# Third-party biller fraud may hook your practice, unless you protect yourself

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***Question:*** *I recently read about a third-party biller who was charged with health care fraud and eventually entered a plea agreement — but the practice he worked for was not charged. I thought fraudulent medical billings were always the responsibility of the provider whose services were billed. Is it possible for a biller to be guilty but not the provider?*

**Answer:** You appear to be talking about the Scott Newcombe case settled by the U.S. Attorney for the Northern District of New York in October. Since this was a plea agreement, not many facts in the case are publicly available; but health care attorneys who have seen similar situations say a health care provider might get out from under such charges by pleading ignorance — but it's a much better idea to make sure you're not left in the dark in the first place.

According to a statement by the U.S. Attorney, Newcombe was an office manager and health care claims biller who, doing business as SJ Healthcare Management Services LLC, "performed various management, administrative, and billing services" for two physicians' practices in Plattsburgh, N.Y., charging a flat fee. Newcombe, the U.S. Attorney says, has admitted to making "false and fraudulent claims" on behalf of his clients on services that "were never provided and, in other instances, were provided at lower reimbursement rates than the amounts billed." He even filed claims, the complaint says, on services allegedly but not actually performed on himself.

Court documents reveal Newcombe has agreed to make restitution on payments to several payers for a total of $36,352.96, not a large amount in terms of U.S. health care fraud. Nonetheless, when Newcombe is sentenced on March 6, 2025, the U.S. Attorney says he could get as much as 20 years (though the plea agreement makes that unlikely).

**No percentage, no incentive?**

In New York, billers are prohibited by law from charging a percentage of receipts, on the understandable grounds, Paul Werner of the Buttaci, Leardi and Werner law firm in Princeton, N.J., says, that such an arrangement incentivizes the biller to increase reimbursement and may tempt them to commit fraud.

Keith Lefkowitz, a health care attorney with Hendershot Cowart in Houston, points to the Office of Inspector General (OIG) compliance program guidance for third-party billers published in 1998, in which OIG "talks about concerns with percentage-based compensation arrangements between a practice and a biller because it could incentivize a third party biller to upcode, unbundle, or [perform other actions] that would lead to a false claim because the biller would receive that financial benefit," he says.

But Geoffrey R. Kaiser, senior counsel in the compliance, investigations and white collar and health services practices of Rivkin Radler in Uniondale, N.Y., says the flat fee offers its own motivation for misappropriation, though the practice would not necessarily be aware of the biller's actions.

It's true that "if a biller charges a percentage of collections... there would be an obvious financial motive for the biller to upcode the claims and increase the reimbursement amounts," Kaiser says. However, "if the biller is receiving a fixed monthly fee... it is still possible that the biller could falsify claims submissions and then — particularly if the biller was also performing management and administrative services, as in the cited case — keep the 'delta' between the inflated reimbursement amounts and the true reimbursement amounts, returning only the lower amount to the provider."

Jason N. Silberberg, a partner in Frier Levitt's health care litigation section and co-chair of the firm's value-based care litigation group, has seen similar situations in which a practice has discovered fraud of the sort described in the Newcombe documents and self-disclosed to OIG. He cites the 2023 Health Sun Medicare Advantage case, in which "a Medicare Advantage Organization avoided criminal prosecution [by the U.S. Department of Justice] and potential False Claims Act-based treble damages through its timely use of the OIG self-disclosure protocol. The MRA [Medicare Risk Adjustment] director, however, who had allegedly orchestrated the fraud, found herself criminally indicted."

**Pay attention, and audit**

While the entirety of Newcombe's scenario is not known, Werner has seen situations in which "a physician is riding off into the sunset of his career and allows someone to come in and *de facto* run the practice." In such cases, the administrator can do all sorts of financial mischief without the provider paying attention. "When a medical provider contracts with someone to provide billing services," Werner says, "that provider is generally not looking at the paid claims — they're mainly interested in claims that are *not* being paid."

As long as the claims keep getting paid, Werner says, the provider may not bother with details. “In these cases, they may not even be getting the EOBs,” he says.

The fraud may keep going until “someone else, maybe a new guy in the practice more in tune with the scams, discovers some problems and reports them himself,” Werner says. Or it may be ended by a payer audit and investigation, in which case the provider and their practice will probably not be able to plead ignorance.

Werner suggests that you conduct reviews of relevant billing materials even if everything looks rosy.

“As the provider, you are always able to get access to your EOBs,” Werner says. “They don’t just tell you what you got paid; they tell you what you got paid *for*. So if you know, for example, that your office policy is never to bill higher than a level three E/M and you spot check and find a lot of level fours or fives, you know there’s something wrong.”

“It’s generally not enough to just hire a third-party biller, bury your head in the sand and hope for the best,” Lefkowitz says. “[Your practice] should conduct spot audits, and if you see a pattern or other potential issues [that suggest] improper billing, you may need to expand your audit — or even consult another third-party billing company other than your current billing company to help conduct that audit.”

“In this instance it looks like the providers are going to skate,” Werner concludes. “Maybe there’s more context that we don’t know. But often in these cases the providers and the [third-party biller] go down on the Titanic together. Because at the end of the day, it’s the physician’s name on the claim form.”

**Resources**

- U.S. Department of Justice, Northern District of New York, “Medical Billing Company Owner Pleads Guilty to Health Care Fraud,” Oct. 29, 2024: *www.justice.gov/usao-ndny/pr/medical-billing-company-owner-pleads-guilty-health-care-fraud*
- USDOJ, Criminal Division, “HealthSun Health Plans, Inc.”: www.justice.gov/criminal/case/healthsun-health-plans-inc
- USDOJ, “Former Executive at Medicare Advantage Organization Charged for Multimillion-Dollar Medicare Fraud Scheme,” Oct. 26, 2023: *www.justice.gov/opa/pr/former-executive-medicare-advantage-organization-charged-multimillion-dollar-medicare-fraud*
- OIG, “Publication of the OIG Compliance Program Guidance for Third-Party Medical Billing Companies,” U.S. Federal Register, Dec. 18, 1998: *https://oig.hhs.gov/documents/compliance-guidance/805/thirdparty.pdf*

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