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## OSN COMPLIANCE and the Law

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COMPLIANCE and the Law brings you valuable information on billing and coding regulations.

### Government enforcement of health care fraud increasingly aggressive

Power of the False Claims Act illustrates how errors by health care providers may cause unanticipated liability.

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I have been writing about health care compliance issues for many years, but never have I written about a managed care case. And before you turn the page to look for something relevant to your practice, I urge you to be patient and read on. Although this article involves a managed care company, it really is about the extraordinary reach of government enforcement and how missteps by health care providers may generate unanticipated liability. It is a lesson that applies to everyone.

For years, health care enforcement has been driven by the extraordinary power of the False Claims Act. A violation of the act triggers liability of three times the amount of damages, plus a penalty of \$5,500 to \$11,000 per claim. Although early False Claims Act cases

focused on prosecuting providers for submitting claims that were false, such as upcoding, billing for a non-covered service as if it were a covered service or billing for a service not performed at all, government theories of liability under the statute have expanded dramatically. For example, in the early 1990s, laboratories were pursued under the False Claims Act, not because they submitted false claims, but because they influenced physicians to order tests that were not medically necessary, thereby causing a false claim to be submitted.

Violations of the anti-kickback statute, it is argued, also generate false claims because if the government knew that the service was the product of an inappropriate referral, it would not have paid for that service. That theory has not been adopted by every court, but in most cases, that is the rule.

Another theory that has been the subject of several lawsuits arises from the failure of a hospital or other institutional provider to comply with the Medicare conditions of participation. Here, the argument goes, if an entity does not comply with those standards, it is not entitled to be paid for services rendered, and therefore, the claims submitted for services rendered are false. Thankfully, most courts have rejected this theory, but several cases continue to promote it.

More recently, the pharmaceutical industry has been besieged with investigations relating to the promotion of off-label uses. In these cases, if an off-label use is not covered by a particular payor, the promotion of an off-label use causes a false claim to be submitted, thereby triggering False Claims Act liability for the pharmaceutical company. The fact that a physician may make an independent, professional judgment to prescribe a particular drug for an off-label use apparently does not matter.

## Amerigroup case

But the recent False Claims Act case of Amerigroup Inc., which settled with the federal government for \$225 million, takes the prize for aggressive government enforcement theories, at least in my view. Amerigroup is a Medicaid managed care company that arranges for the provision of health care services to patients enrolled in Medicaid. It is paid on a fixed, capitated rate, based on the number of patients enrolled in its plan. Amerigroup does not submit claims. Among the many requirements to which it must adhere, it is forbidden from discriminating against patients for any reason, including health status. In fact, there are federal regulations that provide for prescribed penalties if these anti-discrimination provisions are violated.

In a False Claims Act case filed in Illinois, it was alleged that Amerigroup and its subsidiary, Amerigroup Illinois, discriminated in its enrollment against women in their third trimester of pregnancy, presumably because the cost of providing services to these patients was higher than the cost of providing services to other patients. Although the company disputed the allegations, the major focus of its argument was that even if the allegations were true, the appropriate remedy was a penalty for each incident of alleged discrimination. Certainly, there was no basis to pursue this case under a False Claims Act theory. After all, the company did not file any claims.

Despite this apparently logical position, the court disagreed and allowed the suit to go forward. A jury found that

the company had, indeed, discriminated against patients, and then confronted the question of damages. Based on the judge's instruction, the jury used the number of patients enrolled in the Amerigroup plan to serve as the number of false "claims" submitted, and then calculated the damages, as well as the penalties. Because there were more than 18,000 enrollees during the period in question, when the total liability was calculated, the judgment was in excess of \$334 million. Amerigroup filed an appeal, but before the question of whether this theory could survive a challenge, Amerigroup entered into negotiations with the government and eventually settled for \$225 million.


## Illogical conclusion

A close review of the damages calculation in this case reveals how remarkable enforcement theories have become. The 18,000 enrollees represented the number of patients who had been enrolled in the Amerigroup program. Yet, the allegation was that Amerigroup discriminated against certain individuals, ie, prevented patients from enrolling in its plan. And while the only "victims" of Amerigroup's discrimination were individuals who were not able to enroll, the damages were calculated on the basis of those individuals who did enroll.

Looking at it another way, if Amerigroup had been more compliant and enrolled more Medicaid subscribers, the damages calculation would have been even greater. This is not simply counter-intuitive, it is totally illogical. This case never should have been brought under the False Claims Act; it should have

been pursued under a civil penalty theory, and the penalty should have been based on the number of patients against whom Amerigroup had discriminated, not the number it enrolled.

This presents two obvious questions. First, why did Amerigroup not continue to fight this case but instead decide to settle for such a large amount? My assessment is that the company recognized that regardless how illogical the result, there was no assurance that it would succeed on appeal, despite what seemed to be a clear error at the trial court level. Furthermore, no doubt this case and the uncertainty surrounding it were creating difficulties for the company's operations.

For the second question, I return to the beginning of the article: Why is this relevant to you? The relevance lies with the harsh reality that as government enforcement continues to become more aggressive and more creative, operating your practice or facility in a fully compliant manner becomes more and more critical. Although it is appropriate to continue to focus attention on proper billing and coding, in this highly regulated industry, physicians, suppliers and institutional providers must focus their compliance efforts to all aspects of their operation. Failure to meet those regulatory requirements could have unanticipated consequences. 

## For more information:

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