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March 2012

CMS'S PROPOSED REPAYMENT RULES: A TICKING TIMEBOMB FOR MEDICAID & MEDICARE PROVIDERS!

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Earlier this month, the Center for Medicaid and Medicare Services ("CMS") issued a new proposed rule governing the reporting and returning of over-payments made by Medicaid and Medicare providers. While most providers know that existing law requires providers to report and return any over-payment and notify CMS (or the appropriate contractor) that the payment was, indeed, returned, CMS has, until now, provided little guidance concerning the scope of the rule.

Once a potential over-payment has been identified, a "reasonable inquiry" must be undertaken. If it is determined that the transaction does indeed represent an overpayment, the provider then has sixty (60) days to report and return the monies at issue. According to CMS, the failure to conduct this reasonable inquiry "with all deliberate speed" may give rise to liability under the False Claims Act.

CMS has provided several examples of when an over-payment has been truly identified, at which time the sixty (60) day clock will begin to tick and they include circumstances under which a provider:

1. finds that services have been incorrectly coded resulting in increased reimbursement;
2. becomes aware of a patient's death occurring prior to the service date;
3. learns that a service was provided by an unlicensed or excluded provider;
4. discovers an over-payment by virtue of an internal audit;
5. fails to make further inquiry upon the notification of an over-payment by government agency or contractor; and
6. experiences a significant increase in Medicare revenue for no apparent reason.

While the proposed rule sets a ten (10) year timeframe for the repayment of over-payments, that timeframe seemingly conflicts with the False Claims Act's three-year statute of limitations. Thus, while repayments beyond the three-year statutory limit are outside of the reach of the False Claims Act, the proposed rule imposes a ten-year obligation upon providers to identify and return over-payments. Therefore, while the failure to report and repay (claims over three

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years old) may not give rise to liability under the False Claims Act, it would, nonetheless, expose providers to other administrative sanctions and potentially exclusion or debarment from participation in federally funded health care programs.

The proposed rule acknowledges the existence of both the Medicare Self-Referral Disclosure protocol and the OIG Self-Disclosure protocol and CMS is in the process of developing a Uniform Reporting Form that will be available on its website.

CMS welcomes comments on the proposed rule and will consider them before promulgating final rules with respect to reporting and returning over-payments. In the interim, providers are well advised to revisit internal audit and other compliance polices to assure that there are effective systems in place for indentifying and returning overpayments.