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CLIENT ALERT

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# DOJ Criminal Health Care Enforcement: It's Not Just for Federal Programs Anymore

On July 10, 2020, in *United States v. Ruan*, the Eleventh Circuit affirmed the convictions of two Alabama doctors for running an opiate "pill mill." Among many other things, the government charged that the doctors used "incident to" billing to charge Blue Cross Blue Shield of Alabama under the doctor's identification for visits conducted entirely by nurse practitioners, which that insurer (unlike some others) prohibited under its policy. Based in part on the testimony of a BCBS fraud investigator, the jury found that this amounted to conspiracy to commit health care fraud, and the appellate court agreed.

Health care providers who bill Medicare or other federal government payers are well-acquainted with the risk of civil or criminal enforcement by HHS-OIG and the Department of Justice. Meanwhile, those who accept only private insurance often imagine that they remain off the government's radar screen and face little danger of DOJ subpoenas or indictments. But such complacency is no longer an option, as the government has increasingly used creative legal theories and has partnered with commercial insurers to launch investigations and prosecutions, often resulting in jail time for providers. In some cases, these enforcement actions have resulted from payers' use of law enforcement referrals as an aggressive tactic in provider reimbursement disputes. Providers should thus be aware of when and how such enforcement actions can unfold.

**Evolving Theories of Federal Criminal Liability Involving Private Insurance**

DOJ has used an assortment of legal tools to pursue cases involving commercial payers, some old and some new. When providers knowingly bill for services not provided or not medically necessary, the mail and wire fraud statutes (18 U.S.C. §§ 1341 and 1343) – federal prosecutors' go-to weapons for many white collar crimes – are often charged. Conviction under those laws requires proof that the provider intentionally misled the insurer through false statements designed to induce payment. In some cases, prosecutors will charge health care fraud under § 1347, which is similar but requires proof that the provider acted "willfully"; that is, he knew he was breaking the law. That was the crime at issue in *Ruan*, where the misrepresentation at issue was the claim that the doctor was personally attending the patient visits being billed, as required under the particular payer's latest guidelines.

For kickbacks, DOJ had historically focused on cases involving Medicare and other federal programs, as the Anti-Kickback Statute applies only in that context. But in recent years, federal prosecutors have become more creative in pursuing referral payments involving patients using commercial insurance, which had previously been the purview of state and local governments. One statute that has recently found favor is the Travel Act, 18 U.S.C. § 1952, which makes it illegal to, among other things, "use the mail or any facility of interstate commerce" to "promote" or "facilitate" any of a specified list of crimes, which includes "bribery" under state law. That has been interpreted to include state anti-kickback laws and other forms of commercial bribery. *Perrin v. United States*, 444 U.S. 37 (1979). For example, in the series of prosecutions involving kickbacks paid by Pacific Hospital of Long Beach, which largely involved patients with commercial or other non-federal insurance, a number of indictments featured Travel Act charges incorporating California Business and Professions Code § 650 and Insurance Code § 750, California laws barring referral payments. *See, e.g.*, *United States v. Payne*, No. 8:17-cr-00053-JLS (C.D. Cal. April 25, 2018). In another case, various doctors, investors, and staff in Dallas's Forest Park Medical Center were convicted of Travel Act violations based on kickbacks in violation of a Texas commercial bribery statute. *See United States v. Beauchamp, et al.*, No. 3:16-cr-00516-JJZ (N.D.Tx. Nov. 16, 2016).

DOJ has also stretched beyond the Travel Act to pursue commercial payer cases. In *United States v. Reynolds*, Case No. 12-cr-708 (S.D.N.Y), the government charged a hospital CEO who had taken kickbacks from vendors under the Racketeering Influenced and Corrupt Organizations statute (RICO), which required demonstrating a racketeering enterprise involving various criminal actions over an extended period, but can also be based on state anti-kickback laws. Separately, in the Pacific Hospital cases, hospital owner and ringleader Michael Drobot pled guilty to honest services fraud under 18 U.S.C. § 1346, as he had induced surgeons and other doctors to violate their fiduciary duties to patients by secretly accepting kickbacks for referring them to Drobot's hospital. More recently, DOJ has begun aggressively pursuing cases against addiction treatment providers and clinical laboratories under the Eliminating Kickbacks in Recovery Act (EKRA), 18 U.S.C. § 220, a 2018 statute that outlaws referral payments involving those providers regardless of the type of insurance used.

**Takeaway**

If providers could once assume that eschewing federal insurance programs would immunize them from DOJ scrutiny, that is no longer the case. Even those dealing only with commercial payers must consider whether any of their practices, from marketing to billing, may run afoul of either state or federal criminal laws. And particularly when disputes arise with commercial payers, providers should be attuned to the risk that their counterparts may turn to the government as a powerful negotiating device, one whose impact could easily overshadow the payment issue itself. Managing these new risks requires designing and implementing a robust compliance program with annual audits, ideally with the coordination and advice of experienced health care regulatory counsel. If there is any indication that a matter could be referred to the government, a provider should consult counsel experienced in managing health care investigations.

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