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UPDATE
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OIG Releases Revised Provider Self-Disclosure Protocol

On April 17, 2013, the Office of the Inspector General (OIG) released a revised Provider Self-Disclosure Protocol (SDP). The SDP allows health care providers to voluntarily self-disclose potential fraud involving federal health care programs. Details of the revised SDP are highlighted below. To view the entire revised SDP, please click here.

BACKGROUND

The SDP is available to all health care providers, suppliers, individuals, or entities (referred to as a Disclosing Party) that are subject to the OIG's civil monetary penalty (CMP) authority. Providers can use the SDP to self-disclose conduct that violates federal criminal, civil, or administrative laws.

BENEFITS OF DISCLOSURE

The OIG has stated that a good faith disclosure under the SDP signifies that the disclosing party has an effective compliance program. Self-disclosing parties with effective compliance programs are often able to resolve noncompliance by settlement and to avoid the imposition of a corporate integrity agreement. Furthermore, the OIG has stated that self-disclosing parties may pay a lower multiplier on single damages than would normally be required in the case of a government-initiated investigation. While the OIG determines the specific multiplier based on the individual facts of each case, the OIG suggests that the minimum multiplier of 1.5 times single damages may be the starting point for determining damages for self-disclosing entities.

THE LOOK-BACK PERIOD

The OIG expects parties using the SDP to disclose and be willing to resolve all liability that occurred within a six-year period from the time at which any claim, request for payment, or other occurrence took place. After disclosure of a potential violation, the disclosing party agrees not to plead any statute of limitations, laches, or similar defense to any action filed related to the disclosed conduct.

SUBMISSION AND ESTIMATED DAMAGE CALCULATION

The SDP describes all of the requirements needed to make a disclosure under the SDP. Entities disclosing conduct that involves false billing must disclose the claim sampling and statistical methodology used to estimate the amount of the overpayment. The OIG has stated

that the sample size must be at least 100 claims. The SDP also includes detailed requirements for disclosures of other types of conduct, including the employment of excluded individuals and violations of the Stark and Anti-kickback laws.

A voluntary self-disclosure to the government of possible violations of federal or state laws carries significant risk of criminal and civil sanctions and should only be pursued after a careful evaluation with the aid of experienced legal counsel of the potential advantages and disadvantages that the particular disclosure may present.

CMS Issues Ruling and Proposed Rule Regarding Part B Billing Following Part A Overpayment Determination

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The Centers for Medicare & Medicaid Services (CMS) recently released a CMS Ruling (the Ruling) and a Proposed Rule (the Proposed Rule) addressing the ability to submit Medicare Part B claims following a denial of a Medicare Part A claim for inpatient services. The Ruling and the Proposed Rule respond to recent decisions by administrative law judges and the Medicare Appeals Council holding that hospitals can bill Part B when Part A payments are denied on retrospective review by a Medicare review contractor. The Ruling is effective as of March 13, 2013 (the Ruling Effective Date), and will remain in effect until CMS issues a final rule on the issue.

THE RULING

The Ruling revises prior CMS policy regarding Part B billing for inpatient hospital claims denied as a result of a Medicare review contractor's determination that an inpatient admission and inpatient services were not reasonable and necessary. The revised policy allows a hospital to submit a Part B claim for all reasonable and necessary inpatient services provided to a Medicare beneficiary (a Beneficiary) that would have been payable under Part B if the Beneficiary had been treated on an outpatient basis following the denial of the Part A claim for payment. Prior Medicare policy allowed Part B claims for only a limited range of inpatient services.

The Ruling also creates an exception to Medicare's general three-day payment window rule, which requires bundling of payment for outpatient services provided during the three days prior to inpatient admission, or one day for hospitals not paid under the hospital inpatient prospective payment systems (IPPS), with the payment for the inpatient stay. Under the Ruling, a hospital may submit separate Part B claims for the outpatient services provided during such three-day window (or one-day window for non-IPPS hospitals) and the inpatient services.

As of the Ruling Effective Date, pending appeals involving the denial of Part A claims subject to the Ruling may be withdrawn, and a hospital may submit a Part B claim within 180 days following the withdrawal. Failure to withdraw an appeal results in an automatic denial of any Part B claim submitted for the inpatient services related to the appeal. Such Part B claims are not subject to Medicare's general one-year timely filing requirement (the Timely Filing Period).

THE PROPOSED RULE

Much of the Proposed Rule mirrors the Ruling; there are, however, some notable distinctions between the two publications. First, CMS proposes to allow a hospital to submit a Part B claim for all reasonable and necessary services provided to a Beneficiary that would have been payable under Part B if the Beneficiary had been treated on an outpatient basis. The Part B claim may be submitted (1) following a denial of Part A payment by a Medicare review contactor; or (2) provided the Beneficiary has already been discharged from the hospital, following a determination by a hospital's utilization review committee that inpatient services should have been provided on an outpatient or observation status basis. In addition, the Part B claims for inpatient services are subject to Medicare's Timely Filing Period.

The Proposed Rule bars a hospital from filing a Part B claim for inpatient services if the hospital, or the Beneficiary, appeals the denial of Part A payment for such services. Such a Part B claim is considered a duplicate claim and automatically denied.

The Proposed Rule also addresses Beneficiary liability for Part B inpatient services. If a hospital submits a timely Part B claim for inpatient services that have been denied as not reasonable and necessary under Part A, the Beneficiary is liable for applicable Part B deductible and copayment costs, and any other amounts due for noncovered services.

CMS is soliciting comments on the Proposed Rule, which must be submitted to CMS no later than May 17, 2013.

If you have any questions regarding the OIG's revised Self-Disclosure Protocol or would like assistance in submitting comments to the CMS in response to the Proposed Rules, please contact a member of Robinson & Cole's Health Law Group.

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