60-Day Repayment Rule: Implications for Internal and External Audits

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Agenda

- History/background of 60-Day Repayment Rule
- Meaning of “Overpayment” & “Identification”
- Guidance on “Credible Information”
- Cost reporting issues and interpretation of “applicable reconciliation”
- Reporting and returning overpayments
- Intersection of the 60-Day Repayment Rule and the FCA
- Conducting an internal audit
- Responding to external audits
- Q&A

History and Background of 60-Day Repayment Rule

History and Background

- 1128B(a)(3) of the Social Security Act

Whoever . . .having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized . . . [shall face criminal penalties]

History and Background *(cont.)*

- OIG Compliance Program Guidance
  - Requires reporting within 60 days of "credible evidence" of a violation of criminal, civil, or administrative law

- CMS issued two proposed rules on repayment obligations, but never finalized
  - Would have required reporting and returning overpayments within 60 days of identification

History and Background *(cont.)*

- ACA enacted Section 1128J(d) (42 U.S.C. § 1320a-7k(d))
  - Must "report and return" overpayment and notify government of the reason for the overpayment
  - Must make repayment:
    - within "60 days after the date on which the overpayment was identified;" or
    - at time of cost report filing (if applicable)
  - Overpayments may require "reconciliation" before due

History and Background *(cont.)*

- ACA intersection with False Claims Act
  - Congress specified that overpayments to Medicaid & Medicare, if not returned w/i 60 days, would become subject to FCA fraud damages and penalties
  - "Any overpayment retained by a person after the deadline for reporting and returning the overpayment… is an obligation under the False Claims Act."
- False Claims Act is a civil statute oft-described as the government's "most effective tool" to combat fraud, waste, and abuse of government funds
- Generally, FCA prohibits false claims involving government funds or property

History and Background *(cont.)*

- Part A/B (Physicians and Hospitals)
  - Proposed rule published on Feb. 16, 2012
  - Final rule published on Feb. 12, 2016
- Part C/D (Medicare Advantage plans and Drug Benefits)
  - Proposed rule published on Jan. 10, 2014
  - Final Rule published on May 23, 2014
- Medicaid
  - No rule published
  - Limited FCA case law development

Meaning of “Overpayment”

Meaning of "Overpayment"

- Defined as "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."
- Overpayments include (in CMS's view):
  - Payments tainted by AKS violations
  - Payments without documentation support
  - Medicare secondary payments
- No right to offset underpayments
- No *de minimus* exception

Meaning of “Identification”

Meaning of Identification

- Part A/B provider has "identified" an overpayment when it "has, or should have, through the exercise of reasonable diligence, determined that [it] has received an overpayment and quantified the amount of the overpayment"
  - Includes proactive compliance activities; and
  - Responses to "credible information"

Guidance on "Credible Information"

Guidance on "Credible Information"

- Responding to "credible information" is a subset of "reasonable diligence," which includes proactive monitoring and reactive investigating
- "Credible information" is not the same as "identification" – it is what triggers the duty to investigate
- "Credible information" includes information that supports a reasonable belief that an overpayment may have been received

Guidance on "Credible Information" *(cont.)*

- Acting on "credible information"
  - Providers have 6 months from receipt of credible information to investigate and decide if in fact they have an overpayment or not
  - Providers that receive credible information but do not have proactive measures to monitor for such credible information, and therefore do not know that they have credible information, have liability 60 days after receipt
  - "Credible information" is credible information, no matter who in the organization receives it

Guidance on "Credible Information" *(cont.)*

- Acting on "credible information" *(cont.)*
  - CMS's view is that even a *single claim* that has been overpaid can be "credible information" that requires further investigation
  - CMS's further view is that extrapolation is *always* appropriate, no matter what the error rate from a probe sample
- CMS acknowledges, however, that it is only concerned with 60 Day Repayment Rule implementation and is not describing whether FCA liability is triggered

Cost Reporting Issues and Interpretation of “Applicable Reconciliation”

Cost Reporting Issues and Interpretation of "Applicable Reconciliation"

- "Applicable reconciliation" is the filing of the cost report (for reimbursement matters calculated through the cost report)
  - CMS declined to use cost report settlement as the trigger for reconciliation
- Issues identified after the initial submission must be disclosed through the filing of an amended cost report
- Exceptions are the SSI fraction and outlier recalculations, where reconciliation occurs at cost report settlement

Cost Reporting Issues and Interpretation of "Applicable Reconciliation" *(cont.)*

- Issues subject to "applicable reconciliation" include:
  - DSH
  - GME
  - Bad debt
  - Organ transplant

Reporting and Returning Overpayments

Reporting and Returning Overpayments

- Lookback period is 6 years.
- CMS allows for either a voluntary refund and disclosure process or use of adjustment claims, even though such adjustments do not involve an express disclosure.
- Stark and OIG self-disclosures toll the obligations under the 60 Day Repayment Rule

Reporting and Returning Overpayments *(cont.)*

- When making a disclosure, consider including:
  - Name, provider number, NPI, TIN of entity making repayment
  - Description of how the error was discovered
  - What circumstances led to the repayment
  - Applicable timeframe
  - Whether a statistical sampling was used to quantify the overpayment
  - The corrective action plan to prevent the error from occurring again
  - List of claims to which the overpayment applies

Reporting and Returning Overpayments *(cont.)*

- **OIG Self-Disclosure Protocol**
  - Disclose: potential violations of federal criminal, civil, or administrative law for which CMPS are authorized (e.g., False Claims or Knowingly Retained Overpayments)
  - Not Eligible: Errors or **overpayments**, advisory opinions on conduct, or Stark-only conduct
  - Settlement Multiplier: Benchmark of 1.5x
  - Six-year statute of limitations
  - Tolling of the 60-day period after submission
  - May help limit FCA exposure60-day concerns

Intersection of the 60-Day Repayment Rule and the FCA

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- An overpayment under the 60 Day Rule becomes an "obligation" under the FCA
- Liability attaches to a person who "knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government."

Conducting an Internal Audit

Conducting an Internal Audit

- Proactive and reactive reviews are necessary
- Proactive reviews are not necessarily based on “credible information”
  - Work Plans should establish what is the basis for a review and expressly state where an entry is not based on credible information

Conducting an Internal Audit *(cont.)*

- Sources of "credible information" triggering a reactive review
  - Hotline calls
  - Allegations of misconduct
    - Falsification of medical records
    - Potential AKS/Stark violations
  - Uncovering evidence that conditions of payment had not been met
  - Unexplained pattern of, or increase in, payment denials
  - PEPPER reports, etc.
  - CMS would include unexplained increases in payment
  - External audits (but only in some cases)

Conducting an Internal Audit *(cont.)*

- Determining the Audit Scope
  - The scope will determine the size of the universe, as well as the potential exposure
  - Question is how the uncovered item (or work plan item) creates some form of "reasonable belief"
  - For example, if a hospital learns that some of its PT services were medically unnecessary, does it need to do an audit of all of its PT services? Suggestions for trying to focus on the potential problem include:
    - Determining if the services were all furnished by the same therapist
    - Determining whether only a small number of procedures are involved
    - Determining if only a certain patient type is affected
    - Determining if the problem existed only during a certain timeframe

Conducting an Internal Audit *(cont.)*

- Sources for proactive review work plan entries can include:
  - OIG Work Plan
  - New policies
  - Auditing corrections to prior instances of non-compliance
  - Other stakeholders within the organization
  - Reviewing and assessing LCDs and MLN Matters

Conducting an Internal Audit *(cont.)*

- Structuring the Audit
  - Probe audit vs. statistically valid random sample
    - How much knowledge does the auditor already have? Is it no longer appropriate to do a mere probe audit?
  - Determining the unit
    - Is it a claim? Is it contracts where FMV issues are questioned? For medical necessity of a series of services, is the patient the unit?
  - The structure of the audit must reflect the nature of the information that formed the "reasonable belief" of an issue and generate reliable results

Conducting an Internal Audit *(cont.)*

- Audits should be based on a policy, which can include:
  - Key definitions, such as “credible information,” “reasonable diligence,” and “overpayment”
  - Which payers the policy applies to
  - Who in the organization can conduct the audit
  - When a statistical sampling is to be used
  - What constitutes an acceptable error rate
  - How to effectuate repayment, including timelines
  - When to conduct the audit under privilege or otherwise consult Legal regarding the structure of the audit
  - Corrective actions and reaudits
  - Applicable stakeholders within the organization

Conducting an Internal Audit *(cont.)*

- Once a policy is finalized, there must be competent training.
  - Individuals within the organization must know when to report.
  - It is also critical that individuals learn that words have meaning. Words like “identification” and “overpayment” should only be used once the policy processes have been followed and an official determination has been rendered.

Responding to External Audits

Responding to External Audits

- CMS expressly states that contractor audit findings (including cost report adjustments) are "credible information"
  - OIG routinely states that auditees must comply with the 60 Day repayment rule based on audit report findings
- CMS states that must go beyond original audit scope once have audit findings
- CMS acknowledges that, if a denial is appealed, it would be premature to perform more diligence

Responding to External Audits *(cont.)*

- Questions to ask when deciding whether an audit has led to "credible information"
  - Is the provider appealing or protesting the determination?
  - Is the issue one like medical necessity, where the findings are likely unique to the patients reviewed?
  - Has the law or interpretation recently changed?
  - Have other auditors looked at the same records and determined that the provider billed appropriately?
- If there is "credible information," then make sure the scope of the follow-on review is well-defined.

Q&A

- *Q1: Should the 60 Day Repayment Rule apply to funds received from MA Plans and Medicaid MCOs?*

Q&A *(cont.)*

Q2: Which of the following qualifies as "credible information"?

A) An OIG report following an audit of the provider in question?

B) An OIG report of some other provider or providers (e.g., a series of reports regarding misuse of modifier 59)?

C) A TP&E development letter from CMS indicating a 30% coding error rate, but noting that the letter is for training purposes?

D) A RAC finding that, in a probe sample, there was a 20% error rate on medical necessity issues?

Q&A *(cont.)*

Q3: CMS has in effect stated that extrapolation is "always" necessary. Most providers generally set a threshold before they extrapolate, which might vary depending upon the nature of the self-audit (usually 5% for a general audit and 10% for an audit of a targeted area). Below that threshold, providers believe they do not have "credible information" of a systemic issue. Is that appropriate?

Q&A *(cont.)*

Q4: CMS has stated that it would be premature for a provider to consider an audit adjustment to be "credible information" if the provider has the issue under appeal. Are there any exceptions to that?

Q&A *(cont.)*

- ***Q5: Once a provider has credible information, it then must perform reasonable diligence. If it receives an audit report from OIG, a RAC, ZPIC, MAC, etc., that claims that certain claims were incorrectly paid, but the provider, with the help of legal counsel, decides that it disagrees with the government's contention, has it still identified an overpayment?***

Q&A *(cont.)*

Q6: Does FCA liability attach on the 1st day of the 9th month?

Q&A *(cont.)*

Q7: Does the 8 month window apply to Medicaid?

Q&A *(cont.)*

Q8: In light of the Jan. 28, 2018 Rachel Brand memo, could knowledge of a potential violation of a Medicare Manual provision ever constitute "credible information?"

Q&A *(cont.)*

- ***Q9: Although the 60 Day Repayment Rule requires that all overpayments be "reported and returned," is it ever acceptable to simply "report" without "returning"?***