Overpayments and Voluntary Repayments Under the New 60-Day Rule

Daniel F. Shay*

In 2010, with the passage of the Affordable Care Act, Congress created an obligation for healthcare providers to return overpayments that they receive within 60 days, or risk False Claims Act exposure. This year, CMS finally published regulations that clarify this statutory language. The regulations, however, impose strict standards on healthcare providers, wherein constructive knowledge can be imputed to a healthcare provider if that provider failed to exercise reasonable diligence. This article explores the new regulations, examines the practical implications of these new standards, and discusses the risks providers may face if they fail to engage in ongoing compliance efforts.

KEY WORDS: Compliance plan; false claims; overpayments; voluntary repayments; ostrich defense; obligation.

*Alice G. Gosfield and Associates, PC, 2309 Delancey Place, Philadelphia, PA 19103; phone: 215-735-2384; e-mail: dshay@gosfield.com.

The federal government is looking for a few good volunteers, and you have been selected. In regulations published this past February, CMS elaborates precisely on how one can be obligated to voluntarily repay money that has been improperly received from Medicare. Setting aside the linguistic backflips necessary to parse the terminology, the bottom line is relatively simple: if you receive an overpayment from Medicare, you are required to repay the overpayment within 60 days of when you discovered it (or when you reasonably should have discovered it). Of course, the actual details surrounding this concept are more complicated. The good news is that the regulations have clarified much previous ambiguity. The bad news is that, having clarified these issues, the regulations make it clear that physicians and physician practices can no longer simply claim ignorance of having received an overpayment, and must instead engage in ongoing, active compliance efforts.

A BIT OF BACKGROUND

The obligation to repay voluntarily any overpayments received from Medicare was first imposed under the Fraud Enforcement Recovery Act of 2009 (FERA), which itself modified provisions of the Federal False Claims Act (FCA). The law defined an "obligation" to be "the retention of *any* overpayment" (31 USCA sec. 3729(b)(3). Emphasis added.). In 2010, with the passage of the Patient Protection and Affordable Care Act (PPACA), the concept of retained overpayments as "obligations" was clarified to apply to overpayments retained for 60 days after the date on which the overpayment was identified (42 USCA sec 1320a-7k(d)(2)).

This language left several questions open, however. What, specifically, would trigger the 60-day clock? What constituted an overpayment having been "identified"? What actually constituted an "overpayment" for statutory purposes? How far back could the federal government look? Fortunately, these questions were answered on February 12, 2016, with the publication of regulations governing the retention of overpayments. The new regulations apply only to Medicare, and have not (yet) been extended to Medicaid. Future regulations may address Medicaid, however.

WHAT CONSTITUTES AN OVERPAYMENT?

Under the regulations, an "overpayment" means "any funds that a person has received or retained under [Medicare] to which the person, after applicable reconciliation, is not entitled . . ." (42 CFR 401.303). This language is broad and inclusive by design. In fact, although some commenters on the proposed rule requested that the regulations include exceptions for certain kinds of payments, CMS disagreed, stating, "We do not see any basis to exclude an overpayment . . . because it may not have been caused by or was otherwise outside the control of the provider or supplier" (81 Fed. Reg. 7657 (February 12, 2016)).

Certain types of overpayments are obvious, such as payments for services never rendered, or duplicate payments for the same service. However, overpayments can also include payments for services where services do not meet coverage requirements, payments for upcoding (including unintentional upcoding), payments for services that were not medically necessary, and payments for claims that violate the Stark self-referral law or the Federal anti-kickback statute. The regulations also explain that overpayments include the difference between appropriately paid amounts and inappropriate payments: for example, when a provider was entitled to a $50 payment, but actually received $70, in which case the overpayment would be $20 (and not the entire $70). However, the regulations also clarify that payments that were proper at the time will not become improper at a later date due to a subsequent change in law or regulation, or in guidance or coverage policy, although CMS describes that "there can be circumstances in which guidance is issued to clarify existing law, regulation, or coverage rules that would make clear that a past payment is an overpayment" (81 Fed. Reg. 7658, (February 12, 2016)).

WHEN IS IT IDENTIFIED?

Providers are required to return overpayments within 60 days of identifying the overpayment. Otherwise they convert to false claims, making them targets for whistleblowers as well as government enforcers. After this point, the overpayment converts to a false claim, which is subject to a fine of up to three times the amount of actual damages from the claim plus between $5500 and $11,000 per claim (31 U.S.C.A. &s;§3729(a). This amount was increased with the passage of the Bipartisan Budget Act of 2015, in November 2015, which instructs the Department of Justice to issue regulations raising the amount of damages by the percentage the Consumer Price Index has risen since the last time damages were increased. An Interim Final Rule was published June 30, 2016, and increased the penalties to a minimum of $10,781, up to a maximum of $21,563 per claim, for violations occurring after November 2, 2015, and penalties assessed after August 1, 2016 (81 Fed. Reg. 42491). Naturally, this raises the question of when exactly the 60-day clock begins ticking. The regulations state that a person is determined to have 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" (42 CFR 401.305(a)(2)). With respect to the "should have" language, the regulations state "A person should have determined that the person received an overpayment and quantified the amount . . . if the person fails to exercise reasonable diligence and the person in fact received an overpayment" (42 CFR 401.305(a)(2)).

Quantification of an overpayment (part of the identification process) may be done using statistical sampling and extrapolation, as long as the provider returns an amount based on the total extrapolation, rather than on a subset of actually identified overpayments. Except under extraordinary circumstances, CMS' expectation is that this investigation will take no longer than six months to complete. Once the investigation is complete, providers are expected to report and return any overpayments discovered within two months. However, what constitutes "extraordinary circumstances" is fact-specific. As examples, CMS describes unusually complex investigations, such as where Stark violations occur and the violation is referred to the CMS Voluntary Self-Referral Disclosure Protocol. Other examples include scenarios involving natural disasters or states of emergency.

WHAT TO DO WHEN AN OVERPAYMENT IS IDENTIFIED

Once the overpayment is identified, the good news is that the process for reporting and repaying the overpayment is relatively straightforward. The statutory language requires that the provider submit voluntary repayments to the Secretary of Health and Human Services, although CMS has explicitly stated that "sending an overpayment report and refund to anyone other than the appropriate Medicare contractor" is improper; send to the Medicare Administrative Contractor (MAC) instead. Most MACs have forms on their websites to submit voluntary repayments, or at least outline the process by which voluntary repayments may be made (81 Fed. Reg. 7678 (February 12, 2016)). These forms may differ from MAC to MAC. CMS has indicated that it does not consider the lack of standardization to be a problem, although it intends to standardize the forms (81 Fed. Reg. 7676 (February 12, 2016)). It is also worth noting that CMS will look back up to six years prior to the date the overpayment is reported, if it investigates a provider. CMS has also explicitly stated that failure to report and return overpayments received before March 23, 2010, will not be considered improper retention of overpayments (81 Fed. Reg. 7674 (February 12, 2016)).

The regulations also permit overpayments to be returned through claims adjustment, credit balances, self-reported refunds, or any other method permitted by the MAC. In addition, reporting using the Office of Inspector General's Self-Disclosure Protocol or the CMS Voluntary Self-Referral Disclosure Protocol will satisfy the reporting requirement, and will halt the 60-day clock (42 CFR 401.305(d)). Voluntary offsets are also available (wherein the provider volunteers to have future payments offset against any overpayment debts it owes). However, voluntary offsets carry with them the additional burden of slowing or stopping cash flow, and the MAC might withhold too much money or not enough. It probably is better to simply send a single check that covers the entire overpayment amount.

INTERSECTION WITH QUALITY METRIC PROGRAMS

In addition to more obvious issues such as upcoding, duplicate payments, or retaining payments for services that did not meet coverage requirements, the regulations also implicate Medicare's various quality reporting programs, including the Physician Quality Reporting System, the Value-based Payment Modifier, Meaningful Use, and the not-yet-implemented Merit-based Incentive Payment System. Each of these programs involves "payment adjustments" (a kinder, gentler phrase for "penalties") for providers who fail to meet the requirements of the program. These payment adjustments, however, usually take the form of a negative reduction, often by –2.0%, of *all* of a provider's Medicare Physician Fee Schedule (MPFS) payments for a given year. This creates significant potential false claims liability arising from improperly reported data.

If, for example, a provider attests to having met the requirements for Meaningful Use in a given year, but failed to do so, and the provider later manages to avoid a payment adjustment, then an *entire year* of MPFS claims—if retained after the provider knew or should have known it improperly attested to Meaningful Use, and therefore received overpayments—will convert to false claims. The amount of the overpayment will be 2% of the value of the claim, but each claim submitted during the year could be considered a separate false claim, meaning that each claim submitted during a year could create a fine of $5500 to $11,000 on top of up to three times the actual damages.

These programs also operate on a delay (often of two years) between the application of the payment adjustment and the actual reporting year. For example, information reported in 2014 forms the basis for 2016 payment adjustments. Thus a provider—especially one that does not have an active compliance program in place—may be unaware of having received the overpayments until well past the time when it originally submitted the data.

NO MORE OSTRICHES

As discussed earlier, CMS has adopted a standard that addresses when a provider "should have" known it received overpayments. In explaining its rationale for using this standard, CMS stated that it wanted to avoid an "ostrich defense," wherein the provider remains intentionally ignorant of the existence of an overpayment. As a result, CMS requires active, ongoing compliance efforts. The preface to the regulations explains that "reasonable diligence" means both proactive compliance activities to monitor for the receipt of overpayments, and investigations conducted in a timely manner in response to obtaining credible information of a potential overpayment (81 *Fed. Reg.* 7661 (February 12, 2016). Indeed, the preface explicitly states "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 . . . based on the failure to exercise reasonable diligence if the provider or supplier received an overpayment" (81 *Fed. Reg.* 7661 (February 12, 2016)).

The significance of this language cannot be overstated. No longer can providers turn a blind eye toward having received overpayments. Instead, they must engage in ongoing, proactive compliance efforts. Nor is it enough to simply have a compliance plan collecting dust on a shelf somewhere; providers must live by the compliance plans they set in place. Many existing compliance plans may not even address the potential triggers for exercising reasonable diligence under these regulations, and therefore will need to be revised.

When an overpayment is suspected, providers should consult healthcare legal counsel.

The "should have known" standard also means that what otherwise might be simple technical failures in adhering to billing rules, can convert into false claims if the provider in question neglects its duty to return overpayments. The reasonable diligence standard is so high that CMS states that a single denied claim triggers the responsibility to look further, and that look back must take into account six years of payment. The regulations further make clear that providers are responsible for the actions of third parties who work on their behalf, meaning one cannot simply blame the billing company and expect to avoid penalties (81 *Fed. Reg.* 7666 (February 12, 2016)). Billing companies should be required to report denied claims or assertions of overpayments by MACs immediately, and billing agreements should be revised to reflect this, if they do not already require such activity by the billing company.

When an overpayment is suspected, providers should consult healthcare legal counsel. How to design a sample from which to extrapolate, whether to review every claim paid for the problem, and whether the problem is limited to one practitioner or the whole practice, are all issues with which knowledgeable lawyers can help. The six-month window to investigate should be long enough for most providers to determine the extent of any overpayments received, but working with an attorney may make the process more efficient. In addition, by working with an attorney—especially to engage a private auditor to conduct a self-audit—will place much of the communication about potential overpayments under attorney-client privilege. A lawyer can also help draft a compliance plan, or revise an existing one to take into account the new reality resulting from these regulations.