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Medicare

CMS Cuts Lookback Period to Six Years in Final Rule on Overpayments

Medicare providers must report and repay any overpayments within 60 days of identifying them, according to a final rule released Feb. 11

Providers will be responsible for reporting and returning all overpayments identified within six years of when the overpayment was received, which differs from the 10-year period that was included in the proposed rule.

While there are no major surprises in the final rule, there are some important conceptual and operational aspects of it, Laurence Freedman, an attorney with Mintz, Levin, Cohn, Ferris, Glovsky and Popeo PC, Washington, told Bloomberg BNA Feb. 11.

''It's very important that CMS added a critical clarification that 'identification' of an overpayment includes the '[quantification] of the amount of the overpayment','' Freedman said.

The rule (RIN 0938-AQ58, CMS-6037-F), which implements Section 6402(a) of the Affordable Care Act, will be published in the Feb. 12 Federal Register and is effective March 14.

A proposed rule was released in February 2012. The final rule was scheduled to be released in February 2015 but was delayed for a year due to its complexity (31 HCDR, 2/17/15).

Overpayment Identification. The Centers for Medicare & Medicaid Services' final rule requires health-care providers to repay an overpayment and to notify the federal government, the state and any ''intermediary, carrier or contractor to whom the overpayment was returned in writing of the reason for the overpayment,'' all within 60 days of first identifying the overpayment.

According to the final rule, an overpayment identification occurs when a provider verifies an overpayment has been received, after exercising due diligence.

The CMS defined reasonable diligence as ''proactive compliance activities to monitor claims and reactive investigative activities undertaken in response to receiving credible information about a potential overpayment.''

The 60-day period begins after a provider has investigated an overpayment identified through a compliance program, or on the day credible information of a possible overpayment is received, assuming reasonable diligence wasn't exercised.

However, Freedman said the final rule might cause substantial confusion and disagreement over whether an overpayment should be considered identified in the absence of any reasonable diligence.

Sigh of Relief. Several aspects of the final rule are sure to please the provider community, including clarity over when the 60 days begin. ''There was a collective sigh of relief this morning as the health-care industry read the CMS press release regarding the new rule,'' Danielle Sloane, an attorney with Bass, Berry & Sims in Nashville, told Bloomberg BNA Feb. 11.

By clarifying that overpayment identification includes both determining that a provider has received an overpayment and quantifying the amount based on reasonable diligence, the CMS is giving providers more time to thoroughly review the overpayment and make one repayment, rather than requiring them to do a rushed review or submit piecemeal repayments, Sloane said.

Overall, the final rule offers a fairly balanced and reasonable approach, Sloane said, while still setting high expectations for providers to exercise diligence and return any overpayments that are due.

For example, the CMS clarified there's no overpayment if the identified error didn't result in an increase in reimbursement, and clarified that where there is a reimbursement increase, the overpayment is only the difference between what was paid and what should have been paid if the claim had been submitted correctly, Sloane said. It wouldn't include repayment of the entire claim.

''This clarification relieves providers and suppliers concerns about having to repay entire claims for patient care services due to an identified problem without then being able submit corrected claims because of the timely filing limitations,'' Sloane said.

Sloane said providers and suppliers shouldn't breathe too easily, however, because the final rule sets high expectations for what constitutes reasonable diligence.

Providers and suppliers must investigate potential overpayments within six months, unless there are extraordinary circumstances, and then report and return within 60 days, Sloane said.

''I suspect that many providers and suppliers will still find that time line pretty tight, but CMS seems to leave what constitutes extraordinary circumstances pretty open ended,'' Sloane said.

Six-Year Lookback. While the proposed rule included a 10-year lookback period, many comment letters argued that it would be burdensome and costly for providers.

Comment letters also said a six-year lookback is a more commonly used statute of limitations under the

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False Claims Act, while a 10-year period is only used in certain circumstances.

The CMS agreed and said a six-year lookback would address many of the concerns held by commenters.

''I'm pleased that there is no more threat of a 10-year lookback period,'' Freedman said.

Though the six-year lookback period was expected, it's overly broad, Freedman said.

''CMS should have kept the reasonable four-year period under the CMS SRDP [Self Referral Disclosure Protocol], and should have given more weight to the administrative re-opening deadlines,'' Freedman said.

Freedman also said it was disappointing the CMS wants overpayments going back six years, but won't permit identification and claiming of underpayments for the same time period.

''CMS said it was outside the scope of the rulemaking, but it's not fair for CMS to have one-way rules on re-openings,'' Freedman said.

Lookback Burdens. While a six-year lookback period is better than 10 years, it's still an excessive amount of time for providers and suppliers to be forced to conduct audits for overpayments, Scot Hasselman, an attorney with Reed Smith in Washington, told Bloomberg BNA Feb. 11.

''Many providers and suppliers will be unable to conduct their own lookback and will have to hire third parties to do it for them. And, because limitation periods will have ended, or because record retention policies permitted earlier destruction, necessary documentation may not be available,'' Hasselman said.

Potential costs and resources necessary for a six-year lookback shouldn't be minimized, Hasselman said.

Providers and suppliers can take the risk of not conducting a six-year lookback, but the chance of potential liability may affect their business, particularly in connection with potential sale of transfer, Hasselman said.

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