Billing and the false claims act

It only takes one improperly trained person to create the potential for a False Claims Act suit.

"Given today's heightened regulatory scrutiny and activity, provider organizations must be especially vigilant in their efforts to identify and monitor those bad actors or departments that are more susceptible to inappropriate billing behavior."

– Jen Shimek, Principal, KPMG

$19+ billion

Total amount recovered between 2009 and 2016 under the **False Claims Act**.

Are you able to quickly and effectively spot inappropriate billing behavior? Stamping out healthcare fraud has become a top priority for government with the False Claims Act quickly becoming the number one tool of enforcement.

Indeed, between 2009 and 2016, the Healthcare Fraud Prevention and Enforcement Action Team or HEAT (a specialized interagency enforcement team dedicated to identifying healthcare fraud) recovered more than $19 billion under the False Claims Act; almost $3 billion was recovered in 2016 alone.

The message from government and regulators is clear: those providers that engage in inappropriate billing behavior—or that do not monitor such practices diligently—will be heavily scrutinized and susceptible to significant penalties under the False Claims Act.

At KPMG LLP (KPMG), we understand the complex relationship between billing and regulatory compliance and know what it takes to drive real and sustainable improvements that reduce the risk of healthcare fraud.

Is your organization at risk of a False Claims Act suit?

Has your organization reviewed each department's routine auditing and monitoring processes for billing within the past two years?

Does your organization fully understand the evolving billing landscape and the impacts and challenges that ICD-10 has on your billing compliance programs?

Are you confident that you have the right controls in place to identify groups or individuals that fail to maintain the proper standards?

Are you able to identify and return overpayments from Medicare and Medicaid on a timely basis as required by the Affordable Care Act (ACA)?

Does your organization appropriately track physician conflicts of interest and industry compensations to ensure that bills are being submitted for services free of outside influences and in accordance with related fraud and abuse laws?

If you answered "no" to any of these questions, you may be exposing your organization to potential suits under the False Claims Act.

"Our foothold in the healthcare industry, combined with our deep understanding of the current risk landscape gives KPMG professionals valuable insight into the areas or departments that have the attention of the regulators."

— Glen Moyers, Partner, KPMG

The Multiplying Whistleblower Effect

Ever since President Lincoln first passed the False Claims Act in 1863, the legislation has encouraged citizens to bring forward suits through qui tam provisions that reward whistle-blowers with a portion of the sum recovered from successful suits.

Today, successful plaintiffs in healthcare fraud suits are often entitled to anywhere from 15 to 25 percent of recovered sums—or more if the government declines to join the case. Many receive millions to tens of millions of dollars.

With the introduction of the Patient Protection and ACA, whistle-blowers can now review and rely upon publicly available information in order to support a False Claims Act claim.

Immediate results from long-range approaches

From assessing the effectiveness of existing processes and identifying potential risks to establishing the right processes to identify and return Medicare and Medicaid payments on a timely basis, our team takes a long-term view of your business and the regulatory landscape to deliver immediate benefits through improved processes and controls.

Every day, our professionals leverage our firm's capabilities to deliver outstanding value to our clients. Leading healthcare organizations choose KPMG because:

Our experience is impressive: Our people have decades of experience managing and evaluating provider billing and monitoring practices and know what it take to uncover and apply practical and actionable insights.

We know what effective compliance looks like: With one of the largest healthcare client bases in the industry, we have helped some of the country's largest and most complex providers understand what regulators are looking for and execute strategies for improving billing controls and compliance.

We take a multidisciplinary and holistic approach: Our team consists of lawyers, nurses, compliance officers and financial professionals who work together as a team to help ensure that all aspects of billing and coding compliance are being considered.

We deliver a sustainable methodology: We use our insight to help our clients drive sustainable change by embedding control improvements and creating in-depth education programs.

We get to the source of the problem: We help our clients understand which departments or physicians pose the highest risk of billing noncompliance and then help them reeducate their staff or restructure their department hierarchies to address the issues.

We help clients move from strategy to reality: Our professionals do not just deliver robust strategies; they also help implement them in coordination with our clients' own legal, IT, operations and compliance functions.

For more information, contact:

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