



# University of Connecticut Health Center

**POLICY NUMBER: 2007-12**

**May 19, 2008**

**POLICY: Determination, Reporting, Investigation and Correction of Errors Related to Reimbursement from Federal or other Healthcare Insurance Programs**

**POLICY STATEMENT:**

The University of Connecticut Health Center (UCHC) is committed to accurate billing, charging and collections. Whenever the UCHC determines that an error in billing, charging, or collections has occurred, staff responsible for the clinical operations, billing operations, and reimbursement operations will investigate the cause, define the scope and remedy those errors in a timely manner and in accordance with payor requirements. The Compliance Office and the UCHC Assistant Attorney General may be utilized to clarify the cause, scope and remedy.

An employee with knowledge of an error in billing or reimbursement from a federal or other healthcare insurance program is required to provide that information in a timely manner to their supervisor. Whenever possible, the information provided should be specific to include the type of problem or error, the date and place of occurrence and the dollar amount involved. Delay of corrections of errors should be promptly reported to the Compliance Office.

Potential errors may include:

- **Overpayments** – an overpayment results when a claim is submitted to a federal healthcare program or other payor and
  - is paid higher reimbursement for services rendered when there is not appropriate documentation to support the claim; or
  - is paid for a service that should not have been charged, billed or was not rendered; or
  - is paid incorrectly at a higher reimbursement because of an incorrectly submitted claim.
  
- **Underpayments** - an underpayment results when a claim is submitted to a federal healthcare program or other payor and
  - is paid a lower reimbursement for the services rendered when the documentation supports a claim for reimbursement at a higher reimbursement rate; or
  - billable services were rendered that were not billed; or
  - is paid incorrectly at a lower reimbursement because of an incorrectly submitted claim.

- **Data Errors** – data errors may occur when data on a claim is erroneous and the claim cannot be supported by any documentation. Data errors can be caused by inaccurate information in electronic systems or when a code is used but has been changed, modified, or no longer exists.

When it is determined that an error resulted in an overpayment that is routinely reconciled or adjusted pursuant to policies and procedures established by the payor, this amount shall promptly be refunded to the appropriate payors. Notification and repayment to payor(s) shall be done in accordance with the payors policies. If an overpayment involves monies from a federal program payor (e.g., Medicare fiscal intermediary or carrier), notification must be made within 30 days after identification of the overpayment and take remedial steps within 60 days after identification (or such additional time as may be agreed to by the payor) to correct the problem, including preventing the underlying problem and the overpayment from recurring. If the error did not result in a substantial overpayment, but involved a larger volume of services, notification to the Associate Vice President of Patient Financial Services and/or the Chief Clinical Revenue Cycle Officer and the Corporate Compliance, Integrity and Privacy Officer must be made.

When it is determined that a substantive error or significant problem resulted in an overpayment, the department head must notify the Compliance Office. This type of error would be one where a reasonable person would consider the error to have resulted in a *substantial* overpayment or a probable violation of criminal, civil, or administrative laws applicable to any Federal health care program for which penalties or exclusion may be authorized. Determination of the necessary steps to address the error will be made in discussions with the Associate Vice President of Reimbursement, the Associate Vice President of Patient Financial Services, the Chief Clinical Revenue Cycle Officer, and the Corporate Compliance, Integrity and Privacy Officer (CCIPO). These steps may include but are not limited to investigating the particular situation, determining whether the matter is an isolated incident or part of a pattern of errors, determining the scope and developing any corrective actions required to remedy the situation.

The UHC will refund any money it does not rightfully deserve. To the extent an error is determined to involve a federal healthcare program, the UHC will observe federal regulations governing the payback of money and may determine direct communication of the error to the federal government may be necessary. Self reporting of substantive errors and/or significant problems resulting in *substantial* overpayments to the federal government will be done by the CCIPO, with the advice of the UHC Assistant Attorney General, once Finance Senior Management as well as the Chief Financial Officer has knowledge of the situation.

Reference: Policy #2006-03 Billing for Professional Services  
[http://www.policies.uhc.edu/policies/policy\\_2006\\_03.pdf](http://www.policies.uhc.edu/policies/policy_2006_03.pdf)

Policy #2006-04 Refiling of Claims  
[http://www.policies.uhc.edu/policies/policy\\_2006\\_04.pdf](http://www.policies.uhc.edu/policies/policy_2006_04.pdf)

Iris Mauriello (signed)

6/10/08

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**Corporate Compliance, Integrity and Privacy Officer**

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**Date**

Dan Upton (signed)

6/10/08

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**Chief Financial Officer**

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**Date**

Peter J. Deckers, M.D. (signed)

6/10/08

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**Executive Vice President for Health Affairs**

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**Date**

**New Policy: November 27, 2007**

**Updated: May 19, 2008**