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Todd A. Zigrang, MBA, MHA, ASA, FACHE, Publisher • Jessica L. Bailey, Esq., Editor ©

Physicians Increasingly Targeted in Fraud & Abuse Lawsuits

In the midst of growing regulatory scrutiny regarding fraud and abuse, regulatory agencies are increasingly pursuing physicians, individually, under fraud and abuse laws. In *United States ex rel. Williams v. Banks-Jackson-Commerce Hosp. & Nursing Home Auth.*, a case stemming from the complaint of a relator (i.e., a private citizen) in the small community of Commerce, Georgia, a physician agreed to pay $200,000 to the U.S. to settle allegations regarding improper kickbacks in violation of the *False Claims Act* (FCA), Stark Law, and *Anti-Kickback Statute* (AKS).[1] While the settlement agreement, which was executed on September 22, 2014, led to the lawsuit's dismissal,[2] the announcement of the agreement is yet another sign of federal regulatory authorities utilizing a new tactic to boldly pursue fraud and abuse lawsuits, whereby individual physicians who receive improper payments may be liable under federal fraud and abuse laws.[3] This approach could drastically alter the relationship between healthcare entities and physicians who provide medical services for the entity, as physicians will be increasingly incentivized to closely adhere to fraud and abuse statutes and regulations.

As mentioned in a December 2013 Health Capital Topics article, entitled "*Emboldened Pursuit of Healthcare Fraud and Abuse*," the *Department of Justice* (DOJ) and the *Office of Inspector General* (OIG) are increasingly using their authority through the AKS, Stark Law, and FCA to combat healthcare fraud and abuse.[4] The AKS imposes criminal liability on persons who "*knowingly and willfully*" receive, solicit, offer, or pay remuneration for the exchange of a patient referral payable by a federal healthcare program.[5] The Stark Law prohibits the submission of claims to federal healthcare programs when a physician or immediate family member refers Medicare or Medicaid patients to an entity for a *designated health service* when that physician has a financial relationship with that entity.[6] Finally, the FCA imposes civil liability on persons who knowingly present a false or fraudulent claim for payment to the U.S.[7] Utilizing these authorities, the DOJ and OIG recouped over $2.6 billion in improper payments under Federal healthcare programs in 2013,[8] an increase over the $1.0 billion collected in 2008.[9] Federal regulatory bodies have utilized initiatives such as the *Healthcare Fraud Prevention and Enforcement Action Team* (HEAT) to recover these funds to promote the solvency of the Medicare Trust Fund and remove incentives for patient care based beyond the considerations of the patient.[10] One of the key elements of the HEAT initiative is the utilization of the FCA, which includes a *whistleblower provision* allowing "*any private citizen*," called a *relator*, "*to enforce the FCA by filing a qui tam action against an entity on behalf of the government*."[11] The DOJ has used the FCA to recoup over $14 billion in federal healthcare program funds since January 2009.[12]

The FCA's *whistleblower* provision directly impacted the ability of the federal government to uncover the facts underlying the *Banks-Jackson* case. According to the unsealed complaint in that case filed on October 16, 2008, relator Ralph D. Williams alleged that Banks-Jackson-Commerce Hospital & Nursing Home Authority (now known as Northridge Medical Center)[13] entered into arrangements with Dr. Narasimhulu Neelargaru, a board-certified cardiologist practicing in Commerce, Georgia, involving improper payments for *electrocardiogram* (EKG) and other cardiology test "*over-reads*."[14] The complaint stated that the *over-read* interpretations performed by Dr. Neelargaru were reviews of cardiology tests previously performed by another doctor and were done for the purpose of "*quality control assessments*," not for diagnosis or treatment purposes.[15] The complaint alleged that this practice of cardiology test *over-reading* occurred consistently between the hospital and Dr. Neelargaru from 1999 to August 15, 2008.[16] The complaint further alleged that Dr. Neelargaru knowingly "*bill[ed] professional fees for the over-reading of EKGs that he harvested from (the) Hospital's inpatient and outpatient populations*," which the relator claimed violated Dr. Neelargaru's various contracts with the hospital.[17] The complaint alleges that, on the date of filing, the federal government only reimbursed EKG interpretations upon: (1) proof of "*medical necessity*"; and, (2) proof of the interpretation "*directly (contributing) to the diagnosis and treatment of the individual patient*."[18] Accordingly, the complaint stated that Dr. Neelargaru's *over-readings* violated the FCA because of their improper submission to the government for reimbursement, and Dr. Neelargaru's knowledge of their impropriety. Further, the complaint alleged Dr. Neelargaru also billed the hospital at $167 per hour for his time performing the

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over-reads, which the complaint described as "*double-billing*."[19]

The relator instituted internal action to stop the practice in 2008 through his authority as Chief Financial Officer and Compliance Director.[20] First, the relator, acting on behalf of the hospital, claimed to withhold payment from Dr. Neelargaru for the months of June, July, and August of 2008, seeking to determine what services Dr. Neelargaru properly performed when he billed the hospital for EKG *over-reads*.[21] Second, the relator claimed to have met with the CEO and Dr. Neelargaru regarding the allegedly improper billing for the *over-readings*, but Dr. Neelargaru provided no concrete information and sought to speak with legal counsel.[22] Third, the relator claims he spoke to the hospital's board of directors regarding the issue, upon which the Board advised the relator to continue "*negotiations*" with Dr. Neelargaru.[23] Fourth, the relator claimed to submit over 500 pages of documentation related to the issue to outside counsel.[24] After performing these actions, the complaint alleges that the hospital terminated the relator with "*absence of cause*" as defined by his employment contract.[25]

The hospital settled its claims with the federal government and entered into a *corporate integrity agreement* with OIG in 2010.[26] Nevertheless, the federal government continued to prosecute the case against Dr. Neelargaru individually to seek recoupment of allegedly improperly-paid federal healthcare funds. The federal government and Dr. Neelargaru engaged in litigation surrounding the case for approximately four years beyond the hospital's settlement agreement, which ultimately ended with the parties signing a sealed settlement agreement that was executed on September 22, 2014.[27] In a statement provided to Bloomberg BNA, Dr. Neelargaru denied the allegations against him throughout the entirety of the six-year litigation, characterizing the claims against him as "*meritless allegations*" and stated that he "*always had legal guidance to ensure that all of (his) contracts fully complied with every regulation*."[28] Additionally, Dr. Neelargaru claimed that he settled the allegations, in part, because he could no longer "*stand up to the unlimited resources of the federal government*."[29] Mr. Williams, as the relator in the *qui tam* suit, will receive a portion of Dr. Neelargaru's payment to the federal government.[30]

Healthcare entities should note that the post-filing tactics of the federal prosecution in the *Banks-Jackson* case serve as another example of OIG's growing trend of seeking damage payments from individual physicians in healthcare fraud and abuse prosecutions. In April 2014, the federal government and an Ohio cardiologist named Devender Batra entered into a settlement agreement obligating Dr. Batra to pay $1 million to settle allegations of FCA violations.[31] Similar to the *Banks-Jackson* suit, the allegations against Dr. Batra and the medical corporation he directs stemmed from a related lawsuit in which the federal government settled FCA allegations with Ohio Valley Health Services, but continued to prosecute the individual physicians involved in the underlying allegation against the health system.[32] Additionally, in September 2014, the federal government entered into settlements with a Florida sleep clinic, as well as two affiliated doctors, regarding FCA allegations involving the submission of claims for allegedly unnecessary sleep studies and psychological tests.[33] In one of the settlement agreements, Dr. George Restea agreed to personally pay $100,000 to the federal government to settle the allegations against him.[34] The federal government is continuing to prosecute two other physicians for their roles in the underlying facts of each case.[35]

While none of the settlements place civil or criminal liability on individual physicians, each agreement reflects the federal government's increasingly utilized strategy of targeting physicians individually for liability under the federal fraud and abuse laws, rather than holding hospitals liable for all financial penalties. This strategy could affect the course of physician medical practice with hospitals and other large healthcare entities.[36] If found liable for an offense under federal fraud and abuse laws, the imposition of financial penalties on individual physicians may serve as an additional penalty beyond potential removal from participation in Medicare, Medicaid, or another federal healthcare program. Moreover, the relationship between a hospital and a physician could change, as physicians and hospitals will enter contractual negotiations with the knowledge that physicians have a greater financial stake in maintaining compliance with fraud and abuse statutes and regulations. Currently, the targeting of physicians, individually, for liability under fraud and abuse laws is relatively rare; however, as enforcement agencies continue to utilize this approach, it will likely play an important role in shaping commitment to regulatory compliance in the healthcare industry, and the willingness of both hospitals and physicians to enter into transactions that are *commercially reasonable* and do not exceed *Fair Market Value* (FMV).

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Robert James Cimasi, MHA, ASA, FRICS, MCBA, CVA, CM&AA, serves as Chief Executive Officer of **HEALTH CAPITAL CONSULTANTS** (HCC), a nationally recognized healthcare financial and economic consulting firm headquartered in St. Louis, MO, serving clients in 49 states since 1993. Mr. Cimasi has over thirty years of experience in serving clients, with a professional focus on the financial and economic aspects of healthcare service sector entities including: valuation consulting and capital formation services; healthcare industry transactions including joint ventures, mergers, acquisitions, and divestitures; litigation support & expert testimony; and, certificate-of-need and other regulatory and policy planning consulting.

Mr. Cimasi holds a Masters in Health Administration from the University of Maryland, as well as several professional designations: Accredited Senior Appraiser (ASA – American Society of Appraisers); Fellow Royal Institution of Chartered Surveyors (FRICS – Royal Institute of Chartered Surveyors); Master Certified Business Appraiser (MCBA – Institute of Business Appraisers); Accredited Valuation Analyst (AVA – National Association of Certified Valuators and Analysts); and, Certified Merger & Acquisition Advisor (CM&AA – Alliance of Merger & Acquisition Advisors). He has served as an expert witness on cases in numerous courts, and has provided testimony before federal and state legislative committees. He is a nationally known speaker on healthcare industry topics, the author of several books, the latest of which include: "*Accountable Care Organizations: Value Metrics and Capital Formation*" [2013 - Taylor & Francis, a division of CRC Press], "*The Adviser's Guide to Healthcare*" – Vols. I, II & III [2010 – AICPA], and "*The U.S. Healthcare Certificate of Need Sourcebook*" [2005 - Beard Books]. His most recent book, entitled *"Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services"* was published by John Wiley & Sons in March 2014.

Mr. Cimasi is the author of numerous additional chapters in anthologies; books, and legal treatises; published articles in peer reviewed and industry trade journals; research papers and case studies; and, is often quoted by healthcare industry press. In 2006, Mr. Cimasi was honored with the prestigious "*Shannon Pratt Award in Business Valuation*" conferred by the Institute of Business Appraisers. Mr. Cimasi serves on the Editorial Board of the Business Appraisals Practice of the Institute of Business Appraisers, of which he is a member of the College of Fellows. In 2011, he was named a Fellow of the Royal Institution of Chartered Surveyors (RICS).

Todd A. Zigrang, MBA, MHA, ASA, FACHE, is the President of **HEALTH CAPITAL CONSULTANTS** (HCC), where he focuses on the areas valuation and financial analysis for hospitals and other healthcare enterprises. Mr. Zigrang has significant physician integration and financial analysis experience, and has participated in the development of a physician-owned multi-specialty MSO and networks involving a wide range of specialties; physician-owned hospitals, as well as several limited liability companies for the purpose of acquiring acute care and specialty hospitals, ASCs and other ancillary facilities; participated in the evaluation and negotiation of managed care contracts, performed and assisted in the valuation of various healthcare entities and related litigation support engagements; created pro-forma financials; written business plans; conducted a range of industry research; completed due diligence practice analysis; overseen the selection process for vendors, contractors, and architects; and, worked on the arrangement of financing.

Mr. Zigrang holds a Master of Science in Health Administration and a Masters in Business Administration from the University of Missouri at Columbia. He is a Fellow of the American College of Healthcare Executives, and serves as President of the St. Louis Chapter of the American Society of Appraisers (ASA). He has co-authored *"Research and Financial Benchmarking in the Healthcare Industry"* (STP Financial Management) and *"Healthcare Industry Research and its Application in Financial Consulting"* (Aspen Publishers). He has additionally taught before the Institute of Business Appraisers and CPA Leadership Institute, and has presented healthcare industry valuation related research papers before the Healthcare Financial Management Association; the National CPA Health Care Adviser's Association; Association for Corporate Growth; Infocast Executive Education Series; the St. Louis Business Valuation Roundtable; and, Physician Hospitals of America.

Matthew J. Wagner, MBA, CFA, is Senior Vice President of **HEALTH CAPITAL CONSULTANTS** (HCC), where he focuses on the areas of valuation and financial analysis. Mr. Wagner has provided valuation services regarding various healthcare related enterprises, assets and services, including but not limited to, physician practices, diagnostic imaging service lines, ambulatory surgery centers, physician-owned insurance plans, equity purchase options, physician clinical compensation, and healthcare equipment leases.

John R. Chwarzinski, MSF, MAE, is Vice President of **HEALTH CAPITAL CONSULTANTS** (HCC). Mr. Chwarzinski holds a Master's Degree in Economics from the University of Missouri – St. Louis, as well as, a Master's Degree in Finance from the John M. Olin School of Business at Washington University in St. Louis. Mr. Chwarzinski's areas of expertise include advanced statistical analysis, econometric modeling, and economic and financial analysis.

Jessica L. Bailey, Esq., is the Director of Research of **HEALTH CAPITAL CONSULTANTS** (HCC), where she conducts project management and consulting services related to the impact of both federal and state regulations on healthcare exempt organization transactions and provides research services necessary to support certified opinions of value related to the Fair Market Value and Commercial Reasonableness of transactions related to healthcare enterprises, assets, and services. Ms. Bailey is a member of the Missouri and Illinois Bars and holds a J.D. and Health Law Certificate from Saint Louis University School of Law, where she served as Fall Managing Editor for the Journal of Health Law and Policy.