# CMS ISSUES FINAL OVERPAYMENT REFUND RULE

## EXECUTIVE SUMMARY

On February 11, 2016, the Centers for Medicare & Medicaid Services ("CMS") issued its long-awaited Final Rule ("Final Rule") implementing the overpayment reporting and repayment provisions of the Patient Protection and Affordable Care Act ("PPACA"). The Final Rule clarifies certain provisions set out in the February 14, 2012 Proposed Rule ("Proposed Rule"), modifies certain provisions that were controversial for providers and suppliers and provides additional information regarding the intersection between the overpayment obligations and existing CMS and Office of Inspector General ("OIG") self-disclosure protocols.

As was true for the Proposed Rule, the Final Rule will apply only to Medicare Part A and Part B providers and suppliers. The Final Rule discusses additional guidance for other stakeholders, including Medicare Part C, Part D and Medicaid managed care organizations. The Final Rule becomes effective on March 14, 2016. A copy of the Final Rule is available here.

## PPACA

Section 6402 of PPACA outlined the requirement that health care entities report and return overpayments to the Secretary, the State, an intermediary, a carrier or a contractor as appropriate. The entity must report and return the overpayment within 60 days "after the date on which the overpayment was identified or the date any corresponding cost report is due, if applicable." Failure to meet the deadline for returning an overpayment exposes the entity to civil monetary penalties under the Federal False Claims Act ("FCA").

The PPACA language above caused significant concern and confusion in the health care industry as providers and suppliers scrambled to interpret when the repayment obligations would apply and the timeline for returning overpayments.

## FINAL RULE

The Final Rule provides valuable guidance in areas that were previously unclear, including:

- When does the 60 days start; that is, when is an overpayment considered "identified"?
- How far back in time must a provider or supplier look in quantifying the overpayment amount; that is, how long is the "lookback" period?
- Is there a time limit to identify the overpayment amount?
- How does this repayment obligation work with other repayment protocols (for example, the OIG Self Disclosure Protocol ("SDP") and the CMS Self-Referral Disclosure Protocol ("SRDP"))?
- Does the Final Rule affect previously reported overpayments?

## WHEN DOES THE 60 DAYS START?

The Proposed Rule acknowledged that some "reasonable inquiry" might be required to determine whether an overpayment exists; however, little guidance was provided regarding exactly when an overpayment is "identified." The Final Rule addresses this issue directly, stating that "identified" means a person has, or should have: (i) determined that an overpayment was received; and (ii) quantified the amount of the overpayment. Notably, a person "should have" determined that the person received an overpayment if that person fails to exercise "reasonable diligence" and did, in fact, receive an overpayment. "Reasonable diligence" includes both proactive measures, such as compliance audits, and retroactive measures, such as an investigation conducted when a potential overpayment is identified.

Practically speaking, this means that if an entity learns that an overpayment may have occurred, that entity must return the overpayment either:

1. Not more than 60 days after the amount of the overpayment is determined *if* the entity acted with reasonable diligence as defined above (that is, timely investigated and quantified the amount of the overpayment); or
2. Not more than 60 days after the entity learned that an overpayment may have occurred *if* the entity did *not* act with reasonable

diligence.

**HOW LONG IS THE "LOOKBACK" PERIOD?**

The Proposed Rule would have established a 10-year lookback period, the maximum permissible under the FCA. This period was the subject of intense commentary, and in response, CMS shortened the lookback period. According to the Final Rule, overpayments must be reported and returned if an entity identifies the overpayment within six years of the date the overpayment was received.

This six-year limit does *not* apply, however, if there is evidence of fraud or similar fault attendant to the overpayment. In that case, the lookback period can extend as far as necessary to determine the extent of the fraud or other wrongful activity. This provision could become important if, for example, an entity learns of a possible overpayment and does not act to investigate. In such circumstances, a regulator could allege that the entity fraudulently retained the overpayment and could look back as far as it wished to determine if that allegation was true.

One potential point of confusion is that CMS indicates in the commentary that the lookback period extends back six years from the date the overpayment is identified. This creates ambiguity because providers may not know in advance the time period necessary to quantify the overpayment.

**IS THERE A TIME LIMIT TO IDENTIFY THE OVERPAYMENT AMOUNT?**

The Final Rule includes discussion of the work that is required to quantify an overpayment amount, and the variations in the time required to do so, depending on the facts and circumstances of each case. For example, if an overpayment results from inappropriately adding a particular modifier to a particular CPT code, quantifying the amount of the overpayment might require only running a billing system query for that code and modifier, and subtracting the amount that should have been received from the amount that was received. However, if an overpayment results from a more complex situation, for example, a relationship that violates the physician self-referral statute, its investigation could involve contract reviews, identification of referral patterns involving multiple patients and procedures and other time-consuming tasks.

CMS acknowledges these variations and states that a reasonable timeframe for investigation is six months from the date a possible overpayment is flagged, barring "extraordinary circumstances." Practically applied, this means that an entity has eight months to report and return the overpayment: six months for the investigation to quantify the overpayment amount and two months following that investigation to return the overpayment. In discussing "extraordinary circumstances," CMS refers to "unusually complex investigations...such as physician self-referral violations[,]...natural disasters or a state of emergency." Even under extraordinary circumstances, however, an entity must act with reasonable diligence as discussed above.

**HOW DOES THIS REPAYMENT OBLIGATION WORK WITH OTHER REPAYMENT PROTOCOLS?**

As was the case in the Proposed Rule, CMS acknowledges the intersection of this repayment obligation and that imposed by other regulations, including the SDP and the SRDP. CMS notes that providers and suppliers submitting disclosures under those protocols must use the reporting processes described in each protocol. For purposes of the 60-day repayment obligation, however, the Final Rule tolls - or stops the clock on - the 60-day reporting and repayment period for any entity that has submitted a disclosure under either the SDP or the SRDP. With respect to the SRDP, the clock remains stopped for the full duration of time that the entity is negotiating a potential settlement with CMS under the SRDP. Once negotiations have concluded, the clock starts and the entity must comply with the 60-day requirement to return any overpayment.

**DOES THE FINAL RULE AFFECT PREVIOUSLY REPORTED OVERPAYMENTS?**

The Final Rule is not retroactive. Entities that reported or returned overpayments prior to the Final Rule's effective date are not expected to have complied with the Final Rule. Additionally, entities that entered the SRDP prior to the Final Rule's effective date are not subject to the six-year lookback period but remain subject to the SRDP's prior four-year lookback period. Following the effective date of the Final Rule, however, all providers and suppliers reporting and returning overpayments on or after the effective date must comply with the Final Rule's requirements.

**CONCLUSION**

The Final Rule brings welcome clarity to several issues that have burdened providers and suppliers since enactment of PPACA. It is obvious that CMS recognized many of the concerns raised in comments to the Proposed Rule. The above issues are the major refinements to come

out of the Final Rule but not the only changes. Accordingly, we encourage providers and suppliers to consult with counsel when addressing a potential overpayment issue. If you would like to discuss the Final Rule or other matters around overpayments, please contact**:**

- Scott W. Taebel at staebel@hallrender.com or (414) 721-0445;
- Sandra T. Johnson at sjohnson@hallrender.com or (206) 459-3094;
- Leia C. Olsen at lolsen@hallrender.com or (414) 721-0466;
- Regan E. Tankersley at rtankersley@hallrender.com or (317) 977-1445;
- Lori A. Wink at lwink@hallrender.com or (414) 721-0456; or
- Your regular Hall Render attorney.

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