

Voluntary Refunds: The 60-Day Rule and More

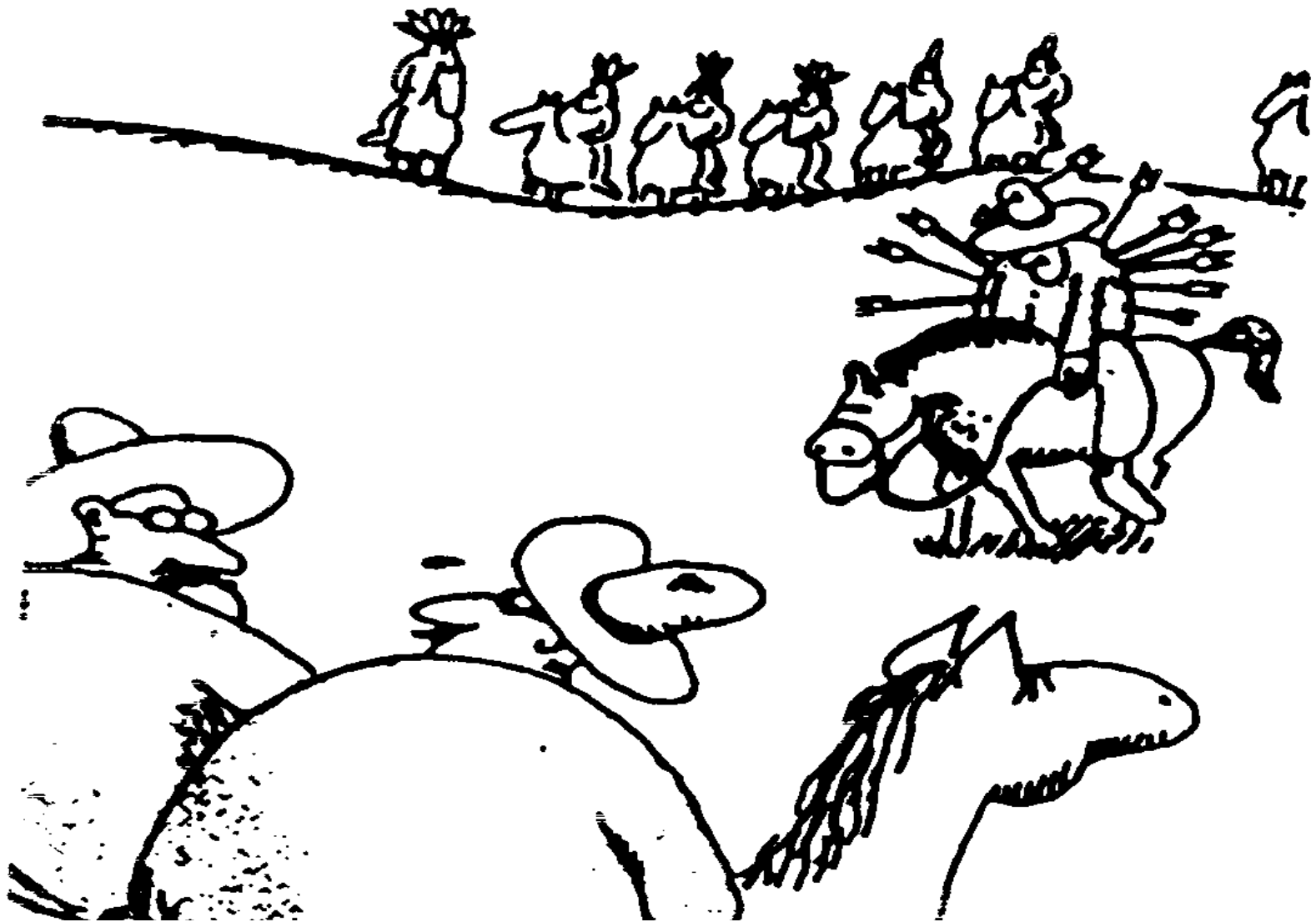
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Fredrikson
& BYRON, P.A.



“Now stay calm...Let’s hear what they said to Bill.”

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.

Important Statutory Quirk

- The law defines “knowing” and “knowingly” as having “the meaning given those terms in Section 3729(b) of title 31 of the United States code.”
- The statute then never uses the words “knowing” or “knowingly.”
- CMS uses the definition as the basis for its “reasonable diligence” standard.

What do you know?

- The duty to “report and return” applies to an overpayment.
- The 60 day clock runs only when the overpayment is identified.
- One would think an overpayment is not “identified” if you don’t know about it.

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.”

Knowingly?

“While we acknowledge the terms ‘knowing’ and ‘knowingly’ are defined but not otherwise used in Section 1128J(d) of the Act, we believe that Congress intended for Section 1128J(d) of the Act to apply broadly. If the requirement to report and return overpayments only applied to situations where the providers or suppliers had actual knowledge of the existence of an overpayment, then these entities could easily avoid returning improperly received payments and the purpose of the section would be defeated.”

- 81 FR 7660

Expansive Reading

“*Comment:* Several commenters suggested applying the ‘knowing’ concept to ‘retained’ instead of our proposed approach.

Commenters believed that applying the constructive knowledge standard to trigger the enforcement provisions would be more appropriate than our proposal.”

Expansive Reading

“*Response:* We considered applying a constructive knowledge standard to the term ‘retained’ and determined that our approach was both a better reading of the law and a better approach to protecting the program. As discussed previously, we believe there is a strong statutory basis for our rule...”

– 81 FR 7660

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 compliance programs are not

Are You Required to Do Audits?

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

Are You Required to Do Audits?

“We also stated that defining ‘identification’ in this way gives providers and suppliers an incentive to exercise reasonable diligence to determine whether an overpayment exists. Without such a definition, some providers and supplier might avoid performing activities to determine whether an overpayment exists, such as self-audits, compliance checks and other research.”

- 81 FR 7659

Are You Required to Do Audits?

Comment. Several commenters suggested an alternative definition to identification as ‘when, after the person receives reliable evidence that it has received an overpayment ...

Commenters stated that such a standard would provide some degree of comfort that providers and suppliers would not be under a duty to investigate every ‘whiff’ of an overpayment ...

Are You Required to Do Audits?

Response: ... Finally, we also disagree with the commenters' proposals to the extent they suggest identification efforts are limited to reactive investigations (and do not include the proactive compliance activities necessary to monitor for receipt of overpayments) or actual knowledge (and do not include the constructive knowledge standard discussed previously).”

– 81 FR 7663

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

*This is important, but we will come back to it.

Applicable Reconciliation

“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' interpretation seems baseless.

How far back must you go?

- The law had no explicit temporal limits.
- 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** (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 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.

Social Security Act § 1879

... Any provider or other person furnishing items or services for which payment may not be made by 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.**

(4) At anytime if the initial determination is unfavorable, in whole or in part, to the party thereto, but only for the purpose of correcting a clerical error on which that determination was based.

(5) At any time to effectuate a decision issued under the coverage appeals process.

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.

Summing It Up...

- The government things you must go back six years from the date you have quantified.
- They are disregarding conflicting statutory guidance.
- You have to decide whether to go along or opt to fight.
- Does a fight require challenge to the rule under the APA?

Did They Get This Right?

Comment: Some commenters stated that the concept of “overpayment” is not fair in some situations. The commenters stated that certain reasons for an overpayment, such as “insufficient documentation” or “lack of medical necessity” are extremely difficult to define objectively.

Response: “The definition of overpayment is fixed in statute. Sufficient documentation and medical necessity are longstanding fundamental prerequisites to Medicare coverage and payment.” - 81 FR 7658

Duty to Report?

“To the extent that a provider or supplier who has received an overpayment resulting from a kickback arrangement and it not a party to a kickback arrangement but has sufficient knowledge of the arrangement to have identified the resulting overpayment, the provider or supplier must report the overpayment to CMS.” - 81 FR 7666

Duty to Report?

“Our expectation is that only the parties to the kickback scheme would be required to repay the overpayment that was received by the innocent provider or supplier, except in extraordinary circumstances.” - 81 FR 7666

Can You Appeal Following Your Refund?

Comment: Several commenters requested that CMS confirm that refunds based on statistical sampling will maintain appeal rights. Because individual claim adjustments may not be made when sampling is utilized to estimate an overpayment amount, CMS should confirm that providers and supplier may still appeal such findings if necessary.”

Can You Appeal Following Your Refund?

Response: To the extent that the return of any self-identified overpayment results in a revised initial determination of any specific claim or claims, a person would be afforded the appeal rights that currently exist. As is currently the case under the existing voluntary refund process, there are no appeal rights associated with the self-identified overpayments that do not involve identification of individual overpaid claims and individual claim adjustments.” – 81 FR 7668

Continuum SDNY Case Allegations

- DOJ filed intervention complaint June 2014.
- Starting in 2009 – software compatibility issues resulted in submitting improper Medicaid secondary payor claims.
- Sept. 2010: Contacted by NYS about a few claims.
- Dec. 2010: Software vendor notice of error cause.
- Feb. 4 2011: Kane email identifying 900 claims likely overpayment.
- Feb. 8 2011: Kane terminated.
- Feb. 2011: Refund 5 claims.
- April 5 2011: Kane became a Relator.
- April 2011-March 2013: Sporadic refunds after prompting by NYS.
 - √ 300 claims refunded after receiving CID in June 2012.

Overpayment

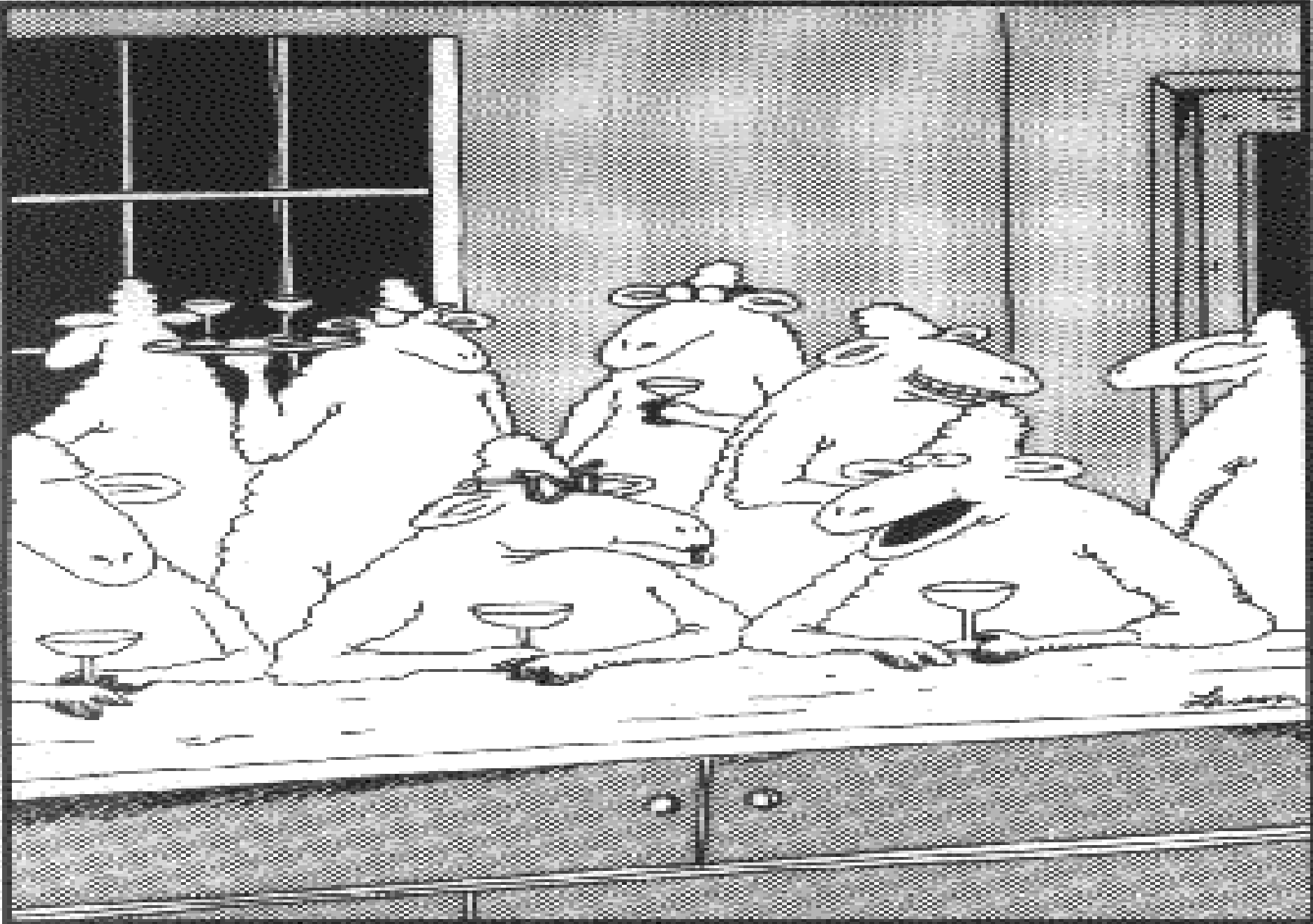
- “Any funds that a person receives or retains under title [Medicare or Medicaid] to which the person, after applicable reconciliation, is not entitled under such title.”
- Many things are NOT overpayments.
 - √ Poor documentation.
 - √ Violations of COP.
 - √ Reassignment problems.

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.

Investigation Tips

- Make people comfortable.
- Let them talk!
- Educate your witness.
- No need to be conventional. Be a salmon!



"Well, what d'ya know! ... I'm a follower, too!"

Investigation Tips

- Make people comfortable.
- Let them talk!
- Educate your witness.
- 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.

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

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. See:
<https://www.youtube.com/watch?v=7c3REpkbPLw&list=PLyjeM-paimEeqo2KRcc26MEHs5nAWhBn2&index=1>

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)

Audit Results

	Under-coded	Correctly-coded	Over-coded
Dr. A	13%	76%	11%
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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	3

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.

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?

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?

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?

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?



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