



HEALTH CARE NEWS

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CLAIMS PAYMENT A TOP CONSUMER COMPLAINT

If complaints received by the Health Care Bureau are any indication, it seems that consumers' problems with the health care system begin with the paperwork and electronic transmissions that inevitably follow any doctor-patient encounter. Almost 30% of all consumer complaints received over the last year-and-a-half by the Bureau's *Helpline* related to provider mistakes in preparing claims or health plan errors in processing them.

Failure by health plans to pay claims or process them in a timely manner – the most common complaint – accounted for almost one in eight calls. Other errors by health plans included payment of the wrong amount, payment to the wrong person, mistaken application of consumers' deductibles, and inaccurate co-payment assessment.

One in ten consumer complaints about claims processing and payment arose from mistakes made by doctors and hospitals when submitting consumer claims. The most common provider mistake: entering the wrong diagnostic or procedure code on a claim form. Health plan computer systems set up to catch these problems reject such a claim, typically stating that the health service identified by the (incorrect) code is not medically necessary or is not a covered benefit. The next most common provider error was found to be late filing of claims, followed closely by failure to submit sufficient clinical information that health plans must review before approving coverage. Virtually all of these cases were resolved promptly by Helpline staff. See the "Did You Know" box for tips on avoiding provider and health plan errors.



HEALTH CARE HELPLINE AT 1-800-771-7755 option 3

Ms. B, a Dutchess county resident, called the Health Care Bureau's Helpline after receiving calls from collection agencies about unpaid hospital bills. She told a Helpline mediator that her health plan was refusing to pay the hospital's claims for cancer treatment for her three-year-old daughter even though Ms. B had already met her \$2,500 deductible. She had already spent several hours arguing with the plan's customer representatives, even offering to send copies of canceled checks to prove that she had met her deductible, but the plan was refusing to process her claim. The mediator reviewed Ms. B's records, contacted both the hospital and the plan, and quickly discovered that, when processing the hospital claims, Ms. B's plan had mistakenly applied \$1,904 towards her deductible even though the deductible had already been satisfied. The plan acknowledged its error (attributing it to a "computer glitch"), recalculated Ms. B's out-of-pocket payments, and paid the hospital claim in full.

Q & A

Q: I am an HMO member. Is my plan required to process my claims quickly?

A: The New York State Prompt Payment Law (NY Insurance Law 3224-a) mandates that health insurance companies and HMOs pay undisputed or "clean" claims within 45 days of receipt. But plans don't have to promptly pay claims that are "not reasonably clear" or where there is evidence that the claim may be fraudulent. If the obligation to pay in full is not clear, insurers and HMOs must notify you or your provider in writing within 30 days of receipt of any claim it disputes, state the specific reasons why it believes it is not liable and request all additional information needed to determine liability to pay the claim. When you or your provider submits the information, the 45-day time period for payment commences again. *Remember*, insurers and HMOs must pay the portion of the bill that is undisputed within 45 days. Also, the law requires that any "clean" claim paid after 45 days must include payment of interest at the rate of at least 12%, calculated from the date payment was due, i.e., 45 days from date of submission.



DID YOU KNOW?

Checking the accuracy of your provider's bill could help avoid claims errors. Here are more tips:

- Read your health insurance policy to know the extent and limits of your coverage.
- Take special note of the services for which you have to pay - through co-pays, deductibles or co-insurance - and make sure you understand how much you have to pay.
- Keep a careful record of all expenses that should be applied toward your deductible such as receipts showing co-payments and co-insurance payments.
- If you are asked to pay a charge you do not understand, ask your plan or provider to explain the charge and direct you to the relevant provision of your policy that requires it.

Attorney General Eliot Spitzer's Health Care Bureau protects - and advocates for - the rights of all health care consumers statewide. The Bureau operates a Health Care Helpline that assists thousands of New Yorkers with individual problems; investigates and takes law-enforcement actions to address systemic problems in the operation of the health care system; and proposes legislation to enhance health care quality and availability in New York State. **To share your views contact the Editor: Rashmi.Vasisht@oag.state.ny.us**