Declaratory Ruling 87-8986-M

Applicability of managerial-level conference and review process to audits of providers

June 16, 1987

I. BACKGROUND

By a letter dated April 23, 1987, Blue Cross and Blue Shield of Michigan (BCBSM) requests a declaratory ruling. It summarizes its request as follows:

> For all of the foregoing reasons, BCBSM respectfully requests a declaratory ruling pursuant to Section 63 of the Administrative Procedures Act that the managerial level conference process does not apply to any provider audit matters. Alternatively, in the event that you determine that the process should continue to be available to providers contesting audits, BCBSM requests a declaratory ruling that providers should be required to identify the precise provisions that have allegedly been violated, specify those actions which constitute the violations and any relief granted by Bureau staff should be substantially limited in scope and nature.

The Commissioner of Insurance (Commissioner) is authorized to issue a declaratory ruling on this matter pursuant to Section 63 of the Administrative Procedures Act of 1969, as amended (APA), MCLA 24.263; MSA 3.560(163), which provides:

> On request of an interested person, an agency may issue a declaratory ruling as to the applicability to an actual state of facts of a statute administered by the agency or of a rule or order of the agency. An agency shall prescribe by rule the form for such request and procedure for its submission, consideration and disposition. A declaratory ruling is binding on the agency and the person requesting it unless it is altered or set aside by any court. An agency may not retroactively change a declaratory ruling, but nothing in this subsection prevents an agency from prospectively changing a declaratory ruling. A declaratory ruling is subject to judicial review in the same manner as an agency final decision or order in a contested case.

BCBSM requests a declaratory ruling as to the applicability of certain informal review procedures established by statutory provisions and rules to provider audit disputes. The statutory sections identified are Sections 402, 403, and 404 of the Nonprofit Health Care Reform Act (the Act), MCLA 550.1402; MSA 24.660(402), MCLA 550.1403; MSA 24.660(403), and MCLA 550.1404; MSA 24.660(404). The rules involved are Procedures for Informal Managerial-Level Conferences and Review by Commissioner of Insurance (the Rules), R 550.101 et seq. of the 1979 Michigan Administrative Code. BCBSM's request is properly made under Section 63 of the APA.

Two attorneys each responded to BCBSM's request. They represent health care providers. They argue that the managerial-level conference process and review by the Commissioner do apply to provider audit matters.

II. ANALYSIS

BCBSM is a health care corporation governed by the Act, MCLA 550.1101 et seq.; MSA 24.660(101) et seq. BCBSM makes payments to some health care providers on behalf of its subscribers subject to audit. If a later audit shows that the payments were unwarranted, BCBSM recoups the amount of the overpayments.

In its letter, BCBSM explains its audit process. It reports that some providers, after notice of audit determinations, request conferences under Section 404 of the Act rather than using BCBSM's audit review process. BCBSM argues that the conference provisions do not apply to provider audits.

Health Care Providers

An initial issue to determine is whether health care providers are entitled to managerial-level conferences and a review before the Commissioner under Section 404(1) of the Act, which provides:

> A person who has reason to believe that a health care corporation has violated Section 402 or 403, if the violation was with respect to an action or inaction of the corporation with respect to that person, shall be entitled to a private informal managerial-level conference with the corporation, and to a review before the commissioner if the conference fails to resolve the dispute.

A person is defined in Section 107(3) of the Act as follows:

> "Person" means an individual, corporation, partnership, organization, or association.

There is nothing restrictive in the definition to preclude a participating provider from being a person who has reason to believe that a health care corporation has violated Section 402 or 403. Moreover, an examination of Section 403(1) shows that participating providers are conferred rights under that section that could lead to a need for dispute resolution:

> A health care corporation, on a timely basis, shall pay to a member or a participating provider benefits as are entitled and provided under the applicable certificate. When not paid on a timely basis, benefits payable to a member shall bear simple interest from a date 60 days after a satisfactory claim form was received by the health care corporation, at a rate of 12%

> interest per annum. The interest shall be paid in addition to, and at the time of payment of, the claim.

Thus, Section 403(1) creates a statutory obligation upon a health care corporation to make certain payments to participating providers. If it fails to do so, a participating provider is a person who has reason to believe that the health care corporation has violated Section 403. This statutory basis for concluding that a participating provider has rights under Section 404(1) is underscored by the definition of claim in Rule 101(a) of the Rules:

> As used in these rules:
>
> (a) "Claim" means a request for payment by a provider under his or her agreement with a health care corporation or a request for benefits or payment by a subscriber or the subscriber's agent or representative under the subscriber's contract, certificate, or rider. A claim does not include applicable copayments or deductibles.

The Rules implement Section 404 of the Act. They include providers among those persons who may utilize the conference and review process established by that section.

Provider Audits

Since a health care provider is a person who may be entitled to a private informal managerial-level conference with a health care corporation and to a review before the Commissioner if a conference fails to resolve the dispute, it is necessary to determine whether disputes arising from provider audits may be the subject of those conferences and reviews.

As discussed above, if BCBSM has not made payments required by Section 403, the participating provider has a right to a conference and review as specified in Section 404(1). Where BCBSM has paid a participating provider; and then recouped payments following a provider audit, it has retroactively denied claims. The participating provider is in the same position as if BCBSM had never paid the claims in the first place. That participating provider whose claims are denied retroactively is, therefore, entitled to the conference and review provided by Section 404(1).

In a similar manner, a participating provider whose claims are denied retroactively would be entitled to a conference and a review with respect to a violation of Section 402. Several provisions of Section 402 may have a bearing upon a dispute arising with respect to a provider audit. For example, if a participating provider perceives that the provider audit was performed incorrectly or utilized a defective methodology, the provider might assert a violation of Section 402(1)(d):

> (1) A health care corporation shall not do any of the following: . . .

(d) Refuse to pay claims without conducting a reasonable investigation based upon the available information.

In asserting that Sections 402, 403, and 404 do not apply to provider audits, BCBSM raises three principal arguments. First, it asserts that Sections 402 and 403 apply to individual claims or a series of claims, but not to claims that may arise with respect to a provider audit. Second, BCBSM notes that there have been no decisions involving any form of post-payment audit under provisions under the Uniform Trade Practices Act, MCLA 500.2001 et seq.; MSA 24.12001 et seq. Sections of that act are comparable to Sections 402 and 403. BCBSM asserts that Sections 402 and 403 should not be interpreted to have a broader application than the comparable provisions in the Uniform Trade Practices Act. Third, Section 404 of the Act is derived from Section 2113 of the Code, MCLA 500.2113; MSA 24.12113. Section 2113(1) states:

> A person who has reason to believe that an insurer has improperly denied him or her automobile insurance or home insurance or has charged an incorrect premium for that insurance shall be entitled to a private informal managerial-level conference with the insurer and to a review before the Commissioner, if the conference fails to resolve the dispute.

BCBSM contends that, since Section 2113 only grants a right to a conference in limited circumstances, the comparable right in Section 404 should be similarly limited.

Sections 402 and 403 of the Act are designed to ensure prompt and fair claims payment by a health care corporation. BCBSM maintains that these sections only apply to single claims or a series of claims, not the assembled claims that are the subject of a provider audit. However, since Sections 402 and 403 are designed to protect the reasonable expectations of subscribers and providers to claims payment in accordance with applicable certificates, the distinction put forth by BCBSM must be rejected. It thwarts the Legislature's intent to protect subscribers and providers. It suggests that a health care corporation may not unfairly deny claims payment with respect to individual claims, but may do so if the claims are taken together as a group.

With respect to the comparable provisions in the Uniform Trade Practices Act to Sections 402 and 403, there have been no contested cases with respect to provider audits. Thus, there have been no decisions as to the scope of the Uniform Trade Practices Act sections. There is no basis, therefore, to infer that Sections 402 and 403 of the Act should be interpreted narrowly, since there are no decisions interpreting the Uniform Trade Practices Act sections narrowly.

As to Section 2113 of the Code, the Legislature established an informal dispute mechanism with respect to coverage and premiums in connection with car and home insurance. The Legislature drew upon that informal dispute mechanism for resolving claims disputes involving health care corporations. That the procedures for resolving disputes are similar between Section 2113 of the Code and Section 404 of the Act has no bearing on the types of disputes to be resolved. The subject matter of the disputes is

determined by looking at each section individually. The focus of Section 2113 of the Code on premium and coverage disputes does not serve to limit the scope of claims disputes that are covered by Section 402 of the Act.

Notice of Alleged Violations

BCBSM reports that it has not had adequate notice of the charges against it arising from grievances filed by providers with the Commissioner. While the Act and the Rules do not specify the notice to which a health care corporation is entitled, several provisions have a bearing upon this matter. Section 404(4) of the Act states:

> The Commissioner shall by rule establish a procedure for determination under this section, which shall be reasonably calculated to resolve these matters informally and as rapidly as possible, while protecting the interests of both the person and the health care corporation.

A health care corporation is entitled to notice of a dispute and the opportunity to answer allegations made against it. In connection with decisions based on written materials, Rule 105(1) provides:

> When conducting a review of the dispute through written materials, the Commissioner shall, by first-class mail, notify the health care corporation of the matter under consideration and inform the health care corporation of the time period within which any reply shall be made. Such notification shall be given within 10 working days after the Commissioner receives the grievance.

As to dispute resolution through a meeting, Rule 105(2) states in part:

> When conducting a review of a dispute through a meeting with the parties involved, the Commissioner shall do all of the following within 10 working days after he or she receives the grievance:
>
> (c) Inform the health care corporation of the time period within which any answer shall be made.

A health care corporation has the right to answer alleged violations. A health care corporation will be denied a meaningful opportunity to answer the allegations either in writing or at a meeting if it is not clearly notified of the facts and statutory sections involved. To provide this opportunity, where the grievant is a participating provider alleging a violation of Section 402 or 403 with respect to a provider audit, the written appeal of the grievant to the Commissioner should contain a reference to the particular sections of the statutes involved and a short and plain statement of the matters asserted.

Remedies

In BCBSM's request for declaratory ruling, BCBSM seeks a statement that any relief granted by the Insurance Bureau staff should be substantially limited in scope and nature. Rule 108 of the Rules states the remedy in the event of an improperly refused claim:

> (1) If the decision by the Commissioner or the Commissioner's designee indicates that the grievant's claim was wrongfully refused in violation of Section 402 or Section 403 of Act No. 350 of the Public Acts of 1980, as amended, being 550.1402 or s 1403 of the Michigan Compiled Laws, the wrongfully refused claim shall be paid within 30 days of the date the decision is mailed to the health care corporation.
>
> (2) A claim which is payable to a member shall bear simple interest from a date of 60 days after a satisfactory claim form was received by the health care corporation, at a rate of 12% interest per annum. The interest shall be paid in addition to, and at the time of payment of, the claim.

In circumstances where a health care corporation is seeking recoupment and the Commissioner or the Commissioner's designee determines that recoupment would result in an improperly refused claim, the Commissioner or the Commissioner's designee will declare that no repayment needs to be made by the provider.

III. FINDINGS OF FACT AND CONCLUSIONS OF LAW

Based upon the foregoing considerations, it is FOUND and CONCLUDED that:

1. The Commissioner has authority to issue this declaratory ruling pursuant to Section 63 of the APA.

2. BCBSM is a health care corporation governed by the provisions of the Act.

3. BCBSM pays some participating providers benefits on behalf of its subscribers subject to audit.

4. Where an audit discloses, in BCBSM's opinion, that payments to a participating provider were unwarranted, it seeks repayment from the participating provider.

5. Where BCBSM is successful at recouping payments, a participating provider is in the same position as a provider that was not paid in the first place.

6. Section 404(1) of the Act provides that a person who has reason to believe that a health care corporation has violated Section 402 or 403, if the violation was with respect to an action or inaction of the corporation with respect to that person, shall be entitled to a private informal managerial-level conference with the corporation, and to a review before the Commissioner if the conference fails to resolve the dispute.

7. A participating provider is a person for purposes of 404(1) since person is defined in Section 107(3) of the Act as an individual, corporation, partnership, organization, or association.

8. A participating provider is a person to whom a health care corporation has an obligation, under Section 403(1) of the Act, to pay benefits as are entitled and provided under an applicable certificate. A wrongful refusal by a health care corporation to pay benefits may constitute a violation of Section 403.

9. If a provider audit is performed incorrectly or is based upon a faulty methodology, it could lead to a refusal of claims payment in violation of Section 402 of the Act. For example, Section 402(1)(d) provides that a health care corporation shall not refuse to pay claims without conducting a reasonable investigation based upon the available information.

10. A health care corporation is entitled by Section 404 and the Rules to answer allegations that it has violated Section 402 or 403.

11. In order for a health care corporation to have an opportunity to meaningfully answer an alleged violation, the allegations must be detailed and the statutory provisions at issue identified.

12. Rule 108 of the Rules provides that a health care corporation, upon a finding by the Commissioner or the Commissioner's designee that the corporation has wrongfully refused to pay a claim, shall pay that claim within 30 days of the date the decision is mailed to the health care corporation. Where the corporation has already paid a claim and is seeking to recoup the amount paid and where the Commissioner or the Commissioner's designee finds that the recoupment would result in a wrongful refusal to pay claims, the Commissioner or the Commissioner's designee will make a determination that the provider is not obligated to make a repayment.

IV. RULING

I therefore enter this declaratory ruling that:

1. The managerial-level conference and the review process of Section 404 applies to provider audit matters.

2. A health care corporation is entitled to a reasonable notice of allegations that it has violated Sections 402 and 403. Where a provider files a grievance involving a provider audit, the grievance shall state the particular sections of the statutes involved and contain a short and plain statement of the matters asserted. A definite and detailed statement of the factual allegations shall be included.

3. Remedies for wrongfully refused claims are specified in Rule 108 of the Rules.

This ruling is limited to facts which were presented by BCBSM and the statutory sections and rules identified by BCBSM.

The Commissioner specifically retains jurisdiction of the matters contained herein and the authority to issue such further ruling or rulings as he shall deem just, necessary, and appropriate.

Herman W. Coleman
Commissioner of Insurance