APPEAL TRAINING COURSE 4

UTILIZATION MANAGEMENT

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Utilization Management Appeals

A preapproved claim usually results in a paid claim. Therefore, it is imperative that medical professionals demand a quality utilization review decision each time prior approval is sought.

Effective Utilization Management appeals are vastly important to patients and can greatly reduce unwanted lack of authorization denials. Utilization management personnel are well trained in clinical appeal but often are provided insufficient information regarding the carrier's legal responsibilities related to coverage terms and appeal review. As a result, utilization management personnel conduct appeals almost blindfolded, without policy coverage information, clinical review criteria, and even utilization review standards applicable to claim review. In addition, appeal letters generated by utilization management often do not make a routine attempt to obtain the information that is so vital to post-treatment appeals.

Utilization management processes should be an extension of the registration department's efforts to obtain benefit clarification. A letter from the carrier authorizing care is your best insurance against nonpayment. Insurance carriers often include stern, written warnings stating that prior authorization is no "guarantee of payment." However, many managed care and utilization review mandates prohibit carriers from retracting authorizations unless incorrect information was submitted to secure authorization. Therefore, every effort, including at least one level of appeals, should be initiated in any preauthorization denial. The appeals should focus not only on clinical justification for the planned care, but also on making sure the medical review was conducted in a professional manner with due attention to the patient's legal rights, addressing the potentially applicable review standards designed to ensure that a quality medical decision is reached. Use of such information often depends on the level of training provided to the utilization review personnel, which should include the following:

- Review and use of state utilization review mandates applicable to commercial, government, and workers' compensation carriers

- Review and use of utilization review standards such as Utilization Review Accreditation Commission (URAC) standards, InterQual standards, or specialty-specific treatment standards
- Frequent training and communication regarding utilization auditing efforts, including discussion of organization performance on Medicare PEPPER reports
- Frequent training and communication focusing on managed care contract requirements related to utilization review

Review and use of state utilization review mandates including Peer Discussion

Just as doctors must practice medicine within the scope of each state's health laws, a number of managed care mandates have been passed since the advent of managed care to ensure a prompt, professional decision on the part of carrier utilization review personnel. In almost every state, utilization review mandates specify a time frame for responding to preauthorization requests. However, you need to review your state's utilization review laws for the following protections which can be cited in situations involving adverse determinations:

- **Peer Review:** A number of states require that adverse utilization review determinations can be made only by a provider practicing in the same or similar specialty as the treating provider.
- **Provider's Right to Appeal**: A number of states specifically state that a provider has the right to appeal an adverse determination.
- **Disclosure:** A number of states require that clinical criteria used in the decision-making process must be released to the provider if requested.
- **Limits on Retroactive Denial:** One of the most important protections addressed in utilization review is the right to obtain payment based on authorizations.
- **Health Plan Liability:** Some states allow patients to bring suit against a health plan for damages related to healthcare decision-making involvement. According to *http://statehealthfacts.org*, the following 11 states have health plan liability protection: Arizona, California, Georgia, Maine, New Jersey, North Carolina, Oklahoma, Tennessee, Texas, Washington, and West Virginia.

Appealing carrier's failure to provide peer review within one day of denial
Under the time constraints forced by managed care, doctors often forego peer-to-peer discussion of denials. However, this fundamental protection should be demanded if at all possible. Furthermore, potentially applicable state and federal mandates often specify the

time frames for providing peer-to-peer discussion. Noncompliant carriers who do not have ready access to specialty peer reviewers may be forced to reconsider denials due to the inability to promptly comply with such requests.

Check the state-specific letter below for letters citing peer review protections. If a request for peer-to-peer review is made, specify a time frame for the peer discussion to take place. Further, under most utilization review protections, the clinical peer must be a physician or other health professional that holds an unrestricted license and is in the same or a similar specialty as typically manages the medical condition, procedures, or treatment under review. Generally, the individual must be in the same profession, that is, the same license category as the ordering provider. This protection is meant to achieve the objective of informed discussion between the providers and reviewers of services, and to this end, participants should have similar medical credentials.

Always request peer-to-peer review in writing and include references to your state peer-to-peer review requirements or industry standards such as the American Accreditation of Utilization Review URAC standards. It is also helpful to attach the treating provider's board certification or curriculum vitae, or both. Submission of specialty-specific credentials and training can be used to demonstrate the treating physician's expertise in the field as well as the need for the reviewing peer to have similar knowledge and experience.

Peer to peer reviews are a concern to many busy practitioners. However, your request for peer review can specify a time that the attending physician or other healthcare professional can accommodate peer discussion. A suggested time can be incorporated into your written request as follows:

> *We are in receipt of your recent adverse determination and wish to schedule peer discussion to discuss the denial. As you are likely aware, peer-to-peer conversation regarding treatment provides an opportunity for the face-to-face treating medical professional to discuss the reasons for the proposed treatment,*

unique medical factors complicating the treatment plan, clinical standards of care and available treatment options which are covered by your company. A clinical peer is defined by the Utilization Review Accreditation Commission (URAC) as a physician or other health professional who holds an unrestricted license and is in the same or similar specialty as typically manages the medical condition, procedures, or treatment under review. Generally as a peer in a similar specialty, the individual must be in the same profession, i.e., the same licensure category as the ordering provider. Dr. (insert name of ordering provider) is available for peer discussion on Tuesdays from 3 to 4 p.m. CST. Please have a clinical peer call Dr. (name) at that time to discuss this patient's care.

If peer review is not provided as requested, subsequent appeals can demand assurance that a quality review process is in place which includes input from specialty providers in active practice. Consider wording such as the following:

Since peer-to-peer discussion was not provided as requested, it is your duty to demonstrate that a quality medical review was provided. Therefore we request continued review of this denial with a detailed response from a peer reviewer in active practice who regularly performs the medical services and/or procedure in question. As you are likely aware, peer reviewers in active practice generally have the advantage of experience with integration of clinical care standards with daily medical decision-making challenges.

Review and use of utilization management standards

Because state utilization review laws and regulations vary, the health industry has identified the need for one set of standards which can be widely used to assess the quality of the utilization management programs in place. URAC (urac.org) has established rigorous standards for utilization review and developed voluntary carrier accreditation programs to both promote and protect the quality of healthcare treatment decision-making. The standards were developed to ensure that appropriately trained clinical personnel conduct and oversee a timely and responsive utilization review process and that medical decisions are based on valid clinical criteria. The standards apply to accredited members of URAC and to organizations that fall under state-mandated URAC compliance.

Some of the more protective aspects of the standards are not widely known among medical providers, and therefore, carrier noncompliance to URAC standards is not widely tracked and its seriousness is not fully understood. Instances of noncompliance can seriously compromise the carrier's ability to defend a denial because, much like our justice system, any failure to follow established procedures for every participant in the process indicates an inherent unfairness in the process. If the process is not conducted consistently, the results become suspect. As a result, carrier noncompliance to utilization review standards is a valid appeal argument for requesting a higher level of review and, ultimately, reconsideration of subsequent denials. Noncompliance should also be considered at each managed care contractual negotiation, and ongoing problems should be brought to the attention of compliance officers for the carrier.

Appealing carrier's failure to provide written notice

URAC Standards 22 and 23 require that notices of noncertification decisions must state in writing the principal reasons for the decision. A principal reason must be a clinical or nonclinical statement describing the general reasons for the noncertification and must be more detailed than "lack of medical necessity"; furthermore, the clinical rationale must be provided upon request.

Many carrier and utilization review organizations use published clinical criteria for treatment plan assessment. According to a 2003 study conducted by URAC, most insurers use an externally developed medical review standard, with the most widely used standard being Milliman & Robertson. Any source used, such as Milliman & Robertson guidelines or InterQual guidelines, should be fully cited as the principal reason for URAC compliance. This information assists the provider with assessing appropriate use of the guidelines and to respond with any information regarding why the guidelines may not be appropriate for assessing quality medical care.

There are thousands of published medical guidelines and many contradictory recommendations for appropriate care. One study compared the guidelines of InterQual and Milliman & Robertson and found that InterQual was more likely to deny compensation in Medicare hospitalization. See "Retrospective Evaluation of Potential Medical Admission Denials Using InterQual and Milliman & Robertson Admission Criteria," by Irvin, Monfette, and Lowe (2000, 543). The abstract is available at *www.aemj.org/cgi/content/abstract/7/5/543-a*.

Appealing carrier's duplicate or overly broad medical record requests

Submitting medical records to insurance carriers for medical review is a time-consuming but unavoidable medical billing activity. Many insurance carriers require documentation on any medical treatment that is above and beyond standard medical treatment protocols developed by the carriers, and providers must be able to provide requested documentation in order to obtain payment.

Submitting duplicate copies of medical records or unnecessary, likely ignored documentation, such as progress notes and medication tracking notes, is a frustrating, often unnecessary burden on medical providers. Unfortunately, when carriers request such medical records, you have little recourse other than to engage in the process of copying, preparing, and shipping an often voluminous file. You may want to deal with "repeat offenders" by requesting a review of the carrier's medical request protocols. Such

a request could ask the carrier to perform an audit to ensure that medical records are being processed in compliance with the carrier's case management and security/privacy protocols.

URAC Standard 26 states that organizations conducting prospective, concurrent, and retrospective reviews must collect only the information necessary to certify the admission, procedure, or treatment, length of stay, or frequency or duration of services. Organizations are prohibited from requiring hospitals, physicians, and other providers to numerically code diagnoses or procedures before consideration for certification. If medical records are requested, organizations are directed to be specific regarding what portion of the medical record is required.

If an overly broad request is received, this standard can be cited in your response. It is important to include the medical documentation that is necessary to complete the review. However, if certain portions of the requested record do not appear to be necessary, ask the carrier to provide a complete explanation for additional records or to describe the specific items from the medical records that would be needed so that only those portions can be submitted.

Insurance carriers have a duty to maintain professional standards in processing submitted medical documentation. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a covered entity (group health plan) must "reasonably safeguard protected health information from any intentional or unintentional use or disclosure that is in violation of the standards, implementation specifications or other requirements of this subpart." To comply with HIPAA, covered entities such as group health plans have developed written procedures for protecting the privacy of patient medical records. HIPAA has also required group health plans to designate a privacy/security officer who is responsible for assessing compliance with those written procedures.

If a medical provider has a problem with a carrier losing records, an inquiry can be sent to that carrier's compliance officer to try to determine what could be happening to the

protected health information submitted as instructed. To assist with the review, the provider should outline what records were mailed, the date of the mailing, the address used, and how the records were sent. Providers could then also request that the carrier review its records for all medical records received during the week before and the week after the anticipated arrival date of the submitted records. If the carrier refuses the request, providers could also seek from the carrier a description of the efforts made to locate the submitted information as well as a summary of the carrier's written policy and procedures for handling protected health information.

Appealing carrier's failure to abide by required deadline for decision

It is crucial to demand a prompt response to any request for precertification, and several different regulations may potentially apply. As previously indicated, state and federal law likely dictate the time frame for response and may differ from the URAC standard, but the URAC standard is widely recognized as a rigorous standard which ensures a quality utilization review process. The standards were developed to ensure that appropriately trained clinical personnel conduct and oversee a timely and responsive utilization review process.

URAC Standard 3, "Review Service Communication and Timeframes," requires organizations to respond to communications from providers and patients within one business day. URAC UM Standard 17, "Prospective Review Timeframes," requires prior approval, or prospective reviews, to be decided as soon as possible but within 72 hours of a request involving urgent care, and within 15 calendar days of a request involving nonurgent care. Retrospective review decisions must be issued within 30 calendar days of the request and concurrent reviews must be decided within 24 hours of a request for urgent care and four calendar days of a request for nonurgent care (Standards 18 and 19). Standard appeals must be completed within 30 calendar days of the appeal and expedited appeals must be completed no later than 72 hours from the initiation of the appeal (Standards 33 and 34).

Demanding compliance with utilization review standards

Using the tracking tool provided will alert the utilization review organization that you expect a prompt response to care requests and approvals. However, some requests may regularly be met with delays, and written demands must often be generated to reiterate the carrier's duties and responsibility to ensuring a quality review process.

URAC provides education opportunities and on-site inspections in an effort to ensure compliance with its utilization review standards. It also reviews complaints filed against members. Your best protection is awareness of both state utilization review laws and the industry standards. If you are aware of the standards that must be followed and cite the standards in phone calls and request letters to the carriers, you will establish your office as progressive, informed, and unwilling to accept a poor-quality review of requested treatment.

Step 1: Download the URAC Health Utilization Management Standards. Read them yourself. The state of Illinois is one entity that has enacted URAC compliance for utilization review companies operating in that state. It provides an online copy of the standards to encourage consumer use. Go to *www.idfpr.com/DOI/URO/URO_links.asp* and click on "URAC Standards – version 5.0" to download a copy.

Step 2: Find out your state's utilization review laws and to what extent the URAC utilization review standards are recognized in your state. Even if they are not officially recognized, the majority of the major insurance carriers are accredited organizations that have voluntarily agreed to the guidelines. A member directory is available at *http://urac.org* and contains information for each organization's compliance contact person to whom complaints should be made regarding noncompliance issues.

Step 3: Make it a point to request a peer-to-peer conversation regarding any certification denial and remind the carrier of applicable deadlines. If the carrier does not provide peer review as required, explain that this noncompliance seriously compromises the carrier's ability to defend any noncertification if an appeal is filed with the state independent

review process or if the matter is litigated. Routinely note in patient records any noncompliance with state or other utilization review industry guidelines.

Step 4: Always require carriers to provide written notification of a certification denial and specify that you are particularly interested in the principal reason(s) for the decision. You may have to provide URAC's definition of *principal reason* that makes it clear that "lack of medical necessity" is not an adequate response.

Step 5: Review medical record requests with a sharp eye for unnecessary and overly broad requests, and again, do not hesitate to send carriers actual copies of the URAC standards when you feel the carriers are not in compliance.

Step 6: Review any noncertification or unfavorable appeal responses for compliance with URAC decision deadlines. Every appeal letter regarding the treatment should include a reference to any failure to respond within these time frames. Make it clear that the ordering physician does not have the benefit of such leisurely reviews.

URAC.org has on online complaint filing form. Member profiles also list executive-level representation from member organizations that are responsible for compliance with the standards.

Tracking Preauthorization Response Compliance

The premise of the utilization review exchange is that every request deserves a prompt response; instead, both medical organization and patients suffer through unnecessary, unprofessional and uncompassionate review processes.

The following quote from William Sage, in “Managed Care’s Crimea” (*Duke Law Journal*, 53: 593–666) establishes the importance of quality preauthorization responses:

> “(P)hysicians give information to patients not only to help patients make decisions but to promote trust, which has both intrinsic health benefits and instrumental effects on health by inducing patients to share relevant facts about themselves with their providers and improving compliance with therapy. In particular, when doctors convey their professional opinion that a specific therapy is not advisable, they also maintain hope, offer explanations and alternatives, and assure patients that they will not abandon them. Health plans should try to follow this example when relaying determinations of medical necessity or other coverage matters. For example, written and oral communications denying coverage or requesting additional information should be compassionate, should be forthcoming about reasons for the health plan’s action, should take responsibility for the consequences instead of disclaiming them in anticipation of litigation, should offer alternatives to the denied treatment, and should avoid giving the impression of abandonment.”

It is up to providers to ensure that the patient is not abandoned and that pressure is placed on uncooperative insurers. Although some requests are more pressing than others, the urgency is not always communicated to the carrier who relies largely on the healthcare organization to determine whether the requested preauthorization should be expedited.

The Employee Retirement Income Security Act of 1974 (ERISA) claims procedure regulations are the most widely used standards regarding the time frames for response,

and several accreditation agencies and even some state utilization mandates have been brought into synchronization with the ERISA requirements. This federal regulation applies to the majority of group health plans, with the exception of state and federal workers and certain religious organization health plans. It contains specific protections regarding time frames for group health plan responses to inquiries, as well as protections related to medical decision-making on claims. Therefore, it is a good attachment for stalled claims, prior authorization appeals, and medical necessity appeals involving applicable group health plans. It is available at *www.dol.gov/dol/allcfr/ebsa/Title_29/Part_2560/29CFR2560.503-1.htm*. Because of its length, pertinent protections such as timing of benefit determination, disclosure requirements, and expert review procedures should be highlighted when submitted for consideration.

According to the ERISA regulation, all time frames start upon receipt of the request and must be answered as follows:

- Nonurgent preservice decisions are compliant if the decision is made within 15 calendar days of the request
- Urgent preservice decisions are compliant if the decision is made within 72 hours of receipt of the request
- Urgent concurrent review decisions are compliant if the decision is made within 24 hours of receipt of the request
- Post-service decisions are compliant if the decision is made within 30 calendar days of receipt of the request
- Requests for additional information must be made within 24 hours of an incomplete urgent request and within five days of a nonurgent request
- Notification of an incomplete request may be oral, unless written notification is requested by the claimant or authorized representative

Most important, it is up to you, not the carrier's utilization review staff, to determine whether a preauthorization request, called a "preservice" claim under ERISA, is for urgent care. The ERISA definition is fairly broad in that it includes any signs and symptoms that "could seriously jeopardize the life or health of the claimant or the ability...to regain maximum function" or, in the opinion of a "physician with knowledge of the claimant's medical condition," would subject the claimant to "severe pain." You should clearly identify precertification requests as *nonurgent*, *urgent*, *urgent concurrent review*, or *post-service* when seeking information.