A 60-Day Overpayment Refund Rule update

January 31, 2019

The 60-Day Overpayment Refund Rule (60-Day Rule) was enacted as Section 6402 of the Affordable Care Act (ACA) on March 23, 2010. Since that time, the Centers for Medicare & Medicaid Services (CMS) has issued final regulations implementing the 60-Day Rule for Medicare Parts A and B and for Medicare Parts C and D. Settlements, as well as challenges, have been announced under both regulations.

Here are some recent happenings with the 60-Day Rule.

- **Premier Medical Management, Inc.** (June 2017) – The District Court for the Southern District of Alabama denied Premier's motion to dismiss a reverse false claims lawsuit. The court alleged that a kickback scheme for patient referrals tainted the Medicare claims and subsequently created an obligation for Premier to reimburse the government for payments received for services performed pursuant to those referrals. As of the end of 2018, the court's docket noted that a settlement in principle had been reached, but the case has not yet been officially settled.
- **Dental Dreams, LLC** (September 2017) – Dental Dreams paid nearly $1.4 million to resolve whistleblower allegations that it was informed it received a Medicaid overpayment and failed to return the overpayment.
- **First Coast Cardiovascular Institute** (October 2017) – First Coast paid $448,821 to resolve allegations brought by a former employee-turned-whistleblower that First Coast delayed repayment of approximately $175,000 in overpayments resulting from accrued credit balances beyond the 60-day deadline.
- **Plaza Medical Centers and Humana Inc.** (October 2017) – Defendants agreed to pay $3 million (plus $4 million in attorneys'

fees) to resolve allegations that Humana recklessly disregarded false billing by Plaza Medical Centers (including knowledge that Plaza was reporting an unusually sick population) and that Humana disregarded its own obligation to return overpayments. Interestingly, the court rejected Humana's argument that the existence of its compliance program meant it could not have acted recklessly, pointing out shortcomings in its compliance program.

- Genesis Medical Center (March 2018) – Genesis paid $1.9 million to resolve allegations that Genesis improperly retained Medicare overpayments for hospital services billed as inpatient that should have been billed as outpatient or observation services.
- UnitedHealth (September 2018) – The D.C. District Court issued an opinion that invalidated CMS's 2014 final rule implementing the 60-Day Rule Medicare Advantage plans. The court found that the final rule violated the Administrative Procedure Act because (1) it was contrary to the statutory requirement of actuarial equivalence between traditional Medicare and Medicare Advantage, and (2) the intent standard associated with "identifying" an overpayment in the final rule (when it has determined or should determine through reasonable diligence) was not the same as in the proposed rule and was higher than the actual knowledge/reckless disregard standard in the ACA. CMS filed a motion for partial reconsideration of the decision, as well as a notice of appeal. Meanwhile, even though the regulation may have been vacated, Medicare Advantage Plans must still comply with the statutory ACA requirement to report and return any overpayment "after reconciliation" within 60 days after the date on which the overpayment was identified.

Authors