

# Maximizing Reimbursement by Appealing Claim Denials

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In the previous issue of this journal (Vol. 20#3: 135-137), I discussed how state prompt pay statutes and the Employment Retirement Income Security Act (ERISA) can be used to maximize the prompt payment of provider claims. Providers, however, are confronted with more issues than simply the delayed payment of claims. Payers apply a wide variety of tactics to deny providers the appropriate reimbursement, including but not limited to:

- Downcoding
- Bundling
- Applying the wrong fee schedule
- Refusing to recognize modifiers

Payers also deny claims based upon medical necessity on grounds contrary to current medical standards.

***Payers apply a wide variety of tactics to deny providers the appropriate reimbursement . . .***

Prompt pay statutes and the claims processing provisions of ERISA place the burden on the payer to process clean claims within statutory time periods. These statutes, however, require the payer only to process the claim; they do not prevent the payer from denying or underpaying the claim. When claims are denied or underpaid, the burden falls upon the provider to take the next step to ob-

tain the correct amount of reimbursement. Usually, this means appealing the claim denial or underpayment.

## **CONTRACTUAL APPEAL REQUIREMENTS**

Most managed care agreements require the provider to seek written review of the denied or underpaid claim. These review provisions may be labeled “physician appeals process,” “medical review,” or “appeals process.” The specific review provisions are often not in the main body of the agreement. Many managed care agreements reference program attachments, addenda, or plan manuals that you may or may not have in your office. If the documents are referenced in the agreement, they are most likely part of your contract whether you physically have them or not. The burden is on you to understand your agreement and to comply with its terms. Therefore, make sure you have all the documents that comprise your agreement with the managed care organization, including all attachments and any documents that are referenced in the agreement—such as schedules and exhibits. If you don’t have these documents, send a letter to the payer requesting all attachments, schedules, and the plan manual.

### **Read and Understand Your Contract**

Review provisions vary in description and requirements. The clause may state whether the request for review can be submitted verbally, electronically, or in writing. The review clause should delineate the following:

- The time period for seeking a review
- The documentation required to seek a review

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- The address and title of the person to whom to direct the appeal or review

There may be more than one level of review. If the clause says that the provider *must* or *shall* seek review, then the provider is contractually required to seek review of an adverse claim determination.

***... the burden falls upon the provider to take the next step to obtain the correct amount of reimbursement ...***

In such circumstances, courts require providers to exhaust the administrative/contractual review process before proceeding in court or with arbitration. Participating in the review process is mandatory. A provider that does not seek a review with the payer is usually barred from challenging the adverse claim determination in any other forum.

### **Appealing When There Is No Contract**

Even if you have no contract with the payer, you may still be required to follow the review process stated in your patient's certificate of insurance or summary plan. The appeal or review requirements are usually stated on the explanation of benefits. Assuming that your patient has signed and delivered to you a written assignment of benefits, you then have standing to seek payment directly from the payer. The assignment of benefits places you in the shoes of the patient and gives you standing to seek payment directly from the payer. Once you receive a written assignment from the patient, you have to pursue the same appeals/review process that your patient would have been required to follow.

If possible, appeals or review requests should be on a claim-by-claim basis, with each one accompanied by the required documentation and a letter explaining the reasons for the request. A form letter can be developed for each CPT code. Your office should keep a log of when the appeal was made, what documents were sent, and all phone calls and correspondence between you, your practice manager, and the payer. This documentation can be used as evidence in your favor if you ultimately have to pursue legal action against the payer. Providers increase the likelihood of a successful review if their appeal is detailed and fully documented.

### **Abusive Appeal and Review Practices**

It is not uncommon for payers to unnecessarily delay the review process or to repeatedly ask for documents that providers have previously submitted. Unfortunately, most state prompt pay statutes do not address this issue.

If you have a contract with the payer, it may have provisions that address how a clean claim is defined and when the payer must decide on a request for review. It is important to keep a record of the appeal delays and the number of times you are asked to document the claims. If

the practice of asking for documents previously submitted continues, it may give you a basis for arguing that the payer is in fact violating the prompt pay statute by not making a meaningful claim determination in the first instance. Further, a provider subject to repeated review abuses may be able to assert a right to bypass the appeals process and proceed directly to court because the appeal is a futile act.

## **USING ERISA TO OBTAIN SWIFT REIMBURSEMENT**

Perhaps your patient is receiving health benefits through an ERISA employee benefit plan. If your patient has given you a written assignment of benefits, your right to payment or to appeal an adverse claim determination is governed by ERISA unless you have a direct contractual relationship with the payer.

Many providers and their counsel focus on the fact that ERISA preempts all state law claims and limits the provider's remedies to those set forth in the ERISA statute. Therefore, a great deal of effort is often spent trying to get around the ERISA shield, an effort that is usually futile.

Instead, you should consider using the claim benefit requirements described in this article as a sword to ensure prompt and complete payment of claims.

### **How Does ERISA Assist the Provider?**

ERISA has a number of provisions that providers can use to their advantage to overturn or successfully challenge a claim denial or underpayment. ERISA imposes on the ERISA employee welfare and benefit plan (the "ERISA plan") certain initial claim determination requirements. It requires the ERISA plan to establish and follow specific review and disclosure requirements. Section 502(a) of ERISA gives providers the right to bring a lawsuit in federal court to recover payment for health-care services wrongfully denied or underpaid by an ERISA plan.

***The provider's best opportunity to reverse a claim denial is often during the administrative appeals process provided by ERISA.***

Many payers do not bother to appeal pursuant to the ERISA review procedures and instead try to go straight to federal court pursuant to Section 502(a) of ERISA. This is a mistake. Except for certain limited circumstances, the provider must appeal and exhaust all administrative remedies provided for in the ERISA statute. The provider who fails to appeal is barred from proceeding in federal court.<sup>1</sup> The provider's best opportunity to reverse a claim denial is often during the administrative appeals process provided by ERISA. The provider that uses the ERISA appeals process is most likely to prevail, either at the administrative level or in federal court.

## A Prompt Claim Determination

ERISA plans must make a claim determination within 30 days for post-authorization/service claims. The claim determination must set forth, among other things, a specific reason or reasons for the adverse determination, a description of any additional information the provider may need to perfect the claim if it was submitted incomplete, and a description of the plan's review procedures.

If the adverse determination is based on medical necessity or experimental treatment, the claim determination must provide an explanation of the scientific or clinical judgment, applying the terms of the plan to the claimant's medical determination. If the ERISA plan does not respond within 30 days, the claim is deemed denied. As a result, whether the ERISA plan acts or not, the provider's right to appeal starts after 30 days unless the ERISA plan properly seeks an extension.

## A Full and Fair Review

ERISA requires employee benefit plans to establish and maintain appeals procedures that give claimants a reasonable opportunity to appeal an adverse benefit determination. The appeal must give the claimant a "full and fair review" of the claim and the adverse benefit determination. An ERISA plan must give the provider 180 days to appeal an adverse determination. If the ERISA plan fails to establish such an appeal process, the provider is deemed to have exhausted all administrative remedies and may proceed under Section 502(a) of ERISA to sue in federal court.

## The Right to Request Documents

The ERISA plan is required to give the provider documents to enable the provider to challenge the adverse claim determination. Effective January 2002, the Department of Labor expanded the types of documents that ERISA plans are required to give to the provider in responding to a claim denial. The provider is now entitled to request and to receive all the documents considered relevant to the adverse claim determination. Relevant documents include, but are not limited to:

- The plan summary description explaining its benefits
- The documents the ERISA plan considered in denying the claim
- The documents related to the claim that the ERISA plan received but did not consider
- The grounds for the claim denial
- The ERISA plan's guidelines in reviewing or deciding the claims
- The customary fee schedule applicable to the denial

Armed with this information, diligent providers can materially enhance their chances of overturning an ad-

verse claim determination. The requested documents may also show that the ERISA plan failed to follow its own internal claims guidelines or that the decision was inconsistent with plan requirements. In such instances, federal courts have found that the plan administrator's decision was "arbitrary and capricious" and have overturned the claim denial.<sup>2</sup> Clearly, the provider appealing an ERISA plan's adverse claim determination has more information available than a provider challenging a private payer's non-ERISA claim determination.

The ERISA plan must produce the requested documents within 30 days of receipt of the provider's written request for information. What if the plan fails to produce documents? The ERISA plan can be subjected to civil penalties of up to \$110 per day. In addition, the appeal will be deemed denied if the ERISA plan fails to produce documents. The provider under such circumstances will be considered to have exhausted all administrative remedies and may proceed directly to federal court.

## Proceeding to Federal Court

The ERISA plan must decide the provider's appeal within 60 days of the request for review. If the appeal is denied or if the plan fails to respond within 60 days, the provider may proceed to federal court. If an ERISA plan fails to establish and follow any of these requirements, the provider is also deemed to have exhausted all administrative remedies available under the ERISA plan. Under any of these circumstances, the provider is entitled to immediately file suit in federal court and pursue the remedies available under Section 502(a) of ERISA. The federal court has the discretion to award attorneys fees to the prevailing party.

## CONCLUSION

All providers should know and understand when and how to appeal adverse claim denials. These requirements are sometimes set forth in the provider's contract or by statute. It is good practice to always appeal adverse determinations of clean claims. Not only is a demand for review required, but repeated appeals can be a cost-effective way to increase reimbursement. With respect to ERISA claims, providers can and should use the statute's procedural requirements to their advantage when appealing adverse claim determinations. ■

## REFERENCES

1. *Cole v. General Electric Co.* 32 Employee Benefits Case (BNA) 2195.
2. *Mitchell v. Eastman Kodak Co.*, 113 F.3d. 433 (3d. Cir. 1997).