

Physicians Hope for a Speedy Recovery

Recent Developments in Prompt-pay Legislation and Litigation

By Richard Romero, AVA, PAHM, CMBS

As physicians and other providers continue to battle with HMOs and insurance companies in state and federal courts across the country, state prompt-pay laws are playing an increasingly important role. Author Richard Romero reviews recent developments in the legislatures and courts that may make it easier for providers to recover damages for late payments.

In their quest for prompt and complete reimbursement of claims, physicians rely on a variety of legal theories including breach of contract, unjust enrichment, fraud, unfair trade practices and violation of federal racketeering laws.

Recently, state prompt-pay laws have emerged as a viable litigation strategy. One advantage of prompt-pay claims, at least in theory, is simplicity. To recover, a physician only needs to show the insurer failed to pay within the required time period. In reality, though, it is a little more complicated.

This article provides a brief overview of state prompt-pay laws and discusses some recent developments in the legislatures and courts.

Prescription for a Chronic Problem?

Beginning in the late 1990s, physicians and other providers sought a legislative solution for what they characterized as a chronic and widespread problem: late payment of claims by HMOs and insurance companies. With support from the American Medical Association

(AMA) and other groups, they succeeded in getting legislation passed. Today, almost every state has enacted prompt-pay laws or regulations.

Although each state's approach is different, all prompt-pay laws contain three key elements:

- A time period in which claims are required to be processed;
- The type of claims covered (usually described as "clean" claims); and
- Penalties — including interest, fines and restitution — for failure to comply.

Deadlines for processing claims range from 15 to 60 days, although 30 and 45 days are the most common. A number of states apply shorter time frames to electronic claims and some states impose different deadlines, depending on whether a claim is contested.

Several states require health plans to process a specified *percentage* of claims within the prescribed time frame. Florida's law, for example, requires insurance companies to process 95 percent of uncontested electronic claims within 20 days, 95 percent of contested electronic claims within 90 days, 95 percent of uncontested paper claims within 40 days and 95 percent of contested paper claims within 120 days (different requirements apply to HMOs).



A majority of states limit their prompt-pay requirements to claims that provide the plan with adequate information. Many of them have adopted the Medicare definition of “clean claim” as one “that has no defect or impropriety (including any lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made . . .” (Section 1842 (c)(2) of the *Social Security Act*). Some states apply their deadlines to all claims unless they are “contested.”

Forty-five states and Washington, D.C., impose interest ranging from 6 percent to 18 percent for late processing or payment. Fifteen states assess administrative fines in addition to interest, and seven states require restitution.

How Effective Are Prompt-pay Laws?

According to an AMA survey of physicians and other providers, prompt-pay laws have shortened average recovery times somewhat, but the respondents said that most payors still fall well outside the prescribed limits. One reason for this is providers and plans disagree on what constitutes a clean claim.

Payors say they often need extra time to process and properly adjudicate complex claims. But providers accuse plans of exploiting clean-claim provisions as a “loophole,” allowing them to delay payment on legitimate claims.

Part of the problem, providers argue, is that many state-law definitions of clean claim are ambiguous, and some do not define the term at all. In the Medicare definition, for example, it is not clear what constitutes a “circumstance requiring special treatment.” And few of the prompt-pay laws specify which fields must be filled out in claim forms.

Some states have responded by tightening their definitions of clean claim. Texas, for example, amended its prompt-pay law in 2003, making it easier for providers to submit clean claims. Under the new law, an electronic claim is clean if it complies with the standards for electronic claim submission established by the *Health Insurance Portability and Accountability Act of 1996* (HIPAA).



In Texas, for example, paper claims are clean if they contain specific data elements spelled out in the law. Health plans must process clean electronic claims within 30 days and clean paper claims within 45 days. Plans may make a one-time request for additional information, then must pay or deny the claim by the later of 15 days after they receive the information or the end of the applicable payment period.

Last year, New York’s insurance superintendent issued an emergency regulation to clarify the state’s clean-claim definition. The regulation lists the specific fields that must be filled out on two popular claim forms (CMS Form 1500 and CMS Form 1450).

Can Providers Sue Health Plans?

State regulators have become more aggressive in enforcing prompt-pay laws. Since 1997, 14 states have levied more than \$54 million in fines for prompt-pay violations, the AMA reported Aug. 10, 2005. And in the last four years, Texas alone has ordered 47 health plans to pay more than \$64 million in restitution for violations of its prompt-pay laws.

Still, providers feel that prompt-pay laws will have more teeth if they have the ability to sue health plans for noncompliance. Unfortunately, most

prompt-pay laws are silent on whether providers have a private right of action. A few years ago, two Pennsylvania courts — one state and one federal — reached opposite conclusions on this issue.

In *Solomon v. United States HealthCare Systems of Pennsylvania, Inc.*,¹ a Pennsylvania Superior Court dismissed a physician’s claim, concluding that the state’s prompt-pay law did not create a private right of action. Even though the plaintiff was part of the class the law was meant to benefit, the court found that the legislature intended to place the power to enforce the law solely in the hands of the state’s insurance commissioner.

Since 1997, 14 states have levied more than \$54 million in fines for prompt-pay violations.

The following year, however, in *Grider v. Keystone Health Plan Central*,² a federal district court rejected the state court’s holding. “We do not believe,” the court explained, “that the Pennsylvania General Assembly went through the effort to enact a statute requiring

healthcare providers to be paid on undisputed claims in a timely manner, setting forth a specific sanction for failing to do so, without implying that a private cause of action exists”

Providers feel that prompt-pay laws will have more teeth if they have the ability to sue health plans for noncompliance.

More recently, a number of courts have allowed prompt-pay actions by providers. In *Baylor University Medical Center v. Arkansas Blue Cross Blue Shield*,³ for example, a federal court remanded the case to state court, holding that a medical center’s claims for breach of contract and violation of the Texas prompt-pay law were not pre-empted by the *Employee Retirement Income Security Act* (ERISA).

The substance of the plaintiff’s claims, the court found, was governed by state laws that require prompt payment of claims by insurers to independent healthcare providers, not to plan participants or beneficiaries.

In *Sutter v. Horizon*,⁴ a New Jersey superior court certified a class-action on behalf of more than 40,000 New Jersey physicians against the largest HMO in the state. The action sought tens of millions of dollars in damages for Horizon’s “consistent failure” to pay claims on time as well as its failure to pay interest on late payments in violation of New Jersey’s prompt-payment law.

Interestingly, the court rejected class status for the portion of the suit alleging that Horizon denied or underpaid physician’s claims through downcoding, bundling, and other wrongful practices. These practices form the basis for federal racketeering claims against the largest managed care organizations in a nationwide class action pending in a Miami federal court.

In *Westside EKG Associates v. Foundation Health*,⁵ a Florida appellate court ruled that providers can sue HMOs for breach of contract for violating the prompt-pay provisions of the state’s *Health Maintenance Association Act* (HMAA). Despite a Florida Supreme Court ruling that the HMAA provides no private right of action for damages, the appellate court found that the ruling did not apply to an action founded on breach of contract.

The appellate court held that Westside and other providers were third-party beneficiaries of HMO-subscriber contracts and that those contracts were deemed to incorporate the HMAA’s prompt-pay provisions.

The court also held that language in one section of the HMAA stating that it “shall not be construed as creating a civil cause of action” was limited to that section and did not extend to violations of other parts of the act.

As states continue to fine-tune their prompt-pay laws and more courts recognize a private right of action, we can expect prompt-pay claims to play an increasingly important role in managed care litigation.

Richard Romero can be reached at 615.360.5540 or rromero@crowechizek.com.

1. 797 A.2d 346 (Pa. Super. Ct. 2002), appeal denied 808 A.2d 573 (Pa. 2002).

2. No. 2001-CV-05641 (E.D. Pa. 9/18/03).

3. 331 F. Supp. 2d 502 (N.D. Texas 2004).

4. No. L-3685-02 (N.J. Super. Ct. 7/27/04).

5. No. 4D03-3533 (Fla. Dist. Ct. App. 5/4/05).





Crowe's Forensic Services Group

Crowe Chizek and Company LLC's forensic experts use insight and broad technical and industry knowledge to cut beneath the surface and uncover the real story behind the numbers. Crowe's professionals tell the story to the judge, jury or arbitrator through clear, convincing expert testimony and compelling visual presentations. Whether you are assessing liability or damages, investigating fraud or pursuing alternative dispute resolution, Crowe's proven, multidisciplinary team can provide the support you need to succeed.

How to Reach Us

Visit us on the Web at www.crowechizek.com or e-mail Annika Jaspers at ajaspers@crowechizek.com for more information.

If you would like to start receiving information via e-mail about topics of importance to you, please sign up on our Web site at www.crowechizek.com/emailsingup.

About Crowe

Crowe provides innovative business solutions in the areas of assurance, benefit plan services, financial advisory, forensic services, performance services, risk consulting and tax consulting. Crowe, a Crowe Group LLP entity, was founded in 1942. One of the top 10 public accounting and consulting firms in the United States, Crowe also serves clients worldwide as a leading independent member of the Horwath International global professional services organization.

"Expert Perspective" is published regularly by Crowe.



Crowe Chizek and Company LLC is a member of Horwath International Association, a Swiss Association (Horwath). Each member firm of Horwath is a separate and independent legal entity. Accountancy services in the state of California are rendered by Crowe Chizek and Company LLP, which is not a member of Horwath. This material is for informational purposes only and should not be construed as financial or legal advice. Please seek guidance specific to your organization from qualified advisors in your jurisdiction. © 2005 Crowe Chizek and Company LLC