Overview of Health Care (Medicare and Medicaid) Fraud

Medicare fraud and Medicaid fraud by hospitals and doctors have cost the federal government billions of dollars. Qui tam/ whistleblower lawsuits filed under the False Claims Act ("FCA") and/or Texas Medicaid Fraud Prevention Act ("TMFPA") have been responsible for some of the government's biggest health care fraud recoveries.

Call the **DALLAS QUI TAM ATTORNEYS AND DALLAS FALSE CLAIMS ACT ATTORNEYS** at the Law Offices of James R. Tucker, P.C., at 214-505-0097 for a free consultation if you suspect health care fraud.

There are many different ways hospitals and doctors can bilk Medicare and Medicaid. The examples of health care fraud that are discussed give an idea of the types of fraud that have been or could be the basis of qui tam lawsuits.

- False claims involving pharmaceutical companies
- Kickbacks and off-label marketing of medical implants and medical devices
- Kickbacks and improper payments to group purchasing organizations (GPOs)
- Services not rendered/add-on services
- Upcoding and unbundling/fragmentation
- Kickbacks
- False certifications and information
- Lack of medical necessity
- Fraudulent cost reports
- Grant or program fraud
- Home health care fraud

Our Firm Obtained What is believed to be the Largest Home Health Care Fraud Judgment in the United States!

Attorney Rusty Tucker represented a whistleblower who obtained a **$339.4 Million Judgment** obtained against 4 individuals in one of the largest recoveries for home health care fraud in the history of the United States. The whistleblower/relator is entitled to 23% of the recovery from a Related criminal case resulting in an order of forfeiture of hundreds of millions of dollars by the Defendants. All 4 Defendants (two of whom were doctors) were found guilty and/or pled guilty and received jail sentences ranging from 2 ½ to 17 years.

Services Not Rendered/Add-On Services

Probably the clearest example of fraud by hospitals and doctors involves billing for services that were never delivered to patients. The basic scheme can involve as many variations as there are treatments.

For example, some physicians bill Medicare or Medicaid for diagnostic procedures they never performed, physical therapists bill for sessions that never took place, and nursing homes might bill for supplies that were never actually purchased or used. There is often some falsification of records to support improper billings.

Billing for unnecessary procedures or services that have been added to a bill for legitimate charges is another type of false claim under the FCA and constitutes and Unlawful Act in violation of the TMFPA. The government also has held clinical laboratories liable when they induced physicians to order unnecessary add-on tests by including the extra test in a standard blood chemistry panel at minimal or no extra charge to the physician. The lab then bills Medicare for the additional test without the doctor's knowledge. When the physician doesn't have the option of ordering the standard panel without the extra test, the lab may be liable for claims submitted for the extra test.

Upcoding and Unbundling/Fragmentation

Billing Medicare and Medicaid by doctors and hospitals for medical services is done using a complex system of numerical codes that designate various diagnoses and procedures. Reimbursements are based on those codes. The coded, computerized bills submitted by providers are processed by large insurance companies (known as "intermediaries" or "carriers") that contract with the government to pay claims using government funds.

Because different codes or code combinations may produce dramatically different reimbursements from government programs, there is a financial incentive to "upcode" or bill for a more serious (and more expensive) diagnosis or procedure.

Another common example of improper coding by doctors and hospitals is called "unbundling," also known as "fragmentation." Medicare and Medicaid often have special reimbursement rates for a group of procedures commonly done together such as typical blood test panels by clinical laboratories. Some health care providers seeking to increase profits will "unbundle" the tests and bill separately for each component of the group, which totals more than the special reimbursement rates.

Kickbacks

One of the most complicated and troubling aspects of the health care system involves hidden financial arrangements between various health care providers. There are a variety of improper arrangements where providers will provide some material benefit in return for other providers prescribing or using their products or services.

In most instances, such arrangements are illegal. Doctors are supposed to decide on the most appropriate treatment for their patients without consideration of their own financial interests. Kickbacks often result in medically unnecessary treatment.

False Certifications and Information

Health care providers who submit Medicare and Medicaid claims containing false statements also may be liable under the False Claims Act.

Lack of Medical Necessity

Some doctors and hospitals bill Medicare and Medicaid for services or procedures that are not medically necessary. They would be liable under the FCA and the TMFPA for those false billing practices.

Fraudulent Cost Reports

Medicare reimburses health care institutions for certain costs in addition to paying for individual procedures and treatment. Virtually every hospital and many other providers submit cost reports to Medicare, which are used to calculate how much the government will reimburse the provider for expenses related to patient care. This includes the costs of capital improvements like new medical equipment and bigger wards. Over the years, cost reports can represent billions of dollars in payments for some providers.

Doctors and hospitals who knowingly inflate the costs they incurred, mischaracterize the nature of those costs or give the wrong percentage of their services dedicated to Medicare patients are liable under the FCA. Likewise, if doctors and hospitals knowingly inflate the costs they incurred, mischaracterize the nature of those costs or give the wrong percentage of their services dedicated to Medicaid patients are liable under the TMFPA.

Contact a Dallas Health Care Fraud Attorney

To talk with me about your hospital or doctor fraud case, call my Dallas law offices at 214-505-0097 or contact me online. Consultations with a Dallas County Health Care Fraud attorney are free and confidential. I handle these types of cases on a contingent fee basis, meaning you owe me no legal fees or expenses unless I obtain a recovery for you.