GOVERNMENT INVESTIGATIONS: HEALTHCARE

PREVENTING OVERPAYMENTS FROM BECOMING FALSE CLAIMS

Andrew L. Sparks

Overpayments to healthcare providers receiving Medicare reimbursements are at risk of civil and criminal enforcement action if not attuned to a particular reimbursement rule and diligent in compliance with the rule's requirements. In short, the overpayment rule turns potential billing mistakes into fraud. A healthcare provider cannot keep money paid in error. The Government and relator bar are certain to address fully this theory of liability against every healthcare provider who ends up in litigation. If an overpayment is identified and the provider does nothing, then the provider will end up paying significantly more to the Government. It's the proverbial pay (less for compliance) now or more (to the Government) later. Put differently, healthcare providers should address the smaller problem sooner rather than the bigger problem later.

Last year Centers for Medicare and Medicaid Services (CMS) released its Final Rule concerning overpayment procedures for Medicare Parts A and B. The Rule implements Section 6402(a) of the Affordable Care Act, which addresses the identification, reporting and repayment of overpayments. Healthcare providers reasonably should expect to see increased use of this provision in Government enforcement and whistleblower lawsuits now that the overpayment requirements have been disseminated fully throughout the healthcare community.

The Sixty-Day Rule

Federal law obligates providers to report and return any overpayment within 60 days after "the date on which the overpayment is identified." 42 U.S.C. § 1320a-7k(d)(2) ("Statute"). The failure to return an overpayment may be a violation of the False Claims Act. Statute at 1320a-7k(d)(3). CMS's 2016 Rule clarifies that a provider is permitted to conduct the auditing and investigative work required to determine the overpayment amount before the 60-day clock starts to run. "The 60-day time period begins when either the reasonable diligence is completed or on the day the person received credible information of a potential overpayment if the person failed to conduct reasonable diligence and the person in fact received an overpayment." 81 Fed. Reg. at 7661 ("Rule"). Credible information is defined as "information that supports a reasonable belief that an overpayment may have been received." Rule at 7662.

CMS does not allow providers to simply ignore evidence of possible overpayments. The Rule expressly states that an overpayment has been identified "if the person fails to exercise reasonable diligence and the person in fact received an overpayment." Rule at 7661.
While "reasonable diligence" is fact dependent, CMS states that it "includes both proactive compliance activities conducted in good faith by qualified individuals to monitor for the receipt of overpayments and investigations conducted in good faith and in a timely manner by qualified individuals in response to obtaining credible information of a potential overpayment." Rule at 7661. Critically, the rule states that "undertaking no or minimal compliance activities to monitor the accuracy and appropriateness of a provider or supplier's Medicare claims would expose a provider or supplier to liability under the identification standard articulated in this rule based on failure to exercise reasonable diligence if the provider or supplier received an overpayment." Rule at 7661. Senior leadership of healthcare organizations cannot avoid responsibility simply by ignoring or delegating compliance responsibility. "[O]rganizations are responsible for the activities of their employees and agents at all levels." Rule at 7665.

The Rule requires a six-year lookback period to determine the extent of any overpayments. Rule at 7671. In plain English, that means the Government will scrutinize a healthcare provider's records going back six years in evaluating overpayments. CMS encourages the use of statistical sampling and extrapolation to investigate and calculate overpayment amounts. Rule at 7663. Providers have six months to conduct reasonable inquiries into potential overpayments before the 60-day clock starts. Rule at 7662. While "extraordinary circumstances" might justify additional time, providers should plan to have no more than eight months to report and return overpayments to Medicare.

Finally, the amount of overpayment is not typically the full amount of the claim, but rather the "difference between the amount that was paid and the amount that should have been paid." Rule at 7658. However, fraudulent claims or claims tainted by Anti-Kickback or Stark Law violations must be returned in their entirety. Rule at 7658.

Reverse False Claims Investigations

So what does this mean for health care professionals faced with a potential overpayment issue? First, providers should embrace their obligation to investigate fully all credible allegations of overpayments. The failure to do so may very well turn an overpayment situation into a False Claims Act violation. Providers should assume all overpayment issues will ultimately be brought to the attention of the Government and act accordingly.

The case of *United States v. Continuum Health Partners, Inc., et al.*, illustrates this point. In Continuum, the health system was alerted about a small number of overpayments. Continuum hired a consultant to look into the matter, who identified hundreds of potential overpayments. The health system fired the consultant instead of returning the overpayments. The consultant subsequently filed a whistleblower lawsuit, alleging Continuum committed fraud by failing to return the overpayment. The health system eventually settled the case for $2.95 million. This total included the overpayment — approximately $850,000 — and $2.1 million in civil penalties.

The *Continuum* settlement should serve as a cautionary tale as to the dangers of ignoring evidence of overpayments. Providers should assume both the Department of Justice and the relators' bar are fully aware of the overpayment Rule and will aggressively

use the requirement in current and future litigation. The relevant inquiry will focus on whether the provider undertook a good faith, timely investigation conducted by qualified people. And, once the Government is poking around and investigating, the susceptibility to identifying potential criminal violations also hit the radar.

While the specific facts will drive each case, healthcare providers can be assured that Government attorneys will thoroughly explore an institution's compliance and internal monitoring programs should the Government open a False Claims Act investigation. The Government likely will expect providers to disclose the procedures by which they collect and review information about potential overpayments. The Government will certainly demand to see a provider's compliance program and the provider's guidelines for investigating and evaluating potential overpayment issues. Consistent with the Yates memo addressing individual criminal liability and prosecution for corporate conduct, the Government likely will place particular emphasis on identifying the ultimate decision-maker for returning overpayment. Investigators will establish a full and accurate timeline for when an issue was, or should have been, first identified, as well as a list of all knowledgeable individuals. Finally, the Government will delve into the resources and emphasis placed on fulfilling the provider's repayment obligations to determine whether FCA liability exists.

Our experience is the best medicine is early and diligent review and assessment by counsel who are attuned to the potential exposure to both civil and criminal liability. Our additional experience is that a focus simply on potential civil liability can leave exposure on the criminal flank. Providers, therefore, should have an effective compliance program to address timely any credible allegation of overpayment. This will require the coordinated effort of counsel with a variety of trained compliance and other professionals. While no provider wants to return money, the risk of keeping potentially tainted funds is simply too high. Addressing an overpayment issue within six months likely is the best medicine and potential cure for preventing far greater problems.

FOR MORE INFORMATION CONTACT:

Andrew L. Sparks is a Of Counsel in Dickinson Wright's Lexington office. He can be reached at 859.899.8734 or asparks@dickinsonwright.com.