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Best Practices to Combat Denials: Keep Calm and Appeal Like a Lawyer

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Objectives

1. Introduce concepts to maximize your recovery and “Appeal like a Lawyer”.
2. Learn legal and organizational rules for best practice appeal writing (PLEA and IRAC).
3. Applying our Knowledge!

Best Practices - Evaluate Internal Resources

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Non-Covered

Clinical

- Lack of Medical Necessity
- Re-Admission
- DRG Downcode
- Delay in Service
- Non Emergent Service
- Experimental/Investigational
- Medically Unlikely Edits
- Lower Level of Care

Contractual/Technical/Administrative

- Lack of Authorization
- Re-Admission
- DRG Downcode
- Lack of IP Notification
- Out of Network
- Not Covered Under Clinical Policy
- Lack of Eligibility/Benefits
- Coordination of Benefits
- Untimely Claim
- Untimely Appeal
- Billing Error

Best Practices - Create a Payer Matrix

- This is an extremely beneficial tool for ALL team members.
  - Claim submission and resubmission timeframes
  - Coordination of Benefits
  - Timeframes for first and second level appeals
  - External appeal options and timeframes
  - Correct addresses, phone numbers, and fax numbers
  - Any key contract terms to assist in the appeals process
  - Availability of retro-authorization and timeframes

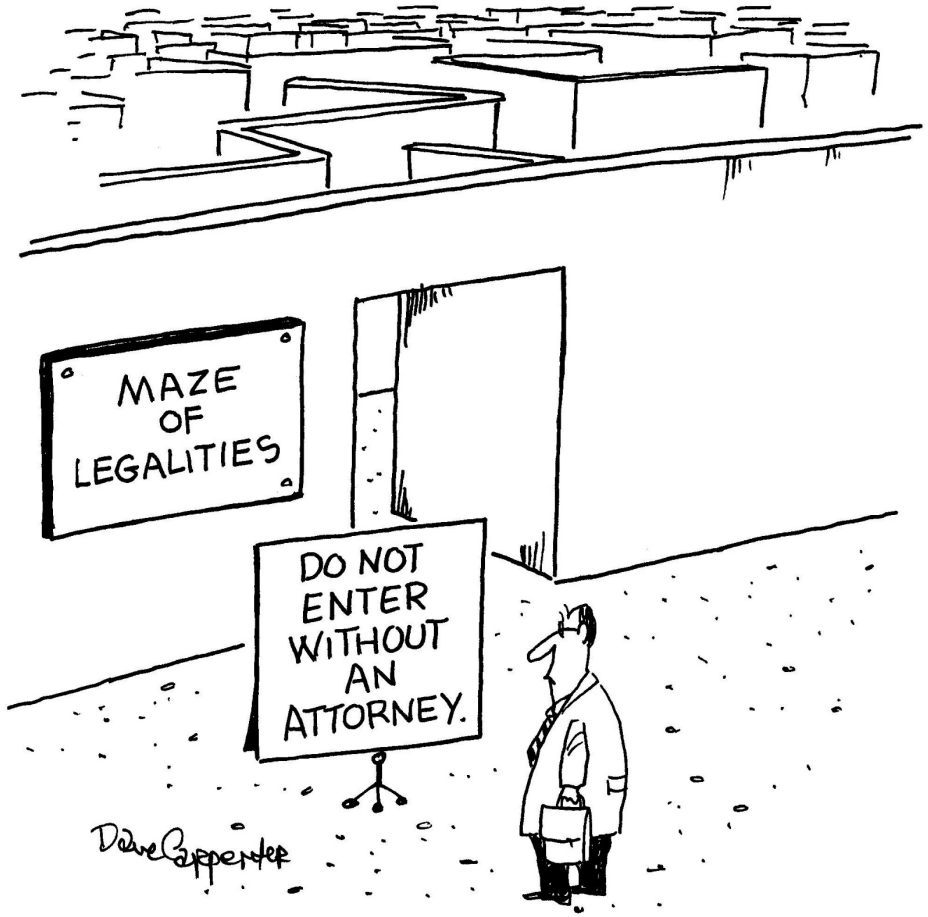
Best Practices - *Example* Payer Matrix

Payer	Claim Submission	Reconsideration/First	Second	Appeal Address
Aetna **Contracted all lines**	**180 days**	**180 days from denial** Reconsideration considered first level	**60 days from denial of reconsideration**	Attn: Provider Resolution Team PO Box 14079 Lexington, KY 40512-4079 **Must submit appeal form with appeal*
Cigna **Contracted all lines**	**180 days**	**180 days from denial**	**NO second level**	Attn: National Appeals Unit PO Box 188011 Chattanooga, TN 37422
United Healthcare **(Commercial Product Lines)** **Contracted**	**180 days**	**365 days from denial**	**365 days from denial**	e-file through UHC portal
United Healthcare **(Medicare Products)** **NOT contracted**	**1 year** Based on Medicare Rules	**60 days from denial** Submit Waiver of Liability due to Non-Contracted Status	Appeal to be forwarded to Maximus for Independent Review if denied or appeal not completed within 60 days	PO Box 6106 MS CA 124-0157 Cypress, CA 90630-9948

Best Practices - Utilizing State & Federal Law

Type of Plan	Controlling Law
Fully insured (Insurance)	State
Self-funded (Claims paid by employer group)	Federal
Medicaid/Medicaid MCOs	State
Medicare	Federal
Medicare Advantage	Federal

The Continuously Evolving Landscape of Today's Denials



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HAVE NO FEAR!

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The Revenue Manager's Lawyerly Oath

I will appeal all denials with:

Persistence
Logic
Exculpation and
Advocacy

Persistence is Key

"The prosecutor says you have to roll over."

REFUSE TO ROLL OVER

Persistence: Example

Provider gets authorization for CPT code **29823** (Arthroscopy w/ debridement)
but bills CPT code **29826** (Arthroscopy w/ ligament release) and **23430** (Tenodesis)
that deny for lack of authorization.

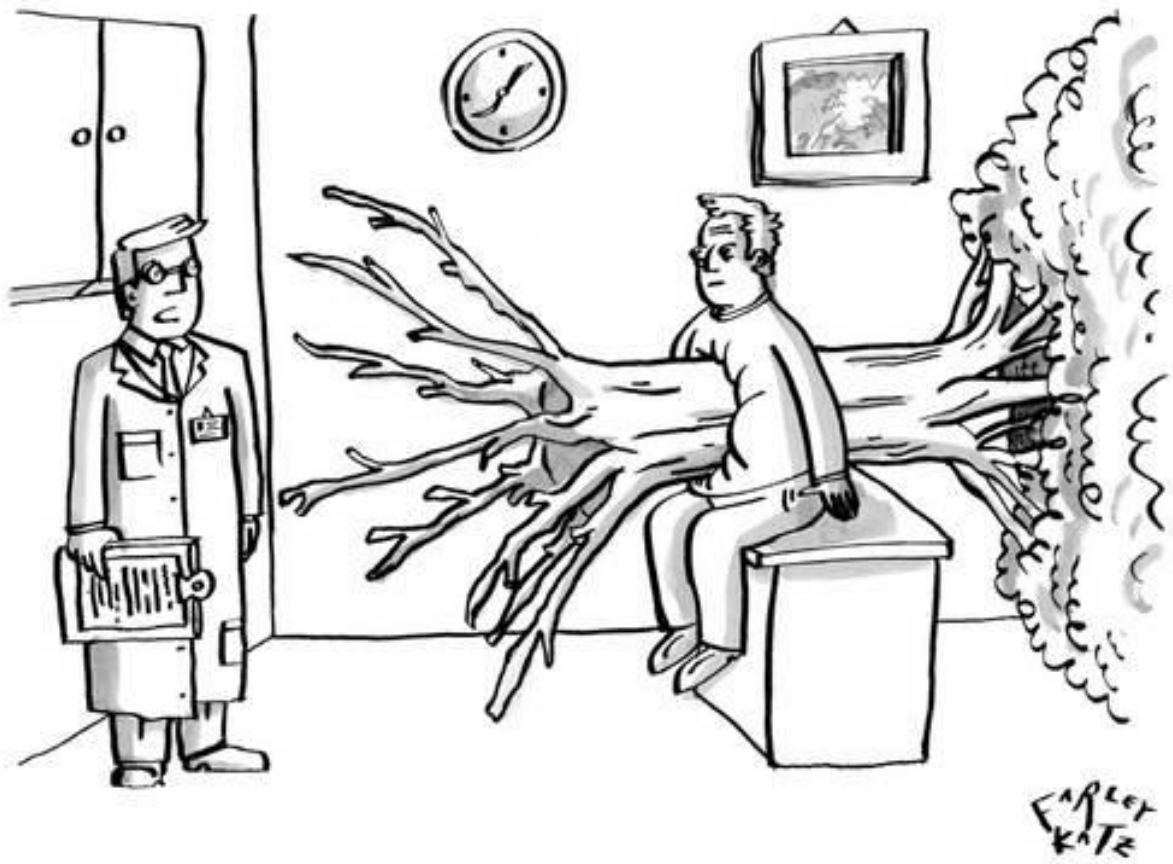
The provider's appeal asks the payer to make an "exception"
since "we neglected to get authorization for the two CPT codes".

Does this sound like a lawyer?

Never Concede. Never Roll Over. Never Accept Blame.

We'll cover this example in more detail in a bit…

Apply Logic



"Actually, this is the one condition your insurance does cover."

IF IT SEEMS WRONG, IT PROBABLY IS!

a.k.a. Smell Test

Apply Logic: Example - The Smell Test

Benefit Exclusion: Plan denied benefits to a child with cancer stating that Plan does not have to pay if the patient himself would not have to pay. Original intent was to exclude payment to family member-caretakers.

Issue: National Children's Hospital advertises no patient will ever receive a bill.

Logic: A Plan provision cannot be so distorted from its original intent to the detriment of a Provider.

Exculpation & Advocacy

NEVER ACCEPT DENIALS AT FACE VALUE

Exculpation & Advocacy: Example

Payer denied a claim for Lack Notification of an ER Admission, but the Contract states the Payer has to pay for the first 48 hours.

Provider files an appeal which is rightly denied as **untimely**.

Give up?

NO: The Payer's obligation for prompt pay under the Contract and law is not contingent on Provider filing a timely appeal.

Contract payment at DRG pays the claim in full.

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Legal Writing Tools

I **ISSUE:** What's the issue you need to address?

R **RULE:** What rule(s) apply to the denial?

A **ANALYSIS:** How do the rules apply to your facts?

C **CONCLUSION:** The logical conclusion of the analysis.

Issue

I

Clinical	Technical/Administrative
Not Medically Necessary	Precertification
Lower Level of Care	Notification
Experimental/Investigational	Untimely Claim
MUE	Untimely Appeal
DRG Down Code	Coordination of Benefits
Clinical Policy/NCD/LCD	Out of Network
Readmission	Stalled Appeal

Rule

What the provider was supposed to do.

What the payer was supposed to do.

- Contract
- Provider Manual/Clinical Policies
- Law
  - State
  - Federal

Analysis

- **Why the provider followed the rules.**
- **Why the payer did not follow the rules.**
- **Apply rules to facts.**

Conclusion

Only logical outcome is overturn.

Example #1

Issue

Provider gets authorization for CPT code **29823** (Arthroscopy w/ debridement) but bills CPT code **29826** (Arthroscopy w/ ligament release) and **23430** (Tenodesis) that deny for lack of authorization.

Rule

Provider Manual:

(1) Surgical codes need precertification

(2) If you don't follow authorization protocols, you must show **extenuating circumstances** why you couldn't.

Example #1, Cont.

Analysis → **Conclusion**

- Provider did follow the rules and got precertification for the intended code. **(E)**
- Because Provider followed the rules, the denial goes against Payer's own policy and they should have reviewed clinically on appeal. **(A)**
- Extenuating clinical circumstances also exist when a slightly different or additional procedure is not foreseeable. **(P)**
- Physicians aren't coders so the whole process of issuing approvals based on CPT codes is flawed. Claims are coded based on medical records after-the fact. **(L)**

Example #1, Cont.

Editorial note: case was referred after provider-exhausted appeals

Payer denied CPT codes **29826** *(Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed)* and **23430** *(Tenodesis of long tendon of biceps)* based on **alleged** lack of authorization. **The denial goes against Payer policy and the provider's Contract with Payer.** We therefore appeal the denial and expect payment of the claim in full.

ISSUE

Example #1, Cont.

Rule

Analysis

Conclusion

Payer Failed to Conduct Clinical Review Per Provider's Contract

Payer's Administrative Guide only requires proof that "extenuating circumstances" for a clinical review on appeal if the provider failed to follow precertification requirements. **In this case:**

1) the provider followed all contractual protocols and **obtained approved authorization** number [redacted] from Payer to perform CPT code 29823 *(Arthroscopy, shoulder, surgical; debridement, extensive);* **and**

2) clinical extenuating circumstances do exist which caused the provider to bill a slightly different code, which Payer failed to acknowledge in its appeal review.

As evidenced by the enclosed operative report, the provider began with the planned arthroscopy and extensive debridement, which revealed an unstable type II SLAP tear of the biceps anchor:

Biceps and labrum:
Long head biceps tendon: Intact
Biceps anchor: Unstable type II SLAP tear
Anterior/inferior labrum: Frayed, debrided
Posterior labrum: Frayed, debrided
Axillary pouch: No loose bodies

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The decision was **then made intra-operatively** to perform the tenodesis:

Based on these findings, we began with an extensive debridement of the glenohumeral joint. This included debridement of areas of synovitis, debridement of the anterior, posterior, and superior labrum, chondroplasty of the humeral head and glenoid, debridement of the undersurface supraspinatus fraying. Based on the unstable type II SLAP tear, we decided to proceed with subpectoral biceps tenodesis.

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Intra-Operative Change is not Foreseeable

Example #2 – Prompt Pay

Issue

Provider files a timely claim. Payer denies the claim for "lack of documentation" but does not indicate what documentation is required to perfect the claim.

Rule

18 V.S.A. § 9418 (b)(1-2) No later than 30 days following receipt of a claim, a health plan, contracting entity, or payer **shall** do one of the following:
(1) Pay or reimburse the claim.
(2) **Notify the claimant in writing that the claim is contested or denied**. The notice shall include **specific reasons** supporting the contest or denial and a description of any additional information required for the health plan, contracting entity, or payer to determine liability for the claim…

Analysis

In violation of **18 V.S.A. § 9418 (b)(2)**, Payer failed to provide sufficient information regarding the documentation needed for payment of the claim. Provider has been prejudiced in its ability to appeal the claim denial.

Conclusion

Payer must pay the claim immediately with interest. **18 V.S.A. § 9418 (e)**

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Applying our Knowledge!

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Problem 1 - Audit & Recoupment

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Facts: Your facility obtains authorization for an infant's 4-month admission at the NICU 4 level of care. The claim is filed timely and paid in full by the Managed Care Payer. 2 years after the date of EOB the payment is recouped based on an alleged lack of medical necessity for the NICU 4 level of care and stating that the baby could have been transferred to the regular Peds unit after 2 weeks. Your contract with the Payer is silent on a retrospective recoupment timeframe. The Payer has recently instituted a new "Cost Containment" audit policy with a lookback of 2 years, which is why this claim was reviewed. The language in the contract permits the Payer to "amend policies and procedures from time to time as deemed appropriate by the Payer." The denial has a large financial impact on your payment under the high-cost outlier of your contract.

Toolbox: NH Rev Stat § 420-J:8-b. Retro Active Denials Prohibited; Exceptions

II. No health carrier shall impose on any health care provider any retroactive denial of a previously paid claim or any part thereof unless:

(a) The carrier has provided the reason for the retroactive denial in writing to the health care provider; and

(b) The time which has elapsed since the date of payment of the challenged claim does not exceed 18 months. The retroactive denial of a previously paid claim may be permitted beyond 18 months from the date of payment only for the following reasons:

(1) The claim was submitted fraudulently;

(2) The claim payment was incorrect because the provider or the insured was already paid for the health care services identified in the claim;

(3) The health care services identified in the claim were not delivered by the physician/provider;

(4) The claim payment was for services covered by Title XVIII, Title XIX, or Title XXI of the Social Security Act;

(5) The claim payment is the subject of an adjustment with a different insurer, administrator, or payor and such adjustment is not affected by a contractual relationship, association, or affiliation involving claims payment, processing, or pricing; or

(6) The claim payment is the subject of legal action.

I-Issue(s) -
R-Rule(s) -
A-Analysis -
C-Conclusion(s) -

Problem 1 - Issue

- Your facility obtains authorization for an infant's 4-month admission to the Level 4 NICU. The claim is timely filed and paid in full by Payer.
- **Issue**: 2 years after the date of EOB, the payment is recouped based on alleged lack of medical necessity for the NICU 4 level of care.
- Your contract is silent on recoupment, but allows the payer to amend policies and procedures as it deems appropriate.

Problem 1: Audit & Recoupment - Rules

Toolbox:

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Problem 1: Audit & Recoupment – Analysis & Conclusion

- Authorization was obtained for the level of services provided.
- State law forbids recoupment if more than 18 months has elapsed since payment of the claim, unless specific exceptions are present.
- Is the contract provision allowing payer unilateral changes sufficient under the statute to give the payer 2 years?
- The recoupment in this case should not be permitted.

Problem 2 - ERISA Benefit Exclusion

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Facts: 36-year-old man was the driver in a single car accident. He had a blood-alcohol well over the legal limit for driving but was not charged. He was taken to your ER with multiple fractures and injuries. Provider faxed all relevant clinical information to self insured Plan the same day for approval of the admission.

Six days later the Plan denies the request for authorization under the plans "Limitations and Exclusions" under the exclusion policy below.

Plan Terms & Law:

Benefit Exclusion: Services, supplies, care or treatment to a Covered person for an Injury or Sickness which occurred as a result of that Covered person's **illegal use of alcohol**. The arresting officer's determination of inebriation will be sufficient for this exclusion.

ERISA: Urgent care claims. In the case of a claim involving urgent care, the plan administrator shall notify the claimant of the plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt (29 C.F.R. 2560.503-1).

State Motor Vehicle Laws makes it unlawful to operate a motor vehicle while intoxicated.

I-Issue(s) -
R-Rule(s) -
A-Analysis -
C-Conclusion(s) -

Problem 2: ERISA Benefit Exclusion: Issue

- 36-year-old man was in a single car accident. His blood-alcohol was well over the legal limit for driving but he was not charged. He was taken to your ER with multiple fractures and injuries. Provider faxed all relevant clinical information to self-insured Plan the same day for approval of the admission.

- Patient's plan is governed by ERISA.

- **Issue**: The Plan denies the request for authorization under the plans “Limitations and Exclusions" policy which will not cover:
  - **Alcohol.** ***Services,*** supplies, care or treatment to a Covered person ***for an Injury or Sickness which occurred as a result of that Covered person's illegal use of alcohol.*** The arresting officer's determination of inebriation will be sufficient for this exclusion.

Problem 2: ERISA Benefit Exclusion: Rules

Benefit Exclusion: Services, supplies, care or treatment to a Covered person for an Injury or Sickness which occurred as a result of that Covered person's illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion.

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State Motor Vehicle Laws makes it unlawful to operate a motor vehicle while intoxicated.

Problem 2: ERISA Benefit Exclusion – Analysis & Conclusion

- Plan erred in not issuing a determination within 72 hours. This is particularly important in an ERISA non-covered denial when the balance is patient responsibility.
- There was no arrest - patient was transferred directly to the ER so no independent determination.
- *State Motor Vehicle Laws* makes it unlawful to operate a motor vehicle while intoxicated. There was ***no illegal use of alcohol*** under the State law.

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THANK YOU

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Q&A