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Providers Wary after First Ruling on CMS 60-Day Rule

Article By:

Christopher J. Shaughnessy

The ***False Claims Act*** ("FCA") is already a minefield for healthcare providers, especially when coupled with the Stark Law. Treble damages and fines of up to $11,000 per violation add up quickly under the FCA. The U.S. District Court for the Southern District of New York just made further FCA "reverse false claims" nightmares that much more of a reality in the case of *Kane v. Healthfirst*. That case is illustrative of how the government will interpret and enforce the Centers for Medicare & Medicaid Services' ("CMS") "60-day rule" for retention of overpayments, and the result should make all healthcare providers take notice.

Kane is the first case to interpret the 60-day rule, which requires providers to report and refund "identified" overpayments. The 60-day period is a safe harbor to return the payments. Delays past that period result in a violation of the FCA. The not-yet-final rule will enforce a provision of the Affordable Care Act and was delayed by CMS in February of 2015 for one more year. The question in both the finalization of the proposed rule and the *Kane* case is how to interpret how and when overpayments are "identified" for purposes of the rule. Congress did not define what constitutes the identification of an overpayment in the ACA. CMS issued a proposed rule in February of 2012 to clarify for Medicare providers that an overpayment is identified if a provider either actually knows of the overpayment or "acts in reckless disregard or deliberate ignorance of the overpayment."[1]

In *Kane,* a software issue from a private insurer, Healthfirst, caused a nonprofit hospital system, Continuum, to erroneously bill claims to New York's Medicaid program as a secondary insurer. New York's Comptroller identified a relatively small number of claims that had been erroneously billed in September of 2010. The hospitals then conducted an internal investigation starting in February of 2011 and discovered that potentially up to 900 claims were submitted wrongfully. The investigator, Robert Kane, determined the number of potential claims and amount of prospective liability and informed Continuum's administrators of the issue. He was immediately sacked. Kane's report did not say that all the claims were actual overpayments, but that they contained an erroneous billing code that warranted further investigation. The New York Comptroller continued to investigate Continuum's billing system, identifying more and more erroneous claims and bringing them to Continuum's attention. Continuum began to pay the claims back over a period that began in April 2011 and ended in March 2013. 300 of those claims were reimbursed only after Continuum received a Civil Investigative Demand seeking information on the payments. Continuum never released Kane's report to the Comptroller. Kane brought a *qui tam* whistleblower suit against Continuum, and the government intervened.

The court in *Kane* ruled in line with the CMS proposed rule as to the definition of "identified", although that rule only would apply to Medicare, and not Medicaid, providers. Continuum's overpayments were "identified" as soon as it became aware that there might have been an overpayment, as per Kane's report. The court rejected Continuum's argument that the obligation to repay the overpayment would not be triggered until a conclusive determination had been made as to the exact nature and amount of the overpayment, suggesting that such a result would create an incentive to delay investigations into potential overpayments.

This decision highlights the urgent need for providers to conduct investigations into overpayments as stridently as possible. Overpayments are common among healthcare providers, but the government is taking a hard line on the identification and repayment of these payments. This new standard of "identification" sets the bar relatively low for knowledge of such payments, exposing providers to potentially serious liability for failing to act on any possible notice of potential overpayments. The court in *Kane* sent a very clear message – the government wants it money back, and failure to return it in a timely fashion can wreak havoc on even the most well-intentioned healthcare provider.

[1] 77 Fed. Reg. 9179-9187 (Feb. 16, 2012).

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