

# Voluntary repayments and the obligation of reasonable diligence

BY ALICE G. GOSFIELD, ESQ. AND DANIEL F. SHAY, ESQ.



*Every month, Dermatology World covers legal issues in Legally Speaking. This month's authors, attorneys Daniel F. Shay, Esq. and Alice G. Gosfield, Esq., are health care attorneys at Alice G. Gosfield and Associates, P.C.*

New regulations under Medicare Part B address the obligation of voluntary repayments — when, how, and to whom they should be repaid. How can “voluntary” repayments be an obligation, you might wonder. The answer lies in the risks from failure to repay: any amounts which a party receives from Part B to which he was not entitled which are not repaid within 60 days of identifying them convert to false claims. That means they are then subject to whistleblower lawsuits as well as enforcement by the government. **The dollars at risk — up to \$11,000 for each claim plus triple the charges — are draconian.**

The regulations have broad impacts, defined timeframes, and nuanced implementation issues. All physicians who bill Medicare Part B need to understand them, and adopt new processes to avoid trouble. This article sets forth what an overpayment is, how they are identified, how to report, and some other implications.

## What is an overpayment?

The regulations define an overpayment as “any funds a person has received or retained under Medicare Part B to which the person is not entitled.” That would include:

- Obvious overpayments such as duplicate payments, payments in excess of the allowable amount, and payments when another payer is primary.
- Payments for non-covered services including for services that do not meet coverage requirements (such as “incident to” rules and the teaching physician rules).
- Payments as a result of upcoding whether intentional or not.
- Claims resulting from anti-kickback statute or self-referral law (“Stark”) violations, payment for services of an excluded person.

- Payment for non-medically necessary services.

## The obligation to investigate

The regulators have taken the position that certain kinds of information create a duty to make reasonable inquiry as to whether an overpayment has occurred. The specified triggers are not exclusive, broad as they are. Complaints made on a compliance hotline would be an obvious trigger, because that is the reason for a hotline. Other examples include where in review of explanations of benefits (EOBs) over-coding is found; a provider learns a patient died before the date of service on the claim; a provider learns services were performed by an unlicensed individual; an internal audit suggests an overpayment has occurred. Two additional triggers offered by the regulators speak to the breadth of awareness they expect providers to exercise: when a provider gets a significant increase in revenues without an obvious reason; when the profits from a practice or physician are unusually high in relation to hours worked or the RVUs associated with the work. In addition, if a government agency says there is an overpayment or an audit by a government contractor finds overpayment, the provider would be required to engage in reasonable inquiry to confirm or contest the findings.

The government takes the position that the duty of “reasonable diligence” includes “both proactive compliance activities conducted in good faith by qualified individuals to monitor for the receipt of overpayments and investigations conducted in good faith and in a timely manner by qualified individuals in response to obtaining credible information of a potential overpayment.” The investigation must be concluded within six months. In the discussion of the proposed regulations,

## Legally Speaking Online



To view the archives of Legally Speaking, visit the DW website at [www.aad.org/dw](http://www.aad.org/dw)



commenters had suggested no firm timeframe, or a longer timeframe. The government demurred, taking the position that six months is enough time to act diligently; and, they expect providers to prioritize these activities with appropriate manpower and resources when credible information is received. You should understand that the government takes a very strict view of this issue. “After finding a single overpaid claim, we believe it is appropriate to inquire further to determine whether there are more overpayments on the same issue, before reporting and returning the single overpaid claim.” So, not only is there an ongoing obligation to be reviewing EOBs for overpayment, the duty of reasonable diligence would require a broader investigation in an instance of once!

For those who would respond by saying in effect, “we just won’t look,” that won’t work since the 60 days to report and repay any identified overpayment occurs “when the person has or **should have** through the exercise of reasonable diligence determined the person has received the payment and quantified the amount.” The words “should have” mean that liability will attach to those who choose to remain willfully ignorant as to whether they have received overpayments. Any practice that does not have a compliance plan, and one which defines the processes addressed by these regulations, is simply asking for trouble.

### Quantifying the overpayment

Assuming an overpayment is found, there are two basic approaches to quantifying the amount of money that needs to be repaid: (1) doing a claim-by-claim review and calculation; (2) extrapolating from a sample of claims. In doing a claim-by-claim review, depending on the nature of the problem each claim would have to be reviewed and quantified to create a grand total. The regulators have provided that the look-back period is fully six years. So depending on what caused the problem, you might find yourself looking for a full six years, or if, by contrast, for example, there was one person who was unlicensed who worked for a year and a half, you would only have to look at the year and a half of her employment. An audit of a year of claims with a finding of an overpayment would require a look back on that issue of up to six years.

Extrapolation is recognized as a legitimate technique to use to avoid looking at every single involved claim, when the problem involves a large number of claims. There is no bright line as to how many claims need be at issue to extrapolate. There is also no specified algorithm or methodology. The technique used must be reliable and accurate, using a random selection of a statistical sample. The methodology need not be statistically valid in technical terms, an issue which has been problematic with some Medicare Administrative Contractors (MACs) which have required statistically valid samples. But, again, depending on the facts and circumstances, if the look back must be six years, then there may have to be a different sample calculated for each year.

In the Office of the Inspector General Model Compliance Guidance for Physician Practices (<http://oig.hhs.gov/authorities/docs/physician.pdf>), the use of probe samples to conduct internal audits has been addressed. There they suggested that a sample of 10 claims per provider might serve as a legitimate probe. In the new context, however, this issue is addressed in a manner that makes clear that a probe sample is just a beginning. The regulators take the position that if a probe sample is used, it is not appropriate for a provider to only return a subset of claims identified as overpayments and not extrapolate the full amount of the overpayment. The provider should not repay specific claims from the probe sample until the full overpayment is identified. Once the overpayment is identified and quantified the repayment must be made within 60 days.



## Key takeaways



**There is an obligation on medical practices to report and repay any amounts paid to them by Medicare Part B to which they were not entitled within 60 days of identifying them or they convert to false claims, subject to enforcement and whistleblower actions.**



**The practice is expected to exercise ‘reasonable diligence’ in identifying and quantifying overpayments based credible information.**



**The standard for repayment is when the practice knew or should have known an overpayment was received, so not looking or ignoring the issue is no strategy.**



**The triggers for exercising reasonable diligence are far more than most people understand, including a single denied claim.**



**The look-back period is six years for calculation of the overpayment.**



**Compliance plans will have to be updated to accommodate this new obligation.**



**It will be important to involve a knowledgeable attorney as soon as an overpayment is suspected.**

The regulations impose no obligations regarding record-keeping on extrapolated repayments, but it would be folly not to have explicit documentation of the claims in the sample as well as the universe of claims that were impliedly included by virtue of the extrapolation. Unlike a claim-by-claim repayment, where the MAC can adjust its records for each claim, it is possible that even after a voluntary repayment has been made based on extrapolation, an audit agency might come back and seek to audit the same universe of claims, which they would not know had been repaid in effect, because they aren't adjusted in the claims database. Being able to demonstrate the claims have been repaid based on extrapolation will be critical to avoiding an additional repayment.

### To whom to report and how

Although the statute provides that a report and repayment can be made to the Secretary of Health and Human Services, the regulators have specifically said "sending an overpayment report and refund to anyone other than the appropriate Medicare contractor" does not comply with the reporting requirements. The MACs have a form on their website to make a voluntary overpayment. Today they are not all the same, although the regulators have said these will be standardized in the near future. Some MACs have refused to accept bundled claims, set forth on a spreadsheet. They may no longer refuse to accept those. Some MACs require the report to be sent to one location, but the money sent to a different location. Others accept the report and the money in the same place. You would have to check their website.

There is no standardized or required statement to be made for the report. The regulators suggest reporting how the problem was discovered. We have typically recommended reporting how the problem was discovered, what corrective action has been taken to prevent its recurrence, and, if extrapolation was used, an explanation of the methodology. In making the actual repayment, the new regulations permit the payment to be made using claims adjustment, credit balance, or voluntary offset by the MAC. We recommend using claims adjustment only when a handful of claims are involved. Otherwise reporting a claim-by-claim calculation on the voluntary repayment form is better. We never recommend voluntary offset by the MAC because the claims payment processes and the audit processes are rarely well integrated and things go wrong, with not enough money being withheld or too much money being withheld. We recommend sending one check. It is possible to get a hardship extension when the amount at issue is more than 10 percent of the Medicare monies received in the previous year, but the information to be submitted to substantiate the hardship is onerous and the interest rate for the current year (2016) at 10 percent

is much higher than borrowing at a bank. The rates are even higher going back six years, to 2011, when they were 11.50 percent.

### Implications

Some consultants have, over the years, advised clients that if they monitor claims on a prepayment basis, they have no obligation to look at post-payment issues if they find a problem. This is now unequivocally untrue. The reasonable diligence standard requires all practices to deploy techniques to prevent and detect overpayments, and to look back up to six years if they find problems. The need for an updated compliance plan to take these new requirements into account is also manifest.

Because of the new significance of an audit which finds overpayments, handling an audit request carefully becomes paramount. When an auditor requests records, someone in the practice should have the responsibility of reading them to be certain there are no issues lurking which require explanation. If upon reading them, overpayments are found within the documents, you will have a new obligation to inquire further even as you send the records for review. Send absolutely everything requested and provide a guidebook in a cover letter to what is there. The goal is to prevent any interpretation or analysis by the reviewer because the records and the cover letter will explain completely why everything has been done properly. If the medical necessity for services was established in an earlier progress note that was not requested, provide it anyway with an explanation as to why it is included.

If you use an outside billing company, it will be important to review the agreement between them and the practice to be certain they have the obligation to notify the practice immediately of denied claims or assertions of overpayments by payers. The agreement should also give the practice the right to use an outside auditor to monitor the billing company annually. If, however, that right exists, reasonable diligence would require that it be used.

### Using a lawyer

Conferring with a knowledgeable lawyer when an overpayment is suspected can be critical to efficient management of the six-month investigation and inquiry process. Using attorney-client privilege can also be important, especially when an outside auditor is brought in. Identifying a proper sample to review, determining whether claims have been compliant, and crafting the report to the MAC are all roles the right kind of lawyer can play. Revising the compliance plan to incorporate these issues will be essential to practices that hope to survive under this system. A lawyer can be useful in that endeavor as well. *dw*

## Office of the Inspector General



To view the Office of the Inspector General Model Compliance Guidance for Physician Practices, visit

<http://oig.hhs.gov/authorities/docs/physician.pdf>