# Just Say No to Insurance Company Requests for Overpayments- Part Two

When the insurance companies send you a "request" for repayment of an overpayment -
JUST SAY NO!

In the first "Just Say No" article a sample letter was included for the CPMA membership to use when a letter is received demanding repayment of an "overpayment." Following publication of that article I received several phone calls asking what to do when the insurance company responds with a letter stating they have or will deduct the amount of the overpayment from other current or future earnings.

Here is a more complete response you may wish to use when you receive one of these demands. But please note I am not interested in representing doctors against insurance companies regarding overpayments. My practice is limited to the representation of doctors regarding denied payments.Therefore, I am only offering this letter to my CPMA colleagues as a form of response you may wish to use. And yes, this research was done, and a slightly different version of this letter was written, on behalf of an out-of-state podiatrist with whom I have been friends for more than 30 years. It worked for him and I hope it works for you. Here it is.

> I am a contracted provider with ___________ Insurance Company. I accepted assignment for the services provided to (name of patient) on (date of service). The services billed were provided as stated on the claim form. I made no misrepresentation to ___________ Insurance Company to induce this payment, and had no notice of any ___________ Insurance Company mistake at the time payment was made. Therefore, based on these facts and based on prevailing case law in California as stated in City of Hope Medical Center v. Superior Court. 8 Cal. App. 4th 633 (1992), I am respectfully declining your request for repayment.
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> In City of Hope (Supra), recovery was denied to an insurance company who sought reimbursement of payments it had made to a hospital before the insurer determined that there was no coverage in its policy for the patient's medical treatment at the hospital. The Court decided that "in the absence of fraud, an insurer may not recover

from a health care provider payments made under the mistaken belief that the patient's treatment was covered under a policy issued by the insurer to the patient." The hospital did not have to repay the insurance company for the mistaken payments.

This case emphasized that while "unjust enrichment" permits restitution when a payment is made based on a bona fide mistake of fact, it should be denied when the payment is made to a bona fide creditor of a third person [the health care provider] — a creditor without fault, who had made no misrepresentation and was not on notice the payment had been made by mistake at the time it was made. If the health care provider disclosed all material facts in connection with presenting the claim to the insurer and received payment without knowledge of the insurer's mistake, the insurer has no claim for equitable restitution. If there was no fraud or misrepresentation by the health care provider, there was no duty to repay the insurance company for its mistaken payments.

In Nebraska, a widely known case arrived at the same conclusion in a similar situation. An insurance company overpaid the hospital but could not recover the difference between the policy coverage and the patient's paid bill, because the overpayment was due solely to the insurance company's mistake and lack of care. The hospital had made no misrepresentation to induce payment, and the hospital had acted in good faith in receiving the overpayment. The Supreme Court of Nebraska explained why this was the correct result in Federated Mut. Ins. Co. v. Good Samaritan Hosp., 191 Neb. 212 (1974). The Court noted that the widespread use of assignments of policy benefits to health care providers by patients is well known and is recognized by the health insurance industry. To subject a health care provider to possible refund liability if the insurer later discovers a mistaken overpayment, would be to place an undue burden on the provider. The burden of determining the limits of the policy is squarely on the insurance company because it is the one in the position to know the policy provisions and the extent of its coverage obligations.

In Texas, the Appellate Court ruled in favor of a health care provider in an action brought by an insurance company for reimbursements of payments mistakenly made after the expiration of coverage. As between those two innocent parties, the loss was placed on the one who created the situation — the insurance company — as it was in the best position to have avoided it. Lincoln Nat. Life Ins. Co. v. Brown Schools, 757 SW2d 411(Tex. App. 1988).

Across the country in Mississippi, the United States District Court again relied on the Restatement of Restitution as well as on a respected commentator, S. Williston, in his treatise on contract law, and reached the same decision that the health care provider did not need to repay the insurance company for mistaken payments. That Court wrote that the widely-recognized exception to the general

rule is that restitution may not be had in cases in which the mistaken payment is made to an innocent third-part creditor, that is, one who had made no misrepresentations and had no knowledge of the mistake when he accepted payment. The insurance company created the situation and it was in the best position to have avoided it, so the insurance company had to bear the loss. The health care provider was "an innocent third party creditor." National Benefit Admin. v. Mississippi Methodist Hospital, 748 F. Supp. 459 (S.D. Miss. 1990).

So, the law protects innocent doctors from being forced to repay mistaken payments made by insurance companies. Based on the Restatement of the Law of Restitution, the rule commonly used is that doctors don't have to repay overpayments that the insurance companies made by mistake, as long as the doctor made no misrepresentation concerning the mistake, and the doctor had no notice of the mistake when accepting payment. This is fair policy because between the two innocent parties, the insurance company and the doctor, the insurance company is the one in the position to have known the policy coverage, it created the mistake, and it was in the best position to have avoided it. The doctor actually provided the medical services, and was a bona fide creditor.

Please note this _______________ Insurance Company demand for reimbursement of this alleged "overpayment" is being contested within thirty days of receipt of the notice of overpayment. As a result, _______________ Insurance Company must process this contested notice of overpayment of a claim as a provider dispute pursuant to the Department of Managed Health Care, Title 28, Sections 1300.71(d)(4) and 1300.71.38(a)(1). _______________ Insurance Company may not offset the alleged "overpayment" amount from other current or future benefits to which I am entitled. Enclosed please find a copy of the _______________ Insurance Company notice of overpayment confirming this less than thirty days response time.

Because my contract with _______________ Insurance Company, written by _______________ Insurance Company, specifically requires arbitration of all provider fee disputes, you may certainly file for arbitration regarding this fee dispute. However, if _______________ Insurance Company unlawfully pursues collection of this alleged "overpayment" through a collection company, or if _______________ Insurance Company deducts this alleged "overpayment" from other current or future benefits to which I am entitled, I may pursue all available causes of action against _______________ Insurance Company for bad faith conduct and for violation of the arbitration requirement - as spelled out in my _______________ Insurance Company provider contract.

If you correctly decide to drop this request for overpayment, I would greatly

appreciate a note stating so. If you decide to prosecute collection in this case please send my copy of the 'demand for arbitration' to this office.

Respectfully,

As a post script, it costs $500 to file a case with the American Arbitration Association and approximately $3000-$5000 a day for the arbitration itself. The purpose of this letter is to let the insurance company know why they are pursuing a loser case before they get started. Rest assured, any insurance company is going to weigh the expense of arbitration and the likelihood of winning against the amount of money they are trying to collect. When the applicable law goes against the insurance company, as is the case with overpayments, and when the amount of money demanded is small, it would be foolish for an insurance company to waste resources fighting this losing fight.

And one last word of caution, the citation to the Department of Managed Health Care, Title 28, Sections 1300.71(d)(4) and 1300.71.38(a)(1) is bullet proof only if the offending insurance company (PPO plan) is Blue Cross or Blue Shield of California. If the demand for repayment of an alleged "overpayment" comes from another insurance company, then these statue sections would be very persuasive to a court but not absolutely binding, as would be the case when the offending company is Blue Shield or Blue Cross of California.

Good luck and by all means, call if you have a question. Two last unrelated thoughts: If you are getting denials for strapping and injections performed at the same office visit - call me. If you are using consultation codes instead of the assistant surgeon's -80 modifier for osteotomy bunionectomy assistant surgeon's fees - because you are afraid you won't get paid otherwise — call me. I can help and there is no reason you should have to take this nonsense.

Written by David Mullens, D.P.M., J.D. published in the California Podiatric Physician October/November/December 2004 as "When the insurance companies send you a "request" for repayment of an overpayment - JUST SAY NO!"

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