NEW YORK STATE OF OPPORTUNITY. | Office of the Medicaid Inspector General

Self-Disclosure Program Requirements

Instructions & Guidelines

August 2023

Self-Disclosure Guidance

Medicaid entities/Providers are required to report, return, and explain any overpayments they have received to the New York State Office of the Medicaid Inspector General (OMIG) Self- Disclosure Program within sixty (60) days of identification, or by the date any corresponding cost report was due, whichever is later. See Social Services Law (SOS) § 363-d(6).

OMIG has enacted self-disclosure processes to afford Medicaid entities/Providers a mechanism to report, return, and explain overpayments from the Medicaid program. These processes cover all Medicaid-program providers. See SOS § 363-d(7).

Additionally, the Self-Disclosure Program accepts provider reports of damaged, lost or destroyed records. Pursuant to Title 18 of the New York Codes Rules and Regulations, Section 504.3, providers are required to prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program and furnish the records, upon request. **If a provider becomes aware that their records have been damaged, lost or destroyed they are required to report that information as soon as practicable, but no later than thirty (30) calendar days after discovery.**

Overpayment Identification

Pursuant to SOS § 363-d (6)(b), an overpayment has been identified when a Medicaid entity/Provider has, or should have, through the exercise of reasonable diligence, determined that a Medicaid fund overpayment was received, and they have quantified the amount of the overpayment.

Medicaid entities/Providers who have a compliance program should be utilizing routine internal audits to review compliance with Medicaid requirements and identify any Medicaid fund overpayments that may have been received. Additionally, if a Medicaid entity/Provider is the subject of a government audit, part of that Medicaid entity's/Provider's due diligence is to review the results of the audit and look at past and future periods - not covered in the audit scope - to identify any overpayments resulting from similar issues. If overpayments exist, Medicaid entities/Providers are obligated to take corrective action, which includes reporting and returning any Medicaid overpayment identified to OMIG's Self-Disclosure Program.

Please Note: **Voiding or adjusting claims does not satisfy the Medicaid entity's/Provider's obligation to report and explain the identified overpayment.**

Anticipated Timeframes and Process

While both Federal and State regulations require a Medicaid entity/Provider to report, return, and explain an overpayment within sixty (60) days from identification, the actual timeframes for processing can vary. A Medicaid entity's/Provider's 60-day time frame will be tolled, or paused, when a completed Self-Disclosure Full Statement is received from an eligible Medicaid entity/Provider. The time frame to repay will remain tolled

during OMIG's review.

In a typical self-disclosure, a Medicaid entity/Provider would submit all information to OMIG electronically through the secure online portal available in the Self-Disclosure section of the OMIG website. The Medicaid entity/Provider would receive an automatic confirmation reply notifying them that the disclosure was received, which occurs on the same day the disclosure was submitted.

Subsequent to receipt, OMIG staff review the information and data submitted in an effort to understand the error that occurred. For overpayments disclosed using the Self-Disclosure Full Statement, OMIG staff will verify that the disclosed overpayment amount is correct. OMIG staff will notify the Medicaid entity/Provider within twenty (20) days from the date of receipt confirming acceptance of the submission or rejecting the submission for failure to meet eligibility criteria. For overpayments disclosed using the Self-Disclosure Abbreviated Statement, OMIG staff will verify that the voids or adjustment transactions were completed successfully and review to ensure no larger issues exist that need further corrective action.

The review process includes steps to understand the reason that caused the overpayment including any law, regulation or policy that was violated. The claim data is reviewed and verified against paid Medicaid claim information when applicable. For disclosures using the Self-Disclosure Full Statement, OMIG staff also review the Medicaid entity's/Provider's disclosed plan of corrective action to confirm it is sufficient to prevent the error from reoccurring in the future. If additional information is needed, OMIG staff will request it from the Medicaid entity/Provider to complete the disclosure. OMIG staff will request that a Medicaid entity/Provider respond with appropriate information within fifteen (15) days of notification.

The overpayment amount will be determined by OMIG and, if not already voided or adjusted, must be paid within fifteen (15) days from the date of the Determination Notice detailing the overpayment amount due, or no later than the expiration of the deadline to report, return and explain.

If a Medicaid entity/Provider submits a Self-Disclosure Full Statement and is unable to pay in full within fifteen (15) days of notification, the Medicaid entity/Provider *may request* an installment-payment agreement, which includes the execution of a Self-Disclosure Compliance Agreement (SDCA). Requests for full repayment within two (2)-years will be considered and may be approved based on a review of the Medicaid entity's/Provider's annual billings. A request for an extended repayment plan (beyond two (2)-years) is not guaranteed to be approved, and a Medicaid entity/Provider must demonstrate a financial need for extended repayment options through the submission of a financial hardship application. Please see OMIG's website for more information: https://omig.ny.gov/information-resources/financial-hardship-application-information.

The self-disclosure process, and the information required to determine confirmation of the overpayment amount, is unique to the circumstances disclosed. OMIG staff update disclosing Medicaid entities/Providers at each stage of the case process and are

available to discuss any questions or concerns that may arise. OMIG staff make every effort to process cases within 90 days.

Eligibility

Eligibility to participate in the Self-Disclosure Program is detailed in SOS § 363-d(7)(c). To be eligible, a Medicaid entity/Provider must meet ***all*** the following criteria:

- The Medicaid entity/Provider must not currently be under audit, investigation, or review by OMIG, unless the overpayment and the related conduct being disclosed does not relate to OMIG's audit, investigation, or review.
- The Medicaid entity/Provider is disclosing an overpayment and related conduct that OMIG has not determined, calculated, researched, or identified at the time of disclosure.
- The Medicaid entity/Provider has reported the overpayment and conduct within sixty (60) days from identification, or by the date any corresponding cost report was due, whichever is later.
- The Medicaid entity/Provider is not currently a party to any criminal investigation conducted by the deputy attorney general for the Medicaid Fraud Control Unit (MFCU) or any agency of the United States government or any political subdivision thereof.
- The Medicaid entity/Provider must submit the Self-Disclosure Statement appropriate to their overpayment type in the format required by OMIG. The Self-Disclosure Full Statement and Self-Disclosure Abbreviated Statement can be found here: https://omig.ny.gov/self-disclosure-submission-information-and-instructions

How to participate

1. Apply

If a Medicaid entity/Provider meets the eligibility criteria and has identified an overpayment, the self- disclosure process provides the mechanism for reporting and returning the overpayment.

A self-disclosure submission related to a Medicaid program overpayment requires completion of either a Self-Disclosure Full Statement (including a Claims Data File of affected Medicaid claims or Mixed Payer Calculation (MPC) form for Excluded providers, or a completed Self-Disclosure Abbreviated Statement. If the Medicaid program overpayment is not related to claim data or is related to an excluded or non-enrolled provider, disclosure using a Self-Disclosure Full Statement and additional explanation to allow for the verification of the overpayment is required.

The determination of which form is appropriate for a Medicaid entity's/Provider's self-disclosure should be based on the error identified. Errors that require formal corrective

action plans should always be self-disclosed using the Self-Disclosure Full Statement, while errors that are more transactional or routine in nature and already repaid through voids or adjustments may be better suited to for the Self-Disclosure Abbreviated Statement.

Self-Disclosure Full Statement

Examples to be self-disclosed using the Self-Disclosure Full Statement include but are not limited to:

- Any error that requires a Medicaid entity/Provider to create and implement a formal corrective action plan;
- Actual, potential or credible allegations of fraudulent behavior by employees or others;
- Discovery of an employee on the Excluded Provider list;
- Documentation errors that resulted in overpayments;
- Overpayments that resulted from software or billing systems updates;
- Systemic billing or claiming issues;
- Overpayments that involved more than one Medicaid entity/Provider (example – Health Homes & Care Management Agencies);
- Non-claim-based Medicaid overpayments;
- Any error with substantial monetary or program impacts; and
- Any instance upon direction by OMIG.

Note: The Self-Disclosure Full Statement includes embedded links to the Claims Data File and MPC form.

For disclosures using the Self-Disclosure Full Statement OMIG requires:

- The overpayment amount
- A detailed explanation of the reason the Medicaid entity/Provider received the overpayment or caused the overpayment to be received, including an explanation of the circumstances that led to the overpayment
- Identification of any rule, policy, regulation or statute that was violated
- Identification of the individuals involved in the error and discovery of the error
- The type of Medicaid program affected
- Corrective measures put in place to prevent a recurrence, etc.
- Contact information
- Signature of the disclosing Medicaid entity/Provider on the form

- Signatory and Title of the responsible person who will sign the documents
- Claims Data File or MPC form if applicable
- Agreement to the terms of disclosure
- Confirmation that void or adjustment transactions have been processed, or agreement to return the overpayment amount within fifteen (15) days of written notification from OMIG, or if approved by the OMIG, agreement to executing a SDCA to repay in installments

The Claims Data File should include the following for each disclosed claim:

- Payer Name (Medicaid FFS or MCO/MLTC name)
- Claim Reference Number (CRN) or Transaction Control Number (TCN), a 16-digit number
- Claim Line Number
- Medicaid Group ID (if applicable)
- Billing Provider's Medicaid MMIS ID (Billing Provider ID) and NPI number
- Servicing Medicaid MMIS ID (Servicing Provider ID) and NPI number
- Medicaid recipient's first name
- Medicaid recipient's last name
- Medicaid recipient's Medicaid ID number (CIN), an 8-character number (e.g., AA######A)
- Medicaid recipient's Date of Birth
- Medicaid recipient's Social Security Number
- Date of service *(not the date billed or payment date)*
- Incorrect rate or procedure codes (if applicable)
- Correct rate or procedure codes
- Incorrect Units paid (if applicable)
- Correct Units
- Amount Medicaid paid
- Amount that Medicaid should have paid
- Amount paid by Medicare or any other third party (if applicable)

Self-Disclosure Abbreviated Statement

Examples to be self-disclosed using the Self-Disclosure Abbreviated Statement:

- Routine credit balance/coordination of benefits overpayments;
- Typographical human errors;
- Routine Net Available Monthly Income (NAMI) adjustments;
- Instance of missing or faulty authorization for services due to human error;
- Instance of missing or insufficient support documentation due to human error;
- Inappropriate rate, procedure or fee code used due to typographical or human error;
- Routine recipient enrollment issue

For disclosures using the Self-Disclosure Abbreviated Statement OMIG requires:

- Provider Federal Employer Identification Number (FEIN) or Social Security Number (SSN
- Provider Name or DBA
- Contact Name, title, phone number and email
- Overpayment Identification Period
- TCN(s) of voided or adjusted claim(s)
- Overpayment Reason for each voided or adjusted claim
- Total amount voided or adjusted during the Identification Period

2. Wait for a response and provide additional information if requested

OMIG will review the submission and determine eligibility to participate in the Self-Disclosure Program. For disclosures made through a Self-Disclosure Full Statement, the Medicaid entity/Provider will receive notification from OMIG with a project or case number for reference.

OMIG may ask for additional information to process the submission, or to determine eligibility for an installment payment plan requiring a SDCA. If requested, the Medicaid entity/Provider must respond within the time frame indicated in the request. Failure to do so may result in the determination that the Medicaid entity/Provider has become non-compliant with the Self- Disclosure process. The consequences for failing to cooperate with the Self-Disclosure process are detailed below in section #4 Compliance with the Self-Disclosure Process.

3. Determination and Payment

After OMIG's review of all self-disclosure submission material provided in a Self-Disclosure Full Statement, the Medicaid entity/Provider will receive a Determination Notice for their disclosure case.

It is expected that Medicaid entities/Providers will implement the corrective action they have specified in their Self-Disclosure Full Statement to prevent recurrence of the disclosed issue. For those Medicaid entities/Providers required to adopt and implement an effective compliance program, implementation (or failure to implement) corrective action(s) will be taken into consideration during any compliance program review by OMIG.

If OMIG determines an overpayment is due, OMIG will send a Determination Notice confirming the overpayment amount, and the instructions regarding repayment.

To remain compliant with the self-disclosure process, payment of the full overpayment amount, plus any interest, must be paid within fifteen (15) days from the date of the Determination Notice, or no later than the expiration of the deadline to report, return, and explain, unless the Medicaid entity/Providers had previously requested and was approved for an installment repayment agreement (SDCA).

Payment can be made by:

- Lump-sum check, money order or electronic check payment. Please do not send payment in with your submission.
- Voids or Adjustments of the overpaid claims. These transactions should be completed prior to submission.

In certain circumstances and at the sole discretion of OMIG, installment repayment terms may be permitted. All installment payment agreements will require the Medicaid entity/Providers to execute a Self-Disclosure Compliance Agreement (SDCA) within fifteen (15) days from the date of the Determination Notice. Medicaid entities/Providers will be required to demonstrate financial need by including a detailed request for consideration of installment payments with their Self-Disclosure Full Statement, along with copies of any requested financial documentation.

4. Compliance with the Self-Disclosure Process

Once a Medicaid entity/Provider has submitted a Self-Disclosure Full Statement or a Self-Disclosure Abbreviated Statement, they must remain compliant and cooperate with the self-disclosure process and share any additional information that may be requested.

Violations of Self-Disclosure process include but are not limited to:

- Providing false material information in any disclosure documents
- Failure to cooperate in validating the overpayment amount disclosed
- Intentional omission of material information from any disclosure documents, including the failure to submit a completed Self-Disclosure Full Statement when directed.
- Failure to pay the overpayment amount and interest as agreed

- Failure to execute the SDCA
- Violation of the provisions detailed in the SDCA

Violations of the Self-Disclosure Process, including the SDCA, shall result in:

- Termination of the Medicaid entity's/Provider's participation in the self-disclosure process. The Medicaid entity's/Provider's 60-day timeframe will un-toll. Failure to report, return, and repay a Medicaid overpayment within 60 days from identification is a violation of SOS § 363-d
- OMIG may seek to impose penalties pursuant to SOS §145-b(4)(a)(iii) for failure to report, return, and explain the overpayment
- Other penalties that may be available under State and Federal law

Please note that OMIG may use disclosed information and shall pursue any civil or criminal penalty that might apply to the misconduct disclosed as part of the program process.

Monetary Penalties

In addition to recovery of any overpayment, failure to participate or meet the requirements of the self-disclosure process may result in monetary penalties.

SOS §145-b(4) Penalty for failure to report, return and explain:

- The penalties imposed for failure to report, return, and explain shall be based on the guidelines specified in SOS § 145-b(4) and the process outlined 18 NYCRR Part 516.
- This penalty is not to exceed $10,000.00 per item or service, except when a penalty under this section has been imposed on the Medicaid entity/Provider within the previous five years. In those cases, the penalty shall not exceed $30,000 per item or service.

Disclosing Damaged, Lost or Destroyed Records

Pursuant to Title 18 of the New York Codes Rules and Regulations, Section 504.3, providers are required to prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program and furnish the records, upon request. **If a provider becomes aware that their records have been damaged, lost or destroyed they are required to report that information to the Self-Disclosure Program as soon as practicable, but no later than thirty (30) calendar days after discovery.**

How to Report

A submission for lost, destroyed, or damaged records requires completion of a Statement of Lost or Destroyed Records form and submission of any accompanying documentation to support the report of loss or damaged records.

For reports of lost, destroyed, or damaged records OMIG requires:

- A detailed explanation of the event that caused the loss, destruction, or damage of records and
- Identification of the records affected including document type, Medicaid recipients affected, dates of service; etc. and
- Identification of the steps taken to report the lost, destroyed, or damaged records.

OMIG's Response

A notification letter detailing the acceptance of the report will be issued to the provider or the provider's authorized representative.

Recordkeeping

OMIG's receipt and acknowledgement of a provider's Self-Reporting Notification does not absolve the provider of its recordkeeping responsibilities. The paid claims and/or program associated with the lost/destroyed records remain available for audit, review, or investigation. OMIG will evaluate whether there are mitigating circumstances for the failure to maintain these documents in conjunction with any audit, review or investigation that involves the reportedly lost/destroyed records.

For More Information

Contact OMIG's Self-Disclosure Unit by email at: selfdisclosures@omig.ny.gov.