

Title: Compliance: 60 Day Report/Repay Overpayments	
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Discrete Operating Unit/Facility: Banner Baywood Medical Center Banner Behavioral Health Banner Boswell Medical Center Banner Casa Grande Medical Center Banner Churchill Community Hospital Banner Del E Webb Medical Center Banner Desert Medical Center Banner Estrella Medical Center Banner Fort Collins Medical Center Banner Gateway Medical Center Banner Goldfield Medical Center Banner Heart Hospital Banner Ironwood Medical Center Banner Lassen Medical Center Banner Payson Medical Center Banner Thunderbird Medical Center Banner—University Medical Center Phoenix Banner—University Medical Center South Banner—University Medical Center Tucson Community Hospital East Morgan County Hospital McKee Medical Center North Colorado Medical Center Ogallala Community Hospital Page Hospital Platte County Memorial Hospital Sterling Regional MedCenter Washakie Medical Center	Banner Corporate Banner Health Clinics Banner MD Anderson Cancer Center Banner Health Network Banner Home Care and Hospice Banner Plan Administration Banner Pharmacy Services Banner Surgery Centers Banner Urgent Care Centers Occupational Health/Employee Services Post-Acute Care Services Research Rural Health Clinics University Physicians Health Plans

I. Purpose/Population:

- A. **Purpose:** To ensure that Banner Health (Banner) reports and returns Overpayments to Federal Health Care Programs within sixty (60) days as required by law. Failure to comply with the requirements of this Policy can lead to liability under the federal False Claims Act.
- B. **Population:** All Employees

II. Definitions:

- A. **Federal Health Care Program:** Any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded in whole or in part by the United States Government (other than the Federal Employees Health Benefit Program) or any State health care program (as defined in 42 U.S.C. § 1320a-7(h)). Federal Health Care Programs include, but are not limited to, Medicare, Medicaid, Indian Health Service, TRICARE/CHAMPUS/Department of Defense health care programs, and Veterans Administration.
- B. **Identified:** When Banner Health has determined, or should have determined through the exercise of Reasonable Diligence, that (1) an Overpayment has been received and (2) the amount of the Overpayment has been quantified.
- C. **Lookback Period:** Six (6) years from the date that an Overpayment is received.
- D. **Overpayment:** The amount of money received in excess of the amount due and payable under any Federal Health Care Program requirements. There is no minimum monetary threshold for an Overpayment.
- E. **Patient Financial Services:** Central Business Office and/or Physician Billing Office.
- F. **Reasonable Diligence:** Consists of both:
 - 1. Proactive compliance activities conducted in good faith by qualified individuals to monitor for the receipt of Overpayments; and
 - 2. Reactive investigations conducted in good faith and in a timely manner by qualified individuals in response to obtaining credible information of potential Overpayments.
- G. **Substantial Overpayment:** For purposes of this policy, a "Substantial Overpayment" is defined as a single Overpayment or a series of Overpayments that (1) meets a threshold amount of \$100,000 and (2) is considered substantial based on several factors, including, but not limited to, the number of affected claims, the time period over which the Overpayment(s) occurred, the dollar amount involved, and the nature of the error that led to the Overpayment(s).

III. Policy:

- A. Banner is committed to complying with all applicable Federal Health Care Program requirements for billing and claims reimbursement, including the preparation and submission of accurate claims consistent with such requirements.
- B. Banner exercises Reasonable Diligence to Identify Overpayments from Federal Health Care Programs.
 - 1. Banner conducts proactive compliance activities to monitor the accuracy and appropriateness of claims submitted to Federal Health Care Programs. Publicly available information, such as work plans from the Department of Health and Human Services Office of Inspector General (OIG) and guidance from the Centers for Medicare and Medicaid Services (CMS) notices, may be taken into account when planning such monitoring activities.
 - 2. Banner investigates information that supports a reasonable belief that an Overpayment has been received based on the facts and circumstances of the situation. For example, audit findings by CMS, the OIG, or government contractors may be credible information of a potential Overpayment.

- a. Investigations are generally completed within six (6) months from the receipt of credible information, except in extraordinary circumstances.
 3. Overpayments may be the result of non-adherence to Federal Health Care Program requirement errors by Banner personnel, payment processing errors by Federal Health Care Programs, or erroneous or incomplete information provided to Banner by the patient or his/her responsible party.
 4. If a single overpaid claim is found, Banner may inquire further to determine whether there are more claims with the same issue before reporting and returning the Overpayment.
 5. Any single Overpayment or series of Overpayments greater than or equal to \$100,000 must be immediately reported to the Ethics & Compliance Department.
 - a. Several factors as described above will be considered in making the determination whether the Overpayment or series of Overpayments is substantial.
 - b. If a Substantial Overpayment has occurred, the Ethics & Compliance Department must notify the OIG within thirty (30) days of making that determination in accordance with Banner's Corporate Integrity Agreement (CIA).
- C. Overpayments must be reported and returned to the applicable Federal Health Care Program using a claims adjustment, credit balance, self-reported refund, or other reporting process no later than sixty (60) days after the Overpayments are Identified.
1. Overpayments that are routinely reconciled or adjusted pursuant to Federal Health Care Program policies and procedures are handled in accordance with such policies and procedures.
 2. The Ethics & Compliance Department decides whether to report and return an Overpayment using a method other than routine claims adjustment, including, but not limited to, using the OIG Self-Disclosure Protocol (SDP) or the CMS Voluntary Self-Referral Disclosure Protocol (SRDP).
 - a. If Banner engages in either the SDP or SRDP process, the 60-day reporting period is tolled and remains suspended until such time as a settlement is entered or Banner withdraws or is removed from protocol. If no settlement is reached with the government, Banner has the remaining balance of the 60-day period to report and return any Overpayments.
 3. Banner may use statistical sampling and extrapolation to approximate the amount of an Overpayment.
 - a. If extrapolation can be completed within sixty (60) days, Banner does not need to separately report and return Overpayments on the claims in a probe sample.
 4. If a Federal Health Care Program notifies Banner that it has committed a payment error and will adjust claims to correct the error, Banner does not need to separately report and return the Overpayment.
- D. Banner reports and returns Overpayments that are Identified within the Lookback Period.
- E. **Cost Reports:** Overpayments associated with cost reports may be reported by the Finance Department through the existing cost report reconciliation process on the date the corresponding cost report is due. The Finance Department may also need to revise past cost reports based on audit findings pertaining to the current cost report. For example, if a government contractor finds an improper cost report payment, the Finance Department may need to ascertain whether that finding constitutes credible information necessitating the review of other cost reports within the Lookback Period.

IV. Procedure/Interventions:

- A. Identify Overpayments through the exercise of Reasonable Diligence and in the course of ordinary operations. (**All Employees**)

- B. **Reporting and Returning Overpayments:**
 - 1. No later than sixty (60) days after an Overpayment has been Identified, report the Overpayment using an applicable claims adjustment, credit balance, self-reported refund, or other reporting process set forth by the Federal Health Care Program.
 - a. If applicable, refund Overpayments in accordance with the applicable Federal Health Care Program's policies and procedures. (**Patient Financial Services**)
 - i. Patient Financial Services will coordinate with the Ethics & Compliance Department and/or Revenue Cycle, as necessary, to report and return the Overpayment.
 - ii. When indicated, determine whether to use an alternative reporting process, including, but not limited to, the SDP or SRDP, to report and return Overpayments. (**Ethics & Compliance Department**)
 - i. When engaged in either the SDP or SRDP, the Ethics & Compliance Department coordinates the disclosure and uses the reporting process described in the applicable protocol. The Ethics & Compliance Department notifies the Finance Department of any disclosure using either the SDP or SRDP.
 - ii. When using another reporting process, the Ethics & Compliance Department works with Patient Financial Services and/or Revenue Cycle, as necessary, to report and return Overpayments.
 - iii. If the Overpayment for the SDP protocol or another reporting process is calculated using a sampling methodology, the methodology is conducted in a manner that conforms to sound and accepted principles and is described in the report to the applicable Federal Health Care Program.
 - b. When indicated, determine whether to use an alternative reporting process, including, but not limited to, the SDP or SRDP, to report and return Overpayments. (**Ethics & Compliance Department**)
 - i. When engaged in either the SDP or SRDP, the Ethics & Compliance Department coordinates the disclosure and uses the reporting process described in the applicable protocol. The Ethics & Compliance Department notifies the Finance Department of any disclosure using either the SDP or SRDP.
 - ii. When using another reporting process, the Ethics & Compliance Department works with Patient Financial Services and/or Revenue Cycle, as necessary, to report and return Overpayments.
 - iii. If the Overpayment for the SDP protocol or another reporting process is calculated using a sampling methodology, the methodology is conducted in a manner that conforms to sound and accepted principles and is described in the report to the applicable Federal Health Care Program.

- C. **Reporting and Returning Substantial Overpayments**
 - 1. Immediately notify the Ethics & Compliance Department of any Overpayment or series of Overpayments that is greater than or equal to \$100,000. (**All Employees**)
 - 2. Leads and/or assists in the investigation of the potential Substantial Overpayment in accordance with Compliance: Reporting and Investigating Potential Compliance Issues. (**Ethics & Compliance Department**)
 - a. The investigation will include a consideration of the factors to determine whether the Overpayments or series of Overpayment is substantial.
 - b. If a Substantial Overpayment **has** occurred, the Ethics & Compliance Department:
 - i. Decides how and when to notify the applicable Federal Health Care Program, if it is determined that the Overpayment is an actual Substantial Overpayment that was the result of an act or omission by Banner.
 - ii. Notifies the OIG of the Substantial Overpayment in accordance with the requirements of the CIA.
 - iii. Informs the Finance Department of the Substantial Overpayment.
 - c. If the Substantial Overpayment **has not** occurred, the Ethics & Compliance Department:
 - i. Works with Patient Financial Services and/or Revenue Cycle, as necessary, to report and return Overpayment(s).

V. Procedural Documentation:

- A. N/A

VI. Additional Information:

- A. Self-Referral Disclosure Protocol, *available at* https://www.cms.gov/medicare/fraud-and-abuse/physiciansselfreferral/self_referral_disclosure_protocol.html.
- B. Self-Disclosure Protocol, *available at* <https://oig.hhs.gov/compliance/self-disclosure-info/files/Provider-Self-Disclosure-Protocol.pdf>.

VII. References:

- A. Medicare Program; Reporting and Returning Overpayments, 81 Fed. Reg. 7654 (Feb. 12, 2016) (codified at 42 C.F.R. pts. 401 & 405).

VIII. Other Related Policies/Procedures:

- A. [Compliance: Reporting and Investigating Potential Compliance Issues](#)

IX. Keywords and Keyword Phrases:

- A. Overpayment
- B. Substantial Overpayment
- C. Federal Health Care Programs
- D. 60 Days
- E. Lookback Period

X. Appendix:

- A. N/A