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The 2018 Bad Boys of Healthcare

By Chuck Dinerstein — December 27, 2018

Defrauding the federal government has a long and colorful history. The practice dates as far back as the Civil War, when companies tried to foist lame horses, sick mules and even sawdust in place of gunpowder on our troops. So it's time to cue the theme music ... for this roundup (pun absolutely intended) of this past year's notable healthcare frauds.

Courtesy of Joealfaraby [1]

> *Bad boys, bad boys*
>
> *What'cha gonna do?*
>
> *What'cha gonna do when they come for you?*

As in last year's edition, "they" are the Department of Justice and before we get to the bad boys, we should note that nearly 90% of $2.8 billion in collected fines were due to healthcare fraud, up from 66% last year. Defrauding the federal government has a long, and colorful history beginning with the Civil War and the attempt by companies to foist lame horses, sick mules and even

sawdust in place of gunpowder on our troops. But enough of those historical considerations, what are the current bad boys doing?

Upcoding

The feds pay for services based upon codes describing services and there is a lot of room to interpret the services as greater than what was provided, or to describe patients being more ill or even changing the location for delivery of care – all to someone, other than the taxpayer's advantage.

When DaVita Medical Holdings acquired HealthCare Partners, they also acquired the responsibility for the false information HealthCare Partners submitted to the federal government in upcoding the severity of beneficiaries illness to receive more substantial Medicare Advantage payments. DaVita having uncovered the fraud made a voluntary disclosure. Cost them $270 million. The Qui Tam payment (to which we will return in a few moments) to the whistle blower, $10.1 million.

Similar concerns about United Healthcare continue to be litigated

Location, location, location was the motto of Health Management Associates (HMA) which billed Medicare for unnecessary in-patient care when the same services could be provided as an out-patient or on observation status. They paid a fine of $216 million. But wait, there's more, HMA ran a second related scan.

Pay to Play

Part of Health Management Associates fraud was pressuring it's employed physicians to admit patient to the hospital, rather than to locations that provided the same service at a lower cost, as out-patient services – requiring as their corporate benchmarks that 15-20% of Emergency Department patients be admitted, the percentage rising to 50% for patients older than 65. The evidence of the corporate benchmarks checked-off the conspiracy box and added another $35million in criminal penalties to their fines.

Dr. Prem Reddy, CEO of Prime Healthcare Services ran the same scam, admitting patients for care that could have been provided in less costly settings. He paid $3.25 million, and his company paid the rest of the $65million fine.

Wm. Beaumont Hospital of Detroit made use of a technique as old as that email from an African prince that needs to store their fortune, temporarily, in your account. They disguised kickbacks to physicians for referrals by paying them far more than market value for services they purchased from the eight physicians involved and charged them far less than market value for office space and employees. Fines to the hospital totaled $84.5m and again, the case was brought to the DOJ's attention by whistleblowers. Not to be outdone, Health Management Associates, mentioned previously, made it a trifecta of fraud by running the same scam in their Florida hospitals trading free office space for referrals.

Unnecessary Services

This is really a category reserved for budding physician-entrepreneurs. Corporate malfeasance is

at a greater scale, as we will see momentarily. But certainly, these innovative businessmen deserve some mention.

Three individuals were fined $114m for paying physicians “handling fees” for blood work done at two of their laboratories and for prescribing unnecessary tests. Dr. Arthur Portnow was fined $1.95 million for unnecessary ultrasound tests which he prescribed and performed removing the middleman and in some twisted way might be considered more convenient care. A watchful employee became the whistleblower and received $350,000.

Special mention should go to two physicians whose spouses aided and abetted their enterprise. A neurosurgeon used spinal implants purchased from a company where his fiancé worked and who received a 50% commission for the sale of the implants. A pain specialist bought durable medical goods from a company “employing” his wife in a no-show job and also received kickbacks from both a compound pharmacy making a pain crème for his practice and from Insys for promoting sublingual fentanyl spray. [1]

Part of why drug prices are so high

Medicare beneficiaries are not allowed to receive help in paying their drug co-payments unless they are covered by a Medicare Advantage or a Medigap program. All of those little messages at the end of the drug commercial saying some company can help with the cost do not apply because “Congress included co-pay requirements in these programs, in part, to encourage market forces to serve as a check on health care costs, including the prices that pharmaceutical manufacturers can demand for their drugs.” Let us leave aside the question of whether this makes good policy and see how the system is gamed.

Pfizer, the second largest Big Pharma on the Forbes 500 (at position 57 behind #1 J&J) used a charitable foundation to help patients pay for drugs used to treat a kidney cancer as well as a atrial fibrillation, an abnormal heart rhythm. The foundation opened its doors and wallet on the same day the price of the atrial fibrillation drug rose 40%. Pfizer directed patients to the foundation giving them grants of aid to pay those co-payments or in the words of the DOJ “masking charitable contributions to increase company profits.” They were fined 23.85 million.

United Therapeutics makes a drug to treat pulmonary hypertension a disease that affects 1-2 patients/1 million people (heart disease would affect about 250,000/million). Using a “purportedly independent charitable foundation” Medicare beneficiaries were given grants to cover their co-payments. DOJ found that United Therapeutics colluded with the charity looking at the amount the charity was given to patients and adjusting their donations accordingly. Their fine was $210 million. Makes you wonder how much they made to cover that settlement.

Who’s responsible?

Alere sells a medical device used in the Emergency Department to quickly identify patients with heart attacks, heart failure, drug overdoses using a simple blood test. Unfortunately, the device did not work as well as advertised, and there were multiple complaints about false positive and false negative results. Despite receiving complaints for six years, they failed to act, and in 2012 the FDA began its investigation. Allere’s fine was $33.2m and the senior quality control analyst that blew

the whistle received $5.6 million. You have to ask two questions here, what took so long from 2012 to 2018 to resolve this case; and, what about all those complaints by physicians about errors in the electronic health record systems we purchase? When will there be an accounting?

The number 1 bad boy of 2018

Strictly by the numbers, the fine of $581 million paid by Amerisource Bergen Corporation (ABC), a drug wholesaler is the winner. Multidose and single-dose vials of injectable drugs come with a bit of overfill, to make sure that enough of the drug is available. ABC took advantage of that fact to pool vials and create more doses from the overfill. These injectables, used as supportive medications in treating cancer, were then repackaged and sold as single dose pre-filled syringes, presumably as a convenience for physicians. The repackaging was done by a subsidiary "pharmacy;" unfortunately this was not a registered pharmacy and all the necessary safety, stability, and sterility data required was never submitted. This fine represented only the civil penalties, the criminal penalties ran to another $260 million.

Qui tam pro domino rege quam pro se ipso in hac parte sequitur

The Latin phrase refers to he who sues for himself and the king, the whistle blowers. Most often these are insiders who have developed a concern about what is taking place around them. DOJ continues to receive these concerns at about 12 a week and the evidence provided by these whistleblowers represent 75% of the fines collected, roughly $2.1 billion. They received approximately $301 million for that information. When you consider it as return on investment, it is nearly a 10-fold return for every dollar paid to these whistleblowers. Most of us would be ecstatic with a 15% return, getting $115 for every $100 invested, this is by any measure a great return.

[1] In breaking news, a Christmas buzzkill moment, Michael Babich, Insys's former CEO pleaded guilty to conspiracy and mail fraud on bribery charges in connection with these kickbacks.

Source: Justice Department Recovers over $2.8 Billion From False Claims Act Cases in Fiscal Year 2018 [2]

Links
[1] https://pixabay.com/en/thief-burglar-cartoon-criminal-3600349/
[2] https://www.justice.gov/opa/pr/justice-department-recovers-over-28-billion-false-claims-act-cases-fiscal-year-2018