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CMS ISSUES PROPOSED RULE ON REPORTING AND RETURNING MEDICARE

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On February 16, 2012, the Centers for Medicare & Medicaid Services (CMS) issued a widely anticipated proposed rule (the proposed rule) implementing the statutory requirement of Section 6402(a) of the Affordable Care Act (the ACA) that providers and suppliers report and return overpayments from Medicare and Medicaid. As proposed, the new rule would impose significant risks and burdens on providers and suppliers, including a requirement to promptly investigate potential overpayments occurring within a 10-year lookback period. Public comments on the proposed rule are due by April 16, 2012.

General

Section 6402(a) added a new Section 1128J(d) of the Social Security Act, under which a person that has received an "overpayment" must notify the appropriate payor and make a refund by the later of (i) 60 days after the date on which the overpayment was identified or (ii) the date on which any cost report corresponding to the overpayment is due, if applicable. Importantly, Section 1128J(d) creates potential liability under the federal False Claims Act (the FCA), and the possibility of program exclusion, for knowingly retaining overpayments beyond the new statutory deadline, as amplified under the proposed rule.

The proposed rule applies only to Medicare Part A and Part B overpayments. However, CMS underscores that entities receiving other types of covered overpayments, including under the Medicaid and Medicare Advantage programs, are still subject to the underlying statutory requirement. Adhering to the proposed rule to the extent possible would appear to be a reasonable means of resolving questions in dealing with Medicaid and Medicare Advantage overpayments as well.

The information called for by CMS under the proposal answers some questions, but raises others. For example, CMS does not mandate that providers and suppliers extrapolate from a sample of erroneously paid claims to arrive at a larger overpayment determination. The proposed rule, however, can be read to suggest the need to do so in certain circumstances. Also, CMS makes clear that a report under the proposed rule is not a proper means of resolving an overpayment resulting from a violation of law. That leaves open the possibility that reports and repayments required by the 60-day rule will result in a further referral under the FCA or Civil Monetary Penalties Law.

The proposed rule generally provides that a person must report and return an identified overpayment in the "form and manner" set forth in the rule. CMS' guidelines include definitions and clarifications, a prescribed format for making reports, reporting deadlines, and enforcement and lookback period provisions, as follows.

Definitions and Clarifications

The proposed rule defines a *person* as a Medicare provider or supplier, and an *overpayment* as any funds received under Medicare to which the person – after "applicable reconciliation" (narrowly defined as cases where estimated payments are made in anticipation of a later reconciliation to costs or amounts owed) – is not entitled under the Medicare rules.

Examples of overpayments given by CMS include payments for noncovered services, duplicate payments, payments in excess of the allowable amount, and receipt of primary Medicare payments made when another payor is primary. Overpayments listed by CMS also include payments resulting from violations of the anti-kickback statute, as well as claims based on insufficient documentation or for which the documentation does not demonstrate medical necessity. In this regard, the proposed rule may be overly aggressive in treating some "documentation errors," inherently, as "payment errors."

Reporting Format

The proposed rule sets forth a laundry list of 13 items that must be included in the overpayment report. The list encompasses basic information, such as the name of the reporting person, how the error that led to the overpayment was discovered, and the reason for the overpayment, as well as more detailed explanations, such as descriptions of the corrective action being taken to ensure that the error does not recur and of the statistically valid methodology used to determine any overpayment estimated through the use of statistical sampling.

Providers and suppliers can and should, to the extent feasible, meet the reporting requirements under the proposed rule though the existing Medicare voluntary refund process, by using the reporting form that each Medicare contractor makes available on its website as a part of that process. The forms require sufficient information so

as to allow CMS to identify the affected claims, such as the health insurance claim number, the provider's or supplier's name and tax identification number, and the date of the service. Recognizing that these forms currently vary among contractors, CMS intends eventually to develop a uniform reporting form for all Medicare overpayments, while prescribing use of the contractors' existing forms in the interim. For now, it appears that an entity making an overpayment report must supplement the information in the contractor form with a separate filing that includes the additional information (comprising the total list of 13 items) requested by the proposed rule.

Reporting Deadlines

The proposed rule mirrors and explains further Section 1128J(d)'s reporting deadlines. At the outset, CMS clarifies that a later cost report deadline will only take precedence over the standard "60 days from identification" deadline if the overpayment at issue is of the type that would generally be reconciled on the cost report. (Unfortunately, the proposed rule does not broadly define payments due after an "appropriate reconciliation" as involving a "netting" of overpayments and underpayments, but rather limits that concept to interim payments subject to a later cost report reconciliation.)

Overpayments resulting from upcoding – and other "claim specific" payments – would be subject to a 60-day period running from the identification of an erroneous claim, for example, while reports of overpayments related to Graduate Medical Education payments could be made by the corresponding cost report deadline, if that deadline is later than 60 days after identification. Examples of items that do not require immediate repayment include the receipt of updated SSI ratios (used to compute Medicare hospital DSH payments) or an awareness that outlier payments will be reconciled, both of which can be corrected through the final cost report reconciliation.

As to the critical question of when an overpayment has been "identified," so that the 60-day clock starts to run, the proposed rule clarifies that this occurs when the person has actual knowledge of, *or* acts in reckless disregard or deliberate ignorance of, an overpayment. To avoid potential liability for acting with reckless disregard or deliberate ignorance, moreover, a person must conduct a "reasonable inquiry" with "all deliberate speed" after receiving information, such as a tip from a compliance hotline, concerning a potential overpayment.

The proposed rule furnishes several examples of when overpayments should be deemed to have been identified, including when a provider or supplier learns that a patient died prior to the date on which it billed for services provided to the patient, or when it verifies information from a government audit indicating that a potential overpayment exists.

The proposed rule also acknowledges potential overlapping obligations to report and return overpayments under Section 1128J(d), and under Medicare's Self-Referral Disclosure Protocol (SRDP) and the OIG's Self-Disclosure Protocol (SDP). A proper submission under the SRDP would suspend the repayment deadline under Section 1128J(d), while such a submission under the SDP would suspend both the repayment and reporting deadlines.

Finally, a delay in repayment is not permitted solely because of the size of the overpayment. A provider or supplier, however, may request additional time under CMS' existing Extended Repayment Schedule process, which requires detailed documentation demonstrating a "true financial hardship" arising from the repayment obligation.

Enforcement and Lookback Period

The proposed rule has significant enforcement implications in at least two respects. First, it echoes statutory language indicating that retaining an overpayment beyond the applicable reporting deadline can lead to liability under the FCA. It also provides that a person that knows of and fails to report and return an overpayment in accordance with the rule may be liable under the Civil Monetary Penalties Law, and therefore excluded from participation in the Medicare and Medicaid programs.

Second, the proposed rule requires reporting and returning any overpayment within 10 years of the date the overpayment was received. CMS explains that it has adopted this expansive lookback period because it is consistent with the outer limit of the FCA statute of limitations. It is not clear, however, that attempts to impose FCA liability for overpayments made prior to the March 23, 2010 enactment of the ACA, which added Section 1128J(d) of the Social Security Act, will withstand judicial scrutiny. In one recent decision, for example, a federal district court in Illinois refused to consider FCA claims arising out of retained overpayments for services discovered prior to the effective date of the relevant FCA amendments, including Section 6402(a) of the ACA.

Please contact the authors or any members of Cozen O'Connor's Health Law Practice Group if you would like additional information or require assistance with the proposed rule or any Medicare, Medicaid, or private pay or overpayment issues.