Next Steps: Helping Your Organization Implement the New Medicare Overpayment Rule

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Part I: Key Takeaways from the Final Rule for Reporting and Returning Medicare Overpayments

On February 12, 2016, the Centers for Medicare & Medicaid Services ("CMS") published a final rule that explains the requirements for providers and suppliers reporting and returning overpayments under Medicare Parts A & B (the "Overpayment Rule"). Hospitals, physicians, reference laboratories, home health agencies and anyone receiving funds from Part A or B are affected by the Overpayment Rule. It took CMS nearly six years to finalize the Overpayment Rule after Section 1128J(d) of the Patient Protection and Affordable Care Act ("PPACA") became law and explicitly required providers and suppliers to return overpayments to Medicare.

Since you probably have neither the time, nor the desire, to read every comment and response from CMS regarding the Overpayment Rule, outlined below are key takeaways, which summarize the processes providers must follow for identifying overpayments, calculating the repayment period, quantifying an overpayment, as well as reporting and returning overpayments.

Part II of the series will provide a practical action plan to address the Overpayment Rule.

Takeaway No. 1

An overpayment must be returned "by the later of either of the following: (i) the date which is 60 days after the date on which the overpayment was identified; and (ii) the date any corresponding cost report is due, if applicable." 42 C.F.R. § 401.305(b)(1).

What is an "overpayment"? Overpayments are any funds received by a provider, which exceed the amount the provider is entitled to under the Medicare program, regardless of fault. Some examples of overpayments are payments for non-covered services, errors in the cost report, and coding errors.

When is an overpayment "identified"? An overpayment is identified when a provider knows or should have known that it received an overpayment. CMS expects that providers will exercise reasonable diligence in identifying overpayments.

What is "reasonable diligence"? Reasonable diligence means that a provider takes proactive measures to find overpayments and reactive measures to identify an overpayment once the provider receives credible information that it received an overpayment. CMS notes in the Overpayment Rule that providers and suppliers will have in place compliance plans that include both proactive activities and ongoing monitoring of payments. In other words, providers and suppliers cannot use the "ostrich defense" and take the position that "the plain mandate to report and return overpayments received [can] be avoided by not taking action to obtain actual knowledge of an overpayment." 81 Fed. Reg. at 7,661.

How much time is permitted to "identify" an overpayment? CMS explained that when a provider or supplier receives credible information that an overpayment may exist, a provider has 8 months (6 months for timely investigation and 2 months for reporting and returning overpayments). The 60-day clock to report and return an overpayment is suspended if a provider or supplier filed a self-disclosure with CMS or OIG and the provider has not yet reached a settlement with the respective agency. 42 C.F.R. § 401.305(b)(2). A provider, who discovers a systematic problem of overpayments, can quantify the overpayments collectively for the entire universe of claims in a large audit and repay the overpayments as a settlement of the entire group of overpayments, instead of returning each overpayment on an individual basis.

What are the practical implications for your organization? Train employees at every level of the organization to prevent overpayments from occurring and identify overpayments that have already occurred. For example, training programs should teach employees: (i) how to prevent coding and billing errors that lead to overpayments; and (ii) how to identify payment inconsistencies, such as unexplained increases in payments that cannot be linked to changes in clinical practice, providers or procedures, which may indicate the organization's receipt of overpayments. This is also a great time to revisit your organization's compliance plan and determine whether it requires sufficient compliance activities given the location, size, and nature of services offered by your organization. CMS recognizes that "compliance programs are not uniform." 81 Fed. Reg. at 7,661. Make sure your compliance plan is appropriate for your organization.

Takeaway No. 2

Providers and suppliers "must use an applicable claims adjustment, credit balance, self-reported refund, or other reporting process set forth by the applicable Medicare contractor to report an overpayment…." 42 C.F.R. § 401.305(d).

What are the practical implications for your organization? Develop an action plan to address every overpayment, regardless of its size. The plan should identify the individuals responsible for assembling documentation, reviewing the claim(s), determining whether an overpayment exists (which may include contacting legal counsel to analyze the documentation), quantifying the overpayment, as well as reporting and returning the overpayment. Consider using a hypothetical overpayment scenario to test whether the action plan achieves the desired results of reporting and returning the overpayments through one of the processes approved by CMS. Discuss periodically with key clinical and administrative staff members how the action plan can be improved. Update the plan as necessary in order to make sure only current staff members hold responsibilities under the plan. A template "Action Plan" developed in response to the Overpayment Rule will be published in Part II of this alert.

Takeaway No. 3

An overpayment retained by a provider and supplier "after the deadline for reporting and returning the overpayment…is an obligation for purposes of 31 U.S.C. 3729," which can lead to liability under the False Claims Act "FCA." 42 C.F.R. § 401.305(e).

What are the penalties under the FCA (31 U.S.C. 3729)? A provider's violations under the FCA are punishable through penalties of $5,500 - $11,000 and damages that are the equivalent of three-times the value of the claim that the government considers an unreturned overpayment or false claim. 31 U.S.C. § 3729(a).

What are the practical implications for your organization? Conduct regularly-scheduled, proactive audits on high volume, high revenue procedures or procedures targeted by OIG and other government auditors. Carefully review the findings of the audits in a timely manner with appropriate clinical and administrative staff members who are trained to recognize overpayments. If an audit reveals credible information that the organization has received overpayments, staff members should diligently work to determine if the overpayments are widespread in the organization. While an organization may not be able to prevent every overpayment, it can use audits to retroactively identify overpayments. Remember, unreturned overpayments become false claims and false claims lead to serious penalties!

Takeaway No. 4

An overpayment must be returned if it is identified "within 6 years of the date the overpayment was received." 42 C.F.R. § 401.305(f).

What are the practical implications for your organization? Clinical records and billing documentation must be meticulously organized for claims that have been submitted to Medicare for reimbursement within the past 6 years. As your organization modifies and upgrades its electronic medical records or billing software, including those systems managed by third parties, the organization needs to ensure that information contained on the systems is stored in a physical or electronic location that is easily accessible and searchable in the event it is required for an internal or government audit in the future.

Conclusion

FirmLogic and attorneys from our Healthcare Practice can provide a webinar regarding the final rule and implementation of a practical action plan for your organization.

FirmLogic, an affiliate of Womble Carlyle Sandridge & Rice LLP ("WCSR"), has a division of Healthcare Audits that is staffed with experienced healthcare auditors including nurses, physicians and certified coders who can assist your organization with any educational or audit-based recommendations contained in this article.

Contact Information

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