Modern Healthcare

Providers must report Medicare overpayments going back six, not 10 years

By Virgil Dickson | February 11, 2016

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The CMS has finalized a controversial rule that will require providers to return Medicare[1] overpayments.

The Affordable Care Act compels providers to return overpayments within 60 days of identifying them. Failing to report overpayments can result in liability under the False Claims Act. That means a provider could either face financial penalties or be excluded from billing the CMS programs.

The CMS estimates that the annual administrative costs for industry reporting and returns of overpayments will fall between $120 million and $200 million. It did not estimate how much money it may recover.

The rule, first proposed in 2012, alarmed many healthcare organizations when the

CMS floated the idea that providers would be liable for returning Medicare overpayments going back as far as 10 years. The American Hospital Association and the Federation of American Hospitals criticized the proposal at the time, saying the time frame was unreasonable.

In response to these objections, the CMS said the period will now be six years. Many providers and suppliers retain records and claims data for between six and seven years based on various existing federal and state requirements.

"Thus, we believe our final rule does not create additional burden or cost on providers and suppliers in this regard," the CMS said in the rule.

Still, industry stakeholders were disappointed.

"We had requested a three year look back period, but six is better than 10," said Wanda Filer, President of the American Academy of Family Physicians.

For years, the CMS has told Medicare Administrative Contractors (MACs) that they could only reopen claims from the past 48 months, or four years for review of potentially improper payments.

"We appreciate the CMS's recognition of the burden extended look back period places on hospitals," said Sean Brown, spokesman for The Federation of American Hospitals, "We continue to believe, however, that six years is still too much. A four-year look back period is more appropriate and consistent with existing Medicare rules for reopening payment determinations."

Others agreed.

The rule "still places healthcare providers in a position of having to spend too much time looking back for inadvertent errors thereby shifting their focus away from providing care to their patients and improving healthcare delivery into the future," said Mark Silberman, a partner at Duane Morris in Chicago.

But there are some bright spots in the rule.

It provides more flexible and streamlined ways to return over payments. The proposed rule outlined one method that was largely paper based, burdensome and not commonly used by providers or MACs, according to Tony Maida, a former

deputy chief at HHS's Office of the Inspector General who advised the CMS on the proposed and final rule. Maida is now a partner in the Health Industry Advisory Group at the international law firm McDermott Will & Emery LLP.

Providers also should be pleased that the CMS has defined the "reasonable diligence" necessary for providers to comply. In the rule, the CMS said it expects providers to implement compliance programs.

An overpayment is "identified" if the provider or supplier has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment, according to the rule.

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