COSMOS
Navigate the Compliance Universe

Report on Medicare Compliance Volume 29, Number 13. April 06, 2020

Even One Error Required Six-Year Lookback Audit, Except When Appealed

By Nina Youngstrom

The power of the Medicare 60-day rule was felt in the downstream effects of a national audit of positive airway pressure (PAP) device supplies by the HHS Office of Inspector General (OIG). Even durable medical equipment (DME) suppliers that submitted one improper claim were required to look back at six years' worth of similar claims. Usually Medicare administrative contractors (MACs) oversee the self-audits, which was the case here, but unified program integrity contractors (UPICs) are also starting to pursue six-year "lookback audits," according to attorneys who represented DME suppliers included in the OIG review.

"You could have a minor technical error, and then you're embroiled in a six-year lookback [audit]," said Wayne van Halem, president of the van Halem Group, at the Health Care Compliance Association's Compliance Institute on March 30.

The lookback audits stem from the 60-day rule, which requires providers and suppliers to report and return Medicare and Medicaid overpayments within 60 days of identifying them. The 2016 regulation interpreting the 60-day rule, which was created by Sec. 6402[1] of the Affordable Care Act, requires providers to use reasonable diligence to identify overpayments by doing proactive compliance activities to monitor for overpayments and investigating potential overpayments in a timely manner. CMS defined "timely" as within six months of receiving "credible information" about an overpayment.

Six Months Can Fly By

"The final rule said the lookback period is six years, and that's an awfully long time to go back," said attorney Denise Leard, with Brown & Fortunato, who also spoke at the Compliance Institute. Although providers have six months to investigate, "it can take a long time to determine whether you have an overpayment that needs quantifying," she said, "particularly if you're not getting buy-in from the top."

In the PAP audit,[2] OIG reviewed a random sample of 110 claims submitted in 2014 and 2015 and found 86 didn't comply with Medicare requirements. The reasons: Physician orders didn't comport with local coverage determinations; suppliers had no proof of delivery; replacement supplies weren't reasonable or necessary; and/or suppliers didn't respond to OIG's request for documentation. OIG attributed the errors to CMS's lack of oversight of suppliers.

As a result, Medicare overpaid suppliers $13,414, which OIG extrapolated to $631 million for the audit period. Of the 86 claims, 57 had more than one error. In addition to recommending that MACs collect the overpayments from the four-year reopening period, OIG said MACs that process DME claims should inform the 82 suppliers associated with the 86 claims "to exercise reasonable diligence to investigate and return any identified overpayments, in accordance with the 60-day rule, and to identify and track any returned overpayments as having been made in accordance with this recommendation."

Then there was a scene change and the MACs took over. They put the suppliers on a timetable consistent with the 60-day rule and directed them to provide a written description of how they would audit their own claims for the past six years, according to a letter from one MAC. "It was a fairly small number of claims in the sample per supplier," van Halem said. "In the six-year lookback, some suppliers only had one claim."

If suppliers planned to use sampling and extrapolation in the audits, they were required to "provide a written description of how each self-assessment was conducted; the universe, sample size and service dates of the claims identified and reviewed in the self-assessments; the statistically valid sampling and extrapolation methodology used to identify the universe and sample; and if extrapolation/sampling was not used, details of how you completed the self-assessment." In other words, Leard said, suppliers would "have to prove to the contractor they personally reviewed 100% of claims going back six years. With PAP supplies replaced on a three-month basis, the amount of claims was significant. They had to review a sample of claims."

When suppliers were finished with the audit, the letter said, "please provide your MAC with written confirmation that you performed a self-assessment of the claims and determined that either no claims were submitted in error or that you have identified and returned, or are working to return, applicable overpayments to the MAC."