APPEAL TRAINING COURSE 7

PROMPT PAY

COURSE HANDOUT

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Prompt Pay and Mandatory Coverage Laws

State and federal mandatory coverage laws apply to certain types of treatment and regulate how such claims are processed. It is often difficult to determine whether the denied claim falls under these mandatory coverage requirements. These letters can be used to appeal a denial seeking compliance with the cited state or federally mandated coverage requirements and, if benefits remain unpaid, to seek input regarding why the mandatory coverage law did not apply to the claim in question.

The Kaiser Family Foundation tracks state insurance mandates at *www.statehealthfacts.org*. The individual state profiles at this site provide information on a state-by-state basis regarding patient rights and state-mandated insurance benefits. After determining what state mandates are applicable in your state, it is important to obtain copies of the applicable laws to incorporate the wording of these laws into your appeals.

Prompt payment

The American Medical Association (AMA) tracks prompt payment fines assessed against insurance carriers that fail to process claims within state-required time frames. As of July 2006, the AMA estimated that 49 states and the District of Columbia have prompt payment legislation and that an estimated $70 million in state payment fines, interest, and restitution has been collectively awarded under these state mandates (source: *www.ama-assn.org/ama/pub/category/9879.html*).

It is very important to incorporate your state's prompt payment mandate into an appeal which can be used as a follow-up letter for stalled claims. Stalled claims require action. The error may be traceable to the provider, the carrier, or even a third party such as an outside billing representative or clearinghouse. However, inaction will likely result in nonpayment. Simply rebilling the initial claim can result in the same lack of response from the carrier. An appeal letter citing the state prompt payment mandate can (1) attempt to establish the initial filing date so that a lack of timely filing denial is avoided and (2) demand compliance with the prompt payment mandate and justification for the payment delay.

Once you have obtained a copy of your state prompt payment mandate, carefully review the law for both the clean claim definition and any sanctions related to prompt payment violations. These terms may need to be incorporated into separate prompt payment appeal letters, as described shortly.

Clean claim definition

Prompt payment laws typically require claims to be paid on "clean claims." However, many states leave the important decision of what constitutes a clean claim to carriers. The article "Prompt Pay: Getting Paid Gets Easier for Michigan's Health Care Providers," by Attorney William S. Hammond (available online at *www.michbar.org/journal/pdf/pdf4article507.pdf*), explains the importance of the clean claim definition. Hammond writes:

> "Like prompt pay laws in other states, Michigan's prompt pay rules apply with respect to clean claims. That is, a Health Plan's or QHP's duty to pay is conditioned upon the provider submitting a claim that has all the information necessary for the claim to be processed. What information is necessary for a claim to be deemed clean is, therefore, critical to the effectiveness of Michigan's prompt pay statutes. Many prompt pay laws have been criticized as ineffective, allowing third-party payors to manipulate the clean claim requirement to avoid paying claims within prescribed timeframes or interest and penalties on late payments. This is particularly the case when the statute fails to define what a clean claim is, or when the definition permits the third-party payor broad discretion in determining what information is necessary to make a claim 'clean.'
>
> Both the commercial and Medicaid prompt pay rules define a clean claim as one that contains certain standard information (patient, date and place of service, service code, etc.). Unfortunately for providers, both also provide that a claim is not clean unless it contains such additional documentation as is required by the QHP or Health Plan. Thus, a Health Plan has some discretion with respect to the information it may require for a claim to be clean."

If your state prompt payment mandate does specify the data elements that are required to constitute a "clean claim," your appeal letter will likely need to list these elements and confirm on a claim-by-claim basis that all required elements for compliance with the law were submitted. If the state statute is silent on defining a clean claim, it is important to negotiate clean claim terms as part of any managed care contract and cite this agreed-upon provision in appeals.

Prompt payment violation sanctions

State prompt payment sanctions vary widely. The most frequent sanction provided in prompt payment

laws is interest payments on claims not paid in a timely manner. Unfortunately, state mandates do not routinely extend to providers the right to pursue and collect interest related to claim violations if interest and/or penalties are not paid on a voluntary basis. If a claim is paid late, your appeal letter can always outline the filing date and payment date, and seek a voluntary interest payment on the time frame beyond the state-imposed deadline. However, the success of such efforts will depend largely on how the law is written and what managed care contractual protections you have negotiated regarding prompt pay. Therefore, it is important to negotiate the right to pursue and collect interest as part of the managed care contract.

Mandatory coverage laws

Mandatory coverage laws place further limits on denying treatment for certain types of care. You will need appeal letters citing these specific protections if your facility or office routinely provides emergency, obstetric, mental health, or alternative/complementary care.

Emergency treatment mandates

Are insurers calculating out-of-network emergency claim payments correctly? How do you know? Emergency care is one of the most protected areas of medical care. Although scheduled procedures fall under a number of cost-containment features, emergency care is, by definition, not as easily managed by managed care. Further, a number of state and federal "access to care" mandates protect patients against unjust penalization from seeking emergency care from the most easily accessible emergency care provider. Many of these state mandates incorporate what is known as the **prudent layperson** standard as part of the access to care protections.

Prudent layperson is a well-recognized consumer protection involving the assessment of urgent medical treatment. Under this standard, a condition will qualify as needing "urgent" care if the medical condition manifests itself "by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the individual (or, with respect to a pregnant woman the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part."

Under this standard, insurance companies can be restricted from establishing a list of certain signs and symptoms which cannot be treated in the emergency room. Instead, the insurance carrier must request

medical records in order to review the severity of the problem and the patient's layperson's perspective on the need for immediate treatment.

New York recognized the prudent layperson standard in both managed care and utilization review mandates. In a 2002 instructional letter to insurance carriers, the State of New York Insurance Department instructed carriers to discontinue denying claims without a thorough investigation. The letter reads:

> "It has come to our attention that insurers, Article 43 corporations and HMOs may be denying coverage for emergency services based upon the final diagnosis code, such as ICD 9 or CPT 4 codes, assigned to the emergency room visits. Although the diagnosis code may be used to approve coverage of emergency services, its use as the basis for denial of coverage is improper. The standard by which to evaluate whether a denial of coverage is supportable is the 'prudent layperson' standard required by the Insurance Law. Whenever a claim is denied, the determination of whether the prudent layperson standard has been met (1) must be based on all pertinent documentation, (2) must be focused on the presenting symptoms and not on the final diagnosis, and (3) must take into account that the decision to seek emergency services was made by a prudent layperson rather than a medical professional.

Emergency care appeals should summarize the patient's condition upon admission and detail the emergency care service provided, including both critical care and post-stabilization care. Attaching medical records is not sufficient. Medical records contain important information but do not adequately address the treatment in the contest of your internal quality care guidelines and pertinent industry standards of care. The internal criteria being used by the insurance carrier may not be as up-to-date or thorough as the clinical standards followed by your organization, and your appeal is the opportunity to detail this information.

Second, emergency care appeals should demand full disclosure of denial details. Denials can be vague. Even clearly stated denials such as "denied due to lack of medical necessity for emergency care" do not provide you with important information such as the clinical criteria used to assess treatment. Therefore, a Level I appeal should request the specific written limitation, exclusion, or internal guideline that

applies to the denial. If the appeal is related to poor reimbursement, your letter should also request disclosure of the methodology used to calculate the payment.

Last and perhaps most important, emergency care appeals should identify any potential compliance issue, such as the prudent layperson standard, related to emergency care coverage. This requires obtaining information on both state and federal claim processing requirements and potentially applicable utilization review standards. Some of the legal protections applicable to out-of-network care include federal and state disclosure laws related to benefit calculation disclosure, state emergency and trauma coverage laws, and prudent layperson federal and state mandates.

Sample Appeal Letter O, “Lack of Precertification Appeal – Prudent Layperson Standard,” seeks review of a denied claim for compliance with the prudent layperson standard of emergency care.

Newborns’ and Mothers’ Health Protection Act of 1996

The federal Newborns’ and Mothers’ Health Protection Act of 1996 (the Newborns’ Act) requires certain group health plans that offer maternity coverage to pay for at least a 48-hour hospital stay following childbirth (96-hour stay in the case of a cesarean section). Most states have a similar coverage mandate which may contain additional protections related to newborn aftercare.

Typically, these laws prohibit plans from requiring providers to obtain authorization from the plan for prescribing the stay. In addition, plans may be prohibited from denying care within the 48-hour (or 96-hour) period because of medical necessity determinations. Your appeals seeking compliance with the Newborns’ Act mandates should provide confirmation that the care was rendered during the 48-hour (or 96-hour) time frame protected by the laws and ask for clarification regarding whether benefits are compliant with newborn/maternity coverage mandates. If the carrier claims an exemption from these laws, the exemption should be clearly explained in the denial letter. If such clarification is not provided, your Level II appeal should explain that newborn/maternity health protection laws are widely applicable and that it is the carrier’s duty to explain any exemption from these laws in the denial so that compliance may be fully assessed. Sample Appeal Letter P, “Maximum Benefit Appeal – Request for Newborns’ and Mothers’ Health Protection Act Compliance,” cites the protections available under the Newborns’ Act and seeks compliance with these benefit protections.

Mental health treatment protections

State and federal mental health parity laws have given many behavioral health treatment providers hope regarding mental health care reimbursement. However, a General Accounting Office report studied the effect of mental parity mandates and found that insurance carriers often modify policies to allow more equal coverage for mental health treatment but offset parity costs through higher deductibles, copays, treatment caps, and other subtle limitations to coverage. Furthermore, most parity laws specifically state that medical necessity policy provisions still apply to coverage availability, thus leaving insurance carriers with this additional avenue of cost control. The result is a confusing array of mental health limitations and clinical guidelines which can be difficult to assess for health parity compliance.

Mental health care appeals should demand full disclosure of denial details in order to determine whether correct benefits have been released. All mental health care appeals should request the specific written limitation, exclusion, or internal guideline which applies to the denial. Mental health care claims denied due to "lack of medical necessity" must be appealed to obtain the specific behavioral health criteria used to assess treatment. Furthermore, if the appeal is related to poor reimbursement, appeals should request disclosure of the methodology used to calculate the payment.

Mental health claim appeals should cite either the U.S. Mental Health Parity Act (MHPA) or potentially applicable state mental health coverage requirements. This requires being familiar with state and federal requirements, what policies and plans fall under their respective jurisdictions, and how these mandates affect copays, coverage caps, and medical necessity review. For example, some state mental health parity laws specifically apply to out-of-network care whereas others reference only in-network care.

The U.S. Mental Health Parity Act

The **U.S. Mental Health Parity Act (MHPA)** applies to group health plans and provides for parity in

the application of aggregate lifetime and annual dollar limits on mental health benefits with dollar limits on medical/surgical benefits. A plan that does not impose an annual or lifetime dollar limit on medical and surgical benefits may not impose such a dollar limit on mental health benefits offered under the plan. The MHPA does not apply to benefits for substance abuse or chemical dependency. Health plans are not required to include mental health benefits in their benefits packages. The MHPA applies to only those plans that do offer mental health benefits.

One of the most obvious violations would be a plan that places yearly maximum benefit levels on mental health care that are less generous than the yearly benefit for medical care. The MHPA also prohibits the common practice of offering mental health care benefits with number-of-yearly-visit caps. The U.S. Department of Labor enforces the MHPA and has extensive information on group health plan compliance, including the following information on per-visit caps:

> "While the plan does not impose an annual dollar limit on outpatient medical/surgical benefits, the 50 doctor visit per year limitation on mental health services, coupled with the absolute $50 maximum payment per visit, is a constructive annual dollar limit on outpatient mental health benefits of $2,500.
>
> Under MHPA, a plan may not impose annual or lifetime dollar limits on mental health benefits that are lower than those for medical/surgical benefits. Here, the plan is not in compliance with MHPA because, with respect to outpatient services, the plan imposes a $2,500 constructive annual dollar limit on mental health benefits and no annual limit on medical/surgical benefits.
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> The plan should eliminate any constructive dollar limit on mental health benefits that is lower than that for medical/surgical benefits. The plan can still impose visit limits under MHPA, provided they are not coupled with absolute dollar limitations, which would constitute a constructive dollar limit."
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> (Source: *www.dol.gov/ebsa/publications/caghp.html*)

Sample Appeal Letter Q, "Maximum Benefit Appeal – Request for U.S. Mental Health Parity Act Compliance," cites the protections available under the MHPA and seeks compliance with these benefit protections.

Alternative/complementary care

Coverage and benefit payment for alternative and complementary care providers varies widely. Even when coverage is available, alternative/complementary care claims are also scrutinized from a utilization and medical necessity standpoint.

These challenges often require that alternative/complementary care providers establish an exemplary process for pretreatment verification of benefits and post-claim filing follow-up and appeals. Therefore, it is especially important to use a written request, such aSample Letter A, Pretreatment Request for Benefit Disclosure , prior to treatment to clarify coverage and/or appeal lack of coverage for alternative/complementary care.

A significant problem with alternative care/complementary care is that the applicable exclusion or limitation is not disclosed with the initial denial. Many state and federal laws require insurers to disclose the specific plan or policy language used in making the adverse determination. This information is helpful in understanding the basis of the denial and assessing the likelihood of appeal success. Therefore, your appeal will be strengthened by a disclosure request such as the following:

> As you are likely aware, many state and federal disclosure laws require insurers to provide detailed information to support a denial of benefits. Therefore, please provide the following information so that we may assess the accuracy of this decision:
>
> 1. A copy of the applicable policy or plan limitation as it reads in the policy or plan description
> 2. Any applicable definitions or provider-specific limitations, such as alternative/complementary provider, chiropractic care, or advanced nurse practitioner definitions and payment policies
> 3. Benefit information regarding coverage of physical and occupational therapy and type of provider who can render therapy-related care

4. A copy of any authorizations or verification of benefits extended to this patient related to this treatment

Often, state and federal insurance and labor code provisions will specify when and to what extent alternative/complementary care should be covered. For example, the American Chiropractic Association confirms that all 50 states have authorized the provision of chiropractic care under state workers' compensation laws (source: *www.acatoday.com/level2_css.cfm?T1ID=21&T2ID=97*). However, each state has different treatment caps and may use specific medical necessity criteria for allowing visits beyond the allowed number. The state of California's Labor Code instructs workers' compensation carriers to use the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines for assessing the need for chiropractic, occupational therapy, or physical therapy visits. Any appeals related to this type of care for workers' compensation claims should use the referenced guidelines to justify the proposed or rendered treatment.

Further, procedure-specific insurance mandates, such as mandatory mammography coverage laws, may specify whether an alternative or complementary provider is covered. State professional organizations can be very helpful in locating and understanding the state mandates applicable to complementary and alternative care.

Workers' Compensation

Almost every state has a Workers' Compensation prompt payment law. However, because Workers' Compensation claims often involve a number of forms and coordination of care, payment delays are common.

It is important to cite the applicable workers compensation requirements when appealing non payment of a workers compensation claims.

The Office of Workers' Compensation Programs administers disability compensation programs that provide benefits for certain federal programs, including Federal Employees' Compensation (FEP), Energy Employees Occupational Illness Compensation, Longshore and Harbor Workers' Compensation and Coal Mine Workers Compensation. Information about the regulations and medical fee schedules applicable to there programs are at the dol.gov website.

Claims falling under state jurisdiction should be appealed with pertinent state regulatory information. Be sure to review your state's specific claims processing requirements and include requires claim elements and any required forms.

ERISA Prompt Pay

The Employee Retirement Income Security Act of 1974, also known as ERISA, is a federal law applicable to most employee benefit plans, excluding state and federal employees and certain religious organizations. The Department of Labor estimates that ERISA applies to more than 2.5 million group health plans. Because many such plans are exempt from state prompt payment regulations, it is important to know and use the ERISA Claim Procedure Regulations to demand prompt action on ERISA claims.

Under ERISA, a medical claims is know as a "post-service health claim." Applicable time frames to processing a post service health claim are explained at the U.S. Department of Labor's "How to File a Health Claim" instruction page:

Post-service health claims must be decided within a reasonable period of time, but not later than *30 days* after the plan has received the claim. If, because of reasons beyond the plan's control, more time is needed to review your request, the plan may extend the time period up to an additional 15 days. However, the plan administrator has to let you know before the end of the first 30-day period, explaining the reason for the delay, requesting any additional information needed, and advising you when a final decision is expected. If more information is requested, you have at least 45 days to supply it. The claim then must be decided no later than 15 days after you supply the additional information or the period of time given by the plan to do so ends, whichever comes first. The plan needs your consent if it wants more time after its first extension. The plan must give you notice that your claim has been denied in whole or in part (paying less than 100% of the claim) before the end of the time allotted for the decision. (Source: *www.dol.gov/ebsa/publications/filingbenefitsclaim.html*)

The ERISA Claims Procedure Regulations does not, however, clarify when payment has to be released once the claim has been decided upon. Instead, payment of services must be provided "within a reasonable time". The Department of Labor's Frequently Asked Questions page confirms the absence of an ERISA prompt payment rule in FAQ A-10 which states:

A-10: Do the time frames in these rules govern the time within which claims must be paid?
No. While the regulation establishes time frames within which claims must be decided, the regulation does not address the periods within which payments that have been granted must be actually paid or services that have been approved must be actually rendered. Failure to provide services or benefit payments within reasonable periods of time following plan approval, however, may present fiduciary responsibility issues under Part 4 of title I of ERISA.
Source: http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html

References

American Chiropractic Association, *www.acatoday.com/level2_css.cfm?T1ID=21&T2ID=97*.

American Medical Association, *www.ama-assn.org/ama/pub/category/9879.html*.

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