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NEW CMS PROPOSED RULE CONCERNING REPORTING AND RETURNING OVERPAYMENTS

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As part of CMS' continued efforts to implement the provisions of the Patient Protection and Affordable Care Act, CMS proposed a new rule on February 16, 2012 (the "Proposed Rule") that will require providers to report and return self-identified overpayments by the later of: (1) the date which is 60 days after the date when the incorrect payment was identified; or (2) the date any corresponding cost report is due, if applicable. Failure to report and return an overpayment within 60 days could result in a violation of the False Claims Act, civil monetary penalties, or exclusion from participation in Federal health care programs.

What constitutes an overpayment?

For purposes of the Proposed Rule, an "overpayment" is defined as any funds that a "person" receives or retains under Medicare to which the person is not entitled. A "person" includes Medicare providers and suppliers. The Proposed Rule provides several examples of overpayments, which include: duplicate submissions, payment to the incorrect payee, payment for medically-unnecessary services, and payment for non-covered services.

When is an overpayment identified?

In the Proposed Rule, CMS stated a person has identified an overpayment "if the person has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment." The comments to the Proposed Rule make clear that this broad definition was utilized to incentivize providers to exercise reasonable diligence to determine whether an overpayment exists, and to ensure that providers do not seek to avoid liability by limiting activities such as self-audits and compliance checks. The Proposed Rule further states that in certain circumstances, a provider "may receive information concerning a potential overpayment that creates an obligation to make a reasonable inquiry to determine whether an overpayment exists."

While the Proposed Rule attempts to clearly define when an overpayment has been identified, there remains a number of unanswered questions that will require further clarification. For example, it remains unclear when a person has "actual knowledge" of an overpayment, particularly when dealing with a large organization or when interpreting the results of an internal audit. Oftentimes, the determination as to what constitutes an overpayment is not patently clear, and while an item could be flagged by an internal auditor as a potential overpayment, the ultimate determination may be subject to review, or the decision may be made by someone else in the organization. In situations such as this, the Proposed Rule does not make clear when the overpayment has been "identified", for purposes of reporting and repayment.

In an attempt to minimize uncertainty, the Proposed Rule provided the following non-exhaustive list to demonstrate when an overpayment has been "identified":

- A provider reviews billing or payment records and learns that it incorrectly coded certain services, resulting in increased reimbursement.
- A provider learns that a patient death occurred prior to the service date on a claim that has been submitted for payment.
- A provider learns that services were provided by an unlicensed or excluded individual.
- A provider performs an internal audit and discovers that overpayments exist.
- A provider is informed by a government agency of an audit that discovered a potential overpayment, and the provider fails to make a reasonable inquiry in response.
- A provider experiences a significant increase in Medicare revenue and there is no apparent reason—such as a new partner added to a group practice or a new focus on a

particular area of medicine—for the increase.

While CMS did not specifically request comments concerning the "identification" of overpayments, the issue has already begun to generate much speculation within the health care industry. Accordingly, we will continue to monitor the issue and will provide an update when additional information is available.

Look-Back Period

The Proposed Rule requires that overpayments must be reported and returned if they are identified within 10 years of the date that the overpayment was received. CMS stated that this time period was chosen to correspond with the statute of limitations for False Claims Act violations. The length of the look-back period is a highly controversial aspect of the Proposed Rule and is likely to generate significant comments.

Cost-Reporting Concepts

It is important for providers that submit cost reports to understand when overpayments are required to be reported and returned. As noted above, the Proposed Rule requires that providers report and return self-identified overpayments by the later of: (1) the date which is 60 days after the date when the incorrect payment was identified; or (2) the date any corresponding cost report is due, if applicable. In the comments to the Proposed Rule, CMS makes clear that the phrase, "if applicable", is meant to reflect overpayments that would typically be reconciled on the cost report, "such as overpayments related to graduate medical education payments." On the other hand, if the overpayment is claims-related, such as an incorrectly upcoded claim, and is not the type of claim that would be reconciled on a cost report, the provider is required to report and return the overpayment within 60 days.

Contents of Report

The Proposed Rule requires disclosure of the following information, in writing, when reporting an overpayment: (a) provider's name; (b) provider's tax identification number; (c) how the error was discovered; (d) reason for the overpayment; (e) health insurance claim number; (f) date of service; (g) Medicare claim control number, as appropriate; (h) Medicare National Provider Identification (NPI) number; (i) description of the corrective action plan to ensure the error does not occur again; (j) whether the person has a Corporate Integrity Agreement ("CIA") with the OIG or is under the OIG Self-Disclosure Protocol; (k) timeframe and the total amount of refund for the period during which the problem existed that caused the refund; and (l) if a statistical sample was used to determine the overpayment amount, a description of the methodology.

Interaction with Existing Self-Disclosure Regulations

The Proposed Rule acknowledges the potential intersections between the reporting obligations created under the Proposed Rule and current self-disclosure obligations under the Medicare Self-Referral Disclosure Protocol ("SRDP") and the OIG Self-Disclosure Protocol ("OIG SDP"). With respect to overpayments required to be reported under the SRDP, the Proposed Rule states that the obligation to return overpayments under the Proposed Rule would be suspended upon CMS' acknowledgement of a disclosure made pursuant to the SRDP. However, the provider would still be obligated to report the overpayment using the process identified in the Proposed Rule.

With respect to overpayments required to be reported under the OIG SDP, the Proposed Rule states that the obligation to return and report overpayments under the Proposed Rule would be suspended when the OIG acknowledges receipt of a submission to the OIG SDP, and that the suspension would continue until a settlement agreement is entered with the OIG, or the provider is removed from the OIG SDP.

Comments to the Proposed Rule must be submitted by April 16, 2012, after which CMS will release a final rule. While we recognize that certain aspects of the Proposed Rule may change, the Proposed Rule nevertheless provides valuable insight into CMS' objectives. As a result, providers should review their current reporting policies and be prepared to implement policies and procedures to ensure that all overpayments are reported and returned in a timely manner.

You can get a copy of the Proposed Rule here: Proposed Rule

Additional Information

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