# Is it Found Money?

## WHAT TO TELL YOUR CLIENTS REGARDING OVERPAYMENTS

*By Rich Papperman, CHBME*

*This is the first in a two-part series on overpayments. In the next issue, Bob Burleigh will further explore this difficult issue.*

**HBMA has advocated for compliance since 1995, when the association was still called the International Billing Association.** Programs followed each year. The first "big" compliance course under the HBMA banner was presented by Steve Vincze in Atlanta, GA, in 1999, which followed the release of the OIG Model for Billing Companies. Since then, the Ethics and Compliance Committee has presented numerous programs, articles, website offerings, etc, to further the "climate of compliance" for our members.

Unfortunately, we have often heard HBMA members comment that our clients do not believe us when we tell them that they need to issue refunds, can't upcode E&M services, and are prohibited from many other "no-no's." Members have asked for specific citations that they can show their clients to make their point.

This article offers tools that HBMA members can use in discussing compliance with their clients. A real-life scenario is followed by specific federal and state laws that were used to prosecute each case, including available penalties. The specifics of the Office of Inspector General (OIG) Compliance Program Guidance for Third-Party Medical Billing Companies and the Compliance Program for Individual and Small Group Physician Practices are cited. So when Dr. Jones says "Show me," you will have the answers on these tough issues.

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### A Typical Case

Do you have clients who think hanging on to insurance overpayments is "no big deal?" If so, you may want to caution them to reconsider that stance. East Tennessee Heart Consultants (ETHC) is a cardiology practice that neglected to refund overpayments to federal and private insurers and patients. It learned a rather expensive lesson: if you have money you're not entitled to, you better give it back!

ETHC entered into a $2.9 million settlement with the US Attorney in connection with its alleged failure to refund overpayments over a period of six years. The allegations focused on the practice's failure to refund overpayments to Medicare, Medicaid, and other state and federal payers. The US Attorney's office for the Eastern District of Tennessee began its investigation as result of two former employees of ETHC filing a qui tam action using the federal False Claims Act and the Tennessee Medicaid False Claims Act. The employees alleged that ETHC had established a policy to retain overpayments that were paid by government insurance programs and only issued refunds if those programs specifically sent a request.

What made this case unique and significant was the government's approach using the Federal False Claims Act (FCA). The argument was that the claims billed during those six years were false because they were made during a time that ETHC had an existing legal obligation to refund money that had been received previously as overpayments on prior claims. The government based its case on ETHC submitting claims even though it knew there was a legal obligation to promptly refund the prior overpayments.

To explain it another way, these claims were valid as submitted to the insurers for payment. But the prosecution took the stance that if a provider knowingly was retaining credit balances from those insurers, then those claims were false under both state and federal false claims statutes.

***EPILOGUE:* ETHC entered into:**

1. A criminal pretrial diversion agreement
2. Separate civil settlements with the federal and state governments
3. A five-year Corporate Integrity Agreement (CIA) with DHHS OIG.

**Of the approximately $3.3 million paid by ETHC, $2.9 million in penalties included:**

- $1.5 million to the Department of Justice
- $1.2 million to patients and/or their *(continued on page 12)*

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health insurers
- $200,000 to the state of Tennessee

Plus, the whistle blowers were paid over $300,000 and their attorneys nearly $72,000.

***MORAL OF THE STORY:*** Providers really are required, legally and morally, to return overpayments on a timely basis. If you overpaid for something, wouldn't you want your money back?

## CITATIONS

Here are the citations to use with your clients that cover the issues and actions in the above scenario.

**OIG Compliance Program Guidance for Third-Party Medical Billing Companies.**
(Federal Register / Vol. 63, No. 243 / Friday, December 18, 1998).
Web link: http://oig.hhs.gov/fraud/docs/complianceguidance/thirdparty.pdf

- In Section II. Compliance Program Elements, Written Policies and Procedures, page 70144, Sub-section 2. Written Policies for Risk Areas, (page 70142): *"Among the issues to be addressed in the polices are the education and training requirements for billing and coding personnel… the procedure for identifying and reporting credit balances; …"*

In Sub-Section 2.a. Risk Assessment – All Billing Companies: *"Among the risk areas the OIG has identified as particularly problematic are: Inadequate resolution of overpayments." This statement is identified with footnote 32, which defines an overpayment as: "… an improper or excessive payment made to a health care provider as a result of patient billing or claims processing errors for which a refund is owed by the provider. Examples of Medicare overpayments include instances where a provider is: (1) paid twice for the same service either by Medicare or by Medicare and another insurer or beneficiary; or (2) paid for services planned but not performed or for non-covered*

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*services. Billing companies should institute procedures to provide for timely and accurate reporting to both the provider and the health care program of overpayments."*

- In Section II. Compliance Program Elements, Written Policies and Procedures, Sub-section 4. Credit Balances, (page 70144) states: *"Credit balances occur when payments, allowances, or charge reversals posted to an account exceed the charges to the account. Providers and their billers should establish policies and procedures, as well as responsibility, for timely and appropriate identification and resolution of these overpayments.55 For example, a billing company may redesignate segments of its information system to allow for the segregation of patient accounts reflecting credit balances. The billing company could remove these accounts from the active accounts and place them in a holding account pending the processing of a reimbursement claim to the appropriate payor. A billing company's information system should have the ability to print out the individual patient accounts that reflect a credit balance in order to permit simplified tracking of credit balances. The billing company should maintain a complete audit trail of all credit balances. In addition, a billing company should designate at least one person (e.g., in the patient accounts department or reasonable equivalent thereof) as having the responsibility for the tracking, recording, and reporting of credit balances. Further, a comptroller or an accountant in the billing company's accounting department (or reasonable equivalent thereof) may review reports of credit balances and adjustments on a monthly basis as an additional safeguard."*

Footnote 55 states, "*The billing company should also refer to State escheat laws for the specific requirements relating to notifications, time periods and payment of any unclaimed funds.*"

**OIG Compliance Program for Individual and Small Group Physician Practices**

(Federal Register/ Vol 65, # 194, Thursday, October 5, 2000)
Web link: http://oig.hhs.gov/authorities/docs/physician.pdf.

**D. Billing for Non-covered Services as if Covered**

*In some instances, we are aware that physician practices submit claims for services in order to receive a denial from the carrier, thereby enabling the patient to submit the denied claim for payment to a secondary payer…. In some instances, however, the carrier pays the claim even though the service is non-covered, and even though the physician did not intend for payment to be made. When this occurs, the physician has a responsibility to refund the amount paid and indicate that the service is not covered.* (Footnote page 59446)

## Federal Laws

From the "OIG Compliance Program for Individual and Small Group Physician Practices," Section III. Physician Billing Practices, Sub-section B titled "Billing Practices by Non-Participating Physicians," Heading "Refund of Excess Charges'" (page 59447). This section addresses Medicare patients when they see a non-participating physician:

*"42 U.S.C. 1395w–4(g) mandates that if a nonparticipating physician collects an actual charge for a service that is in excess of the limiting charge, the physician must refund the amount collected above the limiting charge to the individual within 30 days notice of the violation. For example, if a physician collected $50 from a Medicare beneficiary for an office visit, but the limiting charge for the visit was $35, the physician must refund $15 to the beneficiary, which is the difference between the amount collected ($50) and the limiting charge ($35). Failure to comply with this requirement may result in a fine of up to $10,000 per violation or exclusion from participation in Federal health care programs for up to 5 years."*

Specifically, 42 U.S.C. 1395u(l)(A)(iii) mandates that a nonparticipating physician must refund payments received from a Medicare beneficiary if it is later determined by a Peer Review Organization or a Medicare carrier that the services were not reasonable and necessary. Failure to comply with this requirement may result in a fine of up to $10,000 per violation or exclusion from participation in Federal health care programs for up to 5 years.

## State Laws

Twenty states have state False Claims Acts with qui tam whistleblower provisions that closely resemble the Federal False Claims Act. One of the most recent is New Jersey, where Governor Corsine just signed into law the state's version of the Federal False Claims Act on January 13, 2008. It took effect in March, 60 days after it was signed.

## Benefits of an Effective Compliance Program

One of the benefits of having an effective Compliance Program is credit, under the Federal Sentencing *(continued on page 18)*

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Guidelines, to reduce your penalties. Footnote 19, page 70141, under "Written Policies and Procedures" states: *"According to the Federal Sentencing Guidelines, an organization must have established compliance standards and procedures to be followed by its employees and other agents in order to receive sentencing credit for an ''effective'' compliance program. The Federal Sentencing Guidelines define ''agent'' as ''any individual, including a director, an officer, an employee, or an independent contractor, authorized to act on behalf of the organization."* See United States Sentencing Commission Guidelines, *Guidelines Manual*, 8A1.2, Application Note 3(d). ▲

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the efficiency of the physician's practice. However in reality, if "change" is not embraced, the probability of success is very low. We learned in the 1980's that we needed to change the process of billing for services or we would not be paid in a timely and effective manner. Therefore, the practice of medicine, from the business point of view, changed.

Now with newer technologies, government regulations, and the right financial incentive, physicians can embrace new levels of technology that were not available just five years ago. But where does a physician in a small practice turn to learn about the hundreds of technology choices? The physician can spend hours searching and evaluating all of the opportunities. Or maybe in the near future, physicians will be able to look towards leaders within their own medical specialty for guidance and knowledge. ▲

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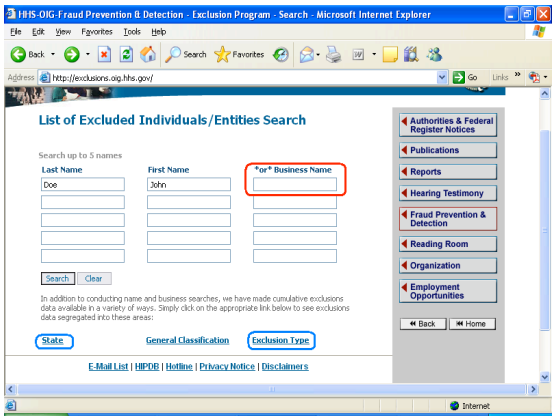
Employees HR file under OIG. If any excluded businesses match previous companies that the applicant worked for, check the exclusion code (see example in blue, below); this will be a number something like this: 1128(a)(1), you can also check the alpha listing by state (see example in blue, below). This will tell why the company is excluded. Print out this information and forward it to the HR manager, for further review, as the applicant may need to be excluded from being hired.




K. The prior business search procedure must be followed only before an applicant is hired. It does not need to be done on an annual basis, as is the case with an individual. This procedure will only apply to businesses that may be in the healthcare field, such as doctor's offices, insurance/billing companies, etc. Searches do not need to be performed on companies that are not in the healthcare field, such as restaurants, retail stores, or other industries besides healthcare.

**Disciplinary:** Written Warning