February 24, 2012

CMS Proposes to Crack Down on Delinquent Refund of Medicare Overpayments

The Centers for Medicare & Medicaid Services (CMS) plans to get aggressive about Medicare overpayments. The agency has recently proposed a rule requiring providers and suppliers receiving funds under the Medicare program to report and return any overpayment within 60 days after the date on which the overpayment was identified.[1] The proposed rule is designed to implement a provision in the Affordable Care Act.[2] Failure to report and refund overpayments within the specified time frame could result in liability under the False Claims Act[3] and other penalties, including exclusion from federal healthcare programs. An "overpayment" is defined as any funds that a provider or supplier is not entitled to retain. Such overpayment could include:

- 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.[4]
- Duplicate payments.

Providers and suppliers must submit a report and pay the refund within 60 days after the overpayment is "identified." An overpayment is identified when a person acts with actual knowledge of, in deliberate ignorance of or with reckless disregard to its existence. A provider or supplier may receive information (e.g., via an anonymous hotline call) 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 overpayment, the provider has 60 days to report and return the overpayment. Failure to investigate under these circumstances can result in the provider or supplier knowingly retaining the overpayment because it acted in deliberate ignorance or reckless disregard of whether it received such overpayment. Knowingly retaining an overpayment can constitute a false or fraudulent claim under the False Claims Act. The report required to be filed with the refund must state the reason for the overpayment, for example: (i) incorrect service date, (ii) duplicate payment, (iii) incorrect CPT code, (iv) insufficient documentation and (v) lack of medical necessity. The report must also provide additional information, including (1) how the error was discovered, (2) a description of the corrective action plan implemented to ensure the error does not recur, and (3) whether the provider or supplier has a corporate integrity agreement with the Office of Inspector General (OIG) or is under the OIG voluntary disclosure program. In addition to the 60-day requirement, the proposed rule would impose a 10-year look-back period. Under the look-back provision, overpayments identified within 10 years of the date received must be reported and returned. Ten years was selected because this is the outer limit of the False Claim Act's statute of limitations. Such a look-back provision would seem to place a burden on providers and suppliers: all a qui tam whistleblower has to do is allege that an overpayment was received within the past 10 years and the provider or supplier would be obliged to open an extensive investigation to ascertain whether the allegation has merit. It should be noted that this proposed rule applies only to Medicare Part A and Part B providers and suppliers. It does not, at this time, apply to Medicare Advantage organizations, prescription drug plan sponsors and Medicaid managed care organizations. CMS seeks comments on the proposed rule through April 16, 2012. For more information on the proposed rule or its application to your business, please contact any of the individuals listed, members of the Healthcare Compliance practice group.

[1] Medicare Program; Reporting and Returning of Overpayments, file code CMS-6037-P (proposed Feb. 16, 2012) at http://federalregister.gov/a/2012-03642.

[2] Patient Protection and Affordable Care Act (Pub. L. 111-148) as amended by Health Care Education Reconciliation Act of 2010 (Pub. L. 111-152), collectively known as the Affordable Care Act. Section 6402(a) of the Affordable Care Act establishes a new section 1128J(d) of the Social Security Act (title XVIII) titled "Reporting and Returning of Overpayments."

[3] False Claims Act, 31 U.S.C. 3729 *et seq.* The government has the authority to impose severe penalties on contractors who knowingly present false or fraudulent claims to the government for payment or approval or to avoid or decrease an obligation owed to the government. Liability under the act can be established in the absence of actual knowledge of the falsity of information where it can be shown that a contractor submitted claims in deliberate ignorance, or in reckless disregard, of the truth or falsity of the information.

[4] Overpayments can also result from estimated payments made to providers or suppliers for services with the knowledge that a reconciliation of those payments to actual costs will be done when the actual costs or related information becomes available. In those situations (e.g., payments for graduate medical education), the overpayment is due either 60 days after it has been identified or on the date any cost report is due, whichever is later.