Roadmap

- Brief History of 60-Day Rule
- Key Themes of the Final Rule
  - Identification of Overpayments
  - Applicable Lookback Period
  - Mechanics of Reporting and Returning Overpayments
- Preventative Measures
Brief History

- Affordable Care Act (Act) – SSA § 1128J(d)

- Proposed Rule (77 Fed. Reg. 9,179; Feb. 16, 2012)
  - “Reckless disregard”, “deliberate ignorance”
  - 10-year lookback period
  - No clear “identification” standard to trigger 60-day clock


Brief History

  - First case involving alleged failure to refund Medicaid overpayments
  - Motion to dismiss denied and court read duty to inquire broadly
  - Settled for $3M in Sept. 2016 (overpayment was ~$850,000)
Brief History

- Final Rule (Feb. 12, 2016)
  - Overpayments under Medicare Parts A and B must be reported and returned within 60 days of identification or the date any corresponding cost report is due.
  - An overpayment is “identified” when a provider or supplier has or should have, through the exercise of reasonable diligence, determined that it has received an overpayment and quantified the amount of the overpayment.
- Effective Date: March 14, 2016

Brief History

- Three key themes:
  - Identification of overpayments
  - Lookback period
  - Mechanics of reporting and returning overpayments
Key Concepts

- An overpayment is not identified until it is quantified.
- Reasonable diligence to identify overpayments starts with “credible information” that an overpayment may exist and should take no more than six months.
- The lookback period is 6 years, not 10.
- Providers must report and return overpayments within 60 days of the date of identification.
- The methods to report and return overpayments are considerably more flexible.

Identification of Overpayments
Identification of Overpayments

- An overpayment must be reported and returned by –
  - Claims-based overpayments: 60 days after the date on which the overpayment was “identified”
  - Cost-report-based overpayments: the date any corresponding cost report is due

Examples of Causes of Overpayments

- Insufficient Documentation
- Lack of Medical Necessity
- Credit Balances
- Non-covered Services
- In Excess Of Allowable
- Duplicate Payments
Claims-Based Overpayments

- Identified when
  - “Has determined [it] received an overpayment and quantified the amount” or
  - Should have determined/quantified “through the exercise of reasonable diligence”

- Exercise of reasonable diligence is a multi-step process
  - Credible information
  - Reasonable diligence
  - Identification and quantification
  - Report and return

Credible Information: information that supports a reasonable belief that an overpayment may have been received

- Triggers duty of “reasonable diligence” inquiry
- Many potential sources of credible information
  - (Final) Medicare contractor audit findings (e.g., RAC, MAC)
  - Hotline Complaints
  - Improper Coding Identified
  - Sudden Increase In Revenue
  - Internal/External Audits
Claims-Based Overpayments

- **Reasonable Diligence**: Demonstrated through timely, good faith investigation: “at most six months from receipt of the credible information”
  - Replaces “reckless disregard,” “deliberate ignorance” and “all deliberate speed”
  - Requires proactive and reactive investigative activities
  - Six months is guidance in CMS preamble, not it rule itself

Claims-Based Overpayments

- CMS Notes “undertaking no or minimal compliance activities to monitor the accuracy and appropriateness of a provider or supplier’s Medicare claims” would fall short of the “reasonable diligence” standard.
- If provider receives credible information that an overpayment may exist, and fails to exercise reasonable diligence to determine if there is an overpayment, 60-day period begins when provider received the credible information.
Claims-Based Overpayments

- **Identification & Quantification**
  - An overpayment is “identified” only following reasonable diligence inquiry and quantification
  - No materiality or *de minimus* threshold
  - For probe samples, an overpayment is not “quantified” until the entire claim universe is analyzed

- **Report and Return**

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**Basic Process**

- **Credible Information Received**
  - Information that supports a reasonable belief that an overpayment may have been received.

- **Timely Investigation up to 6 Months**
  - Reasonable diligence to determine whether an overpayment has been received and to quantify the amount.

- **Reporting & Returning Up To 60 Days**
  - The 60-day time period begins when reasonable diligence is completed.
Claims-Based Overpayments

Start Here if Not Quantified

Start Here if Quantified

Cost Report-Based Overpayments

- Reconcile and refund:
  - At the time the cost report is due
  - The 60-day rule applies before the Notice of Program Reimbursement is issued
- Adjustments made by a MAC on retrospective audit is “credible information”
  - May trigger obligation to review prior years’ cost reports
- If issue identified in audit with respect to one cost report, it is “credible evidence” of a potential overpayment on other cost reports within the 6-year lookback
Cost Report Overpayments

- Where interim payments are made based on estimated costs, an overpayment is not deemed to exist until *applicable reconciliation*.

- Applicable reconciliation occurs and refunds due when:
  - The cost report is filed (initial or amended),
  - If related to updated SSI ratios from CMS, the final reconciliation of the cost report,
  - If part of an outlier reconciliation, the final reconciliation of the cost report.

Cost Report Overpayments

- No change in reopening rules, but given timing in getting a Notice of Program Reimbursement (NPR) (3-4 years) and subsequent 3-year reopening period, 6 year lookback period likely covered.

- Examples:
  - Overpayment discovered during preparation of cost report → Reconcile and refund when cost report submitted
  - Overpayment discovered prior to Notice of Program Reimbursement (NPR) → Submit amended cost report and refund
  - Overpayments discovered after NPR → Seek reopening to amend and refund.
Cost Report Overpayments

Basic Process

Applicable Reconciliation
- Provider’s yearend reconciliation of payments and costs to create the cost report.

Filing Within 5 Months of FYE
- Allows the provider time to reconcile payments and costs and identify any funds to which the provider is not entitled.

Reporting & Returning
- Overpayment should be returned at the time the cost report is filed.

Lookback Period
Lookback Period

- Lookback period is six years (not 10 years)
  - Refund overpayments identified “within six years of the date” overpayment was received

- Reopening Rules
  - New 42 C.F.R. § 405.980(c)(4) allows providers to request six-year reopening to address overpayments
  - No change to time periods for contractor-initiated reopenings

Lookback Period

- Final Rule is not retroactive
  - Does not apply to amounts actually refunded prior to March 14, 2016
  - Applies to amounts refunded after March 14, 2016—*even for overpayments received prior to that date*

- Important implications for provider/supplier audits currently in-process
Mechanics for Reporting and Repayment

The Mechanics

- Clarified the acceptable reporting method
  - MAC voluntary refund process
  - Requesting a claim adjustment or offset
- Clock is tolled for providers/suppliers who:
  - Request an Extended Repayment Schedule, or
  - Use another approved disclosure method (e.g., OIG Protocol, CMS Stark Process)
- Repay after full review, not after probe sample
The Mechanics

- Permits MAC voluntary refunds to be submitted with one form with spreadsheet identifying all claims
- Does not require providers/supplies to submit specific data points with each refund
  - Exception: Overpayments calculated through extrapolation must include details of the statistical sampling method

Impact on Other Payors

- Final Rule applies only to Medicare Parts A & B
- What is lookback period for other payer
- Medicare Advantage Organizations
  - Medicaid FFS
  - Medicaid MCO
- Considerations:
  - Application of ACA
  - Contracted Status
  - State Law
  - Operational/Administrative Burden
Scope of Investigation

- Certain investigations may need to be conducted under the attorney-client privilege
  - Consider at the beginning of the review
  - Use privilege if high probability of uncovering significant misconduct

- How much time?
  - Need to be diligent
  - CMS suggest that 6 months should be adequate
  - 6 months can go quickly

Case Study

<table>
<thead>
<tr>
<th>After Submission?</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>What if provider self-identifies an overpayment after the submission and applicable reconciliation of the Medicare cost report?</td>
<td>Submit an amended cost report.</td>
</tr>
<tr>
<td></td>
<td>Report and return overpayment within 60 days of identification.</td>
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### Impact of Affordable Care Act on 60-Day Rule

**Affordable Care Act**
- Requires any entity that receives or makes payments to the State Medicaid Program of at least $5,000,000 annually, to provide federal False Claims Act education to their employees.

**Medicaid and Whistleblowing**
- Affordable Care Act requirement to provide False Claims Act education to employees.

### Key Communication Controls

**Effective Communication**
- Internal Reporting Policies
- Event Reporting Systems
- Confidential Hotlines
- Monitoring

**Effective Controls**
- Training
- Supervision
- Monitoring
- Office Morale
- No Retaliation
Preventative Measures

1. Take stock of all audits currently in-process
   – If possible, quantify and refund prior to March 14, 2016
   – For all others, consider modification for six-year lookback

2. Develop a process to:
   – Identify credible information relating to possible overpayments and the date received
   – Conduct reasonable diligence to identify overpayments

3. Update documentation policies, if needed, to support reasonable diligence reviews looking back six years

4. Revise existing audit policies to ensure compliance with six-month reasonable diligence and 60-day refund timeframes

5. Establish (or improve) lines of communication internally between internal audit and external audit response teams
   – Critical as external audit findings (from RACs, MACs, etc.) represent “credible information” and trigger six-month timeline

6. Maintain documentation of all refunds including: retraction requests, revised claims, form and check submissions and extrapolation methodologies
Questions?

Thank You