



Via Electronic Submission

April 16, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare Program; Reporting and Returning of Overpayments AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS ACTION: Proposed Rule [CMS-6037-P] RIN 0938-AQ58.¹

Dear Acting Administrator Tavenner:

The American Association for Homecare (AAHomecare) submits these comments in response to the Centers for Medicare and Medicaid Services' (CMS') request for comments on the above captioned proposed rule. The proposed rule would require providers and suppliers receiving funds under the Medicare program to report and return overpayments by the later of the date that is 60 days after the date on which the overpayment was identified, or [the date] any corresponding cost report is due.

AAHomecare is the national trade association representing providers and manufacturers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) used by Medicare beneficiaries in their homes. In light of our members' expertise and experience, AAHomecare is uniquely qualified to comment on the proposed rule.

AAHomecare has a strong record of support for effective Medicare program integrity controls. CMS must ensure that funds intended to pay for items and services covered by Medicare are not diverted from the program. Consequently, AAHomecare supports the goals underlying the proposed rule. Providers and suppliers should make a prompt refund once they have actually identified an overpayment and should implement and

¹ 77 Fed. Reg. 9179 (February 16, 2012).

maintain programs to prevent, identify and resolve instances of incorrect billing. AAHomecare adopted a Code of Business Ethics to promote ethical and compliant business practices throughout the DMEPOS provider industry.² While the Association emphatically supports the goals the regulation intends to accomplish, we have a number of concerns about the potential scope of the proposed rule.

Specifically, the regulation adopts a broad definition of when an overpayment is “identified” and imposes an unreasonably long “look back” period for determining whether a provider identified overpayments subject to the rule. These provisions open the door to contractors “second-guessing” a provider’s determination of whether an actual overpayment exists (i.e., whether an overpayment has been identified by the provider), creating exposure to significant liabilities for providers who have otherwise acted in good faith.

In the case of DMEPOS providers who are reimbursed on a claims basis, an overpayment is “identified” if the provider has actual knowledge that an overpayment exists *or* the provider “acts in reckless disregard or deliberate ignorance of an overpayment.” Application of the 60-day refund requirement to overpaid claims under the first prong of this definition should be straightforward. That is, the provider must refund the overpayment within 60 days of the date that he or she has actually identified an overpayment amount. The 60-day refund requirement also applies from the date a provider has information that an overpayment may have occurred but does nothing to determine whether an overpayment actually exists.

AAHomecare agrees that providers have an obligation to promptly investigate and resolve allegations that an overpayment exists. As noted above, the AAHomecare Code of Business Ethics requires providers who adopt the Code to refund of any overpayment and the applicable patient copayment and deductible amounts promptly. However, providers who conduct an internal investigation consistent with their company policies and procedures should not be subjected to the government second-guessing their determinations on the basis that they were not sufficiently “diligent” or “reasonable” as the preamble to the proposed rule suggests. This latter scenario gives rise to a number of grey areas that CMS has not adequately addressed in the proposed rule and whose outcome can have important consequences for otherwise well-meaning and honest providers, especially in light of the ten-year look back period CMS proposes to include in the rule. AAHomecare addresses these issues in more detail below.

I. THE DEFINITION OF “IDENTIFIED” IS TOO BROAD AND SHOULD BE LIMITED TO INSTANCES WHERE A PROVIDER HAS “IDENTIFIED” AN ACTUAL OVERPAYMENT AMOUNT

² AAHomecare Code of Business Ethics available at: <http://www.aahomecare.org/codeofethics>

The proposed rule implements §6402 of the Patient Protection and Affordable Care Act (ACA), which requires providers and suppliers to report and refund an overpayment to the Secretary, the state, a carrier or a contractor and to provide the Secretary, state, carrier or contractor an explanation for why the overpayment occurred. An overpayment is defined as “any funds that a person receives under Title XVIII . . . to which the person, after applicable reconciliation is not entitled under such title.” A provider or supplier has 60 days after the date an overpayment is identified to report and refund the overpayment to the appropriate entity. Importantly, providers who fail to report and refund overpayments within the 60-day deadline would face liability for false claims.

Section 6402 defines “knowing” and “knowingly” as those terms are defined under the False Claims Act (FCA) even though the statutory text does not use those terms other than in the definitions.³ CMS acknowledges this point in the preamble, but the Agency nonetheless over reaches to adopt the definition, giving itself broad discretion to claim, for up to ten years after the fact, that a provider’s efforts to comply with the requirements of 6402 were inadequate. The definition of “identified” under the proposed rule is too broad, unfairly exposing providers to liability for false claims based on purely subjective second guessing of conduct that does not involve fraud or other misconduct.

Consequently, AAHomecare recommends that CMS revise the proposed rule to state that an overpayment is “identified” when the provider has actual knowledge of an overpayment amount.

II. PROVIDERS SHOULD NOT BE OBLIGATED TO REFUND DISPUTED AMOUNTS

It is clear that a provider or supplier has identified an overpayment if he or she has actual knowledge of the existence of an overpayment amount. The preamble to the proposed rule cites a number of examples to demonstrate instances where a provider who identifies an actual overpayment has an obligation to make a refund and comply with the other provisions of the proposed rule. The examples include:

- A provider of services or supplier reviews billing or payment records and learns that it incorrectly coded certain services, resulting in increased reimbursement;

³ (1) the terms “knowing” and “knowingly” --

(A) mean that a person, with respect to information --

(i) has actual knowledge of the information;

(ii) acts in deliberate ignorance of the truth or falsity of the information; or

(iii) acts in reckless disregard of the truth or falsity of the information;

- A provider of services or supplier learns that a patient death occurred prior to the service date on a claim that has been submitted for payment;
- A provider of services or supplier learns that services were provided by an unlicensed or excluded individual on its behalf; and,
- A provider of services or supplier performs an internal audit and discovers that overpayments exist.

A provider should not, however, have an obligation to make a refund triggered as of the date a provider learns of a *possible* overpayment if, as the preamble suggests, CMS is dissatisfied with the length or scope of the provider's investigation and/or determines that his or her efforts were not "diligent" or "reasonable." For example, there may be unresolved factual or legal issues that call into question the existence of an overpayment, especially in situations involving government audits. In these cases, the fact that the disputed legal or factual issues are not resolved in the provider's favor does not mean that the provider acted in "reckless disregard" or "deliberate ignorance" of the overpayment.

CMS implicitly acknowledges this point both in the preamble and in the language of the proposed rule by suspending the obligation to refund overpayments when providers self-disclose under the Office of Inspector General's (OIG) self-disclosure protocol (SDP) until the provider reaches a settlement with the OIG or is removed from the SDP. The proposed rule would also suspend the refund requirement when providers self-disclose potential Stark violations. However, the proposed rule does not contain a similar provision for appeals of a government audit. Instead, the preamble states that providers who receive a demand letter must investigate the audit findings and refund any overpayment they find. Presumably, a provider who appeals audit findings would not have to refund monies within 60 days of having received a contractor demand letter even though the preamble to the proposed rule does not state this explicitly.

CMS' silence on this issue is troubling because an overpayment resulting from an audit can include hundreds of beneficiaries and dates of service and requires volumes of documentation to support the medical necessity of each claim. The broad definition for when an overpayment is "identified" is, again, the source of these concerns. It is nearly impossible to investigate and resolve all of these allegedly overpaid claims within a 60-day window.⁴ Yet providers who appeal and do not prevail on all of the claims could be open to FCA liability under the terms of the proposed rule if CMS were to determine at the conclusion of the appeal that the provider was not diligent in conducting its

⁴ The statutory Medicare claims appeals procedures recognize this. Suppliers have 120 days to request a redetermination and 180 days to request a reconsideration of claim reopenings.

investigation.⁵ Under these circumstances, however, the overpayment, if any, is factually and/or legally *disputed* such that an obligation to report and refund should not apply.⁶ Similarly, if an investigation presents unusual legal or factual or other issues (e.g., the need to locate witnesses or archived materials) that take time to resolve, a provider who acts without fraud should not have exposure to FCA liability on the basis that its investigation was dilatory.

AAHomecare reiterates its recommendation that CMS revise the definition of when an overpayment is “identified” to instances where a provider has actual knowledge of an overpayment amount. Additionally, AAHomecare recommends that CMS revise the proposed rule to include an exception to the duty to refund an overpayment when a provider appeals a government audit.

III. THE TEN-YEAR “LOOK BACK” PERIOD IS UNREASONABLE

Providers would have an obligation to refund overpayment for claims up to ten years from the date the claim was adjudicated and paid. CMS believes that a ten-year look back period would be an appropriate bar to the obligation to refund overpayments, giving providers finality on their exposure for liability under the law. CMS is also of the view that a ten-year look back period is proper because it is the outer limit for initiating an action under the FCA. Finally, CMS intends to allow contractors to reopen claims within ten years of the date the claim was paid.

The proposed ten-year look back period is unreasonable, and CMS’ rationale for adopting it is flawed. First, while it is correct that there is a ten-year statute of limitations for the government to initiate an action under FCA, this limitations period applies only when a defendant intentionally concealed the false claim, preventing the government’s timely prosecution. In other words, the ten-year limitations period is an exception that applies only when the defendant’s fraud or other misconduct conceals the false claim from the government.

In contrast, CMS is proposing to implement a ten-year look back period for refunding overpayments despite the lack of evidence that a provider acted fraudulently or intentionally to conceal an overpayment. The excessive look period would also unfairly impact providers that have to defend an FCA violation based on stale claims. All providers understand that they must retain documentation for claims they submit for a period of seven years. Expanding the look back period to ten years for an FCA violation is not only inconsistent with the statutory limitations period in the absence of fraud or

⁵ We note that providers who appeal are not subject to recoupment of the alleged overpayments on appeal until the conclusion of the reconsideration level of appeal.

⁶ This is also the case when is placed in the position of defending a *Qui Tam* action. Although technically a *qui tam* might put a provider on notice that an overpayment may exist, the existence of disputed law and facts do not trigger the obligation to refund an overpayment under the provisions of the proposed rule.

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concealment but also would hinder most providers' ability to defend such claims because the documentation is not available.

Moreover, rather than affording providers finality with respect to their obligation to refund overpayments, the ten-year look back period will have the opposite effect by permitting CMS or a contractor to reopen claims for as long as ten years after the date they were adjudicated on the basis that a provider acted in reckless disregard or deliberate ignorance of an overpayment. The ten-year look back period, coupled with the broad standard for determining when an overpayment is identified, unreasonably exposes providers to liability under the FCA in the absence of fraud or other misconduct.

The look back period for refunding overpayments should be consistent with the rules governing claim reopenings. In the alternative, if CMS' intent is to make the application of the proposed rule consistent with the FCA, CMS should limit the look back period to six years as the FCA provides. Finally, AAHomecare reiterates its recommendation that CMS revise the definition of "identified" to instances where a provider has identified an actual overpayment amount.

IV. CONCLUSION

AAHomecare requests that CMS modify the proposed rule as we have requested above. Specifically, AAHomecare recommends that CMS revise the proposed rule to state that an overpayment is "identified" when the provider has actual knowledge of an overpayment amount. Additionally, AAHomecare recommends that CMS revise the proposed rule to include an exception to the duty to refund an overpayment when a provider appeals a government audit. Finally, the look back period for refunding overpayments should be consistent with the rules governing claim reopenings. In the alternative, if CMS' intent is to make the application of the proposed rule consistent with the FCA, CMS should limit the look back period to six years as the FCA provides.

The Association is available to discuss the issues we have raised at your convenience.

Sincerely,



Walter Gorski

Vice President of Government Affairs