SHARP HEALTH PLAN POLICY AND PROCEDURE	
Title: **Claims Overpayment and Retractions**	**Product Line** (check all that apply)**:** ☒ Group HMO ☒ Individual HMO ☐ PPO ☒ POS ☐ N/A
Division(s): Finance and Managed Care	
Department(s): Accounting, SHP Administration	
Owner (Title): SHP Claims Administration	
Relevant Regulatory/Accrediting Agencies/Citations (specify): 0.71 (AB 1455) ☐ CMS: _____ ☒ DMHC: Title 28, California Code of Regulations Section ☐ 130 _____ ☐ NCQA- _____ HP: ☐ NCQA- _____ WHP: OTHER:	
Approved by: (Signature of VP, Compliance Officer, or CEO) Signature on file	**Approval date:** 12/06/12

I. PURPOSE: This Policy and Procedure establishes Sharp Health Plan's (Plan) guidelines for the processing of claims overpayments.

II. POLICY:

A. It is the policy of Sharp Health Plan (Plan) to request claims overpayments as prescribed by regulations outlined in Title 28, California Code of Regulations (CCR), Section 1300.71 (AB1455).

1. All claims overpayment issues shall be researched by the Claims Research department.

2. In the event that an overpayment has been verified and is within 365 days of payment or last action, the Plan or its delegated provider shall issue a notice of the findings to the provider and request that the provider refund the Plan the amount overpaid within 30 working days of receipt of the

notice. If the provider contests the overpayment or any portion thereof this must be done in writing within 30 working days and will be subjected to the Plan's Provider Dispute Process.

3. All refunds received from providers will be processed in the claims processing system to reflect receipt.

4. If the provider does not reimburse the Plan for an uncontested overpayment within 30 working days of receipt of the notice, then those claims will be offset against future payments only when agreed to by contract and authorized by the provider.

5. The Plan will not offset an overpayment of a claim against a non-contracted provider's current claim submissions. For non-contracted providers and those providers with no offset provisions in their contract then interest shall accrue at the rate of 10 percent per annum beginning with the first calendar day after the 30 working day period per Health & Safety Code Section 1371.1

III. DEFINITIONS:

A. Date of Service (DOS): The date on which the service was provided.

B. Explanation of Benefits (EOB): A statement sent to providers listing services provided, amounts billed and payments made.

C. Provider: Physicians, hospitals, skilled nursing facilities, home health agencies, pharmacies, medical transportation companies, laboratories, X-ray facilities, durable medical equipment supplies and other licensed health care entities or professionals which or who provide Covered Benefits to Members. A Provider of health care services may or may not be contracted with Sharp Health Plan.

IV. PROCEDURE: (Applies for both Contracted and Non-Contracted Providers)

A. Identify all potential overpayments: In the event of a suspected overpayment any concerns will be forwarded to SHP Claims Administration in order to make a determination. At a minimum the following information must be presented in order to research any overpayment issue. a. Patient Name
   b. Claim Number
   c. Date of Service
   d. Billed Amount
   e. Approved Amount
   f. Reason for the suspected overpayment.
   g. CMS or UB-04

B. Research all potential overpayments: After a suspected case of overpayment has been sent to SHP Claims Administration, the Claims Auditor researches all the relevant aspects of the case within 30 working days of receipt of the issue.

a. If a determination cannot be reached within 30 working days, the Claim Auditor discusses all relevant issues with the Claims Administration Manager in order to resolve the situation.
b. If the Claims Auditor determines that a claim has been overpaid and identifies the reason for the overpayment, a query must be made against other claims paid to the provider to ensure no other claims were paid similar to the overpaid claim.
c. After the Claims Auditor has identified all overpayments made to the provider, then he or she issues an Overpayment Refund Request letter to the provider with the following information on a monthly basis.
    a. Member Name
    b. Claim Number
    c. Date of Service
    d. Provider Account Number
    e. Health Plan
    f. Total Billed
    g. Amount of the Overpayment/Refund Request
    h. Reason for the Overpayment.
d. The Claims Research Specialist monitors the Refund Database on a monthly basis to verify that no prior refund letters have exceeded the 30 working day time limit.
    a. The Claims Auditor monitors the Refund database monthly to ensure that all provider refund letters have been resolved in accordance to the Plan's policy.

C. Reprocess of Claims: After the receipt of a refund by the provider, the Claims Auditor posts the refund in HealthEdge and gives the check to Accounting Department to cash the refund.

D. The Accounting Specialist logs checks into the refund spreadsheet on a daily basis.

    a. The Accounting Manager reviews the in-house claim refund checks inventory twice per month to ensure that refunds are posted timely.

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E. The Plan will not offset an overpayment of a claim provider's current claim submissions.

V. ATTACHMENTS: N/A

VI. REFERENCES: N/A

VII. TAGS: Overpayments, Retractions, Claims, AB 1455

VIII. REVISION HISTORY:

Date	Modification (Reviewed and/or Revised)
9/12/19	Revised & Updated
12/12/2017	Reviewed Document
08/29/2013	Reviewed Document
11/12/2012	Revised Document
12/23/2011	Reviewed Document
02/22/2011	Revised Document
11/01/2010	Revised Document
08/27/2009	Revised Document
01/01/2004	Original Document