Michigan State Medical Society

Legal Alert

Health Law Update

Enforcement of Michigan's Medicaid Timely Payment Law

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The Michigan State Medical Society, working with the American Medical Association (AMA) in its Campaign to Promote Timely Payment, continues to fight to guarantee that physicians receive timely payment for the care they provide.

Delayed payments severely hinder physicians' ability to keep their practices afloat. They also increase the cost of health care for patients and put billions of dollars in the 'pockets' of health plans as they earn cumulative interest on every late claim.

Our efforts include monitoring health plan compliance with state prompt payment laws and promoting legislative and regulatory remedies that provide for stricter enforcement of existing laws. We are also working to strengthen and expand the prompt payment law, holding more health plans accountable for delaying payments to physicians.

MSMS has prepared a Timely Payment Toolkit for physicians, which includes health plan financial information, a health plan complaint form, the MSMS Managed Care Contracting Checklist, support from the MSMS Reimbursement Advocate, and other resources for physicians. This Legal Alert, prepared by MSMS Legal Counsel, Kerr, Russell and Weber, gives you complete information on how to file for enforcement of the Medicaid timely payment law. The process for commercial health plan claims is described in a separate MSMS Legal Alert.

An Overview of the Medicaid Timely Payment Law

Public Act 187 of 2000 (Senate Bill 938), effective June 20, 2000, requires the Commissioner of Financial and Insurance Services to establish timely claims processing and payment procedures for the billing, processing and payment of Medicaid claims. The procedures are for use by health professionals, facilities and qualified health plans (QHP).

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1. Timely Payment of Clean Claims

A QHP must pay a "clean claim" within 45 days after receipt. Pharmaceutical clean claims must be paid within the industry standard time frame or 45 days after receipt, whichever is sooner. A clean claim that is not paid timely bears simple interest at 12% per annum.

A QHP must timely pay a claim to the extent that it is "clean." A QHP cannot deny an entire claim because one or more services listed on the claim are defective or are not covered services.

A "clean claim," at a minimum, does all of the following:

- Identifies the health professional or facility that provided the treatment or service, including a matching identifying number.
- Identifies the patient and QHP.
- Lists the date and place of service.
- Is for covered services.
- Is certified by the provider as required by law (i.e., the claim is true, accurate, prepared with the provider's knowledge and consent, and does not contain untrue, misleading, or deceptive information).
- If necessary, substantiates the medical necessity and appropriateness of the care or service provided.
- If prior authorization is required for certain patient care or services, includes any applicable authorization number, as appropriate.
- Includes additional documentation, based upon services rendered, as reasonably required by the QHP.

2. Corrective or Defective Claims

Within 30 days after receipt of the claim, the QHP must give the provider written notice of any defect in the claim. The provider has 30 days after receipt of the notice to correct the defect. If the defect is corrected, the QHP must pay the claim within 30 days.

A QHP must notify the provider and the Commissioner of the defect if a claim (or a portion of a claim) is returned from the provider and remains defective for the original reason or a new reason.

3. External Review of Adverse Payment Determinations

The Commissioner is required to establish an external review procedure for adverse payment determinations. The costs for the external review procedure will be assessed by the Commissioner. A health professional or facility may request an external review by making a request within 30 days after receiving notice from the QHP that a claim remains defective.

Within 10 days after receiving a request for an external review, the Commissioner must complete a preliminary review to determine whether the external review may proceed or to request more information from the provider or the QHP. The requested information must be supplied within 10 business days, and the Commissioner must complete the preliminary review within five business days of receipt of the requested information.

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If the Commissioner determines that the external review may not proceed, the Commissioner must give the provider written notice of the specific reasons for the determination. The Commissioner may permit the provider to reapply for a preliminary review.

If the Commissioner determines that the external review may proceed, the Commissioner must notify the provider and the QHP in writing. Within seven business days after receiving the notice, the QHP must provide any information it used in making the adverse determination. The Commissioner must also immediately assign an independent review organization (IRO) to conduct the review. The IRO must satisfy certain qualifications established by the Commissioner.

The IRO must review all pertinent information submitted by the provider and the QHP and the QHP's terms of coverage. The IRO may request the QHP or provider to supply additional information. Within 30 days after being assigned to the review, the IRO must give the Commissioner its written recommendation, including the rationale, supporting documentation and any recommended assessment of interest.

The Commissioner must issue a written decision to the provider and the QHP within 15 days after receiving the IRO's recommendation. The decision may reverse or affirm the QHP's adverse determination and must include the principal reasons. If an adverse determination is reversed, the QHP must immediately pay the claim and any interest assessed by the Commissioner.

4. Miscellaneous

Other provisions of the law include the following:

- Failure by a health professional, facility or QHP to provide the Commissioner with requested information during an external review permits the Commissioner to terminate the review and issue a decision reversing or affirming the adverse determination.
- The Commissioner must establish a universal claim system of coding to be used on all Medicaid claims submitted to QHPs.
- Claims must be transmitted electronically or as otherwise specified by the Commissioner. Qualified health plans must be able to receive claims submitted electronically.
- A health professional or facility must bill a QHP within one year after the date of service or date of discharge.
- It is not a fraudulent act for a health professional or facility to submit a claim that includes one or more rendered services that are determined not to be covered services.
- A health professional or facility cannot resubmit the same claim to a QHP unless the 45 day payment period has passed or to correct a defective claim.
- The Commissioner is required to establish penalties to be applied to health professionals, facilities, and QHPs which fail to adhere to the timely claims processing and payment procedures.
- The State will not contract with QHPs which fail to agree to follow the timely claims processing and payment procedures. Qualified health plans must require contracted health professionals and facilities to do the same.

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How to Seek Enforcement

Physicians and other providers may choose from one of three methods to enforce the payment of clean claims and any interest owed under Michigan's Medicaid timely payment legislation:

- Review by the Commissioner under the procedures the Commissioner established pursuant to Public Act 187;
- Binding arbitration with the QHP pursuant to the process administered by the Michigan Department of Community Health ("MDCH"); and
- Litigation in the court system.

Before pursuing any of these remedies, physicians must first comply with the obligations imposed on providers under Public Act 187. This includes, but is not limited to, timely submitting a "clean claim" as defined in Public Act 187 and timely correcting any defects in the claim following notice from the QHP. It is important for physicians to document compliance with Public Act 187 not only to prove entitlement to payment, but also to limit the risk of a determination that they have violated their obligations under the legislation. As noted below, civil fines and costs can be assessed not only against QHPs, but also against health professionals and facilities that violate the legislation.

Physicians under contract to QHPs must first satisfy any applicable contractual obligations, which may include exhausting any internal QHP grievance procedures before pursuing any external remedies. Contracted providers also need to determine whether they have contractually agreed to payment procedures and remedies which differ from those specified in Public Act 187, in which event the contractual procedures and remedies will take precedence.

Option 1: Review by the Commissioner

Physicians and other providers may request review by the Commissioner by filing form FIS 0278 (Attachment 1). The form is one page in length and is filed with the Commissioner. Physicians may attach any additional information providing facts or proof that will assist the Commissioner in resolving the claim. One form must be submitted for each claim. Claims may not be batched. You can download the form from the Financial and Insurance Services web page at http://www.michigan.gov/documents/cis_ofis_fis_0278_24222_7.pdf.

The review process established by the Commissioner is not a model of clarity and may be a less satisfactory process for physicians than arbitration through the MDCH or even litigation. It should be remembered that in connection with the debate on the timely payment legislation for commercial/non-Medicaid plans, the Commissioner opposed what he characterized as efforts to make his office "a bill collector for the medical community."1

1. The Types of Claims Subject to Review Are Unclear

The review process established by the Commissioner clearly applies to claims requiring external review by an independent review organization under contract to the Commissioner. However, neither Public Act 187 nor the Commissioner's procedures define or give guidance as to the types of claims which are subject to external review. Claims involving disputes over medical necessity probably require review by an independent review organization because the Commissioner does not have the necessary expertise on staff. However, this begs the question as to whether claims that do not require review by an independent review organization—e.g., a QHP which simply refuses to pay an undisputed clean claim—are subject to review by the Commissioner. The Commissioner's position on this point is unclear.

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2. The Time Periods for Requesting Review Are Unclear

If a QHP makes an adverse determination following a physician's attempt to correct any defects in a claim, the physician must request external review within 30 days after receipt of the QHP's notification. The Commissioner is not obligated to accept a request for external review which is not timely filed. However, the Commissioner's procedures acknowledge that the failure of a physician or other provider to meet the timelines required in the process does not absolve a QHP of its responsibility to pay claims for covered services.

Neither Public Act 187 nor the Commissioner's procedures specify any time limit for submitting form FIS 0278 in circumstances that do not appear to require an external review (e.g., a QHP's failure to pay an undisputed clean claim). Public Act 187 and the Commissioner's procedures are likewise unclear as to whether claims not involving external review are subject to the same procedures as those involving external review.

3. The Commissioner's Enforcement Authority Appears to be Less Than Satisfactory

If the Commissioner issues a decision reversing a QHP's adverse payment determination, the measures that the Commissioner can or will take to force the QHP to pay the claim may be less than satisfactory. Neither Public Act 187 nor the Insurance Code authorizes the Commissioner to garnish payment from a QHP. The Commissioner could attempt to enforce the decision by fining the QHP or suspending its HMO license, but the Commissioner is unlikely to do this except in cases involving persistent violations. Unless a QHP voluntarily complies with its legal obligations or the Commissioner actively pursues compliance enforcement under the general authority conferred by the Insurance Code, physicians and other providers may have no choice but to bear the cost of filing suit against the QHP to collect payment.

Public Act 187 permits, but does not obligate, the Commissioner to assess penalties against health professionals, facilities and QHP's for failure to comply with the timely payment procedures. Any penalties which the Commissioner assesses are payable to the State of Michigan, not the provider. Penalties are imposed to punish and deter, not to compensate.

If a QHP has violated the timely claims payment process, costs incurred by the Commissioner for external review services may be assessed against the QHP. A health professional or facility may be assessed a similar penalty if it is determined that the QHP rejected a claim for cause and has not violated Public Act 187. However, any costs assessed are payable to the State, not the provider.

4. Other Issues

The Commissioner will not accept for review any claims submitted to the arbitration system administered by MDCH. The Commissioner's position is that a provider must choose between the Medicaid arbitration system and the Commissioner's review process. It is not unreasonable to require providers to select one forum or the other to resolve disputed claims.

Option 2: Michigan Department of Community Health Arbitration Process

Each QHP under contract to the Michigan Medicaid Program is required to participate in a binding arbitration process administered by MDCH to resolve claims disputes between providers and the QHP. In order to pursue arbitration, a physician or other provider must first exhaust the QHP's internal appeals process. The provider can then request arbitration by notifying the QHP or MDCH. There apparently is no specific form that needs to be filed.

MDCH will provide list of neutral arbitrators that can be made available to resolve the dispute. The arbitrators will be organizations with the appropriate expertise to analyze medical claims and supporting documentation and to determine whether a claim is complete, appropriately coded and should or should not be paid.

MDCH has developed a model agreement that the provider and QHP will be required to sign. The agreement will specify the name of the arbitrator, the dispute resolution-processing time frame for the arbitrator's decision, and the method of payment for the arbitrator fee. The party found to be at fault will be assessed the cost of the arbitrator. If both parties are at fault, the cost of the arbitration will be apportioned.

The QHP will be subject to an interest charge based on the value of unpaid claims when clean claims are not processed and paid timely. Applicable interest rates for the unpaid claims are specified by MDCH based on Medicare guidelines. MDCH's reasons for failing to require payment of the 12% annual interest rate specified in Public Act 187 are unclear.

A provider that submits a duplicate claim that has been previously denied or returned with notice by the QHP that the claim is incomplete or incorrect will be subject to a service charge if the duplicate claim is submitted without completion, correction or further information that addresses the denial or return.

Unlike the Commissioner's review process, the MDCH arbitration system gives physicians and other providers direct access to the arbitrator. The arbitration process appears less bureaucratic than the Commissioner's process. As noted below, the arbitration process will result in an arbitration award that may be confirmed as a court judgment, at which point the physician or other provider may commence collection by garnishment or other means permitted by law.

Option 3: Litigation

Public Act 187 does not affirmatively authorize or prohibit physicians from filing lawsuits in order to collect payment for the principal amount of a claim and the 12% statutory interest rate on clean claims that are not paid timely. Efforts by MSMS to amend the legislation to expressly authorize collection suits by physicians and other providers, as well as to provide for the award of attorney fees, were unsuccessful politically. Nevertheless, physicians and other providers have an obvious legal right to payment for clean claims and should be entitled to recover statutory interest by filing suit, notwithstanding the absence of language in Public Act 187 affirmatively authorizing collection suits.

Neither Public Act 187 nor the procedures established by the Commissioner require physicians or other providers to seek review by the Commissioner before filing suit. If a provider pursues review by the Commissioner and obtains a favorable determination, but the QHP fails to pay, the provider may need to file suit to obtain a judgment and to pursue collection. A provider who successfully pursues arbitration through MDCH can have the arbitrator's award confirmed as a judgment and pursue collection.

For more information on the MSMS Timely Payment Toolkit, visit the MSMS web page at www.msms.org, or contact the MSMS Department of Medical Economics at 517-336-5723.

1 Testimony of Frank M. Fitzgerald on SB 694, 696 and 698, House Committee on Health Policy, June 6, 2000, at page 1.

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FIS 0278 (10/00) Office of Financial & Insurance Services Division of Insurance

Medicaid Clean Claim Report

You may file this report for an individual claim if it is a payable clean claim.
It must be a claim filed with an HMO for a Medicaid-covered service for a Medicaid member.
After April 1, 2001, the claim must have been electronically filed with the HMO.
If claim meets each of these conditions, continue.
If claim does not meet each condition, you may not file this report.

Provider Tax ID number (FEIN)	
Provider's HMO Plan ID Number	
Member's HMO ID number (Not member's Medicaid ID)	
Procedure Code	
ICD-9-CM Diagnosis Code	
Authorization No (if required by HMO for particular service)	

Provider Name

Provider Address

City **State** **Zip**

HMO Name

Member Name

Important Note: Format all dates as MM/DD/YY

Date of Service	Date Provider billed Plan

1. Did Provider have proper plan authorization (including authorization number) at the time of service, if required? ☐ Yes ☐ No ☐ NA

2. Did Provider use a clearinghouse to check for completeness of claim form? ☐ Yes ☐ No

3. Did Provider verify plan membership of patient at time of service? ☐ Yes ☐ No

4. Did Provider verify Primary Care Provider (PCP) status at the time of service? ☐ Yes ☐ No ☐ NA

5. Did HMO communicate any denial of your request for payment? *If Yes, proceed to 6. If No, complete 5A and skip to 7.* ☐ Yes ☐ No

5A. *If HMO did not respond to the request for payment, describe any proof you have that claim was received by the HMO:*

6. Reason given by HMO for denial of payment: *Explain in words. Do not use Plan rejection codes!*

6A. Date of 1st Denial by HMO

7. Was a second denial received? ☐ Yes ☐ No

7A. If yes, was corrected information given? ☐ Yes ☐ No

7B. Reason given by HMO for 2nd denial of payment:

7C. Date 2nd claim submitted

7D. Date of 2nd Denial by HMO

8. Have you discussed this claim with HMO staff? ☐ Yes ☐ No

8A. If yes, what was the Plan's explanation (if any) for the claim rejection?

9. Have you requested arbitration of this claim as permitted under the HMO contract administered by the Medical Services Admin., Dept. of Community Health (Medicaid)? ☐ Yes ☐ No

Certification: I certify that this information is complete and correct. I have followed the requirements of Public Act 187 of 2000. This claim is a payable clean claim that met all required timelines for claims submission under the act.

Signature of Provider or represenative	Date signed	Signer's name and title typed or printed

PA 187 of 2000 as amended requires submission of this form by any provider seeking relief for clean claims not paid in a timely manner as described in the act.

Attach any additional information that provides facts or proof that will assist us in settlement of this claim. Any such attachments are subject to the above certification of Provider or representative.

Our web address is:http://cis.state.mi.us/ins
Our toll free phone number is 1-877-999-6442
Our fax number is: 517-241-4168

MSMS Mission Statement

The mission of the Michigan State Medical Society is to promote a health care environment which supports physicians in caring for and enhancing the health of Michigan citizens through science, quality and ethics in the practice of medicine.

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