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 #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) –