The Law Offices of
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Long-Term Acute Care Hospital Legal Alert

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CMS Proposed Rule on Overpayment Reporting and Repayment

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On February 16, 2012, the Centers for Medicare & Medicaid Services ("CMS") published a proposed rule to implement the health reform law mandate that Medicare providers and suppliers report and return overpayments within 60 days.[1] The requirement is based in section 6402(a) of the Patient Protection and Affordable Care Act, as amended by the Health Care Education Reconciliation Act of 2010 (collectively, the "Affordable Care Act"), which created new section 1128J(d) of the Social Security Act ("SSA" or "the Act").[2] Medicare Part A and Part B providers and suppliers[3] have been waiting for CMS to clarify this requirement for almost two years. Unfortunately, the proposed rule falls short by raising new questions that continue to make it difficult for providers and suppliers to know what their obligations are for reporting and repaying detected overpayments. In addition, CMS uses the proposed rule to bring routine payment corrections closer to the realm of Medicare fraud and abuse, where False Claims Act liability and civil monetary penalties raise the stakes for noncompliance.

Comments on the proposed rule must be received by CMS prior to **April 16, 2012**. Please let us know if you have questions about the proposed rule or would like assistance preparing a comment letter.

Scope. Section 1128J(d) imposes two obligations on a person who has received an overpayment:

> (1) report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and
> (2) notify the party to whom the overpayment was returned in writing of the reason for the overpayment.[4]

An "overpayment" is defined as any Medicare or Medicaid funds that a person receives or retains to which the person, after applicable reconciliation, is not entitled.[5] An overpayment must be returned by the later of 60 days after the overpayment is identified or, for claims that are settled via cost report submission, the date the corresponding cost

report is due.[6]

Identifying Overpayments. Section 1128J(d) of the Act and the proposed rule provide alternative timeframes for reporting and returning an overpayment. For providers that submit cost reports, an overpayment that "would generally be reconciled on the cost report" must be reported either when the cost report is due or 60 days after the overpayment is identified, whichever is later.[7] However, if an overpayment is related to a paid claim, it must be reported within 60 days of being identified, no matter where the overpayment falls in the cost reporting cycle.[8] While the term "identified" is not defined in Section 1128J(d), the terms "knowing and knowingly" are defined in Section 1128J(d)(4)(A) despite not being used at all in Section 1128J(d).

In the proposed rule, CMS suggests that Congress intended for the definitions of "knowing and knowingly" to guide the determination of whether a provider has "identified" an overpayment.[9] Section 1128J(d)(4)(A) adopts the definitions of "knowing and knowingly" used in the False Claims Act at 31 U.S.C. § 3729(b)(1). Thus, CMS proposes that a provider has identified an overpayment when it "has actual knowledge of the existence of the overpayment or acts in reckless ignorance of the existence of the overpayment."[10] To illustrate, CMS gave the following examples of a provider identifying an overpayment, including when:

- Incorrect coding leads to increased reimbursement;
- A patient died before the service date submitted for payment;
- Claimed services were provided by an unlicensed or excluded individual;
- An internal audit discovers overpayments;
- A government agency informs the provider of a potential overpayment and the provider fails to conduct an adequate inquiry;
- A provider experiences a sudden unexplained increase in Medicare revenue.[11]

The 60-Day Deadline. The proposed rule suggests two exceptions to the 60-day requirement. When the Medicare Self-Referral Disclosure Protocol ("SRDP") is followed for physician self-referral (Stark) issues, the overpayment still must be reported but the obligation to return the overpayment is suspended under Section 1128J(d) due to possible resolution through the SRDP.[12] Likewise, when possible fraud is reported using the OIG Self-Disclosure Protocol ("OIG-SDP") return of the overpayment is suspended pending the outcome of the investigation.[13] The report through OIG-SDP would satisfy the proposed rule.

Reconciliation and the Cost Report Deadline. When submission of the cost report is the "applicable reconciliation" for a particular overpayment, the deadline is the later of 60 days after the overpayment is identified or when the cost report is due. In two instances, though, CMS noted that reconciliation occurs after the cost report is submitted. First, in the event that the Social Security Income ratio used to calculate a provider's Disproportionate Share Hospital adjustment changes after the provider submits its cost report, the provider will not be required to amend its cost report or return the related overpayment until the final reconciliation of the cost report occurs.[14]

Second, and of particular interest to LTACHs, if Medicare payments are subject to outlier reconciliation after submission of the cost report, the actual amount of the overpayment will not be known when the cost report is due. Accordingly, CMS is *not* requiring providers to estimate the overpayment and make repayment before reconciliation occurs. Instead, providers cay delay repayment until the precise amount is determined by the Medicare contractor during outlier reconciliation.[15]

The proposed rule does not address the statutory protection that providers are afforded under Section 935 of the Medicare Modernization Act, which prohibits the recoupment of overpayments by Medicare contractors during the first two levels of the claims appeal process if appeals are filed quickly enough. Presumably, the requirement to refund overpayments would yield to these appeal rights, but it would be helpful if CMS clarified this issue in the final rule.

The Logistics of Reporting and Repaying. The proposed rule would require providers to use the existing voluntary refund process described in the Medicare Financial Management Manual, CMS Publication 100-06, Chapter 4. The process will be renamed the "self-reported overpayment refund process." As part of this process, the provider must refund the overpayment to its Medicare payment contractor and, using the overpayment form from the contractor, provide information about the overpayment including a reason for the overpayment, such as "[i]ncorrect service date," "duplicate payment," "incorrect coding," "insufficient documentation," or "lack of medical necessity."[16] Additionally, if a provider cannot make a large repayment within the applicable deadline, it must apply for an Extended Repayment Schedule by demonstrating hardship.[17]

Enforcement. The failure to follow these overpayment reporting and repayment requirements will expose providers to potential liability under the False Claims Act for "knowingly conceal[ing] or knowingly and improperly avoid[ing] or decreas[ing] an obligation to transmit money or property to the Government."[18] In addition, Section 6402 of the

Affordable Care Act amended Section 1128A(a)(10) of the Act such that when a person, not including a beneficiary, "knows of an overpayment … and does not report and return the overpayment" the person is subject to a civil monetary penalty or possible exclusion from participation in the Federal health care programs. Importantly, CMS is proposing to borrow the 10-year lookback period for overpayment reporting to coincide with the longest statute of limitations under the False Claims Act, rather than the shorter four year lookback period for reopening claims.[19] *This means that any overpayments identified within 10 years of the overpayment must be reported and repaid.*

Impact on LTACHs. If CMS finalizes this rule as proposed, LTACHs along with other providers and suppliers will be forced to assume greater responsibility for reporting and repaying identified Medicare overpayments quickly. They will also be exposed to greater potential financial risk as the overpayment lookback period is expanded from 4 years to 10. At the same time, CMS has not clarified when a provider or supplier "has actual knowledge" of an "identified" overpayment to trigger the 60-day reporting and repayment requirement. Although CMS states that the failure to make a reasonable inquiry about a potential overpayment can result in the provider "knowingly retaining an overpayment," the precise point in time when an overpayment is "identified" remains subject to interpretation. Fortunately, CMS has clarified for LTACHs that hospitals need not act on overpayments subject to outlier reconciliation until the Medicare contractor has completed such reconciliation using the filed cost report.

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1. Reporting and Returning of Overpayments, 77 Fed. Reg. 9179 (Feb. 16, 2012).
2. Codified at 42 U.S.C. § 1320a-7k(d).
3. 77 Fed. Reg. at 9180.
4. SSA § 1128J(d)(1).
5. *Id.* at § 1128J(d)(4)(B).
6. *Id.* at § 1128J(d)(2).
7. 77 Fed. Reg. at 9182.
8. *Id.*
9. *Id.*
10. *Id.* at 9187.
11. *Id.* at 9182.
12. *Id.* at 9182-83.
13. *Id.* at 9183.
14. *Id.* at 9184.
15. *Id.*
16. *Id.* at 9181.
17. *Id.* at 9183.
18. SSA § 1128J(d)(3).
19. 77 Fed. Reg. at 9184.

About Us

The Law Offices of Jason M. Healy PLLC is a health care law firm that focuses exclusively on legal issues affecting health care providers. We help health care providers and their trade associations understand Medicare and Medicaid laws and regulations. We also represent health care providers in reimbursement audits, appeals, and litigation. Located in Washington, DC, we are well positioned to provide legal support for advocacy efforts. Our principal, Jason M. Healy, is a health care lawyer with over 14 years of experience with the array of legal issues facing health care providers.

Please feel free to reach us at the phone number or email address above if we can be of assistance. We look forward to working with you and your company.