POLICY INFORMATION

Policy Title: Identification, Quantification and Repayment of Overpayments Policy and Procedure

Departmental Owner: Chief Compliance, Audit, and Privacy Officer

Version Effective Date: 4/20/24

Last Reviewed: 4/20/24

SCOPE

This policy applies to the following individuals and/or groups:

☒All of the below categories

☐All Employees ☐CT Employees ☐NY Employees ☐Remote Employees ☐Contractors☐Volunteers ☐Students/Interns ☐Vendors

This policy applies to all above listed Nuvance Health workforce members including but not limited to the following locations:

☒All of the below entities

☒Nuvance Health Systems

☒ Danbury Hospital (including New Milford Hospital Campus)	☒ Health Quest Systems, Inc. "(HQSI)"	☒ Western Connecticut Home Care, Inc ("WCHN")
☒Northern Dutchess Hospital	☒ Health Quest Home Care, Inc	☒ Western Connecticut Health Network Physician Hospital Organization ACO, Inc.
☒Norwalk Hospital	☒ Hudson Valley Cardiovascular Practice, P.C. (aka The Heart Center) ("HVCP")	☒Western Connecticut Home Care, Inc
☒ Putnam Hospital	☒ Other HQSI-affiliated Entities Not Listed	☒ Other WCHN-affiliated Entities Not Listed
☒Sharon Hospital	☒ Any Non-HQ Nuvance Health facility, unit or entity enrolled in the NYS Medicaid Program[1]	☒Nuvance Health Medical Practices (NHMP PC, NHMP CT, ENYMS & HVCP)
☒Vassar Brothers Medical Center		

POLICY STATEMENT/PURPOSE

The purpose of this policy is to provide Health Quest Systems, Inc., ("HQ") workforce members, business affiliates, and agents (hereinafter "Covered Individuals") [2] guidance regarding reporting and returning overpayments received or retained from Government and Non-Government Payors related to healthcare services provided to patients of Health Quest Systems, Inc., and its affiliates ("HQ").[3]

[1] In addition to governing the reporting and returning of Identified Overpayments at the HQ facilities, units, and entities (collectively hereinafter "Entities" or "Entity") first listed above, this document also establishes the policy that all non-HQ Nuvance Health Entities enrolled in the New York State ("NYS") Medicaid program shall follow when reporting and returning Identified Overpayments by NYS Medicaid and NYS Medicaid Managed Care Organizations.

[2] Note, the term "Covered Individual" as used herein includes, among other HQ stakeholders, all individuals and entities defined as "Affected Individuals" under 18 NYCRR § 521-1.2 [b][1].

[3] See, generally, Social Services Law 363-d [6], [7]; 18 NYCRR 521-3.1 [a]; 42 USC § 1320a-7k[d]; 42 CFR §§ 401.301 et seq.; Centers for Medicare and Medicaid Services, Reporting and Returning Overpayments, 81 Fed. Reg. 7653 [2016].

DEFINITIONS [4]

Covered Individual: Any HQ workforce member, business affiliate, or agent, as those terms are described in subdivisions A-C i-iii below:

I. Workforce Members: For purposes of this Policy, the term "workforce member" shall include any of the following individuals at Nuvance Health who on a fulltime, part time or per diem basis, whether functioning remotely, onsite, or any combination thereof, performs, executes, or otherwise carries out Nuvance Health functions, duties, or services:

- Members of the Nuvance Health Board of Directors, and Members of the Boards of any HQ related entity including, without limitation, any HQ entity first highlighted above on the top page of this policy; [5]
- Chief Executive Officer;[6]
- Corporate Officers;[7]
- Executives;[8]
- Employees;[9]
- Administrators;[10]
- Managers;[11]
- Affiliates;[12]
- Medical Staff Members;[13]
- Appointees;[14]
- Volunteers;[15]
- Personnel;[16]
- Interns;[17]
- Students;[18]
- Trainees; and
- Any individual whose performance or other conduct is under the direction and control of Nuvance Health, whether or not they are paid by Nuvance Health;

[4] When addressing an Overpayment received by a non-HQ Nuvance Health Entity as prescribed in footnote 1, supra, the Definitions used herein in ¶¶ 3, 4, 6 and 7 of this section shall substitute the word "HQ" with "Nuvance Health" and, along with the other definitions used in this section, shall otherwise remain unchanged and maintain its original meaning

[5] For purposes of this Policy, "members of the Nuvance Health Board of Directors and Members of the Boards of any Nuvance Health related entity" shall be construed to include members of any associated Board committee.

[6] 18 NYCRR 521-1.2 [b][1]

[7] 18 NYCRR 521-1.2 [b][1]

[8] New York State Office of the Medicaid Inspector General, Compliance Program Review Guidance, New York State Social Services Law 363-d and Title 18 New York Codes Rules and Regulations Part 521 (10/26/16) (hereinafter 2016 OMIG Compliance Program Guidance), p.3

[9] 18 NYCRR 521-1.2 [b][1]

[10] 18 NYCRR 521-1.2 [b][1]

[11] 18 NYCRR 521-1.2 [b][1]; see also, generally, OIG Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8987, 8988, § [I] (1998)

[12] 2016 OMIG Compliance Program Guidance, p.3

[13] See, generally, 2016 OMIG Compliance Program Guidance, p.3; see also OIG Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8987, 8995-8996, § [II][E][1] (1998)

[14] 2016 OMIG Compliance Program Guidance, p.3

[15] 2016 OMIG Compliance Program Guidance, p.3

[16] See, generally, OIG Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8987, 8993, § [II][A][9] (1998)

[17] 2016 OMIG Compliance Program Guidance, p.3

[18] 2016 OMIG Compliance Program Guidance, p.3

II. Business Affiliates: For purposes of this Policy, the term "Business Affiliate" shall include any non-workforce member contractor, independent contractor, vendor, subcontractor, third-party, or person (collectively "Contractors"), who or that, in acting on behalf of Nuvance Health:

- Delivers, furnishes, prescribes, directs, orders, authorizes, administers, or otherwise provides Federal healthcare program items, supplies, and services; [19]
- Performs coding or billing functions; [20]
- Monitors the healthcare provided by Nuvance Health; [21]
- Contributes to Nuvance Health's entitlement to payment under Federal healthcare programs or payment from private payors; [22]
- Is affected by any of the following HQ risk areas:[23]
  - Medical record documentation;[24]
  - Coding;[25]
  - Billings;[26]
  - Claims preparation and submission;[27]
  - Claims reimbursement;[28]
  - Payments;[29]
  - Patient collections;[30]
  - Order services;[31]
  - Medical necessity;[32]
  - Quality of care;[33]

[19] See CMS, DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions, p.6 (available at: https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd032207att1.pdf (last accessed on 4/20/24); See, also, generally, U.S. Department of Health and Human Services, Office of Inspector General, OIG Special Advisory Bulletin on the Effect if Exclusion from Participation in Federal Health Care Programs (Updated, 5/8/13) (available at: https://oig.hhs.gov/exclusions/files/sab-05092013.pdf)(last accessed on: 4/20/24).

[20] See CMS, DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions (available at: https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd032207att1.pdf)(last accessed on 4/20/24; see also CMS, Center for Medicaid and State Operations, Dear State Medicaid Director Letter dated 12/13/06): https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD121306.pdf)(last accessed on 4/20/24)

[21] See CMS, DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd032207att1.pdf (last accessed on 4/20/24; see also CMS, Center for Medicaid and State Operations, Dear State Medicaid Director Letter dated 12/13/06): https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD121306.pdf)(last accessed on 4/20/24)

[22] 2016 OMIG Compliance Program Guidance, p.3

[23] Note, business affiliates affected by "other risk areas that are or should reasonably be identified by [HQ] through its organization experience" are also covered under this policy to the extent that the potential impact of such risk areas when exploited could reasonably lead to, or result in, a potential or actual overpayment. (10 NYCRR 521 -1.3 [d][10]).

[24] See 18 NYCRR 521-1.3 [d][10]

[25] See 18 NYCRR 521-1.3 [d][10]; see also CMS, DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions (available at: https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd032207att1.pdf)(last accessed on 4/20/24; see also CMS, Center for Medicaid and State Operations, Dear State Medicaid Director Letter dated 12/13/06): https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD121306.pdf)(last accessed on 4/20/24)

[26] See 18 NYCRR 521-1.3 [d][1]

[27] See 18 NYCRR 521-1.3 [d][10]

[28] See 18 NYCRR 521-1.3 [d][10]

[29] See 18 NYCRR 521-1.3 [d][2]

[30] See 18 NYCRR 521-1.3 [d][10]

[31] See 18 NYCRR 521-1.3 [d][3]

[32] See 18 NYCRR 521-1.3 [d][4]

[33] See 18 NYCRR 521-1.3 [d][5]

- Governance;[34]
- Mandatory reporting;[35]
- Credentialing;[36]
- Contractor oversight;[37]
- Identification and returning of overpayments;[38]
- Joint ventures;[39]
- Improper referrals, incentives, or financial arrangements[40]
- Cost reporting;[41] or

- Is otherwise affected by this policy due to their duties, functions, role, or responsibilities; [42]

III. Agents: For purposes of this Policy, the term "Agent" shall mean individuals or entities that have entered into an agency relationship with Nuvance Health. Agents may fall under the categories of either Workforce Members or Business Affiliates.

Government Payor: Any plan or program that provides health benefits, whether directly, through insurance, or otherwise, that is funded directly, in whole or in part, by the United States Government or New York State, including but not limited to: Medicare, Medicaid, Managed Medicare, Managed Medicaid, Tricare/VA/CHAMPUS, SCHIP, Federal Employees Health Benefit Program, National Association of Letter Carriers HBP, Indian Health Service, health services for Peace Corps volunteers, Railroad Retirement Benefits, Federal Black Lung Program, services provided to federal prisoners, Pre-Existing Condition Insurance Plans ("PCIPs"), Section 1011 requests, New York State Department of Corrections, NY Crime Victims, and AIDS Drug Assistance Program ("ADAP").

Identification Date: The date on which HQ has determined, after a reasonable opportunity to conduct an appropriate review or investigation of the Potential Overpayment, determined an Overpayment exists and has quantified the amount of the Overpayment.

Identified Overpayment: HQ has determined that it has received or retained funds from a government or Non-government Payor that it is not entitled to, but Reasonable Diligence has not been completed and an Identification Date has not been determined.

Lookback Period: The period of six (6) years from the date the Overpayment was received for Government Payors, or contractual or appropriate period from the date the Overpayment was received for Non-Governmental Payors.[43]

Non-Government Payor: Any entity that is not a Government Payor and has paid or reimbursed HQ for healthcare services provided to patients of HQ.

Overpayment: Funds HQ received or retained from a Government or Non-government Payor during the Lookback Period that HQ has determined, through Reasonable Diligence, it is not entitled to and has established the Identification Date of the overpayment.[44] Overpayment includes, for example, any claims for medical care, services, items or supplies that should not have been submitted or otherwise not authorized to be paid by Government or Non-government payors due to, as applicable, lack of medical necessity or in

[34] See 18 NYCRR 521-1.3 [d][6]
[35] See 18 NYCRR 521-1.3 [d][7]
[36] See 18 NYCRR 521-1.3 [d][8]
[37] See 18 NYCRR 521-1.3 [d][9]; see also 42 USC 1396a [a][68][A]
[38] See 18 NYCRR 521-1.3 [d][10]
[39] OIG Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8987, 8990, § [II][A][2] (1998)
[40] See 18 NYCRR 521-1.3 [d][10]
[41] See 18 NYCRR 521-1.3 [d][10]
[42] See 18 NYCRR 521-1.3 [d]; see also OIG Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8987, 8989 § [II][A].
[43] See 42 CFR § 401.305 [b], [f]; see also Reporting and Returning Overpayments, 81 Fed. Reg. 7653, 7671-7674, [II][C][3] [2016].
[44] See 42 CFR § 401.303

excess of a patient's needs, the provision of medical services that fall below established standards of quality of care, faulty cost reporting, error, fraud, abuse, improper submission of claims, or any other practices prohibited under Federal healthcare program and private payor requirements that may lead to the submission of a fraudulent or other types of false claims or otherwise result in HQ receiving funds from payors it is not entitled to. [45]

Potential Overpayment: A suspected Overpayment that requires further research and confirmation.

Potential Substantial Overpayment: A Potential Overpayment that occurred due to either an isolated error or a pattern of errors that totals $200,000 or more for one provider number.

Reasonable Diligence: A timely, good faith investigation that determines if HQ has received or retained an Overpayment and has quantified the excess amount. The investigation and quantification will be concluded in at most 6 months from the receipt date of information that supports a reasonable belief that an Overpayment may have been received.

Substantial Overpayment: An Overpayment that occurred due to either an isolated error or a pattern of errors which total $200,000 or more for one provider number.

POLICY

A. Overview

HQ will identify, quantify, track, report and return Overpayments received or retained from Government and Non-Government Payors within 60 days of the Identification Date. Such identification shall include exercising Reasonable Diligence to quantify the amount of the Overpayment within no more than 6 months from the date credible information was obtained that supports a reasonable belief that an Overpayment may have been received.

B. Identification of Overpayments

Potential Overpayments may be identified and reported as a result of various proactive and reactive compliance activities conducted by HQ management, HQ employees, the HQ revenue cycle ("RC") staff, the Corporate Compliance Office, or any other Covered Individual. Examples of proactive and reactive compliance include, without limitation, the following: reports filed under the disclosure program; internal auditing and department monitoring activities; external audits, processing or correcting documentation, code/coding, charge, claim submission and payment transactions or exceptions; review of physician arrangements or payments; review of current or past cost reports; the identification and assessment of any risk area related to a HQ operation that could lead to an overpayment; discovery of an employee or other Covered Individual on an excluded provider or ineligible person lists; and/or review of external agency correspondence or audit findings.

C. Where applicable, HQ will return overpayments utilizing the self-disclosure protocol outlined under applicable State law.

RECORDS RETENTION

All documentation, to include due diligence to resolve the Potential Overpayments, findings and other relevant information (i.e., summary of error, refund methodology, etc.), must be saved to the centralized audit depository for documentation purposes, and must be maintained for six (6) years.[46]

CORRECTIVE ACTION

[45] 18 NYCRR §§ 504.8 [d], 515.2, 518.1 [b-c]
[46] See, generally, 18 NYCRR 521-1.3 [b][1]

HQ will take remedial steps to correct the underlying cause of the Overpayment within ninety (90) days of the Identification Date, or within such additional time period as may be agreed upon by the Payor. The corrective action shall include correcting the underlying cause of the Overpayment and taking remedial action to prevent the Overpayment from recurring. The Corporate Compliance Office will review the remedial actions taken and make a determination as to whether further action is warranted, such as further auditing or monitoring.

RESPONSIBILITY

A. Covered Individuals
   i. It is the responsibility of all Covered Individuals to report potential billing errors or overpayments that they become aware of to:
      - management, the RC team, the billing office; and
      - the Corporate Compliance Office.
   ii. All Covered Individuals whose duties, functions, role or responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities as set forth herein and as provided under any implementing procedure.

B. Corporate Compliance Office and RC Staff
   i. The respective RC staff for the affected HQ Affiliate, in conjunction with the Corporate Compliance Office, are responsible for administering this policy.
   ii. The Corporate Compliance Office, in conjunction with Human Resources Department, Supply Chain, and Officer of Legal Affairs, is responsible for enforcing this policy.

DISCIPLINARY ACTION

Failure to comply with this policy and any corresponding implementing procedure will result in, subject to and consistent with corresponding and applicable collective bargaining agreements, peer review procedures, employment contracts, and Contractor agreements, progressive disciplinary action up to and including termination of employment, contract or other affiliation with HQ and Nuvance Health.

PROCEDURE

Potential Overpayments may be identified and reported as a result of various proactive and reactive compliance activities conducted by HQ management, HQ employees, the HQ revenue cycle ("RC") staff, the Corporate Compliance Office, or any other Covered Individual. Examples of proactive and reactive compliance include, without limitation, the following: reports filed under the disclosure program; internal auditing and department monitoring activities; external audits, processing or correcting documentation, code/coding, charge, claim submission and payment transactions or exceptions; review of physician arrangements or payments; review of current or past cost reports; the identification and assessment of any risk area related to a HQ operation that could lead to an overpayment; discovery of an employee or other Covered Individual on an excluded provider or ineligible person list; and/or review of external agency correspondence or audit findings.

1. The following process shall be followed when a Potential Overpayment is identified by or reported to the RC or the Corporate Compliance Office:
   a. Isolated clerical errors, unintended patient specific coding, charging, or billing errors, or any non-repetitive errors resulting in a Potential Overpayment should be dealt with in the normal course of business and refunded within sixty (60) days of the Identification Date.
   b. Repetitive errors that result in a Potential Overpayment shall be reported to either: (i) a supervisor; (ii) a member of management; (iii) the Compliance Office; or (iv) the Compliance Hotline upon discovery of the potential repetitive error. If the matter is reported to a supervisor or a member of management, the person who receives such report shall then

report the matter to the Compliance Office. Reports to the Compliance Office or to the Compliance Hotline may be made as follows:

i. Anonymous and Confidential Compliance Hotline – 1-844- YES-WeComply (844) 937-9326)
ii. Direct telephone to the Compliance Office – (203) 739-7110
iii. Direct email to the Compliance Office – compliance@nuvancehealth.org

2. Potential Substantial Overpayments, whether due to a single claim or to a pattern of errors affecting many claims, shall in all cases be reported to the Compliance Office.

3. If the Compliance Office or RC receives a report of a Potential Overpayment, they will create a new folder in a centralized audit repository designated by the Compliance Office.

4. Appropriate actions will be taken immediately by the RC to make an initial assessment of whether or not the Potential Overpayment is an Identified Overpayment.

   a. If the RC determines that there is not an Identified Overpayment, the RC, Billing Director, or designee, will communicate in writing to the Compliance Office why no Overpayment has been identified. Once agreed to by the Compliance Office, the Compliance Office will document the conclusion and close the related investigation.
   b. If the RC determines that there is an Identified Overpayment, the RC will coordinate actions among appropriate HQ managers to determine: the cause for the Identified Overpayment; the scope of the problem causing the Identified Overpayment: the appropriate corrective action steps to stop the Identified Overpayment from reoccurring; and the expected deadline for implementing the corrective actions. The RC, in consultation with the Compliance Office, shall decide whether or not to suspend submission of claims involving the underlying problem until the corrective actions can be implemented.
   c. If the RC cannot determine that there is an Identified Overpayment from an initial assessment due to the complexity of the issue, the need for appropriate fact finding, or to conduct appropriate legal and regulatory research, the RC, in consultation with the Compliance Office, shall decide whether or not to suspend submission of appropriate claims until an investigation has been completed.

OVERPAYMENT REPORTING AND RETURNING

1. Once a Potential Overpayment has been confirmed to be an Identified Overpayment, the RC, Billing Director, or designee, and the Compliance Office, with inclusion of General Counsel when necessary, are responsible for determining the scope of the audit, including the Lookback Period, identifying the impacted accounts, conducting the audit with Reasonable Diligence, determining the Overpayment amount and reporting and returning the Overpayment, within the later of either 60 days from the Identification Date or the date any corresponding cost report is due.

2. Preparation for the audit should include:
   a. Consideration of potential violation of criminal, civil or administrative law applicable to any Federal health care program for which penalties or exclusions may be authorized.
   b. Research of applicable laws, regulations and manual instructions.
   c. Determination of the Lookback Period needed to quantify the Overpayment amount, including: what caused the Overpayment; when did the Overpayment begin; which accounts were impacted; what data is available and in what format does the data it exist (ex: paper, electronic).
   d. Audit methods to be used such as 100% review or statistical sampling techniques.
   e. Whether or not extrapolation will be necessary to quantify the overpayment amount.

3. The RC and the Corporate Compliance Office will be responsible for determining the amount of the refund and to document the methodology used to determine the amount prior to the completion of any refund form(s). These accounts will be identified and maintained by the RC in a spreadsheet in the centralized audit repository and shall include the following: payer name; claim

reference number; claim line number; Medicaid Group ID (if applicable); billing provider's Medicaid MMIS ID (if applicable); HIC number (if applicable); patient first name; patient last name; patient health insurance number; patient date of birth; patient social security number (if available; date of service; incorrect rate or procedure code (if applicable); correct rate of procedure code; incorrect units paid (if applicable); correct units; amount paid; amount that should have been paid; and amount paid by other third party (if applicable).

4. The Corporate Compliance Office will create refund cover letters for mailing the appropriate forms and checks to the payors (if applicable). The Compliance Office will seek legal advice as necessary. Overpayments must be refunded to the appropriate payor within sixty (60) days of the Identification Date.

5. To report and return the Overpayment, HQ shall, as set forth below, use an applicable claims adjustment, credit balance, self-reporting refund or other reporting or disclosure process established by the appropriate Government or Non-Government Payor:
    a. Repayment of Medicare Overpayments: HQ may use any applicable claims adjustment, credit balance, self -reported refund (e.g., voluntary refund process), or other reporting set forth by National Government Services, HQ's Medicare Administrative Contractor, to report a Medicare Overpayment.[47]
    b. Repayment of Medicaid Overpayments: Overpayments by New York State Medicaid, fee for service must be reported, returned, and explained through the submission of a Self-Disclosure Abbreviated Statement, in accordance with the New York State Office of the Medicaid Inspector General ("OMIG") Self-Disclosure Program. Please see Attachment "A" for OMIG Self-Disclosure Abbreviated Statement.[48]
    c. Repayment of Medicaid Managed Care Organization ("MMCO") Overpayments: HQ shall report and refund overpayments in accordance with the MMCO's repayment process.[49]
    d. Repayment to Payers other than Medicare/Medicaid: Repayments of overpayments shall be done in accordance with the applicable payor's policies and procedures and the contractual agreements.
    e. Self-pay accounts: Identified Overpayments shall be refunded to patients in accordance with applicable policies and procedures. If it is not possible to refund the overpayment to the patient, HQ will follow the relevant New York laws pertaining to unclaimed property.[50]

6. When a Government Payor Overpayment has been calculated using statistical sampling methodology, HQ will describe the sampling extrapolation methodology in the report.

7. Claim Corrections in Billing System: The billing department will determine the amount of overpayment after the payor has recouped the dollars and adjusted the claim. The billing department will communicate these types of Overpayments to the Corporate Compliance Office on a monthly basis.

8. Substantial Overpayment: The Chief Compliance, Audit, and Privacy Officer, upon consultation with the Chief Legal Officer, shall report any Substantial Overpayment to the Audit and Compliance Committee of the Nuvance Health Board of Directors.

9. In addition to the foregoing, all Covered Individuals shall:

[47] See National Government Services Overpayment, available at: https://www.ngsmedicare.com/overpayments?selectedArticleId=2108148&lob=93617&state=97256&rgion=93623 (last accessed on April 20, 2024)
[48] See 18 NYCRR Subpart 521-3; see also, generally, 18 NYCRR § 521-1.3 [g]; 18 NYCRR § 521-1.3 [d][7]; 18 NYCRR § 521-1.1 [a].
[49] See 18 NYCRR Subpart 521-3; see also, generally, 18 NYCRR § 521-2.4 [f]
[50] See Office of the New York State Comptroller, Reporting Unclaimed Funds to New York State (available at: https://www.osc.state.ny.us/unclaimed-funds/reporters (last accessed on April 20, 2024).

a. As set forth in the Identification, Quantification and Repayment of Overpayments Policy, Report any potential or confirmed billing errors or overpayments that they become aware of to the Corporate Compliance Office;
b. Become familiar with the procedures and responsibilities provided in this procedural document;
c. Refrain from engaging in any form of retaliatory conduct as a result of another Covered Person's:
    i. reporting of a potential or confirmed billing issue, overpayment, or any violation of this policy or government payor or non-government payor requirements;
    ii. Fulfillment of their duties, obligations, and responsibilities under this procedure.

REBILLING PROCESS

1. For claims identified as requiring correction via the billing system, upon receipt of an email communication summarizing the information, the Billing Director, or designee, will initiate and oversee the rebilling process to correct the erroneous claims. The rebilling process will be tracked in the centralized audit repository. The Billing Director, or designee, will notify the Compliance Office once the rebilling process is complete.

2. The Billing Director or designee will promptly initiate and oversee a claim adjustment process. All claim adjustments will be reviewed by the billing department on a weekly basis. The Billing Director or designee will inform the Compliance Office in writing if research reveals that an Overpayment is likely to take more than thirty (30) days to refund. Any such cases will be reviewed with the Executive Compliance Committee ("ECC").

REFERENCES

Compliance Disclosure Program Policy and Procedure

81 Federal Register, February 12, 2016, p7654 (available at: https://www.govinfo.gov/content/pkg/FR-2016-02-12/pdf/2016-02789.pdf) (last accessed on: April 20, 2024).

42 CFR §§ 401.301, 303, 305 [Reporting and Returning of Overpayments] (available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-A/part-401/subpart-D) (last accessed on: April 20, 2024).

NYS Social Services Law § 363-d (6) & (7) (available at https://www.nysenate.gov/legislation/laws/SOS/363-D (last accessed on April 20, 2024).

Affordable Care Act (ACA) of 2010 § 6402 (codified at: Title 42 of the United States Code (USC) §1320a7k(d)(1) & (2) (available at: USCODE-2021-title42-chap7-subchapXI-partA-sec1320a-7k.pdf (govinfo.gov) (last accessed on: April 20, 2024).

18 NYCRR Subpart 521-3 18 NYCCR § 504.8 (available at: https://regs.health.ny.gov/content/section-5048-audit-and-claim-review) (last accessed on: April 20, 2024);

NY State Office of Medicaid Inspector General Compliance Program Guidance (Jan. and Sept. 2023) (available at https://omig.ny.gov/compliance/compliance-library) (last accessed 4/20/24)

Approval

DocuSigned by:
Jared B Gaynor
6D04982F5DB24D1...

Signature

5/1/2024

Date

Original Effective Date: LHQ= 10/25/2017
Revision Dates: 4/20/24
Supercedes: 5.1.19 Identification, Quantification and Repayments of Overpayments Policy
5.1.19 Identification, Quantification and Repayments of Overpayments Procedure

ATTACHMENT “A”

OMIG Self-Disclosure Abbreviated Statement

Self-Disclosure Abbreviated Statement

This form is required for the reporting and explaining of voids and adjustments where the error was routine or transactional in nature.

By completing and submitting this form you are attesting that all of the information provided is accurate.

Provider FEIN or SSN	

Provider Contact Information

First Name	
Last Name	
Title	

Overpayment Information

Total Voided/Adjusted *automatically calculated*	**$0.00**

Overpayments must be reported within 60 days from the date identified

Overpayment Identification Period		
Total Amount Voided or Adjusted	**Overpayment Reason**	**Additional Information**

Self-Disclosure Abbreviated Statement

This form is required for the reporting and explaining of voids and adjustments where the error was routine or transactional in nature.

By completing and submitting this form you are attesting that all of the information provided is accurate.

Overpayment Reason	TCNs of voided or adjusted claims