Billing Paper

American Association of Oral and Maxillofacial Surgeons

Understanding Explanation of Benefits and Reimbursement Audits

I. INTRODUCTION

The explanation of benefits (EOB) contains a lot of useful information for patients and providers. An EOB is a statement sent by a health insurance company to covered individuals and/or providers detailing the charges billed to a carrier; the amount being reimbursed by the carrier; the status of the patient's deductible; and contractual discounts or other patient responsibilities, including non-covered services or services not deemed medically necessary. An EOB also may be helpful to explain out of network charges to a patient.

In the context of coding and billing, auditing is a process of verifying the adequacy of medical record documentation and subsequent code selection. Monitoring may encompass audits or computerized report reviews and, typically, results from an audit that identified coding errors or questionable coding and billing behavior. Practices and payers alike may conduct audits and/or monitor claim activities. OMS practices should have procedures in place to conduct periodic internal audits and be prepared to respond to a carrier audit. Understanding the EOB and accompanying remark codes may provide the OMS some insight as to claim behavior that carriers may be monitoring.

II. UNDERSTANDING THE EOB AND ACCOMPANYING REMARK CODES

EOBs will vary between carriers, especially medical and dental carriers; however, most will include:

- Guarantor/patient information.
- Claim information/claim type/provider information.
- Dates of services submitted – the dates the procedures were performed.
- Service description – the services that were rendered by the OMS and submitted for benefit determination using CDT and CPT codes.
- Billed amount – the total of all procedures submitted for reimbursement consideration.
- Network discount, if applicable.
- Covered amount or provider's allowed amount – the maximum amount the carrier allows the OMS to charge for the specific service due to contractual agreements.
- Plan payment – the total amount the carrier paid for the procedure.
- Guarantor/patient's co-pay/deductible amount – the amount that is expected to have been paid upfront due to the insurance contract patient responsibility.
- Service line details – each charge is broken down separately and adjudicated for payment per each CDT/CPT code reported.

All EOBs will contain reason or remark codes explaining how or why the claim was processed. Reason/remark codes appear on an EOB to communicate why a claim has been adjusted, such as a non-covered procedure, maximum benefit reached, out-of-network denial, etc. If there is no adjustment to a claim/line, then there will not be an adjustment reason code. The OMS and his or her staff should be familiar with EOB language, remark codes and payer agreements (if contracted) to ensure the services have been properly adjudicated and any adjustments were properly made. It also is important to determine primary and secondary overage when a patient has dual coverage so claims are submitted in the correct order. This practice will help avoid a delay in payment.

According to the X12 website, Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) are used to provide additional explanation for an adjustment made by the insurance carrier on an EOB. CARCs explain an adjustment (an amount paid that is different than the amount billed, including a zero payment or a denial) to the amount submitted by the provider. RARCs accomplish two purposes: they

convey informational messages about general remittance practices or they provide supplemental explanation for an adjustment already described by a CARC.

A list of common RARCs and CARCs can be found on the X12 Standards website at X12.org. Dental and medical payers also may utilize a unique carrier-specific list of remark codes on their EOBs. AAOMS encourages OMSs and their staff to become familiar with the X12 remark codes as well as those used by insurance carriers they often bill to or are contracted with. These are a few examples of CARCs and RARCs commonly seen by an OMS:

Claim Adjustment Reason Codes (CARCs)

16 Claim/service lacks information or has submission/billing error(s).

50 These are non-covered services because this is not deemed a "medical necessity" by the payer.

169 Alternative benefit has been provided.

290 Claim received by the dental plan, but benefits not available under this plan. Claims had been forwarded to the patient's medical plan for further consideration.

Remittance Advice Remark Codes (RARCs)

M77 Missing/incomplete/invalid place of service.

M81 You are required to code to the highest level of specificity.

MA130 Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

N37 Missing/incomplete/invalid tooth number/letter.

N56 Procedure code billed is not correct/valid for the services billed or the date of service billed.

When payments are applied, the EOBs should be carefully reviewed and any adjustments made should be documented through the practice management system. This information should be easily extracted from the system for use by the office when negotiating new or revised fee schedules or contracts.

As a reminder, patients receive EOBs from their insurance carriers to inform them of the charges billed and benefits paid to date. Patient EOBs often contain the same information as the EOB sent to a provider, including the doctor's charge as well as the carrier's usual and customary rate, which may prompt calls from patients questioning the disparity in fees, if one exists. Patient EOBs also contain information on fraud and abuse hotlines. Therefore, it is imperative OMS practices ensure provider documentation supports the code and charges billed and that OMSs inform their patients of their financial obligations with a signed pretreatment estimate prior to rendering any services to avoid any disputed charges. This practice also will keep the OMS in line with surprise billing laws and good faith estimates.

For additional information on claim denials, register for the on-demand webinar, Navigating through Claim Denials and Effective Appeal Writing, at AAOMS.org/CEonline.

III. PAYER REIMBURSEMENT AUDITS

Most medical and dental insurance carriers conduct retrospective audits. Retrospective audits are mechanisms used by insurance carriers to detect fraudulent billing behavior and recoup costs associated with administrative oversights. Carriers also may conduct retrospective audits if they have "red flagged" a physician because of what they believe to be overutilization of services or improper use of certain codes or modifiers. Audits may be triggered by computerized monitoring of a practice's claim patterns, a patient or employee complaint, or simply a random review. Carrier audits typically result in the recoupment of overpayments due to lack of medical necessity, incorrect coding, insufficient documentation or administrative errors. However, carrier audits do occasionally detect truly fraudulent behavior, such as billing for services that were not rendered, knowingly billing for unnecessary services, falsifying records or "creative coding" in an effort to purposely override coding edits or unbundle services.

Audits may be automated or personally conducted by an employee of the insurance company. Automated reviews may result in a simple request for a refund of payment made for a particular service or services or may result in the review of a patient's medical record. In larger

audits, the carrier may send an auditor to the practice to conduct an audit of several patients' medical records. Nonetheless, an insurance carrier's request to audit one's records or request a refund should not be ignored or taken lightly.

Every OMS office should have written protocols in place describing the process for responding to carrier audits. With simple refund requests, it is best to evaluate the carrier's reason for the refund. If challenging the carrier's audit findings, it is most helpful if the OMS and his or her staff become familiar with the medical necessity criteria of the plans in which they most frequently bill or obtain a copy of the patient's benefit language to confirm benefits in the event the carrier states the services were not medically necessary or not covered. OMSs may refer to their provider contracts for instructions on the handling of refunds and carrier audits. OMSs also must ensure their documentation is as detailed as possible and clearly describes the surgical procedure(s) to support possible challenges from insurance payers. If one's documentation does not support the service billed, it will be difficult to challenge a payer's refund request or audit determination.

Finally, if an OMS knows the claim resulted in double payment or was submitted fraudulently or incorrectly, the OMS has a responsibility to refund the carrier. In fact, the Affordable Care Act requires a "person" who has received an overpayment to report and return it in writing with the reason for the overpayment no later than 60 days after the date the overpayment was identified. A person violating this requirement also may be considered in violation of the False Claims Act. While this 60-day timeframe mainly applies to Medicare and Medicaid, other third-party payers also may adopt the same policy. Therefore, be sure to review provider contracts and/or speak with a provider relations representatives to determine each carrier's policy. OMSs also should familiarize themselves with their states' insurance laws. An OMS may wish to contact the State Department of Insurance for additional information. If a dispute cannot be satisfactorily resolved through the plan's internal and external review processes, further appeals through an arbitrator or the court may be required.

IV. INTERNAL AUDITS/COMPLIANCE PLAN

The Affordable Care Act (ACA) of 2010 requires all Medicare and Medicaid providers to maintain a mandatory compliance program within their practice. This provision states that "all providers and suppliers, regardless of size, must institute formal compliance programs." Practices without a compliance program cannot enroll in these programs, and those already enrolled risk losing eligibility. Providers who choose to opt out must still follow proper steps when treating Medicare or Medicaid beneficiaries.

While Medicare enrollment mandates a compliance program, implementing such a plan also demonstrates to all insurance carriers a good-faith effort to comply with payer and governmental policies. The Office of Inspector General (OIG) offers General Compliance Program Guidance for individual and small group practices, along with a resource portal that includes toolkits, provider compliance resources and physician-specific training. This guidance is voluntary and nonbinding, outlining best practices for healthcare compliance programs. It emphasizes tailoring programs to organizational size, complexity, and risk profile, with priorities such as annual risk assessments, quality of care, and board/executive oversight. These resources are available at OIG.HHS.gov.

OMS practices should develop internal auditing procedures and a comprehensive compliance plan to ensure adherence to proper coding principles, provider contracts and state and federal laws. A staff member with compliance expertise should be appointed as the practice's compliance officer to oversee the plan, resolve issues promptly and respond to payer audits if necessary. Consulting the practice's attorney is recommended when creating the compliance plan, establishing audit procedures and addressing payer audits.

OIG's Seven Elements of an Effective Compliance Program

OIG identifies these seven core elements as the foundation of a strong compliance plan:

Written Policies and Procedures – Include a Code of Conduct and compliance policies addressing operations and risk areas, that are reviewed and updated regularly.

Compliance Leadership and Oversight – Designate a Compliance Officer and, ideally, a Compliance Committee to establish and enforce the practice's compliance plan.

Effective Training and Education – Provide ongoing, role-specific compliance training for employees within the practice.

Open Lines of Communication – Offer confidential reporting channels and encourage a speak-up culture.

Enforcement and Discipline – Establish and apply consistent disciplinary standards for noncompliance.

Auditing and Monitoring – Conduct regular internal audits and annual risk assessments to identify and mitigate compliance risks.

Response and Corrective Action – Investigate detected issues promptly and implement corrective measures and track remediation.

Internal Audit Best Practices

Assign Responsibility – Designate an independent auditor (not coding/billing staff). This may be the practice administrator or coding/billing supervisor and may include the OMS.

Select Records and Sampling – Use random sampling and standardized audit forms; post-payment audits are most informative.

Establish Compliance Goals – Define acceptable claim submission standards and error thresholds.

Review Entire Patient Record – Check coding accuracy, documentation completeness, and claim integrity.

Prepare Final Report – Summarize findings, identify issues, and outline corrective actions.

Hold Review Meetings – Discuss results with surgeons and staff, particularly the coding/billing staff to improve accuracy and reinforce compliance culture.

Document Actions and Follow-up – Track corrective measures and adjust the compliance plan as needed.

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