New York Law Journal
A NEW YORK LAW JOURNAL SPECIAL SECTION
An ALM Publication
Insurance Law
WWW.NYLJ.COM
MONDAY, DECEMBER 1, 2014

Fighting Back Against Repayment Demands and Offsets

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Insurance companies routinely enhance their revenue, at the expense of medical providers and their patients, by retroactively denying previously paid claims and then "recouping" those prior payments by refusing to pay claims submitted on behalf of different patients.

Doing so is commonplace and profitable—insurers trumpet the fact that they recoup hundreds of millions of dollars every year from providers through these tactics.

The process is simple. Insurers send letters to providers informing them that they were previously overpaid on particular claims submitted on behalf of particular patients. The letters demand immediate repayment. Then, if the provider cannot or will not voluntarily pay the demanded amount, insurers recover it by withholding different benefit payments owed by different plans on behalf of different patients. They do all of this unilaterally, without giving providers or their patients due process rights and without submitting their findings or offsets to any judicial review.

While most would agree that providers should be required to return benefit payments where there has been a judicial finding of provider fraud, where the overpayment resulted from a provider's undisputed error (for example, when the provider acknowledges having accidently submitted—and been paid on—the same claim twice), or where the provider was allowed to meaningfully challenge the overpayment determination. The problem is that insurers do not limit their recoupments to these situations—instead, they regularly recoup alleged overpayments when there is no allegation of provider fraud, no allegation of provider error, and no way for a provider or her patients to challenge the insurer's determination.

Insurers often demand repayments from out-of-network doctors, for example, even when the alleged overpayment was the insurers' mistake, such as in failing to indicate that a patient was not insured when the medical services were received. In such a situation, the provider has not been "overpaid" in the way the term is commonly understood. She has received compensation for performed services. Although insurers might reasonably assert the right to recover the alleged overpayment by offsetting the patient's future claims (if the patient is still insured), or bringing a lawsuit against the patient to recover the money paid to the provider (if the patient is no longer insured), it is difficult to see why insurers should

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be allowed to offset the cost of their mistakes by refusing to pay a claim for a different patient.

In fact, there is substantial authority indicating that offsets in this circumstance are illegal. Where the provider did nothing wrong, but was merely paid for his services, he was not unjustly enriched even if the insurer wrongly paid the benefit instead of making the patient pay for it. As the Nebraska Supreme Court held some 40 years ago: "[W]e place the burden for determining the limits of policy liability squarely upon the only party (as between the insurer and the assignee hospital) in a position to know the

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policy provisions and its liability under the contract of insurance. Someone must suffer the loss, and as between the insurer and the hospital, the party making the mistake should bear that loss." Federated Mut. Ins. Co. v. Good Samaritan Hosp., 191 Neb. 212, 214 N.W.2d 493, 495-96 (1974). This view is shared by the California Supreme Court, which held in City of Hope Nat'l Med. Center v. Sup. Ct. of Los Angeles County, 8 Cal. App.4th 633 (1992), that an insurer could not recover an overpayment from a hospital when the payment was solely the mistake of the insurer. As the court explained to the insurer, "Stated plainly, if it's your mistake, you get to pay for it—unless the recipient misled you or accepted the payment knowing you didn't owe it."

This view is also shared by prominent federal judges. Recently, Judge Richard Posner rejected an insurer's effort to recover a mistaken overpayment because the overpayment was not the provider's fault. While Posner stated that the plan might be entitled to a refund under the provider's contract had the hospital made a mistake leading to an overpayment, in this case "the hospital had made no mistake." Rather, "the plan had paid the hospital to treat the child and it had treated her, and there is no suggestion that there was anything amiss in the treatment or in the charges for it." Thus, Posner asked "[s]o what could be the source of a legal right to a refund?" He then points out: "It's one thing for a seller to refund money or take other reparative measures because of a mistake it's made, and another to do so because the buyer has made a mistake. It's not as if the hospital has been unjustly enriched by keeping the money that [the insurer] paid it." Kolbe & Kolbe Health and Welfare Ben. Plan v. Medical College of Wisconsin, 742 F.3d 751, 753 (7th Cir. 2014). This analysis suggests that insurers have no legal right to take back money from providers based solely on their own mistakes.

Yet, they do so—frequently.

In 2012 and 2013, for example, an insurer erroneously failed to apply an annual out-of-network cap on chiropractic services found in the insurer's ERISA plans, leading it to pay benefits to chiropractors that exceeded the cap. The chiropractors had no reason to know of this limitation, and they filed claims on behalf of their patients and received benefit payments from the insurer. In 2014, the insurer apparently discovered its error and demanded that all of the chiropractors repay the "overpaid" benefits. A number of the chiropractors filed appeals with the insurer, protesting that they should not be held responsible for its mistake, particularly since they merely received payment for the chiropractic services they provided. The insurer rejected the appeals and began unilaterally collecting the alleged overpayments by denying new claims submitted by the chiropractors on behalf of different patients insured under different plans.

Insurers often demand repayments from out-of-network doctors even when the alleged overpayment was the **insurers' mistake,** such as in failing to indicate that a patient was not insured when the medical services were received.

Given recent legal developments, it is quite possible that providers in this and similar situations can effectively challenge recoupments under ERISA. ERISA and its accompanying regulations establish detailed and comprehensive procedural guidelines that must be followed when benefits are reduced or denied. These courts have held that if the decision to deny benefits would trigger ERISA rights when the claim was initially submitted (e.g., the treatment was not medically necessary or otherwise not covered under the plan), then it also applies if the same decision is made after-the-fact. They have also held that if ERISA applies, insurers cannot unilaterally demand the money and then take it back. Instead, they must follow ERISA's comprehensive guidelines by disclosing the basis for the demands, providing access to the policies relied in making the decision, and offering a "full and fair review" of the retroactive denial.

Moreover, such procedures must be provided for each claim that is allegedly overpaid, thereby eliminating one of the most common means for insurance companies to recoup funds: auditing a small sample of prior claims and then extrapolating the results to several years of payments to the provider without reviewing the medical records or otherwise considering individual issues related to the provided services.

Three recent cases litigated by the authors highlight how providers can challenge these recoupment practices. In Blue Cross & Blue Shield of R.I. v. Korsen, 2013 WL 2247460 (D.R.I. May 22, 2013), BCBS sued two individual providers for billing fraud and breach of in-network provider contract under state law, seeking over $400,000 in previously paid benefits. The insurer claimed that the providers had used the wrong billing codes for intersegmental traction, a type of physical therapy, and that the underlying services were, in fact, not covered under the plans. Because the claim ultimately was based on whether the services were covered (since there would be no injury from billing the wrong code if the service was covered either way), the court found that ERISA "completely preempted" the state law claims.

Following a bench trial under ERISA, the court found entirely in the providers' favor. In reaching its decision, the court noted that the repayment demand arose from an audit conducted by BCBSRI, which was initiated as

a "friendly chat," but was "really a fraud investigation in sheep's clothing." The court further found that it was "unjust" that the providers were not "given any opportunity to appeal or have Blue Cross's determination reviewed, despite the inclusion of review procedures both under ERISA and the Provider Agreements." This holding sustained the providers' contention that they were entitled to ERISA rights when being subjected to the repayment demand.

Ultimately, the court concluded that "the equities weigh heavily in favor of [the providers], both of whom did no wrong," while Blue Cross's fraud allegations were based on "its cursory and unsupported assessment that any experienced medical practitioner would know that intersegmental traction was not mechanical traction," and "its investigation into both the operation of the intersegmental traction equipment and the use of this equipment in the chiropractic community was limited and perfunctory." The court ordered BCBS to return over $80,000 in recouped funds, plus interest, and enjoined it from seeking to recover any further funds, finding that it had no basis for its repayment demand.

In Pennsylvania Chiropractic Association v. Blue Cross Blue Shield Association, 2014 WL 1276585 (N.D. Ill. March 28, 2014), the court similarly found that ERISA governed an insurer's effort to recover overpaid benefits from members of the PCA. In late 2006, IBC purportedly experienced a "computer glitch," which "caused IBC to pay PCA members who were not authorized to provide services on a capitated basis for services that are supposed to be reimbursed on a capitated basis only." It then demanded repayment of those funds and recovered them by offsetting benefits from claims submitted in 2007 and 2008 on behalf of new and unrelated patients. Finding that the repayment demand and subsequent offsets constituted adverse benefit determinations under ERISA, the court held that "PCA members who were subjected to recoupments of amounts IBC had previously paid were entitled to notice and appeal procedures that complied with [ERISA] standards." After evaluating IBC's conduct when pursuing the repayment demands, and detailing the ERISA requirements, the court concluded that IBC's practices came "nowhere near to substantial compliance with ERISA's notice and appeal requirements." The court issued a permanent injunction that forced IBC to comply with ERISA, and thereby to materially change the procedures it followed when seeking to recover alleged overpayments from members of the association.

ERISA and its accompanying regulations establish **detailed and comprehensive procedural guidelines** that must be followed when benefits are reduced or denied.

In a subsequent decision regarding two individual chiropractors who were also plaintiffs in the action, the court held that they were entitled to receive back the funds that IBC had recouped from them, plus interest, as a result of IBC's ERISA violations. See Pennsylvania Chiropractic Association v. Blue Cross Blue Shield Association, 2014 WL 4087221 (N.D. Ill. Aug. 19, 2014). It further held that they "are entitled to an injunction requiring IBC to provide them with ERISA-compliant notice and appeal procedures" going forward.

Finally, in Premier Health Center, P.C. v. UnitedHealth Group, 2014 WL 4271970 (D.N.J. Aug. 28, 2014), the court certified a nationwide class of out-of-network providers seeking to require UnitedHealth to comply with ERISA when pursuing repayment demands. In reaching this decision, the court held that an insurer cannot unilaterally assert a basis for a repayment without giving the provider the due process rights ERISA provides. This is true regardless of the reason, even if the insurer asserts fraud. As the court found, "[w]hile an insurer's cause of action against a provider in court for fraud often does not implicate ERISA ... the administrative procedure by which an insurer attempts to recoup overpayments based on what it believes to be fraudulent activity must allow the provider the opportunity to challenge that determination in accordance with ERISA procedures, lest the determination be accepted at face value." As a result, the plaintiffs in the case are now free to seek widespread injunctive relief under ERISA on behalf of all out-of-network providers nationwide.

These cases demonstrate that providers do not have to simply accept an insurer's demand that they repay benefits previously issued to them. They can assert their rights to ERISA and require due process. By using ERISA effectively, providers may be able to halt insurers from continuing to act as judge, jury and executioner in taking back funds that were properly paid in the first place.