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Providers face new arsenal of anti-fraud weapons

Attorneys offer tips for responding to new breed of government investigations

The most alarming anti-fraud development facing hospitals is a growing arsenal of weapons wielded by the federal government and state investigators, warns **Lou Pichini**, a health care attorney with Deloitte & Touche in Philadelphia and former head of the U.S. Attorney's Office criminal division in Philadelphia.

Pichini says the FBI and other enforcement agencies are increasingly shifting resources from organized crime and public corruption to health care. "That is happening not only with respect to the FBI, but other agencies," asserts Pichini. "It has created a highly regulated arena."

Chief among the new weapons employed by those agencies is the Health Insurance Portability and Accountability Act subpoena power that federal prosecutors now possess on top of their already existing grand jury subpoena power, says Pichini.

Assistant U.S. attorneys can now issue those subpoenas without the use of a grand jury. "That is an additional weapon to conduct these investigations," he explains.

Pichini says the result of the growing emphasis on health care fraud is that civil divisions are no longer the stepchild in U.S. Attorney's offices. That has led to a new trend called "parallel proceedings" between the two divisions, with the civil division now on equal footing with the criminal division.

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Nursing home plan focuses on quality-of-care issues

The Department of Health and Human Services' Office of Inspector General (OIG) released its final compliance plan for nursing homes earlier this month. Experts say the final plan includes mostly subtle changes from the draft, which introduced a heavy emphasis on quality-of-care issues.

Howard Sollins of the Baltimore-based Ober Kaler, says long-term care providers should pay close attention to the government's increased scrutiny of those quality-of-care issues. "The

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How to deal effectively with fiscal intermediaries

There is no shortage of potential pitfalls when hospitals deal with Medicare fiscal intermediaries — and no shortage of suggested methods for dealing with those problems, says health care attorney **Dennis Barry**, a partner with the Washington, DC-based firm Vinson & Elkins.

Barry's initial advice to hospitals is that, when they make a disclosure, they should be less concerned with minimizing their False Claim Act exposure by reporting it within 30 days than they are with accurately assessing the situation. "What I find a lot more important than counting days is getting the facts right," he asserts. "There have been occasions when it turned out [that] there was not even an overpayment, yet some people were ready to slice their veins in the U.S. Attorney's office."

Most of the time, the government does not penalize disclosures, adds Barry. Settlements reported in the Department of Health and Human Services' Office of Inspector General's (OIG) semi-annual

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New weapons

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"Believe it or not, you have attorneys who are working together, and what they do is double-team you," says Pichini. "They have a civil attorney and a criminal attorney working the same investigation. That way, they get more bang for their buck and they wind up with a greater intensity."

That is not the only growing threat facing health care providers, according to **Eugene Tillman** of the Washington, DC-based law firm of Reed, Smith, Shaw & McClay. Determining whether to make a voluntary disclosure is another area that carries growing risks, he warns.

"There is a major dispute between the private bar and the government over whether the mere fact of nondisclosure constitutes an independent criminal offense," says Tillman.

Pichini argues that mere knowledge of a criminal offense that is not disclosed does not create an independent violation. But he says he was "mildly shocked" to hear his former colleague, Philadelphia-based assistant U.S. Attorney Jim Sheehan, take the opposite position.

Sheehan argued that, depending on subsequent action on the part of the provider, the nondisclosure may become criminal. "I don't think that theory has ever been tested, but it is something to be aware of," warns Pichini. "This is territory in which you are really walking on quicksand."

It is easy enough to establish a list of policies and procedures for responding to government investigations, but according to Tillman, things are rarely that simple.

"It tends to sound neat and clean and clinical," he says, "but investigations are anything but predictable, and anything but the type of experience that lends itself to a cookbook approach."

On the other hand, Tillman says there are certain principles that companies can follow, so there are at least some guideposts along that path. According to Tillman, internal discoveries, such as thorough self-audits, often create an inherent tension. "It is important to realize that internal discoveries can lead to government investigations as a result of voluntary disclosures or whistle-blowers." Sometimes those internal discoveries are the result of what Tillman ironically refers to as "post-acquisition due diligence."

"It is not at all unusual that companies that do inadequate due diligence on the front end discover serious issues as integration takes place. Worse yet, government investigations can lead to discoveries that may or may not be the focus of the government's investigation.

"Be ready, but don't overreact," cautions Pichini. "If you are prepared for it, you will be able to react with the proper strategy and control you need to maintain your credibility," he says. "That is one of the most important things you can do."

Pichini and Tillman also recommend these steps:

- **Maintain control of the sensitive documents you have in your possession and make sure they are properly restricted.** "You may have a *qui tam* relator on your premises, which is almost like having an insider wearing a body recorder," warns Pichini.
- **Establish written procedures beforehand because it is difficult, if not impossible, to do so in the context of an investigation.** Tillman says employees require guidance, and suggests that guidance should be included in the company's compliance program and compliance training.
- **Evaluate all requests for documents carefully.** Tillman advises that counsel should determine the legal basis for a subpoena to determine whether there are appropriate and responsible objections, including that it is too broad in scope or beyond the authority of the agency making the request. ■

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Fiscal intermediaries

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reports arising from provider self-disclosures appear to be settled on the basis of an overpayment with interest that tends to be less than double damages, he says.

Here is a rundown of some of the most hotly contested areas between hospitals and intermediaries, and Barry's advice for managing those situations:

♦ **Routine supply charges.** According to Barry, routine supply charges, which Medicare lumps in with routine room and board, are suddenly coming under the scrutiny of many intermediaries. "They are going into hospitals and challenging hospitals that are charging for what they call routine supplies," he reports.

He says some intermediaries have published lists of the supplies that they deem to be routine and those that should be included in the ancillary cost center medical supplies charge.

Under the intermediary's theory, if a hospital finds that it has used routine supplies in its outpatient area, it probably has some claims that have been improperly charged. "Do you have a cost reimbursement problem?" he asks. "This is a complicated area, but often my answer is no."

If the charges for routine supplies had been applied uniformly, then removing those charges from both the Medicare and total charge statistics should leave the net cost reimbursement amount unchanged unless there is a "lower cost or charges" issue.

"Believe it or not, even though you have been charging incorrectly, you have not, when the cost report gets filed and settled, been overpaid," Barry asserts. "You probably have not even been overpaid on an interim basis because your interim rate is based upon last year's cost report and you have the same charge structure in last year's cost report."

♦ **Is any overpayment too small to return?** As a practical matter, Barry says there are certain overpayments that the government will conclude are not worth collecting. "They will never say that there is a *de minimus* threshold, I can guarantee that," he adds. But, he notes, even to appeal a case to the Provider Reimbursement Board, there is a $10,000 threshold.

♦ **Stark violations.** Barry says it is not uncommon to find possible self-referral violations where there are financial relationships between hospitals and physicians or between other entities and physicians, where physicians are making referrals for designated health services. But when hospitals discover there is a "clear violation" of the Stark law, the repercussions are too awful to imagine, he asserts.

"The consequence of that determination is that all of the services ordered by the physician with whom you have the financial relationship are not Medicare-covered," says Barry. He says the good news is that the government appears to be relaxing those interpretations before the Stark II regulations become final in May. "But at some point Stark is going to be a real problem for us," he cautions. "The government is really going to start enforcing this law."

♦ **Medical directors.** Suppose a hospital is paying a physician a fee of $400,000 a year, and that person shows up for an hour a year to collect the check. The hospital has a 10-year binding contract, but tells the physician the contract violates the law and therefore is void as a matter of public policy.

"This is a valid defense to a contract that violates the illegal remuneration statute," argues Barry. "The problem is that the government applies the same theory to illegal remuneration as it does to Stark." He says the government will maintain that if a hospital files a claim for services that had been ordered by a physician who is being paid illegal remuneration, the hospital is filing a false claim and the services are not covered.

"This is something to consider the next time you file suit against a physician because you want to break a contract that you feel violates the illegal remuneration statute," he warns. "I don't think you are going to get hammered by the government for trying to do the right thing, but it is certainly something to put into the equation."

♦ **Is any overpayment too old to return?** Barry says that confusion often surfaces when a hospital discovers an overpayment that is more or less ancient history. "Under the Medicare reopening rules, you can only reopen a cost report within three years after the initial date of program reimbursement; but as a practical matter, that is a five-year period," says Barry, "because it usually takes two years for a cost report to be settled."

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According to Barry, claims can be reopened within four years of the adjudication date for the claim. "That is when you get paid or when the hospital receives the remittance advice," he says. But the government tends to be sloppy about that, and treats some claims issues as cost report issues, he adds.

"In my view, if it is beyond that reopening period, you are entitled to the money because it is not an overpayment unless somebody in the organization knew about this within the reopening period and sat on it," he explains.

♦ **What if the amount of the overpayment is unclear?** According to Barry, another frequent problem is that an overpayment is discovered but the amount is uncertain, such as self-administered drugs billed to Medicare Part B. "You can't pick a revenue code and pull this off the computer system because the same revenue code was used to bill for covered drugs," Barry explains. "The only way to get at this is to go into the claims."

But then the question arises over whether the hospital has an affirmative obligation to go into all those claims for either the claims reopening period or the cost report reopening period. "You are talking an incredible volume of work," warns Barry. "I am sure that some vendors would be happy to argue for using that approach, but this is a situation where you ought to use a sampling approach." He says hospitals may even want to consult the intermediary beforehand to work out a mutually acceptable approach. ■

Nursing home plan

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guidance highlights the agency's major focus on quality of care and its relationship to regulatory compliance," he asserts. "Especially noteworthy are the OIG's recommendations on the implementation of systems to measure resident outcomes."

He also points to the plan's emphasis on monitoring and screening employees, including temporary employees.

In addition, Sollins says the OIG is very concerned about the accuracy of billing and coding, especially as consolidated billing for those facilities draws near. "Relationships with outside vendors will need to be scrutinized closely," he warns.

Among the recommendations included in the guidance are these items:

♦ Make sure there is a comprehensive, accurate assessment of each resident's functional capacity and a comprehensive care plan that includes measurable objectives to meet residents' medical, mental and psychosocial needs.

♦ Refrain from discriminatory admissions or improper denial of care, verbal, mental or physical abuse, corporal punishment, and involuntary seclusion, as well as inappropriate use of physical or chemical restraints.

♦ Investigate the background of employees by checking with all applicable licensing and certification authorities to verify that requisite licenses and certifications are in order.

♦ Refrain from routinely waiving coinsurance or deductible amounts without a good-faith determination that the resident is in financial need.

♦ Maintain all records and documentation, including billing and claims information, that are required for participation in federal, state and private health care programs, including the resident assessment instrument, the comprehensive plan of care, and all corrective actions taken in response to surveys.

The complete nursing facility guidance is available at www.hhs.gov. ■

OIG: No conflict in private billing arrangement

In its first advisory opinion of the year, the Department of Health and Human Services' Office of Inspector General (OIG) has determined that a consulting firm's potential arrangements for auditing services associated with private payers do not constitute grounds for sanctions under the anti-kickback statute because the arrangement does not involve federal health care program business. In addition, the principal activity under the arrangement is a one-time retrospective billing audit, the OIG found.

But **Dan Mulholland**, a partner with Horty, Springer & Mattern in Pittsburgh, warns that the opinion was looking only at a potential violation under the anti-kickback statute and not exposure under the False Claims Act because advisory opinions are limited to the question asked by the provider. ■