IN THE COURT OF COMMON PLEAS OF PHILADELPHIA COUNTY
FIRST JUDICIAL DISTRICT OF PENNSYLVANIA
TRIAL DIVISION - CIVIL

FREEDOM MEDICAL SUPPLY, INC.,	:	FEBRUARY TERM, 2009
Plaintiff,	:	NO. 04484
v.	:	COMMERCE PROGRAM
AMERICAN INDEPENDENT INS. CO.,	:	Control Nos.: 12031436, 12041601
Defendant	:	

ORDER

AND NOW, this 2nd day of July, 2012, upon consideration of the parties' Cross-Motions for Summary Judgment, the responses thereto, and all other matters of record, and in accord with the Opinion issued simultaneously, it is **ORDERED** that defendant's Motion is **DENIED** and plaintiff's Motion is **GRANTED** as follows:

1. 75 Pa. C.S. § 1716 requires that an insurer pay a medical bill within thirty days of the insurer's receipt of reasonable proof of the amount of the benefits;
2. A completed HCFA-1500 form provides reasonable proof of the amount of the benefits, triggering the insurer's payment obligations under 75 Pa C.S. § 1716; and
3. All payments made more than thirty days after receipt by the insurer of a completed HCFA-1500 form accrue interest at the rate of 12% per annum beginning thirty days after such receipt.

BY THE COURT:

GLAZER, J.

Freedom Medical Supply, Inc. Vs American Ind-ORDOP

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OPINION

Plaintiff Freedom Medical Supply, Inc. ("Freedom"), provides durable medical equipment to patients, including many who are insured under the Pennsylvania Motor Vehicle Financial Responsibility Law ("Act 6").[1] Defendant American Independent Insurance Company ("AIICo") is an insurance company that issues automobile insurance policies under which claims are made in accord with the provisions of Act 6. In this class action, Freedom purports to represent the following two classes of medical providers:

> The "Interest Class" is defined as: all Providers who submitted bills under Act 6 to American Independent Insurance Company, who received payment for such bills more than thirty (30) days after the submission of the bills, and who were not paid interest or were paid less than the amount of interest provided for in Act 6.
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> The "Payment Class" is defined as: all Providers who submitted bills under Act 6 to American Independent Insurance Company, and who did not receive a denial of the bills or payment for such bills within thirty (30) days after American Independent Insurance Company's receipt of the bills.[2]

The parties have cross-moved for summary judgment on the issues of: 1) what constitutes reasonable proof of medical benefits so as to trigger AIICo's duty to pay under Act 6;

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[1] 75 Pa. C.S. § 1701 *et seq.*

[2] Amended Complaint, ¶¶ 5-6.

and 2) what effect, if any, AIICo's submission of a claim to a Peer Review Organization ("PRO") has on its payment obligations under Act 6. Act 6 provides in relevant part as follows:

> Benefits are overdue if not paid within 30 days after the insurer receives reasonable proof of the amount of the benefits. If reasonable proof is not supplied as to all benefits, the portion supported by reasonable proof is overdue if not paid within 30 days after the proof is received by the insurer. Overdue benefits shall bear interest at the rate of 12% per annum from the date the benefits become due. In the event the insurer is found to have acted in an unreasonable manner in refusing to pay the benefits when due, the insurer shall pay, in addition to the benefits owed and the interest thereon, a reasonable attorney fee based upon actual time expended.[3]

Another judge of this court previously held, in a substantially similar class action, that submission by a provider to an insurer of a completed HCFA-1500 form constitutes receipt by the insurer of "reasonable proof of the amount of the benefits."[4] The HCFA-1500 form is a standardized Medicare form approved and preferred for use under Act 6 by the governing regulatory agency, the Department of Insurance.[5] The HCFA-1500 provides the information necessary for an insurer, such as AIICo, to determine, within the thirty days allotted to it under Act 6, the amount of benefits due and whether the insurer wishes to challenge the claim.

If the insurer does wish to challenge the claim, Act 6 provides that the insurer must do so within ninety days from receipt of the HCFA-1500 form, and it must do so through the mechanism of a PRO:

> (1) Insurers shall contract jointly or separately with any peer review organization established for the purpose of evaluating treatment, health care services, products or accommodations provided to any injured person. Such evaluation shall be for the purpose of confirming that such treatment, products, services or accommodations conform to the professional standards of performance and are medically necessary. An insurer's challenge must be made

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[3] 75 Pa. C.S. § 1716.

[4] Glick v. Progressive Northern Ins. Co., March Term, 2002, No. 01179 (Phila. Co., April 14, 2009).

[5] *See* 31 Pa. Code § 69.25 ("To the extent possible, a Part B provider shall utilize Medicare procedure codes for the service rendered and shall utilize Form HCFA-1500 or the form currently in use by Medicare.")

to a PRO within 90 days of the insurer's receipt of the provider's bill for treatment or services or may be made at any time for continuing treatment or services.

* * *

(4) If the insurer challenges within 30 days of receipt of a bill for medical treatment or rehabilitative services, the insurer need not pay the provider subject to the challenge until a determination has been made by the PRO. The insured may not be billed for any treatment, accommodations, products or services during the peer review process.

(5) PRO determination in favor of provider or insured. – If a PRO determines that medical treatment or rehabilitative services or merchandise were medically necessary, the insurer must pay to the provider the outstanding amount plus interest at 12% per year on any amount withheld by the insurer pending PRO review.

* * *

(7) Determination in favor of insurer. -- If it is determined by a PRO or court that a provider has provided unnecessary medical treatment or rehabilitative services or merchandise or that future provision of such treatment, services or merchandise will be unnecessary, or both, the provider may not collect payment for the medically unnecessary treatment, services or merchandise. If the provider has collected such payment, it must return the amount paid plus interest at 12% per year within 30 days. In no case does the failure of the provider to return the payment obligate the insured to assume responsibility for payment for the treatment, services or merchandise.[6]

AIICo argues in the face of such provisions that it has the right to deny or delay payment for any reason more than ninety days after submission of the HCFA-1500. At the very least, it claims a right to deny or delay payment for any reason more than thirty days after submission of the HCFA-1500. To the extent that AIICo asserts it does not have to pay interest even if it withholds payment beyond the thirty day deadline and does not submit a challenge to a PRO within that first thirty days, its claim is specious as clearly set forth in the applicable insurance regulation:

> An insurer shall make a referral to a PRO within 90 days of the insurer's receipt of sufficient documentation supporting the bill. An insurer shall pay bills for care that are not referred to a PRO within 30 days after the insurer receives sufficient

[6] 75 Pa. C.S. § 1797(b)(1), (4), (5) and (7).

documentation supporting the bill. If an insurer makes its referral after the 30th day and on or before the 90th day, the provider's bill for care shall be paid.[7]

As the regulation makes clear, if the insurer does not refer the claim to a PRO within thirty days, it must pay the claim even if it ultimately decides to refer the claim to a PRO within the remaining sixty days of its ninety day window. In other words, upon receipt of a completed HCFA-1500 form, an insurer, such as AIICo, has the following options:

a) Pay the claim within thirty days of receipt and pay no interest;

b) Deny the claim within thirty days of receipt;[8]

c) Challenge the claim by way of a PRO review within thirty days of receipt and not pay the claim and interest until after the PRO decides against the insurer;[9]

d) Pay the claim more than thirty days after receipt and pay interest; or

e) Pay the claim more than thirty days after receipt, pay interest, and challenge the claim by way of a PRO review within ninety days after receipt.

After receiving a completed HCFA-1500 form documenting the claim, the insurer may not withhold payment indefinitely while it "investigates" the claim.[10]

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[7] 31 Pa. Code § 69.52(b).

[8] If the denial is later found to be improper, the insurer must pay the claim plus interest running from the date thirty days after the HCFA-1500 form was submitted. *See* 75 Pa. C.S. § 1716.

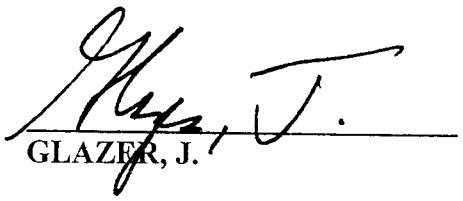
[9] If the PRO rules against the insurer and the insurer does not appeal or ask for reconsideration, the insurer must then pay the claim plus interest running from the date thirty days after the HCFA-1500 form was submitted. *See* 75 Pa. C.S. § 1797(b)(5).

[10] AIICo argues, in essence, that thirty days is far too short a time in which to investigate a claim and decide whether to pay it or not. If so, it must request relief from the Legislature, which imposed the thirty day payment deadline found in Act 6.

CONCLUSION

For all the foregoing reasons, Freedom's Motion for Summary Judgment is granted and AIICo's Motion for Summary Judgment is denied.

BY THE COURT:



GLAZER, J.