



## legal matters

**Fear of False Claims** Living in fear of a false claim charge doesn't have to be a fact of life. With the help of new laws, you can dodge problems if you know the rules and keep an eye on your claim procedures.

BY JOHN ALLEVATO



According to some portrayals of the situation, the Justice Department is ready to chew

up and spit out health-care providers who defraud the government by submitting false or erroneous claims for Medicare and Medicaid services.

At health-care legal conferences, the department is painted as a beast on the prowl, ready—even anxious—to throw the book at anyone who even accidentally violates the federal False Claims Act. Granted, the Justice Department, which is charged with enforcement of the federal laws, does have a

goal of aggressively enforcing and prosecuting violators of the Act. But if you can trust your partners, employees, and billing service, you should be able to avoid becoming a target of the monster by taking a few basic precautions.

Unlike the Fraud and Abuse statutes, particularly the Stark provisions of law, the False Claims Act was not designed to specifically target the health-care industry. Rather, its use in the

health-care field has arisen from an increase in the perceived need to monitor claims, mostly revolving around the Social Security Act.

The Social Security Act includes Medicare, Medicaid, and other federal programs. For health-care providers, that means claims for reimbursement of Medicare and Medicaid services fall squarely within the purview of this law. False Claim Act violations can be civil or

criminal violations, depending on whether the supposed violator intended to defraud the government or was merely careless.

### The Law

The law has its genesis in the Civil War, when Congress enacted it to thwart procurement fraud in Union contracts. The law has always also contained “whistleblower” provisions, which are intended to encourage tattle-telling through financial incentives given to the whistleblower. In addition, the law permits private citizens to do the job of federal prosecutors by rewarding private citizens who initiate successful prosecutions against putative wrongdoers with a percentage of the amount

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falsely claimed. These suits brought by private citizens are commonly referred to as “qui tam” actions.

Congress overhauled the law in 1986 to make it a primary litigative tool for the government to use in combating fraud—not necessarily Medicare or Medicaid fraud, but any type of fraud which would endanger public funds. For the purposes of health-care providers who submit claims for reimbursement to Medicare or Medicaid, the law generally provides:

- Civil liability for the submission of false claims;
- Treble damages and mandatory penalties of no less than \$5,000 and no more than \$10,000 for each false claim presented;
- A burden of proof standard of preponderance of the evidence (a typical civil burden of proof meaning “more likely than not”);
- A general intent evidentiary burden, meaning that a violation of the law can be proven without proof that the accused individual knew he was violating the law. Violation of the law can be proven by deliberate ignorance or reckless disregard of the truth or falsity of the information submitted.

It is the latter point which can send chills down the spines of physicians. It means that a physician need not actually know that a false claim (i.e., a miscoding, say an upcoding) occurred, only that the physician “knew or should have known” that a claim was false or fraudulent.

According to the Office of the Inspector General (“OIG”), the investigative arm of the government charged with the enforcement of the law, that standard means that the submitter of claims has a duty to ascertain the truth and accuracy of the submitted claims. According to the OIG, providers who bill Medicare and

Medicaid programs have a responsibility to ensure that the claims they submit are true and accurate representations of the items or services actually provided. If criminal sanctions are involved, on the other hand, the standard of proof is much higher: The government must show actual knowledge or intent to defraud.

### Reaching for violators

One of the most sobering aspects of the False Claims Act is its broad reach for finding those who have violated its provisions. The Act reaches not only those who personally submit claims or make statements which are false, but those who cause the submission of such claims. The common forms prescribed by HCFA, either paper or electronic, have clauses which the submitter (the physician) must sign to start the reimbursement process. Those statements are certifications as to the truth, accuracy, and completeness of the claim being submitted.

Physicians will generally be liable for false claims submitted by employees and agents even if the physician neither knew nor should have known about the false claims, since a section of the Act provides that, under those circumstances, the physician is liable for actions of her employee if the employee is acting within the scope of his employment. While harsh, it starkly illustrates the need for care, attention, and focus on all aspects of a physician’s billing practice.

Employees, in most circumstances, who are not in a position where it can be said that they “knew or should have known” about the submission of a claim which is false will not be held liable.

However, the billing clerk, office manager, or anyone else who is in a position to know of the fraudulent nature of the claim can be held in violation of the Act along with the physician.

As a physician, you should assume that you will be charged with complete knowledge of whatever claim is submitted. The cases also can hold corporate officers or others in a position of control liable even if the claims submitted were not for services provided by that officer. Therefore, the fact that it is your medical partner’s claim that is fraudulent, for services which you didn’t provide or even know about, will not necessarily shield you from liability under the Act.

### Minimizing the Risk

The harshness of the potential penalties and the almost “strict liability” exposure to problems with false or fraudulent claims raise lots of questions about what can be done in your medical practice and medical office to minimize your exposure to risk.

Here are some key guidelines and tips to follow:

**Know the rules.** Too often, mistakes are made inadvertently. Ignorance of the law is not a good excuse here, just as it usually doesn’t work elsewhere. Train your staff and follow up that training with refresher courses. As the physician, make it a priority to know the evaluation and management codes and their nuances. No one said this was going to be easy. No, the rules are not simple or logical, and yes, they must be followed.

**Understand “incident to” services.** These are services provided incident to the physician’s care by ancillary clinical personnel, such as physician assistants, nurses, and medical assistants. Physicians can include these services on Medicare claim forms as if the physician had provided the services, under certain circumstances. Those circumstances are if the service was an integral, but incidental, part of the physician’s service; it is commonly rendered without

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charge or inclusion on the physician's bill; it is commonly furnished in a physician's office or clinic; it is furnished under the physician's direct supervision; and it is furnished by the physician or someone who qualifies as an employee of the physician.

**Review the billing company.** Understand that you, the physician, are responsible for the claim even if it is made by a billing company. Review your billing contracts carefully and only utilize the most reputable billing companies. Periodically, have someone who is knowledgeable (such as a consultant or another billing company) evaluate some of the claims submitted by your billing company for accuracy and completeness. If you anticipate you may have some problems which will be exposed, you may want to have your legal counsel involved, and have them hire the consultants.

**Know your practice.** Know which areas of your practice place you at higher risk for billing errors and focus additional attention on claims from that area.

**Document encounters.** Make it a habit to develop accurate documentation aids and physical and encounter forms for

use in your practice, or dictate accurate information to be placed in the patient charts. One way to tell if you have a problem is then to compare the claim forms with the information in your patient records. That is what an investigator from the government would do. See if everything matches up.

**Know claim requirements.** Third-party payers all have different requirements for submitting claims. You and others in your organization should know them intimately.

**Have a compliance plan.** Adopt and abide by a compliance plan for your office. Hire a consultant to establish a system for your office and rigorously follow it. Such a plan can be beneficial if a false claim slips through your safety net and is submitted.

#### **New relief**

Reacting to the outcry coming from some professional medical societies and the potentially devastating effects of what could be innocent billing errors, bills have been introduced in Congress to either modify the Act or make it not apply to medical professionals not overtly engaging in fraud. In June of 1998, the OIG and the

Department of Justice issued new health-care fraud enforcement guidelines.

The new guidelines provide some relief in the case of very small errors, or if a false claim was filed based on advice given by fiscal intermediaries and carriers, or if the provider adopted an effective compliance plan. The new guidelines also help by raising the burden of proof for prosecution under the Act from preponderance of the evidence to clear and convincing evidence.

Many cases being tried are claiming that the Act is not applicable, or should not be applicable, to cases of physician billing errors. While there has been some success on this front, further legislation (which is pending) will provide the most relief from the onerous reach of the Act. ■

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