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Foulston Siefkin Health Care Issue Alert

CMS Issues *Final* 60-Day Overpayments Rule: It's All About A Provider's Risk Tolerance

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On February 12, 2016, the Centers for Medicare & Medicaid Services (CMS) published the long-awaited Final Rule regarding the reporting and returning of Medicare Part A and B overpayments. Providers have been left in a state of confusion since enactment of Section 6402(a) of the Affordable Care Act (ACA) nearly six year ago. Section 6402(a) requires providers to return and report identified overpayments within 60 days. A provider's knowing retention of an overpayment after 60 days may be pursued as a violation of the False Claims Act.

The Proposed Rule published in February 2012 left providers with more questions than answers. The ruling on a motion to dismiss in *Kane v. Healthfirst* in August 2015 only fueled the sense of uncertainty. In the Final Rule, CMS does provide some much needed clarification, however, questions still remain.

Identification

In the Proposed Rule, CMS stated that an overpayment is "identified" if the provider: (1) has "actual knowledge" that an overpayment exists; or (2) acts in "reckless disregard" or "deliberate indifference" of the overpayment. CMS ditched these ambiguous terms in the Final Rule adopting a "reasonable diligence" standard. Under the Final Rule, an overpayment has been identified when a "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."

"Reasonable diligence" includes: (1) ***proactive compliance activities*** to monitor for the receipt of overpayments; and (2) reactive investigations conducted in response to obtaining credible information of a potential overpayment. CMS is sending a clear message to providers that they must proactively look for overpayments. Providers that undertake no or minimal proactive compliance activities do so at their own risk.

Quantification

This is a big win for providers. One of the most significant clarifications of the Final Rule is that an overpayment is not "identified" until the amount of the refund has been "quantified." According to CMS, quantification of the amount may be determined using statistical sampling, extrapolation methodologies, and other methodologies, as appropriate.

Timeliness

Another significant pro-provider clarification is that providers have time to complete a reasonable investigation before the 60-day clock starts running. The clock does not start ticking until after the reasonable diligence is completed or on the day the person received credible information of a potential overpayment if the person failed to conduct reasonable diligence and the person in fact received an overpayment. The reasonable diligence standard can be demonstrated through the timely, good faith investigation of credible information. CMS advises providers to keep records that accurately document their reasonable diligence efforts to establish compliance with the Rule.

At most, the investigation period may take 6 months from receipt of the credible information, except in extraordinary circumstances. The Final Rule does acknowledge that complex investigations, like a Stark Law violation, fall within the

extraordinary circumstances exception. Thus, providers will have a total of 8 months from the receipt of credible information to comply with this Rule – 6 months for timely investigation and 2 months for reporting and returning any overpayments.

Six-Year Lookback Period

CMS reduced the lookback period from the required 10 years in the Proposed Rule to 6 years in the Final Rule. The 6-year lookback period will be measured from the date the person identifies the overpayment. To accommodate this lookback period, CMS amended the language concerning reopenings at the provider's request, extending the period from 4 to 6 years. In addition, self-referral overpayments reported in accordance with the CMS Voluntary Self-Referral Disclosure Protocol (SRDP) will be subject to the 6-year lookback period.

Reporting & Repayment

CMS clarified that providers may use an applicable claims adjustment, credit balance, self-reported refund process, or another appropriate process to report and return overpayments. This means that providers may utilize the current claims adjustment and reversal process for Part A and B claims, noting an adjustment reason code on the claim. The claim is then reprocessed and the overpayment is recouped via the remittance advice. Hospitals may also utilize the Credit Balance Report (CMS-838) to return overpayments.

In the event a Medicare contractor refuses to accept a voluntary refund, CMS acknowledged that a provider has satisfied all of the obligations of the Rule when the provider in good faith follows the appropriate process to return the overpayment.

Many commenters requested that CMS adopt a minimum monetary threshold as the costs and resources devoted to reporting and returning small-dollar overpayments often exceeds the amount of the overpayment. However, CMS was unwilling to establish a regulatory minimum threshold amount for the voluntary refund process. CMS did note that it was considering such a threshold for cost report-related overpayments.

Parting Takeaway

A recurrent theme throughout the Final Rule is the importance of an effective compliance program in meeting the "reasonable diligence" requirement. The resources devoted to compliance program activities are often driven by the provider's risk tolerance. Does a provider roll the dice on identifying and reporting small-dollar overpayments? Or does the provider turn over every rock? Is a single overpaid claim credible evidence of a systemic problem? Or is it just an isolated incident requiring repayment and nothing more? These are the types of questions providers will be forced to answer and the answers will vary depending upon risk tolerance. Providers must ensure that their internal compliance policies and procedures are consistent with the Final Rule and their corresponding level of risk tolerance.

The full text of the Final Rule can be found at https://www.federalregister.gov/articles/2016/02/12/2016-02789/medicare-program-reporting-and-returning-of-overpayments. The Final Rule is effective on March 14, 2016.

For More Information

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