LEGAL CORNER

What physicians, hospital administrators, billing personnel need to know about the False Claims Act

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Unfortunately, when billing for Medicare and Medicaid patients, there exists a compendium of complex and confusing rules and regulations that the health care provider must abide by. To make sure that you will not have problems, you must ensure that employees will take care in documenting their charts and billing personnel will competently and accurately assign CPT codes. In a similar fashion, financial officers preparing cost reports must accurately reflect costs, DRG classifications and the like and must insist on accurate information in order to do so.

Adding to the complexity of billing and cost reports is increased scrutiny. Unfortunately, health care fraud and abuse is big business, costing Americans billions of dollars each year. The good news is that the federal government has shown strong signs of having "caught up" to today's health care industry realities. Broad statutory changes in fraud and abuse enforcement contained in the 1996 Health Insurance Portability and Accountability Act, new and creative uses of the False Claims Act, the potential for strong government scrutiny of physician-sponsored businesses through enforcement of the Stark Law, and the commitment of more federal funds to health care fraud prosecution efforts, all suggest a greater emphasis on federal enforcement of its health care fraud and abuse laws. When combined with the new aggressive attitudes displayed by the federal prosecutors and various state attorneys general, better coordination of information and prosecutorial efforts among federal, state, and local enforcement agencies, and, notably, the relatively new public recognition that actions brought under the federal *Qui Tam* statute can be financially rewarding to private relators, the next several years will continue to be a time of intense fraud and abuse enforcement activity.

In this context, this article is intended to arm the reader with only the most basic of framework for an understanding as to the nature and content of the Federal civil False Claims Act, the primary tool used to recover Medicare, Medicaid and CHAMPUS funds.

The False Claims Act

Currently, the overwhelming majority of civil health care fraud violations against the Medicare Program are prosecuted under the Federal False Claims Act, 31 U.S.C. Sections 3729 et. seq. The most common health care applications of the False Claims Act include, but are not limited to, the following areas: billing for services not rendered, falsification of cost reports, upcoding, double billing, unbundling, and billing for services that were not medically necessary.

Liability under the False Claims Act occurs when one "knowingly" presents or causes to be presented a false or fraudulent claim for payment or approval, a false record or statement to get a claim paid or approved, or a false or fraudulent claim or record to decrease an obligation to pay. "Knowingly" is defined as having "actual knowledge", or acts in "deliberate ignorance" or in "reckless disregard" of the truth or falsity of the information.

If a false claim is proven, the defendant is liable to the government for a civil penalty of between $5,000 and $10,000 for each claim. Each separate bill, voucher, or other "false payment demand" constitutes a separate claim for which a civil penalty may be imposed, and this is true although many such claims may be substituted to the government at one time. In addition to the stiff monetary penalty for each claim, the defendant is liable for an additional three times the amount of damages which the government sustains because of the fraud. For instance, if unwarranted charges are in the amount of $1 million, the defendant is liable for $3 million, plus civil penalties for each false claim (invoice, demand, document for payment, etc.).

Voluntary disclosure by the defendant to the government of all information concerning possible false claim within 30 days after the date on which the defendant first obtained the information may limit assessment to two times the amount of damages.

Fired Whistleblowers

The False Claims Act also contains a section which has become commonly known as the "whistleblower protection" provision. An employee who is discharged, demoted, suspended, threatened, harassed or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of the employee or others in furtherance of an action under the False Claims Act, including preliminary investigation, is entitled to special protection. The protection afforded to whistleblowers includes reinstatement with the same seniority status as such an employee would have had, but for the discrimination, two times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

War on Fraud

Honest providers need to be aware of the *Qui Tam* provisions of the False Claims Act. Other than computer audits, a disgruntled employee is a likely way in which a health care provider will be targeted. The *Qui Tam* provisions of The Federal False Claims Act allow any citizen who has knowledge of fraud that has taken place against the government to bring a civil action in Federal Court in the name of the United States under the False Claims Act. In return for his/her efforts, the citizen is entitled to share in the proceeds of the recovery, ranging from 15 percent to 30 percent of the recovery. In 1997, the top five whistleblower/relator recoveries have ranged from $1.5 to $2.7 million.

Success of *Qui Tam*

Since the 1986 amendments, *Qui Tam* suits have proven successful beyond even Congress' expectations. According to Department of Justice statistics as of October 1996, recoveries to United States Treasury as a direct result of *Qui Tam* suits are $1.83 billion. The average Relator (whistleblower) reward where there has been recovery is $1.005 million.

Conclusion

Health care providers must emphasize to their employees the importance of accurate billing and documentation. Honesty, well-documented charts and accurate billing, together with a compliance plan, is the first step to avoiding any government investigation or ultimately a False Claims Act action. The government policy is not to prosecute innocent mistakes. In fact, government prosecutors are mandated to only file False Claims Act lawsuits where the claims are "knowingly false" or filed with "deliberate ignorance" or "reckless disregard" as to the truth of falsity. If a provider is honest and accurate, the False Claims Act should not be a concern. If a provider is not honest or is inaccurate - beware; increased federal scrutiny coupled with the *Qui Tam* provisions of the False Claims Act make it likely that the dishonest providers will be caught, it just being a matter of time. ◆

(Kenneth J. Nolan, PA is a specialized law firm concentrating in Qui Tam, or Civil False Claims Act litigation and health care compliance issues.

Mr. Nolan's trial experience spans 12 years in both state and federal court. He is a member of the Florida as well the Trial Bar of the United States District Court for the Southern District of Florida, as well as other District Courts, in Florida, and other states. Mr. Nolan received degrees from Yale University and the University of Florida and is a Trial Practice Adjunct Professor at Nova Southeastern University School of Law.)