CMS Publishes Proposed Rule on Reporting and Returning Medicare Overpayments

February 21, 2012

The Centers for Medicare & Medicaid Services released a proposed rule implementing section 6402(a) of the U.S. Patient Protection and Affordable Care Act regarding reporting and returning overpayments under the Medicare program.

On February 16, 2012, the Centers for Medicare & Medicaid Services (CMS) published a proposed rule implementing section 6402(a) of the U.S. Patient Protection and Affordable Care Act (PPACA) regarding reporting and returning overpayments under the Medicare program. The proposed rule will have meaningful implications for provider compliance programs. Providers are encouraged to review the rule carefully and consider providing comments, which are due April 16, 2012.

Background

Section 6402(a) of PPACA established a new section 1128J(d) in the Social Security Act regarding reporting and returning Medicare and Medicaid overpayments. Specifically, section 1128J(d) requires a person who has received an overpayment to report and return the overpayment by the later of (i) 60 days after the overpayment was identified or (ii) the date any corresponding cost report is due. Significantly, the knowing and improper failure to return an overpayment is subject to liability under the Federal False Claims Act, which exposes the provider or supplier to treble damages and penalties.

The proposed rule implements section 1128J(d) as it relates to providers and suppliers of services under Medicare Parts A and B.

The Proposed Rule

What is an "overpayment" and when has it been "identified?"

CMS proposes to define an overpayment as "… any funds that a person receives or retains under title XVIII of the [Social Security] Act to which the person, after applicable reconciliation, is not entitled under such title." The preamble provides a number of examples of overpayments,

and clarifies the only overpayments by a cost reporting provider that can be delayed until the cost report is due are those payments that are reconciled by the cost report (*e.g.*, graduate medical education payments), not overpayments arising from claims-related issues, such as upcoding.

A person would be considered to have "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. Where a provider receives information about a potential overpayment, such as from an anonymous tip through a compliance hotline, the provider would have a duty to investigate the information. If the reasonable inquiry identifies an overpayment, the provider would then have 60 days from that time to report and return the overpayment. While CMS recognizes a provider may not be financially able to return the full amount of the overpayment within the 60-day period (directing such providers to use the existing Extended Repayment Schedule process), CMS does not address the critically important fact that providers will usually require more than 60 days to determine the actual amount of the overpayment for purposes of making a refund to the government.

With respect to overpayments that arise from violations of the Federal Anti-Kickback Statute, CMS acknowledges that in certain instances (*e.g.*, where the alleged kickback involves a physician and manufacturer) the provider is unaware of the kickback scheme. Even where the provider becomes aware of a potential kickback, the provider is often not in a position to evaluate whether an actual violation of the Anti-Kickback Statute has occurred. Thus, the preamble to the proposed rule states "providers who are not a party to a kickback arrangement are unlikely in most instances to have 'identified' the overpayment that has resulted from the kickback arrangement and would therefore have no duty to report it or … repay it." However, CMS indicates that even if a provider is not a party to a kickback arrangement, it may have a duty to *report* if it has sufficient knowledge of the arrangement. Although CMS indicates it would "refer the reported overpayment to OIG [Office of Inspector General] for appropriate action and would suspend the repayment obligation until the government has resolved the kickback matter," the reporting obligation in effect requires the provider to become a whistleblower, or possibly risk false claims accusations from a third-party whistleblower even if not from the government directly. Moreover, neither the proposed rule nor the Medicare contractors' voluntary refund processes provide a process for a provider to report without *payment* in such circumstances.

Interaction with Stark Law and OIG Self-Disclosure Protocols

For overpayments that are the subject of a disclosure made pursuant to the Medicare Self-Referral Disclosure Protocol (SRDP) or the OIG Self-Disclosure Protocol (OIG SDP), CMS would suspend the 60-day deadline for returning the overpayment. Under the proposed rule, a self-disclosure under the SRDP would not alleviate the provider's obligation to report the overpayment. However, a disclosure under the OIG SDP would be treated as a report for purpose of the reporting requirement. CMS requests comments on alternative approaches to prevent providers who make disclosures under the SRDP from having to make multiple reports of identified overpayments.

Procedural Issues

CMS proposes overpayments be reported using the existing voluntary refund process, under which overpayments are reported using a form established by the Medicare contractor.

CMS also proposes a 10-year look-back period (*i.e.*, the obligation to report and return an overpayment applies if the overpayment is discovered within 10 years of the date the overpayment was received). To facilitate this look-back period, CMS proposes to amend its regulations that generally limit the claims reopening period to four years to allow for a 10-year reopening period for claims resulting in a reported overpayment. CMS's stated rationale is to align the look-back period with the outer limits of the False Claims Act statute of limitations. This would mean SRDP disclosures would also be subject to the 10-year look-back period.

Future Guidance Regarding MAOs, Medicare Part D Plan Sponsors and MMCOs

The proposed rule only describes the reporting and returning requirements as they relate to Medicare Part A and B providers and suppliers, and expressly states the obligations of "other stakeholders," including Medicare Advantage Organizations (MAOs), Medicare Part D Plan Sponsors (Plan Sponsors) and Medicaid managed care organizations (MMCOs), "will be addressed at a later date." Nonetheless, CMS reminds such stakeholders that they are still subject to the reporting and returning requirements of Section 1128J(d), and could face potential liability under the Federal False Claims Act and the Federal Civil Monetary Penalties law, as

well as exclusion from federal health care programs for a failure to comply with these obligations.

The proposed rule also does not address any potential reporting and returning requirements that providers and suppliers may have under Medicare Parts C or D or the Medicaid Program, although such obligations may be addressed in providers and suppliers contracts with MAOs, Plan Sponsors and/or MMCOs.

Conclusion

The proposed rule has important implications for provider and supplier compliance programs and creates the potential for greater exposure under the Federal False Claims Act. Providers and suppliers should review the rule carefully and consider providing comments to CMS.