# Feds utilize 1960s-era organized crime law to attack private insurance fraud

**William H. Maruca, Esq.**

A Federal law enacted nearly six decades ago to combat interstate organized crime has become the latest weapon in the government's arsenal against healthcare fraud. The Travel Act, signed by President John F. Kennedy in 1961, prohibits interstate or foreign travel, or use of the mails or any facility in interstate or foreign commerce, for the purpose of distributing the proceeds of an unlawful activity, committing a crime of violence in furtherance of an unlawful activity, or to promote, manage, establish, or carry on an unlawful activity. It makes travel or the use of the mails or other interstate facilities in furtherance of a state or federal crime a separate federal offense.

The Travel Act allows federal prosecutors to reach conduct that only relates to private insurance payments, which are generally regulated only by state law. This approach significantly expands federal authority beyond the False Claims Act, which requires proof of presenting or causing to be presented a false claim to the government. Some critics allege that it allows the federal authorities to usurp state prosecutors' discretion.

In April 2019, the U.S. Department of Justice prevailed in a case against physician-owners and administrators of Forest Park Medical Center (FPMC), a Dallas private surgical hospital, for allegedly violating a state commercial bribery law that has rarely, if ever, been enforced at the state level. Federal prosecutors indicted 21 individuals associated with FPMC, alleging that they had paid more than $40 million in bribes and kickbacks to surgeons, primary care physicians, chiropractors, lawyers, workers' compensation preauthorization specialists and others to induce referrals of patients to FPMC, with one doctor receiving as much as $7 million. Unlike most federal anti-kickback enforcement actions, this case did not involve payments made by Medicare or Medicaid, although there were several counts citing violations of the anti-kickback statute regarding payments by other federal programs including TRICARE, the Federal Employees Health Benefits (FEHB) Program and the Federal Employees Compensation Act (FECA). In fact, FPMC discouraged referrals of Medicare and Medicaid patients due to their relatively lower reimbursement rates by financially incentivizing other facilities to accept those cases. As a physician-owned hospital, FPMC was prohibited from accepting referrals from its investing doctors under the Stark law.

FPMC was a luxury-oriented private hospital marketing its services to upscale neighborhoods. The hospital did not participate with most insurers and took advantage of out-of-network arrangements to inflate its fees. Patient coinsurance payments were routinely waived, and patients were falsely advised that their insurers would cover their costs at in-network rates. Kickbacks were paid to surgeons and referring physicians through shell companies, sham marketing arrangements, sham lease payments and other benefits, and referrals were tracked to facilitate crediting referral sources for kickbacks. The indictment alleged that FPMC had billed payors more than half a billion dollars and collected more than $200 million pursuant to these schemes from 2009 to 2013. Underperforming surgeons and referral sources were pressured to increase their volume, including one who was sent an email reading: "[It] appears that your projections of cases have fallen whole-fully (sic) short. You said 20 in November and 40 in December. I want to sit down as soon after the beginning of the year and before the 15th to find out why my $150k investment has not produced Jack."

OK, this was a particularly egregious and blatantly illegal operation, with an unusually explicit paper/email trail, but why is it national news? It's

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because the government has found a way to federally prosecute violations of state law that only involve private insurance payments, even where state authorities failed to enforce their own laws.

The defendants were charged with violating the federal Travel Act by "using and causing to be used facilities in interstate commerce with the intent to promote, manage, establish, carry on, distribute the proceeds of, and facilitate the promotion, management, establishment, carrying on, and distribution of the proceeds of unlawful activity, specifically, Commercial Bribery" in violation of the Texas Penal Code. The "interstate commerce" facilities used by the defendants included uploading deposit information from FPMC kickback checks paid in Texas to a server in Georgia.

The prosecutors could have simply relied on the non-Medicare government claims, which included more than $10 million billed to TRICARE, more than $25 million billed to FECA, and more than $60 million billed to FEHBP, and they did include counts under the more commonly cited kickback law for these claims. By using the Travel Act, the government could considerably widen its net to include the payments made by private insurers, which exposed additional millions to civil forfeiture.

This is not the first such use of the Travel Act in a federal healthcare fraud matter. In 2016, Biodiagnostic Laboratory Services, LLC, a New Jersey clinical laboratory, its owners and employees and a large number of physicians were charged under the Travel Act as well as the anti-kickback statute and Federal money laundering laws as a result of a scheme in which the lab paid kickbacks to physicians for referrals. These kickbacks were disguised as lease payments, consulting agreements and blood-drawing fees. A record number of 38 physicians have been convicted or entered guilty pleas in connection with this case.

The former CEO and owner of a Pacific Hospital in Long Beach, Calif., along with several physicians and

hospital officials, was charged with Travel Act violations in 2015 under an investigation called "Operation Spinal Cap" which involved kickbacks paid to dozens of surgeons, orthopedic specialists, chiropractors, marketers and other medical professionals. The CEO was sentenced to five years in prison for his role in the scheme.

As a healthcare attorney, I often hear the suggestion that as long as no Medicare or Medicaid patients are involved in a transaction, there is no risk of federal fraud enforcement. This has never been entirely true – the Office of Inspector General has consistently stated its concerns about arrangements that "carve out" Federal healthcare program beneficiaries or business generated by Federal healthcare programs from otherwise questionable financial arrangements because they may disguise remuneration for Federal business through the payment of amounts purportedly related to non-Federal business. Now, the Travel Act may be used to federalize violations of state statutes including those laws that have rarely been actively enforced by state prosecutors, so long as some nexus to interstate commerce can be shown. This nexus can be as simple as using the mail, telephone calls or electronic transactions that cross state lines.

So how did the saga of FPMC end? Seven of the nine defendants were convicted and are awaiting sentencing. One surgeon was acquitted, and the jury could not reach a decision on charges against a FPMC surgical director. Ten other defendants have filed guilty pleas. And FPMC, with its chain of six physician-owned hospitals, has filed for bankruptcy.

*Mr. Maruca is a healthcare partner with the national law firm Fox Rothschild LLP in the Pittsburgh office. He can be reached at wmaruca@foxrothschild.com or (412) 394-5575.*

# Legal Briefs

## Commonwealth Court again declines to extend Consent Decree

Michael A. Cassidy, Esq.

The Pennsylvania Commonwealth Court, on remand from the Pennsylvania Supreme Court, has again decided that the previously agreed termination date of the access provisions contained in the UPMC/Highmark Consent Decrees, i.e. June 30, 2019, is not a term subject to the modification provisions of those Consent Decrees, and is definite. The adjudication of the Commonwealth Court, attached hereto, discusses the history of the negotiation of the terms, especially the termination date, and confirms the Consent Decrees will expire on June 30, 2019.

For more information and court opinions, visit https://www.acms.org/2019/06/consent-decree/.

## Pa. Supreme Court decides Mitchell v. Shikora in favor of Pennsylvania physicians

Pennsylvania Medical Society

The Pennsylvania Supreme Court decided *Mitchell v. Shikora* in favor of Pennsylvania's physicians.

All seven justices agreed and held that evidence regarding risks and complications of a surgical procedure may be admissible in medical negligence actions to assist in establishing the standard of care. In a dissenting/concurring opinion, however, two of the justices essentially opined that risks and complications evidence is not always germane and should be considered on a case-by-case basis.

**PAMED action:** On Dec. 1, 2017, the Pennsylvania Medical Society (PAMED) Executive Committee approved the filing of an amicus curiae brief with the American Medical Association (AMA) in the state Supreme Court case *Mitchell v. Shikora*. The brief argued that the Superior Court has misapplied the holding in *Brady v. Urbas* and its decision should be reversed. The state Supreme Court heard the case in October 2018. On June 18, 2019, also relying on its decision in *Brady v. Urbas*, the Court reversed the Superior Court. The state Supreme Court held that evidence regarding risks and complications of a surgical procedure may be admissible at trial.

For more information and to see the court opinions, visit https://www.acms.org/2019/06/pa-supreme-court/.