SANDBERG PHOENIX

LONG TERM CARE & SENIOR LIVING BLOG

Health Care Providers Beware - Overpayment Claim News

AUTHOR: SANDBERG PHOENIX

Two recently announced settlements with Washington State and the Federal government show two potential overpayment issues for providers.

Molina Healthcare of Washington, Inc., announced in an SEC filing on September 5th, that it agreed in principle with the Washington Health Care Authority (HCA) to settle the two outstanding overpayment matters brought by HCA demanding recoupment of claims for psychotropic drugs and claims for health plan members under the Washington Community Options Program Entry System (COPES). The total payment agreed to be made by Molina Healthcare of Washington to HCA for these two matters will be approximately $19.2 million. Molina Healthcare of Washington expects to make the settlement payment to HCA prior to September 30, 2014.

Another overpayment settlement in the news involved Life Care Services LLC (LCS), a manager of skilled nursing facilities based in Des Moines, Iowa, and CoreCare V LLP, doing business as ParkVista, a skilled nursing facility in Fullerton, California, agreeing to pay a total of $3.75 million to the federal government for causing the submission of false claims to Medicare for unreasonable or unnecessary rehabilitation therapy purportedly provided by RehabCare Group East Inc., a subsidiary of Kindred Healthcare Inc. U.S. Attorney Carmen M. Ortiz for the District of Massachusetts was quoted by the Department of Justice in response to this settlement as stating: “Patients in skilled nursing facilities and the patients’ families should be able to have confidence that the facilities are not allowing therapy companies to manipulate the amount of therapy being provided based on financial motives. Settlements like this one show that, when a facility contracts with an outside rehabilitation therapy provider, the facility has a continuing responsibility to ensure that the provider is not engaged in conduct that causes the submission of false claims to Medicare.”

State and federal government is focused on combating health care fraud. The Molina settlement demonstrates state action, while the Life Care and CoreCare settlement represents another achievement for the Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative, a partnership between the U.S. Attorney General and the Secretary of Health and Human Services. HEAT has recovered more than $14.2 billion through False Claim Act cases involving fraud against federal health care programs since January 2009. The Washington State settlement involves overuse of psychotropic drugs, while the Federal one alleges unreasonable or unnecessary rehabilitation therapy. Healthcare providers need to understand how important proper documentation is to getting paid and avoiding scrutiny of the medical necessity of the care being provided. These settlements represent the need to realize that besides impacting their revenue stream, denied Medicare and Medicaid claims raise providers' risk for fraud and abuse allegations.

Being proactive in ensuring that documentation meets medical necessity standards can help providers avoid scrutiny as a result of denied Medicare and Medicaid claims.

By Denise Bloch

Denise Bloch

Image not found or type unknown