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CONSULTING GROUP

How to Manage Medicare/Medicaid Overpayments

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Objectives for Today's Webinar

- List applicable rules
- Define overpayments and how they arise
- Discuss the provisions of the CMS "60-day" rule
- List audit criteria to detect overpayments
- Describe how to report and repay overpayments
- Examine the risks and liabilities resulting from the failure to timely report and repay overpayments
- Case examples

Applicable Rules

- 2009: FCA amended to include a reverse "false claims" provision that covers any "knowing" failure to return payments received in error
- 2010: ACA mandated reporting and return of overpayments; established the 60 day rule
- 2012: CMS published proposed overpayment rule
- 2014: OIG published proposed overpayment CMP rule

False Claims Act

- Added by the Fraud Enforcement and Recovery Act of 2009 ("FERA")
- Failure to report and return an overpayment within 60 days of identifying its existence
- Reverse false claims provision
- $5,500 to $11,000 per violation
- Treble damages
- Exclusion from Medicare and Medicaid Programs

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Patient Protection and Affordable Care Act ("ACA")

- Mandatory reporting and return of overpayments
  - Within 60 days after the date on which the overpayment was identified or
  - Date any corresponding cost report is due, if applicable
- Any overpayment retained by a person after the deadline for reporting and returning the overpayment is an "obligation"
  - Actionable under the False Claims Act

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CMS Proposed Overpayment Rule

- Despite proposed rule, CMS cautions that overpayments could result in FCA and CMP law liability and Federal program exclusion
- Identification of overpayments linked to FCA "knowing" definition
- Deadline suspended if prior report pursuant to OIG or CMS Disclosure Protocol
- 10 year "look back" period; overpayments identified within this period must be reported

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Civil Monetary Penalty Law

- ACA Section 6402(d) also 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
- Potential exclusion from participation in federal health care programs, including Medicare and Medicaid

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OIG Overpayment CMP Rule (Proposed)

- $10,000 per day for any overdue overpayment … or per item or service?
- $15,000 per day for failing to grant OIG access to records
- $10,000 per "excluded individual" violation
- $50,000 per false statement, omission or misrepresentation in enrollment or similar program application
- $50,000 per false record or statement material to a false or fraudulent claim

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What are "Overpayments"

- Any payment amount received by a provider, supplier or beneficiary in excess of the amount due and payable under any Federal Program requirements, whether as the result of non-compliance, inadvertent error or incomplete information or process.

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How Overpayments Arise

- Payment of claim submitted in excess of reasonable charge
- Payment of claim for items or services submitted with false or erroneous information relevant to payment
- Duplicate payments
- Credit balances
- Other Federal Program debt

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How Overpayments Arise

- Payment of claim for services after benefits have been exhausted
- Payment resulting from misapplication of the deductible or coinsurance requirement
- Payment of claim that should have been first submitted to primary payor

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How Overpayments Arise

- Mathematical or clerical error
- Payment of claim that failed to include necessary documentation
- Payment of claim for services to beneficiary not entitled to benefits

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How Overpayments Arise

- Services provided by an unlicensed or otherwise unqualified practitioner
- Services (or related support) provided by an excluded individual
- Services were not covered or not medically necessary
- Provider had errors and non-reimbursable expenditures listed in cost report

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How Overpayments Arise

- Services rendered in a nonparticipating portion of the facility or in a bed certified for a type of care other than that furnished
- 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"

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How Overpayments Arise

- Provider or supplier of services has "knowledge" that an overpayment exists
  - Actual knowledge … performs an internal audit and discovers that overpayments exist
  - Reckless disregard … fails to confirm all licenses and registrations are in effect
  - Deliberate ignorance … fails to investigate report of non-compliant billing practices
- Claim submitted for services resulting from an improper referral in violation of the Stark Law

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Provisions of the 60-day Rule

The ACA requires that Medicare "overpayments" be reported and returned by the latter of 60 days after the overpayment was "identified" or the date any corresponding cost report is due (if applicable).

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"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.

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Reasonable Inquiry

- Providers must make reasonable inquiry
- CMS did not detail what constitutes a "reasonable inquiry" to allow for wide variety of potential overpayments
- Failure to make any reasonable inquiry may be considered to have acted in reckless disregard or deliberate ignorance of the overpayment

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Reasonable Inquiry

- OIG Compliance Guidelines recommend self-audits be used to determine whether:
  - Bills are accurately coded and accurately reflect the services provided (as documented in the medical records);
  - Documentation is being completed correctly;
  - Services or items provided are reasonable and necessary; and
  - Any incentives for unnecessary services exist.

https://oig.hhs.gov/compliance/compliance-guidance/index.asp

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Reasonable Inquiry

- Baseline audit – 3 months after education to benchmark against future compliance effectiveness
- Audit at least once each year to ensure that the compliance program is being followed
  - Randomly select medical records
  - 5 or more medical records per Federal payor
  - 5 to 10 per physician
- Best performed by independent reviewer as staff will be less objective when reviewing their own organization

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Applicable Reconciliation

- Occurs when a cost report is filed (initial or amended)
- 2 exceptions – occurs upon final reconciliation
  - Provider receives updated SSI ratio information
  - Outlier reconciliation

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Look Back Period

- Providers should report overpayments that may have occurred within a ten-year look-back period
- Medicare contractors can reopen claims
  - within one year for any reason
  - within four years for "good cause"
  - any time evidence of "fraud or similar fault" exists
- Keep records for ten years

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How to Report Overpayment

- Reporting overpayments to appropriate Medicare contractors who process claims using the existing voluntary refund process
- Reporting overpayments using the OIG Provider Self-Disclosure Protocol

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How to Report Overpayment

- Requires reporting of information specified in the regulation
  - Description of corrective action plan to ensure the error does not occur again
  - Timeframe and total amount of refund for period during which the problem existed
  - If a statistical sample was used to determine the overpayment amount, a description of the statistically valid methodology used to determine the overpayment

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OIG Self-Disclosure Protocol

- Notice to OIG through OIG SDP constitutes notice to appropriate parties
- Timeliness requirements still apply – no additional delay
- Gives providers the opportunity to avoid the costs and disruptions associated with a Government-directed investigation and civil or administrative litigation

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Types of Medical Review

- OIG (Office of Inspector General)
- Medicare Administrative Contractor (MAC)
- Zone Program Integrity Contractor (ZPIC)
- Supplemental Medical Review Contractor (SMRC)
- Comprehensive Error Rate Testing (CERT) Contractor
- Recovery Auditors (RA), formerly known as RAC

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Comprehensive Error Rate Testing (CERT) Contractor

- Most common cause of improper payments during 2013 report period (56.8 %) due to lack of documentation to support the services or supplies billed to Medicare
- Highest improper payment rates were home health, hospital outpatient, skilled nursing facility, physician/lab/ambulance, DMEPOS and inpatient hospital services

http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/CERT-Reports.html

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2013 Improper Payment Rates and Projected Improper Payments by Claim Type (Dollars in Billions)

Claim Type	Total Payment	Projected Improper Payment	Improper Payment Rate	95% Confidence Interval
Part A (Total)	$257.4	$20.9	8.1%	7.5% - 8.7%
Part A (Excluding Inpatient Hospital PPS)	$140.0	$11.4	8.2%	7.2% - 9.1%
Part A (Inpatient Hospital PPS)[4]	$117.4	$9.4	8.0%	7.3% - 8.8%
Part B	$90.3	$9.5	10.5%	9.5% - 11.5%
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	$9.7	$5.7	58.2%	54.9% - 61.5%
Overall	**$357.4**	**$36.0**	**10.1%[5]**	**9.5% - 10.7%**

http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/CERT-Reports-Items/Downloads/MedicareFee-for-Service2013ImproperPaymentsReport.pdf

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What are Auditors Looking For?

Collection of clinical information to ensure payment is made only for services that meet the requirements for:

- Coverage
- Medical Necessity
- Qualified Practitioners
- Non-Excluded Individuals
- Proper Site of Service and Supervision
- Documentation and Coding

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Policy and Guidance

Coverage Determinations define medical necessity for services provided

- **National Coverage Determination (NCD)**
  - Developed by CMS
  - Apply to all jurisdictions
- **Local Coverage Determination (LCD)**
  - Contractor specific guidelines
  - Companion articles
  - Coding and Billing Guidelines

http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx

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General Principles of Documentation

1. Documentation must be complete and legible
2. Each patient encounter should include:
   - Reason for the encounter and relevant history
   - Physical examination findings
   - Prior diagnostic test results
   - Assessment, clinical impression, or diagnosis
   - Plan of care
   - Date and legible identity of the observer

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General Principles of Documentation

3. Reason for, and results of, ancillary services (x-rays, labs, etc.)
4. Rationale for ordering diagnostic/ancillary services should be easily inferred
5. Past and present diagnoses accessible to treating/consulting physician
6. Risk factors identified
7. Written treatment plan

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Medicare Signature Requirements

All entries must be dated and authenticated

"If the practitioner's signature is missing from the medical record, you can submit an attestation statement from the author of the medical record.

If an order for tests is unsigned, you may submit progress notes showing intent to order the tests. The progress notes must specify what tests you ordered. A note stating "Ordering Lab" is not sufficient. If the orders and the progress notes are unsigned, your facility or practice will be assessed an error, which may involve recoupment of an overpayment."

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf

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Examples of Audit Findings

1. Physician order states “observation” but billed as inpatient services
   - All care is assumed outpatient in the absence of an inpatient order or clear intent to admit

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Examples of Audit Findings

2. Diagnostic clinical laboratory services missing order or documentation of intent to perform test
   - A signed order or documentation in the progress notes of the intent to perform tests should be provided for review as well as the test results
   - Be specific –
     - “urinalysis” vs. “urinalysis, automated with microscopy”
     - “CBC” vs. “CBC with diff”
     - “performed in the office today” vs. script given

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Examples of Audit Findings

3. Venipuncture charges deemed not medically necessary when labs are denied due to
   - Invalid/missing physician order
   - No intent to order lab services is documented

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Progressive Corrective Action

Targeted activities based on severity

- Data analysis
- Error detection
- Validation of errors
- Provider education
- Sampling claims
- Payment recovery

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Overpayment Collection Process

Demand Letters

- First demand letter will be sent requesting payment
- Interest will accrue from the date of the letter if the overpayment is not received by the 31st calendar day from the date of the letter
- Second demand letter is sent on day 31, if no response is received

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Overpayment Collection Process

- Recoupment begins on day 41, if payment is not received
- Overpayment will be recovered from current payments due or from future claims submitted

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Overpayment Collection Process

- Intent to Refer letter will be sent within 120 days indicating that the overpayment may be eligible for referral to the Department of Treasury for offset or collection

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Inability to Repay the Overpayment

- Use Extended Repayment Schedule (formerly "Extended Repayment Plan")
- ERS requests will not be automatically granted
- Significant documentation of financial hardship required

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The Case of ABC Health

- On July 31, 2012, ABC Health acquired a therapy company
- On January 11, 2014, ABC did a routine screening against the Office of Inspector General and System for Award Management (OIG/SAM) List of Excluded Individuals/Entities (LEIE), and discovered that one of the therapy employees, John Quinn, was on the exclusion list

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The Case of Reliable Health Care

Reliable Health Care received a payment from Medicare twice for the same services billed on behalf Ms. Smith, a Medicare resident. This created a credit balance on Ms. Smith's account. At the same time, Medicare denied a claim for another resident, Mr. Jones. Since the service was provided to Mr. Jones, the billing staff decided it would be okay to apply Ms. Smith's credit balance against Mr. Jones' unpaid balance. After all, the service was performed; it just was not allowable under Medicare.

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The Case of Excel Health Care

Excel Health Care is experiencing low census. To attract more referrals, it ran an advertisement waiving copayments and deductibles for new patients.

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The Case of Advanced Care

- Advanced Care is a Medicare Part A provider.
- The Business Office Manager (BOM) always prepares the Credit Balance Reports (CMS Form 838) for the administrator.
- The BOM is aware that there are credit balances on some of the Medicare accounts, but always indicates there are none on the CMS From 838. She knows from past experience that the Fiscal Intermediary never looks at it.
- The administrator always signs it without reviewing the documentation.

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A Recent FCA Action Merits Attention …

- **U.S. v. Continuum Health Partners, Inc. et al**
  - U.S. Department of Justice ("DOJ") intervened in FCA action
  - Health system conducted audit which confirmed incorrect claims to Medicaid program due to computer program malfunction
  - Health system "knowingly" retained and failed to timely refund payments
  - DOJ seek maximum CMP under FCA -- $11,000 per overpayment or $9.9 million PLUS treble damages

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Important Action Items

- Create overpayment policy; update record retention policy (10 years)
- Internal controls to detect and prevent overpayments
- Training (and more training)
- Compliance audits
- Suspected overpayments reported to designated representative(s) to confirm overpayment and to oversee timely reporting and repayment

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Questions?

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