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OVERPAYMENT RULE PROPOSED

On February 16, 2012, the Center for Medicare & Medicaid Services ("CMS") published a proposed rule for providers and suppliers as described below concerning the reporting and returning of overpayments under the Medicare program. This proposed rule implements Section 6402(a) of U.S. Patient Protection and Affordable Care Act ("PPACA") and will affect certain providers and suppliers. Comments to this rule are due by April 16, 2012.

Overview

Section 6402(a) of PPACA established a new section 1128J(d) of the Act titled "Reporting and Returning Overpayments." This provision requires a person who has received an overpayment to report and return it by the later of (1) the date which is 60 days after the date on which the overpayment is identified, or (2) the date any corresponding cost report is due, if applicable. It is important to note that this provision provides that any overpayment retained by a person after the deadline for reporting and returning an overpayment is an obligation under the False Claims Act, which has the potential for treble damages and penalties.

What is an Overpayment?

The proposed rule embraces the definition set forth in PPACA for the term "overpayment," which it defines as " ...any funds that a person received or retains under title XVIII of the Act to which the person, after applicable reconciliation, is not entitled under such title." The preamble to the proposed rule provides some examples of an overpayment under this proposed definition, which includes the following:

- 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.
- Duplicate payments.
- Receipt of Medicare payment when another payor had the primary responsibility for payment.

Additionally, the proposed rule and preamble provide some information about the applicable reconciliation in the cost report context.

When is the Overpayment Identified?

Under the proposed rule, 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 overpayment." The preamble notes that "in some cases, a provider or supplier may receive information concerning a potential overpayment that creates an obligation to make a reasonable inquiry to determine whether an overpayment exists. If the reasonable inquiry reveals an

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overpayment, the provider then has 60 days to report and return the overpayment. On the other hand, failure to make a reasonable inquiry, including failure to conduct such inquiry with all deliberate speed after obtaining the information, could result in the provider knowingly retaining an overpayment because it acted in reckless disregard or deliberate ignorance of whether it received such an overpayment."

The preamble provides a number of examples of when an overpayment has been identified:

- 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 particular area of medicine—for the increase. Nevertheless, the provider or supplier fails to make a reasonable inquiry into whether an overpayment exists. [ ]

Process

CMS proposes to use the existing voluntary refund process and renamed it the "self-reported overpayment refund process."

With respect to the 60 day repayment time frame, there are certain provisions concerning the financial limitations of the provider to meet this timeframe. If the provider is not able to meet this time frame due to financial limitations, the provider would use the Extended Repayment Schedule process.

One of the open issues that remains is that it sometimes takes the provider more than 60 days to determine the amount of the overpayment in order to make the refund. This varies based on a number of factors, such as the types and complexity of issues.

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Look Back Period

The proposed rule provides for a 10 year look back period. Specifically, an overpayment must be reported and returned in accordance with this rule only if "a person identifies the overpayments within 10 years of the date that the overpayment was received." This time period was chosen since this is consistent with the outer limit of the statute of limitations for the False Claims Act.

Other Disclosure Protocols

The proposed rule provides some guidance about the interplay of this rule with the current Medicare Self-Referral Disclosure Protocol ("SRDP") as well as the OIG Self-Disclosure Protocol and other OIG guidance. Additionally, the preamble seeks comments regarding the SRDP about the alternate approaches that would allow providers and suppliers to avoid making multiple reports of identified overpayments.

Anti-Kickback Statute

With respect to overpayments that arise from violations of the Anti-Kickback Statute, CMS acknowledges that the provider may be unaware of the kickback arrangement in certain circumstances. There is a discussion in the preamble regarding this issue.

Application

The preamble notes that the rule is proposing to implement the provisions of Section 1128J(d) of the Act only as they relate to Medicare Part A and Part B providers and suppliers. The preamble does note that other stakeholders, including MAOs, PDPs and Medicaid MCOs, will be addressed at a later date. Furthermore, CMS cautions all stakeholders about the current statutory requirements under PPACA and the potential False Claims Act liability, Civil Monetary Penalties Law liability, and exclusion from federal health care programs for the failure to report and return an overpayment.

Conclusion

As noted from above, this proposed rule has significant implications for providers and suppliers on a number of fronts.

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