What To Do When You MIGHT Have an Overpayment from Medicare

LeadingAge Minnesota
2020 Institute and Expo
River Center, St. Paul, Minnesota
February 5-7, 2020

Jesse A. Berg, J.D., M.P.H.
Julia C. Reiland, J.D.

Lathrop GPM

Agenda

- Introduction to 60-day Overpayment Rule
- Overview of the legal framework:
  - Discuss Affordable Care Act (“ACA”) statutory change, authorization of civil monetary penalties (“CMPs”), and linkage to False Claims Act (“FCA”) liability
  - Overview of other overpayment regulations and enforcement risks, such as exclusion and criminal liability
  - Overview of 2016 final rule
- Enforcement Examples
- Hypotheticals

Introduction

- The ACA created a new requirement that providers and suppliers report and return overpayments of federal health care dollars by the later of 60 days after the overpayment was identified or the date an applicable cost report is due

Non-ACA Authorities Addressing Overpayments

- 31 U.S.C. § 3729(a)(1)(G) (False Claims Act): exposure for overpayment retention
  - Added in 2009 under Fraud Enforcement and Recovery Act:
    - "Any person who ... knowingly conceals or knowingly and improperly avoids or decreases an *obligation* to pay or transmit money or property to the Government...."
  - "Obligation" (31 U.S.C. §3729(b)(3)):
    - "an established duty … arising from an express or implied contractual … relationship, from a fee-based or similar relationship, *from statute or regulation, or from the retention of any overpayment*...."
- 42 U.S.C. 1320a-7b(a)(3)—felony and punishable by $25,000 fine for failure to disclose with fraudulent intent
  - Language is unclear
  - Enforcement?

Non-ACA Authorities Addressing Overpayments (continued)

- 42 U.S.C. 1395nn(g)(2) (Stark Law) requires “timely” refund of amounts improperly collected
- HHS has previously issued proposed regulations on overpayment issues:
  - 1998 proposed rule (63 Fed. Reg. 14506)
  - 2002 proposed rule (67 Fed. Reg. 3662)

ACA Statutory Change: the 60-day Rule

42 U.S.C. § 1320a-7k(d):

- Reporting and returning of overpayments
  - (1) In 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.
  - (2) Deadline for reporting and returning overpayments. 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.

ACA Statutory Change: the 60-day Rule

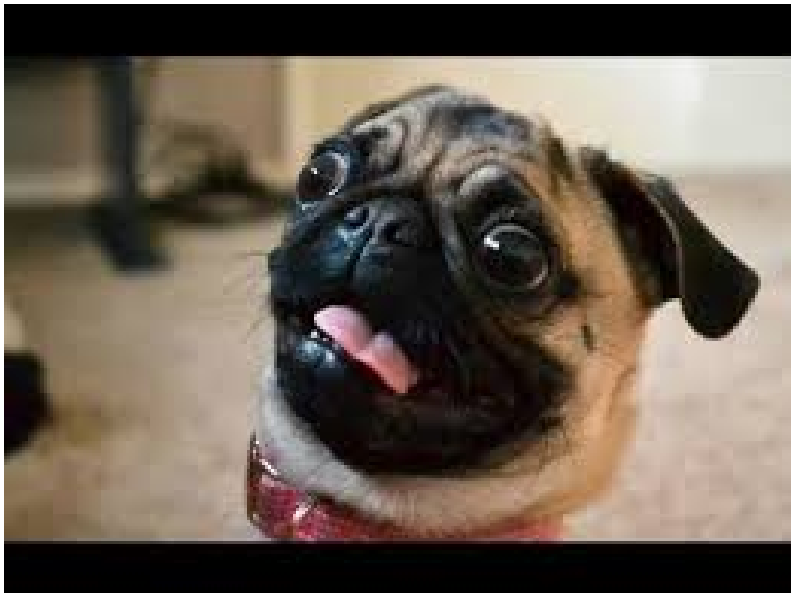
- (3) Enforcement. Any overpayment retained by a person after the deadline for reporting and returning the overpayment under paragraph (2) is an obligation (as defined in [the FCA]).
- (4) Definitions. In this subsection:
  - (A) Knowing and knowingly. The terms "knowing" and "knowingly" have the meaning given those terms in [the FCA].
  - (B) 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.
  - (C) Person
    - (i) In general. The term "person" means a provider of services, supplier, Medicaid managed care organization (as defined in section 1396b(m)(I)(A) of this title), Medicare Advantage organization (as defined in section 1395w-28(a)(1) of this title), or PDP sponsor (as defined in section 1395w-151(a)(13) of this title).
    - (ii) Exclusion. Such term does not include a beneficiary.

ACA Statutory Change: CMPs and Exclusion

- 42 U.S.C. § 1320a-7a(a)(10) creates CMP exposure for a person "that knows of an overpayment … and does not report and return the overpayment”
- “Overpayment” as defined in 60-day statute
- CMP of up to $10,000 for each item or service, plus an assessment of up to three times the amount claimed for each such item or service.
- OIG can also seek to exclude party from federal health care programs.

ACA Statutory Change: CMPs and Exclusion (continued)

- Consequences of exclusion are profound.
  - No payment will be made for any item or service furnished, ordered or prescribed by an excluded individual or entity.
  - CMPs may be imposed against providers who employ or contract with excluded individuals or entities.



Enforcement Options: ACA Rule creates ties to FCA

- 42 U.S.C. § 1320a-7k(d) ties ACA overpayment to FCA by defining unreturned overpayment as an "obligation"
- Implications:
  - A significant fine for *each* violation
  - Possibility of treble damages
  - *Qui tam* suits
- Questions:
  - Does failure to return within 60 deadline automatically create FCA liability?
  - Reasonable to equate errors/mistakes in reimbursement process with fraud of nature that is punishable under FCA?
  - Do *qui tam* relators have chance to file as soon as 60-day window is missed?

Overview of Final Rule

- CMS issued a final rule for Parts A and B of the Medicare program on Feb. 12, 2016 (81 Fed. Reg. 7654)
- The final rule made several positive changes to the proposed rule
- The final rule did not change the proposed definition of “overpayment” or “applicable reconciliation.”

What is an “Overpayment”?

- An “overpayment” is “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.”
- Commentary provides examples:
  - Medicare payments for noncovered services
  - Medicare payments in excess of the allowable amount for an identified covered service
  - Errors and nonreimbursable expenditures in cost reports
  - Duplicate payments
  - Receipt of Medicare payment when another payor had the primary responsibility for payment
- Commonality: all of these things can happen without fraud

"Identification" of Overpayment Under the Final Rule

- Removal of "deliberate ignorance" and "reckless disregard" standard that was in the proposed rule
- "*Identified*"—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*.
- 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."

“Reasonable Diligence”

- “*Reasonable diligence*” includes “both proactive compliance activities to monitor claims and reactive investigative activities undertaken in response to receiving credible information about a potential overpayment.”

“Quantification” of an Overpayment

- The final rule recognizes that part of identification of an overpayment is quantifying the amount *and the 60-day clock does not start until the provider has quantified the amount*.
- This is a significant change from the proposed rule and the *Kane* case

Note on the Kane case

Kane ex rel. U.S. v. Healthfirst, Inc.

- Kane highlights a challenge with the rationale of the proposed rule. 120 F. Supp. 3d 370 (S.D.N.Y. 2015)
- Kane began as a qui tam and DOJ intervened
- NY Comptroller General notified a hospital that a Medicaid managed care company allegedly sent it inaccurate remittances, which caused billing errors
- Hospital tasked an employee to investigate, he found $1 million in potential overpayments, was fired, and became a whistleblower

Note on the Kane case

- Defendants argued that the ACA 60-day clock should not begin until the amount of the overpayment is “known with certainty”
- Court: clock begins when a provider “is put on notice of a potential overpayment, rather than the moment when an overpayment is conclusively ascertained”

Timeline of a Reasonably Diligent Investigation

- Quantification may not stretch on forever
- Proposed rule required “all deliberate speed”
- Final rule requires a “timely, good faith investigation of credible information, which is *at most 6 months* from receipt of the credible information, except in extraordinary circumstances.”

Timeline of a Reasonably Diligent Investigation

- The term “applicable reconciliation” is a central component of the term “overpayment.”
- “Applicable reconciliation” occurs when cost report (initial or amended is) filed.
- 2 exceptions:
  - Provider receives updated SSI ratio information (for DSH adjustment)
  - Knows outlier reconciliation will be performed
- Not required to return overpayment until final reconciliation

Lookback Period under the Final Rule

- Final rule shortened the “lookback” period from the proposed 10 years to 6 years.
- CMS reasoned that this period is less burdensome for providers and aligns with the most commonly applicable FCA limitation period, the period in 42 U.S.C. § 1320a-7a (which concerns CMPs)

Reporting and Returning Overpayments under the Final Rule

- Improved from Proposed Rule
- 13 data elements requirement scrapped
- Methods include “applicable claims adjustment, credit balance, self-reported refund, or other reporting process set forth by the applicable Medicare contractor”
- Credit balancing reporting is OK even if the report is not due within 60 days of the overpayment
- Providers can report using either the CMS’ SRDP or the OIG’s SDP (Discussed below)

Relationship to Stark and Anti-kickback Statute ("AKS")

- Compliance with AKS is a "condition of payment" and violating AKS creates FCA liability.
- Generally, the *entire amount* of a payment made in violation of AKS or the Stark Law is an "overpayment".
- CMS recognizes that providers may not be aware of an arrangement between third parties that causes the provider to submit claims that violate AKS.

Reporting and Returning Overpayments Using Stark Law or AKS Self-Disclosure

- SRDP and SDP allow self-reporting of Stark Law and AKS violations.
- The obligation to *return* overpayments is suspended upon receipt of acknowledgment of a SRDP or SDP submission.
- A person also satisfies the *reporting* obligations by making a qualifying disclosure under SDP or SRDP.

CMS' recent clarification of how the SRDP and 60-day rule fit together

- CMS' website recently clarified how 6-year lookback period corresponds to the reporting period used in the SRDP.
- Paperwork Reduction Act limits CMS to collecting financial analysis of overpayments that occurred during a 4-year time frame.
- CMS is seeking authority to collect analysis from the whole 6-year lookback period.
- In the meantime, providers can voluntarily provide this information using the SRDP.
- Overpayments reported under the SRDP prior to March 14, 2016 are not subject to the 6-year lookback period established under the Final Rule.

Other Stark Law Changes

- HHS made several changes to the Stark Law in 2016.
- Lots of pre-2016 self-disclosures involved “technical” violations like failure to have a formal “writing” as was arguably required by some exceptions.
- CMS clarified that a series of contemporaneous documents (rather than a formal contract) that clearly evidence a relationship can qualify.
- Likewise, the requirement found in certain Stark Law exceptions that a compensation arrangement must have a “term of at least one year” now does not require a “formal contract with an explicit ‘term’ provision”.
- In addition, HHS now allows indefinite “holdovers” of leases and PSAs that expire so long as the holdover continues on the same terms as the original arrangement and the arrangement continues to meet the requirements of the applicable exception.

Lingering Questions

- What is required of providers by virtue of the “proactive compliance” standard?
- What standards will HHS apply to smaller providers?
- How will providers ensure that information regarding overpayments is reported up the chain to those who can investigate, report, and return?
- Will regulators give providers the benefit of the doubt regarding the vague, undefined standards used in the Final Rule (i.e., “reasonable diligence” and “proactive compliance”)?

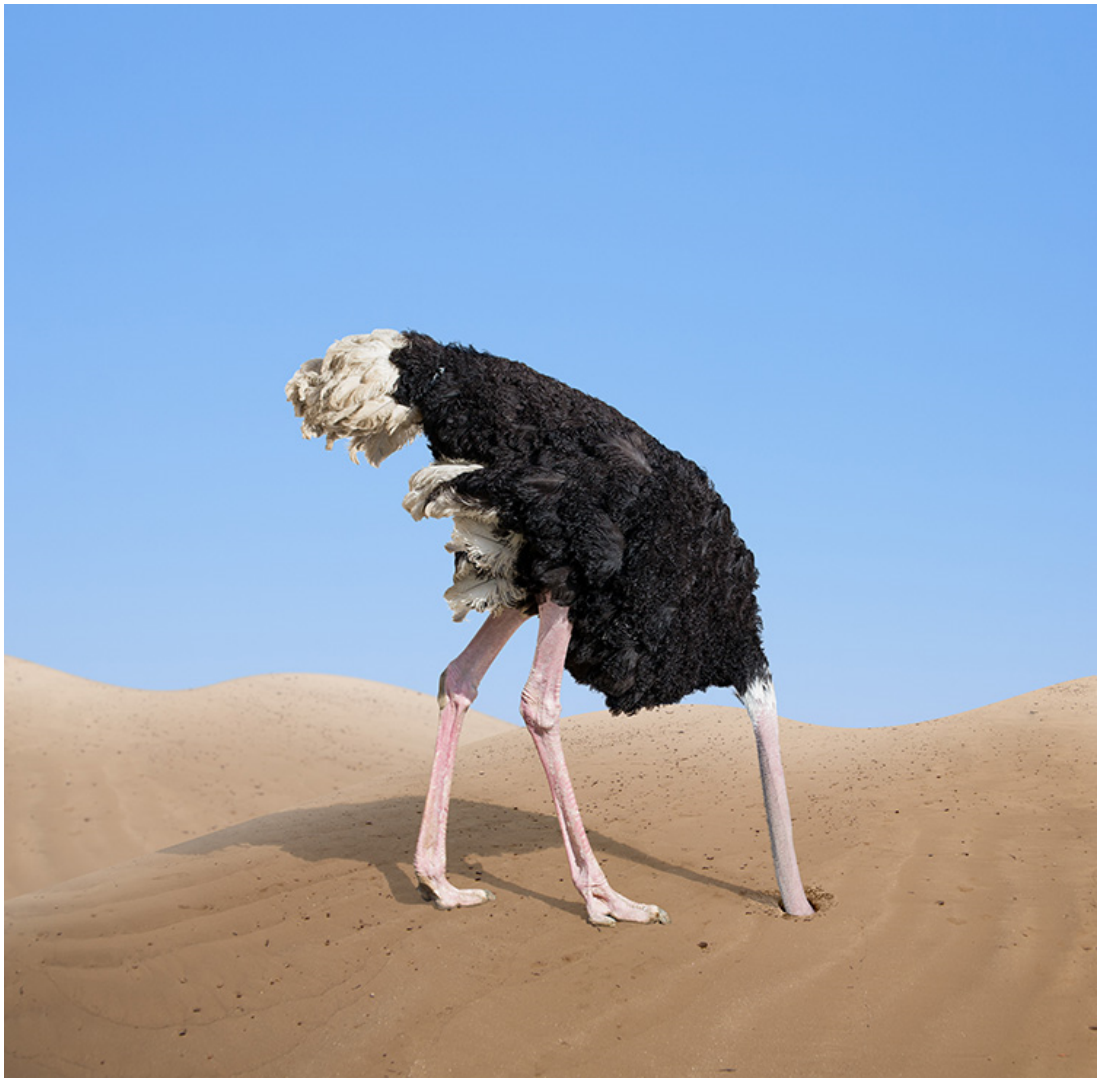
Lingering Questions (continued)

- How will HHS define the scope of the “extraordinary circumstances” that permit more than 6-months for “reasonably diligent” investigations?
- How will providers determine what kind of information is sufficiently “credible” to warrant investigation?
- What is the best way to report an overpayment? There are many options, each with pros and cons (e.g., OIG via the SDP, CMS via the SRDP, Medicare Administrative Contractors/State Medicaid agencies, U.S. Attorney’s Office, State Medicaid Fraud Control Unit, etc.).

Take Away

- Even with the improved Final Rule, robust compliance programs are essential.
- Providers must promptly evaluate credible information regarding an overpayment, carefully document any resulting inquiry, and diligently follow-up.

Enforcement Examples



McBride Clinic Orthopedic Hospital (11-1-2018)

- After it self-disclosed conduct to OIG, McBride Clinic Orthopedic Hospital (McBride) agreed to pay $414,649.91 for allegedly violating the Civil Monetary Penalties Law.
- OIG alleged that McBride improperly submitted claims to Federal health care programs for:
  - (1) professional services related to surgeries performed by two employee-physicians improperly appended by Modifier 51, 58, and/or 59;
  - (2) professional and facility fees related to post-surgical patient visits performed by a licensed practical nurse without physician supervision; and
  - (3) evaluation and management services performed by an employee-physician during office visits improperly appended by Modifier 25 and/or billed as split/shared.

McBride Clinic Orthopedic

- OIG further alleged that McBride knew of overpayments and did not report and return those overpayments in accordance with Medicare rules.
- Specifically, OIG alleged that McBride allowed the accrual of overpayments owed to Medicare and, when McBride became aware of these overpayments through educational audits, it failed to return those overpayments to Medicare.

Tri-Med Ambulance (3-29-18)

- After it self-disclosed conduct to OIG, Tri-Med Ambulance, LLC (Tri-Med) agreed to pay $71,880.66 for allegedly violating the Civil Monetary Penalties Law.
- OIG alleged that Tri-Med filed duplicate claims for ambulance transportation services provided to Medicare beneficiaries.
- Additionally, OIG alleged that Tri-Med identified the overpayments related to the submission of these duplicate claims, but Tri-Med failed to timely return those overpayments.

Medicaid Overpayments: The pressure is on

- In December 2018, OIG issued a report summarizing its findings from a Medicaid overpayment recovery audit
  - OIG evaluated CMS's efforts to collect Medicaid overpayments
- OIG reviewed 313 audits issued in FYs 2010 through 2015 (the current period) that recommended recovering overpayment amounts totaling $2.7 billion and 10 audits issued for FYs 2004 through 2009 (the prior period) that recommended recovering overpayment amounts totaling $225.6 million.
  - For these 323 audits, OIG evaluated only the overpayments that OIG had recommended for recovery and with which CMS had concurred, which totaled $2.6 billion for the current period and $191.3 million from the prior period.

Medicaid Overpayments: The pressure is on

- OIG found that CMS had not recovered all of the overpayments identified in OIG audit reports in accordance with Federal requirements.
  - Specifically, CMS did not collect $1.6 billion in overpayments identified in 77 current period audits and $188.6 million in overpayments identified in 7 prior period audits.
- OIG concluded that this arose due to CMS's failure to:
  - Maintain policies and procedures that include timelines for resolving overpayments when State agencies disagreed with the recommendations;
  - Ensure that States correctly reported Medicaid overpayments; and
  - Retain documentation to support that overpayments were recovered

Medicaid Overpayments: The pressure is on

“We recommend that CMS recover the remaining $1.6 billion due the Federal Government from the current period and $188.6 million due the Federal Government from the prior period and improve the timeliness of recovering overpayments by setting guidelines about the time CMS has to work with States to obtain documentation and issue disallowance letters to States. We also recommend that CMS verify that States report overpayments correctly, require States to resubmit corrected CMS-64s when they do not, and continue to educate States about their responsibility to report overpayments correctly. In written comments on our draft report, CMS concurred with our recommendations and described actions that it has taken or plans to take to address the recommendations.”

Hypotheticals

"Let's go back to the scenario in which none of this is my fault."

Hypo One: Double Trouble

- You work in the billing department of Homeaway, a Skilled Nursing Facility, and are tasked with reviewing claims for which Homeaway recently received reimbursement.
- As you review claims for radiology services provided by Dr. Dan, you notice that two of the claims overlapped:
  - Claim A was for therapeutic injections provided by Dr. Dan at 10:00am, which requires Dr. Dan to be physically present in the room.
  - Claim B was for interpretation services by Dr. Dan at 10:00am, which requires Dr. Dan to review and interpret x-rays, MRIs, CAT scans, etc.
- Either Dr. Dan has figured out how to be in two places at once, or one of the claims is incorrect. *What do you do*?

Hypo Two: A Patient Complaint

- Homeaway received a complaint from a former patient stating that they never received or consented to Homeaway's Notice of Privacy Practices (NPP) and, therefore, that Homeaway was not permitted to bill for the services that were provided.
- You know that Homeaway is require to provide a copy of the NPP, and you are sure that the NPP was provided. But you review the patient's chart and do not find a signed consent form confirming that the NPP was provided, nor do you see any other evidence verifying that the NPP was given.
- *What do you do? Do you have to repay the claims?*

Hypo Three: Coding Confusion

- Homeaway received reimbursement for 30 minutes of manual therapy services provided to Patient A. Manual therapy services are reimbursement using a time-based code that allow for variable billing in 15-minute increments.
- Homeaway later found out from the scheduling department that Patient A checked out early that day, and did not attend the full 30-minute appointment.
- After investigating the situation, you confirm that Patient A only received manual therapy services for 20 minutes.
- *What do you do?*

Questions?

Jesse A. Berg
Lathrop GPM LLP
612.632.3374
jesse.berg@lathropgpm.com

Julia C. Reiland
Lathrop GPM LLP
612.632.3280
julia.reiland@lathropgpm.com