T Minus 60 Days and Counting: CMS's New Repayment Deadline

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The Basics

The Patient Protection and Affordable Care Act, Public Law 111-148 (Act), creates new potent requirements for providers and suppliers to return Medicare and Medicaid overpayments. Subsection 6402(d)(1) of the Act says:
If a person has received an overpayment, the person shall—

- Report and return the overpayment to the Secretary [of the U.S. Department of Health & Human Services], the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and
- Notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.

In Subsection 6402(d)(2), the Act goes on to set the deadline to return the overpayment:

- An overpayment must be reported and returned under paragraph (1) by the later of --
- The date which is 60 days after the date on which the overpayment was identified; or
- The date any corresponding cost report is due, if applicable.

Note that everyone will always have at least 60 days to report and reply, but providers who file cost reports may have longer, because they may have until their next cost report is due.

Failure to return the overpayment on time is a so-called "reverse" false claim. Subsection 6402(d)(3). Like any other false claim, it is potentially subject to the per-claim penalties and treble damages in the federal False Claims Act, 31 U.S.C. § 3729.

The new provisions apply to all Medicare and Medicaid providers and suppliers (as well as Medicaid managed care organizations, Medicare Advantage organizations, and Medicare prescription drug plan sponsors), but not to beneficiaries. Subsection 6402(d)(4)(C). The provisions apply to any and all funds the provider or supplier receives from Medicare or Medicaid which, after reconciliation, the provider or supplier is not entitled to receive or retain.

Subsection 6402(d)(4)(B).

Note this is not part of the new Stark Voluntary Self-Referral Disclosure Protocol, OMB Control Number 0938-1106, discussed elsewhere in this issue, but it complements the Protocol.

The Judgment Calls

No one should ignore the teeth in this provision, but it does also have some potential leeway built into it, which providers – both hospitals and physicians – can use to their reasonable advantage when they realize they have probably received and must deal with an overpayment. The key thing to remember is the 60-day repayment period to report and return starts on the date the overpayment is "identified." Identified does not mean suspected, detected, or "guess-timated." Identified means – within reason and good faith – known and calculated. Some things cannot be known and calculated within 60 days of being suspected or detected, but necessarily take longer. Therefore, when an overpayment is suspected, the provider does not need to race to meet an impossible 60-day deadline. Instead, the provider and can take these steps:

1. Immediately assign someone qualified to figure out if there has been an overpayment and, if so, how much. You may want to assign it to counsel to take advantage of the "attorney work product" rules.
2. Quickly set a prompt, but reasonable, schedule for determining if an overpayment exists and, if so, how large it is. If you can do it in 60 days, so much the better. But the most important thing is to be able to show you worked steadily and reasonably.
3. Document the investigation to identify the overpayment while it is going on. During the investigation, use the future tense and choose words such as "suspect," "investigate," "inquire," and "look into" to describe your efforts. Avoid the past tense, and shun words such as "identified," detected," and "determined" until you actually have reached solid conclusions.
4. If you identify overpayments in stages, report the overpayments and refund the money in stages.
5. Do not forget to report the reasons for the overpayment, and correct these reasons going forward.
6. Consider whether you want to (i) report to and repay the government or (ii) report to and repay your contractor, carrier, or intermediary.
7. Be diligent and make the repayments as soon as you reasonably can.

Following these steps, diligently and in good faith, should protect a provider who is trying to meet the requirements of the law but cannot get the work done in just 60 days.

These steps are not, of course, camouflage for the provider who wants to delay or avoid repayment. Unreasonable delays will violate the provisions of the False Claims Act, which say willful ignorance or deliberate disregard of the

facts is equivalent to actual knowledge.

Conclusion

With these developments, there is no doubt that a provider has a duty to report and repay Medicare and Medicaid overpayments. Moreover, the penalties for failing to do so are severe and are ignored only at your peril.

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