Health Law
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CMS Issues Final Rule Regarding Reporting and Returning Medicare Overpayments

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The Centers for Medicare and Medicaid Services (CMS) on February 11, 2016, issued its final rule requiring providers receiving payments from Medicare to report and return overpayments 60 days after an overpayment is identified, implementing the Affordable Care Act's requirement to return Medicare overpayments. Retention of Medicare monies after this time could expose the provider to liability under the False Claims Act. This final rule, which is effective March 14, 2016, contains several significant changes from the proposed rule.

After the proposed rule was published in 2012, questions arose as to when an overpayment is "identified" for purposes of starting the 60-day clock to report and return. There was a concerning case in the Southern District of New York in 2015, when the federal district court in *Kane v. Healthfirst, Inc. et al. and US v Continuum Health Partners et al.* ruled that a provider is required to report and return money to Medicare even if the precise amount has yet to be determined. This final rule instead states that a person has identified an overpayment when the person has or should have, through the exercise of reasonable diligence, determined that the person has received an overpayment and quantified the amount of the overpayment.

In the commentary to the regulations (not in the regulations themselves), CMS states that providers may conduct a timely investigation before the 60-day deadline is triggered. The commentary states that providers may have up to six months from receipt of credible information to do a good faith investigation (e.g., to quantify the amount of the overpayment), but warns that such investigations must be prioritized and may require the devotion of resources and time. Therefore, providers have up to a total of eight months (six months for timely investigation and 60 days for reporting and returning an overpayment) after first becoming aware of a possible overpayment to comply with the reporting and return period.

The law defines "overpayment" as any funds that a person has received or retained under Title XVIII (Medicare) to which the person, after applicable reconciliation, is not entitled. Examples given 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
- Duplicate payments
- Receipt of Medicare payment when another payer had the primary responsibility for payment
- Overpayments that arise due to a violation of the Anti-Kickback Statute (compliance with the Anti-Kickback Statute is a condition of payment) or the Stark law (note the changes to the Stark regulations in late 2015)

Whereas the proposed rule stated that overpayments must be reported and returned if a person identifies the overpayment within *10 years* of

the date it was received, the final rule changes the lookback period to *six years*. Therefore, a provider who has identified a possible overpayment must (if the overpayment is not time limited because tied to a specific claim or claims) determine if the issue may have occurred over time, and if so, look back up to six years if appropriate. This six-year lookback period applies even if the overpayment is identified through a Recovery Audit Contractor (RAC) audit, which has a three-year timeframe. (RAC audit findings, as well as other Medicare contractor findings, are credible information of at least a potential overpayment, requiring a review of the audit findings and a lookback if the facts warrant).

CMS recognizes in the rule commentary that under the existing voluntary refund process, reports of overpayments are made using a form that each Medicare contractor makes available on its website. Since the final rule permits using the most applicable process set forth by the Medicare contractor to report and return overpayments, CMS has not included a specific list of data necessary to be reported with the repayment, as the information required may vary by contractor. CMS states that they will consider creating a standardized form in the future. As is currently the case, the final rule allows additional processes beyond the voluntary refund process. Providers may use the claims adjustment, credit balance, self-reported refund process or another process allowed by its Medicare contractor to return overpayments. Additionally, a refund form does not have to be completed for each account identified as an overpayment; one single refund form with an attachment that contains the required elements is acceptable.

There is no minimum threshold amount for the voluntary refund process. Although the CMS commentary recognizes the New York State Office of Medicaid Inspector General (OMIG) $5,000 reporting threshold, CMS states that even under the New York OMIG process, overpayments of any size must be returned. If a provider needs additional time to return the overpayment due to financial limitations, it can request payment over time using the Extended Repayment Schedule (ERS) as outlined in Publication 100-06, Chapter 4 of the Financial Management Manual.

CMS also recognizes that overpayments associated with cost reports should be reported through the existing cost report reconciliation process. Hospice and home health providers who may have received cap overpayments are not responsible to refund until their Medicare Administrative Carrier (MAC) calculates the final cap amount.

The 60 days is tolled if a provider has made a self-disclosure under the CMS Voluntary Self-Referral Disclosure Protocol or the OIG Self-Disclosure Protocol, while the provider is negotiating a potential settlement.

This rule applies to Medicare Parts A and B only. The rules for reporting and returning of overpayments in Medicare Parts C and D were published in separate rulemaking (79 FR 29843 published on May 23, 2014).

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