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Physician and Practice Pay $6.5M to Settle FCA Case; Two-Phase Kickback Scheme Alleged

By Nina Youngstrom

A New York City cardiologist and his medical practice have agreed to pay $6.5 million to settle false claims allegations of a two-part kickback scheme involving inflated rent payments to physicians and per-test fees to cardiologists, the U.S. Attorney's Office for the Southern District of New York said Sept. 18.[1]

Klaus Peter Rentrop and his practice, Gramercy Cardiac Diagnostic Services P.C., allegedly choreographed the placement of independent-contractor cardiologists in primary care and other physician practices to "funnel patients to Gramercy Cardiac for tests and procedures," according to the complaint in intervention filed by the U.S. attorney's office Sept. 15.[2]

As part of the resolution of the case, Rentrop entered into a voluntary agreement with the HHS Office of Inspector General to be excluded from federal health care programs for five years. There's also a $64 million consent judgment the defendants may be required to pay if they don't make the settlement payments.

"This settlement is unique because it's targeted at one physician" although the allegations are that many participated, said attorney Bob Wade, with Nelson Mullins in Nashville, Tennessee. The consequences pack a punch—exclusion, the forced divestiture of Rentrop's practice by the end of the year and the consent judgment, he said. It's a reminder to ensure physicians and health care executives receive compliance training, Wade noted. "Any physician who has received any amount of compliance education should have identified issues with this scheme."

The case was set in motion in 2018 by whistleblower Michele Martinho, "a physician to whom Gramercy Cardiac and Dr. Rentrop unsuccessfully marketed their scheme," according to a press release from Kirby McInerny, the law firm that represented Martinho. The False Claims Act complaints alleged that Rentrop and Gramercy Cardiac Diagnostic Services—which provides echocardiograms, PET scans, SPECT scans and other tests—submitted claims to Medicare and Medicare that were false because they ran afoul of the Stark Law and Anti-Kickback Statute (AKS).