When and How to Self-Disclose Medicaid Fraud, Waste, and Abuse

The Office of the State Comptroller, Medicaid Fraud Division recognizes that situations involving disclosure of self-identified receipt of overpayments of Medicaid funds may vary significantly; therefore, this protocol is written in general terms to allow providers the flexibility to address the unique aspects of the matters disclosed.

Advantages of Self-Disclosure

Self-disclosing overpayments is required by law and, in most circumstances, will result in a better outcome for a provider than if MFD staff discover the matter independently. While the specific resolution of self-disclosures depends upon the individual merits of each case, MFD will extend the following benefits to providers who, in good-faith, participate in a self-disclosure:

- Avoidance of False Claims penalties if reported within 60 days of identification;
- Forgiveness or reduction of interest payments (for up to two years);
- Extended repayment terms;
- Waiver of penalties and/or sanctions;
- Timely resolution of the overpayment; and
- Developing such a partnership with MFD during the self-disclosure process may also lead to a more thorough understanding of MFD's audit and investigatory processes, benefitting the provider in the future.

When to Disclose

Section 1128J (d)(2) of the Social Security Act requires a provider to self-disclose an overpayment within 60 days of the overpayment being identified or the date any corresponding cost report is due, if applicable. Under subsection (3) of the statute, failure to report the overpayment in a timely manner makes the claims comprising the overpayment subject to the penalties described in the False Claims Act.

Matters related to an ongoing audit or investigation of the provider are not generally eligible for resolution under the self-disclosure protocol. Unrelated matters disclosed during an ongoing audit or investigation may be eligible for processing under the self-disclosure protocol assuming the matter has received timely attention. If MFD is already auditing or investigating the provider, and the provider wishes to disclose an issue, in addition to submitting a disclosure under this protocol, the provider should bring the matter to the attention of MFD. If another outside agency is auditing or investigating the provider and the provider seeks to disclose an issue to MFD, the provider should follow this guidance accordingly. However, because of the variance in the nature, the amount and frequency of overpayments that may occur over a wide spectrum of provider types, it is difficult to present a comprehensive set of criteria by which to judge whether formal self-disclosure is appropriate. Providers must determine whether the repayment warrants a self-

disclosure or whether it would be better handled through administrative billing processes. Because of the complexity of some issues surrounding self-disclosures, providers may want to consider obtaining the advice of experienced healthcare legal counsel or consultants.

Each incident must be considered on an individual basis. Factors to consider include the exact issue, the amount involved, any patterns or trends that the problem may demonstrate within the provider's system, the period of non-compliance, the circumstances that led to the non-compliance problem, the organization's history, and whether or not the organization has a corporate integrity agreement (CIA) in place.

Issues appropriate for disclosure may include, but are not limited to:

- Substantial routine errors;
- Systematic errors;
- Patterns of errors; and/or
- Potential violation of fraud and abuse laws.

The self-disclosure process outlined herein is not intended to fundamentally alter an organization's day-to-day business for handling minor or insignificant matters. Consequently, the repayment of simple, more routine occurrences of overpayment should continue through typical methods of resolution, which may include voiding or adjusting the amounts of claims. A provider may not extend the time to resubmit claims to Medicaid through the self-disclosure; therefore, any overpayment must not include a reduction, or "netting" for any underpayments discovered in the review. Providers should be aware that MFD monitors both the number of occurrences and dollar amounts of voids and/or adjustments, as well as any patterns of voids and/or adjustments. MFD highly discourages providers from attempting to avoid the self-disclosure process when circumstances in fact warrant its use.

The Process

Once a provider determines disclosure is warranted, an initial report should be prepared which includes gathering the following information:

- The basis for the initial disclosure, including how it was discovered, the approximate time period covered, and an assessment of the potential financial impact;
- The federal and/or state laws and/or rules potentially implicated;
- Any corrective action taken to address the problem leading to the disclosure, the date the correction occurred, and the process for monitoring the issue to prevent reoccurrence; and
- The name and telephone number(s) of the individual making the report on behalf of the provider. The individual may be a senior official within the organization or an outside consultant or counsel and should be in an appropriate position to speak for the organization.

Contact MFD with the above information by telephone or via formal letter to the Chief of Investigations, Medicaid Fraud Division at provider.self-disclosures@osc.nj.gov. Providers may also use MFD's Self-Disclosure Form.

After this initial reporting phase, MFD will consult with the provider and determine the most appropriate way to proceed. MFD staff will discuss the next steps, which may include requesting additional information. Ultimately, the provider should be prepared to present the following:

- A summary of the identified underlying cause of the issue(s) involved and any corrective action taken;
- An Excel file including a detailed list of claims paid that comprise the overpayments. A Claims Data Form Template is provided. Each claim should list:
    - the Payer (FFS or MCO), Medicaid Claim Internal Control Number (icn), Recipient Medicaid ID, Recipient Last Name, Recipient First Name, Recipient Date of Birth, Billing Provider Medicaid Idn (if applicable), Billing Provider Name, Billing Provider National Provider Identifier, Servicing Provider Medicaid Idn (if applicable), Servicing Provider Name, Servicing Provider National Provider Identifier, Beginning Claim Service Date, Ending Claim Service Date, Rate Code or Procedure Code Billed, Correct Rate Code or Procedure Code, Units Paid (if applicable), Units Should Have Paid (if applicable), Claim Payment Amount, Corrected Claim Payment Amount, and the Claim Error Reason;
- The names of individuals involved in any suspected improper or illegal conduct and whether they are still employed by the provider, the names of the individuals who found the problem, and the names of the individuals involved in rectifying the problem;
- The nature and extent of any investigation or audit conducted to identify and determine the amount of overpayment;
- The signed Certification Statement For Self-Disclosure, which is provided on the website, is accurate and complete; and
- The name, correspondence address, email address, and telephone number(s) of the individual making the report on behalf of the provider. The individual may be a senior official within the organization or an outside consultant or counsel and should be in an appropriate position to speak for the organization.

Assuming a provider completely cooperates and responds promptly to information requests, MFD expects that the vast majority of self-disclosures will be completed within six months of submission of this information.

MFD will consider the provider's involvement and level of cooperation throughout the disclosure process in determining the most appropriate resolution and the best mechanism to achieve that resolution. In the event that the provider and MFD cannot reach agreement on the amount of overpayments identified, or if a provider fails to cooperate in good faith with MFD to resolve the disclosure, MFD may pursue the matter through established audit or investigation processes, and any less stringent repayment and/or sanction terms that would apply for a self-disclosure may no longer apply in such circumstance.

Upon review of the provider's disclosure and related information, MFD may conclude that the disclosed matter warrants referral to the New Jersey Attorney General's Medicaid Fraud Control Unit (MFCU). Alternatively, the provider may request the participation of a representative of the MFCU, U.S. Department of Health and Human Services, Office of Inspector General, the Department of Justice, or a local United States Attorney's Office in settlement discussions in order to resolve potential liability under the False Claims Act or other laws.

Provider Options for Determining the Overpayment

Claim-by-Claim Review

A provider may conduct a 100% claim-by-claim review to identify inappropriate payments.

Non-Claim Overpayment

If the disclosed conduct is related to the employment of an ineligible provider, and the services provided were not separately billable claims, it may be appropriate to calculate a non-claim overpayment. For further information on calculating the overpayment, please review OIG's Health Care Fraud Provider Self-Disclosure Protocol.

Statistical Sampling & Extrapolation

If a provider determines that it is appropriate to sample and extrapolate as part of a self-disclosure, it should do so in a manner that is statistically supportable. Given the complexity of statistical sampling, all work should be performed by qualified personnel. The provider should include the name, educational background, and related work experience of the person performing the sampling/extrapolation when submitting the Self-Disclosure to MFD. MFD does not require providers to use any specific sampling or extrapolation method but provides an excel template for the minimum information that is required to be provided for illustrative purposes.

A Self-Disclosure Random Sample and Extrapolation Template (SD RS&E Template) can be found here. The following items are required (as shown in the template): the background information for the person(s) performing the work; a Sampling Plan; the Universe/ Sampling Frame; the Random Numbers used to select the sample; the Sample that was selected and the corresponding Review that shows the errors that were identified and the overpayment amounts for each claim; and the extrapolation. Any tools or software used to perform the sample or extrapolation must be disclosed.

For self-disclosures involving statistical sampling and extrapolation, MFD has some key requirements and restrictions regarding this process:

- Prior to sampling, the provider must have an accurate and detailed data set that establishes the Universe/ Sampling Frame. If the provider does not have a detailed data set on hand that meets all of the requirements listed above (see Claims Data Form Template), then the provider must request a "Judge Run" via the NJMMIS portal.
- The sample size must be at least 100 sampling units for unique claim samples. If a cluster sample is selected (i.e., recipient or date of service), then smaller sample sizes may be considered if proper statistical evaluations/ calculations are performed.
- Spares or alternates are not acceptable or necessary when performing statistical sampling based on Medicaid claims data. The Universe/ Sampling Frame is a known quantity (i.e., all paid claims for which the provider has been reimbursed). Therefore, if documentation is unable to be located for a particular claim, then that claim should be marked as an error.

- Self-disclosures only pertain to overpayment amounts. Therefore, if any underpayments are identified, they should be reported as non-errors and should not be netted out against the overpayments.
- The extrapolated amount to be repaid to the Medicaid program must be greater than or equal to the Point Estimate.

Access to Information

Providers are expected to promptly comply with MFD requests to speak with relevant individuals and provide documents and information materially related to the disclosure. MFD also expects the provider to execute and provide business record affidavits whenever requested, in a form acceptable to MFD.

MFD is committed to working with providers in a cooperative manner to obtain relevant facts and evidence without interfering with the attorney-client privilege or work-product protection. Discussions with the provider's counsel will explore ways to gain access to factual or other non-protected information pertinent to the case without the need to waive the protection provided by an appropriately asserted claim of attorney-client privilege or attorney work product. Assuming the provider acts in good-faith, the mere fact that the provider and MFD are unable to agree on an amount and resolve the disclosure will not automatically preclude favorable repayment terms, particularly related to the portion of the matter to which the provider and MFD are able to agree.

Restitution

All provider self-disclosures are subject to a thorough MFD review to determine whether the amount identified is accurate. MFD will not accept any payment for self-disclosures prior to reviewing the provider's submission and confirming the accurate amount of the overpayment.

Following the review, MFD staff will establish a repayment amount and schedule and explore the need to pursue any further administrative action. MFD's determination will be based on several factors, including the nature of the problem, the effectiveness of the provider's compliance program, the dollar amounts involved, the time period, thoroughness and timing of the provider's disclosure, the provider’s financial ability to pay the identified amount, any potential harm to the health and safety of Medicaid recipients, and the provider's demonstrated efforts to prevent the problem from reoccurring.

Once a repayment amount has been established, assuming full repayment has not previously been made, MFD expects the provider to reimburse the State of New Jersey for the overpayment with a check for the full amount or enter into a repayment agreement. MFD will work with providers to establish repayment terms, which may include some forgiveness of interest and/or extended repayment. Providers interested in extended repayment terms will be required to submit audited financial statements, if available, and/or other documentation to assist MFD in making that determination.

MFD will assess a provider's culpability and good-faith efforts in reaching the disposition of a self-disclosure. Cooperation will be measured by the extent to which a provider discloses relevant facts and evidence, not its waiver of the attorney-client privilege or work product protection. A lack of information may make it difficult for MFD to determine the nature and extent of the

conduct which caused the improper payment. The self-disclosure process will conclude with a letter indicating that the matter has been resolved or through a signed agreement memorializing the settlement terms.