WOODLANDS BEHAVIORAL HEALTHCARE NETWORK

F I N A N C E P O L I C Y

Subject: CLAIMS OVERPAYMENT AND REFUNDS

Originated: 06/23/2015
Reviewed: 03/15/2017, 12/15/17
Revised: 07/25/2018

I. Purpose

To establish a standard policy on the identification and processing of overpayments for a Provider. A Medicaid overpayment occurs where the Medicaid payment exceeds what should have been paid. Examples of situations in which a Provider is liable for an overpayment are as follows:

- The patient was not eligible for Medicaid at the time the services were provided
- Medicaid has made a payment where there was another responsible payer
- The services are not Medicaid-covered
- The services were covered but not medically necessary
- Medicaid was the responsible payer for a medically-necessary, covered service but the payment amount was incorrect and excessive.
- Due to a mathematical or clerical error
- Woodlands Behavioral Healthcare (WBHN) paid for services that the Provider should have known were not covered.

This process initiates when the following occurs:

- The provider submits notification indicating an overpayment exists
- An overpayment is identified as a result of an internal claim audit analysis by payor

II. Policy Summary

In accordance with State and Federal Guidelines for the recovery of overpayment to providers, the WBHN claims staff will initiate recovery of overpayments for providers that were a result of a number of scenarios, including, but not limited to the following:

- Overpayments made to providers that are discovered by WBHN
- Overpayments made to providers that are initially discovered by the provider and made known to WBHN.
- Overpayments that are discovered through external agency audit.

WBHN will recover or attempt to recover any overpayment. Notification of an overpayment to a provider will be done in writing with reasonable actions to attempt to recover overpayments. Once WBHN has identified an overpayment and has captured the appropriate documentation that addresses the overpayment (i.e. cost report, provider correspondence, claim audit details, etc.), WBHN will maintain a separate record of overpayment activities for each provider in a manner that satisfies retention and access requirements.

III. Standards and Guidelines

Claims Processor handling potential overpayment via Claims System

A. The claims processor will review the claim history for member to confirm overpayment
B. If overpayment exists, go to step E
C. If no overpayment exists, go to step D
D. The processor will document findings within claim system that claims review did not confirm an overpayment and close out the case.

E. Adjust or deny the claim per claim adjustment guidelines and note the reason for denial. The reason for denial will always be noted for denials that are a result of a compliance audit.
F. For providers that do not have a regular claim history with WBHN or the overpayment amount is considered high dollar, go to Step G. For providers that submit claims on a regular basis, adjust the claim and apply any negative adjustment to the claim. *(Note: Claims processor will determine if provider submits claims on a regular basis after review of previous claim history for Provider).* The negative adjustment will be removed once future claims are offset and overpayment amount is satisfied. If overpayment amount is not met within 30 days, a demand letter will be issued.
G. Issue overpayment demand letter to provider that includes the following details: (42 CFR 433.316)
    1. That an overpayment was made
    2. The interest will begin to accrue if the overpayment is not paid in full within 30 days
    3. The name and member identification number of the member/patient involved
    4. How the overpayment was calculated
    5. Why it is liable for recovery of overpayment (i.e. the reasons for finding the provider at fault)
    6. That recoupment of the overpayment from all available payments is occurring
    7. A description of the appeal process.
H. Document in the claim notes the overpayment
I. Gather the following documentation to create a hard copy file to be given to the Corporate Compliance Department for possible compliance investigation.
    1. Claim notes
    2. Copy of claim
    3. Copy of cost report, cashed check, email, etc.

IV. Definitions

A. Discovery: Identification by any State Medicaid agency official or other State official, the Federal Government, or the provider of an overpayment, and the communication of that overpayment finding or the initiation of a formal recoupment action without notice.
B. Provider: Any individual or entity furnishing Medicaid Services under a provider agreement with the Medicaid Agency.
C. Overpayment: Amount paid by a Medicaid agency to a provider which is in excess of the amount that is allowable for services furnished under section 1902 of the Act and which is required to be refunded under section 1903 of the Act.
D. Recoupment: Any formal action by the State or its fiscal agent to initiate recovery of an overpayment without advance official notice by reducing future overpayments to a provider.

V. References

A. 42 CFR 433.300
B. 42 CFR 433.304
C. 42 CFR 433.312
D. 42 CFR 433.316
E. Section 1903(d)(2)(C) and (D) of the Social Security Act
F. 42 CFR 433.310
G. 42 CFR 433.322-Maintenance of Records
H. 42 CFR 92.42-Retention and Access Requirements for Records