Recent False Claims settlements, case developments and communications from the Office of Inspector General

July 1, 2014

Elizabethtown Hematology Oncology PLC to Pay $3.7 Million Settlement

Elizabethtown Hematology Oncology, PLC, and its owners (Elizabethtown) recently agreed with the United States Attorney's Office for the Western District of Kentucky to pay more than $3.7 million to resolve allegations that Elizabethtown violated the False Claims Act in at least two separate ways.

First, during the period from January 1, 2006, to December 31, 2012, Elizabethtown was alleged to have improperly extended the duration of patients' chemotherapy infusion treatments to bill government payors for the increased treatment time. Second, during the period January 1, 2005, through December 31, 2010, Elizabethtown was alleged to have billed for unnecessary office visits to evaluate patients prior to their receiving infusion services. The allegedly incorrect bills used an evaluation and management code with Modifier-25, used when an evaluation of the patient prior to each initiation of the infusion therapy is clinically necessary. The government contended that such evaluations were not necessary for each initiation of the infusion therapy.

The case against Elizabethtown was initially brought by a qui tam relator physician familiar with the details of the alleged conduct, who will earn more than $280,000 for his role as a whistleblower. The government later intervened in the whistleblower action. The case is somewhat unique in that the alleged false claims expressly included not only claims submitted to the Medicare and Medicaid programs, but also other government payor programs: TRICARE (covering uniformed service members and their families) and the Federal Employee Health Benefit Program (FEHBP). While Medicare and Medicaid are the most common government payors implicated in False Claims Act cases, the Act applies equally to all government payors.

Providers should note that the case, at its base, involves neither purely illusory services nor services rendered to fictitious patients. It rather involves the extension of actual services rendered and the improper inclusion of additional services to the care rendered. While the infusion services rendered may have been of extra-long duration or involved the more frequent evaluation and management services provided by Elizabethtown, the government alleged that these patients didn't require such additional services.

King's Daughters Medical Center to Pay Nearly $41M for False Claims Act and Stark Law Settlement

Ashland Hospital Corporation d/b/a King's Daughters Medical Center (KDMC) has recently entered into a settlement with the Department of Justice to pay $40.9 million to resolve allegations that it violated both the False Claims Act and the Stark Law. Of this settlement, the state of Kentucky will receive more than $1 million as its share of the recovered state Medicaid funds.

The government alleged two types of conduct that violated the False Claims Act. First, the government claimed that between 2006 and 2011, KDMC billed for numerous unnecessary coronary stents and diagnostic catheterizations performed by KDMC physicians on Medicare and Medicaid patients. Included in this allegation were claims that the physicians falsified medical records in order to justify these unnecessary procedures. Second, the government alleged that KDMC violated the Stark Law by paying cardiologists unreasonably high salaries that were in excess of fair market value.

While the alleged violations of the False Claims Act involve the falsification of the records and the billing of fictitious claims, which all providers should know constitutes impermissible activity, the alleged Stark Law violations are somewhat subtler. No other technical Stark Law violations e.g., unsigned agreements, etc., were asserted by the government other than the payment of salaries above fair market value. This settlement shows that the government is actively evaluating the claims of providers regarding the fair market value compliance of the payments they make to physicians under agreements that are otherwise compliant with the Stark Law. Such arguments by the government have been more in evidence since the Tuomey case found excessive physician compensation even in the presence of supporting third-party fair market value opinions. Providers should continue to ensure that all of their agreements comply with the technical Stark Law requirements and that they are truly for fair market value.

Government Files Complaint Against Hospitalist Company Alleging Violations of the False Claims Act

On June 14, 2014, the OIG announced that the government had filed a complaint in the Northern District of Illinois against IPC The Hospitalist Company, Inc. and its subsidiaries (collectively IPC) alleging violations of the False Claims Act for systematically overbilling (i.e., upcoding) for hospital evaluation and management services. The government had previously stated its intention in December 2013 to intervene in the private qui tam whistleblower action that was brought against IPC, which is one of the largest hospitalist companies in the county, employing more than 2,500 health care providers located in more than 1,300 facilities across the country. The original whistleblower was an IPC physician in San Antonio from 2003 through 2008.

The government asserts that IPC pressured its physicians to always bill at the highest level regardless of the level of service actually provided, and that there was pressure for physicians with low billings to "catch up" to their higher billing co-workers through more aggressive up-coding. The government also asserts that, even if there was no overt pressure from IPC toward its physicians to upcode, because IPC was so closely monitoring the billings of its physicians, IPC would have known that the billing patterns of its physicians were dramatically skewed toward the highest-intensity codes, far in excess of normally expected levels. IPC therefore, the government claims, either did know or should have known that its physicians' billing patterns were inauthentic and that they could not be performing the services for which they were seeking reimbursement, due to the lack of consistency with normal billing intensity levels.

While this case has not progressed beyond the complaint stage yet, there are lessons to providers in the government's allegations. The government's argument makes two main points: 1) that IPC was expressly encouraging improper upcoding by its practitioners; and 2) that even if IPC wasn't actively encouraging or requiring the upcoding, it should have known that something was wrong with the billing because of the elevation of the billing levels over what would be considered normal. The government is ascribing responsibility to IPC to self-police its claims submission data for unusual billing patterns, and stating that failure to do so could ascribe liability for false claims submission to IPC under the "should have known" standard of the False Claims Act.

Providers should never impose any overt or implied requirements of upcoding on their practitioners, and should continue to monitor the billing trends and comparative levels of their physicians, raising questions and actively intervening where levels are significantly out of line with normal expectations.

OIG Releases Special Fraud Alert Regarding Physician-Clinical Laboratory Compensation Arrangements

On June 25, 2014, the Office of Inspector General (OIG) released a Special Fraud Alert regarding compensation paid by clinical laboratories to physicians who refer testing work to the laboratories. The OIG has always had concerns that the compensation clinical laboratories pay physicians for business referrals could run afoul of the Anti-Kickback Statue, but in its June 25, 2014, Special Fraud Alert, the OIG specifically identifies two trends in physician compensation that it finds particularly worrisome, and which it believes could induce physicians to order unnecessary tests, direct referrals for other than patient care factors, and engage in unfair competition.

The first type of arrangement with which the OIG is concerned is the payment by laboratories of specimen collection fees to physicians. Laboratories will often pay a per-specimen fee to physicians, either directly or indirectly, to collect, process, and

package patients' blood specimens. The OIG is concerned because sometimes Medicare already includes in its bundled payment for the laboratory service a processing and packaging fee to the physician. When a laboratory pays a physician for work that is already compensated by a government payor, the OIG sees the likelihood of improper intent increase for the payment. The theory is that the laboratory is paying an extra fee to the physician for already-compensated work in order to induce the physician to send the testing work to the laboratory in question.

The second type of arrangement of concern to the OIG is the payment by laboratories of a registry fee to physicians. In exchange for the fee, physicians must, for example, submit patient data to the registry, answer patient questions about the registry, and review registry reports. While the OIG believes that these tasks may be appropriate in certain circumstances, the danger is that physicians may be influenced to order medically unnecessary or duplicate tests and refer the testing business to laboratories that require (and compensate the physician for) registry arrangements.

Providers should examine any laboratory relationships to which they are a party and/or scrutinize individual laboratory relationships or referral patterns their employed physicians maintain to determine if there are any circumstances that might be in line for higher scrutiny from the OIG as a result of the recent Special Fraud Alert. The OIG specifically states that carving out federal health program business from these relationships does not eliminate its concern that such arrangements as those discussed above are being used by laboratories to influence physician referrals.

Authors