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Client Advisory:
CMS Proposes Overpayment Refund Rule

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I. Background

The Affordable Care Act ("ACA") requires that Medicare and Medicaid "overpayments" be reported and returned by the later of (i) 60 days after the overpayment was "identified" or (ii) the date any corresponding cost report is due (if applicable). ACA § 6402(a).

This requirement became effective on March 23, 2010—so, health care providers have been subject to it for nearly two years.

It applies to providers of services, suppliers, Medicaid managed care organizations, Medicare Advantage organizations, and Prescription Drug Plan sponsors. Violations can result in liability under the False Claims Act and the Civil Monetary Penalties Law, and exclusion.

Health care providers have questions about how the ACA requirement will be interpreted and enforced. The questions arose because of the steep penalties, the short 60-day reporting period, and uncertainty about the meaning of certain key phrases—e.g., when is an overpayment "identified"?

On February 16, 2012, CMS issued a long-awaited *proposed* rule to implement the overpayment requirement. Although the rule is only *proposed* and not yet final, it provides certain insights about how CMS views the refund obligation. (77 Fed. Reg. 9179 (Feb. 16, 2012).)

These insights may help providers. However, the rule is not final and CMS may modify its position in the final rule. Also, the ACA's refund obligation remains in effect, irrespective of whether any rule is finalized.

II. The Proposed Rule

Under the proposed rule, a provider or supplier with an "identified" overpayment under Medicare Part A or B must report and return the overpayment by the later of (i) 60 days after the overpayment was identified and (ii) the date any corresponding cost report is due, if applicable. Certain elements of this requirement are discussed below.

Definition of Overpayment

An overpayment means any funds that a provider or supplier received or retained under the Medicare program to which the person is not entitled under the program. CMS provided the following non-surprising examples of overpayments:

- 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.

For funds that are subject to cost reporting, an overpayment does not exist until after the applicable cost report reconciliation occurs.

Refunding "Claims" versus "Cost Report" Overpayments

If an overpayment is "claims" related, the overpayment must be reported and returned within 60 days of "identification." However, for providers that submit cost reports, if the overpayment is such that it would generally be reconciled on the cost report, the provider would be permitted to report and return the overpayment either 60 days from the identification of the overpayment or on the date the cost report is due, whichever is later.

For example, issues involving upcoding must be reported and returned within 60 days of identification because the upcoded claims for payment are not submitted to Medicare in the form of cost reports. However, for an overpayment that would generally be reconciled on the cost report, such as overpayments related to graduate medical education payments, the provider must report and return the overpayment either 60 days after it has been identified or on the date the cost report is due, whichever is later.

"Identified" Overpayments

The "identification" of an overpayment triggers a provider's reporting and refunding obligations, including the commencement of the 60-day period. Hence, the meaning of "identified" is critical.

A person has "identified" an overpayment if the person has "actual knowledge of the existence of the overpayment." Apparently, this standard is met in the following situations—*even though the exact amount of the overpayment may not yet be determined*:

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

Through these examples, CMS seemed to imply that "actual knowledge" is present if the provider knows of an overpayment issue, even if the provider has not determined the amount of the overpayment. CMS needs to clarify this matter in the final rule.

In addition, a person is deemed to have "identified" an overpayment if the person acts i*n reckless disregard or deliberate ignorance of the existence of the overpayment*. CMS has explained this situation as follows: If a provider receives "information concerning a potential overpayment" or has "reason to suspect an overpayment," the provider is obligated to investigate the matter timely, reasonably, and with all deliberate speed. If the investigation reveals or confirms an overpayment, then the person has "identified" an overpayment, and must report and return the overpayment within 60 days (assuming no cost report is involved). *However, if the provider fails to make any reasonable investigation, the provider may be found to have acted in reckless disregard or deliberate ignorance of any overpayment*.

For example, if a provider receives an anonymous compliance hotline complaint about a potential overpayment, the provider has an obligation to investigate. If the complaint is confirmed, the provider has "identified" an overpayment and must a report and refund within 60 days (assuming there is no applicable cost report). If the provider fails to properly investigate, the provider may be found to have acted in reckless disregard or deliberate ignorance of any overpayment and may be exposed to liability under the ACA and rule.

How to Make the Report and Refund

CMS proposes using the existing voluntary refund process, pursuant to which overpayments are reported using a form that each Medicare contractor makes available on its Web site. The information reported would contain:

- Provider/supplier's name.
- Provider/supplier's tax identification number.
- How the error was discovered.
- The reason for the overpayment.
- The health insurance claim number, as appropriate.
- Date of service.
- Medicare claim control number, as appropriate.
- Medicare National Provider Identification (NPI) number.
- Description of the corrective action plan to ensure the error does not occur again.
- Whether the person has a corporate integrity agreement with the OIG or is under the OIG Self-Disclosure Protocol.
- The timeframe and the total amount of refund for the period during which the problem existed that caused the refund.
- If a statistical sample was used to determine the overpayment amount, a description of the statistically valid methodology used to determine the overpayment.
- A refund in the amount of the overpayment. A person may request an extended repayment schedule as that term is defined in § 401.603.

(Parties who have made or plan to make disclosures under the OIG's Self-Disclosure Protocol or the Medicare Self-Referral Disclosure Protocol should consult with their attorney concerning the interplay between the Protocols and the ACA and proposed rule.)

Future Rules

The proposed rule applies only to overpayments to "providers" and "suppliers" under "Medicare Parts A and B." While the ACA provision itself applies to additional programs and provider-types, they apparently will be addressed in subsequent rules. However, the insights provided by the proposed rule may be helpful for all stakeholders.

III. Conclusion

Remember that health care providers are currently subject to the ACA § 6402(a) and its requirements for reporting and returning overpayments, even though a final rule has not been issued. The failure to comply with § 6402(a) can result in liability under the False Claims Act and the Civil Monetary Penalties Law, and result in exclusion. Because questions remain concerning the interpretation of § 6402(a) and because overpayment situations involve varying facts, health care providers will need to proceed diligently and carefully in evaluating and making refunds. One thing is clear: CMS believes that providers should proceed reasonably and with "all deliberate speed" to investigate potential or suspected overpayments.