Three Key Take-Aways from CMS’ Final Rule on Reporting and Returning Overpayments

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In the Centers for Medicare & Medicaid Services’ (“CMS”) Reporting and Return of Overpayments Final Rule, published February 11, 2016 (“Final Rule”), CMS has clarified some outstanding questions faced by healthcare providers and suppliers who may have received overpayments from the Medicare program.

Background

Since the enactment of the Affordable Care Act (“ACA”) on March 23, 2010, providers and suppliers have been required to return any Medicare overpayment within the later of 60 days of identifying the overpayment or the date any corresponding cost report is due, if applicable. Failure to timely report an overpayment risked liability under the False Claims Act. However, these ACA provisions left a tremendous amount of room for interpretation, and providers and suppliers were left to wonder:

- When is an overpayment “identified”?
- How long does the provider or supplier have to investigate to determine whether an overpayment exists?
- If an overpayment exists, how long does a provider or supplier have to quantify the amount of the overpayment?
- What is the lookback period?

In its first effort to answer some of these questions, CMS published a proposed rule in 2012. Although the proposed rule was helpful, for the four years since its publication providers, suppliers, and even courts have struggled to determine the applicable parameters for identifying, investigating, quantifying, and reporting overpayments.

Final Rule

The Final Rule, published by CMS on February 11, 2016, clarifies many of these questions. Here are some key points from the Final Rule:

1. **Meaning of Identification.** The Final Rule states that “a person has identified an overpayment when the 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.” (Emphasis added.) Before the Final Rule, quantification of the amount of the overpayment was not specifically addressed in the definition of identification—leaving providers and suppliers investigating an overpayment wondering whether they must report overpayments before they have had the opportunity to quantify the amount of the overpayment. With the complexity of the issues that often lead to overpayments and the complexity of Medicare reimbursement, it is often not feasible to identify and quantify an overpayment in 60 days. Consequently, under the proposed rule, some providers and suppliers have felt compelled to report within the 60-day window, with a disclaimer that the amount remained under investigation. Now, the Final Rule clarifies that the 60-day period begins when the overpayment is quantified, so providers and suppliers can complete their investigation and quantify the amount to be repaid without risking False Claims Act liability for untimely reporting.

2. **Time for Investigation.** The Final Rule does not provide a specific time frame for investigation of a potential overpayment, but CMS provided clarification in its commentary. The preamble to the proposed rule referenced “all deliberate speed” as the standard for investigation. In the Final Rule commentary, CMS identified “6 months as the benchmark for timely investigation.” CMS stated that “a total of 8 months (6 months for timely investigation and 2 months for reporting and returning) is a reasonable amount of time, absent extraordinary circumstances.” “Extraordinary circumstances” might include unusually complex investigations, such as Stark violations that are referred to the CMS Voluntary Self-Referral Disclosure Protocol.
3. **Lookback Period.** Before the Final Rule, providers and suppliers were left to wonder how far back they would need to investigate issues. Before the proposed rule, commentators speculated about 4-year, 6-year, 10-year, even unlimited, lookback periods. The proposed rule called for a 10-year lookback. The Final Rule establishes a 6-year lookback period.

**Conclusion**

The requirement for reporting and return of overpayments puts considerable pressure on Medicare providers and suppliers to maintain robust compliance programs; identify any credible information suggesting receipt of an overpayment; and exercise reasonable diligence to investigate and, if applicable, quantify, report, and return any overpayment. Many questions will undoubtedly arise as providers and suppliers work to meet these standards, but the Final Rule answers some key questions and provides some very useful guidance.

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