PROMPT PAYMENT, MANAGED CARE CLAIM BILLING AND COLLECTION ISSUES

ERIC D. KATZ, ESQ.

I. PROMPT PAYMENT UNDER THE

- **Laws equally applicable to pars and non-pars (as long as there is an assignment)**
  - Physicians, dentists, DME suppliers, psychologists and other healthcare providers entitled to prompt payment
- **Laws only applicable to New Jersey fully-insured lines of business**
  - Applicable to PA, NY and providers from any state if rendering services to patient under a New Jersey fully-insured plan

I. PROMPT PAYMENT UNDER THE

- **Timely filing requirements imposed on non-participating and participating providers**
  - Non-pars must file claims within 60 days after last date of service of the course of treatment (when no assignment of benefits)
  - Non-pars must file claims within 180 days after last date of service of the course of treatment (when assignment of benefits)
  - For par providers, timely filing deadline based on language of provider agreement
  - Carrier may deny claim if not timely filed

3

I. PROMPT PAYMENT UNDER THE

Prompt Payment Requirements under the HINT Act

(December 1999-July 11, 2006) (?)

- 30/40 day requirement from "receipt" to pay, deny or dispute a claim
    - "Receipt" of paper vs. electronic claims (clearinghouses)
- 10% simple, annual interest on late paid claims paid after 30/40 day period expires

I. PROMPT PAYMENT UNDER THE

THE HINT ACT'S MOST POWERFUL PROVISION:

"A carrier or its agent that does not provide [proper] notice . . . shall waive the right to contest the claim for any reason . . ." *(New Jersey Administrative Code 2001)*

- **Waiver of the right to contest payment** if timely "expeditious" communication is not provided to obtain missing or incomplete information
- **Waiver of the right to contest payment** if claim is not denied until after 30/40 day period expires, regardless of whether there are legitimate defenses (other than fraud)

ALTHOUGH THE LAW, VIRTUALLY NO NEW JERSEY CARRIER PAYS CLAIMS ACCORDING TO WAIVER -- USE A LAWYER TO ENFORCE YOUR RIGHTS!

5

I. PROMPT PAYMENT UNDER THE

Changes to Prompt Pay Requirements after Health Claims Authorization, Processing and Payment Act ("HCAPPA")(July 12, 2006)

- **No regulations in place as of yet (therefore HINT Act "waiver" regulation still in effect?)**
- **Timeframe for payment of claim**
  - Same 30/40 day receipt period as with HINT Act

6

I. PROMPT PAYMENT UNDER THE

- **What "special information" can carrier require to be submitted with claim?**
    - Carrier may require information to be submitted with the claim or shortly thereafter that it believes necessary to process claim
    - But carrier must post on its website what types of clinical notes or other information is required to be submitted as part of claims adjudication process
- **Submitting claims electronically (not mandatory yet but could be soon)**

I. PROMPT PAYMENT UNDER THE

- **Proof of timely filing when provider submits paper claims**
  - "Not on File" Claims issue
  - Not an issue with electronic claims where "instant receipt" provided
  - Need to develop system to prove claim was mailed (send claims in batches using US Postal Service Delivery Confirmation Option or use practice management software to document claim submission date)

I. PROMPT PAYMENT UNDER THE

- **Why are claims denied despite timely filing?**
  - Claim not considered by the carrier to be “medically necessary” or “dentally necessary”
  - Claim not submitted timely
  - Provider was not an eligible provider on the date of service
  - Covered person was not eligible on the date of service
  - Health care services not covered under the terms of the patient’s policy

I. PROMPT PAYMENT UNDER THE

- **More reasons claims denied despite timely filing…**
  - Required documentation supporting the claim is not submitted
  - Coding errors on the claim form
  - Etc., etc., etc.
  - Strong indication of fraud (carrier must notify the provider of suspected fraud)
  - Carriers required to pay all "uncontested" services consistent with the prompt payment time frames

I. PROMPT PAYMENT UNDER THE

- **<u>Notice requirements under HCAPPA to obtain missing or incomplete information</u>**
  - If claim form missing required information, or has been incorrectly coded or has other incorrect information, carrier is required to notify provider within **<u>seven (7) days</u>** of receipt of claim and request information necessary to complete adjudication.

- **<u>12% simple, annual interest on late paid claims paid after 30/40 day period expires</u>**

- **<u>May carrier deny or pend claims on the basis of COB?</u>**
  - No !
  - However, claim can be denied because of COB when carrier's records indicate "reasonable belief" that other coverage exists that should pay first (primary)

I. PROMPT PAYMENT UNDER THE

- **<u>Are carriers permitted to seek recoupment of claims payments the carrier alleges were overpaid?</u>**

  - Yes !

  - Limited to <u>18 months</u> from the date the claim was paid except when fraud or pattern of inappropriate billing suspected

  - Only <u>one</u> recoupment per claim permitted

  - Carriers required to provide written notification identifying carrier's adjudication/payment error on which recoupment effort is based

  - Provider then has <u>45 days</u> to repay overpayment or dispute carrier's allegations of overpayment

  - Provider may file an appeal to contest recoupment request

II. APPEALING CLAIM

- Under HCAPPA, provider may appeal unpaid claims, denied claims or claim recoupments.

- Use "appeal form" on Department of Banking & Insurance website (www.state.nj.us/dobi) or carrier's specific form that is virtually identical DOBI form

  - See DOBI "appeal form" attached to this outline

Carrier Logo	Submit to: Carrier's Name If by mail, at: Mailing Address for Receipt of Claims Appeals by Carrier If by courier service, at: Street Address for Receipt of Claims Appeals by Carrier Explanation of Electronic Submission Process, if any

YOU MUST COMPLETE A SEPARATE APPLICATION FOR EACH CLAIM APPEALED

Section			
A. Provider Information	1. Provider Name:		2. TIN:
	3. Provider Group (if applicable):		
	4. Contact Name:		5. Title:
	6. Contact Address:		
	7. Phone:	8. Fax:	9. Email:
B. Patient Information	1. Patient Name:		2. Ins. ID:
	3. Have you attached a copy of (check the appropriate response):		
	a. the assignment of benefits? ☐ Yes ☐ No ☐ NA		
	b. the *Consent to Representation in Appeals of Utilization Management Determinations and Authorization to Release of Medical Records for UM Appeal and Arbitration of Claims*? (Not required for this appeal, but **required if** the matter goes to arbitration.) ☐ Yes ☐ No		
C. Claim Information	1. Claim # (if known):		2. Date of Service:
	3. Claim filing method (check only one): a. ☐ electronic (**submit** a copy of the electronic acceptance report from Our clearinghouse or Us) b. ☐ facsimile (**submit** a copy of the fax transmittal) c. ☐ mail or courier service (**submit** a copy of the delivery confirmation evidence)		
	4. Read the following and check the condition(s) that describe this appeal: a. ☐ Action has not been taken on this claim b. ☐ Dispute of a denied claim → provide **date of denial**: ___/___/___ c. ☐ Claim was paid but not in a timely manner (provide more information): ☐ Yes ☐ No Additional information was requested? If yes, date: ___/___/___ ☐ Yes ☐ No Additional information provided? If yes, date: ___/___/___ ☐ Yes ☐ No Interest paid correctly? d. ☐ Claim was paid, but the amount is in dispute (not including interest) e. ☐ Dispute of carrier's allegations of overpayment or amount of overpayment f. ☐ Dispute of carrier's offset amount against this claim		

In an attachment, explain why you dispute handling of the claim. Be specific about billing codes. Also, submit (copies only):

- ☆ The relevant HCFA 1500(s) or UB92(s)
- ☆ The relevant Explanation(s) of Benefits or Remittance Advice
- ☆ A statement specifying the line items that you are appealing
- ☆ Information We previously requested that you have not yet submitted, if available
- ☆ Itemization of the contract provisions you believe We are not complying with, if any
- ☆ Pertinent correspondence between you and Us on this matter
- ☆ A description of pertinent communications between you and Us on this matter that were not in writing
- ☆ Relevant sections of the National Correct Coding Initiative (CCI) or other coding support you relied upon IF the dispute concerns the disposition of billing codes
- ☆ Other documents you may believe support your position in this dispute

Signature:______________________ Date: ___/___/___

DOBICAPPCAR 07/06 Page 2 of 2

II. APPEALING CLAIM

- Internal appeal to the carrier must be submitted within ninety (90) days of receiving explanation of benefits
- Carrier must respond within thirty (30) days of receipt of appeal
- Include with the appeal form a copy of the explanation of benefits and any other relevant documentation and fully complete the form
- If internal appeal is denied, provider has the right to arbitrate
    - See DOBI website for information about arbitration
    - Cost is $50.00 to the provider

III. WORKERS' COMPENSATION BILLING AND COLLECTION ISSUES

- When services are rendered to a worker hurt on the job
- Must be submitted to workers' compensation carrier
- Get carrier information by asking the patient or his employer
- Participating providers paid based upon fee schedule amounts
- Non-par providers are paid based upon UCR

III. WORKERS' COMPENSATION BILLING AND COLLECTION ISSUES *continued...*

- **If provider cannot resolve payment:**
  - Because there has been no payment at all, provider can intervene in patient's workers' compensation action (need lawyer)

This may be a waiting game because the patient has to establish a work-related injury before the carrier will pay medical bills

III. WORKERS' COMPENSATION BILLING AND COLLECTION ISSUES *continued…*

- **If provider cannot resolve payment *continued*:**

  - Because there has been insufficient payment, the provider can file a Medical Provider Application for Payment or Reimbursement of Medical Payment (need lawyer)

Provider may need to show comparable claims and payment information to establish UCR

  - If the employer has no workers' compensation insurance, medical bills will be handled by New Jersey Uninsured Employer's Fund (need lawyer)

- Situation arises following motor vehicle accident (including where pedestrian or passenger is involved)

- Most often claims must be submitted to auto insurer first (primary over medical carrier)

- Providers are generally subject to the PIP (Personal Injury Protection) fee schedule set forth in New Jersey No Fault Insurance Statute

•Exceptions to when fee schedule does not apply:

- Most services rendered by neurosurgeons and other high end surgeons are not the subject of a PIP fee schedule, so providers are entitled to UCR (legislation may change this)

- Certain trauma services provided at trauma center hospitals

- Certain emergency surgical services are reimbursed at 150% of the fee schedule amount

IV.

- For co-surgeries, the fee schedule amount is 62.5% of the eligible charge for each co-surgeon

- For medically necessary assistant surgeons, eligible charge is 20% of the primary physician's allowable fee

- For multiple surgeries (multiple procedures), the highest valued procedure is reimbursed at 100% of the eligible charge, and additional procedures are reimbursed at 50 % of the eligible charge.

- If the provider cannot resolve payment with the carrier, options are to file a PIP arbitration or a lawsuit. (need a lawyer)

- For participating providers -- standard, boilerplate contracts. No real opportunity to negotiate terms. Take it or leave it.

- Always request and maintain a fully executed copy of your agreement

- **<u>For non-participating providers -- Anti-assignment clauses. What do they mean?</u>**

  - Patient gets paid directly (have to track down payment)

  - **<u>BUT</u>** non-pars generally get paid more per service because they are not subject to fee schedules and paid based on UCR

22

- **Par providers should always request “complete” fee schedule information**

- Under the law the carrier has to provide you certain minimum fee schedule information

- **Always maintain all provider office manuals as they are incorporated into the provider agreement**

- Review the carrier provider portal, provider newsletters and/or request from the carrier all code editing policies

- **Providers should understand what they can collect from their patients (co-pays and deductibles)**

Avoid billing and collection improprieties and/or fraud allegations

- **Know responsibilities to patients should par provider leave the network**

VI. MAXIMIZING UCR FOR NON-PARTICIPATING PROVIDERS

- Non-pars not subject to contract fee schedules like par providers

- The “Usual, Customary and Reasonable" (UCR) fee for a procedure is an ongoing debate between non-participating physicians and insurance companies. When carrier fee schedules and reimbursement policies do not coincide with the realities of a practice’s UCR, physicians get short-changed.

VI. MAXIMIZING UCR FOR NON-PARTICIPATING PROVIDERS *continued…*

Non-par can maximize reimbursement by implementing the following practical tips…

- **Enlist a Service:** Leverage available software and services. Companies like Ingenix, among other useful offerings, provide solutions to help calculate UCRs. Remember that a true UCR is based on what providers with the same background and experience charge for the same service in your geographic region. Thus, the UCR for a particular procedure rendered by a spine surgeon in Bergen County may be different than in Gloucester County.

- **Establish "Comparable" Reimbursements:** Save your explanations of benefits with highest reimbursement rates for particular CPT codes. Then use these "comparables" as proof of your UCRs when an insurer disputes the level of payment.

VI. MAXIMIZING UCR FOR NON-PARTICIPATING PROVIDERS *continued…*

More Non-par practical tips…

- **Document Emergencies:** Carefully track your emergency services. They are typically reimbursed at 100% of the UCR pursuant to state regulation.

- **Obtain Pre-certification:** For non-emergency services, obtain pre-certification and verify payment terms with the carrier - by calling the phone number on the back of the patient's insurance card - before rendering services. Confirm that you will get paid at the *doctor's* UCR. Then document the approval in the patient's chart or your practice management software, including who you spoke to, when and the terms that were verified.

- **Get Upfront Payment:** Obtain pre-payment from patients whenever possible and particularly when you have doubts about the availability of insurance or the patient's ability to pay at a later date. A credit card is preferable for full recourse if there is a dispute.

VII. USE OF ATTORNEYS IN COLLECTION AND BILLING

- **Why you should consider using an attorney**
  - Exhaust all your efforts first before hiring an attorney
  - Benefits of having an attorney
    - As we have seen, the legal issues are "tough" to deal with and providers are in business of rendering care, not tracking down claim payments and enforcing their rights
    - Carrier "knows you mean business"
    - Attorney often have "decision maker" contacts that cut to the chase and resolve the issue more quickly and favorably on behalf of the provider

VII. USE OF ATTORNEYS IN COLLECTION AND BILLING *continued...*

- **Why you should consider not using an attorney**

  - Cost to provider (provider should request a contingency arrangement so the attorney is only paid if there is a recovery)

  - Minimal risk of being viewed as "troublemaker"

VIII. QUESTIONS?

PLEASE DON'T HESITATE TO CALL ME ANYTIME!

ERIC D. KATZ, ESQ.

MAZIE SLATER KATZ & FREEMAN, LLC
103 Eisenhower Parkway
Roseland, New Jersey 07068
(973) 228-9898
(973) 228-0303 Fax

www.provideradvocate.com
www.njlawyer-blog.com
ekatz@mskf.net