IBJ
INDIANAPOLIS
BUSINESS JOURNAL

Subscribe Now Log In

Anthem pays $4.5M to Indiana hospitals in ER billing dispute

April 15, 2022 | John Russell

KEYWORDS ELEVANCE / HEALTH CARE / HEALTH CARE & INSURANCE / HOSPITALS / LAWSUITS

For five years, health insurer Anthem Inc. has tried to clamp down on what it considered unnecessary, expensive visits to emergency rooms by denying claims or downgrading reimbursements for ER visits that turned out not to be life-threatening.

But now, that policy has come back to bite the Indianapolis-based company.

A group of 11 Indiana hospitals complained that Anthem's policy was unlawful and breached their contracts, costing them millions of dollars. And a federal arbitrator has agreed, ordering Anthem to pay them $4.5 million.

Anthem, which fought the case for two years, says it has complied with the order.

But the hospitals say they can claim at least another $12 million from Anthem for tens of thousands of additional claims that it says Anthem has downgraded and not paid in

full. And the count of improperly denied or downgraded claims, they say, is growing by the day.

That matter is still playing out. The arbitrator's ruling says Anthem must stop using a list of diagnostic codes to downgrade and deny the hospitals' claims.

It also has ordered Anthem to pay for all claims that were downgraded, but it did not issue a dollar amount for that set of claims. Anthem has not said whether it will pay additional damages.

The case has thrust into the spotlight the issue of how giant insurance companies decide whether to limit or deny claims for emergency treatment and whether it's proper to use diagnosis codes to determine payment.

For Anthem, it's a setback that some say could reverberate far beyond this group of Indiana hospitals, into other states where the insurer does business.


Alan Lash

"From our perspective, this is a chronic situation with Anthem, not only in Indiana, but in other parts of the country," Alan Lash, a partner at Lash & Goldberg LLP in Miami, Florida, who is representing the hospitals, told IBJ.

What's a proper ER visit?

The case involves contracts Anthem held with hospitals to cover Medicaid patients.

The insurer used a system called AutoPay which identified ER claims and matched them to approved diagnosis codes.

For claims that didn't match approved codes, Anthem downgraded the claim to a "triage fee," usually between $50 and $70, and asked the hospitals to submit additional medical records for review.

The hospitals said Anthem's practice adversely impacted between 60% and 70% of the thousands of ER claims submitted between January 2017 and May 2020, and was unlawful, as hospitals are required to treat all patients who request emergency service, at least to the point of stabilizing their injuries or conditions.

Anthem initially declined to answer questions from IBJ about the case and asked two separate courts to seal all arbitration and contract records on the matter.

Arbitration awards are not typically made public. In this case, however, the hospitals attached the arbitration rulings as exhibits in a filing in U.S. District Court on March 25 and in Marion County Superior Court on April 10.

IBJ obtained records on the dispute from the Marion County Superior Court online docket. As of Wednesday, the court had not acted on Anthem's request to seal the records.

Based on those documents, IBJ posed a list of questions to Anthem. In response, the insurance company acknowledged the dispute concerned "a policy intended to deter the inappropriate use of the ER for non-emergencies."

"Anthem's use of the policy, namely the AutoPay list, was specifically approved and authorized by the state of Indiana to identify ER claims that do not need to be reviewed any further for appropriateness of services," Anthem said in its statement. "Anthem is required by the state to use the same list the state

and the other Medicaid managed care organizations use to expedite these payments without further review. The AutoPay list facilitates faster payment of claims, not claim denials."

Anthem Inc. has been ordered to pay 11 hospitals $4.5 million after they complained about it denying claims or downgrading reimbursements for ER visits. (IBJ file photo)

Are chest pains an emergency?

But as far as the hospitals are concerned, the use of diagnosis codes to determine reimbursement is fraught with complications.

They say a patient's decision to go to the emergency room is often complex. For example, a person having chest pains during the day might call a primary doctor or go to a walk-in clinic seeking help. But if that same patient is having chest pains in the middle of the night and can't reach his primary care doctor, he might go to the emergency room.

If an ER doctor examines the patient and decides the pains were only indigestion and not a heart attack, the doctor would likely enter a diagnosis code that didn't match with Anthem's approved list of emergency diagnosis codes. Then the hospital or the patient, or both, could be on the hook for thousands of dollars in unreimbursed claims.

Anthem and other big insurers have said minor injuries should be treated by a primary-care physician or at a lower level of care, such as a retail clinic or urgent-care clinic.

"What we've seen over the last three or four years is a gradual, increased use of the emergency room," said Dr. Joseph Fox, medical director for Anthem's Indiana operations, told IBJ in 2017, as it began implementing the policy. "And some of those visits could be performed at a lower-cost site of service."

But as in the case involving chest pains, patients might not always know the difference.

Too many ER visits?

Nationally, nearly three-quarters of ER visits are for non-emergencies, Anthem said in 2017. And at that point, insurers had been trying to discourage unnecessary use of the ER for years, sending brochures and letters to members, employers and benefits managers.

A national study published by Indianapolis-based Truven Health Analytics in 2013 found that 71% of ER visits were unnecessary or could have been avoided. The study analyzed insurance claims for more than 6.5 million ER visits in 2010 and found that most patients could have been treated in a primary care setting or did not require immediate attention.

But the American College of Emergency Physicians has pushed back, saying the true number is much lower. The organization, based in Irving, Texas, said fewer than 8% of ER patients are classified as "non-urgent" by the Centers for Disease Control and Prevention. The CDC's definition of non-urgent includes such conditions as broken bones and bronchitis.

Anthem's policy of denying or modifying claims caused an uproar among doctors and patient advocates, who said that patients might start to second guess whether their middle-of-the-night chest pains were a heart attack. They feared patients might avoid going to the ER for a true emergency if they are frightened by the prospect of receiving a large medical bill.

Anthem said it developed its list of hundreds of diagnosis codes it considers to be non-emergencies with board-certified ER doctors employed by the company.

In response, the American College of Emergency Physicians said the list of medical diagnoses could violate the "prudent layperson standard," which is part of federal law. That standard requires that insurers cover a person's symptoms, not the final diagnosis.

It says any person who suffers from symptoms that appear to be an emergency, as determined by an average layperson, should not be denied emergency treatment and insurance coverage if the final diagnosis does not turn out to be an emergency.

Case at a glance

Plaintiffs

A group of Indiana hospitals all indirectly owned by Community Health Systems, a Fortune 500 hospital chain based in Franklin, Tennessee, that is not related to Indianapolis-based Community Health Network.

- **Bluffton Regional Medical Center,** Bluffton
- **Dukes Memorial Hospital,** Peru
- **Dupont Hospital, Fort Bluffton Regional Medical Center,** Wayne
- **Kosciusko Community Hospital,** Warsaw
- **La Porte Hospital,** La Porte
- **Lutheran Hospital of Indiana,** Fort Wayne
- **Orthopedic Hospital of Lutheran Health Network,** Fort Wayne
- **Porter Regional Hospital,** Valparaiso
- **Rehabilitation Hospital of Fort Wayne,** Fort Wayne
- **St. Joseph Hospital,** Fort Wayne
- **Starke Hospital,** Knox

Defendant

Anthem Inc., a Fortune 500 company based in Indianapolis, the predominant health insurer in Indiana.

Court

Marion County Superior Court

So far

- The hospitals alleged Anthem did not reimburse them for certain services at their most recent contracts' agreed rates and brought a claim to arbitration.
- Anthem brought a counterclaim, alleging the hospitals refused to comply with the contracts.
- The issue went to arbitration in 2019, and Anthem says it made full payment on the arbitration award. Terms of the arbitration remain secret.
- The hospitals are now demanding further, unspecified payment over disputed claims for medical treatment.

Sources: court filings, IBJ research

Seeking a court seal

The 11 Indiana hospitals challenging Anthem are asking a judge to confirm the arbitration decision, which was finalized in February.

The hospitals in the group include Lutheran Health System in Fort Wayne and Porter Regional Hospital in Valparaiso. They are all owned directly or indirectly by Community Health Systems of Franklin, Tennessee, a large, for-profit company that rang up $3.2 billion in revenue last year. (It is unrelated to Indianapolis-based Community Health Network).

In recent weeks, the case bounced between two courts, both based in Indianapolis. In both cases, the hospitals filed the cases as plaintiff, seeking to have a judge confirm the arbitration award, and naming Anthem as the defendant.

The hospitals originally filed the case in U.S. District Court in March. Anthem quickly moved to seal the petition, along with the arbitration and contract exhibits.

"The information should be maintained under seal and from the public eye, despite its potential materiality to this case, to give effect and enforcement to contract terms, the confidential nature of arbitration proceedings and to the protective order in place in the arbitration," Anthem wrote March 31 in its motion.

In response, the federal court automatically sealed much of the docket on a provisional basis.

But just one day later, the hospital system voluntarily dismissed the federal motion. It told IBJ it did so in response to a U.S. Supreme Court ruling limiting federal jurisdiction on arbitration awards.

Nine days later, the hospital group filed a nearly identical petition and set of exhibits in Marion County Superior Court. Again, Anthem moved to seal much of the record, but as of midweek, the documents remained unsealed.

Considering symptoms

The relationship between the hospitals and Anthem seemed on its face to be a standard one for treating Medicaid patients. Under the arrangement, Indiana's Medicaid program gives Anthem a fixed monthly payment for each enrolled member for use in paying for covered costs and services. Anthem agrees to pay the hospitals for treating the patients.

But the relationship between Anthem and hospitals took a big turn in 2017, when the insurer started restricting ER payments.

Within two years, the hospital system had gathered enough evidence of what is said was improper behavior by Anthem to submit a complaint to a federal arbitrator. It said a patient or a hospital should not have to worry whether the condition would be approved based on the doctor's final diagnosis.

The law, the arbitrator wrote, was "crystal clear" that to deny or downcode an emergency claim, Anthem must first consider all the pertinent information and documentation with a focus on the patient's symptoms, and not just a final diagnosis code.

"Anthem does not do so," the arbitrator, wrote in his interim decision on Oct. 21.

Lash, the hospitals' attorney, estimated there are more than 30,000 additional claims affected by Anthem's policy, which could cost the insurer more than $12 million. He said Anthem has yet to make good on that amount.

Anthem did not respond to IBJ's questions about whether it agrees with that amount or plans to pay it.

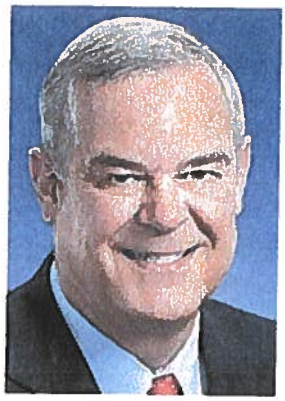
Lash said other health insurers have been taking similar steps with restrictive ER reimbursement policies in recent years and are also facing a pushback from hospitals. "We have been litigating cases like this for hospital providers across the country for years, against other insurance companies that are engaging in these kind of emergency room downgrade policies," he said.

Lash said he was not at liberty to discuss the details of those proceedings or disclose the outcomes. "But I'll just say that we've been successful in those endeavors, consistently."

Secrecy waning

The confidentiality surrounding the case, and particularly Anthem's efforts to seal the exhibits, are typical of the longtime secrecy over health care prices charged by hospitals and the discounts negotiated under contract by insurers for their members under various health plans, some longtime observers say.

"Once Anthem has to disclose what its rates are, well, then all of a sudden, United, Cigna and all the other major players say, this is what they're getting, why can't we get the same," said Ed Abel, former director of health care practice at Indianapolis-based Blue & Co., an accounting and consulting firm.



Ed Abel

"And hospitals feel the same way," he added. "They don't want to give United and Cigna, etc., the same discounts that they're giving to Anthem.

Such secrecy has started to wane in the last year, thanks to new federal rules that require hospitals to post prices online for 300 "shoppable services," such as a CT scan or a blood test.

The new rules also require hospitals to post a machine-readable file of every negotiated price paid to the hospital by every insurer it had a contract with for in-network care, plus the list price, cash price, and the high and low prices for those services.

The American Hospital Association challenged those provisions in court, saying the prices, known as the chargemaster, were private and could hurt their operations if published. But the association lost its fight, and hundreds of hospitals have yet to comply with the new requirements.

Nicolas Terry

"The agreed rates and the underlying hospital chargemasters were viewed as strictly confidential," said Nicolas Terry, executive director of the Center for Law and Health and the Indiana University McKinney School of Law.

"Hence the hospital system pushback and in many cases non-compliance with the Hospital Price Transparency Rule."•

Editor's note: You can comment on IBJ stories by signing in to your IBJ account. If you have not registered, please sign up for a free account now. Please note our updated comment policy that will govern how comments are moderated.