



COMPLIANCE

Health Care Providers Beware: Congress Expands The False Claims Act

On May 20, 2009, President Obama signed the Fraud Enforcement and Recovery Act of 2009 ("FERA"), which significantly expanded the federal False Claims Act. When the Senate considered FERA, its stated purpose for the legislation was to combat financial fraud that helped trigger the recent economic downturn, but FERA applies well beyond the financial services sector. Health care providers especially should be aware of several amendments to the False Claims Act, some of which are discussed in this update.

Liability for Retained Overpayments

Perhaps most importantly for health care providers, Congress amended the False Claims Act to provide for liability for the knowing and improper retention of overpayments. Providers now may be subject to False Claims liability if they avoid or decrease an obligation to pay the government, and FERA defined "obligation" to mean "an established duty, whether or not fixed, arising . . . from the retention of any overpayment." One of the alarming aspects of this development is that this liability can attach whether or not there was a "false claim" or in fact any affirmative representation to the government. However, the "knowing and improper" requirement and the "established duty" language seem to give providers some room to defend an inadvertent failure to refund monies. The obligation to repay any known overpayment does not necessarily mean that a health care provider will risk False Claims Act liability if the facility fails to return overpayments immediately upon discovery. The Senate implied (in legislative history) that a provider would not risk False Claims liability if, upon discovering an overpayment, the provider notified the government and sought to return the money through the cost reporting process. The Senate interpreted the new provision of the False Claims Act to mean that the "retention of an overpayment beyond or following the final submission of payment as required by statute or regulation - including relevant statutory or regulatory periods designated to reconcile cost reports" - could subject a provider to liability.

Lowering the Intent Hurdle

In passing FERA, Congress eliminated provisions of the False Claims Act that required the government to prove defendants had the specific intent to defraud the government. Previously, persons who knowingly made, used or caused to be made or used a false record or statement would be subject to False Claims liability only if the false record or statement was made "to get a false or fraudulent claim paid or approved by the government." Now, such persons may violate the False Claims Act if the false record or statement is "material to" a false or fraudulent claim, regardless of whether they intended to obtain payment from the government. In making this change, Congress's explicit purpose was to annul the unanimous U.S. Supreme Court decision in *Allison Engine v. United States ex rel. Sanders*, a case in which the Court held that a person violated the prior version of the False Claims Act only if the person intended the false or fraudulent claim to be paid by the government itself.

Materiality

Although courts had previously read a materiality requirement into the False Claims Act, Congress has now made that requirement explicit. In very general terms, the materiality requirement meant that a false claim or statement had to have some effect - in theory or in reality - on the government's decision to pay. Congress enacted a subjective definition of material: "Material" means "having a natural tendency to influence, the payment or receipt of money or property."

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Thus, the government needs to prove only that a false record or statement could have influenced the government to approve payment, not that a government decision maker actually relied on the false record or statement in approving payment. It remains to be seen how broadly courts will interpret this materiality standard and whether, for example, statements certifying compliance with the Medicare Conditions of Participation "hav[e] a natural tendency to influence" payment by Medicare so that violation of a single Condition could lead to liability.

Government Contractors and Grantees

Under the pre-FERA version of the False Claims Act, providers could be subject to liability for knowingly presenting or causing to be presented a false or fraudulent claim "to an officer or employee" of the federal government. In *United States ex rel. Totten v. Bombardier Corp.*, the D.C. Circuit Court of Appeals interpreted this "presentment clause" to provide for liability only if a claim was presented directly to a government officer or employee but not if a claim was presented to a non-governmental entity receiving government funds. In FERA, Congress expressly abrogated *Totten* by removing the above quoted language from the False Claims Act and by defining "claim" to clearly include claims made to federal government contractors, grantees or other recipients of government funds who are further spending those funds on the government's behalf or to advance a governmental interest. For health care providers, this amendment means that any federal health care dollars, regardless of which entity paid the dollars, could be the basis for False Claims liability.

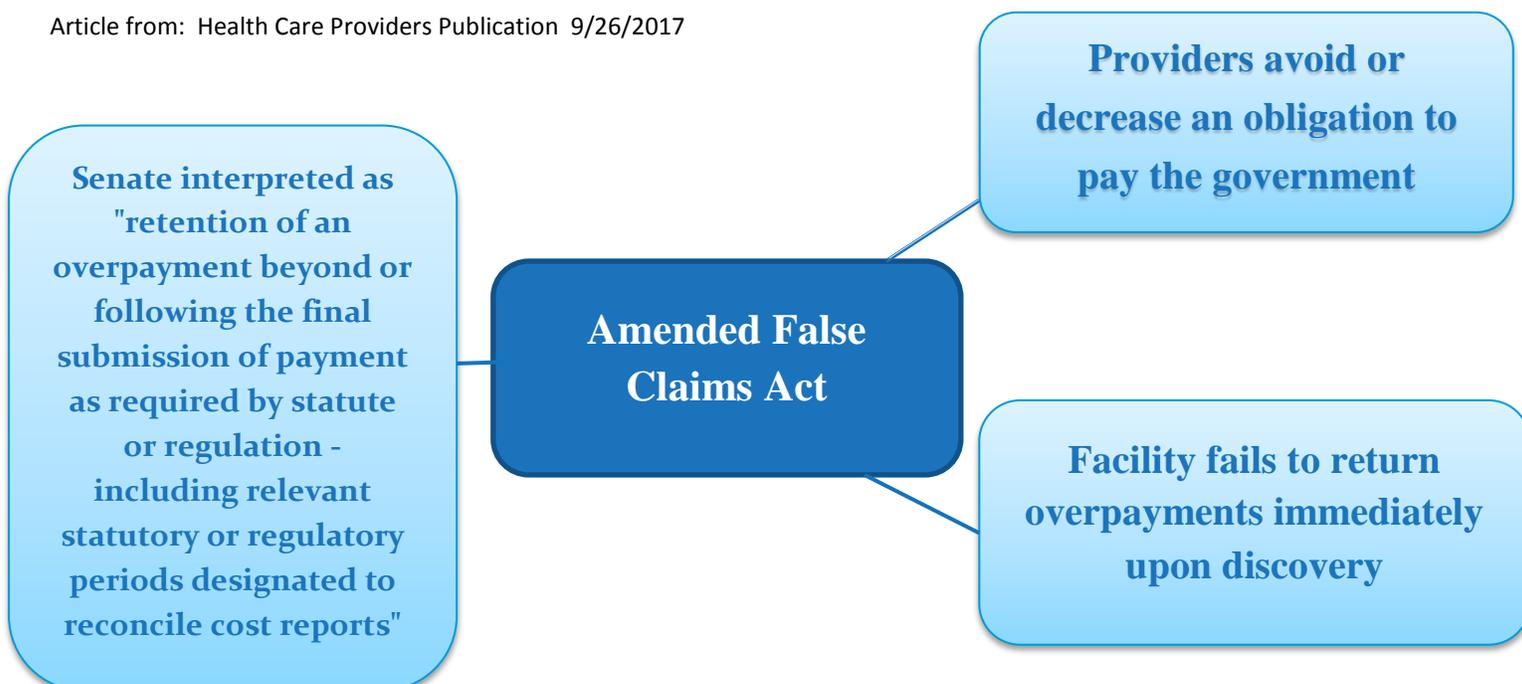
Strengthened Investigative Authority

Since 1986, the U.S. Attorney General has been authorized to issue civil investigative demands (CIDs) prior to commencing a suit or joining a qui tam action under the False Claims Act. CIDs permitted the Attorney General to require production of documents, responses to interrogatories or furnishing of testimony. Before FERA, CIDs were infrequently issued because the Attorney General had to approve the issuance of a CID. However, FERA has significantly increased the power of CIDs by permitting a designee of the Attorney General to issue them and by permitting the Attorney General to share any information received pursuant to a CID with a qui tam relator. Both provisions are likely to increase the use and usefulness of CIDs in False Claims investigations.

A Changing Landscape?

With the passage of FERA, health care providers may be entering an era of increased False Claims investigations and liability. Unfortunately, the FERA amendments generate as many questions as they do answers, and the full import of the FERA amendments will be determined by courts as they interpret the amended False Claims Act.

Article from: Health Care Providers Publication 9/26/2017



SUBSTANCE USE

WHAT MAKES A GOOD ASAM ASSESSMENT?

Written by: Joseph Gorndt, DPH OCPA Assistant Auditor. January 2019.

The assessment is the foundation on which worthwhile, directed treatment of our substance use disorder clients is built. This has always been true, but is even more true under the Organized Delivery System due to its focus on matching the client as he or she is with the least restrictive level of care that is appropriate for his or her situation. The idea of learning how to do a “biopsychosocial” or “multidimensional” assessment may be intimidating to staff, but, even though the jargon may make it seem complex, the actual assessment is not much different than what the SUD system has been doing for years with the Addiction Severity Index.

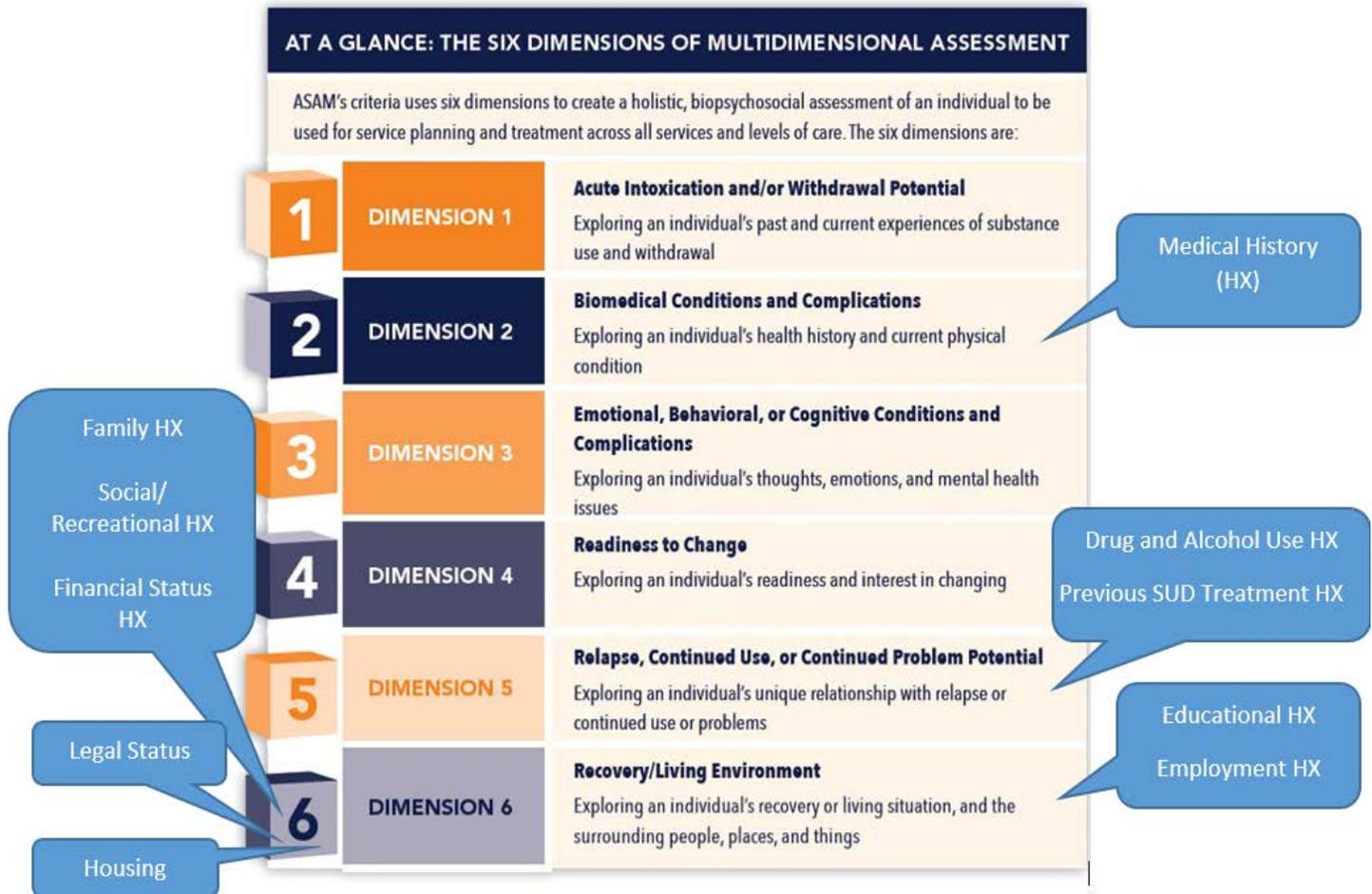


Image from: <https://www.asam.org/resources/the-asam-criteria/about>

HX = history

As you can see, almost all of the ASAM dimensions would be covered by a traditional ASI assessment. The only areas that need to be explored in ASAM but not the ASI would be dimension 1 – Acute intoxication and withdrawal potential and dimension 4 – Readiness to change. Another similarity between the ASAM and ASI assessment is that the client should be assessed in as much depth as they would be in an ASI assessment. This means that sometimes, a client’s answer will require follow-up questions that should be recorded in the assessment, regardless of if the form being used asks for it. For example, if a client states that he or she has been hospitalized, the assessor should follow up with questions about how many times, when, for what, where, and any other questions that might help the assessor to develop a complete and accurate picture of the client.

By making sure to cover all of the elements of an assessment and following up on answers that require it, you can ensure that your assessments meet all the requirements of the Intergovernmental Agreement, and it will permit you to develop a treatment plan that will care for the whole client, rather than focusing on just one aspect of his or her life.

SUBSTANCE USE

ASAM CRITERIA DEFINITION OF MEDICAL NECESSITY

Written by: Joseph Gorndt, DPH OCPA Assistant Auditor. January 2019.

One of the biggest changes in the switch from the Drug Medi-Cal State Plan to the Organized Delivery System was that San Francisco's substance use disorder treatment had to be reorganized around the concept of the ASAM continuum. This move improves client outcomes by ensuring a close match between the individual and the most appropriate level of care for him or her at that time, and allows the client to move up and down through the levels of care as the individual's situation changes. This required a tweak to the definition of medical necessity in SUD services. Now, not only does the individual need a diagnosis for a substance use disorder, he or she also needs to "meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria." But what does that mean?

In the third edition of [The ASAM Criteria](#), the American Society of Addiction Medicine says that a "more holistic" term for medical necessity would be "clinical appropriateness." A Licensed Practitioner of the Healing Arts must determine, through a multidimensional assessment, which level of care would be most appropriate for a client, and document why that is. Without the foundation of a thorough biopsychosocial assessment, it is impossible to accurately determine the correct level of care for a person. Once the assessment has been completed, the assessor must determine what risks and strengths exist in **each** individual dimension and assign a severity rating to the dimension, taking all of those risks and strengths into account. It is possible that dimensions may have effects on each other, but just one consideration should not be entirely determinative of the level of care. Recall that the ratings, generally, work out to the following (please note that dimension 4 – readiness to change, has ratings that work differently. In that dimension, the less ready a person is to change, the higher the rating):

ASAM Criteria Severity Rating

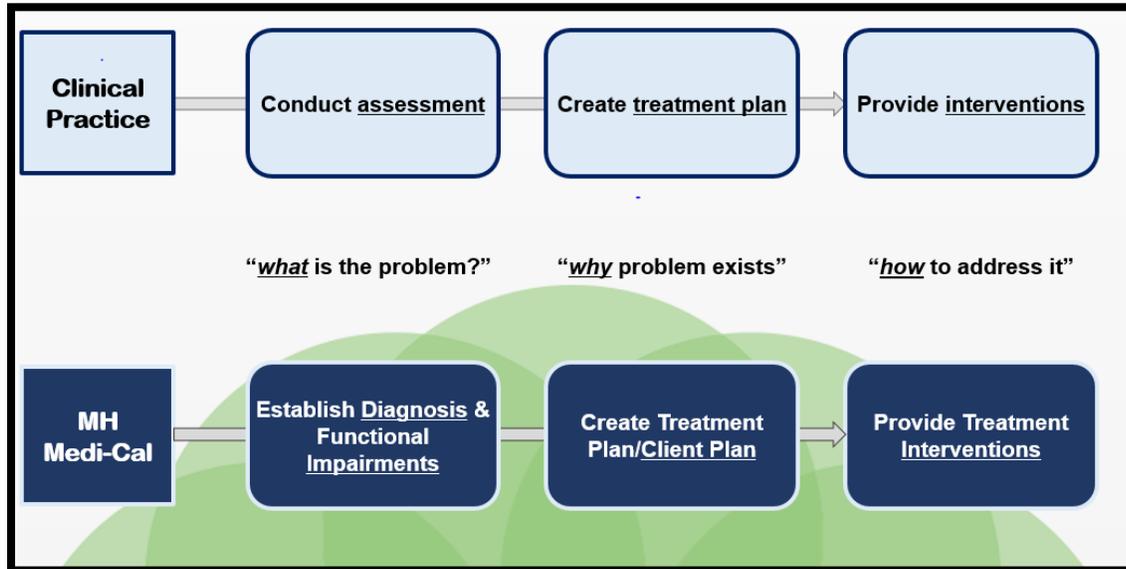
0	1	2	3	4
Indicates that this dimension is a non-issue for the client	Indicates that the client has either a mildly difficult issue in the dimension, or that there are presently only minor signs of problems or symptoms	Indicates that the client has moderate difficulty in functioning in this dimension	Indicates that the client has a serious issue or difficulty coping with this dimension of his or her life. This client is likely to suffer harm due to this dimension if he or she does not begin treatment, but that harm is not likely to be as immediate or as serious as a person who rates a four in that dimension	Indicates that a client will be likely to suffer serious harm in the next few hours or days due to problems in this dimension unless he or she immediately begins treatment in an appropriate institution
non-issue	mild	moderate	severe	immediate danger

Keep in mind that any auditors that review a level of care determination will only look within the four corners of the document to justify the ratings, so the documentation must contain all of the considerations that led to that severity rating. For example, if dimension 2 indicates that a client has been hospitalized four times, an auditor would expect a higher severity rating, but document that those hospitalizations occurred twenty years ago, and the auditor would expect a lower rating. Also, keep in mind that in order to be treated in a substance use disorder program, a client should be suffering from some sort of issue in the substance use related dimensions, 1 and 5. Finally, these severity ratings are used to arrive at the indicated level of care for a client. Crosswalks showing what is required for each level of care are found on pages 175-178 of [The ASAM Criteria](#). If it is clinically appropriate, the final determination may deviate from this indication, but the reason why must be documented. This is how to "meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria."

MENTAL HEALTH

WHAT IS THE “GOLD STANDARD STRATEGY” FOR HIGH QUALITY DOCUMENTATION?

Created by Joseph A Turner, PhD, PSY22453 Former Clinical Documentation Specialist, BHS-QM. Oct 2018.



Once we have established that there is Medical Necessity (refer to prior issue of Compliance Newsletter), with identified functional impairments and the treatment interventions...

I. Assessment

- A. **What is the service?** An activity to evaluate current mental, emotional, behavioral health (includes MSE- Mental Status Examination, analysis of clinical history, relevant cultural issues, diagnosis)
- B. **What is the document and when do you complete it?** A form you fill out initially, annually, OR when there is a change in the client's impairments
- C. **What is the phase of treatment?** A period of time when you are determining medical necessity for services.

Examples of Assessments:

- a) Mental Status Determination
- b) Analysis of the beneficiary's clinical history
- c) Analysis of relevant cultural issues and history
- d) Diagnosis
- e) Use of testing procedures
- f) Any service activity designed to evaluate the current status of a beneficiary's mental, emotional, or behavioral health.

- The **PURPOSE** of Assessment is to determine medical necessity for SMHS
- Sign and date the document, then finalize and submit it. Drafts will **NOT** be accepted.
- **Never copy and paste documents!!!**

II. Create Treatment Plan of Care (TPOC)

Does the TPOC address the functional impairments identified in the current assessment?

Does the TPOC have the Goals/Objectives/Interventions that address the functional impairments?

Has the TPOC been updated when there are significant changes in the client's condition? (at a minimum, updated annually)

MENTAL HEALTH

What Is The “Gold Standard Strategy” for high quality documentation? Cont. from page 5

Other requirements for the TPOC:

1. Client’s signature or your attempt to get the client’s signature (and documented in the progress note attempt was made)
2. Staff signature and date
3. TPOC must be finalized before providing treatment services. In other words, you cannot bill “**planned services**” until the Client Plan is finalized—you will only be able to bill “**Plan Development services**” until the Client Plan is finalized.

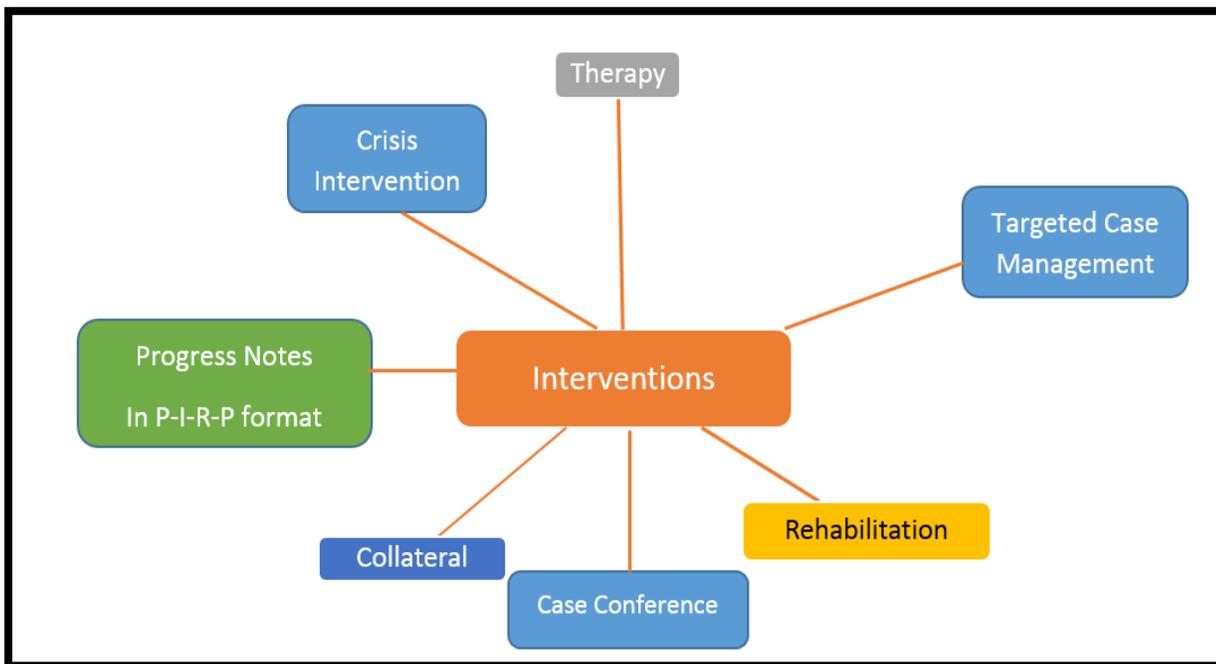
Case Conference as Plan Development:

DHCS has clarified (and BHS/SFMHP has implemented) “case conference” may be billed as plan development, as follows.

CASE CONFERENCE = discussions between direct service providers and other significant support persons or entities involved in the care of the beneficiary. Could be similar or comparable to a multi-disciplinary team meeting.

CASE CONFERENCE AS PLAN DEVELOPMENT = If the case conference concerns the development of a treatment plan for a beneficiary, the conference could be claimed as Plan Development.

III. Provide Intervention/Services



IV. Progress Notes in P-I-R-P Format:

- **Problem** = Problem from the treatment plan you are focusing on
- **Intervention** = Your interventions and activities that address functional impairments (i.e., significantly diminishing impairments/preventing significant decline)
- **Response** = Client’s response to your interventions (with details about how/why the interventions work, changes that are needed, etc.)
- **Plan** = You and the client’s next steps to achieve treatment goals