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HEALTH CARE LAW
FOULSTON SIEFKIN ISSUE ALERT

CMS Issues *Proposed* Overpayments Rules: When Does the 60-Day Clock Start Running?

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On February 16, 2012 the Centers for Medicare & Medicaid Services (CMS) published the long-awaited Proposed Rules for Medicare Part A and Part B providers implementing Section 6402(a) of the Affordable Care Act (ACA), which requires providers to return and report identified Medicare overpayments within 60 days. For nearly 2 years, providers have been left to speculate on what exactly constitutes "identification" of an overpayment so as to trigger the 60-day clock. The Proposed Rules offer providers a first look at how CMS intends to implement Section 6402(a), but questions still remain as to the workability of the proposed policies and procedures.

Identification

Under the Proposed Rules, an overpayment is "identified" if the provider: (1) has "actual knowledge" that an overpayment exists; or (2) acts in "reckless disregard" or "deliberate indifference" of the overpayment. This means that if there is reason to suspect an overpayment, providers cannot ignore it. Rather, they must exercise reasonable diligence to determine whether the overpayment actually exists. "Reasonable diligence" includes performing activities such as self-audits, compliance checks, etc. The failure to perform such an inquiry could constitute "reckless disregard" or "deliberate ignorance." Also, providers cannot delay the reasonable inquiry. A suspected overpayment could turn into a false claim if the inquiry is not done with "deliberate speed." CMS offers the following examples of when an overpayment has been "identified":

- A provider discovers that it incorrectly coded certain services, resulting in increased reimbursement;
- A provider learns that a patient died before the service date on a claim that has been submitted for payment;
- A provider learns that services were provided by an unlicensed or excluded individual on its behalf;
- A provider performs an internal audit and discovers an overpayment;
- A provider is informed by a government agency of an audit that discovered a potential overpayment, and the provider fails to make a reasonable inquiry;
- A provider begins receiving a significant increase in Medicare revenue for no apparent reason, but fails to make a reasonable inquiry.

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Reporting

CMS proposes to implement the overpayment reporting requirements by using the existing voluntary refund process in which providers report overpayments to Medicare contractors via forms available on the contractors' websites. Until CMS develops a uniform reporting form for all providers, providers should use the form found on their Medicare contractor's website. The Wisconsin Physicians Service forms can be found at http://www.wpsmedicare.com/j5macparta/forms/index.shtml (Medicare Part A) and http://www.wpsmedicare.com/j5macpartb/forms/index.shtml (Medicare Part B).

Interplay with Self-Referral Disclosure Protocol (SRDP) and Anti-Kickback Statute

CMS proposes to suspend the 60-day requirement to return the overpayment when a disclosure is made under the SRDP. Providers, however, would still be obligated to report the overpayment as discussed above.

CMS offers some good news for providers that receive overpayments that resulted from a kickback arrangement to which they were not a party. CMS will not seek repayment from the provider, except in the most extraordinary circumstances. For example, a hospital may be unaware that a DME supplier has paid a kickback to a physician on the hospital's staff to induce the physician to utilize the supplier's DME for patients treated at the hospital. If the hospital discovers the kickback, it is obligated to report it, but the parties to the actual kickback arrangement (and not the innocent provider) would be required to repay the overpayment.

Providers Needing Additional Time for Repayments

One concern with the 60-day window to return overpayments is that some providers may not have the funds needed to return the overpayment within such a brief period. Even so, CMS proposes that providers may not delay identification of overpayments because of their financial constraints. If the provider is unable to repay the overpayment within 60 days, it should use the existing Extended Repayment Schedule process to request an extension.

Lookback Period

CMS proposes a 10-year "lookback period" under which providers are not required to return overpayments received more than 10 years before they are identified. CMS's self-serving justification for this lengthy period is that providers should be able to close their books at some point and should not be subject to false claims liability forever, but this provides little comfort to providers facing overpayment liability for up to a decade after a payment is received.

Unresolved Questions

CMS fails to address the issue of the hard to quantify overpayment. In many cases, it may take providers much longer than 60 days to quantify and actually refund the overpayment.

The full text of the Proposed Rules can be found at http://www.ofr.gov/OFRUpload/OFRData/2012-03642_PI.pdf. These rules are only proposed and are subject to change when CMS issues the final rules.

For Further Information

If you have questions or want more information, you should contact your legal counsel to ensure compliance with the Affordable Care Act. If you do not have regular counsel, Foulston Siefkin LLP would welcome the opportunity to work with you to specifically meet your business needs. Brooke Bennett Aziere is available to assist you. Brooke Bennett Aziere can be reached at 316.291.9768 or **baziere@foulston.com .** If you are looking for general health care counsel you may contact Scott Palecki at (316) 291-9578 or **spalecki@foulston.com** .

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