NATIONAL ASSOCIATION OF
Community Health Centers

Important Content Note:

This technical assistance resource was developed prior to the August 2017 release of the Health Center Compliance Manual by the Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care (BPHC). The BPHC Compliance Manual, issued August 2017, indicates where PINS, PALs and other program guidance are now superseded or subsumed by the BPHC Compliance Manual.

See: https://bphc.hrsa.gov/programrequirements/pdf/healthcentercompliancemanual.pdf

NATIONAL ASSOCIATION OF Community Health Centers

RM

Information Bulletin #17

Updated January 2016

Billing and False Claims: Hot Issues and Potential Exposures

Coding, documentation, and billing of claims submitted to federal health care programs for payment or reimbursement for health care services constitute one of the most significant risk areas for any health center.

This Information Bulletin:

- Reviews key risk areas for liability that involve billing and false claims;
- Highlights amendments to the False Claims Act which are likely to increase state and federal enforcement activities related to false claims;
- Makes several recommendations for health centers that wish to incorporate billing and false claims risk areas into existing compliance programs.

POTENTIAL RISK AREAS

To assist health care providers, the Office of Inspector General ("OIG"), a component of the U.S. Department of Health and Human Services ("DHHS"), has published compliance program guidance for the health care industry that identifies risk areas for fraud and abuse in federal health care programs.[1] The OIG has identified four potential risk areas for individual and small group physician practices:

- Coding and billing
- Reasonable and necessary services

In this information bulletin of the National Association of Community Health Centers (NACHC), the term "health center" refers to public or private nonprofit entities that: (1) receive grants under Section 330 of the Public Health Service Act (Section 330), including Sections 330(e), 330(f), 330(g) and 330(h) (collectively "Health Center Program Grantees"); and (2) entities that have been determined by the Department of Health and Human Services (DHHS) to meet the requirements to receive funding without actually receiving a grant ("health center look-alikes").

1 Department of Health and Human Services, Office of Inspector General, OIG Compliance Program for Individual and Small Group Physician Practices, (Oct. 5, 2000).

- Documentation
- Improper inducements, kickbacks, and self-referrals

In addition to compliance program guidance, the OIG publishes other documents throughout the year, such as its work plan, advisory opinions, and fraud alerts. Taken together, these documents allow providers to identify trends and priorities in government enforcement of the fraud and abuse laws.

WHAT IS A FALSE CLAIM?

The Federal False Claims Act

The Federal False Claims Act ("FCA" or "Act") is a law that prohibits the making of a false claim or statement to any federal employee or officer to obtain money.[2]

A false claim is:

- A fraudulent claim for payment to the U.S. government,
- A false record or statement that is used to support a claim approved for payment.

The FCA applies to any request or demand for money or property that the federal government wholly or partially provides. This includes claims for reimbursement from federal health care programs, including Medicare and Medicaid. In addition, health centers should recognize that any false statements on applications or reports related to funding under Section 330 of the Public Health Service Act could give rise to a false claims action.

In general, a billing error or honest mistake does not constitute a false claim under the Act. Typically, a false claim requires actual knowledge that the claim or statement is false. However, a false claim can also exist when the claim is made with deliberate ignorance or reckless disregard of the claim's truth or falsity. For example, a health center manager that assigns a billing function to an untrained clerk may be said to have acted in reckless disregard of the claim's truth or falsity. The lack of intent of the health center manager to make a false claim does not excuse the health center.

Because of the broad reach of the FCA, the Act is arguably the federal government's most potent weapon in combating fraud and abuse. Under the Act:

1. A health care provider may be fined up to $11,000 per claim, plus damages calculated as three times the amount that was falsely claimed,[3] and
2. The provider can be excluded from participating in federal health care programs.

On May 20, 2009, President Obama signed Public Law No. 111-21, the Fraud Enforcement and Recovery Act of 2009 ("FERA"). FERA significantly expanded the scope of the FCA. FERA removed the threshold for liability under the FCA requiring that the false claim be submitted to a federal employee or officer and the requirement that a false record or statement be made to obtain money from the Government—the threshold for liability for a false record or statement is now that the false record or statement be "material" to a false claim.

In the health care context, whereas the FCA previously applied to any request or demand for money or property that the federal government wholly or partially provides, the changes effectuated by FERA mean that the FCA reaches requests for payment or reimbursement submitted to intermediaries, such as Medicaid Managed Care Organizations, Medicare Advantage Organizations, and Medicare Prescription

2 31 U.S.C. § 3729-3733.

3 31 U.S.C. § 3729(a)(1)

Drug Plans. FCA liability may even attach if the record or statement is material to a claim for which the federal government would pay in part, even if the person or entity did not know that the claim would be submitted for payment by the federal government.[4]

Furthermore, the Patient Protection and Affordable Care Act of 2010 (the "Affordable Care Act") codified that health care providers that do not report and return overpayments in a timely manner have an obligation to the federal government for purposes of the FCA. This law defines an overpayment as Medicare or Medicaid funds to which, after applicable reconciliation, the provider is not entitled, and requires the provide to return and report such overpayment by the later of sixty days from identification of the overpayment or the date the applicable cost report is due.

The Affordable Care Act does not define when an overpayment is considered "identified". It can take a couple of months for the existence of an overpayment to be confirmed and the amount of an overpayment to be quantified. In some cases, it can take even longer where it is possible to calculate an amount that could have been appropriately paid to the health center and deduct that amount from the overpayment. It is not clear whether the clock starts running for the sixty day time period at the point the potential overpayment is identified or at the point the overpayment amount is confirmed and quantified. Thus, health centers should develop internal processes to move quickly once any potential overpayment is identified so that both confirmation and quantification of an overpayment occur within the sixty-day time period.

Based on these trends, health centers should develop internal processes to move quickly once any potential overpayment is identified so that both confirmation and quantification of an overpayment occur within the sixty-day time period.

Qui Tam Actions

Under the FCA's qui tam provisions (also known as "whistleblower" provisions), a private individual, including, but not limited to, any health center employee, contractor, patient, or agent who has knowledge of a violation can initiate an action under FCA. Under the standard set forth by the Affordable Care Act, a whistleblower may bring suit if he or she voluntarily provides information to the Government prior to public disclosure of that information or if the relator's knowledge is independent of, and materially adds to, publicly disclosed information.

When a whistleblower suit is filed, the Government may decide to take over the case, but, if it declines to do so, the whistleblower still may pursue the suit. A whistleblower who prevails may qualify for 15 to 30 percent of the amount recovered on the Government's behalf, depending on whether the Government intervened in the case, as well as attorney's fees and costs.

The FCA has long prohibited employers from retaliating against employees who file or participate in the prosecution of a whistleblower suit. FERA further extends the FCA's whistleblower protections to contractors and agents who suffer retaliation as a result of their filing or participating in the prosecution of a whistleblower suit. Relief from retaliation can include: "reinstatement with the same seniority status that employee, contractor, or agent would have had but for the discrimination, two times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees."[5]

4 This provision overturns the Supreme Court case, *Allison Engine Co. v. United States ex rel. Sanders,* 128 S. Ct. 2123 (2008), where the Court held that FCA liability did not attach where the person submitting the false claim intended only to defraud a government contractor, not the government.

5 31 U.S.C. § 3730(h).

State False Claims Laws

Health centers are increasingly at risk under state false claims laws for making a false claim or statement to any state employee or officer to obtain money. Moreover, state false claims laws would likely apply not only to claims involving the Medicaid program, but would also likely apply to health care programs exclusively funded by states, such as state health care programs that provide insurance coverage to uninsured adults who do not qualify for Medicaid or state pharmaceutical assistance programs (SPAPs). Each state law will vary and therefore health centers are cautioned to review their own state's FCA.

AREAS OF POTENTIAL FALSE CLAIMS EXPOSURES FOR HEALTH CENTERS

Because a false statement supporting a claim for payment can just as easily constitute a violation of the False Claims Act as a false claim itself, a broad range of conduct comes within the definition of a "false claim." For this reason, some types of false claims are easy to spot, such as billing for care that was not provided or coding services at a higher reimbursement level than what was actually provided. In contrast, other types of false claims are more subtle, such as billing for care under another provider's number or billing for care that is ineligible for reimbursement due to an underlying regulatory violation, i.e., a violation of the Stark Law.

On the basis of government trends and priorities, this section reviews high-risk areas relevant to health centers that involve false claims and billing.

Billing and Coding Fraud

Billing and coding fraud are the basis for many false claims suits. The OIG regards these issues as high-risk for fraud and abuse. Examples of billing and coding fraud include:

- **Insufficient documentation**

  Example: A health center submits a claim for reimbursement for services rendered to a patient but does not document the services in the medical record. Because the medical record must document services rendered, this billing may constitute a false claim.

- **Double billing for the same service**

  Example: A health center submits a claim for reimbursement for an office visit provided by a contracted health care practitioner and the contracted health care practitioner also submits a claim for reimbursement for the same office visit. Because two bills were submitted for the same service, this billing may constitute a false claim.

- **Billing under another provider's number**

  Example: A health center submits a claim for reimbursement under one practitioner's number when the service was actually provided by another practitioner. Because the practitioner's number is a false statement used to obtain payment from a federal program, the billing may constitute a false claim.

- **Billing for care that was not provided**

  Example: A health center submits a claim for reimbursement for a physician office visit when the patient was only seen by a nurse. Because physician services were not provided, the billing may constitute a false claim.

- **Not following billing rules**

  Example: Recently a health center paid $3.65 million to settle allegations that it submitted false Medicaid claims for dental services to children. At issue were fluoride treatments that the health center billed as stand-alone appointments with a dentist or hygienist at the FQHC encounter rate. The state asserted that the fluoride treatments did not require the skills of a dentist or hygienist and therefore did not qualify for the encounter rate. The state also alleged that in billing for the appointments, the health center exceed the number of dental exams allowed per patient under Medicaid and the health center did not document the findings of such exams or that the exams were actually performed.

- **Not having a reasonable degree of knowledge about Medicare billing rules and regulations.**

  Example: A court held a dentist liable under the FCA when the dentist billed for oral cancer examinations that were performed as part of routine dental screenings.[6] Under applicable billing rules, the cancer examinations were reimbursable to the dentist only if the exam was requested by an attending physician, not as part of routine dental screenings. The court found that a dentist acted in reckless disregard of the truth or falsity of the claims submitted to Medicare because the dentist should have had a reasonable degree of knowledge about Medicare billing rules and regulations.

- **Improper inducements, kickbacks and self-referrals**

  The federal government has also used the FCA to prosecute violations of other federal laws or regulations, such as the Anti-Kickback Statute and the Stark Physician Self-Referral Law (Stark Law). Because claims for payment under federal health care programs often require providers to certify that they are in compliance with all health care laws, regulations and program instructions, the federal government contends that a claim is false if the underlying claim is prohibited under another federal law or regulation.

  Example: In *McNutt v. Haleyville Medical Supply, Inc.*, a former employee of a medical supply company brought a whistleblower action under the FCA, and the federal government intervened.[7] The government alleged that the supply company's arrangements violated the Anti-Kickback Statute, and because (1) the supply company later submitted claims to Medicare for reimbursement for services, and (2) those claims falsely certified their compliance with Anti-Kickback Statute as required as a condition of payment by their Medicare provider agreements, the claims were a violation of the FCA. The U.S. Court of Appeals for the Eleventh Circuit held that the government had alleged a valid claim against the supply company. The Court stated that "when a violator of government regulations is ineligible to participate in a government program and that violator persists in presenting claims for payment that violator knows the government does not owe, the violator is liable, under the Act, for its submission of those false claims."[8] In sum, the Court found that a violation of the Anti-Kickback Statute can form the basis of an FCA claim. Because the Affordable Care Act codified in law that claims resulting from violations of the Anti-Kickback Statute are false claims for purposes of the FCA, violations of the Anti-Kickback Statute will automatically be viewed as false claims.

6 *United States v. Lorenzo,* 768 F.Supp. 1120 (E.D. Pa. 1991).

7 423 F.3d 1256 (11th Cir. 2005).

8 423 F.3d at 1259.

Treatment by Providers who were Excluded, Unlicensed, or Uncredentialed

Excluded Providers

A false claim exists when a health centers bills for services provided by providers who are excluded from participation in federal health care programs, including Medicare, Medicaid, and Children's Health Insurance Programs (CHIP). Health centers should recognize that providers may be excluded from participation in federal health care programs not only for fraud, but also for failure to repay student medical loans.

Accordingly, health centers should ensure that individuals employed or contracted by the health center are regularly checked against the OIG's list of excluded providers available online at: http://www.oig.hhs.gov/ fraud/exclusions.html

Unlicensed or Non-Credentialed Providers

A false claim also exists when a health center bills for services provided by an unlicensed or un-credentialed provider. *Example*: A health center hires a new physician whose license is pending in the state in which the health center is located. Because a valid provider license is a prerequisite for reimbursement for services, the health center's billing for that physician's services would constitute a false claim.

A false claim may also arise if a health center bills for services that, under state law, exceeds the license of a non-independent professional. For example, if a state were to define the term "direct supervision" to require a physician to examine the patient after completion of work by a non-independent professional, the failure to document the physician's examination can be tantamount to failing to meeting this requirement. Accordingly, the health center's submission of a claim for the services may constitute a false claim.

Medicaid Fraud

State Medicaid agencies have long been authorized to withhold payments in cases of fraud or willful misrepresentation. Section 6402(h)(2) of the Affordable Care Act now prevents state Medicaid programs, absent good cause, from receiving federal financial support in cases where they fail to suspend Medicaid payments to a provider for which there is a pending investigation of a credible allegation of fraud. Because federal financial support may be denied if states fail to suspend Medicaid payments, health centers should be aware that payment suspension authority is likely to be used more frequently than in the past.

Legal Standard: "Credible Allegations of Fraud"

On February 2, 2011, the Centers for Medicare and Medicaid Services ("CMS") modified its prior regulations (See 52 F.R. 48814, Dec. 28, 1987, creating final regulations at 42 C.F.R. § 455.23 and, more recently, 76 F.R. 5862). The new regulations incorporate new terminology from the Affordable Care Act.

The term "credible allegation of fraud" is defined by regulation as an allegation, which has been verified by a state, from any source, including, but not limited to the following: (1) a fraud hotline complaint; (2) claims data mining; or (3) patterns identified through provider audits, civil false claims cases and law enforcement investigations.

For purposes of Medicaid program integrity, the definition of fraud is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. Notably, it includes any act that constitutes fraud under applicable federal or state law, such as the Federal False Claims Act.

Allegations are considered to be credible when they have indicia of reliability and the state Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis. The regulations do not contain a definition of the term "indicia of reliability."

Notice of Payment Suspension to Providers

Unlike payment recoupments that arise from billing errors found in audits, state Medicaid agencies may suspend payments without first notifying the provider of its intention to suspend such payments. Thereafter, a state must notify the provider within five days of the suspension unless requested in writing by a law enforcement agency to temporarily withhold such notice.

If law enforcement requests such a delay, the notice can be postponed for 30, 60, or 90 days. CMS provided states with the ability to delay notice if an investigation is at a sensitive stage, involving undercover personnel or a confidential informant, where notification to the provider might jeopardize the investigation.

Referrals to Medicaid Fraud Control Units

Whenever a state Medicaid agency investigation leads to the initiation of a payment suspension, the state Medicaid agency must make a fraud referral to either a Medicaid Fraud Control Unit (MFCU) or appropriate law enforcement agency. If the MFCU or other law enforcement agency accepts the fraud referral for investigation, the state must request, on a quarterly basis, a certification from the MFCU or law enforcement agency that any matter accepted on the basis of a referral continues to be under investigation thus warranting continuation of the suspension. This is to ensure that timely investigations occur of any suspected fraud and that suspensions end after a law enforcement agency closes an investigation but neglects to alert a state Medicaid agency of that fact.

Good Cause Exception to Suspend Payments

In certain circumstances, the state Medicaid agency may elect not to suspend payments to a provider if good cause exists. Good cause is defined as any of six situations.

(1) Law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation.

(2) Other available remedies implemented by the state more effectively or quickly protect Medicaid funds.

(3) The state determines, based upon the submission of written evidence by the provider that is subject of the suspension, that the suspension should be removed.

(4) Recipient access to items or services would be jeopardized by a payment suspension because an individual or entity is the sole community physician or the sole source of essential specialized services in a community or the individual or entity serves a large number of recipients within a Health Resources and Services Administration designated medically underserved area.

(5) Law enforcement declines to certify that a matter continues to be under investigation.

(6) The Medicaid agency determines that payment suspension is not in the best interests of the Medicaid program.

Termination of Payment Suspensions

The regulations describe all payment suspensions as temporary, requiring them to terminate if the prosecuting agencies determine that there is insufficient evidence of fraud by the provider or legal proceedings related to the provider's alleged fraud are terminated. Given that fraud investigations by enforcement agencies tend to be lengthy, these temporary periods may actually go on for many months since the regulation permits the payment suspension to continue until such time as the investigation and any associated enforcement proceedings are completed.

In light of the significant financial harm that can result from payment suspensions, health centers that have their payments suspended should immediately seek the advice of qualified counsel to determine their rights to appeal the suspension under state law, conduct an investigation to determine the precise types of claims that have triggered the payment suspension, and seek to narrow payment suspensions to the fewest types of claims as possible.

INCORPORATING BILLING AND FALSE CLAIMS IN CORPORATE COMPLIANCE PROGRAM

When a health center considers relevant risk areas related to billing and false claims, the center should:

1. Identify and prioritize risk areas for internal compliance audits and related corporate compliance training;

2. Incorporate the risk areas in all aspects the health center's corporate compliance program and policy development;

3. Consider conducting a compliance audit to determine whether the procedures are being followed;

4. If not, then incorporate findings into the health center's compliance work plan. For example, a health center may need to provide additional employee education sessions, or take corrective action.

5. Design (or redesign) a compliance program around the areas most at risk for government enforcement.

By taking those steps, health centers can both improve compliance with regulatory requirements, as well as reduce the risk of liability under state and federal fraud and abuse laws.

This Information Bulletin was written for NACHC by:

Adam J. Falcone, Esq.

Feldesman Tucker Leifer Fidell LLP

Washington, D.C.

For information about these bulletins, contact:

Betsy Vieth at NACHC at bvieth@nachc.com

NATIONAL ASSOCIATION OF
Community Health Centers

7501 Wisconsin Avenue, Suite 1100W

Bethesda, MD 20814

Telephone: 301-347-0400

Fax: 301/347-0459

Website: www.nachc.com