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Medicare Clarifies 60 Day Overpayment Rule

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On February 12, 2016, the Centers for Medicare & Medicaid Services ("CMS") published the long-awaited final rule implementing an Affordable Care Act requirement for healthcare providers and suppliers to report and return identified Medicare Part A and Part B overpayments ("Final Rule"). Under the Final Rule, overpayments must be reported and refunded by the later of: i) 60 days of identification, or ii) the date of any corresponding cost report, if applicable. Clarifications in the Final Rule create more reasonable requirements for returning Medicare overpayments before penalties start accruing.

One of the most important clarifications is CMS' interpretation of when an overpayment is 'identified' for purposes of starting the 60 day repayment deadline. The proposed rule failed to define what CMS would consider as 'identification,' and, therefore, providers were uncertain as to when the 60 day time frame began. The Final Rule defines "identify an overpayment" as when 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." CMS concluded that an overpayment must be quantified to be identified because "that calculation necessarily must happen before the overpayment can be reported and returned." This is one of the most important clarifications under the Final Rule because it gives providers a better understanding of when the "identification" is deemed to occur so providers can avoid potential penalties for failing to report timely.

The Final Rule also implemented a requirement for providers to exercise "reasonable diligence" when determining whether an overpayment occurred. In the Final Rule, CMS replaced 'all deliberate speed' to identify and return an overpayment, with a 'reasonable diligence' standard. CMS further explained when a person obtains credible information concerning a potential overpayment; the person needs to act with reasonable diligence through a "timely, good faith investigation", over a period of time, which may be "at most six (6) months from receipt of credible information, absent extraordinary circumstances", to determine whether an overpayment has been received and to quantify the amount. The reasonable diligence requirement, and six (6) month time frame, will help to provide protection for good faith efforts to report and return an identified overpayment within the 60 day requirement. The 60 day clock will begin when either the reasonable diligence is completed, (or on the day the person received the credible information of a potential overpayment if the person failed to conduct reasonable diligence). Thus, a provider or supplier that conducts a timely investigation has a total of up to eight (8) months to identify, report and return Medicare overpayments, absent extraordinary circumstances. CMS indicated that if a health care provider or supplier has reported a self-identified overpayment to either the Self-Referral Disclosure Protocol managed by CMS or the Self-Disclosure protocol managed by the Office of the Inspector General the provider or supplier is considered to be in compliance with the provisions of the Final Rule so long as they are actively engaged in the respective protocol.

While technically there is no legal basis to hold providers and suppliers accountable for overpayments that they "should have" known about, CMS also made clear that effective compliance programs must be proactive, not just reactive. The Final Rule intends for 'reasonable diligence' to include both proactive compliance activities conducted in good faith by qualified individuals to monitor claims and reactive investigative activities undertaken in good faith and in a timely manner in response to receipt of credible information about a potential overpayment. Along with the requirements to remain reasonably diligent and institute compliance programs, CMS also advised providers to document their diligence efforts in a way which serves as concrete evidence to satisfy the requirements, such as time stamping documents to show when a potential problem was first brought to the attention of the provider, as well as the initial response to the information about an overpayment.

CMS also shortened the proposed 'look back' period once an overpayment is discovered. Under the proposed rule, providers were required to look back 10 years once an overpayment was identified to determine if similar overpayments occurred within the previous10 year period. Many commenters to the proposed rule expressed concern that a 10 year look back period would be overly burdensome and costly. The Final Rule relaxed that requirement, and reduced the time period that overpayments must be reported and returned to within six (6) years of the date the overpayment was received. CMS indicated it chose six (6) years because "many providers and suppliers retain records and claims data for between 6 and 7 years based on various existing federal and state requirements."

The Final Rule becomes effective on March 14, 2016 and implements many provisions which make compliance with the 60-Day Overpayment Rule more realistic for providers. If you have questions about any of the updates to Medicare's 60 Day Overpayment Rule, or general compliance concerns, please contact either Erin Aebel at 813.227.2357 or eaebel@slk-law.com, or Kelly Thompson at 813.676.7281 or kthompson@slk-law.com for Florida inquiries, and Kelly Leahy at (614) 628-6815 or kleahy@slk-law.com for Ohio and other inquiries.

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