| **Title**: Identification, Quantification and Repayment of Overpayments Policy | **Reference Number**: HQ 5.1.19 |
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| **Signature:** Chief Compliance Officer | **Effective Date**: 4/20/2023 |
| **Approved by:** Chief Compliance Officer | **Page #:** Page 1 of 9 |

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|---|---|---|
| ☒Health Quest Systems, Inc. | ☒Northern Dutchess Hospital | ☒Putnam Hospital Center |
| ☒Sharon Hospital | ☒Vassar Brothers Medical Center | ☒Heart Center |
| ☒HQ Home Care | ☒HQ Medical Practice | ☒Sharon Hospital Medical Practice |
| ☒Thompson House | ☒ Any Non-HQ Nuvance Health facility, unit or entity enrolled in the NYS Medicaid Program[1] | |
| ☒Other HQ Entities Not Listed Above | | |

## I. 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]

## II. 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

[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].

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.

D. This policy shall be read and followed in conjunction with HQ Procedure 5.1.19, *Identification, Quantification and Repayment of Overpayments Procedure*

## III. 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.[4]

## IV. CORRECTIVE ACTION:

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.

## V. 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

[4] *See, generally,* 18 NYCRR 521-1.3 [b][1]

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.

## VI. 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.

## VII. DEFINITIONS:

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

[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]

- 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

[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

- 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;

(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]

[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 3/29/23); *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: 3/29/23).
[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 3/29/23; *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 3/29/23)
[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 3/29/23; 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 3/29/23)
[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]

- 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]
- Governance;[34]
- Mandatory reporting;[35]
- Credentialing;[36]
- Contractor oversight;[37]
- Identification and returning of overpayments;[38]

[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 3/29/23; *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 3/29/23)
[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]
[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]

- 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.

B. 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").

C. 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.

D. 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]

[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].

E. 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.

F. 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 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]

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

H. 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.

**ADDITIONAL REFERENCES:**

HQ Procedure 5.1.19, *Identification, Quantification and Repayment of Overpayments Procedure*
HQ 5.1.25 *Compliance Disclosure Program Policy*.
Affordable Care Act (ACA) of 2010 § 6402.

**POLICY HISTORY:**

Supersedes: 09/14/2020
Original Implementation Date: 10/25/2017
Date Reviewed: 9/30/2019, 9/14/2020, 9/1/2021, 09/1/2022, 9/1/2022, 2/8/2023, 3/29/2023
Date Revised: 10/25/2017, 4/25/2018, 9/21/2018,4/18/2023

[44] See 42 CFR § 401.303

[45] 18 NYCRR §§ 504.8 [d], 515.2, 518.1 [b-c]

**APPROVAL:**

Wayne A. McNulty
Chief Compliance, Audit & Privacy Officer

4/18/23

Policy Owner

Date[46]

[46] Note: This Policy was subsequently approved by the Audit & Compliance Committee of the Nuvance Health Board of Directors on Thursday, April 27, 2023.