Conditions, preconditions and the False Claims Act

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Health care providers are familiar with the notion that certain things have to be true for any claim for payment for services rendered to be honored: For example, the service must in fact be provided; it must be provided by an appropriately licensed provider; it must be medically necessary; and it must be a benefit covered by the payer. Under the federal (and in Massachusetts, the state) False Claims Act, a claim for payment can be denied and the claimant held liable if the claim involves a false or fraudulent statement that is material to the government's decision to pay a claim. Under this FCA standard, what facts are material to that decision to pay a claim, such that falsehood may lead not only to denial of the claim but liability for the provider?

A recent federal court decision involving a mental health clinic's failure to have adequately licensed and supervised therapists focuses on this question and answers it in a way that should alert providers to the notion that every claim for payment implicitly certifies the provider is compliant with a wide range of regulatory requirements. These requirements need not be explicitly linked to eligibility for payment. The decision stands for the proposition that what has to be true about a claim, and about a provider submitting that claim, can be a "precondition to payment" that is not expressly designated as such, that depends on the context, and that is deemed "material" by the governmental payer.

The case involved some undeniably horrid facts: A teenaged MassHealth beneficiary saw a series of staff members at a mental health clinic in Lawrence licensed by the Department of Public Health. Many of these therapists and counselors were either unlicensed, unsupervised or both. At one point, a nurse, held out by the center as a psychiatrist, prescribed a medication for bipolar disorder. The patient suffered an adverse reaction, and the nurse repeatedly failed to return phone calls regarding the patient's condition. After a seizure and a hospitalization, the patient resumed treatment at the center, but shortly thereafter, suffered a second, fatal seizure.

Throughout their child's treatment, her mother and stepfather raised concerns about the qualifications and supervision of the various clinicians involved in the case. After her death, they filed complaints with a variety of state agencies. The DPH issued a report concluding that in treating the young woman, the center had violated 14 separate regulations concerning staff supervision and licensure. More generally, the DPH found that 23 therapists at the center required clinical supervision, but there were no records documenting any such supervision for a number of years.

The mother and stepfather filed a complaint in federal court under both the state and federal False Claims Acts. They alleged the center engaged in fraudulent misrepresentations and fraudulent billing based on failure to meet staff licensure and supervision regulatory requirements. At trial, the district court dismissed the claims based on a distinction between conditions of participation in the MassHealth program as a mental health center and conditions of provider payment by the MassHealth program. In the trial court's view, only violations of conditions of payment, not conditions of participation, could lead to a false claim.

On appeal, the First Circuit court rejected the relevance of that distinction. Instead, the court ruled that "[w]e ask simply whether the defendant, in submitting a claim for reimbursement, knowingly misrepresented compliance with a material precondition of payment [citation omitted]. Preconditions of payment, which may be found in sources such as statutes, regulations, and contracts, need not be 'expressly designated' [citation omitted]. Rather, the question whether a given requirement constitutes a precondition to payment is a 'fact-intensive and context-specific inquiry,' [citation omitted]." It concluded, after a review of both MassHealth and DPH regulations, that the staff supervision and licensure provisions violated by the center in this case were conditions of payment.

Many of the regulations requiring adequate supervision of staff purportedly violated by the center did not explicitly state that a provider's compliance with them was required for reimbursement. The appeals court nevertheless held that proper supervision is a condition of payment. Likewise, the provider never explicitly stated in its claims that it was in compliance with those regulations. However, the appeals court noted that the center "implicitly communicated that it had conformed to the relevant program requirements" (i.e., the DPH clinic licensure and the MassHealth mental health center regulations) each time it submitted a claim.

This decision is a strong message to health care providers that just because a regulatory requirement is not expressly tied to or made a prerequisite of reimbursement does not mean that violation of that regulation cannot lead to liability under the False Claims Act. Whatever the governmental payer considers a "material precondition" to its obligation to pay for services rendered could form the basis for FCA liability. Given the draconian penalties under the FCA – civil penalties up to $11,000 per false claim and up to three times the dollar value of each false claim – this decision raises the stakes on providers' compliance programs. Given the open-ended nature of the court's rationale – how can providers know what's material to a government payer's decision to pay a claim? – this decision also broadens to an unclear extent providers' potential for False Claims Act liability.

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