

Claim Retraction Lookback Period Policy

Policy

Unless otherwise specifically set forth in an agreement with the provider, this policy defines the lookback periods by product line for claim payment integrity.

- Medicare – 6 years from the date of payment
- Medicaid – 3 years from the date of payment
- Commercial plans – 1 year from the date of payment

This policy is intended for general purposes and shall not to be construed or interpreted in any way to supersede anything to the contrary in the provider's agreement.

Legal/Regulatory Support for Policy

Medicare

[42 CFR 401.305 Requirements for reporting and returning of overpayments.](#)

- (f) Lookback period. An overpayment must be reported and returned in accordance with this section if a person identifies the overpayment, as defined in paragraph (a)(2) of this section, within 6 years of the date the overpayment was received.

Medicaid

[§ 32.1-325.1. Appeals of agency determinations.](#)

B. The Director of Medical Assistance Services shall collect by any means available to him at law any amount owed to the Commonwealth because of overpayment for medical assistance services. Upon making an initial determination that an overpayment has been made to the provider pursuant to [§ 32.1-325.1](#), the Director shall notify the provider of the amount of the overpayment. Such initial determination shall be made within the earlier of (i) four years, or (ii) 15 months after filing of the final cost report by the provider subsequent to sale of the facility or termination of the provider. The provider shall make arrangements satisfactory to the Director to repay the amount due. If the provider fails or refuses to make arrangements satisfactory to the Director for such repayment or fails or refuses to repay the Commonwealth for the amount due for overpayment in a timely manner, the Director may devise a schedule for reducing the Medicaid reimbursement due to any successor in interest.

Virginia Commercial

[§ 38.2-3407.15. Ethics and fairness in carrier business practices.](#)

8. No carrier shall impose any retroactive denial of a previously paid claim or in any other way seek recovery or refund of a previously paid claim unless the carrier specifies in writing the specific claim or claims for which the retroactive denial is to be imposed or the recovery or refund is sought, the carrier has provided a written explanation of why the claim is being retroactively adjusted, and (i) the original claim was submitted fraudulently, (ii) the original claim payment was incorrect because the provider was already paid for the health care services identified on the claim or the health care

services identified on the claim were not delivered by the provider, or (iii) the time which has elapsed since the date of the payment of the original challenged claim does not exceed 12 months. Notwithstanding the provisions of clause (iii), a provider and a carrier may agree in writing that recoupment of overpayments by withholding or offsetting against future payments may occur after such 12-month limit for the imposition of the retroactive denial. A carrier shall notify a provider at least 30 days in advance of any retroactive denial or recovery or refund of a previously paid claim.