Policy and Procedure Title:	Reporting, Returning and Explaining Overpayments
Policy Owner:	Quality Assurance
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Approved by:	Valerie Way, President and CEO

Purpose:

The purpose of this policy is to provide guidance on how to promptly report, return, and explain overpayments received by Mental Health Association of Rochester ("MHA") in accordance with applicable laws and payor protocols.

Definition(s):

Affected Individuals: All persons who are affected by MHA's risk areas including MHA's employees, the chief executive and other senior administrators, volunteers, interns, managers, contractors, agents, subcontractors, independent contractors, governing body and corporate officers.

Knowingly: Means having actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information; or acts in reckless disregard of the truth or falsity of the information. Requires no proof of specific intent to defraud.

Overpayment: Any funds received or retained to which the recipient, after applicable reconciliation, is not entitled. This includes any amount not authorized to be paid by the payor, whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake.

Risk areas: Areas of operation affected by MHA's Compliance Program, including (1) billings; (2) payments; (3) ordered services; (4) medical necessity; (5) quality of care; (6) governance; (7) mandatory reporting; (8) credentialing; (9) contractor, subcontractor, agent or independent contract oversight; (10) review of contracts and relationships with contractors specifically those with substantive exposure to government enforcement actions; (11) review of documentation and billing relating to claims made to Federal, State, and third party payers for reimbursement; (12) compliance training, (13) effectiveness of the Compliance Program and (14) other risk areas reasonably be identified by MHA through its organizational experience.

Policy:

This policy and procedure apply to all affected individuals of MHA.

Overpayments include, but are not limited to, payments received from using incorrect service code(s), services not provided, system errors, or services ordered by an excluded provider. All affected individuals must report a suspected or confirmed overpayment to the Corporate Compliance Officer per the Compliance Plan. The Compliance Officer will promptly inform the Billing Director of all overpayments.

Overpayments must be refunded to all applicable payors, including federal healthcare programs (E.g., Medicaid, Medicare, Tricare, VA health care, CHIP), managed care plans, commercial insurances, and self-pay as outlined in the procedure below.

When an overpayment is received, whether directly or indirectly, the reporting, explaining, and returning of the overpayment must be prioritized.

Overpayments received from federal healthcare programs, such as Medicare and/or Medicaid, must be reported and returned by the later of 60 days after the date the overpayment was identified; or, the date any corresponding cost report is due, if applicable. If not reported and refunded to federal healthcare programs timely, MHA and any affected individuals involved can be subject to program exclusion, civil monetary penalties and/or False Claims Act liability.

Records must be maintained to accurately document timely, good faith investigative efforts. All documentation associated with an overpayment must be provided to and retained by the Compliance Officer. A summary of overpayments and actions taken will be provided by the Billing Director at the bi-monthly billing meetings and the Billing Director will prepare an annual summary for the Compliance Committee.

Procedure:

1) Upon discovery of a suspected overpayment, the Compliance Officer will do an initial assessment of the scope of the overpayment and determine whether it is an isolated overpayment or if there are potential related overpayments.
2) The Compliance Officer has authority to and will promptly initiate placing a hold on claims billed until the errors contributing to the concern are resolved. The Compliance Officer will notify the applicable Program Director and Billing Director to ensure that the billing is placed on hold.
3) A timely, good faith investigation is initiated immediately and coordinated by the Compliance Officer to determine if there are other related overpayments that may arise from the same or similar cause or reason. Corrective action must be taken to address source(s) of error identified.
4) The lookback period for self-disclosure is 6 years by date of service. The investigation will factor in the lookback period in its review of potentially impacted claims. The Compliance Officer will involve additional resources, as necessary, who have expertise to assist with the investigation/review of the claims and payments. This may include consultants and third-party experts. Prior to engaging third parties, the Compliance Officer will consult legal counsel about pursuing the engagement under attorney-client privilege.
5) With respect to Medicaid overpayments, to be eligible to use OMIG's Self-Disclosure Program (SDP) MHA:
    - Must not be currently under audit, investigation, or review by OMIG. If under audit, investigation, or review, but the overpayment being disclosed does not relate to the existing audit, or investigation, MHA shall be eligible to participate,
    - Must be disclosing an overpayment/related conduct that OMIG has not identified at time of disclosure;
    - Must be reporting the overpayment and related conduct by the deadline; and,

- Must not currently be a party or subject of any criminal investigation related to participation in the Medicaid program being conducted by the Medicaid Fraud Control Unit or a U.S. Government agency.

6) Regardless of SDP eligibility, for any Medicaid overpayment, a Self-Disclosure Statement must be submitted.
7) The Compliance Officer will coordinate with the Billing Director to ensure that Medicaid overpayments are returned in accordance with OMIG's requirements.
8) An overpayment received from Medicaid must be reported, returned and explained to OMIG by the later of 60 days after the date the overpayment was identified; or the date any corresponding cost report is due, if applicable. For the purpose of Medicaid overpayments, an overpayment has been "identified" when a person (as defined at 18 NYCRR § 521-3.2) has or should have through the exercise of reasonable diligence, determined that they have received an overpayment and quantified the amount of the overpayment. The appropriate self-disclosure protocol will be used (abbreviated or full self-disclosure), as described below:

I. OMIG Abbreviated Self-Disclosure Process.

a. This is used to report and explain identified Medicaid overpayments resulting from routine and transactional errors.
b. Examples of when to use the abbreviated process include:
    - Routine credit balance/coordination of benefits overpayments
    - Typographical human errors
    - Routine Net Available Monthly Income adjustments
    - Instance of missing or faulty authorization for services due to human error
    - Instance of missing or insufficient support documentation due to human error
    - Inappropriate rate/procedure/fee codes used due to typographical or human error
    - Routine recipient enrollment issue
c. The Billing Director/designee must void/adjust overpaid claim(s) first, then add the required information to OMIG's Self-Disclosure Abbreviated Statement.
d. Abbreviated Self-Disclosures can be submitted for each identified instance, or aggregated monthly and submitted monthly for claims voided/adjusted the previous month on https://apps.omig.ny.gov/SelfDisclosures/selfdisclosures.aspx.
e. Once the Abbreviated Self-Disclosure is submitted, a receipt confirmation will be provided via email with a unique reference code for the Self-Disclosure. This must be provided to and retained by the Compliance Officer.

II. OMIG Full Self-Disclosure Process.

a. Examples of when to use the Full Self-Disclosure Statement for Medicaid overpayments include, but are not limited to:
    - Error requiring a provider to create & implement a formal corrective action plan
    - Actual, potential or credible allegations of fraudulent behavior
    - Discovery of an employee on an Excluded Provider list
    - Documentation errors that resulted in overpayments
    - Overpayments that resulted from software or billing system updates
    - Systemic billing or claim processing issues
    - Non-claim-based Medicaid overpayments
    - Any error with substantial monetary or program impacts
    - Any instance upon direction by OMIG
b. A completed Full Self-Disclosure Statement Form, signed Certification Form, and Claims Data File (or mixed payer calculation form if self-disclosing salary/benefits paid to an excluded or non-enrolled employee), should be uploaded by the Billing Director/ designee

to the secure link on https://omig.ny.gov/full-self-disclosure-process within the 60 day timeframe. The Compliance Officer may consult legal counsel prior to submission.

c. A receipt confirmation will be given. This must be provided to and retained by Compliance. This submission pauses the 60 days while OMIG processes the disclosure.
d. Once OMIG's review is complete, MHA will receive a Determination Notice with instructions for repayment and the 60 days will un-toll. Repayment within the time frame in the Determination Notice will satisfy the return requirement.

8) The Self-Disclosure Statement to OMIG must contain the following information:
   a. A calculated estimate of the amount of the Medicaid overpayment. Information must be provided to OMIG which supports the calculated overpayment amount.
   b. Detailed explanation of the overpayment reason, which at a minimum has:
      - Description and explanation of circumstances that gave rise to the overpayment;
      - how the circumstances giving rise to the overpayment were discovered;
      - the date the overpayment was identified;
      - how the person calculated the amount of the overpayment;
      - the date(s) the overpayment(s) were received; and
      - the action taken to correct the error which caused the overpayment.
   c. the person's contact information;
   d. data file, in the form and format specified by OMIG;
   e. whether requesting to repay through installment payments *(full self-disclosure only)*
   f. whether requesting the waiver of any applicable interest; *(full self-disclosure only)*
   g. The person's agreement to return the full amount of the overpayment and interest if applicable, as determined by OMIG; and
   h. Any other documentation, or information OMIG shall require/request through the issuance of guidance or in response to its review of the submission.
9) With respect to overpayments received from Medicaid Managed Care Plans, refunds and self-disclosure will follow the applicable Plans' Self-Disclosure policies and procedures within 60 days of identification. If a Medicaid Managed Care Plan is unresponsive, MHA will document its attempts to contact the Plan and submit that documentation along with a completed Full Self-Disclosure to OMIG's Self-Disclosure Program. OMIG will review the submission and work with the Network Provider to determine the appropriate course of action.
10) For overpayments received from commercial payors, the returning, reporting and explaining process will be executed in accordance with each payor's contract terms, policies, and procedures. The Billing Director/designee must be familiar with each payor's requirements and timeframes and ensure they are met.
11) All overpayments received from patients will be refunded to the patient. Good faith efforts will be made and documented to return the funds. If after reasonable attempts MHA is unable to refund the patient (such as due to out-of-date contact information), then MHA will follow the unclaimed property process and report the matter to the New York State Comptroller's Office.
12) Direct any questions about how to address an overpayment to the Compliance Officer.

Regulatory References:

18 NYCRR 518.1
18 NYCRR 521-3
42 CFR 401.305(a)(2)
42 U.S.C. § 1320a-7k(d)
NYS Social Services Law § 363-d(6)(b)
Social Security Act §1128J