

LECOM 2018 Primary Care Conference at Peek'n Peak.

Fraud and Abuse in Healthcare
What You Don't Know May Scare You

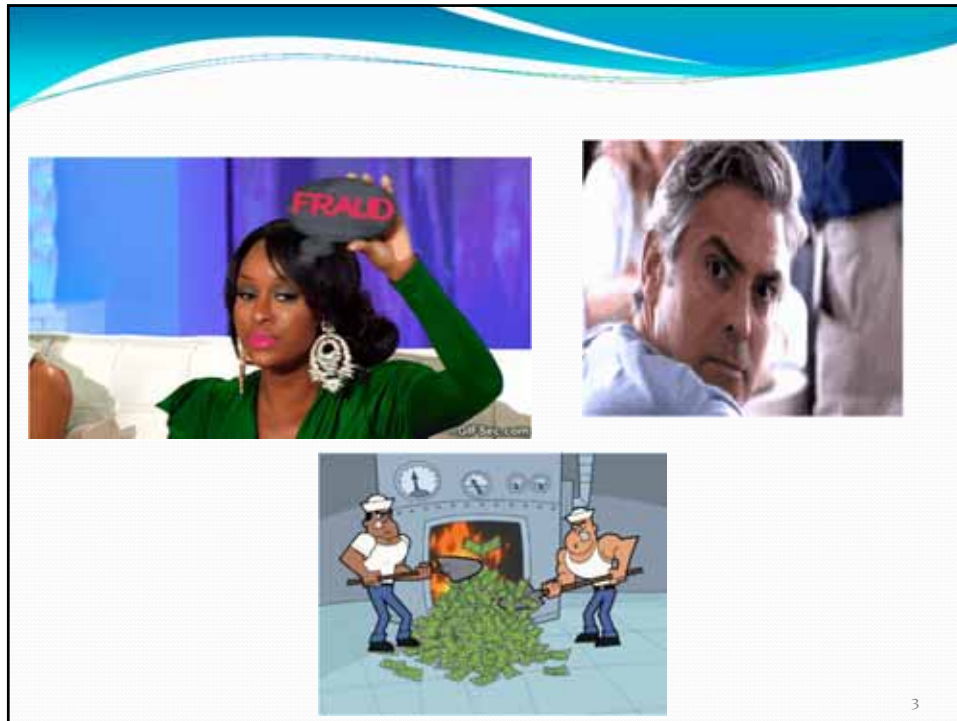


Richard E. Ferretti, Esq.
Jeffrey E. Myers, Esq.

1



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Mens rea
Amount
<h2>Fraud and Abuse</h2>
<ol style="list-style-type: none"> 1. Mix of criminal, administrative and civil law; enforced at federal and state levels. 2. Key reference sources: <ol style="list-style-type: none"> a. Federal Dept. of Health & Human Services Office of Inspector General (HHS OIG). b. State Medicaid Fraud Control Units (MFCU's). 3. Health Care Fraud Prevention and Enforcement Action Team (HEAT), created in 2009 to prevent fraud, waste and abuse in the Medicare and Medicaid programs (Miami & Tampa). RACs handle civil matters in four regions. 4. 4.13B in recoveries expected for FY 2017, w/ over 3200 exclusions. 881 criminal and 826 civil prosecutions pending.
<p>https://oig.hhs.gov/reports-and-publications/archives/semiannual/2017/sar-fall-2017.pdf</p>

4

Sidebar: State Fraud Units

- ✓ New York: The MFCU, is the largest unit within the Attorney General's Criminal Division. It "targets, among other things, large-scale frauds involving overbilling, kickbacks, substandard drugs and medical equipment, and "Medicaid mills." The New York MCFU excluded 6,291 individuals and entities: 5,508 individuals, 783 entities in FY 2016 (3d highest in the US). <http://www.cpfny.org/wp-content/uploads/2017/05/MFCU-Presentation-to-NYSARC-May-2-2017-Final.pdf>
- ✓ PA: Medicaid Fraud Control Unit of Pennsylvania: The Medicaid Fraud Control Section executive staff and intake team can be reached at the Pennsylvania Office of Attorney General Strawberry Square Headquarters in Harrisburg, PA, at (717) 783-1481. https://www.attorneygeneral.gov/Criminal/Medicaid_Fraud_Section/
- ✓ Ohio: The Attorney General's Office battles fraud in the health care industry through the Medicaid Fraud Control Unit and the Workers' Compensation Unit. Over five (5) years (2012 – 2016), the Section has handled 5,648 complaints; posted 1,231 indictments; 1,134 convictions; 119 civil settlements; and recovered more than \$310 million in restitution and penalties. <http://www.ohioattorneygeneral.gov/About-AG/Service-Divisions/Health-Care-Fraud>

5

Fraud and Abuse (cont.)

5. Fraud: "intentional and knowing deception or misrepresentation with knowledge of possible unauthorized benefit..."
6. Abuse: "practices that are inconsistent with sound fiscal, business or medical practices that result in unnecessary costs or in reimbursement for services that are medically unnecessary or that fail to meet recognized health care standards..."
7. Waste: "negligent or reckless actions that result in unnecessary costs or unnecessary consumption of health care resources..."

6

Fraud and abuse (cont.)

8. Current HHS priorities:
 - a. Beneficiary recruitment/unnecessary services.
 - b. Fraudulent Medicare Part D claims.
 - c. Home health care.
 - d. Assisted living facility referrals from hospices.
 - e. Substandard nursing care.

7

Fraud and Abuse (cont.)



9. Fifteen federal laws in play:

FCA	PPACA	Stark	Anti-kickback
Exclusion	Wire Fraud	Civil Money Penalties	Criminal Penalties
Anti-Embezz.	False Statements	Obstruction Of Justice	Program Fraud
Rx Marketing	Beneficiary Inducement	MACRA 2015	?

10. States have laws too. Which applies?

8

Sidebar: the Inimitable Dr. Roy

1. 2006-12: **\$350M** in fraud.
2. Indicted on 2/22/12: 10 counts.
3. Facing life + \$18.5M.
4. Recruited 11,000 *fake* home health patients who were recruited in poor areas door to door, often w/ bribes.
5. Recruited a boiler-room full of employees who wrote fake records of treatments and signed certifications of the need of the treatments that either did not occur or were not needed.
6. When his original company was suspended by Medicare, he seamlessly switched all services to another entity.
7. Has yet to stand trial, while all of his confederates are guests of the state.
8. One of Roy's confederates, Patricia Akamnonu, an owner of a nursing home, was sentenced to ten years in jail on January 19, 2016.



9

Fraud and Abuse Laws

1. The False Claims Acts:
 - a. Have both civil (31 USC 3729) and criminal (18 USC 287) components.
 - b. Exist at both the federal and (virtually every) state level.
 - c. Make it illegal to submit claims for payment that a party knows or should know are false or fraudulent.
 - d. "**Knowing**" encompasses when a party acts in "deliberate ignorance or reckless disregard of the truth . . .".
 - e. Have whistleblower components that allow private citizens to institute actions on behalf of the government.
 - f. Do not cover simple negligence or common errors.
 - g. Can be part of Anti-Kickback or Stark Act violations.
 - h. Federal civil penalty is **treble damages** plus 11K per count.
 - i. Criminal penalty includes imprisonment.

10

Fraud and Abuse Laws (cont.)

2. The PPACA:
 - a. Essential structure: the five mandates (in order of implementation):
 - i. The insurance mandate;
 - ii. The individual mandate;
 - iii. The employer mandate;
 - iv. The EMR mandate; and
 - v. The Compliance mandate.

11

Fraud and Abuse Laws (cont.)

2. The PPACA (cont.):
 - b. Fraud and abuse provisions:
 - i. Provides 350M fraud enforcement funding over 10 years.
 - ii. Anti-Kickback violations are now automatically FCA violations.
 - iii. All overpayments of reimbursements must be returned within 60 days.
 - iv. Greater allowance for individual whistleblower suits.
 - v. Payments made through state exchanges will be subject to the FCA .
 - vi. Compliance programs mandated.
 - vii. Additional screenings and checks of new applicants.
 - viii. CMS can withhold payment upon suspicion of fraud.
 - ix. More scrutiny for “high risk” areas, e.g. home health & durable medical equipment.
 - x. More data sharing between agencies

12

Fraud and Abuse Laws (cont.)

3. The Physician Self-Referral Law (42 USC 1395 nn), AKA The “Stark Law”:
 - a. Prohibits referral of patients for “designated health services”:
 - i. Laboratory services;
 - ii. Durable medical equipment sales;
 - iii. Radiology/Radiation services and supplies;
 - iv. Prosthetic devices and supplies;
 - v. Inpatient and outpatient hospital services
 - vi. Home health services; and
 - vii. Outpatient prescription drugs;
 - b. That are payable by Medicare or Medicaid;
 - c. To entities in which a physician or a family member has a financial interest (ownership/investment/compensation).
 - d. *Strict liability* statute; no intent needed.
 - e. Penalties include fines and exclusion.

13

Fraud and Abuse Laws (cont.)

3. The Stark Law (cont.):
 - f. 2015 regulatory changes (CMS final rule 10/30/15):
 - i. Payments to physicians by hospitals, Federally Qualified Health Centers or Rural Health Clinics to compensate for non-physician practitioners costs will be permitted if they involve access to mental health services or for primary care.
 - ii. “Timeshare arrangements” between providers will be allowed for the shared use of premises, equipment, personnel or supplies. These must be in writing, for the evaluation and management of services to patients and not conditioned upon referrals. As always, compensation must be consistent w/ *fair market value*.
 - iii. Differing terminology relating to the required avoidance of patient referrals being part of transactions between providers will be standardized to read that any arrangement must not “**take into account**” referrals.
 - iv. Typically all arrangements must be for at least one year.
 - v. Where a writing is required, a collection or group of documents is permissible.

14

Fraud and Abuse Laws (cont.)

4. Anti-Kickback Statute (42 USC 1320 (b)):
 - a. Forbids knowing or willful payment of "remuneration", i.e.:
 - i. Cash;
 - ii. Barters;
 - iii. Payment in kind;
 - iv. Excessive compensation;
 - v. Shady "consulting" deals; or
 - vi. Gifts:
 - b. To induce or reward patient referrals or generation of business; and
 - c. That involve items or services payable by Federal health care programs.
 - d. Routinely waiving co-pays could be a violation.
 - e. Prohibitions go to both payers and recipients.
 - f. Penalties include fines of up to 50K per incident plus 3X amount of remuneration received.

15

Fraud and Abuse Laws (cont.)

5. The Exclusion Statute (42 USC 1320, et. seq.):
 - a. HHS OIG is *mandated* to exclude from participation in federal health care programs individuals convicted of:
 - i. M&M fraud (+ up to 50K per count);
 - ii. Offenses relate to the delivery of M&M services;
 - iii. Patient abuse or neglect;
 - iv. Other felonies related to health care operations; and
 - v. Felony drug convictions.

16

Fraud and Abuse Laws (cont.)

5. The Exclusion Statute (cont.):
 - b. OIG *may* exclude individuals:
 - i. Convicted of misdemeanor M&M or drug offenses;
 - ii. Who are found to interfere with or obstruct any investigation;
 - iii. Who suffer license suspensions or revocation; or
 - iv. Who default on student loan obligations.
 - c. Effects:
 - i. No federal programs will pay for services.
 - ii. No billing for treatment of M&M patients.
 - iii. Services may not be billed by another party.
 - iv. Participating health care professionals should not employ or contract with excluded individuals.

17

Fraud and Abuse Laws (cont.)

6. Mail and Wire Fraud (18 USC 1341,1343):
 - a. Prohibits the use of mail, private courier or wire service to defraud another.
 - b. "Wire" includes telephone, fax or computer.
 - c. Penalties include fines and imprisonment of up to 5 years.
 - d. Example: e-mailing up coded claims to Medicare.



18

Fraud and Abuse Laws (cont.)

7. The Civil Monetary Penalties Law:
 - a. Complementary penalty law; adds “teeth” to other laws.
 - b. Offenses include:
 - i. Presenting false or fraudulent claims to a governmental entity;
 - ii. Violating the Anti-Kickback Statute;
 - iii. Providing false information to a government official to influence a decision;
 - iv. Providing inadequate medical screening to emergency patients;
 - v. Incentivizing a physician to limit services to M&M patients; or
 - vi. Making false statements in applications to participate in federal health care programs.
 - c. Provides for penalties of 10-50K per instance.

19

Fraud and Abuse Laws (cont.)

8. Criminal Penalties for Acts Involving Federal Health Care Programs (42 USC 1320a):
 - a. Additional penalties for:
 - i. Making false claims in connection with federal health care reimbursements;
 - ii. Concealing or falsifying an individual's right to receive benefits;
 - iii. Converting (stealing) of federal health care benefits;
 - iv. Filing claims for services performed by someone other than a licensed healthcare practitioner;
 - v. Counseling an individual to dispose of assets to become eligible for medical assistance; or
 - vi. Violating the Anti-kickback Statute.
 - b. Penalties include fines of up to 25K or imprisonment of up to 5 years.
 - c. Example: physician accepts payment to sign certificates of medical necessity for DME for patients she never examined.

20

Fraud and Abuse Laws (cont.)

9. Theft or Embezzlement in Connection with Health Care (18 USC 669):
 - a. May not knowingly embezzle, steal or intentionally misapply any assets of a health care benefits program.
 - b. Penalties include fines and imprisonment of up to 10 years.
 - c. Example: a pharmacy employee embezzles money from an account that contains Medicare reimbursements.

21

Fraud and Abuse Laws (cont.)

10. False Statements Relating to Health Care Matters (18 USC 1035):
 - a. Prohibits:
 - i. Knowingly and willfully;
 - ii. Falsifying or concealing a material fact;
 - iii. Making a materially false statement; or
 - iv. Using a false writing or document;
 - v. In connection with the delivery or payment of health care services.
 - b. Penalties include fines and imprisonment of up to 5 years.
 - c. Example: giving an affidavit concealing the exclusion of an employee from Medicare.

22

Fraud and Abuse Laws (cont.)

11. Obstruction of Criminal Investigations of Health Care Offenses (18 USC 1518):
 - a. Forbids the willful prevention, obstruction, misleading or delay of communication of records relating to the investigation of a health care related offense or any attempts to do the same.
 - b. Penalties include fines and imprisonment of up to 5 years.
 - c. Example: a physician alters subpoenaed medical records or deletes prescribing data.



Fraud and Abuse Laws (cont.)

12. The Health Care Fraud Act (18 USC 1347):
 - a. Forbids schemes/conspiracies to defraud any health care benefit program; or to
 - b. Obtain benefits through false pretenses.
 - c. Provides for fines and imprisonments of 10-20 years.
 - d. Example: Two or more practitioners concoct plan to bill for services not actually performed or not by the person who is identified as the provider.



24

Fraud and Abuse Laws (cont.)

13. The Prescription Drug Marketing Act (1988 amendment of the FDCA).
 - a. Prohibits the sale, purchase, or trade of a drug sample or the *offer* to sell, purchase, or trade a drug sample.
 - b. Also banned is the the sale, purchase, or trade of a coupon, the offer to sell, purchase, or trade such a coupon, or the counterfeiting of such a coupon for drug purchases.
 - c. Most resales of Rx first purchased by a hospital or other health care entity are prohibited.
 - d. Wholesalers must provide pedigree papers to purchasers of Rx.
 - e. Penalties include fines and up to ten years as a guest of the federal government.

21 U.S.C. 331 (t), 333 and 353.

25

Fraud and Abuse Laws (cont.)

14. The Beneficiary Inducement Statute (42 U.S.C. 1320 a).
 - a. Prohibits giving something of value to an individual if the remuneration is likely to influence that individual's selection of a particular provider, supplier or practitioner for services covered by federal health care programs.
 - b. Designed to prevent:
 - i. Over-utilization;
 - ii. Misleading patients in provider choices; and
 - iii. Unfair trade practices.
 - c. Same penalties as the Anti-Kickback law.
 - d. Example: waiving of co-pays without good reason.

26

Fraud and Abuse Laws (cont.)

15. Medicare Access Act of 2015.
 - a. Greater scrutiny to be given to physician compensation arrangements and incentives (6/10/15).
 - i. Must be in line **w/ fair market value**; and
 - ii. Not tied to referrals.
 - b. Gainsharing arrangements between hospitals and physicians will be scrutinized to ensure that all compensated services are medically necessary.
 - c. **Auditors** will have outreach programs for providers on proper billing.
 - d. Providers with the highest amount of improper payments will be targeted.
 - e. Exclusion rules to be expanded to include those who individually or through a practice owe Medicare money.

www.hhsoig.gov; www.cms.gov

27

Review of Fraud and Abuse Offenses

1. Phantom billing;
2. Patient bribery;
3. Up coding;
4. Unbundling;
5. Equipment swaps;
6. HIV injection scams;
7. Phantom employees;
8. Billing for services not provided as claimed (e.g., of such low quality as to be worthless);
9. Billing for services performed by an unsupervised or unqualified employee;
10. Billing for services provided by an excluded individual;

28

Fraud and Abuse Offenses (cont.)

11. Double billing (2 providers or “annual fees”);
12. Billing for non-covered services (e.g. annual physical);
13. Knowing misuse of provider identification numbers; or
14. Claims for equipment and/or services that are not reasonable or necessary.

29

Fraud and Abuse Offenses (cont.)

15. Six things to avoid:
 - a. Submitting a bill you are not sure of or does not conform to program rules;
 - b. Routinely waiving/advertising forgiveness of co-pays, except to the indigent;
 - c. Taking a “friends and family” approach to referrals or business;
 - d. Paying for referrals to you;
 - e. Charging patients “access”, “administrative” or “yearly fees”; or
 - f. Selling samples.

30

Elements of a Compliance Program per HHS

1. Audit, audit, audit – baseline and periodic, including all standards and practices, especially:
 - a. Claims submissions;
 - b. Coding;
 - c. Meeting the reasonable and necessary standard; and
 - d. Avoiding improper incentives/kickbacks.

Note: consider involvement of independent auditors or counsel.

31

Compliance Programs (cont.)

2. Establish all *expected* procedures:
 - a. Use any problem areas seen in the baseline audit as a guide to prioritizing corrective actions;
 - b. Have a procedure manual;
 - c. Update practice forms; and
 - d. Have records' policies:
 - i. Contents;
 - ii. Retention;
 - iii. Correction;
 - iv. Protection; and
 - v. Disposition, upon practice closure.

32

Compliance Programs (cont.)

3. Designate a compliance officer:
 - a. Can be internal or external;
 - b. Administers the program and updates and educates staff on all compliance measures;
 - c. Ensures that all providers are competent and eligible; and
 - d. Conducts investigations.
4. Training:
 - a. Set objectives;
 - b. Answer 5 W's;
 - c. Recommend types:
 - i. Compliance;
 - ii. Pricing; and
 - iii. Legal updates.

33

Compliance Programs (cont.)

5. Be ready to implement corrective action plans:
 - a. Have personnel assigned;
 - b. Have warning indicators:
 - i. Increase in number of claims rejections;
 - ii. Changes in number/type of prescriptions; or
 - iii. Changes in cash on hand.
 - c. Investigate with alacrity;
 - d. Get counsel involved;
 - e. Correct problems promptly:
 - i. Return overpayments;
 - ii. Terminate excluded persons;
 - iii. Refer appropriate matters to law enforcement; and
 - iv. Self-report to HHS OIG www.hhs.gov/oig.

34

Compliance Programs (cont.)

6. Maintain robust communications within the practice or facility:
 - a. Require employees to report problems;
 - b. Make it easy to report;
 - c. Have anonymous reporting as one option;
 - d. Have a clear anti-retaliation policy; and
 - e. Have reporting obligations in vendor/business associate agreements, e.g., a billing service or an EMR service.



35

Compliance Programs (cont.)

7. Maintain and enforce disciplinary guidelines:
 - a. Well-publicized;
 - b. Reasonable;
 - c. Connected to legitimate goals;
 - d. Consistently enforced;
 - e. Investigations required; and
 - f. Provide for due process.

**No good deed goes unpunished...but
You Don't Want an Employment Claim Either!**

36

Representative Recent Cases

1. The “Big Takedown”, *2017 version*.
 - a. More than 400 defendants in 41 federal districts were charged for their alleged participation in schemes involving more than \$1.3 billion in false billings . Of those subjects charged, 115 are medical professionals.
 - b. As part of this year’s takedown, 295 individuals were served with exclusion notices by HHS-OIG for conduct related to opioid diversion and abuse. Among those issued exclusion notices were 57 doctors, 162 nurses, and 36 pharmacists.
 - c. One scheme involved a medical professional in Texas was charged with overprescribing medically unnecessary narcotics to patients, some of whom died from drug overdoses.

https://oig.hhs.gov/newsroom/media-materials/2017/2017HealthCareTakedown_FactSheet.pdf

37

Representative Cases (cont.)

2. *Insys Therapeutics case*:
 - a. On December 8, 2016, six *former* executives, including the former CEO were indicted for running a massive kickback scheme.
 - b. The case involves paying kickbacks to induce physicians to prescribe Subsys, a drug containing fentanyl, even to patients w/ no therapeutic need.
 - c. They also falsified documents to insurers and prescription benefit managers to have reimbursements for the prescriptions approved.
 - d. Charges included conspiracy to commit racketeering; conspiracy to commit wire fraud and Anti-Kickback law violations.

<http://www.chicagotribune.com/business/ct-biz-insys-john-kapoor-pharma-drug-bribery-20171027-story.html>

38

Representative Cases (cont.)

3. The former chief operating officer of a Miami-area hospital, who was indicted last year, recently pleaded guilty to one count of conspiracy to commit fraud and for paying and receiving kickbacks.
 - a. He participated in a scheme that resulted in the submission of more than \$67 million in fraudulent claims to Medicare by a state-licensed psychiatric hospital located in Hollywood, Florida, that purported to offer both inpatient and outpatient mental health services.
 - b. For nine years the hospital submitted claims for treatment that was either not medically necessary or never even provided!
 - c. At times, patients would be admitted to the hospital without any need and/or without seeing a doctor.
 - d. The defendant also maintained a network of “*patient brokers*” who funneled patients to the hospital.

39

Representative Cases (cont.)

4. U.S. vs. Teshler (December 2017).
 - a. A New York medical doctor, who had a family practice and was enrolled in the DATA program for recovering addicts, was indicted for unlawfully prescribing oxycodone and fentanyl to a patient without legitimate medical purpose, resulting in patient’s death.
 - b. While under the doctor’s care, the decedent tested positive for cocaine, heroin, morphine and methadone, in addition to the oxycodone and fentanyl Dr. Teshler was prescribing to him.
 - c. The doctor was previously indicted for unlawfully prescribing *thousands* of oxycodone pills to patients without a legitimate medical purpose.
 - d. The doctor is looking at twenty years to life.

<https://www.justice.gov/usao-edny/pr/medical-doctor-indicted-causing-patient-s-overdose-death-staten-island>

40

Representative Cases (cont.)

5. *United States ex rel. Mason et al.*, Case No. 1:14-cv-579 (D.D.C.), and *United States ex rel. Miller & Metts v. HMA*, et al, Case No. 14-00339 (D.D.C.).
 - a. The Justice Department on 12/19/17 announced settlements with two physician groups, EmCare Inc. (EmCare) and Physician's Alliance Ltd (PAL), for allegedly receiving illegal remuneration in exchange for patient referrals to hospitals owned by the now-defunct Health Management Associates (HMA).
 - b. In a separate settlement, PAL, headquartered in Lancaster, Pennsylvania, and three of its executives, agreed to resolve allegations that, from 2009 until 2012, PAL accepted illegal remuneration from HMA to refer patients to two HMA hospitals.
 - c. The cases were the product of whistleblower reports, which included complaints from two physicians.
 - d. The total tab? 37M!

<https://www.justice.gov/opa/pr/two-physician-groups-pay-over-33-million-resolve-claims-involving-hma-hospitals>

41

Representative Cases (cont.)

6. New Jersey Doctor And Chiropractor Son Sentenced To Prison For Defrauding Medicare (December 2017).
 - a. The two owned and operated Atlantic Spine & Joint Institute, a medical practice with offices in New Jersey, and Pennsylvania.
 - b. Under Medicare rules, physical therapy had to be provided by the son or by a trained physical therapist under his supervision. However, from January 2011 through April 2016, the defendants sought to defraud Medicare by employing unlicensed, untrained persons to give physical therapy to Medicare patients, at times when neither was not even in the office to supervise. They then submitted bills to Medicare fraudulently identifying the son as the provider of physical therapy.
 - c. The father and son received terms of 30 and 12 months, respectively; three years of supervised release; and must pay restitution of \$890,000.

<https://www.justice.gov/usao-nj/pr/cherry-hill-doctor-and-son-sentenced-prison-defrauding-medicare>

42

Representative Cases (cont.)

7. 21st Century Oncology to Pay \$26M to Settle False Claims Act Allegations.
 - a. This is mainly a Stark Law case.
 - b. The Fort Myers practice and certain of its subsidiaries and affiliates were charged with making false attestations regarding the company's use of electronic health records software by submitting claims for certain services provided pursuant to referrals from physicians with whom they had improper financial relationships.
 - c. The company's employees falsified data regarding the company's use of EHR software, fabricated software utilization reports, and superimposed EHR vendor logos onto the reports to make them look legitimate.

<https://www.justice.gov/opa/pr/21st-century-oncology-pay-26-million-settle-false-claims-act-allegations>

43

Representative Cases (cont.)

8. Home Health Agency Owner Sentenced *in Absentia* to **80** Years for Medicare Fraud Conspiracy and for Filing Fraudulent Tax Returns.
 - a. The defendant submitted over \$10 million in false and fraudulent claims for home health services to Medicare through over a nine year period.
 - b. He paid illegal kickbacks to patient recruiters for referring Medicare beneficiaries for home health services.
 - c. He paid illegal kickbacks to Medicare beneficiaries for allowing his company to bill Medicare using beneficiaries' Medicare information for home health services that were not medically necessary or not provided.
 - d. He and his employees falsified medical records and directed others to falsify medical records of Medicare beneficiaries to make it appear that they qualified for and received home health services.
 - e. He attempted to destroy evidence, blackmail a witness, and suborn perjury from witnesses, including a co-defendant while in the federal courthouse.
 - f. His tax returns did not reflect his ill-gotten gains.

<https://www.justice.gov/opa/pr/owner-home-health-agency-sentenced-absentia-80-years-prison-involvement-13-million-medicare>

44

Representative Cases (cont.)

9. Chemed Corp. and Vitas Hospice Services to pay \$75 Million for False Claims Act offenses relating to billing for Ineligible patients and inflated levels of care.
 - a. Over and eleven year period, Vitas knowingly submitted or caused to be submitted false claims to Medicare for services to hospice patients who were not terminally and not eligible for benefits.
 - b. The defendants were also charged w/ seeking reimbursement for services that were not necessary, not actually provided, or not performed in accordance with Medicare requirements.
 - c. Vitas also entered into a five-year Corporate Integrity Agreement (CIA) with the HHS Office of Inspector General (HHS-OIG) to settle the agency's administrative claims.

<https://www.justice.gov/opa/pr/chemed-corp-and-vitas-hospice-services-agree-pay-75-million-resolve-false-claims-act>

45



Representative Cases (cont.)

10. "The Whole Nine Yards".
 - a. "Retired" hit man Jimmy "the Tulip" Tedesky is hiding in a suburban neighborhood.
 - b. He foils a plot by his former boss to kill him with the help of his new next door neighbor, dentist Nicholas "Oz" Oseransky.
 - c. The good doctor, however, has a problem: he engaged in "commerce" with Jimmy's estranged wife.
 - d. To fix things up with Jimmy, Dr. Oz comes up with a plan to make it look like Jimmy died—to avoid future attempted "hits".
 - e. They then alter a dead man's restorations to mirror Jimmy's; put the decedent's body, along with the corpse of Jimmy's former boss, into Oz's car and set it on fire, rendering the bodies unidentifiable, except by dental records.

Did Jimmy T and Dr. Oz commit healthcare fraud?

46

