CCH Healthcare Compliance LETTER

Volume 6, Issue 15 www.cchgroup.com August 4, 2003

No antikickback sanctions for rural MRI

by Geraldine S. Stroka, R.N. J.D.

Although an existing rural joint venture involving a magnetic resonance imaging (MRI) system failed to meet the two applicable safe harbors, the Office of the Inspector General (OIG) permitted the arrangement. OIG based its decision on the totality of facts and services presented.

Plan to raise capital. A limited partnership has owned and operated a free-standing center for MRI services in a federally designated rural, but not medically underserved (MUA), tri-county area since 1990. To raise needed capital, all physicians and former board members of the three area hospitals were offered limited partnerships. These partnerships were all on the same terms and conditions of ownership irrespective of their ability to refer patients or generate business for the MRI. In addition, all returns on the investments were directly proportional to the investors' capital contributions.

Ownership, revenue and safe harbors. The ownership distribution, revenue generation, and safe harbor certification are important to note. In this arrangement, one of the three hospitals and its foundation owned 30 percent of the partnership units; interested investors, those who could influence referrals or provide items or services, owned 30 percent; and the remaining 40 percent was owned by disinterested investors.

The MRI's revenue was not primarily investor based; in 2002 and 2001 approximately 37 percent was derived from this source. Disinterested parties generated over 60 percent.

The MRI met the applicable safe harbors. The limited partnership certified that the space lease met the rental safe harbor at 42 C.F.R. §1001.952(b), and that the management of the MRI by a company comprised of a radiology group practice met the personal services and management contract safe harbor at 42 C.F.R. § 1001.952(d).

No safe harbor. This limited partnership failed to meet the two applicable safe harbors, the small entity at 42 C.F.R. §1001.952(a)(2) and the rural entity at 42 C.F.R. §1001.952(a)(3). The small entity test requires that interested investors own no more than 40 percent of the ownership interests and generate no more than 40 percent of the revenues. Here the investors owned approximately 60 percent of the venture.

The limited partnership also failed the rural entity safe harbor, which requires that the entity in a medically underserved area will be protected if the interested investors own no more than 50 percent of the entity, even if all revenues are generated by interested investors. Here the limited partnership

Letters to the Editor

The CCH Healthcare Compliance team welcomes comments regarding articles published in the CCH Healthcare Compliance Letter. Send comments to Jeff Reinholtz, Managing Editor, at reinholj@cch.com. For more information about the CCH Healthcare Compliance Portfolio visit our online store at http://health.cch.com.

was not located in a MUA and its interested investors owned 60 percent of the joint venture.

Gets OIG nod. OIG determined that although there was some risk, factors existed that reduced the potential for fraud and abuse under the statute. The factors were that:

- the arrangement had the earmarks of a bona fide business;
- the arrangement was structured so that it conformed to then-existing guidance related to the Antikickback statute related to rural joint ventures. It did not have the suspect characteristics found in OIG's Special Fraud Alert (OIG 89-4) and would have complied with the 1993 proposed safe harbor for rural entities in 58 Fed. Reg. 49008 (Sept. 21, 1993) although not with the final safe harbor issued in 1999;
- the arrangement was developed as a community-oriented effort to provide access to MRI services and provided a substantial community benefit;
- the limited partnership has certified that the management agreement and space lease comply with the relevant safe harbors.

Importance. OIG has recently demonstrated a renewed interest in joint ventures. It has issued its first advisory bulletin on this topic since 1998. See Special Advisory Bulletin On Contractual Joint Ventures, April 23, 2003, CCH Healthcare Compliance Reporter ¶154,110. Also, it has recently issued another advisory opinion specifically on a joint venture involving another MRI. See OIG Advisory Opinion 03-12, CCH Healthcare Compliance Reporter, ¶150,209.

What is driving this renewed interest? Although only OIG can actually answer that question, it is apparent that financing healthcare programs has reached the crisis level. States and individual hospitals are slashing programs in order to attain some financial stability.

Creative partnering in strategic healthcare projects may be the answer for many institutions. Plans to generate capital, like the arrangement for this MRI unit, may be on the increase, as healthcare facilities struggle to render care under extreme budgetary constraints. The Special Advisory Bulletin in addition to the recent OIG advisory opinions give healthcare institutions guidelines for their partnering ventures. ■

OIG Advisory Opinion 03-13, June 23, 2003,¶150,210

Testimony about Medicare & Medicaid fraud, waste, abuse

by Jennifer Carsen, J.D., Contributing Editor

The House Committee on the Budget recently heard testimony from Dara Corrigan regarding fraud, waste, and abuse in Medicare and Medicaid. Corrigan is acting principal deputy inspector general of the Office of Inspector General (OIG).

Corrigan says Medicare and Medicaid combined constitute the largest single purchaser of health care in the world, with FY 2003 projected outlays of over $435 billion. The programs are vulnerable to fraud, waste, and abuse by virtue of their sheer size, as well as their complex reimbursement rules and decentralized operations.

Medicare. Specific areas of Medicare are particularly vulnerable, including the following:

- **Prescription drugs:** Medicare and its beneficiaries paid more than $8.2 billion for covered drugs in FY 2002. The Department of Health and Human Services (HHS) has consistently found that Medicare pays too much for prescription drugs, more than most other payers. These excessive payments are caused by a number of factors, including billing errors, misinterpretations or abuse of existing rules, and flaws in the reimbursement system.
- **Medical equipment and supplies:** In FY 2002, Medicare allowed $9.4 billion in claims for medical equipment and supplies, of which beneficiaries paid at least $1.9 billion. Medicare covers nine varieties of medical equipment and supplies, such as durable medical equipment. Corrigan says Medicare pays too much for some of these items because Medicare reimbursement rates are based on charges submitted to the program in 1987. Accordingly, Medicare payments bear little resemblance to current prices. There are also flaws in payment methods and practices for specific kinds of medical equipment.

continued on page 3

CCH Healthcare Compliance Letter

Managing Editor
Jeff Reinholtz, J.D.

Coordinating Editors
Raio G. Krishnayya, J.D.
Sharon Sofinski
Geraldine S. Stroka, J.D., R.N.
Judith A. Tichenor, J.D., LCSW

CCH Washington Bureau
HHS, CMS–Brendan Frost
DOJ, FTC–Peter Feltman
Catherine Hubbard,
Jeff Carlson
White House–Paula Cruickshank

Designer
Erika Dix

Comments from readers are welcome and should be directed to Jeff Reinholtz at REINHOLJ@CCH.COM, Tel. 847-267-7316, Fax 847-267-2514. Customer service inquiries should be directed to 800-449-9525.

CCH Healthcare Compliance Letter is published 24 times a year by CCH INCORPORATED, 4025 W. Peterson Avenue, Chicago, IL, 60646. Subscription rate is $305 per year. First-class postage paid at Chicago, Illinois, and at additional mailing offices. POSTMASTER: SEND ADDRESS CHANGES TO *CCH Healthcare Compliance Letter*, 4025 W. PETERSON AVENUE, CHICAGO, IL 60646. Printed in U.S.A.

- **Medicare contractors:** The Medicare program is administered by the Centers for Medicare and Medicaid Services (CMS) with the help of 47 contractors that handle claims processing and administration. Corrigan noted one of the most troubling problems observed by the OIG "has to do with the contractors' own integrity." She cited misuse of funds, active concealment, and altering documents and falsifying statements.

Medicaid. The Social Security Act authorizes grants to states to provide medical assistance to the needy, and the Medicaid program is administered by the states in accordance with approved state plans. Medicaid has its own set of weaknesses:

- **Prescription drug pricing and drug rebates:** Medicaid currently reimburses for many more drugs than does Medicare. Vulnerabilities exist in both reimbursements and the collection of rebates under the Medicaid drug rebate program. Currently, rebates are based on the average manufacturer's price while reimbursement is generally based on the average wholesale price. "Significant savings" could be realized if drug rebates and drug reimbursements had the same basis, said Corrigan.
- **Payment problems:** The OIG has found problems with states billing the federal government for payments made to public providers when in fact the funds do not remain at the provider for use for medical services. This was particularly prevalent with Medicaid enhanced payments available under upper payment limits and Medicaid disproportionate share hospital payments. CMS rules regulating upper payment limits, which become fully effective in 2008, will limit state financial manipulation, says Corrigan. Corrigan also recommended that public hospitals retain enhanced Medicaid payments and allowable disproportionate share payments and use the funds for delivering medical services to Medicaid beneficiaries.

Remedial Measures. Since the passage of HIPAA, reported Corrigan, the OIG's effectiveness has been strengthened through increased and predictable funding for fraud and abuse control efforts. In FY 2002, OIG conducted or participated in 568 successful health care prosecutions or settlements.

The OIG is not alone in its enforcement efforts. The responsibility for detecting, investigating, and prosecuting fraud and abuse in the Medicaid program is shared between the state and federal governments. Most states have a Medicaid Fraud Control Unit (MFCU), and the MFCUs work together with the OIG and other law enforcement agencies to coordinate anti-fraud efforts. Since the inception of the Medicaid fraud control program, MFCUs have recovered hundreds of millions of program dollars. Additionally, state Medicaid audit partnerships have been developed in 25 states, and the OIG also engages in outreach and various prevention initiatives.

The OIG is not alone in its enforcement efforts.

According to Corrigan, over 92 percent of the 2002 fee-for-service payments met Medicare reimbursement requirements. CMS "has demonstrated continued vigilance in monitoring the error rate and developing appropriate corrective action plans."

Corrigan says the first step in combating fraud and abuse is to prevent abuses from happening in the first place. This can be achieved through corrective legislation, while being careful to ensure that new legislation does not create new vulnerabilities. The second step is to ensure that adequate, reliable, and predictable resources are available to the OIG and its law enforcement and administrative partners. *Source: http://oig.hhs.gov/testimony/docs/2003/070903fin.pdf.* ■

CCH Chicago Bureau, July 2003

Whistleblowers: Practical guidance on establishing a policy

by Raio G. Krishnayya, J.D.

In December 2002, TIME magazine honored three women, Sharon Watkins, Coleen Rowley, and Cynthia Cooper, as "Persons of the Year." Professionally, these three had little, if anything, in common. The roles they played in the national spotlight, however, initiated what TIME dubbed the "Year of the Whistle-Blower."[1] The risk of whistleblower lawsuits are a fact of everyday business. Yet, the uncertainty of who they are and when they will blow the whistle is unsettling for any corporation. This is especially true with regard to the role of the whistleblower, or relator, in the health care setting and as defined under the False Claims Act (FCA). However, even in health care settings and especially given the trends in corporate governance and best practices, the whistleblower has several legal remedies at his or her disposal. Thus, the importance of implementing a policy for addressing whistleblower complaints, as part of a total compliance program, cannot be understated.

When a whistleblower action has occurred, often the initial reaction is to isolate the whistleblower. The focus is to prevent additional potentially damaging information from getting into the hands of the whistleblower/threat. The other response includes mitigating the damage caused if the whistleblower leaked the information into the public domain. This reactive mode of response creates a two-fold problem. First, it provides the public with the sense that the corporation is "hiding" something, even if untrue. Second, it may give credence to a whistleblower's anti-retaliation claims.

Instead of merely reacting to whistleblowers, compliance officers should consider tailoring their compliance plans to address this issue. The goal of such a plan should be to address potential whistleblower complaints/problems *before* the problem reaches the litigation process. A proactive plan will both prevent anti-retaliation claims (or at least minimize the likelihood of success beyond the pleadings phase of a case) and mitigate any damage to reputation.

"Adopt an 'open door' policy that allows an employee to report a discrepancy to his or her immediate supervisor."

In developing measures to address potential whistleblower claims, a compliance program should consider the most relevant statutory provisions that apply to whistleblowers. These statutory provisions become the underlying bases for policies that should be implemented across the entire health care operation.[2] After reviewing relevant provisions, analyzing case studies illustrates how policies—or lack of policies—affected the outcome of a case. From a case study analysis, the policies can be tailored to both meet the needs of protecting the entity as well as ensuring protection for the whistleblower.

Statutory Landscape

Most compliance officers, health care attorneys, and even corporate officers are well aware of the FCA's provisions regarding whistleblower, or *qui tam* actions. The *qui tam* provision of the FCA has two major components. The first deals with applicability of the statute. The applicability component of the *qui tam* provision is broad in terms of who may be considered a whistleblower.[3] Generally, the only strict requirement for a whistleblower is that the person be an "original source" of the information. That is, the person must have direct and independent knowledge of the false claim.[4] Thus the wide scope of coverage under these provisions justifies the assertion that "profiling" for whistleblowers is not an effective method for addressing any problems that arise.

The second component is the anti-retaliation provision. This provision states that a whistleblower may not be discriminated against or discharged on the basis that the person is involved in a FCA investigation. The provision also allows a whistleblower to seek remedies in cases where this provision

has been violated. The exact language of the statute is "entitled to all relief necessary to make the employee whole."[5]

Realize, however, that today other statutes operate to protect whistleblowers in a similar capacity. The Sarbanes-Oxley Act has also created whistleblower protections. Section 806 of the Act states:

> No company with a class of securities registered under section 12 of the Securities Exchange Act of 1934 (15 U.S.C. 78l), or that is required to file reports under section 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. 78o(d)), or any officer, employee, contractor, subcontractor, or agent of such company, may discharge, demote, suspend, threaten, harass, or in any other manner discriminate against an employee in the terms and conditions of employment because of any lawful act done by the employee.

"Create a standard reporting format and detail a policy that includes specific time lines for redress of the problem."

Similarly to the *qui tam* provision of the FCA, Section 806 allows relief to "make the employee whole." However, Section 806 allows for specific compensatory damages such as:

- attorneys' fees,
- expert witness fees,
- litigation costs,
- back pay with interest, and
- same seniority status notwithstanding the discrimination.

Policy considerations. Several practical considerations can be gleaned from these statutes that can provide a basis for compliance policies aimed at addressing potential whistleblower complaints. First, the broad scope of coverage with regard to who may be a whistleblower under both provisions indicates that the whistleblower may hold any position in the corporation and may have access to any information regarding the corporation. Thus, a policy should not be aimed at targeting a particular individual or, more specifically, at targeting "difficult employees". In fact, as will be illustrated, whistleblowers vary greatly with regard to education, qualifications, status, and even professional responsibility within the organization. Therefore, the key to a whistleblower policy is not the person but rather the *information* that is the subject of the whistleblower complaint.

A second consideration is that the anti-retaliation provision provides the whistleblower redress to any discrimination or termination that occurs as a result of his or her assistance into investigation of prosecution of a particular statutory violation. Thus, reactions that include terminating or even isolating the whistleblower can, as mentioned previously, open the door to the generous damages available to the whistleblower as well as mar the image of the corporation publicly. Therefore, the anti-retaliation provisions suggest that compliance policies shouldn't be aimed at targeting the whistleblower as an employee but rather should address the information that is the subject of the whistleblower's complaint.

A third consideration is that compliance officers and health care attorneys should be well versed in their respective state false claims statutes. Consider that many states have statutory equivalents of the FCA.[6] A whistleblower may seek to tie his or her complaints to both a federal and a state claim. Thus, it is important to know the precise language of the state law as well so as to tailor a policy that conforms to both the federal and state requirements.

Fourth, compliance officers and health care attorneys must be cognizant that not only are there statutory provisions in place to protect whistleblowers, but also that the Department of Health and Human Services Office of Inspector General (OIG) has codified these protections in almost every compliance guidance issued. Most relevant to hospitals is the OIG Compliance Program Guidance for Hospitals.[7]

According to this Guidance, compliance officers must establish "a process, such as a hotline, to receive complaints, and the adoption of procedures to protect anonymity of complainants and to protect whistleblowers from retaliation." In addition, the Guidance suggests that compliance officers solicit information through other mediums such as e-mails or written memos. Finally, the Guidance states:

> A log should be maintained by the compliance officer that records such calls, including the nature of any investigation and its results. Such information should be included in reports to the governing body, the CEO and compliance committee. Further, while the hospital should always strive to maintain confidentiality of an employee's identity, it should also explicitly communicate that there may be a point where the individual's identity may become known or may have to be revealed in certain instances when governmental authorities become involved.[8]

The Guidance continues to acknowledge that these suggestions with regard to whistleblowers may cause complex legal issues. However, the OIG has suggested consulting with legal counsel and addressing these problems on a case-by-case basis. Unfortunately, while this provides a starting point for adopting a whistleblower policy, this information is of little help when fending off an actual legal action.

continued on page 6

Case Studies

Familiarity with the language of the law is only part of the solution. To develop a good policy, one must first consider how the legal provisions protecting whistleblowers operate on a practical level. The three case studies discussed below illustrate four important points:

- Not all whistleblowers are the same (*i.e.*, disparity in professional responsibilities, educational status, etc.);
- A policy on addressing a whistleblower's complaint should not be based on whether the whistleblower had actual physical contact with the allegedly false claim; [9]
- The whistleblowers attempted to notify their superiors (in some cases, the "governing body" as alluded to in the OIG Guidance); and
- The employer responded by either discriminating against the whistleblower or terminating the whistleblower, allowing him or her to pursue an anti-retaliation claim.

Directors, distance, and discharged. The case of *U.S. ex rel. Chandler v. Cook County* is well known among health care attorneys, compliance officers and FCA practitioners generally. [10] Dr. Janet Chandler was hired to be the project director for the "New Start" program, a program that sought federal funding by Cook County, Illinois, to study the treatment of drug-dependent pregnant women. A year into her role as director, Dr. Chandler noted fraudulent conduct with regard to the operation of the program, including reporting on "ghost" participants, failure to follow research protocols, and other problems. Dr. Chandler reported these problems to her supervisors and was subsequently terminated. Her termination led to her FCA claim, the outcome of which proved successful for her.

Analogous to Dr. Chandler's situation is the case of Sandra Johnson and Genesis Clinical Laboratory.[11] Ms. Johnson, the Director of Operations with Genesis, became suspicious about the coding operations at the lab, noting that billing clerks were repeatedly and improperly entering diagnostic codes for claims submitted to Medicare. Ms. Johnson notified Genesis management about the problem and subsequently found herself discharged. [12]

"Instead of merely reacting to whistleblowers, compliance officers should consider tailoring their compliance plans to address this issue."

Although the case is still pending, Genesis's claims that Johnson was not directly involved, proved to be insufficient to have her case dismissed. The court expressly noted that "[t]here is no legal requirement that Johnson must have physically held a bill submitted by Genesis and scrutinized its information for Medicare compliance." [13]

In August of 2002, a case, *U.S. ex rel. Schuhardt v. Washington University* appeared, in which two coding workers at Washington University—a teaching hospital—noted a number of instances where services had been upcoded to reflect services performed by an attending physician but which, in fact, had not been performed under the supervision of an attending physician.[14] The disclosure of the improper coding led to the workers' harassment and subsequent discharge.

Even though the federal government declined to intervene in Schuhardt's (one of the coding workers) case—on the basis that the government believed Schuhardt had not pled her FCA claim with particularity—the district court held that Schuhardt had properly delineated the FCA violation in her complaint. The court subsequently allowed her to proceed on the merits of her FCA claim as well as her anti-retaliation claim. [15]

Piecing It Together

Taking the statutory/regulatory scheme and the case study data together, several key concepts arise that should be considered in developing a policy.

- **Attitude adjustments.** There are several important facets to this point. Generally, attitudes about key issues trickle down from corporate leaders to line employees. Thus, consider viewing the employees who are potential whistleblowers not as threats to the organization but rather as quality assurance measures. Consider the following.

  WHO ARE THESE WOMEN? For starters, they aren't people looking to hog the limelight. All initially tried to keep their criticisms in-house, to speak truth to power but not to Barbara Walters. They became public figures only because their memos were leaked. [16]

  While this does not suggest that all whistleblowers have purely altruistic reasons for their actions, the better approach is to consider the information they are relating rather than passing judgment on them. The concept of whistleblower as quality control is difficult to assume, but can lead to a better, long-term outcome. Furthermore, this attitude can only be fostered through actions such as incorporating training for line managers and by reviewing policies as well as displaying the policies in a prominent manner for all employees to see.
- **Communication is key.** The cases cited above show a recurring pattern. The whistleblower found a discrepancy, attempted to communicate the problem, and was either ignored or retaliated against, which led to the whistleblower filing a lawsuit. While the OIG Guidance emphasizes a hotline, it shouldn't be the sole mode for reporting. Adopt an "open door" policy that allows an employee to report a discrepancy

to his or her immediate supervisor with an assurance that this will be addressed at the appropriate level.

- **Dismissal.** When a complaint is raised by an employee about a corporate practice, don't put the problem aside or patronize the employee. Create a standard reporting format and detail a policy that includes specific time lines for redress of the problem. Provide a thorough explanation to the employee/whistleblower of the next steps to resolving the problem and when these steps will occur. Explain what role the employee may play and what information will be disclosed to other parties (including Government investigators) in resolving the problem. Also, explain the specific rights he or she has as well as possible disciplinary action for false reporting. [17]
- **Due process.** Most corporations have internal auditing systems to investigate problems; however, often the employee is left out of the process. Have the employee draft a formal letter detailing the problem or use a standard reporting form and include this in the investigation. Again, stick to a time line for concluding this process so that the problem does not perpetuate. Inform the employee of the results of the investigation and allow the employee to respond to the results in writing. Consider implementing an appeal process that would allow the employee to present his or her side of the problem to the appropriate panel that would determine the appropriate course of action. Again, provide a written explanation of the result.
- **Anti-retaliation.** Make everyone, especially line supervisors and "governing bodies," aware that should the employee decide to pursue legal remedies with regard to the complaint, retaliation or discrimination will not be tolerated. In other words, the policy should allow the compliance officer and legal counsel as well as appropriate corporate officers to address the problems associated with the employee, not other employees or line supervisors.

Realize that not all whistleblowers have an altruistic motive. However, the point that a policy should be focused on the *information* provided by the whistleblower rather than the whistleblower or their intentions, cannot be understated. In fact, a policy that adjudicates the merits of a claim will be better received by the whistleblower, possibly averting a disastrous outcome. Be cognizant that in many cases, the whistleblower feels isolated and ignored which prompts them to seek legal and public redress. "But ask them if they have been thanked sincerely by anyone at the top of their organization, and they burst out laughing. Some of their colleagues hate them...."[18]

These are only a few suggestions for creating a whistleblower policy. Clearly the issue of how to address whistleblower complaints is a difficult one. However, the practical examples indicate that in many cases, the whistleblower's case was not predicated on malicious intent, but rather out of frustration at being ignored or harassed for trying to resolve a problem. The lessons learned from these cases indicate that for the corporate entity, the ramifications of ignoring or terminating a whistleblower can be extremely damaging. In contrast, the benefits of adopting a policy that views employee complaints as a system of quality assurance may alleviate the damaging effects.

Raio G. Krishnayya, J.D., is an Attorney Analyst and Writer for the CCH Healthcare Compliance Portfolio. Raio brings a broad background—from his formal education in molecular biology and genetics to his prior law enforcement/prosecutorial experience—to coverage of issues ranging from the federal False Claims Act and fraud and abuse to bioterrorism preparedness. Please direct questions or comments about this article to krishnar@cch.com or call Raio at (847) 267-7040.

1 Richard Lacayo & Amanda Ripley, Persons of the Year, *TIME*, Dec. 22, 2002. A copy of the article may also be found on the internet at http://www.time.com/time/magazine/printout/0,8816,401944,00.html.

2 Realize that there is no single profile for a whistleblower. They may be located in any department and may be any employee. Therefore, do not try to profile who a potential whistleblower might be or the probability of a whistleblower complaint originating from any particular department. This is not only a wasted effort but also could bolster any retaliation claims.

3 The FCA uses the language, "a person" which, subject to certain requirements, is broad in scope. *See* 31 U.S.C. §3730(b).

4 31 U.S.C. §3730(e)(4).

5 31 U.S.C. §3730(h).

6 Important to note is that although some states do have a false claims statute, the statute does not cover Medicaid fraud. However, in those circumstances, a state may have a specific Medicaid fraud statute that contains a whistleblower protection provision (e.g., Tennessee).

7 63 FR 8987 (Feb. 23, 1998).

8 *Id.*

9 Important to differentiate is the difference between "independent and direct knowledge" of the false claim or fraud versus being directly involved with the actual claim.

10 CCH ¶300,162 The U.S. Supreme Court case that held that counties and municipalities fall within the purview of the FCA.

11 *U.S. ex rel. Johnson v. MacNeal Health Services Corp.*, CCH ¶305,266.

12 *Id.*

13 *Id.*

14 CCH ¶301,466.

15 *Id.*

16 Richard Lacayo & Amanda Ripley, Persons of the Year, TIME, Dec. 22, 2002. A copy of the article may also be found on the Internet at http://www.time.com/time/magazine/printout/0,8816,401944,00.html. Describing the three whistleblowers profiled.

17 One method may be to develop a standard form that addresses the responsibilities and rights of an employee who may wish to report a claim. Have them sign the form indicating that the information has been reviewed with them by a supervisor.

18 Richard Lacayo & Amanda Ripley, Persons of the Year, TIME, Dec. 22, 2002. A copy of the article may also be found on the Internet at http://www.time.com/time/magazine/printout/0,8816,401944,00.html.

Nature of employee's investigation unclear; FCA retaliation claim denied

by Jennifer Carsen, J.D., Contributing Editor

A new Illinois district court case sheds some light on the type of activity protected by the anti-retaliation clause of the False Claims Act (FCA). Not every investigation by an employee qualifies for FCA protection, although—as this case illustrates—the line can sometimes be difficult to draw.

Nurse complains of understaffing. Pamela Robbins, R.N., worked at Provena Saint Joseph Hospital (Provena). She was chair of the Illinois Nurses Association, the exclusive bargaining unit for Provena's registered nurses. Robbins frequently complained about the adequacy of staffing and advised other nurses to file forms with Provena supervisors alleging delays in patient treatment and unsafe staffing levels. Hundreds of such forms were filed. Robbins also met with the director of the Illinois Department of Public Health (IDPH) and other officials to discuss concerns that delays in patient care could affect Provena's right to participate in and receive reimbursement for Medicare- or Medicaid-related services.

In early 2002, Robbins and other nurses helped organize televised legislative hearings on an Illinois bill that proposed to give nurses a role in determining staffing levels and to impose penalties on facilities that refused to do so. Robbins alleged she was detained and questioned by Provena security guards regarding the hearings. Later, she circulated a petition addressed to the IDPH demanding investigation into whether Provena was providing safe nursing standards. Over 160 nurses signed the petition, and it was eventually confiscated from a nurse.

Termination after meeting. On May 22, 2002, Provena notified several nurses that their jobs had been eliminated. One of the nurses asked Robbins to represent her in a meeting with Human Resources. Several of the other affected nurses joined Robbins at the meeting. When HR told the nurses they could not all be present, Robbins asked the others to wait in the cafeteria. Two weeks later, Provena told Robbins it needed to interview her regarding the events of May 22, and that she should retain a grievance representative. After the meeting, Robbins was placed on indefinite suspension and later terminated for allegedly violating an agreement prohibiting nurses from engaging in strikes and work stoppages.

Robbins filed a lawsuit against Provena, alleging among other things that she had been illegally terminated in violation of the anti-retaliation provision of the FCA. To establish this claim, said the court, Robbins had to show: (1) that her actions were taken in furtherance of an FCA enforcement action, (2) that Provena knew she was engaged in this protected conduct, and (3) that Provena's motivation to discharge her, at least in part, was motivated by her protected conduct.

Claim of FCA retaliation. The court noted that "attempting to correct regulatory noncompliance, absent fraud, is not actionable under the FCA." Provena claimed Robbins was simply attempting to force the hospital to hire more registered nurses. At best, she was investigating nurse understaffing that could ultimately disqualify Provena from participating in Medicare or Medicaid reimbursement programs.

If Robbins was trying to determine Provena's future Medicare/Medicaid participation, said the court, her activity would not be protected because she was not investigating fraud. However, if she was investigating staffing levels to show that Provena was not compliant with regulations that were conditions for payment, and thus falsely representing its compliance with the regulations, then her actions would be protected.

Documenting staffing levels and delays in patient treatment would be one way to investigate Provena's regulatory compliance, said the court, which could later be used to show false representations. Also, Robbins had also asked the IDPH to intervene, and it was possible Robbins knew that the IDPH investigates fraud on behalf of the Centers for Medicare and Medicaid services. Accordingly, ruled the court, Robbins sufficiently pled protected conduct.

No notice of fraud claims. However, Robbins could not show that Provena knew she was engaged in protected conduct at the time she was terminated. While Provena knew about Robbins's investigation, and that she had contacted government authorities regarding that investigation, Provena was not on notice that Robbins's actions related to alleged false claims. There was no evidence that Robbins threatened a qui tam action; notified Provena that she was investigating fraud; or accused Provena of making false representations, violating the FCA, or defrauding the federal government. Because Robbins could not prove this essential element of her FCA claim, the claim was dismissed. ■

Robbins v. Provena Hospitals, N.D. Ill. No. 03 C 1371, 2003, ¶305,269