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Legislative and Practice Affairs Division

Department Of Managed Health Care Action Against Health Net May Signal New Era

Noncontracted Physicians Ruled Entitled to “Reasonable and Customary” Fees—Amount is Next Question

By David E. Willett, Esq., and Phillip Goldberg, Esq., CSA Legal Counsel

A January 13 announcement by California’s Department of Managed Health Care (DMHC) appears to signal a new attitude, apparently prompted by Governor Schwarzenegger’s March 2004 appointment of a new Director, Cindy Ehnes. In recent years, the Department has been the captive of the health plans it regulates. Physician complaints were ignored, and patient complaints were resolved one by one, rather than by broad enforcement actions. The January 13 announcement describes the results of an investigation prompted by complaints of noncontracted hospital-based physicians, whose claims were paid by Health Net at 80 percent of Medicare fees. Consequently, many patients were balance billed. The outcome this time favors patients and physicians. Unreasonably low fees cannot be imposed on noncontracting physicians, and payments must meet specific criteria.

Health Net has agreed to a settlement which fines Health Net \$250,000, sets up a process for adjusting past claims, and establishes rules for the future. This settlement has broad significance because it spells out Department policy regarding health plan obligations in paying for services provided by noncontracted physicians, including anesthesiologists. Some questions have not been answered, but on balance this settlement seems more in conformity with CSA’s position than was previous DMHC policy.

The settlement agreement abandons the contention, regularly made by the Department under the prior administration, that noncontracted physicians cannot balance bill patients. The Health Net agreement makes no explicit statement regarding the right to balance bill, but instead takes the position that balance billing can be avoided by paying reasonable and customary fees, and by acknowledging that the burden is then on the health plan to protect members from inappropriate balance billing by noncontracted physicians.

DMHC found that 80 percent of Medicare was not “reasonable and customary.” Health Net itself acknowledged this when the investigation began, and converted

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to a commercial database for fee determination. Health Net will be permitted to use this database in the future, so long as it is updated at least annually. In addition, Health Net must establish a process for appeals by noncontracted physicians, under which Health Net must consider additional information submitted by the physician as to reasonable and customary value. Neither Health Net nor the Department will disclose specific information regarding fees payable under the commercial database. CSA members not contracted with Health Net who feel that current Health Net claim payments for specific services have not been reasonable are invited to communicate with CSA. Department regulations (adopted following the January 1, 2001, effective date of AB 1455) state that fees must be based upon “statistically credible information that is updated at least annually.” Criteria include fees usually charged and prevailing rates charged in the area, as well as physician training and experience, the nature of the services, other aspects of the physician’s practice, and any unusual circumstances. Conspicuously absent from the enumerated criteria are Medicare fees, partly due to CSA efforts when these regulations were adopted.

Health Net must reimburse HMO subscribers amounts they paid on balance billings for services between January 1, 2000, and October 12, 2004, less deductibles or co-pays. The agreement is ambiguous as to what should happen when a patient has paid a balance billing for services after October 12, 2004, but the expectation seems to be that at least subscribers not put on notice by Health Net as to the proper disposition of balance billings should also receive reimbursement. The agreement does not spell out how Health Net should discharge its obligation to protect members for inappropriate balance billing. Presumably, Health Net could defend collection attempts, or even institute legal action on behalf of subscribers when balance billing exceeds reasonable and customary fees. The obligation of a noncontracting physician to participate in the Health Net appeal process, or to be bound by the outcome, is not described. However, courts are unlikely to be sympathetic to physicians who ignore the process or its outcome. Noncontracting physicians can challenge plan appeal decisions in court when they do not conform to the criteria set out in Department regulations or court cases defining reasonable and customary fees. One would expect that Health Net by now is putting subscribers on notice as to the steps to be taken when balance billings are received from noncontracting providers.

DMHC does not regulate PPO or point-of-service plans, other than Blue Cross and Blue Shield. As a consequence, Health Net’s settlement does not extend to its PPO plans. Its obligation to PPO subscribers depends on the wording of the PPO contract, and perhaps other representations made to subscribers. Last fall, Health Net apparently amended PPO contracts to provide for reasonable and customary fees for out-of-network providers, rather than 75 percent of Medicare

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RBRVS. Legislation has already been introduced to extend DMHC requirements to PPOs.

Summary: DMHC’s action regarding Health Net signals new willingness to intervene when health plans regulated by DMHC attempt to impose unreasonable fee schedules for services by noncontracting physicians, many of whom have refused to contract precisely because of inadequate and unreasonable fees. There is still controversy over health plan obligations when DMHC has no authority over particular arrangements, such as PPOs. Patients who have received balance billings continue to complain. Anesthesiologists who have not contracted with the responsible plan have the right to balance bill patients. However, it is prudent to make every effort to assist patients in securing reasonable reimbursement from the health plan before collection from the patient is contemplated. This may require appealing to the health plan. Changes in the law governing health plans, now being considered, can ensure that all covered patients are protected.

Medi-Cal Enrollment Eased for Some Anesthesiologists

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

Enrollment as Medi-Cal providers for anesthesiologists who render care to Medi-Cal beneficiaries only in acute-care hospitals has been made easier under a new rule recently adopted by the California Department of Health Services (DHS).

Earlier, DHS disclosed plans to require “facility-based providers” to submit evidence of contracts with the hospitals where they practice in order to gain the ability to bill Medi-Cal for services rendered to Medi-Cal patients. This proposed rule was withdrawn after CSA representatives convinced DHS officials that many anesthesiologists practice in hospitals without a formal written contract but pursuant to hospital staff privileges.

The difficulty in gaining Medi-Cal provider status was brought to CSA’s attention by Shauna Brown, Credentialing Manager for RC McLean and Associates, an Anesthesia Billing and Management Service Organization located in Orange County.

The requirement is based on DHS regulations requiring Medi-Cal providers to have an “established place of business.” When DHS launched a crackdown on Medi-Cal fraud a few years ago, it discovered that some providers were using mail drops and non-existent places of business for billing purposes. As a result,

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elaborate rules were adopted to assure that providers were operating and rendering services at established places of businesses.

Unlike most other physicians, many anesthesiologists do not have office practices. For those wishing to use a hospital as their “established place of business,” problems have ensued.

The initial DHS proposal for “facility based providers” required submission of three letters. One was required from the provider certifying, under penalty of perjury, that he or she will render services exclusively at a named hospital and also that Medi-Cal enrollment “is based in part on a contractual agreement” between the provider and the hospital. A second letter, to be signed by a person authorized to legally bind the hospital and the applicant provider, was to “affirm” that DHS “may rely on the veracity” of the applicant provider, and that claims for Medi-Cal reimbursement will be submitted under the applicant’s provider number and will not include services reimbursed to the hospital. The third was to be signed by a responsible official for the facility attesting that there are no Medi-Cal, Medicare or licensing sanctions pending against the facility.

Under the new rule, an applicant anesthesiologist must only submit his/her own letter declaring, under penalty of perjury, that services to Medi-Cal beneficiaries will be provided at a named hospital “based in part on a non- contractual agreement” with the hospital.

CSA had urged that evidence of medical staff privileges at a hospital serve as the equivalent of a contract for this purpose. Even though Medicare accepts evidence of current staff privileges for this purpose, Medi-Cal seems not quite ready to use that standard as yet.

Tracking detailed rules imposed by government programs can be mind- numbing at times, but it can be of some benefit to CSA members. Simplifying and expediting the ability of anesthesiologists to receive reimbursement for services rendered to Medi-Cal recipients is, in our view, worth the effort.

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GASPAC Honor Roll

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

CSA owes a major expression of gratitude to the 537 individuals who contributed more than \$91,000 to GASPAC during the current 2004-05 fiscal year.

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.

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.

In today's world of political campaign financing, GASPAC is small in size but large in impact. Thanks to a "catchy" acronym and careful handling of available funds, GASPAC is well-known around Sacramento. Its visibility underlines CSA's insistence on being an active participant in California politics and civic affairs.

The 2004-05 Honor Roll of GASPAC donors follows. Our salute and thanks to everyone listed. The 2005-06 CSA dues notices and GASPAC requests 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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