Healthcare Law Alert – Another Large Stark/False Claims Act Settlement

On September 4, 2015, the Department of Justice announced that Columbus Regional Healthcare System, a large Georgia hospital system, and Dr. Andrew Pippas, one of the System's employed oncologists, agreed to pay a maximum of $35 million and $425,000 respectively to settle a whistleblower case alleging violations of the federal False Claims Act and the federal physician self-referral prohibition or "Stark" law. **Click here to view a link to the Department of Justice Press Release.**

While the large settlement amounts grab attention, it is equally fascinating to read the various claims of wrongdoing alleged by the whistleblower. These are just allegations, not facts. They describe only one side of the story – the whistleblower's. They were never proven in court, but they highlight conduct that the government presumably found objectionable. While perhaps there was not definitive evidence – no smoking gun – it appears there was enough "smoke" to pique the interest of the government and cause the Hospital and the physician to choose not to risk going to court.

The allegations included:

- The physician was paid $400,000 per year for two medical directorships. He filed time records showing that he performed 60 to 80 hours of work per month, but the validity of these time records were questioned.
- The amount paid to the physician per WRVU varied based upon the E&M level coded; the higher the code the higher the per WRVU payment amount.
- The physician had asserted that he was underpaid because his referrals generated millions of dollars for the Hospital in technical fees.
- The physician was paid at least two times the total revenue amount collected for his personally performed services.
- The physician's WRVU total included WRVUs attributable to services that were performed by a nurse practitioner and another physician but, nonetheless, billed using the physician's name and NPI.
- An audit of the physician's medical records and assigned billing codes charts revealed a 68% coding error rate (meaning that the medical record documentation did not support the code that was billed).
- The physician enlisted the assistance of a major Hospital donor and Board member to apply pressure to Hospital administration to maintain his compensation – which exceeded the 90th percentile of a major national benchmark.
- Multiple directives from Hospital administration had been issued highlighting the importance of physician compensation being fair market value and commercially reasonable – suggesting that the Hospital was keenly aware of the compliance rules, while at the same time ignoring them.

While these allegations are not necessarily fact, they demonstrate the type of conduct the government is interested in pursuing and stopping. This matter also highlights how documentation – or the lack thereof – can give traction to qui tam allegations. What would a review of the documentation of your hospital's financial relationships with referring physicians reveal? What would a comparison of such physicians' medical record documentation and the codes billed for the related physicians' services show? In a qui tam case, it is all about the evidence.

Visit our Healthcare Practice Area to learn more about the legal services we can provide in this area. If you have any questions or would like more information on the issues discussed in this communication, please contact any member of our Healthcare Practice Area.