Client Alert: CMS Final Rule Clarifies and Eases Obligation to Report and Return Medicare Overpayments

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CLIENT ALERT | 2.11.2016

On February 11, 2016, Medicare regulators issued a final rule that relaxes the obligations for doctors and hospitals to report and return Medicare overpayments (RIN 0938-AQ58, CMS-6037-F). By this final rule, the Centers for Medicare and Medicaid Services (CMS) clarified requirements for the reporting and return of self-identified overpayments required under the Affordable Care Act (ACA). Key elements of the rule include clarification of the meaning of overpayment identification, and the required look-back period for overpayment identification. These clarifications significantly impact the ability of healthcare providers to avoid federal False Claims Act (FCA) liability.

The final rule dealt with the ACA's requirement that obligates healthcare providers to report and return identified Medicare overpayments within 60 days. (42 U.S.C. § 1320a-7k(d).) If an overpayment is retained after the 60-day report and return deadline, the overpayment is considered an "obligation" for the purposes of FCA.

Under the newly-published rule, the identification of an overpayment covered by the provisions of the ACA occurs when a healthcare provider "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." Thus, the rule embraces a two-pronged standard for overpayment identification—(1) determination of receipt of an overpayment, and (2) quantification of the overpayment. This approach recognizes that a reasonable amount of investigation is required before an overpayment can be considered "identified" for the purpose of triggering the 60-day report and return period under the ACA.

As for the look-back period for overpayment identification, the new rule requires healthcare providers to review their records for additional overpayments once an overpayment has been identified. Under the initial proposal of the rule in 2012, the applicable look-back period was 10 years. However, when publishing the final rule, CMS reduced that look-back period to 6 years. The rule explained that this limitation on

the look-back period "is necessary in order to avoid imposing unreasonable additional burden or cost on providers and suppliers." By issuing the rule, CMS has reduced the potential time period that a healthcare provider must review records for additional overpayments (after an initial overpayment has been identified) by 40% from the original proposal.

The issuance of this final rule is a positive development for all Medicare providers. Recognition by CMS that reasonable investigation is required to identify an overpayment and the rule's shortening of the look-back obligation significantly ease the burden on healthcare providers in their efforts to ensure ACA compliance and to avoid liability under the FCA.