# Michigan State Medical Society
# Legal Alert

**Health Law Update**

## Enforcement of Michigan's Timely Payment Laws for Commercial Health Plans

*By Patrick J. Haddad, JD, Member of Kerr, Russell and Weber, PLC, MSMS Legal Counsel*

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 commercial timely payment law. The process for Medicaid claims is described in a separate MSMS Legal Alert.

### An Overview of the Commercial Timely Payment Law

Public Act 316 of 2002 (Senate Bill 451), requires health professionals, facilities (excluding pharmacies) and health plans to follow timely claims processing and payment procedures for the billing, processing and payment of health care claims. The legislation applies to claims with dates of service on and after October 1, 2002.

Health plans subject to Public Act 316 are health insurers, HMOs, and Blue Cross Blue Shield of Michigan underwritten benefit plans. Public Act 316 does not apply to workers' compensation and auto no-fault insurers and ERISA self-funded plans (including BCBSM administrative services only arrangements). Medicaid health plans are subject to timely payment legislation enacted in 2000.

MSMS
*The Voice of 15,000 Michigan Physicians*
www.msms.org
517-337-1351

**1. Timely Payment of Clean Claims**

A health plan must pay a "clean claim" within 45 days after receipt. A clean claim that is not paid timely bears simple interest at 12% per annum.

A "clean claim" is a claim that satisfies all of the following:

- Identifies the health professional or health facility that provided the service sufficiently to verify, if necessary, affiliation status and includes any identifying numbers.
- Sufficiently identifies the patient and health plan subscriber.
- Lists the date and place of service.
- Is a claim for covered services for an eligible individual.
- If necessary, substantiates the medical necessity and appropriateness of the service provided.
- If prior authorization is required for certain patient services, contains information sufficient to establish that prior authorization was obtained.
- Identifies the service rendered using a generally accepted system of procedure or service coding.
- Includes additional documentation based upon services rendered as reasonably required by the health plan.

**2. Correction of Defective Claims**

Within 30 days after receipt of the claim, the health plan must notify the health professional or facility of all known reasons that prevent the claim from being a "clean claim." The provider has 45 days, plus any additional time the health plan permits after receipt of the notice, to correct all known defects. The health plan's 45-day payment period is tolled from the date the provider receives the notice until the health plan receives a response from the provider. If the provider's response makes the claim "clean," the health plan is required to pay the claim within the remainder of the 45-day period. If the provider's response does not make the claim "clean," the health plan must notify the provider of an adverse claim determination, including the reasons, within the remainder of the 45-day period.

**3. Review by Commissioner**

Health professionals, facilities or health plans alleging that a timely processing or payment procedure has been violated may file a complaint with the Commissioner of the Office of Financial and Insurance Services. Although health professionals, facilities and health plans have a right to a determination of the matter by the Commissioner, the legislation does not bar providers or health plans from seeking court action. In addition to any other penalty provided by law, the Commissioner may impose a civil fine of not more than $1,000 for each violation of the timely payment and processing procedures, not to exceed $10,000 in the aggregate for multiple violations.

The Office of Financial and Insurance Services has developed an approved complaint forms for use by health professionals, facilities and health plans (Attachment 1).

### 4. Provider Protection from Discrimination

A health plan is bared from terminating affiliation status or the participation of a health professional or facility with an HMO provider panel or otherwise discriminating against a health professional or facility because a provider claims that a health plan has violated the legislation's timely processing and payment procedures.

### 5. Other Provisions

Health professionals and facilities are required to bill health plans within one year after the date of service, or the date of discharge from a facility, in order for a claim to be "clean."

Health professionals and facilities are prohibited from resubmitting the same claim to a health plan, unless the 45-day payment period has passed, or if the provider is submitting information in response to a notification from a plan.

If a health plan determines that one or more services listed on a claim are payable, the plan must pay for those services and cannot deny the entire claim because one or more other services are defective. However, this provision does not apply if a health plan and health professional or facility have an overriding contractual reimbursement arrangement.

All notices required under the legislation must be made in writing or electronically.

## How to Seek Enforcement

Physicians and other providers may pursue enforcement of the timely payment legislation by filing a complaint with the Commissioner or by pursuing litigation in the court system. The remedy which physicians and other providers will seek is payment of unpaid clean claims and/or 12% annual interest on clean claims that are not paid timely.

Before pursuing enforcement of Public Act 316 by the Commissioner or through litigation, physicians and other providers must first comply with their obligations under the legislation. This includes, but is not limited to, timely submitting a "clean claim" as defined in Public Act 316 and timely correcting any defects in the claim following notice from the plan. It is important for physicians to document compliance with Public Act 316 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, the Commissioner is authorized to assess civil fines not only against plans, but also against health professionals and facilities that violate the legislation.

In addition, physicians under contract to plans must first satisfy any applicable contractual obligations, which may include exhausting any internal plan 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 316, in which event the contractual procedures and remedies will take precedence.

### 1. Review by the Commissioner

Physicians, other providers and plans alleging a violation of Public Act 316's timely processing and payment procedures may file a complaint with the Commissioner on a form approved by the Commissioner, FIS-0284 Clean Claim Report (Attachment 1). You must fill out a separate form for each claim. You can download the form from the Financial and Insurance Services web page at http://www.michigan.gov/documents/cis_ofis_fis_0284_50170_7.pdf.

Michigan State
Medical Society
*the Voice of 15,000 Physicians*
www.msms.org
517-337-1351

Unlike the Medicaid timely payment legislation, Public Act 316 does not establish any specific process or procedures for the Commissioner to review and correct alleged violations of the law. Because Public Act 316 took effect only recently, it remains to be seen whether review by the Commissioner will furnish physicians and others a satisfactory alternative to litigation. It should be remembered, however, that in connection with the legislative debate that preceded the enactment of Public Act 316, the Commissioner opposed what he characterized as efforts to make his office "a bill collector for the medical community."1 This view, along with the legislation's failure to give the Commissioner specific enforcement powers, may not bode well for physicians and others.

If the Commissioner issues a decision in favor of a physician or other provider, the enforcement measures that the Commissioner may or will take to force the plan to pay the claim and interest appear to be less than satisfactory. Neither Public Act 316 nor the Insurance Code authorize the Commissioner to garnish payment from a plan. The Commissioner could attempt to enforce the determination by fining the plan or suspending its license, but the Commissioner is unlikely to do this except in cases involving persistent violations. Unless a plan 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 plan to collect payment of the claim and interest.

Public Act 316 permits, but does not obligate, the Commissioner to assess civil fines against health professionals, facilities and plans for violating the legislation's timely payment procedures. Any penalties which the Commissioner assesses are payable to the State of Michigan, not the provider or plan. Penalties are imposed to punish and deter, not to compensate. Whether the risk of penalties will deter plans from violating the legislation remains to be seen.

**2. Litigation**

Public Act 316 does not prohibit physicians and other providers from filing lawsuits to collect the payment of clean claims and interest. Efforts by MSMS to amend the legislation to permit physicians and other providers to collect attorney fees and costs incurred in litigation were unsuccessful politically.

Public Act 316 does not 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 plan fails to pay, the provider may need to file suit to obtain a judgment and to pursue collection in order to collect payment.

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.



Michigan State Medical Society
*the Voice of 15,000 Physicians*
www.msms.org
517-337-1351

**FIS 0284** (11/02) Office of Financial & Insurance Services

# 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 a Health Care Plan for a covered service.*

*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 Plan ID Number** | |
| **Member's ID number** (Not member's Medicaid ID) | |
| **Procedure Code** | |
| **ICD-9-CM Diagnosis Code** | |
| **Authorization No.** (if required for particular service) | |

**Provider Name**

**Provider Address**

**City** **State** **Zip**

**Health Care Plan 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 if required?** ☐ Yes ☐ No ☐ NA

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

5A. *If Health Care Plan did not respond to the request for payment,* d*escribe any proof you have that they received the claim:*

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

| **6A. Date of 1st denial by plan** |
|---|
| |

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

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

| **7C. Date 2nd claim submitted** |
|---|
| |

7B. Reason given by *Health Care Plan* for 2nd denial of payment:

| **7D. Date of 2nd denial by plan** |
|---|
| |

**8. Have you discussed this claim with Health Care Plan staff?** ☐ Yes ☐ No

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

**9. Did you send a copy of this report to the Health Care Plan?** ☐ Yes ☐ No

If Yes, complete **9A**. If No, your clean claim report processing will be delayed.

| **9A. Date of notification** |
|---|
| |

**Certification:** I certify that this information is complete and correct. I have followed the requirements of Public Act 316 of 2002. 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 |
|---|---|---|
| | | |

**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.**

PA 316 of 2002 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.

**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.*

MSMS

*The Voice of 15,000 Michigan Physicians*

120 West Saginaw Street, East Lansing, Michigan 48823 • www.msms.org • 517-337-1351