CMA Survey Finds Widespread Unfair Payment Practices by Health Plans

March 22, 2018

Despite the California Legislature's enactment of Assembly Bill 1455 (Stats. 2000 Ch. 827) to address widespread payment abuses by health care service plans, many of them continue to flout the law.

The Department of Managed Health Care (DMHC) has been slow to address provider complaints and has taken few enforcement actions against health care service plans that unlawfully underpay providers. When DMHC has acted, the penalty amounts have been small in relation to the economic injury to consumers and providers. DMHC also has refused to issue enforcement actions to cover the entire period of underpayment and has not required health care service plans to pay providers even after it has determined payment should have been made. Accordingly, health care service plans make economic decisions to violate the law, knowing that any penalty amount that may be imposed will be outweighed by the extra revenue the health plans will generate by, for example, underpaying medical care. This results in a loss of resources that should be invested on patient care.

CMA, along with its county medical societies and several specialty societies, conducted a survey of physicians to obtain feedback on the health plans that are routinely engaging in unfair payment patterns, the types of violations and the results of physician efforts to resolve the issues both through internal plan processes as well as through DMHC. In a period of nine days, 741 physician practices representing thousands of physicians responded to the survey.

The survey results confirm that health plans overwhelmingly continue to engage in the unfair payment practices, despite the legislation that passed 18 years ago attempting to stop these abuses. It further demonstrates that though plans are required to maintain fast, fair and cost-effective provider dispute processes, the health plan processes are largely ineffective.

To address this issue, CMA is sponsoring AB 2674 (Aguiar-Curry), which would require the DMHC to investigate provider complaints that a health care service plan has underpaid or failed to pay the provider in violation of the Knox-Keene Act. If the DMHC finds that a health plan has unlawfully underpaid a provider, AB 2674 would require the penalty amount to, at a minimum, equal the amount of the underpayment plus interest. Further, AB 2674 would protect the health care delivery system by ensuring providers are made whole when health care service plans violate the law. The bill would also deter future violations of the law, thereby saving providers and the state vital resources that should be invested in patient care.

Survey Summary

- The survey gathered data from 741 practices within California representing physicians across a vast range of specialties and practice sizes in 40 different counties over a period of 9 days.

- Health plans continue to engage in widespread payment abuses. Two thirds of physician practice respondents report routine problems with plans engaging in various unfair payment patterns, defined as a practice, policy or procedure that results in repeated delays in the adjudication and correct reimbursement of provider claims, as outlined in 28 C.C.R. §1300.71.

- More than half of practices report that health plans continue to attempt to rescind or modify authorizations after the physician renders the service in good faith.

- Respondents overwhelmingly (62 percent) report that Anthem Blue Cross is the most problematic when it comes to violating the unfair payment practices and Blue Shield of California was second most problematic (52 percent).

- The health plan provider dispute resolution (PDR) processes are largely ineffective, with 32 percent of practices indicating disputes are resolved only half of the time and 29 percent indicating disputes are rarely resolved through the plans' PDR processes.

- Though most practices utilize the health plans' internal processes to attempt to resolve issues, 63 percent of practices report that plans routinely fail to respond to their appeals within 45-business days of receipt, as required by California law. Anthem Blue Cross is identified as the most problematic (66 percent) with Blue Shield the second most problematic (61 percent).

- When health plans do respond to physician appeals, 74 percent of practices state the health plan responses do not include a clear explanation for the plans' determination.

- Twenty one percent of practices report they don't use the plans' PDR processes. When asked why, 59 percent cited administrative burden as the main reason and 44 percent said the process was ineffective – a "rubber stamp" of the initial processing. More than a third of practices report staff reviewing clinical and administrative appeals are under-qualified and 35 percent state they rarely receive a response to their appeals (respondents allowed to mark multiple reasons).

- Only 26 percent of respondents currently utilize the DMHC's provider complaint process when the health plans' PDR processes fail. More than half of respondents were unaware that DMHC accepted complaints, but more than a third of practices cited administrative burden as the reason they don't use the process, 21 percent stated the DMHC process was ineffective and 15 percent indicated they don't file through DMHC because it doesn't investigate all complaints filed.

✳ When practices do file complaints through DMHC, 11 percent report their issues are resolved only half of the time and 62 percent report they are rarely or never resolved through the DMHC complaint process.

CMA Survey –Results

Survey Results – 741 practices representing physicians in 40 different counties practicing across a variety of different specialties and practice sizes responded to the survey.

1. **Does your practice experience routine requests for overpayments on fully insured claims from health plans that are beyond 365-days from the date of payment? (28 C.C.R. §1300.71(a)(8)(D))**

Yes	51.42%
No	48.58%

2. **Which health plans are most problematic?**

Anthem Blue Cross	64.33%
Blue Shield of California	47.45%
United Healthcare	42.68%
Aetna	34.39%
Health Net of California	28.03%
CIGNA	25.16%
Other	23.57%

3. **When health plans are recouping, does your practice routinely receive an overpayment notice identifying the claim, patient name, date of service and a clear explanation of the reason the plan believes the claim was overpaid? (28 C.C.R. §1300.71(a)(8)(D))**

Yes	43.49%
No	56.51%

4. **Which health plans are most problematic?**

Anthem Blue Cross	56.33%
Blue Shield of California	41.33%
United Healthcare	30.00%
Aetna	25.67%
Health Net of California	23.00%
Other	22.33%
CIGNA	18.33%

5. **Does your practice routinely receive health plan explanation of benefits (EOBs) that fail to clearly explain the specific reason for the denial or underpayment? (28 C.C.R. §1300.71(a)(8)(F))**

Yes	68.46%
No	31.54%

6. **Which health plans are most problematic?**

Anthem Blue Cross	61.79%
Blue Shield of California	53.66%
United Healthcare	41.19%
Health Net of California	30.62%
Aetna	30.08%
CIGNA	25.75%
Other	23.31%

7. **Does your practice routinely receive requests for medical records that aren't necessary to determine health plan liability on services that were previously authorized? (28 C.C.R. §1300.71(a)(8)(H))**

Yes	72.46%
No	27.54%

8. **Which health plans are most problematic?**

Anthem Blue Cross	67.89%
Blue Shield of California	57.63%
United Healthcare	41.32%
Aetna	31.05%
Health Net of California	28.42%
CIGNA	25.79%
Other	19.21%

9. **When a health plan has pended payment on one of your practice's claims due to a request for records from another provider or facility, does it indicate which provider or facility on the EOB? (28 C.C.R. §1300.71(h)(3))**

Yes	23.56%
No	76.44%

10. **Which health plans are most problematic?**

Anthem Blue Cross	59.74%
Blue Shield of California	46.75%
United Healthcare	35.32%
Health Net of California	27.53%
Aetna	25.97%
Other	22.08%
CIGNA	18.70%

11. **Does your practice routinely experience problems with health plans that fail to pay, contest or deny claims within 30-working days of receipt for PPO or 45-working days for HMO? (28 C.C.R. §1300.71(a)(8)(L))**

Yes	73.07%
No	26.93%

12. Which health plans are most problematic?

Anthem Blue Cross	61.94%
Blue Shield of California	55.56%
United Healthcare	45.28%
Health Net of California	35.56%
Aetna	35.56%
CIGNA	29.72%
Other	24.44%

13. When a health plan fails to pay timely, does it automatically pay interest once the claim is paid? (28 C.C.R. §1300.71(a)(8)(K))

Yes	13.16%
No	86.84%

14. Which health plans are most problematic?

Anthem Blue Cross	59.86%
Blue Shield of California	50.47%
United Healthcare	43.43%
Aetna	36.85%
Health Net of California	33.80%
CIGNA	32.16%
Other	27.23%

15. If the plan contests or denies a line item on a claim, does your practice experience problems with health plans repeatedly failing to pay the uncontested portions of that claim (line items) within the appropriate time frames? (28 C.C.R. §1300.71(a)(8)(L))

Yes	68.16%
No	31.84%

16. Which health plans are most problematic?

Anthem Blue Cross	67.17%
Blue Shield of California	57.75%
United Healthcare	45.29%
Health Net of California	36.47%
Aetna	36.17%
CIGNA	31.00%
Other	18.54%

17. Does your practice routinely experience problems with health plans failing to pay the correct (contracted) payment? (28 C.C.R. §1300.71(a)(8)(K))

Yes	64.39%
No	35.61%

18. Which health plans are most problematic?

Anthem Blue Cross	62.62%
Blue Shield of California	52.08%
United Healthcare	45.05%
Health Net of California	40.26%
Aetna	35.78%
CIGNA	32.27%
Other	23.96%

19. Has your practice experienced a health plan failure to provide 45-business days advance notice of a material change to the reimbursement rates associated with your contract? (28 C.C.R. §1300.71(a)(8)(N))

Yes	39.20%
No	60.80%

20. Which health plans are most problematic?

Anthem Blue Cross	68.54%
Blue Shield of California	54.49%
United Healthcare	47.19%
Aetna	41.01%
Health Net of California	39.33%
CIGNA	35.39%
Other	16.85%

21. Has your practice experienced problems with a health plan attempting to rescind or modify an authorization on fully insured claims after the physician renders the service in good faith? (28 C.C.R. §1300.71(a)(8)(T))

Yes	52.95%
No	47.05%

22. Which health plans are most problematic?

Anthem Blue Cross	63.03%
Blue Shield of California	57.82%
United Healthcare	43.13%
Health Net of California	34.60%
Aetna	32.70%
CIGNA	29.86%
Other	19.91%

23. Does your practice utilize the health plans' internal dispute resolution (written appeal) processes?

Yes	78.50%
No	21.50%

24. Please check all reasons why your practice does not utilize the internal dispute resolution processes.

Administrative Burden	58.82%
Ineffective-Plan Always Upholds the Initial Decision	43.53%
Under-Qualified Staff Reviewing Clinical and Administrative Appeals	36.47%
Rarely Receive a Response to Our Appeals	35.29%
Other	35.29%

25. Which health plans' dispute processes are most problematic?

Anthem Blue Cross	47.06%
Blue Shield of California	38.82%
Other	31.76%
United Healthcare	30.59%
Aetna	22.35%
Health Net of California	20.00%
CIGNA	20.00%

26. Does your practice routinely have problems with health plans failing to respond to a written appeal within 45 working days of receipt? (28 C.C.R. §1300.71(a)(8)(S))

Yes	63.09%
No	36.91%

27. How often are your appeals resolved through the plans' internal dispute resolution process?

Always	7.14%
Most Often	32.14%
Half of the Time	32.14%
Rarely	28.57%
Never	0.00%

28. Which health plans are most problematic?

Anthem Blue Cross	65.54%
Blue Shield of California	60.67%
United Healthcare	47.94%
Aetna	35.21%
Health Net of California	32.21%
CIGNA	28.46%
Other (please specify)	19.85%

29. Do the plans' written responses to your appeals routinely include a clear explanation of the reasons for their determination? (28 C.C.R. §1300.71(a)(8)(S))

Always	5.16%
Most Often	20.64%
Half of the Time	31.70%
Rarely	32.92%
Never	9.58%

30. Does your practice utilize the Department of Managed Health Care's (DMHC's) provider complaint system?

Yes	26.04%
No	73.96%

31. How often are your appeals resolved through the DMHC's resolution process?

Always	7.55%
Most Often	18.87%
Half of the Time	11.32%
Rarely	43.40%
Never	18.87%

32. Please check all reasons why your practice does not utilize the DMHC complaint process.

I Was Not Aware the DMHC Had a Complaint Process	51.49%
Administrative Burden	37.31%
Other	24.25%
Ineffective	21.27%
Resolution Takes Too Long	20.90%
DMHC does not investigate all complaints filed	15.30%

33. Do you have any stories or experiences that you think are particularly compelling examples of unfair payment patterns or ineffective dispute resolution processes?
(Sample)

- United Healthcare and Optum - we send the chart notes with the claim but they repeatedly send requests for the chart notes for the same DOS delaying payment.
- Blue Cross is notorious among all providers for nonpayment, authorizing and then denying payment.
- Recently, a patient died in July of 2017, However the payor entered the wrong date of death in their system (three years prior). This triggered a refund request for the deceased patient. Our appeals went unanswered. We had to contact the deceased patients' wife to resolve. In the meantime, we filed an appeal that went unanswered. We called multiple times but BS started to recoup the money on future payments. The patient's family worked to get the date of death corrected, however, we still have not been paid the amount the payor recouped.
- We send written appeals and end up placing several phone calls to get an answer. Claims adjusters do not take the time to look at the information provided. They do not seem to understand the process on how to help resolve claim issues. They continue to say we did not receive the claim or appeal or just say it is still in process.
- United Healthcare almost always requires submittal of medical records to get anything paid. It is very burdensome.

- A Blue Shield patient with prostate cancer received a Lupron injection in my office. I billed Blue Shield but they refused payment. Appeals were delayed citing they are “backlogged.” Finally, I had to complain to the DMHC, and I was ultimately paid but two years after the services were rendered.
- Molina has routinely underpaid our claims for over a year. Also, Blue Cross and Blue Shield routinely deny payment for our services for sedation for colonoscopy. They are the only health insurer we work with that does this.
- Anthem Blue Cross denied all claims for 3.5 months because of an internal error on their system regarding provider credentials. After 3.5 months of numerous calls and emails they finally corrected their error & started paying. However, they refused to pay interest or reimburse for the additional administrative costs. Anthem was completely at fault for erroneous denials and delayed reimbursement.
- There is no provider relations telephone number with Anthem Blue Cross. To get an answer, you have to send an email to a third party that gets forwarded to Blue cross. Then someone will call with a number that works for few days then back to Philippines and India call center.
- Magellan administers and pays claims for Blue Shield. But, they have systematically denied all E&M codes for psychiatric care during January and February 2018.
- Blue Cross paid for and IUD with the modifier 59 but didn’t pay for a yearly well woman visit. BlueCross paid for an insertion of an IUD but not the IUD.
- So many it's overwhelming. I am a surgeon. I used to be an accountant and have an MBA. I have a very specific Breast Reconstruction Practice, so I do the same procedures over and over. I bill my own consults and surgeries...so they are clean. I would estimate I don’t get paid for at least 1 in 3 claims. My office manager estimates we continually waste 10 staff hours per week in the pre-authorization or appeals process. Breast Reconstruction is covered by law. The problems with the health plans never end....
- Cigna has a claim of ours and continues to promise payment every time I call and still have not received payment for date of service 7/2017
- United will deny surgery claims after an authorization has been given. United HC, BC & BS request refunds stating simply "overpayment."
- Many. Prime example is emergency spinal surgery performed on a patient who could not walk and Anthem Blue Cross denying payment as "non- emergent". Anthem does this routinely. Another Anthem denial was emergency spinal surgery due to a lumbar fracture (patient could not stand), at the same time of repair of fracture a cyst was seen and biopsied and Anthem denied the emergency spinal surgery because the cyst turned out to be cancer and "non- conservative treatment was not tried for 6 months to treat the cancer". Do they want the doctor to stop the fix of the fracture and sew him up? Unbelievable.
- Aetna is the worst, after submitting medical records twice, appealing 3 times, calling numerous times, the representative will not give any reason but just say we are denied and the appeal is upheld. This is happening more than once. It is a constant issue.
- Molina is particularly bad.
- Yes, we have claims from many insurance companies that have not been paid. The "dispute resolution process" is useless and ineffective. The DMHC is mostly ineffective and cannot resolve our billing issues.
- A psychotic patient who did well on long-acting medication was denied coverage, relapsed into psychosis, and committed suicide.
- I have seen a pattern of payment denials on claims filed on patients receiving emergency services. I am a surgeon who sees patients in the ER and have received denial of payments in the past because a prior authorization was not obtained. I suspect I am not the only one with this problem.
- We receive late payments from La Salle and Independence Medical Group without receiving interest.
- Continual denial of claims for payment for devices - IUD inserted and not acknowledging the device code and even supported by the documents - processed over 1 year
- Service was authorized, but once the service was provided, Blue Cross denied payment.
- Blue Shield mental health - Magellan is currently requiring that medical records be sent EVERY time there is a coding of 99214 or 99215 with an add-on code. They ask that we bill electronically but send the records by US mail. This is obviously a ridiculous request on several levels and delays payment.

- Currently we have been having problems with UHC when I bill for infused drugs. They want the NDC and other info about the drug on the claim and I provide it but somehow their system doesn't show it. I hear this complaint from many of my colleagues around the country, specifically regarding United Healthcare.
- Requesting records on every claim for same treatment. Denying claims for precert/auth when on claim or not required.
- United Healthcare requesting medical records for routine annual physical exams is frustrating (as we are internal medicine). Cigna has fought with us to recoup money from 2+ years ago because they discovered the member wasn't insured.
- Often times, we verify that a patient was eligible through the insurance portal or with a live representative. We then later receive a request for refund because the patient was not eligible at the time of service due to a retro termination. We send in an appeal with reference number or proof of eligibility attached but insurance still denies our appeal and we have to refund or the insurance recoup from future payments.
- Getting worse and the worst is Anthem.
- The problems are mostly with Anthem. They can no longer be reached by phone.
- Cigna failed to pay the office contracted rate for over six months on all claims. Aetna still does not pay the contracted rate on all immunizations.
- I had a patient who had been on a medication for years for severe bipolar disorder. His medication required a renewed authorization. I sent documentation through to authorize meds. The diagnosis, apparently, fell outside of the plan's authorization policy and the payor did not cover the meds. Within a short period of time after being off his meds, the patient committed suicide.
- United Health Care denied the surgical insertion of the implant that was used to straighten out the patient's scoliosis. United Health only paid for the fusion. They denied the implant due to a lack of prior authorization claiming we only sent them the fusion code when in fact they were told in writing during the more detailed authorization process with ORTHONET that the Synthes implants would be used. We received a response to our appeal of their nonpayment that simply said DECISION UPHELD... no explanation to the 20 pages of documentation that was submitted. TOTAL ABUSE!
- I have a contract with Molina (single case agreement). There are seven claims they underpaid and another 8 the denied payment on altogether. I've followed their procedures and they have never provided explanation for the denial. I am missing payments dating back to June 2017.
- Anthem Blue Cross requests refunds that are sometimes 2-3 years old. Or if we refund they still take payment out of other claims.
- Blue Shield and United Health consistently reject payments or request overpayments, then nearly 100% of the time "lose" our appeal (i.e., can't find the letter/paperwork), then ultimately deny the appeal because it wasn't filed "in a timely manner" due to them "losing" the papers. Ridiculous and happens very frequently. Department of managed care has been utterly useless in helping resolve this problem.
- I have filed five appeals with DMHC regarding failure to authorize additional sessions when the patient clearly met medical necessity. All of those were resolved in each of the patient's favor. I filed one appeal regarding unfair payment practices and never heard anything from DMHC.
- Some claims were denied because they were submitted in the same envelope.
- Blue Shield has been paying incorrect rates for one of our providers for over 2 years as they mixed up our PA with another provider who is an acupuncturist. We have spent many, many hours trying to get resolved and our claims reprocessed. Blue Cross and Blue Shield continue to not follow their own rules regarding add-on CPT codes. Per their guidelines, "add on codes" are exempt from multiple procedure reduction. However, they both continue to reduce payment on the add on code. Appealing sometimes works, sometimes it doesn't. Blue Shield routinely "loses" our medical records when they request them. Blue Shield will send us letters stating they received our appeal; but then we never get any response to outcome. There more and more administrative burden to just get paid.
- Anthem once denied payment for an emergency surgery payment for spinal cord compression and labelled it a "cosmetic procedure."
- Health plans keeps denying payment stating that they were not billed on time. Luckily our biller has proof of electronic submission and receipt.

- We may bill the medical group (ER professional services), who refers the claim to the health plan, who refers the claim back to the medical group. This is ongoing, routine and takes considerable effort to resolve.
- Blue Cross massive billing errors over an extended period resulted in large amount of repayments demanded for "overpaid" claims, creating a huge administrative burden and cost without compensation for their error.

Specialty

Allergy	1.1%
Anesthesiology	4.1%
Cardiology	3.0%
Dermatology	4.1%
Emergency medicine/Trauma/Urgent Care	1.6%
Endocrinology	0.3%
Gastroenterology	1.1%
General surgery	3.3%
Infectious disease	1.6%
Internal medicine, Family Practice, General Practice	14.6%
Neurology	0.8%
Nephrology	0.8%
OB/GYN	4.9%
Oncology	5.2%
Ophthalmology	4.9%
Orthopedic surgery	3.8%
Orthopedics	0.3%
Other	4.3%
Otolaryngology	1.9%
Pain medicine	2.2%
Pathology	0.5%
Pediatrics	6.0%
Plastic & reconstructive surgery	1.9%
Psychiatry	18.2%
Pulmonary	0.8%
Radiology	1.6%
Rheumatology	0.5%
Surgery	3.0%
Urology	3.5%
Vascular surgery	0.3%

County

Alameda	6.5%
Amador	0.5%
Butte	1.1%
Calaveras	0.5%

Contra Costa	3.0%
El Dorado	0.3%
Fresno	1.9%
Humboldt	0.5%
Imperial	1.4%
Kern	0.5%
Los Angeles	16.0%
Madera	0.3%
Marin	0.3%
Merced	0.3%
Monterey	1.1%
Multiple	0.3%
Napa	0.8%
Nevada	0.8%
Orange	6.3%
Placer	2.2%
Riverside	4.1%
Sacramento	7.6%
San Benito	0.8%
San Bernardino	4.6%
San Diego	8.7%
San Francisco	3.8%
San Joaquin	2.2%
San Luis Obispo	1.1%
San Mateo	3.8%
Santa Barbara	1.9%
Santa Clara	6.5%
Santa Cruz	0.8%
Santa Barbara	0.5%
Shasta	0.5%
Solano	1.4%
Stanislaus	1.9%
Tulare	1.4%
Tuolumne	0.3%
Ventura	6.5%
yolo	0.8%
(blank or other)	5.4%

Number of physicians in practice

1	48.78%
2-5	25.47%
6-10	7.86%
11-25	6.78%
26-50	3.25%
51-100	4.88%
>100	2.98%