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REFUNDS & RECOUPMENTS

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Refund and Recoupments

The U.S. Health and Human Services Office of Inspector General developed a self-disclosure compliance program to encourage medical providers to report suspected overpayments that might violate the False Claims Act (31 U.S.C. 3729-3733). The General Accounting Office issued a 2001 report, "Consultants' Billing Advice May Lead to Improperly Paid Insurance Claims," which identified potentially faulty advice being given by industry consultants who discouraged providers from voluntarily reporting overpayments. The report describes a give-and-take between provider and consultant during an auditing/reimbursement seminar:

> "When asked the proper course of action to take when an overpayment is identified, the consultant responded that providers are required to report and refund overpayments. He said, however, that instead of refunding overpayments, physician practices generally fix problems in their billing systems that cause overpayments while 'keeping their mouths shut' and 'getting on with life.' Such conduct, however, could result in violations of criminal statutes."
> (Source: *www.gao.gov/new.items/d01818.pdf*)

Medical providers have become increasingly aware of the potential for criminal and civil violations related to fraudulent billing. Managed care contracts contain similar protections requiring providers to detect and reimburse the carrier for overpayments. Therefore, industry experts routinely advise providers to develop an auditing program that involves detection and repayment of overpaid claims to ensure both legal compliance and a good working relationship with payers.

Responding to refund requests

Many overpayments, such as duplicate payments or clearly erroneous payment amounts, are often easy to detect due to credit balances. More problematic, however, are refund requests received which request reimbursement for claims that appear to have been paid correctly by the carrier. Such requests may result from post-claim medical necessity reviews or from retroactively activated coding/bundling edits which may not be widely agreed upon within the billing industry.

Most prevalent among these requests are those that involve third-party auditing companies, which track

down the overpayments and then try to collect the money for the carrier. Because of the increased use of such outside auditing companies, providers and billers need to have an internal policy for assessing whether the claim was paid correctly and a plan for responding to unsubstantiated requests for refunds.

Each refund request must be thoroughly researched to determine the accuracy of the payment in question. This may require seeking additional information from the carrier and the patient regarding benefits. If you believe you are entitled to the payment, healthcare attorney Andrew Wachler explains that you should send a written response to the carrier explaining your position in regard to the request. Wachler's firm, Wachler and Kopson, based in Royal Oak, MI, has an audit program to assist providers in determining their right to retain disputed benefit payments. Wachler said they have also recently put together a credit balance plan for physician offices. But because many balances are too small to justify legal representation, providers should have a plan for appealing any refund request that does not appear appropriate.

Timely action

A refund request should never be ignored. Failure to respond to a carrier's notification of overpayment can be construed as a tacit agreement that the carrier's position is uncontested. Some state statutes sanction the accrual of interest if the refund is not made within the specified time frame. Each state's overpayment or refund/recoupment law should be read carefully for the following variables which may affect how it applies to your claims:

- **Scope:** Some state mandates apply to all healthcare claims whereas other laws are directed at network payment arrangements
- **Refund vs. recoupment:** Some state mandates place greater restriction on recoupment of disputed funds against future claims
- **Specific coordination of benefits wording:** Some mandates expand the time frame for seeking refunds which involve coordination of benefits
- **Prior authorization protections:** Often in a separate mandate, many states prohibit the retroactive rescission of a prior authorization, making refund requests on authorized care more difficult
- **Exceptions to time restrictions:** State mandates that restrict carriers from seeking refunds after a specific period often include exceptions from the time frames in cases

involving fraud or misrepresentation by the healthcare provider

About half of the states have specific mandates regarding refund and recoupment attempts. In states without such provisions, carriers may still have a legal right to seek repayments of incorrect claims under common law theories involving unjust enrichment. Therefore, it is important when developing a compliance program to seek legal advice regarding state-specific legalities. Table 8.1 provides basic information on the states with specific statutes applicable to refund requests.

Table 8.1 States with Specific Statutes Applicable to Refund Requests

State and Statute Citation	Time Frame for Carrier Action (Refund/Recoupment)	Time Frame for Provider Response
Alabama, Ala. Code 27-1-17	12–18 months	30 days
Arizona, A.R.S. 20-3102	12 months	30 days
Arkansas, Rule and Regulation 85	18 months	Unspecified
California Health & Safety Code Section 1371	12 months	30 days
Colorado Insurance Code, 10-16-704	12 months	Unspecified
Florida Insurance Code 627.6131	30 months	40 days
Georgia Insurance Code 33-20A-62	18–24 months	45 days
Kentucky Insurance Code 304.17A-714	24 months	30 days
Louisiana Insurance Code 22:250.38	Unspecified	30 days
Maine 24-A M.R.S.A. § 4304(4)	18 months	Unspecified
Missouri Insurance Code V.A.M.S. 376.384	12 months	Unspecified
Montana Insurance Code M.C.A. 33-22-150	12–24 months	Unspecified

Nebraska Insurance Regulation 009	3 years	Unspecified
New Hampshire RSA 420-J:8-b	18 months	Unspecified
New Jersey Insurance Code 17B:26-9.1	18 months	45 days
Ohio Insurance Code 3901.388	2 years	30 days
Oklahoma Insurance Code 36 O.S. § 1250.5(15)	24 months	Unspecified
Texas Insurance Code Chapter 1301.132	180 days	45 days
Tennessee Insurance Code 56-7-110	6–18 months	Unspecified
Utah Insurance Code 31A-26-301.6	18–36 months	Unspecified
Virginia Insurance code 38.2-3407.15	12 months	Unspecified
Washington Insurance Code 48.43.600	24 months	30 days
West Virginia Insurance Code 33-45-2	1 year	40 days

Demanding disclosure of denial basis

If not addressed in the notification of overpayment letter, demand the disclosure of denial basis and clarify your right to appeal. A refund request will frequently state that an error or overpayment has been paid for a particular claim. Instructions will be given for repayment. Noticeably absent is clear, persuasive clarification regarding why a claim once deemed payable is now being denied. In such situations, full disclosure of the denial basis should be demanded before benefits are acquiesced. Place the burden on the carrier to explain why the initial processing of the claim was not the correct one and to provide the complete basis for the denial, including the following:

- Applicable internal rules, guidelines, protocols, or policy/plan language which supports the denial
- Date the error was detected
- Confirmation that the policy/plan beneficiaries are aware of the denial and in agreement

with any financial responsibility they might incur

Sample Appeal Letter T, "Refund/Recoupment Request Response," cites the information to initiate and allows you to respond promptly in a way that attempts clarification of the denial so that liabilities will be clearer.

Referring to law

The legalities related to refund/recoupment request can be complex. Prior to the emergence of managed care, providers were often able to argue that they had innocently extended credit by treating patients without demanding prepayment. Therefore, they had no obligation to return payment because the insurance carrier could as easily pursue the patient for the erroneously paid funds. The following quote from *The South Texas Law Review* article, "The Retention of Insurance Overpayment by Health Care Providers," sums up this legal theory which may still apply in commercial healthcare claim overpayments that are not governed by the terms of a managed care contract, or state or federal law:

> Overpayments or payments otherwise mistakenly made by an insurer may be retained by a health care provider who is innocent, acts in good faith without prior knowledge of the mistake, and makes no misrepresentation to the insurer, provided the amount retained relates only to the amount actually due for services rendered. Overpayments may also be retained despite knowledge by the health care provider of a potential dispute in coverage if the health care provider changes its position in reliance on continued payment. The continuation of health care service in reliance on continued payments may constitute a sufficient change in position. Other principles may, on a case-by-case basis, justify retention of an overpayment—these principles would be in the nature of equitable estoppel, failure by the insurer to act earlier, absence of an unconscionable loss, absence of an unjust enrichment, and other rules developed under the law of restitution (30 So Tex L Rev 387-395).

Because of the legal complexities, you should seek legal advice regarding your rights and responsibilities related to overpayment requests. Further, such advice should differentiate between in-network and out-of-network payments so that your response is appropriate for each situation.

Contesting the decision

If the request was made within mandatory time frames and includes the required explanation of the adverse determination, you need to assess your billing. For legal and ethical reasons, anytime the error was the result of an incorrect bill filed by your office, the carrier should be reimbursed immediately.

If your billing is compliant with known customary billing practices, you may want to appeal using the techniques discussed in previous chapters. However, you will have to determine whether the applicable mandates require you to pay the claim back while the appeals are conducted or whether you have the right to retain the funds until appeals are exhausted. The answer will depend on the type of coverage and the applicable laws.

Many refund requests involve unusual circumstances, and it might be worth a phone call, perhaps even a conference call among all parties—patient, carrier, and yourself—to attempt to resolve the issue. During a phone conversation, you may be able to more fully explain why the payment was appropriate for the treatment rendered. You may also be able to determine your patient's position regarding the carrier action and what input he or she has regarding coverage availability. Likewise, the insurer may have a very good explanation of why the claim was originally paid in error.

When contesting a refund request, be sure to reference any verification and prior authorization that was extended for the treatment. Some states that do not have a specific state statute that addresses limitations on carrier refund/recoupment efforts may still have a protection related to authorization. For example, the state of Vermont does not have a mandate specifying the conditions and time frames applicable to carrier notification and provider repayment, but Rule 10 of the Vermont Quality Assurance Standards and Consumer Protections for Managed Care Plans prohibits certain carriers from retroactively denying payment of authorized care. Paragraph 6 of Section 10.203 of the regulation states that managed care plans must ensure that they do not retroactively deny reimbursement for a covered service provided to a member by a provider who relied upon the written or oral authorization of the managed care plan or its agents prior to providing the service to the member, or for a covered service provided to a member by his or her primary care provider or a network specialist who relied upon the written or oral referral of the primary care provider, except in cases where there was material misrepresentation or fraud.

A number of state statutes prohibit retroactive denials of approved care unless the care has been misrepresented. Insurance carriers accredited by the Utilization Review Accreditation Commission

(URAC) program, discussed in detail in Chapter 3, must abide with the URAC Standard (which is also cited in Sample Appeal Letter U, "Refund/Recoupment URAC Protections)," which states, "The organization does not reverse a certification determination unless it receives new information that is relevant to the certification and that was not available at the time of the original certification."

Offering to pay on a "contingency basis"

One last option that might be explored with the carrier is an offer to repay the incorrectly paid claim once other payment has been secured.

One of the more common reasons for an overpayment is related to coordination of benefits. A carrier often pays as primary only to find out later that other coverage was primary. Carriers have a written agreement with the policyholder related to disclosure of other coverage. Based on that contractual relationship, the carrier may have more legal rights in pursuing damages related to the patient/policyholder's failure to provide correct information. The carrier's duty to investigate coordination of benefits should be emphasized in any appeal related to refund requests as follows:

> *It is our position that your company should have conducted a coordination of benefits investigation prior to releasing payment. As you are likely aware, your contractual relationship with the insured can and may require the patient to provide coordination of benefits information when requested. However, our office has limited legal rights or resources to conduct such inquiries. Therefore, we maintain that it is your company's duty to resolve any coordination of benefits issues prior to claim payment. If your decision on this appeal is unfavorable, please provide this office with the coordination of benefits clause as it reads in the applicable policy or plan document and more complete information regarding when the other coverage information was obtained. This will allow us to more fully determine liability for this claim.*

A number of laws also require carriers to waive timely filing requirements and allow late filing related to coordination of benefits issues. Once you are notified of the other coverage, you may be able to file with the primary carrier and receive primary coverage benefits. When this payment is received, you will be able to apply the secondary payment to the balance and determine the exact amount the secondary carrier has overpaid.

References

"The Retention of Insurance Overpayment by Health Care Providers." *The South Texas Law Review,* 30: 387–395.