

## 6. Reconciliation of Credit/Negative Balances

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## 6.1 Procedure for Reconciliation of Credit/Negative Balances

In the case where an insurer requests a refund of a claim they paid because, in their view, either they should not have paid the claim or they paid too much, the first step is to evaluate the following:

- If the insurer verbally requested a refund, the insurer must be informed that the refund request must be submitted in writing.
- Validate the requesting party by calling the payer.
  - Note in the Messaging option of the RPMS Accounts Receivable application.

Examples of refund requests:

- The patient was not insured at the time the services were rendered.
- The payment was for services or supplies not covered under the patient's benefit plan.
- The payment was greater than the amount owed for the services provided.
- The insurer was not the party obligated to make payment. For example, the secondary insurer paid for the services yet the primary insurer was truly obliged to make payment.

Each case is unique and the answer is always a combination of legal and business factors.

Two factors need to be considered when submitting claims and/or evaluation overpayments or incorrect payments.

- 1) Always protect your insurance payments at the outset by sending clean claims and keeping a record of all interaction with the insurer.
- 2) Never refund money without researching. If you return the money that was not truly an overpayment, it will be very difficult to get back.

## 6.1.1 Exceptions to Restitution

A party that paid money by mistake is entitled to have that money back, even if due to the payer's negligence. This rule, known as the "General Rule of Restitution," includes the following exceptions:

- **The innocent third-party creditor exception**

This situation is where the health care provider is owed money from someone and if it unknowingly accepts money from the wrong party, the provider will be harmed by having to refund the money. To qualify for this exception, the party seeking to avoid restitution cannot

- 1) Be unjustly enriched because of the mistake (received more than full payment for services rendered – a true overpayment);
- 2) Have induced the mistake (billing errors); or
- 3) Have notice of the mistake (knew payment was made in error, but took the money anyway).

- **Material change in positions**

This means a provider will not have to refund the payment if payment is unlikely to come from another source. Material change in positions can be demonstrated by

- 1) Never starting collection efforts from the patient, or discontinuing those efforts, or
- 2) Not seeking other sources of payment that may be available.

If the provider knew the insurer was not required to pay, yet failed to seek payment elsewhere, a refund must be given.

- **Assumption of risk**

This exception puts the burden on the insurer. It is the insurer's responsibility to investigate all doubtful facts in a claim before making payment. If the insurer fails to adequately investigate, then a refund is not required. In short, the insurer was negligent, and in balancing the equities, it would be unfair to allow the insurer to recover the payment it made.

*Remember:*

- Establish policies and procedures, as well as responsibility for timely and appropriate identification and resolution of overpayments.
- Maintain a complete audit trail of all credit balances.
- Designate at least one person as having the responsibility for the tracking, recording, and reporting of credit balances.
- Payers may choose to adjust a future remittance rather than request a refund. As an alternative to issuing a refund check, encourage your payer to adjust from a future remittance.

Under Medicare if a physician or facility submits a Medicare claim, receives the Medicare payment, and finds that the claim has been overpaid by the Medicare program, the physician or facility is responsible for immediately refunding the overpayment amount to the Medicare carrier.

Overpayments should be refunded to Medicare in one of two ways:

- 1) Return the original Medicare check (only when the entire check amount is overpaid), or
- 2) Make the refund via a business check.

Overpayments assessed by Medicare that are not repaid within 30 days of the initial demand letter will result in the offset of monies. Interest begins accruing and any payments due on submitted claims are used to offset the overpayment obligation.

Multiple overpayments initiated on the same date but in different files will be combined to show one total amount due, even though multiple demand letters were sent. Overpayments are always recovered in date order. Accrued interest is withheld before withholding for the principal balance.

To reconcile these Medicare Remittance Notices, a specific overpayment file should be kept in date order. The file should contain the initial demand letter and the listing of the claims involved.

Follow up with the insurer is necessary for negative balances or for being paid less than the facility expected. The follow-up process may vary depending on the process set up by the insurer and their preference, such as:

- online requests for review
- completion of forms stating the reduced payment
- Fax process, or other

Regardless, if your facility has been paid previously at a higher rate for this specific service or procedure or inpatient stay, you need to challenge the insurance company. If you have a previous example of what was paid, then you need to reference it with the insurance company. As with all follow-up, it is important to query the insurance company in a timely manner, document all the conversations in the patient account, and continue to follow up until the claim(s) are adjusted.

## 6.2 Processing Payments Received and Batched in Error

The Explanation of Benefits (EOBs) and Remittance Advices (RAs) received from PNC Bank are sorted by facility and entered into a collection batch. After the collection batches are created for the facilities by the Area or Service Unit Finance office, the EOBs or RAs are sent to each facility for posting and/or follow up.

However, in this process, insurers may record payment to an “incorrect” facility, or the Area or Service Unit office may batch the funds to the wrong facility.

In the case of an insurer recording payment to an "incorrect" facility, the best accounting approach is to return the check and the Explanation of Benefits to the insurance company.

In the case of an Area or Service Unit Finance office batching the funds to the wrong facility,

- Notify the Area or Service Unit Finance office of the need to transfer the third party revenue between the respective locations,
- Notify the correct facility of the transfer.
- Send the EOB documentation to the correct facility.

For the complete process, see the *Indian Health Manual*, Part 5, Chapter 1, “Third Party Revenue Accounts Management and Internal Controls,” Exhibit 5-1-A, “Accounts Receivable Posting and Reconciliation Instructions,” which is available at this website:

<http://www.ihs.gov/PublicInfo/Publications/IHSMannual/Part5/pt5chpt1/pageone.htm>

## 6.3 Medicare Provider Credit Balance Reporting

The Paperwork Burden Reduction Act of 1995 was enacted to inform you

- Why the Government collects information.
- How it uses this information.

In accordance with 1815(a) and 1833(e) of the Social Security Act (the Act), the Secretary is authorized to request information from participating providers that is necessary to properly administer the Medicare program. In addition, section 1866(a) (1) (C) of the Act requires participating providers to furnish information about payments made to them and to refund any monies incorrectly paid.

In accordance with these provisions, all providers participating in the Medicare program must complete a **Medicare Credit Balance Report** (CMS-838) to help ensure that monies owed to Medicare are repaid in a timely manner.

### 6.3.1 Medicare Credit Balance Report (CMS-838)

The CMS-838 report is used specifically 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 a 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;
- Paid for services planned but not performed or for non-covered services;
- Overpaid because of errors made in calculating beneficiary deductible and/or coinsurance amounts; or
- A hospital that bills and is paid for outpatient services included in a beneficiary's inpatient claim.

Credit balances would not include proper payments made by Medicare in excess of a provider's charges such as DRG payments made to hospitals under the Medicare prospective payment system.

For purposes of completing the CMS-838, a Medicare credit balance is an amount determined to be refundable to Medicare. Generally, when a provider receives an improper or excess payment for a claim, it is reflected in their accounting records (patient accounts receivable) as a credit.

However, Medicare credit balances include monies due the program, regardless of its classification in a provider's accounting records. For example, if a provider maintains credit balance accounts for a stipulated period, for example, 90 days, and then transfers the accounts or writes them off to a holding account, this does not relieve the provider of its liability to the program. In these instances, the provider must identify and repay all monies due the Medicare program.

Only Medicare credit balances are reported on the CMS-838 report. To help determine whether a refund is due to Medicare, another insurer, the patient, or beneficiary, refer to the sections of the manual (each provider manual will have the appropriate citation) that pertain to eligibility and Medicare Secondary Payer (MSP) admissions procedures.

### **6.3.2 Procedure for Handling Medicare Credit Balances**

This is the procedure for handling Medicare credit balances:

1. Remittance Advice (RA) is received without payment.
2. Remittance advice is batched, and a copy of the RA is held in a holding file.
3. The Medicare credit balance is posted as an ADJ, adjustment, non-payment, Pending Documentation.
4. Post as a zero pay with a note explaining the reason.

### **6.3.3 Notification of Payments Withheld**

Notification of Payments Withheld is a penalty that is applied when facilities do not submit monthly credit balance reports to Medicare on a timely basis. Medicare has set guidelines notifying all Medicare providers that when credit balance reports are not submitted, payments will be withheld and a penalty will be charged.

Not all insurers will charge a penalty but just may hold payment until the credit balance reports is filed.

## 6.4 Adjustment Request Form

This form is used to notify Finance of any adjustments required, which will affect the reconciliation process.

For a sample of the Adjustment Request form, see the *Indian Health Manual*, Part 5, Chapter 1, Exhibit 5-1-A, “Accounts Receivable Posting and Reconciliation Instructions,” Attachment 2, which is available at this website:

<http://www.ihs.gov/PublicInfo/Publications/IHSMannual/Part5/pt5chpt1/pageone.htm>