ANESTHESIOLOGY NEWS
PRN
MAY 11, 2016

# CMS Resets the Clock for Return Of Medicare Overpayments

Mark F. Weiss, JD

Finders keepers, losers weepers. Except in connection with overpayments from Medicare, then it's a violation of the federal False Claims Act leading to significant liability—that is, unless you repay the overpaid sum within 60 days.

But when does the 60-day period begin?

On Feb. 12, the Centers for Medicare & Medicaid Services (CMS) answered that question as to Medicare Part A and Part B when they released final regulations on the reporting and return of overpayments.

**A Bit of Background**

You're undoubtedly familiar with the concept of the federal False Claims Act, often referred to as the "whistleblower" law. It's a Civil War–era statute that imposes liability for making fraudulent claims for payment to the U.S. government. Penalties are three times the amount of the improper payment plus up to $11,000 per claim.



Subsequently, the concept of a "reverse false claim" came into being by way of amendment of the False Claims Act. Essentially, it makes it a false claim to conceal, to knowingly and improperly avoid, or decrease an obligation to pay or transmit money or property to the federal government.

Due to a provision in the Affordable Care Act (ACA), overpaid Medicare (as well as Medicaid) claims must be paid back to the government within 60 days of the "date on which the overpayment was identified." The provision does not require a specific intent to defraud.

In other words, the failure to return Medicare overpayments within 60 days of the "date on which the overpayment was identified" makes each of the underlying claims a "reverse false claim" subject to the False Claims Act's draconian penalties. One defect, however: The ACA did not define what constitutes "identification," leaving open the question of when the 60-day period actually begins.

Until the release of the new final regulations, the answer to that question was unclear.

**Prior Proposed Regulations**

On Feb. 16, 2012, CMS proposed regulations stating that a Part A or Part B overpayment would be "identified" when a provider had "actual knowledge of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment."

Those proposed regulations were criticized on multiple grounds. On the central issue of what "identified" meant, what would happen if the provider could not quantify the extent/amount of the overpayment within 60 days? The proposed regulations also imposed a 10-year lookback period, consistent with the outer limit of the statute of limitations in the False Claims Act. That meant that a provider must repay if the overpayment is "identified" within 10 years of its date.

But proposed regulations are just that, proposals, and they have no legal effect.

**One Court Opinion**

To date, and before the release of the new final regulations, only one court opinion, United States ex rel. Kane v Healthfirst Inc., has addressed the issue of what "identified" means for purposes of the 60-day repayment language in the ACA.

In very abbreviated form, the facts underlie that Aug. 13, 2015, opinion centered on a coding error caused by a software glitch that led to overpayments to Healthfirst's parent entity, Continuum Health Partners Inc. (Continuum), in connection with Medicaid cases. (As mentioned above, the 60-day repayment rule applies to both Medicare and Medicaid overpayments.) In September 2010, auditors from the Office of the New York State Comptroller approached Continuum with questions regarding the incorrect billing. Continuum assigned one of its employees, Robert Kane, to investigate what had been improperly billed.

Approximately five months later, Kane emailed his report and spreadsheet to Continuum's management. His report indicated more than $1 million of improper billing due to the coding error, but said further analysis was required to confirm his initial findings.

Rather than voluntarily following up, Continuum terminated Kane.

Under pressure from the state of New York, Continuum began making a handful of repayments. However, it didn't finish repaying until after March 2013 following receipt of a civil investigative demand from the U.S. government.

In 2011, Kane filed a whistleblower action under the False Claims Act as well as under New York's counterpart state law.

Prosecution of the case was taken over by the United States and by the state of New York. They alleged that Continuum fraudulently delayed repayment by up to two years after it knew of the extent of improper billing, and that by "intentionally or recklessly" failing to take necessary steps to timely identify claims affected by the software glitch, Continuum violated the "reverse false claims" provision of the False Claims Act and of its New York corollary.

The central question: When had there been an "identification" of overpayment triggering the start of the 60-day time period?

The government argued, and the District Court in Kane agreed, that the definition of "identified" is satisfied when a person is "put on notice that a certain claim may have been overpaid."

The federal District Court held that Kane's email and spreadsheet properly "identified" the overpayments and that those overpayments matured into obligations in violation of the False Claims Act when they were not reported and returned within 60 days.

As had been the case in connection with reaction to the 2012 proposed regulations, many feared that United States ex rel. Kane v Healthfirst Inc. was imposing an unworkable standard. For example, the opinion in that case revealed that there was no dispute that Kane's analysis was rough and that in the end only about half of the identified claims were indeed overpaid.

So, what was a provider to do if it could not identify with any certainty exactly what suspect claims were overpaid within the short 60-day time period? Should he or she repay every potentially overpaid claim just to make certain that they did not violate the False Claims Act? And, must they go back and do that analysis for an entire 10-year lookback period?

## The New, Final Regulations

Fortunately for providers, the new, final regulations released in February, which became effective on March 14, provide both clarity and relief.

Definition of Identified

The final rule states that "a person has identified an overpayment when the person 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."

In other words, although there is a requirement of reasonable diligence, "identification" doesn't occur—and, therefore, the 60-day time period does not begin to run—until the provider both determines that it received an overpayment *and* quantifies the overpayment.

Note, however, that the "reasonable diligence" requirement means that a provider cannot simply ignore the possible existence of an overpayment or delay quantifying the amount due back to the government. In the event of a failure to exercise reasonable diligence, the 60-day clock would start running.

In the explanatory language referred to as the "preamble" to the new regulations, CMS explained its position that "reasonable diligence" includes both proactive compliance activities conducted in good faith by qualified individuals to monitor for the receipt of overpayments, and investigations conducted in good faith and in a timely manner by qualified individuals in response to obtaining credible information of a potential overpayment.

Although the regulations do not state how much time a provider may take to complete its investigation, CMS's preamble comments are that reasonable diligence is demonstrated through the timely, good-faith investigation of credible information, which is at most six months from receipt of the credible information, except in extraordinary circumstances. In CMS's opinion, then, absent extraordinary circumstances, a provider would have six months to investigate and quantify, and then 60 days to report the overpayment.

## Alternative Routes To Report Overpayments

The regulations set out alternatives for reporting an overpayment.

The provider may report the overpayment and return the overpayment to the provider's applicable Medicare administrative contractor. The payment must be made in compliance with the 60-day rule.

Or, the provider may make a disclosure under the Office of the Inspector General's self-disclosure protocol or the CMS voluntary self-referral disclosure protocol resulting in a settlement agreement using the process described in the respective protocol. The 60-day period is tolled while the provider is actively engaged in one of those processes.

Lookback Period

Instead of the 10-year lookback period set out by CMS in the 2012 proposed regulations, the final regulations require providers to look back only six years when identifying an overpayment.

*—Mark F. Weiss, JD*

---

*Mr. Weiss is an attorney who specializes in business and legal issues affecting physicians and physician groups. He served as clinical assistant professor of anesthesiology at the Keck School of Medicine of the University of Southern California, in Los Angeles, and practices with The Mark F. Weiss Law Firm, a firm with offices in Dallas, Los Angeles and Santa Barbara, Calif. His email address is markweiss@weisspc.com.*