Long-Term Care Survey Alert

Compliance: 2 Steps Can Help You Ward Off Payment Suspensions for 'Credible' Fraud Allegations

Home in on these 3 potential sources of complaints.

Your facility no doubt has a plan to preempt IJ citations, which can lead to huge CMPs and even decertification. But now you need to address a new threat in the payment compliance realm -- and fast.

Step 1: Know What You're Up Against

A provision required by the Affordable Care Act allows the government to withhold Medicare or Medicaid payments "where there's a credible allegation of fraud," says attorney **Paula Sanders,** with Post & Schell in Harrisburg, Pa. The provision went into effect on March 25.

If the government decides to investigate an allegation against you, don't expect a quick resolution. The final rule implementing the provision "generally established an outside limit of 18 months for the government to conclude its investigation of the allegation," says attorney **Donna Senft** with Ober/Kaler in Baltimore, Md.

Definition critical: The language used related to "credible allegations" is one with "an indicia of reliability," notes Senft. And that has generated significant concern among providers who wonder if the term will be interpreted "to parallel the concept of a scintilla of evidence applied in administrative law cases," she adds. "It appears to be a very low bar."

How the government construes a "credible allegation" is very important, agrees attorney **Robert Markette Jr.,** with Gilliland & Markette in Indianapolis, Ind. He notes that the rules do include a rebuttal process where the provider can submit a statement explaining why it shouldn't have its payment suspended.

Option? "Instead of shutting down payments, which effectively puts a provider out of business, it would be better for the government to put the provider on prepayment review where they audit every claim," Markette observes. The Affordable Care Act "provided for more prepayment reviews for certain providers." But he doesn't know whether "that will be a broader response or not."

The payment suspension rules would, of course, go away if Congress repealed the entire Affordable Care Act. But Markette believes that if Congress attempts to "repeal the ACA piecemeal, it will be hard for [lawmakers] to get enough votes to eliminate the fraud provisions."

However, "at some point, the Supreme Court will rule on the healthcare reform bill," Markette points out. And if it rules that the whole bill has to fall due to the insurance mandates, "then maybe Congress can have a more reasonable conversation about fraud and abuse and ask: Do we really want to shut down providers without a hearing?" He thinks the answer may still be yes, but at least providers will have another opportunity to discuss the it with lawmakers, says Markette.

Step 2: Home In On These 3 Potential Allegation Sources

"When trying to avoid anonymous complaints, providers should keep in mind the No. 1 source of tips may be their own staff," warns Markette. "That's why you want to have an effective compliance plan and culture in the organization. Staff should be able to access an internal reporting system. You want staff to know they can report."

Tip: "Don't promise you will maintain their anonymity," however, warns Markette. "That's a bad promise to make, as management may have to reveal at some point who made the complaint."

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2 smart moves: Conducting exit interviews to document whether departing staff members have compliance concerns can be helpful, suggests Sanders. The interviews "are time consuming and a lot of times you don't get information. But at least you can say you asked and the employee didn't bring an issue to your attention." She also recommends conducting an annual attestation where you ask every employee "to fill out a form indicating if they have seen or heard anything or have any concerns about potential problems or wrongdoing."

Complaints could also come from competitors, who are disgruntled for any number of reasons, says Markette. "Maybe your business is doing better or you have a better referral source. And they see your census growing faster than theirs and presume you have to be doing something wrong." So they report their suspicions to the government.

But "if you are known in the community as being very clearly concerned about compliance, a competitor may come to understand that you are just successful," says Markette.

Sharing best practices informally and through professional meetings, as well as trying to maintain collegial, friendly relationships with other providers, can also help. That approach may not protect you against an anonymous tip or other "credible allegation," says Markette, but it could help your case when making a rebuttal. "It may also help the industry, as it becomes clearer that providers are taking compliance more seriously," he adds.

"There is always going to be the green-eyed monster, however," Markette cautions. He points to an Arkansas case where a provider filed a lawsuit under the False Claims Act alleging that a provider was involved in a kickback scheme with a nursing home. But "most providers aren't going to go down the road of trying to get their competitor's payment suspended without having some evidence."

Watch out for this: While staff and competitors could complain, Markette thinks credible allegations of fraud will probably come from auditors, such as ZPICs. That's where having an effective compliance program can detect and correct mistakes before they become a repeated pattern that "morphs into fraud," he says.

Editor's note: See the related sidebar, "Prepayment Audits Can Help You Maintain Clean Claims" on page 34.

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