Healthcare Fraud

A Primer for the Nurse Executive

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ABSTRACT

Healthcare fraud has become an issue about which all healthcare providers must be aware. Unfortunately, for most of us, the laws and the regulations developed to enforce the laws regarding fraud in healthcare are among the most confusing ever written. Healthcare fraud is an important area of risk for the nurse executive and an area about which all nurse executives need to be aware. Healthcare fraud primarily relates to improper billing of governmental healthcare programs. A basic understanding of these programs is therefore fundamental to understanding the problem of healthcare fraud and how to prevent it. This article will provide a basic overview of this subject for the nurse executive.

Governmental Healthcare Programs

Many patients in the acute care setting are insured by Medicare and Medicaid. Medicare, enacted in 1965, is a federally funded health insurance program contained in Title 18 of the Social Security Act.[1] The Medicare program provides health insurance benefits to Social Security recipients older than 65 years and to those who are permanently disabled as defined under the Social Security Act. Medicare is a federal program and pays only for services that are ''reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.''[1] Participating healthcare providers must ensure that any services rendered to Medicare recipients are supported by sufficient evidence of medical necessity (42 U.S.C. Section 1320c-5(a)(1)).[2] Under the laws that govern Medicare, the Secretary of Health and Human Services regulates the administration of the program through the Centers for Medicare and Medicaid Services, with regulations totaling more than 1,600 pages in length. Medicaid, also enacted in 1965, is jointly financed by the federal

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and state governments and is administered by the states. Medicaid provisions are contained in Title 19 of the Social Security Act.[3] This program authorizes federal grants to states for medical assistance to low-income persons who are 65 years or older, blind, disabled, or members of families with dependent children or qualified pregnant women or children (42 C.F.R. Section 430.0).

The Secretary of Health and Human Services is primarily responsible for the administration of these programs. In 1978, the Office of the Inspector General (OIG) was created by Congress to detect and prevent fraud and abuse in the Medicare and Medicaid programs (5 U.S.C. App. Section 2(2)). State Medicaid Fraud Control Units are authorized by the Medicare-Medicaid Anti-fraud and Abuse Amendments to the Social Security Act. The purpose of the state units is to administer a state level program to investigate and prosecute violations of applicable state laws regarding all aspects of fraud in connection with the provision of medical assistance and the activities of providers of such assistance under the federal Medicaid program (42 U.S.C. Section 1396b(q)(3)). To obtain Medicaid funding, a state must have a plan for medical assistance, which must contain procedures for payment for services sufficient to ensure that these payments are consistent with quality of care (42 U.S.C. Section 1396a(a)(30)(A)). Each state must have a fraud detection program, and the state plan must provide for the exclusion of any person or entity that commits fraud or abuse. The federal statute defines abuse as ''provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare'' (42 C.F.R. 455.2).

TRICARE is the federal health insurance program for Department of Defense employees. Like Medicare, TRICARE pays only for medically necessary services and supplies (32 C.F.R. Section 199.4(a)(1)(i)).

The Cost of Healthcare Fraud

In May 1995, the Department of Health and Human Services (HHS) began a 2-year demonstration project entitled Operation Restore Trust. The purpose of this project was to test new approaches to fighting fraud and abuse in the Medicare and Medicaid programs. This program initially targeted 5 states: California, Florida, Illinois, New York, and Texas. These states were chosen because, collectively, their residents included more than one third of all Medicare and Medicaid beneficiaries. The goal of Operation Restore Trust was to increase enforcement in healthcare programs where the government believed that fraud and abuse were prevalent. The project also focused on high-growth program areas, including home health agencies, nursing homes, hospice care, and durable medical equipment suppliers. As a result of the success of this program in decreasing improper claims and erroneous payments, HHS expanded the program to include all 50 states.

In addition to its well-publicized privacy mandates, the Health Insurance Portability and Accountability Act of 1996 established a national healthcare Fraud and Abuse Control Program, under the joint direction of the Attorney General and the Secretary of the Department of Health and Human Services, acting through the Department's Inspector General (HHS/OIG). This program was designed to coordinate federal, state, and local law enforcement activities to identify and prosecute healthcare fraud, to prevent future fraud and abuse, and to protect program beneficiaries. In 2006, federal prosecutors filed 472 criminal healthcare fraud cases and 272 civil actions.[4] The OIG reports that for fiscal year 2006, it generated savings and expected recoveries of nearly $38.2 billion from fraud and abuse enforcement and prosecution.[4]

Fraud is also a problem in the private sector. A survey done by the Health Insurance Association of America revealed that 9 out of 10 private insurers have launched antifraud programs since 1995. The savings from these antifraud programs totaled $260 million, an average $2.3 million per insurer, which represented a savings of $7.50 for each dollar spent on fraud detection.[5] According to Greg Anderson, director of corporate finance investigations for Blue Cross–Blue Shield of Michigan, billing for services not rendered and upcoding fraud* constitute 100% of the provider fraud in fee-for-service plans.[5(p32)] Ultimately, the cost of healthcare fraud is passed on to patients and providers in the form of lower payments for services rendered, higher co-payments, and higher costs of health insurance.

False Claims

The False Claims Act

The Federal False Claims Act[6] prohibits presenting any false claim for reimbursement to the United States if the provider knows the claim is false or the provider has deliberate ignorance or reckless disregard of the claim's falsity. This law also prohibits submitting or causing to submit a false claim, conspiring to obtain a false claim, and making or using false records to obtain a payment. This means that employers may be liable for the acts of employees as well as contractors who submit claims that are false. In the healthcare setting, the False Claims Act can be used to prosecute the

*Upcoding is a term used to describe the practice in which a different billing code is used to maximize reimbursement for a service or procedure done instead of using the specific code designated for that service or procedure.

institution, entity, or individual provider for a variety of actions, including the following:[7]

1. Billing for goods and services not provided
2. Billing for unnecessary goods and services
3. Submitting false cost reports
4. Billing for substandard care
5. Acceptance or giving of kickbacks
6. Unbundling of services or supplies that should be grouped together

It is important for clinicians to realize that the False Claims Act allows for actions against individual clinicians. Therefore, false claims are not merely a problem for the healthcare corporation. Nurse executives must exercise caution in any professional responsibility involving the billing of care or the documentation of that care to avoid the submission of potentially false claims.

Whistleblowers

The whistleblower or ''Qui tam'' provisions of the False Claim Act allow individuals, known as ''relators,'' to file suit on behalf of the United States against those who have falsely or fraudulently claimed federal funds. Kleiman[7] reminds us that fraud in any program depending on federal funding[†] may be prosecuted under this act. The whistleblower can be a current or former employee, a patient, a competitor, or any other person who obtains knowledge of fraudulent and/or abusive behavior. Generally, the knowledge must be firsthand; that is, it cannot come from a public source. Persons who file qui tam suits can recover from 15% to 25% of any settlement or judgment reached in a case if the United States intervenes in the action or up to 30% if they pursue it on their own (31 U.S.C. Section 3730(d)(1)). Given the stiff penalties that apply in fraud and abuse cases, the whistleblower can receive a great deal of money if the government wins such a case. As a result, the number of these lawsuits, known as ''Qui Tam'' cases, has increased dramatically since 1993.

Under the False Claims Act, an employee who is fired, demoted, or otherwise discriminated against for furthering an investigation into false claims is entitled to double back pay with interest, litigation costs, attorney's fees, general damages, and reinstatement (31 U.S.C. Section 3730(h)). This reflects the fact that whistleblowers are protected by law against retaliatory actions for investigating or reporting fraud. Both federal and state laws protect whistleblowing employees. In addition, the US Supreme Court has ruled that federal civil rights law protects employees who are fired to deter them from testifying in a federal trial against their employers (*Haddle v Garrison*, 119 [S.Ct. 489, 1998]). Kleiman[7] notes that since all False Claim Act suits must be filed under seal, the healthcare entity may not know about the suit for months or even years, with the result that the whistleblower may remain anonymous and may continue working in the industry during most of the time the suit is in process.

DEALING WITH WHISTLEBLOWERS: CAUTIONS FOR THE NURSE EXECUTIVE

The nurse executive must exercise great caution when dealing with a subordinate employee who is a whistleblower. The case of *Neal v Honeywell* (826 F. Supp 266 [7th Cir. 1994]) provides an illustration of how not to deal with a whistleblower. In this case, a human resources department psychologist reported fraud to the company hotline. She immediately experienced retaliation, despite promises of anonymity. After she was forced to quit, she sued her employer under the False Claims Act for the retaliation. In this case, the plant manager, who had been involved with the fraud, was promoted with a salary increase. The whistleblower, Dr Neal, was given a 1-month paid leave when she was subjected to death threats and was denied a routine promotion. Dr Neal was eventually awarded $294,000. Her employer was also required to pay nearly $1 million of her attorney's fees. Even though she did not file a false claims case, this whistleblower was able to use the False Claims Act to receive compensation for the retaliatory actions of her employer.

It is important to remember that retaliation does not always mean firing the employee. Courts may also consider actions such as breaking promises of confidentiality, reducing the responsibilities of employees who come forward with problems, or subtly punishing them in other ways to be retaliation. This means that when faced with the need to take action regarding an employee who has reported fraud and/or abuse, it is imperative to discuss the matter with your institution's risk manager or in-house attorney before acting.

Corporate Compliance: Managing the Risk

The nurse executive must be aware of the requirements regarding compliance plans for several reasons. First, if the nurse executive is involved in developing or administering the compliance program, it is imperative to be familiar with the *standards* against which the program will be judged. Second, each nurse executive must be familiar with his or her own employer's compliance plan and program in order to comply with it, and being aware of the standards will provide a background of understanding why the plan was developed as it was.

[†]This includes Medicare, Medicaid, the Veterans Administration, TRICARE, and private health insurance purchased for federal employees, as well as federal support for medical or nursing education or biomedical research.

The Compliance Program and Plan

If an agency or facility finds itself in question of having violated legal prohibitions against fraud and abuse, one of the best defenses it will have is a well-developed corporate compliance program. The Federal Sentencing Guidelines[8] provide for decreased monetary fines and other penalties if the defendant entity had in place at the time of the alleged fraud and abuse a corporate compliance program that was developed and carried out in accordance with these guidelines. Although adopting and implementing a compliance program is voluntary, the OIG believes that such programs prevent fraud, abuse, and waste and at the same time further the providers' fundamental mission to provide quality care.

There are 2 aspects to corporate compliance described by Cantone:[9] the corporate compliance program, which is the total of a corporation's efforts to comply with the various laws and regulations, and the corporate compliance plan, which is a detailed document specifically addressing those areas identified as presenting the corporation with significant liability.

Cantone[9] identifies several benefits to a corporate compliance plan for healthcare organizations, including the following:

1. Potential reduction of civil or criminal wrongdoing
2. Potential reduction of administrative or civil penalties if a violation occurs
3. Provision of a more accurate view of employees' behaviors
4. Identification and elimination of criminal and unethical conduct
5. Provision of a means for efficient dissemination of information relating to changes in government requirements
6. Establishment of a structure that encourages employees to deal with concerns internally, which reduces the potential for qui tam actions and governmental investigations

Stahl[10] identifies additional benefits of a compliance program, cited by the OIG in its guidelines for compliance, which were released on February 11, 1998:

1. Ensures that accurate claims will be submitted to government and private payers
2. Enables the hospital/facility to fulfill its caregiving mission
3. Assists hospital/facility in identifying any weaknesses in internal systems and management
4. Demonstrates a strong commitment to honest, responsible provider and corporate conduct
5. Improves quality of care
6. Develops a procedure that allows for prompt, thorough investigation of alleged misconduct by corporate officers, managers, employees, independent contractors, physicians, other healthcare professionals, and consultants
7. Initiates immediate and appropriate corrective action
8. Minimizes the loss to the government from false claims and thereby reduces the hospital's/facility's exposure to civil damages and penalties, criminal sanctions, and administrative remedies

Developing a Compliance Plan

When developing a corporate compliance plan, the Federal Sentencing Guidelines must be referred to carefully. To meet the Federal Sentencing Guidelines, a compliance plan must include the following:[8]

1. Compliance standards and procedures
2. Overall compliance program oversight by high-level personnel
3. Due care delegating authority
4. Employee education and training
5. Monitoring, auditing, and reporting systems
6. Consistent enforcement and discipline
7. Response and corrective action

In developing a compliance plan, the first step is to perform a baseline risk assessment to determine responsibilities and existing processes for compliance, focusing on the most common types of compliance problems.[9] Part of this risk assessment should include auditing clinical charts, financial operations, policies and procedures, contracts, and billing processes to search for miscoding, double billing, and credit balances.[9] Common areas of risk can include the following:

1. Billing for services not provided
2. Plan of care documents not signed by the physician
3. Falsification of physician signatures
4. Backdating physician signatures
5. Physician consultation and administrative fees
6. Kickbacks
7. Cost report fraud

The second step is to establish a code of conduct, which will apply across the board in the organization. A code of conduct should include the following:

- Ethical principles
- Explanation of laws
- Schedule for amending the code
- A vehicle to report potential compliance issues
- A nonretaliation policy for whistleblowers
- Description of disciplinary measures

Third, oversight for the compliance program must be assigned to a high-level person in the organization. In some institutions, a corporate compliance officer is solely responsible for compliance. In others, the functions of the corporate compliance officer are assigned to a high-level corporate officer such as the

chief financial officer or the executive director. Some organizations also appoint a compliance committee that provides oversight to all compliance activities.

It is important to remember that to meet federal guidelines, the compliance plan must be more than just carefully written documents. The plan must truly function in accordance with the Federal Sentencing Guidelines as follows:

1. The organization must have established compliance standards and procedures to be followed by its employees and other agents that are reasonably capable of reducing the prospect of criminal conduct.
2. Specific individuals within high-level personnel of the organization must have been assigned overall responsibility to oversee compliance with the standards and procedures.
3. The organization must have used due care not to delegate substantial discretionary authority to individuals whom the organization knew, or should have known through the exercise of due diligence, had a propensity to engage in illegal activities.
4. The organization must have taken steps to communicate effectively its standards and procedures to all employees and agents.
5. The organization must have taken reasonable steps to achieve compliance with its standards.
6. The standards must have been consistently enforced through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals for failure to detect an offense. Adequate discipline of individuals responsible for an offense is a necessary component of enforcement; however, the form of discipline that will be appropriate will be case specific.
7. After an offense has been detected, the organization must have taken all reasonable steps to respond appropriately to the offense and to prevent further similar offenses, including any necessary modifications to its program to prevent and detect violations of law.[8]

Documentation

As with defense of malpractice litigation, good documentation can be an important way to defend against charges of fraud and abuse. Stahl[10] suggests that policies and procedures related to the processing and submitting of claims should do the following:

1. Provide for proper and timely documentation of all physician and other healthcare professional services that substantiate billed services.
2. Specify the documentation requirements in the patient's medical records, which, at a minimum, should include the length of time spent in providing the service, who provided the service, why the service was provided, and the clinical outcomes. This documentation is essential to justify reasonableness and medical necessity.

It is imperative, however, that documentation never be falsified. The Federal False Entry Statute provides the following;

> . . .[W]hoever, in any matter within the jurisdiction of the executive, legislative, or judicial branch of the Government of the United States knowingly and willfully:
> 1. falsifies, conceals, or covers up by any trick, scheme, or device a material fact;
> 2. makes any materially false, fictitious, or fraudulent statement or representation; or
> 3. makes or uses any false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry;
>
> shall be fined under this title or imprisoned not more than 5 years, or both (18 U.S.C. Section 1001).

Providers have an obligation to ensure that their Medicare-funded services are ''supported by evidence of medical necessity... as may reasonably be required by a reviewing peer review organization.'' (42 U.S.C. Section 1320c-5(a)(3)).[11]

Duty to Report

If an institution receives an overpayment from Medicare, whether this arises from simple negligence or from the presentation of false claims, it must report this overpayment to the Centers for Medicare and Medicaid Services. Stahl[10] notes that when violations of the compliance program are identified, the matter must be reported to the appropriate governmental authority within a reasonable time frame, but no later than 60 days after the violation is identified. If the nurse executive is aware of overpayments and fails to report them, he or she could be liable for concealment of a felony. US Code Title 18, Section 4 states: ''Whoever, having knowledge of the actual commission of a felony cognizable by a court of the United States, conceals and does not as soon as possible make known the same to some judge or other person in civil or military authority under the United States, shall be fined under this title or imprisoned not more than three years, or both.'' Nurse executives who fail to report knowledge of false claims are therefore at risk of their entire professional and personal lives.

Potential Penalties for Lack of Compliance

Penalties for fraud and abuse can literally ruin the nurse executive's personal and professional life. Cantone[9]

notes that the potential consequences for failing to comply include the following:

1. Probation and a court imposed, government-designed program
2. Fines set at an amount sufficient to divest the organization of all of its net assets
3. Exclusion from the Medicare and Medicaid programs
4. Management liability
5. Stockholder lawsuits
6. Qui tam lawsuits

Exclusion

Section 1320a-7 of Title 42 provides that individuals can be excluded from participation in Medicare and state healthcare programs under certain circumstances, including (1) conviction relating to fraud, (2) conviction relating to obstruction of an investigation of Medicare fraud, (3) claims for fraud or excess charges, and (4) furnishing patient services of a quality that fails to meet professionally recognized standards of healthcare (42 USC Sections 1320 a-7(b)).[11] A minimum of 5-year exclusion from participation in Medicare and/or any state healthcare program is mandatory for any individual or entity that (1) has been convicted for Medicare-related crimes, (2) has been convicted of a criminal offense relating to neglect or abuse of patients, or (3) has been convicted of a criminal offense related to the delivery of an item or service under Medicare, Medicaid, or any state healthcare program (42 U.S.C. Section 1320a-7(a) and 1320a-7(c)(3)(B)).[11] Generally, when a provider is going to be excluded, that provider is provided with a notice indicating that within 60 days of the notice, they can request a hearing before an administrative law judge to challenge whether they were in fact convicted, whether their convictions were related to the delivery of an item or service, and the length of their exclusion from the program. In 2006, HHS excluded 3,425 individuals and entities from participating in federally sponsored healthcare programs.[4]

Suspension of Payments

A state Medicaid agency is also allowed to suspend provider payments ''upon receipt of reliable evidence that the circumstances giving rise to the need for a withholding of payments involve fraud or willful misrepresentation under the Medicaid program'' (42 C.F.R. Section 455.23(a)). The regulation provides that payments may be suspended ''without first notifying the provider,'' but requires that notice be given within 5 days of taking such action and specifies that the provider may request and must be granted administrative review where state law so requires (42 C.F.R. Section 455.23(a)).

Financial Penalties

The False Claims Act allows potentially enormous financial penalties for individuals or facilities found liable under the act, including treble damages and straight fines of up to $10,000 for *each* false claim submitted.

License Revocation

The individual state in which a practitioner convicted of fraud against a government program is licensed can also take action against that practitioner, including revocation of professional licenses and imposition of fines in addition to those imposed by the federal government. For example, in Louisiana, the statutory maximum penalty for Medicaid fraud is 5 years with or without hard labor and/or a fine of not more than $10,000 (Louisiana Statutes Annotated—R.S. 14:70.1). Many states have adopted the Federal Sentencing Guidelines as mandatory in dealing with Medicaid fraud cases on a state basis. In the New York case of *Harshad v DeBuono*,[12] the New York appeals court upheld the decision of the State Board for Professional Medical Conduct to revoke the medical license of a physician who was convicted upon his plea of guilty to a felony charge of insurance fraud. As another example, in California, a conviction of a crime involving theft, dishonesty, fraud, or deceit is determined to be substantially related to the qualifications, duties, and functions of a registered nurse and can therefore serve as the basis for discipline of the involved nurse's license by the state board of nursing (16 California Code of Regulations, Section 1444).

False Claims Resulting From Substandard Care

The nurse executive needs to direct particular caution toward the potential for false claims as a result of substandard care. There have been several important cases alleging fraud in substandard care. The first case occurred in the Eastern District of Pennsylvania in February of 1996. At this time, the US attorney's office filed a civil complaint against the owner and former manager of Tucker House, a 180-bed nursing facility located in Philadelphia. This lawsuit alleged that 3 former residents had been subjected to substandard care, in that inadequate nutrition was maintained, as evidenced by the development of multiple stage III and IV pressure ulcers, secondary infections in the ulcers, precipitous and severe weight loss, and other symptoms of malnutrition, as well as improper wound care. The government also found that the staff failed to recognize the malnutrition or intervene early enough to prevent further decline of the patients' health.

The suit was based on both the False Claims Act and the Nursing Home Reform Act (42 U.S.C.A. Section

1396r et. seq.). The government's contention was that the defendants had violated the False Claims Act by submitting claims for services provided to these residents when the residents had not been provided with adequate care. The government's argument was that noncompliance with quality of care standards applicable to nursing facilities under both federal and state law was the same as intentional noncompliance with the required Medicare and Medicaid provider certification agreement between the government and the facility. This is because, under the certification agreement, all providers are charged with knowing all federal and state laws that apply to them and to the services they provide; the government has interpreted the knowledge requirement to be a compliance requirement as well. Because submitting claims for services to the government is a certification that all such services were provided in compliance with all quality of care laws and regulations, submitting such claims while not complying with the quality of care standards was false certification actionable under the False Claims Act.

The Nursing Home Reform Act requires nursing facilities participating in Medicare and Medicaid to ensure that their residents are cared for adequately and appropriately. The regulations under the Nursing Home Reform Act specifically require that facilities identify when a resident's nutritional status falls below what is considered acceptable for that patient's age and health status and must correct, if possible, whatever is causing the nutritional problem (42 C.F.R. Section 483.25(i)). This act also requires comprehensive assessment and treatment of pressure ulcers (42 C.F.R. Section 483.25(c)). In this case, state laws in Pennsylvania also required that facilities meet daily nutritional requirements of patients (28 PA Code Section 211.6a) and that the director of nursing services ensure that all prescribed health services for patients are properly implemented (28 PA Code Section 211.12e).

One of the important facts of this case was that the medical records of these patients indicated that the facility's staff had or should have had some knowledge that the nutritional intake of the residents was not sufficient. Even worse, the nursing staff's treatment notes were not entirely consistent with the severe problems obviously present in these patients. The fact that the facility failed to determine what the patients' true conditions were before submitting the claims constituted, in the government's eye, reckless disregard for the truth. The case was settled for $500,000 and consent orders imposing rigorous quality of care standards on the facility.[7,13]

Two years later, in January 1998, the same US attorney filed a similar action against 3 additional nursing homes. This case also settled for $500,000 and an agreement to implement the same kinds of quality of care standards as in the Tucker House case.[7] In August of 1998, the US attorney's office in Baltimore filed suit against Greenbelt Nursing and Rehabilitation Center. The suit was settled only 1 month after it was filed. In a detailed court order agreed to by both parties, Greenbelt's owner agreed to strict standards for staffing, staff training, quality assurance, medical and nursing care, nutritional needs, psychiatric services, wound care, and resident safety. Greenbelt was also required to hire a monitor and an interim manager to be approved by the government. Most importantly, Greenbelt agreed that the US government could interview its staff outside the presence of supervisors and without company lawyers present.[7] In 2001, the principle operator and co-owner of 2 nursing homes and other healthcare businesses in Pennsylvania agreed to a 5-year exclusion for his role in providing substandard care to residents of those homes, representing the first time HHS/OIG excluded the owner of a healthcare facility based on the owner's responsibility for poor care at the facility.[14] In 2001, Manor Care, Inc, settled a civil false claims act case arising from inadequate care to Medicare patients at one of its skilled nursing facilities and paid a $90,000 fine to the government as well as agreeing to retain an independent consultant to monitor quality of care at the facility.[14]

Other Relevant Federal and State Laws

In addition to charges under the False Claims Act, providers may be charged with mail fraud in violation of 18 U.S.C. Section 1341 if they have used the US mails in furtherance of their fraudulent behavior and may be charged with wire fraud in violation of 18 U.S.C. Section 1343 if they have engaged in telephone conversations or used wire transmissions in furtherance of their fraudulent behavior.

The Medicare antikickback statute (42 U.S.C. Sections 1320a-7b(b))[11] represents a culmination of several years of congressional effort to combat fraud and abuse in the Medicare and Medicaid programs. Congress first enacted these laws in 1972. The law made it a misdemeanor to solicit, offer, or receive any ''kickback or bribe in connection with'' furnishing covered services or referring a patient to a provider of those services.[15]

In 1977, Congress expanded on the 1972 statute, making violations of the statute a felony and additionally proscribing the solicitation or receipt of any ''remuneration,'' including any kickback, bribe, or rebate, in return for referring a patient to a provider of covered services, regardless of whether the prohibited act was done ''directly or indirectly, overtly or covertly, or in cash or in kind.''[16] The statute was revised again in 1980 because there was uneasiness regarding the application of the statute to include what is known as a ''scienter'' requirement, which means that the person accused must have knowingly and willingly engaged in the prohibited conduct to be subject to criminal sanctions. This does not mean that the accused had to know that the conduct was illegal.

In 1987, Congress streamlined this statute into a single statutory scheme, 42 U.S.C. Section 1320a-7b(b).[11] The current version of the statute provides in part:

> 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 Healthcare 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 healthcare 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 5 years, or both.

Providers can also be punished under state laws for accepting kickbacks. Safe harbor regulations were issued by the Department of Health and Human Service in 1991 (42 C.F.R. Section 1001.952 (a)-(m), 1992). The Department of Health and Human Service explained that ''[I]f a person participates in an arrangement that fully complies with a given [safe harbor] provision, he or she will be assured of not being prosecuted criminally or civilly for the arrangement that is the subject of that provision'' (Background to Safe Harbor Provisions, 56 Fed. Register 35952, 35958, July 29, 1991). The safe harbor provision allowing for payments pursuant to personal services and management contracts provides as follows:

> The following payment practices shall not be treated as a criminal offense under section 1128B of the Act and shall not serve as the basis for an exclusion: (d) Personal services and management contracts. As used in section 1128B of the Act, ''remuneration'' does not include any payment made by a principal to an agent as compensation for the services of the agent, as long as all of the following six standards are met—(1) The agency agreement is set out in writing and signed by the parties.(2) The agency agreement specifies the services to be provided by the agent.(3) If the agency agreement is intended to provide for the services of the agent on a periodic, sporadic, or part-time basis, rather than on a full-time basis for the term of the agreement, the agreement specifies exactly the schedule of such intervals, their precise length, and the exact charge for such intervals.(4) The term of the agreement is for not less than one year.(5) The aggregate compensation paid to the agent over the term of the agreement is set in advance, is consistent with fair market value in arms-length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare or a State healthcare program.(6) The services performed under the agreements do not involve the counseling or promotion of a business arrangement or other activity that violates any State or Federal law.For purposes of paragraph (d) of this section, an agent of a principal is any person, other than a bona fide employee of the principal, who has an agreement to perform services for, or on behalf of, the principal. (42 C.F.R. Section 1001.952(d), 1992)

Kickbacks can be an issue for nurse executives who are involved in contracting for goods and services. It is imperative to refuse to accept any type of gift or payment that depends on your making referrals of federally insured patients. If such gifts or payments are offered to you, your facility's risk manager or in-house attorney should be contacted at once.

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