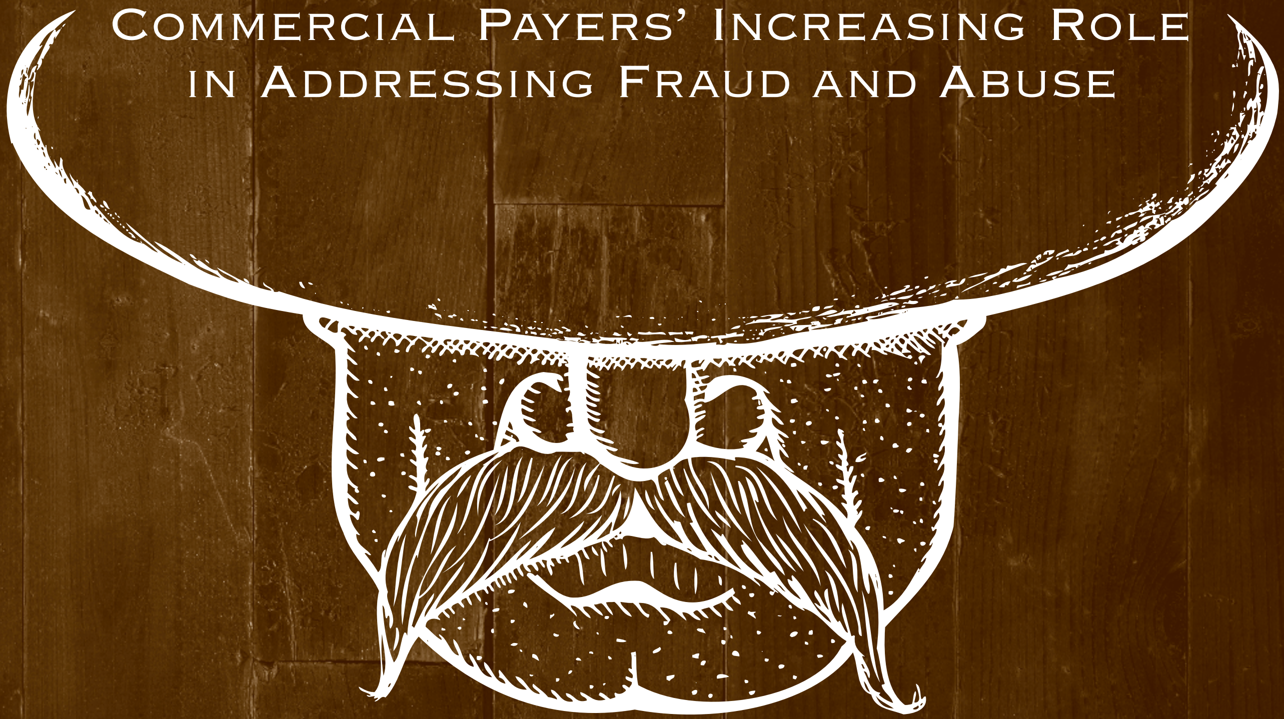
New Sheriffs in Town:

Commercial Payers' Increasing Role in Addressing Fraud and Abuse



By Anthony Argiropoulos, William Gibson, Gary W. Herschman, and Andrew Kuder, Epstein Becker & Green PC

There is a growing trend of commercial payers invoking "fraud and abuse" theories to deny health care providers' claims or to recoup claims paid over many years. A few states even have laws that allow commercial payers to file "whistleblower" claims for alleged fraud in claims submissions with the incentive of recovering significant trebled damages, statutory penalties, and attorney's fees. This article describes the various (and growing) methods of commercial payer fraud and abuse enforcement against health care providers, offers some practical recommendations for health care providers to mitigate the risk of potential exposure, and discusses potential affirmative actions that providers can launch against payers.

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Commercial Payers' Lawsuits Against Providers

Commercial health maintenance organizations are suing providers for fraud and other noncompliance. The predicate for these suits include: (1) improper waiver of copays and deductibles; (2) violations of federal and/or state anti-kickback and self-referral prohibitions; and (3) failure to abide by licensure requirements. Upcoding, unbundling, and other billing manipulation also may be a predicate.

For example, in *Connecticut General Life Insurance Co. v. Elite Ambulatory Surgery Centers LLC,* Cigna alleged that the defendant surgery centers violated the Employee Retirement Income Security Act of 1974 (ERISA) and various state law prohibitions against fraud and negligent misrepresentation by waiving patients' financial responsibilities for out-of-network services.[1] Cigna argued that ERISA empowers insurers to deny coverage for services (including out-of-network services) where a provider has not enforced a plan's patient cost-sharing requirements, and further that insurers are entitled to recover overpayments that were made to providers pursuant to promises that patients would pay their cost-sharing requirements.

In 2016, Aetna Life Insurance Company (Aetna) won a $37 million verdict against a group of Northern California surgical centers, Bay Area Surgical Management, LLC and its affiliates, for an out-of-network overbilling scheme and making kickbacks to referring physicians.[2] Aetna argued that Bay Area engaged in a "massive conspiracy" to defraud Aetna by inducing physicians to refer Aetna insureds to Bay Area facilities through kickbacks. Physicians were sold shares in the ambulatory surgical facilities at below-market value, which resulted in disproportionally high returns of several hundred percent per year to the physician owners.

That same year, UnitedHealthcare (UHC) sued American Renal Associates, a public company that operates nearly 200 dialysis clinics across the country, for allegedly fraudulently billing millions of dollars. UHC alleged that American Renal convinced Medicare- and Medicaid-eligible patients to drop their government coverage and sign up for UHC plans, which would reimburse American Renal at far higher rates.[3] According to the lawsuit, to make the UHC plans affordable to the generally low-income patients, American Renal enlisted the nonprofit American Kidney Fund to pay for the patients' commercial plan premiums with grants funded by American Renal donations that were earmarked for this very purpose. According to UHC, American Renal illegally, and in violation of the terms of UHC plans, waived patients' copay, coinsurance, and deductible obligations.

Government Employees Insurance Co. v. Bakst[4] illustrates the use of state licensing and regulatory requirements as a reason to deny payment to doctors, as well as the expanding use of civil Racketeer Influenced and Corrupt Organizations claims by insurers. GEICO asserted that defendants engaged in a racketeering scheme to defraud GEICO of over $6 million in fees for treatment of injuries sustained in motor vehicle accidents. GEICO alleged that defendants recruited doctors to "sell" their names and medical licenses and pose as the nominal owners of professional corporations on behalf of the non-physician, "management" defendants, who allegedly own, control, and operate the professional corporations in violation of applicable New York law. Besides the lack of corporate control and management by the defendant doctors, GEICO also alleged that the defendant doctors do not actually practice medicine through the professional corporations as required under New York law, that they unlawfully split fees with non-physicians in violation of New York law, and that the medical services for which payment is sought are frequently provided by independent contractors, not by the professional corporations or their employees. GEICO claimed that as a result of the defendants' fraudulent organization, ownership, and operation of the professional corporations, the defendants submitted hundreds of materially false and misleading bills for services over a six-year period, constituting a pattern of racketeering activity.

The Next Phase: Commercial Carriers Blowing the Whistle

Most states have "baby false claims acts" that mirror the federal False Claims Act (FCA) remedies and whistleblower (qui tam) provisions to provide similar recourse for false claims filed with states and state agencies, such as Medicaid programs. Many states also have "insurance fraud prevention acts" that provide for criminal and civil penalties for filing fraudulent insurance claims.

California and Illinois, however, go one step further, and allow private persons and entities (including commercial insurers) to bring "qui tam" actions on behalf of the government for allegedly fraudulent claims filed with *commercial* carriers. The California Insurance Fraud Prevention Act (IFPA) and the Illinois Claims Fraud Prevention Act (ICFPA) include qui tam provisions that are similar to federal FCA and analogous state FCA statutes; *however, the alleged fraud brought under these provisions relates to claims filed with private payers, not the government.* The theory underlying these laws is that

insurance fraud is a problem that affects the public at large by causing an increase in premium and insurance rates.[5] As such, the government can recover a portion, if not a majority, of a settlement or other recovery against an entity or individual that defrauds a private payer.

Relators—including insurance companies, insureds, and employees of health care providers—can bring an action against a health care provider and collect a portion of the judgment or settlement. The benefit of filing a claim under these statutes, as opposed to some other form of civil action, is the potential for a much higher recovery (even more than triple). The statutes also allow reimbursement of relators' legal fees.

The California IFPA allows private qui tam actions against those who violate several sections of the California penal code related to the submission of false claims and other insurance frauds.[6] In particular, claims can be based on:

- Soliciting, accepting, or referring "any business to or from any individual or entity with the knowledge that, or with reckless disregard for whether, the individual in question intends to [submit a false or fraudulent claim],"[7]
- Submitting, or aiding, or conspiring to submit, false or fraudulent claims. Such fraudulent claims include claims for payment of a loss or injury, any false or fraudulent claim for payment of a health care benefit, a claim for a health care benefit that was not used on behalf of the claimant, and the submission of multiple claims for payment of the same health benefit.[8]
- Knowingly presenting or assisting in the presentation of a statement that one knows to be false or misleading for a claim of payment, concealing or knowingly failing to disclose an event that affects a person's initial or continued right to any insurance benefit, or presenting any statement to an insurer that one knows to be false or misleading concerning material facts.[9]

Unlike the federal FCA and many state analogs that allow the relator to recover a minimum of 15% and maximum of 30% of the proceeds from the recovery or settlement (in addition to reasonable costs and attorney's fees), the California statute provides that the relator be paid 30%–40% of the proceeds if the state Attorney General (AG) or Commissioner becomes involved, and 40%–50% of proceeds if the AG or Commissioner does not become involved (plus reasonable costs and attorney's fees).[10] In Illinois, the statute goes even further, and although it sets similar "floors" for a relator's recovery, it does not cap the percentage of a relator's recovery.[11] Additionally, much like federal FCA claims, the total statutory recoveries for these commercial payer fraud actions include $5,000–$10,000 per fraudulent claim, plus up to three times the amount of each fraudulent claim.[12]

ADDRESSING PAYMENT PROBLEMS AS SOON AS THEY ARISE WILL CREATE A LIMITED UNIVERSE OF DOCUMENTS AND CLAIMS, AND WILL FORCE THE PAYERS TO JUSTIFY THEIR INDIVIDUAL DECISION ON EACH DISPUTED CLAIM.

As in the realm of the FCA, plaintiffs in these cases often agree to settle. The California and Illinois private qui tam statutes hand the reigns over to the state AG, who largely controls when settlements occur, and may or may not be concerned with making the insurer whole, but rather with guaranteeing a large recovery to the state through settlement.

Private Qui Tam Suits and Smaller Providers

While claims relating to larger systems and dollars grab the headlines, smaller providers are not immune, but rather make prime targets. In *People ex rel. Allstate Ins. Co. v. Dahan,* where 487 claims submitted by a diagnostic imaging company were found to be fraudulent, the court awarded the full possible damages of $10,000 per claim ($4.8 million), treble damages for $306,172.26 of billed claims ($900,000), and attorney's fees, costs, and expenses of investigation totaling $1,222,151.62.[13] All told, for $306,172.26 of fraud, defendants paid $7,010,668.40.[14] Because the government did not intervene in the action, Allstate collected 40–50% of penalties and treble damages, plus costs and attorney's fees, or between $3,537,558 and $4,116,410. Minus the $1.2 million in legal fees, and the return of the $306,172, Allstate likely achieved a net benefit of between $2 million and $2.6 million.

Furthermore, the California Court of Appeal ruled, when defendants attempted to make their assets uncollectable, that Allstate had the legal authority to sue for enforcement of the judgment amount.[15]

What's a Provider to Do?

How can a provider best protect itself in this environment? Two words: vigilance and awareness.

Providers must ensure that their billing is accurate and supported by treatment records. If a provider bills for a service that is not supported by an underlying treatment record, then for all intents and purposes, the service was not rendered. At the same time, providers must be wary of potential unbundling claims and overutilization. Of course, providers should properly bill for the service rendered, and it is better to err on the side of conservative billing and coding than the alternative. The opioid crisis has cast pain management and prescription abuse under particular scrutiny, and even those providers involved in referrals for pain management (as opposed to actual treatment and writing prescriptions) should be on high alert.

Providers should adhere to and regularly scrutinize their compliance plans, which must include frameworks for the detection of and response to potential problems. Provider-specific guidelines (e.g. hospital, nursing, hospice, third-party billing, home health, clinical laboratory) are available on the Office of Inspector General's website[16] and supply a useful tool in compliance efforts.

Active and preferably live compliance training and an open and obvious commitment to compliance create a culture that,

along with self-audits and a serious approach to complaints, helps curb potential whistleblowers. A complaining employee whose complaint is addressed in a serious and documented fashion is less likely to be a whistleblower.

Providers also must keep all correspondence and communications with insurance carriers. Payers often deny payment or raise billing/coding issues contrary to the payers' instructions. This scenario frequently occurs when hospitals or large medical practices deal with multiple payer contacts or where the payer changes personnel. Payers may verbally offer billing instructions from time to time. The provider must confirm these (sometimes ever-changing) instructions in writing and maintain the supporting written records. After all, a payer cannot point to billing anomalies as proof of fraud where the payer has created or contributed to those anomalies.

If a provider uses a competent third-party billing company, it is helpful to maintain a long-term relationship so that if billing/compliance issues arise, the individuals directly involved are available (and invested) to assist in resolving those issues.

Providers must be aware that potential whistleblowers exist at every point in the delivery of health care: from the classic disgruntled employee (including senior managers) to contracting parties to the recipients of services, and in some cases, even the payers themselves. Vigilance and a culture of compliance are key tools to prevent potential claims.

And Now the Flip Side . . . Actions Against Payers

Despite the trends discussed above, providers have been making, and occasionally succeeding, in bringing claims against insurers for improper denials and underpayments.

Humble Surgical Hospital, LLC recently successfully prosecuted counterclaims in a case brought by a payer to recover alleged overpayments made to Humble due to fraudulent billing practices in violation of both ERISA and state common law.[17] The payer alleged, among other claims, that Humble engaged in a fee-forgiving practice by consistently waiving the "patient cost-share" of the hospital's billed charges. The insurer refused payment on these claims, arguing that Humble's practice allowed plan participants to pay nominal amounts, while burdening the payer with more than its required share. According to the insurer, if a provider waived or made no effort to collect a plan participant's deductible, co-pay, or co-insurance amount, an exclusionary provision in the patients' insurance contracts allowed the insurer to withhold or decrease payment.

After a nine-day bench trial, the presiding judge denied the payer's reimbursement demand for alleged overpayments and awarded Humble more than $13 million to cover underpaid claims and ERISA penalties.[18] The court rejected the payer's interpretation of relevant plan documents and found that the payer abused its discretion in refusing to pay Humble. According to the court, the payer's interpretation of the plan was contrary to how the average plan participant would interpret the boilerplate exclusionary provision.

Section 502(c) of ERISA offers another avenue for providers to bring claims against payers and their associated plan administrators. The provision provides penalties of up to $110 per day if the insurance plan administrator does not "upon written

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request of any participant or beneficiary, furnish a copy of the latest updated summary plan description, and the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated."[19] Providers in possession of valid assignments of benefits from their patients can stand in the shoes of plan beneficiaries and demand ERISA plan documents. Notably, in the *Humble Surgical* case described above, the court assessed $2.2 million in statutory penalties against the payer for failure to provide participant plan documents to Humble.

Although the deck may be stacked against providers to some extent, the *Humble Surgical* case demonstrates that they can prevail in claims against insurers if they are meticulous record keepers, follow all contractual or statutory requirements, and do not sit on their rights. In particular, if an underpayment problem persists for a long period of time, the volume of claims at issue in litigation can strain the provider's ability to manage and respond to discovery. Addressing payment problems as soon as they arise will create a limited universe of documents and claims, and will force the payers to justify their individual decision on each disputed claim.

Conclusion

While providers understandably and rightfully focus on the delivery of high-quality health care, the fact remains that every provider—irrespective of size—is a potential target of fraud and abuse claims. A culture of compliance not only will aid a provider's defense of potential fraud accusations by payers, who may now have an additional economic incentive to make such claims, but also arm providers in the event that payers fail to pay providers what they deserve.

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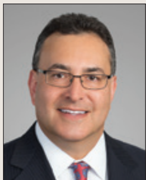

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Endnotes

1 No. 4:16-cv-571 (S.D. Tex.).
2 *Aetna Life Ins., Co. v. Bay Area Surgical Management LLC,* No. 1:12-cv-217943 (Cal. Super. Ct. Santa Clara Cty. 2016).
3 *UnitedHealthcare of Florida Inc. v. American Renal Assocs. Holdings Inc.,* No. 9:16-cv-81180 (S.D. Fla.).
4 No. 15-cv-537 (E.D.N.Y).
5 Lisa Schencker, *Lawsuits Filed Under Potentially Lucrative California, Illinois Insurer Fraud Laws May* Increase, Modern Healthcare (Feb. 17, 2016), *available at* http://www.modernhealthcare.com/article/20160217/NEWS/160219916.
6 Cal. Penal Code § 549-551; Cal Ins. Code § 1871 et seq.
7 Cal. Penal Code § 549.
8 *Id.* at § 550.
9 *Id.*
10 Cal. Ins. Code § 1871.7.
11 740 Ill. Comp. Stat. § 92/25.
12 Cal. Ins. Code § 1871.7; 740 Ill. Comp. Stat. § 92/25.
13 *People ex rel. Allstate v. Dahan,* No. BC-397695 (Cal. Super. Ct. Los Angeles Cty. 2012).
14 Judgment at 2, *People ex rel. Allstate v. Dahan,* No. BC-397695 (Cal. Super. Ct. Los Angeles Cty. 2012).
15 *People ex rel. Allstate Ins. Co. v. Dahan,* 207 Cal. Rptr. 3d 569 (2016).
16 *See* Dep't of Health and Human Services Office of Inspector Gen. *Compliance Guidance, available at* https://www.oig.hhs.gov/compliance/compliance-guidance/index.asp.
17 *Connecticut Gen. Life Ins. Co. v. Humble Surgical Hosp., LLC,* No. 4:13-cv-3291 (S.D. Tex. June 1, 2016).
18 *Id.*
19 29 U.S.C. § 1132(c); 29 U.S.C. § 1024(b)(4).

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