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Everything I Need to Know About Long Term Care Medicare and Medicaid Overpayments I Learned from Pulling Weeds

The regulatory environment in which long term care (LTC) providers must operate is constantly changing and increasing in complexity. The Affordable Care Act (ACA) adds to this complexity by requiring providers to correct all Medicare and Medicaid overpayments by reporting and repaying them within 60 days of identification. An LTC provider's failure to comply can potentially result in significant liability under the False Claims Act. Because of this, it is increasingly and critically important for LTC providers to have a set of working procedures in place to address overpayment issues when they arise.

Of course, that is easier said than done. Aside from the familiar difficulties that accompany any effort to change organizational behavior, LTC providers must also decipher the meaning of the law before they can act. On its face, the 60-day correction period seems relatively straightforward, but looks can be deceiving. Industry stakeholders are currently struggling to understand when the overpayment clock begins to tick.

This is not an easy question to answer. The correction period begins when an overpayment is identified, but "identification" is an ambiguous event. The Centers for Medicare and Medicaid Services (CMS) recently proposed regulations that many hoped would clarify the matter, but CMS declined to adopt a bright line standard. Instead, the proposed regulations largely defer to existing standards under the False Claims Act, the application of which can be fact-specific and lead to results that differ on a case-by-case basis.

Thus, given a quick turnaround period and limited guidance, how should LTC providers implement procedures to timely address overpayment issues and maintain compliance with the law? To find the answer, LTC providers should handle overpayments in the same way a gardener goes about pulling weeds.

Know Your Environment

Weeds are diverse, and different environments are more hospitable to different types of weeds.

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An LTC provider's first step is to narrow the field of potential risks. This way, the LTC provider can focus its efforts on those operations needing the most attention. Government enforcement history and guidance is instructive in identifying risks. In the long-term care context, the Department of Health and Human Services (HHS) published a report in December 2010 questioning the medical necessity of billing trends observed at many LTC providers.

Thereafter, the 2012 Work Plan of the Office of the Inspector General (OIG) cited a study that found inadequate documentation may have led to overpayments in up to 26% of billings for certain skilled nursing facility services. The Work Plan indicated that OIG would focus its 2012 review efforts on coding, documentation and medical necessity issues. An LTC provider can also look to its business model and institutional history to identify risks. For example, a facility that offers only routine and basic services is, at least in theory, less likely to receive erroneous reimbursement for noncovered services. On the other hand, an LTC facility belonging to a large health care system may learn of an investigation into possible Stark Law violations at another facility within the system. If bad advice from in-house counsel caused the problem, a high-risk issue may not be localized to the single facility but may exist throughout the system.

In sum, there are a multitude of sources from which overpayments can arise. To focus on the most pertinent issues, the most effective first step an LTC provider can take is to become familiar with its specific regulatory environment. When this is done, an LTC provider can at least anticipate the landmines that lie ahead by monitoring industry and institutional trends.

Develop a Sifting Process

Inexperienced hands can have difficulty telling weeds from other plants.

While an LTC provider must be able to anticipate potential overpayments, anticipation is not enough; recognition is the next important step. LTC providers need to implement a sifting process that differentiates overpayments from legitimate reimbursement. Some overpayments are relatively easy to identify. For example, overpayments occur when a health care provider engages the services of an individual provider who has been excluded from Medicare.

But the sifting process is not always so cut-and-dried. For example, Anti-Kickback Statute violations will result in overpayments, but establishing that a violation has occurred can be complicated and time-consuming; fair market value assessments

must be conducted, audits performed, documents reviewed, legal precedent analyzed, meetings held, communications drafted, opinions rendered, etc.

Thus, establishing when an overpayment has matured to the point of identifiability can be difficult. Questions about medical necessity may require a physician's eye, inquiries over legal matters may require an attorney's perspective, and billing problems may require the expertise of a certified coder. Essentially, the LTC provider's task is to develop institutional expertise in those areas susceptible to overpayment risk.

Whether accomplished through internal processes, outside services, or both, the development of this expertise is vital to an LTC provider's overpayment identification capabilities because the 60-day correction period demands a fast response. When institutional expertise is present, overpayment identification problems are reduced, the LTC provider is much more responsive to overpayment issues, and the correction process can move much more quickly.

Be Adaptable

Weeds can grow almost anywhere, seemingly at will.

LTC providers should be ready to adapt, because new overpayments can arise in areas that may have been previously regarded as low-risk. For example, LTC facilities currently are under no strict requirement to maintain a written compliance program. This will soon change, however, as the ACA requires all nursing homes to adopt and implement compliance programs by early 2013. This in itself will change the LTC compliance landscape, but additional changes are scheduled for the near future.

The ACA requires CMS to issue new Conditions of Participation that will add to the compliance program standards. CMS has missed the deadline for issuing such regulations, and to date has not provided them. Thus, LTC providers are in the position of needing to prepare now for the ACA requirements, knowing that the environment may change pending these additional regulations. These new conditions alter the risk environment, and an LTC facility's noncompliance could result in overpayments. LTC providers should therefore prepare by drafting their policies and building their compliance procedures to be adaptable to regulatory changes.

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Be Thorough

Unless you pull them out by the root, weeds will keep coming back.

Once an overpayment has been identified, LTC providers must determine whether it represents an isolated event or an ongoing problem. Under the ACA, LTC providers do not have the luxury of simply correcting overpayments as they arise. Instead, they have an affirmative obligation to investigate whether an overpayment is indicative of a deeper problem. Failure to fulfill this duty can result in substantial liability. Thus, when an overpayment is discovered, an LTC provider must look at the root of the problem to determine whether it has a chance of, or already has, repeated itself.

An isolated event might occur when a facility employs an unlicensed health care provider because the facility failed to check the provider's credentials as it normally does. On the other hand, billing and coding problems might be ongoing, wherein a provider discovers that a procedure was billed improperly only to find that the same billing error has taken place for a period of months or longer.

When an issue has deeper roots, the LTC provider's challenge will be to know when to stop digging. Under the proposed regulations, CMS can look as far back as ten years to recover overpayments. This expansive look-back period largely removes any temporal component of the overpayment analysis and forces a health care provider to rely heavily on the sifting process described above. Such reliance further reinforces the LTC provider's need to develop institutional expertise regarding its high-risk operations, and to cultivate a good working relationship with external experts and regulatory agencies.

What LTC Providers Can Do

Neither CMS nor anyone else can do much to provide an absolute timeline for overpayment corrections periods. That is because overpayments come in different shapes and sizes, so the identifiability of an overpayment can vary dramatically depending on the circumstances. Therefore, correction periods may have vastly different start times. With this background, it is easy to see why a one-size-fits-all approach to managing overpayment correction is unworkable for LTC provider or government policies alike.

The health care attorneys at Reinhart Boerner Van Deuren are well-versed in the challenges identified in this article, and can help LTC providers monitor their

environment, develop institutional expertise, identify when overpayment correction is necessary, discern whether a problem is isolated or deeply rooted, and keep the LTC provider abreast of frequent changes to the legal environment.

Reinhart can also help LTC providers meet the daunting task of setting up or updating a compliance program to satisfy the ACA and CMS requirements. Internal billing audits, resident chart reviews, professional credentialing, employee training and other steps are all elements of a successful compliance program, and Reinhart can provide guidance through every step of this process.

In sum, an LTC provider's compliance efforts must be continuous and proactive. A gardener cannot control the weather, but he can prepare for it. Successful gardens are a product of constant effort, and even short delays in care can have damaging effects. LTC facilities and other providers must cultivate a similar mindset when it comes to Medicare and Medicaid overpayments.