

In Focus

So What's in a Word

Three simple words: Usual, Customary and Reasonable. For benefits managers whose careers go back to the 1980's, before the advent of provider networks and discounts, some combination of the words Usual, Customary and Reasonable (UCR) was the bed rock for determining physician reimbursement. UCR was simple and almost universally applied. To refresh our readers:

"Usual" means that a physician's fee is what the physician normally charges for a particular service. "Customary" means that a physician's fee is within the range of fees that most physicians of similar background in the same geographic area (typically zip code) charge for a service. And "Reasonable" means that the charge is both usual and customary or that it is justifiable because of special conditions. Carriers or self-insured employers choose a percentile of the UCR charges to apply in reimbursing physicians. In the 1980's and even into the 1990's, the 90th percentile was common. Today, most plans use the 85th or 80th percentile of UCR.

Since the 1990's, UCR primarily has been operational only in the low-volume world of non-network provider reimbursement (with negotiated provider discounts holding sway for in-network reimbursement).

As PPO networks have become the norm, the gap between billed charges and negotiated [discounted] allowable charge levels has grown dramatically. It is no longer unusual for billed charges to exceed allowable charges by two or three times – especially in major metropolitan areas. In essence, it has become a bit of a "gotch ya" for those receiving care from non-network providers, as billed charge levels no longer have any relationship to what most providers are willing to accept as payment in full. Even though the billed charge amounts are inflated, patients can't do much about it without the protection of agreed-upon pricing (ala a PPO contract).

So, what does this have to do with UCR? Most PPOs have relied upon UCR (or its cousins U&C and R&C) to reimburse non-network providers. However, what is "usual" or "customary" or "reasonable" in a marketplace dominated by negotiated, heavily discounted provider fees? Is what is "Usual, Customary and Reasonable" determined by the prevalence of these PPO payment levels? Is it determined by Medicare, the nation's largest single payor for most services? Or is it determined by an analysis of non-network billed charge levels?

Even though billed charges are generally much higher than negotiated in-network levels, doctors still have argued the meaning and application of UCR limits. They have alleged that UCR charge data is out of date, meaning that reimbursements are necessarily lower than current charge levels; that UCR percentiles are manipulated to the disadvantage of physicians and that the whole premise of UCR reimbursement is fundamentally flawed. Their loathing frequently has turned into litigation, both threatened and actual. All the major health plans have felt the sting of physicians' wrath and generally have found it less expensive to settle out of court, change their reimbursement vocabulary and sometimes, their non-network provider reimbursement methodologies as well.

Consequently, many employer SPDs initially drafted by carriers or TPAs now contain relatively new words and phrases that describe non-network provider reimbursement; words like "Maximum Allowable Amount" and "Maximum Reimbursable Charge", to name two used by prominent national carriers. So what is underneath these words?

One leading health plan defines its "maximum reimbursable amount" as:

The amount that the Administrator, or the Administrator's Subcontractor, determines is the maximum payable for Covered Services the Member receives, up to but not to exceed charges actually billed. Generally, to determine the Maximum Reimbursable Amount for a Covered Service, the Administrator, or the Administrator's Subcontractor, use internally developed criteria and industry accepted methodologies and fee schedules which are based on estimates of resources and costs required to provide a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply.

Or, how about:

Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply; or a percentile of charges made by providers of such service or supply in the geographic area where the service is received. These charges are compiled in a database we (the carrier) have selected.

They Said It!

Sara Palin, Republican candidate for Vice President, to radio talk show host Hugh Hewitt: "We've gone through periods of our life here with paying out-of-pocket for health coverage until Todd and I both landed a couple of good union jobs."

Sure sounds like what we have historically known as UCR. But, the subtle name and process changes are intended to put the decision making in the hands of the payor and not the marketplace. However, are these changes mere nuances or are they material changes that courts will endorse?

Then there are those major health plans that want to avoid word play entirely and therefore they scrap the whole notion of reliance on databases of physicians' historical charges. These health plans instead use a percentage of Medicare reimbursement rates; say 110%, to pay non-network providers. Physicians are not wild about Medicare's reimbursement levels and those levels have as much politics behind them as they do objectivity. Nevertheless, Medicare reimbursement rates apply to more health care events than any other reimbursement methodology and seemingly, with Medicare, the physicians' plaintiffs bar has met its match.

Through the haze of all this linguistic dancing, one point seems to be shining more clearly - namely, it's probably not in an employer plan's best interest to rely on UCR for non-network provider reimbursements. The new names may be a little more defensible in the courts, but the greatest protection seems to found in relying on a stated percent of Medicare's reimbursement levels. If your plan isn't using Medicare as its source for non-network reimbursement, it might be time for a conversation with your network organization's rep. about the fine print footnoted under the Non-Network benefits schedule in your SPD.

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