Law Update

By Eric Moch

Federal Health Care Fraud Prosecution Spotlights the Intersection of a Familiar Fraud Medium and New Technology: Bribes for Unnecessary Durable Medical Equipment Prescriptions in the Telehealth Context

BACKGROUND

Organized health care fraud is a billion-dollar industry driven by shrewd and nimble wrongdoers who often manage to stay one step ahead of investigators. U.S. health care spending exceeded $4 trillion in 2020, and in a system that large, featuring claims distributed through Medicare, Medicaid, group health plans and auto and casualty insurers, opportunities to commit fraud abound. An old standby health care fraud medium, into which wrongdoers have breathed new life in recent years, is prescription durable medical equipment ("DME"), including reusable orthotic neck, back and joint braces. DME in injury claims is no longer confined to the occasional soft neck collar. In the most active fraud hot spots today, a DME bill in an injury claim can exceed $10,000 and include, at least according to DME invoices, very sophisticated equipment.

Emerging at the same time as this renewed focus upon DME as an instrument of fraud is telehealth, a promising advancement in health care convenience. The popularity of telehealth is growing; it can be easier for people to engage with physicians from the comfort of their own home even in the best of times, but especially during a pandemic. Patients in rural or health professional shortage areas may not have other options. However, telehealth presents its own opportunities for fraud and abuse, and we have not had to wait very long to see what this might look like. Two recent health care fraud prosecutions demonstrate, yet again, that the more things change, the more they can stay the same.

UNITED STATES OF AMERICA V. JANAE NICHOLE HARPER (4:20 CR 65 U.S. DIST. CT. DIST. MONTANA)

UNITED STATES OF AMERICA V. MARK ALLEN HILL (4:20 CR 67 U.S. DIST. CT. DIST. MONTANA)

Janae Harper and Mark Hill are nurse practitioners in Montana. Both were affiliated with Integrated Support Plus, Inc., a telemedicine company located in Spring Hill, Florida. Harper, Hill and Integrated Support Plus, Inc. were Medicare providers, which required them to comply with all Medicare-related laws, including the Anti-Kickback Statute. Among the services Harper and Hill provided with Integrated Support Plus were telehealth consultations with patients who suffered from injuries and musculoskeletal conditions and the prescription of medically necessary DME to those patients in appropriate cases. Under Montana law, nurse practitioners enjoy prescriptive authority to issue DME to patients without a licensed physician's oversight.

Medicare does not place onerous obstacles in front of a telemedicine patient in need of an orthotic brace. A patient needs to undergo a customary telehealth consultation with qualified healthcare professional, who determines that prescription of DME is medically necessary. Medicare then readily pays for the DME, as long as the claim does not come about through kickbacks or bribes.

Harper and Hill, alas, did not clear this low bar. On September 3, 2020, a federal grand jury in Montana indicted both for conspiracy to commit healthcare fraud (18 U.S.C. 1349) and health care fraud (18 U.S.C. 1347 & 2(b)). Both charges carry sentences of up to ten years in prison and a $250,000 fine.

THE DURABLE MEDICAL EQUIPMENT SCHEME

The grand jury determined that between the fall of 2017 and spring of 2019, Harper and Hill, in connection with their affiliation with Integrated Support Plus, Inc. and its call centers, knowingly engaged in a scheme to collect bribes from various DME providers in exchange for DME prescription orders. However, many of their DME prescriptions were not based on any sort of patient examination, but rather a very brief telephone conversation well short of a customary telehealth encounter, or in some instances, no patient interaction at all. Harper and Hill went on to prescribe DME often without regard for medical necessity and then billed Medicare. Together, they placed orders for a staggering 14,700 braces during the relevant time period.

The purpose of the scheme was not better health outcomes for patients. The purpose was to bill Medicare in high volume and see what Medicare would pay. It worked well: Medicare paid over $4 million as a result of Harper's fraud and over $5 million as a result of Hill's.

In April of this year, both Harper and Hill pled guilty to conspiracy. As of this writing, they have yet to receive their sentences. Nor has the Montana Board of Nursing determined what licensure sanction is appropriate for them. It seems probable that a key component of their sentences will be cooperation with the Department of Justice in the prosecution of others who helped orchestrate the scheme.

DME FRAUD: CHARACTERISTICS AND INVESTIGATIVE STRATEGY

A modern DME fraud case contains some of the characteristics present in the Harper and Hill indictments. Total absence of medical necessity for the DME is a near universal component. So is an illegal relationship between a prescribing physician and a DME supplier, either because the relationship is premised upon bribes or because the physician owns a stake in the DME company, thereby creating an improper self-referral.

However, the shrewd perpetrators of DME fraud play other angles too, and they can disguise their actions well. It is not uncommon to see very professional and content dense DME order and customer information checklist forms which lend the appearance of propriety, especially when an overwhelmed claims representative looks at them. Yet additional scrutiny at the claims stage and in litigation has revealed numerous instances of the absence of any physician documenting the necessity of the DME or even ordering it as part of a treatment plan. More than a few supposed DME patients, upon examining supposed customer checklists during depositions, disavow that the customer signature on the form is theirs. DME bills might describe a high-end, several thousand dollar back brace, when in fact the patient actually received the sort of neoprene and Velcro brace that one might purchase at any pharmacy without a prescription for less than $100. Billing for as many as a dozen complimentary braces when a patient receives just one, or sometimes none at all, is a routine occurrence in this type of fraud.

The truly shrewd perpetrators of these schemes will elect, as a matter of strategy, to not bill Medicare or Medicaid at all, even though they may serve low income and senior patient populations. Many states regrettably do not prosecute health care fraud with the same zeal and frequency as the Department of Justice. Steering clear of federal reimbursement from Medicare and Medicaid while engaging in fraud in such states is an effective strategy for avoiding federal investigative scrutiny. After all, private insurers can decline payment, but they cannot send anyone to prison.

CONCLUSION

Durable medical equipment fraud has metastasized back into prominence in the injury claim context because it can be lucrative for those who commit it. The means and methods change as the insurance industry catches on to them, but the one constant that will serve every insurer well in the fight is vigilance. Special investigations units should commit to regular training with experienced professionals who can help them identify and defend against the current trends. It may seem a questionable use of training and investigative resources to spend so much time combatting bills of a few thousand dollars which might constitute a relatively small fraction of total medical specials in an injury claim. But this is exactly the attitude these fraud perpetrators are hoping for.

Eric W. Moch, *a partner in the Chicago office of HeplerBroom, LLC, focuses his practice on organized medical fraud and insurance fraud, including organized activity and staged losses, as well as first- and third-party coverage and bad faith defense. Mr. Moch counsels and represents national insurers, businesses, not-for-profit organizations and individuals in a variety of matters and litigated disputes. His insurance fraud practice entails the defense of insurers and their insureds against fraudulent claims at trial and the pursuit of civil recoveries for insurance carriers resulting in recoveries against medical fraud perpetrators. He has extensive civil litigation experience in Illinois state and federal courts, including more than fifty jury verdicts, victorious oral arguments before the Illinois Supreme Court and Seventh Circuit U.S. Court of Appeals and several published appeals. He is a former national board member of the National Society of Professional Insurance Investigators and is the former President of the Illinois chapter. Mr. Moch has also held several positions in the insurance industry, including as a founding member of a Special Investigations Unit for an international insurer, a role in which he investigated alleged fraudulent claims across a wide range of insurance lines. Mr. Moch can be reached at (312) 205-7712 and at eric.moch@heplerbroom.com*

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There are seven award categories, which include:

- Investigator of the Year
- Analyst of the Year
- Anti-Fraud Insurance Professional of the Year
- Public Service
- Outstanding Service
- Multi-Jurisdictional Investigative Excellence Award
- Chapter of the Year

Nominations are received from various sources including peers, supervisors and other sources within the SIU community. An individual, as well as their organization, should consider the nomination to be a significant honor, representing the hard work of the individual and the support of their respective company in the continual fight against insurance fraud.

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