

PUBLICATION

Proposed Rule for Overpayment Reporting Obligation under Section 6402(a) of the ACA

February 21, 2012

On February 16, 2012, the Centers for Medicare and Medicaid Services (CMS) published in the Federal Register the Proposed Rule implementing Section 6402(a) of the Affordable Care Act (ACA) (Section 1128J (d)(1) of the Social Security Act). The proposed rule, regarding reporting and returning overpayments, proposes a deadline of 60 days after the date on which the overpayment was identified or the date any corresponding cost report is due, if applicable, whichever is later. Section 1128J (d)(3) further specified that any overpayment retained past the deadline could give rise to a False Claim under 31 U.S.C. 3729. By way of example, CMS states that an upcoded claim must be reported within 60 days of identification, while certain graduate medical education overpayments must be reported either within 60 days of identification or on the date the cost report is due, whichever is later, since this is the type of claim that may not be discovered until reconciled on the cost report. For compliance hotline reports, CMS proposes that an obligation to make reasonable inquiry arises and timely reporting would be triggered by conducting the "reasonable inquiry with deliberate speed after obtaining the information..."

The proposed rule, under the 42 C.F.R. 401.301 definition section, provides examples of "overpayments" including incorrect, duplicate or medically unnecessary claims, payments received in error under the Medicare Secondary Payor rules, incorrect interim payments or claims made under cost reports. It further defines the "person" obligated to report the overpayment as a provider or supplier but not a beneficiary.

The repayment obligation is the existing voluntary refund process renamed the "self-reported overpayment refund process" described in Publication 100-06, Chapter 4 of the Medicare Financial Management Manual. CMS provides a non-exclusive list of reasons for the overpayment obligation including: "(1) incorrect service date; (2) duplicate payment; (3) incorrect CPT code; (4) insufficient documentation; and (5) lack of medical necessity."

CMS proposes to elucidate when identification of an overpayment occurs citing the terms "knowing" and "knowingly" under the False Claims Act. CMS states that a person has identified an overpayment if the person "has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment" suggesting that providers and suppliers have "an incentive to exercise reasonable diligence to determine when an overpayment exists."

CMS points out the natural intersection between this reporting obligation and the Medicare Self-Referral Disclosure Protocol (SRDP). Under SRDP, CMS has the authority to reduce the amount due and owing for violations of the physician self-referral statute and also to suspend the obligation to return overpayments under Section 6402(a) when CMS acknowledges receipt of the SRDP disclosure. CMS also acknowledges the intersection with the OIG Self Disclosure Protocol (OIG SDP) wherein upon settlement, the OIG releases its Civil Monetary Penalties Law (CMPL) and permissive exclusion authorities in exchange for the negotiated payment which would include any overpayment. In this proposed rule, CMS proposes to suspend the overpayment return obligation which the OIG acknowledges receipt of a submission to the OIG SDP until the settlement is reached or the provider or supplier withdraws or is removed from the OIG SDP process. Further, CMS proposes that any notice to the OIG of the identified overpayment is a report under 401.305 of this proposed rule.

Lastly, CMS proposes that overpayments may arise as a result of violations of the anti-kickback statute since compliance with the law is a condition of payment. Therefore, a knowledge of a kickback will give rise to a repayment obligation. By the same token, a provider unaware of or not a party to a kickback is unlikely to have identified the overpayment and would therefore not have a duty to report, except in certain extraordinary circumstances.

CMS also proposes that financial ability should not be a reason to delay reporting an overpayment but instead a provider should timely report an overpayment using the existing extended repayment schedule (ERS) process outlined in Publication 100-06, Chapter 4 of the Financial Management Manual.

CMS proposes reconciliation of payment rules in the case of overpayments and a look back period for overpayments of 10 years coinciding with the False Claims Act statute of limitations. This is an especially controversial time frame as a normal look-back period is 1 year absent good cause or fraud. This essentially rewrites the repayment obligation for all purposes.

Comments on the proposed rule must be received 60 days after the Federal Register publication date. The proposed rule can be found at 77 Fed. Reg. 9179 (February 16, 2012). [Click here](#) for a PDF version of the proposed rule.

If you have questions or need any additional information about how the proposed rule for overpayment may affect you or your company, please contact your Baker Donelson attorney.