

1 By Supervisor Alexander

2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46

A RESOLUTION

Urging the State of Wisconsin to create and pass legislation placing a one-year limit on the timeframe in which insurance companies and third party payers seeking recoupment of previously paid claims may notify the service provider of such intent.

WHEREAS, more than twenty states have established a time limit for insurance companies to initiate claims when seeking recoupment on previously paid claims for behavioral and health care services, as evidenced in the refund recoupment law summary chart attached hereto; and

WHEREAS, it is reasonable and prudent that the State of Wisconsin draft and adopt similar legislation in order to alleviate the draining of valuable resources from critical service areas which creates revenue shortfalls; and

WHEREAS, the Milwaukee County Behavioral Health Division (BHD) budget is presented in a programmatic format based on service areas that consist of the following programs;

- Management/Support Services
- Inpatient Services
- Adult Community Services
- Child and Adolescent Community Services
- Adult Crisis Services
- AODA Services

and under this format, program costs consist of both direct expenditures and allocated costs that are attributable to the operation of each program; and

WHEREAS, revenues for each program consist of charges directly associated with the provision of services to patients and other operating revenues that are not directly related to patient services, and insurance companies cover some of the costs for services provided to patients, and in turn, reimburse BHD for services provided; and

WHEREAS, within programmatic areas, insurance companies submit insurance recoupment claims to BHD many years after the initial claim is fulfilled; and

WHEREAS, Wisconsin State Regulation DHS 1 establishes the requirement that county social service agencies bill their cost for the services they provide, directing that:

47 DHS 1.05 (6) (a) All billing and collection efforts shall strive toward
48 what is fair and equitable treatment for both clients who receive
49 service and taxpayers who bear unmet costs... and, that (c) All
50 billing and collection activity shall be pursued in a forthright and
51 timely manner according to these rules:

- 52
- 53 1. Where applicable insurance exists, the insurance company shall
54 be billed directly wherever possible by the unit with collection
55 responsibility for the facility providing the service. Where a
56 responsible party is covered by Medicare and private insurance,
57 Medicare shall be billed for the full coverage it provides and the
58 private insurance company shall be billed for any remaining
59 amount. Medicaid, where applicable, is the payer of last resort.
60 For services exempted by DHS 1.01 (4), third-party
61 reimbursement shall be pursued where applicable, but direct
62 billings to the client or other responsible parties shall no occur.
63 Agencies shall follow the claims processing procedures of third-
64 party payers to assure payment of claims.
65
 - 66 2. Responsible private parties shall be billed for liability not
67 covered by insurance, according to the applicable provisions of
68 DHS 1.03.
69

70 WHEREAS, payment errors are subject to interpretation by payers and
71 are generally not eligible for appeal; and
72

73 WHEREAS, there is an undue strain on taxpayers and staff to go years
74 back to recalculate patient accounts for possible errors and overpayments; and
75

76 WHEREAS; the Milwaukee County Behavioral Health Division closes its
77 books on an annual basis, in consideration of all expenditures and revenues and
78 these unanticipated recoupment costs create many financial difficulties for BHD
79 as well as patients, now therefore,
80

81 BE IT RESOLVED, the Milwaukee County Boards of Supervisors hereby
82 requests the State of Wisconsin to legislate a one-year limit, from the date of
83 initial claim payment, on the timeframe in which insurance companies and third
84 party payers seeking recoupment of previously paid claims may notify the service
85 provider of such intent and initiate such recoupment claims; and
86

87 BE IT FURTHER RESOLVED, that upon passage of this resolution, the
88 Milwaukee County Clerk is authorized and directed to send copies of this
89 resolution to the Governor of Wisconsin and the Milwaukee County State
90 Delegation.
91
92

MILWAUKEE COUNTY FISCAL NOTE FORM

DATE: September 12, 2013

Original Fiscal Note

Substitute Fiscal Note

SUBJECT: Urging the State of Wisconsin to create and pass legislation placing a one-year limit on the timeframe in which insurance companies and third party payers seeking recoupment of previously paid claims may notify the service provider of such intent.

FISCAL EFFECT:

- | | |
|--|--|
| <input checked="" type="checkbox"/> No Direct County Fiscal Impact | <input type="checkbox"/> Increase Capital Expenditures |
| <input checked="" type="checkbox"/> Existing Staff Time Required | <input type="checkbox"/> Decrease Capital Expenditures |
| <input type="checkbox"/> Increase Operating Expenditures
(If checked, check one of two boxes below) | <input type="checkbox"/> Increase Capital Revenues |
| <input type="checkbox"/> Absorbed Within Agency's Budget | <input type="checkbox"/> Decrease Capital Revenues |
| <input type="checkbox"/> Not Absorbed Within Agency's Budget | |
| <input type="checkbox"/> Decrease Operating Expenditures | <input type="checkbox"/> Use of contingent funds |
| <input type="checkbox"/> Increase Operating Revenues | |
| <input type="checkbox"/> Decrease Operating Revenues | |

Indicate below the dollar change from budget for any submission that is projected to result in increased/decreased expenditures or revenues in the current year.

	Expenditure or Revenue Category	Current Year	Subsequent Year
Operating Budget	Expenditure	0	0
	Revenue	0	0
	Net Cost	0	0
Capital Improvement Budget	Expenditure	0	0
	Revenue	0	0
	Net Cost	0	0

DESCRIPTION OF FISCAL EFFECT

In the space below, you must provide the following information. Attach additional pages if necessary.

- A. Briefly describe the nature of the action that is being requested or proposed, and the new or changed conditions that would occur if the request or proposal were adopted.
- B. State the direct costs, savings or anticipated revenues associated with the requested or proposed action in the current budget year and how those were calculated.¹ If annualized or subsequent year fiscal impacts are substantially different from current year impacts, then those shall be stated as well. In addition, cite any one-time costs associated with the action, the source of any new or additional revenues (e.g. State, Federal, user fee or private donation), the use of contingent funds, and/or the use of budgeted appropriations due to surpluses or change in purpose required to fund the requested action.
- C. Discuss the budgetary impacts associated with the proposed action in the current year. A statement that sufficient funds are budgeted should be justified with information regarding the amount of budgeted appropriations in the relevant account and whether that amount is sufficient to offset the cost of the requested action. If relevant, discussion of budgetary impacts in subsequent years also shall be discussed. Subsequent year fiscal impacts shall be noted for the entire period in which the requested or proposed action would be implemented when it is reasonable to do so (i.e. a five-year lease agreement shall specify the costs/savings for each of the five years in question). Otherwise, impacts associated with the existing and subsequent budget years should be cited.
- D. Describe any assumptions or interpretations that were utilized to provide the information on this form.

Approval of this resolution will urge the State of Wisconsin to create and pass legislation placing a one-year limit on the timeframe in which insurance companies and third party payers seeking recoupment of previously paid claims may notify the service provider of such intent.

Approval of this resolution will not require an expenditure of funds, but will require staff time to communicate its contents to State policymakers.

Department/Prepared By CB/Martin Weddle

Authorized Signature _____

Did DAS-Fiscal Staff Review? Yes No

Did CBDP Review?² Yes No Not Required

¹ If it is assumed that there is no fiscal impact associated with the requested action, then an explanatory statement that justifies that conclusion shall be provided. If precise impacts cannot be calculated, then an estimate or range should be provided.

² Community Business Development Partners' review is required on all professional service and public work construction contracts.

1 By Supervisor Alexander
 2
 3

4 **A RESOLUTION**

5 urging the State of Wisconsin to draft and pass legislation placing a one-year
 6 time limit on insurance companies seeking refunds from overpaid claims for
 7 behavioral health services and extending legal filing times for behavioral health
 8 providers to submit recoupment claims to insurance providers
 9

10 WHEREAS, the mission for the Milwaukee County Behavioral Health
 11 Division (BHD) is for the empowerment and recovery of all people with behavioral
 12 health needs in Milwaukee County; and
 13

14 WHEREAS, BHD's budget is presented in a programmatic format based on
 15 service areas that consist of the following programs:
 16

- 17 Management/Support Services
- 18 Inpatient Services
 - 19 -Nursing Facility Services
 - 20 -Acute Adult/ Child Services
- 21 Adult Community Services
- 22 Child and Adolescent Community Services
- 23 Adult Crisis Services
- 24 AODA Services

25
 26 ; and
 27

28 WHEREAS, under this format, program costs consist of both direct
 29 expenditures and allocated costs that are attributable to the operation of each
 30 program; and
 31

32 WHEREAS, revenues for each program consist of charges directly
 33 associated with the provision of services to patients and other operating
 34 revenues that are not directly related to patient services; and
 35

36 WHEREAS, insurance companies cover some of the costs for services
 37 provided for patients, and in turn, are reimbursed by BHD for services provided;
 38 and
 39

40 WHEREAS, based on experience, within certain programmatic areas,
41 insurance companies have been submitting insurance recoupment claims to BHD
42 three to five years after BHD has reimbursed them, claiming that BHD was
43 charged a lower rate than it should have been; and
44

45 WHEREAS; this creates many financial difficulties within the division in the
46 current year, as it is not anticipated; and
47

48 WHEREAS, payment errors are subject to interpretation by the service
49 provider and insurance companies; and
50

51 WHEREAS, this places an undue strain on BHD staff and resources to go
52 years back to recalculate patient accounts for possible errors and overpayments;
53 and
54

55 WHEREAS, recoupment claims found to be valid cause perpetual billing
56 discrepancies when secondary and tertiary payers refuse to adjust their prior
57 underpayments in light of the recoupment, causing an incurable revenue
58 deficiency; and
59

60 WHEREAS; more than twenty States currently have laws placing a time
61 limit for insurance companies seeking refunds for overpaid claims for behavioral
62 and health care services, as evidenced in the refund recoupment law summary
63 chart that is hereto attached to this file; and
64

65 WHEREAS, it is reasonable and prudent that the State of Wisconsin draft
66 and adopt similar legislation placing a time limit on insurance companies seeking
67 refunds for overpaid claims for behavioral and health care services to alleviate
68 billing errors which drain valuable resources in such a critical service such as
69 behavioral and mental health care as well as extend filing times for behavioral
70 health providers to submit recoupment claims to insurance providers; now,
71 therefore,
72

73 BE IT RESOLVED, the Milwaukee County Board of Supervisors hereby urges
74 the State of Wisconsin to draft and pass legislation placing a one-year time limit,
75 from the date the claim was initially paid, on insurance companies and health
76 care insurers seeking refunds for overpaid claims for behavioral health services;
77 and extending legal filing times for behavioral health providers to submit
78 recoupment claims to alternate insurance providers as evidence of the validity for
79 good faith payment adjustments; and

80

81 BE IT FURTHER RESOLVED, that upon passage of this resolution, the
82 Milwaukee County Clerk is authorized and directed to send copies of this
83 resolution to the Governor of Wisconsin and the Milwaukee State Legislative
84 Delegation.

MILWAUKEE COUNTY FISCAL NOTE FORM

DATE: June 7, 2013

Original Fiscal Note

Substitute Fiscal Note

SUBJECT: A resolution urging the State of Wisconsin to draft and pass legislation placing a one-year time limit on insurance companies seeking refunds from overpaid claims for behavioral health services and extending legal filing times for behavioral health providers to submit recoupment claims to insurance providers

FISCAL EFFECT:

- | | |
|--|--|
| <input checked="" type="checkbox"/> No Direct County Fiscal Impact
<input checked="" type="checkbox"/> Existing Staff Time Required
<input type="checkbox"/> Increase Operating Expenditures
(If checked, check one of two boxes below)
<input type="checkbox"/> Absorbed Within Agency's Budget
<input type="checkbox"/> Not Absorbed Within Agency's Budget
<input type="checkbox"/> Decrease Operating Expenditures
<input type="checkbox"/> Increase Operating Revenues
<input type="checkbox"/> Decrease Operating Revenues | <input type="checkbox"/> Increase Capital Expenditures
<input type="checkbox"/> Decrease Capital Expenditures
<input type="checkbox"/> Increase Capital Revenues
<input type="checkbox"/> Decrease Capital Revenues
<input type="checkbox"/> Use of contingent funds |
|--|--|

Indicate below the dollar change from budget for any submission that is projected to result in increased/decreased expenditures or revenues in the current year.

	Expenditure or Revenue Category	Current Year	Subsequent Year
Operating Budget	Expenditure	0	0
	Revenue	0	0
	Net Cost	0	0
Capital Improvement Budget	Expenditure	0	0
	Revenue	0	0
	Net Cost	0	0

DESCRIPTION OF FISCAL EFFECT

In the space below, you must provide the following information. Attach additional pages if necessary.

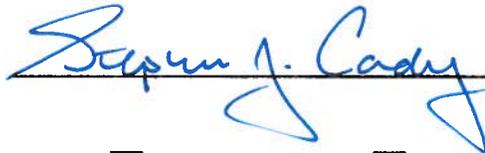
- A. Briefly describe the nature of the action that is being requested or proposed, and the new or changed conditions that would occur if the request or proposal were adopted.
- B. State the direct costs, savings or anticipated revenues associated with the requested or proposed action in the current budget year and how those were calculated. ¹ If annualized or subsequent year fiscal impacts are substantially different from current year impacts, then those shall be stated as well. In addition, cite any one-time costs associated with the action, the source of any new or additional revenues (e.g. State, Federal, user fee or private donation), the use of contingent funds, and/or the use of budgeted appropriations due to surpluses or change in purpose required to fund the requested action.
- C. Discuss the budgetary impacts associated with the proposed action in the current year. A statement that sufficient funds are budgeted should be justified with information regarding the amount of budgeted appropriations in the relevant account and whether that amount is sufficient to offset the cost of the requested action. If relevant, discussion of budgetary impacts in subsequent years also shall be discussed. Subsequent year fiscal impacts shall be noted for the entire period in which the requested or proposed action would be implemented when it is reasonable to do so (i.e. a five-year lease agreement shall specify the costs/savings for each of the five years in question). Otherwise, impacts associated with the existing and subsequent budget years should be cited.
- D. Describe any assumptions or interpretations that were utilized to provide the information on this form.

Approval of this resolution will urge the State of Wisconsin to draft and approve legislation placing a one-year time limit, from the date the claim was initially paid, on insurance companies and health care insurers seeking refunds for overpaid claims for behavioral health services; and extending legal filing times for behavioral health providers to submit recoupment claims to alternate insurance providers as evidence of the validity for good faith payment adjustments.

Approval of this resolution will not require an expenditure of funds, but will require staff time to communicate its contents to State policymakers.

Department/Prepared By Steve Cady, Fiscal and Budget Analyst, County Board

Authorized Signature



Did DAS-Fiscal Staff Review? Yes No

Did CBDP Review?² Yes No Not Required

¹ If it is assumed that there is no fiscal impact associated with the requested action, then an explanatory statement that justifies that conclusion shall be provided. If precise impacts cannot be calculated, then an estimate or range should be provided.

² Community Business Development Partners' review is required on all professional service and public work construction contracts.



DEPARTMENT OF HEALTH & HUMAN SERVICES
BEHAVIORAL HEALTH DIVISION

Milwaukee County

Note Date



May 13, 2011

ForwardHealth
Managed Care Appeals
PO Box 6470
Madison, WI 53716-6470

To Whom It May Concern::

This letter is in reference to an Overpayment Notification from OptumHealth Behavioral Solutions for Milwaukee County Mental Health Complex, Tax ID 396005720 (see attached). The overpayment is in the amount of \$115917.50 representing 9 member episodes from 2006. ← Note Date.

For all 9 episodes, the overpayment reason was "incorrect contract rate applied" and contained the following note:

NOTES: Wisconsin Non Par Medicaid Rates provide that DRG 715 is reimbursed at a base rate of \$500.00 times a weight of 1.1223 = \$5611.50

NOTES: Wisconsin Non Par Medicaid Rates provide that DRG 714 is reimbursed base rate of \$5000.00 times a weight of 2.0075 = \$10037.50.

During 2006, the United Health Group paid all Milwaukee County charges based on our per diem rate. This is true of the claims in question. This overpayment claim is one of nine long-stay 2006 claims UBH has hand picked as an overpayment based on conversion to a DRG rate. UBH cannot opt to have long-stay episodes paid using the DRG and short stay claims paid using the per diem rate. If UBH wishes to change from a per diem to a DRG rate for 2006 claims, it must be done for all claims in 2006 reflecting a total underpayment of \$91,272.09. The Milwaukee County Behavioral Health Division will agree to pay the overpayment for this claim when it receives a check from UBH for the 2006 claims that were underpaid based on the DRG rate. I have attached a spreadsheet for the 2006 claims.

Your prompt attention to this matter is greatly appreciated.

Sincerely,

A handwritten signature in cursive script that reads "N. Maslanka".

Nicki Maslanka
Accounts Receivable/Billing Supervisor
Milwaukee County Behavioral Health Division
(414) 257-6675
nicole.maslanka@milwcnty.com



REFUND RECOUPMENT LAWS

State	Statute/Code	Time limit for seeking refund of overpaid Claim	Other factors concerning time limit for seeking refund of overpaid Claim	Exemptions	Period
ALABAMA	Al 27-1-17	An insurer, health service corporation, and health benefit plan shall not retroactively seek recoupment or refund of a paid claim after the expiration of one (1) year from the date the claim was initially paid or after the expiration of the same period of time that the health care provider is required to submit claims, whichever date occurs first.	An insurer, health service corporation, or health benefit plan shall not retroactively seek recoupment or refund of a paid claim for any reason that relates to the COB of another carrier responsible for the payment of the claim after expiration of eighteen (18) months from the date claim was paid.	An insurer, health service corporation, and health benefit plan shall not retroactively seek recoupment or refund of a paid claim from provider for any reason, other than fraud or coordination of benefits or for duplicate payments after the expiration of one year from the date that the initial claim was paid.	12 Months
ALASKA	AS 21.54.020	A healthcare insurer can recover an amount, wrongly paid to a provider.	—	—	No Limit
ARKANSAS	Ann. § 23-61-108, §23-63-1806, §25-15-201	A health care insurer cannot seek refund of paid claim after the expiration of eighteen (18) months from the date the claim was initially paid.	A health care insurer has one hundred and twenty (120) days from the date of payment to notify the provider of a verification error and the fact that services rendered will not be covered if the error was made in good faith at the time of the verification.	Except in cases of fraud committed by the health care provider, means fraud that the insurer discovered after the eighteen (18) month period and could not have discovered prior to the end of the eighteen-month period.	18 Months
ARIZONA	§20-3102	A health care insurer shall not adjust or request adjustment of a payment or denial of claim more than one year after the date health care insurer has paid the claim. If a provider and insurer agree through contract about adjustment then even they have same length of time to request adjustment of a claim. Once claim is adjusted an insurer or provider shall owe no interest on the overpayment or underpayment resulting from the adjustment as long as the adjustment or recoupment taken within the period of 30 days of the date of claim adjustment.	—	This Section shall not apply in case of fraud.	12 Months

REFUND RECOUPMENT LAWS

State	Statute/Code	Time limit for seeking refund of overpaid Claim	Other factors concerning time limit for seeking refund of overpaid Claim	Exemptions	Period
CALIFORNIA	110133.66 (2005 Cal ALS 441; 2005 Cal SB 634; Stats 2005 ch.44)	Reimbursement request for the overpayment of a claim shall not be made, unless a written request for reimbursement is sent to provider within 365 days of the date of payment on the overpaid claims.	—	Time limit of 365 days shall not apply if the overpayment was caused in whole or in part by fraud or misrepresentation on the part of the provider.	12 Months
COLORADO	C.R.S 10-16-704 (2009)	Adjustments to claims by the carrier shall be made within the time period set out in contract between the provider and the carrier. The time period shall be the same for the provider and the carrier and shall not exceed 12 months after the date of the original explanation of benefits. If no contract exists then adjustments to claims shall be made 12 months after the date of the original explanation of benefits.	Adjustments to claims related to coordination of benefits with federally funded health benefit plans, including medicare and medicaid, shall be made within thirty-six (36) months after the date of service.	Adjustments to claims made in cases where a carrier has reported fraud or abuse committed by the provider, shall not be subject to the requirements of this subsection.	12 Months
CONNECTICUT	SB 764	Insurers and HMOs are prohibited from seeking to recover an overpayment for a claim paid under a health insurance policy unless they provides written notice to the person from whom recovery is sought within five (5) years after receiving the initial claim.	—	—	60 Months
DISTRICT OF COLUMBIA	D.C Code § 31-3133	Insurer may only retroactively deny reimbursement to provider for services subject to COB during the 18-month period after the date that the health insurer paid the health care provider; or during the 6-month period after the date that the health insurer paid the health care provider.	A health insurer that retroactively denies reimbursement to a health care provider shall provide a written statement specifying the basis for the retroactive denial. If the retroactive denial of reimbursement results from COB, the written statement shall provide the name and address of the entity acknowledging responsibility for payment of the denied claim.	This section will not apply if information submitted was fraudulent; or improperly coded or duplicate claim or does not otherwise conform with the contractual obligations. If insurer retroactively denies reimbursement for services as a result of cob the provider shall have 180 days after the date of denial, unless the insurer permits longer time insurer that denies reimbursement to provider shall give provider a written notice specifying the basis for the retroactive denial. This section shall not apply to an adjustment to reimbursement made as an annual contracted reconciliation of a risk-sharing arrangement.	6 Months

REFUND RECOUPMENT LAWS

State	Statute/Code	Time limit for seeking refund of overpaid Claim	Other factors concerning time limit for seeking refund of overpaid Claim	Exemptions	Period
FLORIDA	FL §627.6131	If an overpayment in result of retroactive review or audit of coverage decisions or payment levels a health insurer must submit the claims details to provider within 30 months after the health insurer's payment of the claim.	A provider must pay, deny, or contest the claim for overpayment within 40 days after the receipt of the claim and must pay or deny within 120 days of the receipt. Failure to the above creates an uncontestable obligation to pay the claim. The health insurer may not reduce payment to the provider for other services unless the provider agrees to the reduction in writing or fails to respond to the health insurer's overpayment claim.	Time limit of 30 months. Except in the case of fraud committed by the health care provider.	30 Months
GEORGIA	O.C.G.A. § 33-20A-62	No carrier may conduct a post payment audit or impose a retroactive denial of payment on any claim that was submitted within 90 days of the last date of service or discharge covered by such claim unless: (1) notice of intent to conduct such an audit is provided; (2) Not more than 12 months have elapsed since the last date of service or discharge covered by the claim; (3) Any such audit or retroactive denial of payment must be completed and notice provided to the claimant of refund due within 18 months of the last date of service or discharge covered by such claim	No insurance carrier may conduct a post-payment audit or impose a retroactive denial of payment on any claim submitted after 90 days unless a written notice is provided, not more than 12 months have elapsed and it should be finalized within 24 months.	Any such audit must be completed within 18 months from the date of final discharge of claim.	18 Months
INDIANA	IC 27-8-5.7-10	Insurance may request the provider to repay the overpayment or adjust a subsequent claim after the expiration of two years from the date claim is paid.	—	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.	24 Months
IOWA	191-15.33 (507B)	Insurance may not audit a claim more than two years after the submission of the claim to insurer & not a claim billed for less than \$25.00.	—	The law applies only if the carrier did not suspect fraud.	24 Months

REFUND RECOUPMENT LAWS

State	Statute/Code	Time limit for seeking refund of overpaid Claim	Other factors concerning time limit for seeking refund of overpaid Claim	Exemptions	Period
KENTUCKY	304-17A-708	An insurer shall not be required to correct a payment error made 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.	—	Time limitation shall not be applicable in case of fraud.	24 Months
LOUISIANA	LRS 22:250.38	health insurance shall provide the health care provider written notification in accordance with LRS 22:250.38. Health care provider shall be allowed thirty days from receipt of written notification of recoupment to appeal the health insurance issuer's action.	If a healthcare provider disputes insurance's notification of recoupment and a contract exists, the dispute shall be resolved according to terms of contract. If no contract exists, the dispute shall be resolved as any other dispute under Civil Code Article 2299 et seq.	—	—
MAINE	24-A - §4303.	The time that has elapsed since the date of payment of the previously paid claim does not exceed 12 months.	—	The retrospective denial of a previously paid claim may be permitted beyond 12 months from the date of payment only if: 1. The claim was submitted fraudulently 2. Duplicate payment 3. Services identified in the claim were not delivered by the provider 4. Adjustment with another insurer COB 6. The claim payment is the subject of legal action.	12 Months
MARYLAND	M. A. Code section 15-1008	A carrier may only retroactively deny reimbursement paid to healthcare provider during the six month period after the date the carrier paid the claim.	This Section Provides time frame for the period of 18 months in case of services subject to coordination of benefits with another carrier.	The time period is not limited if: 1. Information submitted was fraudulent. 2. Improperly Coded 3. Payment was made for duplicate claim. 4. a claim submitted to MCO & the claim was for services provided to a MD Medical Assistance Program recipient during a time period when Program has permanently retracted the capitation payment for the Program recipient.	6 Months

REFUND RECOUPMENT LAWS

State	Statute/Code	Time limit for seeking refund of overpaid Claim	Other factors concerning time limit for seeking refund of overpaid Claim	Exemptions	Period
MASSACHUSETTS	HB 976	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 if: (1) claim was submitted fraudulently; (2) claim payment was incorrect because the provider or the insured was already paid ; (3) health care services were not delivered by the physician/provider; (4) claim payment is the subject of adjustment with another insurer; or (5) claim payment is the subject of legal action	12 Months
MISSOURI	Sec. 376.384	Prohibit requesting 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.	12 Months
MONTANA	33-22-150	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.	—	If insurance does not limit the time for submission of a claim for payment, then insurance 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.	12 Months
NEW HAMPSHIRE	Insurance Code 420-J;8-b.	No health carrier shall impose on any health care provider any retroactive denial of a previously paid claim or any part thereof unless: (a) the carrier 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 18 months.	—	Time limit can be extended beyond the period of 18 months provided claim was submitted fraudulently or claim was incorrect because the provider was already paid for the services claim payment is the subject of adjustment with a different insurer.	18 Months

REFUND RECOUPMENT LAWS

State	Statute/Code	Time limit for seeking refund of overpaid Claim	Other factors concerning time limit for seeking refund of overpaid Claim	Exemptions	Period
NEW JERSEY	C.17B:30-48 Chapter 352	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.	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.	18 Months
NEW YORK	§ 3224-b	Prohibit HMOs and other insurers from demanding refunds from a physician more than two years after the claim was initially paid.	Require 30 days notice to providers when the insurer is seeking a refund.	This limitation does not apply if it involve fraud, intentional misconduct, abusive billing or when initiated at the request of a self funded plan or required by a federal or state government program.	24 Months
NORTH CAROLINA	—	Depends upon the contractual terms of a healthcare provider and insurance.	—	—	—
OHIO	Revised Code 3901.38.8 & 3901.388	Third party insurer may recover an overpaid amount not later than two year from the date the claim was paid to the provider. The Provider should be informed about the overpayment practices through notice. Provider shall have a right to file appeal. In case of no response from the provider the carrier is free to initiate recovery practices.	—	Time limitation shall not be applicable in case of fraud.	24 Months
OKLAHOMA	§36-1250.5	Act of insurance company will be considered as unfair claim settlement practices act if insurance request refund from the provider after the period of 24 months from the date claim was paid.	—	This section shall not apply where the claim was submitted fraudulently or provider otherwise agrees to make a refund of claim.	24 Months

REFUND RECOUPMENT LAWS

State	Statute/Code	Time limit for seeking refund of overpaid Claim	Other factors concerning time limit for seeking refund of overpaid Claim	Exemptions	Period
SOUTH CAROLINA	§ 38-59-250	An insurance may not initiate overpayment recovery process from a provider more than 18 months after the initial payment was received by the provider.	An insurer shall initiate any overpayment recovery efforts by sending a written notice to the provider at least 30 business days prior to engaging in the overpayment recovery efforts.	This time limit does not apply to the initiation of overpayment recovery efforts: (1) based upon a reasonable belief of fraud or other intentional misconduct; (2) required by a self-insured plan; or (3) required by a state or federal government program.	18 Months
TEXAS	§ 3.70-3C	The insurer has no later than the 180 day after provider receives payment to recover an "overpayment" must provide written notice and mention specific reasons for request of recovery of funds.	If carrier as secondary payer pays a portion of a claim that should be paid by the primary carrier, the secondary payer may recover overpayment from the carrier that is primarily responsible for that amount. If the portion of the claim overpaid by the secondary payer was also paid by the primary payer, the secondary payer may recover the amount of overpayment from the physician	—	180 Days
UTAH	§ 31A-26-301.6	The insurer may recover any amount improperly paid to a provider or an insured (a) within 24 months of the amount improperly paid for a coordination of benefits error; (b) within 12 months of the amount improperly paid for any other reason; or (c) within 36 months of the amount improperly paid when the improper payment was due to a recovery by Medicaid, Medicare, the Children's Health Insurance Program, or any other state or federal health care program	—	—	12 Months

REFUND RECOUPMENT LAWS

State	Statute/Code	Time limit for seeking refund of overpaid Claim	Other factors concerning time limit for seeking refund of overpaid Claim	Exemptions	Period
VERMONT	18 V.S.A. § 9418	A health plan shall not retrospective deny a previously paid claim unless at least 30 days notice of any retrospective denial or overpayment recovery is provided inwriting to the provider or the time that has elapsed since the date of payment of the previously paid claim does has exceeded 12 months	—	The retrospective denial of a previously paid claim shall be permitted beyond 12 months if (1) the plan has a reasonable belief that fraud or other intentional misconduct has occurred; (ii) the claim payment was incorrect because the health care provider was already paid; (iii) health care services identified in the claim were not delivered by the provider; (iv) the claim payment is subject of adjustment with another health plan; or (v) the claim is the subject of legal action.	12 Months
VIRGINIA	§ 38.2-3407.15	Carrier can only impose retroactive denial of claim if provided the reason for denial, provider was already paid for the services and time period does not exceed the lesser of 12 months or a number of days mentioned in a contract.	—	Exception of fraud is not provided.	12 Months
WASHINGTON	Chapter 48.43.600	A carrier may not 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.	A carrier may not for reasons related to coordination of benefits with another carrier (a) Request refund from a health care provider; 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, and include the name and mailing address of the entity that has primary responsibility for payment of the claim.	This Section shall not apply in case of fraud.	24 Months
WEST VIRGINIA	WVC § 33-45-2	Carrier can only deny a claim where a provider was already paid for the service, claim was not covered under the service and provider not entitled to reimbursement for the period of one year from the date when the claim was paid to the provider.	—	Limitation shall not be applicable in case of misrepresentation or fraud by provider.	12 Months

Disclaimer: The information contained in this spreadsheet is provided for general educational and informational purposes only and should not, under any circumstances, be construed as legal advice. MTBC makes no claims or warranties as to the accuracy, veracity or completeness of the information contained in this spreadsheet and assumes no liability arising therefrom. MTBC reserves the right to amend, supplement or delete the contents of this spreadsheet or stop publication thereof at any time and without notice.

1 By Supervisor Haas

2 **A RESOLUTION**

3
4 to modify the Milwaukee County Fiscal Note Form to add a check off box as to whether
5 an intergovernmental agreement requires the approval of an Executive Council per State
6 Statute 59.794 and related procedures
7

8
9 WHEREAS, 2013 Wisconsin Act 14 requires certain intergovernmental
10 agreements, before they may take effect and become binding on the county, must be
11 approved by the executive council" as defined by State Statute 59.794(d), which states:
12

13 "Executive council" means a body that consists of the mayor of a 1st class
14 city, and the elected executive officer of every city and village that is wholly
15 located within the county and who is also a member of the executive council as
16 described in s. [200.23 \(2\) \(b\)](#).
17

18 ; and
19

20 WHEREAS, the Intergovernmental Cooperation Council (ICC) of Milwaukee county
21 currently serves as the Executive Council for the review of certain intergovernmental
22 agreements; and
23

24 WHEREAS, the Milwaukee County Fiscal Note Form is produced and distributed
25 by the Office of the Comptroller and is required to be completed for every resolution or
26 ordinance that is considered by the County Board; and
27

28 WHEREAS, it would be helpful if a "check box" was included on the Fiscal Note
29 Form to report whether any resolution or ordinance relating to an intergovernmental
30 agreement require approval by the Executive Council prior to agreement taking effect
31 and becoming binding on the County; and
32

33 WHEREAS, a check box will also provide transparency to policymakers and the
34 public regarding the need for Executive Council review and help ensure that
35 intergovernmental agreements are approved and handled in accordance with state law;
36 now, therefore,
37

38 BE IT RESOLVED, that the County Board of Supervisors hereby supports the
39 addition of a check box on the Milwaukee County Fiscal Note Form that states:

40
41
42
43
44

Does this resolution or ordinance relate to an intergovernmental agreement that is believed to require approval by an Executive Council pursuant to Wisconsin Statute 59.794?

45

YES

NO

UNCERTAIN

46 ; and
47

48
49
50
51
52

BE IT FURTHER RESOLVED, that the Office of the Comptroller is requested to update the official Milwaukee County Fiscal Note Form to include the aforementioned question and to distribute the new form to County departments as soon as practicable; and

53
54
55
56
57

BE IT FURTHER RESOLVED, that any approved resolution or ordinance related to an intergovernmental agreement where the check off box is marked "yes" or "uncertain," the County Clerk is authorized and directed to mail (postal service and email) the resolution and any documents in the file to the Executive Council when practicable; and

58
59
60

BE IT FURTHER RESOLVED, that a copy of this resolution shall be sent to the Office of the Comptroller and Executive Council by the County Clerk.

MILWAUKEE COUNTY FISCAL NOTE FORM

DATE: September 18, 2013

Original Fiscal Note

Substitute Fiscal Note

SUBJECT: A resolution to modify the Milwaukee County Fiscal Note Form to add a check off box as to whether an intergovernmental agreement requires the approval of an Executive Council per State Statute 59.794 and related procedures

FISCAL EFFECT:

- | | |
|--|--|
| <input checked="" type="checkbox"/> No Direct County Fiscal Impact
<input checked="" type="checkbox"/> Existing Staff Time Required
<input type="checkbox"/> Increase Operating Expenditures
(If checked, check one of two boxes below)
<input type="checkbox"/> Absorbed Within Agency's Budget
<input type="checkbox"/> Not Absorbed Within Agency's Budget
<input type="checkbox"/> Decrease Operating Expenditures
<input type="checkbox"/> Increase Operating Revenues
<input type="checkbox"/> Decrease Operating Revenues | <input type="checkbox"/> Increase Capital Expenditures
<input type="checkbox"/> Decrease Capital Expenditures
<input type="checkbox"/> Increase Capital Revenues
<input type="checkbox"/> Decrease Capital Revenues
<input type="checkbox"/> Use of contingent funds |
|--|--|

Indicate below the dollar change from budget for any submission that is projected to result in increased/decreased expenditures or revenues in the current year.

	Expenditure or Revenue Category	Current Year	Subsequent Year
Operating Budget	Expenditure	0	0
	Revenue	0	0
	Net Cost	0	0
Capital Improvement Budget	Expenditure	0	0
	Revenue	0	0
	Net Cost	0	0

DESCRIPTION OF FISCAL EFFECT

In the space below, you must provide the following information. Attach additional pages if necessary.

- A. Briefly describe the nature of the action that is being requested or proposed, and the new or changed conditions that would occur if the request or proposal were adopted.
- B. State the direct costs, savings or anticipated revenues associated with the requested or proposed action in the current budget year and how those were calculated.¹ If annualized or subsequent year fiscal impacts are substantially different from current year impacts, then those shall be stated as well. In addition, cite any one-time costs associated with the action, the source of any new or additional revenues (e.g. State, Federal, user fee or private donation), the use of contingent funds, and/or the use of budgeted appropriations due to surpluses or change in purpose required to fund the requested action.
- C. Discuss the budgetary impacts associated with the proposed action in the current year. A statement that sufficient funds are budgeted should be justified with information regarding the amount of budgeted appropriations in the relevant account and whether that amount is sufficient to offset the cost of the requested action. If relevant, discussion of budgetary impacts in subsequent years also shall be discussed. Subsequent year fiscal impacts shall be noted for the entire period in which the requested or proposed action would be implemented when it is reasonable to do so (i.e. a five-year lease agreement shall specify the costs/savings for each of the five years in question). Otherwise, impacts associated with the existing and subsequent budget years should be cited.
- D. Describe any assumptions or interpretations that were utilized to provide the information on this form.

Approval of this resolution will authorize and request the Office of the Comptroller to modify and distribute a revised Milwaukee County Fiscal Note Form (this form) that includes a check off box on that asks:

Does this resolution or ordinance relate to an intergovernmental agreement that is believed to require approval by an Executive Council pursuant to Wisconsin Statute 59.794?

YES

NO

UNCERTAIN

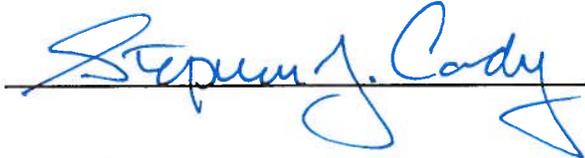
In addition, the resolution authorizes and directs the County Clerk to mail (postal service and email) the resolution and any documents in the file to the Executive Council related to an intergovernmental agreement where the check off box is marked "yes" or "uncertain" to the Executive Council as soon as practicable.

Approval of this resolution will not require an expenditure of funds but will require existing staff time to comply with the provisions.

¹ If it is assumed that there is no fiscal impact associated with the requested action, then an explanatory statement that justifies that conclusion shall be provided. If precise impacts cannot be calculated, then an estimate or range should be provided.

² Community Business Development Partners' review is required on all professional service and public work construction contracts.

Department/Prepared By Stephen Cady, Fiscal and Budget Analyst, County Board

Authorized Signature 

Did DAS-Fiscal Staff Review? Yes No

Did CBDP Review?² Yes No Not Required

1 By Supervisor Dimitrijevic
2
3

4 **A RESOLUTION**

5 authorizing and directing the Director of the Department of Health and Human
6 Services to enroll Milwaukee County in the National Association of Counties
7 Dental discount program.
8

9 WHEREAS, Milwaukee County is a member in good standing of the
10 National Association of Counties (NACo); and
11

12 WHEREAS, WHEREAS, NACo sponsors a prescription drug discount
13 card program for its member counties to provide to their citizenry through
14 Caremark Rx, Inc. and has recently voted to modify the program to allow a small
15 amount of revenue to flow back to participating counties; and
16

17 WHEREAS, the Milwaukee County Board of Supervisors authorized
18 enrollment in NACo's prescription drug discount card program by a unanimous
19 vote in September 2005 (File No. 05-419); and
20

21 WHEREAS, since Milwaukee County began participating, cardholders in
22 Milwaukee County have received over \$1 million in discounts on more than
23 109,000 prescriptions, for a per-prescription savings of between 25 and 30
24 percent off retail drug pricing; and
25

26 WHEREAS, the NACo Dental Discount Program gives counties an
27 opportunity to offer its uninsured residents dental and orthodontics savings; the
28 discount card allows people to save from 5% to 50% on routine dental care and
29 20% on orthodontics; and
30

31 WHEREAS, member counties of NACo can sign up for the program for
32 free; and
33

34 WHEREAS, the plan can complement health insurance plans or work
35 with health savings accounts, flexible spending accounts and health
36 reimbursement arrangements for maximum savings; and
37

38 WHEREAS, with the NACo Dental Discount Program, a county resident
39 can schedule an appointment with a participating dentist or specialist and present
40 the program membership card to receive a discount at the time of service; now,
41 therefore
42

43 BE IT RESOLVED, the Director of the Department of Health and Human
44 Services is authorized and directed to enroll Milwaukee County in the National
45 Association of Counties Dental discount program.

MILWAUKEE COUNTY FISCAL NOTE FORM

DATE: September 17, 2013

Original Fiscal Note

Substitute Fiscal Note

SUBJECT: A resolution authorizing and directing the Director of the Department of Health and Human Services to enroll Milwaukee County in the National Association of Counties dental discount program.

FISCAL EFFECT:

No Direct County Fiscal Impact Expenditures

Increase Capital

Existing Staff Time Required

Decrease Capital

Expenditures

Increase Operating Expenditures
(If checked, check one of two boxes below)

Increase Capital

Revenues

Absorbed Within Agency's Budget

Decrease Capital

Revenues

Not Absorbed Within Agency's Budget

Decrease Operating Expenditures funds

Use of contingent

Increase Operating Revenues

Decrease Operating Revenues

Indicate below the dollar change from budget for any submission that is projected to result in increased/decreased expenditures or revenues in the current year.

	Expenditure or Revenue Category	Current Year	Subsequent Year
Operating Budget	Expenditure	0	0
	Revenue		
	Net Cost		
Capital Improvement Budget	Expenditure		
	Revenue		
	Net Cost		

DESCRIPTION OF FISCAL EFFECT

In the space below, you must provide the following information. Attach additional pages if necessary.

- A. Briefly describe the nature of the action that is being requested or proposed, and the new or changed conditions that would occur if the request or proposal were adopted.
- B. State the direct costs, savings or anticipated revenues associated with the requested or proposed action in the current budget year and how those were calculated.¹ If annualized or subsequent year fiscal impacts are substantially different from current year impacts, then those shall be stated as well. In addition, cite any one-time costs associated with the action, the source of any new or additional revenues (e.g. State, Federal, user fee or private donation), the use of contingent funds, and/or the use of budgeted appropriations due to surpluses or change in purpose required to fund the requested action.
- C. Discuss the budgetary impacts associated with the proposed action in the current year. A statement that sufficient funds are budgeted should be justified with information regarding the amount of budgeted appropriations in the relevant account and whether that amount is sufficient to offset the cost of the requested action. If relevant, discussion of budgetary impacts in subsequent years also shall be discussed. Subsequent year fiscal impacts shall be noted for the entire period in which the requested or proposed action would be implemented when it is reasonable to do so (i.e. a five-year lease agreement shall specify the costs/savings for each of the five years in question). Otherwise, impacts associated with the existing and subsequent budget years should be cited.
- D. Describe any assumptions or interpretations that were utilized to provide the information on this form.

- A. A resolution authorizing and directing the Director of the Department of Health and Human Services to enroll Milwaukee County in the National Association of Counties dental discount program.
- B. N/A
- C. N/A
- D. No assumptions made.

Department/Prepared By CB/ Weddle

Authorized Signature Martin Weddle

Did DAS-Fiscal Staff Review? Yes No

Did CDBP Review?² Yes No Not Required

¹ If it is assumed that there is no fiscal impact associated with the requested action, then an explanatory statement that justifies that conclusion shall be provided. If precise impacts cannot be calculated, then an estimate or range should be provided.

² Community Business Development Partners' review is required on all professional service and public work construction contracts.

NACo Dental Discount Program

The NACo Dental Discount Program gives your county a great opportunity to offer your uninsured residents dental and orthodontics savings. The discount card allows people to save 5% to 50% on dental care and 20% on orthodontics.

The NACo Dental Discount Program is easy to use. Members simply pay an annual or monthly fee for access to participating providers who have agreed to give services at discounted rates. For individuals, the fee is \$59 per year or \$6.95 per month. For families, the fee is \$69 per year or \$8.95 per month. With the NACo Dental Discount Program, a member simply schedules an appointment with a participating dentist or specialist and presents the membership card to receive a discount at the time of service. It is important to note:

- Everyone is accepted
- Family membership includes all family members
- All discounts are available at time of service
- Unlimited plan usage, with no administrative forms or waiting periods
- Significant savings on dental cleanings, x-rays, braces, dentures, crowns, root canals and more
- Discount dental plans are a great option for individuals or families on tight budgets, but who still place great importance on their family's dental hygiene
- The plan can complement health insurance plans or work with health savings accounts, flexible spending accounts and health reimbursement arrangements