



AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

April 11, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–6037–P
P.O. Box 8013
Baltimore MD 21244–8013

Re: Reporting and Returning of Overpayments

Dear Ms. Tavenner:

On behalf of the American Academy of Family Physicians (AAFP), which represents more than 100,300 family physicians and medical students nationwide, I write in response to the [proposed rule](#) by the Centers for Medicare & Medicaid Services (CMS) on the Reporting and Returning of Overpayments as published in the February 16, 2012 *Federal Register*.

As called for in the *Affordable Care Act* and once finalized, CMS will require physicians who receive an overpayment to report and return the overpayment to CMS, the state, or other relevant contractor along with a written explanation of the reason for the overpayment within 60 days. Failure to comply potentially exposes physicians and others to *False Claims Act* lawsuits, civil monetary penalties, and further oversight from Medicare and Medicaid contractors.

The AAFP recognizes that CMS must strive to protect the Medicare trust fund, and we appreciate that CMS intends to use the existing voluntary refund process for reporting overpayments. However, we remain seriously concerned that the proposal confuses the occasional overpayments made by a CMS contractor with malicious or fraudulent activities on the part of Medicare providers and suppliers. While an overpayment can be indicative of fraud and abuse, most overpayments are caused by inadvertent errors and should be treated as such. The AAFP offers the following comments in the spirit of improving the final rule.

Use of Existing Voluntary Refund Process

In the proposed rule, CMS states that it intends to implement the requirements of the *Affordable Care Act* related to overpayments by using the existing voluntary refund process, which CMS will rename as the “self-reported overpayment refund process.” We believe that this is a good decision on the part of CMS, because physicians are familiar with this process and will not have something new to learn in this regard. We encourage CMS to maintain this part of the proposed rule. In addition, we believe there is an opportunity to streamline the reporting form used in this process. We urge CMS to publish the uniform reporting form as part of the final rule.

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Identification of overpayments

The *Affordable Care Act* specifies that the 60-day period begins with “identification” of the overpayment. Unfortunately, CMS does not clearly specify whether actual knowledge of an overpayment is when a physician learns of a case that caused the overpayment or when the overpayment is determined and calculated. CMS proposes to define “identification” as “actual knowledge of the information; acts in deliberate ignorance of the truth or falsity of the information; or acts in reckless disregard of the truth or falsity of the information.” The proposal then suggests that, “without such a definition, some providers and suppliers might avoid performing activities to determine whether an overpayment exists, such as self-audits, compliance checks, and other additional research.”

The AAFP is troubled that this proposal essentially creates an unfunded requirement that forces medical practices to implement self-audits and internal compliance plans. Though often recommended business practices, they are time-consuming, expensive, and never before required by Medicare. Further troubling is that this considerable burden is not even addressed in the regulatory impact section. The AAFP urges CMS to further consider the rule’s financial impact on medical practices.

The AAFP recommends that the 60-day timeframe begin after an audit has determined the overpayment and the actual amount to be returned, which would give physicians, as well as other providers and suppliers, time to complete the audit before the repayment period begins.

The proposal requests comments on the burden assumptions and associated calculations. In this section, CMS estimates it will take a physician 2.5 hours to both complete a typical overpayment reporting form (at an estimated cost of \$37.10 per hour) and return the overpayment. The AAFP finds it alarming that CMS seems comfortable subjecting physicians to these timeframes and costs. We strongly urge CMS to facilitate overpayment reporting and refunding by streamlining the form and reducing the cost of reporting. If the overpayment is less than \$100, medical practices will likely expend as much or more to report and return the overpayment, for which they may not even be at fault. Therefore, the AAFP urges CMS to consider establishing a minimum overpayment threshold in the spirit of simplifying inadvertent and innocent errors.

The AAFP also urges CMS to expound further on circumstances that would constitute “failure to make a reasonable inquiry, including failure to conduct such inquiry with all deliberate speed after obtaining the information”, since these are fairly subjective terms.

The AAFP is pleased that CMS acknowledges that the agency will not target an “innocent provider or supplier” in the case where an overpayment resulted from an anti-kickback scheme to which the physician or supplier was not a party. However, we were perplexed that CMS did not discuss other, potentially more common situations in which the physician or supplier is not at fault due to overpayment received by a Medicare contractor error. The AAFP urges CMS to elaborate further in the final rule on “innocent provider or supplier” circumstances.

Inconsistent implementation

The reporting and returning of overpayments applies to all Medicare programs (Part A/ hospital coverage, Part B/ medical insurance, Part C/ Medicare Advantage Plans and Part D/ Prescription

Drug Plans) and Medicaid Managed Care Organizations (MCOs). Yet in this proposed rule, CMS states that standards for Medicare Advantage, Prescription Drug Plans, and Medicaid MCOs will be addressed at a later date. Nevertheless, CMS cautions that the 60-day repayment obligation is effective even without implementing regulations.

Physicians interact regularly with all Medicare programs and a variety of Medicaid payers. To be consistent in implementing this *Affordable Care Act* requirement, the AAFP requests that the final rule thoroughly outline when and how CMS intends to address this requirement with the Part C, Part D, and Medicaid programs.

Potential overlap with other CMS efforts

The proposal did not reference the Medicare and Medicaid Recovery Audit Contractor programs, the Comprehensive Error Rate Testing Program, or other CMS and HHS initiatives aimed at reducing improper payments. The AAFP urges CMS to specify how existing fraud, waste, and abuse detection efforts interact with the proposed rule.

Look-back period

Without clear evidence of fraud or abuse, the AAFP adamantly opposes CMS' proposal to utilize a 10-year look-back period. Since the *Health Insurance Portability and Accountability Act* requires physicians to maintain billing records for six years, the records needed to conduct this review may not even be available to the provider. If they are available, they may be archived, and may not be readily retrievable. Further, changes in the regulatory requirements over the past 10 years would also have to be reverse-engineered by physicians to determine whether an overpayment was in fact made. Consequently, physicians will inevitably have great difficulties investigating a potential overpayment in a situation where medical documentation and billing information regarding the questionable claim is no longer readily available and bear the cost of searching old records and analyzing old laws or regulations to determine whether an overpayment in fact existed.

In proposing the unwieldy and unmanageable 10 year look-back period, CMS also amends regulations to allow its contractors to re-open claims with errors that negatively impact the government for 10 years back. However, CMS has not proposed to change the four year window for physicians to request re-open claims for "good cause." Thus, the proposal would decidedly favor the government's financial interests by giving it a long period of time (10 years) to pursue claims against physicians and providing a much more limited ability for physicians to pursue their rights.

The AAFP strongly urges CMS to enforce a 3 year look back period as it is a more compatible and considerate timeframe for medical practices. Since the *Affordable Care Act* was signed into law on March 23, 2010, CMS must limit the reach of this obligation to no earlier than March 23, 2010, as statutorily authorized.

Lastly, we urge CMS to clearly describe the processes that will be used to ensure that any refunded overpayments are recorded and removed from the total amount ultimately paid, for purposes of determining the total Medicare Part B expenditures with respect to the sustainable growth rate formula (SGR). CMS must ensure that overpayments are not counted as expenditures against the SGR target.

Marilyn Tavenner
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We appreciate the opportunity to provide these comments and make ourselves available for any questions you might have or clarifications you might need. Please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or rbennett@aafp.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Roland A. Goertz". The signature is written in a cursive style with a large, stylized initial "R".

Roland A. Goertz, MD, MBA, FAAFP
Board Chair