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Timeliness is critical when managing credit balances in the unclaimed property process

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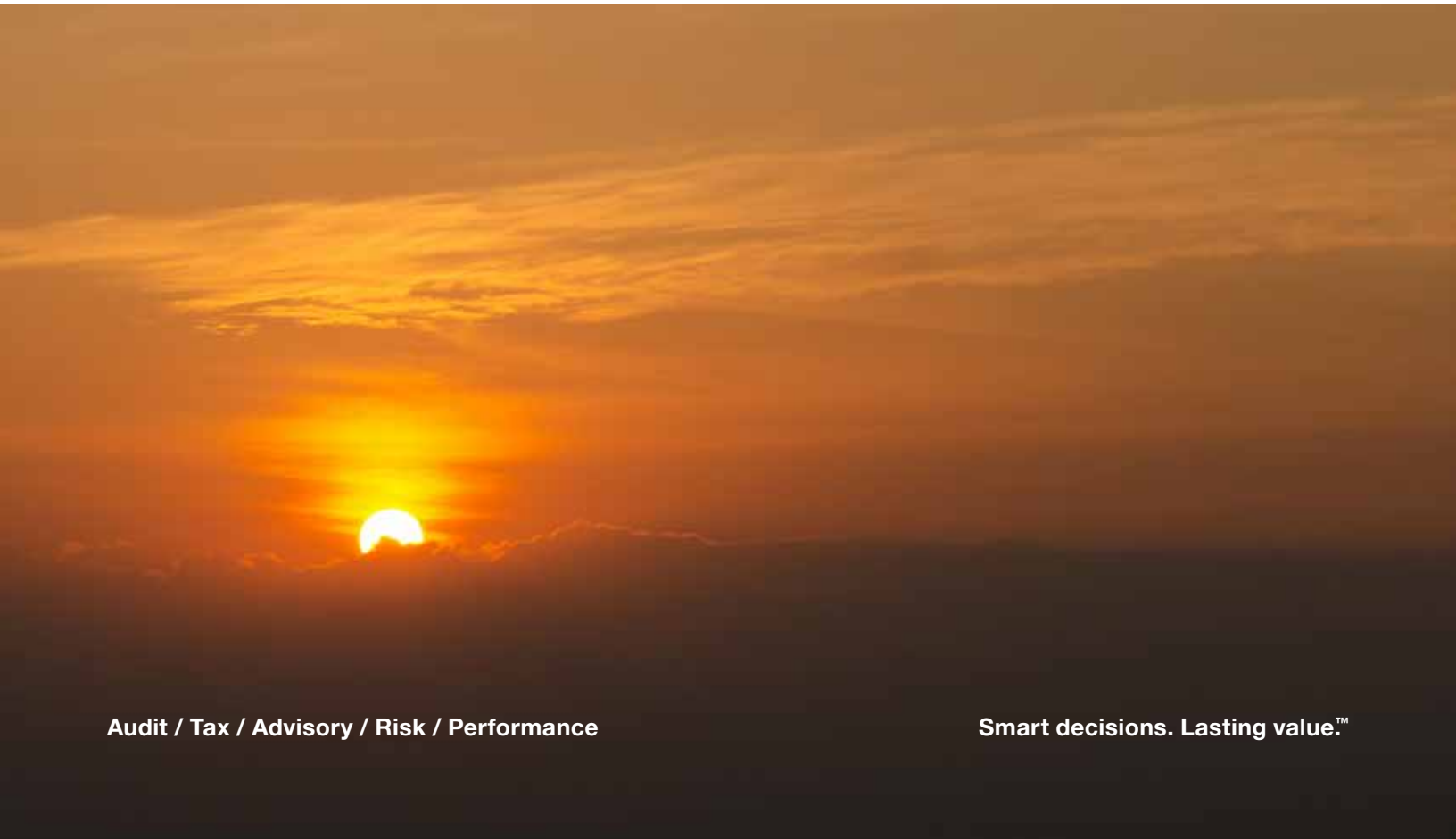

In today's dynamic healthcare environment, with tight financial restraints and limited resources, aged credit balances and unclaimed property may not be top priorities for many healthcare organizations.

Increased scrutiny of credit balances at the federal and state levels, however, have put unclaimed property in the spotlight. Organizations should take note in an effort to mitigate financial risk or unwanted media attention.

Common types of unclaimed property in healthcare include accounts receivable credit balances, unapplied cash, unidentified remittances, overpayments, patient refunds, small credit balance write-offs, accounts payable, and payroll. Although there have been laws in place for years, new requirements set forth by the *Affordable Care Act* (ACA) and clarified by the Centers for Medicare & Medicaid Services (CMS) Medicare Reporting and Returning of Self-Identified Overpayments (60-day overpayment) rule (final rule issued in February 2016)[1] have made it more important than ever for healthcare organizations to consider unclaimed property ramifications and address credit balances in a timely manner.

The U.S. District Court for the Southern District of New York in the August 2015 case *Kane v. Healthfirst, Inc., et al.*[2] determined that a credit balance is identified when a provider is made aware of a potential overpayment, and at that time the 60-day reporting period begins. Most patient accounting systems have a standard functionality to identify credit balances; therefore, organizations should make every effort to review potential credit balances periodically and resolve them as soon as they are identified. Cases such as *Kane v. Healthfirst* suggest that CMS will continue to focus on overpayments.

In addition, state governments, many of which are cash strapped, recently have been more assertive in enforcing their unclaimed property laws as a way to raise revenue. Increased focus on and activity surrounding aged credit balances have led to a growing number of unclaimed property audits by the states. These audits often are conducted by third-party contract auditors – paid by the states on a contingency of their findings – to review an organization's records to determine its compliance with applicable state unclaimed and abandoned property laws.

Often, credit balances appear as a surprise in the audits, unveiling liabilities that may have been written off or are no longer on an organization's books. Credit balance resolution efforts often are poorly documented in hospital recordkeeping systems. In these situations, auditors use extrapolation techniques to estimate prior liability. An organization can mitigate its unclaimed property liability and risks by implementing sound policies and procedures for identifying, reviewing, and attempting to resolve credit balances and other types of unclaimed property common in the industry. The policies and procedures should ensure any outstanding credit balances are escheated to the state as unclaimed property.

Timely resolution is essential

Although the CMS 60-day overpayment rule applies to Medicare credit balances, health systems should focus on the timely resolution of all types of credit balances, including commercial credit balances and patient credit balances.

All types of credit balances carry a degree of risk if left unresolved:

- Unresolved patient credit balances can create a customer service or customer satisfaction issue for providers, potentially damaging the organization's reputation in the community.
- Insurance credit balances often come up in contract discussions, creating leverage for the payer to impose harsher requirements on the provider.

How can organizations work credit balances effectively? A best practice is to focus on identification, frequency of review, and timely resolution. Actively identifying and working accounts in a timely manner can help an organization identify and resolve credit balances that are not truly overpayments but, rather, incorrect contractual or administrative adjustments. These adjustments typically result in an immediate positive balance sheet pick-up for an organization.

Another advantage of working credit balances in a timely manner is the greater likelihood that a patient's contact information, such as a mailing address or phone number, is current and can be used for due diligence outreach. The longer credit balances are aged and left unresolved, the less likely a patient can be contacted with the information on file. If an organization is unable to contact a patient to return a credit balance, then that balance needs to be included in its unclaimed property reporting process.

Industry best practice is for an organization to review and resolve credit balances in its patient accounting system after a defined period, typically 12 to 18 months, versus leaving the credit balance open and active in the system for months or even years.

Suppose there is a credit balance on an account that has not had any activity for one year. Best practices suggest posting an administrative adjustment in the patient accounting system to resolve the credit and then tracking the liability in a separate escheat general ledger account that is reviewed on an annual basis and, if unremediated, including the credit in the organization's unclaimed property process.

A good control method reduces risk

Risk can occur when credit balances are active and overlooked from an unclaimed property perspective when an organization does not have an adequate review process. Resolving credit balances in the patient accounting system and including the overpayments in a regular review and follow-up process generally is a good control method and mitigates risks for the health system.

The risk surrounding credit balances and unclaimed property is an important but often overlooked area as healthcare organizations juggle myriad regulations and rules associated with the ACA. A well-coordinated and controlled process for reviewing and resolving credits – in a timely manner – can go a long way to helping an organization be cognizant of and compliant with state unclaimed property laws.

Learn more

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[1] The "Medicare Reporting and Returning of Self-Identified Overpayments" rule "requires Medicare Parts A and B health care providers and suppliers to report and return overpayments by the later of the date that is 60 days after the date an overpayment was identified, or the due date of any corresponding cost report, if applicable" (https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-11.html).

[2] *Kane v. Healthfirst, Inc. et al.*, No. 1:11-cv-02325-ER, Doc. No. 63 (S.D.N.Y., Aug. 3, 2015).

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