursing logs to make it appear that the nurses delivered a disproportionately higher number of hours of nursing care to Medicare patients in the "Medicare distinct" beds, when in fact they were attending to Medicaid and indigent or private pay patients.

- A public hospital district agreed to pay $2.7M settlement because of its up-coding fraud. The hospital was submitting claims for a complex form of pneumonia when the correct diagnosis indicated a simpler form that is reimbursed at a lower rate. In addition, the hospital agreed to pay $562,201 for other up-coding, including false claims for septicaemia, a blood infection.

- A Psychiatric physician group agreed to pay $3.4M to the government to settle charges that it defrauded the Medicare program. The group billed Medicare for unqualified patient visits b tween February 2004 and October 2009. The US attorney's office s id the company billed for outpatient treatment for patients who rarely attended, failed to get proper approvals for treatment and did not get physician orders for tests.

- A hospital chain agreed to a $1.5M settlement of a qui tam lawsuit in which it was alleged that the hospital billed under physician provider numbers when, in fact, the services were rendered by nurses rather than physicians. Nursing services are reimbursed at a lower rate than physician services, so the hospital used the physician numbers to achieve a higher reimbursement rate.

- A jury awarded $28M in fines against a nu sing home for fraudulently billing Medicare and Medicaid. $19M of the fine as attributable to 1,700 false or fraudulent claims. The whistleblowers who originated the Qui Tam lawsuit after witnessing fraudulent billing practices for substandard care received roughly 25% of the verdict.

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