

Anatomy of a Fraud Indictment and Acquittal

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Just because a physician/practice is innocent of any wrongdoing does not mean that it won't be captured in a net of prosecution. Each practice must look at what it needs to do defensively to both avoid the possibility of prosecution and, if an indictment is handed down, proactively defend itself in a cost-effective and positive fashion without having to negotiate a settlement when no fraud has been committed. This article examines the case of one physician's healthcare criminal indictment and his ultimate acquittal; learn from his experience.

Key words: Criminal fraud; federal indictment; healthcare defense team; expert witness; compliance, coding; documentation; Hyde amendment; coding patterns; CMS1500 signature on file; audit.

In July 2005, the Nevada U.S. Attorney's Office charged otolaryngologist Mark Capener, MD, with 38 counts of healthcare fraud, 13 counts of mail fraud, and one count of making a false statement to the FBI. The events and outcome of the trial that followed should serve as a cautionary tale for all healthcare providers, regardless of practice size or the payors involved.

Federal investigators initially approached Capener in early 2002. At that time (and for several years prior), he operated a one-physician practice in rural Elko, Nevada, population 40,000. Capener's billing practices had raised several "red flags" during an independent review by a local health plan. Government briefs subsequently described a "huge discrepancy" in the number of sinus surgeries that Capener billed for his small community when compared with the rest of the state.

More than three years after the investigation began, the U.S. attorney indicted Capener for billing Medicare and other payors for services not rendered, billing for surgeries not required by the patient, billing for surgeries not supported by documentation, and billing for more expensive services than he actually provided (upcoding), among other charges. By that time, allegations of fraud had long since driven Capener from his Elko practice, although he was able to reestablish himself in Idaho Falls, Idaho.

If convicted, Capener faced up to 10 years in prison and a \$250,000 fine for each healthcare fraud charge; up to 20 years in prison and a \$250,000 fine for each mail fraud charge; and up to five years in prison and a \$250,000 fine on the False Statement charge. In a *Catch-22* situation, the False Statement charge arose from Capener's denial of wrongdoing when asked if he submitted fraudulent claims.

The government built its case against Capener on "four pillars," as articulated by its expert witness, ENT specialist Dale Rice, MD:

1. Capener's patients' pathology reports did not contain bone fragments (therefore Capener did not perform many of the frontal nasal sinus surgeries he claimed to have performed, the government's expert witness testified);
2. Capener could not have completed many of the procedures he claimed in the time reported for each surgery;
3. CT scans on some patients showed an absence of surgery; and
4. CT scans confirmed that Capener "billed for procedures beyond those he actually performed."

The defense team successfully undermined each of the four pillars, either by refuting the testimony of government witnesses or by demonstrating through its expert witness team that clinical details the government specified were not applicable to the case. For example, the defense team showed a video recording of Capener performing sinus surgery while an expert witness narrated for the jury, thus proving that Capener could complete the surgeries in the time he had documented.

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Even more damaging to the government's case was that all of Capener's pathology slides had, indeed, contained bone fragments. Although the pathologist had not noted this in his initial documentation, the slides remained available for examination and confirmation by an on-call expert witness retained by the defense. The government apparently had knowledge of this, but did not present the findings at trial or share exculpatory evidence with the defense team.

Capener maintained his innocence throughout the trial. His attorney, James R. Tate, would later comment that although Capener may have performed more surgeries than what might be considered "normal" among other doctors, he did what was best for his patients.

In November 2006, following a nearly month-long trial, a jury fully acquitted Capener of the remaining 25 counts against him (*U.S.A. v. Mark Capener*, U.S. District Court, District of Nevada, 3:05-CR-0114-RCJ-RAM). The court had dismissed 27 of the 52 total counts originally brought against Capener prior to trial, due to lack of sufficient evidence.

Having been found not guilty, Capener sought redress under the 1997 Hyde Amendment (18 USC 3006A), which allows a federal judge to award attorneys' fees and court costs to defendants "where the court finds that the position of the United States was vexatious, frivolous, or in bad faith." U.S. District Judge Robert C. Jones agreed that government prosecutors had acted frivolously. In a rare turnabout, Capener won a judgment of approximately \$279,000 to offset the cost of his defense.

Judge Jones, in handing down his decision, explained:

At trial, [the pathologist] testified that contrary to the Government's assertion, bone fragments existed in all the pathology slides, and that he would have so told anyone who asked him before trial. The evidence confirmed that Capener's pathology slides contained bone fragments. . . . Either the Government consciously decided to proffer a theory it knew was false, or it failed to conduct any investigation or inquiry to confirm whether Dr. Rice's contentions regarding lack of bone fragments was in fact accurate. In addition, the Government failed to produce to Capener expert disclosures from Dr. Rice, which discussed the lack of bone as a basis for his opinions. Taken together, these facts indicate the Government had reason to believe their lack-of-bone theory was without support.

Attorney Tate would sum up, "Dr. Capener spent a lot of time and money to defend himself in a case that never should have been brought in the first place."

Although Judge Jones' ruling may have offered some sense of vindication, Capener had, in fact, spent in excess of \$1 million on his defense. Government officials have since appealed Judge Jones' decision to the 9th U.S. Circuit Court of Appeals.

Capener's experience invalidates many common misconceptions regarding a physician's vulnerability to healthcare fraud charges and criminal investigation, while further emphasizing the importance of careful documentation, accurate coding, and proactive measures such as audits and controls. Important lessons include the following.

SIZE DOESN'T MATTER

Many physicians believe that investigators will target only larger practices or those that generate high-dollar charges. Capener operated a single-physician practice in a small, rural community. He employed a single physician assistant (PA), plus a single individual to act as his office manager and coder/biller.

ALL PAYORS PUT YOU AT RISK

Federal prosecutors will pursue charges on behalf of any payor, not just Medicare and Medicaid. A private insurer was the first to alert the government when it became concerned about Capener's claims. Prosecutors would accuse Capener of defrauding eight different private health insurers, in addition to Medicare and Medicaid.

Just because an insurer pays a claim doesn't mean that it agrees with the coding or accepts the claim as correct.

A third-party payor may target a physician practice even if it receives payment only from the patient and never directly from the payor. Patients can apply charges from nonparticipating physicians to their insurance deductible, or credit those charges against their flexible healthcare spending accounts. In this way, even nonparticipating physicians are accountable to the insurer.

Physician practices should treat every claim—regardless of who's footing the bill—as if it will undergo strict scrutiny (because someday it may).

REIMBURSEMENT DOESN'T EQUAL ENDORSEMENT

Just because an insurer pays a claim doesn't mean that it agrees with the coding or accepts the claim as correct. If a subsequent audit reveals any problems, the payor can (and often will) ask for a refund. As in Capener's case, neither does initial payment guarantee that investigators won't pursue fraud charges and criminal prosecution at some later time.

Some physicians may believe that they can code for everything and let the insurer decide what it will pay, what it will bundle, and what it will reject. Ultimately, however, responsibility for correct coding lies with the physician.

Payors base claims on the CPT, ICD-9, and place-of-service codes the physician submits, not on the documentation itself. Even if the physician submits full documentation with a claim (as Capener did for many of his claims from 1999 to 2002), the payor can later argue that the physician coded incorrectly.

AN AUDIT CAN HAPPEN AT ANY TIME

Any physician practice can face an audit, even if it has never been audited before, and even if its claims have been paid consistently without apparent problems. So-called “red flags” can attract a payor’s attention regardless if the physician has done anything wrong.

Jeffrey S. Parker, a criminal law professor at George Mason University School of Law in Arlington, Virginia, who assisted in Capener’s defense, has commented that in many cases, “[the government] is just looking at CPT code usage, and anybody out on the tail of the distribution is targeted for criminal prosecution. That’s not the same thing as intentional wrongdoing.”

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Although the government must prove intent to make a healthcare fraud charge stick, any statistical anomaly in your claims (whether legitimate or otherwise) can attract investigators’ attention. And it is not uncommon for a member of the physician’s own staff to report perceived violations.

A COMPLIANCE PLAN ALONE WON’T HELP YOU

An unused compliance plan prominently displayed on the shelf provides no protection. In fact, an unused compliance plan actually puts a practice at greater risk because it shows that the practice knew better, but ignored its own policies and procedures. A working, breathing, compliance plan can provide you with a measure of protection, however, as well as a clear set of procedures to resolve unintentional errors.

TAKE ACCUSATIONS SERIOUSLY

Any physician practice that finds itself the focus of a fraud investigation or criminal allegation should enlist the help of a qualified healthcare attorney. Many attorneys—even criminal attorneys—are out of their depth when dealing with healthcare cases. Even if a physician is not guilty, the physician may lose the case if his or her attorney does not understand the complexities of coding and

billing, or if the attorney does not assemble the best team of experts to mount an adequate defense.

Anytime a physician settles a case, the findings may be used against the physician at a later time, even if there was no admission of guilt.

Capener made this mistake initially, hiring a criminal attorney after the FBI first came calling in 2002. The criminal attorney had no experience in healthcare cases, however, and was unable to counter the government’s accusations effectively. Capener would eventually enlist the help of an experienced healthcare criminal defense lawyer—who would assemble an effective defense team of expert witnesses and others—but by that time the government had made an irreversible decision to move forward with prosecution. Had a well-constructed defense been mounted from the beginning, the case may have been dismissed on its merits before going to trial.

The threat of jail time and economic ruin often prompts physicians to settle cases out of court. Be aware, however, that anytime a physician settles a case, the findings may be used against the physician at a later time, even if there was no admission of guilt. Further, a settlement does not necessarily “settle” anything. The issue can return in the form of another action, such as a civil malpractice case, civil fraud and abuse case, criminal fraud and abuse case, or an administrative action by the medical board (licensure hearing).

ACCURATE CODING IS YOUR BEST DEFENSE (AND OFFENSE)

Documentation should substantiate every service the physician provides, and coding should be based on the available documentation. Physician practices that follow these rules are much less likely to prompt an investigation and much better prepared to defend themselves from charges of impropriety.

In Capener’s case, the lack of documentation in the pathology reports from a distinct physician helped to drive the government’s inquiry, even though evidence would later show that bone fragments were present on the slides. Had the slides not been available for further investigation, Capener’s defense may have been sunk by the insufficient initial documentation.

Medicare, Medicaid, and third-party payors change guidelines frequently, and physician practices are responsible for keeping up with these changes. Payors rarely allow a “grace period” for new regulations, and investigators do not have to prove that a physician was aware of payor guidelines to prosecute the physician for failing to follow those guidelines. Claiming that you “didn’t know” there was a problem

with your coding does not excuse your responsibility as far as the government is concerned. This is based on the attestation on the back of the CMS 1500 form that is represented by the “signature on file” for each claim, which states:

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as “incident” to a physician professional services, 1) they must be rendered

under the physician’s immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be the kinds commonly furnished in physician’s offices and 4) the services of nonphysicians must be included on the physician bills.

As Parker notes, it may be difficult to prevent an unwarranted investigation, but physicians should at least use a trained coding expert to help them to file claims and track their billing patterns accurately. ■

Editor’s Note: The author is specialty certified in Otolaryngology and was one of the expert witnesses for Dr. Capener.