FACT SHEET

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Medicare Reporting and Returning of Self-Identified Overpayments

CMS 6037-F Final Rule

The Centers for Medicare & Medicaid Services (CMS) has published a final rule that requires Medicare Parts A and B health care providers and suppliers to report and return overpayments by the later of the date that is 60 days after the date an overpayment was identified, or the due date of any corresponding cost report, if applicable. A separate final rule was published in the May 23, 2014 **Federal Register** (79 FR 29844) that addresses Medicare Parts C and D overpayments.

Summary

The requirements in this rule are meant to support compliance with applicable statutes, promote the furnishing of high quality care, and to protect the Medicare Trust Funds against improper payments, including fraudulent payment. This rule clarifies requirements for the reporting and returning of self-identified overpayments. Health care providers and suppliers have been and will remain subject to the statutory requirements found in section 1128J(d) of the Social Security Act (the Act) and could face potential False Claims Act (FCA) liability, Civil Monetary Penalties Law (CMPL) liability, and exclusion from federal health care programs for failure to report and return an overpayment. Health care providers and suppliers will also continue to be required to comply with current CMS procedures when we, or our contractors, determine an overpayment exists and issue a demand letter.

Background

Section 6402(a) of the Affordable Care Act established a new section 1128J(d) of the Act. Section 1128J(d)(1) of the Act requires a person who has received an overpayment to report and return the overpayment to the Secretary, the state, an intermediary, a carrier, or a contractor, as appropriate, at the correct address, and to notify the Secretary, state, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment. Section 1128J(d)(2) of the Act requires that an overpayment be reported and returned by the later of: (A) the date which is 60 days after the date on which the overpayment was identified; or (B) the date any corresponding cost report is due, if applicable. Section 1128J(d)(3) of the Act specifies that any overpayment retained by a person after the deadline for reporting and returning an overpayment is an obligation (as defined in 31 U.S.C. 3729(b)(3)) for purposes of 31 U.S.C. 3729. In the February 16, 2012 Federal Register (77 FR 9179),

CMS published a proposed rule to implement the provisions of section 1128J(d) of the Act for Medicare Parts A and B providers and suppliers.

Major Provisions

The major provisions of this final rule include clarifications around: the meaning of

overpayment identification; the required lookback period for overpayment identification; and the methods available for reporting and returning identified overpayments to CMS.

Meaning of "Identification"

Section 1128J(d) of the Act provides that an overpayment must be reported and returned by the later of: (i) the date which is 60 days after the date on which the overpayment was identified; or (ii) the date any corresponding cost report is due, if applicable. This 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. Creating this standard for identification provides needed clarity and consistency for health care providers and suppliers regarding the actions they need to take to comply with requirements for reporting and returning of self-identified overpayments.

Lookback Period

Under this final rule, overpayments must be reported and returned only if a person identifies the overpayment within six years of the date the overpayment was received. Specifying the length and other parameters of the look back period provides additional clarity for providers and suppliers who have identified an overpayment that is covered by the provisions of 1128J(d).

How to Report and Return Overpayments

This final rule provides that providers and suppliers must use an applicable claims adjustment, credit balance, self-reported refund, or another appropriate process to satisfy the obligation to report and return overpayments. This approach for returning overpayments provides an array of familiar options from which providers and suppliers can select.

This rule also provides that if a health care provider or supplier has reported a self-identified overpayment to either the Self-Referral Disclosure Protocol managed by CMS or the Self-

Disclosure Protocol managed by the Office of the Inspector General (OIG), the provider or supplier is considered to be in compliance with the provisions of this rule as long as they are actively engaged in the respective protocol.

For additional information for Reporting and Returning of Overpayments (CMS-6037-F) click here (PDF) https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-02789.pdf and on 02/12/2016 and available online at http://federalregister.gov/a/2016-02789

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