AUBURN COMMUNITY HOSPITAL (ACH),
AUBURN MEMORIAL MEDICAL SERVICES (AMMS), ANESTHESIA GROUP, &
THE FINGER LAKES CENTER FOR LIVING (FLCL)
17 LANSING STREET
AUBURN, NEW YORK 13021

Subject: **SELF-DISCLOSURE POLICY**	Policy No.: CC: 24
Department: Administration: Corporate Compliance	Page: 1 of 4
	Date Issued: 12/07/2023

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, 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 guidance and training to all Affected Individuals on the Office of the Medicaid Inspector General (OMIG) Self -Disclosure initiative adopted in October 2023, including responsibilities of what and who is to report, return and explain overpayments received to the OMIG Self-Disclosure Program, including use of approved log sheet to monitor compliance.

Policy:
It is the policy of the Hospital to follow the OMIG Self -Disclosure Program requirements to correctly identify and self-disclose any overpayments received from the Medicaid program.

Procedures:

General Principles of Compliance and Reporting:

OMIG has adopted a self-reporting process for disclosing, returning and explaining overpayments received to the OMIG Self-Disclosure Program. The goal is to encourage providers to investigate and report matters that involve possible fraud, waste, abuse, or inappropriate funds that are identified through self-review, the Compliance Program, or internal controls affecting the State's Medicaid program. This policy outlines OMIG's newly adopted self-disclosure program regarding the return of overpayments of fee for service or waiver program Medicaid and provides an overview of the self-disclosure process. This policy should be reviewed collectively with the Hospital's *Reporting and Returning Overpayments* policy, which governs the Hospital's handling of overpayments.

Areas to consider for investigation include: credit balance coordination of benefits overpayment, NAMI adjustments, missing authorizations, missing or insufficient support documentation, inappropriate rate or fee code, recipient enrollment issue, adjusted claims, fraudulent behavior, employees on the Excluded Provider list, software or billing system updates, and non-claim-based overpayments.

Prior to this new directive, NAMI adjustment or "rest of the month" bills were submitted bi-weekly. With this directive in place, all overpayments also need to be reported to OMIG when claims are adjusted.

All self-identified inappropriate Medicaid payments should be self-disclosed. Billing Managers from ACH, FLCL, and AMMS are responsible for oversight of their organization's billings for overpayment investigations, final approval, and any monthly submissions. **Voiding or adjusting claims does not satisfy the Hospital's obligation to report and explain the identified overpayment**. Audits are completed monthly by the Billing Managers from ACH, FLCL, and AMMS, or their designated representative(s). All audits identifying[1] an overpayment of funds must be reviewed promptly by the Director of Revenue Cycle and Integrity or Chief Financial Officer prior to submission. All Managers will be required to track submissions using the Self-Disclosure Statement Log (attachment #1) to assure the 60-day reporting compliance requirement is met. All disclosures must also be reported to the Corporate Compliance Officer who will retain copies for any audit purposes.

Self-Disclosure Processes:

Provided the Hospital has met the eligibility criteria to participate in the Self-Disclosure Program and has identified an overpayment, self-disclosure of a Medicaid program overpayment requires completion of either (1) a Self-Disclosure Full Statement; or (2) a completed Self-Disclosure Abbreviated Statement. Both the Full Self-Disclosure Process and the Abbreviated Self-Disclosure Process are outlined below.

1. <u>Abbreviated Self-Disclosure Process:</u>

- The Hospital may utilize the Abbreviated Self-Disclosure Process to report and explain identified overpayments resulting from routine and transactional errors.
- An identified overpayment is voided or adjusted within 60 days, as appropriate, and added to the Self-Disclosure Abbreviated Statement form.
- The Hospital aggregates the submission of any overpayments through submission of the Self-Disclosure Abbreviated Statements on a monthly basis, which is submitted

[1] Pursuant to Social Services Law §363-d(6), an overpayment has been identified when a provider has, or should have, through the exercise of reasonable diligence, determined that a Medicaid fund overpayment was received, and they have quantified the amount of the overpayment. Providers are required to report, return and explain any overpayments received to OMIG within 60 days of identification, or by the date any corresponding cost report was due, whichever is later.

by the 5th day of each month following the month in which the claim(s) were voided or adjusted.

- Overpaid claims reported and explained through this Abbreviated Self-Disclosure Process are repaid by void or adjustment (no Determination Notice will be issued by OMIG for Abbreviated process submissions).
- OMIG may request additional information, as needed. Any additional information will be supplied within 15 calendar days of such request.
- OMIG may, in its discretion, request that the Hospital submit a Full Self-Disclosure Statement.

Examples to be self-disclosed using the Self-Disclosure Abbreviated Statement:

- Routine credit balance/coordination of benefits overpayments;
- Typographical human errors;
- Routine Net Available Monthly Income (NAMI) adjustments;
- Instance of missing or faulty authorization for services due to human error;
- Instance of missing or insufficient support documentation due to human error;
- Inappropriate rate, procedure or fee code used due to typographical or human error; and
- Routine recipient enrollment issue.

Full Self-Disclosure Process:

Within 60 days from identification and quantification (when applicable) of an overpayment, the Hospital will:

- Submit a completed Self-Disclosure Full Statement, Certification form and Claim Data form (or Mixed Payor calculation), if applicable
- Self-Disclosure Unit will review submission documentation and verify overpayment amount as applicable.
- Total overpayment amount and reason confirmed through a Determination Notice, accounting for any repaid amounts (adjustments) and any balance still due.
- Repayment instructions (as applicable) will be included, and any requested extensions for repayment to be determined by OMIG Office of Counsel.

Examples to be self-disclosed using the Self-Disclosure Full Statement include but are not limited to:

- Any error that requires the Hospital to create and implement a formal corrective action plan;
- Actual, potential or credible allegations of fraudulent behavior by employees or others;
- Discovery of an employee on the Excluded Provider list;
- Documentation errors that resulted in overpayments;
- Overpayments that resulted from software or billing systems updates;

- Systemic billing or claiming issues;
- Overpayments that involved more than one Medicaid entity/Provider;
- Non-claim-based Medicaid overpayments;
- Any error with substantial monetary or program impacts; and
- Any instance upon direction by OMIG.

*For complete information including which forms to complete, refer to OMIG's website which outlines the OMIG Self-Disclosure Program:
https://omig.ny.gov/provider-resources/self-disclosure
* Medicaid Managed overpayments should be reported and repaid in accordance with the MMCO's process for reporting overpayments.

What information should NOT be self-disclosed?

Certain Medicaid overpayments received may have been identified by OMIG or another enforcement entity. Accordingly, the Hospital should not self-disclose the following:

1. When an overpayment is included in another separate review or audit being conducted by OMIG, the Office of the Inspector General, Attorney General, etc. The Hospital is required to seek permission from the investigating entity before voiding or adjusting claims.
2. When an overpayment is included in a broader state-initiated rate adjustment cost settlement or other payment adjustment mechanisms (e.g., retroactive rate adjustments, charity care, cost reporting, etc.)

For any questions concerning whether an overpayment may be self-disclosed, or the requirements under this Policy, the Compliance Officer should be contacted.

Non-Compliance with OMIG's Self-Disclosure Process:

Violations of the Self-Disclosure Process include but are not limited to:

- Providing false material information in any disclosure documents.
- Failure to cooperate in validating the overpayment amount disclosed.
- Intentional omission of material information from any disclosure documents.
- Failure to pay the overpayment amount and any interest as agreed.
- Failure to timely execute a self-disclosure and compliance agreement (SDCA) or any violation of the provisions detailed in the SDCA.

If the Hospital receives a Medicaid overpayment and does not self-disclose it, or fails to exercise reasonable diligence in discovering and identifying that overpayment, it will be subject to penalties pursuant to SSL §145-b(4) for failure to report, return and explain the overpayment.

Once the Hospital has self-disclosed, violations of the self-disclosure process shall result in the Hospital becoming ineligible for the benefits of the OMIG Self-Disclosure Program. Failure to

complete the self-disclosure process will result in OMIG's perusal of any civil or criminal penalty that might apply to the misconduct disclosed as part of the program process, and OMIG shall impose penalties pursuant to SSL §145-b(4)(a)(iii) for failure to report, return and explain the overpayment.

Penalties for failure to report, return and explain Medicaid overpayments:

- Up to $10,000 per item or service, unless this penalty has already been imposed within the previous five years; in those cases the penalty can be up to $30,000 per item or service.
- The Hospital may be subject to other penalties under State and Federal law for failing to report and return overpayments to the Medicaid program.

Lost, Damaged, or Destroyed Records:

The OMIG Self-Disclosure Program is also responsible for accepting reports of damaged, lost or destroyed records. The Hospital is required to (1) prepare and maintain records that demonstrate its right to payments received under the Medicaid program and be able to furnish such records upon request, and (2) report the loss, damage or destruction of such records as soon as practicable, but no later than thirty (30) days after discovery. Affected Individuals should promptly notify the Compliance Officer upon becoming aware that any of the Hospital's records have been damaged, lost or destroyed to assure the Hospital is able to meet applicable reporting/notification requirements.

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

Approved:	John W. Bagenski	Corporate Compliance Officer	07/11/2024
	Name	Title	Date

Approved:			
	Name	Title	Date

Revised: 10/18/2023, 7/10/2024

Reviewed: 10/18/2023, 7/10/2024, 10/29/2024

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Self-Disclosure Log

Auburn Community Hospital, Finger Lakes Center for Living, Auburn Memorial Medical Services

Date	Location AC FLCL AMMS	Date Identified	Submission Full (F) Abbreviated (A)	Overpayment Cause	Acknowledged	Closed	Manager

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