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AAHAM
American Association of Healthcare Administrative Management

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

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## Objectives

1. Review best practice 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!

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# Best Practices - Evaluate Internal Resources

| | | | |
|---|---|---|---|
| **Compliance** | **Care Management** | **Patient Financial Services** | **Clinical Documentation Integrity (CDI)** |
| **Health Information Management (HIM)** | **Patient Access** | **Contracting** | **Utilization Review** |

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# Best Practices - Root Cause Analysis

## 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

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**The information obtained during the registration/admitting process is crucial to prevent and fight denials!**

**Almost all technical denials can be challenged.**

# Best Practices - Eligibility & Insurance Verification

***Just asking the right questions can prevent denials!***

Verify eligibility and plan type and elicit information that is not routinely provided:

- Specific policy exclusions
- Pre-existing conditions limitations

Opportunity to correct potential benefit problems:

- Early registration
- Lapses in coverage during admission/patient involvement
- Has the patient paid their premium?

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# Best Practices - Obtaining/Confirming Authorization

Is authorization needed for this particular service under this patient's plan?

Check provider website/portal and/or call to verify.

Even if authorization wasn't required prior, make sure nothing has changed! (ex. unclassified drugs or temporary codes)

If authorization was obtained:

- Does it cover this particular service?
- Is it for this date?
- Is it still valid?
- Has it been used already?
- Number of units and effective date?
- Documentation of authorization & reference number(s)

***Document, Document, Document!***

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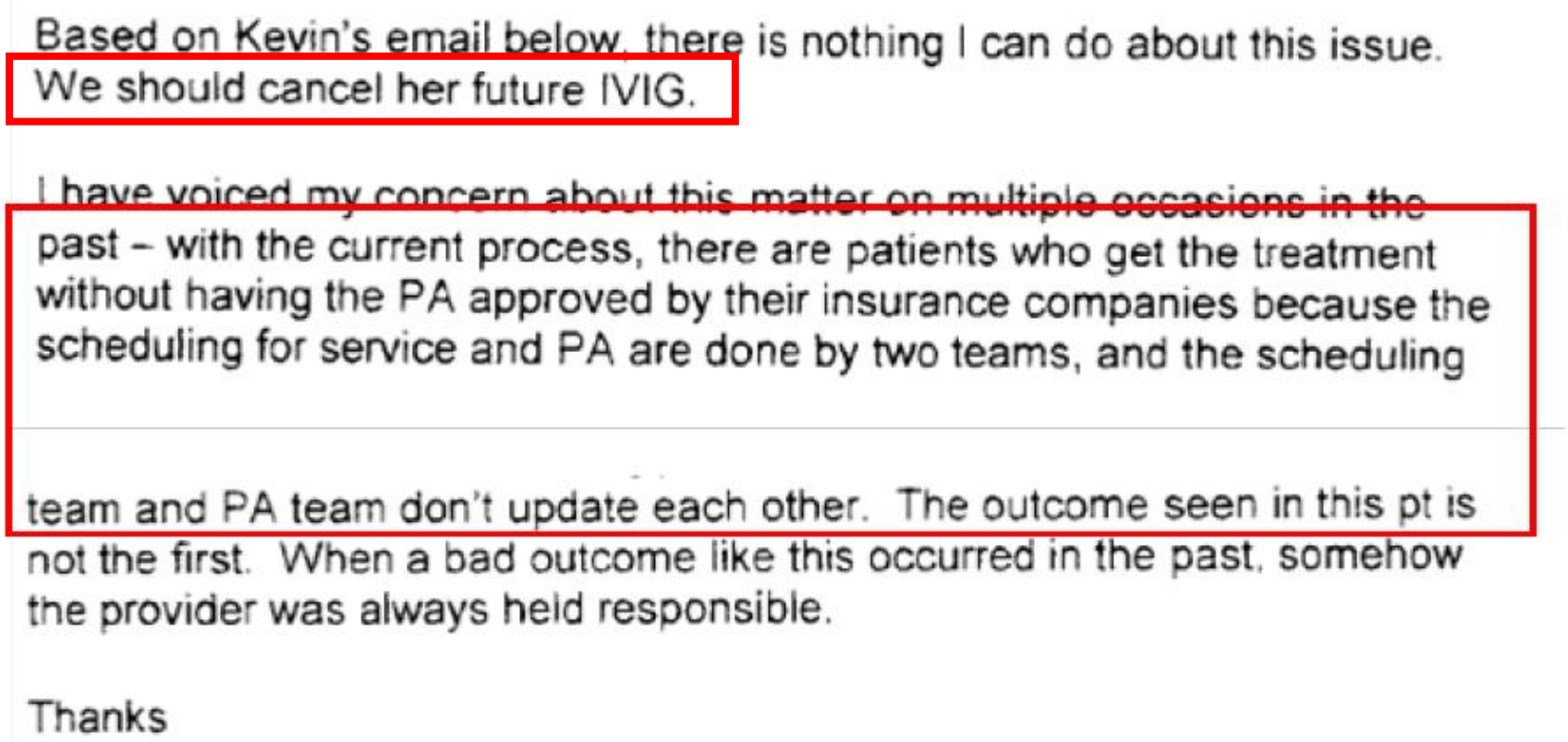
# An ineffective process can impact patient care!



Based on Kevin's email below, there is nothing I can do about this issue. We should cancel her future IVIG.

I have voiced my concern about this matter on multiple occasions in the past – with the current process, there are patients who get the treatment without having the PA approved by their insurance companies because the scheduling for service and PA are done by two teams, and the scheduling team and PA team don't update each other. The outcome seen in this pt is not the first. When a bad outcome like this occurred in the past, somehow the provider was always held responsible.

Thanks

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# Best Practices - Contracting for Protection

*In the event that the lack of authorization can reasonably be shown to have* ***resulted from an action or inaction by Hospital****, and* ***Insurer determines the services to be Medically Necessary****, then Insurer* ***shall*** ***reimburse Hospital for all Medically Necessary Covered Services*** *rendered to the Member.*

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# 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 |

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# Best Practices - State Laws for your Appeal Toolbox

**WAC 284-43-2060 Extenuating circumstances in prior authorization.**

(2) A carrier or its designated or contracted representative must have an **extenuating circumstances policy** which eliminates the administrative requirement for a prior authorization of services when an **extenuating circumstance prevents a participating provider or facility from obtaining a required prior authorization before a service is delivered.**

(3) …an extenuating circumstance means an unforeseen event or set of circumstances which adversely affects the ability of a participating provider or facility to request prior authorization prior to service delivery.

**WAC 284-170-431 Provider contracts - Terms and conditions of payment.**

(2)(a) For health services provided to covered persons, a carrier shall pay providers and facilities as soon as practical but subject to the following minimum standards: (i) Ninety-five percent of the monthly volume of clean claims shall be paid within thirty days of receipt by the responsible carrier or agent of the carrier; and (ii) Ninety-five percent of the monthly volume of all claims shall be paid or denied within sixty days of receipt by the responsi-ble carrier or agent of the carrier, except as agreed to in writing by the parties on a claim-by-claim basis.

(d) Any carrier failing to pay claims within the standard established under subsection (2) of this section **shall pay interest on undenied and unpaid clean claims more than sixty-one days old** until the carrier meets the standard under subsection (2) of this section. Interest shall be assessed at the rate of one percent per month, and shall be calculated monthly as simple interest prorated for any portion of a month. The carrier shall add the interest payable to the amount of the unpaid claim without the necessity of the provider or facility submitting an additional claim.

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# Best Practices - Helpful Legal Theories for your Appeal Toolbox

- Course of Dealing
- Misrepresentation
- Detrimental reliance

*"But for" or without the affirmative action on the part of the insurer, the provider would not have provided the medically necessary services.*

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# 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

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# Best Practices - Example Payer Matrix

| Payer | Claim Submission | Reconsideration/First | Second | Appeal Address |
|---|---|---|---|---|
| **Aetna**<br>**Contracted all lines** | **180 days** | **180 days from denial**<br>Reconsideration considered first level | **60 days from denial of reconsideration** | Attn: Provider Resolution Team<br>PO Box 14079<br>Lexington, KY 40512-4079<br><br>*Must submit appeal form with appeal |
| **Cigna**<br>**Contracted all lines** | **180 days** | **180 days from denial** | **NO second level** | Attn: National Appeals Unit<br>PO Box 188011<br>Chattanooga, TN 37422 |
| **United Healthcare**<br>**(Commercial Product Lines)**<br>**Contracted** | **180 days** | **365 days from denial** | **365 days from denial** | E-file through UHC portal |
| **United Healthcare**<br>**(Medicare Products)**<br>**NOT contracted** | **1 year**<br>Based on Medicare Rules | **60 days from denial**<br>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<br>MS CA 124-0157<br>Cypress, CA 90630-9948 |

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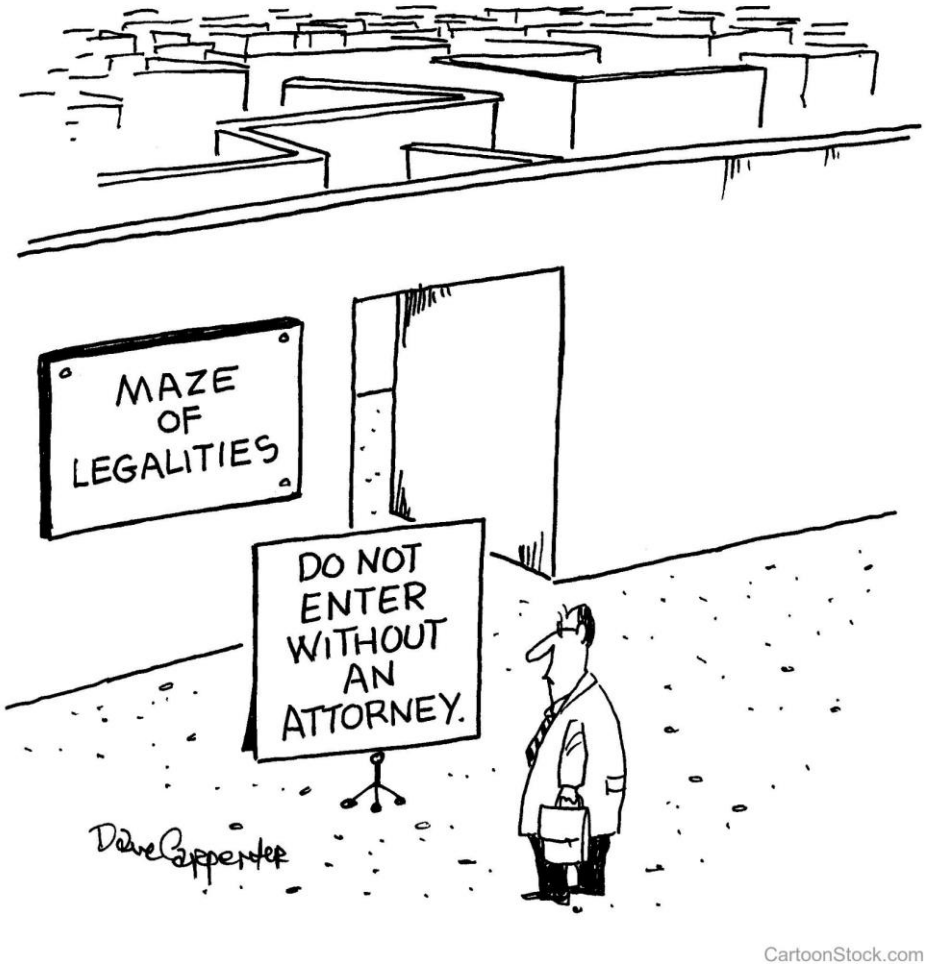
# The Continuously Evolving Landscape of Today's Denials




**HAVE NO FEAR!**

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# The Revenue Manager's Lawyerly Oath

I will appeal all denials with:

**P**ersistence
**L**ogic
**E**xculpation and
**A**dvocacy

# Persistence is Key

"The prosecutor says you have to roll over."

**REFUSE TO ROLL OVER**

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# 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…

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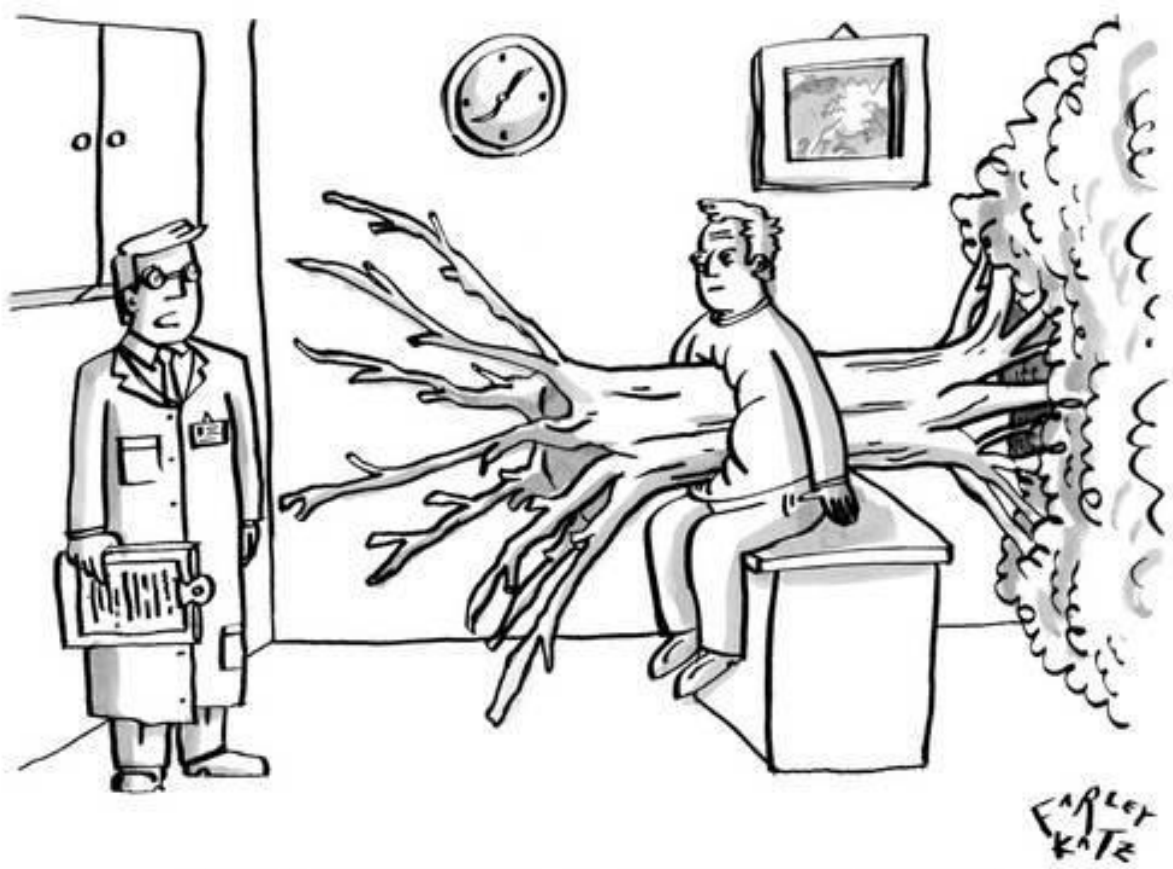
# Apply Logic



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

**IF IT SEEMS WRONG, IT PROBABLY IS!**

a.k.a. Smell Test

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# 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.**

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# Exculpation & Advocacy


**NEVER ACCEPT DENIALS AT FACE VALUE**

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# 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.

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# 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 |

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# Rule


**What the provider was supposed to do.**

**What the payer was supposed to do.**

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

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# Analysis


**Why the provider followed the rules.**

**Why the payer did not follow the rules.**

**Apply rules to facts.**

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# Conclusion


**Only logical outcome is overturn.**

**Explain the expected remedy.**

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# Example

**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.

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# Example

**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)**

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# Example

## 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**

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# Example

**Rule**

**Analysis**

**Conclusion**

**Intra-Operative Change is not Foreseeable**

***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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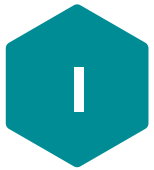
# Applying our Knowledge!




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


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


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


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

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# Problem 1 - Audit & Recoupment

## Problem 1 - Audit & Recoupment

**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. A little over two 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 audit policy with a lookback of up to 3 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.

**Revised Code of WA 48-43-600 – Overpayment Recovery**
(1) Except in the case of fraud, or as provided in subsections (2) and (3) of this section, a carrier may not: (a) Request a refund from a health care provider of a payment previously made to satisfy a claim unless it does so in writing to the provider within twenty-four months after the date that the payment was made; or (b) request that a contested refund be paid any sooner than six months after receipt of the request. Any such request must specify why the carrier believes the provider owes the refund. If a provider fails to contest the request in writing to the carrier within thirty days of its receipt, the request is deemed accepted and the refund must be paid…
(4) If a contract between a carrier and a health care provider conflicts with this section, this section shall prevail. However, nothing in this section prohibits a health care provider from choosing at any time to refund to a carrier any payment previously made to satisfy a claim.

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

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# 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**: A little over two 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.

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# Problem 1: Audit & Recoupment - Rules

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(4) If a **contract** between a carrier and a health care provider **conflicts with this section, this section shall prevail**. However, nothing in this section prohibits a health care provider from choosing at any time to refund to a carrier any payment previously made to satisfy a claim.

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# Problem 1: Audit & Recoupment – Analysis & Conclusion

- Authorization was obtained for the level of services provided.
- No written notice received with a rationale for the recoupment.
- State law forbids recoupment if more than 24 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 3 years?
- The recoupment in this case should not be permitted.

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# Problem 2 - ERISA Benefit Exclusion

## Problem 2 - ERISA Benefit Exclusion

**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) -**

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# 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.

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# 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.

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# 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