Internal investigations can be best fraud defense

Internal investigations are the best way to detect fraud in your healthcare system and can substantially reduce the fallout from any improprieties found then or later, says **J. Scott Newton**, JD, shareholder with the law firm of Baker Donelson in Jackson, MS.

The $26 million settlement by Shands Healthcare in Gainesville, FL, is a good example of how an internal investigation can mitigate the damages from a spate of improper billing, he says. *(For more on the Shands case, see the story on p. 112.)*

Inpatient billing is likely to remain the hot topic for government investigators for a while, Newton says, so risk managers should conduct internal investigations in that area. Following the $75 million Medtronic settlement in 2008, the government launched what would become a successful, high profile, national initiative targeting hospital inpatient kyphoplasty admissions, which fraudulently increased Medicare reimbursement because the minimally invasive procedures could have safely been performed as an outpatient or observation service.

"Inpatient billing is likely to remain the hot topic for government investigators for a while."

"While the Shands case involves a different relator and allegations, the similarity of the OIG [Office of Inspector General] investigations clearly indicates that enforcement efforts will remain focused on admission status as a proven way to utilize limited resources to maximize False Claim Act [FCA] recoveries," Newton says. "In addition to the OIG's efforts, physician decisions to admit certain inpatients and subsequent Part A claims by hospitals have been increasingly retroactively denied by Medicare administrative contractors [MAC] and recovery audit contractors [RAC] for failing to be reasonable and necessary."

It doesn't help that the rules are constantly evolving. After hospitals enjoyed success on appeals before administrative law judges, the Centers for Medicare and Medicaid Services (CMS) issued an administrative policy and proposed rule in March 2013. The interim policy allowed hospitals to resubmit Part B claims after a Medicare contractor determined that hospital inpatient services should have been provided on an outpatient basis. On Aug. 2, 2013, CMS published the *2014 Inpatient Prospective Payment System (IPPS) Final Rule*, which is

continued below

effective as of Oct. 1, 2013.

The final rule revises CMS criteria for coverage of Part A inpatient hospital claims and adopts CMS' proposal to allow Part B billing of many hospital services following the denial of a Part A inpatient admission based on medical necessity, Newton explains. The final rule benefits hospitals because it increases the number of services hospitals could rebill after a claim is denied for not being reasonable and necessary or when a hospital undertakes a self-audit to determine that the services should have been provided as outpatient, rather than in an inpatient setting.

With the increased enforcement efforts, internal investigations offer the best way to detect and prevent fraud, determine its scope, defend government investigations, ensure compliance, and protect the provider's financial position and public image, Newton says. Hospitals conducting internal investigations must obtain accurate information and respond appropriately while maintaining confidentiality of the investigation and preventing inadvertent disclosure, he advises.

"Employee interviews, document reviews, the preparation of the defense, controlling the flow of information, including document retention, and investigative reports all potentially present difficult attorney-client privilege and work product problems," he says.

Executive Summary

Internal investigations offer the best way to detect and prevent fraud, determine its scope, and defend government investigations. Learning the scope of the problem as early as possible affords the best opportunity to prevent or limit damages.

- Inpatient admissions are particularly challenging for compliance.
- CMS rules on billing change frequently, and policies must be updated.
- An internal investigation can help avoid criminal charges.

For this type of fraud to be prevented, senior management has to know that their compliance programs are effective and where they are not, and make necessary changes to ensure meaningful implementation, Newton says. "One thing that strikes me about the CMS changes is they could have a practical impact on fraud cases by providing defense counsel a better argument with federal prosecutors and the OIG for an offset before single damages are determined as part of a FCA [False Claims Act] settlement or at trial," he says.

Learning the scope of the problem a provider faces as early as possible affords the best opportunity to prevent criminal, civil, or parallel actions and limit damages, particularly if the government has not begun an investigation, Newton says. Preventive action might be taken early to eliminate the intent or knowledge necessary for the government to prosecute a case or to significantly limit exposure.

When the investigation has begun, obtaining a declination of the criminal case against the provider and its senior management is obviously the priority. In some cases, cooperation can be an effective way to obtain the declination and begin defending the civil case, Newton says.

"The importance of relationships and knowing the needs of individual investigators and prosecutors, including their case loads, is also critical," he says. "Moreover, knowing creative ways to reduce time periods for the alleged fraud or penalties, thereby reducing the aggregate settlement, as well as having experience arguing things like the passage of the statute of limitations, inability to pay, or public policy issues can further limit exposure."

SOURCE

• J. Scott Newton, JD, Shareholder, Baker Donelson, Jackson, MS. Telephone: (601) 351-8914. Email: snewton@bakerdonelson.com.

Source:
Healthcare Risk Management, published by AHC Media, Atlanta. Phone: (800) 688-2421.
Email: customerservice@ahcmedia.com