

Returning Medicare Overpayments under the 60-Day Rule: Some Questions Answered, but Others Remain

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PRACTICES Healthcare Transactions and Regulatory, False Claims Act and Qui Tam Defense, Healthcare and Life Sciences

After a long wait, on February 12, 2016, the Centers for Medicare & Medicaid Services for HHS (“**CMS**”) issued a final rule that clarified the obligations of Medicare providers and suppliers to report and return overpayments within 60 days (the “**Rule**”).¹ The Rule becomes effective on March 14, 2016.

The Rule, which applies only to Medicare Part A and B providers and suppliers, enforces a statutory requirement from 2010 implemented by the Affordable Care Act (“**ACA**”).² Under the ACA, overpayments must be returned within 60 days of being “identified.” or providers and suppliers will face potential False Claims Act (“**FCA**”) or criminal liability.³ Two years after the ACA passed, CMS issued a proposed rule to clarify the 60-day requirement and received approximately 200 public comments in response. The proposed rule stated that an overpayment was “identified” when a person had actual knowledge or acted in reckless disregard or deliberate ignorance of the overpayment. Although the rule remained in draft form, in August 2015, a U.S. District Court in New York released the first ever decision finding FCA liability when a provider was put on notice of the overpayment.⁴ The Rule now, however, provides much clearer guidance on how and when to return Medicare overpayments.

When does the 60-day period to report and return overpayments begin?

Under the Rule, the 60-day period is triggered when an overpayment is identified. Identification occurs when providers and suppliers have or should have, through reasonable diligence: (i) determined they received an overpayment and (ii) quantified the amount of overpayment. Providers and suppliers have up to six months to investigate credible information on the receipt of overpayments before the 60-day period begins to run. That is, they have about eight months (six months for investigation and approximately two months for reporting and returning) to report and return overpayments.

How far back must the investigation of overpayments extend?

A provider or supplier must return an overpayment discovered within 6 years of receipt. CMS chose to reduce the look-back period from 10 years to 6 years as providers and suppliers already retain records for 6 years and because the FCA’s limitations period is typically also 6 years.

What other important measures must be taken to comply with the Rule?

The Rule requires providers and suppliers to exercise reasonable diligence to determine if they received an overpayment. “Reasonable diligence” means the proactive monitoring of claims and

reactive investigation of credible information to identify possible overpayments. The accurate retention of such materials can demonstrate such reasonable diligence.

The Rule highlights the importance of reasonable proactive measures to identify and return overpayments to avoid FCA and criminal liability. Failure to comply with the Rule increasingly is the basis for DOJ and whistleblowers to file FCA and criminal cases. Given that reality, a proactive compliance review of problematic or suspect Medicare claims may make sense. Of course, whether the Rule is even implicated or whether FCA or criminal exposure exists is a very factually dependent question.

If you have any questions or require additional information on the Rule, other healthcare regulatory issues or FCA/criminal matters, please contact one of the lawyers listed below.

¹ *Medicare Program; Reporting and Returning of Overpayments*, 81 Fed. Reg. 7653-7684 (Feb. 12, 2016) (codified at 42 C.F.R. §§ 401 & 405), <https://www.gpo.gov/fdsys/pkg/FR-2016-02-12/pdf/2016-02789.pdf>.

² See 42 U.S.C. § 1320a-7k(d).

³ See 42 U.S.C. § 1320a-7k(d)(3); 31 U.S.C. § 3729; 42 U.S.C. 1320a-7b(a)(3).

⁴ *Kane ex rel. United States v. Healthfirst, Inc.*, No. 1:11-cv-02325, 2015 U.S. Dist. LEXIS 101778 (S.D.N.Y. Aug. 3, 2015).