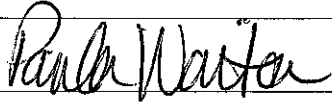


Catholic Charities Disabilities Services	
Agency Standard and Procedure	
Standard Category	Quality Assurance
Standard Title	Medicaid Billing Errors and Disclosures
Regulations	OMIG Self-Disclosure Guidance https://omig.ny.gov/self-disclosure-guidance Full Self-Disclosure: https://omig.ny.gov/full-self-disclosure-process Abbreviated Self-Disclosure: https://omig.ny.gov/abbreviated-self-disclosure-process
Original Issue Date	1/24/2025
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Attachments	
Approved by: Paula Warika, Executive Director	

Standard:

Integrity of services includes ensuring compliance with applicable regulations. Mistakes sometime occur in billing which, when strong systems are in place, will be identified during agency review processes and disclosed as necessary. All self-identified inappropriate Medicaid payments received should be self-disclosed. There is no dollar threshold for reporting. The lookback period is six (6) years by date of service.

The Self-Disclosure Program is the mechanism Medicaid Entities, including Medicaid enrolled Providers, involved in the billing or receipt of Medicaid funds, must use to self-report Medicaid fund overpayments that involve possible fraud, waste, abuse, or inappropriate payment of funds which they have identified through self-review, compliance programs, or internal controls. This program was developed in consultation with healthcare stakeholders to facilitate compliance with their Federal self-disclosure obligation. Medicaid Entities/Providers are required to report, return, and explain any overpayments they've identified to OMIG within 60 days of identification, or by the date any corresponding cost report was due, whichever is later.

Disclosures demonstrate an effective review process in the agency. Disclosures also remove that billing from potential samples in future audits with external auditors who, if the error had not been identified internally and disclosed, may utilize tools such as extrapolation of the error for an even larger financial burden on the agency.

Procedure:

1. All staff with involvement of billable services at any stage must communicate any billing adjustments or voids with the CCDS Quality Assurance Department as soon as they become aware of the issue or potential issue. Potential billing errors that require void or adjustment will be preliminarily reviewed by the program director immediately upon the discovery of the potential error and also immediately communicated to the Quality Assurance Department.

2. All self-identified inappropriate Medicaid payments received should be self-disclosed. This includes issues identified at the program, QA or CCDA Compliance level.

3. If the program determines the issue is a clear mistake requiring an adjustment, this approval for adjustment will be communicated to the Fiscal Department by the direction of the department Director or designee. If the issue is not clearly identifiable, the Quality Assurance department may assist in reviewing the error and advising. If the error requires a void of claims already processed, this void approval will be communicate to the Fiscal Department by the Executive Director or designee. In all email communications related to adjustment or voids, the Quality Assurance Department will be included (generally in the cc line).
 - a) The error will be investigated and the agency will identify if an overpayment exists, as well as the scope and amount of the overpayment. The agency will self-disclose all identified Medicaid fund overpayments to OMIG's Self-Disclosure Program. The only exception to this obligation is if the overpayment is already encompassed by an existing review and will be recovered through that existing review (example – an existing OMIG audit).
 - b) If an error is identified as requiring self-disclosure, the Quality Assurance Department will inform the CCDA Compliance Officer of the circumstances and keep the CCDA Compliance Officer informed periodically throughout the disclosure process.
 - c) As reference, according to OMIG,
 - i. For claims disclosed through the Abbreviated Self-Disclosure Process all claims must be voided or adjusted prior to submission of the disclosure.
 - ii. The Executive Director or designee will provide written approval to the Finance and QA Departments, prior to completion of void and adjustments.
 - iii. For claims disclosed through the Full Self-Disclosure Process voiding or adjusting claims is the recommended form of repayment because it allows the claim record to remain accurate. Please at least initiate the void or adjustment transactions. There is space within the Full Self-Disclosure Statement to explain if claims have been voided or adjusted, or the transactions are in process.”

4. Voiding or Adjusting Medicaid Claims does not satisfy a Medicaid provider's obligation to report and explain the identified overpayment. The Quality Assurance Director or designee will follow up with the program and fiscal departments for completing the required disclosure process. OMIG's Self-Disclosure Program includes two pathways for Medicaid Entities/Providers to report, return and explain self-identified overpayments. Both the Full Self-Disclosure Process and the Abbreviated Self-Disclosure Process begin with the same steps. A Medicaid Entity/Provider discovers that they are in receipt of a Medicaid overpayment and investigates to identify and explain it. This identification includes:
 - a) Determining why the overpayment occurred?
 - b) How the overpayment occurred?
 - c) Who/What was involved in causing the overpayment to occur?
 - d) Who was involved in discovering the overpayment?
 - e) What will be done to correct the overpayment and ensure that it doesn't reoccur?
 - f) Quantification of the overpayment amount (to the best of the Medicaid entity's/Provider's ability)

5. The QA department reviews the reason for the overpayment and determines which of OMIG's self-disclosure processes is appropriate for them to utilize in satisfying their obligation to report, return and explain; and QA will take the lead in completing the required steps.

a) Full Self-Disclosure:

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

- Any error that requires a Medicaid entity/Provider 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 an Excluded Provider list
- Documentation errors that resulted in overpayments
- Overpayments that resulted from software or billing system updates
- Systemic billing or claim processing issues
- Non-claim based Medicaid overpayments
- Any error with substantial monetary or program impacts
- Any instance upon direction by OMIG

- ii. Process

- Within 60 days of the identification of the overpayment, the Medicaid Entity/Provider will submit a completed Full Self-Disclosure Statement, Certification form and Claims Data form or Mixed Payor Calculation (MPC) form, if applicable. They will receive confirmation of receipt via email which confirms the 60-day timeframe has been tolled (paused).
- The Claims Data File is used to disclose overpaid Medicaid claims in the Full Self-Disclosure process. It is embedded in the Full Self-Disclosure Statement
- The Self-Disclosure Unit will review the submission documentation and will verify the overpayment amount. Additional information will be requested, if needed. The Medicaid Entity/Provider will have 15 calendar days to supply any additional information requested.
- Once the review is complete a Determination Notice will be issued to the Medicaid Entity/Provider confirming the total overpayment amount for the overpayment reason(s) disclosed, confirming any amounts already repaid through void or adjustment, and any remaining balance still due. The Determination Notice will also contain repayment instructions as applicable. If the Medicaid Entity/Provider has requested extended repayment terms they will be contacted by OMIG's Office of Counsel.
- Please note that all MMCO identified excess capitation payments must be self-disclosed using the Full Self-Disclosure Process.

- b) Abbreviated Self Disclosure: Medicaid Providers may utilize the Abbreviated Self-Disclosure Process to report and explain identified overpayments resulting from routine and transactional errors that have already been voided or adjusted.

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

- 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 codes used due to typographical or human error
 - Routine recipient enrollment issue
- ii. Process
- Medicaid Providers may utilize the Abbreviated Self-Disclosure Process to report and explain identified overpayments resulting from routine and transactional errors that have already been voided or adjusted.
 - The Medicaid provider voids or adjusts the overpaid claim(s) within 60 days of identification as appropriate and adds it/them to the Self-Disclosure Abbreviated Statement form. Abbreviated Self-Disclosures can be submitted for each identified instance. Alternatively, as a convenience and best practice, Providers may aggregate their submissions into a monthly report which should be submitted each month for the claims that were voided or adjusted in the previous month. Once the Abbreviated Self-Disclosure is submitted, the Provider will receive confirmation of receipt via email and a unique identifier code which should be used to reference the Abbreviated Self-Disclosure if needed.
 - Abbreviated Self-Disclosures are processed as they are received. OMIG will not contact the Provider unless additional information is required. The Medicaid Provider will have 15 calendar days to supply any additional information requested. OMIG may, in its discretion, request that a Medicaid Provider submit a Full Self-Disclosure Statement.
 - Overpaid claims reported and explained through the Abbreviated process are already repaid by void or adjustment, therefore no Determination Notice will be issued for Abbreviated process submissions.
6. Payment options include:
- a) Lump sum check, money order or electronic check payment. DO NOT send payment in with your submission.
 - b) Voids or Adjustments of the overpaid claims.
 - i. Abbreviated Self-Disclosure: Claims disclosed using the Abbreviated Self-Disclosure process MUST be voided or adjusted to repay Medicaid prior to submitting the disclosure.
 - ii. Full Self-Disclosure: Claims disclosed using the Full Self-Disclosure process may be voided or adjusted to repay Medicaid, and this is the recommended repayment option when feasible. Voids and adjustments MUST either be completed prior to submission, or the Medicaid entity/Provider MUST notify OMIG within the Full Self-Disclosure Statement that they are in the process of voiding or adjusting the claims.

- c) Installment Payments via a Self-Disclosure and Compliance Agreement (SDCA). A Medicaid Entity/Provider may request installment payments prior to the issuance of a Determination Notice. This payment option is granted or denied at the discretion of OMIG. A Medicaid Entity/Provider must supply all supporting financial documentation requested by OMIG (i.e., tax returns) by the due date specified to be considered for this repayment option.
7. Other considerations from OMIG: Extrapolation
- a) "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 being requested in their Self-Disclosure Full Statement form. Approval is made in the sole discretion of OMIG.
 - b) The Provider must also provide the data element parameters necessary for OMIG to extract a universe of potentially overpaid claims.
 - i. If the request is not approved, a claim-by-claim review of the potentially overpaid claims will be required.
 - ii. If the request is approved, OMIG will extract a universe of potentially overpaid claims based on the parameters disclosed in the Self-Disclosure Full Statement and a statistically valid random sample of claims will be provided for review. The Provider must review and respond by the due date specified with the entire Sample and an explanation for each claim identifying if it was allowed or disallowed and why. The overpayment will be calculated using the lower limit of the 90% confidence interval based on the Sample response."