Physician, Hospital Organizations Voice Opposition to CMS Overpayment Rule

By

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On February 16, 2012, the Center for Medicare and Medicaid Studies ("CMS") issued a proposed rule (the "Proposed Rule") that would require providers to report and return Medicare Part A and Part B overpayments to CMS within sixty (60) days of identification or face False Claims Act liability. The comment period on the Proposed Rule ended on April 16, 2012.

Since its initial publication, the Proposed Rule has been the subject of controversy among health care providers. Several stakeholder organizations, including the American Hospital Association ("AHA") and American Medical Association ("AMA"), have indicated that key components of the Proposed Rule will place undue administrative burdens on providers while simultaneously increasing their exposure to False Claims Act liability. Highlighting this controversy, 203 organizations and individuals submitted comment letters to CMS opposing the Proposed Rule. This article highlights a number of the more controversial provisions in the Proposed Rule.

First, the Proposed Rule creates an unrealistic approach for measuring the time period within which a perceived overpayment must be disclosed. Specifically, the Proposed Rule indicates that a provider is deemed to have "identified" an overpayment when the provider has actual knowledge of the overpayment. Additionally, incorporating standards from the False Claims Act, the Proposed Rule now indicates that a provider is deemed to have identified an overpayment if the provider acts in "reckless disregard or deliberate ignorance" of the overpayment. Supplementing these standards, CMS provided commentary in the Proposed Rule that, in instances where a provider receives information regarding an overpayment, "an obligation to make a reasonable inquiry" into the overpayment exists. In either of such cases, CMS stated the sixty (60) day period for mandatory disclosure will run from either the time the provider completes the inquiry, or, echoing the "reckless disregard" standard, at the time a provider receives knowledge of an overpayment but fails to act. Exacerbating this situation, CMS commented that the failure to comply with the sixty (60) day reporting period arising out of the murky concept of when a provider "knew" or "should have known" of a set number of claims arising out of hospital institutions with, literally, millions of claims annually results in a breach of a False Claims Act obligation with all of the resultant risk of fines, penalties and debarrment.

Another controversial aspect of the Proposed Rule is a new (10) year "look back" period for potential overpayments. Specifically, the Proposed Rule indicates that, if a provider identifies an overpayment, it will be legally required to review ten (10) years of claims data to determine if similar overpayments have occurred. As a corollary to this new requirement, CMS has also proposed amending the cost report reopening rules to allow it to reopen cost reports for a period of ten (10) years to determine if overpayments have occurred. The ten (10) year period

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reflects the outer limit of the False Claims Act statute of limitations and a significant modification of the more current rules that limit cost year reopenings to three (3) years, CMS having previously emphasized the need for closure to these reports.

In its comment letter to CMS, the AHA other provider organizations voiced strong opposition to the Proposed Rule. The Proposed Rule creates a "legally risky set of expectations for hospitals" and "fails to recognize the compliance burden it creates," AHA wrote. Specifically, AHA said the Proposed Rule places an "unreasonable emphasis on speed" during investigations into what could be thousands if not tens of thousands of patient records, leaving hospitals potentially open to a False Claims Act allegation if an overpayment is not returned within sixty (60) days of receipt. In addition, AHA said the ten (10) year look-back period, expanded from the normal four (4) years, will create "unreasonable burdens" for hospitals, including significant investments in information technology and human resources to ensure compliance.

AHA also characterized the Proposed Rule as a "legally flawed" attempted by CMS to expand False Claims Act liability for overpayments. "We viewed this provision in the ACA, and Congress intended it, as a means to correct mistakes," AHA stated. "Instead, the law is being contorted by this proposed rule to create another confusing, onerous and legally risky set of expectations for hospitals."

AHA also termed as "unreasonable and not feasible" CMS' position that providers must conduct a reasonable inquiry upon receipt of any information regarding an overpayment. According to AHA, CMS must give hospitals discretion to commit resources to overpayment investigations based on the credibility of the information source.

The American Medical Association ("AMA) similarly joined with over 127 physician organizations to oppose the Proposed Rule. In its April 16, 2012, letter to CMS, AMA stated the proposed definition of "identification" would, in effect, create a "perpetual duty" to research whether an overpayment may exist. "This requirement would be extremely burdensome for physicians, as it would impose a boundless duty to troll medical records in search of innumerable vulnerabilities," AMA wrote. AMA asked that CMS "make clear that…physicians are not obliged to proactively search for an overpayment without reason to believe that a specific overpayment exists."

AMA also commented that the Proposed Rule "does not clarify whether the 60-day period begins on the first day that each single overpayment has identified, or on the first day a [reasonable] inquiry has concluded and a 'batch' of possible overpayments has been reviewed." To remedy this ambiguity, AMA recommended that "CMS…finalize a policy that the 60-day period begins on the day that an error-specific overpayment inquiry has concluded."

How CMS will respond to the comments lodged by the AHA, AMA, and other providers remains unclear. In a recent presentation to the American Health Lawyers Association, CMS representatives gave no indication as to what changes they may adopt in the final rule. CMS has not provided a timeframe as to when it will issue a final rule. Providers should monitor this rule to determine what compliance actions may be needed moving forward.