

# Health Law Webinar: Analyzing Possible Overpayments And Refunding When Necessary (and More Incident To!)

Health Law Webinar

May 13, 2026

**Fredrikson**

The logo for Fredrikson, featuring the name "Fredrikson" in a bold, black, sans-serif font. A red horizontal bar is positioned below the "Fred" portion of the name, extending to the right.



# Incident to/split-shared Questions

- Should we just stop doing incident to and split shared?
- Are you required to have an attestation from the physician?
- Can the physician and resident both be remote/ on audio/video performing telehealth?
- If the documentation indicates an equal amount of time between the physician and APP, can the physician bill?

# Incident to/split-shared Questions

- What is the benchmark for how much billing is appropriate by an APP in split shared? Is it okay to have 100% done by the physician?
- What considerations should be made when billing services provided by a licensed PT as incident to?
- Some guidance states incident to does not apply when the service has its own benefit category such as PT, yet Novitas and a consultant say it is allowed if the requirements are met?

# Incident to/split-shared Questions

- Is it better to follow MAC guidance because you will need to go to expensive levels to appeal?
- Do we need to correct a claim if we forgot to include the FS modifier on it?
- Does split/shared and the substantive portion apply in the ED?

# Incident to/split-shared Questions

- Can a split shared be done completely virtually with both the MD and APP on video? What guidance applies when a physician's note copies or summarizes the NPP's documentation, adding no new information or is merely co-signed? Some professionals believe this meets the substantive portion requirement. Does this demonstrate the physician's own work?
- Can you explain what services can have virtual supervision performed incident to? What about a stress test?

# Incident to/split-shared Questions

- Can a physician and an NPP do a co-visit in the office setting with the NPP doing the documentation? Who do we bill the visit under? Must it state something to bill under the physician?
- My question relates to RPM. It falls under incident to which is direct supervision, but CMS designates it as general supervision. How does the billing provider prove oversight of RPM under general supervision?

# Incident to/split-shared Questions

- Psychiatry and psychology clinics should not operate under the primary care exception, did I hear that correctly?
- To adequately support supervision, whether general direct or personal, we believe that would need to be documented within the ancillary staff or APC note. For example, a line saying, “Under the supervision of Dr. X.” Do you agree with that and are there any regulatory references you could point to which firmly support this?

# Refunds



# CAUTION

THERE MAY BE RATTLESNAKES IN THIS AREA.  
RATTLESNAKES ARE ACTIVE AT NIGHT DURING THE  
SUMMER. THEY WILL SEEK OUT SHADY PLACES DURING  
THE HEAT OF THE DAY. CHILDREN SHOULD BE WARNED NOT  
TO GO NEAR ANY SNAKE. REASONABLE WATCHFULNESS SHOULD  
BE SUFFICIENT TO AVOID SNAKEBITE.



# Refunds: Introductory Thoughts

- The legal framework is a bit different for Medicare and Medicaid, and quite different for private insurers, and individual patients.
- I mistakenly focus on Medicare too much.
- Language really matters. Words like “fraud” and “overpayment” are usually unhelpful.

# Legal Framework

- The obligation to refund is, in some cases, statutory.
- Common law can also play a role.
- Fairness/being on TV is worth considering.

# Federal Law

- At the federal level, an old, seldom used statute, was the first legal requirement. It is a criminal statute, used almost exclusively against beneficiaries.
- Now the 60-day rule controls.
- Don't forget HIPAA.

# The Old Days: SSA 1128B. [42 U.S.C. 1320a–7b]

- Whoever has knowledge of...any event affecting his initial or continued right to any [benefit or payment under any federal health care program]...and conceals or fails to disclose such event with an intent to fraudulently secure [the] benefit or payment...shall be guilty of a felony, and upon conviction thereof fined not more than \$25,000 or imprisoned for not more than five years or both.”

# The 60 Day Provision: 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.

# The 60 Day Provision: SSA §1128J

- 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.

# What is “Identified?” 42 CFR §401.305(a)(2)

## § 401.305 Requirements for reporting and returning of overpayments.

### (a) *General.*

- (1) A person that has received an overpayment must report and return the overpayment in the form and manner set forth in this section.
- (2) A person has identified an overpayment when the person knowingly receives or retains an overpayment. The term “knowingly” has the meaning set forth in 31 U.S.C. 3729(b)(1)(A).

# § 401.305 Requirements for Reporting and Returning of Overpayments.

(b) Deadline for reporting and returning overpayments. .

(1) Except as provided in paragraphs (b)(2) and (3) of this section, a person who has received an overpayment must report and return the overpayment by the later of either of the following:

(i) The date which is 60 days after the date on which the overpayment was identified.

(ii) The date any corresponding cost report is due, if applicable.

# § 401.305 Requirements for Reporting and Returning of Overpayments.

(3) (i) The deadline for reporting and returning overpayments will be suspended when both of the following occurs:

(A) A person has identified an overpayment but has not yet completed a good-faith investigation to determine the existence of related overpayments that may arise from the same or similar cause or reason as the initially identified overpayment; and

(B) The person conducts a timely, good-faith investigation to determine whether related overpayments exist.

(ii) If the conditions of paragraph (b)(3)(i) of this section are satisfied, the deadline for reporting and returning the initially identified overpayment and related overpayments that arise from the same or similar cause or reason as the initially identified overpayment will remain suspended until the earlier of:

(A) The date that the investigation of related overpayments has concluded and the aggregate amount of the initially identified overpayments and related overpayments is calculated; or

(B) The date that is 180 days after the date on which the initial identified overpayment was identified.

# Something Weird Stuff

- The statute refers to both Medicare and Medicaid.
- The regulation only applies to Medicare.
- When you complete the investigation, does that mean the money is due that second? That can't be right.

# What About Private Payors?

- Contract.
- State law.
- HIPAA.
- Don't buy the “you must rebill, but bummer about the timely filing” gambit.

# What is an Overpayment?

- This definition REALLY matters.
- We recommend that you only go back 48 months for most Medicare refunds, even though there is a 6-year window in the 60 regulation.
- The reason is all in the definition of overpayment!!
- (Want a free memo on this? Email [dglaser@fredlaw.com](mailto:dglaser@fredlaw.com)!)

## SSA §1128J(d)(4)

- Overpayment.—The term “overpayment” means any funds that a person receives or retains under title XVIII or XIX to which the person, **after applicable reconciliation**, is not entitled under such title.

# 42 CFR §401.303

- “*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.**”
- The main change is the disappearance of Medicaid.
- CMS takes an unreasonably narrow view of “applicable reconciliation.”

# Applicable Reconciliation: Can You Offset Underpayments?

- “The applicable reconciliation occurs when a cost report is filed; and  
...”

– 42 CFR 401.305(c)

- Page 7668 includes a convoluted assertion that reconciliation is cost-report specific. The discussion refers to Parts A and B. Part B doesn't feature cost reports.
- Offsetting underpayments seems entirely consistent with the statute, and CMS's interpretation seems baseless.
- Our core advice: don't voluntarily unreasonably penalize yourself.

# The Overpayment Checklist

- What is the “rule?” Have we violated it? (“Show me the rule/statute/NCD should always be the first question!”)
- Is the “rule” valid?
- Was the rule in effect during the period in question?
- What legal limitations may eliminate liability?
  - For Medicare, are we “without fault?” Is the contradictory guidance?
  - For private payors, is there a state law helps?
  - What is the statute of limitations/time limit on recovery?

# Reading Rules

- The differences between may/must, can/shall.
- Dig into the details. Incident to: the difference between “new problem” and “course of treatment.”
- Is what you are looking at binding? If it is a contractor policy, is it YOUR contractor? If it is a contractor policy, however, there is a bigger issue!
- Mind the gap? Check that effective date!!

# Regulatory Hierarchy

- Constitution (due process, contracts clause, enumerated powers).
- Statutes (U.S. Code/Social Security Act/State statutes.)
- Regulations/National Coverage Determinations.
  - Code of Federal Regulations.
  - State Regulations or Administrative Code.
  - NCD Manual. (A binding manual!).

# Regulatory Hierarchy (Lowerarchy?)

- Everything else is nonbinding.
  - Manuals.
  - Local coverage determinations.
  - Guidance from contractors.
  - Regulatory Preambles.
  - FAQs.

# SSA 1871(a)(2): Gotta Be A Rule

- No rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this title shall take effect unless it is promulgated by the Secretary by regulation under paragraph (1).”

# The Government Disavows Manuals

- “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.

# Azar v. Allina, 139 S.Ct. 1804, 1809 (2019)

- “Notably, Congress didn’t just adopt the APA’s notice-and-comment regime for the Medicare program. That, of course, it could have easily accomplished in just a few words. Instead, Congress chose to write a new, Medicare-specific statute. The new statute required the government to provide public notice and a 60-day comment period (twice the APA minimum of 30 days) for any “rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under [Medicare].” 42 U.S.C. § 1395hh(a)(2).”

# The ICD NCD.

- The DOJ asserted that hospitals that billed for patients who had received an ICD in a way that was inconsistent with the NCD had submitted false claims.
- The NCD “requires” that the ICD be more than 40 days post MI and that the patient have an EF of under .3.
- While “requires” is totally accurate, it is also terribly misleading. It is required to satisfy the NCD, but **YOU DON'T HAVE TO SATISFY THE NCD TO HAVE A COVERED SERVICE.** That distinction confuses people, but is really, really important.

# NCDs Do NOT Automatically Limit Coverage

- Where an item, service, etc. is stated to be covered, but such coverage is explicitly limited to specified indications or specified circumstances, all limitations on coverage of the items or services because they do not meet those specified indications or circumstances are based on §1862(a)(1) of the Act. **Where coverage of an item or service is provided for specified indications or circumstances but is not explicitly excluded for others, or where the item or service is not mentioned at all in the CMS Manual System the Medicare contractor is to make the coverage decision, in consultation with its medical staff, and with CMS when appropriate, based on the law, regulations, rulings and general program instructions.**

– Medicare National Coverage Determination Manual, CMS Pub. 100-03, Chapter 1, Foreword, Paragraph A

# The ICD NCD

## B. Nationally Covered Indications

Effective for services performed on or after February 15, 2018, CMS has determined that the evidence is sufficient to conclude that the use of ICDs, (also referred to as defibrillators) is reasonable and necessary:

1. Patients with a personal history of sustained Ventricular Tachyarrhythmia (VT) or cardiac arrest due to Ventricular Fibrillation (VF). Patients must have demonstrated:
  - An episode of sustained VT, either spontaneous or induced by an Electrophysiology (EP) study, not associated with an acute Myocardial Infarction (MI) and not due to a transient or reversible cause; or
  - An episode of cardiac arrest due to VF, not due to a transient or reversible cause.
2. Patients with a prior MI and a measured Left Ventricular Ejection Fraction (LVEF)  $\leq 0.30$ . Patients must not have:
  - New York Heart Association (NYHA) classification IV heart failure; or,
  - Had a Coronary Artery Bypass Graft (CABG), or Percutaneous Coronary Intervention (PCI) with angioplasty and/or stenting, within the past three (3) months; or,
  - Had an MI within the past 40 days; or,
  - Clinical symptoms and findings that would make them a candidate for coronary revascularization.

For these patients identified in B2, a formal shared decision making encounter must occur between the patient and a physician

# The ICD NCD

For each of the six (6) covered indications above, the following additional criteria must also be met:

1. Patients must be clinically stable (e.g., not in shock, from any etiology);
2. LVEF must be measured by echocardiography, radionuclide (nuclear medicine) imaging, cardiac Magnetic Resonance Imaging (MRI), or catheter angiography;
3. Patients must not have:
  - Significant, irreversible brain damage; or,
  - Any disease, other than cardiac disease (e.g., cancer, renal failure, liver failure) associated with a likelihood of survival less than one (1) year; or,
  - Supraventricular tachycardia such as atrial fibrillation with a poorly controlled ventricular rate.

# The ICD NCD

## C. Nationally Non-Covered Indications

N/A

## D. Other

For patients that are candidates for heart transplantation on the United Network for Organ Sharing (UNOS) transplant list awaiting a donor heart, coverage of ICDs, as with cardiac resynchronization therapy, as a bridge-to-transplant to prolong survival until a donor becomes available, is determined by the local Medicare Administrative Contractors (MACs).

All other indications for ICDs not currently covered in accordance with this decision may be covered under Category B Investigational Device Exemption (IDE) trials (42 CFR 405.201).

(This NCD last reviewed February 2018.)

# Note the Heading on NCDs

A. General

B. Nationally Covered Indications

C. Nationally Non-Covered Indications

D. Other

# 210.2.1 – Screening for Cervical Cancer with Human Papillomavirus (HPV) Testing (Effective July 9, 2015)

- **B. Nationally Covered Indications**

Effective for services performed on or after July 9, 2015, CMS has determined that the evidence is sufficient to add Human Papillomavirus (HPV) testing once every five years as an additional preventive service benefit under the Medicare program for asymptomatic beneficiaries aged 3265 years in conjunction with the pap smear test. CMS will cover screening for cervical cancer with the appropriate US Food and Drug Administration approved / cleared laboratory tests, used consistent with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement act CLIA regulations.

- **C. Nationally non-covered Indications**

Unless specifically covered in this and NCD, any other NCD, by Statute or regulation, preventive services are non-covered by Medicare.

- **D. Other**

# 240.2.1 – Home Use of Oxygen in Approved Clinical Trials (Effective March 20, 2006)

- **B. Nationally Covered Indications**

Effective for services performed on or after March 20, 2006 the home use of oxygen is covered for those beneficiaries with arterial oxygen partial pressure measurements from 56 to 65 mmHg or oxygen saturation at or above 89% or are enrolled subjects in clinical trials approved by the Centers for Medicare & Medicaid services and sponsored by the National Heart, Lung & Blood Institute (NHLBI).

- **C. Nationally non-covered Indications**

N/A

- **D. Other**

This policy does not alter Medicare coverage for items and service that may be covered or non-covered according to the existing national coverage determination for the home use of oxygen provided outside the context of approved clinical trials (National Coverage Determination Manual, section 240.2 and 310.1).

# Role of LCDs

- An LCD is a coverage determination issued by a contractor, not promulgated by the agency, and is not even binding on an administrative law judge. See 42 C.F.R. 405.1062(a).
- “The district court correctly stated in its instructions to the jury that LCDs are ‘eligibility guidelines’ that are not binding and should not be considered “the exact criteria used for determining” terminal illness.”
  - United States v. Aseracare, Inc., et al., 938 F.3d 1278, 1288 (11<sup>th</sup> Circ. 2019).

# If You Do Refund, to Whom?

- Provider Self-Disclosure Protocol.
- Self-Referral Disclosure Protocol.
- US Attorney's Office.
- Medicare Administrative Contractor.
- Medicaid agency.

# Poll: How Far Back Must You Go?

- Forever.
- 10 Years.
- 6 years.
- 5 years after the year in which payment was made.
- 4 years.
- 3 years.
- 1 year.

# How Far Back Must You Go?

- Two statutory provisions limit recovery of overpayments, 1870 and 1879. 1870 seems like a statute of limitation. Note neither statutes mentions “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. NOT the year it was BILLED!
- Payment made 1/4/21. Can recover 5 years after 2021, so count: 2022, 23, 24, 25, 26. Recovery possible through 12/31/26.
- Payment made 12/31/20. Now count 2021, 22, 23, 24, 25. Recovery until 12/31/25.
- Note that references to “five years” are very misleading. In life, simplicity too often 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.

# The Government Wants Refunders To Ignore §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

# 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.”

# How Far Back Must You Go?

- “***Lookback period.*** An overpayment must be reported and returned in accordance with this section if a person identifies 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)

# Bottom Line

- Many people think you must go back six years from when you quantified the overpayment. (Even if the contractor doesn't go back as far!)
- That isn't what the rule says! You have to return overpayments back six year. But an "overpayment" is money you aren't entitled to keep. If the government can't reopen the claim, IT ISN'T AN OVERPAYMENT!!! After 48 months it is only an overpayment if there is fraud or similar fault.

# 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?

# Presenter



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