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TRIAGE: RAPID LEGAL LESSONS FOR BUSY HEALTH CARE PROFESSIONALS

Segment 3 of 3

Insurer Recoupment Demands

Lauren Garraux

WHAT IS RECOUPMENT?

- Insurer notification that a claim (or claims) was improperly paid
- Sent weeks or months after an insurer pays the claim
- Result of post-payment audits/review of payments
- Initially, demands voluntary repayment of the allegedly overpaid amount
- Later, insurer may “recoup” that amount by withholding payment for future claims that the provider submits on behalf of other patients/for unrelated services

HOW HAVE PROVIDERS RESPONDED?

- In-network providers:
  - Provider agreements may address recoupment
  - Provider agreements generally contain dispute resolution procedures that allow providers to appeal the overpayment determinations
- Out-of-network providers:
  - No provider agreements
  - ERISA?

ERISA PROTECTIONS FOR ABDS

- "Adverse Benefit Determination" (ABD)
  - "a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part)…."
- Recoupment demands are ABDs

ERISA PROTECTIONS FOR ABDS

- An ABD triggers "baseline procedural protections":
  - ERISA § 1133:
    - (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant; and
    - (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

ERISA PROTECTIONS FOR ABDS

- An ABD triggers “baseline procedural protections”:
  - 29 C.F.R. § 2560-503.1(g)(1)(i)–(v): requires written notification “in a manner calculated to be understood” by the recipient, including:
    - (i) the specific reason(s) for the adverse determination;
    - (ii) reference to the specific plan provisions on which the determination is based;
    - (iii) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material is necessary;
    - (iv) a description of the plan’s review procedures and the time limits applicable to such procedures, including notice that the claimant has a right to bring a claim under ERISA to challenge the decision; and
    - (v) any internal rule, guideline, protocol, or other similar criterion [that] was relied upon in making the adverse determination

Today's Presenter

Lauren Garraux

Pittsburgh

+1.412.355.6757

lauren.garraux@klgates.com

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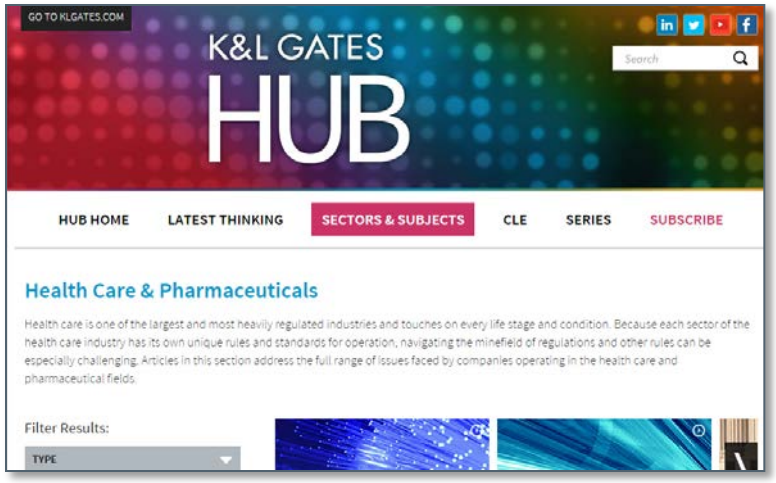

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