CLIENT ALERTS & INSIGHTS

One Of The Country's Largest Hospital Organizations to Pay $98.15 Million Settlement on False Claims Act Allegations

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On Monday, August 4, 2014, The Department of Justice announced that Community Health Systems ("CHS") agreed to pay $98.15 million to settle nine whistleblower lawsuits alleging that the company violated the False Claims Act. The whistleblowers alleged that CHS knowingly billed Medicare, Medicaid, and TRICARE for medically unnecessary inpatient admissions at 119 hospitals that should have been billed as outpatient or observation services. Additionally, allegations were made that services were rendered to patients at one of CHS's hospitals in Laredo, Texas in violation of the physician self-referral law, known as the Stark Law.

Tennessee-based CHS is the nation's largest operator of acute care hospitals. CHS emphasized that under the terms of the agreement, there is no finding of improper conduct by CHS or its affiliated hospitals and that CHS has denied any wrongdoing.

Allegations Concerning Outpatient or Observation Services

According to the whistleblowers' complaints, CHS routinely admitted Medicare patients from their emergency rooms that did not require admission so that it could bill Medicare at the inpatient rates, rather than the lower outpatient rates. To drive these valuable inpatient admissions, CHS allegedly established daily quotas for Medicare and Medicaid admissions through emergency rooms without regard to medical necessity or patient safety. CHS supposedly enforced those benchmarks by incentivizing and pressuring emergency department physicians and administrators to meet them. Physicians and administrators who failed to meet CHS's benchmarks were threatened with termination, and some were allegedly fired. Among a number of allegations, management at CHS's Heartland Regional Center in Marion, Illinois purportedly held daily meetings in the emergency room where personnel were required to explain the release of any Medicare or Medicaid patient treated in ER.

The first four complaints were filed by employees working at different CHS hospitals in various capacities: a case management supervisor; a coding specialist; an emergency room physician; and a director of health information management. Between January 2005 and December 2010, each of them observed the same practices being directed from CHS's corporate offices and felt the practices they felt violated the federal and/or state False Claims Acts.

Allegations Concerning False Claims at CHS's Laredo Medical Center

$9 million of the settlement resolves an allegation that Laredo Medical Center ("LMC"), a CHS hospital in Laredo, Texas, improperly billed Medicare for services referred by a physician with a financial interest in the hospital in violation of the Stark law. Specifically, it was alleged that LMC improperly billed Medicare for services referred by a physician who was offered a medical directorship at LMC, in violation of the Stark Law. Furthermore, it was also alleged by a coding specialist that LMC presented false claims to the Medicare program for certain cardiac and hemodialysis procedures performed on a higher cost inpatient basis that should have been performed on a lower cost outpatient basis.

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Under the settlement, CHS entered into a five-year Corporate Integrity Agreement requiring it to retain independent review organizations to review the accuracy of the claims for inpatient services under federal health care programs, and to engage in significant compliance efforts over the next five years.

CHS Response

CHS and the Justice Department differed on what led up to the alleged misconduct. CHS Chairman and CEO Wayne T. Smith blamed "shifting and ambiguous" regulations on admissions and pushed for the government to "devise sound and reasonable rules for the important decision about whether to admit an individual for inpatient care." The Justice Department maintained its allegation of fraud against the company, netting the largest False Claims Act settlement in the U.S. Attorney's Middle District of Tennessee.

Congressional Hearing by Senate Special Committee on Aging

On July 30, 2014, the Senate Special Committee on Aging held the first Congressional hearing focused on the impact of observation status on patients, just days prior to CHS's settlement. Issues discussed included patients who have been held on observation status in a hospital, and their subsequent stay at skilled nursing facility ("SNF") was not covered by Medicare Part A. Certain testimonies at the hearing explained that observation care is often indistinguishable from inpatient care as it is difficult for the admitting physician to determine whether the patient is an inpatient or an outpatient when they first see the patient. The two-midnight rule, which took effect October 1, 2013, directs physicians to admit a patient to inpatient status if they anticipate that the patient will remain in the hospital for at least two midnights. However, it is sometimes difficult for a physician to make this determination prior to forming a diagnosis or treatment plan for the patient.

Marna Borgstrom, President and Chief Executive Officer of Yale-New Haven Health System, testified that the two-midnight rule causes confusion and huge bills for patients, strains the doctor-patient relationship, and penalizes hospitals that "provide innovative, efficient care," especially academic medical centers and safety-net hospitals. On behalf of the Association of American Medical College's Council of Teaching Hospitals and Health Systems, she recommended that CMS defer to physicians' clinical judgment for hospital stays lasting less than two midnights and that Congress eliminate the (statutory) three-day inpatient stay requirement for coverage of care in a SNF.

Notably, despite the HHS Office of Inspector General ("OIG") expressing its concern about observation status and the need for a careful evaluation of the new two-midnight rule, the OIG's audit division is conducting an ongoing series of audits (Medicare compliance reviews) at acute care hospitals to determine whether the hospitals are appropriately reimbursed by Medicare. The first area evaluated in the inpatient portion of OIG's reviews is short inpatient stays, an area that OIG's work has identified as "at risk for noncompliance."

The Centers for Medicare and Medicaid Services ("CMS") has delayed enforcement of the two-midnight rule through March 2015, at which time hospitals may face financial penalties if auditors determine the hospital could have met the patient's needs in an outpatient setting. Specifically, CMS will not conduct post-payment patient status reviews for claims with dates of admission from October 1, 2013 through March 31, 2015. Recovery Auditors will also not conduct pre-payment patient status reviews for claims with dates of admission October 1, 2013 through March 31, 2015. Unaffected by the delay are other types of inpatient reviews by Medicare administrative contractors ("MACs"), recovery audit contractors ("RACs") and supplemental medical review contractors, such as whether inpatient hospital admissions before October 2013 met the previous admission requirements. RACs also will continue reviews of less-than two midnight stays.

Conclusion

The allegations against CHS demonstrate that hospitals must carefully consider the distinctions between observation status, outpatient status and inpatient status, especially for Medicare patients who need to continue their recovery in a SNF. For more information on the CHS settlement, the two-midnight rule, patient statuses as observation or outpatient, or considerations under the Stark Rule, the Anti-Kickback Statute, or related fraud and abuse issues, please feel free to contact Daniel Meier or any member of our health care practice group for a further discussion.