Addressing and resolving overpayment recovery requests

It is important to address overpayment recovery requests as soon as possible. You must remember that you have the right to challenge a request, but there may be defined time constraints for doing so according to your contract with the health insurer. When receiving an overpayment recovery request, you'll need to know how to effectively handle it.

Please note: The information in this document primarily addresses overpayment recovery requests pertaining to individual claims or claim line items from private payers. For information regarding overpayment recovery requests related to the Centers for Medicare and Medicaid Services (CMS) Recovery Audit Contractor (RAC) program, please visit www.ama-assn.org/go/RAC.

1. What should I do when I receive an overpayment recovery request on an individual claim?

It is important to address the overpayment request as soon as possible. Review the letter or electronic notification from the payer against your account ledger to identify the reason(s) for the request and determine its validity. If the payer does not provide you with enough information to identify the overpaid claim and/or reason for the overpayment, be sure to contact the payer directly in order to obtain the necessary information to determine the appropriateness of the overpayment recovery request. If the requested overpayment is indeed accurate, be sure to follow the payer-specified instructions to either approve auto-recoupment from a future reimbursement or find out where to submit a refund check. If the overpayment recovery request is inaccurate, you have a right to challenge it. However, there may be a limited time period for you to respond, as defined by the payer. In some cases, auto-recoupment is automatic if a health plan doesn't receive a check or appeal within a specified period of time. For this reason, you are encouraged to respond expeditiously to the overpayment recovery request, whether through the direct refund of the overpayment, auto-recoupment approval process or an appeal.

When you receive an overpayment recovery request from a payer, there are some steps that should be followed in order to promptly and accurately address it. These steps are the same whether you follow a manual or electronic process. They are essential to determining the validity of the overpayment recovery request from the payer.

Figure 1: Steps for addressing a claim overpayment recovery request from a payer

- Review the letter or electronic notification from the payer and your patient account ledger for the appropriate request reason and claim data regarding the claim overpayment.
- Contact the payer if additional basic information is needed to process the claim overpayment.
- Determine if the request is valid.

    - If valid, submit a refund check (or approve recoupment from the next payment) of the claim overpayment to the payer. (See questions 2 and 3 for additional information)
    - If not valid, submit an appeal in writing, within the time limits defined by your contract with the payer, to the specific address provided. (See questions 5 and 6, as well as sample claim overpayment appeal letter.)
- Use your practice management system functions to track the following information associated with the refund payment for the claim overpayment. *[Note: The AMA encourages the use of your practice management software system to perform this task. Consult with your practice management software vendor for details.]*
    - Date of service
    - Patient name
    - Patient member/policy ID number
    - Patient account number/Financial Control Number (FCN)
    - Payer claim number
    - Payer invoice number (preferred)

2. What specific actions should I take if an overpayment recovery request is valid?

To the extent that an overpayment has indeed occurred, the practice must pay it back. Repayment is even more important now, since Medicare imposes an affirmative repayment obligation on physicians and other health care providers. Under the law, a physician must report and repay a Medicare overpayment no later than sixty (60) days after the date on which the practice identifies an overpayment. Failure to report and repay the overpayment within this timeframe may result in significant monetary and administrative penalties. Your practice should have procedures in place for repaying identified overpayments to all payers as a matter of good business practice.

For physician practices, attempting to determine the validity of alleged overpayments can divert significant time from direct patient care, which results in loss of practice revenue. All too frequently, overpayment demands are made in the most general terms; the practice is not given the specific information—such as dates of service, patient names or claim numbers—necessary for the practice to determine the validity of the overpayment request.

If the overpayment is valid, abide by the time limit on the notification and send the refund to the payer. If the refund is being sent between 30 and 40 calendar days of the deadline, call the payer to apprise them of the funds being remitted. Provide the following:

- Member/Policy ID
- FCN/Document Control Number (DCN) or Letter ID
- Check number and date
- Date the check was sent or electronic funds remitted
- The amount of the check/remitted funds
- How it was sent (FedEx, UPS, USPS, electronic remittance advice recoupment)

Be sure to notate the patient's account to track the refund or recoupment of the overpayment. File notification letters and other correspondence from the payer regarding the overpayment. Be sure to notate all debits and credits on the appropriate patient account record.

3. What actions can I take to recover revenue from valid overpayment recoupments?

Inaccurate payments, whether they are overpayments or underpayments, require physicians and their practice staff as well as payers to manually rework claims. Revisiting claims that could have been paid correctly the first time greatly increases administrative costs incurred by physicians, payers and the health care delivery system as a whole.

However, investing the time to rework an overpaid claim may prove worthwhile if the practice can recover some, if not all, of the recouped payment. If it is determined that the patient is responsible for payment, the practice can bill the patient. If the overpayment recovery request indicates that another payer is responsible for payment, the practice should submit the claim to the secondary payer.

4. How can I avoid situations that may prompt future overpayment recovery requests from payers?

Physician practices are encouraged to identify the most common reasons for overpayment recovery requests and perform a deep dive into their internal processes to determine why each request occurred. For example, if the most common overpayment request is "coverage terminated before service provided" or "other insurer was responsible," examine your practice's patient check-in process. Always check patients' eligibility and benefits for each date of service.

Your practice can reduce the number of claims that payers deny by tracking routinely denied claims. Tracking the reasons for payer claim denials is critical to improving your claims revenue cycle. Use this information to improve internal processes and to ensure that you meet the payer's requirements for submitting a specific type of claim and following up in the appropriate fashion. Additionally, you are encouraged to perform a routine examination of your claims denial history or claims that have resulted in repeated overpayments and identify and correct the most frequent sources of those denials or overpayments.

It's also important to promptly return erroneous claims payments. When posting, verify if the claim was paid twice for the same date of service and return any duplicate payments. You should also return any payments for patients not treated by you. Do not write "VOID" across any checks to be returned. Instead, write the reason for the check return on the check stub or in the advice section.

Practices may not be able to prevent some overpayment recovery situations. For example, if a patient is retroactively disenrolled from a health plan, there is no way for a practice to anticipate this outcome, as the initial eligibility response from the health plan would have shown that the patient was eligible for benefits at the time of service. In some states, if the

health plan did verify eligibility at the time of the service, then the claim must be paid, independent of retroactive disenrollment. Access the AMA's electronic insurance eligibility toolkit to learn how performing electronic insurance eligibility can save your practice time and money as well as provide you with increased patient insurance coverage information. This is how revisiting your workflow can reduce future overpayment requests or strengthen your appeal.

5. How do I appeal an invalid overpayment recovery request on an individual claim?

Your practice should review and appeal payers' inappropriate claim overpayment requests to avoid lost revenue. Challenging inappropriate overpayment recovery requests through a payer's overpayment appeal process may result in a change to the payer's business practices and can also save your practice money. Payers may support Internet portal appeals or require letters.

If you feel that the claim overpayment recovery request is unjustified, you must appeal. Physicians have the right to appeal any determination made by a payer. The purpose of the appeal process is to address the legitimacy of the claim overpayment recovery request with the payer. The appeal letter should include all information which was relied upon and submitted in making the payment determination on the reimbursed claim. See Figure 2 for the six steps for appealing a claim overpayment recovery request.

Figure 2: Six steps for appealing an overpayment recovery request

Step 1. Review the overpayment recovery request from the payer and identify the reason for the overpayment request and the specific claim information.

Step 2. Prepare an appeal letter that includes the patient's name, subscriber's name, payer identification and insurer numbers, date of service and the reason that you are challenging the overpayment request.

- Be sure to follow the overpayment recovery appeal process as defined in your payer contract that may designate a specific appeal form and location to submit the appeal. Be sure to use the appropriate appeal form as designated by the payer or, if none is defined, the form specified by the physician practice's policy.

- A full explanation of the rationale for the appeal should be detailed within the body of the letter. Your appeal letter should include but not be limited to the following information:

    - Acknowledgement of receipt of the claim overpayment recovery notification
    - Patient account identifying information (i.e. patient name, date of service, claim number/FCN, member ID number, etc.)
    - Detailed explanation for rationale for appeal (with any supporting documentation)
    - Contact information (i.e. name, address, phone number, etc.) for physician or the practice staff designee

Step 3. Thoroughly support and document your argument. Use objective data and gather supporting documentation, including:

- A written explanation supporting the reason for your appeal.
- The necessary documentation of proof (e.g., copy of patient's eligibility verification with dates of coverage, clinical documentation, remittance advices and explanations of benefits from all payers involved, claim submission reports for timely filing, guidelines and/or policies from payer or governing entity, etc.) as indicated by the reason for claim overpayment.

Step 4. Identify the name of the payer's contact person or department who should receive the claim appeal for review.

- Be sure to address the claim overpayment appeal letter to the appropriate payer representative so that a specific person will be responsible for a reply, whenever possible. The payer's recovery notification letter should provide instructions as to where you should send the appeal. If not, review your contract for the payer's claims appeals process or call the payer and request the name and address of the payer representative or department to which you should address the claim appeal.

- If you choose to call the payer, indicate you are seeking to appeal an overpayment recovery request. Some payers have separate processes for claim appeals and overpayment recovery request appeals. Also, ask the payer representative the expected time frame for processing the claim appeal letter. This information will help you determine the appropriate time frame for follow-up procedures.

Step 5. Track the information regarding the claim overpayment for the purpose of assisting with follow up and identification of trends.

Step 6. Follow up and monitor the time it takes for the payer to respond to the appeal. Be sure to consult your contract with the payer in order to ensure compliance with a timely response.

6. What is at stake when I do not appeal an invalid overpayment recovery request?

Payers save money when they partially pay, delay, deny a claim payment or recoup an alleged overpayment because only a small percentage of physicians and their practice staff routinely pursue an appeal. When you do not review and appeal payers' inappropriately paid claims, denied claims or overpayment requests, your practice loses revenue. Challenging inappropriate claim payments through the payer's appeal process also demonstrates that you have made an effort to correct the payer's inaccuracy. Appeal efforts could lead to a change in the payer's business practices and can also save your practice money.