

HB

313

<TARGET><BILL>HB 313</BILL><SUBJECT>HB
313</SUBJECT><COMM>HHSS30</COMM></TARGET>

ALASKA STATE LEGISLATURE

Session

State Capitol, Rm. 418
Juneau, AK 99801
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Interim

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House Finance Committee

Dept. of Law
Finance Subcommittee
Chairman

Dept. of Administration
Finance Subcommittee
Chairman

Rep.Jason.Grenn@akleg.gov

REPRESENTATIVE JASON GRENN

SPONSOR STATEMENT

House Bill 313

Insurance Recoupment

32 states have implemented a statute of limitations for the ability of insurance companies to retroactively recoup indemnities from health care providers. A common practice of many health insurance companies is to perform an audit to make sure the claims paid to them were accurate, a practice that any business trying to become more efficient would perform. Currently in Alaska there is no maximum number of years that limits insurance companies to retroactively recouping indemnities due to our lack of a statute like the one presented in HB 313.

HB 313 simply implements a statute of limitations of 18 months on health insurance companies to recoup mistakenly paid amounts from health care providers in Alaska. HB 313 provides exceptions to this limitation in instances of: a fraudulently submitted claim, a duplicate claim, in the instances of misrepresented or wrongly identified services by the health care provider, a claim that is subject to adjustment by another health care insurer, or any payment or claim that is the subject of legal action. These exceptions are the only instances under which the statute of limitation is flexible for or voided.

HB 313 is not only a bill that focusses on the efficiency of Health Insurers, but most importantly is legislation that ensures that a financial burden may not be passed onto the customer unexpectedly at any time after their visit to the doctor. With the lack of a statute of limitation in this area there exists an inherent liability that can be passed on to any Alaskan at essentially any time.

House Bill 313, serves as a simple fix for a large risk that resides in the current statutes surrounding our health billing structure. HB 313, takes care of patients, doctors, and all health care providers. I humbly ask for your support in this piece of legislation that has proven to be a simple fix to our outdated precedence.

30-LS0852J
Wallace
2/14/18

CS FOR HOUSE BILL NO. 313()
IN THE LEGISLATURE OF THE STATE OF ALASKA
THIRTIETH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES GRENN, Tuck

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to payments to providers and covered persons and recovery of**
2 **payments by health care insurers."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 *** Section 1.** AS 21.54.020(d) is amended to read:

5 (d) This section does not prohibit a health care insurer from recovering an
6 amount mistakenly paid to a provider or a covered person. **A health care insurer may**
7 **not seek recovery of an amount mistakenly paid more than 18 months after the**
8 **date the claim was paid unless the**

9 **(1) claim was submitted fraudulently;**

10 **(2) payment was made for a duplicate claim;**

11 **(3) health care services identified in the claim were not delivered**
12 **by the health care provider;**

13 **(4) payment or claim is subject to adjustment by another health**
14 **care insurer; or**

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(5) payment or claim is the subject of legal action.

* **Sec. 2.** AS 21.54.050(d) is amended to read:

(d) This section does not prohibit an insurer from recovering an indemnity mistakenly paid to a provider or a covered person. **A health care insurer may not seek recovery of an amount mistakenly paid more than 18 months after the date the claim was paid unless the**

(1) claim was submitted fraudulently;

(2) payment was made for a duplicate claim;

(3) health care services identified in the claim were not delivered by the health care provider;

(4) payment or claim is subject to adjustment by another health care insurer; or

(5) payment or claim is the subject of legal action.

* **Sec. 3.** AS 39.30 is amended by adding a new section to read:

Sec. 39.30.093. Recovery of payments. A health care insurance plan obtained under AS 39.30.090 or provided under AS 39.30.091 is subject to the requirements of AS 21.54.020(d) and 21.54.050(d) for recovery of an amount mistakenly paid.



ALASKA STATE HOSPITAL &
NURSING HOME ASSOCIATION

February 20, 2018

Rep. Jason Grenn
State Capitol, Room 418
Juneau, Alaska 99801

Re: HB 313 – Recovery of payment by insurance providers

Dear Rep. Grenn,

The Alaska State Hospital and Nursing Home Association (ASHNHA) writes this letter in support of HB 313, a statute of limitations on insurance refund recoupments. ASHNHA is a membership organization representing Alaska's hospitals, skilled nursing facilities, and other health care providers.

HB 313 limits recoupments of overpayments to health care providers by health insurers to 18 months after the date the claim was paid. This legislation seeks to address difficulties faced by providers in dealing with health insurers, specifically excessive demands for refunds for claims paid years in the past. Many states recognize the administrative burden placed on the health care system by such claims, and have passed laws similar to HB 313. The 18 month limit on recoupments is reasonable and fair and will improve the efficiency of the health care system.

Please let us know how we can further assist your office in advancing this important legislation.

Sincerely,

Becky Hultberg
President/CEO



Spectrum Medical Billing Services
PO Box 221795
Anchorage, AK 99522-1795
907-440-5900

Shea Siegert
Juneau, AK

January 31, 2018

Mr Siegert

I'm writing in response to House Bill 313, to change the Statute AS 21.54.020(d) from an unlimited amount of time a medical insurance company (Payer) can request a refund from HealthCare providers. Currently, Alaska is 1 of 3 states that have an unlimited timeframe a Payer can request a refund from a provider. I've had a handful of experiences the last few years that prompted me to look at Alaska Statutes.

Currently, most payers require the Providers to submit claims within a certain period. Most are 1 year from the date of service, and some are 6 months, or 90 days from the date of service. In turn, the Payers can request a refund from anytime in the future if they did not process the claims correctly. Here are a couple examples that happened to Providers I provider services to:

2016 – EBMS request a refund for 5 dates of service in 2013 as they continued to pay after the patients plan terminated. The provider had to repay approx. \$1,200.00. Thankfully the patient had a secondary insurance that we could appeal for a payment.

2016 – Cigna requesting a refund for 2014 claims they paid in error as the patient was not eligible.

2017 – Cigna requesting a refund for 2015 claims paid in error.

2018 - EBMS requesting a refund for 2015 claims that were paid after the patient was no longer eligible.

2018 – Cigna requesting a refund for claims paid in 2016.

All of the above examples are not from fraudulent claims but the Payer should have some processed the claims correctly the first time. Now the financial burden is on the Provider to refund the Payer. In turn the patient, if still in Alaska, will be responsible for these charges.

I am for limiting the timeframe a Payer can request a refund. The Providers only have a sometimes small timeframe they can submit charges to a Payer. The Payer should be expected to process the charges against the policies of the patient within a timeframe as well.

Thank you for your help on creating this bill!

Please let me know any questions.

Deborah Rieser, Owner
Spectrum Medicaid Billing Services

Nature's Way Rehabilitation Services, LLC



36484 Meandering Rd. Soldotna, AK 99669
Phone: (907) 260-4159 – Fax: (907) 260-4166
natureswayrehab@gmail.com

January 31, 2018

Dear Representative Green and/or To Whom It May Concern,

I am a small, private pediatric outpatient therapy business owner and pediatric occupational therapist in Soldotna, AK. My business is Nature's Way Rehab. Services, LLC. Spectrum Medical Billing is contracted to do the billing for my business.

I am in full support of House Bill 313 on behalf of providers and parents/families. Often, the families we work with are having trouble even making ends meet and can't handle therapy bills if the insurance doesn't pick up the bill for some reason or another. I am working with Cigna private insurance right now with one client in particular that I have been seeing for several years and I have been having ongoing difficulties with Cigna paying me for occupational therapy services and then turning around and asking for their money back, even claims up that are two years old. For example, in April of 2016, I received a request from Accent (Cigna's collection company) to refund all the claims between the dates of 6/20/2014 all the way to 1/20/2016; the denial reason was "termination of benefits." After working with Cigna on several phone calls, we were able to resolve that his benefits had not terminated and he was covered so those claims, dating up to 22 months in retrospect, did not have to be repaid.

Here is another example with the same patient and again with Cigna/Accent and this refund request DOES have to be repaid. On November 21, 2017, I received a request from Accent to refund all the claims between the dates of 3/2/2016 to 9/30/2017; the explanation reason was given as: "Therapies allowance incorrect". Also, received on January 6, 2018, was an Accent request asking for a refund dating back to 1/18/2016 (this is going back two full years from the Date of Service) with the explanation reason being: "Therapist allowance incorrect." After several phone calls with various Cigna personnel and different levels of communication, a supervisor was finally able to tell me that the denial reason was because "Cigna does not cover the Autism diagnosis" in those years (they do starting 1/1/18). Now, thankfully, this particular patient also has Tefra/Medicaid funding and after the money is returned to Cigna by my business, then my biller will have to void any secondary payments from Medicaid for the smaller leftover amount from each Date of Service and then re-bill Medicaid the full amount. This entire process is a waste of time and resources at the Medicaid/state level and not to mention for the provider. I also would like to mention that if this family did not have Tefra as a back-up, my business would have to just absorb the cost of this recoupment or send the family to collections; this family is barely making ends meet; they are living in an ex-boyfriend's trailer home with 2 small bedrooms and 3 young children and their single mother is working at Wal-Mart.

On behalf of families and providers, I am in full support of House Bill 313. Thank you for advocating for persons with disabilities and delays and the providers who serve them.

Respectfully,



Angela Beplat, Occupational Therapist/Business Owner
Nature's Way Rehabilitation Services, LLC
36484 Meandering Rd.
Soldotna, AK 99669
907-250-7317 (cell)

Shea Siegert

From: Louis [REDACTED]
Sent: Monday, January 29, 2018 11:02 AM
To: Shea Siegert
Subject: Healthcare bill for insurers

Mr Siegert,

As an owner of an outpatient Physical Therapy clinic in Anchorage I am in favor of the bill/law limiting the amount on time an insurer has to be refunded funds. One year would be optimal, 18 months acceptable.

Louis Greene MSPT, Dip. MDT

Shea Siegert

From: Andrea Samuel [REDACTED]
Sent: Friday, January 26, 2018 1:28 PM
To: Shea Siegert
Subject: HB 313

Dear Mr. Siegert,

I am favor of HB 313.

I am a sole proprietor, private-practice speech-language pathologist who works with the pediatric population.

I do not make large sums of money from my small caseload. As a speech therapist I am limited in the number of procedure codes I use to treat my particular population of clients.

Having a insurer come back and audit my Dates of Service at any time in the distant future poses unnecessary financial risk -not just to my practice, but to myself and my family.

It is reasonable to mandate that insurance companies be given a term of 12-18 months from date of service to do the following: To request an audit; and further, to seek repayment if they have reasonable evidence that they have overpaid me, or paid for a service/procedure I did not render due to billing errors.

These Insurance companies should be cooperative and fair with individual providers and not predatory in recouping money they feel they've overpaid or need to dispute.

Many thanks for introducing this bill.

Respectfully,
Andrea Samuel

Andrea Samuel, M.S., CCC-SLP
Speech-Language Pathologist

(907) 887-6181

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asamuel.slp@gmail.com

Shea Siegert

From: Yvonne San Juan <yvonesj@gmail.com>
Sent: Saturday, January 27, 2018 10:11 AM
To: Shea Siegert
Subject: House Bill 313

Dear Mr. Siegert,

I want to encourage you to support House Bill 313 on behalf of speech therapists in our community. We work hard to improve the lives of our clients, and to adhere to professional ethics as our national organization (ASHA) requires. Insurance companies billing us or our clients years after the service has been provided is a disservice to both clinicians and the clients we serve. As clinicians, we are often not allowed to bill for services after a specified length of time, so how do insurance companies get away with this? I urge you to act on our behalf and provide a time limit for insurance companies to request reimbursement. Thank you for your time and consideration regarding this matter.

Sincerely,

--
Yvonne San Juan, M.S., CCC-SLP
Achieve Speech Therapy

3401 E. 42nd Ave., Ste. 201
Anchorage, AK 99508

email: yvonesj@gmail.com
phone: [\(907\)868-2753](tel:907868-2753)/fax: [\(907\)868-1410](tel:907868-1410)

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Shea Siegert

From: Sara Garsha [REDACTED]
Sent: Friday, January 26, 2018 11:41 AM
To: Shea Siegert
Subject: HOUSE BILL NO. 313

Hello-

I'm writing in support of HB313. As a provider, the potential for liability currently faced by providers accepting insurance is daunting. I have a colleague that suffered this fate and was required to pay nearly \$500,000 for payments received over 7 years prior. The current ability for insurance companies to place the responsibility of what should be their own business practice (checking the validity of claims) is unseemly and dangerous for anyone accepting insurance. I urge the house to place a cap on the amount of time insurance companies can seek restitution on claims they mistakenly paid.

Thank you for your support,

Sara Garsha, LMT

Fiscal Note

State of Alaska
2018 Legislative Session

Bill Version: HB 313
Fiscal Note Number: _____
() Publish Date: _____

Identifier: HB313-DCCED-DOI-02-02-2018
Title: RECOVERY OF PAYMENT BY INSURANCE PROVIDER
Sponsor: GRENN
Requester: (H) Health and Social Services

Department: Department of Commerce, Community and Economic Development
Appropriation: Insurance Operations
Allocation: Insurance Operations
OMB Component Number: 354

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2019 Appropriation Requested	Included in Governor's FY2019 Request	Out-Year Cost Estimates					
			FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
OPERATING EXPENDITURES								
Personal Services								
Travel								
Services								
Commodities								
Capital Outlay								
Grants & Benefits								
Miscellaneous								
Total Operating	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Fund Source (Operating Only)

None								
Total	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Positions

Full-time								
Part-time								
Temporary								

Change in Revenues

None								
Total	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimated SUPPLEMENTAL (FY2018) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2019) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? Yes
If yes, by what date are the regulations to be adopted, amended or repealed? 06/01/19

Why this fiscal note differs from previous version/comments:

Not applicable, initial version.

Prepared By:	Anna Latham, Deputy Director	Phone:	(907)465-2518
Division:	Insurance	Date:	02/02/2018
Approved By:	Catherine Reardon, Director	Date:	02/02/18
Agency:	Division of Administrative Services, DCCED		

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2018 LEGISLATIVE SESSION

BILL NO. HB 313

Analysis

This legislation amends AS 21.54.020(d) to give health care insurers a deadline of 18 months to recover an amount mistakenly paid to a provider or a covered person. It also provides for extenuating circumstances in which health care insurers are exempt from the 18 month window.

This legislation will result in amending 3 AAC 26.100, which currently restricts health care insurers to initiating recovery of an overpayment within 365 days of when the original payment was made. Regulations updates will be included in planned regulations projects.

The Division of Insurance does not anticipate fiscal impact from this legislation.

State	Statue/Code	Time Limit for Acquiring Refund of Overpaid Claim	Additional Time Limit Factors	Exemptions	Period	Link
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	Statue Link
Alaska	AS 21.54.020	A healthcare insurer can recover an amount, wrongly paid to a provider.	—	—	No Limit	Statue Link
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	Statue Link
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	Statue Link

State	Statue/Code	Time Limit for Acquiring Refund of Overpaid Claim	Additional Time Limit Factors	Exemptions	Period	Link
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	Statue Link
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	Statue Link
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	Statue Link
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 to 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 backdated denial	6 Month	Statue Link

State	Statue/Code	Time Limit for Acquiring Refund of Overpaid Claim	Additional Time Limit Factors	Exemptions	Period	Link
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 date of the claim. 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	Statue Link
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	Statue Link
Indiana	IC27--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	Statue Link
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	Statue Link
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	—	Time limitation shall not be applicable in case of fraud.	24 Months	Statue Link

State	Statue/Code	Time Limit for Acquiring Refund of Overpaid Claim	Additional Time Limit Factors	Exemptions	Period	Link
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.	—	—	Statue Link
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 the subject of legal action.	12 Months	Statue Link
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.Fraudulent information. 2.Improperly Coded 3. Payment was made for duplicate claim. 4. 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 recipient.	6 Months	Statue Link

State	Statue/Code	Time Limit for Acquiring Refund of Overpaid Claim	Additional Time Limit Factors	Exemptions	Period	Link
Massachusetts	HB 976	The time that 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	Statue Link
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	Statue Link
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	Statue Link

State	Statue/Code	Time Limit for Acquiring Refund of Overpaid Claim	Additional Time Limit Factors	Exemptions	Period	Link
Nebraska	Title 210 – NEB. DEPT OF INS. Chapter 60 (011--- 011.01(B))	011.01(B)(3) The insurer has notified the claimant within six (6) months of the date of the error, except that in instances of error prompted by representations or nondisclosures of claimants, the insurer notifies the claimant within fifteen (15) days after the date that clear, documented evidence of discovery of such error is included in its file	011.01(B)(4) Such notice states clearly the nature of the error, the amount of the overpayment, and the three year limitation as provided in subsection 011.01(C).		6 Months	Statue Link
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	Statue Link
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	Statute link
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	Statute Link

State	Statue/Code	Time Limit for Acquiring Refund of Overpaid Claim	Additional Time Limit Factors	Exemptions	Period	Link
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	Statue Link
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	Statue Link
Pennsylvania	HB 1850 -- Session 2005, Subsect 603---B				12 Months	Statue Link
South Carolina	§38---59---250	Insurance may not initiate overpayment recovery process from a provider more than 18 months after the provider received the initial payment.	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	Statue Link
Tennessee	PUB. ACTS, 2003, (SB 460, Chapter # 257) Tenn. Code Annotated, Title 56, Chapt 7	56---7---110 if a health insurance entity or an agent contracted to provide eligibility verification, verifies that an individual is a covered person and if the health care provider provides services to the individual in reliance on such verification, the health insurance entity may not thereafter retroactively deny a claim on the basis that the individual is not a covered person unless such retroactive denial occurs within six (6) months of the date that the health insurance	(from left) the health insurance entity is barred from making such recoupment unless there was fraud by the health care provider.	fraud by the health care provider.	6 Months	Statue Link

State	Statute/Code	Time Limit for Acquiring Refund of Overpaid Claim	Additional Time Limit Factors	Exemptions	Period	Link
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	Statue Link
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	Statue Link
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	12 Months	Statue Link

State	Statute/Code	Time Limit for Acquiring Refund of Overpaid Claim	Additional Time Limit Factors	Exemptions	Period	Link
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	Statue
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	Statue Link
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	Statue Link
Wyoming	HB 0167 Section 26---15---124	(ii) The notice required by paragraph (i) of this subsection is sent by the insurer within eighteen (18) months after the date of payment or twenty---four (24) months after the date of service, whichever is sooner			18 or 24 months	Statute Link

State	Statue/Code	Time Limit for Acquiring Refund of Overpaid Claim	Additional Time Limit Factors	Exemptions	Period	Link
All States	Patient Accountability and Affordable Care Act	Section 6402(a) of the ACA created a new section 1128J of the Social Security Act, and it establishes that the failure to report and return an overpayment within 60 days of identifying its existence can give rise to liability under the False Claims Act (FCA). The proposed rule applies only to overpayments identified by Medicare Part A and B providers and suppliers, but CMS made clear that Medicare Advantage Organizations, Medicaid Managed Care Organizations, and Prescription Drug Plans under Medicare Part D still have an obligation under various statutes to report and return overpayments.	At present, the reopening rules state that the Medicare contractors can reopen claims within one year for any reason, within four years for "good cause," and any time if evidence of "fraud or similar fault" exists. Absent any evidence of wrongdoing, providers and suppliers who identify overpayments typically repay claims received within the last four years. If the reopening rules are amended to require repayment of claims over a ten-year period, providers and suppliers will be required to repay at least ten years' worth of claims in all cases. Areas for Comment and Comment Period	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.	60 Days	Statute Link

References

<http://codes.lp.findlaw.com/nycode/ISC/32/3224---b>

<http://www.healthlawattorneyblog.com/2012/02/cms---issues---proposed---rule---on---re.html#.UBvBWvKJFEc.email>

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Topic:

MEDICAL CARE; HEALTH INSURANCE; STATUTE OF LIMITATIONS;

Location:

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STATUTE OF LIMITATIONS FOR INSURANCE COMPANY RETROACTIVE CLAIM DENIALS

By: Janet L. Kaminski, Associate Legislative Attorney

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, absent 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)).

JLK:ro

LEGISLATIVE RESEARCH SERVICES

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State Recoupment Time Limits for Health Insurers

Tim Spengler, Legislative Analyst

You asked about state laws regarding how long health care insurers have to ask for recoupment after they have overpaid a provider.

After paying claims to health care providers, insurers may conduct an audit to verify that 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. Insurers 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. Insurance companies can request refunds from providers for a variety of reasons including overpayments; duplicate payments; pricing changes; coverage changes; or in instances of provider fraud, waste, or abuse.

State measures regarding time limits for insurance recoupment vary considerably. Thirty-two states—not including Alaska—have statutes of limitations regarding an insurer's ability to make a retroactive claim denial. Maryland, Nebraska, and Texas allow the least amount of time—six months—for an insurance company to request a refund/recoupment, while Florida and Connecticut allow insurers up to 30 and 60 months, respectively. The other states with a time limit allow 12, 18, or 24 months. As you know, Alaska law—AS 21.54.020—does not impose a time limit for such refunds. An additional 17 other states do not have statutes pertaining to the issue.

On the following page, we provide a table showing the time limits for recoupment in states. A more in-depth table, which includes statutory citations, additional factors, and exemptions, is available at www.prorecovery.com/wp-content/uploads/2013/09/PRP-State-Insurance-Recoupment-Laws.pdf.¹

¹ We found refund recoupment information on various other sites as well and ascertained that the PRP table, while created in 2013, is largely up-to-date and accurate.

State Refund Recoupment Time Limits for Health Insurers

No Time Limit or No Statute (18)	Six Months (3)	12 Months (12)	18 Months (7)	24 Months (8)	30 or 60 Months (2)
Alaska, Delaware, Hawaii, Idaho, Illinois, Kansas, Louisiana, Michigan, Minnesota, Mississippi, Nevada, New Mexico, North Carolina, North Dakota, Oregon, Pennsylvania, South Dakota, Wisconsin	Maryland, Nebraska, Texas	Alabama, Arizona, California, Colorado, Maine, Massachusetts, Missouri, Montana, Utah, Vermont, Virginia, West Virginia	Arkansas, Georgia, New Hampshire, New Jersey, Rhode Island, South Carolina, Tennessee	Indiana, Iowa, Kentucky, New York, Ohio, Oklahoma, Washington, Wyoming	Connecticut (60) Florida (30)

Source: Professional Recovery Personnel, Inc. (PRP) at www.prorecovery.com/wp-content/uploads/2013/09/PRP-State-Insurance-Recoupment-Laws.pdf. We identified one inaccuracy in the PRP table; it shows Rhode Island as not having a relevant statute, however, R.I. Gen. Laws § 27-18-65 speaks to this issue and allow insurer up to 18 months to request a refund.

Notes: In addition to PRP, we identified a number of other sources where refund recoupment state information was examined. These sources show information consistent with that provided in PRP's table (see link above).

We hope this is helpful. If you have questions or need additional information, please let us know.