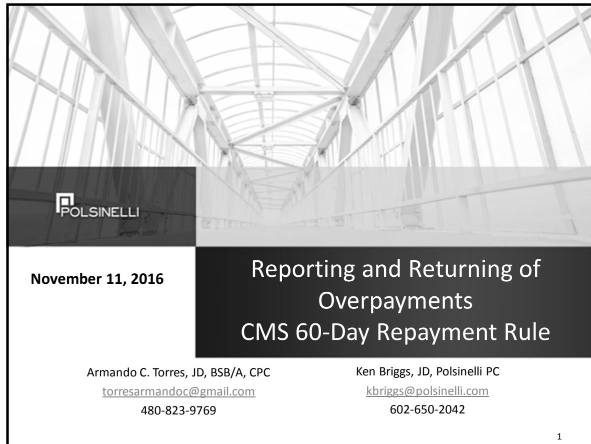


## Roadmap

- Brief History of 60-Day Rule
- Key Themes of the Final Rule
  - Identification of Overpayments
  - Applicable Lookback Period
  - Mechanics of Reporting and Returning Overpayments
- Preventative Measures

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## Brief History

- Affordable Care Act (Act) – SSA § 1128J(d)
- Proposed Rule (77 Fed. Reg. 9,179; Feb. 16, 2012)
  - "Reckless disregard", "deliberate ignorance"
  - 10-year lookback period
  - No clear "identification" standard to trigger 60-day clock
- *U.S. ex rel. Kane v. Healthfirst, Inc.* (Aug. 3, 2015)

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## Brief History

- *U.S. ex rel. Kane v. Healthfirst, Inc.* (Aug. 3, 2015)
  - First case involving alleged failure to refund Medicaid overpayments
  - Motion to dismiss denied and court read duty to inquire broadly
  - Settled for $3M in Sept. 2016 (overpayment was ~$850,000)

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## Brief History

- Final Rule (Feb. 12, 2016)
  - Overpayments under Medicare Parts A and B must be reported and returned within 60 days of identification or the date any corresponding cost report is due.
  - An overpayment is “identified” when a provider or supplier has or should have, through the exercise of reasonable diligence, determined that it has received an overpayment and quantified the amount of the overpayment.
- Effective Date: March 14, 2016

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## Brief History

- Three key themes:
  - Identification of overpayments
  - Lookback period
  - Mechanics of reporting and returning overpayments

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## Key Concepts

- An overpayment is not identified until it is ***quantified***
- Reasonable diligence to identify overpayments starts with "credible information" that an overpayment may exist and should take no more than six months
- The lookback period is 6 years, not 10
- Providers must report and return overpayments within 60 days of the date of identification
- The methods to report and return overpayments are considerably more flexible

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**Identification of Overpayments**

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## Identification of Overpayments

- An overpayment must be reported and returned by –
  - **Claims-based** overpayments: 60 days after the date on which the overpayment was "identified"
  - **Cost-report-based** overpayments: the date any corresponding cost report is due

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## Examples of Causes of Overpayments

- Insufficient Documentation
- Lack of Medical Necessity
- Credit Balances
- Non-covered Services
- In Excess Of Allowable
- Duplicate Payments

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## Claims-Based Overpayments

- Identified when
  - "Has determined [it] received an overpayment and quantified the amount" or
  - Should have determined/quantified "through the exercise of reasonable diligence"
- *Exercise of reasonable diligence* is a multi-step process
  - Credible information
  - Reasonable diligence
  - Identification and quantification
  - Report and return

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## Claims-Based Overpayments

- Credible Information: information that supports a reasonable belief that an overpayment may have been received
  - Triggers duty of "reasonable diligence" inquiry
  - Many potential sources of credible information
    - (Final) Medicare contractor audit findings (e.g., RAC, MAC)
    - Hotline Complaints
    - Improper Coding Identified
    - Sudden Increase In Revenue
    - Internal/External Audits

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## Claims-Based Overpayments

- Reasonable Diligence: Demonstrated through timely, good faith investigation: “at most six months from receipt of the credible information”
  – Replaces “reckless disregard,” “deliberate ignorance” and “all deliberate speed”
  – Requires proactive and reactive investigative activities
  – Six months is guidance in CMS preamble, not it rule itself

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## Claims-Based Overpayments

- CMS Notes “undertaking no or minimal compliance activities to monitor the accuracy and appropriateness of a provider or supplier’s Medicare claims” would fall short of the “reasonable diligence” standard.
- If provider receives credible information that an overpayment may exist, and fails to exercise reasonable diligence to determine if there is an overpayment, 60-day period begins when provider received the credible information.

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## Claims-Based Overpayments

- Identification & Quantification
  – An overpayment is “identified” only following reasonable diligence inquiry **and** quantification
  – No materiality or *de minimus* threshold
  – For probe samples, an overpayment is not “quantified” until the entire claim universe is analyzed
- Report and Return

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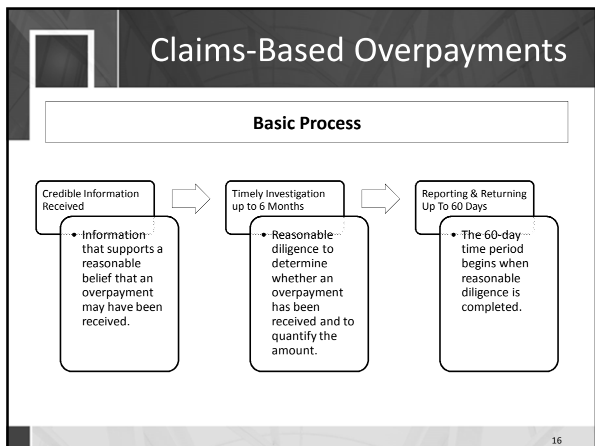


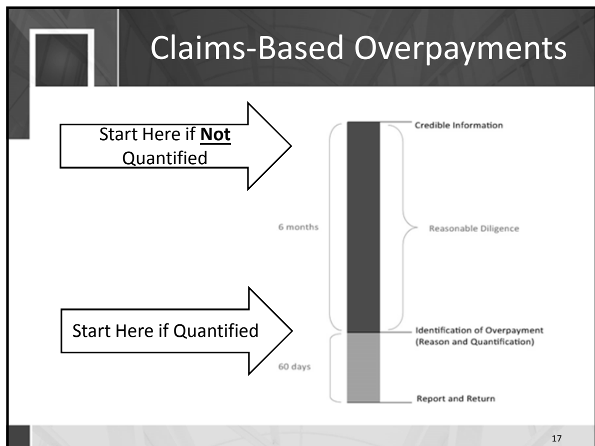


## Cost Report-Based Overpayments

- Reconcile and refund:
  - At the time the cost report is due
  - The 60-day rule applies before the Notice of Program Reimbursement is issued
- Adjustments made by a MAC on retrospective audit is “credible information”
  - May trigger obligation to review prior years’ cost reports
- If issue identified in audit with respect to one cost report, it is “credible evidence” of a potential overpayment on other cost reports within the 6-year lookback

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## Cost Report Overpayments

- Where interim payments are made based on estimated costs, an overpayment is not deemed to exist until ***applicable reconciliation***
- Applicable reconciliation occurs and refunds due when:
  - The cost report is filed (initial or amended),
  - If related to updated SSI ratios from CMS, the final reconciliation of the cost report,
  - If part of an outlier reconciliation, the final reconciliation of the cost report

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## Cost Report Overpayments

- No change in reopening rules, but given timing in getting a Notice of Program Reimbursement (NPR) (3-4 years) and subsequent 3-year reopening period, 6 year lookback period likely covered
- Examples:
  - Overpayment discovered during preparation of cost report → Reconcile and refund when cost report submitted
  - Overpayment discovered prior to Notice of Program Reimbursement (NPR) → Submit amended cost report and refund
  - Overpayments discovered after NPR → Seek reopening to amend and refund

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## Cost Report Overpayments

**Basic Process**

Applicable Reconciliation → Filing Within 5 Months of FYE → Reporting & Returning

- Applicable Reconciliation
  - Provider's yearend reconciliation of payments and costs to create the cost report.
- Filing Within 5 Months of FYE
  - Allows the provider time to reconcile payments and costs and identify any funds to which the provider is not entitled.
- Reporting & Returning
  - Overpayment should be returned at the time the cost report is filed.

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**Lookback Period**



## Lookback Period

- Lookback period is six years (not 10 years)
  - Refund overpayments identified "within six years of the date" overpayment was received
- Reopening Rules
  - New 42 C.F.R. § 405.980(c)(4) allows providers to request six-year reopening to address overpayments
  - No change to time periods for contractor-initiated reopenings



## Lookback Period

- Final Rule is not retroactive
  - Does not apply to amounts actually refunded prior to March 14, 2016
  - Applies to amounts refunded after March 14, 2016—*even for overpayments received prior to that date*
- Important implications for provider/supplier audits currently in-process

## Mechanics for Reporting and Repayment



## The Mechanics

- Clarified the acceptable reporting method
  - MAC voluntary refund process
  - Requesting a claim adjustment or offset
- Clock is tolled for providers/suppliers who:
  - Request an Extended Repayment Schedule, or
  - Use another approved disclosure method (*e.g.*, OIG Protocol, CMS Stark Process)
- Repay after full review, not after probe sample



## The Mechanics

- Permits MAC voluntary refunds to be submitted with one form with spreadsheet identifying all claims
- Does not require providers/supplies to submit specific data points with each refund
  - Exception: Overpayments calculated through extrapolation must include details of the statistical sampling method

## Impact on Other Payors

- Final Rule applies only to Medicare Parts A & B
- What is lookback period for other payer
- Medicare Advantage Organizations
  - Medicaid FFS
  - Medicaid MCO
- Considerations:
  - Application of ACA
  - Contracted Status
  - State Law
  - Operational/Administrative Burden

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## Scope of Investigation

- Certain investigations may need to be conducted under the attorney-client privilege
  - Consider at the beginning of the review
  - Use privilege if *high probability* of uncovering *significant* misconduct
- How much time?
  - Need to be diligent
  - CMS suggest that 6 months should be adequate
  - 6 months can go quickly

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## Case Study

| After Submission? | Answer |
| --- | --- |
| ❑ What if provider self-identifies an overpayment after the submission and applicable reconciliation of the Medicare cost report? | ❑ Submit an amended cost report.<br>❑ Report and return overpayment within 60 days of identification. |

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## Impact of Affordable Care Act on 60-Day Rule

**Affordable Care Act**

- ❑ Requires any entity that receives or makes payments to the State Medicaid Program of at least $5,000,000 annually, to provide federal False Claims Act education to their employees.

**Medicaid and Whistleblowing**

- ❑ Affordable Care Act requirement to provide False Claims Act education to employees.

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## Key Communication Controls

**Effective Communication**

- ❑ Internal Reporting Polices
- ❑ Event Reporting Systems
- ❑ Confidential Hotlines
- ❑ Monitoring

**Effective Controls**

- ❑ Training
- ❑ Supervision
- ❑ Monitoring
- ❑ Office Morale
- ❑ No Retaliation

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## Preventative Measures

1. Take stock of all audits currently in-process
   - If possible, quantify and refund prior to March 14, 2016
   - For all others, consider modification for six-year lookback
2. Develop a process to:
   - Identify credible information relating to possible overpayments and the date received
   - Conduct reasonable diligence to identify overpayments
3. Update documentation policies, if needed, to support reasonable diligence reviews looking back six years

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## Preventative Measures

4. Revise existing audit policies to ensure compliance with six-month reasonable diligence and 60-day refund timeframes
5. Establish (or improve) lines of communication internally between internal audit and external audit response teams
   - Critical as external audit findings (from RACs, MACs, etc.) represent "credible information" and trigger six-month timeline
6. Maintain documentation of all refunds including: retraction requests, revised claims, form and check submissions and extrapolation methodologies

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**Questions?**

**Thank You**

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