Healthcare Law

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CMS Issues Proposed Rule Addressing the 60-Day Overpayment Refund Requirement

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On February 16, 2012, the Centers for Medicare & Medicaid Services ("CMS") issued a long-awaited proposed rule addressing the obligation of health care organizations to return overpayments made by federal health care programs. The proposed rule provides welcome clarity on certain ambiguous aspects of the Patient Protection and Affordable Care Act (the "ACA") provisions governing the return of overpayments. However, the proposed rule introduces certain concepts not found in the ACA, such as a proposed 10-year "look-back" period that, if adopted, would impose significant new burdens on providers.

Refund Obligations Under the ACA

The ACA added a new Section 1128J(d) to the Social Security Act that provides that "[i]f a person has received an overpayment, the person shall . . . report and return the overpayment" to "the Secretary [of Health and Human Services], the State, an intermediary, a carrier, or a contractor, as appropriate," and "notify the Secretary, State, intermediary, carrier or contractor to whom the overpayment was returned in writing of the reason for the overpayment."[1] Section 1128J(d) further requires that an overpayment be reported and returned by the later of (1) 60 days after the date on which the overpayment was identified; or (2) the date any corresponding cost report is due, if applicable. An "overpayment" is "any funds that a person receives or retains under title XVIII [the Medicare statute] or XIX [the Medicaid statute] to which the person, after applicable reconciliation, is not entitled under such title."[2]

Significantly, Section 1128J(d) provides that any overpayment that is "retained" by a person after the deadline for reporting and returning the overpayment is an "obligation" for purposes of the reverse false claims provision of the federal False Claims Act (the "FCA"). The FCA imposes liability on any person who "knowingly conceals" or "knowingly and improperly avoids or decreases" an "obligation to pay or transmit money or property to the Government."[3] Thus, the knowing and improper failure to return "identified" overpayments by the applicable deadline may result in treble damages and monetary penalties under the FCA. The ACA also amended the Civil Monetary Penalties Laws (the "CMPL") to authorize the imposition of civil monetary penalties (and potential exclusion from federal health care programs) on any person who "knows of an overpayment and does not report and return the overpayment in accordance with [Section 1128J(d)]."[4]

Since the ACA was enacted, it has been unclear when an overpayment is "identified" for purposes of triggering the 60-day period – the term

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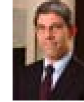

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"identified" is not defined in the ACA. Oddly, Section 1128J(d) defines the terms "knowing" and "knowingly" in the same expansive manner as these terms are defined in the FCA,[5] i.e., to mean actual knowledge, deliberate ignorance, or reckless disregard, although these terms are not actually used in Section 1128J(d).

The Proposed Rule

Definition of an overpayment. Consistent with the ACA, the proposed rule would define an "overpayment" as "any funds that a person receives or retains under title XVIII of the Act [Medicare] to which the person, after applicable reconciliation, is not entitled under such title."[6] This would include, for example, Medicare payments for noncovered services, duplicate payments, and receipt of Medicare payment when another payor had the primary responsibility for payment. Under the ACA and the proposed rule, an overpayment does not exist until an "applicable reconciliation" takes place. The proposed rule would provide that "applicable reconciliation" occurs when a cost report is filed, subject to two limited exceptions related to calculation of disproportionate share hospital payments and outlier reconciliation.[7]

Deadline for overpayment refund and reporting. The proposed rule mirrors the statutory requirement that overpayments must be reported and returned within 60 days after the date the overpayment was identified.[8] For items generally reconciled on a cost report (such as GME payments), providers would have to report and return an overpayment either 60 days from the identification or on the date that the cost report is due, whichever is later.[9] Overpayments that are not reconciled on a cost report (such as upcoded claims) would be subject to the 60-day time frame, regardless of whether the provider is a cost reporting entity.

Identification of an overpayment. One of the most confusing aspects of Section 1128J(d) relates to determining when an overpayment has been "identified." Significantly, the proposed rule provides that a person has "identified" an overpayment if such person has "actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment."[10] CMS specifically notes that this standard is intended to incentivize providers to exercise reasonable due diligence through self-audits and compliance checks. CMS states that in some cases, a provider may receive information regarding a potential overpayment that creates an obligation to make a "reasonable inquiry" to determine whether an overpayment exists. CMS further notes that failure to make such a reasonable inquiry – including failure to conduct such inquiry "with all deliberate speed" – could result in a finding that the provider "knowingly" retained the overpayment because it acted in reckless disregard or deliberate ignorance of whether it received such an overpayment.[11] This commentary suggests that providers would have some time to investigate whether an overpayment exists before the clock starts running. However, it is unclear when the 60-day period would begin to run. In many cases, a provider will become aware of facts resulting in an overpayment – such as a coding issue – but will not be able to complete an investigation and quantify the extent of the problem within 60 days. CMS's commentary could be interpreted to mean that the clock starts running before the specific claims and amounts at issue have been determined.

Look-back period. Significantly, CMS proposes to require that an overpayment be returned and reported if a person identifies the overpayment within 10 years of the date the overpayment was received.[12] The proposed 10-year look-back period is based on the FCA statute of limitations. CMS further proposes to amend the Medicare claim reopening rules to permit overpayments reported in accordance with the proposed rule to be reopened for up to 10 years.[13] Many providers have been operating under a shorter look-back period, such as a 4-year period based on the existing Medicare claim reopening regulations. CMS specifically requests comment on the proposed 10-year period and the proposal to amend the reopening rules. The proposed rule does not address the application of the requirements to historical, pre-ACA overpayments and retroactivity issues.

Other issues addressed in the proposed rule:

- *Process for reporting and returning overpayments*. To report and return overpayments, CMS proposes that providers use the existing voluntary refund process described in Chapter 4 of the Medicare Financial Management Manual.[14] Under this process, providers report overpayments using a form available on each Medicare contractor's website. CMS plans to develop a standardized form and directs providers to use the existing forms on Medicare contractors' websites in the meantime. In addition, providers would be required to refund the overpayment at the time of the report, but could request additional time to repay through the existing Extended Repayment Schedule process.[15]
- *Relationship to Stark Self-Disclosure and OIG Self-Disclosure Protocols*. CMS proposes to suspend the deadline for returning overpayments when the Office of Inspector General ("OIG") acknowledges receipt of a submission to its Self-Disclosure Protocol ("SDP"). The refund obligation is similarly suspended when CMS acknowledges receipt of a submission to the Stark Self-Referral Disclosure Protocol ("SRDP").[16] In addition, a person would satisfy the "reporting" obligation by making a disclosure under the OIG's SDP. However, a provider would not be able to meet the reporting requirement by making a self-disclosure to CMS under the SRDP – in such a case, it appears that a provider would still be required to use the Section 1128J(d) reporting process.
- *Overpayments due to violations of the Anti-Kickback Statute*. CMS notes that in certain cases, a party submitting a claim may be unaware of an improper kickback arrangement that results in an overpayment. CMS clarifies that providers who are not a party to a kickback arrangement are unlikely in most instances to have "identified" the overpayment resulting from such an arrangement and thus would not have a duty to report or repay it.[17] However, a provider that has "sufficient knowledge" of such an arrangement would be required to report the overpayment. In such a case, CMS would refer the reported overpayment to OIG and would suspend the repayment obligation until the kickback matter is resolved. CMS expects that only the parties to the kickback scheme would be required to repay the payment received by an innocent provider, except in the most "extraordinary" circumstances.

Conclusion

The proposed rule offers some clarity to aid providers in structuring their operations to comply with Section 1128J(d), but other areas remain unresolved and are ripe for comment. CMS's proposed approach to interpreting Section 1128J(d) underscores the need for providers to examine their compliance programs and evaluate whether they have appropriate processes in place to flag potential billing errors and act quickly once such errors are identified.

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[1] ACA § 6402(a); codified at 42 U.S.C. § 1320a-7k(d).

[2] *Id*. "Applicable reconciliation" is not defined in the ACA.

[3] 31 U.S.C. § 3729(a)(1)(G).

[4] 42 U.S.C. § 1320a-7a(a)(10).

[5] *See* 42 U.S.C. § 1320a-7k(d)(4)(A).

[6] 77 Fed. Reg. 9181; Proposed 42 C.F.R. § 401.303.

[7] 77 Fed. Reg. 9184; Proposed 42 C.F.R. § 401.305(c).

[8] 77 Fed. Reg. 9182; Proposed 42 C.F.R. § 401.305(b).

[9] *Id*.

[10] 77 Fed. Reg. 9182; Proposed 42 C.F.R. § 401.305(a)(2).

[11] CMS provides the example of a provider receiving an anonymous hotline tip about a potential overpayment – if such provider "diligently conducts the investigation," and reports and returns the overpayments within the 60-day period, it would have satisfied its obligations. 77 Fed. Reg. 9182.

[12] 77 Fed. Reg. 9184; Proposed 42 C.F.R. § 401.305(g).

[13] 77 Fed. Reg. 9184; Proposed 42 C.F.R. § 405.980(b)(6).

[14] 77 Fed. Reg. 9181.

[15] This process is described in Chapter 4 of the Medicare Financial Management Manual. CMS notes that providers seeking to use the ERS process will be required to submit significant documentation to allow CMS to verify that timely repayment of the overpayment represents a true financial hardship. 77 Fed. Reg. 9183.

[16] 77 Fed. Reg. 9183.

[17] *Id*.

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