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Medicare's Final Rule: Reporting and Returning of Overpayments

The Centers for Medicare & Medicaid Services (CMS) has published its final rule on the reporting and returning of overpayments. This rule is a clarification of Section 1128J(d) of the Social Security Act (the Act), which was created by Section 6402(a) of the Affordable Care Act (ACA). As the ACA was implemented March 23, 2010, this final rule and clarification have been a long time in coming. The final rule is effective March 14, 2016 and affects any provider or supplier who may receive an overpayment from Medicare.

Specifically, overpayments must be returned either within 60 days of being identified or by the date the corresponding cost report (applicable to payments to hospitals) is due, whichever is later. In addition, the final rule clarifies that overpayments must be reported and returned if identified within 6 years of the overpayment being received.

For the purposes of this final rule, it does not matter if the overpayment was due to a billing error (intentional or not), nor whether the party at fault was the provider or the payer. The responsibilities as described within this overpayment reporting rule are to be fulfilled by the provider or supplier, not by CMS or its contractors.

Key Terms

To understand the requirements of the rule, you will need to consider some key terms and concepts.

Identification of an overpayment occurs when the *person* has or should have, through the exercise of *reasonable diligence*, determined that the *person* has received an *overpayment* and quantifies the amount of the *overpayment*.

1. The "person" is any provider or supplier of Medicare services under Medicare Part A and Part B (see Timely Topics: The A B C's [and D] of Medicare). It applies to physicians, hospitals, other facilities, DME suppliers, etc. It does not apply to Medicare beneficiaries.

2. "Reasonable diligence" includes both proactive and reactive measures to identify, research and correct potential overpayments or processes that may lead to overpayments. These include self-audits, compliance checks, and research into any possible situations that might indicate a possible overpayment. Monitoring of claims to confirm clean billing and timely investigations (typically within 6 months or less) when "receiving credible information about a potential overpayment" is expected. If the provider is not taking appropriate and timely steps to identify

possible overpayments, and overpayments are identified, the provider may be held accountable under the Act and additional laws.

3. An "overpayment" includes "any funds that a person has received or retained under title XVIII of the [Social Security] Act to which the person, after applicable reconciliation, is not entitled under such title."

Examples of overpayments include:

- Medicare payments for noncovered services;
- Medicare payments beyond the allowable for covered services;
- Duplicate payments;
- Medicare payments for covered services when the primary responsibility was another entity (coordination of benefit errors);
- Errors and other nonreimbursable items on cost reports.

Reporting and Returning Overpayments

This final rule requires providers and suppliers to report and return any overpayments "to the Secretary, the state, an intermediary, a carrier, or a contractor, as appropriate." The reporting of the overpayment must be sent in writing to the correct address and should include the reason for the overpayment. Persons may use existing processes to report and return the overpayment. These current processes include claims adjustments, credit balances, and self-reported refunds. Other appropriate processes may also be used if applicable to the overpayment scenario.

What if I don't return an overpayment?
Any person who does not report and return overpayments according to the provision in the rule could be "subject to the statutory requirements found in section 1128J9d) of the Act and could face possible False Claims Act (FCA) liability, Civil Monetary Penalties Law (CMPL) liability, and exclusion from federal health care programs."

What about underpayments?
This rule only addresses overpayments. Current processes used to request additional adjudication and possible payment on a denied or underpaid claim are not affected by this rule.

Tips

1. Ignorance is not bliss! CMS notes specifically that an "ostrich defense" will not work. If a patient or employee raises credible questions about payment on a claim and the provider does not act promptly to investigate, this lack of action can be construed as acting in reckless disregard of the truth. Be sure to respond to complaints promptly.

2. If the provider has conducted an internal coding audit and identified payments for incorrectly coded or under documented services, these payments could also be considered overpayments and applicable to the terms of this statute.

3. If the provider's claim includes the use of modifiers (e.g, 25 {separately identifiable evaluation and management service} or 59 – {distinct procedural service}) that were not supported by the documentation but allowed the claim to pass by payer edits, these payments could also be considered overpayments and applicable to the terms of this statute.

4. Make sure to review each third party audit (e.g. Recovery Audit Contractor) result for accuracy before confirming the results.

5. Track changes in policy that affect billing, coding and documentation practices so as to limit applicable lookback periods.

6. Ensure policies and processes are in place to proactively and reactively respond to potential overpayment scenarios within your organization.

7. Familiarize yourself with the scope of the Act and CMS' commentary found in the final rule.

8. Providers who have concerns regarding identification, reporting and returning of overpayments should consult with legal counsel for additional guidance.