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Life Sciences Health Industry Alert

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# 10-Year 'Look Back' Proposed for Identification and Return of Medicare Part A and B Overpayments

Providers and suppliers have until April 16, 2012, to comment on the proposed rule to implement provisions of section 6402(a) of the Affordable Care Act that require "persons" receiving Medicare and Medicaid funds to report and return overpayments by the later of 60 days after the date on which the overpayment was identified or, if applicable, the date any corresponding cost report is due.[1]

The proposed rule is important because it clarifies when and how an overpayment must be returned. If promulgated in final form as currently drafted, the rule would also subject providers and suppliers to a 10-year "look back" period, meaning providers and suppliers would have liability for the 10 years preceding the date an overpayment is received. The proposed rule has serious implications for provider and supplier operations if adopted as proposed. Providers and suppliers should consider using the public comment period to voice their concerns while it might still make a difference.

The proposed rule is currently limited to Medicare Part A and B providers and suppliers. The Centers for Medicare & Medicaid Services (CMS) will later promulgate regulations applicable to other stakeholders, to include prescription drug plans under Part D and Medicaid managed care organizations. CMS reminds all stakeholders, however, that the 60-day repayment obligation is already law and that they face potential False Claims Act (FCA) liability, Civil Monetary Penalties law liability and exclusion from federal health care programs for failure to report and return an overpayment.

## Overpayments under the Affordable Care Act

Section 6402(a) amended the Social Security Act to add various program integrity provisions, including a new section that addresses the "Reporting and Returning of Overpayments." Under 42 U.S.C. § 1320a-7k(d)(4)(B), "overpayment" means any funds that a person receives or retains from the Medicare or Medicaid program to which the person, after applicable reconciliation, is not entitled. The term "person" is defined broadly to encompass a provider of services, supplier, Medicaid managed care organization, Medicare Advantage organization and Prescription Drug Plan sponsor.

The law requires a person who receives an overpayment to report and return the overpayment to CMS, the state, an intermediary, a carrier, or a Medicare Administrative Contractor, as appropriate. In addition, the person must provide, to whomever the overpayment was returned, written notification of the reason for the overpayment. 42 U.S.C. § 1320a-7k(d)(1). The Affordable Care Act amendments established the deadline for reporting and returning overpayments at the later of 60 days after identification of the overpayment or by the date that the corresponding cost report is due (as applicable). 42 U.S.C. § 1320a-7k(d)(2).

## Proposed Rule on Reporting and Returning Overpayments

The proposed rule addresses the mechanics of when and how a repayment must be reported and returned under Medicare Part A or B. Consistent with the Affordable Care Act, a person with an identified overpayment must report and return the overpayment by the later of 60 days after the date on which the overpayment is identified, or the date any corresponding cost report is due, if applicable. CMS proposes to use the existing voluntary refund process, which it will rename the "self-reported overpayment refund process."

Currently, overpayments are reported to a Medicare contractor using a form that each contractor makes available on its website. CMS acknowledges that the reporting forms differ among the different Medicare contractors, and states in the preamble to the proposed rule its intention to develop a uniform reporting form. Until such a form is available, providers and suppliers are instructed to use the existing form available on the websites of the Medicare contractors.

In the rulemaking, CMS proposes a long list of items to be included in the contents of a report. These items include:

- Person's name
- Person's tax identification number
- How the error was discovered
- The reason for the overpayment
- The health insurance claim number, as appropriate
- Date of service
- Medicare claim control number, as appropriate
- Medicare National Provider Identification Number (NPI) number
- Description of the corrective action plan implemented to ensure the error does not occur again
- Whether the person has a corporate integrity agreement with the OIG or is under the OIG Self-Disclosure Protocol
- The timeframe and the total amount of refund for the period during which the problem existed that caused the refund
- If a statistical sample was used to determine the overpayment amount, a description of the statistically valid methodology used to determine the overpayment
- A refund in the amount of the overpayment

CMS offered the following examples of circumstances constituting an overpayment under the proposed rule. The list is not exhaustive:

- Noncovered services
- Medicare payments in excess of the allowable amount for an identified covered service
- Errors and nonreimbursable expenditures in cost reports
- Duplicate payments
- Receipt of Medicare payment when another payor had the primary responsibility for payment

The 60-day deadline for returning overpayments will be suspended if the provider or supplier makes a disclosure under the CMS Self-Referral Disclosure Protocol or the OIG Self-Disclosure Protocol.

According to CMS, providers and suppliers that are unable to repay large overpayments immediately may not delay reporting the overpayment but, instead, must make the report within 60 days and use the existing Extended Repayment Schedule process to develop a repayment schedule for the overpayment. This is the only means by which repayment of an overpayment will be extended. 42 FR 9183.

### "Identification" of an Overpayment

"Identification" of the overpayment triggers the 60-day reporting and repayment obligation. The Affordable Care Act amendments did not address how overpayments are identified or otherwise define this term. CMS is proposing that an overpayment is "identified" if the provider or supplier (1) has actual knowledge of the existence of the overpayment; or (2) acts in reckless disregard or deliberate ignorance of the overpayment.

While "actual knowledge" is self-explanatory, there is no express statutory definition of "reckless disregard" or "deliberate ignorance."[2] Providers and suppliers can reasonably expect that these vague standards will be read to require significant affirmative obligations. Thus, in the face of information that suggests an overpayment may exist (even if the chain of causation is remote), a provider would not be able to avoid repayment obligation by failing to perform activities to verify whether such overpayments exist, such as self-audits, compliance checks and other research. CMS provides the example of an instance where a provider experiences a "significant increase in Medicare revenue [where] there is no apparent reason for the increase." Even were an audit or investigation to be made, reckless disregard or deliberate ignorance could still exist if there is a failure to conduct such inquiry with all "deliberate speed" after obtaining information (or an allegation) about a potential overpayment. 42 FR 9182 (February 16, 2012). Because overpayments can be collateral to other behavior, CMS's interpretation of this rule will likely create significant audit obligations.

CMS provides examples of instances when an overpayment has been "identified" and requires repayment, including instances where the provider or supplier:

- Reviews billing or payment records and learns that it incorrectly coded certain services, resulting in increased reimbursement.
- Learns that a patient death occurred prior to the service date on a claim that has been submitted for payment.
- Learns that services were provided by an unlicensed or excluded individual on its behalf.
- Performs an internal audit and discovers that overpayments exist.
- Is informed by a government agency of an audit that discovered a potential overpayment, and the provider or supplier fails to make a reasonable inquiry.
- Experiences a significant increase in Medicare revenue and there is no apparent reason for the increase.

Reading the proposed rule and explanatory text in context, the 60-day period for reporting and repayment appears to begin when there is actual knowledge of an overpayment or when a reasonable inquiry reveals an overpayment. The proposed rule does not address affirmatively what constitutes a "reasonable inquiry." However, because the 60-day reporting and repayment period also may begin to run when information about an overpayment is received but "recklessly" disregarded or deliberately ignored, the threshold for what is a "reasonable inquiry" may be fairly high.

### 10-Year "Look Back Period"

The proposed rule would require providers and suppliers to report and return overpayments that occurred within the preceding 10 years if they want to be certain "that they can close their books and not have ongoing liability associated with an overpayment." 42 FR 9184 (February 16, 2012). CMS states that this 10-year look-back requirement will further its interest in the return of overpayments and give providers and suppliers certainty regarding the period of time to which the overpayment obligation extends. According to CMS, the 10-year look-back period was ostensibly based on the outer statute of limitations under the FCA. The actual law, however, is more narrowly drawn, and provides:

> A civil action under [the FCA] may not be brought—
>
> (1) more than 6 years after the date on which the violation of [the FCA] is committed, or
>
> (2) more than 3 years after the date when facts material to the right of action are known or reasonably should have been known by the official of the United States charged with responsibility to act in the circumstances, but in no event more than 10 years after the date on which the violation is committed, whichever occurs last.

31 U.S.C. § 3731(b). In other words, under the FCA, the government must bring its action within six years of a violation, or within three years of the date that the government learns, or should have learned, that a violation has been, or might have been committed—whichever occurs last.[3] Regardless, there is a 10-year cut-off date from the date of the violation.

The imposition of a 10-year look-back period reaches far beyond section 6402(a) of the Affordable Care Act, which did not include a look-back period. Moreover, a 10-year look-back is incompatible with Medicare conditions of participation that require providers to retain medical records for only five years (42 CFR § 482.24(b)(1) (hospitals); 42 CFR § 483.75(l)(2)(ii) (nursing homes), and a limitation period of six years for civil money penalties (42 CFR § 1003.132). For hospitals and other providers submitting cost reports, the reopening rules currently state that the Medicare contractors can reopen claims within one year for any reason, within four years for "good cause," and any time if evidence of fraud or similar fault exists. CMS proposes to amend the reopening rules to provide for a 10-year reopening.

Many providers and suppliers will be unable to conduct their own look-back and will have to hire third parties to do it for them. Because limitations periods will have ended or because record retention policies permitted earlier destruction, necessary documentation may not be available. In many cases, electronic records will have supplanted paper records. The potential cost, time requirement, diversion of resources, and other burdens for a provider/supplier conducting a 10-year look-back should not be minimized. Providers and suppliers can, of course, take the risk of not conducting the 10-year

look-back. However, this, too, has consequences. The mere specter of potential liability may affect their business, particularly in connection with potential sale of transfer.

### Penalties for Failing to Report and Return Overpayments

Under 42 U.S.C. § 1320a-7k(d)(3), an overpayment that is retained after the 60-day deadline for reporting and returning the overpayment creates an "obligation" for purposes of the FCA and creates potential liability under that statute for concealing or avoiding paying or returning government funds that the person is otherwise obligated to return.

Liability under the FCA includes fines of not less than $5,500 or more than $11,000 per claim, plus treble damages. Liability can also form the basis for administrative sanctions under the Civil Monetary Penalties Law, including exclusion from the Medicare program.

### Implications for Providers and Suppliers

It is important to remember that as of March 23, 2010, the 60-day overpayment requirement was law and the law incorporated the FCA by reference. The proposed rulemaking is merely the regulatory implementation of those legal principles for purposes of Medicare Part A and B providers and suppliers. Seeing these provisions on paper, however, is "eye-opening" for many health care entities because the federal government has spent the past five to 10 years narrowing the leeway that providers and suppliers have to make mistakes. This rule is one of the most severe for the simple reason that a violation cannot be cured; an overpayment reported and returned on the 61st day is a violation of the FCA.

At the same time that the leeway for mistakes has narrowed, the government has promulgated a plethora of additional rules, many of which have "speed traps" to catch even the most diligent providers and suppliers. For example, former conditions of participation (analyzed under a substantial compliance standard) have become specific conditions of payment (where a missed item becomes an overpayment); CMS Manual guidelines that provided factors for analyzing admissions have now become hard and fast rules with long checklists; and temporal requirements where specific authorizations and signatures must be obtained within narrow time windows have become the norm (and any failure usually can't be cured).

The challenge for providers and suppliers is that all of these tripwires create a much-higher likelihood that a regulatory violation will lead to a collateral overpayment. Because providers and suppliers cannot pursue a "head in the sand" approach, there will be substantial pressure to audit operations and billings on a continual basis, and to return overpayments timely. All of this will come at a cost, financial and otherwise. The proposed regulations are the latest manifestation that the "substantial compliance" standard is giving way to a standard of "absolute compliance"—with draconian penalties otherwise. That the audit obligation has been extended to 10 years only underscores the pitfalls.

The proposed rulemaking is found at http://www.gpo.gov/fdsys/pkg/FR-2012-02-16/pdf/2012-3642.pdf. Comments on the proposed rule must be received before 5 p.m. April 16, 2012.

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1 The provisions are codified at section 1128J(d) of the Social Security Act (42 U.S.C. § 1320a-7k(d))

2 There is, however, significant case law under the federal False Claims Act ("FCA") on these standards, if we are to assume a direct corollary.

3 There is a limited exception that allows the government's claim to relate back to the statute of limitations of a relator's claim.

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