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STATUTE OF LIMITATIONS FOR INSURANCE COMPANY RETROACTIVE CLAIM DENIALS

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You asked if any states have a statute of limitations for health insurance company claim audits that result in a retroactive claim denial, often resulting in a request for a refund from the health care provider.

SUMMARY

Health care insurers are subject to various state laws regarding prompt payment of claims. After paying claims in compliance with the timeframes set in such laws (e.g., 30 days), an insurer may choose to conduct a claim audit to verify claims were paid appropriately and accurately. As a result, an insurer may try to recoup payment from a health care provider for claims paid in error. It may do this by reducing payments currently owed the provider, withholding future payments, or otherwise requiring a refund from the provider. This process is often referred to as a retroactive claim denial as a result of a postpayment audit.

States that have a statute of limitations on an insurer's retroactive claim denial include Alabama, Florida, Georgia, Maryland, New Hampshire, Rhode Island, Tennessee, Texas, Virginia, and West Virginia. The time limit in which to retroactively deny claims varies from six months (Maryland, Texas) to 30 months (Florida). Often excepted from such limitations are retroactive denials for claims submitted fraudulently.

ALABAMA

An insurer is prohibited from retroactively denying, adjusting, or seeking a refund of a paid claim for health care expenses submitted by a health care

provider after one year from the date the initial claim was paid or after the same period of time that the provider is required to submit claims for payment pursuant to a contract with the insurer, whichever occurs first. If the claim was subject to coordination of benefits with another insurer, the time period extends to 18 months. If a claim was fraudulent or a duplicate payment, there is no retroactive review time limit (Ala. Code § 27-1-17(e) and (f)).

FLORIDA

An HMO is prohibited from claiming an overpayment refund from a provider beyond 30 months after the HMO's payment of the claim, except if a provider is convicted of fraud (Fla. Stat. Ann. § 641.3155(5)). If the retroactive denial is for subscriber ineligibility, the time period for retroactively denying a claim is reduced to one year (Fla. Stat. Ann. § 641.3155(10)).

GEORGIA

If a provider submits a claim for payment within 90 days of the last date of service or discharge included on the claim, an insurer's postpayment claim audit or retroactive claim denial by an insurer must be completed within 18 months of that date of service or discharge. If the claim was submitted for payment more than 90 days after the date of service or discharge, an insurer's postpayment claim audit or retroactive claim denial must be completed within 18 months of the claim submission date or 24 months after the date of service, whichever is sooner (Ga. Code Ann. § 33-20A-62).

MARYLAND

An insurer may retroactively deny reimbursement only during the 6-month period after the date it paid the health care provider. If the claim was subject to coordination of benefits with another insurer, the time period extends to 18 months. The time limitations do not apply if the retroactive denial is because the claim was fraudulent, the provider improperly coded the claim, or the claim submitted was a duplicate (Md. Code Ann., Ins. § 15-1008).

NEW HAMPSHIRE

An insurer is prohibited from retroactively denying a claim previously paid to a provider after 18 months from the date of payment. The time limit does not apply if the retroactive denial is because the claim is (1) fraudulent, (2) a duplicate, (3) for services the provider did not render, (4) for services covered by a government program, (5) the subject of an adjustment with another insurer or payor, or (6) the subject of a legal action (N.H. Rev. Stat. Ann. §§ 415:6-I, 415:18-m, and 420-J:8-b).

RHODE ISLAND

An insurer's review or audit of a health care provider's claims that results in the recoupment or set-off of funds previously paid to the provider must be completed no later than two years after the completed claims were initially paid. The time limit does not apply to claims that are (1) submitted fraudulently, (2) subject to a pattern of inappropriate billing, (3) related to coordination of benefits, or (4) subject to any federal law or regulation that permits claims review beyond two years (R.I. Gen. Laws § 27-18-65).

TENNESSEE

Except in cases of fraud committed by the health care provider, an insurer may retroactively deny reimbursements to the provider only during the 18 months after the date it paid the claim submitted by the provider. If an insurer verifies that a patient is covered by the plan and if the provider renders services to the patient in reliance on such verification, the time period in which the insurer may retroactively deny a claim on the basis that the patient is not a covered person is six months, absence any provider fraud (Tenn. Code Ann. § 56-7-110).

TEXAS

If an insurer wants to audit a previously paid claim, it must complete the audit within 180 days after the date it received the clean claim (i.e., a complete claim ready for processing). Any additional payment due a preferred provider or any refund due the insurer must be made 30 days after the completion of the audit (Tex. Ins. Code Ann. § 1301.1051).

VIRGINIA

An insurer is prohibited from retroactively denying a previously paid claim submitted by a health care provider after one year from the date the initial claim was paid or after the same period of time that the provider is required to submit claims for payment pursuant to a contract with the insurer, whichever occurs first. The time limit does not apply if the claim is submitted fraudulently, a duplicate, or for services the provider did not render (Va. Code Ann. § 38.2-3407.15).

WEST VIRGINIA

An insurer may retroactively deny a previously paid claim for a period of one year from the date the claim was originally paid if (1) the provider was already paid for or did not render the health care services, (2) the provider was not entitled to reimbursement, (3) the service provided was not covered by the health benefit plan, or (4) the insured was not eligible for reimbursement. An insurer may retroactively deny a claim without a time limitation if the claim

was submitted fraudulently or contained material misrepresentations (W. Va. Code Ann. § 33-45-2(7)).

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