King & Spalding

Client Alert

February 20, 2012

# Proposed Rule: Reporting and Returning of Overpayments

## I. Introduction

On February 16, 2012, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule to implement Section 6402(d) of the Patient Protection and Affordable Care Act (Affordable Care Act) which addresses the identification, reporting, and refunding of certain overpayments (the Proposed Rule). In this Alert we outline several key provisions of the Proposed Rule as well as important questions raised by CMS's approach to these provisions. It is important to recognize that this is only a Proposed Rule, and as such CMS may change certain provisions in any final rule. We will delve into the Proposed Rule in even greater detail during a Roundtable which King & Spalding (K&S) will host on March 9, 2012.

## II. Overview

Since the enactment of the Affordable Care Act in March 2010, providers and suppliers have been grappling with multiple issues emanating from Section 6402's overpayment reporting and refunding requirements, including the issue of when an overpayment is "identified" for purposes of timely satisfying the refunding and reporting requirements. In the Proposed Rule, CMS attempts to clarify the manner in which providers and suppliers are expected to navigate the reporting and refunding requirements outlined in Section 6402 of the Affordable Care Act; however, as detailed below, the Proposed Rule not only fails to address certain questions that were expected to be resolved in this Proposed Rule, but also creates new questions and concerns for the provider and supplier communities.

We encourage providers and suppliers to submit comments on the Proposed Rule, which must be received by CMS on or before **April 16, 2012**. Given several controversial provisions in the Proposed Rule, such as the 10 year look-back period, it is anticipated that providers and suppliers will want to consider submitting comments either directly to CMS or through a trusted trade association.

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## III. SCOPE OF PROPOSED RULE

Section 6402's identification, reporting and refunding requirements greatly expand the scope of potential federal False Claims Act (FCA) exposure for healthcare providers and suppliers who improperly retain overpayments. While CMS presents the Proposed Rule as only applicable to Medicare Part A and Part B overpayments, there are multiple concepts embedded in the Proposed Rule that could conceivably serve as CMS direction regarding the identification, reporting and refunding of overpayments in other federal healthcare programs such as Medicare Advantage, Medicaid managed care, Medicaid fee-for-service and Prescription Drug Plan programs.

In the Proposed Rule, CMS reminds all stakeholders that Section 6402(d) of the Affordable Care Act applies to all Medicare and Medicaid overpayments. Accordingly, even though this proposed rulemaking extends only to Medicare Part A and Part B overpayments, and even though CMS intends to pursue additional rulemaking to implement Section 6402 in other federal healthcare programs, other Medicare and Medicaid stakeholders remain subject to the reporting and refunding requirements set forth in Section 6402(d).

## IV. DISCUSSION

### A. AFFORDABLE CARE ACT REPORTING AND REFUNDING REQUIREMENTS

Section 6402(d) of the Affordable Care Act requires a person who has received an "overpayment" to report and return the overpayment by the later of—(1) the date which is 60 days after the date on which the overpayment was identified; or (2) the date any corresponding cost report is due, if applicable. The term "overpayment" is defined in Section 6402(d) "as any funds that a person receives or retains under title XVIII [Medicare] or XIX [Medicaid] to which the person, after applicable reconciliation, is not entitled under such title." The Affordable Care Act further provides that any overpayment retained by a person after the deadline for reporting and returning an overpayment is an ***obligation*** (as defined in 31 U.S.C. § 3729(b)(3)) for purposes of the federal False Claims Act, 31 U.S.C. § 3729. In other words, failure to comply with Section 6402(d)'s requirements can transform a routine administrative overpayment issue into a potential False Claims Act violation.

In the Proposed Rule, CMS proposes procedures for identifying, reporting and refunding overpayments pursuant to Section 6402 of the Affordable Care Act, and in doing so, provides immediate guidance to the provider and supplier communities regarding the agency's position on key issues embedded in Section 6402.

### B. THE "IDENTIFICATION" OF OVERPAYMENTS (PROPOSED 42 C.F.R. § 401.305(a)(2))[1]

#### 1. Internal Audits

When an overpayment is "identified" has been the subject of much discussion since the enactment of the Affordable Care Act. In 42 C.F.R. § 401.305 (a)(2), CMS proposes that a person has identified an overpayment ***"if the person has actual knowledge of the existence of the overpayment or acts in reckless***

[1] To implement Section 6402(d) of the Affordable Care Act, CMS proposes to establish a new subpart D in Part 401 of CMS's regulations. Accordingly, citations to the Code of Federal Regulations in this Alert refer to *proposed* regulations introduced in the Proposed Rule. Consequently, these cites are subject to change or elimination in any final rule.

***disregard or deliberate ignorance of the overpayment."***[2] While CMS acknowledges that "actual knowledge," "reckless disregard," and "deliberate ignorance" are FCA scienter concepts, CMS further asserts that "Congress' use of the term 'knowing' in the [Affordable Care Act] was intended to apply to determining when a provider or supplier has identified an overpayment. [CMS] believe[s] defining 'identification' in this way gives providers and suppliers an incentive to exercise reasonable diligence to determine whether an overpayment exists." The extension of FCA concepts in this manner is likely to be the subject of many comments to the Proposed Rule.

For example, the Proposed Rule grafts the "knowledge" requirement onto the *identification* of the overpayment—a provider has "identified" an overpayment if it acts in reckless disregard of the existence of the overpayment. The FCA, however, applies its scienter requirement to the *retention* of an overpayment—FCA liability exists for "knowingly and improperly" avoiding an obligation to make a payment (or refund) to the government. The Proposed Rule also does not address the circumstances that would indicate that a provider or supplier has "improperly" avoided the refund of an overpayment, which is a requirement under the FCA.

CMS further notes that in certain instances, a provider or supplier "***may receive information concerning a potential overpayment that creates an obligation to make a reasonable inquiry to determine whether an overpayment exists***." According to the Proposed Rule, "[i]f the reasonable inquiry reveals an overpayment, the provider then has 60 days to report and return the overpayment." CMS further explains that "failure to make a reasonable inquiry, including failure to conduct such inquiry ***with all deliberate speed*** after obtaining the information, could result in the provider knowingly retaining an overpayment because it acted in reckless disregard or deliberate ignorance of whether it received such an overpayment."

CMS identifies the following examples of when an overpayment has been "identified":

- "A provider of services or supplier reviews billing or payment records and learns that it ***incorrectly coded certain services***, resulting in increased reimbursement."
- "A provider of services or supplier learns that a patient death occurred prior to the service date on a claim that has been submitted for payment."
- "A provider of services or supplier learns that ***services were provided by an unlicensed or excluded individual on its behalf***."
- "A provider of services or supplier ***performs an internal audit and discovers that overpayments exist.***"
- "A provider of services or supplier ***is informed by a government agency of an audit that discovered a potential overpayment, and the provider or supplier fails to make a reasonable inquiry***. (When a government agency informs a provider or supplier of a potential overpayment, the provider or supplier has an obligation to accept the finding or make a reasonable inquiry.)"
- ***"A provider of services or supplier experiences a significant increase in Medicare revenue and there is no apparent reason*** – such as a new partner added to a group practice or a new focus on a particular area of medicine – for the increase. Nevertheless, the provider or supplier fails to make a reasonable inquiry into whether an overpayment exists. (When there is reason to suspect an overpayment, but a provider or supplier fails to make a reasonable inquiry into

[2] Throughout this Alert, we have added emphasis by bolding and italicizing certain provisions included in the Proposed Rule.

> whether an overpayment exists, it may be found to have acted in reckless disregard or deliberate ignorance of any overpayment.)"

While CMS has offered some guidance in the Proposed Rule with respect to the "identification" of overpayments, it is still unclear when a provider or supplier "has actual knowledge" of the existence of certain overpayments, particularly those that involve internal investigations. For example, as noted in the Proposed Rule, a provider or supplier may receive information concerning a *potential* overpayment that creates an obligation to conduct an inquiry. While CMS is clear in the Proposed Rule that failure to make such an inquiry can result in a provider "knowingly retaining an overpayment," CMS is not clear as to what point during the provider's diligence the 60-day clock is triggered. As such, unless CMS further clarifies the "identification" of an overpayment in any final rule, it will remain open to interpretation when the 60-day clock is triggered. Further, we are aware of many situations where a provider identifies an overpayment, but is unable to determine the amount of such overpayment. It remains unclear whether the mere identification of the overpayment alone, even if the amount cannot be determined, triggers the 60-day period. This is complicated further by the application of the FCA scienter concept, which creates additional concern for providers during the audit process, i.e., the methodology or timeliness of audits could be open to scrutiny as evidence that the provider acted with "deliberate ignorance" or "reckless disregard" to the overpayment.

Finally, the Proposed Rule does not address how one determines who in the organizational hierarchy can determine when an overpayment has been "identified." Determining whether an overpayment exists under complex billing and cost report rules is often not a black and white exercise, and an initial determination by a lower level employee should arguably be insufficient to trigger the 60-day clock. While providers and suppliers can certainly comment on CMS's proposed description of when an overpayment is "identified," and we would in fact encourage them to do so, we note that CMS did not specifically request comments on this issue.

## 2. "Applicable Reconciliation" (Proposed 42 C.F.R. § 401.305(c))

The Proposed Rule defines the term "overpayment" as "any funds that a person receives or retains under title XVIII [Medicare] of the Act to which the person, after ***applicable reconciliation***, is not entitled under such title." While the term "overpayment" is defined more broadly in Section 6402(d) of the Affordable Care Act in that the law includes both Medicare and Medicaid overpayments, both the law and the Proposed Rule limit the universe of potential overpayments to certain funds recognized after "applicable reconciliation" occurs. The Proposed Rule attempts to clarify the meaning of "applicable reconciliation," which is not defined in the Affordable Care Act.

In 42 C.F.R. § 401.305(c), CMS proposes that "applicable reconciliation" will occur with the provider's submission of a cost report. CMS further explains that applicable reconciliation "would include an initial cost report submission or an amended cost report." CMS proposes two exceptions to the general rule that the applicable reconciliation occurs with the provider's submission of a cost report. Specifically, proposed 42 C.F.R. § 401.305(c) recognizes the following two exceptions:

> **(i) Disproportionate Share Hospital (DSH) Payment Adjustment –** in calculating DSH payments, CMS recognizes that providers often receive more recent Supplemental Security Income (SSI) ratio data after the submission of its cost report and therefore the provider is not required to return any

overpayment resulting from the updated information until the final reconciliation of the provider's cost report; *or*

**(ii) Outlier Reconciliation** – CMS also recognizes that in the context of outlier reconciliation, providers will not be required to estimate the change in reimbursement and return the estimated overpayment until after the final reconciliation of a cost report.

Absent from the Proposed Rule is any discussion relating to the claims appeal process, particularly the application of Section 935 of the Medicare Modernization Act, which *prohibits* the recoupment of overpayment demands by contractors during the first two levels of the claims appeal process if certain conditions are satisfied. CMS should clarify how its Proposed Rule relates to the statutory protection for providers faced with overpayment demands.

### C. COST REPORT REPORTING DEADLINES (PROPOSED 42 C.F.R. § 401.305(b))

As noted, Section 6402(d) of the Affordable Care Act requires a person who has received an overpayment to report and return the overpayment by the later of—(1) the date which is 60 days after the date on which the overpayment was identified; or (2) the date any corresponding cost report is due, ***if applicable***.

In the Proposed Rule, CMS proposes to clarify under what circumstances a provider may wait to reconcile overpayments until the date its cost report is due. CMS reminds providers and suppliers that "if an overpayment is *claims related*, the provider or supplier is required to report and return the overpayment within 60 days of identification." If an overpayment is such that it would generally be reconciled on the cost report by the provider, CMS proposes that the provider would be permitted to report and return the overpayment either 60 days from the identification of the overpayment or on the date the cost report is due, whichever is later.

To illustrate its proposed approach, CMS provides the following two examples:

**Example No. 1: Upcoding** – CMS proposes that "issues involving upcoding must be reported and returned within 60 days of identification because the upcoded claims for payment are not submitted to Medicare in the form of cost reports."

**Example No. 2: Graduate Medical Education (GME)** – CMS also proposes that "overpayments that would generally be reconciled on the cost report, such as overpayments related to GME payments, must be reported and returned either 60 days after it has been identified or on the date the cost report is due, *whichever is later*."

According to CMS, the qualifying language "if applicable" supports its proposed approach of "only permitting providers to rely upon the cost report deadline when relevant to the determination of whether an actual overpayment exists." CMS further states that the clarification as to when the cost report deadline is applicable is necessary in order to "avoid situations in which providers improperly delay reporting and returning a claims-related, identified overpayment until the date a cost report is due." Under the Proposed Rule, providers that submit cost reports will be required to analyze each potential overpayment to determine the reporting deadlines.

## D. THE "SELF-REPORTED OVERPAYMENT REFUND PROCESS" (PROPOSED 42 C.F.R. § 401.305(d))

To accomplish the refunding and reporting requirements outlined in Section 6402(d), CMS further proposes that providers and suppliers must: (i) comply with the existing voluntary refund process outlined in Chapter 4 of the Medicare Financial Management Manual; and (ii) utilize overpayment forms issued by local contractors such as fiscal intermediaries, durable medical equipment Medicare administrative contractors (DME MACs), and Medicare Part A and Part B administrative contractors (A/B MACs). While CMS intends to develop a standardized overpayment reporting form at some point in the future, CMS proposes that in the interim, providers and suppliers use the voluntary refund form that their Medicare contractor makes available on its website until a uniform form is developed.

Under the Proposed Rule, an overpayment report ***"must"*** include the following information:

(1) Person's name.
(2) Person's tax identification number.
(3) How the error was discovered.
(4) The reason for the overpayment.
(5) The health insurance claim number, as appropriate.
(6) Date of service.
(7) Medicare claim control number, as appropriate.
(8) Medicare National Provider Identification (NPI) number.
(9) Description of the corrective action plan to ensure the error does not occur again.
(10) Whether the person has a corporate integrity agreement (CIA) with the Office of Inspector General (OIG) or is under the OIG Self-Disclosure Protocol.
(11) The timeframe and the total amount of refund for the period during which the problem existed that caused the refund.
(12) If a statistical sample was used to determine the overpayment amount, a description of the statistically valid methodology used to determine the overpayment.
(13) A refund in the amount of the overpayment. A person may request an extended repayment schedule as that term is defined in 42 C.F.R. § 401.603.

As noted, CMS proposes that providers and suppliers must both comply with the process and procedures set forth by their Medicare contractor *and* must ensure that the overpayment refund report contains the specific information outlined in proposed 42 C.F.R. § 401.305(d). While CMS recognizes that the content of overpayment refund forms may vary among the different Medicare contractors, CMS does not clarify whether a provider and supplier must include all the information outlined in proposed 42 C.F.R. § 401.305(d) if the Medicare contractor's refund form *does not require such information*. For example, CMS proposes that providers and suppliers must include a description of a corrective action plan in their overpayment report. However, and as just one example, Cahaba GBA, an A/B MAC, does not currently require that providers and suppliers include corrective action measures when submitting a refund form.[3] Accordingly, providers and suppliers may want to determine if their contractor has issued such a form or other directive, and if so, whether such form conforms to the information outlined in the Medicare Financial Management Manual and Proposed Rule. We expect that there may be considerable variation across contractor jurisdictions.

[3] Cahaba GBA's refund form is available at https://www.cahabagba.com/part_b/forms/overpayment_refund.pdf.

CMS also reminds providers that reporting and returning overpayments "cannot resolve any potential False Claims Act or OIG administrative liability associated with the overpayment (even though returning an overpayment may, among other benefits, limit any FCA or administrative liability arising from the retention of an overpayment)." CMS further provides that providers and suppliers "should be aware that the contractors ***will scrutinize overpayments received through this process and may make referrals to OIG*** whenever the contractors believe circumstances warrant such a referral." CMS, however, does not outline circumstances that will warrant referral.

### E. LOOK-BACK PERIOD (PROPOSED 42 C.F.R. § 401.305(g))

A controversial concept introduced in the Proposed Rule involves CMS's position that overpayments must be reported and returned only if a person identifies the overpayment ***within 10 years of the date the overpayment was received***. CMS explains that it selected a 10 year look-back period since this is the outer limit of the FCA statute of limitations. Yet the refunding and reporting requirements included in Section 6402(d) of the Affordable Care Act also apply to routine errors which result in an overpayment, not simply overpayments identified as a result of fraudulent conduct. CMS further proposes to amend the claims reopening rules currently found at 42 C.F.R. § 405.980(b) to provide that overpayments reported in accordance with proposed 42 C.F.R. § 401.305 may be reopened for a period of 10 years. CMS specifically seeks comments on its proposed 10 year look-back period.

We view this provision as highly significant, and one to which many providers and suppliers will likely want to consider submitting comments, as the inclusion of a 10 year look-back period could greatly expand liability for routine errors which potentially result in overpayments. We note that the current claims-reopening period is limited to 4 years, so this is a substantial expansion that is not mandated by the statute. Additionally, by proposing a 10 year look-back period, it is unclear whether CMS expects providers and suppliers to utilize such a look-back period when conducting audits; however, it clearly opens the door to such a prospect.

Moreover, the proposed amendment to the reopening period rule for claims appears to suggest it would apply only "to ensure that [CMS's] reopening regulations are consistent with the look-back period [CMS is] proposing [under 42 C.F.R. § 401.305]" (i.e. to permit a longer look-back period for overpayments reported under such rule). Noticeably absent from the Proposed Rule is any indication that the reopening period would be amended to permit a 10 year look-back period or reopening for *underpayments*. CMS does not mention any changes to the cost report reopening period at § 405.1885, which only permits reopenings within three years of a final determination of a fiscal intermediary. Arguably, this would provide a shorter look-back period for overpayment issues arising under the cost report, but at a minimum it presents a regulatory conflict on the look-back period for such items. Adding further regulatory conflict is the fact that CMS does not impose document retention requirements on providers for a 10 year period.

More importantly, the reopening regulations are rules governing routine administrative overpayments and underpayments—*not rules governing fraud like the FCA*. As such, it is anticipated that many providers and suppliers will (and should) take exception with the proposed expansion of the administrative finality rules for simple errors to the length of time for recovering fraudulent payments under the FCA.

## F. MEDICARE SELF-REFERRAL DISCLOSURE PROTOCOL[4] (SRDP) AND THE OIG SELF-DISCLOSURE PROTOCOL[5] (OIG SDP) (PROPOSED 42 C.F.R. § 401.305(b)(2))

In the Proposed Rule, CMS recognizes the potential intersections between the reporting and refunding requirements under Section 6402(d) of the Affordable Care Act and existing self-disclosure protocols. Accordingly, CMS proposes two exceptions relating to the procedures for reporting and refunding certain overpayments for the SRDP and the OIG SDP.

Under the Proposed Rule, CMS proposes to suspend the obligation to ***return*** overpayments when CMS acknowledges receipt of a disclosure made pursuant to the process established by the SRDP. However, the provider or supplier ***is still obligated to report*** the overpayment pursuant to the proposed process outlined in 42 C.F.R. § 401.305(a). CMS seeks comments on alternative approaches that would allow providers and suppliers to avoid making multiple reports of identified overpayments.

CMS further proposes to suspend the obligation ***to return and report*** overpayments under Section 6402(d) of the Affordable Care Act when OIG acknowledges receipt of a submission to the OIG SDP. However, CMS provides that such reports must be made in accordance with the timeliness requirements set forth in proposed 42 C.F.R. § 401.305.

In its proposed regulations, CMS is attempting to more rigidly define under what circumstances a provider or supplier should use the SRDP, OIG SDP, and the reporting and refund requirements outlined in this Proposed Rule, rather than affording providers and suppliers the flexibility of determining which reporting mechanism to pursue in light of specific facts and circumstances.

It is interesting to note that CMS does not propose to create an exception for providers or suppliers reporting an overpayment to the OIG pursuant to the terms and conditions of a CIA, although there would appear to be the same protections for the Medicare program in such a situation.

## G. OVERPAYMENTS RESULTING FROM VIOLATIONS OF THE ANTI-KICKBACK STATUTE

CMS states that compliance with the Anti-Kickback Statute is a condition of payment, and "claims that include items and services resulting from a violation of this law are not payable and constitute false or fraudulent claims for purposes of the FCA." In the Proposed Rule, CMS proposes that providers ***who are not a party to a kickback arrangement*** are "unlikely in most instances to have 'identified' the overpayment that has resulted from the kickback arrangement and would therefore ***have no duty to report it or . . . to repay it."*** However, to the extent that a provider or supplier who is *not* a party to a kickback arrangement has "sufficient knowledge" of the arrangement to have identified the resulting overpayment, CMS contends that the provider or supplier must report the overpayment in accordance with these regulations.

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[4] Pursuant to Section 6409 of the Affordable Care Act, CMS developed the SRDP. The SRDP is a voluntary self-disclosure protocol, under which providers of services and suppliers may self-disclose actual or potential Stark violations.

[5] The OIG SDP is intended to be used by providers who wish to voluntarily disclose self-discovered evidence of potential violations of law. *See* Provider Self-Disclosure Protocol Federal Register Notice, 63 Fed. Reg. 58399 (Oct. 30, 1998).

## V. NEXT STEPS

While we recognize that the identification, reporting, and refunding procedures included in the Proposed Rule may change in any final rule, the Proposed Rule provides valuable insight into CMS's current thinking of Section 6402's requirements. Accordingly, providers and suppliers may want to consider:

- Reviewing current reporting and refunding policies to confirm the policies comply with Section 6402(d)'s requirements;
- Submitting comments to CMS on controversial provisions included in the Proposed Rule;
- Identifying additional reconciliation processes not specifically addressed in the Proposed Rule; and
- Registering for King & Spalding's March 9, 2012 Roundtable on the significant provisions included in the Proposed Rule. (For registration details on this no charge program, visit http://www.kslaw.com/RefundRoundtable.)