Policy:	HH.5000
Title:	**Provider Overpayment Investigation and Determination**
Department:	Office of Compliance
Section:	Fraud, Waste, and Abuse – Special Investigations Unit
CEO Approval:	*/s/ Michael Hunn 11/19/2024*
Effective Date:	12/01/2016
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy establishes an effective system for the review of suspect claims to detect and prevent Fraud, Waste, and Abuse (FWA) within a CalOptima Health program, in accordance with federal and state regulations, and to identify resulting Overpayments for recoupment.

II. POLICY

A. The CalOptima Health Special Investigations Unit (SIU) shall be responsible for identifying Overpayments for recoupment opportunities that may emerge in the course of an FWA investigation.

B. During the course of an investigation, the SIU team shall review claims, review Medical Records and other records, and/or conduct interviews or surveys to either verify if services were rendered, or if services were appropriately billed, as applicable.

C. Medical Records shall be established and maintained in accordance with CalOptima Health Policy GG.1603: Medical Records Maintenance.

D. CalOptima Health may receive complaints of suspected FWA from any of the following sources, including but not limited to:

1. Compliance and Ethics Hotline;
2. Internal audits;
3. Internal operational reviews;
4. External audits, including audits conducted by consultants and regulatory agencies;
5. FWA software runs;
6. Pharmacy Benefits Manager (PBM);
7. Compliance Committee;

8. Delegation Oversight Committee (DOC);

9. Internal department referrals;

10. Claims auditors who review Provider claims through the claims review software system;

11. Internal and external claims and compliance audits; and

12. Any other source that identifies potential FWA.

III. PROCEDURE

A. Identification of Overpayments

1. CalOptima Health's SIU team shall investigate any identified Overpayments that are suspected to be the result of inappropriate and/or inaccurate billing activity.

2. CalOptima Health's SIU team shall utilize investigation software or internal data reports to identify suspicious billing patterns, or industry-identified FWA trends, to determine whether CalOptima Health disbursed an Overpayment to a Provider.

   a. Suspicious billing patterns or trends may include, but are not limited to, Providers who:

      i. Demonstrate a pattern of billing their claims with inappropriate or inaccurate modifiers;

      ii. Repeatedly submitting claims for procedures, items or units of services, that are excessive and/or not covered by Medi-Cal or Medicare;

      iii. Submit claims for particular procedure codes at a significantly higher frequency than other Providers within the same specialty.

      iv. Bill with inaccurate NPI(s);

      v. Bill a large proportion of high-level Evaluation and Management (E/M) Codes; or

      vi. Prescribe an unusual amount of Schedule II Medications in relation to their peers.

B. Investigation Protocol of Overpayments

1. FWA investigations may identify inappropriate and inaccurate activity through a variety of means, including but not limited to, inbound complaints, proactive data analysis, collaboration meetings with internal and external departments, and the Centers for Medicaid & Medicare Services (CMS) Health Plan Management System (HPMS) memoranda.

2. CalOptima Health's SIU investigation may include the following elements:

   a. Interviews with Members, Providers, and other witnesses;

   b. Data analysis, including but not limited to analysis of claims billing, payment trends, and procedure code combinations, etc.;

c. Review of Medical Records and other records by the SIU investigator, or, for complex reviews, a clinician, such as a Registered Nurse (RN), Licensed Vocational Nurse (LVN), Medical Doctor (MD), and Doctor of Pharmacy (Pharm. D); and

d. All relevant and pertinent data/information, as appropriate, that will aid in completing the investigation to closure.

3. The SIU shall obtain Medical Records and other records from the Provider if it is necessary to determine if an Overpayment occurred. The SIU may utilize a copy service, as needed, to obtain Medical Records from a Provider.

   a. The SIU shall make three (3) attempts to obtain Medical Records and other records from a Provider.

   b. The number of records requested may vary depending on the nature of the investigation.

   c. Records shall be submitted to the SIU within the timeframes outlined below:

      i. Initial request – records must be returned within fifteen (15) business days.

      ii. Second request – records must be returned within five (5) business days.

      iii. Final warning – records must be received the next business day.

      iv. An extension may be granted upon written request and at the discretion of the SIU management.

   d. Failure to provide records after the final warning has been issued in writing or past the approved extension deadline will result in CalOptima Health initiating an Overpayment request due to the Provider's not being able to corroborate services rendered.

   e. Providers must adhere to the requirements for the Medical Record and other record request set forth in the demand letter issued by the Office of Compliance.

4. CalOptima Health's SIU shall consult with qualified personnel in reviewing the Medical Records and other records. If CalOptima Health's SIU investigation yields findings, and if an Overpayment is determined to be an appropriate administrative action that is based on potential FWA, inappropriate, and/or inaccurate billing, SIU shall proceed with Overpayment recoupment activities. SIU shall provide guidance to CalOptima Health Claims Administration Department, including drafting the content of Overpayment letters.

C. Documentation

1. If SIU identifies an Overpayment as a result of an investigation, an "Overpayment Spreadsheet" shall be provided by CalOptima Health SIU team in detail with each determination to the Claims Administration Department.

2. The "Overpayment Spreadsheet" shall include the minimum necessary information to adequately review, investigate, and determine if claims were overpaid. The "Overpayment Spreadsheet" may include the following details, as applicable:

   a. Tax ID;

b. Billing Provider NPI;

c. Rendering Provider NPI;

d. Member name;

e. Unique Member identification (ID) number;

f. Claim number;

g. HCPCS/CPT Code;

h. ICD-9 and/or ICD-10 codes;

i. Revenue codes;

j. Place of service;

k. Modifier;

l. Date(s) of service;

m. Number of services billed;

n. Number of units allowed;

o. Billed amount;

p. Allowed amount;

q. Paid amount;

r. Overpayment amount; and

s. Overpayment recovery reason.

D. Resolution

1. If CalOptima Health's SIU investigation has identified an Overpayment, and does not contain a component of FWA, the Overpayment shall be referred to CalOptima Health Claims Administration Department for Overpayment set up, collection, and recoupment, as outlined in CalOptima Health Policy FF.2001: Claims Processing for Covered Services for which CalOptima Health is Financially Responsible.

2. The SIU shall notify the Department of Health Care Services (DHCS) and/or the CMS of Overpayment determinations, in accordance with CalOptima Health Policy HH.1107: Fraud, Waste, and Abuse Investigation and Reporting and as required by law and state and federal regulations, but no later than ten (10) business days to the DHCS Contract Manager and DHCS Audits and Investigations Unit, and thirty (30) calendar days to the CMS, after the date CalOptima Health identified the Overpayment.

3. If the claim(s) review determines that the billing was improperly paid and if the payment was determined to be based on inappropriate and/or inaccurate billing activity, and it contains a component of FWA, CalOptima Health's SIU shall:

    a. Document the rationale for assessing the Overpayment;

    b. Initiate recoupment process of the Overpayment through appropriate channels, including coordination with the CalOptima Health Claims Administration Department;

    c. Send the Provider the required demand letter, signed by SIU management;

    d. Continue collection activity, as necessary, and assist respective department(s) as needed with investigation in coordination with the CalOptima Health Claims Administration Department, such as prepayment reviews;

    e. Notify the DHCS and/or the CMS of Overpayment determinations, in accordance with CalOptima Health Policy HH.1107: Fraud, Waste, and Abuse Investigation and Reporting and as required by law and state and federal regulations, but no later than ten (10) business days to the DHCS Contract Manager and DHCS Audits and Investigations Unit, and thirty (30) calendar days to CMS, after the date CalOptima Health identified the Overpayment.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health PACE Program Agreement
D. CalOptima Health Policy FF.2001: Claims Processing for Covered Services for which CalOptima is Financially Responsible
E. CalOptima Health Policy GG.1603: Medical Records Maintenance
F. CalOptima Health Policy HH.1107: Fraud, Waste, and Abuse Investigation and Reporting
G. CMS Guidance for Reporting Medicare Advantage Organization and/or Sponsor Identified Overpayments for CMS
H. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-026: Actions Required following Notice of a Credible Allegation of Fraud
I. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-011: Treatment of Recoveries Made by the Managed Care Health Plan of Overpayments to Providers (Supersedes APL 17-003)
J. California Health and Safety Code §1371
K. Social Security Act, §1128J(d)
L. Title 22, California Code of Regulations (C.C.R.), §§51045, 51047, 51458.1
M. Title 28, California Code of Regulations (C.C.R.), §1300.71
N. Title 42, Code of Federal Regulations (C.F.R.), §§405.980, 405.982, 405.984, 405.986, 405.978, 405.990, 422.326 and 423.360
O. Title 42, Code of Federal Regulations (C.F.R.), §§411.404, 411.406, 411.408
P. Title 45, Code of Federal Regulations (C.F.R.), §79
Q. Welfare and Institutions Code, 14172, 14172.5, 14173, 14176, 14177

VI. REGULATORY AGENCY APPROVAL(S)

Date	Meeting	Response
09/01/2023	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/2016	HH.5000	Provider Overpayment Investigation and Determination	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.5000	Provider Overpayment Investigation and Determination	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.5000	Provider Overpayment Investigation and Determination	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.5000	Provider Overpayment Investigation and Determination	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.5000	Provider Overpayment Investigation and Determination	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.5000	Provider Overpayment Investigation and Determination	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.5000	Provider Overpayment Investigation and Determination	Medi-Cal OneCare PACE
Revised	07/01/2023	HH.5000	Provider Overpayment Investigation and Determination	Medi-Cal OneCare PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	11/07/2024	HH.5000	Provider Overpayment Investigation and Determination	Medi-Cal OneCare PACE

IX. GLOSSARY

Term	Definition
Abuse	Medi-Cal: Practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program. OneCare: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima Health and the OneCare program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima Health and the OneCare program. A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima Health and the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima Health and the Medi-Cal program.
Delegation Oversight Committee (DOC)	A subcommittee of the Compliance Committee chaired by the Director(s) of Delegation Oversight to oversee CalOptima Health's delegated functions. The composition of the DOC includes representatives from CalOptima Health's departments as provided for in CalOptima Health Policy HH.4001: Delegation Oversight Committee.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or Fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347.)
Medical Record	Medi-Cal: The record of a Member's medical information including but not limited to, medical history, care or treatments received, test results, diagnoses, and prescribed medications. OneCare: A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal. PACE: Written documentary evidence of treatments rendered to plan Members.
Overpayment	For purposes of this policy, a payment disbursed in excess amounts properly payable under Medicare and Medi-Cal statutes and regulations.

Term	Definition
Provider	Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Schedule II Medication	Narcotic substances with a high potential for Abuse which may lead to severe psychological or physical dependence.
Waste	Medi-Cal: The overutilization or inappropriate utilization of services and misuse of resources. OneCare: The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources, overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare Program.