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AAHAM
American Association of Healthcare Administrative Management
Maryland Chapter

Best Practices to Combat Denials: Keep Calm and Appeal Like a Lawyer

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Vice President, Denials

Objectives

1. Review best practice concepts to maximize your recovery and “Appeal like a Lawyer”.
2. Learn legal and organizational rules for best practice appeal writing (PLEA and IRAC).
3. Applying our Knowledge!

Best Practices - Evaluate Internal Resources

Compliance	**Care Management**	**Patient Financial Services**	**Clinical Documentation Integrity (CDI)**
Health Information Management (HIM)	**Patient Access**	**Contracting**	**Utilization Review**

Best Practices - Root Cause Analysis

Non-Covered

Clinical

- Lack of Medical Necessity
- Readmission
- DRG Downcode
- Delay in Service
- Non-Emergent Service
- Experimental/Investigational
- Medically Unlikely Edits
- Lower Level of Care

Contractual/Technical/Administrative

- Lack of Authorization
- Readmission
- DRG Downcode
- Lack of IP Notification
- Out of Network
- Not Covered Under Clinical Policy
- Lack of Eligibility/Benefits
- Coordination of Benefits
- Untimely Claim
- Untimely Appeal
- Billing Error

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The information obtained during the registration/admitting process is crucial to prevent and fight denials!

Almost all technical denials can be challenged.

Best Practices - Eligibility & Insurance Verification

Just asking the right questions can prevent denials!

Verify eligibility and plan type and elicit information that is not routinely provided:

- Specific policy exclusions
- Pre-existing conditions limitations

Opportunity to correct potential benefit problems:

- Early registration
- Lapses in coverage during admission/patient involvement
- Has the patient paid their premium?

Best Practices - Obtaining/Confirming Authorization

Is authorization needed for this particular service under this patient's plan?

Check provider website/portal and/or call to verify.

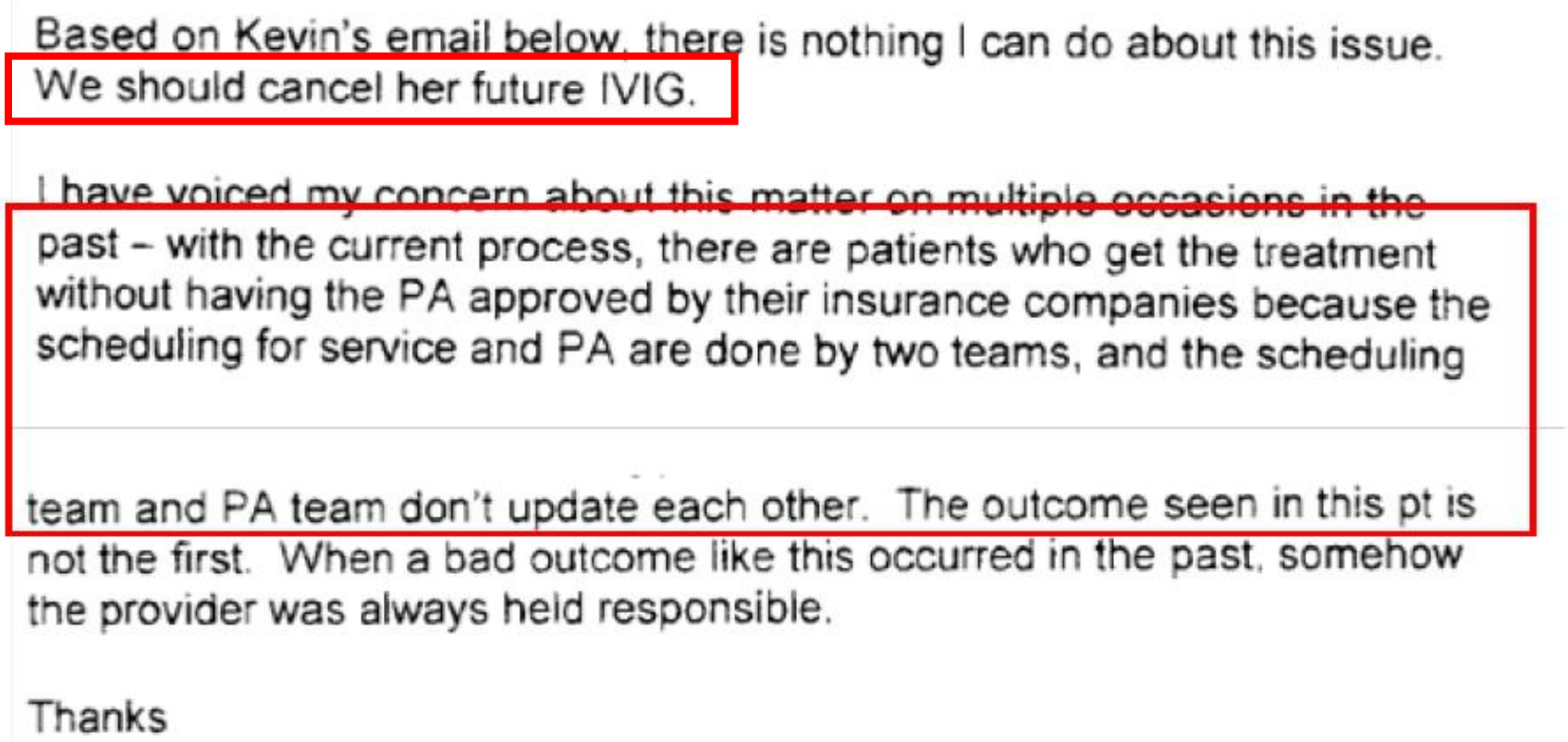
Even if authorization wasn't required prior, make sure nothing has changed! (ex. unclassified drugs or temporary codes)

If authorization was obtained:

- Does it cover this particular service?
- Is it for this date?
- Is it still valid?
- Has it been used already?
- Number of units and effective date?
- Documentation of authorization & reference number(s)

Document, Document, Document!

An ineffective process can impact patient care!



Based on Kevin's email below, there is nothing I can do about this issue. We should cancel her future IVIG.

I have voiced my concern about this matter on multiple occasions in the past – with the current process, there are patients who get the treatment without having the PA approved by their insurance companies because the scheduling for service and PA are done by two teams, and the scheduling team and PA team don't update each other. The outcome seen in this pt is not the first. When a bad outcome like this occurred in the past, somehow the provider was always held responsible.

Thanks

Best Practices - Contracting for Protection

In the event that the lack of authorization can reasonably be shown to have ***resulted from an action or inaction by Hospital****, and* ***Insurer determines the services to be Medically Necessary****, then Insurer* ***shall*** ***reimburse Hospital for all Medically Necessary Covered Services*** *rendered to the Member.*

Best Practices - Utilizing State & Federal Law

Type of Plan	Controlling Law
Fully insured (Insurance)	State
Self-funded (Claims paid by employer group)	Federal
Medicaid/Medicaid MCOs	State
Medicare	Federal
Medicare Advantage	Federal

Best Practices - Helpful Legal Theories for your Appeal Toolbox

- Course of Dealing
- Misrepresentation
- Detrimental reliance

"But for" or without the affirmative action on the part of the insurer, the provider would not have provided the medically necessary services.

Best Practices - Create a Payer Matrix

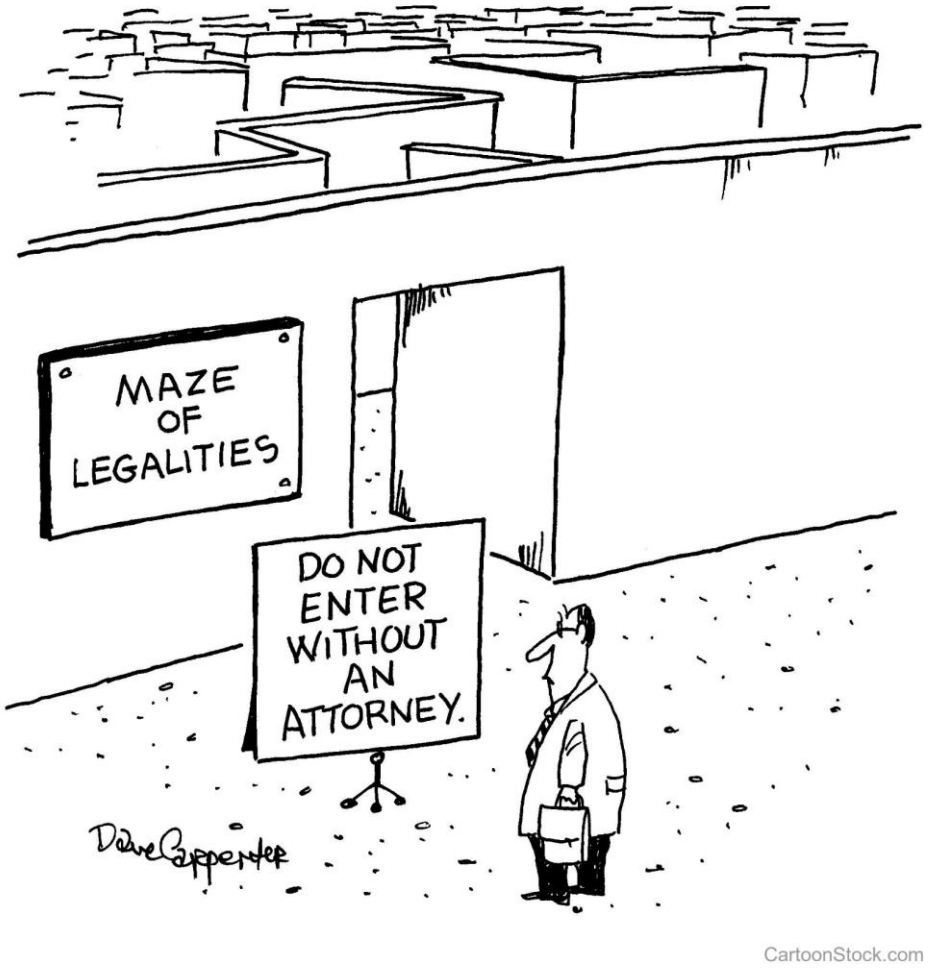
This is an extremely beneficial tool for ALL team members.

- Claim submission and resubmission timeframes
- Coordination of Benefits
- Timeframes for first and second level appeals
- External appeal options and timeframes
- Correct addresses, phone numbers, and fax numbers
- Any key contract terms to assist in the appeals process
- Availability of retro-authorization and timeframes

Best Practices - Example Payer Matrix

Payer	Claim Submission	Reconsideration/First	Second	Appeal Address
Aetna **Contracted all lines**	**180 days**	**180 days from denial** Reconsideration considered first level	**60 days from denial of reconsideration**	Attn: Provider Resolution Team PO Box 14079 Lexington, KY 40512-4079 *Must submit appeal form with appeal
Cigna **Contracted all lines**	**180 days**	**180 days from denial**	**NO second level**	Attn: National Appeals Unit PO Box 188011 Chattanooga, TN 37422
United Healthcare **(Commercial Product Lines)** **Contracted**	**180 days**	**365 days from denial**	**365 days from denial**	E-file through UHC portal
United Healthcare **(Medicare Products)** **NOT contracted**	**1 year** Based on Medicare Rules	**60 days from denial** Submit Waiver of Liability due to Non-Contracted Status	Appeal to be forwarded to Maximus for Independent Review if denied or appeal not completed within 60 days	PO Box 6106 MS CA 124-0157 Cypress, CA 90630-9948

The Continuously Evolving Landscape of Today's Denials



HAVE NO FEAR!

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The Revenue Manager's Lawyerly Oath

I will appeal all denials with:

Persistence
Logic
Exculpation and
Advocacy

Persistence is Key

"The prosecutor says you have to roll over."

REFUSE TO ROLL OVER

Persistence: Example

Provider gets authorization for CPT code **29823** (Arthroscopy w/ debridement)
but bills CPT code **29826** (Arthroscopy w/ ligament release) and **23430** (Tenodesis)
that deny for lack of authorization.

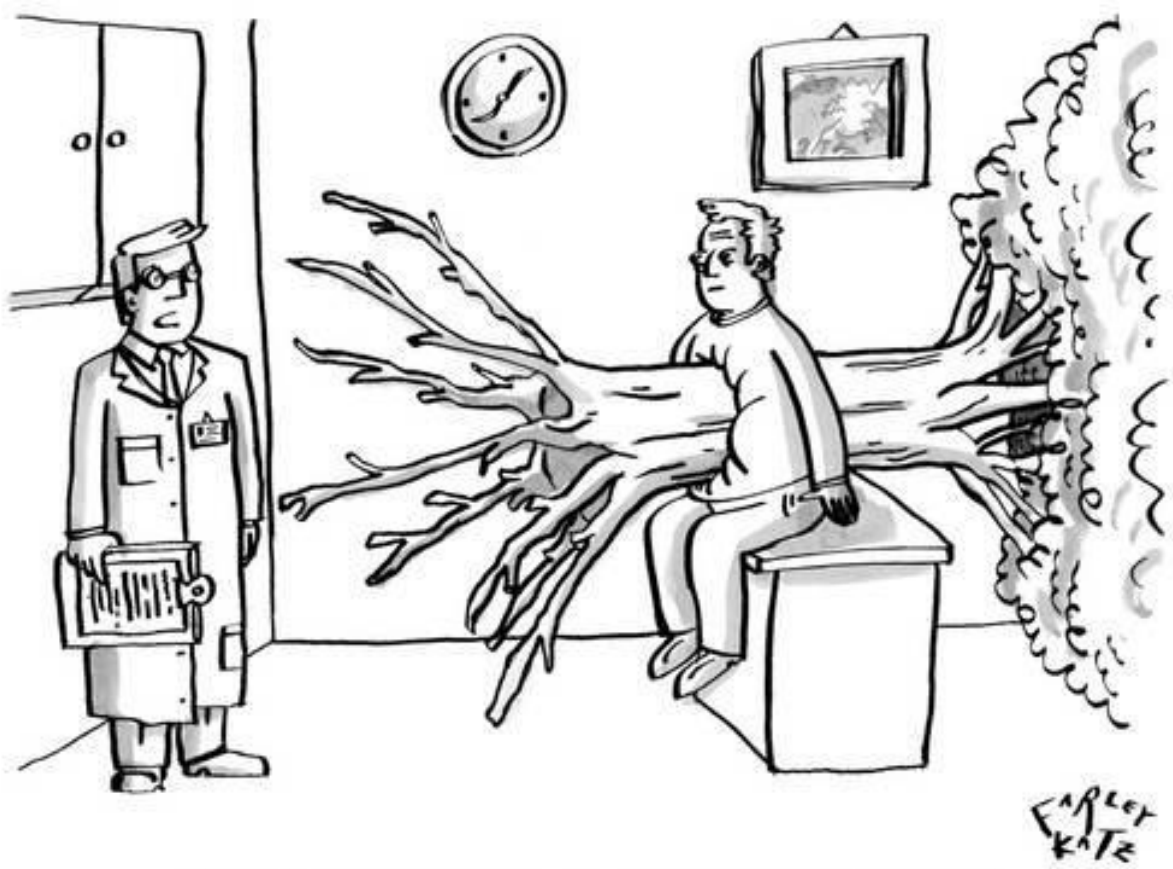
The provider's appeal asks the payer to make an "exception"
since "we neglected to get authorization for the two CPT codes".

Does this sound like a lawyer?

Never Concede. Never Roll Over. Never Accept Blame.

We'll cover this example in more detail in a bit…

Apply Logic



"Actually, this is the one condition your insurance does cover."

IF IT SEEMS WRONG, IT PROBABLY IS!

a.k.a. Smell Test

Apply Logic: Example - The Smell Test

Benefit Exclusion: Plan denied benefits to a child with cancer stating that Plan does not have to pay if the patient himself would not have to pay. Original intent was to exclude payment to family member-caretakers.

Issue: National Children's Hospital advertises no patient will ever receive a bill.

Logic: A Plan provision cannot be so distorted from its original intent to the detriment of a Provider.

Exculpation & Advocacy

NEVER ACCEPT DENIALS AT FACE VALUE

Exculpation & Advocacy: Example

Payer denied a claim for Lack Notification of an ER Admission, but the Contract states the Payer has to pay for the first 48 hours.

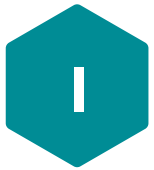
Provider files an appeal which is rightly denied as **untimely**.

Give up?

NO: The Payer's obligation for prompt pay under the Contract and law is not contingent on Provider filing a timely appeal.

Contract payment at DRG pays the claim in full.

Legal Writing Tools



ISSUE: What's the issue you need to address?

RULE: What rule(s) apply to the denial?

ANALYSIS: How do the rules apply to your facts?

CONCLUSION: The logical conclusion of the analysis.

Issue

Clinical	Technical/Administrative
Not Medically Necessary	Precertification
Lower Level of Care	Notification
Experimental/Investigational	Untimely Claim
MUE	Untimely Appeal
DRG Down Code	Coordination of Benefits
Clinical Policy/NCD/LCD	Out of Network
Readmission	Stalled Appeal

Rule

What the provider was supposed to do.

What the payer was supposed to do.

- Contract
- Provider Manual/Clinical Policies
- Law
  - State
  - Federal

Analysis

Why the provider followed the rules.

Why the payer did not follow the rules.

Apply rules to facts.

Conclusion

Only logical outcome is overturn.

Explain the expected remedy.

Example

Issue

Provider gets authorization for CPT code **29823** (Arthroscopy w/ debridement) but bills CPT code **29826** (Arthroscopy w/ ligament release) and **23430** (Tenodesis) that deny for lack of authorization.

Rule

Provider Manual:

(1) Surgical codes need precertification

(2) If you don't follow authorization protocols, you must show **extenuating circumstances** why you couldn't.

Example

Analysis → **Conclusion**

- Provider did follow the rules and got precertification for the intended code. **(E)**
- Because Provider followed the rules, the denial goes against Payer's own policy and they should have reviewed clinically on appeal. **(A)**
- Extenuating clinical circumstances also exist when a slightly different or additional procedure is not foreseeable. **(P**)
- Physicians aren't coders so the whole process of issuing approvals based on CPT codes is flawed. Claims are coded based on medical records after-the fact. **(L)**

Example

Editorial note: case was referred after provider-exhausted appeals

Payer denied CPT codes **29826** *(Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed)* and **23430** *(Tenodesis of long tendon of biceps)* based on **alleged** lack of authorization. **The denial goes against Payer policy and the provider's Contract with Payer.** We therefore appeal the denial and expect payment of the claim in full.

ISSUE

Example

Rule

Analysis

Conclusion

Intra-Operative Change is not Foreseeable

Payer Failed to Conduct Clinical Review Per Provider's Contract

Payer's Administrative Guide only requires proof that "extenuating circumstances" for a clinical review on appeal if the provider failed to follow precertification requirements. **In this case:**

1) the provider followed all contractual protocols and **obtained approved authorization** number [redacted] from Payer to perform CPT code 29823 *(Arthroscopy, shoulder, surgical; debridement, extensive);* **and**

2) clinical extenuating circumstances do exist which caused the provider to bill a slightly different code, which Payer failed to acknowledge in its appeal review.

As evidenced by the enclosed operative report, the provider began with the planned arthroscopy and extensive debridement, which revealed an unstable type II SLAP tear of the biceps anchor:

Biceps and labrum:
Long head biceps tendon: Intact
Biceps anchor: Unstable type II SLAP tear
Anterior/inferior labrum: Frayed, debrided
Posterior labrum: Frayed, debrided
Axillary pouch: No loose bodies

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The decision was **then made intra-operatively** to perform the tenodesis:

Based on these findings, we began with an extensive debridement of the glenohumeral joint. This included debridement of areas of synovitis, debridement of the anterior, posterior, and superior labrum, chondroplasty of the humeral head and glenoid, debridement of the undersurface supraspinatus fraying. Based on the unstable type II SLAP tear, we decided to proceed with subpectoral biceps tenodesis.

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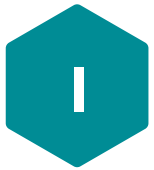
Applying our Knowledge!



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Problem 1 - Inpatient Clinical Denial

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Facts: Your facility obtains authorization #242424 from ABC Medicare Plan for the patient's scheduled total knee revision on 2/15/24. The patient is admitted as an inpatient on 2/15 and undergoes a successful surgical procedure, removing & replacing the previously placed prosthesis. The patient recovers well and is able to be discharged the next day, 2/16. Your facility bills the claim to ABC Medicare Plan, who denies the inpatient claim as not medically necessary. Your facility is not contracted with this plan.

42 CFR 422.138
(c) Effect of prior authorization or pre-service approval. If the MA organization approved the furnishing of a covered item or service through a prior authorization or pre-service determination of coverage or payment, it may not deny coverage later on the basis of lack of medical necessity and may not reopen such a decision for any reason except for good cause (as provided at § 405.986 of this chapter) or if there is reliable evidence of fraud or similar fault per the reopening provisions at § 422.616. The definitions of the terms "reliable evidence" and "similar fault" in § 405.902 of this chapter apply to this provision.
42 CFR 419.22
Hospital services excluded from payment under the hospital outpatient prospective payment system. The following services are not paid for under the hospital outpatient prospective payment system (except when packaged as a part of a bundled payment): (n) Services and procedures that the Secretary designates as requiring inpatient care.
42 CFR 412.3 – Admissions
(d)(2) An inpatient admission for a surgical procedure specified by Medicare as inpatient only under § 419.22(n) of this chapter is generally appropriate for payment under Medicare Part A regardless of the expected duration of care. Procedures no longer specified as inpatient only under § 419.22(n) of this chapter are appropriate for payment under Medicare Part A in accordance with paragraph (d)(1) or (3) of this section… **(3)** Where the admitting physician expects a patient to require hospital care for only a limited period of time that does not cross 2 midnights, an inpatient admission may be appropriate for payment under Medicare Part A based on the clinical judgment of the admitting physician and medical record support for that determination. The physician's decision should be based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. In these cases, the factors that lead to the decision to admit the patient as an inpatient must be supported by the medical record in order to be granted consideration.

I-Issue(s) -
R-Rule(s) -
A-Analysis -
C-Conclusion(s) -

Problem 1 - Issue

- Approved authorization was obtained for the surgery.
- The patient was admitted to the inpatient level of care.
- The patient did not remain in the hospital for two midnights or greater.
- **Issue**:
  - Was the patient admitted to the appropriate level of care?
  - What is our argument to obtain payment?
  - What are our avenues to appeal since this is a non-par relationship?

Problem 1 - Rules

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An inpatient admission for a surgical procedure specified by Medicare as inpatient only under § 419.22(n) of this chapter is generally appropriate for payment under Medicare Part A regardless of the expected duration of care.

Problem 1 - Analysis & Conclusion

- Approved authorization was obtained for the surgical procedure.
- The surgery performed is on CMS' Inpatient Only List.

27486	Revise/replace knee joint	C					
27487	Revise/replace knee joint	C					

- As of 1/1/24, Medicare managed care plans must follow the Inpatient Only List and adhere to other CMS guidance such as LCDs & NCDs and the Two Midnight Rule.
- Inpatient Only List procedures are an exception to the Two Midnight Rule.
- Since this is a non-contracted relationship with the payer, should the denial be upheld on appeal, we would then proceed to the IRE, and then to hearing with OMHA, if necessary.

Problem 2 - ERISA Benefit Exclusion

Problem 2 - ERISA Benefit Exclusion

Facts: 36-year-old man was the driver in a single car accident. He had a blood-alcohol well over the legal limit for driving but was not charged. He was taken to your ER with multiple fractures and injuries. Provider faxed all relevant clinical information to self insured Plan the same day for approval of the admission.

Six days later the Plan denies the request for authorization under the plans "Limitations and Exclusions" under the exclusion policy below.

Plan Terms & Law:

Benefit Exclusion: Services, supplies, care or treatment to a Covered person for an Injury or Sickness which occurred as a result of that Covered person's **illegal use of alcohol**. The arresting officer's determination of inebriation will be sufficient for this exclusion.

ERISA: Urgent care claims. In the case of a claim involving urgent care, the plan administrator shall notify the claimant of the plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt (29 C.F.R. 2560.503-1).

State Motor Vehicle Laws makes it unlawful to operate a motor vehicle while intoxicated.

I-Issue(s) -
R-Rule(s) -
A-Analysis -
C-Conclusion(s) -

Problem 2 - Issue

- 36-year-old man was in a single car accident. His blood-alcohol was well over the legal limit for driving but he was not charged. He was taken to your ER with multiple fractures and injuries. Provider faxed all relevant clinical information to self-insured Plan the same day for approval of the admission.

- Patient's plan is governed by ERISA.

- **Issue**: The Plan denies the request for authorization under the plans “Limitations and Exclusions" policy which will not cover:
  - **Alcohol. *Services,*** supplies, care or treatment to a Covered person ***for an Injury or Sickness which occurred as a result of that Covered person's illegal use of alcohol.*** The arresting officer's determination of inebriation will be sufficient for this exclusion.

Problem 2 - Rules

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State Motor Vehicle Laws makes it unlawful to operate a motor vehicle while intoxicated.

Problem 2 - Analysis & Conclusion

- Plan erred in not issuing a determination within 72 hours. This is particularly important in an ERISA non-covered denial when the balance is patient responsibility.
- There was no arrest - patient was transferred directly to the ER so no independent determination.
- *State Motor Vehicle Laws* makes it unlawful to operate a motor vehicle while intoxicated. There was ***no illegal use of alcohol*** under the State law.

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Q&A

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THANK YOU

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