

Arkansas Medicaid Inspector General



SELF-DISCLOSURE PROTOCOL

2013

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The following protocol is based on the federal Provider Self-Disclosure Protocol (SDP) found at 63 Fed. Reg. 58,399 (1998). This 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 exorbitant costs associated with each. Although the Office of Inspector General (OIG) does not administer any health and human services programs, it does consult with these programs when seeking to recover overpayments.

I. Introduction

The Arkansas Medicaid Inspector General's Office (OMIG) is making a concerted effort to recognize providers who find problems within their own organizations, reveal (self-disclose) those issues, and return inappropriate payments.

A. Purpose of Self-Disclosure Protocol

OMIG's principal purpose in publishing this Protocol is to provide guidance to Medicaid providers that decide voluntarily to disclose irregularities in their dealings with the Medicaid program. OMIG 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, OMIG'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.

B. 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.

C. 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 provides the OMIG's views on what are the appropriate elements of an effective investigative and audit working plan to address instances of non-compliance. Although OMIG will accept a self-disclosure in any form, disclosures that comply with the Protocol will expedite the OMIG'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.

D. 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, OMIG understands that it is essential to develop and maintain a fair, reasonable process that will be mutually beneficial for both the State of Arkansas and the provider involved. Because a provider's disclosure may involve anything from a simple error to intentional fraud, OMIG 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 OMIG 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 OMIG staff had discovered the matter independently. While the specific resolution of self-disclosures depends upon the individual merits of each case, OMIG may extend the following benefits to providers who initiate a good-faith self-disclosure:

1. Extended repayment terms;
2. Waiver of penalties or sanctions;
3. Allowance for probe sample sizes that are less rigorous than the standards employed by the OIG;
4. Timely resolution of the overpayment; and

5. Recognition of the effectiveness of the provider's compliance program and a decrease in the likelihood of imposition of an OMIG Corrective Action Plan with additional required reviews;

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

B. Self-Disclosure to OMIG versus Administrative Recoupment

OMIG 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. Factors to Consider

The Provider should consider multiple factors in determining whether to self-disclose to OMIG, including the following:

1. Nature of the noncompliant event;
2. Amount involved;
3. Patterns or trends of repeated program violations or routine errors;
4. Duration of non-compliance;
5. Systemic failures within Provider's compliance program;
6. Circumstances leading to the non-compliant event;
7. Potential violation of fraud or abuse laws; and
8. Existence of a pre-existing Corrective Action Plan Agreement.

D. Effect of Self-Disclosure

OMIG 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, OMIG may conclude that the disclosed matter warrants a referral to other county, state, or federal authorities for additional civil or criminal enforcement. If OMIG 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, OMIG 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 to the Office of the Medicaid Inspector General, P.O. Box 1437, Slot S-414, Little Rock, AR 72203-1437. Submissions by telecopier, facsimile or other electronic media may not be considered.

B. Contents of Report

The submission should include the following information:

1. Name, address, provider identification number(s), other provider billing number(s), and tax identification number(s) of the disclosing Medicaid Provider. If the provider is an entity that is owned, controlled or is otherwise part of a system or network, include a description or diagram describing the pertinent relationships and the names and addresses of any related entities, as well as, any affected corporate divisions, departments or branches.
2. Name and address of the disclosing entity's designated representative for purposes of the voluntary disclosure.
3. Whether the Medicaid Provider has knowledge that the matter is under current inquiry by any government agency or contractor. If so, identify the governmental entity or individual representatives involved.
4. Whether the Medicaid Provider is under investigation or other inquiry for any other matters relating to a state or federal health care program. If so, identify the nature of the investigation and the governmental entity or individual representatives involved.
5. Full description of the nature of the matter being disclosed, including the type of claim, transaction or other conduct giving rise to the matter, the names of entities and individuals believed to be implicated, and an explanation of their roles in the matter.
6. Dates of the program violations and any other relevant periods.
7. The type of health care program affected, as well as any other involved parties, such as contractors, carriers, intermediaries and third party payers.
8. Citations to any state or federal laws or regulations that may have been violated, along with the reasons why the disclosing provider believes that a statutory or regulatory violation may have occurred.
9. Citations to any program policies that may have been violated, along with the reasons why the disclosing provider believes that a program violation may have occurred.
10. A certification by the Medicaid 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.

C. Additional Substantive Information

As part of its participation in the disclosure process, the disclosing Medicaid Provider will be expected to conduct an internal investigation and a self-assessment, and then report its findings to the OMIG. The internal reviews may occur after the initial disclosure of the matter. OMIG may agree, for a reasonable period of time, to forego an investigation of the matter if the provider conducts the reviews in accordance with the Internal Investigation Guidelines and the Self-Assessment Guidelines set forth below.

IV. Internal Investigation Guidelines

All disclosures to the OMIG under the Provider Self-Disclosure Protocol should be accompanied by a narrative report based on an internal investigation conducted by the Medicaid Provider. The narrative report should demonstrate due diligence in the investigation, and should account for the following facts:

A. Nature and Extent of the Improper payments or Improper program or practice

1. Identify the potential causes of the incident or practice, e.g., intentional conduct, lack of internal controls, circumvention of corporate procedures or governmental regulations.
2. Describe the incident or practice in detail, including how the incident or practice arose and continued.
3. The division, departments, branches or related entities involved.
4. The impact on, and risks to, health, safety, or quality of care posed by the incident, with sufficient information to allow OMIG to assess the immediacy of the impact and risks, the steps that should be taken to address them.
5. The period(s) during which the incident or practice occurred.
6. The corporate officials, employees or agents who knew of, encouraged, or participated in, the incident or practice.
7. The corporate officials, employees or agents who knew or should have known of, but failed to detect or report, the incident or practice.
8. Estimate the monetary impact of the incident or practice upon the state Medicaid Program, pursuant to the Self-Assessment Guidelines below.

B. Discovery and Investigation

1. Describe how the incident or practice was identified, and the origin of the information that led to its discovery.
2. Names and titles of the individuals who detected the matter.
3. Names and titles of the individuals who investigated and documented the matter. If the investigators were external to the company, describe their business relationship with the provider and provide their office contact information.
4. Detailed chronology of the investigative steps in the internal inquiry, including:
 - (a) A list of all individuals interviewed, including each person's business address and telephone number, position, and title during both the relevant period and at the time the disclosure is being made.
 - (b) Dates of all interviews and the subject matter of each interview, with narrative summary of each. The health care provider will be responsible for advising the individual to be interviewed that the information the individual provides ay, in turn, be provided to the OMIG.
 - (c) Names of any individuals who refused to be interviewed and the reasons cited.
 - (d) Description of files, documents, and records reviewed with sufficient particularity to allow their retrieval, if needed.
 - (e) Narrative summary of auditing activity undertaken and a summary of the documents relied upon in support of the estimation of losses. These documents and information must accompany the report, unless the calculation of losses is undertaken pursuant to the Self-Assessment Guidelines, which contain specific reporting requirements.

C. Organizational Responses to the Matter

1. Describe the actions by the provider to stop the inappropriate conduct.
2. Describe the actions taken by the provider to prevent a recurrence, e.g., new accounting or internal control procedures, increased supervision by higher management, or training.
3. Describe any related businesses affected by the inappropriate conduct in which the provider is involved, and all efforts by the provider to prevent a recurrence of the incident or practice in the related business.
4. Any disciplinary action taken against corporate officials, employees and agents as a result of the disclosed matter.
5. Any additional self-disclosure notices sent by the provider to other governmental or regulatory agencies in connection with the disclosed matter.
6. Identify any risks to health, safety, or quality of care posed by the incident, and the measures taken by the provider to address those risks.

D. Certification

Certification by the Medicaid provider stating that the investigation was conducted in good faith, the submitted investigative summary contains true, accurate, and complete information, and that it contains no material misstatements or omissions of fact or law.

V. Self-Assessment Guidelines

The Medicaid provider should conduct an internal financial assessment of the monetary impact of the disclosed matter, and prepare a report of its findings. This self-assessment may be performed at the same time as the internal investigation, or commenced after the scope of the incident has been established. In either case, the OMIG will verify the Medicaid provider's calculation of program losses. Accordingly, the financial assessment should conform to the following guidelines.

A. Approach

The self-assessment should adhere to one of the following methodologies:

1. Dollar-for-dollar review all of the claims affected by the disclosed matter for the relevant period; or
2. Statistically valid random sample of the claims that can be projected to the population of claims affected by the matter for the relevant period.

The reviewer's determination should be based on the size of the population believed to be implicated, the variance of characteristics to be reviewed, the cost of the self-assessment, the available resources, the estimated duration of the review, and other factors as appropriate.

B. Pre-Approval

Regardless of the chosen methodology, the provider may submit a Corrective Action Plan describing its proposed self-assessment process to the OMIG. OMIG will review the proposal and, where appropriate, provide comments on the plan. At its option, the OMIG may choose to monitor any of the review activities to verify that the process is undertaken correctly and to validate the review findings.

C. Corrective Action Plan

The Corrective Action Plan should address the following issues:

1. *Review Objective*: There should be a statement clearly articulating the objective of the review and the procedure or combination of procedures applied to achieve the objective.
2. *Review Population*: The plan should identify the population from which the sample(s) will be extracted and to which any findings will be extrapolated. In addition, there should be an explanation of the methodology used to identify, characterize, and develop the population and the basis for this determination.
3. *Sources of Data*: The plan should provide a full description of the sources of the information upon which the review will be based, including the legal or other standards to be applied, the sources of payment data, and the documents that will be relied upon.
4. *Personnel Qualification*: The plan should identify the names, titles, and credentials of those individuals involved in any aspect of the self-assessment, including statisticians, accountants, auditors, consultants and medical reviewers.

D. Statistically Valid Random Sampling Plan

If the provider bases the financial review upon a statistically valid random sample, the Corrective Action Plan should also include the following:

1. *Sampling Unit*: The plan should define the sampling unit, that is, the specific designated elements that comprise the population of interest.
2. *Sampling Population*: The plan should identify the totality of the sampling units from which the sample will be selected.
3. *Sample Size*: The size of the sample must be determined through the use of a probe or discovery sample. Accordingly, the plan should include a description of both the probe sample and the full sample. At a minimum, the full sample must be designated to generate an estimate with a ninety (90) percent level of confidence and a precision of twenty-five (25) percent of the mean overpayment, but must comprise at least 75 items. The probe or discovery sample must contain at least thirty (30) sample units and can be used as part of the full sample only if the seed value and population applicable to the probe sample and the full sample are identical. The error rate found in the probe or discovery sample may be used in determining the sample size in the full sample.

4. *Random Numbers*: Both the probe sample and the full sample must be selected through random numbers. The source of the random numbers used must be shown in the sampling plans. Microsoft Access, Microsoft Excel, ACL, SAS, SPSS, Minitab, RATSTATS, and other such software can generate such random numbers.
5. *Sample Design*: Unless the disclosing provider demonstrates the need to use a different sample design, the self-assessment should use simple random sampling. If necessitated, the provider may use stratified, cluster, or multistage sampling. Details about the strata, stages and clusters should be included in the description of the audit plan.
6. *Estimate of Review Time per Sample Item*: The plan should estimate the time expended to locate the sample items and the staff hours expended to review a sample item.
7. *Characteristics Measured by the Sample*: The sampling plan should identify the characteristics used for testing each sample item. For example, in a sample drawn to estimate the value of overpayments due to duplicate payments, the characteristics under consideration are the conditions that must exist for a sample item to be a duplicate. The amount of the duplicate payment is the measurement of the overpayment. The sampling plan must also contain the decision rules for determining whether a sample item entirely meets the criterion for having characteristics or only partially meets the criterion.
8. *Missing Sample Item*: The sampling plan must include a discussion of how missing sample items were handled and the related rationale.
9. *Other Evidence*: Although sample results should stand on their own in terms of validity, sample results may be combined with other evidence in arriving at specific conclusions. If appropriate, indicate what other substantiating or corroborating evidence was developed.
10. *Estimation Methodology*: Because the general purpose of the review is to estimate the monetary losses to the Federal health care programs, the methodology to be used should be based on variable sampling theory. As such, the difference method is generally used, although the ration method, mean-per-unit method, regression method, and mean-dollars-per-mean-error method may also be employed. At its option, OMIG may request information on the rationale for method selection. To estimate the amount implicated in the disclosed matter, the provider must use the mean point estimate. The statistical estimates must be reported using a ninety (90) percent confidence level. Microsoft Access, Microsoft Excel, ACL, SAS, SPSS, Minitab, RATSTATS, and other such software can generate these estimates. Contact OMIG if assistance is needed in this area. If a random sampling approach is used, the random numbers and, thereby, the random sample must be reproducible by reusing the seed value.
11. *Reporting Results*: The sampling plan should indicate how the results will be reported at the conclusion of the review. In preparing the report, enough, details must be provided to clearly indicate what estimates are reported.

VI. Payments

A. Interim Payments

Upon receipt of a Medicaid provider's disclosure submission, the OMIG 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 OMIG 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, OMIG will verify the request on a claim-by-claim basis. After verification, OMIG will 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. OMIG 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; and
8. Financial solvency of the provider.

Repayments may occur through periodic payments to OMIG or by authorizing OMIG 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 OMIG in making a repayment determination.

D. Final Payment

Upon completion of the verification process, OMIG will notify the provider of the full settlement amount. If the full settlement amount is greater than the amount disclosed by the provider, OMIG will send the provider a notice of potential overpayment. Upon receipt of the notice, the provider may request an informal review, and the case will proceed according to the applicable administrative rules.

VII. OMIG's Verification

A. Verification Process

Upon receipt of the provider's self-disclosure submission, the OMIG may attempt to verify the submission if necessary. OMIG will convey its findings back to the provider. While the OMIG 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 OMIG's verification and validation processes, OMIG investigators or audits may request access to audit work papers and supporting documents. Although OMIG expects to receive documents and information from the provider without the need to resort to compulsory methods, OMIG 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 OMIG, 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, OMIG may submit a written statement of the provider's cooperation and other mitigating factors to the DOJ or other state or federal enforcement agencies.