

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, Claims Processing and Claims Research

Owner (Title): Claims Research Supervisor

Relevant Regulatory/Accrediting Agencies/Citations (specify):

- CMS: _____
- DMHC: Title 28, California Code of Regulations Section 1300.71 (AB 1455)
- 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 (GE) 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 the Claims Research Department 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 the Claims Research Department, the Claims Research Specialist 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 Research Specialist discusses all relevant issues with the Claims Research Supervisor in order to resolve the situation.

- b. If the Claims Research Specialist 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 Research Specialist 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. After the Claims Research Specialist issues the Overpayment Refund Request letter, the Claims Research Specialist updates the Refund Letter Tracking Log with the new letter.
 - a. 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. If any providers have not responded to the Overpayment Refund Request letter within the 30 working day limit then the Claims Processor follows the Plan's policy for uncontested claims overpayments.
 - b. The Claims Research Supervisor 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 Specialist instructs the Accounting Department to process the refund.
- a. The Accounting Specialist logs checks into the refund spreadsheet on a daily basis.
 - a. The refund log is located at: [\\G\Common\FINANCE\Claims\Claim Refund Log Detail.xls](#). The spreadsheet is password protected. To access the read-only version of the spreadsheet type: "sharp".
 - b. For all refund checks received, log information on the Provider refunds FY YYYY tab.
 - c. The following fields are populated on the day the check is received:
 - a. Vendor
 - b. Refund amount
 - c. Check Date and Number
 - d. Original Claim
 - e. Check received date.

- d. The Claims Research Specialist forwards the refund information via CSR to the Claims Adjuster to apply the refund in GE after validating the refund.
- e. The Accounting Manager reviews the in-house claim refund checks inventory twice per month to ensure that refunds are posted timely.
- f. The Claims Research Supervisor monitors the Open Payables Report.

D. The Plan will not offset an overpayment of a claim against a non-contracted 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)
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