THE GIBSON FIRM
Healthcare Law

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Trends in Healthcare Law

Federal Health Insurance Reform

The Patient Protection and Affordable Care Act (PPACA) was enacted last year and created many reforms that have already taken effect:

- No pre-existing conditions for children
- Extension of dependent coverage for young adults
- Free preventative service benefits
- Abolishment of lifetime benefit caps
- Regulations on annual benefit caps
- Prohibition of coverage rescissions
- Expanded appeal procedures

Additionally, 2011 marks the implementation of the medical loss ratio—requiring insurers to spend 80–85% of premium dollars on clinical services and quality activities.

Insurance reform is a dynamic concept, as agencies charged with implementing the law continually release guidance on implementation. Stay tuned this year for updates!

Trends in Group Health and Commercial Reimbursement

Repricers and "Cost Containment" Solutions

In 2010, we saw an explosion in the number of benefit plans employing repricers and "cost containment" companies. Typically, these companies offer to review charges submitted by providers and reduce the charge to a "reasonable" amount under the auspices of "usual and customary" reimbursement. In exchange, the repricer is usually paid a percentage of the difference between the billed charge and the repriced amount. This arrangement frequently results in payments to the repricer that exceeds payments to the provider for medical services.

Repricers and cost containment companies purport to use "proprietary information," often characterizing it as "industry accepted" or "national." In fact, most repricers do little more than access discredited databases, such as Ingenix, or use a Medicare plus formula, such as reimbursement at 125% of the Medicare rate.

Although it is often difficult to determine whether a plan is using a repricer, there are several key indicators:

- EOBs that falsely state the adjustment is based on a contract or negotiated rate when there is no agreement
- Delays in processing and payment of claims
- Drastic changes in reimbursement rates during a course of treatment for later dates of service—sometimes these will be accompanied by refund demands for earlier dates of service
- Involvement of reinsurers, who often require the use of repricers

Repricers and cost containment companies should be aggressively fought. They rarely comply with applicable plan language and frequently mislead providers, plans, and patients. The Gibson Firm has successfully handled repricers in the past and looks to continue preventing these abusive reimbursement practices in the future.

Medicare Secondary Payer

Despite the longstanding prohibition against such activity, Group Health Plan's (GHPs) continue to search for ways to take Medicare into account, denying plan member's benefits to which they are entitled and leaving the federal government to pay for treatment cost the GHPs are required to cover.

The Gibson Firm has encountered two main trends in this area. First, GHPs often drastically reduce benefits to Medicare beneficiaries, knowing that the beneficiary cannot be balanced billed because of federal laws protecting Medicare beneficiaries from financial liability. GHPs often reduce reimbursement only upon Medicare entitlement, paying at a different rate until then. Second, rather than terminating GHP coverage upon Medicare entitlement—a practice The Gibson Firm helps to prevent—many

GHPs are now converting enrollees from GHP coverage to Medicare Advantage coverage upon Medicare entitlement. While many of these conversions are legal, many are not. The result is that the provider often receives less reimbursement, the GHPs incur less cost, and the federal government pays despite laws in place to prevent these occurrences.

COBRA Coverage

Existence of COBRA coverage, with all of its deadlines and mind-numbing rules, creates headaches for providers, but managed effectively, also provides reimbursement unavailable without the coverage.

Plans required to offer COBRA also see it as a headache, but for the opposite reasons. Plans want to avoid extra reimbursement and they adroitly use the complex laws and regulations to do so. In order to effectively combat plans attempting to shirk COBRA obligations, providers must be alert to COBRA laws.

Here are a few things to watch for:

- Premium increases—plans can charge up to 102% of the actual cost of coverage; however, premiums cannot be increased more than once annually and excessive increases are prohibited
- Changing policy numbers—plans often change the policy numbers on COBRA policies, making it extremely difficult to verify coverage and pre-authorize treatment
- Improper notice of status—plans that terminate coverage before the grace period are required to tell inquiring providers that there is no coverage but coverage will be reinstated if premiums are paid within the grace period; plans that do not terminate coverage before the grace period ends are required to tell inquiring providers that coverage will be terminated if no payment is made within the grace period
- Early termination—coverage can only be terminated in certain circumstances

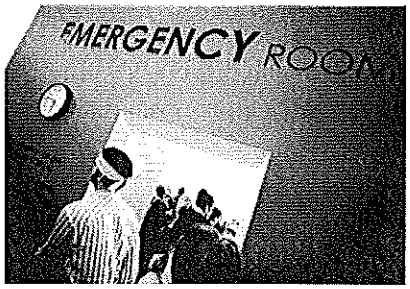
Retro-Termination of Coverage

We continue to see huge numbers of retro-terminations, often occurring when coverage is verified, but an employer subsequently notifies the insurer or TPA that employment terminated at an earlier date and coverage is no longer available.

Retro-terminations lead to outright denials and refund demands or recoupment efforts. The Gibson Firm vehemently fights refund demands and recoupment efforts arising from retro-terminations. Providers should not be forced to bear the loss created when an employer does not promptly communicate termination with an insurer or an insurer does not promptly update its records. The Gibson Firm also pursues insurers and employers for unpaid balances when claims are denied because of retro-terminations. When providers do everything right, they should not be denied reimbursement for valuable medical services rendered.

Emergency Services

Hospitals, required to provide certain services in emergency situations, are seeing increasing denials of emergency room claims as insurers and plans seek to avoid paying for costly services. In most situations, plans cannot deny the claim based on network status, so claims are frequently denied for medical necessity. In many circumstances, insurers and plans are not allowed to second guess the medical judgment of attending physicians, whose determination that the service rendered is medically necessary actually triggered the duty to treat.



Insurers who deny medical necessity of emergency services are blatantly disregarding public policy (and frequently the plan letter of the law). The Gibson Firm can work to ensure that providers are not harmed by fulfilling their obligations to provide emergency services.

Coordination of Benefits

Recently, United Healthcare announced that it is changing its coordination of benefits procedure. UHC will no longer determine conclusively whether it is primary or secondary before paying claims less than $10,000 (previously, UHC implemented this procedure for claims under $400). While UHC is spinning this as a positive for providers because claims will no longer be pended for COB information, UHC will continue to

pursue COB information—but it will be done after the claim is paid. The change means that when UHC identifies situations where they could have (or believe they could have) paid secondary benefits, they will seek refunds or recoupment. Ultimately, this change will decrease UHC's administrative burdens and give them more time to identify secondary situations while increasing providers' administrative burden.

We expect this change to result in increased refund demands and recoupment activity. We also expect that other insurers have either already adopted similar approaches or will soon follow suit. Refund demands and recoupments, especially when brought about by the payer's egregious derogation of responsibility at the time of payment, should be aggressively fought and defeated.

Refund Demands

One result of the actions discussed in the preceding topics is an increase in payer refund demands and unilateral payment offsets.

When you treat a patient, you are entitled to payment up to the full amount of your usual and customary billed charges, as long as the payment does not exceed your billed (or contractual) charges. Providers are protected by a number of state and federal laws which supersede contract language to the contrary. Payers are not simply entitled to "help themselves" to a refund through offsets and recoups. Providers have the recourse of appeal before any offsets or recoupment; and frequently the contracts are written to state that any offset or recoupment requires the provider's approval in advance.

After many years of challenging such demands, The Gibson Firm has found that most payers ultimately withdraw such demands, or discontinue pursuing them, when properly and vigorously challenged.

Alternative Sources of Reimbursement

Accident Victims and Hospital Liens

More and more insurance companies and personal injury attorneys are trying to settle claims for motor vehicle accidents with the patient and leaving it up to the patient to pay the bills. This practice does not protect your investment and often results in unpaid medical bills.

The Gibson Firm will protect your interests by filing a valid hospital lien, following up with all involved parties and ensuring that your lien is paid when settlement occurs, therefore eliminating the hassle of trying to pursue the patient for payment after settlement occurs.

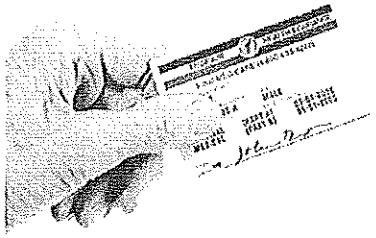
Medical Bill Payment for Victims of Crime

In the U.S., all 50 states have crime victim compensation programs that can provide substantial financial assistance to victims of crimes and help get your bills for these services paid. Maximum benefits available from the states average $25,000. Eligible victims include victims of rape, assault, child sexual abuse, drunk driving, and domestic violence, as well as the families of homicide victims.

Telling crime victims about compensation programs is a responsibility shared by those who provide medical care to victims of crimes. It is one that may very well ensure that your treatment expenses are paid.

The Gibson Firm works with the provider and the patient to ensure program compliance and that program benefits for related medical claims are paid directly to the provider.

Medicare and Medicaid



Medicare Advantage Plans: New Non-Contracted Provider Payment Dispute Process

Through a new program, non-contracted providers who are paid less than original Medicaid would have paid for a covered service, may obtain an independent review of the claim by CMS' Payment Dispute Resolution Contractor. The provider must first obtain review from the MA plan. If the MA plan affirms its original decision, the provider may request an independent review by submitting the request in writing within 180 days from the MA plans final decision.

This new process is only available for situations in which a

payment is made and the amount is disputed. Complete denials or delays in making any payment whatsoever continue to be handled through the standard non-contracted provider appeals process.

Medicare Advantage Plans: Document Requests

MA plans have recently stepped up document requests to providers. These requests are often vaguely worded and purport to be prompted by CMS Risk Adjustment Data Validation audits; however, production often leads to identification of "overpayments" and resultant refund demands. MA plans are attempting to deceive providers into voluntarily providing requested documents by implying that they are needed by CMS. Records provided voluntarily may be used for whatever purposes the MA plan wishes.

While it is possible that CMS will need documents from providers in connection with a RADV audit, such requests will always be accompanied by an official letter from CMS explaining the reason for the request. If such letter is not provided or if there is any reason to doubt that the MA plan's request is made in connection with an actual CMS initiated audit, providers should clarify the purpose of the request.

When dealing with a non-CMS-initiated records request, providers are not required by CMS to comply. Providers may have contractual agreements with the MA plan that obligate cooperation, but those are beyond the purview of CMS.

MA plans are also using record requests to delay payment of claims. MA plans are required to pay clean claims within the times specified in provider contracts. Plans cannot avoid these obligations by requesting records and delaying payment.

The trend of increased MA plan-initiated record requests adds administrative burden on providers, and compliance with these requests potentially exposes the provider to refund demand activity. Refund demands can be prevented by ensuring documents are supplied only when required by CMS or contract provisions.

Medicaid moves to EDS

On November 1, 2010, Medicaid implemented a system conversion. EDS won a seven year contract to design, develop and implement a new Medicaid Management Information System for the state of Georgia. With the implementation of the new system, providers are finding themselves with delays in processing of their claims. At The Gibson Firm, we have established a successful working relationship with DCH and can ensure that your claims not only remain timely, but follow up to expedite proper claim processing. Whether it is a regular claim or a claim requiring DMA526 expertise, we are here to help.

The Gibson Firm

The Gibson Firm is a small, full-service healthcare law firm. We are located in metro-Atlanta, Georgia, though we routinely handle cases throughout the United States. We are highly specialized in medical reimbursement issues, primarily representing hospitals, long-term acute care and rehabilitation centers, outpatient facilities, large physician groups, dialysis facilities and similar specialty medical practices.

We are proud to be known as not only a law firm, but as provider and patient "advocates" due to the wide range of services we provide in these areas. Our focus is not centered strictly on the "legal issues" pertaining to a specific case, but on finding solutions that benefit our clients, other healthcare service providers, and their patient's long term.

For information on how The Gibson Firm can help you increase your bottom line while freeing you to provide the care your patients need and deserve, contact us at:

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