Time is Money: CMS Proposes 10-Year Look-Back Period for Returning Overpayments

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By now, most everyone is aware of Section 6402(a) of the Affordable Care Act ("ACA"), which was signed into legislation on March 23, 2010, requiring that an overpayment be reported and returned by the later of – (1) the date which is 60 days after the date on which the overpayment was identified; or (2) the date any corresponding cost report is due, if applicable. On February 16, 2012, the Centers for Medicare & Medicaid Services ("CMS") proposed new rules to implement this requirement. The new rules will expand the power of CMS to recover overpayments, contributing to paying for of the expensive ACA, while simultaneously costing providers millions of dollars in cost-reporting expenses.

What is an overpayment?

An "overpayment" means "any funds that a person receives or retains under [Medicare] to which the person, after applicable reconciliation, is not entitled . . . ."[1] Examples of overpayments include:

1. Medicare payments for non-covered services;
2. Medicare payments in excess of the allowable amount for an identified covered service;
3. Errors and non-reimbursable expenditures in cost reports;
4. Duplicate payments; and
5. Receipt of Medicare payment when another payer has the primary responsibility for payment.

Overpayment may also result from Medicare's overestimating payments for services. Medicare may overestimate payments to providers throughout the cost year with the expectation that those overpayments will be returned upon reconciliation.

What are the requirements for reporting and returning overpayments?

A person who has received an overpayment must return the overpayment to the Secretary and inform of the reason for the overpayment.[2] This requirement will be implemented through the existing voluntary refund process. Providers will report overpayments using an appropriate form from a Medicare contractor, an intermediary. The purpose of the form is to identify the claim to CMS. Additionally, the provider is burdened with the requirement to inform CMS of the following information:

1. How the error was discovered;
2. A description of the corrective action plan implemented to ensure the error does not occur again;
3. The reason for the refund;
4. Whether the provider has a corporate integrity agreement ("CIA") with the OIG or is under the OIG Self-Disclosure Protocol;
5. The timeframe and the total amount of refund for the period during which the problem existed that caused the refund;
6. Medicare claim control number, as appropriate;
7. Medicare National Provider Identification ("NPI") number; and
8. If a statistical sample was used to determine the overpayment amount, description of the statistically valid methodology used to determine the overpayment.

Of course, along with satisfying the onerous reporting requirement, the provider must submit a refund in the amount of the overpayment. The slew of requirements will render reporting and returning of overpayments, which should be a simple and uncomplicated accounting task, a form of art.

What does "identified" mean?

The proposed regulations attempt to clarify the statute which does not define when an overpayment is "identified." Under

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CMS' proposal, 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. CMS believes defining "identification" in this way gives providers an incentive to exercise reasonable diligence to determine whether an overpayment exists.

CMS has provided examples of when a provider might act in reckless disregard or deliberate ignorance. In some cases, a provider may receive information concerning a potential overpayment that creates an obligation to make a **reasonable inquiry** to determine whether an overpayment exists. Failure to conduct such inquiry could result in the provider knowingly retaining an overpayment. A provider may be required to make a reasonable inquiry when, for example:

Provider beware: failure to report or return an overpayment may give rise to liability under the False Claims Act and the Civil Monetary Penalties Law.

1. A provider receives an anonymous tip of an overpayment from a compliance telephone hotline;
2. In reviewing records, a provider determines a service was improperly coded, resulting in an increased reimbursement;
3. A provider learns a patient died prior to the service date on a claim submitted for payment;
4. A provider learns an unlicensed or excluded individual provided a service;
5. An internal audit reveals overpayment(s);
6. A government agency advises a provider of a potential overpayment; and
7. A provider receives, for no apparent reason, a significant increase in Medicare revenue.

If reasonable inquiry reveals that an overpayment has been received, the 60-day clock begins to run from that revelation. There is no further guidance as to how long a provider may take to conduct the reasonable inquiry. Thus, the meaning of "identified" remains elusive.

Is it possible to extend the time to return an overpayment?

The 60-day deadline to return an overpayment can be extended if the provider will suffer a financial hardship. Financial hardship exists when the total amount of outstanding overpayments is 10 percent or greater than the total Medicare payments made for the cost reporting period: (1) covered by the most recently submitted cost report, or (2) for the previous calendar year for a non cost-report provider.[3]

However, provider beware: failure to report or return an overpayment may give rise to liability under the False Claims Act and the Civil Monetary Penalties Law.

What is the look-back period?

The proposed regulations extend the look-back period for reporting overpayments from 4 years 10 years.[4] However, not surprisingly, the proposal is silent as to whether the new 10-year look-back period begins immediately or whether it will be applied prospectively. Expect the proposed look-back period to be applied from the date the regulations are adopted. After all, all is fair in love, war, and regulating Medicare.

Comments to the proposed rules must be received by 5 p.m. on April 16, 2012.

About the Author

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Footnotes

[1]42 C.F.R. § 414.303.

[2]*Id.* at § 401.305.

[3]*Id.* at § 401.607. Amounts included in an approved, existing repayment schedule are excluded from the calculation pertaining to financial hardship. *Id.*

[4]*Id.* at § 401.305(g).