EPIC MANAGEMENT, L.P.
BEAVER MEDICAL GROUP, L.P.
EPIC HEALTH PLAN

ADMINISTRATIVE POLICY AND PROCEDURE
COMPLIANCE

SUBJECT: Review of Potential Federal Health Care Program Overpayments	
DRAFTED BY: Sherry Miller, CCO	**DATE:** 8/17/2020
REVIEWED BY:	**DATE:**
REVISED BY:	**DATE:**
APPROVED BY: Compliance Committee	**DATE:** 8/17/2020
BOARD APPROVAL DATE: 8/18/2020	
EFFECTIVE DATE OF POLICY: 9/1/2020	

1. **PURPOSE:** This EPIC Policy on the Review of Potential Federal Health Care Program Overpayments sets forth EPIC's processes for (1) reviewing potential Overpayments (including, but not limited to, those that may arise from Personnel reports), and (2) the quantification and repayment of Overpayments.

2. **ATTACHMENTS:** N/A.

3. **DEFINITIONS:**

a. All capitalized terms used but not defined in this Policy shall have the meaning attributed to them in the EPIC Compliance Program Definitions Policy.

b. In addition, the following capitalized terms shall have the following meanings for purposes of this Policy:

i. "Identification" of an Overpayment occurs when either:

(1) EPIC has determined that it received an Overpayment and quantified the amount of the Overpayment; or

(2) EPIC should have, through the exercise of reasonable diligence, determined that it received an Overpayment and quantified the amount of the Overpayment.

ii. "Overpayment" refers to any FFS Overpayment or any Managed Care Overpayment.

(1) "FFS Overpayment" refers to any funds that EPIC receives or retains under any fee-for-service Federal Health Care Program that EPIC determines, after applicable reconciliation and quantification, was paid to or retained in error, meaning that EPIC is not entitled to such funds under such fee-for-service Federal Health Care Program.

(2) "Managed Care Overpayment" refers to any funds that EPIC receives or retains from any Federal Health Care Program managed care payor that EPIC determines, after applicable reconciliation and quantification, was paid or retained by EPIC in error, meaning that EPIC is not entitled to retain such funds from the Federal Health Care Program managed care payor under contract and applicable law.

iii. "PFS Department" refers to EPIC's Patient Financial Services Department.

iv. "Potential Substantial Overpayment" refers to an Overpayment of at least One Hundred Thousand Dollars ($100,000).

v. "Substantial Overpayment" refers to a Potential Substantial Overpayment that is determined by the Corporate Compliance Officer, in consultation with Health Care Counsel, to be a Substantial Overpayment based on the relevant facts and circumstances.

4. **POLICY:** EPIC, under the direction of the Corporate Compliance Officer (or their designee) and/or Health Care Counsel, as appropriate, shall (i) report and return all FFS Overpayments to the appropriate Federal Health Care Program no later than sixty (60) days after the date of Identification, (ii) report and return all Managed Care Overpayments to the appropriate Federal Health Care Program managed care payor to the extent and in the manner required by contract and applicable law, and (iii) ensure that appropriate action is taken to prevent Overpayments from recurring.

a. **Review of Potential Overpayments**

i. Determining Whether There is Credible Information of a Potential Overpayment.

(1) For every suspected Overpayment reported by a Personnel member, the Corporate Compliance Officer (or their designee) shall make a preliminary, good faith inquiry into the allegations to determine whether there is credible information of a potential Overpayment.

(2) The Corporate Compliance Officer (or their designee) also shall review all findings from the Compliance Department's proactive compliance activities (e.g., audits performed in connection with EPIC's centralized annual risk assessment and internal review process) to determine whether there is credible information of a potential Overpayment.

ii. Initiation of Internal Investigation; Investigators.

(1) With the exception of Overpayments arising from Routine Processing Errors (which shall be addressed by EPIC's PFS Department or Risk Adjustment Department, as applicable, in accordance with the EPIC Policy on the Duty to Report Suspected Federal Health Care Program Overpayments), if the Corporate Compliance Officer (or their designee) determines that there is credible information of a potential Overpayment, the Corporate Compliance Officer shall initiate and oversee an internal investigation to determine whether EPIC actually received an Overpayment. In undertaking an internal investigation of this kind, the Corporate Compliance Officer will consult and coordinate with the appropriate EPIC department, officer, and/or designee, including, but not limited to, EPIC's PFS Department, and with Health Care Counsel.

(2) Depending on the nature and severity of the potential Overpayment (e.g., for potential Overpayments involving a significant number of potentially affected claims or encounters, or complex reimbursement rules), the Corporate Compliance Officer shall:

(a) Consult with Health Care Counsel and consider utilizing Health Care Counsel and/or other outside legal counsel to assist in conducting the internal investigation(s);

(b) Consider whether submission of potentially affected claims or encounters should be suspended until the investigation has been completed.

iii. Investigation.

(1) The Corporate Compliance Officer, in consultation with any other person(s) assisting with the investigation shall conduct the investigation in accordance with the EPIC Review of Compliance Concerns Policy.

(2) If the Corporate Compliance Officer determines that the relevant act or omission at issue does not give rise to an Overpayment, the Corporate Compliance Officer (or their designee) will document in writing why no Overpayment has been identified and close the investigation.

(3) If the Corporate Compliance Officer determines that there is an Overpayment, the Corporate Compliance Officer (or their designee) shall conduct an analysis to determine:

(a) The cause of the act or omission giving rise to the Overpayment;

(b) How long the act or omission occurred;

(c) Where the act or omission occurred (e.g., one site or multiple sites); and

(d) If the act or omission is still occurring or has been mitigated.

(4) The Corporate Compliance Officer shall conduct (or oversee) the investigation described in this section with reasonable diligence. While EPIC generally expects that the Corporate Compliance Officer will complete the investigation no later than six (6) months following the receipt of credible information of a potential Overpayment, the time required to complete the investigation may be longer depending on the specific facts and circumstances (e.g., with respect to potential Overpayments that may be addressed through a government disclosure).

b. **Quantifying Overpayments**

i. FFS Overpayments

(1) If the Corporate Compliance Officer determines, through the investigation process described above, that a FFS Overpayment exists, the Corporate Compliance Officer shall conduct a claims audit to quantify the amount of the FFS Overpayment. The Corporate Compliance Officer will consult and coordinate with the appropriate EPIC department, officer, and/or designee, including, but not limited to, EPIC's PFS Department, and with Health Care Counsel.

(2) In designing the claims audit, the Corporate Compliance Officer shall determine:

(a) The parameters for determining the universe of affected claims, including the appropriate lookback period, and

(b) Whether the audit shall consist of (i) a review of all affected claims, or (ii) a review of a statistically valid random sample of claims with extrapolation.

(3) For claims audits that consist of a review of a statistically valid random sample of claims with extrapolation, the Corporate Compliance Officer shall consult with Health Care Counsel and consider utilizing an outside statistician to assist with the claims audit. The outside statistician may be engaged directly by EPIC or under privilege.

ii. Managed Care Overpayments

(1) If the Corporate Compliance Officer determines, through the investigation process described above, that a Managed Care Overpayment exists, the Corporate Compliance Officer shall notify the Federal Health Care Program managed care payor and may, after consultation with such Federal Health Care Program managed care payor, conduct an audit to quantify the amount of the Managed Care Overpayment or provide additional information to the Federal Health Care Program managed care payor as needed for the Federal Health Care Program managed care payor to quantify the amount of the Managed Care Overpayment. The Corporate Compliance Officer will consult and coordinate with the appropriate EPIC department, officer, and/or designee, including, but not limited to, EPIC's Managed Care Finance Department and Health Care Counsel.

(2) In designing any such audit, the Corporate Compliance Officer shall determine:

(a) The parameters for determining the universe of affected managed care patients, encounters, or incidents, as relevant, including the appropriate lookback period, and

(b) Whether the audit shall consist of (i) a review of all affected managed care patients, encounters or incidents, as relevant, or (ii) a review of a statistically valid random sample of affected managed care patients, encounters, or incidents, as relevant, with extrapolation.

(3) For audits that consist of a review of a statistically valid random sample of managed care patients, encounters, or incidents with extrapolation, the Corporate Compliance Officer shall consult with Health Care Counsel and consider utilizing an outside statistician to assist with the audit. The outside statistician may be engaged directly by EPIC or under privilege.

c. **Report and Return of Overpayments**

i. FFS Overpayments

(1) Governmental Disclosures.

(a) The Corporate Compliance Officer, in consultation with Health Care Counsel, shall determine whether a governmental disclosure is appropriate or warranted for reporting a FFS Overpayment.

(b) In the event that a governmental disclosure is determined to be appropriate or warranted, the Corporate Compliance Officer, in consultation with Health Care Counsel, shall ensure that the disclosure is submitted to the relevant government agency no later than sixty (60) days after the date of Identification.

(2) Rebilling and/or Refunding of All Other FFS Overpayments. With the exception of FFS Overpayments addressed in a governmental disclosure, the Corporate Compliance Officer (or their designee) shall ensure that all FFS Overpayments are rebilled and/or refunded by EPIC's PFS Department no later than sixty (60) days after the date of Identification.

(a) For each FFS Overpayment (other than those addressed in a governmental disclosure), EPIC's PFS Department, under the direction of the Corporate Compliance Officer (or their designee), shall issue claims corrections and/or refunds to the relevant Federal Health Care Program(s). The PFS Department also shall return to the patient any copayment or deductible amounts to which EPIC determines it is not entitled.

(b) The PFS Department shall document that the FFS Overpayment was refunded and submit this documentation to the Corporate Compliance Officer.

ii. Managed Care Overpayments

(1) The Corporate Compliance Officer shall ensure that all Managed Care Overpayments are reported and returned to the extent and in the manner required by contract and applicable law.

d. **Corrective Actions and Ongoing Monitoring**

i. For all Overpayments, the Corporate Compliance Officer (or their designee) shall determine appropriate corrective action to address the underlying cause of the Overpayment, and monitor the effectiveness of the same, in order to prevent its recurrence.

ii. The Corporate Compliance Officer (or their designee) shall periodically, but no less than quarterly, review all identified Overpayments to determine whether there are any patterns or common issues for which further review is warranted. The Corporate Compliance Officer shall report all findings from these reviews to the Compliance Committee.

e. **Potential Substantial Overpayments**

i. The Corporate Compliance Officer shall report all Potential Substantial Overpayments to the Board.

ii. For any Potential Substantial Overpayment, the Corporate Compliance Officer, in consultation with Health Care Counsel, shall assess whether, based on an analysis of the relevant facts and circumstances, there is a Substantial Overpayment for which EPIC has a reporting obligation under the CIA.

(1) This facts-and-circumstances assessment shall include, but not necessarily be limited to, consideration of the following factors: (a) the number of affected claims (for FFS Overpayments) or affected managed care patients, encounters or incidents (for Managed Care Overpayments); (b) the time period over which the Overpayment occurred; (c) the dollar amount involved; and (d) the nature of the error that led to the Overpayment. A Substantial Overpayment may be the result of an isolated event or a series of occurrences.

(2) All Substantial Overpayments shall be reported to HHS-OIG, in compliance with the requirements of the CIA.

f. **Documentation**

i. In conformity with generally accepted compliance review procedures, final copies of work papers and reports generated in connection with the review of any potential Overpayment shall be maintained in the EPIC Compliance Program files.

ii. All documentation enumerated above shall be maintained in compliance with the EPIC Compliance Program Records Retention Policy.