

Key Considerations When Pursuing Overpayment Recoveries

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Recent estimates suggest that Medicare's fee-for-service program overpaid claims by approximately \$43 billion in fiscal year of 2015.¹ With overpayment recovery efforts against providers and suppliers yielding as much as an \$11 to \$1 return on investment,² the government and private health plans are making overpayments a bigger focus of their operations. Providers are increasingly facing overpayment claims as defendants and as counterclaims when they bring actions to recover unpaid or underpaid medical claims. While overpayment recoveries should be pursued when appropriate, they should be thoroughly vetted before any action is taken. This article examines recent trends with overpayments, identifies the risks with overpayment claims, and provides insight on how to deal with such claims from both plan and provider perspectives.

Legal and Regulatory Framework

The Affordable Care Act requires providers, suppliers, Medicaid managed care organizations (MCOs), and Medicare Advantage Organizations (MAOs) to report and return overpayments within "60 days after the date on which the overpayment was identified" or on "the date any corresponding cost report is due, if applicable," whichever is later (60-day Rule).³ According to the Centers for Medicare and Medicaid Services (CMS), the 60-day Rule should give plans and providers "an incentive to exercise reasonable diligence to determine whether an overpayment exists."⁴ In addition to the 60-day Rule, MCOs and MAOs are required to establish policies and procedures for overpayments as part of their contracts with the federal or state governments.⁵

Insurers that administer Employee Retirement Income Security Act (ERISA) plans should comply with ERISA's notice and appeal requirements for adverse benefit determinations (ABDs) when recovering overpayments.⁶ Further, most states have enacted laws that dictate how and when plans may seek recovery of overpayments.⁷

Recent Developments

The trustees in two Chapter 11 bankruptcy cases for RadioShack and Corinthian Colleges are evaluating potential overpayment recovery actions to recover money for the estates. In both cases, the court granted the trustees' requests to audit the companies' health care claims data for former employees and dependents; the trustees hope to locate and recover overpayments from providers for the benefit of creditors.⁸ We expect overpayment recoveries to continue in bankruptcies and other areas of the law.

Best Practices for Health Plans

Policies and Provider Manuals

Health plans should have policies and a provider manual that discuss the plan's procedures for overpayment recoveries that are consistent with state and federal law and provider and government contractual requirements. Those procedures should:



1. Require the plan to provide written notice to the provider with a description of the claims at issue and the reason that the plan overpaid the claims;⁹
2. Describe the process for how a provider may challenge or appeal an overpayment determination;
3. Specify the time period in which providers must challenge the overpayment determination; and
4. Specify the time period for which the plan may audit and recoup claims.

Plans should also maintain broad language in their policies and provider manuals that describe their right to audit providers and obtain medical records for review upon request. Including this information in the plan's policies and readily accessible provider manual will not only help ensure compliance with legal and contractual requirements, but also place out-of-network providers on notice of the proper procedures in case of a dispute.

Provider Contracts

Health plans should ensure that their provider agreements include comprehensive requirements that support the plan's right to audit providers and recoup overpayments. These provisions are crucial in the event that a dispute arises between the provider and the health plan. For example, in *Bircumshaw v. State of Washington, Health Care Authority (HCA)*,¹⁰ HCA recouped funds from Dr. Bircumshaw after determining that he had insufficient documentation to substantiate the claims.¹¹ Bircumshaw challenged HCA's recoupment by alleging, among other things, that HCA was not authorized to recoup overpayments based on his failure to keep adequate documentation for billed services.¹² The parties' contract, which gave HCA the power to audit and recoup funds from Bircumshaw, also provided that Bircumshaw must "keep complete and accurate medical and fiscal records that *fully justify and disclose* the extent of the services...furnished and claims submitted to the department" for six years.¹³ The contract further specified that the provider's "*failure to submit or failure to retain adequate documentation for services billed to the department may result in recovery of payments for medical services not adequately documented...*"¹⁴ The court determined that under the contract, Bircumshaw was "clearly" required to keep sufficient records that "fully justify" billed services, and his "[f]ailure to submit records fully justifying billed services is grounds for recoupment of money paid for those services under the contract."¹⁵

A plan's provider agreements should anticipate ways that the plan may seek to recover overpayments, such as a lack of medical necessity, improper coding, and/or a lack of supporting medical documentation, and incorporate specific affirmative obligations on providers that allow recoupment in cases of noncompliance.

Extrapolation

Many health plans use sampling and extrapolation when auditing providers for overpayments. Typically, the plan will audit a sample of the provider's claims, determine the percentage of claims in that sample on which the plan overpaid, and then extrapolate the percentage across all claims submitted by the provider. While extrapolation can be a powerful and time-saving tool, it also carries compliance risks and proof issues if the case goes to trial.

Certain states require the insurer to give the provider written notice of an overpayment that includes the patient name, date of service, and an explanation of the basis of overpayment.¹⁶ Health plans that are considering extrapolation in those jurisdictions must be mindful of these notice requirements. Moreover, at least one state forbids payers from using extrapolation when determining reimbursement, absent certain exceptions.¹⁷

Plans that intend to or are using extrapolation to identify overpayments must confirm that their methods comply with all applicable laws, regulations, and guidance. They may look to the standards that Medicare Recovery Audit Contractors use to ensure statistically sound methods.¹⁸ For trials, plans and providers should be prepared to handle massive amounts of data and deal with numerous reasons for claims denials and underpayments including authorizations, medical necessity, and coding. Hiring an expert that has experience in coding, data analytics, and claims hearings is crucial.

Third-Party Vendors

Health plans often use third party vendors to assist with various parts of the overpayment recovery process. While third party vendors can be useful, plans should be supervising and confirming that vendors are following their policies, procedures, and applicable law. In *N.C. Dept. of Health and Human Services (DHHS) v. Parker Home Care*,¹⁹ DHHS retained a third party vendor, Public Consulting Group (PCG), to conduct post payment audits of providers.²⁰ PCG audited a small number of claims from a provider, identified overpayments, and then extrapolated its findings to a larger number of claims.²¹ PCG sent letters entitled "TENTATIVE NOTICE OF OVERPAYMENT" (TNOs) that set forth the audit findings and informed the provider of its right to appeal.²² While North Carolina law allows DHHS to use third party vendors for auditing and overpayment recoveries, a provider is not obligated to appeal a determination until DHHS reaches a "final decision."²³ The court concluded that the language of the TNOs failed to inform the provider that the TNO was a final decision by DHHS and thus denied the claims.²⁴ The upshot of *Parker Home Care* is that DHHS was unable to recover overpayments from the provider because its vendor failed to follow the applicable law.

Provider Defenses

Know the Law

Most states have laws that require health plans to follow certain procedures when identifying and recouping overpayments.²⁵ Generally, plans must give notice to the provider before recouping overpayments,²⁶ and most states prohibit plans from recouping payments more than a specified time after the original payment was made except in limited circumstances, such as fraud.²⁷ These laws are meant to protect providers from surprising and oppressive recoupments. Providers should be familiar with their local laws and use them during appeals, litigation, and arbitration.

Know the Plan's Contractual Requirements, Policies, Procedures, and Provider Manual

Providers should also be familiar with their contract language, provider manuals, and the relevant plan's policies and procedures for overpayment recoveries and appeals. In *Connecticut Gen. Life. Ins. Co. v. Humble Surgical Hosp., LLC*,²⁸ the provider defeated the insurer's \$5.1 million claim and succeeded on its own counterclaims for over \$11 million because (1) the money that the insurer was attempting to recover was paid according to the ERISA plan terms, and (2) the insurer failed to process claims pursuant to the plan's terms.²⁹ By knowing the plan's contractual requirements and policies and procedures, providers will be in the best position to prevent and defend against overpayment recoveries.

Voluntary Payment Doctrine

The voluntary payment doctrine “preclude[s] actions to recover payments that parties paid voluntarily, with full knowledge of the material facts, and absent fraud or wrongful conduct inducing payment.”³⁰ A federal court interpreting Wisconsin law recently applied the voluntary payment doctrine to bar a health plan administrator's overpayment claim against a health care provider.³¹ The court held:

One of the primary justifications [for the voluntary payment doctrine] is to “allow[] entities that receive payment for services to rely upon these funds and to use them unfettered in future activities.” [citation]. When a health care provider in good faith treats a patient, bills the patient's health insurer, and receive full payment of the amount billed[,] it may use those funds without having to worry that the insurer will claw them back later because of its own mistakes in processing claims.³²

Some courts have refused to apply the voluntary payment doctrine where the provider's contract with the plan permits recoupments.³³ Still, providers should explore how courts apply the doctrine in their jurisdictions when defending overpayments.

Conclusion

Plans and providers should consistently be reviewing the applicable law and the relevant contracts, policies, procedures, provider manuals, and guidance that govern overpayments. Such action will help prepare for the growing number of overpayment disputes that we expect to see in the coming years.

- 1 Council For Medicare Integrity, 2016 State Of The RAC Program, *available at* <http://medicareintegrity.org/wp-content/uploads/2016/03/2015StateOfTheProgram-FINAL.pdf>.
- 2 Department of Health and Human Services, FY 2016 Agency Financial Report, *available at* <https://www.hhs.gov/sites/default/files/fy-2016-hhs-agency-financial-report.pdf>.
- 3 42 U.S.C. § 1320a-7k(d); *see* 31 U.S.C. § 3729(a)(1)(G).
- 4 *See* 77 Fed. Reg. 9179-02 (Feb. 16, 2012).
- 5 *See, e.g.*, 42 C.F.R. § 438.608; 42 C.F.R. §§ 422.326, 422.504, 423.360.
- 6 29 C.F.R. § 2560.503-1; *see, e.g.*, *UNUM Life Ins. Co. of Am. v. Zaun*, Civil No. 13-1214 (MJD/TNL), 2014 WL 3630340, at *6-7 (D. Minn. May 29, 2014); *Fanelli v. Cont'l Cas. Co.*, Civil No. 1:06-CV-0141, 2006 WL 4318721, at *1, 5 (M.D. Pa. Sept. 13, 2006); *see also Premier Health Ctr., P.C. v. UnitedHealth Grp.*, No. 11-425 (ES), 2014 WL 4271970, at *29 (D.N.J. Aug. 28, 2014).
- 7 *See* ALA. CODE § 27-1-17; ALASKA STAT. § 21.54.020; ARK. CODE § 23-63-1801 *et seq.*; ARIZ. REV. STAT. § 20-3102; CAL. INS. CODE § 10133.66; COLO. REV. STAT. 10-16-704; D.C. CODE § 31-3133; FLA. STAT. ANN. § 627.6131; GA. CODE ANN. § 33-20A-62; 215 ILL. COMP. STAT. 5/368d; IND. CODE § 27-8-5.7-10; IOWA CODE § 191-15.33 (Iowa); KY. REV. STAT. ANN. § 304.17A-714; LA. REV. STAT. § 22:1838; ME. STAT. tit. 24-A § 4303; MD. CODE ANN., INS. § 15-1008; MO. REV. STAT. § 376.384; MONT. CODE ANN. § 33-22-150; 210 NEB. ADMIN. CODE CH. 60 § 011; N.H. REV. STAT. § 420-J:8-b; N.J. STAT. § 17B:30-48 *et seq.*; N.Y. INS. LAW § 3224-b; OHIO REV. CODE ANN. § 3901.388; OKL. STAT. ANN. tit. 36 § 1250.5; 40 PA. CONS. STAT. § 3803; S.C. CODE ANN. § 38-59-250; TENN. CODE ANN. § 56-7-110; TEX. INS. CODE §§ 843.350, 1301.132; UTAH CODE ANN. § 31A-26-301.6; VT. STAT. ANN. tit. 18 § 9418; VA. CODE ANN. § 38.2-3407.15; WASH. REV. CODE § 48.43.600; W. VA. CODE § 33-45-2.
- 8 Vince Sullivan, *RadioShack Can Audit United HealthCare Claim Information*, LAW360 (Feb. 8, 2017), <https://www.law360.com/articles/889776/radioshack-can-audit-united-healthcare-claim-information>; Matt Chiappardi, *Corinthian Ch. 11 Estate Can Access Health Provider Info*, LAW360 (Oct. 13, 2017), <https://www.law360.com/articles/850996/corinthian-ch-11-estate-can-access-health-provider-info>.
- 9 Some states have specific requirements for what information must be included in the notice. *See supra* note 7; *infra* note 16.
- 10 194 Wash. App. 176 (2016).
- 11 *Id.* at 185.
- 12 *Id.* at 183.
- 13 *Id.* at 193-94 (emphasis in the opinion).
- 14 *Id.* (emphasis in the opinion).

- 15 *Id.* at 194.
- 16 *See, e.g.,* CAL. INS. CODE § 10133.66(b); N.Y. INS. LAW § 3224-b(b); S.C. CODE ANN. § 38-59-250(A); VT. STAT. ANN. tit. 18 § 9418(h).
- 17 N.J.S.A. §§ 26:2J-8.1d(10), 17b:27-44.2d(10).
- 18 *See* 42 U.S.C. § 1395ddd(f)(3); *see also generally* the Medicare Program Integrity Manual.
- 19 784 S.E.2d 552 (N.C. Ct. App. 2016).
- 20 *Id.* at 553-54.
- 21 *Id.*
- 22 *Id.*
- 23 *Id.* at 561 (citations omitted).
- 24 *Id.* at 560-62.
- 25 *See supra* note 7.
- 26 *Id.*
- 27 ALA. CODE § 27-1-17(f) (18 months); ARK. CODE ANN. § 23-63-1802 (18 months); ARIZ. REV. STAT. ANN. § 20-3102(I) (1 year); CAL. INS. CODE § 10133.66(b) (365 days); COLO. REV. STAT. 10-16-704(4.5) (b) (12 months); D.C. CODE § 31-3133(a) (18 months for coordination of benefits, 6 months for all other overpayments); FLA. STAT. ANN. § 627.6131(6)(a)(1) (30 months); GA. CODE ANN. § 33-20A-62 (18 months); 215 ILCS 5/368d(c) (18 months); 215 ILL. COMP. STAT. 5/368d(c) (18 months); IND. CODE 27-8-5.7-10(b) (2 years); IOWA CODE § 191-15.33(1) (2 years); KY. REV. STAT. ANN. § 304.17A-714(1) (24 months); ME. STAT. tit. 24-A § 4303(10)(B) (12 months); MD. CODE ANN., Ins. § 15-1008(c)(1) (18 months for coordination of benefits, 6 months for all other overpayments); MO. REV. STAT. § 376.384(1)(1) (1 year); MCA 33-22-150(2) (12 months); 210 NEB. ADMIN. CODE CH. 60 § 011.01(B)(3) (6 months); N.H. REV. STAT. § 420-J:8-b(II)(b) (18 months); N.J. STAT. §§ 26:2J-8.1d(10), 17b:27-44.2d(10) (18 months); N.Y. INS. LAW § 3224-b(b)(3) (24 months); OHIO REV. CODE ANN. § 3901.388(B) (2 years); OKL. STAT. ANN. tit. 36 § 1250.5(15) (24 months); 40 PA. CONS. STAT. § 3803(a) (twenty-four months); S.C. CODE ANN. § 38-59-250(B) (eighteen months); TENN. CODE ANN. § 56-7-110(b) (18 months); TEX. INS. CODE §§ 843.350(a)(1), 1301.132(a)(1) (180 days); UTAH CODE ANN. § 31A-26-301.6(14) (24 months for coordination of benefit, 12 months for any other overpayment); VT. STAT. ANN. tit. 18 § 9418(h) (12 months); VA. CODE ANN. § 38.2-3407.15B(6) (12 months); WASH. REV. CODE 48.43.600(1) (24 months); W. VA. CODE § 33-45-2(7) (C) (1 year).
- 28 No. 4:13-CV-3291, 2016 WL 3077405, at *18 (S.D. Tex. June 1, 2016).
- 29 *Id.* at *18.
- 30 *Auxiant v. Total Renal Care Inc.*, No. 15-CV-404, 2016 WL 4769369, at *1 (E.D. Wisc. Sept. 13, 2016) (citation and internal quotations omitted).
- 31 *Id.* at *2.
- 32 *Id.*
- 33 *See, e.g., Medical Center, Inc. v. Humana Military Healthcare Services, Inc.*, No. 4:10-CV-124 (CDL), 2012 WL 3295640, at *4 (M.D. Ga. Aug. 10, 2012); *Alexian Bros. Health Providers Ass'n, Inc. v. Humana Health Plan, Inc.*, 277 F. Supp. 2d 880, 891 (N.D. Ill. 2003).

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