General Information

Policy Name:	Overpayments & Refunds
Category:	Risk Management – Corporate Compliance
Applies To:	Patient Financial Services, Finance, Risk Management, Corporate Compliance & Patient Access
Key Words:	Overpayment, Refund, 60 Day Rule, Credit, Balance, Self-Disclosure, Payer, Medicare, Medicaid
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Policy

The purpose of this policy is to provide for timely and appropriate refunds for documented overpayments in compliance with third party payer requirements, including obligations under the Patient Protection and Affordable Care Act (ACA) section 6402[1] applicable to Medicare and Medicaid.

Overpayments are any funds that Crouse Hospital receives or retains to which, after applicable reconciliation, it is not entitled.[2] Overpayments occur when the amount of money the Hospital receives for services or supplies is in excess of the amount due and payable under a particular health care program, by a third party payer, including Medicare and Medicaid, or by a self-pay patient. This includes any amount not authorized to be paid under the medical assistance (MA) program, whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, waste, abuse or mistake. Events leading to overpayments may include, but are not limited to, duplicate payments or payment for non-covered services. Once verified, overpayments must be refunded to the appropriate payer or patient and/or processed according to the payer contracts.

As a result of changes under the ACA, it is crucial to report a suspected overpayment from Medicare or Medicaid within 60 days, as failure to do so could result in liability under the False Claims Act. Procedures for reporting and returning overpayments from Medicare or Medicaid are discussed under Section V. of this policy.

Procedure

Identification of Potential Overpayments:

Patient Financial Services (PFS) staff, government or private payers, as well as patients, can initiate requests for refunds. Audits will also be conducted on a periodic basis, to verify the accuracy of Crouse's claims submission process and reimbursement practices (see Compliance: Federal and State False Claims Acts (P0079)). The PFS staff will evaluate and process refunds, as appropriate, after a thorough review. The review will incorporate an evaluation of billing, expected reimbursement, remittance notices and

[1] See also Medicare regulations at 42 CFR §§ 401.301 – 401.305
[2] This definition of overpayment is based on Medicare rules. Crouse has elected to use this same definition for other payers as well.

Explanations of Benefits (EOBs), payer and patient correspondence documentation, or other documentation as necessary. Corporate Compliance may get involved and work with the PFS staff and Business Office Management in the event that an overpayment is identified through a compliance-related activity.

Non-Governmental Payers:

A. Commercial Payer or Patient Request Refund of Overpayment

1. The PFS Rep receives a request for a refund for a potential overpayment(s) from either a third party payer (government or private), or patient.
2. The PFS Rep will review the request and will verify the overpayment for refund after thorough review of the documentation.
3. The PFS Rep will promptly process for refund if appropriate to the payer or patient, or will follow guidelines for overpayment processes per payer contract. For Medicaid and Medicare overpayments, voided claims and adjusted claims will be submitted to those payers as soon as the overpayment is verified so that they can retract the overpayment on a future remit.
4. Once the PFS Rep has verified that the third party payer (government or private) or patient has made an overpayment, they will first determine if the overpayment can be refunded through an electronic voided claim or adjusted claim. If the overpayment can be refunded through an electronic submission of a voided claim or adjusted claim, then they will send that request to billing. If the PFS Rep determines the overpayment cannot be refunded through a voided or adjusted claim, then they will submit an overpayment letter to the payer with our calculations for expected reimbursement and in this letter, they will advise the payer our calculations show the payer made an overpayment. The PFS Rep will then allow 30 days for the payer to review and retract their overpayment. If the payer doesn't have the ability to retract their overpayment through 835 transactions or by offsetting future payments to the hospital, then the PFS Rep will initiate a paper check refund detailed in step 5 of this procedure. For Non-Medicare/Medicaid overpayments, if the payer doesn't respond to our overpayment letter or the payer responds to our overpayment letter stating they show they paid correctly, then the PFS Rep will Credit Balance Write Off the overpaid amount and notate Soarian Financials of why they're taking this action. If at some point a payer conducts an audit and determines they have overpaid after the overpayment has been Credit Balance Written Off, the PFS Rep will review that correspondence and initiate a refund action (detailed in steps 3 & 4) if the overpayment request is accurate and within appropriate timeframes detailed in that payer's contract.
5. The Manage/Create Refund function should only be performed in the event that an overpayment cannot be refunded through an electronic transaction. The Manage/Create Refund function should be performed in Soarian Financials and the request is also entered onto the Refund request Spreadsheet. Refund paperwork with supporting documentation is kept in the Business Office for Manager to review. The account is noted that the refund is in process.
6. The Manager will review the refund request for accuracy.
7. Any refund over $1,000.00 has to follow an approval process. All refunds over $1,000.00 will be reviewed in detail by the Manager for approval. Refunds over $5,000.00 are sent to the Director for approval, refund requests over $10,000.00 are sent to the CFO for approval. If the Manager cannot verify the overpayment, the request will go back to the PFS staff for further review and clarification.
8. Once the approval process is complete, the Manager will enter the requests onto an approved template report and forward to the Accounts Payable Department for processing.
9. Payers may, pursuant to their contracts with the Hospital, request the refund for an overpayment be processed through future deductions in payments to accommodate the overpayment.

B. Payment Rep or other Patient Account Rep Request Refund of Overpayments

1. Through the usual Account Review process which includes credit balance reports, a PFS Rep may identify a potential overpayment(s) made by a third party payer (government or private), or patient.
2. The PFS Rep will promptly verify the overpayment after thorough review of the documentation.
3. The refund process will then follow steps 3-7 in the above procedure.

C. Non-Routine Processing Errors

- In the event that a review of a potential overpayment(s) reveals more than a routine processing error, warranting further auditing or review, the PFS Rep will promptly inform the Manager and/or Director for appropriate resolution.

D. Medicare Credit Balance Reporting

- Under Medicare guidelines, the hospital is responsible to report any Medicare credit balances quarterly to their fiscal intermediary. The hospital runs reports of all Medicare payer plans for credit balances quarterly. Any credit balance outstanding is submitted electronically to Medicare through the Connex system. A certification page signed by the Billing and Accounts Receivable Manager is also faxed to the fiscal intermediary.

E. Unclaimed or Abandoned Property

1. For some verified overpayments it may be impossible after reasonable attempts for the Hospital to locate or identify the intended recipient of the overpayment.
2. If it is not possible to locate or identify the payer or patient to whom a refund is owed, the Hospital will follow the relevant New York laws pertaining to unclaimed property and/or abandoned property, for resolution of the matter. The Hospital will maintain appropriate records of unclaimed and/or abandoned property.

Overpayments from Medicare and Medicaid

A. The 60 Day Rule

As mentioned above, there is the potential for an overpayment received from Medicare or Medicaid to become the basis for a violation of the False Claims Act (FCA) if such overpayment is not reported or repaid within 60 days of being identified or the date any corresponding cost report is due.

An overpayment is “identified” when a person has, or should have through the exercise of reasonable diligence, determined that the person has received an overpayment and quantified the amount of the overpayment. The 60 day time period begins when either the reasonable diligence is completed (including any activities necessary to quantify the amount of the overpayment) **or** on the day the person received credible information of a potential overpayment and failed to conduct an inquiry. Accordingly, staff should not ignore information regarding the existence of a potential overpayment. It is to Crouse’s benefit to proactively investigate any situation to identify whether an overpayment was received.

For purposes of the 60 Day Rule, an overpayment may be “identified” before it is received (i.e. the date of payment), or the full amount of the overpayment is understood or quantified. The following are some examples of when an overpayment may be “identified”:

- An employee or contractor identifies an overpayment in a phone call or e-mail;
- A patient advises that a service was not received, but was billed;

- A coder identifies a charging or coding concern;
- A Recovery Audit Contractor (RAC) advises that a dual eligible Medicare overpayment has been found;
- OMIG sends a letter regarding a deceased patient, unlicensed or excluded employee or ordering physician;
- Where *qui tam* or government lawsuit allegations arise; or
- When a criminal indictment or information is filed.

Provided Crouse conducts a reasonable inquiry, the 60 day clock will not start to run until Crouse has quantified the amount of the overpayment. However, the investigation of an overpayment should in no event take longer than 8 months (6 months for investigation and 2 months for reporting and returning the overpayment), absent extraordinary circumstances. Thus, as explained below, Crouse will conduct an inquiry to determine if an overpayment was received as soon as the potential overpayment is identified. Crouse will then follow the procedures below for repayment of the overpayment to Medicare and Medicaid, which must be done within 60 days.

B. Medicare Procedure – How to Report and Return Overpayments

Crouse can use any applicable claims adjustment, credit balance, self-reported refund (i.e. voluntary refund process) or other reporting process set forth by the Fiscal Intermediary to report a Medicare overpayment. If a statistical sampling methodology was used to calculate the overpayment, the statistically valid sampling and extrapolation methodology must be included in such a report.

The reporting obligation is also satisfied by making a disclosure under the OIG's Self-Disclosure Protocol or the CMS Voluntary Self-Referral Disclosure Protocol resulting in a settlement agreement. The 60 day deadline for returning overpayments is suspended once OIG or CMS acknowledge receipt of a submission for self-disclosure, and will remain suspended until a settlement agreement is reached or Crouse withdraws or is removed from the self-disclosure process.

Typically, routine overpayments will be handled using the claims adjustment or credit balance process. The Compliance Officer should be notified immediately in the event a non-routine overpayment, such as a significant overpayment or systemic error, is identified. The Compliance Officer, with assistance from legal counsel if necessary, will determine whether self-disclosure through OIG or CMS is required.

1. Credit Balances and Routine Claims[3]

The procedure for routine Medicare overpayments is as follows. When an overpayment is identified on a Medicare account, this information is given to the Medicare Billing Specialist who submits an electronic voided or adjusted claim to Medicare and they retract their payment. We do not, per Medicare policy, submit paper check refunds to Medicare.

With regard to Medicare credit balances, staff follow the instructions contained in the CMS-838. The CMS-838 is specifically used to monitor identification and recovery of "credit balances" owed to Medicare. A credit balance is an improper or excess payment made to a provider as the result of patient billing or claims processing errors. Examples of Medicare credit balances include instances where a provider is:

- Paid twice for the same service either by Medicare or by Medicare and another insurer;

[3] Overpayments may also be reported and returned using the voluntary repayment or "self-reported refund" process through National Government Services ("NGS"). Forms are available through the NGS website. Please refer any questions on which process should be used for a Medicare Overpayment to the Compliance Officer.

- Paid for services planned but not performed or for non-covered services;
- Overpaid because of error made in calculating beneficiary deductible and/or coinsurance amounts;
- A hospital that bills and is paid for outpatient services included in a beneficiary's inpatient claim;
- Overpaid because of a DRG denial;
- Overpaid because of inaccurate coding, charging and/or abstraction of information for inpatient or outpatient accounts.

The CMS-838 is completed by the Billing and Accounts Receivable Manager. This captures any account in a credit balance with a Medicare plan loaded. Once a Medicare overpayment is identified, the above process for voiding and retracting payment is followed. Also, per Medicare regulations, credit balances are reported quarterly directly to National Government Services electronically via the Connex website and is signed by the Billing and Accounts Receivable Manager.

1. Non-Routine Overpayments

As mentioned above, any non-routine overpayments which cannot be handled through the claims adjustment, credit balance, or self-reported refund process should be immediately reported to the Compliance Officer, as they may need to be self-reported via the appropriate self-disclosure process. Typically, this would be through the OIG Self-Disclosure Protocol (SDP).[4] Alternatively, overpayments related to a potential violation of the physician self-referral ("Stark") Law may need to be disclosed via the CMS Self-Referral Disclosure Protocol, and should also be reported to the Compliance Officer.

The Compliance Officer will consult with legal counsel, as necessary, to determine if self-disclosure of an overpayment is necessary.

C. Medicaid – How to Report and Return Overpayments

Overpayments by New York State Medicaid must also be returned and reported within 60 Days of being identified. In the event that an overpayment by Medicaid cannot be reported to OMIG within 60 days, contact the Compliance Officer or legal counsel to discuss how the overpayment should be handled.

1. OMIG Self-Disclosure Process for Overpayments

The repayment of simple, more routine occurrences of overpayments from Fee-for-Service Medicaid will be processed through typical methods of resolution, including voiding or adjusting the claims. In addition, these overpayments will be reported to OMIG within 60 days of identification once they have been corrected.

When such an overpayment is identified on a Medicaid account, this information is given to the Medicaid Billing Specialist who submits an electronic voided or adjusted claim to Medicaid and they retract their payment. We do not, per Medicaid policy, submit paper refunds to Medicaid.

Typically, such overpayments are identified by PFS Representatives while reviewing the aged trial balance. The aged trial balance is reviewed and completed every 30 days. These instructions are contained in the Social Services regulations under 18 NYCRR 540.6, which provides specific details on the Medicaid billing process.

[4] Please note, the SDP is not intended for a matter that does not involve potential violations of federal criminal, civil, or administrative law for which civil money penalties are authorized, such as routine overpayments or errors.

Any potential overpayments that cannot be corrected through simple voids or adjustments should be immediately reported to the Compliance Officer. The Compliance Officer, with assistance of legal counsel, if necessary, will determine whether self-disclosure to OMIG is appropriate, or whether the overpayment should be handled through the administrative billing processes explained above. OMIG does not request restitution at the time of self-disclosure, and will typically confirm the amount of the overpayment before requiring repayment. However, if the overpayment is not reported to OMIG within 60 days of being identified, it could lead to liability under the FCA.

Overpayments involving Medicaid Managed Care Organizations (MCOs) will be reported and returned to the MCO within 60 days of being identified.

References

Patient Protection and Affordable Care Act (ACA) section 6402

Form CMS-838: Medicare Credit Balance Report. http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS838.pdf

National Government Services Voluntary Repayment Forms (Forms are available from the NGS website under the “overpayment” tab)

OMIG Self Disclosure Program - https://omig.ny.gov/provider-resources/self-disclosure

OIG Self-Disclosure Protocol - https://oig.hhs.gov/compliance/self-disclosure-info/

CMS Self-Referral Disclosure Protocol - https://www.cms.gov/medicare/regulations-guidance/physician-self-referral/self-referral-disclosure-protocol

NYS Public Health Law (NYS PHL §32(18)

NYS Social Services Law (SOS) §363-d (6(a)(1) & (2))

NYS OMIG Mandatory Provider Compliance Plan, 18 NYCRR § 521. OMIG’s website is: https://omig.ny.gov/compliance/compliance

Definitions

MA: Medical assistance for needy persons provided under Title 11 of Article 5 of the Social Services Law

Addendums, Diagrams & Illustrations

Not Applicable