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*Practice Groups:*

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## Health Care Reform Client Alert Series: CMS Issues Proposed Regulations on Liability for Failure to Disclose and Return “Identified” Overpayments in 60 Days

*By Stephanie D. Wall and Richard P. Church*

### Overview

In May 2010, K&L Gates LLP published a client alert regarding the new statutory provision entitled “Reporting and Returning Overpayments” (“Overpayment Statute”) issued under the Patient Protection and Affordable Care Act of 2010 (“PPACA”).<sup>1</sup> [Click here](#) to view that alert. On February 16, 2012, the Centers for Medicare and Medicaid Services (“CMS”) released proposed regulations clarifying key concepts in the new disclosure/repayment requirement which is the topic of this alert.<sup>2</sup> While the regulations are proposed, CMS emphasizes that the overpayment obligation under PPACA is currently in effect.

The Overpayment Statute requires a provider, supplier, Medicaid managed care organization (Medicaid MCO), Medicare Advantage organization (MAOs), or prescription drug plan sponsor (PDP) who has received any overpayment (“Recipient”) to report and return such overpayment no later than 60 days after “identifying” the overpayment or the due date for any corresponding cost report, if applicable. An overpayment is defined to be any Medicare or Medicaid fund that a Recipient improperly received or retains after an applicable reconciliation.<sup>3</sup>

Any overpayment retained by the Recipient after this statutory deadline is deemed an obligation under the federal False Claims Act, which can subject a Recipient to as much as treble damages in regard to the overpayment as well as additional fines per claim and other penalties.<sup>4</sup>

The 60 day overpayment refunding requirement in PPACA left many questions regarding how to interpret and comply with this new requirement, most importantly, at what point has a Recipient “identified” an overpayment during the process of investigating a matter that may have resulted in an overpayment. CMS’s proposed regulations, which are applicable only to Part A and Part B providers and suppliers,<sup>5</sup> provide instruction on that question, as well as other key issues including when does a Recipient have a duty to investigate a potential overpayment, how does the overpayment reporting

<sup>1</sup> On March 23, 2010, President Obama signed into law the comprehensive health care overhaul known as PPACA, Pub. Law 111-148, as amended by the reconciliation bill (H.R. 4872) signed on March 30, 2010. See PPACA § 6402(a), 42 U.S.C. § 320a-7k(d).

<sup>2</sup> See Medicare Program; Reporting and Returning of Overpayments, 77 Fed. Reg. 9179 (proposed Feb. 16, 2012) [hereinafter Overpayment Proposed Rule].

<sup>3</sup> See 42 U.S.C. § 1320a – 7k(d)(4)(B).

<sup>4</sup> See 31 U.S.C. §§ 3729 – 3733.

<sup>5</sup> CMS indicates other Recipients (e.g., Medicaid MCOs, MAOs, and PDPs) and Medicaid overpayments will be addressed in a subsequent rule. See Overpayment Proposed Rule, 77 Fed. Reg. at 9180-81.

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provision interact with other Department of Health and Human Services self-reporting programs, and for how long of a period must Recipients investigate and refund overpayments.

### Identifying an Overpayment

While CMS does not expand upon the statutory definition of an overpayment set forth above, in commentary to the proposed rule, CMS offers some examples of overpayments, including:

- Medicare payments for noncovered services.
- Medicare payments in excess of the allowable amount for an identified covered service.
- Errors and nonreimbursable expenditures in cost reports.
- Duplicative payments.
- Receipt of Medicare payment when another payor had the primary responsibility for payment.<sup>6</sup>

More importantly, CMS defines when an overpayment has been “identified” under the Overpayment Statute, thus starting the 60 day clock. The proposed rule provides, “A person has 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 existence of the overpayment.”<sup>7</sup>

In this regard, CMS explains in commentary that in certain situations a provider/supplier may receive information that triggers an obligation to make a reasonable inquiry into whether there is an overpayment. If the investigation reveals an overpayment, then it must be reported and returned within 60 days.<sup>8</sup> Accordingly, CMS suggests that the failure to conduct an inquiry “*with all deliberate speed*” could result in a provider/supplier violating the Overpayment Statute for acting with reckless disregard or deliberate ignorance regarding a potential overpayment even if the provider or supplier did not have actual knowledge of the overpayment.<sup>9</sup>

In light of this guidance, CMS then offers some examples of “identified” overpayments, which include:

- A provider of services or supplier reviews billing or payment records and learns that it incorrectly coded certain services, resulting in increased reimbursement.
- A provider of services or supplier learns that a patient death occurred prior to the service date on a claim that has been submitted for payment.
- A provider of services or supplier learns that services were provided by an unlicensed or excluded individual on its behalf.
- A provider of services or supplier performs an internal audit and discovers that overpayments exist.
- A provider of services or supplier 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 – such as a new partner added to a group practice or a new focus on a

<sup>6</sup> See *id.* at 9181.

<sup>7</sup> See *id.* at 9187 (to be codified at 42 C.F.R. § 401.305(a)(2)).

<sup>8</sup> See *id.* at 9182.

<sup>9</sup> See *id.* (emphasis added).

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particular area of medicine – for the increase. Nevertheless, the provider or supplier fails to make a reasonable inquiry into whether an overpayment exists.<sup>10</sup>

With this said, in regard to the provider’s/supplier’s obligation to investigate a potential overpayment, CMS acknowledges limitations on the identification of overpayments that necessarily involve third parties, such as in connection with potential federal anti-kickback violations where the provider is not a party to the problematic arrangement. Such an example could include a device manufacturer allegedly paying a kickback to a physician to induce him/her to implant a device in a hospital patient. CMS notes that even if the hospital becomes aware of such an arrangement, it may be unable to evaluate whether there is an actual violation of anti-kickback statute.<sup>11</sup> CMS notes in regard to these situations:

[W]e believe that 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 ... to repay it. To the extent that a provider or supplier who is not a party to a kickback arrangement has sufficient knowledge of the arrangement to have identified the resulting overpayment, the provider or supplier must report the overpayment to CMS.<sup>12</sup>

In regard to cost report filings, CMS clarifies in the proposed rule that the later deadline permitting return of an overpayment on the due date of the cost report is only for providers that submit cost reports and in regard to an overpayment that would be reconciled on the cost report – for example, graduate medical education payments. In this regard, CMS makes clear that the 60 day deadline applies for all fee-for-service claims-related overpayments.<sup>13</sup>

Furthermore, CMS asserts that providers are required to report and repay any overpayments at the time they submit a cost report – regardless of whether it is the initial cost report or an amended cost report<sup>14</sup> except in cases when the provider (1) receives more recent CMS information on supplemental security income ratios (used to calculate disproportionate share hospital payment adjustments) and (2) knows that an outlier reconciliation will be performed.<sup>15</sup>

### How to Report and Return an Overpayment

In the proposed rule, CMS directs providers/suppliers to follow the existing voluntary refund process found in the Medicare Financial Management Manual as clarified by each Medicare contractor on its website.<sup>16</sup> CMS indicates its intent however to develop a uniform reporting form. Consistent with current practice, the overpayment refund must contain certain information, including, for example, how was the overpayment discovered; the total amount of the overpayment and how long the error existed; a description of any statistical methodology that was used to calculate the overpayment; and what steps the provider/supplier will put in place to ensure the error does not occur again.<sup>17</sup>

<sup>10</sup> See *id.*

<sup>11</sup> See *id.* at 9183.

<sup>12</sup> *Id.*

<sup>13</sup> See *id.* at 9182.

<sup>14</sup> See *id.* at 9181.

<sup>15</sup> See *id.* at 9184.

<sup>16</sup> The process is described in Chapter 4 of the Medicare Financial Management Manual (Pub. 100-06). See *id.* at 9181.

<sup>17</sup> See *id.*

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### Overpayment Reporting and the Self-Disclosure Protocols

Currently, there are self-disclosure protocols in place to voluntarily report violations of the federal fraud and abuse laws and corresponding overpayments through the Medicare Self-Referral Disclosure Protocol (“SRDP”)<sup>18</sup> and the OIG Self-Disclosure Protocol (“OIG SDP”). Both of these disclosure protocols authorize the enforcing agencies to settle overpayment claims at a reduced amount. While working similarly, CMS proposes to treat submission under these protocols differently under the Overpayment Statute.

Under the OIG SDP, CMS proposes that the 60 day deadline is suspended when OIG acknowledges receipt of a submission to the disclosure protocol and that such notice would satisfy the reporting obligation under the Overpayment Statute. However, with respect to the SRDP, while CMS also proposes to suspend the 60 day deadline when CMS acknowledges receipt of a disclosure by the provider/supplier, CMS is proposing to still require the provider/supplier to report the overpayment separately through the Overpayment Statute process. CMS is soliciting comments on this approach. Under both scenarios, CMS proposes that the 60 day deadline to actually make the repayment will be suspended until a settlement agreement is entered into by the parties or the provider/supplier withdraws or is removed from the disclosure process.<sup>19</sup>

### Lookback Period

In one of the most surprising elements of the proposed rule, CMS suggests that a provider’s/supplier’s duty to identify, report and return an overpayment under the Overpayment Statute exists for a period of 10 years from the date the overpayment was received, because 10 years is the outer limit under the False Claims Act statute of limitations. Under the False Claims Act, such a claim must be brought by the later of 6 years after the violation occurred or 3 years after the date when facts material to the right of action are known or reasonably should have been known, but in no event more than 10 years after the date on which the violation was committed.<sup>20</sup> While administrative reopening of claims is normally limited to at most four (4) years absent reliable evidence of fraud or similar fault,<sup>21</sup> CMS also proposes to amend the reopening rule to permit reopening of claims associated with self-reported overpayments for 10 years to accommodate claims reprocessing.<sup>22</sup>

### Recommendations

CMS makes clear in commentary to the proposed rule that providers and suppliers must comply with the Overpayment Statute at the present time. As such, the proposed rule is not only an important first step in the rule-making process regarding the Overpayment Statute, but it also provides significant guidance as to CMS’s view of how providers and suppliers should be operating presently under the Overpayment Statute.

<sup>18</sup> See PPACA, Pub. L. No. 111-148, § 6409, 124 Stat. 125, 772 (2010).

<sup>19</sup> See Overpayment Proposed Rule, 77 Fed. Reg. at 9182-83.

<sup>20</sup> See 31 U.S.C. § 3731(b).

<sup>21</sup> See 42 C.F.R. § 405.980.

<sup>22</sup> See Overpayment Proposed Rule, 77 Fed. Reg. at 9184.

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In this regard, the proposed rule is particularly noteworthy in assisting providers and suppliers in understanding CMS’s expectations in regard to the type of information that should trigger an investigation of a potential overpayment, the period of time that providers and suppliers might potentially be expected by government regulators to have reviewed, and when the 60 day refund clock for an “identified” overpayment will begin ticking.

Given the severity of the penalties for failing to report and return overpayments and the aggressive position that CMS has taken in regard to the Overpayment Statute, providers and suppliers may also want to consider providing feedback to CMS on the implications of the proposed rule on their operations. CMS is accepting comments on the proposed regulations until *April 16, 2012*.

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### Authors:

**Stephanie D. Wall**

stephanie.wall@klgates.com

+1.412.355.8364

**Richard P. Church**

richard.church@klgates.com

+1.919.466.1187

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