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Table of Contents

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—from a declaration of the American Bar Association

HIPAA Litigation over the Past Decade

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When the Health Insurance Portability and Accountability Act (HIPAA) was enacted, a violation by a covered entity was to result in civil or criminal penalties and was to be handled by the Department of Health and Human Services (HHS). Thus, HIPAA does not specifically provide for a private right of action for those who assert that their protected health information has been unlawfully disclosed… or does it? Over the past decade, a variety of state courts have allowed private individuals to successfully litigate general negligence claims citing the Security and Privacy Rules.

The first notable claim to successfully apply this theory occurred in 2006 in North Carolina, *Acosta v. Byrum*, involving an employee and a psychiatric patient.[1] The patient alleged the psychiatrist allowed the employee access to the patient's confidential psychiatric and medical records. The patient filed suit in state court and alleged invasion of privacy and emotional distress. The court noted the patient did not bring a specific claim under HIPAA but used the Act as the applicable standard of care owed by the physician to the patient and, ultimately, ruled the doctor breached this duty by providing his access code to his employee.

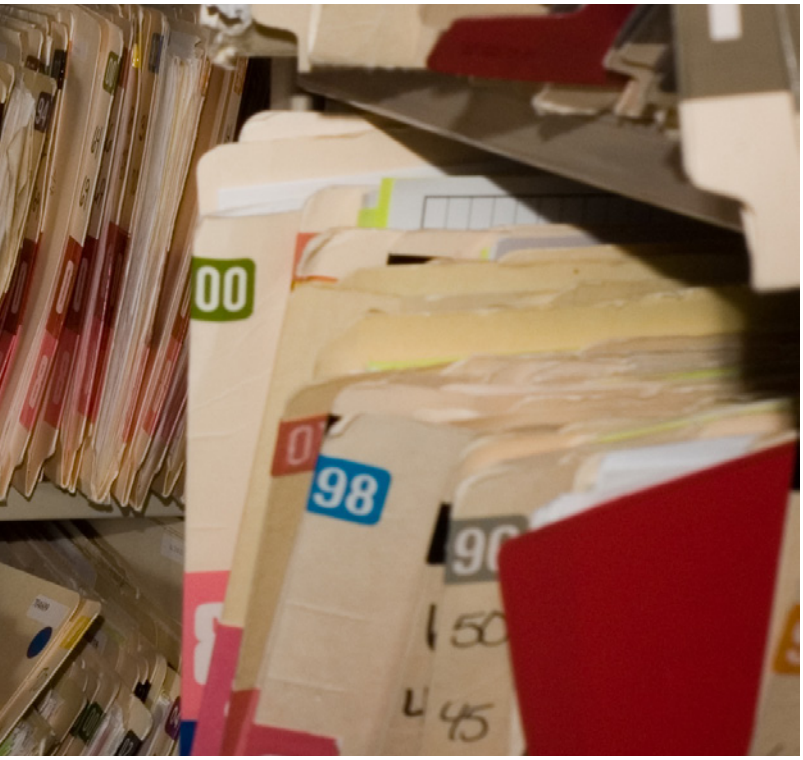
The next notable claim took this theory one step further. The Connecticut Supreme Court tested the negligence theory in *Byrne v. Avery*.[2] In this case, the plaintiff sought to recover damages from the provider for negligence and negligent infliction of emotional distress for the defendant's failure to properly comply with a subpoena served as part of a paternity suit. In response to the defendant's summary judgment motion, the court ultimately held that "to the extent that Connecticut's common law provides a remedy for a health care provider's breach of its duty of confidentiality in the course of complying with a subpoena, HIPAA does not preempt the plaintiff's state common-law causes of action for negligence or negligent infliction of emotional distress against the health care providers in this case and, further, that HHS regulations implementing HIPAA may inform the applicable standard of care in certain circumstances."[3] Of note, *Byrne* likely became the basis for class action plaintiffs to argue that other federal privacy statutes that lack a private right of action should be applied as standards of care for state law claims.

Indiana followed this trend when the Indiana Court of Appeals issued an opinion in *Walgreen Co. v. Hinchy*, upholding a $1.4 million dollar verdict where the plaintiffs successfully argued that an employer is subject to vicarious liability for the negligence of an employee who committed a HIPAA violation.[4] The court held "the pharmacist was authorized to use the computer system and printer, handle prescriptions for customers, look up customer information on the computer system, review patient prescription histories, and make prescription-related printouts. Hinchy was at work, on the job, and using equipment when the actions at issue occurred."[5] Thus, the court held the theory of respondeat superior was applicable because the pharmacist's "conduct was of the same general nature as her ordinary job duties, and much of her conduct was of the same general nature authorized by her employer."[6]

The *Hinchy* decision reinforced the fact that employers can potentially limit exposure by not only providing detailed HIPAA training and education but by taking swift disciplinary action if an employee commits a violation. For example, in *Robbins v. Clarion*, the Indiana Court of Appeals effectively limited *Hinchy*'s reach on vicarious liability claims for an employee's bad behavior, and, in doing so, relied upon the hospital's written privacy and confidentiality policies in support of its ruling.[7] Specifically, the court in *Robbins* noted that the hospital's employee signed the facility's Commitment of Confidentiality Agreement in which she agreed she would only access, use, read, add, change, delete, or disclose information for which she had a business reason and was authorized to do so. She had also agreed that at no time would she access, use, or disclose confidential or sensitive information to any person or third-party for a personal, unauthorized, unethical, or illegal reason. In addition, the nurse stated in her affidavit that she inappropriately accessed the plaintiff's medical records "for personal reasons" and not as part of her course or scope of her employment by the university. The nurse also admitted that there was no legitimate business reason for her to access the records and explained that her sole motivation was personal.

In addition to the common law negligence theories discussed above, plaintiffs have used these theories to bring a variety of class action claims resulting from HIPAA breaches. Following a breach of unsecured protected health information affecting 500 or more individuals, covered entities must provide notification of the breach to affected individuals, HHS, and, in certain circumstances, to the media. These individual notifications must be provided without "unreasonable delay" and in no case later than 60 days following the discovery of a breach. For those under the magic 500 figure, the covered entity must notify HHS of the breach within 60 days of the end of the calendar year in which the breach was discovered. 45 CFR §§ 164.400-414[8]. On its face, this seems like a reasonable feat to accomplish; however, insuring thousands and possibly millions of patients receive proper notification can be a daunting task as well as an opportunity for class action claims.

In that same light, a federal court dismissed the majority of fraud claims in *In re Premera Blue Cross Customer Data Security Breach Litigation*; however, the court allowed the



complaint to be re-filed with more definite allegations.[9] In that matter, the alleged breach went undetected for nearly a year and involved the sensitive information of approximately 11 million members and employees, including names, dates of birth, social security numbers, member I.D. numbers, contact information, medical claims information, financial information, and other protected health information. The lawsuit alleged Premera was negligent in its data security practices and failed to honor the promises of confidentiality in its HIPAA privacy notice. The amended complaint further alleged that, upon discovering the breach, Premera actively and fraudulently concealed the breach for several months before taking remedial action and notifying those affected. Recently, the Oregon federal judge concurred with the plaintiffs and agreed that the plaintiff's revised fraud allegations were sufficiently specific that its privacy notice, code of conduct, and other materials provided to consumers actively concealed the laxity of its privacy practices.[10]

Hospital systems must also be prepared for when they are the direct targets of criminal activity. In the current class action lawsuit, *John Doe v. Florida Health Sciences Center Inc. d/b/a Tampa General Hospital*, the plaintiffs alleged the hospital had been negligent for failing to protect patient data; it breached its fiduciary duty, breached an implied contract, and violated Florida's Deceptive and Unfair Trade Practices Act.[11] The class action claimed that, beginning in May 2014, the hospital had actual or constructive knowledge that unknown individuals wrongfully accessed and obtained plaintiff's and class members' protected health information (PHI) and personally identifiable information (PII) in defendant's possession, which included names, addresses, dates of birth, Social Security numbers, admitting diagnoses, and insurers. The lawsuit listed several instances of data theft at the hospital over a three year period, including an incident in 2014 that was exposed by local law enforcement. The individual arrested for the theft was not a hospital employee but had allegedly obtained the data from a hospital employee. From the HIPAA perspective, the class action focused on allegations the Hospital failed to put into place the proper technical safeguards required by CMS to protect its patient's personal information from being disseminated, in this case, by rogue employees and identity thieves.

While it appears HIPAA litigation is on the rise, many challenges remain for plaintiffs to show concrete "injury in fact" to obtain standing to bring a claim in federal court. Plaintiffs also face an uphill battle in state court proceedings to prove the covered entity's negligence and if compensable harm is warranted. All this aside, the greater risk remains in various federal and state enforcement agencies, which have successfully collected several multi-million dollar enforcement actions in the past few years.

The practical takeaways to avoid potential litigation are to confirm the covered entity has completed a privacy and security assessment and has up to data network security, including firewalls and encryption. It is necessary to address the covered entity's policies and procedures, which should include HIPAA training as well as disciplinary action for employees who improperly access PHI. It is also a must that the covered entity should have proper business associate agreements in place as well as cyber risk insurance and testing of its cyber response plan, which includes patient notifications and proper response procedures.

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1 *Acosta v. Faber,* 638 S.E.2d 246 (N.C. App. 2006).
2 *Byrne v. Avery Ctr. for Obstetrics and Gynecology P.C.,* 102 A.3d 32, 42 (Conn. 2014).
3 *Id*. at 42.
4 *Hinchy v. Walgreen*, 21 N.E. 3d 99 (Ind. Ct App. 2014).
5 *Id*. at 108.
6 *Id*. at 109.
7 *Robbins v. Trustees of Indiana University*, 45 N.E. 3d 1 (Ind. Ct. App. 2015).
8 45 C.F.R. §§ 164.400-414.
9 *In Re Premera Blue Cross Customer Data Security Breach Litigation*, 198 F. Supp. 3d 1183 (D. Or. 2016).
10 Opinion and Order Granting in Part and Denying in Part Motion to Dismiss, *Colcord v. Premera Blue Cross*, No. 3:2015cv00516 (D. Or. 2016), ECF No. 75.
11 Amended Class Action Complaint, *Doe v. Florida Health Sciences Center Inc. d/b/a Tampa Gen. Hosp.*, Case No. 14-CA-012657 (Fla. Cir. Ct. Feb. 16, 2015).

Applying Data Analytics as a Strategic Tool in Health Care Payment Disputes

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In the same way that tablet devices have changed how we read newspapers, and mobile telephones have changed the way we take pictures, the delivery of legal services has changed in ways that were previously unfathomable. Legal pads are artifacts, law books are obsolete, and large firm overhead is, well, expensive and no longer necessary. Today's law firm is paperless and trial lawyers present their cases to the judge or jury on tablet devices, with do-it-yourself apps.

Over the last few years, data analytics has emerged as a tool for the litigant and counsel alike. Algorithms thread through docket sheets and track case filings, creating statistics that enable in-house counsel to consider the "success rate" of a lawyer, the number of times a litigant has sought affirmative relief or defended similar claims, and calculate probabilities of whether a motion might be granted before a given judge.

This article will explore the application of such technology to health care disputes and how arbitration Neutrals treat such data, including the admissibly of such data in an arbitration proceeding.

Compilation of Litigant Data and Judicial Data

Legal research is no longer simply about finding an appellate decision that, when incorporated into a brief, persuasively moves the judge/arbitrator to accept your legal argument. Rather, today's legal research includes offering *practical* advice to a sophisticated client that can greatly assist in case evaluation and settlement considerations: how has the judge/arbitrator ruled in similar cases? What cases has this health care provider filed before and did the provider prevail? Has this payer denied a particular plan benefit in other jurisdictions? Is there a pattern in the provider's behavior, or payer's behavior, or the judge/arbitrator's behavior that makes the outcome more predictable? Data that existed in PACER and/or state court electronic filing systems is being fed through computers that allow litigants for both payers and providers to better assess the probability of outcomes, which is demanded by clients who themselves face pressure on their litigation budget.

In addition to offering practical value to clients, the compilation of this data is a way to show the potential for bias in the underlying proceeding: a payer that is repeatedly sued in a certain jurisdiction for failing to cover certain mental health benefits may not be covering those benefits "in parity" with the health plan's medical benefits. Likewise, a provider that frequently visits the courts complaining that it is being underpaid may be a marker to payers who either question the need for the billed charges or the appropriate coding of those charges. In the same vein, a payer's provider contracting or network development group may look askance at multiple lawsuits by the provider complaining of underpayments.

Putting aside the data assembled by litigants to assess probabilities of a certain action by the presiding judge or arbitrator, the admissibility of such trending data warrants careful consideration.

Use of Data Compilations or Statistical Analyses in Arbitration Proceedings

As we know, the rules of evidence are relaxed in arbitrations, and much is admitted "for what it's worth" in order to move hearings along. Rule 6.6 of the American Health Lawyers Association Commercial Arbitration Rules is straightforward enough:

> The parties may offer whatever evidence the arbitrator regards as relevant and material to the dispute. …. In determining what evidence to admit, the arbitrator need not follow rules applicable in court proceedings, but should generally permit evidence to be introduced that is relevant, material, and will allow for a fair adjudication of the matter. Unless the parties agree otherwise, the arbitrator should not allow them to introduce information that is determined to fall within an applicable evidentiary privilege.

The American Arbitration Association's Commercial Rule 34 is similar, stating that "[c]onformity to legal rules of evidence shall not be necessary." Most seasoned arbitrators discourage objections based on relevancy, and if counsel goes overboard with such evidence, arbitrators themselves will usually suggest that counsel move on.

Thus, common sense rules apply to evidence in arbitrations. Accordingly, data compilations and statistical analyses *are* admissible in arbitrations *if* they are relevant and material. That is the default. So let us discuss some of the sorts of data compilations and statistical analyses that may be presented in an arbitration proceeding:

Statistical Analyses and Summaries of Large Numbers of Transactions or Data

Such analyses and summaries are often used in payer/provider or other health care disputes where there may be years of claims or other data and accompanying financial information to go through. Experts will analyze such data using their expertise and technology not only to slice and dice the data and summarize the numbers for damages, but also at times to prove liability. In arbitration, this sort of testimony and evidence is quite admissible and is very helpful to the arbitrator. The typical foundations would have to be laid regarding expertise of the witness offering the information, and relevance of the data. The safeguards are that such analyses should be exchanged sufficiently in advance of the arbitration so that they can be analyzed and rebutted by the opposing party's own experts and analyses. There is nothing controversial about such use of data.

Cutting Edge Analytics That Predict Behavior, Actions, or Outcomes

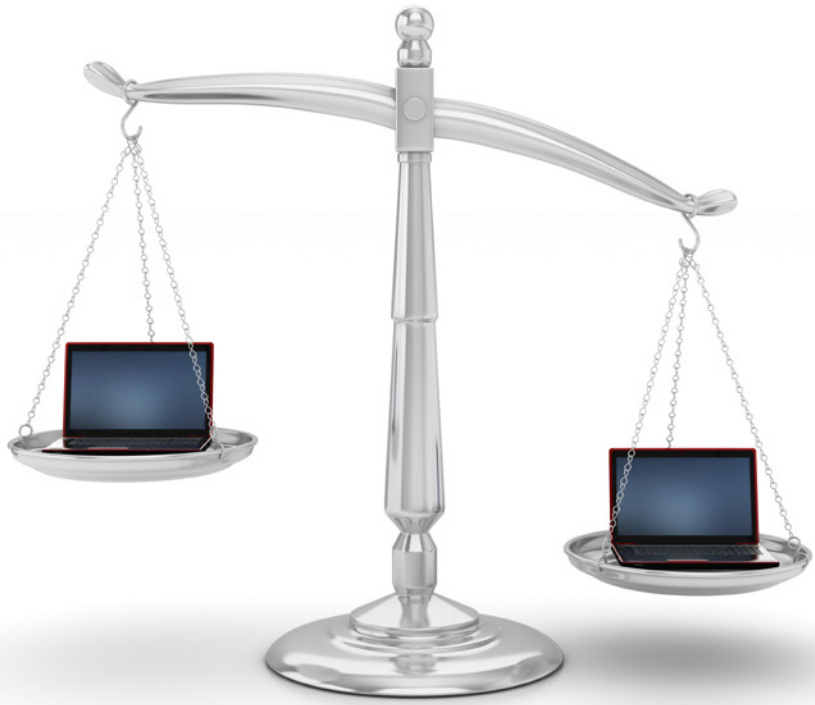
Predictive analyses are used not only in medicine today, but increasingly in litigation and arbitration.

Predicting Arbitrator Actions

When selecting an arbitrator, counsel used to send out memos or emails to colleagues asking what they knew about a panel of prospective arbitrators. The feedback usually was happenstance and greatly colored by anecdotal observations (and of course whether the informant won or lost). Less than perfect. Vendors of these newer analyses use a form of (allegedly) artificial intelligence that looks for patterns, trends, and outliers among arbitrators (and of course judges), selling their analyses as litigation "edges." They tout such individualized information as:

- Relevant subject matter knowledge
- Decisional patterns by specific motion or case
- Discovery allowed
- How long cases might take
- Perceived bias based on decisions or language in other decisions

When counsel is selecting an arbitrator, such information is incredibly valuable, although it must be taken with at least a grain of salt. What an arbitrator has done in the past in a similar, but not on all points identical, case is not necessarily a predictor of future behavior by that arbitrator. But it's better than nothing, which is what practitioners usually have today. Also, while there may be significant data for judges, there will be far less for arbitrators given that most arbitral decisions are not published, and many are confidential.



Some vendors claim that the "human element" can increase wine rate, but one should be cautious of such claims. What the term "human element" means is anyone's guess, and it is questionable how a vendor could ever measure a causal relationship between use of such data and an increased winning percentage. But if the stakes are high enough, use of such analyses is tempting, and parties and counsel do not like to leave stones unturned.

Predicting What Counsel May Do

Some vendors tout compilations that predict behavior of lawyers, using what such lawyers did in other, similar matters as a predictor of what they will do in the instant matter. This may include success rate, litigation strategy, and the like. Again, such information would be much more available in court litigation than for arbitrations, but lawyers often act similarly in arbitrations as they do in court litigation (they call that "litigation envy"), so such information might be predictive.

In-house counsel might use such data when picking a lawyer or firm to represent the client in a particular matter. Information such as experience in similar cases or subject matter or the industry would be very helpful. Win-loss information searches are inevitable, but that information alone seldom tells the tale accurately. And most cases, whether court litigation or arbitration, are settled before trial or hearing anyway.

Perhaps such data might be useful to counsel when considering arbitration strategy, although spending significant sums of money to predict how opposing counsel will handle an arbitration seems excessive. That is determined quickly enough and is usually quite predictable.

How Neutrals View Statistical Compilations That Predict Behavior of a Party or Counsel

No competent lawyer would attempt to introduce compilations or analyses regarding opposing counsel (success rate; criticism in opinions; industry or subject matter knowledge; etc.) in an arbitration. The same is true for compilations of information or results from other (perhaps similar, perhaps not) cases involving a party to the arbitration. For an arbitrator to even consider such as evidence might give rise to a claim of evident bias, grounds for appeal in most jurisdictions.

What about use of such a compilation using past activity of a party to prove a likelihood that it did the same in the arbitration at hand? That gets a little more interesting, and there are evidentiary rules regarding use of prior bad acts or conduct in other instances to demonstrate a probability of the party doing the same thing in the present arbitration. But again it would depend on many factors, such as how similar the conduct was, was it invariable, etc.

Virtually no seasoned arbitrator would admit such evidence. They would gently but firmly tell counsel to present the facts of *this case*--not some other case.

How Neutrals View Such Compilations Regarding Their Actions or Decisions

Assuming that the data are accurate, neutrals would (or at least should) welcome a fact-based review of their prior actions. Neutrals should support anything that improves not only the reality but also the perception of complete disclosure of information regarding prospective arbitrators, including any perceived biases indicated by prior patterns in decisions or actions. This is little different from searching blogs or publications by prospective arbitrators to cull out biases.

While counsel might be tempted to use such compilations to predict how best to present to an arbitrator on motions, requests for discovery, and the ultimate decision, too much reliance on the past being a predictor of the future has its own risks, and may distract counsel from focusing on the facts and the law and old fashioned persuasive presentations. While one should never ignore pertinent information, reliance on the facts and law of the case at hand rather than perceived biases based on prior conduct seems the better approach.

Conclusion

The days of sitting at large conference tables, surrounded by thick law books, in an effort to develop a legal position have passed. Today's in-house counsel direct their outside trial counsel to develop data on their adversary and the presiding judge or arbitrator, all to assess the best probabilities against a fixed legal spend, keeping in mind that over 95% of all cases settle eventually. The data abounds and can be an extraordinarily useful tool, if not always admissible.

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Key Considerations When Pursuing Overpayment Recoveries

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Recent estimates suggest that Medicare's fee-for-service program overpaid claims by approximately $43 billion in fiscal year of 2015.[1] With overpayment recovery efforts against providers and suppliers yielding as much as an $11 to $1 return on investment,[2] the government and private health plans are making overpayments a bigger focus of their operations. Providers are increasingly facing overpayment claims as defendants and as counterclaims when they bring actions to recover unpaid or underpaid medical claims. While overpayment recoveries should be pursued when appropriate, they should be thoroughly vetted before any action is taken. This article examines recent trends with overpayments, identifies the risks with overpayment claims, and provides insight on how to deal with such claims from both plan and provider perspectives.

Legal and Regulatory Framework

The Affordable Care Act requires providers, suppliers, Medicaid managed care organizations (MCOs), and Medicare Advantage Organizations (MAOs) to report and return overpayments within "60 days after the date on which the overpayment was identified" or on "the date any corresponding cost report is due, if applicable," whichever is later (60-day Rule).[3] According to the Centers for Medicare and Medicaid Services (CMS), the 60-day Rule should give plans and providers "an incentive to exercise reasonable diligence to determine whether an overpayment exists."[4] In addition to the 60-day Rule, MCOs and MAOs are required to establish policies and procedures for overpayments as part of their contracts with the federal or state governments.[5]

Insurers that administer Employee Retirement Income Security Act (ERISA) plans should comply with ERISA's notice and appeal requirements for adverse benefit determinations (ABDs) when recovering overpayments.[6] Further, most states have enacted laws that dictate how and when plans may seek recovery of overpayments.[7]

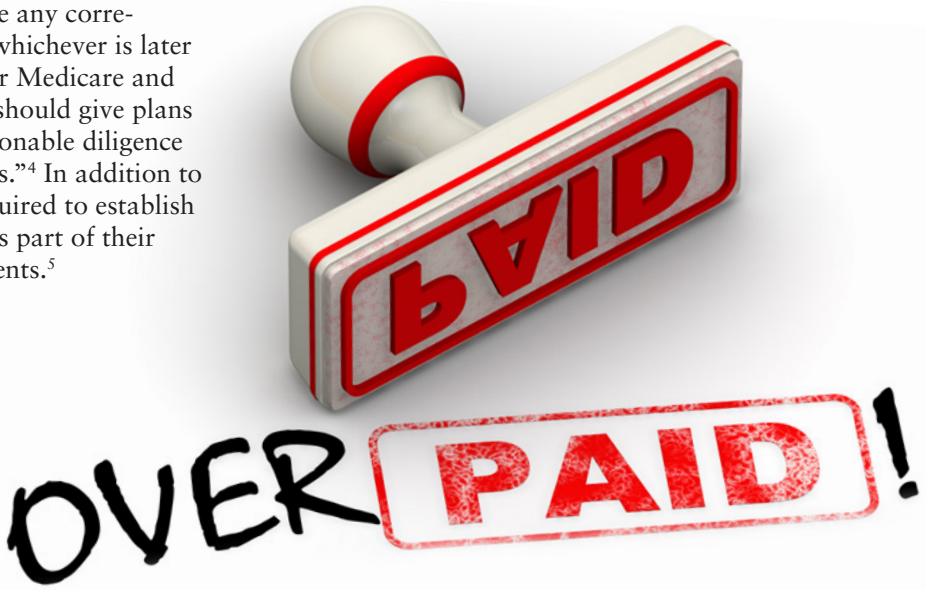
Recent Developments

The trustees in two Chapter 11 bankruptcy cases for RadioShack and Corinthian Colleges are evaluating potential overpayment recovery actions to recover money for the estates. In both cases, the court granted the trustees' requests to audit the companies' health care claims data for former employees and dependents; the trustees hope to locate and recover overpayments from providers for the benefit of creditors.[8] We expect overpayment recoveries to continue in bankruptcies and other areas of the law.

Best Practices for Health Plans

Policies and Provider Manuals

Health plans should have policies and a provider manual that discuss the plan's procedures for overpayment recoveries that are consistent with state and federal law and provider and government contractual requirements. Those procedures should:



1. Require the plan to provide written notice to the provider with a description of the claims at issue and the reason that the plan overpaid the claims;[9]
2. Describe the process for how a provider may challenge or appeal an overpayment determination;
3. Specify the time period in which providers must challenge the overpayment determination; and
4. Specify the time period for which the plan may audit and recoup claims.

Plans should also maintain broad language in their policies and provider manuals that describe their right to audit providers and obtain medical records for review upon request. Including this information in the plan's policies and readily accessible provider manual will not only help ensure compliance with legal and contractual requirements, but also place out-of-network providers on notice of the proper procedures in case of a dispute.

Provider Contracts

Health plans should ensure that their provider agreements include comprehensive requirements that support the plan's right to audit providers and recoup overpayments. These provisions are crucial in the event that a dispute arises between the provider and the health plan. For example, in *Bircumshaw v. State of Washington, Health Care Authority (HCA)*,[10] HCA recouped funds from Dr. Bircumshaw after determining that he had insufficient documentation to substantiate the claims.[11] Bircumshaw challenged HCA's recoupment by alleging, among other things, that HCA was not authorized to recoup overpayments based on his failure to keep adequate documentation for billed services.[12] The parties' contract, which gave HCA the power to audit and recoup funds from Bircumshaw, also provided that Bircumshaw must "keep complete and accurate medical and fiscal records that *fully justify and disclose* the extent of the services…furnished and claims submitted to the department" for six years.[13] The contract further specified that the provider's "*failure to submit or failure to retain adequate documentation* for services billed to the department *may result in recovery of payments for medical services not adequately documented*…"[14] The court determined that under the contract, Bircumshaw was "clearly" required to keep sufficient records that "fully justify" billed services, and his "[f]ailure to submit records fully justifying billed services is grounds for recoupment of money paid for those services under the contract."[15]

A plan's provider agreements should anticipate ways that the plan may seek to recover overpayments, such as a lack of medical necessity, improper coding, and/or a lack of supporting medical documentation, and incorporate specific affirmative obligations on providers that allow recoupment in cases of noncompliance.

Extrapolation

Many health plans use sampling and extrapolation when auditing providers for overpayments. Typically, the plan will audit a sample of the provider's claims, determine the percentage of claims in that sample on which the plan overpaid, and then extrapolate the percentage across all claims submitted by the provider. While extrapolation can be a powerful and time-saving tool, it also carries compliance risks and proof issues if the case goes to trial.

Certain states require the insurer to give the provider written notice of an overpayment that includes the patient name, date of service, and an explanation of the basis of overpayment.[16] Health plans that are considering extrapolation in those jurisdictions must be mindful of these notice requirements. Moreover, at least one state forbids payers from using extrapolation when determining reimbursement, absent certain exceptions.[17]

Plans that intend to or are using extrapolation to identify overpayments must confirm that their methods comply with all applicable laws, regulations, and guidance. They may look to the standards that Medicare Recovery Audit Contractors use to ensure statistically sound methods.[18] For trials, plans and providers should be prepared to handle massive amounts of data and deal with numerous reasons for claims denials and underpayments including authorizations, medical necessity, and coding. Hiring an expert that has experience in coding, data analytics, and claims hearings is crucial.

Third-Party Vendors

Health plans often use third party vendors to assist with various parts of the overpayment recovery process. While third party vendors can be useful, plans should be supervising and confirming that vendors are following their policies, procedures, and applicable law. In *N.C. Dept. of Health and Human Services (DHHS) v. Parker Home Care*,[19] DHHS retained a third party vendor, Public Consulting Group (PCG), to conduct post payment audits of providers.[20] PCG audited a small number of claims from a provider, identified overpayments, and then extrapolated its findings to a larger number of claims.[21] PCG sent letters entitled "TENTATIVE NOTICE OF OVERPAYMENT" (TNOs) that set forth the audit findings and informed the provider of its right to appeal.[22] While North Carolina law allows DHHS to use third party vendors for auditing and overpayment recoveries, a provider is not obligated to appeal a determination until DHHS reaches a "final decision."[23] The court concluded that the language of the TNOs failed to inform the provider that the TNO was a final decision by DHHS and thus denied the claims.[24] The upshot of *Parker Home Care* is that DHHS was unable to recover overpayments from the provider because its vendor failed to follow the applicable law.

Provider Defenses

Know the Law

Most states have laws that require health plans to follow certain procedures when identifying and recouping overpayments.[25] Generally, plans must give notice to the provider before recouping overpayments,[26] and most states prohibit plans from recouping payments more than a specified time after the original payment was made except in limited circumstances, such as fraud.[27] These laws are meant to protect providers from surprising and oppressive recoupments. Providers should be familiar with their local laws and use them during appeals, litigation, and arbitration.

Know the Plan's Contractual Requirements, Policies, Procedures, and Provider Manual

Providers should also be familiar with their contract language, provider manuals, and the relevant plan's policies and procedures for overpayment recoveries and appeals. In *Connecticut Gen. Life. Ins. Co. v. Humble Surgical Hosp., LLC*,[28] the provider defeated the insurer's $5.1 million claim and succeeded on its own counterclaims for over $11 million because (1) the money that the insurer was attempting to recover was paid according to the ERISA plan terms, and (2) the insurer failed to process claims pursuant to the plan's terms.[29] By knowing the plan's contractual requirements and policies and procedures, providers will be in the best position to prevent and defend against overpayment recoveries.

Voluntary Payment Doctrine

The voluntary payment doctrine "preclude[s] actions to recover payments that parties paid voluntarily, with full knowledge of the material facts, and absent fraud or wrongful conduct inducing payment."[30] A federal court interpreting Wisconsin law recently applied the voluntary payment doctrine to bar a health plan administrator's overpayment claim against a health care provider.[31] The court held:

> One of the primary justifications [for the voluntary payment doctrine] is to "allow[ ] entities that receive payment for services to rely upon these funds and to use them unfettered in future activities." [citation]. When a health care provider in good faith treats a patient, bills the patient's health insurer, and receive full payment of the amount billed[,] it may use those funds without having to worry that the insurer will claw them back later because of its own mistakes in processing claims.[32]

Some courts have refused to apply the voluntary payment doctrine where the provider's contract with the plan permits recoupments.[33] Still, providers should explore how courts apply the doctrine in their jurisdictions when defending overpayments.

Conclusion

Plans and providers should consistently be reviewing the applicable law and the relevant contracts, policies, procedures, provider manuals, and guidance that govern overpayments. Such action will help prepare for the growing number of overpayment disputes that we expect to see in the coming years.

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1 Council For Medicare Integrity, 2016 State Of The RAC Program, *available at* http://medicareintegrity.org/wp-content/uploads/2016/03/2015StateOfTheProgram-FINAL.pdf.

2 Department of Health and Human Services, FY 2016 Agency Financial Report, *available at* https://www.hhs.gov/sites/default/files/fy-2016-hhs-agency-financial-report.pdf.

3 42 U.S.C. § 1320a-7k(d); *see* 31 U.S.C. § 3729(a)(1)(G).

4 *See* 77 Fed. Reg. 9179-02 (Feb. 16, 2012).

5 *See, e.g.*, 42 C.F.R. § 438.608; 42 C.F.R. §§ 422.326, 422.504, 423.360.

6 29 C.F.R. § 2560.503-1; *see, e.g., 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); *Fanelli v. Cont'l Cas. Co.*, Civil No. 1:06-CV-0141, 2006 WL 4318721, at *1, 5 (M.D. Pa. Sept. 13, 2006); *see also Premier Health Ctr., P.C. v. UnitedHealth Grp.*, No. 11-425 (ES), 2014 WL 4271970, at *29 (D.N.J. Aug. 28, 2014).

7 *See* Ala. Code § 27-1-17; Alaska Stat. § 21.54.020; Ark. Code § 23-63-1801 *et seq.;* Ariz. Rev. Stat. § 20-3102; Cal. Ins. Code § 10133.66; Colo. Rev. Stat. 10-16-704; D.C. Code § 31-3133; Fla. Stat. Ann. § 627.6131; Ga. Code Ann. § 33-20A-62; 215 Ill. Comp. Stat. 5/368d; Ind. Code § 27-8-5.7-10; Iowa Code § 191-15.33 (Iowa); Ky. Rev. Stat. Ann. § 304.17A-714; La. Rev. Stat. § 22:1838; Me. Stat. tit. 24-A § 4303; Md. Code Ann., Ins. § 15-1008; Mo. Rev. Stat. § 376.384; Mont. Code Ann. § 33-22-150; 210 Neb. Admin. Code Ch. 60 § 011; N.H. Rev. Stat. § 420-J:8-b; N.J. Stat. § 17B:30-48 *et seq.;* N.Y. Ins. Law § 3224-b; Ohio Rev. Code Ann. § 3901.388; Okl. Stat. Ann. tit. 36 § 1250.5; 40 Pa. Cons. Stat. § 3803; S.C. Code Ann. § 38-59-250; Tenn. Code Ann. § 56-7-110; Tex. Ins. Code §§ 843.350, 1301.132; Utah Code Ann. § 31A-26-301.6; Vt. Stat. Ann. tit. 18 § 9418; Va. Code Ann. § 38.2-3407.15; Wash. Rev. Code § 48.43.600; W. Va. Code § 33-45-2.

8 Vince Sullivan, *RadioShack Can Audit United HealthCare Claim Information,* Law360 (Feb. 8, 2017), https://www.law360.com/articles/889776/radioshack-can-audit-united-healthcare-claim-information; Matt Chiappardi, *Corinthian Ch. 11 Estate Can Access Health Provider Info,* Law360 (Oct. 13, 2017), https://www.law360.com/articles/850996/corinthian-ch-11-estate-can-access-health-provider-info.

9 Some states have specific requirements for what information must be included in the notice. *See supra* note 7; *infra* note 16.

10 194 Wash. App. 176 (2016).

11 *Id.* at 185.

12 *Id.* at 183.

13 *Id.* at 193-94 (emphasis in the opinion).

14 *Id.* (emphasis in the opinion).

15 *Id.* at 194.
16 *See, e.g.,* Cal. Ins. Code § 10133.66(b); N.Y. Ins. Law § 3224-b(b); S.C. Code Ann. § 38-59-250(A); Vt. Stat. Ann. tit. 18 § 9418(h).
17 N.J.S.A. §§ 26:2J-8.1d(10), 17b:27-44.2d(10).
18 *See* 42 U.S.C. § 1395ddd(f)(3); *see also generally* the Medicare Program Integrity Manual.
19 784 S.E.2d 552 (N.C. Ct. App. 2016).
20 *Id.* at 553-54.
21 *Id.*
22 *Id.*
23 *Id.* at 561 (citations omitted).
24 *Id.* at 560-62.
25 *See supra* note 7.
26 *Id.*
27 Ala. Code § 27-1-17(f) (18 months); Ark. Code Ann. § 23-63-1802 (18 months); Ariz. Rev. Stat. Ann. § 20-3102(I) (1 year); Cal. Ins. Code § 10133.66(b) (365 days); Colo. Rev. Stat. 10-16-704(4.5)(b) (12 months); D.C. Code § 31-3133(a) (18 months for coordination of benefits, 6 months for all other overpayments); Fla. Stat. Ann. § 627.6131(6)(a)(1) (30 months); Ga. Code Ann. § 33-20A-62 (18 months); 215 ILCS 5/368d(c) (18 months); 215 Ill. Comp. Stat. 5/368d(c) (18 months); Ind. Code 27-8-5.7-10(b) (2 years); Iowa Code § 191-15.33(1) (2 years); Ky. Rev. Stat. Ann. § 304.17A-714(1) (24 months); Me. Stat. tit. 24-A § 4303(10)(B) (12 months); Md. Code Ann., Ins. § 15-1008(c)(1) (18 months for coordination of benefits, 6 months for all other overpayments); Mo. Rev. Stat. § 376.384(1)(1) (1 year); MCA 33-22-150(2) (12 months); 210 Neb. Admin. Code Ch. 60 § 011.01(B)(3) (6 months); N.H. Rev. Stat. § 420-J:8-b(II)(b) (18 months); N.J. Stat. §§ 26:2J-8.1d(10), 17b:27-44.2d(10) (18 months); N.Y. Ins. Law § 3224-b(b)(3) (24 months); Ohio Rev. Code Ann. § 3901.388(B) (2 years); Okl. Stat. Ann. tit. 36 § 1250.5(15) (24 months); 40 Pa. Cons. Stat. § 3803(a) (twenty-four months); S.C. Code Ann. § 38-59-250(B) (eighteen months); Tenn. Code Ann. § 56-7-110(b) (18 months); Tex. Ins. Code §§ 843.350(a)(1), 1301.132(a)(1) (180 days); Utah Code Ann. § 31A-26-301.6(14) (24 months for coordination of benefit, 12 months for any other overpayment); Vt. Stat. Ann. tit. 18 § 9418(h) (12 months); Va. Code Ann. § 38.2-3407.15B(6) (12 months); Wash. Rev. Code 48.43.600(1) (24 months); W. Va. Code § 33-45-2(7)(C) (1 year).
28 No. 4:13-CV-3291, 2016 WL 3077405, at *18 (S.D. Tex. June 1, 2016).
29 *Id.* at *18.
30 *Auxiant v. Total Renal Care Inc.,* No. 15-CV-404, 2016 WL 4769369, at *1 (E.D. Wisc. Sept. 13, 2016) (citation and internal quotations omitted).
31 *Id.* at *2.
32 *Id.*
33 See, e.g., *Medical Center, Inc. v. Humana Military Healthcare Services, Inc.,* No. 4:10-CV-124 (CDL), 2012 WL 3295640, at *4 (M.D. Ga. Aug. 10, 2012); *Alexian Bros. Health Providers Ass'n, Inc. v. Humana Health Plan, Inc.,* 277 F. Supp. 2d 880, 891 (N.D. Ill. 2003).

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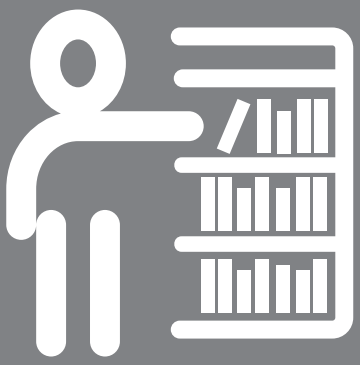

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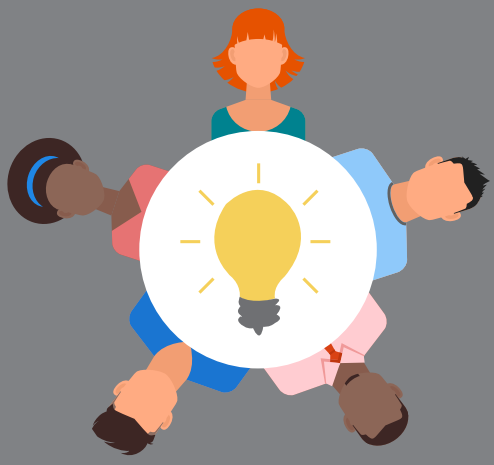

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