Report on
MEDICARE COMPLIANCE

Reprinted From Volume 27, Number 38 • October 29, 2018

Weekly News and Compliance Strategies on Federal Regulations, Enforcement Actions and Audits

Provider Settles 60-Day Rule Case; Contractor Letters Now Include Refund Obligations

In a case about the 60-day overpayment rule, Southern Cancer Center in Alabama agreed to pay $538,545 in a civil monetary penalty (CMP) settlement for allegedly keeping money owed to Medicare and Medicaid too long after realizing it was due. The 60-day rule is considered fertile ground for enforcement actions, and its obligations are turning up in letters to providers from program-integrity contractors.

The HHS Office of Inspector General (OIG) alleged that Southern Cancer Center allowed the accrual of overpayments from March 21, 2007, to Feb. 1, 2017, and failed to timely return them after they came to light, according to the settlement. The overpayment rule requires providers to report and return Medicare and Medicaid overpayments 60 days after identifying them. Southern Cancer Center came forward on its own and was accepted into the OIG Self-Disclosure Protocol in November 2017, the settlement states.

When hospitals and other providers knowingly hang onto overpayments, they are at risk of a False Claims Act lawsuit, and there have been several settlements in this area *(RMC 9/5/16, p. 1)*.

OIG also has CMP authority to impose fines for knowing retention of an overpayment.

But eight years after the 60-day rule came to life in the Affordable Care Act and more than two years after CMS finalized a regulation interpreting the provision *(RMC 2/15/16, p. 1; 2/22/16, p. 1*), providers still find it challenging to pin down when they have an error that requires an internal investigation of overpayments and how far to hunt them down.

CMS said in the regulation that providers have "the responsibility to conduct an investigation in good faith and a timely manner in response to obtaining credible information of a potential overpayment and to return identified overpayments by the deadline…We believe that contractor overpayment determinations are always a credible source of information for other potential overpayments."

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CMS suggests that when a Medicare administrative contractor (MAC), recovery audit contractor (RAC) or zone program integrity contractor (ZPIC) informs providers of potential overpayments, they should take the ball and run with it—reviewing their claims for similar errors as far back as six years.

"What many providers struggle with is figuring out what exactly constitutes credible evidence of an overpayment," says attorney Jacob Harper, with Morgan Lewis in Washington, D.C. "Where does the obligation start? Does a single letter from the Medicare administrative contractor trigger credible information? Is a minor error on just a few claims credible information? The inquiry is very fact specific, which makes it difficult to apply bright-line rules."

Contractors Are Chiming In

Contractors recently have chimed in. Their letters to providers are starting to include "explicit language" about the requirements of the 60-day rule, says attorney Michael Paulhus, with King & Spalding in Atlanta, Georgia.

One ZPIC letter to a provider states that it "recommends that you conduct a self-assessment in order to identify any additional overpayments you have received as a result of the actions which are the subject of this letter—perhaps pertaining to other states. If you identify overpayments, you are obligated to refund the program. Contact your MAC for instructions on making a voluntary refund. Additionally, CMS has published a final rule regarding overpayments on February 12, 2016 [CMS-6037-F] to provide clarity and consistency in the reporting and returning of self-identified overpayments."

Paulhus says he has seen this language in a number of contractor letters. Obviously, he says, providers were subject to the 60-day rule anyway, but "this is putting them on even more notice." However, providers may wait until they exhaust an appeal of the overpayment determination before investigating further because "the provider may reasonably assess that it is premature," CMS said in the regulation. If providers decide against appealing an overpayment, however, "they may need to expand the time period they're looking at," Paulhus says. "It is a facts and circumstances analysis."

Harper isn't convinced it's always necessary to disclose to OIG any overpayments that were retained more than 60 days. "While circumstances always matter, providers might consider whether a simple disclosure to the MAC is acceptable and gets them to the appropriate risk footing."

There was no information about the nature of the overpayments, and Southern Cancer Center's president, who signed the settlement, didn't respond to a request for comment. Southern Cancer Center didn't admit liability.

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Report on Medicare Compliance (ISSN: 1094-3307) is published 45 times a year by the Health Care Compliance Association, 6500 Barrie Road, Suite 250, Minneapolis, MN 55435. 888.580.8373, hcca-info.org.

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