RAC MONITOR

"Audit Impact: Expanded Liability for Overpayments"

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Recent changes under the Patient Protection and Affordable Care Act (PPACA) create new risks for false claims liability when auditors identify overpayments. Section 6402(d) of PPACA amended the Social Security Act to require an entity to notify and return any overpayment that it has received. The overpayment must be reported and returned to the appropriate entity (such as CMS, OIG, or the carrier) no later than 60 days from "the date on which the overpayment was identified" or "the date any corresponding cost report is due, if applicable." Furthermore, PPACA makes the retention of an overpayment beyond this timeframe an obligation under the False Claims Act.

Prior to the Fraud Enforcement and Recovery Act of 2009 (FERA), the False Claims Act extended liability to "any person who...knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease any obligation to pay or transmit property to the Government." FERA focused on retention of an overpayment ("reverse false claims") rather than the affirmative submission of a false record or statement. FERA expanded false claims liability to include a person who "knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the government." The term "knowing" is defined to include "deliberate ignorance" or "reckless disregard." Thus, FERA eliminated the requirement of an affirmative act of concealment and expanded false claims liability to include the knowing failure to repay an overpayment.

The changes implemented under PPACA and FERA directly impact overpayments identified by audit contractors and raise important issues for providers weathering a RAC or Medicare audit. For instance, when does an overpayment become "identified" in order to trigger the 60 day time period for reporting and returning the overpayment? The Office of the Inspector General (OIG) has yet to clarify at what point these obligations are triggered in the audit context. The Medicare appeals process may shelter providers appealing claim denials from an immediate obligation to repay during the appeal, but the obligation may apply once the appeals process is completed. The appeals process also offers providers a limitation on recoupment of current Medicare payments during the first two stages of appeal and may satisfy the overpayment reporting requirement. At present, the application of the 60 day timeframe for reporting and returning remains unclear as it applies to the various aspects of the appeals process.

The interplay between PPACA and FERA also raises questions about the responsibilities of providers who realize during an audit review that they received an overpayment and the potential penalties for providers with an inability to pay back an overpayment. While these issues do not have clear answers at this time, providers can expect to gain a greater sense of clarity as to their liabilities and responsibilities pertaining to the retention of overpayments as these statutory provisions are applied in practice. In the meantime, it is important for entities in the RAC and Medicare audit process to carefully consider whether, at any stage in the appeals process, the facts demonstrate an existing overpayment. If an overpayment is discovered, healthcare providers are advised to discuss their obligation to repay

the overpayment with legal counsel in order to help minimize the risk of liability under the False Claims Act.

Liability under the False Claims Act is significant. The retention of an identified overpayment can result in civil monetary penalties, which includes $10,000 for each item or service and an assessment of three times the amount claimed for each item or service. Moreover, failure to report and return an overpayment may result in an exclusion from participation in the federal and state health care programs.

In addition to the aforementioned liability under the False Claims Act, any potential liability is enhanced by Medicare's new recoupment authority under PPACA. Section 6401(a) of PPACA grants CMS the authority to adjust payments to related providers and suppliers on the basis of their federal tax identification numbers. The new rules allow CMS to hold providers and suppliers with the same tax identification number, regardless of their billing number or NPI number, liable for the debts of "related parties." Previously, CMS could only recover unpaid Medicare overpayments from related entities sharing the same provider number. The previous system limited Medicare's recoupment ability since most entities with multiple sites enroll under different provider numbers. CMS may now reduce funds due to related providers and suppliers as long as they share a federal tax identification number. This change to permit "cross-provider" recoveries enhances Medicare's ability to collect overpayments from entities with multiple locations and provider numbers.

As increased audit activities from a variety of audit contractors continue to pick up steam, providers are advised to become aware of the potential liabilities related to the identification of Medicare overpayments and develop a comprehensive plan for a successful audit appeal.