After Nearly Six Years of Uncertainty, CMS Establishes Final Standards for Reporting and Returning Medicare Overpayments

February 17, 2016

Background

Today, the Centers for Medicare & Medicaid Services ("CMS") published the long-awaited Final Rule establishing CMS's official policy for the timely Reporting and Returning of Medicare overpayments received by health care providers (the "Final Rule"). Providers[1] have been subject to a statutory 60-day timeline for reporting and returning Medicare overpayments since the enactment of the Affordable Care Act on March 23, 2010, and faced liability under the False Claims Act, Civil Monetary Penalties Law and the Medicare exclusion authorities for the failure to meet the statutory deadline. Today's Final Rule was preceded by CMS's Proposed Rule published on February 16, 2012, and brings some clarity to issues such as when an overpayment is considered to be "identified," for purposes of the 60-day deadline, as well as how far providers must look back when identifying overpayments subject to the reporting and return requirement.

Basic Standard

Under the Final Rule, a person who has received an "overpayment" must report and return the overpayment by the later of either (i) the date which is 60 days after the date on which the overpayment was "identified," or (ii) the date any corresponding cost report is due, if applicable. For purposes of the Final Rule, an "overpayment" means any funds that a person has received or retained under Medicare Parts A or B to which the person, after applicable reconciliation, is not entitled.[2]

Six-Month Investigation Benchmark

For purposes of the Final Rule, an overpayment is "identified" when a person has, or should have through the exercise of reasonable diligence, determined that the person has received an overpayment and quantified the amount of the overpayment. With this definition, CMS acknowledges that "identification" of an overpayment involves *quantifying* the amount, which requires time for a reasonably diligent investigation.

According to CMS, "reasonable diligence" includes both proactive compliance activities conducted in good faith by qualified individuals to monitor for the receipt of overpayments and investigations conducted in good faith, and in a timely manner by qualified individuals in response to obtaining credible information of a potential overpayment.

Significantly, CMS establishes a six-month period as the "benchmark" for what it considers to be a timely investigation, absent extraordinary circumstances. According to CMS, a total of eight months (six months for timely investigation and two months for reporting and returning) is a reasonable amount of time, absent extraordinary circumstances. CMS states that "extraordinary circumstances" may include unusually complex investigations that the provider reasonably anticipates will require more than six months to investigate, such as Physician Self-Referral Law (also known as the "Stark Law") violations that are referred to the CMS Voluntary Self-Referral Disclosure Protocol ("SRDP"). Specific examples of other types of extraordinary circumstances cited by CMS include natural disasters or a state of emergency.

Six-Year Look Back Period

Overpayments are subject to a six-year "look-back" period, meaning that overpayments must be reported and returned if they have been identified within six years of the date the overpayment was received.

Although CMS had originally proposed a 10-year "look-back" period to be consistent with the outer limit of the False Claims Act statute of limitations, CMS recognized that a 10-year period would be overly burdensome for providers in terms of retaining records and retrieving information from electronic legacy systems.

Reporting and Return Process

Under the Final Rule, a provider must use the reporting process established by the applicable Medicare Administrative Contractor ("MAC") to report the overpayment. This may include an applicable claims adjustment, credit balance, self-reported refund or other process set forth by the MAC. If the amount of the overpayment was calculated using a statistical sampling methodology, then the provider must describe the statistically valid sampling and extrapolation methodology in the report.

Notably, in finalizing this section of the rule, CMS removed a requirement under the Proposed Rule which would have required providers to include 13 specific data elements when reporting overpayments to a MAC. CMS acknowledged that allowing providers to follow the processes established by each MAC would avoid the administrative burden of reporting information that the MAC considers unnecessary.

CMS also allows the deadline for *returning* an overpayment to be suspended with a provider's submission of a request for an extended repayment schedule to the MAC. The deadline will remain suspended until such time as CMS or the MAC rejects the suspended repayment schedule request or the provider fails to comply with the terms of the extended repayment schedule.

Relationship to Self-Disclosure Protocols

The Final Rule affords special treatment for overpayments that implicate the Fraud & Abuse laws enforced by the Office of Inspector General ("OIG") or the Physician Self-Referral Law enforced by CMS.

Specifically, a person satisfies the *reporting* obligations of the Final Rule by making a disclosure under the OIG Self-Disclosure Protocol or the CMS Voluntary Self-Referral Disclosure Protocol ("SRDP") resulting in a settlement agreement using the process described in the respective protocol.

With respect to the OIG, the deadline for *returning* an overpayment is suspended when the OIG acknowledges receipt of a submission to the OIG Self-Disclosure Protocol. The repayment deadline remains suspended until such time as a settlement agreement is entered, the person withdraws from the OIG Self-Disclosure Protocol, or the person is removed from the OIG Self-Disclosure Protocol.

Similarly, with respect to the CMS Voluntary SRDP, the deadline for *returning* an overpayment is suspended when CMS acknowledges receipt of the self-disclosure. The repayment deadline remains suspended until such time as a settlement agreement is entered, the person withdraws from the SRDP or the person is removed from the SRDP.

Effective Date

While the Final Rule is effective on March 14, 2016, it is important to note that even without this Final Rule, providers have been subject to the Affordable Care Act's provisions for the timely reporting and returning of Medicare overpayments since March 23, 2010.

CMS states that provisions of the Final Rule are not retroactive. Therefore, providers that reported and/or returned overpayments prior to March 14, 2016, and made a good faith effort to comply with the Affordable Care Act's "report and return" requirements, are not expected by CMS to have complied with each provision of the Final Rule. However, all providers reporting and returning overpayments on or after March 14, 2016 - even overpayments received prior to this date - must comply with the requirements of the Final Rule.

Recommendations

Although health care providers have long been subject to the obligation to report and return overpayments, providers should take a number of steps in response to the Final Rule.

- First, providers should implement or review processes to assure that they respond appropriately to receipt of credible information regarding a potential overpayment. Credible information may include, for example, the discovery of a single overpaid claim (which may trigger the need to make further inquiries) or one or more hotline complaints regarding the same or similar payment-related issue.
- Second, providers should recognize that although CMS allows for the identification and quantification of a potential overpayment to occur after a "reasonably diligent" investigation, providers should be prepared to take no more than six months to complete the investigative process, absent extraordinary circumstances.
- Third, providers should maintain records that accurately document their reasonable diligence efforts to be able to demonstrate their compliance with the Final Rule.

- Finally, providers should be prepared to "look back" six years when identifying potential overpayments.

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1. For purposes of the article, "provider" or "person" refers to both a "provider," as defined in 42 CFR 400.202 (e.g. a hospital), and a "supplier," as defined in 42 CFR 400.202 (e.g. a physician).

2. CMS published rules for reporting and returning of overpayments in Medicare Parts C and D in a separate rulemaking (79 Fed. Reg. 29843 May 23, 2014).

If you have any questions about the information above, please contact your Lathrop Gage attorney or any of the attorneys listed above.