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Fraud and Abuse in Private Payor Situations

Insight — March 12, 2020

Healthcare attorneys and their clients are generally aware of and take appropriate steps to avoid the severe penalties that may follow fraud and abuse of government payor programs such as Medicare and Medicaid. They may be less attuned to their potential liability in private payor situations and, consequently, more cavalier when considering mistakes, misconduct, and potential repayments to private payors, including patients, residents, insurers, or other third parties. Red flag situations may include, *e.g.*, waiving copays or deductibles; providing patient or resident discounts or other inducements to receive services, especially for out-of-network patients; kickbacks or similar arrangements to induce referrals; billing and coding errors; false claims; billing for medically unnecessary services; billing for services that were provided by unlicensed or uncredentialed providers or misrepresenting the provider of services; failing to comply with coordination of benefits or secondary payor rules; double payments; claims that lack sufficient documentation; or claims for substandard care. Whether due to business concerns or regulatory mandates, private payors seem to be increasingly active in monitoring and responding to potential provider fraud or abuse. This memo will summarize some of the statutory, contractual, and common law bases for private payor enforcement.

I. Federal Statutes and Regulations.

A. False Claims Act, 42 U.S.C. § 3729. The federal False Claims Act ("FCA") generally prohibits "knowingly present[ing], or caus[ing] to be presented, a false of fraudulent claim for payment or approval" to the federal government. (42 U.S.C. § 3729(a)(1)). In the wake of the Affordable Care Act, entities that have received an overpayment from the government must affirmatively report and repay the overpayment within 60 days or face FCA penalties. (42 U.S.C. § 1320a-7k(d)). The federal FCA generally does not apply to payments by private payors, but may be relevant to private payor situations in at least three contexts:

1. *Qui Tam* Litigation. The FCA authorizes private parties to assert private *qui tam* actions on behalf of the government. Providers usually participate in federal programs as well as private payor arrangements. Private payors or beneficiaries who become aware of provider fraud and abuse involving federal programs may bring FCA *qui tam* actions along with or as an alternative to any claims they may have for fraud or other misconduct against their private interests. (*Cf. Allstate Ins. Co. v. Dahan*, 207 Cal. Rptr. 3d 569 (Cal. App. 2016) (insurer brought state law whistleblower against imaging company based on allegedly

fraudulent billing).

2. Risks in "Carve Out" Situations. Providers may try to circumvent FCA liability by limiting kickback, self-referral or similar arrangements to private pay payor situations. However, the OIG has warned that such "carve out" programs may not insulate providers from liability:

> The OIG has a long-standing concern about arrangements under which parties "carve out" Federal health care program beneficiaries or business generated by Federal health care programs from otherwise questionable financial arrangements. Such arrangements implicate, and may violate, the anti-kickback statute by disguising remuneration for Federal health care program business through the payment of amounts purportedly related to non-Federal health care program business.

(OIG Advisory Opinion No. 12-06 at p.6-7). In other words, remuneration paid to induce private pay referrals may also, intentionally or unintentionally, induce referrals for items or services payable by federal healthcare programs and, hence, violate federal fraud and abuse laws and trigger FCA liability.

3. Repayments to Private Parties. Providers who are obligated to repay overpayments to federal government programs under the FCA or otherwise should carefully consider whether they have a corresponding duty to repay related amounts received from private parties, including copays from government program beneficiaries or payments from secondary payors. By its express terms, the FCA's "report and repay" rule would only appear expressly to require repayments "to the Secretary, the State, an intermediary, a carrier, or a contractor…." (42 U.S.C. § 1320a-7k(d)(1)(A)). There does not appear to be anything in the report and repay regulations or associated HHS commentary that expressly requires the return of private payments associated with a government overpayment. (*See* 81 F.R. 7654). Nevertheless, some commentators have suggested that such payments may be appropriate if not required. (*See, e.g., R. Homchick, Overpayment Self-Disclosure: Should You Open Your Kimono?*, AHLA In-House Counsel Meeting (6/27/11), citing HCFA Prog. Mem. HDFA-Pub. 60AB No. AB-99-33 (June 1, 1991), *Tracking and Reporting Procedures for Unsolicited/Voluntary Refund Checks from Providers/Suppliers—Interim Instructions*). That would appear to be a fair conclusion, especially when government beneficiaries suffer losses as a result of claims that should not have been billed, *e.g.*, through a patient's or resident's copayments associated with the claim (which payments really are not "**co**-payments" if the government is repaid or otherwise not responsible for any payment because of provider misconduct).

Even if not expressly required by the federal FCA, other laws may expressly or by implication impose an affirmative obligation to repay patients, residents, or private payors for overpayments or amounts received in violation of applicable laws or payor requirements. (*See,*

e.g., T. Crane, *Self-Disclosure of Overpayments and Violations of Healthcare Laws: An Analysis of Applicable Laws and Strategies of Whether, When, How, and How Much to Self-Disclose*, J Health & Life Sci. L. (1/08) at p.63-64). For example, the Ethics in Patient Referrals Act ("Stark") states:

> An entity that furnishes DHS pursuant to a referral that is prohibited … may not present or cause to be presented a claim or bill to the Medicare program **or to any individual, third party payer, or other entity for the DHS performed pursuant to the prohibited referral.**

(42 C.F.R. § 411.353(b), emphasis added). Furthermore,

> An entity that collects payment for a designated health service that was performed pursuant to a prohibited referral **must refund all collected amounts** on a timely basis…

(*Id.* at 411.353(d)). By its express terms, Stark would appear to require the return of copayments or other amounts paid by private as well as government payors.

Repayment may also be—and likely is—required by other state laws, regulations, common law principles, or contractual obligations discussed below. In its Compliance Program Guidance for Third-Party Medical Billing Companies, the OIG recognized providers' affirmative obligation to address overpayments by private payors as well as government programs:

> The statutes, regulations and guidelines of the Federal and State health insurance programs, **as well as the policies and procedures of the private health plans**, should be integrated into every billing company's compliance program.

(63 F.R. 70152, emphasis added).

> Credit balances occur when payments, allowances or charge reversals posted to an account exceed the charges to the account. **Providers and their billers should establish policies and procedures, as well as responsibility, for timely and appropriate identification and resolution of these overpayments.** For example, … [t]he billing company could remove these accounts from the active accounts and place them in a holding account pending the **processing of a reimbursement claim to the appropriate payor…**.
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> …
>
> The billing company should also refer to State escheat laws for the specific requirements relating to notifications, time periods and payment of any unclaimed funds.

(*Id.* at 70144-45, emphasis added).

B. Medicare Conditions for Participation, *e.g.*, 42 C.F.R. part 483. Federal Medicare conditions for participation and parallel state licensing or payor program requirements may be read to require providers to not only avoid but remedy fraud and abuse situations, including making appropriate repayments to program beneficiaries. For example, Medicare nursing facility regulations confirm, among other things, the facility's obligation to safeguard, account for, and refund patient funds. (42 C.F.R. § 482.10(f)(10); *see also id*. at § 483.10(g)(13), (17)-(18)). Facilities must also protect residents from exploitation and the misappropriation of resident property. (*Id.* at § 483.12).

> *Exploitation* means taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion.
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> …
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> *Misappropriation* of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.

(*Id.* at § 483.5). Among other things, "[m]onies due residents should be credited to their respective bank accounts within a few business days." (CMS, State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities at Tag F567). Surveyors might easily apply those requirements to situations in which the facility engaged in fraudulent actions, mischarged the resident, and/or failed to return amounts fairly due the resident.

C. Federal Criminal Health Care Offenses. Federal law includes a number of specific health care criminal offenses, many if not all of which apply to private as well as government payment programs:

> (a) … [T]he term "Federal health care offense" means a violation of, or a criminal conspiracy to violate—
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> > (1) section 669, 1035, 1347, or 1518 of this title…; or
> >
> > (2) section 287, 371, 664, 666, 1001, 1027, 1341, 1343, 1349, or 1954 of this title section 301 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 331), or section 501 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131), or section 411, 518, or 511 of the Employee Retirement Income Security Act of 1974, if the violation or conspiracy relates to a health care benefit program.
>
> (b) As used in this title, the term "health care benefit program" means any public **or private plan or contract**, affecting commerce, under which **any medical benefit, item, or service is provided to any individual**, and includes any individual or entity who is providing a medical benefit, item, or service for

which payment may be made under the plan or contract."

(18 U.S.C. § 24, emphasis added). For purposes of this memo, the following would appear to be the most relevant:

1. Health Care Fraud, § 18 U.S.C. 1347. Section 1347 states:

(a) Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice-

(1) to defraud any health care benefit program; or

(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program, in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 10 years, or both….

(b) With respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section.

(18 U.S.C. § 1347). The OIG warns that "this law applies not only to Federal health care programs, but to most other types of health care benefit programs as well." (65 F.R. 59448). The OIG has offered the following examples of § 1347 violations:

1. Dr. X, a chiropractor, intentionally billed Medicare for physical therapy and chiropractic treatments that he never actually rendered for the purpose of fraudulently obtaining Medicare payments.

2. Dr. X, a psychiatrist, billed Medicare, Medicaid, TRICARE, **and private insurers** for psychiatric services that were provided by his nurses rather than himself.

(*Id.*, emphasis added). Many § 1347 cases have been brought based on fraudulent actions toward private payors. (*See, e.g.*, *United States ex rel. Kristi Moore v. East Tennessee Health Consultants*, No. 3:03-CV-577 (E.D. Tenn. 2007) (failure to return overpayments to public and private payors); *United States v. Baldwin*, 277 F.Supp.2d 67 (D.D.C. 2003) (submitting false invoices to a private plan). As explained below, § 1347 violations may also serve as a basis for asserting state unfair trade practices claims.

2. False Statements Relating to Health Care Matters, 18 U.S.C. § 1035. Section 1035 states:

Whoever, in any matter involving a health care benefit program, knowingly and willfully—

(1) falsifies, conceals, or covers up by any trick, scheme, or

> device a material fact; or
>
> (2) makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry,
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> in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 5 years, or both.

(18 U.S.C. § 1035). Again, "this law applies not only to Federal health care programs, but to most other types of health care benefit programs as well." (65 F.R. 59448). The OIG gave the following example:

> Dr. X certified on a claim form that he performed laser surgery on a Medicare beneficiary when he knew that the surgery was not actually performed on the patient.

(*Id.*). It could also apply to false or fraudulent claims submitted by long term care providers.

> **3. Mail and Wire Fraud, 18 U.S.C. §§ 1341 and 1343**. Section 1341 states: Whoever, having devised or intending to devise any scheme or artifice to defraud, or for obtaining money or property by means of false or fraudulent pretenses, representations, or promises, … for the purpose of executing such scheme or artifice or attempting so to do, places in any post office or authorized depository for mail matter, any matter or thing whatever to be sent or delivered by the Postal Service, or deposits or causes to be deposited any matter or thing whatever to be sent or delivered by any private or commercial interstate carrier, or takes or receives therefrom, any such matter or thing, or knowingly causes to be delivered by mail or such carrier according to the direction thereon, or at the place at which it is directed to be delivered by the person to whom it is addressed, any such matter or thing, shall be fined under this title or imprisoned not more than 20 years, or both….

(18 U.S.C. § 1341). Section 1343 states:

> Whoever, having devised or intending to devise any scheme or artifice to defraud, or for obtaining money or property by means of false or fraudulent pretenses, representations, or promises, transmits or causes to be transmitted by means of wire, radio, or television communication in interstate or foreign commerce, any writings, signs, signals, pictures, or sounds for the purpose of executing such scheme or artifice, shall be fined under this title or imprisoned not more than 20 years, or both…

(*Id.* at § 1343). Taken together, the statutes prohibit:

> Use [of] the mail, private courier, or wire service to conduct a scheme to defraud another of money or property. The term "wire services" includes the use of a telephone, fax machine or computer. Each use of a mail or wire service to further fraudulent activities is considered a separate crime. For instance, each fraudulent claim that is submitted electronically to a carrier would be considered a separate violation of the law.

(65 F.R. 59449). The OIG gives the following examples:

> 1. Dr. X knowingly and repeatedly submits electronic claims to the Medicare carrier for office visits that he did not actually provide to Medicare beneficiaries with the intent to obtain payments from Medicare for services he never performed.
>
> 2. Dr. X, a neurologist, knowingly submitted claims for tests that were not reasonable and necessary and intentionally upcoded office visits and electromyograms to Medicare.

(*Id.*). Although the examples refer to Medicare, 18 U.S.C. § 24 confirms that the statutes also apply to actions involving private "health care benefit programs." Accordingly, insurers have asserted mail/wire fraud as a way to support civil RICO claims. (*See, e.g.*, *UnitedHealthcare Serv., Inc. v. Next Health, LLC*, No. 3:17-CV-00243-E-BT (N.D. Tex. 2020)).

> **4. Theft or Embezzlement in Connection with Health Care, 18 U.S.C. § 669.** Section 669 states:
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> > Whoever knowingly and willfully embezzles, steals, or otherwise without authority converts to the use of any person other than the rightful owner, or intentionally misapplies any of the moneys, funds, securities, premiums, credits, property, or other assets of a health care benefit program, shall be fined under this title or imprisoned not more than 10 years, or both; but if the value of such property does not exceed the sum of $100 the defendant shall be fined under this title or imprisoned not more than one year, or both.

(18 U.S.C. § 669). Again, "this law applies not only to Federal health care programs, but to most other types of health care benefit programs as well." (65 F.R. 59448). The OIG offered the following example:

> > An office manager for Dr. X knowingly embezzles money from the bank account for Dr. X's practice. The bank account includes reimbursement received from the Medicare program; thus, intentional embezzlement of funds from this account is a violation of the law.

(*Id.*). However, the statute might conceivably extend to other situations in which a provider improperly obtains or retains amounts from a

private payor to which the provider is not entitled.

5. Eliminating Kickbacks in Recovery Act ("EKRA"), 18 U.S.C. 220. Congress passed EKRA in the midst of and in response to the opioid crisis. Although patterned after the federal anti-kickback statute ("AKS"), it is broader than the AKS in that it extends to items or services payable by private payors as well as federal programs:

> [W]hoever, with respect to services covered by a health care benefit program, in or affecting interstate or foreign commerce, knowingly and willfully-
>
> (1) solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, in return for referring a patient or patronage to a recovery home, clinical treatment facility, or laboratory; or
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> (2) pays or offers any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind-
>
> > (A) to induce a referral of an individual to a recovery home, clinical treatment facility, or laboratory; or
> >
> > (B) in exchange for an individual using the services of that recovery home, clinical treatment facility, or laboratory,
>
> shall be fined not more than $200,000, imprisoned not more than 10 years, or both, for each occurrence.

(18 U.S.C. § 220(a)). Unlike the AKS, EKRA only applies to referrals to a recovery home, clinical treatment facility, or laboratory.

> (2) the term "clinical treatment facility" means a medical setting, other than a hospital, that provides detoxification, risk reduction, outpatient treatment and care, residential treatment, or rehabilitation for substance use, pursuant to licensure or certification under State law;
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> …
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> (4) the term "laboratory" has the meaning given the term in section 353 of the Public Health Service Act (42 U.S.C. 263a) [i.e., "a facility for the biological, microbiological, serological, chemical, immuno-hematological, hematological, biophysical, cytological, pathological, or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human

beings"]; and

(5) the term "recovery home" means a shared living environment that is, or purports to be, free from alcohol and illicit drug use and centered on peer support and connection to services that promote sustained recovery from substance use disorders.

(*Id.* at § 220(e)). The statute excepts the following remunerative relationships:

(1) a discount or other reduction in price obtained by a provider of services or other entity under a health care benefit program if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity;

(2) a payment made by an employer to an employee or independent contractor (who has a bona fide employment or contractual relationship with such employer) for employment, if the employee's payment is not determined by or does not vary by-

(A) the number of individuals referred to a particular recovery home, clinical treatment facility, or laboratory;

(B) the number of tests or procedures performed; or

(C) the amount billed to or received from, in part or in whole, the health care benefit program from the individuals referred to a particular recovery home, clinical treatment facility, or laboratory;

(3) a discount in the price of an applicable drug of a manufacturer that is furnished to an applicable beneficiary under the Medicare coverage gap discount program under [42 U.S.C. § 1395w–114a(g)];

(4) a payment made by a principal to an agent as compensation for the services of the agent under a personal services and management contract that meets the requirements of [the AKS safe harbor, 42 C.F.R. § 1001.952(d)];

(5) a waiver or discount [as defined in the AKS safe harbor, 42 C.F.R. § 1001.952(h)(5)] of any coinsurance or copayment by a health care benefit program if-

(A) the waiver or discount is not routinely provided; and

(B) the waiver or discount is provided in good faith;

(6) a remuneration described in [42 U.S.C. § 1320a–

> 7b(b)(3)(I)];
>
> (7) a remuneration made pursuant to an alternative payment model (as defined in section 1833(z)(3)(C) of the Social Security Act) or pursuant to a payment arrangement used by a State, health insurance issuer, or group health plan if the Secretary of Health and Human Services has determined that such arrangement is necessary for care coordination or value-based care; or
>
> (8) any other payment, remuneration, discount, or reduction as determined by the Attorney General, in consultation with the Secretary of Health and Human Services, by regulation.

(18 U.S.C. § 220(b)). We are still waiting on the regulations to clarify and/or expand the EKRA exceptions.

D. Travel Act, 18 U.S.C. § 1952. Recently, there seems to have been an upswing in the use of the federal Travel Act to prosecute fraud and abuse involving private payor programs. The Travel Act essentially makes it a federal crime to violate specified state crimes, including state bribery laws. Section 1952 states, in relevant part:

> Whoever travels in interstate or foreign commerce or uses the mail or any facility in interstate or foreign commerce, with intent to—
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> (1) distribute the proceeds of any unlawful activity; or
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> …
>
> (3) otherwise promote, manage, establish, carry on, or facilitate the promotion, management, establishment, or carrying on, of any unlawful activity,
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> and thereafter performs or attempts to perform—
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> (A) an act described in paragraph (1) or (3) shall be fined under this title, imprisoned not more than 5 years, or both…

(18 U.S.C. § 1952(a)). "Unlawful activity" means, among other things, "bribery … in violation of the laws of the State in which committed or of the United States." (*Id.* at § 1952(b)). State commercial bribery laws may, *e.g.*, prohibit offering or receiving anything of value without the knowledge of the employer in return for inappropriately using the employee's influence to benefit the person offering the bribe. (*See, e.g.*, Cal. Penal Code § 641.3; Del. Code Title 11, § 881; Mass. Gen. Laws Title I, Ch. 271, § 39(a); N.J. Stat. Ann. § 2C:21-10; and Tex. Penal Code Ann. § 32.43). Thus, the Travel Act "federalizes" state bribery laws, thereby allowing federal prosecutors to prosecute providers for giving or receiving kickbacks or entering similar arrangements to induce private pay business in violation of state

bribery laws even though such conduct would not violate the federal AKS because no federal programs are involved. (*See, e.g.*, *United States v. Beauchamp*, No. 3:16-CR-00516 (N.D. Tex. 2019) (Travel Act prosecutions based on alleged kickbacks paid to providers to refer lucrative cases to out-of-network hospital); *United States v. Biodiagnostic Lab. Serv.*, 16-CR-304 (D. N.J. 2016) (Travel Act prosecutions based on New Jersey bribery statutes arising from payments to physicians); *United States v. Canedo*, No. 8:15-CR-00077 (C.D. Cal. 2015) (Travel Act prosecutions based on California bribery statutes arising from payments to physicians).

E. Other Federal Statutes. Other federal statutes may be relevant depending on the circumstances. For example, insurers have sometimes alleged violations of the Racketeer Influenced and Corrupt Organizations Act ("RICO") as part of a civil lawsuit to recover damages. (*See, e.g.*, Next Health; Aetna Inc. v. The People's Choice Hosp., LLC, No. 5:18-cv-00323 (W.D. Tex. 2018). Also, actions involving employee benefit plans may raise issues under the Employee Retirement Income Security Act ("ERISA").

II. Common State Statutes. State statutes are often more important than federal statutes in addressing fraud and abuse in private payor situations. State statutes vary broadly so providers and payors must confirm the laws applicable in their relevant jurisdictions, but the following are some of the more common statutes that should be considered:

A. Insurance Fraud / False Healthcare Claims. In addition to state law equivalents of the federal FCA, most—but not all—states have statutes that prohibit insurance fraud and/or submitting false or fraudulent information in support of healthcare benefits, including claims submitted to private payor programs. (*See, e.g.*, Ariz. Rev. Stat. § 20-463(A); Cal. Penal Code § 550; Colo. Rev. Stat. § 10-1-128; Fla. Stat. § 817.234; Mass. Gen. Laws ch. 12, §§ 5A-5O; Or. Rev. Stat. § 165.690 to -.698; Wash. Rev. Code § 48.80.030). The remedies vary widely, and may include civil, criminal and/or administrative penalties; restitution (*see, e.g.*, Cal. Penal Code § 550; Idaho Code § 41-293); a private cause of action (*see, e.g.*, Conn. Gen. Stat. § 53-44; 18 Pa. Cons. Stat. § 4117); and even *qui tam* litigation. (*See* Cal. Ins. Code § 1871.7). Such statutes are a common basis for fraud and abuse claims against providers. (*See, e.g.*, *UnitedHealthcare of Florida, Inc. v. American Renal Associates Holdings, Inc.*, No. 9:16-CV-81180-KAM (S.D. Fla. 2016) (program whereby provider arranged for third party to pay patient's premiums, copays and deductibles allegedly violated Florida's insurance fraud statute).

B. Repayment. Some state statutes may require providers and others to repay amounts received improperly from insurance companies. (*See, e.g.*, Cal. Govt Code § 12651(a)(8); D.C. Code § 2-308.14(a)(8); Mass. Gen. Laws ch. 175H, § 2(4); Nev. Rev. Stat. § 357.040(1)(h)).

C. Recoupment. Many states expressly allow insurance companies to recoup or offset overpayments or other improper payments made to

payors. (*See, e.g.*, Ariz. Rev. Stat. § 20-3012; Cal. Ins. Code § 10133.66; Col. Rev. Stat. § 10-16-106.5; Fla. Stat. § 627.6131; N.J. Stat. C.17B:30-48; N.C. Stat. § 58-3-225; Ohio Rev. Code § 3901.38.8; S.C. Code § 38-94-40; Tex. Ins. Code § 1301.1051; Utah Code § 31A-26-301.6). The statutes often have limitations or conditions associated with the recoupment, including time limits ranging from six months to two years; notice requirements; and appeal processes. (*See, e.g.*, Cal. Ins. Code § 10133.66; D.C. Code § 31-3133; Fla. Stat. § 627.6131; Ohio Rev. Code § 3901.388).

D. Anti-Kickback Statutes. States often have anti-kickback statutes that generally prohibit remuneration to induce referrals payable by health insurance programs. Like the federal AKS, most states limit the statute to referrals for items or services covered by Medicaid or other government programs, but a few extend the statutes to items or services payable by private payors. (*See, e.g.*, Cal. Bus. & Prof. Code § 650; Cal. Health & Safety Code § 445; Cal. Ins. Code § 754; Fla. Stat. § 456.054; Idaho Code § 41-348; Mass. Gen. Laws ch. 175H, § 3; Nev. Rev. Stat. § 493B.420; Tex. Occ. Code Ch. 102). Violations usually result in criminal, civil or administrative fines and penalties. For example, Arizona law authorizes the suspension or revocation of any nursing facility administrator's license if they solicit or procure, directly or indirectly, nursing home patronage. (Ariz. Rev. Stat. § 36-446.07). Insurers have sued providers to recover funds based on violations of the state anti-kickback statutes. (*See, e.g.*, *American Renal Associates* (program whereby provider allegedly arranged for third party to pay patient's premiums, copays and deductibles)).

E. Fee-Splitting / Patient Brokering Statutes. State licensing acts, regulations or other statutes often prohibit physicians and other licensed providers from splitting fees, giving rebates, using “runners”, “cappers”, or “steerers”, or otherwise offering inducements for referrals. (*See, e.g.*, Cal. Bus. & Prof. Code § 2273; Colo. Rev. Stat. § 12-36-125 to -127; Fla. Stat. § 817.505; Idaho Code § 54-1814; Tex. Hum. Res. Code Ch. 32; Wash. Rev. Code § 18.130.180). Violations usually result in adverse licensure actions and corresponding administrative penalties. Recent cases alleging violations of state fee-splitting or similar statutes include *American Renal Associates Holdings* and *Aetna Life Ins. Co. v. Bay Area Surgical Mgmnt, LLC*, No. 1-12-CV-217943 (Cal. Super. 2016) (insurer alleged kickbacks in the form of favorable investment terms, bonuses, and other illegal remuneration).

F. Self-Referral (“Mini-Stark”) Laws. Some states have self-referral laws that mirror or parallel the federal Stark law. (*See, e.g.*, Colo. Rev. Stat. § 25.5-4-414). Again, the limitations vary: some essentially incorporate Stark and its exceptions; others apply to certain types of providers, services, or payor programs. (*See, e.g.*, Cal. Bus. & Prof. Code § 650.01). Some statutes simply require disclosure of the relationship rather than prohibiting referrals.

G. Consumer Protection / Unfair Trade Practices / Unfair Competition. Most if not all states have consumer protection or unfair trade practices statutes that generally prohibit unlawful, unfair,

fraudulent or deceptive trade practices. (*See, e.g.*, Cal. Bus. & Prof. Code § 17000 et seq.; Conn. Gen. Stat. § 42-110b; Fla. Stat. § 501.201; Mass. Gen. Laws ch. 93A §§ 2, 9 and 11; Nev. Rev. Stat. § 598.0923). In some states, the violation of other state or federal statutes may provide a basis for asserting unfair trade practices claims. (*See, e.g.*, *Almont Ambulatory Surgical Center, LLC v. UnitedHealth Group, Inc.*, 121 F. Supp. 3d 950, 975 (C.D. Cal. 2015)). Violations typically result in statutory penalties, a private cause of action for damages, and potential punitive damages. (*See, e.g.*, Conn. Gen. Stat. § 42-110b)). Recent cases asserting unfair trade practices claims include *American Renal Associates Holdings* (alleged payments patients to induce referrals); *United Healthcare v. Sky Toxicology, Ltd.*, No. 9:16-cv-80649-RLR (S.D. Fla. 2016) (alleged kickbacks, artificial increase in tests, and routine waivers of coinsurance); *Almont* (allegations based on waiving copays and promises of "insurance only" billing; allegedly false claims, violation of California corporate practice of medicine, and improper incentives to physicians for patient referrals).

H. Commercial Bribery. As discussed above, some states have commercial bribery statutes that may apply to kickback situations involving private payors. And, as discussed above, such statutes may also provide a basis for federal prosecutors to pursue federal Travel Act claims. (*See, e.g.*, Beauchamp (Travel Act prosecutions based on alleged kickbacks paid to providers to refer lucrative cases to out-of-network hospital); Biodiagnostic Lab (Travel Act prosecutions based on New Jersey bribery statutes arising from payments to physicians); United States v. Canedo, No. 8:15-CR-00077 (C.D. Cal. 2015) (Travel Act prosecutions based on California bribery statutes arising from payments to physicians)).

I. State Licensure Laws. As discussed above, state facility licensure laws or regulations likely impose obligations on facilities to avoid or respond to suspected fraud or abuse, which may include failing to repay amounts owed to a patient or resident. Providers and facilities should at least consider whether any compliance lapse might subject them to adverse action under the licensing regulations, including but not limited to the failure to conduct criminal background checks or otherwise credential providers and staff; billing for facilities or staff that are not properly licensed or credentialed; misuse, exploitation or misappropriation of patient resources (which may include the return of overpayments); failing to comply with admission agreements; or failing to provide quality care and/or billing for inadequate or unnecessary care.

J. Unclaimed Property / Escheat Laws. Most if not all states have laws that require entities to transfer unclaimed property or accounts to the state within a certain period of time. Providers should be aware of and comply with those statutes; they may not simply retain money to which they are not otherwise entitled.

III. Common Law Theories. In addition to or in the absence of statutory remedies, private payors may be able to address fraud and abuse

concerns through common law theories, including but not limited to the following:

A. Breach of Contract. Instead of depending on a patchwork of state and federal laws, most insurers and other commercial payors typically address fraud and abuse issues in the payor contract, including the obligation to submit timely and accurate claims, repay overpayments, require copayments and deductibles, and allow the payor to recoup or offset amounts improperly paid. (*See, e.g.*, *Blue Cross & Blue Shield of Mississippi v. Sharkey-Issaquena Comm. Hosp.*, No. 3:17-CV-00338-DPJ-FKB (S.D. Miss. 2017) (suit based on alleged breach of payment terms)).

B. Using Statutes to Avoid Contract Obligations. Even if a statute does not provide a private cause of action, parties may use the statute as a way to void the contract or avoid contractual obligations if performance would violate the contract or contravene the public policy established by the statute. (*See, e.g.*, *Medical Devel. Network, Inc. v. Prof. Respiratory Care/Home Med. Equip. Serv., Inc.*, 673 So. 2d 565 (Fla. Dist. Ct. App. 1996) (percentage-based compensation formula to marketer violated anti-kickback statute and was, therefore, unenforceable); *Miller v. Haller*, 924 P.2d 607 (Idaho 1996) (agreement requiring referrals was unenforceable because it violated the anti-kickback statute).

C. Unjust Enrichment. The elements for an unjust enrichment claim usually include: (1) the plaintiff provided the defendant with something of value while expecting compensation in return; (2) the defendant accepted and benefited from whatever the plaintiff provided; and (3) it would be inequitable or unconscionable for the defendant to enjoy the benefit of the plaintiff's actions without paying for it. Recent cases in which insurers alleged unjust enrichment include *Next Health* (alleged kickbacks, improper use of standard test protocols, and billing for unnecessary tests); *The People's Choice Hosp.* (hospital allegedly billed for services performed by outside labs); *RightCHOICE Managed Care, Inc. v. Hosp. Partners, Inc.*, No. 5:18-CV-06037-DGK (W.D. Mo. 2018) (hospital allegedly billed for services performed by outside labs); *Sharkey-Issaquena* (alleged payment for claims contrary to contract terms); *Sky Toxicology* (alleged kickbacks, artificial increase in tests, and routine waivers of coinsurance); *American Renal Associates* (alleged arrangement to pay patients' expenses); *Aetna Life Ins. Co. v. Bay Area Surgical Mgmt, LLC*, 2016 Cal. Super. LEXIS 145 (Cal. App. Dep't Super. Ct.) (alleged out-of-network billing and kickbacks).

D. Restitution / Money Had and Received. Insurers may seek to recover money paid to providers under the theory of restitution or money had and received. “A case for money had and received looks solely to whether the defendant holds money that belongs to the plaintiff.” (*Aetna Life Ins. Co. v. Humble Surgical Hosp*., LLC, 2016 WL 7496743 at *2 (S.D. Tex. 2016). Cases asserting such theories include *Humble* (providers received payments in violation of the law and contract terms); *RightCHOICE* (hospital allegedly billed for services performed by outside labs); *Sky Toxicology* (alleged kickbacks,

artificial increase in tests, and routine waivers of coinsurance); and *Next Health* (alleged kickbacks, improper use of standard test protocols, and billing for unnecessary tests).

E. Common Law Fraud / Misrepresentation. Common law fraud generally requires (1) a misrepresentation (*e.g.*, false representation, concealment or nondisclosure); (2) knowledge of falsity; (3) intent to defraud or induce reliance; (4) justifiable reliance; and (5) resulting damage. (*Almont*, 121 F. Supp. 3d at 971). Recent cases by insurers alleging common law fraud include *Almont* (alleged misrepresentations arising from undisclosed patient inducements, inflated costs, and claims for services that were not performed); *Next Health* (alleged misrepresentations re claims); *Sharkey-Issaquena* (alleged misrepresentations concerning provider of services); *American Renal Associates* (alleged arrangement to pay patients' expenses); *Sky Toxicology* (alleged kickbacks, artificial increase in tests, and routine waivers of coinsurance); *Bay Area Surgical Mgmt* (alleged waiver of copays and submission of false claims); *Connecticut Gen. Life Ins. Co. v. True View Surgery Center One*, 128 F. Supp.3d 501 (D. Conn. 2015) (asserting common law fraud claims based on alleged fee-forgiving practices).

F. Negligent Misrepresentation. The elements of a negligent misrepresentation claim are generally (1) a party make a representation in the course of business or in a transaction in which it has a pecuniary interest; (2) the representation supplies false information for the guidance of others in their business; and (3) the party making the representation did not exercise reasonable care or competence in obtaining or communicating the information. (*Humble Surg. Hosp.* 2016 U.S. Dist. Lexis 71127 at *49). Relevant cases asserting negligent misrepresentation include *Humble; Next Health* (alleged kickbacks, improper use of standard test protocols, and billing for unnecessary tests); *RightCHOICE* (hospital allegedly billed for services performed by outside labs); *The People's Choice Hosp.* (hospital allegedly submitted bills for services performed by outside labs); *Sharkey-Issaquena* (alleged misrepresentation concerning the true provider of services); *Sky Toxicology* (alleged kickbacks, artificial increase in tests, and routine waivers of coinsurance); *American Renal Associates* (alleged arrangement to pay patients' expenses); *Bay Area Surgical Mgmt* (insurer alleged kickbacks in the form of favorable investment terms, bonuses, and other illegal remuneration).

G. Intentional or Tortious Interference with Contractual Relationships. The elements of a tortious interference claim generally include: (1) a valid and existing contract with a third party; (2) defendant's knowledge of the contract; (3) defendant's intentional act designed to induce a breach of disrupt the contractual relationship; (4) actual breach or disruption of the relationship; and (5) resulting damages. (*Almont*, 121 F. Supp. 3d at 979). Recent cases by insurers alleging intentional interference include *Almont* (alleged illegal interference by waiving required copays); *The People's Choice Hosp.* (hospital alleged billed for services performed by outside labs); *RightCHOICE* (hospital allegedly billed for services performed by

outside labs); *Sky Toxicology* (alleged kickbacks, artificial increase in tests, and routine waivers of coinsurance); *Bay Area Surgical Mgmt* (alleged inducements to referring physicians, waiving patient copays, and failure to disclose practices to insurer).

H. Negligent Interference with Prospective Economic Relations. The elements of a negligent interference claim usually include: (1) the existence of a valid contract between the plaintiff and a third party; (2) the defendant's knowledge of that contract; (3) the defendant's intentional acts designed to induce a breach or disruption of the contractual relationship; (4) actual breach or disruption of the contractual relationship; and (5) resulting damage. Negligent interference claims were asserted in *Bay Area Surgical Mgmt* (insurer alleged kickbacks in the form of favorable investment terms, bonuses, and other illegal remuneration).

I. Other Claims. Payors asserted claims may often add other claims related to the foregoing, *e.g.*, conversion, civil conspiracy, or claims for injunctive or declaratory relief to stop misconduct or recover amounts paid. (*See, e.g.*, *The People's Choice Hosp.* (hospital allegedly billed for services performed by outside labs); *RightCHOICE* (hospital allegedly billed for services performed by outside labs); *Sky Toxicology* (alleged kickbacks, artificial increase in tests, and routine waivers of coinsurance).

IV. Common Contract Terms. It is increasingly common for payors to address fraud and abuse issues in their contracts with payors or their internal claims policies that are referenced in their contracts. Common terms may include, *e.g.*, (1) the requirement to collect copays and account for deductibles; (2) the payor's right to offset or recoup amounts improperly paid; and (3) the provider's obligation to affirmatively self-report and repay overpayments or amounts that were improperly paid by the payor. Payor contracts may define or impose conditions on properly submitted claims, *e.g.*, claims that are (1) medically necessary; (2) rendered consistent with the applicable standard of care; and (3) supported by adequate documentation. The contract may expressly subject the provider to payor audits, investigations, or other review processes. Some insurers may even expressly prohibit fraudulent or abusive practices such as prohibiting patient or referring provider inducements; alternatively, they may require the provider to comply with applicable laws and regulations, which condition may extend to federal or state fraud and abuse laws. Of course, failure to comply with contract provisions may subject the provider to breach of contract and/or restitution claims without having to establish the wrongful intent that may predicate the statutory remedies discussed above.

V. Mitigating Liability. Given the statutes and standards discussed above, providers must take appropriate steps to avoid or mitigate any fraud and abuse in private payor programs as well as government programs. Among other things, providers should do the following:

1. Render and document appropriate patient care and maintain accurate records necessary to support the care rendered in case they are ever challenged. The statutes and cases cited above generally

apply to or arose out of truly fraudulent or abusive practices, not good faith efforts to render appropriate care documented through accurate records.

2. Establish an effective compliance plan applicable to private payors as well as government payors. Compliance plans are already mandatory for skilled nursing facilities; they will become mandatory for other providers in the future. The OIG publishes helpful compliance program guidance for different provider types at https://oig.hhs.gov/compliance/compliance-guidance/index.asp. Providers should periodically review, update, and train staff concerning their compliance plans. Among other things, providers should affirm a culture of integrity and compliance and ensure staff understands their compliance obligations and that the provider will hold staff responsible for compliance.

3. Beware any actions that would constitute fraud and abuse under laws applicable to federal healthcare programs, including offering inducements to patients, kickbacks to referral sources, mischaracterizing the services that were actually provided, misrepresenting the person who rendered the services, etc. If any conduct violates fraud and abuse laws applicable to government payors it likely also triggers fraud and abuse concerns by private payors. As discussed above, the private payors have a fairly broad arsenal to use when challenging such practices.

4. Know the state laws applicable to private payor programs, including but not limited to those laws governing insurance fraud, kickbacks, patient inducements, claim submissions, insurer recoupment rights, appeal processes, relevant time limits or statutes of limitation, etc. Knowledge is power, and such knowledge may help the provider to both ensure its own compliance as well as ensure that the payor does not overstep its rights concerning payment and/or recoupment.

5. Know and comply with payor contracts, including but not limited to policies or other requirements referenced in the contract. Where possible, providers should negotiate contract terms in a manner that minimizes provider liability or at least ensures the provider is given a fair opportunity to challenge payor actions before the payor may recoup or offset payments. Network adequacy laws may give providers more leverage than they have previously had.

6. If a provider has questions about billing or coverage, they should contact the payor then document the communication, *e.g.*, send a confirming e-mail or letter to the payor representative confirming the substance of the communication, and advise the representative that the provider will proceed accordingly unless the payor instructs otherwise. Such communication may help avoid misunderstanding and protect the provider if there is a dispute in the future, including giving providers the evidence they need to establish waiver or estoppel that may bar claims by payors.

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