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# Health Care Fraud & Provider Billing Litigation in the Era of COVID-19

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**Seyfarth Shaw LLP**



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**03** Types of Health Care Provider Billing Fraud and Select Key Issues

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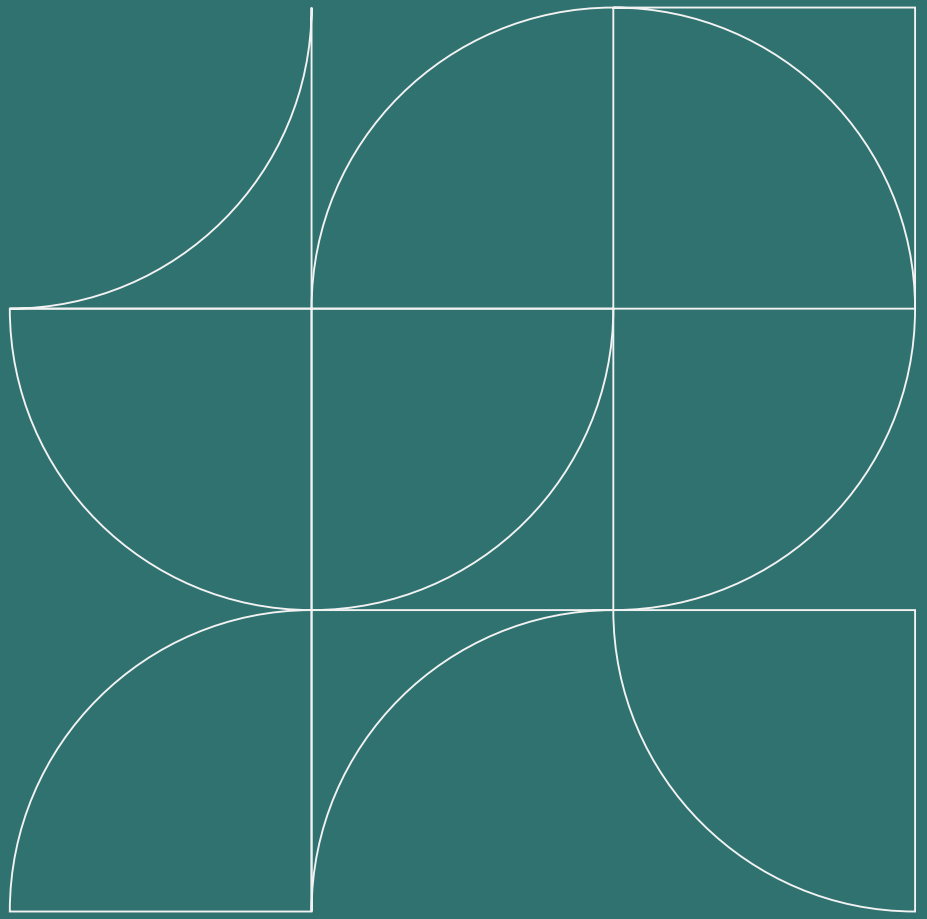
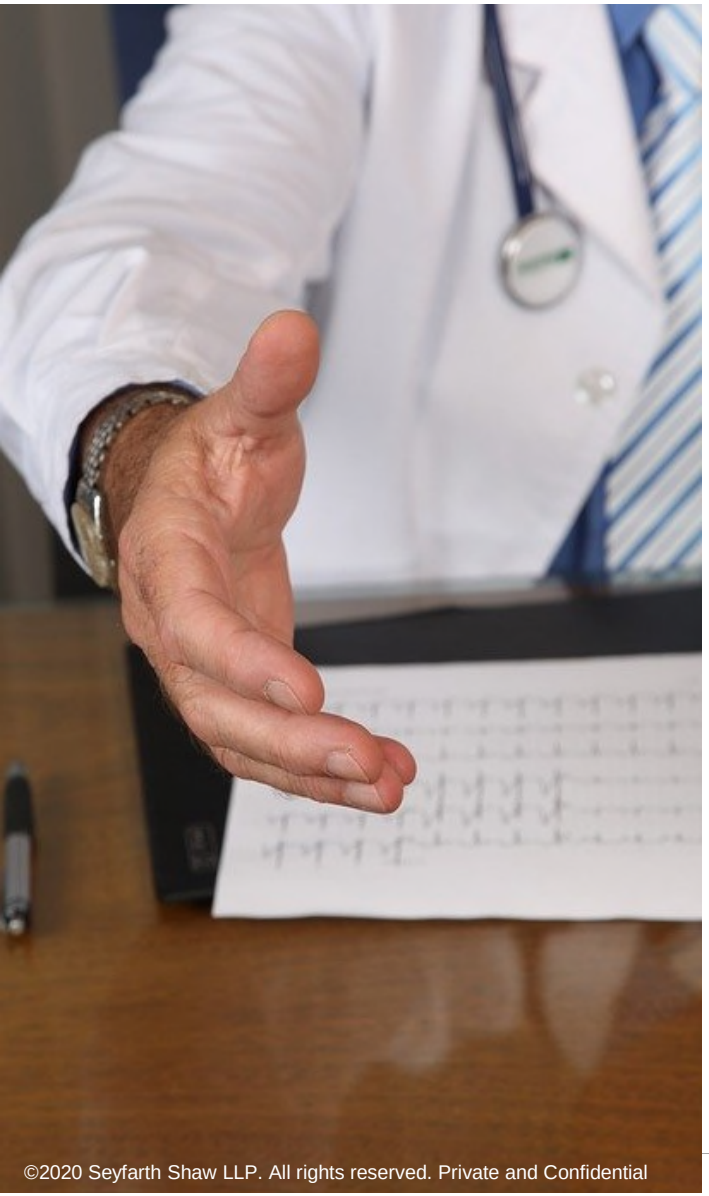
# Introduction: Health Care Fraud is a Big Problem





# Health Care Fraud: A Massive Problem

Health care fraud represents a massive financial and social problem:

- Over **$3 trillion** spent annually in the US on health care expenditures
- Tens, if not hundreds, of billions of dollars misspent annually on fraudulent health care services
- Preventing fraud to reduce spending, recovering wrongful payments to fraudulent providers, and protecting members/consumers from scams are important priorities to insurers and ERISA-governed health care plans.
- The introduction of technology and electronic health records has increased the number and variety of different fraud schemes.
- The federal government has the DOJ, state governments have Attorney Generals, and insurers have SIUs, but self-funded plans are often under-protected.

# What is Health Care Fraud?

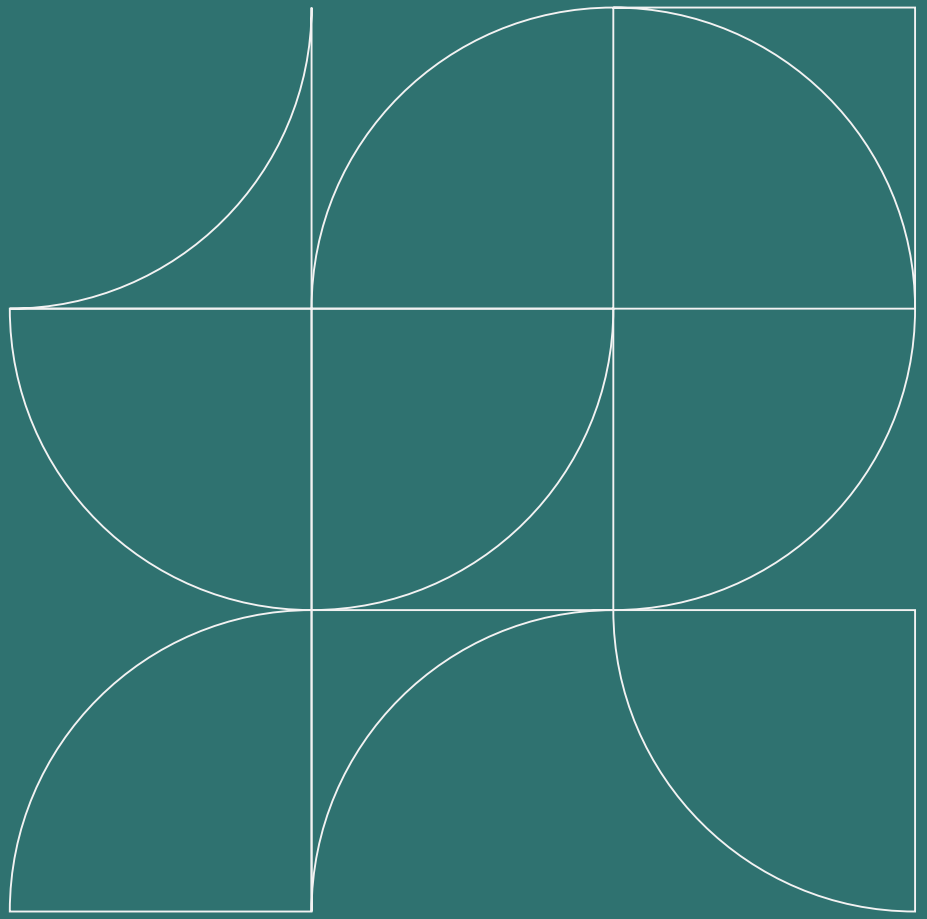
Health care fraud is the intentional deception or misrepresentation of health care transactions by a provider, employer group, or member for the sake of receiving unauthorized benefit or financial gain.

Health care fraud is committed when a dishonest provider or consumer intentionally submits, or causes someone else to submit, false or misleading information for use in determining the amount of health care benefits payable by an insurer, health plan, or other payor.

# Why Focus on Health Care Fraud?

- Reducing costs of health care **without cutting benefits**
- Lower costs to government, and lower costs to private payors including insurers, employers, plans, and employees (and their beneficiaries).
- Under ERISA, fiduciaries have duties to protect plan assets – liability may arise from failure to implement adequate detection and deterrence systems
- Collateral damage: corruption of patient medical histories, HIPAA violations, data and privacy breaches, identity theft, patient physical and financial harm

# Impact of COVID-19 on Health Care Fraud



# COVID-19: A Breeding Ground for Fraud

- Math: Money + Opportunity + Scale = Massive Fraud
- Per the FBI, US domestic fraud totals ~ $80 billion per year
- Add “waste and abuse” – arguably hundreds of billions of dollars more per year
- New government programs and economic stimulus have pumped trillions of dollars into widespread circulation and created an unprecedented cash grab.
- People are stressed, scared, and vulnerable.
- New government programs can lead to confusion, mistakes, and fraud.
- Everything is uncertain and moving fast.
- Lack of sufficient prescreening and quality controls
- Scale: truly a global pandemic; impacting everyone

# COVID-19 – US Government Monetary Response

- **Coronavirus Preparedness and Response Act**
  **$8 Billion** (directed towards immediate response, including vaccine development, health preparedness and community health centers, Medicare and telehealth waivers, increased CDC funding)

- **Families First Coronavirus Response Act**
  **$192 Billion** (increased agency spending and cost sharing waivers for COVID-19 diagnosis care, Medicaid matching funds to states, partial funding for COVID-19 testing).

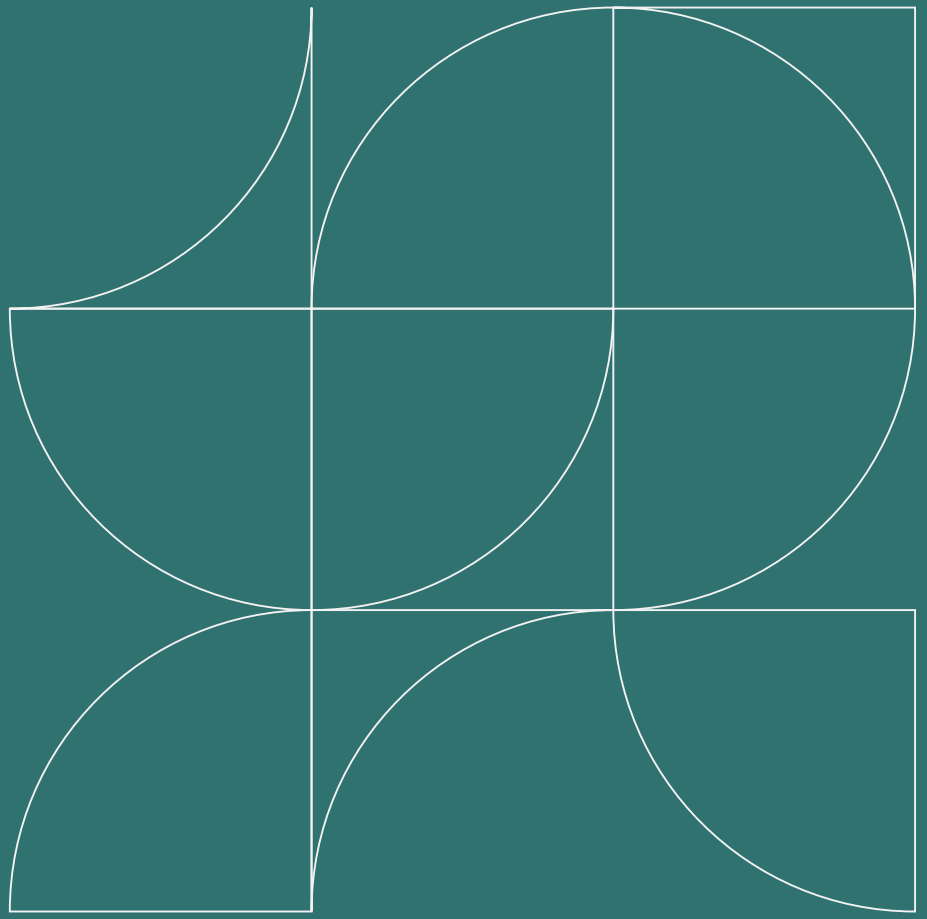
- **Coronavirus Aid, Relief, and Economic Security Act**
  **$2.7 Trillion** (includes PPP program, state aid for pandemic related costs, provider relief fund, increased Medicare payments, expanded telehealth and home services, funding for community health centers)

- **Paycheck Protection Program and Health Care Enforcement Act**
  **$733 Billion** (additional funding for PPP, emergency injury disaster loans and grants, COVID-19 testing, preparedness and expenses).

# COVID-19 – Opportunities for Health Care Fraud & Health Insurance Fraud

- **Provider billing fraud** (performance, diagnosis, necessity, kickbacks, bundling, coding)
- **Price gouging** (medical supplies and personal protective equipment)
- Various mail, phone, text, and door to door solicitations
- Fake testing sites – trolling for cash and PHI
- Scams selling fake treatments/cures/disinfectants
- Cyberattacks – malware, ransomware
- Scams regarding economic stimulus payments (e.g., offers to help process, track payments)
- False claims for unemployment benefits
- Employment fraud – pretending to have COVID-19 to avoid having to work
- Scams selling fake coronavirus insurance
- Life insurance marketing scams (bogus pitches, proffered discounted rates)
- Telehealth fraud
- Auto insurance personal injury scams

# Types of Health Care Provider Billing Fraud and Select Key Issues



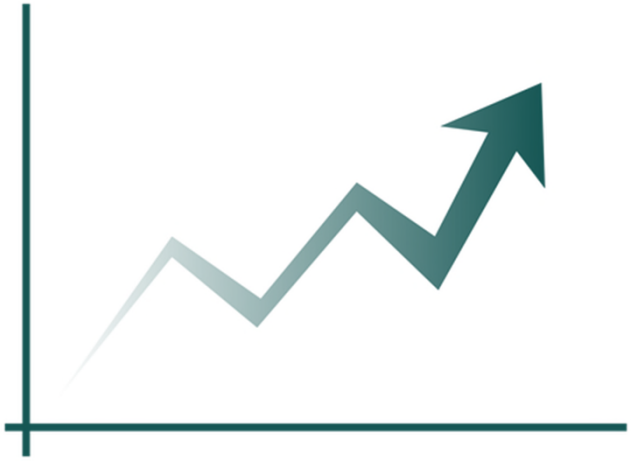
# Common Forms of Health Care Provider Fraud

## Types of health care provider billing fraud:

- Billing for services, procedures, or supplies not provided
- Billing for non-covered services as covered items (e.g., cosmetic surgeries, massages, physical therapy)
- Performing medically unnecessary services
- Incorrect reporting of diagnoses or procedures to maximize reimbursement (e.g., double billing, “up-coding,” and “un-bundling”)
- Kickbacks to patients
- Corporate fraud
- Medical claims and prescription drug fraud
- Identify theft
- Excessive charges and **price gouging**

# Issue Highlight: “Price Gouging”

- Price gouging occurs when, during abnormal market conditions, a seller increases the prices of goods, services, or commodities to a level much higher than is considered reasonable or fair.
- **Unconscionable or exorbitant** pricing after a demand spike or supply disruption during a public emergency. The most common examples involve **excessive** price increases for basic necessities after natural disasters.
- In many jurisdictions (like California), price gouging during a declared state of public emergency is a crime. Cal. Penal Code Section 396. Whether criminal or not, price gouging is generally discouraged and may be considered **exploitative** and **unethical**.
- Price gouging is usually short-term, localized, and restricted to essentials such as food, clothing, shelter, medicine, and equipment needed to preserve life and property.



# COVID-19 Price Gouging

- COVID-19 pandemic presents uniquely different issues than natural disasters:
  - Expansive geographic scope – a worldwide phenomenon
  - Long period of emergency with uncertain end date
  - Run on both expected and unexpected, traditional and non-traditional necessities (e.g., personal protective equipment, disinfectants, hand sanitizers, surgical masks, and medical supplies, but also toilet paper, hair dye, etc.)
  - Items that did not exist, or had limited pricing data, prior to the declaration of emergency (e.g. COVID-19 testing kits)
- COVID-19 presents tremendous, unprecedented, far reaching, long lasting, high dollar profit, and windfall opportunities. Follow the money $$$.
- **Health care services and supplies are particularly susceptible to fraud, aggressive billing practices and price gouging during COVID-19.**
  - Ex: counterfeit goods and trademark infringement.
  - Ex: mandated coverages and limitations on utilization review.

# Issue Highlight: Waiver of Co-Pays and Deductibles

- Co-pays, deductibles, and co-insurance serve an important role: they require members to “have skin in the game.” Absent enforcement, plan members and insureds are less incentivized to monitor (e.g., review EOBs) to report health care fraud, waste, and abuse (and may become complicit in it themselves).

- Providers may waive co-pays or deductibles, yet invoice plans or insurers for full amount. What is the actual charge? Waiver of co-pays and deductibles increases utilization and distorts pricing.

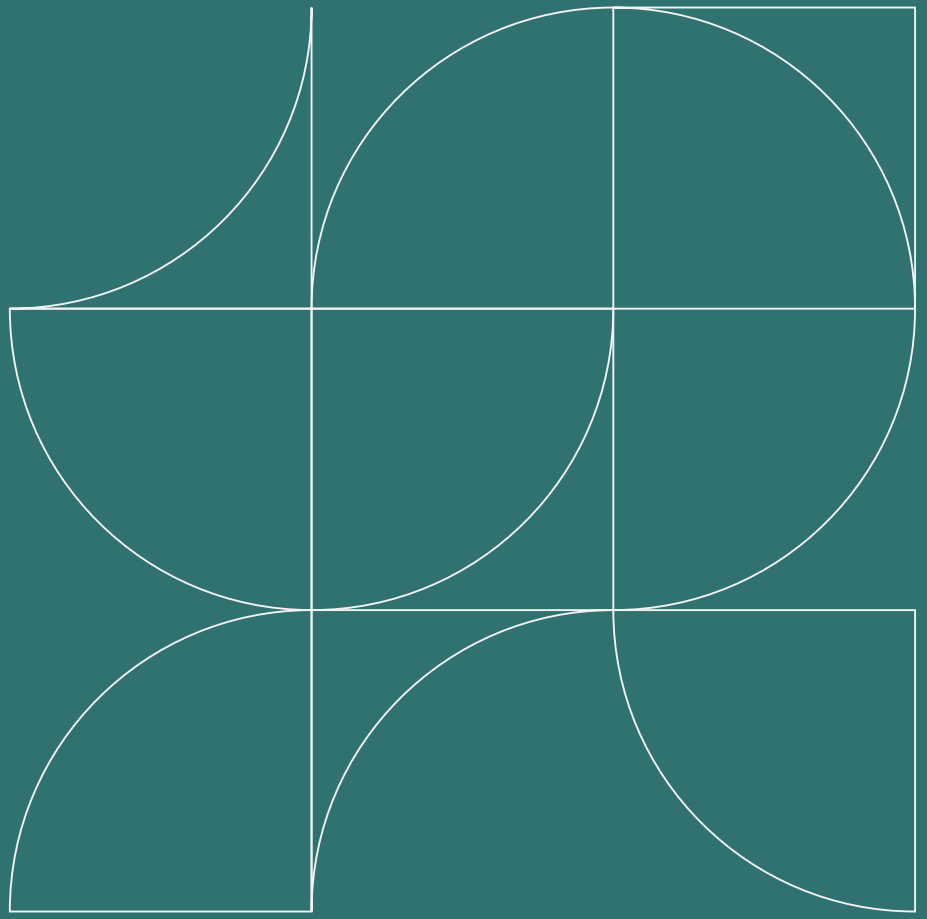
- Can **constitute fraud**: See *U.S. v. Javan*, 383 F. App’x 596 (9th Cir. 2010) (upholding provider conviction for health care fraud for not charging patients a co-payment or deductible); also *Connecticut Gen. Life Ins. Co. v. Humble Surgical Hosp., L.L.C., 878 F.3d 478, 487 (5th Cir. 2017); but see N. Cypress Med. Ctr. Operating Co., Ltd. v. Aetna Life Ins. Co., 898 F.3d 461, 475 (5th Cir. 2018)*

# Issue Highlight: Corporate Fraud

## Corporate Fraud

- Violation of practice ownership laws. **Does this make every claim from the practice fraudulent?**
- *The People of California, ex rel. Monterey Mushroom, Inc. v. Thompson*, 136 Cal. App. 24 4th (2006)

# Collection and Fraud Litigation Between Providers and Payors



# Litigation by ONET Providers against Health & Welfare Benefit Plans, Insurers and Other Payors

- Out-of-network (“ONET”) providers can attempt to bill payors any amount they please, unlike in-network (“INET”) providers, who are contracted to receive predetermined rates.
- When payors detect perceived or actual overcharging, fraudulent or improper billing by ONET providers, the payors may refuse to pay, which is often the starting point of provider billing disputes and litigation.
- Having suffered revenue losses due to COVID-19, providers may be motivated and incentivized to aggressively maximize reimbursements and pursue collections via litigation.

# Litigation by Providers: Actions and Claims

**Providers are under intense pressure to maximize reimbursements following lost revenue due to COVID-19 closures. As such, providers will be aggressive in pursuing collections and litigation.**

1. Claims against ERISA plans under ERISA Section 502(a), 29 U.S.C. §1132, for benefits, breach of fiduciary duty, and/or other equitable relief
2. Claims against insurers, ERISA plans, or other payors under state law for:
   - Breach of contract (express, oral, implied)
   - Misrepresentation (intentional or negligent)
   - Violations of state unfair competition law
   - *Quantum meruit* (services rendered)
   - Promissory or equitable estoppel
   - Intentional interference with economic relations
   - Intentional interference with prospective economic advantage
3. On unique facts, potentially other claims (e.g., RICO, FCA, etc.)

# Litigation by Providers: Select Issues and Considerations

## Preemption

- To remove or not to remove, that is the question
- Conflict preemption as a defense to state law claims

## Standing

- Constitutional vs. statutory standing
- Assignee vs. authorized representative
- Patient financial responsibility and defenses to provider claims against the patient

## Pricing

- Billed Charges
- “UCR”
- “MAC”

# Provider Collection Actions: Remedies Against Patients

- ONET providers who can't sue a plan may have recourse against patients (e.g., some assignments or independent contracts include provisions obligating the patient to pay the provider if the Plan/insurer does not). See, e.g., *Brown v. Blue Cross Blue Shield of Tennessee, Inc*., 2015 WL 3622338 (E.D. Tenn.)

- Not necessarily a viable remedy – Provider relies on plan's deep pocket in providing services; patients often judgment proof; suing a patient may alienate other potential patients (e.g., *Premier Health Ctr., PC v. UnitedHealth Group*, 2014 WL 4271970 *14 (D.N.J.))

- Provider can acquire right to sue a plan by joining its network – but Hobson's choice (network means lower reimbursement and no recourse against the patient)

# Actions and Claims by Payors Against Providers

- Upon discovery that providers have defrauded a payor, the insurer or a plan (through its trustees) may initiate a “claw-back” action to recover payments already made.
- Claw-back claims may be presented as stand alone lawsuits, or as cross-claims or counterclaims to lawsuits by providers for non-payment or under-payment.
- Some claw-back actions previously proceeded as ERISA 502(a)(3) claims for equitable relief, but recent authority (e.g., *Montanile*) somewhat limits such claims and relief.
- Other potential federal claims include RICO, FCA, etc.
- State law causes of action by payors against providers may include fraud, negligent misrepresentation, conversion, civil conspiracy to defraud, unfair competition, false advertising, and/or violations of insurance code provisions (e.g., Cal. Ins. Code § 1871.7)

# RICO & Conspiracy

- The Racketeer Influenced and Corrupt Organizations Act (18 U.S.C. §§1961-1968) is a federal law that provides for extended criminal penalties and a civil cause of action for acts performed as part of an ongoing criminal organization.

- However, RICO claims are not necessarily limited to allegations against organized crime. See *H.J. Inc. v. Northwestern Bell Tel. Co. (1989) 492 U.S. 229, 244.*

- The elements of a civil RICO claim under 18 U.S.C. § 1963(c) are "(1) conduct (2) of an enterprise (3) through a pattern (4) of racketeering activity." *Reznver v. Bayerische Hypo-Und Vereinsbank AG (9th Cir. 2010) 630 F.3d 866, 873.*

- "The evidence used to prove the pattern of racketeering activity and the evidence establishing an enterprise may in particular cases coalesce." *Boyle v. U.S. (2009) 556 U.S. 938, 947.*

# RICO & Conspiracy

- "The elements of an action for civil conspiracy are the formation and operation of the conspiracy and damage resulting to plaintiff from an act or acts done in furtherance of the common design." *Los Angeles Mem'l Coliseum Comm'n v. Insomniac, Inc. (2015) 182 Cal.Rptr.3d 888, 911*

- Example: *Connecticut Gen. Life Ins. Co. v. New Images of Beverly Hills*, 321 F.3d 878 (9th Cir. 2003), 482 F.3d 1091 (2007) -- Plaintiff insurers brought state law fraud and federal civil RICO claim. Court granted terminating sanctions against several defendants for failure to comply with court orders. Case resolved after discovery uncovered false billings and patient recruiting.

- Example: *Blue Cross-Blue Shield v. Unity Outpatient Surg. Ctr.*, 490 F.3d 718 (9th Cir. 2007), 2010 WL 5313748 (C.D. Cal. 2010) --- Plaintiffs brought state law fraud and federal civil RICO claims alleging fraudulent billing and patient recruiting. $3 million awarded on summary judgment as to one defendant.

# False Claims Act

- The **False Claims Act** (FCA) is an American federal law that imposes liability on persons and companies (typically federal contractors) who defraud governmental programs. 31 U.S.C. §§ 3729 to 3733. It is the Federal Government's primary litigation tool in combating fraud against the Government.
- The law includes a qui tam provision that allows people who are not affiliated with the government, called "relators," to file actions on behalf of the government (referred to as "whistleblowing" when the relator is employed by the organization accused in the suit). The quit am relator stands to receive a portion (15-30 percent, depending on certain factors) of any recovered damages.
- As of 2019, over 71 percent of all FCA actions were initiated by whistleblowers. FCA claims have typically involved health care, military, or other government spending programs, and dominate the list of largest pharmaceutical settlements. The government recovered more than $62 billion under the FCA between 1987 and 2019, including more than $3 billion in 2019 alone. (Per Department of Justice, January 9, 2020).
- Many states have similar, parallel FCA laws. See e.g., Cal. Govt. Code Sections 12650-12656.

# False Claims Act

The statute identifies seven types of prohibited conduct, the two most often litigated of which are:

- the false claims provision, which creates liability for knowingly presenting, or causing to be presented, a false or fraudulent claim for payment (31 U.S.C. § 3729(a)(1)(A)); and
- the false statement provision, which creates liability for knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim (31 U.S.C. § 3729(a)(1)(B))

- Includes overpayments. Even if innocently received, one you discover it you must return it.
- Remedies include mandatory treble damages (which may be reduced to double damages if the defendant self-discloses fraudulent activity), civil penalties of up to $21,563 per false claim, and attorneys' fees.
- Strong whistleblower incentives – qui tam plaintiffs receive a share of any successful recovery.
- Procedure: Relator files suit under seal. Gov't investigates. Gov't can (1) intervene and take control -- settle or prosecute, (2) decline to intervene and allow relator to prosecute, or (3) move to dismiss.
- Trending Scenario: Disgruntled employee whistleblower sues his/her employer (provider or health plan contractor). Whistleblowers often bring an FCA claim in the name of the state, plus personal retaliation and employment claims.
- Select issues and defenses: Is it a claim(?); pleading standards; materiality; implied certification; public disclosure bar; first to file rule; government consent/acquiescence.
- If a provider is submitting false claims to a private plan or insurer, query if they are also submitting them to the gov't.

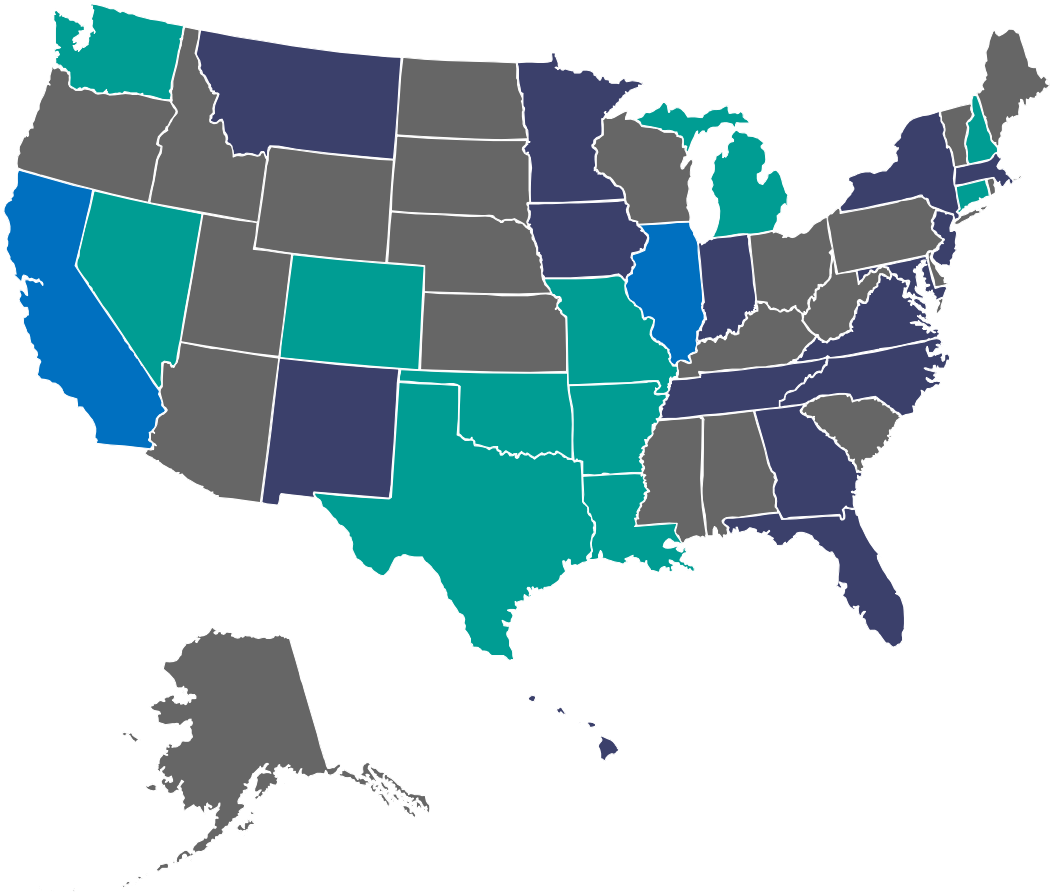
# State Whistleblower Laws

States with false claims laws that apply only to Medicaid funds

States with laws that apply to fraud in a broad range of state programs*

States with *qui tam* statutes that apply to private insurers

*- also includes CA and IL



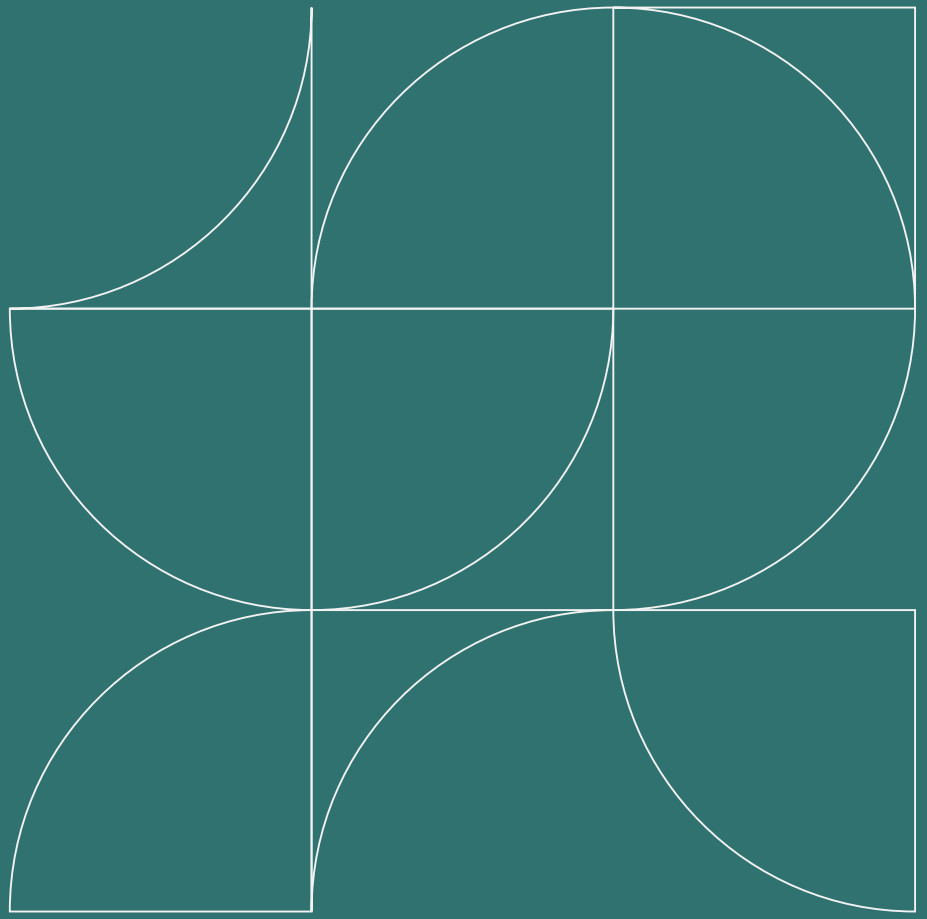
# State Whistleblower Statutes for Private Insurance

**California Insurance Frauds Prevention Act**
Ca. Ins. Code §§ 1871 *et seq.* (IFPA)

**Illinois Insurance Claims Fraud Prevention Act**
(740 ILCS 92/1 *et seq.*)

- State insurance statutes modeled after False Claims Act
- State insurance statutes provide assessments equal to **treble the billed amount**, in addition to penalties of $5-10k **per billed claim**, allowing for massive exposures and recoveries.
- Can a **self-insured ERISA Plan** bring suit under these statutes? See *People of the State of California v Amador*, No. BC672072, 2019 WL 2522198, at *2 (Cal. Super. June 6, 2019).

# Administrative Changes Related to Provider Litigation



# Administrative Best Practices to Protect Plan Payors

## Changes to Plan Terms

- Prohibit fee forgiveness
- Allow recoupment
- Denials based on fraud
- Require participant cooperation
- Allow Plan Trustees to remove eligibility from fraudulent or abusive providers/participants

## Improve Contracts with Administrators

- Acknowledge fiduciary duties
- Obligate recoupment of overpayments
- Hold administrators responsible for enforcing plan terms

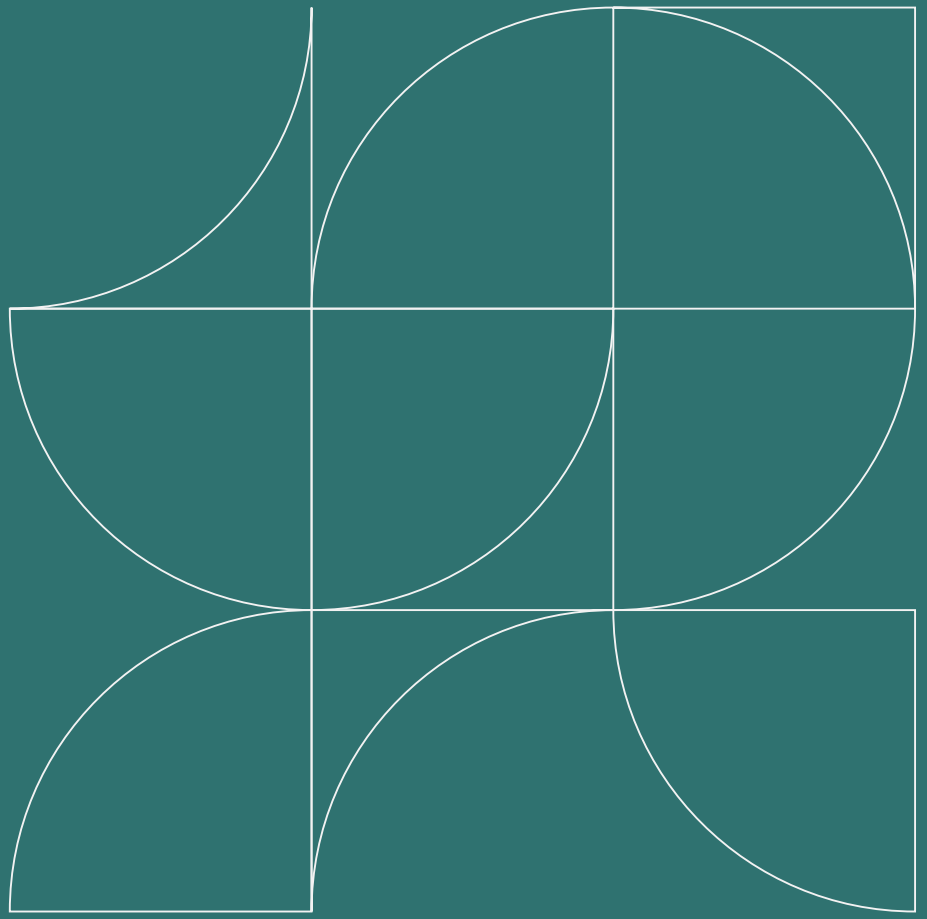
## Other Administrative Changes

- Pend claims for review pre-payment
- Institute claim edits
- Improve preauthorization process
- Kick out abusive providers and known fraudsters
- EOBs for pharmacy claims

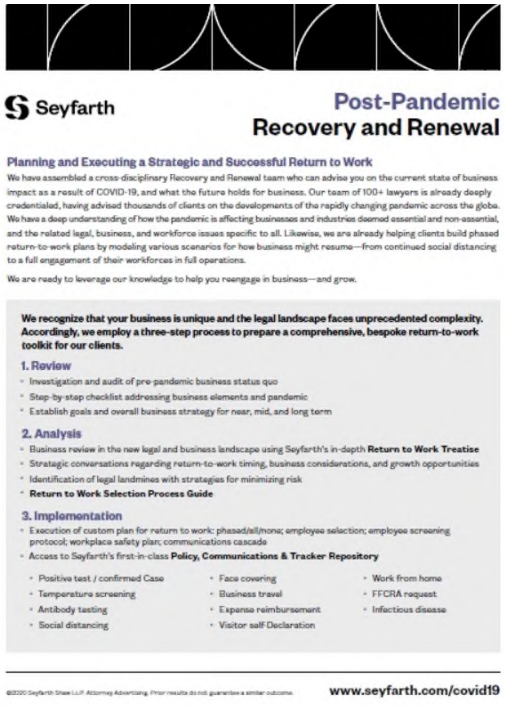
***If a provider of service or supplies fails to collect all or a portion of an applicable copayment or deductible from a Covered Person (i.e. "fee-forgiving"), resulting in a reimbursement claim that misstates the amount actually charged by the provider of service or supplies, the Administrator may deny payment for the reimbursement claim or require repayment of any amounts the Plan paid to the such provider. The Administrator also reserves the right to recover any such overpayment by appropriate legal action.***

Sample language prohibiting fee forgiveness

# Questions?



# Seyfarth's COVID-19 Resources



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Post-Pandemic
Recovery and Renewal

**Planning and Executing a Strategic and Successful Return to Work**

We have assembled a cross-disciplinary Recovery and Renewal team who can advise you on the current state of business impact as a result of COVID-19, and what the future holds for business. Our team of 100+ lawyers is already deeply credentialed, having advised thousands of clients on the developments of the rapidly changing pandemic across the globe. We have a deep understanding of how the pandemic is affecting businesses and industries deemed essential and non-essential, and the related legal, business, and workforce issues specific to all. Likewise, we are already helping clients build phased return-to-work plans by modeling various scenarios for how business might resume—from continued social distancing to a full engagement of their workforces in full operations.

We are ready to leverage our knowledge to help you reengage in business—and grow.

**We recognize that your business is unique and the legal landscape faces unprecedented complexity. Accordingly, we employ a three-step process to prepare a comprehensive, bespoke return-to-work toolkit for our clients.**

**1. Review**
- Investigation and audit of pre-pandemic business status quo
- Step-by-step checklist addressing business elements and pandemic
- Establish goals and overall business strategy for near, mid, and long term

**2. Analysis**
- Business review in the new legal and business landscape using Seyfarth's in-depth **Return to Work Treatise**
- Strategic conversations regarding return-to-work timing, business considerations, and growth opportunities
- Identification of legal landmines with strategies for minimizing risk
- **Return to Work Selection Process Guide**

**3. Implementation**
- Execution of custom plan for return to work: phased/all/none; employee selection; employee screening protocol; workplace safety plan; communications cascade
- Access to Seyfarth's first-in-class **Policy, Communications & Tracker Repository**
  - Positive test / confirmed Case
  - Temperature screening
  - Antibody testing
  - Social distancing
  - Face covering
  - Business travel
  - Expense reimbursement
  - Visitor self-Declaration
  - Work from home
  - FFCRA request
  - Infectious disease



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- **COVID-19 Resource Center**
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- **Sign Up For Latest COVID-19 Updates**
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- **Post-Pandemic Recovery & Renewal**
  https://www.seyfarth.com/services/practices/advisory/post-pandemic-recovery-and-renewal.html
- **On-Demand Webinars**
  www.youtube.com/playlist?list=PLg0AI7yn7R3cVmPQJEuTYilEffzrSgJdv

# Thank You