



RISK MANAGEMENT SERIES

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Billing and False Claims: Hot Issues and Potential Exposures

Health centers are expected to maintain risk management programs that pro-actively identify and plan for potential and actual risks to the health center.¹ In developing a successful risk management program, one of the most important steps is identifying and prioritizing key risk areas. Because health centers operate within a highly regulated industry, many of the key risk areas for liability involve fraud and abuse in government-funded health care programs.

Based on recent OIG publications, this Information Bulletin:

- ◆ Reviews key risk areas for liability that involve billing and false claims;
- ◆ Highlights provisions in the recently enacted Deficit Reduction Act of 2005 (DRA)² 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 branch of the U.S. Department of Health and Human Services (DHHS), has published compliance program guidance for the health care industry that

1 Bureau of Primary Health Care, *Health Center Program Expectations*, Policy Information Notice (PIN) # 98-23 (Aug. 17, 1998), p. 32. The different types of risk categories are defined and highlighted more fully in the NACHC Information Bulletin Risk Management Series #1, *An Introduction to Risk Management Concepts*, and the implementation of risk management programs are discussed more fully in NACHC Information Bulletin Risk Management Series #2, *Implementing a Risk Management Program For Your Health Center*. Readers can obtain copies of these bulletins from the NACHC website at www.nachc.com (under Publications) or by calling the NACHC Publications Department at (301) 347-0400.

2 Public Law No. 109-171.

identifies risk areas for fraud and abuse in federal health care programs.³ For example, the OIG has identified four potential risk areas for individual and small group physician practices:

- ◆ Coding and billing
- ◆ Reasonable and necessary services
- ◆ Documentation
- ◆ Improper inducements, kick-backs, and self-referrals⁴

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. Based on these trends, health centers can focus their risk management programs on the key areas of regulatory compliance in which they face potential liability.⁵

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WHAT IS A FALSE CLAIM?

The Federal False Claims Act

The Federal False Claims Act (the FCA or the Act) is a law that prohibits the making of a false claim or statement to any federal employee or officer to obtain money.⁶

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 fed-

eral health care programs, including Medicare, Medicaid, and Section 330 grants.

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; and
2. The provider can be excluded from participating in federal health care programs.

In 2005, the federal government initiated 537 criminal actions and 262 civil actions under the FCA that resulted in the exclusion of 3,806 individuals and entities from participation in federal health care programs. The fines can also be substantial. In 2003, the U.S. Department of Justice recovered \$2.1 billion under the Act. In 2005, the government expected to recover \$1.8 billion.

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

4 *Id.*

5 Assessing risk should also involve examining internal areas of vulnerability that have been identified in prior financial audits, government investigations, and internal compliance reviews.

6 31 U.S.C. § 3729-3733.

Qui Tam Actions

Unlike other laws, the False Claims Act allows private individuals to bring false claims actions in the name of the government, the so-called *qui tam* actions. This means:

any health center employee, contractor, or agent who has personal knowledge of a violation can initiate an action under the Act.

To create incentives for individuals to bring *qui tam* actions, these individuals are rewarded with as much as 25% of the recovery from a successful claim. Moreover, such individuals are protected from retribution by their employer under whistleblower provisions in the False Claims Act.

For many health care providers, the risk of *qui tam* actions will increase beginning January 1, 2007 due to a provision in the DRA that requires health care providers to educate employees about *qui tam* actions and whistleblower protections. The DRA requires entities that annually receive at least \$5 million in Medicaid payments to:

- ◆ Establish written policies and procedures for all employees, contractors, and agents about the organization's protocols for fraud and abuse detection and prevention;
- ◆ Inform them about the federal False Claims Act, any state false claims laws, and whistleblower protections;⁷ and

- ◆ Include a specific discussion of these policies and procedures, related laws and whistleblower protections in its employee handbook.

The DRA fraud and abuse requirements are discussed in more detail below.

State False Claims Laws

Many states do not have state laws equivalent to the federal False Claims Act that allow *qui tam* actions and contain whistleblower protections. Consequently, Congress included provisions in the DRA to create economic incentives for states to pass their own false claims laws or to strengthen existing false claims laws.⁸ States that have false claims laws that are at least as stringent as the FCA will be entitled to keep an additional 10 percent of any Medicaid recovery rather than turning that 10 percent over to the federal government.

To qualify for the additional Medicaid recovery, the state false claims statute must prohibit the same type of conduct and impose the same penalty (if not greater) as the federal law, as well as permit *qui tam* actions. At this point, only fifteen states and the District of Columbia have false claims laws that meet this federal standard. However, as states adopt new false claims laws (or strengthen existing ones) that include financial incentives to individuals who bring suit against providers, state health care

enforcement actions are likely to rise.

Accordingly, 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 probably 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 (which may currently be under revision, to meet the DRA deadline of January 1, 2007).

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

7 Section 6033, Deficit Reduction Act of 2005, Pub. L. No. 109-171.

8 Section 6032, Deficit Reduction Act of 2005, Pub. L. No. 109-171.

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 a laboratory test for a patient whose medical record does not present any risk factors for the particular condition the test is designed to detect. Because the medical record must document medical necessity, this billing constitutes 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 provider and the contracted health care provider also submits a claim for reimbursement for the same office visit. Because two bills were submitted for the same service, this billing constitutes a false claim.

Example: A health center submits Medicaid claims for FQHC per-visit rate for primary care services based on allowable costs which includes costs to provide dental services. However, the health center bills the Medicaid fee-for-service (FFS) program for dental services provided to patients. Because the per-visit rate includes the costs for dental services, the health center is billing twice for the same service when it bills the FFS program separately for dental services (unless the State carves dental services out of the per-visit rate).

◆ Billing under Another Provider's Number

Example: A health center submits a claim for reimbursement under one provider's number when the service was actually provided by another provider. Because the provider's number is a false statement used to obtain payment from a Federal program, the billing constitutes a false claim. It is no justification that a provider left precipitously, leaving the health center without a provider with a valid provider number.

◆ 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 physician assistant. Because physician services were not provided, the billing constitutes a false claim.

◆ Not Following Billing Rules

Example: A health center submits a

claim for reimbursement under multiple procedure codes when the official coding guidelines indicate that a single code should be used. Because some of the procedure codes were not permitted to be billed, the billing of those codes constitutes a false claim.

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

Example: A court recently held a non-health center dentist liable under the FCA when the dentist billed for oral cancer examinations that were performed as part of routine dental screenings.⁹ 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

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

instructions, the federal government contends that a claim is false if the underlying claim is prohibited under another federal law or regulation.

Example: A health center contracts with a vendor to provide diagnostic laboratory services. The laboratory offers a discount based on the volume of services the health center refers to it. If the OIG or other authorized enforcement agency concludes that the arrangement constitutes an illegal inducement under the Anti-Kickback Statute, insofar as the provider has been found not in compliance with all health care laws, the billing of the laboratory services could constitute a false claim.¹⁰

Federal courts have supported the government's application of the FCA to prosecute improper inducements, kickbacks, and self-referrals.

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.¹¹ 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 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."¹² In sum, the Court found that a violation of the Anti-Kickback Statute can form the basis of an FCA claim.

The OIG also regards violations of the Stark Law and the Anti-Kickback Statute as a false claim. On April 24, 2006, the OIG issued "An Open Letter to Health Care Providers" discussing a new initiative that promotes use of the OIG's Provider Self-Disclosure Protocol (SDP) for resolving penalties the OIG can levy under the civil monetary penalties (CMP) law¹³ for billings done in violation of the Stark Physician Self-Referral Law and the Anti-Kickback Statute. This letter confirms that the OIG intends to use its authority under the CMP law to enforce the Stark Law and Anti-Kickback Statute.

Treatment by Providers who were Excluded, Unlicensed, or Uncredentialed

Excluded Providers

A false claim exists when a health center bills for services provided by providers who are excluded from participation in federal health care programs, including Medicare, Medicaid, and State Children's Health Insurance Programs (SCHIP). 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.

In FY 2006, the OIG intends to conduct two audits in this area.

1. The OIG will quantify the extent to which Medicare services are provided by physicians excluded from participation in federal health care programs.
2. The OIG will determine if states have improperly claimed federal financial participation (FFP) under the Medicaid program for providers who have been excluded from participation.

This is an area of high risk for health centers not only because of the OIG's audit of Medicare services but also because the OIG's audit of states is likely to result in many states conducting their own audits of providers in this area. Accordingly, health centers should ensure that physicians employed or contracted by the health center are

10 On the other hand, such an arrangement may be subject to the new health center safe harbor enacted by Congress on December 8, 2003 if the health center is a Section 330 grantee and relevant safe harbor standards are met. See 42 U.S.C. § 1320a-7b(3)(H); 70 Fed. Reg. 38088 (July 1, 2005).

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

12 423 F.3d at 1259.

13 42 U.S.C. § 1320a-7a.

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 uncredentialed 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.

In FY 2006, the OIG intends to conduct an audit to determine if improper or ineligible claims for physician assistant reimbursement have been made to Medicaid. The OIG states that many doctors' offices employ physician assistants, particularly in areas where doctors are difficult to recruit. However, in order to claim Medicaid reimbursement 1) the physician assistants must be enrolled as non-billing providers, 2) claims by the physician assistants must be submitted by the employing physician or physician group, and 3) the employing physician or physician group must directly supervise the physician assistants.

Example: A health center employs a physician assistant to see patients. Although the physician assistant is

enrolled as a non-billing provider, there was no direct supervision by a physician. Consequently, the billing constitutes 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 could constitute a false claim.

False Statements on Grant Applications, Cost Reports

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 FY 2006, the OIG indicates that it will evaluate oversight by the Health Resources and Services Administration (HRSA) of grants to community health centers.** OIG indicated that it will review the nature and extent of HRSA's review of reports submitted by health center grantees and the actions taken by HRSA as a result of its reviews.

Entities that Fail to Educate Employees on False Claims and Compliance Programs

As discussed above, effective January 1, 2007, the DRA requires entities that receive at least \$5 million in Medicaid payments to establish written policies and procedures for all employees, contractors, and agents about the organization's protocols for fraud and abuse detection and prevention as well as to inform them about the Federal False Claims Act, any state false claims laws, and whistleblower protections.¹⁴ In addition, entities must include a specific discussion of those policies and procedures and those laws and whistleblower protections in any employee handbook.

This requirement is a "condition of payment" – any entity that does not comply with this requirement may not be entitled to payment and therefore could be liable under the FCA for submitting false claims. Accordingly, health centers that receive at least \$5 million in Medicaid payments should:

- ◆ Ensure that they have developed written policies and procedures that cover each of the types of risk, and
- ◆ Review their compliance policies and procedures as well as any employee handbook to assure that they meet the requirements established in the DRA for educating employees on false claims, whistleblower protections, and its corporate compliance pro-

¹⁴ Section 6033, Deficit Reduction Act of 2005, Pub. L. No. 109-171.

gram, *e.g.*, to assure that they explain the FCA, any state false claims law (which may be under revision at the present time), and whistleblower protections against retaliation.¹⁵

Medicaid Fraud

The DRA established a new program to prevent and detect Medicaid fraud and abuse called the Medicaid Integrity Program.¹⁶ Under the new program, the Centers for Medicare and Medicaid (CMS) will contract with private entities to:

- ◆ Review the actions of individuals and entities that provide Medicaid services to determine whether fraud, waste, or abuse has occurred, or is likely to occur, and whether such actions have the potential to increase Medicaid expenditures;
- ◆ Audit claims, cost reports, consulting contracts, and risk contracts to managed care entities that pay for Medicaid items and services;
- ◆ Identify overpayments to individuals or entities receiving Federal matching payments; and
- ◆ Educate providers, managed care entities, beneficiaries, and other individuals on payment integrity and quality of care.

Under the DRA, Congress authorized funding for the Medicaid Integrity Program in the amount of \$5 million for FY 2006, \$50 million for 2007 and 2008, and \$75 million for 2009 and thereafter. Moreover, Congress authorized funds to CMS to hire an additional 100 FTEs to perform reviews and audit Medicaid providers.

As a result of the new federal resources devoted to detecting Medicaid fraud and abuse, Medicaid regulatory compliance is now an even higher risk area than before. Health centers, which receive a significant portion of their revenue from Medicaid, should ensure that claims and cost reports submitted for Medicaid payment comply with their state's billing rules and cost report requirements.

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.

Because of the allocation of significant new federal resources to detect and prevent Medicaid fraud under the DRA, health centers should expect an increase in enforcement activities by both state and the federal governments related to Medicaid fraud and abuse. Health centers should plan accordingly:

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.

15 For guidance on updating compliance programs after passage of the Deficit Reduction Act, see "More Compliance Sticks and Carrots: The Deficit Reduction Act of 2005", (Issue Brief #87), July 2006, available online at <http://www.nachc.com/pubmgr/Files/issuebrief87.pdf>.

16 Section 6035, Deficit Reduction Act of 2005, Pub. L. No. 109-171. Congress also increased existing funding for Medicaid Fraud Control Units ("MFCUs") by \$25 million between 2006 and 2010.



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