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CMS Relaxes 60-day Overpayment “Look Back” Period for Medicare Providers

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Federal regulators have relaxed the provider reporting obligations for overpayments by decreasing the period of time providers or suppliers must “look back” when reporting and repaying overpayments from ten to six years. The final rule issued by the ***Centers for Medicare and Medicaid Services (CMS)*** on Feb. 11, provides much needed clarity and consistency for providers and suppliers who participate in the ***Medicare*** program.

Section 1128J(d)(1) of the ***Social Security Act*** requires a provider who has received an overpayment to report and return the overpayment to the Secretary of Health and Human Services, the state, an intermediary, a carrier, or a contractor. Providers must also provide written notification to the entity to which the overpayment was returned explaining the reason the overpayment occurred. The act requires that overpayments be reported and returned by the later of either:

1. the date 60 days after the provider identifies the overpayment or,

2. if applicable, the date any corresponding cost report is due.

The act further states that, “any overpayment retained by a person after the deadline for reporting and returning an overpayment is an obligation” under the False Claims Act (FCA).

The final rule does not alter the statutory requirements imposed on providers and suppliers under the act or the fact that violation of such provisions, including the failure to report and return overpayments, could result in provider FCA liability, Civil Monetary Penalties Law liability, and exclusion from federal healthcare programs. Additionally, CMS makes clear that providers and suppliers must continue to comply with its procedures for identified overpayments when CMS or one of its contractors issues a demand letter related to overpayment. The final rule also maintains former CMS procedures for provider repayment of identified overpayments, including applicable claims adjustment, credit balance, self-reported refund, and other CMS-approved procedures.

Under the final rule, an overpayment is considered “identified” when the provider/supplier has, or should have, through the exercise of reasonable diligence, determined that an overpayment was received and subsequently quantified its amount. Significantly, in accordance with the final rule, only

those overpayments that have been identified within six years of receipt must be reported and returned. This is particularly important to providers as it should act to reduce their burden, and potentially costs, for reviewing and reporting overpayments.

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