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What Do You Do When Commercial Payers Want Their Money Back?

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Overview

- The Changing Commercial Payor Landscape
- Commercial Payors Are Applying Fraud and Abuse Principles to Labs
- Typical Demands from Commercial Payors and Potential Responses
- Potential Legal Defenses to Commercial Payor Demands

The Changing Commercial Payor Landscape

- Payor Consolidation:
  - The Department of Justice is suing Anthem to block a proposed deal to buy rival Cigna;
  - DoJ also is seeking to block a proposed merger between Aetna and Humana.
  - Consolidation happening at lower levels at well:
    - Kaiser and GHC

The Changing Commercial Payor Landscape (cont.)

- Tighter Profit Margins/Losses Due to the ACA
  - UnitedHealth expects to lose $850 million due to the ACA in 2016
  - Aetna, Anthem, and Humana are on track to lose at least $300 million each on their ACA plans this year
- The Old School Commercial Payor Strategy of Slow Pay/Not Paying Claims Isn't Enough to Stem this Tide of Red Ink
- The New Payor Strategy: Try to Get Back What Was Already Paid, Using Increased Market Power and Threats of Lawsuits.

Humana
Attn: Provider Payment Integrity Department
P.O. BOX 14501
Lexington, KY 40512-4601

HUMANA.

January 15, 2015

[redacted]

REFUND REQUEST — SEE ENCLOSED CHART

Dear Patient Account Manager:

Humana strives to offer our members high-quality health care at affordable rates. To facilitate this objective, we review our payments for accuracy. While it is certainly our desire to pay all claims accurately the first time, occasionally we find that claims have been paid incorrectly. As part of a recent review, we determined the claim(s) referenced on the enclosed chart to be overpaid by $34,750.87. The reason(s) for the overpayment(s) is/are on the overpayment chart enclosed.

Please review your files with the enclosed chart. If you confirm our findings, please send a refund, along with a copy of the enclosed chart, to the address below within 45 days from the date of this letter. If you do not agree with these findings, wish to dispute this notice or have questions regarding this overpayment, please contact us within the next 45 days to advise us of your concerns at 1-800-438-7885, 24 hours a day, seven days a week. Please be prepared with the following information: provider name, provider tax identification number (TIN), provider phone number, provider fax number, patient name, patient member ID, claim number, recovery item number and date of service for the claim.

To submit a refund for this overpayment amount, please direct your refund check to the address below:

Humana Health Care Plans
P.O. Box 931655
Atlanta, GA 31193-1655

If you have already issued a refund check for these claims, please disregard this request and accept our thanks. If not, it is important that we hear from you within the next 45 days to resolve this refund request and avoid having the overpaid amount deducted from future payments or referred to our outside collection agency.

Please accept our apologies for any inconvenience, and thank you for the continued care you provide to our members.

Sincerely,

Amy Schelb

Amy Schelb
Provider Payment Integrity Manager
Humana

Enclosure

[redacted]

Commercial Payors Are Applying Fraud and Abuse Principles to Labs

Fraud, Abuse, Kickbacks and Related Issues

- Federal Anti-kickback Statutes, False Claims Acts, and the Federal Stark Law only apply to claims involving Federal Health Care programs
- States laws have similar limitations
- Neither the federal nor the state fraud and abuse laws have private rights of action, so they cannot be used to sue labs *directly*
  - But they are nevertheless being asserted by payors as justification for recoupments
  - Payors are hiring former prosecutors to help them do this

Lab Payment Challenges Continues to Evolve

The new molecular and genomic tests raise a host of new issues:

- The tests are expensive and easy to order, leading to the potential for rapid volume increases
- Methodology is “research use only” (RUO) or “investigational use only” (IUO)
- No/new/different CPT codes assigned
- LCDs / NCDs not issued, not issued widely, or negative
- Potentially high cost of tests to patients
- Increasing concern about surprise bills

Issues of Concern to Payors

- Seeking reimbursement for tests not performed
- Tests performed, but not ordered
- Tests “ordered” by a non-authorized individual
- Payments to physicians for referrals
- Markup of purchased tests
- Inaccurate or inappropriate selection and reporting of the diagnosis and procedure codes
- Waiver of patient copays/contributions

All of these issues are now being asserted by private payors as reasons why past payments should be recouped.

Emerging Commercial Payor Recoupment Strategies

Routine Waiver of Cost-Sharing Asserted as a Kickback and Reason Recoupment

Good Start Routinely Waived, or Failed to Collect, Member Cost-Sharing:

The anti-kickback statute of the Federal Social Security Act (the "Act") makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a Federal health care program. See section 1128B(b) of the Act. Section 1128A(i)(6) of the Act defines "remuneration" as including, inter alia, the waiver of cost-sharing obligations (or any part thereof). The statute contains an exception to the definition of remuneration for certain waivers of cost-sharing obligations that are not advertised, are not routine, and are made on the basis of individual determinations of financial need or for which reasonable collection efforts have been made. See Section 1128A(i)(6) of the Act. Similarly, Massachusetts General Law c. 175H, §3 prohibits this conduct in relation to claims paid for by private health insurers.

In-Network Contract Terms Used Against Out-of-Network Providers

Relevant HPHC Policy Provisions[2]

From HPHC's *Laboratory and Pathology* Policy:

- Testing must be based on a specific written request from an authorized treating prescriber for the purpose of diagnosis, treatment, or an otherwise specified medically necessary reason.

From HPHC's *Non-Covered Services* Policy:

- Services or procedures that are experimental, unproven, or investigational and not supported by evidence based medicine and established peer reviewed scientific data are not covered. This may include, but is not limited to, drugs, devices, treatments, procedures, and laboratory and pathology tests.

From HPHC's *Genetic Testing* Policy:

- Harvard Pilgrim covers genetic tests when all of the following conditions are met:
  - A member displays clinical features, or is at direct risk of inheriting a known mutation(pre-symptomatic); OR after history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain and a gene-linked disease is suspected;
    AND
  - The result of a test will directly impact a member's clinical treatment or management.

Private Court Actions Against Perceived Billing Abuses

Blue Cross & Blue Shield of Mass., Inc., v. Dr. Alfredo Chan and United Esoterics (Massachusetts Superior Court, Suffolk County)

- Blue Cross and Blue Shield of Massachusetts is suing Alfredo Chan, a doctor with a psychiatry practice, alleging a scheme in which Blue Cross was overbilled for laboratory services provided to Dr. Chan's patients.
  - According to the complaint, Chan entered into an agreement with United Esoterics (UE).
  - UE provided all laboratory services to Chan's patients.

  But:
  - UE was not properly certified (under CLIA) to provide such services, and not eligible under Chan's network provider agreement with Blue Cross.

BCBS-MA v. Dr. Chan and United Esoterics (cont.)

> 25. Upon information and belief, UE advertised itself as a turnkey laboratory service that would provide profits to physicians at no cost to them.

- Through Chan, UE billed Blue Cross at high out-of-network provider rates for laboratory services.
  - Blue Cross alleges it overpaid UE, compared to Chan's contract for in-network rates.
- UE allegedly "unbundled" its services to increase payments from Blue Cross, and charged for services that were never ordered by a physician.
- Allegedly, charges were passed on by Chan. UE allegedly provided referral fees or profit-splitting with Chan.
- Blue Cross was seeking damages in the amount it says it overpaid -- $255,104 -- as well as attorney's fees and the costs of its investigation.

Strategies to Push Back on Aggressive Commercial Payors

Turnabout is Fair Play: Use Payors' Own Rules and Policies Against Them

Jujutsu is a Japanese martial art and a method of close combat for defeating an armed and armored opponent in which one uses no weapon or only a short weapon.

Jujutsu developed to combat the samurai of feudal Japan as a method for defeating an armed and armored opponent in which one uses no weapon, or only a short weapon. Because striking against an armored opponent proved ineffective, …[t]hese techniques were developed around the principle of using an attacker's energy against him, rather than directly opposing it.

Payor Jujutsu

- They are bigger and stronger than you
- You need the to pay you going forward
- Attack and defense has to be strategic
- So what to do?
- Take a close look at the payor provider manuals. They can both help and hurt, but you need to know what’s in there regardless
- Understand the payor's dispute resolution process and follow it to the letter

In Combat with Medicare Advantage Plans, Know and Apply the CMS Rules

- CMS, in its September 27, 2013 “MA Payment Guide for Out of Network Payments,” clearly states, “The Medicare payment is the lesser of the submitted charge, the fee schedule, or the national limitation for each lab HCPCS code.” http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/downloads/oon-payments.pdf at 19.
- In order to comply with existing law, payors must -- both retroactively and going forward -- pay the Medicare rate on each MA claim.

State Consumer Protection Laws (Particularly Those Aimed at Insurance Practices)

- California Business and Professions Code § 17200 et seq. (prohibiting "any unlawful, unfair or fraudulent business act or practice")
- California Insurance Code § § 790-790.15
- Mass. Gen. L. ch. 93A
- Mass. Gen. L. ch. 176D, 3(9)("Unfair claim settlement practices: An unfair claim settlement practice shall consist of any of the following acts or omissions: (a) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue…; (f) Failing to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear….")

Can ERISA Also Help Labs Fight Back Against Payor Demands?

- Under the principles set out by a federal District Court in Pennsylvania Chiropractic Ass'n v. Blue Cross Blue Shield Ass'n, No. 09 C 5619, 2014 WL 1276585 (N.D. Ill. Mar. 28, 2014), labs may have the right to request an appeal of a third party payor's recoupment decision before any monies are actually recouped or offset.
  - May depend on whether patient claims are assigned to the lab.
- If ERISA does apply, the payor must clearly explain to the lab in advance why the recoupment is being requested and must detail the specific plan provisions that it used in making its determination.

Can ERISA Also Help Labs Fight Back Against Payor Demands? (cont.)

- ERISA requirements on the payor:
  - Inform the lab precisely what material and documentation are needed to avoid claims repayments
  - Notify the lab of its appeal and litigation rights.
  - Provide a claimant with “all documents, records, and other information relevant to the claimant’s claim for benefits.”
- Each failure to comply is an ERISA violation: “IBC's practice of withholding or reducing payments to a provider when it determines that a previous payment was made incorrectly therefore falls within the applicable regulation's definition of an adverse benefit determination.”

Delay is Still a Concern, So Know Your State Prompt Payment Laws

- New York law requires prompt payment of claims with 45 days of receipt, or within 45 days of settlement of an appeal. The Department of Financial Services views each claim processed outside of that 45 day time period as a separate violation for which interest is due.
- See New York State Insurance Law § 3224-a, which "requires insurers and health maintenance organizations to pay undisputed claims within 45 days after the insurer receives the claim, or within 30 days if the claim is transmitted electronically." New York State Department of Insurance OGC Op. No. 11-05-03, available at http://www.dfs.ny.gov/insurance/ogco2011/rg110503.htm.

Thank you.

- For follow-up questions, please contact:

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