CMS finalizes 60-day overpayment rule

The Centers for Medicare & Medicaid Services (CMS) has finalized the 60-day overpayment rule and clearly indicated its expectation that providers establish robust compliance plans and promptly investigate credible overpayment allegations.

Statutory background

As with most health care regulations, it takes CMS a while to adopt regulations. The 60-day repayment rule was implemented by the § 6402 of the Affordable Care Act (ACA) in 2010, which is 28 U.S.C. § 1128j(d). The 60-day repayment rule requires a:

"person to report and return any Medicaid and Medicare overpayment by the later of either (a) the date which is 60 days after the overpayment was identified or (b) the date when the corresponding cost report is due.

"Failure to return the overpayment will subject the person to civil money penalties of $5,500 to $11,000 per claim plus for treble damages in addition to potential state claims if there are Medicaid claims involved."

The final regulations actually consist of three separate but similar regulations applying to Part A (Hospital Payment) and Part B (Physician Payment) of Medicare, Part C (Medicare Advantage) and Part D (Prescription Drug) of Medicare. The regulations can be accessed at this link: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-11.html.

Key issues

The key issues are the definition of overpayments, the process for identification of overpayments and the "Six-Year Look Back Period."

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1. Definition of overpayment

CMS defines "overpayment" as "any funds that a person has received or retained under title XVIII of the [Social Security Act] to which the person, after applicable reconciliation, is not entitled under such title." The obligation to report and return an overpayment exists regardless of whether that overpayment resulted from intentional or unintentional conduct. CMS makes clear in the preamble to the rule it believes overpayment includes claims resulting from Anti-Kickback Statute or physician self-referral law violations or claims for items and services furnished by an excluded person.

2. Determining when an overpayment is identified

Regulations clarify "identification" as occurring when "the person has, or should have through the exercise of reasonable diligence, determined that the person has received the overpayment and quantified the amount of the overpayment." Identification does not occur until the provider has quantified the amount of the overpayment identifying the substance of the illegality and quantifying the substance of the amount, which is intended to allow providers to have sufficient time to fully investigate and calculate an overpayment before the 60 days. CMS explains in the preamble that reasonable diligence means both:

- proactive compliance activities conducted in good faith by qualified individuals to monitor for the receipt of overpayments, and
- investigations conducted in good faith and in a timely manner by qualified individuals in response to obtaining credible information of potential overpayment.

3. Six-Year Look Back Period

The rule also finalized the issue of defining the "look back period," which originally was proposed to be 10 years. This obviously means if you identify an overpayment that occurred in 2016, and you have been billing the same way for the last six years, then you need to look back for six years and return any proceeds obtained using the process now deemed improper.

Exceptions to 60-day repayment rule

CMS has provided the following exceptions to the 60-day rule:

1. Submission to the OIG Self-Disclosure Protocol suspends repayment until such time as a settlement agreement is entered, the person withdraws from the OIG Self-Disclosure Protocol, or the person is removed from the OIG Self-Disclosure Protocol.

2. Submission to the CMS Voluntary Self-Referral Disclosure Protocol suspends payment until such time as a settlement agreement is entered, the person withdraws from the CMS Voluntary Self-Referral Disclosure Protocol, or the person is removed from the CMS Voluntary Self-Referral

Disclosure Protocol.

3. Payment is suspended if the parties are negotiating an extended repayment schedule under 42 C.F.R. § 401.603, and remains suspended until such time as CMS or one of its contractors rejects the extended repayment schedule request or the provider or supplier fails to comply with the terms of the extended repayment schedule.

Conclusion

Although there never was any legitimacy to the idea that physicians were not required to return mistaken payments, this makes it both official and very expensive.

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