Review

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The Ultimate Cure For The Covid Syndemic

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Keywords: COVID-19; Pandemic; syndemic; USA; Mortality; Lethality; Age; Aging; Life expectancy; Political; Death; Hearsay; Viral test; Underlying cause of death; UCOD; code U07.1; code U07.2; WHO; CDC; flu; false claim; FCA; federal law; up-coding; medical fraud; political bias; miss-information; quo tam; provider relief fund; PRF

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Review

The Ultimate Cure for the COVID Syndemic. Complete and Long-Lasting Recovery from the COVID-19 Syndemic in the USA Is Not Possible Only by Using Vaccines but Even Invoking the Federal False Claim Act Is Necessary

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Abstract: Background: Four research article had been published recently in peer-reviewed scientific journals reviewing and reevaluating the key statistical data of the COVID-19 pandemic in the USA.1. The first article [1] introduced the "political score" for quantitative characterization of the political orientation of the 50 states and concluded that the most alarming signals regarding the dangerousness of COVID infection had been originating in a few states with predominantly left oriented citizens.2. The second article [2] critically reviewed the diagnostic and statistical support for COVID epidemic in USA and concluded, that many states largely ignored the importance of a) specific viral tests and b) considerations of the "natural", age-related deaths when determining and reporting the correct number of COVID mortality and lethality. 3. The third article [3] focused on the effects of restrictions on the COVID lethality and concluded that restrictions had no health benefits at all. 4. The fourth article [4] focused on the "human" contributions to the demages caused by the virus and concluded, that much of the negative effects of the pandemic was actually self-made. **Objective:** The resent article is aiming to go one step further and concludes that much of the mistakes during the COVID pandemic were a) the result of well-meaning but poorly executed actions by unprofessional actors; b) the excessive involvement of left oriented states in the overestimation of the virus related harm and enforcement of harsh restrictions were the signs of political bias; c) there were strong political and monetary motives behind the interpretation of the COVID events. We can understand and even forgive the ignorance and political blindness behind most of the mistakes, however the economic incentive is not excusable. Profiting on other people's fear and despair is - in our opinion - a criminal act even if it is not by any means a new phenomenon in the history of mankind. **Conclusion:** It is suggested that the "new" political and scientific leaders (following the latest presidential election in 2024) seriously consider invoking the *Federal False Claim Act* for definitively ending the COVID syndemic in the USA and effectively preventing 'relapse' in the near future.

Keywords: COVID-19; Pandemic; syndemic; USA; Mortality; Lethality; Age; Aging; Life expectancy; Political; Death;; Hearsay; Viral test; Underlying cause of death; UCOD; code U07.1; code U07.2; WHO; CDC; flu; false claim; FCA; federal law; up-coding; medical fraud; political bias; miss-information; quo tam; provider relief fund; PRF

Introduction

The manifestation of every epidemic/pandemic depends on the pathogen as well as the recipient. It is especially true for the COVID-19 infections where it is very well recognized that the outcome of

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every infection is determined by the age and preexisting conditions of the affected person, i.e. the same virus harmless for one person but fatal for another. Therefore the use of the term 'syndemic' is to prefer when speaking about the effects of COVID virus on a larger population.

(A syndemic is a combination of two or more health conditions or diseases that cluster in a population, and are influenced by social and structural factors. The term is a combination of the words "synergy" and "epidemic").

The clinical picture of the COVID disease is strongly and unusually dependent on the age and general health of the infected person. Therefore it was difficult for doctors to agree over the seriousness of the pandemic. Hospital doctors, especially on ICUs, were shocked over the high mortality of the disease, while general practitioners and scientist studying random population saw "*just another flu*" [5]. There were large regional differences in the mortality estimates (especially initially): Sothern European countries perceived Covid completely differently than the Nordic population [6]. Some very influential persons were speaking about the "*ones in a century pandemic*" [7]. However some leading epidemiologists and statisticians warned, at the same time, for the poor reliability of the alarming data and the dangers of uncritical use of low quality information for decision making. They believed that "*an ones in the century evidence fiasco*" is in making [8]. The public debates over the correct interpretation of the threat by the COVID pandemic was intense but short lived. The governmental authorities quickly decided that the country is facing a very serious threat that has to be stopped by any means and for any costs. The alternative opinions and suggestions simply disappeared.

Critical Review of the Critical Decisions: The Triumvirate of Errors with Consequences

One decision had especially large impact on the spreading of the COVID related fear and ensuring the unrestricted acceptance of all restrictions by the public. The evidence based COVID diagnostic became impossible when the distinction between "true" and "hearsay" COVID cases had been erased by the authorities. Initially doctors followed the WHO-s guidelines and carefully separated the 'true' COVID deaths (there specific laboratory viral test existed and evidenced that the COVID virus was the Underlying Cause of Death, UCOD) from the 'hearsay' COVID deaths (there the UCOD was established without laboratory confirmation) and reported the cases under separate diagnostic codes (U07.1 and U07.2 respectively). However this well motivated distinction had been cancelled and all COVID suspected cases were pooled and reported as true COVID cases under U07.1 code. This action lead to the explosion of allegedly COVID-caused deaths (mortality, lethality) and professional fact-checking was no longer possible.

Another circumstance that seriously inflated the COVID mortality statistic was that the fatal consequences of the virus infection were limited, almost exclusively, to the elderly population, i. e. those who reached or were very close to the natural end of their life. It was recognized that many COVID infected persons died 'with' the virus but they passed away not 'due to' virus infection. This epidemiological, statistical problem had never been addressed - not even discussed – by the responsible authorities. Every viral test positive person who died had been regarded and recorded as COVID victim.

However it became possible to estimate the magnitude of these two fundamental errors in determination of COVID mortality [1-4] and even locate the possible origin of these misleading statistical data.

It was found, that a) ~46% of all reported COVID deaths – the so called PSEUDO COVID deaths - were in reality age related, natural deaths; b) ~40.3% of all reported COVID deaths were not substantiated with specific laboratory viral test, the so called "HEARSAY COVID" deaths; c) the number of correctly identified COVID related deaths were – in these studies - only about 32% of the officially published number; d) the average fatality of COVID were estimated to remain ~0.54% and mortality ~ 53/100K (May 2021) that was more than the mortality of an average, seasonal flu (26.6/100K in 2022-23) [9] but not alarmingly.

The statistical error due to PSEUDO COVID counting is about the same in every state, however the statistical error caused by HEARSAY COVID reporting progressively increased from right to left

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on the political scale. (It remained 0% in the most right oriented states (D/R<0.7) but increased to above 90% (SIC!) in the most liberal states (D/R>2.0). (**Figures 1, 2 and 4).** It had significant influence even on the degree of mandatory restrictions enforced by the different states (**Figure 3**).

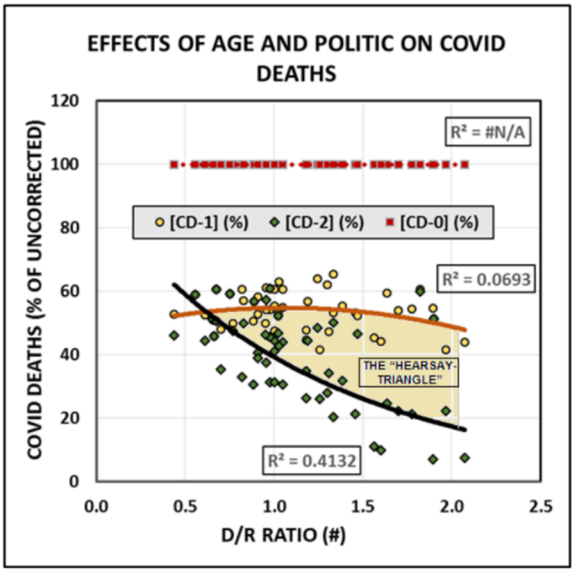

Figure 1. Effect of Age and Politic on COVID deaths.

The total reported number of COVID deaths were uniformly regarded to be 100% [CD-0]. The remaining % of deaths after subtraction of age-related error [CD-1] and "hearsay COVID" cases [CD-2] are indicated by circles and squares. The yellow area defines deaths there COVID as the UCOD was not substantiated by laboratory viral test, called "The Hearsay Triangle". D/R: Democrat/Republican ratio of the state, called the "Political Score".

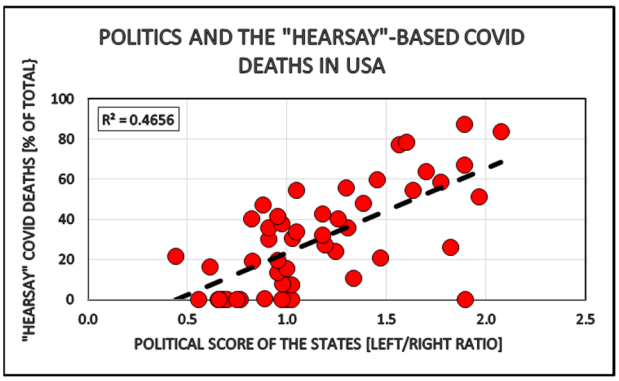

Figure 2. Correlation between state politics and the proportion (%) of "hearsay COVID" deaths (UCOD was not confirmed by specific laboratory viral test).

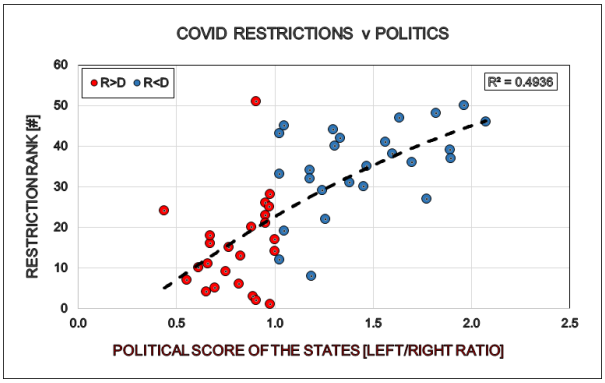

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Figure 3. Correlation between state politics and the severity of state mandated COVID restrictions in % of maximal number and severity or the restrictions (100%). States with republican majority (R>D) and democrat majority (R<D) are indicated by blue, respective red symbols.

CORRECTION OF POTENTIAL FLAWS IN DETERMINATION OF COVID-RELATED DEATHS

			ORIGINAL		ACTUARIAL		"HEARSEY" [NO TEST?]		LAB CONFIRMED		TRUE [AGE+TEST]	
STATE	STE	D/R	[CD-0] (#)	[CD-0] (%)	[CD-1] (#)	[CD-1] (%)	H-CD (#)	H-CD (%)	[CD+] (#)	[CD+] (%)	[CD-2] (#)	[CD-2] (%)
Alabama	AL	0.67	12,009	100	7,296	60.8	0	0.0	12,009	100.0	7,296	60.8
Alaska	AK	0.82	395	100	240	60.7	179	45.4	216	54.6	131	33.1
Arizona	AZ	0.98	16,802	100	10,221	60.8	0	0.0	16,802	100.0	10,221	60.8
Arkansas	AR	0.83	7,125	100	4,078	57.2	890	12.5	6,235	87.5	3,569	50.1
California	CA	1.63	67,734	100	40,263	59.4	39,567	58.4	28,167	41.6	16,743	24.7
Colorado	CO	1.02	7,441	100	3,889	52.3	0	0.0	7,441	100.0	3,889	52.3
Connecticut	CT	1.56	8,406	100	3,823	45.5	6,340	75.4	2,066	24.6	940	11.2
Delaware	DE	1.90	1793	100	922	51.4	0	0.0	1,793	100.0	922	51.4
DC	DC	1.33	1501	100	981	65.4	1,032	68.8	469	31.2	306	20.4
Florida	FL	1.19	42,772	100	24,324	56.9	9,283	21.7	33,489	78.3	19,045	44.5
Georgia	GA	1.00	19,257	100	11,692	60.7	5,146	26.7	14,111	73.3	8,568	44.5
Hawaii	HI	1.82	565	100	342	60.6	6	1.1	559	98.9	339	59.9
Idaho	ID	0.65	2352	100	1,205	51.2	0	0.0	2,352	100.0	1,205	51.2
Illinois	IL	1.45	23,241	100	12,382	53.3	13,857	59.6	9,384	40.4	5,000	21.5
Indiana	IN	0.88	14,150	100	7,189	50.8	5,619	39.7	8,531	60.3	4,334	30.6
Iowa	IA	0.98	6,322	100	2,890	45.7	1,967	31.1	4,355	68.9	1,991	31.5
Kansas	KS	0.67	5,427	100	2,748	50.6	0	0.0	5,427	100.0	2,748	50.6
Kentucky	KY	0.98	8,150	100	4,414	54.2	1,268	15.6	6,882	84.4	3,728	45.7
Louisiana	LA	1.05	10,626	100	6,436	60.6	5,232	49.2	5,394	50.8	3,267	30.7
Maine	ME	1.31	1027	100	486	47.3	283	27.5	744	72.5	352	34.3
Maryland	MD	1.77	10,639	100	5,789	54.4	6,429	60.4	4,210	39.6	2,291	21.5
Massachusetts	MA	2.07	13,817	100	6,076	44.0	11,409	82.6	2,408	17.4	1,059	7.7
Michigan	MI	1.38	18,995	100	10,544	55.5	8,113	42.7	10,882	57.3	6,040	31.8
Minnesota	MN	1.18	7,920	100	3,542	44.7	3,229	40.8	4,691	59.2	2,098	26.5
Mississippi	MS	0.95	8,588	100	5,254	61.2	543	6.3	8,045	93.7	4,922	57.3
Missouri	MO	1.02	12,870	100	6,819	53.0	1,463	11.4	11,407	88.6	6,044	47.0
Montana	MT	0.61	1789	100	942	52.7	275	15.4	1,514	84.6	797	44.6
Nebraska	NE	0.77	3,039	100	1,521	50.0	143	4.7	2,896	95.3	1,449	47.7
Nevada	NV	1.24	6,633	100	4,247	64.0	1,594	24.0	5,039	76.0	3,226	48.6
New Hampshire	NH	1.26	1397	100	582	41.6	516	36.9	881	63.1	367	26.3
New Jersey	NJ	1.70	25,092	100	13,568	54.1	14,718	58.7	10,374	41.3	5,609	22.4
New Mexico	NM	1.30	4359	100	2,711	62.2	2,390	54.8	1,969	45.2	1,225	28.1
New York	NY+C	1.89	55,610	100	30,473	54.8	48,269	86.8	7,341	13.2	4,022	7.2
North Carolina	NC	1.05	15,965	100	8,762	54.9	3,143	19.7	12,822	80.3	7,037	44.1
North Dakota	ND	0.66	1779	100	817	45.9	0	0.0	1,779	100.0	817	45.9
Ohio	OH	0.95	23,638	100	11,790	49.9	1,635	6.9	22,003	93.1	10,974	46.4
Oklahoma	OK	0.89	9,192	100	5,235	56.9	0	0.0	9,192	100.0	5,235	56.9
Oregon	OR	1.47	3,076	100	1,613	52.4	343	11.1	2,733	88.9	1,434	46.6
Pennsylvania	PA	1.18	29,072	100	13,876	47.7	7,787	26.8	21,285	73.2	10,159	34.9
Rhode Island	RI	1.60	2,731	100	1,206	44.2	2,107	77.2	624	22.8	275	10.1
South Carolina	SC	0.91	10,355	100	6,035	58.3	3,112	30.1	7,243	69.9	4,221	40.8
South Dakota	SD	0.70	2119	100	1,020	48.1	562	26.5	1,557	73.5	750	35.4
Tennessee	TN	0.75	14,364	100	8,501	59.2	0	0.0	14,364	100.0	8,501	59.2
Texas	TX	1.03	60,043	100	37,808	63.0	19,187	32.0	40,856	68.0	25,726	42.8
Utah	UT	0.56	2790	100	1,646	59.0	0	0.0	2,790	100.0	1,646	59.0
Vermont	VT	1.97	242	100	101	41.7	112	46.1	130	53.9	54	22.5
Virginia	VA	0.91	11,558	100	6,096	52.7	3,006	26.0	8,552	74.0	4,511	39.0
Washington	WA	1.33	6,267	100	3,343	53.3	373	6.0	5,894	94.0	3,144	50.2
West Virginia	WV	0.95	3072	100	1,668	54.3	938	30.5	2,134	69.5	1,159	37.7
Wisconsin	WI	1.00	8,551	100	4,080	47.7	1,155	13.5	7,396	86.5	3,529	41.3
Wyoming	WY	0.44	743	100	393	52.9	95	12.7	648	87.3	343	46.1
USA TOTAL	USA	1.00	633,400	100	351,880	55.6	233,314	36.8	400,086	63.2	223,259	35.2
STATE	STE	D/R	[CD-0] (#)	[CD-0] (%)	[CD-1] (#)	[CD-1] (%)	H-CD (#)	H-CD (%)	[CD+] (#)	[CD+] (%)	[CD-2] (#)	[CD-2] (%)

D/R: LEFT/RIGHT POLITICAL RATIO; **[CD-0]**: THE OFFICIAL NUMBER OF COVID DEATHS ON 2021.09.16;
[CD-1]: CORRECTED FOR AGE-RELATED DEATHS; **[CD-2]**: ADDITIONALLY CORRECTED FOR "HEARSAY" COVID DEATHS.
[H-CD]:THE NUMBER (#) AND PROPORTION (%) OF "HEARSAY" COVID DEATHS RELATIVE TO THE EVIDENCE BASED (TRUE) COVID DEATHS **[CD+]**.

Figure 4. State-by-state correction of errors in determination of UCOD.

The largest deviations are highlighted by red numbers. "Hearsay" cases are highlighted by yellow background.

These data suggest that the USA was and is dealing with a triumvirate of cardinal statistical errors when evaluating the impact of the COVID virus on the population and determining the necessary epidemiological defense: 1) PSEUDO COVID counting and reporting; 2) HEARSAY COVID counting and reporting; 3) POLITICAL BIAS in counting and reporting [especially the count of deaths there COVID virus was decided to be the UCOD].

These errors were recognized only by a few scientists and doctors but they were not able to attract serious attention. The COVID panic was spreading faster than the virus itself and the

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worldwide attitude permitted overestimation of danger and radical defense policies. Nobody knew exactly how the epidemic will develop and how it will influence the life of the people. The focus was on the potential harm of the virus and the potential harm caused by the restrictions was underestimated or not considered at al.

Today, 4 years after the start and 2 years after the end of the COVID pandemic we have much better insight into the dynamic and consequences of the syndemic 2020-2021 and we can understand that the potential harm of the biological component (virus) was strongly overestimated, meanwhile the harm of the erroneous human interventions (the human component) was catastrophically ignored [4].

It wouldn't be productive to blame anybody for erroneous actions when the intent with those actions was fundamentally good. However it is necessary to understand and face with the mistakes – even if that will be painful – and learn from them. Retroactive research and review of the history of the COVID in USA is necessary even to isolate actions (if any) which had malicious and criminal motivation.

1) PSEUDO COVID counting and reporting occurred in every state. It contributed with ca 45-50% to the overestimation of the COVID mortality/lethality by adding cases, there the person died "with COVID" (test positive) but not "due to COVID" disease. Separation of the pathological (abnormal) and physiological (normal, usual, expectable) deaths is not possible at the bedside. It is possible only statistically. Ignoring natural deaths is a shameful error for an epidemiologist who supposed to be expert of all possible aspect of a pandemic. However rationally dealing with the natural deaths is not easy for many Americans, because of their cultural/religious traditions. Therefore the PSEUDO COVID counting remains an unintentional error that we have to live with.
2) HEARSAY COVID counting and reporting is when the virus is regarded to be the case of disease or the UCOD without access to specific laboratory viral test. This situation can occur at the beginning of an epidemic - when test is not developed yet - or when the viral test is too expansive for routine clinical diagnoses. This was certainly not the case after Marsh 2020 in USA. Accepting test-free diagnosis of the UCOD is difficult even if we consider that there are doctors who don't like to spend valuable time lamenting over the correct death-diagnoses, insisting that "death is death".
3) POLITICAL BIAS in counting and reporting COVID deaths is certainly the most disturbing form of statistical error under the pandemic. It is caused by the excessive HEARSAY COVID diagnostic by the states with large left-oriented population. Political leaning is obviously not caused or recognized by any virus, therefore this bias is man-made.

The existence of political bias in the COVID diagnostic is very well hidden. It is concealed by a) pooling the well- and poorly supported COVID diagnoses under one single diagnostic code (U07.1), b) correlation analyses between political leaning and mortality is not used by scientists and it is probably only useful in the USA, because of its 50 states structure.

However this political bias became well visible, when looking for it and introducing the political score based analyses. It was found at many level and time of the epidemic, including even the use and enforcement of the restrictive orders by different states (**Figures 1–4**).

This article is not meant to speculate over the possible explanation behind the reason or purpose of the politically tainted estimation of the COVID mortality/lethality except the *monetary incentives*. It was found at least 3 monetary reason why some powerful business minded actors exaggerated the COVID threat and kept the epidemic going as long as it was possible:

1) COVID was almost exclusively targeted elderly and chronically sick persons, those who provided the largest income for the medical-pharmaceutical industry. The epidemic threatened the largest and most profitable market of the healthcare- and related industries.
2) The well-meaning emergency Provider Relieve COVID Fund (PRF) provided extra profit for everybody who became involved into the care of COVID patients. Diagnosing and treating COVID disease became much more profitable than, say, a very similar seasonal flu. It was an

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effect that was certainly not intended by the fund providers – the US Government – but it became the result and nobody wanted to know about it and prevent it.

3) The strongly promoted need of vaccination provided the "*ones in the lifetime opportunity*" for the pharmaceutical industry to generate the largest possible market for their vaccine products and access to a flood of Federal 'easy money'. The US Government (taxpayers) marketed, sold and payed for the COVID vaccines. No other industry was ever in this dream situation, with the only exception of the wapen manufacturers and related industries under WWII.

Ironically, fighting back the virus seems to have been the easy part of the COVID syndemic, the more difficult part will be the elimination of the associated, man-made damage and preventing its repetition in the near future.

Some of the HEARSAY COVID counting and reporting is strongly suspected to be motivated by profit interest, i.e. a criminal actor intentionally gained profit by knowingly claiming payment for dealing with false COVID cases. "Up-coding" is well known fraudulent behavior in healthcare related activities and occurs when a provider performs a simple diagnostic or treatment but claims payment for a much more complex procedure that has never been provided. This fraction of the misguided actions during the pandemic is actionable in the USA by enacting the Federal False Claim Act (FCA).

An Example of Misleading COVID Information

An often repeated and widely accepted statement is that COVID infection is exceptionally harmful (fatal) for elderly. The factual basis of this statement is the research published and regularly updated by the CDC – called *"Risk for COVID-19 Infection, Hospitalization, and Death by Age Group"* [10]. The update, Feb. 18. 2021, stated that: *"compared with 5-17 year olds, the rate of death is 3,200-8,700 times higher in the 65+ year old population"*. The context suggests that the statistic is about the effect of the COVID infection. In reality comparison of two similarly virus infected age-groups (here the young and elderly) will show the effect of aging. The correct statistic should compare virus positive vs virus negative groups belonging to the same age normalized groups (**Table I).**

Table I

Risk for COVID-19 Infection, Hospitalization, and Death By Age Group - Rate ratios compared to 5-17 year olds

Updated Feb. 18, 2021

	0—4 years old	5—17 years old	18—29 years old	30—39 years old	40—49 years old	50—64 years old	65—74 years old	75—84 years old	85+ years old
Cases	<1x	Reference group	2x	2x	2x	2x	1x	1x	2x
Hospitalization	2x	Reference group	6x	10x	15x	25x	40x	65x	95x
Death	2x	Reference group	10x	45x	130x	440x	1300x	3200x	8700x

All rates are relative to the 5—17-year-old age category. Sample interpretation: Compared with 5—17-year-olds, the rate of death is 45 times higher in 30—39-year-olds and 8,700 times higher in 85+-year-olds. Rate compared to 5-17-years-old

https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-age.html#footnote02 - Accessed: 2021.05.02

The possible curative and preventive use of the Federal False Claim Act [31 U.S.C. §3730(B)(2).] - (FCA, Quo Tam).

The Provider Relief Fund, PRF - Terms and Conditions

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The FCA was passed 1863, during the American Civil War. It was created to address widespread fraud by contractors who were billing the Union Army for goods and services that were never delivered or were of poor quality.

The FCA includes a provision called qui tam, which allows citizens to sue on behalf of the government and receive a percentage of the recovery. The FCA has been highly effective in combating fraud and abuse in government contracts and healthcare-related lawsuits.

The FCA seems to be relevant to recover some of the reimbursements from the Federal Emergency COVID Funds because this fund was earmarked and access was clearly regulated:

The federal government has allocated $186.5 billion in payments to be distributed through the Provider Relief Fund (PRF) to support healthcare providers in the battle against the COVID-19 pandemic [11].

Qualified providers of healthcare, services and support may receive PRF payments for healthcare-related expenses or lost revenue due to COVID-19. While these distributions do not need to be repaid to the U.S. government—so long as providers comply with the terms and conditions established by HHS—the funds come with unique compliance, reporting and audit requirements that recipients must adhere to once they attest to the receipt of these funds [12].

The PRF distributes funds "…to prevent, prepare for, and respond to coronavirus, domestically or internationally, for necessary expenses to reimburse, through grants or other mechanisms, eligible health care providers for health care related expenses or lost revenues that are attributable to *Coronavirus."* [13].

The related documents underlines, that 'the clear-cut' definition of COVID infection/disease is essential for medical/epidemiological as well as for administrative (managerial) purposes'.

Providers receiving payments from the Provider Relief Fund must comply with the Terms and Conditions and applicable legal requirements. Failure by a provider that received a payment to comply with any term or condition can result in action by HHS to recoup some or all of the payment. Per the Terms and Conditions, all recipients will be required to submit documents to substantiate that these funds were used for health care-related attributable to coronavirus, and that those expenses or losses were not reimbursed from other sources and other sources were not obligated to reimburse them. HHS monitors the funds distributed, and oversees payments to ensure that Federal dollars are used in accordance with applicable legal and program requirements. In addition, the HHS Office of the Inspector General fights fraud, waste and abuse in HHS programs, and may review these payments [14][15].

The official documents clearly and consequently states that PRF-grants can only and exclusively be used to reimburse providers for a) COVID related expenses or losses, b) which were not reimbursed from other sources and other sources were not obligated to reimburse them

"Discharges of individual diagnosed with COVID-19 will be identified by the presence of following International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis codes:

* B97.29 (Other coronavirus as the cause of diseases classified elsewhere) for discharges occurring on or after January 27, 2020, and on or before March 31, 2020.

* U07.1 (COVID-19) for discharges occurring on or after April 1, 2020, through the duration of the COVID-19 public health emergency period." [16]

Providers may refer to the following ICD-10-CM coding guidance for coding encounters related to COVID-19: a) For discharges on or after April 1, 2020, the ICD-10-CM Official Coding and Reporting Guidelines [17], For discharges prior to April 1, 2020, the ICD-10-CM Official Coding Guideline – Supplement [18].

Shortly, after April 1, 2020 COVID-specific laboratory viral test is requested to establish the diagnosis of COVID disease or COVID as the UCOD. Without this laboratory evidence the use of U07.1 code shouldn't be used for reporting and/or requesting elevated payment from COVID related funds.

> *"To address potential Medicare program integrity risks, effective with admissions occurring on or after September 1, 2020, claims eligible for the 20 percent increase in the MS-DRG*

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weighting factor will also be required to have a positive COVID-19 laboratory test documented in the patient's medical record. Positive tests must be demonstrated using only the results of viral testing (i.e., molecular or antigen), consistent with CDC guidelines. The test may be performed either during the hospital admission or prior to the hospital admission".

"…payments for discharges that report the ICD-10-CM diagnosis code U07.1 (COVID-19). CMS may conduct post-payment medical review to confirm the presence of a positive COVID-19 laboratory test and, if no such test is contained in the medical record, the additional payment resulting from the 20 percent increase in the MS-DRG relative weight will be recouped." [13,19]

CDC INSTRUCTION FOR DETERMINATION COVID RELATED DEATHS AND REPORTING USING THE U07.1 CODE

The Centers for Disease Control and Prevention (CDC) / US Dep. of Health & Human Services - ultimate health authority in USA - Adopted the WHO created code U07.1 for reporting COVID-19 deaths in cases when the virus had been identified (laboratory test, viral test, confirmed). The ICD-10-CM Official Guidelines for Coding and Reporting FY 2021 explicitly instruct – p28: g.1) (a):

"Code only a conformed diagnoses of the 2019 novel coronavirus disease (COVID-19) as documented by the provider or documentation of a positive COVID-19 test result. For confirmed diagnoses, assign code U07.1, COVID-19." [20]

CDC did not adopt the WHO created code U07.2 for reporting COVID-19 when the virus was not identified (clinically diagnosed) however clearly instructed the providers not to use U07.1 for reporting uncertain cases:

"If the provider documents "suspected," "possible," "probable," or "inconclusive" COVID-19, do not assign code U07.1. Instead, code the signs and symptoms reported." [21]

CDC explained the importance of accurate and timely death reporting as fundamental to assess accurately the effects of pandemic and appropriately direct public health response. [22]

"Monitoring the emergence of COVID–19 in the United States and guiding public health response will also require accurate and timely death reporting. The purpose of this report is to provide guidance to death certifiers on proper cause-of-death certification for cases where confirmed or suspected COVID–19 infection resulted in death. As clinical guidance on COVID–19 evolves, this guidance may be updated, if necessary. When COVID–19 is determined to be a cause of death, it is important that it be reported on the death certificate to assess accurately the effects of this pandemic and appropriately direct public health response."

The diagnostic and coding guidelines of COVID infection and determination of UCOD is complex and but the core principle is clear: [23,24]

1. reliable COVID diagnostic is only possible by positive laboratory viral test;
2. Report only test positive (confirmed) cases of death under code U07.1;
3. Claim elevated reimbursement from the insurance or emergency fund only for procedures on confirmed (test positive) cases.

IS IT POSSIBLE TO RECOVER FALSELY CLAIMED (PREMIUM)-PAYMENTS FOR "HEARSAY COVID CASES"?

1) Technically: YES.

Computer comparison of the list of individual payments for COVID treatment and diagnostic with the list of individual viral tests under the relevant time period should quickly identify individuals who received treatment or diagnosed with COVID but laboratory records didn't confirm any viral testing.

2) Legally: YES.

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It is not rational or possible to audit millions of cases. However the Supreme Court acknowledged in 2016 that, *"[i]n many cases, a representative sample is the only practicable means to collect and present relevant data establishing a defendant's liability."* [25].

3) Politically: MAYBE.

The newly elected federal Government declared its ambition to reduce wasteful spending and correct former mistakes.

"A False Claims Act violation includes four elements: falsity, causation, knowledge, and materiality." [26]

The *'fraudulent scheme'* itself is sufficient to prove liability: a) the defendants signed a contract with the Federal government about b) receiving benefits from the PRF, in c) exchange for COVID related medical services that d) COVID disease should be diagnosed/confirmed by specific laboratory test and reported under U07.1 code. Defendants violated every element of the contract when misused the COVID privileges for not COVID conditions.

'*Knowledge / intent to commit fraud*'**.** The plaintiff does not need to prove that the defendant actually knew that he or she was committing fraud [27]. Not every doctor is motivated to spend valuable time to produce an immaculate death certificate. "*Death is death- whatever you call that.* However '*deliberate ignorance*' or '*reckless disregard*' are enough, a defendant can be found liable for fraud even if all they did was recklessly ignore the entire situation or bury their head in the sand [28]

However signs of intent – '*intelligent design*' – is well visible behind the COVID related criminal scheme. Relator observed a positive correlation between the number of "hearsay" diagnoses [number of potential false claims] and the political score (expressed as democrat/republican ratio) of the states. The states of defendants are all on the far left side of the political balance. This can't be explained by any random variation in the effects of COVID epidemic.

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