

CMS Floats 60-Day Medicare Overpayment Refund Rule

By **Rachel Slajda**

Law360, New York (February 14, 2012, 4:59 PM ET) -- The Centers for Medicare and Medicaid Services on Tuesday announced a proposed rule that requires Medicare providers to report and return overpayments within 60 days or face False Claims Act liability, a requirement called for by the health care reform law.

Providers have been anxious for clarification since the law was signed in March 2010. In what one attorney described as a “bombshell,” the rule proposes a look-back period that would apply the refund requirement to 10-year-old overpayments.

“If this proposed rule is finalized along the lines of the proposal, this is going to be a real field day for the qui tam whistleblowers,” Howard Young, a partner in Morgan Lewis & Bockius LLP’s health care practice, told Law360.

Young suggested that if a provider went back through, for example, three years of records and found an overpayment, it could open the provider to substantial FCA liability for the rest of the decade. Audit contractors and whistleblowers could claim that the provider was showing reckless disregard by not diligently searching for, and thereby keeping, similar overpayments from the previous seven years.

CMS made a point in the proposed rule to ask the industry for comment on the look-back period.

Providers have also been waiting to find out how the CMS would define the trigger date for the 60-day deadline.

Under the statute, providers have 60 days from when an overpayment is “identified” to report the overpayment and return the funds.

According to the proposed rule, the clock starts ticking when a provider “acts with actual knowledge of” an overpayment. If, for instance, a provider was told of a suspected overpayment and investigated, the clock would start on the day the provider determined, as a result of an investigation, that an overpayment had in fact occurred, according to the rule.

Providers and suppliers could also be held liable if they hear of a potential overpayment and do not investigate, the rule said.

The 60-day deadline applies mostly to overpayments made as the result of claims, be they medically unnecessary, duplicated or otherwise uncovered.

There's another deadline for a different type of overpayments. Under Medicare, providers often receive estimated payments, such as graduate medical education payments that cover a portion of the costs of training residents, that are later reconciled with actual costs the provider incurred.

When providers and suppliers receive an overpayment for that type of payment, they have until the next cost report, reconciling the estimated payments with the actual costs, is due.

The proposed rule makes clear that the cost report deadline can only be used for payments that would have been reconciled on the report.

"We do not believe that Congress intended to create a loophole that would allow providers to delay reporting and returning an identified overpayment until a cost report is due," the rule states, "if the overpayment would not ordinarily be reconciled on the cost report."

The proposed rule will apply only to Medicare Part A and B suppliers and providers for the time being. Further regulations will apply to Medicaid managed care organizations, Medicare Advantage organizations and Part D prescription drug plan sponsors.

CMS has tried to create a deadline for reporting and refunding overpayments before, and proposed such rules twice, once in 1998 and once in 2002. Neither rule was finalized.

The proposed rule will be published Thursday, and open for public comment for 60 days.

--Editing by John Quinn.

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