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HEALTHCARE FRAUD AND FALSE CLAIMS ACT LITIGATION

# The Chart as Evidence of Fraud

## *False Claims Act Cases That Turn on Clinical Review*

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**F**alse Claims Act enforcement hit a record last year. DOJ reported more than \$6.8 billion in settlements and judgments for fiscal year 2025, about \$5.7 billion of it from healthcare. Whistleblowers filed 1,297 qui tam suits, also a record.

Medicare Advantage is front and center. In January 2026, Kaiser Permanente affiliates agreed to pay \$556 million to resolve allegations that they submitted unsupported diagnosis codes to boost MA payments, without admitting liability. In fiscal 2025, Independent Health resolved similar allegations for up to \$98 million. Medical necessity cases keep coming too: Vohra Wound Physicians resolved allegations of billing for unnecessary wound care for \$45 million.

The legal elements, including knowledge and materiality, are for counsel. On knowledge, the Supreme Court in *SuperValu* (2023) focused on what the defendant actually believed; on materiality, *Escobar* (2016) remains the touchstone. But a large share of these cases turn on a clinical question: does the chart support what was billed?

### DIAGNOSIS CODING IN MEDICARE ADVANTAGE

Medicare pays MA plans more for sicker members, based on reported diagnoses. The government's theory in these cases is that plans and providers added diagnoses the records didn't support, often through chart reviews or home visits designed mainly to find codes, and didn't delete codes later found unsupported.

For each diagnosis, the clinical question is whether the record supports it. Industry coding practice generally looks for evidence the condition was monitored, evaluated, assessed, or treated in a face-to-face encounter with a qualified provider. Heart failure sitting on a problem list, with no symptoms, medications, testing, or plan addressed at the visit, is weak support. It also has to be supported in the year it was reported. Depression from ten years ago in a patient who's now well doesn't carry forward forever.

Reviewing that across a sample, diagnosis by diagnosis, takes someone who understands both the medicine and the coding rules, and applies them consistently.

## **MEDICAL NECESSITY**

Medicare generally pays only for services that are reasonable and necessary. Take wound care. A case might allege debridement done far more often than needed, or billed at a deeper level than performed. The clinical review looks at wound measurements, descriptions of the wound bed, photographs, the tissue removed, the depth, and whether the wound was healing. Was the procedure indicated each time? Does the note describe enough to support the code?

The same kind of question drives hospice eligibility cases (a real six-month prognosis?), skilled nursing therapy cases (did the intensity billed match the patient's needs?), inpatient admission cases (inpatient stay or observation?), and cardiac and spine procedure cases (did the documented indications support the procedure?).

## **A FICTIONAL CASE**

A former coder at a physician group alleges that nurse practitioners doing annual home visits routinely added diagnoses that appeared nowhere else in the record and were never treated. The government pulls a sample of a few hundred patients. The clinical review asks, for each disputed diagnosis: Is there history, exam, testing, or treatment behind it? Did any treating physician ever address it? Was it a legitimate new finding or a code with nothing behind it? The answers won't be uniform.

## **SAMPLING IS ONLY AS GOOD AS THE REVIEW**

Reviewing every claim is rarely practical, so a statistical sample is reviewed and the results extrapolated. The statistics are a question for statisticians and counsel. But every extrapolation inherits the quality of the clinical review underneath it. Inconsistent reviewers, the wrong standard, or incomplete records all get multiplied. Defense counsel should scrutinize the sample review closely. Relators and the government need it to be consistent, documented, and defensible.

## **POOR DOCUMENTATION ISN'T THE SAME AS FRAUD**

Honest reviews usually find a mix: some services clearly supported, some clearly not, and some poorly documented but probably necessary. That last group matters. A clinical reviewer can help by separating records showing a service wasn't needed from records that just don't explain it well. What the defendant knew and believed is a legal question, but the clinical distinction feeds directly into it.

## WHEN PATIENTS WERE HURT TOO

Unnecessary procedures carry real risk. A stent that wasn't needed, spine surgery without a proper indication, repeated debridement of a healing wound, or hospice enrollment that meant giving up needed treatment can injure patients, not just bill the government. The same review supporting a fraud case can identify patients with injury claims, and a malpractice case built on an unnecessary procedure can reveal a billing pattern worth a closer look.

## WHAT WHISTLEBLOWERS BRING

Relators are often insiders: coders, nurses, billing staff, physicians. Their emails, audit results, and training materials are powerful, but they need clinical context. A complaint that the group “codes aggressively” is a starting point. The records show whether it's right. A pre-filing clinical review can tell relator's counsel whether the charts actually back the allegations.

## FOR PROVIDERS

Regular internal audits comparing documentation to billing, done by people who know both the medicine and the codes, are one of the best defenses. What happens after an audit finds a problem matters enormously. Medicare requires providers to report and return identified overpayments within set time frames, and failing to do that can create its own FCA exposure.

## RECORDS WORTH REQUESTING

- Complete medical records for each sampled claim, not just the billed date's note
- Claims data for the sample and universe
- Coverage rules and local coverage determinations in effect at the time
- Internal audits, compliance reviews, and responses to findings
- Coding policies and training materials
- For MA cases: chart review and home visit program documents, vendor contracts, and deletion policies

## SOURCES

- U.S. Department of Justice, FY 2025 False Claims Act statistics; White & Case, “DOJ's record-breaking 2025 False Claims Act recoveries and key healthcare fraud enforcement trends” (Jan. 2026)
- *United States ex rel. Schutte v. SuperValu Inc.*, 598 U.S. 739 (2023); *Universal Health Services, Inc. v. United States ex rel. Escobar*, 579 U.S. 176 (2016)
- 42 U.S.C. § 1320a-7k(d) (report and return of overpayments)

*This newsletter is for education only and isn't legal advice. The case is fictional.*

#### ABOUT LEXCURA CLINICAL INTELLIGENCE

Lexcura Clinical Intelligence provides integrated clinical and regulatory analysis for attorneys handling healthcare litigation. If you have a False Claims Act matter that turns on medical necessity or diagnosis support, and you need a consistent, defensible clinical review of the records, we'd welcome the conversation.

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