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CMS Proposal on Overpayments Adds Clarity But 'Lookback Period' Raises Concern

CMS's valentine to the compliance world was its proposed regulation on the Medicare overpayment return mandate, which is a challenge for many providers. Candy and flowers would have been preferable, because CMS's proposal would require providers to investigate the 10-year history of a potential overpayment.

Providers are required to return and explain Medicare and Medicaid overpayments within 60 days of identifying them, according to the health reform law. Sec. 6402(a) says that an overpayment must be reported and refunded 60 days from the day it was identified or from the date any corresponding cost report is due, whichever is later. Keeping overpayments past the deadline exposes providers to false claims lawsuits and civil monetary penalties.

Now CMS has set forth the ins and outs of the newly dubbed "Self-Reported Overpayment Refund Process." The proposed regulation, which was published in the Feb. 16 *Federal Register*, addresses aspects of overpayment returns and clarifies the meaning of "identifying" an overpayment. "I'm glad they are starting the conversation," says Boston attorney Larry Vernaglia, with Foley & Lardner LLP. "Clients have been panicked for a long time." But the proposed regulation has a few "bombshells," says former OIG senior attorney Howard Young, with Morgan Lewis & Bockius in Washington, D.C.

The chief complaint is the "lookback period." CMS says providers have to return overpayments only if they are "within 10 years of the date the overpayment was received" because it's the outer limit of false claims liability. And "we believe that providers and suppliers should have certainty after a reasonable period that they can close their books and not have ongoing liability associated with an overpayment," while at the same time Medicare recovers money it's owed. By contrast, the RAC audit lookback period is three years.

"This is a dramatic expansion of CMS's authority," Vernaglia says. It means when a billing error is identified — through hotlines, audits, tips, happenstance — hospitals must determine how long the error persisted, as far back as a decade. He worries about the financial havoc a Stark violation could wreak if a hospital had to repay 10 years' worth of Medicare reimbursement stemming from a noncompliant physician arrangement. "That can tank a provider," Vernaglia says.

The 10-year lookback period also is impractical and runs up against the Medicare conditions of participation, which require hospitals to retain medical-record documentation only for five years, Young says. Hospitals face the challenge of staff turnover, faded memories and inability to locate documents. For example, "our eight-year-old medical records are on tapes in our storage facility," says Ed Gaines, chief compliance officer at Medical Management Professionals in Greensboro, N.C.

Even if the overpayment were an honest mistake, failure to go back that far may be perceived as reckless, and whistleblowers may hammer that point home, Young says. In fact, the lookback period is a gift to whistleblowers and their lawyers, Vernaglia says. "It's an opportunity for them to dig into ancient problems and identify [alleged] false claims cases," he says.

CMS recognizes the challenges and asks for comments. "There will be significant industry pushback on well-founded concerns, although CMS seems to signal they expect that," Young says.

CMS Wants Reasons for Refunds

The regulation tackles many other aspects of the overpayment return mandate. In terms of procedure, CMS will develop a uniform voluntary refund form, but for now providers should continue to use the form provided by each Medicare administrative contractor on its website, the rule states. These forms require providers to list the health insurance claim number and date of service.

However, the proposed rule says CMS now wants additional information that supports the reason for the refund:

(1) How the provider found out about the error;

(2) What corrective action plan is in place to prevent the error from happening again;

(3) The reason for the refund;

(4) The existence of any corporate integrity agreement (CIA) or OIG self-disclosure protocol;

(5) The timeframe and amount of refund for the period during which the problem existed that caused the refund;

(6) Medicare claim control number, as appropriate;

(7) The national provider identifier (NPI);

(8) A refund in the overpayment amount; and

(9) A description of the statistically valid methodology used to calculate the overpayment, if a statistical sample was used.

"There's no room for any of these things on the MAC refund form," Vernaglia notes. He figures providers should add a piece of paper so they can comply with this request for more information.

CMS also shed light on when the 60-day clock starts ticking, which has been a sticking point for many providers. According to the regulation, when providers learn about a potential overpayment, they are obliged to make a "reasonable inquiry" to figure out whether an overpayment exists. For example, after a hotline call about a possible error, the hospital must get to the bottom of it in a timely manner. And "if the reasonable inquiry reveals an overpayment, the provider then has 60 days to report and return the overpayment," CMS says.

That gives providers some breathing room, Vernaglia says. CMS has recognized that the overpayment is not identified simply because an allegation has been made, he notes. "People were saying that at the first whiff of smoke, you had to begin the 60-day [countdown], but CMS says you have time to do some due diligence before the clock starts," Vernaglia says. That's essential because many complicated Medicare reimbursement problems can't be analyzed so fast, he notes.

CMS cites these examples of when an overpayment has been identified:

◆ A provider reviews billing or payment records and determines it coded certain services inaccurately, which triggered more reimbursement.

◆ A provider learns that services were provided on its behalf by someone who doesn't have a license or has been excluded from Medicare.

◆ A provider finds overpayments through an internal audit or is informed of a potential overpayment uncovered by a government audit and doesn't make a reasonable inquiry.

◆ A provider realizes it has submitted a claim for services with a date of service after the patient's death.

When providers don't promptly investigate error reports, they could be accused of knowingly retaining an overpayment. Actual knowledge of overpayments or just acting "in reckless disregard or deliberate ignorance of whether it received such an overpayment" may be enough to set the false claims wheels in motion, according to the proposed regulation.

RAC Overpayment Recoveries, October through December 2011

CMS has posted new data on overpayments for the last quarter of 2011 and the top cause of errors in each region. Visit www.cms.gov/Recovery-Audit-Program/Downloads/FY2012NationalProgramCorrections_vj.pdf.

	Recovery Audit National Program – Fiscal Year 2012			
	FY 2010 Oct 2009-Sept 2010	**FY 2011 Oct 2010-Sept 2011**	**FY 2012 Oct 2011-Dec 2011**	**Total National Program**
Overpayments Collected	$75.4M	$797.4M	$397.8M	$1.27B
Underpayments Returned	$16.9M	$141.9M	$24.9M	$183.7M
Total Corrections	$92.3M	$939.3M	$422.7M	$1.45B
Top Issue per Recovery Auditor (October 2011 – December 2011)				
	Overpayment Issues			
Region A: Diversified Collection Services	**Neurological Disorders:** (Medical Necessity) Medicare pays for inpatient hospital services that are medically necessary for the setting billed. Medical documentation for patients with neurological disorders needs to be complete and support all services provided in the setting billed.			
Region B: CGI, Inc.	**Cardiovascular Procedures:** (Medical Necessity) Medicare pays for inpatient hospital services that are medically necessary for the setting billed. Medical documentation for patients undergoing cardiovascular procedures needs to be complete and support all services provided in the setting billed.			
Region C: Connolly, Inc.	**Neurological Disorders:** (Medical Necessity) Medicare pays for inpatient hospital services that are medically necessary for the setting billed. Medical documentation for patients with neurological disorders needs to be complete and support all services provided in the setting billed.			
Region D: HealthDataInsights	**Minor Surgery and Other Treatment Billed as an Inpatient Stay** (Medical Necessity Review): When beneficiaries with known diagnoses enter a hospital for a specific minor surgical procedure or other treatment that is expected to keep them in the hospital for less than 24 hours, they are considered outpatient for coverage purposes regardless of the hour they presented to the hospital, whether a bed was used, and whether they remained in the hospital after midnight.			

In fact, failure to conduct periodic audits could support allegations of reckless disregard or deliberate ignorance, says attorney Alan Rumph, with Smith Hawkins in Macon, Ga.

CMS says the overpayment-refund mandate applies to Medicare payments for noncovered services; Medicare payments above the allowable amount for a covered service; cost-report mistakes and nonreimbursable expenditures; duplicate payments; and Medicare payments when another payer was actually primary payer. Providers must report the reasons for the overpayment, and the regulation cites some options: wrong service date, wrong CPT code, duplicate payment, inadequate documentation; and lack of medical necessity.

Reg Will Apply to Other Federal Programs

For now, the regulation would apply only to Medicare Parts A and B. CMS will get to Medicaid managed care, Medicare Advantage and the prescription drug benefit program later, although it emphasized that the obligation to return Medicare overpayments is statutory and in effect now, with or without regulations.

In terms of the mandate's impact on providers, Young says CMS isn't being very realistic. In its regulatory impact statement, CMS predicts that 8.5% of providers and suppliers will report and return overpayments annually, and each of them will refund three to five overpayments. Employees (e.g., auditors, clerks) fill out the voluntary refund forms, which take 2.5 hours to complete. "They seemed to dramatically underestimate the cost to the industry," he says. CMS is not including the expenses of the internal investigation, which may include medical-record reviews, and the costs of attorneys who may be necessary because "the rule is chock full of imposing language about civil money penalty and False Claims Act liability, the anti-kickback statute and Stark issues," Young says. "Providers should look carefully at the rule, assess the reality of what CMS is proposing and comment on it."

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