

**Texas Health and Human Services Commission**

**Office of Inspector General**

**SELF-DISCLOSURE PROTOCOL**

**February 2016**

## **I. Introduction**

### **A. Implementation of IG Mission Statement**

The mission of the Texas Department of Health and Human Services Office of the Inspector General (IG) is to protect integrity and ensure accountability in health and human services programs, and protect the health and welfare of recipients of those programs, by identifying, communicating, and correcting activities of waste, fraud, or abuse in Texas. The IG is committed to fulfilling this mission, in part, by recovering inappropriate payments. As part of our multi-disciplinary approach to fulfilling this mission, the IG is making a concerted effort to recognize providers who find problems within their own organizations, reveal (self-disclose) those issues, and return inappropriate payments.

### **B. Purpose of Self-Disclosure Protocol**

Section 1128J(d)(2) of the Affordable Care Act requires that a Medicaid overpayment be reported and returned by the later of (1) the date that is 60 days after the date on which the overpayment was identified or (2) the date any corresponding cost report is due, if applicable. 42 U.S.C. 1320a-7k(d). The following Protocol is designed to provide guidance to a health and human services program provider who has self-discovered evidence of an overpayment by a health and human services program due to a mistake or potential fraud by a provider. Self-disclosure by a provider allows that provider to potentially avoid prolonged investigation and litigation, and the costs associated with each. Although the IG does not administer any health and human services programs, it does consult with these programs when seeking to recover overpayments.

The IG's principal purpose in publishing this Protocol is to provide guidance to health care providers that decide voluntarily to disclose irregularities in their dealings with the Medicaid and other state health and human service programs. The IG has developed this approach to encourage and offer incentives for providers to investigate and report matters that involve possible fraud, waste, abuse or inappropriate payment of funds, whether intentional or unintentional. By forming a partnership with providers through this self-disclosure approach, the IG's overall efforts to eliminate fraud, waste and abuse will be enhanced, while simultaneously offering providers a mechanism or method to reduce their legal and financial exposure.

### **C. Applicability of Self-Disclosure Protocol**

This Protocol is open to all Medicaid health care providers, whether individuals or entities, and is not limited to any particular industry, medical specialty or type of service. This Protocol may

also be used by other health and human service providers, contractors, grant recipients and vendors whose compliance may be audited or investigated by the IG.

#### D. Requirements of Self-Disclosure Protocol

This Protocol has no rigid requirements or limitations, and no written agreement setting out the terms of the self-assessment is required. Rather, this Protocol and the Self-Report Checklist, set forth below, provide the IG's views on what are the appropriate elements of an effective investigative and audit working plan to address instances of non-compliance. Although the IG will accept a self-disclosure in any form, disclosures that comply with the Protocol, including the Self-Report Checklist, will expedite the IG's verification process and thus diminish the time it takes before the matter can be formally resolved. Moreover, a thorough self-disclosure that complies with this Protocol will carry more weight in supporting subsequent requests for leniency.

#### E. Limits of Self-Disclosure Protocol

While providers who identify that they have received inappropriate payments from the Medicaid program are obligated to return the overpayments, the IG understands that it is essential to develop and maintain a fair, reasonable process that will be mutually beneficial for both the State of Texas and the provider involved. Because a provider's disclosure may involve anything from a simple error to intentional fraud, the IG cannot reasonably make firm commitments regarding how a particular disclosure will be resolved or whether a specific benefit will inure to the disclosing entity. Nevertheless, experience dictates that a provider's initiative in opening communication and making full disclosure to the IG at an early stage generally benefits the individual or company.

## **II. Determining Whether to Self-Disclose**

#### A. Benefits of Self-Disclosure

Self-disclosing overpayments, in most circumstances, will result in a better outcome than if the IG staff had discovered the matter independently. While the specific resolution of self-disclosures depends upon the individual merits of each case, the IG may extend the following benefits to providers who initiate a good-faith self-disclosure:

1. Forgiveness or reduction of interest payments (for up to two years);
2. Extended repayment terms;
3. Waiver of penalties or sanctions;

4. Allowance for probe sample sizes that are less rigorous than the standards employed by the IG;
5. Timely resolution of the overpayment;
6. Recognition of the effectiveness of the provider's compliance program and a decrease in the likelihood of imposition of an IG Corporate Integrity Agreement; and
7. Possible preclusion of subsequent State of Texas False Claims Act actions based on the disclosed matters.

Developing such a partnership with the IG during the self-disclosure process may also lead to more thorough understanding of the IG's audit and investigatory processes, which could benefit the provider in the future.

#### B. Self-Disclosure to IG versus Administrative Recoupment

The IG recognizes that many improper payments are discovered during the course of a provider's internal review processes. Because of the wide variance in the nature, 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 disclosure is appropriate. Providers must determine whether the repayment warrants a self-disclosure or whether it would be better handled through an administrative billing process. Each incident must be considered on an individual basis, and the provider's initial decision of where to refer a matter of non-compliance should be made carefully.

#### C. Effect of Self-Disclosure

The IG is not bound by any findings submitted by the disclosing provider, and it is not obligated to resolve the matter in any particular manner. Furthermore, the IG may conclude that the disclosed matter warrants a referral to other county, state, or federal authorities for additional civil or criminal enforcement. If the IG makes a case referral, it will report on the provider's involvement and level of cooperation throughout the disclosure process to any other governmental agencies. Additionally, the IG will attempt to work closely with self-reporting providers in coordinating any investigatory steps or other activities necessary to reach an effective and prompt resolution.

### **III. Submission of a Self-Disclosure Report**

#### A. Transmittal

The disclosure must be submitted in writing. Submissions should be directed to the HHSC-IG Deputy Chief Counsel for Litigation, P.O. Box 85200, MC-1350, Austin, Texas 78708-5200 or to OIGSelf-Report@hhsc.state.tx.us. Submissions that contain personal health information must be sent securely.

## B. Self-Disclosure Report Checklist

Providers may elect to submit a letter or may use the IG Self-Disclosure Checklist form. Providers who have identified specific claims affected by an error should use the IG Self-Disclosure Checklist Form to report on claims information.

### *Self-Disclosure Letter Checklist*

If the provider chooses to submit a letter, the letter should contain a complete description of the circumstances surrounding the disclosure including:

- \_\_\_ Provider's name
- \_\_\_ Provider's Medicaid TPI, tax ID number and/or NPI number
- \_\_\_ Description of the error that occurred
- \_\_\_ How the error was found
- \_\_\_ Amount of Medicaid overpayment
- \_\_\_ Dates of service (DOS) the error encompasses
- \_\_\_ Actions taken to stop the error and prevent recurrence
- \_\_\_ Names of personnel involved in the error, those who discovered the problem, and those involved in rectifying the problem
- \_\_\_ Provider's contact person's name, phone number, and both mailing and e-mail addresses
- \_\_\_ If the claims at issue have been voided, or if the provider has notified either TMHP or an MCO about the error, please note this in the self-disclosure letter
- \_\_\_ A certification by the health care provider stating that the submission contains true, accurate, and complete information, and that there are no material misstatements or omissions of fact or law. If the provider is a business entity, an authorized representative of the entity may execute the certification.
- \_\_\_ Anything else the provider deems relevant.

### *Claims Data File (if the provider can identify specific claims that have been affected by the error)*

Claims should be submitted in an Excel format (properly encrypted) and should include the following:

- \_\_\_ Complete claim number (ICN)
- \_\_\_ Provider's Medicaid TPI, tax ID number and/or NPI number
- \_\_\_ Medicaid recipient's first name
- \_\_\_ Medicaid recipient's last name
- \_\_\_ Medicaid recipient's identification number (PCN)
- \_\_\_ Date of service (*not the date billed*)
- \_\_\_ Incorrect rate or procedure codes, if applicable
- \_\_\_ Correct rate or procedure codes
- \_\_\_ Amount paid
- \_\_\_ Amount that should have been paid, if applicable
- \_\_\_ Amount paid by Medicare or any other third party, if applicable.

The submission also should include a brief narrative explaining how the overpayment came about, how it was discovered, and what the provider feels would be the fairest resolution of the overpayment claim.

## **IV. Payments**

### **A. Interim Payments**

Upon receipt of a health care provider's disclosure submission, the IG will begin its verification of the disclosure information. Payments submitted along with the self-disclosure will be accepted as interim payments pending final outcome of the verification process. Interim payments will not be considered full and final payment of the self-disclosure, notwithstanding any such representations on the provider's check or self-disclosure report. Submission of an interim payment constitutes an agreement by the provider that the IG is entitled to apply and disburse the interim payment to the affected program area. All interim payments will be credited toward the final settlement amount.

### **B. Claims Adjustment**

If the provider has submitted an interim payment that was calculated by a dollar-for-dollar review, the provider may elect to have the individual claims at issue adjusted to reflect the repayment. Upon receiving notification from the provider, the IG will verify the request on a claim-by-claim basis. After verification, the IG will submit a State Action Request to the claims administrator, instructing it to adjust the individual claims. The provider should be aware that if the rates have changed since the claim was originally filed the adjustment may result in a refund or may result in the assessment of an additional overpayment.

### C. Payment Terms

The provider may request a payment schedule upon submission of the self-disclosure report or upon final settlement of the matter. The IG will consider the circumstances of each case in determining whether to offer a payment schedule, including, but not limited to, the following:

1. Nature of the matter being disclosed;
2. Effectiveness of the provider's compliance program;
3. Dollar amounts involved;
4. Duration of the program violations;
5. Thoroughness and timing of the self-disclosure report;
6. Provider's efforts to prevent a recurrence of the matter;
7. Access to care within the provider's geographical region;
8. Financial solvency of the provider and
9. Willingness of the provider to respond to the IG's additional requests for documentation or information.

Repayments may occur through periodic payments to the IG or by authorizing the IG to withhold a portion of the provider's regular reimbursement. Providers interested in extended repayment terms may be required to submit audited financial statements or other documentation to assist the IG in making a repayment determination.

### D. Final Payment

Upon completion of the verification process, the IG will notify the provider of the full settlement amount. If the full settlement amount is greater than the amount disclosed by the provider, the IG will send the provider a notice of potential overpayment pursuant to the IG's rules contained in the Texas Administrative Code, Title 1, Part 15, Chapter 371, Subchapter G.

## **V. Verification by the IG**

### A. Verification Process

Upon receipt of the provider's self-disclosure submission, the Litigation section of IG Chief Counsel Division may refer the self-disclosure report to IG's Medicaid Provider Integrity (MPI), Audits, or other section for verification, or may request additional information from the provider if necessary. If referred, appropriate section will convey its findings back to the Litigation section for final resolution of the matter. While the IG is not obligated to accept the results of a

provider's self-assessment, findings based upon procedures that conform to this Protocol will be given substantial weight in determining any program overpayments.

#### B. Access to Records

To facilitate the IG's verification and validation processes, IG personnel may request access to provider's audit work papers or other relevant and supporting documents. Although the IG expects to receive documents and information from the provider without the need to resort to compulsory methods, the IG is entitled to impose a payment hold without prior notice upon any provider that refuses to comply with a request for records.

#### C. Collateral Matters

Matters uncovered during the verification process, which are outside of the scope of the matter disclosed to the IG, may be treated as new matters outside the Provider Self-Disclosure Protocol. Such collateral matters may be consolidated into the self-disclosure to facilitate final settlement, or they may be severed into a separate investigation. Collateral matters may also be referred to other federal or state agencies for criminal, civil, or administrative enforcement action.

#### D. Mitigating and Aggravating Circumstances

The provider's diligent and good faith cooperation throughout the entire process is essential, and it will be considered as a mitigating circumstance. Conversely, failure to work in good faith or lack of cooperation, submission of false or otherwise untruthful information, and the omission of relevant facts will be considered as aggravating factors and may constitute grounds for independent enforcement action. Upon request, the IG may submit a written statement of the provider's cooperation and other mitigating factors to other state or federal enforcement agencies.