Policy and Procedure No: CL 2.4	**Revision No: 4**
Division: Care Management	
Department: Claims Operations	
Title: PHC-CA Claim Overpayments	
Effective Date: 12/31/2019	
Supersedes Policy No: CL 2.0, CL 2.1, CL 2.2, CL 2.3	
Reviewed/Revised by: Sandra Holzner	**Review/Revision Date: 12/8/2025**
Approving Committee: Member Provider Committee	**Date: 12/15/2025**
Executive Oversight Committee Date: 12/16/2025	

Purpose:

To establish the process PHC California (the Health Plan) utilizes to collect overpayments made to provider(s).

Policy:

The Health Plan identifies overpayments to contracted providers during our normal course of business through the post payment claims review process, fraud waste and abuse investigations, and case specific high dollar claims review for coding accuracy.

A. Provider Identified Overpayment Submission

1. The Plan requires Network Providers to report when they have received an overpayment.

2. The Provider must report the overpayment to the Plan within sixty (60) calendar days after the date the overpayment was identified

3. If the provider identifies an overpayment, the provider shall report the overpayment to the Health Plan in writing. The Provider shall notify the Plan in writing of the reason for the overpayment pursuant to 24 CFR 438.608(d)(2).

4. This section does not address a situation where the Plan identifies an overpayment and notifies the institutional or professional providers. In this case, the Plan must follow the requirements in applicable law and regulation, including Health and Safety Code section 1371.1. See section B below.

B. Health Plan Identified Overpayment Process

1. The Plan shall request reimbursement of the overpayment from the provider within three-hundred and sixty-five (365) days of the date of payment on the overpaid claim, except where the overpayment was caused in whole or in part by fraud or misrepresentation.

2. The Plan shall send a written notice to a provider of an overpaid claim within thirty (30) working days of the receipt of the notice of overpayment. The Health Plan shall send a second notice if a refund is not received within thirty (30) days of initial notice.

    a. The written notice shall contain the reason for the overpayment and why the Health Plan is requesting the reimbursement. The written request shall contain all elements required by applicable regulation, including a clear and specific basis for the overpayment determination; identification of the associated claim(s), member, and

date(s) of service; a statement of any applicable interest and/or penalties; and detailed instructions for the submission of a dispute.

3. The Plan shall not apply the three-hundred and sixty-five (365) day time limit if the overpayment was caused in whole or in part by fraud or misrepresentation on the part of the provider. In the event the Plan identifies or recovers an overpayment of any amount due to potential fraud, the Plan will notify DHCS (Audits and Investigations Intake Unit and its MCOD CM) within ten (10) days.

4. If the Provider contests the notice of reimbursement of the overpayment of a claim, the provider, within thirty (30) working days of the receipt of the notice of overpayment, shall send a written notice stating the basis upon which the provider believes the claim was not overpaid.

5. If the provider **does not** contest the notice of reimbursement, the provider shall reimburse the Plan within thirty (30) working days of the receipt of the provider notice of overpayment of a claim.

6. An offset of an uncontested notice of payment is only applied if the provider has failed to reimburse within thirty (30) days and if the provider has a contract agreement to offset the current claims submissions. Offsets may be applied only when expressly authorized under the terms of the provider's contract. Under no circumstances shall offsets be applied to payments made to non-contracted providers.

C. Plan Retention of Provider Overpayments

1. The Plan shall have internal retention and documentation process for recovery of all overpayments and review bi-annually for accuracy.

2. Recoveries of less than $25,000,0000.00.

    a. The Health Plan shall retain all recoveries of a single overpayment occurrence less than twenty-five million dollars ($25,000,000.00).

    b. The Plan is required to report all overpayments in their annual report to DHCS, using the rate development template (RDT), including recoveries that are less than $25,000,000.00.

    c. The Plan is not required to report overpayments that are less than $25,000,000.00 within sixty (60) calendar days of when the overpayment was identified, which is a Plan reporting requirement for overpayments that are equal to or more than $25,000,000.00.

3. Recoveries equal to or more than $25,000,0000.00.

    a. In the event the Plan recovers an overpayment to a provider of twenty-five million dollars ($25,000,000.00) or more, DHCS and the Plan will share the recovery amount equally.

    b. Within sixty (60) days after the date that the overpayment was identified, the Plan must report the overpayment to DHCS through their contract manager and provide the following information:

        i. The overpayment amount that was recovered;

ii. The reason for overpayment;

iii. The service(s) the overpayment was related to, if applicable;

iv. The Provider(s) information; and

v. The steps taken to correct and/or prevent future occurrences.

c. DHCS will recoup the overpayment from the Plan capitated payment. The statement issued to the Plan will reflect the overpayment.

d. The Plan shall submit the overpayment amount that was recovered, the provider(s) information, and steps taken to correct future occurrences to the Plan's assigned Managed Care Operations Division Contract Manager.

4. Recoveries of any amount related to potential fraud

a. In the event the Plan identifies or recovers an overpayment to a Provider to potential fraud, waste, or abuse, the Plan shall notify its MCOD CM and the DHCS Audits and Investigations Unit at piu.cases@dhcs.ca.gov within ten (10) working days of identifying the overpayment, regardless of the amount.

D. Annual Reporting Requirements

1. Pursuant to DHCS All Plan Letter (APL) 23-011 the Plan must report more frequently than annually to DHCS on the Health Plan's recoveries of overpayments that are in excess of $25 million, including those made to a network provider that was otherwise excluded from participation in the Medicaid program and those made to a network provider due to fraud, waste or abuse. These reports shall be submitted though the existing rate-setting process in a manner specified by DHCS. If requested by DHCS, the Plan shall submit documentation, including retention policies, process, timeframes, and documentation required for reporting the recovery of all overpayments.

2. The Plan must report annually to DHCS using the rate development template its recoveries of overpayments, regardless of the amount or category. This includes overpayments made to a Network Providers that was otherwise excluded from participation in the Medicaid program, and those made to a Network Provider due to fraud, waste, or abuse.

E. The Health Plan is further responsible for ensuring that Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including All Plan Letters (APLs) and Policy Letters. These requirements must be communicated by the Plan to all Subcontractors and Network Providers. DHCS may impose Corrective Action Plans (CAP), as well as administrative and/or monetary sanctions for non-compliance. For additional information regarding administrative and monetary sanctions, see DHCS APL 22-015 and any subsequent iterations on this topic.

Procedure:

1. The Managed Care Senior Director of Finance has an internal retention and documentation process for recovery of all overpayments.

a. All overpayment refunds received are reviewed and reconciled by the AHF Finance Department on a monthly basis.

b. All overpayments shall be reviewed bi-annually for accuracy by the Managed Care Senior Director of Finance. The results of this review shall be tracked by the Compliance Department in Report Manager to ensure completion.

c. The Managed Care Senior Director of Finance and/or her designee logs and scans all provider refunds.

d. The Managed Care Senior Director of Finance and/or her designee enters the refund into the claims processing system.

e. The refunds are sent to Accounts Receivables in the Finance Department and deposited into the Plan account.

2. Health Plan Identified Overpayments

a. Should the Health Plan identify an overpayment through the bank reconciliation process or the Plan's coding analytics vendor, the Provider Data Management Department (PDM) generates a written request for return of overpayment amount.

i. The notice shall also include information clearly identifying the following:

1. The claim

2. The name of the patient

3. The date of service and

4. A clear explanation of the basis upon which the Plan believes the amount paid on the claim was in excess of the amount due and

5. Interest and penalties on the claim.

b. If the provider of the overpaid claim sends a written notice of disagreement on the overpayment amount, the Provider Data Management Department shall resolve, and provide a written resolution letter to the Provider within forty-five (45) days of receipt of the dispute.

i. If the contracted provider fails to respond or refund the uncontested overpayment amount within thirty (30) working days of the receipt of the notification, the Senior Director of Finance and Claims Operations will offset the overpayment amount due from current or future claims, if the provider contract allows for offsets.

ii. An overpayment amount can be offset if the provider has entered into a written contract with the Plan specifically authorizing the offset an uncontested notice of overpayment of a claim from the contracted provider's current claim submissions.

iii. Offsets cannot be applied to non-contracted providers

iv. The Plan shall provide a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim or claims.

v. The Senior Director of Finance of Claims operations shall record the offset as an adjustment in the Claims Processing system.

3. Provider Identified Overpayments

    a. If a provider identifies an overpayment, the provider is instructed to issue a refund check to the Plan and mail the refund to the following address:

4. Recoveries of any amount related to potential fraud

    a. In the event the Plan identifies or recovers an overpayment to a Provider to potential fraud, the Plan's Compliance/SIU Manager shall notify its MCOD CM and the DHCS Audits and Investigations Unit at piu.cases@dhcs.ca.gov within ten (10) working days of identifying the overpayment, regardless of the amount.

5. Annual Reporting Requirements

    a. The AHF Finance Department shall complete the annual report through the DHCS RDT Process.

Definitions:

1. Overpayment: Any payment made to a network provider by the Health Plan to which the network provider is not entitled to under Title XIX of the Social Security Act.

2. Network Provider: Any provider, group of providers, or entity that has a network provider agreement with the Health Plan, or a subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer or render covered services as a result of the state's contract with the Health Plan.

3. Fraud: is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

4. Waste: is generally understood to mean the overutilization or inappropriate utilization of services and misuse of resources and typically is not a criminal or intentional act.

5. Abuse: is defined as provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Monitoring:

1. The Health Plan Compliance Department will review and monitor this process as needed to ensure compliance with Federal and State Regulatory agencies.

2. This policy is updated, as necessary, reviewed and approved annually by the Member Provider Committee.

Reference(s):

1. 42 CFR §438.608(d)
2. 42 CFR §438.2
3. 42 CFR §455.2
4. Welfare and Institutions (W&I) Code §14043.1
5. Fraud, Waste, and Abuse Toolkit. Healthcare Fraud and Program Integrity: An Overview for Providers. (2014). Centers for Medicare and Medicaid Services. Retrieved at http://ow.ly/Mnb130al2By.
6. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-011, Treatment of Recoveries Made by the Managed Care Health Plan of Overpayments to Providers (Supersedes APL 17-003), published May 8, 2023.
7. California Code of Regulations, Title 22, Sections 50781-50791
8. California Department of Health Care Services Contract 18XXXXXX, Exhibit A, Attachment 8