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The Physician/Attorney/Consultant Relationship:
Challenges Posed by the 60 Day Overpayment Disclosure Rule

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"60 Day Rule"

- The Affordable Care Act of 2010 imposed a requirement on providers who submit claims to the Medicare and Medicaid programs to report and return identified overpayments within 60 days ("60-Day Rule").
- Failure to report identified overpayments within 60 days carries liability under the United States False Claims Act (31 U.S.C. § 3729 *et. al*).
 - Issues arose as to what constituted an "identified overpayment" and what kind of event would trigger the 60-day clock.

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Final Rule Provides Clarity

- The Final Rule Addresses the following questions:
 - When is an overpayment "identified" for purposes of the reporting requirement?
 - What steps constitute "reasonable diligence" to determine if an overpayment has been made?
 - What is the lookback period for identifying overpayments?
 - What are a provider's options for repayment?

Definition of an "identified" overpayment

- Providers are responsible for overpayments that they **know or should have known** about through the exercise of "reasonable diligence."
- Providers that deliberately choose not to investigate when they are made aware of the existence of potential overpayments, would be held liable under the False Claims Act.
- The scope of a provider's obligation.
 - A provider will be held responsible for overpayments that the provider causes as well as those that were not caused by the provider (e.g., an error by CMS or a Medicare Administrative Contractor (MAC)).

Exercising "Reasonable Diligence"

- Providers exercise reasonable diligence in identifying overpayments when they:
 - (1) implement proactive compliance activities to monitor for the receipt of overpayments
 - (2) undertake investigations "in a timely manner" in response to obtaining "credible information" of a potential overpayment.
 - CMS considers a "timely" investigation to be at the most 6 months from receipt of the credible information, except in extraordinary circumstances.

Exercising "Reasonable Diligence" (cont'd)

- CMS commented on additional steps a provider should take if a single overpayment is identified.
 - Further inquiry would be advisable because "it is not appropriate for a provider or supplier to only return a subset of claims identified as overpayments and not extrapolate the full amount of overpayment."
 - Exercising reasonable diligence, may require a provider to use statistical sampling in order to appropriately quantify the overpayment.
 - A provider's compliance and audit activities should be adept at detecting potential overpayments in the timeliest manner.
- The 60-Day period does not begin until provider has had opportunity to undertake follow-up activities and quantify the amount of the full overpayment.

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Lookback Period

- The 60-Day Rule applies to overpayments identified within six years after they were received.

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Options for Repayment

- Providers may use several options when returning overpayments to CMS.
 - Providers may use claims adjustment, credit balance, OIG's Self-Disclosure protocol, or other appropriate processes to report or return overpayments.
 - CMS reserves the right to modify or create new processes in the future.
- Regardless of the process used, the refund should include an explanation or the statistical sampling methodology used if the overpayment was extrapolated.

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Action Items for Compliance

- Promptly evaluate any evidence of potential overpayments to determine whether the report is credible.
- Document the process of validating the potential of an overpayment and any follow up investigation.
- If the evidence is reliable, promptly investigate with reasonable diligence whether additional overpayments exist and how they should be quantified.
- Ensure the overpayment period encompasses 6 years.
- Once the overpayment is quantified, ensure that it is submitted within 60 days through one of the methods deemed acceptable by CMS.
- Implement policies, procedures and training regarding compliance with the 60-day rule.

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If providers are supposed to proactively identify potential overpayments, and they are, what do you look at?

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Potential Areas of Focus

- Levels of E&M service
- Ancillary services
 - IPPE/AWV
 - Orders for diagnostics, infusion, therapy
 - Staff credentials
- Separate reports (tests, procedures)
- Can you tell who provided the service?
 - Is it billed under that provider?
- Any incident-to issues?
- Medical necessity

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Potential Areas of Focus

- Modifiers?
- Unbundling?
- ICD-10 code supported by documentation and is linked to the appropriate CPT/HCPCS code?
- Billing for noncovered services as covered?
 - Annual screening stress test
- Use of ABNs and routine use
- Denials

Case Example #1

“Let’s have someone look at a few of each of our records to see how we’re doing with our coding. A couple of us are wondering how Stan has so many level 4 and 5 visits – he sees more patients than any of us.”

- Great idea not to single out Dr. Stan!
- Audit vs. chart review
- Prospective v. retrospective review
- Limit the scope to E&M only?
- Was there data behind the question?
 - Should that impact the approach?

Case Example #1

- No attorney involved at the onset – prospective review
- Stan has a 40% error rate for new patient encounters
 - 4:10 99204s have documentation issues
 - His exam and medical decision making documentation consistently support 99204.
 - Documentation does not support he reviewed any family history
 - His review of systems does not meet the E&M DG’s requirement of 10 or more systems for a comprehensive history.

Case Example #1 Discussion

- Are there potential overpayments or documentation issues, or both?
- Time to call counsel?
- Written or verbal report
- Next steps to consider

Case Example #2 (Stan with a twist)

“Let’s have someone look at a few of our records to see how we’re doing with our coding. A couple of us are wondering how Stan has so many level 4 and 5 visits – he sees more patients than any of us.”

- In addition to the prior findings, new patient visits are seen by Dr. Stan’s Physician Assistant who performs the history and physical, evaluates the patient’s medical condition, orders tests, and develops the treatment plan. He presents this to the doctor and the physician enters the examination room to confirm the diagnosis and treatment plan with the patient. Dr. Stan co-signs the notes.

Case Example #2 (Stan with a twist)

- Under §1861(s) of the Social Security Act:
 - Medicare pays for certain services and supplies furnished incident to a physician’s/NPP’s services and for which payment is not made under a separate benefit category
- Understanding the incident-to benefit is critical for proper payment
 - 100% versus 85% of the Medicare allowable

‘Incident to’ Requirements

- The services/supplies are an integral, although incidental, part of the physician’s/NPP’s professional services.
 - Course of treatment initiated by physician
 - Physician involvement reflected as continuing active participation in the patient’s management/care
- The services/supplies are of a type that are commonly furnished in a physician’s office or clinic.
 - Rules out services performed in the hospital

'Incident to' Requirements, cont'd

- The services/supplies are furnished under the physician's direct personal supervision.
 - A member of the practice who is physically in the office suite
- The ARNP/PA is enrolled as a Medicare Provider
- The services/supplies are furnished by an individual who qualifies as an employee of the physician.
 - W2, 1099 or leased employee
 - Cannot bill for the hospital's PA/ARNP

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Back to Case #2

- The P.A is employed by the group
- There's always a doctor in the office when the PA sees patients
- All services provided by the PA are billed under the supervising physician.
- When asked if the PA has a Medicare number:
 - "No, we bill everything incident to"

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Case Example #2 Discussion

- Are there potential overpayments or documentation issues, or both?
 - Based on E&M documentation
 - Based on not meeting incident-to payment criteria
- Time to call counsel?
- Does it matter who the payers are in this case?
- Written or verbal report
- Next steps to consider

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Issues to Consider

- Type of audit – Compliance vs. Investigation
- Attorney/Client Privilege
- Standards – Authoritative vs. Guidance
- Code Description vs. "Guidance"
- Escobar Standard – Material to payment of claim but that is False Claims Act standard vs. overpayment

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Authority vs. Guidance

- Criteria to be used at the front end.
- The Nature of Authoritative Standards
- Segregating "musts/shalls" from "shoulds" within the standard.

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Authority vs. Guidance

- Types of Authority –
 - Case Law – It depends.
 - Social Security Act (Medicare Statute)
 - HHS Regulations, unless determined:
 - to conflict with statute
 - to be unconstitutional
 - CMS Interpretive Guidance
 - Internet Only Manuals – These do not have the force of law and are therefore not technically binding
 - Local Contractor Rules
 - LCDs – These do not have the force of law and are therefore not binding. Expressly not binding on QICs or ALJs.

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Authority vs. Guidance

- **Guidance**
 - Provide guidance in the absence of statutory, regulatory or contractual provisions.
 - Not all are of equal value or validity. The quality of the source and the basis for the opinion will determine its value.
 - Coding Decisions
 - Persuasive standards can be used by providers to explain why a particular code was used but only in the absence of a binding standard to the contrary.
 - Audit Determinations:
 - **Guidance cannot be imposed as a basis for error but can be used to identify potential risk**

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Understanding Standard's Significance

- Identifying the Significance of the Authoritative Standard
 - Condition of Participation?
 - Condition of Payment?
- What is the difference?

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Condition of Participation or Payment?

- Conditions of Participation:
 - A condition or performance standard that must be met in order to be a participating provider.
- Conditions of Payment
- Medicare
 - Conditions of payment are usually found in statute or regulation
 - In many cases, documentation guidance is written as a condition of participation but applied as a condition of payment.

Condition of Participation or Payment?

- Does non conformance with interpretive guidance mean that you are not entitled to payment?
- FCA Case law:
 - *Universal Health Services v. United States ex rel. Escobar* – US Supreme Court held:
 - The precise label that the government affixes to the relevant law or contract such as, compliance is a "condition of payment"-is not determinative of whether the claim is "false or fraudulent"
 - Instead, it ruled that an implied certification theory can be a basis for FCA liability only if two conditions are satisfied:
 - (1) "the claim does not merely request payment, but also makes specific representations about the goods and services provided", and
 - (2) the defendant must fail to disclose its noncompliance with a provision that is "material" to the government's decision to pay.

Example – Resolving a Coding Dispute – Who is Right and How do you Prove It?

- Most disputes result from the application of unincorporated standards by one side of the dispute or the other.
 - Reliance on the "everyone knows" standard
 - Reliance on published guidance that is not incorporated by the applicable statute, regulation or medical policy
 - Failing to differentiate between coding rules and reimbursement rules.
- Some disputes are the result of legitimate ambiguity in a binding standard.

Audit Reporting

- Selected Code vs. Correct Code
- Identify Standard – Authoritative vs. Guidance
- Identify Risk Concerns
- Recommend Corrective Action
- No legal conclusions such as "overpayment"
- Verbal vs. Written

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Recommendations

- Education before audit
- Review current compliance – not past deficit
- Audit still required for effective compliance program

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Questions?

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