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The fraud and abuse laws that compliance professionals need to know

By Donald H. Romano

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Have you wondered how many different authorities the government can bring to bear on suspected fraud or abuse? This article provides an introduction to all of the major fraud and abuse statutes and other authorities and where to find them. It is geared toward the newer compliance officer, who may or may not be an attorney. Experienced compliance professionals may nevertheless find it useful as a quick reference guide.

Anti-kickback Statute

Section 1128B(b) of the Social Security Act (SSA), 42 U.S.C. § 1320a-7b(b)

In some contexts, paying people to refer customers to you is a good business practice. In the federal and state health care programs arena, doing so could land you in jail. The Anti-kickback Statute (AKS) prohibits the knowing and willful offer, solicitation, payment, or receipt of anything of value that is intended (1) to induce the referral of an individual for which a service may be made by Medicare and Medicaid or certain other federal or state health care programs[1] or (2) to induce the ordering, purchasing, leasing or arranging for, or recommending the purchase, lease, or order of, any service or item for which payment may be made by such federal or state health care programs (collectively referred to as an illegal inducement).

The AKS not only applies to referrals for "designated health services" subject to the Stark prohibition against physician self-referrals (discussed below), it also covers referrals for any item or service that might be paid for by Medicare or any other federal or state health care program. Further, the statute ascribes criminal liability to both sides of an impermissible "kickback" transaction, and has been interpreted to apply to any arrangement where even one purpose of the remuneration offered, paid, received, etc. is to obtain money in exchange for referrals or to induce referrals.

The AKS contains a number of exceptions, called safe harbors, and the Department of Health and Human Services (DHHS) Office of Inspector General (OIG) has implemented those, and promulgated additional safe harbors, through regulations at 42 C.F.R. §1001.952. If all the criteria of a safe harbor are met, the arrangement is not subject to criminal prosecution under the AKS, and not subject to administrative penalties under the Civil Monetary Penalty (CMP) Statute (discussed below), regardless of whether there is an intent to induce referrals. The failure to meet a safe harbor does not mean that the AKS is violated – again, it is an intent-based statute.

OIG also publishes advisory opinions (AO), addressing whether a proposed or actual arrangement implicates the AKS, and if so, whether OIG might seek administrative sanctions. An AO is binding only on the requester of the opinion and OIG, but provides valuable guidance to those parties that are in, or are contemplating, a similar arrangement. All of the past and current AOs are available on the OIG's website at http://www.oig.hhs.gov/fraud/advisoryopinions/opinions.asp.

An AKS violation can form the basis for a physician self-referral (Stark) violation or a False Claims Act violation (both the Stark Law and the False Claims Act are discussed below).

Note that several states have their own version of the federal AKS, which can apply to any payer (that is, the law could apply to services covered under the state's Medicaid progam as well as services covered under commercial insurance or other coverage for which the patient would be responsible for paying). The state laws may be criminal or civil.

Physician Self-Referral Statute (Stark)

Section 1877 of the Act, 42 U.S.C. § 1395nn

The Stark Law generally prohibits a physician from referring a patient to an entity with which the physician (or an immediate family member) has a financial relationship, for the furnishing of "designated health services" (DHS),[2] and prohibits the entity from billing Medicare[3] for such DHS. There are many exceptions to the general prohibition. Some of the exceptions are contained in the statute and implemented through regulations; other exceptions are strictly a creature of the regulations, based on authority in the statute to create exceptions that do not pose a risk of program or patient abuse. The regulations appear at 42 C.F.R. §411.350 et seq. Financial relationships, for purposes of the statute, are direct and indirect relationships, and include ownership/investment interests as well as compensation interests. Responsibility within DHHS for interpreting the Stark Law and

issuing regulatory and sub-regulatory guidance (such as advisory opinions) rests with CMS.

When confronted with a potential Stark issue, it is usually best to first determine whether the statute is implicated, and if so, then determine whether an exception applies. Where the statute is implicated, the financial relationship must satisfy at least one exception, or a violation will occur. In this regard, the Stark Law is a strict liability statute, meaning that no intent to violate it is necessary for a violation to exist. Although the formula (as stated in the previous paragraph) for determining whether the statute is implicated is straightforward, the actual analysis under the formula is often anything but easy. Each one of the elements is a defined term of art, and the answer as to whether one or more of the elements is present is not always intuitive. For example, although there is a general definition of "referral," there are exceptions to the definition. Similarly, it is not always clear whether there is an indirect compensation relationship between the parties. After determining that the statute is implicated, analyzing whether an exception is satisfied is often a laborious process.

The penalties for a Stark violation can be quite severe. As noted above, no intent to violate the law is necessary to be in violation, and CMS has a very limited ability to compromise liability for violations. Therefore, for example, if a hospital has a noncompliant financial relationship with a physician (e.g., a lease arrangement for which, unknown to the parties, the compensation is not at fair market value) all of the referrals from the physician to the hospital for inpatient or outpatient hospital services provided to Medicare patients will be tainted and the hospital will not be able to bill Medicare for any of the services. When the hospital has billed Medicare before discovering the mistake, the hospital is subject to recoupment from Medicare for those referred services for which it received payment, and is also responsible for refunding co-pays and deductibles to the beneficiaries. If the same mistake is made with respect to multiple physicians, and if the mistake goes undiscovered for a long period of time, the number of potentially denied claims increases exponentially. Moreover, although no intent to violate the statute is necessary to incur claims denials, a "knowing" violation carries with it the possibility of civil monetary penalties/assessments and exclusion under the CMP statute[4] and penalties under the civil False Claims Act and certain criminal statutes (all of which are discussed below). OIG is the component within DHHS responsible for assessing administrative penalties for "knowing" Stark violations.

Where there is a knowing violation of the Stark Law, often there will also be a violation of the AKS, but not necessarily. (For example, parties could knowingly fail to meet one or more elements of a Stark exception that would have nothing to do with an illegal intent to induce referrals under the AKS.) Likewise, an AKS violation may, but not necessarily, establish a Stark violation. (Several Stark exceptions have as a required element that the arrangement not violate the AKS.) Other points of comparison between the Stark Law and the AKS include the following:

- Stark is a civil statute, AKS is a criminal statute (although there are also administrative penalties set forth in the CMP statute that can be assessed for AKS violations);
- Under Stark, the parties must prove they meet an exception in order to avoid a claims denial, whereas under the AKS the government must prove beyond a reasonable doubt there was an illegal inducement;
- Stark applies only where there has been a referral by a physician for DHS otherwise payable by Medicare, whereas the AKS can apply to any type of health professional (as well as anyone else) for any type of health service covered by a federal or state health care program;
- CMS has very limited authority to compromise Stark violation, and OIG has plenary authority under the CMP statute to compromise administrative penalties for AKS violations.

Many states have enacted their own version of a physician self-referral prohibition.

False Claims Act (FCA)

(31 U.S.C. § 3729 et seq.) and common law rights to recovery

The False Claims Act has been the Department of Justice's (DOJ) chief weapon in fighting health care fraud. Violations are punished by penalties of not less than $5,500 and not more than $11,000 per claim, plus treble damages for the amount of damages the government sustains. Because of the severe penalties, DOJ is often able to convince the defendant to settle, frequently for twice the amount of claimed damages. An FCA action can be brought by DOJ, or, under the *qui tam* (whistleblower) provisions of the FCA, a private citizen (termed a "relator") can file the complaint on behalf of the government and obtain a portion of any recovery the government obtains. The *qui tam* complaint is filed under seal (meaning that the defendant does not get a copy of it until the seal is lifted) with a copy served on DOJ, which investigates the allegations in the complaint. If DOJ decides to intervene, DOJ takes over the case; or if DOJ declines to intervene, the relator may forge ahead on his or her own. The FCA was strengthened by amendments in 1986 and strengthened further by the Fraud Enforcement and Recovery Act of 2009 (FERA), (Pub. L. No. 111-21). As amended

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by FERA, liability under the False Claims Act occurs when a person or entity:

- knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;
- knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; or
- conspires to commit a violation of any of certain provisions of the False Claims Act (including the two listed above).

In addition, the FCA punishes other knowing, wrongful behavior, including what is known as a "reverse false claim." As amended, and now codified at 31 U.S.C. § 3729(a)(1)(G), the reverse false claims provision covers the situation in which a person knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the government.

As applied to funds in the possession of a party, the reverse false claims provision reaches two types of behavior:

- taking the affirmative action of using or causing to be used a false record or statement in order to avoid having to pay money to the government; and
- affirmatively hiding the existence of the funds, or "improperly avoid[ing]" an "obligation" to pay the funds to the government.

There is currently much discussion and debate as to what it means to "improperly avoid" an obligation, and even as to what "obligation" means (despite the fact that the term is defined in the statute). For example, does a party violate the FCA by not disclosing to the government that it has money that it has discovered was paid incorrectly to it (i.e., the party was not aware at the time it submitted the claim that the claim was incorrect), or does there have to be an independent obligation existing elsewhere (e.g., in a Medicare regulation) to report a self-discovered overpayment?

Because there are heightened pleading requirements under the Federal Rules of Civil Procedure (FRCP) for allegations of fraud, and because of the "knowingly" requirement, DOJ will plead common law theories of recovery in addition to its claim under the FCA when bringing a case, or when intervening in a case brought by a relator. Such common law actions include: unjust enrichment, payment by mistake, breach of contract, and negligent misrepresentation. These common law causes of action will not allow the government to recover more than single damages, but, by allowing the government to recoup money by alleging and proving that the government is entitled to recovery under an equitable theory, they provide a hedge against having the complaint dismissed in its entirety due to the FRCP's requirement that fraud be pleaded with particularity. One court has held that the government is entitled to recover under mistake of fact or unjust enrichment, even where CMS's reopening regulations (discussed below) would prevent, as time-barred, CMS from reopening and revising a payment determination.[5]

Many states have their own False Claims Acts. The Deficit Reduction Act of 2005 (DRA) provided that a state that has a False Claims Act that is substantially similar to the federal FCA will receive a larger percentage of the recovery in a state FCA case involving Medicaid. In other words, because the federal government paid a share of the Medicaid claims in the first place, it is entitled to a portion of the recovery but will take a smaller percentage than what it otherwise would be entitled to take. OIG makes the determination of whether a state's FCA is substantially similar to the federal FCA. Copies of the OIG's determination letters are available on the OIG's website (http://www.oig.hhs.gov/fraud/falseclaimsact.asp). It is not clear at this point whether states need to change their FCAs to conform to the FERA changes (and if so, by when) in order to receive a larger percentage of the recovery in a Medicaid state FCA case.

Medicare reopening regulations

42 C.F.R. §405.980 et seq. (coverage determinations), 42 C.F.R. §405.1885 et seq. (cost report determinations)

CMS long has had regulations that allow it to reopen and revise a favorable payment determination and turn it into an unfavorable payment determination, and treat the amount paid to the provider or supplier as an overpayment. The regulations also permit a contractor to reopen an unfavorable determination and issue a revised, partially, or fully favorable determination. In the absence of fraud or similar fault, there are time limits on the agency's contractors' ability to reopen a determination. With respect to coverage determinations, a contractor may reopen and revise its initial determination or re-determination (the determination made at the first level of appeal) on its own motion

- within 1 year from the date of the initial determination or redetermination for any reason,
- within 4 years from the date of the initial determination or redetermination for good cause, or
- at any time if there exists reliable evidence that the initial determination was procured by fraud or similar fault.

With respect to cost report determinations, the time limit is 3 years after the date of the determination, but again, there is no time

limit where the determination was procured by fraud or similar fault.

The determination by a contractor whether or not to reopen is not reviewable, either administratively or judicially. Where a revised determination is made, however, the revised determination is treated like any other initial determination, giving rise to the usual appeal rights under the applicable administrative appeals process. Thus, if a coverage determination is reopened and revised, the beneficiary, supplier, or provider (as applicable) may appeal the revised determination under the appeals procedures at 42 C.F.R., Part 405 Subpart I, and if a cost report determination (notice of program reimbursement or other determination) is revised, a provider may appeal the revised determination under the appeals procedures at 42 C.F.R., Part 405 Subpart R.

Civil and criminal statues in Title XI of the Social Security Act

In addition to the AKS, discussed above, there are several other important criminal and civil fraud and abuse statutes in Title XI of the SSA. As delegated by the Secretary of HHS, OIG has the responsibility within HHS for interpreting these statutes and imposing civil penalties (or "remedies" as they are sometimes euphemistically called). DOJ (either through the Criminal Division of Main Justice or through the various US Attorney Offices) has sole responsibility for prosecuting violations under the criminal statutes.

The Exclusion Statutes (section 1128 of the SSA, 42 U.S.C. §1320a-7, and section 1128A of the SSA, 42 U.S.C. §1320a-7a) and Government-wide Debarment Authority

Exclusion from participation in (i.e., the right to bill) federal and state health care programs is the civil equivalent of capital punishment. Exclusion for even a brief period (and most exclusions are for at least a few years) is a death knell for an entity that relies on income from Medicare and/or Medicaid to any significant degree. Exclusion can be used in lieu of or in addition to other weapons in the OIG's arsenal. As an example, consider the case of Alvarado Hospital.[6] In that case, the CEO of the hospital, some physicians, and others were prosecuted under the AKS. After the judge declared a mistrial in the second trial (the first ended in a hung jury), the government decided not to try the case again, but OIG stepped in and threatened to exclude the hospital; at that point, the hospital's owner, Tenet Healthcare, termed the threatened action a "death sentence" and subsequently agreed to pay a large fine.

Paragraph (a) of section 1128 of the SSA sets forth mandatory grounds for exclusion (conviction of program related crimes, conviction relating to patient abuse, felony conviction relating to health care fraud, and felony conviction related to a controlled substance[7]), and paragraph (b) sets forth a long list of permissive grounds for exclusion. Permissive grounds include, among others: misdemeanor conviction relating to health care fraud or controlled substance; license revocation or suspension; fraudulent billings; failure to disclose certain information; failure of a provider to grant immediate access upon reasonable request to CMS or a state agency in connection with a survey to determine compliance with the conditions of participation; and failure to grant immediate access upon reasonable request to OIG for the purpose of reviewing records or other documents.

To make matters more complex, the CMP statute, section 1128A of the SSA (discussed below) also contains exclusion authority. That is, the CMP statute sets forth a long list of actions for which OIG can issue civil monetary penalties and assessments, and also allows OIG to exclude an individual or entity for any of those actions. There is overlap, but not complete identity, of the grounds for exclusion in section 1128 of the SSA as compared to the grounds for exclusion in section 1128A of the SSA. Also, whereas section 1128 specifies set periods for exclusion (generally not less than 5 years), section 1128A of the SSA prescribes no minimum or maximum length for exclusion. It is important to note that, notwithstanding that an individual has served the time imposed for exclusion, reinstatement is not automatic. The excluded individual or entity must apply for reinstatement, and OIG must be persuaded that there are reasonable assurances that the types of actions that formed the basis for the exclusion have not recurred and will not recur, and that there is no additional basis under section 1128 or 1128A of the SSA for continuing the exclusion.[8]

Where OIG imposes an exclusion (or directs a state agency to exclude), the excluded individual or entity has the right to a hearing before an administrative law judge (ALJ).[9] Where the exclusion is based on the conviction of an individual or entity, the individual or entity may not re-litigate before the ALJ the issue of whether s/he or it was guilty of the offense. Judicial review of exclusions is in the district court with respect to exclusions imposed under authority of section 1128 of the SSA, and in the circuit court of appeals with respect to exclusions imposed under authority of section 1128A of the SSA.

OIG maintains a list of excluded individuals and entities on its website, available at http://www.oig.hhs.gov/fraud/exclusions/exclusions_list.asp . Before hiring any health care professional, it is important to check this list (and to be careful about name changes through marriage or divorce). Under section 1128A(a)(6), hiring an individual whom the employer knows or reasonably should know is currently excluded is itself grounds for a CMP/assessment and/or exclusion.

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If exclusion is the equivalent to capital punishment, government-wide debarment is akin to shooting the corpse. Government-wide debarment means that an entity that has been excluded or barred from participation in one or more programs (such as exclusion by OIG from federal and state health care programs) or barred from contracting with one agency, is debarred from participating in any federal program or contracting with any federal agency. A 1986 Executive Order (E.O. 12549) provided for the creation of a government-wide system for debarment and suspension from such programs. Under the leadership of the Office of Management and Budget, 28 federal agencies developed a "common rule" (patterned after the corresponding Federal Acquisition Regulation provisions) that deals with procurement. The "common rule" governs suspension and debarment from the non-procurement programs of these 28 agencies. Almost all agencies have adopted the common rule, (with some minor variations to accommodate their particular needs or practices). Where a party has been debarred or suspended for a period of time, the party is prohibited from contracting with an agency that has adopted the common rule, either directly or as an agent or representative of another non-debarred or non-suspended contractor.

The Civil Monetary Penalty (CMP) Statute (section 1128A of the SSA, 42 U.S.C. § 1320a-7a)

The CMP statute authorizes the Secretary to issue CMPs and assessments, and/or to exclude persons and entities for a host of bad acts. By way of example only, the statutory sanctions can be levied against a person who knowingly presents, or causes to be presented a claim:

(i) that the person knows or should know is false or fraudulent;
(ii) for a physician's service that the person knows or should know that was performed by a "physician" who was unlicensed;
(iii) for a medical or other item or service furnished during a period in which the person was excluded from the program under which the claim was made; and
(iv) for a pattern of medical or other items or services that a person knows or should know are not medically necessary.

Also, the sanctions can be issued against a person who hires an individual or entity that the person knows or should know is excluded from participation in a federal or state health care program for the provision of items or services for which payment may be made under such a program.

Three other provisions of the CMP statute bear special mention—those that are often addressed by OIG Advisory Opinions, First, section 1128A(a)(7) authorizes the Secretary to issue sanctions again persons who engage in violations of the AKS; thus, as noted above with respect to the *Alvarado* case, irrespective of whether DOJ seeks a criminal prosecution under the AKS or is successful in a prosecution, OIG can take administrative action under the CMP statute to address what it considers to be violations of the AKS.

Second, the "beneficiary inducement statute" at section 1128A(a)(5) prohibits a person from offering or transferring remuneration to any Medicare beneficiary or individual eligible to benefit under a state health care program, where the person knows or should know that the offer or transfer of remuneration is likely to influence such individual to order or receive from a particular provider or supplier any item or service for which payment may be made, in whole or in part, under Medicare or a state health care program. There are statutory exceptions to what constitutes remuneration for purposes of the beneficiary inducement statute (and for purposes of the other provisions of the CMP statute where remuneration is at issue).[10] In particular, remuneration does not include a waiver of coinsurance and deductible amounts by a person, if (i) the waiver is not offered as part of any advertisement or solicitation; (ii) the person does not routinely waive coinsurance or deductible amounts; and (iii) the person waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need, or fails to collect coinsurance or deductible amounts after making reasonable collection efforts.

Remuneration also does not include any permissible practice described in a statutory or regulatory safe harbor (subject to certain limitations involving a provider paying, in whole or in part, premiums for Medicare supplemental policies for individuals entitled to Medicare on the basis of end-stage renal disease).

Third, the anti-gainsharing provision of the CMP statute, section 1128A(b)(1) – (b)(2) of the SSA, prohibits a hospital (including a critical access hospital) from knowingly making a payment, directly or indirectly, to a physician as an inducement to reduce or limit services provided with respect to individuals who are entitled to Medicare or eligible for Medicaid and who are under the direct care of the physician.

The amount of the CMP that can be issued is generally (not always) not more than $10,000 for each item or service. The amount of an assessment that can be issued is not more than three times the amount claimed for each such item or service in lieu of damages sustained by the federal or state agency because of such claim.[11] There is a 6-year statute of limitations on the Secretary's authority to issue sanctions under the CMP statute (see section 1128A(c)(1) of the Act). In determining whether to issue a CMP and/or assessment or exclusion the Secretary is required to take into account (1) the nature of claims and the circumstances under which they were presented; (2) the degree of culpability, history of prior offenses, and financial condition of the person presenting the claims, and (3) such other matters as justice may require. In lieu of imposing the full range of sanctions available to it, OIG may compromise the amount and subject the party to a Corporate Integrity Agreement (CIA), which imposes many duties related to compliance (including mandatory reporting of colorable Stark and AKS violations). Not fulfilling the duties imposed under a CIA can subject the party to penalties set forth in the CIA, such as monetary penalties, or in the case of a material breach, exclusion. Copies of the CIAs entered into between the OIG and named individuals and entities are on the OIG's website at http://www.oig.hhs.gov/fraud/cia/cia_list.asp.

The administrative appeals process for sanctions issued under the CMP statute is contained in 42 C.F.R., Part 1005, and judicial review is by the circuit court of appeals in the first instance (bypassing the district court).

Other criminal statues in Title XI of the SSA

(Section 1128B of the SSA, 42 U.S.C. § 1320a-7b)

Section 1128B of the SSA, home of the AKS, sets forth various provisions that impose criminal penalties for prohibited acts. Generally, a violation is a felony, punishable by up to 5 years in prison, or a fine of up to $25,000, or both.

Health care fraud statute, Section 1128B(a)

This statute proscribes various acts, including knowingly and willfully making, or causing to be made, a false statement in order to get a benefit or payment under a federal or state health care program, and also for presenting or causing to be presented a claim for a physician's service payable under a federal or state health care program where the party knows that the individual who furnished the service was not a licensed physician. Paragraph (3) of section 1128B(a) is the most interesting. This provision forbids one, who

> 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[.]

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It is clear that this section punishes the failure to disclose an overpayment where the recipient knew, at the time of receipt, that the payment was incorrect (such as where the recipient receives a Social Security check, knowing that his or her entitlement was determined to have ended). What is not clear is whether it also punishes the act of failing to disclose an overpayment that was received without knowledge that the payment was incorrect (but later discovered by the recipient that payment was incorrect). Both CMS and OIG seem to have interpreted the provision as applying to this latter situation, but both agencies have simply cited the statutory provision for the proposition that an overpayment must be returned, without providing any analysis as to why the provision applies to mere overpayments. It is submitted that, because of the inclusion of the word "fraudulently," the better reading is that it does not apply to such self-discovered overpayments. There are no reported decisions that have found a defendant criminally guilty or not guilty of violating the statute.

Medicaid Anti-supplementation Statute Section 1128B(d) of the SSA, 42 U.S.C. §1320a-7b(d)

This provision prohibits charging a Medicaid recipient for any amount in excess of what Medicaid pays under the provider agreement with state agency. It also prohibits charging any person, or receiving from any person (except a charity) a fee, gift, etc. as a condition of admitting a Medicaid recipient to a hospital (or for keeping the recipient in the hospital).

Criminal Statutes in Title 18, U.S.C.

There are several provisions in Title 18 that impose criminal liability. These provisions are either directed specifically at health care fraud or are of general applicability and could be invoked in a health care fraud case. They include: 18 U.S.C. §371 (conspiracy to defraud the government); 18 U.S.C. §1001 (false statements); 18 U.S.C. §1035 (scheme to defraud health care benefit program); 18 U.S.C. §1341(mail fraud); 18 U.S.C. §1343 (wire fraud); 18 U.S.C. §1347 (false statements relating to health care); 18 U.S.C. §1518 (obstruction of health care offense investigation); 18 U.S.C. §1956 (money laundering); and 18 U.S.C. §§1961-64 (Racketeer Influenced and Corrupt Organizations Act, also known as RICO). At least for the most part, these statutes do not punish passive behavior, but rather address false statements, fraudulent acts of concealment, and other bad behavior. One possible exception is section 669 of 18 U.S.C., entitled "Theft or embezzlement in connection with health care," which provides:

> (a) Whoever knowingly and willfully embezzles, steals, or otherwise without authority converts to the use of any person other than the rightful owner, or intentionally misapplies any of the moneys, funds, securities, premiums, credits, property, or other assets of a health care benefit program, shall be fined under this title or imprisoned not more than 10 years, or both; but if the value of such property does not exceed the sum of $100 the defendant shall be fined under this title or imprisoned not more than one year, or both.

Like section 1128B(a)(3) of the SSA, discussed above, section 669 of Title 18 is frequently cited by OIG in its compliance guidance for the proposition that an overpayment (how ever it was received) must be returned. Section 669 clearly punishes intentionally bad behavior such as stealing, and the only reported cases on this statutory section have involved convictions on that basis. What is not entirely clear is whether this law punishes the mere retention of funds that were received without knowledge that the recipient was not entitled to them, but the better reading suggests the answer is no. In particular, the language "or otherwise converts" would seem to refer to the act of criminal conversion, which involves intentionally wrongful conduct. Likewise, in order to intentionally misapply funds of the government, the actor must have engaged in a "voluntary, intentional violation of a known legal duty." Thus, the language "otherwise without authority converts to the use of any person other than the rightful owner, or intentionally misapplies" seems to be directed at proscribing certain actions with respect to a legal duty rather than establishing the legal duty itself. ■

1 The AKS speaks only of federal health care programs, but, as defined in section 1128B(f) of the Act, a "Federal health care program" includes "any State health care program, as defined in section 1128(h)" of the Act. Federal and state health care programs chiefly include Medicare, Medicaid, TRICARE, and State welfare programs that receive federal funding.
2 The Stark statute applies only to referrals for DHS, which are: clinical laboratory services; physical therapy, occupational therapy, and outpatient speech-language pathology services; radiology and certain other imaging services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment, and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services. See 42 C.F.R. § 411.351.
3 Although the original statutory prohibition was later amended to apply it to Medicaid, CMS has not implemented regulations to extend it to Medicaid.
4 The provision for civil monetary penalties, assessments and exclusion under the CMP Statute (discussed below) is not in the CMP Statute, but rather is in the Stark statute, at section 1877(g)(2) of the Act, which makes the sanctions in the CMP Statute applicable to knowing Stark violations.
5 U.S. v. Lahey Clinic Hosp. Inc., 399 F.3d 1 (1st Cir. 2005).
6 See United States v. Weinbaum Indictment, July 17, 2003, available at http://news.corporate.findlaw.ca/hdocs/docs/tenet/ustenet71703sind.pdf and Tenet Press Release, Jury Deadlocks in San Diego Hospital Trial: Mistrial Declared, April 4, 2006, available at http://www.tenethealth.com/TenetHealth/PressCenter/PressReleases/Jury+Deadlocks+in+San+Diego+Hospital+Trial+Mistrial+Declared.htm
7 Under section 1128(i) of the Act, an individual or entity is "convicted" of a criminal defense regardless of whether there is an appeal pending or whether the conviction has been expunged.
8 42 C.F.R. §1001.3002 (exclusions under section 1128 of the Act); 42 C.F.R. §1003.135.
9 Sections 1128 and 1128A describe somewhat different administrative appeals rights, but the OIG has, by regulation, prescribed the same administrative appeals process for exclusions imposed under either section 1128 or 1128A. See 42 C.F.R. §1001.2007(e).
10 See section 1128A(i) of the Act, 42 U.S.C. §1320a-7a(i).
11 See section 1128A(a) of the Act, 42 U.S.C. §1320a-7a(a).