Missed Opportunities-Missed Appeals, Missed Deadlines
SCHFMA Annual Institute

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After this session, you will be able to:

1. Look at the appeals process from a different prospective
2. Understand the importance of creating, maintaining and updating an appeals matrix for all your payers, and instituting time sensitive deadlines in follow up based on your matrix and payer/payment experience
3. Better understand how the appeals process is legally driven by EOB’s, written documents, but follow up is conducted by phone and the errors and disconnects that causes on a daily basis
4. Use takeaways from this presentation to improve your appeals process with at least one payer class upon your return to your hospital.
How has the process itself changed?

- 30 years ago, most claims resolved over the phone, very few technically “appealed”. What was resolved over the phone paid, what wasn’t was written off. Gradually over time, the number of formal appeals has increased and an even smaller percentage have even been formally “appealed” both internally and externally, and by vendors and by licensed professionals, attorneys, CPAs, MD’s, RN’s.

How has the role of the revenue cycle employee changed?
Introduction
How the Role of Revenue Cycle Has Changed over time
The Appeals Matrix

- Who?
- What?
- When?
- Where?
- Why?
Workers Compensation

- Verifying authorization to treat between provider and payers. Medical providers must receive authorization from the employer or insurance carrier prior to providing treatment, except for emergency care when the carrier cannot be reached. An employer who authorizes treatment, whether verbally or in writing, enters into a contract with the provider and is responsible for paying for that service, even if it is determined later than the injury was not work related. When getting authorization, every effort should be made to verify as specifically as possible what services the provider is proposing. Whenever possible, approve services by CPT® codes(s). If possible obtain written authorization for all treatment. This will help eliminate any possibility of a dispute between the provider and the employer/carrier regarding the review and payment of the bill.
Workers Compensation

- Home > Insurance and Medical Services > Medical Services Division
- [http://www.wcc.sc.gov/insurance/Pages/MedicalServicesDivision.aspx](http://www.wcc.sc.gov/insurance/Pages/MedicalServicesDivision.aspx)
- The commission has now moved their fee dispute provisions to an online form. The following link gives full and accurate description of the appeal process including sample letters, and the online form. [http://www.wcc.sc.gov/insurance/Pages/MedicalProvidersPaymentDispute.aspx](http://www.wcc.sc.gov/insurance/Pages/MedicalProvidersPaymentDispute.aspx)
• When is payment to a medical provider due? By South Carolina Law, payment of authorized services to a medical provider must be made within 30 days of the tender of the payment request to the employer's representative. The only exception to the 30-day requirement may occur in very rare cases when the Commission has accepted a properly filed request from the payer or provider to resolve a billing dispute (SC Code of Law 42-9-360; SC Code of Regulations 67-1305). After 30 days, resort to the procedure online.
A Medicaid Appeal is called a “Fair Hearing Request”. Is the same for a provider, or a beneficiary.

https://www.scdhhs.gov/site-page/appeals-and-hearings-frequently-asked-questions

Must be 30 days after you’ve received written notice of action (denial).

Discuss corrected billings, etc.
Medicaid Managed Care

- Contracts/Arbitration
- Federal Regulation which provides for beneficiary request
- Amend assignment/designation of authorized representative
- Fair hearing requests on managed care issues twist……
Medicaid CFR § 438.400

- Action means—
- In the case of an MCO or PIHP—
  1. The denial or limited authorization of a requested service, including the type or level of service;
  2. The reduction, suspension, or termination of a previously authorized service;
  3. The denial, in whole or in part, of payment for a service;
  4. The failure to provide services in a timely manner, as defined by the State;
  5. The failure of an MCO or PIHP to act within the timeframes provided in § 438.408(b); or
Appeal means a request for review of an action, as “action” is defined in this section.

§ 438.402 General requirements.
(a) The grievance system. Each MCO and PIHP must have a system in place for enrollees that includes a grievance process, an appeal process, and access to the State’s fair hearing system.
(b) Filing requirements—(1) Authority to file. (i) An enrollee may file a grievance and an MCO or PIHP level appeal, and may request a State fair hearing. (ii) A provider, acting on behalf of the enrollee and with the enrollee’s written consent, may file an appeal. A provider may file a grievance or re-quest a State fair hearing on behalf of an enrollee, if the State permits the provider to act as the enrollee’s authorized representative in doing so.
Appeals to Third-party Claims Processors

First-level Appeals: Preauthorizations and Claims
- You may appeal an initial denial of a preauthorization (to Medi-Call) or a claim (to BCBSSC) within 180 days of the decision. If you would like for someone else to appeal on your behalf, you may make this request in writing.

Please include in your appeal:
- The subscriber’s Benefits Identification Number (BIN) (ZCS followed by eight numbers)
- Your name and date of birth
- A copy of the decision that is being appealed
- The claim number of the services that are being appealed, if applicable (This is on your Explanation of Benefits.)
- A copy of medical records that support your claim and
- Any other information or documents that support your appeal.

Your appeal rights and instructions for an appeal are outlined in your denial letter.
State Health Plan

- Please note: Procedures to appeal preauthorization decisions by National Imaging Associates (NIA) are different from other appeal procedures.

- If NIA denies a procedure on the grounds that it is not medically necessary, you have three days to file an appeal with NIA if the services have not been received. If three days have passed, you may request Medi-Call review the decision.

- Appeals to PEBA – Reauthorizations and Services That Have Been Provided

- If you are still dissatisfied after the decision is re-examined, you may request a second-level appeal by writing to PEBA Insurance Benefits within 90 days of notice of the denial. If the denial is upheld by the PEBA Insurance Benefits Health Appeals Committee, you have 30 days to seek judicial review as provided by Sections 1-11-710 and 1-23-380 of the S.C. Code of Laws, as amended.

- **Please note: A provider may not appeal to PEBA Insurance Benefits, even if it appealed the decision to the third-party claims processor. Only a subscriber may initiate an appeal through PEBA Insurance Benefits.**
Appeals

You have the right to appeal any decision by BlueChoice HealthPlan to deny an authorization for services you have requested or deny payment for services you have received. To request an appeal, you (or your designated representative) may call Member Services at 803-786-8476 (Columbia area) or 800-868-2528 (toll-free outside the Columbia area). If you prefer, you may send a written appeal request to:

BlueChoice HealthPlan Member Services (AX-435) P.O. Box 6170 Columbia, SC 29260-6170.

You may also email your appeal request to BlueChoice HealthPlan through its website at www.BlueChoiceSC.com. Sign on to “My Health Toolkit” and click on “Ask Customer Service.”

You must file your appeal within six months of the date you were notified that the authorization or claim was denied. BlueChoice HealthPlan will reach a decision on your appeal and send you notification of that decision within 30 days of receipt of your appeal request if you are appealing a decision on a service that has not been provided. If the service has already been provided, you will be notified of the decision within 60 days of receipt of your appeal request. BlueChoice HealthPlan and BlueCross

If you would like for someone else to appeal on your behalf, you may make this request in writing.

Vs

Please note: A provider may not appeal to PEBA Insurance Benefits, even if it appealed the decision to the third-party claims processor. Only a subscriber may initiate an appeal through PEBA Insurance Benefits.
12.2 Payment of Claims

The Third Party Claims Processor will pay benefits, as described in Article 7, Schedule of Benefits, of this Plan directly to Providers who are members in the Plan’s Provider Networks (hereinafter referred to as “participating providers”) and any other Providers with whom the Plan Administrator has agreed to make direct payments, automatically, and without any assignment of benefits by the subscriber, when the participating or contracting provider files a health insurance claim form with the Third Party Claims Processor signed by a Covered Person, completed in full, using procedure codes designated by the Third Party Claims Processor for all services rendered.

The right to assign any benefits due and payable hereunder is expressly prohibited except as provided herein. In particular, and without limiting the generality of the foregoing, the Covered Person may not assign any benefits, and the Plan Administrator shall not recognize any assignment of benefits to: (1) a non-participating provider who was offered and declined membership in the networks; or, (2) a non-participating Provider who did not meet the standards and qualifications for membership in the networks, or (3) a supplier of medical goods, supplies or drugs, unless specifically authorized by the Plan Administrator. Provided, however, the Covered Person may assign benefits to non-participating Providers rendering Medical Care under the Plan who are not within the scope of the networks, or who were not offered and did not decline membership in the networks or as specifically authorized by the Plan Administrator. Failure by the Plan Administrator or the Third Party Claims Processor to reject an assignment of benefits prohibited by this section shall not be construed as a waiver of its rights to enforce this section in the event of subsequent assignments.
Medicare Appeals

- Make sure deadlines are clearly on Matrix
- Just because hearings may not come for two years is no reason not to appeal
- If confused by whether it is straight Medicare or MA, take shorter appeal deadline
Medicare Timely Filing

- U.S. Supreme Court Story
- Very Few Exceptions
- **70.7 - Exceptions Allowing Extension of Time Limit**
  - (Rev. 2140, Issued: 01-21-11, Effective: 01-01-10, Implementation: 02-22-11)
  - Medicare regulations at 42 C.F.R. §424.44(b) allow for the following exceptions to the 1 calendar year time limit for filing fee for service claims:
(1) Administrative error, if failure to meet the filing deadline was caused by error or misrepresentation of an employee, Medicare contractor, or agent of the Department that was performing Medicare functions and acting within the scope of its authority (See 70.7.1).

(2) Retroactive Medicare entitlement, where a beneficiary receives notification of Medicare entitlement retroactive to or before the date the service was furnished. For example, at the time services were furnished the beneficiary was not entitled to Medicare. However, after the timely filing period has expired, the beneficiary subsequently receives notification of Medicare entitlement effective retroactively to or before the date of the furnished service (See 70.7.2).

(3) Retroactive Medicare entitlement involving State Medicaid Agencies, where a State Medicaid Agency recoups payment from a provider or supplier 6 months or more after the date the service was furnished to a dually eligible beneficiary. For example, at the time the service was furnished the beneficiary was only entitled to Medicaid and not to Medicare. Subsequently, the beneficiary receives notification of Medicare entitlement effective retroactively to or before the date of the furnished service. The State Medicaid Agency recoups its money from the provider or supplier and the provider or supplier cannot submit the claim to Medicare, because the timely filing limit has expired (See 70.7.3).
(4) Retroactive disenrollment from a Medicare Advantage (MA) plan or Program of All-inclusive Care of the Elderly (PACE) provider organization, where a beneficiary was enrolled in an MA plan or PACE provider organization, but later was disenrolled from the MA plan or PACE provider organization retroactive to or before the date the service was furnished, and the MA plan or PACE provider organization recoups its payment from a provider or supplier 6 months or more after the date the service was furnished (See 70.7.4).
The conditions for meeting each exception, and a description of how filing extensions will be calculated, are described in sections 70.7.1 – 70.7.4.

Where the initial request for an exception to the timely filing limit is made by a provider or supplier, the Medicare contractor has responsibility for determining whether a late claim may be honored based on all pertinent documentation submitted by the provider or supplier. As explained in sections 70.7.1 – 70.7.4, the contractor will determine if the requirements for a particular exception are met. The contractor should contact the appropriate CMS regional office (RO) to see if it wants to participate in the review and decision-making of the exception request. In limited circumstances, the RO will determine if the exception request should go to CMS Central Office for a final determination. (translation? Anyone?)
Submissions that are found to be incomplete or invalid are returned to the provider (RTP). The incomplete or invalid information is detected by the FI’s claims processing system. The electronic submission is returned to the provider of service electronically, with notation explaining the error(s). Assistance for making corrections is available in the on-line processing system (Direct Data Entry) or through the FI. In the limited cases where paper submission are applicable, paper submissions found to be incomplete or invalid prior to or during entry into the contractor’s claims processing system are returned to the provider of service by mail, with an attached form explaining the error(s).
The electronic records of claims that are RTP are held in a temporary storage location in the FI’s claims processing system. The records are held in this location for a period of time that may vary among FIs, typically 60 days or less. During this period, the provider may access the electronic record and correct it, enabling the submission to be processed by the FI. If the incomplete or invalid information is not corrected within the temporary storage period, the electronic record is purged by the FI. There is no subsequent audit trail or other record of the submission being received by Medicare. These submissions are never reflected on a RA. No permanent record is kept of the submissions because they are not considered claims under Medicare regulations.
If contracted, must arbitrate.
If no contract, you can appeal, but must sign waiver of liability for the patient
See Rev 105 Issued 4-20-12, effective, implemented same date, 70.1.
Prior to ACA, almost all commercial coverage was through an employer and therefore governed by ERISA except for church plans, government plans and workers comp.

Many church plans and government plans choose ERISA in their plans.

About to get more confusing because of ACA, many of those covered will appear to have ERISA coverage, because they have carriers who have contracted with you, but they are not employer sponsored, or worse, they have contracted with you, but not for ACA products.
Commercial Coverage

1. Legally, the process is driven by the written EOB’s, remittances, letters of denial, depending upon the Plan or policy and whether it is governed by ERISA, or by a combination of the ACA and state law.

2. In other words, generally speaking, what is said over the phone before during and after treatment, in regards to payment, is not legally relevant in getting the claim paid.
Commercial Coverage Deadlines

1. Has there actually BEEN a denial? Is there a dispute as to whether or not there is a clean claim? Have they communicated to you whether there is or isn’t a clean claim? Have they communicated what they need or do not need in order to have a clean claim? Generally speaking, they have 45 days to do this from the date they received the claim.

2. Do we have a contract with this payer? What are the appeals deadlines per our contract?

3. Are the health benefits provided by or sponsored by the patients employer or relative of patients employer (participant or beneficiary). Then generally 180 days. Will say on EOB
Commercial Claims Appeals: Strategy

- Statutes allows for no MORE than two levels of Appeal.
- Must think strategically now more than ever BEFORE you appeal for the first time.
- Some Payers already reducing their appeals levels from two to one.
- Internal appeals must be EFFECTIVE appeals
SAMPLE ASSIGNMENT/ DESIGNATION OF AUTHORIZED REPRESENTATIVE

I/we assign to and authorize payment directly to Hospital and/or physician(s) any and all rights that the I/we have, or to which we may become entitled, under any policy of insurance or any employee welfare benefit plan, or government health care plan, including, but not limited to: (1) hospital benefits; (2) medical benefits; (3) health benefits; (4) PIP benefits; (4) benefits due to sickness or injury; (5) or any other health, accident, or welfare benefit of any type relating to or benefiting the patient, whether insured or self-funded; (6) and the proceeds of any claim resulting from or relating to the liability of, or payments made by a third party or by any person, employer, or insurance company on the third party’s behalf to or for the patient unless the account is paid in full. This applies to any plan or program governed by any State or Federal law or program; including but not limited to: Plans governed by the Employee Retirement Income Security Act; Medicare, Medicaid, Champus, and Workers Compensation.
I/we authorize Hospital/physician, or their designated representative, to act in my/our behalf as “Authorized Representative”, as defined by ERISA and US Dept. of Labor Regulations, and attorney in fact: (1) in the collection of benefits from any responsible third party through whatever means may be deemed necessary; and (2) in the endorsement of benefit checks made payable to myself and/or Participant and/or Insured, (3) request and receive a copy of the summary plan description; (4) pursue a benefit claim; (5) appeal an adverse benefit determination; and/or (6) file a legal/equitable action to recover benefits due under the Plan in my behalf, regardless of the validity of any assignment herein, (7) to appeal and or request a "Fair Hearing" before SCDHHS any Medicaid or Medicaid Managed Care Organization claim disputes, (8) appeal and/or request a hearing for Medicare or Medicare Advantage claims on my behalf.

I/we further warrant and represent that any insurance that we assign is valid insurance and in effect, and that we have the right to make this assignment. I/we agree to cooperate with the hospital as necessary to exercise their rights as Authorized Representative. If eligible for Medicare or Medicaid, I/we request Medicare/Medicaid services and benefits. I understand that I am responsible for any charges not covered by insurance, Medicare, Medicaid, or any another form of health or welfare benefit.

Patients Initials

Appropriate Signature Lines
Outline for rest of presentation

- Assignment more important than ever.
- Go back and fill out first slide on change in process change in people – revenue cycle as air traffic controller
- Ok, up to here, went through all payers, deadlines, emphasize and discuss matrix,
Takeaways – things to do

- Prepare your own Appeals Matrix
  - can deadlines be incorporated into your software?
  - If not, now are these calendared in each individual file for the collectors notes?

- Review and update your Assignment.
  - Regularly
  - Will need to be adapted to changing appeal problems
  - Large deductible plans and decreasing provider appeal rights will require a return to requiring patient involvement
  - Hold harmless clauses and appeal clauses are no longer boilerplate
Takeaways Things to do part II

- Take a look at how your EOB’s are integrated into your follow up process
  - Track exactly how they come into hospital mail room, then scanned, then what?
  - How are they provided to denial analysts who do follow up
  - How are deadlines which are provided in EOB’s calendared in files?
  - How are reasons for denial compared to information which has been provided over the phone in follow up
  - What are your decision points for when to formally file an appeal versus following suggestions for corrected claim or other corrected action
Takeaways Things to Do Part III

- Review your process for selecting files for appeal
  - Who – Follow up personnel should have true both authority and responsibility to identify worthwhile accounts for appeal. First step in ATC (air traffic control process)
  - System for routing to outside vendors/ automatic/ manual selection.
  - System for recognizing legitimate denials, which should not consume additional resources. Vendors as additional verification
Questions

“Champions know that success is inevitable; that there is no such thing as failure, only feedback. They know that the best way to forecast the future is to create it.” Michael J. Gelb

- The Emperors New Clothes
- Freakonomics