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The value of an IT background

an interview with Trish Manna

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COLUMNS

DEPARTMENTS

by Joan W. Feldman, Esq.

Reducing the risk of False Claims Act *qui tam* actions

» All alleged false claim complaints should be taken seriously.
» Respond to the complaint in a timely manner.
» Develop a plan and timeline for the investigation.
» Keep complainant(s) informed and report results of the investigation to them.
» Keep clear documentation as to the analysis and process followed.

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Under the Federal False Claims Act (FCA), the presentation of a false claim for payment to the federal government can result in significant liability for providers participating in government-payer programs such as Medicare or Medicaid. Liability for false claims submitted to a state's Medicaid program can also result in false claims liability pursuant to state or federal law.

Feldman

Liability typically arises one of two ways: (1) the government itself brings an FCA action against the provider; or (2) a private individual(s) brings an FCA action (known as a *qui tam* or whistleblower claim) against a provider on behalf of the government.[1] In the event that the government pursues an FCA *qui tam* action brought by a whistleblower, the individual claimant gets to share between 15% and 25% of the government's recovery.[2] Given the financial incentives to share in the government's recovery, it should come as no surprise that the number of FCA *qui tam* actions being brought against healthcare providers is on the rise.[3,4]

Ironically, many of these FCA actions are brought by individuals who are either wholly or partially responsible for the alleged FCA liability or conversely, wholly or partially responsible for addressing the perceived FCA issue. Unfortunately, their involvement or responsibility for the issue does not preclude them from participating in the recovery. Although there is no particular set of facts that is more likely than others to result in a FCA *qui tam* action, the decision to bring an action on behalf of the government, rather than to try to address or resolve the matter internally, may be motivated by a number of factors, such as: (1) personal gain if the FCA *qui tam* action is successful; (2) internal conflict between the claimant and management; (3) the claimant's frustration and/or anger because the perceived problem is not taken seriously or responded to in a timely manner by the provider; and/or (4) the claimant hopes to be shielded from losing their job, vis-à-vis the non-retaliation laws intended to protect whistleblowers.

Regardless of why the action is brought or whether the FCA *qui tam* action has any

merit, the fact that an action is brought is likely to have a number of negative consequences for the provider. At the very least, the provider will likely be subject to an extended and intensive government investigation that will undoubtedly result in the incurrence of significant legal expense. In addition to the legal expense, if the claim does have merit, the provider could also potentially be liable to the government for civil penalties, and the amount will vary depending upon the dates of the violation and the assessment. For example, for a civil penalty assessed after February 3, 2017, whose associated violation occurred after November 2, 2015, a provider would be liable to the government for a civil penalty of not less than $10,957 and not more than $21,916 per claim, along with (the possibility of) treble damages assessed by the government for each claim.[5]

...many FCA *qui tam* actions arise because the provider failed to follow through after identifying a problem.

The aforementioned consequences are on top of the reputational damage and the impact it may have on the provider's staff, morale, and resources. Thus, prevention of these potential claims before they occur should be considered an important risk-avoidance strategy. The following is an example of what can happen if compliance concerns are not fully addressed in a timely manner.

Scenario

An internal auditor conducts a medical record review and identifies minor documentation deficiencies relating to previously submitted Medicaid claims. These findings are brought to management's attention, but management does not believe that these documentation issues are material enough to constitute an overpayment from Medicaid. Management decides not to refund the money received for the claims and implements a corrective action plan to address these documentation deficiencies on a prospective basis. The employee involved in the audit strongly disagrees with this decision and believes the payments received should be returned to the government. In response to the employee's persistent concerns, management brings in a third-party expert to review the issue, and the expert agrees that the documentation deficiencies do not constitute overpayments. However, this information from the independent expert is not communicated to the employee, who continues to consider these documentation deficiencies to be overpayments. One year later, the employee brings a FCA *qui tam* action that results in four years of government investigation and significant legal expense for the provider.

Discussion

Although there is no question that having an effective corporate compliance program is essential for all providers that participate in government payer programs, many FCA *qui tam* actions arise because the provider failed to follow through after identifying a problem. Failure to properly follow through in resolving the issue creates an opportunity for a disgruntled or frustrated employee to retaliate or attempt to correct a perceived wrong. Thus, while it may be obvious to most that there should be a defined process for timely responding to an error or regulatory

issue whenever such an issue is identified, most FCA *qui tam* actions are brought because there was not an adequate plan for addressing these potential false claim issues.

To minimize risk of a FCA *qui tam* action, providers should have a defined and clear process (or policy) for identifying and responding to potential FCA compliance issues. The response process should require that any issue that could potentially result in a FCA action be reported simultaneously to the corporate Compliance Office, along with a designated member of senior executive leadership, to ensure corporate accountability. Additionally, some providers may decide to report such issues to an Audit Committee of the provider's board. Such notice should include the plan for investigation and review, the timeline for corrective action (if indicated) and, if no corrective action is necessary, the clear written rationale for why no action is indicated. The corporate compliance officer and/or the senior executive should then have the responsibility for ensuring that the timeline for investigating, reporting, and addressing the issue(s) is strictly adhered to. The timeliness of the response is critical, because failure to refund an actual overpayment to a government payer program within 60 days of when the overpayment was identified can result in what is commonly referred to as "reverse false claims liability."[6]

If the review is conducted in a timely manner, but there is lack of consensus or agreement with respect to the resolution, the individual with the dissenting opinion should not be ignored. Those who do not agree with the resolution should be consulted, and if consensus is still not reached, timely consultation with a qualified third-party expert or the government payer itself is advisable. If a third-party expert is consulted, that feedback should be shared with the individual who still believes there is a compliance issue. Reconciliation to the extent feasible is important and, if reconciliation is impossible, clear documentation of the issue and possible consultation with the government payer is advisable to mitigate the risk of a FCA *qui tam* action. Providers do not always know that there is disagreement with their handling of a potential FCA issue. Hence, good documentation of the investigation and the rationale for a decision not to refund reimbursement is the best protection if an FCA *qui tam* action is brought. Consultation with qualified healthcare counsel for a recommendation regarding resolution of the matter can also afford the provider additional protection.

Conclusion

The mere fact that you took all of these steps to prevent an FCA *qui tam* action does not mean that you will prevent one from occurring. However, taking these steps and documenting everything the provider did and the reasons for such action will likely mitigate the risk of the government pursuing the FCA action. In particular, documentation should be maintained by the provider in a memorandum to the file with an explanation of the issue, how it was addressed, when it was addressed, and the reasons for taking or not taking action. This should be a worthwhile investment of time, because memories tend to fade over time.

1. See 31 U.S.C. § 3730.
2. See 31 U.S.C. § 3730(d).
3. U.S. Department of Justice, Office of Public Affairs press release: "Justice Department Recovers Over $4.7 Billion from False Claims Act Cases in Fiscal Year 2016" December 14, 2016. Available at http://bit.ly/2pIjnmb.
4. U.S. Department of Justice, Civil Division: "Fraud Statistics – Overview, October 1, 1987 - September 30, 2016" December 13, 2016. Available at http://bit.ly/2pHNIOP.
5. 28 C.F.R. § 85.5; see also 31 U.S.C. § 3729(a)(1).
6. See 42 U.S.C. § 1320a-7k(d).