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Hospital Claims Submitted to Health Plans: Timely Or Not, That is The Question

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Almost everyone at some point during their lifetime will receive care and treatment at a hospital or community medical center. In today's society, most hospitals are usually funded by the state, health organizations (for profit or nonprofit), health insurances or charitable organizations. Many of the individuals who obtain the care and treatment from these hospitals have health coverage under either a Preferred Provider Organization ("PPO") or Health Maintenance Organization ("HMO") plan through one of the major health plans or health insurance companies.¹ The major health plans in California include Aetna, Blue Cross, Blue Shield, Cigna, and Health Net.

These health plans typically enter into agreements with hospitals throughout California in order to establish the various obligations between the hospital and the health plans concerning the care and treatment being provided to their members. The main objective of these hospital agreements is to set forth the different payment rates that will be applied for care and treatment, and how the payments will be made. These agreed-upon rates are typically well below the amount of the "full-billed" charges by the hospital in its item-

ized statements and Uniform Billing ("UB") claim forms.² These are mutually beneficial relationships in which the hospitals are considered preferred providers, which guarantees them a steady flow of patients. In turn, the health plans have a place to send their members to obtain treatment at acceptable rates.

The hospital agreements also specify the time within which the claim forms must be submitted by the hospitals to the health plans so that the hospitals will be reimbursed at the agreed-upon rates for the care and treatment. The hospital agreements typically require the claims to be submitted within a time frame that could range from as little as 90 days to upwards of 180 days from the "date of the patient's discharge" for inpatient claims or from the "date of service" for outpatient claims.

The primary reason given by the health plans for having claim submission deadlines in the contracts is that they want to be able to better manage their accounts and cash flow.

But, what happens when the hospital fails to submit the claim to the health plan within the contractual time limits? Should the hospital be required to forfeit all payment on claims that miss the claim submission deadline by a few days or even months? Does it matter if there were internally created problems that caused the delay in the claim submission by the hospital or if there were external issues outside the control of the hospital that led to the delay in submission?

When a hospital submits a claim to the health plan, if the date of submission is beyond the filing limit, the health plan uniformly denies the claim. Most hospital agreements have dispute resolution procedures that the hospital can employ when it believes a claim has been

¹ The insured persons are typically called "members."

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² There is the UB-92 claim form which has been replaced by the UB-04 claim form.

improperly denied. This includes the right to appeal adverse decisions, meet and confer rights, and, if necessary, the right to binding arbitration. Unless the hospital can produce acceptable evidence of an earlier timely submission of that claim, short of arbitration, it is very likely that the claim will remain denied.

However, once the claim is in the arbitration forum, it will then be up to the arbitrator—the trier of fact—to decide whether the hospital will be entitled to reimbursement for the particular claim. During the arbitration process, the hospital will typically raise various arguments in support of their position that the “untimely” filed claim should be paid. The health plans will respond with their own arsenal of counter-arguments.

These are the typical arguments and counter-arguments:

Argument:

The claim was, in fact, timely submitted to the health plan and the denial was in error.

Analysis:

The question is, what is acceptable “proof of timely filing”? Will the arbitrator accept the date on the claim form, or entries in claim notes, as valid proof of timely filing? In our experience, this type of proof is generally not acceptable proof of timely submission.³ It is recommended that the hospitals maintain the best proof possible. The types of documents that arbitrators frequently look to as “the best proof possible” are clearinghouse reports confirming acceptance of electronic submission, denial/request for information letters, explanation of benefits (“EOBs”) showing timely submission, overnight airbill slips, certified mail return slips, and other insurance carrier EOBs. The extent of the required proof will generally be on a case by case basis. Without such proof, the hospitals bear the risk of the claim being denied for “proof of timely filing.”

Argument:

Regardless of whether the hospital can prove timely submission with actual documentation called for by the contract, valid and legitimate services to the health plans’ members have been provided at a cost to the hospital, which should be reimbursed for such care and treatment.

The hospital will also likely argue that the health plans would suffer little or no prejudice if they were required to make payment on untimely filed claims, especially with regard to claims that were only a few days or months late, but that the lack of payment on such claims would cause and is causing serious financial problems for many hospitals affecting their ability to stay in business.

Counter-Argument:

The counter to the previous argument is that the parties agreed to a contractual provision setting forth a deadline for claim submission and that the timely submission of a claim is a condition precedent to payment. “An obligation is conditional when the rights or duties of any party thereto depend upon the occurrence of an uncertain event.” (California Civil Code Section 1434.)

“A condition precedent is one which is to be performed before some right dependent thereon accrues, or some act dependent thereon is performed.” (California Civil Code Section 1436.)

If the hospital fails to comply with the condition precedent, i.e., the timely submission of a claim, then the hospital’s right to payment does not accrue and the health plan is not obligated to make payment. To require the health plan to make a payment on the claim absent the hospital’s adherence to the condition precedent of the timeliness provision, would give the hospital the power to unilaterally convert the health plan’s conditional obligation to make the required payments into an independent, unconditional obligation notwithstanding the terms of the hospital agreement.

The health plans would also argue that the late submission of claims affects the financial, actuarial, and business determinations made in the pricing of a product, the ability to set up reserves to protect the claim loss and the mandatory earnings reports the health plans are required to provide to the public and regulatory agencies. The health plans would further claim that perpetual late claims payments would greatly impact their ability to do business in today’s market.

Argument:

The hospitals are entitled to recover in quantum meruit for the services rendered.⁴ Some arbitrators believe that hospitals should not be in the position of having provided care and treatment to the health plans’ members without being paid for having rendered that care and treatment despite the lack of generally acceptable proof of timely filing.

Counter-Argument:

The health plans counter by arguing that, people enter into agreements everyday which set forth certain terms and conditions and those terms and conditions must be complied with for performances to be received and payments to be made. Moreover, California case law supports a finding that “there is no equitable basis for an implied-in-law promise to pay reasonable value when the parties have an actual agreement covering compensation.” (*Hedging Concepts v. First Alliance Mortgage Company* (1996) 41 Cal. App. 4th 1410, 49 Cal.Rptr.2d 191 [review denied].)

Argument:

The hospitals also frequently argue forfeiture. Forfeiture is generally defined as “a divestiture of specific property without compensation; it imposes a loss by the taking away of some pre-existing valid right without compensation.” (Black’s Law Dictionary (6th ed. 1990).) California Civil Code Section 3275 provides that:

Whenever, by the terms of an obligation, a party thereto incurs a forfeiture, or a loss in the nature of a forfeiture, by reason of his failure to comply with its provision, he may be relieved therefrom, upon making full compensation to the other party, except in case of a grossly negligent, willful, or fraudulent breach of duty.

³ Nor should it be under the language usually contained in these hospital agreements.

⁴ The legal term for the recovery of the reasonable value of services provided when no contract exists.

The hospitals claim that a forfeiture has occurred because they have not received payment for services that were rendered. The hospitals raise the issue that the health plans are not entitled to receive the benefits of the medical treatment provided to the members for review. Under such circumstances, the hospitals believe that they should receive such payments regardless of when the claim was submitted to the health plan and that the health plans would only be entitled to, at most, collecting damages for the breach, i.e., the delay in the submission of the claim.

Counter-Argument:

The counter-argument by the health plans is that there was no divestiture of the hospital's property because the hospitals' right to payments on these untimely filed claims never arose due to the fact that they failed to comply with the timeliness provisions of the hospital agreements.

Additionally, the health plans will argue that, although the law looks with disfavor upon forfeitures, this does not mean that the courts are free to make for the parties a different contract from what they voluntarily agreed upon, or resort to a strained and unnatural construction to defeat or nullify their clearly expressed purpose or intention. (*Troughton v. Eakle* (1922) 58 Cal. App. 161, 173; see *Parsons v. Smilie* (1893) 97 Cal. 647, 657)

Moreover, the health plans argue that California *Civil Code* Section 3275 is inapplicable to their claims because the hospitals had no obligation upon which they could make full compensation to the health plan since it would be impossible to compute the compensation owed to the health plans due to the breach by the hospitals. If the nature of plaintiff's breach be such that it is impossible to compute the actual damages suffered by defendant, the claim for relief from forfeiture must fail. (*Lines v. Marin Mun. Water Dist.* (1964) 228 Cal.App.2d 155, 158; see *Parsons, supra*, 97 Cal. at 654

[“If an act is one for which the court has no certain rule by which to measure the damages, beyond their own arbitrary judgment in the matter, equity will not relieve.”].)

Argument:

Another argument raised by the hospitals is that the health plans apply the time limit rules for submission in an arbitrary or capricious manner, i.e., strictly only for some hospitals.⁵

Analysis:

If the hospitals can produce such evidence, which they generally have none, then they may very well have a legitimate basis to obtain relief in the form of payment. However, without evidence that the timely filing provisions are not being applied uniformly or have been used to punish certain providers, there is no basis for a claim by the hospitals that such a provision is invalid and unenforceable. See *Life Care Centers of America v. CalOptima*, (2005) 133 Cal. App. 4th 1169, 1183.

Conclusion

As can be seen above, both the hospitals and the health plans can make meritorious arguments as to why payments should be made (or not made) on these untimely filed claims. This issue arises with amazing frequency and seems to survive whatever contract language is drafted to address it. The question of how to resolve this issue perpetuates. More time to submit claims does not appear to be the solution, because disputes ultimately arise regardless of agreed upon time limits.

⁵ How health plans treat a hospital not in the dispute really is irrelevant to how the health plan is treating the disputed claim. Additionally, the respective contracts may be different, as may be the course of conduct between the health plan and the two hospitals. But hospital lawyers who represent multiple hospitals often raise this issue.