CMS Proposed Rule: Reporting and Returning Overpayment

On February 16, 2012, the Centers for Medicare & Medicaid Services ("CMS") published a proposed rule requiring Medicare providers and suppliers to report and return overpayments ("Proposed Rule"). The Proposed Rule implements Section 6402(a) of the Patient Protection and Affordable Care Act ("Act") dealing with reporting and returning overpayments. The Act requires that an overpayment be reported and returned by the later of: (1) the date which is 60 days after the date on which the overpayment is identified, or (2) the date any corresponding cost report is due, if applicable. Section 6402(a) also provides that any overpayment retained after that deadline is an "obligation" that may cause the provider or supplier to be liable under the False Claims Act ("FCA").

The Proposed Rule only applies to Medicare Part A and Part B overpayments. It addresses three critical questions left unanswered by the Act: (1) when an overpayment is "identified"; (2) what procedures apply to report and return overpayments; and (3) how far back identified overpayments should be reported and returned (the "look back period").

1. When is an overpayment identified?

Under the Proposed Rule, 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 overpayment." CMS explains that this provision "gives providers and suppliers an incentive to exercise reasonable diligence to determine whether an overpayment exists." CMS notes that receipt of information concerning a potential overpayment may create an obligation to make a reasonable inquiry to determine whether an overpayment exists; and failure to conduct such reasonable inquiry (including failure to act with all deliberate speed) could result in the provider knowingly retaining an overpayment because it acted in reckless disregard or deliberate ignorance of whether it received such an overpayment.

CMS gives the following examples of when an overpayment has been identified:

- A provider reviews billing or payment records and realizes it incorrectly coded certain services resulting in overpayments;
- A provider learns that a patient death occurred before the service date on a claim that was submitted for payment;
- A provider learns that services were provided by an unlicensed or excluded individual on its behalf;
- A provider performs an internal audit and discovers that an overpayment exists;
- A provider is informed by a government agency that an audit indicates a potential overpayment and the provider fails to make reasonable inquiry thereafter; or
- A provider notices a significant increase in Medicare revenue for no apparent reason (*e.g.,* no

new physician in the group, no new service line) but fails to make reasonable inquiry as to the cause.

It remains somewhat unclear as to when during a provider's reasonable inquiry the 60-day clock starts ticking. It seems likely that the 60-day requirement starts when the provider completes its investigation and determines that an overpayment has been received; accordingly, providers should document their conduct of an investigation and the date on which a determination is made on behalf of the organization that an overpayment exists.

It is also noteworthy that the time for *returning* an overpayment (but not reporting the overpayment) is suspended if a provider self-discloses under either the OIG Self-Disclosure Protocol or the CMS Medicare Self-Referral Disclosure Protocol. In the event of self-disclosure under either protocol, the deadline for repayment is suspended until a settlement agreement is entered.

2. What is the procedure to report and return overpayments?

CMS proposes that providers and suppliers use the existing voluntary refund process outlined in Chapter 4 of the Medicare Financial Management Manual. Providers are to use overpayment forms issued by the applicable Medicare contractors until a standardized form is created.

3. How long is the look-back period?

CMS proposes that overpayments must be reported and returned if "identified" within 10 years of receipt. Although the Department of Justice usually limits its investigation and settlements to a 6-year period and the Medicare claim reopening period is currently limited to 4 years in the absence of a fraud allegation, CMS selected a 10-year lookback period based on the "outer limit" of the FCA statute of limitations.

It is important to realize that this is only a proposed rule. Public comments are invited and CMS may change certain provisions in the final rule. We encourage providers and suppliers to submit comments which must be received by CMS by April 16, 2012.

If you have any questions, please contact Lin Ye or any member of Miller & Martin's Health Care Practice Group.

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