



LEGAL BRIEFS

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False Claims Act Liability for CRNAs Related to Medical Direction

It has never been a secret to Certified Registered Nurse Anesthetists (CRNAs) that anesthesiologists are often not able to consistently comply with all of the requirements of TEFRA (Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97-248).

This was all but acknowledged in a recent article in *Anesthesiology*.¹ Throughout it all, CRNAs' focus has remained on their primary responsibilities: the actual administration of anesthesia and the welfare of the patient.

However, once there is even a whiff of blood in the water, enter the lawyers. Lawsuits have been filed under the False Claims Act (FCA) alleging fraud against anesthesiologists for falsely claiming to have complied with TEFRA. The question addressed herein is whether CRNAs face a likelihood of liability for these false claims of proper medical direction.

The potential for liability will turn on a CRNA's role in billing, knowledge of any improper conduct, and improper retention of funds obtained through fraudulent conduct. CRNAs focused solely upon the administration of anesthesia and uninvolved in submitting bills or executing certifications should be at minimal risk.

What Does TEFRA Require?

TEFRA was a tax bill intended to address shortfalls in the gov-

ernment's budget. Why then are CRNAs routinely discussing a bill designed for closing tax loopholes? Because there is language within TEFRA that permits an anesthesiologist to be paid for medically directing anesthesia services.

Anesthesiologists are allowed to provide medical direction for up to 4 concurrent cases. Medicare, however, will only pay for medical direction if the services meet *all* of the following conditions. The anesthesiologist must:

1. Perform a preanesthetic examination and evaluation of the patient;
2. Prescribe the anesthesia plan;
3. Personally participate in the most demanding aspects of the anesthesia plan, including induction and emergence, when applicable;
4. Ensure that any procedures in the anesthesia plan that are not performed by the physician are performed by a qualified anesthetist;
5. Monitor the course of anesthesia administration at frequent intervals;
6. Remain physically present and available for immediate diagnosis and treatment of emergencies; and
7. Provide indicated postanesthesia care.

Regulations further require the physician to document in the patient's medical record that all of these requirements have been satisfied, and must specifically document performing the prean-

esthetic exam and evaluation, providing the postanesthesia care, and being present during the most demanding procedures.

So, what are the consequences if this information is falsely documented? The prevailing notion is that, under the FCA, this constitutes fraud.

The False Claims Act, 31 U.S.C. §§ 3729-3733

The FCA was designed to protect the government from fraud. Enacted during the Civil War, it was created to address fraud perpetrated by those selling supplies to the Union Army. "For sugar, [the government] often got sand; for coffee, rye; for leather something no better than brown paper; for sound horses and mules, spavined beasts and dying donkeys...." *United States ex. rel. Newsham v. Lockheed Missiles and Space Co., Inc.*, 722 F. Supp. 607, 609 (N.D.Cal. 1989).

The textbook case is the government buying bullets filled with sawdust rather than gunpowder. When the government buys a bullet that will not fire, it is clear that the government did not get the value for which it bargained. However, when the government is buying healthcare, it is often less clear whether the benefit the government is bargaining for is being obtained.

The FCA, in relevant part, provides liability for any person who:

- knowingly submits a false

claim to the government;

- causes another to submit a false claim to the government;
- knowingly makes a false record or statement to get a false claim paid by the government; or

- conspires to violate the FCA.

See 31 U.S.C. §§ 3729(a)(1)(A), (B), and (C).

Simply being the individual who submits the false claim does not subject you to liability unless you had *knowledge* that the claim was false. The FCA defines *knowledge* as: (1) actual knowledge; (2) deliberate ignorance of the truth or falsity of the information; or (3) reckless disregard of the truth or falsity of the information. Therefore, if you submit a claim *knowing* it to be false, you could be subjecting yourself to potential liability.

Putting it All Together

An anesthesiologist falsely documenting compliance with TEFRA could expose the anesthesiologist to FCA liability. Documenting physician compliance with TEFRA is what triggers the government's payment to the anesthesiologist. Courts have held that "where the government has conditioned payment of a claim upon a claimant's certification of compliance with, for example, a statute or regulation, a claimant submits a false or fraudulent claim when he or she falsely certifies compliance with that statute or regulation."² It follows, then, that an anesthesiologist submitting a bill to the government for medically directed services—while knowing he or she did not perform all of the obligations enumerated by TEFRA—could be liable for submitting a false claim. But what of the CRNA who actually administered the anesthesia?

The first potential risk turns on the role of the CRNA in billing and creating the documentation serving as the basis for coding and/or billing. If the billing department assumes medical direction based

solely upon an anesthesiologist's documentation and not upon information provided by the CRNA, the risk to the CRNA is minimal. However, if the CRNA knowingly prepares or submits documentation falsely reflecting medical direction, there is an increased potential for liability. The FCA imposes liability on any person knowingly making a false statement in order to get a false or fraudulent claim paid. See 31 U.S.C. § 3729(a)(2).

It Does Not Matter that CRNAs Are as Much the Victim of this Fraud as Anyone

Liability under the FCA exists even if an individual does not profit from the false claim. Medically directed reimbursement (billed QX) is split 50% to the CRNA and 50% to the anesthesiologist. The same services billed by a CRNA without medical direction (QZ) yields 100% reimbursement to the CRNA. Complicity in fraud cannot be viewed as the cost of doing business.

CRNAs must realize that there is no requirement that you intend to defraud the government. Any CRNA being asked to prepare false billing records needs to pay attention. A CRNA who knows that an anesthesiologist did not perform all of the required duties under TEFRA and yet facilitates billing Medicare using the QX modifier (signifying the services were medically directed) and/or who certifies on the claim form that the services were medically directed could be liable for submitting a false claim.

It is the obligation of each CRNA to avoid unknowingly or unwittingly being branded as a participant in wrongdoing. Depending upon the frequency or scope of the misconduct, the government could allege a conspiracy to violate the FCA. While an unlikely occurrence, this would be the worst case consequence of looking the other way.

There is no obligation for anyone to be a whistleblower, and blowing

the whistle on wrongdoing comes with its own share of trials and tribulations. However, a CRNA should maintain enough understanding to avoid circumstances in which he or she could find him- or herself the target of a whistleblower investigation or the subject of a whistleblower complaint.

Failing to Repay Overpayments Violates the FCA

What about the funds obtained by the CRNA who actually performed the administration of anesthesia? Absent the false certification that the CRNA's services were medically directed, the CRNA (or hospital or medical practice) would have received more money for the services performed by the CRNA. The government's analysis, however, is not limited to a question of provider profit or government loss.

The government is continuing its trend of aggressively pursuing allegations of healthcare fraud. The government expects (in fact, has budgeted) to recover billions of dollars attributable to healthcare fraud in the coming fiscal years. The government has revealed the FCA to be a substantial revenue-generating tool and has expanded potential recoveries by adding FCA liability for the failure to timely return overpayments. (These resulted from amendments to the FCA under the Fraud Enforcement and Recovery Act in 2009 and the Patient Protection and Affordable Care Act in 2010.)

Overpayments are defined as any government funds (Medicare or Medicaid) that an individual receives or retains to which they are not entitled. The regulations basically require healthcare providers to report and return any overpayments within 60 days after the overpayment is identified.

A CRNA could certainly argue that he or she was entitled to the funds received, and arguably entitled to more than was received. The

government, however, could easily adopt the position that the CRNA might have been entitled to funds under services billed as QZ, but not entitled to anything for services billed under QX because the requirements of TEFRA were not fulfilled, thus making the claim false. The government could then deem all of those funds, not just those obtained by the anesthesiologist, tainted.

Honesty Is the Best Policy

The CRNA simply providing patient care and leaving the billing to someone else should be at minimal risk. Even if you suspect that a false claim is being submitted, you are under no legal obligation to investigate or report it. If, however, a CRNA is falsely certifying the accuracy of information or submitting bills while knowing them to be inaccurate, the CRNA is exposing himself to potential liability.

These circumstances do not have the hallmarks of a traditional FCA case because there is no immediately identifiable loss to the government. However, the government can and does look beyond government loss. There is the burden of increased administrative costs, as well as the harm to the public flowing from payments for dishonest services. Even though the immediate amount the government is paying might not increase, there are losses to the government and the potential to recover substantial sums. (Anyone found to have submitted false claims is liable for three times the government's damages plus civil penalties of \$5,500–\$11,000 per false claim. See 31 U.S.C. § 3729(a).)

Conclusion

The amount of unnecessary time and energy spent evaluating compliance with TEFRA provides another

example of why Medicare should give substantial consideration to repealing medical supervision and medical direction of CRNAs. The focus of any anesthetist, CRNA and anesthesiologist alike, should be the welfare of the patient before them. Unnecessarily complex billing and oversight requirements yield potential distractions from the primary task at hand and present unnecessary and avoidable risks.

REFERENCES

1. Epstein RH, Dexter F. Influence of supervision ratios by anesthesiologists on first-case starts and critical portions of anesthesiology. *Anesthesiology*. 2012; 116:683-691.
2. *U.S. ex rel. Thompson v. HCA Columbia Healthcare Corporation*, 125 F.3d 899 (5th Cir. 1997).

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