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THE FALSE CLAIMS ACT: DO YOU REALLY HAVE JUST 60 DAYS TO REPAY?

One of your employees informs you of a potential overpayment from Medicare. Do you really only have 60 days from that point to determine if it is indeed an overpayment and repay it?

The Patient Protection and Affordable Care Act of 2010 requires that a person who receives an overpayment of Medicare or Medicaid funds report and return the overpayment within 60 days of the "date on which the overpayment was *identified,"* and makes the failure to do so a violation of the False Claims Act.42 U.S.C. 1320a-7k(d)((2)-(3) (emphasis added). However, Congress didn't define what it means to *identify* a false claim.

On August 3, 2015, the United States District Court for the Southern District of New York issued the first federal court decision addressing when an overpayment should be considered to be "identified" for purposes of determining whether there has been a False Claims Act violation.

The ruling came in the case of *Kane v. Healthfirst, et al. and U.S. v. Continuum Health Partners Inc. et al.*, in which Continuum Health Partners Inc. – which operated and coordinated a network of non-profit hospitals – was accused of failing to make timely repayment of identified overpayments.

The potential false claim was first brought to the defendants' attention in September, 2010 by New York State auditors. An employee of Continuum subsequently provided a preliminary list of potential overpayments to management in February, 2011. He was fired four days later and subsequently filed a whistle-blower action. It wasn't until the government issued a Civil Investigative Demand in June, 2012 that Continuum reimbursed the government for a large number of claims. Continuum did not return all of the overpayments to the government until May, 2013 approximately two years after the initial internal email.

According to the ruling, approximately half of the February, 2011 preliminary list of overpayments did, in fact, constitute overpayments. The Continuum defendants had argued that the 60-day period began only after the overpayment was "classified with certainty." The court, however, sided with

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the government and found that the 60-day clock starts when a person is "put on notice" that a claim may be overpaid.

The court tempered its ruling, though, by stating that a false claims violation occurs only when the "obligation is knowingly concealed or knowingly and improperly avoided or decreased." Further, the court stated that "prosecutorial discretion would counsel against" an enforcement action in a situation involving "well intentioned" providers working with "reasonable haste" to rectify the issue. In such a case, the healthcare provider wouldn't have acted with the "reckless disregard, deliberate ignorance, or actual knowledge" required to support a false claims case.

While the decision didn't provide bright lines and identify exactly when that 60-day clock starts, one of the key takeaways is that once a potential overpayment is identified, a health care provider *must* take prompt action and follow through with a thorough internal review process to determine whether an overpayment truly exists. Then, it must make repayments to the extent required.

Armstrong Teasdale's Health Care Group has counseled many clients on false claims cases, from the internal investigation stage through litigation with relators and the Department of Justice. We have found that involving outside counsel early in the process is key to minimizing the potential impact of these types of claims.