

Health Care Compliance
Association
***Enforcement Compliance
Institute***

**P10 Criminal and Civil Liabilities for
Overpayments**

Washington, DC
October 29, 2017

Sanford "Sandy" Teplitzky, Esq.
Shareholder
Baker Donelson
Baltimore, MD

David Glaser, Esq.
Shareholder
Fredrikson & Byron, P.A.
Minneapolis, MN

BAKERDONELSON HEALTH LAW
A BAKER DONELSON PRACTICE

Fredrikson
& BYRON, P.A.

Overpayments - History

- Old Order:
 - Action = Liability
- New Order:
 - Inaction = Liability

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Evolution of Overpayment Liability

- Medicare criminal overpayment statute
- Requires knowledge of overpayment upon receipt and affirmative concealment
- Criminal charges against health care executives in late 90's
- Health care industry response and compliance program effect
- Compliance Program Guidance and Corporate Integrity Agreements

Pre-2009: False Claims Act (FCA) – “Reverse False Claims”

- Overpayment an FCA violation only if defendant:
 - Used a “false record” or “statement”
 - To conceal, avoid, or decrease an obligation to pay money to the government.

F E R A

- FCA liability for:
 - “knowingly concealing,” or
 - “knowingly and improperly avoiding or decreasing,”
 - “an obligation to pay” funds owed the government.

Arguably:

Still required some affirmative act.

A C A

- Makes reporting and repaying any overpayment an “obligation” under the FCA. (31 USC § 3729(b)(3))
- Failure to report and return an overpayment within the deadline may result in FCA liability.

1. Define

- **Overpayment:**

Section 1128J(d) of the Act provides that an overpayment means “* * * any funds that a person receives or retains under Title XVIII * * * to which the person, after applicable reconciliation, is not entitled under such title.”

2. Investigate

- 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 existence of the overpayment.

42 CFR 401.305
(emphasis added)

2. Investigate – Due Diligence

CMS:

“We believe defining ‘identification’ 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 additional research.

Federal Register, Vol. 77, No. 32
Feb. 16, 2012

2. Investigate – Confusion

When is it over?

- Affirmative Duty to “Investigate”?
- Perpetual Duty to “Investigate”?

2. Investigate – Example

CMS:

“ . . . a provider that receives an anonymous compliance hotline telephone complaint about a potential overpayment has incurred an obligation to timely investigate that matter. If . . . the provider fails to make any reasonable inquiry into the complaint, the provider may be found to have acted in reckless disregard or deliberate ignorance of any overpayment.”

Federal Register, Vol. 77, No. 32

Feb. 16, 2012

3. Identify – Examples

CMS:

- A Provider or Supplier:
 1. Reviews billing or payment records and learns that it incorrectly coded certain services, resulting in increased reimbursement.
 2. Learns that a patient death occurred prior to the service date on a claim that has been submitted for payment.
 3. Learns that services were provided by an unlicensed or excluded individual on its behalf.

3. Identify – Examples (cont'd.)

4. Performs an internal audit and discovers that overpayments exist.
5. Is informed by a government agency of an audit that discovered a potential overpayment, and the provider or supplier fails to make a reasonable inquiry.
6. Experiences a significant increase in Medicare revenue and there is no apparent reason – such as a new partner added to a group practice or a new focus on a particular area of medicine – for the increase.

4. Report

- Section 1128J of the Act provides that if a person has received an overpayment, the person shall
 - i. “report . . . the overpayment to the Secretary . . . an intermediary, a carrier, or a contractor . . .; and
 - ii. notify the Secretary . . . intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.”
(More on this later.)

Affordable Care Act Requires Clarification

- What does “identify” mean? (The House bill required reporting if you “know of an overpayment.”)
- When does 60-day clock begin to run?
- What if the provider cannot quantify the amount within 60-days?
- What does “after applicable reconciliation” mean?
- How does the cost report deadline apply?

Affordable Care Act Requires Clarification (cont'd.)

- What information should be included in the report of the overpayment?
- How should providers report and return overpayments?
- What is the overlap with other existing reporting mechanisms?
- How does this statute relate to the reimbursement appeals process already in place?

How far back must you go?

- The law had no explicit temporal limits.
- If the government can't recoup the money, is it still an overpayment?
- Various statutory and regulatory provisions limited the government's ability to recoup money.
 - SSA 1870, 1879.
 - Reopening regulations.

Legal Framework

- Two statutory provisions limit recovery of overpayments, 1870 and 1879 don't use the word "reopening."
- 1870 focuses on "without fault" and includes a time frame, 1879 uses "did not and should not" have known, no timeframe.
- Regulations limit reopening, are silent on recovery.
- Manuals both limit reopening and recovery.

Social Security Act § 1870

(c) There shall be no adjustment as provided in subsection (b)(nor shall there be recovery) in any case where the incorrect payment has been made (including payments under section 1814(e)) with respect to an individual who is **without fault or** where the adjustment (or recovery) would be made by decreasing payments to which another person who is without fault is entitled as provided in subsection (b)(4), **if such adjustment** (or recovery) would defeat the purposes of title II or title XVIII **or would be against equity and good conscience.**

Social Security Act § 1870

Adjustment or recovery of an incorrect payment (or only such part of an incorrect payment as the Secretary determines to be inconsistent with the purposes of this title) against an individual who is without fault shall be deemed to be against equity and good conscience **if** (A) the incorrect payment was made for expenses incurred for items or services for which payment may not be made under this title by reason of the provisions of paragraph (1) or (9) section 1862(a) **and** (B) if the Secretary's determination that such payment was incorrect was made subsequent to the third [**FIFTH**] year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-**[FIVE]** year period to not less than one year if he finds such reduction is consistent with the objectives of this title.

How does § 1870 work?

- Focus only on the YEAR payment is made.
- Payment made 1/4/13. Can recover 5 years after 2013, so count: 2014, 15, 16, 17, 18. Recovery possible through 12/31/18.
- Payment made 12/31/12. If new provision applies, 2013, 14, 15, 16, 17. Recovery until 12/31/17.
- Note that references to “five years” are very misleading. Simplicity trumps accuracy.

How far back must you go?

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

- 42 CFR 401.305(f)

If You Are Entitled to Keep The Money...

“*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.”

- 42 CFR 401.303

- If the contractor can't reopen the claim, doesn't that mean you are entitled to keep the money?

CMS Disagrees

Comment: Commenters questioned whether they had a responsibility to go back beyond the 3 years covered in a Recovery Audit Contractor (RAC) audit that identifies overpayments.

Response: Yes, as discussed previously, this final rule clarifies that when the provider or supplier receives credible information of a potential overpayment, they need to conduct reasonable diligence to determine whether they have received an overpayment.

CMS Disagrees

RAC audit findings, as well as other Medicare contractor and OIG audit findings, are credible information of at least a potential overpayment. Providers and suppliers need to review the audit findings and determine whether they have received an overpayment. As part of this review, providers and suppliers need to determine whether they have received overpayments going back 6 years as stated in this rule. - *81 FR 7672*

Six years from when?

- Remember “identify” includes quantification.
- The six years runs from the date the overpayment is quantified not from the first suspicion of an overpayment.
- Operationally, this may be challenging.

Summing It Up...

- The government thinks you must go back six years from the date you have quantified.
- There are disregarding conflicting statutory guidance.
- You have to decide whether to go along or opt to fight.
- Does a fight require challenge to the rule under the APA?

Did they get this right?

Comment: 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.

Response: “The definition of overpayment is fixed in statute. Sufficient documentation and medical necessity are longstanding fundamental prerequisites to Medicare coverage and payment.” - 81 FR 7658

Duty to report?

“To the extent that a provider or supplier who has received an overpayment resulting from a kickback arrangement and it not a party to a kickback arrangement but has sufficient knowledge of the arrangement to have identified the resulting overpayment, the provider or supplier must report the overpayment to CMS.” - 81 FR 7666

Duty to report?

“Our expectation is that only the parties to the kickback scheme would be required to repay the overpayment that was received by the innocent provider or supplier, except in extraordinary circumstances.” - 81 FR 7666

Can you appeal following your refund?

“Comment: Several commenters requested that CMS confirm that refunds based on statistical sampling will maintain appeal rights. Because individual claim adjustments may not be made when sampling is utilized to estimate an overpayment amount, CMS should confirm that providers and supplier may still appeal such findings if necessary.”

Can you appeal following your refund?

“Response: To the extent that the return of any self-identified overpayment results in a revised initial determination of any specific claim or claims, a person would be afforded the appeal rights that currently exist. As is currently the case under the existing voluntary refund process, there are no appeal rights associated with the self-identified overpayments that do not involve identification of individual overpaid claims and individual claim adjustments.” – 81 FR 7668

Continuum SDNY Case Allegations

- DOJ filed intervention complaint June 2014.
- Starting in 2009 – software compatibility issues resulted in submitting improper Medicaid secondary payor claims.
- Sept. 2010: Contacted by NYS about a few claims.
- Dec. 2010: Software vendor notice of error cause.
- Feb. 4 2011: Kane email identifying 900 claims likely overpayment.
- Feb. 8 2011: Kane terminated.
- Feb. 2011: Refund 5 claims.
- April 5 2011: Kane became a Relator.
- April 2011-March 2013: Sporadic refunds after prompting by NYS.
 - 300 claims refunded after receiving CID in June 2012.

Overpayment

- “Any funds that a person receives or retains under title [Medicare or Medicaid] to which the person, after applicable reconciliation, is not entitled under such title.”
- Many things are NOT overpayments.
 - Poor documentation.
 - Violations of Escobar.
 - Reassignment problems.

Do you have an overpayment??

- This is often the most important question.
- Intellectual consistency is key.
- If you really did the work, it is fair and appropriate for you to work to justify payment.
- Good lawyering can pay off.

Short Stays: Pre 10/1/13 Guidance

**Medicare Benefit Policy Manual
(CMS Pub. 100-02)
§ 10 - Covered Inpatient Hospital Services Covered
Under Part A**

An **inpatient** is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. **Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.**

Pre 10/1/13 Guidance

The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. **Physicians should use a 24-hour period as a benchmark, i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis. However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors,**

Pre 10/1/13 Guidance

including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting. Factors to be considered when making the decision to admit include such things as:

- The severity of the signs and symptoms exhibited by the patient;
- The medical predictability of something adverse happening to the patient;

E&M Issues

An internal documentation review finds...

Audit Results

	Under-coded	Correctly-coded	Over-coded
Dr. A	13%	76%	11%
Dr. B	50	30	20
Dr. C	15	50	35
Dr. D	0	19	81
Dr. E	33	33	33

What is the relevant law?

- “If it isn’t written, it wasn’t done,” right?
- Good advice, but not the law.
- Medicare payment is determined by the content of the service, not the content of the medical record.
- The documentation guidelines are just that: guidelines (although the Medicare contractor won’t believe that).

Role of Documentation: The Law

“No payment shall be made to any provider of services or other person under this part **unless there has been furnished such information** as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period.”

Social Security Act § 1833(e)

Role of Documentation: Guidance from CPT and CMS

- The CPT Assistant explains: “it is important to note that these are *Guidelines*, not a law or rule. Physicians need not modify their record keeping practices at all.”

*CPT Assistant Vol. 5, Issue 1, Winter
1995*

- Then HCFA, now CMS publicly stated that physicians are not required to use the Documentation Guidelines.

Role of Documentation: Guidance from CMS/HCFA

Documentation Guidelines for Evaluation and Management Services Questions and Answers

These questions and answers have been jointly developed by the Health Care Financing Administration (CMS/HCFA) and the American Medical Association (AMA) March 1995.

1. Are these guidelines required?

No. Physicians are not required to use these guidelines in documenting their services.

Guidance from CMS/HCFA

However, it is important to note that all physicians are potentially subject to post payment review. In the event of a review, Medicare carriers will be using these guidelines in helping them to determine/verify that the reported services were actually rendered. Physicians may find the format of the new guidelines convenient to follow and consistent with their current medical record keeping. Their usage will help facilitate communication with the carrier about the services provided, if that becomes necessary. Varying formats of documentation (e.g. SOAP notes) will be accepted by the Medicare carrier, as long as the basic information is discernible.”

Guidance from CMS/HCFA

“6. How will the guidelines be utilized if I am reviewed by the carrier?

If an evaluation and management review is indicated, Carriers will request medical records for specific patients and encounters. The documentation guidelines will be used as a template for that review. If the documentation is not sufficient to support the level of service provided, the Carrier will contact the physician for additional information.”

Audit Results

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Audit Review Results What Do They Mean?

	Documentation Exceeds Code Under-coded	Documentation Supports Code Correctly-coded	Documentation Does Not Support Code Over-coded
Dr. A	13%	76%	11%
Dr. B	50	30	20
Dr. C	15	50	35
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How do we figure out if the service was done?

- Ask.
 - The physicians.
 - Others (nurses, receptionists).
 - Secret shopper/shadowing.
- Schedules/time-based billing.
- Patient complaints.
- Production data.

Our Facts:

- Physician D is a very hard worker, is at the 75th percentile for RVUs.
- Physician C is a hard worker, is at twice the 90th percentile for RVUs.

Preliminary Conclusions

- Dr. D is ok. Educate, don't refund.
- Dr. C: Need more development. Begin interviews, etc.
- If you conclude the work wasn't done, how do you calculate the amount?
 - Sample?
 - Calculation?

What if??

- One day, a patient who was treated by the very productive president of your group calls and complains she was billed for a complete physical, but she never removed any clothes.
- What do you do?

What if??

A review of that physician's appointment book reveals that the physician worked from 9-3, took lunch, and saw 67 patients; 6 of the visits were billed as comprehensive physicals. The documentation supports all but 5 of the visits. (There is a comprehensive physical documented for the woman who called.)

Unsigned Charts

Many unsigned physician encounters are discovered. Must all of the services be refunded?

The Part B Side

The rules will vary based on the payor, but Medicare doesn't require a signature.

“11. Is the physician's signature required on each page of the documentation?”

No. The guidelines only state that the identity of the observer be legibly recorded.”

Program Integrity Manual, CMS Pub 100-08 § 3.3.2.4, *Signature Requirements*

- *If the signature is missing from an order, MACs and CERT shall disregard the order during the review of the claim (e.g., the reviewer will proceed as if the order was not received).*
- *If the signature is missing from any other medical documentation (other than an order), MACs and CERT shall accept a signature attestation from the author of the medical record entry.*

What if this is in the hospital?

- Violations of the CoP Aren't Overpayments:
 - Universal Health Services v. U.S. ex rel Escobar.
 - Important PIM text.

Program Integrity Manual § 3.1 - Introduction

Contractors must analyze provider compliance with Medicare coverage and coding rules and take appropriate corrective action when providers are found to be non-compliant. MR staff should not expend resources analyzing provider compliance with other Medicare rules (such as claims processing rules conditions of participation, etc.).

Program Integrity Manual

§ 3.1 - Introduction

If during a review it is determined that a provider does not comply with conditions of participation, do not deny payment solely for this reason. Refer to the applicable state survey agency. The overall goal of taking administrative action should be to correct the behavior in need of change, to collect overpayments once identified, and deny payment when payment should not be made.

Program Integrity Manual

§ 3.1 - Introduction

For repeated infractions, or infractions showing potential fraud or pattern of abuse, more severe administrative action should be initiated. In every instance, the contractor's priority is to minimize the potential or actual loss to the Medicare Trust Funds while using resources efficiently and treating providers and beneficiaries fairly.

Manuals Are NOT a Basis For an Overpayment

- “Thus, if government manuals go counter to governing statutes and regulations of the highest or higher dignity, a person ‘relies on them at his peril.’ Government Brief in Saint Mary’s Hospital v. Leavitt.
- “[The Manual] embodies a policy that itself is not even binding in agency adjudications.... Manual provisions concerning investigational devices also ‘do not have the force and effect of law and are not accorded that weight in the adjudicatory process.’ ” Gov’t brief in Cedars-Sinai Medical Center v. Shalala.

Manuals/Guidance Can’t Limit Coverage

42 USC § 1395hh(a)(1) says nothing other than an NCD may change benefits unless promulgated as a regulation.

Hard Questions About Internal Reviews

- If an internal review identifies an error, when do you just refund on the claims reviewed and when do you project to a larger universe?
- If a review of ten claims finds three identical errors, does that trigger the duty?
- What if there are three errors, but each one is different?

Hard Questions About Internal Reviews

- If you have identified a problem, how large a sample should you select?
- Do you use the same approach used by Medicare, and use the lower bound of the 95 percent confidence interval?
- How much effort do you put into developing a statistically valid sample?
- Do you use the same approach for all payors?

Hard Questions About Internal Reviews

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Private Insurers

- Can you discern anything from the initial contact?
- Is it a “routine audit?”
- Does the title of the person matter?
- Can you tell if the cops are involved?
- Should you record calls? Keep notes?
- Do you have to send the records? Should you?

The Letter

- Requests for multiple records are much more troubling.
- Make sure you keep a copy of everything you send.
- Use tracked delivery.
- Do you only send what was requested?
- When do you talk to counsel?

Interacting With Auditors

- Be friendly.
- Keep them in a room where you know what they have.
- Make sure they don't get any originals.
- Keep them in a low trafficked area.
- Take advantage of any exit conference. Involve your counsel if possible.

What Ifs...

- What if your documentation is hard to follow?
- What if your documentation is missing?
- How long should you expect to wait to hear something?
- What do you do if you hear nothing?

Preparing a Defense

- Do you interview staff?
- Do you do a review while the insurer is doing theirs? If so, who do you use?

Hiring Consultants

- Consider using work product privilege.
- Discuss the consultant's role; is s/he an advocate or a cop?
- Get references. There are some horror stories.

Legal Questions

- What rules apply?
 - Is there a contract?
 - Do Medicare rules matter?
 - What if it is a Medicare Advantage Patient?
 - Are you bound by the Insurer's Manuals?
 - How do industry norms factor in?
- Do you have a legal duty to return overpayments?

Practical Questions

- What dispute resolution mechanisms exist?
- Can a payor just take the money?
- Can a payor require rebilling?
- If so, do timely filing limits apply to the rebilling?

Practical Questions

- What about copayments/deductibles?
- Can they just terminate you?
- What do you do with patients?

Self-Disclosure Options

- Contractor Refund.
- CMS Self-Referral Disclosure Protocol (Stark).
- OIG Self Disclosure Protocol (Fraud).
- State Medicaid agencies.
- DOJ.
- Why pay a multiplier in a refund?

The Refund Letter

- Do you ever send a “placeholder” letter?
- Who is it from?
- Who is it to?
- How much detail do you provide?
- What about small issues where cost of investigation exceeds overpayment?
- What don't you say?

Dr. C's Letter

We **recently** discovered that one of our physicians **was committing billing fraud**. She was **not documenting services properly**. We **inadvertently** billed for these services. We did a **statistically valid sample**. We **have corrected the problem**.

The Refund Letter

- “As part of our ongoing compliance process.”
- “More appropriate” is a great phrase.
- “Possible issues.”
- Reserve the right to recant.
- “Level we are confident defending...”
- Beware of “our attorney has told us . . .”
- “Refund” vs. “overpayment.”
- “Steps to improve...”

What do you do with copayments?

- Law is less clear.
- Size matters. (Would you bill the patient if they owed you the same amount?)
- State law.

Do you rebill or refund?

- Rebilling generates timely filing issues.
- Refunding leaves bad claims data in the insurer's system.
- For private payors, beware of your contract.
- Refund is the way to go.

How do refunds affect RACs?

- If you have sampled, no one claim has been “refunded.”
- This will be something to watch.
- Note this is an issue even if the audit is on a different problem.
- In any overpayment situation, always look at prior refunds/audits on the same issue.
- (Note tie-in to rebill/refund issue!)

QUESTIONS?

Sanford “Sandy” Teplitzky
steplitzky@bakerdonelson.com
410.347.7364



David Glaser
dglaser@fredlaw.com
612.492.7143

