



HEALTH CARE FRAUD REPORT



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Tennessee Settlement Shows Failure to Refund Overpayments Can Be a Crime

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How could the failure to refund overpayments be considered a crime? Just ask the U.S. attorney for the Eastern District of Tennessee, who took this position against the practices of the East Tennessee Heart Consultants (ETHC) as seen in the Jan. 4 settlement with the group (11 HFRA 73, 1/17/07).

This case is very significant to health care providers and their counsel for a number of reasons. It is the first enforcement action against providers for failing to repay overpayments. It sets new ground in the use of government fraud authorities related to provider conduct affecting private payers and patients, not just Medicare and Medicaid programs. And, the government used the criminal process to break this new legal ground to effectuate a result it felt was needed.

I. BACKGROUND AND ALLEGATIONS

ETHC is a medical practice of 42 cardiologists that employs more than 250 people and includes 12 offices

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and eight clinics in Knoxville, Tenn., and surrounding counties.

The settlement is the product of an investigation that began as a result of allegations brought by two former employees of ETHC who filed a *qui tam* action under the False Claims Act against ETHC on Nov. 6, 2003. These employees had worked as ETHC's Patient Financial Services Representatives ("PSRs").

The allegations involve what are known as credit balances.¹ This is an accounting entry that is an account payable and shows amounts owed to payers and patients as a result of overpayments.

An overpayment can generally exist for a number of reasons, including a false claim filed by a provider, a double payment by a payer, an incorrect copayment paid by a patient, or a secondary payer error where two payers pay as if they are both primary payers.

It is important to emphasize that this case has nothing to do with the first type of cause for an overpayment because there were *no* allegations of false claims or poor quality of care.

The allegations in this case were essentially that ETHC had a number of credit balance practices which, taken together, amounted to a "policy" to avoid repaying credit balances or making refunds difficult for payers and patients seeking money owed them. Effectively, ETHC's policy was to retain overpayments unless specifically asked by a payer or patient, and on occasion it took actions to delay or obstruct the return or refund of such overpayments.

The vast amounts of credit balances that the practice owed related to patients, not Medicare, Medicaid or

¹ The authors gratefully appreciate the time given by the prosecutor in this case, defense counsel, and relators' counsel in providing their perspective to the authors. The authors' characterization of the facts is exclusively their own.

other payers. The alleged practices appeared to have taken place over a number of years and involved intentional senior management actions.

Other allegations were that ETHC's year-end books did not reflect credit balances as accounts payable, and therefore had the effect of allowing these monies to be treated as year-end profits to physicians.

In addition, at one point several years ago when the practice converted to a new billing system, a large portion of the credit balances at that time did not move over into the new system and thus were removed from the practice's books.

II. THE SETTLEMENT

In brief, ETHC agreed to enter into a criminal pretrial diversion agreement (PDA), separate civil settlements with the federal and state governments, and a five-year Corporate Integrity Agreement with the Department of Health and Human Services Office of Inspector General (CIA; collectively, the Settlement).

Under the terms of the Settlement, ETHC agreed to pay more than \$2.9 million in civil penalties and restitution to private payers and 11,220 patients. ETHC fully cooperated with the government and prior to the Settlement, it had issued refunds of approximately \$700,000, for which it received credit.

Of the \$2.9 million, the approximate allocation of payments was as follows:

Government Programs:

- \$1.5 million to DOJ for settling civil claims under the FCA related to federal health care programs;

- \$200,000 to the state for settling state laws claims;

Restitution:

- \$1 million to 11,220 patients; and

- \$200,000 to private health plans.

Out of the government settlement proceeds, the Relators' share came to over \$330,000. In addition to the amounts listed above, ETHC paid \$71,868 for Relators' attorney's fees.

The following is a brief summary of the each of the agreements that comprise the Settlement.

Pretrial Diversion Agreement. What is truly remarkable in this case is that the government brought criminal charges against ETHC under Title 18 of the United States Code, specifically health care fraud under Section 1347 and theft or embezzlement in connection with a health care benefit program under Section 669.

A PDA is a process by which a prosecutor agrees to waive criminal charges for a defined period of time during which the target agrees to undertake certain activities, either under the oversight of the probation department or a court-appointed monitor.

If the target fully complies with the conditions of the PDA, charges are dropped at the end of the specified period. Also, critical to any PDA, "ETHC acknowledges that the [Government] has developed evidence that one or more employees may have violated certain federal criminal statutes, and that ETHC accept responsibility for the conduct of its employees. . . ."

While stopping short of an outright admission of criminal conduct, this is a very different statement than typically appears in FCA settlements where the provider does not admit liability. The PDA has the following conditions:

- 18 month supervision by U.S. Probation Office;

- The payment of restitution for all overpayments which ETHC received since January 1, 1995 from all parties, including both individual patients and health care benefit programs;

- \$167,449 to private health plans, including commercial insurance—

- \$78K to commercial entities

- \$45K in cash payments from unidentified parties

- \$44K to BC/BS of Tennessee

- \$1,043,629 to 11,220 patients.

Importantly, the PDA does not permit ETHC to waive refunds for amounts below a dollar threshold. In addition, to the extent that ETHC is unable to locate an individual or payer and not make the required repayment, it may not keep the funds.

Instead, all unpaid credit balances as identified in the PDA at the end of this 18 month process must be paid to the Government's Crime Victim Fund. Not included in these costs is the tremendous undertaking and expense associated with identifying and making payments to each of these 11,220 patients.

Civil Settlements. ETHC also entered into separate civil settlement agreements with the federal government and state of Tennessee. The government's view was that ETHC's claims for payments were false claims because ETHC had a legal obligation to pay the government previously received overpayments on prior claims.

Additionally, ETHC submitted duplicate claims to both primary and secondary payers resulting in overpayments. Moreover, the Government alleged that ETHC submitted all these claims despite the knowledge that it had a legal obligation to promptly refund such overpayments.

Corporate Integrity Agreement. Lastly, ETHC entered into a CIA as a condition of its FCA settlement agreement. The CIA requires ETHC to develop and implement specific policies and procedures to encourage full compliance with all federal health care program requirements, including its commitment to prepare and submit accurate claims consistent with such requirements. This policy must be reflected in ETHC's Code of Conduct.

Additionally, ETHC employees with responsibilities for submitting claims are required to attend to five (5) hours of specific training annually that focuses on, among other things, requirements for accurate coding and claims submission, requirements for the documentation of medical records, personal obligations to ensure that claims are accurately submitted, sanctions for violations of Federal health care program requirements, and examples of proper and improper claims submission practices.

The CIA also requires that ETHC engage an Independent Review Organization to perform reviews to assist ETHC in assessing and evaluating its billing and coding practices

III. ANALYSIS

It was just a matter of time before a provider would get caught up in an enforcement action for not fully refunding overpayments.

Many readers might look at the facts of this case and say, "Well, I don't do that," and then conclude they have no problem. But this case suggests that such thinking might be a mistake if only because it shows that

there are many whistleblowers out there and this prosecutor focused on the impact of ETHC's practices on patients.

Compliance Issues. From a compliance perspective, this case suggests to all providers to review their credit balance policy, including all payers and patients. It was not too long ago that the common practice was like ETHC's—to make refunds, but only when asked. Most providers have recently adopted more proactive policies regarding refunding Medicare and Medicaid overpayments.

But this case demonstrates that prosecutors believe they are free to scrutinize how credit balance policies impact private payers and patients. Indeed, our review of the settlement dollars indicates that ETHC had relatively few problems with their Medicare and Medicaid refunds.

Markedly, the fact that \$1,043,629 in restitution to 11,200 patients was ordered as a condition of the PDA clearly demonstrates that this case was largely about the failure to make patient refunds.

Because ETHC is making these repayments pursuant to the PDA, they have no ability to waive refunds of de minimis overpayment amounts where the expense of such refunds might exceed the amount itself.

But for other providers, we think policies to waive small refund amounts make sense and should be considered in appropriate situations.

Legal and Enforcement Issues. Many health care attorneys have suggested there is no clear statutory or regulatory authority requiring providers to refund Medicare overpayments.

In January of 2002, the Centers for Medicare & Medicaid Services proposed changes to a prior proposed rule regarding reporting and repaying overpayments. According to CMS, the proposed rule “would further memorialize the longstanding responsibility for all providers, suppliers, individuals, and other entities, including managed care organizations . . . to report overpayments and establish the time frame and process for making those reports” 67 Fed Reg. 3662 (Jan. 25, 2002).

This rule was never enacted in final form, and therefore has the effect of being withdrawn. Notwithstanding CMS's preamble statement, there is no current plain-English CMS regulation making this policy clear, and we continue to be baffled as to why CMS allows this debate to continue.

Nonetheless, we can now add the HIPAA criminal health care fraud and theft and embezzlement provi-

sions (18 U.S.C. § 1347 and 669) as the potential authority to consider for the proposition that providers have a legal duty to refund Medicare and Medicaid overpayments.

Let's turn to private payers and patients. Clearly, the Government invoked these authorities with equal force to mandate refunds to these sources. This, standing alone, would make this case an important reminder that these HIPAA fraud authorities apply to “health care benefit programs” and this term includes private health plans.

But any obligation for a provider to refund overpayments to a private health plan must first be analyzed as a matter of contract law. Either a plan requires such refunds or it does not. If, and only if, a plan requires the refund of overpayments, the Government may have an argument that a provider's conduct could meet the elements of the offenses prohibiting health care fraud or theft or embezzlement of a health care benefit program.

Turning to patients, an argument can be made that retaining patient money is not the same as retaining Medicare or private health plan funds, and therefore the government has no authority to impose patient refunds.

Whatever the merits of such a technically accurate argument, this case also stands out because it shows how other prosecutors may be willing to use any argument at his/her disposal if he believes patients are being hurt financially. We suggest that the Government here saw a case with good jury appeal and was willing to risk the weak legal support and pursue the criminal process of a PDA to obtain the result it wanted.

One final legal issue for providers and their counsel to be aware of is the potential application of state escheat laws to credit balances that linger on a provider's books.

Enforcement Issues. We understand that prosecutorial zeal was softened by the use of a PDA, and also that prosecutors tend to focus on the facts of individual cases before them. Nevertheless, we are troubled by the use of the criminal process in a new enforcement area. In particular, here, the Government can point to no Medicare statute or regulation that was violated.

As we have pointed out above, CMS has continued to refuse to write a plain-English sentence that makes clear that a provider has a legal obligation to refund Medicare overpayments. But absent such authority, we think that the use of the criminal process in this context is inappropriate.