TITLE 42. THE PUBLIC HEALTH AND WELFARE
CHAPTER 7. SOCIAL SECURITY ACT
TITLE XI. GENERAL PROVISIONS, PEER REVIEW, AND ADMINISTRATIVE SIMPLIFICATION
PART A. GENERAL PROVISIONS

Go to the United States Code Service Archive Directory

42 USCS § 1320a-7b

§ 1320a-7b. Criminal penalties for acts involving Federal health care programs

(a) Making or causing to be made false statements or representations. Whoever--
(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program (as defined in subsection (f)),
(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,
(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized,
(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,
(5) presents or causes to be presented a claim for a physician's service for which payment may be made under a Federal health care program and knows that the individual who furnished the service was not licensed as a physician, or
(6) for a fee knowingly and willfully counsels or assists an individual to dispose of assets (including by any transfer in trust) in order for the individual to become eligible for medical assistance under a State plan under title XIX [*42 USCS §§ 1396* et seq.], if disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1917(c) [*42 USCS § 1396p(c)*],

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any other person in connection with the furnishing (by that person) of items or services for which payment is or may be made under the program, be guilty of a felony and upon conviction thereof fined not more than $ 25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, conversion, or provision of counsel or assistance by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $ 10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a Federal health care program is convicted of an offense under the preceding provisions of this subsection, the administrator of such program may at its option (notwithstanding any other provision of such program) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b) Illegal remunerations.
(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind--
(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or
(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program,
shall be guilty of a felony and upon conviction thereof, shall be fined not more than $ 25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person--

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $ 25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to--

(A) a discount or other reduction in price obtained by a provider of services or other entity under a Federal health care program if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under a Federal health care program;

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services;

(C) any amount paid by a vendor of goods or services to a person authorized to act as a purchasing agent for a group of individuals or entities who are furnishing services reimbursed under a Federal health care program if--

(i) the person has a written contract, with each such individual or entity, which specifies the amount to be paid the person, which amount may be a fixed amount or a fixed percentage of the value of the purchases made by each such individual or entity under the contract, and

(ii) in the case of an entity that is a provider of services (as defined in section 1861(u) [*42 USCS § 1395x(u)*]), the person discloses (in such form and manner as the Secretary requires) to the entity and, upon request, to the Secretary the amount received from each such vendor with respect to purchases made by or on behalf of the entity;

(D) a waiver of any coinsurance under part B of title XVIII [*42 USCS §§ 1395j* et seq.] by a Federally qualified health care center with respect to an individual who qualifies for subsidized services under a provision of the Public Health Service Act;

(E) any payment practice specified by the Secretary in regulations promulgated pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987 [note to this section] or in regulations under section 1860D-3(e)(6) [1860D-4(e)(6)] [*42 USCS § 1395w-104(e)(6)*];

(F) any remuneration between an organization and an individual or entity providing items or services, or a combination thereof, pursuant to a written agreement between the organization and the individual or entity if the organization is an eligible organization under section 1876 [*42 USCS § 1395mm*] or if the written agreement, through a risk-sharing arrangement, places the individual or entity at substantial financial risk for the cost or utilization of the items or services, or a combination thereof, which the individual or entity is obligated to provide;

(G) the waiver or reduction by pharmacies (including pharmacies of the Indian Health Service, Indian tribes, tribal organizations, and urban Indian organizations) of any cost-sharing imposed under part D of title XVIII [*42 USCS §§ 1395w-101* et seq.], if the conditions described in clauses (i) through (iii) of section 1128A(i)(6)(A) [*42 USCS § 1320a-7a(i)(6)(A)*] are met with respect to the waiver or reduction (except that, in the case of such a waiver or reduction on behalf of a subsidy eligible individual (as defined in section 1860D-14(a)(3) [*42 USCS § 1395w-114(a)(3)*]), section 1128A(i)(6)(A) [*42 USCS § 1320a-7a(i)(6)(A)*] shall be applied without regard to clauses (ii) and (iii) of that section);

(H) any remuneration between a federally qualified health center (or an entity controlled by such a health center) and an MA organization pursuant to a written agreement described in section 1853(a)(4) [*42 USCS § 1395w-23(a)(4)*];

(I) any remuneration between a health center entity described under clause (i) or (ii) of section 1905(l)(2)(B) [*42 USCS § 1396d(l)(2)(B)*] and any individual or entity providing goods, items, services, donations, loans, or a combination thereof, to such health center entity pursuant to a contract, lease, grant, loan, or other agreement, if such agreement contributes to the ability of the health center entity to maintain or increase the availability, or enhance the quality, of services provided to a medically underserved population served by the health center entity; and

(J) a discount in the price of an applicable drug (as defined in paragraph (2) of section 1860D-14A(g) [*42 USCS § 1395w-114a(g)*]) of a manufacturer that is furnished to an applicable beneficiary (as defined in paragraph (1) of such section) under the Medicare coverage gap discount program under section 1860D-14A [*42 USCS § 1395w-114a*].

(c) False statements or representations with respect to condition or operation of institutions. Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution, facility, or entity in order that such institution, facility, or entity may qualify (either upon initial certification or upon recertification) as a hospital, critical access hospital, skilled nursing facility, nursing facility, intermediate care facility for the mentally retarded, home health

agency, or other entity (including an eligible organization under section 1876(b) [*42 USCS § 1395mm(b)*]) for which certification is required under title XVIII [*42 USCS §§ 1395* et seq.] or a State health care program (as defined in section 1128(h) [*42 USCS § 1320a-7(h)*]), or with respect to information required to be provided under section 1124A [*42 USCS § 1320a-3a*], shall be guilty of a felony and upon conviction thereof shall be fined not more than $ 25,000 or imprisoned for not more than five years, or both.

(d) Illegal patient admittance and retention practices. Whoever knowingly and willfully--

(1) charges, for any service provided to a patient under a State plan approved under title XIX [*42 USCS §§ 1396* et seq.], money or other consideration at a rate in excess of the rates established by the State (or, in the case of services provided to an individual enrolled with a medicaid managed care organization under title XIX under a contract under section 1903(m) [*42 USCS § 1396b(m)*] or under a contractual, referral, or other arrangement under such contract, at a rate in excess of the rate permitted under such contract), or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under title XIX [*42 USCS §§ 1396* et seq.], any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)--

(A) as a precondition of admitting a patient to a hospital, nursing facility, or intermediate care facility for the mentally retarded, or

(B) as a requirement for the patient's continued stay in such a facility,

when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $ 25,000 or imprisoned for not more than five years, or both.

(e) Violation of assignment terms. Whoever accepts assignments described in section 1842(b)(3)(B)(ii) [*42 USCS § 1395u(b)(3)(B)(ii)*] or agrees to be a participating physician or supplier under section 1842(h)(1) [*42 USCS § 1395a(h)(1)*] and knowingly, willfully, and repeatedly violates the term of such assignments or agreement, shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $ 2,000 or imprisoned for not more than six months, or both.

(f) "Federal health care program" defined. For purposes of this section, the term "Federal health care program" means--

(1) any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the health insurance program under chapter 89 of title 5, United States Code [*5 USCS §§ 8901* et seq.]); or

(2) any State health care program, as defined in section 1128(h) [*42 USCS § 1320a-7(h)*].

(g) Kickbacks. In addition to the penalties provided for in this section or section 1128A [*42 USCS § 1320a-7a*], a claim that includes items or services resulting from a violation of this section constitutes a false or fraudulent claim for purposes of subchapter III of chapter 37 of title 31, United States Code [*31 USCS §§ 3721* et seq.].

(h) Intent. With respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section.

HISTORY:

(Aug. 14, 1935, ch 531, Title XI [XVIII, Part C] [XIX], § 1128B [1877(d)] [1909], as added Oct. 30, 1972, P.L. 92-603, Title II, §§ 242(c), 278(b)(9), 86 Stat. 1419, 1454; Oct. 25, 1977, P.L. 95-142, § 4(a), (b), 91 Stat. 1179, 1181; Dec. 5, 1980, P.L. 96-499, Title IX, Part A, Subpart II, § 917 in part, 94 Stat. 2625; July 18, 1984, P.L. 98-369, Division B, Title III, Subtitle A, Part I, § 2306(f)(2), 98 Stat. 1073; Aug. 18, 1987, P.L. 100-93, §§ 4(a)-(d), 14(b), 101 Stat. 688, 689, 697; Dec. 22, 1987, P.L. 100-203, Title IV, Subtitle A, Part 2, Subpt. C, § 4039(a), Subtitle C, Part 2, § 4211(h)(7), 101 Stat. 1330-81, 1330-206; July 1, 1988, P.L. 100-360, Title IV, Subtitle B, § 411(a)(3)(B), 102 Stat. 768; Dec. 19, 1989, P.L. 101-239, Title VI, Subtitle A, Part 1, Subpart A, § 6003(g)(3)(D)(ii), 103 Stat. 2153; Nov. 5, 1990, P.L. 101-508, Title IV, Subtitle A, Part 2, Subpart B, §§ 4161(a)(4), 4164(b)(2), 104 Stat. 1388-94, 1388-102; Oct. 31, 1994, P.L. 103-432, Title I, Subtitle B, Part II, § 133(a)(2), 108 Stat. 4421; Aug. 21, 1996, P.L. 104-191, Title II, Subtitle A, § 204(a), Subtitle B, § 216(a), 110 Stat. 1999, 2007; Aug. 5, 1997, P.L. 105-33, Title IV, Subtitle C, § 4201(c)(1), Subtitle H, Ch 1, § 4704(b), Ch 4, § 4734, 111 Stat. 373, 498, 522; Dec. 8, 2003, P.L. 108-173, Title I, § 101(e)(2), (8)(A), Title II, Subtitle D, § 237(d), Title IV, Subtitle D, § 431(a), 117 Stat. 2150, 2152, 2213, 2287.)

(As amended March 23, 2010, P.L. 111-148, Title III, Subtitle D, § 3301(d)(1), Title VI, Subtitle E, § 6402(f), 124 Stat. 468, 759.)

HISTORY; ANCILLARY LAWS AND DIRECTIVES

References in text:

The "Public Health Service Act", referred to in this section, is Act July 1, 1944, ch 373, 58 Stat. 682, which appears generally as *42 USCS §§ 201* et seq. For full classification of such Act, consult USCS Tables volumes.

Explanatory notes:

In subsec. (b)(3)(E), "1860D-4(e)(6)" has been inserted in brackets to indicate the section reference probably intended by Congress.

Amendments:

1972. Act Oct. 30, 1972, in subsec. (c), substituted "skilled nursing facility" for "skilled nursing home".

1977. Act Oct. 25, 1977 (applicable to acts occurring and statements made on or after 10/25/77, as provided by § 4(d) of such Act, which appears as a note to this section), substituted this section for one which read:

"(a) Whoever--

"(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,

"(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

"(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment is authorized, or

"(4) having made such application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $ 10,000 or imprisoned for not more than one year, or both.

"(b) Whoever furnishes items or services to an individual for which payment is or may be made in whole or in part out of Federal funds under a State plan approved under this title and who solicits, offers, or receives any-

"(1) kickback or bribe in connection with the furnishing of such items or services or the making or receipt of such payment, or

"(2) rebate of any fee or charge for referring any such individual to another person for the furnishing of such items or services

"shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $ 10,000 or imprisoned for not more than one year, or both.

"Whoever knowingly or willingly makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditioned or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $ 2,000 or imprisoned for not more than 6 months, or both.".

1980. Act Dec. 5, 1980, in subsec. (b), in par. (1), inserted "willingly and knowingly", and in par. (2) inserted "willingly and knowingly".

1984. Act July 18, 1984, in subsec. (e), inserted "or agrees to be a participating physician or supplier under section 1842(h)(1)" and substituted "or agreement" for "specified in subclause (I) of such section".

1987. Act Aug. 18, 1987 (effective as provided by § 15(a) of such Act, which appears as *42 USCS § 1320a-7* note) substituted the section catchline for one which read: "Offenses and penalties"; in subsec. (a), in para. (1), substituted "a program under title XVIII or a State health care program (as defined in section 1128(h))" for "a State plan approved under this title", in para. (3), deleted "or" following "authorized,", in para. (4), inserted "or" following "person,", and added para. (5), and, in the concluding matter, substituted "the program" for "this title" preceding "be guilty", substituted "title XIX" for "this title" preceding "is convicted" and substituted "that title" for "this title" preceding "or of such plan)"; in subsec. (b), in paras. (1)(A), (1)(B), (2)(A), and (2)(B), substituted "title XVIII or a State Health care program" for "this title", in para. (3), in subpara. (A), substituted "title XVIII or a State health care program" for "this title", deleted "and" following the concluding semicolon, in subpara. (B), substituted "; and" for the concluding period and then deleted "and" following "services;", added subpara. (C), and in subpara. (C), as so added, substituted "; and" for the concluding period, and added subpara. (D); in subsec. (c), substituted "home health agency, or other entity for which certification is required under title XVIII or a State health care program" for "or home health agency (as those terms are employed in this title)"; and in subsec. (d), in paras. (1) and (2), substituted "title XIX" for "this title".

Act Dec. 22, 1987, in subsec. (c), substituted "institution, facility, or entity" for "institution or facility" wherever appearing, and inserted "(including an eligible organization under section 1876(b))".

Such Act further (applicable as provided by § 4214 of such Act, which appears as *42 USCS § 1396r* note), in subsec. (c), substituted "nursing facility, intermediate care facility for the mentally retarded" for "intermediate care facility"; and, in subsec. (d)(2)(A), substituted "nursing facility, or intermediate care facility for the mentally retarded" for "skilled nursing facility, or intermediate care facility".

1988. Act July 1, 1988 (effective as provided by § 411(a) of such Act, which appears as *1 USCS § 106* note), amended the directory language of Act Dec. 22, 1987, P.L. 100-203, without affecting the text of this section.

1989. Act Dec. 19, 1989, in subsec. (c), inserted "rural primary care hospital,".

1990. Act Nov. 5, 1990 (applicable as provided by § 4161(a)(8) of such Act, which appears as *42 USCS § 1395k* note), in subsec. (b)(3), in subpara. (C), deleted "and" following the semicolon, redesignated subpara. (D) as subpara. (E), and added a new subpara. (D).

Such Act further (applicable as provided by § 4164(b)(4) of such Act, which appears as *42 USCS § 1320a-3a* note), in subsec. (c), substituted "health care program, or with respect to information required to be provided under section 1124A," for "health care program".

1994. Act Oct. 31, 1994 (applicable to items or services furnished on or after 1/1/95, as provided by § 133(c) of such Act, which appears as *42 USCS § 1395m* note), in subsec. (b)(3)(B), purported to substitute "1834(j)(5)" for "1834(j)(4)"; however, inasmuch as no such reference appeared, the amendment could not be executed.

1996. Act Aug. 21, 1996 (effective 1/1/97 as provided by § 204(b) of such Act, which appears as a note to this section), in the section heading, substituted "Federal health care programs" for "Medicare or State health care programs"; in subsec. (a), in para. (1), substituted "a Federal health care program (as defined in subsection (f))" for "a program under title XVIII or a State health care program (as defined in section 1128(h))", in para. (5), substituted "a Federal health care

program" for "a program under title XVIII or a State health care program" and, in the concluding matter, substituted "a Federal health care program" for "a State plan approved under title XIX" and substituted "the administrator of such program may at its option (notwithstanding any other provision of such program)" for "the State may at its option (notwithstanding any other provision of that title or of such plan)"; in subsec. (b), substituted "a Federal health care program" for "title XVIII or a State health care program" wherever appearing; in subsec. (c), inserted "(as defined in section 1128(h))"; and added subsec. (f).

Such Act further (effective 1/1/97, as provided by § 218 of such Act, which appears as *42 USCS § 1320a-7* note), in subsec. (a), in para. (4), deleted "or" after the concluding comma, in para. (5), added "or" after the concluding comma, and added para. (6).

Such Act further (applicable to written agreements entered into on or after 1/1/97, as provided by § 216(c) of such Act, which appears as a note to this section), in subsec. (b)(3), in subpara. (D), deleted "and" after the concluding semicolon, in subpara. (E), substituted "; and" for a concluding period, and added subpara. (F).

1997. Act Aug. 5, 1997, § 4201(c)(1) (applicable to services furnished on or after 10/1/97, as provided by § 4201(d) of such Act, which appears as *42 USCS § 1395f* note), in subsec. (c), substituted "critical access" for "rural primary care".

Section 4704(b) of such Act (effective and applicable as provided by § 4710 of such Act, which appears as *42 USCS § 1396b* note), in subsec. (d)(1), inserted "(or, in the case of services provided to an individual enrolled with a medicaid managed care organization under title XIX under a contract under section 1903(m) or under a contractual, referral, or other arrangement under such contract, at a rate in excess of the rate permitted under such contract)".

Section 4734 of such Act, in subsec. (a), substituted para. (6) for one which read: "(6) knowingly and willfully disposes of assets (including by any transfer in trust) in order for an individual to become eligible for medical assistance under a State plan under title XIX, if disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1917(c)," and, in the concluding matter, substituted "failure, conversion, or provision of counsel or assistance by any other person" for "failure, or conversion by any other person".

2003. Act Dec. 8, 2003, in subsec. (b)(3), in subpara. (E), deleted "and" following the concluding semicolon, in subpara. (F), substituted "; and" for a concluding period, and added subpara. (G).

Such Act further purported to amend subsec. (b)(3)(C) by inserting "or in regulations under section 1860D-3(e)(6)" after "1987"; however, this amendment was executed by making the insertion in subsec. (b)(3)(E) in order to effectuate the probable intent of Congress, since "1987" did not appear in subsec. (b)(3)(C).

Such Act further (applicable to services provided on or after 1/1/2006, and contract years beginning on or after such date, as provided by § 237(e) of such Act, which appears as a note to this section), in subsec. (b)(3), in subpara. (F), deleted "and" following the concluding semicolon, in subpara. (G), substituted "; and" for a concluding period, and added subpara. (H).

Such Act further purported to amend subsec. (b)(3) by deleting "and" following the semicolon in subpara. (F), substituting "; and" for a concluding period in subpara. (G), and adding subpara. (H); however, because of prior amendments, these amendments could not be executed as directed. Subpara. [(I)](H) was added in order to effectuate the probable intent of Congress.

2010. Act March 23, 2010 (applicable to drugs dispensed on or after 7/1/2010, as provided by § 3301(d)(3) of such Act, which appears as a note to this section), in subsec. (b)(3), in subpara. (G), deleted "and" following the concluding semicolon, in subpara. (H), substituted the concluding semicolon for a period, redesignated subpara. [(I)](H) as subpara. (I), and in such subparagraph as redesignated, substituted "; and" for a concluding period, and added subpara. (J).

Such Act further added subparas. (g) and (h).

Redesignation:

This section, enacted as § 1909 of Title XIX of Act Aug. 14, 1935, ch 531, was redesignated § 1128B of Title XI of such Act by Act Aug. 18, 1987, P.L. 100-93, § 4(d), 101 Stat. 689, effective as provided by § 15 of Act Aug. 18, 1987, which appears as *42 USCS § 1320a-7* note.

Subsec. (e) of this section, enacted as subsec. (d) of § 1877 of Part C of Title XVIII of Act Aug. 14, 1935, ch 531, by Act Oct. 25, 1977, P.L. 95-142, § 4(a), 91 Stat. 1179, was redesignated as subsec. (e) of § 1909 of Title XIX of such Act by Act Aug. 18, 1987, P.L. 100-93, § 4(d), 101 Stat. 689, effective as provided by § 15 of Act Aug. 18, 1987, which appears as *42 USCS § 1320a-7* note.

Other provisions:

Application of Oct. 30, 1972 amendments. Act Oct. 30, 1972, P.L. 92-603, Title II, § 242(d), 86 Stat. 1420, provides: "The provisions of amendments made by this section [enacting *42 USCS §§ 1320a-7b* and *1396h* and amending *42 USCS § 1395ii*] shall not be applicable to any acts, statements, or representations made or committed prior to the enactment of this Act.".

Effective date of Oct. 25, 1977 amendments. Act Oct. 25, 1977, P.L. 95-142, § 4(d), 91 Stat. 1183, provides: "The amendments made by subsections (a) and (b) [amending this section] shall apply with respect to acts occurring and statements or representations made on or after the date of enactment of this Act.".

Standards for anti-kickback provisions. Act Aug. 18, 1987, P.L. 100-93, § 14(a), 101 Stat. 697 (effective as provided by § 15 of such Act, which appears as *42 USCS § 1320a-7* note), provides:

"(a) Regulations. The Secretary of Health and Human Services, in consultation with the Attorney General, not later than 1 year after the date of the enactment of this Act shall publish proposed regulations, and not later than 2 years after the date of the enactment of this Act shall promulgate final regulations, specifying payment practices that shall not be treated as a criminal offense under section 1128B(b) of the Social Security Act [subsec. (b) of this section] and shall not serve as the basis for an exclusion under section 1128(b)(7) of such Act [*42 USCS § 1320a-7(b)(7)*]. Any practices specified in regulations pursuant to the preceding sentence shall be in addition to the practices described in subparagraphs (A) through (C) of section 1128B(b)(3) [subsec. (b)(3) of this section].".

Effective date of amendments made by § 204 of Act Aug. 21, 1996. Act Aug. 21, 1996, P.L. 104-191, Title II, Subtitle A, § 204(b), 110 Stat. 2000, provides: "The amendments made by this section [amending this section] shall take effect on January 1, 1997.".

Negotiated rulemaking for risk-sharing exception. Act Aug. 21, 1996, P.L. 104-191, Title II, Subtitle B, § 216(b), 110 Stat. 2007, provides:

"(1) Establishment.

(A) In general. The Secretary of Health and Human Services (in this subsection referred to as the 'Secretary') shall establish, on an expedited basis and using a negotiated rulemaking process under subchapter 3 of chapter 5 of title 5, United States Code [*5 USCS §§ 571* et seq.], standards relating to the exception for risk-sharing arrangements to the anti-kickback penalties described in section 1128B(b)(3)(F) of the Social Security Act [*42 USCS § 1320a-7b(b)(3)(F)*], as added by subsection (a).

"(B) Factors to consider. In establishing standards relating to the exception for risk-sharing arrangements to the anti-kickback penalties under subparagraph (A), the Secretary--

"(i) shall consult with the Attorney General and representatives of the hospital, physician, other health practitioner, and health plan communities, and other interested parties; and

"(ii) shall take into account--

"(I) the level of risk appropriate to the size and type of arrangement;

"(II) the frequency of assessment and distribution of incentives;

"(III) the level of capital contribution; and

"(IV) the extent to which the risk-sharing arrangement provides incentives to control the cost and quality of health care services.

"(2) Publication of notice. In carrying out the rulemaking process under this subsection, the Secretary shall publish the notice provided for under *section 564(a) of title 5, United States Code*, by not later than 45 days after the date of the enactment of this Act.

"(3) Target date for publication of rule. As part of the notice under paragraph (2), and for purposes of this subsection, the 'target date for publication' (referred to in section 564(a)(5) of such title) shall be January 1, 1997.

"(4) Abbreviated period for submission of comments. In applying section 564(c) of such title under this subsection, '15 days' shall be substituted for '30 days'.

"(5) Appointment of negotiated rulemaking committee and facilitator. The Secretary shall provide for--

"(A) the appointment of a negotiated rulemaking committee under section 565(a) of such title by not later than 30 days after the end of the comment period provided for under section 564(c) of such title (as shortened under paragraph (4)), and

"(B) the nomination of a facilitator under section 566(c) of such title by not later than 10 days after the date of appointment of the committee.

"(6) Preliminary committee report. The negotiated rulemaking committee appointed under paragraph (5) shall report to the Secretary, by not later than October 1, 1996, regarding the committee's progress on achieving a consensus with regard to the rulemaking proceeding and whether such consensus is likely to occur before one month before the target date for publication of the rule. If the committee reports that the committee has failed to make significant progress toward such consensus or is unlikely to reach such consensus by the target date, the Secretary may terminate such process and provide for the publication of a rule under this subsection through such other methods as the Secretary may provide.

"(7) Final committee report. If the committee is not terminated under paragraph (6), the rulemaking committee shall submit a report containing a proposed rule by not later than one month before the target publication date.

"(8) Interim, final effect. The Secretary shall publish a rule under this subsection in the Federal Register by not later than the target publication date. Such rule shall be effective and final immediately on an interim basis, but is subject to change and revision after public notice and opportunity for a period (of not less than 60 days) for public comment. In connection with such rule, the Secretary shall specify the process for the timely review and approval of applications of entities to be certified as provider-sponsored organizations pursuant to such rules and consistent with this subsection.

"(9) Publication of rule after public comment. The Secretary shall provide for consideration of such comments and republication of such rule by not later than 1 year after the target publication date.".

Application of amendments made by § 216(a) of Act Aug. 21, 1996. Act Aug. 21, 1996, P.L. 104-191, Title II, Subtitle B, § 216(c), 110 Stat. 2008, provides: "The amendments made by subsection (a) [amending subsec. (b)(3) of this section] shall apply to written agreements entered into on or after January 1, 1997, without regard to whether regulations have been issued to implement such amendments.".

Application of amendments made by § 237 of Act Dec. 8, 2003. Act Dec. 8, 2003, P.L. 108-173, Title II, Subtitle D, § 237(e), 117 Stat. 2213, provides: "The amendments made by this section [amending *42 USCS §§ 1320a-7b(b)(3)*, *1395l(a)(3)*, *1395w-21(i)*, *1395w-23*, and *1395w-27(e)*] shall apply to services provided on or after January 1, 2006, and contract years beginning on or after such date.".

Rulemaking for exception for health center entity arrangements. Act Dec. 8, 2003, P.L. 108-173, Title IV, Subtitle D, § 431(b), 117 Stat. 2287, provides:

"(1) Establishment.

(A) In general. The Secretary shall establish, on an expedited basis, standards relating to the exception described in section 1128B(b)(3)(H) of the Social Security Act [*42 USCS § 1320a-7b(b)(3)*[(I)](H)], as added by subsection (a), for health center entity arrangements to the antikickback penalties.

"(B) Factors to consider. The Secretary shall consider the following factors, among others, in establishing standards relating to the exception for health center entity arrangements under subparagraph (A):

"(i) Whether the arrangement between the health center entity and the other party results in savings of Federal grant funds or increased revenues to the health center entity.

"(ii) Whether the arrangement between the health center entity and the other party restricts or limits an individual's freedom of choice.

"(iii) Whether the arrangement between the health center entity and the other party protects a health care professional's independent medical judgment regarding medically appropriate treatment.

The Secretary may also include other standards and criteria that are consistent with the intent of Congress in enacting the exception established under this section.

"(2) Deadline. Not later than 1 year after the date of the enactment of this Act the Secretary shall publish final regulations establishing the standards described in paragraph (1).".

Appplication of amendments made by § 3301(d) of Act March 23, 2010. Act March 23, 2010, P.L. 111-148, Title III, Subtitle D, § 3301(d)(3), 124 Stat. 468, provides: "The amendments made by this subsection [amending *42 USCS §§ 1320a-7b(b)(3)* and *1396r-8(c)(1)(C)*] shall apply to drugs dispensed on or after July 1, 2010.".

NOTES:

Code of Federal Regulations:

Office of Inspector General-Health Care, Department of Health and Human Services--Program integrity-Medicare and State health care programs, *42 CFR 1001.1* et seq.

Related Statutes & Rules:

Sentencing Guidelines for the United States Courts, *18 USCS Appx §§ 2B1.1, 2B4.1*.

This section is referred to in *11 USCS § 362*; *42 USCS §§ 1320a-3a, 1320a-7, 1320a-7a, 1320a-7c, 1320a-7d, 1320a-7e, 1395b-5, 1395w-104, 1395w-141, 1396r-6, 1397gg*.

Research Guide:

Forms:

21 *Rabkin & Johnson, Current Legal Forms, § 16A.38*, Professional Corporations.

Criminal Law and Practice:

5 Business Crime (Matthew Bender), ch 26, Fraud in the Health Care Industry PP 26.03, 26.08, 26.09.

Bankruptcy:

3 Collier on Bankruptcy (Matthew Bender 16th ed.), ch 362, Automatic Stay P 362.05.

Annotations:

Illegal remuneration under Medicare Anti-Kickback Statute (Social Security Act § 1128B) (*42 USCS §§ 1320a-7b*). *132 ALR Fed 601*.

Law Review Articles:

Stanger. A HIPAA Primer: Simplifying "Administrative Simplification". 45 Advoc (Boise) 11, May 2002.

Standard HIPAA Order in Civil Actions. *65 Ala Law 332*, September 2004.

Matthew. An Economic Model to Analyze the Impact of False Claims Act Cases on Access to Healthcare for the Elderly, Disabled, Rural and Inner-City Poor. *27 Am J L and Med 439, 2001.*

Blair. The "Knowingly and Willfully" Continuum of the Anti-Kickback Statute's Scienter Requirement: Its Origins, Complexities, and Most Recent Judicial Developments. *8 Ann Health L 1, 1999.*

Rountree. Health Care Providers and Fraud Investigations: What Can You Do When the Government Changes the Rules in the Middle of the Game? *8 Ann Health L 97, 1999.*

Jacobs; Goodman. Splitting Fees or Splitting Hairs? Fee Splitting and Health Care--The Florida Experience. *8 Ann Health L 239, 1999.*

Aspinwall. The Anti-Kickback Statute Standards of Intent: The Case for a Rule of Reason Analysis. *9 Ann Health L 155, 2000.*

Rawlings; Aaron. The Effect of Hospital Charges on Outlier Payments Under Medicare's Inpatient Prospective Payment System: Prudent Financial Management or Illegal Conduct? *14 Ann Health L 267*, Summer 2005.

Ramirez. The Science Fiction of Corporate Criminal Liability: Containing the Machine Through the Corporate Death Penalty. *47 Ariz L Rev 933*, Winter 2005.

Krause; Frost. "Promises to Keep": Health Care Providers and the Civil False Claims Act. *23 Cardozo L Rev 1363*, March 2002.

McKenzie. Handling medical data? Think HIPAA now. 17 Computer Internet Law 15, November 2000.

Antognini. The Law of Unintended Consequences: HIPAA and Liability Insurers. *69 Def Couns J 296*, July 2002.

Grosso. Medical necessity and the Medicare and Medicaid anti-kickback statute. 40 Fed B News & J 301, June 1993.

Lovitky. The Privacy of Health Information: Consents and Authorization under HIPAA. *76 Fla BJ 10*, May 2002.

Kirschenbaum; Kuhlik. Federal and state laws affecting discounts, rebates, and other marketing practices for drugs and devices. *47 Food & Drug LJ 533, 1992.*

Krause. The Changing Face of White-Collar Crime: A Patient-Centered Approach to Health Care Fraud Recovery. *96 J Crim L & Criminology 579*, Winter 2006.

Rabecs. The Changing Face of White-Collar Crime: Health Care Fraud Under the New Medicare Part D Prescription Drug Program. *96 J Crim L & Criminology 727*, Winter 2006.

Roach. HIPAA privacy: "individual rights" and the "minimum necessary" requirements. 33 J Health L 549, Fall 2000.

Rosati. HIPAA privacy: the compliance challenges ahead. 35 J Health L 45, Winter 2002.

Tatelbaum. Practice Resource: Checklist of Federal and State Privacy Issues. 35 J Health L 283, Spring 2002.

Stein. What Litigators Need to Know about HIPAA. 36 J Health L 433, Summer 2003.

Tedrick. Legal issues in physician self-referral and other health care business relationships. *13 J Legal Med 521*, December 1992.

Krause. A Conceptual Model of Health Care Fraud Enforcement. *12 JL & Pol'y 55, 2003.*

Rabecs. Kickbacks as False Claims: The Use of the Civil False Claims Act to Prosecute Violations of the Federal Health Care Program's Anti-Kickback Statute. *2001 L Rev MSU-DCL 1*, Spring 2001.

Eddy. The Effect of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) on Health Care Fraud in Montana. *61 Mont L Rev 175*, Winter 2000.

Remus; L'Huillier. HIPAA and lawyers: yes, lawyers! *44 NH BJ 14*, March 2003.

Krause. Regulating, Guiding, and Enforcing Health Care Fraud. *60 NYU Ann Surv Am L 241, 2004.*

Greene. False Claims Act Liability for Off-Label Promotion of Pharmaceutical Products. *110 Penn St L Rev 41, 2005.*

Wallander. Physician employment, recruitment contracts: OIG issues final anti-kickback safe harbours. 43 Res Gestae 14, May 2000.

Brainin. Health Care: A Unique Criminal and Civil Enforcement Environment. *45 S Tex L Rev 131*, Winter 2003.

Bucy. The Path from Regulator to Hunter: The Exercise of Prosecutorial Discretion in the Investigation of Physicians at Teaching Hospitals. *44 St Louis LJ 3*, Winter 2000.

Cohen. An Examination of the Right of Hospitals to Engage in Economic Credentialing. *77 Temp L Rev 705*, Fall 2004.

Woody. Health Information Privacy: the Rules Get Tougher. *37 Tort & Ins LJ 1051*, Summer 2002.

Cohen. The Controversy Over Hospital Charges to the Uninsured--No Villains, No Heroes. *51 Vill L Rev 95, 2006.*

Weeks. Gauging the Cost of Loopholes: Health Care Pricing and Medicare Regulation in the Post-Enron Era. *40 Wake Forest L Rev 1215*, Winter 2005.

Hartin. New federal privacy rules for health care providers. 75 Wis L 14, April 2002.

Langer. The HIPAA Privacy Rules: Disclosures of Protected Health Information in Legal Proceedings. 78 Wis L 14, April 2005.

Ehler-Lejcher. The Expansion of Corporate Compliance: Guidance for Health Care Entities. *25 Wm Mitchell L Rev 1339, 1999.*

Interpretive Notes and Decisions:

1. Generally 2. Constitutional issues 3. Relationship with other criminal statutes 4. Bribes and kickbacks, generally 5.--Particular cases 6.----Sentencing matters 7. Excessive charges 8. Discount exception 9. Miscellaneous

1. Generally

1977 amendments to former *42 USCS § 1396h* were passed to strengthen pre-existing valid law, not to validate it; penalties listed for offenses occurring before 1977 amendments remain as listed. *United States v Tapert (1980, CA6 Mich) 625 F2d 111*, cert den *(1980) 449 US 952, 66 L Ed 2d 216, 101 S Ct 356* and cert den *(1980) 449 US 1034, 66 L Ed 2d 496, 101 S Ct 609, 101 S Ct 610.*

"Knowledge of falsity" is essential element of Medicaid fraud; thus, jury instruction that failed to apprise jury that defendant's statements or representations must not only be false but that defendant must also have known them to be false when he submitted his claim was error. *United States v Laughlin (1994, CA10 Okla) 26 F3d 1523, 44* Soc Sec Rep Serv 615, *126 ALR Fed 749*, cert den *(1994) 513 US 965, 130 L Ed 2d 342, 115 S Ct 428.*

Former *42 USCS § 1396h* did not impose duty on states to set minimum rates for prescriptions. *Ostrow Pharmacies, Inc. v Beal (1975, ED Pa) 394 F Supp 22,* affd without op (1976, CA3 Pa) *527 F2d 645.*

Allegations that health services providers have violated *42 USCS § 1320a-7b* and state statute prohibiting Medicaid and Medicare fraud will be stricken, where provisions are criminal statutes that provide no private right of action, because violations of such criminal fraud statutes cannot serve as basis for injunctive relief under either federal antitrust or state unfair business practice laws. *Action Ambulance Serv., Inc. v Atlanticare Health Servs., Inc. (1993, DC Mass) 815 F Supp 33, 40* Soc Sec Rep Serv 419, 1993-1 CCH Trade Cases P 70220.

Action challenging *42 USCS § 1320a-7b* did not present cognizable case or controversy, absent objectively reasonable fear of prosecution, where U.S. Attorney General informed Congress of her unequivocal opinion that statute was unconstitutional, and commanded U.S. attorneys not to investigate or prosecute alleged violations. *Magee v United States (2000, DC RI) 93 F Supp 2d 161.*

Relators failed to state claim under Anti-Kickback Act, *42 USCS § 1320a-7b(b),* because there was no private right of action under Act. *United States ex rel. Barrett v Columbia/HCA Healthcare Corp. (2003, DC Dist Col) 251 F Supp 2d 28.*

No private cause of action exists under federal health care fraud statute, *42 USCS § 1320a-7b*; only federal government may bring lawsuits for recovery of loss caused by alleged *Medicare fraud. Rzayeva v United States (2007, DC Conn) 492 F Supp 2d 60, 68 FR Serv 3d 424.*

2. Constitutional issues

Fair reading of *42 USCS § 1320a-7b(b)* provides reasonably clear guidelines for law enforcement officials, juries and courts to evaluate and discern illegal conduct. *United States v LaHue (2001, CA10 Kan) 261 F3d 993,* cert den *(2002) 534 US 1083, 122 S Ct 818, 151 L Ed 2d 701* and cert den *(2002) 534 US 1083, 122 S Ct 819, 151 L Ed 2d 701* and cert den *(2002) 534 US 1084, 122 S Ct 819, 151 L Ed 2d 701* and post-conviction relief den, in part (2003, DC Kan) *2003 US Dist LEXIS 11626,* motion gr, in part, motion den, in part, motion to strike den, reconsideration den (2003, DC Kan) *2003 US Dist LEXIS 19213,* post-conviction relief den (2004, DC Kan) *2004 US Dist LEXIS 5087,* reconsideration gr, amd, motion den (2004, DC Kan) *2004 US Dist LEXIS 9786,* app dismd (2005, CA10) *133 Fed Appx 549.*

Commerce Clause permitted regulating health care fraud under *18 USCS § 1347* and illegal remuneration under *42 USCS § 1320a-7b(b)(2)(A)*; provision of medical services affected interstate commerce because both physicians and hospitals served nonresident patients and received reimbursement through Medicare payments, thus, defendants' convictions were affirmed. *United States v Ogba (2008, CA5 Tex) 526 F3d 214.*

Woman, who had transferred assets for purposes of Medicaid eligibility, and her attorney did not have standing to seek declaration of unconstitutionality of *42 USCS § 1320a-7b(a)(6),* where they had not been indicted, arrested, threatened with arrest, or even granted an "advisory opinion" by Department of Health and Human Services concerning application of statute, and where government had represented in its motion to dismiss that, if woman waited until certain date to apply for Medicaid benefits, no period of ineligibility for such benefits would be imposed, in which case neither plaintiff could be prosecuted under statute. *Peebler v Reno (1997, DC Or) 965 F Supp 28, 53* Soc Sec Rep Serv 601.

U.S. and its agents are preliminarily enjoined from commencing, maintaining, or otherwise taking action to enforce *42 USCS § 1320a-7b(a)(6),* even though U.S. Attorney General does not actively contest unconstitutionality of statute criminalizing advising individuals to dispose of assets in order to become eligible for Medicaid benefits, and states U.S. will not enforce statute, because irreparable harm still exists in potential for self-censorship among state bar association members. *New York State Bar Ass'n v Reno (1998, ND NY) 999 F Supp 710.*

Where defendant allegedly organized and operated purported health care business, recruited fake patients to see doctors, and had prescriptions filled, suppression of evidence obtained from wiretaps was not warranted, because special agent's affidavits satisfied necessity requirement since, inter alia, special agent explained particularly why every traditional investigative technique failed, reasonably appeared unlikely to succeed if tried, or was too dangerous to try. *United States v Williams (2010, ED Mich) 693 F Supp 2d 745,* magistrate's recommendation (2010, ED Mich) *2010 US Dist LEXIS 89774,* magistrate's recommendation (2010, ED Mich) *2010 US Dist LEXIS 98182* and rejected, motion gr (2010, ED Mich) *2010 US Dist LEXIS 91244.*

While doctors and medical center violated Stark Act. *42 USCS § 1395nn(a)(1),* genuine issues of material fact existed that precluded finding that they also violated Anti-Kickback Act, *42 USCS § 1320a-7b*; it could not be concluded

as matter of law that these defendants "knowingly and willfully" paid and received remuneration under their financial arrangements for referrals of services. *United States ex rel. Singh v Nadella (2010, WD Pa) 752 F Supp 2d 602.*

Unpublished Opinions

Unpublished: Medical equipment provider received effective assistance of counsel under *U.S. Const. amend. VI* in his trial for violation of Medicare Anti-Kickback Statute, *42 USCS § 1320a-7b(b)(2)(A)*, and for health care fraud under *18 USCS § 1347*; although counsel was being represented in another case by attorney who was representing provider's co-defendant, there was no actual conflict of interest because conflict did not arise from conflict of multiple representation but instead arose from counsel's self-interest in his representation by attorney in another case. *United States v Job (2010, CA5 Tex) 2010 US App LEXIS 12359.*

3. Relationship with other criminal statutes

Medicaid fraud provision found in former *42 USCS § 1396h* shares common language and purposes with Medicare fraud provision (*42 USCS § 1395nn*). *United States v Greber (1985, CA3 Pa) 760 F2d 68,* cert den *(1985) 474 US 988, 106 S Ct 396, 88 L Ed 2d 348* and (criticized in *United States v McGuire (1996, CA5 Miss) 96-1 USTC P 50163)* and (ovrld as stated in *United States v Friedberg (1997, ED Pa) 1997 US Dist LEXIS 783)* and (ovrld as stated in *United States v Rankin (1998, ED Pa) 1 F Supp 2d 445).*

Difference between offenses delineated in former *42 USCS § 1396(b)(2)(A)* and (B) is sufficient to require that indictment and evidence at trial match, but such is not true for *42 USCS § 1395nn(a)(1)* and (3). *United States v Lipkis (1985, CA9 Cal) 770 F2d 1447.*

In action brought under False Claims Act, *31 USCS § 3729*, district court erred by granting summary judgment to hospital because hospital's arrangement with anesthesiologists at pain clinic triggered Stark Act, *42 USCS § 1395nn*, and Anti-Kickback Act, *42 USCS § 1320a-7b*, and hospital failed to carry its burden to demonstrate that exception to those statutes applied; personal service exception did not apply because there was no written contract governing services provided at outpatient pain clinic, and no written agreement specifying compensation terms. *United States ex rel. Kosenske v Carlisle HMA, Inc. (2009, CA3 Pa) 554 F3d 88.*

Declaratory judgment action, brought under *28 USCS § 2201*, that had been dismissed as attempt at private enforcement of *42 USCS § 1320a-7b(b)* was remanded for dismissal on jurisdictional grounds because litigation was simply state-law contract dispute between non-diverse parties, for which federal courts did not have subject-matter jurisdiction; party who brought action was simply anticipated state law suit by surgical center to enforce terms of contract between them. *DeBartolo v HealthSouth Corp. (2009, CA7 Ill) 569 F3d 736.*

Without some evidence of legislative intent, there can be no presumption that former *42 USCS § 1396h* was intended to pre-empt use of other federal criminal statutes in prosecution of Medicaid fraud. *United States v Simon (1981, ED Pa) 510 F Supp 232.*

Administrative subpoena duces tecum issued by HHS is proper under *42 USCS § 1320a-7b*, where subpoena concerns Medicare fraud investigation, because HHS has authority to investigate fraud in its programs, notwithstanding argument that alleged criminal activity must be referred to Attorney General under Inspector General Act (*5 USCS Appx §§ 1* et seq.). *United States v Medic House, Inc. (1989, WD Mo) 736 F Supp 1531.*

Fifteen-year exclusion of former hospital chief executive officer who was convicted of violating Medicare Anti-Kickback Statute, *42 USCS § 1320a-7b(b)*, from participation in Medicare, Medicaid, and all federal health care programs was supported by substantial evidence; fifteen years was reasonable period of exclusion, based on nature, length and effect of executive officer's acts. *Anderson v Thompson (2004, DC Kan) 311 F Supp 2d 1121.*

State of California stated valid claim for recovery under California False Claims Act, *Cal. Gov't Code §§ 12650* et seq., by alleging that pharmaceutical companies knowingly caused drug providers, such as pharmacies and doctors, to submit false claims to Medi-Cal, California's version of Medicaid, and it denied, in part, joint motion to dismiss State's action which pharmaceutical companies filed under *Fed. R. Civ. P. 12(b)(6)* and *9(b)*; State's claims alleging that pharmaceutical companies violated California's Anti-Kickback statute, *Cal. Welf. & Inst. Code § 14107.2*, were not preempted by federal Medicare Anti-Kickback statute, *42 USCS § 1320a-7b*, but court reserved right to revisit issue when State specified specific theory of remuneration for each defendant after discovery. *California, ex rel. Ven-A-Care of the Fla. Keys., Inc. v Abbott Labs., Inc. (In re Pharm. Indus. Average Wholesale Price Litig.) (2007, DC Mass) 478 F Supp 2d 164.*

Unpublished Opinions

Unpublished: In case in which defendant was sentenced to 57-months' imprisonment for violating *18 USCS § 371* and *42 USCS § 1320a-7b(b)(2)(A)* and (B), defendant argued unsuccessfully that district court in applying enhancement under *USSG § 2B1.1(b)(1)* based on amount of loss caused Medicare because he not been convicted of filling fraudulent prescriptions for Medicare patients, such that his offense did not cause government loss; enhancement was not based on causing loss to Medicare, but rather on paying kickback, fact that defendant did not contest. *United States v Ferreiro (2008, CA11 Fla) 2008 US App LEXIS 792.*

Unpublished: Evidence that defendant intentionally submitted Medicare claims for wheelchairs but provided scooters and pocketed difference was sufficient to support her convictions under *18 USCS § 1347* and *42 USCS § 1320a-7b*, and transfer of venue was properly denied under *18 USCS § 3237(a)* because scheme was directed to persons in district; district court's loss calculation and application of *USSG § 2B1.1* were not error because figure was derived from presentence report, and defendant did not present any countervailing evidence. *United States v Ubak-Offiong (2010, CA5 Tex) 2010 US App LEXIS 2220.*

4. Bribes and kickbacks, generally

In action arising from indictments filed against chiropractors for soliciting and receiving kickbacks in Medicare [former *42 USCS § 1395nn(b)(1)*] and Medicaid [former *42 USCS § 1396h(b)(1)*] cases, term "kickback" was not limited to return of funds to earlier possessor, but included "percentage payment for granting assistance by one in a position to open up or control a source of income."; former § 1396h(b)(1) was not so overbroad and vague as to be unconstitutional. *United States v Hancock (1979, CA7 Ind) 604 F2d 999,* cert den *(1979) 444 US 991, 62 L Ed 2d 420, 100 S Ct 521.*

Alcoholic beverages received in return for giving substantial Medicare business to certain pharmacy amounted to illegal kickback under former *42 USCS § 1396h*. *United States v Perlstein (1980, CA6 Mich) 632 F2d 661,* cert den *(1981) 449 US 1084, 66 L Ed 2d 809, 101 S Ct 871.*

Definition of "offer" with respect to bribe or kickback for purposes of former *42 USCS §§ 1395nn, 1396h*, was definition used in federal bribery cases under *18 USCS §§ 201* et seq. rather than contract definition of offer; offer was to be defined as representation expressing ability and desire to pay remuneration coupled with intent to induce desired action; proposal suggesting 15 percent rebate in exchange for referral of Medicare business constituted offer of bribe or kickback. *United States v Duz-Mor Diagnostic Lab. (1981, CA9 Cal) 650 F2d 223* (criticized in *United States v Chilingirian (2002, CA6 Mich) 280 F3d 704).*

Willfulness requirement of statute does not carve out exception to traditional rule that ignorance of law is no excuse; knowledge that conduct is unlawful is all that is required. *United States v Starks (1998, CA11 Fla) 157 F3d 833, 12 FLW Fed C 146.*

Jury instruction regarding mens rea of defendants in prosecution for violating Anti-Kickback statute, that defined "willfully" as "committed voluntarily and purposefully, with specific intent to do something law forbids" was correct. *United States v Starks (1998, CA11 Fla) 157 F3d 833, 12 FLW Fed C 146.*

42 USCS § 1320a-7b(b)(2)(A) and (B) do not distinguish between physicians and lay persons; rather, subsections refer to difference between referral of individuals and recommendation of specific services. *United States v Polin (1999, CA7 Ill) 194 F3d 863.*

Person who offers or pays remuneration to another person violates *42 USCS § 1320a-7b(b)(2)* so long as one purpose of offer or payment is to induce Medicare or Medicaid patient referrals. *United States v McClatchey (2000, CA10 Kan) 217 F3d 823, 2000 Colo J C A R 3386,* cert den *(2000) 531 US 1015, 148 L Ed 2d 492, 121 S Ct 574.*

Person who offers or pays remuneration to another person violates *42 USCS § 1320a-7b(b)(2)* so long as one purpose of offer or payment is to induce Medicare or Medicaid patient referrals. *United States v McClatchey (2000, CA10 Kan) 217 F3d 823, 2000 Colo J C A R 3386,* cert den *(2000) 531 US 1015, 148 L Ed 2d 492, 121 S Ct 574.*

Defendant may be convicted under statute when his offer, payment, solicitation, or receipt of remuneration was motivated in part to induce or in return for referrals; motivation to induce or in return for referrals need not be defendant's primary purpose. *United States v LaHue (2001, CA10 Kan) 261 F3d 993,* cert den *(2002) 534 US 1083, 151 L Ed 2d 701, 122 S Ct 818* and cert den *(2002) 534 US 1083, 151 L Ed 2d 701, 122 S Ct 819* and cert den *(2002) 534 US 1084,*

151 L Ed 2d 701, 122 S Ct 819 and post-conviction relief den, in part (2003, DC Kan) *2003 US Dist LEXIS 11626*, motion gr, in part, motion den, in part, motion to strike den, reconsideration den (2003, DC Kan) *2003 US Dist LEXIS 19213*, post-conviction relief den (2004, DC Kan) *2004 US Dist LEXIS 5087*, reconsideration gr, amd, motion den (2004, DC Kan) *2004 US Dist LEXIS 9786.*

Term "kickback" refers not only to return of part of sum received but also to forwarding of sum to third party for services performed for payor of kickback by third party payee although payee may not originally have given payor any payment. *United States v Weingarden (1979, ED Mich) 468 F Supp 410.*

Although as matter of law Academic Medical Center (AMC) exception, *42 CFR § 411.355(e)*, does not apply to Anti-kickback statute, as practical matter satisfaction of former will indicate there has been no violation of latter; payments made between components of AMC necessarily support missions of teaching, indigent care, research, or community service and may not exceed fair market value of academic and clinical teaching services provided; as such, they are not made "to induce" referrals and thus cannot be characterized as kickbacks that would violate *42 USCS § 1320a-7b*. *United States v Solinger (2006, WD Ky) 457 F Supp 2d 743.*

5.--Particular cases

Payments to nursing home operator above and beyond Medicaid payments did not increase cost to government of patient care, decrease quality of patient care purchased by government or involve misapplication of government funds; therefore, nursing home operator was not guilty of bribery for such conduct within parameters of former *42 USCS § 1396h*. *United States v Zacher (1978, CA2 NY) 586 F2d 912.*

In proceedings brought by Inspector General of Department of Health and Human Services charging that physician self-referral joint venture violated *42 USCS § 1320a-7b* by offering and paying remuneration to physician investors to induce them to refer lab tests to certain labs, proof of agreement is not required to establish violation. *Hanlester Network v Shalala (1995, CA9 Cal) 51 F3d 1390, 47* Soc Sec Rep Serv 404, *95 CDOS 2470.*

Amount of physician's gain is highly appropriate measure of loss suffered by American taxpayers where amount of loss caused by his conduct cannot be determined with any certainty and where money paid to physician represented money that other physician, who gave kickbacks to defendant, apparently did not receive from federal funds in order to cover costs of care he provided, and was therefore money needlessly drained from Medicare system. *United States v Adam (1995, CA4 Md) 70 F3d 776* (criticized in *United States v Kuku (1997, CA11 Ga) 129 F3d 1435, 48 Fed Rules Evid Serv 331, 11 FLW Fed C 850)* and (criticized in *United States v Anderson (1999, DC Kan) 85 F Supp 2d 1084).*

Case in which doctor and nurse at vascular studies center paid pacemaker salesman for referrals of Medicare patients was classic case of illegal kickback prohibited by *42 USCS § 1320a-7b*. *United States v Polin (1999, CA7 Ill) 194 F3d 863.*

In *42 USCS § 1302a-7b* matter, where company's payments were not illegal kickbacks under *42 USCS § 1320a-7b(b)(2)(A)*, court of appeals reversed convictions of appellants, who were two principals of company. *United States v Miles (2004, CA5 Tex) 360 F3d 472.*

In *42 USCS § 1320a-7b* matter, payments from company were not made to relevant decisionmaker as inducement or kickback for sending patients to company, and were not illegal kickbacks under *42 USCS § 1302a-7b*(b)(2)(A). *United States v Miles (2004, CA5 Tex) 360 F3d 472.*

Motion to dismiss claim filed qui tam against owners and their companies was denied because Government had adequately stated claims for violations of False Claims Act, *31 USCS § 3729*, when it was alleged that owners got patients through illegal kickback scheme, in violation of *42 USCS § 1320a-7b(b)*, and then billed Medicare for those patients' services. *McNutt ex rel. United States v Haleyville Med. Supplies, Inc. (2005, CA11 Ala) 423 F3d 1256, 18 FLW Fed C 950.*

Although paying kickbacks violated *42 USCS § 1320a-7b*, that alone was insufficient to convict for health care fraud under *18 USCS § 1347* without defendant making knowing false or fraudulent representation to Medicare; fraud was established for one defendant who had signed documents as Medicare provider, stating that she would follow rules. *United States v Medina (2007, CA11 Fla) 485 F3d 1291, 20 FLW Fed C 628.*

Manager did not deny on appeal that illegal referrals in violation of Stark Amendment, *42 USCS § 1395nn*, and Anti-Kickback Act, *42 USCS § 1320a-7b*, occurred, that kickbacks were paid, that bills sent to U.S. omitted this information, and that he knew what was going on; his argument that these omissions were not material failed because infor-

mation that hospital had purchased patients by paying kickbacks was material for purposes of False Claims Act, *31 USCS §§ 3729-3733. United States v Rogan (2008, CA7 Ill) 517 F3d 449.*

District court did not commit reversible error when it refuse to give two of proposed intent to defraud jury instructions that defendant tendered in his trial on charges of health care fraud and fraudulent concealment of health care benefits because (1) instructions jury received already conveyed theories in defendant's proposed jury instructions; (2) failure to give instructions did not deny him fair trial as district court properly instructed jury on elements necessary to convict defendant of charges presented to jury, and defendant was allowed to argue his theory of defense to jury; and (3) while second proposed instruction contained correct statement of law under *42 USCS § 1320a-7b(b)(1)(A),* (b)(3)(B), it was not relevant as indictment did not charge defendant with making improper payments to persons who helped him sell device at issue, nor did it make any mention of payments. *United States v Choiniere (2008, CA7 Ind) 517 F3d 967.*

District court properly denied defendant's motion to dismiss indictment against her for failing to state offense, pursuant to *Fed. R. Crim. P. 12(b)(3)(B),* with regard to her conviction for Medicaid fraud under *42 USCS § 1320a-7b(a)(3),* as indictment charged that she had knowledge of event that affected her facility's right to receive Medicaid payments, she concealed that event, and in so concealing, acted knowingly and willfully with intent to fraudulently secure Medicaid payments; language in indictment sufficiently tracked language of statute. *United States v Anderson (2010, CA6 Tenn) 605 F3d 404, 2010 FED App 147P.*

Relator's allegations that defendant paid kickbacks to physicians so that they would use its products and that hospital and physician Medicare claims represented compliance with material condition of payment that was not in fact met were sufficient to state claim that defendant knowingly caused submission of materially false or fraudulent claims in violation of *31 USCS § 3729(a)(1)* because provider agreements and hospital cost reports showed that compliance with *42 USCS § 1320a-7b(b)* was precondition for Medicare reimbursement and court could not conclude as matter of law that alleged misrepresentations in hospital and physician claims were not capable of influencing Medicare's decision whether to pay claims. *United States ex rel. Hutcheson v Blackstone Med., Inc. (2011, CA1 Mass) 647 F3d 377.*

In doctor's conviction for Medicare fraud based on accepting salary from hospital in exchange for continually referring patients to facility, court declined to adopt primary motivation theory and properly found that in order to convict, jury was required to find beyond reasonable amount that some amount was paid to defendant that was not pursuant to bona fide employment relationship. *United States v Borrasi (2011, CA7 Ill) 639 F3d 774.*

Drug manufacturer is not entitled to preliminary injunction enjoining competitor from engaging in allegedly false and misleading promotional campaign on ground that it is kickback scheme in violation of *42 USCS § 1320a-7b(b)(2),* where competitor terminated pharmacy information program and entered formal agreement with 11 states not to resume program or to implement substantially similar program. *Pfizer, Inc. v Miles, Inc. (1994, DC Conn) 868 F Supp 437, 1995-1* CCH Trade Cases P 70863.

Marketing agreement between nursing home consultants and health services provider is illegal under *42 USCS § 1320a-7b(b)(1),* where, under agreement, consultants were paid for referring persons who needed Medicare-covered supplies to provider, which in turn sold them those supplies, because consultants' compensation is directly pegged to number of sales generated on behalf of provider, and such arrangement is not saved by "safe harbor" regulations narrowing scope of antikickback statute. *Nursing Home Consultants v Quantum Health Servs. (1996, ED Ark) 926 F Supp 835,* affd without op (1997, CA8 Ark) *112 F3d 513,* reported in full (1997, CA8 Ark) *1997 US App LEXIS 10544.*

Physician's claim for breach of agreement with hospital may proceed, even though hospital's assignee argues agreement must be terminated because it is illegal under *42 USCS § 1320a-7b,* because genuine issue of material fact exists as to intent of parties to agreement with respect to patient referrals. *Feldstein v Nash Community Health Servs., Inc. (1999, ED NC) 51 F Supp 2d 673.*

Consignment agreement between orthopedic products manufacturer and distributor is illegal and unenforceable in Indiana, where inclusion of percentage-based compensation scheme makes performance under agreement type of conduct anti-kickback statute was enacted to prevent, because agreement violates *42 USCS § 1320a-7b(b)(1). Zimmer, Inc. v Nu Tech Med., Inc. (1999, ND Ind) 54 F Supp 2d 850, 63* Soc Sec Rep Serv 160.

Base offense level for commercial bribery and kickbacks, under Sentencing Guidelines, was appropriate for sentencing following conviction for violation of *42 USCS § 1320a-7b(b)* by defendants offering and accepting bribes to physicians in return for referrals of patients to hospitals, rather than base offense level for deceit. *United States v Anderson (1999, DC Kan) 85 F Supp 2d 1084.*

Qui tam relator failed to allege that physicians either expressly certified or, through their participation in federally funded program, impliedly certified their compliance with antikickback statute, *42 USCS § 1320a-7b(b)*, as prerequisite to participating in federal program, or that drug manufacturer caused or induced physicians and/or pharmacists to file false or fraudulent certification regarding compliance with antikickback statute, as required to state claim against manufacturer for violation of antikickback statute. *United States ex rel. Franklin v Parke-Davis (2001, DC Mass) 147 F Supp 2d 39.*

Where defendants were charged with kickbacks in violation of Anti-Kickback statute, *42 USCS § 1320a-7b(b)(2)(B)*, based on sales of supplies to company organized for undercover investigation into Medicare fraud and falsification of sales records to this company, indictment sufficiently set forth crime because (1) defendants' actions constituted kickbacks; (2) defendants were not protected by discount safe harbor as transaction was lease, not sale, and discount was not fully and accurately reported; and (3) government was not precluded, as matter of law, from proving that defendants had actual knowledge that they violated this law. *United States v Carroll (2004, SD Ill) 320 F Supp 2d 748.*

In action in which United States filed suit against defendant alleging violations of *31 USCS § 3729*, judgment was entered in favor of government where (1) defendant caused medical center to submit claims for reimbursement from Medicare and Medicaid for services to patients referred to medical center by co-conspirators; such claims were required to be in compliance with Stark and Anti-Kickback Statutes; they were not and were, therefore, false; (2) government would not have paid claims if it had known claims were false (in claiming statutory compliance) because compliance with Stark and Anti-Kickback Statutes was statutory condition of payment; and (3) evidence produced by government more than established defendant's knowledge that these claims were false or, at very least, that defendant acted with deliberate indifference or reckless disregard of truth or falsity of claims. *United States v Rogan (2006, ND Ill) 459 F Supp 2d 692*, affd (2008, CA7 Ill) *2008 US App LEXIS 3508.*

Where doctor allegedly was required to provide doctor's own operating room staff, doctor could not state False Claims Act, *31 USCS § 3729*, claim under Medicare anti-kickback statute, because (1) dispute did not affect Medicare payments, and (2) hospital did not have duty to disclose alleged "events" to government since scrub staff proposal did not constitute kickback. *United States ex rel. Conner v Salina Regional Health Center, Inc. (2006, DC Kan) 459 F Supp 2d 1081.*

Medical device manufacturer and medical clinic were entitled to *Fed. R. Civ. P. 12(b)(6)* dismissal of consumer/patient's action arising from alleged nationwide conspiracy for purpose of monopolizing sale and controlling prices of medical equipment; *42 USCS § 1320a-7b* was criminal statute that provided no private right of action. *Roberson v Medtronic, Inc. (2007, WD Tenn) 494 F Supp 2d 864.*

Where whistleblower alleged that pharmaceutical company's claims were false as contemplated by False Claims Act, *31 USCS §§ 3729* et seq., if they were caused by unlawful kickbacks pursuant to *42 USCS § 1320a-7b(b)*, to state cause of action under *31 USCS § 3729(a)(1)*-(2), he would have to allege that company caused submission of false claim by doctor; because whistleblower could not allege that improper financial incentives were paid to doctors who made prescriptions in Indiana because that information was not in his possession, discovery was permitted relating to sales and marketing regions that included *Indiana. United States ex rel. Rost v Pfizer, Inc. (2008, DC Mass) 253 FRD 11.*

On summary judgment, disputed fact issues remained as to whether health care company that established treatment centers at 120 hospitals to coordinate specialized care for diabetes patients induced its medical directors to submit false Medicare and Medicaid claims in violation of False Claims Act, *31 USCS § 3729*, and Anti-Kickback Statute, *42 USCS § 1320a-7b*, by tying directors' remuneration to number of referrals to treatment centers. *United States ex rel. Pogue v Diabetes Treatment Ctrs. of Am. (2008, DC Dist Col) 565 F Supp 2d 153.*

Defendants that owned an ambulance service were properly convicted of conspiracy to commit health care fraud under *18 USCS § 371*, falsely billing Medicare and Medicaid in violation of *18 USCS § 1347*, and violating the anti-kickback statute, *42 USCS § 1320a-7b(b)(2)(A)*, because the government circumstantially proved that defendants knew that their clients did not satisfy the medical necessity requirements of *42 CFR § 410.40(d)(1)* and were ineligible for Medicare transport. *United States v Abdallah (2009, SD Tex) 629 F Supp 2d 699.*

In qui tam action in which relators alleged that manufacturer engaged in fraudulent scheme to increase use of its medical devices in spinal surgeries by entering sham consulting agreements and paying kickbacks to physicians in violation of *42 USCS § 1320a-7b(b)* and that manufacturer's fraudulent behavior caused hospitals and doctors to submit false claims for payment by federally-funded government healthcare programs, relators failed to state claim under *31*

USCS § 3729(a)(1), because express certification by hospitals in seeking payment for use of manufacturer's devices was personal to hospital and, with no allegations that hospital knew of kickbacks, those claims were not false, and doctors' false express certifications regarding compliance with Medicare and Medicaid Patient Protection Act were not material given that purchase of manufacturer's devices were not underlying transaction to doctors' requests for reimbursement for their services. *United States ex rel. Hutcheson v Blackstone Med., Inc. (2010, DC Mass) 694 F Supp 2d 48.*

In action in which former employee alleged that drug manufacturer offered kickbacks and other illegal inducements to encourage doctors to write off-label prescriptions for drug, employee's allegation of kickback scheme under *42 USCS § 1320a-7b(b)(2)* did not satisfy requirements of *Fed. R. Civ. P. 9(b)* because employee did not allege that money was paid directly to doctors to promote off-label uses nor did employee offer any particulars as to names, dates, amounts, or incentives doctors were alleged to have been offered. *United States ex rel. Carpenter v Abbott Labs., Inc. (2010, DC Mass) 723 F Supp 2d 395.*

Relator's *31 USCS § 3729* claim that her former employer had pursued various schemes to pay patients and their families kickbacks, or to offer extra services, to encourage them to enroll in hospice care, or not to revoke prior enrollments, and that employer paid kickbacks to unidentified nursing home employees for patient referrals survived motion to dismiss where relator asserted that employer, through its foundation, paid or offered to pay patient money, in order to induce or reward patient for referring other patients to become Medicare patient, employer submitted false or fraudulent claims for Medicare reimbursement, and that government would not have paid claims submitted by employer had it known of alleged kickbacks employer allegedly concealed. *United States ex rel. Wall v Vista Hospice Care, Inc. (2011, ND Tex) 778 F Supp 2d 709.*

Government did not allege that doctor ever reviewed slides, instead, government alleged that doctor billed Medicare for reviewing slides even though he did not do work that would permit him to seek such reimbursement; therefore, government had sufficiently alleged that doctor billed Medicare for work he did not perform, and as such, government's payment of his claims constituted damages to government. *United States ex rel. Freedman v Suarez-Hoyos (2011, MD Fla) 781 F Supp 2d 1270.*

Conviction of former *42 USCS § 1396h* misdemeanor for receiving kickback was not such offense so as to be included in general term "gross immorality" with regard to state pharmacist licensing law. *Miller v Department of Registration & Education (1979) 75 Ill 2d 76, 25 Ill Dec 644, 387 NE2d 300.*

Unpublished Opinions

Unpublished: Defendant's contention, that jury instructions for counts 9 and 10 contained plain error, failed because jury was instructed that it could convict him based on any kickback paid to any person because: (1) district court instructed jury that it was to decide whether government had proved beyond reasonable doubt that defendant was guilty of crimes charged and that defendant was not on trial for any act, conduct, or offense not alleged in indictment; (2) in instructions pertaining to counts 9 and 10, court explained that indictment charged defendant with making specific payments in amounts of $ 300 and $ 200; and (3) district court's instruction on first element simply tracked substantially language of *42 USCS § 1320a-7b(b)(2). United States v Jackson (2007, CA5 Tex) 220 Fed Appx 317*, cert den (2007, US) *128 S Ct 122, 169 L Ed 2d 85.*

Unpublished: In case in which defendant argued that his 57-month sentence for violating *18 USCS § 371* and *42 USCS § 1320a-7b(b)(2)(A)* and (B) was unreasonable, that argument failed; district court correctly calculated U.S. Sentencing Guidelines imprisonment range, it considered *18 USCS § 3553(a)* factors, it more than sufficiently explained its reasoning, and § 3553(a) factors supported district court's sentence. *United States v Ferreiro (2008, CA11 Fla) 2008 US App LEXIS 792.*

Unpublished: There was sufficient evidence to show that defendant, while working in community health center, conspired with others to pay kickbacks under *42 USCS § 1320a-7b(b)(2)* to owners and administrators of assisted living facilities for referrals of residents to center so that false Medicare claims could be made by defendant and co-conspirators. *United States v Richards (2008, CA11 Fla) 2008 US App LEXIS 21738.*

Unpublished: Plaintiff employee's *42 USCS § 1320a-7b(b)* claim failed because she had not alleged that there was any remuneration made in exchange for referrals. *United States ex rel. Lacy v New Horizons, Inc. (2009, CA10 Okla) 2009 US App LEXIS 22294.*

Unpublished: Physician was properly convicted of violating Medicare Anti-Kickback Statute, *42 USCS § 1320a-7b(b)(2)(A)*, where evidence was sufficient to show that physician possessed specific intent to violate law; evidence

showed that physician was motivated by kickbacks and that he intended to violate law by writing prescriptions for power wheelchairs for every Medicare beneficiary who was assessed in perfunctory manner. *United States v Job (2010, CA5 Tex) 2010 US App LEXIS 12359.*

6.----Sentencing matters

Where hospital entered into series of agreements with two doctors who referred patients to hospital, district court did not err in calculating offense level for defendant, hospital executive, by considering only $ 50,000 of $ 150,000 paid under one of agreements to be relevant bribe for sentencing purposes; defendant negotiated that agreement after learning that doctors failed to perform substantial services required under prior contracts. *United States v McClatchey (2003, CA10 Kan) 316 F3d 1122.*

Illegal remuneration under *42 USCS § 1320a-7b(b)(1)(A)* was lesser included offense of health care fraud, under *18 USCS § 1347*, that involved charge of illegal remuneration committed with intent to defraud, and not knowing which portion of health care fraud theory jury's verdict rested upon, one defendant's sentence of 54 months for health care fraud and 54 concurrent months for illegal remuneration was multiplicitous under Double Jeopardy Clause and plain error. *United States v Ogba (2008, CA5 Tex) 526 F3d 214.*

Because defendant's conspiracy scheme to defraud Medicare under *18 USCS §§ 287, 371, 1349, 42 USCS § 1320a-7b*, continued after *18 USCS § 1349* became effective, district court's forfeiture order did not violate *Ex Post Facto Clause. United States v Valladares (2008, CA11 Fla) 544 F3d 1257, 21 FLW Fed C 1175.*

Value of bribe, for purposes of sentencing man convicted under *42 USCS § 1320a-7b*, is amount agreed upon in contract or $ 50,000, even if man only actually paid doctors $ 37,500 of that amount, because it cannot be true that guidelines intend that convict who offers bribe but cheats intended recipient out of full amount should get lesser sentence. *United States v McClatchey (2001, DC Kan) 160 F Supp 2d 1254,* affd in part and revd in part on other grounds, remanded (2003, CA10 Kan) *316 F3d 1122.*

Unpublished Opinions

Unpublished: District court did not abuse its discretion when it denied defendant's motion to withdraw his guilty plea, pursuant to which he was convicted of violating *42 USCS § 1320a-7b(b)(1)(A)* and *18 USCS § 2*: (1) defendant moved to withdraw his guilty plea after district court calculated federal sentencing guidelines range applicable to his offense, which range was higher than he had anticipated; (2) defendant did not contend that district court failed to comply with *Fed. R. Crim. P. 11* requirements at his plea hearing or that his counsel rendered ineffective legal assistance to him during plea negotiations or plea hearing; (3) defendant acknowledged at plea hearing that he was voluntarily and knowingly pleading guilty and that he had not been coerced into entering guilty plea, and those statements were presumed to be true; and (4) although defendant claimed that his counsel coerced him into pleading guilty, evidence did not support that claim, and he failed to present any other evidence showing good cause for allowing him to withdraw his guilty plea. *United States v Perez (2007, CA11 Fla) 218 Fed Appx 927.*

Unpublished: Defendant's appeal of within-guidelines 21 month sentence imposed on him, after he pleaded guilty to violating *42 USCS § 1320a-7b(b)(1)(A)* and *18 USCS § 2*, was dismissed; as part of his plea agreement, defendant waived his right to appeal or collaterally challenge his sentence, and his Booker unreasonableness challenge did not fall within one of three grounds for appeal that were exempted from appellate waiver provision. *United States v Perez (2007, CA11 Fla) 218 Fed Appx 927.*

Unpublished: Because defendant furthered Medicare conspiracy by aiding others in recruiting durable medical equipment companies, and had knowledge of those companies, those companies' criminal activities were reasonably foreseeable under *USSG § 1B1.3(a)(1)(B)* and he was responsible for conspiracy's entire loss under *USSG § 2B4.1(b)(1)*, and his sentence was affirmed. *United States v Aguera (2008, CA11 Fla) 2008 US App LEXIS 13075.*

Unpublished: In case in which defendant received 46-month sentence for violating *18 USCS §§ 371* and *1349* and *42 USCS § 1320a-7b(b)(1)*, district court did not err in applying four-level leadership-role enhancement, pursuant to *USSG § 3B1.1(a). United States v Perez (2008, CA11 Fla) 2008 US App LEXIS 16180.*

Unpublished: In case in which defendant appealed his 151-month sentence for violating *18 USCS §§ 2, 371*, and *1349* and *42 USCS § 1320a-7b(b)(1)*, he argued unsuccessfully that sentence violated his Fifth and Sixth Amendment rights; that claim was subject to plain error review, and defendant's constitutional rights clearly were not violated when district court considered his uncharged conduct in arriving at his ultimate sentence, where government proved by pre-

ponderance of evidence that defendant did in fact engage in such conduct. *United States v Valdes (2009, CA11 Fla) 2009 US App LEXIS 5578.*

Unpublished: In case in which defendant appealed his 151-month sentence for violating *18 USCS §§ 2, 371*, and *1349* and *42 USCS § 1320a-7b(b)(1)*, he argued unsuccessfully that district court erred in calculating amount of loss under *USSG § 2B1.1*; defendant invited any error resulting from district court's adoption of amount of loss calculated in presentence investigation report when he urged court to adopt probation officers' position with respect to intended loss. *United States v Valdes (2009, CA11 Fla) 2009 US App LEXIS 5578.*

Unpublished: In case in which defendant appealed his 151-month sentence for violating *18 USCS §§ 2, 371*, and *1349* and *42 USCS § 1320a-7b(b)(1)*, he argued unsuccessfully that district court misapplied sophisticated means enhancement under *USSG § 2B1.1(b)(9)(C)*; information provided at trial and contained in presentence investigation report--that defendant recruited beneficiaries and sought out doctors so as to aid in hiding illegality of his Medicare claims, and converted medical company into pharmacy through which he continued to defraud Medicare--plainly supported application of that provision. *United States v Valdes (2009, CA11 Fla) 2009 US App LEXIS 5578.*

Unpublished: In case in which defendant appealed his 151-month sentence for violating *18 USCS §§ 2, 371*, and *1349* and *42 USCS § 1320a-7b(b)(1)*, he argued unsuccessfully that sentence was unreasonable; district court specifically noted its awareness of defendant's ill health and his request for departure, but explained that it was not persuaded to grant that departure which was meant for extremely rare and very complicated medical impairments; district court then imposed sentence of 151 months, at high end of U.S. Sentencing Guidelines range, observing that such sentence reflected seriousness of defendant's offenses and fact that conviction was defendant's third conviction for *Medicare fraud. United States v Valdes (2009, CA11 Fla) 2009 US App LEXIS 5578.*

Unpublished: In case in which defendant pled guilty to conspiracy to commit health care fraud and pay illegal remuneration, he argued unsuccessfully that district court erred by calculating his offense level under *USSG § 2B1.1* instead of *USSG § 2B4.1*; his assertion that § 2B1.1 was only listed as appropriate U.S. Sentencing Guideline for violations of *42 USCS § 1320a-7b(b)(2)* because § 2B4.1 cross-referenced loss amount table contained in § 2B1.1 was without merit; since defendant's primary offense was health care fraud, § 2B1.1 was more appropriate U.S. Sentencing Guideline for his substantive offense of payment of illegal remuneration. *United States v Edet (2009, CA5 Tex) 2009 US App LEXIS 8138.*

Unpublished: District court properly applied *USSG § 1B1.3* in imposing 14-level adjustment to medical equipment provider's offense level for improper benefit derived from Medicare following his convictions for health care fraud under *18 USCS § 1347* and violation of Medicare Anti-Kickback Statute, *42 USCS § 1320a-7b(b)(2)(A)*; statements in presentence investigation report and evidence adduced at trial established by preponderance of evidence that fraudulent claims to Medicare were reasonably foreseeable to provider. *United States v Job (2010, CA5 Tex) 2010 US App LEXIS 12359.*

7. Excessive charges

Whether costs were directly and immediately increased by "fee agreements" was irrelevant; such schemes had potential for increased costs which Congress intended to avoid by enacting former *42 USCS § 1396h. United States v Ruttenberg (1980, CA7 Ill) 625 F2d 173.*

Evidence was sufficient to convict physician and his office manager-wife under former *42 USCS § 1396h*, because of their use of certain billing code when other billing code exactly fit services rendered, and testimony that state administrative representative informed them of their misuse of code. *United States v Larm (1987, CA9 Hawaii) 824 F2d 780*, cert den *(1988) 484 US 1078, 98 L Ed 2d 1019, 108 S Ct 1057.*

There was sufficient evidence to support jury's conclusion that defendant participated in Medicare fraud in foreign state where he took part in determination of where to send claims after they were rejected in home state, he instructed employee to use double-envelope scam for postmarking in foreign state, and where he signed service agreement with company that received and forwarded to other state mail and telephone calls. *United States v Weiss (1991, CA2 NY) 930 F2d 185, 32 Fed Rules Evid Serv 877*, cert den *(1991) 502 US 842, 116 L Ed 2d 100, 112 S Ct 133.*

Argument that Medicare "Contract Alternate Payment Demonstration Project" exceeded authority of Secretary of Health and Human Services and violated Medicare Fraud and Abuse Act by approving 100 percent payment by Medicare was made moot when project moved beyond demonstration stage and new procedures required 20 percent co-pay

by patients. *Lowe v Southmark Corp. (1993, CA5 Tex) 998 F2d 335, 62 BNA FEP Cas 1087, 1 BNA WH Cas 2d 1016, 62* CCH EPD P 42521, 126 CCH LC P 33004.

Evidence supported conviction of physician defendants for violating *42 USCS § 1320a-7b(b)(1),* where defendants received large amounts of money from number of hospitals to which they referred Medicare patients, pursuant to ostensible services contract under which they performed few or no services, and defendants were aware of statutory prohibitions. *United States v Anderson (1999, DC Kan) 85 F Supp 2d 1047, 67 Soc Sec Rep Serv 350, 53 Fed Rules Evid Serv 1255,* revd, in part, on other grounds, remanded, in part (2000, CA10 Kan) *217 F3d 823, 2000 Colo J C A R 3386,* cert den *(2000) 531 US 1015, 121 S Ct 574, 148 L Ed 2d 492* and affd, in part (2001, CA10 Kan) *254 F3d 900, 2001 Colo J C A R 3108,* reh den, reh, en banc, den, amd (2001, CA10) *261 F3d 993, 57 Fed Rules Evid Serv 254* and reprinted as amd (2001, CA10 Kan) *261 F3d 993,* cert den *(2002) 534 US 1083, 122 S Ct 818, 151 L Ed 2d 701* and cert den *(2002) 534 US 1083, 122 S Ct 819, 151 L Ed 2d 701* and cert den *(2002) 534 US 1084, 122 S Ct 819, 151 L Ed 2d 701* and post-conviction relief den, in part (2003, DC Kan) *2003 US Dist LEXIS 11626,* motion gr, in part, motion den, in part, motion to strike den, reconsideration den (2003, DC Kan) *2003 US Dist LEXIS 19213,* post-conviction relief den (2004, DC Kan) *2004 US Dist LEXIS 5087,* reconsideration gr, amd, motion den (2004, DC Kan) *2004 US Dist LEXIS 9786,* app dismd (2005, CA10) *133 Fed Appx 549.*

Lease agreement, where, either utilizing base rental plus percentage arrangement, or "incentive rent" figures, profits do not appear to be so exorbitant as to be clear abuses, is not per se violation for which felony may be charged under federal law. *Tanquilut v Illinois Dep't of Public Aid (1979, 1st Dist) 78 Ill App 3d 55, 33 Ill Dec 402, 396 NE2d 1126.*

Violation of former *42 USCS § 1396h(d)(2)(B)* occurred whenever provider of services charged in excess of rates established by state. *Glengariff Corp. v Snook (1984, Sup) 122 Misc 2d 784, 471 NYS2d 973.*

8. Discount exception

Issue for jury to decide, when faced with defendant whose contention is that defendant is not criminally liable under *42 USCS § 1320a-7b(b)(3)(A)* because of "discount exception," is whether reason for offering or accepting "discount or other reduction in price" was to induce referrals of or to be reimbursed for federal health-care program business. *United States v Shaw (2000, DC Mass) 106 F Supp 2d 103,* reconsideration den, motions ruled upon (2000, DC Mass) *113 F Supp 2d 152.*

Having found that alleged anti-kickback violation, *42 USCS § 1320a-7b(b)(1),* of not reporting discounts for materials submitted to Medicare for reimbursement in violation of False Claims Act, *31 USCS § 3729(a)(1),* was material to government's treatment of defendants' reimbursement claims, court denied summary judgment. *United States ex rel. Bidani v Lewis (2003, ND Ill) 264 F Supp 2d 612.*

Manufacturer's motion to dismiss government's claim for violation of federal Anti-Kickback statute, *42 USCS § 1320a-7b(b)(2),* was denied where because Medicare program required providers to affirmatively certify that they complied with Anti-Kickback Statute, failure to comply with kickback laws, was, in and of itself, false statement to government; therefore, government stated claim under False Claims Act, *31 USCS §§ 3729* et seq., for antecedent violation of Anti-Kickback Statute for claims submitted through Medicare program; moreover, government properly pled violation of Anti-Kickback Statute since manufacturer directly offered kickbacks to providers with allegedly improper intent to induce purchase of drugs. *United States ex rel. Ven-A-Care of the Fl. Keys, Inc. v Abbott Labs. (In re Pharm. Indus. Average Wholesale Price Litig.) (2007, DC Mass) 491 F Supp 2d 12,* findings of fact/conclusions of law, claim dismissed, claim allowed (2007, DC Mass) *491 F Supp 2d 20.*

9. Miscellaneous

In prosecution for filing false claims for payment under Medicaid program in violation of former *42 USCS § 1396h(a)(1)(i)* jury could properly infer intent to defraud from circumstantial evidence; in prosecution of pharmacy and dispensing pharmacist under former § 1396h(a)(1)(i) for dispensing generic drug but submitting claim for more expensive brand name drug, convictions were supported by evidence establishing repetitious pattern of submitting claims for brand name drugs even though generics had been dispensed, along with pharmacist's actions in filling prescriptions and preparing labels for vials and records to be kept on file which led to submission of false claims; submission of claims for brand name drugs even though generics had been dispensed not only demonstrated requisite knowledge and willfulness, but such action also constituted misrepresentation of material fact within meaning of statute. *United States v Brown (1985, CA8 Ark) 763 F2d 984,* cert den *(1985) 474 US 905, 88 L Ed 2d 234, 106 S Ct 273.*

In suit under Medicare anti-kickback statute, *42 USCS § 1320a-7b*, plaintiff's contention that claims for services rendered in violation of *42 USCS § 1395nn* were in and of themselves fake or fraudulent claims under False Claims Act, *31 USCS §§ 372a* et seq., requires district court to determine whether government's payment of hospital's Medicare claims was conditional on hospital's certifications of compliance. *United States ex rel. Thompson v Columbia/HCA Healthcare Corp. (1997, CA5 Tex) 125 F3d 899, 39 FR Serv 3d 251,* reh den (1998, CA5 Tex) *1998 US App LEXIS 2050* and (criticized in *Harrison v Westinghouse Savannah River Co. (1999, CA4 SC) 176 F3d 776)* and (criticized in *United States ex rel. Barmak v Sutter Corp. (2002, SD NY) 2002 US Dist LEXIS 8509).*

Because doctors could submit claims for athletic trainers' services and disclose they were not Medicare benefit, and appeal denial, exception to *42 USCS § 405(h)* did not apply, dismissal of plaintiff athletic trainers' association's claim, challenging defendant Secretary of Department of Health and Human Services' new Medicare Part B rule, *69 Fed. Reg. 66,236, 66,352* (Nov. 15, 2004), for lack of subject matter jurisdiction, was affirmed; criminal liability under *18 USCS §§ 287, 1001, 1035, 1341, 1343, 1347, 1963(a), 42 USCS § 1320a-7b(a),* required knowing or intentional false statement; consequently, disclosure that services were not Medicare benefit diminished disincentive to challenge rule administratively. *Nat'l Ath. Trainers' Ass'n v United States HHS (2006, CA5 Tex) 455 F3d 500.*

Former *42 USCS § 1396h(b)(1)* prohibited health care provider from collecting from Medi-Cal beneficiaries who were also Medicare beneficiaries (cross-over beneficiaries) those Medicare Part B costs in excess of any amounts individual was required to pay in order to meet monthly Medi-Cal share of cost requirement for certification, even when state limitation on reimbursement to health care providers for services rendered to cross-over beneficiaries resulted in absence of deductible or co-insurance payment from Medi-Cal program for services offered by Medicare Part B by reason of buy-in agreement. *Samuel v California Dep't of Health Services (1983, ND Cal) 570 F Supp 566,* amd on other grounds (1983, ND Cal) *572 F Supp 273.*

Court could have inferred that amounts over fair value of selling physicians' practices were intended to induce physician referrals to defendant, purchasing hospital, in violation of Antikickback Statute (AKS) and Stark Act, but relator doctor failed to show fair market value, much less that purchase prices exceeded that value; since doctor failed to show any violation of either AKS or Stark Act upon which false claim could be predicated, thus his claim was without substance and court granted summary judgment for hospital. *United States ex rel. Perales v St. Margaret's Hosp. (2003, CD Ill) 243 F Supp 2d 843.*

In nurse's *31 USCS § 3729* qui tam action accusing her former employer and others of Medicare fraud, 66 UB-92 forms that employer submitted were not claims under *31 USCS § 3729* simply because employer was allegedly perpetrating underlying scheme to raise Tax Equity and Fiscal Responsibility Act of 1982 rates because nurse failed to identify any explicit term, condition, or regulation upon which payment was specifically conditioned in this case; although *42 USCS § 1320a-7b,* as well as other Medicare-related statutes such as *42 USCS §§ 1320* et seq., criminalize Medicare fraud, they do not create independent duties to disclose existence of fraud when filing other claims under *Medicare. United States ex rel. Debra Hockett v Columbia/HCA Healthcare Corp. (2007, DC Dist Col) 498 F Supp 2d 25.*

Defendants' motion for summary judgment was granted because defendants met legal requirements of academic medical center (AMC) exception with regard to Medicaid reimbursement claims; as such, there remained no underlying *42 USCS § 1395nn* or anti-kickback violations upon which plaintiffs' False Claims Act (FCA), *31 USCS § 3729* et seq., claim could proceed. *United States ex rel. Villafane v Solinger (2008, WD Ky) 543 F Supp 2d 678.*

Under Anti-Kickback Statute, *42 USCS § 1320a-7b,* presentment of Medicare claims to government by hospitals with which it contracted was adequately proved by federal official's authentication by declaration of electronic data of presented claims; because official could testify to such information at trial, evidence was permissibly considered by court on summary judgment in government's suit under False Claims Act, *31 USCS § 3729. United States ex rel. Pogue v Diabetes Treatment Ctrs. of Am. (2008, DC Dist Col) 565 F Supp 2d 153.*

Relators' claims, brought pursuant to *31 USCS § 3730(b),* were partially dismissed because although relators asserted actionable claims under *31 USCS § 3729(a)(1),* (2), against pharmaceutical company, arising from its aggressive marketing to hospitals of off-label uses of prescription drug, they did not assert actionable claim under § 3729(a)(2), arising from kickbacks that company allegedly paid to hospitals to encourage them to prescribe drug; although kickbacks violated federal anti-kickback statute, *42 USCS § 1320a-7b(b),* relators did not assert actionable *31 USCS § 3729(a)(2)* kickback-related claim because they did not allege that hospitals falsely certified that they complied with anti-kickback statute in order to receive Medicare outlier payments or that hospitals sought Medicare reimbursement after being convicted of violating anti-kickback statute and losing their eligibility to participate in Medicare program

under *42 USCS § 1320a-7b(b)(1). United States ex rel. Kennedy v Aventis Pharms., Inc. (2009, ND Ill) 610 F Supp 2d 938.*

Although claim might be made under *31 USCS § 3729(a)(2)* based on theory of implied false certification, i.e., based on notion that act of submitting claim for reimbursement itself implies compliance with governing federal rules that are precondition to payment, this theory is viable only if underlying statute upon which False Claims Act relator relies expressly states that provider must comply in order to be paid; Medicare statutes do not require compliance with federal anti-kickback statute, *42 USCS § 1320a-7b(b),* and thus to state actionable claim under *31 USCS § 3729(a)(2)* based on alleged illegal kickbacks paid to providers, relator must allege that provider certified that it complied with anti-kickback statute or that it submitted Medicare reimbursement claims after being convicted of violating anti-kickback statute, which pursuant to *42 USCS § 1320a-7b(b)* rendered it ineligible to participate in Medicare program. *United States ex rel. Kennedy v Aventis Pharms., Inc. (2009, ND Ill) 610 F Supp 2d 938.*

Restitution would be limited to amounts agreed to in defendants' *Fed. R. Crim. P. 11* plea agreements because (1) they pleaded guilty to violating *42 USCS § 1320a-7b(a)(6)(ii)* and had to be sentenced accordingly; (2) § 1320a-7b(a)(6)(ii) was not included in any of statutes that specifically authorized court to order restitution; (3) under *USSG § 5E1.1(a)(1),* restitution was limited to government's actual loss, which had not been established in case; and (4) restitution could not be ordered under *42 USCS § 1395nn* because it was civil statute, and defendants' liability under statute had not been established. *United States v Razalan (2010, ED Mich) 725 F Supp 2d 636.*

Under *31 USCS § 3729(a)(1)(A)* implied certification theory could not be used to impose liability on manufacturers of growth hormone deficiency drug for paying kickbacks to physicians because pharmacies that submitted claims to Medicaid agencies were innocent of wrongdoing, claims were not factually false, claims were not legally false due to express certification of compliance with federal anti-kickback statute, *42 USCS § 1320a-7b*, and compliance with federal anti-kickback statute was not expressly stated precondition of payment. *United States ex rel. Rost v Pfizer, Inc. (2010, DC Mass) 736 F Supp 2d 367.*

Relator's allegations that drug manufacturers gave excess overfill of drug to providers for which providers did not pay, advocated that providers bill Medicare for free doses, and induced providers to purchase drug and make false certifications of compliance under anti-kickback statute, *42 USCS §§ 1320a-7b(b)(1)(B)* and *1320a-7a(i)(6),* were sufficient to state claim for violation of *31 USCS § 3729* because excess overfill constituted free doses of drug and created potential for providers to profit from Medicare reimbursement; claim satisfied *Fed. R. Civ. P. 9(b)* because relator provided factual and statistical evidence supporting conclusion that since manufacturers began giving kickbacks, providers involved in kickback scheme had likely made knowingly false statements on Medicare reenrollment forms. *United States ex rel. Westmoreland v Amgen, Inc. (2010, DC Mass) 738 F Supp 2d 267.*

Qui tam relators' complaint under False Claims Act (FCA), *31 USCS §§ 3729* et seq., did not sufficiently allege false claims based on false certifications of compliance with anti-kickback statute, *42 USCS § 1320a-7b*, because relators did not allege that medical device manufacturer that allegedly provided such kickbacks caused any physicians or hospital to make false certifications of compliance. *United States ex rel. Benett v Medtronic, Inc. (2010, SD Tex) 747 F Supp 2d 745.*

In action in which United States alleged that drug supplier recommended manufacturers' drugs in exchange for kickbacks disguised as payments for physician data and that improper incentives caused supplier to make false certifications and file false claims for Medicaid reimbursements, United States stated claims against manufacturers for violations of *31 USCS § 3729*, because compliance with *42 USCS § 1320a-7b* was material to government's decision to pay claim. *United States ex rel. Lisitza v Johnson & Johnson, Ortho-McNeil-Janssen Pharmaceuticals, Inc. (2011, DC Mass) 765 F Supp 2d 112.*

Unpublished Opinions

Unpublished: Medical equipment provider was properly convicted of conspiracy to violate Medicare Anti-Kickback Statute in violation of *18 USCS § 371* and *42 USCS § 1320a-7b(b)(2)(A)* because there was no fatal variance between conspiracy charge in indictment and evidence at trial; indictment charged single criminal enterprise and defendant contended that evidence showed, at most, existence of several distinct conspiracies, but evidence viewed in light most favorable to Government would not preclude reasonable jurors from finding single conspiracy beyond reasonable doubt. *United States v Job (2010, CA5 Tex) 2010 US App LEXIS 12359.*

Unpublished: District court did not plainly err in failing to sua sponte give Medicare safe-harbor jury instruction under *42 CFR § 1001.952(i)* in medical equipment provider's trial for violation of Medicare Anti-Kickback Statute, *42 USCS § 1320a-7b(b)(2)(A)*, because there was insufficient evidentiary foundation for showing that provider and another co-defendant were in bona fide common-law employment relationship. *United States v Job (2010, CA5 Tex) 2010 US App LEXIS 12359.*