April 16, 2012

Marilyn B. Tavenner
Acting Administrator
Centers for Medicare and Medicaid Services
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 [CMS-6037-P]

Dear Acting Administrator Tavenner,

The undersigned organizations appreciate the opportunity to provide comment on the proposed rule entitled *Returning and Reporting of Overpayments* [CMS-6037-P]. We are cognizant that physicians are currently obliged to return overpayments, per § 6402(a) of the Patient Protection and Affordable Care Act (ACA), and are pleased that the Centers for Medicare and Medicaid Services (CMS) is promulgating further guidance regarding how physicians may comply with this obligation. However, the proposed rule fails to clarify key elements of the obligation and contravenes other existing CMS overpayment initiatives. CMS should finalize clear, bright-line guidance in accordance with our comments below.

No Perpetual Duty to Identify

CMS proposes that a person has identified an overpayment if the person has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment. Should CMS decide to proceed with the proposed definition of "identified," CMS should clarify in the final rule that this does not impose an ongoing duty on physicians to proactively search for overpayments absent receipt of information that an overpayment may exist. CMS states in the preamble that:

> We believe defining "identification" in this way gives providers and suppliers an incentive to exercise reasonable diligence to determine whether an overpayment exists. Without such a definition, some providers and suppliers might avoid performing activities to determine whether an overpayment exists, such as self-audits, compliance checks, and other additional research.

This commentary indicates that a physician has a perpetual duty to "research" whether any overpayment may exist. This requirement would be extremely burdensome for physicians, as it would impose a boundless duty to troll medical records in search of innumerable vulnerabilities. Moreover, § 6402(a) does not impose such a requirement. We understand that CMS' requirements for periodic self-audits and compliance checks will be promulgated in a separate rulemaking pursuant to § 6401(a) of the ACA; that rulemaking is a more appropriate vehicle for CMS' proposals on those topics. **CMS should make clear that in the context of § 6402(a), physicians are not obliged to proactively search for an overpayment without reason to believe that a specific overpayment exists.**

60-Day Reporting Period

Section 6402(a) requires that a physician report and return an overpayment by 60 days after the date on which the overpayment was identified. We are concerned that without further clarification from CMS, this time period may prove a source of contention. Physicians who identify an initial overpayment are likely to inquire over the following days or weeks regarding the existence of other overpayments based on the same error. This will be a particularly laborious process for physicians who utilize external billing services and need to obtain records from third parties. The proposed rule does not clarify whether the 60-day period begins on the first day that each single overpayment is identified, or on the first day that the inquiry has concluded and a "batch" of possible overpayments has been reviewed. **To avoid the confusion that numerous, subsequent reporting days would cause, CMS should finalize a policy that the 60-day period begins on the day that an error-specific overpayment inquiry has concluded.**

Look Back Period

We are adamantly opposed to the proposed 10-year look back period. Even absent a perpetual duty to identify overpayments, CMS' proposal could require physicians to comb through 10 years of files to conduct a reasonable inquiry regarding whether an overpayment exists. As many physicians transition from paper-based files to electronic files, this could require physicians to adopt several methods of review based on file type. Further, this would require physicians to cross-reference code sets with those codes designated for use at the time of billing—a daunting task for a few year period, and an insurmountable burden for a 10-year period.

The proposed 10-year look back period is extreme in comparison to other reopening laws and regulations. The Medicare reopening regulation allows a claim to be reopened with one year for any reason, within four years with good cause, and at any time if there is evidence of fraud. Similarly, the False Claims Act (FCA) generally allows a six-year look back period. CMS inaccurately cites the FCA as the basis for the proposed 10-year look back period; the FCA only allows a 10-year look back period in the rare case where facts material to the right of action were not previously known by the government. Furthermore, the federal health care programs have historically required a shorter record retention requirement. For example, Medicare fee-for-service providers are generally bound to retain documentation for six years.

To remain consistent with other CMS overpayment initiatives, CMS should provide for a three-year look back period. CMS recently published its final rule on the Medicaid Recovery Audit Contractor (RAC) program to allow for a three-year look back period. Similarly, the Medicare Recovery Auditor program allows for a three-year look back period. CMS and medical societies have spent substantial resources over a number of years to educate physicians about the overpayment look back period of three years. To finalize a different, substantially longer look back period in the context of § 6402(a) would confound those efforts, cause confusion, and prove unduly burdensome for physicians. Furthermore, as other CMS overpayment initiatives often require good cause for reopening of claims, we do not believe that an amendment of the reopening statute is warranted, and ask that CMS omit this provision from the final rule.

We note that as § 6402(a) became law on March 23, 2010, the obligation under the FCA was not clear before that date, and should not be retroactively applied by CMS. **CMS should limit the reach of the obligation to no earlier than March 23, 2010, as statutorily authorized.** Such a limit would enable physicians to be comply with the obligation of § 6402(a) without the unprecedented burden of identifying overpayments accrued any time in the past 10 years.

Overpayment Initiative Duplication

CMS should clarify how other CMS overpayment initiatives reconcile with § 6402(a). CMS proposes that when a government agency informs a physician of a potential overpayment, the physician has an obligation to accept the finding or make a reasonable inquiry. If the inquiry verifies the auditor's results, the physician must report and return the overpayment within 60 days. CMS should consider that if the audit is in furtherance of another CMS overpayment program, there will likely be conflicting guidelines that could inequitably impact physicians. For example, in the Medicare Recovery Audit program, an overpayment is recouped on the 41st day following demand letter issuance (barring timely appeal). In light of the proposed rule, we are concerned that some physicians could be obliged to report and return the overpayment, while, at the same time, the Recovery Auditor proceeds with recoupment. This scenario could result in double repayments by physicians.

Furthermore, federal overpayment initiatives generally provide for appeal processes that may be confounded by the proposed rule. For example, in the Medicare Recovery Audit program, physicians may appeal an overpayment determination within 30 days. In addition, if a physician timely appeals, recoupment on the 41st day is stayed pending a determination on appeal. The proposed rule raises important questions: Is a physician who has appealed a Recovery Auditor determination compelled to report and repay the auditor-identified overpayment within 60 days? If the physician disagrees with the Recovery Auditor determination, is the physician compelled to undertake a "reasonable inquiry" with "all deliberate speed" to identify similar claims?

These problems are not limited to the Medicare Recovery Auditor Program. There may also be conflicts with audits undertaken by the Medicaid RACs and Medicaid Integrity Contractors (MICs), and with recoupment actions prompted by Zone Program Integrity Contractors (ZPICs), Program Safeguard Contractors (PSCs), Comprehensive Error Rate Testing (CERT) contractors, and Payment Error Rate Measurement (PERM) contractor audits. **To avoid duplication and confusion, CMS should provide that if a physician has received an overpayment determination from a CMS auditor, the processes and appeals rights of that overpayment audit program control, and the physician is exempt from obligations under § 6402(a) related to that overpayment.**

Due Process

As CMS has done in its other overpayment programs, CMS should provide the process by which physicians may administratively appeal an overpayment determination in the context § 6402(a). Medical billing is complex and requires clinical expertise to accurately interpret. A physician may anticipate that the federal government will consider a certain claim to be an overpayment, but may disagree with that perception. A physician who returns an overpayment, but who disagrees with the basis for the error, should have an avenue to address that disagreement. Due process concerns will also arise for hospital-employed physicians, who may have little say over the billing processes at a hospital and the subsequent hospital determination that an overpayment has occurred.

Reporting Requirements

CMS' proposal would require overpayment reports to correspond to the existing voluntary refund process. Among other requirements, CMS proposes that the reports detail: 1) how the error was discovered; 2) a description of the corrective action plan to ensure the error does not occur again; and, 3) if a statistical sample was used to determine the overpayment amount, a description of the

statistically valid methodology used to determine the overpayment. **CMS should omit these three proposed reporting requirements.** Compliance with these requirements is not prescribed by § 6402(a). The statute only requires that the overpayment be reported and that the reason for the overpayment be conveyed. Furthermore, compliance with these proposed reporting requirements would incur additional costs for physicians, including retention of legal counsel, statisticians, compliance consultants, and others.

Uniform Reporting Form

CMS notes in the proposed rule that it recognizes that current overpayment reporting forms may differ among Medicare contractors. CMS states that it plans to develop a uniform reporting form that will enable all overpayments to be reported and returned in a consistent manner across all Medicare contractors. CMS proposes that until such form is made available, physicians should utilize the existing form on the website of the applicable Medicare contractor. **The uniform reporting form should be published in tandem with the final rule.** The availability of the form would help minimize physician confusion and facilitate education and outreach from medical societies. We also ask that CMS solicit stakeholder input while developing the uniform reporting form, as the medical community can provide productive input regarding the specificities of the form and help CMS avoid unanticipated challenges.

A checkbox should be included on the uniform reporting form to denote that a physician is reporting and remitting an overpayment "with reservation." This checkbox would provide an avenue for physicians to note that they do not agree that the reported amount is an overpayment per se, but are reporting and remitting the payment to ensure that they are in compliance with § 6402(a). This notation could be particularly important if CMS decides not to exempt overpayments based on federal auditor inquiries.

Estimate of the Information Collection Burden

CMS' projection of the cost burden of the proposed rule is artificially low. CMS estimates that accountants, auditors (external and in-house), and miscellaneous in-house administrative personnel could be required, at an estimated hourly cost of $37.10. Physicians will indeed face increased costs for these personnel. In addition, physicians are likely to be mindful of their liability under the FCA for noncompliance, and will perform due diligence to ensure that they are compliant. This will mean the retention of high-cost legal counsel, statisticians, and compliance consultants—particularly if CMS adopts the proposed reporting requirements. We also disagree with CMS' assertion that it will only take 2.5 hours to report and return an overpayment. CMS should review and revise its proposal with any eye toward reducing unnecessary costs for physicians.

Conclusion

Thank you for your consideration of our comments. We look forward to working closely with you to ensure that CMS' final rule on reporting and returning of overpayments sets clear guidelines and does not overly burden physicians.