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Medical Cost Remedy, Inc.

Usual and Customary

The terms usual, customary, and reasonable (UCR) have not been clearly defined, especially as they pertain to out-of-network negotiations for emergency medical care.

The American Medical Association (AMA) captures the consensus of the provider community regarding usual, customary, and reasonable charges:

- "usual" fee to mean that fee usually charged, for a given service, by an individual physician to his private patient (i.e., his own usual fee);
- a fee is "customary" when it is within the range of usual fees currently charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area; and
- a fee is "reasonable" when it meets the above two criteria and is justifiable, considering the special circumstances of the particular case in question, without regard to payments that have been discounted under governmental or private plans.

A provider's charges can be usual according to their charge master, and a review of the charges of all providers in a given geographic area can produce an average or customary charge for a specific service. However, if these two points are satisfied, does that then make the charge necessarily reasonable? The answer is a steadfast "No".

A plan will typically only face full UCR charges if a participant uses an out-of-network facility. All other things being equal, the plan should have clear measures in place to ensure that covered participants use in-network resources. The "in" versus "out" distinction is based on a theory which exchanges participant steerage for a discount on healthcare services. That is, participants can choose or be compelled to choose an "in-network" facility over an "out-of-network" facility due to insurance benefit differentials. Incentive-based contracts are premised on controllable variables.

Whether due to error, personal preferences, or specialized needs, some of the covered plan participants may choose an out-of-network provider. The average out-of-network exposure for a plan is between 10%-12% of their total claims. It is therefore important to have clear benefit differentials in the policy and participant education.

Of course, we cannot forget emergent care. These are not controllable events, and can be quite expensive. The Emergency Medical Treatment and Active Labor Act (EMTALA) ensures that financial considerations do not hinder the well-being of the patient, and as a result, providers must treat the participant, and the plan must pay.

In these situations, there is no time to decide on terms for payment and there is no meeting of minds. Under the Quantum Merit principle of equity, based on a Latin phrase for paying what is deserved), any time there is an exchange of goods or services, the provider has a right to recover

the reasonable value for the services rendered regardless of the absence of a formal contract. Of course, providers suggest that the reasonable value of their service is their normal charge.

Florida's Personal Injury Protection statute outlines considerations to assess the reasonableness of a provider's charge:

"With respect to a determination of whether a charge for a particular service, treatment, or otherwise is reasonable, consideration may be given to evidence of usual and customary charges and ***payments accepted by the provider*** involved in the dispute, and ***reimbursement levels*** in the community and various federal and state medical fee schedules… and other information relevant to the reasonableness of the ***reimbursement*** for the service, treatment, or supply." Florida Statute 627.736(5) (a) (emphasis added)

The State of California has also addressed this situation with emergency services and seems to propose a distinction between a provider's charge and the reasonable and customary value of the service (Cal .Code Regs tit 28 § 1300 71 subd (a)(3).)n5).

By and large; the value of a good or service is determined by its market. However, the provider community is critical of any UCR argument that factors contract rates or discounting arrangements. The provider community wants payers to recognize UCR rates "without regard to payments that have been discounted under governmental or private plans." They consider it unreasonable for a non-contracted payer to expect the same rate as a contracted payer.

Appropriately, provider UCR rates are formulated to ensure their ongoing sustainability and profitability. Providers must factor governmental programs, per diem arrangements, PPO/HMO contracts, rising costs, new technology, and bad debt. Most provider payments are fixed payments, and so only a small percentage of their claims are paid though charge-based contracts. Correspondingly, they must increase their charges significantly in order to capitalize on their small percentage of charge-based contracts, and make up for the limited profitability of their other payer mix. However, an emergency, by its very nature, is sudden and unforeseen, and payment thereof should not be charges that are created to support an incentive-based paradigm.

Interestingly, UCR charges are rarely collected in full. It is therefore not usual and customary for a provider to collect their UCR rates (pun intended). Providers collect at best an average of 40%-45% of what they bill. Most providers only collect on average 15% from their non-commercial payers. This again shows that UCR charges have no bearing on the value of the service.

As mentioned earlier, most providers bill all payers in a manner that is usual to their practices, and maintain that these charges are within the current norm. A provider's billed charges represent their assessment of the value of their services. The average reimbursement, which represents the aggregate of all payers, reveals the actual market value of the services rendered. A charge is meaningless if it is not representative of payment that is routinely collected. In sum, a strong argument can be made that a hospitals average reimbursement represents the de facto

UCR charge for services rendered.

The California Statute adds some criteria in order to determine the reasonable value of services. This data should be “based upon statistically credible information that is updated at least annually” and considers the following:

1. the provider's training, qualifications and length of time in practice;
2. the nature of the services provided;
3. the fees usually charged by the provider;
4. prevailing provider rates charged in the general geographic area in which the services were rendered;
5. other aspects of the economics of the medical provider's practice that are relevant;
6. any unusual circumstances in the case (Cal .Code Regs tit 28 § 1300 71 subd).

Financial considerations like average reimbursement and cost-to-charge ratios are necessary to effectively analyze out-of-network costs, but as seen above, this data alone will not suffice to establish the reasonable value of the services. There must be additional consideration given to the specific service and the service provider.

Interestingly, the Centers for Medicare and Medicaid (CMS) use the term reasonable to describe their reimbursements and their methodologies. CMS pays for services under a resource-based relative value reimbursement system, which assigns a higher relative value for services that are more difficult to perform or more time consuming. CMS also weighs any unique characteristics of a given market, and unusual circumstances/costs with their cost-outlier apportionment system. Their data is also updated at least annually by the Medicare Payment Advisory Commission (MedPAC).

In every other arena of life and business, one has the option of walking away from a deal, but this option is simply not present in emergency situations. Neither the provider nor the payer can walk away, and so there should be a mutual understanding to accept fair payment for services. This fair payment ought to be based on the value of the specific service while at the same time factoring in the specific financial situation of the provider.

Overall, it may be “reasonable" for a provider to bill in the current fashion, but it seems a far cry to expect the self-insured market to reimburse accordingly, particularly for emergency claims at out-of-network facilities.