FREE SAMPLE
APPEAL LETTER

PAYMENT REDUCTIONS MEDICAL APPEAL LETTER

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Payment Reductions

A new generation of claim auditing software is now available to insurers, medical networks and repricing companies. In slick marketing to these organizations, many software dealers tout the millions of dollars which can be saved by implementing new Claims Checking software. One such company recently announced that its new claims auditing software typically reduces claims processing costs by 15 percent by using "Sophisticated Coding Logic."

Sophisticated coding logical means one thing to providers – less reimbursement. Such constant changes in reimbursement leave providers feeling in the dark regarding what their services are worth on any given day. However, providers should not feel compelled to accept any level of payment just because "Sophisticated Coding Logic" was used. Here are some steps you can take to protect your practice from incorrect claims auditing.

The Appeal

Laying the Groundwork

1. Insurance verifiers should be trained to not just seek confirmation of coverage but to also request a quote regarding the anticipated reimbursement for the planned procedure. Request that an approximate reimbursement amount be supplied for the codes you intend to bill with and that specific information be supplied in writing about any applicable reductions which might be taken on the claim. While many insurers may not be able to provide a quote, their failure to advise you prior to treatment of the anticipated reimbursement can be decisive in any legal action which might ensue. Some states have passed strict disclosure laws which requires insurers to respond to such requests and their inability to do so may be in your favor.

2. Identify your top payer partners and find out what data they use to establish the fee schedule or to calculate usual and customary rates. If many of them are using the same data and arriving at different payment levels, this is a clear signal that the lower paying payers may be interpreting the data incorrectly.

3. Determine if most of your benefit reductions are based on managed care fee schedules, usual and customary reductions, downcoding or auditing issues. If you are particularly hard hit by fee schedule and usual and customary reductions, you may want to purchase a health industry fee analyzer so that you can review your charge amounts with an independent source. This information can also be used in

contract negotiations and appeals as an independent source of the typical billing rates for your region.

Writing a Benefit Reduction Appeal

1. If a quote was requested at the time of verification but not provided by the carrier, take the position that proper disclosure was not made to you or the patient. Cite ERISA or state disclosure laws, whichever is applicable, to support your position that carriers must be able to provide detailed information about reimbursement prior to treatment.

2. Provide reimbursement statistics on what you believe the average reimbursement for a given procedure is. Attempt to challenge the inclusion of providers who offer a different level of service than what you provide or for providers who are not within your immediate geographical area.

3. Take the position that contract discounts are only available to prompt payers. If the payment was received beyond the contractually agreed upon deadline, maintain that this failure to promptly pay nullifies the contract and makes them liable for full-billed charges. Some medical providers have been able to successfully negotiate contract terms that state that payers forfeit applicable discounts if they do not pay within the contractually agreed timeframe.

4. <u>Demand Documentation</u>: Every appeal letter sent from your office should request payment of the claim. Every appeal letter should also state that if the denial is upheld, certain documentation should be presented to your office to substantiate the denial. On an incorrect payment, ask the carrier to supply a copy of the fee schedule or other data used to determine the payment level. Many insurers balk at providing hard copies of the data used to determine the payment levels. However, some state and federal disclosure laws appear to support the providers' right to review the actual data used to determine payment levels. As follows is a Department of Labor Advisory Opinion interpreting whether ERISA requires plan administrators to provide evidence of the basis for usual and customary charges. This letter states that ERISA does require plan administrators to provide, upon written request, certain documents that specifies procedures, formulas, methodologies, or schedules to be applied in determining or calculating a participant's or beneficiary's benefits. This would be a good enclosure to include with any appeal of usual and customary reductions taken on a claim filed with an employee benefits plan.

U.S. Department of Labor Advisory Opinion 96-14A

July 31, 1996

Frederick W. Dennerline III, Esq.
Fillenwarth, Dennerline, Groth & Towe
1213 N. Arlington Avenue, Suite 204
Indianapolis, Indiana 46219

96-14A
ERISA SEC.
104(b)

Dear Mr. Dennerline:

This is in response to your request for an advisory opinion concerning the scope of section 104(b)(2) and 104(b)(4) of the Employee Retirement Income Security Income Act of 1974 (ERISA). Specifically, you have inquired whether the schedule of "usual and customary" fees, which is used as a basis for determining the dollar amount that will be paid for health claims made under a welfare benefit plan, must be made available for examination and/or furnished by the plan administrator upon the request of a plan participant or beneficiary.

You represent the Oil, Chemical and Atomic Workers Local Union No. 7-159, whose members are employed by the Kokomo Gas & Fuel Company (the Company). The Company maintains the Kokomo Gas & Fuel Company Health Plan (the Plan). The Plan is a welfare benefit plan and, in many instances, provides for the reimbursement of the full cost of medical care incurred by the employee-participants, based on a "usual and customary" fee.

The Plan document, however, does not include the schedule of "usual and customary" fees. In response to questions concerning the basis for the "usual and customary" charge allowed for certain procedures, participants and beneficiaries have been advised that the information from which the determination of the "usual and customary" fee is derived is proprietary and not disclosable to them. You represent that several participants in the Plan believe that, in order for them to be fully cognizant of their benefit entitlement, they are entitled to disclosure of all of the "usual and customary" recitations set forth in any document which the plan administrator may use to calculate the payment of benefits.

Section 104(b)(2) of ERISA requires that the administrator shall make copies of the plan description, the latest annual report, bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated available for examination by any plan participant or beneficiary. Section 104(b)(4) requires the furnishing of such documents to participants and beneficiaries upon written request, although plan administrators may impose a reasonable charge to cover the cost of providing these documents.[1]

DOL Advisory Continued...

The legislative history of ERISA suggests that plan participants and beneficiaries should have access to documents that directly affect their benefit entitlements under an employee benefit plan.[2] Consistent with this Congressional intent, it is the view of the Department of Labor that, for purposes of section 104(b)(2) and 104(b)(4), any document or instrument that specifies procedures, formulas, methodologies, or schedules to be applied in determining or calculating a participant's or beneficiary's benefit entitlement under an employee benefit plan would constitute an instrument under which the plan is established or operated, regardless of whether such information is contained in a document designated as the "plan document." Accordingly, studies, schedules or similar documents that contain information and data, such as information and data relating to standard charges for specific medical or surgical procedures, that, in turn, serve as the basis for determining or calculating a participant's or beneficiary's benefit entitlements under an employee benefit plan would constitute "instruments under which the plan is . . . operated." Thus, it appears that the schedule of "usual and customary" fees described in your letter would be required to be disclosed to participants and beneficiaries in accordance with section 104(b)(2) and 104(b)(4) of ERISA.

This letter constitutes an advisory opinion under ERISA Procedure 76-1. Accordingly, this letter is issued subject to the provisions of that procedure, including section 10 thereof, relating to the effect of advisory opinions.

Sincerely,
JOHN J. CANARY
Chief, Division of Reporting and Disclosure
Office of Regulations and Interpretations

[1] Pursuant to 29 C.F.R. § 2520.104b-30, the charge assessed by the plan administrator to cover the costs of furnishing documents is reasonable if it is equal to the actual cost per page for the least expensive means of acceptable reproduction, but in no event may such charge exceed 25 cents per page. No other charge for furnishing documents, such as handling or postage charges, is considered reasonable.

[2]See H.R. Rep. No. 533, 93d Cong. 1st Sess. 10-11 (1973), and S. Rep. No. 127, 93d Cong., 1st Sess. 27-28 (1973).

Sample Benefit Reduction Appeal Letter

Date

Attn: Director of Claims
Insurance Policy Carrier
Insurance Policy Address

Re: Patient: Patient Name
Policy: Insurance Policy Number
Insured: Responsible Party Name
Treatment Dates: Admission Date - Discharge Date
Amount: Total Charges

Dear Director of Claims,

We are in receipt of the benefit payment for the above referenced claim. It is our understanding that benefits were significantly reduced due to your determination that the billed charges are more than the usual and customary rate for certain procedures or items.

We do not believe the reduction is justified. As you are likely aware, such provider reimbursement rates are typically adjusted based on the usual and customary treatment charges for that specialty and the geographical region where treatment was provided. Further, many state and federal disclosure laws require insurers and administrators to advise beneficiaries and providers as to how the reimbursement rate is determined. However, the payment rendered does not appear to be comparable to rates charged for this service locally and no information has been given to support your position that the denial is correct.

Based on this information, we request that the reductions be reversed and an additional payment be made. If your company does not release additional benefits, please submit the applicable policy language which justifies the reduction as well as the data used to establish the reimbursement rate so that we may determine your company's and the patient's liability in regards to the unpaid balance.

We appreciate your prompt attention to this matter.

Sincerely,

Patient Accounts Manager

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Blanchard, OK 73010

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