Report from a Medicare Whistleblower Part 2: Qui Tam Follies

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ABSTRACT

My efforts to expose and stop the malfeasance that I discovered while working for the Medicare carrier failed miserably, as I outlined in Part 1 of this series,[1] despite pursuit of wrongdoing through several government agencies. I had hoped, in vain, that Congress and the courts would correct the problems. When it appeared to me that no one was going to hold the carrier accountable for wrongdoing, I resorted to filing a qui tam action against the Medicare contractor in 1991.

Barriers to uncovering facts were nearly insuperable. The executive branch and the judicial system acted as though they were in collusion with the carrier. The threshold for investigating fraud at the carrier level was $200 million at that time, and there is no meaningful accountability for gross malfeasance. Whistleblower protections are of little effect.

The Process

In 1992, the Department of Justice decided to intervene in my action and submitted an amended complaint. By doing this it acknowledged those areas in which it recognized carrier fraud. While the intervention lent credibility to my allegations, it also gave the Department of Justice complete control of the case.

I continued to work with the Office of the Inspector General of the Department of Health and Human Services (OIG), turning over all of my documents and testifying before the grand jury. The grand jury process moved very slowly. The court granted a stay on the qui tam case until the grand jury made its decision about criminal charges. Meanwhile, many people targeted in the complaint were scrambling to cover up potentially damaging information.

Subsequent events showed that a single person could keep a case open–even though I was only a medical analyst with a high school diploma, who had been acting as supervisor and project leader. However, the carrier had so much control over claims processing that it assumed it would never be punished or even prosecuted for blatant wrongdoing. The agency overseeing Medicare, the Health Care Financing Administration (HCFA), feared that no other company would take the Medicare contract, and thus they were extremely reluctant to take any adverse action that might put the carrier out of business. Meanwhile, the carrier halted the processing of millions of Medicare claims.

It was also apparent that if anyone did take over the Medicare contract, it would first need to find and deal with the evidence of massive overpayments. During the trial that eventually occurred, one of the top officials from the carrier said, "You will never find it if you don't know where to look."

Between 1989 and 1990, erroneous payments under the Medicare program exceeded $199 million, which the carrier glibly dismissed by saying that since the threshold for fraud investigations was $200 million, and since erroneous Medicare payments had not yet reached that threshold, it really wasn't a significant problem. Moreover, this figure did not include the errors from 1991, 1992, or 1993–years that were included in the settlement agreement.

The OIG agent, who had been assigned to the case for more than four years, however, told me all along that there was clear evidence of wrongdoing, and indictments were imminent. Yet in a deposition, the top OIG official denied that he had made any statements about any indictments, or the prospect of major changes in people's positions, or any limitations on contracts. The court ignored evidence to the contrary that I submitted.

OIG, unfortunately, was virtually totally dependent on the accused Medicare carrier to provide the evidence of wrongdoing. On the day before the trial, the carrier's top official–who had issued most of the orders to turn off claims edits and audits, delete claims en masse, and pay at random–was granted immunity from prosecution. Despite immunity, no significant admissions of guilt were forthcoming.

Moreover, although the OIG had spent more than $700,000 on its investigation, its own agent answered "I don't recall" to more than 80 percent of the questions he was asked in court. There was clearly a double standard being applied here. I have no doubt that I would have been prosecuted to the fullest extent of the law for perjury had I lied in a deposition; but when top officials were questioned, and either denied or claimed they had forgotten their prior statements, they were instead promoted to higher positions in the government. The Department of Justice essentially defines what it considers to be perjury, and in this case it simply chose not to pursue these peculiar memory lapses or creative testimony provided by OIG officials. Accountability was totally nonexistent. Instead of pursuing the truth, officials subjected the whistleblower to name-calling, mockery, and excessive delays in the legal process. As more time elapsed, fewer people cared about the flagrant abuses committed by the Medicare contractor, and the prospect of remedy became increasingly remote.

Agreed Upon Estimates vs. Truth

I soon realized that standards were compromised, and that job security was considered more important than any standard of truth or correction of crime or wrongdoing.

Meetings with the lawyers and agencies that considered all the allegations were designed to reach what was, for them, a "win-win" settlement. The government's statement that "if the contractor was prosecuted, it would go bankrupt" indicated that no one would ever bring this action to real justice. Instead, the objective was to get the claims processed at all costs: pay the carrier more money, promote the government officials assigned to investigate for fraud to ensure their cooperation, offer more government contracts to the carrier, impose a minimal penalty on the carrier, and continue business as usual. After all, as the carrier's top lawyers stated in their report to the government's general counsel in the Department of Health and Human Services, all the other carriers were doing the same types of things, which according to the government constituted fraud, without penalty, so it would be unfair to single out their client for punishment.

It became eminently clear that the government applies a double standard in dealing with those who are accused of fraud: one for large Medicare carriers and one for individual suppliers. If the same allegations were brought against suppliers (physicians, for instance), there would be no question about applying draconian penalties and ruinous fines.

The ultimate findings of the investigation had to be carefully tailored to fit the desired outcome. The carrier had complete control over the magnetic tapes containing evidence of carrier wrongdoing. We were offered the opportunity to look for wrongdoing on the tapes, supposedly so we could match the government's quantification of damages. But when the judge asked whether we received the same tapes the government had been given, and the carrier said we did not, the judge did not even rule on the obvious discrepancy.

HCFA used a nonvalidated computer program to seek evidence of duplications in durable medical equipment charges, and this program captured about 55,000 line items. The government agency, however, was looking for only $10 million in payment discrepancies, and upon finding that looked no further. The years from 1989 to 1993 were not examined at all. When I met with HCFA representatives and proved we had claims with discrepancies, they didn't consider it significant.

HCFA, as we saw, tends to work in close collaboration with Medicare carriers. It has on-site representatives, and the carrier's figures, statistics, and methods curiously always seem to look just as the government expects them to look – i.e. the appearance of complete compliance. The carrier, in fact, frequently hires former HCFA employees for high positions.

Some of the experts we sought to help quantify the damages, although unable to take part because of ties to the carrier, provided estimates of wrongful Medicare payments well in excess of $900 million! Yet when the top officials investigating the case made their own minimal estimates of the damages, it became apparent that even with the evidence right in front of them, they would never be given the authority to hold the carrier accountable for anything close to the $900 million figure. It was apparent that estimates by our own experts would not be considered at all.

The carrier had a very efficient shredding device, which it referred to as "Jaws." A vice-president testified on the witness stand that he "knew nothing about the thousands of letters being trashed," and that his investigation found only one. He contradicted himself, however, when he admitted that claims edits and audits were turned off, but said quality was heralded as being excellent on all HCFA reports during the time period in question.

Ultimately, none of the real evidence mattered. The presiding federal judge said, "Even though we do not acknowledge the actions of the carrier as being right," and "even if Ms. Burr could prove $900 million, we will accept $10 million [in damages]."[2]

The carrier filed a complaint with HCFA in 1993, asking for $15 million in additional administrative reimbursement because the Medicare electronic claims processing system was defective, a fact that the carrier did everything to conceal from HCFA. The carrier eventually settled for $10 million in fines (for wrongdoing) and HCFA's liability was reduced to $4 million in additional administrative payments made to the carrier. The carrier also filed a suit against the electronic claims processing system's contractor for $11 million because the newly installed system provided was not what was promised – i.e. it didn't work.[3]

Fraud Pays

The apparent lesson from my qui tam case against the carrier is that fraud pays handsomely if you are a Medicare contractor. The "error threshold" was $200 million at that time, and damages far in excess of this were simply ignored.

The carrier emerged from the government-arranged out-of-court settlement essentially undamaged. The contractor awarded the bid for the defective claims processing system had to pay the carrier $10 million. The carrier, in turn, had to pay $10 million to the government in fines. HCFA withheld an additional $4 million, which was to have covered additional processing costs. The carrier paid its attorneys about $5 million.[2]

Additional costs resulting from mishandled Medicare Secondary Payor (MSP) claims of approximately $34 million, and interest of $5.7 million, paid out for not processing claims on time, were barred as part of the settlement. The carrier's admission of more than $199 million in erroneous Medicare payments simply did not matter, apparently showing that the contract between the carrier and HCFA promised payment for claims processing irrespective of performance. The global settlement required the carrier to recoup the funds that it had

erroneously paid out, essentially making it look as though it was the fault of physicians and suppliers instead of the carrier. Meanwhile, physicians who suffered from extreme delays in payments and wrongful claim denials did not receive recompense for their financial loss. Table 1 also illustrates the effects of government price-fixing wherein the Medicare carrier typically pays 50 percent or less of submitted charges.

Table 1. Data Submitted During Negotiations Between the Carrier and the Dept of Justice

	Submitted Charges	Benefits Paid	Benefit $ as % of Submitted $	Claims Processed
FY 1985	$2,758,577,440	$1,354,468,078	49.10%	18,753,119
FY 1986	$3,182,513,218	$1,518,473,698	47.70%	20,442,140
FY 1987	$3,991,480,242	$1,996,273,126	50.00%	25,353,998
FY 1988	$4,525,602,145	$2,230,581,579	49.30%	28,543,804
FY 1989	$5,369,144,523	$2,467,771,036	46.00%	32,694,130
FY 1990	$6,343,896,668	$2,955,563,822	46.59%	36,652,687

The Medicare contractor that was under investigation was awarded another major government contract before the investigation was even concluded. When we questioned HCFA about this, suggesting that the contractor had already committed wrongdoing on a grand scale and it would be unwise to expand the scope of their government contracts, we were told that unless the entity was actually prosecuted, the awarding of further government contracts was not improper.

It's startling to realize that 100 percent of the people who held positions of authority with the carrier stayed in those positions. One even became president. Government contracts continued to pour in while a nominal penalty made it appear that the government had taken some appropriate action. The carrier was even awarded a contract to investigate others for Medicare fraud! Suspicion was then turned on all the suppliers (including physicians) for all of the erroneous payments made during the time period the carrier's claims processing system malfunctioned. The welfare of patients, the most important people in the whole process, was completely ignored.

In her declaration, a top HCFA official stated, "Settlement of this long-standing litigation will, in my view, enhance the public's confidence in, and perception of, the integrity of the Medicare program. Further, protracted discovery and litigation in connection with this matter would not be in the best interests of the Medicare program, as it would encumber HCFA and the carrier with a significant administrative burden. With important health care reforms looming on the horizon, the expenditure of scarce resources must be carefully controlled."[4]

When I appealed the decision, the appeals court judge told me, "Yes, you have the law, and yes, you have the facts. But you don't deserve anything else. Therefore we will not grant your appeal."[5] Upon hearing the judge's statement, my attorney, who had been acting-attorney general at the beginning of the case said, "They just don't want you to have anything."

Although whistleblowers are supposed to be protected under 1986 amendments to the False Claims Act, many of my rights were violated. Although the "whistleblower act" says that the person who files an action on behalf of the government is entitled to a portion of the award, it does not explain how to collect it. The attorneys' portion of the award typically ranges from 33 to 60 percent. After the settlement, the whistleblower must then go to court in an attempt to obtain reimbursement of attorneys' fees and for lost wages or damages for any retaliation taken against the whistleblower by the carrier. An attorney is required again for this process, and more fees are charged. The reality is that it can be years before the whistleblower receives any compensation at all, and the ultimate award is often severely reduced by all of the attorneys' fees.

If the whistleblower wishes to pursue the funds that he is entitled to seek because of lost wages or retaliation by the carrier, the attorneys typically demand about 50 percent up front. Ultimately the whistleblower is often blackballed, not only by the parties he pursued, but even by those who claimed to be allies in the battle against injustice. In addition, the information that was provided to attorneys to help them with other cases is now being used to promote seminars to teach corporations how to prevent qui tam actions like this from being brought against *their* companies!

Conclusions

One might ask whether I would be willing to go through such a prolonged and onerous process again, knowing the final outcome. Those who speak out against wrongdoing are frequently not treated very well by the government bureaucracy. Physicians who fight for the rights of their patients who are in the Medicare program know this all too well.

Truth, in the end, rises above opinion, interpretations, and machinations. If we are to honor the gift of medicine and to be worthy vessels to aid the sick, we must continue the fight for truth and integrity.

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REFERENCES

[1] Burr T. Report from a Medicare whistleblower. Part 1: Claims processing goes awry. *J Am Phys Surg* 2003;8:87-88.

[2] Report and Recommendation by the Magistrate, U.S. District Court for the Middle District of Florida, 91-134-Civ-J-16.

[3] Complaint, 93-02380 CA, 4th Circuit, Duval County, Florida.

[4] Declaration of HCFA Representative Carol Walton. Case 91-134-Civ-J-16.

[5] *Theresa Burr v. Blue Cross/Blue Shield*, Case No. 95-2833, United States Court of Appeals (11th Cir. 1996).