# Automating the overpayment recovery process

Standard electronic health care transactions can help a physician practice make significant progress in improving administrative workflows. By automating the overpayment recovery process, a practice can save time and find ways to prevent future overpayments.

**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 are the different ways in which payers can use the Accredited Standards Committee (ASC) X12 835 electronic remittance advice (ERA) transaction to communicate information regarding overpayment recovery?

The ASC X12 835 Implementation Guide details multiple ways that the ERA transaction can be used to communicate overpayment recovery information. The X12 835 can:

1) Report the overpayment in the form of a reversal of the previous adjudication and the correction statement of the revised adjudication, leading to immediate recoupment;
2) Report delay of recoupment of the overpayment identified in the reversal and correction;
3) Report receipt and crediting of a check sent to the health plan to cover the overpayment; or
4) Report recoupment of a delayed overpayment recovery that was originally reported in a prior 835 or on a paper notification.

Payers' usage of the X12 835 will depend on state laws regarding overpayment recovery notification and the plans' particular business practices.

### 2. How can I use my practice management software system (PMS) to reduce the number of overpayment recovery requests that my practice receives and automate the process when overpayments occur?

All physician practices are encouraged to keep track of overpayment recovery requests and utilize a payer follow-up log and other electronic tracking mechanisms for payer under- or overpayment requests as process improvement tools. Using electronic transactions to automate and standardize the workflows in your practice can reduce the likelihood of payer overpayment recovery requests. If your PMS does not allow you to handle immediate responses from payers or provide the electronic functionality that your practice needs to address overpayment recovery requests on individual claims, visit the AMA's Selecting a practice management system toolkit for guidance.

In order to assist physicians in maximizing their benefits from the use of the ASC X12 835 and minimizing the administrative burden associated with manual processing, the AMA created a white paper (log in) that details how the ASC X12 835 overpayment recovery and balance forward process works, associated accounting processes and how to use the information in order to automate administrative workflows. Physician practices can share this document with their technology partners, including clearinghouses, billing services, PMS vendors and information technology staff. These technology partners can then use the white paper to learn how to automate their overpayment recovery processes, which will in turn reduce the administrative burden for their physician practice customers and increase customer satisfaction.

**3. How can I leverage practice automation to track overpayment recovery requests?**

When tracking overpayment recovery requests, be sure to monitor follow-up activity that identifies each claim you have submitted and contains the payer's rationale for partially paying, delaying or denying a claim on first submission or requesting a refund of an alleged overpayment, along with the outcome of your collection efforts. Your practice management software should offer an electronic tickler file or tracking capabilities to help you to closely monitor overpayment recovery requests (by payer) in addition to your practice's overpayment recovery activity.

Necessary information for tracking overpayment recovery requests includes:

- Payer name
- Reason for originally partially paying, delaying or denying a claim, or requesting a refund
- Dates of appeal attempts
- Payer staff contact(s)
- The reason the claim was not paid in full (if applicable)

**4. How can an overpayment recovery be tracked between multiple ERAs when the amount being recouped exceeds the amount of the current payment?**

The balance forward process applies when overpayment recoveries or other reductions in payment exceed the payment amounts for claims or other physician payments, like capitation payments. The ASC X12 835 Implementation Guide expressly forbids sending a payment amount that is negative. As a result, the balance of that specific 835 must be increased to zero. This is done by "moving" the deficit from the current remittance advice into the next remittance advice.

The health plan is required to report the deficit that is moving using Provider Adjustment code "FB", meaning Forwarding Balance. Just like with overpayment recovery, an identifier is also required. In this case, the identifier for this remittance advice is used as the identifier for the balance forward. The related dollar amount is a negative number.

In the next remittance advice, the health plan is obligated to report the same forwarding balance information, but with a positive dollar amount (of the same magnitude). That moves the entire forwarding balance into this next remittance advice.

If the new remittance advice doesn't include sufficient funds to cover the balance forward and any new overpayment recoveries (ends up with a negative balance), then a new balance forward is created to start the process again.

**5. How do I know if the payer overpayment recovery requests that I receive are compliant with ASC X12 version 005010?**

The ASC X12 version 005010 Implementation Guide allows for multiple business scenarios. The payer must send notification (i.e., paper or electronic) which should illustrate the reason(s) for the overpayment recovery request on the individual claim. Certain identifying information must be available within the notification of the overpayment recovery request in order to be compliant with ASC X12 version 005010. Such content should set forth the timeframe by which the provider should respond to the overpayment recovery request and the consequences beyond this defined timeframe. In addition, the notifications must, at a minimum, display the: 1) Financial Control Number (FCN)/Other identifier and 2) qualifier (i.e., WO), and 3) the amount of the overpayment. In most cases, a correction and/or reversal of the overpayment is shown on the electronic notification as well.

The Health Insurance Portability and Accountability Act (HIPAA) requires payers to send standard electronic health care transactions that are compliant with the ASC X12 005010 Implementation Guides, which means the payer is required to send specific information regarding an overpayment on the ERA for the intended business purpose that includes notification of an overpayment, recoupment of an overpayment and confirmation of the receipt of a check for payment of an overpayment.

Visit the AMA's ERA toolkit for more information and resources on how your practice can transition to ERA today.

**6**. **What do I do if the electronic overpayment recovery notification, recoupment or payment acknowledgement is not being sent within my ERA?**

Payers are required to provide specific information in the ERA. All public and private payers must be able to handle all mandated electronic transactions in HIPAA-compliant electronic formats. This includes claims and ERA transactions. Automation of the physician practice is dependent on payer compliance with these standards in order to eliminate administrative waste. If you are not receiving such information on your ERA, consult your PMS vendor, billing service and clearinghouse directly. You may need to contact the payer in question in order to determine if such electronic options for their overpayment recovery notification, recoupment and acknowledgment process are available. If you feel that your inquiries are not being properly addressed by the payer, the AMA encourages you to file a formal complaint with the Office of E-Health Standards and Services (OESS).