Dealing with Insurance Company Recoupments of Payments

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Almost every practice has received a notice from an insurance or benefits payor requesting money back because the payor determined an overpayment occurred. No one is happy when this type of notice appears; however, understanding the state laws and developing a standard process for dealing with such requests may ease some of the stress.

Mississippi Laws: **Mississippi Code Title 83. Insurance § 83-41-219** details the time requirements for recoupments. This rule applies except in the following case: "Claims submitted in the context of misrepresentation, omission, concealment, or fraud by the health care provider or other person." Otherwise, this statute states that a claims payor has the same amount of time to review and recoup any payments made as the payor gives providers to file a claim after the date of service. In other words, if a payor allows the provider 90 days in which to file an original claim, that payor has 90 days in which to review any payments and request recoupments. Further, if a payor does not specify how long a provider has in which to file a claim, the payor has 24 months to request any payment recoupment. This statue makes an exception for Mississippi Division of Medicaid (DOM) claims. Mississippi DOM has five years in which to request a recoupment of payments. Understanding these time constraints is important when faced with a recoupment that could be outside of the legal time frame.

Contracted Fee Schedules: Providers should always maintain a current, updated copy of their contract and contracted fee schedule. Since fee schedules can change periodically, a good practice is to review each payors' fee schedules yearly for any changes. Keep in mind that since fee schedules are typically contracted, any changes might require an addendum to the contract. Providers should ensure that they are being paid according to their contracted fee schedule and question any time a deviation occurs, whether that payment is increased or decreased. In the event of a recoupment, providers should immediately refer to their up-to-date fee schedule to understand if any errors were made in the original payment. If the provider cannot locate their contracted fee schedule, they should request one via the on-line portal or directly through the payor.

Understanding Reason for Recoupment: If a recoupment is requested, the provider should investigate why such a request was made. Once the reason for any recoupment is identified, the provider should then determine if the request was within the appropriate time frame and if the reason holds any validity. If the provider determines the recoupment is valid, no further action should be required unless the recoupment was not automatically taken from other payments. If the recouped amount was not automatically taken, the provider should immediately issue a payment back to the payor for the appropriate amount following the payor's instructions. However, if the provider determines the payor is requesting a recoupment in error, an appeal should be immediately initiated citing the specific reasons they think the recoupment request is in error.

Appeal Steps: It is vital for a provider to initiate an appeal immediately and to strictly adhering to any time frames for such appeals. A formal letter of appeal should be written that details all the reasons and cites all the applicable contract language or agreements and any state insurance laws that may apply. Filing any objection or appeal typically halts any recoupment further action on the part of the payor. If an initial appeal is denied, the provider should request an escalation to the next level within the payor company. Filing a complaint with the state insurance regulator should also be considered if the provider does not receive a satisfactory response from any escalation.

Any providers dealing with recoupments or any other issues regarding insurance companies and benefits payors are encouraged to report issues to the Mississippi Optometric Associate for help. This step allows the MOA to stay informed of current issues, to monitor for payor patterns that could indicate issues impacting a broad number of providers and to escalate such issues directly to higher-level payor contacts and the American Optometric Association Third Party

Committee (AOA-TPC). Often the higher-level payor contacts developed by the MOA and AOA-TPC can get results when a particular provider has been unable to find relief through the appeals process. Happy Coding….