AAOE
American Association of Orthopaedic Executives

MEMORANDUM

Date: March 19, 2012

To: AAOS Council on Advocacy
c/o Matthew Twetten, Senior Manager of Regulatory, Quality and Medical Affairs

From: Chris Dugger
Chair, AAOE Federal Regulations Subcommitee
Member-at-Large, AAOE Advocacy Council

Re: Proposed Rule Issued by the Centers for Medicare or Medicaid (CMS) Clarifying the 60-Day Re-Payment Rule

As you know, the American Association of Orthopaedic Executives (AAOE) is the professional association of orthopaedic practice managers and senior level leadership in the orthopaedic industry. The AAOE has an Advocacy Council and a Federal Regulations Subcommittee. The Subcommittee has evaluated the proposed rule. It is the consensus of our subcommittee and our membership that this rule is highly problematic for a variety of reasons. AAOE sought feedback from our members and have consolidated the most salient points below.

In providing this feedback to the AAOS, we will assume that you are generally aware of the content of the regulations and, except as necessary to frame the discussion points, we will not restate the specifics of the rule.

Treating Unrecognized Overpayments as False Claims Violations

Under this rule, CMS or another auditing agency could identify an overpayment and make a determination that the practice could have or should have known that there was a payment error, and treat the un-refunded overpayment with the same force of penalty reserved for fraudulent claims as defined under the False Claims Act. The penalties under that Act include treble damages of the amount paid in error, plus civil fines up to $11,000 per claim. This regulation would also open the potential for Qui Tam (whistleblower) lawsuits.

The number of situations where a claim could be overpaid inadvertently are too numerous to list, and in many cases they are a result of inadequate information regarding primary payers or errors by the CMS or the Government's contracting intermediaries. These are often problems that the practice can neither prevent nor control. All reputable practices seek to maintain accurate patient accounts and issue a refund or request a recoupment when these situations arise. However, there is always a chance that over the course of tens of thousands of transactions that an unrecognized overpayment might exist. The language of the rule lacks any level of proportionality (or reasonable-ness test), in that an unreturned overpayment of $10 is treated with the same scope of

sanction as if it were a $10,000 error.

Because honest clerical mistakes can be made both inside and outside of the practices' control, and because not all over or underpayments are of any materiality, it is unwise, unfair and inappropriate to classify all undiscovered payment errors in the same manner as overt fraud.

Timeframe for Returning Overpayments

The rule states that money must be returned within 60 days of when the practice becomes aware of an overpayment, or in the judgment of CMS, *should have been aware*, and taken steps to investigate an overpayment. For single instances of payment or coverage errors leading to overpayments this timeframe is probably reasonable. For situations where there may be multiple instances of an overpayment requiring detailed account research, practices might not be able to identify every account that is affected and still meet the refund timeframe.

The extension application itself is just another burden put on practices. There is also no guarantee that an extension would be granted, leaving practices to assume that they would have to complete their refund/review within 60 days until they have an affirmation of an extension. Thus, there appears to be no flexibility in situations where time is required to do a thorough investigation. Faced with this situation, a practice could be forced to expend money on staff overtime, outside staffing, or consulting services in order to meet a 60 day deadline or face sanctions.

The rule also states that practices should use the current refund process for their Medicare Contractor (MAC), but does not mention that there is a great deal of variability in the process, MAC to MAC. Nor does it mention that Medicare changes contractors from time to time and a new MAC may not be able to process refunds from time periods not under their oversight. Feedback from practices stated that in many cases refunded claims are also later subjected to "recoupment" from subsequent payments, thus forcing the practice to refund the claim twice.

Of further concern is when a practice identifies an overpayment and requests a recoupment, this can take longer than 60 days for the MAC to comply**.**

The language should allow for the practice to request a recoupment and be deemed to have been in compliance, whether the MAC has actually recovered the funds within 60 days or not. A practice that requests additional time to do accurate research should be automatically granted an extension without penalty.

Ten Year Look Back

This provision would obligate the practice to review ten years of prior claims history if an overpayment problem was discovered that could have occurred and been undiscovered during prior periods. Most practices have had at least one major computer conversion over the past ten-

year period where inevitably some detail may be lost, and old computer systems are sunset when they become obsolete or fail. Less than half of the practices had a full ten years of scanned or paper records payment records, and this is not surprising since for most business records the standard of retention is seven years.

Of the practices that responded to our questionnaire very few felt that they could run accounts receivable reports over that span of time to search for claims that might need to be researched, and the minority of practice managers that said that they could review ten years of billing history all stated it would be extremely difficult and time-consuming to review information that old.

There are many possible scenarios that could put practices and administrators in significant jeopardy. For example, a random coding audit finds one Medicare claim where the physician's note did not support the level of service. Does the new rule then obligate the practice to expand the audit? How extensive an expanded audit would be necessary to allow the practice to feel that they had satisfied their obligations under this rule? Could CMS apply statistical sampling to extrapolate a repayment amount if the records or the resources do not exist to fully audit prior history?

Many MACs require a refund of the entire date of service and ask for resubmission of the full claim. They could then refuse to reprocess the other line items on that claim because the date of service would now be well beyond the timely filing limits, even though only one single line might have been billed in error.

The 10-year look back period is unreasonable and, for most practices, impossible to meet.

Finally, coding and coverage guidelines change on a yearly, if not more frequent, basis. Both the practices and the CMS contractors lack the institutional memory to recall that a claim that now appears to have been overpaid was in fact correct at the time it was initially processed. Furthermore, to cover a ten-year look back, the historical narrative of every Current Procedural Terminology (CPT) code (or other code used to identify an item or a procedure billed), the then current Correct Coding Initiative (CCI) editing protocols, and history of local carrier determinations and CMS policies would all need to be considered in nearly any review that spanned a lengthy timeline. This Subcommittee doubts that this data and historical context could be fully recovered and accessed by practices who might wish to undergo such an exercise.

In summary, many of the practice leaders who responded felt that this sets up a complete "no-win" situation and that the ongoing potential liability of seeing Medicare patients with the sword of the Office of Inspector General and CMS swinging overhead would lead practices to stop treating CMS patients if they had the option. This rule as proposed, with a ten-year look back period is likely to have an unintended adverse effect because it could further jeopardize a patient's ability to find a provider that accepts patients covered under one of these plans. Our members also expressed concerns that a process of routine audits to provide feedback and improve coding

could become a financial time bomb, leading risk-averse practices to simply choose not to expose themselves through self–audit unless it is forced upon them.

The AAOE membership hopes that the AAOS will be drafting a response to these proposed regulations and that there may even be an opportunity to jointly author a response. If AAOS is unwilling or unable to draft a response to these comments or is not able to allow a joint response to CMS on this issue, the AAOE would like to be advised so that we may respond separately.