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Someone Else's Computer Glitch May Create Your False Claim

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Law360, New York (July 14, 2014, 3:51 PM ET) -- Yes it can, according to the United States' recently filed complaint in intervention against a number of hospitals in the Southern District of New York. The complaint alleges failure to make timely repayment of money overbilled to Medicaid as a result of a software problem creates liability under the False Claims Act (FCA). United States v. Continuum Health Partners Inc., et al., No. 11-2325 (S.D.N.Y.), one of the first cases under recent amendments to the FCA, could potentially shed light on the scope of FCA liability for retained overpayments — an issue many anticipated would be a hotbed of FCA activity.

In 2009, the Fraud Enforcement and Recovery Act (FERA) revised the FCA to expand liability for reverse false claims to anyone who "knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government."[1] "Obligation" includes "the retention of any overpayment."[2] The following year, the Patient Protection and Affordable Care Act (PPACA) established that failure to report and return a health care overpayment (Medicare or Medicaid funds that a person receives or retains to which the person is not entitled) within "60 days after the date on which the overpayment was identified" can give rise to FCA liability.[3]

Although it was widely anticipated that the overpayment issue would create a flurry of FCA activity, to date there have been few decisions. Last year, in United States v. Lakeshore Med. Clinic Ltd., No. 11-CV-00892 (E.D. Wis. Mar. 28, 2013), the court denied defendant's motion to dismiss allegations that it violated the reverse false claims provisions of the FCA.[4] The Lakeshore whistleblower alleged the defendant medical group violated the FCA's overpayment provision when it discovered through an annual audit that two of its doctors were overbilling Medicaid for services. The whistleblower further claimed that although the medical group repaid the overpayments identified in the audit, it did not follow up by reviewing other claims submitted by the two doctors. The district court held that upon discovering some overpayments, the medical group had a duty to investigate and identify potential additional overpayments by the two doctors. The court denied defendant's motion to dismiss because defendant "intentionally refused to investigate the possibility that it was overpaid," and "may have unlawfully avoided an obligation to pay money to the government."

The government's current case against Continuum may further define the bounds of federal health care providers' duty to investigate potential overpayments and the time period in which to do so. In its complaint in intervention, the government alleges Continuum operated three hospitals in New York City that provided services to numerous patients enrolled in a Medicaid Managed Care Organization (MCO). Under Medicaid regulations, the hospitals were entitled to receive payment for their services only in the amount paid by the MCO, and not any additional payments. According to the complaint, between January 2009 and late 2010 Continuum submitted numerous claims to Medicaid for additional payments due to the MCO's software billing code error which caused the MCO to erroneously indicate the hospitals should seek additional Medicaid reimbursements.

The government alleges the following timing of events. In September 2010, Continuum was first notified by auditors from the New York State Comptroller's office of a small number of improper claims caused

by the MCO's software error. In December 2010, following discussions between the Comptroller's office, Continuum and the software vendor, the software error was corrected. In late 2010 and January 2011, Continuum analyzed billing data in its attempt to identify additional potentially affected claims. On Feb. 4, 2011, relator (a former employee involved in the analysis) sent an email to several Continuum executives identifying more than 900 improper claims, totaling more than $1 million.

The government alleges that rather than repaying those 900 plus improper claims within sixty days following their discovery (by the government's calculus the 60-day clock started on Feb. 4, 2011), Continuum repaid the overpayments in dribs and drabs over a two year period. Moreover, Continuum allegedly only repaid 300 of these claims after receiving a Civil Investigative Demand from the government. The government alleges that Continuum violated the FCA by intentionally and recklessly failing to timely reimburse Medicaid for these overpayments.

The Continuum case may provide answers to a number of interesting questions about the FCA's overpayment provision. For example, what will the court say about when an overpayment is "identified" for purposes of triggering the 60-day repayment clock?[5] According to the complaint, in the Feb. 4, 2011, email identifying more than 900 claims, relator "indicated that further analysis was needed to corroborate his findings." Were the overpayments identified at that point, or did Continuum have additional time to determine whether they were actual overpayments and if so, how many and in what amounts? Similarly, the case may shed light on how vigorously the government can punish defendants for failing to return the overpayments within sixty days and whether the fact that a defendant ultimately repays all amounts owed has any mitigating impact on its liability, damages or potential penalties. And finally, may this duty be relaxed when the overpayments were initially caused by a software glitch that was no fault of the defendant?

The Continuum case may be one of the first of many overpayment cases that are making their way through the pipeline. Stay tuned.

[1] 31 U.S.C. § 3729(a)(1)(G).
[2] Id. at § 3729(b)(3).
[3] 42 U.S.C. § 1320a-7k(d).
[4] The United States declined to intervene in the Lakeshore case. Relator voluntarily dismissed her claims with prejudice in September 2013.
[5] According to the proposed regulation issued by the Centers for Medicare & Medicaid Services (CMS) in 2012, a Medicare overpayment is "identified" if the person has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment. Although not included in the actual proposed regulation, in the preamble to the proposed regulation CMS explained its view of when the 60 day clock starts running. According to CMS, if a provider receives information that it has potentially received an overpayment, it must conduct a reasonable inquiry with all deliberate speed to determine whether the overpayment exists. CMS, however, did not define the bounds of reasonable inquiry or deliberate speed. 77 Fed. Reg. 9179.

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