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healthcare financial management association

Medicare Overpayments Final Rule Fact Sheet

The Centers for Medicare and Medicaid Services (CMS) published a final rule requiring providers and suppliers receiving funds under the Medicare program to report and return overpayments by the later of the date that is 60 days after the date on which the overpayment was identified; or the date any corresponding cost report is due, if applicable. The requirements in the rule are meant to ensure compliance with applicable statutes, promote high quality care, and protect the Medicare Trust Funds against fraud and improper payments.

The rule provides needed clarity and consistency in the reporting and returning of self-identified overpayments. However, even without the final rule, providers and suppliers are subject to the statutory requirements found in section 1128J(d) of the Social Security Act (the Act), and could face potential False Claims Act (FCA) liability, Civil Monetary Penalties Law (CMPL) liability, and exclusion from participation in federal healthcare programs for failure to report and return an overpayment. Additionally, providers and suppliers continue to be required to comply with current procedures when CMS, or its contractors, determine an overpayment and issue a demand letter.

The potential financial benefits of the rule from the standpoint of its effectiveness in recouping overpayments are not easily quantifiable, as CMS does not have sufficient data on which to base a monetary estimate of recovered funds.

Background

Providers and suppliers furnishing Medicare items and services must comply with the Medicare requirements set forth in the Act and in CMS regulations. As part of its efforts to reduce fraud, waste, and abuse in the Medicare program, CMS twice proposed, but did not finalize, rules that would have amended its regulations. On March 23, 2010, the Affordable Care Act (ACA) was enacted. Section 6402(a) of the ACA established a new section 1128J(d). This section requires a person who has received an overpayment to report and return the overpayment to the HHS Secretary, the state, an intermediary, a carrier, or a contractor, as appropriate, at the correct address, and to notify the entity to whom the overpayment was returned in writing of the reason for the overpayment. Section 1128J(d)(2) of the Act requires that an overpayment be reported and returned by the later of: (A) the date which is 60 days after the date on which the overpayment was identified; or (B) the date any corresponding cost report is due, if applicable. Section 1128J(d)(3) of the Act specifies that any overpayment retained by a person after the deadline for reporting and returning an overpayment is an obligation (as defined in 31 U.S.C. 3729(b)(3)) for purposes of 31 U.S.C. 3729. CMS published a proposed rule to implement the provisions of section 1128J(d) of the Act for Medicare Parts A and B providers and suppliers in the Feb. 16, 2012, *Federal Register* (77 FR 9179).

Many commenters stated their support for many provisions and goals of the proposed rule. Commenters generally agreed that providers and suppliers should promptly refund overpayments and maintain efforts to prevent and detect improper payments. While these commenters also suggested changes to certain provisions of the proposed rule, they stated that many of the rule's requirements were reasonable. Some commenters stated that they were pleased that CMS issued the proposed rule and believed it would motivate providers and suppliers to educate billing staff

and practitioners on Medicare billing rules. They were also hopeful that the rule would reduce improper payments and would help ensure the viability of the Medicare Trust Funds.

Proposed Rule Provisions

In the proposed rule, CMS defined a Medicare contractor as a fiscal intermediary, carrier, durable medical equipment Medicare administrative contractor, or Part A/Part B Medicare administrative contractor. Since the publication of the proposed rule, CMS has ceased using fiscal intermediary and carrier contracts, and accordingly, has removed these terms from the definition of Medicare contractor in the final rule. Overpayment was proposed to be defined as any funds that a person has received or retained under title XVIII of the Act to which the person, after applicable reconciliation, is not entitled under this title. This is the same definition that appears in the statute. CMS proposed to define “person” as a provider (as defined in §400.202) or a supplier (as defined in §400.202). CMS noted that this proposed definition does not include a beneficiary and that its proposal was consistent with the definition of “person” in section 1128J(d)(4)(C) of the Act. CMS reviewed and responded to comments received on the proposed rule in the final rule.

Summary of Major Provisions

The major provisions of the final rule center around three core components: the meaning of overpayment identification; the required lookback period for overpayment identification; and the methods available for reporting and returning identified overpayments to CMS.

1. Meaning of Overpayment Identification

CMS defines overpayment as any funds that a provider or supplier has received or retained to which the person, after applicable reconciliation, is not entitled. Creating a standard for identification provides needed clarity and consistency for providers and suppliers on the actions they need to take to comply with requirements for reporting and returning of self-identified overpayments.

2. Lookback Period

Overpayments must be reported and returned only if a provider or supplier identifies the overpayment within six years of the date the overpayment was received. Creating this limitation for how far back a provider or supplier must look when identifying an overpayment is necessary in order to avoid imposing unreasonable additional burden or cost on providers and suppliers.

3. Reporting and Returning Overpayments

Providers and suppliers must use an applicable claims adjustment, credit balance, self-reported refund, or another appropriate process to satisfy the obligation to report and return overpayments. This position preserves CMS’s existing processes, and preserves its ability to modify these processes or create new processes in the future. In the event that an OIG Self-Disclosure Protocol (SDP) settlement is not reached, the provider or supplier has the balance of the 60-day time period remaining from identification to the suspension of that 60-day period when OIG acknowledged receiving the SDP submission to report and return any overpayment to the contractor. The final rule contains the same language as the proposed rule concerning the returning obligation

Cost and Benefits

Not only must a provider or supplier report and return an overpayment to the HHS Secretary, the state, an intermediary, a carrier, or a contractor to the correct address by the later of 60 days after the overpayment was identified or the date the corresponding cost report is due, it must also state in writing the reason for the overpayment. Further, the 60-day time period begins either when the reasonable diligence is completed and the overpayment is identified, or on the day the person received credible information of a potential overpayment if the person fails to conduct reasonable diligence and the person in fact received an overpayment. CMS believes that this standard, as well as the requirement to conduct a timely, good faith investigation in response to obtaining credible information of a potential overpayment, provide “bright line” standards that should assist providers and suppliers in structuring their compliance programs to comply with the rule. The costs associated with these requirements are the time and effort necessary for providers and suppliers to identify, report, and return overpayments in the manner described in the rule.

Important Changes

For the most part, the final rule incorporates the provisions of the proposed rule, but there are some changes, as discussed below:

Overpayments

CMS proposed that overpayments be reported and returned only if a person identifies the overpayment within 10 years of the date the overpayment was received. CMS proposed this timeframe because it is the outer limit of the FCA statute of limitations. Commenters rejected this 10-year lookback period because of the burden and financial strain this requirement would place on providers and suppliers to implement the significant changes to hospital recordkeeping and information systems. After considering the comments received, CMS concluded that a 6-year time period is most appropriate for the final rule. According to commenters, many providers and suppliers retain records and claims data between 6 and 7 years based on various existing federal and state requirements. Therefore, CMS believes the final rule does not create additional burden or cost on providers and suppliers in this regard. Also, 6 years is consistent with the more commonly applicable FCA statute of limitations, as well as the statute of limitations under section 1128A of the Act, which contains a variety of civil monetary penalty authorities applicable to Medicare and Medicaid, including the CMP applicable to section 1128J(d) of the Act.

The enforcement mechanisms, the FCA and section 1128A of the Act, have time limits ranging from 6 to 10 years. CMS believes that the current reopening rules need to be adjusted to properly reflect section 1128J(d) of the Act, specifically the statute’s enforcement aspects. Therefore, CMS is amending the reopening rules to provide for a reopening period that accommodates the 6-year lookback period for reporting and returning overpayments, and to ensure that the reopening rules do not present an obstacle or unintended loophole to compliance and enforcement of section 1128J(d) of the Act.

Reporting and Returning Overpayments

In the Feb. 16, 2012, proposed rule, CMS proposed to require the use of the existing voluntary refund process, which will be renamed the “self-reported overpayment refund process,” set

forth by the applicable Medicare contractor to report and return overpayments. Under the existing voluntary refund process, providers and suppliers report overpayments using a form that each Medicare contractor makes available on its web site. CMS also proposed a specific list of 13 data elements that were required in the report. CMS recognized that some of the current reporting forms may differ among the different Medicare contractors and noted that it planned to develop a uniform reporting form that will enable all overpayments to be reported and returned in a consistent manner across all Medicare contractors. Until such uniform reporting form is made available, CMS directed providers and suppliers to utilize the existing form. CMS removed the proposed list of data element from the final regulation to eliminate confusion between compliance with the regulation and compliance with the applicable refund process, with the exception of the statistical sampling methodology explanation.

While commenters appreciated CMS's use of the existing voluntary refund process as the method for reporting and returning overpayments, they also noted that this it is not the only way to make overpayment refunds. This method is usually only used when a refund is made by check and the overpayment was calculated using a sampling methodology. In most overpayment cases, other processes are used that are effective and efficient both for the Medicare program and providers and suppliers. CMS agreed with commenters and amended the final rule accordingly by allowing for additional processes beyond the voluntary refund process. Thus, providers and suppliers may use the claims adjustment, credit balance, self-reported refund process, or another appropriate process to report and return overpayments. This position preserves CMS's existing processes, and also preserves its ability to modify these processes or create new ones in the future. CMS will continue to review its processes, and will consider suggestions to improve them. Any changes to these administrative processes, including the self-reported refund process, will be addressed in the applicable manual.

Hardship

In response to commenters' requests that the definition of "hardship" and the documentation requirements be changed so that providers and suppliers could more easily utilize the extended repayment schedule (ERS), CMS amends the definition by removing the phrase "outstanding overpayments (principal and interest)" and adding in its place the phrase "outstanding overpayments (principal and interest, and including overpayments reported in accordance with §§401.301 through 401.305)."

In the Feb. 16, 2012, proposed rule, CMS stated that providers or suppliers who needed additional time to return overpayments due to financial limitations should use the existing ERS process as outlined in Publication 100–06, Chapter 4 of the Financial Management Manual. CMS also noted that requests for ERS are not automatically granted and that providers and suppliers seeking to use ERS must submit significant documentation to verify true financial hardship. In the final rule, CMS allows for suspension of the deadline for returning overpayments when a provider or supplier requests an ERS as defined in §401.603. Explanation of the ERS and its documentation requirements are also contained in Publication 100–06, Chapter 4 of the Financial Management Manual.

More Information

The final rule is published in the Feb. 12, 2016, *Federal Register*. The regulations are effective on March 14, 2016.