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▶ ***Navigating Treacherous Waters:
Medicare's Final Rule for Reporting
and Returning Overpayments***

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Background

- ▶ In October 2010 a provision of the Affordable Care Act, Section 6402(a) amended the Social Security Act by inserting several “program integrity” elements into that law. The focus of those program integrity elements is Medicare providers and suppliers. 1 These new requirements provide direct statutory support of the long standing principle that participating providers must report and return to the Medicare Trust Fund any “unearned payments” they have received net of any applicable reconciliation. 2 A sixty-day time period was established for returning any monies received for such “overpayments.”

It soon became clear, however, that the language in this provision of the Affordable Care Act was deficient. This was principally due to a woeful lack of details regarding the “mechanics” of the process that providers were expected to follow in making overpayment returns and concerns over the length of time that providers would remain liable to repay Medicare for overpayments under this provision.

Two years later in 2012, CMS responded to the situation by publishing a set of “proposed final rules” governing overpayment reporting and recoveries. This proposed rule was designed to flesh in by way of regulatory guidelines the gaps in Section 6402(a) so that providers could better comply with the law.

However, the guidelines in the proposed rule were themselves widely criticized in the provider community. Specific issues focused continuing ambiguities on (1) The calculation of the starting point for the mandated 60 day repayment time frame, (2) The length of time that providers would continue to assume repayment liabilities for any overpayments uncovered in their historical claims experience, and (3) Continuing uncertainties as to how CMS's general overpayment recovery policies would be applied across the alphabetical family of Medicare Programs (e.g., Parts A, B, C and D) given the significant differences in the structure and payment models under which each of these programs operates.

On February 12, 2016, CMS issued a long anticipated new "Final Rule." That Rule became effective on March 14th. The content of this rule significantly refines and clarifies both the assumptions and operational details as to how providers are to identify any undue payments received and the process for reporting and returning them to comply with Section 6402(a).



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1. The Social Security Act was amended by adding a new Section 1128J (d) to that Act. The statutory vehicle which accomplished that was Section 6402(a) of the Affordable Care Act.
 2. An applicable reconciliation is defined in the statute as a reconciliation that enables the "person", in our example the professional provider, to identify the funds to which he/she was not entitled.

The objective of this paper is to, in an economical fashion; sort out the content and requirements of this Final Rule. In so doing, our focus will be on the identification, reporting and payment return requirements that are applicable to providers and suppliers of professional services. Very little will be said as to how these program integrity requirements apply to institutional providers such as hospitals, the organizational sponsors of Medicare health plans, or Medicare contracted organizations which provide prescription drugs to beneficiaries under Part D of Medicare.

The “Regulatory Scope” of the Overpayments Rule

Section (1128J (d) (4) (C) of the Affordable Care Act identified the class of eligible “persons” who were responsible for returning overpayments to Medicare. They were service providers and suppliers, Medicaid Managed Care Organizations, Medicare Advantage Organizations and Medicare Prescription Drug Plans. It is important to note that Medicare beneficiaries are not affected parties in this overpayment rule.

However, the guidance provided by CMS for the rule interpretation makes it clear that the policies and procedures outlined in this rule *only apply to providers and suppliers participating in Medicare Part A and Part B*.³ Medicare Advantage Part C Plans, Managed Medicaid programs, and the contracts negotiated by the federal government and/or states, under either Medicare or Medicaid for prescription drugs, for example Medicare Part D, do not fall under the scope of this Final Rule.⁴

CMS overpayment regulations for Part C Medicare Advantage and Part D Prescription Drug Plan Sponsors are outlined in a separate Final Rule that was issued in May of 2014. The content of *those rules* focus on the mechanics of the newly expanded reporting and payment return responsibilities applicable to the organizational sponsors of Part C and Part D Plans. For example, relative to Medicare Part C Plans those rule provide regulatory guidance to the CMS’s privately contracted Plans on how to identify and report over payments that are the result of the risk adjusted HHC reimbursement model that CMS uses to make payments to the sponsor of such Plans.

3. On May 6th 2016 a set of expanded and revised overpayment reporting and recovery rules applicable to the Medicaid Program were announced as part of an omnibus Medicaid Managed Care “Final Rule”. The substance those rules which become effective on July 1 of 2017 require state contracted Medicaid Managed Care Programs to adopt some of the features and definitions contained of the overpayments Final Rule applicable to Medicare Parts A and B that are the focus of this paper. For example, there is a sixty day time requirement for reporting identified overpayments. However CMS also offers State Medicaid programs a significant amount of flexibility in mechanics of implementing overpayment recovery rules. See Federal Register, Volume 81, No. 88 Friday, May 6, 2016, “ Medicaid and Children’s Health Insurance program (CHIP) Delivered in Managed Care and Revision Related to Third Party Liability; Final Rule”. Overpayments are discussed on pages 277891-27892.

4. CMS overpayment regulations for Part C Medicare Advantage and Part D Prescription Drug Plan Sponsors were outlined in a separate Final Rule issued in May of 2014. The content of those rules focus on clarifying the mechanics of the expanded reporting and payment return responsibilities of those organizational sponsors to CMS Medicare to those Plans and not to any overpayment regulations that CMS imposed on Part C Plan sponsors and their contracted network providers. See Federal Register, Vol.79. No 100 Friday, May 23, 2014, Rules and Regulations, Pages 29918-29926.



What Constitutes an Overpayment?

Overpayments are any funds received and retained by the professional providers after any applicable reconciliation that he/she is not entitled to receive under Titles 18 or 19 of the Social Security Act... Examples include payments for (a) non-covered or duplicate services, (b) payments beyond the Medicare Allowable Amount for the covered service, (c) payments received from Coordination of Benefits errors, or (4) as applicable, any errors on Medicare cost reports. Potential underpayments to providers are not a part of the Final Rule and potential allowances or offsets are not a part of the Final Rule's overpayment regulations.

Understanding the Overpayments Final Rule

The mechanics of the revised overpayment reporting and recovery rules can be best explained through a series of "Questions and Answers," with an occasional narrative detour and, as necessary, footnotes to provide additional detail, rule exceptions, and to reference sources.

Question 1: "At What Point in Time Does the Professional Provider's / Supplier's Liability for the Overpayment begin? When does a received overpayment become an *identified overpayment*?"

The Answer: To answer this Question, we must first explore two key concepts that are embedded into the Final Rule: (1) how CMS determines when an overpayment becomes "identified" by the provider and (2) a focus on quantification. The identification of an overpayment must be expressed in quantitative terms. The Final Rule states that an overpayment is identified when "... *the eligible "person," in our case the Part B professional provider, has knowingly identified or should have knowingly identified the overpayment, through the exercise of reasonable diligence.*"⁵

5. Federal Register Vol.81, No. 29 Friday, February 12, 2016 Rules and Regulations, Page 7680.

CMS's underlying reasoning is that a provider's knowledge of an overpayment is based on either "active knowledge" or "passive knowledge." If the provider has active knowledge that he or she has been overpaid by Medicare then in fact he or she has identified it! If the provider's overpayment knowledge was "passive," the identification of that overpayment should have been made if reasonable diligence had been exercised by the provider. If the Provider failed to identify it (i.e., reasonable diligence was not used) this does not exempt that provider from being penalized for any failure to identify, value, and report it.⁶ Said another way, not taking reasonable actions to identify an overpayment is not an excuse. An "Ostrich defense" says CMS, cannot be used.⁷

In the Final Rule CMS spells out, in some detail, both the likely circumstances and the affirmative obligations or "actions" that providers must take to avoid the penalties for failing to make an overpayment return. Those shall be explored later. But first we need to review the second concept that is an essential part of the answer to Question 1. This is the quantification requirement.

CMS's position is that a credibly identified overpayment does not become fully identified until it has been quantified. That makes quantification a concurrent part of overpayment identification. The process of quantifying an initially "suspect overpayment" works in tandem with its identification. This quantification of the amount of the overpayment is to be completed by the provider before the overpayment is reported. This is an important point and it works to the benefit of the provider in a couple of ways.



6. The penalty statutes that are applicable are The False Claims Act and the Civil Monetary Penalties Law. CMS estimates that the civil penalties would range from \$5,500 to \$11,000 per claim.

7. CMS observes in its commentary that "If the requirement to report and retrain overpayments only applied to situations where providers or suppliers had actual knowledge of any overpayment, then these entities could easily avoid returning the improperly received payments Federal Register Vol.81, No. 29 Friday, February 12, 2016 Rules and Regulations, Page 7660.

First, under the Final Rule, a provider who discovers (i.e., identifies) that he or she may have been overpaid is given time to investigate whether indeed he or she was overpaid. That investigative process delays (e.g., tolls) the start of the “first tick” of the statutory based sixty day overpayment clock. The progression of that clock toward that due date does not begin until the provider has quantified the suspect overpayment. Only then is it required to be reported to the applicable Medicare entity. It is at that point when the statutory designated allowed time for making the payment begins. The Final Rule does not require CMS to preemptively start the 60-day repayment clock based on its own volition nor does that clock begin until the suspected provider overpayment has been researched and confirmed by the provider. However, the Rule does state that the provider’s time frame for completing this investigative process must be “timely.” Just how timely will be discussed later.

Second, based on the Rule’s mandate that the credibly identified overpayment must be quantified before it is required to be reported allows the provider to assess if the identified overpayment is, after examination, an actual overpayment. In so doing, this quantification requirement works to minimize the provider’s risk of prematurely reporting to Medicare or its Agents an overpayment that subsequently is determined to be false or incorrect. Given the technical complexities involved in sorting out “correct” payment amounts for individual line items in large batches of claims, this is an important practical consideration.

Finally, we should note that, at the technical level, the Final Rule also allows providers to use statistical sampling and projection methodologies in evaluating the overpayment. The provider does not have to completely enumerate each claim in the process of determining the size of the final overpayment amount. The methodology the providers used, however, must be transparent and be included in the accompanying repayment report.⁸



8. Providers must provide written descriptions of their sampling or extrapolation methods in determining overpayment, irrespective of the language in any contractual agreement between Medicare and its various contracting organizations.

Question 2: *What are the likely circumstances that cause overpayments and what are the specific steps that providers can take to demonstrate the “reasonable diligence” that is required to identify overpayments?*

The Answer: Commentary in the Final Rule on this point starts out by reviewing a number of provider behaviors which are likely to generate an overpayment to the provider by Medicare. The regulatory commentary then goes on to catalogue some specific actions that providers can take to demonstrate that the required “due diligence” is being exercised to detect them.

The first example that CMS suggests as the likely cause of overpayments is errors in the initial coding of the service(s). Whether the unearned monies generated by coding errors is the result of unintentional or intentional up-coding is not the immediate concern in this rule.⁹ What is of concern is that the unearned dollars paid by Medicare to the provider are identified, valued and reported.

Another more generalized scenario in the Final Rule is providers failing to act on the *credible information* provided by an internal or external source. For example, the provider’s failure to respond to the result of its own internal audit or lapses in investigating an external party’s (e.g., a government agency’s) notifications that a possible overpayment may have been made, for example, a failure to follow up on a CMS CERT Report indicating that the practice is an outlier compared to peers.

A pattern of systemic inactions by providers such as a failure to perform routine compliance efforts or neglecting to investigate unusual or unexplainable increases in the practice’s Medicare revenue are examples that is mentioned in the regulatory guidance. A practice’s failure to respond to beneficiary hotline calls made to CMS reporting suspected overpayments would also constitute evidence of the failure to exercise the degree of diligence that CMS now expects.

9. Commentary in the Final Rule addresses the relationship between deliberately engineered overpayments that result from monies collected from fraudulent activities and standard failures to report overpayments. CMS notes that this rule goes beyond overpayments caused by fraud or abuse violations where the provider is a party to the illegal activity. That, of course, clearly generates unearned funds. In this Rule if, on investigation, the provider was unaware or can demonstrate that they could not identify illegal activity, they are not responsible for reporting or repaying the funds. To the extent that providers are aware but not an actual party to fraudulent activities, the Rule suggests that those should be reported to CMS Fraud Units or the OIG.


In the Final Rule’s commentary on this all-important issue of how to fulfill the “reasonable due diligence” obligation, the provider’s compliance activities must meet three tests. First, they must be affirmative and not reactive in nature and they must demonstrate “up-front” that the practice has established policies and procedures for monitoring possible overpayments. Second, those monitoring practices must be systemized. “Hit and miss “actions and activities will not do! Finally, what is done must be conducted by appropriately qualified individuals within the organization. Research into their coding practices must be performed by qualified coders. Financial information should be reviewed by trained personnel. Monitoring overpayments will require that information be gleaned from many sources: periodic audits, investigations of signal or sentinel events, medical record reviews, communications and reports from external sources. Providers will also be expected to be on the alert for services delivered by unqualified or improperly licensed providers and providers who are excluded from Medicare.

Question 3 *What timelines apply in the Final Rule? How are these timelines calculated? Are there any exceptions? What about the Final Rule’s Requirements that the Provider is retroactively responsible for making Overpayment Returns?*

The Answer: The new overpayment rules contain three key timelines. They are “Sixty Days,” “Six Months” and “Six Years.” Taken together, the three time frames can serve as a “memory jog” that sums up the requirements found in the Final Rule with respect to allowable times. Let’s take a look at each.

“Sixty-Days” As was briefly noted in the Introduction, the Final Rule requires providers to report, in writing, any overpayment within sixty (60) calendar days after the date on which that overpayment is first identified. That Report must be forwarded to the “appropriate entity” and must contain the reason for the overpayment. It must also contain the quantitatively expressed estimate of the overpayment amount since any identified overpayments must be quantified.

It is worth re-emphasizing that the Final Rule specifies that the count against the sixty-day grace period that is allowed before the provider’s re-payment to Medicare becomes due varies based on the degree of diligence that was prospectively exercised. CMS’s guidance in the Final Rule makes this clear when it states:



“The sixty-day time period begins either when the reasonable diligence is complete and the overpayment is identified or on the day the person (i.e., the provider) received credible information of a potential overpayment if that person failed to conduct reasonable diligence and the person in fact received an overpayment.”

“Six Months” The Final Rule allows the provider “at most six months” for the practice to complete its due diligence investigation. That six month time frame starts to run when the credible evidence of a potential overpayment was first received. When combined with the sixty-day time period we just noted an actual total of eight months is afforded to the Provider by the Final Rule. Additionally, in extra ordinary circumstances (e.g., natural disasters or national emergencies) or unusually complex investigations, additional time may be allowed by CMS based on case specific the factual circumstances.

“Six Years” Without a doubt the most controversial issue in the long-standing tug- of-war between providers and Medicare relative to overpayment recovery regulations has been achieving a consensus on the “Look-back Period.” How far back is that practice responsible for the erroneous overpayments that are or may be identified? Is the provider’s responsibility for reporting and repaying Medicare for potential similar undiscovered overpayments chronologically unlimited?

In its earlier regulatory efforts Medicare had initially proposed a ten year “Look-Back Period”. * Provider organizations have long argued for a four year time frame for reporting retroactively. In 2010 the overpayment regulations in Section 1128J (d) of the Affordable Care Act failed to address the Look-Back issue.

After much wrangling the Final Rule established a compromise setting a six-year “Look Back” window. Providers, with one exception, are not required to report identified overpayments with services dates that are greater than six years from the Final Rule’s effective date of March 14, 2016. The provider’s responsibility to request from Medicare or its Agents claims re-openings for the express purpose of reporting and returning of identified overpayments does not extend beyond that time limit.¹⁰

It is important to note that the new six year period will not itself be applied retroactively. Providers who have been making “good faith efforts” to comply with the preexisting regulations (i.e., those reimbursing Medicare for overpayments prior to March 16, 2016) will not hold to the new six-year look back period established in the Final Rule.¹¹

There is, however, one exception here. Providers making payments under Medicare’s Self Referral Disclosure Program prior to March 14, 2016, will have a special four-year “Look Back Period” applied to them. Participants in that program making payments after that date will be held to for the standard six year Look-Back period.

Question 4 *What is the process for reporting identified overpayments to Medicare? What are the terms and conditions applicable to overpayment returns? What are the consequences if the overpayment is not returned?*

The Answer: The Final Rule requires providers receiving overpayments to both report and returns them to the Secretary, an Intermediary, a Carrier or a Contractor, as appropriate.¹²



10. Federal Register, Vol. 81 No 29 Friday February 12, 2016, Rules and Regulations ,Page 7662 Col 3 Paragraph 4.3 and Page 7663 column two Paragraph 5.

11. This period mimicked the outer period for pursuing actions under the False Claims Act’s existing Statute of Limitations Register, Vol. 81, No. 29 Friday February 12, 2016, Rules and Regulations Page 7662 Col3 Paragraph 1.

12. This may be the State, the Medicare Part B Carrier or Fiscal Intermediary for professional providers or Medicare contractors such as a RAC.

Medicare's existing voluntary refund process, now renamed the "Self-Reported Overpayment Refund Process" has been and will continue to be the primary vehicle providers will use in reporting and making repayments. That process is described in the Medicare Program Integrity Manual (Publication 100-08 Section 4.16).

The forms currently provided by various Medicare contractors should be used and they are available on those contractor's Websites. For providers of professional services, these are, of course, Medicare Carriers and Fiscal Intermediaries. A new "Standard" Uniform Overpayments Reporting Form" is being developed by CMS and will, going forward, be used by all contractors. In the interim, the current Forms should be used.

CMS has also made it clear that at the technical level for both Part A and Part B providers it will allow the existing repayment channels to be used to make repayments. For example, for Part B of Medicare, the claims adjustment and credit balance processes currently in effect will be acceptable avenues for making returns.

However, for providers and suppliers using either the OIG's Self Disclosure Protocol or CMS Voluntary Self Disclosure Reporting Protocols, the provider must continue to follow the reporting and repayment guidelines applicable to those programs when making those types of re-payments.

The Final Rule does make allowances for "hardship cases" when a practice retains significant financial liability for overpayment returns. The current Extended Repayment Schedule (ERS) process outlined in Publication 100-06 Chapter 4 of the Medicare Financial Management Manual I will continue to be the vehicle for applying for a request to extend the time for making repayments. Providers will, however, have to meet the significant documentation requirements outlined in that process.¹³

The submission of an ERS request does suspend the deadline for returning the overpayments. Providers may also "toll" that deadline and satisfy the reporting requirements of the Final Rule through disclosing by self-identification overpayments and initiating the CMS Voluntary Self Referral Disclosure Protocol mentioned above.¹⁴

13. Federal Register, Vol. 81 No 29 Friday February 12, 2016, Rules and Regulations, Page 7679 Col 3.

14.. The expiration of the suspension (e.g. the tolling") of that deadline varies depending on whether the provider's request for an extension of the repayment plans is pursued through the ERS or the OIG or CMS Self Disclosures programs.

Per Section 1128j9d of the Affordable Care Act, a provider who fails to return an overpayment risks being in violation of both the Federal False Claims and the Civil Monetary Penalties Law. In the extreme case, the provider could face expulsion from the Medicare program.

Finally, CMS acknowledges that the many requirements in this Final Rule will materially add to a practice's cost of doing business. Based on CMS's calculations, the high end estimate of meeting these requirements would collectively be about 60 million dollars per annum assuming five overpayments per impacted provider or supplier which CMS estimates to be 125,000. That's approximately \$500.00 in additional expense per provider, per year.¹⁵

At the end of the day, however, the publication of this Final Rule has pulled back the curtain on the ever-tightening regulatory process that has characterized Medicare's regulatory stance on the issue. What is unique about this rule is its severity. As one commentator has wryly put it:

"This rule is one of the most Severe for the simple reason that a violation cannot be cured; an overpayment reported and return on the 61st day is a violation of the FCA."¹⁶



15. Federal Register, Vol. 81 No 29 Friday February 12, 2016, Rules and Regulations, Page 7681 Col 1.

16. FCA is the Federal False Claims Act. Reed Smith Life Science Health Industry Alert Claim Alert 12-076 March 2012, Page 4.



Practical Suggestions for Providers Navigating the Final Rule

- *Time stamp all documents so that both the overpayment problem and its solution can be chronologically tracked.*
- *Create a paper trail to provide credible documentation of the required due diligence scrupulously monitor any incoming overpayment candidates.*
- *When a reason for a specific overpayment is identified, be sure to ascertain its “Look-Back” implications in order to determine the length of its tail.*
- *All internal audits should be carefully constructed and methodologically explicit and transparent.*
- *The operative rule should be that, relative to monitoring overpayments, ignorance is not bliss.*
- *Respond to external reports, evaluation, notices and complaints promptly.*
- *Failures to respond to overpayments are likely to be viewed as negative acts of intentional avoidance and not as inadvertent mistakes.*
- *Incorrect coding, including the incorrect use of payment modifiers is a fertile ground generating overpayments.*
- *Put someone in charge of this but hold everyone in the practice responsible including yourself!*
- *Established written policies and processes should be put in place for identifying overpayments.*
- *Understand what your options are for making or delaying overpayment returns.*
- *When in doubt, consult a qualified attorney or consultant who is familiar with the Final Rule.*

About the author

Ms. Andria Jacobs is the chief operating officer for PCG Software and has more than 25 years’ experience in the healthcare industry, encompassing both administrative and clinical arenas. Prior to joining PCG, Ms. Jacobs was the administrative director, medical management for VertiHealth Administrators. Previously, she was an independent consultant in ambulatory care and practice management, where her clients have included hospitals, physician groups, and the University of California, Los Angeles.



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