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Compliance Concerns After CMS 60-Day Overpayment Rule

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This month, the final rule takes effect that clarifies the Affordable Care Acts' requirement that healthcare providers must report and return overpayments within 60 days after identifying the overpayment or the date any applicable corresponding cost report is due, whichever is later.


Rick Robinson

The final rule, 81 Fed. Reg. 7654 (Feb. 12, 2016), relaxes the Centers for Medicare and Medicaid Services' proposed rule by shortening the proposed lookback period and giving providers time to quantify amounts, although it maintains a strict approach that all overpayments — no matter how small — will require investigation and action.

"Reasonable Diligence" Is More Than Reactive


Selina Coleman

Providers will be held to a "reasonable diligence" standard, which replaces the previously proposed "actual knowledge," "reckless disregard," and "deliberate ignorance" standards for identifying overpayments. The new standard means that providers and suppliers have an affirmative duty to proactively determine whether overpayments have been made.

The 60-day time period for report and return begins when either reasonable diligence is completed (including determination of the overpayment amount) or on the day the person received credible information of a potential overpayment if the person failed to conduct reasonable diligence and the person in fact received an overpayment.

Parameters — Although Narrower Than Proposed — Are Still Stringent

No overpayment is too small: CMS expects that "after finding a single overpaid claim, we believe it is appropriate to inquire further to determine whether there are more overpayments on the same issue before reporting and returning the single overpaid claim," and the agency expressly declined to adopt a de minimis threshold.

CMS provided for a shortened lookback period of six years — rather than the proposed lookback period of 10 years: consistent with the False Claims Act's standard statute of limitations; although longer than the four-year time frame set forth in the reopening regulations at 42 C.F.R. 405.980(b).

The interplay of these requirements is that any evidence of an overpayment requires a thorough review for the preceding six years. For example, after resolving a third-party or internal audit involving a shorter time period, providers will need to expand the scope to cover the six-year time frame, unless there is a reason (like a change in the law) not to do so.

The Clock May Run More Slowly, But it Ticks Steadily

Under the final rule, "reasonable diligence" includes both identifying the existence of an overpayment and quantifying the amount of the overpayment: a more practicable approach for both providers and the contractors or other entities who may otherwise receive a series of partial refunds. Nevertheless, providers cannot idle or delay in the review.

CMS provides a benchmark of six months for timely investigation: a more concrete approach than the proposed rule's language of "all deliberate speed" — the standard for implementation of desegregation under Brown v. Board of Education that is now associated with endless delay.

More Avenues Are Open to Refund, But Only a Few Stop the Clock

CMS has provided an expanded list of acceptable methods for reporting and returning overpayments to include applicable claims adjustment, credit balance, and other reporting processes. For example, providers can achieve a refund through an offset, as well as a direct payment.

As expected, providers and suppliers are encouraged to file under the self-referral disclosure protocol that CMS offers for Stark Law violations or the Office of Inspector General's self-disclosure protocol for violations of federal law as soon as possible after identifying an overpayment. Generally, the requirement to return the overpayment is tolled for the full amount of time needed to negotiate a potential settlement with either agency.

The expanded six-year lookback period will affect not only the financial impact of self-disclosures with CMS (which, unlike the OIG, had a four-year lookback), but also the scope of assessing documentation for Stark Law compliance under the liberalized requirements outlined in the November Medicare Physician Fee Schedule final rule. In other words, in the absence of a formal agreement, providers may need to dig out archives to gather sufficient documentation to support a Stark Law compliant arrangement.

Outside of CMS's protocol for Stark Law issues and the OIG's broader protocol — which carries a standard 1.5 multiplier — providers aren't guaranteed that the clock will stop when they submit a disclosure through other means, such as to a local U.S. attorney's office.

There's Added Incentive to Self-Disclose Quickly

In the event that settlement negotiations with CMS or the OIG are unsuccessful, the tolling ceases and the providers or suppliers risk running out of time to satisfy the overpayment return requirement within the 60-day time period after identification.

Key Takeaway is Proactively Monitoring and Addressing Compliance Risks

The lesson here is that an organization's monitoring systems need to be on the lookout at the very least for the overpayments the government might later deem to have been foreseeable.

One way to do this is to make sure that the organization is monitoring for potential overpayments in areas identified in the OIG's annual work plan. Organizations may also look to qui tam litigation, compliance guidance, CMS notices, OIG reports, and other early warning signs of potential overpayments to develop a monitoring and auditing plan.

Rather than exploring and abandoning a large number of potential risk areas, however, an organization may be better served by identifying its highest risk areas, conducting robust reviews, and ensuring appropriate corrective actions.

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