
Update on AB1455 - Prompt Payment Legislation





Scope/ Background

- **Escalating tension between plans and providers.**
- **Concern over balance billing and the impact on consumers.**



AB1455

- **Facilitate prompt payment of claims.**
- **Streamline dispute resolution mechanisms.**
- **Prohibit unfair practices.**
- **Authorize the DMHC to adopt new regulations.**

The Suite of Statutes Involved

Amended Health & Safety Code, Sections

➤ **1367**

➤ **1371**

➤ **1371.35**

Added Health & Safety Code, Sections

➤ **1371.36**

➤ **1371.37**

➤ **1371.38**

➤ **1371.39**

Section 1371- Payment Deadlines

- **Payment of claims 30 days after receipt. 45 days if the plan is an HMO.**
- **Interest penalty.**
- **If contested, must provide written notice within same time frame.**
- **Notice must identify the contested portion and specific reasons.**

Reasonably Contested Claims

- **Incomplete claim**
- **Lack of necessary information.**
- **May request additional information within 30/45 day timeframe.**
- **Must contest/deny claim subject to need for additional information.**
- **Plan has 30 days after receipt of the additional information to complete reconsideration. 45 days if an HMO.**

What is Necessary Information?

- **H&S Code section 1371**
 - Investigation reports.
 - Necessary consents.
 - Releases and Assignments.
 - Information necessary to determine medical necessity.

- CCR 1300.71 specifies the UB92 or successor NUBC form and any other data mandated by state/federal law.

Section 1371.35 – Payment Deadlines For Emergency Claims

- **Same payment deadlines and interest penalty.**
- **Contested Claims:**
 - written notice within 30/45 day time frame.
 - notice must identify the contested portion, *by revenue code*, and the specific information needed to reconsider the claim.
 - notice of denial must identify denied portion, *by revenue code*, and specific reasons for denial.
 - May delay payment of uncontested portion subject to interest penalty.

What is Necessary Information Under Section 1371.35?

➤ Paper Claims

- Emergency department report
- UB 92 or other NUBC form
- Reasonable information requested within 30 days.

What is Necessary Information?

➤ **Electronic Claims**

- UB 92 or other NUBC form
- Reasonable information requested within 30 days.
- If plan requests emergency department report within 30 days, may also request additional information within 30 days after receipt of the emergency department report.
- 30/45 day deadline applies to complete reconsideration of the claim.

Other Reforms

Section 1367

- **Licensing Requirements**
- **All contracts must contain a “fast, fair, and cost-effective dispute resolution mechanism”.**
- **Dispute resolution mechanism accessible to non-contracting providers.**
- **Annual reports to the DMHC**

Other Reforms

Section 1371.36 - Authorization

Plans may not deny payment based on lack of authorization under certain circumstances, including:

- **services related to previously authorized services.**
- **services provided after plan's normal business hours.**
- **plan does not maintain contact/response system.**



Other Reforms

Section 1371.37

- **Prohibition against unfair payment patterns**
- **Director authorized to investigate unfair payment patterns.**
- **Specific definition of unfair payment pattern left to the DMHC to define.**



Section 1371.38 (added)

- **Department to adopt regulations requiring appropriate dispute resolution mechanism.**

Section 1371.39 (added)

The online Complaint System:

- providers may report unfair payment patterns
- plans may report unfair billing patterns

The DMHC Regulations

CCR 1300.71

Highlights:

- **Outlines list of practices and procedures that “may” constitute an “unjust payment pattern”.**
- **Sets forth criteria for determining “reasonable and customary” value for healthcare services.**

Practices that may constitute unfair payment practices.

- **Failure to forward misdirected claims**
- **Failure to accept late claims**
- **Failure to request reimbursement of overpayment w/in 1 year**
- **Failure to provide adequate reasons for denying/adjusting claims.**
- **Contract provisions that require unnecessary medical record submissions**
- **'Allowing' a provider to waive statutory protections**
- **Failure to reimburse complete claims with correct payment**
- **Failure to contest/deny within timeframes of section 1371 or 1371.35**

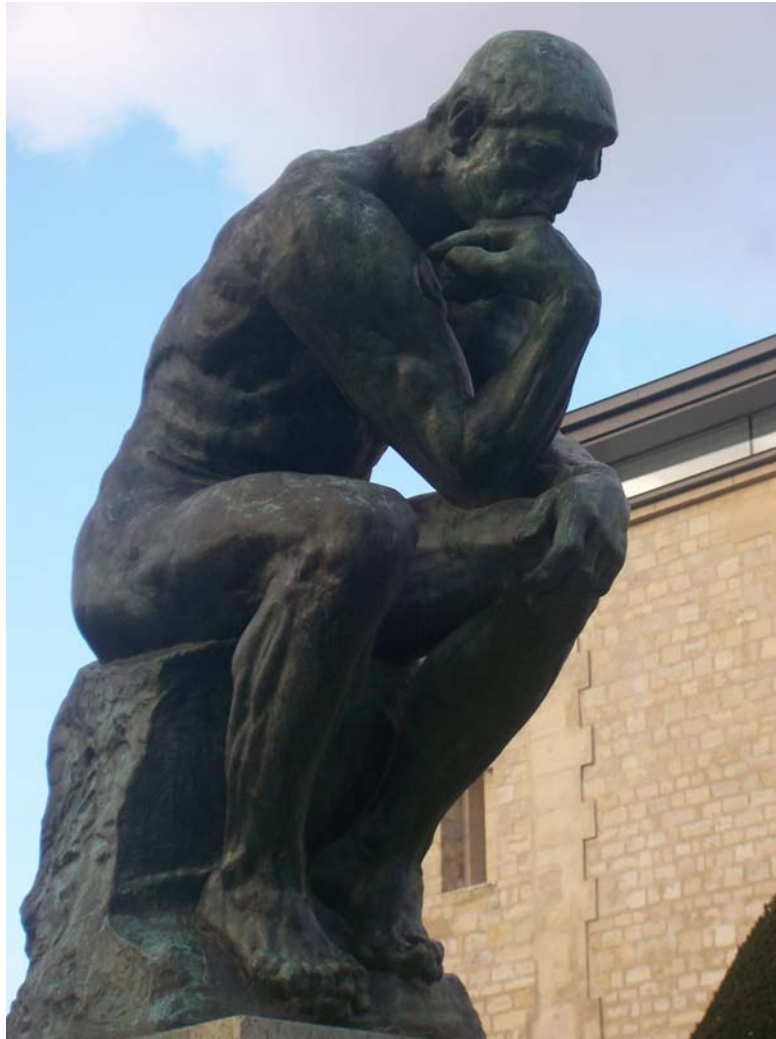
Reasonable and Customary Criteria – the Gould Factors

For contracted providers without a written contract and non-contracted providers, except those providing services described in paragraph (c) below: the payment of 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: (1) 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.

Factors Analysis

- **provider's training, qualifications and length of time in practice?**
- **nature of services provided?**
- **fees usually charged?**
- **prevailing provider rates in general geographic area?**
- **other economic aspects of the practice?**
- **any unusual circumstances?**

What Did the Plans Do?



Plan Methodologies

Health Plan	Methodologies
Health Net	Concentra (Facility), Ingenix MDR (Prof.)
PacifiCare	Ingenix MDR
Aetna	Concentra (Facility), Ingenix (Prof.)
Blue Cross	Internal Database / determines percentiles for each major CPT code.
Cigna	PHCS from Ingenix
Kaiser	R&C Methodology
Blue Shield	Billed Charges

DMHC Review of Methodologies

- **DMHC may question/provide comments.**
- **Compliance addressed based on complaints/during routine exams.**
- **Focus is on payment consistent with method filed with the DMHC.**
- **To extent Gould factor compliance analyzed, addressed in the appeal process.**
- **Updates are voluntary.**

Related Issues:

- **Attorney General’s “industry wide investigation into a scheme by health insurers...”. At the center of the scheme is Ingenix, Inc...which serves as a conduit for rigged data...”**



Remedies

DMHC Action:

- **Monetary penalties – PacifiCare**
- **Require claims to be paid in shorter timeframe**

Other Remedies: Civil Actions

- **Direct claims under the Health & Safety Code (1371.4; 1317.2a)**
- **CCR 1300.71**
- **Quantum Meruit Claims – reasonable value**
- **Implied Contract Claims**
- **Unfair Competition Claims – Bus. & Prof. 17200**

Jurisdictional Issues:

Bell v. Blue Cross, 131 Cal.App.4th 211

- provider's private right of action for reimbursement under UCL does not infringe upon the Department's jurisdiction over the Knox Keene Act.

Coast Plaza Doctors Hosp. 105 Cal.App. 4th.

- Concluded that DMHC does not have exclusive jurisdiction.

The Balance Billing Dispute

Governor's Executive Order.

DMHC's Response: 2006 Proposed Amendments

- Defined balance billing as an unfair billing practice.
- Proposed revision to reasonable and customary criteria to include “any additional documents.”
- Proposed an Independent Dispute Resolution Process (IDRP) for unresolved non-contracted provider claims.
- Proposal was allowed to expire in August of 2007.

The Balance Billing Dispute

Prospect v. Northridge Emergency Medical Group, 136 Cal.App. 4th 1155 (2006).

- **Section 1379 does not prohibit balance billing by non-contracted emergency providers**
- **Before the Supreme Court. No date has been set for oral argument.**



DMHC 2007 Proposed Revisions

- **Define balance billing as an unfair billing practice.**
- **Revise the criteria for determining the reasonable and customary value of health care services.**
- **Establish the IDRPs.**

Proposed Criteria for Determining Reasonable and Customary Value

Two new criteria added:

- (6) that Medicare rates are based on a federal government reimbursement methodology and shall not be solely used as a basis for payment
- (7) that contracted rates normally reflect a discount, and therefore, shall not be solely used as the basis for payment.

New Proposal

Expedited Payments to Non-Contracted Emergency Service Providers

- Plan must make an “expedited” payment equal to 150% of Medicare rates.
- Expedited payment is not reasonable and customary value.
- Acceptance means cannot balance bill the enrollee.
- Either party may seek an adjustment.

The IDR

- **Baseball style arbitration.**
- **Voluntary for providers, mandatory for plans.**
- **Provider must first utilize plan's internal dispute resolution mechanism.**
- **Arbitrator makes a decision between the offers within 60 days.**
- **Either party may appeal the decision to civil court within 60 days of the award.**
- **Payments awarded must be paid prior to filing the appeal.**

Comments:

- **New proposal raises same complaints/ comments previously raised.**
- **New proposal expires in August 2008.**
- **CHA anticipates DMHC will re-write or submit.**
- **If submitted, CHA anticipates filing lawsuit on the same grounds as before.**



DMHC Comments

- **Expect a final product on the proposed revisions before August 2008.**
- **Committed to the consumer.**
- **Acknowledge difficulties, attempting a solution.**

SB 981

- **Applicable to hospital based physicians.**
- **Requires payment at lesser of physician's full charges or no less than interim payment.**
- **Interim payment means 190% of 2007 Medicare rates.**
- **May seek adjustment through any available process. (IDRP)**

Legal Developments and Related Policy Concerns

River Park Hosp., Inc. v. Blue Cross/Blue Shield of Tenn., Inc. 173 S.W.3d 43

- defendant's average in network reimbursement rates may be considered but not determinative.

Temple University Hosp., Inc. v. Healthcare Mgt. Alternatives, Inc., 832 A.2d 501

- hospital entitled to average rates collected from contracted and government payers.