



*Sound Policy. Quality Care.*

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April 16, 2012

Marilyn B. Tavenner  
Acting Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Room 445-G, Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

RE: Medicare Program; Reporting and Returning of Overpayments [CMS-6037-P]

Dear Acting Administrator Tavenner,

The undersigned members of the Alliance of Specialty Medicine (Alliance) are writing to share our concerns regarding the Medicare Reporting and Returning of Overpayment Proposed Rule. The Alliance is a coalition of 12 national medical specialty societies representing more than 200,000 physicians and surgeons. We are dedicated to the development of sound federal health care policy that fosters patient access to the highest quality specialty care. We trust that the agency and the entire administration are sincere in their commitment to reducing regulatory stress on physicians, not adding to it, and our comments are offered in that spirit. The vast majority of physicians are striving to comply with the letter and intention of law and regulation. However, numerous new requirements and audits are adding to the expense and paperwork burden of practicing medicine and must be made as reasonable and manageable as possible. Below are some specific comments about the provisions of the proposed rule that are of particular concern.

### ***10 Year Look Back Period***

The ten year look-back period is too long. This time-frame is pushing the outer limit of the False Claims Act, which is designed to identify intentional fraud not routine errors. The proposed 10-year look back period is extreme and not in keeping with the number of years that CMS allows for other programs. Medicare typically only requires fee-for-service providers to retain documents for six years. We recommend the look-back period be limited to three years, to be consistent with other CMS audit programs. In the case of criminal activity and intentional fraud, the Federal government has the authority to audit for longer periods of time and a 10-year look-back for this rule is unwarranted.

### ***Definition of "Identified" Overpayment***

The definition of when the 60-day period would start is unclear. On the first day that a potential overpayment is brought to the attention of the provider, the individual would likely begin a process of trying to determine if an overpayment actually occurred, and this process would require time. For those physicians who use external billing services, there may be considerable lag between requesting necessary documents and receiving and analyzing them.

The provider is liable if they learn that an overpayment has been given to a supplier who billed in the provider's name. Chasing down the detail of such a situation could take considerable effort and conceivably more than 60 days. The proposed rule does not clarify whether the 60-day period begins on the first day that each single overpayment is identified, or on the first day that the inquiry has concluded. We urge CMS to adopt a policy allowing the 60-day period to begin at the completion of the review confirming the overpayment.

### ***Process for Identifying Overpayments***

The rule assumes that every practicing physician has office staff dedicated to identifying overpayments and inconsistencies without fail, which may not always be feasible. Although physicians strive to run their practices using best business models, they need further guidance to be sure they are not at risk of "acting in reckless disregard or deliberate ignorance" of the overpayment and therefore liable under the false claims act. Certainly inadvertent errors in payment occasionally happen resulting in overpayments or underpayments and most physicians employ competent office personnel dedicated to correct reporting and review of payment. However, CMS should not impose a level of on-going intense review that would increase the already overwhelming administrative regulatory burden on physicians.

### ***Coordination with Other CMS Audit Programs***

Providers are still liable for repayment of overpayments under existing law through the Recovery Audit Contractors (RACs), the Comprehensive Error Rate Testing (CERT) program, many audit initiatives of the Medicare Administrative Contractors (MACs), and other efforts. Multiple programs are causing confusion and anxiety for physicians. If a provider is notified of an overpayment through one of these existing CMS audit initiatives, we urge CMS to suspend the reporting requirement for that provider under the proposed rule. The programs should be coordinated to prevent a single provider required to report and/or need to appeal to different Medicare programs for the same overpayment.

### ***Penalties***

CMS should clearly define the difference between an honest error and deliberate failure to report an obvious overpayment. The penalties outlined in the rule are harsh and the level of error—honest or deliberate—can have significant impact on a physician's practice. If a provider takes 61 days to return an overpayment, would they be liable for the \$10,000 plus three times amount of overpayment and/or exclusion from Medicare and Medicaid? This seems unreasonable for an inadvertent oversight. Enforcing the rule, or defending a practice against penalties outlined in the rule, will be nearly impossible until the penalties, types of errors, and definitions are improved. Again, we urge clear guidance and a reasonable definition of the 60-day "start time."

### ***Reporting Forms***

The form to use to return the overpayment requires the provider or supplier to give the reason for overpayment. Some of the causes could be an error on the part of the Medicare carrier and the physician may not know the reason. In addition, the proposed rule requires providers to report overpayments using the form made available by its MAC but some existing forms do not incorporate all 13 of the mandated elements for a report. Until CMS creates a new

standard reporting form, a provider should only be required to provide the information requested in its MAC's overpayment refund form.

## **Conclusion**

We are deeply concerned that many of the provisions of the proposed rule are onerous and unnecessary. We feel the agency has underestimated the burden some of the requirements would impose. We urge the agency to limit the regulation to the simplest statutory requirements, to coordinate clearly with existing audit programs, and to provide specific guidance for providers

Sincerely,

American Association of Neurological Surgeons  
American Gastroenterological Association  
American Society of Cataract and Refractive Surgery  
American Society of Echocardiography  
American Society of Plastic Surgeons  
American Urological Association  
Coalition of State Rheumatology Organizations  
Congress of Neurological Surgeons  
Heart Rhythm Society  
North American Spine Society  
Society for Cardiovascular Angiography and Interventions

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