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False Claims Act threat moves to states and localities

*State false claims/*qui tam *laws often are more potent than their federal counterpart*

Most health care providers are aware of the liability risks associated with the federal False Claims Act (FCA). What many don't know is what FCA expert **John Boese** calls "a rapidly growing movement among state and local governments" to enact similar laws.

"The growing trend toward enacting state and local false claims laws merits close attention for a number of important reasons," says Boese, of the Washington, DC, law firm Fried Frank.

The first reason is that experience with the oldest state FCA law, the California False Claims Act, which was enacted in 1987, shows these laws "have teeth," he says. In fact, reportedly, more than 130 *qui tam* actions are pending under the California FCA, which already has yielded a number of multimillion-dollar settlements, Boese says.

"This is definitely a significant development," says **William Saraille**, a health care attorney with Arent Fox in Washington, DC. "It is a trend that has more than caught hold at the state level and is quite literally sweeping across the country."

Saraille says this trend is especially significant because the new laws provide states with much greater capacity to work independently of the federal government in connection with Medicaid issues and, in many cases, with

*See **State FCAs**, page 2*

Successfully manage overpayment demands

In-house and outside health care counsel routinely confront questions about how to handle overpayment demands from fiscal intermediaries and carriers. The lack of uniformity among these payers often makes this task even more complex, says **Carrie Valiant**, a health care attorney at the Washington, DC, office of Epstein Becker.

The ability of counsel to effectively respond to these demands is largely a function of when they learn about the problem. That is true for in-house lawyers as well, she says.

When providers receive a large documentation request, several steps can be taken at the front

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Preparing for HIPAA: How does your facility compare?

Most health care providers are doing what's necessary to comply with the Health Insurance Portability and Accountability Act (HIPAA), according to the results of the Philadelphia-based Health Care Compliance Association's (HCCA) second HIPAA Readiness Survey, released April 22.

For example, survey respondents indicate that most organizations have held one or two hours of training on HIPAA privacy regulations for the majority of their stakeholders, including physicians, staff, executives, and board members. Most of them also report an increase of more than five hours of training for these stakeholders.

According to the survey, organizational steps also are well under way. "Most have begun to separate the areas of privacy and security," HCCA reports.

Here are some of the important benchmarks

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respect to private-payer issues. The latter is true because many of the statutes are not limited to Medicaid funds but also apply to private-payer relationships, he explains.

Saraille says that another important difference is the standing that whistle-blowers often have under the state statutes. "That increases dramatically the potential range of plaintiffs," he asserts.

On the federal side, whistle-blowers are increasingly important in setting the health care enforcement agenda. "To add this additional avenue, particularly in the context of private-payer relationships, is going to be a very significant development over the long term," Saraille contends.

Last month, Virginia became the 12th state to enact a *qui tam* false claims law modeled on the federal FCA. California, Florida, Illinois, the District of Columbia, Nevada, Hawaii, Delaware, Massachusetts, and Tennessee also have *qui tam* false claims laws closely modeled on the federal FCA, notes Boese, while Louisiana, Tennessee and Texas have *qui tam* false claims laws that apply only to health care claims.

But it doesn't stop there. Boese says a recent search revealed false claims bills pending in at least 11 other states — Alaska, Connecticut, Kansas, Maryland, Mississippi, Missouri, New Jersey, New York, Oklahoma, Pennsylvania, and Washington.

"This development is especially significant because, as drafted, these bills apply to an expansive range of business activity," Boese says. "Many of these bills contain oppressive damages, penalties, and attorneys' fees provisions that could result in liability even greater than that which could be imposed under the Federal False Claims Act."

To date, health care providers have paid out the lion's share of the more than $5.2 billion to settle suits filed by private citizens under the federal FCA. But, as Boese points out, that does not include money paid to settle suits litigated by the Department of Justice without the assistance of whistle-blowers, much less the significant amounts paid to settle whistle-blower retaliation claims and the plaintiffs' attorneys' fees. ■

Preparing for HIPAA

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included in the study:

- 96% (93% previous survey) report that a HIPAA Task Force has been established;
- 83% (77% previous survey) indicate that a privacy officer has been designated;
- 67% (60% previous survey) have designated a security officer;
- 61% (40% previous survey) have developed organization structure delineating responsibilities for privacy and security;
- 82% (81% previous survey) have determined the organization's designation as a covered entity;
- 68% (64% previous survey) have reviewed employee screening and background-checking practices.

Thirty-seven percent of the 253 respondents, roughly three-quarters of whom were from hospitals, have developed cost estimates for privacy, security, and transaction requirements.

Notably, only 38% indicated that the privacy and security responsibilities have been assigned to one individual, compared to 53% who reported doing so in the first survey, conducted last year. HCCA suggests that one explanation for this is that most large organizations have separated the privacy officer role from the security officer role.

According to the survey, providers are moving

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ahead with the development of privacy policies and procedures. For example, 44% have developed a grievance policy to address complaints and breaches of confidentiality, compared to 41% in the first survey. Meanwhile, 59% have developed policies related to patient access records (53% first survey), and 44% have developed disposal of personal health information (37% first survey).

For additional findings from the survey, go to www.hcca-info.org. ■

Overpayment demands

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end, she says. While the initial demand often will notify the provider that it has 15 or 30 days to provide documentation, often that is not enough time. "You cannot do a good job of documentation in that short period of time," Valiant argues.

According to Valiant, the first thing providers should do is get an extension. "People are sometimes not thrilled about even asking for an extension because they feel it is admitting their documentation is not in order," she says. "But most carriers and intermediaries are very willing to give extensions to let you put the documentation together."

Another thing providers can do is examine the documentation to assure that everything is complete. Valiant says she routinely discovers a variety of documentation glitches, such as missing pages that were not copied from the patient record, forms with critical signatures on the backside that were not copied, and a lack of supporting documentation that may fall outside the patient record.

"Proof of delivery is not always in the patient record," she adds. Many times, audit requests are handled by people who simply copy the patient file and send it without reading the letter closely enough to realize that proof of delivery is required, she says.

Another thing that counsel can do at the front end is to make sure that providers are allocating sufficient resources to the overall effort, says Valiant. Many times, it is difficult to convince providers this is important, she adds. But allocating sufficient resources at the front end often means that a lot of claims are saved, she says.

Valiant says many providers deal with audits at "a rote level," when it is people higher up in the company who should be thinking about the bigger picture early in the process.

According to Valiant, it also makes sense to establish a dialogue between the client and the carrier when audit requests are received to help learn about ongoing issues. "I have had a lot of situations where people are basically saying the same words, but they are speaking a different language," she explains. "There is a disconnect and they do not understand what the other party is saying."

When providers begin a genuine dialogue rather than simply sending paper back and forth, they begin to understand exactly what the carrier requirement is, Valiant says. "It is often far different than what jumps off the printed page," she warns.

Valiant points out that carriers sometimes misread the manual. When that occurs, counsel should try to have the demand withdrawn, she suggests. "Think outside the box," she asserts, adding that demand letters are withdrawn with enough frequency to make that worth attempting. "They don't always get it right."

Finally, Valiant says that providers should consider raising statistical sampling issues. "If there is a glaring error in the sampling, sometimes you can have the letter retracted," she says.

Many sampling issues are less contentious than before because carriers and intermediaries now are more educated about what will stand up at the appeals level, says Valiant. But she adds that it often makes sense to talk to a statistician to find out if there is a significant issue. ■

Building a profitable compliance plan

Securing an adequate budget for compliance programs presents a challenge for compliance officers because it is very difficult to demonstrate added value. **Kathleen Burke Merlo**, director of compliance at the St. Louis University Medical School, recently outlined how her organization

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managed to accomplish just that by turning its existing billing processes into a compliance program.

According to Merlo, who outlined the program in a Health Care Compliance Association audio conference, the hospital did not set out to design a compliance plan that would make money. "Our focus was not initially on profitability," she says. "It was on building an organizational process that would work and improving our efficiency, accuracy, and effectiveness."

However, the hospital eventually managed to turn a billing process into a compliance program while at the same time reducing costs. The billing process efficiencies resulted in an increase in revenues, says Merlo.

Merlo says the effort was initiated in 1995, when management indicated that a significant problem existed regarding lost charges. "We had doctors carrying around billing cards in their pockets that never ultimately made it to the desk of anyone," she says.

Merlo says the first step was to determine how to account for all of the patients and go about finding lost charges. Initially, the hospital focused all of its efforts in the inpatient area. She points out that schedules can be used as a tracking mechanism for outpatient visits and procedures. "On the inpatient side, it is a little more difficult," she argues.

That problem is compounded when an organization does not know who all of its patients are until they arrive, as was the case in her facility, she adds.

Several challenges quickly arose, Merlo says. For one thing, a hiring freeze prevented any new positions for this project. In her capacity as business manager, Merlo was able to use two employees who had been the "middle men" between the central billing office and the physician division requesting additional information for claim denials. Those two people were used as a pilot staff for the program.

"We also had a marvelous opportunity to use technology to support what we were doing," she says. A decision was made to use a network manager to test new ideas on the hospital's ACCESS database, which then was used to create a program called Internal Medicine Patient Account Tracking (IMPACT).

Merlo says the key to recovering lost charges was tracking what services were provided. Hospital registration staff were used to provide a list of all patients who had been admitted the day before. Admissions staff also inserted a discharge day, and that information was transferred as an update.

The problem of inaccurate data also quickly surfaced. Initially, the hospital used parallel systems by having the regular billing process utilize encounter forms that were sent to a central billing office where the charge was entered. To reduce keystroke errors, Merlo says the pilot program used a fee-abstraction process using just one division.

"We immediately noticed that the number of keystroke errors was reduced," she reports. Those errors included wrong date of service and two charges for the same date of service. It was not as common to find an error in the CPT code, she adds.

Using parallel systems proved very effective because it helped demonstrate how much "faster and cleaner" the new IMPACT system would be, says Merlo. "By the end of three months, it was very clear that we were on the right track," she says.

The parallel systems also made it easier to transition when the hospital moved from sending the encounter forms to the central billing office. Using the ACCESS database, the hospital configured the process so that information could be received from anywhere and sent in a compatible format.

"The system itself was very simple," Merlo says. Moreover, it did not cost anything, because St. Louis already had the people on board who could write the scripts that were required.

Eventually, four fee abstractors developed a shorthand for common diagnoses, such as congestive heart failure, that were repeatedly used, Merlo says.

The program also developed the use of a special CPT code that was called the "unbillable code." While that was one of the more controversial steps, Merlo says it was useful to have a code that could be used internally to track what was billable and unbillable. ■