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Compliance Today - June 2019
With every new year, a new lookback period for Medicare claims audits

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Voluntary self-audits of Medicare claims should be part of any provider's compliance program. For fee-for-service claims, these often focus on coding and billing of services. Both for purposes of defining the audit universe and for issuing refunds when appropriate, this article offers a consistent approach to defining a lookback period for auditing, and possibly refunding overpayments to, Medicare.

Traditional fee-for-service Medicare

It is well-established that Medicare overpayments must be returned by the later of: (1) 60days after the date on which the overpayment was identified, and (2) the date any corresponding cost report is due.[1] Less well-known is how far back in time one should self-audit to identify potential Medicare overpayments.

The answer depends on whether one views the circumstances surrounding the potential overpayment as: (1) a mere error, or (2) potentially a false claim by the provider under the federal False Claims Act (FCA) that resulted from either reckless disregard for the veracity of the claim, or deliberate ignorance of the same or, even worse, actual intent to file an improper claim.[2]

Overpayment resulting from mere error

Regarding an overpayment through mere error, although not a model of clarity, the prevailing lookback period in the applicable authorities appears to be a period that runs from the date of the Medicare remittance advice to a date that is five years from the first day of the following year. For example, if the remittance advice is dated June 1, 2019, proceed to the next New Year's Day (i.e., January 1, 2020) and add five years (i.e., January 1, 2025). Assuming one is auditing only claims recoverable from the Centers for Medicare & Medicaid Services (CMS), an audit of Medicare claims occurring on or after January 1, 2025, need not include claims prior to January 1, 2020.[3]

By way of further example, if the audit itself occurs during 2019, the lookback period would cover claims back to January 1, 2014. Any claim with a remittance advice during 2014 would look to the next New Year's Day (January 1, 2015) and add five years (through 2020) for the auditable period.

It is worthwhile to understand the authoritative support for this lookback period. The Office of Inspector General (OIG) routinely performs studies and makes recommendations on CMS operations in the interest of reducing fraud, waste, and abuse. In so doing, OIG recommended CMS pursue legislation to increase its lookback period for recovering overpayments. Accordingly, CMS proposed legislation in the American Taxpayer Relief Act of 2012 to establish a period of five years from the first day of the year following the date of payment.

The resulting statute is found at 42 U.S.C. § 1395gg(c). The statute as drafted does not create an across-the-board

lookback period. Instead, it applies the lookback period to a list of reasons for claim denial found at 42 U.S.C. § 1395y(a)(1) and (9).[4] The reasons at section (a)(1) relate mostly to the denied service being "not reasonable and necessary" to treat the illness or injury, or for the service being administered "more frequently than is covered" by Medicare. In the case of section (9), the service being denied would be for non-covered custodial care.

Of course, many types of claims denials are not included in 42 U.S.C. § 1395y(a)(1) and (9), including coding and billing errors. Rather than create one system for the statutory variants and another system for everything else, CMS appears to have adopted one standard for all circumstances in its administrative materials.

The Medicare Financial Management Manual addresses overpayments in Chapter 3 in a manner that supports the above interpretation.[5] Specifically, the five-year lookback period is found in section 80, "Individual Overpayments Discovered Subsequent to the Fifth Year," and states:

> There are special rules that apply when an overpayment is discovered subsequent to the fifth year following the year in which notice was sent that the amount was paid. Ordinarily, the provider or beneficiary will be considered without fault unless there is evidence to the contrary. In the absence of evidence to the contrary, the contractor will not demand and recover the determined overpayment. (One example of evidence to the contrary would be a pattern of billing errors. See, Medicare Program Integrity Manual, Publication (PIM) 100-08, Chapter 3.)

In light of the above quote, it is critical to determine what constitutes "evidence to the contrary" that would supplant the five-year lookback period. TheMedicare Program Integrity Manual does not provide much concrete assistance. It states that Medicare Administrative Contractors (MACs) "shall target providers/suppliers who have historically high claim denial rates, who have billing practices that vary from their peers, or when evidence suggests that there is a potential risk to the Medicare Trust Fund."[6]

These examples are insufficiently concrete. How should we determine what constitutes "evidence to the contrary"? This article proposes to use the same standards that apply to a potential FCA violation to determine when to override the five-year lookback period for overpayments and instead use the FCA statute of limitations.