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Private-sector fraud seen affecting health care compliance

Compliance officers say internal audits and interactions with boards are key components

While the Health Insurance Portability and Accountability Act now is taking up half the time of most compliance officers, **Bret Bissey**, chief compliance officer at Deborah Heart and Lung Center in Brown Mills, NJ, predicts the financial upheaval and corporate fraud unfolding in the private sector will significantly affect the role of compliance officers as well. Specifically, he says, compliance officers are likely to find themselves helping to make sure the right decisions are made at the corporate level and that external auditors do not have any conflicts of interest.

David Orbuch, corporate compliance officer at Allina Health System in Minneapolis, argues that, going forward, the role of compliance officers should be to create strategies that, if implemented by operation leaders, will ensure that the company is doing it right the first time. "Previously, compliance officers were more about ensuring that the 'I's were dotted and the 'T's were crossed," he says.

The question is more than speculative for many compliance officers. For example, Bissey says he now is formulating plans on how to present these types of issues to his board. "Most board members are going to want to know how to make sure the integrity of the organization is protected," he argues.

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State laws complicate HIPAA compliance efforts

On of the thorniest issues surrounding the Health Insurance Portability and Accountability Act (HIPAA) is the patchwork of existing state privacy laws that will pre-empt federal requirements when state laws are more stringent. According to **Alan Goldberg**, one of the problems is that many state laws are changing.

There are a variety of ways to approach the analysis, according to Goldberg. He says many groups are performing analyses, and the challenge is to piece all of this together and come out with some consistent, coherent policy and practice for addressing the pre-emption issues. "The analysis

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How, when, and where to return an overpayment

The first problem providers confront when faced with a potential overpayment is that the Centers for Medicare & Medicaid Services (CMS) has yet to provide any definition of what precisely constitutes an overpayment. **(See *Compliance Hotline,* July 8, 2002.)** But that is only the first of several important questions that must be answered, says **Greg Luce**, a partner with Jones Day in Washington, DC.

Once a decision to make a repayment is made, hospitals must determine how quickly to do so, over what period of time, and how far back to go in looking for overpayments. According to Luce, there is a widespread belief among many providers that when an overpayment is discovered there is a need to repay it immediately regardless of the calculation and interpretation. That is a dangerous view, he warns.

Complicating matters is the fact that as hospitals

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Private-sector fraud

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Bissey says the background of individual compliance professionals will likely affect this trend because there is a wide disparity of skill sets among compliance professionals. "When you begin to look at corporate communications and monitoring different organizational tactics, it really becomes a business function vs. the classic E&M [evaluation and management] coding type of issue," he explains.

Al Josephs, director of corporate compliance at Hillcrest Health System in Waco, TX, says that is why he does not think compliance officers necessarily will be part of that corporate-level corrective activity. While Josephs has a financial background, he notes that most compliance officers do not possess the same experience. Rather than assume responsibility for those areas, he says, compliance officers often are more likely to become involved in the internal control process for review of financials.

John Harrison, corporate compliance officer at TMC HealthCare in Tucson, AZ, says that is how the upheaval in the private sector is affecting his responsibilities. He says he is looking at an expanded internal audit function, and deciding who should determine the agenda for the audit committee and what resources that might require. He also is trying to assess how vigilant boards should be and what role compliance should play in that regard.

Harrison says he also is branching out from an internal audit function to help the board understand its responsibilities from a financial reporting standpoint and to determine whether it follows all of its policies and procedures in areas such as pay practices.

"It reaches beyond traditional fraud and abuse," says Harrison, who reports to the audit and compliance subcommittee of the board of directors. "With all the financial reporting issues that are surfacing, the board may want somebody besides the CFO addressing financial reporting practices and disclosure," he says.

Harrison says he also is considering more education for the board on how the revenue cycle works. "Board members have to understand the exposure areas and how the auditors will go about testing that," Harrison explains. He says the company's outside consultant will likely give all board members a primer on financial information to help them understand the key risk areas in health care finance. "Compliance is a part of that because of cash flow," he says.

"The question is whether we are following our own procedures and where boards can go to look for those answers," Harrison concludes. "There may be a realization that the previous channels for information and early detection may have been inadequate given the complexity of health care today." ■

Returning overpayments

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go through the internal debate over how much to repay and when, someone might file a *qui tam* suit. Once that happens, the benefits of making a voluntary disclosure can be lost or reduced significantly.

In terms of where to report, providers basically have three places to go when they uncover an overpayment, says **Rick Ward** of the law firm Ropes and Gray in Boston. The lowest level is the intermediary, and if it is just an overpayment, that is the place to go. In most cases, overpayments can be made to the fiscal intermediary or the carrier with a check or an adjustment on the credit balance report or the cost report, he says.

If the overpayment is more complex, it may be

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necessary to go to the Department of Health and Human Services' Office of Inspector General (OIG) or the Department of Justice (DOJ), Ward says. If a hospital believes the government could reasonably make a case that there was fraud, the place to go is the U.S. Attorney, he argues, because that is where decisions about the False Claims Act will be made.

Ward says the OIG protocol for overpayment disclosure is daunting because it requires providers to explain why it may have been a violation of the law. "I would rather deal with the U.S. Attorney because it is going to end up there anyway if it is truly a fraud case," he says. The OIG has generally allowed that, he adds.

On the other hand, Luce says, the OIG and DOJ typically do not want to handle disclosures to Medicare Fraud Control Units. "You are going to have to go to the state Medicaid Fraud Control Unit separately," he says. Hospitals also should determine if a repayment is due to private payers based on the same type of mistake where private payers paid on the same basis, he adds.

All intermediaries and carriers now have benefit integrity units, and providers must keep that in mind, says Ward. Those units are required in any unusual payback to make sure the provider explains how the overpayment was discovered, how long it has been there, what caused it, how the payback was calculated, and what was done to make sure that it will not happen again.

Those units can decide to turn an overpayment over to the OIG. But he says that most U.S. attorneys will not pursue cases that were paid back several years ago. "That is the only safe way to go, despite the fact that it is not risk-free," he says.

In terms of when to disclose, Luce says that sooner is better than later and that how far back and what to cover also are very important. "Be very clear about what timeframe was reviewed in the disclosure," he says.

According to Luce, hospitals should not stumble over 30- or 60-day requirements. "Premature disclosure is not necessarily the way you want to go," he warns. "Get the right information to them, and if you can't get to it then think about a way to make some kind of notice."

Ward says the most important timeframe is the 30 days under the False Claims Act when providers believe the overpayment was more than just an honest mistake. That is because going to the U.S. Attorney within 30 days will limit damages under the False Claims Act, and providers will face double damages instead of triple damages. "All other time limits are totally arbitrary," he says.

Another question is whether to return an overpayment if you are being investigated, says Ward. "For some reason, it is counterintuitive to most [providers] that maybe you should pay it back when the investigation is taking place," he says. "If you know you owe it, I don't see any reason why you would wait."

In terms of how far back to go, Luce says the four-year civil recoupment provision provides that, in the absence of fraud, that is the measure for determining how far back to go. There is some recent support for that position, he adds. According to Luce, the prospective payment system transfer cases have revealed a disagreement between CMS and the OIG. CMS relies on the four-year measure while the OIG wants to go back even farther.

"Don't get cute when you are making these repayments," Ward concludes. "Be candid. Tell them exactly what you did, how you did it, how far back you went and what your rationale was." ■

State laws

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will have to be done, and the question is, 'Does it have to be done on a day-by-day or moment-by-moment basis?'"

The first challenge is to understand the preemption requirements. The primary difficulty with preemption is that, as of April 14, 2003, providers, health plans, and other covered entities are going to be required to comply with the more stringent of two sets of laws, says **Mark Barnes**, a partner with Ropes and Gray in Boston and a former associate commissioner for Medicaid with the New York City Department of Health.

On one hand, there are the federal HIPAA privacy regulations, he says. On the other hand, in a variety of states and other jurisdictions such as Puerto Rico, there are laws that will to be more

stringent than the HIPAA laws.

"The bottom line is that providers are really given a free pass on neither side," he says. "They are really going to have to comply with the toughest parts of both laws." According to Barnes, this means that in terms of pre-emption analyses and HIPAA compliance program development, state laws must be taken into account as fully as the federal laws.

Goldberg points out that there also are several exceptions for state law that the Department of Health and Human Services Secretary can determine are necessary to prevent fraud and abuse or ensure appropriate state regulation of insurance and health plans, for state reporting on health care delivery or other purposes, or for laws that address controlled substances.

Goldberg says the most problematic are the state laws that relate to the privacy of individually identifiable health information as provided for by related provisions of the act that are contrary to and more stringent than the federal requirements. "This has created a tremendous tension in that there are 54 jurisdictions involved in an analysis of HIPAA," he asserts.

Goldberg says it is important to be sensitive to the interrelationship of the other federal laws and the interrelationship of state laws that might seemingly be in conflict in terms of their force and effect on the state level. "That is going to create some tension as well, particularly when legislative law and common law differ," he explains.

According to Barnes, coverage varies dramatically from state to state. Many states such as Massachusetts, New York, and California already have rigorous state laws governing the confidentiality of medical information. ■

Cost reports and home health still under scrutiny

Tenet Healthcare Corp. subsidiary Lifemark Hospitals of Florida agreed to pay the government $29 million to resolve allegations that the hospital submitted false claims for Medicare home health services between 1994 to 1997, the Department of Justice announced July 17. Lifemark, which does business as Palmetto General Hospital in Hialeah, FL, was acquired by Tenet in March 1995.

The government contended the claims were based on false, fraudulent, and misleading statements or omissions regarding the patient's medical condition, history, and/or eligibility for coverage by Medicare. It also alleged that the hospital's submissions included claims for services that were not reimbursable by Medicare because they were not rendered; were provided by unskilled, unlicensed, or uncertified personnel; were based upon insufficient, forged, or missing documents; or were never ordered by a physician.

The government also alleged that certain cost reports Palmetto submitted between 1994 and 1997 improperly maximized its Medicare reimbursements through various means, including the reclassification of the costs of one of the home health agencies to the other two and the misallocation of certain capital-related, operating, nursing administration, cafeteria, and social services costs.

In a separate settlement dealing with the issue of cost reports, Catholic Healthcare West and its affiliate Mercy Healthcare Sacramento last month agreed to pay $8.5 million to settle allegations that it along with 13 of its hospitals defrauded Medicare by filing false cost reports.

This case involved not only reserve cost reports but an insider who brought a *qui tam* action, notes former federal prosecutor **Robert Salcido**, now with Akin Gump in Washington, DC. "I think that continues to be a red flag," he says. "One suit triggers the notion in many people's minds about circumstances they are confronting, which trigger more lawsuits."

In this case, the government alleged that the hospitals kept two sets of books, one for government auditors and a second "reserve" or "booked" set hidden from the government that identified the unallowable and inflated costs included in the filed cost reports, according to assistant U.S. attorney John Vincent of the Eastern District of California.

The government also alleged that the hospitals established undisclosed reserves, setting aside funds to repay the government in case the unallowable costs were eventually discovered. The government also alleged that fraudulent submissions were made to the Medicaid and TRICARE/CHAMPUS programs. ■