

# MEDICARE COMPLIANCE

## First Beneficiary Whistleblower Case Settles Over Hospital's Pathology Claims

Retired plumber Abe Hertz is probably the first Medicare beneficiary to extract a false claims settlement from a hospital in an unusual case that began when he thought the hospital overcharged for a biopsy two years in a row but the hospital wouldn't fix the bill — despite warnings from the fiscal intermediary.

So the 72-year-old Hertz sued Delray Community Hospital in Florida, which is owned by Tenet Healthcare Corp., for submitting false claims for surgical pathology procedures. The Justice Department took over the case, and last week the hospital settled for \$175,000. It's not a ton of money, but the case is notable for several reasons.

For one thing, it appears to be the first whistleblower lawsuit settled that was initiated by a Medicare beneficiary, says Lesley Ann Skillen, the attorney for Hertz. With very little to go on — some paperwork from the hospital and the fiscal intermediary — Hertz was able to get a law firm to mount a false claims case. Beneficiaries may be motivated to sue initially by the inflated copays that result from abusive Medicare charges, notes Skillen, with the law firm of Getnick & Getnick, which specializes in whistleblower cases.

And some of the alleged misconduct occurred while Tenet was under a corporate integrity agreement, raising questions about why the hospital chain's vaunted compliance program didn't kick into high gear when the fiscal intermediary twice disallowed the surgical pathology claims. Delray Community Hospital wouldn't comment and referred calls to Tenet, which didn't return calls.

Perhaps this case is a call for health care organizations to open their compliance programs to the public. "The hotline and other reporting processes should be made available to patients because they are a real source of information about how well you are doing," notes Mark Pastin, president of the Council of Ethical Organizations.

### Each Specimen Allegedly Billed as Three

When Hertz retired to Florida from his native New Jersey, he started having his yearly colonoscopies at Delray Community Hospital. In 1992, he noticed from his bill that Delray overcharged Medicare for the biopsies on his colon tissue.

Providers bill Medicare for surgical pathology procedures using CPT codes 88300 through 89399 — for gross

and/or microscopic examination of tissue samples taken from patients for testing, and cover accession, examination and reporting. The CPT book describes the unit of service for codes 88300 through 88309 as the specimen, which is identified as "tissue or tissues that is or are submitted [to a physician] for individual and separate attention, requiring individual examination and pathological diagnosis. Two or more specimens from the same patient ... are each appropriately assigned an individual code reflective of its proper level of service."

According to the lawsuit, providers should bill CPT 88300 when pathologists can diagnose without microscopic examination. CPT codes 88302 to 88309 are for specimens needing gross and microscopic examination and require more and more physician work. "Therefore, under CPT codes 88300 through 88309, a provider of surgical pathology services is reimbursed once, under a single code, for each specimen that he or she takes, examines and reports on," the lawsuit says.

But when Delray Community Hospital performed a surgical pathology procedure under CPT codes 88300 through 88309, Medicare and Medicaid allegedly were billed "four times the legitimate charge for the procedure by making three microscopic slides of the tissue sample taken from the patient for pathological examination, and billing each one as a separate and additional test."

When Hertz saw his bill, he was surprised to find that the six pathology procedures he had were billed as 24:

- ◆ CPT 88300 SMALL SPCMN (BLK) x 9, total \$396
- ◆ CPT 88304 SPATH DIAG, SMALL x 6, total \$558
- ◆ CPT 88300 SMALL SPCMN (BLK) x 9, total \$396

In the settlement, however, the Justice Department contends that the hospital billed three times more surgical pathology tests than were performed, not four.

### Aetna Finds Overbilling, Recoups Money

Hertz complained to Delray's billing office and asked for an audit and corrected statement, the lawsuit contends. Delray denied that the pathology charges were excessive. So Hertz complained to HHS, asserting that only six procedures were performed despite the claims for 24, and the fiscal intermediary, Aetna Life Insurance Company, investigated.

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Aetna's findings? In late 1992, Aetna told Hertz that \$792.00 — representing two lots of nine tests billed under CPT 88300 as SMALL SPCMN (BLK) — was a double charge and that it would recover the money from Delray. Aetna sent a corrected statement to Hertz.

But the lawsuit alleges that history repeated itself a year later, in 1993. Hertz went back to Delray for his colonoscopy, and again Delray sought Medicare reimbursement for 20 surgical pathology procedures when Hertz believed only five were performed.

Hertz again asked the hospital to audit and correct the pathology charges. This time the hospital audited, but then sent Hertz a letter stating that the charges were correct. Three slides were prepared for each of the five tissue samples, the hospital said, and that explained the billing for 15 tests.

A chart auditor for the hospital reviewed Hertz's account, and the auditor's report, obtained by RMC, states that "Audit completed. All charges are correct per chart documentation and physician order. There were five biopsies done and specimens were sent to pathology. The specimens are as follows: (1) cecum, (2) hepatic flexure, (3) splenic flexure, (4) colon, (5) rectum. There were 3 microscopic slides prepared for each of the five specimens which gives the correct amount of 15."

Aetna again looked into Hertz's allegations and agreed that because only five specimens were submitted for testing, only five should be billed. The payment for the 15 additional tests was disallowed.

The same thing allegedly happened when his wife and neighbor had colonoscopies at Delray. And after Hertz filed the false claims lawsuit against Delray in 1996, Skillen says the government investigated and found a pattern of pathology billing abuse that extended beyond these three seniors and continued until 1996.

The beneficiaries are directly affected by this because Delray billed them for copays of 20% of the charges for all the extra tests billed, the lawsuit alleged.

Tenet denied the false claims allegations and attributed the pathology billing to computer errors, Skillen says.

Hertz will never enjoy the fruits of his lawsuit because he died last year at age 76. But his wife will collect the whistleblower's share of the lawsuit.

### Will Beneficiary Lawsuit Floodgates Open?

This case raises several issues. For one, remember that HHS-AARP initiative to enlist and train beneficiaries to recognize and report fraud and abuse? This could be the beginning of a wave of Medicare beneficiary lawsuits against health care organizations fueled partly by the training of volunteer senior fraud warriors, says attorney Gabe Imperato. What is really scary is that it seems these

lawsuits can be mounted with just an erroneous bill or suspicious explanation of medical benefits form if it turns out that it's not just a fluke, he says. This case highlights the compliance risks inherent in bills and EOMBs, says Imperato, with Broad and Cassel in Florida. The details may be just plain indecipherable, or they could reflect that the billing is wrong.

Yet health care organizations are so focused on whistleblowers from their own ranks, particularly billing and finance, Pastin says. As a result, they are blind both to the risk that beneficiaries present and the opportunity they offer to improve compliance.

"Compliance officers are resistant to talking to beneficiaries," but they are a huge potential source of information about billing and other problems, Pastin says. He suggests health care organizations publish the hotline number on bills. "You should use every source of knowledge you could get to prevent problems from becoming false claims. These beneficiaries are your customers and if you are any good you will treat them with great dignity and respect."

Patients should be told "I'm glad you called us and we will look into it. We will tell you what the situation is when we get back to you," Pastin says.

On the other hand, so many compliance offices are understaffed, so it might be nearly impossible to take beneficiary calls until senior management allots more resources.

### Ignoring FI Notices Increases Your Risk

And why wasn't the alleged billing problem addressed when it was allegedly brought repeatedly to the hospital's attention, by Hertz and then the fiscal intermediary? Hospitals that ignore intermediary warnings to fix a billing problem are at risk of rising to the burden of proof of a false claim: deliberate ignorance or reckless disregard that something's being done wrong, Imperato notes.

Former prosecutor Andy Grosso also sees risks in a hospital not correcting problems once they are identified. "If you have any questions about your billing, the procedure is very clear," says Grosso, now a Washington, D.C., lawyer. "You put the FI and HCFA on notice as to what you're doing and then the FI or HCFA has the opportunity to say yes or no."

In fact, this is exactly why a compliance program exists: to intercept communications about internal mistakes or misdeeds, and investigate and if necessary fix them. Why didn't that happen? One insider says that Delray Community Hospital has a good compliance program and that its CEO is compliance-savvy. Plus Tenet has gotten a lot of praise for its corporate compliance program, which began as a mandate in 1994 as part of a

massive fraud settlement between the government and Tenet's predecessor, National Medical Enterprises. The insider doubts that Tenet has problems with company-wide patterns of misconduct. And he notes that Medicare will pay for multiple pathology tests run on the same specimen if there's medical necessity. "The amount of the settlement indicates there wasn't much of a pattern here," the insider says.

But Skillen counters that the false claims fine was derived from overcharges pulled from the hospital's cost report, and Medicare's formula of cost-to-charge ratios kept the recovery low.

When there are material violations of existing CIAs, the HHS Inspector General's office has the authority to either exclude the health care organization or impose "stipulated penalties" of \$2,500 per violation. The OIG would not comment on whether any further action is planned against Tenet over this case.

But OIG spokeswoman Judy Holtz did note that "The Department of Justice entered into this settlement agreement [with Delray]. The OIG is not a party to it and did not give up any of its rights in case anything needs to be pursued further."

This settlement does not include a corporate integrity agreement. Sometimes that occurs because the OIG has faith in the organization's existing compliance program.

### **Does Money Trump Ethics?**

Grosso notes that these kinds of situations often indicate that the bottom line trumps ethics and compliance. It's dangerous, he notes, when ethics and compliance are just one factor in the hospital's decision-making process when a decision is being made where a violation could occur. Some CEOs can't see beyond the money and that can put the organization at risk.

That's why the job of compliance officer is by definition adversarial, he says. Grosso says organizations must (1) ensure their compliance officers can end-run the CEO and go to the board if necessary; (2) give compliance officers a contract that protects their job and salary if they have to expose internal misconduct (*RMC 4/12/01, p. 1*); (3) have senior managers "who will give [the compliance program] life," he says. "It doesn't matter how good the compliance officer is. He can't be everywhere at once."

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