

## Insurance Refund Recoupment Laws By State

State	Statute/URL	What it says	Other Notes	Short Take
AL Code of AL 27-1-17 (Section 7, item 2e)	<a href="http://www.legislature.state.al.us/CodeOfAlabama/1975/27-1-17.htm">http://www.legislature.state.al.us/CodeOfAlabama/1975/27-1-17.htm</a>	Insurer, health service org and health benefit plan cannot retroactively deny, adjust or seek refund of a paid claim after the expiration of one year from the date the initial claim was paid or whatever terms are in the contract Other – Refunds of paid claims by insurers are barred after the expiration of 12 months from date of payment. Insurer cannot avoid this requirement via their contracts with the provider.	(as of 2004)	12 mos
AK (HB 113)	<a href="http://www.legis.state.ak.us/basis/get_bill_ext.asp?hsid=HB0113E&amp;session=22">http://www.legis.state.ak.us/basis/get_bill_ext.asp?hsid=HB0113E&amp;session=22</a>	(h) This section does not prohibit a health care insurer from recovering an amount mistakenly paid to a provider or a covered person.		none
AR Code Ann. §§ 23-61-108, 23-63-1806, 25-15-201, et seq	<a href="http://insurance.arkansas.gov/Legal%20Databases/rulesandregs/rnr85_May_1_2006.doc">http://insurance.arkansas.gov/Legal%20Databases/rulesandregs/rnr85_May_1_2006.doc</a>	Section 3. Time  a. Except in cases of fraud committed by the health care provider, a health care insurer may only exercise recoupment from a provider during the eighteen-month period after the date that the health care insurer paid the claim submitted by the health care provider. The exception for fraud means fraud that the insurer discovered after the eighteen-month period and could not have discovered prior to the end of the eighteen-month period by the exercise of reasonable diligence; it does not permit a health care insurer to extend the eighteen-month period under the rationale that it is still investigating a claim for fraud or any similar reason.	5/1/2006 The Rule shall apply to all payments made by health care insurers to providers on or after 8/12/2005 the effective date of Act 422 of 2005.	18 mos
AZ Ins. Code 20-3102	<a href="http://www.azleg.gov/ars/20/03102.htm">http://www.azleg.gov/ars/20/03102.htm</a> and <a href="http://www.id.state.az.us/bulletin/2006-02.pdf">http://www.id.state.az.us/bulletin/2006-02.pdf</a>	Payment Adjustments ARS § 20-3102(l) provides that an insurer or provider shall not adjust or request adjustment of a payment or denial of a claim more than one year after the insurer has paid or denied the claim.	ARS § 20-3102 Eff 1/20/2006	1 yr
CA (SB 634 10133.66.(b) )	<a href="http://www.leginfo.ca.gov/pub/bill/sen/sb_0601-0650/sb_634_bill_20050930_chaptered.html">http://www.leginfo.ca.gov/pub/bill/sen/sb_0601-0650/sb_634_bill_20050930_chaptered.html</a>	10133.66 (b) Reimbursement requests for the overpayment of a claim shall not be made, including requests made pursuant to Section 10123.145, unless a written request for reimbursement is sent to the provider within 365 days of the date of payment on the overpaid claim. The written notice shall clearly identify the claim, the name of the patient, and the date of service, and shall include a clear explanation of the basis upon which it is believed the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim. The 365-day time limit shall not apply if the overpayment was caused in whole or in part by fraud or misrepresentation on the part of the provider."	9/30/2005	365 dys

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<p><b>CO</b> Colo. Rev. Stat. § 10-16-106.5 (HB 99-1250, 1999) and (H.B. 02-1353, 2003)</p>	<p><a href="http://www.state.co.us/gov_dir/leg_dir/olls/digest2002a/INSURANCE.htm">http://www.state.co.us/gov_dir/leg_dir/olls/digest2002a/INSURANCE.htm</a></p>	<p>Retroactive denials allowed in certain cases; carrier may deny claim if additional info. requested is not received within 30 days of request and H.B. 02-1353 Managed care plans - adjustments to health care claims. Requires that adjustments to health care claims be made within 12 months after the date of the original explanation of benefits except in the case of adjustments to claims paid under a risk assumption or risk sharing agreement, which must be made within 6 months after the last date of service. Requires adjustments to claims related to coordination of benefits with federally funded health plans to be made within 36 months after the date of service. Prohibits retroactive adjustment of claims based on eligibility for coverage if the health care provider (provider) received eligibility verification within 2 business days prior to delivery of service.</p>	<p>Eff. 1/1/2003 and 5/2002</p>	<p>12 mos</p>
<p><b>CT</b> (SB 764 )</p>	<p><a href="http://www.cga.ct.gov/2005/ct/2005SB-00764-R000156-FC.htm">http://www.cga.ct.gov/2005/ct/2005SB-00764-R000156-FC.htm</a></p>	<p>This bill prohibits insurers and HMOs from seeking to recover an overpayment for a claim paid under a health insurance policy unless the insurer or HMO provides written notice to the person from whom recovery is sought within five years after receiving the initial claim.</p>	<p>Eff. 10/1/2005</p>	<p>within 5 yrs</p>
<p><b>DC</b> D.C. Code Ann. § 31-3133(a)(b)</p>	<p><a href="http://weblinks.westlaw.com/Find/Default.w?DB=DC%2DST%2DTC%3BSTADCTOC&amp;DocName=DCCODES31%2D3133&amp;FindType=W&amp;AP=&amp;fn=top&amp;rs=WEBL6.08&amp;vr=2.0&amp;spa=DCC-1000&amp;trailtype=26">http://weblinks.westlaw.com/Find/Default.w?DB=DC%2DST%2DTC%3BSTADCTOC&amp;DocName=DCCODES31%2D3133&amp;FindType=W&amp;AP=&amp;fn=top&amp;rs=WEBL6.08&amp;vr=2.0&amp;spa=DCC-1000&amp;trailtype=26</a></p>	<p>(a) A health insurer may only retroactively deny reimbursement to a health care provider:</p> <p>(1) For services subject to coordination of benefits with another health insurer during the 18-month period after the date that the health insurer paid the health care provider; or</p> <p>(2) Except as provided in paragraph (1) of this subsection, during the 6-month period after the date that the health insurer paid the health care provider.</p> <p>(b)(1) A health insurer that retroactively denies reimbursement to a health care provider under subsection (a)(1) of this section shall provide the health care provider with a written statement specifying the basis for the retroactive denial. If the retroactive denial of reimbursement results from coordination of benefits, the written statement shall provide the name and address of the entity acknowledging responsibility for payment of the denied claim.</p>	<p>7/23/2002</p>	<p>6 mos</p>
<p><b>DE</b> Title 18, Chap. 33</p>	<p><a href="http://www.delcode.state.de.us/title18/c033/index.htm">http://www.delcode.state.de.us/title18/c033/index.htm</a></p>			<p>none</p>

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<p><b>FL</b> (State Statutes 627.6131, 2003)</p>	<p><a href="http://www.flsenate.gov/Statutes/index.cfm?App_mode=Display_Statute&amp;Search_String=&amp;URL=Ch0627/Sec6131.HTM">http://www.flsenate.gov/Statutes/index.cfm?App_mode=Display_Statute&amp;Search_String=&amp;URL=Ch0627/Sec6131.HTM</a></p>	<p>(a) If an overpayment determination is the result of retroactive review or audit of coverage decisions or payment levels not related to fraud, a health insurer shall adhere to the following procedures:</p> <p>1. All claims for overpayment must be submitted to a provider within 30 months after the health insurer's payment of the claim. A provider must pay, deny, or contest the health insurer's claim for overpayment within 40 days after the receipt of the claim. All contested claims for overpayment must be paid or denied within 120 days after receipt of the claim. Failure to pay or deny overpayment and claim within 140 days after receipt creates an uncontestable obligation to pay the claim.</p>		<p>30 mos</p>
<p><b>GA</b> (SB 476) 33-20A-62.</p>	<p><a href="http://www.legis.state.ga.us/legis/2001_02/fulltext/sb476.htm">http://www.legis.state.ga.us/legis/2001_02/fulltext/sb476.htm</a></p>	<p>(a) No carrier, plan, network, panel, or any agent thereof may conduct a post-payment audit or impose a retroactive denial of payment on any claim by any claimant relating to the provision of health care services that was submitted within 90 days of the last date of service or discharge covered by such claim unless:</p> <p>(1) The carrier, plan, network, panel, or agent thereof has provided to the claimant in writing notice of the intent to conduct such an audit or impose such a retroactive denial of payment of such claim or any part thereof and has provided in such notice the specific claim and the specific reason for the audit or retroactive denial of payment;</p> <p>(2) Not more than 12 months have elapsed since the last date of service or discharge covered by the claim prior to the delivery to the claimant of such written notice; and</p> <p>(3) Any such audit or retroactive denial of payment must be completed and notice provided to the claimant of any payment or refund due within 18 months of the last date of service or discharge covered by such claim.</p>	<p>2/2001</p>	<p>18 mnths</p>
<p><b>HA</b></p>				<p>none?</p>
<p><b>ID</b></p>	<p><a href="http://www3.state.id.us/idstat/TOC/41056KT OC.html">http://www3.state.id.us/idstat/TOC/41056KT OC.html</a></p>	<p>The prompt pay information does not contain language re: retroactive denials, recoupments or offsets</p>		<p>none</p>
<p><b>IL</b></p>				<p>none</p>
<p><b>IN</b> Ind Code Title 27-8-5.7-10</p>	<p><a href="http://www.in.gov/legislative/ic/code/title27/ar8/ch5.7.html">http://www.in.gov/legislative/ic/code/title27/ar8/ch5.7.html</a></p>	<p>Claim payment errors</p> <p>Sec. 10. (a) An insurer may not, more than two (2) years after the date on which an overpayment on a provider claim was made to the provider by the insurer:</p> <p>(1) request that the provider repay the overpayment; or</p> <p>(2) adjust a subsequent claim filed by the provider as a method of obtaining reimbursement of the overpayment from the provider.</p> <p>(b) An insurer may not be required to correct a payment error to a provider more than two (2) years after the date on which a payment on a provider claim was made to the provider by the insurer.</p> <p>(c) This section does not apply in cases of fraud by the provider, the insured, or the insurer with respect to the claim on which the overpayment or underpayment was made.</p> <p>As added by P.L.55-2006, SEC.1</p>	<p>"As added by P.L.55-2006, SEC.1"</p>	<p>2 yrs</p>

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<b>IA</b> Iowa (Admin. Code 191-15.33 (507B))	<a href="http://www4.legis.state.ia.us/IAChtml/191.htm#rule_191_15_32">http://www4.legis.state.ia.us/IAChtml/191.htm#rule_191_15_32</a>	Audit procedures for medical claims.  15.33(1) Prohibitions. This rule applies to all claims paid on or after January 1, 2002:  a. Absent a reasonable basis to suspect fraud, an insurer may not audit a claim more than two years after the submission of the claim to the insurer. Nothing in this rule prohibits an insurer from requesting all records associated with the claim.  b. Absent a reasonable basis to suspect fraud, an insurer may not audit a claim with a billed charge of less than \$25.	7/1/2002	2 yrs
<b>KS</b>	<a href="http://www.ksinsurance.org/consumers/ppstatutes.htm">http://www.ksinsurance.org/consumers/ppstatutes.htm</a>		none mentioned	none
<b>KY</b> Ky. Rev. Stat. Ann. §§ 304.17A et seq.	<a href="http://www.lrc.state.ky.us/KRS/304-17A/708.PDF">http://www.lrc.state.ky.us/KRS/304-17A/708.PDF</a>	An insurer shall not be required to correct a payment error to a provider if the provider's request for a payment correction is filed more than twenty-four (24) months after the date that the provider received payment for the claim from the insurer.	7/14/2000	24 mos
<b>LA</b> Regulation 74 and R.S. 22:250.34 B. And Louisiana (HB 2052, 1999)	<a href="http://www.lidi.state.la.us/Health/Quality_Assurance/frequently_asked_questions.htm">http://www.lidi.state.la.us/Health/Quality_Assurance/frequently_asked_questions.htm</a>	According to Regulation 74 and R.S. 22:250.34 B., "Health insurance issuers that limit the period of time that a preferred provider or entity under contract for delivery of covered benefits has to submit claims for payment under R.S. 22:250.32 or 250.33 shall have the same limited period of time following payment of such claims to perform any review or audit for purposes of reconsidering the validity of such claims".		same deadline as sending claims
<b>ME</b> Me. Rev. Stat. Ann. tit. 24-A, § 4303 (10A & B)	<a href="http://tinyurl.com/kv36b">http://tinyurl.com/kv36b</a>	10. Limits on retrospective denials. A carrier offering a health plan in this State may not impose on any provider any retrospective denial of a previously paid claim or any part of that previously paid claim unless:  A. The carrier has provided the reason for the retrospective denial in writing to the provider; and [2003, c. 218, §9 (new).] B. The time that has elapsed since the date of payment of the previously paid claim does not exceed 18 months. The retrospective denial of a previously paid claim may be permitted beyond 18 months from the date of payment only for the following reasons: (1) The claim was submitted fraudulently; (See the rest of the Statute)	T. 24-A, §4303, sub-§9, amended in 2003	18 mos

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<b>MD</b> Md. Code Ann., Ins. §§ 15-1003 et seq. Md. Code Ann., Hlth § 15- 102.3 Md. Regs. Code tit. 31, Subtitle 10, § 11	<a href="http://www.msdc.org/pp_and_summary.pdf">http://www.msdc.org/pp_and_summary.pdf</a>	Insurer may retroactively deny reimbursement up to 6 months after claim payment is made	(applies to all claims recv'd on or after 9/7/2003) See page 4 of 6 from 2002	6 mos
<b>MA</b> (H.B. 3906) Amended: MGL 176G Section 6 (Managed Care)	<a href="http://www.mass.gov/legis/bills/house/ht03pdf/ht03906.pdf">http://www.mass.gov/legis/bills/house/ht03pdf/ht03906.pdf</a>	No insurer shall impose on any health care provider any retroactive denial of a previously paid claim or any part thereof unless: (a) The insurer has provided the reason for the retroactive denial in writing to the health care provider; and (b) The time which has elapsed since the date of payment of the challenged claim does not exceed 12 months. The retroactive denial of a previously paid claim may be permitted beyond 12 months from the date of payment only for the following reasons: (see Statute)	2005 (exact date not stated) In the URL to the left, see Section 5 for Managed Care Organizations	12 mos
<b>MI</b>	<a href="http://www.legislature.mi.gov/documents/2005-2006/billintroduced/House/htm/2005-HIB-4084.htm">http://www.legislature.mi.gov/documents/2005-2006/billintroduced/House/htm/2005-HIB-4084.htm</a>	Prompt pay laws are in the process of being updated as of 2/2005 see HB 4084:		none
<b>MN</b>	<a href="http://www.revisor.leg.state.mn.us/bin/bldbill.php?bill=H2438.0&amp;session=ls84">http://www.revisor.leg.state.mn.us/bin/bldbill.php?bill=H2438.0&amp;session=ls84</a>			none
<b>MS</b>				none
<b>MO</b> Missouri (HB 328 & 88, 2001) Sect. 376.384	<a href="http://www.moga.state.mo.us/statutes/C300-399/3760000384.HTM">http://www.moga.state.mo.us/statutes/C300-399/3760000384.HTM</a>	(3) Not request a refund or offset against a claim more than twelve months after a health carrier has paid a claim except in cases of fraud or misrepresentation by the health care provider;	8/28/2005	12 mos

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<p><b>MT</b> Montana Code Annotated 33-22-150</p>	<p><a href="http://data.opi.state.mt.us/bills/mca/33/22/33-22-150.htm">http://data.opi.state.mt.us/bills/mca/33/22/33-22-150.htm</a></p>	<p>33-22-150. (Effective January 1, 2006) Reciprocal limitations on claim filing and claim audits -- time limit for reimbursements or offsets -- exceptions. (1) Except as provided in subsection (3), (4), or (5), if a health insurance issuer limits the time in which a health care provider or other person is required to submit a claim for payment, the health insurance issuer has the same time limit following payment of the claim to perform any review or audit for reconsidering the validity of the claim and requesting reimbursement for payment of an invalid claim or overpayment of a claim.</p> <p>(2) Except as provided in subsection (3), (4), or (5), if a health insurance issuer does not limit the time in which a health care provider or other person is required to submit a claim for payment, a health insurance issuer may not request reimbursement or offset another claim payment for reimbursement of an invalid claim or overpayment of a claim more than 12 months after the payment of an invalid or overpaid claim.</p>	<p>Eff. 1/1/2006</p>	<p>12 mos</p>
<p><b>NE</b> Title 210 – NEB. DEPT OF INS. Chapter 60 (011-011.01(B))</p>	<p><a href="http://www.sos.state.ne.us/business/regse/arch/Rules/Insurance_Dept_of/Title-210/Chapter-60.pdf">http://www.sos.state.ne.us/business/regse/arch/Rules/Insurance_Dept_of/Title-210/Chapter-60.pdf</a></p>	<p>(See Statute for qualifiers)</p> <p>011.01(B)(3) The insurer has notified the claimant within six (6) months of the date of the error, except that in instances of error prompted by representations or nondisclosures of claimants, the insurer notifies the claimant within fifteen (15) days after the date that clear, documented evidence of discovery of such error is included in its file; and</p> <p>011.01(B)(4) Such notice states clearly the nature of the error, the amount of the overpayment, and the three year limitation as provided in subsection 011.01(C).</p>	<p>9/1/1992</p>	<p>6 mos</p>
<p><b>NV</b></p>	<p><a href="http://www.leg.state.nv.us/NAC/NAC-686A.html#NAC686A_Sec304">http://www.leg.state.nv.us/NAC/NAC-686A.html#NAC686A_Sec304</a></p>	<p>discussion of prompt pay; no discussion of refund, recoupment or offset. These are amended laws NAC 686A.306 NAC 686A.280 Effective April 16, 2004</p>		<p>none</p>
<p><b>NH</b> (Ins. Code 420-J:8-b) and eff. 4/9/2006 (HB 1652)</p>	<p><a href="http://www.gencourt.state.nh.us/rsa/html/XXXVII/420-J/420-J-8-b.htm">http://www.gencourt.state.nh.us/rsa/html/XXXVII/420-J/420-J-8-b.htm</a></p>	<p>II. No health carrier shall impose on any health care provider any retroactive denial of a previously paid claim or any part thereof unless:</p> <p>(a) The carrier has provided the reason for the retroactive denial in writing to the health care provider; and</p> <p>(b) The time which has elapsed since the date of payment of the challenged claim does not exceed 18 months. The retroactive denial of a previously paid claim may be permitted beyond 18 months from the date of payment" with certain exceptions listed in this statute.</p>	<p>HB 1652 - This bill clarifies when an insurer may impose a retroactive denial of a previously paid claim beyond 18 months. Amended version passed the House, awaiting action in the Senate. - per 4/09/2006 <a href="http://www.seacoastonline.com/news/04092006/news/96821.htm">http://www.seacoastonline.com/news/04092006/news/96821.htm</a></p>	<p>18 mos</p>

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<p><b>NJ</b> P.L. 2005 c.352 (52824 1R) 10(a)-10(d), 11(a)(b)</p>	<p><a href="http://www.njleg.state.nj.us/2004/Bills/PL05/352_.HTM">http://www.njleg.state.nj.us/2004/Bills/PL05/352_.HTM</a></p>	<p>(10) With the exception of claims that were submitted fraudulently or submitted by health care providers that have a pattern of inappropriate billing or claims that were subject to coordination of benefits, no payer shall seek reimbursement for overpayment of a claim previously paid pursuant to this section later than 18 months after the date the first payment on the claim was made. No payer shall seek more than one reimbursement for overpayment of a particular claim. At the time the reimbursement request is submitted to the health care provider, the payer shall provide written documentation that identifies the error made by the payer in the processing or payment of the claim that justifies the reimbursement request. (See Statute for more information)</p>	<p>Amended and Approved 1/12/2006</p>	<p>18 mos</p>
<p><b>NM</b></p>				<p>none</p>
<p><b>NY</b> Managed Care Reform S.8417/A.11996</p>	<p><a href="http://www.nyssos.org/newsletter/newsletter.html">http://www.nyssos.org/newsletter/newsletter.html</a></p>	<p>Legislation was introduced in the last few days of session to enact several important managed care reform measures. The bill was passed by the Senate on June 22nd and the Assembly on June 23rd. The bill was the product of negotiation by the Medical Society of the State of NY and includes the following items:</p> <ul style="list-style-type: none"> <li>* prohibits an insurance company from demanding a refund from a health care provider for a claim previously paid, except for limited situations involving fraud and abusive billing, to no more than two years after the time that such payment was initially made;</li> <li>* requires 30 days written notice to a provider that the insurer will be seeking a refund. The notice must include specific information about the previous payment that is being reviewed;</li> <li>* requires some "transparency" regarding the manner by which health insurance companies "bundle" billing codes submitted by physicians for health care services rendered and ensures the disclosure of the software systems the insurers are using and significant edits made to standardized software programs;</li> </ul>	<p>passed 6/23/2006</p>	<p>2 yrs</p>
<p><b>NC</b> G.S. 58-3-225(h)</p>	<p><a href="http://www.ncdoj.com/LH/Documents/Cheeklists/NorthCarolinaDepartmentOfInsurancePromptPayGuidance.pdf">http://www.ncdoj.com/LH/Documents/Cheeklists/NorthCarolinaDepartmentOfInsurancePromptPayGuidance.pdf</a></p>	<p>The prompt pay law does not specify a time limit within which insurers can recoup overpayments made to providers but states that the time period for recoveries can be established in the contract between the insurer and the provider. If this is not specifically addressed in the provider contract, then the appropriate statute of limitations would apply.</p>	<p>4/27/2001</p>	<p>per contract</p>
<p><b>ND</b></p>				<p>None?</p>

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<p><b>OH</b> Ohio Rev. Code Ann. §§ 3901.38.1 et seq.</p>	<p><a href="http://www.ohioinsurance.gov/company/PLaws.pdf">http://www.ohioinsurance.gov/company/PLaws.pdf</a></p>	<p>A) A payment made by a third-party payer to a provider in accordance with sections 3901.381 [3901.38.1] to 3901.386 [3901.38.6] of the Revised Code shall be considered final two years after payment is made. After that date, the amount of the payment is not subject to adjustment, except in the case of fraud by the provider. (B) A third-party payer may recover the amount of any part of a payment that the third-party payer determines to be an overpayment if the recovery process is initiated not later than two years after the payment was made to the provider. The third-party payer shall inform the provider of its determination of overpayment by providing notice in accordance with division (C) of this section. The third-party payer shall give the provider an opportunity to appeal the determination. If the provider fails to respond to the notice sooner than thirty days after the notice is made, elects not to appeal the determination, or appeals the determination but the appeal is not upheld, the third-party payer may initiate recovery of the overpayment.</p>	<p>Eff 7/24/2002.</p>	<p>2 yrs</p>
<p><b>OK</b> Title 36, Chapt 1, Art. 12-A 1, Sect 1250.5</p>	<p><a href="http://www.oscn.net/applications/oscn/DeliverDocument.asp?cited=445085">http://www.oscn.net/applications/oscn/DeliverDocument.asp?cited=445085</a></p>	<p>15. Requesting a refund of all or a portion of a payment of a claim made to a claimant or health care provider more than twenty-four (24) months after the payment is made. This paragraph shall not apply:</p> <p>a. if the payment was made because of fraud committed by the claimant or health care provider, or</p> <p>b. if the claimant or health care provider has otherwise agreed to make a refund to the insurer for overpayment of a claim.</p>	<p>Amended - 11/1/2000</p>	<p>24 mos</p>
<p><b>OR</b></p>	<p><a href="http://www.cbs.state.or.us/external/ins/rules/insurance_laws_2005.pdf">http://www.cbs.state.or.us/external/ins/rules/insurance_laws_2005.pdf</a></p>			<p>none</p>
<p><b>PA</b> HB 1850 - Session 2005, Subsect 603-B</p>	<p><a href="http://www2.legis.state.pa.us/WU01/LI/BI/BI/2005/0/HB1850P2486.pdf">http://www2.legis.state.pa.us/WU01/LI/BI/BI/2005/0/HB1850P2486.pdf</a></p>	<p>(a) General rule – if an insurer retroactively denies reimbursement to a health care provider, the insurer may only:</p> <p>(1) retroactively deny reimbursement for services subject to coordination of benefits with another insurer, the medical assistance program or the Medicare program during the 12-month period after the date that the insurer paid the health care provider; and (See Statute for more information – THIS IS PENDING PASSAGE)</p>	<p>Referred to committee 7/02/2005 Still pending Aug 2006 <a href="http://tinyurl.com/qhzph">http://tinyurl.com/qhzph</a></p>	<p>pending</p>
<p><b>RI</b></p>				<p>none?</p>

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<p><b>SC</b> <b>Section 38-94-20.</b></p>	<p><a href="http://www.scstatehouse.net/sess116_2005-2006/bills/53.htm">http://www.scstatehouse.net/sess116_2005-2006/bills/53.htm</a></p>	<p>(1) notify the provider in writing that the provider shall provide the information not later than the forty-fifth day after the date of the notice or forfeit the amount of the claim; and (2) if the provider does not provide the information required by this subsection, recover the amount of the claim. (G) The insurer shall complete the audit on or before the one hundredth eightieth day after the date the clean claim is received by the insurer, and any additional payment due a provider or any refund due the insurer must be made not later than the thirtieth day after the completion of the audit. If a provider disagrees with a refund request made by an insurer based on the audit, the insurer shall provide the provider with an opportunity to appeal, and the insurer may not attempt to recover the payment until all appeal rights are exhausted.</p>	<p>introduced to the statehouse in Jan. 2005</p>	<p>180 dys</p>
<p><b>SD</b></p>				<p>none?</p>
<p><b>TN</b> <b>PUB. ACTS, 2003, (SB 460, Chapter # 257)</b> <b>Tenn. Code Annotated, Title 56, Chapt 7</b></p>	<p><a href="http://www.state.tn.us/sos/acts/103/pub/pc0257.pdf">http://www.state.tn.us/sos/acts/103/pub/pc0257.pdf</a></p>	<p>56-7-110 (f) Notwithstanding subsection (c), if a health insurance entity or an agent contracted to provide eligibility verification, verifies that an individual is a covered person and if the health care provider provides services to the individual in reliance on such verification, the health insurance entity may not thereafter retroactively deny a claim on the basis that the individual is not a covered person unless such retroactive denial occurs within six (6) months of the date that the health insurance entity paid the claim; otherwise the health insurance entity is barred from making such recoupment unless there was fraud by the health care provider.</p>	<p>amended 6/2003</p>	<p>6 mos</p>
<p><b>TX</b> <b>Tex. Ins.Code Ann.§ 3.70-3C and §§ 843.000 et seq.*</b> <b>*§ 3.70-3C is entitled Pref. Prov. Benefits Plans, while §§ 843.000 et seq. is entitled Hlth Maint. Organiz ALSO (SB 418)</b></p>	<p><a href="http://info.sos.state.tx.us/pls/pub/readtac\$ext.TacPage?sl=R&amp;app=9&amp;p_dir=&amp;p_rloc=&amp;p_tloc=&amp;p_ploc=&amp;pg=1&amp;p_tac=&amp;ti=28&amp;pt=1&amp;ch=21&amp;rl=2818">http://info.sos.state.tx.us/pls/pub/readtac\$ext.TacPage?sl=R&amp;app=9&amp;p_dir=&amp;p_rloc=&amp;p_tloc=&amp;p_ploc=&amp;pg=1&amp;p_tac=&amp;ti=28&amp;pt=1&amp;ch=21&amp;rl=2818</a></p>	<p>Under § 3.70-3C, the insurer has no later than the 180th day after provider receives payment to recover an "overpayment" (must provide written notice re specific reasons for request of recovery of funds)</p>	<p>10/05/2003</p>	<p>180 dys</p>
<p><b>UT</b> <b>Utah (SB 69, 2001)</b></p>	<p><a href="http://www.leg.state.ut.us/~2001/bills/sbillint/SB0069.htm">http://www.leg.state.ut.us/~2001/bills/sbillint/SB0069.htm</a></p>	<p>13) Nothing in this section may be construed as limiting the ability of an insurer to: 145 (a) recover within 12 months any amount improperly paid to a provider pursuant to Section 146 31A-31-103 or any other provision of state or federal law;</p>	<p>1/9/2001</p>	<p>12mos</p>

## Insurance Refund Recoupment Laws By State

<b>VA</b> Va. Code Ann. § 38.2-3407.15	<a href="http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+38.2-3407.15">http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+38.2-3407.15</a>	For any contracts entered into, amended, extended or renewed on or after 7/1/04, no carrier shall impose any retroactive denial of payment UNLESS the carrier specifies in writing (1) the specific claim or claims for which this retroactive denial is being sought and (2) the reason for the retroactive denial.	1999	
<b>VT</b>	<a href="http://www.leg.state.vt.us/statutes/fullsection.cfm?title=18&amp;chapter=221&amp;section=09418">http://www.leg.state.vt.us/statutes/fullsection.cfm?title=18&amp;chapter=221&amp;section=09418</a>		1997	none
<b>WA</b> Wash. (SB 6184, 2004) and NEW - (HB 418) Chapter 48.43 RCW	<a href="http://www.leg.wa.gov/pub/billinfo/2003-04/Pdf/Bills/Senate%20Bills/6184.pdf">http://www.leg.wa.gov/pub/billinfo/2003-04/Pdf/Bills/Senate%20Bills/6184.pdf</a>	(3) An insurer may not retroactively deny, adjust, or seek recoupment or refund of a paid claim submitted by a health care provider for reasons related to coordination of benefits with another insurer or entity responsible for payment of the claim after the expiration of eighteen months from the date that the original claim was paid. (HB 418) Chapter 48.43 RCW to read as follows: (1) Except in the case of fraud, or as provided in subsections (2) and (3) of this section, a carrier may not: (a) Request a refund from a health care provider of a payment previously made to satisfy a claim unless it does so in writing to the provider within twenty-four months after the date that the payment was made; or (b) request that a contested refund be paid any sooner than six months after receipt of the request. Any such request must specify why the carrier believes the provider owes the refund. If a provider fails to contest the request in writing to the carrier within thirty days of its receipt, the request is deemed accepted and the refund must be paid (see statute)	7/24/05 - NEW - (HB 418) Chapter 48.43 RCW <a href="http://www.leg.wa.gov/pub/billinfo/2005-06/Pdf/Bills/Session%20Law%202005/1418-S2.SL.pdf">http://www.leg.wa.gov/pub/billinfo/2005-06/Pdf/Bills/Session%20Law%202005/1418-S2.SL.pdf</a> NEW SECTION. Sec. 1. A new section is added to chapter: .	18 mos
<b>WV</b> HB 2486, Article 43, WV Code §33-45-7A	<a href="http://www.legis.state.wv.us/Bill_Text_HTML/2001_SESSIONS/R/S/BILLS/hb2486%20sub.htm">http://www.legis.state.wv.us/Bill_Text_HTML/2001_SESSIONS/R/S/BILLS/hb2486%20sub.htm</a>	(B) No insurer may impose any retroactive denial of a previously paid claim for services which were not preauthorized unless the insurer has provided the reason for the retroactive denial and: (i) The original claim was submitted fraudulently; (ii) the original claim payment was incorrect because the provider was already paid for the health care services identified on the claim or the health care services identified on the claim were not delivered by the provider; or (iii) the time which has elapsed since the date of the payment of the original challenged claim does not exceed the lesser of: (I) Twelve months; or (II) the number of days within which the insurer requires under its provider contract that a claim be submitted by the provider following the date on which a health care service is provided.	07/01/2001	12 mos
<b>WI</b>	<a href="http://www.legis.state.wi.us/statutes/Stat0628.pdf">http://www.legis.state.wi.us/statutes/Stat0628.pdf</a>			none



## Insurance Refund Recoupment Laws By State

<b>WY</b> HB 0167 Section 26-15-124	<a href="http://legisweb.state.wy.us/2004/introduce/hb0167.pdf">http://legisweb.state.wy.us/2004/introduce/hb0167.pdf</a>	(ii) The notice required by paragraph (i) of this subsection is sent by the insurer within eighteen (18) months after the date of payment or twenty-four (24) months after the date of service, whichever is sooner;	Eff 7/01/2004	18 or 24 months
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**With very special thanks to Cyndee Weston of AMBA and Edwina Sprow, CPC of Sprow Consulting.**

**Disclaimer:**  
 This chart is to be used AS A GUIDE so that if necessary, you can seek legal counsel.

We are not lawyers. We cannot advise you of any law. What we can advise you to do, is to know your state laws. Each state above has a link to the actual law when one could be found. \*NOTE\* In some cases, there are other factors or conditional terms that should be known. Reading these terms will help you know what is the right way to handle a refund request.

For example, some states have a time limit for providers to respond to the insurance company's refund request, regardless of time limits in the statute.

Finally, between the time of passage and the date you're reading this, the law for your state may have been changed or the URL provided here doesn't go where it did when this chart was created. If you find either to be the case, it would be appreciated if you would contact us so we can keep this chart up to date. You already know how hard it is to find this information - that's why you came to AskLeslie.net .

Ultimately, it remains the Provider's responsibility to know and follow the applicable laws of his/her own state. If legal help is needed, you must contact an attorney to represent you; we can't help in this regard. There's no way we can advise anyone and we can't recommend an attorney for you..

For this reason, we feel the need to remind you that the above chart is meant to be used only as a GUIDE; it isn't meant to be considered a 100% completely reliable reference tool.

LJ 9/2006