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ALERTS

# False Claims Act Case May Proceed Against Medicare Advantage Organization, Subsidiaries

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**Highlights**

A federal court recently interpreted the International Classification of Diseases (ICD) Guidelines to require that diagnoses added through addenda must have required or affected patient care or management at the encounter

Defendants conceded that the ICD Guidelines "have the force of law"

The *Ross* holding reinforces that MAOs and providers should have robust compliance programs to ensure that retrospective reviews and the use of addenda comply with CMS guidance

A decision earlier this month allowing a case to proceed regarding alleged fraud by a Medicare Advantage Organization (MAO) and its subsidiaries signals the continued scrutiny of certain risk-adjustment practices in the healthcare industry.

The Honorable William Skretny of the U.S. District Court for the Western District of New York issued an order in *U.S. ex rel. Teresa Ross v. Independent Health Corporation* granting in part and denying in part the defendants' motion to dismiss the government's intervention complaint

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alleging the defendants engaged in fraudulent risk-adjustment practices relating to retrospective chart reviews and the use of addenda.

The government's intervention complaint alleges that Independent Health Association, an MAO, and its subsidiaries overstated patient health conditions by submitting inaccurate and unsupported diagnosis codes in violation of Centers for Medicare & Medicaid Services (CMS) regulations and contractual obligations, which resulted in unwarranted overpayments. On Jan. 17, 2023, the defendants moved for an extension of time to file their answer to the government's complaint-in-intervention.

The government alleges that Independent created a subsidiary, DxID, for the purpose of capturing diagnosis codes for MAOs like Independent to submit to CMS to receive higher monthly payments for providing insurance to beneficiaries. Specifically, DxID offered: 1) a retrospective chart review program that re-reviewed enrollees' medical records for additional diagnosis codes and 2) an addenda process that "nudged" medical providers to retroactively add diagnoses to medical records. These new diagnosis codes allegedly were not documented by qualified health care providers, did not exist at the time the patient was seen by staff physicians, did not require or affect the patient's care, treatment, or management, and were otherwise unsupported by the patient's medical records.

These allegedly inaccurate diagnosis codes functioned to increase a beneficiary's risk-adjustment score, thereby increasing the monthly payments Independent received from CMS.

## What Legal Obligation?

In their motion to dismiss, the defendants argued the government failed to state a claim under the False Claims Act because it did not sufficiently allege a violation of any legal obligation under the statute. Although they acknowledged the International Classification of Diseases (ICD) Guidelines "have the force of law," the defendants argued the government "badly misread[]" the single provision it relied upon. That provision states: "Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management." While the government contended this provision required documentation that the physician treated the condition during the encounter or that the condition otherwise affected care, the defendants argued the provision required only that the condition be documented and no more.

Interestingly, though the allegations against Independent are similar to those against Kaiser in the *Osinek* matter. Independent chose to concede that the ICD Guidelines have the force of law rather than follow Kaiser's lead to challenge the guidelines as a basis for liability under the False Claims Act entirely.

The court sided with the government on this one – holding the government sufficiently alleged a violation of a legal obligation. The court noted that, "[a]t the outset, there is no dispute that federal regulations require the submission of accurate, complete, and truthful data in support of a claim for payment." Importantly, the court held that federal regulations require compliance with national standards for medical record documentation, which are contained in the ICD Guidelines.

This is consistent with the *Osinek* court's holding that the governing federal regulations incorporate the ICD Guidelines as the relevant national standard and are thus binding on the defendants. Moreover, the court here found "no support" for the defendants' "exacting" reading of the applicable guidelines and concluded the provision did not support the defendants' "no-further-documentation-required interpretation." Instead, the court concluded an erroneous comma in the text of the guidelines suggested a more natural reading requiring documented conditions have at least two attributes: 1) they "coexist at the time of the encounter/visit," and 2) they "require or affect patient care treatment or management." This determination, according to the court, is a fact-driven one.

The court also rejected the defendants' position that its coding and addenda policies were consistent with their legal obligations and agency guidance. The court noted that the defendants relied largely "on favorable readings of guidance and factual inferences drawn in their favor, each of which is precluded" at the motion to dismiss stage. Ultimately, the court determined the government sufficiently alleged (1) a scheme in which codes were submitted for conditions that enrollees did not have," (2) that "addenda forms DxID created were false records or statements," and (3) that defendants could not attest that diagnosis codes derived solely from the addenda forms were accurate, complete and truthful.

## MAOs Continue to Face Increased Scrutiny Under the False Claims Act

In 2022, Medicare Advantage plans comprised 28.7 million beneficiaries, or 49 percent, of all federal healthcare program beneficiaries – nearly doubling in growth over the last decade. Such growth in popularity is not without increased scrutiny, however, and the government continues to make healthcare fraud, and matters related to the Medicare Advantage program, a top priority. In recent years, the government has increased its focus on MAO risk adjustment reporting, reaching a $270 million settlement with DaVita Medical holdings in 2018 and a $90 million settlement with Sutter Health in 2021. The government's current focus on Medicare Advantage cases involving risk adjustment include, among others, those against Kaiser Permanente alleging $1 billion in overpayments and Anthem alleging $400 million in overpayments – both involve claims relating to improper retrospective chart review programs and the use of addenda.

While tools such as chart reviews and addenda are entirely appropriate and can often assist MAOs in ensuring they receive the funds necessary to cover their enrollees, they must be used with care. MAOs, and those acting to support them, must ensure retrospective reviews comport with applicable CMS regulations and guidance. Importantly, adding codes should be complemented by deletions of codes, where applicable. Encounter data must be complete and up-to-date and diagnoses supported by medical records. At the end of the day, a robust compliance program is paramount to ensuring high quality of care as well as the success and overall integrity of the Medicare Advantage program.

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