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Retain payment for your services! Claiming offsets in overpayment appeals

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Payer audits of provider claims are inevitable, even for the most compliant providers. The first line of defense in response to payer audits, if appropriate, is often a challenge to the asserted basis for the entire overpayment: The claim is medically necessary or the technical denials are not material to payment of the claim and should be reversed.

Case law evolving from the wave of recovery audit contractor programs in the early to late 2000s and the *Universal Health Services, Inc. v. United States ex rel. Escobar* and its progeny support a second step in payer appeals: the assertion of claims for offsets. The principle is simple: The provider should be allowed to retain the fair value of the medically necessary services rendered (the fair value received by the payer).

This article is intended to introduce provider appeal teams to the offset concept and set forth steps for the team to undertake in order to support appeals asserting this alternative claim to retain the value of medically necessary services rendered.

Offsets explained

An offset in the provider overpayment setting means an amount the provider is entitled to retain that reflects the value of the services rendered. The amount of an offset a provider claims will vary widely depending on the provider and services rendered, but an offset is calculated based on the value of the medically necessary services rendered and is meant to offset a payer's claim that the entire amount paid constitutes an overpayment.

Providers often face notification of alleged overpayments from payers who have audited paid claims and identified certain claims as potential overpayments. Alleged overpayments can be identified by any type of payer who has received claims for reimbursement from providers, including traditional federal payers (such as Medicare, Medicaid, and TRICARE), managed care organizations for government programs (such as Medicaid managed care organizations or Medicare Advantage plans), or commercial payers (such as Blue Cross Blue Shield, UnitedHealthcare, Cigna, Aetna, and other commercial health insurance companies).

The basis stated for alleged overpayments is often a lack of medical necessity to support a claim filed or a technical reason, such as missing or incomplete claim forms. Then, as payers identified overpayments, payers would claim the entire amount of reimbursement paid for each claim constituted related overpayments.

A provider's first line of defense in a payer audit is usually to refute the underlying basis for the alleged overpayment, arguing the services rendered were medically necessary or that the alleged technical error did not occur or should not result in an overpayment.

What has been missing in many provider appeals is the next step: a claim for an amount of an offset, in the event the overpayments are upheld. This involves a demonstration that medically necessary services were provided to the beneficiary and, in the event the overpayment is confirmed, an assertion that the provider is entitled to retain

the value of those services as an offset to the overpayment identified.

Offsets recognized in the hospital setting

Centers for Medicare & Medicaid Services has long recognized that payment may be made under Part B in many circumstances when Part A payment is denied. This was demonstrated in a decision rendered in 2010 by the Centers for Medicare & Medicaid Services Departmental Appeals Board in *In the Case of O'Connor Hospital*.[1]

In the *O'Connor Hospital* decision, the recovery audit contractor had determined the hospital's claims for Medicare coverage for inpatient hospitalization services were not medically necessary and asserted the entire amount of the claims constituted the overpayment. However, the Departmental Appeals Board ordered payment under Part B to be paid when payment under Part A was denied and ordered the contractor to offset the Part A overpayment. In rendering the decision, the Departmental Appeals Board referred to the Medicaid Benefits Policy Manual, Chapter 6, which allows for Part B payment to be made in many circumstances if Part A payment is denied.[2]

Providers appealing Part A overpayments can therefore examine the rationale in the *O'Connor Hospital* decision and Medicare manuals to determine if an offset is supported by these authorities.

Offsets for other types of provider appeals

Recent case law supports not only hospital offset claims, but also offset claims made by any type of healthcare provider facing payer overpayment demands.

In *Universal Health Services, Inc. v. United States ex rel. Escobar*, referred to as the *Escobar* case, the U.S. Supreme Court made clear that not all violations of an express condition of payment are material or significant.[3] In interpreting *Escobar*, a recent district court decision, *United States v. Salus Rehab., LLC*, describes the practical effect of the *Escobar* decision and describes it as assuming and enforcing a course of dealing between the government and a supplier of goods or services based on "proven and successful principles of exchange — fair value given for fair value received."[4]

To this end, the *Salus Rehab* decision describes *Escobar* as rejecting a "system of government traps, zaps, and zingers that permits the government to retain the benefit of a substantially conforming good or service but to recover the price entirely…because of some immaterial contractual or regulatory non-compliance."

When raising an offset, a provider is asserting that it should retain the fair value of the medically necessary services rendered (the fair value received by the payer), even if there were technical issues associated with the claim.

When an offset argument will not work

Claims for offsets are only viable when the underlying services were medically necessary and of value to the beneficiaries receiving the services. If a payer or prosecutor alleges fraud or abuse, the allegation may be based on an assertion that the underlying services were not medically necessary. As examples, a payer or prosecutor may allege overpayments and/or fraud on the basis that the services in question were not provided or were "worthless services" because the services were not received by the beneficiary or are of such poor quality the services are deemed "worthless." In this setting, the provider may disagree with the payer or prosecutor about the allegations and can robustly defend against the allegations, if warranted. But, in these cases, an alternative argument for offsets based on the fair value of medically necessary services is not viable where the payer or prosecutor is arguing none of the services are medically necessary.

When to raise the right to an offset

The time to raise the right to an offset is within the first response or first appeal raised in defense of the payer

audit. If an appeal is already ongoing, consider adding it to the pending appeal.

At the beginning of an appeal, when a provider receives a payer's audit results and related overpayment demand, the provider first assesses whether the asserted basis for the overpayment demand is accurate or if the provider needs to challenge the entire overpayment as unfounded. If the provider determines that the overpayment should be challenged, the provider then gathers evidence and clinician support to substantiate the medical necessity for the claim submitted.

This is where the payer will add the offset alternative—an argument that if the claim is upheld as an overpayment, the provider is entitled to an offset in the amount of the value of the medically necessary services provided.

How to request and calculate an offset

The calculation of an offset may be fairly straightforward in some cases, as demonstrated by the following hospital inpatient stay example. Several years ago, the federal and state recovery audit contractors focused on short hospital admissions, arguing in many instances that the one- to two-night inpatient stays should have instead been billed as observation claims. Assuming the hospital provider believed the one- to two-night stay in the inpatient setting was appropriate, the hospital provider would first defend against the audit findings by demonstrating the medical necessity of the inpatient setting. However, it was common to add the alternative claim for an offset in the form of *observation reimbursement* if the *Part A admission* was upheld as an overpayment. The idea is to get paid some reimbursement for the service provided instead of the entire claim being denied and no payment being made for the services provided.

Physician evaluation & management (E&M) claims can also be fairly straightforward: If the alleged overpayment is based on an argument the level of E&M coding was too high, the claim for an offset would be to keep the reimbursement related to a lower E&M claim. Claims for offsets in other provider appeals, including hospice, can be more complex, but all involve the same following steps:

1. Identification of medically necessary services,
2. Clinician or expert support for the assertion of the medical necessity claim, and
3. Claim for offset and related calculation.

Identification and support of medically necessary services (for the offset)

In an appeal concerning the issue of medical necessity, where a payer has identified an overpayment on the basis of lack of medical necessity, a provider often sets forth a clinician or expert witness presentation refuting this payer position and supporting the medical necessity of the services.

Here, to support an alternative claim for an offset, the same clinician or expert witness would add additional language, such as:

> In my judgment, beneficiary NAME was eligible for TYPE OF SERVICES. However, in the event beneficiary NAME was found to not be eligible for TYPE OF SERVICES, medically necessary services were provided to beneficiary NAME, and TYPE OF SERVICES should be compensated by PAYER for these services.

This clinical analysis of the offset will constitute a new and separate section of the in-house or expert's affidavit or report. This section can be placed after the presentation concerning the beneficiary's eligibility for services and before the conclusion and signature block.

Instead of overpayments based on a lack of medical necessity, payers may deny claims based on technical

grounds. Such technical grounds might include payer form not being used, missing or incomplete payer forms, missing preauthorization paperwork, etc. In technical cases, in addition to challenging the technical grounds, the provider will want to set forth a clinician or expert witness presentation supporting the underlying medical necessity of the services. In technical cases, the clinical analysis of the offset will resemble a clinician's report to support the overall medical necessity of a claim.

Claim for offset and related calculation

The related calculations of the overpayments should be prepared by the provider's chief financial officer or designee, a director or leader in the revenue area, and/or by a director or leader in the billing department. The process for calculating the offset should constitute a new section in the appeal letter and potentially include a related spreadsheet showing the offset calculations.

In the previous hospital short inpatient stay example, the hospital would argue that, as an alternative to Part A reimbursement, an observation setting would have been appropriate. Then, the hospital would calculate the expected reimbursement for the observation stay as an amount to offset against an overpayment stemming from a denial of the inpatient claim.

In contrast, in many other cases, the most complex aspect of asserting the right to an offset is often the identification of the services rendered and related calculation of the amount of the offset. As an example, a hospice may face notification of alleged overpayments from a payer such as Medicare claiming that the beneficiary in question was not eligible for hospice. The payer then often issues a demand seeking the repayment of the entire amount paid for the hospice benefit period in question.

Again, the first line of defense, if true, is to first defend against the audit findings by demonstrating the medical necessity of eligibility for hospice. This argument would be similarly supported by an in-house clinician or expert witness affidavit or report. The next step to support a claim of offset would be to work with the same in-house clinician or expert witness state to set forth the beneficiary's diagnosis, comorbidities, and services rendered in order to demonstrate the beneficiary's chronic medical condition(s) and confirm the hospice's provision of medically necessary services to address the beneficiary's conditions and symptoms.

The hospice with its clinical expert will then determine the total value of the services rendered: Is the alternative payment in this instance analogous to a home health payment? Is the proper measure a skilled nursing payment? Or should the value of the individual services be identified and calculated? Each beneficiary's case will need to be individually examined to determine the most accurate measurement of the offset payment. After the clinician affidavits or reports have been drafted, the hospice will work to calculate the offset amount for each beneficiary.

For overpayment denials based on technical grounds, a similar process of completing clinician affidavits or reports will be completed, along with the calculation of the offset amount for each beneficiary. What is key here, however, is that the offset claim is likely to be the entire amount of the claims, because, unless medical necessity grounds are also cited, technical grounds will not include medical necessity challenges.

Conclusion

Even the most compliant provider will face payer audits, including findings of overpayments based on lack of medical necessity or for technical errors. As the provider team begins its response to the payer audit, consider not only challenging the basis for the entire overpayment, but whether it might be helpful to include alternative claims for offsets. Including assertions to retain the fair value of the medically necessary services rendered (the fair value received by the payer) may help you retain the reimbursement fairly paid for your services.

Takeaways

- Start asserting right to retain value of services rendered.
- Begin supporting claim for offsets in first level of appeal.

- In medical necessity cases, consider adding a section in clinical reports to support alternative claim for offsets.
- For technical denials, add medical necessity clinical reports to support claim for offsets.
- Work with financial colleagues to calculate individual beneficiary offsets.

1 Department of Health & Human Services, Departmental Appeals Board, Action and Order of Medicare Appeals Council, *Claim for Hospital Insurance Benefits in the case of O'Connor Hospital (Part A)*, February 1, 2010, https://bit.ly/31X3uKO.
2 Centers for Medicare & Medicaid Services, *Medicare Claims Processing Manual*, Pub. 100-04, ch. 6.
3 Universal Health Services, Inc. v. United States ex rel. Escobar, No. 15–7, 579 U.S. ___ (2016).
4 United States v. Salus Rehab., LLC, CASE NO. 8:11-cv-1303-T-23TBM (M.D. Fla. Jan. 11, 2018).