Criminal enforcement of improper health system billing

A Law Review Q&A

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As **CMS** increases its oversight of provider billing practices, the government has ramped up efforts to identify potential fraud in the Medicare program. For hospitals and health systems, federal enforcement—and corresponding recovery audits— hold significant consequences, potentially including payment denials, recoupment of overpayments, and referral to other federal agencies.

While these endeavors have resulted in a wave of False Claims Act settlements nationwide, recently the **Department of Justice** (DOJ) has taken an unprecedented action: criminal prosecution of a hospital for improper billing. If convicted of fraud in a criminal case, a provider is mandatorily excluded from participation in Medicare and other federal health programs.

We spoke with **Jesse Witten** from the firm **Drinker Biddle & Reath LLP** to highlight key legal considerations for hospitals and health systems.

1) What is the existing legal environment for investigating and identifying fraud in the Medicare program?

There are a variety of avenues by which an issue can come to the attention of regulators and law enforcement officials, more so today than in the past. One common way is through qui tam actions under the whistleblower provisions of the False Claims Act, which remains the number one source of cases for the government. The qui tam provisions aren't new, but are being used with more frequency as the government looks to clamp down on fraud and abuse.

Recovery Audit Contractors (RACs) are also required under their contracts and by law to refer possible Medicare fraud and abuse to the CMS program integrity office when matters come to their attention. Additionally, hospitals and other health care providers are subject to oversight by the Zone Program Integrity Contractors (ZPICs). CMS has rolled out the ZPIC program to investigate Medicare fraud for administrative action or referral to law enforcement. Most recently, CMS has implemented a Fraud Prevention System that includes predictive analytics for identifying improper billing.

2) What circumstances led to the recent criminal prosecution of a health system for improper billing practices?

The case was referred to DOJ by a Medicare program integrity contractor, a ZPIC predecessor. The contractor audited the hospital's inpatient claims for cardiac implant procedures and felt that most of them should have been billed as outpatient stays. DOJ interviewed employees, obtained hospital records from a subpoena, and reviewed zero-day stays— patients admitted and discharged in the same day. Based on its investigation, DOJ charged that the hospital was following an internal directive to treat all cardiac implant procedures as inpatients without regard to the wording in the physicians order. DOJ's filings in this case also indicate DOJ's belief that hospital representatives may not have fully responded to the government's investigative inquiries. In this case, and so many other cases like it, there's really no difference in the level of services provided for the patient. However, the billing practice directly impacts Medicare reimbursement for the hospital.

3) Will criminal enforcement of fraudulent provider coding have the potential to set precedent for future cases involving hospitals and health systems? Do you see this as an emerging trend?

This case appears to be the first criminal prosecution of a hospital for improper Medicare billing and I don't see it as setting a precedent for other hospitals and health systems. The consequences of a conviction under a criminal Medicare fraud case involve automatic exclusion from Medicare and Medicaid, creating a cascading set of problems for the community that the government would prefer not to trigger.

However, the risk of criminal prosecution of individuals is high and the risk is increasing. The government is most likely to pursue criminal cases against individuals where the government believes that the individual falsified or destroyed records or spoke untruthfully to investigators, or otherwise obstructed justice during the course of an investigation. What we're likely to see in the future is more aggressive action by the **Office of the Inspector General** (OIG) to exclude responsible hospital employees—including executives—from participation in Medicare and other federal health care programs following major fraud and abuse settlements.

4) Given the substantial consequences associated with a federal audit and investigation, what steps should organizations pursue to ensure compliance?

Maintaining a corporate compliance program that adheres to the OIG guidelines is critical for reducing compliance risk,and the Affordable Care Act will make compliance programs mandatory.

Additionally, legal and compliance teams should stay current on the enforcement literature, government announcements and press releases, and the latest fraud and abuse settlements nationwide. While every organization is unique, many compliance risks are not unique and an organization can learn a great deal from reading the literature about enforcement against other health systems.

In addition, a very significant risk for providers—where a civil case can easily turn into criminal prosecution—is in the response to a government investigation. It's very important that organizations retain qualified counsel to guide them through a federal investigation to ensure that the response to the government's investigation does not itself create or aggravate problems.