Topic: Unsupported claims, repayment/financial adjustments and voluntary self-disclosure	**Department:** Entire agency
Original effective date: 1/1/07 (Voluntary Self-Disclosure); 5/14/08 (Unsupported claims)	**Last revision date:** 9/13/23
Owner: VP for Quality and Compliance	**Frequency of reviews:** Annual
Regulatory Reference(s) (all that apply): 42 U.S.C. 1320a-7k(d); SSA 1128J(d); NYS Public Health Law 32(18); 18 NYCRR 521-1; 42 USC 1320a-7k(d)(1)&(2); 31 USC 3729; NYS Finance Law Article 13 (187-194)	
Related documents/Links: NA	

Policy: It is The Arc's policy to implement sound fiscal practices.

Additional Information: The Arc is committed to and has an obligation to comply with all applicable federal and state standards. This includes, but is not limited to, The US Centers for Medicare and Medicaid Services (CMS), The NYS Department of Health, The NYS Office of Medicaid Inspector General (OMIG), and OPWDD. We are additionally committed to accurate and timely billing and claims management in order to receive the correct reimbursement for the services we have provided.

State and federal regulations require us to pay back money that we received to which we were not entitled. Such funds are required to be paid back within 60 days of meeting both of the following criteria:

- When determine that we were overpaid; AND
- We know how much we were overpaid.

Failure to meet this timeline makes The Arc subject to:

- Federal and/or state false claims acts (please see the related policy); AND
- The following penalties:
    - Up to $10,000 per violation; or
    - Up to $30,000 per violation if there was a previous violation in the prior 5 years

This policy applies whenever it's determined that The Arc received funds we are not entitled to, regardless as to who discovered this or how, including outside auditors.

All agency staff are required to report if they believe that the agency has received funds it should not have or was not entitled to. For information on how to report this or any concerns you may have, please cross reference the policy, "Non-compliance detection and response, and confidential communications."

This policy applies to persons affected by the agency's risk in this areas (to the degree that they are so affected) including employees, managers, contractors, interns, and the Treasurer of the Board of directors (or designee), hereafter referred to as "affected individuals."

Procedure	
Task:	**Responsible Party:**
General Guidelines:	
1. In order to ensure monitoring, tracking and trending at the agency level, all overpayments or paybacks/financial adjustments must be reported to the VP for Quality and Compliance within 3 business days of of identifying the amount and scope of the overpayment, even if	Affected individuals

these would not result in the opening of a formal compliance case (please cross reference the policy, "Management of situations reported to the Compliance Office" for more information).	
2. Regardless as to whether the situation is handled at the program level or within the compliance office, the 60-day payback rule applies. Specifically, the 60-day clock starts when we have confirmed that we were overpaid AND we have reasonably quantified the amount of the overpayment (amount and scope).	Program management and finance office staff
Formal (Full) Self-Disclosures:	
1. For Medicaid, serious situations such as those listed below will be reported individually to the NYS OMIG via a full self-disclosure in order to ensure ongoing compliance with Medicaid requirements: *A potential payback for a single reason is deemed to be significant; *The amount we received in error is material (e.g., could impact the financial condition or operating performance of the agency when we pay it back); *It was due to a systemic or pervasive issue; OR * *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; *Discover 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; *Any instance upon direction by OMIG; *At the discretion of the VP for Quality and Compliance, the Internal Compliance Committee, and/or legal counsel	VP for Quality and Compliance
2. Regardless of the reason for considering a self-disclosure of this nature, we may talk with our lawyers before proceeding.	VP for Quality and Compliance
3. If we believe that it will take us an extended period of time to determine the full scope of the potential payback, we may notify the OMIG and work with them around timelines.	VP for Quality and Compliance
4. We will follow the procedures as outlined on the OMIG website for the completion of the self-disclosure.	VP for Quality and Compliance
5. The ArcNY will be notified of all full self-disclosure, consistent with their requirements, via the governance portal.	VP for Quality and Compliance
6.	
7. If overpayments are related to Medicare funds, we will pay it back to the federal government by contacting the Centers for Medicare and Medicaid Services (CMS). We will follow their instructions.	Program management and finance office staff

8. If the overpayment was from other payers (third party insurance or grants), we will contact them directly for guidance on how to refund the money.	Program management and finance office staff
Abbreviated Self-disclosures:	
1. Situations meeting the criteria listed below may be submitted as an abbreviated self-disclosure: *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; *Routine recipient enrollment issue	VP for Quality and Compliance
2. We will follow the procedures as outlined on the OMIG website for the completion of the self-disclosure.	VP for Quality and Compliance
Manager Responsibilities:	
1. Managers have a responsibility for understanding the requirements of this policy, the risks of not following it, and their role in it, including the criteria for when to bring a concern to the attention of the VP for Quality and Compliance.	Managers
2. Managers understand that all overpayments of government funds must be returned within 60 days of determining the scope and amount of the overpayment. It is understood that only a reasonable amount of time may be taken to determine the amount and this cannot be used as an excuse to avoid or delay repayment.	Managers
3. Managers will cooperate with the VP for Quality and Compliance and OMIG (or other appropriate governmental agency) in responding to formal self- disclosures.	Managers
VP for Quality and Compliance:	
1. The VP for Quality and Compliance acts as the agency's Compliance Officer, as required in NYS law.	VP for Quality and Compliance
2. Has primary responsibility for administering the agency's compliance program, and related policies and procedures.	VP for Quality and Compliance
3. Is responsible for submitting, monitoring and managing formal self-disclosures through resolution.	VP for Quality and Compliance
4. Acts as a resource for agency staff and management around complying with federal and state requirements, including the management of overpayments.	VP for Quality and Compliance

Document revision record:

Revision Date	Release Date	Reason for change	Approver

5/27/08	5/27/08	Voluntary self-disclosure: Clarified procedure	CCO
6/25/09	6/25/09	Voluntary self-disclosure: Added OMIG reference	CCO
10/21/11	10/21/11	Unsupported claims: Reason for change not archived	CCO
1/31/12	1/31/12	Voluntary self-disclosure: Added ACA 60-day payback requirement	CCO
6/7/12	6/7/12	Unsupported claims: Added ACA 60-day payback requirement	CCO
10/2/15	10/2/15	Combined voluntary self-disclosure and unsupported claims procedures into one joint procedure	CCO
5/30/17	5/30/17	Simplified language in the text	CCO
11/9/18	11/9/18	Adjusted the minimum payback dollar amount requiring notification to VP for Quality and Compliance	VP for Quality and Compliance
12/30/20	12/30/20	Added that we will follow OMIG requirements for completing a self-disclosure; and will notify ArcNY as well	P Dancer
8/18/21	9/8/21	Added new penalties that can be applied for failure to repay within 60 days; fleshed out details; added discrete sections for managers and VPQC; added that all paybacks must be reported to the VPQC	ICC
7/18/22	7/18/22	Corrected bullet numbering error and typos	ICC
7/21/22	8/8/22	Defined “staff” for the purposes of this policy	ICC
3/15/23	3/15/23	Added a statement regarding our commitment and obligation to comply with government standards; specified whom this policy applies to; added a statement regarding our commitment to accurate and timely management of billing and claims; added and defined a material overpayment	ICC
3/24/23	4/28/23	Removed reference that not all paybacks require a self-disclosure; updated the formal self-disclosure section to reflect the batch self-disclosures and when individual disclosures would occur	ICC
9/13/23	9/13/23	Updated timeline for reporting overpayments; updated self-disclosure sections to specify requirements for full or abbreviated; clarified scope and amount	ICC