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The NYS False Claims Act: A Brave New World for Health Care Fraud Litigation

By Douglas M. Nadjari, Esq.

Marking what may well prove to be the onset of unprecedented scrutiny of Medicaid claims in this state, Governor Eliot Spitzer recently signed into law New York's first False Claims Act. The cornerstone of the new legislation is its qui tam provision, which allows those with knowledge of alleged fraud in state funded programs to bring a lawsuit and do so in the name of the State of New York. Qui tam actions under the new legislation may be brought by state governments, local authorities and even individuals.

Although some allege that as much as ten percent of the State's $45 million Medicaid budget consists of fraudulent claims, attempts to pass similar legislation failed on numerous other occasions. Apparently, the federal Deficit Reduction Act (DRA), provided New York with an offer it could not refuse – a strong financial incentive to finally get the job done. The DRA permits states that enact their own false claims acts to keep: (1) a portion of any verdict or settlement brought under the new law in an amount equal to the percentage it contributes to the Medicaid program and (2) an additional ten percent of any amount recovered. Qui tam plaintiffs reap the benefits too. Based upon a sliding scale set by statute, the new law permits them to keep between fifteen to thirty percent of the recovery.

New York's new law is modeled upon the Federal False Claims Act, which also has a qui tam provision. The federal legislation was enacted after the Civil War and was used to target corrupt "carpetbaggers" seeking to capitalize on reconstruction. The federal statute, dormant for many years, was resurrected in the 1970's to combat profiteering in the defense and aerospace industries. In the 1990's, this powerful statute became the first line of defense against those engaged in Medicare and other health care fraud schemes. The federal statute is predicated upon proof of intentional or reckless conduct in obtaining (or avoiding) payment. In pertinent part, it holds that any person who presents a fraudulent claim for payment to the federal government (or so conspires to defraud the federal government) may be held liable for three times the amount of the loss and, a further civil penalty of not less than $5,000 and not more than $10,000.

New York's new False Claims Act is identical in its liability provisions to that of the federal statute and both laws authorize, as a punitive measure, recovery of sums representing three times the alleged loss. Under both state and federal laws, in addition to proving falsity (or willful ignorance of the claim's falsity), the party bringing the action must also prove that: (1) he or she was the original source of the allegation and (2) that it was voluntarily brought to the government's attention. However, unlike the federal statute, New York's False Claims Act permits both private parties and local governmental authorities to bring qui tam actions and, of course, share handsomely in the recovery (i.e., between fifteen and thirty percent of the recovery based upon a sliding scale set by statute). In addition to providing for the recovery of three times the alleged loss, as does its federal counterpart, the New York statute provides for slightly stiffer civil penalties (i.e., $6,000 to $12,000 dollars per violation).

Additionally, as of January 1, 2007, federal law requires providers receiving payments from Medicaid which equal or exceed $5 million annually to establish written policies for all their employees and provide them with "detailed information" about the federal and state laws which create civil or criminal penalties for false claims. In addition, employee handbooks for such providers must include information concerning both these legal provisions and the rights of employees to be protected as "whistle blowers." Of course, the legislation is designed and implemented for the express purpose of increasing False Claims Act litigation and recoveries.

Efforts at combating alleged Medicaid fraud will be augmented by the appointment of a new Deputy Attorney General charged with the responsibility of running the Attorney General's Office of Medicaid Fraud Control and the creation of the Office of Medicaid Fraud Inspector General (OMIG) which combines the audit functions previously divided between the Attorney General's Office and the state Department of Health. OMIG will enjoy increased staffing and unprecedented funding. Both units are run by former federal prosecutors with substantial experience in the area of health care fraud and will be under enormous pressure to decrease Medicaid costs by increasing the recoveries attributable to alleged false claims. Therefore, in the face of stepped-up enforcement efforts, new federal education requirements and the advent of a new private right of action (in the form of the state's False Claims Act), the level of scrutiny upon Medicaid providers in New York is likely to be unprecedented.

Tales of abuses in nursing homes and elsewhere in the Medicaid system are legion. Accordingly, it is only a matter of time until the plaintiffs' bar turns to the new False Claims Act and sets its sights on Medicaid providers. Of course, patients and their families are all potential qui tam plaintiffs. In the nursing home setting, claims of substandard care may even prove to be fodder for false claims litigation under the new law. The recent criminal prosecution of one or more nursing home medical directors based upon claims of malfeasance or nonfeasance preceded the enactment of New York's False Claims Act but may nonetheless foreshadow the fact that the New York State Attorney General may couple criminal prosecutions for nonfeasance with civil False Claims Act litigation. Therefore, those physicians who continue to provide services in a nursing home setting (and more particularly, medical directors at such facilities) should be on notice that they may be the subject of the most intense scrutiny of all.

More importantly, one must be aware that every present or former employee is a potential qui tam plaintiff. Exit interviews of all outgoing employees should be conducted. The interview should be witnessed and the subject should be queried, albeit diplomatically, about his or her awareness of any unusual or improper practices. Memorializing the interviewee's remarks (which in most cases will be benign) will later serve to diminish that person's effectiveness as qui tam profiteer. The best defense is the implementation of plan that will negate or diminish allegations that your Medicaid claims were false or submitted in "deliberate ignorance of the truth", as the law requires qui tam plaintiffs to prove. Consider implementing a Compliance Plan that assures substantial compliance with Medicaid's billing and documentation requirements. Any such plan should include periodic test audits, preferably conducted by an outside consultant. We suggest permitting counsel to retain the consultant on your behalf. By doing so, the consultant becomes an "arm" of the law firm and his or her findings will, if necessary, be protected from discovery by the government or qui tam plaintiffs by operation of the attorney-client privilege. On a practical level, one should be familiar with Medicaid's documentation requirements. Be involved in your billing and review all correspondence from Medicaid, OMIG or any health plan administering or auditing a Medicaid program. Train your staff to bill properly (or hire a reputable billing company, one that does not charge on a percentage basis). By following this advice, you will be able to demonstrate a lack of any intent to defraud by simply showing the existence of a vital, ongoing and professional effort to identify and report erroneous claims.

Finally, be aware that you, as the physician providing the service, have no obligation to speak with investigators who may arrive at your door unannounced. Every practice should adopt policies and train employees about: (1) when it is (or is not) permissible or appropriate to communicate with investigators and (2) when counsel should be consulted. The physician that is equipped with a good compliance plan, increased efforts to monitor staff members and a healthy skepticism of government investigators is well-equipped for survival in this brave new world.

***Douglas M. Nadjari**, is a partner in the law firm of Ruskin Moscou Faltischek, P.C. where he represents healthcare providers in criminal and civil litigation matters, disciplinary proceedings, in managed care disputes and before hospital committees. Prior to joining his firm, Mr. Nadjari was a partner in a major medical malpractice defense firm. Before joining the private sector, he served as a member of the Homicide Bureau and served as Deputy Chief of the Investigations, Felony Trial and Major Frauds Bureaus in the Brooklyn District Attorney's Office where he spearheaded the investigation and prosecution of homicide cases, health care and other complex financial fraud cases. He can be reached at (516) 663-6536 or dnadjari@rmfpc.com.*