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AAA® Healthcare Payor Provider Dispute Resolution: A Model for Streamlining the Arbitration Process

Most in the healthcare industry would agree with Benjamin Franklin's assessment that "an ounce of prevention is worth a pound of cure." However, many may not be aware that conflicts in the **payor provider segment of the healthcare industry** in particular can be managed in much the same way.

This white paper serves as an introduction to how, through efforts such as these taken by the AAA, the arbitral process for specific groups can be effectively streamlined by focusing on the needs of the end users, in this case the Payor Provider segment of the healthcare industry.

Defining the End User: Payor Provider Disputes Are Different

Major stakeholders within the healthcare industry (see table, page 2) sit on the **AAA Healthcare (HC) Dispute Resolution (DR) Advisory Council**, which is charged with lending its expertise to fostering and developing business-to-business dispute resolution solutions for healthcare.

After determining that payor provider claims comprised the largest volume of healthcare cases that utilized binding arbitration, the Council examined that body of claims closely to tease out if and how these disputes truly are unique as contrasted with many other types of healthcare-industry disputes.

Payors are the insurance companies or other parties responsible for (1) paying all or part of a claim relating to the rendering of healthcare services; or (2) administering the payment of such a claim for another entity. Included as payors are third parties who administer self-funded plans on the plans sponsor's behalf. Not included are employers who sponsor benefit plans.

Providers are the hospital or hospital system, physician or physician group, laboratory services provider, ambulatory care center, dentist, chiropractor, optometrist, therapist, nurse, or other party that provided healthcare services and seeks payment for one or more claims from a payor.

The conclusion? Payor Provider disputes have distinct characteristics in that:

- There are details unique to claims dealing with, for example, physician reimbursement and treatment coding, that lend themselves to more efficient and less costly handling.
- The payor sector and the provider sector have ongoing, intertwined relationships with disputes that will resurface.
- These parties must interact with each other more than other sectors of the healthcare industry. For example, there are patients who are members of payors who need ongoing services from providers such as hospitals.

Changing the "Rules of Engagement": The AAA Healthcare Payor Provider Arbitration Rules Modify Key Areas of the AAA Commercial Arbitration Rules

The HC DR Advisory Council's goal was to formulate and implement ways that this constituency could more efficiently and cost effectively resolve its disputes while keeping them as free from acrimony as possible.



AAA HC DR ADVISORY COUNCIL REPRESENTS MAJOR STAKEHOLDERS IN THE HEALTHCARE INDUSTRY

- General Counsel, UnitedHealth Group
- General Counsel, American Hospital Association
- General Counsel, America's Health Insurance Plans
- Vice President, American Medical Association
- CEO, Medical Group Management Association
- CEO, Health Information Management Systems Society
- Associate GC, Blue Shield of CA
- Past President, American College of Legal Medicine
- Past President/CEO, Blue Cross Blue Shield of Rhode Island
- Experienced Healthcare Lawyers (Hogan Lovells, Boies, Schiller & Flexner)

Standard disputes between payors and providers are covered by the AAA Commercial Arbitration Rules. The Council concluded that modifying these rules with provisions unique to governing commercial disputes between hospitals / physicians and insurers would create a more effective framework for dispute resolution for this group.

For maximum usability and manageability, the scope of disputes that fall within these particular rules was carefully crafted. It does not cover disputes between physicians and hospitals, or between patients or consumers and their health plans. In the interest of efficiency, the rules allow payors and providers to file a single case that consolidates multiple disputes, patients, contracts and/or dates of service.

Because a cross-section of payors and providers participated (the vice president of the American Medical Association and the general counsel of the American Hospital Association, among others), the result is a set of rules fair to both sides with the flexibility to be tailored to special issues.

A comprehensive review of the **AAA Healthcare Payor Provider Arbitration Rules** as well as comparisons with the **AAA Commercial Arbitration Rules** can be found at www.adr.org/healthcare. Following are the critical attributes of the Payor Provider Rules specifically geared to this end user.

New Specialized Panels

Payor provider cases are heard by arbitrators selected from the **AAA National Healthcare Panel** or the **Judicial Payor Provider Panel**.

The **AAA National Healthcare Panel** was created to provide parties with arbitrators who have detailed subject-matter knowledge of the types of information necessary (for example, *proper billing of CPT codes*) to drive the resolution of these particular disputes.

Healthcare neutrals must meet stringent criteria above the already strict AAA requisites for panel member inclusion; they must spend a significant percentage of their professional time in their specific healthcare field, as demonstrated in special supplementary healthcare forms they submit. These forms are available to the parties, along with the standard AAA resume, which provides an extra layer of transparency for outside counsel vetting a potential arbitrator for these types of disputes. All healthcare panel members are trained in the Payor Provider Rules and understand the framework of both payor and provider organizations.

The five major "sub-panels" of the Healthcare Panel handle:

- Payor provider reimbursement
- Healthcare transaction and contract issues
- Credentialing, medical staff, and peer review
- Provider contract issues
- Medical malpractice (post dispute or mediation)

The **Judicial Payor Provider Panel** is composed of judges who have spent at least 10 years on the bench and have participated in AAA training on managed care concepts and the new Payor Provider Rules.

Administrative Track Choice

The administrative track (*desk/telephonic; regular; complex*) is determined by the parties, not the amount of the claim, which is a departure from the AAA Commercial Rules.

This rule recognizes the need for flexibility in determining the framework of a payor provider case in order for parties to make the most efficient choices. In this arena, the complexity of a case does not always turn on the claim amount. A dispute might generate a large dollar amount due to a high case volume yet be relatively simple from a case-tracking perspective — for example, it might concern a very narrow legal issue that could be resolved without a lot of discovery or depositions. A more detailed discussion of track selection follows in the section on discovery.



The **regular track** is the default track.

The **desk/telephonic track** decides cases on “documents only” — claims and medical records submitted; these cases often can be distilled to whether or not the claims should be approved. This track is possible because of the subject-matter expertise of the trained arbitrators on the National Healthcare Panel; if necessary, the arbitrator can schedule a telephonic hearing for advocates to clarify the documents. This option also gives access to a wider span of arbitrators outside the locale of the dispute.

The **complex track** is selected by parties if they agree there is a need for additional discovery.

Number of Arbitrators: 1 vs 3

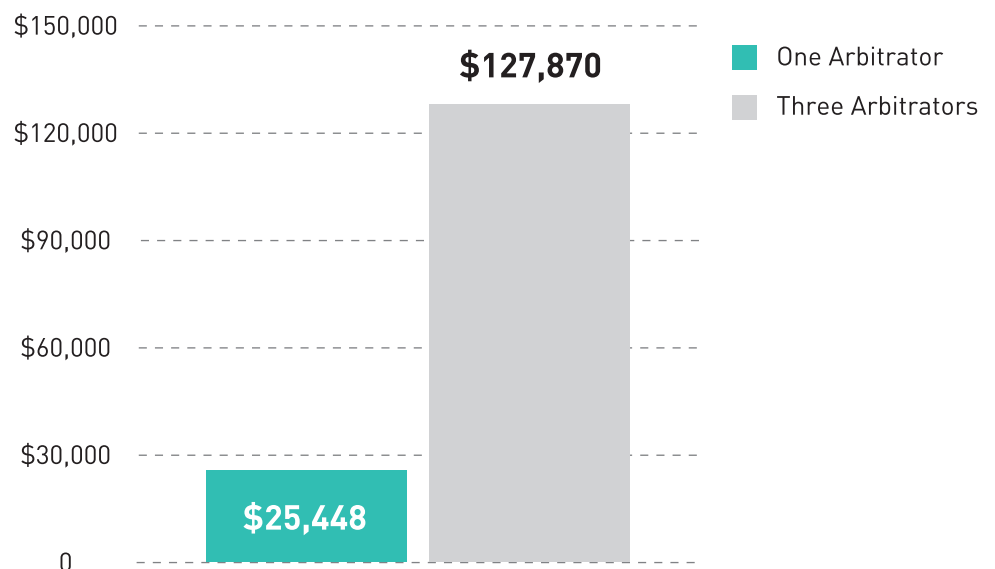
Each case is heard by one arbitrator, unless parties agree otherwise.

Using one arbitrator obviously saves on arbitrator fees. This rule also limits the amount of time that would be spent on selection of three arbitrators without sacrificing any breadth of experience; this serves a payor/provider case well, since, as noted in a previous section, the arbitrator will be a specialist in the area of the healthcare dispute in question.

A study done by the AAA (see *below*) illustrates an analysis of the last 243 awarded large, complex cases with regard to cost of arbitrator compensation and length of time of proceeding. The median arbitrator compensation when a panel of three was used was 5 times higher than for a single arbitrator; the median time frame for resolution increased from 443 days to 613 days when three versus one were used.

	ONE ARBITRATOR	THREE ARBITRATORS
Cases	124	119
Largest Claim	\$600 Million	\$5 Billion

Median Arbitrator Compensation



Streamlined Discovery

Parties are limited to one deposition for the regular and desk/telephonic tracks and two for the complex track, unless both parties agree otherwise or the arbitrator orders more for good cause. The Commercial Rules have no such limitations to what is called therein “exchange of information.”

Representatives from both the payor and provider sides agreed that in order to fulfill the intention of establishing a framework for their disputes that encourages efficiency, discovery had to be limited. Recognizing that the arbitrators and attorneys for the parties bring their own experience with the permitted scope of discovery and number of depositions, the Council set expectations for discovery while allowing for the option of flexibility if the arbitrator or parties decide otherwise.

This serves to prevent the arbitration of payor provider claims from becoming protracted and can represent an enormous savings in time and cost for this population; no one party can hold up proceedings with requests for more discovery.

It is significant to note again that the limits are not in any way dictated by the amount in controversy but by the nature of the dispute.

Example A in the table below illustrates a case with a high volume of claims at issue — numerous patients, numerous services. There might be a high dollar amount in controversy but a relatively narrow issue.

A case of this type does not dispute whether the provider has furnished the service or whether the service was medically necessary. The dispute may be a coverage issue technical in nature, for example, if, under the person’s scope of covered benefits, this service could properly be provided by a clinical social worker instead of a psychiatrist. This relatively narrow issue could turn on contractual interpretation. Therefore, regardless of the number of claims at issue, there is little need for depositions, and this case might be appropriate for submission to the desk or documents-only track.

Example B contrasts with a case where, although the volume of claims or money is not high, the area is subjective.

A case of this type could be a procedure considered experimental in nature that may not be covered by the payor. Or a case might generate involved, more subjective medical-necessity questions. Expert testimony to develop the record is needed for the arbitrator to understand coverage issues. Therefore, although low dollars are at stake, parties would want to submit this type of case to the complex case track.

CLAIM AMOUNT DOES NOT DETERMINE TRACK

EXAMPLE A

High volume of claims
Multiple patients
Multiple services
Multiple revenue codes
High amount in controversy
Narrow issue — no need for discovery
Result: Submit to Desk/Telephonic Track for decision on the records (*documents only*)

EXAMPLE B

Newly executed manage care agreement
Small number patients
Small number services
Small number revenue codes
Low amount in controversy
Complicated contractual interpretation — discovery needed
Result: Submit to Complex Case Track

Preliminary Case Preparation and Document Exchange

Directly after arbitrator appointment, the arbitrator is required to conduct a preliminary hearing by phone or video conference to consider matters such as confidentiality agreements, scheduling of hearings, selection of track, and disclosure of information. Guidelines for initial disclosures, tailored for payors and providers to include issues that continually come up, are detailed in the Rules. Documents necessary to the resolution of payor provider disputes (*medical records, invoices, explanation of benefits*) must be exchanged at least five days prior to the arbitration.



Under the **AAA Commercial Rules**, the timing of the initial conference is less defined.

Prompt establishment of the schedule and details as well as the early upfront and uncontested exchange of crucial information sets the stage for an arbitration to proceed toward the most expeditious outcome achievable. Early surfacing of issues enables the parties to intelligently evaluate their positions in the dispute as well as educates the arbitrator as quickly as possible. The intent is for parties to have discussions around efficiency regarding resolving multiple claims that are embedded in different contracts or issues that could recur during the life of the same contract, which the arbitrator could resolve at this point in the disputes, so the parties don't have to revisit them.

In particular, the AAA here strongly encourages the parties and the arbitrator to have an early discussion about confidentiality. Members of the Council, aware that almost all agreements between payors and providers have confidentiality provisions, knew these payors and providers would feel more comfortable and free engaging in their resolution activities in a confidential environment.

These rules set the parties' expectations that when they come into this process, they have to have their "ducks in a row." They've got to have the package of information pulled together that's going to enable an arbitrator to resolve the dispute.

Dissemination and Precedential Effect of the Award

These two issues are not expressly addressed in the Commercial Rules.

Publication or dissemination of awards is prohibited, unless required by law or the parties agree otherwise in writing.

This explicitly protects confidentiality — unlike the Commercial Rules, which address confidentiality only on the part of the AAA and the arbitrators and not of the parties, or court, where proceedings are public. In an arena where organizations repeatedly meet in arbitration, as payors and providers do, this is significant.

Precedential effect does not apply to awards made under the Payor Provider Rules; awards will have no effect on future rulings unless parties agree otherwise in writing.

For the vast majority of payor and provider disputes, parties are not interested in making published, precedent-setting law; there is always the option of court if that is the case. However, the nature of most payor provider cases is such that the outcome of each case should be decided on the merits of that case alone.

Drafting the Payor Provider Clause

Following is the Standard AAA Payor Provider Arbitration Clause. This can be inserted by payors and providers into their contracts to specify the selection of the AAA Healthcare Payor Provider Arbitration rules should disputes arise.

Any controversy or claim arising out of or relating to this contract, or the breach thereof, shall be settled by arbitration, administered by the American Arbitration Association pursuant to its Healthcare Payor Provider Arbitration Rules, and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.

The default for disputes between parties with agreements containing an AAA arbitration clause that does not designate the Payor Provider Rules clause is submission under the AAA Commercial Rules; however, parties can mutually agree and elect the Payor Provider Rules.

Parties lacking any commercial contract between them (for example, an out-of-network provider and a payor) also can agree to submit their dispute to the AAA for resolution and elect to follow the Payor Provider Rules.

It is important to note that the standard healthcare payor provider arbitration provision provides defaults built into the rules for a number of various areas including arbitrator selection process, qualifications, and hearing locale.



Leveraging a Specialized Panel: Creative Strategies for Utilizing the AAA National Healthcare Panel

Using healthcare neutrals to evaluate large, complex cases

Highly specialized neutrals can be used in the resolution of a dispute before triggering formal arbitration processes. This typically is used in cases of some significance, where the client scrutiny — perhaps by the Board or the CEO — is more rigorous than usual, as this use of neutrals adds a layer of cost and time. (*Neutrals who perform this service are of course disqualified from future arbitration of that case.*)

A very well-qualified and experienced neutral can be drawn upon to strengthen the quality of internal case assessment, give a stamp of approval on a course of action, and/or inform case strategy. Expert neutrals also can be used to evaluate outside counsel and/or potential witnesses. Selecting an expert for this purpose with experience aligned with that of the adversary could provide a unique point of view on the case.

Other ways neutrals can be used to provide internal case assessment are:

- **Mock arbitrations** for neutrals to give an informed view early on in the presentation about how the case is trending.
- **Moot court exercises** to vet counsel, witnesses, and opening and closing arguments. Witnesses testify in front of neutrals retained on a consultative basis to provide feedback for both witness and counsel.

Neutrals also can be used for external case assessment, as with:

- **Non-binding arbitrations**, where one party's view of a case is fundamentally different from the adversary's view of a case. The neutral weighs in and can provide a strong basis for one party to adjust its views of the case in a way that wouldn't be available if left to its own devices.
- **Mediation**, where parties can select a neutral whose mediation philosophy reflects a style that will be more directive and evaluative of the claims in a healthcare case.

Utilizing the "Ounce of Prevention": Targeted Payor Provider Rules Set a Tone for Expectations and Efficiency

The structure of the AAA Healthcare Payor Provider Arbitration Rules sets the tone for how each side will come to the dispute and manages what both their expectations and those of the arbitrator will be.

Because the rules are tailored to the specific types of disputes that come up between payors and providers, an appropriate underpinning is created to enhance the possibility of efficient resolution in the various types of matters that can arise. For example, setting up three different tracks parties can elect for their disputes sets the tone from the outset for the possibility of resolving these disputes with a lot more efficiency than might otherwise be the case.

Parties are not required to use these new rules, but parties filing any new case that meets the requirements and definition for utilization of the new rules are encouraged to consider using them.



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For More Information:

For the complete **AAA Healthcare Payor Provider Arbitration Rules**, please visit www.adr.org/Healthcare.

Also available on that page are resources including articles on healthcare ADR, information on healthcare case services and neutrals, the Healthcare Dispute Resolution Advisory Council, and available education programs.