AMERICAN ACADEMY OF AUDIOLOGY
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April 16, 2012

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

Re: CMS-6037-P Medicare Program; Reporting and Returning of Overpayments; Proposed Rule

Dear Acting Administrator Tavenner:

The American Academy of Audiology is the world's largest professional organization of, by, and for audiologists, representing over 11,000 members. The American Academy of Audiology (the "Academy") promotes quality hearing and balance care by advancing the profession of audiology through leadership, advocacy, education, public awareness, and support of research.

The Academy appreciates the opportunity to comment on policies addressing the reporting and returning of Medicare program overpayments under the Affordable Care Act (ACA) published in the February 16, 2012 *Federal Register*. The Academy addresses several specific areas outlined in the proposed rule with special attention to the needs and potential burdens placed on small audiology practices. With the exception of those audiologists practicing in hospital settings, a large portion of our membership represents small practice settings.

Requirements for Reporting and Returning of Overpayments

One of the reporting requirements described in the proposed rule includes stating the reason for the refund being made to the contractor and the proposed rule indicates several examples a provider may offer as the reason for the Medicare refund. The Academy asserts that the provider may not know for certain that an incorrect payment was made but, in an effort to comply and avoid liability, a provider may over-correct and choose to report any outliers in payment to the Medicare contractor. Alternatively, a provider may not be immediately aware of a change in Medicare coverage policy and thus would not be able to identify a reason for an overpayment since they would not have recognized the overpayment. For these reasons, the Academy appreciates the development underway of a uniform reporting form that will enable all overpayments to be reported and returned in a consistent manner, but also to identify the source of incorrect overpayments and be in

close communication with the reporting provider. Ultimately, the Academy requests that provider education regarding the reasons for reporting an overpayment will be better explained so a provider, who does not have the resources to engage in ongoing Medicare education regarding coverage guidelines or Medicare allowable amounts, will be able to better understand the reporting and returning requirements.

Definition of "Identified"

CMS states in the proposed rule that a person has identified an overpayment if the person has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment. We agree that the ACA definition of "knowing" could lead a provider to "exercise reasonable diligence to determine whether an over payment exists", as supposed in the proposed rule. However, other solo practitioners or small practices simply may not have the infrastructure to audit claims at the frequency required to be in speedy compliance with the proposed rule.

These small practices wish to be in compliance with the standards set forth in the proposal for reporting and returning of overpayments, but are at a great disadvantage based on the size of their practices. In fact, many small audiology practices do not have separate coding and/or billing staff that may be responsible for auditing claims and quickly following up regarding denials such as what might be available at larger practices or facilities. These smaller practices are not "avoiding performing activities to determine whether an overpayment exists" as assumed in the text of the proposed rule; rather, they wish nothing other than to be in regulatory compliance and to run successful businesses. In these practices, the audiologists must monitor payer claims, documentation, and billing practices through self-audits and compliance checks on a different schedule that permits the practice to remain viable, while still in compliance with all the related rules and regulation of operating a health care business.

Reporting/Returning Deadlines

The Academy respectfully requests additional exceptions and/or lengthier timeframes based upon the size of the practice for health care provider practices that may lack the infrastructure to audit claims at the frequency required to be in compliance with the proposed rule. The Academy appreciates the requirement of reporting overpayments 60 days after the date that the overpayment is identified; however we read the CMS definition of "identified" to mean that a provider could be viewed as acting in "reckless disregard or deliberate ignorance" of an overpayment that they have innocently not identified or that did not yet trigger a red flag in their systems as a potential overpayment. It is not entirely clear from the proposal when the 60-day timeframe begins, but it appears that deliberate ignorance could inadvertently be assigned to a well-meaning provider.

For the reasons outlined in the section above, this is a particular concern for solo or small audiology practices. While we appreciate the ability for practices with financial constraints to use the Extended Repayment Schedule option, that process assumes that the provider or practice had the necessary systems in place to identify an overpayment in the short timeframe consistent with the proposed rule policies. The Academy requests that CMS give consideration to exceptions or longer reporting timeframes based upon

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practice size for both the reasonable inquiry stage and the actual reporting discussed in the proposed rule. The Academy further requests clearer definitions of the terms "reasonable inquiry" and what it entails as well as the use of the term "all deliberate speed" when a provider makes that inquiry.

This request is particularly important in light of the strong enforcement associated with the proposed rule that could result in False Claims Act or Civil Monetary Penalties violations, each of which could result in liability for up to three times the amount of the identified claim. Furthermore, the proposed rule does not discuss what the role of the Recovery Audit Contractors (RAC) will be in this process or whether the RACs will operate under a separate and unrelated system. The Academy requests clarification regarding the role of the RAC in this process after a provider identifies and reports an overpayment.

Look back and Reopening Periods

The Academy does not agree with the use of 10 years, the outer limit of the False Claims Act statute of limitations period, for the look back and reopening period timeframes. The Academy requests that CMS consider a 5-year term for each of these periods. The Academy views 5 years as a reasonable timeframe in light of the fact that most state medical malpractice tort statute of limitations fall in the range between 2 and 5 years.

While an overpayment could be the result of fraudulent or abusive activities, at least some of the overpayments occurring will be a result of Medicare program error and/or non-malicious provider mistakes in billing practices, which are becoming more and more complex by the day. Applying a False Claims Act enforcement policy in a regulation intended to, at least in part, identify overpayments that result from an unintended oversight either on the part of the provider or the Medicare program itself has the appearance of being inequitable.

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Thank you for your consideration of these comments. If there are any questions about our recommendations, please contact Sharmila Sandhu, Esq., Director of Regulatory Affairs at 202.544.9337 or via email at ssandhu@audiology.org.

Sincerely,

Therese Walden, AuD
President, American Academy of Audiology

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