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Some Compliance Programs May Fail To Reduce the Risks of False Claims

Hospitals put themselves in the line of false-claims fire when they don't act on information that could identify billing errors or update their compliance programs in response to new enforcement activities, a federal prosecutor says.

"I often hear compliance officers talk in the following language as it relates to right versus wrong: Conduct is characterized as either intentional fraud or inadvertent overbilling, as if there is nothing in between. But there is a range of conduct between inadvertent good-faith mistakes and criminal wrongdoing — and that is the False Claims Act," says Assistant U.S. Attorney Robert Trusiak, head of the national kyphoplasty admission-necessity enforcement initiative. "Unless they recognize there is a breadth of misconduct between them, compliance programs are not doing what they should be doing, which is in part mitigating their liability under the False Claims Act," he tells *RMC*.

This mutually exclusive thinking is riskier in the new enforcement environment that includes the 2009 Fraud Enforcement and Recovery Act, which makes it a violation of the False Claims Act to knowingly retain Medicare overpayments; the health reform law requiring the return of Medicare and Medicaid overpayments within 60 days of identifying them; and the rise in Medicare and Medicaid reviewers, such as recovery audit contractors (RACs) and zone program integrity contractors (ZPICs).

The Department of Justice has its eye on billing errors identified by program-integrity contractors. When auditors identify billing errors, they go back only so far in the hospital's billing history. RACs, for example, have a CMS-mandated three-year "look-back" period. But investigators may follow the trail of bread crumbs further back in time, says Trusiak, who is chief of the affirmative civil enforcement unit in the U.S. Attorney's Office for the Western District of New York. "An argument can be made that the hospital avoided repayment" because it did not audit a billing error identified by a RAC or ZPIC for times that predated the audit, he says. It's not a tough case for the Department of Justice to make, he says: "You had to repay this money so you knew there were incorrect claims submissions, but didn't undertake the pedestrian step of getting back to the billing misconduct and addressing it. The compliance program that doesn't grasp the realities of the multitude of RAC and ZPIC audits is leaving that hospital exposed to False Claims Act liability," he says.

Given developments like the new law and its interface with the audits, compliance programs should be "regularly and critically analyzed to assure [their] continued reliability in the same way we check our smoke detector batteries every fall when we turn back our clocks," Trusiak says.

Hospitals Are Obligated to Interpret Outliers

The standard of proof for an FCA case is reckless disregard or deliberate ignorance, which fall along the continuum between innocent errors and criminal behavior. For example, if hospitals receive information that their billing is way out of line, the government expects them to act on it. The Program for Evaluating Payment Patterns Electronic Reports (PEPPERs) are free quarterly reports generated by CMS that compare hospital billing in the state, Medicare administrative contractor (MAC) jurisdiction and country in certain risk areas. When hospitals are outliers in a risk area, they are expected to audit medical records and find out if there's a compliance problem or a reasonable explanation (RMC 9/12/11, p. 1).

"To the extent the hospital is always on the high end of the PEPPER report, does that mean there is False Claims Act liability? Of course not," Trusiak says. "But a hospital needs to police the PEPPER reports" and has an obligation to assess, analyze and explain billing outliers.

"Compliance programs have to do more than say 'we won't take kickbacks or employ excluded people,'" Trusiak says.

Compliance officers often think it's the Department of Justice that judges hospital conduct in a bilateral way — fraud versus errors, says Washington, D.C., attorney

Heidi Sorensen, with Foley & Lardner LLP. While compliance officers generally understand the gray area in between and are well-versed in the concepts of reckless disregard and deliberate ignorance, they worry that the government doesn't appreciate Medicare's complexity and applies the False Claims Act where it doesn't belong, she says.

"One thing that concerns the provider community is the difficulty in impressing on folks who haven't worked in the industry that it's not always as black and white as some DOJ attorneys might perceive it to be. It's a reflection of the background of folks who come from different perspectives," says Sorensen, former chief of the HHS Office of Inspector General's administrative and civil recoveries branch. Since counsel for providers and government attorneys don't tend to walk a mile in each other's shoes, however, they may continue to "disagree factually," she says.

Four Angles for Updating Compliance Programs

Trusiak encourages compliance officers to use their compliance programs as a shield against the False Claims Act. That means keeping compliance programs "dynamic," he says, and critically assessing them to:

(1) Keep up with current enforcement efforts. Compliance programs shouldn't focus only on early targets, such as DRG window unbundling and Physicians at Teaching Hospitals. "Any compliance program seeking to avoid false claims liability better audit areas of current liability. So if DOJ is addressing site of service, you better audit site of service," Trusiak says. In addition to site of service (i.e., medical necessity of admissions versus observation), hospitals may want to be aware of the liability risks stemming from nonemployed physicians.

(2) Account for statutory changes. For example, "FERA was very powerful" because of its "expansion of reverse false claims," he says. "This change ensures if a facility is aware of an overpayment and conceals it and knowingly and improperly avoids it, then it may be liable under the False Claims Act."

(3) Insert compliance into some decisions about new service lines. "The decision whether to permit physicians to employ new procedures is a multi-faceted process, including clinical and financial considerations. The inclusion of the compliance officer will help ensure the institutional provider credits the clinical considerations in addition to the legitimate cost and reimbursement considerations," Trusiak says.

(4) Make sure the compliance program accurately defines the conduct it seeks to guard against, including the False Claims Act.

Some compliance officers continue to overlook the potential for false claims cases because their hospital didn't set out to commit fraud, Trusiak says. "Many people misapprehend the type of conduct that can be problematic for their facility — good-faith mistakes versus fraud — but if it's reckless or deliberately ignorant it can implicate the False Claims Act," he asserts. He cites the example of a hospital he investigated for emergency department upcoding. For three years in a row, the hospital coded at the highest level for all ED visits that culminated in admissions. Then the coding went back to normal — a bell curve — for a year before spiking again. It turned out the highest-level codes were the work of one coder who had the weird idea that ED patients should be coded at the highest-level evaluation and management service if they were later admitted as inpatients. The reason ED coding was normal for a year was the coder had a baby and went on maternity leave. Although the coder made an innocent mistake — she implemented a coding "rule" she learned, and misinterpreted, at a conference — the hospital neglected to identify the problem and fix it. "If you recklessly assign codes contrary to CPT rules, that may imply recklessness," Trusiak says. "The compliance plan needs to address that." The hospital wound up settling a false claims case with the U.S. attorney's office.

Sorensen doubts there is a wealth of false-claims fodder in RAC, ZPIC and other Medicare and Medicaid reviews. There's often a reason why hospitals don't audit all historical claims that potentially have the same billing errors. The RAC audit may have identified noncompliance with a new coding rule that took effect, for example, in 2008. Consequently, there wouldn't be any reason to look back further than 2008. Plus the reopening period for Medicare, absent fraud, is four years, and the False Claims Act statute of limitations is six years. "There isn't always going to be False Claims Act liability," she says. Sometimes, though, the hospital identifies a long-term problem when it conducts a root-cause analysis to get to the heart of a problem identified by a Medicare or Medicaid auditor, she notes. In that case, the provider is going to want to audit a longer time period than the RAC or ZPIC initially identified.

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