

How to Defend Against Insurance Company Audits and Recoupments for IL AAHAM July 14, 2021

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What is a Recoupment?

- A Recoupment is a request for a refund when an insurer or claims administrator believes it overpaid a medical claims account.

Why is the recoupment brought by the SIU Unit?

- Fraud trumps Prompt Pay Laws – claims don't have to be paid within 30 days
- Scare tactic

How are Recoupments started?

- Insurer/Claims Administrator requests 10 or more patient charts;
- Negative EOB.
- Refund Letter from Overpayment Vendor.
- Cross Plan Off-setting.

What are the most common forms of Recoupments?

- Other coverage existed at the time of services.
- Claims lack medical necessity.
- Services billed are unsupported.
- Upcoding.
- Bundling.
- Fee forgiving (OON Only)

What law applies to Recoupments?

➤ Federal Law – ERISA

- Applies where the health plan is self-funded and employer-sponsored.

✓ State Law – Insurance Law.

- Applies where the health plan is fully-insured (an actual policy of insurance)

Understanding Basic ERISA Obligations

- Written notice to the provider.
- Written notice stating the specific reason for the audit and the recoupment.
- Written notice that the provider has the right to receive all relevant claim documents and audit materials “free of charge”.
- Written notice setting forth specific plan provisions on which the determination is based, specific references to the plan documents and citations of exclusions and limitations that preclude coverage and which resulted in the over-payment.

ERISA Obligations (continued)

- ◉ Written notice setting forth the Plan's review procedures and the time limits applicable to such procedures; including a statement of the claimant's right to bring a civil action as well as an explanation of appeals rights and specifically how to file an appeal.
- ◉ If over-payment resulted from lack of medical necessity, or for experimental, written notice explaining the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- ◉ Written notice explaining, and providing the specific rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination with specificity, protocols, guidelines and/or service standards that were allegedly consulted

Full and Fair Review

- ⦿ The most important concept to understand is that Courts have ruled that recoupments are “Adverse Benefit Determinations”
- ⦿ That means that the health provider is entitled to anything relevant to the recoupment determination.
- ⦿ A provider is entitled to the health plans investigative file including internal emails, memos and basically anything relied upon by the health plan in making the ERISA determination.

What is Cross-Plan Off-Setting

An insurer taking back funds on a case they believe was paid incorrectly from another unrelated medical claim to satisfy a recoupment/refund demand.

Recent Cases

- ◎ Recent 8th Circuit case, ***Peterson on behalf of Peterson v. United Health Group Inc., Peterson et al. v. UnitedHealth Group, Inc., et al.***, Eighth Circuit Appeal No. 17-1744 (January 15, 2019). ***The Appellate court in that case expressly stated that a plan administrator is not allowed to engage in cross-plan offsetting, the practice of not paying a benefit due under one plan to recover an amount believed to be owed to another plan because of that other plan's overpayment.***
 - Significantly, the Secretary of Labor also filed a brief as *Amicus Curiae* in support of the plaintiff's position in *Peterson* and against the offsetting practice of United Health Group.
- ◎ The U.S. District Court in New Jersey ***ruled that Aetna's cross-plan offsetting violated ERISA*** (namely, sections 404 and 406). See ***Lutz Surg. Ptnrs. PLLC et al. v. Aetna, Inc. et al.***, U.S.N.J., Case No. 3:15-cv-02595 (June 21, 2021).

Peterson

- ⦿ The court determined that United HealthCare's practice was not expressly permitted by any of its customers' plan documents. Recognizing this, United HealthCare argued that each plan granted it broad authority to interpret plan terms and administer the plan, and that its discretion extended to the cross-offsetting procedure.
- ⦿ The court was not persuaded, stating that to adopt United HealthCare's position "would be akin to adopting a rule that anything not forbidden by the plan is permissible."

Peterson (cont'd)

- ⦿ The Court stated, “Cross-plan offsetting is in tension with this fiduciary duty because it arguably amounts to failing to pay a benefit owed to a beneficiary under one plan in order to recover money for the benefit of another plan.”
- ⦿ The court did not feel the need to specifically determine whether the cross-plan offsetting procedure violated ERISA itself.

Lutz

- ◎ The District Court determined that Aetna's practice, as the plan administrator, of cross-plan offsetting violated ERISA.
 - It was stated that Aetna's cross-plan offsetting resulted in Aetna violating its ERISA-based fiduciary duties, including its duty of loyalty and obligations to comply with the prohibited transaction rule and the exclusive purpose rule.

Lutz (cont'd)

- ⦿ The District Court further noted, citing prior cases, that “[w]hen a plan administrator ‘happen[s] to be fiduciaries of multiple plans... ‘each plan is a separate entity’ and a fiduciary’s duties run separately to each plan.”
 - In other words, the two (2) plans are for the benefit of separate and distinct members/ beneficiaries and, therefore, cross-plan offsetting would harm the interests of those not involved with any alleged overpayment.
- ⦿ The District Court further noted that ERISA’s preemption of State Law made any defense based on State Law invalid.

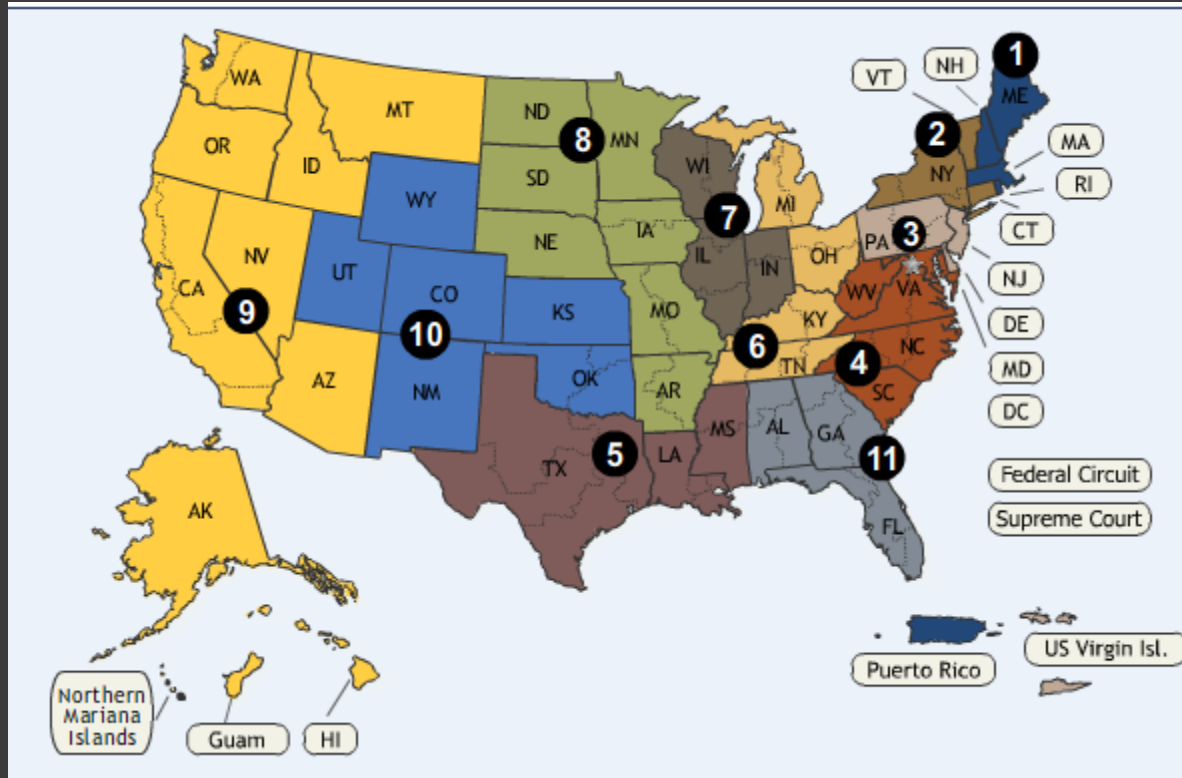
Conflicting Cases & Continued Concern

- The Eighth Circuit's conclusion, however, conflicts with the Fifth Circuit's decision in *Quality Infusion Care Inc. v. [Health Care Service Corp.](#)* which involves plans "materially identical" to plans in the *UnitedHealth* case allowed for the so-called practice of cross-plan offsetting. While the Fifth Circuit said plans in the *QIC* case that were silent about cross-plan offsets were still "reasonably construed" to authorize such offsetting, the Eighth Circuit's decision rejected that position.
 - The Third and Seventh Circuits are also in line with the Fifth Circuit.
- The *Lutz* case is, thus far, only a District Court case, which is the lowest level of federal case. While it is a step in the right direction, it lacks binding effect in most jurisdictions.

What Does This Mean?

- ① 1. Use the 8th Circuit case in your appeal letters, as well as the *Lutz* case (even though it is non-binding), as it demonstrates the validity of the reasoning, which is rooted in ERISA's statutory requirements.
- ② 2. Courts have indicated in other cases that any investigation involving an audit or refund conducted by or on behalf of the payor must be thorough. It cannot be a hasty, rush to judgment investigation.
- ③ 3. ERISA applies to Payor Health Actions, therefore, the health plan may not retaliate against the provider for asserting its rights under ERISA. ERISA §502(a) (3) prohibits retaliatory behavior from insurance companies.

The Circuit Courts



When Might an Expert be Required?

- To counter the auditor's contention that a claim was not supported by the medical records, not medically necessary, not experimental or investigational, not bundled or incidental etc.

Unsupported Services

- ◎ The recoupments are based on:
 - The healthcare provider's alleged lack of documentation in the chart which does not support all of the services billed, or
 - Alleged non-compliance with an internal policy of the health plan, or
 - Billing of services allegedly not covered under the health plan

Unsupported services (cont'd)

- ⦿ Always object in writing
- ⦿ Always appeal any and all unpaid claims (send with Objection Letter)
- ⦿ Always ask for a written audit report outlining the health plan's rationale for the recoupment
- ⦿ Always ask for 30 days to evaluate the findings
- ⦿ Always retain separate coding and compliance expert to file a written "expert response"
- ⦿ Try for a "going forward" action plan in lieu of payment of funds

Interplay with Insurance Law

- ⦿ Don't forget to consult your state insurance law which may limit the time frame in which health plans may perform recoupments.
- ⦿ For example, under NY Prompt Payment Law, Section 3224-b, a health plan may only recoup funds not more than 24 months from the date of payment.

If ERISA Demands Are Not Met

**Do not agree to refund
anything until your ERISA
demands have been
complied with by the health
plan!**

ERISA Penalties for Non-Compliance

- If an administrator fails or refuses to comply with a written request within thirty days, the administrator could be held personally liable to the participant in the amount of up to \$110 a day from the date of such failure or refusal
 - Pursuant to 29 U.S.C.A. § 1021(a)(1) & (2) and 29 U.S.C.A. § 1024(b)(4), the administrator is required to supply a participant or his/her designee with the Summary Plan Description ("SPD") and, upon written request, a copy of any ". . . trust agreement, contract, or other instruments under which the Plan is established or operated . . ." 29 U.S.C.A. § 1132 (c)

When Faced with a Recoupment

1. Respond in writing objecting to the recoupment, take back, refund demand or special investigation; and
2. Make sure you remind the health plan in writing that they are obligated to comply with federal ERISA Regulations by virtue of the Health Plan Action which is essentially an “Adverse Benefit Determinations” much like a claim denial is, as defined by ERISA; and
3. Make an ERISA Demand in writing (you are entitled to anything “relevant” to the ABD so request the health plan’s entire investigation file including any internal memos, emails and so on); and
4. Take allegation of insurance fraud seriously but determine the exact reasons that the health plan believes fraud was committed (most times, the term is used to intimidate only and there is little to no evidence of insurance fraud).

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