You're on the clock: Getting ahead of the 60-day overpayment provision

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Revenue integrity professionals are on the clock—the 60-day clock, otherwise known as the 60-day provision or the 60-day rule. The Affordable Care Act (ACA), Section 6402, subsequently codified in 42 *U.S.C.* §1320a-7k, established that healthcare providers and suppliers must report and return Medicare overpayments and must do so within 60 days of identification of the overpayment. On February 12, 2016, CMS published a final rule providing regulatory guidance for compliance with the 60-day provision (*Federal Register,* 2016). Because noncompliance can result in a violation of the False Claims Act (FCA), determining when the clock starts is very important (GPO, 2011). The FCA underscores that all providers and suppliers must report and return overpayments, regardless of the source of federal funds.

Anyone connected with an organization can bring attention to a potential overpayment. A patient complaint, a hotline call, or an employee identifying an issue through normal work process (for example, in the course of a revenue integrity professional's duties) are all valid ways an issue might come to management's attention. The following are some examples of overpayments:

- Anti-kickback statute or Stark Law violation
- Chargemaster error
- Duplicate payment
- Excluded provider
- Failure to return credit balance
- Incorrectly coded service
- Medicare paid as primary when another carrier was primary
- Payment for a noncovered or uncovered service
- Payment for a service that did not meet medical necessity
- Payment in excess of the allowable amount for an identified covered service
- Unit error for services provided

CMS final rule

According to the final rule, "An overpayment must be reported and returned regardless of the reason it happened—be it a human or system error, fraudulent behavior, or otherwise" (*Federal Register,* 2016). In addition, an overpayment is not excluded from the requirements of the 60-day rule even if the overpayment was outside the control of the provider or supplier. Providers and suppliers are obligated to report and return any overpayments they have received within the specified statutory time frames. As previously noted, an overpayment can come from almost anywhere. If the funds received were funds the provider was not entitled to, they constitute an overpayment (*Federal Register,* 2016; GPO, 2013).

Reporting deadlines are one of the key elements to keep track of. A person who has received an overpayment must report and return it by the later of the following:

- The date that is 60 days after the date on which the overpayment was identified
- The date any corresponding cost report is due, if applicable

The 60-day time period begins either:

- On the day on which reasonable diligence is completed and the overpayment is identified (including quantification)
- If the person fails to conduct reasonable diligence, on the day the person received credible information of a potential overpayment

The 60-day rule defines "identified" as when a provider "has or should have, through the exercise of reasonable diligence, determined that the [provider] has received an overpayment and quantified the amount of the overpayment" (*Federal Register,* 2016). In the final rule, CMS indicated that a timely investigation and quantification should be completed within six months of receiving credible information. Once the overpayment is identified, the 60-day clock starts. That said, identification and quantification are complex processes with some exceptions, so it is highly recommended that qualified healthcare counsel and competent consulting professionals be consulted as early as possible in the process.

Once an overpayment is reported, management has an obligation to investigate and demonstrate due diligence. As long as management is exercising reasonable diligence to identify the overpayment, the 60-day repayment clock does not start. Failure to exercise reasonable diligence could cause the 60-day clock to start as of the date the provider received and identified credible information that an overpayment occurred.

The United States of America ex rel. Kane v. Continuum Health Partners, Inc. is a good example of why a timely investigation is crucial. In September 2010, the New York state comptroller's office raised questions regarding incorrect Medicaid billing and payment with several hospitals, including Continuum. Continuum gave its revenue cycle director, Robert Kane, the task of identifying the claims incorrectly billed. On February 4, 2011 (five months after the comptroller contacted Continuum), Kane provided the management team a spreadsheet identifying the claims with the wrong code. This amounted to more than 900 claims totaling more than $1 million. Kane's cover email said that additional analysis was required to confirm the findings but that the spreadsheet gave "some insight into the magnitude of the issue." Continuum terminated Kane four days after the email, reimbursed the government for only five claims on the Kane spreadsheet, and, according to the government, "did nothing further." Kane filed a *qui tam* (whistleblower) complaint in April 2011. After the government issued a civil investigative demand in June 2012, Continuum refunded more than 300 affected claims. If Continuum had taken steps to further investigate and had exercised due diligence, it would have paid the quantified amount of $844,000; instead, Continuum agreed to pay $2.95 million to resolve FCA allegations that it failed to investigate and repay overpayments in a timely manner under the 60-day provision (SDNY, n.d.).

Determining credibility

Prompt evaluation of the information that a potential overpayment has been received is necessary to determine the information's credibility. Answers to the following questions are vital:

- How was the potential overpayment discovered?
- Who discovered it?

- Who needs to be involved in the investigation?
  - Legal counsel
  - Compliance personnel
  - Others
- Are those involved in the investigation unbiased and independent?
- Is it necessary to engage independent, qualified, and competent counsel and consulting professionals?
- What system(s), if any, contributed to the potential overpayment? For example, does the chargemaster include inaccurate Current Procedural Terminology® codes?
- How long has the potential issue existed?

If the investigation finds a credible overpayment occurrence, it does not mean the 60-day clock has started since the amount of overpayment has not yet been quantified.

Quantifying the overpayment

Quantifying the amount of overpayment is challenging. To start, the provision indicates the "look-back period" can be up to six years. That means if there was a systemic error within the chargemaster, the provider is obligated to not only look at recent claims but also determine how long ago the overpayment occurred. This may require doing a probe sample and then additional sampling by using either statistical methodologies or data reports. At the point when the quantification is completed, the clock starts ticking, and the provider has 60 days to repay. As seen in the *Kane* case, the provider is obligated to perform these tasks in a timely manner.

Documenting due diligence

Maintaining complete documentation of the investigation and the quantification methodology is an important factor in proving due diligence. This really is no different than other compliance-related investigations. Documentation should include:

- All internal memos, reports, work papers, activity logs, and resolutions or outcomes
- Identification of interviewers and their qualifications
- Identification of who was interviewed
- Information about legal counsel involvement
- Look-back period
- Methodology used to quantify the overpayment
- Outcome of the interview(s)
- Rationale for the methodology used to quantify the overpayment
- Rationale used to determine the look-back period
- Repayment methodology

Repayment

Section 6402(a) of the ACA established a new Section 1128J(d) of the Social Security Act. The new section states, "the person [provider] shall both report and return the overpayment to the Secretary, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and notify the Secretary, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment" (*Federal Register,* 2016). Numerous repayment methodologies exist:

- The provider could use the normal claims adjustment process. If this is the methodology used, claims should be documented and tracked to substantiate the adjustment was properly adjudicated.
- A credit balance adjustment could be made.
- A self-reported refund could be completed (CMS, 2018).
- A voluntary offset from the contractor could be requested. If the overpayment is related to violations of the physician self-referral law, then the self-referral disclosure protocol may be applicable.

For more information, refer to the CMS website, and seek advice from legal counsel.