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United States Intervenes and Files Complaint in False Claims Act Suit Against Health Insurer for Submitting Unsupported Diagnoses to the Medicare Advantage Program

The United States has intervened and filed a complaint in the U.S. District Court for the Western District of New York under the False Claims Act against Independent Health Association, Independent Health Corporation (Independent Health), DxID LLC (DxID) and Betsy Gaffney, former CEO of DxID. The government alleges that Independent Health, DxID and Gaffney violated the False Claims Act by submitting or causing the submission of inaccurate information about the health status of beneficiaries enrolled in Medicare Advantage Plans in order to increase Independent Health's reimbursement. Independent Health is headquartered in Buffalo, New York. DxID was headquartered in Buffalo until it ceased operations in August.

"The Medicare Advantage Program relies on accurate information about the health status of enrollees to ensure that they receive appropriate treatment and that participating health plans receive proper compensation for the services they actually provide," said Deputy Assistant Attorney General Michael D. Granston of the Justice Department's Civil Division. "The department will continue to hold accountable health plans or providers that report unsupported diagnoses to inflate risk adjustment payments."

"The defendants are alleged to have submitted unsupported diagnosis codes to inflate reimbursements, which enabled them to receive payments from Medicare that were greater than they were entitled," said U.S. Attorney James P. Kennedy Jr. for the Western District of New York. "Defrauding taxpayer funded health care programs such as Medicare hurts not only taxpayers but our nation's entire healthcare system."

Under Medicare Advantage, also known as Medicare Part C, Medicare beneficiaries have the option to enroll in managed healthcare insurance plans called Medicare Advantage Plans (MA Plans) that are owned and operated by private Medicare Advantage Organizations (MAOs). MA Plans are paid a fixed amount per enrollee to provide benefits covered by traditional Medicare to beneficiaries who enroll in their MA Plan. The Centers for Medicare and Medicaid Services (CMS), which oversees the Medicare program, make upward payment adjustments to MA Plans based on demographic information and the health status of each plan beneficiary. The adjustments are made using what are commonly referred to as "risk scores." In general, a beneficiary with more severe diagnoses will have a higher risk score, and CMS will make a larger risk-adjusted payment to the MA Plan for that beneficiary.

Independent Health offers two MA Plans in New York State. Its wholly-owned subsidiary, DxID, provided retrospective chart review and addenda services to Independent Health and other MA Plans.

The United States alleges that DxID coded conditions that were not documented in the patient's medical record during a visit or encounter. The government further alleges that DxID also asked health care providers to sign addenda forms up to a year after a visit or an encounter and subsequently used the addenda as substantiation for adding risk-adjusting diagnoses that were not documented during the patient encounter, in violation of Medicare requirements. DxID operated on a contingency fee of up to 20% of the additional recovery that the MA Plans received based on diagnoses captured by DxID.

The complaint alleges that these unsupported diagnoses inflated the risk scores of beneficiaries, resulting in inflated payments to Independent Health and other MA Plans. The lawsuit further alleges that once Independent Health became aware of these unsupported diagnosis codes, it failed to take corrective action to identify and delete the unsupported codes.

The lawsuit was filed under the *qui tam*, or whistleblower, provisions of the False Claims Act, which permit private parties to sue on behalf of the government for false claims and to receive a share of any recovery. The False Claims Act also permits the government to intervene in such lawsuits. Although the United States initially advised the court that it was not intervening in this case, the court subsequently granted the United States' motion to intervene for good cause. The whistleblower, Teresa Ross, is a former employee of Group Health Cooperative (GHC). GHC was an MAO that offered MA Plans in Washington State. From 2011 to 2012, GHC used DxID's chart review services. In November 2020, GHC entered into a settlement with the United States and Ross to resolve the claims against it arising out of this matter.

The United States' intervention in this matter illustrates the government's emphasis on combating health care fraud. One of the most powerful tools in this effort is the False Claims Act. Tips and complaints from all sources about potential fraud, waste, abuse and mismanagement, can be reported to the Department of Health and Human Services at 800-HHS-TIPS (800-447-8477).

This matter is being handled by the Civil Division's Commercial Litigation Branch (Fraud Section) and the U.S. Attorney's Office for the Western District of New York, with assistance from the U.S. Department of Health and Human Services Office of Inspector General.

The case is captioned *United States ex rel. Ross v. Independent Health Association et al.*, No. 12-CV-0299(S) (W.D.N.Y.). The claims asserted against the defendants are allegations only, and there has been no determination of liability.

Attachment(s):
Download Independent Health Complaint in Intervention.pdf

Topic(s):
False Claims Act

Component(s):
Civil Division
USAO - New York, Western

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