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.

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.

Medicare reimbursement can be best fraud defense

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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
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Executive Summary

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