POWERS

POWERS PYLES SUTTER & VERVILLE PC

ATTORNEYS AT LAW

MEMORANDUM

To: **MEDICAL GROUP MANAGEMENT ASSOCIATION**

From: **POWERS LAW FIRM**

Date: **FEBRUARY 19, 2016**

Re: **CMS RULE CLARIFIES ACA's 60 DAY REPAYMENT REQUIREMENT**

Medical group practices have long been accustomed to refunding Medicare payments in response to demand letters from Part B administrative contractors, and more recently from Medicare Recovery Audit Contractors. These demands typically resulted from claims reviews or audits, and the group's refund exposure was generally limited to amounts paid in connection with the disputed claims. Groups also voluntarily work credit balances for Medicare, other payors, and patients, and generally reconcile minor over and under payments through routine claims processing adjustments. In rare instances, groups have faced more serious claims under the False Claims Act, initiated either by the government or by *qui tam* "whistleblowers."

Congress "upped the ante" for physicians and other Medicare providers and suppliers when it included in the Affordable Care Act what is generally referred to as the "**60 day repayment rule**." That provision requires **timely refund** of **any overpayment** which has been **identified** by the provider. In some circumstances, failure to identify the overpayment or make the timely refund can become grounds for a False Claims Act charge.[1] CMS considers the ACA's statutory requirement to be effective on its face, without implementing regulations. However, CMS published a proposed implementing rule in February of 2012 [2], and that rule, somewhat revised, was just published as a final regulation on February 12, 2016 (the "Final Rule").[3]

The Final Rule provides greater clarity to medical groups on how the repayment requirement will be interpreted and applied. It represents, in our opinion, an improvement over the earlier proposal, and is responsive to comments filed by MGMA and others at the proposed rule stage. At the same time, because the Final Rule is now out, the "rubber meets the road" in a more visible manner, and enforcement of the underlying ACA provision, whether by government or by whistleblowers, becomes more likely.

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[1] 42 U.S.C. § 1320a-7k(d)(2).

[2] *See* 77 Fed. Reg. 9172-9187 (Feb. 16, 2012).

[3] *See* 81 Fed. Reg. 7654-7684 (Feb. 12, 2016). CMS issued a separate Final Rule on the 60 day repayment requirement for Medicare Parts C and D overpayments in 2014. *See* 79 Fed. Reg. 29844 (May 23, 2014). CMS has not issued rules with respect to Medicaid overpayments.

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Highlights of the Final Rule are these:

- An overpayment is any Medicare payment received or retained by the group to which it is not entitled, **regardless of the cause**. An erroneous payment by the Medicare contractor, through no fault of the provider, is still an overpayment.

- The 60 day repayment clock will begin to run **only after the provider has identified** the overpayment **and quantified** the amount, so long as the provider exercises **reasonable diligence in doing both.**

- Reasonable diligence includes both **proactive compliance activities** designed to detect overpayments and **reactive investigations** designed to quantify overpayments **in response to credible information.**

- Whether a group had credible information of an overpayment triggering an obligation to investigate, and whether it exercised reasonable diligence in investigating, **are both fact specific**. They may also be, at least to some extent, **resource specific**. CMS is not likely to expect the same sophistication, particularly in terms of proactive compliance activities, from a three person primary care practice as compared to a 20 person single-specialty or 100 person multi-specialty group.

- In nearly all circumstances, investigation and repayment should be completed **within eight months**—six months to investigate and quantify, and the ACA's 60 days to refund and report.

- **Failure to exercise reasonable diligence** causes the 60 day repayment clock to revert back to the date the provider received credible information. For example, if the group gets credible evidence and ignores it, or drags its feet in quantifying the repayment, it will be deemed in violation after 60 days, not eight months.

- The obligation to refund, particularly when the overpayment problem is systemic, can **go back six years**. CMS originally proposed this "lookback" period at 10 years, so the Final Rule is a modest improvement. But RAC audits have only looked back 3 years, and routine contractor demand letters typically only go back one year, or four for "good cause."

- **Reporting and refund forms and procedures** are determined by the Medicare contractor from whom the overpayment was received.

For further information, contact Bob Saner, MGMA Washington Counsel, at 202-466-6550, or Bob.Saner@ppsv.com. Powers lawyers Mark Fitzgerald, Christina Hughes and Sarah Imhoff contributed to this summary of the Final Rule.