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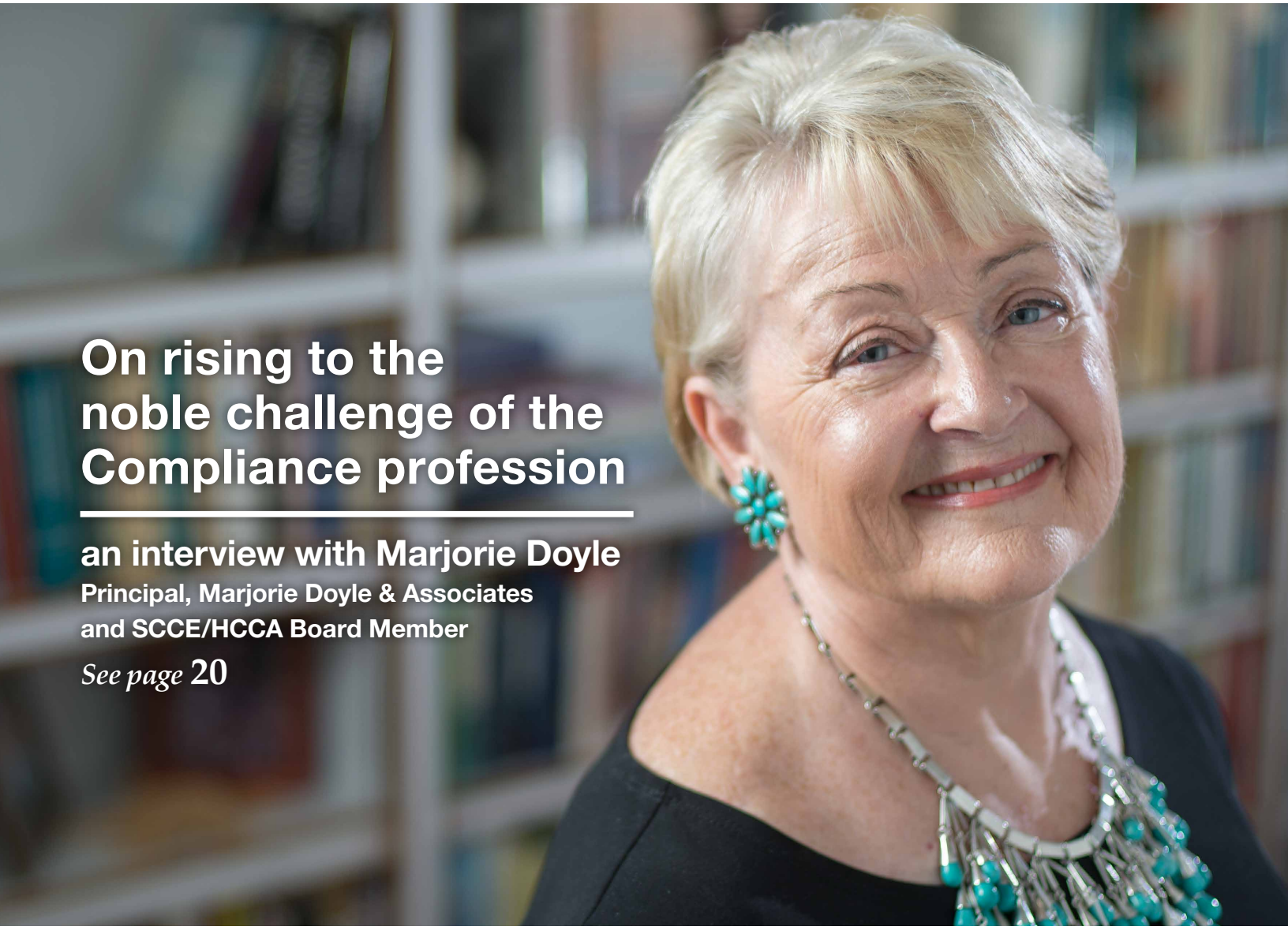

On rising to the noble challenge of the Compliance profession

an interview with Marjorie Doyle

Principal, Marjorie Doyle & Associates and SCCE/HCCA Board Member

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by Erin M. Duffy and Alison T. Rosenblum

The 60-day Overpayment Rule: Strict standards enforced in first legal case

» Recent litigation demonstrates the federal government's intention to strictly construe and vigorously enforce the 60-day Overpayment Rule.

» Providers should promptly investigate all reports of potential overpayments.

» Providers should independently review claims for potential overpayments on a routine basis.

» Providers should document all steps taken to investigate any alleged overpayments.

» Providers should have policies and procedures designed to address how identified overpayments will be disclosed and repaid to the federal government.

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When the Affordable Care Act (ACA) was passed in 2010, it created new requirements for healthcare providers to report and return overpayments from Medicare and Medicaid. The Department of Health and Human Services (HHS), Office of Inspector General (OIG) has issued several proposed rules elaborating on this new provision, but has yet to publish a final version. Despite ongoing ambiguities as to how the overpayment provisions will be applied, the federal government has forged ahead with its first major legal attempt to enforce the new provisions. The government's role as intervener in *Kane v. Healthfirst*,[1] provides insight into how the government may ultimately choose to implement and enforce the overpayment requirements.

The 60-day Overpayment Rule

Under Section 6402(d)(2)(A)(iii) of the ACA,[2] healthcare providers must report and return overpayments within 60 days after identifying the overpayments or by the date on which a corresponding cost report is due. In notifying the party to whom the repayment will be made, the provider must also explain the reason for the overpayment. A failure to refund an overpayment by the requisite deadline will expose the provider to enforcement under the False Claims Act.[3] Furthermore, under Section 6408(a) of the ACA,[4] providers who do not report and repay an identified overpayment will be subject to significant civil monetary penalties. Overpayments from Medicare or Medicaid can arise in a number of forms (e.g., payments for non-covered services, payments in excess of the allowable amount for an identified covered service, duplicate payments, payments where another payer has the primary responsibility for the payment). The crucial question, however, is at what point a provider can be deemed to have "identified" such an

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overpayment. Rules proposed by HHS (and those already finalized for Medicare Parts C and D) have indicated an expectation that providers exercise "reasonable diligence" to investigate possible overpayments. For example, the regulation pertaining to Medicare Advantage (MA)-related overpayments states that an MA organization has identified an overpayment when it "has determined, or *should have determined through the exercise of reasonable diligence*" that it received an overpayment (emphasis added).[5] Notably, the MA overpayment regulations also provide for a look-back period of six years.

Kane v. Healthfirst, Inc.

The federal government has demonstrated its intent to enforce the 60-day rule through its decision to intervene in litigation against Continuum Health Partners, Inc., Healthfirst, Inc., Mount Sinai Beth Israel, Mount Sinai St. Luke's, and Mount Sinai Roosevelt (collectively, Healthfirst) for the defendants' alleged violations of the 60-day Overpayment Rule. The case concerns claims erroneously submitted to the New York State Medicaid program for services provided to Medicaid managed-care patients insured by Healthfirst, a managed-care organization (MCO). Under the hospitals' agreements with Healthfirst and New York's Medicaid program, the hospitals could only be reimbursed for care provided to Medicaid managed-care patients by Healthfirst; the hospitals were not permitted to submit claims to Medicaid as a secondary payer.

However, because of an incorrect remittance code mistakenly used by Healthfirst, the hospitals inadvertently billed Medicaid for services provided to various MCO patients from 2009 to 2010.

According to the Complaint-in-Intervention (complaint), the New York Office of the State Comptroller notified one of the defendants in September 2010 about a number of claims for which it had erroneously billed Medicaid as a secondary payer. Although the problem was corrected by the end of that year, an internal investigation conducted in late 2010 and early 2011 revealed the possibility that more than 900 claims had been mistakenly billed to the New York Medicaid program. Relator Robert Kane, who had participated in the investigation and sent an email to several colleagues about the potential erroneous claims, filed a *qui tam* lawsuit against the defendants in April 2011. In June 2014, the federal government opted to formally intervene in the litigation.

The government's complaint alleges that the defendants took more than two years to repay the money and did so only sporadically. The complaint further alleges that defendants "intentionally or recklessly failed to take the necessary steps to timely identify the claims affected" by the billing issue and repay the improper payments to Medicaid. According to the complaint, the defendants "made or caused to be made or used false records or statements" or "knowingly concealed, avoided, or decreased an obligation to pay or transmit money to the United States," thereby violating the False Claims Act. Accordingly, the United States is seeking treble damages and $11,000 for each overpayment.

The defendants, in their September 2014 motion to dismiss, dispute the government's apparent contention that the overpayments were identified in February 2011. They point out that Kane's email, which had initially alerted the defendants to the possible extent of the overpayments, only indicated the *possibility* of 900 erroneous claims, but did not provide a precise or accurate list of which specific claims involved actual overpayments from Medicaid. The defendants thus assert a different interpretation from the government as to when the 60-day clock began to run. In contrast to the

government's contention, the defendants claim that they had not yet *identified* the overpayments upon receipt of Kane's February 2011 email. The defendants also note that they ultimately repaid all outstanding overpayments and dispute the government's contention that they had intentionally or recklessly delayed doing so.

What does this mean?

The *Kane v. Healthfirst* case indicates the federal government's intent to enforce the 60-day rule in a strict and robust manner. The complaint and briefs related to defendants' motion to dismiss underscore several areas of disputed interpretation of the new overpayment provisions. These contentious issues will be crucial to the outcome of the case as well as future enforcement of the 60-day Overpayment Rule. First, what exactly constitutes "identification" of an overpayment, thereby starting the 60-day reporting and repayment period? Second, is this period triggered by mere notice of a potential overpayment, or does it require the definitive identification of a specific overpayment? Third, does the definition of "identification" incorporate, as the government appears to contend, some sort of recklessness standard? Fourth, to what extent must providers act upon and further investigate indications of possible overpayments? And finally, are providers required to act with "reasonable diligence" to investigate possible overpayments, and what does such diligence entail?

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Healthcare providers should watch closely the ongoing developments in *Kane v. Healthfirst*, because the case will prove critical to future enforcement of the 60-day rule. Providers should also remain on the lookout for final rules that will further illustrate and define how the 60-day Overpayment Rule will be applied. Finally, when providers discover possible overpayments, they would be wise to promptly and diligently investigate, making certain to report and repay any discovered overpayments within the 60-day window.

1. *Kane vs. Healthcare, Inc, et al*, Civ. No. 1:11-2325, Southern District of New York, June 27, 2014. Complaint-in-Intervention available at http://1.usa.gov/1Aixc7B
2. Medicare and Medicaid program integrity provisions. Codified at 42 U.S.C. § 1320a-7k(d). Available at http://bit.ly/2kGT3gh2
3. False Claims Act, 31 U.S.C. § 3729 *et seq.*
4. Civil Monetary Penalties. Codified at 42 U.S.C. § 1320a-7a(a)(10). Available at http://bit.ly/1vcxCNG
5. Medicare Advantage Program: Reporting and returning of overpayments. 42 C.F.R. § 422.326(c). Available at http://bit.ly/1DmL58L