

Legal Q/A

by Bruce E. Wood, Esquire

Q: One of our HMOs has asked to audit claims that we submitted and paid over a year ago. What rights do we have?

A: That depends on both state law and your contract with the HMO. Since 1998, NY law has required HMOs to include in contracts with physicians detailed provisions which address retrospective adjustments to compensation. The provider contract must include: (1) the methods for making prospective or retroactive adjustments in payments, (2) the time periods for completing those calculations, the dates upon which any payments and adjustments will be determined to be due, and the dates upon which any payments and adjustments will be made, (3) a description of the records or information relied upon to calculate any payments, and a description of how the physician can access a summary of such calculations and adjustments, (4) the process to be employed to resolve disputed incorrect or incomplete records or information, and (5) the right of either party to submit the claims dispute to binding arbitration.

You should ask the HMO for proof that its contract complies with the law. Many existing provider contracts pre-date the enactment of these new requirements and will not meet the statutory requirements. In that event, it is likely that the HMO will attempt to rely on principles of contract law, for example, that an overpayment can be recouped on the theory that the claim submitted by the physician did not meet the HMO's criteria for full payment.

If the physician believes that the HMO is not following the law, or is acting unreasonably, arbitration should be considered. In egregious cases, the matter should be taken up with the State Insur-

ance Department. Unfortunately, if the HMO does not abide by the statutory requirements for claims resolution, there is no right to sue the HMO to enforce your rights. The statute does not confer a private cause of action upon an affected physician so the best recourse would be to seek the intervention of the Insurance Department.

When negotiating a contract with an HMO, it's a good idea to seek a provision limiting the time period during which the HMO can audit claims, especially since you must usually submit your claims within a designated period – often 90 to 120 days. The HMO should also act diligently in reviewing and auditing claims. It's not unreasonable to require finality on all paid claims 180 days after payment has been made.

Q: Can our medical group charge an administrative fee to a patient for the collection of the patient's co-payment fee that was charged at the time of delivery of service which was not paid?

A: According to a recent opinion of the State Insurance Department, it depends on whether or not charging of an administrative fee is stated in the "certificate of coverage" which is approved by the Department. If the certificate of coverage does not state that an administrative fee can be charged in the event that a patient neglects to pay the co-payment at the time of service, then it may not be charged to the patient.

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