Protect Revenue and Optimize Insurance Reimbursement Using Payor Compliance Requirements

Essential Laws and Appeal Strategies That Support Claim Payment
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Are You Getting Paid What You Are Suppose To?
CREATIVE TACTICS

Contracted and Non-contracted

- Payment Denials
- Unreasonable Delays
- Underpaying Claims
- Misrepresenting Policy Coverage
- Refund Requests/Recoupments
ERISA Group Health Plan

Employee Retirement Income Security Act

- Health Insurance Through Employment In Private Sectors

- Plan Can Provide Benefits Through
  - Fully Insured
  - Self Insured
  - HRA (employer based)
Plan Vs. Policy
ERISA Does Not Apply To:

- Government
- School
- Church
- Individual Plans
Protected Rights = “Truthful and Non-Misleading Rules” Not Previously Acknowledged

- Patient
- “Rights”
- Provider

- Employer Group “Plan & Laws”
- Payer Mandates and Obligations

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Quality Denial Management Tools

- Valid Assignment of Benefits
- Pre-authorization/Precert
- Verification of Benefits
- Supportive Documentation
- Claim Scrubbers
- Clinical Rationale
- Applicable Laws
Disclaimer

This presentation is intended to be used as an educational tool and should be used for instructional purposes only. The material herein is not intended to provide legal advice nor is the presenter qualified to do so. You should consult with legal counsel specializing in the area of concern for any legal matters.
I authorize and direct all entitled Plan benefits for services rendered to be paid directly to (provider name). I authorize (Provider Name) to release medical records and documents necessary to receive payment for services rendered.
DOL FAQ B-2: Does an assignment of benefits by a claimant to a health care provider constitute the designation of an authorized representative?

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.
I specifically appoint as my authorized representative, the above provider and/or designated business associate to: File and prosecute any required appeal or grievance with my health plan and/or health insurer for any denial of: medical tests, treatment or surgical care; benefit payment, in whole or in part, of medical claims or benefits submitted by or on behalf of my treating or medically related provider; File any required litigation or arbitration against my health plan and/or health insurer for any benefit denial related to medical tests, treatment or surgical care; and to exert or receive any other rights or benefits entitled under my health plan or policy.
Appeals

Are Appeals Currently Being Done In Your Facility?

- Denials Appealed
- Handling of Denials
- Appeal Process
- Appeal Follow-up
- Point of Write-off

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When Do Insurance Co’s First Notify Us They Are Likely To Deny Benefits?
Promissory And Equitable Estoppel

Promissory Estoppel
“The Doctrine Allowing Recovery On A Promise Made Without Consideration When The Reliance On The Promise Was Reasonable, And The Promisee Relied On To His Or Her Detriment.”

Equitable Estoppel
Some Intended Deception In The Conduct Or Declarations Of The Party To Be Estopped, Or Such Gross Negligence As To Amount To Constructive Fraud, By Which Another Has Been Misled To His Injury.
Verification of Benefits

Cited Court Case


- Verification of benefits was relied upon in rendering service to the patient

- Misrepresenting material fact or relevant policy provisions in connection with a claim

- Failure to uphold information provided Results in:
  - Misrepresentation
  - Estoppel
  - Breach of Contract
Health insurers and group health plans will provide clear, consistent and comparable information about health plan benefits and coverage to the millions of Americans with private health coverage. Specifically, the rules ensure consumers receive two key forms that will help them understand and evaluate their health insurance choices:

- A short, easy-to-understand *Summary of Benefits and Coverage* (or “SBC”); (4 Page Mini SPD)
- A list of definitions (called the “Uniform Glossary”) that explains terms commonly used in health insurance coverage such as “deductible” and “co-payment”.

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Summarize The Key Features Of The Plan Or Coverage

- Covered Benefits,
- Cost-sharing Provisions,
- Coverage Limitations And Exceptions
- Glossary of Terms – Better Understanding of Language

The SBC will be available to consumers at important points in the enrollment process, such as when they are shopping for coverage, when they apply for coverage, at each new plan year, and at any time upon request.
Retroactive Termination of Benefits
Title 29 CFR §2590.715-2712

Under the **new standard for rescissions** set forth in PHS Act section 2712 and these interim final regulations, **plans and issuers cannot rescind coverage unless an individual was involved in fraud or made an intentional misrepresentation of material fact.** This standard **applies to all rescissions, whether in the group or individual insurance market, and whether insured or self-insured coverage.** These rules also apply regardless of any contestability period that may otherwise apply.
Untimely Filing Penalty
The Insurance Company Provides A Penalty For Untimely Filing – Non-Payment!!

Disclosure Rights
Timely Filing

Court Cases

Court Case Decisions:

Insurer may not refuse to process a claim due solely to lack of timely filing unless the insurer can prove that it was substantially prejudiced by the late filing.


In the Jones case, the court recognized the policyholder's reasonable expectations of coverage under the insurance policy unless there has been an unequivocal, conspicuous, plain, and clear manifestation by the insurance company of its intent to exclude based on late notice.
Title 29 CFR § 2560.503-1(b)(3) Lack Of Timely Filing Appeals

Filing limitations on initial claims cannot be mandated with a maximum period for filing. Falls under disclosure

Title 29 CFR §2560.503-1(b)(3) *A plan’s claim procedure must be reasonable and not contain any provision, or be administered in any way, that unduly inhibits or hampers the initiation or processing of claims for benefits.*

Adoption of a period of time for filing claims that serves to unduly limit claimants’ reasonable, good faith efforts to make claims for and obtain benefits under the plan would violate this requirement.
(1) Except for claims involving organ transplants, each insurer shall reimburse a provider for a clean claim or send a written or an electronic notice denying or contesting the claim within thirty (30) calendar days from the date that the claim is received by the insurer or an entity that administers or processes claims on behalf of the insurer. Clean claims involving organ transplants shall be paid, denied, or contested within sixty (60) calendar days from the date that the claim is received by the insurer or an entity that administers or processes claims on behalf of the insurer.

(2) Within the applicable claims payment time frame, an insurer shall: (a) Pay the total amount of the claim in accordance with any contract between the insurer and the provider; (b) Pay the portion of the claim that is not in dispute and notify the provider, in writing or electronically, of the reasons the remaining portion of the claim will not be paid; or (c) Notify the provider, in writing or electronically, of the reasons no part of the claim will be paid.
Prompt Payment Interest Penalty
KRS 304.17A-706

- If an insurer conducts a retrospective review of a claim and requires an attachment not specified in the provider manual or other document that sets forth the procedure for filing claims, the insurers shall:

- (1) Notify the provider, in writing or electronically within the claim payment time frame established in KRS 304.17A-702, of the service that will be retrospectively reviewed and the specific information needed from the provider regarding the insurer's review of a claim.

- (2) Complete the retrospective review within (20) business days of the insurer's receipt of the medical information described in this subsection; and

- (3) Subject to paragraph (d) of this subsection, add interest to the amount of the claim, to be paid at a rate of twelve percent (12%) per annum, or at a rate in accordance with KRS 304.17A-730, accruing from the appropriate claim payment time frame established in KRS 304.17A-613 after the claim was received by the insurer through the date upon which the claim is paid.
An insurer that fails to pay, deny, or settle a clean claim in accordance with KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123 shall pay interest according to the following schedule on the amount of the claim that remains unpaid:

(a) For claims that are paid between one (1) and thirty (30) days from the date that payment was due under KRS 304.17A-702, interest at a rate of twelve percent (12%) per annum shall accrue from the date payment was due under KRS 304.17A-702;

(b) For claims that are paid between thirty-one (31) and sixty (60) days from the date that payment was due under KRS 304.17A-702, interest at a rate of eighteen percent (18%) per annum shall accrue from the date payment was due under KRS 304.17A-702; and

(c) For claims that are paid more than sixty (60) days from the date payment was due under KRS 304.17A-702, interest at a rate of twenty-one percent (21%) per annum shall accrue from the date that payment was due under KRS 304.17A-702.
Prompt Pay Under ERISA

- Title 29 CFR 2560.503-1(f)(2)(iii), "Other Claims," requires certain group employer-sponsored plans to issue an initial benefit determination on post-service claims within 30 days.

- Section 2560.503-1(f)(4), "Calculating time periods," calculating the 30-day claim review time frame
## Interest Rates Set by Treasury Department

By Date Interest Becomes Due

<table>
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<tr>
<th>Applicable Period and Rate - Federal Register</th>
<th>Federal Register</th>
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<tbody>
<tr>
<td>Jul -2014 – Dec 2014  2.00</td>
<td>(Volume 79, Number 126, 07/01/14, page 37391)</td>
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<tr>
<td>Jan-2014 - Jun-2014  2.125</td>
<td>(Volume 79, Number 2, page 424)</td>
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<td>Jul-2013 - Dec-2013  1.750</td>
<td>(Volume 78, Number 125, page 39063)</td>
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<tr>
<td>Jan-2013 - Jun-2013  1.375</td>
<td>(Volume 77, Number 249, page 76624)</td>
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</tbody>
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http://fms.treas.gov/prompt/rates.html

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Claim and Appeal Decision

Timeframes

Initial claims
Urgent claims - 3 days § 2560.503-1(m)(1)
Preservice Claims - 15 days
Post-service claims - 30 days

Appeals
Urgent claims - 3 days
Preservice Claims - 30 days
Post-service claims - 60 days
Handling Refund Requests

Refund Required

- Unjust Enrichment
- Fraud

Refund Not Required

- Services Rendered In Good Faith
- When The Insurance Company Was In The Best Position To Know How The Claim Should Have Been Processed And Paid
Things To Consider With Refund Requests

- Promissory and Equitable Estoppel
- Misrepresentation of Material Facts
- Possible Breach of Contract
- Minimum HIPPA Security Requirements
- Eligibility Denials
Paragraph three of this law states the following:

- (3) (a) Except in cases of fraud, an insurer may only retroactively deny reimbursement to a provider during the twenty-four (24) month period after the date that the insurer paid the claim submitted by the provider.

- (b) An insurer that retroactively denies reimbursement to a provider under this section shall give the provider a written or electronic statement specifying the basis for the retroactive denial.

- (c) If the retroactive denial of reimbursement results from coordination of benefits, the written statement shall specify the name and address of the entity acknowledging responsibility for payment of the denied claim.

- (d) If an insurer retroactively denies reimbursement for services as a result of coordination of benefits with another insurer, the provider shall have twelve (12) months from the date that the provider received notice of the denial, unless the insurer that retroactively denied reimbursement permits a longer period, to submit a claim for reimbursement for the service to the insurer, the medical assistance program, or the Medicare program responsible for payment.
This law provides the following dispute rights which may be exercised prior to recoupment:

(1) Except for overpayments which are a result of an error in the payment rate or method, an insurer that determines that a provider was overpaid shall, within twenty four (24) months from the date that the insurer paid the claim, provide written or electronic notice to the provider of the amount of the overpayment, the covered person's name, patient identification number, date of service to which the overpayment applies, insurer reference number for the claim, and the basis for determining that an overpayment exists. Electronic notice includes e-mail or facsimile where the provider agreed in advance in writing to receive such notices. The insurer shall either: (a) Request a refund from the provider; or (b) Indicate on the notice that, within thirty (30) calendar days from the postmark date or electronic delivery date of the insurer's notice, if the insurer does not receive a notice of provider dispute in accordance with subsection (2) of this section, the amount of the overpayment will be recouped from future payments.
This law provides the following dispute rights which may be exercised prior to recoupment:

(2) If a provider disagrees with the amount of the overpayment, the provider shall within thirty (30) calendar days from the postmark date or the electronic delivery date of the insurer's written notice dispute the amount of the overpayment by submitting additional information to the insurer.

(3) If a provider files a dispute in accordance with subsection (2) of this section, no recoupment shall be made until the dispute is resolved. If a provider does not dispute the amount of the overpayment and does not provide a refund as required in subsection (2) of this section, the insurer may recoup the amount due from future payments.

(4) All disputes submitted by providers pursuant to subsection (2) of this section shall be processed in accordance and completed within thirty (30) days with the insurer's provider appeals process.
Retroactive Audits & Refund Requests
KRS 304.17A-714

This law provides the following dispute rights which may be exercised prior to recoupment:

(6) If an insurer chooses to collect an overpayment made to a provider through a recoupment against future provider payments, the insurer shall, within twenty-four (24) months from the date that the insurer paid the claim, and at the actual time of recoupment give the provider written or electronic documentation that specifies: (a) The amount of the recoupment; (b) The covered person's name to whom the recoupment applies; (c) Patient identification number; and (d) Date of service.
Retroactive Termination of Benefits
Title 29 CFR §2590.715-2712

Under the **new standard for rescissions** set forth in PHS Act section 2712 and these interim final regulations, **plans and issuers cannot rescind coverage unless an individual was involved in fraud or made an intentional misrepresentation of material fact.** This standard **applies to all rescissions, whether in the group or individual insurance market, and whether insured or self-insured coverage.** These rules also apply regardless of any contestability period that may otherwise apply.
Unfair Claims Settlement Practices
KRS 304.12-230b

Addresses Insurer Denials Related To:

- Misrepresentation Of Benefits, Provisions And Facts Related To Coverage
- Failure To Provide Prompt, Fair and Equitable Settlement of Claims
- Underpayment of Claims
- Requiring Duplication Of Claim Or Medical Records Already Submitted
- Unreasonable Delay of Claim Investigation
- Refusing To Pay Claims Without Providing An Adequate Claims Investigation
- Knowingly or Willfully Failing To Comply With Statutes Relating To Retroactive Denials And Collecting Claim Overpayments
DOL FAQ C-12 clarifies that "under the regulation, an adverse benefit determination generally includes any denial, reduction or termination of or a failure to provide or make payment, in whole or in part, (paying less than 100%) for a benefit. In any instance where the plan pays less than the total amount of expenses submitted with regard to a claim, while the plan is paying out the benefits to which the claimant is entitled under its terms, the claimant is nonetheless receiving less than full reimbursement of the submitted expenses. Therefore, in order to permit the claimant to challenge the plan’s calculation of how much it is required to pay, the decision is treated as an adverse benefit determination under the regulation."

Title 29 CFR 2560.503-1(m)(4)
Stall Tactic Involving: **Lost Documents Or Multiple Requests for Medical Records**

- Request a summary of the company’s written policy and procedures for handling protected health information.
- Request an internal investigation and security audit into the insurance company’s security/privacy safeguards as they pertain to the recovery and protection of your patient’s private healthcare information (since records are missing).
- Request a security audit to be done to ensure that medical records are being processed in compliance with the company’s own security/privacy protocols, state and federal regulatory guidelines.
- Request to receive updated weekly reports including the status and all efforts in place to recover your patient’s medical records **and**

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ERISA EOB Requirements
29 C.F.R. § 2560.503-1(g)(i) to –(iv).

- (i) The specific reason or reasons for the adverse determination;
- (ii) Reference to the specific plan provisions on which the determination is based;
- (iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- (iv) A description of the plan's review procedures and the time limits applicable to such procedures.
- (v) A statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review.
Our Medical Policy is not your patient's Benefit Plan. Medical benefits are governed and determined by a benefit document, either a Certificate of Coverage or a Summary Plan Description. You should not rely on the information contained in this Web site section to determine insured’s medical benefits. Federal and state mandates and the insured’s benefit document take precedence over insurance company policies. The participant’s benefit document lists the specific services that have coverage limits or exclusions.
Implement Contract Protection

Review and “Reference” Provision(s) In Provider Contracts Regarding Governing Laws

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Example Contract Provision Involving Governing Laws

"Federal law and the applicable law of the jurisdiction where you provide healthcare services govern our agreement. Such laws and the rules and regulations promulgated under them, when they are applicable, control and supersede our agreement.

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Rights of Appeal

KY Rights of Appeal KRS 304.17A-617

Federal Statutes – ERISA and PPACA
Recent Federal Court Ruling in a Case with $10,600 medical claim, insurance Co. refused to pay, provider made numerous demand for payment in almost one year, but no appeals filed, the court dismissed the lawsuit because provider failed to exhaust administrative remedy, as required under ERISA,
Writing An Appeal Letter

- Denial Reason
- Disclosures
- Facts and Documents Supporting Payment
- Regulatory Guidelines
- Contract Support
- Supportive Information From Website (Clinical Rationale, etc)
- Address Prompt Pay and Interest Compliance Requirements
Successful Appeals

- Decrease In Revenue Loss
- Increase In Reimbursement
- “Gold Card” Status
Q & A
Claim Recovery and Insurance Reimbursement Services

Specialized Appeal Assistance Overturning Challenging Insurance Denials

Consultant Services

Denial Management Training

Contact Information
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