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Recent Challenges To The Use Of “Usual, Customary And Reasonable” Medical Provider Charge Data For Price Reimbursement To Non-Contracted Medical Providers, And The Potential Implications For Payors And Providers

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Hospitals, physicians, and other healthcare providers often have reimbursement contracts with healthcare payors that define the payment rates for enumerated lists of medical services and procedures that the provider furnishes to patients. But it is also not uncommon for some providers to lack payor reimbursement contracts for some patients. In the absence of a payment contract or a legally mandated rate, in most states a non-contracted medical provider's reimbursement is limited to the “reasonable value” of the services provided.^[1] One of the most common methods used to establish the reasonable value of healthcare services furnished by a non-contracted provider is to apply “usual, customary, and reasonable” (UCR) healthcare provider charge data. UCR data are typically gathered through surveys and other means to arrive at the “going rates” for various healthcare services and procedures furnished by healthcare providers in defined local geographical areas.

Managed healthcare regulations and statutes in many states generally seek to efficiently promote both the delivery of high-quality patient healthcare and fair reimbursement rates for healthcare providers. Some healthcare providers have challenged the fairness of the UCR pricing concept, as well as the validity of the underlying UCR data that support UCR payment rates. Although this UCR “going rate” pricing can be lower than some of the highest provider “billed charge” rates, it also may be higher than some of the lowest provider billed charges. But if UCR pricing is not used to establish reasonable value, what other readily available means exist in the absence of a contract or statutory rate? Some providers argue that “billed charges” reflect reasonable value. But many healthcare payors believe billed charges are arbitrary and overstate “reasonable value.” Several state courts have also rejected “billed charges” as the appropriate standard for “reasonable value.” Some payors believe that “Medicare-allowable” reimbursement rate equivalents more equitably reflect reasonable value for healthcare services. But some providers furnish healthcare procedures and services that do not have a “Medicare-allowable” reimbursement equivalent. Others maintain that various state workers' compensation statutes contain reimbursement rates that may better indicate the “reasonable value” for healthcare services furnished by non-contracted providers.

Recent Legal Challenges to UCR Pricing

Four recent court actions reflect many of the various legal challenges to the use of UCR pricing data by healthcare payors and other insurers to set the reimbursement rates for non-contracted healthcare providers.

In *Davekos v Liberty Mutual Insurance Co.*,^[2] a Massachusetts appellate division court addressed the admissibility of UCR non-contracted provider pricing data that was used by Liberty Mutual. This data was provided by Ingenix, a widely used and well-known supplier of UCR medical provider pricing data. Plaintiff Davekos was a non-contracted chiropractor who challenged Liberty Mutual's third-party insurer payment to Davekos, which was based on UCR reimbursement rates. Davekos had treated a patient who had sustained injuries in an automobile accident that was caused by a Liberty Mutual insured. Davekos had no reimbursement contract with Liberty Mutual, so he sought payment for his full “billed charges” from Liberty Mutual. Liberty Mutual instead apparently paid a UCR reasonable value amount to Davekos. Davekos challenged Liberty Mutual's payments as not being usual, customary, fair, or reasonable. Although the trial court accepted the general admissibility of the Ingenix UCR provider pricing data submitted by Liberty Mutual and UCR reasonable value amount paid to Davekos, the appellate court reversed and ordered a fresh look in a new trial. The appellate court held that this particular “reasonable value” pricing submitted in the Davekos trial should not have been admissible. This court explained that Liberty Mutual did not prove the

underlying UCR data was reliable or that it contained representative charges for the specified chiropractic services within Davekos' geographic area.

In February 2008, the New York Attorney General (AG) issued 16 subpoenas and service of a Notice of Proposed Litigation on several large healthcare insurers. The notice claimed that the Ingenix UCR payment databases used by such insurers to reimburse non-contracted providers are not accurate. The AG asserted that the failure to properly reimburse non-contracted providers at accurate UCR rates for comparable physician services creates higher premiums and uninsured portions for patients. The AG also claimed that any entity that contributes to the Ingenix UCR database is motivated to downwardly manipulate the data. A separate fraud claim also alleges that high outlier rates are not in the database, which further skews downward the UCR rates.

A federal class action in New Jersey, *McCoy et al., Wachtel, et al., and Scharfman, et al., v Health Net, et al.*,^[3] challenged the use of Ingenix data to set UCR payments for non-contracted providers. Plaintiffs alleged that the UCR data improperly includes two separately acquired databases consisting of data that was estimated and calculated, rather than collected. This allegedly skews downward all of the UCR pricing data values above the 70th percentile. Plaintiffs also alleged that the absence of proper statistical methodology to gather and sort the data also skews the data downward. Plaintiffs further argued that Ingenix only gathers data from voluntary contributors, which is not representative of all providers, and that the data is blended, which ignores the different licensure, qualifications, and types of providers and facilities.

In July 2007, the American Medical Association (AMA) and others commenced a federal action in New York for a myriad of provider reimbursement issues, one of which challenged the accuracy of the Ingenix UCR data. As in the New Jersey class action, the AMA alleged that a major portion of the database was derived and calculated, similar to Medicare reimbursement methodology, rather than being "collected." Also similar to the New Jersey action, plaintiffs claimed that another acquired portion of the Ingenix database was originally designed to only provide a general idea of prevailing provider charges, not precise, gathered values for reimbursement purposes.

Recent Challenges to UCR Pricing Have Not Addressed the Key Issue: Whether the Actual Payment Amounts "Accepted" by Non-Contracted Providers Best Indicate Reasonable Value

Notwithstanding the allegations in the four court actions discussed above, some appellate decisions suggest that a better indicator of the reasonable value for healthcare provider reimbursement is the amounts typically accepted as payment in full by these providers.

In *Temple University Hospital, Inc. v Healthcare Management Alternatives, Inc.*,^[4] a hospital brought an action and alleged it was underpaid for a specified time period in which it lacked a reimbursement contract with a particular healthcare payor. The court rejected the hospital's claim for fully billed charges, holding that this hospital cannot "unilaterally set a price for its services that bears no relationship to the amount typically paid for those services." The court explained that "in the absence of an express contract, the law requires the payment of reasonable value," which is normally what someone "receives for a given service . . . from the community that it serves." The "relevant community" in this case was comprised of "the Hospital's patients who are covered by insurance policies and federal programs."

Similarly, in *River Park Hospital, Inc. v BlueCross BlueShield of Tennessee*,^[5] a Tennessee court held that emergency services furnished by the non-contracted medical provider were to be paid at a "reasonable rate of reimbursement." Further, the hospital's "full standard [billed charges] rate" may be pertinent to the determination of a reasonable rate, but hardly conclusive regarding the reasonable value of emergency services furnished by the hospital. This important distinction between a provider's billed charges, and the payment rates typically accepted by providers, was expressly recognized in *Vencor, Inc. v National States Insurance Company*, where the court states that "providers' supposed ordinary or standard rates" may only be "paid by a small minority . . ." of healthcare payors.^[6]

Potential Implications for Providers and Payors

Litigation will most likely continue to evolve to address the absence of a clear definition of "reasonable value" reimbursement for non-contracted providers. Some providers who challenge UCR pricing assert that charges for the same healthcare services should not be blended across all the different types of providers and facilities to arrive at a reasonable value. But payors maintain that if a medical service can be safely furnished by a physician, physician's assistant, or advanced practice nurse, or if physicians can perform the same service in their office, hospital or clinic, then pricing data for the same services provided in each of these different settings should be blended to determine the reasonable value.

Payors maintain that the providers' criticisms of the statistical methodology used to gather and ascertain UCR data to establish reasonable value are misplaced. For example, the U.S. Census utilizes voluntary data collection activities that neither reach nor include responses from all residents. Yet these statistical method imperfections do not undermine the value of, or widespread reliance on, the collected census data, as it is routinely cited and relied upon by academic and governmental entities. If the usage of UCR data to establish reasonable value is completely rejected, courts may instead use workers' compensation rates, Medicare equivalent rates, or even other lower rates to set the reasonable value for non-contracted provider reimbursement. Perhaps instead of completely rejecting the use of UCR data to establish "reasonable value," it might be best to allow courts to apply accurate and comprehensive UCR data and reject incomplete UCR data on a case-by-case basis.

Appellate cases that have addressed the best manner to ascertain the reasonable value of healthcare services have held that "billed charges" may not indicate "reasonable value." These cases also indicate that the amounts providers typically accept as payment in full from all types of healthcare payors best indicate reasonable value. In sum, the best overall solution will be one that equitably balances the patient's needs for timely, high-quality medical services, with society's need for efficiency and cost containment for the delivery and reimbursement of healthcare services.

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[1] See, e.g., *Temple University Hosp. v. Healthcare Management Alternatives*, 832 A.2d 501, 508-509 (Pa. Super. Ct. 2003); *River Park Hosp. Inc. v BlueCross BlueShield of Tenn.*, 173 S.W.3d 43, 60 (Tenn. 2003); *Victory Mem'l Hosp. v. Rice*, 143 Ill.App.3d 621, 623 (1986); *Coalition for Quality Health Care v New Jersey Dep't of Banking and Ins.*, 358 N.J. Super 123 (2003).

[2] 2008 WL 241613 (Mass. App. Div. 2008) (Not reported in N.E.2d.).

[3] Civil Action No. 03-cv-1801 et al., (D.N.J.).

[4] 832 A.2d 501 (Pa. Super. Ct. 2003).

[5] 173 S.W.3d 43 (2003).

[6] 303 F.3d 1024, 1029 n. 9 (9th Cir. 2002).