Overpayments & Refunds Policy

PURPOSE

The purpose of this policy is to ensure the appropriate handling of errors received from Federal healthcare programs.

POLICY

Bluestone Physician Services (BPS), through its Compliance Officer, must report and return any overpayment received during the look back period by the date which is sixty (60) days after the date on which the overpayment was identified. BFS will promptly process such payments and adjustments. Errors that do not require payment adjustment will be assessed and handled on a case-by-case basis.

SCOPE

This policy applies to all *covered persons of Bluestone Physician Services, P.A., Bluestone National, LLC, and Bluestone Physician Services Wisconsin, and its subsidiaries and affiliates, (collectively, Bluestone Physician Services (BPS)).

*Covered persons means: (a) all owners who are natural persons, officers, board members, and employees of Provider; (b) all contractors who furnish patient care items or services or perform billing or coding functions on behalf of Provider; and (c) all physicians and other non-physician practitioners who are members of Provider's active medical staff.

DEFINITIONS:

Error – The word "error" as used in this policy refers to prohibited conduct as it relates to billing, charging, or coding errors. For example, a billing error could be a claim incorrectly submitted for a service that is not medically necessary, or a claim submitted in violation of Medicare's Regulations. A charging error could be a claim submitted for two procedures in a

day when in fact only one procedure was performed. A coding error could be a claim for a higher-level CPT code when in fact the documentation only supports a lower-level CPT code.

Federal health care programs means any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government, including, but not limited to: Medicare, Medicaid, managed Medicare/Medicaid, TriCare/VA/CHAMPUS, SCHIP, Federal Employees Health Benefit Plan, Indian Health Services, Railroad Retirement Benefits, Black Lung Program, Services Provided to Federal Prisoners, PreExisting Condition Insurance Plans (PCIPs) and Section 1011 Requests.

"Identification" of or "Identified" means that a determination has been made, through the exercise of "Reasonable Diligence," that an overpayment has been received, and the amount of the Overpayment has been quantified.

Non-Routine Overpayment: Overpayments identified through non-routine charging and billing processes. Examples of Non-Routine Overpayments include but are not limited to: re-bills identified through a Compliance Matter /investigation, Stark-related canceled claims, a risk-related case that was originally billed without regard to the risk event and then required an adjustment or cancelled claim, DHS/OIG requested reviews, Third-party payer, Medicare Administrative Contractor (MAC) Comprehensive Error Rate Testing(CERT), MAC Target, Probe and Educate (TPE) reviews, Coding reviews, etc.

Overpayment means any funds that Bluestone Physician Services receives or retains under any Federal health care program to which BPS, after applicable reconciliation, is not entitled to under such Federal health care program.

Reasonable Diligence shall mean a timely, good faith investigation of credible information, which is generally 6 months from receipt of credible information, except in extraordinary circumstances. A determination that extraordinary circumstances exist that may permit extension of the reasonable diligence period beyond 6 months is a factually-specific determination that must be made and documented by Regulatory Counsel, if applicable. Examples of extraordinary circumstances may include unusually complex investigations, natural disasters, or a state of emergency.

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PROCEDURE:

I. Identification of Errors.

1. When a staff member identifies an error, as defined above (e.g., through an audit or complaint), he or she must promptly notify the Compliance Department of the error, regardless of the amount overpaid or the time passed.

BPS Compliance Officer with the Legal Department will identify errors and payments subject to adjustment under this policy.

Types of errors include, but not limited to:

Documentation errors are those relevant to the content and quality of the claim, including but not limited to:

a) Coding changes to reflect corrections for undocumented procedures originally charged to the payer;

b) Originally billed services or service levels not appropriately supported by medical record documentation;

c) Inappropriately authorized or documented services, procedures or tests;

d) Unauthorized or undocumented services, procedures, or tests;

e) Documentation deemed illegible; and

f) All undocumented charges.

Operational errors are those that result from operations processes. These errors must be refunded if the documentation cannot be properly and legally corrected.

Operational errors include, but are not limited to:

a) Incorrect date of services;

b) Medical record unavailable at time of audit;

c) Incorrect place of service;

d) Inappropriate application of charge code (CPT/HCPCS).

e) Unbundling of charges.

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2. Staff members or departments who believe that the criteria a potential refund is met will submit an online PACE Refund Form (See Attachment A) located on the BPS Compliance Intranet and email it to Compliance@bluestonemd.org.

a. Except as described in Section 3 below, refunding of Overpayments shall be done through claims adjustments, credit balance, self-reported refunds, or other reporting processes set forth by the applicable payer to report an overpayment. To the extent an Overpayment is calculated through the use of a statistical sampling methodology, the methodology must be described in the report. For all payers, the BPS report shall include the information required by Attachment A, the Payment Adjustment Correction of Error Form. The Compliance Officer or designee shall notify the payer, in writing, of any:
    i. Substantial Overpayment;
    ii. Matter that a reasonable person would consider a probable violation of criminal, civil, or administrative laws applicable to any Federal health care program for which penalties or exclusion may be authorized;
    iii. The employment of or contracting with an ineligible person;
    iv. Any other overpayment determined to be material by the Legal Department and Compliance Officer as reportable.

3. The Compliance Department will review and identify if the errors and payments are subject to adjustment under this policy, reasonable diligence, and determine if it meets the criteria for a refund and will consult with the Legal Department if Corporate Compliance deems necessary.

a. To the extent Bluestone Physician Services is subject to a Corporate Integrity Agreement, the Compliance Officer or designee will evaluate all non-routine overpayments for potential reporting to Federal Health Care Program payors or under the requirement to report all substantial overpayments within 30 days after determining a reportable event exists.

4. Determination will be made whether the error resulted in an overpayment, under-payment or no reimbursement impact and whether payment adjustments will be required.

5. At any time while a potential overpayment is being investigated, the Compliance Officer or designee may seek approval to put a hold on billing for services that may have been submitted in error.

6. Payment adjustments resulting from errors discovered in Government Audits, and other governmental filings will be processed through the appropriate repayment mechanism (e.g., disclosure for audit correction, amendment to reports filed). Identification and communication of potential payment adjustment issues will be addressed in accordance with BPS Revenue Cycle procedures.

7. If there is reason to believe that the error was the result of a systemic error that would cause the same errors in other similarly situated cases, the scope of the overpayment review will include a look-back period.

a. Look-back Period.
Government Payers: The look-back period for overpayments for all payers should go back to the date when the error began, if it can be reasonably determined. The standard look-back is 6 years unless advice from the Legal Department deems a different time frame.

II. Processing Payment Adjustments

1. BPS Revenue Cycle Business Office will process claims payment adjustments via established procedures.

2. For claims payment adjustments that meet the criteria for a refund, a coordinated approach will be followed.

3. The Corporate Compliance Department and Revenue Cycle Management are required to document the reason for the payment adjustment and verification of the completion of the payment adjustment. The Compliance Department is responsible for maintaining the documentation regarding the final disposition of any payment adjustments made under this policy.

4. For operational errors which do not result in payment adjustments, the relevant business unit and revenue cycle must document the rationale supporting the decision not to process repayment. A "Documentation of Errors Not Refunded Form" may be required and submitted to the Compliance Director for signature.

ENFORCEMENT

All staff whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination

RESOURCES

- CMS: Medicare Reporting and Returning of Self-Identified Overpayments
- CMS MLN: Medicare Overpayments (03.2021)
- Public Law 111-148, Section 6402(a) (d) (codified at Section 1128I (d) of the Social Security Act) (requires overpayments owed to the federal government to be reported and returned within 60 days of identification).
- 2010 Minn. Law Ch. 331, § 5 (codified at Minn. Stat. § 62Q.75, subd. 4(a)(establishes a 12-month deadline to adjust payments made by Non Government Payers to providers, with some exceptions, effective for contracts entered into after August 1, 2010).
- 2010 Minn. Law Ch. 331, § 6 (codified at Minn. Stat. § 62Q.751) (requires deductibles and coinsurance amounts paid by patients in error to be refunded within 30 days of the date in which the adjudication is received by the provider).

Approval History

Date (MM/YYYY)	Stakeholders	Name/Title
8/9/24	Executive Compliance Committee	Approved at August ECC meeting

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Revision History

Date (MM/YYYY)	Revisions	Name/Title	Version
7/2024	Updated	Andrea Furmannek-Kloubec, CO	1.0

Revision History

Date (MM/YYYY)	Revisions	Name/Title	Version
1/2021	Original	Candice Levy, VP, Clinical Operations	V1.0
1/2021	Final Approved	Tim Kohler, COO Sarah Keenan, CCO	V1.0
4/2022	Added Purpose, Scope, Definitions, and resources	Candice Levy, VP, Corporate Compliance	V1.1
05/2022	Formatting Changes	Christy Roarke, Compliance Program Manager	V1.1
10/2023	Procedures Updates	Andrea Fuhrmannek-Kloubec	V1.1
12/11/2023	Policy Revisions, Final Approved	Rajiv Patel, CEO, Andrea Fuhrmannek-Kloubec, VP of Compliance, David Nelsen, CFO, Sarah Keenna, COO	V2.0

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Attachment A:

Payment Adjustment Correction of Error (PACE) Form:

Bluestone Corporate Compliance
Payment Adjustments and Corrections of Errors (PACE) Form

Completion of the PACE form is required when an error is discovered and criteria is met as outlined in Compliance Overpayments and Refunds Policy.

Instructions: Complete all fields on this form and submit the completed form to the Compliance Department by email: compliance@bluestonemd.com. Once submitted, this will be presented at the External and Internal Steering Committee for review and guidance towards timely resolution. You may be contacted to attend this committee to provide additional information. NOTE: Do not order/compile claim data reports until requested by Corporate Compliance (refer to Compliance Refund and Overpayments Policy).

Today's/Submission Date:		**Date Discovered:**	
Reporter Name, title, department:		**Date Error Started:** (if unknown, please indicate greater than 1 yr, etc.)	
Reporter Email:		**Date Error Fixed:**	
Reporter Phone:		**Date work-around initiated** (if applicable)**:**	
Error Type/Title:			
Dept Impacted:		**Other**	
Entity Designation (Facility, Markets impacted)		**Claim type impacted:**	☐Phys/Profees (1500) Other:
Payers impacted:		**Names of individuals aware/involved:**	
Summary/Description of error (below – please include how this was discovered, service -CPT/HCPCS codes-Status indicators, approximately how many claims impacted, and example claim/patient encounter)**:**			
Source of Error (below)**:**			
Action required to fix error (below – please include IT ticket # when applicable)**:**			

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Error resulted in (i.e. overpayment, incorrect charges, etc.)**:**	
Attachments (i.e. email communications, educational documents, policies, regulatory, payer or other billing guidance documents, etc.)	

Date closed -

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[1] Prepared at the direction, request, and in furtherance of the purposes of a review organization and any and all information and documentation prepared in furtherance of this policy is confidential and should not be shared outside of Bluestone Physician Services or its Affiliates. Protected under Wis. Stat. 146.38 and Minn. Stat. 145.61et seq. and FL Stat 766.101. The information contained herein is provided for informational purposes only and does not constitute legal, medical, or professional advice. Further, these policies and procedures are subject to change without prior notice, and Bluestone makes no representation to reliance on users of outdated information. Users should check back here for updates regularly.