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Medicare 60-Day Rule Proposal Raises Concerns; MAC Process is 'Best Way' to Repay Money

By Nina Youngstrom

Because physicians may not know about or always comply with Medicare's requirement for shared decision-making with three services—automatic implantable cardiac defibrillators, lung cancer screening with low-dose CT scans and percutaneous left atrial appendage closure for atrial fibrillation—a routine audit may sniff out trouble. If that's the case, hospitals may have to do a more expansive audit under Medicare's 60-day overpayment return rule—going back years depending on the date of the national coverage determination (NCD). That's an example of the kind of audit that requires some time to get a full picture of where the hospital stands.

But hospitals won't have much time to identify possible overpayments and quantify them if CMS finalizes changes to Medicare's 60-day overpayment refund rule that were proposed Dec. 27, said Patrick Kennedy, executive system director of hospital compliance at UNC Health in North Carolina.[1] Organizations would be hampered in their ability to "determine whether we have an overpayment and return it" by the 60-day deadline, Kennedy said Jan. 13 at the Health Care Compliance Association's regional conference in Charlotte, North Carolina. That may be the case with the shared decision-making requirement, which involves a physician-patient encounter to evaluate the pros and cons of the procedure using an evidence-based decision tool, and other risk areas sprouting from NCDs or local coverage determinations (LCDs) that might take some time to nail down, although there are a number of other types of overpayments that could put hospitals in a jam if the time frame is tighter.

The 60-day rule—which came to life in the Affordable Care Act (ACA)—requires providers to report and return Parts A and B overpayments within 60 days of identifying them. According to the 2016 regulation interpreting the 60-day rule, providers are obligated to use reasonable diligence to identify overpayments by doing proactive compliance activities to monitor for overpayments and investigating potential overpayments in a timely manner.[2] CMS defined timely as within six months of receiving "credible information" about an overpayment. Now CMS envisions replacing "reasonable diligence" with language more consistent with the False Claims Act's knowledge standard. "Under the proposed rule, a provider or supplier has identified an overpayment if it has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment," according to CMS.