

**NAATP**  
NATIONAL 2019





NATIONAL ASSOCIATION  
OF  
ADDICTION TREATMENT PROVIDERS

# Quality Assurance Breakout Session 2: Billing

Calculating Cost, Margins, Usual and Customary Rates,  
Balance Billing, Toxicology, Deductibles and Copays

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## QA 2: Billing

### Moderator



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### Panelists



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# Wit v. UBH: Class Action Lawsuit

Kelly J. Epperson  
Rosecrance Health Network



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# Wit v. UBH Class Action

- United States District Court - Northern District of California
- Class action involving 50,000 patients
- ERISA: Employee Retirement Income Security Act of 1974
- 10-day bench trial
- March 5, 2019 - Findings of Fact and Conclusions of Law

# Wit v. UBH Class Action

## ERISA Claims:

### 1. Breach of Fiduciary Duty:

- Developed Guidelines that were more restrictive than generally accepted standards of care
- Prioritized UBH's financial interests over Plaintiffs' interests

### 2. Arbitrary and Capricious Denial of Benefits

- Improperly denied coverage using flawed Guidelines

# Wit v. UBH Class Action

- Lawsuit did not seek coverage determinations
  - Only facial challenges to the Guidelines
- Challenges to UBH's Guidelines:
  - Plaintiffs' health insurance plans required coverage consistent with ***generally accepted standards of care***
  - State law mandated the use of certain clinical criteria

# Wit v. UBH Class Action

**Critical Question:**  
**Whether the Guidelines conformed to  
generally accepted standards of care?**

# Wit v. UBH Class Action

- Evidence re: Generally Accepted Standards of Care:
  - Expert medical testimony
  - Consensus guidelines from professional organizations
    - ASAM; LOCUS; CALOCUS; CASII
  - Guidelines distributed by government agencies
    - CMS Manual

# Wit v. UBH Class Action

- Generally Accepted Standards of Care:
  - Treatment should address the patient's *underlying condition*
  - Treatment should address *co-occurring conditions*
  - Treatment should be in the least restrictive level of care that is *both safe and effective*
  - Clinicians should *err on the side of caution* by placing the patient in a higher level of care when uncertain

# Wit v. UBH Class Action

- Generally Accepted Standards of Care:
  - Treatment should include services needed to ***maintain functioning or prevent deterioration***
  - Guidelines should consider the unique needs of ***children and adolescents***
  - Decisions should be ***individualized*** and based on a ***multidimensional assessment*** of the patient

# Wit v. UBH Class Action

- Guidelines Deviated from Generally Accepted Standards:
  - Emphasized treating acute symptoms and stabilizing crises
  - Ignored treatment of the patient's underlying conditions
  - Failed to address co-occurring conditions
  - Failed to consider both safety and effectiveness
  - Guidelines erred toward moving to lower levels of care

# Wit v. UBH Class Action

- Guidelines Deviated from Generally Accepted Standards:
  - Guidelines focused solely on improvement
  - Did not consider multidimensional assessment
  - Did not include different standards for children and adolescents
- UBH also violated Texas, Illinois, Connecticut, and Rhode Island law

# Wit v. UBH Class Action

- Guideline Development Process:
  - Inherent structural conflict of interest
  - Process infused with financial considerations:
    - Guidelines committee included financial representatives
    - Guidelines committee received financial briefings
    - Guidelines viewed as a tool for meeting UR targets and keeping benefit expenses down

# Wit v. UBH Class Action

- Examples of actual impact due to conflicts of interest:
  - Transcranial magnetic stimulation
  - Applied behavioral analysis
  - Rejection of ASAM Criteria
- The Court reviewed UBH decisions with:
  - Less deference
  - Significant skepticism

# Wit v. UBH Class Action

- Legal Conclusions:
  - Liability under both breach of fiduciary duty and denial of benefits claims
  - Guidelines were “unreasonable” and did not reflect generally accepted standards of care
  - UBH denied Plaintiffs’ claims based on faulty Guidelines

# Wit v. UBH Class Action

- Potential Remedies:
  - Injunction ordering UBH to stop using the Guidelines
  - Develop new Guidelines consistent with generally accepted standards of care and state law
  - Reprocess claims that were denied under the Guidelines



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# Quality Assurance Guidebook Section 6

Calculating Cost, Margins, Usual and Customary Rates,  
Balanced Billing, Toxicology, Deductibles and Copay

Ben Dittman

CEO & Founder, Avea Solutions



## Discussion:

Guideline D-1: Calculating Cost of Service

Guideline D-2: Reasonable Billing Margins

Guideline D-3: Usual, Customary, and Reasonable Rates

Guideline D-4: Balance Billing and Receiving

Guideline D-5: Toxicology

Guideline D-6: Deductibles and Copays

Why? NAATP Members reported that approximately 60% of revenue came through insurance reimbursements.

Despite this being the primary source of revenue for addiction treatment providers, some providers remain ignorant of regulations governing insurance billing at the policy, state, and federal levels, and continue to engage in inappropriate billing practices.

# Guideline D-1: Calculating Cost of Service

## From the NAATP QA Guidebook

*Addiction treatment providers should understand the cost of providing the services offered at their facility and have a methodology for calculating these costs. Providers should utilize the cost of providing a given service when calculating their billed rates, developing network contracts, and forecasting business operations.*

- Current environment – price to market
- Why is calculation important?
  - Insurance negotiation – *the power of data* (note: include “risers” in your calculation – automatic adjustment for inflation (2-5%))
- What does it cost to deliver a unit of service?
  - Full census
  - Average bed utilization rate
- Example:
  - Cost of RTC bed = \$500 @ full capacity – What is the cost at 75% capacity? Does it change your cost?
    - \$100 facility costs + \$200 staffing costs + \$100 admin costs + \$100 marketing costs

# Guideline D-2: Reasonable Billing Margins

## From the NAATP QA Guidebook

*Addiction treatment providers should utilize their calculated cost of providing services in the development of billed rates. Billed rates should reflect reasonable profit margins consistent with other healthcare areas.*

- What are reasonable rates?
- What are reasonable margins?
- What factors impact margins?
  - Payment by payers – On a per claim basis, what are you able to collect with reasonable efforts
  - Understand the percentage and effort of appealing claims
  - As your collection rate goes up, so will your costs for an internal billing team or billing provider
  - Data – the only way to know where you can impact margins is through tracking and monitoring
- Helpful hints:
  - Start contracting process in October
  - Understand payer stratification within markets
  - United "Platinum Status" – invite payers out and establish a relationship  
Example: Facilities getting 20 days+ RTC authorized automatically

# Guideline D-3: Usual, Customary, and Reasonable Rates

## From the NAATP QA Guidebook

*Addiction treatment providers should work with payers and trade groups to standardize and make public usual, customary and reasonable rates, and understand the usual and customary rates for the services they provide. Addiction treatment providers should consider these rates when developing their billing policies and have justification for billing amounts that significantly differ from what is usual and customary.*

- Only with data, can you appeal and win when claims get paid out of UCR
  - One client: 80% success rate on appealing claims that differ from UCR by 20%

# Guideline D-4: Balance Billing and Receiving

## From the NAATP QA Guidebook

*Addiction treatment providers should develop and adhere to a written policy regarding balance billing that complies with state law, network contracts, and insurance policy documents. Balance billing should be uniform for all patients and insurance policies, except if specifically addressed in an in-network contract or policy documents when billing out of network.*

- Understand the difference between in-network and out-of-network payers
- Balance billing generally involves those amounts that are not otherwise covered by insurance or patient financial responsibility portions (e.g. copayments, deductibles, or coinsurance)
- Clear and consistent communications with patients
- Understand surprise billing laws (state laws requiring providers to adhere to very strict disclosure, notification, and patient signature requirements)
- HMO contracts generally prohibit in-network providers from balance billing their members.

# Guideline D-5: Toxicology

## From the NAATP QA Guidebook

*Addiction treatment providers should have a written policy governing the use of and billing for toxicology provided at the facility. The type and frequency of testing should be decided based on disease severity, current best practices, and the clinical interests of the patient. Drug testing regimens should consider past toxicology results, length of sobriety, patients' stated history of recent substance use, and other bio- psycho-social-spiritual considerations that may influence the likelihood of substance use. Billing for toxicology should be reasonable and related to the actual cost of providing the service.*

- Test selections should be individualized based on patients' clinical needs
- Develop and adhere to a written policy for toxicology provided at the facility

# Guideline D-6: Deductibles and Copays

## From the NAATP QA Guidebook

*Addiction treatment providers should, by policy, collect all patient responsibility under the insurance policy being billed including deductibles and copayments, in alignment with the network contract, or policy documents when billing out of network. Exceptions to the policy should be documented, comply with insurance policy or contract guidelines, and not be standard business practice. Routine waiver of patient financial responsibility related to deductibles and copays is prohibited. Waivers must not be provided except in the case of demonstrable financial hardship, based on written objective criteria in alignment with insurance policy guidelines.*

- Written and consistent policies
- Payment plans – “people don’t value free”
- Industry shift to patient collections



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Thank you!

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