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FINAL RULE REGARDING RETURN OF MEDICARE OVERPAYMENTS IS MORE FAVORABLE TO PROVIDERS THAN ANTICIPATED

by Stephanie S. Sobkowiak and Daniel J. Kagan

One element of the Affordable Care Act (ACA), enacted in March 2010, requires providers to identify, report and return Medicare overpayments. A provider's failure to do so can result in False Claims Act liability, Civil Monetary Penalties and, in serious cases, exclusion from federal health care programs. On February 11, the Centers for Medicare and Medicaid Services (CMS) issued a long-awaited final rule implementing this requirement. A few key provisions of this final rule are much more favorable to providers than those contained in CMS' earlier proposed rule.

The ACA requires that providers report and return any Medicare overpayments by the later of (i) 60 days after the date on which the provider identified the overpayment or (ii) the date that any corresponding cost report is due. Until the issuance of the final rule, providers were uncertain of two things. First, how far back does the obligation to return overpayments extend? In other words, how far back does a provider need to look in determining whether it was overpaid? Second, when is a provider deemed to have "identified" an overpayment, starting the 60-day clock? We now have answers to these questions.

Look Back Period

The final rule requires that a provider report and return an overpayment if it identifies the overpayment within six years of the date that the overpayment was received. This 6-year look back period is down from the 10-year period reflected in the proposed rule. This change aligns the final rule with similar state and federal record retention requirements and helps to address providers' concerns regarding the burden and cost of a 10-year look back period.

Identification of an Overpayment

The final rule also provides additional helpful guidance regarding when an overpayment is "identified" and thus when the 60 day clock starts ticking to return the overpayment. Prior to the issuance of this final rule, providers felt immense pressure to investigate a potential overpayment at lightning speed,

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trying to balance the accuracy of the investigation and the subsequent report with the need to act rapidly. The final rule makes clear that the 60-day clock starts only after the provider, using reasonable diligence, determines and quantifies the amount of the overpayment. "Reasonable diligence" is demonstrated through the timely, good faith investigation of credible information, which takes a maximum of six months following the receipt of the credible information, except in extraordinary circumstances (*i.e.* complicated self-referral law violations, natural disasters or states of emergency). We note that CMS' commentary makes clear that reasonable diligence may include an audit and subsequent extrapolation to arrive at the reasonable overpayment amount. However, CMS' commentary also makes clear that providers must engage in proactive measures to determine whether they have received overpayments – simply waiting for a problem to come to light is not enough. As you would expect, maintaining documentation of all investigatory efforts is critical and should not be overlooked. Of course, if the provider did in fact receive an overpayment and fails to conduct reasonable diligence, the 60-day clock starts to tick on the date that the provider received credible evidence of the overpayment.

The final rule takes effect on March 14, 2016. You can read the text of the final rule by clicking here.

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