alameda county behavioral health MENTAL HEALTH & SUBSTANCE USE SERVICES	By: Carol F Burton **Carol F. Burton, MSW** Interim Behavioral Health Director
POLICY TITLE **Identifying, Reporting, and Recovering Overpayments**	**Policy No:** 1350-1-4 **Date of Original Approval**: 4/24/19 **Date(s) of Revision(s):**

PURPOSE

This policy addresses the need to identify Drug Medi-Cal overpayments, promptly report the overpayment to the state, and recover overpayment if passed along to a provider. If potential fraud is suspected, this will also be reported to the state.

AUTHORITY

California Department of Health Care Services (DHCS) Intergovernmental Agreement for Drug Medi-Cal Organized Delivery System services for substance use disorder treatment, Exhibit A, Attachment I, section H, part 5, ii, b.

> *Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the Department,*

SCOPE

All Alameda County Behavioral Health Care Services (BHCS) administrative units and substance use disorder providers under a contract with BHCS.

POLICY

This policy establishes procedures to avoid errors that lead to overpayment and to monitor for overpayment. Furthermore, it establishes the requirement to promptly report overpayments and suspected fraud to the DHCS analyst assigned to BHCS.

If the payment has been passed along to a provider, BHCS Network Office will notify the provider and arrange to either reduce the provider's next payment by the amount of the overpayment or to receive repayment from the provider.

BHCS Finance will return the overpayment to DHCS by a reduction to a subsequent payment. If this is not possible, then BHCS will seek Board approval to repay the overpayment.

PROCEDURE

The following procedures are implemented and shall be followed in order to avoid situations that may result in Drug Medi-Cal overpayment:

I. Verification of Services Claimed to Drug Medi-Cal

a. Multiple checkpoints exist before services are billed to Drug Medi-Cal. Initially, providers document services in the BHCS Clinicians Gateway electronic health record by selecting the appropriate service code and duration of services. When the note is finalized, it will be included in the nightly download to InSYST for billing. The following day, a report displaying all service entries is sent to the provider for validation. Next, at month end providers receive a page for each client with services for the month. This report is designed as an audit tool for comparison to client charts. Finally, two test claims are sent to providers so services can again be verified, before the actual Medi-Cal claim is sent to the state.

b. BHCS Quality Assurance conducts clinical chart audits of all SUD contracted providers. At a minimum, these audits are done annually. Quality Assurance has established clinical documentation standards, and an audit instrument provides a documented system for monitoring and evaluating the quality, compliance, and appropriateness of care.

c. The Medi-Cal Billing Unit monitors 835 denials resulting from duplicate services. While same day billing is now allowed for most services, duplicate dosing should result in a denial and will be referred to BHCS Quality Assurance to research.

II. Report to Identify Payments Exceeding Cost

InSYST Report PSP 144 identifies all payments in the system that are in Refunded status. A payment (or part of a payment) moves into refunded status when the receivable is overpaid. This may occur when a client has more than one insurance policy.

III. Verification of Rates Claimed to Medi-Cal

a. A variance between the claimed rate and the correct interim rate will be detected when Finance completes quarterly revenue projections by program.

b. A variance between the claimed rate and the allowable cost to deliver services will be detected when the cost report is completed. Since the cost report settles to the lesser of allowable cost or the usual and customary charge, any overpayment will be returned.

IV. Medi-Cal Processing Error

The Medi-Cal Billing Unit imports 835 data, allowing each claimed service record (837) to be appended with approval data. The paid amount is compared to the claimed amount and the anticipated payment amount based on aid code. The Unit analyzes any anomalies, follows up with providers and other BHCS departments, and voids approved services if necessary. Variances between claims and payments will be reported to the state.

V. Audit Disallowance

BHCS Quality Assurance notifies providers in writing if services are disallowed per an audit. The provider is given 30 days to appeal, after which time the Medi-Cal Billing Unit will void the services. At year end, Drug Medi-Cal utilization reports are prepared for the cost report, and the voided services will not be claimed. When DHCS completes its cost report review 18 months later, the state system will also exclude the voided units from Drug Medi-Cal reconciliation reports.

In addition, the notification from Quality Assurance is sent to Finance, which will track repayments and follow up as needed. The Cost Reporting Unit will contact the provider to arrange a repayment plan if there is no reponse within 30 days. The replayment schedule

will be communicated to and approved in writing by the provider, so that repayment can be monitored and enforced.

CONTACT

BHCS Office	Current as of	Email
Finance	March, 2018	

DISTRIBUTION

This policy will be distributed to the following:

- BHCS Staff
- BHCS County and Contract Providers

ISSUANCE AND REVISION HISTORY

Original Authors: Andrea Judkins, Jill Louie

Original Date of Approval: 04/24/2019 by Carol F. Burton, MSW, Interim Behavioral Health Director

Date of Revision:

Revise Author	Reason for Revise	Date of Approval by (Name)

DEFINITIONS

Use matrix below

Term	Definition