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Medicare Overpayments: Analyzing the CMS 60-Day Rule

Reporting and Refunding Overpayments for Providers, Suppliers, Drug Plan Sponsors, and Medicaid MCOs

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Today's faculty features:

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Medicare Overpayments: Review and Analysis of CMS's Proposed "60-Day Rule" Regulations

Presented by

Paul A. Deeringer and Robert L. Roth

Hooper, Lundy & Bookman, P.C.

Introduction

- Feb. 16, 2012: CMS issues NPRM implementing "60-day rule" 77 Fed. Reg. 9179
- Would implement 42 U.S.C. § 1320a-7k(d)
- Resolves some ambiguities under 60-day rule, raises significant challenges for providers
- Comments due April 16, 2012
- HLB Client Alert Included

Goals for Today's Webinar

- Review the statutory authority for the 60-day rule
- Discuss the provisions of the 60-day rule NPRM
- Review a hypothetical to help understand the practical effect of the NPRM if adopted in its current form
- Identify areas where providers may wish to consider submitting comments to CMS

- **Overview of statutory 60-day rule provisions and related background**
- Provisions of the 60-day rule NPRM and challenges for providers
- Hypothetical
- Conclusions and questions

How Did We Get Here?

Three Sources of Liability for Failure to Report/Repay Medicare and Medicaid Overpayments

- Overpayment liability under 42 U.S.C. §1320a-7k(d) – Added by the Patient Protection and Affordable Care Act ("ACA")
- False Claims Act ("FCA") liability under 31 U.S.C. §3729(a)(1)(G) – Added by the Fraud Enforcement and Recovery Act of 2009 ("FERA")
- Civil Monetary Penalty and Exclusion liability under 42 U.S.C. §1320a-7a(a)(10) – Added by ACA

How Did We Get Here? 2009 FCA Expansion

- 2009: FERA expands federal FCA liability to include, among other things, retention of overpayments

- 31 U.S.C. § 3729(a)(1)(G)
  - "Any person who … knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government or **knowingly conceals** or **knowingly and improperly avoids or decreases** an **obligation** to pay or transmit money or property to the Government…." (emphases added)

- "Obligation" (31 U.S.C. § 3729(b)(3))
  - "an **established duty**, whether or not fixed, **arising from** an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from **statute** or regulation, **or from the retention of any overpayment**…." (emphases added)

How Did We Get Here? 2009 FCA Expansion

- FERA left undefined several critical terms
- "Improperly"
  - Committee Report states: "The Committee does not intend this language to create liability for a simple retention of an overpayment that is permitted by a statutory or regulatory process for reconciliation provided that the receipt of the overpayment is not based on any willful act of a recipient to increase the payments from the Government when the recipient is not entitled to such Government money or property."
- "Established duty … arising from"
- "Overpayment"
- Congress attempted to further clarify liability for retention of overpayments under two provisions in 2010 health reform bill
  - Section 6402(a) – 60-day rule for reporting/returning overpayments
  - Section 6402(d) – CMP for retaining overpayments beyond 60 days

How Did We Get Here? ACA 60-Day Rule Provisions

- ACA Section 6402(a) (42 U.S.C. § 1320a-7k(d))

(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.

How Did We Get Here? ACA 60-Day Rule Provisions

(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 section 3729(b)(3) of Title 31) for purposes of section 3729 of such title.

(4) Definitions. In this subsection:

(A) Knowing and knowingly. The terms "knowing" and "knowingly" have the meaning given those terms in section 3729(b) of Title 31.

(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)(1)(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.

How Did We Get Here? ACA CMP Provisions

- ACA Section 6402(d) amends Federal CMP statute
- New 42 U.S.C. § 1320a-7a(a)(10) imposes CMP liability on any person "that **knows** of an **overpayment** (as defined in paragraph (4) of [42 U.S.C. § 1320a-7k(d)]) and does not report and return the overpayment in accordance with such section."
- Penalties: 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
- Also potential exclusion from participation in federal health care programs, including Medicare and Medicaid

How Did We Get Here? Questions Post-ACA

- When is an overpayment "identified"?
- What is the meaning of "applicable reconciliation"?
- What specific information must a report contain?
- What effect will voluntary pre-enforcement self-disclosures (e.g., SRDP and OIG SDP) have on the report/repay obligation?
- How do the mandatory repayment provisions affect appeal rights and waiver of liability?
- What if the amount of the overpayment cannot be determined in 60 days?

How Did We Get Here? Questions Post-ACA (cont.)

- To what extent is administrative finality available as a defense?
- Can overpayments be corrected through adjustment bills, in lieu of reporting/returning?
- What is the relationship between the overpayment refund requirements and the government's recovery rights?
- Do the FERA provisions apply to overpayments that occurred before March 23, 2010?
  - *U.S. ex rel. Stone v. OmniCare, Inc.* (N.D. Ill. 7/7/2011)

- Overview of statutory 60-day rule provisions and related background
- **Provisions of the 60-day rule NPRM and challenges for providers**
- Hypothetical
- Conclusions and questions

Scope of the NPRM

- NPRM applies only to Medicare Part A/B providers and suppliers (together "providers" unless otherwise noted)
- Overpayment retained after deadline under NPRM creates an "obligation" for purposes of the federal FCA
- Providers still potentially liable under other laws even with timely report/repayment
  - Federal FCA
  - Civil Monetary Penalty Law
- Future rulemaking for other "persons"

Scope of the NPRM

- Unclear why CMS limited scope of NPRM only to Part A and Part B providers/suppliers
  - "Person" defined broadly under statute to also include Medicaid MCOs, MA plans, PDPs
  - "Overpayment" definition does not create particularly unique issues for Part A/B providers/suppliers vs. other "persons"
  - Limited scope inconsistent with CMS historical approach
    - Jan. 25, 2002 proposed rule regarding Medicare overpayments: "we intend to issue one comprehensive rule on this subject." 67 FR 3663
    - 2002 proposed rule would have covered providers, suppliers, MCOs, and "other entit[ies] … contracting with CMS."

NPRM Defines "Identified" Using FCA Standard

- A person "identifies" an overpayment if the person has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment
- Oddly, statute defines, but does not use, "knowing" and "knowingly"
- CMS believes FCA's "deliberate ignorance or reckless disregard" standard encourages self-directed compliance
  - May impact future rulemaking around compliance programs

NPRM Examples of "Overpayments"

- 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

NPRM Examples of "Identified"

- Provider receives an anonymous compliance hotline complaint about a potential overpayment and fails to make a reasonable inquiry into the complaint
- Provider or supplier reviews billing or payment records and learns that it incorrectly coded certain services, resulting in increased reimbursement
- Provider or supplier learns that a patient death occurred prior to the service date on a claim that has been submitted for payment

NPRM Examples of "Identified"

- Provider or supplier learns that services were provided by an unlicensed or excluded individual on its behalf
- A provider of services or supplier performs an internal audit and discovers that overpayments exist
- A provider of services or supplier is informed by a government agency of an audit that discovered a potential overpayment, and the provider or supplier fails to make a reasonable inquiry
  - Duty to make reasonable inquiry
  - "All deliberate speed"

Challenges for Providers – "Identified"

- No statutory basis for applying FCA knowledge standard to definition of "identified"
  - Statute defines, does not use "knowing" or "knowingly"
  - No nexus between "identified" as used in Section 6402(a) and FCA knowledge standard
  - Prior bill (H.R. 3962) considered – and rejected – including the FCA knowledge standard
- NPRM definition of "identified" does not address complex overpayment situations
  - Wholly silent about how provider cannot quantify overpayment within 60 days (even with reasonable diligence)

Challenges for Providers – "Identified"

- NPRM's expansive approach to "identification" would place significant pressure on providers
  - internal reporting capabilities
  - ability to conduct relatively rapid investigations of any potential indication that an overpayment may have occurred
- Use of FCA knowledge standard creates substantial uncertainty about second-guessing provider's efforts
  - Obligation to "make a reasonable inquiry" "with all deliberate speed" appears to set a higher standard than FCA
  - More appropriate std.: CMS comment re failure to make "any reasonable inquiry" where provider receives evidence of potential overpayment
- NPRM does not specify how strong the evidence needs to be to trigger a provider's "obligation to make a reasonable inquiry"

"Applicable Reconciliation"

- NPRM confirms CMS's intent to limit "applicable reconciliation" to cost report reconciliation
- Only applies where reconciliation relevant to determination of whether actual overpayment exists
- Occurs when a cost report is filed (initial or amended)
- 2 exceptions – occurs upon final reconciliation
  - Provider receives updated SSI ratio information
  - Outlier reconciliation

"Applicable Reconciliation"

- "Applicable reconciliation" construed narrowly to be limited to cost reports

- FERA Committee Report states: "The Committee does not intend this language to create liability for a simple retention of an overpayment that is permitted by a statutory or regulatory process for reconciliation provided that the receipt of the overpayment is not based on any willful act of a recipient to increase the payments from the Government when the recipient is not entitled to such Government money or property. . . . Accordingly, any knowing and improper retention of an overpayment beyond or following the final submission of payment as required by statute or regulation--including relevant statutory or regulatory periods designated to reconcile cost reports, but excluding administrative and judicial appeals--would be actionable under this provision."

Challenges for Providers – "Applicable Reconciliation"

- Narrow construction unsupported by statutory text or FERA legislative history
- Inconsistent with CMS comments in previous rulemakings relating to Medicare overpayments
  - Indicate that applicable post-payment adjustments should be allowed to run their course before an "overpayment" exists
  - "Once a determination and any necessary adjustments in the amount of the overpayment have been made, the remaining amount is a debt owed to the United States Government." 63 Fed. Reg. 14506
  - "Submission of corrected bills in conformance with our policy, within 60 days, fulfills [reporting and repayment] requirements for providers, suppliers, and individuals." 67 Fed. Reg. 3663
- What about adjustment bill process? Contractor processes? Pending government investigations? Form CMS-838?
- Limitation on Authority of States?

Challenges for Providers – "Applicable Reconciliation"

- Unclear why "exceptions" for when "applicable reconciliation" occurs are limited to SSI ratios and outlier reconciliation – what about
  - Home office cost issues
  - IME/GME
  - Other DSH adjustments

NPRM Provisions – Intersection with SRDP

- Receipt of acknowledgment from CMS of SRDP submission suspends obligation to return
  - Does not constitute "report" for purposes of 60-day rule
- CMS seeking comment on how to avoid duplicate reporting under SRDP

NPRM Provisions – Intersection with OIG SDP

- Upon acknowledgement of receipt of submission, duty to return suspended
- Notice to OIG through OIG SDP also constitutes notice to appropriate parties for purposes of the NPRM
  - Timeliness requirements still apply – no additional delay

Challenges for Providers – SRDP and OIG SDP

- No clear basis for distinguishing between SRDP and OIG SDP
  - Self-disclosure under SRDP would suspend provider's obligation to return, but not to report, an overpayment
  - Self-disclosure under OIG SDP would suspend both a provider's obligation to return and to report an overpayment
  - No legal or policy basis for distinguishing between these two processes
  - NPRM would subject providers to duplicative and unnecessary reporting requirements in cases where a provider self-discloses an overpayment to CMS under the SRDP

NPRM Provisions - AKS - Innocent Provider/Supplier Exception

- "…if the provider has not identified the kickback or if it reported it when it did identify the kickback, generally, only the parties to the kickback scheme are required to repay the overpayment that was received by the innocent provider or supplier…" 77 Fed. Reg. 9184

- However, potentially cold comfort
  - If provider who is not a party to a kickback arrangement has sufficient knowledge to have identified the resulting overpayment, must report overpayment to CMS
  - CMS will refer the matter to OIG
  - "the government may always seek repayment of claims paid that do not satisfy a condition of payment"

NPRM Provisions – Refund Process

- Utilize existing Voluntary Refund Process
  - Renamed "Self-Reported Overpayment Refund Process"
  - Will be standardized...eventually
- Requires reporting of information specified in the regulation
  - Description of the corrective action plan to ensure the error does not occur again
  - The timeframe and the total amount of refund for the period during which the problem existed that caused the refund
  - If a statistical sample was used to determine the overpayment amount, a description of the statistically valid methodology used to determine the overpayment

Challenges for Providers – Existing Refund Process

- Use of "existing refund process" requires further guidance from CMS
  - Existing voluntary refund forms may not incorporate all of the NPRM's mandated elements for a report
  - *E.g.*, Palmetto's current overpayment refund form for Region IX does not provide for at least four of the fields the Proposed Rule mandates:
    - TIN
    - How error was discovered
    - Description of corrective action plan
    - If a statistical sample used, description of the statistically valid methodology used to determine the overpayment

Nuances – Inability to Repay the Overpayment

- Use Extended Repayment Schedule (formerly "Extended Repayment Plan")
  - Publication 100-06, Chapter 4 Financial Management Manual
- ERS requests will not be automatically granted
- Significant documentation of financial hardship required
- A bit of a straw man viz. quantification problems?

NPRM Provisions – 10-Year Lookback Period

- NPRM provides that overpayment must be reported and returned if a person identifies the overpayment "within 10 years of the date the overpayment was received"
  - CMS chose 10-year lookback because this is the outer limit of the federal FCA statute of limitations and will "further our interest in ensuring that overpayments are timely returned to the Medicare Trust Funds."

NPRM Provisions – 10-Year Lookback Period

- NPRM also amends Medicare claims reopening rules
  - Overpayments reported under 60-day rule implementing regulations may be reopened for a period of 10 years from the date of initial determination or redetermination
  - No corresponding amendment to 3-year NPR determination regulatory reopening period (absent fraud or similar fault)

Challenges for Providers Under the NPRM

- No sound basis to expand lookback period to 10 years
- Inappropriately links even simple payment errors with the FCA liability standard
  - 10-year FCA limit intended to address intentional fraud
  - What if FCA settlement based on 6 years?
  - Mere retention of overpayment past 60-day deadline, without more, does not give rise to FCA liability
- What about identifying and offsetting underpayments?

Challenges for Providers Under the NPRM

- Existing Medicare claims reopening regulations sufficiently address reopening issues 60-day rule disclosures may create
  - 4-year lookback where no evidence of "fraud or similar fault"
  - No express limit where evidence of fraud or "similar fault" does exist
  - Provider already subject to up to 10-year lookback period under FCA

Challenges for Providers Under the NPRM

- Application of 10-year lookback period still may raise retroactive enforcement issues
  - Unclear whether sanctions for failure to comply with 60-day rule will apply to overpayments identified before 3/23/2010
  - "Continuing violation" theory would conflict with existing case law and Medicare's "without fault" rules
    - *U.S. ex rel. Stone v. OmniCare, Inc.* (N.D. Ill. July 7, 2011)
  - Unclear on what basis CMS believes Congress provided it with authority to extend retroactively the time limit under the Medicare reopening regulation from 4 to 10 years
  - NPRM is silent regarding retroactive application of 60-day rule and how CMS will interpret these significant legal issues

Challenges for Providers Under the NPRM

- Practical regulatory/policy changes/evolution and document retention issues

- *But see* MSP Manual Chapter 3, Sections 20.1 and 20.2.2:

5. Policy for Provider Records Retention of MSP Information

Title 42 CFR 489.20(f) states that the provider agrees to maintain a system that, during the admission process, identifies any primary payers other than Medicare, so that incorrect billing and Medicare overpayments can be prevented. Based on this regulation, hospitals must document and maintain MSP information for Medicare beneficiaries. Without this documentation, the contractor would have nothing to audit submitted claims against. CMS recommends that providers retain MSP information for 10 years.

Challenges for Providers Under the NPRM

MSP Manual Chapter 3, Section 20.2.2:

Medicare permits providers to retain hard copy questions and responses on paper, optical image, microfilm, or microfiche. Hard copy and data must be kept for at least 10 years after the date of service that appears on the claim. (See Chapter 5 for information about the documentation to be used in a hospital review.) If the provider's admissions questions are retained online, Medicare requires it to retain ***negative*** *and* ***positive*** *responses to admission questions for 10 years with DOJ's record retention requirements, after the date of service. Online data may not be purged before then.*

Challenges for Providers Under the NPRM

- NPRM dramatically understates compliance burden
  - NPRM's interpretation makes it much more likely that providers will err on the side of overpayment disclosure
  - CMS's rosy estimates of implementation costs do not appear to reflect the compliance reality providers would face
- Medicare data suggest that number of overpayments reported per provider would be significantly higher than NPRM estimates
  - 8.6% error rate * 1.2 B claims = 103.2 M erroneous claims
  - Roughly 69 improperly paid claims per provider per year
  - Even if many resolved through audits or other means, still far more than the NPRM estimates
- NPRM only includes accountants and administrative staff in cost estimates – no provision for counsel or billing consultants

REPORTING AND RETURNING OF OVERPAYMENTS UNDER 1128(d)

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NO REGULATION, NO PROBLEM

- “We remind all stakeholders that even without a final regulation they are subject to:”
  - The requirements of 1128 (d) (to report, refund, and explain
  - Potential False Claims Act liability
  - Potential Civil Monetary Penalty Law
  - Potential exclusion from from Federal health care programs for failure to report and return overpayment (9180-9181)

WHEN IS AN OVERPAYMENT IDENTIFIED?

- CMS “We propose that a person has identified an overpayment if the person has actual knowledge of the existence of an overpayment or acts in reckless disregard or deliberate ignorance of the overpayment.” (77 FR 9182)
- “incentive to exercise reasonable diligence to determine whether an overpayment exists”
- Problem of corporate knowledge-no one person knows, but sum of knowledge of employees and systems
- Interaction with compliance obligations

“Overpayments”

- “Duplicate payments”
- “Receipt of Medicare payment when another payor had primary responsibility” (77 FR 9181)

"Person"

- We propose that a person means a provider or supplier" (77 FR 9181)
- Not managed care? (not a provider under 400.202, not a supplier of services under Medicare)
- Not managed care provider network entity?
- Not state or local government?
- Not Medicare intermediary or contractor?
- Not subcontractor?
- Not RAC?

"PERSON"

- ". . .we are proposing to implement proposed requirements. . . only as they relate to Part A and Part B providers and suppliers. Other stakeholders, including, without limitation, MAOs, PDPs, and Medicaid MCOs will be addressed at a later date."

Kickbacks

- “Compliance with the anti-kickback statute is a condition of payment.” (77 FR 9183)
- “To the extent that a provider or supplier who is not a party to a kickback arrangement has sufficient knowledge of the arrangement to have identified the resulting overpayment, the provider . . .must report the overpayment to CMS” (9183)
- Repayment obligation for non-party suspended pending CMS referral to OIG (9l84)and resolution

CMS expectations

- “125,000 providers will report and return overpayments in a typical year”
- Typical provider would return “approximately” 3 to 5 overpayments
- CMS expects “it would take provider or supplier approximately 2.5 hours to complete the applicable form and return the overpayment.” No allowance for attorney costs
- Expected cost per disclosure: $37.10
- Capturing ten years of data-priceless
- “not an economically significant rule” (9l86)

FALSE CLAIMS

- “Any overpayment retained by a person after the deadline for reporting is an obligation for purposes of 31 U.S.C. 3729”
- “a person must use the self-reported overpayment refund process set forth by the applicable Medicare contractor” (9187)
- “an overpayment must be reported and returned . . . If a person identifies the overpayment within 10 years of the date the overpayment is received.” (9187)
- False Claims Act exposure for person who“knowingly conceals or knowingly and improperly avoids or decreases an **obligation** to pay or transmit money or property to the Government.”

COLLATERAL ISSUES

- Medicaid obligations
- Refunds to patients and other payors?
- Class actions?
- FOIA
- Whistleblower access
- Discovery/Admissions
- Reporters/bloggers
- Competitors
- Zero is a bad number

SAMPLE REPAYMENT FORM

- **OVERPAYMENT REFUND/NOTIFICATION FORM**
  www.cahabagba.com/part_b/forms/overpayment_refund.pdf

- Overview of statutory 60-day rule provisions and related background
- Provisions of the 60-day rule NPRM and challenges for providers
- **Hypothetical**
- Conclusions and questions

Hypothetical

- June 20, 2011: general acute care hospital discovers potential overpayment through a routine internal claims audit
  - On several occasions during Jan. 2011 – Mar. 2011, hospital billed Part A for inpatient services that should have been billed as outpatient

- Aug. 30, 2011: hospital's initial investigation concludes, reveals the following:
  - Patients all had been admitted through the ED for inpatient stays of less than 72 hours;
  - Patients presented to the ED in distress with conditions that ordinarily would be treated on an outpatient basis;
  - Hospital licensed to provide the necessary services on an inpatient, not an outpatient, basis;
  - No local outpatient clinic was willing or able to provide the services when patients presented to the ED;
  - Services that hospital provided were medically necessary, actually rendered by qualified personnel, but patients who received these services did not meet inpatient criteria;
  - Due to timing of hospital's URC meetings, these patients were not identified as not meeting inpatient criteria until after discharge;
  - Hospital found no indication that the claims were submitted with intent to defraud Medicare

- Based on this information, hospital believes this issue may have affected other claims

Hypothetical (cont.)

- Sept. 1, 2011: hospital instructs staff that if patients meeting the criteria outlined above are admitted as inpatients, staff must immediately notify hospital administrator, who will contact the URC to conduct an expedited review to determine whether the patient met inpatient criteria or whether use of Condition Code 44 is necessary
  - Chief Compliance Officer instructs patient accounts to submit corrected bills for affected claims discovered during initial investigation (all still within 12-month claims correction window), at the appropriate outpatient rate

- Sept. 15, 2011: Chief Compliance Officer retains outside counsel. Based on discussions with counsel, hospital implements several corrective measures:
  - Pursues flex request with state licensing agency to permit admission of these patients as "OBS";
  - Develops structured outreach protocol to local outpatient clinics when these patients present in the ED;
  - If no outpatient provider available, admit as inpatient but conduct expedited UR to determine whether use of Condition Code 44 would be appropriate.

- Oct. 15, 2011: Based on discussions with counsel, hospital reviews all inpatient claims with dates of service June 1, 2007 - Sept. 1, 2011, for patients with lengths of stay of less than 72 hours and who received the service in question
  - Evaluation requires review of whether each patient met the criteria for inpatient admission; hospital forms a special UR subcommittee to assist in reviewing the charts underlying these claims
  - Claims universe associated with this inquiry includes approximately 600 claims

Hypothetical (cont.)

- Mar. 15, 2012: UR subcommittee completes its analysis, determines that 60 claims did not meet inpatient criteria
  - Subcommittee met as schedules permitted (holidays/patient schedules), prioritized completing its analysis quickly
- Mar. 16, 2012: Subcommittee reports its findings to Chief Compliance Officer
- Mar. 17, 2012: Chief Compliance Officer instructs patient accounts to submit corrected bills for all affected claims within the 12-month claims correction window to the MAC at the proper outpatient rate
- Mar. 17, 2012: Chief Compliance Officer instructs outside counsel to draft self-disclosure to the MAC

Hypothetical (cont.)

- Mar. 21, 2012: Counsel and hospital finalize self-disclosure, hospital submits disclosure, refund to the MAC
  - For claims with dates of service June 1, 2007 - Mar. 16, 2011
  - Overpayment calculated as difference between what inpatient payment and what proper outpatient payment would have been, to the extent hospital has not already submitted corrected claims
  - Self-disclosure outlines how hospital discovered the problem, methodology by which hospital analyzed the claims universe, hospital's use of claims correction process, total amount of refund, and hospital's corrective action plan

- While waiting to hear from the MAC, hospital is stunned to learn that one of its employees has reached out to a local Assistant U. S. Attorney with a reputation for being very aggressive in health care cases

- The Assistant has asked the hospital to come in a discuss
  - the "obvious" violation of the 60-day report and return statute
  - why the government should not proceed with a False Claims Act prosecution
  - why the U.S. Attorney's office should not refer this matter to the OIG for civil monetary penalties and program exclusion

Hypothetical (cont.)

- Now what?
  - When did the hospital "identify" overpayments?
    - Initial investigation – June 20 or Aug. 30?
    - Deep dive – Mar. 15?
  - Did the hospital conduct
    - a "reasonable inquiry?"
    - "with all deliberate speed?"
  - Did the hospital go back far enough?
    - 4 years?
    - 6 years?
    - 10 years?
  - Was it proper to exclude corrected claims from the refund?

- Overview of statutory 60-day rule provisions and related background
- Provisions of the 60-day rule NPRM and challenges for providers
- Hypothetical
- **Conclusions and questions**

Conclusions

- NPRM appears to start from DOJ litigation position in FCA cases
  - Knowledge of the "fact" of an overpayment = "identified"
  - 10-year lookback period
- If NPRM finalized as proposed, 60-day rule will create intense time pressure for providers
  - Will significantly increase operational, potentially financial, burdens of overpayment disclosure
    - Internal controls and compliance program, ability to move fast
    - Providers likely will err on the side of overpayment disclosure
- NPRM is notable in its silences
  - Difficulties quantifying overpayments within 60 days
  - Reliance on existing Medicare claims correction process
  - Retroactive enforcement issues
  - CMS's silence can be viewed as an invitation for providers to comment

Questions?

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