PMBA

PROFESSIONAL MEDICAL BILLERS ASSOCIATION

"Certifying Excellence in Medical Billing."

Medical Billing Overpayments - Refunds

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Refunding Overpayments in Medical Billing: Ensuring Fairness and Accuracy

In the dynamic world of medical billing, ensuring accuracy and fairness in financial transactions is paramount. As healthcare professionals, we understand the importance of issuing refunds when necessary, ensuring transparency and trust with our patients and insurance partners.

Refunds of payments within the healthcare system may arise for various reasons, including patient overpayments, insurance company over-reimbursements, or erroneous copayment collections. As custodians of financial integrity, it is our duty to handle such situations with diligence and efficiency.

- Legal Responsibility: Healthcare facilities hold a legal obligation to issue refunds promptly and fairly for any overpayments made by patients or insurance companies. This responsibility demonstrates our commitment to ethical billing practices and fosters confidence in our services.
- Timely Refunds: Patients rightfully expect timely resolution of any overpayment issues. By promptly addressing and processing refunds, we reinforce our commitment to patient satisfaction and financial integrity.
- Ensuring Accuracy: Before issuing refunds, it is essential for our offices to thoroughly verify that the payment is genuinely an overpayment, and not a result of miscommunication or filing errors. This diligence protects both our patients and our reputation.
- Strengthening Trust: Handling refunds with professionalism and transparency builds trust with our patients and insurance partners. It assures them that we prioritize accuracy, fairness, and ethical practices in every aspect of our medical billing process.

The statute provides a definition for overpayment, stating that it refers to a payment made to an individual or entity without entitlement. This can occur in various scenarios, such as billing for services that were not actually provided, offering medically unnecessary services, billing at a higher code than the services delivered, violating the Stark Laws by providing services inappropriately, or delivering services of insufficient quality.

Scenario

A patient, John, visits a physician's office for a medical procedure. The office collects the necessary payment at the time of service, and John pays the specified amount of $200. However, due to a system error, the payment is inadvertently recorded twice, resulting in an overpayment of $200.

Step 1 - Immediate Notification: Upon discovering the overpayment, the office must promptly notify John about the error. Open communication is vital to maintain transparency and assure John that the situation is being addressed.

Step 2 - Patient's Choice: The office offers John two options for resolving the overpayment. He can either have the $200 applied as a credit toward his next visit or choose to receive a refund check for the overpayment amount.

Step 3 - Insurance Overpayment: In another scenario, the office receives an insurance payment for a patient's visit, but the insurance company inadvertently overpays the claim by $100. The medical office specialist reviews the claim to ensure there are no errors from their end.

Step 4 - Contacting the Insurance Company: After verifying the claim, the medical office specialist reaches out to the insurance company to understand the reason behind the overpayment. If it is confirmed that the overpayment was made in error, the insurance company will initiate the process of reprocessing the claim.

Step 5 - Request for Return of Overpayment: Alongside reprocessing the claim, the insurance company also sends a formal request to the physician's office, asking for the return of the $100 overpayment.

Step 6 - Handling Mistaken Overpayment Check: In some cases, the physician's office may receive a mistaken overpayment check from the insurance company. To rectify the error, the office voids the check and promptly sends it back to the insurance company.

Step 7 - Appeals Process: In rare instances, a claim may be denied, leading to a potential overpayment situation. In such cases, the office has the option to appeal the denied claim by submitting additional clinical and pertinent information to the insurance carrier. This process aims to overturn the denial and resolve any overpayment issues.

Refunds

Refunds in the context of medical billing and insurance occur when overpayments are made by either the insurance payer or the patient. Let's explain this with an example:

Example:
Imagine a patient named Sarah visits a healthcare provider for a medical procedure. Sarah has both primary and secondary insurance coverage. After the visit, the healthcare provider submits the claim to both insurance companies, as is common practice. Unexpectedly, both insurance companies process the claim and pay the full amount, resulting in an overpayment for the services provided.

Overpayment by Insurance Companies

Sarah's primary insurance pays $500 for the medical procedure, and her secondary insurance also pays $500 for the same service. This means the healthcare provider received a total payment of $1000 for a service that should have only been reimbursed once.

Overpayments as payments made by Medicare

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- For non-covered services
- In excess of the allowed amount for an identified covered service
- In error
- As duplicate payments
- When another entity had primary responsibility for payment (63 FR 14517).

Other reason Common Reasons for Overpayment

- Staff collected too much upfront based on an estimate
- A patient's coverage changed in the time between the healthcare encounter and the billing process
- There was an error in the billing process
- The patient overpaid by mistake

Overpayment example

Imagine a radiology practice that provides professional X-ray interpretations for a clinic or an independent diagnostic testing facility (IDTF). The radiologists in the practice interpret X-ray images and generate reports, which are then billed to insurance companies for reimbursement. For professional services like X-ray interpretations, a CPT code with a 26 modifier should be appended to indicate that only the professional service was provided, not the technical component of performing the actual X-ray.

Error in CPT Code Usage:
In this example, the radiology practice mistakenly bills the insurance companies using the CPT code for the global service, which includes both the professional interpretation and the technical component of performing the X-ray. Without appending the 26 modifier to indicate that only the professional interpretation was provided, the claim is processed as a global payment.

Impact of the Error:
As a result of not appending the 26 modifier, the insurance companies process the claims and generate payments based on the global service rates. The global payment includes reimbursement for both the professional interpretation and the technical component, even though the practice did not perform the X-rays themselves. This leads to significantly higher payment amounts compared to what the practice should have received for providing just the professional service.

Potential Replication of the Error:
If the radiology practice continues to submit claims without the correct 26 modifier, this error may be replicated numerous times for various patients and interpretations. Over time, the practice may inadvertently receive much higher payments for services they did not actually provide.

Identifying the Cause:
The error may arise due to various reasons, such as a problem in the billing system where the modifier is not automatically appended, or it could be a data entry error caused by insufficient staff training in proper coding procedures.

Corrective Action:
Once the radiology practice becomes aware of this issue, they must take corrective action immediately. This involves identifying the root cause of the problem, ensuring staff members are properly trained in coding procedures, and updating their billing system to include the necessary 26 modifier for professional interpretations.

Credit Balance

- Incorrect payment posting
- Additional payment from the patient apart from the insurance amount
- Usually it happens in the form of deductibles and co-pays
- In case the patient has two insurance payers, both might have been treated as primary. Hence payment might have been double.

Issuing a Refund

Once the healthcare provider becomes aware of the overpayment, they must issue a refund to one of the insurance companies to correct the situation. However, before doing so, they must conduct a thorough review of the claim and the payments received to ensure accuracy and avoid any potential errors.

Overpayment Refunds to Insurance

When dealing with an overpayment issue from an insurance provider, follow these steps to address and resolve the situation:

Verify the Overpayment:
Before taking any action, thoroughly review the payment received from the insurance provider to determine if it indeed constitutes an overpayment. Cross-reference the payment with the details of the claim and the services provided.

Seek Clarification:
If you believe there is an overpayment, reach out to the insurance provider to ask for a clarification of the calculated sum and the claim processing. Request them to provide a breakdown of the payment and the reasoning behind it.

Request Corrected Processing:
Once the overpayment is confirmed, ask the insurance provider to reprocess the claim with the correct and accurate amount.

Initiate the Refund Request:
The insurance provider may request a refund for the overpaid amount. Ensure you receive a written record of this refund request to avoid any misunderstandings in the future.

Issue the Refund:
After receiving the written refund request, issue a refund to the insurance provider. Prepare a check for the refund amount and send it to the insurance provider's designated address.

Addressing Incorrect Payments:
If the entire payment made by the insurance provider was faulty (for example, payment made for services not availed by the patient), void the check and explain the payment status to the provider. Provide necessary documentation or notes to support your claim, such as stating that the patient never visited the office for the particular service.

Sending the Refund Check:
Ensure that the check is accurately assigned to the refund request and appropriately labeled. If you are unsure of the insurance provider's address, send the check to their claims department and mark the envelope with 'Attention: Overpayments.'

****Please take note that each insurance company has its own specific rules regarding the process of refunding overpayments. In the case of the Anthem Blue Cross Provider Agreement, section 2.8 deals with adjustments for incorrect payments. If the healthcare provider receives an excessive or mistaken payment, which could result from various reasons such as billing errors, miscoding, or other billing mistakes, they are required to promptly inform Anthem or the relevant Plan. The provider must then reimburse the appropriate entity within thirty (30) days. Anthem or the Plan has the option to recover the overpayment through remittance adjustment or other recovery actions, as outlined in the provider manual.

It's important to note that in this agreement, Anthem's policy is particularly stringent, as they require refunding within 30 days of identifying an overpayment. This policy is even more aggressive compared to the standard 60-day requirement set by Medicare and Medicaid for overpayment refunds. Healthcare providers working with Anthem must adhere to these guidelines to ensure compliance with the agreement and to manage overpayment issues in a timely and efficient manner.

Appeal Process

In some cases, the insurance payer may request a refund from the healthcare provider. However, if the provider's records and documentation do not align with the payer's claim, the provider may need to appeal the refund request. This situation can arise due to discrepancies in paperwork or coding errors. The appeal process involves submitting additional documentation or clarifications to support the original payment.

Patient Overpayment Scenario

Now, let's consider the situation where a patient, Sarah, makes an overpayment to the physician's office for her medical services.

Overpayment by the Patient:
After Sarah receives medical treatment, she mistakenly makes an extra payment to the physician's office, resulting in an overpayment on her account.

Checking the Patient's Account:
The physician's office must carefully review Sarah's account to confirm the overpayment and check if she has any outstanding balances.

Applying the Refund:
If Sarah has outstanding payments on her account, the physician's office will typically apply the refund to the amount owed first. This helps to clear any existing balances before issuing any remaining refund amount to Sarah.

In both cases, whether it's an overpayment by insurance companies or patients, it's essential for healthcare providers to conduct thorough reviews and handle refunds accurately to maintain transparent financial practices and avoid potential billing disputes.

Rejected Claim

When a claim is rejected, it means that errors are identified before the claim undergoes processing. In such cases, the insurance company sends the claim back to the healthcare provider, requesting corrections to be made. The purpose is to enable the corrected claim to be resubmitted and, hopefully, receive payment. One common reason for claim rejection is when there is a discrepancy between the ICD-10-CM diagnosis code and the submitted CPT procedure code. For instance, if a patient visits the doctor with Strep throat, but the claim includes a procedure code for wart removal, it would likely lead to questions and result in the claim being rejected.

Denial Claim

A denied claim refers to a claim that has undergone processing by the insurance payer but is marked as ineligible for payment. The denial usually arises from issues related to the coverage contract or other errors that were detected after the claim processing. The insurance payer provides an explanation for the denial in such cases. Generally, denied claims can be appealed, but the reprocessing of appealed claims often takes a significant amount of time.

It is crucial to understand that when a claim is rejected or denied, it implies that the healthcare provider did not receive reimbursement for the services rendered. If a physician's office experiences a high number of rejected or denied claims, it can lead to cash flow challenges for the business. Consequently, healthcare providers aim to submit accurate and error-free claims during the initial filing to ensure prompt and regular reimbursement.

A denied claim refers to a claim that has been processed and the insurer has found it to be not payable. Denied claims can usually be corrected and/or appealed for reconsideration.

A rejected claim has not been processed so it cannot be appealed. Instead, rejected claims need to be researched, corrected and resubmitted.

The frequency of rejections, denials, and over payments may be high (often reaching 50%), mainly because of high complexity of claims and/or errors due to similarities in diagnosis' and their corresponding codes. This number may also be high due to insurance companies denying certain services that they do not cover (or think they can get away without covering) in which case small adjustments are made and the claim is re-sent. Depending on the denial, filing an appeal with the appropriate documentation and proof can successfully overturn the original decision.

In conclusion, irrespective of the payer, be it Medicare, Medicaid, commercial insurance, HMO, PPPO, or an out-of-network claim, it is imperative for your practice to refund any overpayment received, regardless of whether the payer explicitly requests it. The refund should be made within the timeframes specified in the contract or within 60 days or fewer. Adhering to these refund obligations ensures your practice remains compliant with billing guidelines and minimizes the risk of legal issues, helping to maintain a smooth and reputable healthcare operation.

Source:

https://www.federalregister.gov/documents/2016/02/12/2016-02789/medicare-program-reporting-and-returning-of-overpayments

https://www.in.gov/medicaid/providers/files/self-disclosure-of-overpayment-packet.pdf

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