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*Practice Groups:**Health Care**Commercial Disputes**Insurance Coverage*

Health Care Providers Can Fight Back Against Insurer Recoupment Demands Using ERISA

By Lauren Garraux

In the daily skirmishes between health care providers and payors, this scenario is not uncommon: A health care provider renders services to a patient and submits a reimbursement claim to the patient's insurer. The insurer pays the claim. Weeks or months after the claim is paid, the provider receives a letter from the insurer stating that the claim was improperly paid and demanding repayment of the allegedly overpaid amount. When the provider refuses to voluntarily return the amount the insurer claims it overpaid, the insurer "recoups" that amount by refusing to pay the provider for future claims submitted on behalf of other patients or unrelated services.

Post-payment audits and recoupment demands have become commonplace in today's health care environment. While provider agreements between in-network providers and insurers generally contain dispute resolution procedures that afford providers an opportunity to appeal insurers' overpayment determinations, out-of-network providers — which lack such agreements — often are not afforded such a process.

In recent years, both in- and out-of-network providers have fought back against insurers' recoupment demands using the Employee Retirement Income Security Act of 1974 (ERISA). In many cases, they have been successful.

Recoupment of Prior Payments

An insurer generally initiates the recoupment process through a letter to the provider stating that the insurer overpaid the provider on one or more past claims and demanding immediate repayment of the amount allegedly overpaid. The insurer may not provide a reason why it believes the provider was overpaid, or, if a reason is given, the justification often does not dispute that the services actually were provided.

The insurer also may not detail how it calculated the overpayment amount, including whether it used sampling and extrapolation. Through sampling and extrapolation, the insurer considers only a small sample of prior claims and then extrapolates the alleged overpayments to other claims that the provider submitted over a period of several years without actually considering those claims or reviewing related medical records.

The provider may be given a short amount of time — sometimes days — to make arrangements to voluntarily repay the alleged overpaid amount. If the provider does not do so, the insurer simply offsets the amount against future claims that the provider submits on behalf of other patients and for other services. Often, an out-of-network provider is given no due process, and there is no judicial or administrative procedure offered for reviewing the validity of the insurer's position. If any review procedure is offered, the insurer generally handles the review through an internal audit department, special investigations unit, or in-house legal department. As noted, in-network providers have the process for contract disputes afforded in the provider agreement.

Health Care Providers Can Fight Back Against Insurer Recoupment Demands Using ERISA

Provider Challenges to Recoupments

The question thus becomes how does a provider — particularly one that is out-of-network — fight back against insurer recoupment demands? A growing body of caselaw indicates that providers may be able to challenge insurer recoupments under ERISA through the procedures afforded to plan participants.

ERISA grants a plan participant or beneficiary certain procedural protections when an ERISA plan issues an “adverse benefit determination” (ABD), which is defined broadly to include “a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part). . . .” See 29 C.F.R. § 2560.503-1(m)(4). Specifically, upon issuing an ABD, the plan must both:

- (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.

29 U.S.C. § 1133. The regulations further expand on these requirements and provide that when an administrator makes an ABD, it must provide written notification “in a manner calculated to be understood” by the recipient, including the following: (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 (iv) any internal rule, guideline, protocol, or other similar criterion [that] was relied upon in making the adverse determination. See 29 C.F.R. § 2560-503.1(g)(1)(i)–(v).

Courts have described these requirements as “baseline procedural protections” that “insure that when a claimant appeals a denial to the plan administrator, [she/he] will be able to address the determinative issues and have a fair chance to present [her/his] case.” *DiGregorio v. Hartford Comprehensive Emp. Benefit Serv. Co.*, 423 F.3d 6, 14 (1st Cir. 2005) (citations omitted). These protections are also important because they may permit the resolution of claims without the need for judicial intervention. *Id.*

In the past few years, courts have extended the definition of ABD to include insurer recoupment demands, a move that is significant in that it grants ERISA’s procedural protections to providers who receive those demands. See, e.g., *Premier Health Ctr., P.C. v. UnitedHealth Grp.*, No. 11-425 (ES), 2014 WL 4271970, at *29 (D.N.J. Aug. 28, 2014) (“[T]he Court agreed with Plaintiffs in this case [in- and out-of-network providers], that any and all repayment demands constitute ABDs under ERISA and therefore must comply with ERISA’s notice and appeal requirements.”); *Blue Cross & Blue Shield of Rhode Island v. Korsen*, 945 F. Supp. 2d 268, 282–83 (D. R.I. 2013) (insurer’s repayment demand entitled in-network providers to ERISA’s procedural protections); see also *Wright v. Hartford Life & Accident Ins. Co.*, No. 5:14-CV-00126-RLV-DSC, 2015 WL 4488656, at *5 (W.D.N.C. July 23, 2015)

Health Care Providers Can Fight Back Against Insurer Recoupment Demands Using ERISA

(insurer's "reduction of Plaintiff [enrollee's] benefits, whether justified by the policy or not, constitutes an adverse benefit determination subject to [ERISA's] notification requirements"); *UNUM Life Ins. Co. of Am. v. Zaun*, Civil No. 13-1214 (MJD/TNL), 2014 WL 3630340, at *6, 7 (D. Minn. May 29, 2014) (letter to enrollee seeking payment for alleged overpayment was an ABD); *Fanelli v. Cont'l Cas. Co.*, Civil No. 1:06-CV-0141, 2006 WL 4318721, at *1, 5 (M.D. Pa. Sept. 13, 2006) (letter informing enrollee that insurer had overpaid benefits was an ABD); *Cherene v. First Am. Fin. Corp. Long-Term Disability Plan*, 303 F. Supp. 2d 1030, 1036 n.1 (N.D. Cal. 2004) (insurer's claim for reimbursement is an adverse benefit determination that triggers ERISA's procedural protections). For in-network providers, courts have also indicated that ERISA's procedural protections may be available in addition to the procedures set forth in their provider agreements. See, e.g., *Korsen*, 945 F. Supp. 2d at 283 (explaining that the insurer's "failure to provide Dr. Korsen and Barlow with any meaningful review process, given the procedures specified by ERISA and included in their own Providers Agreements, was also unjust.").

Using ERISA, providers have recovered amounts withheld with respect to unrelated claims through lawsuits they have filed based on assignments of benefits from their patients.¹ See, e.g., *Korsen*, 945 F. Supp. 2d at 283 (ordering insurer to return to providers amounts unrelated to contested claims that insurer withheld because providers "did nothing wrong"). Courts have also indicated that a provider may be able to recover other amounts, including attorneys' fees and costs. *Id.* at 283–84 (ordering further briefing regarding whether providers were entitled to attorneys' fees and noting that courts have "leeway to fashion an appropriate remedy" when sitting in equity on an ERISA case).

Conclusion

A provider's ability to challenge an insurer's recoupment demand may depend on a number of factors, including, among others, whether the provider has a valid assignment of benefits from the patient-participant, details underlying the insurer's overpayment determination, the contract between the provider and the payor, if any, and potential fault or misconduct by the provider. Nonetheless, when a provider is confronted with a payor recoupment decision, the provider should consider whether it can challenge the decision through ERISA.

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¹ A provider's ability to bring an ERISA claim based on a patient's assignment of benefits is addressed [here](#).

Health Care Providers Can Fight Back Against Insurer Recoupment Demands Using ERISA

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