QUARTERLY NEWSLETTER - FALL EDITION 2014 - #13

SAC REVIEW

REPRESENTING HOSPITALS FOR DECADES

More Content Coming Your Way!

Friends and Colleagues,

It is our hope that the *SAC Review* has given you insight into some of the most important and relevant topics in the healthcare sphere. Over the past 2 years we have had the pleasure of providing you with an inside look into the lives of some of our attorneys and staff members as well as sharing information and tools that we hope can assist you in staying up to speed on current topics in our industry. Now, you can look forward to more of the same great information, but more frequently than ever. With the introduction of our Blog (bookmark it at **www.sacfirm.com/blog**), which carries new articles twice per week, and the expanded *SAC Review* going from a quarterly publication to a monthly one, you now have access to significantly more up-to-date content than ever before. We truly hope you enjoy the expanded coverage from SAC.

"MEDICALLY NECESSARY" Who Gets to Decide?

By The SAC Litigation Team

Being hospitalized is stressful enough without having to worry about whether your insurance company will actually pay the hospital for the medical services you needed to get well. Unfortunately, one of the most frequent ways health insurers try to avoid having to pay for a procedure or treatment is to claim after-the-fact that it was not really medically necessary or that it was experimental. These claims, which are more frequent than you may think, sometimes seem to defy logic. You, the patient, didn't feel well. You needed medical treatment to get better. The hospital treated you and now you are okay. How can anyone then say this treatment wasn't medically necessary? What is going on here?

It all has to do with the way contracts between health insurance plans and hospitals are worded. Many of these require the hospital to agree to the health plan's medical policies, also sometimes known as clinical policies. The medical policies determine when medical procedures are considered by the health plan to be medically necessary, and therefore payable, and when they are not. Some contracts even give the health plan full latitude to make the final call. This means a plan can literally say "It was not medically necessary because we say it wasn't." And it ends right there.

These contract provisions come in a number of forms, some less clearly identifiable than others. For instance, "medical necessity" may be defined as services that are (1) necessary for the diagnosis or treatment of a condition, illness or injury; (2) provided in accordance with recognized medical practices and standards; and (3) in accordance with the health plan's medical policies. Under the last definition, the health plan can argue that any procedure that does not comply with its medical policies is by definition not medically necessary and thus the health plan has no obligation to pay for the treatment.

Health plans also like to include provisions that expressly incorporate their medical policies into the hospital agreement. These policies are completely within the control of the plan. Agreeing to make the policies part of the contract means the hospital agrees to be bound by them even though they had no input in creating them.

The health plans then rely on their own policies to decide on whether any given treatment or procedure is medically necessary. What is important to know, however, is that SAC's clinical investigations of those claims often show that the denied procedures would be considered medically necessary under traditional medical practices and standards. But since they don't meet the health plan's policies, they are denied. That denial however, is not the end of the story, as SAC has often been successful in recovering on clinical denials even in the face of such language.

To level the playing field, SAC recommends that hospitals and other health care providers remove contractual language binding them to health plan medical policies in future agreements, especially since the hospitals have no role in drafting the medical policies and most agreements give the health plans the right to revise the policies at any time.

In the meantime, it's important that hospitals be aware of the applicable medical policies so that they can make informed decisions regarding treatment of non-emergency patients. ■

DEALING WITH THE RAC MEDICARE APPEALS LOGJAM

By The SAC Litigation Team

Conventional wisdom supports the theory that when the government steps in to try and solve one problem, it usually ends up creating new ones. A perfect example of this "rule of unintended consequences" is what happened when the Federal Government introduced Recovery Audit Contractors (RACs) to better regulate payments to hospitals for medical services rendered to Medicare patients.

The stated mission of the RAC program was to"identify and correct" improper Medicare payments. This means that they were required to utilize "efficient detection" methods to determine whether claims for health care services provided to Medicare beneficiaries were overpaid or underpaid. If the claims were overpaid, the government would recoup the payment from the hospital and if the hospitals were underpaid, the government would pay the hospital. (For more information, visit http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/). Sounds simple enough.

From the government's point-of-view, the program worked brilliantly with nearly $2.4 billion recouped from hospitals during the first nine months of 2013 alone. The problem for hospitals, of course, is that many of these recoupments were neither

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justified nor supportable. So hospitals and other healthcare providers are now in the unenviable position of having to work to either recover payments that were taken back by challenging the validity of the RAC audit results or trying to stop the take-backs before they happen. In short, the RAC process has resulted in a series of additional hurdles hospitals must now overcome to ensure they are properly compensated for the medically necessary services they provide to Medicare patients.

Hospitals are now faced with battling a burdensome and time-consuming appeals process to either stop the Medicare payment 'claw-back' from happening or to appeal for a reinstatement of the 'claw-back' that has already occurred. The process includes a two level written appeals process and a hearing before an Administrative Law Judge (ALJ). These ALJ hearings offer the best opportunity for providers to prevail on their previously denied RAC appeals because it is the first time in the appeals process that the claims are evaluated by an impartial person. But as late as May 2014, there was a backlog of nearly 480,000 RAC appeals cases waiting for adjudication before an ALJ. As of this writing, it can take up to six months to get a hearing scheduled on a Judge's calendar. This long wait leaves billions of dollars in provider revenue within the administrative system rather than with the providers of the medical services.

As lengthy as the six month wait may be, it is going to get even longer since the Centers for Medicare & Medicaid Services (CMS) has said that it will suspend RAC's ability to request documents related to claims review as well as halt all ALJ appeals until CMS obtains new RAC contracts. As soon as this moratorium is lifted, the waiting line for an ALJ could easily stretch to as long as three years.

But there may a light at the end of the tunnel for hospitals and other healthcare providers. The American Hospital Association (AHA) has sued the U.S. Department of Health and Human Services on the grounds the lengthy RAC appeals process is prejudicial to providers. The AHA hopes the court will mandate statutory deadlines for timely review of Medicare claims denials. In the meantime, we have news that this light may be brightening. CMS recently announced a "Hospital Appeals Settlement" for fee for service denials based on patient status reviews for admissions prior to October 1, 2013. CMS is offering an administrative agreement to any provider willing to withdraw its pending appeals in exchange for timely partial payment (68% of the net allowable amount).

SAC is currently assisting its clients in evaluating the propriety of accepting this offer as opposed to continuing to trudge through the appeals process. ■

SAC SPOTLIGHT

Annie Chang

This quarter's Spotlight is on attorney Annie Chang.

Spotlight Q&A

What is your area of expertise within SAC?

I am a litigation attorney at SAC, and I handle cases in court and also cases in arbitration. I have specialized experience in patients who seek treatment in U.S. hospitals, but are non-U.S. citizens. I also have experience in cases against public entities, and understand how to overcome the many hurdles a hospital must surpass before suing the public entity in court.

What one piece of sage advice can you offer to our clients that can help them in the future?

Hospitals often treat patients who are visiting from a foreign country or provide care to newborns with parents from a foreign country. The problem with these foreign patients is they can easily evade paying for the medical services by going back to their home country right after being discharged. The best way to maximize the hospital's ability to get reimbursed is to start collecting evidence and building a case right from when they enter the hospital doors. Ensure you have everything in writing. Having the foreign patient enter into a confession of judgment or having them served with a lawsuit before they leave the U.S. would be the best way to safeguard payment and the hospital's rights against the foreign patient.

Can you talk about a recent success story of yours? What was the challenge and how were you able to overcome it?

I had a case where parents from a foreign country came to the U.S. to have their babies, orally promised the hospital that they would pay for the medical services provided by the hospital, but subsequently went back to the foreign country without paying a significant part of the bill. The problem faced in situations like this where the financially responsible party is physically in another country, is how to subject them to the jurisdiction of California courts and perfecting service of a complaint if we need to file a lawsuit. In this case, I was able to reach a favorable settlement for the hospital without having to file a lawsuit. I also set up legal safeguards for the hospital in the settlement agreement, such as a confession of judgment, just in case the foreign parents do not honor the agreement.

Do you have any hobbies or interests outside of work?

I enjoy yoga, cooking, and gardening. I like to go to the Los Angeles Flower District on the weekends, pick out fresh flowers, and make floral arrangements. My friends and I did all of the flower arrangements at my wedding, and I've been hooked on it since then! I am also participating in SAC's Health Challenge, sponsored by pH Labs. This includes taking 10,000 steps per day, eating healthy, staying hydrated, and exercising at least 30 minutes per day. This health challenge has inspired me to train for a half marathon in 2015. A huge shout out to my team, #1 TEAM - Joy, Maria T., Karlene, Armineh, Rosio, Maria B., Caroline, Cynthia, Stephanie, Veronica, and Cece !!!

Do you have any charitable causes that interest you and events you have participated in recently?

I am an attorney volunteer at the California Innocence Project, which involves reviewing case files to determine whether there is a substantial amount of evidence in the case that may show an appeals court that an inmate may be wrongly convicted. I am also a part of the Beagle Brigade, a group of beagle enthusiasts that get together monthly to socialize their beagles, and also to ban the use of beagles in lab testing/experiments and promote adoption over buying dogs from breeders.

Do you have family and/or pets you'd like to tell us about?

I recently just celebrated my one year wedding anniversary with my wonderful husband, Richard. We also have a dog, Enzo. He is an adorable, adopted beagle/dachshund/chihuahua mix. We recently purchased a home and are working on renovating and making the house our own. We're excited to move into the house, each for our own reasons: Richard can't wait to work on his car in the garage, I can't wait to start a vegetable garden, and Enzo can't wait to dig holes and chase squirrels in the yard!

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GOING THE DISTANCE

By The SAC Litigation Team

It's no surprise that payment delays, avoidance and reduction are tools that health insurance companies use to increase their profit margin. But when this strategy results in a broken promise to pay for contracted medically necessary services, the insurer needs to be held accountable. One of the most effective ways to hold an insurer accountable is through trial in a formal lawsuit or binding arbitration.

While both a trial and an arbitration have the same goal of making the insurer fulfill its contractual obligations, they are slightly different in how they work and looking at this difference is important in determining which is best in any given situation. A lawsuit is where SAC, on behalf of a client, files a formal complaint with a court. The case is assigned to a state or federal judge who then directs the lawyers in the handling of the case by setting deadlines for them to complete their investigation and a date for the trial. The trial is a formal proceeding much like you see on TV.

Arbitration, in contrast, is much less formal than a lawsuit but, in general, it proceeds in a similar manner. An arbitrator is assigned based on input from both sides and he or she then sets deadlines for the attorneys to meet. The hearing is held in a conference room, but proceeds just like a trial would. The biggest difference between arbitrations and trials is that arbitrations are binding with no right to appeal (except in very limited circumstances) and are usually more expensive.

The decision to pursue arbitration or a lawsuit is generally based on the contract between the health insurer and the health care provider that dictates the ways in which the parties may seek to resolve disputes.

Why should you go the distance? Unlike a health care provider, an insurer remains profitable by collecting premiums for many consumers but slowly or not paying claims for a substantial number. Denials and slow payment increase profitability! A health care provider remains profitable by being promptly and accurately paid for providing services to consumers. Obtaining payment for medical services can be frustrated when these opposing business objectives meet. To combat this trend of slow, reduced or lack of payment, providers must be prepared to go the distance. When the insurer has wronged the provider the provider should take action — sue the insurer or, if contracted, follow the dispute resolution steps in the contract and be prepared to proceed to arbitration or trial.

The reluctance by health care providers to go the distance is understandable because of the time involved. Arbitration and trial take time away from primary work responsibilities to deliver medically necessary care to patients and may be costly. Moreover, there is often a scramble to determine which lucky individual is going to testify on the provider's behalf. But keep in mind that insurers rely on providers' indecision and unwillingness to attend hearings to escape paying what is owed.

Although the risk of losing is a serious consideration, taking the appropriate case to trial or arbitration is a very good way to send a message to the insurer. Taking a hard stand also pays dividends in creating a track record with the insurer. If you take a case to trial or arbitration, that insurer will know you mean business in future cases and the recovery of future claims becomes easier. This has proven true for many of our clients in the past. Moreover, insurers may deny fewer claims overall and pay more of what they owe before arbitration hearing or trial, which may ultimately result in fewer disputes.

In short, if providers are prepared to take cases to arbitration or trial on stronger cases then they can often obtain better results in most claim disputes. ■

THE HIGH STAKES OF GOOD PATIENT CARE

By The SAC Litigation Team

Good hospitals generally try to insure that their patients have the broadest scope of medical services as well as top quality treatment. To help them do this, many offer relocation and other financial assistance packages to highly qualified doctors and specialists they want to have available to their patients.

Let's say that Hospital X, for example, wants to improve its expertise in cardiology. The hospital decides that the best way to do this is to recruit a highly qualified specialist in cardiology who happens to live in another state. In order to persuade the cardiologist to pull up roots and join its medical staff, the hospital may offer the doctor a "start up" loan package to help cover the costs for relocation and to establish a practice in a new community.

This loan, like any other, would require the doctor to sign a loan agreement with the hospital. The loan payments would likely be made periodically, perhaps monthly, with the cardiologist obligated to repay the loan funds after some time, usually a year or more. The cardiologist is usually required to also maintain a practice within the hospital's service area for several years. In the event the cardiologist relocates out of the hospital's service area before the loan is repaid, the doctor would be required to immediately repay any balance to the hospital.

But what happens if the cardiologist does, in fact, move out of the service area before the contractual term expires or before the loan is paid off? The good news is that the hospital can aggressively seek recovery from the cardiologist or any other physician that breaches a financial assistance agreement. But to prevail, the hospital needs to ensure that these types of agreements are outlined with a clear and concise contract that includes a promissory note signed by the physician.

The hospital can achieve this by, first, having expert legal representation in the drafting of these types of contractual documents, preferably with attorneys who understand the intricacies of the health care system. The second is representation by competent and aggressive litigators in the event the hospital needs to sue the doctor for breaches of the agreement, whether due to relocation or nonpayment for some other reason.

By taking a few simple steps to protect themselves, hospitals can feel confident in offering recruitment incentives to the best medical talent that will ultimately benefit consumers – their patients. ■

JOIN TEAM BILI!

asics LA MARATHON 30TH EDITION

The Bili Project Foundation will be a 'Participating Charity' in the 2015 ASICS LA Marathon! Be a part of an exciting group of BILIevers as they run for one of the best foundations in one of the best marathons in the country. For more information on how to be a part of our team visit **www.thebiliproject.org**

SAC SPOTLIGHT - CONT'D

Do you have any guilty pleasure television shows, movies or other activities to tell us about?

I never miss an episode of Scandal and The Good Wife. I also love macarons from the Euro Pane bakery in Pasadena.

What are your favorite foods? Colors? Other favorites?

I enjoy all foods and especially learning about different cultures through their food and way of dining. Currently, my colleague has introduced me to Middle Eastern food, and I absolutely love the food and the culture! The Barg Kabob (sliced filet mignon) and KashkO'Bademjan (fried eggplant/caramelized onion) are fantastic at Raffi's in Glendale.

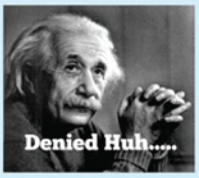
QUESTIONS / COMMENTS

We would love to hear from you! If you have questions, comments or feedback please email us at **SACReview@sacfirm.com**.

WWW.SACFIRM.COM

Social Media Highlights!

TOP SAC FACEBOOK POST FOR SEPTEMBER 2014



The "expert" way to get your insurance claim denial reversed

Sometimes figuring out how to get your health insurance bill paid seems like the job for a scientist. Did you know that hospitals have to hire experts to get your bills paid? This way the consumer doesn't have to worry about large bills after they have paid for health insurance.

Read more about the critical role of experts in reversing denials on our blog. **http://www.sacfirm.com/blog**

UPCOMING EVENTS

- **October 15 - 17, 2014 - Annual National Institute - Manchester Grand Hyatt, San Diego, CA**
  - Go to http://www.aaham.org/Events/AnnualNationalInstitute.aspx for more information
- **January 11 - 14, 2015 - 17th Annual HFMA Region 11 Healthcare Symposium San Diego, CA**
  - SAC will be in attendance at this years HFMA Symposium and will be sponsoring an evening cocktail reception during the festivities. Please be sure to swing by!
  - http://www.hfmaregion11symposium.org/ for more information!

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QUARTERLY NEWSLETTER
FALL EDITION ENCLOSED

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