| | |
|---|---|
| **Origination:** | *05/2019* |
| **Effective:** | *05/2019* |
| **Last Approved:** | *05/2019* |
| **Last Revised:** | *05/2019* |
| **Next Review:** | *05/2020* |
| **Owner:** | *Laura Carrico: Director of Compliance* |
| **Area:** | *Corp CCE - Corporate Compliance & Ethics* |
| **References:** | |

# Identification, Quantification, and Repayment of Overpayments

## PURPOSE

This policy sets forth a framework for Tennessee Health Management, Inc. (THM) and its affiliate entities d/b/a American Health Communities to identify, report and return overpayments. This policy applies to all healthcare services for which THM or American Health Communities have submitted a claim and received payments from a government source, such as a federal healthcare program, or if a government source funded any portion of the payment received. Any identified overpayments by a Federal Health Care Program to any THM affiliated entity shall be reported and returned according to this policy.

## DEFNITIONS

***Federal Health Care Program***

***A "Federal Health Care Program" means any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government, or any State health care program.***

Examples of federal health care programs include, but are not limited to: Medicare, Medicaid/TennCare, Managed Medicare and Medicaid, TriCare/VA/CHAMPUS, SCHIP, Federal Employees Health Benefit Plan, Indian Health Services, Health Services for Peace Corp Volunteers, Services Provided to Federal Prisoners, Black Lung Program, or Railroad Retirement Benefits.

***Overpayment***

***An "Overpayment" means any funds that a person (a provider or supplier) receives or retains to which the person, after applicable reconciliation, is not entitled under applicable laws or regulations. An overpayment includes any amount in excess of the amount due and payable under any Federal health***

***care program requirements.***

Overpayments may be the result of upcoding; incorrect code or modifier resulting in a higher level of reimbursement; insufficient or lack of documentation to support billed services; services billed under the wrong provider; lack of medical necessity; duplicate payment; payment to the incorrect payee; or any other finding that reflects an overpayment was received as a result of inaccurate or improper coding or reporting of health care items or including, but not limited to, services.

***"Identification" of or "Identifying"***

***An overpayment is "identified" when a provider has, or should have, through the exercise of reasonable diligence, determined the person has received an overpayment, and quantified the amount of the overpayment."***

"Reasonable diligence" includes both proactive compliance activities conducted in good faith by qualified individuals to monitor for the receipt of overpayments and investigations conducted in good faith and in a timely manner by qualified individuals in response to obtaining credible information of a potential overpayment.

Note that an overpayment is "identified" only after a person has, or should have, quantified the amount of the overpayment.

***Person***

***A "person" includes a provider or supplier of health care services or goods.***

THM affiliated entities include both providers (skilled nursing facilities, home health agencies, hospice agencies, etc.) and suppliers (durable medical equipment).

**POLICY**

THM and American Health Communities are committed to conducting their business operations consistent with all applicable laws. Employees of THM and American Health Communities will comply with federal and state laws with respect to the appropriate handling of overpayments received from Federal Health Care Programs.

Providers and suppliers can only bill health care programs and payors for items and services for which they are entitled to be paid. The Patient Protection and Affordable Care Act of 2010 established a new provision of the Social Security Act. Section §1128(d)(1) requires a person who has received an overpayment to report and return the overpayment by the later of sixty (60) days after the date on which the overpayment was ***identified*** and the date any corresponding cost report is due, if applicable. Any overpayment retained after this deadline becomes an obligation potentially subject to enforcement under the federal False Claims Act (FCA).

Together, the Fraud Enforcement and Recovery Act (FERA) and Section 1128 establish the retention of overpayments by a health care provider, as well as the failure to report and return such overpayments within prescribed time periods, may constitute violations of the federal FCA.

This policy does not apply to routine processing errors. Routine processing errors should be corrected by the individual who detects the error by following applicable entity procedures for reconciling such errors.

**PROCEDURE**

***Reporting Potential Overpayments***

Anyone who believes there may be an overpayment must notify his/her supervisor, the Facility Compliance Officer, the Regional Compliance Director, or the Chief Compliance and Ethics Officer immediately with as much of the following information as possible:

1. Patient Name(s);
2. Type and amount of overpayment;
3. Date; and
4. Payor(s).

***Reporting and Returning of Identified Overpayments***

Identified overpayments shall be reported and or credited to the payor within sixty (60) days from the date the overpayment is identified and quantified in accordance with this policy.

When it has been determined that an overpayment exists, the Compliance Department will:

1. Calculate the overpayment;
2. As necessary, consult with management and/or legal counsel to determine the method by which the error will be reported to the applicable agency or payment contractor;
3. In accordance with government agency directions, notify the appropriate agency or payment contractor in writing and refund the overpayment. The report shall notify the payor in writing of the reason for the overpayment and shall contain an explanation of the methodology used to determine the amount of the overpayment. If reprocessing of a claim is an acceptable method of repayment, appropriate documentation will be maintained to verify the repayment;
4. Assure the appropriate leadership is notified of the overpayment;
5. Notify the appropriate government agency when circumstances will not allow the return of an overpayment within sixty (60) days of identification and quantification; and
6. In consultation with General Counsel and/or outside legal counsel, determine if the overpayment is a Reportable Event under the Corporate Integrity Agreement between THM and the Office of the Inspector General of the Department of Health and Human Services (which became effective February 1, 2019).

Where overpayments are reconciled via the cost report, each entity cost reporting office will report and return overpayments by the date of the corresponding final cost report.

**CORRECTIVE ACTION**

The Chief Compliance and Ethics Officer, in conjunction with subject matter experts, shall determine the appropriate corrective actions to address the causes of any identified overpayments, and shall oversee the implementation of corrective actions within THM affiliates.

**REFERENCES**

Social Security Act § 1128J(d)(1)

False Claims Act (FCA), 31 U.S.C. §§ 3729 – 3733, and amendments to FCA contained in the Patient Protection and Affordable Care Act of 2010, Pub. L. 111-148, 42 U.S.C. § 18001 (2010).

Fraud Enforcement Recovery Act (FERA) of 2009, Pub. L. 111-21, 123 Stat. 1617.

Medicare Program; Reporting and Returning of Overpayments (Final Rule), Centers for Medicare & Medicaid Services (CMS), 81 Fed. Reg. 7654, (Feb. 12, 2016); https://www.gpo.gov/fdsys/pkg/FR-2016-02-12/pdf/2016-02789.pdf)

Tennessee Medicaid False Claims Act, Tenn. Code Ann. § 71-5-181 et seq. (West, 2019)

## Attachments:

No Attachments

## Approval Signatures

| Approver | Date |
|---|---|
| Ben Sparks: AGC [LC] | 05/2019 |
| Kelly Thomas: Chief Compliance & Ethics Officer [LC] | 05/2019 |
| Laura Carrico: Director of Compliance | 05/2019 |
| Laura Carrico: Director of Compliance | 05/2019 |