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25 Appeal Letters And Using PPACA For Today's Appeals

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PPACA Appeal Standards

- PPACA sought to improve “the inconsistent claims and appeals processes applied to plan sponsors and issuers and a patchwork of consumer protections provided to participants, beneficiaries, and enrollees.” Interim Rule
- The applicable processes and protections depended on several factors including whether (i) Plans were subject to ERISA, (ii) benefits were self-funded or financed by the purchase of an insurance policy; (iii) issuers were subject to State internal claims and appeals laws, and (iv) issuers were subject to State external review laws, and if so, the scope of such laws.

Patchwork Overview

- **ERISA - Employee Retirement Income Security Act**
  - Timely Decisions, Strict Disclosure, $110/day fine on disclosure violations, Expert Review
- **PPACA expands ERISA. By 2014, estimated 88 million under ERISA appeal provisions.**
- **Medicare Appeal Review Protections**
- **State Laws and Standards**
  - Claim Processing & UR Protections - Prompt decision making, Peer to Peer Review
- **Contractual Language**

PPACA Simplification/Cost Savings Goal

- Jurisdiction confusion remains but minimum appeal review standards are set
- Expanded benefits/clarity for providers/patients and lack of provider discrimination protections
- “...expenditures by plans may be reduced as a fuller and fairer system of claims and appeals processing helps facilitate enrollee acceptance of cost management efforts.” Interim Rule on Appeals 7/23/2010
- Efficiencies/cost management control for insurers

Provider Acceptance?

What about provider acceptance of cost containment measures? PPACA offered providers increased insured/less uninsured. However, provider appeals still go to the provider appeal process unless there is a authorization/assignment to act on the patient's behalf (exception emergency care appeals). Authorization to appeal for the patient surest way to get at PPACA appeal enhancements.

25 Compliance-Focused Appeal Letters

- Provider appeal process has very little regulatory protection.
- Quality appeal process (NAIC):
  - Review by unbiased, qualified, credentialed professionals not involved in initial determination
  - Disclosure of denial details and “discussion” of decision
  - Compliance with coverage laws and industry standards (claim processing)

Disclosure Most Frequently Overlooked Protection

- Carriers have the power. Balance of power tipped if there is a very clear, well documented, provable violation of law.
- Medical necessity, incorrect payment decisions often fall in difficult gray area as violations are not documented/provable.
- ERISA requires disclosure of “rule, guideline, protocol ... free of charge to the claimant on request.”
- Discussion in final adverse determination

PPACA “In Between” Appeals Disclosure

“…plan or issuer must provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan or issuer (or at the direction of the plan or issuer) in connection with the claim. Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.”

PPACA Appeal Access Forms

- Revised Model Benefit Determination: dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/internal-claims-and-appeals
- externalappeal.com/Portals/8/Forms/Appointment%20of%20Representative%20Form.pdf
- States and self-funded plans have their own forms but may honor blanket form

Every Provider Appeal should:

- ***Establish authorization***
- ***Request for Disclosure Compliance* specific to the denial, ie medical necessity definition, coding standard, clinical guideline**
  - "It is our position that failure to provide the requested information may violate state and/or federal claim processing disclosure laws or, in the minimum, non disclosure reflects a poor quality medical review process which discourages treatment provider input. Disclosure standards are meant to ensure that all qualified parties have access to the information necessary to properly appeal an adverse determination."

Prompt Payment

- If no response is received to initial bill, appeal.
- Stalled claims should be appealed:
  - Appeals reviewers process fewer claims than claims processors.
  - Many states have shorter time deadlines for responding to appeals.
  - Request disclosure of denial details and seek review by a qualified professional.

Affidavits As Proof of Filing

- Attach Signed, Notarized Affidavit as recommended by local attorney, ie I, (name), am responsible for patient financial billing and posting for (provider name). As a part of my regular duties, I attest to
  - (filing a claim...)(posting a payment…)
  - No response was received.
  - Payment was received on (date) which appears to be beyond the required time frame for prompt payment.

Lack of Timely Filing Denials

- Appeal a claim which is not responded to with a letter citing the applicable state prompt payment regulation and proof of original submission. Level I Appeal Letter 2
- Submit Proof Of Filing with Other Insurance Carrier, if applicable. Level II Appeal Letter 3

In Network Can Be Detriment

- Negotiate Protective Contract Terms
- Timely filing period should not be more restrictive than state requirements.
- MCO may not return claims for lack of information but must process and pend/deny any claim and request information.
- Exceptions to the timely filing requirement for coordination of benefits issues or as the result of inadequate information from the insured party.

Appealing Medical Necessity Denials

- MN appeals should go beyond clinical issues by demanding disclosure/citing compliance issues.
  - Obtain Name and Credentials of Reviewer and Clinical Criteria. Focus on inadequacies such as:
    - Unsatisfactory Review ID/Qualifications. Letters 4, 5
    - Unsatisfactory use of clinical criteria. Letters 6, 7

PPACA External Review Requirement – Letters 8, 9

- Appealable decisions include MN, setting, level of care, effectiveness
- 4 months from final denial to file.
- Expedited access for emergency situations or cases where health plan did not follow PPACA internal appeal rules
- Plans must pay cost. Filing fee can’t be above $25.
- Binding on carrier.
- Applies to non grandfathered plans/policies

Medicare Appeals

- 5 Step FFS Appeal Process or Medicare Advantage Appeal Process (CMS.gov)
- PPACA enhanced data access
- OIG 2017 Workplan
  - We will determine the extent to which services were denied, appealed, and overturned in MA from 2013 to 2015 (for) inappropriate denial of care in MA. Future work in this area may include medical record reviews to examine whether denials are appropriate. (Due - 2018)

Denial Prevention

- PPACA impact on case management (plan required to track quality/reduce medical errors) has resulted in ongoing change to preauth requirements
- Patient access training and retention is critical
- Request Peer-to-Peer Review/Discussion at both UR and Post Treatment and demand Prompt Decisions:
  - URAC standards - URAC.org has carrier accreditation. Letters 10 - 11
- Cite ERISA if applicable. Level II Letter 12
- Seek specialty care review of Experimental/Investigational. Letters 13, 14.

Emergency Care Denials

PPACA protections on out-of-network emergency copays:

- Enrollees may be required to pay, in addition to the in-network cost-sharing, any excess provider charges beyond the greater of:
  - **median amount negotiated with in-network providers**
  - **Method plan usually uses to calculate out-of-network (UCR)**
  - **Medicare rate**

Emergency Care Denials

- Cite 72 hours rule (PPACA - 24 hours). Letter 15
- Continuity of Care for Post-emergency Treatment Denials. Letter 16
- Develop customized templates for frequently denied ER diagnoses (headache, persistent cough, earache)

Summary: 8 Steps To Medical Necessity Appeals

1 - Seek Peer-to-Peer Review at both UR/Appeals.

2 - Review carrier's compliance with UR standards and describe deficiencies in previous reviews.

3 - Request MN definition and publisher/date of review criteria.

4 - Cite patient specific complications.

5 - Cite internal quality care guidelines.

6 - Cite peer-reviewed literature.

7 - Submit letter of MN from referring physician as well as treating physician. Point out consensus among face-to-face treating providers.

8 - Pursue external review.

Appealing Maximum Benefit Denials

- PPACA Patient Bill of Rights no limit on lifetime max applies to all policies and plans renewed after 9/23/2010 - Letter 18
- Appeal Max benefit denials by requesting disclosure and audit of benefit payment. Level II appeals can drill down on:
  - Lifetime vs annual maximum
  - VOB disclosure/misrepresentation

Appealing Preexisting Denials

- HIPAA defines only preexisting conditions as conditions “for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the insured's enrollment date.”
- PPACA prohibits plans from denying benefits to those under 19 for preex. Applies to all coverage except grandfathered individual policies. Letter 19

Appealing Incorrect Payment Denials

- Appeal Incorrect Payment Denials with Request for Review By Certified Coder. Letter 20. Level II appeals can drill down on:.
  - Bundling. Letters 21
  - Incorrect Contractuals. Letter 22
  - Usual, Customary, Reasonable (UCR). Letters 23 and 24
  - Get publisher/publication date of pricing/coding data
  - Preventative care - Immunizations. Letter 24

Appealing Incorrect Payment Denials

- ERISA beneficiaries should have access to “studies, schedules or similar documents that contain information and data, such as information and data relating to standard charges for specific medical or surgical procedures.” Attachments spell this out:
  - dol.gov/agencies/ebsa/employers-and-advisers/guidance/advisory-opinions/1996-14a
  - “For out-of-network providers, it would seem clear that usual and customary rates paid to behavioral providers need to be comparable to those paid to substantially all medical/surgical providers.” Source: us.milliman.com/uploadedFiles/insight/healthreform/implementing-parity-investing-behavioral.pdf
  - Cite your source (Fairhealth.org)

ERISA Full and Fair Review Letter 25

- 180 to appeal
- submission of comments, documents, records
- reasonable access to all documents, records, and other info relevant to decision
- allows for submission of new information
- no deference to the initial adverse benefit determination and review by the plan fiduciary
- in denials involving medical judgment, plan must consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment
- Can be used for poorly worded refund/recoupment requests involving ERISA plans

Resources

- AppealTraining.com has 1600 appeal letter templates including state-specific, Medicare and more
- www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html
- www.healthcare.gov
- Onsite Consulting - Submit 10 - 15 denials and we will develop customized appeal letters. Email t.tipton@appealsolutions.com for quote.
- Upcoming Webinars - Medical Necessity, ERISA, Medicare, Medicaid
- Ask your organization: “Can I sit in on any phase of contract negotiation?”