CMS Issues Final Word on 60-Day Overpayment Rule

Neil W. Hoffman and Alexander B. Foster

The Centers for Medicare & Medicaid Services (CMS) has just released the final 60-day overpayment rule (the Rule) on February 11, 2016, in what the agency describes as a continuing move targeted at rooting out fraudulent payments, providing greater clarity to providers, and promoting high quality care.[1] The release comes almost four years after CMS published the proposed 60-day rule on February 16, 2012.[2] The Rule (RIN 0938-AQ58, CMS-6037-F) requires Medicare Parts A and B health care providers and suppliers to report and return overpayments by the later of the date that is 60 days after the date an overpayment is identified, or the due date of any corresponding cost report, if applicable.[3]

The Rule implements Section 6402(a) of the Affordable Care Act, which established a new section 1128J(d) of the Social Security Act entitled ‘‘Reporting and Returning of Overpayments.’’[4] Section 1128J(d) sets forth the reporting requirements described above and provides in Section 1128j(d)(3) that any overpayment retained by a person after the deadline for reporting and returning an overpayment is an obligation,[5] defined in the U.S. Code as “an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment . . .”[6] Providers who do not comply with the reporting/return requirements may incur False Claims Act (FCA) liability, which includes severe penalties, such as civil monetary penalties and exclusion from Medicare, even if the overpayment was received without any wrongdoing.

The February 16, 2012, proposed regulations provided for a 10-year look-back period for overpayment disclosures. Thus, any provider who identified one overpayment would have been required to review its records and search for other overpayments during the 10-year period, which aligns with the maximum window for bringing an FCA suit.[7] However, the final rule requires that “overpayments must be reported and returned only if a person identifies the overpayment within 6 years of the date the overpayment was received,” imposing a look-back period that matches the statute of limitations for bringing a civil action under the FCA.[8] According to CMS, this change in the look-back period, from what the agency had earlier proposed, avoids the imposition of unreasonable additional burdens and costs on providers.

Importantly, the final Rule includes the determination of the amount of overpayment in the concept of “identifying” an overpayment. The Rule states “a person has identified an overpayment when

1 To see the text of the Rule, see Medicare Program; Reporting and Returning of Overpayments, https://www.federalregister.gov/articles/2016/02/12/2016-02789/medicare-program-reporting-and-returning-of-overpayments.
2 77 Fed. Reg. 9179, 9180 (February 16, 2012).
3 A separate final rule was published in the May 23, 2014 Federal Register that applies to Medicare Parts C and D overpayments.
4 77 Fed. Reg. 9179, 9180 (February 16, 2012).
5 *Id.*
6 31 U.S.C. § 3729(b)(3).
7 31 U.S.C. § 3731(b)(2) (“A civil action under section 3730 may not be brought . . . more than 3 years after the date when facts material to the right of action are known or reasonably should have been known by the official of the United States charged with responsibility to act in the circumstances, but in no event more than 10 years after the date on which the violation is committed . . .”).
8 31 U.S.C. § 3731(b)(1) (“A civil action under section 3730 may not be brought . . . more than 6 years after the date on which the violation of section 3729 is committed . . .”).

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." This language is in contrast to the proposed rule, which defined "identification" as a person having actual knowledge of the existence of the overpayment or acting in reckless disregard or deliberate ignorance of the existence of the overpayment. CMS indicated that the language was revised to clarify "that part of identification is quantifying the amount, which requires a reasonably diligent investigation." The Rule also requires that providers use an applicable claims adjustment, credit balance, self-reported refund, or another appropriate process to satisfy the obligation to report and return overpayments.

In conclusion, the Rule is somewhat more favorable to providers than the earlier proposed rule in two respects: (1) the overpayment look-back period is shorter (6 vs. 10 years), and (2) the Rule clarifies that the "identification" of an overpayment includes quantifying the amount of the overpayment. The Rule requires, however, the exercise of "reasonable diligence" in completing this identification process. It is not unlikely that government regulators and healthcare providers may differ on what constitutes reasonable diligence and that, ultimately, courts may have a say in the matter.

Authors and Contributors

Neil W. Hoffman
Partner, Atlanta Office
404.873.8594
neil.hoffman@agg.com

Alexander B. Foster
Associate, Atlanta Office
404.873.8598
alexander.foster@agg.com

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