

Diving in to the SRDP – CMS Self-Referral Disclosure Protocol vs OIG SDP Self Disclosure Protocol

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Health care providers and suppliers face a dilemma when they identify that potentially problematic claims have been submitted to a federal health care program (i.e. *Medicare, Medicare Advantage Programs, Tricare and Medicaid Programs*,). Balancing legal disclosure obligations and business interests can be difficult when entities look at short term risks and benefits, to disclose to the OIG or CMS or simply, voluntarily refund the overpayment to the provider's Medicare Administrative Contractor.

When balancing those interests, many providers are inclined to keep a potential violation quiet and hope that the government does not independently discover the violation. Is that a good strategy? Probably not. At a minimum, reporting and refunding wrongfully obtained reimbursement to Medicare is now a requirement. Likewise, depending on the circumstances, providers may be under an obligation to engage in a more expanded self-disclosure, which may not only be an obligation but may also provide concrete benefits to the provider or supplier. But the dilemma does not end there. If a provider does decide to engage in the self-disclosure process, there are several options available to make that disclosure.

Returning Overpayments

The starting point is that providers and suppliers are now required to report and return overpayments to Medicare as a result of a provision in the Affordable Care Act. Specifically, a provider or supplier must report and return an overpayment "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." Failure to return an overpayment can result in the imposition of civil monetary penalties and exclusion from federal health care programs. Moreover, the retention of an overpayment beyond 60 days, from the identified over-payment, becomes an "obligation" under the False Claims Act (the FCA), such that, if the provider knowingly avoids the obligation to repay the funds, the provider will be subject to the FCA per claim penalty and costly damages.

This overpayment obligation applies to Medicare providers and suppliers, Medicare Advantage plans, Medicaid managed care organizations, Tricare and Medicare Part D prescription drug plan sponsors and other governmental payors.

The regulations define the term "overpayment" broadly to include any funds received and to which a provider or supplier is not entitled. When is an overpayment "identified" for purposes of these rules? An

overpayment is identified when the provider or supplier has, or should have through the exercise of reasonable diligence, determined that the provider has received an overpayment and quantified the amount of the overpayment. The Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) has commented that reasonable diligence includes engaging in both proactive compliance activities and investigations conducted in response to obtaining creditable information of a potential overpayment. 81 F.R. 7654, 7661 (2016).

The rule also contains a six year look back period, so that when an overpayment is identified, the provider should repay improperly paid claims going back a maximum of six years. Finally, the rule provides that, when the repayment is made, the provider must also identify the reason for the overpayment.

This method of refunding an overpayment is simple and, because it appears to be administrative in nature with the refund being made to the Medicare contractor, it may seem like the route that will least likely attract the attention of regulators and law enforcement. As a result, it is an attractive option for providers and suppliers. However, if there is a risk that the payments at issue were obtained in violation of the Department of Health and Human Services Office of Inspector General's (OIG) civil monetary authority or the FCA (both of which involve "knowingly" submitting false claims) or criminal law (involves intentional conduct), this option does not afford the provider protection from further action by the OIG or by the Department of Justice (DOJ). These protections can only be obtained through self-disclosure to the OIG or the DOJ. This is why, it is recommended that healthcare entities engage a healthcare attorney to assist with the decision on what is appropriate for the practice.

OIG Self-Disclosure Protocol

Another potential option for reporting an overpayment is the OIG Self Disclosure Protocol (SDP). The SDP is available to providers and suppliers to facilitate a resolution of matters that, "within the disclosing party's reasonable assessment, potentially violate federal criminal, civil, or administrative laws for which civil monetary penalties (CMPs) are authorized." By referencing federal criminal, civil, or administrative law in the protocol, the OIG acknowledges that the SDP is intended for those situations in which the overpayment involved more than an innocent or negligent billing error. For example, the OIG CMP statute regarding false claims imposes liability when a provider "knowingly" submits, or causes to be submitted, a false claim. This means that the healthcare attorney would look at potentially three things before moving into an SDP:

1. Intent – was their “deliberate ignorance”? or
2. Reckless disregard for the rules? Staff identified the problem, but the physician chose to ignore it?
3. How long as this behavior been going on?

The term knowingly includes situations not only where claims are submitted with actual knowledge that they are false, and that the intent was more than simple negligence.

Then we have The Centers for Medicare and Medicaid, Voluntary Self-Referral Disclosure Protocol (SRDP), which enables providers of services and suppliers to self-disclose actual or potential violations of the physician self-referral statute, (the so-called “Stark Law”).

CMS published the Medicare Self-Referral Disclosure Protocol (SRDP) pursuant to Section 6409(a) of the Patient Protection and Affordable Care Act (ACA). According to CMS, “[t]he SRDP sets forth a process to

enable providers of services and suppliers to self-disclose actual or potential violations of the physician self-referral statute.

The Stark law is designed to contain Medicare costs by preventing physicians from enriching themselves through referrals for services or to hospitals in which they have a financial stake. The law states that all Medicare money paid to a doctor under a noncompliant contract must be returned, even if it's only a technical violation of the Stark law.

The SRDP disclosures are reviewed by CMS, rather than the OIG. Importantly, it should be noted that while violations of Stark are reported through the SRDP, violations of the Anti-Kickback Statute or violations that involve both the Anti-Kickback Statute and Stark should be reported to OIG through the SDP.

As most providers and suppliers are aware, Stark liability is triggered when there is an arrangement to provide designated health services between a physician and an entity with which the physician has a financial relationship and the relationship does not fall within one of the exceptions to Stark. No intent to induce referrals is required. The violation is related to a tainted referral and the remuneration received by the physician caused by that referral. An important benefit to using the SRDP is that CMS employs several factors in considering whether to reduce the amount owed for Stark liability. Those factors include:

- The nature and extent of the improper or illegal practice(s);
- The timeliness of the self-disclosure; and
- The cooperation in providing additional information.

So, What Is the Best Option?

If a provider or supplier identifies a potential overpayment, it may be inclined to take the route that appears easiest and least likely to result in a government investigation – that is, to simply refund the money through the Medicare Administrative Contractor (MAC). In many cases, reporting and refunding the overpayment to the Medicare contractor is the appropriate channel. However, it is important for a provider/supplier to engage in at least two additional steps to determine the most appropriate and advantageous method of reporting and repaying an overpayment.

First, the provider/supplier should conduct an internal investigation to determine whether the overpayment was simply an innocent billing mistake or whether it was associated with a potential violation of federal criminal, civil, or administrative laws. We recommend, again that you hire a healthcare consultant and healthcare attorney that specializes in this type of investigative work.

And second, carefully assessing the potential costs and benefits of reporting the overpayment through the various mechanisms described above. Due to the significant costs to a provider/supplier should it be faced with an enforcement action for failing to make a refund or an appropriate disclosure, all providers and suppliers should consider incorporating this analysis into their compliance efforts and required corporate compliance plans.

You can hear more about this timely topic in the February 8th 2022, EP:15 of the NSCHBC Edge Podcast with Healthcare Consultant Terry Fletcher and Healthcare Attorney Amanda Waesch, available on all listening platforms and the NSCHBC.org website.

References:

Physician Self-Referral CMS [Physician Self Referral | CMS](#)

Physician SRDP [https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Self Referral Disclosure Protocol](https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Self%20Referral%20Disclosure%20Protocol)

CMS SRDP Instructions <https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Downloads/Disclosures-Noncompliance-Instructions.pdf>