Your Provider Number = Your Responsibility

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As an institutional provider, if you hire a vendor to perform billing, claims submission or collection services or to manage the delivery of health care services on your behalf, you may be held responsible for the vendor's actions. As far as the Medicare, Medicaid and other third party payment programs are concerned, the billing, claims submission and quality problems caused by your vendors are your problems. This holds true regardless of whether you ultimately have the ability to obtain restitution from your vendors for billing and claims submission problems that they cause. You will be held accountable by both governmental and other payors to make repayment for any incorrect payments made utilizing your provider number, even if you can establish that the incorrect payments were caused entirely by your vendor, and even if you did not realize any personal benefit as a result.

As an institutional provider, you must take care to ensure that:

- Claims that you submit for care rendered to individual patients are documented as medically necessary, appropriately coded and accurately billed;
- Your cost report accurately reflects the costs incurred by your organization to deliver health care services;
- Individuals with whom you contract to provide clinical services are appropriately credentialed, are not an excluded provider, and provide services which are medically necessary and appropriately documented;
- The medical services provided under your vendor's supervision are integrated into your organization's quality review process and, where appropriate, are subject to your medical staff bylaws; and
- The confidentiality of protected health information relating to an individual's past, present or future health is maintained.

The consequences of failing to adhere to the legal requirements regarding billing and claims submission, or the failure to conduct an adequate background check of a vendor, can be severe. The federal civil False Claims Act prohibits a health care provider from knowingly presenting (or causing to be presented) to the federal government a false or fraudulent claim for payment. 31 U.S.C. §3729-3733. A false claim is a claim for payment for services that were not provided in the manner represented on the claim form or a claim for which the provider is otherwise not entitled to payment. Examples of false claims include the submission of claims for services that were not actually rendered, submission of a claim for services provided by an unlicensed individual, or the submission of a claim which is coded to indicate a higher level of service than was actually provided. The law covers not only intentional conduct, but also the submission of claims in deliberate ignorance of the truth or falsity of the information on the claim or in reckless disregard of the truth or falsity of the information on the claim. The penalty for violating the False Claims Act is a penalty of between $5,000-$10,000 for each false claim submitted. In addition, treble damages of up to three times the amount unlawfully claimed may be assessed.

Under the False Claims Act, a lawsuit may be initiated on behalf of the government by a private individual filing a lawsuit known as a "qui tam" action. See 31 U.S.C. 3730. If successful in the litigation, the private individual is entitled to a direct financial benefit, since they are permitted to share in a portion of any recovery imposed against the provider. Thus, either a vendor's employees, your own employees or employees of another institution that has a contract with the same vendor are provided with a significant incentive to report alleged wrongful activities to the federal

government. A qui tam action may be commenced even before you realize that you have a problem if you do not provide sufficient oversight of your vendor's activities. You are generally not informed that a qui tam action has been filed until the government elects to pursue or not pursue the action.

There are also criminal statutes where liability can be imposed for the submission of false or improper claims. They include, but are not limited to, the health care fraud statute (18 U.S.C. §1347), laws regarding theft or embezzlement in connection with health care (18 U.S.C. 669); and the federal antikickback statute (42 U.S.C. §1320a-7b). If convicted under one of these criminal statutes, the provider may be subject to both the imposition of fines and penalties and imprisonment for five to ten years.

The Office of Inspector General, U.S. Department of Health & Human Services (hereinafter "OIG") is authorized by law to impose civil monetary penalties for any one of a host of violations which can arise from your relationship with contractors. Such penalties may be imposed upon anyone who arranges or contracts (by employment or otherwise) with an individual or entity that the person knows or should know is excluded from participation in the Medicare or Medicaid programs. In addition, civil monetary penalties may be imposed for many other types of violations, including billing for services not provided as claimed, upcoding, or billing for medically unnecessary services. Id. 42 U.S.C. §1320a-7a. A civil monetary penalty of up to $11,000 for each item or service claimed may be imposed. Treble damages may also be assessed, and the provider may be excluded from participation in the Medicare or Medicaid programs. Id.

Even if a provider receives an improper payment as a result of an isolated, inadvertent clerical error, the provider in whose name the claim is submitted is responsible for repayment of the resulting overpayment. 42 C.F.R. §405.371. If the government discovers a pattern of overpayments and determines that they may have been caused by fraud or misrepresentation, Medicare regulations authorize the government to initiate the suspension of payment to the provider without notice. 42 C.F.R. §405.372. Thus, the adverse impact upon a provider in whose name an improper claim is submitted can be severe. At the very least, the provider will have to make repayment of any overpayment amounts, whether or not the overpayment was caused by the actions of the provider. At worst, the provider may be subject to suspension of payment, the imposition of fines and penalties, exclusion from the Medicare program or even jail time.

In addition, the Department of Health and Human Services recently issued comprehensive regulations regarding the confidentiality of patient medical information. These regulations require that the confidentiality of protected health information relating to an individual's past, present or future health is maintained. The regulations further require that health care providers include certain obligations regarding the protection of the privacy of patient health information in contracts with vendors where the vendors will have access to that information. This is another area of potential financial exposure, since violation of the privacy regulations can result in the imposition of fines and penalties (or in the case of intentional violations, jail time). 45 C.F.R. Parts 160 and 164.

To the extent a facility contracts with individuals who are providing hands on care, but are not employees of the facility, these individuals should be privileged in the same way any other such individual would be privileged pursuant to the medical staff and/or allied staff bylaws. In that privileging process, the facility must verify the individual is appropriately licensed or certified by the State. A hospital or other facility which submits a claim for payment for a physician's services when that individual is not licensed not only creates a significant risk management issue, but also may be subject to liability under the federal civil monetary penalties law. 42 U.S.C. §1320a-7a(a)(1)(C). Moreover, if the individual is not an employee and not a member of the medical staff, then it is difficult to justify that the patient treated and billed by the hospital is properly categorized as a hospital inpatient or outpatient service . This sounds self-evident, but there have been circumstances in which hospitals have run into billing difficulties where clinical services provided by a vendor have also been provided by physicians or other hands on care professionals who have arrangements with that vendor but who have not been privileged by the medical staff. Medical records created in circumstances where the services delivered involve an activity controlled by, managed by, or provided by a vendor, should be subject to the same performance improvement and utilization review oversight review as medical records created in the remainder of the facility. These records should also be maintained as part of the facility's medical records system and should be subject to all the same reviews and confidentiality restrictions as other facility records.

In addition, recent changes in Medicare regulations require that when a hospital department is operated pursuant to a management

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contract, all clinical personnel must be employed by the hospital, and not by the manager. 42 C.F.R. 413.65(f)(1). The administrative functions of the department must be integrated with those of the hospital, and the hospital must retain significant control over the operation of the department. 42 C.F.R. §413.65(f)(2) and (f)(3). Thus, the Medicare program has emphasized the importance of facility oversight regarding contracted activities.

All this is particularly difficult where a facility has retained a vendor because it does not have the expertise in-house to provide the service. It requires that the hospital become comfortable initially with the conduct of the vendor and ensure the vendor's continual compliance with applicable law. All payors assume that facilities exercise reasonable diligence in the selection of vendors. While this may be a common sense approach, it ignores the fact that the in-house expertise is not in these areas.

It is virtually impossible for a provider to ensure that its billing practices will not be subject to investigation or audit by a governmental or other third party payor. However, there are a number of steps you can take to lessen the risk that your facility will be found liable for improper acts committed by your vendor:

1. Compliance Program. Ensure that the facility has its own corporate compliance program, and insist that vendors will abide by it. Require vendors to maintain compliance programs where appropriate.

2. Check for Exclusion. Before hiring a contractor, verify that they are appropriately licensed in good standing and have not been excluded as a provider of services under Medicare, Medicaid or any other governmental program. The Internet can be a helpful resource in making these inquiries, since both the OIG and state licensing boards often have online services available where you can check the status of a particular individual or entity. The OIG maintains a data base of excluded individuals. The OIG list of excluded individuals/entities can be found at the following website: http://exclusions.oig.hhs.you/home.htm. The General Services Administration's searchable data base can be found at www.arnet.gov/epls. In addition, professional licensing boards often have an Internet data base available where you can check whether a licensee has been the subject of disciplinary action. For example, the New Jersey Board of Medical Examiners has an online data base that can be queried for this information. It is available at www.state.nj.us/lps/ca/bme/docdir.htm. The Office of Inspector General also maintains a list of entities and individuals that have entered into corporate integrity agreements and settlement agreements with the OIG and, in some instances, even has the text of these agreements on the Internet. See www.hhs.gov/oig/cia/index.htm.

3. Check References. Even if a prospective contractor has not been formally excluded from a governmental program or disciplined by a professional licensing board, there are still ways to learn about a contractor's reputation. You should ask the contractor for a list of references and check with the references regarding their experience with this provider. It may also be helpful to do a search for newspaper articles on the Internet, as there is sometimes useful information published if a provider is the subject of a fraud or false claims lawsuit.

4. Written Agreement. The agreement that you have with the outside contractor to provide services on the facility's behalf (whether clinical, billing or otherwise) should be in writing and should contain a representation that both parties will comply with all applicable laws and regulations pertaining to the services that are the subject of the contract. In addition, the contract should comply with the federal regulations regarding the privacy of individual health information if you are sharing such information with the vendor. It is also advisable to incorporate language in the agreement specifying that the contractor will abide by the requirements of your code of conduct and your corporate compliance plan. You should also incorporate a representation that the contractor operates its own corporate compliance program. This is particularly advisable in the case of third party billing companies in light of the fact that the Office of Inspector General has published compliance guidance for those entities. 63 F.R. 70138 (December 18, 1998).

5. Contracted Departments. If the contractor is operating a clinical department on your behalf, you need to ensure that a review of the services rendered in that department is integrated into your performance improvement and utilization review activities, and that the medical records for services rendered in that department document both the care actually rendered to the patient and the medical necessity of that care.

6. Internal Review. Conduct an internal review of claims being submitted on your behalf to third party payors. Particular emphasis should be placed upon problem billing areas that have been targeted by the OIG. The OIG has published compliance

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guidance for various segments of the health care industry which sets forth some of the problem areas. These can be found at www.hhs.gov/oig/modcomp/index.htm. Information concerning investigatory initiatives of the OIG are contained in the OIG Work Plan, which is published annually and is available on the Internet at www.hhs.gov/oig/wrkpln/index.htm. This document often provides a useful outline of potential problem areas.

7. Accounting Review. Consider utilizing outside resources to audit the services provided by the vendor. A common sense approach would be to have your accountants spot check the services performed by your vendors when they are doing your annual financial statements and tax returns. While the accounting firm may not have billing and coding expertise, you may be able to have the firm compare the 1099 you will receive documenting payments made to the facility by third party payment programs with a list of the payments received from the vendor.

8. Audit the Vendor. Engage the services of an outside auditor with expertise in coding, billing and claims submission to review your billing activities periodically to identify any problem areas. Having a "second pair of eyes" look at a sample of your bills can often help to identify systemic problems.

Operating in today's complex health care environment presents all providers with challenges on a daily basis. While implementing the organizational oversight activities referenced above will not remove the possibility that your facility will become the target of a governmental investigation, these activities can help to lessen the ultimate liability risk. In the event your facility does become the subject of an investigation, establishing that you have taken these steps will make it more likely that the government will avoid initiating a criminal action and/or may result in the imposition of a less severe financial penalty upon the facility. Should you become aware of a possible investigation of your facility, you should immediately contact the facility's attorney, who must be knowledgeable in the area of health care fraud, to conduct a review, and to provide relevant information, if appropriate, to the investigating party, and to advise you on how to proceed to further minimize, to the extent possible, the facility's ultimate risk.

Frank Ciesla, Beth Christian and Sharlene Hunt are all shareholders in the law firm of Giordano, Halleran & Ciesla, P.C., located in Middletown, New Jersey. They each have represented numerous health care facilities and individual health care providers with respect to many different aspects of health law, including but not limited to, structuring transactions with vendors and representing providers during governmental investigations.