The 411 on Patient Refunds*

As a billing manager for many years, and a patient advocate, the subject of overpaid accounts has come up all too often. If patients were truly aware of how much sits, not refunded to them, in the books of medical providers, they might gather pitchforks and descend onto offices to reclaim their money.

This is a ugly yet common practice in the industry. While it has worked well for many providers, it is time to let the public in on the deal, and come clean with patients who are, after all, customers. Does the clerk at the supermarket, or at any other business, require your formal request to hand over your change? Does your credit card company not send you a statement indicating you have a credit balance?

1. Why is it happening?

Unlike any other business, insurance reimbursement will take a couple of weeks at best, months at worst. Paid charges may be appealed or disputed, payments recouped or claims denied or pended. Account balances remain fluid until fully settled, yet patients are usually billed after the first insurance notice. Even if the error or the fault for a denial lies with the medical provider, the patient will receive a statement of insurance non-payment. Threats of collection action will prompt your writing a check.

The other major side to this sad story is "office policy". Though rarely advertised (and for cause!), many practices have a "refund on demand" rule. Don't ask? Don't get!
The administrative burden of processing refunds as soon as a positive balance is noted is often cited as the main excuse. While it is a valid reason, a good compromise would be "refund on demand for sums under $ 50.00 or $ 100.00", and automatic reimbursements for larger overpayments.

2. Common reasons for credit balances:

- Premature payment: your claim had not reached final processing before you received a doctor's bill.
- Pre-Payments: the office demands your payment up front, to cover a deductible, or if out of network.
- Double coverage: If you have two policies, especially primary, overpayments are more likely.
- Double payments: an assistance program may have made payment on a charge, or you may have paid the same bill twice.
- Billing error: an erroneous adjustment may have been posted or an inaccuracy in the billing process may have occured. If you have a common name, expect such errors.

3. What can you do?

Keeping track of your bills, insurance explanations of benefits ("EOB") and payments is crucial. Any statement not matching an EOB should be questioned, and a call placed for confirmation or clarification.

Request a copy of your ledger, or itemized bill, at the end of each year, or after your last visit to a medical facility. Useful for tax purposes as well, it will allow you to scan for errors and check the balance.

Get receipts for any payments, especially if paying cash. At the time of payment, indicate on it whether this is an advance on a future liability, partial payment or payment in full.

Decline to make a payment in advance, even if you have not met your deductible or yearly liability. A contractual adjustment will reduce your bill, but it often is difficult to know how much before a claim is processed. If the facility is in network, they should not ask for any up front payment except for the set office co-pay.

At any suspicion or knowledge of an overpayment, contact the billing department and ask for a refund. While it is certainly unprofessional and deeply disrespectful of patients, expect to wait a while before a

check is cut. Many offices are on top of billing patients but are reluctant, if not outright combative about refunding them.

Do not hesitate to contact the office manager or physician if you are given the run-around or further delay is unacceptable. A complaint to your insurer might be helpful too.

In conclusion:

A French saying proclaims:" Good accounting makes for great friends". This goes for your medical providers and health practitioners. If you cannot trust the staff or the practices they follow, can you really trust the practitioner?
If transparency and patient satisfaction are two important cornerstones of the ACA ("Obamacare") reforms, then surely this practice must be ended.

* as seen on NerdWallet