



# TURNING INSURANCE DENIALS INTO DOLLARS

## Slow-Pay, No-Pay Claims

Reasonable and Customary Charges

**METHODS AND LETTERS  
PROVEN EFFECTIVE AT RESOLVING  
INCORRECT INSURANCE DENIALS**

Incorrect Benefit Reductions

Stalled Claims

Lack of Medical Necessity

Refund Requests

Timely Filing Requirements

Preexisting Conditions

Substance Abuse

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# **Turning Insurance Denials Into Dollars**

**Methods and Letters Proven Effective  
at Resolving Incorrect Insurance Denials**

**By Appeal Solutions**

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# Turning Insurance Denials Into Dollars

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## What Gets Studied, Gets Improved

Your denials tell a story.

Insurance carriers are increasingly sophisticated in their scrutiny of medical bills. Claims payments keep medical providers in business, but unpaid claims tell providers where they and their payer partners are heading. Denials may also indicate which managed care organizations to participate with and which ones to drop. This publication is meant to help you both interpret denial patterns and respond aggressively to the financial impact of such denials.

Your first step in this effort is to track your denial rate. As the management adage goes - what gets studied, gets improved. You can have little success in denial management until you know what your denial rate is as a percent of revenue and under what circumstances most denials occur. Study denials with the goal of avoiding them.

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## Measuring Improvement

In order to study your denial information, denials must be organized so that you will begin to see the patterns that emerge. Every denied and incorrectly paid claim should be assigned a unique status code. Categorizing denials allows you to review the type of denial by payer, by department or physician, by date and by billing code. This gives you an accurate picture of the financial effect of denials over time as well as an indication of the cause of the denials. It also allows you to spot trends which may be the result of internal procedures or external changes in payer payment policies.

Once you determine the net effect of denials to your office revenue, you must establish your denial management goals. The Health Care Advisory Board's publication, "Capturing Lost Revenues, Best Practices for Minimizing Managed Care Denials," estimates that denials make up an average of 1 to 3 percent of total revenue in a multi-hospital system. Some health care consultants encourage establishing a goal of keeping denials under two percent of revenue.

Medical denial rates vary heavily based on some uncontrollable factors such as your specialty and managed care concentration. However, front-end procedures, verification and billing technology utilized and collection follow-up procedures also have an impact. Quantifying the exact dollar amount of denials in your business office may help justify investment in staff and technology. Monetary incentive programs for staff members are also very effective and should be considered at least on a trial basis. However, before such investments can be justified, It is imperative to know the approximate monetary effect of claim denials to your office's profitability.

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## Improving performance

The financial facts you gather may be better or worse than expected. However, as Psychiatrist Karl Menninger once said, facts are never as important as your attitude toward those facts. How you think and what you believe possible, or impossible, may defeat you before you ever do anything about those facts.

Zimmerman and Associates' "Best Practices of Denial Management, Improved Profitability and Enhanced Third-Party Reimbursement" estimates that 90 percent of denials are preventable. Further, they estimate that between 50 to 70 percent of denials are recoverable. Appeal Solutions has been able to achieve 70 to 90 percent recovery rates for certain clients. Our success rate often depends on the promptness of the appeal and the documentation available to support the appeal.

If medical providers have a process for sending timely appeals which cite sound supporting evidence, an 80 percent recovery rate is an attainable goal. A prompt, aggressive appeal program will help you realize not only recoveries on previously denied claims but also provide solid information to assist you in your decisions regarding payer mix, staffing and technology.

The 11 sections of this publication each discuss a different denial type in two parts. The first portion, "The Appeal," discusses the how-to's of successfully appealing each type of denial, including pre-treatment groundwork and the actual components of a good appeal letter related to that topic. However, our recommendation on how to successfully appeal claims can be summed up as follows:

**Always place the burden on the payer to prove that its denial is correct and can be supported with written documentation.**

To successfully appeal denials, you must have a conviction that it is the payer's burden of proof to establish that no more benefits are available. Just as insurers now require medical providers to document each step in the patient-provider relationship, so must claim payers document the claim file with all the necessary information to support their decision. We will tell you what types of information to request and how

to pursue a payer that is resistant to providing documentation. However, make it your first appeal writing rule to always require insurers and third party administrators to provide the proof to support any denial.

The second portion, "Training Notes," indicates what issues to review to ensure that your internal process is not contributing to a high rate of denial in each of these subject areas. Appealing current denials and curtailing future denials is your goal. Strict attention to both issues will help you turn your office's denials into dollars.

Insurance carriers require you to keep extensive medical records to prove that the medical treatment occurred. What proof do you require insurance carriers to provide when they deny your carefully documented claim?



# Payment Reductions

A new generation of claim auditing software is now available to insurers, medical networks and repricing companies. In slick marketing to these organizations, many software dealers tout the millions of dollars which can be saved by implementing new Claims Checking software. One such company recently announced that its new claims auditing software typically reduces claims processing costs by 15 percent by using “Sophisticated Coding Logic.”

Sophisticated coding logical means one thing to providers – less reimbursement. Such constant changes in reimbursement leave providers feeling in the dark regarding what their services are worth on any given day. However, providers should not feel compelled to accept any level of payment just because “Sophisticated Coding Logic” was used. Here are some steps you can take to protect your practice from incorrect claims auditing.

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## The Appeal

### Laying the Groundwork

1. Insurance verifiers should be trained to not just seek confirmation of coverage but to also request a quote regarding the anticipated reimbursement for the planned procedure. Request that an approximate reimbursement amount be supplied for the codes you intend to bill with and that specific information be supplied in writing about any applicable reductions which might be taken on the claim. While many insurers may not be able to provide a quote, their failure to advise you prior to treatment of the anticipated reimbursement can be decisive in any legal action which might ensue. Some states have passed strict disclosure laws which requires insurers to respond to such requests and their inability to do so may be in your favor.
2. Identify your top payer partners and find out what data they use to establish the fee schedule or to calculate usual and customary rates. If many of them are using the same data and arriving at different payment levels, this is a clear signal that the lower paying payers may be interpreting the data incorrectly.
3. Determine if most of your benefit reductions are based on managed care fee schedules, usual and customary reductions, downcoding or auditing issues. If you are particularly hard hit by fee schedule and usual and customary reductions, you may want to purchase a health industry fee analyzer so that you can review your charge amounts with an independent source. This information can also be used in

contract negotiations and appeals as an independent source of the typical billing rates for your region.

## Writing a Benefit Reduction Appeal

1. If a quote was requested at the time of verification but not provided by the carrier, take the position that proper disclosure was not made to you or the patient. Cite ERISA or state disclosure laws, whichever is applicable, to support your position that carriers must be able to provide detailed information about reimbursement prior to treatment.
2. Provide reimbursement statistics on what you believe the average reimbursement for a given procedure is. Attempt to challenge the inclusion of providers who offer a different level of service than what you provide or for providers who are not within your immediate geographical area.
3. Take the position that contract discounts are only available to prompt payers. If the payment was received beyond the contractually agreed upon deadline, maintain that this failure to promptly pay nullifies the contract and makes them liable for full-billed charges. Some medical providers have been able to successfully negotiate contract terms that state that payers forfeit applicable discounts if they do not pay within the contractually agreed timeframe.
4. Demand Documentation: Every appeal letter sent from your office should request payment of the claim. Every appeal letter should also state that if the denial is upheld, certain documentation should be presented to your office to substantiate the denial. On an incorrect payment, ask the carrier to supply a copy of the fee schedule or other data used to determine the payment level. Many insurers balk at providing hard copies of the data used to determine the payment levels. However, some state and federal disclosure laws appear to support the providers' right to review the actual data used to determine payment levels. As follows is a Department of Labor Advisory Opinion interpreting whether ERISA requires plan administrators to provide evidence of the basis for usual and customary charges. This letter states that ERISA does require plan administrators to provide, upon written request, certain documents that specifies procedures, formulas, methodologies, or schedules to be applied in determining or calculating a participant's or beneficiary's benefits. This would be a good enclosure to include with any appeal of usual and customary reductions taken on a claim filed with an employee benefits plan.

## U.S. Department of Labor Advisory Opinion 96-14A

July 31, 1996

Frederick W. Dennerline III, Esq.  
Fillenwarth, Dennerline, Groth & Towe  
1213 N. Arlington Avenue, Suite 204  
Indianapolis, Indiana 46219

96-14A  
ERISA SEC.  
104(b)

Dear Mr. Dennerline:

This is in response to your request for an advisory opinion concerning the scope of section 104(b)(2) and 104(b)(4) of the Employee Retirement Income Security Act of 1974 (ERISA). Specifically, you have inquired whether the schedule of "usual and customary" fees, which is used as a basis for determining the dollar amount that will be paid for health claims made under a welfare benefit plan, must be made available for examination and/or furnished by the plan administrator upon the request of a plan participant or beneficiary.

You represent the Oil, Chemical and Atomic Workers Local Union No. 7-159, whose members are employed by the Kokomo Gas & Fuel Company (the Company). The Company maintains the Kokomo Gas & Fuel Company Health Plan (the Plan). The Plan is a welfare benefit plan and, in many instances, provides for the reimbursement of the full cost of medical care incurred by the employee-participants, based on a "usual and customary" fee.

The Plan document, however, does not include the schedule of "usual and customary" fees. In response to questions concerning the basis for the "usual and customary" charge allowed for certain procedures, participants and beneficiaries have been advised that the information from which the determination of the "usual and customary" fee is derived is proprietary and not disclosable to them. You represent that several participants in the Plan believe that, in order for them to be fully cognizant of their benefit entitlement, they are entitled to disclosure of all of the "usual and customary" recitations set forth in any document which the plan administrator may use to calculate the payment of benefits.

Section 104(b)(2) of ERISA requires that the administrator shall make copies of the plan description, the latest annual report, bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated available for examination by any plan participant or beneficiary. Section 104(b)(4) requires the furnishing of such documents to participants and beneficiaries upon written request, although plan administrators may impose a reasonable charge to cover the cost of providing these documents.<sup>1</sup>

## **DOL Advisory Continued...**

The legislative history of ERISA suggests that plan participants and beneficiaries should have access to documents that directly affect their benefit entitlements under an employee benefit plan.<sup>2</sup> Consistent with this Congressional intent, it is the view of the Department of Labor that, for purposes of section 104(b)(2) and 104(b)(4), any document or instrument that specifies procedures, formulas, methodologies, or schedules to be applied in determining or calculating a participant's or beneficiary's benefit entitlement under an employee benefit plan would constitute an instrument under which the plan is established or operated, regardless of whether such information is contained in a document designated as the "plan document." Accordingly, studies, schedules or similar documents that contain information and data, such as information and data relating to standard charges for specific medical or surgical procedures, that, in turn, serve as the basis for determining or calculating a participant's or beneficiary's benefit entitlements under an employee benefit plan would constitute "instruments under which the plan is . . . operated." Thus, it appears that the schedule of "usual and customary" fees described in your letter would be required to be disclosed to participants and beneficiaries in accordance with section 104(b)(2) and 104(b)(4) of ERISA.

This letter constitutes an advisory opinion under [ERISA Procedure 76-1](#). Accordingly, this letter is issued subject to the provisions of that procedure, including section 10 thereof, relating to the effect of advisory opinions.

Sincerely,  
JOHN J. CANARY  
Chief, Division of Reporting and Disclosure  
Office of Regulations and Interpretations

<sup>1</sup> Pursuant to 29 C.F.R. § 2520.104b-30, the charge assessed by the plan administrator to cover the costs of furnishing documents is reasonable if it is equal to the actual cost per page for the least expensive means of acceptable reproduction, but in no event may such charge exceed 25 cents per page. No other charge for furnishing documents, such as handling or postage charges, is considered reasonable.

<sup>2</sup> See H.R. Rep. No. 533, 93d Cong. 1st Sess. 10-11 (1973), and S. Rep. No. 127, 93d Cong., 1st Sess. 27-28 (1973).

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## Sample Benefit Reduction 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,

We are in receipt of the benefit payment for the above referenced claim. It is our understanding that benefits were significantly reduced due to your determination that the billed charges are more than the usual and customary rate for certain procedures or items.

We do not believe the reduction is justified. As you are likely aware, such provider reimbursement rates are typically adjusted based on the usual and customary treatment charges for that specialty and the geographical region where treatment was provided. Further, many state and federal disclosure laws require insurers and administrators to advise beneficiaries and providers as to how the reimbursement rate is determined. However, the payment rendered does not appear to be comparable to rates charged for this service locally and no information has been given to support your position that the denial is correct.

Based on this information, we request that the reductions be reversed and an additional payment be made. If your company does not release additional benefits, please submit the applicable policy language which justifies the reduction as well as the data used to establish the reimbursement rate so that we may determine your company's and the patient's liability in regards to the unpaid balance.

We appreciate your prompt attention to this matter.

Sincerely,

Patient Accounts Manager

### **Tip: Cite Contract Language in Managed Care Appeals**

Many managed care contracts state that reimbursement levels will be reviewed on a certain schedule, often yearly. Review your contract to see if there is such a stipulation and cite this clause in your incorrect payment appeals. Ask that the MCO provide the exact date when the reimbursement for the codes in questions were reviewed and what factors were considered so that you can determine compliance with their contractual obligations.

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## **Training Notes**

1. **Examine benefit reduction denials data by payer.** If most of your incorrect or poor payments are from one carrier, this may indicate that this carrier has implemented a much more aggressive claims auditing system. Schedule a meeting with the carrier representative to discuss reimbursement issues to see if a resolution can be reached. Collect independent reimbursement data to support your effort to negotiate higher fees. Stay in close and constant contact with colleagues, through professional organizations and local networking, to see if they are experiencing similar reimbursement issues with the carrier in question.
2. **Examine benefit reductions by code.** Some treatments simply do not pay enough to cover the time and supplies utilized. You may not be able to completely avoid such codes but you should be aware of what they are and train care givers or medical staff on the best setting for extending such services, what alternative treatments should be considered for these procedures and under what circumstances such services can be avoided.
3. **Include a certified coder as part of the denial management team.** A certified coder should be reviewing the use of modifiers and bundled codes to ensure correct and optimum reimbursement. A certified coder may also be able to appeal denials with more information regarding Medicare's Correct Coding Initiative and recent coding changes which affect reimbursement.
4. **Use technology to your benefit.** Just as insurers use technology to audit claims, software is available to help providers identify incorrectly paid claims. Such systems allow you to enter in your anticipated payment amounts for codes. When payments are posted, the software compares payment amounts with contract information you have entered and generates reports on underpaid claims.

# Lack of Timely Filing

Insurers have become increasingly tough in enforcing timely filing limitations. Also, many states have passed specific regulations requiring medical claims to be filed in a certain time frame. However, such laws, depending on how they are worded, may or may not take precedence over your managed care contract stipulations.

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## The Appeal

### Laying the Groundwork

1. Data accuracy – The accuracy of the insurance carrier database is paramount to getting paid timely. An error report should be reviewed daily or at least weekly by management to ensure that all information is correct and to spot problems.
2. Communications from your payer partners should be carefully reviewed for any changes in filing information. Personnel responsible for credentialing should be in regular contact with business office management to ensure that any information received from the carrier is updated into the billing system.
3. Follow-up. Telephone follow up is a critical, yet time consuming, component of accounts receivable management. However, claims which are approaching 45-90 days with no payment should be followed-up on by phone or e-mail. Many carriers will allow you to fax a claim to them if the claim is not showing up on the system.

### Appeal Options

1. Many claims denied for timely filing were filed promptly but were lost on route and did not make it into the carrier payment system. Such claims should always be appealed with proof of the initial filing date. Electronic billing and clearinghouse reports can be used to substantiate the original date of billing. When submitting such information, highlight the pertinent information so that the appeals reviewer can easily match the confirmation with the patient in question. Be sure to explain any codes or account notations which might not be apparent to the reviewer.
2. If a delay was caused by a coordination of benefits question, appeal with a copy of the explanation of benefits from the other carrier with whom the claim was filed. If the delay was related to a carrier's change in address, appeal with proof that the claim was filed with an old address. Some states may also have insurance

regulations regarding timely filing of claims. For example, The Texas Clean Claims Act requires payors to inform and update providers regarding claims payment addresses, telephone contact numbers, delegated claims processors and similar information 60 days prior to any change. If notice is not provided as required, the insurer is prohibited from barring payment for lack of timely filing.

3. Many carriers will attempt to enforce a timely filing limitation on out-of-network care. However, if a contract is not in place between you and the carrier, you may have even better grounds for an appeal. According to *Insurance Coverage Litigation* by Anderson, Stanzer, Masters and Rodriquez, there has been a shift in insurance legal court decisions toward requiring insurance carriers to prove it was prejudiced by the policyholder's delay or failure to provide notice in order for the carrier to deny liability.

Your appeal letter should raise the question of whether the insurer was prejudiced by the late filing. In *Insurance Coverage Litigation*, the authors state that most court cases applying the modern rule have recognized that the purpose of notice provisions are to give the carrier an opportunity to investigate the claim, prepare for an adequate defense and to protect against fraud. If the carrier can still fully perform these routine claim processing and risk management functions, it may not be able to prove it was prejudiced in court and may be liable for coverage.

4. Demand Documentation. Since the burden of proof is on the carrier to show prejudice, you may want to write your appeal as a demand for them to explain how the company was prejudiced by the late filing of the claim. Ask that the carrier legal department review the matter and provide a written explanation as to the prejudice done to them by the late filing. Further, point out that the complete medical record is available to them and contains all the necessary information to correctly process the claim.
5. For MCO's with which you participate, request confirmation of the exact date they received the claim and what their claims backlog was at that time. Also, if there was a recent change in processing address, ask that a copy of the notice and the date the notice was mailed to you be confirmed in writing so that you can verify that sufficient advance notice was given your organization.

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## Sample Lack of Timely Filing 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,

This letter is to request immediate payment of the above referenced claim. According to your representative, this claim was not processed due to failure to meet the applicable timely claim filing requirement.

Our records indicate the claim was filed timely. Attached is documentation to establish the initial date of filing. Your lack of receipt may be due to a change of address, electronic transmission failure or other internal issue. However, it is our position that we have met our timely filing obligation.

Further, insurance-related court decisions indicate that an 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. Prejudice is a legal term used to describe conditions where one party is at a disadvantage in asserting and establishing a claimed right or defense. According to Ostrager & Newman's *Handbook on Insurance Coverage Disputes* (9th Edition), several cases have ruled that an insurer may be prejudiced by its inability to contemporaneously investigate the claim, interview witnesses or make an early settlement of the claim.

It is our position that your company was not prejudiced by late filing. Therefore, we appreciate your prompt processing of this claim. If payment is not released, please provide the exact date the claim was entered on your system, an estimate of the claims backlog which your company experienced at that date as well as your written response to our enclosed proof of timely filing.

Sincerely,

Patient Accounts Manager

### **Tip: Cite Contract Language in Managed Care Appeals**

Managed care contract wording on timely filing of claims varies from contract to contract. Some clauses state that the medical provider should use “his or her best efforts to submit all claims” within a certain time frame.

If the delay was caused by an identifiable factor, such as a change in billing software or vendor, explain the contributing issues as well as your attempts to file late claims as soon as they were detected.

Additionally, if the timely filing wording does not appear to be an iron-clad requirement, cite the terms and argue that your office made an effort to comply with the agreement and should not be penalized for a one-time technology or staffing problem.

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## **Training Notes**

1. **Examine Lack of Timely Filing Denials by Payer** – If most of your lack of timely payments are from one carrier, this may indicate a problem with that carrier’s claim data entry. It may also indicate that this carrier has more stringent requirements for what they consider to be a clean claim. Many states have recently enacted prompt payment laws and, as a part of that process, some states have stipulated what constitutes a clean claim. Know the clean claim filing requirements so that these elements can be reviewed frequently with the billing staff.
2. **Track Claim Returns** – The Health Insurance Association of America reports that a quarter of all claims are rejected because they are not clean. And MedUnite, an electronic claims-processing joint venture by seven large health plans, including Aetna, Anthem and Cigna, claims that 50% of claims contain mistakes. While claims can be sent back for other reasons, such as uncovered services, nearly 80% of delayed payments at United Healthcare lack “one of the basic pieces of data” on the billing form, according to an article in American Medical News. See “Clean Claim” rules defang state prompt-payment laws” by Leigh Page. December 4, 2000.

If most of your claim returns are from a single carrier, that may indicate that the carrier has more stringent requirements for what they consider to be a clean claim. Many states have enacted prompt payment laws which include a definition of clean claim. You should be familiar with clean claim definitions for your state

and Medicare and cite such definitions if it appears the carrier is requiring more information than is necessary to process the claim.

Examine Lack of Timely Filing Denials by Payer – If most of your lack of timely filing denials are from one carrier, this may indicate a problem with the carrier’s data entry. You may want to send such claims by certified mail to the attention of the claims director. A prompt follow-up program should also be initiated for those carriers who do not appear to have good data entry records.

The following states have enacted a clean claim definition:

- Alabama
- Arizona
- Colorado
- Florida
- Kansas
- Kentucky
- Minnesota
- New Jersey
- New Mexico
- Pennsylvania
- Tennessee
- Texas
- Virginia
- West Virginia

*Note: Many states which do not define “clean claim” still require the insurance processor to notify the provider of any deficiency in a claim within a certain timeframe. You should cite this mandate if you suspect that the original claim was not processed due to lack of or incorrect information and you were not notified of the need for additional information.*



# Preexisting Conditions

Many medical providers do not appeal preexisting condition denials. Often, however, the medical provider is in the best position to discuss the pathology of the patient's illness. With many illnesses, establishing the date of the onset of the illness can be problematic. The patient may have had symptoms of the illness but did not receive a diagnosis until after the insurance became effective. Also, the patient may have received treatment prior to the effective date for an unknown illness. These details should be reviewed for any potential appeal based on medical facts.

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## The Appeal

### Laying the Groundwork

1. Make it part of your verification policy to ask the carrier if the patient is still within the time frame for preexisting investigations and how the preexisting exclusion reads. This will alert you to the possibility of a preexisting denial.
2. Review State and HIPAA laws regarding denials of preexisting treatment so that you will be able to spot questionable denials and review them for compliance.

### Appeal Options

1. If not obtained during verification, request in writing the policy or plan definition regarding preexisting. The major difference in most preexisting definitions is that some exclude any condition which existed prior to the effective date of coverage while others state that the condition must be diagnosed prior to the effective date for coverage to be denied.
2. Determine if treatment was diagnosed prior to the effective date and if the diagnosis prior to the effective date matches the one currently being treated. If the treatment prior to the effective date was for an unknown condition, make sure to appeal the denial on this basis. There are many court decisions in the patient's favor against a carrier's efforts to apply the preexisting exclusion when the patient merely had symptoms prior to the effective date and not a firm diagnosis.
3. Demand documentation. Ask for written description of the records obtained by the carrier to prove that the condition existed prior to the effective date. Also, ask if the carrier has investigated whether the policyholder had prior coverage that might affect the enforcement of the preexisting terms.

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## Sample Preexisting Condition 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,

It is our understanding that this claim was denied as a preexisting condition.

The explanation of benefits did not give adequate information to establish the accuracy of this decision. Therefore, please provide the following information to support the denial of benefits for this treatment.

Please furnish the name of the medical providers which treated the patient for this condition prior to the policy effective date and the specific date on which treatment occurred. Also, please provide a copy of the pre-existing exclusion as it reads in the patient's policy or plan description.

Further, we would appreciate any information from your files as to whether this patient had previous insurance coverage and the potential applicability of the Health Insurance Portability and Accountability Act.

Thank you for your assistance.

Sincerely,

Patient Accounts Manager

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## Training Notes

Different practices have a different level of pre-existing denials. For example, treatment providers who file a higher number of claims under the mental/nervous benefits often have a higher rate of denials due to pre-existing. If you have very few pre-existing denials, it is often tempting to leave these types of denials for the patient to appeal. However, make it a point to at least review the history and physical for any patient with a pre-existing denial. This information should give you a hint to whether you have the basis for appeal. Also, do not ignore the opportunity to appeal just because the patient has retained an attorney. It is often helpful for that attorney to have a copy of your written appeal that explains the medical history as taken by your office. Also, your appeal will get your office's opinion into the record in case the attorney does not obtain depositions or is not able to get the depositions entered into evidence.



# Medical Necessity

Medical necessity denials are the ultimate thorn in the side of most medical providers. It is the issue that most vividly reveals the different goals of the medical provider and the insurance company. Practicing medicine is still about healing and easing pain. Insurance is still about profitability. Neither side is anxious to sacrifice its goals to the other. Most medical providers also see a medical necessity denial as very damaging to the patient-provider relationship. However, being aggressive in appealing a medical necessity denial will reaffirm to patients that the medical provider is their advocate acting in their best interest.

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## The Appeal

### Laying the Groundwork

1. Establish a proactive precertification procedure. State and federal law specifies the time frames for responding to requests for precertification. Demand a response within those deadlines through follow-up phone calls and faxes to the case management departments.
2. Demand a review by a reviewer with similar credentials as the treatment provider who is recommending the treatment. Ask that treatment provider to schedule time to speak personally with their peer in case management regarding the proposed treatment. Doctors are much more willing to take the time for a phone conference if they are aware they will be discussing the medical issues with a colleague and not a bureaucratic reviewer.
3. Get the exact medical necessity definition, specific medical guidelines used in the decision and the name and credentials of the final reviewer of any denied care.

### Appeal Options

1. Cite specific medical information which leads to the decision on the treatment course, taking care to discuss factors the case management department may have overlooked, such as less invasive measures already taken, drug interactions and home environment. Cite medical guidelines, such as Milliman & Roberts Care Guidelines, to support the decisions involved. Milliman & Roberts Care Guidelines compile best practices drawn from medical literature, practice observation and expert medical opinions and can be purchased for different treatment settings.

2. Request a review by a medical professional with the same training as the one who made the decision. Check for state licensing of the reviewer. Review for compliance with legal and contractual utilization review requirements. Some laws require an adverse determination to be made by a medical provider licensed in the state.
3. If you believe certain medical records were ignored, argue that they have insufficient medical records to prove the case. Often the failure of a previous treatment course is a key component in the treating physician's decision to pursue a more aggressive treatment. Make sure the reviewers are aware and have secured the medical records for the previous treatment so they have a complete picture of the patient's medical condition.
4. Seek an independent review of the denial. A majority of the states now have a system for seeking an independent review of a medical necessity denial. In some states, the patient must file this request. Keep several forms on hand in your office for the patient to complete. That way, you can ensure that the request is mailed timely with complete medical records.
5. Demand Documentation – Request a complete description of the medical opinions the reviewer secured to support its position so that you may review the information for applicability to the patient's unique medical condition. Also, demand a copy of the definition of medical necessity as it appears in the policy or employee benefit plan description.

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## Legal Highlight

### **Carriers Expect Results, but the Medical Necessity Definition May Not Require Them**

Cost containment has lead insurers to increasingly ask for not only a treatment plan but a treatment plan with a good conclusion. However, providers who treat patients with progressive illnesses often are unable to assure case management of a healthy outcome.

In the early 1990's, a multiple sclerosis sufferer began a course of physical therapy and home health care which would ultimately be denied by her insurance carrier, Prudential. Prudential denied about \$47,000 in claims under a general exclusion of unnecessary services or supplies. The company's medical director who reviewed the case stated that the claim denial was correct partly because "physical therapy does not affect the course of MS."

The medical team treating the patient argued that the physical therapy had helped arrest the disease progression. The patient's attorney also successfully argued that improvement was not a criterion under the plan document in question. The plan document defined medical necessity as a service or supply which was (a) ordered by a doctor; (b) recognized as safe and effective, is required for the diagnosis or treatment of the particular sickness or injury and is employed appropriately in a manner and setting consistent with generally accepted U.S. medical standards, and (c) is neither educational nor experimental or investigational in nature.

"Part of the problem with the denial is that if you looked at the plan document's definition of medical necessity, it did not have the requirement of significant improvement. They just had an internal office memo referring to that. The court said it does not govern," said Glen Mullins, the Oklahoma City, OK, attorney who represented the patient.

Mr. Mullins indicated that he compiled about 25 peer reviewed medical articles regarding the medical necessity of physical therapy for multiple sclerosis patients. He also stated that the treating physician's deposition regarding the necessity of care was instrumental in the case. However, Mr. Mullins said the case was unusual in that he was able to get all the documentation he compiled admitted as evidence in the case.

Often, Mr. Mullins said, such lawsuits come down to an administrative law judge reviewing only the records on file at the time the lawsuit is filed. That often includes the medical records as obtained by the insurance carrier but often does not include a description narrative where a more detailed justification for treatment is outlined.

"It is impossible to prevail in a lawsuit if you don't have the evidence on records before the final decision. Sometimes you know what the doctor ordered X but not the reason for X. You need a detailed narrative," he said.

In this situation, the need for care was well documented by the physician. Further during the deposition, the doctors were able to expand on the medical issues and one analogized the use of physical therapy in the MS setting to treating malignancies with chemotherapy. He observed that many people suffering from certain incurable cancers are routinely given chemotherapy, a treatment which in some instances, makes the patient worse and often has no effect on the progress of the disease at all. No one, he offered, would characterize chemotherapy as not medically necessary.

Although the medical necessity appeal may be ultimately unsuccessful, Mullins encourages medical providers to consider the potential long-term benefits to filing an appeal with a detailed letter of medical necessity. Even if the appeal is unsuccessful, submitting an appeal will ensure that, if the case goes to trial, the court will have this additional piece of medical information to consider. Mullins also recommends attaching a curriculum vitae or resume to letters of medical necessity to establish the provider's authority on the subject.

Any information reviewed by the insurance carrier during the appeals process typically becomes part of the claim records and will likely be reviewed by the court if a lawsuit ensues. After reviewing the medical literature and Prudential's claim file, the Oklahoma Supreme Court overturned the lower court ruling in favor of Prudential.

“Our odyssey through this record makes clear Prudential never evaluated Ms. McGraw's individual case but rubber stamped the “nature of her condition and denied each subsequent claim arising from her MS,” the court finding states.

*Legal Cite: McGraw v. Prudential Insurance Company of America  
U.S. Court of Appeals for the 10<sup>th</sup> Circuit, No. CIV-95-1076-T  
From the U.S. District Court for the Western District of Oklahoma*

### **Appealing ERISA Claims Involving Urgent Care**

In January 2002, the Department of Labor enacted new regulations for responding to claims for urgent care. ERISA group health plans must initially decide urgent care claims within 72 hours after receipt of the claim. Further, the treating physician is given the authority to determine what is an “urgent” claim or not and plans must treat as urgent those requests that are so indicated by the treating provider.

Notification of a decision on an ERISA group health claim can be orally. However, a written or electronic notice of the decision must follow the oral notice within three days of the oral notice. The group health plan must also notify an urgent care provider if there is insufficient information for a decision. Notice must be made not later than 24 hours after receipt of the claim and must indicate the specific information needed to review. Providers are allowed a minimum of 48 hours to provide the requested information.

For more complete information about recent changes in ERISA claims processing procedures go to <http://www.dol.gov/dol/pwba/> and click on frequently asked questions.

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## Sample Medical Necessity 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,

It is our understanding that this claim was denied pursuant to your decision that the care was not medically necessary. The explanation of benefits did not give adequate information to establish the accuracy of this decision. Therefore, please provide the following information to support the denial of benefits for this treatment.

Please furnish the name and credentials of the medical professional who reviewed the treatment records. This information is necessary to determine if the medical professional maintains a medical license for this state. Also, please provide an outline of the specific records reviewed and a description of any records that would be necessary in order to approve the treatment.

Further, we would appreciate copies of any expert medical opinions which have been secured by your company in regards to treatment of this nature and its efficacy so that the treating physician may respond to its applicability to this patient's condition.

Thank you for your assistance.

Sincerely,

Patient Accounts Manager

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## Training Notes

1. Examine denials by Physician and Code – Reviewing denials by physician and code is the surest method of detecting over utilization of a specific code or procedure. As discussed previously, your office may not be able to entirely avoid problematic codes. However, utilization of codes should be fairly consistent among treatment providers offering similar medical services. Aberrations from the standard should be accounted for by clear documentation in the medical records. Ongoing training in the need for accurate, detailed medical records is a must in today’s medical reimbursement environment. Medical record templates should contain reminders to medical providers regarding critical information which must be completed. Incomplete records should be brought to the attention of the provider.
2. One of the primary reasons cited by providers as the reason for incomplete records is the amount of time it takes to complete medical charts. If incomplete records are a persistent problem for your office, investigate whether electronic medical records would be a good investment for your organization. Even if you do not decide to purchase electronic medical records software, the templates used in such systems may help you to better design you own medical record templates.
3. Finally, determine if your medical necessity denials tend to be more related to length of treatment issues or one-time procedure denials. Length of treatment denials may indicate that your precertification staff is more concentrated on getting initial approval to begin treatment and not supplying ongoing medical information to justify continued treatment. Also, the precertification staff should be very familiar with your state’s direct access and standing referral laws as they may be applicable to certain length of treatment denials.

# 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.

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## 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. Demand Documentation. 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.

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## 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 BCBS 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 11<sup>th</sup> 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 11<sup>th</sup> Circuit, No. 01-1037  
Docket No. 99-01748-CV-N-S  
Appeal For US District Court for the Northern District of AL

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## 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](http://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.

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## 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

# Treatment Exclusion/Limitation

Treatment exclusions and limitation must be clearly outlined in the insurance policy or employee benefit plan description. The exclusion or limitation must also be unambiguous and many health benefits lawsuits involving plan exclusions and limitations seek to prevail based on the ambiguity of the limiting language or the insurer's or plan administrator's failure to consistently apply the limitation.

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## The Appeal

### Laying the Groundwork

1. Many state and ERISA laws appear to indicate that limitations and exclusions must be disclosed prior to treatment, if requested by the beneficiary. It is especially important that an inquiry be made to the carrier regarding upcoming treatment which may have an applicable exclusion or limitation. Specifically, ask the insurance carrier to explain the exclusion or limitation in writing to allow you to better understand the benefits available. A carrier's failure to properly disclose the limitation or exclusion may affect its ability to enforce the clause if the benefit denial ends up in court.

### Appeal Options

1. If the denial is based on medical judgement, as with experimental treatment exclusions, find out the medical credentials of the reviewer. Provide information regarding the treating physician's credentials and past success with the treatment in question as well as peer-reviewed medical literature supporting the efficacy of the treatment.
2. If the denial is based on the diagnosis, make sure that the diagnosis fits the description of the exclusion. For example, some policies may strictly exclude or limit mental nervous treatment. However, some diagnoses are of an organic nature and may not fall under the mental nervous limitation. Some policies name the specific diagnoses that fall under the mental/nervous definition. If mental nervous is not defined by the policy or plan description, you may have an argument that the clause is ambiguous and that the diagnosis you are treating is medical in nature. Also, many mental/nervous treatments begin with a medical treatment period, such as detoxification or emergency treatment of injuries sustained in a psychotic episode, and should be covered under the medical benefits.

3. If the diagnosis is based on an exclusion for criminal activity, make sure the patient was convicted of the alleged crime. Also, domestic abuse, which was once commonly excluded by most policies, is now a mandated coverage in many states.
4. Demand Documentation. Request a copy of the policy or plan exclusion or limitation and look for an ambiguity in the wording. Court cases consistently require insurance policies and plan descriptions to clearly and in plan language explain any exclusions or limitations to coverage. The courts recognize that the policy or plan language is written by the insurance company or employer and terms are not negotiable. Therefore, any ambiguity or contradictory language is interpreted to the policyholder's benefit.

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## Legal Highlight

### **Medical Necessity Wording May Take Precedence Over Policy Exclusions**

In October, 1997, the patient in this case began suffering neck, back and headache pain. Her primary care physician recommended bilateral breast reduction. Prior to treatment, she requested a precertification. Precertification was denied based on the fact that the procedure was not a covered benefit based on the following exclusion:

Exclusions or Limitations: We will not pay for:...(q) cosmetic or reconstructive surgery (or any treatment resulting therefrom) ... and (tt) breast augmentation or reduction not associated with cancer of the breast.

However, the policy also stated medically necessary services are covered. A medically necessary service or supply was defined as one which is ordered or authorized by the Primary Care Physician, and which the Primary Care Physician, our medical staff or our Medical Director and/or a qualified party or entity selected by us determines is: provided for the diagnosis or direct treatment of an injury or sickness; (b) appropriate and consistent with the symptoms and findings or diagnosis and treatment of the member's injury or sickness; (c) provided in accord with generally accepted medical practice on a national basis; and (d) the most appropriate supply or level of service which can be provided on a cost-effective basis (including but not limited to, inpatient vs. outpatient care, electric vs. manual wheelchair, surgical vs. medical or other types of care). The fact that the member's physician prescribes services or supplies does not automatically mean such services or supplies are medically necessary and covered by the contract.

In reviewing the matter, the insurance carrier submitted information that one to two cases per week were denied by their precertification department due to the exclusion referenced in this denial. However, the insurance carrier also testified that three requests for breast augmentation had been granted in situations which did not involve cancerous patients. Therefore, the court found that the carrier went beyond a simple cancer review before denying benefits and found that medical necessity was the most likely consideration when such requests were reviewed.

The insurer was not able to establish how many of the past denials were “medically necessary” and how many were simply for cosmetic surgery unrelated to cancer. Because they were not able to demonstrate that the limitation was consistently applied against patients who sought medically necessary treatment for non-cancerous diagnoses, the court found in the favor of the patient and awarded medical benefits.

**Legal Cite:** *Milone vs Exclusive Healthcare, Inc.*

United States Court of Appeals for the 8<sup>th</sup> Circuit, No. 00-1445/1934

Appeal From US District Court for the District of NE

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## Sample Treatment Exclusion/Limitation 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,

It is our understanding that this claim was denied pursuant to a treatment exclusion or limitation in the policy.

The explanation of benefits did not give adequate information to establish the accuracy of this decision. Therefore, please provide the following information to support the denial of benefits for the claim referenced above.

Please furnish a copy of the exclusion or limitation as it reads in the policy or plan booklet. Also, please provide a copy of any definitions related to the exclusion/limitation as specified in the policy or plan booklet. We would also appreciate a description of any documentation gathered by your company to substantiate that the patient's illness or injury meets the policy definition.

Thank you for your assistance.

Sincerely,

Patient Accounts Manager

# Maximum Benefits Reached

Due to the costly nature of medical treatment, providers often find that their sickest patients may run out of insurance benefits. Although the patients are responsible for payment of medical treatment after coverage has been exhausted, such patients often have exhausted personal resources as well during their sicknesses. Before writing off such accounts, you still want to ensure that benefits have been correctly applied.

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## The Appeal

### Laying the Groundwork

Compare the benefits provided with the level quoted during verification of benefits to ensure that there has not been a change in the benefits levels. Secure a copy of the policy or plan description to see if the maximum benefit levels were clearly explained to the patient.

### Appeal Options

1. Many states have passed mandatory coverage laws which require a minimal level of benefits be provided for specific conditions. The most frequent example is mental parity laws which require insurers to offer the same level of benefits for mental illness as is available for physical illness. Know your mandatory coverage laws so you can cite these laws in your appeals.
2. Demand documentation - Ask that the claim history be audited for accuracy and that you be provided with the specific treatment providers to whom benefits were paid. This information should also reference the dates and diagnoses related to the exhausted benefits. If the maximum benefits allow a prescribed number of dates of treatment, you want to ensure that the carrier is not counting each different provider rather than the number of days. Also, you want to confirm that all the treatment was related to the diagnosis in question.

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# Sample Maximum Benefits Exhausted 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,

It is our understanding that the above referenced claim was partially denied due to the fact that the maximum benefits were reached for this illness.

According to the verification of benefits obtained at the time treatment was initiated, your plan provides 30 days of treatment for inpatient treatment for this diagnosis. The plan also allows 30 visits for outpatient services.

Please be advised, it appears that we were among the earliest treatment providers for this condition. Therefore, it would appear that benefits would likely be available for this patient for this time period. Therefore, we again request the names, dates and amounts paid to previous medical providers for treatment of this and related illnesses so that we may confirm that plan benefits have been exhausted.

We appreciate your prompt attention to this matter.

Sincerely,

Patient Accounts Manager

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## Training Notes

1. Insurance verification is your first line of defense in managing denials related to maximum benefits exhausted. While knowledge that the benefits have almost been exhausted may not change the treatment course, it will allow you to refer the patient to assistance programs for which he or she may qualify and may also alert you to the need to file promptly with a secondary carrier.
2. Verifiers should be trained to seek information about policy maximums and specify whether they are dollar amount or number of visit maximums. Again, understanding the importance of such information will go a long way in getting verifiers to secure such detail. Provide ongoing training to them to demonstrate how the verifications they perform help to ensure payment. Also, provide ongoing training on how the information they obtain is utilized in appeals.



# Subrogation/Coordination of Benefits

The U.S. Supreme Court recently ruled against an insurance carrier's attempt to enforce subrogation rights against a patient's liability settlement. The decision (*Great West Annuity Insurance Company v Knudson, Jan 2002*) may force health insurers into a quandary on whether to pay, deny or indefinitely stall the release of medical benefits on injury-related claims.

Medical office's must carefully monitor injury-related medical claims to insure that they do not sit for months in the insurance carrier's "pending" Subrogation/Coordination Inquiry black hole. Such inquiries often result in an even longer wait for reimbursement on the most costly types of treatment.

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## The Appeal

### Laying the Groundwork

1. Injury-related claims should be clearly identified for insurance verifiers so they will know to not only seek information from the medical carrier, but also any potential liability or auto policy carrier.
2. Pediatric claims are increasingly pending due to coordination of benefits. Ensure that verifiers are trained to verify both parents insurance information in an effort to determine the primary coverage.

### Appeal Options

1. Don't wait for a denial on a claim which is pending in the system based on a subrogation/coordination inquiry. The sooner you begin putting pressure on the carriers to pay pursuant to applicable prompt payment laws, the sooner the carriers will make a decision on claims which are pending. Don't rebill the pending claim but instead, appeal using the applicable prompt payment regulation. Refer to the story below regarding why rebills are ineffective.
2. Demand documentation - Ask that the subrogation or coordination of benefits policy or plan language be provided to you for your review. Many subrogation clauses state that the insurance carrier's rights to subrogate the claim are only

effective after the medical claim payment has been made. Barron's Law Dictionary, Third Edition, by Steven H. Gifis, defines subrogation as

*“one's payment or assumption of an obligation for which another is primarily liable... Subrogation typically arises when an insurance company pays its insured pursuant to a policy; the company is then subrogated to the cause of action of its insured. Similarly, under worker's compensation acts the board is subrogated to the injured worker's right (up to the amount of the board's payments) to sue the responsible party.”*

3. If the medical claim has not been paid, the carrier does not have a right to subrogation. The entire concept hinges on whether payment has been released.

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## Case Study: Rebilling Pended Claims Versus Appealing

Rebilling unpaid claims at 60 to 90 days has long been a rule of thumb in medical receivables management. However, a California hospital has found a much more appealing method of handling aged claims that resulted in an immediate drop in aged accounts.

Presbyterian Intercommunity Hospital in Whittier, California, recently started appealing all unpaid claims at 70 days rather than sending a rebill or tracer on the claim. The process is simple. The hospital generates an appeal letter indicating that the claim was previously submitted. The letter goes on to cite California's prompt payment mandate requiring carriers to pay clean claims within 45 days. The appeal is mailed to the carrier's appeal department along with another copy of the claim.

The result has been an eight percent drop in the hospital's over ninety day accounts.

“We are finding that payers have a whole different mechanism in place for handling appeals than tracers. The tracer they treat like a brand new claim, which usually takes 45 to 60 days for a response. With an appeal, we get paid in eight to fourteen days,” said Sue Ponce, Administrative Director of Business Services for the 339-bed hospital.

Ponce said the hospital business office implemented the change shortly after bringing hospital rebilling back internally as a business office function. The hospital had been outsourcing low balance accounts and found that the vendor was primarily rebilling the claims. When they took over these duties, Ponce said her business office management team, Ana Sanchez, insurance supervisor and Dan Martinez, Manager of

Business Services, noticed the wide discrepancy in the response time carriers have for new claims versus appealed claims.

Appeals are typically directed to a different department with most carriers. Many state laws have separate statutes governing how appeals are processed. Such statutes often require the carrier to process and track appealed claims differently than new claims.

“We just sort of stumbled on to this. My business office wanted to try addressing a few of these claims as appeals rather than rebills. It worked and now we are appealing everything – underpayments, wrongful denials and tracers – with an appeal letter at 70 days,” Ponce said.

In Texas, the Health Maintenance Organization Act requires HMO’s to pay new claims within 45 days after receipt of the claim and documentation reasonably necessary for the HMO to process the claim. However, the act requires that an HMO acknowledge a complaint within five days within receipt of the complaint. The HMO then has 30 days to investigate and respond in writing. Alaska, Arizona, Maryland, Massachusetts and Utah are other states which have passed laws to specify the timeframes for certain types of appeal responses.

Often claims which remain unpaid and undenied at the 45-day prompt payment deadline are usually pended in the claims payer system. Claims can be pended for a number of reasons, including lack of medical necessity documentation, coordination of benefits reviews and eligibility issues. Therefore, a simple rebill of the same claim does not likely address the cause of the payment delay.

Ponce said the appeal form letters have been particularly effective on underpaid claims. Because the insurance carrier’s appeal personnel routinely deal with problematic claims rather than routine claims, appeal personnel may be more familiar with identifying incorrectly paid claims and, thus, can more easily reprocess such claims for the correct payment.

Implementation of such a change may require reexamination of staff organization and better communication between various departments, particularly between billing and clinical personnel. However, a five to ten percent decrease in accounts receivable is well worth the initial cost and the increase in customer satisfaction makes everyone’s job a little more meaningful.

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# Sample Subrogation/Coordination 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,

It is our understanding that this claim is pending due to your company's attempt to enforce your right to subrogation or coordination of benefits.

Please be advised, the claim is beyond the time frame allowable for prompt claims processing. We are unaware of other coverage for this claim. Please forward to this office any information you have regarding other coverage. Further, we would appreciate your company providing a copy of the applicable subrogation/coordination clause so that we may determine the liability of your company for this claim.

Thank you for your prompt attention to this matter.

Sincerely,

Patient Accounts Manager

## Training Notes

1. Many offices rely on patients to try to resolve subrogation/coordination issues with their respective payers. However, patients may be intimidated by the carriers and unfamiliar with their rights regarding payment. If you have to contact a patient regarding their coverage, make it a practice to encourage them to stay on the telephone for a conference call with the carrier. This way, all parties can share information and work together to make sure all necessary information is supplied and the claim moves forward.
2. If the patient has an attorney, do not be hesitant to ask the law office to supply information to the carrier necessary to get the claim paid.



# Appealing for Interest/Penalty Payments

Seeking interest and penalty fines is not just a financial benefit to your office but also a deterrent to payers that unfairly deny and delay claims. For this reason, it is important to take the time to seek any interest or penalty payment available to you for incorrectly denied and late payments.

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## The Appeal

### Laying the Groundwork

1. Some laws require interest payments to be automatically included with late payments. Payment posters should be familiar with such laws and be on the lookout for late payments which do not include interest. Also, appeal staff should always seek interest payments on claims denials which are ultimately overturned.
2. If you outsource accounts receivables at a certain date, discuss collection of interest payments with your vendors to ensure that they are assisting you collect interest payment on claims paid beyond the deadline.

### Appeal Options

1. Always cite your state's prompt payment act when seeking payment of interest claims. Both state departments of insurance and state medical associations have become much more active in monitoring which carriers are not in compliance with prompt payment regulations. Therefore, you might also establish a policy of reporting late payers to such agencies in an effort to place more pressure on carriers to pay timely.
2. Demand documentation - Ask the carrier to confirm in writing the date the claim was initially received and the date the claim was paid. Also ask them for a written explanation of the applicability of the interest or penalty fine as quoted in your appeal.

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## Training Notes

1. Address The Penalty for Payment Delays in Managed Care Contracts - Most states prompt payment laws have wording that indicate that state can pursue those carriers who routinely pay late or appear to have a general practice of paying beyond the deadline. Most regulatory bodies understand that it is the cumulative affect of a repeat offender which really hurts the medical community. Therefore, your contract should also contain language that indicates that carriers which routinely pay beyond the agreed upon deadline will face a monetary penalty. If you are unable to negotiate such strict terms, at least seek inclusion of wording that allows you to terminate a contract for the carrier's repeated failure to pay promptly.
2. Know the ERISA and State Prompt Payment Laws And Contract Wording - Once again, knowledge of the law is very pertinent to your staff's ability to collect interest and penalty payments. The better medical billing employees know the law, the more comfortable they will be in enforcing those rights when communicating with insurers. Ongoing education regarding legal changes and managed care contractual commitments will assist your staff in dealing confidently with these matters.

# Appealing Refund or Recoupment Requests

Many medical providers and billing companies are seeing a spike in the number of refund requests received on commercial insurance accounts. Most prevalent among these requests involve third parties which carriers retain to audit accounts for incorrect payments. Due to the increased use of such outside auditing companies, providers and billers need to have an internal policy for assessing whether the claim was paid correctly or not and a plan for responding to unsubstantiated requests for refunds.

Due to changes in federal and state claim processing law, medical providers have an increased responsibility to ensure the accuracy of the money received. However, if you believe the money is not due and owing due to the unique circumstances of the case, you are entitled to an appeal of such claims. “Basically, the carriers policy will indicate is it is due and owing. If the policy says if the physician has to do X, Y and Z and get paid, and that is what they physician did, then the benefits are due and owing,” said Andrew Wachler, of Wachler and Kopson, P.C. Wachler and Kopson, a Royal Oak, Michigan-based law firm, specialized in health care consulting. Wachler states that there are many refund situations where the providers might have a right to retain the requested funds. The most obvious, he states, are situations where there is a dispute over the extent or existence of coverage for the treatment.

“The provider may argue that there is not a policy exclusion or limitation regarding the treatment rendered, particularly if you precertified the treatment and relied on that precertification when making the treatment decision.”

Many court cases address the issue of insurers seeking funds paid the beneficiaries and third-party beneficiaries. The South Texas Law Review indicates that many courts have recognized the provider’s right to dispute a refund request. An article entitled, “The Retention of Insurance Overpayment by Health Care Providers,” states the following about this subject.

*“Overpayments or payments otherwise mistakenly made by an insurer may be retained by a health care provider who is innocent, acts in good faith without prior knowledge of the mistake, and makes no misrepresentation to the insurer, provided the amount retained relates only to the amount actually due for services rendered. Overpayments may also be retained despite knowledge by the health care provider of a potential dispute in coverage if the health care provider changes its position in reliance on continued payment. The continuation of health*

*care service in reliance on continued payments may constitute a sufficient change in position. Other principles may, on a case-by-case basis, justify retention of an overpayment - these principles would be in the nature of equitable estoppel, failure by the insurer to act earlier, absence of an unconscionable loss, absence of an unjust enrichment, and other rules developed under the law of restitution.”*

Some states have enacted legislation to limit the amount of time an insurer can take to detect overpayments. Arizona, Kentucky, Louisiana, Nebraska, Ohio, Oklahoma, Utah and Virginia all have time stipulations which may apply. Several other states also have limitations regarding retroactively rescinding a prior authorization which might also apply to the refund request.

Providers should not immediately refund requested benefits to the insurance carrier. Each refund request must be thoroughly researched to determine the accuracy of the payment in question. This may require seeking additional information from the carrier and patient regarding benefits. If you believe you are entitled to the payment, the following steps will help you appeal.

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## The Appeal

### Laying the Groundwork

1. Have a written policy regarding dealing with credit balances and refund/recoupment requests. This will insure that a credit balance or refund request does not sit for a long period and remain unattended. Lack of response on your part may be construed to be a tacit agreement that the insurer's benefit determination is correct. Further, some states, like California, have enacted specific timeframes for overpayments to be paid back by the provider and failure to respond can subject your office to interest and penalties in certain situations.

### Appeal Options

1. Know your state's managed care regulations regarding retroactive review of prior authorization. Such laws protect you from certain types of retroactive denials.
2. If no contract exists between you and the insurer, you may maintain the position that, as a innocent third party provider, you have not been unjustly enriched by the payment and that reparations must be sought from the person with whom they have a contractual relationship. However, this would not provide protection under

a situation where duplicate or double payment was made on a single account as this could be construed as unjust enrichment.

3. Take the position that the appeals process must be exhausted before money is taken back. This will give you some time to research the denials and also gather information from the patient.
4. Demand Documentation. Ask for written confirmation from the insurer of the exact date the error was detected and protest the amount of time taken to find the error if a long period has elapsed. Also request copies of the exclusion/limitation applicable to the denial to review it for applicability to the paid claim.

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## Training Notes

There is little use of having a written policy regarding credit balances and refund/recoupment requests unless it is followed. Train all personnel on the policy and make it a part of your management review to insure that it is being followed.

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# Sample Refund/Recoupment Request 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,

We are in receipt of a refund request in the amount of \$ \_\_\_\_\_. According to our records, the books are closed on this claim and your company may not have legal standing to enforce the refund/recoupment request. According to our review, the claim was paid appropriately and no credit balance is on the account. Further, we have applied all applicable contractual adjustments and have billed the patient for any applicable patient responsibility. It is our position that the legal theory of laches may prohibit your request for repayment.

Laches is a legal doctrine which, according to Barron's Law Dictionary, Third Edition, provides protection to a party with an equitable defense if situations where long-neglected rights are sought to be enforced against a party. According to general legal rules, as an innocent creditor, we cannot be held liable for mistakes on the payor's part. We obtained the patient's insurance card provided at the time of service and based on that believed that we were entitled to third party payment from your company. We received the payment and explanation of benefits in good faith, and based on that, did not bill the patient for the portion covered by her insurance. We provided services in good faith and the funds received have been exhausted. Now, a reimbursement of the insurance benefit to you would seriously jeopardize our ability to collect the debt from the patient.

Further, your company has not provided sufficient documentation to support the request, including a copy of the policy or plan terms, the date the error was detected and by whom and proof that the patient is aware and agrees with the action taken on the policy.

We feel that we have been properly reimbursed for services rendered and no refund will be issued. If, in the future, you elect to deduct the alleged overpayment from future benefits to be paid, we reserve the right to consult further legal counsel in order to insure that our full rights, which may or may not be addressed in this letter, are preserved.

Please do not hesitate to call me if you have any questions or need additional information.

Sincerely,

Patient Accounts Manager

# Appealing For an Answer to Your Appeal

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## What Do I Do When I Demand Documentation and Don't Get It?

Do you have a legitimate right to the information we encourage you to request as proof of a denial? After all, the patient is the beneficiary, not you.

Not necessarily.

Medical providers routinely obtain an assignment of benefits before providing treatment. However, understanding your rights under the assignment is imperative to enforcing your complete appeal rights. If you believe a claims representative's assertions that they do not have to prove their denial, they will often prevail in the appeals process.

First, courts have recognized that there are actually two types of assignments used by providers. Some providers obtain an authorization to receive payment which allows carriers to remit payment to the provider but does not establish the provider as a beneficiary of the policy. However, some providers obtain a more legally binding assignment of benefits which makes the provider the beneficiary. As such, the provider has all the rights and remedies available to the beneficiary, including the right to file suit, in order to obtain payment of benefits.

The carriers will not be able to tell which assignment you have by receiving a bill stating "signature on file." To fully protect your rights, the insurance carrier should be put on notice of the assignment prior to treatment by sending a copy of the assignment to the Plan Administrator or Claims Director.

Securing a legally binding assignment of benefits is one of the major components of obtaining legal standing to bring a suit for the benefits. However, at least one court has recognized that if providers do not place carriers on notice of the assignment, carriers have no way of knowing what type of standing the provider has in the matter.

A 1996 lawsuit between a policyholder and Principal Mutual Life Insurance over health care eligibility has an excellent discussion of this issue. In the case, Principal Mutual denied the inpatient psychiatric care received by the beneficiary by

successfully arguing that the patient was not really employed with the group at the time of the treatment. The case was settled out of court leaving the medical bill of Charter Barclay Hospital unpaid. After the decision, Charter filed suit against Principal Mutual, claiming that, as the assignee, Charter should have been notified of the denial and allowed to join in the initial suit. Further, they argued that Principal Mutual had fraudulently verified coverage and committed related torts associated with the coverage.

The appeal court reviewed the ERISA regulations pertinent to the suit and noted that the administrator must provide a denial notice to the claimant only. However, if the medical provider has a valid assignment of benefits, the court determined that the medical provider becomes the only claimant to benefits and the patient no longer has a right to receive the denial notice. The court specifically noted that providers should provide a copy of the assignment to the carrier to establish their rights. The decision states the following:

*For reasons well illustrated by this case, medical providers – perhaps especially providers of medical services to psychiatric patients – who take assignments of their patients’ right to reimbursement from insurers (or other payment sources) cannot protect those rights unless the insurer notifies them when the patients’ claims are denied. (The patient) submitted a claim and by the time it was denied he was in another state, has no interest in the payment of his hospital bill, and in all likelihood could not, as a practical matter, be made to pay it. We suspect, while acknowledging a surprising vacuum of case law or of other authority, that an assignee is entitled to notice of the denial of a claim of benefits submitted by the assignor. We recognize the potential burden on insurance companies but point out that they can protect themselves by requiring that hospitals submit clear and unmistakable proof of assignment as distinct from merely an authorization for direct payment.*

Legal Cite: *Principal Mutual Life Insurance Co. v Charter Barclay Hospital, Inc.*  
U.S. Court of Appeals for the 7<sup>th</sup> Circuit No. 95-2786.  
From the U.S. District Court for the Northern District of Illinois, Eastern Division

We recommend that you speak with an attorney about your assignment of benefits and your specific needs regarding ability to pursue legal action against carriers. If you do obtain a strongly worded assignment, make it a practice to use your assignment of benefits by placing carriers on notice with a copy of the assignment. The assignment can also assist you in obtaining more complete documents during appeals because you become the beneficiary, not just a third party, under the insurance terms.

# Pursuing Legal Action

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## Preparing for Legal Action

By now you have read several hints that protect your interest in the event litigation is pursued. However, many medical providers do not pursue insurance carriers in litigation. Those that do have found many such cases thrown out of the courts before the judge even considers the merits of their cases. Why do medical providers' lawsuits so often fail?

Dr. Jin Zhou is a full time chiropractor and part time author and speaker on pursuing ERISA appeals and litigation against insurers and plan administrators. We are concluding this manual with information about him and his book, "ERISA For Physicians: Healthcare ERISA Claim Denials and Appeals." Dr. Zhou has identified three reasons that keep medical providers from prevailing in court. They are:

1. Medical providers often do not obtain standing to sue. Standing is a legal term referring to the right of a person or group to initiate a lawsuit against another party. The assignment of benefits is the critical document to establish standing because it is the document wherein the beneficiary gives the medical provider certain rights to the insurance benefits. However, in many lawsuits, the provider failed to even present a copy of the assignment. In other cases, the assignment was found to be deficient in key elements necessary to perfect the providers claim to benefits. Your attorney should be familiar with such rulings when he drafts your assignment, taking into account whether you plan to pursue legal actions on unpaid claims.
2. Medical providers do not properly notify the insurance company or plan administrator of the assignment of benefits. While this amounts to even more paperwork in a paperwork-laden industry, it is an important component to protecting your rights to file suit.
3. Medical providers do not file the number of required appeals with the insurance company or plan administrator. Medical providers too often view filing an appeal as a courtesy performed for the patient. However, filing appeals is actually a prerequisite to pursuing litigation in many ERISA plans. Many policies and health benefits plans require two appeals to be filed prior to legal action. If you file suit without filing the required appeals, the insurance company and plan administrator will often ask the judge to dismiss the case based on this failure to follow dispute resolutions steps required in the agreement. Judges strictly enforce such wording in order to keep such matters out of the already clogged legal system.



# One Doctor's Success Story

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## Pursuing Legal Action Against ERISA Delays and Denials

Any medical professional who has ever called an insurance carrier to remind them of the state's prompt payment law, a mandatory coverage requirement or newly passed managed care reform has often heard the great payment cop-out:

**“We don't have to abide by state law. This is an ERISA Plan.”**

ERISA has long been the haven employers have flocked to in order to lower health care costs. The rationale behind the implementation of the federal program was that companies operating in multiple states have an undue burden of keeping abreast of the many state-by-state changes in insurance regulations. Therefore, the employee retirement insurance act was created to allow companies to self-insure and create customized insurance and retirement plans to fit their needs. Plans created under the law can be totally outside the jurisdiction of state insurance laws and state regulators. Thus, costly coverage mandates are often avoided. However, medical providers accepting self-funded patients found themselves dealing with a big unknown – there seems no way of knowing how extensive the coverage might be or even when payment will be sent on an ERISA claim, especially a poorly funded one.

Also, ERISA payors were often the slowest payer in the medical payer mix since no mandate is in place requiring prompt payment. Just last year, federal lawmakers passed slightly more stringent claim processing regulations. However, plans still have a wide berth in deciding what to cover and what not to cover and virtually no penalty for paying claims beyond the 90 days processing requirement.

With such laissez-faire processing procedures and dropping fee schedules, some practice management consultants have recommended not accepting assignment of benefits on certain ERISA plans.

However, one doctor is on a personal crusade to educate his colleagues on challenging ERISA delays and denials. He has posted numerous articles on Internet message boards and has sent numerous e-mails to media and health industry leaders.

“One of the fundamental failures of the American Medical Association and any healthcare organizations is lobbying and legislation for new laws. Once enacted, it's history, and no organizations and institutions educate our healthcare providers to utilize and practice or pursue them. It is the attitude of the entire healthcare community that doctors do not file appeals,” he said in a recent letter to the AMA

regarding their lobbying efforts supporting the passage of state prompt payment legislation.

“Your assessment of enacting new laws is defect and incomplete. If we would understand and employ half of the existing laws and regulations, we would be in a much better position in claims reimbursement.”

Dr. Zhou has won numerous reversals of ERISA claim denials, forced federal out of court settlements, and has claims currently pending in court using his techniques developed through the study of hundreds of ERISA court decision. His key to victory is that while ERISA allows companies to write their own plans and processing procedures, ERISA also requires full and complete disclosure and information regarding plan benefits and processing procedures. The problem is that carriers rarely honor a medical provider’s request for disclosure. Dr. Zhou states that he has turned that problem into legally enforceable prejudice that can force carriers to pay.

Dr. Zhou’s routine in dealing with ERISA providers goes like this. A legally enforceable assignment of benefits is obtained from the patient. Dr. Zhou had to significantly rewrite his assignment of benefits to meet the requirements of the many court cases he has studied. He immediately sends the assignment of benefits to the carrier and requests a copy of the summary plan description.

The summary plan description is information the health plan administrator must provide to beneficiaries describing the terms of their coverage. The plan must abide by the terms spelled out in the summary plan document. If this document is provided, which it rarely is, Dr. Zhou can scrutinize it for ambiguities and inconsistencies that he finds are quite frequent. If the carrier violates any of the processing or coverage terms spelled out in the document, Dr. Zhou has the necessary ammunition to appeal it with information directly from the plan description.

If they do not provide it, Dr. Zhou is even more pleased. He believes their failure to provide the requested information can amount to a \$100 per day fine under the ERISA disclosure regulations. Further, he states that their failure to disclose such pertinent information to his claim makes it much harder for them to prevail if the matter is litigated. Courts often rule that health benefit terms that are not disclosed to the beneficiary cannot be legally enforced.

Dr. Zhou sees his program as turning the table on carriers. For the past decade, carriers have required doctors to document in more and more detail of every patient-doctor interaction. Exploiting ERISA disclosure rules, in essence, requires health benefit plans to provide complete details of the employee benefits plans as well as information from the claim file.

“In order to survive for our profession, folks, wake up! Study ERISA now and put it into your practice. Most of you may not know what the heck I am talking about. Before complaining, read something about ERISA, then ask yourself a question, how

come no one said anything about this before?”

Dr. Zhou has found that many carriers consistently fail to abide by the disclosure requirements and end up owing him money as a result. Plus, once information is disclosed to him, he often finds that the carrier has not acquired sufficient information to deny the claim and is able to pursue the carrier for full payment plus penalties for failing to disclose information in a timely manner. We hope his efforts will serve as inspiration for other medical providers to use legal information to support their appeals. His book contains more complete information about ERISA appeals and includes his assignment of benefits form and several sample appeal letters. It is available at his web site, [www.erisaclaim.com](http://www.erisaclaim.com).

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## Notes: