Health Care Reform

Enhances Fraud and Abuse Laws

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The Patient Protection and Affordable Care Act (H.R. 3590), signed into law on March 23, 2010, contains new fraud and abuse provisions. Some of the key fraud and abuse provisions include:

- Requires all providers to implement compliance programs. The U.S. Department of Health and Human Services (HHS) will develop core elements for inclusion in a compliance program.
- Requires providers to report and return overpayments within 60 days of identifying the overpayment (or the date any corresponding cost report is due). Providers must state in writing the reason for the overpayment. Clarifies that an overpayment retained after the deadline for reporting and returning the overpayment is an "obligation" for purposes of the False Claims Act (FCA). Under the FCA, any provider who knowingly retains an overpayment can face civil prosecution.
- Allows HHS to impose Civil Monetary Penalties, including exclusion on any individual or entity that:
  - knows of an overpayment and does not report or return the overpayment;
  - knowingly makes a false statement, omission or misrepresentation of material fact in any application, agreement, bid or contract to participate or enroll in a federal health care program; and
  - fails to grant timely access to the Office of Inspector General for the purpose of audits, investigations, evaluations or other statutory functions.
- Clarifies that services performed and billed as a result of kickbacks are false claims under the FCA. Revises the intent requirement of the Ant-Kickback Statute so that a person need not have actual knowledge of the statute or specific intent to commit a violation of the statute.
- Allows the Centers for Medicare and Medicaid Services to suspend Medicare payments to providers pending an investigation of a credible allegation of fraud against the provider.
- Requires long-term care facilities receiving at least $10,000 in federal funds to report to HHS and one or more law enforcement entities where the facility is located any reasonable suspicion of a crime against a resident. If the event giving rise to the suspicion results in serious bodily injury, the report must be made within two hours. If the event does not result in serious bodily injury, the report must be made within 24 hours. A violation of the reporting requirement can result in civil penalties up to $300,000 and exclusion.
- Requires HHS to screen all providers and suppliers, including advanced screening procedures for certain types of at-risk providers and suppliers.
- Requires HHS to establish within six months a self-disclosure protocol for Stark violations.
- Expands the Recovery Audit Contractor program to Medicaid.

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The Reconciliation Bill, which the U.S. Senate has yet to vote on, includes the following fraud and abuse provisions:

- Permits the IRS to share tax return information with HHS to help screen and identify fraudulent providers.
- Authorizes HHS to apply a 90-day payment hold on Medicare claims from Durable Medical Equipment providers in cases where HHS concludes there are significant risks for fraud.

The Act also increases funding to fight fraud and abuse. With the new provisions and increased funding, providers should anticipate an increase in government audits and investigations. To avoid the potentially ruinous consequences of an audit or investigation, providers should review and strengthen their compliance programs.

If you have any questions about fraud and abuse laws, please contact Robert Cochran at (614) 462-2248 or rcochran@szd.com or any member of SZD's Health Care Practice Group.