

August 23, 2006

Senator Ron Wyden
1220 SW 3rd Avenue, Suite 585
Portland, OR 97204

**RE: GOOD SHEPHERD HEALTH CARE SYSTEM'S FALSE CLAIMS ACT
EXPERIENCE**

Dear Senator Wyden:

This letter is in regards to Good Shepherd Health Care System's recent experience with a *qui tam* fraud investigation under the False Claims Act. We felt it necessary to share our "fraud investigation" experience with you and with our Representatives and other key legislators to point out serious unintended consequences and the vulnerabilities of hospitals when the False Claims Act is misused.

First, I want to make it clear that we support strong legislation and active government programs to identify and eliminate fraudulent activity. Fraud harms all of us and reduces limited resources for *bona fide* healthcare purposes.

Our story starts approximately three and a half years ago when agents from the FBI and the Oregon Medicaid Fraud Unit came to the hospital asking questions about the hospital's billing practices. They talked with the Director of Finance, Director of Nursing and Manager of the Business Office and then left. About a month later we were raided by a team of agents who came to the hospital at night, combed through our records taking boxes of billings, financials, contracts, medical records and other information. We secured legal counsel who was able to ascertain that a *qui tam* case had been filed against us. It was, of course, under seal so we were unaware of the nature of the investigation. The Federal Court in Portland "bungled" the affidavit for the raid prepared by the FBI and made the document public. If it wasn't for this, we wouldn't have had any idea what the issues were, what the government was looking for nor for what we had been charged. We soon found out that the FBI had supposedly developed an inside confidential source. And that the *qui tam* relator and the inside source were supposedly to have verified that the hospital was destroying information that would support their fraud claims. Therefore, the FBI felt that it was necessary to raid the hospital.

You can imagine our dismay the next morning when our local paper's headline was "FBI Investigating Good Shepherd Hospital". Furthermore, *The Oregonian* in Portland obtained a copy of the FBI's request and printed a feature article with all of the allegations in the FBI's affidavit, allegations that the *qui tam* relator had evidently included in their complaint. These allegations included every fraud hot button that you could imagine, including lab unbundling, kickbacks to physicians, three day window billing violation, over-coding, billing for services not provided, cost report irregularities, etc. At the time of the raid, I was informed by one of the

agents that the investigation had been heightened from a civil investigation to a criminal investigation and that if even part of the charges were true, “someone was going to jail”.

Based on the limited knowledge that we had, our hospital and our counsel began our own internal investigation to see if we could uncover what, if anything, the government and *qui tam* relator were alleging. Our counsel was able to work with the Attorney General’s office and the State Medicaid Fraud Unit and began a process of interviewing our employees regarding the allegations. This was the beginning of a significant turnaround. The government began to discover significant irregularities between what the *qui tam* relator and the inside source had told them vis-a-vis actual practices within the hospital. Within a matter of weeks, the government informed us that the investigation had been scaled down to a civil investigation. Even national experts questioned the circumstances of the FBI raid within our hospital. However, the damage to our reputation was significant and, our confidence shaken. And, we still were unaware of the direction or purpose of the investigation.

I must state, however, that during this whole time, the FBI and the federal government were very professional. They were thorough but we found them to be courteous and easy to work with.

Over the course of 2 ½ years, the government investigated each claim. The majority of the allegations were dismissed outright. The investigation revealed that we had some billing irregularities and had made certain billing errors. The investigation ultimately narrowed down to our emergency room billings. It appeared the *qui tam* relator had focused on a consultant’s report which had given critique and made suggestions regarding our ER billings. Previously, following our own investigation of the consultants report, we had determined that the consultant’s recommendations were not entirely correct. We also had a programming error which was unfortunate and an embarrassment to us. Our electronic claims program placed the name of the treating ER physician in the consulting physician box and the former medical director’s name in the treating physician box. Because of these two issues, the Department of Justice requested that we do an extensive audit (at our expense) of our ER claims by an independent third party reviewer recommended by the DOJ. The result of this audit showed that all services were provided by qualified physicians and that all services were appropriately coded. In fact, the audit stated that the federal and state government were slightly underbilled for the level of coding that could be substantiated. Following the results of this audit, the State Medicaid Fraud Unit dropped its investigation and the federal government indicated its willingness to discontinue the investigation as well.

As a sequel to the investigation, the confidential insider and the *qui tam* relator both brought retaliation claims and one of the physicians whose name was placed in the wrong box on the ER form brought an invasion of privacy claim. These claims, unfortunately, had to be settled as the cost of litigating would have exceeded the cost of defending the claim.

Sum total: we were subject to a humiliating raid and investigation by the federal government, a shotgun approach to fraud allegations by the *qui tam* relator (in essence throwing everything on the wall to see if anything might “stick”). We experienced a three year investigation which consumed hundreds of internal man hours, and over \$1,063,000 so far in attorney fees, consultation fees, and in our opinion, undeserved settlement costs.

For a small rural hospital that struggles financially, these are costs that are not includable in our cost report, they are not reimbursed by any third party payor and there has only been a very small insurance recovery to date.

After having experienced what we consider to be a frivolous *qui tam* relator complaint of false allegations, we have learned some lessons. We would like to share with you, as a national leader, what we believe to be wrong with the law as it currently exists and how it could be corrected to protect hospitals against this kind of unnecessary expense and abuse of a process designed to root out fraud.

Here are our suggestions:

1. In order for a *qui tam* relator to share in any proceeds of a recovery, the *qui tam* relator should be required to demonstrate that they have brought the matter to the attention of the hospital (employer) before they bring the matter to the government. In many cases, especially with electronic billing and segregation of duties, there are only a small number of employees that are involved in a particular aspect of billing. Without one of these individuals coming forward, there is virtually no way that Administration or anyone else is going to otherwise know of an error or problem. An organization should always have the first opportunity to correct an error when someone becomes aware of it.
2. If the government extensively investigates a matter and determines that there is not enough evidence to pursue the case, the government needs to have an option to (and should) dismiss the case in its entirety. Currently under the *qui tam* relator provisions, the government's option of bowing out of the case and allowing the *qui tam* relator to proceed with a suit on behalf of the government gives the *qui tam* relator a free "spin at the roulette wheel" to see if they can find a jury sympathetic to their claim. The *qui tam* opportunity at this stage of the post investigation proceeding has relatively little to do with the factual issues of whether intentional fraud was committed.
3. A *qui tam* relator should not be allowed to file a general complaint citing a wide range of fraudulent issues. In our case, when the *qui tam* relator was interviewed, they really had very little specific information or evidence regarding any of their allegations. A *qui tam* relator should have a burden (or a much greater burden) of supplying significant proof of wrongdoing. In our case, hundreds of thousands of dollars were spent in investigation time and expense where no problems existed.
4. The *qui tam* relator should not be allowed to influence the investigation or to suggest possible insiders for corroboration of allegations. In our situation, we have strong reason to believe that the *qui tam* relator suggested the confidential source to the FBI and that the *qui tam* relator and the confidential inside source may well have teamed up before the investigation or shortly thereafter. If the FBI's inside source had been truly neutral and had provided correct information from the beginning of the case, our investigation costs would have been significantly reduced.
5. Somewhat related to #4, an FBI's confidential inside source should not be allowed to transition to a co-*qui tam* relator. In our situation, the confidential inside source "cultivated" by the FBI worked with the hospital and hospital council on investigating the allegations for a

considerable period of time. Once again, it was only by a fluke of the court which made a sealed document public that we discovered that the FBI's confidential inside source supposedly cultivated by the FBI, was also in fact a co-*qui tam* relator. This was an extraordinary breach of attorney-client privilege and corroborates our strong suspicion that the *qui tam* relator and confidential inside source were linked from the beginning of the claim.

6. A *qui tam* relator should not be allowed to amend their complaint after an investigation is started. In our case it became apparent that the confidential inside source and/or other employees fed information to the *qui tam* relator throughout the hospital's investigation. By the time the case closed, the *qui tam* relator was on their third amended complaint. By the disparity between the initial FBI affidavit to the court and the third amended complaint, it was quite apparent that as allegations were determined to be untrue, they were dropped from the *qui tam* relator's complaint and as the hospital and our council discovered errors as a part of our own investigation, they were added to the *qui tam* relator's amended complaints. This should not be allowed to happen.

7. Retaliation claims and complaints should not be allowed to be included as part of the *qui tam* relator false claims act complaint. These should be separate civil issues, subject to conventional statute of limitations and should not be allowed to be hidden within the *qui tam* relator complaint. In our situation, the government dropped our case so we were able to see the retaliation claim hidden within the complaint. However, most hospitals after settling with the federal government and thinking that the matter is over, then discover that the retaliation complaint was hidden within the *qui tam* complaint until such time as it is unsealed. This needs to be a separate and distinct issue. In our case, we committed no retaliation actions whatsoever but employees and *qui tam* attorneys have become sophisticated enough to include this claim as there will almost always be a settlement award since the cost of litigation is expensive and will exceed the cost of a significant settlement.

8. There needs to be much stronger protections for the use of hospital consultants. Hospital billing is extraordinarily complex and a small hospital must rely on consultants from time to time in order to assess processes and recommend improvements. We, and many other hospitals are now "gun-shy" on using consultants because of our experiences. Having a consultant come in and produce a report is an open invitation for someone to file a general fraud allegation and then state the consultant's report "proves it". The investigation which follows can result in thousands of dollars of costs for an organization defending itself vis-à-vis the consultant's report, the recommendations of which were perhaps the very reason that the consultant was brought in to assist the hospital in the first place.

9. There needs to be greater deterrence for a *qui tam* relator filing a frivolous, false or bad faith action against a hospital. In our case, the *qui tam* relator was a disgruntled employee unhappy about a transfer of position some months before. They were quite vocal to a number of people regarding their dissatisfaction. Our own counsel told us repeatedly that a counteraction against the *qui tam* relator would go nowhere because in the current environment, the government is so protective of *qui tam* relators that the government would not risk sending negative signals by allowing any action against them, even for filing a false claim. This is clearly wrong. There needs to be strong penalties for filing a false, frivolous or bad faith action such that it sends a very clear message that *qui tam* "fishing expeditions" or bad faith actions are not going to be tolerated. The consequences of a *qui tam* relator causing a hospital hundreds of

thousands of dollars in defense costs, research costs and other costs associated with a *qui tam* complaint that turn out to be unwarranted should be far more than just a little embarrassment; “oops I guess I was wrong”.

10. There needs to be a special provision for computerized programming repetitive errors. Counting a single programming error as a multiple of the claims that are produced yields astronomically high potential fines and claims. So high in fact that hospitals can no longer afford to take the risk of seeking justice. In an attempt to create strong anti-fraud deterrents, what has effectively been accomplished is that hospitals can no longer take the risk of going to court to defend ourselves. The vagaries and complexities of billing are such that no one can risk how a jury might look at a defense. We feel very fortunate that the government dropped our case. If the potential fine and damages had been more reasonable, we would have been in court much earlier defending ourselves and, most likely, would have spent considerably less dollars and time on this case in doing so.

As a general comment, I understand that the government must rely on individuals coming forward to alert them to potential acts of fraud. However, the current *qui tam* process, as you can see, is badly flawed and in need of a fix. I have been in contact with representatives from the American Hospital Association who have asked me to tell my story. I am also telling our story to our Senators with similar letters to other key congressional health care leaders, especially those that have been leaders in developing the False Claims Act legislation as it exists. We are dependent upon you, our legislator, to create laws that do not create unintended consequences or perverse opportunity as we have suffered.

Our case is an open book. Of necessity, this letter is a brief overview but I would be happy to discuss any aspect of our case in extensive detail, as a learning experience, with anyone willing to work to make positive changes to the healthcare fraud fighting efforts in this country.

Thank you for reading our letter. Please do not hesitate to call or write should you have any questions.

Sincerely,

Dennis E. Burke,
President

DB/kp

Cc: American Hospital Association
Oregon Association of Hospitals and Health Systems