



The Centers for Medicare and Medicaid Services (CMS) published a [final rule](#) pursuant to Section [1128J\(d\)](#) of the Social Security Act (the Act), as amended by the [Affordable Care Act](#), that requires Medicare Parts A and B health care providers to report and return overpayments 60 days after the date an overpayment is identified, or the due date of any corresponding cost report, if applicable, whichever is later. The rule requires providers to maintain responsible compliance practices and conduct a reasonably diligent inquiry when credible information indicates that an overpayment may exist. These regulations are effective 30 days after the date of publication in the [Federal Register](#), or March 13, 2016.

Meaning of Identification: Providers, regardless of size, have a duty to ensure their claims to Medicare are accurate and appropriate and to report and return overpayments they have received. A provider has “identified” an overpayment when he or she has, or *should have* through the exercise of [reasonable diligence](#), determined that the provider (1) *received an overpayment* and (2) *quantified the amount of the overpayment*. “Overpayment” consists of any funds that a provider has received or retained to which the provider, after [applicable reconciliation](#), is not entitled, regardless of the reason, be it human or system error, fraud, or any other, and regardless of whether it was caused by or was otherwise outside the control of the provider.

A provider has “identified” an overpayment when he or she has, or should have through the exercise of reasonable diligence, determined that the provider (1) received an overpayment and (2) quantified the amount of the overpayment.

Overpayments must be reported and returned if a provider identifies the overpayment within 6 years of the date the overpayment was received.

Lookback: Overpayments must be reported and returned if a provider identifies the overpayment within 6 years of the date the overpayment was received. Providers that made a good faith effort to comply with section 1128J(d) of the Act by reporting self-referral overpayments to the SRDP, which, until now, has operated with a [4-year lookback](#) period, are not expected to return overpayments from the fifth and sixth year through other means. Providers reporting overpayments to the CMS Voluntary Self-Referral Disclosure Protocol (SRDP) on or after the effective date of this final rule are subject to the 6-year lookback period specified in this final rule. Consistent with the lookback period, any initial determination that is subsequently reported and returned as an overpayment is subject to [reopening](#) and revision by a contractor whenever the overpayment is returned. An adjustment to any individual paid claim constitutes a revised initial determination for purposes of the reopening rules.

Reporting and Returning of Overpayments: Providers must use an applicable claims adjustment, credit balance, self-reported refund, or another appropriate process to satisfy the obligation to report and return overpayments. **A provider or supplier must:** (1) report and return an overpayment to the Secretary, the state, an intermediary, a carrier or a contractor to the correct address by the later of 60 days after the overpayment was identified or the date the corresponding cost report is due, if applicable, and (2) notify the Secretary, the state, an intermediary, a carrier, or a contractor in writing of the reason for the overpayment.

Reporting methods: Overpayments should be returned at the time the cost report is filed. Unless exceptions apply, interest on the amount due will accrue from the due date of the cost report. In addition to the report, return and notice in writing described above, providers may report self-identified overpayments using the Office of the Inspector General (OIG) [Self-Disclosure Protocol \(SDP\)](#) and the [CMS Voluntary SRDP](#) and will be considered in compliance with this rule as long as they utilize the reporting process described in the respective protocol. However, where the overpayment amount is extrapolated based on a statistical sampling methodology, it is necessary for the overpayment report to explain how the overpayment amount was calculated.

Report and payment is due by the later of 60 days after the overpayment was identified or the date the corresponding cost report is due, if applicable.

“Bright Line” standards: The 60-day time period to report and return begins when either the reasonable diligence is completed or on the day the provider received credible information of a potential overpayment if the provider failed to conduct reasonable diligence and the provider in fact received an overpayment. Providers are obligated to conduct audits that accurately quantify the overpayment. After finding a single overpaid claim, it is appropriate to inquire further to determine whether there are more overpayments on the same issue before reporting and returning the single overpaid claim. Whether a particular provider has satisfied this standard in a particular circumstance is a fact-based inquiry.

The 60-day time period to report and return begins when either the reasonable diligence is completed or on the day the provider received credible information of a potential overpayment if the provider failed to conduct reasonable diligence and the provider in fact received an overpayment.

Reasonable Amount of Time: A total of 8 months -- 6 months for timely investigation and 2 months for reporting and returning -- is deemed a reasonable amount of time, absent extraordinary circumstances affecting the provider, supplier, or their community to report overpayments.

Potential penalty: Even without a final regulation providers are subject to the statutory requirements found in section 1128J(d) of 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. Additionally, providers continue to be required to comply with CMS's current procedures when CMS, or CMS's contractors, determine an overpayment and issue a demand letter.

Covered Period: There are two time periods of concern to providers -- the time prior to the enactment of the Affordable Care Act on March 23, 2010 and the time period between March 23, 2010 and the effective date of this final rule. For the time prior to March 23, 2010, while providers had an existing obligation to return overpayments, the specific obligations contained in section 1128J(d) of the Act are not retroactive prior to March 23, 2010. Therefore, failing to report and

return overpayments within the deadline in section 1128J(d) of the Act would not be actionable prior to March 23, 2010. For the time period between March 23, 2010 and the effective date of this final rule, providers may rely on their good-faith and reasonable interpretation of section 1128J(d) of the Act. Other statutes governed the disposition of overpayments prior to the enactment of the Affordable Care Act.

Proper payments: Payments that were proper at the time the payment was made do not become overpayments at a later time due to changes in law or regulation, unless otherwise required by law. Typically, overpayments would be determined in accordance with the effective date of any changes in law, regulation, or policy. Changes in guidance or coverage policy also usually will not alter whether a prior payment should be considered an overpayment, although there can be circumstances in which guidance is issued to clarify existing law, regulation, or coverage rules that would make clear that a past payment is an overpayment. If the error or non-reimbursable cost at issue did not result in an increase in reimbursement, then no overpayment was received and section 1128J(d) of the Act is not implicated. In instances where interim payments are made based on estimated costs, an overpayment is not deemed to exist for purposes of this rule until an applicable reconciliation has occurred.

Reasonable diligence: "Reasonable diligence" is both *proactive* compliance activities conducted in good faith by qualified individuals to monitor for the receipt of overpayments and *reactive* investigations conducted in good faith and in a timely manner by qualified individuals in response to obtaining credible information of a potential overpayment. When a provider obtains credible information concerning a potential overpayment, he or she needs to undertake reasonable diligence to determine whether an overpayment has been received, and to quantify the amount.

Applicable Reconciliation: "Applicable reconciliation" is the reconciliation that enables a provider to identify funds to which the provider is not entitled. In the context of cost reporting, the applicable reconciliation is the provider's year-end reconciliation of payments and costs to create the cost report. The applicable reconciliation occurs when a cost report is filed. In instances when the provider: (1) Receives more recent CMS information on the SSI ratio, the provider is not required to return overpayment resulting from the updated information until the final reconciliation of the provider's cost report occurs; or (2) Knows that an outlier reconciliation will be performed, the provider is not required to estimate the change in reimbursement and return the estimated overpayment until the final reconciliation of that cost report.

"Reasonable diligence" is both proactive compliance activities conducted in good faith by qualified individuals to monitor for the receipt of overpayments and reactive investigations conducted in good faith and in a timely manner.