1) ANTI-KICKBACK

**Conn. Gen. Stat. § 53a-161c**—Receiving Kickbacks: Class D felony
Except as expressly permitted under the federal Anti-kickback Statute safe harbor regulations, a person is guilty of receiving kickbacks when he “knowingly solicits, accepts or agrees to accept any benefit, in cash or in kind, from another person upon an agreement or understanding that such benefit will influence such person’s conduct in relation to referring an individual or arranging for the referral of an individual for the furnishing of any goods, facilities or services to such other person under contract to provide goods, facilities or services to a local, state or federal agency.” The term “refer” is defined to include sending, directing or recommending. Receiving kickbacks is punishable by up to five years in prison.

**Conn. Gen. Stat. § 53a-161d**—Paying a Kickback: Class D felony
Similarly, it is a felony for anyone knowingly to offer or pay any benefit, “in cash or kind, to any person with intent to influence such person: (1) To refer an individual, or arrange for the referral of an individual, for the furnishing of any goods, facilities or services for which a claim for benefits or reimbursement has been filed with a local, state or federal agency; or (2) to purchase, lease, order or arrange for or recommend the purchasing, leasing or ordering of any goods, facilities or services for which a claim of benefits or reimbursement has been filed with a local, state or federal agency.” Paying kickbacks is punishable by up to five years in prison.

**Conn. Agencies Regs. § 31-280-1**
List of approved physicians, surgeons, podiatrists, optometrists and dentists; standards for approval and removal from the list
Practitioners must comply with “the Medicare anti-kickback regulations promulgated by the United States Department of Health and Human Services”
(among other criteria) in order to be eligible to provide services to injured workers under Connecticut's worker's compensation provisions. The Workers’ Compensation Chairman may remove a practitioner from the list of approved practitioners, following a hearing, if he or she fails to meet this standard or satisfy other prescribed criteria.

2) SELF-REFERRALS


Any practitioner who “(1) has an ownership or investment interest in an entity that provides diagnostic or therapeutic services, or (2) receives compensation or remuneration for referral of patients to an entity that provides diagnostic or therapeutic services shall disclose such interest to any patient prior to referring such patient to such entity for diagnostic or therapeutic services and provide reasonable referral alternatives.” The disclosure may be made either verbally or in a posted writing located in a conspicuous place in the practitioner's office, visible to patients. Although diagnostic services are not defined specifically in the statute, therapeutic services are defined to include physical therapy, radiation therapy, intravenous therapy, and speech and language pathology. The disclosure requirement does not apply to in-office ancillary services. The term “ownership or investment interest” does not include ownership of publicly traded securities. Violation of the statute can subject the practitioner to a civil monetary penalty of up to $25,000.

3) FEE SPLITTING

Conn. Gen. Stat. § 20-579—Causes for suspension, revocation or refusal to issue or renew licenses, temporary permits and registrations and for assessment of civil penalty.

With respect to pharmacies, the Commission of Pharmacy may deny, revoke or suspend a license or temporary permit to practice pharmacy, a license to operate a pharmacy, or a registration of a pharmacy intern or pharmacy technician, if the applicant or holder has “split fees for professional services, including a discount or rebate, with a prescribing practitioner or an administrator or owner of a nursing home, hospital or other health care facility.” Fee-splitting can also subject the applicant or holder of the license, temporary permit or registration to a civil penalty of up to $1000. A pharmacist may also lose his or her license or permit to practice as a pharmacist if the pharmacist violates “a statute or regulation relating to drugs, devices or the practice of pharmacy”; has “been convicted of violating any criminal statute relating to drugs, devices, or the practice of pharmacy” in any state, territory, or country; has “illegally possessed, diverted, sold or dispensed drugs or devices”; or
has abused drugs or used them “excessively.”

**Conn. Gen. Stat. § 19a-30—Clinical Laboratories. Regulation and licensure. Proficiency standards for tests not performed in laboratories**

Clinical laboratories, through their representatives and agents, are prohibited from soliciting referrals of specimens “in a manner which offers or implies an offer of fee-splitting inducements to persons submitting or referring specimens.” Such fee-splitting inducements include inducements via “rebates, fee schedules, billing methods, personal solicitation or payment to the practitioner for consultation or assistance or for scientific, clerical or janitorial services.” The violation of this statute is punishable by a fine between $100 and $300 per offense.

**Conn. Agencies Regs. § 19a-36-D36—Unethical practices prohibited**

This regulation defines conduct prohibited as “bribes,” “fee-splitting inducements,” and “fraudulent practices.” Bribes specifically include offering office equipment or services including receptionists, nurses or other employees; cars; trips; credit cards; similar other favors; and “free or discounted services to private patients of such requester of laboratory services to a greater extent than is provided by such requester.” Bribes do not, however, include the provision of phlebotomists to collect specimens; the provision of equipment or supplies to be used solely for specimens or for ordering or communicating test results or procedures; the provision of supplies needed to obtain and forward specimens; or the provision of goods needed by phlebotomists to obtain the specimens at institutions or other locations outside a physician’s office.

“Fee-splitting inducements” are defined to include payments of cash for referrals; cash rebates; nonfair market value lease payments; payments of excessive fees to the requester of laboratory services “for consultation, filing forms, providing standby emergency services to laboratory and blood collection facilities, or other services”; excessive interest payments in connection with loans of laboratory equipment; prepayments by requesters of the laboratory services that do not result in lower charges to the patient; and the purchase of corporation stock or the purchase or rental of equipment or other tangible assets by the laboratory at more than fair market value.

Prohibited fraudulent practices include agreements “between a clinical laboratory and a requester of laboratory services that results in utilization of laboratory services in excess of that needed to provide information for diagnosis, prevention, treatment, or assessment of health of the patient or recipient of such services or excessive charges for these services.”

Note: The Connecticut Department of Public Health has interpreted this regulation and the foregoing statute to restrict a licensed laboratory’s ability to donate funds to pay for an electronic medical record (EHR) system for a physician who could be a source of referrals. In a declaratory decision on two questions brought by the Connecticut Society of Pathologists, the Department distinguished between the cost
of an EHR system (around $100,000) and an interface (around $10,000). Both allow physicians to send orders for tests to laboratories, and for the laboratories to communicate testing results with physicians. From the lab’s perspective, whether a physician has an EHR system or an interface is irrelevant from a functionality standpoint. Hence, laboratories that donate up to 85% of the funds for an EHR system are paying “valuable consideration” for “office equipment” (as that term is used in the regulation). Such donations are, in essence, bribes to influence behavior, regardless of the labs’ subjective intent. Intent is relevant only in cases of paying or offering to pay for the EHR software interface. Such payments are illegal unless (1) the donation is not meant to induce referrals and (2) the donation pays for little more than the cost of the interface. (In re: Declaratory Ruling Regarding the Permissibility of a Lab Donating Up to 85% of an Electronic Health Record System to a Physician (Aug. 8, 2013).)

4) FALSE CLAIMS / FRAUD & ABUSE

**Conn. Gen. Stat. Ch. 55e**—False Claims and other Prohibited Acts under State-Administered Health or Human Services Programs
The Connecticut False Claims Act is located in Conn. Gen. Stat. §§ 4-274 through 4-289. There are five principal statutes.

**Conn. Gen. Stat. § 4-274**—Definitions
The Connecticut False Claims Act applies to Medicaid, the Department of Public Health, the Department of Social Services, and other state medical assistance programs and agencies. Under the Act, “knowing” and “knowingly” are defined to mean that someone has actual knowledge of a violation, or that the person acts in deliberate ignorance of the information’s truth or falsity, or that he, she, or it (in the case of an entity) acts in reckless disregard as to whether the information is true or not (regardless of whether the person intends to defraud). “Material” is defined as having a natural tendency to influence (or be capable of influencing) paying or receiving money or property. Thus, the False Claims Act may be violated if something was done that could have caused a payment to be made, regardless of whether it was actually made.

**Conn. Gen. Stat. § 4-275**—False claims and other prohibited acts re state-administered health or human services programs. Penalties
The Connecticut False Claims Act prohibits a person from knowingly doing any of the following:

- Presenting (or causing to be presented) a false or fraudulent claim for payment to a state employee or officer;
- Making, using, or causing to be made or used a false or fraudulent statement that is material to a false/fraudulent claim;
- Delivering less money or property than someone is entitled to under a
covered program;
  o Buying or getting public property from a state employee who is not entitled to sell or give it;
  o Making, using, or causing to be made or used a false record or statement material to an obligation to pay the state under a covered program; or
  o Concealing or improperly avoiding or decreasing an obligation to pay the state under a covered program (often done by making a false statement).

It is also illegal to conspire to violate the above provisions or to make or deliver a document certifying receipt of property to be used by the state, without knowing whether information in the document is true and with an intent to defraud. Penalties for violating the False Claims Act run from $5,500 - $11,000, plus treble the state’s damages, plus the costs of investigating and prosecuting the violation.

The Connecticut attorney general has identified several practices that could be considered false claims:
  o Billing for services not provided. (Red flags might be billing for absent patients or billing excessive hours in a 24-hour period.)
  o Billing twice for a service when it is provided only once
  o Providing (and billing for) unnecessary or excessive services
  o Billing for non-covered services as covered services
  o Billing for services by unlicensed individuals as if provided by licensed professionals
  o Billing for more expensive services than those that are necessary or exaggerating the services performed (“upcoding”)
  o Billing separately for services that should be bundled together at a lower rate
  o Altering a claim, or altering a document supporting a claim like a certificate of medical necessity. Falsifying cost reports
  o Providing or receiving something of value (cash, gifts, services) in return for services or referrals for services (i.e. kickbacks)
  o Billing for brand-name drugs when generic drugs are dispensed
  o Off-label marketing of drugs or medical devices
  o Providing false information (or omitting essential information) in connection with a provider application, contract, or other document used for receiving money or property from a state program

Private citizens may sue violators in the state’s name, and the attorney general may intervene.

If the attorney general intervenes and the private citizen’s suit is successful, the citizen receives 15-25% of the recovered proceeds.

**Conn. Gen. Stat. § 4-279**—Civil action when Attorney General declines to proceed. Division of proceeds. Attorneys' fees and costs. Stay of discovery
If the attorney general does not intervene and the suit is successful, the citizen recovers 25-30% of the recovered proceeds.

**Conn. Gen. Stat. § 53-441**—Definitions
The Health Insurance Fraud Act defines “insurer” to include any insurance company or other legal entity authorized to provide health care benefits in Connecticut, including benefits provided under health insurance, disability insurance, workers compensation, and automobile insurance; any entity that is self-insured and provides health care benefits to its employees; and “any governmental entity which provides medical benefits to Medicare or Medicaid recipients.”

**Conn. Gen. Stat. § 53-442**—Health insurance fraud
A person is guilty of health insurance fraud when, with intent to defraud or deceive an insurer (as defined above), he presents or causes to be presented to any insurer or insurer’s agent any statement as part of or in support of any claim for payment, or health insurance application, with knowledge that the statement contains “false, incomplete, deceptive or misleading information concerning any fact or thing material to such claim or application, or omits information concerning any fact or thing material to such claim or application.” It is also a violation to assist, abet, solicit or conspire to prepare or present any such statements in support of such claims. The statute provides specifically that “misleading information” “includes but is not limited to falsely representing that goods or services were medically necessary in accordance with professionally accepted standards.” Health insurance fraud may exist even if a policy has not been issued. Moreover, it is illegal for providers to waive patients’ out-of-pocket costs under this statute because it may lead to overbilling insurance companies.

**Conn. Gen. Stat. § 53-443**—Penalty. Order of restitution. Attorneys’ fees and investigation costs included in restitution
Health insurance fraud may be punished as either a felony or a misdemeanor. Anyone who violates the Health Insurance Fraud Act is subject to the penalties for larceny (fines and imprisonment), as well as being required to make restitution to
the aggrieved insurer, including reasonable attorneys’ fees and investigative costs. Potential imprisonment ranges from up to three months to up to twenty years. Health insurance fraud may result in loss of a professional’s license and/or exclusion from participating in Medicaid.

**Conn. Gen. Stat. § 53-444—Cause of action, when**
Any insurer who is the victim of insurance fraud can institute an action against the perpetrator to recover all damages resulting from the fraud. Health insurance fraud may give the insurer a right to sue the insured even if the time for contestability has expired.

**Conn. Gen. Stat. § 53-445—Knowledge of health insurance fraud, report to Insurance Commissioner. Independent investigation conducted. Subject to civil liability, when**
Any person with knowledge of or reason to suspect health insurance fraud is required to provide notice and supporting information in the person’s possession to the Insurance Commissioner. The Commissioner is required to review and investigate all such reports, as well as to conduct an independent investigation of the suspected fraud and, when applicable, to refer the investigation to the appropriate state agency for criminal or civil enforcement or disciplinary action. Any person disclosing suspect health insurance fraud may disclose otherwise protected personal or privileged information concerning possible health insurance fraud, so long as the disclosure is limited to what is reasonably necessary to detect, investigate or prevent fraud, criminal activity, material misrepresentation or material nondisclosure. No person shall be subject to any civil liability, including liability for libel or slander, in connection with providing information pursuant to these provisions, unless that person did so “with malice or willful intent to injure any person.” In the right circumstances, there may be a cause of action for the willful or malicious false reporting or disclosure of insurance fraud.

**Conn. Gen. Stat. § 53a-119—Larceny defined**
Theft is called “larceny” in Connecticut and is defined to include “defrauding of public community” when a person authorizes, attests, certifies, or submits a claim for reimbursement to a local, state or federal agency, knowing the claim is false, or knowingly accepts benefits from a claim he knows is false, regardless of whether there was actual prejudice or loss to the agency.

**Conn. Gen. Stat. § 53a-290—“Vendor fraud” defined**
A person commits vendor fraud when, with intent to defraud, the person provides services to a Medicaid beneficiary (or to someone else getting medical assistance through a program administered by the Connecticut Department of Social Services) and presents a false claim for payment, accepts payment in excess of the amount due or authorized by law for such goods and services, solicits to perform the services for a beneficiary knowing the beneficiary does not need such services, sells goods or performs services without prior authorization by the Department of Social Services when such prior...
authorization is required, or accepts from anyone but the State any additional compensation for the services in excess of the amount authorized by law. Vendor fraud can constitute a misdemeanor or felony, depending on the resulting payment amount, and it may result in significant fines and imprisonment. Violations may result in treble damages payable to the state plus penalties ranging from $5,500 to $11,000 for each false claim. In addition, anyone found guilty of violating the Connecticut false claims act may lose his or her professional license and be excluded from the Medicaid program. If, before the state takes legal or administrative action, the person or entity makes the false claim reports it to the state within 30 days of discovering it and then cooperates with the state’s investigation, the treble damages may be reduced to double damages.

Note: The Commissioner of Social Services may conduct an audit of a long term care facility without notice in cases of suspected vendor fraud.


Appeal
Any state franchise or license held by a person found guilty of vendor fraud shall be revoked. Any vendor convicted in any state or federal court of a crime involving fraud in the Medicare or Medicaid program shall be terminated from those programs. No vendor may be reimbursed for services performed by a person convicted of a crime involving fraud in those programs. Any amounts paid as a result of vendor fraud may be recovered by the state in an action against the vendor.

Sanctions may be imposed even if the provider agreement with the state was terminated so long as the sanctions relate to when the person or entity was a provider under Medicaid. In addition, a provider may be suspended independent of whether the provider incurs a criminal conviction. Goldstar Med. Servs., Inc. v. Dep't of Soc. Servs., 288 Conn. 79, 955 A.2d 15 (2008).

The Audit Division of the Department of Social Services uses samples of provider claims to project statistically how many payments were made erroneously and the dollar amount of overpayments the Division should collect from service providers who are audited. This statute lets the Department use extrapolation as a basis for finding overpayments to a provider only if (1) the provider has a high or sustained level of erroneous payments, (2) the errors continue despite educational intervention that has been documented, and (3) the claims exceed $150,000 a year. Providers may appeal the Department’s Medicaid Audit Findings to the Connecticut trial court (the Superior Court), which will overturn a decision only if a provider shows either that there was not “substantial evidence” to support the conclusions of the official who oversaw the final audit or “that the department acted unreasonably, arbitrarily, illegally, or in abuse of its discretion.” Bridgeport Dental, LLC v. Comm'r of Social Svs., 165 Conn. App. 642, 140 A.3d 263, cert. denied, 322 Conn. 908, 140 A.3d 221 (2016).
**Conn. Agencies Regs. § 19a-36-D36—Unethical practices prohibited**
The clinical laboratory regulations define as prohibited “fraudulent practices” the following: any agreement between a clinical laboratory and a requestor of laboratory services that results in utilization of laboratory services beyond those necessary for the patient or excessive charges for the services; any billing system that fails to accurately identify the laboratory, requestor, patient or recipient and the cost of the services; and any billing or receipts system that does not accurately indicate the amount and recipient of payment.

**Conn. Gen. Stat. § 20-579—Causes for suspension, revocation or refusal to issue or renew licenses, temporary permits and registrations and for assessment of civil penalty**
With respect to pharmacies, the Commission of Pharmacy may deny, revoke or suspend a license or temporary permit to practice pharmacy, a license to operate a pharmacy, or a registration of a pharmacy intern or pharmacy technician, if the applicant or holder has “performed or been a party to a fraudulent or deceitful practice or transaction.” Such conduct also can subject the applicant or holder of the license, temporary permit or registration to a civil penalty of up to $1000.

5) **UNFAIR BUSINESS PRACTICES**

**Conn. Gen. Stat. § 42-110b—Unfair trade practices prohibited. Legislative Intent**
The Connecticut Unfair Trade Practices Act (CUTPA) generally prohibits anyone from engaging in “unfair methods of competition and unfair or deceptive acts or practices in the conduct of any trade or commerce.” The statute indicates that the state legislature intended that the commissioner and courts be guided in their interpretations of the state law by looking to interpretations of Section 5(a)(1) of the Federal Trade Commission Act as provided by the Federal Trade Commission and federal courts. Advertising falls within the scope of CUTPA.

**Conn. Gen. Stat. § 20-7f—Unfair billing practices**
Connecticut considers it an unfair trade practice for health care providers to bill an enrollee of a managed care organization for medical services covered under a managed care plan, other than for a copayment or deductible. Likewise Connecticut prohibits reporting such a patient to a credit reporting agency for failing to pay a bill for medical services if a managed care organization is primarily responsible for the payment. See **Gianetti v. Fortis Ins. Co., No. CV030403193S, 2007 WL 1120556, at *10 (Conn. Super. Ct. Mar. 29, 2007) (unpublished)** (finding a violation of this statute when a physician billed a patient covered by a managed health care plan “for services not covered” under the patient's policy and for interest and “coinsurance … to which the [physician] was not entitled”).

“Balance billing” – the practice of billing patients for the difference between the
physician’s billed charges and what a health insurance plan pays – is permitted if the physician is outside of the enrollee’s managed care network (that is, when the physician has no contract with the patient’s insurer). In such cases, physicians may bill patients directly. Gianetti v. Rutkin, 142 Conn. App. 641, 650 (May 21, 2013).

**Conn. Gen. Stat. § 20-124a**—Dental referral services: Disclosure of acceptance of fee for referral required
It is an unfair trade practice for any person or entity that engages in the referral or recommendation of persons to dentists for profit to fail to disclose that the dentist has paid a fee for the referral.

**Conn. Gen. Stat. § 20-150**—Where optical goods may be sold. Exception. Unfair trade practice
It is an unfair trade practice for any retailer to sell glasses or contact lenses except under the supervision of a licensed optician and in a registered optical establishment, office or store. Nevertheless, a licensed physician or optometrist may dispense contact lenses.

6) GENERAL WHISTLE-BLOWER PROTECTIONS

**Conn. Gen. Stat. § 53-445**—Knowledge of health insurance fraud, report to Insurance Commissioner. Independent investigation conducted. Subject to civil liability, when
No person shall be subject to any civil liability, including for libel or slander, in connection with filing reports or documents or otherwise submitting information concerning potential insurance fraud, unless the person did so with “malice or willful intent to injure” another person.

This statute, sometimes called The Whistleblower Act, is one of the strongest such statutes in the nation.¹ Any person with knowledge “of any matter involving corruption, unethical practices, violation of state laws or regulations, mismanagement, gross waste of funds, abuse of authority or danger to the public safety occurring in any state department or agency or any quasi-public agency,” or

occurring in any state contract valued at $5 million or more, may transmit all supporting information to the Auditors of Public Accounts. The Auditors of Public Accounts shall review the findings and report their findings and recommendations to the Attorney General, who shall investigate as appropriate. No state officer or employee or officer or employee of a large state contractor shall take or threaten any personnel action against any employee in retaliation for the employee’s or contractor’s testimony, disclosure of such information, or help in a proceeding. Any employee of a state agency or large state contractor who knowingly and maliciously made false charges under this statute shall be subject to disciplinary action up to and including dismissal. Civil penalties are a maximum of $5,000 per offense, up to 20% of the contract’s value. Each day of the violation is deemed a separate offense.

**Conn. Gen. Stat. § 19a-30, Clinical Laboratories. Regulation and licensure. Proficiency standards for tests not performed in laboratories**

Clinical laboratories are prohibited from terminating the employment of any employee in retaliation for reporting a violation of §19a-30 to the Department of Public Health.

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2 Statements to people conducting internal investigations on behalf of the employer are not covered under this statute. *Schumann v. Dianon Sys., Inc.*, No. CV055000747S (Conn. Super. Ct. Sep. 24, 2007) (unpublished) (“although § 19a-30 provides protection against retaliation for reports made to the department [i.e. the Department of Public Health], it does not provide protection for internal reports”).