Overpayments

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When was the last time your credit balance report was reviewed and worked thoroughly? Working the report on a regular basis is an essential step in the revenue cycle.

Understandably, many practices focus on the collection of insurance and patient payments portion of the revenue cycle. Overpayments are often the last priority. However, medical practices can face considerable compliance exposure when it comes to overpayments, especially with Medicare.

In February 2016, the Centers for Medicare and Medicaid Services (CMS) published its final rule addressing a requirement in the Affordable Care Act relating to Medicare Part A and Part B providers and suppliers. The Rule, effective March 14, 2016, includes a provision that providers report and return an overpayment, regardless of the cause, within 60 days after the date it identifies the overpayment for government programs. An overpayment is considered funds received and kept under the Medicare programs to which the practice is not entitled. CMS published the Final Rule that offered some clarity about when the 60-day rule started. “The 60-day time period begins when either the reasonable diligence is completed or on the day the person received credible information of a potential overpayment if the person failed to conduct reasonable diligence and the person in fact received an overpayment.” 81 Fed. Reg at 7661 (“Rule”).

Reasonable diligence would consist of both proactive compliance activities of a possible overpayment and reactive investigations. CMS expects providers to participate in proactive compliance actions, such as random audits, that assist in the identification of potential overpayments. When a provider receives credible information about a possible overpayment then he or she must perform a reasonable inquiry to determine if an overpayment exists and quantify the overpayment amount. The provider has 6 months after receiving the information to respond to the inquiry; and if it is determined that an overpayment did occur, the provider has 60 days to report and return the overpayment.

If a provider fails to comply, he/she could potentially face False Claims Act liability, civil monetary penalties and exclusion from federal healthcare programs. In addition, providers can expect increased enforcement of this provision by the government or whistleblowers.

When analyzing a practice’s revenue cycle, our medical practice consultants often find that physicians and managers do not proactively research credit balances and issue refunds in a timely manner. The Final Rule focuses on Medicare overpayments; however, it is important to work all overpayments. Ignoring credit balances can also have an effect on your total accounts receivable (AR). Depending on how a practice filters their AR report,

your balances may be distorted. If accounts with credit balances are included in the AR report, your balances will be offset by the credits causing the overall AR balance to be less than it actually is. The benchmark for credit balances should be less than two percent of your total AR.

What if a refund cannot be returned because a patient has moved and left no forwarding address? Each state has an escheat law that directs how your practice should handle refunds to the payers or patients.

Failure to comply with the timely investigation of overpayments exposes the practice to considerable risk. If your practice does not have an established routine for auditing for overpayments, this should move to the top of your "To Do" list. The fines associated with the False Claims Act are three times the amount of the false claims plus civil penalties of $10,957 to $21,916 per false claim.
