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Using ERISA Regulations to Challenge Overpayment Demands

From the article:

It is not uncommon for providers to receive notification from an employer-sponsored health plan subject to the Employee Retirement Income Security Act of 1974 (ERISA) alleging that the plan has overpaid the provider and that the provider must immediately repay the plan. In some cases, the plan will start recouping amounts they claim are owed by withholding payment on other, unrelated claims. This can be a frustrating experience for providers, particularly where the plan does not adequately explain the details of the alleged overpayment or the available procedures for challenging the overpayment determination. Providers need to be aware of their rights under ERISA to have a full and fair review of the plan's request for repayment.

It is well-settled that when a plan subject to ERISA makes an "adverse benefit determination," such as an initial denial or underpayment of a claim for benefits, the plan must provide the following:

1. An explanation of the specific reasons why the claim was not paid in full;

2. A reference to the specific plan provisions upon which the plan relied for the denial, and a copy of the plan;

3. A description of any additional information that the plan needs in order to pay the claim;

4. A description and copies of any internal rules, guidelines, protocols or criteria that the plan relied upon in denying the claim;

5. An adequate explanation of the plan's review and appeal procedures for the denial, including any available external appeals.