AppealTraining.com Webinar

50 Appeal Letters And How To Use Them Like A Pro

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What Goes Wrong With Appeals

- **Untimely appeal submission**
  - **Medicare appeal deadline - 120 days**
  - **Commercial appeal deadline - 180 days (ERISA)**
- **Failure to cite a compliance issue**
- **Failure to pursue all appeal levels**

Appeals Should Be Easy

- 50 appeal letter templates which:
  - Demand disclosure of denial details
  - Demand review by a qualified, credentialed professional not involved in the initial determination.
  - Raise potentially applicable compliance issue

Disclosure Most Frequently Overlooked Protection

- Medical necessity, incorrect payment decisions often fall in a very difficult gray area where the carrier's supporting documentation is not disclosed.
- **ERISA Claim Procedure Regulation** requires "the adverse benefit determination must either set forth the rule, guideline, protocol, or criterion or indicate that such was relied upon and will be provided free of charge to the claimant upon request." Source: www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html

How to Raise A Compliance Issue in Every Appeal:

- **“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 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. Therefore, we appreciate your prompt, detailed response to this request.”**

Prompt Payment

- If no response is received to initial bill, appeal.
- Stalled claims should be appealed due to the following:
  - Appeals reviewers process fewer claims than claims processors and likely respond in shorter time frames.
  - Many states have shorter time deadlines for responding to appeals than for responding to new claims.
  - Addendums 1 - 6 request disclosure of denial details and seek review by a qualified professional.

Using Affidavits to establish initial filing date.

- Signed and notarized affidavits may be admissible in court and, therefore, are a better source of proof than computer generated billing notes.
- You need local legal input when drafting the exact wording of the affidavit. See New York Craniofacial Care, P.C, et al v. Allstate. www.nycourts.gov/reporter/3dseries/2006/2006_50500.htm.

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 7
- Submit Proof Of Filing with Other Insurance Carrier, if applicable. Level II Appeal Letter 8

Success In Lack of Timely Filing Appeals Depends on Provider Status

- Use Protective Contract Terms In Appeals and Cite Contract in Appeals
- Timely filing requirements are dictated by managed care contract terms. Providers should negotiate for the following protections:
  - MCO timely filing period may not be more restrictive than state timely filing requirements.
  - MCO may not return claims for lack of information but must process and pend/deny any claim received with sufficient identifying information to process claim.
  - Exceptions to the timely filing requirement will be made in situations where provider has been unable to determine primary carrier due to coordination of benefits issues or as the result of inadequate information from the insured party.

How To Demand Quality Review

- Medical necessity disclosure demand:
  - Obtain Name and Credentials of Reviewer and Clinical Criteria involved in initial decision. Level II appeal can focus on inadequacies such as:
    - Unsatisfactory Review ID/Qualifications. Level II Appeal Letters 9, 10
    - Unsatisfactory use of clinical criteria. Level II Appeal Letters 11 - 13
  - Medicare Medical Necessity definition. Letter 14

Denial Prevention

- Ten Case Management Appeals Letters 15 - 25
  - Compliance Issues: State UR laws, ERISA and URAC
- Cite Continuity of Care Standards to Appeal Post-emergency Treatment Denials. Letters 26, 27
- Contest overly-broad medical records requests. Letter 28

More Pages = More Carrier Review Expense

- A good rule of thumb is the greater the number of pages in the medical record, the more expensive the review.
  - Source: Justine Handelman, VP Regulatory Policy BlueCross BlueShield Association at www.dol.gov/ebsa/pdf/1210-28876-0019.pdf

Appealing Maximum Benefit Denials

- Appeal Max benefit denials by requesting disclosure and audit of benefit payment. Letter 29. Level II appeals can drill down on:
  - Lack of response and VOB misrepresentation. Letter 30
  - Newborn and Mothers Health Protection Act. Letter 31
  - U.S. Mental Parity Requirements. Letter 32
  - Disease and treatment-specific benefit limitations must also be disclosed when requested. Letter 33

Appealing Preexisting Denials

- Appeal preexisting denials by requesting HIPAA/PPACA compliance review. Letter 34
  - Under HIPAA, the only preexisting conditions that may be excluded under a preexisting condition exclusion are those for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the insured's enrollment date. The enrollment date is to be calculated as the first day of coverage. If there is a waiting period, the enrollment date is to be calculated as the first day of the waiting period or date of hire.

Appealing Incorrect Payment Denials

- Appeal Incorrect Payment Denials with Request for Review By Certified Coder. Letter 35. Level II appeals can drill down on:
  - Request for CCI Compliance. Letter 36
    - **Bundling. Letters 37 - 39**
  - Silent PPO/UCR. Letters 40 - 41
  - Incorrect Contractual. Letters 42 - 43

Appealing Refund/Recoupment Attempts

- Demand Appeal of Decision Before Action is taken
  - 3 components of appeal - seek diclosure, request review by credentialed professional and raise compliance issue Letter 44
  - Know your state refund/recoupment law and Medicare RAC regs. Letter45
  - Maintain binding nature of precertification Letter 46

Access to Legally Compliant Appeals

Q: Does an assignment of benefits by a claimant to a health care provider constitute the designation of an authorized representative?

A: An assignment of benefits by a claimant is generally limited to assignment of the claimant's right to receive a benefit payment under the terms of the plan. Typically, assignments are not a grant of authority to act on a claimant's behalf in pursuing and appealing a benefit determination under a plan. The validity of a designation of an authorized rep. may depend on the specific procedures established by the plan, if any.

Source: www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html

Submitting your AOB can establish you as the “authorized representative” for purposes of appeals

- Authorized representatives generally have the right to disclosure and a carrier’s failure to respond (UR, VOB or claims disclosure requests) can have legal consequences.
- Can Carriers Easily Fulfill Provider Disclosure Requests? No. They have set up a system to give only marginal information to providers. They do not routinely give providers benefit estimates, policy language, internal medical guidelines and supporting information regarding a coverage denial. It can be a documentation nightmare, much like asking a provider to detail every facet of patient interaction in order to get claims paid.
- 1-2-3 ERISA Sequence Letters 47, 48, 49

Citing Compliance Issues Helps Get Your Appeal In Legal Review

- **Because health insurance contracts are complicated legal documents, we request that the Agencies require review panels to include attorneys with insurance and contract law experience or individuals with training experience in drafting, reviewing and interpreting insurance contracts.**
  - **Thad Johnson, General Counsel, United HealthCare at www.dol.gov/ebsa/pdf/1210-28876-0016.pdf**

Legal Department Knows The "Full and Fair" Requirement

- 180 to appeal
- opportunity to submit written comments, documents, records & other info
- reasonable access to, and copies of, all documents, records, and other info relevant to the claim decision
- allows for submission of new information
- no deference to the initial adverse benefit determination and review by an appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination nor a subordinate
- in denials involving medical judgment, plan must consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment
- If All Else Fails, Negotiate. Request for Contract Negotiation. Letter 50

Resources

- **AppealTraining.com** has 1700 appeal letter templates including state-specific, Medicare and more ERISA appeal letter templates
- At www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html
  - Chose Laws and Regulations
  - Chose Regulations Under Code of Federal Regulations Heading
  - Chose Part 2560 - Rules and Regulations for Administration and Enforcement
  - Chose 2560.503-1 - Claims procedure
- Onsite Consulting - Submit 10 - 15 denials from your business office and we will develop customized appeal letters. Email t.tipton@appealsolutions.com for quote. .