

The 60-Day Rule: When Does the Clock Start Ticking After the Kane Ruling?

September 3, 2015

Laura Keidan Martin

National Chair, Health Care Practice Group

Katten Muchin Rosenman LLP

312.902.5487

laura.martin@kattenlaw.com

Today's Presentation

- 60-Day Rule for Reporting and Refunding Overpayments – Statutory Requirements
- Types of “Overpayments”
- Proposed Rule for Reporting and Returning Overpayments
- The Kane Ruling – When is an Overpayment “Identified”?
- Implications for Providers – Practical Tips for Reducing Enterprise Risk

60-Day Rule: Statutory Requirements

- Section 6402 of the Affordable Care Act (“ACA”) provides that, if an entity has received an overpayment, it is required to report and return the overpayment to the Secretary or the State Medicaid Agency or the appropriate contractor and notify it of the reason for the overpayment.
- The overpayment must be reported and returned within 60 days of the date on which the overpayment was *identified*, or the date any corresponding cost report is due (if applicable), whichever is later.
- Any overpayment retained past the deadline is an “obligation” under the reverse false claims provision of the False Claims Act (“FCA”).
 - FCA penalties are not less than \$5,500 nor more than \$11,000 per claim plus treble damages.
- “Overpayment” is defined in section 6402 of the ACA as any funds a person receives or retains under Medicare or Medicaid to which the person, “after applicable reconciliation,” is not entitled.

Types of Overpayments

- Payments received as a result of –
 - Coding errors (including improper use of modifiers)
 - Duplicate bills
 - Inappropriate site of service
 - Documentation issues
 - Failure to document medical necessity
 - Failure to adequately support that a service was furnished
 - Failure to comply with Medicare billing and claims submission rules
 - For example, frequency of service limitations, unbundling prohibitions and Medicare secondary payor rules
 - Failure to refund credit balances
 - Violations of teaching physician rules
 - Billing for services rendered pursuant to a Stark-prohibited referral or unlawful referral arrangement under the Anti-Kickback Statute

Proposed Rule for Reporting and Returning Overpayments

- CMS issued Proposed Rules interpreting the 60-day rule in 2012.
 - CMS is not expected to issue final rules until 2016.
 - However, final rules for Medicare Part C and D providers interpret identified to mean having “actual knowledge of the overpayment or act[ing] in reckless disregard or deliberate ignorance of the overpayment.”
- Key features of the Proposed Rule:
 - Adoption of an existing voluntary refund process as the sole methodology for reporting overpayments, absent selfdisclosure under the OIG Self-Disclosure Protocol (“OIG SDP”).
 - An “actual knowledge, reckless disregard or deliberate ignorance” standard for determining when an overpayment is “identified” that leaves significant uncertainty about the point at which the “60-day clock” will begin to run.
 - An extraordinarily lengthy 10-year “lookback” period for reporting.

Proposed Rule: How Do You Report and Refund?

- Absent self-disclosure under the OIG SDP, CMS proposed to establish a single procedure for reporting overpayments:
 - CMS proposes that all overpayments be reported using the existing voluntary refund process in Chapter 4 of the Medicare Financial Management Manual, and renames the process, the “self-reported overpayment refund process” (“SRORP”).
 - Providers and suppliers must follow the SRORP using the format that the applicable Medicare contractor makes available on its website.
 - The Proposed Rule acknowledges that reporting forms may vary among Medicare contractors, but CMS intends to develop a uniform reporting form.
- Alternative reporting would be allowed under two conditions:
 - Actual or potential Stark Act violations may be disclosed under the Medicare Self-Referral Disclosure Protocol (“SRDP”) but reporting (but no refund) will still be required under the SRORP.
 - Matters that are potentially violative of Federal criminal, civil or administrative laws may be disclosed to the OIG under the Self-Disclosure Protocol, obviating the need to report via the SRORP.

Proposed Rule: When is a Payment “Identified”?

- CMS proposed 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 existence of the overpayment.”
- However, CMS acknowledged that a provider or supplier may receive information concerning a potential overpayment but need some time to investigate to determine if an overpayment does indeed exist.
- In such cases, CMS proposed that providers and suppliers must conduct a “reasonable inquiry” to determine if an overpayment exists.
 - If the provider fulfilled its reasonable inquiry obligation, the 60-day clock would not start until after the provider conducts its reasonable inquiry and determines that an overpayment exists.
 - However, if the provider failed to conduct a reasonable inquiry “with all deliberate speed,” the provider might be found to have acted “in reckless disregard or deliberate ignorance of any overpayment.”

Proposed Rule: When is a Payment “Identified”?

- CMS did not specifically address whether “actual knowledge” arises when a provider learns of an issue that generated overpayments or when the overpayments are quantified.
- Rather, CMS provided several examples of when it would consider overpayments identified, including:
 - 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 services were provided by an unlicensed or excluded individual on its behalf.
- These examples implied that a provider identified an overpayment when it acquired knowledge of a set of facts that resulted in overpayments, even before the scope of the problem or the total amount of overpayment was determined.
 - This is particularly problematic in cases involving systemic billing errors, where significant statistical analysis and extrapolation (which CMS specifically allows) may be required, as well as in cases involving Stark Act and Anti-Kickback Statute violations.

The Kane Ruling: Facts of the Case

- Insurance company offering Medicaid managed care plan had a software glitch that led hospitals to erroneously bill Medicaid as a secondary payor.
- Medicaid mistakenly paid the hospitals for many of the improper claims.
- In September 2010, the State Comptroller raised questions regarding the incorrect billing with several hospitals, including Continuum.
- Continuum tasked its Revenue Cycle Director (Kane) to ascertain the claims incorrectly billed to Medicaid.
- On February 4, 2011 (five months after the Comptroller informed the Continuum of the glitch), Kane sent an email to several management team members attaching a spreadsheet with more than 900 claims totaling over \$1M that Kane identified as having the wrong code.
 - Kane's cover email indicated that additional analysis was required to confirm findings, but that the spreadsheet gave "some insight into the magnitude of the issue."
 - Spreadsheet was over inclusive by about 50%, but included the vast majority of claims that were indeed overbilled.
- Continuum terminated Kane four days after the email, reimbursed the Government for only five claims on the Kane spreadsheet and, according to the Government, "did nothing further."
- Kane filed a *qui tam* complaint in April 2011.
- Not until Government issued a CID on June 2012 did Continuum refund more than 300 affected claims.
- Continuum merged with Mount Sinai Health System in September 2013.

The Kane Ruling: When Are Overpayments “Identified”?

- Judge ruled that the clock for returning overpayments started ticking when Kane sent his spreadsheet to Continuum managers identifying 900 claims that had an improper billing code and therefore were potential overpayments.
 - The Government argued that Kane’s email and spreadsheet “identified” overpayments within the meaning of the ACA.
 - The Government proposed that “an entity ‘has *identified* an overpayment’ when it ‘has determined, or should have determined through the exercise of reasonable diligence, that [it] has received an overpayment’ to ‘identify’ ...”
 - Defendants argued that Kane’s email only provided notice of **potential** overpayments and did not identify actual overpayments to start the 60-day clock.
 - Defendants urged Court to define “identified” to mean “classified with certainty.”

The Kane Ruling: When Are Overpayments “Identified”?

- In rejecting Continuum’s argument, the Court stated that interpreting “identified” such that the obligation to pay would not be triggered until a provider did the work necessary to determine conclusively the precise amount owed to the Government would create “a perverse incentive to delay learning the amount due and relegating the 60-day period to merely the time within which they would have to cut the check.”
- The Court did not believe that this is what Congress intended.
 - The Court therefore ruled that “while the Government’s interpretation would impose a stringent – and, in certain cases, potentially unworkable – burden on providers, Defendants’ interpretation would produce absurd results.”
- However, the Court suggested that “prosecutorial discretion would counsel against the institution of enforcement actions aimed at well-intentioned healthcare providers working with reasonable haste to address erroneous overpayments. Such actions would be inconsistent with the spirit of the law and would be unlikely to succeed.”
 - It is worth noting that the Court did not hold that the clock started ticking when the Comptroller notified Continuum of the potential issue, but rather, five months later when Kane issued his email and spreadsheet indicating that overpayments likely were received and providing an initial quantification of the problem.

Implications for Providers

- Act on all reports of potential overpayments immediately.
 - Investigate with deliberate speed, utilizing best efforts to complete investigations within 60-90 days after an issue is raised, absent extraordinary circumstances.
 - Immediately assess severity of issue and whether potential intentional or reckless conduct is at play so that matters may be investigated under direction of in-house or outside counsel under privilege when appropriate.
- Do not unduly postpone quantification of overpayments.
 - However, it is reasonable to get arms around issue with timely investigation before quantifying.
- Treat errors arising from third-party glitches with the same degree of seriousness as those caused by your own mistakes.
- Beware of lurking 60-day rule issues in mergers, acquisitions and joint operating company transactions.
 - Due diligence should seek information about overpayments that have already been refunded, not just those that are outstanding to determine whether a 60-day rule issue might exist.
- When an investigation definitively reveals that overpayments occurred but it will take significantly more than 60 days to quantify, consider a two-step report and refund process, ideally with advice of counsel.
- Evaluate which reporting channel to utilize under the facts and circumstances of the case (e.g., CMS Self-Referral Disclosure Protocol, OIG Self-Disclosure Protocol, Medicare Contractor or Local U.S. Attorney).
- Do not punish the messenger when compliance issues are confirmed.

Questions?

Katten Muchin Rosenman LLP Locations

AUSTIN

One Congress Plaza
111 Congress Avenue
Suite 1000
Austin, TX 78701-4073
+1.512.691.4000 tel
+1.512.691.4001 fax

HOUSTON

1301 McKinney Street
Suite 3000
Houston, TX 77010-3033
+1.713.270.3400 tel
+1.713.270.3401 fax

LOS ANGELES – CENTURY CITY

2029 Century Park East
Suite 2600
Los Angeles, CA 90067-3012
+1.310.788.4400 tel
+1.310.788.4471 fax

ORANGE COUNTY

100 Spectrum Center Drive
Suite 1050
Irvine, CA 92618-4960
+1.714.966.6819 tel
+1.714.966.6821 fax

WASHINGTON, DC

2900 K Street NW
North Tower - Suite 200
Washington, DC 20007-5118
+1.202.625.3500 tel
+1.202.298.7570 fax

CHARLOTTE

550 South Tryon Street
Suite 2900
Charlotte, NC 28202-4213
+1.704.444.2000 tel
+1.704.444.2050 fax

IRVING

545 East John Carpenter Freeway
Suite 300
Irving, TX 75062-3964
+1.972.587.4100 tel
+1.972.587.4109 fax

LOS ANGELES – DOWNTOWN

515 South Flower Street
Suite 1000
Los Angeles, CA 90071-2212
+1.213.443.9000 tel
+1.213.443.9001 fax

SAN FRANCISCO BAY AREA

1999 Harrison Street
Suite 700
Oakland, CA 94612-4704
+1.415.293.5800 tel
+1.415.293.5801 fax

CHICAGO

525 West Monroe Street
Chicago, IL 60661-3693
+1.312.902.5200 tel
+1.312.902.1061 fax

LONDON

Paternoster House
65 St Paul's Churchyard
London EC4M 8AB United Kingdom
+44.0.20.7776.7620 tel
+44.0.20.7776.7621 fax

NEW YORK

575 Madison Avenue
New York, NY 10022-2585
+1.212.940.8800 tel
+1.212.940.8776 fax

SHANGHAI

Suite 4906 Wheelock Square
1717 Nanjing Road West
Shanghai 200040 P.R. China
+86.21.6039.3222 tel
+86.21.6039.3223 fax

Katten refers to Katten Muchin Rosenman LLP and the affiliated partnership as explained at kattenlaw.com/disclaimer.

Attorney advertising. Published as a source of information only. The material contained herein is not to be construed as legal advice or opinion.

Katten

Katten Muchin Rosenman LLP

www.kattenlaw.com

110728211