

Self-discovered Overpayments: Do I Have to Give the Money Back?

Did Recent Amendments to the False Claims Act
Tip the Scales?

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You are the chief executive officer of a large hospital, and you have just received a visit from your chief compliance officer. She informed you that several physicians who take call at your hospital, and receive a fair market value fee for doing so and refer patients to your hospital, began operating without a written agreement last year and still do not have one. What do you do?

There appears to be a common belief that there is an obligation (or at least considerable uncertainty as to whether there is an obligation) to self-report and refund, upon discovery, an overpayment that results from a technical Stark violation or other inadvertent noncompliance with Medicare's payment requirements, but is there such an obligation? In this article, the author examines various civil and criminal statutes, as listed below, and concludes that the better view is that, at least up until very recently, there has not been such an obligation. The amendments to the False Claims Act effected earlier this year, however, may have drastically changed the landscape.

THE REFUND PROVISION IN THE PHYSICIAN SELF-REFERRAL (STARK) STATUTE

Section 1877(g)(2) of the Social Security Act (42 U.S.C. §1395nn(g)(2)) provides:

If a person collects any amounts that were billed in violation of subsection (a)(1), the person shall be liable to the individual for, and shall refund on a timely basis to the individual, any amounts so collected.¹



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The language of the statute and its legislative history indicate that this provision means that entities that collect coinsurance and deductibles from beneficiaries (or, in the case of an unassigned claim, the entire payment) must refund those amounts to the beneficiaries if the underlying claim is not payable by Medicare because of a Stark violation. The liability is to an “individual,” and the refund obligation is to an “individual.”

Whereas the term “person” can refer to a human being or an entity, the term “individual” normally refers only to a human being.² Also, the statute speaks of a person (which should be read to include an entity) “collect[ing]” “amounts,” and this terminology is typically used in the context of a provider or supplier obtaining coinsurance and deductibles from a beneficiary — it is not typically used in the context of a provider or supplier obtaining money from the Medicare program. The legislative history is explicit that the obligation pertains to refunding amounts to the Medicare beneficiary, without giving any indication that the obligation extends to the Medicare program.³

The regulation implementing the refund obligation is 42 C.F.R. §411.353(d). Whereas it certainly can be read as applying only to amounts collected from beneficiaries, it is not as clear as the statutory text. Section 411.353(d) as it first appeared in the 1995 final rule read:

d) Refunds. An entity that collects payment for a laboratory service that was performed under a prohibited referral must refund all collected amounts on a timely basis.⁴

This text was amended slightly in the 2001 Phase I interim final rule and has not been further amended. It currently reads:

d) Refunds. An entity that collects payment for a designated health service [DHS] that was performed under a prohibited referral must refund all collected amounts on a timely basis, as defined in § 1003.101 of this title.

Two things are noteworthy about the regulatory text. First, instead of using “person,” as does the statutory text, the regulatory text uses “entity” to make it clear that the refund obligation is imposed upon hospitals and other institutional providers and other artificial beings as well as upon individuals.⁵ Second, the word “individual” is noticeably absent from the text; instead, the text says only that a refund must be made — it does not say to what or to whom the refund must be made. Based on the statutory language and its legislative history, however, the agency should be precluded from interpreting section 1877(g)(2) of the Act as allowing it, through regulation or adjudication, to impose a duty to make refunds to the Medicare program.⁶

Moreover, although the preambles to the various Stark regulations have not always been clear on this point, there are several indications that CMS has understood section 1877(g)(2) of the Act as imposing an obligation to refund amounts to Medicare beneficiaries, and there are no affirmative indications that CMS has understood the statute to mean that refunds must be made to the program. For example, the 1992 proposed rule stated:

Under section 1877(g)(2), if a person collects any amounts that were billed in violation of section 1877(a)(1), the person will be liable to the individual from whom the amounts were collected and must refund on a timely basis any amounts collected.⁷

Preamble language in the 1995 final rule is interesting because it refers to the Medicare program when discussing the prohibition on billing pursuant to tainted referrals but speaks only of individuals when mentioning the refund obligation:

In general, section 1877 as added by [Omnibus Budget Reconciliation Act] OBRA '89 prohibits a physician with a financial relationship with an

entity that furnishes clinical laboratory services (or a physician with an immediate family member who has such a relationship) from making a referral to that entity for clinical laboratory services for which Medicare would pay. It also prohibits the entity from billing Medicare, an individual, a third-party payor, or other entity for an item or service furnished as a result of a prohibited referral. Additionally, it requires a refund of any amount collected from an individual as the result of a billing for an item or service furnished under a prohibited referral. The statute provides for certain exceptions to the prohibition.⁸

The 1998 proposed rule also described the statutory requirement as requiring refunds to individuals.⁹ On the other hand, there are several references in the various preambles that do not specify that refunds are required to be made to individuals (but neither do they say that refunds must be made to the Medicare program, and the use of the word “collected” is some indication that the agency understood the statutory provision as applying to amounts paid by beneficiaries and not amounts paid by the program).¹⁰ Note that the regulation text states that the refund must be made on “a timely basis, as defined in §1003.101 of this title.” When one turns to 42 C.F.R. §1003.101, it defines “timely basis” with reference to §1003.102 (b)(9), which says that OIG may issue a civil monetary penalty (CMP), and where authorized, an assessment against:

any person...whom it determines in accordance with this part—

(9) Has not refunded on a timely basis, as defined in §1003.101 of this part, amounts collected as the result of billing an individual, third party payer or other entity for a designat-

ed health service that was provided in accordance with a prohibited referral as described in §411.353 of this title.

There are two things noteworthy about §1003.102 (b)(9). First, although it goes so far as to say that the refund obligation is triggered by collecting amounts as a result of billing an “individual, third-party payer or other entity” for DHS that was provided in accordance with a prohibited referral, it does not go further and specify the Medicare program. Is this a concession that section 1877(g)(2) and the regulations do not require a refund to the Medicare program, or is “other entity” intended to be purposefully vague so as to allow the agency to claim at some point that the language was intended to encompass the Medicare program?¹¹

Second, apart from the issue of whether the regulation extends the obligation to refund amounts to the Medicare program, the mere fact that it includes a “third-party payer or other entity” appears to be going beyond the statute, without any proposal to do so in a proposed rule or any explanation in the final rule. Perhaps the reason for including third-party payers was the belief that, where third-party payers make payment for DHS that were furnished as a result of a prohibited referral, beneficiaries will incur higher premiums in the future if the billing entities do not make refunds to the third-party payers.

SECTION 1128B(A)(3) OF THE ACT

Section 1128(B) of the Act (42 U.S.C. §1320a-7b), home of the anti-kickback statute, sets forth various provisions that impose criminal penalties for prohibited acts. Section 1128B(a)(3) of the Social Security Act provides that it is a felony, punishable by up to five years in prison and by a fine of up to \$25,000, if a person:

having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such ben-

efit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized[.]

This section, although not lengthy, is hardly a paragon of clarity.¹² Does it criminalize (1) the act of failing to disclose and return an overpayment that was received without knowledge that the payment was incorrect, or does it apply only to (2) failure to return an overpayment where the recipient knew, at the time it received it, payment was incorrect?

The better reading is that it applies only to the latter situation. The statute criminalizes behavior of an actor who “conceals or fails to disclose such event with an intent *fraudulently* to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized (emphasis added). If Congress intended to punish merely holding on to money that an entity discovered, sometime after receipt, that it was not entitled to keep, the word “fraudulently” would be superfluous. A longstanding principle of statutory construction (which, admittedly is only that, and not a rule of law) is that each word must be given meaning.¹³ Another longstanding principle, one that is a rule of law, is that criminal statutes must be construed narrowly, and where ambiguous, “the tie goes to the defendant.”¹⁴

Both CMS and the OIG seem to have interpreted section 1128B(a)(3) as applying to the second situation, but both agencies have simply cited the statutory provision for the proposition that an overpayment must be returned, without providing any analysis as to why section 1128B(a)(3) applies to mere overpayments.

CMS cited 1128B(a)(3) in a 2002 proposed rule (never finalized) that would have required all overpayments to be refunded to the Medicare program within 60 days of the provider's or supplier's discovery of the overpayment,¹⁵ and the OIG citations to 1128B(a)(3) appear in several draft and final industry guidance documents.¹⁶ Several complaints asserting civil liability under the False Claims Act have asserted a violation of section 1128B(a)(3), but there are no reported decisions that have found a defendant criminally guilty or not guilty of violating the statute.¹⁷ A law review article published in 1999 expresses doubt on the government's ability to use section 1128B(a)(3) to convict someone for failing to return an overpayment if the person did not know at the time of receipt that he or she was not entitled to payment.¹⁸

HHS REGULATIONS REQUIRING THE RETURN OF OVERPAYMENTS

Currently, there are no regulations requiring the return of overpayments. As noted above, in 2002, CMS issued a proposed rule that would have required providers to self-report and return overpayments, but CMS has never finalized the proposal, and the proposed rule does not appear in the current unified agenda of HHS regulations.¹⁹

Manual instructions issued by CMS indicate that there is no debt owed until the agency or its contractors make a determination that a debt is owed.²⁰ As explained below in the discussion of the recent amendments to the False Claims Act, however, CMS may be motivated to revisit the issue.

CRIMINAL STATUTES IN 18 U.S.C.

There are several provisions in title 18 imposing criminal liability that are either directed specifically at health care fraud or of general applicability and could be invoked in a health care fraud case.²¹ For the most part, these statutes do not punish passive behavior but rather address false statements, fraudulent acts of concealment, and other bad behaviors. One possible

exception is section 669 of 18 U.S.C., entitled “Theft or embezzlement in connection with health care,” which was added by section 243(a) of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, and provides:

(a) Whoever knowingly and willfully embezzles, steals, or otherwise without authority converts to the use of any person other than the rightful owner, or intentionally misapplies any of the moneys, funds, securities, premiums, credits, property, or other assets of a health care benefit program, shall be fined under this title or imprisoned not more than 10 years, or both; but if the value of such property does not exceed the sum of \$100 the defendant shall be fined under this title or imprisoned not more than one year, or both.

Like section 1128B(a)(3) discussed above, section 669 of title 18 is frequently cited by the OIG in its compliance guidance for the proposition that an overpayment (however it was received) must be returned.²² What is entirely clear about section 669 is that it punishes intentionally bad behavior such as stealing, and the only reported cases on this statutory section have involved convictions on that basis.²³ What is considerably less clear is whether section 669 punishes the mere retention of funds that were received without knowledge that the recipient was not entitled to them.

The better reading of this section is that merely retaining an overpayment that was not obtained by a bad act is not punishable. In particular, the language “or otherwise converts” would seem to refer to the act of criminal conversion, which involves intentionally wrongful conduct.²⁴ Likewise, to intentionally misapply funds of the government, the actor must have engaged in a “voluntary, intentional violation of a known legal duty.”²⁵

Thus, the language “otherwise without authority converts to the use of any person other than the rightful owner, or intentionally misapplies” seems to be directed at proscribing certain actions with respect to a legal duty rather than establishing the legal duty itself.²⁶ As noted above with respect to section 1128B(a)(3) of the Social Security Act, the rule that criminal statutes should be construed narrowly may make it difficult to successfully prosecute an individual who fails to return an overpayment that was not known to be an overpayment at the time payment was received.

THE FALSE CLAIMS ACT

The civil False Claims Act (FCA), codified at 31 U.S.C. § 3729 et seq., imposes penalties for knowingly submitting or causing to be submitted a false claim to the federal government. The FCA punishes other knowing, wrongful behavior, including what is known as a “reverse false claim.” Prior to the recent amendments to the FCA, the reverse false claims provision was codified at 31 U.S.C. 3729(a)(7) and reached conduct where the actor:

knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government.

Thus, in order to be culpable, it was not enough for a party to have simply avoided repaying the government money owed, but rather the party would have to have taken the affirmative act of making or using (or causing to be made or used) a false record or statement for the purpose of avoiding repayment. In this regard, the reverse false claims provision was not very different from the “regular” false claims provision at 31 U.S.C. 3729(a)(1) and for that reason was relied on sparingly by the government and relators.

On May 20, 2009, however, the President signed into law the Fraud Enforcement and

Recovery Act of 2009 (FERA),²⁷ which makes sweeping changes to the FCA, including the reverse false claims provision. As amended, and now codified at 31 U.S.C. 3729(a)(1) (G), the reverse false claims provision covers the situation in which a person:

knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, *or knowingly conceals or knowingly and improperly avoids or decreases an obligation* to pay or transmit money or property to the Government. (Emphasis added)

As applied to funds in the possession of a party, the change in language means that the reverse false claims provision now reaches two types of behavior: (1) taking the affirmative action of using or causing to be used a false record or statement to avoid having to pay money to the government; and (2) affirmatively hiding the existence of the funds, or “improperly avoid[ing]” an obligation to pay the funds to the government.

Did Congress intend that sitting on one's hands and doing nothing to repay money to the government is “improperly avoid[ing]” an obligation? The language itself is susceptible of more than one interpretation, and there is no definition of “knowingly and improperly avoids or decreases,” but it would seem that the answer is yes, or there would have been little point in amending the provision.²⁸ One could argue that if doing nothing means improperly avoiding an obligation, there would have been no need for the language “knowingly conceals,” and therefore simply keeping quiet is not “improperly avoid[ing]” an overpayment, but “knowingly conceals” is not superfluous if emphasis is given to “improperly.” That is, the phrases “knowingly conceals” and “knowingly and improperly avoids” can be read in harmony with each other, if the lat-

ter is construed as not reaching the situation in which a party does not repay an obligation because it contests the existence or amount of the obligation or is involved in a reconciliation process (such as a cost report reconciliation process).

Assuming for the moment that the FCA now punishes doing nothing to return an overpayment if there is an obligation to return an overpayment, the question becomes where is such an obligation found? One view is that, irrespective of whether the Medicare statute or regulations or other authority imposes such an obligation, the FCA, as amended by FERA, itself imposes that obligation. That, at least, is the view taken by the authors of the Senate Committee Report. The Committee stated:

The new definition of “obligation” includes an express statement that an obligation under the FCA includes “the retention of an overpayment.” The Department of Justice supported the inclusion of this provision and provided technical advice that the proper place to include overpayments was in the definition of obligation.²⁹

New § 3729(b)(3) does not say that the term includes “the retention of an overpayment.” The Committee has misquoted slightly the definition of “obligation,” and its error may be due to cutting and pasting from its earlier report, S.110-507. The definition of “obligation” in S.2041, to which S. Rep. 110-507 pertained, did say that “the term ‘obligation’ means...the retention of any overpayment.” Likewise, early versions of S.386 said that, but the version of S.386 passed by the full Senate, agreed to by the House, and enacted into law says that

the term “obligation” means *an established duty*, whether or not fixed, *arising from* an express or implied contractual, grantor-grantee, or licensor-licensee relationship, *from*

a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment[.] (Emphasis added)

Thus, as enacted, an obligation is an “established duty,” which can arise from various sources. The duty can *arise from*, for example, a contract or statute or regulation, but simply because there is a contract or statute or regulation does not mean there is an obligation that triggers the reverse false claims provision because it has not been complied with by a party—it depends on what the contract or statute or regulation says.

To illustrate, suppose that a party contracts with an agency to supply five gallon containers of bottled water, and the party is accused of a reverse false claims violation for failing to rebate money to the government because of a substantial number of untimely deliveries of the containers. The mere fact that there are statutes and regulations pertaining to contracting with the government, and a specific contract between the bottled water company and the government, will not establish the duty to rebate money to the government; however, the particular terms of the contract between the company and the government may establish such a duty. Similarly, one reading of paragraph (b)(3) is that the mere retention of an overpayment is not an obligation by itself but may trigger an obligation that is established elsewhere.

As a practical matter, however, what exactly is that “elsewhere”? It is one thing to say that, although an obligation may arise from a regulation or a contract, whether it does in fact depends on its precise terms, but this type of argument does not lend itself very easily to an overpayment. If the mere retention of an overpayment does not itself create an “obligation,” what facts and circumstances do, and where would those facts and circumstances be set forth?

The answer to the latter question would seem to be that they would be set forth in a

regulation, or an express or implied contract between the party and the government, and given that paragraph (b)(3) already covers the situation in which the government establishes an “obligation” to repay an overpayment through “an express or implied contractual, grantor-grantee, or licensor-licensee relationship, ...fee-based or similar relationship, [or] statute or regulation, the point of including the language “or from the retention of any overpayment” may very well have been to declare the retention of an overpayment itself an obligation.

Even if a plausible reading of §3729(b)(3) is that the retention of an overpayment by itself is not an “obligation” but rather there must be an established duty elsewhere to repay an overpayment, and even if, for the sake of argument, such reading is the better reading of the provision, it does not necessarily follow that if the government adopts the contrary view, it will fail to prevail in an FCA action. Under step two of the two-step *Chevron* test,³⁰ courts must defer to a reasonable interpretation of the agency that is the delegated authority to implement the statute (even if that interpretation is not the best reading of the statute), provided the interpretation is contained in a validly promulgated substantive regulation.

Where an agency pronouncement does not qualify for *Chevron* deference because it is not contained in a substantive rule,³¹ it is nevertheless eligible for some lesser degree of deference, according to its persuasiveness.³² Although one tends to think of *Chevron* deference as applying to rules issued by regulatory agencies such as HHS or the U.S. Environmental Protection Agency (EPA), it also applies to rules promulgated by the Department of Justice (DOJ).³³ Thus, DOJ could issue a final rule that would adopt the position that retention of an overpayment by itself creates an obligation, and if it does, there would seem to be little prospect for successfully challenging such a rule.

Moreover, although CMS did not finalize its 2002 proposed rule that would have

required providers and suppliers to return overpayments, it could choose to do so now, either to moot out any dispute about what the FERA amendment means or because it may find the timing convenient given the economic downturn and the congressional climate of taking a tougher stance on false claims and program abuse.

It is not clear how the changes made by FERA will affect providers and suppliers that discover they have, or may have, overpayments. *If* the FERA amendment to the reverse false claims provision of the FCA does indeed mean that the mere existence of an overpayment is (at least at some point in time) an obligation, it is not clear how soon after discovery a provider or supplier must return the overpayment³⁴ or how the provision will mesh with current rules affecting Medicare overpayments.

As noted above, section 2409 of the Provider Reimbursement Manual states that, once the intermediary makes a determination that an overpayment has been made, “the amount so determined is a debt owed to the United States Government.” That manual provision could be interpreted to mean that *unless and until* the contractor makes a determination, there is no overpayment. Also, the statute provides for the waiving of overpayments under certain circumstances, and CMS’ regulations provide time limits for reopening determinations that were not procured by fraud or “similar fault.”

Section 1870(a) of the Act (42 U.S.C. §1395gg) provides that a payment to a provider or a supplier is considered to be a payment to the beneficiary who received the items or services. Therefore, all overpayments, with the exception of certain aggregate overpayments described, are considered to be the beneficiary’s overpayment. Under section 1870(b) of the Act, however, if payment was made to a provider or supplier, Medicare looks first to recover any associated overpayment from the provider or supplier unless: (1) the provider or supplier is “without fault” with respect to the overpayment, or (2) the Secretary

determines that the overpayment cannot be recouped from the provider or supplier. Section 1870(b) of the Act also specifies that, in the absence of evidence to the contrary, without fault is administratively presumed for a provider or supplier when an overpayment is discovered after the third calendar year following the year in which notice of the payment was sent to the provider or supplier.

CMS’ rules for reopening and revising claims determinations provide that, in the absence of fraud or similar fault, an initial determination may be reopened within four years of its date for good cause.³⁵ Similarly, the regulations for reopening cost report determinations provide that, in the absence of fraud or similar fault, the time limit for reopening is within three years of the determination.³⁶ In light of the existing statutory and regulatory framework, what would be a provider’s duty to repay if it discovers an overpayment more than, say, four years after payment was made?

A reasonable position would seem to be that it would not be necessary to repay the overpayment because §3729(a)(1)(G) reaches only those who “improperly” avoid or decrease an obligation, and by giving up on overpayments after they reach a certain age, the agency has relinquished any claim that it is improper to keep such overpayments. It would not seem to be reasonable, however, that if a provider or supplier discovers an overpayment prior to the reopening period, it can simply wait out the reopening period. Rather, assuming that the retention of an overpayment is by itself an obligation within the meaning of FCA, a provider or supplier that discovers an overpayment prior to the reopening period would be at risk for an FCA action brought after the reopening period but before the longer (at least six years) statute of limitations under the FCA.

CONCLUSION

A health care entity that discovers it has been overpaid has colorable defenses if the govern-

ment seeks to impose civil or criminal liability for the failure to return it. The recent change by FERA to the reverse false claims provision of the FCA, however, may have tipped the scales in favor of returning all known overpayments within a reasonable time after discovery, given the distinct possibility that the FERA amendment will be so interpreted by courts, combined with the severe penalties imposed by the FCA and the incentive for relators to bring reverse false claims suits.

Endnotes:

1. Note that section 1877(g)(3) of the Act (42 U.S.C. §1395nn(g)(3)) provides for a civil monetary penalty for failure to make such a refund.
2. The Dictionary Act, 1 U.S.C. §1, indirectly defines "individual" as a human being, because it defines "person" as "corporations, companies, associations, firms, partnerships, societies, and joint stock companies, as well as individuals."
3. The physician self-referral statute was enacted in the Omnibus Budget Reconciliation Act (OBRA) of 1989, Pub. L. No. 101-239 and significantly amended in OBRA of 1993, Pub. L. No. 103-66. The OBRA '89 House Report, H.R. Rep. No. 101-247, at 928, 1989 U.S.C.C.A.N. 1906, 2399, states:
(g) Denial of Payments—Medicare payment would be denied for any item or service provided pursuant to a prohibited referral. A person who received any payment from a Medicare beneficiary, including any coinsurance or deductible payments or any payment for an unassigned claim for a service provided pursuant to a prohibited referral, would be required to make a prompt refund to the beneficiary.

Also, the same report at 1014, 1989 U.S.C.C.A.N. at 2515, states:

(h) Sanctions – Medicare payment would be denied for any item or service provided pursuant to a prohibited referral. A person who receives any payment from a Medicare beneficiary (including any coinsurance or deductible payments or any payment for an unassigned claim) for a service provided pursuant to a prohibited referral would be required to make a prompt refund to the beneficiary.

In the Conference Report, H.R. Conf. Rep. No. 101-386 at 849, 850, 1989 U.S.C.C.A.N. 3018, 3452-53, the House bill is described:

(h) Sanctions. –
* * *

(2) Requiring refunds for certain claims. –
Requires a person who collects money billed for a service provided pursuant to a prohibited referral to refund that money on a timely basis

to the individual, and shall be liable to the individual for any amounts so collected.

There is no mention of the refund obligation in the House and Conference Reports to OBRA '93.

4. 60 FR at 41,914, 41,980 (Aug. 14, 1995).
5. "Entity" is defined at 42 C.F.R. §411.351 as including persons and sole proprietorships.
6. The agency likely could invoke its general rulemaking authority in sections 1102(a) and 1871(a) of the Act (42 U.S.C. §§1302(a), 1395hh(a)) to impose such a duty; however, the agency did not invoke those general grants of rulemaking authority when implementing section 1877(g)(2) of the Act.
7. 57 FR 8588, 8592 (Mar. 11, 1992).
8. 60 FR at 41,915.
9. See 63 FR at 1661-62 ("Additionally, [OBRA '89] required a refund of any amount collected from an individual as a result of a billing for an item or service furnished under a prohibited referral").
10. See e.g., 69 FR at 857 ("Additionally, the statute mandated refunding any amount collected under a bill for an item or service furnished under a prohibited referral."); 66 FR at 1695 ("In the August 1995 final rule, we included in §411.353(d) the requirement that an entity that collects payment for a laboratory service that was performed under a prohibited referral must refund all collected amounts on a timely basis."); 60 FR at 41924 ("Under section 1877(g)(2), if a person collects any amounts that were billed for services furnished under a prohibited referral, a timely refund of each amount is required."); *Id.* ("Similarly, the Office of the Inspector General could impose sanctions if, for example, a clinical laboratory has failed to refund an amount that it collected for a service furnished as the result of a referral if the laboratory knew the referral was prohibited."); 60 FR at 41921 ("In section 411.353(c), we provided that we would not pay for a clinical laboratory service that is furnished under a prohibited referral, and we proposed, in section 411.353(d), to require an entity that collects payment for a laboratory service performed under a prohibited referral to refund all collected amounts on a timely basis."); 57 FR at 8601 ("Furthermore, under section 1877(g)(3), should any entity present a bill or claim for an item or service that the entity knows or should have known was furnished under a prohibited referral, or has not refunded amounts collected for the referral, the entity is subject to civil money penalties."); 57 FR at 8600 ("Section 1877(g)(3) authorizes the imposition of a civil money penalty when any person who presents or causes to be presented a bill or claim for a service that the person knows or should know was furnished under a prohibited referral (in contravention of section 1877(a)(1)), or who has not refunded amounts inappropriately collected for a prohibited referral").
11. Note that although the OIG does not have delegated authority to interpret section 1877(g)(2) of the Act (that responsibility lies with CMS), regulations are signed not by the Inspector General or the Administrator of CMS but rather the Secretary, so irrespective of whether CMS had an active role in drafting §1003.102 (b)(9), it (whatever "it" means)

- represents the position of all components of the Department including CMS and OIG.
12. The provision was added as part of the 1972 Amendments to the Social Security Act, Pub. L. No. 92-603, and its legislative history provides no real clue as to its limits. HR. Rep. No. 92-231 stated:

In addition, the provision would include penalties for concealing or failing to disclose knowledge of any event affecting a persons' right to any benefit payment with the intent to defraud, or for knowingly and willfully converting benefits or payments to improper use. Under the bill, the penalty for such acts, as well as false statements or representations of material facts in any application for payment under the Medicare and Medicaid programs, would be a fine of \$10,000, 1 year of imprisonment, or both.

1972 U.S.C.C.A.N. 4989, 5093. The Conference Report merely noted that the Senate amendment substituted "whoever" for "Any provider...or other person" H.R. Conf. Rep. No. 92-1605, U.S.C.C.A.N. at 5387.
 13. *See, e.g., Bailey v. United States*, 516 U.S. 137, 143-45 (1995) (noting the "assumption that Congress intended each of its terms [in a statutory scheme] to have meaning").
 14. *See Santos v. United States*, ___ U.S. ___, 128 S.Ct. 2020 (2008) wherein the Court stated:

The rule of lenity requires ambiguous criminal laws to be interpreted in favor of the defendants subjected to them. This venerable rule not only vindicates the fundamental principle that no citizen should be held accountable for a violation of a statute whose commands are uncertain, or subjected to punishment that is not clearly prescribed. It also places the weight of inertia upon the party that can best induce Congress to speak more clearly and keeps courts from making criminal law in Congress's stead.

___ U.S. at ___, 128 S. Ct. at 2025 (citations omitted).
 15. CMS 6011-P, 67 FR 3662 (Jan. 25, 2002).
 16. *See, e.g.*, 65 FR 36818 (compliance guidance for individual and small group physician practices); 65 FR 14289 (March 16, 2000) (compliance guidance for nursing facilities); 64 FR 54031 (Oct. 5, 1999) (compliance guidance for hospices).
 17. In *United States v. Salina Reg'l Health Ctr., Inc.*, 459 F. Supp.2d 1081 (D. Kan. 2006), the *qui tam* relators alleged the defendant violated section 1128B(a)(3) to establish a violation of the False Claims Act, 31 U.S.C. §3729-31. The court did not agree that section 1128B(a)(3) had been violated.
 18. Nessim, Ronald J., *Health Care Disclosure Statute: What Does it Mean?*, 13-WTR Crim. Just. 34 (ABA Winter 1999); *see also* Brainin, Stacy L., *Health Care: A Unique Criminal and Civil Enforcement Environment*, 45 S. Tex. L. R. 131, 138-39 (Winter 2003).
 19. In the 2002 proposed rule, CMS noted that it had issued an interim final rule in 1998 that required Medicare+Choice organizations (the forerunners of Medicare Advantage organizations) to self-report and return overpayments but that this requirement was eliminated in a 2000 final rule because CMS believed that it was arguably unfair to impose the requirement on managed care organizations without also applying it to fee-for-service providers and suppliers. *See* 65 FR 40170, 40265 (Jun. 29, 2000).
 20. *See* Medicare Provider Reimbursement Manual, CMS Pub. 15-1, § 2409 (1997) (once the intermediary makes a determination that an overpayment has been made, "the amount so determined is a debt owed to the United States Government."
 21. *See, e.g.*, 18 U.S.C. §371 (conspiracy to defraud the Government); 18 U.S.C. §1001 (false statements); 18 U.S.C. §1035 (scheme to defraud health care benefit program); 18 U.S.C. §1341 (mail fraud); 18 U.S.C. §1343 (wire fraud); 18 U.S.C. §1347 (false statements relating to health care); 18 U.S.C. §1518 (obstruction of health care offense investigation); 18 U.S.C. §1956 (money laundering); 18 U.S.C. §§1961-64 (RICO).
 22. *See* note 14, *supra*.
 23. Three defendants were convicted of stealing checks from an insurer, and the district court issued three separate opinions. *See, e.g., U.S. v. Francis*, 2003 WL 1701978 (S.D. N.Y. 2003).
 24. *See e.g., U.S. v. Herring*, 72 Fed. Appx. 57 (5th Cir. 2003) (in appeal of conviction under 18 U.S.C. §§ 371 and 1347, jury was properly instructed that conversion was "the wrongful taking of money or property belonging to someone else with intent to deprive the owner of its use or benefit either temporarily or permanently").
 25. *See U.S. v. Bates*, 96 F.3d 964, 970 (7th Cir. 1996), *citing United States v. Pomponio*, 429 U.S. 10, 12-13 (1976).
 26. For the same reason, sections 1001 and 1035 of title 18, which punish "knowingly and willfully" "conceal[ing] a material fact, would seem to be directed at avoiding a legal duty rather than establishing a legal duty.
 27. Pub. L. No. 111-21.
 28. In the report accompanying S.386, the bill that became law, the Committee stated:

Section 3729(a)(7) of the FCA currently imposes liability on any person who 'knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government.' 31 U.S.C. Sec. 3729(a)(7)(2000). This provision is commonly referred to as creating 'reverse' false claims liability because it is designed to cover Government money or property that is knowingly retained by a person even though they have no right to it. This provision is similar to the liability established under 3729(a)(2) for making 'false records or statements to get false or fraudulent claims paid or approved.' 31 U.S.C. 3729(a)(2)(2000). However, the provision does not capture conduct described in 3729(a)(1), which imposes liability for actions to conceal, avoid, or decrease an obligation directly to

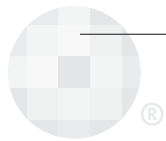
the Government. This legislation closes this loophole and incorporates an analogous provision to 3729(a)(1) for 'reverse' false claims liability.

S. Rep. 111-10, at 13-14 (2009). The same language appeared in the same Committee's report on S. 2041, the False Claims Act Corrections Act of 2008. See S. Rep. No. 110-507, at 17. In its report on S. 386, the Committee stated that the report to S. 2041, S. Rpt. 110-507, should be read as a complement to this report due to a number of similar changes contained in S. 386. S. Rep. 111-10 at 10 n.2.

29. S. Rep. 111-10 at 15. This language (and more) also appeared in S. Rpt. 110-507, the report to S. 2041. The Committee's reference to support from DOJ is to the February 21, 2008, letter from Brian Benczkowski, principal deputy assistant attorney general, United States Department of Justice, to Senator Patrick Leahy, chairman, Senate Committee on the Judiciary. The DOJ letter, available at www.friedfrank.com/practice_groups/qui_tam/DOJ-S2041-022708.pdf, indeed takes the position that knowing that one has an overpayment creates an obligation to return it.

30. *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). Under step one, courts are required to give effect to the unambiguously stated intent of Congress.
31. *Christensen v. Harris County*, 529 U.S. 576, 587 (2000).
32. *U.S. v. Mead Corp.*, 533 U.S. 218, 234 (2001), citing *Skidmore v. Swift & Co.*, 323 U.S. 134.
33. See *Schneider v. Feinberg*, 345 F.3d 135 (2003); see also *Dada v. Mukaskey*, 123 S.Ct. 2307, 2324 (dissenting opinion of Scalia, J.).
34. Again, there should be no liability for failing to return an overpayment if the provider or supplier is still within the time for appealing the overpayment and has a good faith intention of pursuing an appeal. Moreover, because the reverse false claims provision prohibits only "knowingly conceal[ing] or knowingly and improperly avoid[ing] or decreas[ing] an obligation," disclosing a potential overpayment (without making a refund), and leaving it to CMS to decide whether there is in fact an overpayment and whether it wants to recoup should not constitute a violation of the FCA.
35. 42 C.F.R. §405.980(b)(2).
36. 42 C.F.R. §405.1885(b).

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