Baptist Health South Florida

**POLICY NO.: BHSF-851**
**Administrative**

**POLICY TITLE:** Reporting and Returning Overpayments Received from Federally Funded Healthcare Programs

**Responsible Department:** Audit and Compliance

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**SUMMARY & PURPOSE:**
To provide guidance regarding the Federal healthcare program requirement to report and return overpayments by the later of the date that is 60 days after the date on which the overpayment was identified or the date any corresponding cost report is due, if applicable.

**POLICY:**
All overpayments from Federal healthcare programs will be reported and returned within 60 days of identification.

**SCOPE/APPLICABILITY:**
This policy applies to all Baptist Health affiliates.

**PROCEDURES TO ENSURE COMPLIANCE:**

**Definitions**
Federal healthcare program – Medicare, Medicaid, Tricare or Veteran's Administration.

Lookback Period – Six years from the date the overpayment was received.

Contractor – A Part A/Part B Medicare Administrative contractor (A/B MAC), Durable Medical Equipment Medicare Administrative Contractor (DME MAC), or a Medicaid, Tricare, or Veteran's Administration claims processing agent.

Overpayment – Any funds that a person or organization, i.e. a provider, has received or retained under Title XVIII of the Social Security Act to which the person or organization, after applicable reconciliation, is not entitled.

Overpayment Identification – The date on which the provider has or should have, through the exercise of reasonable diligence, determined that the provider has received an overpayment and quantified the amount of the overpayment.

Substantial Overpayment – Identified overpayments which occurred due to either an isolated error or a pattern of errors which total $200,000 or more for one provider number.

**Procedure**

1. Isolated clerical errors, unintended patient specific coding, charging or billing errors, or any other non-repetitive errors resulting in an overpayment of less than $200,000 should be dealt with in the normal course of business and refunded within 60 days of identification. Overpayments in this category which total $200,000 or more should be reported to the Audit and Compliance Department, as outlined in #3 below.
2. Repetitive errors that result in a pattern of overpayments must be reported to a supervisor or member of management upon discovery of the potential repetitive error. Such reports may also be made directly to the Audit & Compliance Department or to the Compliance Hotline.
    a. Such reports should contain as much detailed information as is available to assist in the reconciliation of the potential overpayments and the circumstances leading to its receipt.
    b. Repetitive errors affecting more than 50 claims or totaling more than $50,000 for a single provider number must be reported to the Audit & Compliance Department.
        i. Audit & Compliance will review the remedial actions taken and make a determination as to whether further action is warranted, such as further auditing and monitoring or further reporting to the Federal healthcare program.
3. Substantial overpayments, totaling $200,000 or more, whether due to a single claim or to a pattern of errors affecting many claims, must in all cases be reported to the Audit and Compliance Department.
    a. Audit and Compliance will review the circumstances, remediation, quantification, and reporting to ensure all applicable Federal healthcare program requirements have been followed.
4. Upon discovery of a pattern of overpayments, appropriate actions must be taken to investigate the cause for the overpayments, to remediate the cause, and to quantify the overpayment amount. Under typical circumstances this investigation and quantification must be completed within 6 months of the discovery of potential overpayments.
5. For overpayments received as a result of repetitive errors, a determination must be made as to the timeframe for the repetitive error, up to and including overpayments received within six years of discovery of the error, i.e. the lookback period.
6. Identified overpayments must be returned to the appropriate Federal healthcare program contractor within 60 days of identification.
7. Overpayments must be returned and reported to the appropriate Federal healthcare program contractor using an applicable claims adjustment, credit balance, self-reported refund, or other reporting process set forth by the contractor to report an overpayment.
    a. If the overpayment amount is calculated using a statistical sampling methodology, the methodology must be described in the report.
    b. Should the provider make a disclosure under the OIG's Self-Disclosure Protocol or the CMS Voluntary Self-Referral Disclosure Protocol and enter into a settlement agreement using that process, the reporting obligations are satisfied.
8. Detailed records regarding the due diligence taken to resolve potential overpayments must be maintained for six years.
    a. Specific patient accounts for which refunds were processed must be annotated to identify the amount refunded and the associated reason for the refund.
9. Healthcare providers could face potential False Claims Act liability, Civil Monetary Penalties Law liability, and exclusion from Federal healthcare programs for failure to report and return an overpayment.

**SUPPORTING/REFERENCE DOCUMENTATION:**

- Code of Federal Regulations, Title 42, Chapter IV, Subchapter A, Part 401, Subpart D – Reporting and Returning of Overpayments
- Office of the Inspector General Compliance Program Guidance for Hospitals
- Office of the Inspector General Supplemental Compliance Program Guidance for Hospitals

**RELATED POLICIES, PROCEDURES, AND ASSOCIATED FORMS:**

- BHSF Administrative Policy: 801 Department Responsibilities and Charter – Audit and Compliance
- BHSF Administrative Policy: 819 Code of Ethics – Audit and Compliance
- BHSF Administrative Policy: 824 Review and Resolution of Accounts with Potential Billing Discrepancies
- BHSF Administrative Policy: 841 Submission of Accurate Information to Gov't Payers- False Claims Act
- BHSF Administrative Policy: 845 Compliance with Regulations Governing Third Party Billing

**ENFORCEMENT & SANCTIONS:**

Enforcement of this policy is the responsibility of management throughout Baptist Health. Failure to comply with or report a violation of a compliance program policy may lead to disciplinary action up to and including termination of employment.