60-Day Overpayment
Additional Reference Materials
Duplicative Audits By Contractors

- Concern raised that repaid claims would be involved in a RAC, MAC, or OIG audit
- “We will not recover an overpayment twice.”
- If report and return specific claims, MAC can adjust the claims
- If report through extrapolation, retain documentation in the event of audit of claims included in the universe
- But, refuses to exempt from audit claims that formed the basis for an overpayment
Contractor Or Government Audits

• May give rise to report and return obligation if do not disagree with results
• May give rise to obligation to review similar items outside scope (such as time period) of the audit
• If appeal audit, provider may reasonably assess it is premature to investigate nearly identical conduct for additional time period until appeal is concluded
• OIG Work Plan and similar documents do not automatically give rise to report and return obligation, but providers are “encouraged” to use these materials to inform proactive compliance activities
Anti-Kickback Violations

Where provider is a party to the arrangement giving rise to arrangement, appears to have a duty to investigate, report and return

- Appears to view AKS violation as giving rise to overpayments
- A number of issues arise, such as whether there is sufficient “scienter” for a violation
- Consider report to the OIG through the SDP
Anti-Kickback Violations (cont.)

• Provider not a party to the anti-kickback violation which result in referrals to the provider
• Example, a supplier impermissibly pays a physician to use or order its products in a hospital
• If provider has sufficient knowledge of arrangement to have identified the overpayment, must report (not return) to CMS
• CMS will refer to the OIG and suspend repayment obligation until resolved
• Expectation is that parties to the arrangement, not the provider, would be required to make any repayment except in extraordinary circumstances
Billing Agents And Identity Theft

• Provider is responsible for overpayments resulting from actions of their agents, including billing companies

• Report identity theft to law enforcement and CMS and wait for instructions from CMS regarding overpayments
“Certainly advisable for providers and supplier to maintain records that accurately document their reasonable diligence efforts to be able to demonstrate their compliance with the rule.”

- Internal memos
- Resolutions
- Reports
- Workpapers
- Log of activities
Waiver of Liability

- Liability for return of overpayments for medical necessity and custodial care is waived under the Medicare Act if provider did not know, or could not reasonably have known, of the overpayment.
- Providers may not make own determination if waiver of liability applies in connection with a report and return of overpayments.
- If CMS makes a determination that waiver of liability applies resulting payment is not an overpayment.
- Should a provider request a waiver of liability determination when reporting and returning in appropriate circumstances?
Probe Sample

- If identify a single overpaid claim, appropriate to inquire further to determine where there are more overpayments on the same issue before reporting and returning
- If use a probe sample, not appropriate only to return overpayments identified in probe and to fail to extrapolate
- “In most cases this can be done in a timely manner consistent with the identification requirements of this rule”
- Do not report and return specific claims from probe until full overpayment is identified
Appeals

• If report and return of a claim gives rise to a revised payment determination, can file appeal
• But, would be inconsistent with the rule to report and return and then appeal the same claims
• Perhaps can obtain an waiver of liability or without fault determination this way
• May not be able to appeal self-reported overpayments determined through extrapolation
Reopening

- Rule authorizes MACs to reopen claims related to refunds for the six-year lookback period
- Does not extend reopening period for MAC to reopen claims on own initiative
- Does not extend reopening period for underpayments (door just swings one way)
- Does not address three-year period for reopening an NPR
- So, what happens if cost report overpayment is identified more within six years but more than three years after applicable NPR?
Cost Report Overpayments

• Due later of 60 days after identification or date cost report is due (five months after end of cost reporting period)

• Overpayment arises if provider has received or retained funds to which it is not entitled after “applicable reconciliation”

• In Medicare Parts A and B, “applicable reconciliation” applies only to cost report items

• CMS rejects view that cost report overpayments need not be reported and returned until the cost report is settled despite reconciliation language
Applicable Reconciliation

Occurs when cost report is filed, except

- When provider receive more recent CMS information on the SSI ratio, provider not required to return any overpayment resulting from updated information until final reconciliation of the cost report (NPR?)

- When provider *knows* that an outlier reconciliation will be performed, not required to estimate reimbursement change until final reconciliation
Outlier Reconciliation

- Overpayment is identified when provider receives information from MAC as part of cost report settlement process.
- Provider not responsible for identifying cost report outlier reconciliation overpayment in advance of MAC’s calculation.
- If provider identifies an inaccurate outlier claim payment must report and return using process for claims.
Cost Reports

• Provider that self-identifies a cost report overpayment after filing must report and return within 60 days of identification.

• Submit an amended cost report with return with sufficient documentation to allow MAC to adjust the cost report.

• If overpayment identified by MAC during the audit, MAC determines and demands repayment at final settlement. Provider is responsible for addressing other years.
Lookback Period

- Proposed Rule — ten-year lookback period
- Final Rule — six-year lookback period
- All identified overpayments made within the six-year period
Stark and Lookback

- Overpayments reported and returned, or reported and in process of being reviewed under SRDP before March 14, 2016, subject to only four-year lookback implemented under the SRDP

- SRDP disclosures on or after March 14, 2016
  - Six-year lookback applies
  - Currently, CMS can only collect financial information for four years under SRDP
  - CMS is seeking OMB approval to go back six years
  - Providers may voluntarily provide information for years five and six, or report and return for years five and six “through other means”
Proposed Rule

- Contained 13 elements for inclusion in overpayment reports
- For example:
  - How the error was discovered
  - The reason for the overpayment
  - Description of the corrective action plan to ensure the error does not occur again
  - A description of any statistically valid methodology used to determine the overpayment amount
Final Rule

- Omits list of report elements
- Must use one of the following processes established by the applicable Medicare contractor (in regulation text):
  - Claims adjustment
  - Credit balance
  - Self-reported refund
  - Other reporting process
- Exceptions
  - OIG Self-Disclosure Protocol
  - CMS Self-Referral Disclosure Protocol
  - Must report but may not return if seek ERP until ERP denied or fail to comply with ERP
Final Rule

• If calculated using a statistical sampling methodology, must “describe the statistically valid sampling and extrapolation methodology in the report”

• Single refund form with attached spreadsheet of data is acceptable
Report and Return to Whom?

- The Medicare contractor
  - Part A/B MAC
  - DME MAC
- The OIG under the SDP
- CMS under the SRDP
- Disclosures to DOJ or MFCU do not suspend the deadline
Medicaid Overpayments

- Subject to 60-Day Report and Return Statute
- CMS has not promulgated a 60-day regulation specifically applicable to Medicaid
- Open question whether the Medicare Part A/B Rule will be persuasive authority with respect to Medicaid overpayments? And, if so, on what issues?