1) PROHIBITIONS ON SELF-REFERRAL

Patient Safe-Referral Act of 1993
O.C.G.A. §§ 43-1B-1 to 43-1B-8

A health care provider may not refer a patient for the provision of designated health services (“DHS”) to an entity in which the health care provider (or family member) has an investment interest, unless an exception applies.

- "Health care providers" are defined as physicians, chiropractors, podiatrists, optometrists, pharmacists, and physical therapists licensed by the state.
- "Designated Health Services (DHS)" are defined as clinical laboratory services, physical therapy services, rehabilitation services, diagnostic imaging services, pharmaceutical services, durable medical equipment, home infusion services (including related pharmaceuticals and equipment), home health care services, and outpatient surgical services.

No claim for payment may be presented by a health care provider or entity to any individual, third-party payer, or other entity for services rendered pursuant to a prohibited referral under the Patient Self-Referral Act. If the health care provider or entity collects any amount billed in violation of the Patient Self-Referral Act, the health care provider or entity shall timely refund the amount to the payer or individual.
Potential penalties enumerated in the Act include the following:

- Any person who presents or causes to be presented a bill or a claim for service that is a result of the prohibited referral shall be subject to civil penalty of not more than $15,000 for each service.
- Any health care provider or entity that participates in a cross-referral arrangement or scheme shall be subject to a civil penalty of not more than $50,000 for each arrangement or scheme.
- Any health care provider or entity that divides or agrees to divide fees for DHS with any health care provider or entity resulting from a prohibited referral shall be subject to a civil penalty of not more than $15,000 for each service.

Possible Exceptions to the Prohibition on Referrals: The Act’s prohibition on patient referrals to entities in which the provider has an investment interest does not apply to the referral of patients to any entity or facility providing DHS if there is no entity or facility of reasonable quality, price, or service in the community, alternative financing is not available, and the following criteria are met:

1. No health care provider shall be required to make referrals or otherwise generate business as a condition for becoming or remaining an investor, and all other individuals are given a bona fide opportunity to invest in the facility on the same terms as a referring health care provider;
2. The facility shall not loan funds nor guarantee loans for referring health care providers, nor shall income from the investment be based on the volume of referrals made by the health care provider;
3. The health care provider complies with Code Section 43-1B-5, requiring disclosure of the investment interest to the patient; and
4. The facility shall provide uncompensated health services for indigent or charity patients at a standard that meets or exceeds 3% of the facility’s gross revenues after provisions for bad debts and third-party adjustments have been deducted.

This Act shall not apply to any health care provider or to any entity providing DHS if the financial interest of such health care provider in such entity providing DHS is restricted or regulated pursuant to any federal law that is applicable to such health care provider or entity providing DHS and that covers “private paying patients” as well as Medicare or Medicaid patients.

**O.C.G.A. § 34-9-25**

Physicians treating workers’ compensation claimants must comply with the provisions against patient self-referral (O.C.G.A. § 43-1B-1 through 43-1B-8) as outlined above.
2) FALSE CLAIMS/FRAUD & ABUSE

State False Medicaid Claims Act
O.C.G.A. §§ 49-4-168 to 49-4-168.6

Civil penalties for false or fraudulent Medicaid claims will be imposed upon any person who:

(1) knowingly presents or causes to be presented to the Georgia Medicaid program a false or fraudulent claim for payment or approval;
(2) knowingly makes, uses, or causes to be made or used a false record or statement material to a false or fraudulent claim;
(3) conspires to defraud the Georgia Medicaid program by getting a false or fraudulent claim allowed or paid;
(4) has possession, custody, or control of property or money used by the Georgia Medicaid program and “knowingly delivers, or causes to be delivered, less than all of such property or money” (O.C.G.A. § 49-4-168.1(a)(4));
(5) intends to defraud the Georgia Medicaid program by making or delivering a receipt of property without completely knowing that the information on the receipt is true;
(6) knowingly buys or receives public property from an officer or employee of the Georgia Medicaid program who has no lawful right to the property; or
(7) knowingly makes or uses a false record or statement material to an obligation to pay or transmit property or money to the Georgia Medicaid program, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit property or money to the Georgia Medicaid program.

Potential penalties enumerated in the State False Medicaid Claims Act include the following:

- Persons who violate the State False Medicaid Claims Act shall be liable to the state of Georgia for a civil penalty of not less than $5,500 and not more than $11,000 for each false or fraudulent claim, plus three times the amount of damages that the Georgia Medicaid program sustains as a result of the fraudulent act.
- Alternatively, the court may not assess more than two times the amount of actual damages sustained by the Georgia Medicaid program if the court finds that:
  (1) the person committing the violation of the State False Medicaid Claim Act furnished officials of the Georgia Medicaid program with all information known to such person about the violation within 30 days after the date on which the defendant first obtained the information;
  (2) such person fully cooperated with any government investigation of such violation; and
  (3) at the time such person furnished the Georgia Medicaid program with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under the State False Medicaid Claims Act with respect to such violation, and the person did not have actual knowledge of the existence of an investigation into such violation.
• A person violating the State False Medicaid Claims Act shall also be liable to the
state of Georgia for all costs of any civil action brought to recover the damages
and penalties enumerated above.

**State False Medicaid Claims Act Statute of Limitations:** All civil actions brought
under the State False Medicaid Claims Act may be brought by the state attorney
general or a private citizen and must be filed within six years after the date of the
violation or four years after the date when material facts applicable to the right of civil
action were known or reasonably should have been known by the state official
charged with the responsibility to act in the circumstances, whichever occurs last.
No civil action shall be filed more than ten years after the date upon which the
violation was committed.

**Georgia Medical Assistance Act of 1977**
**O.C.G.A. §§ 49-4-140 to 49-4-157**

It is unlawful for any person or provider to obtain, attempt to obtain, or retain any
medical assistance or other benefits or payments under the Georgia Medical
Assistance Act, or under the managed care program operated, funded, or
reimbursed by the Georgia Medicaid program, to which the person or provider is not
entitled, or in an amount greater than that to which the person or provider is entitled,
when the assistance, benefit, or payment is obtained, attempted to be obtained, or
retained by:

(1) knowingly and willfully making a “false statement” or “false representation”
    (O.C.G.A. § O.C.G.A. § 49-4-146.1(b)(1)(A);
(2) deliberate concealment of any material fact; or
(3) any fraudulent scheme or device.

It is also unlawful for any person or provider to knowingly and willfully accept medical
assistance payments to which he or she is not entitled or in an amount greater than
that to which he or she is entitled, or to knowingly and willfully falsify any report or
document required under the Medical Assistance Act.

**Potential penalties enumerated in the Medical Assistance Act include the
following:**

Violators of the Medical Assistance Act are guilty of a felony and upon conviction
face the following penalties for each offense:

(1) a fine of not more than $10,000;
(2) imprisonment for not less than one year nor more than 10 years; or
(3) both a fine and imprisonment.

Violators are also subject to civil penalties equal to the greater of: (i) “three times the
amount of any such excess benefit or payment” or (2) “$1,000 for each excessive
claim for assistance, benefit, or payment.” (O.C.G.A. § 49-4-146.1 (d)(1) – (2).)
Interest on the penalty shall be paid at the rate of 12% annum from the date of
payment of any such excessive amount, or from the date of receipt of any claim for
an excessive amount when no payment has been made, until the date of payment of such penalty to the department.

**Specific Penalties in the Case of “Abuse:”** Violators found guilty of abuse may be liable for a civil penalty equal to two times the amount of any excess benefit or payment. A provider commits abuse when the provider knowingly obtains or attempts to obtain medical assistance or other benefits or payment under the Medical Assistance Act to which the provider knows he or she is not entitled when the assistance, benefits, or payments are greater than an amount which would be paid in accordance with the Department of Community Health’s policies and procedures manual, and the assistance, benefits, or payments directly or indirectly result in unnecessary costs to the medical assistance program. Isolated instances of unintentional errors in billing, coding, and costs reports do not constitute abuse under the Medical Assistance Act.

**Conditions for Termination:** The Department of Community Health *may* refuse to accept a statement of participation, deny a request for reinstatement, refuse to exercise its option to renew a statement of participation, suspend or withhold those payments arising from fraud or willful misrepresentation under the Medicaid program, or terminate the participation of any provider if that provider or any person with an ownership or control interest in or any agent or managing employee of such provider has been:

1. convicted of violating the Medical Assistance Act;
2. convicted of committing a criminal offense related to a federal government program; or
3. is excluded or suspended from participation in the Medicare program for fraud or abuse.

The Department of Community Health *shall* refuse to accept a statement of participation, deny a request for reinstatement, refuse to exercise its option to renew a statement of participation, or terminate the participation of any provider who is a natural person if that provider or any agent or managing employee of such provider has been convicted of:

1. violating the Medical Assistance Act; or
2. committing a criminal offense related to a federal government program.

The Medical Assistance Act requires any person or provider who commits fraud to forfeit any property or proceeds obtained as a result of such Medicaid fraud. The Medical Assistance Act does not apply to alleged fraud by Medicaid recipients in obtaining medical assistance benefits.

**Offenses Against Public Administration: False Statements and Writings; Concealment of Facts**

**O.C.G.A. § 16-10-20**

A person who knowingly and willfully falsifies or conceals a material fact, covers up a material fact by any trick, scheme, or device, makes a false, fictitious, or fraudulent
statement or representation, or makes or uses any false writing or document, knowing the same to contain any false, fictitious, or fraudulent statement or entry, in any matter within the jurisdiction of any department or agency of state government or of the government of any county, city, or other political subdivision of the state of Georgia shall, upon conviction thereof, be punished through the imposition of a fine of not more than $1,000 or by imprisonment for not less than one nor more than five years, or both.

Offenses Against Public Administration: Conspiracy to Defraud State or Political Subdivision
O.C.G.A. § 16-10-21
Defrauding the state of Georgia or a political subdivision of the state of Georgia occurs when a person conspires or agrees with another to commit theft of any property that belongs to the state of Georgia, a political subdivision, or to any agency thereof, or that is under the control or possession of a state officer/employee or an officer/employee of a political subdivision in his official capacity. The crime is considered complete when the conspiracy or agreement is effected and an overt act in furtherance has been committed, regardless of whether the theft is consummated. The offense of conspiracy to defraud the state or a political subdivision is punishable by imprisonment for not less than one nor more than five years.

3) UNFAIR BUSINESS PRACTICES

O.C.G.A. § 33-20A-6
A managed care plan may not compensate, directly or indirectly, a health care provider or hospital through a financial incentive or disincentive program for ordering or providing less than medically necessary and appropriate care to his/her patients or for denying, reducing, limiting, or delaying such care. This section shall not prohibit a managed care plan from using a capitated payment arrangement consistent with the intent of Georgia law.

O.C.G.A. § 43-1-19.1
It is considered a deceptive or misleading practice for any duly licensed and authorized person to advertise the waiver of a health insurance deductible or copayment under a patient’s health insurance policy or plan as a method of inducement to attract patients. This prohibition does not apply to nonprofit community health centers that primarily serve indigent patients. A provider may, however, occasionally waive a patient’s deductible or copayment if the waiver is authorized by the patient’s insurer or if the waiver is based on “an evaluation of the individual patient” and is not a regular business practice of the provider. (O.C.G.A. § 43-1-19.1(c).) Violation of O.C.G.A. § 43-1-19.1 may lead to revocation of a provider’s license.
4) GENERAL WHISTLEBLOWER PROTECTIONS

**O.C.G.A. § 49-4-168.4**

Any employee, contractor, or agent discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful acts done in furtherance of a civil action under O.C.G.A. § 49.4.168 or other efforts to stop violation(s) of O.C.G.A. § 49.4.168 shall be entitled to all relief to make such employee, contractor, or agent whole. Relief shall include reinstatement with the same seniority status the individual would have had but for the discrimination, two times the amount of back pay, interest on the back pay, and compensation for special damages, including litigation costs and reasonable attorney’s fees. A civil action under O.C.G.A. § 49.4.168.4 may not be brought more than three years after the date the discrimination occurred.

**O.C.G.A. § 45-1-4**

Any person employed by the executive, judicial, or legislative branch, any other department, board, bureau, commission, authority, or agency of the state, or any local or regional government entity that receives any funds from the state or any state agency may submit to his public employer complaints and information regarding possible fraud, waste, and abuse relating to state programs and operations under the jurisdiction of such employer. Upon receipt of such information, a public employer shall not disclose the identity of the public employee, unless written consent is given or disclosure is necessary and unavoidable during the course of the investigation. The employer shall notify the employee in writing at least seven days prior to such disclosure.

No public employer shall make, adopt, or enforce any policy or practice preventing a public employee from disclosing a violation of or noncompliance with a law, rule, or regulation to either a supervisor or government agency.

No public employer may retaliate against a public employee for disclosing a violation of or noncompliance with a law, rule, or regulation to either a supervisor or a government agency, unless the disclosure was made with knowledge that the disclosure was false or with reckless disregard for the truth or falsity. No public employer shall retaliate against a public employee for objecting to or refusing to participate in any employer activity, policy, or practice that the employee has reasonable cause to believe is in violation of or in noncompliance with a law, rule, or regulation. The anti-retaliation provisions do not apply to policies or practices that implement—or to actions by public employers against public employees who violate—privilege or confidentiality obligations recognized by constitutional, statutory, or common law.

A public employee who has been the object of retaliation may institute a civil action in superior court for relief within one year after discovering the retaliation or within three years of the retaliation, whichever is earlier.
In the event retaliation is found to have occurred, the court may order any or all of the following forms of relief:
(1) an injunction restraining continued violation of O.C.G.A. § 45-1-4;
(2) reinstatement of the employee to the same position held before the retaliation or to an equivalent position;
(3) reinstatement of full fringe benefits and seniority rights;
(4) compensation of lost wages, benefits, and other remuneration; and
(5) any other compensatory damages allowable at law.
The court may also award the prevailing employee reasonable attorney’s fees, court costs, and expenses.

5) GEORGIA MEDICAID GUIDANCE

Georgia Department of Community Health, Division of Medicaid, Part I Policies and Procedures for Medicaid/PeachCare for Kids
As general conditions of participation in the Georgia Medicaid program, all enrolled providers must:
- Not contract, provide gratuities, or advertise “free” services to Medicaid or members of PeachCare for Kids for the purpose of soliciting members’ requests for services. Any offer or payment of remuneration, whether direct, indirect, overt, covert, in cash, or in kind, in return for the referral of a Medicaid or PeachCare for Kids member is also prohibited;
- Allow Medicaid or PeachCare for Kids members the opportunity to choose freely among available enrolled providers. It is not the intent of this provision to preclude referrals to other enrolled providers when medically necessary;
- Not engage in any act or omission that constitutes or results in overutilization of services;
- Not bill the Medicaid Division for any amount greater than the lowest price regularly and routinely offered to any segment of the general public for the same service or item on the same date of service or accepted from other third party payers;
- Not bill the Medicaid Division for any services not performed or delivered in accordance with all applicable policies, nor submit false or inaccurate information to the Medicaid Division relating to provider costs, claims, or assigned certification numbers for services rendered; and
- Refund any overpayments or advance payments to the Medicaid Division within required timeframes.

In addition, “[a]s a further term and condition of participation, in compliance with 42 U.S.C. § 1396(a)(68), all entities that receive annual Medicaid payments of at least $5 million shall, as a condition of receiving such payments, establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in 42 U.S.C. § 1396(a)(68)(A).” (Part 1: Policies and Procedures for Medicaid/PeachCare for Kids, at § 106.1(Georgia Department of Community Health)).
Health, Division of Medicaid)). Affected entities shall execute an attestation of compliance that will be maintained by the Department of Community Health. Attestations must be submitted by December 31 of each subsequent year, based upon the amount of payments an entity either received or made under Georgia’s state plan during the preceding federal fiscal year.

6) CASE LAW AND OTHER GUIDANCE

**Brathwaite v. Fulton-DeKalb Hosp. Authority**, 729 S.E.2d 625 (2012); **Hogan v. Hospital Authority of Valdosta and Lowndes County**, 7:15-CV-138 (HL), (M.D. Ga. Jun. 13, 2016); The Middle District of Georgia held that the hospital did not violate O.C.G.A. § 45-1-4 (whistleblower statute) when it terminated an employee medical coder after she complained about the hospital’s medical coding manager to a supervisor. Similarly, the court held that the hospital in **Hogan** did not violate the statute when it terminated an employee dialysis technician after he complained that a nurse was not conducting a particular medical procedure pursuant to specifications issued by the machine’s manufacturer. In both cases, the courts found that the complaints failed to allege a violation of or noncompliance with any law, rule, or regulation as required by the statute, or that the employee objected to or refused to participate in any activity, policy, or practice of the hospital that the employee had reasonable cause to believe was in violation of or noncompliance with a law, rule, or regulation.

**Albers v. Georgia Bd. of Regents of University System of Georgia et al.**, 766 S.E.2d 520 (Ga. App. 2014)

**Coward v. MCG Health, Inc.**, 802 S.E.2d 396 (Ga. App. 2017)

In **Albers**, a former public employee who was terminated from his chief of police position at the state university alleged that this termination was improper retaliation under Georgia’s whistleblower statute, O.C.G.A. § 45-1-4. The Georgia Court of Appeals held that the trial court had erred in granting summary judgment for the University System of Georgia. The trial court found that the employee had not engaged in protected whistleblowing activity, because his objections were based on potential, speculative, or nonexistent violations, none of which constituted protected activity under the whistleblower act. In reversing, the Court of Appeals found that the whistleblower statute protects a public employee who objects to employer-related activity which he reasonably believes violates the law. Because a question of fact existed as to whether the employee reasonably believed the University System’s actions violated the law, the Appellate Court held that the trial court erred in granting summary judgment on that ground.

Most recently, however, the Georgia Court of Appeals found in **Coward v. MCG Health, Inc.** that the plaintiffs’ complaints did not trigger the protections afforded by the whistleblower statute. Specifically, the plaintiff nurses reported that understaffing of nurses was a safety concern for patients, after which the plaintiff nurses were then fired for refusing to perform assigned duties. The Court of Appeals found that these
complaints only identified “internal operating procedures,” and did not identify any violation of law as required by the whistleblower statute. The Court stated “Complaints arising under internal policies are not [] the type of protected activity the Whistleblower Statute was intended to protect.” Coward, 802 S.E.2d at 320.

Malloy v. State, 744 S.E.2d 778 (Ga. 2013)
The Georgia Supreme Court held that an administrative determination of Medicaid fraud did not have a preclusive effect on a subsequent criminal proceeding regarding the same facts. Defendant Malloy, a gynecologist, was charged with Medicaid fraud during a separate administrative hearing before an administrative law judge (“ALJ”) on the same facts. In the separate administrative hearing, the ALJ reversed the Department of Community Health’s decision to withhold reimbursements from the defendant, finding that the record did not support a finding of fraud or willful misrepresentation. The Georgia Supreme Court held that the administrative decision did not have a preclusive effect on the subsequent criminal proceeding because the state was not afforded a full opportunity to litigate the issue. The Supreme Court found that administrative and criminal proceedings serve different purposes. Moreover, the Supreme Court held that affording determinative effect to administrative hearings would inappropriately impose upon the state a burden to investigate and prepare for administrative matters in the same manner it does a criminal prosecution.

In a Georgia Superior Court, a doctor and his employee were found guilty of conspiracy to defraud the state, Medicaid fraud, and false writings for submitting false bills to the Georgia Medicaid program. In regards to the charge of conspiracy to defraud the state, the Court of Appeals in the consolidated cases of Culver v. State and Kell v. State rejected the doctor and employee’s argument that no conspiracy existed because the claimed refunds were not actually received. The Court of Appeals held that the conspiracy to defraud the state is complete when the conspiracy or agreement goes into effect and an overt act is committed to further the conspiracy. In addition, the Court of Appeals found it irrelevant whether the theft was actually committed or the funds were actually received. The Supreme Court in State v. Kell, granting a writ of certiari, ruled that the appropriate venue for claims of fraud in obtaining medical assistance benefits pursuant to O.C.G.A. § 49-4-146.1(b)(1), is the county where the false report was submitted and processed, not the county where they are created. The Supreme Court therefore found the appropriate venue for a conspiracy-related claim is where the fraudulent scheme was hatched, where the overt acts in furtherance thereof were performed, and where payment was received.

Owners of a non-emergency transportation company were found guilty of conspiracy to defraud the state and theft by taking for engaging in Medicaid fraud through the
submission of false billing reports to the Georgia Medicaid program. The Georgia Court of Appeals rejected the argument that theft of Medicaid funds was purely a federal matter. The court reasoned that the Medicaid program established under 42 U.S.C. § 1396 et seq., Title XIX of the Social Security Act, is a jointly financed program between the federal and state governments and administered by the states. The states are given the authority to prosecute persons who violate the provisions of the Medicaid program. The Appellate Court held therefore, that in Georgia, the Department of Community Health has the authority to prosecute any person or provider who knowingly and willingly (1) accepts payments under the Georgia Medicaid program to which they are not entitled or in an amount greater than that to which they are entitled or (2) falsifies any report required under the program.


The defendants, husband (physician) and wife (employee), were found guilty of two counts of Medicaid fraud and one count of false writings for submitting fraudulent claims and accepting payments to which they were not entitled. The Georgia Court of Appeals rejected the wife’s argument that she was wrongly convicted because she was not a “provider” under the Georgia Medicaid program. The Appellate Court upheld her conviction on the basis that the wife was a party to the crime because of her supervisory role in the medical office as well as evidence of her actual participation in the billing scheme. The Appellate Court’s decision was based on O.C.G.A. § 16-2-20(a), which provides that a person may be found guilty as a party to a crime if they intentionally aid or abet in the commission of the crime or intentionally advise, encourage, hire, counsel, or procure another to commit the crime. The Appellate Court reasoned that participants to a crime may be convicted in same manner as the actual perpetrator of the crime.

7) FRAUD RELATED SETTLEMENTS

*Attorney General Announcement: Mylan Pharmaceutical Company*

On October 27, 2017, the Georgia State Attorney General announced that Mylan, a pharmaceutical company, would pay $7 million to the state of Georgia to resolve allegations that it knowingly underpaid rebates owed to the Medicaid program for its dispensing of EpiPens to Georgia Medicaid members. Georgia’s portion is part of a larger settlement involving allegations that Mylan incorrectly classified its EpiPen under the Medicaid Drug Rebate Statute. The Medicaid Drug Rebate Statute requires pharmaceutical manufacturers to sign a Rebate Agreement with the Secretary of the United States of Health and Human Services to provide quarterly rebates to State Medicaid programs for any classifying drugs dispensed to Medicaid beneficiaries. Mylan agreed to a total settlement of $465 million to the United States and other states, including Georgia.
Attorney General Settlement Announcement: The Medical Center, Navicent Health

On August 4, 2017, the Georgia State Attorney General announced a civil settlement with The Medical Center of Central Georgia, Inc., known as Navicent Health (“Navicent”). Navicent agreed to pay the United States and the State of Georgia over $2.5 million to resolve allegations that it had billed for ambulance transports that were either medically unnecessary or inflated. The 27-month investigation into Navicent’s ambulance billing practices was initiated by a whistleblower suit in which the United States and the State Georgia intervened. See United States and the State of Georgia, ex rel. Andre Valentine v. Navicent Hospital, Inc., 5:15-cv-152 (M.D. Ga.). In addition to its settlement payment, Navicent agreed to extend its current Corporate Integrity Agreement to cover the conduct implicated in the allegations.


The Georgia State Attorney General announced on February 2, 2017, that Dr. Robert Windsor, a pain management physician, agreed to a $20 million consent judgment to resolve allegations that Dr. Windsor had violated the Georgia False Medicaid Claims Act and federal False Claims Act by billing federal health care programs for medically unnecessary diagnostic tests and by billing Medicare and Tricare for surgical monitoring services that he did not perform. On October 24, 2016, Dr. Windsor was sentenced to three years and two months in a federal prison, as well as three years of supervision following his release.

Attorney General Settlement Announcement: Tenet Healthcare Corp

On October 3, 2016, the Georgia State Attorney General announced that Tenet Healthcare Corporation (and several of its subsidiaries) would pay $513 million to resolve criminal charges and civil claims relating to a scheme to pay kickbacks in return for patient referrals. The overall civil settlement with the United States, Georgia, and South Carolina totals over $368 million, with an additional $145 million of criminal forfeiture. The government alleged that Tenet paid kickbacks to an obstetric clinic, Clinica de la Mama, to induce the referral of patients to its hospitals for labor and delivery, thus submitting false claims to the Georgia Medicaid program.


In June 2016, the U.S. Attorney’s Office in the Northern District of Georgia announced that Otis Shannon and seven other individuals were indicted for conspiracy to commit health care fraud and conspiracy to commit bribery. Specifically, the U.S. Attorney alleged that Mr. Shannon, a former employee of the Georgia Department of Behavioral Health and Developmental Disabilities, had solicited and accepted bribes from mental health provider applicants to accept falsified and forged documents. The mental health providers were allegedly approved to bill Georgia Medicaid without meeting program requirements and improperly billed Georgia Medicaid for over $6.6 million—$5.9 million of which Georgia Medicaid had paid the providers.
This suit was brought in conjunction with the Medicaid Fraud Strike Force’s nationwide “sweep,” resulting in criminal and civil charges against 301 individuals (including 61 licensed medical professionals), as well as suspensions for a number of providers. According to the U.S. Attorney’s Office, the “takedown” was the largest in the Medicare Fraud Strike Force’s history, both in terms of the number of defendants and amount of loss (estimated at $900 million in false billings).

**Department of Justice Announcement: Columbus Regional Healthcare System**
On September 4, 2015, the Department of Justice (“DOJ”) released that Columbus Regional Healthcare System (“Columbus Regional”) and Dr. Andrew Pippas had agreed to pay over $25 million—and up to $35 million—to resolve allegations of False Claims Act violations. These allegations were based on the submittal of claims in violation of the Stark Law, as well as allegations that Columbus Regional and Pippas had submitted claims for payment to federal health care programs misrepresenting the level of services provided. The DOJ alleged that between 2003 and 2013, Columbus Regional had provided excessive salary and directorship payments to Pippas in violation of the Stark Law’s prohibition on physician referrals where the physician has a financial relationship with the entity to which he refers patients. In addition, the DOJ alleged that from May 2006 through May 2013, Columbus Regional submitted claims to federal health programs for services at higher levels than supported by the documentation; and between 2010 and 2012, Columbus Regional submitted claims to federal health programs for radiation therapy at higher levels than actually provided. As part of the settlement, Columbus Regional agreed to enter into a Corporate Integrity Agreement (“CIA”) with the Department of Health and Human Services—Office of the Inspector General (“HHS-OIG”), requiring Columbus Regional to implement measures designed to avoid or promptly detect future conduct similar to that which gave rise to the settlement.

A public employer is barred from retaliating against an employee who reports fraud, waste, or abuse. There is an exception, however, where the report is made with the knowledge that it is false or with willful disregard for the truth or falsity.

**8) HELPFUL LINKS**
- Georgia Department of Community Health (DCH)
- Georgia Medicaid Division
- DCH Office of Inspector General, Program Integrity
- Georgia Medicaid Fraud Control Unit