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Considering Going Out of Network in New Jersey? Food For Thought

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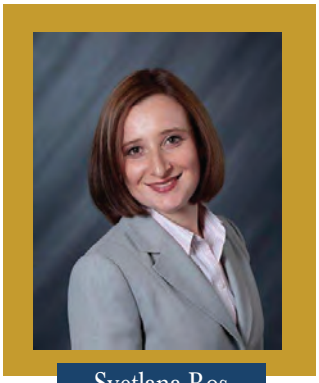

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As insurance companies continue efforts to reduce reimbursement rates and increase administrative burdens on their participating providers, more and more physicians are considering terminating their in-network contracts with private insurance payers and going out-of-network. If you or your practice are contemplating doing so, here are some issues you may want to consider when making that decision.

As an out-of-network physician, you are not limited in the fees that you can charge by either in-network negotiated rates (although you continue to be subject to the Medicare fee schedule for Medicare patients should you continue to accept Medicare); you are free to charge any rate that you believe is commensurate with your expertise and the quality of services you provide, subject to the regulations of the State Board of Medical Examiners prohibiting excessive fees. In this connection, private payers are increasingly attempting to challenge the fees charged by out-of-network physicians. Some insurance companies, such as Horizon, Aetna and United Healthcare are notorious for suing physicians, alleging "excessive" billing/"unconscionable" fees.

Recently, the New Jersey Appellate Division[1] affirmed a trial court's order and final judgment dismissing claims by Aetna against a cardiologist alleging excessive billing and insurance fraud, and awarding nearly $2 million to the doctor for unpaid claims. Although it is an unpublished opinion with limited formal precedential value, it does indicate that the Appellate Division is prepared to support a physician's reasonable fee schedule in the face of insurance company challenges. Of particular note, the Appellate Division in this case recognized that the physicians were allowed to establish their own fee schedule, and declined to impose a "fair market value" standard, while noting that the fees of the physicians were subject to the oversight of the New Jersey State Board of Medical Examiners.

The New Jersey State Board of Medical Examiners is the governing body that not only issues physicians their medical licenses, but also promulgates and oversees compliance with its regulations governing the practice of medicine in New Jersey. The Board regulation prohibiting "excessive fees", N.J.A.C. 13:35-6.11, provides in part that, "A fee is excessive when, after a review of the facts, a licensee of ordinary prudence would be left with a definite and firm conviction that the fee is so high as to be manifestly unconscionable or overreaching under the circumstances." Violation of this Board regulation may result in a finding of professional misconduct subjection the physician to disciplinary action, including reprimand, suspension or revocation of one's license.

One of the most common issues that arise in connection with an out-of-network practice is the extent to which an out-of-network physician is required to collect co-payments, co-insurance and deductibles. The answer is relatively clear when dealing with Medicare and Medicaid - a routine waiver of such payments can constitute a violation of the Anti-Kickback Act or the False Claims Act. Although those statutes do not generally apply to patients with private insurance, it is not advisable to maintain a policy that waives payment by all patients with out-of-network benefits of their co-payment, co-insurance and deductible obligations, and reasonable efforts to collect such obligations is strongly encouraged. While there is currently no specific law or regulation in New Jersey that prohibits an out-of-network physician from waiving such payments, such a practice can be grounds for claims of insurance fraud.

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[1] Aetna Health, Inc. v. Srinivasan, No. A-2035-14T2, slip op. (N.J. App. Div. Jun. 29, 2016)

Therefore, any outright waiver of a co-pay, co-insurance or deductible payment should be made on a case by case basis following a finding of financial hardship.

An exception to the requirement to balance-bill patients arises when services are rendered to an insured patient seeking emergency treatment. New Jersey prohibits physicians from balance-billing patients who receive such emergency services. Department of Banking and Insurance regulations require that, when a patient obtains emergency treatment at an in-network facility, the insurance company must reimburse the out-of-network physician enough to insure that the physician does not balance-bill the patient more than the patient would have been responsible for had such physician been an in-network provider[2].

On June 20, 2016, a state Assembly committee approved legislation that would prevent consumers in New Jersey from getting surprise out-of-network medical bills. The proposed Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act, sets out extensive requirements for hospitals and doctors to disclose to patients whether they are part of the patient's insurance network before treatment occurs. For example, if the bill passes, as it is currently drafted, hospitals and healthcare facilities will be required to: disclose whether they are in the patient's insurance network; advise patients to contact their insurance carriers and doctors for further information; list the names and contact information for all contracted physicians; publish on their websites a list of standard charges for services, the insurance they accept, and a statement saying: "doctors working in the facility may or may not accept the same insurance as the facility".

With regards to physicians, if the bill passes, physicians will be required to: disclose which benefits plans they accept and the hospital with which they are affiliated prior to non-emergency services and at the time of an appointment; inform patients about the specific price of out-of-network services, and provide the contact information for outside anesthesiologists, radiologists and other professionals they use. Of note, this bill would provide that waiver by an out-of-network provider of all or part of a patient's co-payment, co-insurance or deductible would be considered a prohibited inducement to the patient to seek covered services from the physician.

Another very common questions that comes up when physicians are considering going out-of-network, is whether some, not all of the physician, at the practice can go out-of-network. In that case, there are various additional elements to consider. For starters, the practice needs to review its contracts with insurance companies, as some may require that all physicians at the practice be participating providers. In addition, where some practitioners are out-of-network while others are in-network, treatment of any patient by the out-of-network physician may be considered an out-of-network referral by the group, which would be subject to any limitations or prohibitions in the participation agreement, including notice of the out-of-network status and advice regarding the availability of in-network providers.

Finally, where not all physicians in the group have the same participation status, they generally need to bill for their in-network and out-of-network services under separate billing/tax identification numbers. Depending on the proportions involved, this may run the risk of the group ceasing to qualify as a "group practice" within the meaning of the Federal Stark law, the Federal Anti-kickback safe harbors, and the New Jersey Codey law, resulting in practices and transactions which are legal only when conducted within a single group practice, suddenly becoming subject to rules governing transactions between or among separate group practices. Therefore, it is critical that a thorough legal analysis be conducted before any decision is made to include both in-network and out-of-network providers within a single group.

The decision to go out-of-network is not an easy decision, and the anticipated resistance from the insurance industry and the various pending bills in the New Jersey legislature make the future viability of such a decision all the more difficult to predict. However, with careful planning and legal and financial guidance, it is still possible under the right circumstances for physicians to successfully transition to out-of-network status.

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[2] In the Matter of Violations of the Laws of N.J. by Aetna Health Inc., DOBI Order No. A07-59 (July 23, 2007)

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