Voluntary Disclosures: 
Do I Really Need to Give This Back?

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Separating Fact From Fiction

◆ Many “expert” or “official” positions are wrong.

◆ MACs, consultants, and even lawyers are often guilty of mistakenly believing some policy or conventional wisdom is based in law.

◆ Sometimes, they’ll use interesting techniques to change behavior.
Question Authority

- Is it a requirement or a guideline?
- Medicare -- ask if it is in the statute, regulations or the Manuals.
- Get a copy of the rule in writing.
- Determine if the rule was properly promulgated.
- Just because they sound smart doesn’t mean they’re right.

An Example

- WPS, CIGNA and other MACs assert that physicians can not charge Medicare patients interest. (We can now add CMS to the list.) They cite 42 CFR 424.55 (b)(2)(ii) which says a supplier agrees:
An Example

-To collect only the difference between the Medicare approved amount and the Medicare Part B payment (for example, the amount of any reduction in incurred expenses under Sec. 410.155(c), any applicable deductible amount, and any applicable coinsurance amount) for services for which Medicare pays less than 100 percent of the approved amount."

The Flaw

-“The charge for a missed appointment is not a charge for a service itself (to which the assignment and limiting charge provisions apply), but rather is a charge for a missed business opportunity. Therefore, if a physician's or supplier's missed appointment policy applies equally to all patients (Medicare and non-Medicare), then the Medicare law and regulations do not preclude the physician or supplier from charging the Medicare patient directly.”
  – MLN MM5613
The Flaw

◆ A charge for interest is not a service.
◆ The MACs have created a policy that is inconsistent with other Medicare guidance.

Do You Need To Refund All Overpayments?

◆ The answer keeps getting clearer.
◆ If the government detects your violation and learns of your knowledge of it, you don’t need me to tell you it might get ugly.
◆ The 5th Amendment doesn’t really come into play:
  – It doesn’t apply to corporations.
  – Being overpaid isn’t a crime. (If you committed a crime, things get more interesting.).
New Provision

◆ GENERAL.—If a person has received an overpayment, the person shall—
(A) report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and
(B) notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.

The New Provision

◆ An overpayment must be reported and returned under paragraph (1) by the later of—

“(A) the date which is 60 days after the date on which the overpayment was identified; or

“(B) the date any corresponding cost report is due, if applicable.
What is an overpayment?

“(B) OVERPAYMENT.—The term “overpayment” means any funds that a person receives or retains under title XVIII or XIX to which the person, after applicable reconciliation, is not entitled under such title.”

42 U.S.C. § 1320a-7b(a) & SSA § 1128B(a)(3)

“Whoever . . . having knowledge of . . . any event affecting his initial or continued right to any [benefit or payment under any federal health care program] . . . and conceals or fails to disclose such event with an intent to fraudulently secure [the] benefit or payment . . . shall be guilty of a felony, and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both.”
Key Issues

- Statute refers to “individuals” rather than “persons” as defined in 42 U.S.C. § 1301(a)(3) & (4). This means it may not apply to corporations.
- What is an “initial or continued right to a benefit?”
- What is “knowledge”?
- Is an overpayment “fraudulently secured?”

18 U.S.C. § 641

- Whoever embezzles, steals, purloins, or knowingly converts to his use or the use of another, or without authority, sells, conveys, or disposes of any record, voucher, money or thing of value of the United States or any department or agency thereof, or any property made or being made under contract for the United States or any department or agency thereof;
18 U.S.C. § 641

- Whoever receives, conceals, or retains the same with intent to convert it to his use or gain, knowing it to have been embezzled, stolen, purloined or converted shall be fined under this title or imprisoned not more than 10 years or both; but if the value of such property does not exceed the sum of $100, he shall be fined under this title or imprisoned not more than one year or both.

False Statements Involving a Health Care Benefit, 18 U.S.C. § 1035(a)

(a) Whoever, in any matter involving a health care benefit program, knowingly and willfully -

(1) falsifies, conceals or covers up by any trick, scheme, or device a material fact; or
False Statements Involving a Health Care Benefit, 18 U.S.C. § 1035(a)

(2) makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than five years, or both.

The Bottom Line

- Common sense can carry you a long way.
- The key question is whether you have been overpaid.
- My central premise: If you have done the work, an overpayment exists only if there is a crystal-clear regulation or statute that says an overpayment exists.
Scenario 1

◆ Your internal reviewers are examining the E&M coding for physicians. Here is what they find:

Audit Results

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“If it isn’t written, it wasn’t done.”

♦ Good advice, but not the law.

♦ Medicare payment is determined by the content of the service, not the content of the medical record.

♦ The documentation guidelines are just that: guidelines (although the carrier won’t believe that).

Role of Documentation: The Law

“No payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period.”

*Social Security Act §1833(e)*
Role of Documentation: The Cases

◆ Carriers also often cite Anesthesiologists Affiliated v. Sullivan, 941 F.2d 678 (8th Cir. 1991).

◆ Court rejected the defendant’s argument that even if the clinic made billing errors they were “merely a matter of unartful description of the services it provided.”

Role of Documentation: The Cases

◆ Distinguishable from E&M cases because the anesthesiologists’ defense was even if they did not provide services as claimed, they provided other reimbursable services.

◆ The bill did not accurately describe the work done.

◆ In most E&M cases, the bill describes the work done, there is simply a lack of documentation.
Role of Documentation: Guidance from CMS

- The CPT Assistant explains: “it is important to note that these are Guidelines, not a law or rule. Physicians need not modify their record keeping practices at all.”

  *CPT Assistant Vol. 5, Issue 1, Winter 1995*

- CMS has publicly stated that physicians are not required to use the Documentation Guidelines.

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Audit Review Results - What Do They Mean?

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If You Distribute Chart Reviews….

Include a disclaimer like “our chart reviews are not audits designed to determine whether we have been overpaid or underpaid. First, they are not a statistically valid sample. Moreover, they only review the documentation, without attempting to determine the amount of work you actually performed. Therefore, these figures are far from scientific.
If You Distribute Chart Reviews....

However, since a Medicare review would base the initial overpayment determination solely on the documentation, these figures give you some idea of how your charts would fare in the first phase of a Medicare review.”

What Do You Do?

- Determine if the service was provided as billed (underdocumented) or coded at a level higher than billed (overcoded.)
- If underdocumented, educate.
- If overcoded, crack out the checkbook.
Scenario 2: Concurrent Surgeries

- At a teaching hospital, a surgeon is working with residents on 3 cases. One of the cases is being opened, one is being closed, and the third is in a key portion. The teaching physician was in the 3rd case. Someone cites Manual language and claims fraud has been committed.

Medicare Claims Processing Manual
§100.1.2 - Surgical Procedures

2. Two Overlapping Surgeries

In order to bill Medicare for two overlapping surgeries, the teaching surgeon must be present during the critical or key portions of both operations. Therefore, the critical or key portions may not take place at the same time. When all of the key portions of the initial procedure have been completed, the teaching surgeon may begin to become involved in a second procedure. The teaching surgeon must personally document in the medical record that he/she was physically present during the
critical or key portion(s) of both procedures. When a teaching physician is not present during non-critical or non-key portions of the procedure and is participating in another surgical procedure, he/she must arrange for another qualified surgeon to immediately assist the resident in the other case should the need arise. In the case of three concurrent surgical procedures, the role of the teaching surgeon (but not anesthesiologist) in each of the cases is classified as a supervisory service to the hospital rather than a physician service to an individual patient and is not payable under the physician fee schedule.

A. Surgery (Including Endoscopic Operations)

The teaching surgeon is responsible for the preoperative, operative, and postoperative care of the beneficiary. The teaching physician's presence is not required during the opening and closing of the surgical field unless these activities are considered to be critical or key portions of the procedure. The teaching surgeon determines which postoperative visits are considered key or critical and require his or her presence...
Manuals Are NOT a Basis
For an Overpayment

- “Thus, if government manuals go counter to
governing statutes and regulations of the highest or
higher dignity, a person ‘relies on them at his peril.’
Government Brief in Saint Mary’s Hospital v. Leavitt.

- “[The Manual] embodies a policy that itself is not
even binding in agency adjudications…. Manual
provisions concerning investigational devices also ‘do
not have the force and effect of law and are not
accorded that weight in the adjudicatory process.’ ”
Gov’t brief in Cedars-Sinai Medical Center v. Shalala

42 CFR §415.172

(a) **General rule** If a resident participates in a
service furnished in a teaching setting,
physician fee schedule payment is made only
if a teaching physician is present during the
key portion of any service or procedure for
which payment is sought.

(1) In the case of surgical, high-risk, or other
complex procedures, the teaching physician
must be present during all critical portions of
the procedure and immediately available to
furnish services during the entire service or
procedure.
42 CFR §415.172

(i) In the case of surgery, the teaching physician's presence is not required during opening and closing of the surgical field.

(ii) In the case of procedures performed through an endoscope, the teaching physician must be present during the entire viewing.

Medicare Claims Processing Manual
§100.1.2 - Surgical Procedures

A. Surgery (Including Endoscopic Operations)

The teaching surgeon is responsible for the preoperative, operative, and postoperative care of the beneficiary. The teaching physician's presence is not required during the opening and closing of the surgical field unless these activities are considered to be critical or key portions of the procedure. The teaching surgeon determines which postoperative visits are considered key or critical and require his or her presence....
What Do You Do?

◆ If the service was consistent with the regulations, I would not consider it an overpayment.
◆ Absent an overpayment, disclosure seems unnecessary.

Scenario 3: Conditions of Participation

◆ A hospital discovers many unsigned medical records, a violation of the conditions of participation. Must they refund all of the services?
42 CFR § 488.18 & 488.24

If a supplier does not meet a condition for coverage, the state agency may:
- find that the supplier is in compliance, but with deficiencies not adversely affecting patient health safety; or
- If deficiencies “are of such character as to substantially limit the provider’s or supplier’s capacity to furnish adequate care or which adversely affect the health and safety of patients” conclude that the supplier is out of compliance.

Program Integrity Manual
§3.1 - Introduction

 Contractors must analyze provider compliance with Medicare coverage and coding rules and take appropriate corrective action when providers are found to be non-compliant. MR staff should not expend resources analyzing provider compliance with other Medicare rules (such as claims
processing rules, conditions of participation, etc.). If during a review it is determined that a provider does not comply with conditions of participation, do not deny payment solely for this reason. Refer to the applicable state survey agency. The overall goal of taking administrative action should be to correct the behavior in need of change, to collect overpayments once identified, and deny payment when payment should not be made. For repeated infractions, or infractions showing potential fraud or pattern of abuse, more severe administrative action should be initiated. In every instance, the contractor's priority is to minimize the potential or actual loss to the Medicare Trust Funds while using resources efficiently and treating providers and beneficiaries fairly.
Key Points

- Regulations and Manual provisions contemplate that providers/suppliers will be paid through (and in some cases after) the date of termination. State Operations Manual, Ch, 3, §§ 3008-3008.1.
- There is no instruction for CMS to attempt to recoup payments made when a supplier was not in compliance with a condition for coverage.

What Do You Do?

- I wouldn’t consider a violation of a condition of participation as creating an overpayment.
Scenario 4: Short Stays

- A hospital discovers that a number of patients spent the night, but were in the hospital less than 24 hours. Compliance staff begin to investigate the medical necessity of the admissions, and ask whether a stay of less than 24 hours can be considered “inpatient.”

Who is an Inpatient?

Medicare Benefit Policy Manual (CMS Pub. 100-02) §10 - Covered Inpatient Hospital Services Covered Under Part A

- An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.
Who is an Inpatient?

-The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. **Physicians should use a 24-hour period as a benchmark, i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis. However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors,**

- including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting. Factors to be considered when making the decision to admit include such things as:

  - The severity of the signs and symptoms exhibited by the patient;
  - The medical predictability of something adverse happening to the patient;
Who is an Inpatient?

The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and

The availability of diagnostic procedures at the time when and at the location where the patient presents.

Who is an Inpatient?

Admissions of particular patients are not covered or noncovered solely on the basis of the length of time the patient actually spends in the hospital. In certain specific situations coverage of services on an inpatient or outpatient basis is determined by the following rules:

**Minor Surgery or Other Treatment** - When patients with known diagnoses enter a hospital for a specific minor surgical procedure or other treatment that is expected to keep them in the hospital for only a few hours (less than 24), they are considered **outpatients** for coverage purposes regardless of: the hour they came to the hospital, whether they used a bed, and whether they remained in the hospital past midnight.
What Do You Do?

◆ The absence of a clear standard leaves a great deal of discretion with the hospital.
◆ Determine if the physicians chose inpatient care knowingly or out of habit.
◆ This is a tough one.

How Far Back Do You Go?

◆ The False Claims Act’s statute of limitations is:
  – Six years; or
  – Three years from the date when “facts material to the right of action are known are reasonably should have been known” by the United States, but no more than ten years after the violation.
How Far Back Do You Go?

◆ Most billing errors are not false claims.
◆ The law requires the government to waive overpayments when the provider/supplier is “without fault” and recovery violates equity and good conscience.

The New Provision

◆ Doesn’t have a time limitation.
◆ BUT it only applies to funds to which you are not entitled.
◆ If the time limits for recovery have passed, by statute or policy you are entitled to the money.
How Far Back Do you Go?

- Manuals indicate that claims may only be reopened after 48 months when there is evidence of “fraud or similar fault.”
- “Fraud or similar fault” requires some intentional wrongdoing.

Fraud or Similar Fault

- Deception by a person who knows that the deception may result in authorized benefits to someone;
- An act which approximates fraud, i.e., the furnishing of information which the individual knows is incorrect or incomplete, or the deliberate concealment of information, with or without a judicial finding of fraud;
Fraud or Similar Fault

- Deception by a person who knows that the deception may result in authorized benefits to someone;
- An act which approximates fraud, i.e., the furnishing of information which the individual knows is incorrect or incomplete, or the deliberate concealment of information, with or without a judicial finding of fraud;
- A pattern of program abuse by physicians or suppliers resulting from practices that are inconsistent with accepted sound fiscal, business, or medical practice, such as:

Fraud or Similar Fault

- The furnishing of services that are in excess of the individual's needs, or of a quality that does not meet professionally recognized standards of health care; or
- The submittal of incorrect, incomplete or misleading information that results in payment for services:
  - that were not furnished;
  - more expensive than those furnished; or
  - that were not furnished under the conditions indicated on the bill.
Fraud or Similar Fault

– The submittal of, or causing the submittal of, bills or requests for payment containing charges for Medicare patients that are substantially in excess of the amounts the physician or supplier customarily charges; or
– An act or pattern of program abuse involving collusion between the supplier and the recipient that results in higher costs or charges to the Medicare program; or

◆ Any act that constitutes fraud under Federal or State law.

A Determination that ‘Fraud or Similar Fault’ is present depends on the facts. For example, a claim may be reopened more than 4 years after payment was approved, if the evidence establishes a pattern of billing by a physician for weekly routine visits to patients in a nursing home for whom, under established standards of good medical practice, not more than one visit a month is medically reasonable and necessary.
How far back do you go?

- The bottom line: unless you are guilty of fraud or similar fault, 48 months is a reasonable period to use.

RAC Limits

- RACs (Recovery Audit Contractors) may only recover money three fiscal years before the year they assert the overpayment.
- Fiscal years start 10/1.
- They can only go back to October 1, 2007.