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Health Plan Payment Disputes: Getting Paid for Your Services

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Hooper, Lundy & Bookman, Inc., recently held conferences in Northern and Southern California at which we discussed various problems that hospitals, medical groups and other providers have been experiencing with getting paid by the large health plans (e.g., Aetna/Prudential, Blue Cross, Blue Shield, Cigna, Health Net/Foundation, PacifiCare, and others). The substantial provider attendance at these conferences, and their comments at them, speak volumes about the extent to which payment problems with health plans have grown throughout the California market. In short, the payment problems providers are experiencing with health plans appear to be on the rise. Many hospitals, medical groups and other practitioners have seen their accounts receivables and write-offs rise to never before seen levels as health plans have become more aggressive at asserting rationales for delaying or denying claims and have become increasingly less diligent at devoting sufficient resources to processing and paying claims. Some providers have reported that average delay time between when claims are billed and when they are paid has doubled or tripled.

The following Special Report was prepared in response to numerous requests by attendees at the conference for an overview of California's prompt payment laws under the Knox-Keene Act and of some of the more prevalent and egregious payment problems that providers have been experiencing with the health plans. We have put together this material as an aid to providers in understanding their rights and to be aware of what others have been experiencing.

In addition, we have established an e-mail address, overseen by our managed care experts, at which we invite providers to detail their late payment experiences, as part of our educational efforts to inform providers of health plan payment patterns as they emerge and change. By sending us information about your payment issues with health plans, we will better be able to develop effective approaches, identify recurring problems and issue future updates regarding health plan disputes. Please contact us at healthplandisputes@health-law.com.

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The Statutes

The Knox-Keene Act — which begins at Health & Safety Code Section 1340, *et seq.* — contains multiple statutes addressing timely payment. The most pertinent statutes in the Health & Safety Code regarding timely payment are:

(a) Section 1371 — which is the primary timely payment provision;

(b) Section 1371.35 — which is a special timely payment statute for emergency services;

(c) Section 1371.37 — which prohibits unfair payment patterns and authorizes the Department of Managed Health Care (DMHC) to make findings and issue penalties;

(d) Section 1371.39 — which authorizes providers to report unfair payment patterns to the DMHC.

The following discussion highlights key parts of these statutes. ***Caution:*** *You should review these statutes in full and/or consult with appropriate legal counsel before asserting arguments based on them. This article is not intended to, and does not, constitute legal advice or create an attorney-client relationship.*

Section 1371

The primary timely payment statute is Health & Safety Code Section 1371. This statute sets forth statutory requirements for when a health plan must either contest or pay a claim; the penalties for not timely paying; and what constitutes a properly contested claim.

1. Deadlines for Contesting or Paying Claims: For health plans that are health maintenance organizations (HMOs), claims must be either contested or paid within 45 *working* days. Since this is slightly over 60 *calendar* days, most providers track payment on a two month roll. For health plans that are not HMOs, however, the time period for a health plan to pay or contest a claim is 30 *working* days — which is slightly under 45 *calendar* days unless the time period includes multiple national holidays. Therefore, providers who want to enforce their rights to the greatest degree under the law should have a system that distinguishes HMO claims from non-HMO claims for tracking purposes and for calculating late fees where applicable.

2. Penalties for Not Paying Uncontested Claims: The penalties for not timely paying an uncontested claim include two components. The first component is an interest penalty, which applies to all uncontested claims that are not timely paid. Specifically, the health plan is required to *automatically* include in its payment of the claim an additional 15 percent interest per annum beginning with the first calendar day after the 30- or 45- working day period has passed. (The 15 percent figure, which became effective as of January 1, 2001, represents an increase from what had been a 10 percent figure.)

The new interest rate has created disagreement regarding what interest applies for a claim that was not timely paid prior to January 1, 2001, but which remains unpaid after January 1, 2001. One interpretation — which favors providers — is that the interest rate for the penalty on such "stragglers" is 10 percent for the time period through December 31, 2001, and 15 percent for the time period thereafter since the claim remains unpaid after the new statute took effect. The other interpretation — which would favor health plans — is that the interest rate remains at 10 percent since the claim arose prior to the effective date of the new statute.

The second penalty component is an additional $10 *per claim* fee that must be paid by any plan failing to comply with the automatic interest requirement discussed above. This new provision clearly applies when a health plan makes an untimely payment on an uncontested claim without automatically including interest. However, some disagreement exists over whether it applies when a health plan fails to pay an uncontested claim at all for a very lengthy time period after the 30- or 45 - working day period has run. For example, what happens if the health plan lets six months or more pass without paying a uncontested claim at all? One interpretation — favored by providers — is that the new $10 fee should apply to any uncontested claim that is not paid immediately after the statutory time period to pay has passed because, once that occurs, the health plan immediately knows or should have known that it is required to pay the claim. The other interpretation — favored by the health plans — is that the new fee does not apply until the health plan actually pays the claim. The problem with this interpretation, from our standpoint, is that it would result in health plans being penalized less for delaying payment entirely than for paying something but without interest, and thereby being incentivized not to pay anything.

It currently is unclear how the health plans will deal with the situations discussed above that involve differing interpretations of the penalty that applies for "stragglers" and for claims on which no payments were made for extended time periods. These issues may need to be resolved through legal proceedings, regulatory interpretation and/or further legislative amendments.

But for now, we suggest that the providers pursuing untimely payments assert the interpretations that favor the higher penalty amounts on the grounds that they are reasonable and consistent with the statute's purpose to create financial incentives for health plans to pay on time. A health plan may agree to accept that interpretation rather than face a formal legal process to resolve the issue that could result in binding legal precedent unfavorable to the health plan and/or if the provider's market strength or other circumstances give it strong bargaining power against the health plan regarding the claims at issue.

3.What is a Properly Contested Claim? Section 1371 also sets forth standards for what constitutes a properly contested claim. Often the issue gets wrapped up in a debate regarding the industry term "clean" claim. The statute admittedly is imprecise in what constitutes a "clean" claim — presumably because there are so many variations on the types of health care services that may be at issue. But there are at least two important statutory guidelines that are often overlooked on this issue.

First, Section 1371 requires health plans to contest claims *within* the 30- or 45- working day period by providing "notice that [the] claim is being contested," "identifying the portion of the claim that is contested," and providing "the specific reasons for contesting the claim." Thus, health plans who miss the deadline, or who object but do not provide specific reasons, appear to be statutorily required to pay the claim. Similarly, the statute does not appear to permit health plans that have contested a claim within the deadline on certain specified grounds to later raise new grounds after the deadline has passed.

Second, the statute provides insight into what constitutes appropriate grounds to contest a claim. Specifically, it states that "a claim, or portion thereof, is *reasonably* contested where the plan has not received the completed claim and all information necessary to determine payor liability for the claim, or has not been granted reasonable access to information concerning provider services." (emphasis added).

The statute further states that such information "includes, but is not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, a claim on appeal, or other information necessary for the plan to determine the medical necessity for the health care services provided." The statute's list of *reasonable* grounds to contest a claim focuses on "information necessary for the plan to determine the medical necessity for the health care service provided."

Thus, health plans conditioning payment on information having nothing to do with medical necessity arguably are violating the statute. For example, we have seen health plans demand from hospitals "invoice numbers" for implants. Also, we have seen a health plan demand coordination of benefits (COB) information for individuals receiving insurance coverage through California's Access for Infants and Mothers (AIM) Program, who, by definition, must not be covered by Medi-Cal, Medicare or private insurance to receive AIM. (See Cal. Ins. Code § 12698.05). An argument certainly exists that these types of demands are not within Section 1371's standard for "reasonably" contesting a claim.

One unanswered question is whether the statutory definitions for what constitutes a reasonably contested claim can be expanded by contract to be more onerous than the standards set forth in Section 1371. Some health plan contracts, or health plan provider manuals, try to expressly define what is a "clean" claim. These definitions may fit within the terms of section 1371, but if they seek to go beyond the limits of the statute, then an argument exists that the statute must control. We suggest that providers try to avoid this potential inconsistency by including specific language in their contracts with health plans that would limit the grounds on which a claim may be contested to only those specified in the statute. Similarly, providers may wish to seek to include contract language to detail what information the parties will consider to be consistent with the statute so as to reduce subsequent disputes about what constitutes a claim that is "clean" under the law. And, providers should review — and where appropriate promptly object — to any provisions in a health plan's "Provider Manual" that purports to impose more onerous billing requirements than those under the statute, the contract and/or prior versions of such provider manuals.

Section 1371.35 — Emergency Services

Section 1371.35 provides specific standards for timely reimbursing claims for *emergency services.* The time periods are the same as in Section 1371, but this statute contains different penalty provisions, and its own specifications for what constitutes an appropriate claim. The penalty provisions for failure to timely pay claims for these types of services is the *greater* of $15 per year or interest at the rate of 15 percent per year beginning with the first calendar day after the applicable 30- or 45- working day time period to pay has expired.

The 15 percent interest rate figure reflects an increase as of January 1, 2001 (previously it was 10 percent). This statute also contains additional details regarding the format of bills for emergency services, depending on whether the claim comes from an institutional or a professional provider, and whether it is a paper claim or an electronic claim.

In addition, this statute expressly prohibits a health plan from delaying payment to a physician or other provider to await submission of a claim from a hospital or other provider, without citing specific rationale as to why the delay is necessary.

Those who provide emergency services should review this statute and/or consult appropriate legal counsel as needed.

Section 1371.37 — Unfair Payment Patterns

Section 1371.37 is a new statute that became effective January 1, 2001, which prohibits health plans from engaging in "unfair payment patterns." The statute defines such payment patterns to include those that involve:

(1) reviewing and processing complete and accurate claims in a way that results in payment delays;

(2) reducing the amount of payment for, or denying, complete and accurate claims;

(3) repeatedly failing to pay an uncontested portion of a claim; or

(4) repeatedly failing to automatically include interest due on claims that are not paid timely in accordance with Section 1371.

This statute provides for the DMHC to investigate and determine violations. If the DMHC finds that a violation occurred, then the statute gives it the power to impose monetary penalties and/or require the health plan to pay claims in an even shorter time period than the ones set forth by Section 1371. At this time, it is unclear how effective enforcement by the DMHC will be. Among other things, the statute required DMHC to issue regulations by July 1, 2001, to define the term "complete and accurate claim." Those regulations, however, have not yet been issued. Nonetheless, providers should ensure that DMHC is notified, *with documentation,* if they feel that a health plan has engaged in a violation of this statute.

Significantly, although this statute provides for enforcement remedies by the DMHC, it expressly makes those remedies non-exclusive and states that they "shall *not* limit or preclude the use of any otherwise available criminal, civil or administrative remedy." (emphasis added) Therefore, while DMHC hopefully will be aggressive in enforcing Section 1371.37, providers still can invoke any other legal remedies available to them in response to unfair payment practices by the health plans.

Section 1371.39 — Reporting

Section 1371.39 encourages providers to report instances in which the provider believes that a health plan is engaging in an unfair payment pattern. The statute also provides a toll-free number (877-525-1295) and an e-mail address **(plans-providers@dmhc.ca.gov)** for such reports. DMHC has told us that it wants providers to actively use this procedure, and that it intends to use provider complaints received this year in a comprehensive report that it is required to prepare for the Legislature and the Governor by the end of 2001 in accordance with a directive contained in Section 1371.37. Accordingly, providers should be particularly pro-active in reporting their experiences with unfair payment patterns to DMHC prior to December 31, 2001.

Provider reports can be instrumental in enabling the DMHC to effectively develop and initiate enforcement procedures, and helping defend and perhaps expand its statutory authority, and creating effective and adequate administrative regulations. In contrast, silence by providers may be misinterpreted by the DMHC as a lack of problems, so vigorous reporting by providers can help the DMHC more accurately focus on and shape the extent of the enforcement efforts that it will expend in this field. Furthermore, provider reports to the DMHC should include, to the extent available, specific examples, details and documents regarding the payment problems being reported.

As previously mentioned, we have established a web address at which we encourage providers to send us information about health plan payments disputes that they have experienced **(healthplandisputes@healthlaw.com).** This is not a substitute for DMHC's e-mail address, but it is a way to assist us in keeping providers informed of health plan payment patterns as they emerge and change and developing strategies for dealing with payment problems. You may wish to consider e-mailing to us a copy of your complaints to the DMHC as well as other information about the types of problems encountered.

Common Payment Problems

Based on requests from a number of providers, we have prepared a list of some of the common types of payment problems that our clients have experienced and that we have handled:

- **Health Plans Refusing to Pay Customary Charges.** Providers are only required to accept rates from a health plan below their customary charges when they have a binding contract that sets lower rates (except in certain cases involving federally funded programs that set their own rates). Health plans, however, sometimes try to persuade providers to accept lower rates based upon a contract that has expired or on a contract to which the provider is not a party. Often the health plan will pay the lower rate hoping that the provider will accept it without challenge. Then, the health plan will argue that the non-challenged acceptance constitutes an implied contract to accept lower rates. Non-contracted providers should fight this practice by documenting that they do not accept payments that are below their customary charges as full compensation and that they consider the claim underpaid.
- **Risk Pool Manipulations.** Providers who enter into contracts that include risk pools have reported a number of instances in which the health plans have charged the pools at rates higher than the actual costs incurred. For example, with pharmacy risk pools, pharmaceutical companies often give discounts and rebates to health plans that are not passed on by the health plan when calculating the pools. In this way, the provider is charged "retail" for drugs that the health plan receives at "wholesale" rates. This practice generally contradicts risk pool agreements and could constitute fraud depending on the circumstances. Providers who participate in risk pools should demand to know how the charges in the pool were calculated and should insist upon adjustments to improper calculation techniques.
- **Capitation Reduced by Leaving Members Unassigned.** The principle behind capitation contracts is that providers are paid capitation for members assigned to them regardless of whether the member needs services. Providers' participation is premised on the understanding that they will receive payments for some members that need no services. In some cases, however, the health plan manipulates the process by keeping members "unassigned" until services are actually needed. This distorts the capitation system so as to deprive the provider of the benefit of the bargain of the capitation contract. It also may constitute fraud depending on the circumstances. Providers should be alert to whether they are receiving an inordinate amount of newly assigned members just as those members first become in need of health care services.
- **Misplacing or Losing Claims.** Providers often send out bills only to be told by the health plan that those bills supposedly were never received. This has even occurred for claims that were sent with other claims that were processed. The health plan simply claims to have no record and tries to shift the burden to the provider to prove the claim was sent. Furthermore, the health plan sometimes tries to reset the billing clock, or pay a lesser rate, or even deny the claim entirely, based solely on the contention that the provider did not timely send a bill that actually had been sent. If, however, the provider has reliable billing processes in place to track when bills go out and what they included, then there typically is no legal reason to accept the health plan's position. The provider certainly can offer to provide a courtesy copy of the bill to the health plan, but the clock should run from when the original bill was sent, and the provider's cover letter/e-mail should confirm that this is a follow-up courtesy copy regarding a bill that was previously submitted. Providers also may wish to adopt a practice of transmitting with the claims a list of the specific claims included so as to have a contemporaneous record of precisely what was sent. If the health plan later contends that it received certain claims which were submitted by the provider with the transmittal, but not others, then the transmittal will be additional evidence that the claim was sent and that it was the health plan which misplaced and/or lost the missing claims. Moreover, there are legal grounds to challenge a health plan's attempt to refuse to pay based upon contract provisions that require billing within a specific time period, because such provisions likely constitute unenforceable forfeiture clauses. (Note: For the same reason, a provider who discovers claims that were inadvertently, even negligently, not timely billed should nonetheless pursue payment for services that were provided.)
- **Stop-Loss Calculation Carve-Outs.** Some health plans have, at various times, instituted company-wide policies intended to reduce or avoid their obligations to pay traditionally high stop-loss claims. Hooper, Lundy & Bookman has arbitrated these issues on behalf of more than 20 hospitals and has been successful in obtaining judgments against health plans, requiring them to reimburse the hospitals.
- **Responsibility Delegated to Intermediaries.** All of the major health plans delegate payment responsibilities in some instances to intermediaries, such as management companies, area hospitals, area medical groups, etc. Unfortunately, a number of inter-

mediaries have become insolvent, declared bankruptcy, and/or are not diligently paid claims for other reasons. There are a number of legal grounds that may support seeking payment directly from a health plan when an intermediary fails to pay a claim that was delegated to it. The potential for such direct pursuit may be bolstered if the provider (a) has a direct contract with the health plan; and (b) either has no contract with the intermediary or has a contract with the intermediary that indicates, explicitly or implicitly, that the provider may seek payment from either the health plan or the intermediary. Finally, providers should avoid entering into contracts that purport to limit their remedies for non-payment to actions against the intermediary. For example, while it is appropriate to have a clause stating that the provider will not seek payment from the member if the intermediary does not pay, there is no reason to describe such a limitation as an agreement to only seek payment from the intermediary.

Obviously, this is not an exhaustive list of the multiple types of payment problems that providers have experienced. Furthermore, we anticipate that new types of disputes will arise as health plans continue to create additional ways to delay or deny payments, since every dollar not paid out is an additional dollar that goes into their own bottom line.

Conclusion

If you have experienced any of these problems, or other problems with getting paid by health plans for your services, please let us know. Our firm has handled a wide variety of health plan payment disputes in contexts ranging from simple contract negotiations to pre-litigation disputes to full-blown arbitrations and lawsuits when needed. Also, if you have any questions concerning the issues addressed in this report, would like any further information, or have a payment problem that you wish to discuss, please contact us. We can be reached regarding these issues by sending an e-mail to **healthplandisputes@health-law.com,** or by calling or writing in Los Angeles Glenn Solomon (310-551-8179), Jay Hartz (310-551-8164), Daron Tooch (310-551-8192), or Angela Mickelson (310-551-8170); or in San Francisco Mark Reagan (415-875-8501).

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