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Health Care Fraud and Qui Tam Actions Under the False Claims Act: Avoiding the Government's Crosshairs

Medicare and Medicaid provide health care coverage to millions of Americans and are aggressively protected by federal and state authorities. The Department of Health and Human Services Office of Inspector General, the U.S. Attorney's Office, and Kentucky's Cabinet for Health and Family Services routinely pursue criminal and civil enforcement actions against health care companies, providers, and managed care organizations for fraud, waste, and abuse.

In recent years, the Department of Justice has intensified these efforts by deploying advanced data analytics and artificial intelligence to detect suspicious billing patterns. For example, the 2025 National Health Care Fraud Takedown resulted in criminal charges against 324 defendants — including 96 licensed medical professionals — for schemes involving more than \$14.6 billion in intended losses. In parallel, the Centers for Medicare and Medicaid Services reported preventing over \$4 billion in improper payments and suspending or revoking the billing privileges of 205 providers. Civil enforcement was also significant, with actions against more than 120 defendants resulting in tens of millions of dollars in settlements.

Recent decisions by the U.S. Court of Appeals for the Sixth Circuit reflect this aggressive enforcement posture, particularly in cases involving medically unnecessary services, deficient documentation, and inflated or false claims. Together, the cases highlighted below provide a practical roadmap for compliance — and for avoiding the government's crosshairs.

Recent Sixth Circuit Guidance

United States v. Siefert, 161 F.4th 379 (6th Cir. 2025)

In *Siefert*, the Sixth Circuit affirmed convictions stemming from an overbilling scheme involving medically unnecessary definitive urine drug testing. The evidence showed a deliberate practice of ordering high-reimbursement testing without patient-specific medical necessity and continued billing despite malfunctioning equipment and delays in testing rendering the results clinically useless. The court also upheld a conspiracy conviction for the operator of the clinic, and both the clinic owner and medical director received custodial sentences and substantial restitution orders.

Compliance takeaways:

- Document individualized medical necessity for each test and encounter.
- Avoid blanket testing protocols untethered to clinical need.
- Do not bill for testing when equipment malfunctions or results lack clinical utility.
- Ensure internal audits are medically driven, not financially engineered.

United States v. Campbell, 135 F.4th 376 (6th Cir. 2025)

In *Campbell*, the Sixth Circuit affirmed convictions of a physician and nurse practitioner for conspiracy to unlawfully distribute controlled substances, health care fraud, and money laundering. The fraud charges were based on billing for services at improperly high evaluation and management levels and misusing proceeds to fund bonuses. Evidence of drug-distribution conspiracy included brief patient visits, pre-signed prescriptions, long-distance patient travel, and continued prescribing despite failed drug tests.

Compliance takeaways:

- Ensure billed CPT codes accurately reflect the services provided.

- Understand and follow payer-specific rules for “incident-to” billing.
- Structure compensation and bonuses around quality and compliance — not volume.
- Thoroughly document medical decision-making, particularly for short or routine visits.

United States ex rel. Owsley v. Fazzi Associates, Inc., 16 F.4th 192 (6th Cir. 2021)

Civil enforcement under the False Claims Act (FCA) remains a significant risk through *qui tam* actions. In *Owsley*, the Sixth Circuit affirmed dismissal of an FCA case alleging upcoding of home-health assessment data submitted to Medicare.

Although the relator alleged a fraudulent “scheme,” the court held that the complaint failed to meet Rule 9(b)’s heightened pleading standard because it did not identify representative claims or provide sufficient detail — such as dates, amounts, or claim identifiers — to support a strong inference that false claims were actually submitted.

Compliance takeaways:

- Maintain robust, claim-level documentation to defend against FCA allegations.
- Closely oversee third-party coders and vendors; outsourcing does not shift liability.
- Many FCA cases turn on pleading standards, materiality, and threshold defenses at the motion-to-dismiss stage.

Practical Steps to Reduce Criminal and Civil Exposure

Medical necessity and documentation:

- Conduct patient-specific assessments and clearly link each service to current clinical needs.

- Avoid standardized testing or treatment policies that lack individualized justification.

Technology and timeliness:

- Regularly validate equipment performance.
- Suspend billing when delays or deficiencies undermine clinical value.

Coding and billing:

- Match codes to services actually rendered and document elements required for each code.
- Confirm payer- and program-specific billing rules before submission.

Compensation structures:

- Incentivize compliance, quality, and patient outcomes — not raw volume or high-risk services.

Governance and audits:

- Use independent, clinically grounded audits and document corrective actions.
- Take staff compliance concerns seriously and investigate promptly.

Training and vendor oversight:

- Train clinicians and billing staff on documentation and medical necessity standards.
- Contractually require compliance from coding vendors and audit their performance.

How FBT Gibbons Can Help

FBT Gibbons defends health care companies and providers in criminal and civil matters involving alleged health care fraud and false claims. We conduct privileged internal investigations, design and enhance compliance programs, and provide real-time guidance on documentation, coding, billing, compensation structures, and

regulatory interactions — helping clients mitigate risk and stay ahead of enforcement trends. For more information, please contact the authors or any attorney with the firm's [Health Care](#) and [White Collar & Investigations](#) teams.

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