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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.