Med Benefits Co Settles Fraud Suit for $54M; Whistle-blower Set to Be Richly Rewarded

Earlier this month, the United States Department of Justice (DOJ) announced a large settlement in a fraud lawsuit against a benefits management company. If that's not enough to give pause to industry actors who may be filing inappropriate claims, the fact that the whistle-blower stands to receive a huge paycheck should. Insiders have plenty of incentive to initiate fraud action on behalf of the government … in this case, more than ten million incentives.

CareCore National, LLC agreed to settle the *qui tam* lawsuit for $54 million; the relator, John Miller, a Licensed Practical Nurse and former employee of CareCore, stands to receive $10.5 million of that settlement.

The company allegedly employed a scheme to systematically submit hundreds of thousands of false Medicare and Medicaid claims from 2005 to 2013. Mr. Miller's role with CareCore was that of clinical reviewer; he was to determine whether prior authorizations satisfied approval requirements for the medical procedure in question. Approval would trigger a claim to the insurer.

In a press release, Health and Human Services (HHS) Office of Inspector General (OIG) Special Agent in Charge Scott J. Lampert said: "CareCore's irresponsible behavior compromised the integrity of the Medicare and Medicaid programs, and wasted millions of taxpayer dollars. HHS-OIG will continue to ensure that companies that do business with federally-funded health care programs do so in an honest fashion."

CareCore accused of "PAD"ding the system

The complaint alleges that CareCore, overwhelmed by the sheer number of prior authorization requests received by clients, began operating under a "process as directed" (PAD) system in which clinical reviewers like Mr. Miller were to approve prior authorization requests without question or investigation, and without attempting to determine whether the procedure was medically necessary. The government's complaint claims that CareCore was under pressure to hit a certain number of prior authorization approvals within a predetermined window of time.

CareCore is accused of using the PAD program to fraudulently greenlight more than 200,000 prior authorizations during the eight years in question. Specifically, the government is interested in the deceptive claims filed with Managed Care Organizations (MCOs) contracted with CareCore, a population that includes Medicare and Medicaid beneficiaries. When MCOs received the claims, they believed they were appropriately approved and therefore medically necessary, and in turn the MCOs submitted those allegedly false claims to the government for reimbursement.

"CareCore blindly approved hundreds of thousands of medical procedures"

CareCore is a 23-year-old medical benefits management company specializing in consulting services that claim to boost the quality of healthcare and cut overall costs. Three years ago, it merged with MedSolutions, Inc., and in 2015 CareCore was absorbed into the eviCore healthcare network.

In a press release, acting U.S. Attorney Joon H. Kim said: “Benefit management companies are supposed to determine whether medical diagnostic procedures paid for with Medicare and Medicaid funds are necessary and reasonable. Instead, CareCore blindly approved hundreds of thousands of medical procedures over a period of many years, leaving Medicare and Medicaid to foot the bill. This lawsuit and settlement shows our commitment to ensuring that fraud and waste involving federal funds will be identified and stopped.”