DOJ memos reduce danger of FCA prosecutions – but watch for this hidden threat

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Compliance

While the Department of Justice and its prosecutors are racking up big False Claims Act (FCA) settlements in health care, two recent DOJ memos may take some of the heat off.

A Jan. 25 memo tells prosecutors to stick to the law and official regulations and to not rely on agency guidance documents — such as the sub-regulatory guidance CMS often issues in its manuals and transmittals. “Effective immediately for [affirmative civil enforcement] cases, the department may not use its enforcement to effectively convert agency guidance documents into binding rules,” the memo says. “The department should not treat a party’s noncompliance with an agency guidance document as presumptively or exclusively establishing that the party violated the applicable statute or regulation.”

“I believe this is an effort by the administration to distance itself from longstanding policy documents implemented by prior administrations, theoretically yielding [the Trump administration] more discretion in enforcement decisions,” says Mark Silberman, partner in the health care and life sciences practice group at Benesch, Friedlander, Coplan & Aronoff in Chicago.

The memo clearly “wouldn’t be enforceable against DOJ by a defendant,” says David Honig, attorney with the law firm Hall, Render, Killian, Heath & Lyman in Indianapolis. So the question for providers is “how closely the government will hew to the memo when faced with alleged violations based upon guidance.”

Take the old “not documented, not done” standard for denial of claims — “that guidance comes from guidelines, and in some cases, e.g. E/M, from MedLearn Matters, which doesn’t even rise to the level of the Medicare manuals,” says Honig. “I think insufficient documentation can still serve as a basis for audits and recoupments because that is all internal to the agency and the reasonableness of their interpretations. But the question is whether the DOJ, if it sticks to the memo, will stop it there, rather than letting such claims be the basis for FCA enforcement.”

The other memo, issued Jan. 10, suggests a change in standards when prosecutors consider a relator’s *qui tam* case and when and whether “to decline intervention” or, in some circumstances, seek dismissal of the case outright. As the memo seems to lean on reasons to decline or seek dismissal — for example, “a decision not to intervene in a particular case may be based on factors other than merit, particularly in light of the government’s limited resources” — observers expect it to lead to fewer rather than more DOJ interventions.

Silberman hopes this will lead to fewer questionable *qui tam* cases. “Ideally, DOJ will actually implement a meaningful policy regarding the dismissal of meritless cases brought in the name of the government,” he says. “Doing so could convert the False Claims Act back into a beneficial tool for remedying fraud against the government and discourage the initiation of baseless claims hoping for a ‘lottery ticket’ case or quick settlement being driven by the high cost associated with evaluating and defending these claims.”

Recent trends show big recoveries

In 2017, DOJ bagged more than $3.7 billion from FCA cases — $2.4 billion of which “involved the health care industry, including drug companies, hospitals, pharmacies, laboratories and physicians,” says DOJ. It was the department’s eighth straight year of $2 billion-plus health care recoveries.

Experts don’t expect that to slow soon. “I think there has been an uptick in the past few years in the amount of energy and resource DOJ has put into prosecuting health care fraud criminally and civilly,” says Jason Mehta, a former assistant U.S. attorney for the Middle District of Florida, now a partner in the government enforcement and investigations practice group at Bradley Arant Boult Cummings LLP in Tampa, Fla.

“Given the increasing complexity of regulations, even well meaning providers may wind up in DOJ’s crosshairs,” Mehta says. While multimillion-dollar cases of obvious fraud get most of the publicity, there are plenty of smaller cases in which “well meaning institutions [that] through lack of diligence were submitting upcoded claims” get in trouble too, says Mehta, who says he “had several cases” like those while he was a federal prosecutor.

Those prosecutions are generally based on data analysis as prosecutors parse Medicare and other data for outliers, such as practices doing far more of a certain type of service or procedure than their peers.

Among the targets, says Mehta: “pain management clinics, for example, who billed every patient for a toxicology test — yet still prescribed opioids to those patients. Why are we testing, quantifying them, yet never changing prescription habits?” Also, orthopedic groups whose “MRI [ordering] doesn’t add up with their peers in the market.”

In addition to those data-driven actions, there’s also the threat of *qui tam* suits — “when a whistleblower is trying to capture overpayments by categorizing them as false claims, to extrapolate that into an intentional fraud case,” says Mehta. Such cases are usually brought by employees within an organization who, having had no luck getting patterns of abuse turned around by internal means, go to the law to bring action and hope to be joined by government prosecutors so they get a cut of whatever settlement the government shakes out of the defendant.

Change in lawyers’ roles

There’s a wrinkle in such cases, however, that Honig says he’s been noticing lately: *qui tam* actions brought, not by employees or former employees, but by lawyers who have caught wind of abusive billing patterns while prosecuting malpractice cases and who use that information to claim whistleblower status for themselves.

That was made possible by the Affordable Care Act (ACA), which included amendments to the False Claims Act, including one that broadened the sources from which *qui tam* intelligence could be drawn.

As before, information previously revealed by “a federal criminal, civil or administrative hearing in which the government or its agent is a party” or “a congressional, Government Accountability Office or other federal report, hearing, audit or investigation” or “from the news media” cannot lead to a civil action on false claims charges. However, under the ACA, information uncovered by actions involving the state rather than the feds may be considered, and that would include malpractice suits, says Honig.

“We’ve seen incidents where [counsel for malpractice complainants] use discovery on behalf of a client then go on to become whistleblowers themselves,” says Honig. “Discovery requests can be so broad that your malpractice attorney wouldn’t recognize it as something about FCA rather than malpractice.”

Such a request could involve counsel looking for “a history of all billing for similarly situated cases” or “all calendars or schedules which may show prior failures of supervision,” says Honig.

Before the ACA, “state-filed malpractice cases were public disclosure,” says Honig, and the courts would not admit evidence from those in subsequent *qui tam* suits. “But now state cases don’t act as a bar. That’s the statutory difference.”

Tip: Have your own, FCA-savvy lawyer on hand in malpractice cases. “When you’re represented in a malpractice case, you’re usually not hiring a lawyer; your insurer provides one,” says Honig. Such a lawyer probably won’t be thinking of your FCA exposure. Therefore, bring your own — one who would “know when to move to quash [plaintiff motions] on the grounds it’s not relevant to the case, a fishing expedition to pursue other actions.”

Whether or not that lawyer can stop disclosure that could lead to an FCA action, he or she could at least spot the danger if it emerges and “suggest self-disclosure to beat ’em to the door.” — *Roy Edroso (*redroso@decisionhealth.com*)*

Resources:

Jan. 10 DOJ memo: *https://assets.documentcloud.org/documents/4358602/Memo-for-Evaluating-Dismissal-Pursuant-to-31-U-S.pdf*

Jan. 25 DOJ memo: *www.justice.gov/file/1028756/download*

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