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Medicare claim violator receives a plea deal; Experts say health-care fraud cases are typically hard to prosecute

By: Jeremy Cox

Diabetic Services and Supplies Inc. admitted that it filed $230,000 in false claims to Medicare, the insurance program for seniors and the disabled that exists by the grace of American taxpayers.

Despite a nationwide crackdown on health-care fraud in federal courts and regulatory offices, the St. Johns County-based company struck an agreement allowing it to avoid a fine of as much as $500,000. Instead, Diabetic Services offered to pay back the $230,000 it took, and a U.S. district judge, Marcia Morales Howard, accepted the plea deal this month.

The episode underscores the challenges investigators and prosecutors face in bringing health-care fraud cases to justice, according to two experts in the field.

Health-care fraud, to a large degree, remains easy to commit and difficult to prosecute. And even when it's uncovered, as in the Diabetic Services case, mitigating factors may help minimize the penalties.

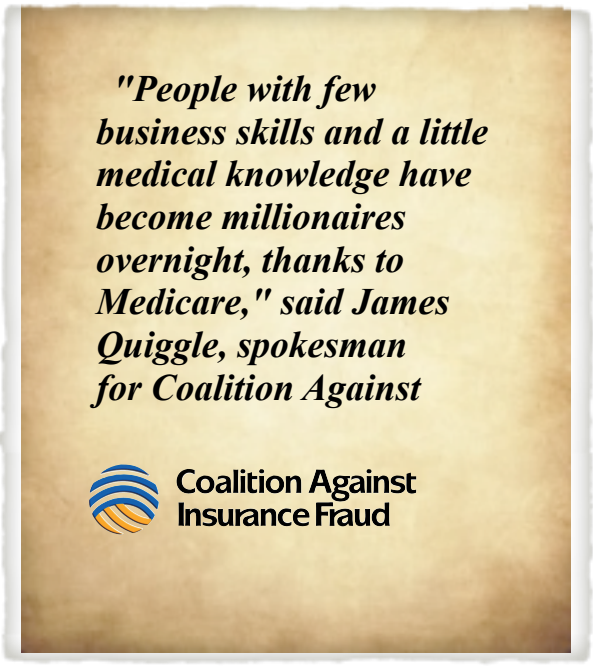
Prosecutors may suggest lighter penalties for first-time offenders, companies that already employ a fraud-deterrence program or defendants who agree to assist investigators in other cases, said Michael Crites, a former U.S. attorney in Ohio who created one of the government's first health-care fraud task forces.

Essentially, Diabetic Services was accused of overbilling Medicare. From January 2006 to July 2008, the company billed Medicare for generic diabetic shoe inserts as if they were more-expensive, custom-molded inserts. The move came after Medicare cut its reimbursement rate for inserts by 20 percent.

It's unclear what, if any, factors were considered in the Diabetic Services case. At an hourlong hearing on Jan. 25 to discuss the company's plea deal, owner Mark Blaker provided mostly one-word answers to a judge's questioning.

Asked whether he understood that his company was pleading guilty to acting "willfully with an intent to defraud" the government, Blaker, 67, replied, "Yes, I do, your honor."

A transcript of the largely procedural hearing doesn't betray any clues into the penalty's rationale. A spokeswoman for the U.S. Attorney's Office of the Middle District of Florida said she couldn't comment on the matter. Blaker and his attorney, Robert Willis of Jacksonville, didn't return messages left for them on Tuesday and Wednesday.



Since the George H.W. Bush administration, when Crites got his go-ahead, health-care fraud has become one of federal prosecutors' top targets. By last year, the amount recovered in billing scams had reached $4 billion, but that total still represented a small fraction of the amount of ill-gotten gains. Estimates fluctuate between $40 billion and hundreds of billions of dollars.

"People with few business skills and a little medical knowledge have become millionaires overnight, thanks to Medicare," said James Quiggle, spokesman for **Coalition Against Insurance Fraud**. "There's a growing recognition that taxpayer money has been flowing out."

Cases like that against Diabetic Services simply might have been missed not that long ago, he added.

Last year's Affordable Care Act, much criticized for its insurance coverage mandate, also included little-noticed provisions aimed at curbing fraud. The law provides $350 million over 10 years to fight fraud and makes prosecutions easier by, among other things, eliminating a requirement in kickback cases for prosecutors to prove that defendants know they are breaking the law.

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