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# 412 - Claims Reprocessing

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Staff responsible for policy: DHCM Operations

## I. Purpose

This policy establishes requirements to be followed by all Acute Care, Behavioral Health Services (BHS), Arizona Long Term Care System Elderly and Physically Disabled (ALTCS/EPD), Children's Rehabilitative Services (CRS), Comprehensive Medical and Dental Program (CMDP) and ALTCS Division of Developmental Disabilities (DDD) Contractors for recoupment and refund activities.

## II. Definitions

**Day** Calendar day unless otherwise specified.

**Provider** Any person or entity who submits a claim and receives payment for the provision of covered services to members pursuant to the provisions A.R.S. §36-2901 et seq. or any subcontractor of a Provider delivering such services. For the purposes of this policy, a Provider shall be further defined as all individuals associated by the same Tax Identification Number utilized for claiming purposes.

**Recoupment** An action initiated by the Contractor to recover all or part of a previously paid claim(s). Recoupments include Contractor initiated/requested repayments as well as overpayments identified by the Provider where the Contractor seeks to actively withdraw funds to correct the overpayment from the Provider. For purposes of this policy, a recovery and subsequent repayment of a claim(s) with a differential greater than $50,000 that is not completed within 30 days from the date of the recovery would be considered a recoupment. A recovery and subsequent repayment(s) of a claim with a differential greater than $50,000 that is completed within 30 days from the date of the recovery is not considered a recoupment. However, the Contractor must report such repayments to AHCCCS on a quarterly basis. The information must include the AHCCCS Member ID number, date of service, original claim number, date of payment, amount paid, amounts recovered and subsequently repaid, and dates of recovery and repayment.

**Refunds** An action initiated by a Provider to return an overpayment to a Contractor. In these instances the Provider writes a check or transfers money to the Contractor directly.

## III. Policy

### A. Single Recoupments in Excess of $50,000

Prior to initiating any single recoupment in excess of $50,000 per Provider Tax Identification Number (TIN), the Contractor must submit a written request for approval to the assigned AHCCCS Operations and Compliance Officer at least thirty (30) days prior to initiating the recoupment, or earlier if the information is available, in the format detailed below:

1. A detailed letter of explanation must be submitted that describes:

   a. How the need for recoupment was identified
   b. The systemic causes resulting in the need for a recoupment
   c. The process that will be utilized to recover the funds
   d. Methods to notify the affected Provider(s) prior to recoupment
   e. The anticipated timeline for the project
   f. The corrective actions that will be implemented to avoid future occurrences
   g. Total recoupment amount, total number of claims, range of dates for the claims being recouped, and total number of Providers impacted
   h. Other recoupment action specific to this Provider within the contract year

2. An electronic file containing the following:

   a. AHCCCS Member ID
   b. Date of Service
   c. Original Claim Number
   d. Date of Payment
   e. Amount Paid
   f. Amount to be Recouped

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3. A copy of the written communication that will serve as prior notification to the affected Provider(s). The communication must include a minimum:

    a. How the need for the recoupment was identified
    b. The process that will be utilized to recover the funds
    c. The anticipated timeline for the recoupment
    d. Total recoupment amount, total number of claims and ranges of dates for the claims being recouped
    e. Listing of impacted claim CRNs

   The written communication must be approved by AHCCCS prior to being sent to the Provider(s).

**B. Recoupment of Payments Initiated More than 12 Months from the Date of Original Payment**

The Contractor is prohibited from initiating recoupment of monies from a Provider TIN more than 12 months from the date of original payment of a clean claim unless approval is obtained from AHCCCS. Retroactive Third Party Recoveries are not included in this discussion.

To request approval from AHCCCS, the Contractor must submit a request in writing to the assigned AHCCCS Operations and Compliance Officer with all of the following information:

1. A detailed letter of explanation must be submitted that describes:

    a. How the need for recoupment was identified
    b. The systemic causes resulting in the need for a recoupment
    c. The process that will be utilized to recover the funds
    d. Methods to notify the affected Provider(s) prior to recoupment
    e. The anticipated timeline for the project
    f. The corrective actions that will be implemented to avoid future occurrences
    g. Total recoupment amount, total number of claims, range of dates for the claims being recouped, and total number of Providers impacted

2. An Electronic file containing the following:

    a. AHCCCS Member ID
    b. Date of Service
    c. Original Claim Number
    d. Date of Payment
    e. Amount Paid
    f. Amount to be Recouped

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3. A copy of the written communication that will serve as prior notification to the affected Provider(s).

## C. Cumulative Recoupments in Excess of $50,000 per Provider per Contract Year

Contractors must continuously track recoupment efforts per Provider TIN. When recoupment amounts for a Provider TIN have or are forecasted to cumulatively exceed $50,000 during a contract year (based on recoupment date), the Contractor must notify the assigned AHCCCS Operations and Compliance Officer at the time total recoupments are anticipated to exceed $50,000 with all of the following information:

1. A detailed letter of explanation that describes:

    a. How the need for recoupment was identified
    b. The process that will be utilized to recover the funds
    c. Methods to notify the affected Provider(s)
    d. Cumulative recoupment amount, total number of claims and range of dates for the claims being recouped

## D. AHCCCS Responsibility and Authority

AHCCCS reserves the right to evaluate and to present the proposed recoupment action to the affected Providers as part of the approval and or notification process. Communication will be at the timing and discretion of the Agency.

The AHCCCS Division of Health Care Management (DHCM) will review all requests for recoupment, evaluating such factors as validity, accuracy, and efficiency of Contractor processes. DHCM will also evaluate the proposed recoupment for the purposes of minimizing provider hardship or inconvenience. DHCM will acknowledge all requests in writing through electronic mail upon receipt of the completed file. A written determination will be sent to the Contractor by electronic mail no later than 30 days from the date of receipt of all required information from the Contractor. Any request to which no response is sent within the 30 day timeframe above will be deemed approved by DHCM.

## E. Data Processes for Recoupment

Upon receipt of approval for recoupment from AHCCCS, the Contractor shall have no more than 120 days to complete the project and submit the following to the assigned AHCCCS Operations and Compliance Officer:

1. Voided or replacement encounters (which must reach adjudicated status) and the appropriate associated information for all impacted encounters for recouped claims;

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2. Upon completion of the recoupment project, an electronic file containing all of the following information for all recouped claims:

   a. AHCCCS Member Identification number
   b. Date of Service
   c. Original AHCCCS CRN
   d. New AHCCCS CRN
   e. AHCCCS Allowed amount
   f. Health Plan Allowed amount
   g. Health Plan Paid amount
   h. Provider Identification Number

   The Contractor must submit the above information for each adjudicated encounter.

- Dependent on the size and/or volume of the recoupment request, AHCCCS may require the Contractor to submit an external file in order to directly update impacted encounters in the timeframe prescribed above. See ACOM Draft Policy, Coordination of Benefits/Third Party Liability for more information on external file processing.

  Failure to submit complete information within the specified timeframe will be considered a violation of the contract and may result in compliance action. AHCCCS will validate the submission of applicable voided and replacement encounters upon completion of this project. As a result of amending the encounter data, AHCCCS may adjust related reinsurance payments, reconciliation payments, or any other amounts paid to the Contractor that are impacted by the recoupment.

**F. Data Processes for Refunds**

Upon receipt of refund from a Provider, the Contractor shall have 120 days from the date of the refund to void or replace related encounters. All voided or replaced encounters must reach an adjudicated status within the 120 days timeframe.

The Contractor must also be able to identify the following for all refunds received and provide this information to AHCCCS upon request:

a. The systemic causes resulting in the need for the refund and/or an explanation of why the refund occurred
b. The corrective actions that will be implemented to avoid future occurrences, if applicable
c. Cumulative refund amount, total number of claims and range of dates for the claims impacted by the refund
d. List of impacted claim CRNs

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**G. Attestation**

All documentation and data submitted by the Contractor for purposes of recoupment and refund activities must be certified by the Contractor as specified in the Medicaid Managed Care Regulations 42 CFR 438.600 et seq.. If it is determined after the recoupment or refund action that information provided to AHCCCS is inaccurate, invalid, or incomplete, or that the Contractor failed to comply with any provision of this policy, the Contractor may be subject to corrective action, up to and including sanctions under the Sanctions paragraph of the contracts.

## IV. References

- Title 42 of the Code of Federal Regulations Part 438 Subpart H, 42 CFR 438.600 et seq.
- A.A.C. R9-22 Article 7 (R9-22-701 et seq.)
- A.A.C. R9-28 Article 7 (R9-28-701 et seq.)
- Acute Care contract, Section D
- ALTCS EPD contract, Section D
- CMDP contract, Section D
- BHS contract, Section D
- CRS contract, Section D
- A.R.S. §36-2923
- Deficit Reduction Act of 2005 (Public Law 109-171)
- ACOM Draft Policy, Coordination of Benefits/Third Party Liability

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