



Protecting Montana's consumers through insurance and securities regulation

An Act Establishing Reciprocal Time Limits for Health Insurance Claim Filing, Claim Reimbursements, and Claim Audits

Bill will address timeliness of claim disputes

HB 156 – Sponsored by Representative Teresa Henry

The Problem:

Currently there is no time limit in Montana on when a health insurance issuer may retroactively audit or deny a claim that was previously approved. Medical care providers are being harmed by this widespread industry practice in which health insurance issuers request reimbursements for alleged claim overpayments made several years earlier. Health insurance issuers will also withhold the disputed claim overpayment amount by offsetting current claim payments to medical care providers being made on behalf of other patients.

The Solution:

House Bill 156 was written to limit the time frame in which health insurance issuers could demand reimbursement of an alleged overpayment, or incorrect payment, from a medical care provider. The time frame would be the same amount of time that the insurer imposes for filing a claim.

This Bill will set a limit of twelve months for medical care providers to submit claims for health insurance issuers to review or audit claims and seek reimbursement except under special circumstances such as coordination among insurers or suspected fraud. Additionally, an insurer would need a prior written agreement with a medical care provider before offsetting current claim payments.

The Bill does not impose a complete ban on recovering erroneous claim payments, but simply requires health insurance issuers to request reimbursement for erroneous claim payments in a timely manner. Although twelve months is established as the outside time limit, if a health insurer requires medical care providers to submit claims within a shorter time, the insurer will have that same time period to request reimbursement for any claim Overpayments. For example, if an insurer allows 90 days for medical care providers to submit claims, then the insurer will also have 90 days from the date of claim payment to request reimbursement for any erroneous overpayment.

Medical care providers are being harmed when a health insurance issuer comes back several years after paying a claim and demands reimbursement from the doctor, dentist, radiologist, or hospital for an alleged overpayment. Hardships for medical care providers in this situation include:

- Patients die or move away preventing recovery from the patient.
- The bookkeeping and balance sheet of the provider are adversely affected – frequently years after a claim was paid – and are always in a state of flux because there is no time limit on the health insurance issuers to demand reimbursement of alleged claim overpayments.
- The provider may never be paid for the services.

This Bill will not take away the ability of health insurance issuers to recover erroneous payments. What it will do is put the insurer under the same time restraints that it imposes upon its insureds and medical care providers to file a claim. The insurer will have the same amount of time to request reimbursement of overpayments.

The Montana Medical Association, Montana Dental Association, and Montana Hospital Association have been contacted regarding this Bill. Each organization has expressed support and is expected to present testimony in favor of this Bill.

HB 156 received great support in the House, passing on a final vote of 97-0.

MONTANA STATE AUDITOR

JOHN MORRISON
STATE AUDITOR



COMMISSIONER OF INSURANCE
COMMISSIONER OF SECURITIES

March 4, 2005

Madam Chairman and Members of the Committee:

Re: HB 156 by Representative Teresa Henry "AN ACT ESTABLISHING RECIPROCAL TIME LIMITS FOR HEALTH INSURANCE CLAIM FILING, CLAIM REIMBURSEMENTS, AND CLAIM AUDITS; SETTING A TIME LIMIT FOR HEALTH INSURANCE ISSUERS TO SEEK REIMBURSEMENT OR AN OFFSET OF A CLAIM AND PROVIDING EXCEPTIONS TO THE TIME LIMIT..."

This letter is intended to give you a sampling of the consumer issues brought to the Montana State Auditor's Office that we believe further demonstrate the need for the protections House Bill 156 could provide.

- The State Auditor's Office received a letter from an orthopedic surgeon whose bill was audited long after it had been processed and paid by the insurer. The insurance company decided to review the various procedures performed during one operation. These items were billed correctly at the time of the first submission of the claim and at the conclusion of the file the insurer agreed. Yet in the interim, the insurer requested a refund of a portion of the surgical charges.
- In another case, a physician in Miles City was requested to refund 1/3 of his fee for a biopsy a year and a half after the procedure had been paid by the insurer.
- The most egregious complaint involved a series of complaints from six different providers who alerted us to the fact that an out of state insurer had hired an independent audit firm to go through all of the claims from Montana for the previous three years. The letters sent to physicians outlined the claims and the amounts the insurer expected to receive from the physicians and mentioned that unpaid amounts would be forwarded to a collection agency.
- On January 11, 2005 the State Auditor's Office received a letter from a specialist in Missoula who has been trying to work out a claim audit for almost a year with an insurer. More than once, he thought the matter was resolved. When he received his next monthly accounting from the insurer, he found that he was billed again for services he provided, but the amount was taken in an offset against another patient's bill.

Our office receives many telephone inquiries about claim audits and we can provide more examples if needed. The need for this legislation has been presented to our office and now, to you. We hope this bill represents a satisfactory solution for all concerned, thank you for your consideration.

Sincerely,

A handwritten signature in cursive script that reads "Alicia Pichette".

Alicia Pichette

Deputy Insurance Commissioner

Phone: 1-800-332-6148 / (406) 444-2040 / Fax: (406) 444-3497

840 Helena Avenue Helena, MT 59601 Website: www.discoveringmontana.com/sao E-Mail: stateauditor@state.mt.us



Other States – time limits on claim filing, claim audits and claim reimbursements

State	Statute or Regulation	Brief Description
Missouri	Mo. Rev. Stat. 376.384.1	Except in cases of fraud, a health insurance issuer may not request reimbursement or make an offset more than 12 months after it paid the health care provider for the claim.
Arizona	Ariz. Rev. Stat. 20-3102(I)	Except in cases of fraud, a health insurance issuer may not adjust or request reimbursement of a claim more than one year after it paid the health care provider for the claim.
Alabama	Ala. Code 27-1-17(e) and (f)	Except in cases of fraud, coordination of benefits, or duplicate payment, a health insurance issuer may not deny, adjust or seek recoupment more than 1 year after it paid a health care provider for a claim.
Louisiana	La. Rev. Stat. 22:250.34	Health insurance issuers that limit the time for a health care provider to submit claims have the same limited period of time following payment of a claim to audit such claim for reimbursement for overpayment.
Maryland	Md. Ins. Code 15-1008	Except in cases of fraud, improper coding, or duplicate claims, a health insurance issuer may not deny, adjust or seek recoupment more than 6 months after payment (or more than 18 months after payment if subject to coordination of benefits, Medicare, or Maryland Medical Assistance Program).
Kentucky	Ky. Rev. Stat. 304.17A-714	A health insurance issuer has 24 months to notify the health care provider of an alleged overpayment including the basis for its overpayment determination. The provider has 30 days to dispute the alleged overpayment. The insurer may not recoup the alleged overpayment until after the dispute is resolved.
Oklahoma	36 Okla. Stat. 1250.5.15	Except in cases of fraud, a health insurance issuer may not request reimbursement for a claim overpayment more than 24 months after it paid the claim.
Virginia	Va. Code Ann. 38.2-3407.15 B 6	Except in cases of fraud or duplicate payments, a health insurance issuer may not request reimbursement for a claim overpayment from a contracted provider more than the lesser of : (a) 12 months after payment; or (b) the number of days that insurer requires the health care provider to submit a claim.



Association For Head And Neck Surgery

Ear, Nose and Throat
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James E. Jarrett, M.D., F.A.C.S.
Diplomate American Board of Otolaryngology
Diplomate American Board of Facial Plastic & Reconstructive Surgery
February 21, 2005

John Morrison
Montana State Insurance Commissioner
840 Helena Ave.
Helena, MT 59601

Dear Mr. Morrison,

Please find enclosed copies of communication from John Alden Insurance Company regarding patient

The patient was initially seen in this office on 11/26/03. My impression was of obstructive sleep apnea and nasal airway resistance syndrome with acute sinusitis. The acute sinusitis was treated and resolved. He was further evaluated over several subsequent visits. An in-lab, split-night sleep study with CPAP trial was reported on 12/01/03 as severe obstructive sleep apnea, placing the patient at risk for a cardiovascular event in his sleep. The patient did not feel that he could accept CPAP as a permanent means of therapy and requested that we proceed with surgery. Preauthorization was requested by phone on 12/01/03 by my nurse and confirmed by documentation from John Alden dated 12/05/03 as "this outpatient service as set forth above has been certified as medically necessary." The procedural services set forth as being medically necessary were codes 42145 for UPPP, 42826 for tonsillectomy, and 30140 for partial resection of inferior turbinates. Please see enclosed copy of confirmation letter from John Alden. The preauthorized surgery was performed on 12/23/03, and the patient did well postoperatively.

I believe it is certainly inappropriate and probably ^{*}illegal in Montana to retrospectively deny or attempt recovery of payment for previously preauthorized services. Since John Alden is intent upon pursuing this, I would respectfully request that this matter be reviewed. I look forward to receiving your opinion and recommendations.

Sincerely,

James E. Jarrett, M.D.

jej/vs

* "Post Claim
Handwriting"
11/8/04