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Health Care False Statement Statute: Lessons From 2013

Law360, New York (December 18, 2013, 8:31 PM ET) -- The U.S. Department of Justice has continued to step up its health care fraud enforcement efforts. Data released in 2013 shows that federal authorities obtained more than 800 convictions, collected nearly $1.4 billion in fines and initiated over 1,000 new health care fraud investigations in fiscal year 2012 — a trend that is almost certain to continue. These cases come in all shapes and sizes. Targets include doctors and nurses, owners of health care-related businesses, executives at health insurance companies, and major pharmaceutical manufacturers.

Health care fraud is not the only criminal statute in a federal prosecutor's toolkit these days. Another statute, which criminalizes false statements relating to health care matters, 18 U.S.C. § 1035, is taking on greater significance as prosecutors have begun to charge Section 1035 alongside health care fraud.

The statute punishes those who "in any matter involving a health care benefit program, knowingly and willfully ... falsif[y], conceal[], or cover[] up by any trick, scheme, or device a material fact; or ... make[s] any materially false, fictitious or fraudulent statements or representations ... in connection with the delivery of or payment for health care benefits." Section 1035 is broader than the health care fraud statute: It does not require proving a scheme to defraud or an attempt to obtain money or property through misrepresentation. Merely falsifying material information in connection with a health care benefit program suffices.

The health care false statement statute is similar to the general criminalization of false statements codified at 18 U.S.C. § 1001, but it does contain significant differences. Unlike Section 1001, Section 1035 requires a false statement made in a "matter involving a health care benefit program" and "in connection with the delivery of or payment for health care benefits, items, or services."

As prosecutors have begun charging Section 1035 with greater frequency, cases interpreting its elements have begun percolating through the courts. Two recent decisions, in particular, will affect health care false statement prosecutions going forward: United States v. Natale, 719 F.3d 719 (7th Cir. 2013) and United States v. Ajoku, 718 F.3d 882 (9th Cir. 2013). Both decisions bear on an essential question unique to the health care false statement statute: To whom must a false statement be made to fall within the statute's purview?

United States v. Natale

Natale, a vascular surgeon in suburban Chicago, specialized in treating aortic aneurysms. Depending on the precise location of the aneurysm, its repair may require one of two procedures, and the difficulty of the surgery varies depending on the location of the repair. Medicare reimburses the more complicated surgeries at higher rates than simpler ones. Natale repeatedly billed for surgeries at the higher rate

when, according to the government's allegations, he had in fact performed the less complicated procedure.

Natale was charged with health care fraud, mail fraud, and making false statements relating to health care matters. The fraud counts stemmed from his allegedly overbilling Medicare and for using the mails to receive Medicare reimbursement checks. The false statement counts stemmed from different conduct: Natale's preparation of allegedly false operative reports. The jury acquitted Natale on the fraud counts but found him guilty of making false statements in the operative reports. On appeal, Natale challenged the jury instructions on the elements of Section 1035.

The Natale court first limited the reach of the health care false statement statute. When instructing the jury, the trial judge omitted any mention of the requirement that the false statement is made in connection with a "matter involving a health care benefit program." Labeling this element "jurisdictional," the court concluded that a "matter involving a health care benefit program" is an essential element of Section 1035 that the jury must find proven beyond a reasonable doubt. As a result, failure to charge the jury on this element was plain error.

Nevertheless, the Natale court did not reverse. Though the error was plain, the court held it did not affect Natale's substantial rights. No one disputed that the surgeries involved Medicare — a health care benefit program — because Natale billed Medicare for them. The false statements thus "involved" a health care benefit program and satisfied the narrow construction of that element adopted by the Seventh Circuit.

The Natale court then delivered a mixed bag — narrowing the statute's reach in some respects, but broadening it in others — concerning the scope of another element of Section 1035: materiality. The trial court's instruction on materiality permitted the jury to convict as long as the false statement had the effect of influencing the action of a person or entity or was capable of or had the potential to do so. Natale asserted that Section 1035 requires a statement material to the health care benefit program, not just any "person or entity."

The Seventh Circuit agreed: "[I]f statements material to the delivery of healthcare benefits, items, or services were sufficient to convict, the statute would criminalize a wide swath of seemingly innocent 'white lies' totally unconnected to the conduct that motivated the passage of the statute." For example, if the materiality requirement applied to anyone and not just the health care benefit program, "a patient who lies on the new patient questionnaire regarding his lifestyle habits ... may violate the law." This interpretation narrowed the reach of the statute by shrinking the universe of false statements that Section 1035 criminalizes.

But soon after adopting this more limited interpretation of materiality, Natale greatly expanded the reach of the term in its application. Natale's operative reports — the documents containing the false statements underlying his conviction — had never been seen by Medicare. Medicare never requested, received or reviewed the operative reports describing the surgeries at issue in this case. Nevertheless, the Natale court found sufficient proof of materiality in evidence that, when Medicare audits claims, it sometimes requests operative reports as well as other physician notes and documentation.

Because materiality requires "only a potentiality of influencing the decisionmaker" and not "actual reliance," the reports were material because Medicare might have requested them in an audit. The implications of this holding are important. Internal documentation, never reviewed by a health care benefit program, can be a material false statement made in connection with that program if the

program might rely on that documentation in an audit or similar procedure. Thus, while Natale narrowed the reach of Section 1035 in several key ways, it adopted this broad concept of materiality.

United States v. Ajoku

Where Natale made clear the need to prove beyond a reasonable doubt that the alleged false statement related to a matter involving a health care benefit program, United States v. Ajoku offered further guidance on the meaning of that element, expanding the reach of health care false statement liability in the process. Ajoku, a vocational nurse, applied for a designation as an "exemptee" under California law. He submitted false information in his application. At the time, Ajoku worked for a medical supply company. Though Ajoku was not aware of it, the company was fraudulently billing Medicare and needed someone with the state law designation of "exemptee" to make the scheme work.

Ajoku was tried and convicted under Section 1035 for the false statements he submitted on his exemptee application. On appeal, Ajoku argued that those statements did not concern a health care benefit program, and thus failed the jurisdictional element of Section 1035. The Ninth Circuit disagreed. It held that the law did not require making a false statement to a healthcare benefit program, just concerning the program. According to the court, the fact that the medical device company used Ajoku's falsely obtained status in its fraudulent scheme was a sufficient tie between the statements and the health care benefit program.

Like Natale, Ajoku has implications for future prosecutions. First, a statement to an entity that is not a health care benefit program may nevertheless "concern" a health care benefit program even if made for a purpose unrelated to the program. Second, the court's statutory interpretation analysis suggests that Section 1035's intent element requires only that the statement be knowingly and willfully false, not that the statement knowingly and willfully be used in connection with a health care benefit program.

As federal authorities charge Section 1035 more frequently, a pattern set to continue as the web of health care benefit programs expands and changes with the implementation of the Affordable Care Act, courts will likely continue to flesh out the meaning of the statute. Natale and Ajoku provide some clue that courts are willing to give these elements an expansive reach. Precisely how far the jurisdictional requirement stretches and just what statements qualify as material, however, are still open questions.

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