I. POLICY INFORMATION

Policy Title: Identification, Quantification and Repayment of Overpayments Policy and Procedure
Departmental Owner: Chief Compliance, Audit, and Privacy Officer
Version Effective Date: October 16, 2024
Last Reviewed: October 16, 2024

II. APPLICABILITY

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

☒All Covered Individuals (e.g., all Nuvance workforce members, business affiliates, and agents) as defined below in Section IV [A], "Covered Individuals".

III. SCOPE

This Policy governs reimbursement of healthcare payor overpayment requirements and associated responsibilities at all Nuvance Health ("Nuvance") facilities, units, and entities, including, without limitation, the following:[1]

☒All of the below entities

☐Nuvance Health	☐Hudson Valley Cardiovascular Practice, P.C.	☐Vassar Brothers Medical Center
☐ Health Quest Systems, Inc.	☐Vassar Health Quest Medical Practice of Connecticut, Inc.	☐Western Connecticut Home Care, Inc.
☐ Western Connecticut Health Network, Inc.	☐Northern Dutchess Hospital	☐Western Connecticut Health Network Physician Hospital Organization ACO, Inc.
☐Danbury Hospital and its New Milford Campus	☐The Norwalk Hospital Association	☐Nuvance Health Medical Practice CT, Inc.
☐Eastern New York Medical Services, P.C.	☐Putnam Hospital	☐The Foundations of Nuvance Health
☐Health Quest Home Care, Inc. (Licensed and Certified)	☐Sharon Hospital	☐Western Connecticut Health Network Affiliates, Inc.
☐Nuvance Health Medical Practice, P.C.	☐Taconic IPA, Inc.	☐Nuvance Insurance Company, Ltd.
☐Alamo Ambulance Service, Inc.	☐New Milford MRI, LLC	☐Norwalk Surgery Center, LLC
☐Physicians Network, P.C.	☐SWC Corporation	☐Hudson Valley Newborn Physician Services, PCCL

IV. DEFINITIONS

For purposes of this policy, the terms listed below shall have the following meanings:

A. Covered Individual: Any Nuvance Health ("Nuvance") workforce member, business affiliate, or agent, as

[1] When used in this document, the term "Nuvance Health" or "Nuvance" shall mean any Nuvance Health facility, unit, and entity as described in § III of this Policy.

those terms are described in subdivisions (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:

1. Members of the Nuvance Health Board of Directors, and Members of the Boards of any Nuvance related entity including, without limitation, any Nuvance entity first highlighted above in Section III of this policy;[2]
2. Chief Executive Officer;[3]
3. Corporate Officers;[4]
4. Executives and other senior managers regardless of title;[5]
5. Employees;[6]
6. Administrators;[7]
7. Managers;[8]
8. Affiliates;[9]
9. Medical Staff Members;[10]
10. Clinicians;[11]
11. Allied Health Professionals;[12]
12. Appointees;[13]
13. Volunteers;[14]

[2] 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.
[3] 18 NYCRR 521-1.2 [b][l]
[4] 18 NYCRR 521-1.2 [b][l]
[5] New York State Office of the Medicaid Inspector Genera1, 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
[6] 18 NYCRR 521-1.2 [b][l]
[7] 18 NYCRR 521-1.2 [b][l]
[8] 18 NYCRR 521-1.2 [b][l]; see also, generally, OIG Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8987, 8988, § [I] (1998)
[9] 2023 OMIG Compliance Program Guidance, p. 18
[10] 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][l] (1998) and 18 NYCRR 521-1.2 [b][l] (last accessed on 9/3/24)
[11] 18 NYCRR 521-1.2 [b][l]
[12] *See, generally*, OMIG Required Risk Areas at 18 NYCRR §521-1.3(d) (last accessed on 9/3/24)
[13] 2016 OMIG Compliance Program Guidance, p.3 (last accessed on 9/3/24)
[14] 2016 OMIG Compliance Program Guidance, p.3 (last accessed on 9/3/24)

14. Personnel;[15]

15. Interns;[16]

15. Students;[17]

16. Trainees; **and**

17. 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, consultant, third-party, or person (collectively "Contractors"), who or that, in acting on behalf of Nuvance Health:

(1) Delivers, furnishes, prescribes, directs, orders, authorizes, administers, or otherwise provides Federal healthcare program items, supplies, and services; [18]

(2) Performs coding or billing functions;[19]

(3) Monitors the healthcare provided by Nuvance Health;[20]

(4) Contributes to Nuvance Health's entitlement to payment under Federal healthcare programs or payment from private payors;[21]

(5) Is affected by any of the following Nuvance risk areas:[22]

[15] See, generally, OIG Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8987, 8993, § [II][A][9] (1998) (last accessed on 9/3/24)
[16] 18 NYCRR 521-1.2 [b][l] (last accessed on 9/3/24)
[17] 18 NYCRR 521-1.2 [b][l] (last accessed on 9/3/24)

[18] *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/smd032207attl .pdf (last accessed on 8/29/24); *See, also, generally* Department of Health and Human Services, Office of Inspector General, *OJG Special Advisory Bulletin on the Effect of 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 9/3/24).

[19] See CMS, DRA 6032 - Employee Education About False Claims Recovery - Frequently Asked Questions (available at: https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd032207 attl.pdf)(last accessed on 8/29/24; *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/SMDl 21306.pdf)(last accessed on 8/29/24)

[20] See CMS, DRA 6032 - Employee Education About False Claims Recovery - Frequently Asked Questions https://downloads.ems.gov/cmsgov /archived-downloads/SMDL/downloads/smd032207att l.pdf (last accessed on 8/29/24; see also CMS, Center for Medicaid and State Operations, Dear State Medicaid Director Letter dated l 2/13/06): https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD121306.pdf)(last accessed on 8/29/24)

[21] 2016 OMIG Compliance Program Guidance, p.3

[22] Note, business affiliates affected by "other risk areas that are or should reasonably be identified by Nuvance 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][l 0]). (last accessed on 9/3/24)

(a) Medical record documentation;[23]
(b) Coding;[24]
(c) Billings;[25]
(d) Claims preparation and submission;[26]
(e) Claims reimbursement;[27]
(f) Payments;[28]
(g) Patient collections;[29]
(h) Order services;[30]
(i) Medical necessity;[31]
(j) Quality of care;[32]
(k) Governance;[33]
(l) Mandatory reporting;[34]
(m) Credentialing;[35]
(n) Contractor oversight;[36]
(o) Identification and returning of overpayments;[37]
(p) Joint ventures;[38]
(q) Improper referrals, incentives, or financial arrangements;[39] or
(r) Cost reporting.[40]

(6) Is otherwise affected by this policy due to their:

(a) duties, functions, role, or responsibilities; or[41]

(b) provision of goods or services to Nuvance.

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

[23] See 18 NYCRR 521-1.3 [d][l0]
[24] See 18 NYCRR 521-1.3 [d][l0]; 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/smd032207attl .pdf)(last accessed on 8/29/24; *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/SMDl21306.pdf)(last accessed on 8/29/24)
[25] See 18 NYCRR 521-1.3 [d][l]
[26] See 18 NYCRR 521-1.3 [d][l0]
[27] See 18 NYCRR 521-1.3 [d][l0]
[28] See 18 NYCRR 521-1.3 [d][2]
[29] See 18 NYCRR 521-1.3 [d][10]
[30] See 18 NYCRR 521-1.3 [d][3]
[31] See 18 NYCRR 521-1.3 [d][4]
[32] See 18 NYCRR 521-1.3 [d][5]
[33] See 18 NYCRR 521-1.3 [d][6]
[34] See 18 NYCRR 521-1.3 [d][7]
[35] See 18 NYCRR 521-1.3 [d][8]
[36] See 18 NYCRR 521-1.3 [d][9]; see also 42 USC 1396a [a][68][A] (last accessed on 9/3/24)
[37] See 18 NYCRR 521-1.3 [d][l0]
[38] OIG Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8987, 8990, § [ll][A][2] (1998) (last accessed on 9/3/24)
[39] See 18 NYCRR 521-1.3 [d][l0]
[40] See 18 NYCRR 521-1.3 [d][l0]
[41] See 18 NYCRR 521-1.3 [d]; *see also* OIG Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8987, 8989 § [II][A] (last accessed on 9/3/24)

insurance, or otherwise, that is funded directly, in whole or in part, by the United States Government, New York State or Connecticut, 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").[42]

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

D. Identified Overpayment: Nuvance 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.

E. Lookback Period: The period 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.

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

G. Overpayment: Funds Nuvance received or retained from a Government or Non-government Payor during the Lookback Period that Nuvance has determined, through Reasonable Diligence, that it is not entitled to, and for which it has established an Identification Date of the Overpayment.[43] 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:[44]

i. lack of medical necessity or services provided in excess of a patient's needs; or

ii. the provision of medical services that fall below established standards of quality of care; or

iii. faulty cost reporting, error, fraud, abuse, improper submission of claims; or

iv. claims submitted by or on behalf of a provider excluded from participation by a government payor; or

v. or any other practices prohibited under Federal or State 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 Nuvance receiving funds from payors it is not entitled to.

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

I. 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.

J. Reasonable Diligence**:** A timely, good faith investigation that determines if Nuvance has received or

[42] *See* 42 CFR § 401.305 [b], [f]; *see also* Reporting and Returning Overpayments, 81 Fed. Reg. 7653, 7671-7674, [II][C][3] [2016] (last accessed on 9/3/24)
[43] See 42 CFR § 401.303
[44] 18 NYCRR §§ 504.8 [d], 515.2, 518.1 [b-c]; *see also,* generally, definition of "Overpayment" at 42 CFR §401.303 (last accessed on 9/3/24)

retained an Overpayment and has quantified the excess amount. The investigation and quantification will be concluded at most six months from the receipt date of information that supports a reasonable belief that an Overpayment may have been received.

K. 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.

V. POLICY STATEMENT / PURPOSE

A. The purpose of this policy is to provide Nuvance workforce members, business affiliates, and agents (hereinafter "Covered Individuals") guidance regarding reporting and returning overpayments received or retained from Government and Non-Government Payors related to healthcare services provided to patients of Nuvance and its affiliates**.**[45]

B. Nuvance 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.

VI. PROCEDURE

A. Discovery of Potential Overpayments - Potential Overpayments may be identified and reported as a result of various proactive and reactive compliance activities conducted by Nuvance management, Nuvance employees, the Nuvance revenue cycle ("RC") staff, the Corporate Compliance Office, or any other Covered Individual. Examples of proactive and reactive compliance include, without limitation, the following:

i. reports filed under the disclosure program;

ii. internal auditing and department monitoring activities;

iii. external audits,

iv. processing or correcting documentation, code/coding, charge, claim submission and payment transactions or exceptions;

v. review of physician arrangements or payments;

vi. review of current or past cost reports;

vii. the identification and assessment of any risk area related to a ~~HQ~~ Nuvance operation that could lead to an overpayment;

viii. discovery of an employee or other Covered Individual on an excluded provider or ineligible person list;

ix. discovery of overpayment of Health Care Worker Bonus ("HWB"); and/or

[45] *See, generally,* Social Services Law 363-d [6], [7]; 18 NYCRR 521-3.1 [a]; 42 USC § l 320a-7k[d]; 42 CFR §§ 401.30 I et seq.; Centers for Medicare and Medicaid Services, *Reporting and Returning Overpayments,* 81 Fed. Reg. 7653 [2016] (last accessed on 9/3/24)

x. review of external agency correspondence or audit findings.

B. Identification, Reporting, and Rebilling of Overpayments - The following processes shall be followed when a Potential Overpayment is identified by or reported to the RC or the Corporate Compliance Office:

i. Identification of Overpayment

1. 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.

2. 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:

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

3. 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.

4. If the Compliance Office, ~~or~~ RC or Human Resources ("HR") receives a report of a Potential Overpayment, they will create a new folder in a centralized audit repository designated by the Compliance Office.

5. Appropriate actions will be taken immediately by the RC or HR to make an initial assessment of whether the Potential Overpayment is an Identified Overpayment as follows:

   a. If the RC or HR determines that there is not an Identified Overpayment, HR or 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 or HR determines that there is an Identified Overpayment, the RC or HR will coordinate actions among appropriate Nuvance 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 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 to suspend submission of appropriate claims until an investigation has been completed.

ii. *Overpayment Reporting and Returning*

1. Once a Potential Overpayment has been confirmed to be an Identified Overpayment, the RC, Billing Director, HR, 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 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, Nuvance 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*: Nuvance 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, Nuvance's Medicare Administrative Contractor, to report a Medicare Overpayment.[46]

   b. *Repayment of New York Medicaid Fee for Service Overpayments*: Overpayments by New York State Medicaid, fee for service must be reported, returned, and explained through the submission of either a Self-Disclosure Full Statement (including a Claims Data File of affected Medicaid claims or Mixed Payer Calculation Form)[47], or a completed Self-Disclosure Abbreviated Statement (where the error was routine or transactional in nature)[48], in accordance with the New York State Office of the Medicaid Inspector General ("OMIG") Self-Disclosure Program as follows:

      i. Examples of overpayment types that must be self-disclosed using the Full Self-Disclosure Statement include, but are not limited to[49]:

         I. Any error that requires a Medicaid Entity/Provider to create and implement a formal corrective action plan;

         II. Actual, potential or credible allegations of fraudulent behavior by employees or others;

         III. Discovery of an employee on an Excluded Provider list;

         IV. Documentation errors that resulted in overpayments;

         V. Overpayments that resulted from software or billing system updates;

         VI. Systemic billing or claim processing issues;

         VII. Non-claim based Medicaid overpayments;

         VIII. Any error with substantial monetary or program impacts; or

         IX. Any instance upon direction by OMIG.

      ii. Examples to be self-disclosed using the Abbreviated Self-Disclosure

[46] *See* National Government Services Overpayment, available at: https://www.ngsmedicare.com/overpayments?selectedArticleId=2108148&lob=93617&state=97256&rgion=93623 (last accessed on 8/29/24)
[47] *See* OMIG Self-Disclosure Guidance (updated January 2024) at https://omig.ny.gov/self-disclosure-guidance (last accessed on 9/3/24)
[48] *See* OMIG Self-Disclosure Abbreviated Statement Web Portal at https://apps.omig.ny.gov/SelfDisclosures/selfdisclosures.aspx(last accessed on 9/3/24)
[49] *See* OMIG Self-Disclosure FAQs (updated January 2024) at https://omig.ny.gov/self-disclosure-frequently-asked-questions (last accessed on 9/3/24)

Statement include[50]:

I. Routine credit balance/coordination of benefits over payments;

II. Typographical human errors;

III. Routine Net Available Monthly Income (NAMI) adjustments;

IV. Instance of missing or faulty authorization for services due to human error;

V. Instance of missing or insufficient support documentation due to human error;

VI. Inappropriate rate, procedure or fee codes used due to typographical or human error; or

VII. Routine recipient enrollment issue

Please see **Attachment** "**A**" for OMIG Self-Disclosure Full Statement, and the OMIG Website for the most up-to-date Self-Disclosure Abbreviated Statement.[51]

iii. For providers not enrolled in the New York State Medicaid Program that obtain overpayments through the New York State Medicaid Program, Nuvance must also report, return, and explain such overpayment through the submission of the appropriate Self-Disclosure Statement type (or, alternatively, through any means required as directed by the Office of Medicaid Inspector General or the New York Department of Health).[52]

c. *Repayment of New York Medicaid Overpayments (other than fee for service):* Overpayments by New York Medicaid for reimbursements other than fee for service must also be reported, returned, and explained through the submission of forms and electronic adjustments appropriate in each circumstance. For example, overpayments by New York Medicaid related to the New York Health Care Worker Bonus Program[53] must be reported, returned, and explained through the submission of the Health Care Worker Bonus Program (HWB) Self-Disclosure Submission Statement, Certification Statement, and HWB Self-Disclosure Overpayment Report Excel Spreadsheet to OMIG.[54].

d. *Repayment of Connecticut Medicaid Overpayments*: Overpayments by

[50] *See* OMIG Self-Disclosure FAQs (updated January 2024) at https://omig.ny.gov/self-disclosure-frequently-asked-questions(last accessed on 9/3/24))

[51] *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] (last accessed on 9/3/24)

[52] Unenrolled providers may make up to 4,500 claims totaling $75,000.00 per year to the New York Medicaid Program, but are not defined as "Providers" subject to normal overpayment rules. See 18 NYCRR §504.1 [d][19] at https://regs.health.ny.gov/content/section-5041-policy-and-scope. (last accessed on 9/3/24) Regardless, these providers are subject to the New York False Claims Act (See State Finance Law §§187-194), and overpayments must be returned.

[53] *See* New York Social Services Law §347-w at https://www.nysenate.gov/legislation/laws/SOS/367-W (last accessed 9/3/24), *See also, generally*, NY Social Services Law §363-d at https://www.nysenate.gov/legislation/laws/SOS/363-D (last accessed 9/3/24).

[54] *See* OMIG Self-Disclosure of Health Care Worker Bonus Payments webpage at https://omig.ny.gov/self-disclosure-health-care-worker-bonus-payments (last accessed 9/3/24)

Connecticut State Medicaid, fee for service must be reported, returned, and explained through the submission Paid Claim Adjustment Request (PCAR) or electronically adjusting the claim pursuant to the Connecticut Medical Assistance Program Provider Manual.[55]

e. *Repayment of Non-New York or Connecticut Medicaid Overpayments*: Overpayments by State Medicaid agencies outside of New York and Connecticut, fee for service must be reported, returned, and explained through the submission paid claims adjustments as directed by applicable state regulations, provider claims manuals, or pursuant to corresponding provider enrollment agreement terms.

f. *Repayment of Medicaid Managed Care Organization ("MMCO") Overpayments*: Nuvance shall report and refund overpayments in accordance with the MMCO's repayment process.[56]

g. *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.

h. *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, Nuvance will follow the relevant New York laws pertaining to unclaimed property.[57]

6. When a Government Payor Overpayment has been calculated using statistical sampling methodology, Nuvance 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 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:

a. 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;

[55] *See* CT Medical Assistance Program Provider Manual at https://www.ctdssmap.com/CTPortal/Information/Publications (last accessed 8/29/24)

[56] *See* 18 NYCRR Subpart 521-3*; see also, generally*, 18 NYCRR § 521-2.4 [f] (last accessed on 9/3/24)

[57] *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 8/29/24).

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.

iii. *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").

VII. RECORDS RETENTION

A. 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.[58] All documentation of claims potentially related to, or under investigation for, Federal or State False Claims Act violations, to include due diligence to resolve the Potential Overpayments, findings and other relevant information (i.e., summary of error, refund methodology, etc.) must be maintained for ten (10) years.[59]

VIII. CORRECTIVE ACTION

A. Nuvance 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

[58] *See, generally,* 18NYCRR 521-1.3 [b][l] (last accessed on 9/3/24)

[59] *See, generally,* Federal False Claims Procedure 31 USC §3731(b) at https://www.govinfo.gov/content/pkg/USCODE-2023-title31/pdf/USCODE-2023-title31-subtitleIII-chap37-subchapIII-sec3731.pdf (last accessed 9/3/24); *see also* NY State Finance Law §192 "Limitations of Actions" at https://www.nysenate.gov/legislation/laws/STF/192 (last accessed 9/3/24); *see also* CT General Statutes "Limitations of Actions" §4-285 at https://www.nysenate.gov/legislation/laws/STF/192 (last accessed 9/3/24).

Office will review the remedial actions taken and make a determination as to whether further action is warranted, such as further auditing or monitoring.

IX. DISCIPLINARY ACTION

A. 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 Nuvance Health.

X. ADDITIONAL REFERENCES

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: August 29, 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: August 29, 2024).
HQ 5.1.25 *Compliance Disclosure Program Policy*
NYS Social Services Law § 363-d (6) & (7) (available at https://www.nysenate.gov/legislation/laws/SOS/363-D (last accessed on August 29, 2024).
Affordable Care Act (ACA) of 2010 § 6402 (codified at: Title 42 of the United States Code (USC) §1320a-7k(d)(1) & (2) (available at: https://uscode.house.gov/view.xhtml?hl=false&edition=prelim&req=granuleid%3AUSC -prelim-title42-section1320a-7k&num=0&saved=%7CKHRpdGxlOjQyIHNlY3Rpb246MTMyMGEtN2EgZWRpdGlvbjpwcmVsaW0p%7C%7C%7C0%7Cfalse%7Cprelim (last accessed on: August 29, 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: 8/29/24);
18 NYCRR Part 518 (available at: https://regs.health.ny.gov/volume-c-title-18/233841597/part-518-recovery-and-withholding-payments-or-overpayments) (last accessed on: 8/29/24).

XI. POLICY HISTORY

Supersedes: 4/20/2024
Original Implementation Date: 10/25/2017
Date Reviewed: 9/30/2019, 9/14/2020, 9/1/2021, 9/1/2022, 2/8/2023
Date Revised: 10/25/2017, 5/25/2018, 9/21/2018, 4/18/2023, 4/20/2024, 10/16/2024

APPROVAL: Signed by: Jared B Gaynor 6D04982F5DB24D1...

Jared Gaynor
Chief Compliance, Audit & Privacy Officer (*Interim*)
Policy Owner

11/5/2024
Date[60]

[60] Note: This Policy was subsequently approved by the Audit & Compliance Committee of the Nuvance Health Board of Directors on October 24, 2024.

ATTACHMENT "A"
OMIG Full Self-Disclosure Statement

Nuvance Health

NEW YORK STATE | Office of the Medicaid Inspector General

FULL SELF-DISCLOSURE STATEMENT

FORM AND INSTRUCTIONS

Pursuant to 18 NYCRR § 521-3.4(c) to participate in the Self-Disclosure program, an eligible person shall apply by submitting a Self-Disclosure Statement. This form is for individuals and entities to report, return, and explain overpayments received from the NYS Medicaid program pursuant to Social Services Law section 363-d and 18 NYCRR SubPart 521-3 and is required for participation in OMIG's Self-Disclosure Program.

WARNING: Failure to report, return, and explain an overpayment within sixty (60) days of identification, or the date any corresponding cost report is due, whichever is later, may result in the imposition of monetary penalties pursuant to Social Services Law section 145-b(4)(a)(iii), and other penalties and sanctions where authorized by State or Federal law. A person who provides false material information on this form, or intentionally omits material information from this form, may have their participation in the Self-Disclosure Program terminated.

Each section of the Self-Disclosure Statement must be filled out in its entirety.

General

Please submit one Self-Disclosure Statement for each MMIS ID Number / NPI Number impacted by the overpayment. If multiple Statements need to be submitted, please explain that in Section 5.

Contact Information

If additional information is required, OMIG will communicate with you using the contact information requested in Section 2. If your contact information changes, you must notify OMIG at selfdisclosures@omig.ny.gov.

Sample & Extrapolation Request

Medicaid entities/Providers who wish to request a Universe, Sample and Extrapolation methodology to calculate their overpayment amount must provide a justification explaining why that methodology is needed in Section 3. They must also provide the data element parameters necessary for OMIG to extract a universe of potentially overpaid claims.

Approval is made in the sole discretion of OMIG. If the request is not approved, a claim-by-claim review of the potentially overpaid claims will be required. If the request is approved, OMIG will extract a universe of potentially overpaid claims based on the parameters disclosed in the Self-Disclosure Statement, and a statistically valid random sample of claims will be provided for review. The Medicaid entity/Provider must respond with the entire Sample and an explanation for each claim, identifying if it was allowed or disallowed and why, by the due date specified in the correspondence.

The overpayment will be calculated using the lower limit of the 90% confidence interval, or another statistically valid calculation, based on the Sample response. The calculation used is determined in the sole discretion of OMIG. The extrapolated overpayment amount repaid through a self-disclosure would reduce any amount owed due to overpayments found in any future review of the same claims. OMIG, however, reserves its right and the rights of any other entity authorized by law to conduct further audits, investigations, or reviews of the Medicaid entity's/Provider's participation in the Medicaid program for the same or a different time period and the same basis.

Voiding or Adjusting Claims for Repayment

Medicaid entities/Providers who wish to repay by voiding or adjusting claims are required to do so **prior** to submission of this Self-Disclosure Statement or **must** state in Section 4 that they are actively voiding or adjusting the claims.

Explaining The Overpayment

Medicaid entities/Providers are required to explain the cause(s) of the overpayment fully and completely, how it was identified, and what corrective action was taken to prevent recurrence of the overpayment.

Repayment

Once OMIG's review is completed, you will be notified of the overpayment amount, the amount due, your options for repayment, and directions for remitting payment. A Determination Notice will be sent to the email address you provided in Section 2. Medicaid entities/Providers who wish for OMIG to consider a waiver of interest for their overpayment are required to request a waiver of

interest in Section 6. OMIG, in its sole discretion, may waive interest on any self-disclosure overpayment reported, returned, and explained by an eligible person. Medicaid entities/Providers requesting extended repayment terms must do so in Section 6. Medicaid entities/Providers approved for repayment through installments will be required to sign a Self-Disclosure and Compliance Agreement (SDCA).

Review of Self-Disclosure

Following a review of the Self-Disclosure Statement, OMIG may determine that the Medicaid entity/Provider is not an "eligible person" because they failed to meet one or more of the eligibility requirements outlined in 18 NYCRR § 521-3.4(b)(1).

Regardless of a Medicaid entity's/Provider's eligibility, a Medicaid entity/Provider who has received an overpayment must report and return that overpayment to OMIG's Self-Disclosure Program in accordance with the requirements found in 18 NYCRR § 521-3.4(b)(3).

PART I REPORTING THE OVERPAYMENT

Section 1: Medicaid enrollment Information

MMIS Number (Provider ID Number)
Click or tap here to enter text.
NPI Number
Click or tap here to enter text.
Medicaid entity/Provider Name
Click or tap here to enter text.
DBA (all that apply)
Click or tap here to enter text.
Medicaid entity/Provider Address (include number, street name, floor/suite number, city, and zip code)
Click or tap here to enter text.

Section 2: Contact Information

NOTE: This contact will be required to respond to requests for information relevant to this submission. If there are any changes to this contact information, you are required to notify OMIG.

Contact Name
Click or tap here to enter text.
Contact Title
Click or tap here to enter text.
Correspondence Address (include number, street name, floor/suite number, city, and zip code)
Click or tap here to enter text.
Email Address: Click or tap here to enter text.
Phone Number: Click or tap here to enter text.

Section 3: Overpayment Information

Estimated amount of the overpayment
Click or tap here to enter text.
Date the overpayment was identified
Click or tap to enter a date.
Dates of Service the overpayment encompasses

Click or tap here to enter text.

Overpayment Calculation Methodology (choose one)

☐ **Claim-by-Claim review** (all overpaid claims are included in the Claims Data Form)

☐ **Non-claim Overpayment** (provide a **detailed explanation below** for how this overpayment was calculated)

Non-Claim Explanation
Click or tap here to enter text.

☐ **Request to use Extrapolation to calculate estimated overpayment amount**

Extrapolation Request Justification (explain why this type of review is necessary)
Click or tap here to enter text.

Extrapolation Universe: Date of Service Start Date
Click or tap to enter a date.

Extrapolation Universe: Date of Service End Date
Click or tap to enter a date.

Extrapolation: Rate, Procedure or NDC Codes impacted
Click or tap here to enter text.

Extrapolation: Other Information (additional information to identify the Universe of potentially overpaid claims)
Click or tap here to enter text.

Section 4: Claim Data Information

Types of claims affected (check all that apply)

☐ **Managed Care** (list managed care or managed long-term care plan names relevant to the overpayment)

MMCO/MLTC Names
Click or tap here to enter text.

☐ **FFS** (Fee for Service)

☐ **FFS APG** (ambulatory patient group)

☐ **FFS EPS** (episodic)

☐ **Other** (please provide additional explanation below to assist in verifying your overpayment)

Description of claim type
Click or tap here to enter text.

Voiding or Adjusting

Have the disclosed claims been voided or adjusted? ☐ Voided ☐ Adjusted ☐ N/A

If yes, please provide the date(s) of the void(s)/adjustment(s) below. If you are currently processing the voids or adjustments, please indicate that.
Click or tap here to enter text.

Claims Data

☐ **Claims Data Form:** Complete this form to disclose overpaid claims.
Access the form here: **Claims Data File**

☐ **Mixed Payer Calculation Form:** Complete this form to disclose Excluded or Non-Enrolled Provider(s).
Access the form here: **Mixed Payer Calculation Form**

PART II EXPLAINING THE OVERPAYMENT

Section 5: Statement Explaining the Overpayment

Describe completely and fully the error or matter that occurred, including an explanation of the circumstances that led to the overpayment, the type of program, services, and claims affected, etc.

Click or tap here to enter text.

List any rules, policies, regulations and/or laws that are relevant to the error or matter that occurred. Also include

identification of your regulatory oversight agency (if applicable), and when they were contacted to report this matter. Attach any guidance or direction you received relevant to this disclosure.

Click or tap here to enter text.

Provide the names and titles of the individuals who were involved in the error or matter that occurred.

Click or tap here to enter text.

Describe completely and fully how the error or matter was found, including the names and titles of the individuals who discovered it.

Click or tap here to enter text.

Describe all actions taken to stop the error or matter, including the names and titles of the individuals who were involved in rectifying the problem.

Click or tap here to enter text.

Describe all corrective actions taken to prevent recurrence of the error or matter.

Click or tap here to enter text.

PART III RETURNING THE OVERPAYMENT

Section 6: Repayment Information

Pursuant to 18 NYCRR § 521-3.5, you are required to pay the full amount due within 15 days of receiving OMIG's notification of the amount due or no later than the expiration of the deadline to report, return and explain, whichever is later. Voiding the claims if overpaid in full, or adjusting the claims if partially overpaid, is repayment of the claims. Overpayments can also be repaid through lump sum check, money order or electronic payment.

Upon the demonstration of financial need, you may be permitted to pay the amount due through installment payments by entering into a **Self-Disclosure and Compliance Agreement (SDCA), pursuant to 18 NYCRR § 521-3.4(e)**. This request must be made below. An SDCA will set forth the terms of repayment and any corrective action necessary to prevent the recurrence of the issues giving rise to the overpayment. To be considered for an SDCA, you must provide a justification of financial need and specify the repayment period you are requesting in the justification section below. The terms of repayment shall be calculated at not less than 15% of total Medicaid receivables or a maximum repayment term of 2-years, whichever period of repayment is less.

If you are requesting a repayment period longer than the maximum repayment term of 2-years, you must indicate that request within the justification section below. OMIG may in its discretion approve a period longer than 2-years through application for Financial Hardship consideration. Once the review of your self-disclosure is complete, you will be directed to contact the Bureau of Collections Management. The Bureau will send you a Financial Hardship Application. Upon receipt, OMIG will review the application and make a determination as to an appropriate re-payment plan. You must complete the application in its entirety to be eligible for relief.

Additional information regarding the Financial Hardship Application process can be found on OMIG's website (Financial Hardship Application Information | Office of the Medicaid Inspector General (ny.gov)).

Check all that apply:

☐ **I am requesting that OMIG consider granting a waiver of interest in this case.**

☐ **I will pay the overpayment amount in one payment. I am not requesting installment payments.**
☐ **I have voided or adjusted my overpaid claims to repay the Medicaid program.**
☐ **I am requesting installment payments. If, in OMIG's discretion, my request is approved, I agree to the terms outlined in this section.**
If requesting installment payments, provide a justification of need below including the repayment term you are requesting.
Click or tap here to enter text.

PART IV INSTRUCTIONS AND SUBMISSION

Section 7: Terms, Conditions, and Other Instructions

In consideration of a person's good-faith participation in OMIG's Self-Disclosure program, the following may be considered by OMIG in determining the terms and conditions of an individual or entity's repayment and corrective action:

- OMIG may waive interest on any overpayment reported, returned, and explained by an eligible person using this form.
- OMIG may permit repayment periods of up to two years without charging interest on the amount of the overpayment. OMIG may consider longer periods of repayment, with interest, upon a showing of financial need.
- A person's good-faith participation in the Self-Disclosure Program may be considered as a mitigating factor in the determination of an administrative enforcement action. This includes determinations regarding, where applicable, whether a Medicaid entity/Provider has adopted and implemented an effective compliance program in accordance with section 363-d of the Social Services Law.

NOTE: Information submitted with this form may be shared with other OMIG divisions, including OMIG's Bureau of Compliance. Where a Medicaid entity/Provider is required to execute an SDCA, outlining, in addition to any terms of repayment, corrective action necessary to prevent recurrence of the error or matter in the future, OMIG may follow-up in the course of a Compliance Program Review (CPR).

Section 8: Submission

By submitting this application and Certification Form, I (or the Medicaid entity/Provider) hereby affirm that:

- I (or the Medicaid entity/Provider) agree to comply with all of the requirements of the Self-Disclosure Program as set forth in 18 NYCRR SubPart 521-3.
- I (or the Medicaid entity/Provider) am not currently aware of being under audit, investigation, or review by OMIG, unless the overpayment and the related conduct being disclosed does not relate to OMIG's audit, investigation or review.
- I (or the Medicaid entity/Provider) am disclosing an overpayment and related conduct that OMIG has not determined, calculated, researched, or identified at the time of this disclosure.
- I (or the Medicaid entity/Provider) am not currently aware of being a party to any criminal investigation conducted by the Deputy Attorney General for the Medicaid Fraud Control (MFCU) or any other agency of the United States Government or any political subdivision thereof.
- I (or the Medicaid entity/Provider) agree to repay the overpayment in full within 15 days of being notified by OMIG of the amount due, unless requested and granted an installment payment agreement.
- I (or the Medicaid entity/Provider) agree to execute and return to OMIG a Self-Disclosure and Compliance Agreement where required to do so.
- I (or the Medicaid entity/Provider) acknowledge that failure to cooperate with OMIG during the Self-Disclosure process may result in penalties, fines or my participation resulting from this submission being terminated in the Self-Disclosure Program and that any amount owed shall become immediately due and payable (but not sooner than 60-days from the date I identified the overpayment), including interest thereon.