On Your Behalf . . .

News and Notes from the Legislative and Practice Affairs Division

Balance Billing Legislation

By William E. Barnaby, Esq., CSA Legislative Counsel

The ability to bill managed health care plans by physicians who have no contract with a patient's plan has been a difficult and persistent problem. The California Department of Managed Health Care (DMHC) has not been helpful in resolving the issue. Indeed, in some ways the DMHC has attempted to make a bad situation even worse for physicians.

CSA Legal Counsel David Willett has participated in litigation and negotiations on this subject and he has attempted to forewarn anesthesiologists of some pitfalls to avoid.

Legislation signed into law in September 2000 (AB 1455) attempted to deal with provider payment problems with health plans. DMHC has been attempting to adopt implementing regulations ever since. One draft of these regulations would have barred "balance billing" by non-contracting physicians for emergency and on-call services. CMA, along with Dave Willett, objected forcefully. The regulations presently are being revised but will not prohibit non-contracting physicians from billing at a level yet to be finalized.

Meanwhile, legislation (AB 1628) was introduced by Assembly Health Committee Chair Dario Frommer (D., Glendale) that would have barred balance billing by non-contracting physicians for emergency services. In view of strong opposition from CSA and California emergency physicians, the offensive provision has been removed and replaced with language that assures that patient treatment does not give rise to an "implied" contract.

AB 1628 is before the Assembly Appropriations Committee and has a long way to go before its final provisions will be determined. But it is unlikely to deal further with a ban against balance billing or the formation of "implied" contracts.

David Willett has more to add on the subject in the following article.

Billing Patients–What Are the Limits?

By David E. Willett, Esq., CSA Legal Counsel

Anesthesiologists are directly billing patients much more frequently than was the case a year or so ago. This has happened as anesthesiologists (and other specialties) terminate managed care contracts. When the California Court of Appeal refused to permit a hospital which had contracted with the patient's health plan to balance bill the negligent third party (who caused the patient's injury) in *Parnell vs. Adventist Health System/ West*, (February 2003) 106 Cal. App. 4th 580, 585, the court took note of the impact of managed care on providers: "As the gap between 'usual and customary charges' and the discounted rate paid by insurers continued to grow, treatment of insured patients began to look increasingly like treatment of uninsured patients, at least from the hospitals' fiscal point of view." This has lead to the abandonment of health plan and IPA contracts, and enforcement of patient responsibility.

Two issues arise. The first question is whether patients may be billed at all under these circumstances. The other question is "how much can the patient be billed?" The Department of Managed Health Care (DMHC) grappled with both issues as it proposed regulations governing health plan claims settlement and dispute resolution practices. In AB 1455, passed in 2000, the Legislature mandated the adoption of regulations which respond to numerous complaints regarding health plan practices. Those regulations have been in the drafting stage ever since. The third version of the proposed regulations is pending.

The Department's second attempt at regulations included provisions which precluded even *non-contracting* providers from billing patients. This prohibition was without any statutory basis. Health and Safety Code Section 1379 prohibits *contracting* providers from collecting or attempting to collect from health plan enrollees. The proposed regulation not only required non-contracting providers to look to the health plan for payment, it also attempted to regulate how much non-contracting providers could collect. DMHC stated that rates paid by Medicare and Medi-Cal should be considered in determining reasonable fees. After objections by both CSA and CMA, the proposed language was withdrawn. Nonetheless, although DMHC had no authority for the regulation it proposed, it should be noted that patient complaints about balance billing, as well as health plan complaints, sparked the Department's attempt.

There is no prohibition against billing non-contracted patients, but the courts may not enforce patient responsibility if inadequate efforts are made by anesthesiologists prior to surgery to notify patients that services will be provided by physicians who may not have contracted with the patient's health plan, and that these

non-contracted physicians can ultimately look to the patient for payment. Moreover, efforts to collect directly from patients, rather than from the health plan, may still meet a frosty reception in court, as well as in the community. The most successful approach is probably to seek collection from the health plan, on the patient's behalf. If need be, an assignment of the patient's rights against the health plan can be obtained, and suit against the health plan may be instituted on that basis.

Balance billing is lawful. The second question remains. How much can an anesthesiologist who has no contract with the health plan bill? The answer is a *reasonable* fee. The issue which remains to be decided is what constitutes a reasonable fee. What are the limits on what an anesthesiologist can charge?

The obligation to pay a reasonable fee, in legal analysis, is based on the assumption that services rendered under circumstances showing that no gift was intended are subject to an implied contract. The courts assume that the physician will charge, and the patient will be obligated to pay, a reasonable fee, pursuant to an implied contract. For a considerable time, physicians had considerable latitude in determining the fee which would be reasonable under the circumstances. For example, even a 1938 appellate decision, in a suit brought by a physician who cared for W. C. Fields, held it was permissible to consider evidence of Field's wealth and annual income in determining a reasonable fee, together with the physician's professional standing, capacity, and reputation, and both the difficulties of the problem presented and the amount of time necessarily occupied in the consideration thereof. In the Field's case, the plaintiff was a general practitioner who presented no evidence to support the very large fee demanded, and the judgment the physician obtained was reversed. Whether a modern-day court would allow consideration of plaintiff's assets and income is questionable. The notion that physicians should be allowed to charge the rich more in order to provide uncompensated services to the poor probably fell victim to enactment of Medicare and Medi-Cal, social programs which also led to the closure of county hospitals, even though the result under those programs is to benefit both the rich and the poor at the expense of the physician.

A reasonable fee is now more often described as "UCR," a term first used in California, meaning "usual, customary, or reasonable." A "usual" fee is the fee most commonly charged by the practitioner. The "customary" fee is the fee charged by similar practitioners in the same geographic area. A fee which is neither usual or customary may still be reasonable, taking into account circumstances such as the difficulty of the case and the special qualifications of the practitioner.

The California Medical Association first published the California Relative Value Studies in 1966, using charge data provided by Blue Shield, to establish non-monetary unit values reflecting relativity or resource costs amongst procedures, and assigning procedure numbers. That work, revised in subsequent editions, became the basis for fee determinations by private and governmental payors alike. Although the FTC forced CMA to cease publishing the CRVS in 1979, CRVS remains the foundation for numerous payment programs.

As the CMA made clear, in order to use the CRVS to determine reasonable charges, conversion factors must be generated, reflecting customary fees. A physician's usual fees might further limit reasonable charges, while specific circumstances might support upward adjustment. This approach has been recognized by the courts in determining reasonable fees.

Returning to DMHC's proposed regulation, the Department now proposes that health plans should determine their obligation to non-contracted physicians by applying criteria which reflect a 1992 appellate decision which drew upon the CRVS in deciding how reasonable fees should be determined. *Gould vs. Workers Compensation Appeals Board,* 4 Cal. App. 4th, 1059, held that a physician did not have to show that extraordinary circumstances existed when claiming that fees exceeding the workers compensation fee schedule were nonetheless reasonable. The decision quotes from the foreward to the 1974 edition of the CRVS:

> "Since the unit values and accompanying ground rules reflect medians of charges by California physicians, they do not necessarily reflect the charges of any *individual* physician *nor the pattern of charges in any specific area of California*." The introduction further states: "Individual physicians are encouraged to establish their fees for individual services in accordance with their own estimates of the value of the service, the time spent, materials used and the economics of their own particular practices. The *Relative Value Studies* is *not* a schedule of fees, nor should it be construed as such. It may, however, be used as a 'guide' by physicians to assist them in establishing fees.... Evidence that a physician has charged a fee similar to fees charged for the same service in the geographical area in which the physician practices does not in itself mean that the physician's fee is reasonable. The introduction to the 1974 Revision of CRVS indicates, however, that the economics of a physician's own practice and the pattern of charges in the general geographical area in which the physician practices are relevant to a determination of whether the physician's fee is reasonable."

The Gould decision sums up the criteria to be applied in determining a reasonable fee by stating:

> In deciding whether fees in excess of the schedule are reasonable, the WCAB may consider evidence regarding the medical provider's training, qualifications, and length of time in practice; the nature of the services provided; the fees usually charged by the medical provider; the fees usually charged in the general geographical area in which the services were rendered; other aspects of the economics of the medical provider's practice that are relevant; and any unusual circumstances in the case.

It is these criteria that DMHC has told health plans to apply when non-contracted physicians, including anesthesiologists, seek payment. The plan's failure to arrange for the provision of necessary services by contracted physicians, as the law requires, should enable providers or at least patients to proceed against the plan. However, anesthesiologists should anticipate that health plans will fall back to a second line of defense. Health plans are likely to contend that "the fees usually charged," whether by anesthesiologists who still have some contracts in place or by other anesthesiologists in the area who are contracted, are fees paid under managed care contracts. They may contend, as DMHC did, that fees paid under Medicare or Medi-Cal, or other public programs, must be included in determining UCR fees. The major flaw in this argument is that the description in Gould and all other discussions take *charges* into account, not what is ultimately paid. To the extent payments under contract reflect an agreement which reflects charges under such contract, the circumstances of those agreements must be taken into account. Discounts may be granted for a variety of reasons, including patient volumes, relationships with other physicians or facilities, or a desire to assist a particular program.

Anesthesiologists applying a conversion factor markedly in excess of the fees charged in the same area by other anesthesiologists should expect difficulties in proving the reasonableness of those fees. Anesthesiologists whose conversion factors result in fees vastly in excess of fees accepted under contracts will be put to the test, in showing why circumstances justify the variation. Increases in conversion factors may reflect the need to find income which will replace shortfalls caused by managed care and public program payments, in order to recruit and retain anesthesiologists. However, anesthesiologists must always be prepared to defend against claims that billings, particularly when the patient is ultimately responsible, seek fees exceeding reasonable fees. While the DMHC proposal is directed to health plans and not non-contracting physicians, the Gould criteria are likely to be applied by the courts in determining reasonable fees.

Payer insistence in forcing unreasonably low payment schedules upon anesthesiologists justifies measures which preserve the right to look to the patient for

payment. It is easy to demonstrate that anesthesiologists have been leaving California and have been refusing positions here when practices rely on managed care and government program income. At the same time, it is imperative that fees charged be *reasonable* fees. The Gould criteria are fair. It is far from certain that a change in the law, if it were to occur, would be fair.

GASPAC Honor Roll

By William E. Barnaby III, Esq., CSA Legislative Advocate

The CSA members who make voluntary donations to GASPAC (the Greater Anesthesia Service Political Action Committee) provide a meaningful and tangible contribution to their specialty and to the medical community. They raise the visibility and credibility of the CSA in the political arena. They demonstrate their desire to have an impact on the laws and regulations affecting patient care and their ability to practice quality medicine. They also demonstrate a refusal to abandon the political field to those who would jeopardize patient safety for their own aggrandizement or to those who would profit financially at the expense of patients and the public health.

During the past year, donations exceeded $120,000–the highest annual total ever. These donations translate into campaign contributions to those candidates, legislators and state officials who are accessible and responsive to physicians and their patients. These contributions pay for CSA representatives to attend Capitol-area political fundraisers and are also available to pay for GASPAC members to attend local campaign events.

The 2002-03 Honor Roll of GASPAC donors follows. Our salute and thanks to every one listed. The 2003-04 CSA dues notices and GASPAC request soon will be issued. **With another election year just ahead, we urge those who have helped in the past to continue the effort, and those not listed to add their names to the Honor Roll for next year**.

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Santa Clara County Medical Association Reimbursement Advocacy Program

By Joetta Cox, Reimbursement Advocate, Santa Clara County Medical Association

Access To Care Issues

There is a growing concern regarding the number of anesthesiologists who have terminated some, or all, of their contracts with health plans. Patients now have been complaining because health plans determine them to be financially responsible for going outside the network, when in fact, they had no choice because there are no anesthesiologists contracted with their health plan. Is it fair for the patients to be held financially responsible when the health plan does not provide the appropriate specialist? Who really is responsible?

According to California Regulations [28 C.C.R., Section 1300.51, (H)(iii)], each health plan should have a complete network of contracting primary care physicians and specialists, each of whom has staff privileges with at least one contracting hospital equipped to provide the range of health care services that the plan has contracted to provide. The use of a non-contracting specialist is still restricted as there is no mandate that a plan refer to a specialist who is not under the contract with the plan, unless there is no specialist within the plan network who is appropriate to provide the necessary treatment. Therefore, one could argue that if the plan is unable to provide a specialist, then the plan should allow the

patient to go outside the plan, and furthermore, the plan should pay that provider's reasonable fee. *[**Editor's Note:** This subject has been treated in considerable detail in the July-September 2001 issue of the CSA* Bulletin*, pages 10-17, in an article by David E. Willett, Esq., CSA Legal Counsel, "'Usual, Customary, Reasonable' Versus Contract Rates."]*

How Is a "Reasonable Fee" Determined?

According to the AMA's Current Opinions of the Council on Ethical and Judicial Affairs, Section E-6.05, Fees for Medical Services, a physician should not charge or collect an illegal or excessive fee. You are referred to the article in this issue by David E. Willett, Esq., CSA Legal Counsel (pages 14-18), for a full discussion of this matter which includes the determination of a "reasonable fee" according to the 1992 appellate court decision (Gould).

In some instances, physicians have been reimbursed 100% of their fees after appealing the initial payment from the health plan, according to the "reasonableness" guidelines of the Gould decision. Some health plans, on the other hand, only pay 100% of their highest allowable schedule for contracted providers, insisting that it falls under the definition of "reasonable fee," or that they are in fact paying 100% of the fee. This would be true only if the provider were contracted with the health plan and obligated to write off the difference between the health plan's allowed fees and their charges. Because the providers are not contracted, they are, by law, allowed to balance bill the patient. What is this California law?

Are Non-Contracting California Anesthesiologists Under Implied Contracts?

The Knox-Keene Act (and Health and Safety Code Section 1379) prohibits contracting physicians from balance billing their patients, freeing enrollees of responsibility for the costs of their care under the terms of that contract. William Barnaby, CSA Legislative Counsel, discusses recent developments on this issue in his column (page 13). Indeed, non-participating providers are not obligated to accept contract rates nor are they bound by contract prohibitions against balance billing. Therefore, it is the patient's responsibility to know if a physician is a contracted provider. In fact, Knox-Keene mandates health plans to inform the subscribers regarding benefits and the nature and extent of choice permitted under the plan, including what should be a current list of contracted providers. *[**Editor's Note:** One prominent health plan refused to delete my name from their provider list despite two certified letters informing them of my intention to terminate my contract.]*

Managing the Non-Contracted Relationship of Anesthesiologist to Patient

Anesthesiologists should attempt to provide patients with as much notice as possible that they may not be contracted with the patient's health plan, and also communicate that the patient will incur full financial responsibility for the physician's claim. Indeed, some anesthesia groups ask the patient to sign an acknowledgement of this. Yet, we know that logistically this is not always a possible scenario for the anesthesiologist. In view of this problem and the potential for bad public relations, the Santa Clara County Medical Association (SCCMA), in conjunction with several private practitioners and the administrator of a local hospital, has created a "Patient Brochure" that alerts—and therein forewarns—patients that the anesthesiologist (and other physicians) providing care may be an independent practitioner and may not be contracted with their health plan. It also advises them that, should they receive care from a non-contracting anesthesiologist, they are financially responsible for these services. Moreover, it offers advice as to how to determine whether their anesthesiologist is contracted with their plan, and an opportunity to discuss billing with the anesthesiologist's billing office prior to surgery. A sample of this brochure is reproduced on pages 26-27. It may be used and modified, as desired, to fit the needs of the anesthesiologist. This brochure has been distributed to all surgeons and hospitals in Santa Clara County. The SCCMA has encouraged surgeons to give the brochure to their patients when they are scheduled for a procedure. The hospitals and surgery centers in the County also have been urged to give the brochure to patients when they register, providing a second opportunity for the patient to receive the brochure. Such preemptive interaction before—not after—the fact is an ethically sound practice and protects the anesthesiologist against charges of unfair dealings with their patients, assuming, of course, that the charge is indeed a "reasonable" one.

Other Helpful Billing Suggestions

Many non-contracting physicians bill the patient's health plan as a courtesy to the patient. It should be clearly noted on the claim form to the health plan that the physician is not a contracted provider. Furthermore, they should specify that the plan should reimburse the patient—not the anesthesiologist! Non-contracting physicians who do not want the contract to be "implied" should seek reimbursement directly from the patient, not the health plan. A suggestion that I have used on behalf of physicians is to attach a cover letter to the claim with the following three statements:

* You are not a contracted provider.

* You have informed the patient prior to performing the anesthesia of that fact and its financial ramification.
* Under no circumstances, do you intend to create an implied contract with the health plan.

How To Appeal Inappropriate Payments

If the health plan has not paid 100% of your fee, and you believe that your fee is "reasonable" for your area, then you can appeal the payment and ask for full reimbursement of your fees. I have been quite successful in obtaining additional reimbursement for physicians in our County by knowing the coding guidelines, knowing California regulations, and letting health plans know that you know. If you have taken all the precautionary steps to avoid implied contracts, then in my appeals letter I consider listing the following applicable guidelines and regulations as they may apply to a specific claim:

* California Regulations (28 C.C.R. Section 1300.51)—see above
* The health plan has failed to provide a contracted specialist for this particular procedure at this particular facility, and therefore, the plan should allow the patient to go outside the plan, and the plan should pay the anesthesiologist a "reasonable fee."
* Your fee is the fee customarily charged in the locality for similar physician services, and further, is a "reasonable fee" according to the AMA Current Opinions of the Council on Ethical and Judicial Affairs (E-6.05)—see above
* The health plan should pay your "reasonable fee" and not the health plan's "reasonable fee."
* The Knox-Keene Act allows non-contracting providers to balance bill patients—see above

Please see the patient brochure on pages 26-27.

"If con is the opposite of pro,
is congress the opposite of progress?"

—Anonymous