hfma
massachusetts-rhode island chapter

24th Annual Revenue Cycle Conference

Rev Cycling Through Adversity

Best Practices to Combat Denials:

Keep Calm and Appeal Like a Lawyer

January 06, 2021

Virtual Webinar

Speakers:
Sarah Mendiola, Esq., LPN, CPC, CPCO, Senior Vice President, Denial Management
Gail Robinson, General Counsel and Chief Compliance Officer

Company: Cloudmed

Objectives

01 Learn legal and organizational **rules** for best practice appeal writing **(PLEA and IRAC).**

02 Introduce how a "legal toolbox" can maximize your recovery to **"Appeal like a Lawyer."**

03 Interactive **Workshop!**

Best Practices
Evaluate Internal Resources

Best Practices – Evaluate Internal Resources

The Changing Landscape

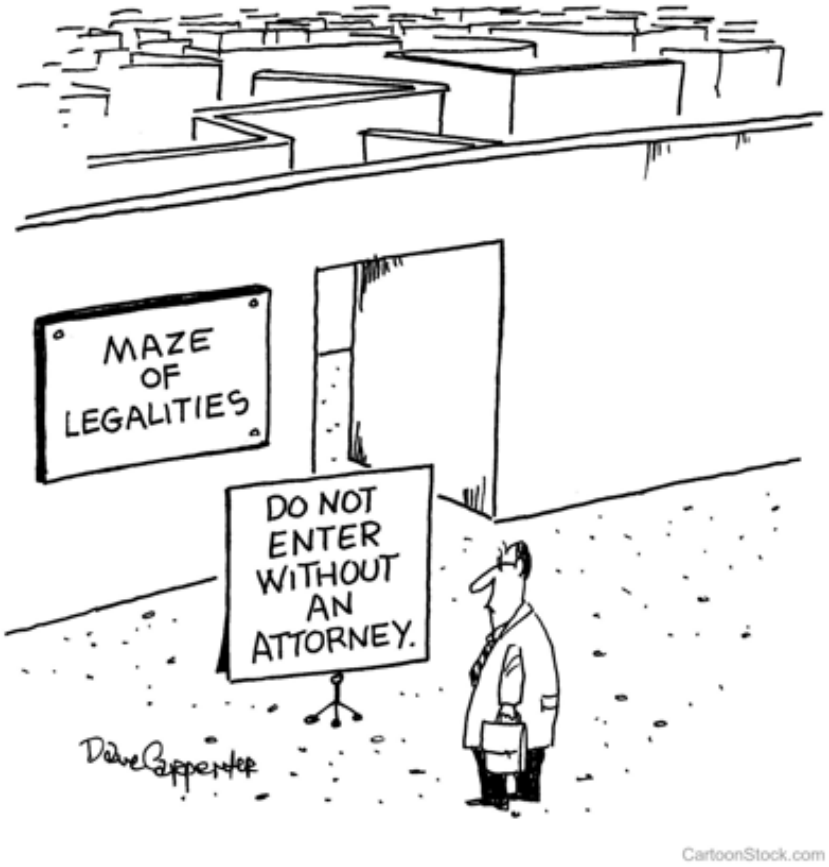
Non-Covered → **Contractual/Technical/Administrative**

Clinical

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

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

The Changing Landscape of Today's Denials



HAVE NO FEAR!

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."

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 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.

Toolbox Item: Tenn. Code §56-7-2302

(c)(1) Notwithstanding any other law to the contrary, **no insurer, or employer or other entity that administers health, medical, or surgical insurance or that has an insurance company administering its health services program**, and no individual, blanket or group policy of insurance issued pursuant to this title, that is entered into, amended, delivered, issued for delivery, or renewed by agreement or otherwise, on or after March 17, 1982, **shall deny, for the reason that the insured or the covered dependent incurred no expense**, charge, or obligation, a claim for expenses incurred **in connection with the patient's hospitalization** for hospital, medical or surgical services rendered by a non-governmental, charitable research hospital that bills all patients for services rendered but does not enforce by judicial proceedings payment from an individual patient in the absence of insurance coverage.

Exculpation & Advocacy

NEVER ACCEPT DENIALS AT FACE VALUE

Exculpation & Advocacy: Example

- Payer denied a claim for Lack of Notification for an ER Admission, but the Contract states the Payer must pay for the first 48 hours.
- Provider files an appeal which is rightly denied as **untimely**.

Give up?

Exculpation & Advocacy: Example, Cont.

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

Contract payment at DRG pays the claim in full.

MGL. Ch. 176G § 6 No contract between a participating provider of health care services and a health maintenance organization shall be issued or delivered in the commonwealth unless it contains a provision requiring that **within 45 days after the receipt… If the health maintenance organization fails to comply with this paragraph** for any claims related to the provision of health care services, **said health maintenance organization shall pay, in addition to any reimbursement for health care services provided, interest on such benefits**, which shall accrue beginning 45 days after the health maintenance organization's receipt of request for reimbursement at the rate of 1.5 per cent per month, not to exceed 18 per cent per year…

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

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

R

What provider was supposed to do

What payer was supposed to do

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

Analysis

A

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

Conclusion

C

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 followed 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's own policy and the provider's Contract.**

ISSUE

Example #1, Cont.

RULE

Payer's Administrative Guide requires proof of extenuating circumstances for a clinical review on appeal, **only when authorization protocols are not followed**. In this case:

ANALYSIS

1) The provider followed all appropriate protocols and obtained approved authorization number 123456 from Payer to perform CPT code **29823** *(Arthroscopy, shoulder, surgical; debridement, extensive);* **and**

2) **Clinical extenuating circumstances** exist that 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

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.

CONCLUSION

1) The provider followed Payer policy, so Payer erred in not conducting a clinical review for medical necessity on appeal,

2) Extenuating circumstances exist because the intra-operative change was unforeseeable; and the provider **could not** have requested authorization, and

3) Therefore, Payer must review this claim for medical necessity and pay in full.

Example #2 – Prompt Pay

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.

ISSUE

MGL. Ch. 176G § 6 … the health maintenance organization **shall**
(i) make payments for such services provided,
(ii) notify the provider in writing of the reason or reasons for nonpayment, or
(iii) **notify the provider in writing of what additional information or documentation is necessary to complete said forms for such reimbursement.**

RULE

ANALYSIS

In violation of **MGL. Ch. 176G § 6 , 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. **MGL. Ch. 176G § 6**

Workshop!

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.

Problem 1
Audit & Recoupment

Problem #1 - Audit and 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 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: **RI Gen L § 27-41-69. Post-payment audits.** (a) Except as otherwise provided herein, any review, audit, or investigation by a health maintenance organization of a healthcare provider's claims that results in the recoupment or set-off of funds previously paid to the healthcare provider in respect to such claims shall be completed no later than eighteen (18) months after the completed claims were initially paid. This section shall not restrict any review, audit, or investigation regarding claims that are submitted fraudulently; are known, or should have been known, by the healthcare provider to be a pattern of inappropriate billing according to the standards for provider billing of their respective medical or dental specialties; are related to coordination of benefits; are duplicate claims; or are subject to any federal law or regulation that permits claims review beyond the period provided herein. (d) Except for those contracts where the health insurer or plan has the right to unilaterally amend the terms of the contract, the parties shall be able to negotiate contract terms which allow for different time frames than is prescribed herein.
I-Issue(s) – **R-Rule(s) -** **A-Analysis -** **C-Conclusion(s) –**

Problem 1
Audit & Recoupment - 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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(d) **Except for those contracts where the health insurer or plan has the right to unilaterally amend the terms of the contract**, the parties shall be able to negotiate contract terms which allow for different time frames than is prescribed herein.

Problem 1
Audit & Recoupment - ANALYSIS & CONCLUSION

- State law forbids recoupment if more than 18 months has elapsed since payment of the claim, unless the contract is negotiated for a longer time frame.
- The contract provision allowing payer unilateral changes is not sufficient under the statute to give the payer 2 years.
- The recoupment in this case is not permitted under the statute!

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) –

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.

Q&A

Thank you for your attendance!

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