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Are You Getting Paid What You Are Entitled to for Emergency Services?

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If a provider participates in a health insurer's Affordable Care Act (ACA) exchange products (or its other plans), there is generally a direct way to determine if it has been paid the amount to which it is entitled: the provider need only consult its participating provider agreement and the incorporated compensation schedules. But what if the provider does not participate in the insurer's ACA exchange products? Because most ACA exchange products provide for reimbursement to participating providers only, the answer is often ''nothing.''

One exception is for emergency services. ACA exchange plans, like other health plans, are required to cover emergency services provided by out-of-network providers. 42 U.S.C. 300gg-19a(b)(1)(C)(i). Indeed, this requirement also applies to self-funded employer plans. *Id.*; 42 U.S.C. § 300gg-91(a) (defining ''group health plan''). It also applies to Medicare Advantage plans. 42 U.S.C. § 1395w-22(d)(1)(E), (3); 42 C.F.R. § 422.113(b).

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Emergency services include the screening, evaluation and stabilization of an emergency medical condition that a hospital is required to treat under EMTALA. *Id.* § 300gg-19a(b)(2). Whether the patient is suffering from an emergency medical condition is evaluated from the perspective of a prudent layperson. *Id.*

1. Reimbursement of the Usual and Customary Rate for Emergency Services Provided by Nonparticipating Providers.

For emergency services, federal law requires a plan to reimburse a non-participating provider the greater of the median amount that it pays to participating providers for the same service, the plan's normal out-of-network payment methodology or the Medicare rate. *See* 42 C.F.R. § 147.138(b)(3)(i); *see also* 29 C.F.R. § 2590.715-2719A(b)(i) (ERISA regulation). Finally, the patient is only subject to his or her in-network cost-sharing requirements, such as copayments and coinsurance. 42 U.S.C. § 300gg-19a(b)(1)(C)(ii)(II); 42 C.F.R. § 147.1238(b)(3)(ii); *see also* 29 C.F.R. 2590.715-2719A(b)(ii).

State law, however, often provides for greater out-of-network reimbursement to providers of emergency services than federal law. For example, Texas requires HMOs (a structure often adopted by ACA exchange plans) to reimburse nonparticipating providers for emergency care at the usual and customary rate or an agreed upon rate. Tex. Ins. Code § 1271.155(a). Texas applies similar protections if the patient has a PPO plan. See Tex. Ins. Code § § 1301.0053, 1301.155; 28 Tex. Admin. Code § § 3.3704(a)(5), 3.3725. Florida law is similar. See Fla. Stat. 641.513(5) (requiring HMOs to reimburse emergency services and care rendered by nonparticipating hospitals at the lesser of the provider's charges, the usual and customary provider charges, or an agreed-upon rate). Additionally, if certain plans do not timely pay a claim for emergency services, a nonparticipating provider in Texas may be entitled to additional amounts up to and including its billed charges. See Tex. Ins. Code § § 843.351, 1301.069.

Although Texas defines ''emergency care'' similarly to the federal definition of ''emergency services,'' the Texas provision also covers, in certain circumstances, post-stabilization care provided to the patient. *See* Tex. Ins. Code § § 843.002(7), 1271.155(b)(3). Specifically, Texas requires an HMO to approve or deny the provision of post-stabilization care within one hour; other-

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wise, the post-stabilization treatment is deemed approved and must be paid at the usual and customary rate. Tex. Ins. Code § 1271.155(b)(3), (c).

California law also requires a health-care service plan that covers emergency services to reimburse out-of-network providers of emergency care the reasonable and customary value of those services. *See* Cal. Health & Safety Code § 1371.4(b)-(c); 28 Cal. Code Regs. § 1300.71(a)(3)(B); *see also Bell v. Blue Cross of Cal*, 131 Cal. App. 4th 211, 215 (2005) (holding that emergency physician could seek reasonable and customary payment from HMO). California's regulations actually specify the information to be considered in determining the amount of the reasonable and customary rate, and also require a health-care service plan to pay for all pre-stabilization care and timely respond to requests to authorize post-stabilization care by nonparticipating providers, or the care is deemed approved at the usual and customary rate. *See* 28 Cal. Code Regs. § § 1300.71(a)(3)(B), 1300.71.4(a)-(b).

2. What Is the Usual and Customary Rate?

It is often difficult to determine what the usual and customary rate for services is, however. California, for example, requires that the usual and customary rate for services be determined using ''statistically credible information that is updated at least annually and takes into consideration: (i) 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.'' 28 Cal. Code Regs. § 1300.71(a)(3)(B). Given the flaws proven to exist in statistical databases historically used to determine the usual and customary rate for services, however, providers are justified in being suspicious of such databases. (One such database, FAIR Health, is a nonprofit that was funded through settlements between the New York Attorney General and various health insurers relating to the use of the Ingenix databases. http://www.fairhealth.org/CorporateFAQs)

A provider's full billed charges may be indicative of the usual and customary rate but often are not. By the same token, government benchmark rates, such as for Medicare, Medicaid or workers' compensation plans, are also not the usual and customary rate. *See, e.g., Children's Hosp. Cent. Cal. v. Blue Cross of Cal.*, 226 Cal. App. 4th 1260, 1272-75 (2014); *Geddes v. United Staffing Alliance Emp. Med. Plan*, 469 F.3d 919, 929-31 (10th Cir. 2006). Usually, the usual and customary rate will be somewhere in between, established by statistically valid databases and, often, expert testimony.

3. Making Sure a Provider Is Paid the Usual and Customary Rate

An out-of-network provider can take several steps to protect its right to be paid the usual and customary rate for emergency services. First, the provider should comply with any state law notification requirements, particularly if the provider provides post-stabilization care to the patient. Many states require notification of post-stabilization care but will deem the care approved if the provider requests approval and the insurer does not respond within a short timeframe (e.g., one hour).

The provider also should create a reliable back-office process for identifying claims submitted to insurers in whose network the provider does not participate, and for reviewing reimbursement for those claims upon receipt. Often, the insurer's reimbursement of these claims is something of a black box: it is difficult for the provider to identify the basis on which the insurer determined the amount to reimburse, as the insurer may have several options. In many instances, this analysis should include a telephone call to the carrier's provider hotline to ask if they can identify the method used to determine the amount to reimburse the provider.

Appeal! A provider should always appeal any perceived underpayments and include any documentation and information to be reviewed in the appeal to the insurer. For emergency care underpayments, the provider should include any information supporting an argument that the payment was less than the usual and customary rate. This includes any studies of prevailing charges in the provider's geographic area, any payments by that insurer for similar care at a higher amount, a description of the amount the provider would have been paid under its commercial fee schedules, any studies showing the cost of care provided to the particular patient and any other information supporting payment of a higher amount. Providers also should compare their reimbursement to the amounts published by various databases (including the FAIR Health database). For particularly high-dollar claims, the provider may wish to engage an expert to conduct an analysis supporting higher payment during the administrative appeals process.

Finally, the provider should track the results of the appeals process to identify patterns in what particular insurers are paying and whether litigation against a particular insurer is warranted. In evaluating whether litigation is warranted, a provider should consider how a jury will perceive the reasonableness of its charges, particularly by comparison to other similar providers in the same geographic area.

4. Conclusion

For out-of-network providers, getting paid an appropriate amount for emergency care is critical. By carefully monitoring claims submission and receipts, documenting the reasonableness of charges and pursuing appeals through available procedures, hospitals that treat emergency patients on an out-of-network basis can ensure they receive the maximum reimbursement for their efforts.

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