Health Care Reimbursement Conundrums: Priorities and Strategies for Commercial Payor Reimbursement in the COVID-19 Environment

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September 16, 2020

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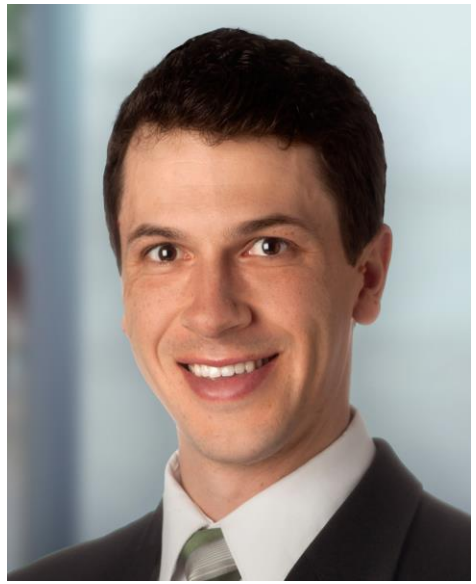

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Introduction

- COVID-19 Impacts on Health Care Industry Substantial
- Commercial Payor Focus Areas for Providers:
  - Claims Reimbursement During the COVID-19 Pandemic
  - Resolving Open Receivables on Past Commercial Claims
  - Responding to Recoupments and Overpayment Requests

Reimbursement Challenges During COVID-19

Challenges with Commercial Payor Claims Reimbursement During the COVID-19 Pandemic

- Overview
  - Ensuring proper reimbursement for COVID-19 related services
  - Objecting and disputing unilateral contract changes
  - Non-contracted payor reimbursement tactics and protecting the provider's rights

Ensuring proper reimbursement for COVID-19 related services

- Focus Areas for Reimbursement of COVID-19 Related Services
  - COVID-19 Diagnosis Services
    - Billed properly with applicable codes and modifiers?
    - Proper reimbursement paid?
  - Laboratory Testing Services
    - Proper rate paid?
    - Improper denials or self-pay responsibility imposed?
  - Waiver of Patient Responsibility
    - Did payor apply properly?
    - Were claims paid in full by commercial payor?

Ensuring proper reimbursement for COVID-19 related services cont'd

- Modified Delivery due to COVID-19
  - Telehealth Services
  - Alternative delivery sites of care
  - Extended Stays due to Required Testing/Clearance, Special Units
- Considerations:
  - Are commercial payors adhering to applicable state or federal waivers?
  - What authorization exists?
  - Basis for denial/underpayment
  - Present to payors as special projects

Objecting and disputing unilateral amendments

- Commercial Payors issuing unilateral amendments:
  - Contract Amendments to revise material terms, e.g. reimbursement
  - Purported Regulatory Amendments, e.g. required by law
  - Policy and Provider Operations Manual Amendments
- All are being used to unilaterally modify provider rights or obligations!
  - Changes are not all COVID-19 related

Objecting and disputing unilateral amendments cont'd

- Assess Changes – are they material? Do they conflict with existing terms in agreement?
  - Changes to "routine" language in contracts
    - Medical Necessity & Site of Service
    - Covered Services
    - Timely Filing
  - "Declared" broad medical policy changes
    - Provider manuals/reference guides
    - Other information incorporated into contract by reference

Objecting and disputing unilateral amendments cont'd

- Assess contract requirements and terms
  - What notice is required? Was it followed?
  - What protections exist? Made whole?
- State law requirements or protections
  - Cite any protections under state law
- Submit objection letter(s) with all available grounds, and escalate as provided by contract
  - Appeal impacted claims

Non-contracted payor reimbursement tactics and protecting the provider's rights

- Landscape:
  - Providers seeing more non-contracted payor members through emergency room
  - Payors reimburse unilaterally derived amounts:
    - "Usual & Customary"
    - Reference Pricing
    - Line item denials, e.g. "unbundling"
  - "Surprise Billing" laws across states
  - Limited timeframes to respond and protect rights

Non-contracted payor reimbursement tactics cont'd

- Special Considerations for OON Disputes
  - Understand rights assigned by patients in Assignment of Benefits (both legal and equitable rights)
  - Understand if denial issue involved in addition to reimbursement level
  - Identify the true payor and product type
    - Insurer
    - Self-funded ERISA plan and TPA
    - Patient responsibility identified on EOB
  - Review course of dealing with OON payor
  - Understand that administrative appeal requirements still apply

Non-contracted payor reimbursement tactics cont'd

- ONN Dispute Escalation
  - Have a strategy with clear objectives
    - Resolve claims only? Go-forward Contract?
  - File 1-2 levels of appeal – 90-180 day requirements may exist
    - Demand copy of benefit plan to assess OON terms and that payor demonstrate compliance with ACA's greatest of 3 methodology
    - Accord & Satisfaction Involved? Refund may be required
  - Attorney demand letter (in-house/outside counsel) or broader proposal
  - Litigation
    - Mediation or arbitration by stipulation

Identifying and Resolving Issues With Underpayments

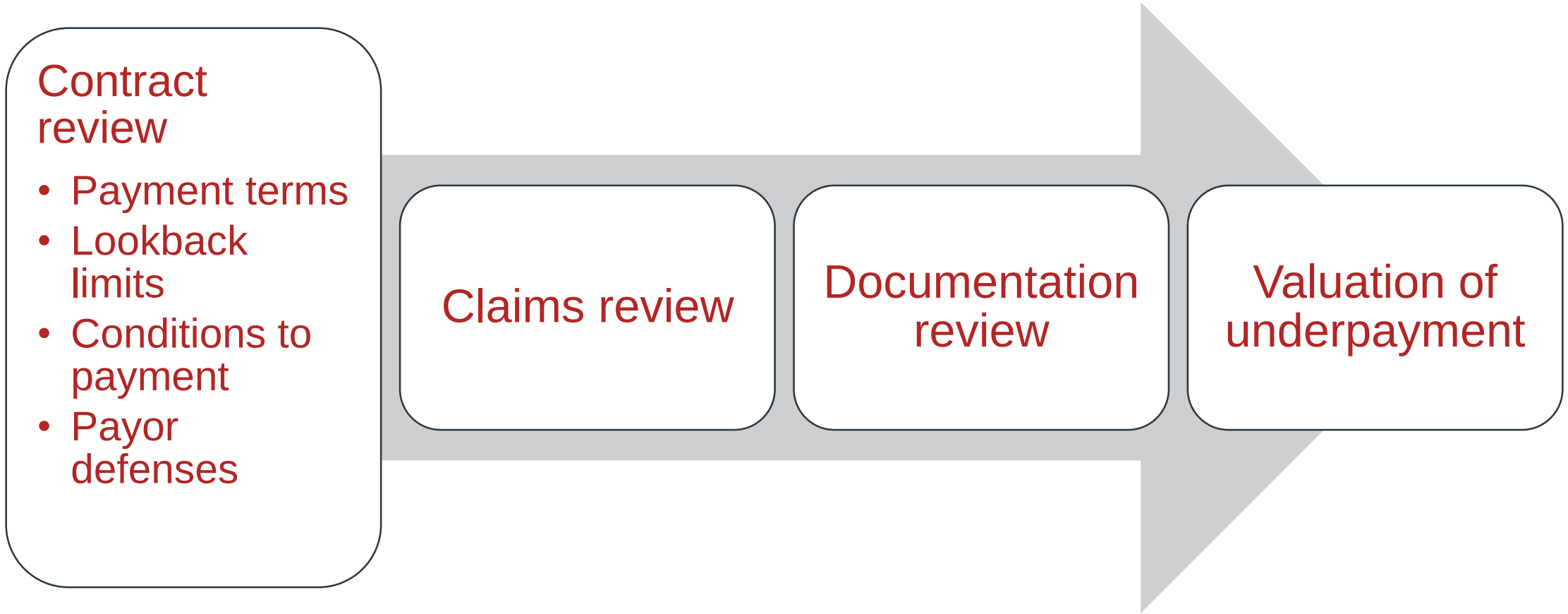
Window of Opportunity to Act

- COVID-19 has been a huge boon to commercial health insurers
  - Deferred care due to COVID restrictions decreased outlays
  - Record profits for commercial insurers:
    - UnitedHealth - $6.6 billion in Q2
    - Anthem - $2.3 billion in Q2
    - Humana - $1.2 billion in Q2
- Maximum Loss Ratio (MLR) concerns
  - ACA requires 85% in large group market; 80% in small group market
- Opportunity for insurers to resolve provider underpayments to achieve MLR goals

Identify Underpayments

- Known: Unexpected claim denials/underpayments
- Unknown: Discovered via internal claims audit
  - Scope of unexpected claim denials/underpayments
  - New payor policies
  - Incorrectly calculated allowed amounts
  - Incorrectly priced claims (Remember Ingenix?)
  - Failure to timely implement charge master increases
- Prioritize top procedure codes

Assess Validity of Underpayments



Contract Terms

- Evaluate Payor Liability – fact specific
  - Confirm it is a “Covered Service” and not “carved out”
  - All conditions to payment met (e.g. PA, medical record support, original claim was complete and “clean”)
  - If reason code on denial, evaluate contractual support for that code
- Payor Defenses
  - Contractual or statutory limitation period
  - Failure to exhaust payor administrative appeals process
  - ERISA preemption of state law (e.g. prompt payment penalties)

Initiate Claim Appeals

- Appeal individual claims ASAP
  - Send copy of fee schedule
  - Send medical record
  - Speak with medical director
- Bulk appeals and demand letters by issue
- Seems obvious but many providers don’t do it
  - Appeals may be required in order to pursue ADR

Initiate Dispute Resolution Process

- Trigger formal dispute resolution process under the applicable contract
  - Commonly notice and a requirement for parties to confer
  - Preserves rights
- Send Demand Letter
  - Attach detailed claims file and fee schedule
  - Assert prompt payment penalties
- Opportunity for ADR/litigation if underpayment is disputed

Audits, Recoupments and Offsets

Background

- Payors use the audit process to “discover” payment discrepancies.
  - Payor audits continue during COVID-19; anticipate ramp up
- After the audit, payors issue a recoupment request:
  - If INN, through a provision in the provider agreement, if applicable;
  - If INN or OON, based on an payment policy.

Recoupment verses Offsets

- Recoupments:
  - Sends provider “notice of overpayment”
  - Within a set number of days, the provider must repay
  - Should allow an appeals process
- Offsets:
  - Payor marks claim as “paid” but withholds/reduces payment on claim B
  - Credits a previous “overpayment” on claim A the reduced amount for claim B
  - Considered self-help
  - Used by payors if provider does not requested recoupment amount.

Challenge: Breach of Contract

- If INN, the contract will govern the right to audit and the right to recoup.
- Was audit conducted properly under the contract?
- Was the recoupment properly noticed?
- Were applicable dispute resolution procedures?
- State laws may also govern in-network recoupments.

Challenge: Violation of State Laws

- Many states have laws governing recoupments that:
  - Set the time period to recoup (1-2 years);
  - Set framework for notice and appeals;
  - Allow or prohibit offsets (may be silent);
  - Provides exemptions, such as fraud or intentional misconduct.
- Does contract incorporate state laws?
- Does state law prohibit contracting around the recoupment statute?
- For OON, recoupment statutes may be preempted by ERISA.
  - Most employer-sponsored plans are governed by ERISA.
  - Exceptions include: governmental, exchange and church plans.

Challenge: Voluntary Payment Rule

- Many states have adopted the Voluntary Payment Rule
- An equitable defense
- *A person cannot recover money which he has voluntarily paid with full knowledge of the facts*
- Exceptions may include fraud, duress or mistake of fact

Challenge: ERISA Lawsuit

- Many jurisdictions consider recoupments “adverse benefit determinations.”
- Provides statutory protections:
  - Disclosure requirements, notice, appeals, and document production.
- To pursue, OON provider must have a broad assignment of benefits (AOB).

Assignment of Benefits (“AOB”)

- OON providers acquire the legal standing to challenge recoupments through an AOB that includes:
  - Right to direct payment;
  - Right to exchange information and documents; and
  - Right to file claims, file appeals, and file a lawsuit for both legal and equitable relief and penalties.

Anti-assignment Clauses

- Many plans now include anti-assignment clauses that prohibit members from assigning their rights to providers.
- POA: The 3rd Circuit stated that an inclusive and valid Power of Attorney may be used to get around an anti-assignment clause. *American Orthopedics v. Horizon Blue*, 890 F.3d 445 (3rd Cir. 2018)

Anti-assignment Clauses

- Designation of Authorized Representative:
  - Payors often allow members to designate an authorized representative to file appeals.
  - Each patient should sign such a Designation upon admission/receipt of service.
  - The Designation of Authorized Representative Form should conform to the payor's form. *Avera McKennan v. Meadowvale Dairy Employee Benefit Plan*, 374 F. Supp. 3d 771 (N.D. Iowa 2019)
  - Uncertain if such can be used alone to file a lawsuit on the patient's behalf.

Offsets

- Used by payors to capture alleged overpayments if provider refuses to pay recoupment demand.
- Contract and state statutes may address payor's right to offset in provider contracts and state statutes.
- Alternatively, the payor might file a lawsuit for equitable relief under ERISA.

Tracing Requirements for Recoupments under Section 502(3)(a)

- Payor must show it has an “equitable lien by agreement” in an overpayment provision in the individual health benefit plans.
- If not, the payor must show it as an “equitable lien by restitution” and be able to trace the paid funds.

Sereboff v. Mid Atl. Med. Servs., Inc., 547 U.S. 356 (2006); *Central States v. Sp. Health Risk Inc.,* 756 F.3d 356 (5th Cir. 2014); *Montanile v. Bd. of Trustees of the Nat’l Elevator Indus. Health Plan,* 136 S. Ct. 651 (2016)

Cross-plan Offsetting

- Withholding payments for services for a participant enrolled under plan A to credit an alleged overpayment for services enrolled under plan B.
- This scheme is suspect when involving self-insured plans.
- In 2018, the 8th Circuit ruled in favor of an OON provider alleging the plan engaged in cross-plan offsetting though it was not allowed expressly by the plan.

Peterson v. United Healthcare

- "*Cross-plan offsetting is in tension with this fiduciary duty because it arguably amounts to failing to pay a benefit owed to a beneficiary under one plan in order to recover money for the benefit of another plan*."
- Provider had standing to file the suit due to a sufficient AOB.
- Did not address whether cross-plan offsetting was generally a violation of ERISA.

913 F.3d, 769 (8th Cir. 2019)

Case to Follow: *Scott, et al v. United Healthcare*

- In the District Court in Minnesota in the 8th Circuit, same as *Peterson*.
- Plaintiffs brought direct class action (not through an AOB) as beneficiaries from CenturyLink, Inc. and AT&T health plans administered by United.
- Alleged breach of fiduciary duty and duty of loyalty pursuant to ERISA §§ 502(a)(2), (a)(3) and 409.
- Challenges United's right across *all* its ERISA plans to engage in cross-plan offsetting regardless of particular plan language.

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