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Medicare Confirms Requirement to Return Overpayments Within 60 Days

By **Jed Morrison**

On February 14, 2012, the Centers for Medicare and Medicaid Services ("CMS") published a proposed rule implementing the requirements of the Affordable Care Act requiring Medicare providers and suppliers to report and return Medicare overpayments by the later of 60 days after the date on which the overpayment was identified, or the date any corresponding cost report is due. Failure to identify, report and return the overpayment within the 60 day deadline constitutes a false claim under the False Claims Act, which subjects the provider or supplier to additional penalties under the law.

Section 6402 of the Patient Protection and Affordable Care Act ("Affordable Care Act") establishes a new section of the Social Security Act entitled "Reporting and Returning of Overpayments." The law requires a person who has received an overpayment from Medicare or Medicaid to report and return the overpayment to the Secretary of Health and Human Services, the State, an intermediary, a carrier, or a Medicare contractor (as appropriate) and to notify such party in writing of the reason for the overpayment. Although the provisions of the statute are self implementing and thus already in effect, the proposed rule published this week (which for now applies only to Medicare Part A and Part B providers and suppliers), gives providers additional detail on the procedures for returning the overpayments, including establishing a mandatory "self-reported overpayment refund process" ("SORP").

Identifying an Overpayment

In addition to when a provider objectively identifies an overpayment, the proposed rule concludes that a person has "identified" an overpayment (thus triggering the 60-day refund window) if the person has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment. CMS notes that it believes that "defining 'identification' in this way gives providers and suppliers an incentive to exercise reasonable diligence to determine whether an overpayment exists. Without such a definition, some providers and suppliers might avoid performing activities to determine whether an overpayment exists, such as self audits, compliance checks, and other additional research." There is thus an affirmative obligation on the part of all Medicare participating providers and suppliers to have procedures in place through which they can identify overpayments. In the event of an identified overpayment, CMS will want to know what those procedures are and how the provider identified the overpayment.

60-day Payment Deadline

If an overpayment is claims related, such as all physician services under Medicare Part B, the provider or supplier will be required to report and return the overpayment within 60 days of identification.

For those providers (like hospitals) that submit costs reports, if the overpayment is one that generally would be reconciled on the cost report in the normal course of business, the provider is permitted to report and return the overpayment either 60 days after identification or on the date the cost report is due, whichever is later. CMS emphasizes that the cost report deadline is not applicable if the overpayment is such that it would not ordinarily be reconciled on a Medicare Cost Report.

Calculation of the 60 day deadline is perhaps the most critical aspect of the rule. CMS notes that:

> "in some cases, 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. If the reasonable inquiry reveals an overpayment, the provider then has 60 days to report and return the overpayment…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…"

Just exactly when a provider adequately has identified the overpayment can be a subjective question. What if the provider has identified a pattern of inappropriate coding for a particular procedure —perhaps extending over several years—but the identification of individual claims, and comparing such claims to the applicable medical records, takes three, four or six months? Has the provider "identified" the overpayment only when the final mathematical calculations are made, or did the provider identify the overpayment when the pattern of inappropriate coding was confirmed? The answer may be somewhere in between. Providers therefore must be diligent not only to identify the source of the overpayment, but to quickly and thoroughly perform the necessary calculations to ascertain the correct amount of such overpayment. Providers would be well advised to document the efforts of their staff making such calculations in order to be able to demonstrate (if ever necessary to do so) that the provider made diligent inquiry during the investigation process.

CMS proposes to implement these requirements by using the existing voluntary refund process described in the Medicare Financial Management Manual. Under that currently voluntary refund process, providers and suppliers report overpayments using a form that each Medicare contractor makes available on its website. In the proposed rule, however, CMS proposes that providers and suppliers would be required to use the self-reported overpayment refund process set forth by the applicable Medicare contractor to report and return overpayments. Thus, a simple letter to the Medicare carrier enclosing a refund check will not suffice to comply with the rule.

Penalties

Providers and suppliers failing to identify, report and return overpayments within the 60 day deadline are deemed to have filed a false claim under the False Claims Act. Liability under the False Claims Act includes treble damages, plus penalties up to $11,000 per false claim. False claims also generate liability of $10,000 per claim under the Civil Monetary Penalties law, and could also result in exclusion from participation in federal healthcare programs.

Question: If a provider or supplier clearly fails to meet the SORP 60 day deadline, thus triggering potential False Claims Act liability, should the provider then report the overpayment using the OIG self disclosure protocol ("SDP") rather than the SORP? The SDP provides a venue for providers to self report Anti-Kickback and False Claims Act violations as a way to limit their exposure under those laws. The two protocols and their respective procedures and benefits differ from one another, and providers will have to evaluate that question if it arises.

If you have any questions about self reporting, please contact **Jed Morrison** at 210.978.7780 (**jmorrison@jw.com**) or any member of

the **Jackson Walker L.L.P. Health Care Section**.

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