White Paper

American Association of Oral and Maxillofacial Surgeons

Timely Insurance Reimbursement

Prompt Payment of Claims

Despite prompt pay laws in almost every state, healthcare providers and patients continue to experience delays in reimbursement from third-party payers.

Some third-party payers may engage in a variety of tactics that result in delayed reimbursement to the provider or patient. For example, they may request additional documentation beyond what was originally required for submission, make the remark codes or reasons for denial on the Explanation of Benefits unclear or in a non-standardized format – causing confusion for the provider and the patient – or claim they have no record of receiving the claim when submitted via paper despite the provider submitting all the correct claims information in the appropriate timeframe.

Although electronically submitted claims have shortened some of the lag time associated with claims payments, delayed reimbursement continues to put a significant burden on many practices. Systematic delays and underpayments of claims create disputes that require significant effort, resources and time to resolve – potentially taxing to the small business. This also impacts patients when it cuts into the amount of time a provider can spend with patients or causes the provider to stop accepting certain insurance plans. It further creates unpredictable situations for the OMS office when practitioners are unable to anticipate cash flow, possibly impacting office payroll.

To expedite claims processing, the American Association of Oral and Maxillofacial Surgeons (AAOMS) supports legislation that:

- Establishes a statutory definition of "complete or clean claim."
- Reduces the timeframe allowed for third-party payers to reimburse complete claims to 15 days for electronic claims and 30 days for non-electronic claims.
- Mandates a 10-day timeframe for third-party payers to notify the claimant that the claim is incomplete and requires, in such cases, third-party payers to specify all deficiencies and any additional information/documentation required to process and pay the claim.
- Mandates third-party payers to pay or deny the claim within 10 days upon the receipt of additional required document or information.
- Requires third-party payers to pay any uncontested portion of the claim within the original 15-day (electronic) and 30-day (non-electronic) time period.
- Obligates third-party payers to pay claims not paid or contested within the established timeframes.
- Establishes stricter fines on third-party payers for delayed payments, including:
  - Interest payments to providers or patients on top of payment for the claim based on a sliding scale from the date of delinquency.
  - Fines imposed by the state insurance commission.

Retroactive Denials and Post-payment Audits of Claims

Third-party payers frequently require pre-authorization or pre-certification prior to delivery of certain healthcare procedures. In such cases, the provider is required to specify the medical justification of the procedure at which time the third-party payer determines whether it will be a covered service. However, third-party payers might retroactively deny reimbursement after the procedure has been rendered.

In cases where the provider or patient was paid for the claim, third-party payers may conduct a post-payment audit that determines the procedure should not have been covered and demand refund of the payment made.

Third-party payers are allowed by law to conduct post-payment audits and frequently do so. Post-payment audits are mechanisms used by insurance carriers to detect fraudulent billing behavior and recoup costs associated with administrative oversights. Carriers also may conduct post-payment audits if they have "red flagged" a provider because of what they believe to be over-utilization of certain procedures or modifiers.

Many states already impose time limitations (e.g., 24 months) for a third-party payer to recoup payment from providers during a post-payment audit, but that timeframe is still too long and leads to accounting nightmares for providers and patients when recoupment attempts occur so long after the initial procedure.

AAOMS supports legislation that:

- Denies third-party payers the ability to retroactively deny coverage for a procedure, if they have already pre-authorized the procedure and the documentation supports the claim originally submitted.
- Imposes a 180-day timeframe for a third-party payer to conduct a retrospective audit and seek a refund from the provider or patient.
- Requires third-party payers, within this 180-day timeframe, to give 30 days' notice to providers and patients that they plan to recoup an overpayment and that the notice be accompanied by adequate specific information to identify the specific claim and the specific reason for the recovery.
- Prohibits third-party payers from automatically deducting any disputed claims from other claims submitted by the provider and approved by the third-party payer.
- Requires third-party payers, in cases where they are seeking a recoupment of payment for services subject to coordination of benefits with another third-party payer, to provide a written statement to the provider or patient within this 180-day timeframe specifying the basis for the recoupment as well as the name and address of the entity acknowledging responsibility for payment of the claim in question. Such notices ensure providers and patients will know from which company they will receive payment.

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