

Colorado's Prompt Pay Statute

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Brown Bag Teleconference TRANSCRIPT

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Welcome and opening comments provided by Marilyn Rissmiller, Director Health Care Finance, Colorado Medical Society.

Kari Hershey: Today we are going to talk about Colorado's prompt pay statute. The first thing that I want to do is provide you with some quick background of the legislation. It was enacted in 1999 and underwent substantial amendment in both 2002 and 2007. The basic requirement for this statute is for healthcare payers to timely process what are defined as "clean claims" under the statute. If they don't timely process then there is penalties in interest. The purpose of the law was to minimize the waste of resources that patients and health care providers had to use to track down payments from third party payers. With that said, the law does not promise to resolve payment issues. The law doesn't say anything about payments and resolutions that are denied or otherwise settled. It doesn't require them to pay for the claim that is submitted. But rather the law requires them to timely pay or otherwise disperse with the claim.

It's important to remember for those of you who do Workers' Compensation in your office that those claims are not included in the act. Up until last year, the act did also not include auto claims until the 2007 amendment when auto claims were included in the act. For those of you working with Workers' Compensation claims, those are not covered. The act applies to private third-party payers but does not apply to Medicare.

Let's talk about what a clean claim is under the act. The act required for the first time in Colorado that carriers had to accept electronic claims but cannot prohibit paper claims. They also required a uniformed claimed form that everyone is using such as the CMS 1500 for professional services, the CMS 1450 (UB-04) for facility services, and for dental services there's an ADA authorized uniform claim form. On those claim forms, for a claim to be considered clean under the guidelines of the act, all the fields in the uniform form have to be completed. Those fields were set up by the Division of Insurance and Regulations which includes demographic information, type of service provided, who the provider was, etc. When you submit a claim the law requires the carrier to confirm the claim. The claim is being accepted in one day if submitted electronically, and if submitted by paper, the carrier needs to have a mechanism that shows whether the claims have been received in ten days.

There are certain types of claims that don't classify as clean claims. A claim is not considered (clean) if all the required fields are not completed or if there is additional information needed for the insurance carrier to process the claim. Additional information can only be requested if the carrier cannot determine their claim liability from the

information submitted. An example of this is an unusual procedure or service code, or multiple surgeons participating in a surgery, repeat procedures, or other types of outpatient supplies and materials that a carrier cannot determine whether or not the claim is a covered claim. Additional information can only be requested if it pertains to the fields on the uniform form. For example, medical necessity is related to those fields except when a carrier has already preauthorized the services. Pre-existing conditions are related to the fields on the form, so they can get additional information about that, and also can get additional information if they have a question about if something is a pre-existing condition, but the question came up was not by anything submitted on the form. For example, you submit the claims for the patient and it appears to be an accident related injury but in other documentation it reports that it is a work related injury. When they request additional information, they must do so within 30 days of receiving the claim, and must do so in writing. If they are asking for additional information about the claim for someone other than in your office, they have to notify you. So, those are important parameters in requesting additional information. They must specifically ask for what they are requesting in terms of records. They can't say I want this patient's whole record. They have to ask for specific dates and times or in regards to a specific injury, and it has to be the minimum necessary to adjudicate the information that they are properly seeking additional information for.

Q: If we are submitting a claim to an insurance company, we have gotten letters stating we are waiting for additional information from another provider before they process the claim. Can they do that?

KH: They can, but it has to be in the 30-day time frame. They are entitled to request additional information from another provider, but they have to notify you about that. That is the letter that you got. That other provider has thirty days to respond to that request.

Q: If the other provider does not respond, what happens then?

KH: It depends on the situation. An insurance company has a contractual relationship with the insured so ultimately the insured is responsible for payments and services. So if requested information was not timely provided, the next step is the insurance company to make a determination on the claim. What they said by requesting additional information is that they are unable to make a determination of the claim with the current information provided. They would most likely deny the claim and tell the patient why. The insured then has to get on the other provider and explain that they needed the additional information.

Q: What point do we make this patient responsibility? Do we have to wait another 30 days or can we make it patient responsibility at that point?

KH: It depends on your provider agreement. All of you should have forms that explain to the patient that you submit claims on the patient's behalf but ultimately it's the patient's

responsibility for payment of things that the insurance company denies. But you can't make the patient responsible until the claim has been denied. Most of your insurance contracts provide that you accept a certain amount percentage for various claims. In other words, you may charge \$100 for a service but for a United patient you charge only \$80. You are not allowed to bill the difference by matter of your United provider contract. Until they actually deny the claim, you cannot make it patient responsibility. What happens as a practical matter for any denials based on medical necessity, the patient could argue that the services provided were not medical necessities and should not have been recommended.

Q: If we have gotten a pre-authorization on injectables and it comes back and they don't pay them, are they allowed to do that?

KH: They are not allowed to deny something that they have pre-authorized.

Q: Even if they come back and say it's pre-existing?

KH: For that purpose they could but they cannot deny it for medical necessity purposes. The reason that you get pre-authorization is not because of a pre-existing condition, you get it to confirm with the insurance company that this is a medical necessary purpose that they are going to cover. If for some reason, they become aware that there is a pre-existing condition that they do not cover then they can deny the claim for that and the patient is responsible.

Q: What if they say the conservative measures had not been met? Is that a valid denial once we have gotten it pre-authorized?

KH: I would say that is not a valid denial because if they say that conservative measures have not been met then they are saying the injections were not medically necessary. There were other things you should have done. The law says if they have pre-authorized a service, they cannot deny it on medical necessity grounds.

Q: We did outpatient surgery at an ambulatory surgery center. We had a form that said it was approved and then it got sent back saying that it could not be done there and that it had to be an inpatient at a hospital. Can they deny that?

KH: That's a tough question. It depends how the pre-authorization was submitted. Did the pre-authorization include where the procedure was to take place?

Q: Yes.

KH: So they were aware that it was being done in a surgery center?

Q: Correct. They were aware of it. They won't pay it and they say the patient isn't responsible for it.

KH: I would argue that one. The reason I would is because the fees at the surgery center were less than if you go to a hospital. The procedure was done there and they pre-authorized it with sufficient information that the request for authorization was at a surgery center so I would appeal that.

Q: Does this exclude ERISA plans?

KH: It does exclude ERISA plans.

Q: So if you submit a claim and they come back and deny it, there is no recourse?

KH: I wouldn't say that. You can follow the appeals procedure within the particular plan. In addition to the contractual arrangements with the plans, the prompt pay law adds additional protections for the providers. Simply because the prompt pay law doesn't apply, doesn't mean the contractual provisions that allow for appeals of denials doesn't apply. You still get those. It's just not covered by the prompt pay laws.

With that, we'll move onto what the prompt pay timelines are. If the claim is clean and submitted electronically, it has to be paid, denied or settled within 30 days. If you submit it by paper, then it's 45 days. All other claims (except fraud) must be paid, denied or settled in 90 days. In other words, if there is claim that is not clean because they needed additional information and no one has responded to that request, they still have to have a final disposition on the claim within 90 days.

Q: What is the recourse if they do not?

KH: You can report them to the Division of Insurance (DOI). In 2004, the DOI did a market conduct survey on PacifiCare and found them not in compliance with the prompt pay laws and ordered them to pay a bunch of interest and penalties. PacifiCare brought that case to court and argued that interest and penalties under the prompt pay act don't accrue if they make a personal payment on a claim or make a payment and do an adjustment to it, or deny and later reimburse. The PacifiCare case really evaluated what was meant by the terms pay, deny or settle. Ultimately, the court clarified the issues and said that penalties and interest do not accrue if a claim is denied and later reimbursed- as long as it's denied in that allowed time frame. But if you don't pay the claim in full, but it's a claim that should have been paid then it is subject to interest and penalty. The interest is 10% in claims that don't comply with the timeline and additional penalty of 10% of the total claim amount if the claim is not paid within 90 days. The DOI also has the authority to enact fines, suspension, and even revoke the certificate of a provider.

Before this conference call, an email was sent out to you for some questions. Let's go over them. One question is, **'who can offer a prompt pay discount?'** I wanted to clarify this question. A prompt pay discount is different than the prompt pay act. The prompt pay act's sole purpose is to ensure timely payment from third party payers. The prompt pay discount is something that health care providers can offer to discount their services for someone to promptly pay a balance they owe. There are certain types of incentives that payers cannot provide under insurance contracts. You all have contracts from various providers to reduce rates for particular services. Those contracts most often prohibit you from balance billing a patient. That doesn't mean you can't offer prompt pay discounts to cash paying patients because you have administrative savings by not having to deal with an insurance company. The one thing I want to point out, you cannot waive people's co-pays and deductibles. That's considered an abuse of health insurance because the legislature is concerned that providers will undermine insurance by competing for patients by not requiring co-pay.

The next question was **'does the interest payment requirement apply to both health insurance companies and health plan administrators?'** The answer is yes. It applies to carriers and any third party that they contract to implement their claims processing functions.

The final question was **'what do medical practices reference when asking for the interest payment and what do we do when they still refuse to pay the interest?'** You reference the prompt pay act, state that you submitted the claim and that the time frame for them to pay, deny or settle has passed, and I am entitled to interest on that late payment. If they still don't pay and it goes over 90 days then they are entitled to a penalty and you should contact the DOI.

Q: If a provider submits a claim, and is then requested to give additional information, you have 30 days to respond to that. If you don't respond within that 30-day window and a denial is issued, can the carrier tell the physician that the denial stands and will not consider an appeal under the law?

KH: That is outside the parameters of the prompt pay act. There are appeals procedures within their insurance laws and contract relationship with their insurers that would allow the patient to appeal that decision. Patients under Colorado law are entitled to a copy of their medical records. If they have authorized you to provide health care information to their insurance company for the purposes of payment then you have an obligation to provide requested records. There are a few exceptions under the law with mental health conditions but otherwise you have an obligation to provide those within a reasonable time that's usually never characterized as being outside that 30-day window.

Q: I could see how a provider could lose the request and not meet the request in a timely manner and receive a denial. Under other provisions you have the right to appeal.

KH: Correct.

Q: If a contract doesn't state that a provider can't collect a percentage of insurance upfront, can an office approximate and collect that upfront.

KH: If the contract doesn't prohibit it then yes. Have you talked to the payer?

Q: They said they didn't prefer but it didn't state no.

KH: You can decide how you want to handle it as long as it's not stated in the contract.

Q: Whom do we report them to when they refuse to pay?

KH: Division of Insurance. You may want to draft a standard letter and submit it online at DOI's website.

Q: We receive a denial for coordination of benefits. The patient calls back and gives the insurance company the information, but when they receive the information, they don't do anything with the claim. It just sits in our system until we call tell them to get the claim. Does this fall under this?

KH: Unfortunately not, requirements under the prompt pay act require them to pay, deny or settle. Once they have complied with that, you are outside the prompt pay act and your back at what their review processes are.

Q: We provide a lot of services to out of state Blue Cross enrollees. The payers access the info to pay the claims, but the out of state will not abide by the prompt pay statutes or timelines, penalties or interest. Does this new legislation then cover those instances?

KH: It does as long as they are doing insurance business in Colorado then report them to the DOI.

MR: The DOI has taken a stand that they do not have jurisdiction over the Blue Card because the contract is written in another state.

KH: They have to company registered to do insurance business in Colorado. Can you explain how that works?

MR: The corporate headquarters might be located in another state but the person lives in Colorado.

KH: The insurance company is not authorized to do business in Colorado?

MR: Right.

KH: I think that there may be potential legal arguments especially since they are doing business here or have an insurance company that has insured here. If the DOI is taking the position that they don't have jurisdiction, then the alternative is to file suit to enforce it, which is a very expensive proposition that probably would not be worth the interest and penalties.

Q: With the Anthem plans, the payment comes from Colorado. Does that make a difference?

KH: Anthem is authorized to do business in Colorado and regularly do business here then they are subject to it. That is something we can take a deeper look at. As a general principle of contract law, a contracts interpretation is subject to the law of the state, which it's either written or interpreted according to Colorado law. There are contractual ways to make it not subject to Colorado law.

Q: Can I be doing an appeal for a denial and at the same time making it a patient's responsibility to cover the balance?

KH: Ultimately, yes, if it takes six months to appeal, the provider should not have to pay for it. That's between patient and insurance company. Outside of the parameters of the prompt pay act, what will govern are the terms of your contract.

Q: Does this law extend to just insurance companies or anyone representing themselves as a claim payer?

KH: In the first section of the law, there is a reference to health care carriers. They talk about health care carriers delegating to a third party. If they are not insurance then the DOI will not have regulatory authority over them. You don't have to accept payment with them though. You can make the patient responsible for payment and have them sort out what reimbursement they are eligible for. Tell patients that they don't pay us on time so you pay the bill and when we receive the payment from them then we will reimburse you.

Q: Regarding an electronic claim and having 30-days to respond, what is the cut off? Is it the actual day they process the claim?

KH: If you submit a claim electronically, it is deemed received the next day. That is when the 30-days start. It doesn't matter when they say they finish. They have to pay, deny or settle and let you know.

Q: So the check has to be in the mail within 30-days?

KH: It has to be paid. I think as long as they cut the check and sent it then that would qualify.

Q: If they have not then, it's 10% penalty?

KH: That kicks in after 90 days.

Q: And the 10% annual?

KH: There are two levels of penalties under prompt pay act. If they don't pay, deny or settle within time frame then they have to pay 10% interest annually for whatever they paid. If they don't pay for 90-days then you get a get an additional 10% in penalties.

Q: If they pay an amount within 30-days but go back and make adjustments?

KH: They have not paid correctly. They must pay the full amount due in 30-days or deny or settle the claims. Or else it would encourage them to pay \$1 in 30-days and the rest they will take their sweet time.

There is a provision in the prompt pay act with respect to delays such as charges, audits and certain types of adjustments. They can adjust for ineligibility. In other words, if they pay a claim and then someone had terminated their insurance and they have 30-days with which to notice that someone was not eligible for insurance to retroactively adjust that. This also doesn't prevent them from correcting mistakes. If they overpaid you and did an audit and found that in 12 months they can make adjustments for those overpayments, but they can't simply pay half of what's due. Most importantly, the interest in the penalty is in the full amount that is ultimately due - not just on the difference. If they owed you \$100 and paid you \$25 and it's determined they owe you \$100, the 10% penalty is on the full \$100 even if they paid you \$25.

Q: We have all these problems with insurances paying wrong amounts or not at all, how do you enforce that? Do you file a complaint with DOI on every one of those?

KH: If you have a particular provider, I would collect examples and submit them all at once. Do it every month. Okay, I have to get going into court now...