Managing CMS Overpayments

MEDICARE/MEDICAID: JULIE A. JACOB

ALTHOUGH CMS PREVIOUSLY HAD GENERAL REQUIREMENTS FOR REPORTING AND REPAYING OVERPAYMENTS, A NEW RULE "PUTS STATUTORY FORM AND TEETH BEHIND IT," SAYS THOMAS FLYNN, HACKENSACK MERIDIAN HEALTH.

A strong compliance program and due diligence in investigating possible overpayments are crucial for complying with the Centers for Medicare & Medicaid Services' (CMS) new rule on reporting and repaying Medicare overpayments.

Although CMS previously had "general requirements" for reporting and repaying overpayments, the rule "puts statutory form and teeth behind it," said Thomas Flynn, vice president and chief compliance officer at Hackensack Meridian Health, Hackensack, N.J. The rule defines provider compliance with an Affordable Care Act (ACA) provision on reporting and repaying Medicare overpayments. CMS issued draft regulations in 2012, and after reviewing public comments, the federal agency issued the final rule earlier this year.

The final rule, published on Feb. 11 in the *Federal Register*, requires hospitals, physicians, and other providers to repay Medicare overpayments within 60 days of identifying the overpayment, although they can take up to six months to investigate suspected overpayments. The regulations require providers to report and repay identified overpayments occurring within the past six years. Repayments can be made by refunds, claims adjustments, a credit balance, or another "appropriate process," CMS stated in its summary of the regulations. Penalties are stiff for noncompliance: Providers that do not report and repay the overpayments are subject to penalties under the False Claims Act and could be prohibited from participating in federal healthcare programs, according to CMS.

Because the stakes are high, it's critical for health systems to be diligent about checking the accuracy of claims, Flynn said.

practices. Staff should understand their role in ensuring compliance, your policy and practice should reflect regulatory requirements, and there should be mechanisms to ensure that they are enforced."

For health systems that already have a strong compliance program in place, the new rule "doesn't really make a significant change in daily life," said Flynn. Still, even for healthcare providers that already have a solid compliance process, Flynn recommended these strategies for minimizing the risk of overpayment errors and quickly rectifying those that do occur.

Act promptly when an overpayment is identified. Although providers can take up to six months to investigate a possible overpayment, once it is identified, it must be repaid within 60 days. "Repay the money once it is determined whether the overpayment can be resolved or repaid," Flynn said.

Document due diligence. This means determining the process that identified the overpayment, how far back staff went to identify it, when the overpayment was repaid, and also the mechanism used to identify the payment, Flynn said. "Involve counsel early based on your policy," Flynn added.

Identify whether overpayments are single occurrences or the result of systemic problems. For example, Flynn explained, if it is determined that an overpayment resulted from a coding error, use reasonable judgment to determine whether the error was an isolated mistake or it was a result of a flaw in the billing system, or if there is a training need for coders, providers, or administrative staff. If the health system concludes that the error resulted from a systemic problem, it should determine when and how that systemic error crept into the billing system.

"That creates an obligation to look back over that period of time," Flynn said. "You either have to look back and say 'this is where the error started' or you have to go back six years."

Overpayment errors also can occur when physicians determine that treatments are medically necessary but CMS doesn't cover or pays at a different level of care than anticipated, Flynn said. He cited as an example the much-discussed two-midnight rule, which requires patients to stay in a hospital two nights in order for the care to be considered inpatient.

"Health care is complex," Flynn said. "There's been a lot of discussion of the two-midnight rule, and the shift of inpatient status to observational status. That's just one area where there's a tremendous risk either to patients in the form of higher out-of-pocket expenses for observation services or to the provider, when payment is denied for failing to meet inpatient criteria. Incorrectly identifying admission status can create a repayment obligation."

It's critical to find and correct overpayments resulting from systemic problems so that mistakes don't snowball into larger problems, he said. "Overpayments can happen every day due to inadvertent errors. A mistake is not fraud, but systemic mistakes uncorrected can be considered fraud over time," Flynn said.

1 2 >> SINGLE PAGE

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