Overpayment Recovery Toolkit

Attempting to determine the validity of alleged overpayments can divert significant time from direct patient care, which results in lost practice revenue. Overpayment demands may be made in very general terms and may also be intimidating. However, it is critical for physician practices to effectively and efficiently address overpayment recovery requests.

In order to help physicians understand health insurer overpayment recovery requests, the AMA has created the following resources:

Table of contents (Click to navigate to sections)

Please note: *The information in this document primarily addresses overpayment recovery requests pertaining to individual claims or claim line items from private payers. For information regarding overpayment recovery requests related to the Centers for Medicare and Medicaid Services (CMS) Recovery Audit Contractor (RAC) program, please visit www.ama-assn.org/go/RAC.*

Recognizing and interpreting overpayment recovery requests

Navigating overpayment recovery requests from health plans can be a challenging, tedious process for physician practices. However, it's important to handle these requests in a timely and efficient manner to prevent invalid recoupments and maintain a physician practice's financial health.

1. What is an overpayment recovery request?

An overpayment recovery request is a proposed retroactive denial or reduced payment of a previously paid claim. Payers use several different overpayment recovery mechanisms—reducing other payments currently owed to the physician, withholding or setting off against future payments, requesting a check from the physician to cover the overpayment or in any other manner reducing or affecting the future claim payments to the physician. While a claim overpayment request may involve multiple claims resulting from a global audit, this resource addresses overpayment recovery requests for individual claims or claim line items. For information regarding overpayment recovery requests related to the Centers for Medicare and Medicaid Services (CMS) Recovery Audit Contractor (RAC) program, please visit www.ama-assn.org/go/RAC.

2. What are the reasons for an overpayment recovery request from a payer on a previously paid claim?

The top reasons payers send an overpayment request on a previously paid claim include:

- Coverage terminated before service provided
- Other insurer was responsible (coordination of benefits questions)
- Duplicate payment
- Paid under incorrect fee schedule (i.e., in-network versus out-of-network)
- Services not covered by patient's benefit plan
- Payment terms differ from contract terms
- Service was deemed not medically necessary
- Lack of authorization

3. What information is included in an overpayment recovery request for an individual claim?

Typically, a payer must provide advance written notice that it intends to recoup funds from the physician due to an overpayment. That written notice can be mailed or reported electronically using the Health Insurance Portability and Accountability Act (HIPAA) electronic remittance advice. The overpayment recovery process should begin with a formal notice of overpayment that is sent to the physician by the payer. Many states have laws or regulations that mandate

payers to send an advance notification letter to the physician prior to recouping the overpayment amount in question.

The notification letter from the payer must contain a reasonable, documented basis that the payer has overpaid the physician. While the required contents of the written notification vary by state, the payer must provide the following information in its notification to comply with all the state advanced notification requirements:

- explain in detail why the previously made payment was an overpayment;
- identify the claim on which the overpayment was made, including any applicable claim numbers;
- identify the subscriber's full name and provide any subscriber identification numbers;
- identify the date(s) on which the physician provided the medical services for which the physician received the overpayment;
- identify the Current Procedural Terminology (CPT®) code(s) on which the overpayment was made, or, if no CPT code is available, provide a description of the medical services for which the payer or the authorized payer overpaid;
- specify the amount of overpayment;
- identify the date the overpayment was made, how overpayment was issued to the physician, e.g., by mail or electronically, and, if applicable, the number of the check containing the overpayment;
- if the alleged overpayment exists because another entity has acknowledged responsibility for payment, specify the name and address of the entity;
- if the payer intends to initiate a retroactive denial on a previously paid claim to recover the overpayment, identify the pending claims from which the payer intends to recoup or offset the overpayment or state that the recoupment or offset will be made from future claims;
- state the specific timeframe within which the physician may dispute the notice of overpayment from the payer;
- state that, if the payer does not receive the physician's notice of dispute within a stated time period, the physician will be deemed to have authorized a recoupment or offset; and
- provide a telephone number or mailing address whereby the physician may submit a dispute concerning the notice of overpayment to the internal dispute resolution process.

If the payer does not provide you with the information listed above, contact the payer for the specific information, especially if the address to send a refund check or appeal is not clearly defined. Payers may have two separate processes for handling appeals on claim denials versus appeals on overpayments. In order to avoid auto-recoupment while a refund check or appeal is in route to the payer, be sure to send it to the correct address for the intended purpose. If you are unable to obtain the specific information necessary to address the payer's overpayment request or are unable to resolve disputes through the payer's internal process, the AMA encourages you to file a formal complaint against the payer with your state's department of insurance.

4. What is the identifier listed on the overpayment recovery notification that is used to identify the requested overpayment by the payer? How is this identifier relevant to my practice?

The payer-assigned identifier is typically the FCN, which stands for Financial Control Number. Payers may call this by other names, such as ICN (i.e. Internal Control Number), Letter ID, claim number or another payer-specific alpha or numeric identifier to identify each overpayment recovery request and its related correspondence. The payer places the assigned FCN or other payer-specific identifier on all communications both written and electronic relating to the specific overpayment request, including the notification letter. In turn, the FCN or other payer-specific identifier should be recorded on all communications relating to the overpayment request with the payer. When mailing a check, it is important to record the FCN on the check as well as on any accompanying correspondence. When electing to have the overpayment auto-recouped or allowing the payer to take the money back on a future claim, the electronic remittance advice [Accredited Standards Committee (ASC) X12 835] will reference the FCN or other payer-specific identifier when the recoupment occurs.

Reporting the payer-assigned identifier is crucial for tracking and reconciling the overpayment and submitting any related correspondence to the payer. This identifier links all the communications and details of an overpayment request with a payer; without it, communication about the overpayment between a payer and your practice might be incorrectly appropriated, misplaced or lost.

Addressing and resolving overpayment recovery requests

It is important to address overpayment recovery requests as soon as possible. You must remember that you have the right to challenge a request, but there may be defined time constraints for doing so according to your contract with the health insurer. When receiving an overpayment recovery request, you'll need to know how to effectively handle it.

Please note: The information in this document primarily addresses overpayment recovery requests pertaining to individual claims or claim line items from private payers. For information regarding overpayment recovery requests related to the Centers for Medicare and Medicaid Services (CMS) Recovery Audit Contractor (RAC) program, please visit www.ama-assn.org/go/RAC.

1. What should I do when I receive an overpayment recovery request on an individual claim?

It is important to address the overpayment request as soon as possible. Review the letter or electronic notification from the payer against your account ledger to identify the reason(s) for the request and determine its validity. If the payer does not provide you with enough information to identify the overpaid claim and/or reason for the overpayment, be sure to contact the payer directly in order to obtain the necessary information to determine the appropriateness of the overpayment recovery request. If the requested overpayment is indeed accurate, be sure to follow the payer-specified instructions to either approve auto-recoupment from a future reimbursement or find out where to submit a refund check. If the overpayment recovery request is inaccurate, you have a right to challenge it. However, there may be a limited time period for you to respond, as defined by the payer. In some cases, auto-recoupment is automatic if a health plan doesn't receive a check or appeal within a specified period of time. For this reason, you are encouraged to respond expeditiously to the overpayment recovery request, whether through the direct refund of the overpayment, auto-recoupment approval process or an appeal.

When you receive an overpayment recovery request from a payer, there are some steps that should be followed in order to promptly and accurately address it. These steps are the same whether you follow a manual or electronic process. They are essential to determining the validity of the overpayment recovery request from the payer.

Figure 1: Steps for addressing a claim overpayment recovery request from a payer

- Review the letter or electronic notification from the payer and your patient account ledger for the appropriate request reason and claim data regarding the claim overpayment.
- Contact the payer if additional basic information is needed to process the claim overpayment.
- Determine if the request is valid.

    - If valid, submit a refund check (or approve recoupment from the next payment) of the claim overpayment to the payer. (See questions 2 and 3 for additional information)
    - If not valid, submit an appeal in writing, within the time limits defined by your contract with the payer, to the specific address provided. (See questions 5 and 6, as well as sample claim overpayment appeal letter.)
- Use your practice management system functions to track the following information associated with the refund payment for the claim overpayment. *[Note: The AMA encourages the use of your practice management software system to perform this task. Consult with your practice management software vendor for details.]*
    - Date of service
    - Patient name
    - Patient member/policy ID number
    - Patient account number/Financial Control Number (FCN)
    - Payer claim number
    - Payer invoice number (preferred)

2. What specific actions should I take if an overpayment recovery request is valid?

To the extent that an overpayment has indeed occurred, the practice must pay it back. Repayment is even more important now, since Medicare imposes an affirmative repayment obligation on physicians and other health care providers. Under the law, a physician must report and repay a Medicare overpayment no later than sixty (60) days after the date on which the practice identifies an overpayment. Failure to report and repay the overpayment within this timeframe may result in significant monetary and administrative penalties. Your practice should have procedures in place for repaying identified overpayments to all payers as a matter of good business practice.

For physician practices, attempting to determine the validity of alleged overpayments can divert significant time from direct patient care, which results in loss of practice revenue. All too frequently, overpayment demands are made in the most general terms; the practice is not given the specific information—such as dates of service, patient names or claim numbers—necessary for the practice to determine the validity of the overpayment request.

If the overpayment is valid, abide by the time limit on the notification and send the refund to the payer. If the refund is being sent between 30 and 40 calendar days of the deadline, call the payer to apprise them of the funds being remitted. Provide the following:

- Member/Policy ID
- FCN/Document Control Number (DCN) or Letter ID
- Check number and date
- Date the check was sent or electronic funds remitted
- The amount of the check/remitted funds
- How it was sent (FedEx, UPS, USPS, electronic remittance advice recoupment)

Be sure to notate the patient's account to track the refund or recoupment of the overpayment. File notification letters and other correspondence from the payer regarding the overpayment. Be sure to notate all debits and credits on the appropriate patient account record.

3. What actions can I take to recover revenue from valid overpayment recoupments?

Inaccurate payments, whether they are overpayments or underpayments, require physicians and their practice staff as well as payers to manually rework claims. Revisiting claims that could have been paid correctly the first time greatly increases administrative costs incurred by physicians, payers and the health care delivery system as a whole.

However, investing the time to rework an overpaid claim may prove worthwhile if the practice can recover some, if not all, of the recouped payment. If it is determined that the patient is responsible for payment, the practice can bill the patient. If the overpayment recovery request indicates that another payer is responsible for payment, the practice should submit the claim to the secondary payer.

4. How can I avoid situations that may prompt future overpayment recovery requests from payers?

Physician practices are encouraged to identify the most common reasons for overpayment recovery requests and perform a deep dive into their internal processes to determine why each request occurred. For example, if the most common overpayment request is "coverage terminated before service provided" or "other insurer was responsible," examine your practice's patient check-in process. Always check patients' eligibility and benefits for each date of service.

Your practice can reduce the number of claims that payers deny by tracking routinely denied claims. Tracking the reasons for payer claim denials is critical to improving your claims revenue cycle. Use this information to improve internal processes and to ensure that you meet the payer's requirements for submitting a specific type of claim and following up in the appropriate fashion. Additionally, you are encouraged to perform a routine examination of your claims denial history or claims that have resulted in repeated overpayments and identify and correct the most frequent sources of those denials or overpayments.

It's also important to promptly return erroneous claims payments. When posting, verify if the claim was paid twice for the same date of service and return any duplicate payments. You should also return any payments for patients not treated by you. Do not write "VOID" across any checks to be returned. Instead, write the reason for the check return on the check stub or in the advice section.

Practices may not be able to prevent some overpayment recovery situations. For example, if a patient is retroactively disenrolled from a health plan, there is no way for a practice to anticipate this outcome, as the initial eligibility response from the health plan would have shown that the patient was eligible for benefits at the time of service. In some states, if the

health plan did verify eligibility at the time of the service, then the claim must be paid, independent of retroactive disenrollment. Access the AMA's electronic insurance eligibility toolkit to learn how performing electronic insurance eligibility can save your practice time and money as well as provide you with increased patient insurance coverage information. This is how revisiting your workflow can reduce future overpayment requests or strengthen your appeal.

5. How do I appeal an invalid overpayment recovery request on an individual claim?

Your practice should review and appeal payers' inappropriate claim overpayment requests to avoid lost revenue. Challenging inappropriate overpayment recovery requests through a payer's overpayment appeal process may result in a change to the payer's business practices and can also save your practice money. Payers may support Internet portal appeals or require letters.

If you feel that the claim overpayment recovery request is unjustified, you must appeal. Physicians have the right to appeal any determination made by a payer. The purpose of the appeal process is to address the legitimacy of the claim overpayment recovery request with the payer. The appeal letter should include all information which was relied upon and submitted in making the payment determination on the reimbursed claim. See Figure 2 for the six steps for appealing a claim overpayment recovery request.

Figure 2: Six steps for appealing an overpayment recovery request

Step 1. Review the overpayment recovery request from the payer and identify the reason for the overpayment request and the specific claim information.

Step 2. Prepare an appeal letter that includes the patient's name, subscriber's name, payer identification and insurer numbers, date of service and the reason that you are challenging the overpayment request.

- Be sure to follow the overpayment recovery appeal process as defined in your payer contract that may designate a specific appeal form and location to submit the appeal. Be sure to use the appropriate appeal form as designated by the payer or, if none is defined, the form specified by the physician practice's policy.

- A full explanation of the rationale for the appeal should be detailed within the body of the letter. Your appeal letter should include but not be limited to the following information:

    - Acknowledgement of receipt of the claim overpayment recovery notification
    - Patient account identifying information (i.e. patient name, date of service, claim number/FCN, member ID number, etc.)
    - Detailed explanation for rationale for appeal (with any supporting documentation)
    - Contact information (i.e. name, address, phone number, etc.) for physician or the practice staff designee

Step 3. Thoroughly support and document your argument. Use objective data and gather supporting documentation, including:

- A written explanation supporting the reason for your appeal.
- The necessary documentation of proof (e.g., copy of patient's eligibility verification with dates of coverage, clinical documentation, remittance advices and explanations of benefits from all payers involved, claim submission reports for timely filing, guidelines and/or policies from payer or governing entity, etc.) as indicated by the reason for claim overpayment.

Step 4. Identify the name of the payer's contact person or department who should receive the claim appeal for review.

- Be sure to address the claim overpayment appeal letter to the appropriate payer representative so that a specific person will be responsible for a reply, whenever possible. The payer's recovery notification letter should provide instructions as to where you should send the appeal. If not, review your contract for the payer's claims appeals process or call the payer and request the name and address of the payer representative or department to which you should address the claim appeal.

- If you choose to call the payer, indicate you are seeking to appeal an overpayment recovery request. Some payers have separate processes for claim appeals and overpayment recovery request appeals. Also, ask the payer representative the expected time frame for processing the claim appeal letter. This information will help you determine the appropriate time frame for follow-up procedures.

Step 5. Track the information regarding the claim overpayment for the purpose of assisting with follow up and identification of trends.

Step 6. Follow up and monitor the time it takes for the payer to respond to the appeal. Be sure to consult your contract with the payer in order to ensure compliance with a timely response.

6. What is at stake when I do not appeal an invalid overpayment recovery request?

Payers save money when they partially pay, delay, deny a claim payment or recoup an alleged overpayment because only a small percentage of physicians and their practice staff routinely pursue an appeal. When you do not review and appeal payers' inappropriately paid claims, denied claims or overpayment requests, your practice loses revenue. Challenging inappropriate claim payments through the payer's appeal process also demonstrates that you have made an effort to correct the payer's inaccuracy. Appeal efforts could lead to a change in the payer's business practices and can also save your practice money.

Automating the overpayment recovery process

Standard electronic health care transactions can help a physician practice make significant progress in improving administrative workflows. By automating the overpayment recovery process, a practice can save time and find ways to prevent future overpayments.

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1. What are the different ways in which payers can use the Accredited Standards Committee (ASC) X12 835 electronic remittance advice (ERA) transaction to communicate information regarding overpayment recovery?

The ASC X12 835 Implementation Guide details multiple ways that the ERA transaction can be used to communicate overpayment recovery information. The X12 835 can:

1) Report the overpayment in the form of a reversal of the previous adjudication and the correction statement of the revised adjudication, leading to immediate recoupment;
2) Report delay of recoupment of the overpayment identified in the reversal and correction;
3) Report receipt and crediting of a check sent to the health plan to cover the overpayment; or
4) Report recoupment of a delayed overpayment recovery that was originally reported in a prior 835 or on a paper notification.

Payers' usage of the X12 835 will depend on state laws regarding overpayment recovery notification and the plans' particular business practices.

2. How can I use my practice management software system (PMS) to reduce the number of overpayment recovery requests that my practice receives and automate the process when overpayments occur?

All physician practices are encouraged to keep track of overpayment recovery requests and utilize a payer follow-up log and other electronic tracking mechanisms for payer under- or overpayment requests as process improvement tools. Using electronic transactions to automate and standardize the workflows in your practice can reduce the likelihood of payer overpayment recovery requests. If your PMS does not allow you to handle immediate responses from payers or provide the electronic functionality that your practice needs to address overpayment recovery requests on individual claims, visit the AMA's Selecting a practice management system toolkit for guidance.

In order to assist physicians in maximizing their benefits from the use of the ASC X12 835 and minimizing the administrative burden associated with manual processing, the AMA created a white paper (log in) that details how the ASC X12 835 overpayment recovery and balance forward process works, associated accounting processes and how to use the information in order to automate administrative workflows. Physician practices can share this document with their technology partners, including clearinghouses, billing services, PMS vendors and information technology staff. These technology partners can then use the white paper to learn how to automate their overpayment recovery processes, which will in turn reduce the administrative burden for their physician practice customers and increase customer satisfaction.

3. How can I leverage practice automation to track overpayment recovery requests?

When tracking overpayment recovery requests, be sure to monitor follow-up activity that identifies each claim you have submitted and contains the payer's rationale for partially paying, delaying or denying a claim on first submission or requesting a refund of an alleged overpayment, along with the outcome of your collection efforts. Your practice management software should offer an electronic tickler file or tracking capabilities to help you to closely monitor overpayment recovery requests (by payer) in addition to your practice's overpayment recovery activity.

Necessary information for tracking overpayment recovery requests includes:

- Payer name
- Reason for originally partially paying, delaying or denying a claim, or requesting a refund
- Dates of appeal attempts
- Payer staff contact(s)
- The reason the claim was not paid in full (if applicable)

4. How can an overpayment recovery be tracked between multiple ERAs when the amount being recouped exceeds the amount of the current payment?

The balance forward process applies when overpayment recoveries or other reductions in payment exceed the payment amounts for claims or other physician payments, like capitation payments. The ASC X12 835 Implementation Guide expressly forbids sending a payment amount that is negative. As a result, the balance of that specific 835 must be increased to zero. This is done by "moving" the deficit from the current remittance advice into the next remittance advice.

The health plan is required to report the deficit that is moving using Provider Adjustment code "FB", meaning Forwarding Balance. Just like with overpayment recovery, an identifier is also required. In this case, the identifier for this remittance advice is used as the identifier for the balance forward. The related dollar amount is a negative number.

In the next remittance advice, the health plan is obligated to report the same forwarding balance information, but with a positive dollar amount (of the same magnitude). That moves the entire forwarding balance into this next remittance advice.

If the new remittance advice doesn't include sufficient funds to cover the balance forward and any new overpayment recoveries (ends up with a negative balance), then a new balance forward is created to start the process again.

5. How do I know if the payer overpayment recovery requests that I receive are compliant with ASC X12 version 005010?

The ASC X12 version 005010 Implementation Guide allows for multiple business scenarios. The payer must send notification (i.e., paper or electronic) which should illustrate the reason(s) for the overpayment recovery request on the individual claim. Certain identifying information must be available within the notification of the overpayment recovery request in order to be compliant with ASC X12 version 005010. Such content should set forth the timeframe by which the provider should respond to the overpayment recovery request and the consequences beyond this defined timeframe. In addition, the notifications must, at a minimum, display the: 1) Financial Control Number (FCN)/Other identifier and 2) qualifier (i.e., WO), and 3) the amount of the overpayment. In most cases, a correction and/or reversal of the overpayment is shown on the electronic notification as well.

The Health Insurance Portability and Accountability Act (HIPAA) requires payers to send standard electronic health care transactions that are compliant with the ASC X12 005010 Implementation Guides, which means the payer is required to send specific information regarding an overpayment on the ERA for the intended business purpose that includes notification of an overpayment, recoupment of an overpayment and confirmation of the receipt of a check for payment of an overpayment.

Visit the AMA's ERA toolkit for more information and resources on how your practice can transition to ERA today.

6. **What do I do if the electronic overpayment recovery notification, recoupment or payment acknowledgement is not being sent within my ERA?**

Payers are required to provide specific information in the ERA. All public and private payers must be able to handle all mandated electronic transactions in HIPAA-compliant electronic formats. This includes claims and ERA transactions. Automation of the physician practice is dependent on payer compliance with these standards in order to eliminate administrative waste. If you are not receiving such information on your ERA, consult your PMS vendor, billing service and clearinghouse directly. You may need to contact the payer in question in order to determine if such electronic options for their overpayment recovery notification, recoupment and acknowledgment process are available. If you feel that your inquiries are not being properly addressed by the payer, the AMA encourages you to file a formal complaint with the Office of E-Health Standards and Services (OESS).

Knowing your overpayment recovery rights

Many contracts between physician practices and private payers place few, if any, restrictions on the payer's ability to recover alleged overpayments via refund demands, offsets, etc. These overpayment recovery efforts place significant and unnecessary administrative burdens on physician practices. Fortunately, you may have rights that, if exercised, may greatly reduce those burdens and help you successfully challenge payers and preserve or even augment the financial stability of your practice.

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1. What are my rights when receiving an overpayment recovery request for an individually paid claim?

Contracts between payers and physicians often permit the payer to recover alleged overpayments by reducing or "offsetting" overpaid amounts from pending or future claims payments, with few, if any, restrictions or transparency requirements. For this reason, many state medical associations sought to reduce the ever-increasing administrative burden that overpayment recovery efforts have placed on physician practices by supporting state legislation that placed limits and specific requirements on payers' overpayment recovery processes, including advance overpayment notification, payment transparency, due process rights and claw-back time limits. As a result, at least 24 states have passed an overpayment statute or regulation that gives physicians significant rights with respect to payer overpayment recovery practices. Each physician practice that receives an overpayment recovery request on a previously paid claim from a payer must therefore not only be aware of the payer's overpayment contract provisions, but also the protections afforded under its state law. Everyone in the practice who deals with claims reconciliation needs to know what protections may exist.

Article XIV, Overpayments and Underpayments, from the AMA's National Managed Care Contract, compiles the best state statutes and regulations as they relate to overpayment recovery requests from payers. The AMA encourages payers to comply with the best overpayment recovery laws, in order to be compliant in all 50 states and improve their relations with physicians. There is an increasing recognition by state legislators and regulators of the problematic effects that payers' unconstrained ability to recover overpayments has on physician practices.

The AMA's National Managed Care Contract (NMCC) is designed to comply with the managed care laws of all 50 states and the District of Columbia, as well as with federal requirements. Its associated database contains all state laws and regulations governing overpayments, as well as an issue brief, which is designed to help physicians negotiate overpayment provisions in managed care contracts and analyze the legitimacy of overpayment demands. Using the NMCC, physicians can better understand, evaluate and negotiate managed care contracts. Please visit ama-assn.org/go/nmcc to watch a five-minute instructional video that provides a high-level overview of the NMCC database functionality and how to navigate the tool.

The information provided by the AMA is not intended as legal advice.

2. How far back can a payer seek recoupment on an overpaid claim?

State laws and regulations protect the rights of payers, physicians and other health care providers, and ultimately work to preserve the financial stability of the health care industry. Timelines for payers to seek recoupment on overpaid claims vary from state to state, and often contain exceptions where the payer has evidence of fraud, abuse or misrepresentation. For example, the state of California limits payers' recoupment requests to one year of the claim's payment date. In enforcing this law, the California Department of Managed Health Care ordered a payer to stop attempting to recoup overpayments beyond the timeframe set forth by state law (i.e., the payer had been attempting to collect millions of dollars in recoupment for overpaid medical claims that were well over one year of their respective payment dates). Visit ama-assn.org/go/nationalcontract to find out how far back a payer can seek recoupment in your state.

3. If I am enrolled in electronic funds transfer (EFT), can a health plan automatically debit payments from my banking account as part of an overpayment recovery process?

No. Although the banking network enables both credits and debits, health plans are not permitted to recoup funds from a provider's bank account due to claims that have been adjusted/readjudicated. According to the Health Insurance and Portability and Accountability Act (HIPAA) standards for electronic remittance advice transactions, readjudication is a separate process and must be handled in accordance with the Accredited Standards Committee (ASC) X12 835 Implementation Guide. Health plans debiting a provider's account for this purpose would be noncompliant with the HIPAA regulations. Providers with concerns about noncompliant health plans attempting an unauthorized debit can discuss their concerns with their banks, who can establish mechanisms preventing the debiting of their account, such as ACH Positive Pay or debit filters.