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Client Alert

Life Sciences Health Industry

Identification of Overpayments: A Win for DOJ Cautions 'Prosecutorial Discretion' in Enforcement of an 'Unforgiving Rule'

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On August 3, 2015, the Southern District of New York issued the first judicial opinion interpreting the Affordable Care Act's "60-Day Overpayment Rule"[1] in a False Claims Act ("FCA") case. In a clear win for the Department of Justice ("DOJ"), the court denied the defendant hospitals' motion to dismiss in *Kane v. Healthfirst, Inc., et al.*,[2] and found that the government stated a claim under the FCA where the hospitals had failed to timely repay overpayments. At the center of the decision was an answer to the question, "What constitutes 'identification' of an overpayment?"

Unfortunately, the old adage proves true once again: bad facts make bad law. While the court clearly counsels against the initiation of enforcement actions aimed at well-intentioned health care providers working with reasonable haste, such policy arguments were not relevant in *Kane* based on the facts alleged. As a result, its holding does not offer the same flexibility: the 60-day clock starts ticking when a provider is "put on notice of a *potential* overpayment." Therefore, the new questions become how will DOJ respond to the court's recommendation of "prosecutorial discretion," and will whistleblowers follow suit? This is a particularly challenging issue for providers and suppliers given that the rule, once violated, cannot be cured by refunding the overpayment.

Background The 60-Day Overpayment Rule requires health care providers to report and return "identified" overpayments within 60 days. An overpayment that is retained after the 60-day deadline creates an "obligation" for purposes of FCA liability. In *Kane*, the defendant hospitals were first alerted by the New York State Comptroller's office in September 2010 to a "software glitch" that may have caused incorrect billing to New York Medicaid. In late 2010, after further discussions with the Comptroller's office and the software vendor, the defendant hospitals received a corrective software patch and tasked an employee, the

Relator, to investigate and ascertain which claims had been improperly billed. On February 4, 2011, the Relator sent an email to several members of management identifying 900 claims with erroneous billing codes, and stating that further analysis would be necessary to confirm his findings. Four days later, the Relator was terminated. While the defendant hospitals ultimately repaid the overpayments associated with the software glitch, they did not inform the Comptroller's office of the Relator's analysis, and the repayments were not completed until March 2013, with the majority being made subsequent to a Civil Investigative Demand issued in June 2012.

Overpayments Are "Identified" When Providers Are "Put On Notice of Potential Overpayments" Congress did not define the term "identified' in the ACA. The defendant hospitals argued that "identified" should mean *"classified with certainty."* By contrast, the government urged a definition that would be satisfied where a provider is "put on notice that a *certain* claim *may* have been overpaid." Ultimately, the court agreed with the government.

Relying primarily on legislative history applicable to the 2009 Fraud Enforcement and Recovery Act ("FERA") amendments to the FCA, and the consequences of adopting each party's position, the court held that overpayments are identified when providers are "put on notice of potential overpayments." More specifically, the court reasoned that Congress intended for FCA liability to attach where "there is an established duty to pay money to the government," and such an "obligation" under the FCA exists "even if the precise amount due has yet to be determined." Therefore, because an overpayment retained more than 60 days after identification creates an "obligation" under the FCA, interpreting the term "identify" as meaning "classified with certainty" would contradict Congress' intentions as expressed during the passage of the FERA amendments.

Separately, while the court recognized that the government's interpretation could impose an unworkable burden on providers, it concluded that requiring "certainty" as to the amount of an overpayment would encourage providers to deliberately ignore potential overpayments and make it all but impossible for the government to enforce the FCA. Critical to this reasoning, however, was the court's acknowledgment that "the mere existence of an 'obligation' does not establish a violation of the FCA."

"Obligations" Must Be Knowingly Concealed or Knowingly and Improperly Avoided To establish FCA liability, the government, in addition to proving the retention of an overpayment, must show that the obligation was knowingly concealed or knowingly and improperly avoided. Of course, the definition of "knowing" under the FCA includes "actual knowledge," as well as situations in which a person "acts in deliberate ignorance" or "reckless disregard." Nevertheless, the court acknowledged that a violation of the 60-Day Overpayment Rule does not automatically trigger FCA liability; in other words, the mere retention of an overpayment for more than 60 days after identification is not a de facto reverse false claim. It is in this space that the court urges "prosecutorial

discretion": where the "unforgiving" 60-Day Overpayment Rule offers no leeway or additional time to a provider, the FCA may, surprisingly, offer providers some cover from strict enforcement. In *Kane*, however, the court did not find that to be the case with the defendant hospitals based on the facts alleged.

Going Forward—DOJ's First Settlement Under the 60-Day Overpayment Rule and Awaiting CMS' Final Rule Given the facts alleged in *Kane*, questions remain regarding how its holding will apply to health care providers who diligently investigate potential overpayments but fail to comply with the strict 60-day report and repayment deadline. Unfortunately, if the only recourse available to providers is to argue that their failure to strictly comply with the 60-Day Overpayment Rule does not amount to a reverse false claim under the FCA, many providers may be forced to settle to avoid the huge consequences associated with FCA liability. For example, one day after the *Kane* decision, DOJ announced its first settlement resulting from a provider's alleged failure to promptly report and return overpayments. Pediatric Services of America and several related entities ("PSA") agreed to pay $6.88 million and enter into a corporate integrity agreement to resolve allegations that it violated the FCA by retaining credit balances on its books related to claims it had submitted to various federal health care programs, including Medicare and Medicaid. According to DOJ, some of the credit balances had been on PSA's books for several years, while others were written off or absorbed without any investigation into the reason for the credit balances. PSA cooperated with a joint audit of the credit balances and explained in a statement that the inaccurate payments were the result of a software glitch associated with a 2008 update that caused 0.8 percent of its claims to be incorrectly billed. These facts are similar to *Kane*, and therefore leave the following question unanswered: should we expect the same results where a provider's return of an identified overpayment takes several months instead of several years?

Without a clear answer to that question, it is more important than ever for providers to carefully consider any internal or external allegations of incorrect billing, and diligently investigate those allegations and document all actions taken. We also expect the Centers for Medicare & Medicaid Services ("CMS") to finalize its proposed rule regarding application of the 60-Day Overpayment Law to providers in the Medicare context, and perhaps expand the rule's scope to apply in the Medicaid context as well.[3] In February 2015, CMS decided to delay this final rule, citing "significant policy and operational issues that need to be resolved in order to address all of the issues raised by comments to the proposed rule and to ensure appropriate coordination with other government agencies."[4] While *Kane* clearly demonstrated that enforcement may proceed under the statutory provisions alone, CMS likely will want to re-emphasize its interpretation of the 60-day report and repayment deadline.

In March 2012, we published a client memorandum that analyzed CMS' proposed rule entitled, 10-Year 'Look Back' Proposed for Identification and Return of Medicare Part A and B Overpayments. Regarding the issue of the identification of

an overpayment, we wrote the following, which is worth revisiting in light of these developments:

> CMS is proposing that an overpayment is "identified" if the provider or supplier (1) has actual knowledge of the existence of the overpayment; or (2) acts in reckless disregard or deliberate ignorance of the overpayment.
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> While "actual knowledge" is self-explanatory, there is no express statutory definition of "reckless disregard" or "deliberate ignorance."[5] Providers and suppliers can reasonably expect that these vague standards will be read to require significant affirmative obligations. Thus, in the face of information that suggests an overpayment may exist (even if the chain of causation is remote), a provider would not be able to avoid repayment obligation by failing to perform activities to verify whether such overpayments exist, such as self-audits, compliance checks and other research. *[Or, in the words of the court in* Kane*, once the provider is "put on notice of potential overpayments," the 60-day clock begins to run.]*
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> In the proposed rule, CMS provides the example of an instance where a provider experiences a "significant increase in Medicare revenue [where] there is no apparent reason for the increase." Even were an audit or investigation to be made, reckless disregard or deliberate ignorance could still exist if there is a failure to conduct such inquiry with all "deliberate speed" after obtaining information (or an allegation) about a potential overpayment. 42 FR 9182 (February 16, 2012). Because overpayments can be collateral to other behavior, CMS's interpretation of this rule will likely create significant audit obligations.
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> CMS provides examples of instances when an overpayment has been "identified" and requires repayment, including instances where the provider or supplier:
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> - Reviews billing or payment records and learns that it incorrectly coded certain services, resulting in increased reimbursement.
> - Learns that a patient death occurred prior to the service date on a claim that has been submitted for payment.
> - Learns that services were provided by an unlicensed or excluded individual on its behalf.
> - Performs an internal audit and discovers that overpayments exist.
> - Is informed by a government agency of an audit that discovered a potential overpayment, and the provider or supplier fails to make a reasonable inquiry.
> - Experiences a significant increase in Medicare revenue and there is no apparent reason for the increase.

Reading the proposed rule and explanatory text in context, the 60-day period for reporting and repayment appears to begin when there is actual knowledge of an overpayment or when a reasonable inquiry reveals an overpayment. The proposed rule does not address affirmatively what constitutes a "reasonable inquiry." However, because the 60-day reporting and repayment period also may begin to run when information about an overpayment is received but "recklessly" disregarded or deliberately ignored, the threshold for what is a "reasonable inquiry" may be fairly high.

Reed Smith will publish further analysis when the final rule is released, and continue to monitor legal developments in this important area.

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1 42 U.S.C. § 1320a-7k(d).

2 No. 11 Civ. 2325 (ER) (S.D.N.Y. August 3, 2015).

3 77 Fed. Reg. 9179 (Feb. 16, 2012).

4 80 Fed. Reg. 8247 (Feb. 17, 2015).

5 There is, however, significant case law under the FCA on these standards, if we are to assume a direct corollary.