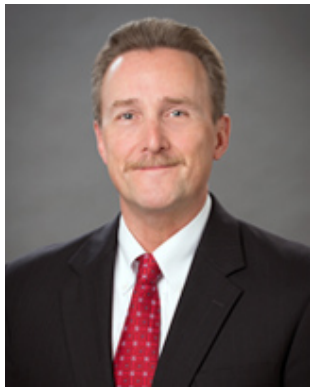
K&L GATES

TRIAGE: RAPID LEGAL LESSONS FOR BUSY HEALTH CARE PROFESSIONALS



Recent Developments in Provider v. Payer Litigation – Encompass v. Blue Cross

Gary S. Qualls and Zachary W. Ernst

BACKGROUND OF RECENT FEDERAL CASE

- The federal lawsuit is Encompass Office Solutions, Inc. ("Encompass") v. Louisiana Health Service & Indemnity Company d/b/a BlueCross BlueShield of Louisiana ("Blue Cross"), No. 17-10736.
- Encompass provides equipment, drugs, supplies, and nursing staff necessary for a doctor to perform outpatient surgery in their own office, rather than in a hospital or ambulatory surgical center.
- This was a novel arrangement at the time, as neither Texas nor Louisiana licensed such mobile providers of ambulatory surgical care.

NOTABLE ASPECTS OF ENCOMPASS' BUSINESS MODEL

- Generally, when a doctor performs surgery at a hospital or ASC, an insurer like Blue Cross receives three claims:
  - one from the surgeon;
  - one from the anesthesiologist, if used; and
  - one from the hospital or ASC for services provided to assist the doctor.
- When a doctor performs surgery in their office, however, there is typically no facility fee claim because there is no separate facility.
- Instead, Blue Cross pays doctors a "Global Fee" for these in-office surgeries.
- The Global Fee is greater than the fee paid to doctors for performing surgery at a hospital or ASC, and is generally intended to compensate for all overhead costs of an in-office procedure.

NOTABLE ASPECTS OF ENCOMPASS' BUSINESS MODEL

- When Encompass entered the market, it expanded doctors' ability to perform in-office surgeries.
- Encompass sought compensation from insurers by filing separate claims for its services.
- At all relevant times, Encompass was an out-of-network ("OON") service provider for Blue Cross members.
- Because of this OON status, Encompass obtained an assignment of benefits from each Blue Cross-insured patient.
- Blue Cross paid Encompass' claims for several months after Encompass entered the Louisiana market.

NOTABLE ASPECTS OF ENCOMPASS' BUSINESS MODEL

- In June 2010, Blue Cross received a tip that Encompass was submitting claims for services that Blue Cross perceived as duplicative.
- On investigation, Blue Cross found that Encompass was submitting claims, and being paid, for the same in-office surgeries as the performing doctors.
- Blue Cross's billing system would normally reject what Blue Cross perceived to be "duplicate" claims for surgery at a doctor's office.
- Blue Cross had been processing Encompass' claims because Encompass was using the "TC Modifier."

PROCEDURAL BACKGROUND

- In the first trial, Encompass sued Blue Cross for ERISA violations and other claims.
- Blue Cross largely prevailed at trial. But the district court granted a new trial because of error in the jury charge.
- At the second trial, Encompass won on all claims and obtained a judgment in its favor.

THE COURT'S ANALYSIS – ENCOMPASS' ERISA CLAIMS

- Encompass argued it was an assignee entitled to enforce patients' rights to benefits under Blue Cross Plans.

- Blue Cross challenged Encompass's right to advance claims for benefits, as well as the district court's ultimate conclusion that Blue Cross abused its discretion in administering the plans.

THE COURT'S ANALYSIS – ENCOMPASS' ERISA CLAIMS

- **The Three Relevant Rulings**
  - First, the Fifth Circuit affirmed the district court's ruling that Blue Cross waived Plan anti-assignment clauses because Blue Cross had communicated with Encompass and paid Encompass for certain claims.
  - Second, the Fifth Circuit upheld the district court's conclusion that the Plan's contractual limitation period provision was unenforceable because Blue Cross failed to give Encompass adequate notice of such a limitation period.
  - Finally, the Fifth Circuit held that Blue Cross abused its discretion by arbitrarily denying Encompass' claims for covered services, as shown by its inconsistent treatment of similar providers (such as ASCs and hospitals).

FINAL TAKEAWAYS

- The Plan says what the Plan says, and ERISA Plan administrators (such as Blue Cross here) cannot simply assume that the Plan is double-paying if the Plan terms do not preclude such payments.
- Here, the Plan failed to distinguish between technical fee payments to physical ASCs vs. what we will call “virtual ASCs.”
- The specific scenario here is not that important, because Blue Cross can always prospectively modify the Plan language to say what Blue Cross thought the language said all along.
- The significance of this “plan interpretation” issue is that the Plan language must be followed, even if it might deviate from either:
  - a customary payment method in the field; or
  - a methodology the federal government might follow.
- That is true even under the deferential arbitrary and capricious standard, which is the standard under which courts typically judge ERISA plan interpretations.

Today's Presenter

Gary S. Qualls
Research Triangle Park
+1.919.466.1182
gary.qualls@klgates.com

Zachary W. Ernst
Research Triangle Park
+1.919.314.5624
Zachary.Ernst@klgates.com

If you have feedback or a topic you want us to analyze in a future episode, **please let us know**.

For more information on our Health Care Practice Group please visit our **website.**

For additional insights into Health Care Law please visit **K&L Gates HUB.**