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COMPLIANCE NEWSLETTER

NAVIGATING THE MAZE

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Final 60-Day Rule

The Centers for Medicare and Medicaid Services (CMS) proposed rules in 1998 and 2002 to amend the regulations regarding the responsibility of reporting and returning overpayments to Medicare. Finally in 2010, provisions were published in the Affordable Care Act (ACA) section 1128J(d(1). These provisions required persons who received overpayments to report the overpayment, describe why the overpayment was received and return the payment either 60 days after it was identified or the date that the corresponding cost report is due.[1] Subsequently in 2012, CMS proposed rules that would implement the provisions published in the ACA. Four years later, the final rules are now available.

Failure to report and return overpayments leave providers and suppliers at risk for potential False Claims Act (FCA) liability, Civil Monetary Penalties Law (CMPL) liability and possible exclusion from participation in federal health care programs. [2] Based upon the ACA, rules were proposed to implement the provisions and offer guidance. However, these proposed rules only created confusion among providers, lawyers and regulators. Much of that confusion centered on the meaning of the word "identified", the phrase "deliberate speed", and the lookback period.

In response to the proposed rules, CMS received several comments that were carefully considered. These comments offered both support and suggested changes to some of the provisions. In February, CMS published the final rules, which will become effective on March 14, 2016.

Final Rule Clarifications

An overpayment exists when a person receives or retains funds under title XVIII, and after reconciling, they determine that they are not entitled to those funds. In the final rule, CMS clarified the meaning of identification. They specifically stated "...a person has identified an overpayment when the person 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".[3]

In the final rule, CMS clarified the meaning of identification. They specifically stated "...a person has identified an overpayment when the person 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".[4] This clarification has helped in some aspects but could very well have created a new area of confusion as providers and suppliers try to decide what "has or should have determined" means.[5]

"All deliberate speed..." what does that mean exactly? Instead of defining the phrase in the final rule, CMS chose to remove the phrase all together. Instead, they have chosen to use the reasonable diligence standard.

> "Reasonable Diligence" includes both proactive compliance activities conducted in good faith by qualified individuals to monitor for the receipt of overpayments and investigations conducted in good faith and in a timely manner by qualified individuals in response to obtaining credible information of a potential overpayment.[6]

Final Rules for reporting and returning overpayments went into effect March 14, 2016.

The proposed rules suggested a lookback period of 10 years. According to McCarthy, this lookback period is the outer limit of the False Claims Act statute of limitations and outraged providers.[7] Providers cited several reasons for their concern with a 10-year lookback period including; maintaining paper and electronic records for 10 years; the cost of and ability of retrieving those records; increased investigative costs due to staff and contractor turnover; and, coding changes.[8] After considering several alternative lookback periods offered by those commenting on the proposed rules, CMS determined that a 6-year lookback period was the most appropriate. This 6-year period will be measured from the date that a person identifies an overpayment. [9]

Retroactivity

There have been questions as to how these new rules apply to the time-period between the rules that were published in the ACA (2010) and these final rules (2016). According to CMS, "...providers and suppliers may rely on their good-faith and reasonable interpretation of the repayment requirements"[10]. For any overpayments that are reported and returned on or after the date the final rules went into effect, these new rules will apply. It does not matter when the overpayments were received; the rules will be applied based on the reporting and return dates.

For overpayments that were reported prior to March 14, 2016, through the CMS Self-Referral Disclosure Protocol (SDRP), providers and suppliers are not required to use the six-year lookback period. Those who made a good faith effort to report using the SDRP system, "...are not expected to return overpayments from the fifth and sixth year through other means"[11] but they could do so voluntarily.

Rogers, Smyer and Nelson identified some key takeaways from the final rules in their February 2016 Health Systems Alert.[12] Those takeaways are listed in the chart below.

Key Takeaways

- Promptly evaluate any information regarding a potential overpayment to determine whether the information is credible.
- If the information is not credible, document the work done and why it was determined to not be credible.
- If the information is credible or potentially credible, promptly begin an inquiry and outline what reasonable diligence is needed to determine: (i) whether an overpayment may exist; and (ii) if there is an overpayment, how to accurately and efficiently quantify it.
- Carefully document the diligence performed, the scope of the inquiry, and the methodology used to quantify the overpayment, understanding that a 6-year lookback period will apply to any overpayments reported or repaid on or after March 13, 2016.

Rogers, A.J., Smyer, B.M. & Nelson, K.

Identifying, reporting and returning overpayments can be a daunting process. The final rules provided additional clarity however, some ambiguity remains. With providers and suppliers facing stiff penalties under the FCA, it is important to use due diligence in resolving overpayment issues. Providers and suppliers should review their policies and procedures governing the investigation of complaints, and maintain accurate and timely documentation. If a potential overpayment is discovered, it may be wise to consult legal counsel for assistance navigating the reporting process.

A complete copy of the final rules are available at https://www.federalregister.gov/documents/2016/02/12/2016-02789/medicare-program-reporting-and-returning-of-overpayments

[1] 81 Fed. Reg. 7653; 7653-7684. Available from https://www.federalregister.gov/documents/2016/02/12/2016-02789/medicare-program-reporting-and-returning-of-overpayments
[2] 81 Fed Reg. 7653; 7653-7684.
[3] 81 Fed Reg. 7653; 7653-7684.
[4] 81 Fed Reg. 7653; 7653-7684.
[5] Davidson, K.J. & Kameen, S.W. (2016, Feb. 18). Final 60-Day Overpayment Rule. Available from http://www.ober.com/publications/3128-final-60-day-overpayment-rule
[6] 81 Fed. Reg. 7653; 7653-7684.
[7] McCarthy, C.P. (2016 May) The final 60-day rule is here: What healthcare providers need to know. Available from http://hdjn.com/wp-content/uploads/2016/05/Compliance-Today-05.2016.pdf
[8] 81 Fed Reg. 7653; 7653-7684.
[9] 81 Fed Reg. 7653; 7653-7684.
[10] 81 Fed Reg. 7653; 7653-7684.
[11] Davidson, K.J. & Kameen, S.W. (2016, Feb. 18). Final 60-Day Overpayment Rule. Available from http://www.ober.com/publications/3128-final-60-day-overpayment-rule
[12] Rogers, A.J., Smyer, B.M. & Nelson, K. (2016 Feb 12). CMS finalizes 60-day overpayment rule: key takeaways for healthcare providers and suppliers. Available from https://www.dlapiper.com/en/us/insights/publications/2016/02/cms-finalizes-60-day-overpayment-rule/

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