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# Medicare 60-Day Rule Proposal Raises Concerns; MAC Process is 'Best Way' to Repay Money

By Nina Youngstrom

Because physicians may not know about or always comply with Medicare's requirement for shared decision-making with three services—automatic implantable cardiac defibrillators, lung cancer screening with low-dose CT scans and percutaneous left atrial appendage closure for atrial fibrillation—a routine audit may sniff out trouble. If that's the case, hospitals may have to do a more expansive audit under Medicare's 60-day overpayment return rule—going back years depending on the date of the national coverage determination (NCD). That's an example of the kind of audit that requires some time to get a full picture of where the hospital stands.

But hospitals won't have much time to identify possible overpayments and quantify them if CMS finalizes changes to Medicare's 60-day overpayment refund rule that were proposed Dec. 27, said Patrick Kennedy, executive system director of hospital compliance at UNC Health in North Carolina.[1] Organizations would be hampered in their ability to "determine whether we have an overpayment and return it" by the 60-day deadline, Kennedy said Jan. 13 at the Health Care Compliance Association's regional conference in Charlotte, North Carolina. That may be the case with the shared decision-making requirement, which involves a physician-patient encounter to evaluate the pros and cons of the procedure using an evidence-based decision tool, and other risk areas sprouting from NCDs or local coverage determinations (LCDs) that might take some time to nail down, although there are a number of other types of overpayments that could put hospitals in a jam if the time frame is tighter.

The 60-day rule—which came to life in the Affordable Care Act (ACA)—requires providers to report and return Parts A and B overpayments within 60 days of identifying them. According to the 2016 regulation interpreting the 60-day rule, providers are obligated to use reasonable diligence to identify overpayments by doing proactive compliance activities to monitor for overpayments and investigating potential overpayments in a timely manner.[2] CMS defined timely as within six months of receiving "credible information" about an overpayment. Now CMS envisions replacing "reasonable diligence" with language more consistent with the False Claims Act's knowledge standard. "Under the proposed rule, a provider or supplier has identified an overpayment if it has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment," according to CMS.

## 'It Makes a Lot of Sense in My Experience'

Kennedy said it seems like CMS is taking away the six months of investigation time by removing reasonable diligence from the definition, squeezing hospitals and other providers. If they find a high error rate in a challenging regulatory area through an internal audit, providers would have very little time to quantify the amount for the six-year lookback period of the 60-day rule. "I can't quantify the overpayment unless I have the number of accounts and total dollar amount," Kennedy said. "By going to a definition of knowingly, once we identify our error rate from a random sample, at that point we know we have an overpayment. Exactly how much,

we don't know yet." The proposal would move up the timeline.

Suppose the compliance team is conducting an audit or investigation and believes its organization has been overpaid because, for example, it doesn't comply with medical-necessity standards (e.g., an NCD) or the patients shouldn't have been admitted as inpatients under the two-midnight rule. "That is actual knowledge that may start the 60-day clock to return the overpayment if the proposed rule is finalized as is," Kennedy said.

Other experts are less worried about the meaning of the proposed change to the 60-day rule. Attorney Gabriel Imperato, who also spoke at the conference, thinks substituting the knowing or knowingly standard under the FCA "makes a lot of sense in my experience." The reasonable diligence requirement in the current rule, "absent the six-month requirement, is more or less the same as the deliberate ignorance or reckless disregard standard," said Imperato, with Nelson Mullins in Fort Lauderdale, Florida. "If you exercise reasonable diligence in responding to reports of potential overpayments, you won't be acting in reckless disregard or deliberate ignorance."

## Change in Ownership May Shorten Lookback Period

While the debate about the implications of the proposed change rages on, providers must continue to abide by the longstanding definitions. Under the meaning of identification of an overpayment, the 2016 overpayment regulation states that an overpayment must be reported 60 days after it was identified or the date the corresponding cost report was due. A provider or supplier "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." Kennedy said generally this means that "as a compliance professional, we have moved through the process of investigating an issue." The six months the regulation allows for the process tends to be enough time, give or take, depending on the issue. UNC generally doesn't start the 60-day clock until it knows the full population of claims in error and has locked down the overpayment amount.

Although the regulation says the lookback period should be no more than six years, it can be shortened in some situations, Kennedy said. For one thing, when organizations change ownership, the lookback period would only go as far back as the date the entity is purchased. Suppose a hospital had bought an entity two years earlier and discovers liability, Imperato said. "The liability only extends to the time of the purchase, not before," he noted. UNC has been through this experience. "UNC took on a new hospital and we had pointed conversations with our legal counsel," Kennedy explained. "If we were doing routine audits, we would not look at any time prior to the change in ownership." Also, a major change in electronic health record (EHR) systems "could be a reason to shorten that time frame, but it's important to work with legal counsel," he said.

## MAC Refund Process Plus Letter Is Effective

The regulation also describes how to report and return overpayments, including the use of self-reporting and credit balances. With routine audits, Kennedy said UNC generally looks back a maximum of 12 months and adjusts any erroneous payments electronically. It's a lot easier from an administrative standpoint to make changes to claims when "we can do it in a compliant way," he said. When claims can't be adjusted electronically or go much farther back than 12 months, UNC uses the Medicare administrative contractor's (Palmetto's) voluntary refund process, which is simply a form, but UNC supplements it with a letter that explains the reason for the overpayment return. "If you can do that, it's the best way to refund overpayments," Kennedy said. "I have been involved in many refund situations over my career and have yet to hear back from Palmetto with concerns. They typically just cash the check."

He said the letter shows that UNC has an effective compliance program, which led to the identification of a

compliance issue that caused the overpayment.

When all signs point to a more significant audit, UNC engages legal counsel and invokes the cloak of attorney-client privilege. "Not every situation needs attorney-client privilege, but you need to think about it and have the conversation about the lookback period," Kennedy said.

Examples of overpayments from the regulation include:

- Payments for noncovered services. He calls this "the art of assessing whether services are medically necessary or noncovered based on the regulations" and LCDs/NCDs. "If you don't have a living, breathing, effective auditing and monitoring program, you're setting up your organization for greater liability in terms of holding payments for services that could be deemed not medically necessary or not covered by some regulation in Medicare."
- Duplicate payments.
- Payments in excess of allowable amounts for covered services.
- Errors and nonreimbursable expenditures in cost reports.
- Payments when another payer has primary responsibility for payment. "We have had our fair share of Medicare as secondary payer audits by Palmetto," Kennedy said. A few years ago, the MAC's Medicare as secondary payer (MSP) auditors started asking about UNC's credit balance processes and whether it had identified any credits. The message: "Pay attention to the way contractors work with you and ask questions because it could implicate overpayments."

## Rating the Relative Risk of a Compliance Issue

Kennedy explained UNC's expectations for identifying and returning overpayment under Medicare's 60-day rule, which he said is considered everyone's responsibility. "First, you need to make sure your entire workforce knows how to report potential and actual issues to your compliance officer," he said. Beyond that, certain people in the C-suite and key noncompliance departments should have a general sense of the 60-day rule and the obligations it places on your organization. More specifically, patient financial services should have a deeper understanding of the 60-day rule because they routinely look at claims going out the door and remittances coming back. The same goes for chargemaster and revenue integrity staff.

In terms of identifying errors and rating the risk they pose to the organization, Kennedy said typically, his compliance analysts audit a random sample of 30 claims from the previous 12 months, although the sample size and audit period will vary by the volume of claims submitted at the time.

## Low, Moderate or High-Risk Category?

Whatever the risk area is, the compliance analysts get a fix on the error rate for the sample. The next phase will be to evaluate whether the risk area falls into a low, moderate or high-risk category by scoring it according to various risk factors. "The error rate is not the same as the risk factor score," Kennedy noted. The risk factor score indicates whether the audit results in low, moderate or high risk. The error rate together with the risk factor score help inform additional audit work or investigations.[3] UNC uses four risk factors to score a risk area as low, moderate or high:

- Financial (claims in error and the amount of overpayments or underpayments identified during the audit).

- Regulatory (extensiveness of regulations and thoroughness of internal documentation to support compliance).
- Operational (expected effectiveness of implemented and planned actions by management).
- Complexity (inherent complexity of the particular service audited).

"We rate them from one to five, with five a very high risk," Kennedy said. "Then there's an algorithm that calculates all those into one score." One to 5.5 is low risk, six to 10.5 is moderate and 11 and above is high risk. The risk rating triggers different responses. For example, a moderate score will trigger education for applicable staff, self-monitoring by the department for three months and reporting to compliance. Actual overpayments identified are returned at all levels of risk.

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**1** Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications, 87 Fed. Reg. 79,452 (Dec. 27, 2022), https://bit.ly/3wl9Cv0.
**2** Medicare Program; Reporting and Returning of Overpayments, 81 Fed. Reg. 7,653 (Feb. 12, 2016), https://bit.ly/2UTAGT2.
**3** Nina Youngstrom, "Rating Risks: Four Risk Factors and the Possible Responses," *Report on Medicare Compliance* 32, no. 3 (January 23, 2023).