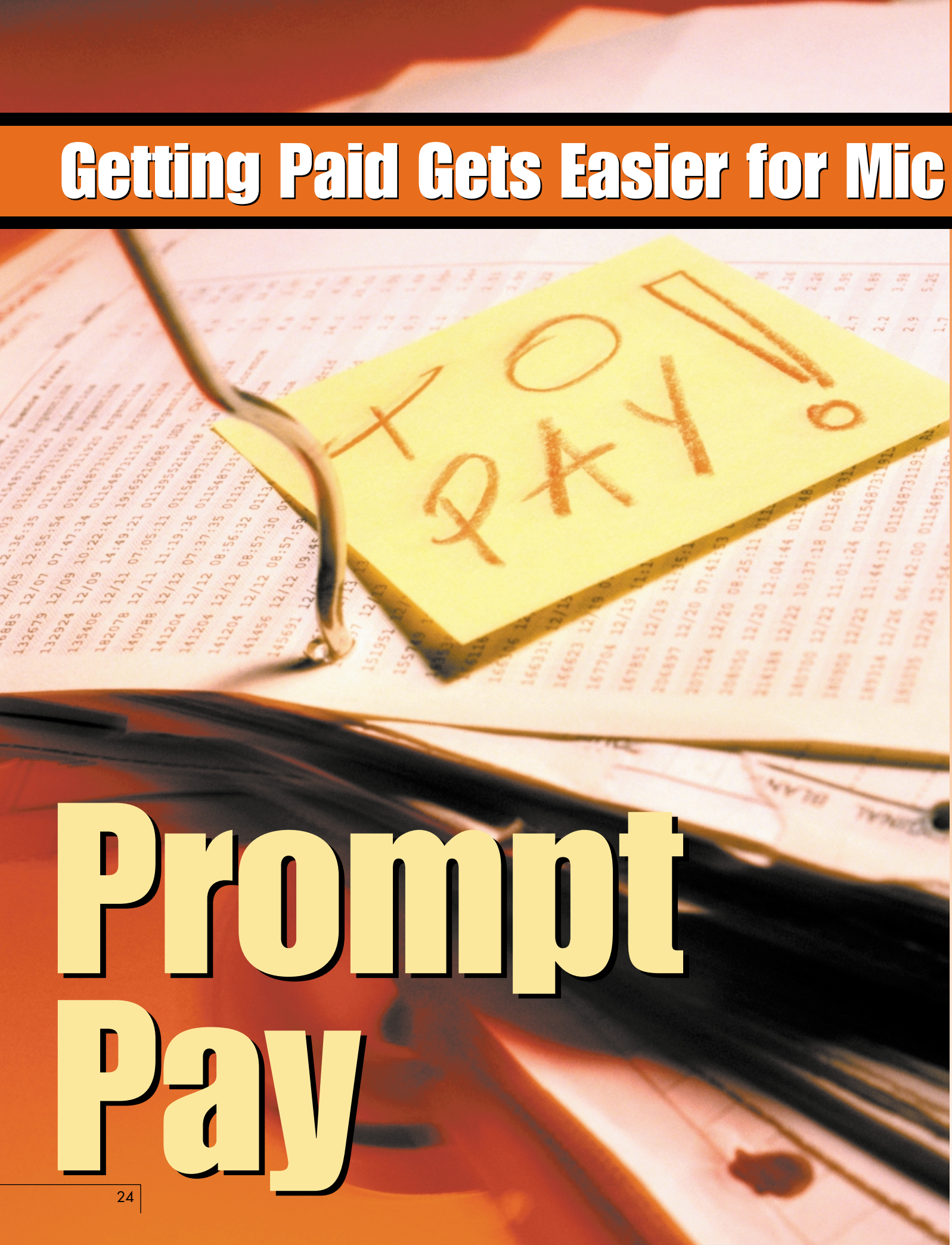
Getting Paid Gets Easier for Mic



Prompt Pay

higan's Health Care Providers

By William S. Hammond

A significant concern for health care providers is the prompt collection of accounts receivable from payors. Cash flow is vital to the success of a health care provider now, more than ever, as a result of reductions in the growth of Medicare and Medicaid spending, which otherwise accounts for a large percentage of the typical health care provider's income. As the amount of reimbursement is reduced, it becomes more important to health care providers that they collect the amounts they are due on a timely basis. Moreover, the recent experience of Michigan health care providers with the rehabilitation of OmniCare Health Plan, and the losses those providers are being forced to absorb, demonstrate the danger of maintaining large receivable balances with any one third-party payor.

At the same time, numerous factors have combined in recent years to make it more difficult for health care providers to realize payment from third-party payors on a timely basis. These factors include the administrative burden of complying with various third-party payor claims procedures, the absence of effective prompt payment laws, the lack of enforcement of such laws when they do exist, and the impracticality of litigating payment disputes on a claim-by-claim basis. These factors, combined with providers' general level of frustration with third-party payor payment practices, has resulted in a number of high profile class action lawsuits against numerous third-party payors alleging prompt pay violations.[1]

In addition to class action litigation, state regulators have made some efforts to force prompt payment by fining delinquent managed care organizations substantial amounts for prompt pay violations, including a recent $1 million fine levied against Kaiser Permanente's Community Health Plan division.[2] State legislatures also have come to the aid of providers, enacting prompt pay statutes that require third-party payors to comply with legislatively mandated timeframes when conducting their payment processing activities.

Michigan has not pursued the hefty fines other states have when it comes to prompt pay violations. Nor has Michigan been the site of provider class action lawsuits against health maintenance organizations (HMOs) or health insurers, though individual health care providers have sought to litigate their claims payment disputes.[3] The Michigan legislature, however, has recently gotten into the game, perhaps belatedly, by enacting prompt pay laws that will make getting paid on time more likely for health care providers practicing in Michigan.

Commercial Payor Prompt Pay Requirements

Michigan's Insurance Code recently was amended to incorporate detailed requirements for claims processing and payment that must be followed by commercial health insurers, HMOs, and Blue Cross Blue Shield of Michigan (BCBSM).[4] The commercial prompt pay requirements, unlike the Medicaid prompt pay requirements discussed below, apply whether the claim is submitted electronically or on paper. The commercial payor prompt pay requirements apply to claims reflecting dates of service on or after October 1, 2002.[5]

The new commercial prompt pay requirements are significant for health care providers because they give providers a direct right to prompt payment that can be enforced against commercial payors. Previously, the Insurance Code's timely payment provision directly benefited only insureds and persons "directly entitled to benefits under [the] insured's contract of insurance" (typically, not health care providers).[6]

Health Plans

The commercial prompt pay requirements apply only to Health Plans.[7] These include commercial health insurers (including Medicare Supplement insurers), commercial HMOs, and BCBSM. Medicaid HMO claims, workers compensation, and no fault automobile insurer claims are not governed by these prompt pay requirements. In addition, claims processed by Health Plans under administrative services only arrangements (such as when an HMO or BCBSM provides claims processing services to a self-funded employer health benefit plan) are not regulated by the commercial prompt pay requirements even though such claims are being processed by an entity that otherwise might be a Health Plan. To the extent that such plans constitute ERISA plans; however, their claims payment activities will have to comply with regulations recently promulgated by the U.S. Department of Labor, which take effect later this year. See 65 Federal Register 70246 (November 21, 2000). These regulations do not directly dictate the timeframes for payment processing by ERISA plans, but govern the timeframes within which ERISA plans must make determinations and handle appeals regarding plan beneficiaries' requests for coverage.

Health Facilities and Health Professionals

The commercial prompt pay requirements apply only to claims for services rendered by a licensed Health Facility or Health Professional.[8] A Health Facility is any facility or agency licensed by the Department of Community Health pursuant to one of the provisions of Article 17 of the Public Health Code.[9] A Health Professional includes any person licensed by the Department of Consumer and Industry Services under one of the provisions of Article 15 of the Public Health Code.[10] While these definitions should encompass the vast majority of health care providers, certain providers, such as independent durable medical equipment suppliers, appear to be omitted as a result of not being subject to licensure. In addition, by their terms, the commercial prompt pay requirements do not apply to pharmacy claims.[11]

Fast Facts:

- The commercial payor prompt pay requirements apply to claims reflecting dates of service on or after October 1, 2002.
- The commercial payor prompt pay requirements do not apply to pharmacy claims.
- The Medicaid prompt pay requirements apply only to claims submitted electronically to Qualified Health Plans.

Medicaid HMO Prompt Pay Requirements

In June 2000, Michigan's Social Welfare Act was amended to require Michigan's Commissioner of the Office of Financial and Insurance Services (commissioner) to establish a timely claims payment processing and payment procedure applicable to health care providers submitting claims for services covered by Michigan's Medicaid program.[12] The commissioner eventually promulgated that procedure on November 16, 2000.[13] The Medicaid prompt pay requirements apply only to claims submitted to Qualified Health Plans (QHPs), licensed HMOs that have entered into contracts with the State of Michigan to arrange for the provision of Medicaid covered services to Medicaid recipients in exchange for a fixed, prepaid monthly payment based upon the number of Medicaid recipients enrolling with that HMO. Thus, the Medicaid prompt pay requirements are not applicable to claims submitted to the state under the traditional, Medicaid fee-for-service program. In addition, the Medicaid prompt pay requirements currently apply only to claims submitted electronically by health care providers. Thus, they do not apply when claims are submitted on paper.

The Importance of a Clean Claim

Like prompt pay laws in other states, Michigan's prompt pay rules apply with respect to clean claims. That is, a Health Plan's or QHP's duty to pay is conditioned upon the provider submitting a claim that has all the information necessary for the claim to be processed. What information is necessary for a claim to be deemed clean is, therefore, critical to the effectiveness of Michigan's prompt pay statutes. Many prompt pay laws have been criticized as ineffective, allowing third-party payors to manipulate the clean claim requirement to avoid paying claims within prescribed timeframes or interest and penalties on late payments.[14] This is particularly the case when the statute fails to define what a clean claim is, or when the definition permits the third-party payor broad discretion in determining what information is necessary to make a claim "clean."

Both the commercial and Medicaid prompt pay rules define a clean claim as one that contains certain standard information (patient, date and place of service, service code, etc.).[15] Unfortunately for providers, both also provide that a claim is not clean unless it contains such additional documentation as is required by the QHP or Health Plan. Thus, a Health Plan has some discretion with respect to the information it may require for a claim to be clean.

Claims Payment Requirements

Following is an overview of the specific claims processing and payment requirements applicable to Health Plans and Qualified Health Plans under Michigan prompt pay laws.

Claims Submission

Health care providers must bill the Health Plan or QHP within one year from the date of service, or one year from the date of discharge with respect to facility services.[16] While this is generally favorable to providers, no exception exists to extend the timeframe for claims submission in circumstances that may be beyond the control of the provider, such as when the provider has attempted to coordinate benefits with other potential payors and is awaiting a payment determination from those other payors.

Payment of Clean Claims

The Health Plan or QHP must pay *all* clean claims within 45 days after receipt.[17] The same timeframe applies whether the claim is submitted by a contracted provider or an out-of-network provider.

Notice and Correction of Defective Claims

Within 30 days of receipt of a claim, the Health Plan or QHP must furnish the provider with written notice of any and all defects with the claim.[18] The same timeframe applies whether the claim is submitted by a contracted provider or an out-of-network provider. The provider has 45 days to correct the defect in the case of a claim rejected by a Health Plan, and 30 days to correct the defect in the case of a claim rejected by a QHP.[19]

Payment of Corrected Claims

In the case of a Health Plan that has rejected a claim as not clean, the 45-day timeframe for payment of clean claims is tolled from the time the provider receives notice of a defect until the time the provider's response is received by the Health Plan.[20] Thus, once the provider has corrected the defect, the Health Plan must pay within 45 days, less the number of days that passed before the provider received notice of the defect in the claim from the Health Plan. QHPs, on the other hand, have 30 days, measured from the date that the defect in the claim is corrected by the provider, to pay the corrected claim.[21]

Interest Penalty

A clean claim not paid by a Health Plan or QHP within the required timeframe will bear simple interest at a rate of 12 percent per annum.[22]

Partial Payments

Neither Health Plans nor QHPs may deny an entire claim if a defect relates only to some services listed on the claim and one or more services listed on the claim are unaffected by the defect and therefore payable. Rather, the Health Plan or QHP may deny payment only for those services affected by the defect, and must pay the non-defective portion of the claim within the normal timeframes.[23] An exception exists; however, with respect to Health Plans, in that a Health Plan need not comply with this requirement if the provider participation agreement between the provider and Health Plan states otherwise. It should be noted that the commercial prompt pay statute specifically suggests that the parties may alter this obligation via the terms of a participation agreement. This makes clear that other aspects of the commercial prompt pay law apply even if there are provisions to the contrary in the provider's participation agreement. The Medicaid prompt pay requirements also apply regardless of what has been agreed upon in the provider's participation agreement with the QHP.

Duplicate Billings Prohibited

Providers are prohibited from submitting duplicate claims to a Health Plan or QHP unless and until the 45-day timeframe for payment has expired.[24]

Sanctions

A provider or a Health Plan may file a complaint with the Commissioner of the Office of Financial and Insurance Services if it believes there has been a violation of the commercial prompt pay requirements. If the commissioner finds in favor of the complainant, he may impose a fine of up to $1,000 per violation and up to a total of $10,000 for multiple violations. Filing a complaint is not a necessary pre-condition to initiating a lawsuit, nor does the filing of such a complaint preclude a party from bringing a lawsuit.[25]

A provider may request that the commissioner review a QHP's refusal to pay, or the provider may elect to pursue arbitration pursuant to the arbitration process that QHPs are required to make available. Although the Medicaid prompt pay rules do not establish specific penalties for violations, the commissioner has the authority to assess penalties for violations of the prompt pay rules, including unfair trade practice penalties for persistent violations.[26]

Conclusion

While Michigan's prompt pay statutes definitely represent a step in the right direction for health care providers, the effectiveness of these statutes will depend, in large part, upon the manner in which complaints are handled by the Commissioner of the Office of Insurance and Financial Services. Swift and decisive action by the commissioner, including the imposition of substantial penalties, as have been seen in other states, will ensure that the law has enough "teeth" to be effective. If on the other hand, these statutes do nothing more than convert the time providers wait for third-party payors to pay claims into time spent waiting for the commissioner to enforce the rules, these statutes may largely be viewed as ineffective. Only time will tell. ✦

William S. Hammond is a business lawyer who concentrates his practice in the area of health and hospital law. He has significant experience in the managed care arena, advising providers and payors on contractual and regulatory issues. He has also advised various types of providers and suppliers on compliance and reimbursement issues pertaining to many third-party payors, including Medicare and Medicaid. Mr. Hammond also has assisted in the successful consummation of numerous health care transactions, including asset acquisitions and sales, stock sales, mergers, and reorganizations among various types of health care organizations.

Footnotes

1. See, e.g., In Re: Managed Care Litigation, 2001 WL 220108 (March 2, 2001).
2. *Managed Care Week* (October 23, 2000) p 6.
3. See, e.g., *Henry Ford Health Sys v Great Lakes Health Plan,* No. 99-915773 (Mich. 3rd Cir. Ct. 1999).
4. 2002 Mich. Pub. Act 316; 2002 Mich. Pub. Act 317.
5. Id. at Enacting Section 1.
6. MCL 500.2006(1).
7. MCL 500.2006(8).
8. MCL 500.2006(8).
9. MCL 333.20101-22260.
10. MCL 333.16101-18838.
11. MCL 500.2006(7).
12. 2000 Public Act 187.
13. See OFIS of Financial and Insurance Services Bulletin No. 2000-09.
14. See Paige, Leigh, "Clean-Claim" Rules Defang State Prompt Pay Laws, *American Medical News* (December 4, 2000).
15. MCL 500.2006(14)(a); OFIS Bulletin No. 2000-09, p 2 ("Clean Claim Definition").
16. MCL 500.2006(8)(f); MCL 400.111i(2)(d).
17. MCL 500.2006(8)(a); MCL 400.111i(2)(f).
18. MCL 500.2006(8)(b); MCL 400.111i(2)(g).
19. MCL 500.2006(8)(c); MCL 400.111i(2)(h).
20. MCL 500.2006(8)(c).
21. MCL 400.111i(2)(h).
22. MCL 500.2006(8)(a); MCL 400.111i(2)(f).
23. MCL 500.2006(10); MCL 400.111i(3).
24. MCL 500.2006(8)(a); MCL 400.111i(2)(e).
25. MCL 500.2006(12)–(13).
26. See OFIS Bulletin No. 2000-09, p 3 ("Penalties").