Law Update

By Eric Moch

"We've Got 'em Right Where we Want 'em! (What Do We Do Now??)"

Extracting Recoveries from Organized Insurance Fraud Perpetrators: Legal Remedies and Strategies

Author's Note: Usually, this column explores legal developments and strategy considerations within the context of publicized SIU-relevant cases. In this issue, however, I depart from that routine to discuss legal strategy for affirmative litigation against organized medical fraud rings, the type of case that most often settles confidentially and rarely is reported. Case law updates will resume in future issues.

BACKGROUND

You are a medical fraud investigator with the special investigative unit (SIU) of a large insurer. Your territory includes one of the largest cities in the United States. You know from your training and experience that a city of this size is susceptible to organized medical fraud rings consisting of chasers, physicians, diagnostic facilities, durable medical equipment and prescription medicine providers, and surgical centers, among other players. And it turns out, thanks to your good faith investigation, you have identified one such enterprising ring that has operated thus far without detection. You confer with your claims team and your trusted legal counsel, and after analyzing years of claim data, it becomes clear that this enterprise has targeted your company with millions of dollars in paid and as-yet unpaid bills through patterns of accident staging, patient recruiting, billing for services not rendered, unbundling, upcoding, falsifying medical records and charging for services with no medical necessity. Your company wants to hold these bad actors accountable. What are your legal options?

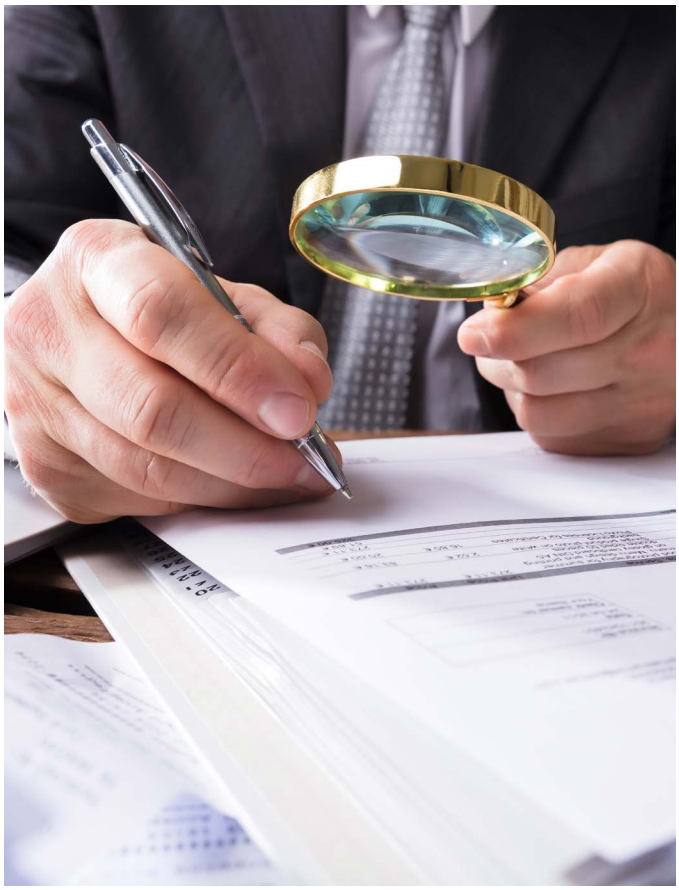
This column provides a general overview of the avenues that we in the medical fraud investigation field travel most often when pursuing recoveries against organized fraud perpetrators. I highlight the statutory and common law causes of action that we often rely upon to secure settlements. This is just an overview, not a seminar or legal brief, and so I do not detail all sub-elements and potential defenses or cite to specific case authority. Nor is this an exhaustive list of all possible causes of action. However, every investigation into suspected organized fraud must proceed with an understanding of available remedies. Let us look at three very good options.

FEDERAL RACKETEER INFLUENCED AND CORRUPT ORGANIZATIONS ACT: CIVIL RICO

The Racketeer Influenced and Corrupt Organizations Act (RICO) statute originated as a sweeping statutory remedy that empowered federal prosecutors to prosecute organized crime enterprises. Prior to RICO, prosecutors struggled to investigate and convict the multiple players of organized crime enterprises. RICO enables the prosecution of the players jointly as part of one large enterprise, instead of forcing the far more cumbersome path of individual prosecutions. RICO offers civil remedies as well.

The essence of a RICO case is the allegation of conspiracy among multiple defendants. To state a claim under RICO, a plaintiff must establish: (i) that the defendant (ii) through the commission of two or more acts (iii) constituting a pattern (iv) of racketeering activity (v) directly or indirectly invests in, maintains an interest in, or participates in (vi) an enterprise (vii) the activities of which affect interstate or foreign commerce.

A plaintiff asserting a cause of action under RICO must satisfy heightened, fact-specific pleading requirements under applicable rules of civil procedure. In short, a plaintiff wishing to pursue a medical fraud ring under RICO must be very specific in his or her factual allegations. A RICO complaint must provide each defendant with specific notice of the alleged fraudulent activity, including the commission date of each fraudulent claim and, if applicable, the date that the defendant engaged the U.S. mail to further the fraud. Mail fraud is a common allegation in civil RICO cases. To demonstrate



mail fraud, a plaintiff must establish: (i) the existence of a scheme to defraud; (ii) the defendant's knowing or intentional participation in the scheme; and (iii) the use of interstate mails in furtherance of a scheme.

Success at trial on a civil RICO claim entitles a plaintiff to triple damages, reasonable costs associated with prosecuting the case and reasonable attorney's fees. The statute of limitations for filing a civil RICO case is four years from the date the claim accrued.

It is important to understand that all statutes of limitations have some elasticity but can also expire sooner than we might think they do. It is not unexpected that parties to insurance fraud cases might spend considerable time litigating the statute of limitations. This issue could easily occupy its own treatise, let alone its own article. Suffice to say, it is crucial that every investigator on the trail of an organized activity ring keep an eye on the calendar.

STATUTORY INSURANCE FRAUD: E.G., ILLINOIS CIVIL INSURANCE FRAUD, 720 ILCS 5/17-10.5(A)

Some states, including Illinois, target insurance fraud specifically by statute. These statutes can be very helpful because they provide remedies similar to those available under RICO, but do not necessitate suit filing in federal court. After all, not every insurer wants to make the proverbial "federal case" out of having fallen prey to an organized ring.

The Illinois statute is similar to many other state statutes and is also quite straightforward. Under the statute:

1. A person commits insurance fraud when he or she knowingly obtains, attempts to obtain, or causes to be obtained, by deception, control over the property of an insurance company or self-insured entity by the making of a false claim or by causing a false claim to be made on any policy of insurance issued by an insurance company or by the making of a false claim or by causing a false claim to be made to a self-insured entity, intending to deprive an insurance company or self-insured entity permanently of the use and benefit of that property.
2. A person commits health care benefits fraud against a provider, other than a governmental unit or agency, when he or she knowingly obtains or attempts to obtain, by deception, health care benefits and that obtaining or attempt to obtain health care benefits does not involve control over property of the provider.

The statute of limitations under this statute is five years. If a defendant is found guilty of civil insurance fraud in Illinois, he or she will be liable for three times the value of the property wrongfully obtained, or if no property was wrongfully obtained, two times the value of the property attempted to be obtained, whichever amount is greater, plus reasonable attorney's fees. In other words, Illinois outlaws the mere *attempt* to commit fraud, and does not penalize an insurer that scrutinizes well and thus does not fall prey to fraudulent billing. An insurer still can pursue recovery of twice the amount of the unpaid fraudulent bill.

COMMON LAW FRAUD

The elements of common law fraud generally are the same just about everywhere. To prevail on allegations of common law fraud an entity must prove that: (1) a defendant made a false statement of material fact; (2) the defendant knew that the statement was false; (3) the defendant intended that the statement would induce the plaintiff to act; (4) the plaintiff relied upon that statement; and (5) the plaintiff suffered damages resulting from reliance on the statement. In Illinois the statute of limitations for a common law fraud case is five years. A plaintiff alleging fraud may seek recovery of any sums it lost to the fraud, as well as punitive damages and costs.

Common law fraud demands a high standard of pleading. A plaintiff must allege the supposed fraud with sufficient specificity, particularity and certainty to apprise the defendant

of the specific wrongful acts. Indeed, failure to plead fraud with sufficient specificity could expose a plaintiff to counter claims for harm to a defendant's reputations, such as defamation or malicious prosecution.

Common law fraud is an excellent, straightforward way for insurers to recoup indemnity dollars they may have been induced into paying through fraud. However, we have argued successfully in certain cases that the legal expenses alone are sufficient to qualify as recoverable damages in a fraud claim, even in the absence of indemnity payments.

STRATEGIC CONSIDERATIONS: PROPOSED LAWSUITS AS STRONG INCENTIVE TO SETTLE

There is an adage in trial advocacy that the best cross examination is the one you do not have to conduct. The adage speaks to the reality that the best laid plans of trial attorneys are not guaranteed to convince a judge or jury. This is true in any case, including civil recovery cases against fraud perpetrators. Fortunately, the best and most common outcome in most organized medical fraud cases is usually a confidential settlement without formal suit filing and without trial. These settlements might include financial payments from wrongdoers, medical bill lien walkaway agreements covering several years of billing and confidentiality provisions.

No plaintiff in any fraud case ever should threaten, let alone institute, litigation without ample factual and legal basis. Any such plaintiff must be ready, willing, and able to file suit and proceed to verdict if settlement discussions fail. The practical reality, however, is that an insurer's thorough good faith investigation that reveals ample basis to file a lengthy fraud and conspiracy complaint most often is rewarded with meaningful settlements from wrongdoers who wish very much to spare their personal and professional reputations the profound damage of becoming a named defendant in a public lawsuit. Beyond reputational harm, a wrongdoer who understands he has no good defense to fraud allegations has strong incentive to spare himself a financially ruinous triple damage award and significant attorney's fees.

This is not always the case though. To borrow a line from the movie *Cool Hand Luke*, "Some men, you just can't reach." So it is, too, in the pursuit of remedies against organize fraud perpetrators. Sometimes, there is no choice but to file suit and prepare for trial.

CONCLUSION

The foundation of any potential legal remedy against organized fraud perpetrators will always be a thorough claim investigation and a correct interpretation of claim data. Consultation with experienced legal counsel is equally important. Thankfully, both federal and state law empower insurers in proper cases to make themselves whole by clawing back the dollars they lost to these perpetrators. Our legal system exists to punish those who commit fraud, and the courthouse doors are just as open to insurers as they are to anyone else who may be victims of fraud. Insurers will always be the prize target of organized rings, and therefore must always be keenly aware of their rights.

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