UPDATE ON HEALTHCARE FRAUD & ABUSE LAWS & ENFORCEMENT ACTIVITIES

1:00 pm Friday, March 6th, 2020
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Fraud and Abuse

- Health Care-related fraud recoveries have surpassed $2 billion dollars annually for ten consecutive years...

- Fraud & Abuse diverts scarce resources meant to pay for care of patients, increases costs for vital health services, and can result in the cause of actual harm to M & M beneficiaries.
Fraud and Abuse

1. Mix of criminal, administrative and civil law; enforced at federal and state levels.
2. Key reference sources:
   a. Federal 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.
4. 5.04B recovered from all Investigations in FY 2019 (1:5 ROI).
5. 3B recovered in Civil Fraud Recoveries in FY 2019.
6. 809 criminal actions against Individuals or Entities.


Fraud and Abuse (cont.)

7. 2640 - # of Exclusion of Individuals & Entities from Federal Healthcare Programs in FY 2019.
8. Fraud: “intentional and knowing deception or misrepresentation with knowledge of possible unauthorized benefit…”
9. 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…”
10. Waste: “negligent or reckless actions that result in unnecessary costs or unnecessary consumption of health care resources…”
Fraud and abuse (cont.)

11. Current HHS/OIG priorities:
   a. Protect Beneficiaries from Prescription drug abuse, including opioids.
   b. Promote Patient Safety & Accuracy of Payments in Home and Community-based settings.
   c. Ensure Health & Safety for Children Served by HHS Grants.
   d. Strengthen Medicaid Protections against Fraud and Abuse.

PERSPECTIVE: FED GOV’T SPENDING on HEALTHCARE

PROJECTIONS FOR MAJOR HEALTH CARE PROGRAMS FOR FY 2020 (As of January 28, 2020)

<table>
<thead>
<tr>
<th>Program</th>
<th>Amount</th>
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<tbody>
<tr>
<td>MEDICARE (Net of Offsetting Receipts)</td>
<td>$695 Billion</td>
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<tr>
<td>MEDICAID</td>
<td>$425 Billion</td>
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<tr>
<td>PREMIUM TAX CREDITS AND RELATED SPENDING</td>
<td>$52 Billion</td>
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<tr>
<td>CHILDREN’S HEALTH INSURANCE PROGRAM</td>
<td>$16 Billion</td>
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$1,188 Trillion

https://www.cbo.gov/topics/health-care
Fraud and Abuse (cont.)

12. Fifteen federal laws in play:

<table>
<thead>
<tr>
<th>FCA</th>
<th>PPACA</th>
<th>Stark</th>
<th>Anti-kickback</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion</td>
<td>Wire Fraud</td>
<td>Civil Money Penalties</td>
<td>Criminal Penalties</td>
</tr>
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<td>Anti-Embezz.</td>
<td>False Statements</td>
<td>Obstruction Of Justice</td>
<td>Program Fraud</td>
</tr>
<tr>
<td>Rx Marketing</td>
<td>Beneficiary Inducement</td>
<td>MACRA 2015</td>
<td>?</td>
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13. States have laws too. Which applies? Depends on whether Fed or State program and other factors. Are Fed dollars involved?

Sidebar Retrospective: the Inimitable Dr. Roy

1. 2006-12: $373M in fraud.
2. August 9, 2017 Convicted of 12 Counts of Health Care Fraud & Obstruction & Sentenced to 35 years in prison
3. Recruited 11,000 fake home health patients who were recruited in poor areas (including homeless shelters) door to door, often w/ bribes.
4. 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.
5. When his original company was suspended by Medicare, he seamlessly switched all services to another entity.
6. At sentencing, Dr. Roy asked for leniency because he “looked forward to giving back to society...” He will be 95 years old if and when he walks out of prison.
Fraud and Abuse Laws

1. **The False Claims Act:**
   - Has both civil (31 USC 3729) and criminal (18 USC 287) components. FCA remains the Feds Primary Civil Enforcement Tool.
   - Exists at both the federal and (virtually every) state level.
   - Makes it illegal to submit claims for payment that a party knows or should know are false or fraudulent.
   - "**Knowing**" encompasses when a party acts in "deliberate ignorance or reckless disregard of the truth . . .".
   - Has whistleblower (Qui Tam) components that allow private citizens to institute actions on behalf of the government.
   - Do not cover simple negligence or common errors.
   - Can be part of Anti-Kickback or Stark Act violations.
   - Federal civil penalty is **treble damages** plus 11K to 22k per count.
   - Criminal penalty includes imprisonment.

2. **The PPACA:**
   - Essential structure: the five mandates (in order of implementation):
     - The Insurance mandate;
     - The Individual mandate (The Tax Cuts and Jobs Act of 2017, reduced to 0 the fine/tax for violating the individual mandate, starting in 2019);
     - The Employer mandate;
     - The EMR mandate; and
     - The Compliance mandate.
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

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.
Fraud and Abuse Laws (cont.)

3. The Physician Self-Referral Law (42 USC 1395 nn), AKA The “Stark Law” (cont.):
   e. October 9, 2019, HHS Proposed Stark Law and AKS Reforms to support Value-Based arrangements and Coordinated Care for patients.
   f. Penalties (only civil, no criminal) of up to $15k per for each billed service that is based on a prohibited referral, plus three times the amount of the government overpayment.

Fraud and Abuse Laws (cont.)

4. Anti-Kickback Statute (42 USC 1320 (b)):
   a. Forbids knowing or willful (so, intent is a necessary element) 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.
Fraud and Abuse Laws (cont.)

4. **Anti-Kickback Statute (42 USC 1320 (b))**:
   
e. Notably, these penalties can be imposed on both parties involved in the illegal kickback arrangement—i.e., the party receiving the kickback and the party making the kickback.

   f. Penalties include fines of up to 50K per incident plus 3X amount of remuneration (overpayment) received. Penalties for Anti-Kickback violations also frequently include a period of debarment or exclusion from participation in Medicare, Medicaid, and all other federal plans and programs that provide health benefits.

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.

   b. Passed in 1977, in the Medicare-Medicaid Anti-Fraud and Abuse Amendments
Fraud and Abuse Laws (cont.)

5. **The Exclusion Statute** (cont.):
   c. 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.

d. 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.

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6. **Mail and Wire Fraud** (18 USC 1341, 1343):
   a. Prohibits the use of mail, private courier or wire service to defraud another. Intent is required, but easy to assert.
   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.
   e. Frequently used in healthcare prosecutions.
   f. Broad & spacious definition of "Fraud" - As Judge Holmes so colorfully put it "[t]he law does not define fraud; it needs no definition; it is as old as falsehood and as versatile as human ingenuity." [Gregory v. United States, 253 F.2d 104, 109 (5th Cir 1958) ]
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 often with a daily penalty amount for ongoing violations.

    d. The Inspector General must only prove liability by a “preponderance of the evidence” rather than the more demanding "beyond a reasonable doubt" standard required in criminal actions.

    e. A health care provider can be held liable based on its own negligence and the negligence of its employees.

    f. There is no requirement that intent to defraud must be proved.
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 50K or imprisonment of up to 10 years (penalties doubled, effective 02/09/2018).
   c. Example: physician accepts payment to sign certificates of medical necessity for DME for patients she never examined.


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 involving amounts greater than $100 include fines and imprisonment of up to 10 years.
   c. Example: a pharmacy employee embezzles money from an account that contains Medicare reimbursements.
   d. Example: a physician’s practice group that withholds (or diverts) health insurance monies from employee checks but does not pay that money to the health insurance provider can be prosecuted under this portion of the US Code.
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/or imprisonment of up to 5 years.
   c. Example: giving an affidavit concealing the exclusion of an employee from Medicare.


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.

https://www.law.cornell.edu/uscode/text/18/1518
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.

   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 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.
Fraud and Abuse Laws (cont.)

   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:
      a. Over-utilization;
      b. Misleading patients in provider choices; and
      c. Unfair trade practices.
   c. Same penalties as the Anti-Kickback law.
   d. Example: waiving of co-pays without good reason.

15. **Medicare Access Act of 2015 (MACRA):**
   a. Greater scrutiny to be given to physician compensation arrangements and incentives (6/10/15).
      i. Must be in line with 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** 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
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;

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 (overprescribing opioids).
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.
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.

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.
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.

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
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.

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!
Representative Fraud and Abuse Cases

1. **The 2018 National Health Care Fraud Takedown: June 2018.**
   a. Nationwide sweep results in the arrest of 601 defendants involved in schemes amounting to $2 billion in losses to Fed HC programs.
   b. Charges included:
      i. Billing fraud;
      ii. Prescription fraud involving opioids and other narcotics;
      iii. Kickback violations;
      iv. Money laundering; and
   c. 67 Docs, 402 nurses, and 40 pharmacy services were issued exclusion notices.

Representative Cases (cont.)

2. **On April 17, 2019 Appalachian Regional Prescription Opioid (ARPO) Strike Force Takedown Results in Charges Against 60 Individuals**
   a. Charges Involved over 350 Thousand Prescriptions for Controlled Substances and over 32 Million Pills.
   b. Across 11 fed districts, Defendants included 31 doctors, 7 pharmacists, 8 nurses and 7 other licensed medical professionals.
   c. Started in October 2018, ARPO is made up of prosecutors and data analysts with the HCF Unit, prosecutors with the nine U.S. Attorney’s Offices in the region, and special agents with the FBI, HHS-OIG and DEA. In addition, the APRO Strike Force will work closely with other various federal law enforcement agencies, including the U.S. Postal Inspection Service and IRS Criminal Investigation, and State Medicaid Fraud Control Units.

Representative Cases (cont.)

d. The ARPO Strike Force targets criminal conduct associated with the improper prescription and distribution of prescription opioids and other dangerous narcotics throughout the Appalachian region and surrounding areas – focusing on criminal conduct by physicians, pharmacists, and other medical professionals. The ARPO Strike Force will also investigate and prosecute violations of health care fraud whenever such fraud is detected throughout the region.

e. The ARPO Strike Force operates out of two hubs based in the Cincinnati/Northern Kentucky, and Nashville, Tennessee, areas, supporting the ten districts that make up the ARPO Strike Force region.

3. In January 2020, a (another) Texas Doctor was found guilty in $325 Million Health Care Fraud Scheme Involving False Diagnoses of Life-Long Diseases.
   a. Dr. Zamora-Quezada falsely diagnosed a large number of patients with rheumatoid arthritis, a life-long, incurable disease – and treated them with toxic, medically unnecessary medications like chemo drugs, lengthy intravenous infusions, injections and other excessive, repetitive and profit-driven medical procedures.
   b. Evidence also showed that the Doctor obstructed and mislead a federal grand jury investigation and falsified medical records.
   c. He traveled to his various offices throughout South Texas on his private jet and in his Maserati.
   d. The good Doctor did not discriminate in those he treated - the vulnerable patient group included the young (a 13 year old), elderly, and the disabled. He will be sentenced March 27, 2020.
Representative Cases (cont.)

4. Called *Operation Brace Yourself*, the investigation discovered that medical brace manufacturers were allegedly paying kickbacks and bribes to doctors working with fraudulent telemedicine companies in exchange for Medicare patient referrals for medically unnecessary braces.
   a. As part of the scheme, doctors were paid to prescribe braces to patients they had little to no relationship with. Prescriptions frequently came after doctors had brief conversations via phone or video conference with patients they had never met.
   b. The global fraud involved call centers in the Philippines and throughout Latin America.
   c. As a result, the personal information of hundreds of thousands of Medicare beneficiaries across the country was compromised and could be used in future schemes.
   d. Five telemedicine companies, the owners of dozens of DME companies and three physicians were involved in this scheme involving more than **1.2 Billion** in losses to Medicare. Them DME companies had submitted over 1.7 Billion in claims and were paid 900 Million.
   e. The operation and enforcement actions were led by the Health Care Fraud Unit (criminal division) and Medicare Fraud Strike Force with assistance from HHS OIG, FBI, and U.S. Attorney’s Offices in Districts of S.C., N.J., and Middle District of FL.
Representative Cases (cont.)

5. In Greensburg, PA, Dr. Milad Shaker, 49, was found guilty of 14 counts of illegally dispensing opioids. Dr. Shaker has been sentenced (February 7, 2020) to 41 months imprisonment, 3 years supervised release, and ordered to pay a $15,000.00 fine.
   a. From October 2014 through March 2017, Shaker (a PCP) illegally dispensed Hydrocodone, Percocet and Tramadol to a patient in return for sex and sexually explicit photos and texts.
   b. The patient testified that Shaker would meet her at various hotels in Westmoreland and Fayette counties and at two locations on the side of the road to engage in sex in return for opioid prescriptions.
   c. During cross examination, Shaker in defending his illegal prescribing, testified that, “opioids are like candy,” and “10 to 20 opioid pills will not hurt you.”
   d. Shaker’s state medical license had been revoked prior to sentencing….

6. Detroit Psychologist Sentenced to 51 Months for Health Care Fraud and Money Laundering.
   a. Psychologist Paul Lucki Smith, who operated multiple clinic locations was sentenced on January 7, 2020 after pleading guilty to health care fraud and unlawful monetary transactions.
   b. Smith had maintained a practice in Metro Detroit for over 20 years. Had submitted numerous claims to BCBS of Michigan for reimbursement for services he did not provide.
   c. In one three period, Smith fraudulently obtained $3 million for BCBS. He subsequently used much of the proceeds of his fraud to purchase real property, liquor licenses, and furniture in his venture to become a hotelier in Arcadia, Michigan.
   d. The Court also forfeited Smith’s interests in funds tied to his fraud and money laundering, liquor licenses, and two pieces of real property. The Court also entered a forfeiture money judgment in the amount of 3 million.
Representative Cases (cont.)

7. Nursing Home Operator Please Guilty to Embezzlement and Tax Offenses.
   a. Chaim Stern (70), principal operator of three privately owned nursing and rehabilitation facilities. Between 2011 and 2018, Stern stole $4.1 million from the facilities pension plan (of which he was the trustee) and diverted the money to purported charity which Stern controlled.
   b. In 2015, Stern diverted $305,608 from the health plan (money was from a stop-loss insurance plan intended to pay for any employee health claim) and instead used the money for his charity and personal use.
   c. From January 2017 to March 2018, Stern failed to pay over employment taxes he collected from his employees. The total tax losses amounted to $4,356,409.

   d. Stern plead guilty to one count of theft or embezzlement from an employee benefit plan, one count of theft or embezzlement in connection with healthcare, and one count of willful failure to pay taxes.
   e. As part of plea agreement, Stern faces maximum sentence of 20 years, must make restitution to Pension Plan of $4.1 million, make restitution to employees in Health Plan with unpaid claims and to the IRS in the total amount of $2.4 million.
Representative Cases (cont.)

8. Millcreek Community Hospital agreed to pay $2.451 million to resolve FCA allegations that it billed Medicare & Medicaid for inpatient rehab service when patients did not qualify for such services & when patient’s medical records lacked adequate documentation of medical necessity.
   b. MCH agreed to enter into a corporate integrity agreement with HHS’ Office of Counsel to the Inspector General. The agreement requires the hospital's billing to be monitored for five years, according to the Justice Department.
   c. “Although Millcreek fully cooperated with the government in its investigation, it did not admit to any wrongdoing in its settlement. It is pleased to have resolved this issue.”

9. In March 2018, UPMC Hamot* and cardiology practice Medicor Associates, finalized an agreement to pay the federal government $20.7 million to settle allegations they knowingly submitted claims to Medicare and Medicaid in violation of the AKS and Stark Law.
   a. The settlement resolves allegations brought in a whistleblower action filed under the False Claims Act alleging that, from 1999 to 2010, Hamot paid Medicor up to $2 million per year under twelve physician and administrative services arrangements which were created to secure Medicor patient referrals.
   b. Filed by Dr. Tullio Emanuele (Relator), who worked for Medicor from 2001 to 2005, under the qui tam, or whistleblower, provisions of the FCA. The Act permits private parties to sue on behalf of the government when they believe that defendants submitted false claims for government funds and to share in any recovery. The Act also allows the government to take over the case or, as in this case, the whistleblower to pursue it. The case was set for trial when the Gov't helped to facilitate the settlement. Dr. Emanuele received $6,017,500.

* (illegal activity occurred prior to UPMC ownership)