CREDIT BALANCE RESOLUTION AND OVERPAYMENT REFUND OBLIGATIONS

Legal and Practical Considerations

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Presented By: Long Do, CMANet and Jarod Baccus, Protiviti
AGENDA

- Objectives
- 60-Day Overpayment Rule: Statutory Basis and Implementation
- The Final Rule: Initial Reactions and Latest Comments
- Key Provisions
- Reporting and Repayment
- Cases to Remember
- The Danger Is Real: The Risks Created by Overpayments and Unresolved Credit Balances
- Find Your Bearings: A Map of the Legal and Regulatory Landscape
- Move to Safer Ground: Best Practices to Facilitate Compliance
- Audit Preparation: Planning, Fieldwork, and Knowing Common Risks
- Shoot the Messengers: Questions and Answers
OBJECTIVES

1. Understand the Risks Created by Overpayments and How to Mitigate Them
2. Understand the Applicable Legal and Regulatory Landscape
3. Understand Auditing and Monitoring Practices to Facilitate Regulatory Compliance
60-DAY OVERPAYMENT RULE

Statutory Basis and Implementation
Statutory Basis

Affordable Care Act, §6402(a) (42 U.S.C. §1320a-7k(d)(1))

Recipients of Medicare and Medicaid funds who:

1. Have “received an overpayment,”
2. Must “report and return the overpayments,”
3. Within 60 days overpayment is “identified”

The law was effective March 23, 2010, but final implementing regulations did not issue until Feb. 12, 2016
CMS IMPLEMENTING RULE

• ACA effective March 2010
• CMS originally proposed the Rule on 2/16/2012
• CMS received more than 200 comments
• Final rule issued 2/12/2016 (81 Fed. Reg. 7654-84)
• Final rule is 30 pages in the Federal Register
  - 1 page to report the text of the new regulations
    (42 C.F.R. §401.301, -.303, -.305, 42 C.F.R. §401.607(c)(2)(i), and §405.980(c)(4))
  - 29 pages to respond to comments and explain the overpayment refund process

• Only applies to Medicare Parts A and B
  - Separate rule for Parts C and D; none yet for Medicaid
THE FINAL RULE

Initial Reaction and Latest Comments
INITIAL REACTION TO THE FINAL RULE

“In the final Overpayment Rule, CMS addressed many stakeholder concerns, and the Overpayment Rule provides a more workable approach than the proposed rule.”

“We readily acknowledge that the Final Rule reflects a significant amount of thought . . . . But in doing so, the agency left many essential terms vague . . . . apparently done to allow an organic application of this Final Rule to evolve over time, informed by experience with real-life circumstances.”
LATEST COMMENTS

“[T]he real life problem is that many of the situations that may lead to an overpayment are complex and heavily fact-dependent . . . . This runs the real potential that significant effort and expense will be required, even where there is absolutely no abuse or harm to the federal programs or, more importantly, to their beneficiaries.”
KEY PROVISIONS
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“Overpayment”

• Any funds a provider has received or retained to which the provider is not entitled

• Fault and motive are irrelevant (human error, system error, contractor fault, vendor mistake)

• Overpayment can be a portion of a paid claim (e.g., wrongly upcoded claims) or the whole claim (e.g., medically unnecessary)
KEY PROVISIONS

Overpayments must be returned when they are “identified”

1. “[H]as, or should have through the exercise of reasonable diligence, determined that [it] has received an overpayment,” and

2. Has “quantified the amount of the overpayment”

Triggers 60-day clock to return overpayment

CMS says “identified” trigger is met if a provider fails to exercise reasonable diligence and the person in fact received an overpayment
“Reasonable Diligence”

CMS explained “reasonable diligence” requires:

1. Proactive compliance activities conducted in good faith by qualified individuals to monitor for the receipt of overpayments, and

2. Investigations conducted in good faith and in a timely manner by qualified individuals in response to obtaining credible information of a potential overpayment
“Proactive Compliance”

- Little guidance from CMS about what constitutes sufficient compliance program
- CMS recognized that “compliance programs are not uniform in size and scope and that compliance activities in a smaller setting, such as a solo practitioner’s office, may look very different than those in larger setting, such as a multi-specialty group”
KEY PROVISIONS

“Credible information” of an overpayment

• Information that supports a *reasonable belief* that an overpayment may have been received

• No duty to investigate every instance or complaint concerning overpayment; CMS acknowledges not all information received will be credible

• A fact-specific determination
KEY PROVISIONS

Investigations in “timely manner”

- Investigation is timely if completed within 6 months, except under “extraordinary circumstances”
  - Natural disasters or emergencies;
  - Unusually complex investigation;
  - Generally fact-specific
KEY PROVISIONS

Overpayment amount is “quantified”

- CMS permits (and encourages) quantification through statistical sampling, extrapolation methodologies, and any other appropriate methodologies.

- *(San Bois Health Servs. v. Hargan* (E.D. Okla. Nov. 6, 2017) – Upheld $4.1M overpayment based on hotly disputed statistical sampling methodology by zone program integrity contractor; Court held the ZPIC method complied with Medicare Program Integrity Manual guidance, which was sufficient, even though provider’s and an ALJ-appointed independent expert thought there were better methods)
KEY PROVISIONS

6-year look back period

- Must return all identified overpayments within six years of the receipt of the funds
  - Proposed rule was for 10 years

- Provider-initiated reopenings can also go back 6 years (reopening regs allow contractors to reopen for only four years with good cause)
  - But cannot reopen claims for underpayment (still limited to 4-year look back period under current regs)
KEY PROVISIONS

Tolling of 60-day Repayment Period

• If the OIG has accepted a voluntary disclosure under its Self-Disclosure Protocol (anti-kickback cases)

• If CMS has accepted a voluntary disclosure under its Voluntary Self-Referral Disclosure Protocol (Stark cases)

• An extended repayment schedule is requested
REPORTING AND REPAYMENT
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Repayment and Reporting Overpayments Using Existing Processes

1. Claims adjustment
2. Credit balance
3. Refunds through Medicare carrier processes
4. OIG Self-Disclosure Protocol (anti-kickback)
5. CMS Self-Referral Disclosure Protocol (Stark)

What must be reported subject to the particular reporting and repayment process
CASES TO REMEMBER
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• Mt. Sinai Health System $2.95M Settlement (8/2016)
  - Actual overpayments - $844K; FCA exposure - $4.9M
  - State comptroller audit alerted overpayment caused by glitch, followed by a whistleblower email
  - Hospital did not refund all overpayments until more than 2 years later

• UnitedHealthCare Ins. V. Hargan (D.D.C., pending)
  - Challenging 60-Day Rule for MA Plans (2014)
  - MA Rule has same “identified” definition requiring “reasonable diligence” and “proactive compliance”
  - Argument: imposes a negligence standard for liability that is inconsistent with the statutory language of the ACA and FCA liability
  - Argument, if successful, is broad enough to potentially nullify definition of “identification” for Part A and B Rule too
THE DANGER IS REAL

The Risks Created by Overpayments and Unresolved Credit balances
THE DANGER IS REAL

- CMS has articulated its expectation that indications of overpayments be investigated by providers
- Credit balances are frequently caused by overpayments
- Overpayments found by a regulator in aged credit balances could be considered a False Claims Act violation
- Overpayments must be returned within 60 days of “identification”
- Ignorance is not (usually) a defense
- Credit balances should be resolved and overpayments should be refunded timely in order to minimize the risk of sanctions and fines
- Overpayments and credit balances proving especially suited for whistleblowers or qui tams
THE DANGER IS REAL: JUST READ THE HEADLINES

**Bloomberg BNA**

**DOJ Cites ‘First of Its Kind’ Settlement on Overpayments**

**WCBS 6 News & TEGNA Company**

Federal audit shows $4.4M in Medicaid overpayments uncollected

**BECKER'S Hospital CFO**

**OIG: Moses H. Cone received $1.83M in Medicare overpayments**

**Modern Healthcare**

**Decision in 60-day repayment rule case puts providers on alert**

**Daily Press**

87 physicians account for more than $7 million in Medicare overpayment for miscoding location of services

**savannahnow.com Savannah Morning News**

Pediatric Services of America, related entities agree to pay $6.88 million to resolve False Claims Act allegations

**BECKER'S Hospital CFO**

New Hampshire hospital received $1.39M in Medicare overpayments, says OIG

**Modern Healthcare**

**Medicare overpaid docs billions for office visits, OIG says**

**New Cover Oregon Error May Put State on Hook for $74 Million in Overpayments**
FIND YOUR BEARINGS

A Map of the Legal and Regulatory Landscape
FIND YOUR BEARINGS: LAW

False Claims Act (FCA)

- Liability for anyone who used a “false record” or “statement” and for individuals who conceal, avoid, or decrease an obligation to pay money to the government. Liability does not require that the person submitting the claim have actual knowledge that the claim is false. A person who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information, also can be found liable under the Act.
- Civil penalties $10,957 to $21,916 per false claim, plus treble damages (annual re-indexing).
- Criminal penalties up to five years and $250K per occurrence for individuals and up to $500K for corporations.
- Private parties may bring an action on behalf of the United States. 31 U.S.C. 3730 (b). These private parties, known as “qui tam relators,” may share in a percentage of the proceeds from an FCA action or settlement.

Fraud Enforcement and Recovery Act (FERA)

- Amended the “reverse false claims” (i.e., overpayments) provisions to expand liability to “knowingly and improperly avoid[ing] or decreas[ing] an obligation to pay or transmit money or property to the Government.”

Affordable Care Act (ACA)

- Requires reporting and repayment of overpayments received from Medicare (all parts) or Medicaid by 60 days from the date the overpayment was “identified.”
- Basis for CMS’s Medicare Program; Reporting and Returning of Overpayments Rules:
FIND YOUR BEARINGS: REGULATIONS

CMS 60-Day Overpayment Rule (Part A & B Providers and Suppliers)

- Overpayment “identified” at the time that a provider has, or “should have”, through the exercise of “reasonable diligence”, determined the presence of an overpayment and quantified the overpayment.
- “Should have…determined…and quantified” triggered when the provider fails to exercise “reasonable diligence” and the provider in fact received an overpayment.
- “Reasonable diligence” undefined, but:
  - Requires proactive compliance efforts and investigations into “credible information.”
  - Providers’ duty to determine whether information is “credible.”
- Six-month Myth?
- Six-year look-back period, consistent with FCA.
- Is the existence of credit balances within your government-paid population “credible information”?

Reference:
“Medicare Program; Reporting and Returning of Overpayments,” 77 Federal Register 32 (February 16, 2012), pp. 9179-87
42 CFR 405.980 – Reopening of initial determinations, redeterminations, and reconsiderations, hearings, and reviews
Overpayment Civil Monetary Penalties Rule

- OIG created a global list of aggravating and mitigating factors that it considers in assessing monetary penalty amounts and exclusion "to add clarity and improve transparency in OIG's decision-making process."
  - (1) the nature and circumstances of the violation;
  - (2) the person's degree of culpability;
  - (3) the person's or entity's history of prior offenses;
  - (4) other wrongful conduct; and
  - (5) other matters, as justice may require.

- Impose civil monetary penalties for any provider that knows of an overpayment and does not report and return the overpayment.

- $10,000 per item or service for failing to report and return an “identified” overpayment in accordance with the 60-day refund rule in the ACA.
MOVE TO SAFER GROUND

Best Practices to Facilitate Compliance
NOT A BEST PRACTICE FOR OVERPAYMENT RULE COMPLIANCE
An Approach to Facilitate Credit Balance Resolution Compliance

1. Assess Your Knowledge and Understand Your Processes
2. Identify and Analyze Your Current Credit Balance Population
3. Perform a Sample Based Audit of Your Population (Optional)
4. Understand Audit Results and Resolve Gaps
5. Plan and Execute A Clean-up (If Necessary)
6. Implement Ongoing Monitoring Efforts
Assess Your Knowledge and Understand Your Processes

- Assess your federal law, state law, case law, and contractual requirements.
- Evaluate policies, standard operating procedures, and training.
  - Credit balance resolution (identification and quantification) processes.
  - Refund (demand letters, self-identified reporting, repayment, and escheatment) processes.
  - Rebuttal and appeals processes.
- Interview key project management and actual processors to understand the processes.
  - How to run system reports, can we get all information needed?
  - Prioritization process defined, work queue assignments operational?
  - Timeliness and accuracy expectations communicated and metrics tracked?
  - Self, peer, manager sample based QA occurring?
- Walkthrough processes to determine if policy and expectations match operations.
- Determine if reporting / dashboards exist.
MOVE TO SAFER GROUND

Identify and Analyze Your Current Credit Balance Population

- Create a report of all unresolved credit balances (6 years)
- The report should contain:
  - Credit balance aging (i.e., the date the account went into credit)
  - Listing of all payers whose funds were credited to the account
  - Account identifiers (e.g., account number, MRN)
  - Charge/transaction identifiers (e.g., date of service, charge number, invoice number, etc.)
  - Payment identifiers (e.g., payment dates, payer name, amounts, etc.)
MOVE TO SAFER GROUND

Perform a Sample Based Audit of Your Population (Optional)

- Determine presence / extent of government overpayments in your credit balance population
- Questions to consider:
  - Probe (e.g., not sure overpayments are in population) or statistically significant (e.g., to extrapolate and refund)?
    - “This final rule expressly anticipates that providers and suppliers may, but are not required to, use statistical sampling and extrapolation for calculating the overpayment amount”
  - Should you engage counsel in an effort to privilege the audit and its results?
  - Do you have “independent,” qualified personnel to conduct the audit?
  - What methodology will be employed for sample selection (e.g., random or targeted?, if targeted, how?)?
  - Do you have a process for refunding overpayments discovered during the audit?
- Validate accuracy of credit balance reports used for management and compliance oversight.
Move to Safer Ground

Understand Audit Results and Resolve Gaps

- Determine who is resolving your credit balances:
  - Is the resource level appropriate?
  - Are they qualified and well-trained?
- Determine whether there are sufficient quality assurance and root cause analysis processes.
- Determine sufficiency and effectiveness of controls used to ensure refund and reporting within 60 days of identification.
- Update policies, standard operating procedures, training, and reporting.
- Work with business owner to plan and implement improvements.
“Large” amount of “old”, government-related credit balance accounts or audit results revealing “significant” aged overpayments in your population?

Things to consider before starting:

- Do I have staff qualified to make credit balance resolution determinations who can be assigned to this effort, without significant interruptions to the current business processes?
- What are the potential downstream bottlenecks (e.g., manager approval for refunds, QA process, check cutting, check mailing with explanation of refund, etc.)?
- How will you prioritize resolution? Typical factors considered include: government payment receipt, age, balance, etc.
MOVE TO SAFER GROUND

Implement Ongoing Monitoring Efforts

- Government payer controls functioning as designed and overpayments refunded to patients and according to commercial payer contracts, as applicable.
- Full (all payers) credit balance population monitoring.
- Overpayment refund timeliness (patients too!) tracking.
- Resolution accuracy (esp. those credit balances determined NOT to be overpayments) analysis.
- Credit balance and overpayment root cause tracking and trending.
- Escheatment and other state requirements analysis (e.g., patient refund timeframes).
AUDIT PREPARATION

Best Practices for Planning, Fieldwork, and Knowing Common Risks
# AUDIT PREPARATION

## Planning

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<th>Documentation:</th>
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<tbody>
<tr>
<td>• Policy and procedures for credit balance resolution, refunds, escheatment processes</td>
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<td>• Population of refunds issued</td>
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<td>• Current population of credit balances (i.e., Aged trial balance or worklists)</td>
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<td>• Historical population of credit balance (e.g., 180 days old, etc.)</td>
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<td>• Population of unidentified payments account</td>
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<td>• Dashboards / Monitoring Reports (including Aging)</td>
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<th>Staff Interviews and Process Walkthroughs</th>
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<td>• Management</td>
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<td>– Reporting / monitoring questions</td>
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<td>– Familiarity with state laws, if applicable</td>
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<td>– Credit balance resolution staff</td>
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<td>– Steps for identifying credit balances / issuing refunds</td>
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AUDIT PREPARATION

Fieldwork

• Data Analysis:
  – Identify aged credit balance population
  – Compare current credit balance population to prior populations
  – Credit balance worklist completeness and accuracy
  – Compare current trial balance to credit balance worklist

• Account-level testing:
  – Overpayment identification and due diligence timeliness
    – Verify due diligence review of credit balance accounts with a government payment was completed in 180 days
  – Refund timeliness and accuracy testing
    – Verify government overpayments were refunded to the correct payer
    – Verify government overpayments were refunded within 60 days of identification
  – Credit balance resolution accuracy
    – Review credit balance accounts that were determined not to be an overpayment for resolution accuracy
  – Unresolved account balance testing
Common Risks

- Unresolved credit balances with potential government overpayments worth $290,000
  - Root Cause: Current reporting did not capture aging of credit balances, and worklists were prioritized by proprietary 3\textsuperscript{rd} party software algorithms
- Government overpayments were not identified / quantified within 180 days of entering a credit balance state
  - Root Cause: Unidentified payments account was not being reviewed timely
- Credit balance worklist did not contain all accounts in a credit balance state
  - Root Cause: Accounts are populated in the worklist based on status, and the system / employees were switching the account status.
- Credit balance resolution accuracy (i.e., credit balances were determined to be over contractual adjustments when they were government overpayments)
  - Root Cause: Lack of sufficient quality assurance over credit balance resolution processes
- Government overpayments were not refunded within 60 days
  - Root Cause: Refunds were not approved or issued in a timely manner
SHOOT THE MESSENGERS: Q&A

Please feel free to contact us, if you have additional questions. Thank you again for your time!

Jarod Baccus, CHC, CHPC
Associate Director & Healthcare Internal Audit Solutions Leader

Phone: 281.513.9559
Jarod.Baccus@protiviti.com

Jarod is an Associate Director and the Healthcare Internal Audit Solutions Leader at Protiviti. Jarod has more than 13 years of internal audit and consulting experience working across multiple countries while based out of the US and UK. Jarod has spent more than 10 years working in the provider and payer segments of the healthcare industry across acute, post-acute, and physician settings. In addition, Jarod has worked with numerous healthcare clients to assess and improve their compliance, revenue cycle, operational, and financial processes.

Long Do
Legal Counsel & Director of Litigation

Phone: 415.948.7554
LDo@cmanet.org

As Legal Counsel and Director of Litigation, Long X. Do manages the California Medical Association’s activities in the courts and regulatory agencies at the state and federal levels. He works with outside counsel, physician members, and other stakeholders to plan and litigate cases that impact physician interests. Mr. Do also has substantive knowledge in the areas of managed care, health insurance, medical board enforcement, medical staff governance, corporate practice of medicine, and peer review. He has two decades of practical legal experience in civil and criminal courts.
REFERENCES

Identify and analyze your current credit balance population

- Medicare Financial Management Manual Chapter 3 – Overpayments
- Medicare Learning Network: Medicare Overpayments – October 2016 (ICN 006379)
- False Claims Act – 31 U.S. Code § 3729
- DOJ Civil Monetary Penalties Inflation Adjustment for 2017 – 82 Federal Register 22 (February 3, 2017), pp. 9131-9136
- Fraud Enforcement and Recovery Act – 123 Stat. 1617 Public Law 111-21
- Affordable Care Act – 124 Stat. 753 Public Law 111–148
- DHHS CMS Medicare Program; Final Rule for Parts A & B Provider and Suppliers – 77 Federal Register 32 (February 12, 2016), pp. 7653-7684
- DHHS CMS Medicare Program; Proposed Rule for Parts A & B Provider and Suppliers – 77 Federal Register 32 (February 16, 2012), pp. 9179-9187
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- DHHS CMS Medicare Program; Final Rule for Parts C & D Sponsors - 79 Federal Register 100 (March 23, 2014), pp. 29843-29968
- DHHS OIG Revisions to the OIG’s Civil Monetary Penalty Rules - 81 Federal Register 235 (December 7, 2016), pp. 88334-88365
- Reopening of initial determinations, redeterminations, and reconsiderations, hearings, and reviews - 42 CFR 405.980
Face the Future with Confidence