How and When to Disclose and Refund Overpayments

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American Health Lawyers Association
Long Term Care and the Law
February 25-27, 2013

Medicare and Medicaid providers and suppliers have always had an obligation to refund overpayments from federal healthcare programs. However, Section 6402 of the Affordable Care Act (42 U.S.C. § 1320a-7k(d)) creates liability under the Federal False Claims Act for persons who fail to disclose and refund Medicare or Medicaid overpayments within the later of 60 days after the date the overpayment is identified or the date the next applicable cost report is due. Section 6402 is self–implementing. Therefore, all providers, suppliers and other persons covered by the Act, have an obligation to report and refund overpayments within the timeframe set out in the statute.

In February 2012, CMS proposed a regulation implementing Section 6402 for Medicare providers and suppliers. Although, this regulation has not been finalized it provides useful insight into how CMS is likely to interpret providers' obligations under Section 6402. The proposed regulation defines key statutory terms and provides guidance as to how overpayments should be handled once they are identified. Importantly, the proposed regulations acknowledge the overlap between the Section 6402 requirement to report and refund overpayments and existing avenues for resolving overpayment liability under OIG Self-Disclosure Protocol and the CMS Self-Referral Disclosure Protocol (collectively, the SDPs).

In its commentary to the proposed regulation, CMS acknowledged that, "the provider's initial decision of where to refer a matter involving non-compliance with program requirements should be made carefully." This is something of an understatement given that reporting and refunding an overpayment under Section 6402 cannot resolve any potential liability under the False Claims Act, or other fraud and abuse laws, that might arise from the conduct that led to the overpayment. Disclosure pursu-

ant to one of the SDPs, on the other hand can lead to settlement agreements in which the provider is released from civil and administrative liability arising from the overpayment and related conduct.

These materials and the accompanying paper and slides prepared by Lew Morris, provide an overview of the reporting requirement under Section 6402 and a discussion of the SDPs, including information on the results of settlement agreements reached by providers under the SDPs.

The Section 6402 60-Day Repayment Requirement.

Section 6402 requires any person who has received an overpayment under Medicare or Medicaid to:

> (A) report and return the overpayment to the Secretary, the State, or intermediary, a carrier or a contractor, as appropriate, at the correct address; and
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> (B) notify the Secretary, the State, intermediary, carrier or contractor to whom the overpayment was returned in writing of the reason for the overpayment.

42 U.S.C. § 1320a-7k(d)(1). The overpayment must be reported and returned within 60 days after the date on which it was identified or the date any corresponding cost report is due. 42 U.S.C. § 1320a-7k(d)(2).

Overpayment means "any funds that a person receives or retains under [Medicare] or [Medicaid] to which the person, after appropriate reconciliation is not entitled." 42 U.S.C. § 1320a-7k(d)(4)(B). Person means a provider or supplier, a Medicaid managed care organization, a Medicare Advantage organization or a PDP sponsor, but does not include a beneficiary under Medicaid or Medicare. 42 U.S.C. § 1320a-7k(d)(4)(C).

The statute further provides that an overpayment retained by a person after the deadline for reporting and returning the overpayment is an obligation for purposes of Section 3729 of the Federal False Claims Act, 31 U.S.C. § 3729. Section 3729(a)(1)(G) provides for civil penalties of up to $11,000 plus three times the amount of the govern-

ment's damages against a person who "knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government." When an overpayment results from numerous claims, the Government could seek to impose a separate penalty for each claim that resulted in an overpayment.

Section 6402 also defines the words "knowing" and "knowingly" at 42 U.S.C. § 1320a-7k(d)(4(A) as having the same meanings set forth in the False Claims Act. In other words, a person acts with knowledge if the person has actual knowledge of information or acts in reckless disregard or deliberate ignorance of the truth or falsity of such information. 31 U.S.C. § 3729(b).

The Proposed Regulation.

On February 16, 2012, CMS published a proposed regulation implementing Section 6402 with respect to Medicare Part A and B providers and suppliers. 77 Federal Register 9179 (February 16, 2012) (the Proposed Regulation). Although the Proposed Regulation applies only to Medicare providers and suppliers, CMS pointed out that even without a final regulation, all persons covered by Section 6402 are subject to the statutory requirements and could face potential False Claims Act liability for failing to report and return overpayments within the applicable timeframe.

The Proposed Regulation restates the statutory requirement that overpayments must be reported and returned within 60 days after the date the overpayment is identified or the date any corresponding cost report is due. 77 Federal Register 9179, 9187 (February 16, 2012) (to be codified at 42 CFR § 401.305). In its commentary to the Proposed Regulation, CMS clarified that the reference to cost reports and an appropriate reconciliation is only applicable to overpayments that arise from interim payments made to a provider that are later reconciled through the cost reporting process. Overpayments that result from claims filed under a fee schedule or prospective payment sys-

tem must be reported and returned within 60 days after they are identified. 77 Federal Register 9179, 9182 (February 16, 2012).

The Proposed Regulation defines "identified" to mean the date a person has actual knowledge of the overpayment or acts in reckless disregard or deliberate ignorance of the existence of an overpayment." As noted above, the 60-day timeline to report and return the overpayment begins when the provider has identified the overpayment. In the commentary to the Proposed Regulation, CMS explained that a provider who receives information regarding a possible overpayment has an obligation to make a reasonable inquiry to determine whether an overpayment exists. If the inquiry reveals an overpayment, then the provider has 60 days from that point to report and return the overpayment.

In contrast, if the provider fails to make a reasonable inquiry, or fails to conduct its inquiry with "all deliberate speed" after obtaining information that an overpayment may have occurred, then the overpayment may have been "identified" on the date the provider learned of the possibility of the overpayment or stopped making its inquiry with all deliberate speed. This is because the failure to make an inquiry or continue an inquiry with all deliberate speed could result in the provider acting in reckless disregard for or deliberate ignorance of whether an overpayment occurred.

CMS's commentary makes it clear that a provider who receives information about a possible overpayment must investigate to determine whether the overpayment has in fact occurred and must continue the investigation without unnecessary, or unreasonable delay. However, CMS's commentary also makes clear that the 60-day period to return and report the overpayment typically begins at the end of the provider's reasonable investigation not on the date the provider received the initial report of a possible overpayment. This means that a provider may take more than 60 days to conduct its inquiry without running afoul of the requirement of Section 6402.

One issue that CMS did not specifically address is whether an overpayment will be considered "identified" for purposes of starting the 60-day reporting requirement if the provider has verified that an overpayment occurred, but has not verified the exact amount of the overpayment. This could occur, for example, when a provider audits a probe sample of claims and determines that overpayments occurred within the probe sample. The provider then has an obligation to expand the scope of the audit to a larger claim sample, or in some cases, the universe of similar claims to determine the total amount of the overpayment. The regulation does not specifically address whether the provider must report and repay the overpayments identified in connection with the probe audit within 60 days after the probe audit is concluded.

The answer to this issue likely depends on the specific facts of a given situation. Since CMS has recognized that the provider has not identified an overpayment until it has concluded a reasonable inquiry with all deliberate speed, it seems likely that in many instances a provider may wait until it has concluded the audit of a wider sampling of claims before the 60 day timeframe for reporting and returning the overpayment begins to run. On the other hand, if the wider audit is expected to take an extended period of time, a provider may wish to report and return the overpayment identified in connection with the probe audit to avoid an allegation that it failed to conduct the rest of the inquiry with all deliberate speed.

Contents of the Report.

CMS recognized in its commentary to the Proposed Regulation that there is an existing process for reporting and returning overpayments to Medicare contractors 77 Federal Register 9179, 9181 (February 16, 2012). This process is described in Chapter 4 of the Medicare Financial Management Manual. CMS has indicated that it will rename this chapter the "Self-Reported Overpayment Refund Process." Under the current process, each Medicare Administrative Contractor (MAC) has adopted a form for the voluntary

repayment of identified overpayments. Examples of forms from Novitas Solutions and Palmetto are attached to this paper as Appendix 1. CMS plans to adopt a single voluntary refund form for all MACs to use, but has instructed providers to use the current forms until a common form has been adopted.

The Proposed Regulation also lists the following elements that must be included with each report of an overpayment:

(1) Person's (*i.e.*, the provider's) name.

(2) Person's tax identification number.

(3) How the error was discovered.

(4) The reason for the overpayment.

(5) The health information claim number, as appropriate.

(6) Date of service.

(7) Medicare claim control number, as appropriate.

(8) Medicare National Provider Identification Number.

(9) Description of the corrective action plan to ensure the error does not occur again.

(10) Whether the person has a corporate integrity agreement with the OIG or is under the OIG Self-Disclosure Protocol.

(11) The timeframe and the total amount of refund for the period during which the problem existed and caused the refund.

(12) If a statistical sample was used to determine the overpayment amount, a description of the statistically valid methodology used to determine the overpayment.

(13) A refund in the amount of the overpayment.

77 Federal Register 9179, 9187 (February 16, 2012) (to be codified at 42 CFR § 401.305(d)). Many of the MAC voluntary refund forms track the requirements of the Proposed Regulation. However, providers should ensure that all of the elements required by the Proposed Regulation are included in any disclosure of an overpayment.

Additionally, it may be advisable to provide a cover letter to give the MAC context in which to evaluate the disclosure and repayment. A template cover letter is attached to this paper as Appendix 2.

One of the most controversial aspects of the Proposed Regulation is the so-called lookback period for returning identified overpayments. CMS proposed that:

> An overpayment must be reported and returned in accordance with § 401.305 only if a person identifies the overpayment within 10 years of the date the overpayment was received.

77 Federal Register 9179, 9187 (February 16, 2012) (to be codified at 42 CFR § 401.305(g)). Section 6402 does not address the length of the lookback period. In its commentary, CMS stated that it selected 10 years as the lookback period to coincide with the outer limits of the statute of limitations under the False Claims Act. CMS also proposed to extend the period in which it may reopen cost reports to 10 years to ensure that the reopening authority is consistent with the lookback period. CMS specifically solicited comments on the proposed 10 year lookback period.

As a practical matter, the length of the lookback period may require providers to audit claims going back 10 years whenever they receive an allegation that an overpayment has occurred. Whether such an extensive audit is necessary will depend on the facts in each specific situation. However, if a provider identifies a practice that led to an overpayment, the failure to audit claims that could have been affected by this practice going back 10 years could lead to allegations that the provider was acting in "reckless disregard of or deliberate ignorance of" past overpayments. Additionally, a MAC evaluating a provider's disclosure of an overpayment may question why the provider did not extend the audit back to the beginning of the 10 year lookback period.

Relationship Between Section 6402 and the Self-Disclosure Protocols.

In its commentary to the Proposed Regulation CMS recognized that there are "intersections" between the obligation to report and return overpayments under Section

6402 and the Self-Referral Disclosure Protocol (SRDP) and OIG Self-Disclosure Protocol (OIG SDP). As noted at the outset, CMS has acknowledged that the decision whether to report overpayments under Section 6402 or under the SRDP or OIG SDP "should be made carefully." This is in part because, other than liability that would have arisen if the provider had retained the overpayment, providers cannot resolve any False Claims Act or Civil Money Penalty liabilities solely by reporting and returning overpayments under Section 6402. In contrast, the SRDP and the OIG SDP both offer providers an opportunity to resolve potential civil and administrative liabilities in addition to resolving the resulting overpayment.

Providers and suppliers may use the SRDP to report potential violations of the Federal Physician Anti-Self Referral Law (Stark Law) and any resulting overpayments. Under the SRDP, CMS may reduce the amount due and owing for potential violations of the Stark Law. Accordingly, providers and suppliers who have identified a potential "pure" Stark violation, should carefully consider whether to report the resulting overpayment solely under Section 6402, or whether to use the SRDP to attempt to resolve any Stark liability as well as the overpayment liability. CMS proposes that if a provider makes a disclosure under the SRDP, it will still be required to report the overpayment to the MAC, but the obligation to return the overpayment within 60 days would be suspended.

The OIG SDP allows providers and suppliers an opportunity to resolve civil and administrative liabilities arising from violations of the False Claims Act and Civil Money Penalties Law that do not arise from violations of the Stark Law. Importantly, a provider that enters the OIG SDP may enter a settlement agreement with the OIG that results in a release of liability for civil money penalties as well as the OIG's permissive exclusion authority. CMS proposes that a provider's obligation to return an overpayment is suspended when the OIG acknowledges that the provider has submitted a disclosure

under the OIG SDP. Moreover, unlike the SRDP, a provider's disclosure under the OIG SDP satisfies the provider's obligation to report the overpayment under Section 6402.

While the SRDP and OIG SDP offer providers the opportunity to resolve additional liability beyond the amount of the overpayment, many providers may view the SDPs as more invasive than the refund process required by Section 6402 and the Proposed Regulation. In many cases disclosure under Section 6402 may be sufficient to resolve overpayment issues. CMS provides the following examples of issues that might be resolved through disclosure under Section 6402:

- Medicare payments for noncovered services
- Medicare payments in excess of the allowable amount for an identified covered services
- Errors and non-reimbursable expenditures in cost reports
- Duplicate payments
- Receipt of Medicare payment with another payor had the primary responsibility for payment

However, providers should be aware that MACs have the discretion to refer a voluntary refund under Section 6402 to the OIG if the MAC believes the circumstances warrant a referral. Accordingly, a provider may disclose an overpayment appropriately under Section 6402 only to face additional investigation and possible enforcement actions based upon a referral of the matter to the OIG. Thus, if a provider wishes to obtain certainty regarding the possibility of any future enforcement actions (*e.g.*, where the provider believes that there could be a potential whistleblower, or where a buyer wishes to have potential liability fixed prior to closing a transaction), the provider may wish to make a submission through the applicable SDP.

Appendix 1

Voluntary Repayment Forms

Appendix 2

Sample Voluntary Repayment Cover Letter