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MONDAY
FEBRUARY 14, 2000

States jump on False Claims Act bandwagon

Many state qui tam *statutes have even more bite than the federal law, experts say*

Hospitals and other health care providers long threatened under the federal False Claims Act now face another threat: A growing list of states have already enacted or are considering enacting their own civil False Claims Acts modeled on the federal law. The statutes include steep penalties, triple damages, and whistleblower provisions.

"The next great wave of whistle-blower lawsuits is going to be at the state level, not at the federal level," predicts health care attorney **Charles Murdter** of Davis Wright Tremain in Seattle. "The federal False Claims Act has been enormously lucrative for many relators, and given that there are a variety of state contracts that federal statutes do not reach, it only makes sense for the states to jump on board."

"This is a way for states to capture what they perceive to be lost revenue," says Murdter. The federal contribution to Medicaid empowers whistle-blowers to bring False Claims Act cases based on Medicaid fraud; however, those recoveries have been limited to the dollar loss that the federal government suffers. "This is now a way to get the full monte," he says.

The principal thrust of law enforcement under the false claims act in the health care arena continues to be at the federal level, agrees **Bob Fabrikant**, a health care attorney in Chicago. But he also believes more states are recognizing that

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'Wave' of cost report cases likely in Beverly's wake

Beverly Enterprises, the nation's largest nursing home chain, has agreed to pony up $175 million to settle charges that it was engaged in a nationwide scheme to defraud Medicare with bogus cost reports. Health care attorneys warn, however, that Beverly won't be the last provider to be targeted.

Health care attorney **Marie Infante** of Pyles Powers Sutter & Verville in Washington, DC, says scores of providers are at risk based on the way the government built its case against Beverly.

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Spike in pneumonia coding settlements sparks concern

Hospitals hoping the government's pneumonia upcoding initiative had receded into the past should take no such solace. "There was a lull in the action for a good part of last year, but now we are seeing a reawakening in that area," asserts health care attorney **Greg Luce** of Jones Day in Washington, DC.

Luce says the current status of the government's overall pneumonia upcoding initiative, launched last year, is a mixed bag. "We have not seen very many coding investigations that we thought were particularly well-founded," he reports. But he adds that the sometimes "disproportionately large" settlements continue to roll in.

Two weeks ago, Columbia Regional Hospital in Kansas City, MO, agreed to pay $359,254 to settle charges that it improperly coded Medicare and Medicaid claims for pneumonia patients who were treated at the hospital between 1993 and 1996.

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the application of False Claims Act statutes is a very lucrative area.

California enacted its own *qui tam* false claims law in 1987, and Florida followed suit in 1994. Other jurisdictions whose false claims statutes have *qui tam* provisions now include Illinois, Nevada and the District of Columbia.

In addition, Texas, Louisiana, and Tennessee have *qui tam* laws dealing with health care false claims, and North Carolina has a health care False Claims Act modeled after the federal law but without a *qui tam* provision.

California and Florida have begun to generate significant recoveries. That may explain why Colorado, Missouri, New York, Washington, Pennsylvania and Massachusetts all have current *qui tam* laws pending and why false claims legislation was also introduced last year in Connecticut and Texas.

San Francisco health care attorney **Mark Kleiman** says this trend is likely to be self-perpetuating. "Typically, the attorneys general in various states will listen more closely to one another than they will to the Justice Department, and as increasing numbers of states begin to report positive experiences with their own false claims statutes, that gets the attention of people in other states," he says.

Kleiman notes that California just raked in close to $200 million under its statute. "I can tell you that when someone reports they put $200 million back in the coffers of state government, attorneys general in other states sit up and pay attention," he asserts.

But that is not the only factor, argues Kleiman. States themselves have been the targets of *qui tam* actions in the past, but if that threat is lifted, states will be increasingly comfortable with *qui tam* provisions, he explains. A Supreme Court decision that would give states just that protection is expected this spring.

Fabrikant points out that some of these proposed or existing laws include provisions that impose even greater liability than under the federal False Claims Act.

For example, the bill introduced in Colorado would require losing defendants to pay not only the relator's attorneys' fees but the state's legal bills, as well.

Similarly, while federal Stark self-referral rules have language that prohibits a provider from "knowingly and willfully" accepting or offering an inducement to procure referrals, the state false claims statute in California does not include that phrase.

"That means the state law in California is not a specific intent statute," Kleiman asserts. "We don't have to prove under state law that a doctor or hospital knew it was a kickback; all we have to show is that they did the act, and that is a much easier standard to prove."

That is not specific to the *qui tam* statute, but rather a piece of anti-kickback legislation imbedded in state law, Kleiman explains. However, it is the state False Claims Act that allows states to use that legislation, he adds. "Each state qui tam statute makes local state laws governing health care much more relevant in these situations," Kleinman says.

The take for whistleblowers also varies among states. In California, it is more generous than in Texas. Illinois mirrors the federal statute but Florida does not.

"There are little idiosynchracies in each of the individual state statutes," concludes Kleiman. "But the basic principle, which is that state governments have signed on to the idea of giving people who come forward an incentive, is the unifying thread." ■

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Pneumonia upcoding

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According to Assistant U.S. Attorney **Andrew Lay**, who negotiated the agreement for the government, the hospital routinely used diagnosis codes for a more complex form of pneumonia than was actually warranted.

Also last month, Lankenau Hospital in Wynwood, PA, and Methodist Hospital in Philadelphia, agreed to pay $303,000 and $103,000 respectively to settle charges that they improperly submitted claims for pneumonia due to "other specified bacteria" when medical records failed to support the diagnoses.

"The government's statistics tend to be less than reliable, and the changes in coding practices are not always attributable to a change in consultants or an effort to recoup reimbursement," Luce argues.

Instead, he says, those changes are often due to appropriate actions taken by hospitals such as a review of charge description masters or the purchase of coding software. Ironically, Luce says that is the very thing the government wants, for hospitals to code more accurately.

"The government's theory has been that sudden upcoding — such as changing DRG-89 to DRG-79 — can only be attributable to efforts at increased reimbursement without appropriate medical decision making, and that is just not true," argues Luce. The fact is that hospitals routinely downcoded to DRG-89, he counters, and it was only in about 1992 with the advent of Medicare payment changes that hospitals started focusing on how they were coding.

In short, Luce argues that the incidence of DRG-89 vs. DRG-79 prior to that period is not evidence of anything. "It would not even be admissible as evidence in a lot of courts because the fact that there was a change is subject to too many variables," he asserts.

Luce also challenges the government's notion that the use of consultants renders the increase in coding intensity suspect. "It should be just the opposite," he asserts. "If a hospital had a responsible coding consultant who advised them that [the data] indicate that it should be nonspecified pneumonia, then they should do that."

"I would always challenge the government's data and reviewers," Luce concludes. "We had a case where the government was relying on a reviewer that did not realize the difference in ICD-9 codes between bacterial and viral pneumonia — and that is pretty fundamental." ■

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"There are a lot of other facilities that are at risk based on this theory," she says. "There is apparently a whole wave of these coming in California."

According to the government, between 1992 and 1998 the Fort Smith, AK-based nursing home chain started improperly billing Medicare for the salaries of nurses by inflating the number of hours attributable to Medicare patients.

"Instead of recording the true time spent on Medicare patients, Beverly-California fabricated nursing cost figures based on set formulas designed to maximize profits while avoiding detection by Medicare auditors," according to the U.S. Attorney's office in the Northern District of California. "The phony cost figures were backed by false documents, such as phony sign-in sheets, that appeared to support Beverly's claims for payment."

Infante says it's the precision with which Beverly was collecting its information that came under fire. "When the government says Beverly 'falsified records,' it's saying estimates of time were not carried out with the degree of precision they want to see," she explains.

The attention of long-term care providers has recently shifted to prospective payment and enforcement, she notes.

"But there is lingering liability here," she cautions. "They must not forget that time and attention must still be paid to old cost reporting issues."

Moreover, she says there is considerable state activity on the Medicaid side to go back and examine Medicaid cost reports with a similar view for expenses that may have been inflated or items that were improperly allocated.

"Prosecutors have the upper hand on this right now," Infante says. "You can have a margin of error that is very small in terms of estimates and actual numbers, but patterns such as rounding up 50-minutes to an hour are probably enough to get you in a lot of trouble these days." ■

Integrated delivery systems pose compliance challenge

Simply by virtue of their sheer size and scope and the range of services they provide, integrated delivery systems (IDS) face unique compliance challenges. But **Dan Roach**, vice president and corporate compliance officer for Catholic Heath Care West (CHW) and former in-house counsel with Minneapolis-based Allina Health System, says systems can improve their overall compliance efforts through diligent attention to operational issues.

"While every hospital, lab, or doctor's office has a certain set of rules to follow, the typical IDS has a much broader set of rules," says Roach. Allina includes hospitals, physicians, managed care, home care and durable medical equipment. "That required me to have a broader understanding of what the laws and issues were, and some understanding of how they worked together," he says.

CHW is no different. That system includes 45 hospitals and 19 home care and hospice providers spread across three states, all with their own divisions and subsidiaries.

Here is a rundown of the operational areas that Roach says require special attention as an IDS establishes its compliance programs:

♦ **Systems and processes.** According to Roach, systems and processes will vary greatly within a large IDS. "Typically, you don't develop a system from the ground up," he says. "You develop it by acquiring different organizations and different entities, each bringing in their own culture, their own information system and their own way of doing things," he warns. "There is ambiguity and the application of the laws and rules in the IDS setting can be unclear at times."

Roach says there is often conflicting authority between licensing and regulatory authorities. For example, CHW had a hospital and clinic in one of its regions that was brought into the system after the clinic had become an outpatient department of the hospital. "From a legal perspective, the clinic is an outpatient department of the hospital, and that is how it is licensed," he explains. But when CHW tries to submit a claim to the Medicare carriers or managed care organizations using a hospital site service code, they often refused to pay it.

"Working through some of these issues is very difficult," says Roach. In some cases, an IDS will face a decision of either billing its claims consistent with the legal structure or billing them consistent with how carriers are actually paying claims. Of course, doing the latter can open the door to charges that an IDS has been falsely billing the Medicare program or managed care payers.

♦ **Organizational maturity.** The maturity of an IDS is another area that has great impact, according to Roach. At Allina, once his compliance program was developed and communicated, he expected that every business unit within the organization would implement it. "CHW is not as closely integrated, and I am not sure in many cases that things are getting implemented," he says.

There are several reasons why, he adds. First, there is a much broader span of control. Also, staff are much more independent and aren't sure what authority this guy from corporate has to tell them to do things.

♦ **Culture.** Culture includes how the corporate policy is developed, whether it's made at the regional or local level, and how it's implemented. It also includes an understanding of who is responsible, what the approval processes are and who must buy in. "My experience at Allina was that we needed corporate buy-in and we wanted input from the systems such as hospitals or clinics because we wanted to be sure we did it correctly," he says.

♦ **Control.** Control includes how a system implements decisions and who bears the financial consequences for those decisions. "There's a lot of financial pressure on hospitals and clinics, and it's not easy for many organizations and CEOs and CFOs to be saddled with demands from someone at the corporate office that will impact their bottom line," he warns. "On the other hand, you need to be constantly communicating to them that it is their hide that is on the line."

Roach says that during the more than 24 investigations he has been engaged in involving OIG or FBI, he has often been asked for specific information about the CFO or person in charge of the business unit. "They wanted information on their compensation structure, and on any bonus provisions and how bonuses were calculated," he says. "If you are having a hard time working with your CFO, remind them that there is nothing that the OIG or DOJ would like better than to throw one of them in jail." ■