

The Practical Essentials of the False Claims Act

2 Easy Pieces

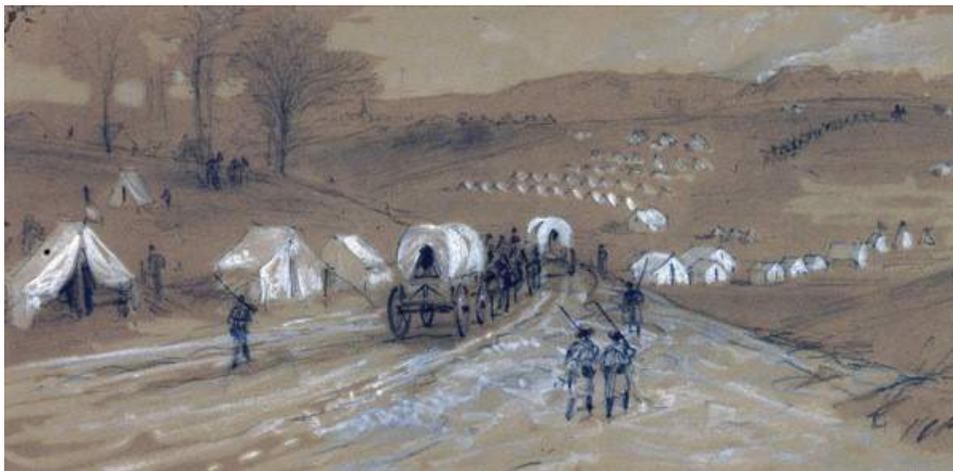
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As prevalent as ads for financial services in the Wall Street Journal, or “made in China” printed on the bottom of nearly everything in your house, health care is bathed in the sound of whistleblowing: whistleblowing as in the FCA, the federal False Claims Act.

On a near-weekly, and some weeks near-daily, basis, the sound of FCA queries—both for strategies to prophylactically defend against it, as well as for assistance in asserting claims under it—ring through to my phone.

And yet, to many, it’s a mystery. “Can an unintentional error drain our group’s bank account?” Yes. “Are there actionable steps that we can take to insulate ourselves against liability?” Yes. “Can I make \$7.2 million as a whistleblower?” Yes.

In this article, we look at the FCA from two vantage points: that of an anesthesia group leader wishing to stay as far away from it as possible, and that of an individual anesthesiologist or CRNA wishing to make “whistleblower” their, well, new middle name.



Supply wagons entering Union Army encampment near Falmouth, Va.

However, note that group leaders wishing to ward off FCA attacks “and” individuals who believe that they might have information to support FCA claims will equally benefit from understanding the FCA from the other’s vantage point.

But to begin, we first have to take a slight detour and learn what the FCA is and what it’s all about. To do that, we have to take a step back in time.

The Birth of the FCA, or a Brief History of the Civil War

It's 1862. The Civil War is raging: the Battle of Oak Grove, the Battle of Savage's Station, the Second Battle of Bull Run.

Back in Washington, D.C., a different sort of war is raging. The U.S. government is buying supplies for the Union Army: rifles, blankets and rations. But to the government's chagrin, its bureaucrats are battling unscrupulous defense contractors engaged in the 1860's version of "upcoding": They're selling crates of sawdust used to pack rifles as crates of rifles themselves; they're selling moth-eaten blankets; they're selling putrid rations.

It soon became apparent that relying solely on criminal law to rein in the scofflaws wasn't effective enough. As a result, in an echo of British laws from as early as the seventh century, President Lincoln advocated for, and Congress began to take action on, a law that would help ferret out fraud: the FCA.

The act's sponsor, Sen. Jacob Howard of Michigan, said he based the law's qui tam provision—that is, the provision that allows a private individual to file suit on behalf of the government and to receive a percentage-based reward —“upon the old-fashioned idea of holding out a temptation, and ‘setting a rogue to catch a rogue,’ which is the safest and most expeditious way I have ever discovered of bringing rogues to justice.”

On March 2, 1863, Congress passed the original version of the FCA. It not only imposed fines based on a multiplier, then two times, of each false, that is, fraudulent claim for payment from the federal government, but it also imposed a \$2,000-per-claim fine. And, as was Mr. Howard's intention, it contained qui tam provisions that allowed private citizens to file FCA lawsuits on behalf of the government and to share in the proceeds of a settlement or judgment.

The FCA has been amended several times over the ensuing years. The multiplier is now three times the amount of the claim. For example, a \$100 false claim results in a \$300 obligation to the government. And, as of 2019, the penalty per false claim is a minimum of \$11,463 and a maximum of \$22,927.

So that \$100 false claim becomes \$300 plus up to \$22,927. And, yes, if a group made 1,000 of those \$100 false claims, the obligation to the government turns into $\$100,000 \times 3$, plus $\$22,927 \times 1,000$, or \$23,227,000. The usual bounty to the whistleblower is in the range of 15% to 25%. You can do the rest of the math yourself, but the real point is that you don't have to do the rest of the math in order to understand the law's impact.

Historically, false claims were often rooted in the delivery of nonconforming goods pursuant to government contracts, an extension of the moth-eaten blanket problem from the Civil War. But, importantly for health care providers, over the decades of revisions to the FCA, the notion of what a false claim is has broadened significantly. As a result, today most false claims allegations relate to health care.

One area of particular concern to anesthesia groups, whose providers can generate tens of thousands of claims per year, is that the law now deems claims submitted in violation of the federal Anti-Kickback Statute (AKS) as false claims for purposes of the FCA.

For example, claims by both an anesthesia group and ambulatory surgery center (ASC) participating in a company model scheme that violates the AKS can result in thousands of claims to federally funded health care programs deemed as false claims.

Of particular importance to anesthesia groups is the 1986 amendment that included the notion of a “reverse false claim.” A reverse false claims situation is centered on the avoidance of an obligation to pay money or return property to the government: for example, being paid twice and then not repaying the overpaid amount.

Lastly, note that FCA cases arise from two different major sources: whistleblowers who bring FCA cases on behalf of the government, as discussed in detail below, and by the government of its own accord, whether in lieu of criminal action—because of the lower burden of proof plus treble damages, plus statutory penalties—or in addition to it.

The First Easy Piece: From the Group Leader Perspective—Steps to Avoid Liability

In this first of the two “easy pieces,” let’s look at some of the many steps that your anesthesia group might take to protect itself against FCA allegations or, if allegations are made, against increased FCA liability.

Start With the Obvious

Because many FCA allegations center on what was, or wasn’t, actually done versus what was billed for, it’s essential that your group requires that all of its providers create well-documented anesthesia records.

Although you may think that this is obvious—I can tell you that it’s not—don’t alter anesthesia records.

Incomplete, unclear and, especially, altered records are rocket fuel for FCA actions. Even if all is on the up-and-up, they are easily “sold” as damaging evidence.

In addition to factually incorrect claims (i.e., the original notion of a false claim), the other hotbed for potential FCA actions against anesthesia groups results from violations of the AKS. Real-life anesthesia group examples include groups that accept rentfree space from hospitals for pain clinic operations and groups that incentivize ASCs by paying “rent” for storage space inside the ASC.

The key in connection with avoiding AKS-related FCA violations—and the criminal penalties of the kickback violations themselves—is to carefully vet every deal. Remember that expression in carpentry, “measure twice, cut once”? Cultivate the same expression in terms of health care deals: “Check compliance issues twice, then do the deal.”

Have an Actual Compliance Program

This is a real no-brainer, right? Well, maybe not, because I said compliance “program,” not compliance “plan.” A plan is nice, but it isn’t what’s needed; it’s actual compliance, which seems to be in shorter supply.

In fact, simply having a compliance plan filed away in some blue binder sitting on your shelf seduces you into the mistaken belief that the plan is somehow the same thing as compliance, just like some people think that a map is an accurate depiction of reality and then get mad at reality when it doesn’t match the map.

So start with assessing the current state of compliance, determining a baseline, so to speak. And yes, even move on to creating that compliance plan. But you still need to keep on moving, to check and audit and educate, and to plug the gaps when you find them.

As trite as it sounds, the best way to avoid FCA liability is not to make a false claim. An active compliance program is the best method of prevention short of not submitting any claims.

Correction

This step is closely related to the first, but it deserves specific attention.

Included within the concept of your active compliance program is an active system of internal audits and reviews. And inextricably linked to those inwardly focused investigations is the notion of actively correcting discovered lapses.

Correction is multifold. Of course, it's correcting whatever lapse resulted in the claims errors, for example, miscoding or outright fraud (e.g., purposefully overstated anesthesia time). That correction might be systemic, or it might be by way of termination of the rogue provider.

Correction often includes repayment of improperly paid claims. There are multiple methods for this, and the issue of selecting the correct one turns on several factors and specific legal advice. However, consider that returning one time of each false claim is cheaper than returning three times plus \$22,947 per claim.

There's another strategic reason for correction. It can be used as part of a strategy of shifting the onus to the rogue provider and away from the group.

Don't Create a Whistleblower

As much as it behooves one to avoid FCA liability, even simply an FCA attack, some anesthesia groups actually create their own whistleblowers.

They ignore employees, subcontractors or even partners who come to the group with complaints related to billing irregularities, questionable business arrangements and so on. In doing so, they squander an opportunity to investigate and correct, and morph an early warning into an ignored insider who becomes determined to alert a higher authority or to assert an FCA claim.

Even worse, others kill the messenger: They reprimand/retaliate or even terminate the complaining physician, CRNA or staff member. That's not only "not" a solution; it increases the odds that the employee or subcontractor will go the Feds or seek counsel to file an FCA lawsuit. That's because, in addition to providing a tool to fight false claims themselves, the FCA creates a right of civil action—with multiple damages, special damages, attorneys' fees and more—for any employee, contractor or agent who's discharged, demoted, suspended, threatened, harassed or in any other manner discriminated against due to efforts to stop FCA violations.

The Second Easy Piece: From the Individual Perspective—Profit From Combating Fraud

As mentioned above, the sponsors of the original FCA legislation understood that simply permitting federal prosecutors to bring FCA suits was not enough. The object, after all, was to amplify the existing deterrent of criminal action against Civil War fraudsters. The brilliant solution was to reach back centuries into history: incorporating "qui tam" provisions.

The Latin phrase qui tam is shorthand for "qui tam pro domino rege quam pro se ipso in hac parte sequitur," which roughly means "[he] who sues in this matter for the king as well as for himself." Although there were Roman antecedents, the "modern" ancestor of the FCA's qui tam provision can be traced back to 656 when King Wihtred of Kent issued a decree that gave whistleblowers half a criminal's fine.

To cut to the bottom line, the FCA pays a percentage bounty to whistleblowers, ranging roughly from 15% to 25% of the government's recovery, whether that recovery is by way of settlement or judgment.

What Has to Be Proved

The elements of an FCA case—in other words, the requirements that must be alleged and proved—are that the defendant submitted a claim to the government, that the claim was false, that the defendant knew that the claim was false, and that the claim caused the government to pay.

Because of the way in which different appellate courts have construed the pleading requirements, the extent of the particular facts that must be pleaded varies. In general terms, the person bringing the claims, called the “relator,” must state with particularity the circumstances constituting fraud. In other words, the relator must plead the “who, what, when, where and how” and its false or misleading nature.

That said, there are different types of false claims. Among them are claims that are obviously false on their face, and those that result from false certification.

An example of an obviously false claim would be one for services that were never actually provided, such as a surgery center billing for surgeries that were never performed.

False certification claims are of two basic subtypes: those in which the certification is express, and those in which the certification is implied.

For example, claims submitted in connection with underlying violations of the AKS or Stark law are false claims because compliance with those laws is expressly certified when presenting the claim.

Implied false certifications arise when the defendant makes representations about the services provided but knowingly fails to disclose noncompliance with a statutory, regulatory or contractual requirement, an omission that renders the defendant’s representations misleading. An example would be claims for physical therapy in which the treatment was actually rendered by unsupervised and unqualified individuals.

Unique Process—Filing Under Seal

Unlike the litigation process of general civil lawsuits, in which pleadings are public and the defendants are usually served with a copy of the summons and complaint shortly after filing, FCA cases are filed under seal. In other words, the public and, particularly, the defendant don’t immediately receive notice of the case.

Although neither the public nor the defendant is notified, the Department of Justice is. The Department of Justice investigates the claim, often in concert with the Office of Inspector General, the FBI and other law enforcement agencies.

The purpose of the seal, which lasts at least 60 days and often longer, is to allow time for the government to investigate the claim. If the defendant were notified immediately, as in a normal lawsuit, it would hamper the government’s investigation.

Upon vetting the claim, the Department of Justice determines whether or not to intervene, that is, take over, in the prosecution of the case. If it does take over the prosecution, then the relator’s bounty is a lower percentage. On the other hand, if the government chooses not to intervene, then the relator is free to continue the prosecution of the case. If the relator does proceed, then any sums received in settlement, which must be approved by the government, or by way of judgment, go to the government, but the relator generally receives a larger percentage award than in intervention cases.

Although intervention by the Department of Justice signals that it believes the relator's case is strong and there is likely liability, its failure to intervene does not necessarily mean that the relator should abandon prosecution of his or her claims.

Health Care: The Hot Area for FCA Claims

In 2017, the Department of Justice recovered \$3.7 billion via the FCA, of which \$2.4 billion came from health care industry cases.

FCA hot spots in health care include claims related to:

- medical direction; unbundling;
- services by unqualified personnel; the failure to
- report and return overpayments; false
- certification of medical necessity; duplicate
- billing; underlying violations of the Stark law; and
- underlying violations of the AKS.
- Anesthesiologists and CRNAs are particularly perched to discover group as well as facility (both hospital and ASC) FCA
- shenanigans. Here are some examples of relatively recent FCA actions:

A \$3.2 million FCA settlement based on claims of an uncompensated medical director provided to an ASC by an anesthesia company.

A \$21,750,000 FCA settlement by a county hospital based on underlying Stark and AKS allegations that it paid referring physicians—including ER physicians, cardiologists, gastroenterologists and urologists, among others— compensation in excess of fair market value. The whistleblowers, competing physicians, received \$5,981,250 from the recovery.

An \$8.5 million settlement by a hospital of claims that it entered into financial relationships with referring physicians in violation of the AKS and Stark law, one of which was a pain medicine joint venture.

A \$260 million settlement by a hospital system based on claims that it billed government health care programs for inpatient services that should have been billed as outpatient or observation services, paid remuneration to physicians in return for patient referrals, and submitted inflated claims for emergency department facility fees. The allegations resolved by the settlement were originally brought in eight whistleblower lawsuits filed under the FCA. One whistleblower received approximately \$15 million as a share of the recovery, two others shared approximately \$12.4 million, with the remaining whistleblower shares to be determined.

Conclusion

Depending on the seat you occupy—anesthesia group leader out to protect the group or anesthesiologist or CRNA with knowledge of impropriety—the FCA has Shakespearean overtones: It's either a tragedy to be avoided or a comedy of sorts to be crushed. Either way, it's a powerful tool in fighting fraud against the government.

The challenge for anesthesia group leaders centers on minimizing the chance that the tool will be used against you. As in any sort of fraud prevention, education, diligence, review and correction are key. The object, of course, is not only to avoid having to repay the government but to avoid having to repay three times that amount plus tens of thousands of dollars more per claim. Even mounting a strong defense could cost you a million dollars or more.

That same incentive applies in the reverse for potential whistleblowers. The bounty paid in an FCA case has gone as high as an estimated \$250 million—the defendant, GlaxoSmithKline, paid \$3 billion to settle—although the average award is much lower but still substantial. As was intended upon the FCA’s passage in 1863, the act’s qui tam provision provides massive motivation to ferret out fraud.

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