Purpose of Webinar

- Discuss the problems PTs are having with OrthoNet's pre-authorization and utilization review practices
- Learn about federal and state laws that govern these practices for *commercial health plans* and what your patients' rights are to a full and fair review on appeal
- Learn how to file appeals *quickly and easily* in an effort to hold OrthoNet and Insurance Carriers accountable for complying with applicable laws
- Discuss the need for appeals data to stop this insanity!

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Disclaimer

The information being offered is for educational purposes and is not intended to serve as legal advice for any specific case or any individual practice or practitioner.

There is no guarantee this Appeals Strategy will work, but nothing else to date has, so it can't hurt to try! Some past success has been reported (approval of more visits on the first pre-auth request)

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The "Mother May I Have Another Visit" Game

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Summary of Claims/Appeals Rules

- All claims procedures, *including prior authorization and utilization review*, be included in the Summary Plan Description (SPD)
- Prohibits claims procedures that *unduly inhibits or hampers* the initiation or processing of claims for benefits.
- Establishes content requirements for the Notice of Adverse Benefit Determination (ABD) letter
- Defines what denials are appealable and who has appeal right
- Establishes standards for a Full and Fair Review on Appeal
- Prohibits conflicts of interest in the appeals process.

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Summary of Claims/Appeals Rules (cont)

- Limits internal appeals to two levels (establishing a "Reconsideration" as an additional *voluntary* level)
- Sets time limits for health plan to respond to Expedited, Standard and Post-service appeals
- Requires External Independent Review after internal appeals are exhausted.
- Requires coverage to be continued pending the outcome of an appeal for "concurrent care," defined as a course of treatment already approved to be provided over a period of time or number of treatments.

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Grandfathered Plan Exception

- Under Federal Law, Grandfathered Plans don't have to offer an independent external review as the final 3rd level of appeal but many do anyway.
- If the Grandfathered Plan does not offer an external review, the patient has to file a lawsuit against the health plan in federal court after exhausting all internal appeals.
- Get the patient's Summary Plan Description to find out whether the plan is Grandfathered.

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What can be appealed?

- Federal rules (for self-insured and ERISA private insurance plans) provide an appeal right for *Any*:
  - denial,
  - reduction, or
  - termination of, or
  - failure to provide or make payment (*in whole or in part*) for a benefit . . . .
  - . . . . resulting from the application of any *utilization review* or treatment determined to be experimental or investigational or not medically necessary or appropriate.
- All adverse benefit determinations have an appeal right.

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Applying these rules to burdensome preauthorization:

- When you request a reasonable number of visits for an episode of care but only *part* of the visits are approved by a utilization review entity (URE), the health plan has, by definition, *denied*, *reduced* or *failed to provide*, ***in part,*** for a benefit *as the result* of *utilization review.*
- The adverse benefit determination letter to the patient *must* notify the patient of the right to an appeal.

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Review the Adverse Benefit Determination Notice

Adverse Benefit Determination must include:

- Specific reason for adverse determination
- Reference to specific plan provisions on which determination is based
- Sufficient information to identify the claim being denied
- Description of the appeals processes and how to initiate an appeal, including right to bring civil action for ERISA plans.
- Contact information for the health insurance consumer assistance ombudsman in the state

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Other Requirements:

- If denial was based on a lack of information, letter must give a description of additional material or information necessary for the claimant to perfect the claim *and* an explanation of why such material or information is necessary (must be sent within 24 hours of denial).
- If denial is a final, it must include a discussion of the reasons for the denial, applying the facts in the case to the plan provisions and any internal rules, guidelines or protocols used as a basis for the denial.

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OrthoNet Letters

- Original Pre-authorization partial denial letter
- New non-compliant letter
- Original Final Denial Letter

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KY Department of Insurance ABD Letter requirements

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The Appeals Process as a *STRATEGY*

- By requesting all the information the plan participant is entitled to, appealing every inappropriate denial *(especially partial denials of number of visits at pre-authorization), and filing complaints with the proper governing agencies, we can* expose bad faith claims handling and change payer conduct!
- Appeals *have to be exhausted* before any government agency or a court of law will intervene.

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Insanity

Doing the same thing over and over again and expecting different results.

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Info you are entitled to for a **Full & Fair Review on Appeal**

- If an internal rule, guideline, protocol, or other similar criteria was relied upon in making the adverse determination, copies must be provided free of charge and in a timely manner to the claimant upon request, or
- If medical necessity is the issue, an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request. ALWAYS ASK FOR THIS!
- A free copy of all documentation, records and anything else used in the making the decision (even your own records!)
- If insurer requires more information, they are required to tell you precisely what information is needed for the beneficiary to perfect his/her claim. Ask for specifics!

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Time Health Plan Has to Respond to Appeals

- 15 days to respond to pre-service request for approval
- ***Concurrent or continuing care claims*** – 24 - 72 hours
- Urgent care claims: Plan administrator/Insurer shall notify the claimant expeditiously, but no later than 72 hours after receipt of claim
- Standard Appeal: 30 days + 1-14 day extension
- Post-service Claims: Within 30 days of receiving appeal + 14 day extension for good cause.

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Request an appeal for a "Concurrent Care" Claim

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Request an ***Expedited*** Appeal for pre-service denials if the patient is currently in PT

"Urgent care" is defined under federal law as:

- Treatment that, if delayed, could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or
- In the opinion of the *attending provider* (old ERISA rule said "physician") with knowledge of the claimant's medical condition, delayed treatment would subject the claimant to severe pain that could not be adequately managed without the care or treatment.

Your state law may add to this definition, entitling more situations to expedited appeals.

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Who gets to decide whether appeal must be expedited?

- Old ERISA rules under federal law required the insurer/health plan to give deference to a physician with knowledge of the claimant's medical condition.
- New federal rules that apply to ERISA plans *and* must be incorporated into state law as minimum consumer protections for state-governed plans require the insurer/health plan to give deference to the treating *provider. But Code of Federal Regulations did not make this word change. Error???*
  - Many state laws use the word "provider," so if the insurer/health plan refuses to expedite the appeal because the PT is not a physician, file a complaint with your Insurance Commissioner and/or the Department of Labor!
  - Grandfathered plans will only have to give deference to the physician unless more stringent state laws apply.
- *Note: Medicare Advantage Plan rules state that the physician is the only provider that the plan must give deference to.*

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Arbitrary & Capricious Denials?

- Inappropriate UR criteria
- NO UR CRITERIA
- Medical necessity denial results in exclusions or limitations not described in the Summary Plan Description
- Need EVIDENCE!
- Appeals *have to be exhausted!*
- Complaints should be filed when payers don't comply with the Claims/Appeals rules

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Does the Clinical Review Criteria for Discharge match the patient's benefit plan?

- Are there any exclusions or limitations on PT benefits stated in the Summary Plan Description or it is just based on medical necessity?
- URE's discharge criteria cannot limit the patient's care more than the policy covers! For example, Discharge when:
  - ROM = 80%
  - Strength is 4/5
  - Pain is 2/10

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Who has the appeal right?

- Your patient is the one with the appeal right under federal and state law, *not you (the provider).*
- If you are an in-network provider for an insurer, you may have an appeal right under the payer's policies/procedures or the dispute resolution clause of your provider agreement, *but it may not count as the patient's appeal.* Issues this creates:
  - Health Plan is not legally accountable for providing a full and fair review for the *Provider.*
  - Adds an extra appeal step and adds time to get to the independent review level. (This is good if you need an extra appeal because you have not submitted all your evidence for an independent external review or civil court claim (ERISA).
- You can file the appeal on behalf of the patient as the patient's Authorized Representative, in which case you stand in the shoes of the patient and the claims/appeals rules apply.

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Who can Deny; Review Internal Appeals

- If denial/partial denial is based on medical necessity (or lack thereof), the opinion must be signed off on by a physician reviewer.
- Review on Appeal cannot be done by the same person (or subordinate of same person) who performed original review.
- Check state law to see if it requires or offers a right to a peer review.
- Recommendation: Find out the specific credentials of the person making the decision. Did the physician *really* do the review or just rubber stamp it? Are ATCs doing the reviews? (not considered health care providers in some states)

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Steps in the Appeal Process

- Have patient designate you as their Authorized Representative in writing
- Request information you are entitled to for a Full and Fair Review. If basis of denial or partial denial was that there was not enough information in your documentation to determine medical necessity, ask for what *specific* information is required.
- Determine whether your appeal is for CONCURRENT OR URGENT CARE which qualifies for an *EXPEDITED Review*
- Request an appeal from the insurer/health plan, *not* the Utilization Review Entity (if there is one).
- Argue your case in your letter of appeal if you need to

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Know how to APPEAL and COMPLAIN!

- Procedures for appealing & complaining depend on who the payer is (what laws govern the payer's procedures for handling appeals and complaints)
- Know who to appeal and complain to
  - Kentucky Dept of Insurance if the health plan is fully insured
  - US Dept of Labor if the health plan is self-insured
- Reference violations of law and health plan breaches in your complaints

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DOL Complaints

UNITED STATES DEPARTMENT OF LABOR

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Employee Benefits Security Administration

DOL > EBSA > Enforcement Manual > Chapter 30

Complaints

Printer Friendly Version

1. Complaints. A complaint refers to information received which indicates or alleges that a violation of the law has occurred or is about to occur. Complaints may be specific or nonspecific, written or oral, within or outside EBSA's jurisdiction and may come from a number of sources, such as individuals, news media, and other enforcement agencies.

2. Complaints From Individuals. Inquiries and complaints from members of the public are generally handled by EBSA's Benefits Advisors in accordance with the procedures established by the Office of Participant Assistance. When appropriate, a participant complaint may be transferred as an investigative lead to the enforcement unit. If a participant complaint is the source of an investigative lead, interim contact with the participant should be made by the investigator or the Regional Director's designee as long as the complaint remains unresolved. Final notification to the participant should be made upon completion of the investigation and documented in the case file.

3. Nonspecific Complaints. If the information is indefinite, general in nature, grounded in rumor or conjecture, or alleges activity which does not constitute a violation of law, the complaint is "nonspecific." Generally, investigations will not be conducted on nonspecific information. However, a number of such complaints relating to the same person, entity, or subject matter, received over a period of time, may indicate the need for investigation because the cumulative effect of such complaints may form the basis for conducting the investigation.

4. Confidentiality of Complaints. If the complainant requests confidentiality, the complainant will be identified as a "Confidential Source" and described as to the degree of reliability, such as "who has furnished accurate information in the past" or "of unknown reliability" in a memorandum that is included in the case file. The complainant's name will only appear in the original written complaint or an original memorandum relating to an oral complaint, which is to be kept in the RD's or DS's safe. No complainant, particularly when the complaint concerns a benefit dispute, can be guaranteed confidentiality. The most that can ever be stated is that we will attempt not to make disclosure unless required by law. Similar protection will be afforded to government agencies which request it, making reference to "Confidential Source A, a U.S. government agency" or "Source D, a municipal agency," etc.

5. Identification of Source. Law enforcement agencies are not to be designated as confidential sources of information except in those instances when the agency involved, or its employee, specifically requests anonymity as a condition precedent to the release of such information. Such instances usually occur when the information is "raw, unevaluated" matter and of such a nature as to be a possible source of embarrassment to the contributor.

6. Information from Other Agencies. Information received from some agencies, such as the FBI, is released to the requesting agency only upon the condition

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Questions & Discussion . . . .

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