

# US District Court Decision Provides Cautionary Tale on False Claim Act Requirement to Return Identified Overpayments from Medicare or Medicaid

## Holland & Hart News Alert

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A recent ruling from the United States District Court for the Southern District of New York is the first decision regarding the requirement of the Affordable Care Act (ACA) to return identified overpayments from Medicare and Medicaid within 60 days and provides a cautionary tale about the failure to do so. The Court's opinion offers clarification about when the 60-day "report and repay" provision of the ACA starts and underscores the importance of identifying and acting on a notice of improper payments in a timely manner.

### **Background**

The action stems from a computer glitch on the part of Healthfirst, Inc. (Healthfirst), a private, non-profit insurance program. The glitch caused three New York City hospitals to submit improper claims to Medicaid for services rendered to beneficiaries of a managed care program administered by Healthfirst. All three hospitals belong to a network of non-profit hospitals operated and coordinated by Continuum Health Partners, Inc. (Continuum).

Under the terms of a 2005 contract entered into by Healthfirst and the New York State Department of Health (DOH), Healthfirst provides Covered Services," including hospital and physician services, to its Medicaid-eligible enrollees in exchange for a monthly payment from DOH. Healthfirst's reimbursement for Covered Services is limited to the monthly fee, and participating providers may not otherwise bill DOH for services rendered. The error giving rise to the lawsuit occurred when certain "codes" mistakenly indicated that providers could seek additional payment from secondary payers in addition to Healthfirst, such as Medicaid, other insurance carriers, or patients themselves. As a result of the software glitch, beginning in approximately January 2009, Continuum submitted claims to DOH on behalf of the hospitals seeking additional payments for Covered Services rendered to Healthfirst enrollees, and DOH paid the hospitals for many of these improper claims.

In September 2010, auditors from the New York State Comptroller's office approached Continuum with questions regarding incorrect billing. Discussions eventually revealed the software glitch responsible for the

improper billings. After the problem was discovered, Continuum tasked its employee, Robert Kane, with ascertaining which claims had been improperly billed to Medicaid. In February 2011, approximately five months after the Comptroller first informed Continuum about the glitch, Kane sent an e-mail to several members of Continuum's management, attaching a spreadsheet that contained more than 900 claims – totaling over \$1 million – that Kane had identified as containing erroneous billing codes. While it is undisputed that Kane's spreadsheet was overly inclusive, approximately half of the claims listed, in fact, did identify improper overpayments. Four days after receiving Kane's e-mail and spreadsheet, Continuum terminated Kane's employment.

According to the United States and New York, Continuum “did nothing further” with Kane's analysis, and in February 2011, Continuum reimbursed DOH for only five improperly submitted claims. Meanwhile, the Comptroller conducted further analysis and identified several additional tranches of wrongful claims, which it brought to Continuum's attention. In 2011, Kane filed suit against Continuum as a qui tam action under the False Claims Act (FCA) on the basis that any person who receives an overpayment from Medicare or Medicaid and knowingly fails to report and return it within 60 days after the date on which it is identified has violated the FCA. In its Motion to Dismiss, Continuum argued that (a) Kane's February 2011 e-mail only provided notice of potential overpayments and did not identify actual overpayments so as to trigger the ACA's 60-day report and return clock, and (b) only “active and conscious action” constitutes knowing avoidance of repayment obligations under the FCA.

### **District Court Opinion**

In a thoroughly-reasoned opinion, the Court rejected Continuum's position that “identified” means “classified with certainty.” Rather, the Court held that identification occurs when health care providers are “put on notice” of potential overpayments. In addition, the Court held that knowing avoidance of repayment obligation includes situations in which a hospital “is put on notice of potential issue, is legally obligated to address it, and does nothing.”

The case is a cautionary tale of how not to respond to notice of potential overpayments. The essential lesson of the case is to respond seriously when reliable information exists suggesting a provider has received an overpayment. The clear expectation of the federal government is that notice will result in good-faith efforts to investigate and repay improper reimbursement. Accordingly, doctors and hospitals will be well served to have a policy concerning the investigation of potential overpayments, including thorough documentation of such efforts. Such steps are particularly important in light of the Court's recognition that evidence of a provider's intent may be a viable defense. In so holding, Judge Ramos wrote that FCA suits “would be unlikely to succeed” if brought against providers that use their best-efforts to return overpayments, even if it takes a little longer than 60 days to do so.

The case leaves open the question of what constitutes being put “on notice” of possible overpayments. The Centers for Medicare and Medicaid

Services (CMS) has proposed a rule suggesting that an 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.” Since the Motion to Dismiss is merely the opening salvo in what will likely be a drawn out appeal, the District Court's opinion should not be overstated. It does, however, provide valuable instruction to every provider who receives notice or has reason to believe it is in receipt of an overpayment from Medicare or Medicaid – the “head in the sand” approach will be costly.

For questions regarding this update, please contact  
Pia Dean  
Holland & Hart, 555, 17th Street, Denver, CO 80202  
email: [pdean@hollandhart.com](mailto:pdean@hollandhart.com), phone: 303-295-8464

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