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## **CMS Issues Proposed Rule on Reporting and Returning Overpayments**

The Centers for Medicare and Medicaid Services (CMS) recently published a proposed rule on reporting and returning overpayments for health care providers participating in the Medicare program. The proposed rule, which applies to Medicare Part A and Part B providers and suppliers, requires such participants to report and return any Medicare overpayment by the later of: 1) the date which is 60 days after the date on which the overpayment was identified, or 2) the date any corresponding cost report is due. CMS will accept comments on the proposed rule until April 16, 2012. [Click here](#) to view the proposed rule.

The Patient Protection and Affordable Care Act (PPACA) established the new 60-day requirement for reporting and returning Medicare overpayments. The proposed rule seeks to clarify this requirement and to provide guidance on the process for reporting and returning overpayments. Under the proposed rule, Medicare providers and suppliers who do not comply with the overpayment reporting and repayment requirements may be subject to liability under the False Claims Act (FCA) and the Civil Monetary Penalties (CMP) law, and may be excluded from participation in federal health care programs. Other key sections of the proposed rule are highlighted below.

### **Definition of an Overpayment**

An "overpayment" includes any funds that a provider or supplier receives or retains to which such provider or supplier, after applicable reconciliation, is not entitled. CMS's examples of overpayments include the following:

- Medicare payments for non-covered services.
- Medicare payments in excess of the allowable amount for an identified covered service.
- Errors and non-reimbursable expenditures in cost reports.
- Duplicate payments.
- Receipt of a Medicare payment when another payor had primary responsibility for payment.

CMS notes that Medicare makes estimated payments for services knowing that a reconciliation of such payments to the actual costs of the services will be completed at a later date. In such instances, CMS provides that the overpayment will not exist until after the applicable reconciliation occurs.

### Identification of an Overpayment

An overpayment is “identified” when a provider or supplier “has actual knowledge of the existence of [an] overpayment or acts in reckless disregard or deliberate ignorance of the overpayment.” The 60-day requirement to report and return an overpayment would run from the date on which the provider or supplier has identified the overpayment.

To clarify the identification requirement, CMS states that “[i]n some cases, a provider or supplier may receive information concerning a potential overpayment that creates an obligation to make a reasonable inquiry to determine whether an overpayment exists. If the reasonable inquiry reveals an overpayment, the provider then has 60 days to report and return the overpayment.” CMS also indicates that when there is reason to suspect an overpayment, but a provider or supplier fails to make a reasonable inquiry into whether an overpayment exists, such provider or supplier “may be found to have acted in reckless disregard or deliberate ignorance of [an] overpayment.” With respect to conducting a reasonable inquiry into an overpayment, CMS notes that when a provider receives an anonymous tip about a potential overpayment, the provider has an obligation to “timely investigate” the complaint. Failure to do so could result in the provider knowingly retaining an overpayment. Other examples of when an overpayment has been identified include when a provider or supplier:

- Reviews billing or payment records and discovers that it incorrectly coded certain services, resulting in increased reimbursement.
- Discovers that a patient death occurred prior to the service date on a claim that has been submitted for payment.
- Discovers that services were provided by an unlicensed or excluded individual working on its behalf.
- Performs an internal audit and discovers that an overpayment exists.
- Experiences a significant increase in Medicare revenue for no apparent reason.

### Process for Returning an Overpayment

CMS proposes that the process for reporting and returning overpayments be via the existing voluntary refund process provided in, Chapter 4 of the *Medicare Financial Management Manual* (Publication 100-06). That process requires that providers and suppliers report overpayments using a form that each applicable Medicare contractor makes available on its website. Providers and suppliers will be required to provide information such as the applicable health insurance claim number, tax identification number, and date of service. Providers and suppliers also must summarize why the refund is being made, which includes providing information such as how the error was discovered, a description of the corrective action plan implemented to ensure that the error does not occur again, whether the provider or supplier has a corporate integrity agreement with the Office of Inspector General (OIG) or is under the OIG Self-Disclosure Protocol (SDP), and a description of the statistically valid methodology used, if any, to determine the overpayment.

**Look-back Period for Reporting Overpayments**

CMS is proposing a “look-back” period of ten years from the date the overpayment was received. CMS chose the ten-year look-back period because it mirrors the outer limit of the FCA’s statute of limitations. Furthermore, to ensure consistency between the proposed 60-day overpayment requirements and the Medicare reopening regulations, CMS is proposing to amend the reopening regulations to provide that overpayments reported under the 60-day rules may be reopened for a period of ten years.

**Exceptions to the Requirements for Reporting and Returning Overpayments**

CMS proposes to suspend the 60-day requirement for returning overpayments when the OIG acknowledges receipt of a provider’s or supplier’s submission to the OIG SDP. Such suspension will be effective until a settlement agreement is entered into, or the provider or supplier withdraws or is removed from the OIG SDP. CMS also proposes that when a provider or supplier notifies the OIG of an overpayment through the OIG SDP, such notice would constitute a report for purposes of the 60-day reporting requirement under the proposed rule.

The proposed rule also would suspend the 60-day requirement for returning overpayments when CMS acknowledges receipt of a provider’s or supplier’s disclosure of actual (or potential) violations under the Medicare Self-Referral Disclosure Protocol (SRDP). However, CMS will require the provider or supplier to report such overpayment using the reporting process described in the proposed rule.

**Implications for Health Care Providers and Suppliers**

Although the proposed rule is not yet in effect, providers and suppliers should be mindful that PPACA already requires that they comply with the 60-day requirement for reporting and returning overpayments. Failure to comply with the current requirements may result in FCA liability, CMP liability and exclusion from federal health care programs. Therefore, providers and suppliers should act now to ensure compliance with the statutory requirements.

For more information on the requirements for reporting and returning overpayments under the PPACA and CMS’s proposed rule or assistance with establishing processes for investigating and documenting potential overpayments, and implementing procedures for reporting and returning overpayments, please contact any member of the Honigman Health Care Department.