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BENEFIT DISCLOSURE

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Benefit Disclosure and Appeals regarding Misquoted Benefits

Despite technology improvements aimed to facilitate the exchange of insurance eligibility information, insurance benefit calculation has grown immensely more complicated. Gone are the days when an "80-20 plan" could actually result in a check for 80% of billed charges. Instead, carrier cost control measures result in confusing benefit calculations. Most carriers now use a fee schedule in combination with claim editing software meant to parse between payable and non payable codes and coding combinations. Furthermore, out-of-network benefits are subject to **usual, customary, and reasonable (UCR)** and **Silent Preferred Provider Organization (Silent PPO)** adjustments. In the end, reliance on online eligibility verification can leave you looking at huge balances on the back end that have no apparent explanation.

If online verification is implemented, it should be supplemented with a system to clarify reimbursement for high charge amount procedures, out-of-network care, or procedures where coverage varies significantly from plan to plan.

Demanding Benefit Clarification Disclosure

Most healthcare organizations supplement online eligibility information with benefit information obtained by phone; however, you can ensure that accurate benefit information is obtained by taking the verification of benefits process one step further, through the process of **benefit clarification disclosure**. Benefit clarification refers to the process of attempting to determine the exact fee schedule, coding criteria, and other cost-containment features and limitations which may be applied to the billed charge.

Requesting disclosure of these potentially applicable limitations can be extremely important. As discussed earlier, healthcare organizations are in a unique position of being third-party creditors for many healthcare services. In exchange for providing valuable medical services, you routinely accept an Assignment of Benefits (AOB) related to the patient's healthcare policy or plan, but the specifics of this coverage are largely unknown to you and may or may not be an equitable arrangement for the planned services. There

are two ways to more accurately determine benefits—obtain a copy of the policy or plan benefits and review the numerous limitations and exclusions, or make a written Pretreatment Disclosure Request asking the carrier to divulge the benefits for the planned services.

The **Right to Disclosure to Insurance Benefit Information** is recognized under many state and federal laws. These laws normally protect the beneficiary's right to obtain detailed benefit information but remain silent regarding the treatment provider's right to benefit information. The insurance company will usually provide benefit information as a courtesy, but such verification does not necessarily have the same implication as a disclosure made in accordance with consumer protection mandates. Because the provider/assignee's right to obtain benefit information is not routinely recognized by the insurance carrier, it is important to submit a copy of the AOB when a disclosure request is made. The wording of this document may play a large role in whether the carrier will recognize the provider's rights or simply ignore the request as being outside the bounds of what is required by law to be provided to healthcare organizations.

The U.S. Department of Labor provides information on protections related to the Employee Retirement Income Security Act of 1974 (ERISA) Benefit Claims Procedure Regulation, which applies to most employer-sponsored benefit plans. This federal regulation requires carriers to disclose certain documents and information used in making group health claim determinations. This protection is very important. You can use it to obtain access to internal clinical criteria, fee schedules, and UCR charge data used to adjudicate and calculate claims. These protections typically mandate disclosure of information to insurance beneficiaries. Litigation initiated by providers has demonstrated that such protections can extend to other qualified parties, however, such as an authorized representative or a third-party assignee, if the request is made in compliance with the regulation.

Many state laws require accurate disclosure of coverage terms. State mandates regarding unfair claims practices often prohibit any misrepresentation of benefit information by an

insurance carrier. These laws usually require insurance commissioners or other insurance authorities to track and investigate potential violations of this law. Most of these investigations focus on whether the violations are a frequent business practice of the insurer under investigation. Therefore, any complaint related to such laws should attempt to show a pattern of violations over time. Some states have passed even more protective managed care disclosure requirements, such as the Alabama Patient Right to Know Act, the Arkansas Patient Protection Act of 1995, and the Texas Verification Law.

Despite these protections, widespread violations are often found by states that assess disclosure law compliance. The state of New York passed the New York Managed Care Consumer Bill of Rights (MCCBOR), which requires the disclosure of denial information including clinical information used in decision-making as well as information regarding the appeal process. To test carriers' compliance with the protections, the New York Office of Attorney General conducted an "undercover investigation" wherein OAG surveyors posed as consumers shopping for healthcare coverage. As part of the investigation, letters were sent to 22 New York-area health plans inquiring about the coverage available through their various plans for specific medical condition. The letters sought specific coverage information related to their healthcare needs such as coverage and clinical review criteria for insulin pumps, surgery for Crohn's disease, arthroscopic knee surgery, and breast reductions. Some carriers did not respond and those that did respond frequently provided insufficient coverage information to comply with the new law. See the New York OAG Web site (*www.oag.state.ny.us/press/reports/hmo_coverage_info_report.pdf*) for a copy of the report, including a list of carriers and the grade each was given. The New York OAG report is an indictment of the carriers' poor attempts to convey coverage information and points out the harmful repercussions on patients and providers, as indicated in the following quote:

> "The impact of these findings must be measured in human terms. Violation of the information of the MCCBOR is not an abstract problem. The direct consequences of such violations are likely to be

> confusion, anxiety and fear among consumers with real medical needs. Navigating the health care market is no easy task, and when the choice is compounded by an imminent or existing medical need, full disclosure by health plans takes on added significance. Each time a plan neglects to provide clinical review criteria, the consumer is cast into a state of limbo in which a critical life decision is reduced to uncertain guesswork and high-risk speculation. Each miscalculation caused by a lack of information could leave the prospective enrollee with the choice of either paying for expensive treatment out of pocket or foregoing necessary medical care. The MCCBOR was passed so that consumers would not face that choice. Our survey demonstrates the urgent need to ensure that New York health plans comply with the law."

In light of carriers' poor performance on disclosure requests, providers will need to cite specific rights related related to requests for benefit information. See the Pretreatment Disclosure Request Letter at AppealTraining.com in the Information Requests Category.

Registration Data Quality and Related Appeals

Quality data collection ultimately depends on the accountability and motivation of the registration personnel and accuracy of patient input. Training, auditing, and ongoing incentive programs can play a big role in assisting registration personnel to achieve high standards in patient registration. In addition, data-scrubbing software is implemented in many hospitals to assist with the identification and correction of incorrect or missing data; however, denials stemming from the patient providing insufficient, out-of-date, and inaccurate information regarding coverage are often unavoidable. With the stress a patient is often facing, such challenges in data collection are inevitable.

How To Appeal Inaccurate insurance information provided by patients during registration

Patients are frequently the source of inaccurate information regarding their coverage. For this reason, all detail supplied must be verified with the insurer, including eligibility, deductibles, preauthorization requirements, and other coverage. Unfortunately, incorrect information can result in lack of timely filing denials, lack of precertification denials, and other technical denials. It is important to clarify in your appeal that the patient or the patient's family was the source of the incorrect insurance information which resulted in the denial.

One of the most frequent areas of confusion for patients involves multiple coverage and how the policies coordinate benefits to avoid overpayments. Although multiple coverage provides additional sources of reimbursement, confusion over primary and secondary designations can be a common cause of insurance payment delays, lack of timely filing, and lack of precertification denials. Inaccurate information about the primary carrier can result in a denial due to other insurance. By the time correct information is obtained, the primary carrier's filing deadline has passed and necessary referrals and precertifications are not in order.

In such cases, your appeal must state that the claim was filed in a timely manner. You should also include any proof you have regarding the date of the original claim filing,

such as a printed report from your billing system. Often, carriers will respond that such reports are not adequate proof of timely filing. If this is the case, ask your attorney to supply you with a blank affidavit addressing the claim filing history, which can be completed by the medical biller, notarized, and submitted to the insurance carrier. Because an affidavit is a more formal legal document, the carrier may accept this as documentation of timely filing.

Your attorney likely has valuable input regarding specific local requirements and necessary clarifications, and affidavit forms are readily available online. See *New York Craniofacial Care, P.C. v.* Allstate Ins. Co. at *www.nycourts.gov/reporter/3dseries/2006/2006_50500.htm*, regarding an affidavit submitted by a medical provider related to prompt payment litigation, which was unpersuasive to the court because it did not clarify that no denial was received by the provider.

In a **coordination-of-benefits (COB)** appeal, you can include the secondary carrier's denial with your proof of timely filing. Ask that the timely filing period be tolled starting with the date you were advised of the true primary coverage. If the patient provided inaccurate information, stress that your office relies on patient-provided information and should not be penalized for unavoidable timely filing delays.

Consumer protections related to COB

Medical billers should also be familiar with state regulations regarding COB. Some states have added consumer protections which go beyond the National Association of Insurance Commissioners' model coordination language. Some of the consumer protections potentially applicable to COB denials are discussed here.

State COB regulations stipulating additional time to file claims involving COB denials:

Alabama law states that if a carrier retroactively denies reimbursement for services as a result of COB with another insurer, the healthcare provider must be given an additional six months from the date the provider received the notice to file the claim with the other

coverage. This type of law can help providers overturn a lack of timely filing denials related to COB.

Florida law prohibits the secondary carrier from denying the claim based on the amount of benefits paid by the primary carrier. Specifically, Florida Insurance Statute § 627.4235 "Coordination of benefits" allows only COB limitations in which"the insurers together pay 100% of the total reasonable expenses actually incurred of the type of expense within the benefits described in the policies and presented to the insurer for payment."

State COB regulations limiting time frame for conducting COB investigation: Iowa, Kentucky, North Dakota, Oregon, and South Dakota all have a law or insurance regulations requiring COB investigations to take no more than 30 days from receipt of all necessary information needed to pay the claim. If the carriers are unable to agree upon primary/secondary designation, the plans are directed to pay the claim in equal shares and determine their relative liabilities following payment. Once liability has been determined, the secondary plan may have the option to exercise a right of recovery against the primary plan for having paid more than its rightful amount.

State COB regulations limiting time frame for recoveries: Utah law states that insurers may make reversals of payments due to COB issues only within 120 days from the date a payment is made, unless the reversal is due to fraudulent acts, fraudulent statements, or material misrepresentation by the insured. Several states' COB regulations imply that recoveries cannot be made by a secondary carrier until the primary carrier has paid benefits.

State COB designation of primary coverage regulations: A few states have issued bulletins to clarify coordination rights between medical and auto coverage and give the insured the right to choose which policy is to act as the primary policy:
New Hampshire: Department of Insurance Bulletin No. 03-051-AB states that MedPay is not a "plan" and the insured can coordinate and access MedPay coverage for expenses

not paid under the group plan. You can find this bulletin at http://www.nh.gov/insurance/bulletins/documents/cob_and_medpay_Ins03-051ab.pdf **New Jersey:** Department of Banking and Insurance Bulletin No. 05-25 clarifies that an insured can chose his or her health plan as primary to auto coverage. You can find this bulletin at *www.njdobi.org/bulletins/blt05_25.pdf.*

A final rule to keep in mind is that if one carrier has a COB provision and the other does not, the one that does not is always the primary carrier. Therefore, if you receive any denial related to COB, ask for disclosure of the COB provision to ensure that the insurance carrier actually has such wording in the policy or plan document.

Inaccurate information provided by insurers during registration

In the landmark Texas ruling of *Hermann Hospital v. National Standard Insurance Company*, the court ruled that a verification of benefits acted as an inducement on medical providers to provide treatment for an insured person. The Hermann decision ruled that insurers who misrepresent coverage during the verification of benefits process can be liable for any damages the hospital suffers as a result of admitting the patient for treatment. A similar ruling came out of at least eight other states after the Hermann case established this important argument in favor of medical providers.

Many cases that followed this reasoning and managed care's process of providing written precertification gave healthcare organizations written confirmation of coverage to use in such litigation. In *Response Oncology, Inc. v. Blue Cross Blue Shield of Missouri*, the court determined that BCBS of Missouri was liable for chemotherapy treatment rendered subsequent to a written preauthorization. Although the treatment was later determined not to be covered under the terms of the preferred provider agreement, the court stated that the theory of promissory estoppel barred the insurer from denying the hospital's claim despite the high-dose chemotherapy exclusion. In order to pursue payment under promissory estoppel, the court stated that four elements must be present: (1) a promise, (2) on which the party relies to his detriment, (3) in way promisor expected or should

have expected, and (4) resulting in injustice which only enforcement of promise could cure.

Such suits are, however, increasingly difficult to pursue. First, insurance carriers have strengthened language in managed care contracts and in oral disclaimers specifying that verifications are not a guarantee of payment. Second, misrepresentation of coverage terms are typically litigated in state courts under state promissory estoppel protections or under state managed care protections which specify that, once preauthorization is extended, it cannot be retracted. However, many health plans fall under ERISA jurisdiction which provides certain exemptions to state regulations.

Protecting your verification efforts

Because of the complication related to litigation, it is very important to negotiate verification protections into your managed care contract. Providers need contract terms that state that the carrier can deny only precertified treatment under agreed-upon circumstances. Contract language can also clarify that the precertification is binding if it was extended due to the carrier's error in applying the policy terms.

All verification of benefits appeals should detail the exact information provided during the verification. It is important that registration personnel obtain the name of the carrier representative who provided the information and whether the phone call was recorded. If a disagreement ensues regarding the information provided, you can request that the carrier review the contents of the recording. In the absence of a recording, registration personnel can be asked to sign an affidavit attesting to the information obtained.

An affidavit can be used during an appeal to legally attest to the facts related to claim submission. An affidavit can be used in a verification of benefits appeal to establish the exact information the verification staff would be willing to confirm in court, such as the eligibility and coverage information obtained, or whether oral preauthorization was granted. Affidavit submission can be highly effective because affidavits are generally admissible in court. Submission of a signed affidavit also signals to the carrier that you have prepared your appeal in such a way that the information could serve you well if legal action ensues. At a minimum, the affidavit should detail the information obtained and include the name and signature of the healthcare registrar who obtained the information.

Your appeal should also cite your state protections related to verification or preauthorization or both. Almost every state has an Unfair Claim Processing Act, which specifically prohibits misrepresentations of coverage terms. Make sure you use any state managed care protections related to preauthorization or verification. Although the state mandates may not be binding because of jurisdictional issues, they are still persuasive in demonstrating the providers' reliance on such information. Further, jurisdiction is often

unclear at the time of appeal, and citing these important state protections may prompt the carrier to respond to its position on the applicability of such information.

If the insurance company does claim ERISA exemption from state law, your use of the Pretreatment Benefit Clarification can be invaluable even if the insurance company did not provide a written response to the request. Under ERISA, failure to properly disclose coverage terms when requested by a qualified party can result in a $110 per day penalty for the time frame the carrier has failed to comply with the request. Employers and insurance carriers can be liable for stiff penalties related to this penalty, especially when it affects coverage availability.

One of the largest ERISA disclosure penalties awarded involved the employer's failure to update eligibility data. An employee of Hanna Steel terminated his employment from the company in December 1996. Hanna Steel was required to update the employee eligibility data in the Blue Cross Blue Shield (BCBS) of Alabama's computer system; however, Hanna Steel entered erroneous information in the system and indicated that the employee was eligible into 1997. As a result of the inaccurate information in the BCBS system, the employee was unable to obtain coverage from his subsequent employer, who also used the services of BCBS. In 1997, a family member contracted Hodgkin's disease and received thousands of dollars' worth of medical care. BCBS denied the claims due to the question of eligibility. The former employer sued Hanna Steel for failing to notify him of his right to continued coverage under the Hanna Steel Health Plan.

The District Court of the Northern District of Alabama determined that Hanna Steel failed to notify the employee and his beneficiaries of the continuation rights. The district court also awarded the family $93,075 in penalties due to Hanna Steel's failure to abide by the ERISA disclosure law. The 11th Circuit Court of Appeals upheld the portion of the penalty fee awarded to the beneficiary but reversed the portion of the penalty fee related to the beneficiary's dependents' claims.

Penalties awarded for failure to disclose are important to healthcare providers because providers are so frequently denied complete access to detailed information regarding denials. Furthermore, citing the potential for disclosure penalties can be effective in appeals that focus on the carrier's failure to abide by disclosure requirements.

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Despite these protections, widespread violations are often found by states that assess disclosure law compliance. The state of New York passed the New York Managed Care Consumer Bill of Rights (MCCBOR), which requires the disclosure of denial information including clinical information used in decision-making as well as information regarding the appeal process. To test carriers' compliance with the protections, the New York Office of Attorney General conducted an "undercover investigation" wherein OAG surveyors posed as consumers shopping for healthcare coverage. As part of the investigation, letters were sent to 22 New York-area health plans inquiring about the coverage available through their various plans for specific medical condition. The letters

sought specific coverage information related to their healthcare needs such as coverage and clinical review criteria for insulin pumps, surgery for Crohn's disease, arthroscopic knee surgery, and breast reductions. Some carriers did not respond and those that did respond frequently provided insufficient coverage information to comply with the new law. See the New York OAG Web site (*www.oag.state.ny.us/press/reports/hmo_coverage_info_report.pdf*) for a copy of the report, including a list of carriers and the grade each was given. The New York OAG report is an indictment of the carriers' poor attempts to convey coverage information and points out the harmful repercussions on patients and providers, as indicated in the following quote:

> "The impact of these findings must be measured in human terms. Violation of the information of the MCCBOR is not an abstract problem. The direct consequences of such violations are likely to be confusion, anxiety and fear among consumers with real medical needs. Navigating the health care market is no easy task, and when the choice is compounded by an imminent or existing medical need, full disclosure by health plans takes on added significance. Each time a plan neglects to provide clinical review criteria, the consumer is cast into a state of limbo in which a critical life decision is reduced to uncertain guesswork and high-risk speculation. Each miscalculation caused by a lack of information could leave the prospective enrollee with the choice of either paying for expensive treatment out of pocket or foregoing necessary medical care. The MCCBOR was passed so that consumers would not face that choice. Our survey demonstrates the urgent need to ensure that New York health plans comply with the law."

In light of carriers' poor performance on disclosure requests, providers will need to cite specific rights related related to requests for benefit information. See the Pretreatment Disclosure Request Letter at AppealTraining.com.

How To Use the Pretreatment Disclosure Request

In light of the potential for error in the verification process and carriers' general unwillingness to guarantee most verification, providers are left with uncertain coverage information. How can providers ensure that accurate coverage information is obtained?

The one clear protection that medical providers have underutilized is that many state laws and the ERISA disclosure requirement can apply to a formal request for coverage information. Unfortunately, carriers often take the position that while policyholders and plan participants have certain disclosure rights about coverage, providers do not necessarily have the same rights. Therefore, it is important that any request for coverage information be in writing and reference the provider's assignment of benefits or any other authorization to represent the patient. See the topic Benefit Disclosure (2MAINBenefitDisclosureandMisquotedBenefits.doc) for a more complete discussion of seeking benefit disclosure.

The Appeal Solutions' Pretreatment Disclosure Request, available below, is much more effective at obtaining accurate information than a mere phone call to verify coverage. First, the written disclosure request demands both eligibility information and coverage availability for a specific procedure or procedure code. In order to provide accurate information, insurance companies require detailed information regarding the planned treatment, such as a presumptive diagnosis, provider identification, and anticipated charge amounts. Such variables can significantly affect benefit calculation. An inadequately detailed request may not provide the information sought and may not even garner a written response. For example, Texas law requires PPOs and HMOs to honor verification requests from contracted providers. Once verification is issued by a carrier, the PPO or HMO may not deny or reduce payment for those healthcare services if the care was provided as described. Texas Administrative Code, Title 29, Subchapter 19.1724 outlines 13 data elements which healthcare providers must submit in order to secure a binding, unique "verification number" under the law. Those elements, listed here, provide insight into what carriers may consider the "minimal" information necessary to adequately respond to a Pretreatment Disclosure Request:

1. Patient name
2. Patient ID number, if included on an identification card issued by the HMO or preferred provider carrier
3. Patient date of birth
4. Name of enrollee or subscriber, if included on an identification card issued by the HMO or preferred provider carrier
5. Patient relationship to enrollee or subscriber
6. Presumptive diagnosis, if known; otherwise, presenting symptoms
7. Description of proposed procedure(s) or procedure code(s)
8. Place of service code where services will be provided and, if place of service is other than provider's office or provider's location, name of hospital or facility where proposed service will be provided
9. Proposed date of service
10. Group number, if included on an identification card issued by the HMO or preferred provider carrier
11. If known to the provider, name and contact information of any other carrier, including the name, address, and telephone number, name of enrollee, plan or ID number, group number (if applicable), and group name (if applicable)
12. Name of provider providing the proposed services
13. Provider's federal tax ID number

The Texas law specifically protects contracted healthcare providers. Many disclosure mandates do not specifically apply to healthcare provider requests and even much of the care rendered in provider-friendly states falls outside the scope of the managed care laws, such as out-of-network care and self-insured coverage. Because there are so many potential exemptions, it is also very important for providers seeking Pretreatment Benefit Clarification to demonstrate that they are a "qualified party" seeking benefit information. The Pretreatment Disclosure Request Letter allows you to submit your request with the AOB which clarifies your rights to the requested information. It is well established that insurance companies have a duty to track correspondence related to assignments of coverage.