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Health Care Compliance Association
April 16, 2018
Session 103

The 60 Day Overpayment Rule: What Does Due Diligence Really Mean?

Paula G. Sanders, Esquire
Amy Brantley, JD, CHC, CHPC

History of the Overpayment Rule

- March 23, 2010: Section 6402 of Affordable Care Act (ACA) requires any provider who receives an overpayment related to federal health care programs to report and return overpayment to appropriate payer within 60 days after overpayment is identified
- February 12, 2016: CMS issues final rule, effective March 14, 2016 (81 *Federal Register* 7654 (Feb. 12, 2016))

What is An Overpayment?

- Any funds that a person has received or retained to which the person, after applicable reconciliation, is not entitled
- Obligation to return overpayment applies to Medicare & Medicaid funds
- CMS final rule effective March 14, 2016 *only* applies to Medicare Parts A & B

Repayment Obligation

- Duty to investigate
- Exercise reasonable diligence
- Quantify amount of overpayment
- Report and return overpayment within 60 days of quantification

Trigger Points

- Receipt of credible information of a potential overpayment
- Six months to investigate and quantify
- 60 days to report and repay
- Six year lookback period

"Identification" of Overpayment

- Determined, through exercise of reasonable diligence, that an overpayment has been received *and* amount quantified or
- S*hould have determined* that overpayment received
  - Constructive knowledge of overpayment exists if there is failure to exercise reasonable diligence upon receiving credible information about a potential overpayment and there is an overpayment

Consequences of Noncompliance

- Retention of an overpayment violates False Claims Act (FCA)
  - Liability is three times the amount of overpayment *plus* penalty of **$11,181** to **$22,363** per claim
- Failure to exercise reasonable diligence to investigate credible information eliminates six month period
  - 60 day repayment clock starts from the receipt of credible information

Duty to Exercise Reasonable Diligence

- Proactive compliance activities conducted in good faith by qualified individuals to monitor for the receipt of overpayments
- Reactive investigative activities undertaken in response to receiving credible information about a potential overpayment
- Investigations conducted in good faith and in a timely manner by qualified individuals

Proactive Compliance Activities

- Train designated staff members about billing, coding, MDS and related processes
- Verify census
- Complete Triple Check process for 100% claims review to assure accuracy of billing prior to claim submission

Proactive Compliance Activities

- Audit Medicare A and B claims for verification of required elements and medical necessity
- Review PEPPER report and related statistics
- Review external overpayments identified through RAC, OIG or similar government audits for trending and/or identification of potential related claims

Proactive Compliance Activities

- Investigate Hotline calls
- Evaluate a significant increase in Medicare payment without an apparent reason
- Review cost reports to reconcile payments and costs and identify any funds to which the provider is not entitled

Staff Training Issues

- Report reasonable suspicion or actual identification of overpayments to Compliance Officer or designee as soon as practicable
- Failure to use reasonable diligence to identify Medicare overpayments or to exercise reasonable diligence related to credible information shall result in corrective action

Credible Information of a Potential Overpayment

- Information that supports a reasonable belief that an overpayment may have been received
- Whether information is sufficiently credible to merit an investigation is a fact-specific determination
- A single overpaid claim triggers further inquiry to determine whether there are more overpayments on the same issue

Any Overpayment is an Overpayment

- Any overpayment, regardless of cause
  - Human or system error
  - Mistake
  - Fraudulent behavior
- Nature of overpayment affects decision about most appropriate mechanism and recipient of overpayment report and refund
- Investigate all allegations

Reporting Overpayments

- Claims adjustment/self-reported refund process to Medicare Administrative Contractor (MAC)
- Credit Balance Report/Cost Report/Cost Report Adjustment Process
- CMS Self-Referral Disclosure Protocol
- Office of Inspector General (OIG) Self-Disclosure Protocol

Suspension of Repayment Obligation

- OIG acknowledges receipt of submission to OIG Self-Disclosure Protocol or
  - Remains suspended until such time as a settlement agreement is entered or there is withdrawal or removal
- CMS acknowledges receipt of submission to the CMS Voluntary Self-Referral Disclosure Protocol
  - Remains suspended until such time as a settlement agreement is entered or there is withdrawal or removal

Suspension of Repayment Obligation

- Extended repayment schedule (ERS) is requested
  - Remains suspended until CMS or contractor rejects ERS request or provider or supplier fails to comply with the terms of ERS

Pediatric Services of America (PSA): $6.88 Million Settlement (Aug. 2015)

- Failed to disclose and return overpayments
- Submitted claims for home nursing care without documenting RN monthly supervisory visits
- Submitted claims that overstated the length of time staff had provided services

PSA: $6.88 Million Settlement

- First settlement under False Claims Act for failure to investigate credit balances to determine whether they resulted from federal overpayments made by a federal health care program
- Section 6402 of ACA requires providers to report and return any overpayments by the later of (i) 60 days after the overpayment was identified or (ii) the date any corresponding cost report is due (if applicable)

$2.9 Million Settlement – Violation of 60 Day Repayment Rule
(8/24/2016)

- *Qui tam* case against St. Luke's Roosevelt and Mt. Sinai Hospitals in New York
- Underlying amount due to Medicaid approximately $800,000 caused by computer error
- Whistleblower fired after identifying overpayments
- Hospitals admitted they did not fully reimburse Medicaid for over two years

$440,000 Settlement – Violation of 60 Day Repayment Rule (10/13/2017)

- $440,000 settlement in qui tam case against First Coast Cardiovascular Institute (FCCI)
- Credit balances totaled approximately $175,000
- Failure to timely refund overpayment received from multiple government health care programs
- Whistleblower, former employee; recovery approx. $90,000

Contact Information

Amy Brantley, JD, CHC, CHPC
Compliance, Privacy and Legal Consultant
brantleyal@gmail.com
501-607-4010

Paula G. Sanders, Esquire
Principal & Co-Chair Health Care Practice Group
Post & Schell, PC
psanders@postschell.com
717-612-6027