Fera, The *Lakeshore* Case and "The Biggest Mistake Of All – Doing Nothing"

by Robert J. Milligan, JD

The complexity of physician documentation, billing and coding requirements, and some recent statutory and judicial pronouncements, create significant risks for physician practices that conduct provider audits. The adverse consequences of failing to conduct audits, and a looming requirement for the performance of audits, make it likely that all practices that participate in Medicare will be conducting provider audits in the not too distant future. This article discusses the unhappy confluence of these forces, as illuminated by a recent federal District Court decision, and offers some thoughts about how to plan for dealing with the issues.

Compliance Programs and Auditing

Many physician practices have already implemented compliance programs to identify and resolve regulatory problems relating to coding and billing, HIPAA and other high risk areas. While a number of practices have not yet implemented these programs, doing so is likely to be a cost of doing business with federal health care programs, sooner rather than later.

Section 6401 of the Affordable Care Act gave the Secretary of DHHS authority to require providers "within a particular industry sector or category" to establish compliance programs as a condition of participation in Medicare and Medicaid/AHCCCS (referred to as "Medicare" in this article). The Act also required DHHS, in consultation with the Office of Inspector General, to establish "core elements" for providers within each sector or category. DHHS has not yet mandated compliance programs as a condition of participation for physician programs; given that physicians directly or indirectly control the bulk of health care spending, however, there is little doubt that it will do so.

Once that occurs, practices that want to do business with federal health care programs will have no choice but to implement compliance plans that contain the core elements specified by DHHS. Based on requirements established by DHHS with respect to skilled nursing facilities (which were required to have programs in place by March of this year), and on guidance issued by OIG with respect to physician practices and other types of

> *"The man who achieves makes many mistakes, but he never makes the biggest mistake of all – doing nothing."*
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> —Benjamin Franklin.

providers, these compliance programs will have to include periodic auditing of claims submitted by the practice's physicians. In fact, the establishment of a periodic auditing process is "Step One" in the OIG's guidance for physician practice compliance plans, which is available at https://oig.hhs.gov/compliance/compliance-guidance/index.asp.

According to the OIG, the auditing process should determine, among other things, whether "bills are accurately coded and accurately reflect the services provided;" whether "documentation is being completed correctly;" and whether "services or items provided are reasonable and necessary." Anyone who has been involved in a chart audit, whether as the reviewer or the reviewed, knows that it is tough to get through an audit of any significant number of charts without the identification of a few possible problems. This is particularly true for evaluation and management codes, where arcane and subjective coding requirements must be divined from the CPT code book and the 1995 or 1997 Documentation Guidelines for Evaluation and Management Services.

Another factor that makes it difficult to achieve a perfect score on a coding audit is the fact that statutes and regulations applicable to federal health care programs require physicians to, e.g., "furnish to the … carrier sufficient information to determine whether payment is due and the amount of the payment." Because of these rules, failure to document, adequately, either medical necessity or the level of service provided can result in a finding that the service is not reimbursable, or that it is not reimbursable at the level billed. These rules provide the provenance for the coding proverb – "If it wasn't documented, it wasn't done." Another coding compliance challenge results from the fact that many audits do not involve a review of the entire relevant medical record. Consequently, if the note that is being audited is deficient in any respect, the fact that the missing piece might be found elsewhere in the record would not avoid an adverse determination by the auditor.

In some practices, these and other factors result in an attitude that a "score" of 90% (the amount of reimbursement supported by the audited documentation is 90% of the amount received for the claims) is acceptable, if not admirable. The enforcement agencies do not share this view, however; they would contend, with some basis in logic if not fairness, that a 90% compliance score means that there was a 10% overpayment.

FERA and the *Lakeshore* Case

Prior to May, 2009, there was at least some small element of uncertainty about a practice's obligation to repay federal health care program overpayments in situations where the errors that led to the overpayment were not discovered until after the claims had been submitted and paid. That uncertainty was resolved, and the obligation to repay became crystal clear, with the passage of the Fraud Enforcement and Recovery Act of 2009 ("FERA"). Under FERA, a provider can be liable under the False Claims Act for retaining federal health care program overpayments, even if the overpayment resulted from an "innocent mistake." Stated differently, doing nothing in response to learning of a Medicare overpayment can give rise to "reverse False Claims Act liability".

The extent of the problem created by a law that makes it illegal to do nothing is highlighted in a recent District Court opinion in a case called *United States ex rel. Keltner v Lakeshore Medical Clinic.* Lakeshore Medical Clinic is a Milwaukee, Wisconsin multispecialty medical group that employs more than 100 physicians. The relator, Elizabeth Keltner, was an administrative employee of the practice whose employment was terminated; she claimed that she was fired in retaliation for "her attempts to remedy [Lakeshore's] fraudulent billing practices."

The filing of a whistle-blower case by a former employee is not newsworthy (type "health care whistle blower law firm" into your internet search engine and see how many hits you get). What is new about the Lakeshore case is that many of Keltner's claims relate not to Lakeshore's

billing practices, but rather to the group's failure to repay overpayments discovered in audits performed as part of its compliance program. Lakeshore moved to dismiss the case, and in a March, 2013 written opinion, the District Court considered a variety of arguments from both parties. (The full written opinion is accessible through an internet search for *"Keltner vs. Lakeshore Medical Clinic."*)

For her part, Keltner claimed that a "2009 audit indicated that two physicians had upcoding error rates greater than 10%." She claimed that Lakeshore's failure to conduct expanded audits on these underperforming physicians encouraged (or at least failed to discourage) upcoding. She also found fault with the group's practice of auditing on a yearly basis the physicians whose coding was deficient, arguing that this practice gave these physicians a free pass to upcode during that one year period. Another damaging allegation made by Keltner was that Lakeshore discontinued its practice of auditing E&M codes, following a period in which audits yielded negative results. She contended that this decision also provided physicians with an opportunity to upcode without being discovered, and that the physicians were incentivized to do so "because their pay was tied to dollars billed."

Keltner claimed that Lakeshore's failure to repay overpayments discovered in its audit process was a violation of the False Claims Act. Recognizing that her claim was not the "typical" False Claims Act case, where a defendant is accused of "knowingly submitting a false or fraudulent claim," the District Court concluded that Keltner's allegations stated facts that, if proven to a jury, could expose Lakeshore to False Claims Act liability:

> *Although she does not allege that defendant knew that specific requests for reimbursement for E/M services were false, she claims that defendant ignored audits disclosing a high rate of upcoding and ultimately eliminated audits altogether. These allegations plausibly suggest that defendant acted with reckless disregard for the truth and submitted some false claims.*

Not surprisingly, Lakeshore pointed out the subjective nature of coding decisions, and noted that most of the "errors alleged" involved "only one-level coding differences." The Court conceded that one-level differences might be due to differences of opinion; it noted, however, that the differences might also have resulted from "wrongful upcoding and from defendant's failure to review bills that it had reason to believe contained errors." The underlined language makes it clear that the Court found some merit in Keltner's claim that the failure to do expanded audits on physicians with subpar performances might support a reverse False Claims Act case.

Lakeshore also argued that Keltner did not "establish that [Lakeshore] failed to provide the services it billed for rather than an absence of medical documentation." The Court seemed to accept that there is a distinction between what services were documented and what services were provided, but noted that the issue of whether services were provided but not documented was an issue to be resolved at trial. As an aside, given that the Medicare rules require documentation to support the claim submitted, Lakeshore may find that the Court's favorable comment on that point turns out to have given false hope.

After discussing the issues summarized above and a significant number of other allegations, the Court ruled that Keltner's allegations with respect to most of her claims

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precluded a dismissal of those claims. Absent a settlement, the case seems likely to proceed to a trial, and Lakeshore's physician owners are facing an expensive and anxiety-producing ordeal.

One other aspect of the case that is worthy of note is the fact that both the Department of Justice and the State of Wisconsin declined to intervene in Keltner's lawsuit, as they were entitled to do under the federal and state whistle-blower statutes. There is no indication in the District Court opinion as to why they declined to intervene. Some commentators have suggested that the use of the whistle-blower provisions available to private plaintiffs and their lawyers under the False Claims Act (and state law analogs) might be causing an expansion of the application of the False Claims Act beyond the point where government attorneys would like to see it applied. That may be another concerning implication of the *Lakeshore* case.

Food for Thought

The combination of the obligations imposed under FERA; the subjectivity of coding decisions; the time pressures that make perfect documentation an ideal instead of a reality; and the enforcement environment, create a considerable risk for physician practices. Many practices already conduct claims audits, either internally or through third party auditing consultants; those practices that currently do not conduct claims audits will be required to do so once DHHS mandates compliance programs as a condition of participation in Medicare. At that point all practices that participate in Medicare will be required to conduct audits.

It is safe to assume that in every practice, those audits will reveal at least some cases in which the documentation does not support the claim selected. Some practices likely will find that some of their physicians fail to document, on a disturbingly regular basis, the elements necessary to support the code they selected. When (not if) that occurs, good business and risk management practices will dictate educational efforts to improve compliance; if those efforts fail, stronger measures, including termination of employment, might have to follow.

However, the *Lakeshore* case makes it clear that those steps alone will not be sufficient to insulate the practice from potential "reverse False Claims Act liability." It seems likely that repayment of the identified overpayments will be necessary. In addition, practices whose physicians have significant noncompliance rates (whatever that means) may be required to expand the

scope of the audits for those physicians. That in turn might lead to increased overpayments; in some cases a "sample and extrapolation" method may be necessary to estimate overpayment amounts.

While there is no clear cut guidance on questions relating to how many claims should be conducted per physician, when the audit sample should be increased, and when and whether extrapolation is indicated, the allegations in the *Lakeshore* case highlight a few key points. One is that when audits appear to reveal a persistent problem, termination of the audit program is not the preferred solution. Similarly, termination of the employment of an individual who reports compliance concerns to management clearly is a high risk decision. Finally, practices that have compensation formulas that include a production component (probably a significant majority of practices), and that do not have any checks or balances in place to ensure compliance, make themselves easy targets for a whistle-blower's argument that they encouraged production of charges but did nothing to defend against abuse. ru

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