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The 60-Day Deadline to Repay Medicare Overpayments: What Did You Know and When Did You Know It?

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On Feb. 16, 2012, CMS published proposed regulations implementing the sections of the Affordable Care Act ("ACA") that require providers to disclose and return overpayments within 60 days of the date an overpayment is identified. The proposed regulations stake out an aggressive interpretation of the congressional mandate and ignore the real world complexities of billing, coding, and regulatory compliance. If these regulations are finalized, providers will regularly face potential civil penalties as well as federal False Claims Act ("FCA") liability based on conduct that can only be appropriately characterized as prudent.

Any providers concerned about these proposals should seriously consider submitting comments on the proposed regulations to CMS by 5 p.m. on April 16, 2012.

The proposed regulations flow from the ACA provision that:

- Imposes a duty on a person who received an overpayment to report and return the overpayment to the "appropriate" agency or government contractor and to submit in writing the reason for the overpayment;
- Characterizes an overpayment retained by a person after the deadline as a "reverse" false claim under the False Claims Act; and
- Incorporates by reference the False Claims Act definitions of when a person "knows" that an overpayment has occurred—acting with either deliberate ignorance or in reckless disregard of the truth or falsity.

The ACA does not define when a provider "identifies" an overpayment, but CMS folds that concept into when a provider "knows" that an overpayment may exist under the FCA. As noted above that definition includes "reckless disregard or deliberate ignorance."

The proposed 60-day repayment regulations only apply to Medicare Parts A and B providers and suppliers. CMS states that future regulations will address the obligations of Medicare Advantage Organizations, Medicaid providers and other stakeholders, while

warning that the ACA puts all of them at risk for FCA violations even without specific regulations.

When do the 60 days begin?

One of the most critical questions raised by the ACA is when the 60-day period begins, because providers are at risk for civil penalties and face potential FCA liability on the 61st day. Under the proposed regulations, the 60-day clock begins running when a provider acts in deliberate ignorance or reckless disregard of information that an overpayment may exist. In CMS's view, "an overpayment has been identified at the time that a person acts with actual knowledge of, in deliberate ignorance of, or with reckless disregard to the overpayment's existence."

However, CMS provides little guidance regarding when a provider's ignorance becomes "deliberate," or when disregard becomes "reckless." It will be critically important for a provider to know how long it has to investigate the possibility that an overpayment may exist. CMS also states that it expects a provider to make a "reasonable" inquiry "with all deliberate speed after obtaining the information" suggesting an overpayment exists, without providing any further useful guidance. CMS clearly states that if a provider fails to conduct any inquiry after learning of a circumstance that may suggest an overpayment has occurred, then that provider will be at risk for FCA penalties. But the proposed regulations leave providers guessing about what inquiries are reasonable and when speed is deliberate. It seems likely that comments to the proposed rule will request further guidance on the meaning of these terms.

As part of its guidance, CMS gives these examples as when an overpayment has been identified:

- A provider ***learns*** that:
    - A review of billing or payment records discloses incorrect coding.
    - A patient death occurred prior to the service date on a claim that has been submitted for payment.
    - Services were provided by an unlicensed or excluded individual on its behalf.
- An internal audit ***discovers*** that overpayments exist.
- A provider 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.

- A provider of services or supplier experiences a significant increase in Medicare revenue and there is no apparent reason, and fails to make a reasonable inquiry into whether an overpayment exists.

Unfortunately, these examples fail to provide sufficient guidance about the nature, scope, and timing of a provider's resulting inquiry. For example, if a provider learns of a circumstance that may have resulted in multiple claims having billed inappropriately, must the provider disclose each individual claim as it is uncovered if it will take longer than 60 days to fully understand the scope of the problem, its cause and the best corrective action? Do CMS and the Medicare contractors really want a potential flood of disclosures when their numbers could be reduced, and these questions better answered, if the provider's inquiry is more extensive and time-consuming?

On the other hand, if CMS has been deliberately vague and chooses not to offer any further guidance, then perhaps this language suggests that CMS may be willing to accept a provider's good faith efforts to understand and quantify a complex overpayment that may take more than 60 days to analyze despite working as quickly as possible under the circumstances.

What is an overpayment?

Although warning that the list is not comprehensive, CMS both defines and provides examples of certain key terms. In paraphrase, ***overpayments*** are "funds . . . to which the person is not entitled." Examples include:

- Payments for noncovered services;
- Payments in excess of the allowable amount;
- Errors and nonreimbursable expenditures in cost reports;
- Duplicate payments; and
- Receipt of Medicare payment when another payor had the primary responsibility for payment.

The commentary to the proposed regulations also makes clear that violations of both the Stark law and the Anti-kickback law can result in overpayments to which the

reporting and repayment obligations apply.

With a stunning disregard for either practical reality or fundamental fairness, the proposed regulations adopt the FCA's 10-year statute of limitations. In other words, a provider's obligation to return an overpayment attaches to any identified Medicare payment received within the last 10 years. It is difficult to understate the negative implications of imposing a 10-year look back period. The industry should take steps to inform the agency of the burden this will impose and the practical impossibility of calculating overpayments that may have occurred over a 10-year period in 60 days.

How will overpayments be reported?

CMS will continue to rely on the existing voluntary refund process defined in the Medicare Financial Management Manual, although the overpayment report forms currently in use by Medicare contractors do not request all of the information which the regulation would require. That information includes, among other things:

- The health insurance claim number;
- How the error was discovered;
- Description of the corrective action plan implemented to ensure the error does not occur again;
- Whether the provider or supplier has a corporate integrity agreement;
- The timeframe and the total amount of refund for the period during which the problem existed that caused the refund;
- The method used to determine the overpayment; and
- The reason for the refund.

CMS expects that reasons commonly given for overpayments by providers to include:

- An incorrect service date;
- A duplicate payment;
- An incorrect CPT code;

- Insufficient documentation; and
- Lack of medical necessity.

CMS states that it will promulgate a new, uniform form for use nationally to report overpayments, and that until then providers should use the contractors' current forms, which must presumably either be supplemented by the providers or changed by the contractors.

An exception for cost report reconciliations

The regulations recognize the differences between payments made on a cost report or based on a fee schedule. A few overpayments may only be identified in the process of reconciling a cost report, in which case the 60-day time limit is inapplicable. This regulation deals only with the much larger majority of scenarios, with payments under the Inpatient and Outpatient Prospective Payment Plans, the Physician Fee schedule, and the various other methods of paying suppliers of Part B items and services.

Relationship to existing self-disclosure protocols

CMS acknowledges that the proposed regulations implicate the existing voluntary disclosure processes. With respect to Stark disclosures, CMS proposes to suspend the duty to ***pay*** under the Stark Disclosure Protocol, but not the duty to ***disclose***. CMS seeks comment on alternative approaches that would allow providers and suppliers to avoid making multiple reports of identified overpayments.

With respect to the OIG self-disclosure protocol, the obligation to return overpayments will be suspended until a settlement agreement is entered, or the provider or supplier withdraws or is removed from the OIG protocol. The provider still has the duty to make the disclosure within the 60-day period.

If the scope of overpayments is such that the amount cannot be determined within the 60-day deadline, providers must use the existing Extended Repayment Schedule process that is outlined in the Financial Management Manual. This process allows CMS to verify that timely repayment of the overpayment represents a true financial hardship to the provider. The ERS is the only means by which extended repayment of an overpayment will be permitted.

Conclusion

The efforts of Congress and CMS to collect overpayments may be laudable, but the agency has once again misjudged the complexity of the tasks it expects providers to perform and the time required to complete them. These proposed regulations beg for a strong response from the provider community, which should not hesitate to respond.