Private Payor Class Action Lawsuits:
WHAT YOU NEED TO KNOW TO MAKE A DIFFERENCE IN YOUR PRACTICE

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PHYSICIAN BILLING –|– PRACTICE MANAGEMENT

Introduction and Background

Since 2004, a series of settlements in class action suits brought principally by the American Medical Association and several large state medical societies against the nation's major managed care companies have - to greater or lesser extents - compelled the health plans to discontinue practices that systematically denied physicians' reimbursement for services rendered to patients.

A primary complaint by the medical societies was the widespread carrier practice of bundling services to avoid paying physicians for specific CPT codes. "Bundling" in this context refers to the use of claim editing software to review certain procedure codes, e.g. a head laceration from a motor vehicle accident, which may be used with a CPT modifier (the -25 modifier) in conjunction with an "evaluation and management" (E/M) service, e.g., CPT 99283 (emergency department visit involving a limited exam and moderate decision making.).

Carriers essentially would bundle the procedure code into the E/M service (or vice versa) and not reimburse for the procedure code. These practices, it was alleged, were not compliant with the Current Procedural Terminology Version IV (CPT-4) coding, which is the standard for professional services coding and billing according to federal HIPAA regulations (HIPAA mandated that CPT-4 codes be used for healthcare transactions). See www.hmosettlements.com.

The settlements have included significant payouts to physicians nationwide and, among other things, prohibited the managed care companies from automatically downcoding. The agreements also required fair coding and bundling rules consistent with CPT, transparent fee schedules and claim edits and a formalized dispute resolution process.

Agreement Expirations Beginning

Although the settlements marked a major victory for physicians, it is critical to note that several of the agreements were effective for four-year terms and the earliest of those settlements will soon expire or have already done so. The Aetna and CIGNA agreements expired on June 2, 2008 (Aetna) and September 4, 2007 (CIGNA), respectively, and Anthem/Wellpoint expired on July 15, 2009.

Consequently, physician groups should reacquaint themselves with the terms of the settlements to ensure a clear understanding of both the agreement's timetable and the conditions stipulated in the settlements. CIGNA, for example, announced in April 2009 (after its settlement agreement expired) that certain code combinations would not be separately eligible for reimbursement, even though other health plans, including Aetna, had been successfully challenged under the settlement agreement and agreed to reimburse for these same code combinations, e.g. CPT 93010 (12 lead ECG) with an emergency department E/M service.

Fortunately, the national Blue Cross Blue Shield (BCBS) Settlement provisions are early in their four-year cycle and thus provide physicians with the opportunity to address complaints with BCBS through a court-ordered and independently monitored legal process. The effective date of the key provisions of the BCBS national settlement was January 18, 2009 (9 months from the final settlement date in 2008), and the agreement's term is currently set to run for a four-year term and expire in 2012. The nine-month transition period from the 2008 settlement date was to permit BCBS plans to bring their systems, policies and procedures into full compliance with the settlement agreement.

Understanding the Agreements

Physicians and practice managers should take the time to reacquaint themselves with the nature of the disputes that triggered the original class action litigation. The American Medical Association provides information about the BCBS settlement agreements on a state-by-state basis at www.ama-assn.org/ama/no-index/ advocacy/17963.shtml.

In addition, details about the entire range of carrier settlements can be found at www.hmosettlements.com. Most state medical societies likewise are well-versed in the specifics of settlements involving health plans in their regions.

Although the language of settlements signed by the carriers varies, the agreements generally included the following changes in business practices:

- Clinical definition of medical necessity
- Prohibition of downcoding evaluation and management codes
- Compliance with most CPT rules, guidelines and conventions, including recognition of standard modifiers, e.g. the -25 modifier
- Disclosure of fee schedules and payment rules, including the explicit listing of "significant edits," i.e. edits that cause the denial of payment
- Prohibition of gag clauses
- Prohibition of "all products" clauses
- Prohibition of "most favored nation" clauses in physician contracts
- Faster credentialing
- Prompt, external dispute resolution

Vigilance Required

Physicians should be particularly vigilant during contract negotiations and renewals to ensure that health plans are complying with the letter and spirit of the settlements. While the agreements ostensibly preclude managed care companies from imposing onerous provisions that restrict reimbursement by disregarding CPT conventions, certain health plans may be reverting to these practices or may ignore the stipulations unless challenged. In addition, many of the pre-lawsuit managed care agreement forms are still in circulation and may contain provisions that could be in violation of the settlement agreement provided the provisions are challenged by the providers.

As a result, physician groups must scrutinize all contract language and eliminate any provisions that give carriers blanket authorization to pay based on "standard payment policies" or other, equally broad language. If these "standard payment policies" are based on bundling edits that do not recognize certain procedures coded and billed with the -25 modifier (for example, a procedure is not "separately eligible for payment" but instead is bundled into the E/M service) then the payment provisions could violate the settlement agreement.

Because failure of the health plans to recognize and reimburse procedures and E/M services coded and billed with the -25 modifier was one of the major problems cited in the original class action lawsuit, specific protections and provisions that the health plans have agreed to exist in the settlement agreements to prevent bundling based on the use of the -25.

During contract negotiations, physicians should strike any language that gives the carrier latitude to pay according to "standard bundling methodology" or any similarly vague payment parameters. Instead, the managed care contract should specifically define the codes that will be paid, including all modifiers, so there can be no disagreement regarding what is covered. If the carrier balks, the physician negotiator should point to the settlement agreement and note that the carrier has already voluntarily agreed to the stipulations the negotiator seeks.

Too often, physicians will focus only on the reimbursement rate during negotiations and assume that the remainder of the contract language is essentially boilerplate that will have no bearing on payments made by the carrier. It is only later that they realize they've inadvertently signed off the very practices the class action settlements were meant to prevent. The result can be a significant loss of practice income. In some instances, up to 20-to-30 percent of codes may be disqualified.

Dispute Resolution

One of the key elements in the settlement agreement is a formalized mechanism that allows for arbitration in the event a dispute cannot be resolved amicably between the parties. The process involves a tiered approach that initially relies on a compliance dispute mediator who will attempt to bring the parties together to resolve the issue without arbitration. Failing that, the dispute is then escalated to a special master (formally known as the Compliance Dispute Review Officer or CDRO), who will either hold additional hearings or eventually make a binding arbitration agreement. In bringing complaints to the dispute resolution process, it is important for physicians to collect evidence that demonstrates a "systemic problem" and not merely isolated incidences of alleged wrong behavior.

Knowledge is Power

Despite the success of the settlement agreements in changing the behavior of managed care companies, physicians must not let down their guard, particularly as the settlement agreements expire. An in-depth understanding of the terms agreed to in the settlements, rigorous scrutiny of carrier behavior and a pro-active stance during contract negotiations should ensure that physicians continue to receive payments to which they are entitled.

Edward R. Gaines, III, JD, CCP serves as Vice President and Chief Compliance Officer for MMP. Prior to MMP's November 2007 acquisition of Healthcare Business Resources, Inc. (HBR), he was Senior Vice President Compliance and General Counsel for HBR. He had responsibility for the legal affairs and compliance functions for all of HBR and served on HBR's Board of Directors. Mr. Gaines is actively involved in legal, coding and compliance issues regarding Medicare Part B billing with CMS, Medicaid intermediaries and commercial payors. For the past several years, he has served on the faculty for the American College of Emergency Physicians (ACEP) national Reimbursement Conference and has presented frequently to state ACEP conferences. In 2006, he received the North Carolina College of Emergency Physicians (NCCEP) Outstanding Emergency Medicine Advocate Award. For several years, Mr. Gaines served as co-chair of the Health Ethics Trust Best Health Care Compliance Practices Forums and in 2003; he was named as a Fellow in the Health Ethics Trust. He serves on the Board of Directors of the Council of Ethical Organizations. Mr. Gaines is a co-founder, past chairman, current Executive Committee and Board of Directors member of the Emergency Department Practice Management Association (EDPMA). In May 2008, EDPMA presented him with its highest honor, the EDPMA Founders Award. Mr. Gaines graduated from Alma College, Bachelor of Arts with honors, and Wake Forest University School of Law, Juris Doctor. Mr. Gaines is a member of the North Carolina State Bar, North Carolina Bar Association's Health Law Section and the Bar of the United States Supreme Court. He is based in Greensboro, NC.

About MMP

Based in Chattanooga, Tennessee, MMP has more than 80 offices and 2,000 employees nationwide. Founded in 1993, MMP serves more than 3,000 hospital-based physicians across the nation and boasts the highest client retention rate in the industry.

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