Refunds: How to Avoid Them

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Refunds have always been a challenge in healthcare. Not only do they create an administrative burden but there is also the potential for compliance risk.

Some common causes for refunds are:

- Not validating the patient's insurance eligibility and collecting the wrong copay amount
- Choosing a blanket amount to collect from all patients up front regardless of whether they have insurance (ie, over collecting at the time of service)
- Sending statements too early, causing duplicate payments

Is a credit balance always a refund? No. Credit balances require research to determine if they are the result of a posting error. An example of this is posting a patient payment to the wrong date of service. For insurance payments, clinics often incorrectly post a contractual insurance reversal on insurance overpayments instead of waiting for insurance to recoup and post automatically through ERA (electronic remittance advice) which causes invalid credits.

A few best practices to consider for your clinic to help tame this "Refund Beast":

- Verify there are no open balances before refunding a patient.
- Check that visits are closed. Open visits may contain credits when there are no charges yet associated to the visits to apply the monies.
- Allow insurance plans to offset rather than writing a check. Insurance refund requests have a time limit before recouping from future payments occurs. If a check gets sent to the payer and the deadline is missed, the insurance plan may also recoup the payment. This will create open account receivables and it is extremely difficult to get repayment.
- For coordination of benefit (COB) errors, where the primary and secondary insurance pay as primary, notify both payers and let them do the work to reprocess the claim. Otherwise, these errors by the insurance plan can create challenging work to determine how the claim should have paid and payments can be returned based on assumptions only. Let the payer do the research and reprocess the claim. This puts the work and burden on them.

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There are instances when you should immediately call the insurance plan to recoup a payment. The first is when the wrong patient is billed in error or a service was not performed. Mistakes happen. Occasionally monies are received for the wrong practice. Insurance companies make mistakes, as well. If you receive a payment that you should not have, it should be refunded immediately.

Self-disclosure comes into play when you identify an incorrect billing practice. Maybe you have been using the wrong CPT code to report a service resulting in overpayment. The Affordable Care Act added the 60-Day Rule to the Social Security Act that requires a person who has received an overpayment to report and return the overpayment to the appropriate entity and to notify the entity to which the overpayment was returned in writing of the reason for the overpayment. The overpayment must be reported and returned by the date that is 60 days after the date on which the overpayment was "identified."

The Centers for Medicare & Medicaid Services (CMS) defines "identification" to mean the following: "A person has identified an overpayment when the person has, or should have through the exercise of reasonable diligence, determined that the person has received an overpayment and quantified the amount of the overpayment." Hopefully, these situations are rare.

The crazy number of visits due to COVID-19 creates plenty of pressure just to get bills out and to post the payments received. It is critical, however, to keep your eyes on potential refunds as you don't want to create any other problems related to compliance and unhappy patients. ■