

# *The Calm Before the Storm*

*Enforcement Trends in Risk Adjustment:  
DOJ and the False Claims Act*

November 17, 2015

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# *The Calm Before the Storm*

- Risk Adjustment Fraud Meets the False Claims Act: The Essentials
- Leading Edge: Janke and Scan
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# Risk Adjustment Fraud Meets the False Claims Act: The Essentials

# Risk Adjustment and the False Claims Act

The False Claims Act prohibits:

- a) knowingly presenting, or causing someone else to present, a false or fraudulent claim;
- b) knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim; and
- c) knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the Government.

31 U.S.C. § 3729(a)(1)(A), (B), (G).

# Risk Adjustment and the False Claims Act

Violation of the False Claims Act subjects violator to liability for:

- Three times the amount of the damages sustained by the United States
- Penalties of up to \$11,000 for each violation

31 U.S.C. § 3729(a)(1).

# Risk Adjustment Claims Submitted to CMS

RAPS submissions to CMS seek payment based on the assertion that a given member:

- Has the given diagnosis; and
- The diagnosis was treated or affected treatment:
  - By a qualified provider;
  - During the relevant treatment year;
  - In a face-to-face visit.

# Risk Adjustment Claims: Falsity

- Each risk adjustment claim is itself a false statement, if the diagnosis is unsupported;
- Any false document created to support the submission of an unsupported claim is an additional FCA violation;
- But wait, there is more ...

# Reverse False Claims

MA Plans face FCA liability for failing to correct (delete) false claims that were previously submitted that the Plan later learns, or in the exercise of reasonable diligence should have learned, were unsupported.

United States v. Lakeshore Med. Clinic, Ltd., 11 Civ. 00892 (E.D. Wis. Mar. 28, 2013)

Finding reverse false claims where defendant found high rates of “upcoding” during physician audit, but failed to conduct expanded audit or other follow up.

U.S. ex rel. Kane v. Healthfirst, Inc., 11 Civ. 2325 (S.D.N.Y. Aug. 3, 2015)

Finding reverse false claims where defendant was provided spreadsheet showing 900 potentially false claims and took no steps to investigate.



# Leading Edge: Janke and Scan

# United States v. Janke, 09-CV-14044 (S.D. Fl.)

- Settled for \$22.6 million in November 2010.
- MA Plan, America's Health Choice Medical Plans Inc. (AHC) – owned by Dr. Walter and Lalita Janke – submitted falsely inflated risk adjustment claims.
- Defendants allegedly combed through patient charts and mined provider data to identify diagnoses to submit to Medicare.
- Newly submitted diagnoses were not supported by the patient medical records.

United States et al. ex rel. Swoben v.  
Scan Health Plan, et al., 09-CV-5013  
(C.D. Ca.)

- Scan Health Plan paid the U.S. and California \$320 million to settle allegations related to overpayments for treatment of nursing home and long term care patients.
- Scan also paid \$3.8 million for submission of false risk adjustment claims to Medicare.

# United States ex rel. Swoben v. Scan Health Plan

Core Medicare Advantage allegations:

- hired chart reviewers to audit claims;
- submitted additional codes chart reviewers found; and
- failed to delete previously submitted codes that chart reviewers did not validate.

# Ominous Silence: Dismissed and Declined Cases

## U.S. ex rel. Swoben v. Scan, Round II ...

- Swoben's complaint also included similar allegations against multiple other MA Plans.
- On July 30, 2013, District Court resoundingly dismissed them.
- Court noted that Swoben lacked detailed inside knowledge of the processes of the other MA Plans.
- MA Plans argued – and Court agreed – that Swoben did not know whether Plans had other evidence (outside the chart review process) to validate previously submitted diagnoses not found by chart reviewers.

# Declined Cases

- United States ex rel. Valdez v. Aveta, Inc. et al. (D. P.R.)
- United States ex rel. Graves v. Plaza Medical Centers, et al. (S.D. Fl.)
- United States ex rel. Silingo, et al., v. Mobile Medical Examination Services Inc., et al. (S.D. Fl.)
- United States ex rel. Ledesma v. Censeo Health LLC, et al. (N.D. Tx.)
- United States ex rel. Conte, et al. v. Blue Cross and Blue Shield of South Carolina, et al. (D. S.C.)

# What's on the Horizon?



# Hints of Cases Under Seal

- False Claims Act Pattern: Sealed Before Unsealed.
- In a recent webinar on the state of the industry, John Gorman reported that 18 MA Plans have been called in to the Department of Justice to explain their risk adjustment practices.
- Public reports about document requests to Humana and Health Care Partners suggest DOJ is actively investigating cases that are still under seal.

# Hints of Cases Under Seal (Humana)

- In its February 18, 2015 SEC filing, Humana reported that it had received a request for information about its risk adjustment practices from the Department of Justice.
- Humana reported that it believed the subpoena was related to the Plaza Medical Center case, but acknowledged that the request went beyond the matters at issue in that case.
- Humana reported that in addition to information about provider-submitted diagnoses, DOJ sought documents concerning, as Humana euphemistically put it, “medical record reviews conducted as part of our data and payment accuracy compliance efforts, the use of health and well-being assessments, and our fraud detection efforts.”

# Hints of Cases Under Seal (Humana)

- In other words, probably: (1) chart reviews; (2) home visits; and (3) whether Humana deleted, for risk adjustment purposes, claims found to be fraudulent by its Fraud & Abuse department.
- According to a Reuters report, Humana later reported that it believed the DOJ “request for information is in connection with a wider review of Medicare risk adjustment generally that includes a number of Medicare Advantage plans, providers and vendors.”

# Hints of Cases Under Seal (DaVita)

- Both DaVita Healthcare and its subsidiary JSA HealthCare Corporation received subpoenas from HHS OIG concerning their risk adjustment practices in the first half of 2015.
- The subpoenas seek documents from as far back as 2008.
- Reports suggest these subpoenas are related to the DOJ investigation of Humana's risk adjustment practices.
- However, DaVita's SEC filings suggest the subpoenas could be broader than that, reporting: "The Company believes that the request is part of a broader industry investigation into Medicare Advantage patient diagnosis coding and risk adjustment practices and potential overpayments by the government."

# Cases Against Providers Rather than MA Plans

- United States v. Thompson, 9:15-cr-80012 (Feb. 3, 2015 S.D. Fl.)
- Dr. Isaac Thompson indicted for causing the submission of at least \$2.1 million in false risk adjustment claims. The indictment was later amended to cover \$4.85 M in false claims.
- Dr. Thompson allegedly falsely claimed he treated patients for certain rare, high cost diseases, including:
  - ankylosing spondylitis (a chronic inflammatory disease of the spine);
  - sacroiliitis (an inflammation in joints in the pelvis);
  - inflammatory polyarropathy (five or more inflamed, swollen, tender joints);
  - major depressive affective disorder.

# Cases Against Providers Rather than MA Plans (U.S. v. Thompson)

- Humana submitted these diagnoses to CMS, and then paid Dr. Thompson 80% of the premiums it received.
- Humana claimed it was cooperating with the United States in its investigation and had repaid the Government as part of its cooperation.
- Humana declined, in response to media requests, to explain why its payment and/or compliance systems failed to detect Dr. Thompson's high rate of billing relatively rare diagnoses.

# Key Theories of Liability

1. Failure to correct provider upcoding
2. MA Plan upcoding through:
  - Chart Reviews
  - Home visits
  - Attestations

# Key Factors to Consider

## 1. Coding Rules:

- Chronic Conditions
- Coding from lists
- Playing Doctor
- Improper linkages
- History of v. Active Treatment

## 2. Documentation Rules:

- Amending charts after the fact
- Leading queries
- EMR issues (copy and paste, mismapped diagnoses, etc.)



# Beyond Traditional Upcoding: Next Frontiers

1. Star Ratings
2. Provider network adequacy
3. Provider-owned MA Plans