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HHS Issues New Requirements To Fraud Self-Disclosure Rules

On April 15, 2008, Inspector General Daniel R. Levinson issued An Open Letter to Health Care Providers announcing that the Office of Inspector General ("OIG") for the Department of Health and Human Services refined the requirements of the OIG Provider Self-Disclosure Protocol (the "SDP"), under which health care providers can voluntarily report fraudulent conduct affecting Medicare, Medicaid, and other Federal health care programs.

The SDP provides guidance to health care providers who voluntarily disclose federal health care program compliance issues that the provider believes potentially violate federal criminal, civil, or administrative laws for which exclusion or civil monetary penalties are authorized. According to the Open Letter, providers who disclose in good faith, fully cooperate with the OIG, and provide requested information in a timely manner will generally not be required to enter into Corporate Integrity or Certification of Compliance Agreements with the OIG.

"A provider's submission of a complete and informative disclosure, quick response to OIG's requests for further information, and performance of an accurate audit are indications that the provider has adopted effective compliance measures. Accordingly, when we negotiate the resolution of OIG's applicable administrative monetary and permissive exclusion authorities in exchange for an appropriate monetary payment, we generally will not require the provider to enter in a Corporate Integrity Agreement or Certification of Compliance Agreement. We believe that this presumption in favor of not requiring a compliance agreement appropriately recognizes the provider's commitment to integrity and also

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advances our goal of expediting the resolution of self-disclosures.”

The Open Letter also specifically addressed what information must be included in a provider’s initial submission in order to improve the disclosure process. The four requirements are: (i) a complete description of the conduct being disclosed; (ii) a description of the provider’s internal investigation or a commitment regarding date of completion; (iii) an estimate of the damages to the federal health care programs and the methodology used to calculate that figure or a commitment regarding when the provider will complete such estimate; and (iv) a statement of the laws potentially violated by the conduct.

The Open Letter discusses how OIG wishes to accelerate the self-disclosure process and that the provider must be in a position to complete the investigation and damages assessment within three months after acceptance into the SDP. The OIG expects full cooperation from disclosing providers during the verification of the matter disclosed. The OIG explained that providers which fail to disclose in good faith and which fail to timely respond to OIG’s requests for additional information will be removed from participation in the SDP.

Finally, the Open Letter added that the efficiency of the SDP process is contingent on providers only submitting appropriate matters through the SDP. The SDP is intended to address matters that potentially violate the law, not merely an overpayment. Disclosures that are characterized as mere billing errors or overpayments are not appropriately addressed by the SDP, and should be submitted directly by the provider to the appropriate claims-processing entity, such as the Medicare contractor.

All health care providers who are contemplating taking advantage of the SDP are advised to review this Open Letter, to confirm the problem is not a mere billing error or overpayment, to confirm that their initial submission fits the requirements described therein, and to confirm that they will be able to answer any questions from the OIG in order to meet the suggested timeline.

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