The Verdict: Your Monthly Health Law Bulletin

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Each email will be written by one of our esteemed health law attorneys and will provide tips, case examples, opinions, and debates on health law concerns. Each monthly email will be archived and placed in the members only portal for easy access and reference.

Below is the May edition of The Verdict, sponsored by the Law Offices of Alice G. Gosfield & Associates, P.C.

LAW OFFICES
ALICE G. GOSFIELD
& ASSOCIATES, P.C.
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The Challenges in Part B Voluntary Repayments

Federal legislation has increasingly made it clear that retaining monies

improperly paid by Medicare Part B can lead to liabilities. The government in 2016 finally published regulations setting forth the standards for managing voluntary repayments. They are not a model of clarity. From the breadth of the types of problems that can qualify as overpayments, to what it means to identify the overpayment, to whether to repay every claim at issue or extrapolate from a sample, to the timeframes for action, challenges abound. The real risk here is that voluntary repayments not returned in accordance with the rules convert to false claims, then vulnerable both to whistleblowers as well as enforcers. Set forth here is only a brief summary of the principal problems Part B providers will have to confront.[1]

What Is An Overpayment?

The regulations[2] broadly define an overpayment as "any funds a person has received or retained under Medicare Part B to which the person, after reconciliation, is not entitled." Fundamentally this would include payment for non-covered services, but services can be non-covered for a wide variety or reasons: they didn't meet coverage requirements like those for incident to services or the teaching physician rules; they were not supported by adequate documentation; they were rendered by unqualified individuals. Far more obvious overpayments are based on payments in excess of allowable amounts, duplicate payments, and payments when another payor is primary. But the regulator have also cited payments as a result of upcoding, intentional or not, payments resulting from anti-kickback statute or physician self-referral (Stark) law violations, payments for non-medically necessary services; payments for services by an excluded individual along with payments on any of these basis where Medicare is secondary.

When is An Overpayment Identified? [3]

Determining when the overpayment has been identified is a critical issue because it is the identification that triggers a sixty day limit to repay the monies, after which the claims convert to false claims. The regulatory provision states that identification 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 of the payment. "Reasonable diligence" is stated to include 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. Credible information can arise from an amazingly broad range of sources: a complaint received on a compliance hotline, in reviewing explanations of benefits overpayments are found; the provider learns a patient death occurred before the date of service; the provider learns services were provided by an unlicensed individual; internal audit suggest an overpayment has occurred. The government says that there is a potential overpayment thus triggers a duty on the provider to look further at the same issue. The government has cited as bases for investigation if the profits from a practice or physician are unusually high in relation to hours or a provider gets a significant increase in revenues without an obvious reason. They state further that where an audit by a contractor or federal agency finds overpayments the provider is required to engage in

reasonable inquiry to confirm or contest the results. In perhaps the most amazing statement in this context, the regulators have specifically said that after finding a single overpaid claim, 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![4] Reasonableness of the investigation is fact dependent, but is demonstrated through the timely, good faith investigation of credible information which may take at most six months from the receipt of the credible information, except in extraordinary circumstances. They say that providers should prioritize these investigations with the understanding that they may require substantial time and resources. They further advise providers to maintain records that accurately document their reasonable diligence efforts. One would think that would go without saying.

Quantification
An essential component of identifying the overpayment is quantifying it. Statistical sampling and extrapolation may be used. The method need not be 'statistically valid' (like RAT-STATS) but merely reliable and accurate, based on a random sample of claims, and extrapolated only within the timeframe of the sample. If a probe sample is used, it is not appropriate to return only a subset of claims 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 primary analysis is done, then the provider has to look back, up to six years earlier. How far to look will vary depending on the fact pattern. For example, if nurse practitioners were only introduced into the practice three years ago and that is where the problem lies, you would look back only three years. But if an external audit covers two years and finds overpayments, the regulations require the group to look back another four years. In addition, depending on the facts, there may have to be a separate sample for each year of the six years.

Reporting and Repaying
The only entity which can accept a voluntary repayment under the regulations is the Medicare Administrative Contractor (MAC). Most have forms on their websites by which to report overpayments, but they are often not quite appropriate for multiple claims repaid at one time. The regulations expect the reporter to indicate why they are repaying. There is no specified list of required information, but they suggest stating how the problem was discovered, what corrective action has been taken, and if the amount was extrapolated, what methodology was used.

The actual payment can be made by affirmatively paying, using claims adjustment, or using credit balances. We generally recommend an affirmative payment since the claims paying divisions of the MACs do not often intersect well with the overpayment departments. Problems can arise. Although the regulations allow the MAC to offset payments against current claims, we also think this creates problems in the implementation.

Implications
Compliance programs ought to address these obligations as well as who has the authority to make the many decisions required. The triggers for

reasonable diligence are manifold and should be taken into account in the compliance plan. A principal issue is what techniques and authority for tracking credible evidence will be used, then who has the authority to investigate and how. Use of attorney-client privilege should be addressed as well and it should be used as early as possible.

There is much nuance in these rules. Billing agent contracts likely need to be reviewed to make sure the company has an obligation to notify the practice immediately of denied claims, given the ticking clock to repay other similar claims. Because the implications of audits are now broader than their stated timeframe, making sure the results of any audit are as favorable as possible is even more important. The best audit defense is carefully preparing the material to be initially submitted.[5] Employment agreements will likely have to be revised to allow not only for proportionate repayment of monies received by employed physicians and other clinicians when an external audit finds overpayments, but also when an internal audit mandates voluntary repayment, even post-termination of employment.

The landscape of voluntary repayments is far different from before. Lawyers will be essential to waging these repayments. Those who counsel physician practices (and others) on their financial and compliance obligations should take heed.

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[1]The rules pertain to Part A repayments as well, but they have some additional issues beyond what is here.
[2] 42 CFR § 401.303
[3] 42 CFR §401.305(a)
[4] 81 Fed Reg. 7663, 2/12/16
[5] For a broader and deeper consideration of all these issues see Gosfield, "The Oxymoronic Landscape of Voluntary Repayments," HEALTH LAW HANDBOOK, (2017 Edition) WestGroup, a Thomson Company, pp. 71-99.

This Month's Bulletin Written By:

Alice G. Gosfield, Esq.
Principal, Alice G. Gosfield and Associates, P.C.
2039 Delancey Place
Philadelphia, PA 19103

To learn more about Ms. Gosfield or Alice G. Gosfield & Associates, P.C., click the logo below or visit www.gosfield.com

LAW OFFICES
ALICE G. GOSFIELD
& ASSOCIATES, P.C.
EST. 1986

National Alliance of Medical Auditing Specialists (NAMAS)
877-418-5564 | namas@namas.co | www.namas.co