

Conducting a Compliant Investigation (Effective Internal Investigation)

By: David Glaser
612.492.7143
dglaser@fredlaw.com

September 29, 2017

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“If we refund, will it raise a red flag?”

The 60-Day Requirement

- The Affordable Care Act included a provision requiring reporting and returning any Medicare/Medicaid overpayment within 60-days of “identification” of the overpayment.
- The statute left many questions.
 - What is an overpayment?
 - What is identification?
- A new regulation purports to answer some of them.

SSA § 1128J

GENERAL.—If a person has received an overpayment, the person shall—

(A) **report and return** the overpayment to the Secretary, the State, an intermediary, a carrier, or a 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.

SSA § 1128J - The Deadline

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.

New Regulation: 42 CFR § 401.305(a)(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.”

Are You Required to Do Audits?

“We believe that undertaking no or minimal compliance activities to monitor the accuracy and appropriateness of a provider or supplier’s Medicare claims would expose a provider or supplier to liability under the identified standard articulated in this rule based on the failure to exercise reasonable diligence if the provider or supplier received an overpayment. We also recognize that

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Are You Required to Do Audits?

compliance programs are not uniform in size and scope and that compliance activities in a smaller setting, such as a solo practitioner’s office, may look very different than those in a larger setting, such as a multi-specialty group.”

– 81 FR 7661

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Overpayment

“*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

- Many things are NOT overpayments.
 - Poor documentation (More soon).
 - Violations of COP?
 - Reassignment problems.

What can you do to prevent an audit?

- A trick question.
- Get an “Anomalies Happen” bumper sticker.
- Goal: Know that you can defend yourself if you are audited.
- Means: investigate like an auditor.

Question

If you could only have one piece of data as part of your compliance review, what would you choose?

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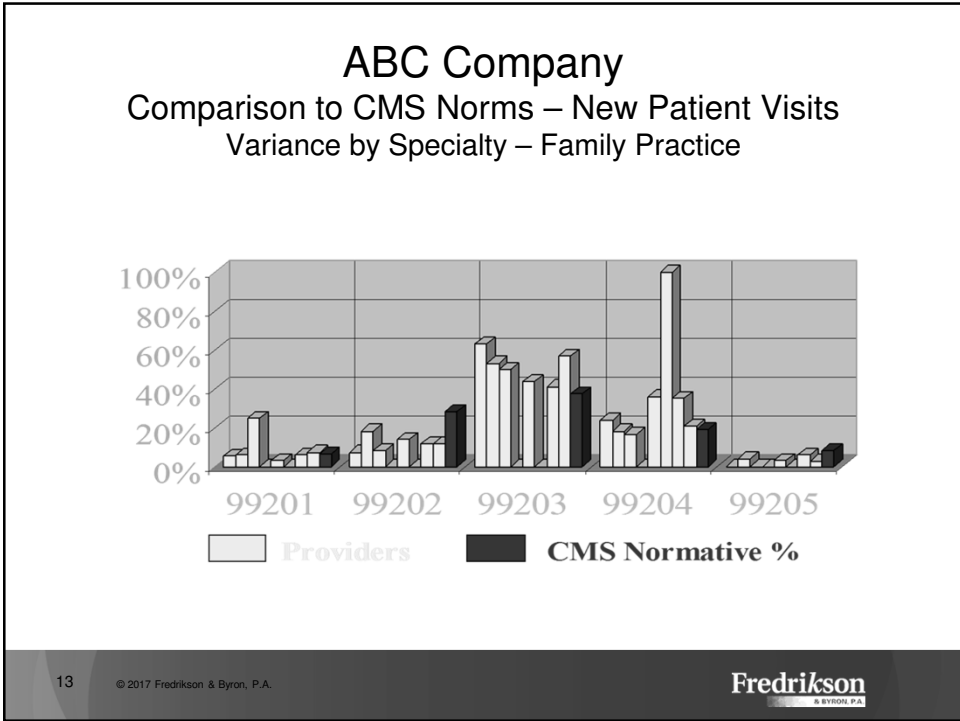
What do you look for?

- Documentation.
- Code Distribution Patterns.
 - Variation from the norm.
 - Changes.
- Total Production.
- Diagnosis coding.
- Bundling.
- Nervous employees.
- Credit Balances.

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- ## Who should do internal investigations?
- Attorney/compliance officer/other?
 - Who will people be most honest with?
 - Who will “ask the next question?”
 - There should be two people; at least one might be a witness.
 - Cost.
 - Privilege.
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Investigation Tips

- Make people comfortable.
- Let them talk!
- Educate your witness about the law.
(Note the difference between facts and law.)
- No need to be conventional.
- Phone interviews can be great when documents aren't important.

What is Privileged?

- Attorney-client privilege:
 - Oral and written communications.
 - Communications from the client as well as advice from the attorney and retained agents.
 - Key issue: whether the communication was in furtherance of obtaining legal advice?
- Work product privilege:
 - Materials prepared or assembled at the direction of counsel.
 - Must be in anticipation of potential litigation.

What is Privileged?

- Exceptions to privilege:
 - Presence of unauthorized third party.
 - Overbroad dissemination of privileged information.
 - Waiver.
 - Business versus legal advice.
 - Crime/fraud exception.
- Labelling isn't required, but sure helps.

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.

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,**

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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...

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E&M Issues

An internal documentation review finds...

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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

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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 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.

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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.”

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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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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

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
Dr. D	0	19	81
Dr. E	33	33	33

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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.

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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

You discover several of your physicians have failed to sign charts on a consistent basis. Must you refund all of the services?

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Conditions of Participation

- In some settings, signatures are COP.
- Hospital, ASC, etc.
- Conditions of Participation are not automatically Conditions of Payment.
- See the Supreme Court case *Universal Health Services v. Escobar*.

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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.

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.*

Concurrent Surgeries

At a teaching hospital, a surgeon is working with residents on three cases. One of the cases is being opened, one is being closed, and the third is in a key portion. The teaching physician was in the third case. Someone notes the following Manual language and believes fraud has been committed.

Medicare Claims Processing Manual § 100.1.2 - Surgical Procedures

2. Two Overlapping Surgeries

In order to bill Medicare for two overlapping surgeries, the teaching surgeon must be present during the critical or key portions of both operations. Therefore, the critical or key portions may not take place at the same time. When all of the key portions of the initial procedure have been completed, the teaching surgeon may begin to become involved in a second procedure. The teaching surgeon must personally document in the medical record that he/she was physically present during the

Medicare Claims Processing Manual § 100.1.2 - Surgical Procedures

critical or key portion(s) of both procedures. When a teaching physician is not present during non-critical or non-key portions of the procedure and is participating in another surgical procedure, he/she must arrange for another qualified surgeon to immediately assist the resident in the other case should the need arise. **In the case of three concurrent surgical procedures, the role of the teaching surgeon (but not anesthesiologist) in each of the cases is classified as a supervisory service to the hospital rather than a physician service to an individual patient and is not payable under the physician fee schedule.**

Medicare Claims Processing Manual § 100.1.2 - Surgical Procedures

A. Surgery (Including Endoscopic Operations)

The teaching surgeon is responsible for the preoperative, operative, and postoperative care of the beneficiary. **The teaching physician's presence is not required during the opening and closing of the surgical field unless these activities are considered to be critical or key portions of the procedure. The teaching surgeon determines which postoperative visits are considered key or critical and require his or her presence. . .**

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.

42 CFR § 415.172

(a) **General rule** If a resident participates in a service furnished in a teaching setting, physician fee schedule payment is made only if a teaching physician is present during the key portion of any service or procedure for which payment is sought.

(1) In the case of surgical, high-risk, or other complex procedures, the teaching physician must be present during all critical portions of the procedure and immediately available to furnish services during the entire service or procedure.

42 CFR § 415.172

(i) **In the case of surgery, the teaching physician's presence is not required during opening and closing of the surgical field.**

(ii) In the case of procedures performed through an endoscope, the teaching physician must be present during the entire viewing.

What Do You Do?

- If the service was consistent with the regulations, I would not consider it an overpayment.
- Absent an overpayment, disclosure seems unnecessary.
- The Manuals can give, but not take away.

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.

Medical Necessity Issues

- Use the “treating physician rule.”
- The theory is that the patient’s physician is objective. Therefore, the physician’s opinion receives deference.
- Medicare’s legislative history supports this argument.

The “Treating Physician Rule.”

“It is a well-settled rule in Social Security Disability cases that the expert medical opinion of a patient’s treating physician is to be accorded deference by the secretary and is binding unless contradicted by substantial evidence... This rule may well apply with even greater force in the context of Medicare reimbursement. The legislative history of the Medicare Statute makes clear the essential role of the attending physician in the statutory scheme; ‘the physician is to be the key figure in determining utilization of health services.’” Gartmann v. Secretary of the U.S. Department of HHS, 633 F.Supp. 671, 680-681 (E.D. N.Y. 1986).

The “Treating Physician Rule.”

A carrier is expected to place “significant reliance on the informed opinion of the treating physician” and to give “extra weight” to the treating physician’s opinion. Baxter v. Sullivan, 923 F.2d 1391, 1396 (9th Cir. 1991).

The “Treating Physician Rule.”

- CPM Ch. 30, § 100.2 forbids carriers from recouping an overpayment on the basis of a lack of medical necessity if a situation is ambiguous enough that the carrier requests its own physician consultant to review whether the services are covered.
- This should place the burden of proof on a carrier during an appeal.
- It provides a firm ground for challenging the carrier’s arguments that office visits can be denied as not medically necessary.

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?

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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?

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How Far Back Must You Go?

- The 60-day law had no explicit temporal limits. The rule says you must go back 6 years for overpayments.
- 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**

Social Security Act § 1870

(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.

Social Security Act § 1879

(a) Where -- (1) a determination is made that, **by reason of section 1862(a)(1) or (9)** or by reason of a coverage denial described in subsection (g), payment may not be made under part A or part B of this title for any expenses incurred for items or services furnished an individual by a provider of services or by another person pursuant to an assignment under section 1842(b)(3)(B)(ii), and (2) both such individual and such provider of services or such other person, as the case may be, **did not know, and could not reasonably have been expected to know**, that

Social Security Act § 1879

payment would not be made for such items or services under such part A or part B, then to the extent permitted by this title, payment shall, notwithstanding such determination, be made for such items or services (and for such period of time as the Secretary finds will carry out the objectives of this title), as though section 1862(a)(1) and section 1862(a)(9) did not apply and as though the coverage denial described in subsection (g) had not occurred. ... Any provider or other person furnishing items or services for which payment may not be made by

Social Security Act § 1879

reason of section 1862(a)(1) or (9) or by reason of a coverage denial described in subsection (g) shall be deemed to have knowledge that payment cannot be made for such items or services if the claim relating to such items or services involves a case, provider or other person furnishing services, procedure, or test, with respect to which such provider or other person has been notified by the Secretary (including notification by a quality improvement organization) that a pattern of inappropriate utilization has occurred in the past, and such provider or other person has been allowed a reasonable time to correct such inappropriate utilization.

42 C.F.R. § 405.980

(b) A contractor may reopen an initial determination or redetermination on its own motion—

- (1) Within 1 year from the date of the initial determination or redetermination for any reason.
- (2) Within 4 years from the date of the initial determination or redetermination for good cause as defined in § 405.986.
- (3) At any time if there exists reliable evidence as defined in § 405.902 that the initial determination was procured by fraud or similar fault as defined in § 405.902.

42 C.F.R. § 405.902

“Similar fault” means “to obtain, retain, convert, seek, or receive Medicare funds to which a person knows or should reasonably be expected to know that he or she or another for whose benefit Medicare funds are obtained, retained, converted, sought, or received is not legally entitled. This includes, but is not limited to, a failure to demonstrate that he or she filed a proper claim . . .”

42 CFR § 411.21 defines a “proper claim” as a “claim that is filed timely and meets all other claim filing requirements specified by the plan, program, or Insurer.”

Financial Management Manual § 70

Examples of § 1870 determinations

A – Overpaid Provider or Physician Not Liable Because It Was Without Fault (§ 1870(b) of the Act.)

If the provider was without fault with respect to an overpayment it received (**or is deemed without fault, in the absence of evidence to the contrary, because the overpayment was discovered subsequent to the third calendar year after the year of payment**) it is not liable for the overpayment; therefore, it is not responsible for refunding the amount involved. The FI or carrier makes these determinations.

Financial Management Manual

§ 170

The Carrier shall not attempt recovery action on individual overpayments if:

B – The Carrier Has Not Taken Action to Reopen the Payment Decision Within Four Years (48 Months) after the Date of the Initial Payment Determination

Unless Fraud or similar fault is present, a payment determination may not be reopened where the Carrier has not taken some action (which can be documented) questioning the correctness of the determination within 4 years (48 months) after the date the initial determination was approved. (See Medicare Claims Processing, Chapter 30, Correspondence and Appeals for policies governing the reopening and revision of decisions to allow or disallow a claim.)

Financial Management Manual,

Chapter 3, § 90

A provider is liable for overpayments it received unless it is found to be **without fault**. The FI or carrier, as applicable, makes this determination.

The FI or carrier considers a provider **without fault**, if it exercised reasonable care in billing for, and accepting, the payment, i.e.,

It made full disclosure of all material facts; **and**

- On the basis of the information available to it, including, but not limited to, the Medicare instructions and regulations, it had a reasonable basis for assuming that the payment was correct, or, if it had reason to question the payment; it promptly brought the question to the FI or carrier's attention.
- Normally, it will be clear from the circumstances whether the provider was without fault in causing the overpayment. Where it is not clear, the FI or carrier shall develop the issue.

Section 1879

“We believe it is inappropriate for providers or suppliers to make determinations regarding their own knowledge of non-coverage or whether they were the cause of an overpayment in lieu of reporting and returning an identified overpayment as required by this rule.” – 81 FR 7666

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.

Bottom Line

- The government thinks you must go back six years from when you quantified the overpayment.
- I think they lack the statutory authority for this.
- You must choose the route you are comfortable with.

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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?

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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!)

What about private payors?

- Contract (and manual??) control.
- Refund requirement is gov. only, but “health fraud” is a federal crime.
- State statute of limitations apply.
- State insurance law.
- Is Medicare Advantage a private payor?

QUESTIONS?



David Glaser

dglaser@fredlaw.com

612.492.7143