THE MANY FACES OF HEALTH CARE FRAUD

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Mary Jean Geroulo has worked in health care her entire career and appreciates the regulatory and operational challenges faced by providers in this dynamic field.

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Mary Jean represents a variety of health care providers in regulatory, operational and transactional matters. She has particular experience with reimbursement issues, including advising on Medicare/Medicaid repayment matters that arise in connection with routine audits, fraud and abuse investigations and whistleblower lawsuits. She guides clients through every step of the reimbursement process and counsels on payment processes and procedures to help avoid regulatory issues.

From a transactional standpoint, Mary Jean assists health care providers with the development and review of their contracts with vendors, employees and other providers; the formation of joint ventures and other business relationships; the execution of mergers and acquisitions; the drafting of offering memoranda and related documents; and the drafting of medical, facility and group governing board documents and bylaws.

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THE MANY FACES OF HEALTH CARE FRAUD

1. INTRODUCTION

Health care fraud has been an issue for a very long time, but in the past 5 -10 years the government has increased its investigation and enforcement of a wide variety of activities under the general heading of health care fraud and abuse, including activities that many practitioners might not immediately equate with fraud or abuse. Activities such as billing for services or products never furnished or intentionally falsifying medical certifications to get beneficiaries “scooter chairs” are clearly improper and will often qualify as fraud. However, what many providers may not understand is that something as simple as inadequately documenting services may qualify as abuse and can even rise to the level of fraud depending on the severity of the violation, thereby subjecting a provider to substantial fines and damages, repayment obligations, exclusion from participation in the Medicare and/or Medicaid programs and/or even jail time.

This paper will briefly review the laws, rules and regulations related to health care fraud investigations and enforcement, and will discuss in more detail activities engaged in by providers that may also be actionable under one or more of these laws. Lastly, this paper will offer some simple steps providers can take to reduce the risk that they will become embroiled in a fraud investigation.

2. FEDERAL LAWS

a. The False Claims Act

The federal government has a number of statutes and laws it can use to prosecute providers who engage in health care fraud and other types of misconduct. Section 1128A of the Social Security Act authorizes the Health & Human Services Office of the Inspector General (“OIG”) to impose civil penalties and assessments on a person or organization who engages in prohibited conduct, including submission of a claim the party knows to be false. Section 1128B of the SSA provides for criminal penalties for wrongdoing involving the federal health care programs.

One of the laws frequently used by the government to enforce wrongdoing related to health care fraud is the federal False Claims Act (“FCA”). This is a law that was first passed in 1863 to address wide-spread fraud by contractors providing goods during the civil war. It is still used to prosecute contractors in the defense industry but has been modified over the years and has been used in recent years to address a wide variety of improper billing practices in the health care industry.

In relevant part, a person or entity violates the FCA if he “(i) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval [or] knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim.” (31 U.S.C. §3729(a). “Knowingly” is defined as (i) having actual knowledge of the falsity of the claim, (ii) acting in deliberate ignorance of the truth or falsity of the claim, or (iii) acting in reckless disregard of the truth or falsity of the information. (31 U.S.C. §3729(b). Individuals or companies who violate the FCA are subject to substantial fines and penalties: up to treble damages plus $5000 to $11,000 in penalties for each false claim submitted for payment.

It is easy to see how the fines and penalties in a FCA action can quickly add up. As example, if a physician submits $200,000 worth of false claims where each claim was paid at $200, in addition to making restitution of the $200,000 in payments, the physician may be liable for up to treble damages or an additional $600,000 in damages and between $5,000,000 and $11,000,000 in penalties (between $5000 and $11,000 for each of the 1000 claims).

Another noteworthy feature of the FCA is that individuals also have the right to initiate an action under the FCA, which is known as a qui tam or “whistleblower” lawsuit. This type of action is brought on behalf of the government and if there is a recovery, the individual bringing the qui tam claim (the relator ), receives a portion of the recovery. (See, 31 U.S.C. §3730(b). Whistleblower lawsuits are becoming very commonplace given the potential for huge recoveries (up to 30% of the total recovery) for both the relators and the attorneys representing the relators. There is an “industry” related to generating whistleblower suites with plaintiffs attorneys actively seeking out individuals who may have information necessary to bring such a suit. Searching the internet will result in hundreds of websites instructing individuals how they can bring such suit. As example, see Whistleblower Center at http://www.whistleblowercenter.com/. This site advertises itself as “your leading resource for everything dealing with the False Claims Act and Whistleblower Law. We work with only the best False Claims Act Attorneys and Whistleblower Lawyers who have recovered millions for the government and whistleblowers to make sure your case is handled professionally and confidentially.” With literally millions in recoveries possible in a simple case, it is easy to see why this type of lawsuit is becoming increasingly common, thereby raising the risk for every health care provider than a colleague or employee will report suspicious billing activity or practices.
b. Civil Monetary Penalties and Exclusion.
   The Social Security Act authorizes the Secretary of Health & Human Services (“HHS”) to seek civil monetary penalties (CMPs) and assessments for many types of conduct. The Secretary of HHS has delegated many of these CMPs to the OIG. In most cases for which the OIG may seek CMPs, the OIG may also seek exclusion from participation in all Federal health care programs. See, Civil Monetary Penalties Law (“CMPL”), 42 U.S.C. § 1320a-7a and 42 CFR § 1003.102. The OIG may seek CMPs against any person who:
   - Presents or causes to be presented claims to a Federal health care program that the person knows or should know is for an item or service that was not provided as claimed or is false or fraudulent. 42 U.S.C. § 1320a-7a(a)(1)(A) and (B).
   - Violates the anti-kickback statute (42 U.S.C. § 1320a-7b(b)) by knowingly and willfully: (1) offering or paying remuneration to induce the referral of Federal health care program business; or (2) soliciting or receiving remuneration in return for the referral of Federal health care program business. 42 U.S.C. § 1320a-7a(a)(7).
   - Presents or causes to be presented a claim that the person knows or should know is for a service for which payment may not be made under 42 U.S.C. § 1395nn, the physician self-referral or "Stark" law. 42 U.S.C. § 1395nn(g)(3).

c. Anti-kickback Law
   The federal Anti-kickback law (42 U.S.C. § 1320a-7b(b)) is another law with a relatively broad application. Anti-kickback is an intent based statute requiring knowing or willful conduct for a violation, which is punishable by fines and penalties and prison time. An interesting and much disputed aspect of Anti-kickback is application of the “one purpose rule,” whereby it has been held that if even one purpose of a financial arrangement is the inducement of referrals, then the law is violated, even if that one purpose was merely incidental to a number of other legitimate purposes for the arrangement. (United States v. Greber, 760 F.2d 68 (3rd Cir. 1985); United States v. McClatchey, 217 F.3d 823, (10th Cir. 2000).

   This one purpose rule is relevant to many, if not most, financial arrangements between health care providers because the purpose of many such relationships is the exchange of referrals. There are, however, a number of safe harbors, which permit what might otherwise be considered prohibited financial relationships between health care providers provided the arrangement complies substantially with an applicable safe harbor. (See, 42 C.F.R. §1001.952).

d. Stark Law
   The Stark law is more limited in scope than the Anti-kickback law and applies only to physician financial relationships and certain types of procedures, which are referred to by the Stark law as designated health services (“DHS”). Stark prohibits a physician from referring patients to an entity that furnishes DHS if the referring physician, or an immediate family member of the referring physician, has a financial relationship with the entity and when payment for the DHS may be made by Medicare unless an exception applies. If a prohibited referral is made, the statute prohibits the DHS entity from billing for the DHS service. If the statute is violated, both the person making the referral and the party billing for the referral are subject to penalties. These penalties include but are not limited to exclusion of the violating providers from the Medicare program, denial of payment on claims for DHS provided to Medicare patients in violation of Stark, requiring the refund of any amounts that have been paid on such claims, and civil monetary penalties of up to $15,000 for each service billed in violation of Stark. (42 U.S.C. §1395nn).

   The Stark law applies only to referrals made to providers of DHS, and the law establishes an exclusive list of services that are designated as DHS. The following is the exclusive list of services and products are designated as DHS:

   (1) clinical laboratory services;
   (2) physical therapy, occupational therapy, and speech-language pathology services;
   (3) radiology and certain other imaging services;
   (4) radiation therapy services and supplies;
   (5) durable medical equipment and supplies;
   (6) parenteral and enteral nutrients, equipment, and supplies;
   (7) prosthetics, orthotics, and prosthetic devices and supplies;
   (8) home health services;
   (9) outpatient prescription drugs; and
   (10) inpatient and outpatient hospital services. (See 42 U.S.C. §1395nn, and 42 C.F.R. §411.351).

e. Federal “HIPAA Fraud” Statutes
   Many of the laws the government uses to prosecute health care fraud are limited to fraud with respect to a federal health care program, such as Medicare or Medicaid. The “HIPAA Fraud Statutes” found at 18 U.S.C. §§1035 and 1347 apply to fraudulent conduct related to the payment of health care services or products from any source, including commercial health plans.
18 U.S.C. §1035 makes it a criminal act to:
“to make any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false writing or document knowing the same to contain any in connection with the delivery of or payment for health care benefits, items, or services.” Penalty for violation may be fines and imprisonment for not more than 5 years.

18 U.S.C. §1347 makes it a crime to defraud any health care benefit program or to obtain “by means of false or fraudulent pretenses, representations, or promises any of the money …of any health care benefit program in connection with the delivery of or payment for health care benefits, items, or services.” Violation is punishable by fines and imprisonment for not more than 10 years.

3. STATE LAWS
a. Texas Medicaid Fraud
The Texas Penal Code makes a variety of activities actionable as Medicaid Fraud under Chapter 35A. A person is guilty of Medicaid fraud in Texas when in part the person:

“knowingly makes or causes to be made a false statement or misrepresentation of a material fact to permit a person to receive a benefit or payment under the Medicaid program that is not authorized or that is greater than the benefit or payment that is authorized” or

“knowingly conceals or fails to disclose information that permits a person to receive a benefit or payment under the Medicaid program that is not authorized or that is greater than the benefit or payment that is authorized,” or

“knowingly makes, causes to be made, induces, or seeks to induce the making of a false statement or misrepresentation of a material fact concerning the conditions or operation of a facility [hospital, nursing facility, hospice, home health agency, assisted living facility] in order that the facility may qualify for certification or recertification by the Medicaid program,” or

“knowingly pays, charges, solicits, accepts or receives … a gift, money, a donation, or other consideration as a condition to the provision of a service or product” or

“knowingly presents or causes to be presented a claim for payment under the Medicaid program for a product provided or a service rendered by a person who is not licensed to provide the product or service.”
(Texas Penal Code §35A.02).

Medicaid fraud is punishable as a misdemeanor up to a felony depending on the dollar amount of the fraudulent activity.

b. Insurance Fraud Texas Penal Code Chapter 35
A person commits insurance fraud in Texas, part, if, “with intent to defraud or deceive an insurer,” the person: “prepares or causes to be prepared a statement that (A) the person knows contains false or misleading material information; and (B) is presented to an insurer.”

Violation of this law is a misdemeanor up to a first degree felony depending on the value of the claim.

4. INITIATIVES AND AUDITS
The government most commonly identifies overpayments, fraud and other wrongdoing through a variety of audit processes, reports from beneficiaries, employees or others who may suspect wrongdoing, and/or through a number of federal and state initiatives whose purpose it is to identify and investigate fraud. For the typical health care provider who is not engaged in intentional wrongdoing on a large scale, the audit process is the mechanism by which they might be drawn into an investigation or enforcement action.

a. Audits and Audit Contractors
HHS and Centers for Medicare & Medicaid Services (“CMS”) have a number of audit programs and contractors available to root out overpayments and wrongdoing, including:

• Medicare Administrative Contractors or “MACs”,
• Comprehensive Error Rate Testing Program or “CERT”,
• Recovery Audit Contractors or “RACs”,
• Zone Program Integrity Contractors or “ZPICs”,
• the Medicaid Integrity Program or “MIP” and
• the individual state Medicare Fraud Programs.

All of these programs are charged with identifying and recovering overpayments, but the ZPICs, the MIPs and the state Medicaid Fraud Programs are
specifically charged with identifying and responding to activities other than simple, unintentional mistakes.

The scope of recoveries possible through these programs is substantial. The MACs, CERTs, and RACs can recover overpayments for up to three years after the payment has been made (the Medicare “at fault” rule as discussed in more detail below). The ZPICs and Medicaid Fraud programs have a far greater reach and can generally go back up to six years to recover improper payments under the FCA (or three years after the facts material to the federal government are known, but in no case no more than 10 years after the date of the wrongdoing). (See 31 U.S.C. §3731(b). Additionally, each type of contractor can refer a provider to another contractor or agency, such as the Department of Justice, OIG and/or US Attorneys Office, for additional investigation and enforcement activity if the contractor believes the activities resulting overpayments or improper payment were the result of more than an unintentional mistake. Thus, a provider subjected to any type of audit should take any audit process very seriously. The following is a brief summary of each of the above contractors or audit programs.

- **MACs** were implemented by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, which phased out the fiscal intermediaries and carriers (such as TrailBlazer) and replaced them with the MACs, whose role is to process and pay claims and process recoveries identified by other contractors. TrailBlazer is the primary MAC operating in Texas. There are 15 MACs assigned by primarily by geographic region. A MAC audit is typically performed on a random sample basis.

- The **CERT** program was established by the Improper Payments Information Act of 2002 to help contractors focus review and education efforts. CERT reviews use randomly selected claims and associated records to determine if payment was proper based on 5 different error categories: no documentation, insufficient documentation, medically unnecessary services, incorrect coding, and other, which includes duplicate payments, payments for non-covered or unallowable services.

- **RACs** are the most well publicized of these audit contractors and are part of the Medicare Integrity Program. The mission of RAC contractors is to reduce improper Medicare payments by investigation and recovery. They may collect directly from providers and are paid by commission. The RAC audits are based on a variety of data mining techniques, benchmarking and profiling.

- **ZPICs** have a dual purpose, which includes identifying simple overpayments, but the ZPICs primary purpose is to identify and investigate Medicare fraud and abuse, and ZPICs frequently refer cases to law enforcement or other agencies for prosecution. Prior to the change from the Program Safeguard Contractor (“PSC”) to ZPICs, in 2009, the rate of recovery for improper payments was only 7%. As a result of this poor recovery rate, CMS transitioned from the 18 PSCs to 7 ZPICs in 2009 and has intensified the oversight of each contractor. ZPICs use a combination of sophisticated data analysis and audits to lead to referrals, but they also use information from informants to identify wrongdoing. The ZPIC responsible for Texas is a company called Health Integrity LLC.

- **State Medicaid Fraud Programs** operate under the authority of the State Attorney Generals and their purpose is to investigate and prosecute civil and criminal violations of the Medicaid programs. Investigations may be triggered by complaints, informants, information from other agencies, or the Fraud Units’ own internal reviews and data mining. The Texas Medicaid Fraud Unit is very active and more information about its activities and prosecutions can be found at [https://www.oag.state.tx.us/forms/mfcu/](https://www.oag.state.tx.us/forms/mfcu/).

b. Federal Initiatives

The government has also implemented a number of national initiatives to identify and prosecute individuals involved in health care fraud. The following are two examples of these initiatives.

- The **Health Care Fraud and Abuse Control Program**, created as part of the Health Insurance Protection and Accountability Act of 1996, better known as “HIPAA” is a program that combines and coordinates the efforts of CMS, the civil and criminal divisions of the U.S. Attorneys Office, the Executive Office for the U.S. Attorneys, the FBI, HHS, and the OIG. Its purpose is to coordinate federal, state, and local law enforcement activities with respect to health care fraud and abuse, conduct investigations, audits, inspections, and evaluations related to the delivery and payment of health care. Detailed information on this program and its activities can be found at [http://oig.hhs.gov/reports-and-publications/hcfac/index.asp](http://oig.hhs.gov/reports-and-publications/hcfac/index.asp).

- The **Health Care Fraud Prevention and Enforcement Action Team** or “HEAT” was
5. APPLICATION OF THE LAWS

It is easy to see how the above laws can be used to prosecute individuals involved in flagrantly fraudulent activities such as billing for Medicaid or Medicare services that were never furnished, falsifying medical necessity certifications or activities such as the well publicized Armenian-American crime ring that defrauded Medicare of more than $35 million by using stolen doctor and patient identities and setting up dozens of phony clinics coast-to-coast. See, http://www.fbi.gov/newyork/press-releases/2010/nyfo101310.htm There have been other major investigations and prosecutions of home health agencies, durable medical equipment providers, hospitals, physicians and other providers under the FCA, the HIPAA Fraud Statutes, and/or Texas Medicaid or Insurance Fraud statutes. More details on these government actions can be reviewed on the OIG’s website at http://oig.hhs.gov/fraud/enforcement/index.asp. Information on Texas investigations and enforcement activity can be found on the Attorney General’s website at https://www.oag.state.tx.us/criminal/mfcu.shtml#mfcu.

However, as mentioned above, these laws can also be used to address a wide variety of situations and activities that may not immediately be identified as fraudulent or abusive. One particularly problematic situation that can give rise to a governmental investigation is the failure by a provider to refund payments received by Medicare or Medicaid the provider had no right to receive or keep. These payments can arise from any number of situations, including without limitation:

- simple billing errors,
- documentation that fails to support the billed codes,
- duplicate payments or other payment mistakes made by Medicare or Medicaid,
- claims submitted in violation of the Stark or Anti-kickback laws,
- billing for provider A’s services under provider B’s name and number,
- not complying with Medicare rules and regulations with respect to billing for services or products, and
- intentional submission of false claims for services never rendered.

These are all activities that we see frequently in our practice and with the exception of the intentionally fraudulent acts, in almost every instance the provider is shocked that the activity may result not only in a repayment obligation, but also in fines and penalties, and in some cases, criminal prosecution.

The law giving the government the right to proceed with enforcement action against providers in these and other similar situations is 42 U.S.C. §1320a-7b(a)(3), which imposes on providers a statutory obligation to refund any money received from a federal health care program the person has no right to receive.

This repayment obligation was substantially reinforced by the Patient Protection and Affordable Health Care Act of 2010 (“PPAHCA”) (Pub. L. 111-148, 124 Stat. 119, Section 6402) which imposes on providers an obligation to disclose (and arguably repay) any overpayments received within 60 days of learning of the overpayment. Failure to at least disclose the overpayment gives the government the right to enforce repayment under the False Claims Act. This modification by PPAHCA can turn what might have been a simply repayment obligation into a potential violation of the FCA, which can result in the fines, penalties and even criminal prosecutions if the conduct is deemed sufficiently egregious.

The repayment obligation established by 42 U.S.C. §1320a-7b(a)(3) has far reaching implications in that it doesn’t just apply to payments received that were the result of intentional acts, but includes any payment for which a provider is considered to be “at fault” as that term is defined by CMS.

Unless evidence to the contrary exists, providers are deemed not to be at fault if the overpayments are...
discovered subsequent to the third year after payment is received or the provider exercised “reasonable care” in billing for and accepting payment. (See Medicare Financial Services Manual, Chapter 3). Although “reasonable care” sounds like it should apply to the typical provider who documents services furnished and bills for those services, it is a much more restrictive definition. “Reasonable care” is defined by Medicare as the provider making full disclosure of all material facts related to the claim and “on the basis of the information available to [the provider], including but not limited to, the Medicare instructions and regulations, [the provider] had a reasonable basis for assuming that the payment was correct, or if [the provider] had reason to question the payment, [the provider] promptly brought the question to the FI or Carrier’s attention.”

The application of this rule means, as example, that providers must comply with all the documentation, claims processing, and coverage rules for all claims paid by Medicare and Medicaid. Failure to comply in full with all rules and guidance, i.e., failure to document services in the detail required by an applicable rule, may result in a repayment obligation. The government is under no obligation to prove that the guidance has been furnished to the provider; only that it has published guidance, rules or regulations and the provider has not complied with these rules.

Prior to enactment of PPACA, a failure to repay an overpayment could be interpreted as an “intentional attempt to conceal the overpayment from the government,” (Office of the Inspector General Compliance Guidance 63 Fed. Reg. 8987 (February 23, 1998), however, there was no express guidance to that effect. The PPAHCA provision requiring disclosure within 60 days of discovering an overpayment together with the express authority to use the FCA for a failure to disclose overpayments within this timeframe adds “teeth” to this repayment obligation and substantially increases the potential consequences related to a failure to promptly refund an overpayment or other payments for which a provider had no right to receive.

It is not unusual to encounter providers who receive overpayments or incorrect payments and do not refund them. In my practice I have had physicians tell me that they keep overpayments because those overpayments make up for services or products not covered by Medicare. Other providers simply don’t have any type of routine process for identifying and refunding overpayments, whether the overpayments are the result of payor or provider mistakes. Additionally, many providers, and specifically many physicians and group practices, do not have adequate audit practices in place to assure that the services billed are supported by documentation sufficient to support the billed code and all services are being furnished in compliance with all applicable rules and regulations. All of these practices and approaches to payments and claims can result in a failure to repay an overpayment which may be actionable under the FCA.

Providers generally correct a non-complaint documentation or claims processing procedure when it is brought to their attention, but many choose to not refund the payments previously received as a result of the non-compliant activity. These providers often take the position that it is unlikely that the non-compliant behavior will be identified by the government. Given the various groups charged with auditing provider claims and the prevalence of whistleblower lawsuits, it is becoming more and more likely that a physician (or other health care providers) will be the subject of an audit by one or more of these contractors or that the non-compliant activity will be reported by an employee, patient or colleague. The finding by an auditor or a government agency that a provider received overpayments but failed to refund them in accordance with the PPACA rule, puts the provider at risk for the audit report to be forwarded to the U.S. Attorneys Office for prosecution under the FCA.

As noted above, the Medicare “at fault” rule requires refund of overpayments for up to three years from the date payment is received. For a provider whose documentation is routinely inadequate (for example, the physician who routinely codes for office visits as CPT 99215 but whose documentation only supports the less intensive CPT 99213 visit) may face a repayment obligation of hundreds of thousands of dollars for the three year period. If it is determined by the government that the provider knew of the overpayments (i.e., knew or should have known the documentation did not support the billed codes) and did not disclose the overpayments as required by PPAHCA, the provider could also be subject to prosecution under the FCA with its additional fines and penalties.

An example of an allegedly “inadequate” documentation overpayment situation was encountered in my practice by a group that was involved in a whistleblower lawsuit. The whistleblower suit was brought by a disgruntled employee of the billing company that processed the group’s claims. After more than three years of investigation, the government could not substantiate the claims made by the whistleblower, but in the course of its investigation it decided that the group’s documentation for its consulting services did not comply with the Medicare rules and guidance. The government claimed that it had grounds to bring a case against the group under the FCA because the consult documentation guidance had been available for years, thereby, in the government’s
opinion, giving the group no excuse for not complying fully with all aspects of the guidance and providing the basis for “knowing” conduct on the part of the group.

The interesting aspect of this case was that the deficiency in the documentation was nothing more than a technical violation of the rules. The consulting rules required in part that the documentation must reflect that a referring physician was requesting a consult for a particular purpose. In the case of my client’s documentation, the consulting reports back to the referring physicians did not explicitly say that the Dr. Jones referred Ms. Smith for a consult on Ms. Smith’s xxx, but it was clearly apparent from the report that it was a consult for this purpose. In other words, the group’s documentation was, for all practical purposes, substantially compliant with the rules in that the reports clearly and unequivocally documented a consult done at the request of the referring physician. Nonetheless, the government persisted, threatening to bring a FCA action against the group with all its associated attorneys’ costs and potential fines and penalties. This group was able to enter into a settlement agreement with the government to refund 4 years of payments for the consults and payment of the lowest level of damages, but this case is a good example of the manner in which the government can use the FCA against providers for documentation that is minimally non-compliant.

Another very common situation where providers can be subjected to substantial fines and penalties for failure to disclose and repay payments the providers had no right to receive is where the provider fails to make an appropriate disclosure and repayment of payments received in violation of the federal Stark law. The following are two common examples of this type of situation:

- A hospital allows a physician who refers Medicare patients to the hospital to use an office in the hospital for the physician’s private practice, but does not enter into a lease agreement with the physician for that space that is in compliance with the lease exception under Stark at 42 C.F.R. §411.357(a). This exception requires, in relevant part that the lease arrangement be in writing, signed by the parties, have a term of at least a year, describes the space to be leased and sets out in advance the rental payments, which may not be based on the value or volume of the physician’s expected referral to the hospital and must be justifiable as fair market value. A hospital giving a referring physician use of office space when the arrangement does not qualify in all aspects with the exception is a violation of the Stark law and the hospital has an obligation to refund all payments received from Medicare or Medicaid that the hospital received as a result of referrals from that physician.

It is not sufficient to simply correct the arrangement. The hospital has a statutory obligation to refund all payments received during the period of noncompliance and failure refund these payments can subject the hospital to fines, penalties, and even exclusion from participation in federal health care programs.

- A physician group practice decides to add an MRI to the services it has available for its patients, but the provision of this service does not comply in all aspects with the Stark exception for in office ancillary services found at 42 C.F.R. §411.355(b). Even if the practice corrects the non-compliant arrangement to comply fully with the exception, it is statutorily obligated to refund payments received for MRI services furnished to Medicare and Medicaid beneficiaries referred by members of the group to the MRI service. If the government discovers the non-compliance and the non-refunded payments, it can demand repayment of all the non-compliant payments, impose fines and penalties pursuant to the CMP.

### 6. STEPS PROVIDERS CAN TAKE TO REDUCE RISK

The heightened scrutiny of provider claims and the potential consequences associated with non-compliant claims and documentation means that every provider, from solo practitioners to national hospital companies, should develop and implement systems to assure that the provider’s practices with respect to claims processing and documentation are substantially in compliance with federal and state laws, rules, and regulations. The OIG has published guidance for compliance programs for just about every type of health care provider that sets out the basic elements for compliance programs. Links to the OIG’s compliance guidance for hospitals, individual and small group physician practices, pharmaceutical companies, home health agencies, billing companies and more can be found at [http://oig.hhs.gov/compliance/compliance-guidance/index.asp](http://oig.hhs.gov/compliance/compliance-guidance/index.asp). In addition to providing a mechanism to monitor compliance with the myriad of laws, rules and regulations associated with billing and collecting for health care services, the presence of a compliance program is often taken into consideration by the government when considering penalties for non-compliant claims processing practices.

However, even if a provider does not implement a comprehensive compliance program as suggested by
the OIG, the following are some steps providers can take to reduce the risk that they might be subjected to a fraud or other type of health care investigation:

- Document services in accordance with the requirements set for by the applicable CPT code in the AMA CPT code book and any Medicare rules or regulations;
- Periodically have records and claims audited by a qualified independent entity to identify any deficiencies or irregularities in coding or documentation. It is not unusual in a physician practice to never have an outside (or even internal) audit of claims and supporting documentation, and given the prevalence of inadequate documentation in most office-based practices (unlike hospitals and other facility based providers that are subjected to routine reviews from entities and agencies such as JCAHO, Medicare or state licensing agencies) it is extremely risky to not have such periodic audits performed.
- Implement and monitor systems for identifying and refunding overpayments received, especially overpayments from Medicare or Medicaid.
- If using a billing company to process claims, make sure the billing company has instituted and maintains an appropriate compliance program, has a routine process for identifying and reporting overpayments, and insist on an appropriate indemnification provision in the provider/billing company contract that requires the billing company to indemnify the provider for mistakes or other misconduct by the billing company that results in refund obligations or other costs, claims or liabilities. Even if a billing company is the cause of an error, the provider is generally responsible for refunding any overpayment received. Many providers operate under the common misconception that a billing error arising from the billing services is the responsibility of the billing service. Although the billing service may have some culpability in the error, the services were billed under the provider’s name and tax identification number, which means the government will typically go to the provider for repayment, not the billing company.
- Do not assume your employees know what they are doing, don’t make mistakes, or won’t intentionally engage in activities that can be interpreted as fraudulent. Providers are responsible for establishing systems to assure that their claims are processed in accordance with the rules and regulations, whether they are processed by employees, spouses, or a billing company.
- Take seriously and respond appropriately to employee concerns or questions about coding, documentation, or claims processing. Failure to do so can result in frustrated, angry, or disgruntled employees who may file whistleblower lawsuits or report the activity to a federal agency.
- Never, never, never, rely on other providers or the “we’ve always done it this way” mantra with respect to proper documentation requirements, coverage issues, and/or claims processing. If adding a new service or product, or have any questions about the proper way to provide, document or bill for a service, either review applicable rules or regulations or consult a qualified health care attorney.