

# PAYOR-PROVIDER CLAIMS DISPUTES: CURRENT TRENDS

January 24, 2010  
12<sup>th</sup> Annual HFMA Region 11 Symposium

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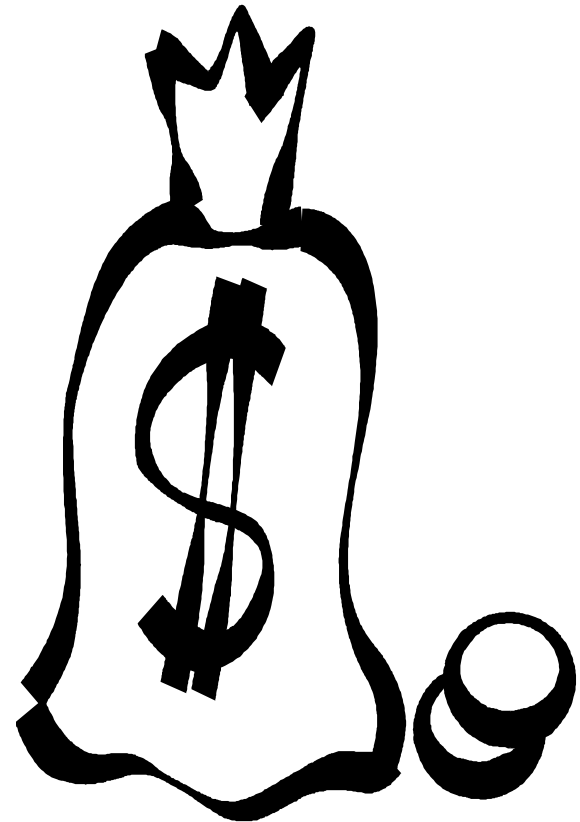
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# Maximizing Reimbursement with Commercial Payors

- Contracted
- Non-Contracted
- Issues Affecting Both
- ERISA
  - Insured
  - Self-Funded





# VIGILANCE AND DELAY

**The law helps the vigilant, before  
those who sleep on their rights.**

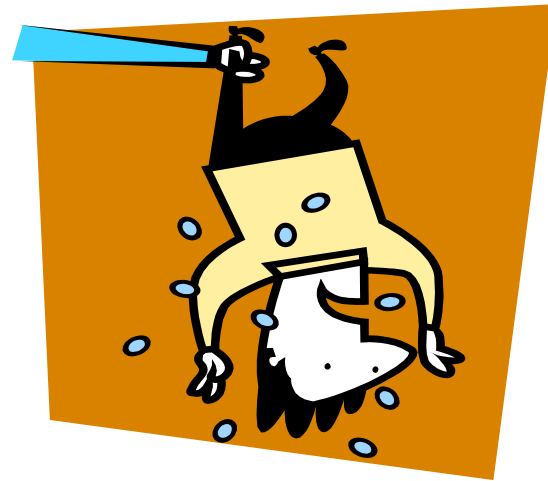
**(Civil Code 3527; Enacted 1872.)**

**PROVIDERS OFTEN LOSE BIG MONEY BY SITTING ON THEIR RIGHTS.  
DON'T SIT ON YOUR RIGHTS.**

## But Sometimes the Law Excuses Delay

- Common Law Forfeiture
  - Neglect / Good Cause / Actual Detriment
  - State Laws
- Unjust Enrichment
- How Untimely?
- Bills vs. Appeals
- Contract Language
  - avoid vs. circumvent

# Issues Affecting Contracted Claims



# Policy Manuals and Protocols

- ❖ Contract requires providers to be bound by the health plan's policy manuals or protocols
- ❖ Contract allows plans to unilaterally change the manner in which providers are under Contract
- ❖ Contract should be changed to state that provider will only be required to use reasonable efforts to comply
- ❖ We recommend adding language that protocols and policies are for administrative purposes only and cannot in any way affect provider's right to reimbursement, or amount of such reimbursement
- ❖ Contract should state that the terms of this Contract should prevail if there is any conflict between the terms of this Contract and protocols and policies

# Prompt Payment Language

- Contracts should require payment within specified time periods
- Contracts should set interest rate for late payments
  - Accelerating interest rates for longer delays?
  - Prompt pay discounts for quicker payments?
- Don't just rely on state law
  - State law may change or be found inapplicable

# Eligibility/Authorization Language

- Language to add: “If Provider has confirmed that a patient is an eligible member of Health Plan or Payor, Health Plan or Payor shall not thereafter deny payment on a claim due to the patient not being an eligible member when the services were provided by Provider.”
- Same for care that has been authorized.
- Remove references allowing plans to refuse to pay if they find fraud by patient. That should not be the provider’s problem. The plan can sue the patient.

# Amendments to Agreement

- Many agreements provide that health plans can amend by providing written notice to Provider, and if Provider does not agree to amendment, it can terminate agreement.
- This Section should simply state that this Agreement can only be amended by a writing signed by both parties, absent legally required amendments.
- Alternative: If rejected, amendment does not become effective, and contract proceeds as is.

# Changing Practices Mid-Contract

- Issue: Plans sometimes change payment practices without changing contract
  - *E.g.*, reinterpreted contract language
- Legal Standard: Conduct of the parties before a dispute arose usually reflects proper contract interpretation
  - Dispute quickly to avoid presumption against you

# Most Favored Nation Rates

- Payors want rates no higher than provider gives to competing payors
  - All other payors or just comparable ones
  - Same rates or similar range, such as 3%-5%
  - May violate confidentiality of other contracts
- Counter: Most Favored Nation so that competing providers don't get far greater rates?

# Chargemaster Neutralization Provisions

- For contracts with reimbursement based on charges, if charges are raised, health plan can reduce reimbursement to neutralize
- Provider should decide whether it wants to give up control of its Chargemaster
- Can provider remember to notify plan?
- Is provision tied to aggregate increase in charges, or any increase on particular services?
- Make sure that reduction doesn't exceed increase
- Counter with "Premium" neutralization language?

## Silent PPO – Problems

- Provisions permit plans to sell or lease the rates in this Agreement to third party Payor
- Provider does not know which Payors are accessing the contract
- Plan may sell or lease the rates to Payors who may not be financially viable or have poor payment practices
- Plan has no financial responsibility for payment of the claim

## Silent PPOs – Solutions

- Agreement should require each Other Payor to agree that it will be bound by the terms of the Agreement
  - Makes Other Payor liable if done
  - Makes Plan liable for breach if not done
- Agreement should require plans to give providers list of Other Payors at time Agreement is entered and updated periodically or on request
- Agreement should include language which gives providers right to prevent any specific Other Payor from accessing it

## What Products Are Really Covered?

- Does the contract cover all existing products?
- Does the contract cover all future products?
- Different rates for different products
- Tiered networks
  - C/HCA v. Regence BlueCrossBlueShield of Utah, Case No. 2:09-CV-1100 (January 5, 2010)
- Skimpy plans
  - \$25,000 lifetime maximum / 25% coverage only
- Contracts including both commercial and Medicare
  - Freedom Blue
  - Aetna Private-Fee-for-Service (PFFS)

# Steerage

- What are you getting for the discount?
- Active encouragement to use you
- Inclusion in all provider directories
- Authorization for all medically necessary services that you can provide
- No favoritism between same types of providers for same services
- Don't be "IINO" – in-network in name only

## Stop Loss – Special Billing Department

- Stop Loss Exception Units
- Timely submission requirements
- Can/will you comply with special requirements?
  - If not, remember forfeiture

## Stop Loss – Disallowed Charges

- Some Health Plans specifically list charges they disallow; some just have vague references to Medicare rules
- Contrary to Plan arguments, Medicare does not require or empower commercial Payors to line item disallow charges
  - Definition of "routine charges"
- Ingenix Chargemaster Guide (formerly St. Anthony's) and other similar payor schemes just implement this concept
- Exclusions – make sure agreement is clear about what parties expect to be included and what should be excluded



# Sales, Mergers and Acquisitions

- Payor Side
  - ❖ *E.g.*, United buys PacifiCare; Anthem buys Wellpoint
  - What is an affiliate?
  - Did provider anticipate this?
- Provider Side
  - ❖ *E.g.*, medical group sells assets to new company
  - "Requirements contract"?
  - Did payor anticipate this?
- Think About Future – Request Parallel Rights

# Rates After Termination for Continuing Care Services

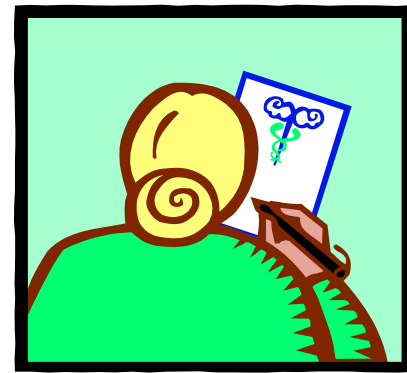
- Contracts should be clear on when provider will be obligated to render continuity of care, and rates
  - Ongoing chronic patients? If so, for how long?
- What rates paid for continuity of care situations?
  - Contract rate?
  - Billed charges?
  - Middle ground?
  - This is negotiable
- Changing reimbursement rates will make it clear that agreement is terminated

# Communicating with Patients

- Some agreements prohibit providers from “soliciting” members after termination of agreement
- No legal requirement that providers agree not to solicit members after contract is terminated
- Communicating healthcare options to patients
- Laws against gag orders

# Dispute Resolution – Internal

- Appeals
  - How quickly?
    - ❖ Note: If you forget, at least remember forfeiture doctrine
  - How many levels of appeal?
  - Who resolves appeal?
  - Are appeals pre-conditions to suing/arbitrating?



# Dispute Resolution -- External

- Lawsuit vs. Arbitration: Pros and Cons
- Mediation as pre-condition
- Arbitration provisions
  - 1 arbitrator or 3
  - Full or limited discovery rights
  - Final, or subject to trial judge review
  - Reviewable for errors of law or fact
  - Scope – all disputes or just some
- Waiving right to class action / joinder / jury
- Links to termination rights
- Attorneys' fees for prevailing party

# Shortened Statute of Limitations

- Statute of limitations
  - State law standards generally range from 4-6 years
  - Forfeiture won't defeat state standards
  - Can be set shorter than state standards by contract ... but don't do it
    - ❖ Often takes longer for the problem to be recognized
- Tolled during appeals?
- Tolled during any meet-and-confer requirements?

# Issues Affecting Non-Contracted Claims, and Oral or Implied Contracts

- A. Rates
- B. Who pays the provider?
- C. ERISA



# Rates

- **Contract Rates Irrelevant**
  - None of the benefits of a contract – steerage, certainty, process
  - Arbitrary and capricious to consider them for non-contracted services
- **Government Program Rates Irrelevant**
  - Not fair market value – not market driven at all
  - Also often paid pursuant to contract
- **Fair Market Value**
  - Same geographic area – state standards? Common sense standards?
  - Same type of service?
  - Same type of service provider?

## Rates (cont'd)

- What was asked/said at verification stage?
  - 80/20 of what?
  - Yearly maximums trumping coinsurance
  - Lifetime maximums not disclosed
- Policy language
  - Does it conflict with what you were told?
  - Emergency care treated in-network?

# Rates (cont'd)

- **State Regulatory Mechanisms**
  - Do you trust the state regulators to determine fair market value?
  
- **State Specific Standards**
  - States generally have no specific standards or just vague ones
  
  - **Most specific = California, which is the six factor “Gould” test based upon *statistically credible information* updated at least *annually* and considering at least:**
    1. Provider’s training, qualifications, and time in practice
    2. Nature of services provided
    3. Fees usually charged by the provider (Usually?)
    4. Prevailing rates charged in the general geographic area (How defined?)
    5. Other relevant aspects of the economics of the provider’s practice
    6. Any unusual circumstances in the case?

# Ingenix and Other Black Boxes

- Plans sometimes have systems or repricers that purport to know "reasonable and customary"
  - *E.g.*, Ingenix – an independent entity swallowed by the largest plan, using unreliable data and arbitrary systems
    - ❖ Underpaid physician claims by hundreds of millions
    - ❖ Used contract rate multiplier for ASCs
  - Line Item Disallowances affect non-contracted claims too
    - ❖ False Medicare standards, and other games payors play
  - ERISA claims
    - ❖ Right to see material used to price claims
    - ❖ Appeal low-ball determinations, at least twice
    - ❖ Review the policy

# Who Pays the Provider

- Health Plan
- Balance Billing
- Payments to Patients

# What Is the Type of Claim?

- Emergency claim
- Post-stabilization claim
- Elective surgery or procedure

# Who is the Payor?

- HMO
- PPO
- Out-of-State Insurer
- ERISA plan

# Emergency Claims

- Some states, like California, have statutes and regulations that require plans to pay providers for emergency services
  - HMO
  - PPO
- EMTALA
  - No specific provision requiring payment of providers for emergency services
  - No private right of action
- Implied-in-law contract under common law. *Bell v. Blue Cross*
- 3<sup>rd</sup> party beneficiary rights
- Usual and customary charges
- No balance billing patients in certain California plans
  - *Prospect Medical Group v. Northridge Emergency*

# Post-Stabilization Claims

- Some states, like California, have statutes requiring plans to pay claims if they do not transfer the patient
- Implied-in-fact contract
  - Contract that arises from a course of conduct
  - Hospital informs payor that patient is stabilized
  - Payor chooses not to transfer patient
  - Payor has, by conduct, authorized hospital to continue to provide care to patient
  - Billed charges v. usual and customary
- Methodist Hospital v. Blue Cross

# Elective Surgeries And Services

- Some states have statutes requiring payors to honor assignments of benefits
- Some states have statutes allowing payors to refuse to honor assignments of benefits
- What is the purpose of having a PPO plan if the out-of-network payment is so low that the patient remains liable for most of the claim?
- Downey v. United Healthcare/Ingenix

# ERISA

- ERISA statute silent on assigning health benefits
- Many courts have held that if a patient assigns benefits, provider has right to pursue payment from plan
- Payment amount may depend on plan documents, absent independent non-ERISA theories
  - % of charges
  - Reasonable and customary
  - Out-of-network maximums

# Protecting Providers In Non-Contracted Situations

- Forms Signed by Patients
  - Get broad assignment of benefits
  - Get designated as authorized representative for appeals
- Notification to Plan that You Have its Patient
  - Gives plan option to arrange for transfer to other location
- Verifications of Benefits from Plan
  - Ask who is the real payor
  - Confirm benefits covered
  - Request authorization to proceed
  - Keep good notes
  - Get it in writing if possible

## Interest: Commercial

- State Law Unless Contract Sets Different Rate
- Uncontested Portion of Claim Should be Paid
  - *E.g.*, payment on approved days held for a few days not yet approved
    - ❖ *E.g.*, tail wagging the dog
    - ❖ Unfair payment practice

# Interest Payments: ERISA

- ERISA

- What do the courts say?
  - ❖ Focus has been on claims by patient so far
  - ❖ Discretion to award interest
  - ❖ Appropriate to borrow interest rate from parallel state laws?
    - Nothing? Unlikely result for good claims
- For contracted claims, what does your contract say?

# Interest Payments: Medicare

- Medicare
  - What does Medicare say?
    - ❖ No specific interest set; but
    - ❖ Contracts must have prompt payment provisions agreed to by plan and provider. 42 C.F.R. §422.520(b).
  - What does the contract say?
    - ❖ Incorporate state law
    - ❖ Says nothing: Violates Medicare laws
  - If no contract, what federal interest rate would government have to pay?

# QUESTIONS

