REIMBURSEMENT: GETTING PHYSICIANS PAID

Andrew H. Selesnick¹

The last few years have been a tumultuous financial time for Physicians². Budgetary difficulties have resulted in the slashing of Medicaid programs; Congress each year barely passes a “fix” to avoid further cuts to Medicare. Private payers – health insurance companies, health care service plans, ERISA plans, Health Maintenance Organizations, Independent Practice Associations, and the like – continue to increase premiums but are reluctant to increase reimbursement rates for Physicians. With health care reform, tens of millions of previously uninsured people will suddenly have insurance, although the question of what kind of insurance they will have remains unclear. The theory behind the health care reform adds yet another wrinkle. It is presupposed that by having more people who pay into the system, Physicians and other providers will treat more patients who can actually pay for services provided. With more people paying, reimbursement can be further reduced. However this is just a theory, the veracity of which will not be known for some time.

In the meantime, Physicians keep providing services, for which they understandably want to get paid. Setting reimbursement rates, collecting on Usual, Customary, and Reasonable rates (UCR), savvy contracting, and litigating reimbursement cases all can increase Physicians’ revenue. Keeping that revenue requires sound coding and

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² Physicians and Physician Groups are collectively referred to as “Physicians”.
documentation for services rendered, and opposing attempts for recoupment by government agencies, RAC auditors, and private payers.

I. Determining Usual, Customary and Reasonable Rates (UCR)

Because of declining contracted reimbursement and Medicare rates, Physicians are choosing to become non-contracted, enter “Concierge” medicine practice, or take a tougher approach to contracting. Irrespective of the route ultimately chosen by a Physician, UCR play a significant role.

A. How do Physicians Determine Their Billed Charges?

Billed charges and UCR should be synonymous, although that is not always the case. Ask most Physicians how they set their billed charges and you may get a blank stare, a remark similar to “this is always the way we do it”, or a response signaling to a percentage multiple of Medicare. Physicians (and payers) will argue that billed charges are a non-factor, as no one pays billed charges. But the reality is that payers will reimburse at or near billed charges, and when they are set properly, billed charges can become leverage for higher contracted rates. In addition, for those non-contracted providers, or those contracted providers with UCR set as the reimbursement rate, reasonable billed charges can result in increased revenue.

There is no clear cut rule on how Physicians should determine their billed charges. They can be based on what a top payer reimburses, on a mathematical calculation of practice costs plus profit, or on a multitude of other formulas. One example of a common sense approach exists in California’s regulatory structure. One of California’s regulators,
after a thorough administrative process involving input from providers and payers alike, promulgated a regulation that requires payers to use a statistically valid database to determine non-contracted reimbursement rates, which takes into consideration the following:

(i) the provider's training, qualifications, and length of time in practice;  
(ii) the nature of the services provided;  
(iii) the fees usually charged by the provider;  
(iv) prevailing provider rates charged in the general geographic area in which the services were rendered;  
(v) other relevant aspects of the economics of the medical provider's practice; and  
(vi) any unusual circumstances in the case


While the payer is required by law to take these factors into consideration, Physicians can use it as a valuable model in setting their rates. By considering each factor in determining how to set their Chargemaster\(^3\), Physicians are far more likely to set realistic rates that are defensible to payers or to a Court. These factors do not require the use of a strict mathematical formula, but rather are based on market forces and the realities of a specific Physician’s practice.

\(^3\) A “Chargemaster” is a Physician’s list of what he or she charges for every CPT Code they could bill. Many Physicians use about 25 CPT codes for the vast majority of bills, but their Chargemasters may cover thousands of codes.
B. Using the FAIR Health Plan Database

For many years, providers and payers alike used the Ingenix database. Owned by UnitedHealth, Ingenix was designed to provide payers or Physicians with an idea of what other providers were charging for specific CPT Codes in a given geographic location. Ingenix, a for-profit company, received data from payers as to what Physicians were charging for CPT Codes, and then sold that information to Physicians and others. Physicians would then take into account Ingenix when setting their reimbursement rates.

Many Physicians questioned the reliability of the Ingenix database, wondering out loud how the country’s largest health insurance company could be trusted to accurately and reliably report Physicians’ billed charges. They likened it to the fox guarding the hen house. Still, Ingenix persisted, as it fought class action lawsuits filed against it in New York. In 2008, New York Attorney General Andrew Cuomo also filed a lawsuit. In 2009, UnitedHealth agreed to disband the Ingenix database and pay $50 million dollars for the creation of a new, non-profit database. This settlement was closely followed by UnitedHealth settling the class action lawsuits for $350 million dollars, allowing Physicians to recover this money for underpayments made based on the faulty Ingenix database. On December 19, 2012, Aetna announced it was settling underpayment claims based on Ingenix for $120 million dollars based on a class action in New Jersey. Other actions remain pending against Anthem/Wellpoint and other health insurers.

The creation of a new database of billed charges – one that would be impartial – was a significant task. The new entity was called FAIR Health, Inc. It describes its mission as follows:
FAIR Health is your source for transparent, current and reliable healthcare charge information. As a national, independent not-for-profit corporation, FAIR Health offers unbiased data products and services to consumers, the healthcare community, employers, unions, government agencies, policymakers and researchers.4

FAIR Health had a significant mandate, as a reliable provider charge database did not exist. Partnering with university researchers in a variety of disciplines, as well as with stakeholders, it offered an easy way for Physicians to check how their billed charges compare to others in their community. Physicians can log on to the website and order products at http://www.fairhealth.org/products/data-products. Alternatively, FAIR Health maintains a free database for consumers, which lets a user know if a charge for a particular CPT Code in a certain zip code is “in the ballpark.” See, http://fairhealthconsumer.org/. Physicians can use the free website (up to 10 CPT Codes can be checked per day per computer) to get an idea of whether their billed charges are on par with other providers. It is expected that comparison to the FAIR Health database will become the norm in determining UCR.

II. MANAGED CARE AND PAYER CONTRACTING TIPS

The Government does not negotiate reimbursement rates. Private payers, however, will negotiate rates and other key contractual terms. Rates can vary based on the size of the group, competition, legal environment, and other factors. Key terms that practitioners

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4 See http://www.fairhealth.org/about-us.
can utilize to balance the payers’ form contracts include termination clauses, utilization review, and attorney’s fee clauses.

A. Negotiating Rates

The number of Physicians who sign whatever the payer sends them, with little regard to the reimbursement rate or other terms of the contract, is surprising. Before negotiating the rates, know the following:

1. The number of average claims with the payer per year;
2. The average payment per claim by the payer;
3. The differential between billed charges and average payment;
4. How the payer compares to the top 5 payers; and
5. Whether there is downcoding?

Having this information, which can be determined (by running a report) by common billing software in small practices and by billing companies in larger groups, gives Physicians an understanding of how payments are being made. Negotiating by comparing the offered rate to the one being paid by a competing payer can result in higher reimbursement. Knowing whether there is downcoding is important as it may lead the Physician to negotiate a case rate where coding is an issue.

With the advent of Accountable Care Organizations (“ACO”), and pay for performance by payers, Physicians will also need to have much better data on patient outcomes, hospital readmissions, and management of chronic illnesses, as well as preventative medicine. Physicians need to have a reason for a large payer to adjust its
rates upwards, and having data points puts the Physician ahead of others who have no data.

Payers will, from time to time, employ unsavory tactics in negotiations. Some may not agree to provide the fee schedule until after the contract is signed, requiring Physicians to “trust” them. Payers have required attorneys who want to negotiate for their clients to sign confidentiality agreement that contain liquidated damages clauses if the attorney discloses any information related to the negotiation, including the rate. Some may refuse to provide the then current fee schedule being applied to the Physicians. After multiple large HMO settlements, most health insurance companies have agreed to stop that practice.5

Hospital based Physicians have special considerations in rate negotiations. Physicians should carefully review their hospital contracts to eliminate language that essentially destroys any negotiating leverage with payers who have strong relationships with the hospital. For example, here is a clause in an agreement between a hospital based Physician and the hospital:

1.4.b. Entrance into Third-Party Payor Arrangements.

(i) Medical Group Obligation. Medical Group shall cooperate to facilitate Hospital's entry into or maintenance of any Third-Party Payor Arrangements during the term of this Agreement, including, without limitation, entering into any third party payor or managed care plan contracts with which Hospital contracts or will contract. To enable Hospital to participate in any Third-Party Payor Arrangements, Medical Group shall, not more than ninety (90) days from Hospital’s request:

5 See further In Re Managed Care Litigation, MDL No. 1334; www.hmosettlements.com.
a. Enroll in any Third-Party Payor Arrangement as a provider separate from Hospital with respect to Medical Group shall enroll individual Physicians as providers in such Third-Party Payor Arrangement as required by third-party payor; and/or

b. Enter into an express agreement with said Third-Party Payor Arrangement, or with any intermediate organization, including any independent practice association (IPA), if required to effect Medical Group’s enrollment as a provider.

(ii) Limitations on Medical Group Obligations. Notwithstanding the above, Medical Group shall only be required to fulfill the obligations set forth in Section 1.41.b above if (i) the contract terms for such agreements do not significantly deviate from industry standards for similar contracts and (ii) the rate offered by said third-party meets the following minimum amount of third-party category: The minimum blended (Senior and Commercial) rate Medical Group has to accept from is 100% of the Official Medicare Fee Schedule (Region X) for the period of Month/Day/Year through Month/Day/Year.

1.5. Managed Care Contracts. Medical Group and each of the physicians providing services on behalf of Medical Group shall negotiate in good faith to become a participating provider in any managed care plan(s) with which Hospital contracts or will contract, provided that such participating provider offers rates that are comparable to rates in place in the local area. If any managed care plan pays on a "global" or "all-inclusive" basis, Hospital will include a professional service fee for Medical Group. After Hospital receives reimbursement from such plan, Hospital shall pay Medical Group a percentage of the payment received based on the percentage the Medical Group's actual charges bore in relation to the total charge.

In this example, the Hospital has required the hospital based Physician to accept 100% of Medicare for all claims (commercial included) for any payer the Hospital contracts with, regardless of whether that rate is fair and reasonable. Besides calling into question whether such language runs afoul of Stark anti-kickback laws, it needlessly ties the Physicians hands. The better language, which still allows the Hospital to make sure the Physician contracts with key payers, could be to eliminate 1.4 in its entirety, and revise 1.5 to read as follows:
1.5. Managed Care Contracts. Medical Group, on its behalf and on behalf of the physicians providing services on behalf of Medical Group, shall negotiate in good faith and use its best efforts to become a participating provider with any payer with which Hospital contracts. If any payer reimburses on a "global" or "all-inclusive" basis, Hospital will include a professional service fee for Medical Group. After Hospital receives reimbursement from such plan, Hospital shall pay Medical Group a percentage of the payment received based on the percentage the Medical Group's actual charges bore in relation to the total charge, within ten (10) days of Hospital’s reimbursement from the payer.

“Best efforts” language allows Physicians to negotiate at arms length, and avoids Stark and anti-kickback issues.

B. Key Contract Clauses

Virtually all payer agreements are lengthy contracts of adhesion that favor the payer over the Physician. To counter this imbalance, counsel can revise (1) termination clauses; (2) utilization review provisions; and (3) add attorneys’ fees language in the event of a dispute.

1. Termination Clauses

Payers commonly have agreements with three year terms or one year terms that renew automatically unless a party gives specified notice. But what if reimbursement changes, the payer (especially IPAs) becomes financially unstable, the payer downcodes, or other actions occur that affect reimbursement? Revise the termination clause to reflect 30 days for cause, or 60-90 days for termination without cause. This allows for maximum Physician flexibility to account for changed circumstances.

2. Utilization Review
Utilization review clauses can be byzantine, requiring multiple levels of appeal, usually with the person who denied the service or claim in the first place also rendering the appeal. Revise language to reflect that whatever is decided in Utilization Review, the Physician can still bring the claim to Court or Arbitration.

3. **Attorneys’ Fees**

When it comes to breaching a payer-Physician agreement, the payer is much more likely to be the offending party. Including a clause specifying that the prevailing party is entitled to attorneys’ fees and costs reduces the chance for a breach, and if one does occur, it can spur a payer to a quicker resolution. Sample language for a contract with an arbitration clause includes:

Payer and Group agree that the prevailing party in any legal dispute among the parties hereto shall be entitled to payment of its reasonable attorney's fees, expert and non-expert witness costs and expenses incurred directly or indirectly with the Arbitration, including but not limited to the fees and expenses of the arbitrator(s) and any other expenses of the Arbitration.

An agreement with no arbitration requirement can simply delete the arbitration references in the paragraph above.

I. **LITIGATING AGAINST PAYERS**

What can Physicians do when faced with non-payment, underpayment, or downcoding? If negotiations fail, litigation is an increasingly attractive option. Physicians
should first determine how much they are owed, and by whom. Physicians with their own billing software should run accounts receivable reports that list the worst five payers, or have their billing company send that information to them if they are using an outside service. Using that report, one can determine how the underpayments are occurring. These underpayments are usually, (1) non-payment of codes; (2) if non-contracted, paying less than UCR; or (3) downcoding.

A. Contract Claims

Most Physicians are contracted with multiple payers and derive the bulk of their revenue from such contracts. It is not uncommon for payers to load the wrong fee schedule into their software and inappropriately reimburse Physicians without the Physicians ever realizing it. Physicians should not simply “trust” that the amount reimbursed by payers is proper. Rather, audits should be undertaken at least once per year to ensure that the Physician is collecting all of the money due.

If underpayments are discovered, the Physician should have a report that identifies every single claim, the amount of the expected reimbursement, the allowed amount or actual reimbursement, and the claimed loss. Many payer contracts have an appeals process that requires the Physician to timely notify the payer of the dispute. Following these provisions are a must, or the Physician faces a quick defeat for failure to comply with contract terms. Counsel should be careful to obtain access to the payers’ additional rules and policies which are usually referenced in the Physician-payer agreement, but are almost never included. These policies and procedures may contain
additional preliminary hurdles that must be satisfied before proceeding to Court or arbitration.

Assuming that there was a contract between the Physician and the payer, the Physician can assert a cause of action for breach of contract. State court is usually the only jurisdiction, unless there is diversity. For the vast majority of disputes, the contracts require arbitration. Before filing, it may be advisable to obtain a reasonable value of services expert for underpayments from UCR, or a coding expert to defend coding and attack the payers’ practices.

B. Non-contracted Claims

Where no provider contract exists such that the provider is out of network, Physicians can assert various causes of action based on quantum meruit, or breach of implied contract and other common counts (open book account, services rendered, etc.). In some States, such as in California, courts have recognized a cause of action under California’s Unfair Competition Law where the physician alleges that the payer engaged in a business practice likely to deceive the reasonable person to whom the practice was directed, not whether there was actual deception.

It is not uncommon for payers to challenge a Physician’s right to maintain an action in the first place. However, the nature of the business relationship does not automatically confer jurisdiction. The Physician treats the patient, and may or may not have an assignment of benefits, which the Physician believes requires reimbursement from the payer. Some states do not recognize assignment of benefits as valid. Instead, the
payer pays the patient directly, and the Physician must chase the patient for years to get repayment, only to find that the patient spent all of the money and has no funds. The public policy is to, (1) encourage Physicians to contract (and thus receive payment) and, (2) contain healthcare costs by limiting out of network care.

Payers will also challenge original jurisdiction. On what basis does the Physician have the right to sue a third-party (the payer), who had no knowledge that the patient was seeking treatment from the Physician? Common law causes of action may not be enough, and each state treats the situation differently. Alleging violation of a statute or prompt-pay laws is always helpful – and sometimes critical – to defeat demurrers or motions to dismiss.

Another potential hurdle is complete preemption based on ERISA, where payers ask for outright dismissal of the case. Despite payers’ efforts, courts have not been keen to dismiss based upon ERISA preemption where the issue is one of payment. See generally *Aetna Health v. Davila*, 542 U.S. 200 (2004) (denial of coverage and interpretation of benefit plans falls under ERISA); *Blue Cross of California v. Anesthesia Care Associates Medical Group, Inc.* 187 F.3d 1045 (9th Cir. 1999) (terms of provider agreements not subject to ERISA); *Lone Star OB/GYN Associates v. Aetna Health Inc.* 579 F.3d 525 (5th Cir. 2009) (provider’s right to payment not subject to ERISA preemption).

Once the case is underway, similar rules apply as to litigating contract claims; retaining the right expert(s), proving UCR is appropriate, and countering any coding or related
defenses. Physicians can expand the scope of their complaint by grouping a large number of claims together in one lawsuit where the harm is similar. Likewise, groups of Physicians who are affiliated can often times file a lawsuit together; if unrelated, lawsuits can be filed and related to achieve litigation efficiencies. Finally, interest is always an issue. Many states have prompt pay laws which require payers to pay interest on claims not adjudicated within a certain period of time – and that interest can be as much as 15% per annum.

II. CODING AND DOCUMENTATION ISSUES

“If it is not documented, it doesn’t exist.” This phrase is used in a variety of contexts, but is particularly apt when it comes to reimbursement. All Physician reimbursement is based upon documentation.

Physicians, especially those who are office based, can neglect their documentation responsibilities. Documenting medical decision making, review of symptoms, and examination elements takes time, and in a busy practice, time is at a premium. It is not enough, however, to simply circle a code on a superbill and assume that will survive an audit. Rather, the chart speaks for itself, and if it is not properly documented, upcoding can be alleged by a payer.

If a Physician, however, properly documents the chart, then the appropriate CPT codes can be assigned by a professional coder or the Physician himself/herself, and that can increase reimbursement significantly. Physicians should, at least once per year, send a random sampling of their charts to an outside professional coder, who can determine if documentation is appropriate. If it is not, the Physician can take steps to ensure proper
coding, including taking classes or outsourcing the coding. The auditor may even find that additional CPT Codes could have or should have been billed, which on a going forward basis can increase reimbursement.

Having a claim downcoded can be prevented by taking steps at the documentation stage. Several issues can cause a claim to be downcoded:

- Documentation in the patient’s medical record must meet the level of service for all three key components for Evaluation & Management services pursuant to CPT guidelines
- Incorrect documentation of abnormal findings with the Review of Symptoms (ROS) and examination
- For audited claims, failing to send all relevant documents in the medical record
- Coders and billers or Physicians being unfamiliar with audit and coding guidelines

It is important for Physicians to take challenges on coding issues seriously. If the code can be defended, it should, as audits can take small samples and then extrapolate them to the universe of claims to recoup a much greater amount than just the sample.

III. PREPARING FOR AND DEFENDING GOVERNMENT AND PAYER REIMBURSEMENT AUDITS

It is not enough just to be reimbursed anymore; Physicians need to be prepared to defend against recoupment of overpayments. The current economic climate has motivated an increase in attempts by government agencies to investigate physician coding and supporting documentation. On October 20, 2011, Michele Kelly and Jodi
Black of the San Bernardino County (California) Medical Society Published the following notification to physicians:

“For the past two years Palmetto GBA has received payment error rates from the Comprehensive Error Rate Testing (CERT) Contractor that have been almost twice the national rate. A large portion of the errors are attributed to insufficient and illegible documentation, and lack of or illegible signatures. Palmetto is now taking steps to correct these errors by reviewing claims to identify potential areas for provider education.

Palmetto will notify affected physicians by mail that a small sample of their claims will be selected for medical review. The notice will also provide recommended resources on documentation and coding. Physicians who are notified will receive a request for medical records in the form of an Additional Document Request (ADR) for each claim selected, along with an example of the information that should be returned. Failure to respond to these requests will result in non-payment of the claim.

Palmetto may also make unannounced site visits to physician offices to establish a date for an educational meeting. Failure to participate in this education will result in 100 percent pre- and post-payment audit of claims. CMA is discussing the nature of these audits with Palmetto and the disruption and burden they will be to physician offices.

We hope to have more detailed information next week.”

CERT is a program designed to measure and improve the quality and accuracy of payments made by Medicare Fee For Service contractors. Based on government statistics, in 2011 the federal government allocated at least $608,065,945 to the CERT Program. In Fiscal Year 2011, it recovered $4,089,043,264 from a number of sources related to audits, government investigations, and civil and criminal penalties. Based on the return on investment, the trend of increased government audits is expected to continue.

1. Preparing for an Audit

Due to the success of the CERT Program physicians should invest in tools that will prepare them for what may be an inevitable event. One of the most useful tools in
preparing for an audit is having a comprehensive Compliance Program. A Compliance Program makes sure that there is a written policy a physician’s practice follows in addressing issues that are commonly the centerpiece of government audits. A well-executed Compliance Program will address issues such as: coding and billing practices, internal coding and documentation auditing, training programs, and procedures for dealing with overpayments and refunds. It should address potential employment issues such as discrimination and sexual harassment and it should assign a compliance officer and/or other methods to address the training, execution, and ongoing compliance of the Program. The Program should also include a HIPAA policy and manual, and a written document retention policy. Finally, even those practices that use outside billing companies must still have their own compliance program, separate and apart from their billing company. This is due to the fact that having a billing company does not transfer liability for coding errors away from physicians.

2. Defending audits

The keys to defending audits from either third-parties or the government are to have capable representation and to take a cooperative approach with the auditing entity. A physician may have an isolated audit, where a pre or post-payment request for medical records only pertains to one specific claim. This can usually be handled by the physician’s office. Requests for a number of claims, however, should be dealt with much differently. Besides examining the claims, a physician’s counsel may want to engage an outside coding expert to do a separate analysis to determine if there are coding discrepancies. Sometimes, physicians will first learn of an investigation, or an audit
through a subpoena. It is imperative that they make sure that the subpoena is routed to legal counsel that is experienced in handling government audits. Skilled legal counsel will ensure that there is an analysis and review of the subpoena and the requested materials, that the response timeline is being met, that litigation hold letters are in place, that insurance coverage is addressed (if applicable), and that internal and external communication strategies are in place to best protect providers.

After the subpoena is received legal counsel will advise the provider of the scope and breadth of the search for documents requested by the subpoena. It is of utmost importance to make a diligent search for responsive documents, as even the inadvertent non-disclosure of evidence can result in serious civil and criminal consequences. This has become more imperative in our electronic age where documents exist in several electronic forms within numerous electronic sources.

Subpoenas now request ESI (Electronically Stored Information) as a matter of course. These requests make all electronic sources of data subject to search. These sources can range from desktop computers, to shared servers, smart-phones, and even tablets. Information stored in these sources last forever. Forensic searches for data can uncover e-mails, text messages, or documents that users thought they had once permanently deleted. Due to this reality, it is more important than ever for Physicians and their employees to be cognizant and careful of what they write or communicate through electronic means.

It is important to note, that upon receipt of a subpoena all information must immediately be preserved, so that all deletion is suspended. The alteration or deletion of
information after receipt of a subpoena, even if inadvertent, can result in civil spoliation or in criminal charges for obstruction of justice. A comprehensive written document retention policy will facilitate the document search process and will protect a Physician’s practice from the possibility of the inadvertent deletion of data.

As set forth above, perhaps the best defense to an audit is when the Physician documents the file. There is no substitute for a well documented file; it increases reimbursement and protects if there are questions about what services were rendered.