COSMOS
Navigate the Compliance Universe

Report on Medicare Compliance Volume 29, Number 24. June 29, 2020
In $16M FCA Settlement, DOJ Alleged Outpatient Orders Were Overturned

By Nina Youngstrom

Piedmont Healthcare Inc. in Atlanta has agreed to pay $16 million to settle false claims allegations over the twin compliance risks of billing for admissions instead of outpatient or observation services and paying more than fair market value for a medical group in violation of the Anti-Kickback Statute, the U.S. Attorney's Office for the Northern District of Georgia said June 25.[1]

The false claims lawsuit against the health system was set in motion by a former Piedmont Healthcare physician who became a whistleblower. He alleged that procedures were performed on an inpatient basis even though physicians ordered outpatient or observation status.

The U.S. attorney's office said the settlement resolves allegations that from 2009 to 2013, "Piedmont's case managers allegedly overturned the judgment of its treating physicians on numerous occasions and billed Medicare and Medicaid at the more expensive inpatient level of care even though the treating physicians recommended performing the procedures at the less expensive outpatient or observation level of care."

The 2016 whistleblower complaint cites specific procedures, including MS-DRGs 238 (major cardiovascular procedures without major complication or comorbidity [MCC]); 243 (permanent cardiac pacemaker implant with complications or comorbidities [CCs]); 244 (the same, only without CCs or MCCs); 280 (acute myocardial infarction, discharged alive, with MCC); 281 (the same, but with CC) and 282 (the same but without CC or MCC).

"Defendants knew that such inpatient stays for the procedures were, in the vast majority of cases, medically unnecessary," the complaint alleged. But encouraging admissions "maximized profit and revenue."

When the recovery audit contractor started questioning the admissions of patients who were in the hospital fewer than 23 hours from 2011 to 2013, Piedmont allegedly brought "enormous pressure" on employees "to create unjustified explanations exaggerating complexity to medical inpatient admissions," the complaint stated. Physicians who were reluctant to comply allegedly suffered the consequences (e.g., they were "ostracized").

The U.S. attorney's office also said Piedmont settled allegations that in 2007 the health system acquired the Atlanta Cardiology Group "in violation of the federal Anti-Kickback Statute by paying a commercially unreasonable and above fair market value for a catheterization lab partly owned by the practice group." The complaint alleged that Piedmont bought the cardiology group and a 49% interest in the cath lab "for an inflated and excessive amount of over $15 million."

Piedmont did not admit liability in the settlement. In a statement, Piedmont said, "Staying true to our purpose, Piedmont Healthcare's doctors and nurses always make decisions based on the best interest and the health of the patient. The care provided in these circumstances from over ten years ago was no different. The issue in this matter from 2009 to 2013 involved decisions regarding whether a hospital patient should be classified as an inpatient status or as on observation status, which was a major challenge for every health system in the country at the time. Since that time, the government itself recognized the confusing standards and in 2013 instituted a

new ‘two-midnight’ rule to provide clarity. During the period in question, Piedmont assigned patient status as best it could, in part with the assistance of an industry-leading third-party vendor that helped interpret these technical definitions.”

1 Department of Justice, U.S. Attorney’s Office for the Northern District of Georgia, “Atlanta hospital system to pay $16 million to resolve false claims allegations,” news release, June 25, 2020, https://bit.ly/387Tksj.