

Annual Meeting (2025)

Bill & Ted's Excellent Adventure in Overpayments



Presented by:

Ted Lotchin, System Chief Compliance Officer, UNC Health

Bill Mathias, Member, Bass Berry & Sims

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Please Join Our Excellent Adventure by Using Slido

slido

To help facilitate today's excellent adventure in overpayments, we are going to use SLIDO, so please scan the QR code.

We are also going to ask for audience participation. The more you participate the better this will be!

Please answer the first SLIDO question.

- ✓ **What word or phrase best describes your experience with the overpayment rule (either old or new)?**

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Leading the Excellent Adventure



Ted Lotchin
System Chief Compliance Officer
UNC Health



Bill Mathias
Member
Bass, Berry & Sims

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Agenda for Today's Excellent Adventure in Overpayments

- Quick look at why overpayments matter
- Historical review of the 60-day Overpayment Rule
- Deep dive into the changes finalized in the CY2025 Medicare Physician Fee Schedule Final Rule
- Interactive time-travel tour through hypotheticals to better understand the new rule



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WHY OVERPAYMENTS MATTER

So-crates. "The only true wisdom consists in knowing that you know nothing." ~ Bill

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Government Wants Its \$

- Medicare is sometimes called a “pay and chase” system
- If you aren’t entitled to the money, then the government wants the money back



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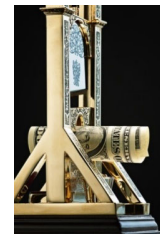
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If You Don't Return the \$, Government May Come for More....



Enforcement Risks

- Civil false claims act
 - Treble (3X) damages
 - Minimum/maximum per claim penalties
 - Originally \$5,000-\$10,000
 - 2025: \$14,308-\$28,619
- Criminal false claims act
 - Monetary penalty
 - Jail time
- Exclusion from federal healthcare programs
 - Economic death penalty



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HISTORY OF OVERPAYMENT RULE

Sometimes things
don't make
sense until the
end of the story.

- BILL AND TED FACE THE MUSIC

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Jump on the Time Machine to Where this Excellent Adventure Begins...



1863

- Congress enacted False Claims Act in response to concerns about fraud by suppliers of goods to the Union Army during the American Civil War

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False Claims Act

- False Claims Act
 - Generally prohibits any person from **knowingly** submitting false or fraudulent claims to the government for payment
 - “knowingly presents” a false or fraudulent claim
 - “knowingly... causes to be presented” a false or fraudulent claim
 - “knowingly makes, uses, or causes to be made or used” a false record or statement material to a false or fraudulent claim
- Conspiracy to violate false claims act

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False Claims Act

- “knowing” or “knowingly”
 - actual knowledge of information
 - acts in deliberate ignorance of the truth or falsity of the information
 - acts in reckless disregard of the truth or falsity of the information
- does not require proof of specific intent to defraud



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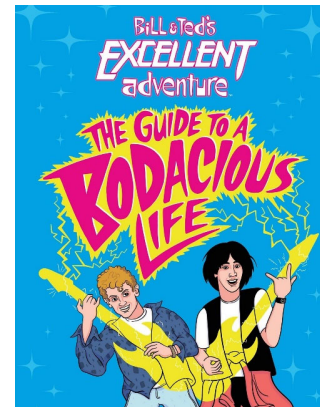
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Reverse False Claims

- Legal theory that retaining money from the government to which you are not entitled violates the law

1986

- “knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government”
 - Required knowledge and false record or statement



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Reverse False Claims – Codified

2009

- Fraud Enforcement and Recovery Act of 2009 (“FERA”)
- “knowingly makes, uses, or causes to be made or used, a false record or statement **material to an obligation** to pay or transmit money or property to the Government, or” **knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government**
- Obligation is defined as “an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or **from the retention of any overpayment**”

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Affordable Care Act §6402 Reporting & Returning Overpayments

2010

(d) Reporting and returning of overpayments

(1) In general

If a person has received an overpayment, the person shall—

(A) report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and

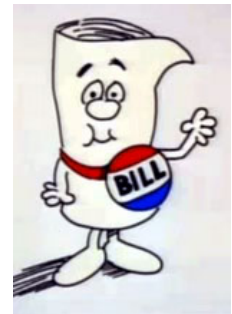
(B) notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.

(2) Deadline for reporting and returning overpayments

An overpayment must be reported and returned under paragraph (1) by the later of—

(A) the date which is **60 days after** the date on which the **overpayment was identified**; or

(B) the date any corresponding cost report is due, if applicable.

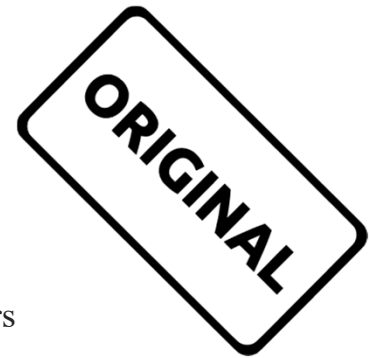


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Original Overpayment Rule



2014

- Medicare Part C – Medicare Advantage Organizations
- Medicare Part D – Prescription Drug Plan (PDP) Sponsors

2016

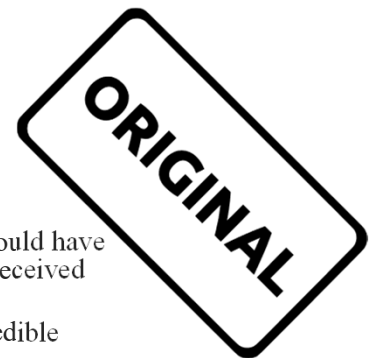
- Medicare Part A – Providers
- Medicare Part B – Suppliers

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Original Overpayment Rule



- Reasonable diligence
 - An overpayment is “identified” when a person has determined or should have determined through the exercise of reasonable diligence, that it has received an overpayment
 - Permitted **six months** to conduct a good-faith investigation once "credible information" about a potential overpayment was received, except in extraordinary circumstances
 - CMS indicated that **extraordinary circumstances** may include unusually complex investigations that the provider or supplier reasonably anticipates will require more than six months to investigate, such as physician self-referral law violations that are referred to the CMS Voluntary Self-Referral Disclosure Protocol (SRDP).
- Quantification
 - For Medicare Parts A&B, the overpayment was generally not identified until the amount of the overpayment was quantified

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Court Challenge

UnitedHealthcare Insurance Co. v. Azar (DDC 1:16-cv-00157)

2016

- Group of Medicare Advantage plans challenged the validity of the overpayment rule applicable to Parts C&D

2018

- US District Court for DC found that CMS lacked the authority to interpret the statute as it had in the overpayment rule applicable to Parts C&D
- District Court found that by using the **reasonable diligence** standard to determine when an overpayment existed, CMS was potentially imposing False Claims Act liability on mere negligence

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New Overpayment Rule



2022

- CMS Proposed New Overpayment Rule

2024 (Effective 1/1/2025)

- CMS finalized New Overpayment Rule in CY2025 Medicare Physician Fee Schedule

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New Overpayment Rule

NEW

Parts A&B – 42 CFR 401.305

- “A person has identified an overpayment when the person **knowingly receives or retains an overpayment**. The term ‘knowingly’ has the meaning set forth in 31 U.S.C. 3729(b)(1)(A).”

Part C – 42 CFR 422.326

- “The MA organization has identified an overpayment when the MA organization **knowingly receives or retains an overpayment**. The term ‘knowingly’ has the meaning set forth in 31 USC 3729(b)(1)(A).”

Part D – 42 CFR 423.360

- “The Part D sponsor has identified an overpayment when the Part D sponsor **knowingly receives or retains an overpayment**. The term ‘knowingly’ has the meaning set forth in 31 USC 3729(b)(1)(A).”

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New Overpayment Rule

NEW

- 60-day Overpayment Clock
 - Starts when you have **knowledge** of an overpayment
 - actual knowledge
 - deliberate ignorance
 - reckless disregard
- **Reasonable diligence** is no longer the standard
- **Quantification** is largely irrelevant

FCA knowledge standard



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New Overpayment Rule – Parts A&B Exception



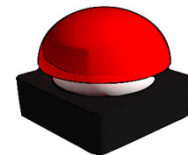
- In an effort to address concerns in comments to the proposed rule about the elimination of the quantification concept, CMS created an exception for Parts A&B that **suspends** the 60-day clock to “allow[] time to investigate and calculate overpayments”
- The exception provides **up to 180-days** to conduct a timely, good-faith investigation to determine whether **related overpayments** exist
- CMS observed that related overpayments “may arise from the same or similar cause or reason as the initially identified overpayment”

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Ask the Audience?



Eliminating the “reasonable diligence” standard means you no longer have to conduct good-faith investigations if you have “credible information” about a potential overpayment because you don’t have knowledge of the overpayment

? **True**

? **False**

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Common Misunderstanding

- Eliminating the “reasonable diligence” standard means you no longer have to conduct good-faith investigations if you have “credible information” about a potential overpayment because you don’t have knowledge of the overpayment

FALSE

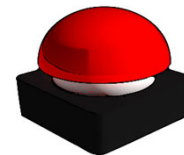
- FCA knowledge standard imposes an obligation to investigate when you have “credible information” about a potential overpayment
- While you may not have actual knowledge, you need to do something – good-faith investigation – to avoid an argument that you acted in deliberate ignorance or with reckless disregard

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Ask the Audience?



Under the new overpayment rule, you always get 180 days to conduct a good-faith investigation to determine whether an overpayment exists and then you get 60 days to repay the overpayment.

? True

? False

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Another Common Misunderstanding

- Under the new overpayment rule, you always get 180 days to conduct a good-faith investigation to determine whether an overpayment exists and then you get 60 days to repay the overpayment.

☒ FALSE

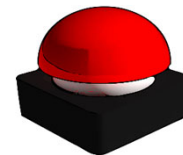
- Whether you are talking about an initial overpayment or a related overpayment, the test is whether you have knowledge using the FCA knowledge standard
- Once you have “knowledge” of an overpayment, you have 60-days to repay it.
- The 180-day exception only applies to [related overpayments](#), once you have determined you have an initial overpayment.
- Plus, the exception provides [up to 180-days](#)
- Once you have “knowledge” of the related overpayments during the 180-day period, then the suspension theoretically ends at that point and the 60-day clock starts up again

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Ask the Audience?



Once you have conducted a good-faith investigation and determined that there are related overpayments arising from the same or similar cause or reason as the initially identified overpayment, do you always get 60 days to repay those overpayments

? Yes, you always get 60 days

? No, sometimes it may be less than 60 days

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Another Common Misunderstanding

- Once you have conducted a good-faith investigation and determined that there are related overpayments arising from the same or similar cause or reason as the initially identified overpayment, do you always get 60 days to repay those overpayments

☒ **No, sometimes it may be less than 60 days**

- The exception **suspends** the 60-day clock; it doesn't reset it
- While you always get a total of 60 days, at least theoretically, you may have used some of them before you started the investigation into the related overpayments
- If the 60-day clock had already started running before you realized there were **related overpayments** arising from "the same or similar cause or reason as the initially identified overpayment," then once the investigation into the related overpayments is over (or 180-days has elapsed) the 60-day clock starts up from where it was when it was paused

TIME TRAVEL TOUR THROUGH HYPOTHETICALS



What Gets Disclosed Where?

- ❖ To Contractor or Payor
 - “merely an overpayment”
- ❖ To CMS (SRDP)
 - Stark only violation
- ❖ To OIG (SDP)
 - Potential fraud against the Federal health care programs, not merely an overpayment
 - Not Stark only violations
 - At least a “colorable” AKS violation
- ❖ To U.S. Attorney’s Office
 - It depends
- ❖ To State
 - Depends on state laws

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- ❖ Contractors have no authority to accept less than the full return of the overpayment
- ❖ CMS generally does not have authority to compromise overpayment claims
 - One exception is an overpayment based on a Stark physician self-referral law violation
- ❖ DOJ theoretically has authority to compromise claims
 - But, as a practical matter, DOJ is usually looking to add a multiplier to the overpayment (not reduce the overpayment)
 - DOJ may exercise its discretion to compromise claims based on detailed “ability to pay” analysis
- ❖ Once the proverbial “kimono” is open, it can be difficult to stop the government from looking inside



Understand the Limitations When Disclosing Overpayments

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CARDIAC DOCUMENTATION



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Hypothetical #1A



- On January 1st, the hospital compliance team conducted a probe sample of 10 claims for a cardiac procedure performed by Dr. Newbie
- The internal audit took 90 days to complete and found that 5 of 10 claims failed to satisfy the Medicare requirements for evaluating patient suitability to bill for the procedure
- In reviewing the audit findings, the compliance officer discovers that only 2 of the 10 claims were actually for Medicare patients and only 1 of those 2 Medicare claims failed to satisfy the Medicare requirements



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Ask the Audience?



If you are the compliance officer reviewing the audit findings, what do you do?

- 1. Repay the 1 Medicare claim, but don't look any further given the small number of Medicare claims reviewed**
- 2. Hire a consultant to perform a statistically valid sample of claims for the procedure performed by Dr. Newbie**
- 3. Do nothing because there is only a problem with 1 Medicare claim**

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Hypothetical #1B



- You hire an outside consultant to conduct a probe sample of 20 presubmission claims for the procedure performed by Dr. Newbie on Medicare patients
- It takes the consultant 120 days to complete the probe sample and prepare a report that finds that 2 of the 20 claims failed to meet the Medicare requirements for a 10% numerical error rate

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Ask the Audience?



If you are the compliance officer reviewing the outside consultant's report from the probe sample, what do you do?

- 1. You violated the overpayment rule because it has taken 210 days (90+120) to conduct your investigation**
- 2. Repay the 1 Medicare claim from the original audit, don't bill for the 2 Medicare claim from the presubmission audit, and make changes to the process for evaluating patient suitability going forward**
- 3. Do nothing because a 10% error rate seems pretty low**

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Hypothetical #1C



- Assume that the outside consultant found errors with 10 of the 20 presubmission claims, so you engage the consultant to conduct a statistically valid sample of claims for the procedure performed by Dr. Newbie
- It takes the consultant 150 days to complete the statistically valid sample which identifies a 25% numerical error rate

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Ask the Audience?



If you are the compliance officer reviewing the outside consultant's report of the statistically valid audit, what do you do?

1. Submit a repayment to the MAC with a check for 25% of the value of the claims for the cardiac procedures performed by Dr. Newbie for the last 4 years
2. Submit a self-disclosure to OIG because you feel like a 25% error rate is pretty high and you're worried there might be a whistleblower
3. You violated the overpayment rule because it took 270 days (120+150) to conduct your investigation, so you submit a self-disclosure to the local US Attorney's Office

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OVERLY AGGRESSIVE ON E&M CODING

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Hypothetical #2A



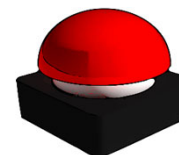
- Large orthopaedic practice with 50 physicians reaches out for advice as they are considering a substantial offer from a private equity firm
- The practice's compliance officer reviews 10 claims for E&M services for 10 of the 50 physicians each year
- Last year, the audit found:
 - 2 physicians had 2+ level errors on 5 of the 10 claims
 - 3 physicians had 1 level errors on 5 of the 10 claims
 - 5 physicians had 0 errors on all 10 claims
- This year's audit was completed 90 days ago and found:
 - 5 physicians had 2+ level errors on 5 of the 10 claims
 - 5 physician had 1 level errors on 2 of the 10 claims

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Ask the Audience?



You're told the practice repaid a total of 10 claims for the 2 physicians who had 2+ level errors last year, what do you tell the practice to do given the results of this year's audit?

- 1. Do nothing because you don't want to do anything that might derail the deal with the PE firm**
- 2. Repay the 25 claims for the 5 physicians who had 2+ level errors, but don't do anything else because the overall error rate is still pretty low**
- 3. You violated the overpayment rule because last year's audit put you on notice of a problem, and it took you more than a year to further investigate the issue**
- 4. Hire an outside consultant to review the internal audit for this year**

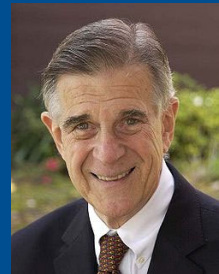
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PUMPKIN SPICE LATTE (PSL) GETS COLD



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Hypothetical #3A



- Hospital's compliance officer hired new director of audit and tasked her with reviewing physician compensation models at affiliated medical practices
- She started with surgeons and discovered that each surgeon was employed in their individual capacity and received base salary and a share of a bonus pool
- After 6 months of painstaking review of how the bonus pool operated, she discovered that the surgeons were getting credit for services performed by APPs employed by the practices
- The compliance officer hired a local law firm to look into the issue
- After 2 months of analysis, the firm concluded that it was not a problem because the surgeons are employees and their base salary plus the bonus was within FMV



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Hypothetical #3A



- Compliance Officer shares these findings during a quarterly compliance meeting
- General Counsel is skeptical of the analysis of the local law firm and hires Big Shot Firm to give a second opinion
- BS Firm spends 6 months interviewing staff and analyzing whether the affiliated practices satisfied all of the elements of the group practice definition so that the surgeons productivity bonuses could take into account “incident to” services performed by the APPs
- BS Firm ultimately finds that the affiliated practices are not groups, so the productivity bonus did not comply with the Stark physician self-referral law (PSL)

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Ask the Audience?



If you are the General Counsel, what do you do?

- 1. Change the compensation going forward, but ignore the past based on the opinion of the local law firm**
- 2. You violated the overpayment rule because it took 14 months (6+2+6) to identify the overpayment**
- 3. Task BS Firm with preparing a disclosure under the CMS self-referral disclosure protocol (SRDP) within 60 days of the date it issued its memo identifying the Stark/PSL violation**

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FINAL THOUGHTS



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Practical Considerations

- Investigate → Get the facts
- Conduct thorough legal analysis → Check all exceptions and other helpful concepts
- Determine if you have a problem or not
- Understand your legal obligations
- Consider your strategic options

Who?

What?

When?

Where?

Why?

How?



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Practical Considerations

- If it's **not** a problem → Maintain contemporaneous documentation of your analysis
- If it's a problem → **Do something**



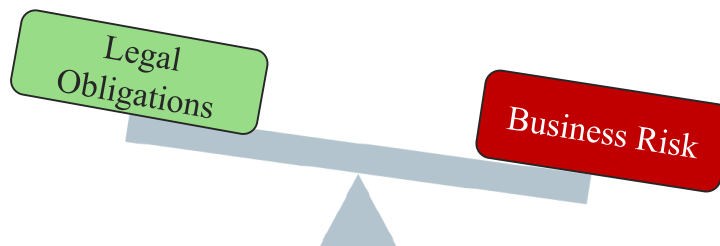
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Practical Considerations for Disclosures

❖ Disclosure calculus



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Time for Questions



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Thanks for Joining Us on Our Excellent Adventure



Ted Lotchin
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