

## MANAGED CARE

## Watch out for these four techniques private payers use to reduce out-of-network payments

by Michael F. Schaff and Brian Kalver

In some regions of the United States, a high percentage of patients have access to out-of-network benefits. In these regions, out-of-network healthcare providers are often able to collect much more for a given service than in-network providers. The payment from a private payer alone is often far more—sometimes several times more—than the amount of a network provider's total allowable charges.

The trick for providers in competitive markets is to attract enough patients with access to out-of-network providers to make it profitable to stay out of the network. Physician-owned ASCs in competitive markets have a built-in mechanism to attract out-of-network patients. Whether they call it self-referral or an effective marketing strategy, physicians who own an interest in an out-of-network ASC are likely to perform a high percentage of their procedures in that ASC, including those done on patients for whom the ASC is out-of-network.

Payers, on the other hand, are developing strategies to keep patients away from out-of-network facilities or, if they cannot do that, are denying or reducing the high charges of out-of-network providers. Out-of-network ASCs that have not already experienced these strategies should brace themselves and their medical staff for the days to come and develop their own responses.

Following is a discussion of methods that private payers use to reduce payments to out-of-network providers or squelch patients' use of these pro-

viders, and what you can do to challenge these attempts.

### Limitations on coverage to allowable charges

Payers reduce payments to out-of-network ASCs by setting low allowable charges for the facility fee. Occasionally they set the allowable charge at levels that are not much higher than the fee schedule for in-network providers. It is often impossible for an ASC to find out in advance what the allowable charge is, which varies from one explanation of benefits to the next, thus adding to the ASC's frustration.

Whether ASCs can effectively challenge this tactic may depend on the terms of the plan. Centers with benefit plans that limit coverage to "usual and customary" charges will have a harder time defending the reduction than those with plans with more nebulous coverage limitations. For example, plans with less-defined limitations may not have a customary usage or may not define the allowable charge as "an amount determined by the plan administrator." (*Note: See Geddes v. United Staffing Alliance Employee Medical Plan*, 2005 U.S. Dist. LEXIS 4758 [D. Utah, March 23, 2005] for more information.)

Allowable charge limitations may also conflict with state insurance regulations that provide mandatory coverage terms for insurance policies. For example, a New Jersey insurance regulation establishes an objective methodology that is required for determining allowable charges for out-of-network providers for small employer group health benefits. (*Note: See New Jersey Administrative Code 11:21-7.13 for more information.*)

**Tip:** Out-of-network ASCs should monitor closely the amounts they receive from payers and appeal reductions when the payers apply severe allowable charge limitations. Even if the payer doesn't concede the issue, the appeal could bring to light errors by the payer in applying its own policies that result in additional payment to the ASC.

Whether the ASC can make a viable challenge to the payer's underlying policy can take a bit of research and legal work. ASCs should check with their local professional societies to see whether other providers are interested in taking legal action.

### Withholding approval of the procedure

Payers may use preapproval requirements applicable to out-of-network benefits to steer patients away from an out-of-network facility by withholding approval if they do not use an in-network facility. Although this might appear to be an improper use of the preapproval process, the effectiveness of a challenge may depend on the terms of the plan.

**Tip:** Out-of-network ASCs should gather from their medical staff whatever information they can about preapproval denials that payers used to direct patients to in-network facilities. If a significant trend is apparent, ASCs may be able to mount a legal challenge to the payer's future practices.

### Provisions in participating physician contracts

For a long time, private payers' participating physician contracts have

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commonly included provisions requiring physicians to refer patients to in-network specialists and facilities whenever possible.

Exceptions frequently acknowledge that there may be instances in which the patients' medical needs can only be met by a facility with special capacities that are not available in-network. However, these situations are unusual, especially when the facility is a physician-owned ASC.

In the past, payers have not enforced contractual prohibitions on out-of-network referrals—even when the network physician is an owner of an out-of-network ASC. This may reflect the payers' concern that consumers or courts will not take kindly to the payers' attempts to keep them from accessing the out-of-network care to which they are entitled.

A newer version of the prohibition on out-of-network referrals requires physicians who make such referrals to pay the patient's deductible or coinsurance. By doing this, the payer is not denying the patient access to the out-of-network facility and is actually doing the patient a favor by shifting the payment burden to the referring physician.

However, given the complicated relationships that sometimes exist between ASCs and their physician owners, such a payment by a physician to the ASC may present issues under state anti-kickback laws or regulations.

**Tip:** Out-of-network ASCs should encourage their referring physicians to review new or renewal contracts and try to delete these prohibitions. ASCs should also alert their medical staff to look for these provisions, although recommending any particular course of action (e.g., refusing to agree to the provision) could raise antitrust law issues.

### Regulatory fee schedules

In some states, government regulations have established medical fee schedules for automobile insurance plans and workers' compensation plans.

Although these fee schedules are not exactly imposed by payers, they must have a hand in promoting the regulation and making sure that the scheduled fees are low.

**Tip:** ASCs and professional societies should watch for these types of regulatory proposals and voice their opinions to government agencies and

the public by writing letters to their legislators and opinion pieces and letters to the editor of their local newspapers, etc.

Mounting a legal challenge to such a regulation is likely beyond the budget of an individual ASC, so ASCs should work through professional societies to generate interest in legal action. ■

### Insider sources

**Michael Schaff** is chair of the corporate and healthcare departments of Wilentz, Goldman & Spitzer, PA. He lectures nationally and publishes extensively on healthcare topics. He is the immediate past chair of the American Health Lawyers Association's Physicians Organization Committee and was the editor of its newsletter. He is a past chair and currently a director of the New Jersey State Bar Association's Health and Hospital Law Section, and chair of its Physician Practice Committee. He represents many ASCs and professional practices.

Contact Schaff at Wilentz, Goldman & Spitzer, PA, 90 Woodbridge Center Drive, Suite 900, Box 10, Woodbridge, NJ 07095; 732/855-6047; [mschaff@wilentz.com](mailto:mschaff@wilentz.com).

**Brian Kalver** is an associate with Wilentz, Goldman & Spitzer, PA. He represents New Jersey physicians and healthcare facilities in a wide variety of business transactions and regulatory matters. Kalver has authored articles and given presentations to physicians and attorneys about various healthcare law topics, including the HIPAA privacy regulations, self-referral and antikickback laws, and establishing a physician-owned interventional radiology facility.

Contact Kalver at Wilentz, Goldman & Spitzer, PA, 90 Woodbridge Center Drive, Suite 900, Box 10, Woodbridge, NJ 07095; 732/855-6124; [bkalver@wilentz.com](mailto:bkalver@wilentz.com).

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