Sorting out the mystery of prompt payment laws

Responsibilities are divided, so providers and insurers have reasonable guidelines for processing payment

BY JOHN W. JONES

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PROMPT PAYMENT LAWS require health insurers to pay "clean claims" within a certain time frame (which generally ranges from 15 to 60 days after receipt of the claim). Enforcement of these laws varies widely and, consequently, physicians and other providers continue to complain about slow processing.

For example, in 2001, the Texas Medical Assn. stated that 60% of its member physicians experienced cash flow problems caused by slow payment or claim denials. Additionally, a 2001 survey of the Louisiana State Medical Society's members found that 75% of physicians reported average payment delays of more than 30 days, and 25% reported average delays of more than 50 days. Louisiana's law requires payment of clean electronic claims within 25 days and paper claims within 45 days.

Insurers have taken the position that many delays are the fault of the providers. Many claims are either filed improperly or, in the hopes of receiving payment sooner, more than once, which only contributes to the delays.

WHAT DOES 'CLEAN' MEAN?

Prompt payment laws vary from state to state, but in general, they set time frames for payment of claims and establish penalties for insurers' failure to comply. Most of the laws define "clean claim" as "a claim with no defects or impropriety, including a lack of any required substantiating documentation or particular circumstances requiring special treatment."

Many providers have criticized the definition as being too vague, leaving control of all of the factors that determine whether a claim is "clean" in the insurers' hands. Several states have responded by clarifying the data elements necessary for a claim to be a clean claim and, therefore, be reimbursable within the applicable time period.

Many prompt payment laws, such as Pennsylvania's, also establish some sort of administrative procedure for reporting violations and taking action against insurers. The Pennsylvania Quality Health Care Accountability and Protection Act requires that managed care plans and licensed insurers pay clean claims within 45 days. If a claim is not paid within that time, the act subjects the insurer to a 10% annual interest penalty.

Additionally, insurers are required to

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give to their participating providers definitions of all the data elements necessary for clean claims. Providers also must be informed of changes in those requirements at least 30 days prior. It is the providers' responsibility to request clarification of any information in the disclosure.

The act provides an administrative remedy for late payment, in which the provider must contact the insurer with the complaint, and the insurer must respond within 45 of the original claim submission (or within 30 days of the complaint if it is made outside the 45-day payment period).

In April 2002, the state Superior Court ruled in Solomon v. United States Healthcare that physicians do not have a private right of action against health insurers for prompt payment under the act.

The court reasoned that although providers were clearly members of a class for whose benefit the statute was intended, it could find no indication of legislative intent in the statute, explicit or implicit, that created a private remedy. Instead, the court pointed out that the administrative complaint procedure of the act was strong evidence that no private cause of action was intended. It remains to be seen what effect, if any, this ruling will have on providers' willingness to dispute claims and insurers' strict compliance with the act.

SEVERE PENALTIES

Failure to comply with prompt payment laws can have serious consequences for insurers. For example, the Texas Department of Insurance conducted an enforcement blitz in 2001 to 2002 that resulted in consent orders against 47 HMOs and insurance companies, requiring them to pay more than $36 million in restitution to providers and nearly $15 million in fines. In 2001, Pennsylvania's insurance regulators fined nine insurers a total of $850,000 for violations of its prompt payment law.

While state prompt payment laws provide administrative recourse for providers who are frustrated by a payer's failure to respond or pay promptly, most (Pennsylvania being an exception) generally do not preclude a lawsuit brought by a provider against an insurer to recover amounts due on bills submitted but not paid. Relations between providers and payers in this context are contractual in nature and can be enforced through litigation like any other contract.

Health insurers must recognize the importance of ensuring that providers have the information needed to file clean claims, and pay them in a timely manner. To do otherwise could result in significant liability to the insurer. Increased communication between insurers and providers, in most cases, could avoid potential litigation and penalties against insurers. For providers, the key to the prompt payment laws is careful recordkeeping, documentation of correspondence, and a thorough understanding of their provider agreements with health insurers. **MHE**