Fairness in Health Care Claims, Guidance and Investigations Act of 2013

Hospitals stand shoulder-to-shoulder with federal enforcement agencies in promoting efforts to detect, deter and eradicate fraud in the Medicare and Medicaid programs. However, conflicting and confusing government regulations covering these federal programs can easily result in unintentional billing mistakes by hospitals.

Such disputes typically bear no relation to fraud — the patient has received appropriate and timely medical care under the direction of his or her physician, and hospitals have established significant compliance programs to achieve accurate billing for those services. Despite hospitals' best efforts, disputes are inevitable because hospitals are required to understand and comply with hundreds of thousands of pages of Medicare and Medicaid regulations, guidelines, billing instructions and similar documents that change frequently and can be interpreted differently by different government officials and the various contractors the government now uses to administer, audit and police federal health care programs.

Case-in-point: The Department of Justice conducted a nationwide investigation claiming hospitals had committed fraud by admitting patients for an overnight stay instead of simply holding them for observation or treating them and releasing them the same day, despite published guidance from a Medicare-recognized expert, the judgment of treating physicians and the best interests of many elderly patients.

The Fairness in Health Care Claims, Guidance and Investigations Act of 2013 amends the *False Claims Act* by: (1) requiring that federal agencies review their own rules and regulations to determine whether a billing dispute should be pursued as fraud before even launching an investigation, and (2) including provisions to ensure that unintentional billing disputes are not penalized as fraud.

Special Rules for Certain Actions Based on Health Care Claims:

- ✔ The bill is limited to health care claims in federal health care programs, including Medicare, Medicaid, TRICARE and insurance plans purchased through exchange Marketplaces. The government would be required to review its own rules and regulations before launching a fraud investigation.
- ✔ Providers meeting the conditions in the bill would be subject to recoupment of any overpayment and interest instead of triple damages plus penalties.
- ✔ The bill would establish a "de minimus" threshold, removing smaller disputes from costly review and litigation under the *False Claims Act*. Medicare overpayments of less than a specified percentage of the provider's total claims would result in penalties of no more than the amount of the claim plus interest.
- ✔ Reliance on information, an audit or a written statement from federal contractors would place providers in a "safe harbor."
- ✔ Adopting and implementing a compliance program in substantial conformance with federal hospital compliance guidelines also would place providers in a "safe harbor."
- ✔ The bill would raise the burden of proof for health care claims required from a "preponderance of the evidence" to a "clear and convincing evidence" standard.