FREE SAMPLE APPEAL LETTER

VERIFICATION OF BENEFITS MEDICAL APPEAL LETTER

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Verification of Benefits

Securing a verification of insurance benefits has long been the first step providers take to ensure payment of medical expenses. In addition to the importance of knowing the patient copay and deductible, a thorough verification of benefits can also give the medical provider an edge if benefits are denied later due to lack of coverage or benefits for the treatment.

In the landmark Texas ruling of *Hermann v. National Standard Insurance Company*, the court ruled that the 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 process can be liable for any damages the hospital suffers as a result of admitting that patient for treatment. Similar rulings came out of at least eight other states after the Hermann case established this important argument in favor of medical providers.

Such suits may become more difficult as managed care contract drafters seek to limit their liability through clauses addressing this issue. However, managed care providers have been vulnerable to suits for misrepresentation of benefits during the verification of benefit process. In *Response Oncology v. Blue Cross of Missouri*, the court determined that Blue Cross 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) promise, (2) on which 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.

The Appeal

Laying the Groundwork

1. When renegotiating contracts, attempt to renegotiate the wording of clauses which indicate that precertification is not a guarantee of payment. Providers may be able to negotiate terms which allow the carrier to deny precertified treatment only under certain agreed-upon circumstances. Or, contract language could be inserted which indicates that precertification is binding if it was extended due to the carrier's error in applying the policy terms.

2. Review and assess the verification of benefits obtained at the time of admission. Also, request from the patient copies of any referral or precertification obtained by him or her.

Appeal Options

1. Appeal with the information requested and obtained during verification. Cite the state fair claims processing act and its requirement that insurers provide complete and correct information regarding policy benefits. Almost every state has an Unfair Claim Processing Act which often prohibits misrepresenting the terms of the insurance policy.

2. Argue that providing a verification of benefits may prevent the carrier from applying limitation or exclusions which were not previously disclosed under the legal theory of estoppel. Provide supporting legal information, if available.

3. <u>Demand Documentation</u>. Request that the verification tape be pulled by the company for review by the legal department. Also, if benefits were wrongly verified because of a recent termination of coverage, ask for the date the payer was notified of the termination of coverage. You may want to check with the human resources department with the patient's employer to verify when they notified the payer of the change and if the patient elected, or can still elect, continuation of coverage through COBRA or through the policy terms.

Legal Highlight

Employers Can Be Liable For Stiff Penalties For Failure To Update Employee Benefit Eligibility

An employee of Hanna Steel terminated his employment with the company in December 1996. It was the responsibility of Hanna Steel to update employee eligibility data in the BCBC of AL computer system. However, Hanna Steel entered erroneous information in the system and indicated that the employee was still eligible into 1997.

As a result of the inaccurate information in BCBS of AL system, the employee was unable to obtain coverage from his subsequent employer, who also utilized the services of BCBS of AL. In 1997, a family member contracted Hodgkin's disease and received thousand of dollars in medical care. BCBS denied the claims due to the question of eligibility. The former employee sued Hanna Steel for failing to notify him of his right to continue coverage under the Hanna Steel Health Plan.

The District Court of the Northern District of Alabama determined that Hanna Steel did fail to notify the employee and his beneficiaries of their continuation rights. The district court also awarded the family $93,075.00 in penalties due to Hanna Steel's failure to abide by ERISA's strict disclosure laws. 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.

Legal Cite: United State Court of Appeals for the 11th Circuit, No. 01-1037
Docket No. 99-01748-CV-N-S
Appeal For US District Court for the Northern District of AL

Training Notes

1. Insurance verifications should be routinely reviewed to ensure that all the necessary information is being obtained. Verifiers typically take greater care in documenting this information if they understand the importance of a complete verification. Provide ongoing training to them as to demonstrate how the verifications they perform helps to ensure payment. Also, provide ongoing training on how such information is utilized in appeals.

2. Online verification is now an option in many regions. Some hospital studies indicated that online verification can increase patient registration accuracy to 97% and decrease claims rejection to 3%. See Passport Health's case study at www.passporthealth.com/cooperstudy.asp. However, online verification may limit you to obtaining only verification of coverage and not a more accurate quote of the anticipated reimbursement. If online verification is implemented, it should be supplemented with phone calls to clarify reimbursement on high charge amount procedures or on procedures where the coverage varies a great deal from plan to plan.

3. Finally, review your managed care contract wording on how changes in eligibility will be handled. For example, many states have laws which indicate that coverage cannot be discontinued while a beneficiary is hospitalized. However, your managed care agreement may take precedence over such a mandate. Also, because HIPAA now prohibits certain groups from declining a new employee based on health history, the primary carriers for a patient may actually change during a hospitalization. For this reason, you may want to negotiate language in your contract that prohibits a carrier from terminating benefits during a hospital confinement. If you are unable to get such wording in your contract, at least negotiate a provision requiring payment to be made until you are notified of the change in coverage.

Sample Verification of Benefits 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,

The above referenced claim was denied despite the fact that verification of benefits and/or preauthorization of care was obtained from your company. Please be advised, our facility relies on information received from your company regarding coverage. We extended treatment in good faith based on the expectation of payment as quoted by your company.

Many state courts have held that insurers can be liable for misrepresentations made during coverage verification and utilization review. Such rulings often rely on the legal theory of equitable estoppel wherein a party who makes a misstatement of fact is estopped from denying another party the right of benefits when that party relied on incorrect information to his or her detriment.

Further, most states have an Unfair Claims Settlement Practices Act prohibiting licensed insurance companies from knowingly misrepresenting material facts or relevant policy provisions in connection with a claim. It is our position that your duty as the insurer is to provide accurate information at the time of verification of benefits/utilization review.

Based on this information, we request immediate payment of the above referenced claim in accordance with the benefits quoted at the time of the patient's admission. We request a response to this appeal within 14 days of your receipt.

Sincerely,

Patient Accounts Manager

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Signature: ______

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