Prime Healthcare, CEO Settle FCA Case for $65M Over Admissions; Accountability Expands

After Prime Healthcare Services in California bought Alvarado Hospital in 2010, Karin Berntsen, who was the director of case management, watched as it became a place where insured patients allegedly were admitted as inpatients whether or not it was medically necessary, with emergency room physicians pressured to admit them and avoid the use of observation. Alarmed by the alleged noncompliance, Berntsen became a whistleblower, wearing a wire to meetings with hospital executives to gather evidence for the Department of Justice (DOJ), according to her attorney, Marlan Wilbanks. DOJ intervened in her false claims lawsuit, and on Aug. 3, Prime Healthcare Services Inc. and its founder/CEO, cardiologist Prem Reddy, M.D.; Prime Healthcare Foundation Inc.; and Prime Healthcare Management Inc. agreed to pay $65 million to settle allegations that 10 Prime hospitals admitted patients who could have been treated in observation or another outpatient setting from 2006 to 2013, DOJ said.

Reddy has to personally pay $3.25 million of the settlement amount. Prime and Reddy did not admit liability in the settlement.

The case represents a core compliance challenge for hospitals—decisions about patient-status—and the use of the Yates Memo, formally known as the Individual

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HCCs Address Some MD Complaints in Value Era, But Not Without MEAT Documentation

As more payment is tied to quality, outcomes and cost, physicians often lament they’re penalized because they see their patients as different—more complex, poorer—or their facilities as disadvantaged, with fewer staff or outdated equipment.

“You hear that often enough and probably there is a lot of legitimacy to it. Patients don’t come in uniform fashion and the human condition is heterogeneous,” said Ellis “Mac” Knight, M.D., senior vice president and chief medical officer for the Coker Group in Alpharetta, Georgia. “We have to take into account whether quality measures are applied evenly to different providers with different populations and practices.”

Physicians’ concerns are somewhat addressed through a risk-adjustment methodology using hierarchical condition categories (HCCs), but only if physicians satisfy unique documentation requirements that may be unfamiliar, Knight said. Their reimbursement depends on it, and accuracy will matter as they start to face audits in this area.

Medicare Advantage plans use HCCs for provider payments, and they will become more pervasive with CMS’s Bundled Payments for Care Improvement Advanced initiative and other Medicare and commercial value-based reimbursement programs, Knight said at a webinar sponsored by the Health Care Compliance Association on Aug. 1. The mother of all pay-for-performance programs—the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs), which were created

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Accountability Policy, which is DOJ’s policy of pursuing culpable individuals in corporate fraud cases.

“It’s an important piece of the puzzle for this case,” Wilbanks says. Naming Reddy as an individual and not just the founder or officer of the company and requiring him to pay millions of dollars “sends a strong message the government will follow up when they find strong evidence that the allegations of fraud are true,” he contends.

Some of the evidence was gathered from Berntsen wearing the recording device to meetings with executives, which short-circuited a “he said, she said” situation “where they could deny the things she was hearing with her own ears,” Wilbanks says. Berntsen would inform DOJ attorneys of upcoming meetings and their agendas, and if they seemed like they would benefit the case, the FBI arranged for her to wear the wire, Wilbanks said. That’s uncommon in whistleblower cases, but not unheard of, he noted.

The false claims settlement also resolved upcoding allegations, which were pursued by the whistleblower because DOJ only intervened in the patient-status allegations. Of the settlement amount, $20 million pertains to upcoding.

**Hospitals Allegedly Had Admission Quotas**

The allegations in the complaint describe how admissions rose at hospitals after Prime Healthcare bought them. Prime and Reddy allegedly gave hospitals admission quotas, with the hospitals told they should admit 20% to 30% of insured patients who came to the emergency department (ED). The ED physicians were told to get with the program, and “low admitters” were warned they would be kicked off the schedule.

“Prime repeatedly told hospital executives, physicians, nursing supervisors, case managers, clinical documentation specialists and other staff that the Defendant Hospitals did not provide observation services, and that patients for whom such services should have been appropriate were to be made inpatients,” according to the complaint. “The ‘no observation’ policy was communicated to ED physicians and hospitalists in meetings with Reddy and other Prime executives and employees, via multiple separate conversations with Reddy and other Prime executives, and through transmission of this information from ED and hospitalist Medical Directors to individual ED physicians and hospitalists.”

Although ED physicians usually don’t have admitting privileges, they consult on admissions with attending physicians or hospitalists. Prime and Reddy allegedly pushed the hospitalists to accept the ED physicians’ admission recommendations, the complaint said.

The ED physicians allegedly were urged to admit insured patients if their evaluation or treatment would last longer than two hours. That wasn’t the case with uninsured patients, who could stay in the ED for longer to avoid the expense of an inpatient admission, the complaint alleged. Order forms used by ED and attending physicians at the hospitals before they were acquired by Prime were replaced with new forms that had no check box option for observation, according to the complaint.

Admission quotas were routinely reviewed by Reddy, Prime and ED directors. They looked at report cards that tracked the number of ED patients admitted to the ICU, the number of insured admissions and the total percentage of ED patients admitted to each Prime hospital, the complaint alleged.

“If a hospital’s admission percentages fell below the target, Reddy would alert hospital management and arrange a meeting with the ED Director and/or the ED physician who were perceived as not complying with Prime’s admission policies,” the complaint alleged.

ED directors and physicians responded to pressure from Prime and Reddy to admit more insured patients, according to the complaint. For example, an email from an ED director at Encino Hospital to an ED physician encouraged more admissions because of its low rate—15%. “While my review of the daily ED logs indicate that we’re clearly doing the right things for our patients, please understand that this is going to stand out to our administration,” the ED director wrote. “Please keep in mind the Prime mindset. Push admissions as necessary and have a low threshold for admission for any insured patient (even Medi-Cal).”

**Reddy Allegedly Flagged ‘Missed Admissions’**

Reddy allegedly taught Prime management to search in ED logs at the 10 hospitals for “missed admissions”—insured patients who could have been admitted — and also reviewed the logs himself and circled what he considered missed admissions. The CEO’s marked-up logs were sent to ED directors, who were told to obtain the physician’s rationale for not admitting an insured patient, the complaint alleged.

This didn’t always go over well. “Some ED Directors expressed frustration with the constant pressure to admit patients with minor ailments and with Reddy’s constant oversight and scrutiny of the medical judgment of the physicians,” the complaint alleged. “An ED Director claimed that he would start circling his own census report so Reddy ‘won’t find the need to circle every cold and kidney stone.’ Another ED director complained that Reddy ‘now wants to admit Otitis Externa and Cystitis,’” which is ear infection and urine infection.

It’s unclear how compliance at Prime fit in. But Wilbanks says the whistleblower tried to get her

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complaints about admissions addressed. “Our client followed internal protocols for reporting fraud. She reported her concerns to the chief nursing officer, who agreed with her. She then took it to her hospital CEO and CFO. They chastised her for speaking up and not being OK with doing things ‘the Prime way.’”

Resignations Tied to Code of Conduct

When potential violations come to their attention, “it’s incumbent on compliance officers to raise these issues to senior leadership” and explain the risk of creating whistleblowers by not bringing the organization into compliance, says Christine Hogan-Newgren, chief compliance officer and chief audit executive at Stormont Vail Health in Topeka, Kansas. They should also be aware of the growing number of executives who are being held personally responsible in corporate fraud cases or for violating the code of conduct in situations that have nothing to do with fraud.

“There is a movement across the nation where people are held accountable,” Hogan-Newgren says. For example, in July, Brian Crutcher, the CEO of Texas Instruments, resigned due to violations of the company’s code of conduct. The violations are related to personal behavior that is not consistent with our ethics and core values, but not related to company strategy, operations or financial reporting,” according to an email sent to Texas Instrument employees.

Hogan-Newgren will be sharing these developments in an upcoming meeting with the audit committee of her board. It’s remarkable to watch executives parting ways with their companies because of violations of the code of conduct, she says. “It has nothing to do with financial statements. This shows compliance and the code of conduct being taken seriously.” That’s on top of false claims penalties hitting health care executives in corporate fraud settlements. Reddy is the latest, but in May, three

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CMS Transmittals and Federal Register Regulations

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Live links to the following documents are included on RMC’s subscriber-only webpage at hcca-info.org. Please click on “CMS Transmittals and Regulations.”

Transmittals

(R) indicates a replacement transmittal.

Pub. 100-04, Medicare Claims Processing Manual

- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - October 2018 Update, Trans. 4109 (Aug. 10, 2018)
- October Quarterly Update for 2018 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule, Trans. 4108 (Aug. 10, 2018)
- Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index and Hospice Pricer for FY 2019, Trans. 4086 (Aug. 10, 2018)
- Update to the Medicare Claims Processing Manual, Chapter 24, Section 90, Trans. 4096 (Aug. 3, 2018)
- Inpatient Psychiatric Facilities Prospective Payment System (IPPS) Updates for Fiscal Year (FY) 2019, Trans. 4104 (Aug. 3, 2018)
- System Changes to Implement Epoetin Alfa Biosimilar, Retacrit for End Stage Renal Disease (ESRD) and Acute Kidney Injury (AKI) Claims, Trans. 4105 (Aug. 3, 2018)

Pub. 100-02, Medicare Benefit Policy Manual

- System Changes to Implement Epoetin Alfa Biosimilar, Retacrit for End Stage Renal Disease (ESRD) and Acute Kidney Injury (AKI) Claims, Trans. 245 (Aug. 3, 2018)

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Pub. 100-22, Medicare Quality Reporting Incentive Programs

- Payments to Home Health Agencies That Do Not Submit Required Quality Data - This CR Rescinds and Fully Replaces CR 9651, Trans. 78 (Aug. 10, 2018)

Pub. 100-20, One-Time Notification

- User CR: FISS to Add Additional Search Features to Provider Direct Data Entry (DDE) Screen, Trans. 2112 (Aug. 10, 2018)
- Medicare Diabetes Prevention Program (MDPP) Service Period Change from 3 Years to 2 Years, Trans. 2125 (Aug. 10, 2018)
- International Code of Diseases, Tenth Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs), Trans. 2122 (Aug. 10, 2018)

Federal Register

Proposed Regulation

- Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program, 83 Fed. Reg. 39397 (Aug. 9, 2018)

Final Regulations

- Medicare Program; FY 2019 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements, 83 Fed. Reg. 38622 (Aug. 6, 2018)

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executives were personally fined $111 million, and two of them paid an additional $3 million after a South Carolina trial (RMC 6/4/2018, p. 1), and there have been others.

These fines and resignations are effective in compliance education with leadership and board members, Hogan-Newgren says. They make the ultimate decisions about the organization’s business development—all you can do is educate them and discuss the implications, but the more talking points you give them, the more of an arsenal of information they have when talking to others about whether or not to do something.”

Prime Emphasizes its Quality of Care

In a statement, Prime Healthcare noted the settlement addressed only “the technical classification of the category under which patients were admitted and billed” and that its “exemplary record of clinical quality care was never in question.” Medicare rules on admissions versus observation are complicated, and CMS appropriately leaves it to treating physicians to decide where patients belong. “Prime has always provided the level of care ordered by physicians for their patients. Medicare second-guesses the treating physician’s decision regarding the level of care a patient needs, arguing that patients should be placed under a lower level of care as observation rather than inpatient care,” according to the statement. “Prime will remain committed to defending patients’ rights and physicians’ decisions in the delivery of excellent care.” The statement contends the government didn’t find merit in the upcoding allegations.

Reddy “rejected the allegations,” saying it was “nonsense” that physicians were coerced, The Wall Street Journal reported.

As part of the settlement, Prime Healthcare entered into a corporate integrity agreement.

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NEWS BRIEFS

◆ WakeMed Health & Hospitals’ 720-bed hospital in Raleigh, North Carolina, was overpaid $697,608 from Sept. 1, 2014, to Aug. 31, 2016, according to a Medicare compliance review. The HHS Office of Inspector General reviewed a stratified random sample of 263 inpatient claims and determined the hospital complied with 187 of them. The other claims had errors, resulting in net overpayments of $249,954. “On the basis of our sample results, we estimated that the Hospital received overpayments of at least $697,608 for the audit period,” OIG contends. The errors were in two areas: incorrectly billed DRG codes and billing for patients as if they were discharges when they were transferred to home health care for services (RMC 7/23/18, p. 1), OIG said. In a written response, Ted Lotchin, WakeMed’s vice president and chief compliance and privacy officer, said, “WakeMed respectfully disagrees with both the number of claims that [OIG’s Office of Audit Services] determined were billed in error, as well as the calculated and estimated overpayment amounts.” One reason: there was no physician order for home health care with 27 of the 37 discharges that OIG said should have been transfers. “Specifically, the Hospital representatives stated that these 27 claims did not include a physician order for home health services in the discharge planning instructions and therefore were coded correctly based on the Hospital’s discharge plan,” the letter stated. Visit https://go.usa.gov/xUAAj.

◆ The HHS Office of Inspector General has updated the Work Plan, its road map of audits, evaluations and investigations. Items include hospital compliance with the transfer policy with “the resumption of home health services and the use of condition codes,” physician billing for critical care evaluation and management services, and blood screening tests. Visit https://go.usa.gov/xUFFz.

◆ Post Acute Medical LLC, which operates long-term care and rehabilitation hospitals across the country, and some affiliated entities, have agreed to pay $131 million to settle false claims allegations, the Department of Justice (DOJ) said Aug. 15. The Pennsylvania-based company and its affiliates, collectively known as PAM, allegedly submitted false Medicare and Medicaid claims stemming from their violations of the Stark Law and Anti-Kickback Statute (AKS) in connection with physician-services contracts. The contracts were supposedly medical directorships or for other administrative or medical purposes, but DOJ alleged they were used to induce physician referrals to PAM’s facilities. “The company allegedly violated the AKS further by entering into what it called ‘reciprocal referral relationships’ with unaffiliated healthcare providers such as home health companies. In the course of those arrangements, PAM allegedly referred patients to those other providers with the understanding that those providers would refer other patients to PAM’s facilities,” DOJ alleged. Visit https://tinyurl.com/y87ey2hq.