Fraud Alert Puts Added Pressure on Physicians

On June 9, 2015, the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS) released a fraud alert entitled, “Physician Compensation Arrangements May Result in Significant Liability.” This alert warns physicians of potential individual liability (in addition to healthcare entity liability) if their medical directorship agreements do not reflect fair market value (FMV) remuneration for bona fide services provided.1 The alert emphasized the penalties from the federal Anti-Kickback Statute or Civil Monetary Penalties law under which physicians may be liable if they do not perform the actual duties listed in their medical directorship agreements.2

The motivation for the OIG’s issuance of the guidance seems to stem from its settlements throughout 2013 and 2014 with 12 physicians who entered into questionable medical directorships and office staff payment arrangements with Fairmont Diagnostic Center and Open MRI, Inc., in Pasadena, Texas, for individual sums ranging from $50,000 to $195,016.3 The specialties of the 12 physicians involved include: family practice (four physicians), orthopedic surgery (two physicians); urology (two physicians); orthopedics; primary care and internal care; gastroenterology; and, occupational health.4 In the fraud alert, the OIG alleged that:

1. The payments with the 12 physicians took into account the volume or value of referrals;
2. The payments did not reflect fair market value for services to be performed;
3. The physicians did not provide the services called for under the agreements; and,
4. Some of the 12 physicians entered into arrangements wherein an affiliated healthcare entity paid the salaries of the physicians’ front office staff, which relieved the physicians of a financial burden they would have otherwise incurred.5

Beyond the medical directorships, the OIG asserted that the relief of the physicians’ financial burden for rendering payment to front office staff was an improper remuneration to the physicians.6 Emphasizing the OIG’s pressure to hold physicians accountable for their role in fraudulent arrangements, the lawsuit alleged that the physicians were integral to the remuneration scheme, and, therefore, were subject to liability under the Civil Monetary Penalties law.7 The radiologist who founded and owned Fairmont Diagnostic Center and Open MRI, Inc., at the time of the alleged fraud also settled for $650,000 with the OIG in 2012 for his and the company’s role in allegedly arranging and entering into the medical directorships with the physicians.8

Although these settlements may represent the OIG’s most significant pursuit of physicians in recent history, it is not the first time the OIG has pursued individual physicians for their role in healthcare fraud schemes. Following an investigation by the OIG, in 2014, the U.S. Department of Justice (DOJ) settled alleged fraud and abuse violations for $380,000 with two cardiologists who allegedly entered into sham management agreements that were not commercially reasonable in exchange for their referral of patients seeking cardiology and other healthcare services.9 The hospital that executed the agreements with the physicians settled with the U.S. Department of Justice (DOJ) for $15.6 million for its part in the alleged sham management agreements and for allegedly billing unnecessary and excessive cardiology procedures that were performed by those and other physicians.10

Former government attorneys and other healthcare industry experts and analysts believe that the recent fraud alert regarding physician liability is an effort by the OIG to remind physicians of their expected role in healthcare organizations.11 A former chief counsel at the OIG has asserted that this is a signal of future increased scrutiny of compensation arrangements, and suggests that physicians and organizations pay closer attention to the contracts they arrange.12 A former special assistant U.S. attorney contends that the fraud alert is a reminder that the OIG is monitoring the arrangements between physicians and the organizations that pay them, and he also notes that the alert serves as a warning to physicians that these fraud cases may be handled either civilly, or even criminally if intent can be proved, increasing the pressure on physicians to inspect their own contracts to ensure they are receiving reasonable compensation for services provided.13 The American Health Lawyers Association (AHLA) also noted that the OIG “seems to be focused on making sure that physicians appreciate that they—and not just the...
institutions that contract with them—could be held liable for entering into questionable arrangements.”

As a result of the recently heightened scrutiny of payment arrangements of physicians and healthcare organizations, the OIG is hiring additional lawyers to investigate physician involvement, according to Kevin Barry, a Deputy Chief in the Administrative and Civil Remedies Branch of OIG who spoke at the American Bar Association Health Law Section’s Physician Legal Issues Conference in June 2015. To decrease the risk of investigation by the OIG, one healthcare attorney who was quoted in an AIS Health article suggested that physicians should obtain their own fair market value assessment when negotiating contracts with hospitals. She further recommended that even if a healthcare organization does not closely monitor the timesheets of its physicians, each physician would be well served to accurately maintain his or her own timesheets and ensure actual performance of his or her contractual duties to avoid a subsequent potential investigation by the federal government.

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2 Ibid.


4 Ibid.


6 Ibid.

7 Ibid.


9 Ibid.

10 Ibid.


12 James Swann, June 10, 2015.


17 Ibid.
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