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Meeting Medicare's 60-Day Refund Rule

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As part of the Affordable Care Act, Congress enacted a statute outlining how providers should report and return Medicare and Medicaid overpayments. The 60-day refund rule, as it's commonly known, requires Medicare and Medicaid providers and suppliers to report and return reimbursements made in error within 60 days of their identification. The Centers for Medicare & Medicaid Services (CMS) issued a proposed rule for this statute in 2012, and while it addresses only Medicare overpayments—CMS proposed leaving treatment of Medicaid overpayments to be addressed at a later date—it's worth noting that some states have implemented local policies addressing Medicaid overpayments.

While CMS's rule has yet to be finalized, the statutory requirement introduces a significant new liability to health care providers: If you fail to return the appropriate reimbursement within 60 days, you may become liable for penalties under the False Claims Act. Failure to return the payment within the 60-day window also puts your provider organization and system at risk of exclusion from the Medicare and Medicaid programs.

Understanding Overpayments

According to CMS, an overpayment refers to any funds received by a health care entity that are in excess of amounts to be paid under Medicare statutes and regulations. Overpayments can be attributed to a variety of operational and payment errors. For example, they may include payments for noncovered services, duplicate payments, eligibility, and receipt of a Medicare payment when another payer had primary responsibility for the payment.

Identifying Overpayments

Identifying overpayments is the critical component to the 60-day refund rule. There has been great uncertainty among providers regarding when an overpayment has been, in fact, identified and when the 60-day "clock" begins ticking.

According to the proposed rule, an overpayment is considered identified when a person has actual knowledge of the overpayment or acts in "reckless disregard or deliberate ignorance" of the existence of the overpayment. To encourage provider self-compliance, CMS has included the "reckless disregard or deliberate ignorance" standards of the False Claims Act although the statute doesn't mandate this interpretation.

In some cases you may receive information regarding an overpayment but need time to investigate the allegation. The investigation is referred to as a "reasonable inquiry." Thus, at least under the guidance available through the preamble to the proposed rule, CMS would agree that the 60-day clock doesn't start until after you've had an opportunity to complete a reasonable inquiry.

Though the rule is unclear about what constitutes a reasonable inquiry, it's reasonable to assume that the scope of the investigation will depend on the type of problem under consideration. For example, a simple and easily understood duplicate payment may be readily identified as an overpayment, then quantified and refunded to the payer. However, complex cases may require extensive input from billing, legal, statistical, and other experts. These inquiries may be much broader and time and resource intensive.

Process for Reporting Overpayments

Day-to-day overpayments may be reported using the overpayment procedure as defined by your carrier. For those that require a self-disclosure per OIG guidance, the reporting is completed through the self-disclosure online submission system or other methods. This process gives you the opportunity to avoid the costs and disruptions associated with a formal investigation or audit.

For physician self-referral (Stark law) issues, CMS also proposed that a self-report of an overpayment along with a separate CMS Self-Referral Disclosure Protocol must be submitted. The information CMS proposed to be submitted includes:

- How the error was discovered
- Scope of the problem
- Cause of the error leading to overpayment
- Comprehensive plan of corrective action, including systemic solutions

Look-Back Period for Reporting Overpayments

CMS's proposed rule may require providers to delve into their records and report and refund overpayments as far back as 10 years preceding the date the problem was identified. Current reopening regulations permit the payer to go back only three or four years for simple Medicare overpayments. The industry will be monitoring this development closely, since the proposed 10-year look back would be extraordinarily difficult for many providers to administer.

Preparing for an Inquiry

Thorough preparation is essential for a swift inquiry and prompt repayment. Using a standard inquiry process can facilitate a smooth return and help you avoid penalties. Prior to opening an inquiry, determine whether the investigation should be conducted under attorney-client privilege or attorney work product. The process should include:

- A standard form to document all allegations
- Systematic methodology and investigation plan
- Clearly defined corrective actions to address root causes and prevent future occurrences

Preventing Future Errors

In light of the dramatic changes in the proposed rule, your health care organization must fortify your processes to both identify past overpayments and prevent future errors. The first step is to implement or update your identification policy and procedures for reporting and refunding identified overpayments within 60 days. Once a plan is in place, take the following measures to both strengthen the overpayment identification process and reform areas of operation prone to error:

- Periodically audit and monitor timeliness, accuracy, and completeness of reporting and refunding identified overpayments.
- Obtain validation that overpayments were correctly reported and refunded or recouped.
- Follow up on corrective action plans and systemic solutions.
- Implement training and education for all entities involved.

We're Here to Help

Complying with the 60-day refund rule adds complexity to your processes and procedures. But failure to comply could expose your organization to an unacceptable level of risk. For more information about the 60-day refund rule or for help determining how your organization should approach compliance, contact your Moss Adams health care professional.

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