Once an Overpayment, Forever an "Obligation"

The ACA's 60-Day Rule Makes Murky Business of "Identifying" Overpayments

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by Leonardo M. Tamburello, Esq.

The Affordable Care Act ("ACA") includes an often overlooked provision that severely punishes anyone who, for sixty (60) days or more, knowingly fails to return Medicare or Medicaid overpayments that have been "identified" as such. Failure to do so transforms the overpayment into an "obligation" under the federal False Claims Act (FCA). The statute does not define what it means by "identified" overpayment, nor has there been any definitive regulatory guidance on this point. Thus, some four years after the ACA's enactment, it is still not known what it meant by the "identification" of an overpayment in this context.

Despite this, the federal government and State of New York have both recently intervened in a federal FCA action alleging that although a hospital eventually repaid overpayments resulting from a third-party's coding error, its failure to refund the overpayments with the alacrity required by the ACA's so-called "60-day Rule" makes it potentially subject to FCA penalties and sanctions. This case should be followed closely to see how the court grapples with providers' obligations to "identify" overpayments in this context.

1. The 60-day Rule: An ACA Trap for the Unwary.

Since 2010, the ACA has required the reporting and return any Medicaid or Medicare overpayments within sixty (60) days of their "identification."[1] An "overpayment" is defined as the receipt or retention of any Medicaid or Medicare funds, by a Medicaid or Medicare provider or supplier, Medicare MCO or Medicare Part D prescription drug plan sponsor, "which the person, after applicable reconciliation, was not entitled."[2] Such overpayments must be returned within sixty (60) days from the date on which they are "identified," or the date that the corresponding cost report was due, whichever is later.[3] Proper return of an overpayment is made by: (1) returning it to the federal government, State Medicaid program, intermediary, carrier, or contractor, as appropriate; and (2) notifying the party to which the overpayment is returned the reason for the overpayment, in writing.[4]

A "knowing" failure to return an overpayment within the sixty days automatically converts it into an "obligation" that is actionable under the FCA.[5] Violations of the FCA are punishable by penalties that include: a fine between $5,000 and $10,000 *per claim*, treble damages, and/or exclusion from federally funded health programs if the offender knowingly conceals or knowingly and improperly avoids or decreases an "obligation" to pay money to the federal government.[6] These penalties supplement Medicaid and Medicare's ability to "offset," or "recoup," overpayments by reducing present or future payments and applying the withholding to the indebtedness.[7]

Although this statute contains some basic definitions, there remain troubling uncertainties concerning what it means for a provider to have "identified" an overpayment. This lack of clarity coupled with the potentially severe penalties under the FCA requires potential overpayments to be investigated and handled in an adroit and expeditious manner.

In February 2012, CMS issued proposed regulations addressing, *inter alia*, the "identification" of overpayments. Unfortunately, these proposed regulations were never finalized or enacted.[8] Thus, neither the statute nor agency regulations have provided any formal guidance as to what it means to "identify" an overpayment, even though this is *the* critical inquiry for determining when the 60-day Rule is triggered.

2. Kane: A First Look at the 60 Day Rule in Action

Although the 60-day Rule has been in effect for over four years, no government agency had invoked it against a provider until June 26, 2014 when U.S. Department of Justice (DOJ) and the New York State Attorney General's office (NYAG) intervened in *Kane ex rel. United States v. Continuum Health Partners, Inc., et al.*, a wrongful termination and FCA matter in the Southern District of New York.[9]

Kane was the Technical Director, Revenue Cycle Operations, Hospital Systems & Operations at Continuum Health (Continuum) from November 4, 2004 until February 8,

2011.[10] In or around September 2010, as a result of a New York State investigation into Medicaid claims of four Continuum patients, Kane discovered that from 2007 to November 2010, an erroneous remittance code ("CAS*CO*2*$$$$.$$") was used by Continuum that resulted in the improper billing of New York Medicaid as a secondary payer.[11] The use of this remittance code was the result of a "coding error" by Healthfirst, the MCO which contracted with the Continuum providers for services to New York Medicaid managed care enrollees.[12]

Kane alleges that in October 2010, he brought the coding error and fact that Continuum had received overpayments to his supervisors and suggested that Continuum stop its automatic processing of Healthfirst's electronic remittance and instead revert to manual posting of payments, but his request was denied.[13] A few months later, in December 2010, Healthfirst corrected the coding error.[14] Notwithstanding this, Kane alleges that Continuum knew of the coding error and resulting overpayments, but took no action to report or return them.[15]

In February 2011, Kane alleges that his employment was terminated at Continuum in retaliation for his requests to switch to manual billing until the coding error was resolved and to investigate and refund the overpayments that had occurred.[16] He filed suit shortly thereafter, but it remained under seal while the DOJ and NYAG investigated the allegations. On June 26, 2014, both the DOJ and State of New York have intervened, asserting their own FCA claims based solely on Kane's allegations that repayment did not occur within the 60-day timeframe required by the ACA and despite Continuum's repayment of all amounts in dispute.[17]

Initially, Kane alleged that the same or similar types of overpayments also occurred at over approximately seventy other hospitals in New York and twenty in New Jersey, but those allegations were voluntarily dismissed without prejudice very early in the case.[18]

Kane is the first case brought which directly implicates the ACA's 60-day Rule and bears close monitoring for all providers, not just those directly involved.

3. Paramount Issue in Kane, and for All Medicaid and Medicare Providers: When Were the Alleged Overpayments "Identified"?

All providers should watch Kane carefully to see how the court deals with some unanswered questions about the 60-day Rule, foremost amount them being: *When did each hospital identify the overpayments in question?*

Since the 60-day Rule was enacted, there has been an ongoing industry concern about what it means to "identify" an overpayment, mostly because the statute does not define this fundamental term. In 2012, CMS proposed regulations that attempted to answer this question, stating that an overpayment is "identified" when a Medicare or Medicaid provider or supplier "has *actual knowledge* of the existence of the overpayment *or acts in reckless disregard or deliberate indifference* of the overpayment."[19] In addition, CMS has commented that a duty to investigate is triggered when a provider "receives information concerning a potential overpayment that creates an obligation to make a *reasonable inquiry* to determine whether an overpayment exists."[20] Failure to do so "with all deliberate speed" may result in a determination that the provider knowingly retained an overpayment as a result of reckless disregard or deliberate ignorance of whether or not it received such an overpayment."[21]

Apropos of Kane, the proposed regulations examine improperly retained overpayments that include the situation where a provider or supplier "reviews billing or payment records and learns that it incorrectly coded certain services, resulting in increased reimbursement….[and where a] provider of services or supplier performs an internal audit and discovers that overpayments exist."[22] Additional examples of overpayments found in the proposed regulations include providers who are "informed by a government agency of an audit that discovered a potential overpayment, and… fail[] to make a reasonable inquiry."[23] In CMS's view, "[w]hen 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. If the provider's or supplier's inquiry verifies the audit results, then it has identified an overpayment and, assuming there is no applicable cost report, has 60 days to report and return the overpayment."[24]

These proposed regulations were promulgated with respect to Medicare (but not Medicaid) and accompanied by a statement from CMS that "[o]ther stakeholders, including, without limitation… Medicaid MCOs will be addressed at a later date."[25] Despite this, and although these regulations were never enacted, CMS nevertheless cautioned that the enforcement of the 60-day Rule would not be delayed by the lack of regulatory guidance, saying: "all stakeholders… even without a final regulation… are subject to the statutory requirements… [requiring the return of "identified" overpayments within 60 days] and could face potential False Claims Act liability, Civil Monetary Penalties Law liability, and exclusion from Federal health care programs for failure to report and return an overpayment."[26]

Based on CMS's own comments and illustrated by Kane, the lack of regulatory authority is not an invitation to institutional indifference. Medicare and Medicaid providers that have "actual knowledge" of overpayments, in addition to those who fail to make a "reasonable inquiry" with "all deliberate speed" after receiving information concerning a potential overpayment, are potentially liable under the FCA and its state-level equivalents. Policies and

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procedures should be created and followed to insure that: first, if overpayments are suspected or suggested, they are promptly investigated; and second, if they are identified, they are properly returned and reported as required by the ACA's 60-day Rule.

Identification of overpayments is one of the "major operational requirements" of the Medicaid Integrity Plan.[27] Special consideration should therefore be given to this issue in the context of RAC audits, as RAC auditors have been specifically tasked to identify and recover potential overpayments, and do so on a contingent-fee basis.[28] To this end, RACs employ "overpayment algorithms" "to identify claims with possible overpayments," which are also used to identify providers suspected of high overpayment.[29] Moreover, if an overpayment is identified during a RAC audit, it must classify it as an improper payment (which includes overpayments and underpayments), a data processing error, a medical review error, fraud, or abuse.[30]

Although it is the first case where the ACA's 60-day Rule has been invoked, Kane is almost assuredly not the last. In addition to providing a powerful tool to government regulators, the ACA's 60-day Rule also strongly incentivizes *qui tam* Plaintiffs to bring potentially costly lawsuits in situations where overpayments are not promptly investigated and reconciled. Policies and procedures, if they have not already been updated, should be revised along with employee training practices to reflect the changes ushered in by the 60-day Rule. Compliance programs should designate individual responsibility for the prompt investigation of possible overpayments from non-commercial payers and insure that any overpayments that are "identified" are repaid and explained with 60 days.

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Endnotes

[1]42 U.S.C. § 1320a-7a(d).

[2]42 U.S.C. § 1320a-7k(d)(4)(B) and –(C).

[3]Id. at § 1320a-7k(d)(2)

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