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Providers Right To Access A Quality Appeal Process

Medical providers who file appeals on behalf of patients provide a valuable service by resolving complex issues that patients are not in a position to effectively resolve. Prior to managed care, providers' rights under traditional health insurance were limited. Insurance carriers often reviewed provider-initiated appeals, and even acted upon them, only as a courtesy to policyholders. If the denial was maintained and litigation ensued, courts were tasked with determining who had clear rights to pursue carriers. Often, medical providers litigating for insurance benefits were denied court access because of rules related to who can rightfully litigate over insurance policy terms. Because the insurance carrier's contractual arrangement was with the patient, only the patient had "legal standing" to litigate many claim issues.

Managed care contracting exponentially complicated coverage terms by introducing many barriers to coverage, such as precertification, referral, and other network arrangements. Although providers now had a contractual arrangement formalizing their relationship with the payer, an insidious deterrent to litigation was made a part of this contractual arrangement in the form of arbitration agreements. Under managed care, providers secured more clearly defined appeal rights but often at the cost of waiving the right to litigate disagreements. Although arbitration and mediation provide a venue for dispute resolution, the decisions reached in such settings are private, do not necessarily apply to future related claims made by that provider or any other provider, and certainly fail to establish legal precedents which have implications on future disputes.

During the past decade, many state and federal healthcare mandates have recognized the role of the medical provider in initiating treatment appeals. Provider appeal rights were broadened in the Medicare Prescription Drug, Improvement and Modernization Act of 2003, and in the group health area, the Employee Retirement Income Security Act of 1974 (ERISA) Benefit Claims Procedure Regulation clarified the rights to providers to appeal urgent care claims. Yet the ability to pursue appeals has not necessarily been coupled with the ability to pursue litigation for poor-quality appeal review and response on the part of the carrier.

Providers still find their efforts stymied by the complexities that dictate appeal rights and, more importantly, the right to litigate. Insurance carriers often process provider appeals differently from patient appeals and may not provide the full range of options to providers that are extended to a beneficiary who has a clearer avenue to litigate.

As might be anticipated, insurance carriers are receptive to clinical appeals submitted by the healthcare organization seeking to clarify the treatment plan and justification for care rendered. Furthermore, most providers have options for getting medical necessity denials reviewed by unbiased reviewers in the form of independent review; however, many appeals relate to legal protections involving authorizations, verification issues, contractual obligations, and specific policy and benefit plan terms and conditions. Payers exercise wide discretion in policy or plan language interpretation knowing that these issues are often not subject to independent review and may also not be litigated by providers due to arbitration clauses and other barriers to provider litigation.

One of the most basic protections affecting the quality of the appeal process is full disclosure of the basis of the claim decision. Carriers often refuse to provide disclosure of requested claim file information or access to upper-level appeals until the provider has demonstrated a legal right to access such information. Access to this level of detail is crucial to the success of your appeal efforts.

Understanding your legal rights to appeal, demand disclosure of denial information, and pursue action beyond appeals is necessary to overturn unfair denials and determine the appropriate course of action when appeal efforts fail. Because this information is so critical to your appeal success, AppealTraining.com provides ongoing, frequently updated information on providers' success in establishing appeal review rights and pursuing those rights in legal venues.

Right to pursue appeals without reprisal from carrier

Physicians who advocate for medically appropriate healthcare for their patients are generally protected from retaliation by state managed care reforms. In the mid-1990s, the American Medical Association accused a number of HMOs of having contract language that limited communication between physicians and patients regarding treatment options. As a result, state after state included in their managed care reforms language to specifically protect the right of physicians to disclose information to patients about their medical conditions and treatment options and protections related to treatment advocacy.

Managed care contracts continue to have broad deselection language in them, however. The article "Patient Advocacy and Termination" from the Nebraska Law Review (2003, 508) states that more than fifteen states have enacted laws declaring that healthcare professionals cannot be terminated from or otherwise penalized by managed care organizations because of their advocacy. But the author, Linda Fentiman, identifies numerous obstacles to enforcement even in those states with such advocacy protections. This article is available online at *http://digitalcommons.pace.edu/lawfaculty/323/*.

Fentiman, L. 2003. "Patient Advocacy and Termination." *Nebraska Law Review*. 82: 508.

Right to litigate

Although appeals may be widely available to providers, the quality of the appeal process is not guaranteed. The quality of the appeals process provided by the carrier depends on a number of variables, including the credentials of the reviewers, the ability to present new information related to the claim, and the availability of information used in reaching the decision, such as internal rules, guidelines, and protocols; however, in the absence of professional standards and transparency in the process, one of the most important rights that require assessment is the right to appeal to an independent review organization and, even more important, the ultimate option of litigation before a judge or jury.

Many managed care contracts specify in clear, nonnegotiable terms the dispute resolution venue to be used in the event of a disagreement among contracting parties. Dispute resolution options, which may be referenced in the contract, range from mediation or arbitration to litigation in a court of law. Often, litigation is specifically prohibited under managed care contracts. Although your contract may include such wording, always consult an attorney at the time of any disagreement to discuss the full implications of this agreement and how breach of contract on the part of the carrier may affect this clause.

An attorney would be able to determine whether your AOB would allow you to litigate as a beneficiary of the insurance claim rather than as a provider. Medical claims must be processed in compliance with the agreed-upon terms in both the provider's managed care contract and the insured's benefit contract. If the dispute involves the insured's benefit terms, the provider may be able to bring suit on behalf of the patient as a third-party assignee. Assignee litigation is an important option to consider because different laws and penalties apply to a carrier's failure to process benefits in accordance with the insurance policy. Furthermore, the right to litigate in court as an assignee is not necessarily prohibited by the arbitration/mediation terms of the participating provider contract.

Assignee litigation can be tricky to pursue for a number of reasons. First, assignments of healthcare benefits vary a great deal in their terms and may not meet state and federal requirements necessary for a true "assignment and transfer" of rights under the policy. Legal requirements regarding AOB wording vary from state to state, so you should seek local legal counsel input when altering the AOB. When you discuss this with your attorney, be sure to explain that, for appeal purposes, the assignment needs to actually transfer rights, including the right to litigate, to your organization. Typically, the AOB will feature the words "irrevocably assign and transfer all rights, title and interest in the benefits payable for services rendered provided in the referenced policy or policies of insurance or benefit and welfare plan benefits." You should also seek input on protecting your organization by using language that would indicate you are under no obligation to pursue any right or recovery. A separate Designation of Authorized Representative is now also helpful in clarifying your appeal rights. We recommend the following wording for the designation section:

Designation of Authorized Representative—I hereby designate this medical provider or practice to act as my representative during an insurance or plan benefits appeal in the event of a coverage denial. I understand that this medical provider or practice has the right to decline or accept this designation at the time a denial is received. If this medical provider or practice accepts this designation, the outcome of any appeal is not guaranteed, and I agree to pay all charges that remain unpaid by the insurance carrier or benefit plan regardless of the outcome of any appeal.

Although an assignment is routinely obtained from patients, it is rarely provided to the insurance carrier when claim-related communications ensue. It is important to advise carriers of the assignment and to provide a written copy of the assignment in order to fully establish your rights.

Some health insurance contacts prohibit an AOB by including an "anti-assignment" provision. If the health benefits are simply not assignable, any assignment given by the patient would be void. Courts have differed in upholding anti-assignment provisions and have even refused to recognize anti-assignment provisions in some instances. However,

the best protection for providers is to attempt to clarify the assignability of insurance benefits when benefits are verified. If the insurance company fails to notify a provider of the anti-assignment provisions when specifically asked, this provision may be discarded in litigation because it was not properly disclosed.

Lastly, many health insurance lawsuits have been thrown out of court because the available appeals were not exhausted. It is important to keep in mind that the carrier appeals are often a prerequisite to litigation. If they are skipped, courts may rule that the litigant did not follow the proper procedures outlined in the policy or plan documents. Both the articles below and the state specific appeal letters related to assignment of benefits have more detailed information about benefit clarification and how to obtain information about the assignability of insurance benefits.

Right to appeal and/or Act as Authorized Representative

Insurance carriers frequently take the position that the beneficiary is the party with the broadest appeal rights. Although your appeals may be accepted and reviewed, pertinent claim information may be withheld if you fail to clarify your authorization to pursue the appeal on behalf of the beneficiary.

An **Assignment of Benefits (AOB)** is the most widely used form for securing both the right to receive benefit payment and the right to pursue appeals if claims are denied. A correctly worded AOB can broaden your rights to a full and fair review of an adverse determination. Many claim processing protections are designed to protect the insured, and providers seeking these protections, such as complete disclosure of the denial details, may be told they do not have the right to act on behalf of the insured party. To clarify the providers' rights, an AOB should specifically grant you the right to act as the authorized representative for purposes of appeal and assign and transfer all rights under the policy to you. This documentation can be attached to every appeal in order to clarify your rights.

The exact wording of the authorization of representation or AOB, however, can play a key role in just how far you can go to resolve the disagreement. The U.S. Department of Labor has indicated that many medical providers obtain only an "authorization to receive payment" rather than a legally compliant "assignment of benefits." An authorization to receive payment often allows carriers to simply redirect benefit payments to your office. A true AOB, however, gives you much more legal authority to pursue payment and may even allow your office to litigate on behalf of the beneficiary. There are many legal distinctions between these two different forms and your organization needs to assess your own forms to determine what rights it grants and what limitations it has related to appeals; however, either of these forms can be improved with a clause which designates your organization to act as the authorized representative for any subsequent appeals related to benefit denials

Right to act as the authorized representative of the patient and/or beneficiary

Both the Centers for Medicare & Medicaid Services and the U.S. Department of Labor have clarified the importance of allowing beneficiaries to designate an authorized representative for the purposes of appeals. In some situations, such as seeking authorization in emergency situations, the treating physician is often recognized as the authorized representative without the need for any particular designation. Under Medicare, providers who accept assignment of an individual claim have standing to appeal, but post-service private insurance and group health appeals may require a formal designation, particularly if the physician is seeking complete disclosure of the claim file and related claim documentation.

Extensive information on acting as an authorized representative of the beneficiary when pursuing an appeal involving an ERISA employer-sponsored benefit plan is available at the Department of Labor Employee Benefits Security Administration Web site (*www.dol.gov/ebsa*). The ERISA Benefit Claims Procedure Regulation addresses the right to appoint an authorized representative for appeals but stipulates that the AOB may not suffice.

The following information is the DOL Employee Benefits Security Administration FAQ page regarding designation of an authorized representative:

FAQ B-2: Does an assignment of benefits by a claimant to a healthcare provider constitute the designation of an authorized representative?

EBSA Response: No. 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. In addition, the validity of a designation of an authorized representative will depend on whether the designation has been made in accordance with the procedures established by the plan, if any.

FAQ B-3: When a claimant has properly authorized a representative to act on his or her behalf, is the plan required to provide benefit determinations and other notifications to the authorized representative, the claimant, or both?

EBSA Response: Nothing in the regulation precludes a plan from communicating with both the claimant and the claimant's authorized representative. However, it is the view of the department that, for purposes of the claims procedure rules, when a claimant clearly designates an authorized representative to act and receive notices on his or her behalf with respect to a claim, the plan should, in the absence of a contrary direction from the claimant, direct all information and notifications to which the claimant is otherwise entitled to the representative authorized to act on the claimant's behalf with respect to that aspect of the claim (e.g., initial determination, request for documents, appeal, etc.). In this regard, it is important that both claimants and plans understand and make clear the extent to which an authorized representative will be acting on behalf of the claimant.
(Source: *www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html*)

Most alarming, providers are not even necessarily have the right to receive an ERISA-compliant denial disclosing the reason for an adverse determination. The ERISA claim processing regulation requires carriers to disclose certain documents and information used in making a claim determination. This protection is very important because medical billing professionals need access to internal clinical criteria, fee schedules, and usual, customary, and reasonable charge data used to adjudicate and calculate claims. Although these protections apply to beneficiaries, they can extend to other qualified parties, such as an authorized representative, only if the request is made in compliance with the regulation.

The following information is the EBSA FAQ page regarding this subject:

FAQ C-17: Is a plan required to provide a copy of an internal rule, guideline, protocol, or similar criterion when the applicable rule, guideline, protocol, or criterion was developed by a third party which, for proprietary reasons, limits the disclosure of that information?

EBSA Response: Yes. It is the view of the department that where a rule, guideline, protocol, or similar criterion serves as a basis for making a benefit determination, either at the initial level or upon review, the rule, guideline, protocol, or criterion must be set forth in the notice of adverse benefit determination or, following disclosure of reliance and availability, provided to the claimant upon request. However, the underlying data or information used to develop any such rule, guideline, protocol, or similar criterion would not be required to be provided in order to satisfy this requirement. The department also has taken the position that internal rules, guidelines, protocols, or similar criteria would constitute instruments under which a plan is established or operated within the meaning of section 104(b)(4) of ERISA and, as such, must be disclosed to participants and beneficiaries. See §§ 2560.503-1(g)(v) (A) and (j)(5)(i); 65 FR at 70251. Also see §§ 2560.503-1(h)(2)(iii) and 2560.503-1(m)(8)(i); Advisory Opinion 96-14A (July 31, 1996).
(Source: *www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html*)

Based on this information, your assignment must include an authorized representative designation to be effective for appeals, or contain specific wording to meet the legal requirements for a "true" assignment and transfer of plan benefits. If the designation is not part of the AOB, it can be secured after treatment on an as-needed basis.