

EXECUTIVE BRIEFING

Dispelling the Myths of Out-of-Network Billing

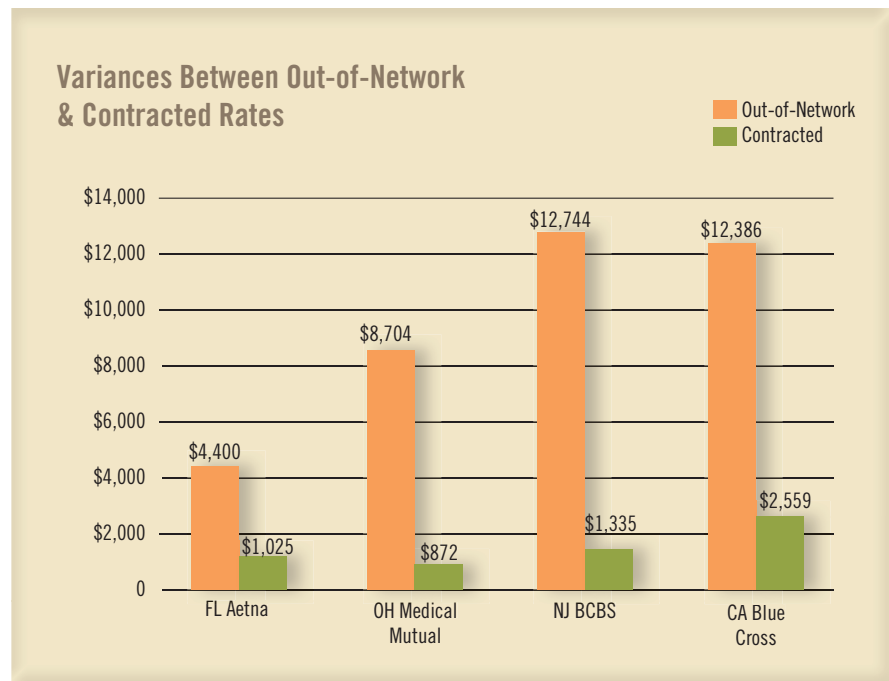
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Executive Summary

There is no more controversial issue in the outpatient market today than out-of-network billing. It is important to understand the risks as well as the benefits for your ambulatory surgery center (ASC). This is particularly true given the dramatic legislative changes and evolving insurance company responses to out-of-network billing that have recently been implemented.

What does being out-of-network mean? Very simply, it refers to a provider that does not have a contract with an insurance carrier. Most providers are out-of-network to some degree and no ASC or physician is contracted with every payor. The controversies around out-of-network billing usually relate to how the non-contracted ASC determines the amount it charges patients who are insured by non-contracted insurance carriers. Typically, charges are based on “usual, customary and reasonable” (UCR) charges. There are huge rewards and risks related to being out-of-network and billing charges at UCR.

There are generally three main categories of risk in terms of out-of-network billing – business, legal and regulatory concerns. If it is done right, it can be extremely beneficial for your ASC, and if the out-of-network billing is done wrong, the consequences can be devastating. This briefing will offer insights into the issues and how to handle them.



Risk #1 – Business Issues

Among the most pressing issues, is the impact on cash flow. Like any business, an ASC needs money to survive and one of the big benefits of contracting with a carrier is that claims are generally paid within 30-60 days of submission. Particularly during challenging times, it can be very important for an ASC's cash flow to have contracts that pay quickly.

In the majority of instances, quick payment is not the case with out-of-network claims, despite the fact that most states require claims to be processed and paid in a timely manner. Statistically, about a third of cases are paid within 60 days. However, in

the balance of those cases, payment is delayed, sometimes significantly because of additional questions and further information requested by the insurance carriers.

As a result, ASCs must have sufficient capital upfront or an established asset based credit line (ABL) to cover cash needs. The ABL provides money in advance based on billings, but if the ASC has a high percentage of out-of-network cases, it is important to negotiate the eligibility period for receivables under the ABL (typical eligibility periods range from 120-150 days from the date of service).

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Another huge problem involves various attempts by insurance carriers to avoid paying at UCR charges. A typical example is the artificial fee schedules applied by some carriers in certain states. Generally, insureds pay a higher premium for the right to choose out-of-network physicians and facilities. The insurer agrees to pay a certain percentage of billed charges calculated commonly by its determination of UCR charges, reserving the right to reimburse the lower amount of the two. But how are those costs determined? Most insurers use healthcare billing information collected from privately-owned databases to determine UCR charges. Many large insurers used Ingenix, the nation's largest provider of healthcare billing information and a wholly-owned subsidiary of UnitedHealth. Recently, the New York Attorney General filed suit against Ingenix for manipulating data to determine UCR charges that were too low, which led to underpaying physicians and facilities, thus forcing patients to pay undue costs for out-of-network medical services.

As part of a settlement reached in this case, UnitedHealth agreed to close the Ingenix database of healthcare billing information and provide funds, along with several other companies, to set up an independent database run by a qualified not-for-profit organization. The organization will be the sole decision-maker for all data protocols and methodologies. It will make rate information available to health insurers and develop a website for providers and consumers to see in advance how much insurers will pay for common out-of-network medical services in their area. It is expected to help bring much-needed transparency to healthcare. This increase in transparency may lead some patients to question whether they are obtaining value in consideration for the far higher fees typically charged by out-of-network providers.

UCR charges will continue to be an issue in litigation as this settlement will lead to more litigation over whether insurers have been underpaying for out-of-network services.

Another business risk is that providers must deal with patients "stealing their money." Since the insurance company has no relationship with the provider, payment will sometimes go directly to the patient for the procedure. In most cases, patients send the check to their doctor. In other cases, obtaining payment from the patient can be time consuming, expensive and sometimes unsuccessful. In New Jersey, at the urging of providers, the legislature enacted a law requiring insurance carriers to honor assignment of benefits forms completed by patients. However,

it was not a complete victory for out-of-network providers. The legislation also permits insurance carriers to require that the checks be endorsed by both the patient and provider, thus creating a new set of obstacles for providers to actually receive payment. As detailed in the above situations, collecting out-of-network claims is harder than contracted claims. Expertise is required in billing and collecting. Out-of-network claims may be scrutinized more than contracted claims, so submitting accurate and complete information is critical. This requires additional time and effort. If billing and collections are handled internally, staff must be extremely knowledgeable on out-of-network billing and collecting. Adding to the dilemma, outsourcing the billing and collections process can be very expensive.

One of the biggest challenges is the lack of understanding of how out-of-network providers must deal with patients regarding communication on billing issues, specifically, some doctors' refusal to have candid conversations with their patients about this. It reflects the discomfort of some surgeons in dealing with financial issues in the doctor patient relationship and the feeling that it is not their obligation to discuss these issues. In virtually all cases, there is a gap between what the insurance carrier pays and what the ASC bills. As required by many state laws, the patient is responsible for paying the balance of the bill and the provider must bill them (although a recent case in New Jersey ruled that the provider has no obligation to the carrier to bill and collect from patients). In some cases, the bill may be substantial and absent discussions ahead of time, the patient may accuse the physician or hospital of overcharging them. If the patient does not pay the balance, the provider must either pursue collection against the patient or accept an underpayment. This kind of payment conflict ultimately undermines the trust between a patient and his or her health provider. Regardless of the patient's clinical experience, receiving a "surprise" bill ultimately results in a negative experience. The patient may then spread the word to their family and friends – tainting the reputation of the ASC.

Being out-of-network requires continued, extensive training and education for surgeons and their office staff, the ASC staff and patients. A great surgical experience can be damaged when several weeks after a procedure the patient receives what they might think is an enormous bill, but it could simply be the Explanation of Benefits (EOB). Patients must be educated so that they understand what the EOB is and the process and responsibilities associated with payment.

Risks #2 and #3 – Legal and Regulatory Concerns

Unfortunately, from state to state, legal and regulatory rules vary widely. For this reason, it is critical to have your facility’s attorney involved in any decisions involving billing issues. One troubling tactic being employed over the last several years has been the effort by carriers to derail referrals from surgeons to out-of-network ASCs. This is accomplished by such methods as calling patients to “warn” them that they are using an out-of-network facility, and sending letters to doctors asking them to fill out lengthy and cumbersome explanatory forms if they refer out-of-network.

In an escalation of the “battle” between physicians, their ASCs and insurance carriers, insurance companies have taken the severe steps of terminating physicians from their networks for referring to out-of-network ASCs. In states such as Ohio and New Jersey, a number of surgeons were terminated from insurance networks until their ASC capitulated and signed contracts with the insurance carrier. Again, the rights of the carrier to take these steps vary widely from state to state. In certain cases, the presumption is strongly with the insurance carrier if they choose to terminate a doctor from their plan for economic reasons, while in other instances, there are severe restrictions on an insurance carriers’ ability to interfere with a physician’s judgment.

Another critical issue that has led to disputes with both carriers and the government is how out-of-network ASCs handle the patient’s financial obligations to the insurance carrier – that is, the deductible, co-payments or any balance remaining after the insurance carrier pays its portion. The issue is typically referred to as balance billing.

Many states have differing laws in this area but in general, ASCs (like other healthcare providers) are free to negotiate discounts with patients or even write off balances if the alternative is to sue or bankrupt a patient. The real question is whether an ASC is permitted to make a deal with a patient ahead of time to accept “insurance only.” This is one of the biggest complaints by insurance carriers and even more so by contracted providers – that the billed charges are artificially inflated. Below is an example to illustrate this point. Suppose a patient has a PPO plan with the following coverage:

	Co-Insurance	Deductible
In-Network	90%	\$250
Out-of-Network	80%	\$500

A contracted ASC may agree to accept a contract rate of \$600 for a 2 code pain block. That means the patient would need to pay the \$250 deductible (if it hasn’t already been satisfied), plus \$35 (10 percent of the balance) so the insurance company pays \$315 and the

patient pays \$285 with the provider being paid a total of \$600. The non-contracted ASC may bill \$2,000 for the same procedure (based on the UCR charges in the geographic area). Under the policy, the insurance carrier is supposed to pay \$1,200 (applying a \$500 deductible which leaves the carrier to pay 80 percent of the \$1,500 balance); the patient responsibility portion is \$800.

	Insurance Portion	Patient Portion
In-Network	\$315	\$285
Out-of-Network	\$1,200	\$800

(Assumes deductible has not been satisfied.)

If the out-of-network ASC waives the \$800, the argument is that the charges were not really \$2,000 but only \$1,200 – the amount the ASC agreed to accept and thus, the insurance carrier really only should have had to pay about \$600 (applying the deductible and co-insurance to \$1,200 rather than \$2,000). Moreover, the contracted providers argue that it is not fair that they had to charge the patient almost \$300 and they only got paid half what the non-contracted ASC received for the procedure. They often claim that the out-of-network ASCs are unlawfully competing.

Some states allow the non-contracted ASC to waive balances, but require the ASC to notify the insurance company that they intend to do so. Other states follow the generally accepted federal rule that a good faith effort is all that is required to collect the balances. The real problem with that rule is that many ASCs do not really engage in a good faith effort and simply “satisfy” the rule by sending out three bills which they inform their patients to ignore.

In states that do not expressly permit providers to write off patient portions of the bills, providers should actively engage in efforts to collect money from patients. First, it is fundamentally fair that they pay. Even if they went to a contracted facility, they would have paid hundreds of dollars for the procedure (this is obviously complicated when certain carriers offer patients the choice of paying zero at a contracted facility.) However, even then it has been found that most patients are willing to pay something for the above average facility. Second, if the owners of an ASC want to sell all or part of a center, any institutional buyer is going to demand evidence that good faith efforts were undertaken to collect from patients. If an analysis shows few, if any, patient payments, it will be difficult to overcome the obvious conclusion that will be drawn. That does not mean that you cannot negotiate discounts or assure patients that you will work with them, but unless you notify the carriers that you intend to charge “insurance only,” it is not advisable to “secretly” write off all patient financial responsibility.

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Out-of-network billing and dropping contracts that are not favorable are keys to developing a policy that melds both areas into a profitable model.

The Benefits of Being Out-of-Network

If the risks and issues involved with out-of-network billing are so daunting, then why do it? The bottom line is that the reimbursements paid at UCR are much higher than the contracted rates typically paid – in some instances the payments can be as much as six to eight times the contracted payments.

One reason for the enormous discrepancy – particularly when starting out – is that insurance companies generally do not want any part of working with new facilities. Insurance companies know that new facilities must beg for a contract in order to reap volume and referral business, so they often offer them unreasonably low rates. Indeed, it can be baffling that ASCs who do not have a contract with a particular insurance carrier, will simply charge that insurance carrier as if they were contracted if an out-of-network case comes in. This gives them all the downside of having a contract without getting any of the supposed benefits, which are a referral pattern and prompt payment. Insurance carriers have far more leverage than any free-standing ASC, and this considerable clout is reflected in the unreasonable rates they offer to many providers. ASCs not willing to go out-of-network are faced with accepting these contracts at unfair rates.

Out-of-network billing and dropping contracts that are not favorable are keys to developing a policy that melds both areas into a profitable model. Every highly successful ASC utilizes out-of-network strategies to some degree. As stated, there can be enormous differences between out-of-network reimbursement rates and contracted rates (See graph on page 1). When done correctly – with a sound policy protecting the facility, doctors and a consistent process for billing – the differences of collecting and dealing with patients are remarkable.

On the downside, being out-of-network may mean significantly longer collection periods, and if there is not sufficient capital in reserve, there could be significant cash flow problems.

Also, success depends on the collaboration of the board of directors and lead surgeons being fully behind the implemented system, as well as having the appropriate expertise, both legally and in billing, to make sure it is done correctly.

Conclusion

With the wrong approach, the risks of not contracting with carriers can be high and the consequences severe. Dissatisfied patients (which are referral sources), increased exposure to legal issues, attack by insurance carriers, the state, and patients; costly legal fees to defend multiple legal proceedings, failure of the business, bankruptcy or involuntary shutdown by a regulatory agency are all possible negative aspects.

Whatever the ASC chooses, out-of-network billing must be part of an overall business strategy. The right approach to out-of-network billing involves careful analysis of existing contracts and payor mix and a willingness of physicians to drop or decline losing contracts. It also involves ensuring charges are correct and supported by the medical record; education and training and a consistent and legal plan for collecting balances.

Do not be afraid to go out-of-network with certain payors. Engage experts to help determine which strategies make the most sense for the ASC. Consult local attorneys to ensure compliance with state laws on balance billing and to help educate physicians and ASC staff on their rights and the rights of the insurance companies. Involve experienced billing and collection experts to ensure maximum reimbursement and minimized exposure to risk.



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Scott J. Rein is the founder and president of Strategic Outpatient Solutions (SOS). He has more than 10 years of experience in healthcare, specifically focused on outpatient surgery.

Mr. Rein has extensive experience in the outpatient sector in both ASC strategic analysis and management. For five years he served as an advisor and general counsel to the most profitable outpatient surgery center in the United States. Mr. Rein then co-founded a Los Angeles based developer and manager of outpatient surgery centers throughout the U.S. During his five years there, he developed four state-of-the-art surgery centers in New Jersey, Ohio, and Florida, and managed a surgery center in California, totaling 29 operating rooms and performing more than 15,000 surgeries per year as a result of his unique business strategies.

Mr. Rein was responsible for all aspects of the ASC business: performing the feasibility analyses for all projects; developing and implementing the business model and strategies; and managing the ASCs. Mr. Rein's strategies focus on improving profitability, expanding the business, and developing tactics to address regulatory issues that ASCs face.

About Amerinet

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