

**HCCA Compliance Institute**  
**April 19, 2015**

**Exploring CMS's Proposed Rule on Reporting  
and Refunding Overpayments**

**Gary W. Eiland, Partner**  
**King & Spalding LLP**  
**Houston, Texas**

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**Background on Government Approach to  
Overpayments**

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**Legal Obligations to Disclose and Refund**

- There is a long history of debate between the provider and supplier communities and the government regarding the duty to refund overpayments and the methods to accomplish such refunds.
- PPACA creates an express “report, notify, and return” requirement for all Medicare and Medicaid overpayments.

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### Potential Criminal Liability

- 42 U.S.C. §1320a-7b(a)(3). Criminal penalties for acts involving federal health care programs
  - (a) Making or Causing to be Made False Statements or Representations-whoever—
  - (3) 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
- Linked to exclusion statute at 42 U.S.C. §1320a-7(a)

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### 1998 OIG Compliance Program Guidance for Hospitals

- Responding to Detected Offenses and Developing Corrective Action Initiatives
  - “The hospital should take appropriate corrective action, including prompt identification and restitution of any overpayment to the affected payor and the imposition of proper disciplinary action. Failure to repay overpayments *within a reasonable period of time* could be interpreted as an intentional attempt to conceal the overpayment from the Government, *thereby establishing an independent basis for a criminal violation* with respect to the hospital, as well as any individuals who may have been involved.”
  - “The OIG Provider Self-disclosure Protocol suggests that after discovery of credible evidence of misconduct from any source and, after a reasonable inquiry, [the hospital] has reason to believe that the misconduct may violate...law, then the hospital promptly should report the existence of misconduct to the appropriate governmental authority within a reasonable period, but not more than sixty (60) days after determining that there is credible evidence of a violation.”
  - Is there a difference between “determining” and “identified?”

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### Additional OIG Compliance Program Guidance

- OIG Compliance Program Guidance (CPG) for various industry segments has provided that overpayments should be “returned promptly” to the affected payor.
  - 1998 Home Health CPG
  - 1999 Durable Medical Equipment, Prosthetics, Orthotics and Supply Industry CPG
  - 1999 Hospice CPG
  - 2000 Skilled Nursing Facility CPG
  - 2003 Ambulance Supplier CPG

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### Review of Prior CMS Rulemaking . . .

- This is not the first time CMS has issued a proposed rule regarding overpayment reporting and refunding requirements.
  - **1998 Proposed Rule:** Proposed criteria under which a provider or supplier would have been released of overpayment liability based on being “without fault.”
  - **2002 Proposed Rule:** Postured as a supplement to the 1998 Proposed Rule to “establish, in regulations, the long standing responsibility of providers, suppliers, individuals and also managed care organizations contracting with us to report and return overpayments to us.”
- Neither rule was finalized.

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### OIG State FCA Reviews

The OIG, in consultation with the Attorney General, determines whether States have FCAs that qualify for an incentive under section 1909 of the Social Security Act. Those States deemed to have qualifying laws receive a 10-percentage-point increase in their share of any amounts recovered under such laws.

#### States Meeting Requirements:

California 4/3/2011, Colorado 10/24/2013,  
 Connecticut 8/22/2014, Delaware 11/12/2013,  
 Georgia 5/22/2014, Hawaii 5/22/2013, Illinois 5/22/2013,  
 Indiana 7/31/2014, Iowa 12/29/2011,  
 Massachusetts 7/31/2013, Minnesota 11/12/2013,  
 Montana 10/24/2013, New York 2/19/2014,  
 Rhode Island 10/24/2013, Tennessee 7/31/2013,  
 Texas 9/12/2013, Virginia 7/31/2014 and  
 Washington 11/20/2012

#### States Not Meeting Requirements:

Florida 8/31/2011, Louisiana 11/15/2011,  
 Michigan 8/31/2011, Nevada 3/12/2014,  
 New Hampshire 7/24/2008, New Jersey 3/21/2011,  
 New Mexico 7/24/2008, North Carolina 3/21/2011,  
 Oklahoma 8/31/2011 and Wisconsin 3/21/2011

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### Corporate Integrity Agreements and Certification of Compliance Agreements

- Providers and suppliers are often obligated to report and refund overpayments under the terms of their Corporate Integrity Agreements (CIAs) or Certification of Compliance Agreements (CCAs).
  - CIAs and CCAs often require that overpayments be reported within 30 days of identification.
- Providers and suppliers may be subject to FCA liability for failing to report and return overpayments pursuant to the terms of their CIA or CCA. *See United States ex rel. Matheny v. Medco Health Solutions, Inc. et al.*, No. 10-15406 (11th Cir.) (Feb. 22, 2012).

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**Medicaid Overpayment Considerations**

- New York Medicaid OMIG Self-Disclosure Program August 2012
  - “The New York State Office of Medicaid Inspector General (OMIG) originally issued self-disclosure guidance for Medicaid Providers on March 12, 2009 and has made enhancements and added resources to the process . . . Providers must determine whether the repayment warrants a self-disclosure or whether it would be better handled through administrative billing processes.”
- Claims older than 6 years from the date of the overpayment are not subject to audit or self-disclosure.
- OMIG requests that providers *do not* send a check for the overpayment or void/adjust claims when submitting a self-disclosure.

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**Medicaid Overpayment Considerations**

- Georgia Medicaid
    - “Once a provider has identified claims that are potential overpayments, a self disclosure letter detailing the potential overpayments should be forwarded to the Program Integrity Unit within the Office of Inspector General.”
    - The suggested overpayment amount should not be included in the self-disclosure.
    - “NO PAYMENT SHOULD BE SUBMITTED PRIOR TO THE EXECUTION OF A SETTLEMENT AGREEMENT.”
- Part I, Policies and Procedures for Medicaid/Peachcare for Kids.

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**Review of FERA and PPACA  
Overpayment Reporting and  
Refunding Requirements**

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**Expansion of FCA Liability for Retention of Overpayment Obligation**

- This may be the single most significant development for the healthcare industry.
- The FERA amendments to the FCA in 2009 expanded liability for overpayments by amending section 3729(a)(7).
- Previously, a “false claim, record, or statement” was required to violate the FCA. Now, “knowing” and “improper” concealment or avoidance of an obligation is sufficient.
- Under FERA, if one knowingly and improperly retains an overpayment from the Government, there is potential liability.
- “Improperly” is not defined.

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**What is an overpayment?**

- “Any funds that *a person receives or retains* under title XVIII [Medicare] or XIX [Medicaid] to which the person, *after applicable reconciliation, is not entitled under such title.*”

PPACA § 6402(d); 42 U.S.C. § 1320a-7k(d)(4).

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**Expansion of FCA Liability for Retention of Overpayment Obligation**

- The FERA amendments added a definition of “obligation” to mean: “an established duty, whether or not fixed, arising from...the retention of any overpayment.”
- The FCA’s requirement to report and return overpayments is linked to the new definition of “obligation” in the statute.

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**FERA Legislative History – Cost Reporting and Other Reconciliations**

- The FERA Committee Report notes that this provision is not intended to capture interim retention of an overpayment permitted by a reconciliation process so long as it is not the product of any willful act to increase interim payments to which the entity is not entitled.
- “This would include reconciliation processes established under statutes, regulations, and rules that govern Medicare, Medicaid, and various research grants and programs.”

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**Overpayment Obligation – 60 Day Time Period**

- PPACA provides a 60-day deadline for **reporting and returning** overpayments and **notifying the payor in writing** of the reason for the overpayment.
- The deadline if 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.
- Effective for overpayments “identified” as of March 23, 2010 PPACA enactment date.
  - Initial reports would have been due on May 22, 2010, and sequentially thereafter.

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**FCA Damages and Penalties**

- Damages equal to 3 times the amount of the Government’s loss
- Civil Penalty of \$5,500 to \$11,000 for each violation

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**Civil Monetary Penalty and Exclusion**

- Failure to report and return an overpayment in accordance with PPACA’s 60-day requirement may subject a person to a civil monetary penalty (CMP) of up to \$10,000 for each item or service.
- In addition, a person may be subject to an assessment of not more than 3 times the amount claimed for each such item or service.
- The Secretary may also make an exclusion determination in “the same proceeding.”

42 U.S.C. § 1320a-7a(a)(10).

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**PPACA Raises Many Questions**

- When is a provider or supplier “not entitled” to funds?
- When is an overpayment “identified”?
- What does “after applicable reconciliation” mean?
- Who can “identify” an overpayment?
- When is the cost report deadline applicable?
- What must be included in the overpayment report?
- What if the overpayment cannot be quantified within 60-days?
- What if the provider or supplier intends to pursue a voluntary disclosure?
- What if a provider or supplier is pursuing an appeal?

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**CMS’s Proposed Rule**

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### CMS Issues Proposed Rule

- On February 16, 2012, CMS issued a Proposed Rule to implement The Patient Protection and Affordable Care Act's (PPACA's) overpayment reporting and refunding requirements.
- In the Proposed Rule, CMS attempts to clarify some of the open questions raised by PPACA's overpayment reporting and refunding requirements.
  - CMS does not address all questions raised by PPACA; and
  - CMS's Proposed Rule introduces new questions.
- The Proposed Rule contains several far reaching questions.
- On February 13, 2015, CMS announced a one-year delay in the final rule publication for policies and procedures, the timeline has been extended to **February 16, 2016**.
- CMS cited "significant policy and operational issues" as the reason for the extension.

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### Scope of the Proposed Rule

- The Proposed Rule applies to Medicare Part A and Part B fee-for-service (FFS) overpayments.
- However, all Medicare and Medicaid providers and suppliers are subject to Section 6402(d)'s reporting and refunding requirements.
- The Proposed Rule offers insight into CMS's current thinking on how to interpret the reporting and refunding requirements set forth in 6402(d).

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### Enforcement of PPACA's Requirements

- The FCA applies its scienter requirement to the *retention* of an overpayment -- "knowingly and improperly" avoiding an obligation to refund.
- In contrast, the Proposed Rule grafts a "knowledge" requirement onto the *identification* of an overpayment -- acting in "reckless disregard" of the existence of an overpayment.

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**The “Identification” of Overpayments**

- CMS proposes that 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 overpayment.*”
- CMS asserts that “Congress’ use of the term ‘knowing’ in the [PPACA] was intended to apply to determining when a provider or supplier has identified an overpayment. [CMS] believe[s] defining ‘identification’ in this way gives providers and suppliers an incentive to exercise reasonable diligence to determine whether an overpayment exists.”

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**CMS Offers Examples of “Identification”**

- “A provider of services or supplier reviews billing or payment records and learns that it *incorrectly coded certain services*, resulting in increased reimbursement.”
- “A provider of services or supplier learns that a patient death occurred prior to the service date on a claim that has been submitted for payment.”
- “A provider of services or supplier learns that *services were provided by an unlicensed or excluded individual on its behalf.*”
- “A provider of services or supplier *performs an internal audit and discovers that overpayments exist.*”

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**CMS Offers Examples of “Identification”**

- “A provider of services or supplier *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.* (When a government agency informs a provider or supplier of a potential overpayment, the provider or supplier has an obligation to accept the finding or make a reasonable inquiry.)”
- “A *provider of services or supplier experiences a significant increase in Medicare revenue and there is no apparent reason* (When there is reason to suspect an overpayment, but a provider or supplier fails to make a reasonable inquiry into whether an overpayment exists, it may be found to have acted in reckless disregard or deliberate ignorance of any overpayment.)”

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**Duty to Investigate Potential Overpayments**

- CMS states that 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.*”
- “[F]ailure 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.”
- It remains unclear whether a determination that an overpayment likely exists when an amount cannot be readily determined triggers the 60-day period.

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**Open Questions . . .**

- The Proposed Rule does not address the circumstances that would indicate that a provider or supplier has “improperly” avoided the refund of an overpayment, which is a requirement under the FCA.
- CMS does not mention the relationship between the identification of overpayments and the ability to quantify overpayments.
- CMS does not mention the claims appeal process as a form of reconciliation.
  - For example, what about the statutory protection from recoupment/repayment under § 935 of the Medicare Modernization Act?
- What if a contractor issues its findings but the demand letter is not issued for several months?

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**Cost Report Considerations**

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### Applicable Reconciliation Considerations

- Both PPACA and the Proposed Rule limit the universe of potential overpayments to certain funds recognized after “applicable reconciliation” occurs.
- The Proposed Rule attempts to clarify the meaning of “applicable reconciliation,” which is not defined in PPACA.
- CMS proposes that “applicable reconciliation” will occur with the provider’s submission of a cost report.
- CMS further explains that applicable reconciliation “would include an initial cost report submission or an amended cost report.”

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### Cost Report Considerations

- If an overpayment is such that it would *generally* be reconciled on the cost report by the provider, CMS proposes that the provider would be permitted to report and return the overpayment either (1) 60 days from the identification of the overpayment or (2) on the date the cost report is due, whichever is later. CMS provides the following two examples:
  - **Example No. 1: Upcoding** -- CMS proposes that “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.”
  - **Example No. 2: Graduate Medical Education (GME)** -- CMS also proposes that “overpayments that would generally be reconciled on the cost report, such as overpayments related to GME payments, must be reported and returned 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 Considerations

- CMS proposes two exceptions to the general rule that the applicable reconciliation occurs with the provider’s submission of a cost report:
  - (i) **Disproportionate Share Hospital (DSH) Payment Adjustment** -- in calculating DSH payments, CMS recognizes that providers often receive more recent Supplemental Security Income (SSI) ratio data after the submission of its cost report and therefore the provider is not required to return any overpayment resulting from the updated information until the final reconciliation of the provider’s cost report; *or*
  - (ii) **Outlier Reconciliation** -- CMS also recognizes that in the context of outlier reconciliation, providers will not be required to estimate the change in reimbursement and return the estimated overpayment until after the final reconciliation of a cost report.

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**Reporting Overpayments**

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**Overpayment Refund Process**

- Under PPACA, providers and suppliers must, *notify, report and refund* identified overpayments.
- CMS proposes for providers and suppliers to use the “existing voluntary refund process,” which will be renamed the “self-reported overpayment refund process.”
- CMS proposes that providers and suppliers must:
  1. Comply with the existing voluntary refund process outlined in Chapter 4 of the Medicare Financial Management Manual; *and*
  2. Utilize overpayment forms issued by 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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**Self-Reported Overpayment Refund Process**

- Under the Proposed Rule, an 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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**Self-Reported Overpayment Refund Process**

- 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 Office of Inspector General 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.
- 12. If a statistical sample was used to determine the overpayment amount, a description of the statistically valid methodology used to determine the overpayment.
- 13. A refund in the amount of the overpayment. A person may request an extended repayment schedule as that term is defined in 42 C.F.R. § 401.603.

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**10 Year Look-Back Period**

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**10 Year Look-Back Period**

- CMS proposes that overpayments must be reported and returned only if a person identifies the overpayment *within 10 years of the date the overpayment was received*.
- CMS explains that it selected a 10 year look-back period since this is the outer limit of the FCA statute of limitations.
- CMS further proposes to amend the claims reopening rules currently found at 42 C.F.R. § 405.980(b) to account for such a look-back period.

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**10 Year Look-Back Period**

- Inclusion of a 10 year look-back period could greatly expand liability for routine errors which potentially result in overpayments.
- By proposing a 10 year look-back period, it is unclear whether CMS expects providers and suppliers to utilize such a look-back period when conducting audits.
- CMS does not mention whether the reopening period would be amended to permit a 10 year look-back period or reopening for *underpayments*.
- CMS also does not mention any changes to the cost report reopening period at § 405.1885, which only permits reopenings within three years of a final determination of a fiscal intermediary.

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**10 Year Look-Back Period**

- Comparison to other “Look-Back” Periods
  - General government claims statute of limitations: 6 years. 28 U.S.C. § 2415.
  - False Claims Act statute of limitations:
    - 6 years, or
    - 3 years from date when facts material to the claim were known or should have been known by U.S. officials, but no more than 10 years after the violation. 31 U.S.C. § 3731.
  - Reopening of claims for good cause: 4 years from claims determination. 42 C.F.R. § 405.980.
  - Reopening of cost reports: 3 years from final determination (e.g. NPR). 42 C.F.R. § 405.1885.

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**10 Year Look-Back Period**

- Other relevant comparisons:
  - HIPAA record retention: retain required documentation for six years from the date of its creation or the date when it last was in effect, whichever is later. 45 C.F.R. § 164.316(b)(2).
  - Providers submitting cost reports: records retained in their original or legally reproduced form for a period of at least 5 years after the closure of the cost report. 42 C.F.R. § 482.24(b)(1).

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**Implications for Health Care Providers to Consider**

- Retention of funds during reconciliation period?
- Internal discovery of an overpayment without voluntary disclosure?
- How quickly must one act? When is an overpayment considered identified?
  - “The OIG Provider Self-disclosure Protocol suggests that after discovery of “credible evidence of misconduct from any source and, after a reasonable inquiry, [the hospital] has reason to believe that the misconduct may violate...law, then the hospital promptly should report the existence of misconduct to the appropriate governmental authority within a reasonable period, but not more than sixty (60) days after determining that there is credible evidence of a violation.”
  - Is there a difference between “determining” and “identified?”

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OIG Provider Self-disclosure Protocol, 63 Fed. Reg. 58399 (Oct 21, 1998) 43

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**Anti-Kickback Considerations**

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**Anti-Kickback Considerations**

- CMS states that for providers and suppliers compliance with the Anti-Kickback Statute is a condition of payment, and “claims that include items and services resulting from a violation of this law are not payable and constitute false or fraudulent claims for purposes of the FCA.”
- CMS proposes that providers *who are not a party to a kickback arrangement* are “unlikely in most instances to have ‘identified’ the overpayment that has resulted from the kickback arrangement and would therefore *have no duty to report it or . . . to repay it.*”

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**Anti-Kickback Considerations**

- However, to the extent that a provider or supplier who is *not* a party to a kickback arrangement has “sufficient knowledge” of the arrangement to have identified the resulting overpayment, CMS proposes that the provider or supplier must report the overpayment in accordance with these regulations.

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**Relationship With Other Reporting Mechanisms**

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**Intersection with Self-Disclosure Protocols**

- CMS recognizes the potential intersections between PPACA’s reporting and refunding requirements and existing self-disclosure protocols.
- CMS proposes exceptions to the proposed PPACA reporting and refunding requirements for providers pursuing the following protocols:
  - Self-Referral Disclosure Protocol (SRDP)
  - OIG Self-Disclosure Protocol (OIG SDP)
- CMS seeks comments on alternative approaches that would allow providers and suppliers to avoid making multiple reports of identified overpayments.

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**Self-Referral Disclosure Protocol**

- The SRDP is a voluntary self-disclosure protocol, under which providers of services and suppliers may self-disclose actual or potential Stark violations.
- CMS proposes the following for providers pursuing the SRDP:
  - Suspend the obligation to **return** overpayments when CMS acknowledges receipt of a SRDP.
  - However, the provider or supplier **is still obligated to report** the overpayment.

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**OIG Self-Disclosure Protocol**

- The OIG SDP is intended to be used by providers who wish to voluntarily disclose self-discovered evidence of potential violations of law.
- CMS proposes the following for providers pursuing the OIG SDP:
  - Suspend the obligation **to return and report** overpayments when OIG acknowledges receipt of a submission to the OIG SDP.

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**Additional Considerations**

- CMS does not propose to create an exception for providers or suppliers reporting an overpayment to the OIG pursuant to the terms and conditions of a CIA.

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**Practical Tips**

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**Remember . . .**

- The Proposed Rule offers valuable insight into CMS’s current thinking on how to implement certain provisions of Section 6402(d).
- Medicare and Medicaid providers, suppliers, and certain contractors *are subject to* PPACA’s overpayment reporting and refunding requirements.

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**Policy Review**

- Audit Policies and Protocols
- Overpayment and Refund Policies
- Disclosure Protocols

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**Policy Review**

**• Audit Policies and Protocols**

- Who has the authority to initiate an audit?
  - Distinction between routine and non-routine audits?
  - Is the ability to use sampling and extrapolation addressed?
  - Distinction between internal and external audits?
  - Distinction from audits conducted pursuant to the attorney-client privilege?
- Is an audit inventory maintained?
- How are audit findings characterized and vetted?
- Are overpayments and disclosures addressed?

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**Policy Review**

**• Overpayment and Refund Policies**

- Who has authority to identify an overpayment?
  - Universe of individuals that are authorized to identify “potential overpayments” should be broader than the universe of individuals authorized to identify “actual overpayments.”
- How is the identification process described?
  - Internal investigations?
  - Review of reconciliation processes?
- Are overpayments defined to exclude those overpayments identified by third parties (e.g. RACs) that are contested?
- Does policy contemplate varying processes for Medicare, Medicaid and commercial payors?

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**Policy Review**

**• Disclosure Protocols**

- Who has authority to initiate a “disclosure”?
- How is disclosure defined?
  - Enforcement agencies?
  - Government contractors?
- Process
  - How are different facts and circumstances taken into account?
  - Distinctions for various federal healthcare programs?
    - Including managed care entities?

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**Additional Practical Tips**

- Review comments submitted to CMS on controversial provisions included in the Proposed Rule.
- Review contractor voluntary refund processes.
  - May be challenging for multi-state providers and suppliers.
- Are appropriate stakeholders within the organization aware of PPACA's overpayment reporting and refunding requirements?

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**Questions**

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**Gary W. Eiland, Partner**  
**King & Spalding LLP**  
**Telephone: (713) 751-3207**  
**Email: geiland@kslaw.com**

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