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CMS Clarifies 60-Day Report and Return Rule in Final Regulation

Legal Update
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Today CMS published a final rule detailing the duty to report and return overpayments with 60 days of their identification. The “report and return” requirement was adopted by Congress as part of the Affordable Care Act. This final rule is the first regulation from CMS interpreting the statute. The final rule makes it clear that the 60-day period does not begin to run until you have **quantified** the amount of the overpayment, or, when you should have quantified the overpayment had you been acting diligently. In other words, the 60-day clock does not start to run when you first discover a potential billing problem.

The final rule also defines the “look back period” for reporting and returning overpayments as **six years**. That requirement is completely inconsistent with the regulation that permits Medicare contractors to reopen claims only up to 48 months after they are paid, absent fraud or similar fault. It is also inconsistent with a federal statute that says recovery against a provider or supplier is deemed to be against equity and good conscience and the provider/supplier is not liable for an overpayment if the overpayment determination is made more than five years after the year in which the claim was paid. Despite the direct conflict with these existing regulatory and statutory provisions, CMS takes the position with this final rule that while contractors may reopen claims for only 48 months, and Recovery Audit Contractors for three years, the provider or supplier has a duty to go back six years.

The new rule takes effect 30 days after it is published. The preamble to the rule indicates that it is **not** retroactive. Thus, if you are in the process of calculating a refund right now, there is a strong incentive to complete the process and submit the check in the next 30 days, when you can quite clearly cap the refund amount at 48 months. Thereafter, the situation is more legally ambiguous. (While the new regulation’s look back period is six years, there will be legal arguments that a shorter time period may apply.)

Takeaways

- The 60-day clock to report and return runs from the date the overpayment is quantified (assuming you act reasonably diligent in investigating and quantifying).

- If at all possible, quantify and return overpayments you are currently processing in the next 30 days before the rule takes effect.
- CMS is clear that refunds may continue to be made to the local Medicare contractor or state agency. (Only rare and extreme circumstances justify a report through the OIG Self-Disclosure Protocol or another formal self-disclosure mechanism.)

We will have more updates as we analyze the full text of the final rule.

Questions?

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