REGULATORY UPDATE – 60 Day Repayment, Compliance, Appeals and CMS/OMHA Appeal-Reduction Strategies

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REPORTING AND RETURNING MEDICARE OVERPAYMENTS

- Section 6402 of the ACA (3/23/2010) established a new Section 1128J(d) of the SSA, requiring a person who receives an overpayment to report and return the overpayment by the later of
  - (A) 60 days after the date on which the overpayment was identified; or
  - (B) the date any corresponding cost report was due (if applicable)

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REPORTING AND RETURNING MEDICARE OVERPAYMENTS

- A Final Rule related to Medicare Part A and Part B providers' and suppliers' obligations to report and return overpayments was effective 3/14/2016.
- Failure to report and return an identified overpayment under the Final Rule could be actionable under the False Claims Act (FCA)
- Regulations codified at 42 C.F.R. 401 Subpart D (https://www.ecfr.gov/cgi-bin/text-idx?SID=cceb1988be95b961d6cfbb49d9873bb2&mc=true&node=pt42.2.401&rgn=div5#sp42.2.401.d)

REPORTING AND RETURNING MEDICARE OVERPAYMENTS

- Final Rule contains 3 defined terms:
  - **Medicare contractor** – Includes a fiscal intermediary, carrier, DME MAC, and a Medicare Part A or Part B MAC
  - **Overpayment** – Any funds a person has received or retained under Title XVIII of the Act, to which the person, after applicable reconciliation, is not entitled
  - **Person** – Includes a provider or supplier, excludes a beneficiary

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REPORTING AND RETURNING MEDICARE OVERPAYMENTS

- **General rule** – A person must report and return an identified overpayment by the later of (A) 60 days after the date on which the overpayment was identified; or (B) The date any corresponding cost report is due, if applicable
- 60-day timeframe suspended where a person:
  - (1) Enters into the HHS OIG Self-Disclosure Protocol
  - (2) Enters into the CMS Voluntary Self-Referral Disclosure Protocol
  - (3) Requests an ERS

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- **Identified** – A person has identified an overpayment when the person 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
- "Reasonable diligence" includes both *proactive compliance activities* to find potential overpayments and *reactive investigative activities* undertaken in response to receipt of credible information related to a potential overpayment

REPORTING AND RETURNING MEDICARE OVERPAYMENTS

- **Proactive compliance activities**
  - No detailed requirements in the Final Rule
  - Section 6401 of ACA amended Section 1866(j) of the SSA to require providers and suppliers to establish compliance programs containing certain core elements.
    - A Proposed Rule was issued 9/23/2010, which solicited comments as to whether the use of the 7 elements of an effective compliance and ethics program set forth in Ch. 8 of U.S. Federal Sentencing Guidelines Manual could serve as the core elements (no Final Rule yet)
    - In the Final Rule related to reporting and returning Medicare overpayments, CMS considered and declined to create a presumption of reasonable diligence for a person whose compliance activities mirror the OIG's compliance program guidance and the U.S. Federal Sentencing Guidelines
  - "Undertaking no or minimal compliance activities to monitor the accuracy and appropriateness of a provider or supplier's Medicare claims would expose a provider or supplier to liability under the *identified* standard articulated in this rule based on the failure to exercise reasonable diligence if the provider or supplier received an overpayment."

REPORTING AND RETURNING MEDICARE OVERPAYMENTS

- **Reactive investigative activities**
  - A provider or supplier may receive credible information concerning a potential overpayment that creates a duty to perform a reasonable inquiry to confirm or deny whether an overpayment exists
  - Such an inquiry must be performed with reasonable diligence (i.e., defined in the preamble language as within 6 months of receipt of information related to a potential overpayment)
  - During its reasonable inquiry, if a provider or supplier confirms the existence of an overpayment, it then has 60 days to report and return the overpayment.
  - If an inquiry is not performed and CMS determines that an overpayment exists, CMS may find that the provider or supplier has knowingly retained an overpayment because it failed to exercise reasonable diligence.

REPORTING AND RETURNING MEDICARE OVERPAYMENTS

- **Reactive investigative activities**
  - Examples that may, depending on the underlying facts, create a duty to perform a reasonable inquiry:
    - Upon review of billing records, a provider or supplier determines certain services were coded incorrectly, resulting in increased reimbursement;
    - A provider or supplier receives notice of a patient's death, which is prior to the date of service on a submitted claim;
    - A provider or supplier obtains knowledge that services were rendered by an unlicensed or excluded individual;
    - An internal audit reveals a potential overpayment;
    - A government audit alleges an overpayment;
    - A provider or supplier experiences an increase in revenue without explanation.

- **Quantifying an overpayment**
  - After a person receives credible information related to a potential overpayment, CMS expects that the person will quantify the amount of the overpayment within a reasonable degree of certainty.
  - CMS allows, and seemingly encourages, the use of statistical extrapolation in order to determine the overpayment amount.

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- **Lookback period**
  - 6 years, measured from the date the person identifies an overpayment

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REPORTING AND RETURNING MEDICARE OVERPAYMENTS

- **How to Report and Return Overpayments**
  - A person may use applicable claims adjustment, credit balance, self-reported refund, or other reporting process set forth by the applicable Medicare contractor to report an overpayment.
  - If the person calculates the overpayment amount using a statistical sampling methodology, the person must describe the statistically valid sampling and extrapolation methodology in the report.
  - A person satisfies the reporting obligations of this section by making a disclosure under the OIG's Self-Disclosure Protocol or the CMS Voluntary Self-Referral Disclosure Protocol resulting in a settlement agreement using the process described in the respective protocol.

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COMPLIANCE RISK AREAS

- 1-MN hospital admissions
  - **Physician judgment exception**
  - **Example of language included in recently received QIC decisions:**
    - "Admission notes, progress notes and physician orders must support a reasonable expectation that hospital care will span at least two midnights, and that expectation must be documented in the medical record. This two midnight benchmark may be waived with a beneficiary's demise, when a beneficiary has been transferred to another acute care hospital for care not available at the original facility, when a beneficiary leaves the hospital against medical advice, with the beneficiary's election to receive hospice care or with documentation of an unexpected early recovery. There are rare and unusual circumstances that may justify an inpatient stay less than two midnights. These rare and unusual circumstances must be properly documented in order to justify this expectation."

MEDICARE APPEALS ENVIRONMENT

Decision Statistics

Appeals	FY12	FY13	FY14	FY15	FY16	FY17
Fully Favorable	53.2%	44.3%	36.7%	33.6%	25.7%	29.0%
Partially Favorable	6.4%	5.2%	2.8%	3.1%	2.0%	1.7%
Unfavorable	27.9%	25.5%	30.1%	37.5%	44.4%	41.8%
Dismissed	12.5%	25.0%	30.4%	25.8%	27.9%	27.5%

Claims	FY12	FY13	FY14	FY15	FY16	FY17
Fully Favorable	33.8%	35.1%	28.4%	18.4%	7.6%	13.9%
Partially Favorable	16.4%	11.6%	11.5%	6.2%	2.4%	4.4%
Unfavorable	34.1%	28.6%	31.4%	23.2%	13.2%	22.7%
Dismissed	15.7%	24.7%	28.7%	52.2%	76.8%	59.0%

*Includes appeals decided in the listed fiscal year

**Run Date: October 17, 2017

https://www.hhs.gov/about/agencies/omha/about/current-workload/decision-statistics/index.html

Average Processing Time By Fiscal Year

Fiscal Year	Number of Days
FY09	94.9
FY10	109.6
FY11	121.3
FY12	134.5
FY13	220.6
FY14	414.9
FY15	661.8
FY16	877.2
FY17	1,108.7
FY18	1,205.8
1st Quarter	1,214.3
2nd Quarter	1,205.8

https://www.hhs.gov/about/agencies/omha/about/current-workload/average-processing-time-by-fiscal-year/index.html

MEDICARE APPEALS ENVIRONMENT

- **HHS and CMS Initiatives to Combat Adjudication Delays**
  1. New OMHA field offices
  2. Hospital Appeals Settlement Process(es) (HASP)
  3. Low Volume Appeals (LVA) settlement option
  4. Settlement Conference Facilitation (SCF)
  5. Statistical Sampling Initiative (SSI)
  6. Recovery Audit (RAC) program improvements
  7. Revisions to Medicare-appeals regulations

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- **New OMHA field offices**
  1. OMHA Arlington field office
  2. OMHA Cleveland field office
  3. OMHA Irvine field office
  4. OMHA Kansas City field office
  5. OMHA Miami field office
  6. OMHA Seattle field office

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MEDICARE APPEALS ENVIRONMENT

- **Hospital Appeals Settlement Process(es) (HASP)**
  - In 2014, CMS first proposed a process for resolving denied inpatient patient status claims that were either under appeal or within their administrative timeframe to request an appeal. CMS proposed to make a partial payment (68 percent of the net payable amount of the denied inpatient claim) in exchange for hospitals agreeing to the dismissal of any associated appeals and accept the settlement as final resolution of eligible claims. Eligible claims were limited to those with dates of admission prior to October 1, 2013 (i.e., the effective date of the 2-Midnight Rule). CMS executed settlements with 2,022 hospitals, representing approximately 346,000 claims.

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  - In 2016, CMS offered to reopen the HASP. The 2016 HASP was similar to the 2014 HASP; however, the partial payment offered in exchange for hospitals agreeing to the dismissal of any eligible claims in 2016 was 66 percent of the net payable amount of the denied inpatient claim. Eligible claims remained limited to those with dates of admission prior to October 1, 2013. The deadline to opt into the 2016 HASP was January 31, 2017. HHS projected that the 2016 HASP could resolve approximately 95,000 more appeals.

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- **Low Volume Appeals (LVA) Settlement Option**
  - CMS made available an administrative settlement process for appellants with fewer than 500 appeals pending at OMHA and the Council, combined, as of November 3, 2017, to settle the portion of their pending appeals that have total billed amounts of $9,000 or less per appeal in exchange for timely partial payment of 62% of the net Medicare approved amount.
  - https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Appeals-Settlement-Initiatives/Low-Volume-Appeals-Initiative.html

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- **Settlement Conference Facilitation (SCF)**
  - SCF is a pilot alternative dispute resolution (ADR) process for appeals pending at the OMHA stage of appeal.
    - The first phase of the SCF pilot was limited to certain Part B appeals and was initiated in June 2014.
    - The Part A SCF pilot began in February 2016.
    - In June 2018, CMS expanded its SCF pilot programs to Medicare provider and supplier appellants with appeals filed on or before 11/3/2017 with:
      - A total of 500 or more appeals pending at OMHA and the Council combined, or
      - Any number of appeals pending at OMHA and the Council that each have more than $9,000 in billed charges
      - The amount of each individual claim in an appeal must be $100,000 or less (for the purposes of an extrapolated statistical sample, the overpayment amount extrapolated from the universe of claims must be $100,000 or less)
- https://www.hhs.gov/about/agencies/omha/about/special-initiatives/settlement-conference-facilitation/index.html.

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- **Statistical Sampling Initiative (SSI)**
  - 1. There is no longer a limitation on appeals that may be processed through SSI based on when they were filed.
  - 2. No hearing may have been scheduled or conducted.
  - 3. Must have a minimum of 250 claims, maximum of 10,000 claims, all in one category:
    - Pre-payment claim denials
    - Post-payment RAC
    - Post-payment non-RAC
  - 4. The appeal assignment process has changed. Appeals will be assigned in accordance with random assignment principles to a lead ALJ. ALJs from the same field office will be assigned as follows:
    - If the universe size is 250-750 claims, a cadre of 2 additional ALJs will be assigned. Each will hear and decide 1/3 of the sample claims.
    - If the universe is >750 claims, a cadre of 3-4 additional ALJs will hear and decide 1/4 to 1/5 of the sample claims.

    Each assigned ALJ will conduct a hearing on their portion of the sample units selected by the OMHA statistical expert. After a hearing is conducted and a decision issued, the decision on the sample units will be extrapolated to the universe by the OMHA statistical expert and the decision will be effectuated based on the extrapolated amount.

- https://www.hhs.gov/about/agencies/omha/about/special-initiatives/statistical-sampling/index.html

MEDICARE APPEALS ENVIRONMENT

- **Recovery Audit Program Improvements**
  - A new medical review policy was made effective October 1, 2015, in which quality improvement organizations (QIOs), rather than RACs, became tasked to perform initial patient status reviews. Under this new medical review policy, beginning in January 2016, RACs became permitted to conduct patient status reviews only for those providers that were referred by a QIO as exhibiting persistent noncompliance with Medicare payment policies.

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  - The new RAC Statement of Work includes financial incentives to encourage accurate claim determinations. Under the new contracts, RACs will receive a 0.1 percent contingency fee increase for each percentage point below 10 percent that RACs maintain an overturn rate, and a 0.2 percent contingency fee increase for each percentage point above 95% that RACs maintain their accuracy rate.

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- **Revisions to Medicare Appeals Regulations**
  - 42 C.F.R. Part 405 Subpart I

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QUESTIONS?

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