Anti-Kickback Statute
Current Developments

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The Anti-Kickback Statute

Makes it unlawful to:

- Knowingly and willfully,
- Offer or pay,
- Any remuneration,
- To induce
  - the referral of an individual to another person or entity for the furnishing of any item or service; or
  - to induce the purchasing or ordering of such item or service

The Anti-Kickback Statute *(Cont.)*

- Payable in whole or in part by Medicare or Medicaid or other federal health care programs.
- Also applies to the solicitation or receipt of such payments.
- "Remuneration" includes the transfer of anything of value, in cash or in kind, whether made directly or indirectly, and whether made overtly or covertly.

The Anti-Kickback Statute *(Cont.)*

- Criminal conviction under the Anti-Kickback Statute requires proof of criminal intent or *scienter*.
- The United States Supreme Court has held that, in the context of the Firearms Owners' Protection Act, one acts willfully when one acts with a bad purpose, with knowledge that his conduct is unlawful. *Bryan v. United States.*

The Anti-Kickback Statute *(Cont.)*

The Statutory Discount Exception

(42 U.S.C. § 1320a-7b(b)(3)(A))

&

The Regulatory Discount Safe Harbor

(42 C.F.R. § 1001.952(h))

The Statutory Discount Exception

The Anti-Kickback Statute contains an exception for: “a discount or other reduction in price obtained by a provider of services or other entity under [Medicare or Medicaid] if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under [Medicare or Medicaid]”

The Statutory Discount Exception *(Cont.)*

"The bill would specifically exclude the practice of discounting or other reductions in price from the range of financial transactions to be considered illegal under medicare and medicaid, but only if such discounts are properly disclosed and reflected in the costs for which reimbursement could be claimed. The committee included this provision to ensure that the practice of discounting in the normal course of business transactions would not be deemed illegal. In fact, the committee would encourage providers to seek discounts as a good business practice which results in savings to medicare and medicaid program costs." (Emphasis added) H.R. Report No. 95-393(II), at 53, *reprinted in* 1977 U.S.C.C.A.N. 3039, 3056

The Regulatory Discount Safe Harbor

- In 1991, the OIG promulgated a regulatory safe harbor for purchasing discounts received by providers. 42 C.F.R. 100.952(h)
- 1999 Clarifying Amendments –
  - Rebates, "the terms of which are fixed and disclosed in writing to the buyer at the time of the initial purchase to which the discount applies, but which is not given at the time of sale."
  - Protects bundled discounts that are "reimbursed by the same Federal health care program using the same methodology ."

The Regulatory Discount Safe Harbor *(Cont.)*

- The safe harbor established separate disclosure obligations for different types of entities:
  - Manufacturers, that furnish goods and services to providers on a discounted basis ("sellers"),
  - Providers that buy such goods and services and submit claims to Medicare and Medicaid ("buyers"), and
  - Parties that are essentially middlemen who arrange for discounts between buyers and sellers ("offerors").

The Regulatory Discount Safe Harbor *(Cont.)*

- The safe harbor's obligations are further differentiated depending on whether the buyer:
  - Is acting under risk contract;
  - Reports costs on a cost report;
  - Or falls under neither of these categories

HIPAA Health Care Fraud Statute

- In 1996, HIPAA created a new category of federal criminal offenses—health care offenses
  - Allows subpoenas, freezing of assets, etc.
- Criminal health care fraud:
  - Knowing and willful execution of a scheme or artifice:
    - To defraud a health care benefit program
    - To obtain through false or fraudulent means any money or property from a health care benefit program
    - Through Federal Sentencing Guidelines, until recently, violations of this provision carried greater penalties than AKS violations

Health Reform Update

Health Care Reform Legislation

- Patient Protection and Affordable Care Act, Pub. L. No. 111-148
  - Enacted March 23, 2010
- Health Care and Education Affordability Reconciliation Act of 2010, Pub. L. No. 111-152
  - Enacted March 30, 2010
- In this presentation, the two will collectively be "ACA"

Health Care Reform Legislation *(Cont.)*

- *Section 6402(f)* – New AKS intent standard –

  "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." § 1128B(h)

- Overturns *Hanlester Network et al. v. Shalala*, 51 F.3d 1390 (9th Cir. 1995).

Health Care Reform Legislation *(Cont.)*

United States v. Bay State Ambulance and Hospital Rental Service, Inc., 874 F.2d 20 (1st Cir. 1989)

- Case involves the awarding of a city ambulance contract in which a member of the city's review committee was given a free car.
- A lesser know part of the case involves a constitutional void-for-vagueness challenge.
- "[T]he unusually high *scienter* requirement mitigates any vagueness."

Health Care Reform Legislation *(Cont.)*

- Now: Same lowered intent level for health care fraud (ACA *Section 10606(b))*
- Now: The definitions of Health Care Offense include:
  - Violations of the AKS
  - With respect to "health care benefit" programs --
    - Violations of the Food, Drug and Cosmetic Act
    - Violations of certain sections of ERISA
- Now: Appears that AKS violations have same enhanced penalties under the Federal Sentencing Guidelines

Health Care Reform Legislation *(Cont.)*

- *Linkage to False Claims Act* – Many courts have held under an express or implied certification theory that a violation of AKS is actionable under the False Claims Act
  - Allows for significant penalties
  - Allows for whistleblowers to bring actions
- *ACA Section 6402(f)* adds language on this issue –

  "In addition to the penalties provided for in this section. . ., a claim that includes items or services resulting from a violation of this section constitutes a false or fraudulent claim for purposes of the [False Claims Act]." § 1128B(g) (Emphasis added)

Case Law and Settlements Update

United States ex rel. Kosenske v. Carlisle HMA Inc., 554 F.3d 88 (3rd Cir. 2009)

- Anesthesiologist brought *qui tam* action under FCA, alleging hospital and owners submitted outpatient hospital claims to Medicare and other federal healthcare programs that falsely certified AKS and Stark compliance.
- 3rd Circuit reversed summary judgment in defendants' favor and found that exclusive service arrangement for pain management services between Relator's former practice (Blue Mountain Anesthesia Associates) and defendants (1) triggered Stark and AKS; and (2) did **not** meet the personal service exception to either statute.
- In 1992, Hospital and BMAA entered Anesthesiology Services Agreement:
  - Hospital would provide space, equipment and supplies at no charge and allow only BMAA physicians to provide anesthesia or pain management services at Hospital;
  - BMAA would provide anesthesia coverage for hospital patients 24/7 and use personnel, space, equipment and supplies provided by Hospital solely for practice of anesthesiology and pain management for Hospital's patients; and
  - BMAA physicians would not practice anesthesia or pain management at any location other than the Hospital or other facilities/locations operated by Hospital et al.

United States ex rel. Kosenske v. Carlisle HMA Inc. (Cont.)

- In 1998, Hospital opened a pain management clinic and BMAA began providing pain management services to its patients. Hospital did not charge BMAA rent for the space or equipment, or a fee for support personnel provided by Hospital. Parties did not execute a new agreement.
- **Lessons:**
  - **Have (and update as necessary) a written agreement.** The only written agreement between parties was executed in 1992 and did not address pain management services later provided at a facility opened after the Agreement was signed. Nor did it address the free hospital space, staff or facilities provided to BMAA.
  - **Beware non-monetary remuneration.** The exclusive right to provide services and in-kind remuneration can also trigger AKS.
- The District Court heard the case on remand and denied the parties' renewed cross-motions for summary judgment, finding numerous disputed issues of fact. (*United States ex rel. Kosenske v. Carlisle HMA Inc., 2010 U.S. Dist. LEXIS 31619* (W.D. Pa. 2010).

United States ex rel. Westmoreland v. Amgen, Inc., 738 F.Supp.2d 267 (D. Mass. 2010)

- A FCA qui tam case, in which the Relator argues, in part, that defendants caused physicians to submit false claims by certifying compliance with AKS.
- In addition to allegations of typical AKS violations, relators present a novel theory of AKS violation: **"overfill kickback scheme"** in which Defendants provided overfill of anemia drug Aranesp vials to dialysis providers and encouraged them to profit therefrom by improperly billing Medicare. Relator alleged:
  - Amgen gave excess (overfill) Aranesp to providers, for which they did not pay;
  - Amgen advocated that providers bill Medicare for the free doses;
  - Medicare does not pay for overfill;
  - Amgen induced providers to purchase the drug and make false certifications of compliance with AKS.

United States ex rel. Westmoreland v. Amgen, Inc., 738 F.Supp.2d 267 (D. Mass. 2010) *(Cont.)*

- Defendants argue overfill is "part and parcel" of the product and cannot be remuneration
- District Court found that Relator adequately plead this count to survive MTD.
  - Cited *Bay State*, 874 F.2d at 29 ("The gravamen of Medicare Fraud is inducement. Giving a person an opportunity to earn money may well be an inducement to that person to channel potential Medicare payments towards a particular recipient.")
- *Affirmed on other grounds*, 2011 U.S. App. Lexis 15036 (1st Cir. 2001)

U.S. ex rel. Westmoreland v. Amgen, Inc., No. 06–10972–WGY, 2011 WL 4342721 (D. Mass. Sept. 15, 2011) (*"Amgen II"*).

- Three issues of importance
  - Was ACA section 6402(f) (AKS violation as a predicate offense to FCA) a clarification or substantive change?
  - Overfill issue (discussed in context of MSJ related to violation of average sales price regulation)
  - Role of affiliate GPO in illegal marketing scheme

Amgen II (Cont.)

- Overfill issue
  - To the extent that properly labeled overfill can't be reimbursed, it is not remuneration because it has no independent value (analogy to a free computer that can only be used to print out laboratory test results)
  - "Excess overfill" above FDA-approved label can constitute remuneration
  - "The illegality arises where drug manufacturers, like Amgen, and their affiliates. . .encourage health care providers to seek reimbursement for any independent value the overfill may have had but for which they did not pay. The fraud is in asking the government to pay a debt that it does not owe because the debt was never incurred by the provider." (Slip op at 65)

Amgen II (Cont.)

- GPO issue – background facts
  - International Nephrology Network ("INN") previously was an independent GPO with 180 members, but is purchased by an affiliate of distributor (AmerisourceBergen) -- ASD
  - Almost all of INN's revenue came from selling Aranesp.
  - INN gets vendor fees from Amgen, some of which are passed through to ASD (issue raised as unearned vendor fee, but not addressed by court)
  - Allegation: "It was assumed that INN, as a purported GPO, could 'go where pharma cannot go.'" i.e., INN was part of the scheme to "market Aranesp based on the amount of overfill."
  - Allegation: INN did not properly disclose its vendor fees.
  - Allegation: "[E]ven if INN did follow [the GPO] disclosure requirement, the close relationships that it maintained with Amgen and ASD are so inconsistent with the congressional intent in creating the GPO safe harbor as to make it inapplicable to INN."

Amgen II (Cont.)

- GPO issue *(cont.)*
  - Court says that the sole issue is whether INN properly mailed the required disclosure information to its members – issue of fact for jury.
  - Compliance with GPO safe harbor is an affirmative defense
  - "[S]tatutory and regulatory compliance alone cannot absolve INN of liability under the False Claims Act if the relationship between the Defendants is shown to have revolved around a marketing scheme intended to induce providers to bill Medicare for the value of Aranesp's overfill, where the Defendants either knew, deliberately ignored, or acted in reckless disregard of CMS's policy that overfill is not reimbursable." Slip op at 92.
  - "[T]his Court is aware of no legal precedent, binding or persuasive, holding that a legitimate GPO cannot be held liable for causing providers to submit false claims for government payment." Slip op at 92-93.

United States ex rel. Lisitza v. Johnson & Johnson, 765 F.Supp.2d 112 (D. Mass 2011)

- Defendants accused of violating the Anti-Kickback Statute, False Claims Act and related state statutes by providing rebates and other payments to Omnicare in connection with its purchases of Defendants' drugs (and other arrangements).
- Defendants' motion to dismiss was denied in part.

United States v. Borrasi,
639 F.3d 774 (7th Cir. 2011)

- Seventh Circuit Court of Appeals upheld Dr. Roland Borrasi's conviction for violations of the Anti-Kickback Statute and joined other circuits in adopting the "one purpose" test.
- **"One purpose" test:** a payment or offer of remuneration violates AKS so long as *part* of the purpose of a payment to a physician or other referral source by a provider or supplier is an inducement for past or future referrals.
- Administrators of an inpatient psychiatric hospital (Rock Creek Center, L.P.) paid Dr. Borrasi and colleagues bribes to refer Medicare patients. Between 1999 and 2002, Dr. Borrasi et al. received $647,204 in potential bribes. In 2001 alone, they referred 484 Medicare patients to Rock Creek.

United States v. Borrasi (Cont.)

- Dr. Borrasi et al. were placed on the Rock Creek payroll, received false titles and job descriptions, and submitted false time sheets. They were not expected to perform any of the duties listed in their job descriptions and attended very few meetings at Rock Creek.

- Dr. Borrasi and certain Rock Creek administrators were charged with conspiracy to defraud the U.S. Government and Medicare-related bribery. Dr. Borrasi was found guilty and sentenced to 72 months in prison, two years of supervised release and $497,204 in restitution.

United States v. Borrasi (Cont.)

- He appealed his conviction, arguing that AKS exempts "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."
- He urged the Court to adopt a **"primary motivation"** doctrine: if, upon examining the defendants' intent , the trier of fact found the ***primary motivation*** behind the remuneration was to compensate for bona fide services provided, the defendants would not be guilty.
- The Court declined, adopted the **"one purpose" test** and held that "[b]ecause at least part of the payments to Borrasi was "intended to induce" him to refer patients to Rock Creek, the statute was violated, even if the payments were also intended to compensate for professional services."

United States v. Borrasi (Cont.)

- **What does *Borrasi* mean for interpreting the employment exception and safe harbor?**
  - Will *Borrasi* limit the protections of the employment exception and safe harbor?
- **How does *Borrasi* assist juries in determining criminal intent?**
  - Should juries focus solely on whether criminal intent was present instead of determining whether the illegal motive was the **primary purpose** or only **one purpose**?
- **What is the textual support for the one purpose rule?**

Relators Chris Riedel &Hunter Laboratories Cases

- In 2005 Relators filed compliant alleging that several laboratories systematically overcharged the state's Medi-Cal program for more than 15 years by giving illegal discounts to doctors, hospitals and clinics for private pay testing in return for referrals of Medi-Cal patients.
  - June 2011, Quest Diagnostics entered a settlement agreement with the State of California for $241 million relating to state False Claims Act violations. This was the largest recovery in the history of California's False Claims Act .
  - A similar suit was filed in S.D.N.Y. in 2005, in which the government declined to intervene.
  - August 2011, Laboratory Corporation of America entered into a similar settlement with state of California for $49.5 million.
  - Other cases pending.

Advisory Opinion Update

OIG Adv Op Website:

http://oig.hhs.gov/compliance/advisory-opinions/index.asp

OIG Advisory Opinions

No. 10-21, Issued September 28, 2010 & No. 11-09, Issued July 21, 2011

- **The Proposed Arrangements:**
  - "Preferred hospital" network as part of a Medicare Supplemental Health Insurance ("Medigap") policy.
    - Medigap plans would contract (through network) with hospitals for discounts on Medicare inpatient deductibles.
    - $100 credit to be redeemed at the next renewal premium payment to policyholders who utilize a network hospital for an inpatient stay.
  - May implicate AKS and Beneficiary Inducement Law. But OIG would not impose sanctions.

OIG Advisory Opinions Nos. 10-21 & 11-09 *(Cont.)*

- **Medicare Cost-Sharing**
  - Discounts on inpatient deductibles present low risk of fraud or abuse.
  - Waivers would not increase or affect per service Medicare payments, as Part A payments to hospitals for inpatient stays are fixed and unaffected by beneficiary cost-sharing.
  - Discounts should not increase utilization because they would be "invisible" to beneficiaries (they apply to the portion of the beneficiary's cost-sharing obligations that Medigap already covers).
  - No unfair affects on competition likely between hospitals because membership in networks would be open to any accredited, Medicare-certified hospital that meets requirements of applicable state law.
  - No likely effect on professional medical judgment because the patient's physician or surgeon would receive no remuneration and patient would remain free to go to any hospital without incurring any additional out-of-pocket expense.

OIG Advisory Opinions Nos. 10-21 & 11-09 *(Cont.)*

➢ Premium Credit

- **AKS Compliance -** Factors stated with respect to discount above apply to the premium credit.
- **Beneficiary Inducement Law -** Would have substantially the same purpose and effect as a differential in a coinsurance and deductible amount and therefore fits within exception
- Ultimately, has potential to lower Medigap costs for policyholders who select network hospitals without increasing costs for those who do not.
- Also has the potential to lower costs for all policyholders because savings realized would be reported to state insurance rate-setting regulators.

Opinions available at:
(11-09) http://www.oig.hhs.gov/fraud/docs/advisoryopinions/2011/AdvOpn11-09.pdf
(10-21) http://www.oig.hhs.gov/fraud/docs/advisoryopinions/2010/AdvOpn10-21.pdf

OIG Advisory Opinion No. 11-01
Issued January 3, 2011

Requestors' plan for their network of pediatric hospitals was:

- To begin billing third-party payers, including Federal health care programs, for services rendered, and waive all cost-sharing amounts without regard to patients' financial need; and
- To adopt a new financial need-based policy of providing lodging assistance and transportation assistance, in limited circumstances, to patients, including Federal health care program beneficiaries, and their families.
- OIG found that the Proposed Arrangements could potentially generate prohibited remuneration under the AKS, if the requisite intent to induce or reward referrals of Federal health care program business was present, but that it would not impose administrative sanctions.

OIG Advisory Opinions No. 11-01 *(Cont.)*

- **The Lodging and Transportation Assistance Programs:**
  - Free lodging and transportation for certain financially needy patients and their families.
  - Programs would fall within the ACA amendments to Beneficiary Inducement Law excepting "remuneration" that promotes access to care and poses a low risk of harm to patients and Federal health care programs.
  - Programs would promote access to care and pose a low risk of harm to Federal health care programs, as they are only provided in the context of a financial need determination and when the Hospitals deem that they are merited by the patient's medical situation.
  - Costs related to the Programs would not appear on any cost report or claim or be otherwise shifted to any Federal health care program.

OIG Advisory Opinions No. 11-01 *(Cont.)*

- **The "Insurance-Only Billing Policy."**
  - Institution's historical commitment to charitable care plus certain aspects of the Requestors' operations and relationships with physicians, taken together, reduce the risk that the Insurance-Only Billing Policy would result in overutilization or unnecessary services.
  - Few, if any, of Requestors' patients are Medicare-eligible, a very small percentage were Tricare-eligible, and Medicaid beneficiaries under age 18 generally have no cost-sharing obligations, thus less than $27,000 of Medicaid co-pays waived annually by the entire Hospital network.
- The following additional considerations contributed to the OIG's decision:
  - The highly specialized nature of services offered at the Hospitals reduces the risk of unnecessary services;

Opinion available at: http://www.oig.hhs.gov/fraud/docs/advisoryopinions/2011/AdvOpn11-01.pdf

OIG Advisory Opinions No. 11-01 *(Cont.)*

- Policy would be discussed with patients only after admission;
- Compensation for employed physicians is fixed and does not, directly or indirectly, take into account or vary based on volume or value of services physicians provide or order;
- Requestors would bear the costs of forgone cost-sharing and would not claim the waived amount as bad debt or shift the burden to payers or individuals;
- Hospitals would offer cost-sharing waivers to all patients, regardless of the network facility treating the patient or the nature of the patient's condition;
- Cost-sharing waiver would not be advertised or marketed;
- Unlikely that Requesters would waive small cost-sharing amounts to generate additional referrals given the already high number of patients seeking care; and
- Public benefits obtained from specialized care.

PHYSICIAN-OWNED DISTRIBUTORS

PODs

- In the medical device world, independent distributors can play an important interface function between the manufacturer, hospital and ordering physician. The roles vary, but can include:
  - "stocking distributors" – buys products (both implants and instruments) from the manufacturer (takes title) and holds inventory vs. "consignment distributors" where distributor does not take title.
  - Distributor makes sure everything is ready for the surgery – takes initial order, has tray ready at hospital OR with implant, instruments, screws, etc.
  - Independent sales organization
- Physician-owned distributors – PODs – adds a new dimension

PODs *(Cont.)*

- PODs appear to be largely confined to spinal and joint implant segments
  - Reports PODs are spreading to other segments
  - But still largely nitch segments
- No POD comes close to complying with the OIG's safe harbor on investment interests.
- Sources of guidance:
  - OIG's 1989 Fraud Alert on Joint Venture Arrangements.
  - 2006 correspondence between AdvaMed and OIG
  - 2008 OIG Congressional testimony
  - FY 2009 Stark Law annual regulatory process
- No clear legal boundaries – case by case analysis

PODs *(Cont.)*

- June 9, 2011 Senate letter to OIG
  - From Senator Grassley and Chairmen and Ranking Members of Finance and Special Committee on Aging
  - "Confusion" in guidance and within medical community
  - Existing guidance "is not adequate to protect against abuse."
  - Concern: inappropriate incentives, conflicts of interest, safety concerns, and potential for overutilization
  - Concern: "the absence of any visible enforcement proceedings"
  - Not all PODs are abusive or illegal – "some of which may indeed be appropriate"
  - Request for an inquiry
  - Detailed questions attached
- Similar letter to CMS re: Sunshine Act

PODs *(Cont.)*

- September 13, 2011 OIG response
  - Conducting a review (could take up to 18 months). Focus –
    - Spinal surgery
    - Whether PODs save money
    - Potential for overutilization
  - "Different POD models can raise varying levels of legal concern"
  - Case-by-case analysis. Factors include –
    - "details of [the POD's] legal structure"
    - Its "operational safeguards"
    - "[I]mportantly, the actual conduct of its investors, management entities, suppliers, and customers during the implementation phase and ongoing operations."
  - Reaffirms existing guidance and advisory opinion process
    - Opportunity to profit "could constitute an illegal inducement"
    - Cites to 1989 Joint Venture Fraud Alert factors
  - Reaffirmed commitment to enforcement actions

OTHER

Trends in Anti-Kickback Enforcement: Prosecution of Patient Recruiters

Why do we care about prosecution of patient recruiters?

Trends in Anti-Kickback Enforcement: Prosecution of Patient Recruiters

- **Vincente Guerra-Nistal (Miami)**
  - On July 21, 2011, Guerra, a patient recruiter, plead guilty for participation in $25 million Medicare fraud scheme with ABC Home Health Care Inc, a Miami home health care agency.
  - ABC purported to provide home health and physical therapy services to Medicare beneficiaries. In reality, it operated for purposes of billing Medicare for expensive physical therapy and home health care services that were medically unnecessary and/or never provided.
  - From January 2006 to March 2009, Guerra offered and paid kickbacks and bribes to Medicare beneficiaries in return for allowing ABC to bill Medicare for services that were not medically necessary and/or never provided. In return, ABC's owners paid Guerra kickbacks and bribes for recruiting the Medicare beneficiaries to ABC.
  - Guerra admitted knowing that the patients he recruited did not qualify for the services billed to Medicare and that their files were falsified to make it appear that they qualified for home health care and therapy services so that Medicare could be billed.

Trends in Anti-Kickback Enforcement: Prosecution of Patient Recruiters *(Cont.)*

- **American Therapeutic Corporation (ATC) & Medlink Professional Management Group, Inc. (Miami)**
  - On May 3, 2011, Marianella Valera, president of ATC, and Lawrence S. Duran, president of Medlink, plead guilty on behalf of the corporations for healthcare fraud charges including conspiracy to defraud the United States and to pay and receive illegal health care kickbacks. Individually, Duran and Valera also plead guilty to 38 and 21 felony charges against them, respectively.
  - ATC operated partial hospitalization programs (PHPs), a form of intensive treatment for severe mental illness. Medlink purported to act as a "management company" for health care businesses, but in reality had only two clients: ATC and the American Sleep Institute (ASI), which was related to ATC.

Trends in Anti-Kickback Enforcement: Prosecution of Patient Recruiters *(Cont.)*

- From 2002 to October 2010, ATC and Medlink perpetrated a scheme to bill Medicare for over **$200 million** for medically unnecessary services, involving:
  - Altering patient files and therapist notes, and instructing employees and doctors to do the same, to make it appear that patients treated qualified for PHP treatments.
  - Causing doctors to refer ATC patients to ASI even though they did not qualify for sleep studies.
  - Paying kickbacks to owners and operators of assisted living facilities (ALFs) and halfway houses, patient brokers and, sometimes, patients, in exchange for delivering ineligible patients to ATC and ASI (for whom false claims were submitted).

Trends in Anti-Kickback Enforcement: Prosecution of Patient Recruiters *(Cont.)*

- They also used Medlink to conceal the health care fraud and kickbacks by transferring money to Medlink once Medicare paid claims.
- On September 16, 2011, Duran was sentenced to **50 years in prison** – the longest prison sentence ever imposed in a Medicare Fraud Strike Force case – and ordered to pay **$87 million in restitution** jointly and severally with his co-defendants.
- Three days later, Valera was sentenced to **35 years** in prison and also ordered to pay the **$87 million in restitution**.
- Judith Negron, the third owner and operator of ATC, was charged as a co-defendant with Duran and Varela. On August 23, 2011 a jury found her guilt of all 24 counts against her. As of late September 2011, she had not yet been sentenced.

Trends in Anti-Kickback Enforcement: Prosecution of Patient Recruiters *(Cont.)*

- **Marion Beverly Metoyer, et al. (Houston)**
  - On May 26, 2011, convicted by a Houston jury of receiving kickbacks for providing Medicare beneficiaries' names to a DME company that submitted false and fraudulent claims to Medicare for medically unnecessary DME, including power wheelchairs, wheelchair accessories, and motorized scooters.
  - Claims were billed to Medicare under a special code designated for power wheelchairs lost or damaged during a series of hurricanes in 2008. This code allowed for claims submission without a medical necessity certification.
  - At trial, beneficiaries for whom Medicare claims were submitted testified that recruiters they had never met, including Metoyer, came to their homes and offered them free power wheelchairs in exchange for their Medicare information. The power wheelchairs were often billed to Medicare at more than $6,000 per chair.

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