Medicare Does Not Govern Commercial Contract Rates

By Frank P. Fedor, Murphy Austin Adams Schoenfeld LLP

A recurring theme in the operation of hospital contracts is the payer's unilateral reduction of negotiated contract rates. One of the latest contract breaches is the payer's disallowance of certain of the hospital's normal charges on the basis that the charge does not conform to Medicare billing guidelines.

This charge rejection of course only applies when some of the negotiated rates are stated as a percent of the hospital's charges. For example, "X" percent of charges for certain procedures, or a stop loss rate based on a threshold of "Y" dollars of charges at which point additional payment is due at "Z" percent of total charges or charges incurred after the threshold is met. The theory of the disallowance goes something like this: because hospitals try to comply with Medicare billing rules, these rules in effect create a national standard of practice. A payer may reasonably rely on the hospital's charge master complying with this national standard of practice. The rejection of charges may occur at the claim's adjudication and show up in the remittance advice, often without specification and only as a total amount of disallowed charges. It more frequently occurs during an audit.

There is no legal basis for this claim that a hospital's charges to payers other than Medicare must meet Medicare billing guidelines. The first thing you will notice is that the payer will be unable to cite a statute, regulation or any other law supporting its position. That is because there is none.

Instead, the custom and practice in the hospital industry is that there are a wide variety of methods of billing for services and supplies. This is primarily because hospitals are unique in their size, scope of services, case mix, competitive position, and many other factors. This variety of charge structures is reflected by the flexibility of the UB-92 Manual. Although revenue codes are assigned to types of services and supplies, there is a wide variety of options available for the use of these codes (e.g. several different ways to bill for a routine room) and very limited specificity as to the scope of what should be included under each revenue code description. Thus while the payer may argue that the Medicare billing rules establish the "practice" in the industry, the reality is much different.

It is the law of contracts, and not a Medicare billing rule, that determines the amount of payment under a contract between a hospital and a payer. The mutual intent of the parties expressed in the contract at the time the contract was signed controls.

When the parties agree on a percent of charges rate, the mutual intent is to accept the hospital's normal charge master rates. Hospital contracts never address the nature and content of the hospital's charge master because the hospital contracts with many payers, but can have only one set of standard charge master rates. When payers do have an issue about a hospital's particular charges or levels of rates they address it by the selection of contract rates (e.g. per diem or case rates), or possibly by negotiating a cap by how much the rates may rise, but not by negotiating the particular content of the charge master.

When the contract does contain one or more rates based on charges these typically make up only a part of the overall package of negotiated rates. This package of rates is modeled by both parties to estimate the yield to the hospital and the cost to the payer. The data that both parties use to conduct this modeling consists of the hospital's charges at its normal charge master rates. Hospitals can thus prove the payer's knowledge of the hospital's normal charge master rates (through the payer's receipt of UB-92s and itemized listings) and reliance upon such rates in modeling a level of cost that the payer ultimately agreed upon.

The payer also has a problem proving damages. For example, many of the charges the payer rejects are characterized as "unbundling". "Unbundling" occurs where an actual rule exists requiring a collection of services to be billed together at a lower combined rate, usually because of the efficiencies gained when all of the services are performed at the same time. The classic example is lab tests. A rate for a panel is generally less than the combination of rates for each test run separately because of the efficiencies in running the panel at once. "Unbundling" occurs when the laboratory uses the individual rates to receive more than the panel rate, and thereby misrepresents that it did not benefit from the efficiencies of the panel. The charges that payers are rejecting from hospitals are not "unbundling". For example, payers may reject a charge for incremental nursing because the payer claims it should have been included in the charge for the routine room. Of course, if the hospital had chosen to

include the cost of this service in the charge for the room, the room charge would have been higher. Thus the payer rejecting this charge is not damaged. Instead, the payer just wants to receive the service for free because the hospital chose to bill for this service separately, and thus only to those patients who consumed it.

In challenging the disallowance of charges hospitals must be prepared to defend the rationale of their charge structure. They must show that the charge is for an actual service or supply that is not already included in another charge.

Hospitals should defend their normal charge master rates with confidence. What is unreasonable is not the structure of the hospital's normal rates, but the conduct of the payer who freely accepts these rates during the negotiation of the contract, and then later raises a new inconsistent argument to obtain these services for free.

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2002 HFMA Golf Champs Defend Title at Canyon Lakes

San Ramon -- This time, only the course had changed. For the second consecutive year, the hacker foursome of Tom Knight, Pat Godley, Mike Smith and Art DeNio captured the HFMA of Northern California Golf Tournament.

The Knight-Godley-Smith-DeNio team, one of a record 14 teams, captured the 4th Annual Golf Tournament on October 3 with a six-under par 65 at the Canyon Lakes Golf Course in San Ramon. The previous three tournaments had been held at Boundry Oaks in Walnut Creek. Second place went to the foursome of Chuck Acquisto, Jerry Klusky, Mike Moody and Chris Pass with a 66 while third place (67) went to Vince Acquisto, Mike Laidlaw, John Duda and Kes Duda. The Acquisto-Laidlaw-Duda-Duda team actually beat the foursome of Phil Boehm, Wayne Silveria, Katrina Bennett and Kevin Lonergan, who also shot a 67, in a tiebreaker format determine ahead of time.
Chris Pass and Katrina Bennett, who bested Barbara Braga by a yard, won the long drive competitions for men and women while Mori Moriuchi captured closest-to-the-pin contest on the tricky, par 3 fifth hole. Stories of success and failure were swapped at the 19th hole over libations and food. Prizes were handed out and the new winner's trophy, to reside with the champions for one year, was unveiled. Even the San Francisco Giants late-inning collapse against the eventual World Champion Florida Marlins could not ruin the festive mood.

"The event was such a success we are please to announce next year's date will be at Canyon Lakes too," said Golf Tournament Chairman Vince Acquisto, who also thanked the day's sponsors: AHC; the Law Offices of Stephenson, Acquisto & Colman; Laidlaw Consulting and Toyon Associates, Inc.

The 2004 HFMA of Northern California Golf Tournament will take place on October 1, 2004, at Canyon Lakes Golf Course in San Ramon. The tournament, expected to be a shotgun format, is expected to fill up fast. For more information, contact Vince Acquisto at 9925) 734-6100 or vaa4sac@aol.com.

SAVE THE DATE : OCTOBER 1, 2004

The 13th Annual Managed Care Conference

Eleana Aguilera, Terri Mainfesto, and Mike Laidlaw speaking a on a panel at the HFMA Managed Care Conference in September.