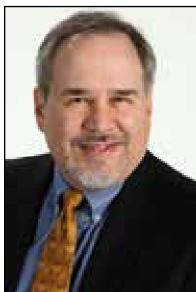

'Clawbacks' declawed: Act 146 limits retroactive denials

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Pennsylvania's General Assembly has provided some welcome news for physicians reeling from uncertainties about the survival of the Affordable Care Act (ACA), insurers fleeing the ACA exchanges and increasingly frequent payer audits. Act 146 was signed into law by Gov. Tom Wolf on Nov. 3, 2016. It adds a new chapter entitled "Retroactive Denial of Reimbursements" to title 40 of the Pennsylvania Consolidated Statutes, which regulates insurance. Act 146 bans retroactive denials of paid claims as a result of an overpayment determination more than two years after the date the insurer initially paid the health care provider, with certain exceptions.

The bill was introduced by Rep. Karen Bobak of the 117th District in northeastern Pennsylvania, and was passed unanimously by both the state House and Senate. The bill was championed by many professional organizations including the Pennsylvania Orthopaedic Society, the Pennsylvania Optometric Association, the Pennsylvania Medical Society (PAMED), the Hospital & Health System Association of Pennsylvania and the Pennsylvania Chiropractic Society. The Insurance Federation of Pennsylvania opposed the legislative effort, primarily citing issues with claims from non-physician practitioners. Upon the enactment of Act 146, the Pennsylvania Orthopedic Society noted, "The General Assembly's actions end a 10-year odyssey that pitted the medical community against the health care insurance industry."

PAMED initially had urged adoption of a 180-day limitation and then worked with lawmakers toward a targeted 12-month limit excepting cases of fraud or improper coding. Although the final legislation as passed adopted a 24-month window, it narrowed the exceptions and no longer allows payers to look back further based on improper coding determinations.

Under Act 146, an insurer may not attempt to retroactively "claw back" payments of claims beyond 24 months after such claims were approved for payment, with the following four exceptions:

- The information submitted to the insurer constitutes fraud, waste or abuse.
- The claim submitted to the insurer was a duplicate claim.
- Denial was required by a Federal or State government plan.
- Services subject to coordination of benefits with another insurer, the medical assistance program or the Medicare program.

As usual with legislation and regulations, definitions are critical. Act 146 includes the following definitions:

- "Abuse." Incidents or practices of providers, physicians or suppliers of services and equipment which are inconsistent with accepted sound medical, business or fiscal practices.
- "Fraud." Any activity defined as an offense under 18 Pa.C.S. § 4117 (relating to insurance fraud)
- "Waste." The overutilization of professional medical services or the misuse of resources by a health care provider.

Equally important is this common-sense rule which requires denials within the 24-month window to be based on policies that the provider could have known about when submitting the disputed claim. It is not uncommon for an insurer to attempt to deny payments based on policies that were never formally adopted or that were adopted after the fact. This section of the law holds insurers to a higher due process standard:

"An insurer that retroactively denies reimbursement to a health care provider under this chapter shall do so based upon coding guidelines and policies in effect at the time the service subject to the retroactive denial was rendered."

Another common issue is a dispute among insurers over which carrier is primary based on each policy's coordination of benefit rules. Act 146 requires the responsible payer to allow resubmission of a denied claim based on coordination

of benefits for a minimum of 12 months after the date of the denial. Consider a patient who is covered by two policies, A and B. If a claim is paid by Insurer A on Jan. 31, 2017, and is retroactively denied by Insurer A on Dec. 31, 2019, due to a determination that Insurer B is liable, Insurer B must allow the provider to resubmit the claim for at least 12 more months, longer if the entity responsible for payment permits a longer time period. This is particularly helpful since the 24-month limit does not apply to coordination of benefit denials, which may otherwise be delayed beyond the second carrier's submission deadlines.

Finally, an insurer may request medical or billing records in writing from a health care provider and the provider must supply those records within 60 days of the request. The period of time in which the health care provider is gathering the requested documentation extends the insurer's 24-month lookback window, so where such records are requested toward the end of such period, it can stretch to 26 months.

In the past, it took protracted litigation to protect physicians from overreaching by payers. You may recall the 2008 class action settlement in the case known as *Rick Love M.D v. Blue Cross Blue Shield Association, et al*., under which Highmark agreed to an 18-month lookback limit in addition to a number of other voluntary reforms. That settlement has now expired and insurers have generally been free to look back as far as four years under Pennsylvania's general contractual statute of limitations. Going forward, insurers in Pennsylvania generally cannot look back more than 24 months and must make all retroactive denial decisions based on policies and guidelines in place at the time of the patient's treatment. Act 146 represents a significant victory for Pennsylvania physicians.

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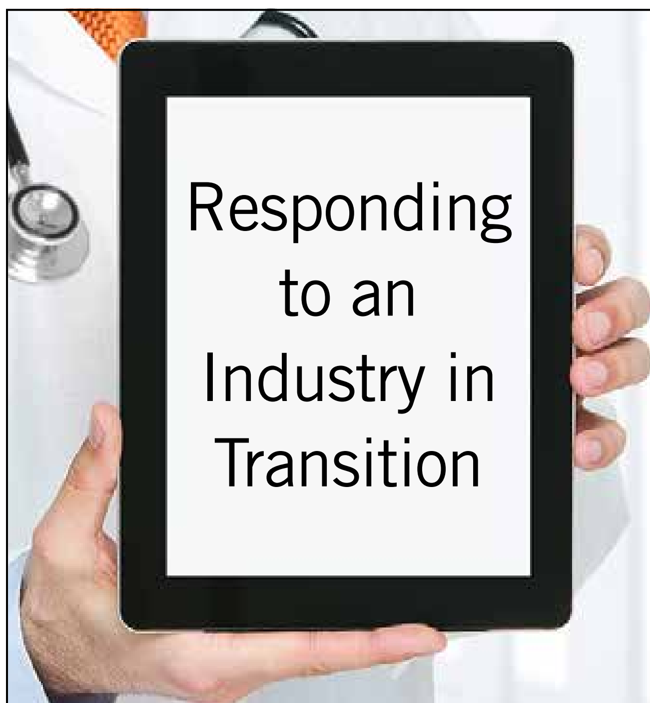

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