DEPARTMENT OF HEALTH & HUMAN SERVICES
BEHAVIORAL HEALTH DIVISION

Milwaukee County

Note Date

May 13, 2011

ForwardHealth
Managed Care Appeals
PO Box 6470
Madison, WI 53716-6470

To Whom It May Concern::

This letter is in reference to an Overpayment Notification from OptumHealth Behavioral Solutions for Milwaukee County Mental Health Complex, Tax ID 396005720 (see attached). The overpayment is in the amount of $115917.50 representing 9 member episodes from 2006. ← Note Date.

For all 9 episodes, the overpayment reason was "incorrect contract rate applied" and contained the following note:

> *NOTES: Wisconsin Non Par Medicaid Rates provide that DRG 715 is reimbursed at a base rate of $500.00 times a weight of 1.1223 = $5611.50*
>
> *NOTES: Wisconsin Non Par Medicaid Rates provide that DRG 714 is reimbursed base rate of $5000.00 times a weight of 2.0075= $10037.50.*

During 2006, the United Health Group paid all Milwaukee County charges based on our per diem rate. This is true of the claims in question. This overpayment claim is one of nine long-stay 2006 claims UBH has hand picked as an overpayment based on conversion to a DRG rate. UBH cannot opt to have long-stay episodes paid using the DRG and short stay claims paid using the per diem rate. If UBH wishes to change from a per diem to a DRG rate for 2006 claims, it must be done for all claims in 2006 reflecting a total underpayment of $91,272.09. The Milwaukee County Behavioral Health Division will agree to pay the overpayment for this claim when it receives a check from UBH for the 2006 claims that were underpaid based on the DRG rate. I have attached a spreadsheet for the 2006 claims.

Your prompt attention to this matter is greatly appreciated.

Sincerely,

N. Maslanka

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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

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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

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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

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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

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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

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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

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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

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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