



REPORT OF THE INSURANCE RECOUPMENT WORKING GROUP

Pursuant to S.C.R. No. 129, S.D. 1 (2013)
REQUESTING THE INSURANCE COMMISSIONER TO CREATE A
WORKING GROUP TO STUDY INSURANCE RECOUPMENT

Prepared by the

INSURANCE DIVISION
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
STATE OF HAWAII

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**REPORT OF THE INSURANCE RECOUPMENT WORKING GROUP
PURSUANT TO S.C.R. NO. 129, S.D. 1 (2013)**

INTRODUCTION

Senate Concurrent Resolution No. 129, S.D. 1 (2013) (S.C.R. No. 129 or Resolution) requested the Insurance Commissioner to form a working group to study insurance recoupment (the "Working Group"). A copy of the Resolution is attached as Appendix A. The Working Group was requested to:

- (1) Assess the problems of insurance recoupment, if any;
- (2) Study the impact of limiting the period allowed to initiate any recoupment or offset demand efforts;
- (3) Review how other states mandate recoupment.

The members of the Working Group are:

- (1) Gordon I. Ito, Chair;
- (2) Loretta J. Fuddy, Director of Health or her designee;
- (3) Pat McManaman, Director of Human Services or her designee;
- (4) L. Martin Johnson, representative from the healthcare provider community and healthcare professionals;
- (5) Gail L. Tice, representative from the healthcare provider community and healthcare professionals;
- (6) Jennifer Diesman, representative from Hawaii Association of Health Plans ("HAHP");
- (7) Howard Lee, representative from HAHP;
- (8) Catherine Xiao, representative from Healthcare Association of Hawaii ("HAH");

- (9) Christopher D. Flanders, representative from Hawaii Medical Association ("HMA"); and
- (10) Robert Hirokawa, representative from Hawaii Primary Care Association ("HPCA").

The Resolution requested the Working Group to report its findings and recommendations, including any proposed legislation, to the Legislature no later than twenty days prior to the convening of the Regular Session of 2014.

DISCUSSION

The Working Group met on August 21, 2013, September 4, 2013, and September 18, 2013, pursuant to public notices filed with the Lieutenant Governor's Office. As the Working Group was convened pursuant to Resolution, the Working Group does not fall within the statutory definition of a "board" as defined in the State's Sunshine Law (Chapter 92, Hawaii Revised Statutes). However, in the interest of promoting open government, the Chair followed the Sunshine Law. Copies of the Working Group's minutes are attached as Appendix B.

The Resolution was originally introduced because healthcare providers in Hawaii may be subject to significant business liability because health insurance carriers can demand the recoupment of funds previously paid at any time without any limitation. Insurance recoupment occurs when a health insurance carrier pays benefits to a healthcare provider and later seeks reimbursement for those benefits after the health insurance carrier determines that the benefits were paid in error.

The Working Group acknowledged that the State of Hawaii does not have authority to change federal insurance recoupment requirements related to the Centers of Medicare &

Medicaid Services. In addition, the scope of the Working Group's report will not include workers' compensation, but will focus solely on health insurance.

1. Assess the problems of insurance recoupment.

L. Martin Johnson, a psychologist and member of the Hawaii Psychological Association, provided a Recoupment Problem Statement to the Working Group members. A copy of the Recoupment Problem Statement is attached as Appendix C. Dr. Johnson's Recoupment Problem Statement included a recommendation to introduce legislation establishing a 12-month recoupment period, with a carve out for fraud.

While the Working Group finds that quantifying the impact of recoupment practices is difficult because claims are handled confidentially and information is generally not shared in the healthcare provider community, several of the Working Group members provided anecdotal examples of healthcare providers who were adversely affected. Dr. Johnson related how healthcare providers have gone out of business or left the State because they were subject to multiple recoupments costing hundreds of thousands of dollars. Dr. Johnson expressed concern that there are not enough healthcare providers in the State and that insurance recoupment practices create a gaping liability over which healthcare providers have no control.

Christopher D. Flanders, an osteopath and member of HMA, also related anecdotal examples and noted that the bulk of physician complaints related to insurance recoupment within the last three to five years have been related to the Centers of Medicare & Medicaid Services.

While the Working Group understands the concerns raised by Hawaii healthcare providers and professionals, the Working Group is also aware that the State has no authority to change any laws affecting insurance recoupment related to federal Medicare and Medicaid programs.

To provide the Working Group a better understanding of how recoupment works under Medicaid, Kenneth Fink, Med-Quest Administrator of the Department of Human Services, explained to the Working Group how recoupment works for Medicaid claims. As Med-Quest is a state program that is financed by Medicaid, his comments were limited to recoupment under Medicaid. Dr. Fink provided the Working Group members with the following documents:

1. Electronic Code of Federal Regulations, Title 42, Part 433, Subpart F, on Refunding of Federal Share of Medicaid Overpayments to Providers; and
2. Unofficial Hawaii Administrative Rules, Title 17, Subtitle 12, Chapter 1705, on Medical Assistance Recovery.

Copies of these documents are attached as Appendix D.

Dr. Fink told the Working Group that the federal government places no time limit on recoupment recovery. From the time overpayment is discovered, there is a one-year time frame for the Medicaid agency to reimburse the federal government. The Medicaid agency would then be responsible for collecting from the providers. While there is a one-year deadline to reimburse the federal government upon discovery of the overpayment, there is no time limit on when the service was provided.

Dr. Fink said that every three years, if there is any overpayment or underpayment in the cycle, the Medicaid agency must recover overpayments or underpayments. Dr. Fink also noted that there is a new federal recovery audit program and that the Office of Inspector General is responsible for the audits. If an overpayment is discovered in the audit, the overpayment will be recovered.

The Working Group also discussed the three-year look-back period for Recovery Audit Contractor audits ("RAC Audits"). Dr. Fink said that Medicaid requires the states to have RACs,

who work on commission, to complete required audits. He also noted that every three years, if an overpayment is identified in the cycle, they must recover the overpayment.

2. Study the impact of limiting the period allowed to initiate any recoupment or offset demand efforts.

HAHP representatives reported that none of their members engage in unreasonable recoupment practices under their health plans. HAHP representatives also reported that they have contracts with their healthcare provider members with 12- to 18-month look-back periods for commercial claims with the exception of claims involving fraud, workers' compensation, and third-party liability.

Howard Lee, President and Chief Executive Officer of University Health Alliance ("UHA") and a HAHP representative, provided written comments to the Working Group, stating that HAHP is not willing to statutorily establish recoupment limits until the problem is clearly identified. He distributed copies of a description of the Centers for Medicare & Medicaid Services Recovery Audit Program, which provided background information for the Working Group. A copy of Mr. Lee's written comments and description of the Centers for Medicare & Medicaid Services Recovery Audit Program is attached as Appendix E.

HAHP representatives stated that they were willing to address healthcare provider recoupment concerns without legislation. Mr. Lee said unintended consequences may result from any changes to the law. In addition, if the Working Group were to recommend a recoupment bill that exempts Medicare and fraud, the bill may not address the problem at hand.

Jennifer Diesman, Vice President of Government Relations of Hawaii Medical Service Association and HAHP member, provided written comments to the Working Group stating that while HMSA understands there may be specific cases of concern to certain providers, HMSA

does not believe they warrant regulatory or statutory action. A copy of Ms. Diesman's comments is attached as Appendix F.

3. Review how other states mandate recoupment.

Dr. Johnson provided the Working Group with the Medical Transcription Billing, Corp. ("MTBC") Report on Refund Recoupment Laws and a table summarizing the report. A copy of the MTBC Report on Refund Recoupment Laws and Summary is attached as Appendix G. The MTBC report indicated that 29 states (including the District of Columbia) have laws in place to set limits on insurance recoupment.

FINDINGS AND RECOMMENDATIONS

The Working Group finds that while anecdotal examples of insurance recoupment have been discussed during the Working Group meetings, most of them related to Medicare or Medicaid. As federal law places no specific time limit on recoupment recovery, state legislation would have no effect on the recoupment practices at issue. In addition, the Working Group finds that several Hawaii health plans already have recoupment time frames established with healthcare providers.

After much discussion and deliberation, the Working Group makes the following recommendations:

1. The Working Group does not recommend introducing legislation establishing insurance recoupment time limits; and
2. The Working Group recommends that HAHP work with its members and the healthcare provider community to ensure HAHP members maintain reasonable insurance recoupment time frames.

SENATE CONCURRENT RESOLUTION

REQUESTING THE INSURANCE COMMISSIONER TO CREATE A WORKING GROUP
TO STUDY INSURANCE RECOUPMENT.

1 WHEREAS, insurance recoupment occurs when a health
2 insurance plan pays benefits to providers and later seeks
3 reimbursement for the benefits, after the health insurance plan
4 determines that the benefits were paid out in error; and

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6 WHEREAS, health care providers in Hawaii have a time limit
7 in which to submit claims to health insurance plans; and

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9 WHEREAS, however, there is no similar time limit in Hawaii
10 that prevents health insurance plans from attempting to recoup
11 funds previously paid to health care providers; and

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13 WHEREAS, the lack of a time limit on insurance recoupment
14 results in an ongoing, open-ended liability for health care
15 professionals and health care providers and undermines the
16 ability for these professionals and providers to build upon and
17 plan a viable, economically feasible practice; and

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19 WHEREAS, thirty states and the District of Columbia have
20 passed legislation limiting the time during which a health
21 insurance plan may take money back for services that have
22 already been provided; and

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24 WHEREAS, time limits for insurance recoupment in these
25 jurisdictions are between six months to sixty months, with the
26 average time frame ranging from twelve to twenty-four months;
27 and

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29 WHEREAS, assessing the issues surrounding insurance
30 recoupment is paramount to maintaining a robust and sustainable
31 health care system; now, therefore,
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1 BE IT RESOLVED by the Senate of the Twenty-seventh
2 Legislature of the State of Hawaii, Regular Session of 2013, the
3 House of Representatives concurring, that the Insurance
4 Commissioner is requested to form a working group to study
5 insurance recoupment; and

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7 BE IT FURTHER RESOLVED that the insurance recoupment
8 working group include the following members:

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10 (1) Insurance Commissioner, who shall serve as chair;
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12 (2) Director of Health, or the Director's designee;
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14 (3) Director of Human Services, or the Director's
15 designee;
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17 (4) Representatives from the health care provider
18 community;
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20 (5) Representatives of health care professionals;
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22 (6) Representatives from the Hawaii Association of Health
23 Plans;
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25 (7) A representative from the Healthcare Association of
26 Hawaii;
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28 (8) A representative from the Hawaii Medical Association;
29 and
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31 (9) A representative from the Hawaii Primary Care
32 Association, who shall advocate for consumer
33 interests; and
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35 BE IT FURTHER RESOLVED that the working group is requested
36 to assess the problems of insurance recoupment, if any, study
37 the impact of limiting the period allowed to initiate any
38 recoupment or offset demand efforts, and review how other states
39 mandate recoupment; and
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41 BE IT FURTHER RESOLVED that the working group is requested
42 to report its findings and recommendations, including any
43 proposed legislation, to the Legislature no later than twenty
44 days prior to the convening of the Regular Session of 2014; and



1
2 BE IT FURTHER RESOLVED that certified copies of this
3 Concurrent Resolution be transmitted to the Insurance
4 Commissioner, Director of Health, Director of Human Services,
5 Hawaii Association of Health Plans, Healthcare Association of
6 Hawaii, Hawaii Medical Association, and Hawaii Primary Care
7 Association.
8



MINUTES OF THE INSURANCE RECOUPMENT WORKING GROUP

Wednesday, August 21, 2013
Queen Kapiolani Conference Room
King Kalakaua Building
335 Merchant Street, 2nd Floor
Honolulu, HI 96813

Members Present: Gordon I. Ito (Insurance Commissioner and Working Group Chair), Lorrin Kim (Department of Health), L. Martin Johnson (healthcare provider community/health care professional), Gail L. Tice (healthcare provider community/health care professional), Jennifer Diesman (Hawaii Association of Health Plans), Catherine Xiao (Healthcare Association of Hawaii), and Robert Hirokawa (Hawaii Primary Care Association)

Members Excused: Pat McManaman (Director of Human Services) and Christopher D. Flanders (Hawaii Medical Association)

Others Present: Stan Inkyo, Alyson Estrella (University Health Alliance), Tamera MezNarich, and Ann Le Lievre and Donna K. Ikegami (both from the Hawaii Insurance Division)

I. Call to Order

Pursuant to written notice, the first meeting of the Insurance Recoupment Working Group (the "Working Group") was called to order and chaired by Gordon I Ito, Insurance Commissioner, at 9:10 a.m.

II. Public Notice/Sunshine Law

The meeting was held pursuant to the public notice filed with the Lieutenant Governor's Office on August 2, 2013.

The Working Group is established pursuant to Senate Concurrent Resolution No. 129, S.D. 1, of the Regular Session of 2013 (SCR 129). SCR 129 requested the Insurance Commissioner to convene a working group to study insurance recoupment and to serve as its chair.

Commissioner Ito noted that while the Working Group was convened pursuant to resolution, the Working Group does not fall within the statutory definition of a "board" as defined in the State's Sunshine Law (Chapter 92, Hawaii Revised Statutes). However, in the interest of promoting open government Commissioner Ito said the Working Group would follow the Sunshine Law. Discussions among members should occur in open hearing.

III. Introduction of Working Group Members

SCR 129 specified that the Working Group be composed of the following:

- (1) Insurance Commissioner (Gordon I. Ito), who shall serve as chair;
- (2) Director of Health (Loretta J. Fuddy), or the Director's designee;

- (3) Director of Human Services (Pat McManaman), or the Director's designee;
- (4) Representatives from the health care provider community/health care professionals (L. Martin Johnson);
- (5) Representatives from the health care provider community/health care professionals (Gail L. Tice);
- (6) Representatives from the Hawaii Association of Health Plans (Jennifer Diesman);
- (7) A representative from the Healthcare Association of Hawaii (Catherine Xiao);
- (8) A representative from the Hawaii Medical Association (Christopher D. Flanders); and
- (9) A representative from the Hawaii Primary Care Association (Robert Hirokawa).

All of the members in attendance introduced themselves.

IV. Scope of Work, Organization, and Deadlines

A. Scope

SCR 129 requested the Working Group to:

1. Assess the problems of insurance recoupment, if any;
2. Study the impact of limiting the period allowed to initiate any recoupment or offset demand efforts; and
3. Review how other states mandate recoupment.

B. Organization

SCR 129 designates the Insurance Commissioner as the Chair of the Working Group.

C. Deadlines

SCR 129 requests that the Working Group report its findings and recommendations, including any proposed legislation, to the Legislature no later than 20 days prior to the convening of the Regular Session of 2014. Commissioner Ito stated that the subject matter considered by the Working Group is straightforward and that he hoped to wrap things up by the end of October or early November, at the latest.

V. Discussion Topics and Presentations

During the discussion, Martin Johnson explained why SCR 129 was originally introduced. Dr. Johnson said healthcare providers face significant business liability because health insurance carriers can demand recoupment of funds previously paid at any time without any limitation. He said there is an unlevel playing field for healthcare providers because health insurance carriers also control the appeals process. He said that 30 states have laws in place to set limits on insurance recoupment.

Dr. Johnson said he knew of healthcare providers who have gone out of business because they were subject to multiple recoupments costing hundreds of thousands of dollars. He is concerned that there are not enough healthcare providers in the State and that insurance recoupment practices create a gaping liability over which healthcare providers have no control.

Health Insurance Focus

It was noted that nothing can be done for insurance recoupment related to Medicare and Medicaid. In addition, the scope of this Working Group will not include workers' compensation, but will focus solely on health insurance.

Fraud

There was consensus that insurance recoupment time limits should not apply when fraud is involved.

Claims Against Facilities v. Individual Healthcare Practitioners

It was noted that claims against facilities often involve third parties and involve much more time than claims involving individual healthcare practitioners.

Medical Necessity/Mental Health Substance Abuse Parity

It was suggested that medical necessity and mental health substance abuse parity should not be within the purview of discussion as this would sidetrack the Working Group from its mission.

Commissioner Ito noted that while he appreciated hearing Dr. Johnson's perspective as a psychologist, it would be beneficial for the Working Group to have an opportunity to hear from healthcare providers in other specialty areas about how they have been affected by insurance recoupment practices in Hawaii. In addition, Commissioner Ito noted that while he appreciated the participation of the Hawaii Medical Service Association as part of the Hawaii Association of Health Plans, he hoped that other Hawaii health plans would share their perspectives in future meetings of the Working Group.

Commissioner Ito said that he hoped that the Working Group would gain a better understanding of the scope of its mission at its next meeting. It was recommended that the members consider the following at future meetings:

- Gain a better understanding of how Medicare and Medicaid define "recoupment"
- What healthcare specialties are impacted the most by insurance recoupment practices?
- Solicit involvement from the Hawaii Medical Association
- Solicit involvement from other health insurance carriers
- Consider other solutions in addition to legislation

VI. Submission of Testimony by Interested Parties and Members of the Public

No written testimony was presented by interested parties or members of the public at the meeting.

VII. Scheduling of Next Meeting

The next meeting will take place on Wednesday, September 4, 2013, at 10 a.m. at a location to be announced at a later time.

VIII. Adjournment

The meeting was adjourned at 9:45 a.m.

MINUTES OF THE INSURANCE RECOUPMENT WORKING GROUP

Wednesday, September 4, 2013
Queen Kapiolani Conference Room
King Kalakaua Building
335 Merchant Street, 2nd Floor
Honolulu, HI 96813

Members Present: Gordon I. Ito (Insurance Commissioner and Working Group Chair), Kenneth Fink (Department of Human Services – participation via conference call), L. Martin Johnson (healthcare provider community/health care professional), Gail L. Tice (healthcare provider community/health care professional), Jennifer Diesman (Hawaii Association of Health Plans), Catherine Xiao (Healthcare Association of Hawaii), Christopher D. Flanders (Hawaii Medical Association) and Robert Hirokawa (Hawaii Primary Care Association)

Members Excused: Lorrin Kim (Department of Health)

Others Present: Alyson Estrella (University Health Alliance), Tamera MezNarich, and Ann Le Lievre and Donna K. Ikegami (both from the Hawaii Insurance Division)

I. Call to Order

Pursuant to written notice, this meeting of the Insurance Recoupment Working Group (the "Working Group") was called to order and chaired by Gordon I Ito, Insurance Commissioner, at 10:04 a.m. The meeting was held pursuant to the public notice filed with the Lieutenant Governor's Office on August 23, 2013.

The Working Group is established pursuant to Senate Concurrent Resolution No. 129, S.D. 1, of the Regular Session of 2013 (SCR 129). SCR 129 requested the Insurance Commissioner to convene a working group to study insurance recoupment and to serve as its chair.

Commissioner Ito noted that while the Working Group was convened pursuant to resolution, the Working Group does not fall within the statutory definition of a "board" as defined in the State's Sunshine Law (Chapter 92, Hawaii Revised Statutes). However, in the interest of promoting open government Commissioner Ito said the Working Group is following the Sunshine Law. Discussions among members should occur in open hearing.

II. Discussion Topics and Presentations

Healthcare Provider Prospective

Commissioner Ito noted that the Working Group only heard a psychologist's perspective of insurance recoupment at the Working Group's last meeting. Christopher D. Flanders of the Hawaii Medical Association ("HMA") was given an opportunity to present his perspective as HMA's representative. Dr. Flanders said that four or six months ago, HMA received three calls within a few

weeks from physicians against whom recoupment was being sought. The physicians were questioned about claims that were four to six years old. Dr. Flanders said no specific specialty was targeted and that the calls were from physicians with practices in obstetrics, family medicine, and gerontology.

Dr. Flanders said it is difficult for doctors to defend old billing claims because their books and files are often closed or placed in storage four to six years later. He said there is a need to shorten this time frame to something more reasonable.

Medicaid Recoupment Requirements

Kenneth Fink, Med-Quest Administrator of the Department of Human Services, was given an opportunity to explain how recoupment works at the federal level. As Med-Quest is a state program that is financed by Medicaid, his comments were limited to recoupment under Medicaid. In response to the Working Group's request for information on how Medicare and Medicaid define "recoupment," Dr. Fink emailed the Working Group members the following documents on August 28, 2013:

1. Electronic Code of Federal Regulations, Title 42, Part 433, Subpart F, on Refunding of Federal Share of Medicaid Overpayments to Providers; and
2. Unofficial Hawaii Administrative Rules, Title 17, Subtitle 12, Chapter 1705, on Medical Assistance Recovery.

Dr. Fink said the federal government places no time limit on recoupment recovery. From the time overpayment is discovered, there is a one-year time frame for the Medicaid agency to reimburse the federal government. The Medicaid agency would then be responsible for collecting from the providers. While there is a one-year deadline to reimburse the federal government upon discovery of the overpayment, there is no time limit on when the service was provided.

Dr. Fink said that every three years, if there is any overpayment or underpayment in the cycle, the Medicaid agency must recover overpayments or underpayments. Dr. Fink also noted that there is a new federal recovery audit program and that the Office of Inspector General is responsible for the audits. If an overpayment is discovered in the audit, the overpayment will be recovered.

Discussion ensued regarding the three-year look-back period for Recovery Audit Contractor audits ("RAC Audits"). Dr. Fink said that Medicaid requires the states to have RACs, who work on commission, to complete required audits. He also noted that every three years, if an overpayment is identified in the cycle, they must recover the overpayment.

Document Retention Requirements

It was noted that since there is a seven-year document preservation requirement, it would be difficult for healthcare providers to retrieve documents going beyond the seven-year period.

Jennifer Diesman stated that with regard to the Hawaii Medical Service Association ("HMSA"), the Centers for Medicare and Medicaid Services ("CMS") can go against a claim as long as HMSA has a contract with the federal government. She said that even if the claim has been open up to 20 years, CMS can go after the claim.

Further discussion ensued about at what point is there a reasonable expectation that a healthcare provider would be required to maintain medical records. Ms. Diesman noted that HMSA has an 18-month look-back period for commercial claims with caveats in certain cases, such as claims involving fraud, workers' compensation, and third-party liability. Alyson Estrella of the University Health Alliance ("UHA") stated that UHA has a one-year look-back period with exceptions for cases of fraud, workers' compensation, and third-party liability. Ms. Diesman said she would survey other members of the Hawaii Association of Health Plans with regard to the length of their look-back periods and report her findings to the Working Group.

Recoupment Limits

Discussion ensued with regard to whether carve outs should be allowed for fraud or other reasons. While there was agreement that criminal activity should not be protected by statutorily-established recoupment limits, the Working Group was not able to come to an agreement on how "fraud" should be defined in the context of recoupment. For example, should fraud include unintentional coding or billing errors?

Commissioner Ito noted that the Insurance Division has a Fraud branch that enforces insurance fraud actions. He also noted that under Hawaii law, fraud comes down to intent.

During the discussion, Ms. Diesman noted that most criminal cases are brought by the government and not the health plans. She asked Dr. Fink if the Department of Human Services has analysis or data regarding the degree of recoupment by DHS for fraud in the last three years. Dr. Fink said that fraud is handled by the Attorney General's Medicaid Fraud Control Unit. It was noted that it may be helpful to obtain data on the number of Medicaid overpayments related to fraud to determine the magnitude of the problem.

Preparation for Next Meeting

Commissioner Ito noted that the Working Group is moving toward consensus and reminded the members that under SCR 129 they have been charged with:

1. Assessing the problems of recoupment; and
2. Studying the impacts of limiting the period allowed to initiate any recoupment or offset demand efforts.

Commissioner Ito encouraged the members to submit their comments on the aforementioned points in writing before the Working Group meets again to enable the Working Group to prepare the report requested by the Legislature.

It was noted that quantifying the impact of recoupment practices may be difficult because claims are handled confidentially and information is generally not shared in the healthcare provider community. In addition, it is difficult to gather this kind of data in a highly regulated market. However, several of the members agreed to put something together in writing. Dr. Johnson noted that another adverse impact of recoupment is that people may be less likely to enter the medical profession because of an increasingly regulated market and when they see the lack of equity in the system.

Commissioner Ito stated that he would like to address the following issues at the next meeting:

1. Is the Hawaii Association of Health Plans willing to set limits or parameters with regard to recoupment practices?
2. If so, what limits are they willing to accept?
3. What kind of carve outs are the Working Group members willing to accept (e.g., fraud, third-party liability, etc.)?
4. Within the scope of SCR 129, identify the impacts placing a time limit would have on recoupment.

Commissioner Ito requested Working Group members to submit written statements on the above points before the next scheduled meeting. He also asked the Working Group members to consider, if the Working Group decides to recommend legislation on this issue, whether they would like to recommend a particular state law as a model or whether they would like to make a general recommendation to the Legislature.

III. Submission of Testimony by Interested Parties and Members of the Public

Dr. Johnson presented the Working Group members with copies of the Medical Transcription Billing, Corp. ("MTBC") report on Refund Recoupment Laws and a table summarizing the MTBC Refund Recoupment Laws.

IV. Scheduling of Next Meeting

The next meeting will take place on Wednesday, September 18, 2013, at 3 p.m. at a location to be announced at a later time.

V. Adjournment

The meeting was adjourned at 10:50 a.m.

MINUTES OF THE INSURANCE RECOUPMENT WORKING GROUP

Wednesday, September 18, 2013
Queen Liliuokalani Conference Room
King Kalakaua Building
335 Merchant Street, 1st Floor
Honolulu, HI 96813

Members Present: Gordon I. Ito (Insurance Commissioner and Working Group Chair), Lorrin Kim (Department of Health), Cori Woo (Department of Human Services), L. Martin Johnson (healthcare provider community/health care professional), Gail L. Tice (healthcare provider community/health care professional – participation via conference call), Jennifer Diesman (Hawaii Association of Health Plans/Hawaii Medical Service Association), Howard Lee (Hawaii Association of Health Plans/University Health Alliance), Catherine Xiao (Healthcare Association of Hawaii), Christopher D. Flanders (Hawaii Medical Association)

Members Excused: Robert Hirokawa (Hawaii Primary Care Association)

Others Present: Alyson Estrella (University Health Alliance), Tamera MezNarich, and Ann Le Lievre and Donna K. Ikegami (both from the Hawaii Insurance Division)

I. Call to Order

Pursuant to written notice, this meeting of the Insurance Recoupment Working Group (the "Working Group") was called to order and chaired by Gordon I. Ito, Insurance Commissioner, at 3:04 p.m. The meeting was held pursuant to the public notice filed with the Lieutenant Governor's Office on September 9, 2013.

The Working Group is established pursuant to Senate Concurrent Resolution No. 129, S.D. 1, of the Regular Session of 2013 (SCR 129). SCR 129 requested the Insurance Commissioner to convene a working group to study insurance recoupment and to serve as its chair.

II. Approval of Past Minutes

Commissioner Ito presented the minutes of the August 21, 2013 and September 4, 2013 Working Group meetings for the Working Group's consideration. A brief discussion ensued.

Motion, Seconded, and Carried (MSC): To approve the minutes of the August 21, 2013 Working Group, as presented.

MSC: To approve the minutes of the September 4, 2013 Working Group, as presented.

III. Discussion Topics and Presentations

Howard Lee's Comments

Howard Lee of the University Health Alliance ("UHA") presented his written comments, which he submitted to Commissioner Ito as a representative of the Hawaii Association of Health Plans ("HAHP"). Mr. Lee said that none of the members of HAHP engage in unreasonable insurance recoupment practices and noted that he was surprised that this happens. Mr. Lee expressed his frustration with not being able to clearly identify who is causing the insurance recoupment problem. He said that he did not want to develop policy on this issue without understanding the problem because statutorily establishing a recoupment deadline may have unintended consequences. Christopher D. Flanders of the Hawaii Medical Association ("HMA") noted that the bulk of the physician complaints to HMA within the last three to five years have been related to the Centers for Medicare & Medicaid Services.

Recovery Audit Program

Mr. Lee discussed the Recovery Audit Program, whereby third-party vendors are hired as Recovery Audit Contractors ("RAC") to conduct RAC audits to identify Medicare overpayments and underpayments to healthcare providers and suppliers. He noted that under the demonstration Recovery Audit Program from 2005-2008, over \$900 million in overpayments were returned to the Medicare Trust Fund. At the same time, it should be noted that nearly \$38 million in underpayments were returned to healthcare providers.

Mr. Lee explained that third-party vendors are typically hired as RACs and paid by commission. If the RAC finds an overpayment, the RAC would seek payment from the Medicare contractor, such as Hawaii Medical Service Association ("HMSA"), who would then go to the healthcare provider for recoupment. Mr. Lee said this appears to be a contractual issue between the plan and Medicare.

In the case of a third-party administrator for another entity similar to a union, if an overpayment is discovered through audit claim processing, the overpayment is returned to the union.

L. Martin Johnson's Comments

L. Martin Johnson's Recoupment Problem Statement was transmitted to the Working Group members via email before this meeting was convened. During the discussion, Dr. Johnson noted that there has been a trend for mainland firms to be third-party administrators. For example, a mainland employer (e.g., big box stores, hotels, airlines, etc.) has an employee in Tuscon, Arizona, but the employee lives in Honolulu. If the employee needs medical attention in Hawaii, the healthcare provider would have to deal with insurance carriers that are not from Hawaii. As a result, healthcare providers may deal not only with Hawaii insurance carriers, but with carriers from all over the U.S.

Dr. Johnson noted that he knew a psychologist who has been in practice for more than ten years, who had been using the same Current Procedural Terminology code for many years. After an audit was conducted, she was told that she had been using the wrong code and was penalized for using the wrong code. After she protested, additional penalties were made for additional years even though there was no attempt at fraud. It was not until she hired an attorney that this misunderstanding was resolved. Dr. Johnson acknowledged that the local carriers appear to have reasonable standards. At the same time, he said this is already a heavily regulated market and keeping things the way they are would

put all healthcare providers at a distinct disadvantage. He also noted that if things are left the way they are, the possibility exists for a solo practitioner to incur six-figure losses from recoupment overpayments.

Recoupment Limits

During the discussion on HMSA's written comments, Jennifer Diesman of HMSA and HAHP noted that from HMSA's perspective, she was not aware of any major concerns with their recoupment policy or experience. She also noted that most HMSA provider contracts only allow them to recover for a period of 18 months from date of payment, and a few provide a 24-month recovery period.

Ms. Diesman said most recoupment cases are government-related, and there is nothing HMSA can do to fix that problem. She said that even if the law were changed, this would not necessarily correct the recoupment problem. While HMSA has an 18-month standard, HMSA may be forced to go back beyond 18 months if Medicare demands it. She did not support introducing recoupment legislation, adding that more data and analysis would be needed before recoupment legislation can be considered.

Mr. Lee agreed with Ms. Diesman, indicating his willingness to address healthcare provider concerns without legislation. Mr. Lee said unintended consequences could result from any changes to the law. In addition, Mr. Lee said that if the Working Group were to recommend a recoupment bill that exempts Medicare and fraud, the bill may not address the problem at hand.

Mr. Lee suggested evaluating healthcare provider contracts to see if contractual provisions can be amended to address recoupment problems. Commissioner Ito said that the Insurance Division generally does not get involved in healthcare provider-insurer contractual disputes. He said that the Insurance Division regulates statutory and regulatory requirements set forth in the Hawaii Insurance Code and Hawaii Administrative Rules. Contractual disputes are outside the scope of the Insurance Division's jurisdiction. However, he said it may be possible for the Insurance Division to get involved if there is a violation of the unfair methods of competition and unfair and deceptive acts and practices in the business of insurance in article 13, chapter 431, Hawaii Revised Statutes.

When asked by Gail L. Tice, Ms. Diesman said all healthcare providers (including social workers, physical therapists, etc.) contracted with HMSA fall under the 18-month period. Ms. Diesman added that it also applies to hospitals. When asked by Dr. Tice, Mr. Lee similarly responded that all healthcare providers contracted with UHA fall under the one-year period.

Fraud

Discussion ensued regarding fraud. Mr. Lee said fraud needs to be proven in court. If a health plan claims fraud, it takes time to get through the judicial system. As a result, in many cases, the claim is often settled or terminated.

Dr. Flanders said that since fraud involves the element of intent, the Working Group needs to keep in mind the potential calamity for physicians with coding problems. Dr. Johnson also raised concerns about DSM-5 (Fifth edition of the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders) coding.

Commissioner's Recommendations and Other Business

Commissioner Ito told the Working Group that he would like to wrap up the activities of the Working Group and begin preparing the draft report. He noted that if health plans, such as HMSA and UHA, already have recoupment time frames established with healthcare providers, there is little value in enacting a law since this is a contractual matter. While anecdotal cases have been discussed in past Working Group meetings, Commissioner Ito noted that most of them are related to Medicaid or Medicare. As a result, the state cannot change federal law. Commissioner Ito also noted that if a recoupment law is passed, the Insurance Division would be responsible for enforcing the law.

The representatives of HAHP agreed to obtain contract information from the other plans, in addition to HMSA and UHA. Although Mr. Lee said that the Insurance Division has the authority to get copies of healthcare provider-insurer contracts, Ms. Diesman said it would only be necessary to get the time frames without looking at each contract.

Dr. Johnson noted that he is disappointed that steps would not be taken to reconcile this institutional inequity. He said that leaving the inequity as it stands is problematic, even though the local insurance companies have been reasonable in their policies, because it puts all healthcare providers at an unfair disadvantage.

Commissioner Ito pointed out that what Dr. Johnson is requesting is beyond the purview of what state law can provide. He also stated that the passage of state law would not necessarily rectify the problem. Commissioner Ito said he would initiate the preparation of the draft report and schedule the next meeting upon the completion of the draft report to provide the Working Group members a chance to review and comment on the draft before the next meeting.

III. Submission of Testimony by Interested Parties and Members of the Public

Dr. Johnson's Recoupment Problem Statement was transmitted to the Working Group members via email before this meeting was convened. He recommended introducing legislation to establish a 12-month recoupment period with an exception for fraud.

Mr. Lee provided written comments stating that HAHP is not willing to change limits until the problem is clearly identified. He also distributed copies of a description of the Centers for Medicare & Medicaid Services Recovery Audit Program to provide background information for the Working Group members.

Ms. Diesman submitted comments on behalf of HMSA, stating that while HMSA understands there may be specific cases of concern to certain providers, HMSA does not believe they warrant regulatory or statutory action.

IV. Scheduling of Next Meeting

The next meeting will be scheduled upon completion of the Working Group's draft report of its findings and recommendations.

V. Adjournment

The meeting was adjourned at 3:50 p.m.



Dr Martin Johnson
<drjohnson.hcp@gmail.com>

09/17/2013 10:34 PM

To Donna.K.Ikegami@dcca.hawaii.gov,
cc
bcc
Subject Recoupment Problem Statement

SCR 129 SD1 Working Group on Recoupment

Background

For the sake of brevity, let us stipulate two basic facts in way of context for this problem:

1. Billing for health care services is a complex process. Different insurance companies have different policies. Regulations change fairly frequently. It is not unusual for professional billers and insurance representatives to have questions and confusion on specific issues, not to mention specific claims. Also, a given patient/beneficiary may have multiple insurance policies and may or may not be well informed as to their coverage. Honest mistakes in the billing process are not unusual.
2. Health care providers typically have no training in business. It would be easy to say simply, that they should get some. However it is important to keep in mind that many providers have already trained for many years, in some cases a decade or more in their chosen field. They often have little time, proclivity or interest in pursuing training in commercial enterprise. This is certainly not the fault or even concern of the insurance industry, but it is a fact that is worth keeping in mind.

Problem Statement

The problem of recoupment of insurance payments from health care providers by commercial insurance companies is significant and damaging to the the health care delivery system in several ways.

First, it institutionalizes an inequity between healthcare providers and insurance companies. While healthcare providers have 12 months to correct and refile any claims, insurance companies are free to recoup funds paid out to providers at any time, back to and including the first claim filed by the provider.

This inequity is unique to the healthcare industry. There is no rational business model where the provider of a service may make adjustments to billing for a relatively short period of time, but the consumer can demand a refund at any time in the future without limit and the burden of defending the charges will be on the provider.

This institutionalized inequity is damaging to the system in that it breeds a sense of fear and distrust. Many providers simply write a check in response to any recoupment effort out of fear that any effort to resist the recoupment will result in further recoupments, which could literally put the provider out of business and into bankruptcy. When faced with more significant recoupments the provider is left with no choice but to seek legal counsel. Providers who have successfully defended against recoupment efforts consistently report that they prevailed by showing the billing policy was

sufficiently complex and unclear that the way they billed was a reasonable attempt to follow the rules and recoupment was unreasonable. They also report that the process goes on for a year or more and is very costly both financially and emotionally. Those that lose a major recoupment often leave practice and seek employment out of financial necessity and discouragement.

On the national level, this problem has resulted in multiple lawsuits resulting in multi-million dollar settlements in favor of providers who have suffered large and systemic and unfair recoupment efforts. More than half of the states have past laws to address this problem.

Finally, there is simply no rationale for leaving this institutionalized inequity in place.

The Need for Action

Healthcare is a highly regulated market facing increased regulations. As Hawaii moves towards new models of healthcare delivery, we propose that as we seek to make the system more efficient with improved outcomes, we must also make it more equitable for all stakeholders.

With new national regulations, we will undoubtedly see national companies are entering the market and mainland executives working locally. That a national problem has not, to date, had as large an impact locally, does make it safe to assume that Hawaii is immune to the significant negative impacts that have been felt in other states.

As other states pass legislation to correct the recoupment problem, Hawaii should not fall behind. This is especially true when the fix is relatively simple, with minimal impact on other stakeholders.

Proposed Remedy – Parity 12 months

The simplest path to fixing the current inequity is to adopt legislation that upholds parity; specifically, to allow insurance companies the same amount of time to correct billing errors and providers are given. Of those states that have passed legislation, the most common period allowed for recoupment is 12 months.

Allowing a continued inequity is problematic. To provide a simple example: a common issue that occurs in billing is determining which insurance coverage is "primary" and which is "secondary" when a patient is covered by two plans. Often the patient does not know which plan is primary.

There is no easy way for the provider to know and it is not uncommon for the provider's office to be completely unaware that there is more than one insurance plan if the patient does not provide the information. As a result, the wrong insurance company may be billed for the services rendered.

That insurance company may take some time to determine that they paid in error. If, for example, insurance companies are allowed to recoup beyond 12 months, then the recoupment can be made after the time period that the provider can go back and correctly bill the other insurance company. It seems only fair that all parties be responsible for catching and correcting billing errors in the same period of time.

Carve out for fraud

Everyone recognizes the need for integrity in the system. No one condones or is seeking to protect fraudulent activities. However, the language used relating to fraudulent claims, needs to be based on standard legal definitions of fraud.

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Respectfully submitted,

Martin

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Title 42: Public Health

PART 433—STATE FISCAL ADMINISTRATION

Subpart F—Refunding of Federal Share of Medicaid Overpayments to Providers

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SOURCE: 54 FR 5460, Feb. 3, 1989, unless otherwise noted.

§ 433.300 Basis.

This subpart implements—

(a) Section 1903(d)(2)(A) of the Act, which directs that quarterly Federal payments to the States under title XIX (Medicaid) of the Act are to be reduced or increased to make adjustment for prior overpayments or underpayments that the Secretary determines have been made.

(b) Section 1903(d)(2)(C) and (D) of the Act, which provides that a State has 1 year from discovery of an overpayment for Medicaid services to recover or attempt to recover the overpayment from the provider before adjustment in the Federal Medicaid payment to the State is made; and that adjustment will be made at the end of the 1-year period, whether or not recovery is made, unless the State is unable to recover from a provider because the overpayment is a debt that has been discharged in bankruptcy or is otherwise uncollectable.

(c) Section 1903(d)(3) of the Act, which provides that the Secretary will consider the pro rata Federal share of the net amount recovered by a State during any quarter to be an overpayment.

[54 FR 5460, Feb. 3, 1989, as amended at 77 FR 31511, May 29, 2012]

§ 433.302 Scope of subpart.

This subpart sets forth the requirements and procedures under which States have 1 year following discovery of overpayments made to providers for Medicaid services to recover or attempt to recover that amount before the States must refund the Federal share of these overpayments to CMS, with

APPENDIX D

certain exceptions.

[77 FR 31511, May 29, 2012]

§ 433.304 Definitions.

As used in this subpart—

Discovery (or *discovered*) means identification by any State Medicaid agency official or other State official, the Federal Government, or the provider of an overpayment, and the communication of that overpayment finding or the initiation of a formal recoupment action without notice as described in § 433.316.

Final written notice means that written communication, immediately preceding the first level of formal administrative or judicial proceedings, from a Medicaid agency official or other State official that notifies the provider of the State's overpayment determination and allows the provider to contest that determination, or that notifies the State Medicaid agency of the filing of a civil or criminal action.

Fraud (in accordance with § 455.2) means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Overpayment means the amount paid by a Medicaid agency to a provider which is in excess of the amount that is allowable for services furnished under section 1902 of the Act and which is required to be refunded under section 1903 of the Act.

Provider (in accordance with § 400.203) means any individual or entity furnishing Medicaid services under a provider agreement with the Medicaid agency.

Recoupment means any formal action by the State or its fiscal agent to initiate recovery of an overpayment without advance official notice by reducing future payments to a provider.

Third party (in accordance with § 433.136) means an individual, entity, or program that is or may be liable to pay for all or part of the expenditures for medical assistance furnished under a State plan.

[54 FR 5460, Feb. 3, 1989; 54 FR 8435, Feb. 28, 1989, as amended at 77 FR 31511, May 29, 2012]

§ 433.310 Applicability of requirements.

(a) *General rule.* Except as provided in paragraphs (b) and (c) of this section, the provisions of this subpart apply to—

- (1) Overpayments made to providers that are discovered by the State;
- (2) Overpayments made to providers that are initially discovered by the provider and made known to the State agency; and
- (3) Overpayments that are discovered through Federal reviews.

(b) *Third party payments and probate collections.* The requirements of this subpart do not apply to—

- (1) Cases involving third party liability because, in these situations, recovery is sought for a

Medicaid payment that would have been made had another party not been legally responsible for payment; and

(2) Probate collections from the estates of deceased Medicaid beneficiaries, as they represent the recovery of payments properly made from resources later determined to be available to the State.

(c) *Unallowable costs paid under rate-setting systems.* (1) Unallowable costs for a prior year paid to an institutional provider under a rate-setting system that a State recovers through an adjustment to the per diem rate for a subsequent period do not constitute overpayments that are subject to the requirements of this subpart.

In such cases, the State is not required to refund the Federal share explicitly related to the original overpayment in accordance with the regulations in this subpart. Refund of the Federal share occurs when the State claims future expenditures made to the provider at a reduced rate.

(2) Unallowable costs for a prior year paid to an institutional provider under a rate-setting system that a State seeks to recover in a lump sum, by an installment repayment plan, or through reduction of future payments to which the provider would otherwise be entitled constitute overpayments that are subject to the requirements of this subpart.

(d) *Recapture of depreciation upon gain on the sale of assets.* Depreciation payments are considered overpayments for purposes of this subpart if a State requires their recapture in a discrete amount(s) upon gain on the sale of assets.

§ 433.312 Basic requirements for refunds.

(a) *Basic rules.* (1) Except as provided in paragraph (b) of this section, the State Medicaid agency has 1 year from the date of discovery of an overpayment to a provider to recover or seek to recover the overpayment before the Federal share must be refunded to CMS.

(2) The State Medicaid agency must refund the Federal share of overpayments at the end of the 1-year period following discovery in accordance with the requirements of this subpart, whether or not the State has recovered the overpayment from the provider.

(b) *Exception.* The agency is not required to refund the Federal share of an overpayment made to a provider when the State is unable to recover the overpayment amount because the provider has been determined bankrupt or out of business in accordance with § 433.318.

(c) *Applicability.* (1) The requirements of this subpart apply to overpayments made to Medicaid providers that occur and are discovered in any quarter that begins on or after October 1, 1985.

(2) The date upon which an overpayment occurs is the date upon which a State, using its normal method of reimbursement for a particular class of provider (e.g., check, interfund transfer), makes the payment involving unallowable costs to a provider.

[54 FR 5460, Feb. 3, 1989, as amended at 77 FR 31511, May 29, 2012]

§ 433.316 When discovery of overpayment occurs and its significance.

(a) *General rule.* The date on which an overpayment is discovered is the beginning date of the 1-year period allowed for a State to recover or seek to recover an overpayment before a refund of the Federal share of an overpayment must be made to CMS.

(b) *Requirements for notification.* Unless a State official or fiscal agent of the State chooses to initiate a formal recoupment action against a provider without first giving written notification of its intent, a State Medicaid agency official or other State official must notify the provider in writing of any overpayment it discovers in accordance with State agency policies and procedures and must take reasonable actions to attempt to recover the overpayment in accordance with State law and procedures.

(c) *Overpayments resulting from situations other than fraud.* An overpayment resulting from a situation other than fraud is discovered on the earliest of—

(1) The date on which any Medicaid agency official or other State official first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery;

(2) The date on which a provider initially acknowledges a specific overpaid amount in writing to the Medicaid agency; or

(3) The date on which any State official or fiscal agent of the State initiates a formal action to recoup a specific overpaid amount from a provider without having first notified the provider in writing.

(d) *Overpayments resulting from fraud.* (1) An overpayment that results from fraud is discovered on the date of the final written notice (as defined in § 433.304 of this subchapter) of the State's overpayment determination.

(2) When the State is unable to recover a debt which represents an overpayment (or any portion thereof) resulting from fraud within 1 year of discovery because no final determination of the amount of the overpayment has been made under an administrative or judicial process (as applicable), including as a result of a judgment being under appeal, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or any portion thereof) until 30 days after the date on which a final judgment (including, if applicable, a final determination on an appeal) is made.

(3) The Medicaid agency may treat an overpayment made to a Medicaid provider as resulting from fraud under subsection (d) of this section only if it has referred a provider's case to the Medicaid fraud control unit, or appropriate law enforcement agency in States with no certified Medicaid fraud control unit, as required by § 455.15, § 455.21, or § 455.23 of this chapter, and the Medicaid fraud control unit or appropriate law enforcement agency has provided the Medicaid agency with written notification of acceptance of the case; or if the Medicaid fraud control unit or appropriate law enforcement agency has filed a civil or criminal action against a provider and has notified the State Medicaid agency.

(e) *Overpayments identified through Federal reviews.* If a Federal review at any time indicates that a State has failed to identify an overpayment or a State has identified an overpayment but has failed to either send written notice of the overpayment to the provider that specified a dollar amount subject to recovery or initiate a formal recoupment from the provider without having first notified the provider in writing, CMS will consider the overpayment as discovered on the date that the Federal official first notifies the State in writing of the overpayment and specifies a dollar amount subject to recovery.

(f) *Effect of changes in overpayment amount.* Any adjustment in the amount of an overpayment during the 1-year period following discovery (made in accordance with the approved State plan, Federal law and regulations governing Medicaid, and the appeals resolution process specified in State administrative policies and procedures) has the following effect on the 1-year recovery period:

(1) A downward adjustment in the amount of an overpayment subject to recovery that occurs after discovery does not change the original 1-year recovery period for the outstanding balance.

(2) An upward adjustment in the amount of an overpayment subject to recovery that occurs during the 1-year period following discovery does not change the 1-year recovery period for the original overpayment amount. A new 1-year period begins for the incremental amount only, beginning with the date of the State's written notification to the provider regarding the upward adjustment.

(g) *Effect of partial collection by State.* A partial collection of an overpayment amount by the State from a provider during the 1-year period following discovery does not change the 1-year recovery period for the balance of the original overpayment amount due to CMS.

(h) *Effect of administrative or judicial appeals.* Any appeal rights extended to a provider do not extend the date of discovery.

[54 FR 5460, Feb. 3, 1989; 54 FR 8435, Feb. 28, 1989, as amended at 77 FR 31511, May 29, 2012]

§ 433.318 Overpayments involving providers who are bankrupt or out of business.

(a) *Basic rules.* (1) The agency is not required to refund the Federal share of an overpayment made to a provider as required by § 433.312(a) to the extent that the State is unable to recover the overpayment because the provider has been determined bankrupt or out of business in accordance with the provisions of this section.

(2) The agency must notify the provider that an overpayment exists in any case involving a bankrupt or out-of-business provider and, if the debt has not been determined uncollectable, take reasonable actions to recover the overpayment during the 1-year recovery period in accordance with policies prescribed by applicable State law and administrative procedures.

(b) *Overpayment debts that the State need not refund.* Overpayments are considered debts that the State is unable to recover within the 1-year period following discovery if the following criteria are met:

(1) The provider has filed for bankruptcy, as specified in paragraph (c) of this section; or

(2) The provider has gone out of business and the State is unable to locate the provider and its assets, as specified in paragraph (d) of this section.

(c) *Bankruptcy.* The agency is not required to refund to CMS the Federal share of an overpayment at the end of the 1-year period following discovery, if—

(1) The provider has filed for bankruptcy in Federal court at the time of discovery of the overpayment or the provider files a bankruptcy petition in Federal court before the end of the 1-year period following discovery; and

(2) The State is on record with the court as a creditor of the petitioner in the amount of the Medicaid overpayment.

(d) *Out of business.* (1) The agency is not required to refund to CMS the Federal share of an overpayment at the end of the 1-year period following discovery if the provider is out of business on the date of discovery of the overpayment or if the provider goes out of business before the end of the 1-year period following discovery.

(2) A provider is considered to be out of business on the effective date of a determination to that effect under State law. The agency must—

(i) Document its efforts to locate the party and its assets. These efforts must be consistent with applicable State policies and procedures; and

(ii) Make available an affidavit or certification from the appropriate State legal authority establishing that the provider is out of business and that the overpayment cannot be collected under State law and procedures and citing the effective date of that determination under State law.

(3) A provider is not out of business when ownership is transferred within the State unless State law and procedures deem a provider that has transferred ownership to be out of business and preclude collection of the overpayment from the provider.

(e) *Circumstances requiring refunds.* If the 1-year recovery period has expired before an overpayment is found to be uncollectable under the provisions of this section, if the State recovers an overpayment amount under a court-approved discharge of bankruptcy, or if a bankruptcy petition is denied, the agency must refund the Federal share of the overpayment in accordance with the procedures specified in § 433.320 of this subpart.

[54 FR 5460, Feb. 3, 1989; 54 FR 8435, Feb. 28, 1989, as amended at 77 FR 31512, May 29, 2012]

§ 433.320 Procedures for refunds to CMS.

(a) *Basic requirements.* (1) The agency must refund the Federal share of overpayments that are subject to recovery to CMS through a credit on its Quarterly Statement of Expenditures (Form CMS-64).

(2) The agency must credit CMS with the Federal share of overpayments subject to recovery on the earlier of—

(i) The Form CMS-64 submission due to CMS for the quarter in which the State recovers the overpayment from the provider; or

(ii) The Form CMS-64 due to CMS for the quarter in which the 1-year period following discovery, established in accordance with § 433.316, ends.

(3) A credit on the Form CMS-64 must be made whether or not the overpayment has been recovered by the State from the provider.

(4) If the State does not refund the Federal share of such overpayment as indicated in paragraph (a)(2) of this section, the State will be liable for interest on the amount equal to the Federal share of the non-recovered, non-refunded overpayment amount. Interest during this period will be at the Current Value of Funds Rate (CVFR), and will accrue beginning on the day after the end of the 1-year period following discovery until the last day of the quarter for which the State submits a CMS-64 report refunding the Federal share of the overpayment.

(b) *Effect of reporting collections and submitting reduced expenditure claims.* (1) The State is not required to refund the Federal share of an overpayment at the end of the 1-year period if the State has already reported a collection or submitted an expenditure claim reduced by a discrete amount to recover the overpayment prior to the end of the 1-year period following discovery.

(2) The State is not required to report on the Form CMS-64 any collections made on overpayment amounts for which the Federal share has been refunded previously.

(3) If a State has refunded the Federal share of an overpayment as required under this subpart and the State subsequently makes recovery by reducing future provider payments by a discrete

amount, the State need not reflect that reduction in its claim for Federal financial participation.

(c) *Reclaiming overpayment amounts previously refunded to CMS.* If the amount of an overpayment is adjusted downward after the agency has credited CMS with the Federal share, the agency may reclaim the amount of the downward adjustment on the Form CMS-64. Under this provision—

(1) Downward adjustment to an overpayment amount previously credited to CMS is allowed only if it is properly based on the approved State plan, Federal law and regulations governing Medicaid, and the appeals resolution processes specified in State administrative policies and procedures.

(2) The 2-year filing limit for retroactive claims for Medicaid expenditures does not apply. A downward adjustment is not considered a retroactive claim but rather a reclaiming of costs previously claimed.

(d) *Expiration of 1-year recovery period.* If an overpayment has not been determined uncollectable in accordance with the requirements of § 433.318 of this subpart at the end of the 1-year period following discovery of the overpayment, the agency must refund the Federal share of the overpayment to CMS in accordance with the procedures specified in paragraph (a) of this section.

(e) *Court-approved discharge of bankruptcy.* If the State recovers any portion of an overpayment under a court-approved discharge of bankruptcy, the agency must refund to CMS the Federal share of the overpayment amount collected on the next quarterly expenditure report that is due to CMS for the period that includes the date on which the collection occurs.

(f) *Bankruptcy petition denied.* If a provider's petition for bankruptcy is denied in Federal court, the agency must credit CMS with the Federal share of the overpayment on the later of—

(1) The Form CMS-64 submission due to CMS immediately following the date of the decision of the court; or

(2) The Form CMS-64 submission for the quarter in which the 1-year period following discovery of the overpayment ends.

(g) *Reclaim of refunds.* (1) If a provider is determined bankrupt or out of business under this section after the 1-year period following discovery of the overpayment ends and the State has not been able to make complete recovery, the agency may reclaim the amount of the Federal share of any unrecovered overpayment amount previously refunded to CMS. CMS allows the reclaim of a refund by the agency if the agency submits to CMS documentation that it has made reasonable efforts to obtain recovery.

(2) If the agency reclaims a refund of the Federal share of an overpayment—

(i) In bankruptcy cases, the agency must submit to CMS a statement of its efforts to recover the overpayment during the period before the petition for bankruptcy was filed; and

(ii) In out-of-business cases, the agency must submit to CMS a statement of its efforts to locate the provider and its assets and to recover the overpayment during any period before the provider is found to be out of business in accordance with § 433.318.

(h) *Supporting reports.* The agency must report the following information to support each Quarterly Statement of Expenditures Form CMS-64:

- (1) Amounts of overpayments not collected during the quarter but refunded because of the expiration of the 1-year period following discovery;
- (2) Upward and downward adjustments to amounts credited in previous quarters;
- (3) Amounts of overpayments collected under court-approved discharges of bankruptcy;
- (4) Amounts of previously reported overpayments to providers certified as bankrupt or out of business during the quarter; and
- (5) Amounts of overpayments previously credited and reclaimed by the State.

[54 FR 5460, Feb. 3, 1989, as amended at 77 FR 31512, May 29, 2012]

§ 433.322 Maintenance of Records.

The Medicaid agency must maintain a separate record of all overpayment activities for each provider in a manner that satisfies the retention and access requirements of 45 CFR 92.42.

[77 FR 31512, May 29, 2012]

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HAWAII ADMINISTRATIVE RULES

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DEPARTMENT OF HUMAN SERVICES

SUBTITLE 12 MED-QUEST DIVISION

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Subchapter 8 Third Party Liability Subrogation

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Historical Note: This chapter is based substantially
upon chapter 17-1352. [Eff 06/29/92; R 08/01/94]

SUBCHAPTER 1

GENERAL PROVISIONS

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§17-1705-1 Purpose. The purpose of this chapter is to establish the requirements for applicants and recipients of medical assistance. Applicants and recipients shall:

- (1) Assign their rights to third party payments and medical support;
- (2) Cooperate in obtaining third party payments for medical assistance, pursuing any third party who may be liable for medical support, and obtaining child support; and
- (3) Be required to satisfy all conditions set forth by the third party to receive coverage, to the extent coverage is available through that third party, before Medicaid reimbursement is allowed. [Eff 08/01/94; am 02/07/05] (Auth: HRS §346-14) (Imp: 42 C.F.R. §§433.138, 433.145, 433.146, 433.147; 45 C.F.R. §§232.11, 232.12)

§17-1705-2 Definitions. As used in this chapter: "Assignment" means assigning to the department, in writing, the right to obtain medical support and other third party payments.

"Caretaker relative" means a relative who provides care and supervision to children.

"Cost-sharing related to Medicare part D" means any premiums, deductibles, co-payments, co-insurance, and any cost incurred within the Part D coverage gap.

"Family" means person or persons applying for or receiving assistance.

"Health plan" means any health plan contracted with the department to participate in QUEST.

"Third party" means any individual, entity, or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished.

"Title IVD" means Title IVD of the Social Security Act, child support enforcement program (42 U.S.C. §§651 through 658, 660, 664, 666, 667, 1302, and 1396a(25)). [Eff 08/01/94; am 01/29/96; am 12/26/05] (Auth: HRS §346-14) (Imp: 42 C.F.R. §§433.138, 433.145, 433.146, 433.147; 45 C.F.R. §§232.11, 232.12, Pub. L. 108-173)

§17-1705-3 Administrative procedures. (a) The adverse action notice requirements of chapter 17-1713 shall apply unless otherwise indicated in this chapter.

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(b) The administrative hearing requirements of chapter 17-1703 shall apply.

(c) The department shall restore to the individual any future rights to benefits assigned to the department when medical assistance terminates and after all medical expenses have been met.
[Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §433.148; 45 C.F.R. §205.10)

§§17-1705-4 to 17-1705-5 (Reserved).

SUBCHAPTER 2

ASSIGNMENT OF AND COOPERATION IN OBTAINING THIRD PARTY PAYMENTS

§17-1705-6 Purpose. The purpose of this chapter is to establish the requirements for assignment of and cooperation in obtaining third party payments that applicants and recipients shall be required to meet to receive medical assistance. [Eff 08/01/94]
(Auth: HRS §346-14) (Imp: 42 C.F.R. §433.137; 433.138; 45 C.F.R. §232.13, HRS §346-37)

§17-1705-7 Medical assignment requirements. (a) All individuals applying for or receiving medical assistance shall assign to the department or health plan:

- (1) The individual's rights to any third party payments; and
- (2) The rights of any other family member included in the application or receiving assistance for whom the applicant or recipient can legally make an assignment.

(b) Assignment of right to payments shall not include assignment of rights to medicare benefits.

(c) An applicant or recipient shall inform the department or health plan of an involvement in an accident within thirty days of the accident.

[Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §346-37(b); 42 C.F.R. §§433.145, 433.146)

§17-1705-8 Cooperation requirements. (a) All applicants and recipients of medical assistance shall

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be required to cooperate with the department or health plan in obtaining third party payments unless there is good cause for refusing to cooperate.

(b) Cooperation shall include:

- (1) Identifying any third party who may be liable for services covered under the Medicaid or the QUEST program;
- (2) Providing relevant information or attesting to the lack of information, under penalty of perjury, to assist the department or health plan in pursuing any such potentially liable third party;
- (3) Appearing at a department designated location to provide information or evidence relevant to the case;
- (4) Appearing as a witness at a court or other proceeding;
- (5) Paying to the department or health plan any support or medical care funds received that are covered by the assignment of rights; and
- (6) Taking any other reasonable steps to assist in securing medical support and payments.

(c) All applicants and recipients of medical assistance shall be required to apply, as a condition of eligibility, for Medicare coverage if:

- (1) The individual may meet the eligibility criteria for the Medicare program, and
- (2) The state agrees to pay any applicable premiums and cost-sharing, except for those related to Medicare part D. [Eff 08/01/94; am 01/29/96; am 12/26/05] (Auth: HRS §346-14) (Imp: 42 C.F.R. §433.138; §433.145; 45 C.F.R. §232.13; Pub. L. 108-173)

§17-1705-9 Good cause determination. (a) The department shall make a determination that cooperation is against the best interests of the individual or other family member to whom financial or medical assistance is being furnished when it is anticipated that cooperation will result in reprisal against, and cause physical or emotional harm to, the individual or other family member.

(b) When the department determines that good cause exists, the department shall make a further determination of whether collection activities could

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proceed without risk of harm to the family provided the activities will not involve the family's participation.

(c) The determination shall be made on a case-by-case evaluation of the circumstances and the family shall be notified of the decision.

(d) The good cause claim procedures of subchapter 4 shall apply. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §433.147; 45 C.F.R. §232.40)

§17-1705-10 Denial or termination of medical assistance. (a) The department shall deny or terminate medical assistance to any applicant or recipient who refuses to cooperate in obtaining third party payments, unless good cause exists.

(b) The department shall deny or terminate medical assistance to applicants or recipients who refuse to assign the individual's own rights or the rights of any other family member for whom the applicant or recipient can legally make an assignment.

(c) The department shall provide assistance to individuals who:

- (1) Cannot legally assign the individual's own rights or the rights of other family members;
- (2) Have good cause for refusing to cooperate; and
- (3) Would otherwise be eligible for assistance but for the refusal by a person legally able to make the assignment or to cooperate.

(d) Any individual denied or terminated for medical assistance as a result of refusal to assign the individual's rights shall have the right to a fair hearing. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §433.148)

§§17-1705-11 to 17-1705-15 (Reserved).

SUBCHAPTER 3

ASSIGNMENT OF AND COOPERATION IN OBTAINING MEDICAL SUPPORT

§17-1705-16 Purpose. The purpose of this subchapter is to establish the requirements for applicants and recipients of medical assistance. Applicants and recipients shall:

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- (1) Assign their rights to medical support; and
- (2) Cooperate in obtaining medical support.
[Eff 08/01/94] (Auth: HRS §346-14)
(Imp: HRS §346-37.1; 42 C.F.R. §§433.146,
433.147; 45 C.F.R. §§232.11, 232.12)

§17-1705-17 Assignment of rights to support. (a)
All individuals shall assign to the state any rights
the individuals may have to receive medical support
payments on the individual's own behalf or on behalf of
any other family member applying for or receiving
assistance.

(b) If the caretaker relative with whom the child
is living, fails to complete the assignment, the
caretaker relative shall be ineligible for medical
assistance.

(c) The department shall provide medical
assistance to individuals who would otherwise be
eligible but for the refusal of the caretaker relative
to complete the assignment. [Eff 08/01/94]
(Auth: HRS §346-14) (Imp: HRS §346-37.1; 42 C.F.R.
§433.148; 45 C.F.R. §§ 232.11, 232.13, 234.60)

§17-1705-18 Cooperation in obtaining support.
(a) Each individual applying for or receiving medical
assistance shall be required to cooperate with the
department in:

- (1) Identifying and locating the parent of the
child for whom medical services are being
claimed;
 - (2) Establishing the paternity of a child born
out of wedlock for whom medical services are
being claimed;
 - (3) Obtaining support payments due the individual
and the child for whom medical services are
being claimed; and
 - (4) Obtaining any other payments due the
individual and the child for whom medical
services are being claimed.
- (b) An individual may be required to:
- (1) Appear in court or at the department's child
support enforcement agency as maybe
necessary, to provide information and
evidence, known to, possessed by, or
obtainable by the individual that may be
achieving the objective of enforcing child
support obligations;

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- (2) Appear as a witness in any legal proceedings;
 - (3) Provide information, or attest to the lack of information, possessed or reasonably obtainable by the individual under penalty of perjury; and
 - (4) Report to the department any child support payments received from the absent parent.
- (c) The department shall provide medical assistance to individuals who would otherwise be eligible for medical assistance but for the refusal by the caretaker relative to cooperate. [Eff 08/01/94]
(Auth: HRS §346-14) Imp: HRS §346-37.1, 42 C.F.R. §§433.147, 433.148; 45 C.F.R. §§232.12, 234.60)

§17-1705-19 Determination of good cause for refusing to cooperate. (a) The department shall determine whether good cause exists for the family's failure to comply with the requirements of section 17-1705-18:

- (1) With respect to establishing paternity or securing support for a child, the department shall make a determination that good cause exists only if the evidence establishes that cooperation is against the best interest of the child.
 - (2) With respect to securing support for individuals not covered by paragraph (1), the department shall make a determination that good cause exists only if the evidence establishes that cooperation will result in reprisal against or cause physical or emotional harm to the applicant or recipient.
- (b) When the department determines that good cause exists, the department shall make a further determination of whether child or medical support enforcement could proceed without risk of harm to the family provided the enforcement or collection activities will not involve the family's participation.
- (c) The good cause determination shall be made on a case-by-case evaluation of the circumstances and evidence provided. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §346-37.1; 42 C.F.R. §433.147; 45 C.F.R. §232.40)

§17-1705-20 Circumstances under which cooperation may be against the best interest of the child. (a) Cooperation shall be against the best interest of the

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child only if it is reasonably anticipated to result in physical or emotional harm to the child or to the parent or caretaker relative, and the harm reduces the parent's or caretaker relative's capacity to care for the child adequately.

(b) Physical or emotional harm shall be of a serious nature that would affect the parent's or caretaker relative's ability to function if cooperation is required.

(c) A determination that good cause exists shall also be applied in cases where:

- (1) The child was conceived as a result of incest or forcible rape;
- (2) Legal proceedings for the adoption of the child are pending before a court; or
- (3) The individual is currently being assisted by a public or private licensed social agency to resolve the issue of whether to keep the child or relinquish the child for adoption. The discussions on whether to keep or give up the child shall not have gone on for more than three months. [Eff 08/01/94]
(Auth: HRS §346-14) (Imp. HRS §346-37.1; 42 C.F.R. §433.147; 45 C.F.R. §232.42)

§17-1705-21 Granting or continuation of assistance. The department shall not deny, delay, or discontinue medical assistance pending the final good cause determination if the individual has complied with the requirement to provide evidence and all other eligibility requirement have been met.
[Eff 08/01/94] (Auth: HRS §346-14) (Imp. HRS §346-14; 42 C.F.R. §433.147; 45 C.F.R. §232.46)

§§17-1705-22 to 17-1705-25 (Reserved).

SUBCHAPTER 4

GOOD CAUSE CLAIM PROCEDURES

§17-1705-26 Purpose. This subchapter establishes the procedures for providing notice and processing an individual's good cause claim for refusing to cooperate

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in obtaining third party payments for medical assistance or securing medical support.

[Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §433.147; 45 C.F.R. §§232.40, 232.41, 232.43, 232.47)

§17-1705-27 Notice to applicant of right to claim good cause. (a) The department shall notify applicants and recipients of medical assistance of the right to claim good cause as an exception to the cooperation requirement.

(b) The applicant or recipient shall be informed in writing that:

- (1) The potential benefits a child may derive from establishing paternity and securing support and the potential benefits for providing information to assist the department in pursuing third party liability for medical services;
- (2) By law, cooperation in establishing paternity, securing support, and identifying and providing information to assist the department in pursuing third party liability for medical services is a condition of eligibility;
- (3) An unexcused refusal to cooperate shall result in loss of medical eligibility for the needy caretaker relative;
- (4) The individual has the right to claim good cause for refusing to cooperate and if the department determines there is good cause, the individual shall be excused from the cooperation requirements of sections 17-1705-8 and 17-1705-18; and
- (5) Upon an individual's request or following receipt of a good cause claim, the department shall provide further notice to the individual with additional details concerning a good cause claim.

(c) A second notice shall be provided in writing, to applicants or recipients who claim good cause or who notify the department of the individual's intention to claim good cause.

(d) The second notice shall be provided promptly, without the applicant or recipient having to reschedule a follow-up appointment. The notice shall inform the individual that:

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- (1) The individual shall be required to provide corroborative evidence of a good cause circumstance as specified in section 17-1705-29, and when requested, shall furnish sufficient information in order to allow the department to investigate the circumstances of the claim;
- (2) Upon the individual's request, the department will provide reasonable assistance in obtaining the corroborative evidence;
- (3) The department shall determine whether cooperation would be against the best interest of the child for whom child or medical support would be sought or the individual for whom third party liability for medical services would be sought based on the corroborative evidence supplied;
- (4) The circumstances under which cooperation shall be determined to be against the best interests of the child or individual;
- (5) The state Title IVD child support enforcement agency (CSEA) may review the department's findings and basis for a good cause determination and may participate in any administrative hearings concerning the issue of good cause; and
- (6) CSEA may attempt to establish paternity and collect support and the department may attempt to collect third party information and payment when the department determines that this can be done without risk to the applicant or recipient if done without their participation. [Eff 08/01/94] (Auth: HRS §346-24) (Imp: HRS §346-37.1; 42 C.F.R. §§433.147, 433.148; 45 C.F.R. §232.40)

§17-1705-28 Processing good cause claims. (a)
An applicant or recipient who refuses to cooperate and who claims to have good cause shall:

- (1) Specify the circumstances which the individual believes establishes good cause to be excused from the cooperation requirement;
- (2) Provide corroboration of the good cause circumstances in accordance with section 17-1705-29 within twenty days from the day a good cause claim is filed;

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- (3) Provide additional corroborative evidence the department deems necessary to make a good cause determination; and
 - (4) Be notified promptly by the department of the specific types of additional evidence required.
- (b) Where a claim is based upon the individual's anticipation of physical harm and corroborative evidence is not submitted, the department may at its own discretion, determine good cause based upon the individual's statement and upon further investigation.
- (c) The department's determination of whether good cause exists shall be made within forty-five calendar days from the day the good cause claim is made except when:
- (1) The department determines it needs additional time because the information required to verify the claim cannot be obtained within forty-five days; or
 - (2) The individual cannot provide corroborative evidence within twenty days from the day the claim is made. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §346-37.1; 42 C.F.R. §433.147; 45 C.F.R. §§232.41, 232.43)

§17-1705-29 Evidence. Good cause shall be corroborated with the following types of evidence:

- (1) Birth certificates or medical or law enforcement records which indicate that the child was conceived as a result of incest or forcible rape;
- (2) Court documents which indicate legal proceedings for adoption are pending before a court;
- (3) Court, medical, child protective services, social services, psychological, or law enforcement records which indicate that the alleged father, absent parent, or others may inflict physical or emotional harm on the child or other family member;
- (4) Medical records which indicate emotional health history and present emotional health status of the child or family member or written statements from mental health professionals indicating a prognosis concerning the diagnosis or emotional health of the individual or family if cooperation is required;

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- (5) A written statement from a public or licensed private social agency that the parent or other caretaker is being assisted to resolve the issue of where to keep the child or relinquish the child for adoption; or
- (6) Sworn notarized statements from persons other than the individual with knowledge of the circumstances which provide the basis for the good cause claim. [Eff 08/01/94]
(Auth: HRS §346-14) (Imp: HRS §346.37.1; 42 C.F.R. §433.147; 45 C.F.R. §232.43)

§17-1705-30 Renewal of good cause claim. (a) In all cases where an initial determination has been made that there is good cause for refusal to cooperate, the recipient shall have the responsibility of renewing a good cause claim at each annual redetermination of eligibility.

(b) If the department determines that circumstances have changed and good cause no longer exists, the department shall proceed to enforce the cooperation requirements. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §433.147; 45 C.F.R. §232.47)

§§17-1705-31 TO 17-1705-35 (Reserved).

SUBCHAPTER 5

THIRD PARTY LIABILITY

§17-1705-36 Definitions. As used in this subchapter:

"Private insurer" means:

- (1) Any commercial insurance company offering health or casualty insurance to individuals or groups;
- (2) Any profit or nonprofit prepaid plan offering either medical services or full or partial payment for the diagnosis or treatment of an injury, disease, or disability; or
- (3) Any organization administering health or casualty insurance plans for professional associations, unions, fraternal groups, employer-employee benefit plans, and any

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similar organization offering these payments for services, including self-insured and self-funded plans.

"Third party" means any individual, entity or program that is or may be liable to pay all or part of the medical cost of injury, disease, or disability of an applicant or recipient. [Eff 08/01/94; am 06/19/00] (Auth: HRS §346-14) (Imp: 42 C.F.R. §433.136; HRS §346-37(c) and (e))

§17-1705-37 Determining liability of third parties. The department or health plan shall determine the legal liability of third parties to pay for services under the medical assistance program. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §346-37; 42 C.F.R. §433.138)

§17-1705-38 Medical payment involving third party. (a) The liability of a third party shall be treated as a resource applicable to the cost of needed medical services when:

- (1) It has been verified that a legal obligation actually exists; and
- (2) The amount of the obligation may be determined within thirty days from the time of the recipient's need for medical care.

(b) No Medicaid payment shall be made under a refund plan for that portion of cost for which a third party has been determined to be liable and reimbursement is forthcoming.

(c) If a liability by an identified third party exists, the recipient shall be required to satisfy all conditions set forth by that third party to receive coverage, to the extent coverage is available through that third party, before Medicaid payment is allowed.

(d) When the existence or extent of third party liability is in question, medical assistance payments may be made in:

- (1) Part, if the recipient has excess income and other assets; or
- (2) Whole, if the recipient accepts, in writing, an assignment of the recipient's third party payment to refund the department.

However, when third party policy prohibits assignment of payment, the recipient, in writing, shall agree to refund the department or health plan upon being paid.

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(e) After a claim is paid or medical services are rendered, if the department or health plan learns of the existence of a liable third party, the department or health plan shall seek reimbursement from the third party within thirty days after the end of the month it learned of the existence of the liable third party.

(f) The department or health plan shall suspend or terminate an effort to seek reimbursement from a liable third party if it determines that the effort would not be cost effective because the amount it reasonably expects to recover will be less than the cost of recovery.

(g) The department or health plan shall accumulate billings with respect to a liable third party when making a decision whether to seek recovery. When the accumulated amount is \$500 or more, the department or health plan shall seek recovery.
[Eff 08/01/94; am 11/25/96; am 04/11/03;
am] Auth: HRS §§346-14, 346-37) (Imp:
HRS §346-37; 42 C.F.R. §433.139)

§§17-1705-39 to 17-1705-43 (Reserved).

SUBCHAPTER 6

RECOVERY OF OVERPAYMENT TO PROVIDERS

§17-1705-44 Definitions. As used in this subchapter:

"Claim" means that document which is submitted by the provider for payment of health-related services rendered to a recipient.

"Noncovered services" means those services not covered under the scope and content of the medical assistance program.

"Provider" means a provider of health care services, equipment, or supplies that is participating in the medical assistance program.

"Recoupment" means to hold back or deduct what is due. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §346-37)

§17-1705-45 Recoupment of overpayment to providers. (a) The department shall recoup overpayment to providers when overpayment occurred for

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reasons including, but not limited to one of the following:

- (1) Ineligible provider;
 - (2) Noncovered service;
 - (3) Noncovered drug;
 - (4) No approved prior authorization when a service requires one;
 - (5) Incorrect payment allowance identified through post payment review by department staff; or
 - (6) Claim processing error.
- (b) The responsibility of recoupment may be assigned to the fiscal agent with whom the department has a contract. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §346-44)

§§17-1705-46 to 17-1705-50 (Reserved).

SUBCHAPTER 7

RECIPIENT RECOVERY

§17-1705-51 Definitions. As used in this subchapter:

"Dependent child" means a child who is under twenty-one years old or a child who is twenty-one years and older and has been determined blind or disabled by the department.

"Discharge from the medical institution and return home" means the release of the recipient from the medical institution to the recipient's home without expectation of returning to a medical institution.

"Equity interest in home" means the value to the property less any encumbrances.

"Estate" means the real and personal property included in an estate under the State's probate law and any other real or personal property and other assets in which the individual had any title or interest in at the time of death (to the extent of such interest). This includes assets conveyed to a survivor, heir, or assign of the deceased through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangements.

"Individual's home" means the property that the recipient lived and had an equity interest in prior to becoming medically institutionalized.

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"Medically institutionalized" means an individual who is an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or a medical facility receiving a nursing facility level of care.

"On a continuing basis" means extending without interruption or break.

"Recipient" means any individual or family receiving medical assistance.

"Residing in the home for at least one (or two) year(s)" means to continuously live in the home as the sole residence.

"Survivor" means the lawfully married spouse, parent, natural and legally adopted child, grandparent, grandchild, great-grandparent, great grandchild, and any subsequent grandparent or grandchild with the designation 'great'. [Eff 08/01/94; am 01/29/96; am 11/25/96, am 05/10/03] (Auth: HRS §346-14) (Imp: 42 C.F.R. 433.36; 42 U.S.C. §1396p)

§17-1705-52 Recovery of medical care payments from recipients. (a) Payments made to medical care providers and payments made to health plans shall be recovered by the department from individuals who:

- (1) Provided erroneous information in qualifying for medical assistance;
- (2) Failed to report a change in circumstances which would have rendered the individual or household ineligible for continued medical assistance;
- (3) Failed to notify the department that a family member is no longer a member of the assistance household;
- (4) Failed to pay the premium-share assessed to the family; or
- (5) Were adversely affected by a fair hearing decision, and who received medical assistance services pending the fair hearing decision.

(b) That portion of the payment to the health plan that is assessed to the recipient as the premium-share shall be recovered from recipients who are subject to recovery.

(c) Recovery of payments shall continue even though the individual is no longer a recipient of medical assistance. [Eff 08/01/94; am 01/29/96] (Auth: HRS §346-14; 42 C.F.R. §431.230) (Imp: HRS §346-44)

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§17-1705-53 Recovery of misspent funds. (a) Individuals subject to recovery of misspent funds under the medical assistance program shall be provided written notice by the department stating:

- (1) The reasons, date, and the amount of the alleged misspent funds;
- (2) Proposed amount to be repaid each month;
- (3) Period over which the repayment shall be made;
- (4) Method by which the proposed overpayment shall be recovered; and
- (5) The right to request a hearing if the individual disagrees with the department's proposed action.

(b) The department may refer an individual to the comptroller of the State to recover overpayments from the individual's personal income tax refund when:

- (1) There is a repayment plan initiated against the individual;
- (2) The individual is delinquent in repayment; and
- (3) The amount owed by the individual exceeds \$25.

(c) The department may place a lien on the real and personal property of an individual subject to recovery of misspent medical assistance funds. Any lien imposed with respect to this subsection shall be dissolved upon the individual's payment of the misspent funds. [Eff 08/01/94; am 11/25/96] (Auth: HRS §§231-51, 231-53, 346-14) (Imp: HRS §346-44)

§17-1705-54 Fraud. If fraud is suspected in any misspent funds under the medical assistance program, the department shall refer the case to the appropriate agency to pursue the investigation of suspected fraud and take action as deemed appropriate.

[Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §346-44)

§17-1705-55 Suspension and waiver of overpayment.

(a) The collection activities on a closed medical assistance case may be suspended when:

- (1) The department has sent one demand letter requesting payment for overpayments under \$100, two demand letters for overpayments between \$100 and \$400, three demand letters for more than \$400 and the department's

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investigative and recovery services office determines that the cost of further collection action is likely to exceed the amount that can be recovered; or

- (2) The assistance unit cannot be located. Collection activities shall not be suspended until the department has initiated action to locate the former recipients. In locating the former recipients, the department shall use appropriate data sources such as state unemployment insurance files, state automobile registration, and the Social Security Administration's benefit data exchange (BENDEX).

(b) Collection activities shall not be suspended on any case where the court has ordered an individual to repay overpayments to the department.

(c) An overpayment on a closed medical assistance case may be determined uncollectible and the overpayment waived when:

- (1) Collection activities have been suspended; and
- (2) No payments have been collected for at least three consecutive years; or
- (3) All of the members of the assistance unit have died. [Eff 08/01/94] (Auth: HRS §§346-14, 346-44) (Imp: HRS §346-44)

§17-1705-56 Limiting provisions. (a) No liens or encumbrances shall be imposed upon both real and personal property of applicants or recipients prior to their deaths except under the circumstances described in section 17-1705-53 or 17-1705-57.

(b) No adjustment or recovery shall be made for correctly made medical assistance payments, except in the case of the following:

- (1) Individuals in nursing facilities, intermediate care facilities for the mentally retarded, or other medical institutions for all individuals on or after October 1, 1993; or
- (2) Benefits paid on or after October 1, 1993 for individuals age fifty-five or older at the time services were received.

(c) Adjustments or recovery under subsection (b) can be made only after the death of the surviving spouse, if any, and when there is no surviving child

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who is under twenty-one years, or child who is blind or disabled as defined in chapter 17-1721.

(d) Adjustment or recovery, if any, shall be from the deceased recipient's estate or upon the sale of property subject to lien imposed under section 17-1705-57.

(e) Recovery may be waived due to hardship for the period the following conditions exist:

- (1) The estate subject to recovery is the sole income-producing asset of the survivors and the following conditions are met:
 - (A) The estate is a family farm or other family business;
 - (B) The income produced by the asset is not greater than one hundred per cent of the federal poverty guidelines for the number of survivors solely dependent on such asset.
 - (2) The estate is a homestead of modest value that is occupied by survivors who meet the following conditions:
 - (A) Lawfully resided in the home for a continuous period that started at least three months immediately before the recipient's admission to a medical institution and provided care to the recipient during that period that allowed the recipient to reside at home rather than in an institution and has continuously lived in the home since the admission;
 - (B) Do not own any real property other than an interest in the home; and
 - (C) Have income not greater than one hundred per cent of the federal poverty limit.
- [Eff 08/01/94; am 01/29/96;
am 11/25/96] (Auth: HRS
§346-14) (Imp: HRS §346-37; 42 C.F.R.
§433.36; 42 U.S.C. §1396p)

§17-1705-57 Liens on real property of institutionalized individuals. (a) A lien may be placed on the real property of a medically institutionalized individual for the amount of medical assistance received, after a determination by the department that the individual cannot reasonably be expected to be discharged from the medical institution and returned home.

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(b) A lien may not be placed on the home property of a medically institutionalized individual if any of the following individuals are lawfully residing in the home:

- (1) The individual's spouse;
- (2) The individual's dependent child; or
- (3) The individual's sibling who has an equity interest in the home and who was residing in the home for a period of at least one year prior to the individual's admission to the medical institution.

(c) The department shall not recover funds from the lien when the individual has:

- (1) A surviving spouse; or
- (2) A surviving dependent child.

(d) The department shall not recover funds from the lien when the individual has:

- (1) A sibling who was residing in the home for a period of at least one year immediately before the individual's admission to the medical institution; or
- (2) A non-dependent child who was residing in the home for a period of at least two years immediately before the individual's admission to the medical institution and who provided care to the individual that allowed the individual to reside at home rather than in an institution;

who has lawfully resided in the home on a continuous basis as a sole residence, without interruption or break, since the date of the individual's admission to the medical institution.

(e) Any lien imposed with respect to this section shall be dissolved upon the individual's discharge from the medical institution and return home.

[Eff 01/29/96; am 11/25/96] (Auth: HRS §346-14)
(Imp: HRS §§346-29.5, 346-37; 42 C.F.R. §433.36; 42 U.S.C. §1396p)

§§17-1705-58 to 17-1705-65 (Reserved).

SUBCHAPTER 8

THIRD PARTY LIABILITY SUBROGATION

§17-1705-66 Definitions. As used in this

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subchapter:

"Subrogation" means the substitution of one creditor for another, along with a transference of the claims and rights of the old creditor. [Eff 08/01/94; am 09/14/98] (Auth: HRS §346-14) (Imp: HRS §346-44)

§17-1705-67 Accident liability. (a) An applicant or recipient shall inform the department or health plan of an involvement in an accident within thirty days of the accident.

(b) The applicant or recipient shall be required to complete the assignment of rights form to assist the department or health plan in subrogation action.

(c) Refusal to sign the assignment of rights form constitutes cause for termination of medical coverage or denial of medical assistance application.

(d) Upon receipt of the assignment of rights form, the department or health plan shall immediately pursue possible recovery of medical care expenses paid on behalf of the recipient through the appropriate agencies. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §346-44)

§17-1705-68 Termination or waiver of subrogation.

(a) Pursuit of recovery shall cease if:

- (1) The recoverable amount is less than the expense of pursuing the recovery;
- (2) The case is more than five years old and amount recoverable is less than \$1,000 and there are no outstanding federal or state issues;
- (3) The department or health plan does not have any legal recourse to pursue recovery; or
- (4) The whereabouts of the recipient are unknown.

(b) Pursuit of subrogation may be waived if the recoverable amount is \$100 or less.

[Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §346-44)



"Howard Lee"
<hlee@uhahealth.com>
09/18/2013 11:51 AM

To Donna.K.Ikegami@DCCA.HAWAII.GOV,
gordon.i.ito@dcca.hawaii.gov,
cc
bcc
Subject Re: Insurance Recoupment Working Group

I have some comments for Commissioner Ito.

Speaking for the members of the HAHP, which is not all the payors in Hawaii, there is some frustration with not being able to clearly identify who is causing the problem. Some of the frustration is due to HAHP Plans being busy with ACA requirements, so this is perceived as unnecessary or a very low priority issue at this time. So, most of the health plan members of HAHP do not see this as a problem or feel they have any unreasonable recoupment policies. Most think this is an issue with the government RAC audits and maybe self funded plan, which places the onus on the contractors to collect the overpayment over one year. There could also be unintended consequences for setting a strict policy, for example, when over payments are made based on COB issues, it is usually the doctor that refunds the plan, since they essentially get paid as primary by both carriers. Would they be allowed to keep the money if they knowingly know that they where paid twice? Some providers could use the law to avoid paying on known errors, while most plans now, at least on the commercial side can work out a reasonable approach without government intervention.

Knowing that you have an obligation to make a recommendation, at this time HAHP is not willing to change limits until we can know where the problem is occurring. Please feel free to share this with the rest of the committee, but I wanted to give you a heads up on our current HAHP position.



Centers for Medicare & Medicaid Services

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Recovery Audit Program

Mission - The Recovery Audit Program's mission is to identify and correct Medicare improper payments through the efficient detection and collection of overpayments made on claims of health care services provided to Medicare beneficiaries, and the identification of underpayments to providers so that the CMS can implement actions that will prevent future improper payments in all 50 states.

Background - The national Recovery Audit program is the product of a successful demonstration program that utilize Recovery Auditors to identify Medicare overpayments and underpayments to health care providers and suppliers in randomly selected states. The demonstration ran between 2005 and 2008 and resulted in over \$900 million in overpayments being returned to the Medicare Trust Fund and nearly \$38 million in underpayments returned to health care providers. As a result, Congress required the Secretary of the Department of Health and Human Services to institute (under Section 302 of the Tax Relief and Health Care Act of 2006) a permanent and national Recovery Audit program to recoup overpayments associated with services for which payment is made under part A or B of title XVIII the Social Security Act.

Each Recovery Auditor is responsible for identifying overpayments and underpayments in approximately ¼ of the country. The Recovery Audit Program jurisdictions match the DME MAC jurisdictions.

The Recovery Auditor in each region is as follows:

Region A: Performant Recovery

Region B: CGI Federal, Inc.

Region C: Connolly, Inc.

Region D: HealthDataInsights, Inc.

All correspondence, Web sites and call centers will be in the name of the Recovery Auditors above. **Click the link below to obtain contact information for each Recovery Auditor.**

04/03/13 - CMS has posted revised **provider (excluding physician and supplier) Additional Documentation Request Limits** and revised **supplier Additional Documentation Limits** on the Provider Resources page.

12/18/12 - Recovery Audit Program Myths

CMS has posted a Recovery Audit Program Myths document in the Download section below. This document hopes provide correct information on the Medicare Fee-for-Service Recovery Audit Program.

Do you have questions or comments about the Recovery Audit Program? Please e-mail us at: RAC@cms.hhs.gov. Please **Do Not** send Personal Health Information to this e-mail address. Thank you.



Centers for Medicare & Medicaid Services

[Home](#) > [Research, Statistics, Data and Systems](#) > [Recovery Audit Program](#) > Current Programs

Current Programs

19 SEPT. 2011 - The CMS has issued CR 7436, which shifts the responsibility for sending demand letters from the Recovery Auditors to the Medicare Administrative Contractors (MACs) starting in January 2012. In preparation for this nationwide change, Connolly, the Recovery Auditor for Region C, and CGS, the DME MAC for Jurisdiction C, will start a pilot program in November 2011. CGS is working to educate its provider and supplier communities on this change.

10 OCT. 2008 - CMS Announces Recovery Auditors Contingency Fee Percentages. The Recovery Auditors are paid a contingency fee; that is, the Recovery Auditors receive payment based on the amount of the improper payment they correct for both overpayments and underpayments. Each Recovery Auditors' contingency fee is established during contract negotiations with CMS and, as such, the contingency fee varies for each Recovery Auditor. Click the link below to view the Recovery Auditors' contingency fees.

Do you have questions or comments about the Recovery Audit Program? Please e-mail us at: RAC@cms.hhs.gov. Please **Do Not** send Personal Health Information to this e-mail address. Thank you.

Downloads

[Feb. 7, 2012 - Medicare FFS Recovery Audit Program, 1st Qtr \[PDF, 162KB\]](#)

[Feb. 7, 2012 - FY2012 National Program Corrections, 1st Qtr \[PDF, 119KB\]](#)

[Nov. 23, 2011 - FY2011 4th Quarter Report \[PDF, 203KB\]](#)

[Nov. 23, 2011 - FY2011 Program Corrections \[PDF, 135KB\]](#)

[March 2011 FFS Update \[PDF, 134KB\]](#)

[National Program Corrections As of June 30, 2011 \[PDF, 133KB\]](#)

[July 2011 FFS Update \[PDF, 214KB\]](#)

[19 SEPT. 2011 - MLN Matters Articles \[PDF, 84KB\]](#)

Related Links

[MLN Provider Compliance](#)

[State Medicaid RACs](#) 

[RAC Contingency Fee Percentages](#)

[RAC 101 YouTube Presentation](#) 

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HMSA



Blue Cross
Blue Shield
of Hawaii

An Independent Licensee of the Blue Cross and Blue Shield Association

September 18, 2013

Mr. Gordon Ito, Chair
and Members
Insurance Recoupment Working Group

Dear Mr. Ito and Members:

On behalf of the Hawaii Medical Service Association (HMSA), I want to thank you for allowing us to comment on concerns raised in recent meetings of the Insurance Recoupment Working Group. From HMSA's perspective, we are unaware of any major concerns with our recoupment policy or experience.

We work on a "pend and pursue" method for Worker's Compensation and No Fault cases. If a claim is coded correctly when it is submitted, we would pend the claim and start an investigation. We employ a "pay and pursue" method for all other cases, including Workers Compensation and No Fault cases, where it is not clear that the claim is the responsibility of another party.

Most HMSA provider contracts only allow us to recover for a period of 18 months from date of payment, and a few provide a 24 month recovery period. The exception to this is for dual coverage and Medicare primary cases, where we only are allowed to recovery a period of 12 months from the date of service.

For a recent 12-month period, there were 7,853 recoveries paid totaling \$3.2 million, and the majority of recoveries include the following:

- Workers Comp (1,772 claims) \$796,144
- No-Fault (943 claims) \$496,835
- Dual Coverage (1,992 claims) \$425,251
- Medicare Primary (2,208 claims) \$622,824
- Duplicate Payment (93 claims) \$121,536
- Processing Errors (247 claims) \$655,044

These amounts, however, truly are miniscule compared to our overall claims volume. In 2012, HMSA received \$2.5 billion in dues revenues, of which 94.5 percent was paid out in member benefits. Those benefits were reflected in the 17 million member claims processed - approximately 66,000 claims per day.

While we understand that there may be specific cases of concern to certain providers, we do not believe they warrant regulatory or statutory action.

Your consideration of these factors as we proceed with are deliberations is appreciated. Thank you.

Jennifer Diesman, Vice President

Hawaii Medical Service Association

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(808) 948-5110

Branch offices located on

Hawaii, Kauai and Maui

APPENDIX F

Summary: Refund Recoupment Laws

Source of information: MTBC.com

PERIOD	STATE
180 days	TX
6 months	DC, MD
12 months	AL, CA, CO, ME, MA, MO, MT, UT, VT, VA, WV
18 months	AR, GA, NH, NJ, SC
24 months	IN, IA, KY, NY, OH, OK, WA
30 months	FL
60 months	CT
No limit	AK

REFUND RECOUPMENT LAWS

State	Statute/Code	Time limit for seeking refund of overpaid Claim	Other factors concerning time limit for seeking refund of overpaid Claim	Exemptions	Period
ALABAMA	Al 27-1-17	An insurer, health service corporation, and health benefit plan shall not retroactively seek recoupment or refund of a paid claim after the expiration of one (1) year from the date the claim was initially paid or after the expiration of the same period of time that the health care provider is required to submit claims, whichever date occurs first.	An insurer, health service corporation, or health benefit plan shall not retroactively seek recoupment or refund of a paid claim for any reason that relates to the COB of another carrier responsible for the payment of the claim after expiration of eighteen (18) months from the date claim was paid.	An insurer, health service corporation, and health benefit plan shall not retroactively seek recoupment or refund of a paid claim from provider for any reason, other than fraud or coordination of benefits or for duplicate payments after the expiration of one year from the date that the initial claim was paid.	12 Months
ALASKA	AS 21.54.020	A healthcare insurer can recover an amount, wrongly paid to a provider.	—	—	No Limit
ARKANSAS	Ann. § 23-61-108, §23-63-1806, §25-15-201	A health care insurer cannot seek refund of paid claim after the expiration of eighteen (18) months from the date the claim was initially paid.	A health care insurer has one hundred and twenty (120) days from the date of payment to notify the provider of a verification error and the fact that services rendered will not be covered if the error was made in good faith at the time of the verification.	Except in cases of fraud committed by the health care provider, means fraud that the insurer discovered after the eighteen (18) month period and could not have discovered prior to the end of the eighteen-month period.	18 Months
ARIZONA	§20-3102	A health care insurer shall not adjust or request adjustment of a payment or denial of claim more than one year after the date health care insurer has paid the claim. If a provider and insurer agree through contract about adjustment then even they have same length of time to request adjustment of a claim. Once claim is adjusted an insurer or provider shall owe no interest on the overpayment or underpayment resulting from the adjustment as long as the adjustment or recoupment taken within the period of 30 days of the date of claim adjustment.	—	This Section shall not apply in case of fraud.	12 Months

REFUND RECOUPMENT LAWS

State	Statute/Code	Time limit for seeking refund of overpaid Claim	Other factors concerning time limit for seeking refund of overpaid Claim	Exemptions	Period
CALIFORNIA	110133.66 (2005 Cal ALS 441; 2005 Cal SB 634; Stats 2005 ch.44)	Reimbursement request for the overpayment of a claim shall not be made, unless a written request for reimbursement is sent to provider within 365 days of the date of payment on the overpaid claims.	—	Time limit of 365 days shall not apply if the overpayment was caused in whole or in part by fraud or misrepresentation on the part of the provider.	12 Months
COLORADO	C.R.S. 10-16-704 (2009)	Adjustments to claims by the carrier shall be made within the time period set out in contract between the provider and the carrier. The time period shall be the same for the provider and the carrier and shall not exceed 12 months after the date of the original explanation of benefits. If no contract exists then adjustments to claims shall be made 12 months after the date of the original explanation of benefits.	Adjustments to claims related to coordination of benefits with federally funded health benefit plans, including medicare and medicaid, shall be made within thirty-six (36) months after the date of service.	Adjustments to claims made in cases where a carrier has reported fraud or abuse committed by the provider, shall not be subject to the requirements of this subsection.	12 Months
CONNECTICUT	SB 764	Insurers and HMOs are prohibited from seeking to recover an overpayment for a claim paid under a health insurance policy unless they provides written notice to the person from whom recovery is sought within five (5) years after receiving the initial claim.	—	—	60 Months
DISTRICT OF COLUMBIA	D.C. Code § 31-3133	Insurer may only retroactively deny reimbursement to provider for services subject to COB during the 18-month period after the date that the health insurer paid the health care provider; or during the 6-month period after the date that the health insurer paid the health care provider.	A health insurer that retroactively denies reimbursement to a health care provider shall provide a written statement specifying the basis for the retroactive denial. If the retroactive denial of reimbursement results from COB, the written statement shall provide the name and address of the entity acknowledging responsibility for payment of the denied claim.	This section will not apply if information submitted was fraudulent; or improperly coded or duplicate claim or does not otherwise conform with the contractual obligations. If insurer retroactively denies reimbursement for services as a result of cob the provider shall have 180 days after the date of denial, unless the insurer permits longer time insurer that denies reimbursement to provider shall give provider a written notice specifying the basis for the retroactive denial. This section shall not apply to an adjustment to reimbursement made as an annual contracted reconciliation of a risk-sharing arrangement.	6 Months

REFUND RECOUPMENT LAWS

State	Statute/Code	Time limit for seeking refund of overpaid Claim	Other factors concerning time limit for seeking refund of overpaid Claim	Exemptions	Period
FLORIDA	FL §627.6131	If an overpayment in result of retroactive review or audit of coverage decisions or payment levels a health insurer must submit the claims details to provider within 30 months after the health insurer's payment of the claim.	A provider must pay, deny, or contest the claim for overpayment within 40 days after the receipt of the claim and must pay or deny within 120 days of the receipt. Failure to the above creates an uncontestable obligation to pay the claim. The health insurer may not reduce payment to the provider for other services unless the provider agrees to the reduction in writing or fails to respond to the health insurer's overpayment claim.	Time limit of 30 months. Except in the case of fraud committed by the health care provider.	30 Months
GEORGIA	O.C.G.A. § 33-20A-62	No carrier may conduct a post payment audit or impose a retroactive denial of payment on any claim that was submitted within 90 days of the last date of service or discharge covered by such claim unless: (1) notice of intent to conduct such an audit is provided; (2) Not more than 12 months have elapsed since the last date of service or discharge covered by the claim; (3) Any such audit or retroactive denial of payment must be completed and notice provided to the claimant of refund due within 18 months of the last date of service or discharge covered by such claim	No insurance carrier may conduct a post-payment audit or impose a retroactive denial of payment on any claim submitted after 90 days unless a written notice is provided, not more than 12 months have elapsed and it should be finalized within 24 months.	Any such audit must be completed within 18 months from the date of final discharge of claim.	18 Months
INDIANA	IC 27-8-5.7-10	Insurance may request the provider to repay the overpayment or adjust a subsequent claim after the expiration of two years from the date claim is paid.	—	This section does not apply in cases of fraud by the provider, the insured, or the insurer with respect to the claim on which the overpayment or underpayment was made.	24 Months
IOWA	191-15.33 (507B)	Insurance may not audit a claim more than two years after the submission of the claim to insurer & not a claim billed for less than \$25.00.	—	The law applies only if the carrier did not suspect fraud.	24 Months

REFUND RECOUPMENT LAWS

State	Statute/Code	Time limit for seeking refund of overpaid Claim	Other factors concerning time limit for seeking refund of overpaid Claim	Exemptions	Period
KENTUCKY	304-17A-708	An insurer shall not be required to correct a payment error made to a provider if the provider's request for a payment correction is filed more than twenty-four (24) months after the date that the provider received payment for the claim from the insurer.	—	Time limitation shall not be applicable in case of fraud.	24 Months
LOUISIANA	LRS 22:250.38	health insurance shall provide the health care provider written notification in accordance with LRS 22:250.38. Health care provider shall be allowed thirty days from receipt of written notification of recoupment to appeal the health insurance issuer's action.	If a healthcare provider disputes insurance's notification of recoupment and a contract exists, the dispute shall be resolved according to terms of contract. If no contract exists, the dispute shall be resolved as any other dispute under Civil Code Article 2299 et seq.	—	—
MAINE	24-A - §4303.	The time that has elapsed since the date of payment of the previously paid claim does not exceed 12 months.	—	The retrospective denial of a previously paid claim may be permitted beyond 12 months from the date of payment only if: 1. The claim was submitted fraudulently 2. Duplicate payment 3. Services identified in the claim were not delivered by the provider 4. Adjustment with another insurer COB 6. The claim payment is the subject of legal action.	12 Months
MARYLAND	M. A. Code section 15-1008	A carrier may only retroactively deny reimbursement paid to healthcare provider during the six month period after the date the carrier paid the claim.	This Section Provides time frame for the period of 18 months in case of services subject to coordination of benefits with another carrier.	The time period is not limited if: 1. Information submitted was fraudulent. 2. Improperly Coded 3. Payment was made for duplicate claim. 4. a claim submitted to MCO & the claim was for services provided to a MD Medical Assistance Program recipient during a time period when Program has permanently retracted the capitation payment for the Program recipient.	6 Months

REFUND RECOUPMENT LAWS

State	Statute/Code	Time limit for seeking refund of overpaid Claim	Other factors concerning time limit for seeking refund of overpaid Claim	Exemptions	Period
MASSACHUSETTS	HB 976	The time which has elapsed since the date of payment of the challenged claim does not exceed 12 months.	—	The retroactive denial of a previously paid claim may be permitted beyond 12 months from the date of payment only if: (1) claim was submitted fraudulently; (2) claim payment was incorrect because the provider or the insured was already paid ; (3) health care services were not delivered by the physician/provider; (4) claim payment is the subject of adjustment with another insurer; or (5) claim payment is the subject of legal action	12 Months
MISSOURI	Sec: 376.384	Prohibit requesting a refund or offset against a claim more than twelve months after a health carrier has paid a claim.	—	Except in cases of fraud or misrepresentation by the health care provider.	12 Months
MONTANA	33-22-150	A health insurance issuer may not request reimbursement or offset another claim payment for reimbursement of an invalid claim or overpayment of a claim more than 12 months after the payment of an invalid or overpaid claim.	—	If insurance does not limit the time for submission of a claim for payment, then insurance may not request reimbursement or offset another claim payment for reimbursement of an invalid claim or overpayment of a claim more than 12 months after the payment of an invalid or overpaid claim.	12 Months
NEW HAMPSHIRE	Insurance Code 420-J;8-b.	No health carrier shall impose on any health care provider any retroactive denial of a previously paid claim or any part thereof unless: (a) the carrier has provided the reason for the retroactive denial in writing to the health care provider; and (b) the time which has elapsed since the date of payment of the challenged claim does not exceed 18 months.	—	Time limit can be extended belong the period of 18 months provided claim was submitted fraudulently or claim was incorrect because the provider was already paid for the services claim payment is the subject of adjustment with a different insurer.	18 Months

REFUND RECOUPMENT LAWS

State	Statute/Code	Time limit for seeking refund of overpaid Claim	Other factors concerning time limit for seeking refund of overpaid Claim	Exemptions	Period
NEW JERSEY	C.17B:30-48 Chapter 352	No payer shall seek reimbursement for overpayment of a claim previously paid pursuant to this section later than 18 months after the date the first payment on the claim was made.	No payer shall seek more than one reimbursement for overpayment of a particular claim. At the time the reimbursement request is submitted to the health care provider, the payer shall provide written documentation that identifies the error made by the payer in the processing or payment of the claim that justifies the reimbursement request.	Claims that were submitted fraudulently or submitted by health care providers that have a pattern of inappropriate billing or claims that were subject to coordination of benefits.	18 Months
NEW YORK	§ 3224-b	Prohibit HMOs and other insurers from demanding refunds from a physician more than two years after the claim was initially paid.	Require 30 days notice to providers when the insurer is seeking a refund.	This limitation does not apply if it involve fraud, intentional misconduct, abusive billing or when initiated at the request of a self funded plan or required by a federal or state government program.	24 Months
NORTH CAROLINA	—	Depends upon the contractual terms of a healthcare provider and insurance.	—	—	—
OHIO	Revised Code 3901.38.8 & 3901.388	Third party insurer may recover an overpaid amount not later than two year from the date the claim was paid to the provider. The Provider should be informed about the overpayment practices through notice. Provider shall have a right to file appeal. In case of no response from the provider the carrier is free to initiate recovery practices.	—	Time limitation shall not be applicable in case of fraud.	24 Months
OKLAHOMA	§36-1250.5	Act of insurance company will be considered as unfair claim settlement practices act if insurance request refund from the provider after the period of 24 months from the date claim was paid.	—	This section shall not apply where the claim was submitted fraudulently or provider otherwise agrees to make a refund of claim.	24 Months

REFUND RECOUPMENT LAWS

State	Statute/Code	Time limit for seeking refund of overpaid Claim	Other factors concerning time limit for seeking refund of overpaid Claim	Exemptions	Period
SOUTH CAROLINA	§ 38-59-250	An insurance may not initiate overpayment recovery process from a provider more than 18 months after the initial payment was received by the provider.	An insurer shall initiate any overpayment recovery efforts by sending a written notice to the provider at least 30 business days prior to engaging in the overpayment recovery efforts.	This time limit does not apply to the initiation of overpayment recovery efforts: (1) based upon a reasonable belief of fraud or other intentional misconduct; (2) required by a self-insured plan; or (3) required by a state or federal government program.	18 Months
TEXAS	§ 3.70-3C	The insurer has no later than the 180 day after provider receives payment to recover an "overpayment" must provide written notice and mention specific reasons for request of recovery of funds.	If carrier as secondary payer pays a portion of a claim that should be paid by the primary carrier, the secondary payer may recover overpayment from the carrier that is primarily responsible for that amount. If the portion of the claim overpaid by the secondary payer was also paid by the primary payer, the secondary payer may recover the amount of overpayment from the physician	—	180 Days
UTAH	§ 31A-26-301.6	The insurer may recover any amount improperly paid to a provider or an insured (a) within 24 months of the amount improperly paid for a coordination of benefits error; (b) within 12 months of the amount improperly paid for any other reason; or (c) within 36 months of the amount improperly paid when the improper payment was due to a recovery by Medicaid, Medicare, the Children's Health Insurance Program, or any other state or federal health care program	—	—	12 Months

REFUND RECOUPMENT LAWS

State	Statute/Code	Time limit for seeking refund of overpaid Claim	Other factors concerning time limit for seeking refund of overpaid Claim	Exemptions	Period
VERMONT	18 V.S.A. § 9418	A health plan shall not retrospective deny a previously paid claim unless at least 30 days notice of any retrospective denial or overpayment recovery is provided inwriting to the provider or the time that has elapsed since the date of payment of the previously paid claim does has exceeded 12 months	—	The retrospective denial of a previously paid claim shall be permitted beyond 12 months if (1) the plan has a reasonable belief that fraud or other intentional misconduct has occurred; (ii) the claim payment was incorrect because the health care provider was already paid; (iii) health care services identified in the claim were not delivered by the provider; (iv) the claim payment is subject of adjustment with another health plan; or (v) the claim is the subject of legal action.	12 Months
VIRGINIA	§ 38.2-3407.15	Carrier can only impose retroactive denial of claim if provided the reason for denial, provider was already paid for the services and time period does not exceed the lesser of 12 months or a number of days mentioned in a contract.	—	Exception of fraud is not provided.	12 Months
WASHINGTON	Chapter 48.43.600	A carrier may not request a refund from a health care provider of a payment previously made to satisfy a claim unless it does so in writing to the provider within twenty-four months after the date that the payment was made.	A carrier may not for reasons related to coordination of benefits with another carrier (a) Request refund from a health care provider; or (b) request that a contested refund be paid any sooner than six months after receipt of the request. Any such request must specify why the carrier believes the provider owes the refund, and include the name and mailing address of the entity that has primary responsibility for payment of the claim.	This Section shall not apply in case of fraud.	24 Months
WEST VIRGINIA	WVC § 33-45-2	Carrier can only deny a claim where a provider was already paid for the service, claim was not covered under the service and provider not entitled to reimbursement for the period of one year from the date when the claim was paid to the provider.	—	Limitation shall not be applicable in case of misrepresentation or fraud by provider.	12 Months

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