CMS Overpayment Final Regulation Summary and Suggested Actions Steps

On February 11, 2016, the Centers for Medicare and Medicaid Services (CMS) released the final version of a 2012 proposed rule that requires Medicare Parts A and B health care providers and suppliers to report and return overpayments by the later of the date that is “60 days after the date an overpayment was identified, or the due date of any corresponding cost report if applicable.” The rule becomes effective 30 days after publication in the Federal Register. Thus the effective date is March 14, 2016. A separate final rule was published on May 23, 2014 that addresses Medicare Parts C and D overpayments.

Below are a key provisions from the final rule:

- **Shorter Look-back Period Defined:** The final rule provides for a six-year lookback period for reporting and returning overpayments, a reduction from the 10-year period previously proposed. The six-year lookback period will be measured back from the date the person identifies the overpayment.¹

- **“Reasonable Diligence” is CMS’ Process for Provider Identification:** The obligation to report and return an overpayment is triggered when a provider or supplier “identifies” the overpayment. 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.” CMS clarified that “reasonable diligence” requires providers and suppliers to undertake ongoing, proactive compliance activities to monitor claims, as well as reactive investigative activities regarding any potential overpayment. According to CMS, this definition ensures that a provider or supplier cannot avoid the obligation to return an overpayment by failing to investigate credible evidence that an overpayment has occurred. Notably, it also exposes providers and suppliers to potential liability if they undertake no or minimal compliance activities. According to the final rule, the 60-day time period begins when either the reasonable diligence is completed or 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.

¹ “Person” means a “provider,” as defined at 42 CFR 400.202. Provider means “a hospital, a CAH, a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, or a hospice that has in effect an agreement to participate in Medicare, or a clinic, a rehabilitation agency, or a public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech pathology services, or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services.”
- **The Obligation to Return Overpayments is Tolled in Certain Circumstances:** The deadline for returning overpayments within 60 days of identification is suspended in the following circumstances: (1) a person submits a self-disclosure to the OIG Self-Disclosure Protocol (“SDP”), receipt of which is acknowledged by OIG; (2) a person submits a self-disclosure to the CMS Voluntary Self-Referral Disclosure Protocol (“SRDP”), receipt of which is acknowledged by CMS; and (3) a person requests an extended repayment schedule (“ERS”) pursuant to 42 C.F.R. § 401.603. In the case of the SDP and the SRDP, the requirement to return the overpayment is tolled for the duration of the time the provider or supplier is negotiating a potential settlement with OIG or CMS in accordance with the requirements of those protocols.

- **Benchmark Six-Month Investigation Period:** The final rule does not contain a time limit for investigations. However, CMS does note that except in “extraordinary circumstances,” reasonable diligence would require not more than six months for a timely, good faith investigation of credible information. “Extraordinary circumstances” may include unusually complex investigations, natural disasters, and a state of emergency.

- **Implications for Stark Self-Disclosures:** CMS states that providers and suppliers reporting overpayments through the SRDP after the effective date of the final rule will be subject to a six-year lookback period. However, providers and suppliers reporting SRDP overpayments prior to the effective date of the final rule will be governed by the four-year lookback period currently applicable to the SRDP process and will not be expected to return overpayments from the fifth and sixth years through other means. Notably, however, CMS also explains that the agency is seeking authorization from the Office of Management and Budget (“OMB”) to collect financial information regarding overpayments using the six-year lookback period, and “until the revised collection is approved by OMB, providers and suppliers submitting to the SRDP may voluntarily provide financial information from the fifth and sixth years or report and return overpayments from the fifth and sixth years through other means.”

- **Overpayment Cause is Irrelevant:** The cause and amount of the overpayment is irrelevant for the determination, e.g., it was due to a mistake, it was someone else’s fault, it is a minor amount. An overpayment is an overpayment and must be returned.

- **Methods for Reporting and Returning Overpayments is Expanded:** Under the final rule, providers and suppliers are not limited to reporting and returning overpayments through the voluntary refund process, and may use the claims adjustment, credit balance, self-reported refund process, or another appropriate process to report and return overpayments.
Failure to Report has Financial Implications: Any overpayment retained by a provider after the deadline for reporting and returning the overpayment becomes an “obligation” for purposes of 31 U.S.C. 3729, commonly known as the False Claims Act (FCA). The FCA prohibits any person from knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the government. Violations of the FCA come with significant civil penalties (between $5,500 and $11,000 for each false claim) and treble the amount of the government’s damages. Additionally, whistleblowers have significant incentives to report violations of the duty to report and return overpayments, as the FCA allows whistleblowers to file qui tam actions on behalf of the government and share in any recovery. Furthermore, failure to return an overpayment can result in liability under the Civil Monetary Penalties Law and potential exclusion from participation in the Medicare and Medicaid program, in addition to other federal health care programs, such as TRICARE.

Background

Section 6402(a) of the Affordable Care Act (ACA) includes the overpayment provision, now codified in Section 1128J(d) of the Social Security Act. Section 6402(a) states that if a person (e.g., a provider or supplier) has received an overpayment, the person must “report and return the overpayment to the Secretary, 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.” The statute then sets forth a deadline for the reporting and repaying of overpayments, specifically stating, “[a]n overpayment must be reported and returned ... 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.”

Section 6402(a) also codifies certain definitions related to the overpayment provision, including “knowing and knowingly,” which have the same definitions as under the federal FCA. In addition, the statute defines overpayment as “any funds that a person receives or retains under subchapter XVIII or XIX of this chapter to which the person, after applicable reconciliation, is not entitled under such subchapter.” Finally, Section 6402(a) defines “person” to include “a provider of services, supplier, Medicaid managed care organization [as defined by statute], Medicare Advantage organization [as defined by statute], or PDP sponsor [as defined by statute],” but excluding beneficiaries.

Importantly, Section 6402 explicitly raises the stakes for providers who fail to timely meet the reporting and repayment requirements. First, if a provider or supplier retains an overpayment past the reporting and repayment deadline set forth in Section 6402(a), the retained overpayment becomes an “obligation” as defined by the FCA, 31 U.S.C. § 3729(b)(3). Second, Section 6402(d)(2) of the ACA amends the federal CMP statute to allow for the imposition of penalties on any person that “knows of an overpayment (as defined in paragraph (4) of [42 U.S.C. § 1320a-7k(d)]) and does not report and return the overpayment in accordance with such section.” The possible implications of providers and suppliers not appropriately reporting and returning an overpayment as required by Section 6402(a) are considerable.
Suggested Member Action Steps

AHCA strongly suggests members undertake steps to prepare for implementation of the overpayment regulation. Below are possible action steps for member consideration in preparation for complying with the rule. The list below is in no way exhaustive and should not be considered legal advice. Rather, the points below are intended to serve as an outline for discussions with legal counsel and accounting experts. In other words, this document is not intended as legal advice and should not be used as or relied upon as legal advice. It is for general informational purposes only and may not be substituted for legal advice.

1. **Exercise “reasonable diligence” to identify and quantify overpayments in response to “credible information.”** Although CMS declined to further define what is considered “reasonable diligence” in the Rule, it identified two primary duties for providers in the Rule’s accompanying guidance: (1) proactive compliance efforts, and (2) reactive investigations in response to credible information of a potential overpayment. This means that all providers should have some form of claims review and billing compliance auditing processes, as well as compliance processes in place to receive reports of potential overpayments and adequately investigate any credible information received. Both proactive and reactive duties should be carried out in good faith and by qualified individuals.

CMS similarly put the onus on the provider to determine whether information regarding a potential overpayment is “credible” and warrants investigation, noting that such a determination will be fact dependent. CMS is clear that providers are not required to investigate every single allegation of an overpayment, but only that information that supports a reasonable belief that an overpayment may have been received. For example, a vague complaint by a volunteer who has no knowledge of billing laws may not be considered credible enough to warrant investigation. On the other hand, a therapist who has a better understanding of Medicare billing requirements and makes a detailed allegation that she suspects another therapist was billing for minutes of therapy not provided, would likely require investigation.

The rule gives providers some relief with respect to quantifying the amount of overpayments by allowing the use of statistical sampling and extrapolation to calculate an overpayment amount for issues involving lengthy claim periods.

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2 Overpayments are broadly defined to include any funds that a person has received or retained under title XVIII of the Social Security Act (Medicare) to which the person, after applicable reconciliation, is not entitled. Some examples of overpayments include payment for noncovered services, payments in excess of the allowable amount, duplicate payments, receipt of Medicare payment when another payer had the primary responsibility, receipt of payment for services that were not medically necessary, and payment for services provided in violation of the Anti-Kickback Statute.
2. **Develop a protocol for reporting and returning overpayments.** CMS leaves it up to the provider to determine which entity to report and return the overpayment to. That is, the provider should determine whether it is most appropriate to report and return the overpayment directly to the Medicare contractor or to use the OIG Self Disclosure Protocol or the CMS Self-Referral Disclosure Protocol (SRDP). For refunds made to the Medicare contractor, providers may use the claims adjustment or reversal, credit balance, self-reported refund process, or another appropriate process. Providers are also permitted to request a voluntary offset from the contractor rather than cutting a check for the overpayment. There is currently no standard form for reporting and returning overpayments, though CMS may create one in the future. Providers should instead look to the specific contractor to obtain its form for reporting and returning overpayments. Providers and suppliers must make their own determination to which entity to report and return the overpayment, i.e. to the Medicare contractor, using the OIG Self Disclosure Protocol or using the CMS SRDP.

3. **Monitor critical points in time as Part of Any Overpayment Protocol.** Except for “extraordinary circumstances, providers and suppliers have a maximum of eight months to report and return overpayments — at most six months to conduct a timely good faith investigation of credible information and quantify the overpayment (i.e. to identify it) and up to 60 days to report and return the overpayment. Providers and suppliers are required to report and return all overpayments within a six-year lookback period. If an overpayment is identified, then it must be repaid within 60 days. An overpayment is identified when a person has or should have, through the exercise of reasonable diligence, determined that the person received an overpayment and quantified the amount.

4. **Providers Have Options for Repaying Overpayments.** Providers and suppliers may use the claims adjustment, credit balance, self-reported refund process, or another appropriate process to report and return overpayments. At this time, there is no standard refund form to use. However, the final rule does offer providers facing particularly burdensome repayment obligations by suspending the deadline for returning overpayments when the provider requests an extended repayment schedule, which are subject to CMS rules on qualification. Of note when developing an overpayment amount or plan, CMS explicitly excludes the treatment of underpayments from the scope of the final rule. That is, in response to comments requesting a process to recoup underpayments or offset identified underpayments against identified overpayments, CMS notes that underpayments are outside of the scope of this rulemaking and that providers and suppliers can seek to address underpayments by requesting re-openings under separate regulations.

5. **Develop a Process for Coordinating an Overpayment Protocol with Cost Reporting.** In some situations, CMS may make interim payments to a provider throughout the cost reporting year and providers reconcile those payments with covered and reimbursable costs at the time their cost reports are due. Under the final rule, CMS considers “applicable reconciliation” to occur when the cost report is filed.
6. **While the Rule is Medicare-specific, Similar Processes Should be Developed for Medicaid.** The February 2016 rule is Medicare fee-for-service specific and CMS already has released a similar overpayment regulation for Parts C and D (e.g., Medicare Advantage and Medicare drug coverage). However, CMS has not yet proposed a similar regulation for Medicaid. In the rule, CMS notes that despite the absence of rulemaking on Medicaid overpayments, the requirements created by Section 6402(a) and Section 1128J(d) of the Social Security Act currently are effective for Medicaid payments. Members should consider contacting their Medicaid agencies on strategies the states may implement to address overpayments under this rule in addition to existing, state-specific efforts. Additionally, it is important to note that providers excluded from Medicaid in one state may be excluded from Medicaid in other states under Medicaid reciprocity exclusion provision.

7. **Work with Legal Counsel and Key Staff to Reduce Potential Penalties or More Substantial Sanctions.** As explained above, any overpayment retained by a provider after the deadline for reporting and returning the overpayment becomes an “obligation” for purposes of the FCA. Failure to return an overpayment may result in significant liability under the FCA as well as potential civil monetary penalties and exclusion. Therefore, providers concerned about a potential overpayment should seek the advice of knowledgeable counsel to provide advice tailored to the facts and circumstances of the potential overpayment and taking into account all relevant law. To view AHCA/NCAL guidance on FCA compliance, click [here](#).

**Conclusion**

AHCA/NCAL will offer an in depth webinar on overpayment compliance in the coming weeks. Additional information on registration will be released shortly. During the interim, if you have questions about the final rule, please contact Mike Cheek at [mcheek@ahca.org](mailto:mcheek@ahca.org).