

OIG FRAUD AND ABUSE ACTIONS AGAINST HEALTH CARE PROVIDERS ON THE RISE

The federal government appears to be picking up steam when it comes to investigating health care providers for fraud and abuse of federal health care programs. On June 1, 2004, the Department of Health and Human Services ("HHS") Office of Inspector General ("OIG") sent to DHH and Congress its semiannual report on OIG investigations. The report reviews the activities of the office during the six month period ending March 31, 2004. The OIG reported "savings to the American taxpayers of over \$16.8 billion"; \$4 billion more than savings for the same period last year. The "savings" are comprised of: \$15.4 billion in implemented recommendations and other actions to put funds to better use; \$213 million in audit receivables; \$8.3 million in additional audit recoveries; and \$1.2 billion in investigative receivables. The OIG also reported the exclusion of 1,544 individuals and entities for fraud or abuse of the federal health care programs; 234 convictions of individuals or entities; 107 civil actions; and \$995 million negotiated in False Claims Act civil settlements related to the Medicare and Medicaid programs. The report states that the OIG "will continue to be an aggressive force" to punish those who defraud HHS programs.

Evidence of the OIG's continuing efforts to punish those who defraud federal programs is found in a recent action by the OIG against PharMerica Drug Systems, Inc. for alleged kickback violations. On June 17, 2004, the OIG sent a demand letter to PharMerica seeking civil monetary penalties and damages totaling \$21.8 million (\$200,000 in civil monetary penalties and \$21,600,000 in damages) and a ten-year

exclusion from participation in federal health care programs. This is the largest amount ever sought by the OIG in a civil monetary penalty case. The ten year exclusion would have a national effect and would prohibit payment by federal health care programs for any items or services furnished by PharMerica. The civil monetary penalty, damages, and exclusion set forth in the demand letter will become automatically effective 65 days after the date of the demand letter unless PharMerica submits a request for hearing.

The OIG alleges that PharMerica knowingly and willfully offered and paid remuneration for the purchase a small pharmacy for an excessive amount of money (\$7.2 million) to induce a commitment from the sellers (owners of 17 nursing homes and 8 assisted living facilities) to refer their Medicaid patient's pharmacy business to PharMerica for the next seven years. The OIG charges that the agreement violated the anti-kickback statute's prohibition on the payment of remuneration to induce the referral of Medicaid patients or business, 42. U.S.C. §§ 1320a-7a(a)(7) and 1320a-7b(b).

The OIG's semiannual report and demand letter to PharMerica can be reviewed on the website: www.oig.hhs.gov.

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MEDICAL REVIEW PANELS CHANGED

The Louisiana legislature recently enacted two new statutes, R.S. 40:1299.39.2 and 1299.49, which provide for a joint medical review panel in medical claims against both a state and a private health care provider.

Louisiana law previously required separate medical review panels for malpractice claims made against state and qualified health care providers. The new statutes, however, effectively change the old process as established by the Louisiana Medical Malpractice Act by providing that, when for the same injury or death of a patient, a malpractice claim alleges liability of both a state health care provider and a qualified health care provider, only one medical review panel must be convened, unless the

parties agree otherwise. The new laws further provide that the panel shall be considered a joint medical review panel, and its actions shall have the same force and effect as the separate panels under prior law. These new laws do not alter the rules or the composition of the panel and specifically provide that R.S. 40:1299.47 shall govern in the event of a procedural conflict between the provisions. These statutes became effective on June 10, 2004.



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OIG ISSUES ADVISORY OPINION ON PHYSICIAN-OWNED PHYSICAL THERAPY CENTER

The Office of Inspector General concluded that a physician group's proposal to develop and own a Physical Therapy Center and to lease the center's space, equipment and personnel to other physicians could potentially generate prohibited remuneration under the federal anti-kickback statute. Under the proposed arrangement, physicians would enter into a one-year lease and pay a monthly rental fee for unlimited use of the Center. The monthly rental fee would have been calculated by totaling the monthly rental value of all space, equipment, and administrative services

provided in the Center and dividing by the total number of lessees. The OIG commented that the overlapping, as-needed aspect of the leases makes it difficult to assess and document fair market value, which increases the risk that some physicians will pay more or less than fair market value for the space, equipment, and administrative services.

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