

Health Care Compliance Association
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Compliance and Overpayments

David M. Glaser, Shareholder, Fredrikson & Byron PA
Tony Maida, Partner, McDermott Will & Emery, LLP

Agenda

- “Identification” of an overpayment and 60-day rule
- Obligation to return “known overpayments”
 - When there is an overpayment?
- Options and strategies for self disclosure



Overpayment Statute: ACA, Section 6402(a); SSA Section 1128J(d); 42 U.S.C. § 1320a-7k(d)

- In general. If a person has received an overpayment, the person shall –
 - report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and
 - notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.
- What is an “Overpayment?”
 - The term “overpayment” means any funds that a person receives or retains under subchapter XVIII or XIX of this chapter to which the person, after applicable reconciliation, is not entitled under such subchapter.

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Overpayments and False Claims

- Deadline for reporting and returning overpayments. The later of –
 - the date which is 60 days after the date on which the overpayment was identified; or
 - the date any corresponding cost report is due, if applicable
- Enforcement: If an overpayment is retained past the deadline, it may constitute an “obligation” under the False Claims Act.
 - False Claims Act: imposes liability for “knowingly concealing or knowingly and improperly avoiding or decreasing an obligation” to pay the United States. (31 USC 3729(a)(1)(G))
 - ACA also created new CMPL action for a penalty of up to \$10,000 per item or service and three times the amount claimed and exclusion for “Any person . . . that knows of an overpayment . . . and does not report and return the overpayment in accordance with [section 6402].”

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Final Part A and B Rule, 81 FR 7954 (February 12, 2016)

- Regulatory provisions interpreting the Overpayment Statute (42 C.F.R. 401.301-5)
 - Lookback period
 - 6 years from the date that the payment was identified
 - How to report and return
 - Use the “most appropriate mechanism” based on the “nature of the overpayment”
 - Meaning of identified
 - When a provider or supplier “has determined, or should have determined through the exercise of reasonable diligence, that [it] received an overpayment and quantified the amount of the overpayment”
 - “Should have determined” means the provider or supplier failed to exercise reasonable diligence and in fact received an overpayment

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When does the 60 day clock start?

- CMS said providers have time to conduct the “reasonable diligence” before the 60 day clock starts to run
 - After receiving “credible information” the provider needs to undertake reasonable diligence
 - CMS articulated a 6 month “benchmark” for conducting reasonable diligence, except in “extraordinary circumstances” such as Stark issues, natural disasters, or states of emergency
 - The 60 day clock starts to run when either:
 - When the reasonable diligence is completed, or
 - On the day the credible information was received and the provider failed to conduct reasonable diligence (and an overpayment in fact was received)

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Is There An Overpayment?

- Documentation deficiencies are NOT always overpayments.
 - Beware of “overcoded.”
 - Some specific Medicare documentation requirements (e.g. DME order prior to delivery, face-to-face encounter for home health services)
- Condition of Participation vs. Condition of Payment.
 - PIM §3.1
 - UHS v. U.S. ex rel Escobar
 - U.S. ex. rel. Hobbs v. MedQuest Assoc., April 1, 2013 (6th Cir.)
- Reassignment violations/Dating errors
- Signatures/orders
- Manual vs. regulation
- Are you “without fault?”



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What is the Relevant Law?

- “If it isn’t written, it wasn’t done,” right?
 - Good advice, and best practice, 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.
- The provider is required to be able to submit “sufficient information” to support the claimed service.
 - This information could include testimony from the physician
 - The key issue here is **reliability**
 - How comfortable are you in using this information to reach a conclusion that payment was appropriate? Would you use this information to support an audit appeal?

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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)

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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.

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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.”

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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.
- Parking garage/badge swipe records.
- Patient complaints.
- Production data.

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

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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.

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Preliminary Conclusions

- Dr. A: Probably ok. Do education and monitor in future audit.
- Dr. B: Probably ok, but under-coding is high. Do education and monitor in future audit.
- Dr. C: Need more development. Begin interviews, etc.
 - If you conclude the work wasn't done, how do you calculate the amount?
 - Sample?
 - Calculation?
- Dr. D: Educate on documentation improvements and further develop facts to be comfortable work was in fact done.
- Dr. E: Need more development.

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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?

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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.)

The EMR record system shows the doctor was logged in after his car left the parking garage.

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Unsigned Charts

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

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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.”

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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.*

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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.

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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.).

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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.

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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.

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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.

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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 critical or key portion(s) of both procedures.

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Medicare Claims Processing Manual §100.1.2 -
Surgical 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.

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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. . .

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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.

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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.

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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.

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What Do You Do?

- If the service was consistent with the regulations, there is a strong argument that there is no overpayment.
- Absent an overpayment, disclosure seems unnecessary.
- The Manuals can give, but not take away.
 - 42 USC §1395hh(a)(1) says nothing other than an NCD may change benefits unless promulgated as a regulation.

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Self-Disclosure: Overpayment or Potential Fraud Liability?

- Legal Questions
 - Applicable coverage and payment statutes and regulations
 - Manual provisions
 - 60 Day Overpayment Rule
- Factual Questions
 - Who, what, when, where, why
 - Internal investigation/review process
- Optics Considerations
 - Comfort level of explaining the decision to the government or other external stakeholder (e.g. potential buyer) in the future

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Deciding Where to Disclose

- If you decide there is an overpayment or potential liability, where to report and return:
 - Contractor Refund
 - CMS SRDP
 - OIG SDP
 - State Medicaid agencies
 - DOJ



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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?

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Sample Letter – What to Say and What Not to Say

“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**.”

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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....”

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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

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Thank you!

David M. Glaser

612-492-7143

dglaser@fredlaw.com

Tony Maida

212-547-5492

tmaida@mwe.com

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