Client Advisory

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Health Care

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CMS Issues Proposed 60-Day Rule for Reporting and Returning of Overpayments

On February 16, CMS issued its long-awaited proposed rule (the Proposed Rule) implementing the requirements for reporting and returning overpayments set forth in the Affordable Care Act (the Act) (available here). The Act requires a person who has received an overpayment to report and return that 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." Failure to comply with these requirements may result in significant penalties, including False Claims Act liability, Civil Monetary Penalties liability, and exclusion from participation in federal health care programs.

The Proposed Rule would result in heightened reporting burdens and uncertainty for providers and suppliers. Key features include the following:

- Adoption of an existing voluntary refund process as the sole methodology for reporting overpayments, absent self-disclosure under the OIG Self-Disclosure Protocol (OIG SDP).
- An "actual knowledge, reckless disregard or deliberate ignorance" standard for determining when an overpayment is "identified" that leaves significant uncertainty about the point at which the "60-day clock" will begin to run.
- An extraordinarily lengthy 10-year "lookback" period for reporting.

The details and impact of these and other key features of the Proposed Rule are discussed below. Of course, the Proposed Rule is not yet law; interested parties have an opportunity to submit comments to CMS until April 16, 2012.

I. The Reporting Process

A. To whom do you report?

CMS reiterates the Act's requirement that overpayments be reported and returned to "the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate," along with the reason for the overpayment. However, as we detail below, the Proposed Rule prescribes that all reports must go to the "applicable contractor," absent self-disclosure to the OIG under the OIG SDP.

B. How do you report and refund?

Absent self-disclosure under the OIG SDP, CMS proposes to establish a single procedure for reporting overpayments:

- CMS proposes that all overpayments be reported using the existing voluntary refund process in Chapter 4 of the Medicare Financial Management Manual, and renames the process the "self-reported overpayment refund process" (SRORP).
- Providers and suppliers must follow the SRORP using the format that the applicable Medicare contractor makes available on its website to report and return overpayments. The Proposed Rule acknowledges that reporting forms may vary among Medicare contractors, but CMS intends to develop a uniform reporting form.

Alternative reporting will be allowed under two conditions:

- Providers or suppliers may self-disclose actual or potential violations of the physician self-referral (Stark) statute through the Medicare Self-Referral Disclosure Protocol (SRDP) but are still obligated to ***report*** (but not refund) the overpayment under both the SRDP and the SRORP.
- In contrast, notice to the OIG of overpayment through the OIG SDP will constitute a report obviating the need to report via the SRORP.

Disclosures made pursuant to the SRDP or the OIG SDP will suspend the 60-day deadline to return overpayments. CMS cautions that providers and suppliers must use the most appropriate reporting process because reporting and returning overpayments via the SRORP will not resolve any False Claims Act or OIG administrative liability. Contractors will scrutinize overpayments and may make referrals to the OIG.

C. What do you need to report?

The Proposed Rule enumerates 13 data points that must be included in a provider or supplier's written overpayment report, including the following:

- The provider or supplier's name.
- The reason for the overpayment.
- How the error was identified.
- The health insurance claim number, as appropriate.
- A description of the corrective action plan to ensure the error does not occur again.

Although CMS does not provide an exhaustive list of all potential reasons for overpayments that must be reported, the Proposed Rule does set forth a list of illustrative examples, including: (a) incorrect service date; (b) duplicate payment; (c) incorrect CPT code; (d) insufficient documentation; and (e) lack of medical necessity.

II. Identification of Overpayments

A key question left by the Act is when a payment will be deemed to be "identified."

- 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 disregard or deliberate ignorance of the existence of the overpayment."
- However, CMS acknowledges that, in some cases, a provider or supplier may receive information concerning a potential overpayment but needs some time to investigate to determine if an overpayment does indeed exist. In such cases, providers and suppliers must conduct a "reasonable inquiry" to determine if an overpayment exists. For example, if a provider receives an anonymous tip on its compliance hotline regarding a potential overpayment, that provider then has an obligation to make a "reasonable inquiry" to determine if an overpayment exists.
  - If the provider fulfills its reasonable inquiry obligation, the 60-day clock will not start until after the provider conducts its reasonable inquiry and determines that an overpayment exists.
  - However, if the provider fails to conduct a reasonable inquiry "with all deliberate speed" after receiving the anonymous tip, the provider may be found to have acted "in reckless disregard or deliberate ignorance of any overpayment." By defining "identification" in this manner, CMS specifically intends to give providers and suppliers an incentive to "exercise reasonable diligence to determine whether an overpayment exists."
- CMS does not specifically address whether "actual knowledge" arises when a provider learns of an issue that generated overpayments or when the overpayments are quantified. Rather, CMS provides several examples of when it will consider overpayments identified, including: (a) "a provider of services or supplier reviews billing or payment records and learns that it incorrectly coded certain services, resulting in increased reimbursement," and (b) "a provider of services or supplier learns that services were provided by an unlicensed or excluded individual on its behalf."
- These examples are alarming because they imply that a provider has identified an overpayment when it acquires knowledge of a set of facts that resulted in overpayments, even before the scope of the problem or the total amount of overpayment is determined. This is particularly problematic in cases involving systemic billing errors, where significant statistical analysis and extrapolation (which CMS specifically allows) may be required, as well as in cases involving Stark Act and Anti-Kickback Statute violations.
- CMS also addresses the intersection of reports regarding overpayments and those regarding kickbacks:
  - CMS reiterates that claims including items and services resulting from a violation of the Anti-Kickback Statute are not payable and constitute false or fraudulent claims for purposes of the False Claims Act.

- However, CMS recognizes that providers and suppliers often are not a party to, and are unaware of, arrangements between third parties that would cause the provider or supplier to submit claims that are the subject of a kickback. Moreover, even if providers or suppliers become aware of such third party arrangements, they generally are not able to evaluate whether an illegal kickback was made. Therefore, providers who are not a party to a kickback arrangement are unlikely to have "identified" the overpayment that resulted from the kickback and would not have an obligation to report or repay it.
- In contrast, if providers or suppliers do have "sufficient knowledge of the arrangement to have identified the resulting overpayment," they must report it.

III. 10-Year Lookback Period

CMS proposes to establish an extraordinarily lengthy lookback period, requiring providers and suppliers to report and return overpayments identified within 10 years of the date the overpayment was received. CMS explains that the 10-year period was selected because this is consistent with the outer limit of the False Claims Act statute of limitations, and it specifically seeks comments on this portion of the Proposed Rule. However, the 10-year lookback period is far longer than the current reopening period (typically four years) in cases that do not involve false claims.

IV. Impact

Unless the Proposed Rule is significantly revised after the comment period, providers and suppliers will face an onerous reporting burden and significant uncertainty regarding when the "60-day clock" starts to run in many cases. Several features of the Proposed Rule warrant comment and reconsideration. For example:

- CMS might be urged to adopt a shorter lookback period or one that coincides with the now-applicable reopening period in a particular case, typically four years. This would not obviate the government's prerogative to assert a False Claims Act violation and seek additional damages under the longer statute of limitations when there is evidence that a provider knowingly filed a false claim or acted in reckless disregard or deliberate ignorance of the falsity of a claim at the time of filing.
- CMS should be encouraged to provide additional guidance on whether an overpayment is "identified" when a provider attains knowledge of a mistake or legal violation that generated overpayments, or when the overpayments are quantified.
- In particular, CMS might be encouraged to clarify that the 60-day clock does not begin once the problem is identified and to specifically allow time to conduct a reasonable inquiry into the scope of the problem **and quantify** the amount of any associated overpayment.
- Additional clarity regarding when a provider will be deemed to have acted in reckless disregard or deliberate ignorance of an overpayment by not conducting a reasonable inquiry with "all deliberate speed" would also reduce uncertainty.

Contact Us

If you have any questions regarding the Proposed Rule or would like to discuss the submission of comments on the Proposed Rule, please contact any of the following members of the Katten Muchin Rosenman LLP **Health Care Practice**.

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