FALSE CLAIMS ACT

It's Not Just a Provider Problem

By Erica Barnes, Esq.

WHY THIRD PARTIES SHOULD TAKE STEPS TO MITIGATE FCA RISK

> **"Billing companies provide a key checkpoint to combat medical billing fraud. Consequently, they will be examined with the same scrutiny as healthcare providers."**
>
> *Former United States Attorney Sally Quillian Yates in 2014* [1]

If you own or work for a third party medical billing company or a company providing revenue management or other healthcare business services ("Third Parties"), you probably already know that your healthcare provider clients face a rising tide of False Claims Act ("FCA") litigation relating to submission of incorrect claims to government payors (Medicare, Medicaid, Tricare, and the VA). But you may not have considered your own company's legal exposure. Many Third Parties do not consider themselves to be healthcare companies or government contractors. They view themselves as service providers efficiently facilitating their *clients'* strategies and wishes.

However, the Department of Justice (DOJ), the Department of Health and Human Services (HHS), and their state equivalents do not view Third Parties in this way. These government entities expect Third Parties to work collaboratively with their clients to ensure compliance. They may hold Third Parties who do not do so accountable for "submitting," "causing to be submitted," or conspiring to submit false claims. Given this environment, Third Parties must proactively manage their own exposure under the FCA.

The FCA: A Scary, Powerful Tool

The FCA, 31 U.S.C. § 3729, *et seq.*, is perhaps the government's most powerful tool for policing waste, fraud, and abuse within the

federal healthcare system and recovering funds because of its draconian penalties, whistleblower incentives, and broad pathways to liability. Those less familiar with the FCA may not understand that a claim for payment may be "false," even when the provider actually provided the services involved if the service was not medically necessary according to government guidelines, adequately supported by documentation, or provided by a properly qualified and credentialed provider, or the provider did not comply with a material rule or regulation in providing the services involved, such as the federal Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b). Further, a provider or third party can be liable for submitting a false claim even when it did not *know* it was doing anything wrong if a jury believes it ignored suspected false information or claims, or it engaged in "reckless disregard" by failing to put the procedures and processes in place to prevent the submission of false claims. With this broad pathway to liability, litigants often settle for extraordinary sums even when they have strong defenses. They fear a negative trial outcome, which can bring damages of three times the value of the claims submitted, statutory penalties of over $10,000 per claim, as currently adjusted for inflation, civil monetary penalties,[2] attorneys' fees and costs, along with the risk of being prohibited from participating in federal healthcare programs.[3] Whistleblowers, or relators, provide a steady stream of FCA cases because they can recover between 15-30% of the ultimate FCA award, and even when their FCA claims are unsuccessful, they can often pursue stand-alone retaliation charges and commensurate attorneys' fees.

In 2024, the United States Government collected more than $1.67 billion in FCA settlements and judgments involving the healthcare industry, including managed care providers, hospitals and other medical facilities, pharmacies, pharmaceutical companies, laboratories, and physicians. This pace of enforcement is not expected to dwindle. The current administration has made FCA prosecutions a cornerstone of its agenda against fraud, waste, and abuse, including in the healthcare sector.

The FCA: There Is Real Risk for Third Parties

While most FCA cases name the provider and perhaps its owners or executives, a meaningful number identify Third Parties as well. A survey of the case law indicates that a case is most likely to involve a Third Party if (1) the Third Party has overlapping ownership with the provider; (2) the Third Party is alleged to have engaged in knowing fraud; or (3) the whistleblower is an employee of the Third Party or an employee of the provider who was actively engaged with the Third Party. A Third Party may also become a target if it is deemed to be a deep pocket and the providers involved do not appear to be a clear source of payment (i.e., struggling community hospitals or entities that are no longer in existence).

When a Third Party has overlapping ownership with the provider, the government or the whistleblower is usually alleging

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that the provider simply directed its billing company to carry out its scheme and then shared in the profit.[4] The complaint often does not clearly distinguish between what the Third Party and the provider did. This can make it challenging for the non-provider ownership of the Third Party to defend the case. For example, in *U.S. ex. rel. Jensen, et. al. v. Genesis Laboratory Mgmt., et. al.*, No. 20-cv-15121 (D.N.J. 2020), two relators working for Genesis, a clinical testing and diagnostic lab, filed a complaint against Genesis and its related biller, Metropolitan Healthcare Billing LLC. The relators alleged that the defendants submitted false claims by routinely bundling medically unnecessary tests with necessary tests or otherwise overpromoting or overbilling for testing services.

In cases where the government or whistleblower is alleging overt fraud, the allegation is often that the Third Party explicitly directed a provider to engage in behavior that would benefit the Third Party's compensation.[5] For example, in *U.S. v. AIMA Business and Medical Support, LLC*, 4:22-cv-01650 (S.D. Fla. 2025), the government brought a case against AIMA, a Florida and India-based third-party billing company retained by a lab to assist with its billing for genetic and pharmacogenetic testing. AIMA allegedly developed a plan to allow the laboratories to code in such a way as to make more money and also ignored clearly sham doctors' notes and letters to support medical necessity.[6]

Third Parties are most likely to face the broadest range of allegations when the whistleblower is an employee or contractor of the Third Party. In these cases, the whistleblower can allege more nuanced false claims theories, including theories based on the Third Parties' processes, systems, or technology. For example, a whistleblower could allege that a Third Party's technology or systems automatically add unnecessary codes or modifiers. The whistleblower can allege reckless disregard based on the fact that the whistleblower

or a colleague told the Third Party about their errors and they failed to correct them. For example, in *U.S. ex. rel. Bolinger, et. al. v. 24th Street, Inc. f/k/a RMB, Inc., et. al.*, No. 18-15446 (D.N.J. 2018), an RMB employee filed a complaint alleging that the defendants engaged in assumptive coding, or coding without supporting clinical documentation, including adding or changing CPT codes, modifiers, and diagnosis codes to get claims paid without the approval of the physician or facility. The relator alleged that the defendants were incentivized based on percentage arrangements and employee productivity commissions. Although the relator alleged RMB submitted false claims on behalf of a long list of hospitals, he did not name any providers as defendants.[7]

Most allegations against Third Parties focus on their billing structure as their incentive. For example, in 2016, Medical Reimbursement Systems, Inc. ("MRS"), a Massachusetts based company providing billing, coding, compliance, and revenue cycle services to hospitals and physicians, agreed to pay $500,000 to resolve allegations that it submitted false claims to Tricare regarding its clients' eligibility to receive bonuses for providing care in Health Professional Shortage Areas (HPSAs).[8] The company allegedly knew that the practice did not qualify but continued to bill Tricare for bonuses anyway because clients paid MRS based on a percentage of its net collections. Likewise, in *U.S. ex. rel. Vaughn v. Medical Billing Services, Inc.*, 1:10-cv-02953 (N.D. Ga. 2010), a former employee alleged that Medical Business Service, Inc. ("MBS"), a third-party billing company providing services to radiologists, fraudulently changed diagnosis codes because it was paid on a percentage basis. MBS paid $1.95 million.

The FCA: What Should Third Parties Do to Prepare?

The cited cases illustrate that the risk is real. While no level of preparation can ensure someone does not name a party in a lawsuit, companies can mitigate their risk of being involved in an FCA matter or incurring substantial penalties by doing the following:

- **Avoiding overlapping interests.** Third Parties should be cautious of overlapping ownership interests with providers who might incentivize poor behavior or give the impression of knowledge.
- **Be mindful of incentives.** While percentage-based arrangements are common in the medical billing industry, DOJ and HHS are inherently skeptical of such arrangements, and Third Parties should avoid them where feasible. Some states, like New York, have prohibited them altogether.[9] Companies should also be mindful of productivity incentives for their staff and the impression they create.
- **Implement an appropriately sized, risk-based compliance program in line with the Office of Inspector General's (OIG) Guidance.** Third Parties should be familiar with the OIG's Compliance Program Guidance for Third-Party Medical Billing Companies ("Guidance"), which, while dated, still provides the best road map of what compliance efforts the OIG expects from Third Parties.[10]
- **Develop detailed contracts with compliance terms.** Third Parties should have clear written contracts with their provider clients that expressly allocate what services each party is providing and who has compliance responsibilities, including training, in those areas. The contract should address audit procedures, how allegations of billing errors should be investigated, and how percentage-based compensation should be handled in the event of errors or reversed claims. The contract should require the provider client to certify that it is complying with all the relevant rules and providing the Third Party with accurate information and to indemnify the Third Party against damages resulting from breaches of those certifications.
- **Be mindful of whistleblowers.** Third Parties should have strong anonymous reporting channels and anti-retaliation provisions to encourage reporting by their employees and contractors and catch and correct problems early. Third Parties should thoroughly investigate problems when reported and ensure that reporters are doing so. Third Parties should be thoughtful about how they handle adverse employment actions that occur shortly after an employee reports a compliance concern. ■

Erica Barnes is the Chair of Maynard Nexsen's Government Investigations & White Collar Defense Practice. She is passionate about criminal law and how actual or threatened government investigations and prosecutions can impact companies and individuals and their pending civil litigation and regulatory actions. Erica assists individuals and entities all along the criminal law spectrum from helping businesses prevent, internally investigate, and remediate potential criminal violations to representing individuals and businesses in active government investigations, criminal prosecutions, and related civil litigation. She has experience in a wide variety of substantive areas including, for example, civil and criminal securities matters, mail, wire, and healthcare fraud, bribery, civil and criminal antitrust violations, trade secrets violations, embezzlement, money laundering (BSA/AML), and criminal and civil false claims. As a member of the Criminal Justice Act Panel for the Northern District of Alabama, Erica is actively involved in white collar and criminal defense organizations locally, regionally, and nationally. Erica has served as a judicial clerk, state prosecutor, and Assistant United States Attorney.

Resources

[1] https://www.justice.gov/usao-ndga/pr/radiology-billing-company-pay-195-million-resolve-false-claims-act-allegations.

[2] HHS OIG may seek civil monetary penalties under 42 U.S.C. 1320a-7a.

[3] Under 42 U.S.C. 1320a-7, HHS OIG may exclude providers the submission of false or fraudulent claims.

[4] See, e.g., *U.S. ex. rel. Albores, et. al. v. Dimitri, et. al.*, No. 2:18-cv-06936 (E.D. La. 2018) (allegations by nurse practitioners against a dermatologist, her clinic, associated persons and related billing company that defendants performed medically unnecessary services and upcoded them); *U.S. ex rel. Napoli v. Premier Hospitalists PL*, No. 8:14-cv-2952-T-33TBM, 2016 WL 5476199, at *1 (M.D. Fla. Sept. 29, 2016)(alleging Primed "through its communications with Dr. Sharma, was well aware that it was billing Medicare and Medicaid for patients never seen by Dr. Sharma yet were billed under his name.").

[5] In the Eastern District of Pennsylvania, Firstsource Solutions USA, LLC, a revenue cycle management service provider, agreed to pay $225,000 to settle allegations it processed false claims to Medicaid for inpatient treatment by knowingly assisting patients to falsely fill out forms indicating they were not employable. See https://www.justice.gov/usao-edpa/pr/phoenixville-hospital-and-firstsource-solutions-agree-pay-325000-resolve-false-claims#:~:text=(collectively%20%E2%80%9C Firstsource%20Solutions%E2%80%9D),claims%20on%20 Phoenixville%20Hospital's%20behalf. These cases can also become criminal. See, e.g., *U.S. v. Townsend*, No. 3:17-cr-00033-GCM-DCK-1 (W.D.N.C. 2017) (criminal case where individual providing billing and credentialing services to mental health companies received 42 months for intentionally billing two to three times the appropriate amount to Medicaid based on client instructions because the biller was being paid 5-7% of reimbursements).

[6] It is also notable that the Government did not name a lab provider as a co-defendant. The case is currently at the initial stage of litigation and will likely reveal interesting factual details and corresponding legal arguments if AIMA files a motion to dismiss or continues litigating the claims.

[7] See also *U.S. ex rel. Worthy v. E. Maine Healthcare Sys., et al.*, No. 2:14-cv-00184 (D. Me. 2014) (settlement of $1.5M based on systematic unbundling and incorrect use of modifiers); *U.S. ex. rel Le Jeanne Harris v. Baton Rouge General Medical Center, et. al*. 3:03-cv-00582 (M.D. La. 2003) (settlement of $4.6M based on allegations a management company billing for ER physicians used a coding formula to upcode and add services).

[8] See https://media.defense.gov/2016/Jan/21/2001711799/-1/1/1/MedicalReimbursementSystems%20Inc_PR_012516.pdf.

[9] See NY Educ. Law § 6530 (19) (prohibiting licensed physicians from splitting fees with a medical biller).

[10] 63 Fed. Reg. 70138-70152 (Dec. 18, 1998), available at https://oig.hhs.gov/documents/compliance-guidance/805/thirdparty.pdf.