

ST. ELIZABETH BILLING FRAUD

Through a former nurse billing auditor whistleblower, we have a massive class action billing fraud lawsuit against St. Elizabeth Medical Center.

We have an insider witness and a top-notch expert.

It's a scheme called "all-inclusive billing."

A class action is moving forward. The attached affidavit explains it all.

The damages are astronomical because it is ongoing and began six years ago. It involves the inflation of bills to max out insurance coverage on inpatient billing. ST. Elizabeth VP Bill Banks referred to it in an email to an insurance company as a "scheme." The tristate press ignores this story. So does JD Vance.

From 2020 to now, if you were an inpatient St. Elizabeth patient we would like to review your bills. If you are sued on a medical bill, contact me. You will receive free representation.

We also have class actions now filed for "double billing," one for falsely claiming simple births as complicated and one for violations of the "No Surprises Act." We expect even more.

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ALL-INCLUSIVE BILLING SUMMARY

St. Elizabeth Healthcare implemented a new billing tactic in February 2021. The rollout to commercial payors was tapered. Medicare and Medicaid were not included in the 2021 implementation.

Historically, inpatient hospital bill totals are determined by level of care room rates, procedures, surgeries, medications and other services. There is a master list of charges. As the charges incur the bill total is determined—much like going to the grocery store. The itemized hospital bill is equivalent to your grocery store receipt. You can justify the charges by comparing them to the documentation in your medical record for the billable services that were rendered.

Payment for those services is typically provided by your insurance company. The payment for the charges is weighted according to the “severity” of your medical diagnosis or the diagnosis you obtained while in the hospital. The weight is called a DRG- diagnostic related grouper. (ie a heart surgery will carry a higher weight/payment than say a broken hip). So, no matter what your total hospital charges are, the insurance will pay the weighted total in accordance with your diagnosis/DRG. If the billed charges are lesser than the “pre-determined” payment for the diagnosis, the insurance company will pay the lesser of the two. If the billed charges are higher than that rate, the insurance company will pay their predetermined rate for that DRG. DRG rates are calculated and determined by geographical areas and cost of living in that area. DRG payment weights are higher in California than say West Virginia because the cost of living is higher in that area.

Example:

Inpatient admission for a total knee replacement surgery:

Total charges incurred are \$5,000.00

The DRG weighted payment is \$10,000.00

The insurance would pay the \$5,000.00

Total charges incurred are \$15,000.00

The DRG weighted payment is \$10,000.00

The insurance would pay \$10,000.00 – the remaining \$5,000 would be written off to contractual adjustment.

Hospitals are constantly doing cost analysis reports to ensure their charge structures less than the maximal DRG

St Elizabeth All-inclusive billing: They’re billing ALL of the patients the same DRG rate – based on the MAXIMAL reimbursement allowed for that DRG.

They have the system compare the itemized bill total at the time of discharge and compare it to the Maximal payment allowed for that DRG (diagnosis) for that patient. The system will apply a “variable” charge to the account to get the total itemized bill to match that maximal payment

amount to the penny. The variable charge applied to the patient bill is NOT substantiated with documentation or procedures. It is a made-up ghost charge to get the itemized bill to a pre-determined dollar amount.

- IE. Patient has baby. Incurred charges are \$8,000.00
- Maximal DRG payment allowed in KY area is \$18,000
- The all-inclusive charge added to the account is \$10,000
- The new bill total for DRG payment is now \$18,000

In the event the incurred charges are higher than the pre-determined amount, the variable all-inclusive charge will credit the account to falsely lower the charges the maximal DRG total.

- II! Patient has a baby, incurred charges are \$28,000
- Maximal DRG payment allowed in KY is \$18,000
- The all-inclusive variable charge added is -\$10,000
- The new billed total for DRG payment is now \$18,000.00

Important point to make is that when the charges are “higher” than the DRG maximal reimbursement amount – usually happens with unforeseen complications. When this happens, typically the DRG will be changed to a DRG with complications and that DRG will carry a might higher weight/payment than the original DRG anyway.

MOST accounts will have charges added to maximize the insurance payments. Very few will be over.

1. Medicare CMS uses hospital billed charges for the previous years to calculate the updated DRG payments for the next/new year. If these are falsely increased, then it looks to CMS that the cost of care is higher. Therefore, increasing payments for that DRG nationwide. This affects everyone in the US. Not just KY
2. Billing regulations stipulate that each patient should be billed the same rate for services regardless of payor. St. E is charging differently for Medicare and Medicaid patients.
3. Bill totals are falsely increased with a phantom charge- causing higher out of pocket/patient responsibility totals.
4. They justify it stating that they do decrease the charges on the accounts for those patients with higher-than-average charges.
5. They state this is better now because each patient knows “prior” to care what their charges will be. In essence the charges are much higher now than they were, and if unforeseen complications occur, the charges will still be higher because the DRG would have changed. (Payments for a normal delivery and newborn care are lesser than a delivery complicated by hemorrhage/corrective surgery- or a newborn who develops respiratory issues and requires a ventilator).
6. This is a tactic to increase charges and payments—bottom line revenue at the expense of community.

AFFIDAVIT OF [REDACTED]

Comes now the affiant, after being duly sworn and cautioned states as follows:

1. I have reviewed the Defendant's Response In Opposition To Plaintiff's Motion For Class Certification.
2. I was employed by St. Elizabeth Medical Center from December 2007 to October 2021 as a Revenue Integrity Analyst. As part of my responsibilities, I performed detailed charge audits of patient bills. I worked in the chargemaster department, and in the EPIC system.
3. I am certified as a Clinical Financial Auditor through AAMAS (American Association of Medical Audit Specialists). I obtained this certification prior to my employment at St. Elizabeth.
4. I have been a Registered Nurse since September of 1985. Currently, I hold an active RN license with the state of OH and KY.
5. While employed at St. Elizabeth as a Revenue Integrity Analyst some of my job responsibilities included performing detailed line by line charge audits (comparing posted itemized charges to the documentation) on inpatient and outpatient claims to ensure charges were correct. These audits were requested from various entities such as payors, patients, departments, billing etc. I would identify and track trends of overbilling, underbilling and missed charges on patient accounts. Not only would I correct the charges in EPIC, I communicated my findings with leadership, and departments within the hospital system in order to problem solve and rectify issues. I would also work with EPIC IT to resolve system issues when identified.

I worked in the chargemaster department under Ed Fritz from 2018 – 2021. As a department we would research CMS regulations for new charges, or questions from billing or Nursing and/or ancillary department heads.

I reviewed all accounts of patients who were pronounced deceased while at St. Elizabeth to ensure the date and time of death was correct in the patient account ensuring the room and board charges would pull correctly. If the date and time were incorrect in EPIC event management, I corrected it so it matched the date and time the patient was pronounced by the physician in the discharge summary. I reviewed these accounts for missed or duplicated bedside procedure charges - a trend that had been previously identified.

As part of my daily functions, I worked the CCI/OCE and SEMC specific built edits in the billing edit work queues for Observation claims as well as Outpatient and Inpatient

claims. I addressed and corrected the charges/claims based on the specific edits that fired on itemized charges and UB04 screens.

I tracked and performed post payment charge audits requested by the insurance companies. Most of the claims I performed these audits on were on outlier or high dollar claims. These accounts were audited by comparing the documentation to the itemized bill. These were “post payment charge audits,” meaning the claim had already been processed and paid. Almost all of these audits were on claims at least a year old or more. The goal was to have a “clean claim”, meaning all of the charges on the itemized bill were provided, documented, medically necessary and ordered by a physician. Any identified errors were corrected on the patient’s itemized bill and a corrected claim was generated. I would then send these claims to the billing department for a corrected claim to be processed. Any findings or identified trends were communicated to the specific department, as well as leadership.

I was the point person in the revenue cycle for issues with Event Management in EPIC – also known as the bed table. At the time I left, I was working closely with nursing administration to correct an error with the CPOE interface within EPIC Event Management. This was a long, ongoing issue.

I worked closely with the observation charge entry team and outpatient infusion services with injection and infusion charges.

The above details my responsibilities but may not include all as it has been several years since I was an employee of St. Elizabeth.

6. Even with the pre-published and pre-determined DRG billed amount – the patient’s bill remains unpredictable. Should the patient suffer a complication or the “pre-admission diagnosis” change, which does occur, the patient will be billed a different DRG and a different price. This is NOT relayed to the consumer on the SEMC website. Should the consumer review the DRG charge on the website, they would be looking at the charge based on the reason they plan to be admitted as an inpatient. Should something unforeseen or a complication occur, the patient would not expect their actual DRG at discharge would be different. The discharge diagnosis determines your DRG,

SEMC website does NOT indicate to patients that their “admission reason” or admission DRG may not be the same as their discharge DRG. Medicine is unpredictable and unexpected events can and do occur. Should they suffer from complications, or their condition be different from what they think it will be on admission (ie admitted for gallbladder surgery and find out they have terminal metastatic cancer or expect to have a normal vaginal delivery and suffer a hemorrhage or need a C-section, their DRG will change, thus change the “posted charge on the website. The lay person does not, nor should be expected to understand the coding terms MCC or CC” when reviewing post DRG charges 5 layers deep in a website.

7. St. Elizabeth misstates that “Test” claims were sent to Anthem. In fact, based on my review, they were real claims that were sent with a single line R&B (room and board) REV code on the UB04, reporting the actual total of accrued itemized totals. To my knowledge, the test claims or (SLIP-single line inpatient billing) were submitted to Anthem from August of 2019 until Anthem went live with the all-inclusive billing practice in July of 2021.
8. Blue & Company (St. Elizabeth's compliance company) sent a question to St. Elizabeth's Medicare contractor CGS. (Blue & Co. letter dated 06/11/19, attached as exhibit 1. An important fact I noted upon my review is that yes, in the letter they ask the question *but* the letter asking the question did not make reference to SEMC adding a *variable all-inclusive charge* to get the total billed charges to reach a predetermined billed total for that specific DRG. The response from CGS was that “The standard charges format is the hospital's choice as long as the sent information represents the /hospital's current standard charges as reflected in its chargemaster.”

The “All Inclusive Billing” variable charge (charge number 80173055) does not pull from the chargemaster. It bypasses the chargemaster and is applied to the patient account after the patient is discharged and the discharge DRG has been assigned and coding completed. This is a variable charge that is SYSTEM GENERATED, NOT CHARGEMASTER generated. This charge is NOT the same (standard) for each patient. The charge is variable and determined using the actual accumulated billed total. If the total accumulated itemized bill total is less than the pre-determined dollar total for that specific DRG, the variable rate adds a charge (the difference between the pre-set rate and DRG max rate) to the itemized bill. Should the total accumulated itemized charge total be higher than the pre-set DRG max total, the variable rate subtracts the difference from the patient bill. The charge adjustment is system generated post discharge. It is a different charge for each patient. This charge is applied only to commercial, self-pay, Medicare Secondary and Medicaid Secondary claims. Medicare and Medicaid payors are excluded from this practice. Medicare and Medicaid patients are billed their actual accumulated itemized billed charge total, not the all-inclusive rate.

When first implemented in February 2021, the all-inclusive billing rollout staggered different commercial payers. Some payers such as Aetna were implemented in February 2021. UHC was implemented in the spring and Anthem in July of 2021.

9. Under Medicare CMS guidelines, all individual itemized charges are to be billed the same to each patient regardless of payor. The Chargemaster for the facility lists the standard charges. The chargemaster contains each individual billable charge along with the CPT (procedure) and Revenue code. The chargemaster is “transparent” to ALL payors. Insurance providers will review the facilities chargemaster prior to any contract with them being signed and implemented. Many payor contracts require that should there be a price change of a certain percentage, it is the facility's responsibility to be transparent with those price increases. Cost of living and annual percentage of price increases are permissible if they are below a pre-set percentage increase.

10. In November of 2019 the Centers for Medicare and Medicaid Services (CMS) issued a final rule entitled "Price Transparency Requirements for Hospitals to Make Standard Charges Public. The KEY word here is "Standard", which means the individual charges from the charge master in which are the same for each patient, regardless of inpatient, outpatient, insured by commercial, Medicaid, Medicare, and Self Pay.

 In contrast, the charges posted on the SEMC website for the DRG are payor-dependent and non-standard, as part of the price is generated outside chargemaster. This practice violates the CMS regulations for standard charge. The variable AIB rate is not standard by any means. The all-inclusive variable rate itemized charge (80173055) fluctuates and is not associated with any documentation in the patient's medical record to substantiate. It is merely a "ghost charge" added to the account to get the total itemized charges to meet a pre-determined dollar total threshold.

11. As St. Elizabeth continued its efforts to develop an all-inclusive pricing program, Mr. Banks determined the price for each DRG using the follow formula: "it comes from setting a base multiplier and using that multiplier against the case weight. (Banks depo doc 63, pg. 37). Mr. Banks testified this is a "universally accepted" formula, "given that it is base rate multiplied by case weight." As he explained: That is how all payers in the industry determine prices" These prices were then published on St. Elizabeth's website. Mr. Banks did not explain what other base multipliers are available and how he determined the base multiplier.
12. Mike Yadav, Director of Systems at SEMC and Bill Banks, VP Managed Care indicated to me and my coworkers of the CDM (chargemaster department) staff that they were basing the AIB on the MAXIMAL reimbursement allowed by CMS for that specific DRG.
13. Regional Cincinnati hospitals list "estimated" charge for their most common inpatient admission reasons. They simply list their standard room and board charge, and common inpatient procedure charges, (I.e. Vaginal delivery, C Section, Circumcision, total knee replacement, total hip replacement, etc.). They clearly indicate that the charges are an baseline estimate and are dependent upon medications and unforeseen, unexpected events.
14. In the revenue cycle, what happens in billing today generally will not be audited for another 2 to 3 years, as it takes at least that amount of time for the payors and the payors systems to catch up.
15. The attached is attested to by me.

Further, Affiant Sayeth Naught.


Valerie Rose

NOTARY

Sworn to and subscribed before me, by  this 13 day of February 2024.

Loretta Little

Notary Public

My Comm. Exp. 12-5-27

Kenton County

State of Kentucky.

