



Clinic Solutions

Taking care of your practice,
so you can take care of your patients

HFMA Spring Conference March 25th 2010

info@clinic-solutions.com www.clinic-solutions.com



Navigating the Treacherous Waters of Insurance Denials



CONTACT: info@clinic-solutions.com

WEB: www.clinic-solutions.com



About the presenter . . .

Sheri Byrne-Haber

- WAY too many letters after my name
 - B.Sc. in Information Technology
 - J.D., emphasis in Intellectual Property
 - About to finish MBA in Health Care practice mgmt
 - M.O.M. – three daughters aged 22, 18, and 7
- CEO of Clinic Solutions
- Member of the Board of Parents Helping Parents



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Presentation Goals

Learn About

- Appeal approaches and denial avoidance
- What questions should you ask to determine a winning approach
- Legal quirks of insurance appeals
- Anatomy of an appeal
- Economic damages of appeal failures



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Client Zero . . . Then



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Insurers Profit From . . .

- Assumptions that insurers will say no
- Attrition
- Uncontested mistakes
- Illegal denials
- Missed deadlines
- No penalties or legal fees awarded when denials are overturned



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Self-Insured vs. Traditionally Insured

- Only matters for appeals
- Dictates which laws apply
- Who bears risk of loss / gets to keep profits?



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Self-Insured Plans

- Large employers (> 500) are usually self-insured
- The **employer** offering the insurance **is the insurer**
- Company named on the card is a **Third Party
(claims) **Addministrator (TPA)****
- Federal law (known as ERISA) **ONLY** applies to self-insured plans



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Appeals Levels

- Internal to Insurer
 - Initial Request
 - First Internal Appeal
 - Second Internal Appeal (usually available)
- External to Insurer
 - Voluntary Review Panel (occasional)
 - External / Independent Medical Review
 - ERISA Arbitration
 - EEOC / ADA Complaint

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Prospective (Pre-Service) vs. Retrospective (Post Service) Appeals

- Process is the same
- Timelines and outcomes are very different
 - 80 % of pre-service denials are eventually overturned
 - But only 36 % of post-service denials are overturned
- Difference is **purely** psychological

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Pre-authorizations only benefit insurers

- Pre-auths are almost never legally binding
- Insurers can refuse to pay after pre-authorizing the procedure.
- Not doing them, if required, is fatal
- Refusal to pre-authorize is not appealable
- If all rules have been followed and medical necessity is established, physician will be paid

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Refusal to Pre-authorize

- Some insurers refuse to pre-authorize for any procedure, you have to proceed “on faith”
- If the insurer later determines the procedure was not medically necessary, they will refuse to pay
- Appeal then becomes post-service
- Little, if any, state insurance law protection and no ERISA protection

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No Preauthorization Required?

- 1) Try to get that statement in writing
- 2) If you can't get it in writing, document:
 - Who you spoke with
 - When you spoke with them
 - Some type of transaction identifier
 - Potentially, send a letter confirming this in writing from your side



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Avoiding the Appeals Process

- Well documented authorization process
- Peer to Peer Reviews
- Cease and Desist Letters



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Basic Theme to Every Appeal

Every successful appeal of a health insurance denial is about making it more expensive for the insurer to continue to say “no” than to say “yes”



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If It's Not in Writing, It Didn't Happen

- All dealings with insurers need to be:
 - IN writing
- or
- summarized IN writing after the phone call and kept in the patient's chart



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Types of Insurance Denials

- Medical Necessity
- Experimental/Investigational
- Contract Exclusions
- Out of Network service provider
- Stupidity



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Medical Necessity Denials

- Insurer is arguing that the procedure is not medically necessary, so argument needs to focus on why it is
- Objective test results are the key component to overturning these denials.
- Appeal can include psychological impact



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Experimental/Investigational Denials

- Arguments need to focus on the following:
 - Research Papers
 - Status of FDA testing
 - Potential danger to patient from not receiving treatment
 - Other Medical Conditions
- Review the papers insurer cites for both timeliness and audience



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Contract Exclusion Denials

- Some contract exclusion denials are illegal
- There may be a contract exclusion in place, but if the alternative (covered) treatment or non-treatment is MORE expensive, insurers can and will overturn their own exclusions



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Out of Network Denials

- Insurance companies are obligated to provide you with a *competent* medical provider, not the *best* medical provider.
- If you are out of network, patient must also visit the proposed provider to determine his/her qualifications, then appeal arguments must be about why the in-network provider is not competent for that patient and you are.



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“Stupidity” Denials

- Wrong criteria applied, wrong date used, wrong side reviewed, etc., etc.
- Don't appeal, ask for the authorization to be restarted
- If you end up appealing later, cite the ERISA requirement for a “reasonable claims process”.



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Pre-existing Condition *Before* Health Care Reform

- Significant difference, depending on whether the plan is an individual plan or a group plan
 - Pre-existing conditions in group plans are always temporary
 - Pre-existing conditions in individual plans can be permanent



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Pre-existing Condition *After* Health Care Reform

- Pre-existing conditions in individual plans against children immediately eliminated
- Pre-existing conditions in individual plans against adults eliminated in 2014
- Until 2014, adults w/ pre-existing conditions expected to participate in high risk exchanges w/ \$5995/\$11,990 premium limits & subsidies



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Appeal Timelines

- Appeals can range from 2 hours to 2 years
- “Average” appeal takes about 4 months from initial denial
- Expedited appeals are available ONLY where condition is deteriorating or life threatening. Even these cases can take up to 2 weeks.

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Appeal Generation Process

1. Obtain patient data
2. Look at exact denial language
3. Request materials denial was based on
4. Obtain LOMN(s)
5. Draft, review, submit appeal
6. Insurance Commission Hearing / Arbitration
7. Watch the mailbox . . . and know your deadlines

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Questions

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Evidence for Cases

- In ERISA (self-insured) cases, evidence based on telephone calls is NEVER admissible
- Summarize all phone calls in writing and mail to the TPA to get them included “in the medical record”



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Anatomy of an Appeal Letter

- Address/Patient info block
- What is this letter about?
- Why are you right and the insurer wrong?
- Patient history
- Appeal history
- Appeal arguments
- Conclusion



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Appeal Letter Strategy

- You are always writing for the NEXT level of reviewer
- Every level of review must have a completely new set of people involved
- Repeat Violators:
 - ERISA Violations / Bad Faith



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Appeal Package Contents

- New appeal materials
- Old appeals, if relevant
- Patient impact statement
- LOMN(s)
- RELEVANT medical records
- Copies of best and most recent research



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Cost of Losing Patient over Insurance Issues

“Quiet Patient” – No internet posts

- 2 visits yr / 5 years
- 1 referral per year
- \$1250 of “other” revenue
- Total lost revenue (CMS) \$5881



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Cost of Losing Patient over Insurance Issues

Medium-Loud Patient (internet posts – Ratemd, Drscore)

- 2 visits yr / 5 years
- 1 direct / 2 internet referrals per year
- \$1250 of “other” revenue
- Total lost revenue (CMS) \$12,925



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Cost of Losing Patient over Insurance Issues

Loud Patient (internet posts – Angie’s List, Yelp, Citysearch)

- 2 visits yr / 5 years
- 1 direct / 5 internet referrals per year
- \$2500 of “other” revenue
- Total lost revenue (CMS) \$27,113



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Sort by: Yelp Sort* | Date | Rating | Useful | Funny | Cool | Total Votes | Friends | Elites

4.1
14

Compliment
Send Message
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5/4/2009

I gave them a decent review a few weeks ago then they hit me like a semi-truck on my last visit. I moved my kids immediately to a new Pediatrician and I'm just looking for somewhere to move myself.

When that move is over, I'll post more details of the horrors of this clinic! Until then, I have to lay low and suck up so they don't alter my medical records.

Was this review ...? Useful (1) Funny Cool

Bookmark Send to a Friend Link to This Review Flag this review

4.3
10

Compliment
Send Message
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11/17/2009

I have been going to these guys for as long as remember and they keep disappointing me over and over. there is NO privacy for patients, and they make the whole experience like what you would expect from a ghetto public facility. their place is outdated and it shows it. there scheduling system is really frustrating, you can never get a hold of anyone to talk to they only call you, always the answering machine.

with all that said Dr. Ettinger is great, he is some what reserved but really smart and patient.

Was this review ...? Useful (2) Funny Cool

Bookmark Send to a Friend Link to This Review Flag this review

4.3
20

Compliment
Send Message
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11/18/2009

Avoid at all costs. I've been in healthcare for 20 years and I was appalled by the behavior of this office.

Was this review ...? Useful (2) Funny (1) Cool

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Questions

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Affect of Healthcare Reform on Appeals

- Types of appeals eliminated
 - Pre-existing Conditions
 - Dependent kids to age 19, now
 - Adults 2014
 - Annual / Lifetime caps, now
 - “Age outs”, now



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Affect of Healthcare Reform on Appeals

- Length of Appeals
 - Levels
 - Length of Time
- Legal Precedence
- Healthcare Exchanges



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