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From: Karl C. Kranz, DC, JD

Re: The Centers for Medicare and Medicaid Services released the Final Rule regarding the reporting and return requirements for “overpayments” received by providers under the Medicare Program.

DRAFTED, NOT PROOFREAD

In brief:

On February 12, 2016, CMS issued its long-awaited 60-day overpayment “final rule” requiring that “providers and **suppliers** receiving funds under the Medicare program to report and return overpayments by the later of the date that is 60 days after (1) the date on which the overpayment was identified; or (2) the date any corresponding cost report is due, if applicable”[1] in comportment with § 1128J(d) of the Social Security Act pursuant to § 6402(d) of the Affordable Care Act.

The Rule defines “*overpayment*” as “any funds that a person has received or retained under title XVIII of the Act to which the person, after applicable reconciliation, is not entitled under such title.” Examples and instances of overpayment may include, among others:

- Medicare payments for noncovered services[2];
- Medicare payments in excess of the allowable amount for an identified covered service[3];
- reimbursement errors and duplicate payments[4];
- or when
  - a provider of services reviews billing or payment records and learns that it incorrectly coded certain service, resulting in increased reimbursement[5];
  - a provider of services learns that services were provided by an unlicensed or excluded individual on its behalf[6];
  - a provider of services performs an internal audit and discovers that overpayments exist[7];
- and when services have been “upcoded” intentionally or unintentionally[8]; and

1 • in instances where there may be “insufficient documentation” or a lack of “medical necessity.[9]”
2
3 Providers and suppliers must use “reasonable diligence” to identify actual and potential overpayments.[10]
4 While the statute at § 1128J(d) of the SSA suggests that that overpayments have been “knowing” or
5 “knowingly” made, in terms with the same meaning under the False Claims Act, CMS states that the final
6 rule indicates “a person has identified an overpayment when the person has, or should have through the
7 exercise of reasonable diligence, determined that the person has received an overpayment and quantified
8 the amount of the overpayment. A person should have determined that the person received an
9 overpayment if the person fails to exercise reasonable diligence and the person in fact received an
10 overpayment. ‘Reasonable diligence’ includes both *proactive compliance activities conducted in good*
11 *faith by qualified individuals to monitor for the receipt of overpayments* and *investigations conducted in*
12 *good faith and in a timely manner by qualified individuals in response to obtaining credible information of*
13 *a potential overpayment*.”[11]
14
15 Providers and suppliers who receive “overpayments” must reconcile and make appropriate restitution
16 using “an applicable claims adjustment, credit balance, self-reported refund, or other reporting process”
17 as required by the “applicable Medicare contractor.”[12] Any overpayment retained and not returned by a
18 provider after the deadline for reporting and making restitution expires, becomes “an obligation”
19 subjecting the individual to civil penalties under the False Claims Act at 31 USC 3729.[13]
20
21 *N.B.: For the purposes of this regulation, a *person* means a “provider” or a “supplier” defined in Federal
22 regulations at 42 CFR 200.202 pertaining to Medicare. For the purposes of this regulation, a “supplier”
23 “means a physician or other practitioner, or an entity other than a provider, that furnishes health care
24 services under Medicare.”
25 ~~~~~
26
27 The regulation itself is fairly brief but the discussion underpinning the regulation was thorough. Some of
28 the more salient points follow, followed again by the complete regulation.
29
30 The rule was actually supposed to be implemented last year, but the Centers for Medicare and Medicaid
31 Services (CMS) issued a one-year delay so the rule could be examined by the Federal Office of
32 Information and Regulatory Affairs, Office of Management and Budget (OMB). OMB completed its review
33 of the HHS-CMS proposed final rule on February 5 – an indication the publication of the final rule was
34 imminent.
35
36 The 60-day Rule has been in development since 2012, and implements§ 6402(d) of the Affordable Care
37 Act (PPACA, P.L. 111-148 & 111-152) which added subsection (d) of § 1128J of the Medicare and
38 Medicaid Program Integrity Provisions of the Social Security Act, as follows:
39
40 Sec. 1128J. [42 U.S.C. 1320a-7k]
41 (d) **Reporting and Returning of Overpayments**.—
42 (1) In general.—If a person has received an overpayment, the person **shall**—
43 (A) report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a
44 contractor, as appropriate, **at the correct address**; and

(B) notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.

(2) Deadline for reporting and returning overpayments.—An overpayment must be reported and returned under paragraph (1) by the later of—

(A) the date which is 60 days after the date on which **the overpayment was identified**; or

(B) the date any corresponding cost report is due, if applicable.

(3) Enforcement.—Any overpayment retained by a person after the deadline for reporting and returning the overpayment under paragraph (2) is an obligation (as defined in section 3729(b)(3) of title 31, United States Code) for purposes of section 3729 of such title [64].

(4) Definitions.—In this subsection:

(A) Knowing and knowingly.—The terms “knowing” and “knowingly” have the meaning given those terms in section 3729(b) of title 31, United States Code.

(B) Overpayment.—The term “overpayment” means **any funds** that a person receives or retains under title XVIII or XIX **to which the person**, after applicable reconciliation, **is not entitled** under such title.

(C) Person.—

(i) In general.—The term “person” means a provider of services, supplier, medicaid managed care organization (as defined in section 1903(m)(1)(A)), Medicare Advantage organization (as defined in section 1859(a)(1)), or PDP sponsor (as defined in section 1860D–41(a)(13)).

(ii) Exclusion.—Such term does not include a beneficiary.[14]

The “Rule” provides the mechanisms of oversight and regulation behind § 1128J(d) of the Social Security statute. Under the final rule, pursuant to § 1128J(d) of the SSA above, “’Overpayment’ is defined to mean “Overpayment means any funds that a person has received or retained under title XVIII of the Act to which the person, after applicable reconciliation, is not entitled under such title.”[15] This is the same definition that appears in the statute. In section II.B. of the February 2012 proposed rule (77 FR 9181), CMS included certain examples of overpayments under this proposed definition as including all of the following:

- Medicare payments for noncovered services.
- Medicare payments in excess of the allowable amount for an identified covered service.
- Errors and nonreimbursable expenditures in cost reports.
- Duplicate payments.
- Receipt of Medicare payment when another payor had the primary responsibility for payment.

A number of commenters were concerned about the breadth of the definition of “overpayment” which could sweep up routine, day-to-day business practices.[16] While CMS concedes that the agency “understands the commenters concerns,” CMS is also bounded by the definition Congress applied to the term under § 1128J(d) of the Social Security Act and CMS is not at liberty to change the will of the Congress. Further, CMS indicated, “Our general aim of this final rule is to strengthen program integrity and to ensure that the Medicare Trust Funds are protected and made whole and that taxpayer dollars are not wasted. An overpayment must be reported and returned regardless of the reason it happened—be it a human or system error, fraudulent behavior, or otherwise.”[17]

In one situation, a commenter asked for that CMS define “over-coding” which could have broad applicability in a number of situations, including the chiropractic field:

> <u>Comment</u>: Some commenters requested that we specifically define what it means to ‘‘over-code’’ and how a determination would be made as to whether the miscoding was deliberate. For example, a commenter referenced a physician billing for an evaluation and management (E&M) code as a level III (CPT code 99213), but an auditor determines that the documentation for the visit only supports a level II service (CPT code 99212). The commenter states that it is unclear from the proposed rule whether, in this instance, the physician would be in violation of the reporting rules and liable for penalties.
>
> <u>Response</u>: Over-coding, or the more commonly used term ***upcoding***, is illustrated by the example given by the commenter. However, the commenter appears to believe that the physician only has an obligation to report and return the overpayment if the upcoding was done deliberately. To clarify, providers and suppliers **must report and return overpayments** identified *as a result of* ***upcoding***, whether the inappropriate coding was intentional or unintentional. We discuss the steps that must be taken when a provider or supplier has identified an overpayment in section II.C. of this final rule.”[18] (Emphases and italics added.)

In another situation, commenters questioned whether “overpayment” consisted of an amount of payment over and above what a provider or supplier would have received for a good provided or a service rendered. CMS dutifully provided an example: “if a supplier was paid $40 for a claim when it should have received $30, the commenters questioned whether the overpayment amount is $10 and not the entire $40 amount paid.”[19] The question is relevant to the upcoding situation raised above. In reply, CMS responded: “In circumstances where a paid amount exceeds the appropriate payment amount to which a provider or supplier is entitled, the overpayment is the difference between the amount that was paid and the amount that should have been paid.”[20] But then, CMS added: “there are instances where payment is made for an item or service specifically not payable under the Act (for example, claims resulting from Anti-Kickback Statute or physician self-referral law violations or claims for items and services furnished by an excluded person), or where the payment was secured through fraud. In these types of situations, the overpayment typically consists of the entire amount paid.”[21]

In another important exchange, CMS tersely replied to commenters complaints about the indefiniteness of the term “overpayment” in particular situations and its fairness to the process:

> <u>Comment</u>: Some commenters stated that the concept of ‘‘overpayment’’ is not fair in some situations. The commenters stated that certain reasons for an overpayment, such as ‘‘**insufficient documentation**’’ or ‘‘**lack of medical necessity**’’ are extremely difficult to define objectively.
>
> <u>Response</u>: The definition of overpayment is fixed in statute. Sufficient documentation and medical necessity are longstanding and fundamental prerequisites to Medicare coverage and payment. (emphases added.)[22]

Some comments questioned “whether providers and suppliers need to report and return Medicare secondary payer refunds under [the] final rule.” To which CMS advised: “Yes, overpayments where

the provider or supplier received primary payment from both a primary payer other than Medicare and a primary payment from Medicare (‘‘provider/supplier duplicate primary payments’’) **must be refunded**. Overpayments where the provider/supplier failed to file a proper claim in accordance with 42 CFR 411.24(l) **must also be refunded**.”[23]

Section 1128J(d) of the SSA above, stipulates in part, that overpayment(s) “must be reported and returned by the later of – (A) the date which is 60 days after the date on which **the overpayment was identified**.”[24] In the proposed rule, controversy and questions arose over what the terms “was identified” mean in conjunction with the laws definition of the terms “knowing” and “knowingly” and what this meant in terms of when the clock started ticking on the 60-day overpayment rule. Originally, in 2012 CMS proposed that “

> ”[A] person has identified an overpayment if the person has **actual knowledge** of the existence of the overpayment or acts in **reckless disregard** or **deliberate ignorance** of the overpayment. We stated in the preamble that we proposed this definition in part because section 1128J(d) of the Act provides that the terms ‘**knowing**’ and ‘**knowingly**’ have the meaning given those terms in the FCA (31 U.S.C. 3729(b)(1)). While the statutory text does not use these terms other than in the definitions, we believed the Congress’ use of the term ‘knowing’ in the Affordable Care Act was intended to apply to determining when a provider or supplier has identified an overpayment. We also stated that defining ‘identification’ in this way gives providers and suppliers an incentive to exercise reasonable diligence to determine whether an overpayment exists. Without such a definition, some providers and suppliers ***might avoid*** performing activities to determine whether an overpayment exists, such as self-audits, compliance checks, and other research.”[25]
>
> * * *
>
> “In some cases, a provider or supplier may receive information concerning a potential overpayment that creates an obligation to make a **reasonable inquiry** to determine whether an overpayment exists. If the **reasonable inquiry** reveals an overpayment, the provider then has 60 days to report and return the overpayment. On the other hand, failure to make a **reasonable inquiry**, including failure to conduct such inquiry **with all deliberate speed** after obtaining the information, could result in the provider knowingly retaining an overpayment because it acted in **reckless disregard** or **deliberate ignorance** of whether it received such an overpayment.”[26]

Following complaints from commenters that terms like “**reckless disregard**” and “**deliberate ignorance**” were “ambiguous” and did “not adequately inform providers and suppliers of the circumstances that would give rise to a duty to investigate and fail to provide sufficient guidance as to what efforts are necessary to avoid overpayment liability,’ CMS agreed and ‘revised the regulatory provision in the final rule by removing the terms ‘**actual knowledge**,’ ‘**reckless disregard**’, and ‘**deliberate ignorance**.’ The final rule states that a person has identified an overpayment when the person has, or should have through the exercise of ***reasonable diligence***, determined that the person has received an overpayment and quantified the amount of the overpayment. A person should have determined that the person received an overpayment if the person fails to exercise reasonable diligence and the person in fact received an overpayment. ‘**Reasonable diligence**’ includes both proactive compliance activities conducted in good faith by qualified individuals to monitor for the receipt of overpayments and investigations conducted in good faith and in a timely manner by qualified individuals in response to obtaining credible information of

a potential overpayment."[27] Similar concerns were expressed with the terms "reasonable inquiry" and "all deliberate speed" which CMS has eliminated as well.

Some commenters questioned how far they had to go with their inquiry if they discovered "a single overpaid claim" considering the amount of time and resources an expanded inquiry might require to which CMS responded "[w]e expect providers and suppliers to exercise ***reasonable diligence*** and to quantify, report, and return the entire overpayment in good faith. Part of conducting ***reasonable diligence*** is conducting an appropriate audit to determine if an overpayment exists and to quantify it. Providers and suppliers are obligated to conduct audits that accurately quantify the overpayment. After finding a single overpaid claim, we believe it is appropriate to inquire further to determine whether there are more overpayments on the same issue before reporting and returning the single overpaid claim. To the extent this concern is based on a question about when the 60-day clock begins to run, the final rule clarifies that identification occurs once the person has or should have through the exercise of reasonable diligence, determined that the person received an overpayment and quantified the amount of the overpayment."[28] CMS suggested that providers might use random "probe audits"

This segues into what CMS considers "reasonable" action for providers to take. Several commenters to the original, proposed rule requested that CMS clarify that there was "no duty to pro-actively search for overpayments without a reason to believe that a specific overpayment exists."[29] They noted that the "preamble language suggests that providers and suppliers have a perpetual duty to research whether any overpayment may exist, which would be overly burdensome and not consistent with the requirements of section 1128J(d) of the Act."[30] "These comments underscore our concern" CMS remarked, "expressed in the proposed rule that some providers and suppliers might avoid performing activities to determine whether an overpayment exists. As discussed earlier, section 1128J(d) of the Act requires a person to report and return overpayments they have received. Thus, **providers and suppliers have a clear duty to undertake proactive activities to determine if they have received an overpayment or risk potential liability for retaining such overpayment**."[31]

These are tasks not easily undertaken, done or affordable for sole/solo practitioners or small group practices. Consequently, "[s]everal commenters requested clarification about the level of resources a small provider or supplier is expected to devote to investigating potential overpayments."[32] CMS' response was not particularly helpful stating, "we are unable to provide specific guidance on resource levels or other measures to ensure compliance with this rule. Providers and suppliers, large and small, have a duty to ensure their claims to Medicare are accurate and appropriate and to report and return overpayments they have received. We have produced a number of educational materials, including the Medicare Learning Network®, which are available on our Web site, http://www.cms.gov.[33] OIG has also produced a number of compliance educational materials that are available on its Web site, http://www.oig.hhs.gov."[34]

The upshot is that providers and suppliers, large and small, should make some effort to document their "reasonable diligence" in complying with CMS 60-day rule whether they conduct an analysis themselves or it is done by an office manager. Nevertheless, some effort should be made and documented regardless.

- Lookback Period

The original, propose rule proposed a lookback period of ten (10) years which specified that "overpayments must be reported and returned only if a person identifies the overpayment within 10 years of the date the overpayment was received. We proposed 10 years because this is the outer limit of the FCA statute of limitations."[35] With the final rule, however, CMS reduced the applicable lookback period to six (6) years: "The 6-year lookback period will be measured back from the date the person identifies the overpayment."[36]

A failure to make restitution for overpayments retained beyond the 60-day window once they are identified subjects the holder to monetary penalties pursuant to 31 U.S.C. § 3729 of the False Claims Act.[37]

The substantive "final rule" regulations are as follows:

List of Subjects

42 CFR Part 401

Claims, Freedom of information, Health facilities, Medicare, Privacy.

42 CFR Part 405

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medical devices, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as set forth below:

PART 401.GENERAL ADMINISTRATIVE REQUIREMENTS

- 1. The authority citation for part 401 continues to read as follows: Authority: Secs. 1102, 1871, and 1874(e) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395w.5).
- 2. Part 401 is amended by adding subpart D to read as follows:

Subpart D. Reporting and Returning of Overpayments

Sec.

401.301 Basis and scope.

401.303 Definitions.

401.305 Requirements for reporting and returning of overpayments.

Subpart D. Reporting and Returning of Overpayments

§ 401.301 Basis and scope.

This subpart sets forth the policies and procedures for reporting and returning overpayments to the Medicare program for providers and suppliers of services under Parts A and B of title XVIII of the Act as

required by section 1128J(d) of the Act.

§ 401.303 Definitions.

For purposes of this subpart. Medicare contractor means a Part A/Part B Medicare Administrative Contractor (A/B MAC) or a Durable Medical Equipment Medicare Administrative Contractor (DME MAC).

Overpayment means any funds that a person has received or retained under title XVIII of the Act to which the person, after applicable reconciliation, is not entitled under such title.

Person means a provider (as defined in § 400.202 of this chapter) or a supplier (as defined in § 400.202 of this chapter).

§ 401.305 Requirements for reporting and returning of overpayments.

(a) General.
- (1) A person that has received an overpayment must report and return the overpayment in the form and manner set forth in this section.
- (2) A person has identified an overpayment when the person has, or should have through the exercise of reasonable diligence, determined that the person has received an overpayment and quantified the amount of the overpayment. A person should have determined that the person received an overpayment and quantified the amount of the overpayment if the person fails to exercise reasonable diligence and the person in fact received an overpayment.

(b) Deadline for reporting and returning overpayments.
- (1) A person who has received an overpayment must report and return the overpayment by the later of either of the following:
  - (i) The date which is 60 days after the date on which the overpayment was identified.
  - (ii) The date any corresponding cost report is due, if applicable.
- (2) The deadline for returning overpayments will be suspended when the following occurs:
  - (i) OIG acknowledges receipt of a submission to the OIG Self-Disclosure Protocol and will remain suspended until such time as a settlement agreement is entered, the person withdraws from the OIG Self-Disclosure Protocol, or the person is removed from the OIG Self-Disclosure Protocol.
  - (ii) CMS acknowledges receipt of a submission to the CMS Voluntary Self- Referral Disclosure Protocol and will remain suspended until such time as a settlement agreement is entered, the person withdraws from the CMS Voluntary Self-Referral Disclosure Protocol, or the person is removed from the CMS Voluntary Self-Referral Disclosure Protocol.
  - (iii) A person requests an extended repayment schedule as defined in § 401.603 and will remain suspended until such time as CMS or one of its contractors rejects the extended repayment schedule request or the provider or supplier fails to comply with the terms of the extended repayment schedule.

(c) Applicable reconciliation.
- (1) The applicable reconciliation occurs when a cost report is filed; and
- (2) In instances when the provider.
  - (i) Receives more recent CMS information on the SSI ratio, the provider is not required to return any overpayment resulting from the updated information until the final reconciliation of the provider's cost report occurs; or
  - (ii) Knows that an outlier reconciliation will be performed, the provider is not required to estimate

the change in reimbursement and return the estimated overpayment until the final reconciliation of that cost report.

(d) Reporting.

(1) A person must use an applicable claims adjustment, credit balance, self-reported refund, or other reporting process set forth by the applicable Medicare contractor to report an overpayment, except as provided in paragraph (d)(2) of this section. If the person calculates the overpayment amount using a statistical sampling methodology, the person must describe the statistically valid sampling and extrapolation methodology in the report.

(2) A person satisfies the reporting obligations of this section by making a disclosure under the OIG's Self- Disclosure Protocol or the CMS Voluntary Self-Referral Disclosure Protocol resulting in a settlement agreement using the process described in the respective protocol.

(e) Enforcement. Any overpayment retained by a person after the deadline for reporting and returning the overpayment specified in paragraph (b) of this section is an obligation for purposes of 31 U.S.C. 3729.

(f) Lookback period. An overpayment must be reported and returned in accordance with this section if a person identifies the overpayment, as defined in paragraph (a)(2) of this section, within 6 years of the date the overpayment was received.

§ 401.607 [Amended]

■ 3. In § 401.607(c)(2)(i), the definition of "Hardship" is amended by removing the phrase "outstanding overpayments (principal and interest)" and adding in its place the phrase "outstanding overpayments (principal and interest and including overpayments reported in accordance with §§ 401.301 through 401.305)."

For a thorough discussion of the complete regulation see:
https://www.federalregister.gov/articles/2016/02/12/2016-02789/medicare-program-reporting-and-returning-of-overpayments

References

1. DEPARTMENT OF HEALTH AND HUMAN SERVICES, Centers for Medicare & Medicaid Services, 42 CFR Parts 401 and 405 [CMS–6037–F], RIN 0938–AQ58, Medicare Program; Reporting and Returning of Overpayments. Federal Register 2016 February 12; 81 (29): 7654.

2. 81 FR 7656.

3. 81 FR 7656.

4. 81 FR 7656.

5. 81 FR 7659.

6. 81 FR 7659.
7. 81 FR 7659.
8. 81 FR 7657.
9. 81 FR 7658.
10. 42 CFR § 401.305 "Requirements for reporting and returning of overpayments, (2). 81 FR 7683.
11. 81 CFR 7661
12. 42 CFR § 401.305 "Requirements for reporting and returning overpayments, (d) Reporting. 81 FR 7683.

13. 31 U.S.C § 3729 – False Claims, provides, in part:

    § 3729. False claims

    (a) LIABILITY FOR CERTAIN ACTS.—
        (1) IN GENERAL.—Subject to paragraph (2), any person who—
            (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;
            (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;
            (C) conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), or (G);
            (D) has possession, custody, or control of property or money used, or to be used, by the Government and knowingly delivers, or causes to be delivered, less than all of that money or property;
            (E) is authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;
            (F) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge property; or
            (G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government,

        is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Public Law 104–410 1), plus 3 times the amount of damages

which the Government sustains because of the act of that person.

14. See: Medicare and Medicaid Program Integrity Provisions, Sec. 1128J. [42 U.S.C. 1320a-7k] Accessed Feb 10, 2016 at: https://www.ssa.gov/OP_Home/ssact/title11/1128J.htm

15. 42 CFR § 401.303 Definitions, 81 FR 7683

16. 81 FR 7656.

17. 81 FR 7656.

18. 81 FR 7657.

19. 81 FR 7658.

20. 81 FR 7658.

21. 81 FR 7658.

22. 81 FR 7658.

23. 81 FR 7658.

24. See: Medicare and Medicaid Program Integrity Provisions, Sec. 1128J. [42 U.S.C. 1320a-7k] Accessed Feb 12, 2016 at: https://www.ssa.gov/OP_Home/ssact/title11/1128J.htm

25. 77 FR 9182.

26. 77 FR 9182.

27. 81 FR 7661.

28. 81 FR 7663.

29. 81 FR 7664.

30. 81 FR 7664.

31. 81 FR 7664.

32. 81 FR 7665.

33. Link CMS: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html?redirect=/mlngeninfo.

34. Link CMS: http://oig.hhs.gov/compliance/

35. 81 FR 7671. See also: 77 FR 9184.

36. 81 FR 7671.

37. 31 U.S.C § 3729 – False Claims, provides, in part:

    § 3729. False claims

    (a) LIABILITY FOR CERTAIN ACTS.—
        (1) IN GENERAL.—Subject to paragraph (2), any person who—
            (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;
            (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;
            (C) conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), or (G);
            (D) has possession, custody, or control of property or money used, or to be used, by the Government and knowingly delivers, or causes to be delivered, less than all of that money or property;
            (E) is authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;
            (F) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge property; or
            (G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government,

        is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Public Law 104–410 1), plus 3 times the amount of damages which the Government sustains because of the act of that person.