Medicare Overpayment 60-Day Rule

What Your Compliance and Auditing Departments Need to Know





Objectives

- Review the key legal, operational and technical takeaways from the ACA 60-Day Report and Repay Statute.
- Discuss the implications of "reasonable diligence" and "credible information" as defined in the clarified rule.
- Review strategies for proactive compliance activities that will reduce risk of overpayments and limit exposure of provider.

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Key Legal, Operational and Technical Takeaways

- Key provisions of the 60-Day Rule
- The 60-day "clock"
- Credible information of an overpayment
- Duty to investigate and quantify
- Reasonable diligence—proactive and reactive
- The six-year "lookback" period
- Reporting and refund process
 - · Impact of contractor audits
 - Appeals
- Pre-payment probe audits

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Statutory Requirement to Report & Repay

- Congress created the new 60-day repayment provision through Section 6402(a) of the Affordable Care Act
- Added section 1128J(d) to the Social Security Act, now codified at 42 U.S.C. 1320a-7k (d)
- Became law March 23, 2010
- CMS asserts that the law has been enforceable since that date, despite the absence of regulations until now, and court decisions support that position

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Final 60-Day Rule

- Final rule applies only to overpayments under Parts A and B of Medicare
 - ➤ CMS issued a separate rule for Parts C and D of Medicare (May 23, 2014)
 - ➤ No rulemaking yet for Medicaid but statute in effect
- Requires providers to investigate with reasonable diligence if credible evidence exists of a potential overpayment
- If an overpayment is identified, the provider has 60 days to report and repay

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Definition of "Overpayment"

- An "overpayment" means any funds a person has received or retained to which the person is not entitled
 - > This has nothing to do with causation or fault
 - ➤ Human error, system error, fraud, contractor error or "otherwise," it can still be funds to which you are not entitled
 - > The amount of the overpayment can be:
 - ➤ A portion of the paid claim (e.g., upcoded claims)
 - > The whole claim (e.g., medically unnecessary or uncovered service)

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Consequences

- Failure to report and repay creates an "obligation" equal to the retained overpayment
- Failure to satisfy an "obligation" is a violation of the False Claims Act
- The FCA is enforceable by the government and whistleblowers, potentially exposing the provider to liability vastly larger than the amount of the overpayment
- Also, violates the Civil Monetary Penalties Law

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Identification

- Under the rule, an overpayment is **identified** when the recipient **has**, or **should have**, through **reasonable diligence**:
 - > Determined that it received an overpayment,

and

> Quantified the amount of the overpayment

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Credible Information

- CMS: "We believe credible information includes information that supports a reasonable belief that an overpayment may have been received."
- Examples of when discovery of credible information triggers a duty to investigate:
 - > Discovery of unlicensed or excluded individual
 - > Certain hotline complaints
 - > Local or national coverage policy
 - ➤ Contractor audits
 - > Internal reviews
 - Unexplained increase in revenue from Medicare

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Duty to Investigate & Quantify

- Even a single overpaid claim may create a duty to look further with respect to similar claims
 - Scope of further inquiry depends on nature of the isolated claim
 - ➤ Do a "**probe**" sample, and if that finds more overpayments, then a broader sample
- Only make repayment at conclusion of investigation
- Extrapolation or claim-by-claim review is permissible

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Reasonable Diligence

- CMS says that reasonable diligence includes both
 - "Proactive compliance activities" to monitor for receipt of overpayments, and
 - ➤ Investigations in response to "credible information" of a potential overpayments
- Facts and circumstances determine
 - > Whether the compliance efforts are "reasonable," and
 - ➤ What rises to the level of "credible information"
- Investigation is expected to take no longer than six months, absent exceptional circumstances

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The "Lookback" Period

- Must return overpayments identified within six years of receipt of the funds
 - ➤ Originally proposed 10 years
 - ➤ Consistent with CMP statute of limitations
- Reopening regulations allow contractors to reopen for only four years (with good cause)
- Final 60-Day Rule extends window for provider-initiated reopenings to six years

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The 60-Day Clock

- Under the rule, 60 days begins to run after "identification"
- Identification occurs after reasonable diligence
- Except, if provider has credible information
 - > Does **not** exercise reasonable diligence
 - > And there is an overpayment
 - > Then you are late after 60 days, not eight months

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The Clock (cont.)

- The deadline for refunding overpayments is **suspended**:
 - ➤ If the **OIG** has accepted a voluntary disclosure under its Self-Disclosure Protocol (kickback cases)
 - ➤ If **CMS** has accepted a voluntary disclosure under its Voluntary Self-Referral Disclosure Protocol (Stark cases)
 - ➤ An **extended repayment schedule** is requested

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The Reporting & Refund Process

- Final rule defers to existing refund processes:
 - ➤ Claims adjustment
 - > Credit balance
 - ➤ Voluntary refund to contractor
 - ➤ Disclosures through CMS or OIG
- Method of repayment chosen will be based on facts and circumstances of overpayment (e.g., amount, culpability)
- Chosen method may dictate the details necessary for the report

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Reporting & Refund (cont.)

- CMS permits and maybe even encourages sampling and extrapolation as part of quantifying overpayments
 - ➤ But only the specific claims identified in the sample will get adjusted on the contractor's books
 - > Only those claims specifically identified are appealable
- Reporting and repaying does not insulate provider against future audits

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Impact of Contractor Audits

- Results of contractor audits can create duty to investigate further
- Contractors limited to four-year reopening period but providers may have duty to go back additional two years
- CMS allows providers who disagree with results of audit to pursue appeals first before exercising reasonable diligence in investigating additional overpayments

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Appeals

- 60-Day Rule does not eliminate appeal rights, even for selfidentified overpayments
- Providers may not "game the system" by appealing a subset of claims identified as overpaid to avoid duty to fully investigate or make full repayment
- Appeals of extrapolated amounts are difficult but not impossible

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Reducing Risk of Overpayments and Limiting Exposure of Provider

COMPLIANCE AND AUDIT ACTIVITIES

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Reasonable Diligence



A provider's compliance with the new rule will require *proactive compliance activities* in addition to *reactive investigations* once "credible information" of an overpayment is received. "Minimal compliance activities" may "expose the provider or supplier to liability," because it may be considered "failure to exercise reasonable diligence."

A "react and respond" approach will no longer be enough.

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Proactive Compliance Activities

- Review compliance plan and assure that the plan is effective in being able to identify, investigate and calculate overpayments for 6 year period
- Ensure monitoring efforts (i.e., self-audits, internal statistical analysis, etc.) are well documented. Potential areas to be monitored:
 - Coding
 - · Claim accuracy
 - · Secondary payer
 - Medical Necessity documentation
- Assessing 3rd Party Risk (e.g., billing companies, coders, etc.)
- Update policies and systems to handle overpayments
- · Ensure that all business units understand the law

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Compliance Program Checklist

- Internal process for collecting data on areas that could trigger overpayments - routine billing errors to deliberate Fraud, Waste and Abuse issues.
- ☐ Guidelines for investigating potential overpayments legal involvement, determining look-back period, how to scope audit.
- Tracking system of potential overpayments- date of determination and repayment timelines.
- Regular audits/review (recommend monthly or quarterly) of potential overpayment issues and decisions.
- Procedure for evaluating potential overpayments and who will be the ultimate decision maker for determining if an overpayment has been received.

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"PRACTICAL APPLICATION OF 60 DAY RULE THROUGH CASE EXAMPLES-INTERACTIVE DISCUSSION"

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