OBER | KALER
Attorneys at Law

Health Law Alert™

Subscribe | Health Law Group | Health Law Alert Archive

2012 Issue 2

www.ober.com

"Worthless Services" May Create Liability Under False Claims Act

By: James P. Holloway

Health care providers should take note of a recent federal court decision from Kentucky, in which the court refused to dismiss a False Claims Act (FCA) case based on a theory that the provider had billed the Medicare and Medicaid programs for "worthless services." Under this theory, when a provider bills the federal government for a service that the provider knows, or should know, has no value, the provider is liable for making a false claim.

In *U.S. v. Villaspring Health Care Center, Inc.*, 2011 WL 6337455 (E.D. Ky. Dec. 19, 2011), the court concluded that the federal government could proceed with FCA litigation based on allegations that a nursing home had billed the Medicare and Medicaid programs for worthless services. According to the court, when proceeding under a worthless services theory, "[i]t is not necessary to show that the services were completely lacking; rather, it is also sufficient to show that 'patients were not provided the quality of care' which meets the statutory standard." That decision does not stand alone. The *Villaspring* court relied on an earlier case that endorsed the use of the worthless services theory against a health care provider, i.e., *U.S. v. NHC Health Care Corp.*, 163 F. Supp. 2d 1051 (W.D. Mo. 2001). Numerous other courts have recognized the general principle that knowingly billing the government for worthless services is tantamount to billing for services that were not provided, which is a false claim in violation of the FCA.

While several courts have rejected the use of the worthless services theory against health care providers – particularly in the case of providers that receive a *per diem* payment rate for bundled services, as is typically the case for a nursing home resident in a Part A Medicare stay – the *Villaspring* decision indicates that some courts may be reluctant to reject such allegations on a motion to dismiss early in a lawsuit. The *Villaspring* court, citing to *NHC Health Care*, concluded that a *per diem* payment for bundled services does not preclude the submission of false claims:

> A per diem billing arrangement presupposes that a nursing facility will agree to provide "the quality of care which promotes the maintenance and the enhancement of the quality of life…. At some very blurry point, a provider of care can cease to maintain this standard by failing to perform the minimum necessary care activities required to promote the patient's quality of life. When the provider reaches that point, and still presents claims for reimbursement to Medicare, the provider has simply committed fraud against the United States…. Whether Villaspring's actions fell within the "admittedly grey area" beyond this "blurry point" is necessarily a fact-intensive inquiry and, therefore, not a proper question for the Court to answer on a motion to dismiss (citations omitted).

The concern highlighted by the *Villaspring* case is the possibility that whistleblowers using a worthless services theory may survive a motion to dismiss, thereby allowing the case to proceed to trial. That means expensive, burdensome and intrusive discovery regarding, for example, a provider's quality of care and quality assurance efforts (or the lack thereof). It also raises the prospect that a jury will determine a provider's potential exposure to crippling treble damages and penalties under the FCA. More specifically, financial liability could be as high as three times the amount of Medicare and Medicaid payments received by a provider, plus civil penalties as high as $11,000 for each false claim submitted to the government.

The risks for providers are enhanced because the government (or *qui tam* relator) is not required to demonstrate that health care services are literally worthless. The *Villaspring* case suggests that proof of a nursing facility requesting federal payment for services while knowingly failing to provide the "minimum necessary care" may be sufficient to win a worthless services case. Furthermore, *knowingly* in the FCA context is not limited to a provider's actual knowledge that it billed a health care program for worthless services. A provider may violate the FCA when it knew – or should have known – that it requested federal payment for worthless services. Thus, it is the provider's responsibility to assure that it is providing at least the minimum necessary care before requesting federal payment. Providers cannot

simply assume the adequacy of their services; rather, they must regularly monitor and validate the adequacy of their services through an effective quality assurance (QA) program.

Such QA programs cannot merely exist on paper in a handbook or policy manual. Providers must actually implement their QA programs and document their use on an ongoing basis. The design of an effective QA program should meet accepted industry standards, yet should be tailored to meet the unique circumstances of each provider. At a minimum, providers should ensure that a sufficient number of objective and measurable quality indicators have been established. Equally important, providers should regularly measure their performance against those indicators, and effectively address any instances where their services fail to meet the expected standard by implementing an effective action plan. The monitoring of care delivery undoubtedly involves additional effort, but minimizing the significant risk presented by worthless service claims is one of many good reasons to engage in a robust QA program.