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How to Avoid Healthcare Overpayments: Top Five Mistakes Providers Make and the Real Cost of Non-Compliance

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Over the last 25 years, I have assisted healthcare providers as a lawyer and as a compliance professional with handling routine overpayment matters, internal and external billing investigations, and fraud and abuse matters. Except for the rare case involving intentional overbilling or fraud, I have found that the overpayment matters are usually caused by one big mistake: not understanding the payor's requirements for billing and not investigating whether other providers in the group or organization understand the payor's requirements.

It seems like a simple task: Understand what the payor requires in order to receive reimbursement from that payor for your services. But, in practice, providers often don't study the payor's requirements or don't investigate whether their providers are billing compliantly. This article is intended to point out the top five mistakes I have observed through the years related to claims submissions and the real cost when the mistakes happen.

Mistake One: Not Studying Payor Requirements Before Submitting Claims

For some reason, it is quite common for a provider to get a contract with a payor and immediately start submitting claims with only a vague idea of what the payor actually requires in order for the provider to be reimbursed for the goods or services. Most payors, for example, require specific paperwork or forms to accompany claims, and I have seen countless denials based on claims that were submitted without the right paperwork or forms. This can result in claims denials, regardless of whether medically necessary goods or services were actually provided.

Payors also commonly set forth specific and detailed documentation expectations, supervision or oversight requirements, signature expectations, and other steps necessary to support claims for reimbursement. But if any of these elements are missing, the claims may be denied or viewed as overpayments when audited.

How to Avoid Mistake One. The key to avoiding Mistake One is to read and understand all the payor's published requirements regarding claims submissions prior to submitting claims (and then keeping current with these requirements). For federal healthcare program payors (Medicare, Medicaid, Tricare), this will include statutes, regulations, manuals, and informal guidance. For commercial payors, the payor contract and all published manuals and policies need to be examined carefully. Then, if you have any questions, get professional help (expert coders, consultants, lawyers, etc.) or contact the payor directly for clarification.

The Real Cost of Mistake One? On several occasions, I have seen a federal healthcare payor insist on repayment of all reimbursement related to a line of claims simply because a certain form was not used or was not fully completed, even though the underlying services were medically necessary and provided. There are many defenses to this type of alleged overpayment, but you are still stuck defending yourself and perhaps paying a lawyer or consultant to help you present your defense. At worst you may also have to pay a substantial penalty for not using the right forms or other documentation errors, or paying back all or a substantial portion of your hard earned reimbursement for these errors.

Mistake Two: Relying on Friends, Colleagues, or Third-Hand Advice for Billing Guidance

This is closely related to Mistake One, but is so common it warrants a category of its own. Instead of studying the payor statutes, regulations, manuals, contracts, and other guidance, providers will often tell me that their friend or their professional colleague told them to bill a certain way, which often turns out to be inaccurate. Or, a provider or the provider's billing staff will attend a conference or a presentation and come back to the office with a misunderstanding of how something actually needs to be billed. In some cases, a provider might rely on what a salesperson or marketer says is needed to support claims.

How to Avoid Mistake Two. To avoid Mistake Two, verify what your friend, colleague, or a salesperson told you or verify what you think you heard or your staff learned at a conference. Follow the previous advice for avoiding Mistake One and read all the payor's published requirements regarding claims submissions and get expert advice if needed.

The Real Cost of Mistake Two? Unfortunately, if your understanding of payor requirements that you learned from friends, colleagues, sales people, or at a conference turns out to be wrong, you may find yourself facing alleged overpayments from payors for failure to comply with their requirements. As with the Real Cost of Mistake One, there might be many defenses you can raise, but you may be again stuck defending yourself and facing penalties or paying back all or a substantial portion of your hard earned reimbursement for not complying with payor requirements.

Mistake Three: Not Understanding the Healthcare Industry and Not Conducting "Compliance" Due Diligence Prior to Closing

Too many times, a potential buyer will proceed with an acquisition of a healthcare entity while not understanding the specific healthcare industry or the highly regulated nature of the healthcare field. Coupled with this, buyers may not conduct due diligence related to the company's coding and billing activities and compliance program.

How to Avoid Mistake Three. First, study and understand the healthcare regulatory landscape before you purchase. If you proceed with a sale, engage in robust compliance due diligence to understand if you are inheriting pending investigations or audits and/or if the provider has been submitting accurate claims. Also, take the time to examine if the target entity has a compliance program and how effective it appears to be.

The Real Cost of Mistake Three? Unless the buyer is lucky, a lack of understanding of the healthcare industry and/or a lack of compliance due diligence will often mean the new buyer is inheriting pending or imminent overpayment exposure, will find the new asset to be a lot less valuable than expected, or find the costs for compliantly operating the new entity are a lot more than expected.

Mistake Four: Not Auditing All New Providers Before They Submit a Single Claim

Whether new providers are being added due to an acquisition or a new provider is joining a practice or entity, many times the new provider simply comes on board and starts billing. The provider's coding and documentation is then not audited for months or years.

How to Avoid Mistake Four. When any new provider joins a practice or entity, the provider should hold the new provider's claims until the new provider's coding and documentation can be reviewed. That way you can ensure the new provider will be submitting compliant claims for reimbursement.

The Real Cost of Mistake Four? Unless you audit the new provider's coding and documentation before you drop claims for the provider you may be allowing numerous inappropriate or unsupported claims to be submitted. The new provider may be engaging in fraudulent billing patterns that will remain undetected if the new provider's coding and documentation is not review. This may lead to a string of unexpected overpayments or worse down the line.

Mistake Five: Not Investing in an Effective Compliance Program

Many providers view compliance programs as an unnecessary cost or, if they have one, as a minor function that doesn't warrant a lot of resources or attention. As someone who has assisted providers with both proactive compliance efforts and compliance program operations and who has defended overpayment matters and fraud and abuse cases on a regular basis, I can say without hesitation that the money spent on an effective compliance program is minimal compared to the cost of defending and appealing overpayment demands and/or defending fraud cases.

How to Avoid Mistake Five. Invest in whatever is needed to either implement a compliance program or assess your current compliance program for effectiveness. A well-run compliance program with appropriate compliance leadership will help you identify billing issues and complaints at an early stage, and can help you avoid many overpayment demands. A well-run compliance program can also be a resource for an employee to express concerns. The goal is to create an open, non-retaliatory atmosphere, so that you can hear and address concerns. A frustrated employee who feels like they cannot raise concerns will often turn to a prosecuting agency for help.

The Real Cost of Mistake Five? If you are not conducting the key functions of a well-run compliance program, you will be missing opportunities to catch billing mistakes before they happen, catch mistakes early, and/or potentially hear of fraudulent or abusive conduct such that you can investigate and self-report issues to the government, if needed. Otherwise, if you lack a compliance program or it is ineffective, the potential for overpayments and/or undetected fraud and abuse grows. Then, instead of being able to handle such problems internally, you are faced with unexpected overpayment audits and demands or federal or state prosecutions.

To sum it up, taking the time to really understand the healthcare payor requirements prior to submitting claims for reimbursement will go a long way towards helping providers retain the reimbursement paid for their hard earned

goods or services. If you are entering the healthcare field through an acquisition, take the time to understand the heavily regulated industry and conduct effective due compliance diligence prior to closing. In addition, ensuring your organization – large or small – has an effective compliance program will help you ensure the other providers in the group or organization understand the payor requirements and will help you identify problems at an early stage. All these measures will save you a lot of administrative time and money in the long run

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This is an article from a series on Effectively Responding to Payor Audits & Program Integrity Investigations. Topics in this series include practical advice and legal developments for providers defending payor audits and investigations, plus articles concerning current audit and investigation targets and the various types of auditors reviewing claims and conducting investigations. The Series covers topics of interest to all providers of health care services, including hospitals, hospices, home health agencies, skilled nursing facilities, DME suppliers, clinical laboratories, pharmacies, FQHCs, RHCs, ASCs, community mental health centers, physicians, therapists, and other health care facilities, entities, practitioners, and clinicians.