Advisory

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Recent Case Highlights Need for Providers to Comply with the 60-Day Overpayment Rule

On October 13, 2017, the United States Department of Justice ("DOJ") announced a $448,821.58 settlement with First Coast Cardiovascular Institute, PA ("First Coast"), a Florida provider of clinical and laboratory services, to resolve allegations that First Coast unlawfully retained $175,000 in overpayments. This settlement sends a clear message to the health care community that the federal government is serious about pursuing providers that fail to report and refund overpayments within 60 days, regardless of the unintentional nature of the underlying conduct that resulted in the overpayment.

The government's complaint alleged that First Coast overbilled federal health care programs. However, instead of alleging that these overpayments resulted from improperly billing a particular service or CPT code, the government stated that the provider violated the federal False Claims Act by retaining certain credit balances that it received and failing to return them to the applicable federal payors within 60 days of their discovery. These credit balances were caused for many different reasons, including overpayments and duplicate payments received from insurers, coordination of benefit conflicts, improper collection of upfront payments, or change corrections made to claims after payments were made. In fact, credit balances are common in the health care industry because payment issues often take a long time to be resolved between providers, payors, and patients. In the complaint, the government explained that "over-billing can occur for a variety of reasons, even innocently- for example, where a patient has two different insurances, sometimes both are billed as a primary insurer, or where an insurer is inadvertently billed twice for the same procedure, and so forth. This is a normal occurrence in the health care field."

Despite the "innocent" nature of the overpayment, the DOJ pursued First Coast because the provider failed to resolve those credit balances by returning overpayments to federal health care programs. In the DOJ's press release announcing the settlement, Acting U.S. Attorney Stephen Muldrow is quoted as saying: "When [First Coast] learned that it had received over $175,000 in potential overpayments to federal health care programs in 2016, it had a legal obligation to return those funds within 60 days."

The Affordable Care Act first created the express requirement for providers to report and return overpayments, but it was

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not until February 12, 2016 that the United States Department of Health and Human Services, Centers for Medicare & Medicaid Services ("CMS") issued the long-awaited Final Rule on Reporting and Returning Overpayments. The Final Rule provided much needed clarity by explaining that an overpayment has been identified when the provider or supplier has, or should have, "through the exercise of reasonable diligence," determined that an overpayment has been received and quantified. Also, the Final Rule clarified that an overpayment must be reported and returned if the overpayment is discovered within six years of the date that the overpayment was received. For more information on the 60-Day Rule, see our advisory available here.

The lawsuit against First Coast was based on a whistleblower complaint by First Coast's former Executive Director, who alleged that he had raised the credit balance issue with leaders within the organization multiple times, but no actions were taken to resolve the problem. Pursuant to the False Claims Act whistleblower provisions, he will receive about $90,000 of the proceeds from the settlement. The credit balance amount that the government claimed First Coast illegally retained was relatively small, especially considering that the provider operates ten different clinics in Florida. However, the settlement amount was over 2.5 times that amount, indicating that the False Claims Act's severe penalties played a role in the settlement negotiations.

Providers should remain vigilant in investigating, quantifying, and reporting overpayments in accordance with the law and CMS guidance. Some steps that providers can take to ameliorate risk include: (1) conducting proactive audits of claims submitted to federal health care programs; (2) educating billers, coders and others involved in the claims process on their obligation to report billing issues to compliance staff; (3) investigating credible allegations of potential overpayments, such as compliance hotline calls, patient complaints, and internal as well as external audits; and (4) documenting responses to credible allegations of potential overpayments.

If you have questions about this advisory or want to learn more about the Health Care Compliance, Fraud and Abuse Practice Group, contact Maureen Weaver at mweaver@wiggin.com or Jody Erdfarb at jerdfarb@wiggin.com