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HEALTH LAW CLIENT ALERT

FEDERAL COURT DECISION HEIGHTENS THE URGENCY OF PROMPT INVESTIGATION OF POTENTIAL OVERPAYMENTS

A recent Federal District Court case in the Southern District of New York, Kane v. Healthfirst, Inc., interpreted for the first time the meaning of a key term of the Affordable Care Act's 60-day "report and return" requirement (the "60 Day Rule"). This rule subjects health care providers to potential civil and criminal False Claims Act liability for retention of overpayments made by federal health care programs. The Kane decision, arising out of a set of "bad facts," puts what the Court recognizes as a steep, if not impossible, burden of compliance on providers, who must trust in the sound exercise of prosecutorial discretion if they are unable to comply.

The 60 Day Rule established by the Affordable Care Act ("ACA") requires reporting and return of overpayments made by Medicare and Medicaid by the later of: (1) 60 days after the date on which the overpayment was "identified" by the provider, or (2) the date any corresponding cost report is due, if applicable. There is substantial – and much discussed – ambiguity as to what it means to "identify" an overpayment. In practice, if a provider uncovers a billing issue which could affect multiple claims, the provider must be able to quantify both the particular invalid claims and the dollar amount of each before making an accurate repayment. However, it is unclear at what point during the provider's investigation the overpayment has been "identified" for purposes of triggering the 60 Day Rule's strict deadline; providers would clearly prefer the time to begin later in the process, such as after they have confirmed the quantity of claims and the amount which must be returned.

In February 2012, however, CMS released a proposed rule regarding reporting and returning overpayments under the 60 Day Rule which we described in a prior Client Alert. The proposed rule tied the term "identified" to the knowledge standard in the federal False Claims Act – i.e., a claim is "identified" at the time the provider has either actual knowledge of an overpayment or has acted in reckless disregard or deliberate ignorance of the existence of an overpayment. However, the proposed rule has not yet been finalized[1] and, until the Kane case, no court had addressed the issue.

[1] CMS has delayed publication of the final rule until February 2016.

Kane is a classic case of bad facts making what providers (and others) may believe is bad law. In Kane, a software glitch caused three New York hospitals to submit more than $1,000,000 in erroneous claims to the New York Medicaid program. After the hospitals performed an internal investigation which resulted in a list of potentially defective claims, it took three years, a whistleblower lawsuit, and multiple outside investigations by regulators before the hospitals refunded all of the overpayments. The hospitals argued that the initial list of claims did not "identify" any overpayments, because the list contained only potential, not confirmed, erroneous claims. After parsing the ambiguous language of the statute and reviewing the ACA's legislative history and the parties' interpretations, the Kane court sided with the federal government, concluding that "the sixty day clock begins ticking when a provider is put on notice of a potential overpayment." (Kane, at 23.) Thus, the overpayments were identified by the time the hospitals had generated the list of potential overpayments, starting the 60-day clock at that time.

The Kane Court acknowledged that "the ACA can potentially impose a demanding standard of compliance in particular cases . . . . The ACA itself contains no language to temper or qualify this unforgiving rule; it nowhere requires the Government to grant more leeway or more time to a provider who fails timely to return an overpayment but acts with reasonable diligence in an attempt to do so." (Kane, at 25.) The Court suggested that providers would have to trust the sound exercise of prosecutorial discretion not to institute enforcement actions against "well-intentioned healthcare providers working with reasonable haste to address erroneous overpayments." (Kane, at 26.)

While the result in the Kane case was clearly colored by the Court's perception that the hospital defendants had purposefully delayed addressing a serious billing issue until both regulators and a whistleblower lawsuit forced them to act, it is largely consistent with the approach taken by CMS in the agency's proposed rule. In general, the Kane decision leaves providers in a challenging situation and highlights the difficulty of arriving at an alternative standard that would encourage appropriate diligence on the part of providers to act promptly.

In sum, providers must take care to act thoroughly and promptly in addressing potential overpayments. As soon as a potential issue is identified, a provider must immediately begin to investigate and consider exactly when the overpayment would be considered to start the 60 day clock.

If you have any questions about the Kane opinion or would like assistance with your overpayment policy and procedure, please contact Attorneys Jennifer Gallop (jgallop@kb-law.com), Robert Griffin (rgriffin@kb-law.com), Tony Cichello (acichello@kb-law.com), Emily Kretchmer (ekretchmer@kb-law.com), or Braden Miller (bmiller@kb-law.com).