# Handling UCR Payment Cuts

On occasion, reimbursement from an insurance carrier will be reduced because the carrier states that the charges for services rendered "exceed Usual, Customary, & Reasonable (UCR) charges for the geographical area or type of service rendered".

Sometimes these reductions are a few percent or a couple of dollars. More recently, we have seen 40%, 50%, or even 70% reductions on your billed fees.

This information below does not apply to managed care contracts that you have knowingly signed and agreed to (or unknowingly, which is another topic), and does not apply to Work Comp (many States have an established fee schedule for WC), or personal injury claims.

While the insurance carrier is sometimes correct, and is within their right in setting UCR levels for reimbursement, this is often used in error by the carrier or unfairly used to reduce your bill. These reductions can wrongly deny medical payments in the millions of dollars.[1,2,3]

Different insurance companies determine what UCR is in different ways. Originally, limiting the top 2% of fees charged for a procedure did this. Insurance companies, as a cost containment measure and as a way of limiting increases in health care costs, have adjusted their limits to the top 5% or 10% or even 20% of fees charged for a procedure.

Again, the insurance company has the right to determine what is UCR for a given procedure, and, by accepting assignment on a patient's insurance, you have agreed to abide by the terms of the policy as written for that patient. Almost every policy contains wording that allows the insurance company to reduce charges that exceed their determination of UCR.

On the other hand, you have a right to be fairly reimbursed for your services. Some insurance companies use the UCR rules to unfairly reduce your claims because of how they determine what UCR is for a given procedure.

There are various, established UCR guidelines according to attorney Dan Riegleman, "One useful source for such guidelines can be found at the State's worker's compensation website dealing with the fee dispute resolution process. Those state orientated guidelines could be referenced as a source in comparing the insurance companies position to that of the State's approved, existing guidelines.[4]" The Wisconsin guidelines can be found here.

If the insurance company bases their determination of UCR on old information, outdated charges, or includes as part of their database reimbursement to managed care (HMO/PPO) plans, their UCR level may not reflect the general charges used in your area for a given procedure.

Handling UCR Follow-up Calls

In disputing UCR reductions, you need to call the carrier and ask the following questions of a supervisor in the claims review department:

a) Explain who you are and that you are calling regarding a reduction of patient's (name) reimbursement based on a UCR determination and that you disagree with the reduction by the carrier.

b) Explain that the patient has signed an "assignment of benefits" form which allows your office to directly appeal and challenge payments or reductions by the insurance company (there is a great sample here),

c) Ask under what section of the of the patient's policy does the carrier have the right to reduce the compensation to the patient,

d) Ask how the determination is made that the charges exceed UCR,

e) Ask what methods are used to determine UCR for your specific area and procedure,

f) Ask what published or unpublished exceptions there may be to the UCR ruling and how to dispute the ruling for the patient.

g) Lastly, ask what your written appeal rights are to the denials. If the CSR you are speaking with doesn't have the information, request a supervisor.

A follow up letter can be sent after the phone call (unless the call resolves the problem) based on the following and on the information above.

Dear _____: (Do not use this as a photocopied form letter)

I am writing on behalf of our patient, who has completed an assignment of benefits form with our office allowing us appeal denials and payment reductions.

We are in receipt of your letter (or EOB) of (date) concerning reduction of (patient name) compensation based on your determination that our fees billed exceeded your UCR guidelines. Certainly, we understand that you must determine UCR for each procedure to assure fair reimbursement. But since we deal with hundreds of insurance

companies all over the State of Wisconsin, and since we seldom have had our fees questioned, we must protest your determination.

Per Federal Guidelines, UCR is defined as: "*The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.*" (www.healthcare.gov/glossary/UCR-usual-customary-and-reasonable/).

It seems that you are not actually paying based on Usual and Customary charges, but rather you have decided you will pay what you want based on what you pay to contracted providers. That is not fair – we are not contracted providers with your company and we are under no contractual obligation to accept whatever fee you determine you are willing to pay.

By the same token, we understand that we cannot bill whatever we want, but must keep our fees within a range charged by the majority of other providers in our area, region and State.

We are familiar with charges for the same services at other offices in our city and we personally know that our charges do not exceed what is usual or reasonable in central Wisconsin. We are also familiar with statistically valid fee surveys published by our State association and others that indicate we are at or below the 80th percentile for fees charged in our area. We are familiar with the State of Wisconsin Worker's Compensation published fee schedules, which are updated regularly, and are well within these guidelines.

Perhaps the data you are using is not current or reflects discounts given in reimbursement to managed care plans, or you are basing your reimbursement on chiropractic based on office visits and not on individual CPT codes charged by our office. In any case, we would like you to review your determination and remit the additional compensation that we are owed for services rendered.

If you are unwilling to remit the additional compensation, on behalf of our patient, your insured, please let us know in writing:

a) Is your determination of UCR charge-based, fee-based or reimbursement based,
b) Does your database include Medicaid, Medicare or managed care statistics,
c) Is the database compiled by CPT code,
d) What is the age of the data gathered and how specific is it geographically,

e) How is the database compiled and from how many providers,
f) What are the published or unpublished exceptions to your UCR determinations.

As you are aware, Wisconsin statute 628.46, specifically subsection 2m, requires you to pay the claim in a timely manner *("a claim for payment for chiropractic services is overdue if not paid within 30 days after the insurer receives clinical documentation from the chiropractor that the services were provided unless, within those 30 days, the insurer provides to the insured and to the chiropractor the written statement under s. 632.875 (2)"*). As we feel payment on these claims is being unfairly reduced, the balance remains due and payable. We are therefore asking if any more information is required to completely process these claims in full and ask that any information which is still required be specified in writing within 30 days of this notification.

Thank you in advance for your review of our request. We realize the amount in dispute is small, but feel that we are entitled to fair reimbursement and that the patient is entitled to all available benefits of their policy.

Sincerely,

Your Name cc: Your Patient

Based on the response (or lack thereof) to your letter, you can pursue the carrier further, bill the patient, or report the matter to the state insurance commissioner for action. It is best to not just drop the issue. Ask the patient to follow up with a complaint to the state's insurance commissioner, as well. At a minimum, a record of abuses should be maintained for the purposes of more extensive litigation against an insurance company.

Petty, Michel & Associates
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1. July 8, 2015, Bloomberg Business News (https://www.bna.com/aetna-ingenix-suit-n17179929923/)

*"The suit charged that Aetna members received adverse benefit determinations that improperly led to reduced health insurance benefits as a result of Aetna's improper usual, customary and reasonable (UCR) rate calculations for all types of services rendered by nonparticipating providers.*

*"The plaintiffs challenged Aetna's use of UCR databases owned and operated by Ingenix, now known as OptumInsight, a wholly owned subsidiary of UnitedHealth Group Inc.*

*"The Ingenix databases were flawed and improperly skewed UCR downward, the plaintiffs contended."*

2. Dispelling the Myths of Out-of-Network Billing Scott J. Rein, President, Strategic Outpatient Solutions, LLC

*"Most insurers use healthcare billing information collected from privately-owned databases to determine UCR charges. Many large insurers used Ingenix, the nation's largest provider of healthcare billing information and a wholly-owned subsidiary of UnitedHealth. Recently, the New York Attorney General fi led suit against Ingenix for manipulating data to determine UCR charges that were too low, which led to underpaying physicians and facilities, thus forcing patients to pay undue costs for out-of-network medical services."*

3. UnitedHealth Group UCR Settlement, American Medical Association

*"UnitedHealth Group was using a flawed database operated by Ingenix, a UnitedHealth Group subsidiary, to determine its out-of-network payment rates. The flawed UCR database increased insurers' profits at the expense of patients and physicians."*

4. Workers Compensation Health Costs Dispute Process, by Attorney Dan A. Riegleman