

Finalized Medicare 60-Day Overpayment Rule Goes Into Effect Today – Providers Are You Ready?

In 2010 the Affordable Care Act ("ACA") implemented a 60-day reporting and refund requirement for Medicare overpayments.^[1] Any provider that has received an overpayment is required to report and return the overpayment within "60 days after the date on which the overpayment was identified."^[2] An overpayment occurs when a provider "receives or retains" funds to which it is not entitled "after applicable reconciliation."^[3] Since the enactment of this rule, significant questions have remained regarding its implementation and enforcement, including when an overpayment is "identified." CMS recently published its final rule providing clarifications of these questions and imposing additional obligations.^[4] The final rule goes into effect today, March 14, 2016.

Why should providers care?

Provider non-compliance with the 60-day reporting rule has the potential to lead to civil liability under the False Claims Act ("FCA"), civil money penalties, and even personal criminal liability. In fact, the ACA specifically makes any overpayment retained by a person after the reporting deadline into an "obligation" under the FCA, subjecting a provider to potential reverse false claims liability.

What are some of the basic terms providers need to know about this new rule?

Identifying an overpayment: Crucially, the new rule clarifies what it means to "identify" an overpayment, which governs when the 60-day reporting clock begins to tick. Under the final rule, a provider identifies an overpayment when it "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."^[5] This update is a significant change from the proposed rules as it acknowledges the need for reasonable assessment. It is now clear that providers have reasonable time to quantify an overpayment before the 60-day reporting clock begins to tick, as long as they exercise reasonable diligence.

Reasonable diligence: In the majority of cases "reasonable diligence" means an investigation concluding no more than 6 months from receipt of credible information of an overpayment.



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To be credible, information must support a reasonable belief that an overpayment may have been received.

Whose credible information: The new rule does not limit the sources of potential credible information. A provider may be found to have “knowledge” of an overpayment if any of its employees or agents, at any level of the organization, have knowledge. Based on the comments and responses to the new rule, potentially credible information may also come from a source outside the provider-organization, including from third-parties involved in Medicare billing. If anyone at the provider has credible information of a potential overpayment, it must investigate—using reasonable diligence—to determine if an overpayment occurred. In contrast, if someone at the provider had credible information, but no investigation was conducted—or it was not conducted in a timely manner—the provider may be exposed to liability because it “should have” determined it received an overpayment.

Provider’s Duty of Diligence: The new rule makes clear that providers may incur liability if they hide their heads in the sand. While the new rule does not mandate any particular compliance program, it makes clear that providers have a proactive duty to constantly examine whether they have received an overpayment from Medicare. If they do not, they may be at risk for liability based on the expiration of the 60-day reporting rule.

Diligence Extends Over 6 years: The new rule includes a “lookback period” of 6 years. Where a provider determines an overpayment exists, and that overpayment could have been recurrent, the provider must investigate back 6 years.

What should providers consider based on the final rule?

- Do we have a policy and procedure regarding Medicare overpayments?
- Do we investigate potential Medicare overpayments?
- Do we have a procedure for documenting investigations into potential overpayments?
- Do we have an appropriate record retention policy and procedure?
- Do we have a compliance program to review Medicare billing and payments?
- Do we have a system for reporting potential overpayments within our organization?
- Do we need to conduct training on the requirements of the 60-day overpayment rule and reporting?

How might senior care providers specifically be effected by this new rule?

Medicare overpayments may arise in multiple, varied situations among providers, including the more obvious situations involving coding and billing. But, senior care providers may also encounter potential overpayments as a result of, among other things, staff eligibility issues, population-specific factors, or regulatory actions. For example, a provider may have billed for the services of an excluded staff member without knowledge. If the provider then receives information that its care staff was excluded it may trigger a responsibility to engage in reasonable diligence. Another example might arise when a provider’s billing staff identifies that the date of service of a claim post-dated the date of a resident’s transfer/discharge. The application of the 60-day rule may also arise after regulatory action, such as DPNA pending a re-survey. Moreover, because the size of senior care providers varies significantly, providers may have questions regarding the scope of compliance, reporting, and diligence required.

The final rule provides much needed clarification, but also puts significant responsibilities on providers. While the new rules may seem daunting, especially to those operating smaller senior care homes, the potential consequences of hiding from the requirements are severe. It is important that providers not hide their heads in the sand, but meet this new rule with their faces forward and their policies ready for

compliance.

The application of the 60-day rule is fact dependent and may appear in varied situations. Providers should seek counsel if questions arise.

^[1] (42 U.S.C. § 1320a-7k.)

^[2] (Id.)

^[3] (Id.)

^[4] Available online at <https://www.federalregister.gov/articles/2016/02/12/2016-02789/medicare-program-reporting-and-returning-of-overpayments#page-7653>.

^[5] 42 CFR 401.305(a)(2).

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