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California's Departments of Managed Health Care and Insurance Publish Their Processes For Resolving Reimbursement Disputes Between Payors and Non-Contracted Individual Providers

This bulletin is a follow-up to the August, 2017 King & Spalding Client Alert, "California's Surprising New 'No Surprise' Health Care Billing Law" ("August Alert").

As described in our August Alert, California's new "No Surprise" billing law required the California's Department of Managed Health Care ("DMHC") and Department of Insurance ("DOI") to develop dispute resolution processes for handling rate disputes between health plans and individual health professionals ("IHPs"), including physicians and other clinicians who are not contracted with their patients' health plans or insurers but who practice at hospitals and other facilities that are contracted, i.e., "in-network." *See* Cal. Health & Safety Code §§ 1371.9(f)(3), 1371.30; Cal. Ins. Code §§ 10112.8(f)(3), 10112.81 ("AB 72"). The DMHC and DOI have now developed their AB 72 processes, which differ in significant ways.

The DMHC's process is described on its website here. The DOI process, which is more formal than the DMHC's, is described here (Implementation Guidance 72:1, 72:2, §§ 2239-2239.8). The DOI provides forms here.

As described in the August Alert, the DMHC's process is available for disputes between managed health care plans and IHPs that are non-contracted but are practicing in-network. (Hereafter, for brevity, "IHP" will refer to such IHPs.) The DOI process is only available for disputes between IHPs and health insurance companies. As also noted in the August Alert, AB 72 does not apply to emergency services, dental providers, or Medi-Cal managed care plans. The AB 72 process is only for rate disputes – not other issues. Emphasizing this limitation, the DHMC lists examples of disputes that cannot be resolved through its AB 72 process, which it calls its "independent dispute resolution process," or "AB 72 IDRP," including disputes over late payments and whether services were emergent, medically necessary or experimental/investigational.

Although the processes' basic requirements are described in the last section of this article, the focus is on potential inequities and due process concerns. Hopefully, highlighting these will help IHPs avoid costly oversights and make informed decisions about the potential risks and benefits.

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As discussed in the August Alert, the expense of going to court and the inequities and expense of fecklessly pursuing a payors' internal system has long stopped most IHPs from seeking recovery from payors. While the new processes could have changed this, they actually make seeking recovery more burdensome than going to court and offer less due process. Ultimately, IHPs likely will end up having to go court anyway. For example, a court action may be filed if they or the payors are unhappy with the DMHC or DOI decisions, or if filing is prudent to preserve the statute of limitations or necessary to address non-rate related denials.

This is important: a casual reader of the new law and the DMHC and DOI guidance could conclude that a lawsuit may not be filed at all or may not be filed before a payor's internal process and an AB 72 process are complete. This could be an expensive misunderstanding. First, the processes are only available for *rate* disputes, not denials. Thus, an IHP must file a lawsuit to pursue recovery of claims denied for such reasons as "not medically necessary" or "not timely filed." Second, IHPs will need to file in court if the applicable statute of limitations will otherwise expire while the AB 72 process is pending.

While the law and DMHC and DOI guidance state that the AB 72 decisions are "binding," they also make it clear that they do not mean such decisions are binding on a court or that a lawsuit cannot be pursued. Thus, IHPs can always file a lawsuit in lieu of or in addition to pursuing the AB 72 process. Unfortunately for IHPs, a payor could also file a lawsuit to harass and overburden the IHP either during the pendency of the AB 72 process or when it is over.

Among these and other problems with the processes, the following inequities, burdens, and concerns readily appear from the new guidance:

- Under the DOI process, if not the DMHC's, the parties are not permitted any hearing;
- The rules of evidence do not apply;
- No discovery or exchange of information is required or contemplated, so IHPs cannot obtain information about the bases for the contract discounts being imposed on them;
- The decision-makers are not necessarily neutral and are not required to be neutral;
- The decisions are to be based only on what documentation the parties submit, requiring essentially a trial on paper without knowledge of the other side's evidence and argument;
- Neither party has an opportunity to view or respond to what the other side presents;
- The DOI process requires IHPs to complete the first level of the insurer's internal appeal process, and the DMHC appears to require IHPs exhaust all levels of a health plan's process before submitting a matter to the DMHC;
- The statute of limitations on a court action for recovery of non-contracted claims may expire while the payor's internal appeal process and/or the AB 72 process is pending;
- If a court action is pursued after the lengthy and expensive AB 72 process is complete, the decision will not bind a court, but a court could find a ruling against at IHP persuasive;
- While not binding on a court, the processes and guidance could be used to convince a court it should consider the same factors outlined in the law and guidance, which are narrowly drawn and do not include the most important information, such as what consideration the payors received in exchange for discounts reflected in prior written contracts with other parties, as explained in the August Alert; and
- The language of the statute and processes may give rise to an argument that exhausting payors' internal appeals and completing the AB 72 process are required before pursuing rate litigation, and although this likely is not a winning argument, it will take time and money to resolve.

Accordingly, at a minimum, because the processes cover so few issues, and for the additional reasons discussed below, the burdens and concerns associated with the processes appear to far outweigh the benefits to IHPs. IHPs may be better advised to file lawsuits in court, where they can raise a host of liability, pricing, and other issues in a single forum.

1. Neither Process Provides Sufficient Guidance To Those Making Important Pricing Decisions

What is perhaps most distressing about the guidance is that it does not require the rate decision to have any foundation in fact, law, or even logic. The DOI and DMHC instruct that the decision-makers will only consider information that the parties submit, which is left to the unfettered discretion of the parties. At the same time, the DOI and DMHC also acknowledge some risk that the decision-makers will look outside the evidence. For example, the DOI instructs that its "Independent dispute resolution organization" ("IDRO") may not consider rate information related to payment for services provided to patients covered by Medi-Cal or out-of-state products for services provided outside California. If the DOI truly expects the IDRO to focus only on the evidence presented, there would be no need for such instruction, and by specifying what should not be considered, the IDRO could conclude it may consider other irrelevant rate information. The DMHC puts no constraints on MAXIMUS in rate-setting, an organization that is accustomed to hearing Medicare claims appeals and dealing with Medicare rates.

Thus it appears that rate-making will be performed through the AB 72 processes by persons who are given unfettered discretion to make decisions based on their own narrow experience, limited information from the parties, and potentially no information whatsoever about what is reasonable and customary under the law. These persons are not trained to be independent and impartial. They are not required to provide greater weight to credible evidence and expert testimony. They are free to give weight to tangential and irrelevant, unsupported assertions. Their decisions may not only lead to even more lawsuits, they could have adverse effects on the market.

We expressed concern in the August Alert that the new "no surprise" billing law did not require the DMHC and DOI to apply the factors set out in 28 Cal. Code of Reg. § 1300.71(a)(3)(B), including the provider's training, qualifications, and length of time in practice, the nature of the services provided. These factors have long provided at least some constraint on wildly different pricing determinations in non-contracted situations. Fortunately, the DMHC and the DOI do acknowledge this law in their guidance. However, they merely state that the IDRO and MAXIMUS ***may consider*** Title 28 of the California Code of Regulations, § 1300.71(a)(3)(B)(i)-(vi) (f) (the provider's training, qualifications, and length of time in practice; the nature of the services provided; the fees usually charged by the provider; prevailing provider rates charged in the general geographic area in which the services were rendered; other aspects of the economics of the medical provider's practice that are relevant; and any unusual circumstances in the case).

Adding to the ambiguity about what the DOI's IDRO and DMHC's MAXIMUS will consider, both the DOI and the DMHC emphasize that the IDRO and MAXIMUS must consider "all relevant factors," but they make it clear this means only what is presented by the parties. Therefore, if the parties do not produce documentation on a factor or the decision-makers do not understand what was presented or decide it is not worthy of consideration, a relevant factor will not be considered. The decision-makers have full discretion to reject what is presented as irrelevant or otherwise unpersuasive, with no checks and balances. Under the guidance as written, the parties may never know what information was and was not considered. No reasoned or supported decision is required.

The DOI's additional guidance provided here creates some additional ambiguity. There, the DOI states, in pertinent part:

1) In determining the appropriate reimbursement amount in a claim dispute, the relevant Average Contracted Rate to be considered by the independent dispute resolution organization is the average as calculated by dividing the total payments for a procedure code by the total number of paid claims incurred in calendar year 2015 for the procedure code in each geographic region. …

a. "Total payments" means, for a covered procedure code, the total dollar amount of all payments made by the insurer plus any patient cost sharing, for all claims incurred in calendar year 2015 in a geographic region for that procedure provided by contracted [IHPs] in connection with the insurer's commercial health insurance coverage. …

b. In resolving a claim dispute for a particular procedure, the independent dispute resolution organization *shall also consider* circumstances where a base rate is adjusted by factors such as physical status of the patient, the duration, complexity, and/or intensity of the procedure, and any applicable conversion factor (such as conversion factors expressed in dollars per unit in the administration of anesthesia) for a particular episode of care, *where appropriate*, in reaching a decision in the dispute resolution process. (Emphasis added.)

The italicized "shall also consider" appears mandatory, in contrast to the "may consider" language relating to the factors set forth in Title 28 of the California Code of Regulations, § 1300.71(a)(3)(B)(i)-(vi) (f). The "where appropriate" language, however, appears to contemplate that the decision-makers may, in their unfettered discretion, ignore the factors.

2. The New Law and Processes Create Unnecessary Burdens on IHPs, Ambiguities, And Potentially Serious Impacts On IHPs' Procedural Rights

As they have in the past, payors likely will seek to discourage IHPs from challenging their payments by making such challenges as expensive and time-consuming for IHPs as possible. The new law and guidance will support these efforts if IHPs use the AB 72 processes.

a. Requirements That IHPs Use the AB 72 Process and That They "Complete" Payors' Internal Appeal Processes

The following in the new law and guidance appear to require that IHPs use the AB 72 process *and* exhaust payors' internal appeals processes:

- Health and Safety Code § 1371.30(a)(3) and Insurance Code § 10112.81(a)(3) state that "[i]f either the noncontracting individual health professional or the insurer appeals a claim to the department's independent dispute resolution process, the other party **shall participate** in the appeal process as described in this section."
- The DMHC restates this strongly in its guidance as"[o]nce a noncontracting provider or payor submits an AB 72 IDRP Application, the opposing party *is required by law* to participate in the AB 72 IDRP" (emphasis added);
- Health & Safety Code §1371.30(a)(2) and Insurance Code § 10112.81(a)(2) appear to require "completion" of the payors' internal processes as a pre-requisite to using the AB 78 processes, even though there is no law or contract requiring IHPs to use any internal payor process, stating: "Prior to initiating the independent dispute resolution process, the parties shall complete the [plan's or insurer's] internal process."
- The DMHC emphasizes this, unnecessarily re-stating that before a party may commence an AB 72 IDRP, it must complete the payor's Provider Dispute Resolution ("PDR") process.

The legislature's and DMHC's use of terms that make the process sound mandatory are misleading. As the DOI recognizes and confirms, the process is a *right*, not an *obligation*. Nothing in the law requires a party to use the AB 72 process *in lieu of or before* a court action.

The legislature's and DMHC's edicts that IHPs must "complete" a payor's internal PDR process also express a requirement that has no basis in law – particularly in a non-contracted situation. Payors' internal PDR processes are typically burdensome, biased in favor of the payors who operate them, and pointless in that they carry no weight in a court of law. Nonetheless, the DMHC reiterates the requirement, emphasizes it, and fails to limit it in any way. Thus, the DMHC uses the statutory language to erect a pre-requisite to use of its process that does not otherwise exist in contract or law: before challenging a health plan under AB 72, IHPs must participate in the health plan's internal PDR process and must appeal all claims *through completion of all levels* of that process.

In contrast, the DOI guidance provides at § 2293.2(c) that for disputes with insurers, an IHP "shall be deemed to have completed the insurer's internal payment dispute resolution process after completing one level of the insurer's internal payment dispute resolution process." Thus the DOI follows the statute in unfairly requiring participation in insurers' PDR processes but it interprets the legislative edict to require only completion of *one level* of the process. While this is one more level than IHPs should have to pursue, at least the burden is not nearly as great as exhausting multiple levels over a year or more.

The legislature's statement that "the parties shall complete the [PDR]" must be interpreted as anticipating at most one level of the PDR process. Otherwise, the burden would fall too heavily on IHPs to the benefit of payors. Despite the legislature's effort to sound even-handed by saying "the *parties* shall complete," anyone remotely experienced with provider/payor disputes knows that *payors* do not appeal adverse rulings issued by their own in their own PDR appeals processes. Only providers appeal through payors' internal processes, and only because the slim chance they may prevail is at least some chance and because payors insist on it. Enticing providers to use PDR processes allows payors more time to hold money they owe providers while the processes are pending, more time to review the claims and create new arguments, more "ammunition" to influence subsequent decision makers, and more opportunity to overburden and discourage providers to the point they give up. Most PDR processes include multiple appeals before different bodies or persons of varying degrees of independence, each level being lengthy and potentially burdensome and having inconsistent or unexplained results, until finally a provider reaches an appeal level that is considered the "highest," or most "complete."

Moreover, interpreting the statute to require completion of more than one level of a payor's PDR process would be grossly inequitable because those processes differ from payor to payor. Some payors have only 1 or 2 levels while others have 3 or more.

Hopefully, the DMHC will not require that IHPs complete all levels of health plans' PDR processes before commencing an AB 72 process while IHPs pursuing an *insurance company* need only complete the first level. (IHPs should also look into whether MAXIMUS or the DOI's IDRO are part of the PDR, for conflict of interest purposes.)

If IHPs decide to complete more than one level of a payors' PDR process, they should remember that this could result in time bars and statute of limitations problems for IHPs when they challenge payors. The DMHC and DOI give payors up to 365 days after "completion" of the payor's PDR process to submit an AB 72 dispute. If completion of all levels of a payor's PDR process takes more than a year, as it often does, and an IHP waits too long to complete the internal appeal and/or finish an AB 72 process, IHPs' court claims could be barred by the applicable statute of limitations by the time the AB 72 process is complete. We have found no California authority for the proposition that a health plan's internal appeal process tolls the applicable statute of limitations. In fact, recently courts have ruled that the period begins to run with the insurer's initial notice that the claim is being denied in part or in whole - usually upon receipt of an EOB or RA. *IV Sols., Inc. v. Health Net of California*, 2017 WL 1488691, at *5 (Cal. Ct. App. Apr. 26, 2017),

unpublished; *Singh v. Allstate Ins. Co*., 63 Cal. App. 4th 135 (1998). Even equitable tolling may not apply. *See Singh,* 63 Cal. App. 4th at 142. Thus, IHPs who are forced to proceed with a payor's PDR process should ensure that they file a court action within the applicable statute of limitations period based on when the payor issued the EOB at issue, regardless of the status of the PDR or AB 72 process. Otherwise, the IHP should get a written contract from the payor agreeing to toll the statute of limitations pending completion of the AB 72 process.

If an IHP files a lawsuit before completing the PDR or AB 72 process, the IHP should not be surprised if a payor argues that an IHP lawsuit that includes a rate dispute may not be pursued until the IHP exhausts the payor's PDR process *and* the AB 72 process. While such an assertion has no well-founded basis in law, the statute and guidance provide unfortunate language to support an argument that a court may need to resolve, and bad law has been made with less.

b. Payment of Claims And/Or Undisputed Portions of Claims Pending Resolution

The law and guidance are also ambiguous with regard to whether a health plan or insurer must pay the undisputed portion(s) of claims while disputes are being resolved. Arguably, payment of the interim rate is required, regardless of whether it is contested, by Health & Safety code § 1371.31 (a)(1) and Insurance Code § 10112(a)(1) (unless otherwise agreed, the health plan or insurer "shall reimburse the greater of the average contracted rate or 125 percent of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered."[interim payment rate"]). However, the DOI guidance introduces ambiguity at § 2239.2 where it states that when an insurer receives a claim for services from an IHP that is subject to Insurance Code § 10112.8(a), the insurer "must pay the amount billed or, unless otherwise agreed by the noncontracting [IHP] and the insurer, reimburse the noncontracting [IHP] at the interim payment rate within 30 business days from the date of receipt of the claim (unless the claim, or portion thereof, is contested by the insurer)." Increasing the ambiguity, the DHMC rule is silent on payment of disputed amounts.

Given the statutory payment requirement in Health & Safety code § 1371.31 (a)(1) and Insurance Code § 10112(a)(1), the DMHC should require payment pending resolution of the dispute, and the DOI guidance, section 2239.2, should be interpreted to mean that insurers should pay claims at the interim payment rate pending resolution of the rate dispute except as to claims or portions of claims that are disputed for non-rate related reasons. Resolution of this ambiguous area may need await further guidance.

3. The DOI Guidance Highlights Serious Due Process Concerns and Prejudices IHPs

The DOI guidance adds at least 2 provisions of concern. First, the DOI explicitly precludes a hearing on the merits. Section 2239.6, Resolution of Claim Disputes, provides that the IDRO "shall decide all claims based on submissions from the parties and their authorized representatives **and shall not conduct an in-person or telephone meeting or hearing**." (Emphasis added.) The complexities and nuances of healthcare pricing are extremely hard to capture and communicate on paper. Expert testimony is almost always required, if not always. Such testimony can be highly technical, and must be presented in a way that permits the judge or other decision-maker to ask questions and make sure they understand it. When opposing experts disagree, their individual credibility often becomes the deciding factor, and such credibility is best accessed in an in-person hearing. Having no ability to present such evidence, no ability to respond to the other side's assertions, and no ability to otherwise present a full argument and evidence in an AB 72 process, IHPs may be well advised to skip the process entirely and go to court.

Second, the DOI adopted a unique and relatively uncommon approach to resolution. Section 2239.6 implements what is known as "Baseball Arbitration." Subsection (g) states: "In resolving the claim dispute, the IDRO shall select one of the parties' final offers for resolution (as stated in the IDRP Request and IDRP Response forms, respectively) only. No other amount may be selected." The "final offer for resolution" is made when the DOI notifies the responding party of the IDRP request by mail pursuant to § 2239.4. This section provides that, the notification will include information

regarding the right to submit a final offer for resolution, and that if the responding party fails to respond within 15 business days:

(1) If the responding party is an insurer, the amount paid pursuant to 2239.2(a) shall be considered its final offer for resolution.

(2) If the responding party is a noncontracting individual health professional, the amount billed shall be considered the final offer for resolution.

Thus, for those involved in the dispute, the result will be "all-or-nothing." While this might cause parties to make offers for resolution that are closer together, it could yield unjust results.

4. IHPs Should Make Sure They Fully Understand Their Responsibilities And Constraints Under The AB 72 Processes

The DMHCs AB 72 IDRP is conducted electronically through a web-based portal that is managed by MAXIMUS Federal Services, Inc. ("MAXIMUS"), which is also currently conducting the IDRP. Similarly, the DOI process starts with submission of its Independent Dispute Resolution Process (IDRP) Request Form through the appropriate portal. The DOI guidance is currently silent on what entity will conduct the review.

Similar documents are required to be included with an AB 72 application. These include:

- Claim Form(s);
- PDR Determination Letter(s) or dated proof that the claimant attempted PDR;
- Explanation(s) of Benefits or Remittance Advice;
- Any evidence a party wants the decision-maker to consider.

The opposing party may submit any information and/or documents "relevant to the reimbursement amount for the claim(s) at issue." The guidance contains no provisions relating to whether a copy of each filing must be provided to the opposing side, and the parties have no opportunity to respond.

Accordingly, it is important that the documents submitted are complete and accurate. The DHMC guidance specifically states: "Parties will not have an opportunity to revise their AB 72 IDRP Application after it is submitted."

With regard to the proof that the claimant attempted PDR, the DMHC and the DOI both provide for the situation in which an IHP submits an appeal to the payor under the payor's PDR process but receives no response. The DOI rules are slightly more favorable to providers than the DMHC's. The DOI permits IHPs, per § 2239.3(a)(3), to submit IDRP requests based on evidence that the IDRP submitted an appeal to the payor through its internal dispute process but received no response within 45 *calendar days* of submission. The DMHC requires documentation showing that an IHP submitted an appeal but received no response from the health plan within 45 *business days*, which is 63 *calendar days.*

Each AB 72 applicant is responsible for redacting all proprietary, confidential, or protected health information that should not be viewed by the DMHC or DOI, the independent organization, or parties to the dispute, including all identifying information relating to patient claims that are not in dispute.

Both the DOI and the DMHC include rather draconian provisos for "default" determinations based on nonpayment. For example, the DMHC guidance states that MAXIMUS will not even start reviewing claims until fees are paid and additional fees must be paid before MAXIMUS will issue its Decision Letter, and the DOI guidance provides that if the responding party fails to remit payment within 15 business days of receipt of the IDRO invoice, the IDRO will first mail a 5 business day notice of intent to issue a decision in favor of the requesting party in the amount of the requesting party's final offer for resolution, and then, if the responding party fails to remit payment within 10 business days after

the date of the 5 business day notice, will issue a decision in the requesting party's favor. In a "Baseball Arbitration," this kind of provision could have dramatic consequences.

Both the DOI and DMHC contemplate that multiple claims will be submitted.

- Under both the DMHC and DOI guidance, noncontracting providers and payors may request independent review for an individual claim or for a "bundle" of up to 50 claims for the same or similar services.
- The DOI defines "same or similar services" in § 2239.1(l) as those that "fall within the same subheading in the Current Procedural Terminology (CPT) code (excluding modifiers), Healthcare Common Procedural Coding System (HCPCS), or similar subclassification in another appropriate procedure code system to the applicable procedure or service."
- The DOI guidance also states at § 2239.1(b) that such claims may be bundled only to the extent that they represent services provided by the same noncontracting IHP.

Fees are split equally between the parties based on the number of claims bundled within a claim(s) dispute and whether there is a dispute over correct coding.

- In the DMHC process, if there is no coding dispute, fees are $315 per review, unless multiple claims are substantially similar, in which case fees are $350 for up to 10, $340 per review of 11-25, $395 per review of 26-50; if the dispute requires a coding review, fees are $330 per review, and for substantially similar claims, $330 per review of 2-10, $355 per review of 11-25, and $415 per review of 26-50;
- The DOI's fees are structured similarly but run slightly less - $295 per single request, as opposed to the DMHC's $315 charge, with the remaining pricing being $15-$20 less than the DMHC's, except that the DOI contemplates some claims will require a coding specialist and physician review, which will cost $495 per request.