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# Patient Complaint Triggers DOJ Settlement With Kentucky Hospital

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A Kentucky hospital has agreed to pay nearly $1 million to settle allegations that it improperly submitted Medicare claims for services as inpatient procedures when they should have been billed as outpatient procedures. In an interesting twist, the feds learned of the alleged billing problem from a beneficiary, not from a whistleblower filing a False Claims Act lawsuit.

According to the feds, Jackson Purchase Medical Center in Mayfield, Ky., overcharged Medicare for some gallbladder and biliary tract procedures between Jan. 1, 2004, and Dec. 31, 2010. The procedures, endoscopic retrograde cholangiopancreatography and laparoscopic cholecystectomy, are used to diagnose and treat gallstones and other conditions. The feds say Jackson Purchase "submitted additional charges for these procedures as inpatient admissions when, in fact, they should have been billed as outpatient admissions," according to a press release.

The settlement agreement itself is not a public record in this case, according to a spokesperson for the U.S. attorney's office. But the feds have said the facility will pay $998,770 to the government, which is twice the amount of the overbilling, the spokesperson tells *RMC*. Jackson Purchase, which did not admit liability, also has entered into a five-year corporate integrity agreement with the HHS Office of Inspector General.

Jackson Purchase "took immediate action" to prevent more billing mistakes once it became aware of the issues, according to Steve Womack, the facility's chief compliance officer. "These steps included adding additional internal and external billing and coding resources. We also further enhanced our existing compliance program," he adds. Womack said he could not be more specific about those steps.

## Whistleblowers Can Be Anywhere

The case is a reminder that providers have more to be concerned about than just the former employee or physician who decides to blow the whistle on perceived misconduct. In this instance, a beneficiary reported to Medicare that some information on her explanation of benefits was incorrect, showing that Jackson Purchase had billed her hospitalization as an inpatient admission instead of an outpatient admission, the feds say. AdvanceMed, Medicare's program safeguard contractor, conducted the investigation.

It is "extremely unusual" for a False Claims Act settlement to stem from a beneficiary bringing his or her concerns to Medicare officials, says Jeb White, former president of Taxpayers Against Fraud and now an attorney with Nolan & Auerbach in Philadelphia. The vast majority of cases come from whistleblowers taking a stand and bringing "boxed fruit" to the feds, he says. "They tend to go after those cases that are already packaged."

On whether this could become a trend, White says he hopes so. "The more eyes you have out there looking for potential fraud, the less likely fraud is going to happen….But given how stretched thin the government is right now when it comes to health care fraud enforcement, this probably will be an outlier."

However, White notes that a major False Claims Act settlement came from a beneficiary who had the chutzpah to file a false claims suit after his warning to Medicare fell on deaf ears. His efforts partly led to HealthSouth's $325 million settlement in December 2004.

The fact that the Medicare contractor initially handled the investigation, then handed it over to DOJ, also is notable, says Gabe Imperato, with Broad and Cassel in Fort Lauderdale, Fla. "That means they made the conclusion that this wasn't just overpayment liability, and there was some kind of knowing conduct," he tells *RMC*. "Even though there was no admission of wrongdoing, the contractor would have just handled it…so that means they saw some kind of deliberate disregard."

As for the allegations themselves, White says they're a variation on an old theme, but they still come down to a question of medical necessity. His firm has been receiving many calls from potential whistleblowers. "A large percentage of the time, it's someone's business decision. 'If we do it this way, we're going to see X amount of dollars and the chances of being caught are

low.'"

For the providers intent on preventing billing mistakes, though, the remedy is double and triple checking claims and making sure the quality committee is checking medical necessity, White says. Also, make sure when a procedure is ordered that the site of service is medically necessary. "There are instances where it does deserve an inpatient code, but put it through that scrutiny instead of submitting it willy nilly," he says.

This has been a RAC and OIG concern and listed on OIG's work plan for several years now, but there have not been many False Claims Act cases so far, White points out. "It's interesting that DOJ put its resources behind this….I think that by settling this case, DOJ has shined a light on something that is extremely common. It will send hospitals the message to make sure they're dotting their Is and crossing their Ts."

Imperato agrees that the issue is on the feds' radar. "It's been used in whistleblower cases, many of which are still pending," he notes.

Contact White at jeb@whistleblowerfirm.com and Imperato at gimperato@broadandcassel.com. Visit www.justice.gov/usao/kyw.

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**Atlantic Information Services, Inc.**
1100 17th Street NW, Suite 300, Washington, DC 20036 - **800-521-4323**