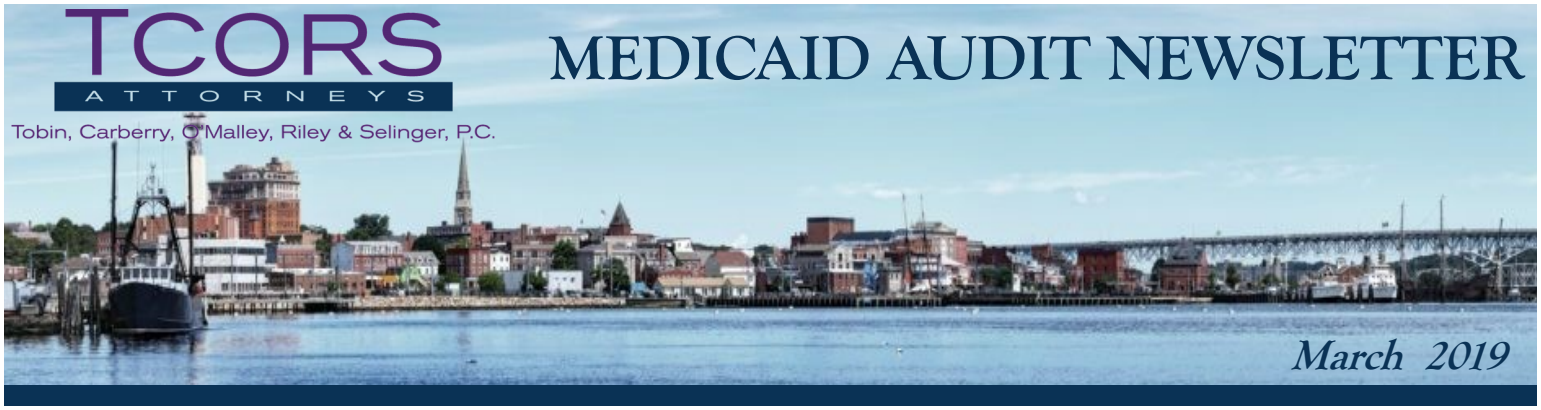

DEFENDING AGAINST QUI TAM ACTIONS

This newsletter is the second of a two part series regarding recent State of Connecticut False Claim Cases. In Part I, we reviewed the Connecticut False Claims Act and in this follow-up we review how to defend against Qui Tam Actions.

A. Confidentiality Agreements

Many qui tam actions are initiated by employees or former employees. Often, these employees will be subject to confidentiality agreements. While some courts have expressed an unwillingness to enforce confidentiality agreements in the FCA context as a matter of public policy, some recent decisions have indicated some limited support for confidentiality agreements, especially if the relator took more confidential documents or information than required for the qui tam action.

Confidentiality agreements are only an imperfect solution to the problem of employee qui tam actions. Nevertheless, any breaches of confidentiality may, in certain circumstances, be included as a counterclaim to any qui tam action, especially if the relator was indiscriminate in collecting documents or data, or careless in its disclosure.

In addition, employee access to sensitive information should be limited, and employee agreements and confidentiality provisions should require the return of any and all company data and documents in possession of the employee at the end of employment or termination.

B. Attorney Client Privilege

The FCA does not trump rules protecting privileged attorney client communications. In United States v. IASIS Healthcare Corp., for example, the court allowed sanctions against a relator and an attorney for failing to notify the court and the defendant that they were in possession of privileged documents after the FCA action was unsealed, and then failing to return them to the defendant corporation.

C. Voluntary Disclosure of False Claims

The FCA allows for reduced damages (a minimum of twice the damages sustained by the government as opposed to triple damages) for voluntary disclosure within 30 days of discovery. The person must not have had any knowledge of the violation beforehand, and the disclosure must occur before any government investigation, including civil, criminal, or administrative actions, begins. The CFCA language tracks that of the FCA in allowing for such a reduction of damages.

E. Compliance Recommendations

Compliance programs for employees should include a clear summary of the CFCA and its prohibitions. Liability for false claims is predicated on "knowing" attempts to defraud the government. The CFCA defines "knowing" to include, beyond actual knowledge, "deliberate ignorance of the truth or falsity of the information; or...acts in reckless disregard of the truth or falsity of the information..." A vigorous compliance program is evidence that your organization did not act recklessly or in an uninformed manner in regard to any unforeseen false claims violations. Internal monitoring and mock audits can also head off larger and costlier false claims violations down the road, in addition to being evidence of good faith.

The Importance of conducting audits

The Centers for Medicare & Medicaid Services (CMS) and the Office of Inspector General (OIG) recommend conducting compliance audits. It is always better to find compliance issues before a government agency or payer does. Pre- or post-billing audits help uncover minor concerns before they become major compliance issues.

The purpose of an audit is to ensure that the claims are submitted with accurate coding data and to evaluate the medical record documentation to ensure it supports the coding and complies with the regulations.

Planning is one of the most important steps to a successful compliance audit. Take the time to assess potential areas of risk and thoughtfully outline the audit objective(s).The planning for the compliance audit should determine its scope and answer the question: “What is the overarching goal of this audit?”

To start the audit process first, identify the universe of claims that could potentially be reviewed based on the scope of the audit determined in the planning process. After the universe has been identified and a report of those claims has been obtained, determine how many claims out of that universe will be reviewed for this audit. Depending on the audit objective and on the number of claims in the universe, it is not always feasible to audit 100 percent of the claims. In those cases, select a sample of claims to review.

Determining the sample size depends on many factors. The concept of statistically valid samples indicates that a sample should be a good representation of the entire population. This becomes more difficult as the population size increases. The OIG provides recommendations on their website, on the Provider Self-Disclosure Protocol page. They also offer free downloadable software that calculates sample size for you.

Once the audit is complete the organization should, review results in person. Start by presenting the audit spreadsheet or checklist in a summarized format. Introduce the audit results by emphasizing strengths and following up on those with opportunities for improvement.

Remind the staff that the goal of these audits is to identify improvement opportunities before they become major compliance issues, and that all staff members must strive to minimize risk to the organization.

Review each claim in the sample and explain any variance, allowing for discussion and questions. Provide open and honest feedback and ask clarifying questions where appropriate.

After the audit results have been presented to the staff, initiate corrective action plans such as training and education, as needed. Follow up after the training with monitoring and subsequent audits of similar claims until improvement is realized. When the corrective action plans have resulted in improvements, then it’s time to start planning the next audit.

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