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ALERTS

Court Rules U.S.' Medicare Advantage Suit Against Kaiser Permanente May Move Forward

November 17, 2022

Highlights

A California federal court partially dismissed the government's claims against Kaiser Permanente, but permitted claims based on sub-regulatory disease classification guidelines to proceed.

Kaiser is alleged to have violated the False Claims Act by submitting inaccurate diagnosis codes via addenda for its Medicare Advantage Plan enrollees to receive higher reimbursements.

The court held that both the Medicare Advantage Contract and the governing regulations require compliance with the coding guidelines.

The U.S. District Court for the Northern District of California determined that the United States' claims against Kaiser Permanente for submission of inaccurate diagnosis codes via addenda may proceed. Although the court narrowed the scope of claims in the action, it determined that both Kaiser's Medicare Advantage contract with the Centers for Medicare & Medicaid Services (CMS) and the governing federal regulations required Kaiser's addenda to comply with the International Classification of Diseases (ICD) coding guidelines.

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This case concerns Kaiser's Medicare Advantage risk-adjustment practices. The government alleges that Kaiser violated the False Claims Act (FCA) by submitting inaccurate diagnosis codes via addenda for its Medicare Advantage Plan enrollees in an effort to increase patients' risk scores and, as a result, receive higher reimbursements. Kaiser previously filed four motions to dismiss the False Claims Act allegations pending against it and focused on whether sub-regulatory guidance could be used to support a legal falsity claim regarding diagnoses added through addenda.

On Nov. 14, the court answered that question with a resounding yes. The court rejected Kaiser's arguments regarding legal falsity and permitted the government's allegations that Kaiser "systematically alter[ed] patient medical records to add diagnoses that . . . were unrelated" to a patient's visit with a Kaiser physician in an effort to inflate patients' risk scores to move forward.

In its motion to dismiss, Kaiser argued that the government failed to sufficiently plead a legal falsity claim based on the addition of diagnoses that were unrelated to the patient's visit with a Kaiser physician because the government improperly relied on non-binding, sub-regulatory and non-governmental coding guidance. It cited the ICD Guidelines (drafted by CMS and the National Center for Health Statistics), the CMS Medicare Managed Care Manual, the CMS Participant Guide, and American Health Information Management Association Practice Briefs, which Kaiser claimed could not support an enforcement action as a matter of law.

The court rejected Kaiser's argument on three separate bases. First, the court reasoned that Kaiser ignored the fact that the government's theory could also be construed as one predicated on factual falsity, which by itself would be enough to permit the claim to go forward. Second, the court rejected "Kaiser's argument that the terms of the CMS/Kaiser contract cannot be read to require compliance with the ICD Guidelines." In the court's view, "incorporation by reference is a common contractual tool" and the contract can therefore be read to incorporate the ICD Guidelines. Moreover, the Court rejected Kaiser's contention that the standard announced in *Azar v. Allina* – that substantive legal standards affecting Medicare benefits are subject to notice and comment – precludes CMS from creating substantive contractual obligations.

Third, the court agreed with the government that compliance with the ICD guidelines is necessary under the relevant regulatory scheme because Medicare Advantage Organizations (MAOs) must submit data to CMS that confirms certain requirements and "all relevant national standards." The court held that because CMS has adopted the ICD Guidelines as a national standard, and the regulations require MAOs "to provide accurate risk adjustment data to CMS," it is clear that MAOs must comply with the ICD Guidelines. In other words, because the regulations incorporate the sub-regulatory ICD guidelines, MAOs are required to comply with them – thus providing a sufficient hook for a legal falsity claim under the FCA.

Although the court has permitted these claims to move forward, it dismissed the government's theory based on the addition of diagnoses that "did not exist" (i.e., those that were clinically inaccurate). The court identified these claims as solely affecting a "factual falsity" theory and agreed with Kaiser that the government's limited examples were insufficient to infer a widespread systemic scheme to add nonexistent

diagnoses, except as to one specific disease, cachexia.

The court also considered Kaiser's motions to dismiss the remaining operative complaints from relators. Because the *Osinek* relator stated she did not intend to pursue any non-intervened claims, the court dismissed the *Osinek* complaint to the extent it included non-intervened claims. The court then dismissed the Bryant relator's claims based on the Affordable Care Act (ACA) because the relator did not sufficiently allege that the purported false statements were material to Department of Health and Human Services, the relevant government agency under the ACA. The court did, however, permit Bryant's FCA retaliation claims to proceed.

In addition, the court granted Kaiser's motion to dismiss the Taylor complaint, with leave to amend, because Taylor failed to sufficiently allege misconduct by newly named defendants, failed to adequately allege materiality, and failed to show that relation back under the statute of limitations would permit his claims against newly named Defendants.

The court's decision should serve as a warning to Medicare Advantage organizations as they implement chart review programs and use addenda to update risk adjustment data. It will continue to be critically important for organizations to demonstrate that delayed additions of diagnoses are supported by medical records and are otherwise compliant with the ICD coding guidelines.

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