

Frank P. Fedor

independent dispute resolution process no cure for the rate issue

In 2000, the California Legislature enacted AB1455, giving power to the state's new Department of Managed Health Care "to assist in the development of a new and more efficient system of claims submission, processing, and payment." On Jan. 1, 2004, the AB1455 regulations (Title 28, California Code of Regulations: §1300.71, Claims Settlement Practices, and §1300.71.38, Fast, Fair and Cost-Effective Dispute Resolution Mechanism) went into effect. The regulations attempted to clear up various billing and claim adjudication issues that had been the source of provider-payer disputes.

From the perspective of hospitals, the most controversial part of these regulations was the subsection that identified criteria the DMHC would use to determine whether the method by which a plan decided to pay less than full charges for non-contracted emergency services was an unfair payment practice. That subsection (§1300.71[a][3][B]) identified a "reasonable and customary value ... based upon statistically credible information that is updated at least annually and takes into consideration: (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 aspects of the economics of the medical provider's practice that are relevant; and (vi) any unusual circumstances in the case."

Quantum Meruit and Market Price

In its final statement of reasons, the DMHC said this definition "is not intended to alter or change existing California law or to establish specific reimbursement rates" and was "designed to reiterate current California law as embodied in *Gould v. Worker's Compensation Appeals Board*." These *Gould* factors were consistent with other California cases that addressed how a court determined the reasonable value of noncontracted health care and other services under the legal doctrine of *quantum meruit*, also known as *quasi-contract*.

Quantum meruit is an equitable doctrine whose purpose is to avoid the unjust enrichment of the person who receives services without a contract by determining what the recipient would have paid for the services if he or she had purchased them from someone else. In other words, it looks for the market price of the services.

Under the law of quantum meruit, a plan paid a hospital its full charges for the noncontracted emergency services provided to the plan's enrollee. Since the promulgation of the *Gould* regulation, some plans have adopted policies to pay

AT A GLANCE

California's pilot independent dispute resolution process to resolve underpayments of non-contracted emergency services went into effect on Feb. 1. Unfortunately, it is a nonstarter for hospitals because it cannot establish the legal precedent that will settle how such services should be valued.

less than full charges. These methodologies often incorporate the notion, which is not found in the cases applying quantum meruit, that the reasonable value of a service is the discounted wholesale price that high-volume purchasers obtain, instead of the full retail price that occasional purchasers pay. Plans have attempted (unsuccessfully to date) to amend the *Gould* regulation to add such a factor.

Some plans also argue that the *Gould* regulation is a “green light” from the DMHC that plans could now pay wholesale (con-

tracted) prices as only retail (noncontracted) purchasers of emergency services. If a plan had tried to do so before, so they argue, the DMHC would have disciplined it for underpaying the claim and exposing its enrollees to

balance billing. Of course, the stunning chasm in logic in this position is that the DMHC expressly disavowed any effort to change the quantum meruit law through its *Gould* regulation. If it had always been legal for plans to claim unpurchased discounts, then the plan would have a defense against the DMHC’s enforcement action. Alternatively, a plan could always have paid the hospital’s full charges under protest to protect its enrollee, and then sued the hospital to recover an overpayment.

This shows that the primary consequence of the *Gould* regulation is that there are now more disputes over the rate paid for noncontracted emergency services than there were before—and the issue is more contentious than ever. Instead of letting the marketplace decide the issue, the legislature has applied pressure to the DMHC to come up with a regulatory “solution” to the problems exacerbated by the earlier regulatory “solution” of adopting the *Gould* criteria.

The solution is the new six-month pilot Independent Dispute Resolution Process, which began on Feb. 1, 2007. Unfortunately, the cure is no more efficacious in resolving the issue than bleeding was in curing illness up through the 19th century.

How the California Pilot IDR Will Work

The pilot IDR is available only for noncontracted emergency services (the IDR rules are summarized at the DMHC web site www.hmohelp.ca.gov/providers/clm/clm_idrp.asp). The DMHC contracted with the Maximus Center for Health Dispute Resolution, an independent medical reviewer of disputed health insurance claims, to act as the arbitrator of submitted disputes. The pilot will be overseen by a governing committee of two payer representatives, two provider representatives, one consumer

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representative, and two DMHC staff members. The process is voluntary for both provider and plan. Both may also reject the IDR’s result and pursue a legal process. However, the provider must agree not to balance-bill the enrollee during the IDR and any ensuing legal process. The plan must agree to pay an award within 15 days before pursuing a court action.

A hospital provider (but not other providers) is required to first participate in the plan’s own internal dispute resolution process. Because the only issue is the method of rate calculation, this is guaranteed to be a waste of time. The hospital may then submit a single claim, or up to 50 substantially similar claims, in a single appeal through the IDR.

The arbitrator “will demonstrate in the findings that he or she has considered the applicability, if any, of the *Gould* criteria.” This choice of language allows a decision to be made in favor of the plan even if none of the *Gould* criteria were applied. The IDR instructions further allow the arbitrator to go beyond the *Gould* criteria: “If other submitted criteria are deemed applicable in that determination, the independent review organization will outline these in the final determination.” This is an open invitation for plans to

avoid the *Gould* criteria and introduce their own alternative arguments that are not supported by the law of quantum meruit.

The provider's claims are presented by the completion of a written form. Although this process might save time and money compared with the process of preparing evidence and witnesses to present the evidence at a trial, much of the preparation to identify, select, and organize the evidence and arguments will still need to be done.

The IDRP instructions do not explain how the plan communicates its agreement to participate in a particular IDRP appeal or its arguments (other than its findings in its own internal appeal process, which becomes part of the hospital's IDRP appeal), and whether the arbitrator is free to communicate with the plan or the provider without the participation of the other. It is implicit that Maximus will have some form of ex parte communication with the plan.

The importance of the content of the form is further heightened in that there is no hearing. An anonymous employee of Maximus will read the written presentation and whatever the plan submits, in addition to considering potential ex parte communications with the plan, and make a decision. There is no opportunity for providers to engage in a dialogue with arbitrators to answer their questions or to persuade them to consider another aspect of the issue.

Arbitrators' decisions are based on the "baseball style" arbitration: They must select between the provider's billed charges and the amount the plan originally paid. A hospital may elect to substitute an alternative amount to its billed charges that it would be willing to accept. In that case, the plan may also submit an alternative amount that it is willing to pay, and the arbitrator must select between these two alternative amounts.

The Problems with IDRs in Action

An example of the Florida version of a similar IDRP process shows the limited utility of the IDRP to resolve new legal issues. In *BayCare Health System, Inc. v. Agency for Health Care Administration et al.*, a hospital filed several claims with an IDR-like program in Florida. The claims totaled more than \$2 million, and Maximus CHDR was the independent third-party claim resolution entity. At issue was the methodology for determining the rate for noncontracted emergency services.

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CASES CITED

BayCare Health System, Inc. v. Agency for Health Care Administration et al., 940 So.2d 563 (2006).

Gould v. Worker's Compensation Appeals Board, City of Los Angeles, 4 Cal. App.4th 1059 (1992).

MANAGED CARE

A Florida statute set reimbursement of emergency claims at "the lesser of (1) the provider's billed charges, or (2) the usual and customary charges for such services in the community" [*BayCare*, 940 So.2d at 565, referring to §641.513(5)(a)-(b), Florida Statutes (2002)]. The dispute was over how to measure the usual and customary charges: The hospital claimed this was its full charge, while the payer claimed this was 120 percent of Medicare on the theory that this represented the usual and customary payment received by the hospital.

The court took care to distinguish the procedure of the IDR from court procedures. The decision was made by unnamed medical and legal professionals, with no record of the proceedings, no formal evidentiary hearing, and "at least some indication that Maximus CHDR's representatives may have engaged in *ex parte* communications with [the plan] to clarify certain factual issues." Under these circumstances, Maximus agreed with the plan's argument that the amount *paid* satisfied the statute's definition of the amount *charged*.

Unlike California's pilot IDR, the Florida IDR did not give the unsuccessful provider a right to reject the IDR result and proceed to court. BayCare Health System was stuck with the poor result and was no closer to clarifying Florida law. The court emphasized that the IDR decision did not set a precedent and concluded, "This case demonstrates that the process created by [the Florida IDR] is not an adequate method to resolve legal issues of first impression that involve the payment of millions of dollars."

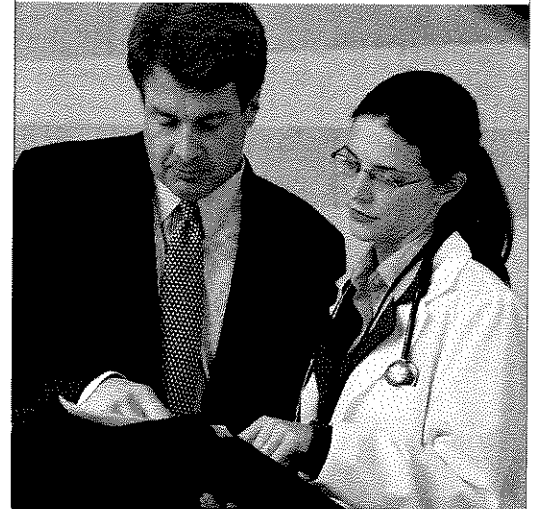
Why IDRs Cannot Solve the Rate Issue

An IDR may make sense when an isolated factual question that is unique to an individual claim determines the outcome because the result will be achieved more quickly, at less expense, with the risk of a wrong decision limited to that single claim and the absence of a right to appeal capping the process cost. An IDR makes no sense when the dispute is over an issue that is common to all present and future claims because the result will not contribute to the making or clarification of case law.

The precise issue for which the California pilot IDR was created is the fundamental issue of the method by which the reasonable and customary value of noncontracted emergency services is determined: That issue is best decided by a court, with a right to appeal, and a body of case law that will create precedents that apply to future cases and end the high volume of emergency services rate disputes. For this simple reason, the IDR is no cure for the malady of payers wanting free access to the emergency services bargains made by others. ●

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