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In Okla. Hospital FCA Case Over Supervision, Top Executive and M.D.s Take the Hit Too

An Oklahoma hospital and a former top executive have agreed to settle false claims allegations that it billed Medicare for radiology procedures without the requisite physician supervision. Six physicians also were held accountable for the false claims allegedly submitted by Norman Regional Health System, and they had to pony up part of the $1.6 million false claims settlement, the U.S. Attorney's Office for the Western District of Oklahoma said April 11.

The false claims complaint centered on radiology services that require personal supervision by radiologists, which means a radiologist must be in the room when the services are performed. The hospital allegedly billed Medicare for procedures performed by radiology practitioner assistants (RPAs) without personal supervision. The scheme allegedly got a hand from Greg Terrell, who was chief operating officer and senior vice president of Norman Regional Health System. "Defendant Terrell abdicated his responsibility and authority to prevent or correct the false billings, and he failed to do so and as a result, [the health system] obtained substantial financial benefit," according to the complaint.

The inclusion of Terrell and the six physicians in the settlement are an example of the Yates memo in action, says former federal prosecutor Melissa Jampol, who is with Epstein Becker in New York City. The Yates memo, formally called the Individual Accountability Policy, is DOJ's blueprint for nailing culpable individuals when settling corporate fraud cases (*RMC 9/14/15, p. 1*). "This shows the strong influence of the Yates memo," she says. Some people think the Yates memo is "confined to the criminal realm, but it also applies to the civil realm. The fact that Terrell held a senior leadership position and was directly responsible for billing put him squarely within the Yates memo's concerns and the allegations were pointed directly at him at times," Jampol says. In another civil case, the former CEO of Tuomey Healthcare System agreed to pay $1 million over the alleged part he played in the sweetheart deals that turned the South Carolina health system inside out (*RMC 10/3/16, p. 1*).

Physician Was Also the Whistleblower

As is typical of many false claims cases, the lawsuit against Norman Regional Health System began with a whistleblower, radiologist Lance Garber, who was employed by the hospital from 2008 to around March 2012. According to the complaint, RPAs performed diagnostic and nondiagnostic procedures at the hospital. "When an RPA performs a procedure that requires personal supervision, the radiologist must be present in the room, even if the RPA has been trained to perform the procedure and it is within his or her stated scope of practice," the complaint states. Without the physician's personal supervision, the hospital and the radiologist are not allowed to bill Medicare for the services performed by the RPAs. Six physicians employed by the hospital allegedly submitted Medicare claims for radiology procedures performed by RPAs without their personal supervision, and they were also named in the complaint.

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"The RPAs performed diagnostic and nondiagnostic/surgical procedures without the required supervision of radiologists and generated preliminary radiology reports reflecting that the physician either performed the service or that the physician personally supervised, when the fact was, the physician did neither, which made the bill a false claim," the complaint alleged. "These reports were then reviewed and approved by the corresponding Defendant physicians, who certified that he personally furnished the service, or that it was furnished under the Defendant doctor's direct personal supervision."

The procedures included lumbar punctures, myelograms, arthrograms, thoracentesis, paracentesis, central line placements, barium swallows, upper G.I. examinations and barium enemas, the complaint alleged.

As for Terrell, he allegedly "had the responsibility and authority to either prevent or correct the hereinafter described violations and he failed to do so," according to the complaint.

The attorney for the hospital was unavailable to comment. The hospital, Terrell and the physicians did not admit liability in the settlement and denied wrongdoing. In a statement, Norman Regional Health System CEO Richie Splitt noted it "has a robust compliance program that focuses on billing accuracy and compliance with all federal health benefit programs. We are entering into this settlement agreement to resolve the allegations so that our employees, physicians, and administration can focus on our mission to serve our community as the leader in health and wellness care."

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DOJ Talks Carrots and Sticks

DOJ stated that the hospital cooperated in the investigation, and that's something more than lip service, Jampol says. Given DOJ policy about rewarding companies that cooperate and its February guidelines on the "Evaluation of Corporate Compliance Programs" (*RMC 3/6/17, p. 1*), it's apparent how much prompt cooperation weighs into DOJ's charging decisions and calculations of civil fines, she says. The guidelines, which dig extraordinarily deeply into compliance programs, supplement the "Principles of Federal Prosecution of Business Organizations" in the United States Attorney's Manual. "DOJ is striving to be much clearer in the kinds of questions they are thinking about and the ways they are analyzing things," she says.

And it's sending its emissaries to get the message across that DOJ will not let up on health fraud even while it values self-policing by industry.

At an April 20 conference on the Foreign Corrupt Practices Act, Acting Principal Deputy Assistant Attorney General Trevor McFadden said the $513 million global settlement with Tenet Healthcare Corp. last year (*RMC 10/17/16, p. 1*) "should send a clear signal to hospitals and health-care companies around the country that they and their management will be held accountable for fraudulent misconduct. Just as no major multinational company would responsibly operate without an anti-corruption policy and program, no American hospital should be taking federal dollars for Medicare and Medicaid without ensuring those funds are being used properly. The American taxpayer does not take kindly to our tax dollars being used to line the pockets of fraudsters masquerading in white coats, and neither will the Justice Department."

Two days earlier, however, McFadden noted that the department regularly takes into consideration voluntary self-disclosures, cooperation and remedial efforts when making charging decisions involving business organizations, Jampol says. In a speech at the Anti-Corruption, Export Controls and Sanctions 10th Compliance Summit, McFadden stated that "Our goal is for companies and individuals to voluntarily comply with the law. And it is by working with companies transparently and in partnership that we can achieve this goal."

There is a context to the DOJ guidelines that underscores the growing importance of self-policing in the eyes of the government, Jampol says. The guidelines are based partly on seminal documents in the compliance field, she says. They include chapter eight of the Federal Sentencing Guidelines, which covers the potential reductions in sentences for corporations that have effective compliance programs, and DOJ's Resource Guide to the Foreign Corrupt Practices Act.

The message of the guidelines is "there needs to be a very structured analysis and remediation of problems through adequate risk assessment and creativity and having firmly clear policies and procedures and that is what we are seeing," Jampol says.

OIG also published guidance on March 27 to help organizations evaluate the effectiveness of their compliance programs (*RMC 4/3/17, p. 1*). The document, *Measuring Compliance Program Effectiveness: A Resource Guide*, is an exhaustive list of "ideas" that covers the seven elements but isn't intended to be used as a checklist.

Supervision has Led to Settlements Before

Norman Regional Health System's settlement is not the first time that alleged problems with physician supervision have landed hospitals and other providers in hot water with the federal government.

Last year, several hospitals and other providers settled cases with DOJ or the HHS Office of Inspector General over physician supervision (*RMC 8/22/16, p. 3*). Westfield Hospital in Allentown, Pa., and affiliated entities, including Lehigh Valley Pain Management, and three physicians agreed to pay $690,441 to settle false claims allegations related to incident-to billing and its supervision requirement, the U.S. Attorney's Office for the Eastern District of Pennsylvania said. The defendants allegedly billed Medicare, the Federal Employees Health Benefits Program and the Department of Labor Office of Workers' Compensation for services performed by non-physicians incident to the supervising physicians when they were away from the office or otherwise unable to supervise, the U.S. attorney's office said.

In an unrelated case, Greene Memorial Hospital and Fort Hamilton Hospital in Ohio agreed to pay $748,968 in a civil money penalty (CMP) settlement. OIG alleged the hospitals billed Medicare and TRICARE for radiation oncology and related services "that were provided without direct supervision by a radiation oncologist or similarly qualified person" from Jan. 1, 2012, to Dec. 2, 2015, according to the July settlement. The hospitals self-disclosed the alleged errors to OIG. Greene Memorial Hospital and Fort Hamilton Hospital are part of Kettering Health Network. Their lawyer declined to comment.

In January 2016, Rose Radiology Centers Inc. in the Tampa, Fla., area agreed to pay $8.71 million to settle allegations that it violated the False Claims Act by billing federal health care programs for radiology procedures that were not medically necessary or were provided in violation of federal regulations, including supervision requirements, according to the U.S. Attorney's Office for the Middle District of Florida. Rose Radiology was accused of administering contrast dye during MRI scans without direct physician supervision, as required by Medicare. "Contrast dye is a chemical that is injected intravenously into the body in order to make certain tissues, abnormalities, or disease processes more clearly visible on an MRI. Federal regulations require that a physician directly supervise the administration of contrast dye when used for an MRI as a potential adverse side effect is anaphylactic shock. Even though Rose Radiology was aware of this safety requirement, there were Rose Radiology locations that rarely, if ever, had a physician present when contrast dye was being administered," according to the U.S. attorney's office.

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