AUBURN COMMUNITY HOSPITAL &
THE FINGER LAKES CENTER FOR LIVING
17 LANSING STREET
AUBURN, NEW YORK 13021

Subject: **REPORTING AND RETURNING OVERPAYMENTS POLICY**	Policy No.: CC: 10
Department: Administration: Corporate Compliance	Page: 1 of 4
	Date Issued: 9/25/2016

SCOPE:
This Policy applies to all persons affected by the organization's risk areas, including employees, the chief executive officer and other senior administrators, managers, and contractors, agents, subcontractors, independent contractors, and governing board and corporate officers of Auburn Community Hospital ("ACH") and its affiliated entities, including Auburn Memorial Medical Services, P.C. ("AMMS"), Anesthesia Group, and Finger Lakes Center for Living ("FLCL") ("Affected Individuals"), as appropriate. Note, ACH, AMMS, Anesthesia Group and FLCL are referred to collectively as "Hospital" hereunder.

Purpose. To provide for timely and appropriate refunds of overpayments in compliance with third party payer requirements, including obligations under the Patient Protection and Affordable Care Act (ACA) Section 6402 applicable to Medicare and Medicaid. (See 42 CFR §§ 401.301 – 401.305).

This policy applies to the Finance, Corporate Compliance and Billing Departments.

Policy. Overpayments are any funds that ACH receives or retains to which, after applicable reconciliation, it is not entitled.[1] Overpayments occur when the amount of money ACH receives for services or supplies is in excess of the amount due and payable by a third party payer, including Medicare and Medicaid, or by a self-pay patient. Events leading to overpayments may include, but are not limited to, duplicate payments or payment for non-covered services. Once verified, overpayments must be refunded to the appropriate payer or patient and/or processed according to the payer contracts.

As a result of changes under the ACA, it is crucial to report a suspected overpayment from Medicare or Medicaid within 60 days, as failure to do so could result in liability under the False Claims Act. Procedures for reporting and returning overpayments from Medicare or Medicaid are discussed under the Procedure section of this policy.

[1] This definition of overpayment is based on Medicare rules. ACH has elected to use this same definition for other payers as well.

General Principles of Compliance.

The 60 Day Rule. There is the potential for an overpayment received from Medicare or Medicaid to become the basis for a violation of the False Claims Act (FCA) if such overpayment is not reported or repaid within 60 days of being identified or the date any corresponding cost report is due.

An overpayment is "identified" when a person has, or should have through the exercise of reasonable diligence, determined that the person has received an overpayment and quantified the amount of the overpayment.[2] The 60 day time period begins when either the reasonable diligence is completed (including any activities necessary to quantify the amount of the overpayment) **or** on the day the person received credible information of a potential overpayment and failed to conduct an inquiry. Accordingly, staff should not ignore information regarding the existence of a potential overpayment. It is to ACH's benefit to proactively investigate any situation to identify whether an overpayment was received.

For purposes of the 60 Day Rule, an overpayment may be "identified" before it is received or the full amount of the overpayment is understood or quantified. The following are some examples of when an overpayment may be "identified":

- An employee or contractor identifies an overpayment in a hotline call or e-mail;
- A patient advises that a service was not received, but was billed;
- A coder identifies a charging or coding concern;
- A Recovery Audit Contractor (RAC) advises that a dual eligible Medicare overpayment has been found;
- OMIG sends a letter regarding a deceased patient, unlicensed or excluded employee or ordering physician;
- Where *qui tam* or government lawsuit allegations arise; or
- When a criminal indictment or information is filed.

Provided ACH conducts a reasonable inquiry, the 60 day clock will not start to run until ACH has quantified the amount of the overpayment. However, the investigation of an overpayment should in no event take longer than 8 months (6 months for investigation and 2 months for reporting and returning the overpayment), absent extraordinary circumstances. Thus, ACH will conduct an inquiry to determine if an overpayment was received as soon as the potential overpayment is identified. ACH will then follow the procedures below for repayment of the overpayment to Medicare and Medicaid, which must be done within 60 days.

The Compliance Officer may, after investigation, find it necessary to report the compliance issue to NYSDOH and OMIG. With any compliance issue found to be substantiated and requiring

[2] Please note, this rule applies to overpayments by Medicare Parts A and B, and does not directly apply to overpayments by New York State Medicaid. The New York Office of Medicaid Inspector General has not yet issued guidance on whether it will follow the federal rule, which allows providers to quantify the overpayment before the 60 day clock starts (as long as the provider is diligent in its investigation). For purposes of Medicaid overpayments, please consider the additional information provided in Section 2 below.

mandatory reporting, whether Quality of Care, Beneficiaries, or any other issue, such report shall be made in a complete, effective, and timely manner to NYSDOH and OMIG.
Report compliance issues to:

New York State Department of Health
Department may vary depending on the issue

And/or

Office of the Medicaid Inspector General
Rochester Regional Office |
259 Monroe Avenue, Suite 312
Rochester, NY 14607
585-238-8166

Identification of Potential Overpayments. Overpayments may be identified a number of ways. For example, a patient can initiate a request for a refund, staff may identify billing errors or an audit conducted by ACH or an outside entity may identify an overpayment.

In general, ACH billing personnel will evaluate and process refunds, as appropriate, through existing routine repayment processes (e.g. voiding payments; claims adjustment). The Corporate Compliance Officer may also review potential overpayments identified through a compliance-related activity, and will work with ACH billing and finance personnel to resolve the overpayment.

Procedures.

1. Medicare Overpayments

ACH can report and return overpayments to Medicare through any of the following processes: claims adjustment, credit balance reporting, the voluntary refund process or other reporting process set forth by National Government Services.[3] The reporting obligation is also satisfied by making a disclosure under the Department of Health and Human Services, Office of Inspector General (OIG)'s Self-Disclosure Protocol or the CMS Voluntary Self-Referral Disclosure Protocol, where such self-disclosure results in a settlement agreement.[4] The 60 day deadline for returning overpayments to Medicare is suspended once OIG or CMS acknowledge receipt of a submission for self-disclosure, and will remain suspended until a settlement agreement is reached or ACH withdraws or is removed from the self-disclosure process.

[3] Overpayments may also be reported and returned using the voluntary repayment or "self-reported refund" process through National Government Services ("NGS"). Forms are available through the NGS website. Please refer any questions on which process should be used for a Medicare Overpayment to the Compliance Officer.
[4] See OIG Self-Disclosure Protocol - http://www.oig.hhs.gov/compliance/self-disclosure-info/index.asp; OMIG Self Disclosure Program - https://www.omig.ny.gov/self-disclosure for additional information on the self-disclosure process related to Medicare payments.

Typically, routine overpayments will be handled using the claims adjustment or credit balance process. The Compliance Officer should be notified immediately in the event a non-routine overpayment, such as a significant overpayment or systemic error, is identified. The Compliance Officer, with assistance from legal counsel if necessary, will determine whether self-disclosure through OIG or CMS is required.

2. Medicaid Overpayments

Overpayments by New York State Medicaid must also be returned and reported within 60 Days of being identified. For purposes of what it means to "identify" an overpayment (and when the 60 day clock starts), the Office of Medicaid Inspector General (OMIG) has not published guidance on whether it will follow the same rules that apply to Medicare Parts A and B overpayments described above. In the event that an overpayment by Medicaid cannot be reported to OMIG within 60 days, contact the Compliance Officer or legal counsel to discuss how the overpayment should be handled.

The repayment of simple, more routine occurrences of overpayment by Medicaid should be processed through typical methods of resolution, including voiding or adjusting the amount of claims.[5] When a routine overpayment is identified on a Medicaid account, it should be corrected using Medicaid's electronic void process.

Non-routine overpayments by Medicaid that cannot be resolved by voiding or adjusting the claim must be reported under the OMIG Self Disclosure Program.[6] However, this process should only be used for an overpayment that is not: (i) included in another, separate review or an audit being conducted by OMIG, vendors or OIG; and (ii) related to a broader state-initiated rate adjustment, cost settlement, or other broader payment adjustment mechanisms.

Any potential overpayments that cannot be corrected through simple voids or adjustments should be immediately reported to the Compliance Officer. The Compliance Officer, with assistance of legal counsel, if necessary, will determine whether self-disclosure to OMIG is appropriate, or whether the overpayment should be handled through the administrative billing processes explained above. OMIG does not request restitution at the time of self-disclosure, and will typically confirm the amount of the overpayment before requiring repayment. However, if the overpayment is not reported to OMIG within 60 days of being identified, it could lead to liability under the FCA.

3. Commercial Payers and Self-Pay Overpayments

ACH billing personnel should follow payer-specific guidelines for refunding overpayments identified through staff as billing errors or by an internal or outside audit.

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[5] Please note: OMIG has previously suggested that overpayments amounting to less than $5,000 can be handled through the regular Medicaid claims adjustment process. Any questions on whether a small claim is appropriate for OMIG self-disclosure should be sent to the Compliance Officer.

[6] See OMIG's website, https://www.omig.ny.gov/self-disclosure for additional information of the self-disclosure process related to Medicaid payments.

Commercial payers may request that refunds for an overpayment be processed through future deductions in payments to accommodate the overpayment. In the event that a review of a potential overpayments reveals more than a routine processing error, warranting further auditing or review, billing personnel should promptly inform the CFO and/or the Corporate Compliance Officer for appropriate resolution.

With regard to self-pay accounts, billing personnel should attempt to return overpayments via the contact information ACH has on file for such payment. If it is not possible to resolve the overpayment because the individual cannot be located, or it is unclear to whom such payment is due, ACH will follow relevant New York laws pertaining to unclaimed property and/or abandoned property, for resolution of the matter. ACH will maintain appropriate records of unclaimed and/or abandoned property.

Approved John W. Bagenski, MT(ASCP) Corporate Compliance Officer 10/29/2024

Name Title Date

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