NEXSEN | PRUET

Provider Credit Balances Under the Microscope: Increased Enforcement Means Need to Review Credit Balance Procedures

Related Professionals

Jenna K. Godlewski*
843.720.1720
JGodlewski@nexsenpruet.com

Alice V. Harris
803.253.8284
AHarris@nexsenpruet.com

Practices

Health Law

Industries

Health Care

Article
01.05.2022

On December 10, 2021 a hospital in Illinois made the news when it was reported that Gibson Area Hospital had agreed to pay $292,000 to settle False Claims Act ("FCA") allegations of failing to return overpayments received from Medicare, Medicaid, and other federal healthcare programs. Gibson City hospital to pay $292,000 to settle claims of Medicare fraud | Courts-police-fire | news-gazette.com The government alleged the hospital retained overpayments for various reasons, including overpayments that were: under $10, over a year old, duplicate payments, payments improperly applied to other claims, and/or overpayments that were not requested to be returned by payors at least three times.

In addition to this recent FCA settlement, State Medicaid Recovery Audit Contractors ("RACs") around the country are routinely conducting credit balance audits. As just one example, one of the stated projects of the newly appointed RAC for South Carolina is to conduct credit balance audits. (2021-4-6) Medicaid Bulletin HMS RAC and CBA Contract FINAL.pdf (scdhhs.gov) This trend towards increased enforcement and oversight is a reminder that the correct handling of payor and patient credit balances is a burdensome but necessary undertaking.

What is a Credit Balance? The Centers for Medicare and Medicaid Services ("CMS") defines the term "credit balance" concisely as "an improper or excess payment made to a provider as the result of patient billing or claims processing errors." CMS-838 Medicare Credit Balance Report

Credit balances can arise in many ways. Examples of credit balances include instances where:

- A provider is overpaid for the same service because of multiple payments by insurers and/or the patient
- A provider is paid for services planned but not performed or for non-covered services

- A provider is overpaid because of errors made in calculating a beneficiary deductible and/or coinsurance
- A patient is owed a refund

What Steps Can a Provider Take to Tighten Payor Credit Balance Processes? Consider conducting a review of your payment processes, from receipt to overpayment policies to exceptions to overpayment processing procedures. Look for indications that you may be retaining overpayments improperly such as the following:

- Credits under a certain monetary threshold are not returned
  - *Fix: Although burdensome, all overpayments should be returned*
- Credits over a certain age are not returned
  - *Fix: Although burdensome, all overpayments should be returned*
- Multiple payors and/or the patient pays the claims for the same service
  - *Fix: A provider must take the time to return amounts overpaid instead of keeping all the payments*
- The payor has not requested a refund
  - *It is the provider's obligation to return overpayments it identifies – the payor does not need to request the return of an overpayment*

What About Patient Credit Balances? This article mainly covers amounts that need to be refunded to payors, but careful attention also needs to be made to patient credit balances. All patient balances either need to be returned to the patient or, if reasonable efforts to return the overpayment fail, the overpayment amount eventually needs to be remitted to the State as part of State unclaimed property processes. The South Carolina Unclaimed Property program is linked here an example of a State Program: Unclaimed Property Reporting For Businesses - SC Office of the State Treasurer

Running a tightly compliant credit balance program is complicated and can be burdensome. Let us know if Nexsen Pruet can help you analyze your credit balance processes in order to stave off enforcement audits and investigations.

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.