

Health Care Compliance Association
2013 Annual Meeting

**Creative Arguments to Avoid/Defend
Overpayments**

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Overpayments - History

❖ Old Order:

➤ Action = Liability

❖ New Order:

➤ Inaction = Liability

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Evolution of Overpayment Liability

- ❖ Medicare criminal overpayment statute
- ❖ Requires knowledge of overpayment upon receipt and affirmative concealment
- ❖ Criminal charges against health care executives in late 90's
- ❖ Health care industry response and compliance program effect
- ❖ Compliance Program Guidance and Corporate Integrity Agreements

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Pre-2009: False Claims Act (FCA) – “Reverse False Claims”

- ❖ Overpayment an FCA violation only if defendant:
 1. Used a “false record” or “statement”
 2. To conceal, avoid, or decrease an obligation to pay money to the government.

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F E R A

❖ FCA liability for:

1. “knowingly concealing,” or
2. “knowingly and improperly avoiding or decreasing,”
3. “an obligation to pay” funds owed the government.

Arguably:

Still required some affirmative act.

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A C A

- ❖ Makes reporting and repaying any overpayment an “obligation” under the FCA. (31 USC § 3729(b)(3))
- ❖ Failure to report and return an overpayment within the deadline may result in FCA liability.

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Overpayments Under the ACA – Key Steps

- ❖ Define
- ❖ Investigate
- ❖ Identify
- ❖ Report
- ❖ Refund

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1. Define

❖ Overpayment:

Section 1128J(d) of the Act provides that an overpayment means “* * * any funds that a person receives or retains under Title XVIII * * * to which the person, after applicable reconciliation, is not entitled under such title.”

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1. Define - Examples

❖ Examples of Overpayments:

- Medicare payments for noncovered services.
- Medicare payments in excess of the allowable amount for an identified covered service.
- Errors and nonreimbursable expenditures in cost reports.
- Duplicate payments.
- Receipt of Medicare payment when another payor had the primary responsibility for payments.

42 CFR Part 401
Federal Register, Vol. 77, No. 32
Feb. 16, 2012

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2. Investigate

- ### ❖ A person has identified an overpayment if the person
- has actual knowledge of the existence of the overpayment or
 - acts in reckless disregard or deliberate ignorance of the existence of the overpayment.

Proposed CFR 401.305
(emphasis added)

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2. Investigate – Due Diligence

CMS:

“We believe defining ‘identification’ gives providers and suppliers an incentive to exercise reasonable diligence to determine whether an overpayment exists.

Without such a definition, some providers and suppliers might avoid performing activities to determine whether an overpayment exists, such as self-audits, compliance checks, and other additional research.

Federal Register, Vol. 77, No. 32
Feb. 16, 2012

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2. Duty to Investigate – Due Diligence

- ❖ Some providers might avoid performing investigation and research to determine whether an overpayment exists.
- ❖ In some cases, a provider or supplier may receive information concerning a potential overpayment that creates an obligation to make a reasonable inquiry to determine whether an overpayment exists.
- ❖ If the reasonable inquiry reveals an overpayment, the provider then has 60 days to report and return the overpayment.
- ❖ On the other hand, failure to make a reasonable inquiry, including failure to conduct such inquiry with all deliberate speed after obtaining the information, could result in the provider knowingly retaining an overpayment because it acted in reckless disregard or deliberate ignorance of whether it received such an overpayment.

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2. Investigate – Confusion

When is it over?

- Affirmative Duty to “Investigate”?
- Perpetual Duty to “Investigate”?

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2. Investigate – Example

CMS:

“ . . . a provider that receives an anonymous compliance hotline telephone complaint about a potential overpayment has incurred an obligation to timely investigate that matter. If . . . the provider fails to make any reasonable inquiry into the complaint, the provider may be found to have acted in reckless disregard or deliberate ignorance of any overpayment.”

Federal Register, Vol. 77, No. 32

Feb. 16, 2012

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3. Identify – Examples

CMS:

- ❖ A Provider or Supplier:
 - Reviews billing or payment records and learns that it incorrectly coded certain services, resulting in increased reimbursement.
 - Learns that a patient death occurred prior to the service date on a claim that has been submitted for payment.
 - Learns that services were provided by an unlicensed or excluded individual on its behalf.

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3. Identify – Examples (cont'd.)

- Performs an internal audit and discovers that overpayments exist.
- Is informed by a government agency of an audit that discovered a potential overpayment, and the provider or supplier fails to make a reasonable inquiry.
- Experiences a significant increase in Medicare revenue and there is no apparent reason – such as a new partner added to a group practice or a new focus on a particular area of medicine – for the increase.

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4. Report

- ❖ Section 1128J of the Act provides that if a person has received an overpayment, the person shall
 - i. “report . . . the overpayment to the Secretary . . . an intermediary, a carrier, or a contractor . . . ; and
 - ii. notify the Secretary . . . intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.”
(*More on this later.*)

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4. Report - Deadline

- b) “*Deadline for reporting and returning overpayments.* (1) A person with an identified overpayment must report and return the overpayment by the later of either of the following:
 - i. The date which is 60 days after the date on which the overpayment was identified.
 - ii. The date any corresponding cost report is due, if applicable. (*More on this later.*)

Proposed CFR 401.305

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4. Report – Explanations

- ❖ Examples of what a person may report as the reason for the overpayment include the following:
 1. Incorrect service date;
 2. Duplicate payment;
 3. Incorrect CPT code;
 4. Insufficient documentation; and
 5. Lack of medical necessity.

Federal Register, Vol. 77, No. 32

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5. Refund

- ❖ Section 1128J of the Act provides that if a person has received an overpayment, the person shall
 - i. “. . . Return the overpayment to the Secretary . . . an intermediary, a carrier, or a contractor . . .’



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5. Refund

- ❖ The deadline for return overpayments will be suspended when:
 - OIG acknowledges receipt of a submission to the OIG Self-Disclosure Protocol until such time as a settlement agreement is entered; or
 - The person withdraws from the OIG Self-Disclosure Protocol, or the person is removed from the OIG Self-Disclosure Protocol.

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5. Refund

- ❖ No corresponding provision for suspension related to CMS Self-Referral Disclosure Protocol (SRDP).

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5. Refund

- ❖ Proposed Rule states that providers and suppliers must both:
 - Comply with existing voluntary refund process, Chapter 4 of the Medicare Financial Management Manual; and
 - Utilize overpayment forms issued by the local contractors, such as fiscal intermediaries, durable medical equipment Medicare administrative contractors (DME MACs), and Medicare Part A and Part B administrative contractors (A/B MACs).

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5. Refund

- ❖ Proposed Rule: overpayments must be reported and returned if a person identifies the overpayment within 10 years of the date the overpayment was received.
- ❖ 10 year period was chosen because this is the outer limit of the FCA's statute of limitations. (*More on this later.*)

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Affordable Care Act Requires Clarification

- ❖ What does “identify” mean? (The House bill required reporting if you “know of an overpayment.”)
- ❖ When does 60 day clock begin to run?
- ❖ What if the provider cannot quantify the amount within 60 days?
- ❖ What does “after applicable reconciliation” mean?
- ❖ How does the cost report deadline apply?

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Affordable Care Act Requires Clarification (cont'd.)

- ❖ What information should be included in the report of the overpayment?
- ❖ How should providers report and return overpayments?
- ❖ What is the overlap with other existing reporting mechanisms?
- ❖ How does this statute relate to the reimbursement appeals process already in place?

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**Center for Medicare and Medicaid Services
Publishes Proposed Rule with Comment Period
Ending April 16, 2012**

❖ Application

- The preamble notes that the rule is proposing to implement the provisions of Section 1128(j)(d) of the Act only as they relate to Medicare Part A and Part B providers and suppliers
- The preamble does note that other stakeholders, including MAOs, PDPs and Medicaid MCOs, will be addressed at a later date.
- Furthermore, CMS cautions all stakeholders about the current statutory requirements under the Affordable Care Act and potential False Claims Act liability, Civil Money Penalty Law liability, and exclusion from Federal health care programs for the failure to report and return an overpayment.

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10 Year Lookback Period (cont'd.)

The Proposed Rule in effect amends the established Medicare claims reopening rules:

42 CFR § 405.980(b): a contractor is currently limited to a one year reopening period (one year from the date of the initial determination or redetermination) for “any reason” and a four year reopening period (four years from the date of the initial determination or redetermination) for “good cause” (as defined in 42 CFR § 405.986).

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10 Year Lookback Period (cont'd.)

Reopening is only permitted “at any time” (including beyond four years) “if there exists reliable evidence as defined in § 405.902 that the initial determination was procured by fraud or similar fault...”

- Expansion of reopening rules not required by Affordable Care Act
- CMS wants “to ensure that [it’s] reopening regulations are consistent with the look-back period...”

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10 Year Lookback Period (cont'd.)

Certain Open Questions:

- ✓ Routine errors vs. intentional fraud
- ✓ Underpayments
- ✓ Cost reporting (reopening is 3 years from final determination)
- ✓ Internal audits
- ✓ Accessing information and documentation retention
- ✓ Retroactive application

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10 Year Lookback Period (cont'd.)

- ❖ “For purposes of this section only, we estimate that approximately 125,000 providers and suppliers (or roughly 8.5 percent of the total number of Medicare providers and suppliers) would report and return overpayments in a typical year under our proposed provisions. In addition, we project that each of these providers and suppliers would, on average, separately report and return approximately 3 to 5 overpayments. We also estimate that it would take a provider or supplier approximately 2.5 hours to complete the applicable reporting form and return any overpayments. Lastly, the two main categories of individuals believed to complete and submit the form include: (1) accountants and auditors (external and in-house); and (2) miscellaneous in-house administrative personnel.”

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Cost Reports

- ❖ If an overpayment is claims related, the provider or supplier would be required to report and return the overpayment within 60 days of identification.
- ❖ However, for those providers that submit cost reports, if the overpayment is such that it would generally be reconciled on the cost report by the provider, the provider would be permitted to report and return the overpayment either 60 days from the identification of the overpayment or on the date the cost report is due, whichever is later.

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Cost Reports (cont'd.)

❖ Example

- For example, issues involving upcoding must be reported and returned within 60 days of identification because the upcoded claims for payment are not submitted to Medicare in the form of cost reports.
- However, for an overpayment that would generally be reconciled on the cost report, such as overpayments related to graduate medical education payments, the provider must report and return the overpayment either 60 days after it has been identified or on the date the cost report is due, whichever is later.

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“Applicable Reconciliation”

❖ Applicable reconciliation

1. The applicable reconciliation occurs when a cost report is filed; and
2. In instances when the provider –
 - i. Receives more recent CMS information on the SSI ratio, the provider is not required to return any overpayment resulting from the updated information until the final reconciliation of the provider’s cost report occurs; or
 - ii. Knows that an outlier reconciliation will be performed, the provider is not required to estimate the change in reimbursement and return the estimated overpayment until the final reconciliation of that cost report

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How to Report and Process

❖ Overpayment Refund Process

As previously noted, under the Affordable Care Act, providers and suppliers must “report and return the overpayment to... an intermediary, a carrier, or a contractor as appropriate...”

- ❖ The proposed Rule proposes that provider and suppliers use the existing voluntary refund process...

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How to Report and Process (cont'd.)

- ❖ More specifically, the Proposed Rule states that providers and suppliers must both:
 - Comply with the existing voluntary refund process outlined in Chapter 4 of the Medicare Financial Management Manual; and
 - Utilize overpayment forms issued by the local contractors, such as fiscal intermediaries, durable medical equipment Medicare administrative contractors (DME MACs), and Medicare Part A and Part B administrative contractors (A/B MACs).

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How to Report and Process (cont'd.)

The process outlined in the Medicare Financial Management Manual will be renamed the "Self-Reported Overpayment Process".

"[We] recognize that the reporting forms my differ among the different Medicare contractors and plan to develop a uniform reporting form that will enable all overpayments to be reported and returned in a consistent manner across all Medicare contractors. Until such uniform reporting form is made available, providers and suppliers should utilize the existing form available from the website of the applicable Medicare contractor..."

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How to Report and Process (cont'd.)

- ❖ The overpayment report must include the following information
 1. Person's name
 2. Person's tax identification number
 3. How the error was discovered
 4. The reason for the overpayment
 5. The health insurance claim number, as appropriate
 6. Date of service
 7. Medicare claim control number, as appropriate

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How to Report and Process (cont'd.)

8. Medicare National Provider Identification (NPI) number
9. Description of the corrective action plan to ensure the error does not occur again
10. Whether the person has a CIA with the OIG or is under the OIG Self-Disclosure Protocol
11. The timeframe and the total amount of refund for the period during which the problem existed that caused the refund

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5. Refund – Comments to Proposed Rule

- ❖ AHA, AMA, ABA, Health Care Providers
- ❖ Key Comments
 - Treating overpayment as a fraud and abuse and False Claims Act issue
 - Time of “identification” of overpayment
 - 10 year look-back period – inconsistent with current rules
 - Materiality standard.

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Comments to Proposed Rule (cont'd.)

- ❖ Perpetual duty to identify overpayments – no obligation to proactively search for overpayments and mere statistical possibility that overpayment exists does not constitute the identification of the overpayment nor should it create a duty of inquiry.
- ❖ Appeal of overpayments.

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Applicable Reconciliation and Relation to Current Administrative Claims Process

- ❖ Hospital timely filing adjustments within 12 months after date of service
- ❖ Credit balance reports and adjustments
- ❖ Cost Report reconciliation process
- ❖ MAC and RAC reviews or claims subject to other government reviews

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Proposed Rule General Deficiencies

- ❖ Drafters disconnected from organization compliance program realities
- ❖ Proposed Rule conflates FCA fraud liability with simple overpayment liability

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Do You Have an Overpayment?

- ❖ “Any funds that a person receives or retains under [Medicare or Medicaid] to which the person, after applicable reconciliation, is not entitled...”
- ❖ Many things are NOT overpayments.
 - Poor documentation (More soon).
 - Violations of COP.
 - Reassignment problems.
 - You are “without fault.”

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Can You “Blame” Someone Else?

- ❖ Hospitals with an independent medical staff may try the “without fault” defense.
- ❖ Any service dependent on physician orders (lab/ambulance/PT) should consider using it.
- ❖ Outside consultant’s advice?

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SSA §1870

- ❖ There shall be no adjustment as provided in subsection (b) (nor shall there be recovery) in any case where the incorrect payment has been made (including payments under section 1814(e)) with respect to an individual who is without fault or where the adjustment (or recovery) would be made by decreasing payments to which another person who is without fault is entitled as provided in subsection (b)(4), if such adjustment (or recovery) would defeat the purposes of Title II or title XVIII or would be against equity and good conscience. Adjustment or recovery of an incorrect payment (or only such part of an incorrect payment as the Secretary determines to

SSA §1870

be inconsistent with the purposes of this title) against an individual who is without fault shall be deemed to be against equity and good conscience if (A) the incorrect payment was made for expenses incurred for items or services for which payment may not be made under this title by reason of the provisions of paragraph (1) or (9) of section 1862(a) and (B) if the Secretary's determination that such payment was incorrect was made subsequent to the ~~third~~ fifth year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such ~~three~~ five year period to not less than one year if he finds such reduction is consistent with the objectives of this title. (some citations omitted)

Scenario 1: E&M

- ❖ An internal documentation review finds....

Audit Results

| | Under-coded | Correctly-coded | Over-coded |
|-------|-------------|-----------------|------------|
| Dr. A | 13% | 76% | 11% |
| Dr. B | 50 | 30 | 20 |
| Dr. C | 15 | 50 | 35 |
| Dr. D | 0 | 19 | 81 |
| Dr. E | 33 | 33 | 33 |

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What is the Relevant Law?

- ❖ “If it isn’t written, it wasn’t done,” right?
- ❖ 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 Medicare contractor won’t believe that).

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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)

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Role of Documentation: Guidance from CPT and 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

- ❖ Then HCFA, now CMS publicly stated that physicians are not required to use the Documentation Guidelines.

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Role of Documentation: Guidance from CMS/HCFA

“Documentation Guidelines for Evaluation and Management Services Questions and Answers

These questions and answers have been jointly developed by the Health Care Financing Administration (CMS/HCFA) and the American Medical Association (AMA) March 1995.

1. Are these guidelines required?

No. Physicians are not required to use these guidelines in documenting their services.

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Guidance from CMS/HCFA

However, it is important to note that all physicians are potentially subject to post payment review. In the event of a review, Medicare carriers will be using these guidelines in helping them to determine/verify that the reported services were actually rendered. Physicians may find the format of the new guidelines convenient to follow and consistent with their current medical record keeping. Their usage will help facilitate communication with the carrier about the services provided, if that becomes necessary. Varying formats of documentation (e.g. SOAP notes) will be accepted by the Medicare carrier, as long as the basic information is discernible.”

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Guidance from CMS/HCFA

6. How will the guidelines be utilized if I am reviewed by the carrier?

If an evaluation and management review is indicated, Carriers will request medical records for specific patients and encounters. The documentation guidelines will be used as a template for that review. If the documentation is not sufficient to support the level of service provided, the Carrier will contact the physician for additional information."

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Audit Results

| | Under-coded | Correctly-coded | Over-coded |
|-------|-------------|-----------------|------------|
| Dr. A | 13% | 76% | 11% |
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| Dr. C | 15 | 50 | 35 |
| Dr. D | 0 | 19 | 81 |
| Dr. E | 33 | 33 | 33 |

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Audit Review Results What Do They Mean?

| | Documentation Exceeds Code Under coded | Documentation Supports Code Correctly coded | Documentation Does Not Support Code Over coded |
|-------|----------------------------------------------|---------------------------------------------------|--------------------------------------------------------------------|
| Dr. A | 13% | 76% | 11% |
| Dr. B | 50 | 30 | 20 |
| Dr. C | 15 | 50 | 35 |
| Dr. D | 0 | 19 | 81 |
| Dr. E | 33 | 33 | 33 |

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How Do We Figure Out If the Service Was Done?

- ❖ Ask.
 - The physicians.
 - Others (nurses, receptionists).
 - Secret shopper/shadowing.
- ❖ Schedules/time based billing.
- ❖ Patient complaints.
- ❖ Production data.

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Our Facts:

- ❖ Physician D is a very hard worker, is at the 75th percentile for RVUs.
- ❖ Physician C is a hard worker, is at twice the 90th percentile for RVUs.

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Preliminary Conclusions

- ❖ Dr. D is ok. Educate, don't refund.
- ❖ Dr. C: Need more development. Begin interviews, etc.
- ❖ If you conclude the work wasn't done, how do you calculate the amount?
 - Sample?
 - Calculation?

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Scenario 2: Marked Up Reads

- ❖ You discover that radiologic reads performed offsite have been marked up. CMS regulations indicate that interpretations are subject to the antimarkup rule if done offsite unless it is by someone who “shares a practice” with the ordering physician.

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The Antimarkup Statute 1842(n)

If a physician's bill or a request for payment for services billed by a physician includes a charge for a diagnostic test described in section 1861(s)(3) (other than a clinical diagnostic laboratory test) for which the bill or request for payment does not indicate that the billing physician personally performed or supervised the performance of the test or that another physician with whom the physician who shares a practice personally performed or supervised the performance of the test, the amount payable with respect to the test shall be determined as follows:.....

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Interpretations are NOT Diagnostic Tests under 1861(s)(3)

❖ Medical and Other Health Services

(s) The term “medical and other health services” means any of the following items or services:

(1) physicians' services;

(2)(A) services and supplies (including drugs and biologicals which are not usually self-administered by the patient) furnished as an incident to a physician's professional service.....;

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Interpretations are NOT Diagnostic Tests under 1861(s)(3)

(3) diagnostic X-ray tests (including tests under the supervision of a physician, furnished in a place of residence used as the patient's home, if the performance of such tests meets such conditions relating to health and safety as the Secretary may find necessary and including diagnostic mammography if conducted by a facility that has a certificate (or provisional certificate) issued under section 354 of the Public Health Service Act, diagnostic laboratory tests, and other diagnostic tests;

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CMS Claims Authority

“Further, we see no reason to distinguish between the TC and the PC of the diagnostic tests for purposes of the anti-markup provisions. Although the Congress did not establish an anti-markup provision in Section 1842(n)(1) of the Act or elsewhere for the PC of diagnostic tests, the omission may have been inadvertent. That is, it is not immediately clear why the Congress, if it wished to prevent overutilization of diagnostic testing, would not have desired an

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CMS Claims Authority

anti-markup on the PC, because without such provision, the incentive to order unnecessary tests (in profit on the PC) remains. We believe that, in order to fully effectuate Congress’ intent to prevent or limit the ordering of unnecessary diagnostic tests, it is necessary to impose an anti-markup provision on the PC of diagnostic tests.”

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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?

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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

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Program Integrity Manual

§3.1 - Introduction

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

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Program Integrity Manual

§3.1 - Introduction

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.

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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.
- ❖ There is a compelling argument violations of the COP are not an overpayment.

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Scenario 4: 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.

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Scenario 5: 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.”

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Legal Analysis: 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.

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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,**

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Who is an Inpatient?

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;

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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.

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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.

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How Far Back Do You Go?

- ❖ False Claims Act says 6 years, or up to 10 if the government was not aware of a situation, BUT....
- ❖ 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.

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How Far Back Do You Go?

- ❖ If the denial based on medical necessity statute presumes “without fault” 5 years after the year in which payment was made.
- ❖ Service 12/20/12. Paid 2/1/13. Can recover until 12/31/18. Note: if paid 12/31/03, can recover until 12/31/17.

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

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The Refund Letter

- ❖ Do you ever send a “placeholder” letter?
- ❖ Who is it from?
- ❖ Who is it to?

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Should I Use the OIG Self-Disclosure Protocol?

- ❖ Take the government at its word: distinguish between “fraudulent” (intentionally or recklessly false) and innocent “erroneous” claims.
- ❖ The Compliance Program Guidance recognizes physicians make “honest mistakes” and these should be refunded without penalty.
- ❖ If someone wasn’t trying to take advantage of the system, I wouldn’t label the conduct as fraudulent.

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The Refund Letter

- ❖ Do you ever send a “placeholder” letter?
- ❖ Who is it from?
- ❖ Who is it to?
- ❖ How much detail do you provide?
- ❖ What about small issues where cost of investigation exceeds overpayment?
- ❖ What don’t you say?

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Dr. C's Letter

- ❖ We **recently** discovered that one of our physicians **was committing billing fraud**. She was **not documenting services properly**. We inadvertently billed for these services. We did a **statistically valid sample**. We **have corrected the problem**.

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The Refund Letter

- ❖ "As part of our ongoing compliance process."
- ❖ "More appropriate" is a great phrase.
- ❖ "Possible issues."
- ❖ Reserve the right to recant.
- ❖ "Level we are confident defending..."
- ❖ Beware of "our attorney has told us . . ."
- ❖ "Refund" vs. "overpayment."
- ❖ "Steps to improve..."

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Should I Ever Ask the Payor?

- ❖ Tough call. If you do:
 - Disclose all relevant facts.
 - Get it (or, better yet, give it) in writing. (Send it certified.)
 - Don't incriminate yourself.

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What Do You Do With Copayments?

- ❖ Law is less clear.
- ❖ Size matters. (Would you bill the patient if they owed you the same amount?)
- ❖ State law.

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Do You Rebill or Refund?

- ❖ Rebilling generates timely filing issues.
- ❖ Refunding leaves bad claims data in the insurer's system.
- ❖ For private payors, beware of your contract.
- ❖ Refund is the way to go.

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How Do Refunds Affect RACs?

- ❖ If you have sampled, no one claim has been "refunded."
- ❖ This will be something to watch.
- ❖ Note this is an issue even if the audit is on a different problem.
- ❖ In any overpayment situation, always look at prior refunds/audits on the same issue.
- ❖ (Note tie in to rebill/refund issue!)

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What About Private Payors?

- ❖ Contract (and manual??) control.
- ❖ Refund requirement is govt. only, but “health fraud” is a federal crime.
- ❖ State statute of limitations apply.
- ❖ State insurance law.
- ❖ Is Medicare Advantage a private payor?

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Questions?

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