CLAIMS RECOVERY

Policy Number: ADMINISTRATIVE 128.13 T0  Effective Date: February 1, 2019

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**PURPOSE**

This policy outlines Oxford’s retrospective recovery rights and processes.

**POLICY**

**Note:** This policy applies to physicians only. It does not apply to facilities or ancillaries.

Oxford periodically requests that providers return overpayments as a result of either:

- **Administrative Reasons:** Duplicate payments, payments relating to fee schedules or billing/bundling issues, payments made where Oxford was not the primary insurer; or
- **Behavioral Issues:** Upcoding, misrepresentation of service provided, services not rendered at all, frequent waiver of member financial responsibility.

Oxford may pursue such claims overpayments as permitted by law and following the state’s applicable statute of limitations. Oxford uses random sampling, examination by external experts, and reliable statistical methods to determine claim overpayments in situations involving large volumes of potentially overpaid claims.

**Note:** Once a provider is given notice of the overpayment, Oxford will initiate discussions and take actions during the following one year period.

**PROCEDURES AND RESPONSIBILITIES**

Oxford will not pursue collection of overpayments when the overpayments are identified as isolated mistakes or where the provider is not at fault, if the overpayments were more than one year prior to the date of notice of the overpayment or use extrapolation. Examples include overpayments related to duplicate claims, fee schedule issues, isolated situations of incorrect billing/unbundling, and situations where Oxford was not the primary insurer.

**Exception:** Oxford will pursue collection of overpayments beyond one year and utilize statistical methods and extrapolation in situations where:

- Oxford has a reasonable suspicion of fraud or a sustained or high level of billing error; this includes situations such as:
  - Extensive or systemic upcoding
  - Unbundling
  - Misrepresentation of services or diagnosis
  - Services not rendered
  - Frequent waiver of member financial responsibility
  - Misrepresentation of provider rendering the services or licensure of such provider, and similar issues
- A provider affirmatively requests additional payment on claims or issues older than one year, whether through suit, arbitration, or otherwise; or
- The Centers for Medicare and Medicaid Services makes a retroactive change to enrollment or to primary versus secondary coverage of a Medicare plan member.

**Related Policies**

None
REFERENCES

Connecticut General Statutes Annotated §52-576.
New Jersey Statutes Annotated 2A:14-1.
New York - McKinney's Civil Practice Law and Rules §213.

POLICY HISTORY/REVISION INFORMATION

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| 04/01/2019 | Reorganized policy template:  
|            | - Simplified and relocated Instructions for Use  
|            | - Removed Applicable Lines of Business/Products section (policy applies to all Commercial plan membership; no exceptions apply) |
| 02/01/2019 | Updated policy guidelines; replaced language indicating "Oxford may pursue such claims overpayments as permitted by law and following the applicable statute of limitations (usually six years)" with "Oxford may pursue such claims overpayments as permitted by law and following the state’s applicable statute of limitations"  
|            | - Updated supporting information to reflect the most current references  
|            | - Archived previous policy version ADMINISTRATIVE 128.12 T0 |

INSTRUCTIONS FOR USE

The services described in Oxford policies are subject to the terms, conditions and limitations of the member's contract or certificate. Oxford reserves the right, in its sole discretion, to modify policies as necessary without prior written notice unless otherwise required by Oxford's administrative procedures or applicable state law. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

Certain policies may not be applicable to Self-Funded members and certain insured products. Refer to the member specific benefit plan document or Certificate of Coverage to determine whether coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies. If there is a difference between any policy and the member specific benefit plan document or Certificate of Coverage, the member specific benefit plan document or Certificate of Coverage will govern.