



## A Tainted Agenda

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By Del Meyer, MD

*The state is that great fiction by which everyone tries to live at the expense of everyone else. — Frederic Bastiat*

**REDUCING HEALTH CARE FRAUD — An Assessment of the Impact of the False Claims Act**, Prepared by Jack A. Meyer, PhD, President & Stephanie E. Anthony, JD, MPH, Senior Policy Analyst, New Directions for Policy, ([www.ndpolicy.com](http://www.ndpolicy.com)) for Taxpayers Against Fraud ([www.taf.org](http://www.taf.org)), with acknowledgment for contributions of various Assistant US Attorneys and attorneys in private practice. 114 pages, 2001.

**TAINTED PROSECUTION OF TAINTED CLAIMS: The Law, Economics, and Ethics of Fighting Medical Fraud Under the Civil False Claims Act**, by Dayna Bowen Matthew, Esq, Assistant Professor of Law, University of Kentucky College of Law, *Indiana Law Journal*, Indiana University School of Law–Bloomington, 73: 525-589, Summer 2001.

When the editor of this journal handed me the hundred-plus pages of *An Assessment of the Impact of the False Claims Act (FCA) for my review*, I felt somewhat like the editorial page editor in the *Wall Street Journal*. When we find ourselves in the same trench as Hillary Clinton, then one of us doesn't understand the issues or we don't understand the hidden agenda. But I was fortunate. One of my friends favored me with a copy of *The Law, Economics, and Ethics of Fighting Medical Fraud under the Civil False Claims Act*, which exposes the "tainted" agenda.

Taxpayers Against Fraud, The False Claims Act Legal Center (TAF) is a nonprofit Washington, DC based organization dedicated to combating fraud against the federal government through the False Claims Act, 31 U.S.C. §§ 3729-3733, and its *qui tam* provision. *Qui tam* allows persons and entities with evidence of fraud against federal programs or contracts to bring suit on behalf of the government. TAF provides information and assistance to *qui tam* plaintiffs.

Jack A. Meyer, PhD, a health economist, is the President and Stephanie E. Anthony, JD, MPH, is a Senior Policy Analyst of New Directions for Policy (NDP), a Washington, DC based firm that assists businesses, purchasers and providers of health care through policy research and analysis, strategic planning, and program evaluation. NDP analyzes the forces driving health care spending, designs innovative strategies to improve financing and delivery systems, and evaluates major reform proposals.

The *Assessment* provides background of the FCA. It dates from the Civil War era, was revised in the second world war, and was resuscitated by amendments in 1986. Since then the government has recovered almost \$7 billion from contractors. The FCA, as amended, enhanced the role of whistleblowers, or individuals with inside information of fraudulent practices, by enabling them to sue companies or individuals and provides a cause of action

against employers who retaliate. These lawsuits, commonly referred to as *qui tam*, are filed on behalf of the United States. Whistleblowers who initiate legal action are termed "relators," and, if successful, can receive up to 30 percent of any funds recovered by legal actions under the FCA. In fiscal year 2000, 80 percent of the \$1.5 billion recovered stemmed from *qui tam* lawsuits and 56 percent came from health-related cases — surpassing defense contractor cases.

The 1986 amendments also increased recoveries under the FCA. Damages went from double to treble, and mandatory penalties were raised from \$2,000 to \$5,000–\$10,000 for each false or fraudulent claim. An attorney at a recent conference stated that a physician's Medicare claim with eight lines of charges resulted in \$80,000 for penalties.

The government has spent over \$200 million in the last three years to recover funds. The authors of the *Assessment* feel the FCA has been effective in deterring fraud beyond individual cases. This is most noticeable in health care.

In the world of clinical medicine, it can be difficult to record the numerous diagnostic and therapeutic thought processes that lead to an appropriate diagnosis. Frequently, the AMA/HCFA codes, which some economist and actuaries feel should be discarded, do not adequately reflect the time spent. But to an outsider, these variations may seem like obvious fraud. A small error is frequently extrapolated to a full practice demanding huge sums.

Listening to legal analysis of these cases makes it appear most charges were without substance. But physicians, unless supported by large organizations, do not have unlimited resources to defend themselves against a bureaucratic onslaught. The authors of *Assessment* recognized this argument, but concluded that the FCA should not be weakened. It is a very effective fraud-fighting tool, returning \$8 for every dollar "invested." Amendments should not be made to exempt certain industries or eliminate the *qui tam* provisions. They conclude that providers should *not* fight the FCA but focus on compliance. But how does one reflect compliance when in fact compliance is already present? Physicians receive books on sophisticated coding and are invited to seminars to improve their reimbursement. Some seminars state that proper billing can increase incomes by 10–25 percent. Many physicians "down code" out of fear. Medicare costs vary over 100 percent from community to community.

Managed care became popular by eliminating the "excess" from expensive practices. However, it is frequently the brightest and the best doctors who can more easily justify a greater number of expensive tests. I'm not sure how the government would fare if billing were optimized with guarantees against destructive government lawsuits. Hiring a CPA to reduce taxes to the absolute minimum required by statute is not fraud; and neither should be a similar mechanism if used by a physician.

Professor Dayna Bowen Matthew, in an Indiana Law Journal review, states that according to the General Accounting Office (GAO), as much as 10 percent of total health care costs are lost to fraudulent or abusive practices by unscrupulous health care providers. The original impetus for the antifraud bills was the well-documented proliferation of illegitimate medical financing practices such as "ping-ponging" and "ganging" (medically unnecessary physician referrals prevalent in urban Medicaid mills), "steering" (directing patients to related pharmacy or laboratory facilities, ignoring freedom of choice) and "upgrading" (increasing billing above services actually provided). However, Matthew questions the economic and ethical wisdom of a major legal weapon, tainted-claims prosecutions under the Federal Civil False Claims Act (FCA).

Traditional FCA claims require proof that the defendant knowingly submitted or caused to be submitted, a false or fraudulent request for payment to the government. "Tainted claims," however, are neither false nor fraudulent, but are actionable under the FCA because the defendant requested payment while allegedly in violation of a separate regulation, statute or law. In the health context, plaintiffs and prosecutors using the tainted-claims approach can impose liability on health care providers even if their

Medicare or Medicaid request for payment was true, accurate, reasonable and arose from the provision of competent, medically necessary care. FCA liability in these cases turns merely on the "taint" of the underlying violation, not on proof that the defendant violated the terms of the FCA.

Matthew focuses specifically on tainted-claims cases based on alleged violations of three medical antifraud statutes: the criminal section of the Medicaid and Medicare Antifraud Act, or the Stark I and II bans against physician self-referrals. She argues that using the FCA to avoid the criminal, civil, and administrative requirements of these statutes raises five important problems.

First, the tainted-claims approach permits plaintiffs and prosecutors to effectively replace existing bodies of state common law, regulations and statutes, as well as existing federal statutes, with a body of federal common law based on the FCA.

Second, tainted-claims cases extend the scope of the FCA far beyond what Congress intended, and abandon the detailed statutory approach to controlling medical fraud that appear in anti-kickback and self-referral laws.

Third, by presuming that all referral fee arrangements give rise to "inappropriate" financial considerations, the tainted-claims approach imposes costly penalties on an overly broad range of commercial activity resulting in the loss of productive activity due to over-deterrence.

Fourth, by allowing anti-fraud enforcement to proceed under the FCA, the tainted-claims approach creates a private cause of action where Congress has not.

Finally, Matthew feels that perhaps the most troubling problem is the extent to which financial self-interest appears to influence both private qui tam plaintiffs and public prosecutors.

Private plaintiffs use the FCA to challenge medical fraud because the qui tam provision rewards them with up to 30 percent share of the damages, penalties or settlement proceeds. This is a virtual lottery jackpot, since trebled penalties and damages accrue for each allegedly tainted patient bill submitted to the government. The government prefers to prosecute medical fraud under the FCA because public prosecutors, like the private qui tam plaintiff, can use their share of the proceeds in future enforcement efforts.

This article sounds a serious note. The anti-kickback and self-referral laws are intended to control the dangers of allowing financial self-interest to distort health care providers' medical judgment. Ironically, the tainted-claims cases present similar dangers because the financial incentives motivating public and private prosecutors in these cases are much like "kickbacks" that threaten to distort prosecutorial discretion and ultimately the quality of the medical anti-fraud effort overall.

This article concludes that Congress should return control of medical anti-fraud enforcement to expert government prosecutors with no financial interest in their cases and who are motivated solely by their obligation to the public to fight medical fraud.

That's the gist of the first three pages of this 60 pages that exposed the hidden agenda. If you're interested in the other 57 pages, please send me an email. To network with concerned physicians one or two Tuesdays a month electronically, send an email outlining your interests to [Info@MedicalTuesday.net](mailto:Info@MedicalTuesday.net).

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