REPORTING ON THE ECONOMICS OF HEALTHCARE DELIVERY
PHYSICIAN MAGAZINE
A PUBLICATION OF PNN
PhysicianNewsNetwork.com
Volume 147 Issue 1

THE 60-DAY SWORD OF DAMOCLES

[You've Got 60 Days to Pay Up- or Else!]

BY: JEREMY N. MILLER

Consider the following scenarios involving medically necessary services for Medicare or Medicaid patients: (1) a medical group learns that its outside billing service has incorrectly used the physician's office site of service code when billing Medicare for hospital consults; (2) an imaging center finds out it did not have adequate physician supervision when performing MRIs using contrast media; (3) a physician discovers it was improper to mark up tests purchased at a discount from an outside lab; and (4) a hospital realizes it has failed to make annual CPI adjustments to the rent under a physician's office lease.

What do these scenarios have in common? First, in each case, the provider or supplier improperly billed Medicare or Medicaid resulting in an overpayment. Second, the overpayments appear to have resulted from innocent billing errors. Third, the provider or supplier must report and refund the overpayment within 60 days of identifying it or risk penalties under the False Claims Act of up to $11,000 per claim, plus treble damages, and possible exclusion from the Medicare program.

How could this be? Prior to the passage of the Affordable Care Act, providers and suppliers were obligated to refund overpayments. However, many chose to wait and see if Medicare asked for the money back, but did not voluntarily refund it. The calculus for treating overpayments has now changed. If a provider or supplier does not make a timely refund of an identified overpayment, it runs the risk of potentially ruinous penalties.

An overpayment is identified (starting the 60 day clock for a refund) when "the person has actual knowledge of the existence of an overpayment or acts in reckless disregard or deliberate ignorance of the existence of an overpayment." In other words, you cannot stick your head in the sand and ignore evidence of a possible overpayment. But what if you have evidence of upcoding of office visits but you do not know how many? If a hospital employee reports potentially improper claims, does the 60-day period start from the date of the employee's report or only after the hospital

The calculus for treating overpayments has now changed. If a provider or supplier does not make a timely refund of an identified overpayment, it runs the risk of potentially ruinous penalties.

has had an opportunity to complete its investigation? In the recent case of Kane v. Healthfirst, Inc., a federal district court in New York held that the clock starts when a provider is put on notice of a potential overpayment, rather than the moment when an overpayment is conclusively ascertained." This standard could impose a very heavy burden on providers where the nature, existence and scope of a potential overpayment cannot be readily ascertained.

Once you have identified a possible overpayment, how far back do you have to look for similar overpayments subject to refunding? Most people assumed the "look back" period extended three or four years in the absence of fraud. But in its 2012 draft regulations, CMS said that the look back period is ten years! Hopefully, this will be changed in final regulations expected in February 2016.

Overpayments must be reported to your Medicare Administrative Contractor (e.g., Noridian in California) using a form specified by the contractor. The report must include how the error was discovered, the reason for the overpayment, the corrective action plan to ensure the error does not occur again, and a claim-by-claim listing of the overpaid claims. Where claims are too numerous to list individually, a statistical sample can be used to determine the amount of the overpayment. The statistically valid methodology must be described. The refund is also sent to the contractor. In the case of large overpayments, a provider or supplier can request an extended repayment schedule based upon its ability to pay, which is subject to review.

If the overpayment resulted from the intentional filing of a false claim, a voluntary refund will not prevent the HHS Office of Inspector General (OIG) from initiating an enforcement action under the False Claims Act or Civil Monetary Penalties Law. In fact, the Medicare contractor to whom the report is made can refer the matter to the OIG. The alternative to reporting to the Medicare contractor is to utilize the OIG's Self-Disclosure Protocol (or CMS' Self-Referral Disclosure Protocol for Stark Law violations) to report the overpayment and resolve potential civil monetary penalties and possible exclusion from the Medicare program.

In light of the foregoing risks, providers and suppliers should:

-Implement a robust compliance program, including regular self-audits, to reduce improper billing leading to overpayments, and to promptly identify any overpayments. Federal enforcement officials look favorably upon good faith compliance efforts.

-If you uncover a possible overpayment situation, proceed with all deliberate speed to determine whether an overpayment exists and, if so, its size and scope.

-Once an overpayment has been identified, make a timely report and refund to your Medicare contractor. If the overpayment is the result of fraudulent billing, consider utilizing the OIG's Self-Disclosure Protocol to report the overpayment, or CMS' Self-Referral Disclosure Protocol for overpayments resulting from Stark Law violations.

If you have an overpayment problem and choose to ignore it, there is a fair chance that a whistleblower in your organization will do the reporting for you, and that is a situation you definitely want to avoid.

Jeremy Miller is the founder of Miller Health Law Group, APLC. 1901 Avenue of the Stars, Suite 1750, Los Angeles, CA 90067. 310.277.9003. jnm@millerhealthlaw.com