



Memorandum

To: Vice President, Business Development
From: Managing Attorney, Legal Research
Date: February 11, 2005
Re: Questions from Regional Hospital (PA)

Below you will find the general informational responses to your recently submitted research questions as prepared by the Legal Research Team. Please advise if any further assistance will be needed.

Question #1: Does the state Prompt Pay Statute apply to the Medicare and Medicaid products managed by a third party (a.k.a. managed care)?

No. Medicare and Medicaid plans are regulated by Federal law. The state prompt payment provision applies only to claims submitted under health insurance policies.

Question #2: TriCare Claims. How can the hospital appeal denials for no authorization when the hospital attempted authorization within the allotted timeframe, however, TriCare did not return their phone calls during the timeframe.

“Preauthorization must be granted before benefits can be extended. In those situations requiring preauthorization, the request for such preauthorization shall be submitted and approved before benefits may be extended, except for emergency treatment. In cases of noncompliance with preauthorization requirements, a payment reduction shall be made [§ 199.15(b)(4)(iii)].” The federal regulations (32 C.F.R., part 199) governing TriCare claims do not specify requirements for the extent of provider access for the purposes of obtaining preauthorization. The preauthorization process is merely depicted as follows according to the TriCare Policy Manual:

1. Preauthorization may be requested from a contractor in person, by telephone, FAX, or mail. The date of receipt of a request shall be the date (business day) on which a contractor receives the request to authorize the medical necessity and

appropriateness of care for which it has jurisdiction.

2. In general, the decision regarding the preauthorization shall be issued by the contractor within one business day of the receipt of a request from the provider, and shall be followed with a written confirmation (if initial notice is verbal).

3. A preauthorization is valid for the period of time, appropriate to the type of care involved. It shall state the number of days/type of care for which it is valid. In general authorizations will be valid for 30 days. If the services are not obtained within the number of days specified, a new preauthorization request is required.

In addition to the above policy requirements addressed above, providers should refer to the network provider agreement or managed care contract for additional requirements regarding preauthorization. Otherwise, the provider may wish to consider filing a factual appeal addressing TriCare's inaccessibility.

Question # 3: Workers' Compensation Claims. Suppose a hospital is paid more than the state fee schedule, but less than total charges. Must the hospital refund amounts over the state fee schedule in cases where the hospital is not aware of mistake or fraud on behalf of the hospital?

Generally, health care costs for a work-related injury or illness are payable up to 113% of the Medicare reimbursement rate, as updated by law. Workers' Compensation rules state that if a provider's actual charges for services rendered are less than the maximum fee allowable under the Workers' Compensation Act, the provider shall be paid only the actual charges for the services rendered. If a Medicare payment mechanism does not exist for a particular treatment the amount of the payment made to a health care provider shall be either 80% of the usual and customary charge in the geographic area where rendered, or the actual charge, whichever is lower. [34 PA ADC § 127.102]. However, 34 PA ADC § 127.101(f) clearly states that "an insurer may not make payment in excess of the medical fee caps, unless payment is made pursuant to a contract with a CCO [coordinated care organization] certified by the Secretary of Health." Furthermore, the Workers' Compensation Act stipulates that a provider shall not require, request or accept payment for the treatment, accommodations, products or services in excess of these set medical fee caps. [See PA ST 77 P.S. § 531]. The preceding statements apply regardless of the provider's knowledge regarding any fraud or mistake on its own behalf.

Question # 4: MVA Claims. Suppose a patient's automobile insurance coverage is exhausted on an initial claim, and the patient returns years later with an injury related to the initial claim. Is the hospital restricted to billing the health insurance and/or patient based on statutory fee restrictions?

It depends on the circumstances:

General Rule - An insurer issuing or delivering liability insurance policies covering any motor vehicle (except recreational vehicles) registered and operated in the Commonwealth, shall make available for purchase first party medical benefits with respect to injury arising out of the maintenance or use of a motor vehicle. Such benefits, subject to certain limitations relating to customary charges for treatment, shall include coverage to provide for reasonable and necessary medical treatment, physical medicine and rehabilitative services without limitation as to time, provided that, **within 18 months from the date of the accident causing injury**, it is ascertainable with reasonable medical probability that further expenses may be incurred as a result of the injury. [PA ST 75 Pa.C.S.A. § 1712]. Furthermore, an insurer shall make available for purchase first party **benefits payable up to 3 years from the date of the accident**. Essentially, there is 3-year limit of liability on continuing medical care under Act 6 [75 Pa.C.S.A. § 1715(a)(5)]. Otherwise, a provider rendering service to an injured person for an injury covered by liability or uninsured and underinsured benefits or first party medical benefits, cannot require, request or accept payment for the treatment in excess of 110% of the Medicare payment, or if a payment has not been calculated under Medicare, to an amount that does not exceed 80% of the provider's usual and customary charge. [PA ST 75 Pa.C.S.A. § 1797].

Question # 5: Prisoner Claims. If the police arrest someone for some type of illegal conduct and take the person to the ER for a general checkup prior to transferring the prisoner to the police station, can the arresting agency refuse to pay the patient's hospital bills?

County prisons are responsible for the medical needs of its inmates until he/she is released from custody as either "not guilty" or for some other reason, such as bail, parole, or pardon. If an inmate is temporarily transferred from a prison to a medical facility, that inmate is still "incarcerated" and, thus, the correctional facility is responsible for medical care of that inmate. The key question of course is whether a patient, who has merely been placed under arrest, been deprived of freedom of movement in such a way as to render him/her under the control and custody of the prison. State law does not clearly address this issue. Thus, there is leeway for a prison warden to argue that prison financial responsibility for medical expenses does not extend to arrestees who have not yet been admitted to the prison.

Question #6: If a hospital has been billing the MA Program (Medicaid) for a period of time and then discovers that the patient actually had Medicare dating back at least 6 months of that time, is the hospital obligated to refund the MA Program?

Other private or governmental health insurance benefits shall be utilized before billing the MA Program. Providers shall make reasonable efforts to secure from the recipient sufficient information regarding the primary coverages necessary to bill the other insurers or programs, such as Medicare. The MA Program is not authorized to pay for services and procedures for which payment is available through other public agencies or private insurance. [55 PA ADC § 1101.54] Such services are considered “noncompensable” under that program. Thus, if a MA recipient also has Medicare coverage, the Department may only be billed for charges that Medicare applied to the deductible or coinsurance, or both. [55 PA ADC § 1101.64]