APPEAL TRAINING
COURSE 10

SPECIALTY CARE

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Specialty Care

Specialty care medical appeals often involve complex clinical information. Hours can be spent crafting a detailed explanation regarding the treatment provided and current specialty care standards.

One of the ongoing challenges of specialty care appeals is demanding a professional review of the complex specialty care information such appeals involve. Specialty care appeal review requires insurers to employ a broad array of specialty care reviews and ensure that such reviewers apply up-to-date specialty care clinical criteria. Often, specialty care denials do not adequately assure specialty care practices that a high quality review of technical specialty care information has been provided.

Specialty care appeals should always contain clear wording demanding that, if a claim denial is upheld, the appeal reviewer must disclose any specialty-specific criteria used in the appeal review and provide detailed information regarding their qualifications to review such claims.

AppealTraining.com has a number of "appeal review demands" which are particularly applicable to specialty care appeals, including the following demands which assist specialty care providers with obtaining information to assess the quality of the review process provided by the carrier:

(1) Demanding Disclosure of Specialty-Specific Coding Rules – Specialty care appeals are often reviewed by insurers for compliance with specialty-specific coding rules. It is important to demand disclosure of the source of the coding rules so that your office can assess the source and the date of such coding information. You may be able to provide additional information regarding the reliability of such information or updated information the carrier has not incorporated into the review process.

(2) Demanding a Review By A Certified Coder – Another approach to take on specialty-case coding issues is to demand a review by a certified coder familiar with the specialty coding in question. Your request can state that "It is our position that appeals involving specialty-care coding should be reviewed by a certified coder with recent training in the specialty coding in question. Therefore, please provide the name of the certified coder involved in this review, the licensing organization and a description of any additional training involving (insert specialty – ie, orthopedic) coding obtained by the reviewer."

(3) Demanding Disclosure of Specialty-Specific Clinical Review Criteria – Specialty-specific clinical

review criteria often dictate the types of treatment available to the patient during treatment. For that reason, it is imperative that carriers disclose clinical review criteria and openly discuss situations where the review criteria may not have been appropriately applied. In particular, any medical necessity appeals should include wording requesting that the carrier release the clinical review criteria and when that criteria were last reviewed and updated.

(4) Demanding Peer-to-Peer Review – Peer to Peer review is one of the most recognized components of a quality review process. Further, demanding peer conversation allows the treating physician to interact with the carrier decision maker and point out any potential risks to any alternative treatment under consideration. Many states include peer review requirements in the utilization review mandates and the Utilization Review Accreditation Commission Standards require member organizations to provide peer conversation when requested by the treating physician. Specialty care appeals can suggest a time for peer conversation or state that arrangements can be made with the treating physician's administrative assistant. However, it is important to put your demand for peer review in writing with the carrier.

Alternative & Complementary Care

Coverage and benefit payment for alternative and complementary care providers varies widely. Even when coverage is available, alternative/complementary care claims are also scrutinized from a utilization and medical necessity standpoint.

These challenges often require that alternative/complementary care providers establish an exemplary process for pretreatment verification of benefits and post-claim filing follow-up and appeals. Therefore, it is especially important to use a written request prior to treatment to clarify coverage and/or appeal lack of coverage for alternative/complementary care. See information under Pretreatment Request for Benefit Disclosure for instructions on seeking accurate benefit information.

A significant problem with alternative care/complementary care is that the applicable exclusion or limitation is not disclosed with the initial denial. Many state and federal laws require insurers to disclose the specific plan or policy language used in making the adverse determination. This information is helpful in understanding the basis of the denial and assessing the likelihood of appeal

success. Therefore, your appeal will be strengthened by a disclosure request such as the following:

> As you are likely aware, many state and federal disclosure laws require insurers to provide detailed information to support a denial of benefits. Therefore, please provide the following information so that we may assess the accuracy of this decision:
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> 1. A copy of the applicable policy or plan limitation as it reads in the policy or plan description
> 2. Any applicable definitions or provider-specific limitations, such as alternative/complementary provider, chiropractic care, or advanced nurse practitioner definitions and payment policies
> 3. Benefit information regarding coverage of physical and occupational therapy and type of provider who can render therapy-related care
> 4. A copy of any authorizations or verification of benefits extended to this patient related to this treatment

Often, state and federal insurance and labor code provisions will specify when and to what extent alternative/complementary care should be covered. For example, the American Chiropractic Association confirms that all 50 states have authorized the provision of chiropractic care under state workers' compensation laws (source: *www.acatoday.com/level2_css.cfm?T1ID=21&T2ID=97*). However, each state has different treatment caps and may use specific medical necessity criteria for allowing visits beyond the allowed number. The state of California's Labor Code instructs workers' compensation carriers to use the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines for assessing the need for chiropractic, occupational therapy, or physical therapy visits. Any appeals related to this type of care for workers' compensation claims should use the referenced guidelines to justify the proposed or rendered treatment.

Further, procedure-specific insurance mandates, such as mandatory mammography coverage laws, may specify whether an alternative or complementary provider is covered. State professional organizations can be very helpful in locating and understanding the state mandates applicable to complementary and alternative care.

Mental health treatment protections

State and federal mental health parity laws have given many behavioral health treatment providers hope regarding mental health care reimbursement. However, a General Accounting Office report studied the effect of mental parity mandates and found that insurance carriers often modify policies to allow more equal coverage for mental health treatment but offset parity costs through higher deductibles, copays, treatment caps, and other subtle limitations to coverage. Furthermore, most parity laws specifically state that medical necessity policy provisions still apply to coverage availability, thus leaving insurance carriers with this additional avenue of cost control. The result is a confusing array of mental health limitations and clinical guidelines which can be difficult to assess for health parity compliance.

Mental health care appeals should demand full disclosure of denial details in order to determine whether correct benefits have been released. All mental health care appeals should request the specific written limitation, exclusion, or internal guideline which applies to the denial. Mental health care claims denied due to “lack of medical necessity” must be appealed to obtain the specific behavioral health criteria used to assess treatment. Furthermore, if the appeal is related to poor reimbursement, appeals should request disclosure of the methodology used to calculate the payment.

Mental health claim appeals should cite either the U.S. Mental Health Parity Act (MHPA) or potentially applicable state mental health coverage requirements. This requires being familiar with state and federal requirements, what policies and plans fall under their respective jurisdictions, and how these mandates affect copays, coverage caps, and medical necessity review. For example, some state mental health parity laws specifically apply to out-of-network care whereas others reference only in-network care.

The U.S. Mental Health Parity Act

The **U.S. Mental Health Parity Act (MHPA)** applies to group health plans and provides for parity in the application of aggregate lifetime and annual dollar limits on mental health benefits with dollar limits on medical/surgical benefits. A plan that does not impose an annual or lifetime dollar limit on medical and surgical benefits may not impose such a dollar limit on mental health benefits offered under the plan. The MHPA does not apply to benefits for substance abuse or chemical dependency.

Health plans are not required to include mental health benefits in their benefits packages. The MHPA applies to only those plans that do offer mental health benefits.

One of the most obvious violations would be a plan that places yearly maximum benefit levels on mental health care that are less generous than the yearly benefit for medical care. The MHPA also prohibits the common practice of offering mental health care benefits with number-of-yearly-visit caps. The U.S. Department of Labor enforces the MHPA and has extensive information on group health plan compliance, including the following information on per-visit caps:

> "While the plan does not impose an annual dollar limit on outpatient medical/surgical benefits, the 50 doctor visit per year limitation on mental health services, coupled with the absolute $50 maximum payment per visit, is a constructive annual dollar limit on outpatient mental health benefits of $2,500.
>
> Under MHPA, a plan may not impose annual or lifetime dollar limits on mental health benefits that are lower than those for medical/surgical benefits. Here, the plan is not in compliance with MHPA because, with respect to outpatient services, the plan imposes a $2,500 constructive annual dollar limit on mental health benefits and no annual limit on medical/surgical benefits.
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> The plan should eliminate any constructive dollar limit on mental health benefits that is lower than that for medical/surgical benefits. The plan can still impose visit limits under MHPA, provided they are not coupled with absolute dollar limitations, which would constitute a constructive dollar limit."
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> (Source: *www.dol.gov/ebsa/publications/caghp.html*)

Emergency treatment mandates

Are insurers calculating out-of-network emergency claim payments correctly? How do you know? Emergency care is one of the most protected areas of medical care. Although scheduled procedures fall under a number of cost-containment features, emergency care is, by definition, not as easily managed by managed care. Further, a number of state and federal "access to care" mandates protect patients against unjust penalization from seeking emergency care from the most easily accessible emergency care provider. Many of these state mandates incorporate what is known as the **prudent layperson** standard as part of the access to care protections.

Prudent layperson is a well-recognized consumer protection involving the assessment of urgent medical treatment. Under this standard, a condition will qualify as needing "urgent" care if the medical condition manifests itself "by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the individual (or, with respect to a pregnant woman the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part."

Under this standard, insurance companies can be restricted from establishing a list of certain signs and symptoms which cannot be treated in the emergency room. Instead, the insurance carrier must request medical records in order to review the severity of the problem and the patient's layperson's perspective on the need for immediate treatment.

New York recognized the prudent layperson standard in both managed care and utilization review mandates. In a 2002 instructional letter to insurance carriers, the State of New York Insurance Department instructed carriers to discontinue denying claims without a thorough investigation. The letter reads:

> "It has come to our attention that insurers, Article 43 corporations and HMOs may be denying coverage for emergency services based upon the final diagnosis code, such as ICD 9 or CPT 4 codes, assigned to the emergency room visits. Although the diagnosis code may be used to approve coverage of emergency services, its use as the basis for denial of coverage is improper. The standard by which to evaluate whether a denial of

> coverage is supportable is the 'prudent layperson' standard required by the Insurance Law. Whenever a claim is denied, the determination of whether the prudent layperson standard has been met (1) must be based on all pertinent documentation, (2) must be focused on the presenting symptoms and not on the final diagnosis, and (3) must take into account that the decision to seek emergency services was made by a prudent layperson rather than a medical professional.

Emergency care appeals should summarize the patient's condition upon admission and detail the emergency care service provided, including both critical care and post-stabilization care. Attaching medical records is not sufficient. Medical records contain important information but do not adequately address the treatment in the contest of your internal quality care guidelines and pertinent industry standards of care. The internal criteria being used by the insurance carrier may not be as up-to-date or thorough as the clinical standards followed by your organization, and your appeal is the opportunity to detail this information.

Second, emergency care appeals should demand full disclosure of denial details. Denials can be vague. Even clearly stated denials such as "denied due to lack of medical necessity for emergency care" do not provide you with important information such as the clinical criteria used to assess treatment. Therefore, a Level I appeal should request the specific written limitation, exclusion, or internal guideline that applies to the denial. If the appeal is related to poor reimbursement, your letter should also request disclosure of the methodology used to calculate the payment.

Last and perhaps most important, emergency care appeals should identify any potential compliance issue, such as the prudent layperson standard, related to emergency care coverage. This requires obtaining information on both state and federal claim processing requirements and potentially applicable utilization review standards. Some of the legal protections applicable to out-of-network care include federal and state disclosure laws related to benefit calculation disclosure, state emergency and trauma coverage laws, and prudent layperson federal and state mandates.

Newborns' and Mothers' Health Protection Act of 1996

Special protections apply to the processing of benefits for infants and mothers. Numerous state laws require coverage for newborns and mothers medical claims. The federal Newborns' and Mothers' Health Protection Act of 1996 (the Newborns' Act) requires certain group health plans that offer maternity coverage to pay for at least a 48-hour hospital stay following childbirth (96-hour stay in the case of a cesarean section). Most states have a similar coverage mandate which may contain additional protections related to newborn aftercare.

Typically, these laws prohibit plans from requiring providers to obtain authorization from the plan for prescribing the stay. In addition, plans may be prohibited from denying care within the 48-hour (or 96-hour) period because of medical necessity determinations. Your appeals seeking compliance with the Newborns' Act mandates should provide confirmation that the care was rendered during the 48-hour (or 96-hour) time frame protected by the laws and ask for clarification regarding whether benefits are compliant with newborn/maternity coverage mandates. If the carrier claims an exemption from these laws, the exemption should be clearly explained in the denial letter. If such clarification is not provided, your Level II appeal should explain that newborn/maternity health protection laws are widely applicable and that it is the carrier's duty to explain any exemption from these laws in the denial so that compliance may be fully assessed.

Further, review any denials for compliance with state direct access laws related specifically to ob-gyn care. Such laws often make it easier to obtain payment without a primary care physician referral.