Think You've Been Overpaid? Better Find Out Within 60 Days.

by Jeffrey S. Baird, Esq.

Section 6402 of the Affordable Care Act states that any provider or supplier that receives an overpayment must report to the Centers for Medicare & Medicaid Services (CMS), and provide written notice of the reason for the overpayment. The overpayment must be reported and returned no later than 60 days after it is identified. Failure to do so may result in civil monetary penalties under the Federal False Claims Act.

In a recently released final rule, CMS has given guidance regarding the obligations of providers and suppliers to report and repay overpayments.

- The final rule addresses the "lookback period." This is the time period for which a pharmacy must examine its patient files for overpayment obligations. CMS originally proposed a 10-year lookback period. However, the final rule has shortened the lookback period to six years.
- The final rule states that, as a general rule, a provider will have six months to investigate possible overpayments before the 60-day clock starts running. Compare this to the proposed rule, which said that the investigation should be conducted with "all deliberate speed."
- The final rule addresses what it means to "identify an overpayment." Identification occurs when a provider "has or should have, through the exercise Section 6402 of the Affordable Care Act states that any provider or supplier that receives an overpayment must report to the Centers for Medicare & Medicaid Services (CMS), and provide written notice of the reason for the overpayment. The overpayment must be reported and returned no later than 60 days after it is identified. Failure to do so may result in civil monetary penalties under the Federal False Claims Act.

In a recently released final rule, CMS has given guidance regarding the obligations of providers and suppliers to report and repay overpayments.

> ***The pharmacy must be proactive, not reactive. It is not an option for the pharmacy to "bury its head in the sand."***

- The final rule addresses the "lookback period." This is the time period for which a pharmacy must examine its patient files for overpayment obligations. CMS originally proposed a 10-year lookback period. However, the final rule has shortened the lookback period to six years.
- The final rule states that, as a general rule, a provider will have six months to investigate possible overpayments before the 60-day clock starts running. Compare this to the proposed rule, which said that the investigation should be conducted with "all deliberate speed."
- The final rule addresses what it means to "identify an overpayment." Identification occurs when a provider "has or should have, through the exercise of reasonable diligence, determined that the person has received an overpayment and quantified the amount of the overpayment." The word "quantified" is significant. In including "quantified," CMS responded to commentators who argued that an overpayment must be quantified before it can be reported and repaid. According to the final rule: "We agree and have revised the language…to clarify that part of identification is quantifying the amount, which requires a reasonably diligent investigation." The "reasonable diligence" requirement differs from the proposed rule which stated that identification occurs when a provider "has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the existence of the overpayment."

Let's focus on the third bullet. Under the final rule, a pharmacy will have identified an overpayment if the pharmacy conclusively knows about it, or if the supplier would have known about it by acting with "reasonable diligence." Although the term "reasonable diligence" gives flexibility to CMS, CMS is unlikely to punish a good faith compliance effort. As stated in a recent court ruling involving the 60-day rule: "[E]nforcement actions aimed at well-intentioned health care providers working with reasonable haste to address erroneous overpayments…would be unlikely to succeed." It is important to note that the 60-day rule requires "proactive compliance activities…to monitor for the receipt of overpayments." Said another way, the pharmacy must be proactive, not reactive. Lastly, the final rule states that it is "certainly advisable" for providers to create a paper trail that serves as evidence of reasonable diligence.

Stripping all of the "legalese" away, what does this mean for the pharmacy?

- The pharmacy must be proactive, not reactive. It is not an option for the pharmacy to "bury its head in the sand."
- There may be various reasons why a pharmacy should not have received payment for a claim. For example: the provider's documentation is deficient and cannot be rehabilitated; or the claim results from actions that violate the Medicare anti-kickback statute…or the Stark physician self-referral statute…or the beneficiary inducement statute…or the telephone solicitation statute. If a claim should not have been paid to the provider, then it is likely that a person knows about it. That person might be a mid-level employee in the billing department, or an intake person, or sales rep.
- An employee who knows that a claim should not have been paid is a potential "whistleblower." If the provider engages in "reasonable diligence," discovers claims that should not have been paid, and reports and repays them, then (depending on the timing involved) the whistleblower will likely not be able to proceed with a whistleblower (or "qui tam") lawsuit.
- If a provider knows that it should not have been paid for certain claims, or if the provider "buries its head in the sand" and does not exercise "reasonable diligence" to determine if some claims should not have been paid, then the provider is racking up potential liability under the False Claims Act (FCA). Note that under the FCA, the provider can be liable for actual damages, treble damages, and up to $11,000 per claim.
- And so all of this boils down to the fact that the pharmacy needs to have a robust compliance program, conduct internal audits, and have an outside auditor come in periodically to conduct audits. When I say "robust compliance program," this means that the pharmacy should examine its document retention, examine how claims are submitted, determine if any of its operations violate the anti-fraud laws referenced previously, and provide regular training to employees.

Attribution: A portion of this article is attributed to two articles written by Jeff Overlay, senior reporter for Law360, on Feb. 11, 2016, entitled "Medicare Eases 60-Day Overpayment Rule" and "6 Policies in Medicare's 60-Day Overpayment Rule." ■

Jeffrey S. Baird, Esq. is chairman of the Health Care Group at Brown & Fortunato, P.C., a law firm based in Amarillo, Texas. He represents pharmacies, infusion companies, home medical equipment companies, and other health care providers throughout the United States. Baird is board certified in health law by the Texas Board of Legal Specialization. He can be reached at 806-345-6320, or at jbaird@bf-law.com.