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Phone: +1 646 783 7100 | Fax: +1 646 783 7161 | customerservice@law360.com

Feds Clear Path For Cos. To Come Clean On Medicare Fraud

By **Rachel Slajda**

Law360, New York (April 17, 2013, 9:18 PM ET) -- Medicare's inspector general on Wednesday detailed what health care providers looking to disclose potential Medicare fraud to the government should do in order to get a break on penalties, issuing a rare update to its self-disclosure guidelines that attorneys say will formalize policies the agency has adopted in practice and help hospitals and others resolve cases quickly.

The U.S. Department of Health and Human Services' Office of the Inspector General released an updated self-disclosure protocol Wednesday, the first time the protocol has been updated since it was first created in 1998. Health care providers and others, including drug manufacturers, can self-disclose potential violations of law, such as the anti-kickback statute, to the OIG.

The benefits to self-disclosing, rather than the information coming out from a whistleblower or government investigation, include potentially significantly lower damages. The OIG also usually does not require self-disclosers to sign a corporate integrity agreement, which can be extremely expensive to implement.

The updated protocol released Wednesday makes several notable changes, including more detail on the information that providers and other disclosing entities should give to the OIG, broken down by the type of disclosure, whether it's related to billing, anti-kickback violations or excluded persons.

Attorneys with expertise handling self-disclosures and the ensuing settlements say such policies have been adopted in practice over the years.

“Many of the things that are in the self-disclosure protocol are really not so much new, but the OIG put in writing what's been long-standing practice,” said Thomas Crane of Mintz Levin Cohn Ferris Glovsky & Popeo PC. “I think a lot of these requirements are things the OIG has been asking for in the past as part of the process. So under the protocol since 1998, you would submit something, and if you didn't include this kind of information, in the back-and-forth with OIG they would say, 'We need information on x and y.' So [now] they're telling you up front, here's what you need to put in your submission.”

Putting the policies down on paper should help providers know up-front what exactly to disclose to the OIG, potentially speeding up resolutions, experts say. It should also be a wakeup call to providers and others to make sure they have as much information as possible when they first submit a disclosure.

“It afforded OIG the opportunity to say, here's what we expect, and there's more detail. There's greater expectations. OIG has now communicated that if you're disclosing, in order for us to accept the self-disclosure, you need this information,” said Howard Young, a partner at Morgan Lewis & Bockius LLP who advises health organizations on fraud and compliance.

Young pointed out that the new protocol also somewhat shortens the timeframe. In the past, if a provider omitted important information, it would have 90 days from the day the OIG accepted the disclosure to tie up loose ends. Now, the 90-day clock starts when the provider submits the disclosure.

“It compresses the time entities have to tie everything up. There's more need for upfront resources,” he said. “It will also allow OIG to expedite resolution of these matters.”

The updated protocol includes several other changes from the original. It makes clear that the OIG will aim to collect damages of about 1.5 times the amount of the overpayments, and that for anti-kickback violations, it will calculate damages based on the amount of the kickback, not the total claims based on the illegal relationship. It also sets out minimum settlement amounts, of $50,000 for a violation of anti-kickback rules, and $10,000 for other violations.

The protocol also acknowledges a major change in the law since 1998. As part of the Affordable Care Act, providers are now required to report and refund overpayments to the Centers for Medicare and Medicaid Services within 60 days of their discovery.

Straight overpayments should be reported to CMS, not OIG. Only overpayments that may be the result of a violation should be reported to the OIG, it said.

For those providers that self-disclose to the OIG, CMS will toll the 60-day deadline for reporting and repayment until the OIG case is resolved, the inspector general said. It also said additional guidance aimed at harmonizing the two rules will come out after CMS finalizes its rule.

Attorneys said they did not expect the new protocols to change the calculus companies face when deciding whether to self-disclose, and to whom. Providers can also self-disclose certain violations to the U.S. Department of Justice, for example.

They said more detailed information on what the OIG is looking for is all for the better.

“There may be some perception that with additional detail, there's less flexibility,” Young said. But “OIG continues to maintain enormous discretion as part of its self-disclosure resolution. … The good news is OIG is in no way signaling it feels more restricted in how it resolves self-disclosures. They still have a lot of discretion.”

--Editing by Sarah Golin and Andrew Park.