Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

MassHealth
All Provider Bulletin 224
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TO: All Providers Participating in MassHealth

FROM: Julian J. Harris, M.D., Medicaid Director

RE: Provider Overpayment Disclosure Process

Introduction

The Affordable Care Act of 2010 (ACA) imposes new federal requirements on MassHealth providers to timely report and return overpayments received from MassHealth. See 42 U.S.C. 1320a-7k(d). Providers must report in writing and return any overpayments within 60 days of (1) the provider identifying such overpayment, or (2) for payments, subject to reconciliation based on a cost report, the date any corresponding cost report is due, whichever is later. Providers who fail to disclose, explain, and return overpayments in a timely manner may be subject to sanctions, including administrative fines and suspension or termination from the MassHealth program. See 130 CMR 450.238. Providers may also be subject to liability under the Massachusetts False Claim Act, the federal False Claims Act, and the Medicaid False Claims Act. See M.G.L. c. 12, §§ 5B-5O, 31 U.S.C. § 3730, and M.G.L. c. 118E, § 40 et seq.

MassHealth, in compliance with the federal requirement, is committed to detecting potential fraud, waste, and abuse within the Medicaid program and recovering improper payments.

MassHealth recognizes that improper payments are often discovered during the course of a provider's internal review process. MassHealth has developed an overpayment disclosure process to give providers the means to report matters that involve possible fraud, waste, abuse or inappropriate payment of funds, whether intentional or unintentional, under the Medicaid program.

Matters related to an ongoing audit or investigation of a provider are not generally eligible for resolution under this disclosure protocol. Unrelated matters disclosed during an ongoing audit may be eligible for processing under this disclosure protocol if the matter has received timely attention.

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If MassHealth 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 the assigned investigator or auditor. If another outside agency is auditing or investigating the provider, and the provider seeks to disclose an issue to MassHealth, the provider should follow the disclosure process described in this bulletin accordingly.

The Overpayment Disclosure Process

All providers must comply with the ACA. The disclosure and repayment of simple, routine overpayments should continue to use the standard administrative and billing methods of resolution.

Returning Overpayments - Pharmacy

Pharmacy providers should continue to submit claim reversals as B2 transactions through the Pharmacy Online Processing System (POPS).

Returning Overpayments – All Other Providers

Nonpharmacy providers should submit voids and, in the case of adjustments, replacement transactions through the Provider Online Service Center (POSC) using the HIPAA-compliant 837 format. Refer to the appropriate 837 implementation guide and MassHealth companion guide for more information. For those providers unable to use the 837 transaction to process voids, the paper MassHealth Void Request Form can be used. This form can be downloaded from the MassHealth Web site from the Provider Forms link under the Publications section of our home page at www.mass.gov/masshealth. For more information on the Void Request Form, refer to All Provider Bulletin 152 (April 2006) in the MassHealth Provider Library.

In all cases, providers who identify that they have received inappropriate payments from the MassHealth program, either as a result of an internal audit or otherwise, must complete and submit the Provider Overpayment Disclosure Form. Due to the wide variance in the nature, amount, and frequency of overpayments that may occur across all provider types, it is difficult to present a comprehensive set of criteria by which to judge whether disclosure through the completion and submission of the Provider Overpayment Disclosure Form is appropriate.

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

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The Overpayment Disclosure Process (cont.)

Issues appropriate for disclosure may include, but are not limited to, systematic errors, patterns of errors, and potential violation of fraud and abuse laws. For example, billing and receiving payment for deceased members, billing and receiving payment for services rendered by an excluded person or entity, and billing and receiving payment for outpatient services or community services during a member's inpatient stay are overpayment situations that must be disclosed through the completion and submission of the Provider Overpayment Disclosure Form.

Providers should be aware that MassHealth monitors both the number of occurrences and dollar amounts of voids and/or adjustments, as well as any patterns of voids and/or adjustments. MassHealth highly discourages providers from attempting to avoid the completion and submission of the Provider Overpayment Disclosure Form when circumstances warrant its use.

Overpayment Recovery

A Provider Overpayment Disclosure Form submitted by a provider is subject to a thorough review by MassHealth to determine whether the amount identified is accurate and whether all claims dealing with the disclosed issue have been identified. MassHealth will not accept any payment from the provider before it reviews the provider's submission, and confirms the accurate amount of the overpayment. During the pendency of the process, the provider should not void or correct any of the claims involved unless instructed to do so by MassHealth. The provider should not send a check for any overpayment, unless the provider has received prior written approval from MassHealth. Once the full overpayment has been determined, MassHealth will initiate its standard recoupment process.

Provider Overpayment Disclosure Form

The Provider Overpayment Disclosure Form is attached to this bulletin and can be downloaded from the MassHealth Web site from the Provider Forms link under the Publication section of our homepage at www.mass.gov/masshealth. For those providers who are unable to access the Provider Overpayment Disclosure Form online, a paper copy of the form can be requested in writing via fax to 617-988-8973 or by mail to the following address.

MassHealth
ATTN: Forms Distribution
P.O. Box 9118
Hingham, MA 02043

Questions

If you have any questions about the information in this bulletin, please contact MassHealth Customer Service at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.

MassHealth
Commonwealth of Massachusetts
EOHHS
www.mass.gov/masshealth

Provider Overpayment Disclosure Form

PROVIDER INFORMATION

Provider (agency) name: _____

Provider contact first name: _____ Last name: _____

Provider ID/Service Location (PID/SL): _____ NPI: _____

Physical address: _____ City: _____ State: _____ Zip: _____

Mailing address: _____ City: _____ State: _____ Zip: _____

Office telephone number: _____ Ext: _____ Fax number: _____

E-mail address: _____

REASON FOR OVERPAYMENT (*Check all that apply.*)

- ☐ Collection from Medicare Part A
- ☐ Collection from Medicare Part B
- ☐ Collection from Medicare (not known if Part A or B)
- ☐ Collection from auto insurance or workers' compensation insurance
- ☐ Collection from commercial health insurance
- ☐ Claim was paid to the wrong provider.
- ☐ Cost report issues
- ☐ Wrong MassHealth member ID was on the claim.
- ☐ Provider billed incorrect service date.
- ☐ Erroneous duplicate payment for the same service date
- ☐ Provider billed for the service twice.
- ☐ Collection from credit balance on patient account
- ☐ Provider performed only a component of the entire service billed.
- ☐ Provider billed incorrectly.
- ☐ Other (specify): _____

_____

1. **Please provide written, detailed information about the overpayment(s). In the space below, describe the facts and circumstances surrounding the possible fraud, waste, abuse, or inappropriate payment(s) and its discovery, the period involved, and an assessment of the potential financial impact. Attach additional sheets, if needed.**

2. **Cite the MassHealth regulations or policies potentially implicated or violated. Enter "not known" if you do not know. Attach additional sheets, if needed.**

3. Identify the underlying cause(s) of the issue(s) involved, specify the nature and extent of any investigation or audit you conducted to identify the overpayment, describe any corrective action taken to address the problem leading to the overpayment, and identify the date the correction occurred and the process for monitoring the issue to prevent recurrence. Attach additional sheets, if needed.

4. Identify the individuals involved in any suspected improper or illegal conduct. Attach additional sheets, if needed.

First name: _____ Last name: _____

Title/Position: _____

First name: _____ Last name: _____

Title/Position: _____

First name: _____ Last name: _____

Title/Position: _____

5. Provide a list of claims that comprise the overpayments. For each claim, provide the member's name and MassHealth ID number, the claim ICN and line detail number, date of service, service code, modifier, units, amount paid by MassHealth, amount paid by a third-party liability (TPL) insurer, and the amount of the overpayment. If there are more than five claims, then the claims must be formatted in an Excel spreadsheet or Access database and transmitted via secure e-mail, or placed on an encrypted CD and mailed with this form.

Member name: _____ Member ID: _____

ICN: _____ Line detail: _____ Dates of service: _____

Service code: _____ Modifier: _____ Units: _____

Paid amount: _____ TPL: _____ Overpayment: _____

Member name: _____ Member ID: _____

ICN: _____ Line detail: _____ Dates of service: _____

Service sode: _____ Modifier: _____ Units: _____

Paid amount: _____ TPL: _____ Overpayment: _____

Member name: _____ Member ID: _____

ICN: _____ Line detail: _____ Dates of service: _____

Service code: _____ Modifier: _____ Units: _____

Paid amount: _____ TPL: _____ Overpayment: _____

Member name: _____ Member ID: _____

ICN: _____ Line Detail: _____ Dates of service: _____

Service code: _____ Modifier: _____ Units: _____

Paid amount: _____ TPL: _____ Overpayment: _____

(over ▶)

Member name: _____ Member ID: _____

ICN: _____ Line Detail: _____ Dates of service: _____

Service code: _____ Modifier: _____ Units: _____

Paid amount: _____ TPL: _____ Overpayment: _____

6. If applicable, provide the primary payor health insurance information. If there is more than one member, then the information must be formatted in an Excel spreadsheet or Access database and transmitted via secure e-mail, or placed on an encrypted CD and mailed with this form.

Member name: _____ Member ID: _____

Policyholder name: _____ Policy no: _____

Employer name: _____ Group no: _____

Insurance company name: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone number: _____ Fax number: _____

E-mail address: _____

List below any family members who are on the health insurance policy:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

7. If applicable, provide information about any federal or state agency involvement.

State or federal agency and/or law enforcement notified:

☐ State ☐ Federal ☐ Law enforcement ☐ Other (Specify): _____

Agency notified: _____ Date notified: _____

Contact person: _____ Title: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone number: _____ Fax number: _____

E-mail address: _____

8. Provide your contact information.

Contact person: _____ Title: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone number: _____ Fax number: _____

E-mail address: _____

(over ▶)

I certify under the pains and penalties of perjury that the information on this form and any attached statement that I have provided has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I also certify that I am the provider or, in the case of a legal entity, duly authorized to act on behalf of the provider. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

_____

Signature of provider or authorized representative *(if legal entity)*

(Signature and date stamps, or the signature of anyone other than the provider or a person legally authorized to sign on behalf of a legal entity are not acceptable.)

_____

Printed legal name of provider

_____

Printed legal name of authorized representative and person's title *(if the provider is a legal entity)*

_____

Date

Mail the completed Provider Overpayment Disclosure Form to MassHealth at the address below.

MassHealth—Provider Compliance Unit
529 Main Street, Schraffts Center
Box #26, 3rd Floor, Suite 320
Charlestown, MA 02129-1120

In addition to mailing the completed Provider Overpayment Disclosure Form, the provider is urged, in the interest of time expediency, to e-mail the completed form to providercomplianceunit@umassmed.edu.

Providers should take precautions appropriate for the transmission of personal information and, in no case, should member names and MassHealth identification numbers or social security numbers be transmitted without using secure e-mail. MassHealth recommends that providers use a secure e-mail site to encrypt all electronic communications. If providers do not have access to a secure e-mail site and would like to use the one maintained by the MassHealth Provider Compliance Unit to transmit personal information or to transmit the Provider Overpayment Disclosure Form, they should send an e-mail requesting access instructions to providercomplianceunit@umassmed.edu.