

# Finders Weepers



It is a given that the historical trend in healthcare spending is unsustainable. It also is an article of faith, particularly in Washington, that various activities, collectively and incorrectly referred to as “fraud and abuse,” add billions of dollars to the cost of healthcare. With increasing frequency, there have been pronouncements about how cracking down on fraud and abuse will reduce healthcare costs and provide additional revenue to fund efforts to expand access to care.

For example, in December of 2011, the Obama administration announced the recovery of over \$5.6 billion in “fraudulent payments” in fiscal year 2011; less than a week later, the Department of Justice announced the recovery of nearly \$3 billion in settlements and judgments in civil fraud cases. One report stated that **the number of healthcare fraud prosecutions increased 85% from 2010 to 2011.**

# Physician Liability for Retention of Overpayments

By: Robert J. Milligan, JD & Ken Briggs, JD

Given these converging forces, it should be no surprise that the Patient Protection and Affordable Care Act (“PPACA”) signed by President Obama included many provisions relating to fraud and abuse enforcement. Some of these provisions set aside additional funds for enforcement efforts, which have been reported to yield a return on investment of between 400% and 1,300%. Other provisions established new substantive rules, and significant penalties for violations of those rules.

Section 6402 of PPACA, codified at 42 U.S.C. Section 1320a-7k(d) (the “Statute”), is the mechanism by which the government enforces the obligation to report and return overpayments. Although the Statute became effective upon the signing of PPACA in March 2010, it has not received much attention from providers or their national associations. This article will outline the obligations imposed by the Statute and a Proposed Rule by issued by CMS in February 2012; discuss the key terms referenced in the Statute and the Proposed Rule (collectively, the “Repayment Rules”); summarize the penalties facing providers who violate the Repayment Rules; and offer suggestions on how to reduce risks associated with the Repayment Rules.

## The Repayment Rules in a Nutshell

Basically, the Repayment Rules state that:

- If a “person”
- Receives an “overpayment”
- From any Medicare or Medicaid program,
- The person must return the overpayment, and
- Provide a written report of the reason for the overpayment,
- Within sixty days after the overpayment is “identified.”

A “knowing” failure to comply with these requirements can result in significant penalties.

Medicare Advantage Plan or a Medicaid Managed Care Plan. Every physician, and every physician practice, that participates in these programs is a “person” subject to the requirements of the Repayment Rules.

The term “overpayment” is broadly defined as “any receipt of funds that a person receives under [the Medicare or Medicaid programs] to which a person is not entitled.” This definition includes payments received for services that are determined not to have been medically necessary; payments that exceed the program allowables; duplicate payments; and payments received in violation of the billing and payment rules, e.g., payments for services billed “incident to,” in situations in which all of the necessary elements for incident to billing were not present. In addition, “overpayment” includes payments received for services provided in connection with arrangements that violate healthcare laws, e.g., the Stark Law and the Anti-Kickback Statute. For example, if a physician practice bills for imaging services provided to its patients, and the practice is structured

in a way that fails to comply with the Stark in-office ancillary services exception, payment received for those imaging services would constitute an overpayment.

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## Key Terms of the Repayment Rules

The Rules define “person” to include just about any provider under Medicare, Medicaid (or AHCCCS), a

An overpayment is “identified,” and the sixty-day report and repay clock begins to run, when a provider has “knowledge” of the overpayment. However, the term “knowledge” is broadly construed under the Repayment Rules to include not only situations in which the provider has actual knowledge of the overpayment, but also includes situations in which the provider acts in “deliberate ignorance,” or with a “reckless disregard” of the facts establishing that an overpayment has occurred. Interestingly (or, perhaps, disturbingly) the Proposed Rule states that if a provider receives a notice of an audit from a government agency regarding a possible overpayment situation, and the provider fails to conduct its own investigation regarding the overpayment “with all deliberate speed,” the provider may be deemed to have acted with deliberate ignorance or reckless disregard of the overpayment.

### The Obligation to Report and Repay Overpayments

Once a provider knows it has received an overpayment, it has sixty days to (a) return the overpayment and (b) provide a written explanation of the reasons for the overpayment to the appropriate government agency or contractor. For physician practices that receive overpayments because of simple billing errors, the report probably should be made to the CMS carrier, which is Noridian Administrative Services for Arizona physicians. If the overpayment arises out of a violation of the False Claims Act or the Anti-Kickback Statute, the provider likely will have to report to the DHHS Office of Inspector General (“OIG”) under the OIG’s Self-Disclosure Protocol. Overpayments arising out of noncompliance with the Stark Law likely will have to be reported to CMS, under its Stark Self-Disclosure Protocol.

### Penalties of Noncompliance

A provider’s failure to properly report and return an identified overpayment could be met with severe penalties. Such a failure constitutes a violation of the False Claims Act, which can result in penalties of five to ten thousand dollars per violation, and treble damages (three times the amount of the overpayment). Further, failure to properly report and return overpayments is a violation of the Civil Monetary Penalties Law, exposing the provider to penalties of up to ten thousand dollars per violation. The OIG also has the authority to exclude from participation in Medicare and Medicaid/AHCCCS any provider that “knows of an overpayment and does not report and return the overpayment.”

While the Proposed Rule tracks the language of the Statute in most respects, there is one new provision in

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the Proposed Rule that is generating a lot of discussion. Under that provision, the obligation to report and repay extends to overpayments received during a “lookback period” of up to ten years prior to the date on which an overpayment is identified. CMS recognizes that this requirement will be controversial, and it has specifically invited comments on the provision; it will consider those comments before issuing its Final Rule. Consequently, it is possible that this lookback period will be shortened in the Final Rule.

retained overpayments received from patients and commercial payors also have been subject to criminal prosecution. Any thought that overpayments

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In addition, the current enforcement environment and the increasingly draconian penalties that can be imposed for “reckless disregard” or “deliberate ignorance” of overpayments require providers to consider seriously whether it is time to implement at least a rudimentary compliance program, one which would include education, auditing and self-reporting modules. These plans will be mandatory before too long, as required by another little-known provision in PPACA. That provision authorizes the

### Proper Risk Management

The Repayment Rules reinforce and expand the existing obligations of physician practices and other providers to police themselves, and to report and return any overpayments received from federal healthcare programs. Under a different set of statutes, providers that have knowingly

from patients or payors can be viewed as a “bank error in my favor” must be abandoned. Given these developments, each practice should examine its policies or processes relating to the management of overpayments or “credit balances” for all patients and payors to ensure that any potential overpayments are evaluated and addressed promptly.

Secretary of DHHS to mandate compliance plans for certain types of providers as a condition of participation in Medicare. Given the fact that physicians control a significant percentage of all healthcare spending, it is all but certain that physicians will be required to implement these plans as a condition of participation.

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At a more mundane level, practices should review their policies for medical records retention, given the fact that the Proposed Rule suggests a ten-year lookback period for overpayments. While that period may be reduced, the “outer limit” of the statute of limitations for False Claims Act violations may reach ten years. Arizona law requires a shorter retention period for medical records (six years for adults and three years after a minor’s eighteenth birthday, A.R.S. Section 12-2297). However, if the Final Rule retains the ten-year lookback period, practices that destroy records before the expiration of the ten-year period may find it difficult to comply with their obligations under the Repayment Rules.

Finally, if a physician practice receives an audit request, civil investigative demand, subpoena or other request from a government agency, and the request suggests that the government has identified a possible overpayment, the practice will need to move “with all deliberate speed” to conduct its own investigation regarding the possible overpayment. While it has always been a good idea for physicians to take a proactive approach in responding to government investigation, the Reimbursement Rules, and the penalties for violating the Rules, now make such an approach essential. 



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