10 Common Obstacles Facing Whistleblowers Pursuing False Claims Lawsuits Against Health Care Organizations

Florida attorney Kenneth J. Nolan compiled this list of factors that can impede a so-called qui tam *lawsuit against your health care organization. Whistleblowers, such as employees or competitors, may file* qui tam *lawsuits on behalf of the government. These lawsuits allege false claims, such as billing Medicare for services that weren't provided as charged. If the lawsuits are successful, whistleblowers share in the money recovered from the organization. Contact Nolan at (954) 779-3943.*

1. Second Place

A whistleblower must be the first to file the lawsuit (upon which the allegations are based). If the government or another whistleblower files first, then any subsequent whistleblower's lawsuit containing substantially similar allegations is barred.

2. Criminal Participation in the Conduct

A whistleblower's conviction of criminal conduct arising from his or her role in the violation of the False Claims Act automatically bars any entitlement to recovery of the proceeds. Even if not convicted, if the Court finds that the action was brought by a whistleblower who planned and initiated the violation of the False Claims Act, then the Court may, to the extent the Court considers appropriate, reduce the share of the would-be whistleblower. These scenarios are entirely distinguishable from whistleblowers who, as part of their employment, just followed upper management's orders and did not benefit from the submission of the false claims.

3. "Public Disclosure" Jurisdictional Bar

If a whistleblower merely repeats allegations or information that is already public knowledge (as defined in the statute and case law), or repeats allegations or information which are otherwise publicly available, then his/her lawsuit is barred. The whistleblower's *qui tam* lawsuit may still proceed if he/she qualified as an "original source," which requires "direct and independent" information of the false claims, and that he/she delivered the information to the government before filing a *qui tam* lawsuit. This obstacle bars individuals who, without direct knowledge of the false claims, come forward with "parasitic" lawsuits, based on information already known publicly, and/or by the government.

4. Mere Mistakes

Even though a provider may have been overpaid and has not repaid the funds, a whistleblower will not necessarily be successful. In order for a false claim to be sustained, the claim must have been submitted with "actual knowledge of the information," or "in deliberate ignorance, or reckless disregard of the truth or falsity of the information." True mistakes and oversights are not false claims. Rather, such a situation is likely to be treated as an "overpayment" situation in an administrative capacity, and the whistleblower either voluntarily goes away, or engages in litigation with the United States over the right to a whistleblower's share from the administrative recovery.

5. False Claims Without Damages

There are situations where a whistleblower correctly alleges false claims that did, in fact, occur. Upon investigation however, it becomes apparent that the United States, despite the false claims, was not damaged. This occurs sometimes, for instance, when a provider submits interim bills throughout the year, which are then reconciled at the end of the fiscal year through the cost report process. Although some have argued that the statutory civil fines ($5,500 - 11,000.00) should still be imposed, this does not appear to be DOJ's position, and is unlikely, in most cases, to work in court.

6. Lack of CMS Support

The Centers for Medicare and Medicaid Services (formerly HCFA) attitude/view towards the alleged false claims does play a significant role in the DOJ's decision whether to intervene. CMS is the client agency of the DOJ, and if it does not feel that false claims have been made, then it is likely that DOJ will not be interested in intervention. Even if DOJ does not intervene, lack of CMS support may result in lack of cooperation from CMS representatives to testify on behalf of the whistleblower in a non-intervened case. Why does this happen? What a whistleblower may perceive as an outrageous false claim may actually be a well-accepted exception to billing rules to which the whistleblower was not accustomed. Alternatively, for example, if a rule is unclear and/or if there is a conflict between the carriers/intermediaries, CMS may have a hard time supporting prosecution of this case.

7. Fishing Expeditions

In cases where the government has elected not to intervene, a portion of these cases are dismissed for failure to comply with Federal Rules of Civil Proce-

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dure. Rule 9(b) requires that the circumstances constituting fraud or mistake shall be "stated with particularity." In other words, a *qui tam* Complaint must provide specific allegations of fact to support a false claim. Whistleblower claims that allege a general false claims scheme, without the ability to detail any specifics of the scheme, usually fail. Of course, if there are hundreds of false claims, then representative examples will suffice, and a whistleblower's Complaint will not be dismissed.

8. Bankruptcy: The Goose that Didn't Lay the Golden Egg

It is axiomatic that a *qui tam* whistleblower who is entitled to recovery will not receive it if the provider files bankruptcy, and there are no, or limited, funds available.

9. Cases Against State or State Entities

In *qui tam* actions in which the United States does not intervene, it is now established that States are not "persons" and hence cannot be subject to liability. The May 2000 U.S. Supreme Court (*State of Vermont v. U.S. ex rel. Stevenson)* decision was extremely significant for existing and to-be filed *qui tam* cases against state healthcare facilities, including state universities. As a result, many *qui tam* lawsuits were dismissed, and many more will not be brought.

10. Defendant's Voluntary Disclosure: Horse is Not so White

The False Claims Act provides that a voluntary disclosure limits a provider's responsibility to double damages. In order to obtain the benefit of this provision, a disclosure must be made within 30 days after the provider first becomes aware of the violation. Why does this put the whistleblower in a weaker position? No longer is the whistleblower the one bringing valuable information to the government. Instead, the whistleblower has brought information to the government which has already been self-disclosed i.e. the whistleblower is of little or no help. Although there are no written laws or regulations which provide as such, it is in practice likely that by the self-disclosure, the provider will receive a benefit (better deal), and the DOJ will more closely scrutinize, defend against, and/or reduce the whistleblower's entitlement to a percentage of the recovery. Moreover, disclosure to the government can also help the Defendant to demonstrate that it did not intend to knowingly submit false claims, thereby precluding any recovery by the whistleblower under the False Claims Act.

Hospitals Confuse Take-Home, Self-Administered Drugs

Some hospitals mistakenly think they can bill Medicare for self-administered drugs in an outpatient setting as long as they aren't the kind patients take home.

A wrong-headed assumption seems to have developed that some self-administered drugs are billable. In reality, none are billable except for those on a short list of exceptions (i.e., oral anti-cancer drugs), says Marcia Caliendo, a senior director with Compliance Concepts, a consulting firm in Pennsylvania.

The feds have been scrutinizing Medicare billing for noncovered self-administered drugs, such as antibiotics and painkillers. Some hospitals have settled false claims cases or returned overpayments for self-administered drugs. Virtually none of the drugs can be billed to Medicare, whether or not they are given to patients while in the hospital ER or clinic, or handed to them to take at home as they walk out the door.

"The Medicare regulation says any drug that is self-administered is not billable, whether or not you take it home," Caliendo says. Confusion also persists about how to report self-administered drugs on claims, which is required even though they are not reimbursable.

Some fiscal intermediaries accept the use of revenue code 637 for self-administered drugs, she says; some intermediaries don't. Other intermediaries want hospitals to use revenue code 259. Under APCs, hospitals bill self-administered drugs under revenue code 250, a generic code for pharmacy. "This makes billing departments crazy because self-administered drugs are covered on the inpatient side [within the DRG] but not on the outpatient side," she says. To keep this straight, your pharmacy really should go item by item through the pharmacy chargemaster to delineate self-administered drugs that are not billable on the outpatient side.

The bottom line: Don't bill for self-administered drugs unless they are on the exceptions list and Medicare pays for them. "All take-home drugs are self-administered, but not all self-administered drugs are take-home drugs. Therefore, you may be missing a set of drugs you are billing that you shouldn't be," Caliendo says.

However, hospitals can bill patients for self-administered drugs without obtaining an advanced beneficiary notice. But make sure you have buy-in from your hospital's administration because billing patients for self-administered drugs could cause a public relations nightmare, Caliendo says.

Contact Caliendo at (724) 940-0077. ✧

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