Medicare and Medicaid Overpayments and Refunds

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Part I:

Payment Determination and Finality, Waiver of Recovery, Overpayment Disclosure and Refund Obligations, and Government Rights of Recovery and Imposition of Interest Relating to the Medicare Program

by:

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I. Introduction

When considering whether to make disclosures and repayments involving the Medicare program, it is important to determine the amount of the overpayment at issue, the reporting and refund obligations, and the recovery rights of the federal government.\(^1\) To assist in making this determination, this outline reviews claims payment, finality, waiver of recovery, disclosure and refund obligations, and government rights of recovery and imposition of interest under Medicare Parts A and B, including the significant changes made by the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148 ("PPACA"), to the duty to report and refund Medicare overpayments. Payments under Medicare Parts C and D, which implicate other rules, including those of the contractor providing the service and/or prescription drug, are addressed only in passing, although many of the provisions and concepts set forth herein related to Parts A and B also apply to Parts C and D.

\(^1\) In this outline, unless otherwise noted, references to (1) the “government” means the federal government and (2) the "Secretary" means the Secretary of the United States Department of Health and Human Services.
II. The Medicare Payment Process


1. The starting point is the provision of a covered service\(^2\) to a Medicare-eligible individual where Medicare is the primary payer.

2. A claim must be submitted within applicable timeframes, generally the period ending one calendar year after the date of service.\(^3\)

3. If a provider determines that the claim it submitted needs to be changed, it can submit an adjustment request.\(^4\) As with the initial claim, the adjustment request generally must be submitted within the timely-filing period.\(^5\)

B. The failure to timely submit a claim for a covered service where Medicare is the primary payer will generally relieve Medicare and the beneficiary/patient of any payment obligation.

1. Even if a claim is timely submitted, a service that was part of that claim but not timely included in it, will not be paid.\(^6\)

\(^2\) In this outline, we use “services” to encompass both “items” and “services,” as those terms are defined for Medicare purposes.

\(^3\) See 42 U.S.C. §1395f(a)(1), as amended by PPACA §§6404(a)(1) and (b) (Part A claims). See also 42 U.S.C. §1395u(b)(3)(B)(ii) (Part B claims); 42 U.S.C. §1395n(a) (conditions of payment for Part B claims). See 42 C.F.R. §424.44 for pre-PPACA timely-filing rule. Submission of claims and the amount of payment due from the beneficiary/patient will depend on whether the provider accepts assignment or has opted out of the Medicare program. Under certain circumstances, the provider “may reassign” its right to payment to another entity. 42 C.F.R. §424.70.

\(^4\) Medicare Claims Processing Manual ("MCPM"), Chapter 1, §130.1 et seq.

\(^5\) MCPM, Ch. 1, §130.1.1.

\(^6\) Id.
2. Certain Part B providers are required to submit assigned or unassigned claims within 12 months of the date of service and face penalties for failing to do so, unless this time-period is extended by CMS.7

C. Medicare contractors are required to process timely-filed claims within certain time frames and the failure to do so will require payment of interest.8

D. Along with payment comes notice of the right of a dissatisfied provider to appeal the “initial determination” of the payment amount.9

1. Although the appeals processes are different under Part A and Part B, each has several steps with jurisdictional time limits culminating with federal court review (for certain jurisdictionally-qualifying claims).

2. The failure to meet a time limit could result in the dismissal of the appeal and the loss of the statutory right to seek correction of the claim through the appeals process.10

E. Claims that are no longer subject to appeal are not necessarily “final.”11 This is because CMS regulations permit, for certain periods of time under certain circumstances, (1) providers to seek reopening of otherwise “final” claims and (2) the government to grant such reopening requests and reopen, sua sponte, these and other otherwise “final” claims.12

7  42 U.S.C. §1395w-4(g)(4).
8  42 C.F.R. §405.922; MCPM, Ch. 1 §80.2.2.
9  The government has taken the position that a provider may not appeal where the underpayment was caused by its own error. Athens Community Hosp v. Schweiker, 743 F.2d 1 (D.C. Cir. 1984) (decision on rehearing).
10 There are special time frames for challenging DRG assignment (42 C.F.R. §412.60(d)) and cost outlier payment (42 C.F.R. §412.84(b)).
11 For a more in-depth discussion of finality, see Roth, Robert L., Heads I Win, Tails You Lose: How Two Recent Circuit Court Decisions Undermine Congress’ Promise of Proper Payments to Medicare Providers, AHLA Health Lawyers News, April 2006 (Enclosure A).
1. CMS regulations permit providers to seek reopening of otherwise “final” claims for certain periods of time under certain circumstances. This is clear from CMS's regulations. For example, with respect to Part B claims, 42 C.F.R. §405.806 states:

   The initial determination is binding upon all parties to the claim for benefits unless the determination is --

   (a) Reviewed in accordance with §§405.810 through 405.812; or

   (b) Revised as a result of a reopening in accordance with §405.841.14

2. Payment determinations are subject to reopening from the date of the determination (1) for three years for matters covered under a Part A cost report15 and (2) for four years under Part B and for other claims under Part A.16

3. After these periods, the payment is generally final and not subject to correction, except that reopening can occur at any time (1) if the payment was the result of “fraud or similar fault,”17 (2) to effectuate a coverage

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13 In 2005, CMS adopted a new regulatory Subpart, 42 C.F.R. §405.900 et seq., setting forth the regulations implementing the unified appeals process enacted by the Medicare Prescription Drug Improvement and Modernization Act of 2003 (“MMA”), which applies to (1) non-cost report Part A claims where the initial determination was made on or after May 1, 2005 and (2) Part B claims where the initial determination was made on or after January 1, 2006. 70 Fed. Reg. 11,420 (Mar. 8, 2005). Therefore, depending on the type of claim and/or initial determination date, the applicable regulation(s) could be in §§405.700 et seq. (Part A – non-cost report), .800 et seq. (Part B), .900 et seq. (Parts A (non-cost report) and B), or .1800 et seq. (Part A – cost report).

14 See also 42 C.F.R. §§405.708., 928, and .1807.

15 42 C.F.R. §405.1885(b).

16 42 C.F.R. §§405.750(b)(2), .841(b), and .980 (applies to reopenings of initial determinations and redeterminations but there are other timeframes for reopenings of hearing decisions under 42 C.F.R. §405.980(d)).

17 42 C.F.R. §§405.750(b)(3)(ii), .841(c)(1), .980(b)(3), and 405.1885(b)(3). With respect to 42 C.F.R. §405.1885(b)(3), the Supreme Court stated in Sebelius v. (continued...)
appeals decision,\textsuperscript{18} or (3) “for the purpose of correcting a clerical error or error on the face of the evidence on which such determination of decision was based.”\textsuperscript{19} In addition, under 42 C.F.R. §405.1885(c):

(1) CMS-directed reopenings. CMS may direct an intermediary or intermediary hearing officer(s) to reopen and revise any matter, subject to the time limits specified in paragraph (b) of this section, and subject to the limitation expressed in paragraph (c)(2) of this section, by providing explicit direction to the intermediary or intermediary hearing officer(s) to reopen and revise.

(i) Examples. An intermediary determination or intermediary hearing decision must be reopened and revised if CMS provides explicit notice to the intermediary that the intermediary determination or the intermediary hearing decision is inconsistent with the applicable law, regulations, CMS ruling, or other interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS in effect, and as CMS understood those legal provisions, at the time the determination or decision was rendered by the intermediary. CMS may also direct the intermediary to reopen a particular intermediary determination or decision in order to implement a final agency decision (as described in §405.1833, §405.1871(b) and §405.1875 of this subpart), a final, non-appealable court judgment §405.1877, or an agreement to settle an administrative appeal or a lawsuit, regarding the same determination or decision.

4. For several years, there was a split in the circuits concerning whether reopening denials were subject to judicial review. This split was resolved when the Supreme Court held that reopening denials were within the unreviewable discretion of the Medicare contractor.\textsuperscript{20}

\textit{Auburn Regional Medical Center, ___ U.S. ___} (2013), at footnote five, that “providers alone are subject to this exception to the time limitation.”

\textsuperscript{18} 42 C.F.R. §405.980(b)(5).
\textsuperscript{19} 42 C.F.R. §§405.750(b)(3)(i), .841(c)(2)., and .980(b)(4).
\textsuperscript{20} Your Home Visiting Nurse Servs. v. Shalala, 525 U.S. 449 (1999). Generally, when confronted by an underpayment, a provider may only access the courts (continued...)
F. If successful on appeal, the claim is reprocessed and paid based on the decision from the reviewing entity.

1. When a claim is changed as the result of a reopening, the Medicare contractor issues a new determination, which yields a new appeal right.

2. CMS has taken the position that this appeal right is limited to the issue that was subject to the reopening.21

G. 42 C.F.R. §405.980(a)(3) requires contractors to process clerical errors as reopenings, instead of as redeterminations, including human or mechanical errors on the part of the party or the contractor such as (1) mathematical or computational mistakes, (2) inaccurate data entry, or (3) denials of claims as duplicates.22 Uncertainty exists about whether there is an effective judicial review mechanism under this provision in light of Your Home.23

III. How Medicare Overpayments Arise

A. A Medicare overpayment occurs where the Medicare payment exceeds what should have been paid. This generally arises in one of five contexts:

1. The patient was not eligible for Medicare at the time the service was provided,

(...continued) through the appeals process. However, courts have, on occasion, recognized mandamus jurisdiction in the context of the Medicare program where the government failed to perform a non-discretionary duty. See, e.g., Monmouth Medical Center v. Thompson, 257 F.3d 807 (D.C. Cir. 2001) (mandamus available to obtain an order requiring reopening of cost report that led to increased payment).

21 See French Hosp. Med. Ctr. v. Shalala, 89 F.3d 1411 (9th Cir. 1996); see also 42 C.F.R. §405.984(f).

22 See also 42 C.F.R. §405.927.

23 The provider community should consider asking the OIG and GAO to study the implementation of this regulation for consistency and reasonableness across all contractors.
2. Medicare has made a primary payment where it was not properly primary under the Medicare Secondary Payer ("MSP") provisions,24

3. Medicare was properly primary but the service was not statutorily-covered,

4. The service was statutorily-covered but not medically necessary, or

5. Medicare was properly primary for a medically-necessary, covered service but the payment amount was incorrect and excessive.

B. MSP overpayments arise where Medicare mistakenly paid as primary in a situation where another third party payer ("TPP") was properly primary. Where this occurs and the time-filing periods have not passed, the Medicare payment generally should be refunded and the claim processed by the primary TPP, before being submitted to Medicare for the proper secondary payment.

C. Coverage issues arise in two basic ways.

1. The item or service must come within one of the statutory benefits and not be subject to statutory exclusion. Providers and beneficiaries have the right to appeal claims that are denied on the basis that the service is not statutorily-covered.25

2. Medicare will not make payment for any statutorily-covered services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”26 This is often referred to as a “medical necessity” denial.

D. If Medicare is properly primary and the service is both statutorily-covered and medically necessary, Medicare will be obligated to make payment on a timely-submitted and otherwise proper claim. The fiscal intermediary or carrier calculates the amount of the payment. If the payment is incorrect, either an overpayment or underpayment occurs, giving rise to the right of:

1. providers to appeal the underpayment, or

2. the government to seek to recover the overpayment.

24 42 U.S.C. §1395y(b).
25 See, e.g., 42 C.F.R. §405.921.
However, before the government can seek to recover an overpayment, as discussed in the next section, the provider and beneficiary have the right to request a waiver of recovery.

**IV. Waiver of Overpayment Recoveries**

A. In general, a beneficiary will be held ultimately liable for any overpayment that relates to services rendered to that specific beneficiary,\(^{27}\) regardless whether the payment at issue was made to the beneficiary or to a provider on behalf of the beneficiary.\(^{28}\) As a practical matter, however, CMS will seek to recover from its payee, which is typically the provider.

B. Providers are required to repay the overpayment unless the provider is “without fault” with regard to causing the overpayment, under which circumstances the liability defaults to the beneficiary.\(^{29}\)

C. When an “overpayment is discovered subsequent to the fifth year following the year in which notice was sent that the amount was paid,” the provider is deemed to be “without fault” unless there is evidence to the contrary.\(^{30}\) CMS states that “[o]ne example of evidence to the contrary would be a pattern of billing errors.”\(^{31}\) Accordingly, the circumstances that gave rise to the overpayment will have to be examined to determine whether the “without fault” provisions will apply.

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27 This is contrasted from, for example, certain cost report errors, such as depreciation, that do not relate to a specific beneficiary.


29 Id.; see also Medicare Financial Management Manual (“MFMM”), Chapter 3, §80 et seq.

30 42 U.S.C. §1395gg(b), subject to the implementation interpretation by CMS at MFMM, Ch. 3, §80 et seq. The time period over which the “without fault” provisions in 42 U.S.C. §1395gg(b) apply was extended from three years to five years by §638 of the American Taxpayer Relief Act of 2012. As of the date of this outline, the Secretary has not yet incorporated the effect of this change into her payment policies. The provision, however, could affect the “lookback” period for purposes of calculating overpayment refunds under U.S.C. §1320a-7(k)(d) and other authorities.

31 MFMM, Ch. 3, §80. This provision references Medicare Program Integrity Manual (“MPIM”), Chapter 3.
D. Where the beneficiary is the target of the overpayment, the recovery will be waived where the beneficiary (1) “is without fault” and (2) “if such adjustment (or recovery) would defeat the purposes of title II or title XVIII or would be against equity and good conscience.”

Medicare contractors determine, in the first instance, the applicability of the waiver of recovery rules. These determinations are subject to appeal.

E. A second waiver, which applies to both providers and beneficiaries, is available only for medical necessity denials under 42 U.S.C. §1395(a)(1) and arises under the “limitation on liability” provisions of 42 U.S.C. §1395pp.

1. Under these provisions, the claim will not be recovered if both the provider and the beneficiary did not know and could not reasonably have been expected to know that the claim would not be covered.

2. If both, or one or the other, could have or should have known, that Medicare would not cover the claim, the party that knew or should have known will be liable for the overpayment, however, the provider can avoid liability by having the beneficiary sign an “advance beneficiary notice” of non-coverage.

3. These provisions generally apply only where the provider accepted assignment, although they do offer protection to the beneficiary for medically unnecessary physician services where assignment is rejected.

V. Selected Medicare Authorities Relating to Reporting and Refunding Overpayments

A. Statutory Authorities:

1. 42 U.S.C. §1320a-7k(d) - Reporting and Returning of Overpayments (added by PPACA):

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32 See, generally, 42 U.S.C. §1395u(l), 1395gg, and 1395pp; see also 42 U.S.C. §1395gg(c); MFMM, Ch. 3 §70.3.C.; Zinman v. Shalala, 835 F. Supp. 1163 (N.D. Cal. 1993), aff’d 67 F.3d 841 (9th Cir. 1995).

33 MFMM, Ch. 3, §70 et seq.

34 Limitation on liability decisions are appealable under 42 U.S.C. §1395pp(d).

35 See 42 U.S.C. §1395gg and MCPM Ch. 30, §20 et seq.

36 42 U.S.C. §1395u(l). A physician failing to make the appropriate refunds is subject to civil monetary penalties. 42 U.S.C. §1395u(l)(3).
“(1) In general.— If a person has received an overpayment, the person shall (A) report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and (B) notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.

(2) Deadline for reporting and returning overpayments.— An overpayment must be reported and returned under paragraph (1) 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.

(3) Enforcement.— Any overpayment retained by a person after the deadline for reporting and returning the overpayment under paragraph (2) is an obligation37 (as defined in section 3729(b)(3) of title 31, United States Code) for purposes of section 3729 of such title.

(4) Definitions.— In this subsection:

(A) Knowing and knowingly.— The terms knowing and knowingly have the meaning given those terms in section 3729(b) of title 31, United States Code.

(B) Overpayment.— The term "overpayment" means any funds that a person receives or retains under title XVIII or XIX to which the person, after applicable reconciliation,38 is not entitled under such title.

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37 PPACA §6402(d)(2) also amended 42 U.S.C. §1320a-7a(a) to provide that a provider who "knows of an overpayment (as defined in paragraph (4) of section [42 U.S.C. §1320a-7k(d)]) and does not report and return the overpayment in accordance with such section" shall be subject to a CMP of not more than $10,000 for each item or service claimed, plus an assessment of not more than three times the amount claimed for each such service in lieu of damages. In addition, the Secretary may make a determination in the same proceeding to exclude the person from participation in the Federal health care programs (as defined in 42 U.S.C. §1320a-7b(f)(1)) and to direct the appropriate State agency to exclude the person from participation in any State health care program.

38 The legislative history of the Fraud Enforcement and Recovery Act of 2009 ("FERA"), Pub. L. No. 111-21, §4(a), 123 Stat. 1621 (which is not directly (continued...)
(C) Person.

(i) In general.— The term person means a provider of services, supplier, medicaid managed care organization (as defined in section 1903(m)(1)(A)), Medicare Advantage organization (as defined in section 1859(a)(1)), or PDP sponsor (as defined in section 1860D-41(a)(13)).

(ii) Exclusion.— Such term does not include a beneficiary.

2. 42 U.S.C. §1395cc(a)(1)(C) – Requirement for participating providers to have an agreement with CMS “to make adequate provision for return (or other disposition, in accordance with regulations) of any moneys incorrectly collected from such individual or other person.”


(1) more than the correct amount is paid under this title to a provider of services or other person for items or services furnished an individual and the Secretary determines (A) that, within such period as he may specify, the excess over the correct amount cannot be recouped from such provider of services or other person, or (B) that such provider of services or other person was without fault with respect to the payment of such excess over the correct amount, or

(2) any payment has been made under [42 U.S.C. §1395f(e)] to a provider of services or other person for items or services furnished an individual,

(...continued)

applicable to construing PPACA, but which may be persuasive in future clarifications of PPACA) indicates that “applicable reconciliation” may refer to statutory or regulatory schemes that permit for cost report reconciliation and permit an unknowing, unintentional retention of an overpayment. See S. Rep. No. 111-10 at 15 (Mar. 23, 2009). In addition, the FERA legislative history also indicates that administrative and judicial appeals would not be considered “applicable reconciliation.” Id. Informal guidance suggests that an “applicable reconciliation” may include, for example, the OIG’s Self-Disclosure Protocol.
proper adjustments shall be made, under regulations prescribed (after consultation with the Railroad Retirement Board) by the Secretary, by decreasing subsequent payments --

(3) to which such individual is entitled under subchapter II of this chapter or under the Railroad Retirement Act of 1974, as the case may be, or

(4) if such individual dies before such adjustment has been completed, to which any other individual is entitled under subchapter II of this chapter or under the Railroad Retirement Act of 1974, as the case may be, with respect to the wages and self-employment income or the compensation constituting the basis of the benefits of such deceased individual under subchapter II of this chapter.

As soon as practicable after any adjustment under paragraph (3) or (4) is determined to be necessary, the Secretary, for purposes of this section, section 1395i(g) of this title, and section 1395t(f) of this title, shall certify (to the Railroad Retirement Board if the adjustment is to be made by decreasing subsequent payments under the Railroad Retirement Act of 1974) the amount of the overpayment as to which the adjustment is to be made. For purposes of clause (B) of paragraph (1), such provider of services or such other person shall, in the absence of evidence to the contrary, be deemed to be without fault if the Secretary’s determination that more than such correct amount was paid was made subsequent to the fifth year following the year in which notice was sent to such individual that such amount had been paid; except that the Secretary may reduce such five-year period to not less than one year if he finds such reduction is consistent with the objectives of this subchapter.39

39 See also, Reporting and Repayment of Overpayments, Proposed Rule, 67 Fed. Reg. 3662, 3662-63 (Jan. 25, 2002), which states that the “obligation to report and return overpayments is derived from” 42 U.S.C. §1395gg and includes an interesting discussion concerning mandatory self-reporting of overpayments. It also references 42 U.S.C. §1320a-7b(a)(3), which provides for criminal liability against whoever “having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized. . . .”
4. 42 U.S.C. §1395y(b)(2)(B)(ii) – “A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this subchapter with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan’s responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient’s compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan’s insured, or by other means. If reimbursement is not made to the appropriate Trust Fund before the expiration of the 60-day period that begins on the date notice of, or information related to, a primary plan’s responsibility for such payment or other information is received, the Secretary may charge interest (beginning with the date on which the notice or other information is received) on the amount of the reimbursement until reimbursement is made (at a rate determined by the Secretary in accordance with regulations of the Secretary of the Treasury applicable to charges for late payments).”

5. There are also other refund requirements in the Medicare Act. For example, although not strictly relating to an overpayment, 42 U.S.C. §1395nn(g)(2) (the “Stark” law) requires refunds to an individual (“If a person collects any amounts that were billed in violation of subsection (a)(1) of this section, the person shall be liable to the individual for, and shall refund on a timely basis to the individual, any amounts so collected.”). CMS’s implementing regulation expansively states, “[a]n entity that collects payment for a designated health service that was performed under a prohibited referral must refund all collected amounts on a timely basis. . . .” 42 C.F.R. §411.353(d) (emphasis added). Under 42 C.F.R. §1003.102(b)(9) (emphasis added), the OIG may impose a CMP against any person that: “Has not refunded on a timely basis . . . amounts collected as the result of billing an individual, third party payer or other entity for a designated health service that was provided in accordance with a prohibited referral as described in §411.353 of this title.” See also 42 U.S.C. §1395nn(g)(3).

6. Similarly, under 42 U.S.C. §1395u(l)(1)(A)-(C), a nonparticipating physician who does not accept assignment on a claim that is found to be medically unnecessary must, in the absence of a valid advanced beneficiary notice, refund any payment collected from a beneficiary “within 30 days after the date the physician receives a denial notice.” “If a physician knowingly and willfully fails to make refunds in violation of
paragraph (1)(A), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2)” (which include CMPs and exclusion from the Medicare program). See also 42 C.F.R. §411.408(b).

7. 42 U.S.C. §1395pp(h) - If a supplier of medical equipment and supplies (as defined in section 1395m(j)(5) of this title) -- (1) furnishes an item or service to a beneficiary for which no payment may be made by reason of section 1395m(j)(1) of this title; (2) furnishes an item or service to a beneficiary for which payment is denied in advance under section 1395m(a)(15) of this title; or (3) furnishes an item or service to a beneficiary for which no payment may be made by reason of section 1395m(a)(17)(B) of this title, any expenses incurred for items and services furnished to an individual by such a supplier on an assignment-related basis shall be the responsibility of such supplier. The individual shall have no financial responsibility for such expenses and the supplier shall refund on a timely basis to the individual (and shall be liable to the individual for) any amounts collected from the individual for such items or services. The provisions of section 1395m(a)(18) of this title shall apply to refunds required under the previous sentence in the same manner as such provisions apply to refunds under such section.

B. Regulatory Authorities:

1. 42 C.F.R. §489.20(h) – “If the provider receives payment for the same services from Medicare and another payer that is primary to Medicare, to reimburse Medicare any overpaid amount within 60 days.”

2. 42 C.F.R. §489.41:

“(a) Prompt refund to the beneficiary or other person is the preferred method of handling incorrect collections.

(b) If the provider cannot refund within 60 days from the date of the notice of incorrect collection, it must set aside an amount, equal to the amount incorrectly collected, in a separate account identified as to the individual to whom the payment is due. This amount incorrectly collected must be carried on the provider’s records in this manner until final disposition is made in accordance with the applicable State law.

(c) Notice to, and action by, intermediary
(1) The provider must notify the intermediary of the refund or setting aside required under paragraphs (a) and (b) of this section.

(2) If the provider fails to refund or set aside the required amounts, they may be offset against amounts otherwise due the provider.”

3. 42 C.F.R. §411.22(a) and (b) – “Reimbursement obligations of primary payers and entities that received payment from primary payers:

(a) A primary payer, and an entity that receives payment from a primary payer, must reimburse CMS for any payment if it is demonstrated that the primary payer has or had a responsibility to make payment.

(b) A primary payer’s responsibility for payment may be demonstrated by --

(1) A judgment;

(2) A payment conditioned upon the recipient’s compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary payer or the primary payer’s insured; or

(3) By other means, including but not limited to a settlement, award, or contractual obligation.”

4. 42 C.F.R. §411.24(h) - “If the beneficiary or other party receives a primary payment, the beneficiary or other party must reimburse Medicare within 60 days.”

C. Overpayments are discussed in several of CMS’s Internet-Only Manuals, including:

1. MFMM:

   a. Chapter 3, entitled “Overpayments.”

   b. Chapter 5, entitled “Financial Reporting” (see §410 et seq. “Unsolicited/Voluntary Refunds” (the Overpayment Refund Form for Medicare Contractors is at MFMM §411.1)). Be sure to
check for the most recent MAC refund form. See, e.g., http://www.palmettogba.com/palmetto/providers.nsf/ls/J1A-7JBHHJ3014?opendocument.


D. Other sources to consider in evaluating overpayment refund obligations include (1) 42 U.S.C. §1320a-7b(a)(3), (2) Corporate Integrity Agreements, (3) Compliance Plans, and (4) Sarbanes Oxley (publicly traded companies).

VI. Overpayment Recovery and Interest Imposition Authorities

A. The Medicare Act, and other statutes incorporated into Medicare rules, most notably, the Federal Claims Collection Act ("FCCA"), and the Debt Collection Improvement Act of 1996 ("DCIA"), give the government effective mechanisms for recovering Medicare overpayments. These authorities are expected to have reduced use in light of the overpayment reporting and repayment obligations enacted in the PPACA.

B. Where the correct amount that Medicare should have paid has not been determined, CMS can reopen and reprocess the claim, thereby correcting the payment. Once the proper overpayment has been determined, the government can collect the difference through administrative offset or by exercise of its broad recovery rights under the Medicare Act.

C. Section 935 of the MMA added statutory language that limits the ability of CMS to recovery Medicare overpayments that the provider has appealed to a Qualified Independent Contractor ("QIC"). See 42 U.S.C. §1395ddd(f)(2). The final rule implementing this provision was published in the Federal Register on September 16, 2009, with an effective date of November 16, 2009. See 74 Fed.

40 31 U.S.C. §3711 et seq. See 42 C.F.R. §405.376(a) and MFMM, Ch. 3, §10 et seq.

41 31 U.S.C. §§3720C. See MSP Manual ("MSPM") Ch. 7, §601. et seq. The civil federal False Claims Act ("FCA"), 31 U.S.C. §3729 et seq., is not discussed herein because this outline is focused on claims where fraud or other illegality is not alleged. But note that to the extent a provider retains an "identified" overpayment beyond the applicable deadline set forth at 42 U.S.C. §1320a-7k(d), such retention constitutes an "obligation" for purposes of the FCA. See 42 U.S.C. §1320a-7k(d)(3).


43 See 42 C.F.R. §§405.370 et seq.

D. With respect to recovering Medicare overpayments, there is a general, six year statute of limitations that applies where the United States is a plaintiff.44

1. Where the government has given timely notice of a Medicare overpayment in accordance with the requirements of the Medicare Act, it has asserted that it has six years to bring a federal court action to recover the overpayment. Although this could stretch out the recovery period to almost ten full years, the government has also argued that the provider would have been given timely notice of the overpayment and, therefore, could not reasonably assert that the claim was final.

2. If timely notice of the overpayment is not given, the claim becomes administratively final and, therefore, should not be subject to recovery, unless the reopening period is extended under the circumstances discussed above. Accordingly, even though the government may have six years to bring its claim, there arguably would be no cause of action because of administrative finality.45

E. Interest begins to accrue on overpayments and underpayments that are not satisfied within 30 days of notice of the determination.46 Interest also is available under certain circumstances when appeal determinations are favorable to a provider.47 Interest is generally not available on payments made after reopenings. Although CMS cannot collect overpayments that a provider has appealed to a QIC, interest will continue to accrue during the period of the suspension of collection activities. See Section VI.C., supra.

F. Where recovery through offset or suspension is not possible, for example with regard to an entity that is bankrupt or that has left the program, the FCCA and DCIA provide authority for recovery from payments due to the entity from the


45 As to finality, see Roth, Robert L., Heads I Win, Tails You Lose: How Two Recent Circuit Court Decisions Undermine Congress’ Promise of Proper Payments to Medicare Providers, supra (Enclosure A).

46 42 C.F.R. §405.378(b)(2).

47 See, e.g., 42 U.S.C. §1395ff(b)(2)(C)(iv) and 42 C.F.R. §413.64(j).
government. This includes referral to the Department of Treasury ("DOT") for (1) offset of the overpayment against amounts owed to the debtor by the United States unrelated to Medicare, such as tax refunds, and (2) referral to a collection agency ("cross-servicing").

G. In addition to these generally-applicable recovery provisions, Congress enacted specific recovery rights for overpayments that arise under the MSP provisions of the Act, 42 U.S.C. §1395y(b).

1. For mistaken primary Medicare overpayments, the MSP statute gives the “United States” a special direct right of action, in addition to a subrogated right of action, to collect overpayments aimed at non-providers, such as other TPPs, including health plans.48

2. In addition, Congress provided for a “private cause of action” under certain circumstances for double the amount that the TPP should have paid.49 These MSP provisions clearly demonstrate that Congress is fully able to provide in the Medicare Act for explicit recovery rights that go beyond what is generally otherwise available in it.

H. The federal government has also sought recovery under (1) common law self-help mechanisms, e.g. recoupment and offset,50 (2) other common law and/or equitable theories of recovery, including unjust enrichment, payment by mistake of fact, and common law fraud and/or misrepresentation, and (3) state law, such as those relating to unfair business practices.

I. These sources are typically used when the government is seeking to recover under a “pay and chase” approach. Because such an approach is both slow and costly, the government has been adopting other strategies including using data mining contractors to identify aberrations in claims. The government then gives notice of overpayment refund expectations and uses spot audit and enforcement actions to encourage internal audits, overpayment refunds, and self-disclosures.

J. Under 42 U.S.C. §1395vv, the Secretary may withhold Medicare payments to recover Medicaid overpayments and, under 42 U.S.C. §1396m, may withhold Medicaid payments to recover Medicare overpayments.

48 42 U.S.C. §1395y(b)(2)(B)(ii) and (iii).
K. Section 189 of the Medicare Improvement for Patients and Providers Act of 2008 ("MIPPA"), Pub. L. No. 110-275, 122 Stat 2494, added the following two important provisions relating to overpayments:

1. This Section requires CMS to process Medicare payments through the Federal Payment Levy Program ("FPLP") under §6331(h) of the Internal Revenue Code of 1986. The phase-in of this requirement requires CMS to process all Medicare payments under the FPLP by September 30, 2011.

2. This Section also extended the administrative offset provisions of 31 U.S.C. §3716 to Medicare payments. Under subsequent legislation, debts referred to the DOT are now subject to recovery without any time limit. See 31 U.S.C. §3716(e)(1) as amended by §14219 of the Food, Conservation, and Energy Act of 2008.

   a. Under an implementing regulation, 26 C.F.R. §301.6402-6(c)(1), a “past-due, legally enforceable debt” may be offset if it is referred to the DOT “within ten years after the agency’s right of action accrues.”

   b. The six-year statute of limitations under 28 U.S.C. §2415 “shall not prevent the United States or an officer or agency thereof from collecting any claim of the United States by means of administrative offset, in accordance with section 3716 of title 31.” See 28 U.S.C. §2415(i)

VII. Important Other Developments

A. Expansion of the FCA. Changes made to the FCA by FERA concerning overpayments:

1. Old 31 U.S.C. §3729(a)(7) read as follows:

   Any person who... knowingly makes, uses, or caused to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government . . . .

2. New 31 U.S.C. §3729(a)(1)(G) now reads as follows:

   Any person who... knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government or knowingly
conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government . . . .

3. FERA, therefore, establishes liability for a person who:

a. “Knowingly makes, uses or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government,” (emphasis added), or

b. “Knowingly conceals . . . an obligation to pay or transmit money or property to the Government,” or

c. “Knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government” (emphasis added).

3. FERA also amended the definition of “claim” 31 U.S.C. §3729(b)(2) so that it:

“(A) means any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that—

(i) is presented to an officer, employee, or agent of the United States; or

(ii) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government’s behalf or to advance a Government program or interest, and if the United States Government—

(I) provides or has provided any portion of the money or property requested or demanded; or

(II) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded; and

(B) does not include requests or demands for money or property that the Government has paid to an individual as compensation for Federal employment or as an income subsidy with no restrictions on that individual’s use of the money or property[.]”
5. FERA was signed into law on May 20, 2009.\textsuperscript{51}

B. Expansion of Medicare Recovery Audit Contractor ("RAC") Program


   a. Coding experts and physician reviewers now required.
   b. RACs are now required to have a physician medical director.
   c. RACs must provide credentials of reviewers upon on request.
   d. Permanent program places limits on the number of medical records a RAC can request.
   e. All new issues a RAC wishes to pursue for overpayments must be validated by CMS or an independent RAC Validation Contractor.
   f. RACs must repay contingency fees when an improper payment determination is overturned at any level of appeal.
   g. Changing from a four-year look-back period to a three-year look-back period, with a maximum look-back date of October 1, 2007.
   h. Provides for a web-based application that will allow providers to look up the status of medical record reviews.
   i. The reason for review must be listed on request for records letters and overpayment letters.

\textsuperscript{51} As to the retroactive application of these provisions, see U.S. ex rel. Stone v. Omnicare, Inc. (N.D. Ill. 7/7/2011).
j. Public disclosure of RAC contingency fees.

3. Expansion of RACs under PPACA. Under PPACA §6411(b), the Secretary, not later than December 31, 2010, shall enter into contracts with RACs to, inter alia, ensure that each Medicare Advantage plan (Part C) and each Part D prescription drug plan has an anti-fraud plan in effect and to review the effectiveness of such anti-fraud plan. See 42 U.S.C. 1395ddd(h).

C. *In the Case of O'Connor Hospital*, Medicare Appeals Council (Feb. 1, 2010) – This Medicare appeal arose after a RAC reopened a Part A inpatient hospitalization claim, determined that the stay at issue was not medically necessary, and sought to recover the full amount of Medicare’s payment. The RAC also found that the beneficiary met the criteria for outpatient observation status but refused to recover only the difference between the Part A payment and the amount that would have been paid for the observation services under Part B. On appeal, the ALJ found that the amount due from the hospital on the Part A claim should be "offset" by the payment due to the provider for the Part B outpatient observation service. CMS asked the MAC to take "own motion review" of the ALJ’s decision. After reviewing the various authorities, the MAC declined to do so.

D. Publication of Proposed Rule on ‘60-Day Report and Return Rule” - On February 16, 2012, CMS published in the Federal Register its notice of proposed rule making regarding Medicare provider and supplier obligations to report and return Medicare and Medicaid overpayments.52 This proposed rule is addressed at length in an article entitled “*Tick, Tick, BOOM: CMS’s Proposed 60-Day Rule Would Create Intense Time Pressure for Providers to Identify, Report, and Return Overpayments,*” reproduced with permission from BNA’s Health Care Fraud Report (Enclosure B). CMS has yet to issue the final rule.