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Health Care

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60-Day Overpayment Reporting Final Rule—The Rule of Six[1]

On February 12, 2016, CMS published the Reporting and Returning of Overpayments Final Rule (Final Rule). The Final Rule takes effect on March 14, 2016. Overall, CMS appears to have listened to stakeholders and acknowledged their comments to the proposed rule. As a result, the Final Rule offers more clarity and reasoned positions than was anticipated. The Final Rule nonetheless will require providers and suppliers to implement various operational changes, some at considerable expense, to satisfy the regulations.

Six Key Themes

1. An overpayment is not identified until it is quantified
2. The lookback period is **six** years
3. Reasonable diligence to identify overpayments starts with "credible information" that an overpayment may exist and should take no more than **six** months
4. Providers must report and return overpayments within **60** days of the date of identification
5. The Final Rule only applies to Medicare Parts A and B
6. The methods to report and return overpayments are considerably more flexible

In this Issue:

[1] We will be conducting a Webinar series in the coming weeks to explore the Final Rule and its application to provider and supplier operations, investigations and transactions.

As providers and suppliers digest the Final Rule, it may be helpful to do so with some contextual framework in mind. First, the Final Rule requires an actual overpayment to exist. Claim or cost report errors that do not result in overpayments are not subject to the Act or the Final Rule.

Second, the Final Rule only focuses on those overpayments that are initiated or discovered by a provider or supplier. That is, the Final Rule governs overpayments that are identified by a provider or supplier in the normal course of business (e.g., routine or specific audits, review of internal processes, etc.), even if first alerted to the possible overpayment by an outside source.

Third, overpayment determinations, demands or other final actions asserted by a MAC, a RAC, CMS, OIG or other federal agency must follow the existing processes for responding to those determinations. The Final Rule does not change those existing processes.

The Final Rule is organized around three main themes, each of which is discussed below, together with some observations:

- Identification of overpayments
- Lookback period
- Mechanics of reporting and returning overpayments

Final Rule Top 6 Tasks

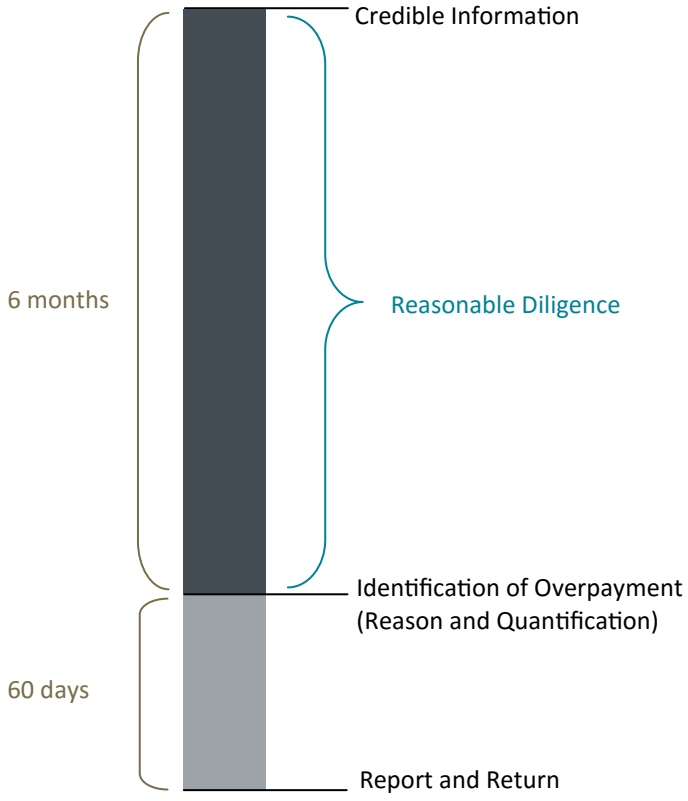
1. Complete overpayment reviews currently underway and refund any overpayment amounts prior to March 16, 2016. If not possible to complete and repay by March 16, 2016, consider adjusting lookback period to 6 years.
2. Develop a process to (a) identify credible information relating to possible overpayments and the date received, and (b) conduct reasonable diligence to identify overpayments.
3. Update documentation policies, if needed, to support reasonable diligence reviews looking back 6 years.
4. Revise existing audit policies and tracking mechanisms to promote completion of reasonable diligence and identification of overpayments within 6 months of receipt of "credible information". Track reporting and returning overpayments within 60 days of identification date.
5. Given that CMS considers external audit findings (from RACs, MACs, etc.) to represent "credible information," ensure that there are open lines of communication between those individuals responding to external audits and those individuals responsible for conducting a follow-up inquiry with reasonable diligence.
6. Maintain documentation of all refunds including: retraction requests, revised claims, form and check submissions and extrapolation methodologies.

I. Identification of Overpayments

The Act provides that an overpayment must be reported and returned by the later of: (i) the date which is 60 days after the date on which the overpayment was identified; or (ii) the date any corresponding cost report is due, if applicable. The Final Rule clarifies both the claims-based and cost report-based overpayment identification standards.

Claims-Based Overpayments. The Final Rule states that a person has identified an overpayment when the person has or should have, through the exercise of reasonable diligence, determined that the person has received an overpayment and quantified the amount of the overpayment.

This new standard effectively establishes a multi-step process for resolving claims-based overpayments, which flows through (1) having credible information that an overpayment is possible, (2) undertaking reasonable diligence to determine an overpayment, (3) identifying (and quantifying) the overpayment, and (4) reporting and returning the overpayment.



The Final Rule offers some guidance and timelines around each of these four steps in the provider/supplier-initiated overpayment refund process.

1. Credible Information. In general, the Final Rule's overpayment review process is triggered when the provider receives "credible information" of a potential overpayment. This trigger point starts the six-month clock for reviewing the issue with "reasonable diligence."

CMS declined to identify all factual scenarios that might represent "credible information," but stated that it includes information that supports a reasonable belief that an overpayment may have been received. CMS recognizes that information may arise that is not credible and should not trigger the diligence process. While credible information may come from a variety of sources (hotline calls, internal questions, unusual payments), the Final Rule states that "contractor overpayment determinations are always a credible source of information." The CMS preamble suggests that contractor audits (unless subject to appeal by the provider or supplier) will always trigger an obligation on the part of the provider or supplier to exercise reasonable diligence and may require the provider to expand the scope of the contractor's audit, looking back for the mandated six-year time period.

Providers and suppliers also must consider, in the context of routine audits, when credible information of a potential overpayment arises.

2. Reasonable Diligence Conducted Within Six Months. In the proposed rule, CMS used the terms "reckless disregard" and "deliberate ignorance" as standards to determine when an overpayment has been identified. The Final Rule replaces these standards with a "reasonable diligence" standard. As a

result, reasonable diligence is now the baseline used to cover both proactive compliance activities to monitor claims and reactive investigative activities undertaken in response to receiving credible information about a potential overpayment.

Reasonable diligence is not defined, except that CMS notes that "undertaking no or minimal compliance activities to monitor the accuracy and appropriateness of a provider or supplier's Medicare claims" would fall short of the "reasonable diligence" standard and expose the provider to liability.

What is defined in the Final Rule (at least via the preamble, but not in the regulation text), is the reasonable diligence timeframe. CMS opined that "reasonable diligence" is "demonstrated through the timely, good faith investigation of credible information, which is **at most six months** from receipt of the credible information, except in extraordinary circumstances." CMS further stated that what constitutes an "extraordinary circumstance" is fact-dependent and may include unusually complex investigations, natural disasters or a state of emergency. It is curious that the discussion of this clear six-month timeframe is only in the preamble and not in the regulation text, leaving open the question whether this was an oversight or intentional. The latter outcome certainly raises the possibility that the six-month timeframe may be viewed more as a guideline than a regulatory requirement.

3. Identification and Quantification. The Final Rule states that a claims-based overpayment is not identified until it has been quantified, a welcome clarification for providers and suppliers. Specifically, the Final Rule states that a person has identified an overpayment when the person has or should have, through the exercise of reasonable diligence, determined that the person has received an overpayment and quantified the amount of the overpayment.

When a provider or supplier knows an overpayment exists (and the specific amount of the overpayment), but only with respect to a single or small probe sample of claims, the obligation to report and return such overpayments does not arise. Rather, CMS stated that an overpayment on a single claim or small probe sample is simply a trigger (the credible information) for further inquiry and reasonable diligence with respect to the full range of claims at issue. As a result, identification does not occur until the entire claim universe at issue is reviewed with reasonable diligence and quantified.

CMS declined to adopt a materiality or *de minimis* monetary threshold for reporting and returning overpayments. Providers and suppliers must continue to report and return overpayments of any size. CMS will consider, however, adopting a minimum with respect to overpayments related to cost reports in future guidance.

4. Report and Return Overpayments. Once an overpayment is identified and quantified following reasonable diligence, the 60-day time period begins. In the event a provider or supplier does not undertake reasonable diligence, the 60-day clock begins "on the day the person received credible information of a potential overpayment if the person failed to conduct reasonable diligence and the person in fact received an overpayment."

The deadline for returning overpayments will be suspended when a person (1) requests an Extended Repayment Schedule as outlined in the Financial Management Manual; or (2) uses another government-approved self-disclosure method, as described in more detail below.

Cost Report-Based Overpayments. Generally, under the Final Rule, any cost report-based overpayments should be reported and returned at the time the cost report is due. That is, if a provider receives interim payments that become reconciled through the cost report that reconciliation should be done by the provider at the time the cost report for the applicable period is filed. Though commenters argued for reconciliation to be at the time the Notice of Program Reimbursement is issued (consistent with general cost

reporting processes), CMS made clear that a provider must reconcile payments and file cost reports accurately, inclusive of reporting and returning overpayments at the time of filing.

CMS also clarified that (1) cost-based payments that require MAC reconciliation are not required to be reviewed for overpayments prior to that reconciliation, and (2) CMS-published SSI ratios that are different (lower) than the ratio used in the provider's cost report do not trigger an overpayment until the final MAC reconciliation of that cost report.

II. Lookback Period

The Final Rule establishes a **six-year** lookback period, meaning that providers and suppliers must report and return overpayments identified within six years of the date the overpayment was received. CMS initially proposed a 10-year lookback period, consistent with the outer limit of the False Claims Act (FCA), but was persuaded by commenters to scale it back to more closely match typical record retention requirements and the more commonly used six-year FCA statute of limitations.

Many commenters suggested a four-year lookback period to correspond with the Medicare claims reopening period at 42 C.F.R. § 405.980, acknowledging that providers and supplier have built their internal audit processes around this rule. Rather than adopt a consistent approach, CMS opted to revise only a portion of the reopening rules – adding § 405.980(c)(4) – to allow a *provider or supplier* to request that a contractor reopen claims dating back six years for the specific purpose of complying with this 60-day overpayment rule. Notably, CMS did not revise the rules as applied to contractor-initiated (rather than provider-initiated) reopenings. In other words, when a Medicare contractor initiates a reopening, it remains limited to the following timeframes: (i) one year for any reason; (ii) four years for good cause; and (iii) at any time if there is evidence of fraud or similar fault. *See,* 42 C.F.R. § 405.980(b).

In addition, in response to industry concerns, CMS clarified that the Final Rule is not retroactive. Providers and suppliers that report and refund overpayments prior to the effective date of the Final Rule (March 14, 2016) are not required to have complied with its terms, as long as a "good faith effort" was made to comply with the statute. By contrast, those providers and suppliers reporting and returning overpayments *after* March 14, 2016, must comply with the new regulatory requirements, "even [for] overpayments received prior to the rule's effective date." This has important implications for providers and suppliers with audits currently in process, particularly those audits that may be in the final stages of "identifying" and quantifying an overpayment. In all likelihood, such an audit would have used a four-year lookback period based on a reasonable interpretation of the Act and the prior reopening rules.

If the provider or supplier is not prepared to finalize its audit and return the overpayment by March 14, 2016, then – consistent with the new rules – the Final Rule suggests that providers or suppliers will be expected to replicate the entire audit and recalculate the overpayment total based on a six-year lookback period instead. This will be particularly burdensome for audits based on a statistically valid random sample, which may require the provider or supplier to redefine the universe of claims.

III. Mechanics of Reporting/Returning Overpayments

The Final Rule clarifies and simplifies the mechanics for reporting an identified overpayment in a number of ways.

First, while CMS had initially proposed that providers and suppliers use the so-called "voluntary refund process" to report overpayments (which involves contractor-specific forms and paper checks), the Final Rule clarifies that there are a number of acceptable reporting methods. Providers and suppliers may report and return overpayments through the OIG Self-Disclosure Process (SDP) or the CMS Voluntary

Self-Referral Disclosure Process (SRDP), by requesting a claims adjustment or a voluntary offset, or by using the credit balance process or "another appropriate process."

For the majority of refunds, this will allow providers and suppliers to use their standard methods for adjusting claims and seeking retractions, while ensuring that beneficiary accounts properly reflect how and why the payment adjustment occurred. Providers and suppliers submitting refunds through the SDP or SRDP must use the reporting processes outlined in the respective protocols, although CMS stated that it would consider electronic correction or claims corrections for these refunds in the future. The 60-day time period will be tolled while going through the SDP or SRDP process. If the parties cannot reach a negotiated settlement, however, the provider or supplier will have only the balance of the 60-day period remaining to report and return overpayments, calculated by subtracting the number of days between original identification of the overpayment and the date the 60-day deadline was tolled by the SDP or SRDP submission.

Second, CMS confirmed that, as long as a provider or supplier follows an "appropriate process" for returning an overpayment and does so within the required timeframe, it will have satisfied its obligation to report and refund. CMS confirmed that a provider or supplier will satisfy the obligation to report and return an overpayment with a single refund form and an attachment containing the relevant claims information. CMS also declined to provide a deadline for Medicare contractors to process a refund or retraction, but any delays by a contractor should not undermine compliance with the Final Rule as long as the provider or supplier followed an appropriate process. When a Medicare contractor identifies its own payment error and provides notice that it intends to adjust claims accordingly, there is no need for the provider or supplier to report and refund the overpayments separately. Although not stated in the Final Rule, we recommend seeking documentation from the Medicare contractor for such adjustments.

Finally, the Proposed Rule would have required providers and suppliers to furnish 13 data points with each reported refund, including a description of how the overpayment was discovered and a corrective action plan for addressing the issue going forward. In response to comments highlighting the various processes for reporting an overpayment, the Final Rule no longer requires specific data points to be reported, with one exception: overpayments calculated through extrapolation must include the details of the statistical sampling methodology used to quantify the overpayment. Sampling should be conducted "in a manner that conforms to sound and accepted principles" and be based on a statistically valid random selection of claims.

IV. Ancillary Overpayment Observations

Although the regulation text is short, the preamble is lengthy and covers many issues beyond the actual regulation. Some noteworthy comments include:

- The Final Rule Does Not Apply to Medicaid Overpayments to Providers and Suppliers. Although the Act clearly applies to Medicaid overpayments, the Final Rule specifically declines to address the interpretation of the Act to Medicaid overpayments. The Act still applies, but the specific requirements of the Final Rule do not, leaving providers and suppliers to engage in a reasonable interpretation of the Act and any corresponding state guidance to meet the reporting and refunding obligations.

- Offsetting Overpayments with Identified Underpayments. In the Final Rule, CMS declined to permit providers and suppliers to offset identified overpayments with underpayments that may be identified in the course of the same review. Noting that underpayment issues are beyond the scope of the Final Rule, CMS also declined to extend the lookback period for underpaid claims to six years. Under current rules,

absent good cause, providers and suppliers are limited to a one-year reopening period for claims with identified underpayments.

- Overpayments Associated with Unlicensed Personnel. CMS clarified in the Final Rule that the provision of services by unlicensed personnel "doesn't automatically imply that an overpayment has occurred," but that an overpayment "can" result in such circumstances. In other words, the provision of covered services by unlicensed personnel is not a bright-line test for overpayments, and – as in all cases – a provider or supplier should review the "relevant laws, regulations and billing rules" to determine whether there is a nexus between licensure and Medicare payment.

- CMS Views Identifying and Refunding Overpayments as a Ministerial Task. In the Information Collection Requirement discussion, CMS estimates that about 125,000 providers will report and refund three to five overpayments each year. Then, CMS suggests that each overpayment should require about six hours to report and return the overpayment, a task that generally should be completed by "miscellaneous in-house administrative personnel," but sometimes accountants and auditors.

This estimate suggests that the majority of the six hours would be spent researching and identifying the overpayment, even though the Final Rule acknowledges that this task should be completed within six months, implicitly recognizing that the work needed to conduct reasonable diligence to identify an overpayment is well beyond six hours. The estimate ignores any other costs, as CMS notes that, "We believe only the rarest of circumstances (such as potential fraud or certain investigations of potential violations of the physician self-referral law) would necessitate more costly personnel, such as legal counsel, to comply with the final rule."

For More Information

For more information regarding this alert, please contact one of the authors, a member of the Polsinelli's Health Care practice, or your Polsinelli attorney.

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** 2016 BTI Client Service A-Team Report*

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