United States of America, ex rel.
Cherri Suter and Melinda Harmer

v.

National Rehab Partners, Inc. and
Magic Valley Regional Medical
Center

Case No.
CV03-128-S-BLW

Report of Ronald H. Clark, Ph.D., J.D.
2/2/07

SIGNATURE:_____

I. Introduction

I have been retained on behalf of relators Cherri Suter and Melinda Harmer ("relators") by the law firm of Holland and Hart to offer an expert opinion relating to the case of *United States of America ex rel. Cherri Suter and Melinda Harmer v. National Rehab Partners, Inc., and Magic Valley Regional Medical Center*, Case No. CV03-128-S-BLW (D. Idaho). Specifically, I was requested to offer an expert opinion establishing the damages the United States and relators would be entitled to recover under the False Claims Act, 31 U.S.C. §§ 3729-33 ("FCA").

II. Nature of the Present Litigation

This case involves allegations relating to Medicare billings by Magic Valley Regional Medical Center, located in Twin Falls County, Idaho ("the hospital"), in connection with physical therapy services rendered in the hospital's Transitional Care Unit ("TCU") for Medicare beneficiaries during the period of July 1, 1998 through September 30, 2000. At certain times pertinent to the allegations, National Rehab Partners, Inc. ("NRP"), a Tennessee corporation, staffed and managed the TCU for the hospital.

Prior to the period covered by the complaint, an important change was made by Medicare in how reimbursement was calculated for physical therapy/TCU services. This was the institution of the so-called "Prospective Payment System" ("PPS") for Skilled Nursing Facilities ("SNF") on July 1, 1998. Prior to the establishment of the PPS, SNF's such as the TCU were paid on a actual cost basis for the services they rendered. PPS changed this so that instead of placing reliance upon actual cost, a system of fixed *per diem* reimbursement rates was instituted. PPS *per diem* rates were established for therapy patients based upon the amount of therapy each patient

required. *See "Interim Final Rule," Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities*, 63 Fed. Reg. 26252 (May 12, 1998). Substantial effort was undertaken by Medicare to inform providers, such as the hospital and NRP, of new rules and procedures that accompanied the implementation of the PPS system. Training materials (including Depo. Exs. 45 & 65) were prepared focusing on these new requirements and were utilized by defendants in training their employees.

Under the PPS, when a patient was transferred to the TCU from the acute care division of the hospital, a physical therapist performed an evaluation in order to design an appropriate treatment program. That plan was to be sent to the patient's physician for review and approval; thereafter, it becomes the patient's plan of treatment. Burdick depo., 78. [1/] A nurse, who is designated as the Minimum Data Set ("MDS") coordinator, also participated in the patient evaluation. *Id.* at 81. The nurse's responsibility was to enter appropriate data, including the minutes of physical therapy administered to the patient since admission, on to the MDS form. The MDS was completed between the fifth and eighth day of each patient's stay. A second evaluation was completed at about the fourteenth day if the patient remained in the TCU. Makay depo., 26; Burdick depo., 82. The MDS is part of the patient's official medical record. Burdick depo., 83. Therefore, during the first five-to-eight day period, a "whole encompassing assessment" is made of the patient, and the resulting data is input into the MDS form. Burdick depo., 78-84.[2/]

[1/] Throughout this report, I shall use this shorthand designation for citing to deposition testimony. Deposition exhibits shall be referenced as Depo. Ex. _____.

[2/] However, the treatment plan does not specify the particular number of physical therapy minutes to be administered to the patient. Burdick depo., 95.

This process of inputting pertinent assessment data into the MDS form is pivotal to understanding the present case. That is because once the pertinent patient data are input on the MDS, the information is placed into a Grouper software program that assigns each patient to a Resource Utilization Group ("RUG") category. The patient is thereby assigned to a particular RUG category, based in large part on the actual minutes of physical therapy administered during the first five to eight days in the TCU, as well as an estimate of projected minutes necessary for treatment before the next assessment is completed on the 14th day. Makay depo., 73; Suter depo., 200-2. 63 Fed. Reg. 26267. TCU patients were assigned to one of five rehabilitation RUG categories, ranging from "low" to "ultra high," based on the number of therapy minutes. *See, id.* at 26262. The rehabilitation RUG categories are differentiated principally by the number of therapy minutes that must be delivered to each patient. Each RUG category has an associated *per diem* reimbursement rate. The higher the designated category, the greater the amount of reimbursement paid by Medicare to the hospital on a *per diem* basis for the rehabilitation services.[3/]

However, certain Medicare rules govern the type and number of minutes that can be counted in the MDS and which determine the patient's RUG category. For example, only 25% of a patient's total physical therapy minutes can be group therapy. In addition, to be reimbursable by Medicare, group therapy must be administered in a group of between two and four patients. Any minutes of group therapy in excess of 25% or in groups larger than four cannot be recorded on the MDS, and thus cannot be used to establish the RUG category or *per diem* rate for that

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[3/] The *per diem* reimbursement rate is an all-inclusive one, covering in addition to physical therapy such services as occupational therapy, pharmacy, room/board, medical supplies and other services rendered to the TCU patient.

patient. Moreover, minutes devoted to individual as contrasted with group therapy can only be included in the MDS if the therapy satisfies the rigorous standards for individual therapy prescribed by the Medicare system.[4/]

The hospital billed Medicare for its TCU services by submitting a claim for payment designated as the UB-92. *See, e.g.,* Depo. Ex. 90. The UB-92 contains the patient RUG category and the number of days for which payment is claimed at the *per diem* rate for that RUG category. This form is submitted to the Medicare fiscal intermediary that pays the claim based on the *per diem* rate associated with that RUG category. According to the testimony of Ms. Carter, there are three ways in which to determine the amount actually paid by Medicare to the hospital: (1) the Meditech patient inquiry screen; (2) the fiscal intermediary remittance advice for the individual patient; and (3) the group remittance advice. Carter depo., 52. Examples of all three of these documents are contained in Depo. Ex. 90.

It is obviously critical to the Medicare payment process that only reimbursable minutes specified in the Medicare regulations and policies be reported on the MDS form. Otherwise, the number of physical therapy minutes will be an inaccurate representation of the patient's actual receipt of therapy during the assessment period and the estimated minutes to be administered before the next comprehensive assessment occurs. Inclusion of inappropriate therapy minutes results in a RUG category and an associated *per diem* rate being assigned to the patient that is directly derived from minutes that could not be counted. It is indisputable that accurate data being submitted on the MDS is the *sine qua non* for accurate billing of Medicare for TCU services. This is because it is the RUG category (generated by the MDS) that becomes the basis

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[4/] I discuss these rules in detail below in Section VII, Regulatory Analysis.

for payment by Medicare. And if the RUG category is falsely derived, then any *per diem* Medicare payments received by the hospital are by definition fraudulent.

There is a second way in which inclusion of inappropriate minutes in the MDS can result in fraudulent payments being made to a TCU provider which constitute FCA violations. That is, setting aside the rate of *per diem* payment per RUG category itself, if the minutes billed to Medicare for physical therapy/TCU services are for therapy that violates Medicare rules, such as the 25% limitation and the four-patient rule, it cannot be reimbursable. Such billings can, as I explain below, constitute fraud against the government in violation of the FCA.

III. Background and Pertinent Experience

I am currently a partner in the health, government contracts and litigation groups at Arent Fox LLP in Washington, D.C. I joined Arent Fox in 1995 after 15 years in the United States Department of Justice, including 2 years as an Assistant United States Attorney ("AUSA") in the District of New Jersey (1982-84), and 11 years (1984-1995) as Trial Attorney and later Senior Trial Counsel in the Civil Fraud Section, Commercial Litigation Branch, Civil Division, at Main Justice in Washington. I first began working with the FCA while an AUSA. When I shifted to Washington, I worked almost exclusively on FCA cases relating to all manner of governmental programs. Principally I was involved in defense procurement fraud cases and Medicare cases, although I also handled FCA cases relating to the Departments of Education, Agriculture, Veterans Affairs and others. In 1986, I participated in the amendment of the FCA, including helping to redraft one section.

Beginning on or about 1988, I undertook initial supervision of all health care fraud cases in the Civil Fraud Section, including cases initiated by the Department as well as an increasing

number of *qui tam* cases. As part of my responsibilities as Senior Trial Counsel, I supervised cases handled by the various U.S. Attorneys' offices across the nation, trained Assistant U.S. Attorneys in a number of offices, and helped write the internal Civil Division FCA manual that is used by United States Attorneys' offices and Main Justice.

An important dimension of my responsibilities as Senior Trial Counsel involved the evaluation of new FCA Medicare cases, whether originated by the Department or filed by *qui tam* relators. That process involved assessing the alleged violation of Medicare rules and regulations, the damages accruing to the government as a result, and the applicability of the FCA's treble damages and penalty provisions. Based upon this analysis, I formulated recommendations to my superiors and the Office of Inspector General, Department of Health and Human Services ("OIG").

As soon as a *qui tam* complaint arrived alleging healthcare fraud, it was assigned to one of the fraud section's Trial Attorneys I supervised for evaluation. Almost immediately, copies of the pertinent materials were dispatched to the OIG, because it was that agency that usually conducted the investigation leading to a recommendation regarding whether the United States should intervene in the action. On occasion, investigative resources from other agencies were utilized, including the FBI, Defense Criminal Investigative Service, and the Office of Management and Budget. At any point during my tenure as Senior Trial Counsel, I coordinated approximately 90-100 cases with the OIG. Following the investigation stage, the OIG would make a recommendation as to whether the United States should intervene in the case. OIG also, as the client agency, would submit recommendations about proposed settlements or complaints. During my tenure, I received four OIG Integrity Awards based on my work with that office in

prosecuting healthcare fraud cases.

If a case were being negotiated with the actual or potential defendant, I would often participate with the Trial Attorneys and Assistant U.S. Attorneys assigned to the matter. If a proposed settlement were reached, I oversaw all memos that would go forward seeking settlement approval.

A key element in every settlement memo is the analysis of damages to the government measured against the elements of the proposed settlement. During this period as well, I handled my own Medicare/ Medicaid/ Federal Employees Health Benefits Plan cases (as well as other cases), which also required me to analyze the potential damages to the government, evaluate acceptable settlement options, and devise appropriate litigation strategy. These cases involved allegations of fraud encompassing virtually every type of healthcare for which the federal government bore the costs. Specifically, my cases involved hospitals, physician practices, laboratories, nursing homes, and medical devices to name some of the areas.

One of my primary responsibilities as Senior Trial Counsel was to train Civil Fraud Section Trial Attorneys and AUSA's in how to evaluate FCA healthcare fraud cases, assess government losses, and develop negotiating positions. In order to effectively negotiate a settlement, or secure authorization to litigate a case, it was essential that DOJ personnel accurately analyze a potential case, both as to legal theories as well as to what would be necessary to make the government whole. In addition, the issue of multiple damages, and more importantly the appropriate component of penalties, is one that usually requires a considerable amount of thought and analysis given the flexibility built into the FCA. Computing the government's losses, and appropriate penalties and damages, can be challenging, particularly in very large cases. I supervised and

participated in both the National Health Labs ($110 million settlement) and the National Medical Enterprises ($324 million settlement) cases which involved months of negotiation on these issues.

A great deal of my previous experience as an expert witness, in Texas state court litigation, involved these same issues, but from the standpoint of evaluating what damages and penalties the government and a group of relators could have recovered in FCA litigation involving government off-shore oil lease royalty payments. While this case obviously did not involve healthcare fraud, I utilized the same tools of analysis in developing that testimony as I had while at DOJ. Of course, while Senior Trial Counsel, I had been involved in a wide variety of fraud cases, not just healthcare, involving government contracts, grants, and a variety of government programs. I employed the same techniques relative to those cases as I did in the healthcare fraud cases, and in developing my testimony in the present matter.

Since April 1995, I have been at Arent Fox, first as Counsel and since 1997 as a partner. My practice is almost exclusively related to defensive FCA and *qui tam* matters. Most of my FCA cases involve healthcare issues. Once again, my primary responsibilities in representing defendants include assessing potential damages the government might seek to recover, resolving regulatory issues pertaining to CMS statutes and policies, and developing litigation strategies. Since many of my cases involve the Department of Justice, I maintain contact with current DOJ thinking regarding theories of liability, methods for computing FCA damages and penalties, and new variations of FCA legal strategy.

In particular, my involvement in working with these damages/penalties issues has continued since I entered private practice. In my defensive practice, I am constantly debating with the government and/or relator's counsel the appropriate measure of damages and particularly

applicable penalties. I have always believed that damages and penalties should be based on some reasonable rationale, and I try and hold opposing counsel to the requirement that they put forth a rationale basis for whatever they are demanding. My tools and methods of analysis remain the same, as they have throughout my career working with the FCA.

As a result of both my 15-year period of service in the Department of Justice, and my tenure in private practice since 1995, I am abundantly qualified to address the issues raised in the present litigation. I have a through and well-grounded background in healthcare fraud. I have worked with the FCA since 1982 in the healthcare fraud area, have written extensively on it, and have personally been involved in the entire range of healthcare fraud matters. Most importantly, for my entire period working with the FCA I have been required to evaluate the financial dimensions to FCA cases–including theories of recovery, losses to the government, and the appropriate role of multiple damages and penalties. And I previously have testified as an expert on FCA damages issues.

Attached to my report, as Exhibit A, are my current Arent Fox webpage resume, including published FCA web articles, reported FCA-related federal decisions, and my general background. Also included is a listing of my published articles, book chapters and book, including those relating to the FCA.[5/]

IV. The False Claims Act Damages and Penalty Provisions

The FCA has become the primary enforcement mechanism employed by the government in combating healthcare fraud, defense industry contractor fraud, and fraud in any other

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[5/] In accordance with Arent Fox firm policy, my rate for expert testimony services is the same as my regular hourly billing rate. For work done in 2006, that rate was $470 per hour; during 2007, my hourly rate is $505.

government-funded program. The *qui tam* or whistleblower provisions (§ 3730), under which this case was brought, have assumed significant importance, especially in the healthcare area.

Section 3729(a) contains the formidable damages and penalty provisions of the FCA. For example, the government is entitled to three times the amount of its losses. However, the more severe provision in cases of healthcare fraud is that addressing penalties: between $5,500 and $11,000 for each false claim submitted and/or fraudulent document used to get a false claim approved for payment. In the healthcare fraud area, it should be noted that the civil penalties apply to each request to the Department of Health and Human Services (including its fiscal intermediary contractors[6/]) for reimbursement, causing a defendant's potential exposure to mount very quickly. As a result, for every 100 false claims a government contractor or health care provider submits, it or can face liability of $1,100,000 dollars in penalties alone. Because of the large number of claims generated by healthcare providers, the penalty provisions of the Act often play a more important role in defining total provider liability than does the multiple damages provision.

V. Summary of Conclusions

I discuss the specific support for my opinions in detail below. However, it seems appropriate at this point to state my overall conclusion as a preface to the more detailed discussion that follows. I have attached as Exhibit B a listing of the materials I consulted in formulating my opinions. As I discuss below, I have placed reliance upon relators' expert Ms. Leslie Mack's exhaustive color-coded charts contained in her initial and rebuttal reports. Ms. Mack's extensive charting employs a direct and simple methodology: she evaluated the patient

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[6/] *See* 31 U.S.C. § 3729 (c).

charts for each day of the pertinent period[7/] and recorded the number of patients receiving therapy at the same time. A review of the Mack data demonstrates that at least 916 false claims, via UB-92 forms, out of a total of approximately 922 Medicare patients who received physical therapy, were submitted during the pertinent period to the government claiming payment for TCU services, including physical therapy services, which were not reimbursable under pertinent HHS regulations. These UB-92's were false claims because they were reimbursed at fraudulent payment levels due to a sabotaged RUG-category designation process, as well as representing billing for services which were not reimbursable at all under Medicare regulations. While I discuss below in some detail the regulatory analysis underpinning my conclusion that the services were not reimbursable, I am principally relying upon Section 2837 of the *Provider Reimbursement Manual* (dated 07-98) (Depo. Ex. 176).

That provision mandates that in order for group therapy time to be counted in the rehabilitation therapy minutes on the MDS, the integral step in seeking reimbursement from the government (*see* Burdick depo., 496), the group must have had four or fewer participants per supervising therapist or therapist assistant. Furthermore, no more than 25% of the minutes reported on the MDS (section P) may be for group therapy. My review of the Mack data establishes that 916 claims in violation of these regulatory criteria were submitted by the hospital, or were "caused to be submitted" by NRP.

The next issue I consider is the extent of the statutorily-mandated damages that are applicable to these 916 false claims. First, the government is entitled to recover three times its losses. The amount the United States paid for TCU services as a result of these false claims totals

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[7/] As contrasted with defense expert Ms. Edford who reviewed a sample.

at least $2,771,586.54. As I discuss below, it is my opinion that the total amount paid by the government for TCU services, not just some portion arguably allocable to purportedly reimbursable physical therapy services, or some other method, constitutes damages to the government. Therefore, under the mandatory treble damages provision, the relators are entitled to recover on behalf of the government three times the single damages of $2,771,586.54, or $8,314,759.62.

In addition, the government is entitled to recover a penalty of between $5,500 to $11,000 for each false document submitted in order to receive improper reimbursement. *See* 31 U.S.C. § 3729(a)(2). I have made the following assumptions. I assume that at least one UB-92 was submitted in connection with each of the 916 fraudulent claims. It may well be for longer stays that more than one UB-92 was submitted—but my analysis is limited to a single UB-92 per claim. In the absence of specific UB-92's, I have relied on data reportedly drawn from Medicare Intermediary Remittance Advices, or other hospital generated documents. It is also evident that fraudulent MDS' themselves may also give rise to FCA liability as a fraudulent document used to get a false claim paid. However, I have chosen to employ a conservative methodology and assign only one penalty per each of the 916 false claims. Conceivably, other documents contained in the hospital's medical files could also constitute additional violations of the FCA if they were fraudulent and were relied upon by the government in making payment decisions, but I have not factored into my calculations that consideration.

Given the repetitive nature of the pertinent claims, the defendants' blatant disregard for Medicare rules and procedures, the large number of claims (i.e., nearly all TCU patients), and the lack of any apparent compliance mentality being present on the part of either defendant (*see*

Section VIII, "Absence of Compliance Mentality," *infra)*, it is my opinion that the United States and the relators are entitled to recover nearly the maximum amount of penalties for each false claim–I believe that figure to be $10,000 per false claim. Therefore, for the 916 pertinent claims, that would add $9,160,000 to the multiple damages figure. As a result, it is my opinion that relators and the United States are entitled to recover at least $17, 474,759.62 as a result of defendants' fraudulent conduct.

VI. Validation of the Mack Data

As I have indicated throughout my report, I have placed substantial reliance upon Ms. Mack's reported data. As explained above, her methodology was direct, straightforward and involved a review of every patient chart during the pertinent time frame. I have found the methodology employed, and the thoroughness of factual analysis, particularly effective and helpful. It is my understanding that thus far in this proceeding, Ms. Mack's chart data has not been challenged. It certainly is not put into issue in Ms. Edford's report. Nonetheless, I undertook a limited cross-check of Ms. Mack's analysis just to assure myself of the accuracy of her findings.

Specifically, I reviewed the data on more than thirty-three randomly-selected days, comparing the Mack color-coded chart data for those days with the data recounted on the corresponding days by Ms. Edford in Exhibit 21 of her report. I found only one minor discrepancy which did not affect the accuracy of the Mack data. To cite one example, I cross-checked the Mack chart for Tuesday, 12/1/1998, against Edford's chart for the same day. My review disclosed that the patient names and times of treatment corresponded. Furthermore, and most important for this case, I was able to cross-check Ms. Mack's color designations (such as

orange = more than four patients having physical therapy simultaneously) against the Edford data. Both Ms. Mack and Ms. Edford also identify the signature of the supervising therapist, which is helpful in determining the presence of group therapy and the size of any group. Therefore, while I did not cross-check every one of Ms. Mack's color-coded charts, I evaluated a large enough sample to convince me that her methodological approach and resulting data were sound.

Therefore, I feel confident in placing reliance upon her finding that between July 1, 1998, and October 1, 2000, out of approximately 950 Medicare patients in the TCU, only six patients did not receive physical therapy in violation of at least one of the two pertinent Medicare rules, or both. See Mack report, 2.

VII. Regulatory Analysis

My conclusion that both defendants submitted, or caused to be submitted, false claims and false documents as defined in the FCA for payment by Medicare, rests upon the following regulatory analysis as applied to the Mack data.

Group Therapy Rules

A. § 2837 *Provider Reimbursement Manual*

My review of the Mack color-coded data compels me to conclude that two primary Medicare rules governing reimbursement for group therapy were contravened consistently by defendants. Moreover, the rule limiting reimbursable group physical therapy to four patients or less had been had been enunciated prior to the promulgation in July 1998 of Section 2837 of the *Provider Reimbursement Manual* (dated 07-98) (Depo. Ex. 176).

B. Four Patient Rule

Medicare has established two rules that fundamentally and directly bear on this issue. First, in order to qualify as group therapy for reimbursement, the group must have four or fewer participants. This rule is well established. For example, this rule is articulated in the August 1996 Medicare-issued *Health Care Financing Administration Long Term Care Resident Assessment Instrument Version 2.0 Questions and Answers , August 1996* ("RAI") (attached hereto as Exhibit C). The response to question number 107 (at 22) makes this "four patient" rule explicit. Another incontrovertible statement of this Medicare rule appears in the Federal Register notice of the PPS system Final Rule for Skilled Nursing Facilities at 64 Fed. Reg. 41644, 41662 (July 30, 1999), quoting the RAI: "It states that if the group has four or fewer participants per supervising therapist (or therapy assistant under general supervision by the therapist) then it is appropriate to report the full time as therapy for each patient)." Finally, in the "*MDS 2.0 Questions and Answers*" (current on-line version attached as Exhibit D hereto), which repeats instructions originally promulgated as early as May 14, 1997, refers back to the RAI as articulating the four patient rule. *Id.* at 5 of 8.[8/]

C. The 25% Rule

The Mack data also leads me to conclude that defendants failed to comply with a second fundamental rule governing the reimbursement by Medicare for physical therapy. That rule states that no more than 25% of the patient's therapy minutes reported on the MDS (section P) may be group therapy. Put differently, group therapy minutes in excess of 25% cannot be counted for reimbursement. This rule is equally well established. For example the PPS Final Rule in the same

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[8/] Certainly senior NRP management recognized the applicability of the rule. *See, e.g.,* Helgerson depo., 75.

paragraph as it discusses the four-patient rule states: "we do not believe that services received within a group setting should account for more than 25% of the Medicare resident's therapy regimen during the SNF stay. For this reason, no more than 25 % of the minutes reported in the MDS may be provided within a group setting." 64 Fed.. Reg. 41662. Similarly, the current *MDS 2.0 Questions and Answers* affirms that the 25% rule is an ironclad condition of reimbursement. See Exhibit D hereto at 5 of 8. It is evident from the deposition testimony that both hospital and NRP senior management and staff were aware of these rules from the inception of the PPS system at the hospital. *See, e.g.,* Helgerson depo. (Part I), 110; Bailey depo., 93; Sjoblom depo., 192 & 196; Burdick depo., 22 & 487; Makay depo., 82. This is equally true of therapists as well. *See, e.g.,* Shaw depo., 109; Clark depo., 29.

D. Group Therapy Conclusion

As established by the Mack data, all of the 916 false claims submitted to the government violated either one or both of these fundamental rules. Therefore, they were non-reimbursable services and cannot knowingly be submitted to the government as purported physical therapy services for payment without constituting violations of the FCA.

Concurrent Physical Therapy

Apparently, both defendants are contending that the physical therapy in the TCU was not impermissible group therapy, but was so-called "concurrent therapy." I reject that contention in its entirety. Rather, I concur with Ms. Mack that concurrent therapy, within the meaning of the Medicare regulations, was not being performed by defendants in connection with any of the 916 claims at issue.

Concurrent therapy was first addressed by the Centers for Medicare and Medicaid Services,

formerly HCFA ("CMS"), in a proposed rule governing PPS for Skilled Nursing Facilities on May 10, 2001. 66 Fed. Reg. 23991 (Depo. Ex. 86). CMS addressed concurrent therapy because it believed the practice was being abused. At no time of which I am aware, has CMS ever endorsed the concept of "concurrent therapy" as encompassing the way therapy was practiced in the TCU.

Beginning with the May 10, 2001, statement, CMS consistently has articulated its concerns about this purported type of therapy:

> The Medicare SNF benefit provides coverage of therapy services only when the services are of such a level of complexity and sophistication (or the beneficiary's condition is such) that the services can be safely and effectively performed only by or under the supervision of a qualified therapist. Therapy services that are concurrently being delivered by one treating therapist to many beneficiaries would not appear to meet these criteria. If the therapist or therapy assistant can provide the distinct services to several beneficiaries at once, then it is unlikely that the services are sufficiently complex and sophisticated to qualify for coverage under the Medicare guidelines...*Id.* at 23991-2.

Medicare then explicitly stated its stringent position on the use of so-called concurrent therapy, as well as articulating major limitations on the practice of concurrent therapy:

> We note that there have always been *isolated instances* in which a professional therapist has been allowed to have some overlap in the time of concluding treatment to one individual and the time of commencing the treatment of another, even to the point of briefly providing therapy concurrently in certain cases. However, the key principle here is that Medicare relies on the professional judgment of the therapist to determine when, based on the complexity of the services to be delivered and the condition of the beneficiary, it is appropriate to deliver care to more than one beneficiary at the same time. *Our concern now is that in some areas of the country, concurrent therapy is becoming a standard practice rather than the exception and is being dictated by facility management personnel rather than according to the professional judgment of the therapists involved. Id.* at 23992 (emphasis added).

Medicare has reiterated those concerns more recently, and stated that even where concurrent

therapy is appropriate, its use must be driven by "valid clinical considerations." 66 Fed. Reg. 39568 (Depo. Ex. 87); 70 Fed. Reg. 29070, 29082-3 (May 19, 2005). It is evident that Mr. Shaw, the principal TCU therapist, did not exercise his "professional judgment" before grouping patients together for his version of concurrent therapy. Shaw depo., 324-5. This is a central finding of Ms. Mack's report as well. *See also, e.g.,* Depo. Exs. 58, 59, 77, 139; Collins depo., 45; Ramsdell depo., 98-110.

Therefore, while Medicare has never said clinically-appropriate concurrent therapy is non-reimbursable, it has made it clear in these pronouncements that concurrent therapy is the exception rather than the standard practice, and it is to be judged by the same criteria as individual therapy, because – fundamentally – it is really just individual therapy for more than one person. In my opinion, the deposition testimony conclusively establishes that defendants were not providing appropriate reimbursable concurrent therapy at all times pertinent to the Complaint. For example, there is a clear lack of agreement in the deposition testimony as to how many patients could and were provided with so-called concurrent therapy at the hospital. *See, e.g.,* the deposition testimony of Mr. Clark at 2 & 134; Mr. Collins at 45; Ms. Ramsdell at 98-110; Ms. Helgerson at 26, 116, 148, 167 and 106 (second part); and particularly Mr. Shaw at 59, 98, 102, 140, 168, 201, 208-9, 318, 341, 351, & 384.

Concurrent Therapy Conclusion

I find it highly significant that I can locate nowhere in the deposition testimony or the defendants' PPS training materials or any other document any indication that defendants' employees were ever trained in the administration of concurrent therapy, or were even aware of the term. For example, Ms. Sjoblom, a senior corporate manager for NRP, stated in her

deposition (at 146) that she had never heard of concurrent therapy. I can find no mention of concurrent therapy in the training materials produced by either the hospital or NRP. *See* Depo. Exs. 45 & 65. In my opinion, the 916 claims at issue were not instances of reimbursable individual or concurrent therapy. They were no more than non- reimbursable group therapy.

VIII. Absence of Compliance Mentality

As one who valued compliance very highly when in the Department of Justice, and having designed numerous compliance plans for hospitals since entering private practice, my conclusion that defendants were engaged in inappropriate TCU billing is reinforced by the almost total absence of any compliance mentality being evidenced in the depositions taken in this case. This situation is particularly egregious given that the NRP and hospital training materials certainly placed appropriate compliance information in the hands of defendants' managers, directors, and employees. Yet almost across the board, with a few notable exceptions (including relators and Ms. Egusquiza), a shocking disregard for compliance issues appears to have permeated both defendants, reaching even to the level of the hospital's Chief Executive Officer, Mr. Kee.

The key actor in making any compliance plan more than just lofty sentiments written on paper is the compliance officer. I have spent a considerable amount of time in working with our firm's hospital compliance clients in helping them designate the appropriate person to serve in this critical role. Unfortunately, given my review of the deposition testimony, it is evident beyond dispute in my opinion that Ms. Fischer simply was ineffectual as a compliance officer. Her lackluster approach to implementing her compliance duties contributed significantly to the ineffectual impact the hospital's compliance plan had in restraining the submission of the false claims at issue in this litigation. While there is much blame to go around in this regard, as I

discuss below, her failure was blatant and crucial.

The following are just a few representative examples I have encountered which evoke this concern on my part. I find it interesting that the designated compliance officer, Ms. Fischer, did not revise compliance procedures following the Michener episode. *See* Fischer depo., 29. Ms. Juker testified that she received absolutely no compliance training from Ms. Fischer, even though her position was crucial to maintaining the integrity of the Medicare billing process. Juker depo., 90. In fact, Ms. Juker testified she had no direct interaction with Ms. Fischer regarding billing issues. *Id.* at 91. Ms. Burdick stated that Ms. Fischer did not understand long-term care, including the TCU. Burdick depo., 218. Ms. Neff testified that Ms. Fisher seemed confounded as to how to implement Medicare regulations; Ms. Egusquiza even had to encourage her to pay more attention to these issues. *See* Neff depo., 63.

Further disturbing examples abound in the deposition testimony. Ms. Sjoblom testified that there was no mechanism in place to check the accuracy of minutes charged to therapy, including compliance with the 25% rule (depo.,72 & 196); that a problem existed with individuals other than those who had performed the therapy signing off on the medical record (*id.* at 131); and that therapists had no clear understanding of PPS rules (*id.* at 202). Mr. Bradley Voss, hospital Vice President of Professional/Ambulatory Services, simply assumed that compliance functions were being executed by Ms. Fischer and neglected to double-check on her activities, including making reports to Medicare. Voss depo., 82, 216, 223-226. Ms Helgerson undertook no audits to evaluate medical documentation, and characterized Medicare regulations as "burdensome." Helgerson depo., 87 & 207. Mr. Bailey, defendant NRP's senior on-site manager, dismissed keeping accurate medical documentation as "nitpicking" and "wasting" a lot of time. Bailey

depo., 256-257.

Particularly serious in my judgment (based on my experience) are the actions of Mr. Kee. Ms. Suter testified that he refused to order audits even though he was aware that 42% of sample outpatient charts were out of compliance (Suter depo., 131), and that Medicare had already contacted the hospital about a sample of excessive RUG categories (*id.* at 222); rescinded the invitation extended to compliance expert Ms. Dewberry to review TCU compliance practices (*id.* at 139-140); indicated to Ms. Suter and others in a January 19, 2000 meeting that the government would never discover hospital billing irregularities (*id.* at 222-3); and manifested hostility to compliance concerns expressed by relators (*id.* at 399). Mr. Taylor (the hospital's outside counsel) testified (depo.,120) that he supported Ms. Suter's request for additional auditing, which Mr. Kee rejected.

Effective compliance implementation in my experience starts at the top; ineffective compliance plans are also usually the result of lack of dedication at the senior executive level. In my opinion, the ineffectual compliance system in effect at the hospital was an indispensable element in contributing to the FCA violations alleged in the complaint.[9/]

IX. Damages Analysis

[9/] From the compliance standpoint, I am also troubled by the apparent inappropriate use of therapy aides and extenders in connection with the TCU. For example, the deposition testimony indicates that aides may have run the TCU with little or no supervision. *See, e.g.,* Bailey depo. 212 & Depo. Ex. 111; Collins depo., 128; Harmer depo., 107; Reed depo., 104; and Suter depo. 116 & 160. There is also indication of aides inappropriately signing patient charts. Ramsdell depo., 80 & 92.

A. Recovery for Total Payments Made to Magic Valley

As I indicated above, I believe the entire amount paid to the hospital for TCU services for each patient should serve as the basis for the loss to the government, not just the amount of each payment arguably allocable to physical therapy, or some differential resulting from other categories placing the patient in a different RUG category. That conclusion rests upon several considerations which I discuss in this section.

This case must be distinguished, for damages purposes, from other categories of FCA cases I supervised at the Department of Justice, where the government has contracted to purchase something, negotiated the specifications of the final product, but yet receives something different than that for which it contracted. In such cases, such as procurement fraud situations, the traditional measure of damages is what the government paid, minus the value of what it received. Using one of my own cases as an example, if the government contracts for certain aircraft parts to undergo specified environmental inspections and tests, which the contractor neglects to perform, the parts may still have some value to the government and in fact be utilized by the government. In that situation, the differential in value between what was received and what was contracted for becomes the appropriate measure of FCA damages.

That damages model is not used generally in cases where healthcare fraud has been demonstrated, and in particular in the present case involving TCU care. The issue in this case is whether TCU services are worth anything to the government if the physical therapy component, certainly the most central component service as reflected on the UB-92's, has not been furnished in accordance with Medicare standards and regulations, and the assignment of the RUG category and *per diem* rate was accomplished by counting minutes of disqualified therapy.

As discussed above, I have concluded that this is exactly the situation as regards the TCU services rendered at the hospital by defendants. I can see no reason whatsoever for not applying this standard FCA healthcare fraud measure of damages in this case.

Several different considerations converge in my opinion to justify assigning the entire amount paid to the hospital as the basis for FCA damages and penalties against both defendants. Where inappropriate therapy minutes were input into the MDS, which resulted in an inflated RUG level assignment, the government should not pay anything for these purported rehabilitation services. Similarly, if both the therapy minutes claimed on the MDS and the UB-92 really represent non-reimbursable therapy, they simply are of no value to the government and do not merit reimbursement.

In all the *healthcare fraud* cases I handled myself or supervised at the Department of Justice between 1984 and 1995, I cannot recall a single instance in which the Department "cherry-picked" only certain components of a fraudulent service for inclusion in the single damages calculation, and did not include the entire amount paid by the government to the FCA defendant. I am thinking particularly of cases with which I was involved, including National Medical Enterprises (1994), National Health Labs (1992), and MetPath/MetWest (1993). This continues to be my experience during the last nearly twelve years as well as a FCA defense counsel, including cases negotiated with the Department that involved physical therapy services administered in nursing homes, and Average Wholesale Price litigation.

The lessons of my experience at the Department of Justice and subsequent private practice are reflected in a related approach suggested by Howard Daniels, for many years in charge of the civil fraud activities of the United States Attorney's Office for the Central District of California,

with whom I have worked extensively. Mr. Daniels – in what he terms "failure-of-care" cases – specifically rejects the argument that defendants often make that they ought not be required to make the government whole for services, such as nutrition, nursing care, and assistance with daily activities which were provided to patients, even if other services were not reimbursable and fraudulently billed to the government.[10/] For example, the UB-92 contained in Depo. Ex. 90 lists a number of services purportedly provided by the hospital (*i.e.*, pharmacy, lab, room-board, etc.) as to which the complaint contains no allegations. Defendants might contend that these services, being other than physical therapy, ought not to be considered as part of the government's losses because they may well have been provided to Medicare beneficiaries at an acceptable level under pertinent regulations.

The Daniels model rejects this argument in its entirety. The key question in this case is what service was the government paying for? In this matter, it was paying for TCU care that supposedly met Medicare-specified standards, and appropriate physical therapy was a principal component of that service. Moreover, the government assumed it was paying at a *per diem* rate that was properly generated. Simply put, the government did not receive that which it paid for. What defendants provided instead was non-reimbursable care that was worth, in Daniels' terms, "nil" to the government, because the key component, physical therapy, was not rendered in accordance with Medicare standards. Mr. Daniels analogizes such cases – quite correctly I believe – to defective product cases: "If the product is of no use to the Government because it does not satisfy the Government's purposes, damage are the full contract amount, even if the

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[10/] K. Blackwood & H.F. Daniels, *Nursing Home Liability for Failure of Care Under the False Claims Act*, 30 TAF Quarterly Review 56-67 (April, 2003) (attached as Exhibit E).

product had some market value." *See id.* at 65, and the authorities cited therein.

Defendants' contention that some other measure of damages should be applied in this action is without substance. The hospital's position that damages should be determined by the differential between what was paid by Medicare and what would have been paid had the defendants reported the proper RUG category data is inapposite. This case is rather straightforward and eliminates any need to consider this contention. This is because what occurred here was the inputting of fraudulent patient minutes of treatment into the MDS system, leading to the assignment of fraudulent RUGs categories. Since these reported minutes did not in fact involve reimbursable therapy rendered in accordance with Medicare requirements, there is no RUG category which can be appropriate. Consequently, there is no legitimate reimbursement in any amount that could be due the hospital for these services. Thus, re-designation of some other RUG category would be of no avail to defendants.

Moreover, 31 U.S.C. § 3730(b) of the FCA vests jurisdiction in relators to litigate claims based upon allegations of fraud against the government. There is no authority that would allow CMS, HHS, or any other government agency administratively to foreclose the right of relators to pursue FCA actions seeking and recovering the full amount of multiple damages and penalties specified in the statute because of policy concerns. This case is not an action for restitution or Civil Monetary Penalties instituted by the HHS Inspector General. Agencies have no authority to resolve claims of fraud against the government--that is the exclusive prerogative of the Department of Justice,.[11/] including actions initiated by relators.

[11/] *See, e.g., United States v. Newport News Shipbuilding & Dry Dock Co.*, 571 F.2d 1283, 1287 (4th Cir. 1978); *Executive Bus. Media v. U.S. Dep't of Defense,* 3 F.3d 7 59, 762 n. 1 (4th Cir. 1993).

This matter became an action under the FCA once the initial complaint was filed. It can only be resolved in accordance with the provisions of the Act.

As a final point, defendants' approach would seem to encourage fraud against the government because if the entity or individual committing healthcare fraud is only required to pay simple restitution, rather than damages and penalties as specified in the FCA, then the deterrent effect of the Act is rendered nugatory.

B. Impact of PPS Payment Effective Date

In her report (page 3 of 43), Ms. Edford suggests that due to the conditions under which the PPS payment system was implemented, the hospital was not subject to the PPS payment system until October 1, 1998. Therefore, the hospital was not paid based on PPS RUG categories until after this effective date. This allegation is irrelevant to my analysis. My damages estimates are based on the fact that the hospital and NRP (via "causing"), during all pertinent periods specified in the complaint, billed for non-reimbursable physical therapy services rendered to Medicare patients as part of their TCU treatment. That conclusion is based, as articulated above, on the defendants' conspicuous violation of the four-patient rule.

That rule was in effect and binding during the period of time Ms. Edford seeks to disqualify, and therefore defendants' actions constitute billings for non-reimbursable therapy services. Under whatever system the hospital's Medicare reimbursement was calculated is not pertinent; what is relevant is that the defendants knowingly billed Medicare for (or "caused" to be billed for) non-reimbursable physical therapy/TCU services and these amounts paid during that period have been included in my damages calculation.

C. Transition Schedule for PPS Payments

At several places in her report (*i.e.*, at 4, 7, 16-17 and 23 of 45, including chart), Ms. Edford attempts to link together two concepts which I believe do not bear the slightest relationship to each other. That is, Ms. Edford contends apparently that the transition schedule for PPS payments that was applied to the hospital, involving blending percentages of the former cost-based system of reimbursement combined with the gradual introduction of the PPS *per diem* payment system, somehow should act to limit and reduce the potential damages.

While I recognize that during the PPS phase-in period, the hospital's reimbursement was comprised of blended percentages based upon its historical costs combined with the new PPS computation, I do not believe this has any effect upon my damages calculations. It should be clear from my report that I have concluded that 916 claims submitted by (or caused to be submitted by) defendants violated the FCA. This is because these claims were for physical therapy/TCU services that did not comply with explicit Medicare rules and guidelines. These Medicare rules were equally applicable whether a TCU provider was receiving cost-based reimbursement, PPS reimbursement, *or any combination of the two*.

When all of these inappropriate Medicare payments are added up, I conclude that the damages suffered by the government were *at least* $2,771,586.54. Where I part company from Ms. Edford is my belief that it is absolutely irrelevant how the government determined the amounts paid in response to the fraudulent claims–whether cost-based, PPS, or any other method. What is relevant is that this amount was paid as a result of fraudulent claims submitted to Medicare for TCU services. Therefore, it is indisputable in my opinion that under the FCA, this figure should serve as the basis for multiple damages. Ms. Edford has confounded two independent and unrelated concepts.

D. Impact of Purported Reimbursement Caps

Similarly, Ms. Edford is further incorrect (at 5 of 45) in suggesting that somehow because the hospital's cost reimbursements were capped that this should have an impact on damages. The simple matter is that pertinent hospital records establish payment to the hospital for fraudulent services. Ms. Edford has offered no proof to establish that any of those Medicare reimbursements were not paid to the hospital because they were included in the amount in excess of the cap. Therefore, I have disregarded this consideration in computing the damages figure.

Conclusion

For the reasons stated above, it is my conclusion that relators on behalf of the United States are entitled to recover *at least* $17,474,759.62 from defendants, jointly and severally.