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Supreme Court may reign in False Claims Act

Circuit court decisions may compel the high court to act, says qui tam expert

The Supreme Court is set to hear arguments next month on the issue of whether municipal entities are immune from False Claims Act (FCA) suits brought by *qui tam* relators. The outcome could have a significant impact on state and local hospitals.

While the court's decision will directly affect local government and quasi-government entities, it also will be closely watched by private entities subject to FCA enforcement, including health care providers, which have been the primary focus of the act, says FCA expert **John Boese**.

According to Boese, of Fried Frank in Washington, DC, the Department of Justice (DOJ) maintains that the federal government is free to sue state and local governments under the FCA, even though a majority of the Supreme Court held in the *Stevens* case two years ago that states are not "persons" subject to such suits when they are filed by *qui tam* relators. He points out that two district courts have held that municipalities are not "persons" subject to liability under the act, even if it is the DOJ alone that initiates the suit.

In the first Department of Justice suit against a county defendant, Boese says the court deferred

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Five steps to limit your risk as a compliance officer

As compliance officers assume a higher-profile role in hospitals, their personal liability also is increasing. However, specific techniques and strategies can minimize that liability, not necessarily at the expense of their employer.

Christopher Ideker, a partner with Ernst & Young in Atlanta, says that while compliance officers can never completely eliminate the conflict of interest or personal liability inherent in their position, they can manage that risk using a range of strategies.

Among the measures he recommends are the following:

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False Claims Act

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judgment on the matter until after the Supreme Court issued its ruling in the *Stevens* case. In *Stevens*, the court ruled that states and state entities are not "persons" subject to liability under the FCA.

In an unpublished opinion that now is awaiting decision in an appeal to the Sixth Circuit, Boese says the district court held that it lacked jurisdiction over the DOJ's FCA claims, because the county is not a person subject to liability under the act.

Like the majority of courts considering *qui tam* cases against county entities, Boese says the court held that counties are immune from FCA liability because the act's damages are essentially punitive, and municipalities are immune from punitive liability. He adds that most courts have dismissed *qui tam* cases on that basis.

While the DOJ has tried to limit the focus in the upcoming case to qui tam cases against county entities, Boese predicts that several other decisions may encourage the Supreme Court to take a broader look at the status of county entities as "persons," just as it did when deciding the status of states in the *Stevens* case just two years ago. ■

New CMS advance notice mandates pose risk

The Centers for Medicare & Medicaid Services (CMS) is warning providers that they must use new Advance Beneficiary Notice (ABN) forms in connection with claims submitted for reimbursement under Medicare Part B. The use of the old ABNs or modified ABNs may not be effective to protect the providers from financial liability, warns **Mary Ellen Allen**, a health care attorney with Foley and Lardner in Los Angeles.

According to Allen, failure to comply with the Medicare rules concerning the use and execution of an ABN creates exposure to numerous risks, including financial liability, and even allegations of fraud and abuse or violation of other Medicare provisions.

An ABN is a written notice given by providers to Medicare beneficiaries before services or items are furnished, notifying beneficiaries that it is likely Medicare will deny payment for that specific service or item, and the reason for the expected denial. The ABN informs the beneficiary that they will be personally and fully responsible for payment if (as expected) Medicare denies payment.

There are two new ABN forms. One form (CMS-R-131-G) is the "general-use" ABN. The other, form (CMS-R-131-L) is designed for use with laboratory tests, including physician-ordered laboratory tests. Laboratories also may use the general ABN form.

Allen says the ABN must identify the specific service or item for which denial is expected and clearly state the reason a Medicare denial is expected. The reason for expected denial may be customized to list the most frequent reasons for denial, she adds, such as if Medicare does not pay for this item or service for a specific condition.

Listing multiple reasons which apply under different circumstances, however, without indicating which reasons apply in the beneficiary's particular case, may render the ABN defective, she cautions.

According to Allen, the CMS guidance highlights several risk areas in implementing the new ABNs, including routine use of ABNs, generic ABNs, and blanket ABNs. "Routine" use of ABNs means providing ABNs to beneficiaries where

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there is no specific reason to expect that the item or service will be denied by Medicare. "Generic" ABNs are ABNs that simply indicate that Medicare denial of payment is possible, or that one never knows whether Medicare will pay or not. "Blanket" ABNs are ABNs that are given for all items or services.

"As a general rule, routinely given ABNs, generic ABNs, and blanket ABNs are considered to be defective notices and provide no protection from liability," she says.

Copies of the approved forms are available in PDF format, at http://cms.hhs.gov/medicare/bni. ■

Limiting risk

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I. Investigate the position before you accept the job. Ideker says compliance officers should become familiar with the company's past history and their response to investigations before accepting a new position. "You have to know the reputation of the company and the community," he warns. Two questions to ask: Are they committed to doing the right thing? Is compliance part of their orientation when hiring new employees?

Recent or anticipated mergers and acquisitions also can be a key factor, he adds. "When you buy a company, you buy their problems," says Ideker. "I had a Department of Justice attorney once tell me that she didn't need whistle-blowers; all she needed was to read *The Wall Street Journal* and find out who was buying who."

II. Understand the role of management. According to Ideker, it is important to understand the organizational structure and the role management plays in compliance. He says compliance officers should speak directly with the CEO to gauge their level of commitment to integrating compliance into the company's mission. That includes what type of infrastructure will be established as well as compensation.

"I believe that measurements in compensation drive behavior," he says. While compliance officers typically will not receive a commitment on precisely what will be spent on compliance, they should get a commitment that their views will be considered strongly.

III. Set ground rules with your employer. Ideker says compliance officers should examine the scope of their duties. Depending on the job description, they may be responsible for compliance, or compliance and internal audit, or compliance and quality control. All of these schemes can work, he maintains, but compliance officers must understand which arrangement it will be.

IV. Ensure proper budgeting. Ideker says the biggest problem he often finds is underfunded plans." He says one way to secure adequate funding is to point out areas where the organization can make additional money through effective compliance. "Point out areas where correcting documentation shortfalls would have led to more reimbursement," he says. "Those are good stories to tell, and it helps make you part of that team. It shows them your value and ensures proper funding."

V. Assess reporting requirements. According to Ideker, compliance officers should be wary of the knee-jerk tendency to report to the CEO. Rather, he says compliance officers should always report parallel to the people who are expected to comply.

Regardless of the arrangement, however, Ideker says compliance officers must have direct access to the governing body and the CEO. That should be documented, he adds. "In any corporate governance litigation you might have downstream, this is your ultimate hammer, but use it sparingly," he advises.

"I think being tightly integrated with operations is the key to compliance," concludes Ideker. "The more you make it a staff function instead of an integrated operational strategy, the less chance of success you will have." ■

Four steps to minimize successor liability

Acquiring a health care organization means acquiring its fraud and abuse liabilities, and limiting that risk is no easy task, says **Joseph Truhe**, general counsel at Eisenhower Medical Center in Rancho Mirage, CA. He says the distinction between ordinary business conduct and fraud and abuse often is too subtle to be detected by the type of due diligence that typically would take place in other industries.

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"A review of basic corporate documents is not going to tell you that there is a coding problem or that there are subtle arrangements to induce referral," Truhe remarked at a Practising Law Institute conference in Washington DC, when he was corporate counsel for Children's National Medical Center in Washington, DC.

His first caution is not to let the lawyers perform due diligence alone. "Attorneys have the tendency to take the biggest due-diligence checklist that is floating around the office and then take all of the checklists they have acquired and add them all together," he warns. "That is a bad sign if that is how it is being done."

Instead, he says attorneys should sit down with senior and middle managers who have a working knowledge of the corporate, clinical, and financial details of the target entity and plan due diligence thoroughly. "Your client and counsel are going to have entirely different resources and competencies in trying to identify what needs to be examined," he warns. "Counsels are not qualified to detect problematic claims profiles."

Truhe also recommends designing the initial request for information in a way that maintains the flexibility to ask for several rounds of documents as the process unfolds. "It is a process, and you have to listen to the answers you get to figure out where to go next," he says. "Just like litigation, you can't follow a predetermined script."

Truhe recommends that providers work backwards. "Ask yourself what would you have to look at and who would you have to talk to in order to find out that they were upcoding pneumonia," he says. "You will be surprised as you go through that mental process how far beyond ordinary due diligence material staff will get you."

Truhe also suggests these four steps:

I. Look in nontraditional places. Focus your attention on department-level policy, not corporate-level policy, because the information needed usually is found in the day-to-day policy sitting in front an accounts receivable person. Truhe says that review should include summary financial data, credit balances, cash balances, volumes of late charge, delayed credits, and re-billings, as well as department performance reviews.

II. Probe the information services department. Truhe says it is important to examine the target's information services department, including logs with corrections and modifications in software, Truhe says. "Look for software conversions and correspondence with software vendors and you will find all the problems with the software that have been detected," he says. "My experience is that about half of all billing errors are buried somewhere in the software, and you don't discover them until somebody questions why they are getting all these denials."

III. Don't overlook human resources. According to Truhe, it is important to scrutinize human resources, including recent personnel changes that look out of the ordinary, training materials for the compliance program, financial policies, as well as the qualifications of the people who handle coding and billing and other sensitive processing. "Look at their human resource folders as if you were a Joint Commission on Accreditation of Healthcare Organizations (JCAHO) examiner coming in to look at documents and competence," he says. "If those qualifications look suspect, the likelihood that something is being done wrong is that much greater."

IV. Examine the compliance plans. Truhe says it is important to pay close attention to the compliance plan of the target. "The longer an effective and vigorous plan has been in effect, the more likely it is going to be that anything you discover after the acquisition will be defended as an innocent mistake that escaped the efforts of a vigorous compliance program," he says. "That way, your exposure will only be repayment or a voluntary disclosure and not treble damages."

Truhe says it's important to look beyond the compliance plan and code of conduct. "Those can be purchased off the shelf and put right back on the shelf."

In addition, he says it is important to review the audit schedule as well. "Even if they successfully keep you from looking at the compliance report itself, they can certainly tell you what their audit schedule has been since their original baseline audit and what they have looked at," says Truhe. He says that will show how vigorous their compliance plan has been and help assess its credibility.

Due diligence does not end after the acquisition, Truhe cautions. "Do a baseline audit immediately after the acquisition so that you can cut short the exposure from the prior activity, and if you find anything that is a problem, go to the government while you are still innocent," he advises. ■