LEGAL UPDATES

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CMS Releases Proposed Rule for Reporting Overpayments

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On February 16, 2012, the Centers for Medicare & Medicaid Services (CMS) published a proposed regulation in the Federal Register implementing an Affordable Care Act (ACA) requirement that Medicare and Medicaid overpayments be reported and repaid within 60 days. Failure to comply with the repayment obligations may lead to False Claims Act liability, civil monetary penalties or Medicare exclusion. Two areas of particular concern in the proposed regulation relate to the definition of "identification" and the extension of the overpayment and returning look-back period to 10 years.

Definition of "Identification"

According to the ACA, the 60-day reporting period begins with "identification" of the overpayment. CMS is proposing that "identification" be defined as actual knowledge of the existence of an overpayment or "reckless disregard" or "deliberate ignorance" of an overpayment. Healthcare providers had hoped that the proposed regulations would provide a more precise definition of this term. Unfortunately, the "reckless disregard" standard offers little, if any, clarification and in some cases may make it more difficult to determine the date an overpayment was identified.

That said, the proposed rule does offer a few somewhat helpful examples of circumstances under which an overpayment has been identified. For example, CMS states that an overpayment has been identified when "a provider . . . performs an internal audit and discovers that overpayments exist." However, it is unclear whether the knowledge of any employee performing a billing audit that indicated possible over coding constitutes "identification" or whether an error must be communicated up through an organization and confirmed in order for an overpayment to be truly identified.

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Despite the clearly inadequate definition, CMS appears to understand that identifying an overpayment can be an unfolding process and that as long as providers act with "all deliberate speed" in investigating, reporting and returning overpayments within the 60-day window, regulatory requirements will have been satisfied.

Stark Implications

The identification of an overpayment clearly implicates Stark Law compliance as well. One of the consequences of a financial arrangement between a physician and an entity failing to meet a Stark Law exception is that any referrals of Medicare reimbursable designed health services are not properly billable to Medicare and are subject to refund. Therefore, identification of a Stark Law issue potentially triggers the 60-day reporting rule at such time as the overpayment created by the Stark Law issue is identified. CMS states that a disclosure under the Self-Referral Disclosure Protocol (SRDP) suspends the running of the 60-day notice period, but this means the SRDP filing must be made within 60 days of identifying the overpayment that results from the Stark Law issue. Because of the complexity of an SRDP filing, care must be taken to see that the filing is timely under the proposed definition.

Extension of Look-Back Period

In its proposal, CMS also suggests that the overpayment reporting and returning look-back period extend to reimbursement received in the previous 10 years. Historically, it was commonly accepted that the look-back period was four years, with providers being obligated to refund any overpayments identified in that timeframe. A 10-year look-back period represents a significant extension of exposure.

To align the proposed overpayment look-back period with regulations governing Medicare claims, CMS further recommends extending the period during which claims identified by providers as overpayments may be reopened to 10 years. It does not appear, however, that CMS intends to similarly expand its current four-year limit for auditing claims. This creates the awkward consequence of competing look-back periods: a 10-year timeframe for overpayments and a four-year period for reopening claims for audit by CMS.

What This Means to You

Providers should consider submitting comments to CMS regarding aspects of the proposed regulations that appear overly burdensome or that would make compliance difficult. Comments are due by April 16, 2012, which is less than 60 days away. Because CMS takes feedback it receives into account in the final rule, it is important that providers make the most of this opportunity to be heard. Please contact us right away if you would like assistance in preparing or submitting comments.

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Contact Info

If you have questions, please contact your Husch Blackwell attorney or Curt Chase at 816.983.8254.

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