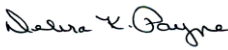
 <p style="text-align: center;"><b>POLICIES AND PROCEDURES</b></p> <p style="text-align: center;">State of Tennessee Department of Intellectual and Developmental Disabilities</p>	Policy #: 80.4.5	Page 1 of 5
	Effective Date: February 23, 2015	
	Distribution: B	
Policy Type: Community/Waiver	Supersedes: P-003 Recoupment & Sanctions Policy	
Approved by:   Debra K. Payne, Commissioner	Last Review or Revision: January 5, 2015	
Subject: RECOUPMENT		

- I. **AUTHORITY:** 42 CFR 431.958 and 960(b) (1) and (b) (2), 42 CFR 433.304 and 455.2, Improper Payments Elimination and Recovery Act (IPERA), Provider Agreement, Tennessee Code Annotated (TCA) 4-3-2708, TCA 4-18-101 through 4-18-106, TCA 33-2-408 (c), TCA 33-3-103, TCA 71-5-181 through 71-5-184, and the Deficit Reduction Act of 2005.
- II. **PURPOSE:** To ensure consistency in application of recoupments when improper payments or fraud have been identified.
- III. **APPLICATION:** This policy applies to divisions, units, or regional departments of the Department of Intellectual and Developmental Disabilities (hereinafter DIDD or Department) that are involved in the application of recoupments when an improper payment or fraud has been identified.
- IV. **DEFINITIONS:**
  - A. **Abuse** shall mean, for the purpose of this policy, incidents or practices of providers that are inconsistent with generally accepted accounting principles and/or result in unnecessary cost to the Medicaid program, or in reimbursement of services that are not medically necessary or that fail to meet professionally recognized standards for health care.
  - B. **Approved Provider or Provider** shall mean a provider who has been approved by DIDD to provide one or more HCBS waiver services and/or state-funded services.
  - C. **Centers for Medicare and Medicaid (CMS)** shall mean the United States federal agency which administers Medicare, Medicaid, and the Children's Health Insurance Program.
  - D. **Fraud**, for the purpose of this policy shall mean the deception or misrepresentation made by a person with the knowledge that the deception could result in an unauthorized benefit to himself or another person. For purposes of this definition, no proof of specific intent to defraud is required.
  - E. **Grier Order** shall mean the Grier Revised Consent Decree, a court-ordered settlement that was the result of a class action lawsuit called *Grier vs. Wadley*. The Grier order outlines requirements which ensure adequate notice and procedural protection upon the denial of Medicaid services to an eligible person.
  - F. **Home and Community Based Services (HCBS) waiver or waiver** shall mean a waiver approved for Tennessee by the Centers for Medicare and Medicaid Services to provide services to a specified number of Medicaid eligible individuals who have an intellectual disability and who meet criteria for Medicaid reimbursement in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). The HCBS waivers for people

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with intellectual disabilities in Tennessee are operated by the Department of Intellectual and Developmental Disabilities with oversight from TennCare, the state Medicaid agency.

- G. **Improper Payment** shall mean any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements, including payments made for acts of fraud, waste, or abuse. An improper payment also includes any payment that was made to an ineligible recipient, payment for non-covered services, duplicate payments, payments for services not received, and payments that are for the incorrect amount. In addition, when it cannot be determined whether a payment was proper because of insufficient or lack of documentation, this payment must also be considered an improper payment.
- H. **Opportunity for Recoupment Review (ORR)** shall mean the DIDD process that allows the provider to request a review and submit additional documentation that may reduce or eliminate a recoupment.
- I. **Pre-Admission Evaluation (PAE)** shall mean the Medicaid data collection form used to document that the person supported meets the initial level of care criteria for reimbursement of services through an HCBS waiver, an ICF/IID, or a nursing facility.
- J. **Provider Agreement** shall mean a signed agreement between the department of Finance and Administration (F&A), DIDD, the Bureau of TennCare, and an approved provider that specifies the terms and conditions a provider must meet to receive reimbursement for services provided, as amended.
- K. **Rebill** shall mean the process by which a provider authorizes the reduction of a future payment by the recoupment amount.
- L. **Recoupment** shall mean the recovery of money paid to an approved provider due to the provider's failure to comply with DIDD or TennCare requirements for service provision or documentation of such.
- M. **Recoupment Letter** shall mean a written document that describes the improper payment and the recoupment to be applied.
- N. **Review** shall mean a methodical examination, audit or survey.
- O. **TennCare** shall mean the single state Medicaid Agency responsible for administering the state's Medicaid Program.
- P. **Waste** shall mean the extravagant, careless or needless expenditure of government funds or the consumption of government property that results from deficient practices, systems, controls or decisions. The term also includes improper practices not involving prosecutable fraud.
- Q. **2362** shall mean the form returned from the **Bureau of TennCare** upon approval of admission into HCBS waiver services.
- V. **POLICY:** Recoupment of improper payment(s) to providers shall be recovered in a consistent fashion and in accordance with current statutes, rules and regulations.

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**VI. PROCEDURES:**

- A. Identification of issues for which recoupments may be applied may originate from DIDD, TennCare and the Office of the Comptroller or other state and federal monitoring agencies. Such issues may involve non-compliance with DIDD or TennCare/Medicaid rules, the Grier order, regulations and policies or non-compliance with other state and federal requirements.
- B. Reasons for Recoupment
  - 1. The Department or its designated fiscal agent may recoup funds for circumstances such as, but not limited to, the following as listed below. See the DIDD Provider Manual for guidelines for documenting services.
    - a. No PAE or Transfer Form (for ISC Agencies, if applicable) for persons supported.
    - b. No forms as required for eligibility for persons supported (for ISC Agencies, if applicable).
    - c. No current Medicaid Waiver Re-evaluation.
    - d. Billing for services for which no or inadequate supporting documentation is found.
    - e. Billing for services, which were not provided.
    - f. Billing for multiple services concurrently except where specifically authorized by DIDD.
    - g. Not meeting defined requirements of service category (consistent lack of adherence to fundamental requirements of each service category).
    - h. License required to be maintained by the Provider has lapsed or expired.
    - i. Services provided at locations other than those specifically approved for an individual.
    - j. Amounts or types of service approved by DIDD which were billed but were not provided.
    - k. Required and approved staffing or caseload ratios were not met.
    - l. Services performed by Provider employees, subcontractors or volunteers who have not completed background or registry checks or who have not completed applicable training requirements.
    - m. Return of Overpayments. In accordance with the Affordable Care Act (ACA) and TennCare policy and procedures, Provider shall report overpayments and, when it is applicable, return overpayments within sixty (60) days from the date the overpayment is identified. Overpayments that are not returned within sixty (60) days from the date the overpayment was identified may result in a penalty pursuant to state or federal law.

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- n. Providers who receive more than Five Million Dollars (\$5,000,000) per year from Federal health programs shall comply with the provisions of 42 United States Code (USC) § 1396(a)(68) *et seq.* as applicable, regarding policies and education of employees, subcontractors and volunteers as regards the terms of the False Claims Act and whistleblower protections.

**C. Recoupments**

1. DIDD or its designated fiscal agent may recoup funds for reasons as described in VI.B.1 of this policy.
2. Recoupment correspondence shall be sent by DIDD via secure email or certified mail to the executive director of the provider agency and/or the board chair or agency owner, if applicable.
3. All recoupment correspondence shall be copied to the Deputy Commissioner of Program Operations, Assistant Commissioner of Quality Management, Office of General Counsel and Regulatory Affairs, Director of Provider Services, Director of Business Services, Director of Risk Management and Licensure, Regional Office Director, Regional Director of Compliance, and Bureau of TennCare.
4. If an ORR is requested by the provider then the procedures outlined in the Provider Agreement section 22(b)(i-vi) shall be followed.
5. If an ORR is not requested by the provider then the improper payments shall be recovered using one or more of the following methods:
  - a. The provider shall be directed to submit rebill document(s) to the appropriate regional office within thirty (30) calendar days of receipt of the recoupment letter or within thirty (30) calendar days of transmission of the email notification (as applicable). If the provider does not submit the rebilling documents in accordance with the above timelines the regional office shall affect the recoupment in accordance with a timeline established by DIDD Business Services.
  - b. The provider shall be directed to submit a paper check within thirty (30) calendar days of receipt of the recoupment letter or within thirty (30) calendar days of transmission of the email notification (as applicable) to:
 

Department of Intellectual and Developmental Disabilities  
ATTN: Office of Fiscal Services  
400 Deaderick Street  
Nashville, Tennessee 37243
  - c. The recoupment amount shall be withheld from future payments until the entire recoupment amount is recovered, as described in section VI.D. of this policy.
6. The Provider shall not bill or accept any payment from the person supported, his/her parent(s), guardian(s), spouse, or any other legally responsible party for any recoupment amounts.

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- D. Installment Payment Plan
  - 1. After a recoupment amount has been finalized, the agency director or board chair may contact the department within five (5) business days of receipt of the recoupment letter or within five (5) business days of transmission of email notification (as applicable) to request an installment payment plan.
    - a. All requests for installment payment plans shall be submitted in writing to the Director of Risk Management and Licensure.
    - b. The Director of Risk Management and Licensure shall review the provider's request, approve or deny it, and inform the provider in writing (via email or certified mail) of the decision within thirty (30) calendar days of receiving the provider's request.
- E. The department may initiate legal action for failure to return recouped payments as directed.
- F. Recoupments shall be reported to TennCare as specified in the Department's contract to operate the HCBS waiver programs.

VII. **CQL STANDARDS:** None

VIII. **REVISION HISTORY:** N/A

IX. **TENNCARE APPROVAL:** December 19, 2014

X. **ATTACHMENTS:** N/A