

HEALTH CARE FRAUD: NEW SHERIFF IN TOWN

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With a 1993 cost of \$146 billion, Medicare is the largest single payer for health care in this country. Thirty-five million beneficiaries are covered and 700 million claims are processed.

The General Accounting Office has estimated that health care fraud costs roughly ten percent of the total cost of health care provided in the United States. For the Medicare program alone, that is \$14.6 billion. It is no wonder that the Department of Justice has made health fraud its number two priority, immediately after violent crime. The GAO also found that "certain characteristics of the program and the way it is administered create a climate ripe for abuse." The program does not "adequately check claims to prevent inappropriate payments," and controls to detect billing abuse are limited.

The cost of health fraud and the problems with its detection has not escaped the notice of Congress. The House version of the Medicare reform bill contains a provision that provides direct spending for Medicare-related activities of the HHS IG. The bill allows the IG to be allocated \$130 million in fiscal 1996, increasing to \$204 million in 1998, with appropriate increases thereafter. One government official indicated that such funding would allow a field office in each state.

In addition, the House version of the reform bill would repeal the anti-kickback statute and replace it with an all payer anti-kickback statute. The Senate version of the bill does not extend the anti-kickback provisions and does not provide for the IG special funding. As of this writing, the parties expect a final vote by Thanksgiving.

What does all mean special interest in health care fraud mean for hospitals and other healthcare providers? A major source of detecting fraud is rapidly becoming disgruntled employees, competitors and physicians. Using the Federal False Claims Act, they can gain as much as 30 percent of the government's total recovery and will receive no less than 15 percent if the government recovers. The number of cases filed under the False Claims Act has shown a steady increase from 32 cases in 1987 to 220 in 1994. Even more significant, total recoveries have grown from \$200,000 in 1987 to \$378 million in 1994. Approximately one-fourth of these cases involve claims under the Medicare or Medicaid programs.

The False Claims Act, 31 U.S.C. §§ 3729-32, provides that any person who knowingly submits a false or fraudulent claim to the United States Government for payment or approval is liable to the Government for a civil penalty of not less than \$5,000 and not more than \$10,000 for each such claim, plus three times the amount of the damages sustained by the Government because of the false claim. The Act allows any person having knowledge of a fraud or fraudulent claim

against the Government to bring an action in federal district court for himself and for the United States Government, called a *Qui Tam* action, and to share in any recovery.

The U.S. District for the Southern District of Ohio, in *U.S. ex rel Roy v. Anthony*, held that there is at least a tenuous relationship between the anti-kickback statute and the False Claims Act. However, in *U.S. ex rel Pogue v. American Healthcorp Inc.*, the U.S. District Court for the Middle District of Tennessee held that in order to prevail in a *Qui Tam* action, the plaintiff must establish four things: that a claim for payment was presented to the federal government by the defendants; the claim was false or fraudulent; the defendants knew that the claim was false or fraudulent; and the government suffered damages as the result of the false or fraudulent claim. The court held: "Even if the defendants submitted the claims in knowing violation of the anti-kickback and self referral statutes, that would not render the claims themselves false." In addition, the plaintiff did not prove that the government was damaged by the submission of the claims.

This Tennessee case aside, healthcare providers are extremely vulnerable to actions brought under the False Claims Act, particularly those brought by employees, former employees and disgruntled physicians. A federal case in the Eastern District of Kentucky demonstrates how vulnerable a health care provider can be. The case, *Brooks v. Pineville Community Hospital, et al.*, is very pertinent to hospitals and members of their medical staff. In April 1995, the Pineville Community Hospital in Pineville, Kentucky settled a Federal False Claims Act lawsuit for \$3.1 million, including damages for retaliation against the relator, attorneys' fees and a contribution to the Kentucky Medicaid program. The lawsuit was brought on behalf of the federal government by a member of the hospital's medical staff, Dr. Hilton Brooks, and alleged that the hospital and two members of the hospital's medical staff were engaged in activity that extended over a number of years and resulted in claims under the Medicare, Medicaid and other federal programs being submitted that violated federal regulations. After three years of attempting to work within the normal channels to correct the situation, with the hospital's response the attempted removal of his privileges, Dr. Brooks brought this case. Mr. Copeland and Mr. Markovits were lead counsel for Dr. Brooks.

The case was the subject of a feature article in the August 7, 1995 issue of *Medical Economics*, and the article gives an excellent overview of the circumstances surrounding the case. A copy is attached for the readers' information.

The Pineville case is dramatic evidence that hospitals need to be ever vigilant about how physicians practice medicine in the hospital, how medical records are completed, and about the billing process. Hospital management must also pay close attention to how medical staff and employee complaints are handled, and must make doubly sure that the peer review process is not used for inappropriate purposes.

The Pineville case is also adequate testimony to the need for a compliance program to ensure that such activities do not happen, or if they do, that they will be uncovered and stopped immediately.

One can never be certain that a disgruntled physician or employee, or one, such as Dr. Brooks, who is simply ignored or dismissed, will not bring an action against the hospital and the physicians involved. After all, the relator, the plaintiff in the case, shares in a substantial way in the government's recovery.

Following is a brief overview of the False Claims Act and its provisions.

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