# PUBLICATION

## Justice Department Lawsuit Reveals Roadmap to Avoid False Claims Act Liability [Ober|Kaler]

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**Earlier this month, the Justice Department filed a lawsuit against Vitas Hospice Services, LLC, and related entities, alleging that Vitas fraudulently billed the Medicare program in violation of the False Claims Act (FCA).**

Although the lawsuit involves hospice services, the government's allegations provide general lessons for any health care provider regarding the types of activity that draw the government's attention. More importantly, the lawsuit reveals a roadmap that any health care provider could follow to reduce its risk of liability under the FCA.

## The Government's Allegations

The government alleged that the Medicare program pays for hospice services provided to eligible Medicare beneficiaries. A beneficiary is eligible for hospice services if he or she is "terminally ill," i.e., "has a medical prognosis of six months or less if the individual's illness runs its normal course." This prognosis must be supported by a physician certification and the beneficiary's medical records.

Medicare pays for hospice services on a per diem basis. There are four levels of per diem payment depending on the intensity of care provided. The lowest level of payment is for "routine care," while the highest level of payment is for "crisis care." The government further alleged that Medicare paid significantly more for crisis care than for routine care.

According to the government, Vitas overbilled Medicare for crisis care services with knowledge that such payment claims were false because the patients did not need crisis care, but rather, should have received routine care paid at the lower per diem rate. In addition, the government alleged, some patients did not qualify for any level of hospice care because they did not have a life expectancy of six months or less. Moreover, the government alleged that publicly available data demonstrated that Vitas was billing Medicare for substantially more crisis care as compared to its peers.

The government also alleged that Vitas engaged in "aggressive marketing tactics" to increase its volume of crisis care that was billed to Medicare, without disclosing the Medicare eligibility criteria for crisis care. In addition, the government asserted that internal Vitas emails demonstrated management's attempt to pressure clinical staff to increase crisis care utilization, without regard to patients' eligibility for that level of care. Vitas allegedly applied such pressure by setting aggressive patient admission goals and tying employee compensation to achieving those goals. Vitas management allegedly monitored patient admissions and discharges closely to assess whether the patient census met corporate goals. Furthermore, Vitas allegedly provided extensive training to staff regarding the "selling" of hospice services to patients and their families, but failed to provide training regarding Medicare's eligibility requirements for hospice services.

According to the government, Vitas management overrode the clinical assessments of physicians and nurses that some patients did not qualify for hospice care. In some cases, the severity of a patient's clinical condition was exaggerated in the medical record to justify a hospice admission. The government's lawsuit also cited to

numerous instances in which patient medical records allegedly demonstrated that patients did not need crisis care or, in some cases, any hospice care. In addition, the government alleged that Vitas conducted internal audits demonstrating that Vitas had overbilled Medicare, yet Vitas allegedly failed to take corrective action, including a failure to return overpayments received for hospice services.

## 10 Lessons Learned

The Justice Department's allegations against Vitas suggest numerous steps that may be taken by any health care provider to reduce liability for the submission of false claims to government health care programs:

1. Staff involved in billing government health care programs must be adequately trained regarding billing requirements – the government will interpret a lack of training as the provider's indifference toward regulatory compliance.
2. If a government health care program involves multiple payment levels, a provider seeking an enhanced level of payment must verify its entitlement to higher payment – enhanced payment often leads to enhanced government scrutiny.
3. Providers should evaluate any publicly available data to compare their performance to peers – significant deviations from industry norms will likely attract the government's attention.
4. Providers' clinical records must support billing to government health care programs – providers should assume the government will eventually inspect the clinical records underlying requests for payment.
5. The alteration of clinical records undercuts a provider's credibility with the government and may lead to FCA liability.
6. Marketing materials should not suggest a provider can offer services without disclosing any regulatory limitations on the availability of such services.
7. Carelessly worded emails from management may create the impression that a provider's profitability trumps regulatory compliance – the government is more likely to take adverse action against a provider whose "corporate culture" downplays the importance of regulatory compliance.
8. Employee concerns regarding clinical practices should be evaluated and, if valid, addressed by the provider – a disregard for employee complaints may create a whistleblower and FCA liability.
9. Internal audits revealing compliance issues should be corrected, not ignored – a provider's "reckless disregard" for compliance issues may lead to FCA liability.
10. A provider's discovery of an overpayment requires the prompt return of the overpayment to avoid FCA liability.

Error-free billing is a goal that's rarely achievable. Providers should implement an effective compliance program to ensure that any billing errors are isolated, identified, and corrected. The effort will go a long way to reduce FCA liability.