Commonwealth of Massachusetts

Executive Office of Health and Human Services

Office of Medicaid

www.mass.gov/masshealth

MassHealth

All Provider Bulletin 224

March 2012

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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Introduction If MassHealth is already auditing or investigating the provider, and

(cont.) 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 All providers must comply with the ACA. The disclosure and repayment of

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

Disclosure Process systematic errors, patterns of errors, and potential violation of fraud and

(cont.) 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 The Provider Overpayment Disclosure Form is attached to this bulletin

Disclosure Form 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.

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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:

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:

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.

ODF (03/12)