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EDUCATIONAL RESOURCES

HOME HEALTH HOSPICE

Disclosure of Overpayments: Voluntary Refunds & OIG Mandated Six-Year Lookback

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Background

- February 12, 2016, CMS issues its final rule that implemented Section 6402 of the Affordable Care Act
- These rules were effective March 14, 2016
- 1128J(d) of the Social Security Act
- 42 CFR Section 401.305 – Requirements for reporting and returning of overpayments

Basics of the “Overpayment Rule”

Basics of the “Overpayment Rule”

- Duty to return overpayment
- Failure to report and repay overpayment subjects provider to False Claims Act Liability

Basics of the “Overpayment Rule”

- Timeframe: Within 60 days after which overpayment is “identified”
- Reporting: A person must use an applicable claims adjustment, credit balance, self-reported refund, or other reporting process to report an overpayment

Basics of the “Overpayment Rule”

- What is an “overpayment”?
  - Overpayment means any funds that a person has received or retained under title XVIII of the Act to which the person, after applicable reconciliation, is not entitled under such title.
  - When a paid amount exceeds the appropriate payment amount entitled, the overpayment is the difference between the amount that was paid and the amount that should have been paid.
  - When payment is made for an item or service specifically not payable under the Act, the overpayment typically consists of the entire amount.

Basics of the “Overpayment Rule”

- Examples of overpayments:
  - Medicare payments for non-covered services
  - Medicare payments in excess of the allowable amount for an identified covered service
  - Errors and non-reimbursable expenditures in cost reports
  - Duplicate payments
  - Receipt of Medicare payment when another payor had the primary responsibility for payment

Basics of the “Overpayment Rule”

- What does “identified” mean?
- A person has identified an overpayment when the person has or should have, through the exercise of reasonable diligence, determined that the person has received an overpayment and quantified the amount of the overpayment

Basics of the “Overpayment Rule”

- What is “Reasonable Diligence”?
  - Reasonable diligence is demonstrated through the timely, good faith investigation of credible information, which is at most 6 months from receipt of the credible information, except in extraordinary circumstances
  - The reasonable diligence time period of 6 months is in addition to the 60-day report and return time period

Compliance with the Overpayment Rule

Compliance with the Overpayment Rule

- Identification of overpayments through the exercise of reasonable due diligence
- Proactive compliance activities
- Investigative activities in response to credible information about potential overpayments

Compliance with the Overpayment Rule

- 6 months is a benchmark for investigation
- 60 days to refund
- 6-year lookback period
- No minimum monetary threshold

Compliance with the Overpayment Rule

- Proactive compliance activities to avoid overpayments
  - Self-audits
  - Compliance checks
  - Training employees

Voluntary Repayments

- Scenario: Patient doesn't qualify for services
- Ideal Response: This is detected quickly, and either:
  - Services stopped and no claim is submitted
  - Voluntary refund submitted to MAC

How to Repay Overpayments – Option 1

- Submit adjustments to correct the claim(s)
- Include adjustment reason code on the claim
- Claim is reprocessed and the overpayment is recouped via the remittance advice

How to Repay Overpayments – Option 2

- Submit the appropriate voluntary refund form
- For multiple claims, attach a listing of the individual claim details so that you do not have to complete a new form for each claim
- Part A and Part B voluntary refunds should be submitted separately with the corresponding voluntary refund form from MAC to ensure proper processing

How to Repay Overpayments – Option 2 (cont'd)

- All claims adjusted as a result of the voluntary refund request will be reflected on the Medicare Remittance Advice
- Voluntary refunds cannot be collected via an immediate offset request - payment must be submitted with a voluntary refund
- To ensure accurate and timely processing, type, don't write by hand

Voluntary Refund Overpayment Form

- Provider name, address, NPI, PTAN, Tax ID
- Patient & claim information
- For multiple claims, can attach a spreadsheet with all data points
- Claim info and overpaid amount

Voluntary Refund Overpayment Form

Reason(s) for Overpayment:

- Billed in error
- Incorrect Service Date
- Duplicate payment
- Incorrect CPT Code
- Not our Patient(s) (explain)
- Service Not Rendered
- Modifier Added or Removed
- Medical Necessity Not Met
- Patient Enrolled in HMO
- Other (describe)

Voluntary Refunds in MSP Scenarios

- Voluntary refunds for Medicare Secondary Payer (MSP) situations must include a copy of the primary insurer's Explanation of Benefits (EOB) to ensure proper processing
- Separate voluntary refund forms are available for MSP and non-MSP situations to ensure sufficient information is received to process the voluntary refund

How to Repay Overpayments – Option 3: Medicare Credit Balance Quarterly Reports

- Under the credit balance reporting process, a provider or supplier files a Medicare Credit Balance Report (CMS-838)
- The CMS-838 is specifically used to monitor identification and recovery of “credit balances” owed to Medicare
- CMS-838 https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS838.pdf

Medicare Credit Balance Quarterly Reports (cont'd)

- Medicare credit balances include instances where a provider is:
  - Paid twice for the same service either by Medicare or by
  - Medicare and another insurer
  - Paid for services planned but not performed or for non-covered services
  - Overpaid because of errors made in calculating beneficiary deductible and/or coinsurance amounts

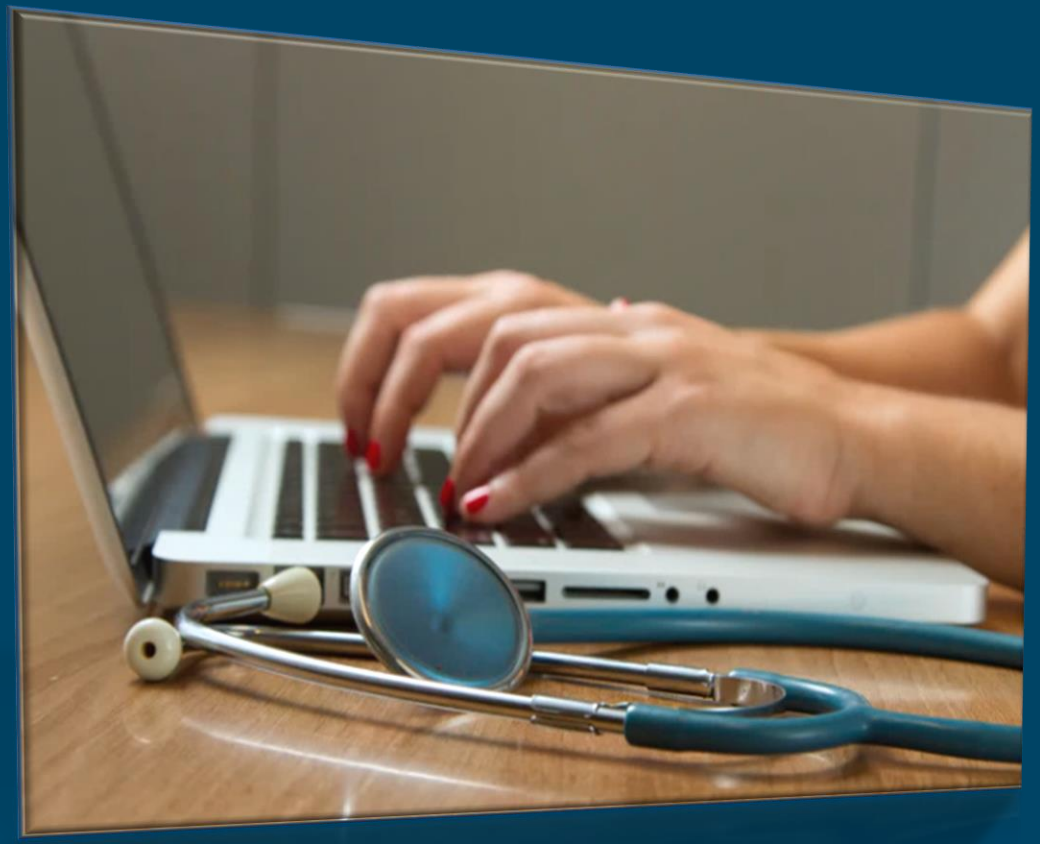
What if I identify a more serious compliance issue?

- Call a qualified health care attorney!

What if I identify a more serious compliance issue?

- 3 options:
  - CMS Self-Referral Disclosure Protocol
  - OIG Self-Disclosure Protocol
  - Self-report to the DOJ/Local U.S. Attorney's office

CMS Self-Disclosure Protocol



CMS Self-Referral Disclosure Protocol

- CMS Self-Referral Disclosure Protocol – for Stark Law Violations
  - Paying a referring physician without a written contract for more than 90 days
  - Paying a referring physician above Fair Market Value
  - Paying a referring physician when not “commercially reasonable”

CMS Self-Referral Disclosure Protocol

- CMS can reduce penalties under Stark Law
- Once you're accepted into the SRDP, the obligation to return the overpayment within 60 days of identification is suspended until a settlement is reached, you withdraw from the protocol, or CMS removes you from the protocol

CMS Self-Referral Disclosure Protocol

- Submit electronically and in hard copy
  - Your identifying information
  - Description of the nature of the matter being disclosed
  - Duration of violation
  - Circumstances of discovery and measure taken to address the issue/prevent future abuses

CMS Self-Referral Disclosure Protocol

- Description of your compliance program
- Legal analysis of how the disclosed matter violated Stark
- Specify a “look back” period during which the violation occurred
- Financial analysis of total amount actually or potentially due and owing as a result of the violation

OIG Self-Disclosure Protocol ("OIG SDP")

- Anti-Kickback Statute Violations, Fraud; Stark Law; Failure to Reach a Settlement; What if we can't afford the entire overpayment

OIG Self-Disclosure Protocol (“OIG SDP”)

- OIG Self-Disclosure Protocol for Anti-Kickback Statute Violations, Fraud
  - Paying referring physician for services not rendered
  - Paying independent contractor sales representative on a commission basis
  - Giving items of value in exchange for referrals

OIG SDP

- May not be used to disclose violations only of Stark Law that have no colorable allegation of an Anti-Kickback Violation
- Disclosing parties must acknowledge that the disclosed conduct is a potential violation of the applicable law to be accepted into the SDP

OIG SDP

- OIG may confer with CMS regarding disclosed conduct that involves violations of both the Anti-Kickback Statute and the Stark Law
- OIG cannot provide a release of the Stark Law overpayment liability through its SDP
- OIG may refer a matter to the DOJ for consideration under applicable criminal laws or the civil FCA

Failure to Reach a Settlement

- Provider or supplier has the balance of the 60-day time period remaining from the identification to the suspension of that 60-day time period when OIG or CMS acknowledged receiving the submission to report and return any overpayment to the contractor

What if we can’t afford the entire overpayment?

- Request an extended repayment schedule for “hardship”
- Regulations:
  - Hardship exists when the total amount of all outstanding overpayments (principal and interest and including overpayments reported in accordance with §§ 401.301 through 401.305) not included in an approved, existing repayment schedule is 10 percent or greater than the total Medicare payments made for the cost reporting period covered by the most recently submitted cost report for a provider filing a cost report, or for the previous calendar year for a supplier or non cost-report provider.

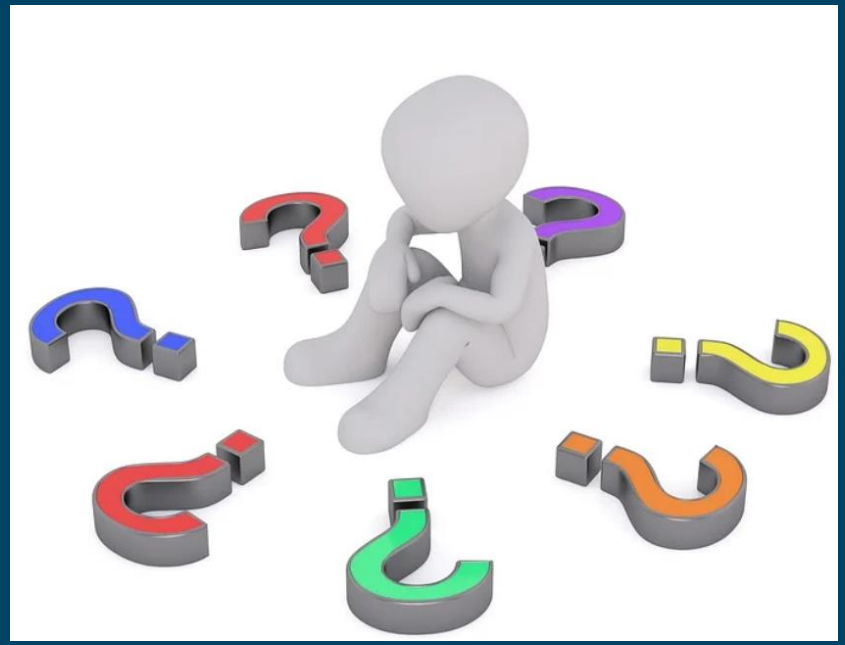
Disclosure to DOJ

Disclosure to DOJ

- Self-Disclosure to the Department of Justice or a local U.S. Attorney's Office
- No formal self-disclosure process
- DOJ and USAO can settle:
  - False Claims Act violations, 31 U.S. C. §§ 3729-3733
  - Civil monetary penalties law violations, 42 U.S.C. §§ 1320a-7a
  - Program Fraud Civil Remedies Act, 31 U.S.C. §§ 3801-3812

Bottom Line

- What lessons can be done now; Lesson learned/best practices



Bottom Line

- This is important - you must act or face FCA liability
  - Treble damages
  - Penalty per false claim:
    - Min. $11,000+
    - Max. $23,000+
- Civil Monetary Penalties Law (CMPL) liability
- Exclusion from federal health care programs
- Violation of Section 1128J(d) of the Affordable Care Act

Bottom Line

- Try to identify claim(s) and denial reasons
- Discuss parameters of the review with your counsel
- Suppliers need to either review 100% of their claims going back 6 years or identify a Statistically Valid Random Sample (SVRS)

Bottom Line

- Suppliers should consider engaging experts:
  - Health care attorney
  - Statistician
  - Third-party reviewers
  - If a supplier uses a statistician and/or third-party reviewer, consider having its health care attorney hire the consultant/reviewer so that the findings fall under the attorney-client privilege

What Can Be Done Now

- You must be proactive in this environment
- If you are not continuously and strictly scrutinizing claims, a 6-year look-back audit could have a devastating impact
- Imagine what your claims looked like 6 years ago
- Many of the errors identified in reviews would have been corrected many years ago, but the suppliers didn’t realize they were erroneous

Lessons Learned/Best Practices

- While employees are good intentioned, you must trust AND verify
- Many in senior positions trust their employees are doing things the correct way
- Problems discovered quickly can be fixed quickly with minimal impact - problems ignored or unnoticed lead to significant issues
- Quarterly auditing at a minimum with follow-up education and training and benchmarking of issues, employees, etc.

Questions?

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Thank You!

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