INSURANCE COMPANY REQUESTING REFUND ON OVERPAYMENT
(DOES NOT APPLY TO MANAGED CARE OR WORKERS COMPENSTION)

Date

Insurance Co.
P.O. Box 90009
Los Angeles, CA 90000

Re: Sally Adams
Claim # 44-8980
Dates of Service: (dates)

Dear Sirs:

On (date), we received a letter from your company requesting that we refund the amount of $276.00 to Blue Shaft for a payment that was made in error *(beyond policy limits)* back in (date).

First of all, I reviewed Ms. Adams records and I do not show that we have an overpayment resulting in a credit on her account.

Secondly, I do not feel that you have the right to place this burden upon my office by asking us to correct your error, chase down this past patient and ask her to make additional payment to our office for a new balance that simply appeared out of nowhere!

I would like to bring to your attention the cases of*: In Federated Mutual Insurance Company vs. Good Samaritan Hospital, (Neb.1974) 214 N.W.2d 493*, where the court held that the insurance company could not recover the mistaken overpayment and determined that "the insurance company is in the best position to know what the policy limits are and must bear the responsibility for their own mistake." As well as, *The City of Hope National Center vs. Western Life Insurance Company, 2 Daily Journal D.A.R. 10728, Decided July 31, 1992,* where the court held that, *in the absence of fraud,* a health care provider is not legally obligated to refund payments it receives from an insurer if the insurer subsequently determines that they were paid in error.

Based on these and other court decisions, I will not be sending your company a refund for $276.00 for the erroneous reimbursement payment you are claiming as due.

Sincerely,

John C. Smith, LAc

Request for Refund by Insurance Company

Date

Mr. _____
Insurance Co.
address
City, State Zip

Re: Your Letter of April 13, 20xx

VIA CERTIFIED MAIL – RETURN RECEIPT REQUESTED

Dear Mr. _____:

We are in receipt of the above-referenced letter by which (Insurance Co. name) requests reimbursement from (Provider name or Clinic name), a third party creditor, in the amount of $_____ based on a glitch in (Insurance Co. Name) processing system that (Insurance Co. Name) now considers an overpayment.

Our records indicate the claims have been paid and there are no credit balances on the patients' accounts. The patients have long since been billed for the balance of their responsibility, if any.

Indeed, according to state and federal law, as a third party creditor we cannot be held liable for mistakes on the insurer's part. We obtained the patients' United Healthcare Insurance cards prior to rendering services, we verified their benefits and eligibility in each instance, and based on the fact that patients were eligible and had benefits for certain services, we rendered such services, billed for such services promptly at the time of rendering, and were paid in accordance with same.

Your payments, and whole or partial denials, and Explanations of Benefits were received by us at the time of the initial billing cycles – between one and four years ago. We received these payments and explanations, as did our patients, and thus did not bill our patients for the portions covered by the insurance based on your Explanation of Benefits. The funds have been exhausted.

There are a number of issues here. One: The law does not recognize a "glitch in processing" as a valid legal basis under state or federal law upon which to seek a refund from a provider. Two--an equitable issue: While we contend (Insurance Co. name) has no valid points needing redress, to the extent there were any, the law does not embrace those who "sleep on their rights." By (Insurance Co. Name)'s own admission, it has sat on its hands for up to four years: ***nearly (number of years or months)*** elapsed prior to (Insurance Co. Name) suddenly manifesting what appears to resemble a case of payor's remorse. Three: (Insurance Co. Name) has a duty to pay or deny at the time of the claim submission. We are aware of no case or statutory law which permits one to try – four years after the fact, during part of a routine audit in which (Insurance Co. Name) decides it would like more money in its coffers – to say that it forgot to deny certain claims years ago, and thus would like to transmorph previously paid codes into codes which now fall outside the purview of payment. And to do so based on no rational explanation whatsoever – other than (Insurance Co. Name) would like to now un-pay certain services we rendered in good faith and which were paid years ago.

Several court cases come to mind, all of which have held that when an insurance company accidentally pays in error, by the insurance company's calculation, they cannot collect a refund from the provider, because it is the insurer, and not the third-party creditor, that is "in a position to know the policy

provisions and its liability under the contract of insurance." Indeed, these cases go on to say that to hold otherwise would subject a provider to "possible refund liability if the insurer later discovers a mistaken overpayment, lasting until all such claims were barred by the statutes of limitation . . . ***[which would] place an undue burden of contingent liability on such [provider] institutions***." See City of Hope Medical Center v. Superior Court of Los Angeles County, 8 Cal. App. 4th 633, 637-38 (1992) (emphasis added) (citing Federated Mutual Insurance v. Good Samaritan Hospital, 214 N.W. 2d 493, 495-96 (1974); Lincoln National Life Insurance v. Brown Schools, 757 S.W. 2d 411, 414 (1988); National Benefit Administrators v. MMHRC, 748 F. Supp. 459 (465-66 (1990)). As you may be aware, there are myriad other cases on point as well.

Put differently, as the courts so aptly did, the third party creditor provider has ***"no responsibility to determine if an insurance carrier is properly tending to its business."*** Id. (emphasis added). Further eviscerating (Insurance Co. Name)'s request, in all the above cases there was clear cut "overpayment" – e.g., the insurer had paid beyond stated policy limits, or paid on a policy that had lapsed – which is not the case here. In this instance, there isn't even an identifiable overpayment… just a code that (Insurance Co. Name) wishes it hadn't paid but which was in fact validly within the scope of payment at the time services were rendered
In conclusion, we feel we have been properly reimbursed for services rendered. Therefore, no refund will be issued.

Do not deduct this alleged overpayment from any future benefits that might be paid. If you do, our legal counsel will immediately initiate a declaratory judgment action in California state court to ensure our rights and those of our patients are preserved, and will additionally seek all damages and remedies provided by law.

Additionally, counsel will be instructed to conduct an investigation to determine if United has violated certain sections of the (Your states name) Insurance Code. To wit, whether (Insurance Co. Name) knowingly committed any of the unfair practices listed below, and/or whether (Insurance Co. Name) performed any of the following acts with reference to audits of other providers in the community or other (Insurance Co. Name) insureds such that it would indicate (Insurance Co. Name) had a "***general business practice"*** of any of the following:

- Failing to act reasonably promptly upon communications with respect to claims;
- Failing to adopt and implement reasonable standards for the prompt investigation and processing of claims;
- Failing to affirm or deny coverage of claims within a reasonable time;
- Failing to provide promptly a reasonable explanation of the basis relied on in the insurance policy, in relation to the facts or applicable law, for the denial of a claim.
- Misrepresenting pertinent facts or policy provisions relating to coverage;
- Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled.

If the facts uncovered during this investigation on behalf of the undersigned and other providers and/or (Insurance Co. Name) insureds indicate that (Insurance Co. Name) currently has – or has had – a general business practice of unfair claims handling, counsel will be retained and instructed to undertake a class action lawsuit against (Insurance Co. Name) (and any affiliated entities which evidence uncovers also engaged in such unfair insurance claims practices). Counsel will be instructed on behalf of the injured

class of providers and/or insureds to recover all sums unfairly denied – or which (Insurance Co. Name) attempts to unfairly retroactively deny by deducting same from future benefit payments to providers or insureds – along with all other damages and fees provided for by law, including but not limited to punitive damages and attorneys' fees if warranted.

Sincerely,

_____
Provider's Name

cc: our attorney, Esq.