The 60 Day Rule: CMS Issues Proposed Rule on Reporting & Return of Overpayments

The February 16, 2012 Federal Register published a proposed rule from the Centers for Medicare & Medicaid Services ("CMS") that attempts to clarify providers' and suppliers' obligation under Section 6402 of the Patient Protection and Affordable Care Act of 2010 ("ACA") to report and return Medicare overpayments within sixty days of their identification. If overpayments are knowingly and improperly retained, a provider or supplier may risk liability under the reverse false claims provision of the False Claims Act.

While the Proposed Rule provides some guidance, it leaves several important questions unanswered, and imposes obligations that may be onerous for providers and suppliers anxious to avoid False Claims Act liability.

Proposed Rule

The Proposed Rule clarifies the following aspects of Section 6402(d) of the ACA:

- **Identification.** The Proposed Rule considers an overpayment to be "identified"—and subject to the sixty-day reporting and return obligation—when a provider or supplier has "actual knowledge" or "acts in reckless disregard or deliberate ignorance of" the "existence of the overpayment." CMS states that this standard will require providers and suppliers to undertake some level of "reasonable" diligence to determine whether overpayments exist, "such as self-audits, compliance checks, and other additional research."

- **Process for Reporting.** The Proposed Rule requires providers and suppliers to "return and report" overpayments through the self-reported overpayment refund process found in the Medicare Financial Management Manual. This requires use of a form developed by each Medicare Administrative Contractor ("MAC"), which calls for, among other categories of information, disclosure of the cause of the overpayment and corrective action that has been taken.

- **Period of Exposure.** The Proposed Rule requires reporting and return of any overpayment that a provider or supplier identifies within ten years from the date it was received. That matches the longest limitations period possible under the False Claims Act, and is much longer than the periods of administrative recoupment or reopening under CMS rules.

The Proposed Rule applies only to Part A and B Medicare providers and suppliers. CMS stated that guidance regarding Medicare Part C and D will come at a later date.

Questions and Compliance Challenges

Despite guidance provided in the Proposed Rule, questions and challenges for providers and suppliers remain. They include the following:

- **Identification.** The Proposed Rule triggers the sixty-day period for reporting and returning an overpayment upon actual or constructive knowledge of "the existence of the overpayment." Thus, the clock may begin when a provider or supplier knows (or should know) that an overpayment *exists*, but has not yet identified the *particular claims* or quantified the amount. With ten years' payments

subject to reporting and return, providers and suppliers may find sixty days insufficient to gather the information necessary to satisfy their obligations.

- **Investigation.** The preamble to the Proposed Rule describes that providers and suppliers must make a "reasonable inquiry" with all "deliberate speed" upon receiving information concerning a "potential overpayment," and provides the example of "an anonymous compliance hotline telephone complaint." Neither the Proposed Rule nor the preamble provides guidance as to these standards.

- **Refund Process.** The Proposed Rule requires providers and suppliers to report and return overpayments through a form that each MAC makes available on its website. The Proposed Rule does not address use of the electronic payment systems and voidance processes that contractors have developed.

- **Third-Party Violations of the Anti-Kickback Statute.** In a passage that appears to be almost an afterthought to the preamble, CMS states that compliance with the Anti-Kickback Statute is a condition of payment, and that providers and suppliers therefore must report any overpayments resulting from *third party* violations, providing the example of a hospital that submits a claim for a surgery that results from an unlawful relationship between a device manufacturer and a physician. CMS states—in the commentary but not the rule—that "HHS's enforcement efforts would most likely focus on holding accountable the perpetrators of that arrangement," and that CMS would "suspend the repayment obligation until the government has resolved the kickback matter," and that CMS's "expectation is that only the parties to the kickback scheme would be required to repay the overpayment . . . except in the most extraordinary circumstances." Nonetheless, the suggestion that a provider or supplier must report such an arrangement upon discovery to avoid False Claims Act liability, the implication that CMS *could* require an innocent provider or supplier to make a repayment, and CMS's choice to address issues of such significance only in a preamble passage all are chilling reminders of the government's expansive view of the False Claims Act's reach.

If you have any questions or concerns about the proposed regulation, please contact the Ropes & Gray attorney who normally advises you.