OIG Reports Exclusions, Criminal Actions, and Civil Actions for First Half of FY 2005

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The Department of Health and Human Services Office of Inspector General (“OIG”) has the authority to impose a number of different sanctions, including exclusion from the Medicare, Medicaid, and other federal health care programs, civil monetary penalties, and criminal fines and imprisonment, on individuals and entities who engage in certain activities. How frequently does the OIG impose these sanctions? What types of activities result in sanctions? The OIG answers these questions in its recently released Semiannual Report to Congress (“Report”), which covers the first half of fiscal year (“FY”) 2005.¹

Section 1128 of the Social Security Act provides several grounds for excluding individuals and entities from participation in Medicare, Medicaid, and other federal health care programs.² The OIG is required to exclude individuals and entities convicted of certain types of criminal offenses, including Medicare and Medicaid-related crimes, patient abuse and neglect, felonies for health care fraud unrelated to the Medicare and Medicaid programs, and felonies for the illegal manufacture, distribution, prescription, or dispensing of controlled substances.³ The OIG has the discretion to exclude individuals and entities for misdemeanors for health care fraud unrelated to the Medicare and Medicaid programs; the illegal manufacture, distribution, prescription, or dispensing of controlled substances; the suspension or revocation of a license to provide health care for reasons relating to professional competence, professional performance, or financial integrity; the provision of unnecessary or substandard services; the submission of false or fraudulent claims to a federal health care program; and unlawful kickback arrangements, among other activities.⁴

How frequently does the OIG exclude individuals and entities from participation in Medicare, Medicaid, and other federal health care programs? During the first half of FY 2005, the OIG excluded 1,695 individuals and entities. According to the Report, most of the exclusions resulted from convictions for crimes relating to Medicare and Medicaid, patient abuse or neglect, or license revocation. For example, the OIG imposed a 50-year exclusion on an Oklahoma pediatrician who confessed to abusing 18 children over a 20-

³ Id. § 1320a-7(a).
⁴ Id. § 1320a-7(b).
year period and whose license to practice medicine was permanently revoked. The OIG also imposed a 28-year exclusion on a Florida durable medical equipment (“DME”) sales representative who filed false claims for medically unnecessary DME items and a 26-year exclusion on a South Carolina physician who illegally sold prescriptions for OxyContin, Percocet, and other controlled substances.

The Civil Monetary Penalties Law (“CMPL”) authorizes the OIG to impose administrative penalties and assessments against a person or entity that, among other things, submits claims to a federal health care program that the person or entity knows or should know are false or fraudulent. How many dollars did the OIG collect during the first half of FY 2005 for activities sanctioned under the CMPL? According to the Report, the OIG collected $6.6 million in civil monetary penalties and assessments. For example, the OIG collected $76,000 from Lansing Surgery Center (“Center”), a freestanding surgery clinic located in Michigan, after the Center admitted that it: (1) submitted improper claims to Medicare and Medicaid for pain management services; (2) engaged in mail fraud, wire fraud, and health care fraud; and (3) upcoded office visits at the Center and other Michigan hospitals.

The Anti-Kickback Statute authorizes penalties against anyone who knowingly and willfully solicits, receives, offers, or pays remuneration, in cash or in kind, to induce or in return for: (1) referring an individual to a person or entity for the furnishing, or arranging for the furnishing, of any item or service payable under the federal health care programs; or (2) purchasing, leasing or ordering, or arranging for or recommending the purchasing, leasing or ordering of any good, facility, service, or item payable under the federal health care programs. Individuals who, and entities that, engage in unlawful referral or kickback schemes may be subject to criminal penalties under the Anti-Kickback Statute as well as civil monetary penalties under the CMPL and program exclusion under the OIG’s permissive exclusion authority.

What types of settlements involving unlawful referral and kickback schemes did the OIG negotiate during the first half of FY 2005? According to the Report, the OIG negotiated the largest settlement involving a kickback scheme to date. Florida’s PharMerica, Inc. and PharMerica Drug Systems, Inc. agreed to pay more than $5.9 million to resolve allegations that PharMerica paid an excessive amount to purchase a pharmacy in exchange for the seller’s agreement to refer its Medicare and Medicaid pharmacy business to PharMerica for the next seven years. In addition, Florida’s Tender Loving Care Health Care Services, Inc. (“TLC”) agreed to pay $130,000 to resolve allegations

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5 REPORT, supra note 1, at 11.
6 Id. at 12.
7 Id.
9 REPORT, supra note 1, at 12.
10 Id.
12 Id. § 1320a-7a.
13 Id. § 1320a-7(b)(7).
14 REPORT, supra note 1, at 13.
that TLC made commission payments to independent contractor sales representatives in exchange for patient referrals.\textsuperscript{15}

Under the civil False Claims Act (“FCA”) a person or entity can be liable for treble damages and up to $11,000 for each false claim knowingly submitted or caused to be submitted to a federal program.\textsuperscript{16} A person or entity also can be liable under the FCA for knowingly making or using, or causing to be made or used, a false record or statement to have a false claim paid. The resolution of FCA allegations usually depends on the investigative efforts and resources of a number of agencies, including the OIG, the Federal Bureau of Investigation, Medicaid Fraud Control Units, and a number of other law enforcement agencies.\textsuperscript{17}

How many dollars in FCA settlements did the federal government negotiate during the first half of FY 2005? According to the Report, the government negotiated $1 billion in civil and administrative settlements involving FCA allegations. For example, Missouri’s Gambro Healthcare, Inc. agreed to pay more than $350 million for allegedly submitting false Medicare claims and engaging in other illegal activities.\textsuperscript{18} Pennsylvania’s Temple University Physicians agreed to pay almost $1.9 million for allegedly submitting false Medicare claims.\textsuperscript{19} A Texas DME company was ordered to pay $1.8 million in restitution for improperly billing Medicare for power wheelchairs and accessories.\textsuperscript{20}

In summary, the OIG reported the following statistics for the first half of FY 2005: (1) exclusions of 1,695 individuals and entities for fraud or abuse of federal health care programs or their beneficiaries; (2) 258 criminal actions against individuals who, or entities that, engaged in crimes against programs of the Department of Health and Human Services; and (3) 105 civil actions, including FCA and unjust enrichment suits filed in district court, CMPL settlements, and administrative recoveries related to provider self-disclosure matters. The Report contains additional statistics, results, and summaries regarding the frequency with which the OIG imposes sanctions and the types of activities that result in sanctions.

\begin{itemize}
  \item \textsuperscript{15} Id.
  \item \textsuperscript{16} 31 U.S.C. §§ 3729-3733 (2005).
  \item \textsuperscript{17} REPORT, supra note 1, at 14.
  \item \textsuperscript{18} Id. at 14-15.
  \item \textsuperscript{19} Id. at 15.
  \item \textsuperscript{20} Id. at 16.
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