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Admissibility of Prior Medicare Administrative Actions in Health Care Fraud Cases

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Attorneys defending Medicare providers in Federal Health Care Fraud (18 U.S.C. §1347) trials should be prepared for the government to file motions in limine seeking to introduce highly prejudicial evidence from prior Medicare civil overpayment recovery efforts that can frequently precede criminal charges. These overpayment recovery efforts are implemented by Recovery Audit Contractors ("RACs") or Zone Program Integrity Contractors ("ZPICs") collectively the "Contractors." Medical providers who bill Medicare Part B services on a "fee for service" basis will receive notice from a contractor that they have received Medicare "payments in error" or "overpayments," and the contractor will demand that the provider return the money. The administrative proceedings that follow provide ripe opportunities for the prosecution to pick poison fruit.

A contractors' opening letter usually tells a provider that it has identified "payment in error," or that a provider is billing more for a service than his or her peers and thus a review is required. Contractors will state that their mission is to promote program "integrity" and that they are tasked with combating "fraud, waste and abuse" in the Medicare program. Thus, initial boilerplate documents can begin tainting a provider's character before a criminal jury regardless of whether the provider successfully appealed a Contractor's initial overpayment demand.

A byzantine four-level administrative appeal process detailed in 42 C.F.R. §§ 405.920-1134 governs a provider's appeals. The third level comprises a hearing before an Administrative Law Judge ("ALJ"), which often requires the medical provider to testify. This testimony is a favorite target for federal prosecutors, who may seek to use it to help rebut "mistake" or "lack of knowledge" defenses to fraud charges. Obtaining the entire administrative record is therefore crucial.

The ALJ's written findings of fact will detail the conclusions about whether medical chart documentation adequately supports billing for Medicare services within the confines of Current Procedure Terminology (CPT) Coding, National Coverage Decisions ("NCDs") or Local Coverage Decisions ("LCDs"). Counsel should focus on ALJ findings that state the documentation in evidence does not support the billing submitted. These findings often highlight where criminal fraud allegations are leveled.

Why the documentation does not support submitted billing is an important question to ask. Innocent reasons could include the patient chart's missing entries, the required referral is missing, a physician's notes may not support medical necessity, or the requirements of an LCD or NCD may not be met. Intentional fraud could also be the reason.

Evidence from Medicare administrative appeals detailing provider conduct should qualify as extrinsic acts. Counsel should demand early and often that the government provide written notice pursuant to Federal Rule of Evidence ("FRE") 404(b) of any extrinsic acts of the defendant it will seek to introduce at trial. Failure to provide adequate notice is fatal. See, Advisory Committee Notes to the 1991 Amendments to FRE 404 (notice is condition precedent to admissibility of 404(b) evidence).

In the Medicare example cited above, the government could respond in two ways: 1) if the government is not alleging that the Medicare provider committed fraud in the prior administrative proceedings, it will argue that FRE 404(b) does not apply since it is not seeking to introduce "prior bad acts;" or 2) if the court holds that FRE 404(b) does apply, the government will seek to introduce the prior administrative evidence to

prove knowledge or absence of mistake or accident. This second tack is especially true if any of the CPT Codes that were disputed in the administrative proceeding are the subject of the criminal prosecution.

The Supreme Court prescribed a four-part test for admissibility of 404(b) evidence. The trial judge must: 1) find a purpose for admission other than simply to show propensity; 2) find the evidence relevant under Rule 402; 3) find the Rule 403 probative value-prejudice test satisfied; and 4) instruct the jury that the evidence is to be considered only for the purpose for which it was admitted, i.e., for the appropriate inference to be drawn. *See Huddleston v. United States*, 485 U.S. 681, 691-92, 108 S.Ct. 1496, 1502 (1988).

Specific, factual arguments provide the best approach to attacking the government's proffered 404(b) evidence under the Huddleston test. In many cases, the conduct at issue in the prior Medicare administrative proceedings will predate the charged criminal conduct. Therefore, specific relevance objections under Rules 401, 402 and 403 are particularly helpful. The Medicare provider and the acts subject to review under the prior administrative could be different in innumerable ways, such as different: 1) professional corporations; 2) billing companies; 3) management companies; 4) medical billing procedures; 5) physicians, physician assistants, or nurse practitioners; or 6) CPT Code, NCD, or LCD updates, just to name a few.

The government's 404(b) application may also be premature, since it may seek to rebut defenses before the defense has even put on a case. Therefore, the Court will be in a better position to rule on the propriety of the government's 404(b) application at the close of the defense case, if the defense presents a case. See, e.g., *U.S. v. Alessi*, 638 F.2d 466, 477 (2d Cir. 1980) (prior conviction should not be admitted until the conclusion of the defendant's case).

Rule 403 states that evidence may be excluded if its probative value is outweighed by the danger of unfair prejudice, confusion of the issues or misleading the jury, or by considerations of undue delay, waste of time or needless presentation of cumulative evidence. If counsel is able to draw on the above strategies to distinguish the administrative proceedings from the criminal case, the distinctions will strengthen an argument that the administrative evidence will only confuse the jury or create unfair prejudice, even if relevant.

Finally, Counsel must have an intimate knowledge of a provider's prior Medicare appeals in order to rebut the government's potentially devastating motions in limine when defending Medicare providers charged criminally.

Note: William J. McDonald is in the Healthcare and White Collar Criminal Practice Groups at Ruskin Moscou Faltischek, P.C. In that role he has defended medical providers in Medicare audits as well as in Federal Health Care Fraud trials. He may be reached at wmcdonald@rmfpc.com or (516) 663j-6635 if you have any questions about this article.