



Call for Data: Out-of-Network Underpayment and Rescission of Treatment Authorization

CMA and specialty physician associations have prepared this survey to gauge the impact on physicians and their patients of the recent balance billing regulation and the Prospect legal decision that prohibits “balance billing” patients for the unpaid portion of bills only partially paid by Knox Keene plans for noncontracted emergency services. CMA is also gathering evidence concerning other, broader industry practices by health insurers to underpay for out-of-network services (e.g., by use of the Ingenix database).

Please take the time to complete this CALL FOR DATA form as completely as possible. The information will be used by CMA in its advocacy efforts and will not be used in a manner that reveals your identity. We will contact you if further information is needed or if we can use your assistance in our advocacy efforts.

Specifically, this survey seeks to collect information regarding underpayment practices for out-of-network emergency services to Knox-Keene enrollees (except with respect to question 13, which seeks information regarding non-emergency services provided to a patient with any type of insurance product). To this end, we would greatly appreciate it if you and/or someone on your behalf (such as your billing or service staff) takes the time to monitor your Knox-Keene plans’ contracting and payment activities to determine what payor changes, if any, have occurred since October 15, 2008, the earliest date that a ban on balance billing took effect. We also seek information to determine the effectiveness or ineffectiveness of alternative avenues to obtain redress for underpayment of billed charges, such as through the plan’s and/or DMHC’s dispute resolution process. The survey also seeks information regarding retroactive rescission of treatment authorizations after the treatment has been provided (a practice that some HMOs and insurers have adopted and which we believe violates California law).

NOTE: For more information on the Prospect decision and the DMHC regulation, both of which ban balance billing in emergency care, see CMA’s Balance Billing Toolkit at www.cmanet.org.

Questions about the survey can be directed to CMA’s Legal Hotline at (800) 786 4CMA. Responses to this survey can be submitted online at www.cmanet.org or by fax to CMA at (916) 551-2885.

Thank you in advance for your assistance.

GENERAL INFORMATION

Note: This survey, except with respect to questions 17 and 18, requests information about payment practices by Knox-Keene plans; that is, commercial HMOs, the medical groups or IPAs that HMOs contract with, and many Blue Cross and Blue Shield PPOs.

Name of physician/group: _____

Contact information for person filling out the form

Phone: _____

County: _____

E-mail: _____

Specialty: _____

Contact information for billing service (if applicable)

Phone: _____

Name: _____

E-Mail: _____

3. **Post-Appeal Payment Practices:** If you utilized the payor’s internal dispute resolution process, whether formally or informally, to appeal an underpayment for non-anesthesia **emergency** services, indicate any additional payment as a result.

Payor	CPT Code	Post-Appeal Payment in \$	
		(Pre-Oct. 15)	(Post-Oct. 15)
Blue Shield PPO			
Anthem Blue Cross PPO			
Aetna			
United			
Health Net			
Other:			
Other:			
Other:			
Other:			

4. **Average Percentage Underpaid:** For each Knox-Keene plan your practice deals with, please calculate the average percentage of underpayment of billed charges that plan paid, after all non-legal efforts have been exhausted. (E.g., if a plan on average pays \$60 of \$100 billed charges, the average percentage of underpayment is 40%).

Payor	Avg. % of Billed Charges Underpaid	
	(Pre-Oct. 15)	(Post-Oct. 15)
Blue Shield PPO		
Anthem Blue Cross PPO		
Aetna		
United		
Health Net		
Other:		
Other:		
Other:		
Other:		

Questions 5-7 are for Anesthesia Emergency Services Only

5. **Initial Payments:** Please list the top 10 CPT codes underpaid for anesthesia **emergency** services only.

Payor	CPT Code	Conversion Factor Billed	Initial CF Payment in \$	
			(Pre-Oct. 15)	(Post-Oct. 15)
Blue Shield PPO				
Anthem Blue Cross PPO				
Aetna				
United				

Health Net				
Other:				
Other:				
Other:				
Other:				
Other:				

6 **Post-Appeals Payments:** If you utilized the payor’s internal dispute resolution process to appeal the underpayment for anesthesia **emergency** services, please indicate any additional payment as a result.

Payor	CPT Code	Post-Appeal CF Payment in \$	
		(Pre-Oct. 15)	(Post-Oct. 15)
Blue Shield PPO			
Anthem Blue Cross PPO			
Aetna			
United			
Health Net			
Other:			
Other:			
Other:			
Other:			
Other:			

7. **Average Percentage of Billed Conversion Factor Disallowed:** For each Knox-Keene plan your anesthesia practice deals with, please calculate the average percentage of the billed conversion factor that plan refused to allow, after all non-legal efforts have been exhausted.

Payor	Avg. % of Billed CF Disallowed	
	(Pre-Oct. 15)	(Post-Oct. 15)
Blue Shield PPO		
Anthem Blue Cross PPO		
Aetna		
United		
Health Net		
Other:		
Other:		
Other:		
Other:		
Other:		

II. OTHER NEGATIVE IMPACTS

8. **Administrative Costs of Disputing Underpayments:** Provide actual data or estimates of staff time/costs (e.g. time to prepare appeals, delays in payment, material costs to mail appeal, time to follow-up on appeals, time to post additional payment, if received).

a. Estimated dollar costs in disputing an underpayment by a Knox-Keene plan:

b. Estimated dollar costs of filing a complaint with the DMHC's Independent Dispute Resolution Process:

9. **Contracting Practices:** Describe any changes in contracting practices by any Knox-Keene plan since October 15, 2008 (e.g. whether proposed rates have decreased, negotiations have ended prematurely, or a payor has terminated a contract). Please be as specific as possible.

10. **Impact on Quality of Care:** Describe any impact on quality of care you have seen since October 15, 2008 (e.g., inability of patients to find an appropriate network physician, less staffing at provider facilities, increased patient wait times to see a provider, difficulty securing on-call coverage).

III. THE DMHC'S DISPUTE RESOLUTION PROCESS

11. Have you used the DMHC's Independent Dispute Resolution Process? (Forms and more information about this process are available at the [DMHC website](#).)

Yes No

a. If yes, were you satisfied with the end result? If not, why? Please explain.

IV. SYSTEMIC PAYOR PROBLEMS

12. Within the past three years, has any Knox-Keene plan or other health insurer (e.g., Blue Shield, United, Pacificare, Blue Cross, etc.) failed to pay for services (either in-network or out-of-network) you rendered after giving specific authorization for you to perform such services?

Yes No

- a. If yes, describe the circumstances, including identifying the plan(s) or insurer(s), the service(s) you performed (by CPT code) and the date(s) of service.

13. Do you believe that any Knox-Keene plan or other health insurer (e.g., Blue Shield, United, Pacificare, Blue Cross, etc.), on a regular or recurring basis, has paid you for out-of-network services below what is reasonable in your market?

Yes No

- b. If yes, please identify the particular plan(s) or insurer(s) and explain why you believe it has paid you below-reasonable rates.

14. If you have any other comments or information you'd like to provide, please do so below.

THANK YOU for participating in this CALL FOR DATA. Your help is important in our advocacy efforts.