

Compliance List



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From: gwalker@allendell.com

Posted by Gary Walker on 11/9/2012 5:02 PM.

Has anyone seen any guidance from CMS with respect to whether the 60 day repayment requirement of section 6402(a) of the Healthcare Reform Act applies to a payment that a physician receives from a private health insurance company through the insurance company's Medicare Advantage plan product?

I had read the 60 day requirement to mean that a Medicare Advantage plan itself would have to repay an overpayment from Medicare within 60 days of indentifying the overpayment, but I had not read the requirement to mean that an overpayment from a Medicare Advantage plan to a physician would be subject to the 60 day repayment requirement.

However, I have seen one article on line which appeared to reach the conclusion that an overpayment from a Medicare Advantage plan to a physician would be subject to the 60 day repayment requirement. The concern obviously is that if an overpayment to a physician from a Medicare Advantage plan is subject to the 60 day repayment provision, then if it is not timely repaid, it may become a false claim.

The Reform Act in section 6402(a) defines "Overpayment" as "any funds that a person receives or retains under title XVIII or XIX to which the person, after applicable reconciliation, is not entitled under such title."

I suppose that there may be an argument that a payment from a Medicare Advantage plan to a physician constitutes funds that the physician received "under title XVIII or XIX," in that the money paid by the Medicare Advantage plan originally was Medicare money.

That section defines "Person" as "a provider of services, supplier, Medicaid managed care organization (as defined in section 1903(m)(1)(A)), Medicare Advantage organization (as defined in section 1859(a)(1)), or PDP sponsor (as defined in section 1860D-41(a)(13))."

In the proposed rule on the 60 day requirement, published in the February 16, 2012 Federal Register, the commentary states:

In proposed Sec. 401.301, we state that subpart D sets forth the policies and procedures for reporting and returning overpayments to the Medicare program for providers and suppliers of services under Parts A and B of title XVIII. At this time, we are proposing to implement the requirements set forth in section 1128J(d) of the Act only as they relate to Medicare Part A and Part B providers and suppliers. Other stakeholders, including, without limitation, MAOs, PDPs, and Medicaid MCOs will be addressed at a later date. Notwithstanding the foregoing, we remind all stakeholders that even without a final regulation they are subject to the statutory requirements found in section 1128J(d) of the Act and could face potential False Claims Act liability, Civil Monetary Penalties Law liability, and exclusion from Federal health care programs for failure to report and return an overpayment. Additionally, providers and suppliers continue to be obliged to comply with our current procedures when we, or our contractors, determine an overpayment and issue a demand letter.

However, that language does not appear to be dispositive of the issue I am raising.

I searched the OIG webpage, and generally on line, but found no guidance on this issue. Is anyone aware of any pronouncements by CMS, or any settlements or other actions that subject overpayments to physicians by Medicare Advantage plans, to the 60 day repayment requirement?

Thanks very much,

Gary Walker
Allen Dell, PA
202 South Rome Avenue, Suite 100
Tampa, FL 33606
Phone: 813-223-5351
Direct: 813-769-2784
Cell: 813-503-6952
Fax: 813-229-6682

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Original topic posted by William Horton on 4/12/2010 7:32:17 PM.

Anonymous Question re: Physician Investors in Clinical Lab Company

Please pardon the cross-posting. A list member, somewhat new to the field, has asked me to post the following question on an anonymous basis. Please reply to the list(s) so that everyone, including the person making the inquiry, can benefit from your thoughts:

We are a start-up company and clinical laboratory. We have a handful of physicians that are investors that also treat Medicare patients. In a perfect world I would not have any physicians investing in our company, but in this economy, funding is funding. How do members of the list propose that we handle avoiding Stark violations? Do you advise speaking to them directly and also sending them a letter? Does anyone have a sample letter they could share? Are physicians only prevented in referring Medicare patients to us or all patients? I would like to handle this as delicately as possible while also protecting the