

Balance Billing Toolkit

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(Physicians are urged to check the CMA website www.cmanet.org regularly to see if this document has been updated and to learn of new developments.)

Many physicians and other healthcare providers have questions in the wake of recent balance billing regulation and the *Prospect* legal decision that prohibits “balance billing” patients for the unpaid portion of bills only partially paid by Knox Keene plans for noncontracted emergency services. The California Medical Association has prepared this toolkit to answer questions and provide options to physicians and their billing agents who can no longer “balance bill.”

The California Supreme Court issued *Prospect* on January 8, 2009, in which it interpreted the Knox-Keene Act to prohibit the practice by out-of-network providers of billing patients the balance of an emergency care bill that the patients’ Knox-Keene-licensed plan refused to pay. For the most part, *Prospect* renders superfluous the DMHC’s regulation defining balance billing as an “unfair billing pattern.” (28 C.C.R. §1300.71.39.) Prior to *Prospect*, the DMHC claimed this regulation alone prohibits balance billing and provides a basis for enforcement action, but no court has validated these contentions. Although CMA disagrees with the DMHC, *Prospect* now renders this issue moot.

Throughout its opinion in *Prospect*, the Supreme Court took care to recognize that out-of-network providers are entitled to the customary and reasonable value of their services. The Court, however, refused to consider arguments in CMA’s amicus brief that plans routinely and systematically reimburse providers at well below this standard.

Notwithstanding *Prospect*, CMA will continue all efforts to ensure that plans and insurance carriers properly and fully pay non-contracted providers the customary and reasonable value of their medical care services.

WHAT PHYSICIANS CAN DO TO HELP.

- 1) COMPLETE CMA’S SURVEY. We have created a survey to determine whether, and if so how, plans are taking advantage of out-of-network providers. The survey is available on CMA’s website (www.cmanet.org) or can be delivered to you in paper form. We strongly encourage physicians to fill out the survey.
- 2) IDENTIFY EGREGIOUS UNDERPAYORS. In addition to filling out the survey, CMA would be very interested to know of any particular underpayors who have egregiously underpaid for out-of-network services. If you can provide such information, call CMA’s legal hotline at (800) 786-4CMA.

NOTE: This toolkit provides timely information about important issues of law affecting physicians, but is not intended to provide readers with professional legal advice of any kind. Nor is this toolkit intended to create, and should not be understood as creating, an attorney-client

relationship between or among any parties. CMA is unable to provide specific legal advice to each of its more than 30,000 members. For a legal opinion concerning a specific situation, consult your personal attorney.

THE *PROSPECT* DECISION

1. What did the Supreme Court do in *Prospect*?¹

Prospect arose out of a dispute between Prospect Medical Group, Inc. (Prospect), an individual practice association, and two separate groups of emergency medical care providers that did not have a contractual relationship with Prospect to serve its enrollees. Although Prospect is a group of providers, in the context of the case, it stood in the shoes of a health care service plan because it was delegated the obligation to pay providers who render services to plan enrollees. Prospect paid non-contracted providers for emergency care rendered to its enrollees at a rate that Prospect unilaterally determined to be reasonable. Often, Prospect's payment was below the providers' billed amounts. Prospect sued the providers when they billed the unpaid balance of their bills to Prospect's enrollees, claiming, in relevant part, that Health & Safety Code section 1379 prohibits such balance billing.

Section 1379 requires all contracts between a Knox-Keene-licensed health plan and a provider to include a provision prohibiting the provider from balance billing plan enrollees for any amounts owed by the plan. In other words, Section 1379 prohibits contracted providers from balance billing. An intermediate appellate court interpreted Section 1379 not to extend to non-contracted providers, such as the non-contracted providers who billed Prospect's enrollees, because by its terms the section only applies when there is a contractual relationship between the plan (or its delegate) and the health care provider, based upon traditional contract principles. No such contractual relationship existed between Prospect and the non-contracted emergency care providers.

The California Supreme Court reversed the intermediate appellate court's interpretation of Section 1379, and held that the statute did apply to non-contracted providers. The Court, however, did not interpret Section 1379 to apply to non-contracted providers under the usual rules of statutory interpretation or upon application of traditional contract principles to the facts of the case. The Court instead took an unusually result-oriented approach, driven by the Court's perception of a "clear legislative policy not to place patients in the middle of billing disputes." According to the Court, several provisions and regulations of the Knox-Keene Act, viewed as a whole, espouse this legislative policy:

- Emergency care providers are required by law to provide necessary emergency care to anyone, until the patient is stabilized, without regard to ability to pay (Health & Safety Code §1317);

¹ The Supreme Court will publicly post a .PDF copy of the *Prospect* opinion on its website for 120 days after it was issued on January 8, 2009, at <http://www.courtinfo.ca.gov/opinions/documents/S142209.PDF>.

- Health plans are required by law to reimburse any emergency care provider for the reasonable and customary value of emergency services the provider rendered to the plans' enrollees (Health & Safety Code §1371.4; 28 C.C.R. 1300.71);
- Health plans are prohibited by law from engaging in “unfair payment patterns” involving unjust payment reductions, claim denials and other unfair practices to be defined by the DMHC (Health & Safety Code §1371.37; 28 C.C.R. 1300.71.37);
- All Knox-Keene-licensed plans must establish an internal dispute resolution system accessible to non-contracted providers to resolve billing and payment disputes (Health & Safety Code §§1367, 1371.38);
- Non-contracted providers can sue the health plan (or its delegate) directly over billing disputes (*Bell v. Blue Cross of California* (2005) 131 Cal.App.4th 121); and
- The Legislature expressed an intent to “ensure the best possible health care for the public at the lowest possible cost by transferring the financial risk of health care from patients to providers” (Health & Safety Code §1342(d)).

Despite recognizing that, “[r]eading the language of section 1379 in isolation, it does not readily apply to the precise situation here,” the Court held that the “only reasonable interpretation” of the Knox-Keene statutory scheme, read as a whole, “is that emergency room doctors may not bill patients directly for amounts in dispute,” especially “when the doctors have recourse against the patient’s HMO.” The Court explained that providers “must resolve their differences with HMO’s and not inject patients into the dispute.”

In sum, the Supreme Court unequivocally held in *Prospect* that non-contracted providers may not balance bill a patient for emergency services rendered when the patient’s plan fails to pay the provider’s full bill. Providers can seek recourse only against the plan if they feel they have been underpaid.

Prospect is binding precedent on all California state courts and, to the extent applicable, all federal courts deciding questions of California law that are addressed in the *Prospect* decision.

2. Are there issues related to balance billing that the Supreme Court did not decide in *Prospect*?

Yes. The Supreme Court recognized that its opinion in *Prospect* does not reach other issues related to the balance billing controversy, issues that arise due to underpayment by plans for out-of-network emergency care services. The Court explicitly noted that a plan does not have “unfettered discretion to determine unilaterally the amount it will reimburse a noncontracting provider.” It elaborated: out-of-network providers “*are* entitled to reasonable payments for emergency services rendered to HMO patients. All we are holding is that this entitlement does not further entitle the doctors to bill patients for any amount in dispute.” (Emphasis in original.)

The Court also identified existing legal and alternative dispute resolution avenues that theoretically avail providers with recourse for underpayment by plans, but the *Prospect* decision



does not resolve the question of how to resolve disputes between the doctors and the plan over the amount that is properly due for emergency care. In other words, the Court did not discuss the wisdom of previous attempts to resolve the issue, such as an interim payment system (proposed by SB 981, which was vetoed by the Governor last year). It did, however, state that “[t]his area of the law might benefit from comprehensive legislation.”

3. Can the *Prospect* decision be reversed?

As a practical matter, no. The California Rules of Court permit the Supreme Court to rehear any of its cases within a certain period of time after an opinion in the case is issued. A decision on rehearing is decided at one of the court’s regular, closed conferences, where counsel and oral argument are not allowed. Rehearing can be ordered only if a majority of the seven justices votes in its favor. Given that the *Prospect* decision was unanimous (all seven justices who heard the case endorsed the opinion), it is virtually impossible that the Court would grant an application for rehearing of this decision.

It also is not possible to appeal the *Prospect* decision to the United States Supreme Court, which hears only cases that involve a federal question of law. The only issues presented in *Prospect* and ruled upon by the California Supreme Court arise out of the California Health & Safety Code, not any federal law.

There may be federal claims that, in theory, can be asserted in a separate lawsuit to try to overcome the holding in *Prospect*. Any such federal claim, however, would likely be novel and stand a very slim chance of prevailing. CMA’s attorneys are open to all viable and wise avenues to address the *Prospect* decision and will not presumptively rule out the possibility of pursuing such federal claims, if asserting such claims makes sense.

4. Does the *Prospect* decision have retroactive application to pending balance bills or bills already collected from patients?

The Supreme Court did not address the retroactivity of its decision in *Prospect*, and unfortunately, a clear answer cannot be discerned just from looking to general legal principles governing the retroactivity of Supreme Court opinions. The issue is susceptible to interpretation and further litigation, and providers are urged to seek advice from an attorney concerning their individual situation if they feel it is necessary.

Certainly, the ban on balance billing applies going forward from the date *Prospect* was issued. The ban on balance billing very likely applies even earlier, to any emergency service rendered on or after October 15, 2008, when the DMHC’s regulation took effect. It is less clear whether the ban applies to bills to patients for emergency services performed before October 15, 2008, are currently uncollected and still pending. Should providers cease any collection attempt on these outstanding bills? The answer may have to be decided in court. However, out of an abundance of caution, and to avoid inviting private actions by plaintiffs’ lawyers under the Unfair Competition Law, physicians are advised not to continue collection actions on any bills to patients that are currently pending.

Generally, Supreme Court decisions are given retroactive application unless considerations of fairness and public policy dictate otherwise. (*Rose v. Hudson* (2007) 153 Cal.App.4th 641, 646.)

As the Supreme Court stated, “[p]articular considerations relevant to the retroactivity determination include the reasonableness of the parties’ reliance on the former rule, the nature of the change as substantive or procedural, retroactivity’s effect on the administration of justice, and the purposes to be served by the new rule.” (*Claxton v. Waters* (2004) 34 Cal.4th 367, 378-379.) Supreme Court decisions announcing a change in law usually are not given retroactive application when there has been a great public reliance on the earlier rule, the new rule was nowhere foreshadowed, and it would be unfair to apply the rule retrospectively. This reliance is most compelling when a party has acquired a vested right or entered into a contract based on the former rule. Thus, where a constitutional provision or statute has received a given construction by the Supreme Court and contracts have been made or property rights acquired under and in accordance with the court’s decision, those contracts will not be invalidated nor will vested rights acquired under the decision be impaired by a change of construction adopted in a subsequent decision.

Although there can be arguments to the contrary, and no court has actually ruled on this issue, applying the general retroactivity considerations indicates that that *Prospect*’s ban on balance billing will apply to currently outstanding bills to patients (regardless of date of the underlying medical services). Given the strong policy cited by *Prospect* to insulate patients from disputes between providers and plans and the fact that providers have available recourse against plans for underpayment, a court probably would find that there is no unfairness in applying the ban on balance billing to any bill that currently are outstanding at the time the decision came down. Providers should not be able to collect from patients on these outstanding bills.

However, a good argument can be made, and it is likely, that the ban should not apply to bills that have already been collected from patients. Extending retroactivity to payments already collected would be cumbersome, generate more protracted litigation, and raise even more questions (for instance, would the ban apply to payments collected last year, five years ago, or ten years ago?). Unlike bills that currently are outstanding, there would be no natural limitation going back in time. Retroactivity to payments already collected also would be extremely unfair and disruptive. Providers, having already collected the payment in reliance on a prior understanding that balance billing was not prohibited, cannot be expected to return amounts that may have already been spent or allocated to other functions of their practice.

THE RELATIONSHIP BETWEEN *PROSPECT* AND THE DMHC’S REGULATION

5. How does *Prospect* impact the legal challenges to the DMHC’s regulation on balance billing?

Prior to issuance of the *Prospect* decision on January 8, 2009 (but while the case was pending before the Supreme Court), the DMHC promulgated a regulation, codified as 28 C.C.R. section 1300.71.39, that seeks to prohibit balance billing of Knox-Keene enrollees by providers for out-of-network emergency services. The regulation took effect October 15, 2008, and applies to anyone enrolled with a licensed HMO, Anthem Blue Cross of California Prudent Buyer PPO or Blue Shield of California PPO. CMA and a coalition of organizations representing hospitals, ER doctors, anesthesiologists, radiologists, and orthopedists filed a lawsuit to invalidate and enjoin

enforcement of the DMHC’s regulation. In early December 2008, the Sacramento County Superior Court issued a ruling finding that the regulation was valid, but only insofar as it is viewed to merely define balance billing as an “unfair billing pattern.” The court did not address what, if anything, the DMHC can do with this definitional regulation, and the DMHC itself admitted that this important question remained open prior to *Prospect*. Thus, there is no court determination that the DMHC has authority, based on this regulation alone, to prohibit or take enforcement action against non-contracted physicians who bill patients for amounts not paid by their health plan for emergency services.

Prior to *Prospect* CMA attorneys intended to appeal the Sacramento Superior Court’s decision and to initiate a separate lawsuit directly challenging the DMHC’s authority to take enforcement action based on the regulation. However, the questions that would be raised in these actions have become moot in light of *Prospect*. The Supreme Court held balance billing is prohibited under Health & Safety Code section 1379 and the overall scheme of the Knox-Keene Act; invalidating or enjoining the DMHC from enforcing the balance billing regulation would have no effect on the conclusion from *Prospect*. In other words, even absent the DMHC’s regulation, the DMHC still could take enforcement action against balance billing because, under *Prospect*, such practices violate the Knox-Keene Act independent of any DMHC regulation. Accordingly, continuing the legal challenges to the DMHC’s regulation would not be worthwhile, and CMA intends to drop these efforts in favor of more productive action.

6. What relationship, if any, is there between *Prospect* and the DMHC’s regulation?

Under both *Prospect* and the DMHC’s interpretation of its regulation, balance billing in the emergency care context is prohibited. The DMHC’s regulation, however, provides more details than the *Prospect* decision concerning the circumstances in which balance billing is prohibited. In briefing before the Supreme Court, the DMHC stated that the regulation can be viewed as further elaboration of how and when balance billing is prohibited. The DMHC cited section 1379 (which provided the “hook” for the Supreme Court to ban balance billing) as a “reference” for the regulation, which means that the regulation is intended to clarify the implementation of section 1379. The regulation therefore can be used to answer some of the questions that the Supreme Court failed to answer in the *Prospect* decision. These questions are addressed below.

Read together, the regulation and *Prospect* shall be referred to herein as the “ban on balance billing.”

APPLICATION OF THE BAN ON BALANCE BILLING

7. **The DMHC’S regulation targets a “pattern” of balance billing; does this limit application of *Prospect*?**

No. Unlike the portions of the AB 1455 regulations defining an “unfair payment pattern” as requiring a threshold number of violations (either a violation on three or more occasions or in more than 5% of claims), the new regulation does not provide any information as to how many violations constitute a “pattern.” Nonetheless, the regulation does require that there be a “pattern,” which California law recognizes in numerous contexts can be just two or more acts.



However, this issue became moot with *Prospect*, which holds that any balance bill (one or more) is unlawful under the Knox-Keene Act.

Affected Enrollees

8. Does the ban on balance billing apply to all patients with commercial insurance?

No. The *Prospect* decision and the DMHC's regulation arise out of the Knox-Keene Act. The ban on balance billing therefore does not apply to insurance products that do not fall within the province of the Knox-Keene Act, including PPOs regulated by the Department of Insurance (DOI). It only applies to patients who are enrollees in Knox-Keene plans, that is, commercial HMOs, and many Blue Cross and Blue Shield PPOs.

The ban on balance billing should not apply to ERISA beneficiaries whose plan is administered by a Knox-Keene plan. However, because of the difficulties in distinguishing between ERISA and non-ERISA plans, and because of the possibility of both government and private attempts of enforcement in this area, CMA urges physicians to exercise extreme caution in this area. Indeed, if it is not clear from the insurance card or EOB that the patient is an ERISA patient, the only practical way for a physician to be sure of the patient's status is to contact the plan's customer service department.

9. How can I tell if my Blue Cross or Blue Shield patient is a Knox-Keene enrollee?

Both of these plans have different PPO products, some of which are regulated by the DOI, though most of which are regulated by the DMHC under the Knox-Keene Act. The law requires that where the product is regulated by the Department of Insurance, the payor's EOB must say so. (Insurance Code §§10123.13 and 10123.147.) Further, for DOI regulated insurers, usually the patient's identification card will state that he/she is a member of a "Life and Health Insurance Company." Knox-Keene plans do not use the word "insurance." If you are in doubt, you should contact the plan for verification.

Affected Providers

10. Are all providers included within the ban on balance billing or are there any exceptions?

All providers are covered. The DMHC's regulation expressly exempts medical transportation providers, however, the *Prospect* decision includes no such exemption. Reading the regulation and the decision together, the ban on balance billing applies to all "providers" within the meaning of the Knox-Keene Act. The Act defines "providers" to include "any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services." (Health & Safety Code §1345(i)).

11. As a non-contracting physician, am I now prohibited from ever balance billing my patients?

No. The ban on balance billing applies only to emergency services rendered pursuant to EMTALA and Health & Safety Code section 1371.4. Non-contracted physicians may still either collect at the time of service (subject to applicable laws in the emergency care context) or bill patients for the remainder of their fee in non-emergency cases. The definition of “emergency medical condition” under California and federal laws is, for the most part, the same: a medical condition manifested by acute symptoms of sufficient severity (including severe pain, psychiatric disturbance and/or symptoms of substance abuse), such that the absence of immediate medical attention could reasonably be expected to result in placing the patient’s health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. (42 U.S.C. §1395dd(e)(1)(A); 42 C.F.R. §489.24(b); Health & Safety Code §1317(b).) In the case of a pregnant woman who is having contractions, determining whether an “emergency medical condition” exists means determining (a) whether there is inadequate time to effect a safe transfer to another hospital before delivery, or (b) whether transfer may pose a threat to the health or safety of the woman or unborn child. (42 U.S.C. §1395dd(e)(1)(B); 42 C.F.R. §489.24(b); Health & Safety Code §1317(c).)

Affected Services

12. Does the ban on balance billing apply if the patient is stabilized, and thus no longer in an emergency condition?

The Supreme Court did not directly address this question in *Prospect*, but this is a situation where the regulation can be used to interpret the ban on balance billing. Under the regulation, the ban on balance billing would not apply in this circumstance, because it applies only to “emergency services.” Once a patient is stabilized, services provided to that patient no longer are “emergency services.” Under California law, a patient is “stabilized” when “in the opinion of the treating provider, the patient’s medical condition is such that, within reasonable medical probability, no material deterioration of the patient’s condition is likely to result from, or occur during, a transfer.” (Health & Safety Code §1317.1(j).) The treatment obligation includes providing specialty consultation as medically appropriate by telephone and, “when determined to be medically necessary jointly by the emergency and specialty physicians,” through personal examination and treatment by the specialist. (Health & Safety Code §§1317.1(i), 1317.2(a).)

Similarly, under federal law, “to stabilize” means to provide sufficient treatment, such that no material deterioration of the patient’s condition is likely to result from or occur during the patient’s transfer. With respect to a pregnant woman, “to stabilize” means to deliver, including the placenta. (42 U.S.C. §1395dd(e)(3)(A); 42 C.F.R. §489.24(b), definition of “stabilized.”) The law requires a “flexible standard of reasonableness,” however, depending on the circumstances. For more information on the emergency transfer laws, *see* CMA ON-CALL #1215, “Emergency Transfer Laws.”

This interpretation of the ban on balance billing is wholly consistent with the reasoning articulated in *Prospect*. The Supreme Court relied on several provisions of the Knox-Keene Act to justify its interpretation that the Act prohibits balance billing. In particular, the Supreme Court relied on Section 1371.4, which states that plans “shall reimburse providers for emergency

services and care provided to its enrollees, until the care results in stabilization of the enrollee.” The Court also relied on Section 1317, which requires providers to provide “emergency services” to any patient without regard to ability to pay. These contours of these statutory obligations are limited to the standard of “stabilization,” as the DMHC’s regulation is so limited. The ban on balance billing therefore would not apply to services rendered after a patient is stabilized.

13. Does the ban on balance billing apply to services by on-call physicians?

Yes, if on-call physicians provided “emergency services” to an enrollee of a Knox-Keene-licensed plan or delegate. As noted, the ban on balance applies to all providers (including on-call specialists) who render “emergency services” to a patient prior to stabilization of the patient.

14. Does the ban on balance billing apply to services medically necessary to maintain the stabilization of the patient, after that patient is stabilized and awaiting transfer to a facility that is contracted with the patient’s plan or delegate?

Neither the DMHC’s regulation nor the *Prospect* decision addresses whether the ban on balance billing applies to services that are rendered, after a patient is stabilized, in order to maintain the stabilization. However, out of caution, providers should assume that such services are covered under the ban. The Legislature passed a new law that addresses this situation with respect to hospitals. This new law, codified at Health & Safety Code section 1262.8, prohibits non-contracted hospitals from balance billing a patient for post-stabilization care, unless the patient’s plan authorizes post-stabilization care, the hospital is unable to identify the patient’s plan in order to request authorization for post-stabilization care, or the patient refuses to be transferred to a contracting hospital and is informed of his or her obligation to pay for post-stabilization care by the non-contracted hospital. Section 1262.8 also prohibits balance billing the patient for (by making plans obligated to pay for) service that is medically required to keep a patient stabilized. Because the Supreme Court relied on the overall scheme of the Knox-Keene Act in banning balance billing, Section 1262.8 could be relied upon to determine whether the ban applies to services that are medically necessary to maintain stabilization after a patient is stabilized, but before a patient is transferred to a contracting hospital.

15. Do physicians need to refund payments made by patients for balance bills that were sent to patients prior to October 15?

CMA does not believe so, and the DMHC has agreed with us when it interpreted the balance billing regulation. (See also the discussion above with respect to Question No. 4.) The regulation, and the *Prospect* decision, prevents “billing” enrollees, not cashing checks for bills that had been sent prior to the regulation’s effective date of October 15, 2008, or the date the *Prospect* decision was issued on January 8, 2009. Nor does the term “billing” encompass payments received from bills sent prior to October 15, 2008. While the law does not define billing, the common usage of the term “invoice” does not include “receiving payment.” See, for example, *Black’s Legal Dictionary* (2004, 8th Ed.), defining invoice as “an itemized list of goods or services furnished by a seller to a buyer, usu. specifying the price and terms of sale.” Under these circumstances, CMA does not believe that physicians are obligated to return payments made for bills sent out prior to October 15, 2008, the earliest date that a ban on balance billing took effect.

ENFORCEMENT

16. What type of enforcement is there for balance billing a Knox-Keene enrollee?

The Knox-Keene Act contains a number of provisions that the DMHC can seek to use to take enforcement action against “violators” of the Act. For example, Health & Safety Code §1387 allows the DMHC to go to court to fine “any person” who violates any regulation adopted by the DMHC by an amount not to exceed \$2,500 for each violation. The DMHC also has general enforcement power to take action against providers who violate any provision of the Knox-Keene Act. Willful violations of the law carry fines up to \$10,000 and/or imprisonment. (Health & Safety Code §1390.) However, because neither the *Prospect* decision nor the DMHC’s regulation sets forth a specific fine or penalty for engaging in balance billing, it is unclear how the DMHC would exercise its enforcement discretion. While CMA does not believe the DMHC will attempt to bring criminal actions against physicians, physicians should understand the DMHC does have broad enforcement powers. Further, CMA is concerned that trial attorneys will attempt to bring lawsuits under the Unfair Competition Laws, Business & Professions Code §§17200 *et seq.* against providers who balance bill in violation of the regulation and *Prospect*.

STEPS PHYSICIANS CAN TAKE—BILLING

17. Does this mean, going forward, I cannot balance bill my Knox-Keene patients for emergency services if their plan underpays me?

Yes, as discussed above, balance billing in this circumstance is now prohibited.

18. So should I inform my billing company of this new restriction?

Yes. To avoid being charged with violating the ban on balance billing, make sure that all entities or agents that perform billing/collection functions for you know about the ban on balance billing.

19. As a non-contracting physician, must I discount my charge when billing the plan?

No. Health & Safety Code §1371.4(b) and 28 C.C.R. section 1300.71, require that plans make payment for the customary and reasonable value of your services, assuming you do not already have a contract with the plan for emergency services, in which case payments will likely already be discounted. Common law also obligates the plan to pay you a reasonable amount. *See Bell v. Blue Cross, supra.* *See also Medina v. Van Camp Sea Food Company, Inc.* (1946) 75 Cal.App.2d 551 (in the absence of a contract, fishing boat owner required to pay reasonable value of services of a fish transporter).

20. What is a “reasonable” rate?

DMHC regulations incorporate court cases setting forth the factors in defining what constitutes a “reasonable fee” and require the payment of the reasonable and customary value for the health care services rendered based upon the statistically credible information that is updated at least annually and takes into consideration:

1. The providers training, qualification, and length of time in practice;
2. The nature of the services provided;
3. The fees usually charged by the provider;
4. Prevailing provider rates in the general geographic area in which the services were rendered;
5. Other aspects of the economics of the medical provider's practice that are relevant; and
6. Any unusual circumstances in the case.

(28 C.C.R. §1300.71(a)(3)(B).) *See also Gould v. Workers' Compensation Appeals Board* (1992) 4 Cal.App.4th 1059, 6 Cal.Rptr.2d 228.

21. How long do I have to take action against the plan or its delegate for underpayment?

Non-contracting physician have up to 180 days from the date of service to submit a claim to a Knox-Keene plan. (28 C.C.R. §1300.71(b).) If you submit bills to the plan during this period, and if the payment is inadequate, you have up to 365 days after the deadline for payors to contest or deny claims (45 days for HMOs, 30 days for PPOs) to file a dispute with the plan. For more information on filing a dispute with a plan, *see* CMA ON-CALL #1051, "Physician Complaints about Managed Care Plans."

22. If I submit the claim to the plan, and I am underpaid, should I use the plan's internal dispute resolution mechanism?

Again, that decision is up to you, and it is one of the options cited by the Supreme Court in *Prospect*. Physicians are reporting varying degrees of success with respect to a plan's internal process. Certainly it is preferable to get the full payment from the plan if you can. Further, if everyone went through the plan's process, plans hopefully would get a better understanding of the degree to which they underpay you, and improve their payment practices accordingly.

23. How can I show that my fee is reasonable?

As part of the dispute process, physicians may wish to send a letter to the plan specifying why they believe their reasonable fee was not paid properly. The DMHC has opined that payors must consider physician charges on an individualized basis to the extent the physician submits information on the regulatory factors set forth above as part of the claim submission or dispute resolution process. Attached is a sample letter that can be helpful when demonstrating those factors.

In addition, the AMA has developed the educational resource, "Fee schedule analysis: Using your complete practice cost as a guide" to help physicians and their practice staff recognize the need to establish their practice fee schedule based on what it actually costs to provide a service rather than basing their fee schedule on what a third-party payor or other entity decides is fair payment. This "defensible fee schedule toolkit" can be downloaded by AMA members from the AMA's website at www.ama-assn.org. Further, as is discussed below, the underpayment should be

immediately reported to the DMHC and CMA. For more information, *see* CMA ON-CALL document #1051, “Physician Complaints About Managed Care Plans.”

24. Will payment from the plan be considered payment in full?

It could be, particularly if the plan writes “payment in full” or other words of similar meaning on the check. Acceptance of that check, however, does not mean that the payor’s liability on the claim is satisfied if the physician (and CMA believes also the physician’s agent) protests the check by striking out or otherwise deleting that notation **before it is cashed**. (Civil Code §1526.) (CMA recognizes that this protection may not apply when funds are transferred electronically.)

25. Can I bill for co-pays, deductibles, and co-insurance? If so, when?

Yes, the regulation and Section 1379 expressly authorize you to do this. Both prohibit balance billing of patients for amounts “owed by the plan.” Co-pays, deductibles and co-insurance are not amounts owed by the plan, and thus can be recovered from the patient.

26. I heard that the DMHC set up an Independent Dispute Resolution Process to help with these disputes. Is that true?

Yes. The DMHC established an Independent Dispute Resolution Process (IDRP) in an attempt to afford non-contracted providers of EMTALA-required emergency hospital and physician services a fast, fair and cost effective way to resolve claim payment disputes with health care service plans and their capitated provider groups (collectively referred to as “payors”). The IDRP is voluntary for both non-contracted providers and payors. In order to submit a claim dispute through the IDRP, the provider must agree that, except for applicable co-payments and deductibles, it will not invoice, balance bill or otherwise seek to collect from the enrollee any payment for the subject services. In order for the payor to participate, it must agree to pay provider the amount found due, if any, by the IDRP, within fifteen (15) days of receiving notice from the DMHC of the IDRP determination. Participation in the IDRP process does not change a payors’ obligation to process and pay the claim within the statutory time period.

The physician will be required to submit an IDRP complaint form and a copy of the disputed claim(s) and required supporting documentation. The payor will also be required to provide supporting documentation. A physician may submit an individual claim or multiple claims (up to 50 claims) that are substantially similar in a single filing. For physicians who utilize the payor’s internal dispute mechanism prior to submitting a dispute through the IDRP, an IDRP decision should be rendered within sixty (60) days of receipt of the provider’s dispute form and all required/necessary supporting documentation. If the physician chooses not to first utilize the payor’s internal dispute resolution mechanism, the IDRP process will be more costly and may take up to 120 days to render a determination.

Voluntary participation in IDRP does not in and of itself waive any rights or remedies a provider may have against the payor, and that participation in IDRP may not toll any statute of limitations applicable to the exercise of such rights and remedies. Payments determined under the IDRP must be paid within fifteen (15) days of issuance of the decision.

More information on this process, including applicable fees, is available on the DMHC website at www.dmhc.ca.gov/providers/clm/clm_idrp.asp.

27. Can I still go to court to enforce my right to a reasonable fee?

Yes. The DMHC and the Supreme Court made it clear that a court action remains an available “recourse” for providers to seek proper reimbursement for emergency care services to a plan’s enrollee. Thus, if a physician disputes the payor’s calculation of a fair and reasonable value for services rendered, the provider is free to seek resolution of that dispute in a court of law or through any other available civil remedy. This interpretation has been confirmed by the courts. Physicians can seek collection through civil courts or, if the disputed amount does not surpass the jurisdictional limit, small claims court. CMA strongly encourages physicians to utilize the small claims court process, and to inquire whether your billing agent can do this for you. We also encourage you to let us know your degree of success through this process. For information on small claims actions, *see* CMA ON-CALL #1055, “Small Claims Action to Recover Payment.” We advise you to seek consultation with your personal attorney if you desire to take legal action.

28. What if my claim was denied because the service was not covered? Can I bill my patient for this service?

Yes. Physicians may bill their patients for non-covered services. The Supreme Court expressly recognized this possibility.

Non-contracting physicians also may dispute the denial with the plan, with or without notifying the patient of the dispute. (28 C.C.R. §1300.71.38.) Physicians can also encourage patients to file disputes for non-covered services with their plan.

STEPS PHYSICIANS CAN TAKE—ADVOCACY

Monitor Your Rate

29. Will the regulation further reduce the rates plans currently pay me?

It shouldn’t, but it could now that the plans believe they can make the final payment determinations. Physicians are urged to compare their non-contracted rates received prior to and post October 15, 2008, and report to CMA any significant changes. This information is being collected in the CMA survey, which is accessible through CMA’s website, www.cmanet.org. Further, it should be noted that the payment should never be below the DMHC minimum payment methodology. According to the DMHC’s September 2, 2005 Compliance Statement for the payment of non-contracted claims under the AB 1455 regulations, a reimbursement methodology may constitute an unfair payment pattern where it does not include:

- A payment methodology based on the 50th percentile or higher of a statistically credible aggregated billed charge database, updated (at least) annually, for the relevant geographic area; and,

- A payment methodology based on an amount at least 10%-20% above the payor's average contracts rates for similar services, and,
- A payment methodology based on an amount above the current Medicare fee schedule for similar services (unless the payor demonstrated that the payor's average contract rates for similar services is 10%-20% less than the current Medicare fee schedule); and
- Adequate procedures to timely and fully consider the remaining “*Gould*” criteria, as set forth in Rule 1300.71(a)(3)(B), upon the provider's submission of relevant supporting documentation as part of either the original claim submission or the payor's appeal process/dispute resolution mechanism. (For more information on the *Gould* criteria, *see* CMA ON-CALL #0121, “Authorization and Payment for Emergency Services.”)

Report Unfair Payments to the DMHC

30. What if the plan underpays me?

In addition to steps outlined in this toolkit, physicians are encouraged to report underpayments to the DMHC through its website, as an “unfair payment pattern” by the plans. For more information, *see* CMA ON-CALL #1051, “Physician Complaints about Managed Care Plans,” or visit the DMHC's provider complaint website at http://www.dmhc.ca.gov/providers/clm/clm_comp.aspx.

Send Letters to the Employer Community

31. What can or should I do to help advocate for fair contracting and payments?

Organized medicine, as well as individual physicians, needs to direct their advocacy towards the private sector and educate the public as to systemic underpayment by plans. We need to explain that the reason balance billing occurred was because Knox-Keene plans fail to offer physicians fair and reasonable contracts, and therefore fail to provide enrollees access to care through adequate networks, as the law requires. Toward that end, we believe that the employer community needs to be even more educated about what is happening in the marketplace and why the coverage they are buying for their employees does not provide what they are paying for—adequate networks.

However, to be effective, individual physician participation is essential. Accordingly, we urge physicians to protest the situation to their patients' employers. Physicians are also urged to contact the state and local chambers of commerce, either directly or as a copy to the letter to the patient's employer. While employers whose patients have received emergency services certainly should be contacted, even employers of patients in your current practice should be aware of the intolerable situation physicians face in the current environment. In your letters, it is important not to disclose any information concerning the identities or medical conditions of your patients. A sample letter is included in this toolkit.

NON-CONTRACTING PHYSICIAN – SAMPLE DEMAND LETTER FOR FULL PAYMENT FOR EMERGENCY SERVICES

[PHYSICIAN LETTERHEAD]

Date:

Re: Patient Name:

Insurance Carrier / Health Plan / IPA

Insurance ID Number:

Date of Service:

Billed Amount:

Payment Received:

Balance Due:

To Whom It May Concern:

I have received your partial payment for the emergent medical care I provided to the above referenced patient at (name of hospital/facility) in (city and state) on (date).

Your decision to pay less than my reasonable, usual and customary fee constitutes an unfair payment practice as identified in regulations implementing A.B. 1455 (Ch. 827, Stats. 2000), legislation that was enacted to protect both physicians and patients from this type of abuse by managed care plans. Moreover, this law was intended to ensure to the public continued access to highly skilled healthcare professionals. This letter is to appeal the arbitrary and capricious nature of your decision to underpay me for my services.

According to the unfair payment regulations, as a non-contracting physician you are obligated to pay me:

the reasonable and customary value for the health care services rendered 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 . . . (28 C.C.R. §1300.71(a)(3)(B).)

I used the following criteria as the basis for establishing the monetary value of my medical expertise and the high quality of medical care that I provided:

(Draft a model letter containing standardized language where possible, with alternative paragraphs when situations are different – e.g., extremely complex case versus routine case.)

- I am Board certified in (name of specialty) with (number) years experience in this field. (Add any additional qualifications (additional training or certification, clinical leadership roles, etc., that may be noteworthy).

- For on call physicians, discuss your on call status and the issue that the patients you are treating in this status are not your own patients – increasing the burden on you due to lack of patient background, relationship, etc. You may also want to discuss the disruption that occurs with your practice (missed appointments, rescheduling, disruption of personal time, extension of normal working hours, unusual travel requirements for rural physicians or during rush hours, etc. In general, articulate relevant issues that affect your charges, particularly if your fees are higher than they would be for an office visit).
- Confirm whether fees for these services are your usual and customary charges. If these fees have not been updated for an extended period, it may be useful to add the length of time these fees have been in effect (e.g., charging these fees for 5 years).
- To establish the comparison to prevailing rates in your area you may wish to obtain a copy of published source of fees, such as Medicode. If you find your fees compare reasonably, you can state that your fees are consistent with those of other physicians in the geographic area based on data published by (name of publication used for comparison such as Medicode).
- If your charges differ from the prevailing rates in your area, discuss the basis of your charges and their relation to any unique cost of providing medical care in your specialty, geographic area, etc. Include any information on practices costs and other considerations that you have used to establish your fees and that you believe are relevant.
- When relevant, note the medical care provided was extraordinary or more complex than usual or any other factor that may justify your fee not addressed above.

I believe I have demonstrated the reasonableness of my fees. Under Health & Safety Code §1371.4, (Health Plan / IPA) is responsible for the payment of all emergency services. Because the emergent nature of these services is not in dispute, I must insist on payment of the balance due without further delay, with interest.

[Further, pursuant to Health & Safety Code §1395.6(e)-(f), to the extent you are claiming entitlement to a contracted discount, you must demonstrate that you are entitled to pay this discounted rate within thirty (30) business days of receipt of this written request; your failure to do so renders you liable for my usual, reasonable and customary rate.]

Please do not hesitate to contact (name of contact) if you have any questions at (phone number).

Sincerely,

[Name of Physician]

cc: Department of Managed Health Care
California Medical Association
Health Plan (if contesting IPA payment)

SAMPLE LETTER FOR PHYSICIANS TO SEND TO EMPLOYER COMMUNITY

Note: If the physician is unable to identify the patient's employer, physicians are urged to send this letter to the state and applicable local chambers of commerce. [See bracketed language for revisions.]

Do not disclose patient-specific information

[PHYSICIAN LETTERHEAD]

[Date]

Address

Re: Inadequate Networks and Payment for Emergency Services

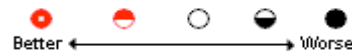
Dear _____:

I am writing to you to urge you to investigate an important matter concerning the insurance you [your members] purchased for your [their] employees. As you may be aware, as a [Name of Specialty] practicing in this community, I have had the privilege of providing medical services to a number of your [members'] employees. Toward that end, I commend you [the employer community] for providing your [delete "your"] employees with insurance so that they can maintain their health and obtain medical services if necessary.

Unfortunately, however, I have serious reservations that the insurance you [your members] have purchased for them [their employees] does not provide the benefits you [they] expected. With today's efforts to contain health costs, it is essential that employees be able to access care through a network of contracted physicians so that (a) employees can obtain care early enough, before their medical conditions worsen, and (b) employees do not incur the added financial responsibility for obtaining out-of-network care. Unfortunately, insurers fail to maintain adequate networks because they attempt to force physicians, such as myself, into contracts that are not clinically or financially appropriate for the type of care employees need. Despite our deep commitment to our patients, we simply cannot provide appropriate medical care under the restraints these contracts impose.

Independent studies confirm that patients are having tremendous difficulties getting seen by an appropriate physician due to inadequate networks. Despite laws requiring plans to contract with an adequate number of physicians, the most recent Consumers Report ranking of access to care in some of California's HMOs shows a very grim picture:

Consumer Reports Chart: Ratings for California For-Profit Plans – HMOs



Plan Name	Access to Physicians
PacifiCare of California	○
Health Net of California	●
Blue Shield of California Access + HMO	◐
Blue Cross of California HMO	●

When an HMO's or a Anthem Blue Cross or Blue Shield PPO network is inadequate, as is plainly the case with the HMOs in this state, everyone suffers. Insured patients unable to obtain care through a physician's office are increasingly seeing their medical conditions worsen as they are forced to delay or even forego care altogether, or visit a more expensive emergency department, further straining such departments, increasing waiting times and health care costs for us all.²

You may be aware of the debate that has plagued the Legislature for the last few years concerning "balance billing," that is, where non-contracting physicians have no choice but to bill patients for the remainder of their reasonable fee when the Knox-Keene plan underpays them for emergency services. This practice has been outlawed, but was the unfortunate by-product of inadequate networks caused by lack of fair contracting. Put another way, if the contracts are fair, physicians would contract, networks would be adequate, and balance billing would not have occurred.

The ban on balance billing does nothing to restore value for the premiums your members have paid to Knox-Keene plans. For example, the ban does not:

- ensure that employees have access to the right care at the right time through network physicians;
- reduce the incidence of employees going to more costly emergency departments for non-emergent care, or emergent care that could have been treated earlier if the network was adequate; or
- require, let alone encourage, fair and reasonable contracting that we all expect.

Knox-Keene plans will no doubt boast the ban on balance billing as a "victory" to take patients out of the middle of payment disputes. The only ones who win here are the Knox-Keene plans themselves. Everyone else loses. With their state-sanctioned ability to continue to underpay

² See Ann S. O'Malley, "Rising Pressure: Hospital Emergency Departments as Barometers of the Health Care System," Center for Studying Health System Change, Issue Brief No. 101, November 18, 2005. See also, Cunningham, Peter J. and Felland, Laurie E., *Falling Behind: American's Access to Medical Care Deteriorates, 2003-2007*, Tracking Report No. 19, Center for Studying Health System Change (June 2008), www.hschange.com/CONTENT/993/. See also, "Ambulatory Medical Care Utilization Reports," No. 8, August 6, 2008, Centers for Disease Control and Prevention.

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physicians, Knox-Keene plans no longer need to ensure they have an adequate network of providers so that patients can access care, and therefore Knox-Keene plans have even less need to provide the very value you [your members] expect when purchasing health insurance.

In sum, we will all continue to lose if the status quo remains. With inadequate networks, little, if any, value is being returned for your [members'] hard-earned premiums. Employees will continue to have inadequate access to care, potentially jeopardizing their health, but certainly increasing health care costs for everyone. Under these circumstances, we urge that when you [your members] purchase insurance, [they] ensure that the insurer is providing you [them] with an adequate network. If it does not provide the appropriate assurances, [we urge you to encourage your members to] express your [their] concerns to all appropriate parties so that whatever coverage you [they] purchase, in fact, has the benefits you [they] expect.

Thank you for your attention to this important matter.

Sincerely,

[_____, M.D.]

cc: California Chamber of Commerce
1215 K Street, Suite 1400
Sacramento, CA 95814

Local Chamber of Commerce

[*See* link at www.calchamber.com/BusinessResources/Pages/CountyListing.aspx for information listing chambers by county]