

CREDIT BALANCES: What to do about them and when

Recent Federal and State Developments

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Patient Accounting: Credit Balance Problem Solving

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CREDIT BALANCES

Credit Balances: accounts receivable with payments and allowances exceeding total charges

- Providers may not retain any overpayments regardless of \$ amount
- If refund impossible, credit balance becomes unclaimed property payable to the state

TOPICS

- Common Causes of Credit Balances
- Risks of Unresolved Credit Balances
- Federal Payer Requirements
- Oregon Payer Requirements
- State Unclaimed Property Laws
- HFMA Recommendations
- Best Practices

COMMON CAUSES OF CREDIT BALANCES

- INSURER OVERPAYMENTS OR DUPLICATE PAYMENTS
- COORDINATION OF BENEFITS CONFLICTS
- INCORRECT PAYMENT RATES IN HOSPITAL BILLING SYSTEM
- INSURER REFUSES TO ACCEPT PROVIDER-IDENTIFIED OVERPAYMENT
- UP-FRONT COLLECTIONS (COINSURANCE/DEDUCTIBLES)
- CHARGE CORRECTIONS
- HOSPITAL BILLS AND IS PAID FOR OUTPATIENT SERVICES INCLUDED IN BENEFICIARY'S INPATIENT CLAIM
- UNCASHED REFUND CHECKS

RISKS OF UNRESOLVED CREDIT BALANCES

- Medicare/Medicaid penalties
- Class action litigation
- Misstated revenues
- Wasted time and resources
- Lost payment opportunities

FEDERAL PAYER REQUIREMENTS

MEDICARE OVERPAYMENTS

Medicare reporting requirements:

- Quarterly reporting on Form CMS-838
- Due w/in 30 days of close of each calendar quarter
- Hospital officer certification
- Repayment required upon submission
- Possible suspension of Medicare payments for noncompliance
- Monitored through cost reporting process

MEDICAID OVERPAYMENTS

- State agencies not required to monitor Medicaid credit balances
- 3 OIG Reports (1989, 1993 and 1995)
 - *Cited substantial Medicaid credit balances nationwide*
 - *Recommended reporting and repayment requirement similar to Medicare*
- CMS concurred w/ OIG's recommendations, but ultimately declined to act

OFFICE OF INSPECTOR GENERAL (OIG) REVIEW ACTIVITIES

- OIG continues to focus on both Medicare and Medicaid credit balances
- OIG's Compliance Program Guidance for Hospitals
- OIG's Work Plan for FFY 2011

FEDERAL LIABILITY

Patient Protection and Affordable Care Act (PPACA)

- *Must report and repay Medicare/Medicaid overpayments w/in 60 days of “identification” or “applicable reconciliation,” whichever is later*
- *Retention of an identified overpayment after the 60-day period considered an “obligation to pay” subject to a False Claims Act (FCA) enforcement action as a so-called “reverse false claim”*
- *PPACA does not define “identification”*
- ***60-day reporting/repayment requirement conflicts with Medicare quarterly reporting requirement***

FEDERAL LIABILITY

(continued)

False Claims Act (FCA)

- 3 sections of FCA could result in liability for retention of overpayments
- FCA penalties include:
 - *Triple damages*
 - *Plus penalties of \$5,500 to \$11,000 per claim*
- Beware of Federal FCA *qui tam* or “whistleblower” provisions

Damages vs. Penalties

Example: 100 small false claims

Total Damages:

*\$10 false claim x 100
= \$1,000 (actual damages)
x (triple damages)
= \$3,000 max*

Total Penalties:

*\$10 false claim (or any
amount) x 100
@ \$11,000 per occurrence
= \$1.1 million max*

Total FCA Liability

**Add \$3,000 damages to penalty
amount**

= \$1,103,000

FEDERAL LIABILITY

(continued)

Other federal statutes provide for:

- Civil money penalties
- Criminal liability/imprisonment
- Program exclusion
- HIPAA fraud provisions w/ penalties including fines and/or imprisonment of up to 10 years
- Various other Federal statutes and theories of liability

OREGON PAYER REQUIREMENTS

OREGON MEDICAID REQUIREMENTS

Oregon regulations specifically address:

Overpayments

- *“Payment(s) made by Division to a provider in excess of the correct Division payment amount for a service. Overpayments are subject to repayment to the Division.”*

False claims

- *“a claim that a provider knowingly submits or causes to be submitted that contains inaccurate, misleading or omitted information and such inaccurate, misleading or omitted information would result, or has resulted, in an overpayment.” (Emphasis added.)*

OREGON MEDICAID REQUIREMENTS

(continued)

Provider-identified overpayments

- *Must reimburse DMAP “immediately” via Individual Adjustment Requests or refund*

DHS identified overpayments

- *Refund due within thirty (30) calendar days from date of notification*

If 3rd party makes payment after providers receives Medicaid payment

- *Provider must refund DMAP amount received from 3rd party within 30 days of date of receipt*
- *Failure to refund considered “concealment of material facts and grounds for recovery and/or sanction”*

OREGON STATE LAW LIABILITY

Oregon False Claims Act –

- *“False claim” = “A false or fraudulent statement to conceal, avoid or decrease an obligation to pay.” (emphasis added)*
- *Statute imposes liability where a person knows of or ignores the false or fraudulent nature of the claim*
- *No proof required that a person “specifically intended to defraud a public agency” to establish that the person acted with knowledge*

OREGON STATE LAW LIABILITY

(continued)

Oregon False Claims Act Penalties –

- *Liability for all damages, plus penalties equal to the greater of \$10,000 for each violation, OR*
- *An amount equal to twice the amount of damages incurred for each violation*
- *Court may mitigate penalties for substantially the same acts or omissions in a judgment under the Federal FCA or CMP Law*
- *No qui tam or “whistleblower” provisions under Oregon’s FCA, but Oregon law does protect whistleblowers*

OREGON SENATE BILL 508 – OVERPAYMENTS / UNDERPAYMENTS

S.B. 508 signed into law on July 3, 2009

- *Imposes timeframes for health plans seeking refunds of overpayment and for providers seeking additional funds in cases of underpayments*

Brought on behalf of the Oregon Medical Association (OMA) to:

- *provide structure to the overpayment process, and correct disadvantages of providers*

OREGON SENATE BILL 508

(continued)

In support of the bill, OMA representatives cited:

- *Boilerplate health plan contracts*
- *Contracts requiring claims submission w/in 60 to 90 days, sometimes a year, from the date of service*
- *Conversely, health plans often seek refunds 2-3 years later, but require repayment within 30 days or impose offsets of future payments*
- *Short repayment time frames insufficient to allow enough time to research and dispute validity of refund request*
- *Offsets often hard to reconcile*
- *Audit contractors hired on contingent basis to identify and collect alleged overpayments*

Overpayment Provisions (ORS 743.912)

- Plans must request refunds w/in 2 years of payment
- Request must be in writing and explain cause of overpayment
 - *Exception: Cases of fraud or billing abuse*
- Provider has 30 days after receipt of refund request to contest
- If provider does not contest, must pay within 60 days after receipt of refund request
- If provider does not pay, plan may offset future claims
- Plan cannot require payment of a contested refund earlier than 6 months after provider receives request

Overpayment Provisions

(ORS 743.912) *(continued)*

Coordination of Benefits

- *Plan may not request a refund from provider unless*
 - Refund requested within 30 months after payment date
 - Request in writing and explain cause of overpayment
 - Request includes name and mailing address of entity with primary payment responsibility

- *Plan cannot require payment of a contested refund earlier than 6 months after provider receives request*

Overpayment Provisions

(ORS 743.912) *(continued)*

No time limit for Plan to request a refund if:

- *A 3rd party is found responsible for satisfaction of a claim
“as a consequence of liability imposed by law”
(e.g., court order),*

AND

- *Plan unable to recover directly from 3RD party because
3RD party has already paid or will pay provider*

Overpayment Provisions (ORS 743.912) *(continued)*

KEY POINTS:

- *New law does not apply to Medicare or other federal payer claims*
- *Statutory provisions may not be altered by contract*
- *Statute applies to contracts entered into or renewed on or after January 1, 2010*
 - *NOT date of overpayment request*
- *Statute does not impose penalties for noncompliance*
- *Disputes governed by contract and/or civil court*

Underpayment Provisions (ORS 743.917)

Allows providers similar timeframe for seeking additional funds for claims underpayment **but** with important differences:

- *No requirement that health plan formally contest refund request*
- *Providers must allow health plan at least 6 months to remit additional payment*
- *No offset mechanism for providers seeking additional payment*

UNCLAIMED PROPERTY LAWS

Enforcement of unclaimed property laws is up!

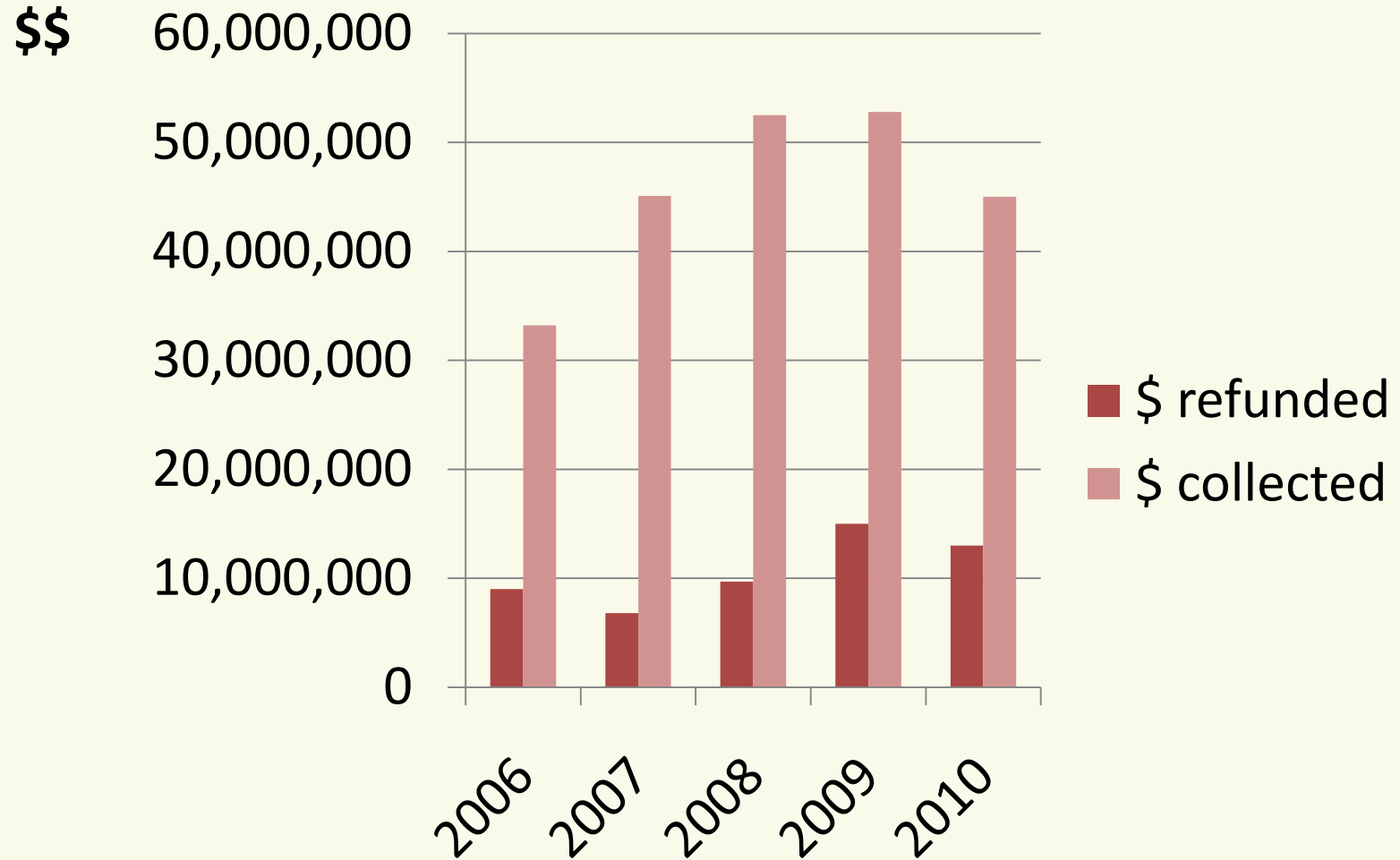
- Great revenue source especially in current economy
- Easy money
 - *Audits usually performed by private contractors*
 - *Paid on contingent fee basis*
 - *States need not expend their own resources to pursue*
- Appearance of credit balance is enough for refund demand

UNCLAIMED PROPERTY LAWS

(continued)

- Auditors often target healthcare providers
 - *Generate significant credit balances*
 - *Payment process usually involves 3+ parties*
 - *Complex billing, payment and accounting rules*
- Few if any administrative remedies, so disputes must be brought in civil court
- No statute of limitations
- No lower limit dollar value exemption

Oregon Unclaimed Property Collections and Refunds 2006 - 2010



OREGON UNCLAIMED PROPERTY RULES

- Oregon law defines “unclaimed property” to include accounts receivable credit balances
- A holder of unclaimed property must:
 - *make a diligent effort to return property valued at \$100 or more to rightful owner*
 - *locating efforts must be documented and completed at least 60 days before filing unclaimed property report with state (prior to August 1st of report year)*
- After 3 years, credit balances considered unclaimed property subject to reporting and payment to Oregon Department of State Lands

OREGON UNCLAIMED PROPERTY RULES

(continued)

- Report due between Oct 1 and Nov 1 annually for property abandoned as of June 30th of report year
- All amounts reportable, but property valued at <\$50 per owner may be reported in the aggregate
- Allows for audit of holder accounts
- No statute of limitations
 - *auditors may go back to effective date of unclaimed property statute August 20, 1957*
- Penalties up to \$50,000 for corporations that fail to report

UNCLAIMED PROPERTY AUDITS

Legal considerations if audited:

- Retain legal counsel
- HIPAA concerns
- Compliance with reporting and payment obligations going forward

HFMA RECOMMENDATIONS

- Assess current volumes and backlogs
 - *To determine current exposure and staffing needs*
- Establish goals
 - *threshold of credit balance amount/volume your facility can reasonably tolerate*
 - *# of accounts to be worked daily, etc.*
- Review current processes
 - *streamline identification/resolution*
 - *consider dedicated staffing*
- Automate manual processes – internal/external software

HFMA RECOMMENDATIONS

(continued)

- Monitor regularly:
 - *Unresolved Medicare credits*
 - *Workload estimates*
 - *Progress reports summarizing new credits created and accounts resolved as compared to goals*
 - *Employee productivity*
 - *Transaction summaries to determine causes of credit balances and final disposition*

HFMA RECOMMENDATIONS

(continued)

- Minimize potential fraud related to refund checks
 - *E.g., use payers' processes and systems for reporting overpaid accounts allowing for resolution on later payment voucher eliminating need for refund check*
- Control payer contracted auditors
 - *Require current letter from each payer authorizing vendor audit*
 - *Allow access only to payer-specific accounts where authorization on file*
 - *Do not issue refund checks to vendor – seek voucher recoveries by payer*

BEST PRACTICES

- Identify true overpayments
 - *Analyze credit balances using*
 - patient admissions forms
 - payer remittance advices
 - patient accounts receivable details
 - other hospital records
 - *Identify whether patient is an eligible Medicare beneficiary*
 - *Identify primary payer and other liable insurers*
 - *Adhere to applicable Medicare payment rules*
 - *Verify that credit balances are due and refundable*

BEST PRACTICES

(continued)

- Medicare recommends identification of credit balances on a daily basis with immediate resolution
- Identify true overpayments
- Work credit balances oldest to newest
- Until CMS clarifies application of PPACA 60-day reporting/repayment rule vs. quarterly reporting/repayment requirement, consider policies that “fast track” reporting and refunding of suspected overpayments by federal payers to ensure compliance with PPACA mandatory requirements

BEST PRACTICES

(continued)

- Return an overpayment to all payers (federal, state, private, patient), regardless of amount, upon identification
- Identify preventable causes of credit balances
- Implement system to identify contract rates
- Monitor staff compliance with policies/procedures
- Verify validity of all refund requests

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