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As the Economy Sours Health Care Providers Will Become More Vulnerable to False Claim Act Lawsuits

by Brian McCaffrey, Esq.

After living off the largesse of a steady stream of growing tax revenues for the last several years, Federal and State governments and some insurance companies are reacting to the current economic crisis by looking for someone to make up their losses.

If you are a Health Care provider, standby to now be characterized by the government as part of the Health Care "Industry" and the government will be looking at you to become a revenue provider under the ruse of making healthcare more affordable to the consumer. One of the tools that they will employ will be stepping up lucrative suits against Health Care Providers under the state and federal FALSE CLAIMS ACTs ("FCA"). These acts have both civil and criminal and administrative consequences for health care institutions and their employees and having an adverse result can have a devastating effect on one's professional practice. A recent amendment to federal law has given state governments an incentive to get into the act, and they are jumping in with both feet.

A perfect example is the recent FCA settlement by Staten Island University Hospital ("SIUH") totaling $89 million dollars which is serving as a wake up call to health care institutions and practitioners throughout the country to assess their vulnerability to these suits.

The US Justice Department has labeled this as one of the largest civil fraud recoveries ever against a single U.S. hospital. The federal and state government claimed that the hospital defrauded Medicare, Medicaid, and the military's healthcare program, TRICARE.

Significantly, the state took an active role in the case that also involved state MEDICAID funds.

In the past, these suits were usually brought by the US Department of Justice which preferred to dedicate its resources to the war on terror, drugs, and organized crime.

Now, however, a 2007 amendment to federal law gives the states an extra financial incentive to get involved. Additionally private suits (known as QUI TAM actions) can be initiated secretly under seal by individuals who claim to have knowledge acts of fraud. As an extra incentive to bring these suits, the Deficit Reduction Act of 2005 requires certain healthcare providers to provide education on federal and state false claims acts, the Program Fraud Civil Remedies Act, other relevant state and federal laws, and whistleblower protections to their employees, contractors, and agents and to post notices so individuals are aware of the financial awards they can receive by participating in a FCA suit.

Classic examples of suspected fraud that these required notices urge people to report are:

- Billing for medical services not actually performed.
- Providing unnecessary services.
- Billing for more expensive services.
- Billing for services separately that should legitimately be one billing.
- Billing more than once for the same medical service.
- Dispensing generic drugs but billing for brand-name drugs.
- Giving or accepting something of value (cash, gifts, services) in return for medical services, i. e., kickbacks.

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● Falsifying cost reports.
Or when someone:
● Lies about their eligibility
● Lies about their medical condition
● Forges prescriptions
● Loans their eligibility card to others
Or when a health care provider falsely charges for:
● Missed appointments
● Unnecessary medical tests
● Telephoned services

Thus malpractice suits, complaints by patients to your office or professional boards, complaints by disgruntled employees or terminated employees can signal the beginning of a FCA suit. The SIUH case contained QUI TAM Actions that were brought by a malpractice claimant, unhappy patient or a disgruntled employee. The New York State version of the FCA provides incentives for potential FCA defendants to reduce their individual exposure by informing on their institutions, themselves, and their coworkers.

Although these actions usually allege acts of a fraud as an attempt to improperly obtain funds from Medicare, Medicaid, Tricare and in some instances private insurance, provider liability under the FCA usually results from mistakes in supplying billing codes and inadequate documentation which supports medical care given or prescribed when the provider seeks reimbursement. Self referrals and issues regarding prescriptions for and sales of durable medical equipment ("DME") are another easy target for the government and qui tam Plaintiffs.

Information about some of these issues and the relevant state and federal laws can be found at the New York State Office of the Medicaid Inspector General's website at: http://www.omig.state.ny.us/data/view/81/65/

The providers usually first learn that they may be the target of these actions by an inquiry letter from the US Attorney General's Medicare Fraud Unit or the State Attorney General's Medicaid Fraud Unit. Although the letter appears as a harmless attempt to gather information, experience has shown otherwise, and the first thing to do at that stage is to contact counsel.

The best defense is to already have a proven compliance program in place to help ensure against the occurrence of Medicare/Medicaid Fraud before you get the letter.

Part two of this article in the next issue of this newsletter will discuss what to do when the letter comes and the kind of compliance program (if there isn't one in place already) should be put in place as soon as possible.

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