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# An Old Compliance Obligation in a Brave New Overpayment World

## A Recent Audit Report Highlights Overpayment Refunds to Beneficiaries

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In some cases, health care providers are overpaid both by a federal health care program (*e.g.*, Medicare) and by a program beneficiary. For example, if (1) a provider inadvertently charges a Medicare beneficiary $200 (instead of $100) for a particular service, and (2) Medicare pays 80 percent of the $200 charge (or $160) and the beneficiary pays the remaining 20 percent (or $40), then the provider has been overpaid $80 by Medicare and $20 by the beneficiary. The 2010 Affordable Care Act (ACA) imposed an obligation on health care providers to report and return "overpayments" from Medicare and Medicaid, and CMS published regulations implementing this provision in 2016.[1] Although the ACA does not address overpayments owed to beneficiaries, providers who participate in the Medicare program have long been required, under their agreement with the U.S. Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS), to make refunds to Medicare beneficiaries if amounts paid by the beneficiaries are "incorrectly collected" by the provider.[2] A recent audit conducted by the HHS Office of Inspector General (OIG) highlights the importance of this refund obligation.[3]

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### OIG Audit Report

In September 2017, the OIG released audit results finding that Medicare improperly paid acute care hospitals for outpatient services the hospitals provided to beneficiaries who were inpatients of other facilities at the time of service.[4] The OIG recommended that CMS direct Medicare administrative contractors (MACs) to instruct acute care hospitals to refund up to $14.4 million in deductible and coinsurance amounts to beneficiaries.[5] CMS agreed with the OIG's recommendation and will be addressing the identified improper payments, including the required refunds to beneficiaries.[6]

Medicare generally pays for services rendered in an inpatient acute care setting for a short period of time

through the Inpatient Prospective Payment System (IPPS) under Medicare Part A.[7] Acute care hospitals also may provide outpatient services, which are paid under Medicare Part B.[8] Certain types of inpatient facilities are excluded from the IPPS and are paid under separate fee schedules. These include long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), inpatient psychiatric facilities (IPFs), and community access hospitals (CAHs).[9] Inpatient facilities that are not paid through the IPPS are required to either (1) directly provide all services furnished during a beneficiary's stay; or (2) arrange for services to be provided on an outpatient basis by an acute care hospital and include those outpatient services on its inpatient claims submitted to Medicare.[10] In general, Medicare should not pay an acute care hospital paid under the IPPS for services furnished to the beneficiary at that facility, while the beneficiary is an inpatient of another facility (*i.e.*, an LTCH, IRF, IPF, or CAH).[11]

As part of its audit, for the period from January 1, 2013 through August 31, 2016, the OIG compared the service dates of inpatient claims from LTCHs, IRFs, IPFs, and CAHs with outpatient claims from acute care hospitals to identify any outpatient claims that overlapped.[12] The agency concluded that Medicare inappropriately paid acute care hospitals for outpatient services provided to beneficiaries who were inpatients of another type of facility at the time the services were rendered.[13] As such, beneficiaries were required to pay deductibles and coinsurance to the acute care hospitals for the outpatient services, which instead should have been included on the inpatient facilities' claims to Medicare.[14]

As noted above, the audit concludes with a recommendation that CMS instruct its contractors to require acute care hospitals to refund up to $14.4 million in deductible and coinsurance amounts that may have been incorrectly collected from either the beneficiaries or from someone who made payment on their behalf.[15]

## Refunding Overpayments to Programs

Among its many reforms, the ACA imposed an obligation on health care providers to report and return "overpayments" received from Medicare and Medicaid.[16] Specifically, a "person" who has received an overpayment is obligated to "report and return the overpayment" to HHS, the state, an intermediary, a carrier, or a contractor, as appropriate.[17] The term "person" is defined to include health care providers, suppliers, Medicare Advantage organizations and Part D Prescription Drug Plan sponsors, and Medicaid managed care organizations.[18] In sum, although health care providers are required to report and return overpayments to the Medicare and Medicaid programs, there is no obligation under the ACA to report and return an overpayment to a beneficiary. CMS promulgated a final regulation implementing the ACA's overpayment provisions on February 12, 2016, confirming that the statutory definition of "person" specifically excludes beneficiaries.[19] It is clear that an amount incorrectly received by a health care provider from a beneficiary does not constitute an "overpayment" for purposes of the ACA or its implementing regulations.

## Refunding Overpayments to Beneficiaries

Separate and apart from the ACA, however, health care providers have long been required to make refunds to beneficiaries as part of their provider agreement with CMS.[20] Regulations originally enacted in 1969 require providers to make a "prompt refund" to a beneficiary in the event the provider has received amounts from a beneficiary to which it is not entitled.[21] The regulation makes it clear that if a refund cannot be made within 60 days of the provider's receiving notice of the incorrect collection, the provider is required to set aside the amount that was incorrectly collected.[22] This amount must be placed "in a separate account identified as to the individual to whom the payment is due."[23] The amount incorrectly collected is required to be kept in the provider's accounts "until final disposition is made in accordance with the

applicable State law."[24] Finally, the provider is required to notify its intermediary of either the refund made to the beneficiary or its setting aside the incorrectly collected amount.[25]

If a provider fails to refund or set aside the incorrect collected amount, CMS has the authority to reduce payments to the provider, in an amount equal to the amount the provider owes the beneficiary.[26] If CMS learns that a provider has failed to refund the amount owed to the beneficiary, CMS must give the provider written notice of its intention to offset the provider's reimbursement.[27] The provider is permitted to submit a "written statement" or "evidence" with respect to the incorrect collection amount before CMS makes a determination as to whether to offset the amount incorrectly collected.[28]

These regulations have not been substantively amended since 1973, although they were simplified somewhat in 1980.[29] When this simplification occurred, CMS stated that the changes were not intended to be "substantive" and, as such, stakeholders' comments, if any, were not considered or discussed in the final regulation.[30]

In terms of further guidance, CMS' Medicare Claims Processing Manual (MCPM) provides that incorrectly collected money is defined as "any amount for covered services that is greater than the amount for which the beneficiary is liable because of the deductible and coinsurance requirements."[31] CMS specifies that this may occur, for example, if (1) the provider believes the beneficiary was not entitled to Medicare benefits, but the beneficiary was later determined to have been entitled to benefits, (2) the beneficiary's entitlement period fell within the time the provider's agreement with CMS was in effect, and (3) the amount collected exceeded the beneficiary's deductible, coinsurance, or non-covered services liability.[32] Regardless of how it occurs, CMS has not provided further guidance on this provider obligation.

That being said, recent guidance from Palmetto GBA, LLC ("Palmetto GBA"), a MAC, sheds some additional light on how providers may determine the amount that should properly be paid by a beneficiary. On July 26, 2017, Palmetto GBA restated CMS's guidance in an online article and advised that the provider must refund the patient when the Medicare Summary Notice indicates that the patient has paid more than the amount required for covered services' copayments, deductibles, and statutorily excluded services on the Remittance Advice.[33] Medicare beneficiaries receive Medicare Summary Notice documents directly from CMS every three months, which indicate the maximum amount the patient may owe providers who submitted claims during the three preceding months to Medicare for items or services the providers provided to the patient.[34] Providers do not receive a copy of the Medicare Summary Notice and instead receive notices of payment referred to as Remittance Advice.[35] The Remittance Advice records explain the claim payment and any adjustment(s) made during claim adjudication, including adjustments that represent an amount that may be billed to the patient or beneficiary.[36]

## Compliance Considerations

Despite the relative paucity of CMS guidance with respect to the beneficiary refund rules, the OIG's September 2017 audit report is a loud reminder that such refund rules exist. Indeed, many acute care hospitals likely will be receiving notice from MACs relating to their beneficiary refund obligation. A "prompt refund" is CMS's preferred method of resolving amounts incorrectly collected from beneficiaries, but the alternative is simple: the provider must set aside the money as a credit to the patient's account.[37]

In the event that the beneficiary cannot be located, the regulation requires that providers keep the amount "until final disposition is made in accordance with the applicable State law."[38] Most states have unclaimed property laws that specify how

intangible personal property that has been abandoned should be addressed, and states have the authority to take or dispose of property that is unclaimed or abandoned, including abandoned or unclaimed insurance money.[39]

The National Conference of Commissioners on Uniform State Laws has promulgated a Uniform Unclaimed Property Act that has been adopted by a number of states.[40] This Act specifies that property is deemed abandoned three years after the obligation to pay or distribute the property arises.[41] Refunds that have been unclaimed for three years, and are thus deemed abandoned, may be subject to general state reporting obligations.[42]

Health care providers should view the OIG's report as a reminder that their compliance policies and procedures should address how the provider will handle the receipt and return of incorrect payments by Medicare beneficiaries. Such policies and procedures should address, for example, the obligations to (1) make "prompt refunds," (2) place amounts that cannot be refunded within 60 days in separate accounts, (3) keep these amounts "until final disposition is made in accordance with the applicable State law," and (4) notify its intermediary of either the refund made to the beneficiary or its setting aside the incorrectly collected amount.

**Endnotes:**

1. Patient Protection and Affordable Care Act § 6402(a), 42 U.S.C. § 1320a-7k(d) (2017); Medicare Program Reporting and Returning of Overpayments, 81 Fed. Reg. 7654, 7658 (Feb. 12, 2016).
2. 42 C.F.R. § 489.20(b).
3. Dep't of Health & Human Servs., Office of Inspector General, A-09-16-02026, Medicare Claims for Outpatient Services Provided During Inpatient Stays (Sept. 2017) [hereinafter HHS-OIG, Medicare Claims for Outpatient Services Provided During Inpatient Stays].
4. OIG, Medicare Claims for Outpatient Services Provided During Inpatient Stays at 6.
5. *Id.* at 11.
6. *Id.* at 16.
7. Social Security Act, § 1886, 42 U.S.C. § 1395ww(d), (g) (2017); *see also* 42 C.F.R. §412.1; CMS, Pub. 100-04, Medicare Claims Processing Manual (MCPM), Ch. 3, § 20.
8. Social Security Act § 1833(t), 42 U.S.C. § 1395l; *see also* MCPM, Ch. 4, § 10.1.
9. Social Security Act §§ 1812, 1814, 1861, 42 U.S.C. §§ 1395d, 1395f, 1395x; *see also* 42 C.F.R. Part 412, Subparts B and P; MCPM, Ch. 3, §§ 20, 10.4.
10. 42 C.F.R. §§ 412.404(d), 412.509(b), 412.604(e); *see also* MCPM, Ch. 3, § 10.4.
11. *Id.*
12. OIG, Medicare Claims for Outpatient Services Provided During Inpatient Stays at 4.
13. *Id.* at 6.
14. *Id.*
15. *Id.* at 11.
16. 42 U.S.C. § 1320a-7k(d)(1).
17. *Id.*
18. *Id.* § 1320a-7k(d)(C)(i).
19. Medicare Program Reporting and Returning of Overpayments, 81 Fed. Reg. 7654, 7658 (Feb. 12, 2016).
20. 42 C.F.R. § 489.20(b); *see also* 45 Fed. Reg. 22937, 22938 (Apr. 4, 1980).
21. 42 C.F.R. § 489.41(a); *see also* 45 Fed. Reg. 22937, 22939 (Apr. 4, 1980).
22. *Id.* § 489.41(b).
23. *Id.*
24. *Id.*
25. *Id.* § 489.41(c)(1).
26. *Id.* § 489.41(c)(2).
27. 42 C.F.R. § 489.42(a), (b).
28. *Id.* § 489.42(c).
29. *See* 20 C.F.R. § 405.620 (1969); 38 Fed. Reg. 3597 (Feb. 8, 1973); 20 C.F.R. § 405.620 (1976); 45 Fed. Reg. 52826 (Sept. 30, 1977); 45 Fed. Reg. 22933, 22935 (Apr. 4, 1980).
30. 45 Fed. Reg. 22933, 22935 (Apr. 4, 1980). ("The creation of a new Part 489 is part of Operation Common Sense, our effort to simplify our regulations and make them easier to use. No substantive changes, other than those discussed above, are intended.").
31. MCPM, Ch. 1, § 30.1.2.
32. *Id.*
33. Palmetto GBA, LLC, Provider Refunds to Patients (July 26, 2017), www.palmettogba.com/palmetto/providers.nsf/docscat/Providers~JM%20Part%20A~Learning%20Education~Job%20Aids~Provider%20Refunds%20to%20Patients.
34. MCPM, Ch. 21, § 10.
35. *Id.*
36. MCPM, Ch. 22, §§ 10, 60.1.
37. 42 C.F.R. §§ 489.41, 489.42.
38. *Id.* § 489.41(b).
39. Jeffrey Shampo, American Jurisprudence § 52 (2d ed. Supp. 2017).
40. U.L.A. Unclaimed Property § 201; *see also* The National Conference of Commissioners on Uniform State Laws, Unclaimed Property Act, http://www.uniformlaws.org/Act.aspx?title=Unclaimed Property Act (last accessed Nov. 2, 2017).
41. Unif. Unclaimed Property Act § 201(13) (2016).
42. *Id.* § 401.