CMS Issues Final Rule on Reporting and Returning Overpayments

Publication — 02/16/2016

On February 12, 2016, CMS issued its Final Rule on reporting and returning of overpayments made to providers and suppliers under the Medicare program (42 C.F.R. §401.301 et seq.) (Final Rule). The Final Rule, which becomes effective March 14, 2016, implements and clarifies Section 1128J(d) of the Social Security Act, even though providers and suppliers have been under an obligation to return overpayments since the passage of the Affordable Care Act in March 2010.

The rule, which was first proposed by CMS in 2012, requires providers and suppliers receiving funds under the Medicare program to report and return overpayments by the later of (a) 60 days after the date on which the overpayment was identified; or (b) the date any corresponding cost report is due. Providers and suppliers who fail to report and return overpayments face potential False Claims Act liability, Civil Monetary Penalties Law liability, and exclusion from federal health care programs. With approximately 15 million beneficiaries enrolled in the Medicare program, CMS estimates that the time and effort necessary to identify, report, and return overpayments will have an annual cost of between $120 million and $201 million. The Final Rule provides clarity on several key provisions.

Meaning of Identified. Under the Final Rule, an overpayment is identified when a 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. The proposed rule had not addressed the issue of quantification. Accordingly, the Final Rule provides needed clarification that an overpayment is not identified until the amount has been quantified.

"Reasonable Diligence" Standard. Providers and suppliers are under an obligation to use reasonable diligence in identifying overpayments. Reasonable diligence includes both (a) pro-active compliance activities conducted in good faith by qualified individuals to monitor for the receipt of overpayments; and (b) investigations conducted in good faith in a timely manner by quality individuals in response to obtaining critical information of a potential overpayment. The Final Rule, therefore, requires both regular compliance activities as well as responsive investigations to credible information suggesting an overpayment has been received. When a person obtains credible information concerning a potential overpayment, CMS instructs that the person needs to undertake reasonable diligence to determine whether an overpayment has been received and to quantify the amount. This obligation, however, is broader than simply receiving a report of a suspected overpayment. In an example provided by CMS, a provider who experiences a significant increase in Medicare revenues for no apparent reason is obligated to make a reasonable inquiry into whether an

overpayment exists.

Calculating the 60-Day Time Period to Report and Repay. The 60-day time period to report and return overpayments begins either (a) when the reasonable diligence is completed; or (b) on the day the person received credible information of potential overpayment if the person failed to conduct reasonable diligence and the person in fact received an overpayment.

Emphasis on Proactive Activities. While the Final Rule clarifies a provider's obligation to actively investigate suspected overpayments, it also emphasizes the need for proactive compliance activities. While CMS recognizes that compliance programs may differ depending on the size and type of provider, the Final Rule emphasizes the importance of regular and thorough compliance activities.

Six-Month Investigation Period. 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. Extraordinary circumstances may include unusually complex and vague investigations that the provider or supplier reasonably anticipates will require more than six months to investigate. In addition, CMS advises that providers and suppliers maintain records and accurately document their reasonable diligence efforts to build and demonstrate their compliance with the Final Rule.

Quantification and Use of Sampling and Audits. Reasonable diligence can include statistical sampling and extrapolation as a way to calculate an overpayment amount. Audits can be used to determine if an overpayment exists and to quantify it. After finding a single overpaid claim, CMS indicates it is appropriate to inquire further to determine whether there are more overpayments on the same issue before reporting and returning the single overpaid claim. The 60-day report and repay window starts to run either when the reasonable diligence is completed and the overpayment is identified, or on the day the person received credible information of potential overpayment if the person fails to conduct reasonable diligence and the person in fact received an overpayment.

Six-Year Lookback Period. The Final Rule clarifies that providers and suppliers are under an obligation to report and return overpayments received within six years of the date of the overpayment. This is a reduction from the 10-year lookback period in the proposed rule but longer than the four-year look back period urged by the American Hospital Association and the Federation of American Hospitals.

Reporting and Repaying. Providers and suppliers may use the claims adjustment, credit balance, self-reported refund process, or another appropriate process to report and return overpayments. Providers and suppliers are tasked with deciding who is the most appropriate recipient of the overpayment report and refund. Unless the overpayment is being made pursuant to the OIG Self-Disclosure Protocol (SDP) or the Stark Self-Referral Disclosure Protocol (SRDP), overpayments should be

reported and returned to the applicable Medicare contractor.

Interface with Stark Self-Referral Disclosure Protocol. Providers and suppliers reporting overpayments under the SRDP prior to the effective date of the Final Rule will be governed by the four-year look back period mandated by the SRDP process. Those providers or suppliers reporting overpayments through the SRDP after the effective date of the Final Rule will be subject to the six-year look back period.

Payment Plan Options. The Final Rule allows for an extended repayment plan for providers faced with burdensome repayment obligations. Providers and suppliers wishing to avail themselves of this option must specifically request an extended repayment schedule and must meet CMS's specific rules on qualification.

Effect on Medicaid Overpayments. While CMS has not yet proposed a rule with respect to Medicaid overpayments, it has made clear that the requirements of Section 1128J(d) are currently applicable to overpayments in the Medicaid program as well.

Holland & Hart will be providing an in-depth discussion of these and other provisions of the CMS Final Rule on reporting and returning of overpayments at a webinar on Thursday, February 25, 2016, from 12:00 – 1: 00 p.m. (MST). For more details and to register for the webinar, click here.

For questions regarding this update, please contact:
Pia Dean
Holland & Hart, 555 Seventeenth Street
Suite 3200
Denver, CO 80202-3979
email: pdean@hollandhart.com, phone: 303-295-8464

This news update is designed to provide general information on pertinent legal topics. The statements made are provided for educational purposes only. They do not constitute legal advice nor do they necessarily reflect the views of Holland & Hart LLP or any of its attorneys other than the author. This news update is not intended to create an attorney-client relationship between you and Holland & Hart LLP. If you have specific questions as to the application of the law to your activities, you should seek the advice of your legal counsel.