TCORS

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SPECIAL POINTS OF INTEREST:

- What is the 60 Day Rule and Why is it Important to Providers?
- What is an Overpayment?
- What Does it Mean to Identify an Overpayment?
- Look Back Period
- How to Report and Return Overpayments

60 DAY RULE FOR OVERPAYMENTS

This newsletter, which is the first of two parts, provides a review of the key provisions of the "60 Day Rule" and its relevance to Medicaid providers. The second newsletter will discuss ancillary provisions of the Rule and questions concerning its practical impacts on providers, including documentation practices and medical necessity.

What is the 60 Day Rule and Why is it Important to Providers?

In 2010, the Affordable Care Act (the "Act") established the 60-day overpayment requirement which requires a provider who has received an overpayment to report and return the overpayment to the government agency/contractor and to notify them in writing why the overpayment was returned. The Act generally requires that the overpayment must be reported and returned by the later of the date that is 60 days after the date on which the overpayment was identified, or the date any corresponding cost report is due, if applicable. Overpayments retained after the deadline become a potential "obligation" under the federal False Claims Act, which could subject the provider to treble damages and per claim penalties and lead to disbarment from federal health care programs.

Since the enactment of the Act, significant questions have remained regarding implementation and enforcement of the 60 Day Rule. On February 12, 2016, CMS issued final regulations on the Rule, which went into effect on March 14, 2016. The purpose of the final regulation is to provide needed clarity and consistency in the reporting and returning of self-identified Medicare Part A and B overpayments.

While no similar regulation have been published that address Medicaid, CMS reminds Medicaid providers that they are subject to the same statutory requirements under the Act on which the new regulations that govern Medicaid Part A and B are based. Medicaid providers of course are subject to the same liabilities under the False Claims Act for failure to report and return an overpayment. Although the final regulations only extend to Medicare Part A and B payments, they provide insight into the approach and attitude that regulators can be expected to apply in defining and dealing with Medicaid overpayments.

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What is an Overpayment?

CMS has defined the term "overpayment" as any funds that a provider receives or retains and, after applicable reconciliation to which it is not entitled. (Reconciliation deals with providers who are subject to cost reporting.) CMS has provided the following examples to assist providers and suppliers with understanding when an overpayment has been identified. This list is intended to be illustrative and not a complete list of circumstances:

- Payments for noncovered services
- Duplicate payments
- After reviewing billing or payment records, you learn that certain services were incorrectly coded resulting in increased reimbursement.
- A provider learns that services were provided by an unlicensed or excluded individual on their behalf.
- A provider performs an internal audit and discovers that an overpayment exists.
- A provider is informed by a government agency of an audit that discovered a potential overpayment and the provider fails to make a reasonable inquiry.

CMS clarifies this last example by stating the scope of the duty to conduct reasonable diligence is defined by the issues that the contractor or government audited. However, providers will need to review the specific facts and circumstances, including the billing and coverage rules, to determine the required scope of their reasonable diligence. Also, the contractor or government audit may be for a limited time period. If the provider confirms the audit's findings, then the provider and supplier may have credible information of receiving a potential overpayment beyond the scope of the audit if the practice that resulted in the overpayment also occurred outside of the audited timeframe. In such situations, providers and suppliers will need to conduct reasonable diligence within the look back period of this rule to comply.

Sufficient documentation and medical necessity are longstanding and fundamental prerequisites to coverage and payment. In our next newsletter, we will discuss some practical impacts these prerequisites have on the question of whether there is an overpayment under the Rule.

What Does it Mean to Identify an Overpayment?

In the proposed rule, the definition of "identify" was vague, leading to the court to interpret the meaning of the word "identified" in Kane v. Healthfirst, Inc. The final regulations clarify this definition by defining what it means to identify an overpayment. A provider has identified an overpayment when the person has or should have, through the exercise of reasonable diligence, determined that the provider has received an overpayment and quantified the amount of the overpayment.

The definition of reasonable diligence is further clarified to include both proactive compliance activities and investigations conducted by qualified individuals. Reasonable diligence may take at most 6 months from receipt of the credible information that an overpayment may have occurred, except in extraordinary circumstances.

Quantifying the amount of the overpayment may be determined using statistical sampling, extrapolation or other methodologies as appropriate. These principles include randomly selecting claims from the population and extrapolating only within the time period covered by the population from which the sample was drawn. It is not appropriate for a provider or supplier to only return a subset of claims identified as overpayments and not extrapolate the full amount of the overpayment.

If the provider fails to conduct reasonable diligence and the provider in fact received an overpayment, the 60-day time period begins on the day the provider received the credible information that an overpayment may have occurred.

Look Back Period

CMS has reduced the look back period from 10 years as stated in the proposed regulations to 6 years. Under the final regulations, overpayments must be reported and returned only if the overpayment occurred within 6 years of the date the overpayment was identified.

How to Report and Return Overpayments

An overpayment must be reported and returned regardless of the reason it happened. CMS has given providers and suppliers additional options for returning overpayments. While the proposed rule only gave providers one option, the final rule has expanded the options to include using an applicable claims adjustment, credit balance, self-reported refund, or another appropriate process to satisfy the obligation to report and return overpayments. A provider can apply for an extension of time to pay if it can substantiate a hardship.

Although CMS has tried to clarify the 60 Day Rule with its Final Regulations, there still may be questions that providers have relative to how it should be applied to their particular situation and/or how the provider's compliance program should be modified to insure compliance with this "Rule". As always, we at Tobin, Carberry, O'Malley, Riley & Selinger, P.C. (TCORS) are available to assist and advise providers as they structure, implement, or audit their compliance programs. We can also review potential overpayments to provide advice on whether they are truly reportable overpayments and quantify any identified overpayments. In addition, to help protect against overpayments from occurring, TCORS can conduct "mock" compliance audits of providers' billing and claims and also can represent providers who are undergoing actual DSS audits as they maneuver their way through the DSS audit process. Please do not hesitate to give our Medicaid Audit team a call.

About the TCORS Medicaid Group

Our Medicaid Audit Department is comprised of Attorney Robert D. Tobin, partner; Attorney Joseph J. Selinger, partner; James Wietrak, former DSS Director of Quality Assurance; and Denise Smith, Certified Professional Coder and Medical Auditor. They are prepared to conduct Medicaid compliance reviews or "mock audits" of a number of Medicaid providers to identify areas of potential weakness and recommended corrective actions. Both Jim and Denise have extensive knowledge of the requirements governing various types of healthcare providers and continuously keep informed as to the ongoing audits and proposed rules affecting Connecticut's providers.

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TCORS MEDICAID AUDIT SERVICES

- **Educational Seminars**

  We help you understand the DSS Medicaid audit process, and proper billing, coding and documentation procedures.

- **Periodic Record Reviews**

  We replicate an actual Medicaid audit to determine your organization's compliance weaknesses that could save you from costly financial disallowances and extrapolated audit adjustments.

- **Assistance During the Audit Process**

  We assist your organization in developing defenses in response to any draft and/or final audit reports and in negotiating settlements.

- **Appeal Audit Decisions**

  We will represent you throughout the entire appeal process

Contact Us To Set Up A Personalized Meeting

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