

You deserve to get paid on time!

To Medical Society of DC member physicians and practice administrators:

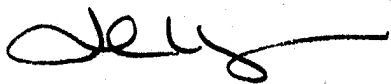
Do you know that DC law now requires many plans to pay clean claims within 30 days or pay interest? The Medical Society of the District of Columbia was instrumental in the passage of the "District of Columbia Prompt Pay Law of 2002." Our efforts locally were strengthened by support from the American Medical Association's nationwide Campaign to Promote Timely Payment.

Generally speaking, the DC law:

- requires covered health plans to pay clean claims within 30 days or pay interest;
- allows physicians 180 days in which to file a claim;
- sets timeframes for the presumptive receipt of claims by a health insurer (to prohibit health plans from "losing" claims) and requires health plans to record when they receive claims and to allow physicians to inspect these records;
- sets limits on the retroactive denial of claims; and
- prohibits "all products" clauses in provider contracts.

This checklist has two purposes. The first purpose is to acquaint you with the law. Accordingly, we have included a summary of the Prompt Pay Act. To read the law in its entirety, please visit www.msdc.org and click on "Resource Center." The second purpose is to make sure that the law "works" – that health plans pay you promptly and that they comply with the other provisions of the Act, too. The checklist is not intended to be a "gotcha" against a company which only rarely pays a clean claim late or miscalculates interest. Rather, it seeks to identify sources of *chronic problems*. So, if you see that a health plan defies the law frequently, please contact the Medical Society of DC at 202-466-1800. We'll work with you to assemble documentation to turn over to the DC Department of Insurance and Securities Regulation, the governmental body charged with enforcing the law.

You deserve to be paid promptly. We hope this Prompt Pay Checklist proves to be a valuable tool to ensure that you are.



John Lawson, MD
President

P.S. The prompt pay law also entitles your patients to prompt payment of their claims. To help you inform your patients of their rights under the law, we enclose two versions of an open letter, one from the Medical Society and one which can be photocopied onto your letterhead.

Medical Society of DC Compliance Checklist District of Columbia Prompt Pay Act of 2002

How to use this checklist. As you monitor the payment of your claims through regular Account Receivables reports or other means, please make note of health plans that are chronically slow payers *or who repeatedly violate any of the 17 provisions noted on the checklist.* If you find

frequent violators, please contact the Medical Society of DC. We will work with you to assemble documentation for submitting to the DC Department of Insurance and Securities Regulation, empowered to enforce the law.

	PAYOR _____	PAYOR _____	PAYOR _____
CLEAN CLAIMS			
Does the plan pay clean claims within 30 days?			
If not, does the plan pay you the correct interest without being asked? (1.5% days 31-60, 2% days 61 through 120, 2.5% after day 120).			
UNCLEAN OR DISPUTED CLAIMS			
Does the plan notify you within 30 days as to why a claim is in dispute and, when applicable, what reasonable and necessary documentation is still needed?			
If the plan asks for additional documentation, does the plan pay you within 30 days of receiving it?			
If only part of the claim is in dispute, does the plan pay the undisputed portion within 30 days?			
If the plan does not pay the undisputed portion within 30 days, does the plan pay you interest on the undisputed portion without being asked?			
TIMELY FILING			
Does the plan allow you at least 180 calendar days from the date of service to file your claim? Your contract may allow for more but not less.			
PRESUMPTIVE RECEIPT OF CLAIMS			
Does the plan maintain that it did not receive claims?			

	PAYOR _____	PAYOR _____	PAYOR _____
Does the plan allow you (upon request) to inspect its written or electronic record of when it received your claims?			
CLAIMS-FILING PROCEDURES			
Are you (or have you been) informed of the plan's claims-filing procedures at the time of contracting and within 30 days prior to any change in the procedures?			
RETROACTIVE DENIALS			
Are you informed in writing as to the basis for retroactive denials?			
Are retroactive denials made within 6 months of the initial payment? (This does not apply to retroactive denials based on coordination of benefits, improper coding or duplicate claims.)			
Are retroactive denials based on a coordination of benefits made within 18 months of your original payment?			
Are retroactive denials accompanied by information about the entity responsible for paying the denied claim?			
Are you allowed 180 days after the date of a retroactive denial to file a claim to the responsible entity?			
PROHIBITION ON "ALL PRODUCTS" CLAUSES			
At the time you execute or renew a contract (on or after 10-16-02), have you been given the opportunity to refuse to participate in one or more provider panels (except Medicare and Medicaid provider panels)?			
If you have exercised this right, have you been free of any adverse effect on your status as a current member of an existing panel or as a potential member of a future panel? This could include being dropped from an existing panel or having your application to participate in a new panel denied..			

SUMMARY OF THE DISTRICT OF COLUMBIA PROMPT PAY ACT OF 2002

This is a *summary* of the provisions of the District of Columbia Prompt Pay Act of 2002 that most affect physicians. For a complete understanding of the Act, refer to the law itself, available at www.msdc.org. Click on "Resource Center."

KEY PROVISIONS

The Prompt Pay Act of 2002 went into effect October 16, 2002 and applies to any individual and group health benefits plan issued or renewed in the District of Columbia except Medicare and Medigap plans, Federal Employee Health Benefits plans, and self-funded coverage administered by a third party administrator. The law requires prompt payment to "any person entitled to reimbursement under the health benefits plan" which can, of course, include physicians, hospitals and patients. *For purposes of this summary and checklist, however, we refer only to physicians.* The law's key provisions are:

- requires health plans to pay clean claims within 30 days or pay interest;
- allows physicians 180 days in which to file a claim;
- sets a timeframe for the presumptive receipt of claims by a health insurer (to prohibit health plans from "losing" claims). Also requires health plans to record when it receives claims and to allow physicians to inspect this record;
- sets limits on the retroactive denial of claims; and
- prohibits "all products" clauses in provider contracts.

PROMPT PAYMENT ¹

For claims that are clean ² . . . a health plan must pay the claim within 30 calendar days of receipt. If it fails to do so, it must pay interest (1.5% from days 31 through 60; 2% from days 61 through 120; 2.5% after day 120) without being asked by the physician.

For claims or portions of claims that are *not* clean (or are disputed by the health plan for other reasons such as the amount of the reimbursement), a health plan must

- notify the physician in writing (within 30 days) stating why the claim (or a portion of the claim or the amount of the claim) is in dispute;
- pay any *undisputed* portion of the claim within 30 days; and
- pay the disputed portion of a claim within 30 days of receiving all reasonable and necessary documentation. If it fails to do so, it must pay interest (see rates above).

Timely filing: A physician has at least 180 days from the date of service to submit a claim. The contract may allow for more but not less than 180 days

Presumptive receipt of claim: A claim is presumed to having been received by a health plan

- 5 days after the claim was mailed;
- 24 hours after the claim was submitted electronically (if it isn't returned electronically); or
- the day the claim was delivered by courier.

¹ *The prompt payment provisions do not apply to payments made on a capitated basis, if the failure to pay promptly is caused in part by the person submitting the claim (e.g. physician does not give a health plan a change of address), or if the health plan's compliance is rendered impossible by acts of God, etc.*

² *A clean claim is "a claim that has no material defect or impropriety, including any lack of reasonably required substantiating documentation, which substantially prevents timely payment from being made on the claim or with respect to a health insurer that has failed timely to notify the person submitting the claim of any such defect or impropriety in accordance with [the law]."*

Health plans must maintain a written or electronic record of claims receipt which the physician may inspect.

Claims filing procedures. A health plan must inform physicians (at contracting time) of the plan's claims submission procedures and within 30 days prior to any changes in those procedures.

RETROACTIVE DENIALS

If a health plan wants to retroactively deny a reimbursement, it must do so within 6 months of the initial payment, *unless*

- it's a coordination of benefits matter and then retroactive denials may be made up to 18 months after the initial payment. The health plan must provide the physician (in writing) the name and address of the entity acknowledging responsibility for payment of the denied claim and the physician has at least 180 days after the date of denial to file a claim to that entity;
- the physician filed a claim that was improperly coded. A claim is considered improperly coded if it does not conform with the insurer's coding guidelines which have to have been provided to the physician at least 30 days prior to the date of service on the claim being retroactively denied;
- the physician filed a claim fraudulently; or
- the physician filed a claim that was a duplicate.

A health plan must notify the physician in writing as to the basis for any retroactive denial.

PROHIBITION ON "ALL PRODUCTS" CLAUSES IN CONTRACTS

On or after October 16, 2002 when a physician executes or renews a contract with a health plan, the physician may refuse to participate in one or more provider panels (except for Medicare and Medicaid provider panels). If a physician opts to exercise this right, a health plan may not adversely affect the physician's status as a current member of any existing panels or as a potential member of any future panels.

If a physician wishes to exercise her right to terminate participation in one or more provider panels,

- The physician must notify the insurer at contract renewal time and at least 90 days before termination; and
- The physician must, for at least 90 days after notifying the health plan of her intentions to terminate, provide health services to enrollees who were her patients on or before the date she notified the health plan of her intentions to terminate.

CLAIMS PAYMENT REPORT

Beginning with annual reports to the Insurance Commission filed on March 15, 2004, each insurer must report the number of claims received, denied, and paid the previous year (showing how many were paid within 30, 60, 120 and 120+ days) and the average number of days to pay a claim in the previous year.

PENALTIES

The Insurance Commissioner determines if a health insurer has violated the Prompt Pay Act. Repeated violations can result in several penalties, including revocation of license or certificate of authority for the insurer and a civil penalty of up to \$1000 per violation.

To read the "District of Columbia Prompt Pay Act of 2002," visit www.msdc.org and click on "Resource Center."

An open letter to my patients

Dear patient,

You deserve to get paid on time!

Have you ever sent a claim to your health insurance company only to have to wait many weeks to get paid? You're not alone. It's a big problem for patients and it's a big problem for doctors like me who need to get paid on time to keep our practices afloat. Why do the health plans take so long to pay? Because the longer these big companies can hold on to your money, the longer they can earn interest on that money. Add up all the money they get from thousands of patients and doctors and you'll see that they get millions of dollars by holding on to the checks! Insurance companies assume that the average patient and doctor will not fight back. That may have been the case before, *but not now!*

The Medical Society of the District of Columbia worked hard to get the DC Council to pass the "DC Prompt Pay Act of 2002" which became law in October 2002. Maryland and Virginia have similar laws. Here are some of the things that the DC law says:

- Your health plan has 30 days from the time it receives your claim to pay you, unless the company disputes (questions or disagrees with) the claim.
- If your health plan does not pay your undisputed claim within 30 days, the plan must pay you interest on top of what it owes for the claim.
- If your health plan disputes the claim, it has to tell you so within 30 days. If the plan needs more information from you, it has to tell you that within 30 days, too.
- You have up to 180 days from the time you see your doctor to send your claim to the insurance company. After that, the company may refuse to pay the claim you because you sent it in too late.

This is just some of what the law says. To read the whole law, go to www.msdc.org and click on "Resource Center" and then click on "DC Prompt Pay Act of 2002."

If you believe that your insurance company is breaking this law, you should file a complaint with the DC Department of Insurance and Securities Regulation. To do so, call 202-727-8000 or visit http://disr.dc.gov/services/insurance_complaint/index.shtm

An open letter to patients

You deserve to get paid on time!

Have you ever sent a claim to your health insurance company only to have to wait many weeks to get paid? You're not alone. It's a big problem for patients and it's a big problem for doctors who need to get paid on time to keep their practices afloat. Why do the health plans take so long to pay? Because the longer these big companies can hold on to your money, the longer they can earn interest on that money. Add up all the money they get from thousands of patients and doctors and you'll see that they get millions of dollars by holding on to your checks! Insurance companies assume that the average patient and doctor will not fight back. That may have been the case before, *but not now!*

The Medical Society of the District of Columbia fought hard to get the DC Council to pass the "DC Prompt Pay Act of 2002" which became law in October 2002. Maryland and Virginia have similar laws. Here are some of the things that the DC law says:

- Your health plan has 30 days from the time it receives your claim to pay you, unless the company disputes (questions or disagrees with) the claim.
- If your health plan does not pay your undisputed claim within 30 days, the plan must pay you interest on top of what it owes you for the claim.
- If your health plan disputes the claim, it has to tell you so within 30 days. If the plan needs more information from you, it has to tell you that within 30 days, too.
- You have up to 180 days from the time you see your doctor to send your claim to the insurance company. After that, the company may refuse to pay the claim you because you sent it in too late.

This is just some of what the law says. To read the whole law, go to www.msdc.org and click on "Resource Center" and then click on "DC Prompt Pay Act of 2002."

If you believe that your insurance company is breaking this law, you can file a complaint with the DC Department of Insurance and Securities Regulation. To do so, call 202-727-8000 or visit http://disr.dc.gov/services/insurance_complaint/index.shtm

You and your doctor work hard to make sure that you get good medical care.

You both deserve to get paid on time!