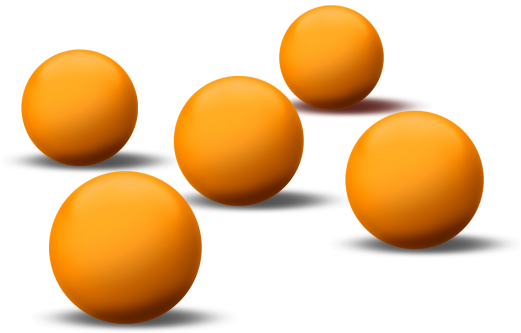
BURR FORMAN LLP



CMS Finalizes the 60 Day Overpayment Rule

By: James A. Hoover

Reprinted with Permission from the *Birmingham Medical News*

The Department of Health and Human Services' (HHS) Center for Medicare and Medicaid Services (CMS) published its final rule on Friday, February 12, 2016. The final rule clarifies two key sections of the often described 60-Day Overpayment Rule.

The statutory 60-Day Overpayment Rule is a product of the Affordable Care Act, which established a new section of the Social Security Act, Section 1128j(d)(1). The statute requires the recipient of an overpayment to report and return the overpayment to the government within 60 days after the date on which the overpayment was "identified." The language in the statute has caused much concern and confusion among health care providers because if an overpayment is not returned by the 60-day deadline, the overpayment is considered a reverse false claim under the federal False Claims Act and subjects the health care provider to treble damages and penalties up to $11,000 per claim. Thus, the date an overpayment is "identified" is extremely important because the moment an overpayment is "identified" the 60-day deadline to report and return an overpayment starts to run.

The standard set forth in the proposed rule was that a provider must report and return an overpayment once it had actual knowledge of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment. CMS diverges from the proposed rule slightly and in the final rule, establishes a "reasonable diligence" standard. Under the "reasonable diligence" standard, "a person has identified an overpayment when the person has or should have, through the exercise of reasonable diligence, determined both that the person has received an overpayment and quantified the amount of the overpayment." However, CMS cautions that providers and suppliers cannot avoid liability by failing or procrastinating to investigate possible overpayments. CMS will deem a provider or supplier to have determined that it received an overpayment and quantified the amount of the overpayment if the person fails to exercise reasonable diligence. According to CMS, the 60-day clock for reporting and returning the overpayment begins when the reasonable diligence is completed 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 did receive an overpayment. CMS explains that reasonable diligence includes both good faith proactive compliance activities to monitor the receipt of overpayments and timely investigations in response to obtaining credible information of a potential overpayment.

The meaning of "identified" is currently being litigated in several cases. One such case caught the nation's attention in the summer of 2015. U.S. District Judge Edgardo Ramos rejected a request by New York City's Mount Sinai Health System to dismiss the government's case against the system, alleging the system failed to return Medicare and Medicaid overpayments within 60 days. The system argued that the 60-day countdown did not start until a provider is sure there is an overpayment. Judge Ramos, however, held the clock for returning the money started to run as soon as the system became aware there might have been an overpayment. The recent enactment of the final rule

provides some clarity to the meaning of "identified" as argued in the Mount Sinai Health System's case.

Another provision that was clarified by the recent final rule was how far back a provider must review to determine the amount of an overpayment. The proposed rule suggested a ten-year look back period. However, the final rule establishes a shorter six-year look back period, which matches the statute of limitations period generally used under the False Claims Act.

The final rule also clarifies how to actually repay the overpayment to the government. Providers and suppliers must use an applicable claims adjustment, credit balance, self-reported refund, or another appropriate process to satisfy the obligation to report and return overpayments. Providers and their counsel must carefully examine the best means of making the repayment in order to satisfy their obligation within the 60-day time frame.

The changes in the final rule provide some clarity for providers concerning their obligation to affirmatively identify and repay overpayments. According to CMS, "creating this standard for identification provides needed clarity and consistency for providers and suppliers on the actions they need to take to comply with requirements for reporting and returning of self-identified overpayments." However, exactly when an overpayment should have been discovered through the exercise of reasonable diligence is likely to be disputed between providers and the government depending on the size of the overpayment and length of time of the identification process.

For more information, please contact:

James A. Hoover
Partner
Birmingham, AL
Phone (205) 458-5111
E-Mail jhoover@burr.com

Jim Hoover is a partner in the Health Care Practice Group at Burr & Forman LLP and exclusively represents health care providers in false claims litigation and regulatory compliance matters.