Steve Verno has written another e-book that we are giving away to those who are interested in learning more about appeals.
The Art of Appealing

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Authors thanks:

I would like to dedicate this E-Manual to the following people:

(1) James McCuen: James gave me my first job as a medical biller. I knew nothing about medical billing and James taught me what I know.

(2) Sharon Morikone: Sharon is co-partner with James McCuen with their company, “The Coding Edge, Inc.” Sharon is one of the best medical coders I have ever known and she taught medical coding to me. She is a stickler for 100% accuracy and it is because of her, I do the same.

(3) Liz Jones: Liz Jones founded the Medical Association of Billers. An international organization of certified coders and billers. She created a free medical coding and billing forum that is the best anywhere. More than 50,000 questions and 4,000,000 visitors are on the forum. Liz is a tireless and caring person and I believe our profession is the best because of her.

(4) Martin Gottlieb: Marty Gottlieb owned Martin Gottlieb and Associates, an emergency care physician coding and billing company, located in Jacksonville, Florida. Marty loved medical billing. He fought the insurance companies like Saint George against the Dragon when he found the insurance companies in the wrong. He fought for emergency care doctors rights and he represented us all with professionalism, dedication, and commitment. He passed away not too long ago and he is truly missed.

(5) Mel Gottlieb: Mel has been in the medical billing business longer than anyone I have ever met. He is Marty’s father and when Marty passed, he took the reins of the company and continues to make MGA one of the most respected medical billing companies ever. I look to him as a father figure.

(6) Kenny Engle: Ken is a certified coder, compliance officer, and works with the AAPP ensuring that there is a high standard of compliance with coding and billing issues. Ken is slowly branching out as a speaker and if you ever see him in your area, I would highly recommend attending his classes and seminars.

(7) Dr. Jin Zhou: Dr. Zhou is a Chiropractor, located near the Chicago area. For years, Dr. Zhou had dedicated himself towards spreading the word about ERISA. I respectfully call Dr. Zhou the Godfather of ERISA because of his masterful knowledge of this unknown law. I always recommend taking Dr. Zhou’s ERISA seminars.

(8) Storm Kulhan: Storm is known to us all as the owner and editor of BC. Advantage Magazine and the BC. Advantage Forum. Storm has obtained the best of the best in the coding and billing industry, so that we can share our knowledge, our experience, and our love for our profession and use that to help others who are new or experienced. It is through Storm that we are all kept up-to-date with current developments that affect not just coders and billers, but hospitals, clinics, doctors, ancillary providers, office staff, and the patient themselves. He receives little praise for his work and deserves much more because it is through him, we are all better at what we do.
(9) I dedicate this manual to everyone that has chosen to enter our profession. Many people think that coding and billing is something that anyone can do. Once they see the complexity of what coding and billing really is, they have a huge respect for what we do. Medical Coding and Billing demands Training. It demands Certification. It demands Experience. We must work together to make our profession respectable, and we must share our information so that we all become better at what we do. Knowledge is power and power is sharing that knowledge because if the person holding the knowledge and power dies, then the knowledge is lost forever.

(10) My Father and Mother: My dad, Steven Verno and my mother, Sylvia were both high school dropouts. They quit high school in their senior year. They somehow raised seven children on the salary of a waitress and whatever jobs came around. What they instilled in us were family values, a respect for the other person regardless of the color of their skin, their religion or medical condition, and a demand that if you are right, you fight back. My father passed away at age 57 from cancer. They also instilled in us, the need for education. Even though they never had a high school diploma, they earned a PhD in life skills.

(11) My family. Last, but not least, I dedicate this to my family, Brenda, Shane and Ian. They have stood behind me during my many days of separation when I was in the military and when I had to leave to work for my providers on Sunday and not return until Friday night. They were with me when I had my heart attack and open heart surgery and they have supported me during my recovery. No person could be so proud of the family that I have.
The Art of Appealing

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Disclaimer: I am not an attorney, nor do I represent myself as one. None of the information in this manual contains legal advice. All of the information in this document is presented for training purposes only.

In my many years in this profession, I have seen many mistakes made by providers, medical billers, office managers, and insurance companies regarding the appealing of a claim denial, incorrect or non-payment or a coding/billing issue. Many of these mistakes I personally made early in my career and my mistakes were simply due to a lack of knowledge and experience.

The mistakes I see being made today are also based on a lack of knowledge and experience, but there are many variables that must be taken into consideration when submitting an appeal.

Some people believe that Modifier -59 will be the cure-all to their denials. Some believe that just because Medicare denies a claim, it cannot be appealed. There are too many myths circulating about appealing a payment or a denial. I always give the following advice: When someone tells you something, always ask them for the documentation or source behind what they say. If they can’t provide the source document, maybe what you are being told is a medical billing urban myth. A legitimate consultant always presents validation behind everything they present.

Today, too many people do not present their appeal in the proper manner (for example - with the documentation to support their appeal, and/or appeal according to the appeals process as defined by State or Federal Law, the insurance company’s appeals process, or per the terms of a legal and binding contract). Some people submit appeals without even knowing if they have the authority to appeal. Some people become frustrated because the insurance company never responds to the appeal, but does the insurance company have a responsibility to respond to the provider or billing agent? This manual will help provide answers so that mistakes can be reduced or eliminated. I wish to recommend that anytime you need legal advice regarding the appeals process, you should always seek the assistance and advice of an attorney that specializes in health care, health insurance contracting and/or ERISA.

WHAT IS AN APPEAL?

An appeal is a very complex process, but to put things simply, an appeal is an oral or written request to have a decision or determination reviewed. You are basically asking the insurance company to reconsider how a claim for health benefits was paid, unpaid, or denied, you are appealing a carrier policy or procedure, or you are appealing a provider contract determination.
WHAT ARE THE VARIABLES YOU MENTION?

When preparing an appeal, you must understand all of the factors involved with preparing an appeal. These variables could include the following, but be aware that these variables are not all and inclusive:

(1) State Law
   (a) Commercial Insurance
   (b) Coordination of Benefits
   (c) Emergency Care
   (d) Health Benefit Contracting
   (e) HMOs
   (f) Medicaid
   (g) Medical Care for Prisoners
   (h) Personal Injury Protection (PIP)
   (i) Prompt Pay
   (j) Refunds
   (k) Timely Filing
   (l) Workers Compensation

(2) Federal Law
   (a) ERISA
   (b) COBRA
   (c) DOD Regulations
   (d) Federal Employees
   (e) Social Security Act

(3) Guidelines
   (a) Medicare Manuals

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As you can see, appealing is not a simple and easy process. **WHAT ARE THE STEPS I NEED TO TAKE TO SUBMIT AN APPEAL?**

**STEP #1: DETERMINE IF AN APPEAL IS NECESSARY**
You need to decide if an appeal is necessary. Sometimes the insurance company is correct. The insurance company may have denied the claim due to timeliness because the claim was sent late. The payment that was made may have been what the insurance company is contractually obligated to pay.

The procedure that was denied as a covered service may not have been a benefit the patient is entitled to receive. The procedure was denied as being inclusive according to the Correct Coding Initiative (CCI) edit guidelines. You can obtain more information about the CCI edits and download the latest version by going here:

http://www.cms.hhs.gov/NationalCorrectCodInitEd/

A PPO you never heard from allowed a discount, under a Silent PPO concept, but the provider agreed to allow other carriers to have access to the contracted discount. The provider may have signed a contract agreeing to the carrier’s policies and procedures so when the carrier denied the claim based on a policy, there is no need for an appeal because the provider unknowingly agreed to that policy. This includes a carrier’s CCI edits. Therefore, you need to do some homework to see if the payment or denial is correct. If so, there is no need to submit an appeal.

**STEP #2: DETERMINE IF YOU HAVE THE RIGHT TO APPEAL**
If you are going to appeal, what you are appealing is a health benefit issue, an insurance company policy, or a provider health insurance contract issue. Some health benefit appeals are protected based on contract and/or Federal Law requiring the member to appeal their benefit determinations themselves. Therefore, we must be careful that we do not deny the patient their protected rights of appeal. The laws may allow the patient to have someone legally represent them during the appeals process but the process for representation is usually defined as being required in writing and according to the insurance company’s representation requirements.

The following is taken from an HMO Benefit Manual regarding the appeals process:  *This right is available only to you or the executor of a deceased claimant’s estate. Providers, legal counsel, and other interested parties may act as your representative only with your specific written consent to pursue payment of the disputed claim.*

If you wish to appeal make sure you obtain the patient’s written permission to appeal, otherwise, you could be interfering with a legal, and binding contract, not to mention the laws that regulate the appeals process. Just for your knowledge, an Assignment of Benefit form

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(b) Medicaid Provider Manuals
(c) Carrier Policy Manuals
(d) Carrier Provider Manuals
(e) CPT Manual
(f) ICD-9-CM Manual
(g) HCPCS Manual
(h) Medical Societies

(4) Provider Health Insurance Contracts

(5) Patient Health Benefit Manuals/Summary Plan Descriptions

(6) United States Supreme Court Decisions
   (a) Davilla vs Aetna
   (b) Calad vs Cigna

(7) Federal Court Decisions

(8) State Court Decisions

(9) Other Carrier Payments (Experimental Denials)

(10) Medical Record

(11) Successful Appeal Decisions

As you can see, appealing is not a simple and easy process.
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does not convey authorization. All an Assignment of Benefit form does is ask permission to have the payment of the health benefit sent to a designated person. In many states, when the provider is not contracted, the Assignment of Benefit form is useless because the contract between the patient and insurance company prohibits the patient from assigning the payment of their benefit.

If you decide to appeal without written authorization, when required, the patient could say that their rights are being denied to them and you could be facing a lawsuit brought forth by the member or member’s attorney, not to mention possible investigation by Regulatory Authorities.

If we are appealing an insurance company’s policy, then we need to know if this policy is affecting a health benefit. For example, the carrier may say that CPT XXXXX is inclusive with CPT YYYYY. If both procedures are a health benefit that the member is contractually entitled to receive, then the appeal may fall under a benefit appeal as defined in the previous paragraph with the member being required to appeal themselves. The non-contracted provider may not wish to appeal the carrier policy because the non-contracted provider never signed a contract agreeing to the carrier policy, therefore the carrier may not be able to enforce their policy on a non-contracted provider. The provider can turn the appeal over to the member to appeal.

For example, let’s say the carrier denied the claim for timely filing. The claim was sent 100 days after the date of service because the patient withheld insurance information. The carrier says the time limit for claims submission is 90 days from the date of service. The member may find that per their contract, the claim has a one year time limit to submit the claim, therefore, the claim was really submitted in a timely manner, and not according to a policy that may or may not even exist.

As the provider or provider’s representative, you may have the right to appeal a contract issue. For example, if the carrier agreed to pay 80% of the current Medicare allowable and the claim was paid at 65% of the 2004 Medicare allowable for a different payment region, then this is a contractual issue that you can and should appeal.

Make sure that once you determine that you don’t have the automatic right to appeal, you obtain the necessary written documentation, from the member, authorizing you to represent the patient with their appeal. Have this authorization accompany the appeal so that the insurance company can respond to your demands and the results of the appeal. Always keep the patient informed of the steps you have
STEP #3: IS THE DOCTOR CONTRACTED OR NOT?

Appeals differ depending on whether the doctor has a contract with the insurance company or not. Contracted providers would normally be appealing a contract issue. A non-contracted doctor would be appealing a health benefit issue with the patient’s written permission. I once appealed a timely filing denial because the patient gave us incorrect insurance information. The insurance company denied the appeal. They stated that (1) I had no right to appeal the denial. The right of appeal was the member’s responsibility. They sent me a copy of the contract they had with the member which clearly stated only the member could appeal. (2) The employer sent me a letter, thanking me for wanting to help the employee, but, like the insurance company, I was told I had no right to appeal because my doctor had no rights in this matter. Other insurance companies would deny my request for information or they would ignore my appeal by simply stating my doctor had no appeal rights and that any communication was between them and their member. This was a rude awakening. Therefore, based on this experience, I differentiate my appeals based on whether the doctor is contracted or not. I learned the claim is not my doctor's claim when the doctor is not contracted. I learned the appeal belongs to the member and the insurance company has no obligation to speak with me when my doctor is not contracted.

If I have permission to appeal, then the content of the appeal addresses the fact that my doctor is not contracted and any decision made by the insurance company has no jurisdiction over my provider because what is being decided is a health benefit issue. If my doctor is contracted, I am appealing a contract issue which does affect my provider. For example, if the denial is a timely filing denial, the contracted provider is appealing the timeframe outlined in the provider contract. If the provider is not contracted, the appeal is based on the claim submission timeframe in the contract between the insurance company and patient, but the non-contracted provider can simply bill the member and not appeal at all. To the non-contracted provider, if the appeal is denied, then the provider has recourse by having the member reimburse the provider because the debt for services rendered belongs to the patient. It is the member's appeal of their health benefit that is being denied. It would be up to the member to continue to resolve the claim denial by their insurance company. If the provider is contracted and the appeal is denied, then the provider has no recourse because the contract may deny the provider the right to seek recourse from the member.

The non-contracted provider can also make a policy change that if the patient has coverage through the insurance that is denying the claims, the provider can refuse to send claims to the insurance company and demand that the member send their own claims as outlined in the patient’s contract with the insurance company. You see, when the doctor is not contracted, sending a claim is a courtesy. Check your own benefit manual to see who sends claims when you seek care from an out of network provider.

The following is from an HMO benefit manual under the heading, “FILING CLAIMS FOR NON-PLAN PROVIDERS”: When you are required to submit a claim to this Plan for covered expenses, submit your claim promptly. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your IDcard. Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied.

As you can see, this HMO informs the member that the non-contracted provider can require them to pay for the medical care and then submit their own claim. The contracted provider has the contract as leverage to require the insurance company to comply with the terms of the contract. The contracted provider can elect to terminate the contract which would then require the patient to pay for the care, in full; submit their own claims; and their own appeals. The insurance company doesn't want this to happen. The non-contracted provider’s leverage is the fact that he/she is not contracted. The non-contracted provider can demand full payment anyway. The non-contracted provider can enforce the patient’s contract. The insurance company cannot force the non-contracted provider to send a claim when it is a contractual requirement for the member to send their own claims. I know some providers do not want to involve the member, but when the provider is not contracted, the provider may have no choice but to involve the member.

The non-contracted provider must understand that the member has agreed to seek care from a network provider and you know that there are network providers that could see the patient. Some member contracts do not pay for services rendered by out of network providers. The following is from an HMO benefit manual: To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area is: South Florida area: Services from Plan providers are available in the following areas: Dade, Broward and Palm Beach Counties. Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, you may have to pay for services out of pocket.
area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval. As you can see, according to the terms of this HMO contract, the member is covered when seeking care, from contracted providers, while in South Florida. If the HMO member visits the Central Florida area, such as Orlando, and decides to visit an Urgent Care Center for non-emergency care without prior approval, and the Urgent Care Center is not contracted with the HMO, the claim will be denied. The Urgent Care Center must inform the member that they need to obtain authorization in order to be treated for a non-emergent medical condition or to pay for the care out of pocket. A Family Practice physician I worked for learned this the hard way. A female patient demanded to be treated. The HMO was contacted for approval and they denied authorization. They specifically told the provider that the member was to return to her Primary Care Physician for medical care and if he treated the patient, the claim would be denied. The provider treated the patient anyway and the claim was denied. The provider demanded the denial be appealed and the appeal was denied. When filing a complaint with the State regulatory authorities, the provider was told that the HMO had proof that the authorization was denied and the provider was well informed to send the patient to the Primary Care Provider. The provider was then told he could not bill the member as it was his own fault for providing care without authorization and without permission from the HMO. As I have said many times, doctors are in the business of providing health care. It is the insurance company that is in the business of paying for that health care and we must follow the rules that are outlined in a legal and binding contract between the insurance company and the member, even if we do not agree with it.

STEP #4: DETERMINE HOW FAR YOU WANT TO TAKE THE APPEAL.

Some people start the appeal process and then quit if the appeal is denied. Sometimes the appeal denial is identical to the original denial. The person who denied the claim also reviewed the appeal and denied the appeal. Some people appeal, receive the denial and then turn the appeal over to the member, when in fact, the appeal should have been placed into the hands of the member in the first place. Some people submit several levels of appeal, only to quit rather than taking the appeal to the next step which could be State Court, Federal Court, or an Administrative Law Judge.

I personally know of a provider that never gave up and once the appeal made it to an Administrative Law Judge, the decision was made in favor of the provider and the provider was awarded a decision that was in the 7 figures.

The following is from a Florida HMO Benefit Manual: You (or a person acting on your behalf) may not bring a lawsuit to recover benefits on a claim for treatment, services, supplies or drugs covered by this Plan until you have exhausted the OPM review procedure, established at section 890.105, title 5, Code of Federal Regulations (CFR). If OPM upholds the Plan’s decision on your claim, and you decide to bring a lawsuit based on the denial, the lawsuit must be brought no later than December 31 of the third year after the year in which the services or supplies upon which the claim is predicated were provided. Pursuant to section 890.107, Title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management in Federal court. Federal law exclusively governs all claims for relief in a lawsuit that relates to this Plan’s benefits or coverage or payments with respect to those benefits. Judicial action on such claims is limited to the record that was before OPM when it rendered its decision affirming the Plan’s denial of the benefit. The recovery in such a suit is limited to the amount of benefits in dispute.

Here in Florida, the Florida HMO and Florida State Insurance Regulation workers would have you believe that Florida Law would have jurisdiction over the HMO health benefit payment issues, but when you read the above documentation from the Florida HMO Benefit Manual, it specifically states that Federal Law has jurisdiction over the health benefit payment issues and the member is required to resolve their benefit issues in Federal Court. The above documentation also shows that a lawsuit can only brought after the HMO’s appeals process is exhausted and the lawsuit must be brought forth no later than 3 years after the services were rendered. You can also see, if the member wins in Federal Court, the recovery is limited to the amount of the health benefit.

Please understand that if you have all of the evidence that shows you are correct and you give up simply because the insurance company denied the claim and the appeal, you have lost everything, not just for now, but with all future appeals and for others that are also fighting. The insurance company knows that all they have to do is to continue to deny or ignore you and you will give up.
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If you are a contracted provider and the insurance company continues to ignore your appeals or deny your appeals without any foundation, they need to make a huge decision as to whether you want to remain contracted with the insurance company. After all, why remain contracted to have your contract issues being denied or ignored? Why allow the carrier to treat your contract with disrespect? It appears as if the carrier doesn’t care about the contract at all. Your contract is your leverage to ensure that the insurance company honors its agreement with you. Sometimes, placing the contract on the line is the only thing that will get their attention. If you terminate, the carrier must know that you are under no obligation to treat their member and if you do, you have no requirement to submit a claim or appeal a benefit determination. This is based on their contract with their member. You are free, as a non-contracted member, to require the member to seek care from a network provider or if the member makes a freedom of choice decision to be treated by your provider, then the member has to pay your full charges and to submit their own claim to be reimbursed. You aren’t even obligated to code the claim, but many do as a courtesy to help the patient.

Does this work? I can say yes, from experience with providers who made the choice to terminate with the carrier. I also have documentation, not only from the patient’s insurance company themselves, but state regulatory agencies that told me, as a non-contracted provider, we were not under any obligation to submit the claim for the patient or appeal the insurance company’s denial of the claim.

Look at your own benefit manual and see who is responsible for submitting a claim when you seek care from an out of network provider and who is responsible for submitting an appeal. You might be surprised at what you see.

My philosophy has always been and will be: Never Give Up and Never Surrender If You Are Right!” Once you begin the appeals process, be sure to go all the way.

STEP #5: GATHER YOUR EVIDENCE TO SUPPORT THE APPEAL.

Watch an attorney prepare an appeal. They never submit an appeal without researching and gathering the evidence to provide solid support and foundation to the original claim and the appeal. I see too many people appeal blindly and without a shred of any documentation to support their appeal. Naturally, the insurance company will deny the appeal. They should, simply because your appeal has nothing to back it up.

(a) Make a Demand for the Foundation Behind the Claim Denial.

The first thing I require, as evidence, is for the insurance company to provide the foundation behind their denial. How do I know that what the insurance company says, is the truth? If they say the claim is denied for timely filing, (1) when did they receive the claim and (2) what is their policy on timely filing? If the claim was denied as being inclusive, then what are the carrier’s CCI edits and if they are not based on National CCI edits guidelines, what are they using to make their CCI edit decisions? If they say they use guidelines from a medical society or information from an independent consultant, then have them show you these guidelines and the information from the consultant, not to mention the credentials of the consultant. A national insurance company once denied a claim based on their inclusive policy. They said that per the American Medical Association (AMA), one of the procedures I submitted is deemed to be inclusive with the visit code. What they didn’t know is that I had a letter from the AMA that said the procedure I billed is NOT included with the visit code. When the carrier saw this and I demanded their documentation from the AMA, the carrier changed their story. Their Medical Director and their Nurse Reviewer responded that now their denial is being based on their “personal opinions.”
I do not accept personal opinion as the basis for a denial. To add to this, another national insurance company denied a procedure stating that it was included with critical care that was performed. The appeal was sent four times by others within the company where I worked and each appeal denial was identical in wording with the denial being made by the same person. The appeal was now given to me. I too received the same denial, by the same person. My next level of appeal was sent to the CEO, demanding a di novo review and I submitted my appeal with copies of the CPT manual regarding critical care as well as supporting documentation from two medical societies that refuted what the Nurse Reviewer stated as the reason for the denial. My appeal was denied by their medical director, but this time, the Medical Director did not state that the procedures were inclusive.

The denial this time was that the services rendered were not supposed to be provided in the emergency room. I appealed this, demanding their documentation and I submitted documentation from the American College of Cardiology, the American College of Emergency Physicians and the American Heart Association.

The next letter, from another Medical Director, denied my request for their data but now the denial was changed. Now the denial is listed that the service we provided was a non-covered service. Wow, I now have three different reasons why the claim was denied. The insurance company could not provide one shred of evidence to support any of their denials.

My last appeal was submitted with copies of the health benefit manual, showing that the services were indeed a covered benefit. I stated that if they continued to deny, using the non-covered excuse, I would bill their HMO member and it would be their member contacting them.

Instead of getting another denial, I received a check for more than $1,200. Now the service was covered and payable. I gathered my evidence, I showed concrete proof behind my appeal and I never gave up. When they denied other claims of this same procedure, I appealed only once and used the previous appeal response as precedence for them to pay the claims. Eventually, the denials ceased and payment was made for the service.

When you receive your denial, you need to make a demand for full disclosure behind the denial. If the plan is an ERISA plan, 29 CFR 2560.503-1 states the following:

(2) Full and fair review.

Except as provided in paragraphs (h)(3) and (h)(4) of this section, the claims procedures of a plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures-

(i) Provide claimants at least 60 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(ii) Provide claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

(iii) Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

(iv) Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The claims procedures of a group health plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless, in addition to complying with the requirements of paragraphs (h)(2)(ii) through (iv) of this section, the claims procedures-

(i) Provide claimants at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal the deter-
mination;

(ii) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(iii) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(iv) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant’s adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

(v) Provide that the health care professional engaged for purposes of a consultation under paragraph (h)(3)(iii) of this section shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

The plan administrator shall provide a claimant with written or electronic notification of a plan’s benefit determination on review. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv). In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant—

(1) The specific reason or reasons for the adverse determination;

(2) Reference to the specific plan provisions on which the benefit determination is based;

(3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

(4) A statement describing any voluntary appeal procedures offered by the plan and the claimant’s right to obtain the information about such procedures described in paragraph (c)(3)(iv) of this section, and a statement of the claimant’s right to bring an action under section 502(a) of the Act; and

(5) In the case of a group health plan or a plan providing disability benefits—

(i) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

(ii) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either 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.

The following is from a National HMO Insurance Company’s health benefit manual:

The notice of denial will set forth the following:

the specific reason or reasons for the denial;

specific reference to Plan provisions on which the denial is based;

a description of any additional material or information necessary for you to complete the claim and an explanation of why such material or information is necessary;

a description of the Plan’s review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA after you have exhausted the appeals process; if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, the specific rule, guideline, protocol, or other similar criterion relied upon in making the determination, or a statement that such rule, guideline, protocol, or the similar criterion was relied upon in making the denial and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request; and if the denial is based on a medical necessity or experimental treatment or similar exclusion or

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limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

As you can see, the HMO has taken the disclosure requirement of Federal Law and incorporated it into the patient’s health benefit manual.

Anytime an insurance company has a question regarding the services that were provided and billed, they submit a request for the medical record. The medical record is your foundation to the claim and the care rendered. You deserve equal treatment when an insurance company performs a denial. How can you appeal their denial if you don’t see the proof behind their denial? If you are refused this proof, you might want to consider hiring an attorney to obtain a subpoena making a demand for the information needed to submit a proper appeal. If you elect to take this to court, you can bet your attorney will make a demand for disclosure and the court could demand the insurance company provide this information.

If an insurance company denies my request for the information to support their denial, then I do not recognize their denial to be valid. You may have to consider involving the patient with the denial of their health benefit, as well as State or Federal regulatory authorities. My letter, which is included with this manual, informs the carrier that if they do not provide the foundation to their denial, then I consider the denial to be invalid and their refusal to comply with my demand constitutes an implied consent to bill the member for a non-covered service. After all, the service is covered or not covered. If the service is covered, then they should pay the covered health benefit. If the health benefit is under ERISA jurisdiction, the member, or the member’s authorized representative, can file a complaint with the EBSA (Employee Benefits Security Administration, which is the enforcement department of the Department of Labor. The member can request an investigation into the possible denial of their right to disclosure under 29 CFR 2560.503-1.

(b) Research State Laws

Look at your State Laws to see what is documented as it relates to the denial. For example, if you submitted a claim on January 10 for a January 5 Date of Service and the insurance company denies the claim for timely filing, your State may have a law on timely filing. For example, in the State of Florida, you have several timely filing limits:

Florida Statute 627.6131: 3) All claims for payment or overpayment, whether electronic or nonelectronic: (a) Are considered received on the date the claim is received by the insurer at its designated claims-receipt location or the date the claim for overpayment is received by the provider at its designated location. (b) Must be mailed or electronically transferred to the primary insurer within 6 months after the following have occurred:

1. Discharge for inpatient services or the date of service for outpatient services; and
2. The provider has been furnished with the correct name and address of the patient’s health insurer.

As you can see, the provider has 180 days from the date of service AND from the date when the provider receives the correct insurance information. Therefore you have the information from State Law to assist you in the appeal of a timely filing denial. You might also want to use this information when negotiating your health insurance provider contracts.
Why accept a 90 day filing limit when State Law allows you more time? Health Insurance contracting will be presented in a separate E-Manual from BC Advantage, in the near future.

When researching State Laws, use your favorite internet Search Engine, such as Google, and search for State Insurance Laws. There are NO laws regarding medical billing. Laws regarding claims issues are usually found in Insurance laws. Some States have separate laws for HMOs, Commercial Insurance, Workers’ Compensation, and Personal Injury Protection (PIP) (Auto Accident). Medicaid laws are usually separate from Insurance Laws. For example in Florida, HMO laws are found in Florida Statute 641. Commercial Insurance and PIP Laws are found in Florida Statute 627, Medicaid Laws are found in Florida Statute 409, and Workers Compensation can be found in Florida Statute 440.

You also want to see if your State has Administrative Codes. For example, Workers Compensation Fee Schedules are found in Florida Administration Code 69L-7.

(c) Investigate Federal Laws.
Not all HMOs, PPOs, and POS plans are equal. Some State Laws lump all HMOs under the law, yet State Law may not have any jurisdiction over the claims process, health benefit, and appeals process. Federal Law may have jurisdiction instead. For example, a Medicare HMO is under the jurisdiction of the Centers for Medicare and Medicaid Services (CMS). A TRICARE HMO is under the jurisdiction of Department of Defense Regulations. The patient’s insurance card may provide you with clues as to who has jurisdiction over the claims process, health benefit payment, and appeals process. Let’s say Mrs. Jones and Mrs. Smith both present themselves with an identical Blue Cross and Blue Shield HMO insurance card. Mrs. Jones’s HMO health benefits are provided to her by her employer, Payless Shoe Store. Mrs. Smith may have her HMO health benefits provided to her by her employer, The City of Orlando. Mrs. Jones’s claim, benefit payment and appeals process may fall under Federal Law jurisdiction (29 USC 18, 1003a, 1004a, and 29 CFR 2560.503-1). Mrs. Smith’s HMO claim, benefit payment and appeals process may fall under Florida Statutes 641.31; 641.3154; 641.3155; and 641.513. Therefore, you need to go to the Federal Laws when researching Mrs. Jones’s claims, benefit payment and appeals issues. If you have a health benefit under ERISA jurisdiction, please refer to the ERISA Appeals E-Manual at the BC Advantage Website for more information about ERISA.
(d) Investigate Medical Society Information.

The various Medical Societies, such as The American College of Cardiology, the American College of Emergency Physicians and others, have excellent information available to you or your provider, that can be used to assist you with your appeal. For example, a National HMO denied a claim stating a Thrombolysis was only allowed to be performed in an ICU or CU setting and not the emergency department. I went to the American College of Cardiology and submitted my appeal with the documentation, from the College, showing that a Thrombolysis was required to be performed in the emergency department. Another national insurance company denied the EKG interpretation (93042) by stating it was deemed to be inclusive with an Evaluation and Management procedure (9928X).

The American Medical Association provided me with a letter stating that CPT 93042 is NOT included with ANY Evaluation and Management procedure. I continue to use this letter to this day.

(e) Research the Patient Benefit Manual

The patient’s health benefit manual or Summary Plan Description (SPD) is one of the most ignored documents that are never looked at by the patient, the provider or a billing agent. I went to several seminars, where I presented a seminar on the benefit manual. Of all of the attendees, none of them even looked at their own manual. My mother sends me hers every year because she finds it very confusing.

This manual contains a list of all health benefits the patient is entitled to receive, all benefits that are excluded for payment or reimbursement, the claims process, the appeals process, and much more. We wonder why the claims are being denied. This is because we have no clue as to whether the patient is entitled to receive the benefit or not. Some benefit manuals are very clear about what will happen when the patient goes out of network, yet the out of network provider is confused as to why the claim is denied when he/she treats the patient. The out of network provider is told he/she is paid usual and customary, when in fact, the claim is supposed to be paid at full charges.

How can you remedy this? Simple. We speak with the patient when they make an appointment and we speak with the patient to remind them of their appointment. How much time would it take to say, “Mr. Jones, when you come in for your appointment tomorrow, please bring a copy of all of your insurance cards, and a copy of your health insurance benefit manual.” If they present it, make a copy and return it to the patient. Then review it with the patient to see if the care they are asking for is a covered service, see if authorization is required, see how much the copays, coinsurance and deductibles are. There is much more and this too will be presented in another E-Manual from BC Advantage.

The following are just excerpts from a National HMO Health Benefit Manual:

*Your primary care physician (“PCP”) is responsible for authorizing and coordinating all of your healthcare needs including providing preventive and routine healthcare, authorizing consultations with specialists, and arranging for hospitalizations and other medical care. In order to obtain In-Network status for care, you must contact your PCP, prior to seeking medical services from a care provider other than your PCP (even if the care provider you wish to use is a Participating Provider), and obtain required authorization for such services.*

If you receive covered, approved services from a non-participating provider (for example, in an emergency), and you pay for those services, you must submit a claim to XXXXXXX for reimbursement.

When you are required to submit a claim to this Plan for covered expenses, submit your claim promptly. The Plan will not pay benefits for claims submitted later than December 31 of the calendar year following the year in which the expense was incurred.

As you can see, the benefit manual or Summary Plan Description is a wealth of information that you can use to not only manage the care of the patient, but also to deal with helping you with a successful appeal.

(f) Review Carrier Policies and Procedures

Every insurance company has a policy or procedure that regulates the payment of health care benefits. These policies or procedures give us guidance with CPT codes, ICD-9-CM codes that provide medical necessity, and other information that is highly useful.

The following are excerpts from Aetna Policy 0180:

**Clinical Policy Bulletins:**

*Vertebral Axial Decompression Therapy*

Aetna considers vertebral axial decompression (e.g., by means of the VAX-D Table, DRX9000, the DRS System, the Alpha-Spina System, the Lordex Lumbar Spine System, or the Internal Disc Decompression (IDD) Therapy) experimental and investigational. Currently, there is no adequate scientific evidence that proves that vertebral axial decompression is an effective adjunct to conservative therapy for back pain. In addition,
vertebral axial decompression devices have not been adequately studied as alternatives to back surgery.

Other CPT codes related to the Clinical Policy Bulletin (CPB):
- 64722
- 97012

HCPCS codes not covered for indications listed in the CPB:
- S9090

ICD-9 codes not covered for indications listed in the CPB (not all-inclusive):
- 720.0-724.9

The above policy is based on the following references:
4. Ramos G, Martin W. Effects of vertebral axial decompression on intradiscal pressure. J Neurosurg. 1994;81(3):350-353. As you can see, this carrier policy provides excellent guidance regarding its payment decision and it provides the reader with the references that provide foundation to the policy and the reader has the ability to go to those references for additional review.

Providers need to be very careful with carrier policies and procedures. When a provider signs a contract without reviewing these policies and procedures, they are agreeing to the contents and then the provider doesn’t understand why the claims are denied because of a carrier policy and procedure.

The provider wants to appeal the denial, but the provider agreed to the policy, so appealing may not be successful. One carrier policy can be regarding its own Correct Coding Initiative (CCI) edits. The National CCI edits developed by the Centers for Medicare and Medicaid Services have no jurisdiction on a private health insurance company, so when the provider blindly agrees to the carrier’s coding policy, then the provider also agrees to accept the carrier’s CCI edits. Before signing any contract where the contract makes reference to a policy or procedure, the provider should ask to review them. For example, when negotiating with a large insurance company, I asked to see their CCI edits. They refused to provide it to me. I also asked to see the documentation providing support to their CCI edits and they refused. We then required the language of the contract to state that the carrier must follow National CCI edit requirements when processing the provider’s claims. If the coding denial was against National CCI edit guidelines, then the carrier had fourteen (14) days to provide the documentation to their denial. If they refused they were obligated to pay the claim. They refused these changes, so the provider decided not to continue with the contract negotiations. If the carrier doesn’t provide the policies and procedures for review, the provider should have all reference to the policy or procedure removed. If the provider has a disagreement regarding a policy, then referenced to the policy should be removed. The provider should not agree blindly to any policy change without being given the opportunity to review and approve the change, in writing.

Government programs such as Medicare, Medicaid, and Tricare have their policies and procedures available on line. Medicare policies can be found through their National Coverage Decisions (NCDs) and Local Coverage Decisions (LCDs). Local Coverage Decisions can vary from State Medicare Carrier to Carrier, so what takes place in Florida, may not be the same as in New York. You can find LCDs by going to your local Medicare Carrier website. Medicare National Coverage Decisions can be found by going to: http://www.cms.hhs.gov/med/search.asp?from2=search1.asp

Medicare also publishes Medicare Learning Matters articles which cover policy changes. You can find MLN articles by going to: http://www.cms.hhs.gov/MLNMattersArticles/ A list of State Medicare Carriers can be found here: http://www.cms.hhs.gov/ContractingGeneralInformation/Downloads/02_ICdirectory.pdf

Some people have questions about Global Periods because some carriers may deny a claim because the service was rendered during the surgical global period. CMS publishes its global periods in its RVU file. These can be obtained by going to: http://www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/list.asp#TopOfPage
Please understand that Global Periods have no jurisdiction over non-Medicare carriers, but they do have jurisdiction over Medicare HMOs. Private health insurance companies can have their own global periods as can State Workers Compensation laws.

Tricare information can be obtained by going to: http://www.mytricare.com/internet/tric/tri/tricare.ns
CHAMPVA information can be obtained by going to: http://www.va.gov/hac/forbeneficiaries/champva/champva.asp
Railroad Medicare information can be obtained by going to: http://www.palmettogba.com/
Medicaid by State can be found by going to: http://www.colorado2.com/medicaid/states.html

(g) Review State Resources
There are many resources on State websites that you can use to help develop your appeal. You have Workers’ Compensation sites where you can download fee schedules, provider manuals, and references to State Workers’ Compensation laws. There is the Division of Corporations where you can do research on a health insurance company to find their corporate office and list of corporate officers. Each State has a Medicaid site where you can download the Medicaid Provider Manual, Fee Schedules, Policy Changes, and the Laws regulating Medicaid. One question I see asked all the time is, “Can I charge a percentage of what I collect?” Many people say NO, but the only laws I have found that prohibit percentage billing is when you are billing for Medicaid. Florida has no percentage billing listed in the Florida Medicaid Provider Manual. Each State has a website where you can research State Laws or Statutes. Again, you need to look for Insurance laws, laws for Medicaid or Social Services and laws for Workers Compensation. State Workers Compensation sites can be found here: http://www.comp.state.nc.us/ncic/pages/all50.htm A link to all 50 State Statutes websites can be found here: http://www.prairienet.org/~scruffy/f.htm Each State also has a Department of Insurance. This site is useful to find lists of insurance companies approved to operate in the state, insurance bulletins, and address to file complaints. Links to all 50 State Department of Insurance websites can be found here: http://www.insbuyer.com/departmentofinsurance.htm

(h) Read Carrier Provider Manuals
The insurance company’s provider manual contains additional information that is not found in the provider contract, yet, the contract makes reference to the provider manual for additional information. It is important that when the provider wishes to be contracted, the provider ask for a copy of the provider manual for review. The provider can ask to have sections of the manual be carved out of the contract if that section conflicts with the provider’s specialty. For example, the provider manual may state that all providers obtain authorization prior to treating the patient. For an emergency care physician, this requirement would conflict with State and Federal Laws regarding emergency care. If the carrier refuses to provide this document, then the provider must have all references to it stricken or removed from the contract. The provider should also ask to have authority to approve any changes made to the provider manual. Some provider manuals are available on the internet. Go to your internet search engine and type, “Provider Manual”.

(i) Review Provider Contracts
Provider Contracts, like the health benefit manual, has information that is vital to preparing an appeal. The contract should contain timely filing limits, exceptions to the timely filing limits, claims payment timeframes, penalties when claims are paid less or unpaid, the appeals process, the payment schedule, all carriers allowed access to the contract, remedy clauses and much more. Sadly, providers sign contracts without knowing what is missing, what clauses are incomplete, no time limits for claims resolution, no appeals process, silent PPO allowance and much more. The contract could be so pro-insurance company, that the provider gives up all rights to any decent reimbursement and rights of appeal. Many times I hear the following: “The insurance company did…… can they do this?

When looking at the contract, I have no choice but to say, ‘Yes, the insurance company can do what they did because you gave them permission to do that and you cannot appeal what they did.’ One clause I see many times says the following: “In the event the claim is denied, the provider is prohibited from balance billing the member unless the member gives the provider written permission to do so.” Ask yourself this question, how many patients will give you written permission to bill them when the claim is denied? Another clause I see is this: “Payment of the claim will be within a reasonable timeframe.” Define reasonable. To the insurance company, a reasonable timeframe could be 2-3 years.

(j) Provide Documentation of Other Carrier Payments
When an insurance company says the service is experimental or investigational, see if other insurance companies such as Medicare, Medicaid or commercial insurance companies are paying the same procedure. If so, then this could be used to show that other carriers have already conducted their own investigation and are now paying for the procedure as a covered service. Naturally, when you have an investigational or experimental denial, you demand a copy of the carrier’s policy and references that provides foundation to their denial.
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(k) Investigate Class Action Lawsuit Settlements
Many times, a class action lawsuit settlement will contain information where the carrier has agreed to certain conditions as part of the settlement. For example, let’s say the carrier has denied CPT 93042 as being inclusive with an E/M code. The carrier was involved in a class action lawsuit and as part of the settlement, the carrier has agreed to stop denying CPT 93042 as being inclusive with an E/M code.

(l) Provide proof of the insurance company’s past payments
It helps to develop a profile on the insurance company. They already have a profile on your provider. They know what CPT and ICD-9 codes are being submitted. They know a provider’s usual and customary charges. You need to be just as smart. I once spoke to a provider’s billing agent and she told me she doesn’t know what Tricare pays for a procedure they must do about 70 times per day and I know they treat many Tricare patients. When I receive a denial, I look to see if they paid for the procedure before. One large insurance company told me several times they do not pay for CPT 93042, yet, when looking at their payment history, they paid this procedure more than 11,000 times in a three year period.

Not only did they pay it, they paid it at 100% of billed charges. When I presented this to their Medical Director, his staff member kept saying they don’t pay it, yet the Medical Director had to concede they did once he saw the stack of EOBs in front of him. When contracting, I make sure the contract stipulates and identifies every procedure, in detail, that the provider renders, that is a covered service, is paid. I provide the carrier with a list of all procedures billed in the past 5 years.

(m) Review the Medical Record
The medical record is your source document for the visit, for the charges, and for the CPT and ICD-9-CM codes submitted. I had a carrier downcode all level 5 visits to a level 3. I used the medical record provide proof that the visit was a true level 5 visit and then I demanded the carrier's coding reasoning as to why they said the visit was a level 3 visit.

I also demanded the qualifications of the person who downcoded the claim. It turned out the person doing the downcoding had no training, background, certification, or experience as a coder. I found it insulting that a non-coder was downcoding my doctor’s claims and I filed a complaint with the regulatory authorities. With another insurance company, the claims were being denied as being a non-emergency medical condition when the services were rendered by a Board Certified Emergency Care Provider in an emergency room. The person doing the review was a Family Practitioner hired by the insurance company, who had no background in emergency medicine. We filed a complaint with the regulatory authorities because Florida Law demanded that the person reviewing the medical record must be a physician of the same specialty as the provider rendering the service.

(n) Use the CPT and ICD-9-CM Manuals
Sadly, I see too many people ignore the documentation that is listed in the manuals. The manuals contain plenty of information that you can use in your appeal. An insurance company once denied the claim saying CPR was included with Critical Care. I showed the insurance company that the CPT manual clearly identifies all codes that are included with critical care and CPR is NOT included with critical care. I also had to show a provider that the insurance company was correct with its denial of the claim. The provider treated the patient early in the day in his office and then later in the day, he admitted the patient and he billed both the hospital admit and the office visit. The insurance company denied the claim saying the office visit was included with the hospital admit. I showed the provider the hospital admit guidelines, which proved the insurance company was correct. I may not agree with an insurance company when they are wrong, but when they are correct, I have to defend their actions.

STEP #6: PREPARE YOUR APPEAL
Once you have done your research and you have all of your evidence to support your appeal, then it’s time to prepare your appeal. Not all appeals will be the same. Each one will be different based on the variables that affect the visit, the services rendered, the benefits the patient is entitled to receive, carrier policies and procedures, the provider contract, the denial itself and all other variables.

Like I mentioned earlier, you may have two people with the same identical insurance card. One policy is under Federal Law jurisdiction, the other State Law. One patient may have benefits, the other may not have benefits. One patient may have a $15 copay, the other $25. One patient may have a $200 deductible, the other none. One patient may have the benefit paid at 60% of UCR with the patient paying the balance and the other patient may have all benefits paid in full. One patient may have a one year time limit for submitting claims, the other 90 days. The appeals process will be different with each patient. So, please, NEVER ASSUME ANYTHING!

James McCuen of The Coding Edge, Inc., a billing company located in Sanford, Florida, is my mentor and he taught me about medical billing. His first words to me were: VERIFY, VERIFY, VERIFY! If I brought anything to his attention, he always told me that he doesn’t believe me. He demanded I provide him with the proof behind what I was presenting him. This made me a better medical biller...
because I learned to research, research and research, plus I don’t believe what people tell me unless they provide me with proof behind what they say.

As you can see from this manual and the ERISA manual, I provide proof behind everything I present. This is in the form of manuals, websites, patient benefit manuals, contracts, and more.

(a) Show Medical Necessity
Your appeal should present the medical necessity behind the visit. This is done to show justification behind the codes you submitted. I usually present what is documented in the medical record. For example:

Mrs. Jones presented herself to the clinic with a complaint of head pain, neck pain and shoulder pain for the last three days. You can see that the documentation shows four HPI Items (Location, Duration, Timing, and Associated Symptoms). The documentation shows four systems reviewed by the physician (Neurological, Musculoskeletal, Integumentary, and Constitutional). The documentation shows two out of the three Past, Family, and Social History, specifically Past and Social History. Based on these three components of the History, we have a Detailed History documented. If you look at the multi-system examination, you have 9 bullet items documented. Therefore, based on HCFA E/M Documentation Guidelines, we have a Detailed Examination. When you review the Medical Decision Making, you have multiple diagnoses, multiple tests and data to review and Risk is Moderate, therefore, the documentation supports a Moderate Medical Decision Making. When you review CPT Guidelines for a New Patient visit, the documentation supports CPT 99204 and not CPT 99202 as your company states.

You want to be very specific, using the evidence you have gathered, along with industry standard guidelines to support the medical necessity in your appeal.

(b) Use References that support your appeal.
You went to a lot of trouble to obtain the evidence, so use it to your best benefit. For example:

As you can see from your EOB, dated, March 3, 2007, your company denied the claim stating the claim was received in an untimely manner. When you review the medical record documentation, the patient was seen on January 12, 2007. The attached report from the Medical Manager medical billing software, a nationally recognized medical billing software, shows the claim was submitted electronically, through our clearinghouse, NCH on January 13, 2007. The report from NHC shows they received the claim and submitted the claim to your company on January 13, 2007. The additional report from NHC shows your company acknowledged receipt of the claim on January 14, 2007. If you review the attached contract you have with Dr. Smith, signed by your company on January 2, 2005, Page 7 clearly shows Dr. Smith has ninety (90) days from the date of service to submit the claim. The claim submitted and received by your company was submitted well within the timely filing limits outlined in the contract. You can also see, from the EOB, dated March 3, 2007, the denial took place well within the ninety (90) day timely filing limit. Therefore, your denial has no validation and we demand payment of the claim.

Everything that you can do to make your appeal rock solid, will provide credence to your appeal. In the event that you or the member may decide to proceed further in a court of law, what you presented in your appeal can also be presented as evidence. As you
may have heard on TV Court shows such as “The People’s Court”, the preponderance of the evidence is on the accuser. Therefore, for you to have the denial, unpaid, or incorrect payment overturned in your favor, you must be absolutely sure of your facts. Once you prove your case, then it will be up to the insurance company to prove their case. As you may have heard, “If the glove don’t fit, you must acquit.”

(c) Keep your appeal professional

You want your appeal to show it is professional, so keep it professional. Do not make any accusations. Just present the facts that are documented. Like coding, if it isn’t documented, it doesn’t exist, so never assume what the insurance company may have thought. Most denials are created by computers using software edits. Your appeal will be read by a real person.

(d) Send your appeal by Certified Mail/Return Receipt

Some people may think that this is an unnecessary expense. How many times have you heard the insurance company say, “We never received it.” I’ve sent many appeals by Certified Mail and the insurance company said they never received it. My response to them was that I was now filing a complaint with the regulatory authorities and they can explain to the regulatory authorities how I have it documented that my claim or appeal was sent Certified/Return Receipt and someone in the company signed for the documents. You would be amazed that when this is presented to them, the document is somehow found. You have to understand that without proof, it is your word against theirs. I once visited a large health insurance company, with the President of the practice.

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We met with their Medical Director and personally handed him more than 500 claims that were at issue with non-payment due to the insurance company’s excuse, “We never received the claim.” The Medical Director gave the claims to an assistant to take to the claims department. When our meeting ended, as we were walking out of the building, we found the claims in a trash can near the exit. It was very embarrassing to the Medical Director to find this. He could never say our claims were never received again.

You may have an appeals process that requires you to send your appeal by Certified Mail/Return Receipt. For example, if you wish to file a complaint with the Florida Division of Workers’ Compensation, then you must show them that you resent the claim or an appeal by Certified Mail/Return Receipt. This way the insurance company cannot tell the State that they never received your documents. The insurance company may say this anyway, but now the State can tell the insurance company that they have proof of receipt of the documents.

(e) Follow the appeals process to the letter

As a contracted provider, your contract should specify the requirements for submitting appeals. Some contracts are very vague and provide no guidance or remedy to an appeal. The following is taken from a national health insurance company provider contract:

Group and Participating Group Physicians agree to (a) cooperate with and participate in Company’s applicable appeal, grievance and external review procedures (including, but not limited to, Medicare appeals and expedited appeals procedures), (b) provide Company with the information necessary to resolve same, and (c) abide by decisions of the applicable appeals, grievance and review committees.

As you can see, the provider who agrees with this has no clue what the appeals procedure includes. There is no process to follow, no address to send the appeal, no timeframe for the insurance company to reply and whatever the insurance company’s response is, the provider agrees to be bound to the insurance company’s decision. Wouldn’t you say you are in a losing situation with any appeal you send?

The following is from an HMO Benefit Manual:

Ask us in writing to reconsider our initial decision. You must:
- a) Write to us within 6 months from the date of our decision; and
- b) Send your request to us at: XXXXX Member Relations, P.O. Box 9999, Anywhere, FL 99999-9999; and
- c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and
- Include copies of documents that support your claim, such as physicians’ letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

1) We have 30 days from the date we receive your request to:
- a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or
- b) Write to you and maintain our denial - go to step 4; or
- c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.

2) You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.
- If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.
- We will write to you with our decision.

3) If you do not agree with our decision, you may ask XXX to review it. You must write to XXX within
- • 90 days after the date of our letter upholding our initial decision; or
- • 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or
- • 120 days after we asked for additional information.
- Write to XXX at: United States XXXXX, Insurance Services Programs, Health Insurance Group, 9999 Street, NW, Washington, DC 99999.

Send XXX the following information:
- • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- • Copies of documents that support your claim, such as physicians’ letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- • Copies of all letters you sent to us about the claim;
- • Copies of all letters we sent to you about the claim; and
- • Your daytime phone number and the best time to call.

Note: If you want XXX to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with XXX. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.

You can see that the member’s appeal rights are very detailed. It contains instructions as to when the appeal is to be sent, what documents should be attached to the appeal, where the appeal is to be sent, the timeframe for the insurance company to respond and other
information. Some appeals processes outline a two-level appeal process.

If a lawsuit may be required, the insurance company can require the member or provider to exhaust the entire appeals process prior to going to court. I have seen lawsuits thrown out of court because the provider failed to exhaust the insurance company’s appeal process.

The following is from another national health insurance company health benefit manual:

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before (name of insurance company) when (name of insurance company) decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

As you can see, per the terms listed above, the only thing that will be allowed in court will be the evidence you presented in your lawsuit. This is why it is important to gather all of the information you must have to support your appeal. You can also see that this national insurance company tells the patient that Federal Law governs the member’s benefit and payment of the benefits, yet, this same insurance company tells the doctor that State law governs the payment of the benefits because State law has a no balance billing of the patient. The insurance company appears to want protection of both Federal and State law as it pleases them.

(f) Follow-Up On Your Appeal

Once you send your appeal, you want to allow the insurance company time to respond. With an ERISA appeal, Federal Law has time limits for the insurance company to respond. With those that appeal without written authorization from the member, you wonder and become upset when the insurance company doesn’t respond to your appeals. This is because they don’t have to respond to you. Their responsibility is to respond to their member. If you have written authorization, the insurance company can still respond to their member. You need to be in constant contact with the member to see if any responses have been received.

I have a tickler file set up for appeals. This is a simple accordion folder you can buy cheaply at any office supply or warehouse store. I prefer the folders with numbers that I use as dates. If I allow the carrier a thirty (30) day time limit to respond and today is the 5th of the month, I put the appeal under number 10. This is to allow the appeal to arrive at the insurance company within 5 days. If you sent the appeal by certified mail, I wait until I have the green card back from the post office. I look at the date that the insurance company signed for the appeal and put the appeal, with the certified mail receipt and green card in the tickler file under the number corresponding with the day of receipt. If the appeal was received on the 5th, I put the appeal under number 5.

I also go into the patient’s account and make notes regarding the appeal, such as the date of the EOB, what was denied, and when the appeal was sent and received. This makes it easy to find the appeal and corresponding paperwork. Each day I run a payment report for the previous days postings. I look to see if any payment came in on my appeal. If payment came in, I pull the appeal from the tickler file. I look to see if the payment is correct. If so, then I scan all documents so I have an electronic file. I then burn the scanned image to DVD for archiving. I also make an entry into the patient’s account regarding the receipt of payment.

If I receive correspondence other than a payment, I go into the account, look at the notes to see where the appeal is located in the tickler file, then I remove the appeal and work it. The insurance company’s response will dictate my next action. I may have to bill the member. I may have to file a second level of appeal or I may have to file a grievance with the regulatory authorities. The one thing I never do is give up. Any further action I do is always documented in the notes of the patient’s account.

Every day when I arrive to work, I pull out my tickler file to see what is in today’s number so that I can work on them to see if I have any appeals left. This means the insurance company never responded to the appeal. I then decide what action to take. This could mean billing the patient, filing a second level of appeal because I deem their non-response to indicate a denial, or I file a grievance with the regulatory authorities. If I bill the patient, this means I must do so, so that the patient can pursue this further continuing their right of appeal. This could require the patient to hire an attorney to take the case to court because all level of appeals have been exhausted.

(g) Make a Decision On Your Final Step

The time has come and the insurance company has ignored you or the insurance company has denied the appeal without any foundation to their denial. You’ve done your homework, you’ve gathered your evidence to show the insurance company that their decision was incorrect, and you have given them ample opportunity to respond correctly. You have just a few choices and they are divided into whether the doctor is contracted or not.

If the doctor is contracted, the doctor must decide whether to write the balance off as an administrative write off, to proceed to court to resolve a contract issue or to terminate the contract. Terminating may be the provider’s only choice if the insurance company refuses to honor the contract and is costing the provider revenue. I know terminating is a tough decision, especially when the provider’s main income is from the insurance company, but if the provider chooses to do nothing, then the provider loses and the provider has no choice but to refrain from complaining about how the insurance company is treating them. The question that should be asked is, If the insurance company has a take it or leave it attitude, why contract with the company when you know you will have these problems once you contract. If you elect to make a freedom of choice decision to contract and you do nothing to prevent the problems you see with a take it or leave it
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attitude, then you decided to accept those problems.

I know providers who have terminated their contracts and feel better about it. The patients elected to continue with the provider, knowing the provider is out of network and they would have higher out of pocket costs. With one provider, the patient’s actually applied pressure on the insurance company to renegotiate the contract with the provider. Through months of negotiations, the provider not only had a better contract with a better reimbursement, but we negotiated a settlement of his outstanding claims.

With the provider that is not contracted, the provider’s only choice is to turn the issue back to the patient so that the patient can decide what action to take regarding their benefit issue. The non contracted provider merely provided assistance to the patient as a courtesy, but as a non contracted provider, you can only do so much and go so far. The patient may have to hire an attorney to resolve their benefit issue and please understand, that the actions you took to help, can be brought forth as evidence during the court proceedings. The patient also has to resolve their debt with the non contracted provider. The insurance company’s sole responsibility with a claim is to pay the benefit, nothing more. It is the patient that must resolve their medical bill with the provider. Patients take the payment of their benefit and apply it to the debt they owe to the provider. People think that the insurance company’s job is to pay the provider. That is true with contracted doctors. This is because the doctor agreed to accept the benefit payment at a rate that is less than the provider’s usual and customary charges.

The following is from an HMO Patient Benefit Manual:

*How we pay providers* We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance. All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure.

*Notwithstanding the above, XXXXX or the Plan Administrator may, in its sole discretion, cause your participation in the Plan to terminate if you provide false information or make misrepresentations in connection with a claim for benefits. If you receive covered, approved services from a non-participating provider (for example, in an emergency), and you pay for those services, you must submit a claim to XXXXX for reimbursement. If your claim or request for benefits is denied in whole or in part, you will receive written notification from XXXXX within a reasonable period of time.*

As previously stated, an E-Manual will be forthcoming on The Patient Benefit Manual and Provider Health Insurance Contracting.

Appealing is an art. It is rarely taught in medical billing classes. Sometimes a simple phone call to the insurance company will correct the problem. Many times, you will need to submit an appeal of the insurance company’s contract with the provider or a health benefit determination. If you wish to submit a successful appeal, you need to do your homework and you need to make sure your appeal can stand up in a court of law.

What you do affects the patient, the provider, and your fellow medical billers. If you don’t know what you are doing, never guess. Turn the issue over to someone who does know what they are doing. Never develop a “We’ve done it this way for years” attitude because things constantly change. As I stated earlier, I made many mistakes early in my career. I am called “The Pitbull” by those that know me. They call me that because I am aggressive when protecting my providers and I don’t give up until the insurance company does what is right.

People have used my appeals successfully. This is because they have been tried before and they are successful. Please understand that insurance companies become immune to hearing the same thing over and over again. This is why you have to be two steps ahead of the insurance company. You must make sure you reference current benefit manuals, current provider contracts, current laws, and anything else that provides foundation to your appeal. If dealing with an insurance company’s claims, appeals, or provider relations departments is getting you nowhere, then send the problem directly to the CEO or President. I never deal with the monkey when I can deal with the organ grinder.

I wish each of you much success with your appeals processing and if you are successful, drop a line to BC Advantage so we can all share in your success.
MEDICARE APPEALS

If you are appealing a Medicare issue, here is the Medicare appeals process:

Five Levels in the Appeals Process
Medicare offers five levels in the Part A and Part B appeals process. The levels, listed in order, are:
• Redetermination by the Fiscal Intermediary (FI) or the carrier
• Reconsideration by a Qualified Independent Contractor (QIC)
• Hearing by an Administrative Law Judge (ALJ)
• Review by the Medicare Appeals Council within the Departmental Appeals Board, (hereinafter “the Appeals Council”)
• Judicial review in U.S. District Court

First Level of Appeal: Redetermination
A redetermination is an examination of a claim by the FI or carrier personnel who are different from the personnel who made the initial determination. The appellant (the individual filing the appeal) has 120 days from the date of receipt of the initial claim determination to file an appeal. A minimum monetary threshold is not required to request a redetermination.

Requesting a Redetermination
A request for a redetermination may be filed on Form CMS-20027 available at www.cms.hhs.gov/forms.

A written request not made on Form CMS-20027 must include:
• Beneficiary name
• Medicare Health Insurance Claim (HIC) number
• Specific service and/or item(s) for which a redetermination is being requested
• Specific date(s) of service
• Name and signature of the party or the authorized or appointed representative of the party

The appellant should attach any supporting documentation to their redetermination request. Contractors will generally issue a decision (either a letter or a revised remittance advice) within 60 days of receipt of the redetermination request.

Note: Contractors can no longer correct minor errors and omissions on claims through the appeals process. For information on how to correct minor errors and omissions, please see the following MLN Matters article located at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0420.pdf on the CMS website.

Second Level of Appeal: Reconsideration
A party to the redetermination may request a reconsideration if dissatisfied with the redetermination. A QIC will conduct the reconsideration. The introduction of QICs allows for an independent review of medical necessity issues by a panel of physicians or other health care professionals. The Part A QICs began processing reconsiderations on May 1, 2005 for redeterminations issued by FIs on or after May 1, 2005. The Part B QICs began conducting reconsiderations on January 1, 2006 for redeterminations issued by carriers on or after January 1, 2006. Redeterminations issued prior to January 1, 2006 have appeal rights to the carrier hearing officer. A minimum monetary threshold is not required to request a reconsideration.

Requesting a Reconsideration
A written reconsideration request must be filed within 180 days of receipt of the redetermination. To request a reconsideration, follow the instructions on your Medicare Redetermination Notice (MRN). A request for a reconsideration may be made on Form CMS-20033. This form will be mailed with the MRN. If the form is not used, the written request must contain all of the following information:
• Medicare Health Insurance Claim (HIC) number
• Specific service(s) and/or item(s) for which the reconsideration is requested
• Specific date(s) of service
• Name and signature of the party or the authorized or appointed representative of the party
• Name of the contractor that made the redetermination

The request should clearly explain why you disagree with the redetermination. A copy of the MRN, and any other useful documentation should be sent with the reconsideration request to the QIC identified in the MRN. Documentation that is submitted after the reconsideration request has been filed may result in an extension of the timeframe a QIC has to complete its decision. Further, any evidence noted in the redetermination as missing and any other evidence relevant to the appeal must be submitted prior to the issuance of the reconsideration decision. Evidence not submitted at the reconsideration level may be excluded from consideration at subsequent levels of appeal unless you show good cause for submitting the evidence late.
Reconsideration Decision Notification

Reconsiderations are conducted on-the-record and, in most cases, the QIC will send its decision to all parties within 60 days of receipt of the request for reconsideration. The decision will contain detailed information on further appeals rights if the decision is not fully favorable. If the QIC cannot complete its decision in the applicable timeframe, it will inform the appellant of their right to escalate the case to an ALJ.

Third Level of Appeal: Administrative Law Judge Hearing

If at least $110* remains in controversy following the QIC’s decision, a party to the reconsideration may request an ALJ hearing within 60 days of receipt of the reconsideration. (Refer to the reconsideration decision letter for details regarding the procedures for requesting an ALJ hearing.) Appellants must also send notice of the ALJ hearing request to all parties to the QIC reconsideration and verify this on the hearing request form or in the written request.

ALJ hearings are generally held by video-teleconference (VTC) or by telephone. If you do not want a VTC or telephone hearing, you may ask for an in-person hearing. An appellant must demonstrate good cause for requesting an in-person hearing. The ALJ will determine whether an in-person hearing is warranted on a case-by-case basis.

Appellants may also ask the ALJ to make a decision without a hearing (on-the-record). Hearing preparation procedures are set by the ALJ. CMS or its contractors may become a party to, or participate in, an ALJ hearing after providing notice to the ALJ and all parties to the hearing.

The ALJ will generally issue a decision within 90 days of receipt of the hearing request. This timeframe may be extended for a variety of reasons including, but not limited to, the case being escalated from the reconsideration level, the submission of additional evidence not included with the hearing request, the request for an in-person hearing, the appellant's failure to send notice of the hearing request to other parties, and the initiation of discovery if CMS is a party. If the ALJ does not issue a decision within the applicable timeframe, you may ask the ALJ to escalate the case to the Appeals Council level.

*Note: The amount in controversy required to request an ALJ hearing is increased annually by the percentage increase in the medical care component of the consumer price index for all urban consumers.

Fourth Level of Appeal: Appeals Council Review

If a party to the ALJ hearing is dissatisfied with the ALJ’s decision, the party may request a review by the Appeals Council. There are no requirements regarding the amount of money in controversy. The request for Appeals Council review must be submitted in writing within 60 days of receipt of the ALJ’s decision, and must specify the issues and findings that are being contested. (Refer to the ALJ decision for details regarding the procedures to follow when filing a request for Appeals Council review.) In general, the Appeals Council will issue a decision within 90 days of receipt of a request for review. That timeframe may be extended for various reasons, including but not limited to, the case being escalated from an ALJ hearing. If the Appeals Council does not issue a decision within the applicable time frame, you may ask the Appeals Council to escalate the case to the Judicial Review level.

Fifth Level of Appeal: Judicial Review in U.S. District Court

If $1,090* or more is still in controversy following the Appeals Council’s decision, a party to the decision may request judicial review before a U.S. District Court judge. The appellant must file the request for review within 60 days of receipt of the Appeals Council’s decision. The Appeals Council’s decision will contain information about the procedures for requesting judicial review.

*Note: The amount in controversy required to request judicial review is increased annually by the percentage increase in the medical care component of the consumer price index for all urban consumers.
Helpful Internet Links

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Insurance Companies Corporate Offices

Aetna:  
151 Farmington Ave.  
Hartford, CT 06156  
Phone: 860-273-0123  
Fax: 860-273-3971  
Toll Free: 800-872-3862

Beechstreet  
25500 Commercentre Drive  
Lake Forest, CA 92630-8855  
Phone: 949.672.1000  
Fax: 949.672.1111

Blue Cross and Blue Shield:  
Go to your Division of Corporations Website

Blue Cross and Blue Shield Association  
225 N. Michigan Ave.  
Chicago, IL 60601-7680  
Phone: 312-297-6000  
Fax: 312-297-6609

Cigna:  
2 Liberty Place, 1601 Chestnut St.  
Philadelphia, PA 19192  
Phone: 215-761-1000  
Fax: 215-761-5515

Humana:  
500 W. Main St.  
Louisville, KY 40202  
Phone: 502-580-1000  
Fax: 502-580-3677  
Toll Free: 800-486-2620

Kaiser Permanente  
One Kaiser Plaza  
Oakland, CA 94612

PacifiCare  
5995 Plaza Dr.  
Cypress, CA 90630  
Phone: 714-952-1121  
Fax: 714-226-3581

United Healthcare  
9900 Bren Road East  
East Minnetonka, MN 55343  
Phone: 952-936-1300  
Fax: 952-936-7430  
Toll Free: 800-328-5979

WellCare Healthplans  
8725 Henderson Rd., Renaissance 1  
Tampa, FL 33634  
Phone: 813-290-6200  
Fax: 813-262-2802

Wellpoint  
120 Monument Cir.  
Indianapolis, IN 46204  
Phone: 317-532-6000  
Fax: 317-488-6028
Sample Appeal Letters

The attached appeal letters were created by myself and used successfully in winning not only reversals of the denial, but settlements for many of my providers.

You are free to use these appeal letters. You cannot claim them as your own, nor can you post them on any website or forum without my written permission. You do not have my permission to place these in any newsletter, book, magazine or any other publication whether it be an electronic or paper publication.

When using these letters, you hold myself and BC Advantage harmless at all times against any lawsuits or complaints.

Titles of letters included:
a) Request for information
b) Timely filing denial
c) Timely filing denial - 2
d) Collection agency demand
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(*Depending upon association)
Subject: Request for Information

Dear Sir or Madam;

As you can see from the attached Explanation of Benefit form, dated (date), your company denied the services rendered to your member on (Date of Service). In order to prepare a proper appeal, we are requesting the following information as part of the claims and appeal disclosure process:

(1) A legible copy of the policy or procedure regarding the health benefit that is being denied.

(2) A legible copy of any and all documents that were used to make the adverse benefit determination.

(3) The Name and Specialty of the person performing the benefit denial.

(4) Any and all information that is needed by your company in order to have the denial reversed.

In accordance with 29 CFR 2560.503-1, we ask that the above information be sent to us, at the address in the above letterhead, to be received no later than thirty (30) days from the date of the receipt of this letter. If you choose not to respond with the above requested information, we will have no choice but to imply that there is no foundation to your denial and we will consider your denial of the benefit to be a non-covered service which could allow us to bill the member for the denied benefit.

I am attaching a copy of your member’s written authorization, allowing us to assist your member with the appeal of the denial of their health benefit. This copy is as valid as the original document.

A copy of this letter is being sent to your member and this letter could be brought forth as evidence in a court of law.

Your cooperation in this matter is greatly appreciated.

Sincerely,

Name of Provider
Dear CEO,

On (Date), I provided medical care to your member (Name of patient). I am not contracted with your insurance company and your member was properly informed that I am not a network provider. Your member made a freedom of choice decision to continue with my care, knowing the full consequences of seeking care from an out of network provider. As a non-contracted provider, I have no obligation to code and submit a claim for your member, this is your member’s contractual responsibility. Your member asked me to send their claim, so as a courtesy, I submitted their claim on (date). Your member’s claim was submitted in a timely manner. I have no reason to withhold claims because to do so benefits no one. I have been withholding the billing of your member, for my full usual and customary charges, pending your payment of your member’s health benefit.

Your company denied your member’s claim by stating the claim was received in an untimely manner. As I stated, this was not my claim you denied, it was your member’s claim you denied and regardless of who sends the claim, whether it be your member or the provider, the claim is the same. I realize that your company has no obligation to pay me. It is your member that must reimburse me for the services they requested. This letter is simply sent as a final courtesy to inform you of my part in sending the claim in a timely manner. If you wish to continue to deny your member’s claim, you must answer to your member for your actions.

If you wish to reconsider, you may send the payment of your member’s benefit to me, per the Assignment of Benefit form that was signed by your member. Upon receipt of the health benefit payment, I will take the health benefit payment and apply it to your member’s debt. If you choose to continue to deny payment of your member’s benefit, this will only cause me to revoke my courtesy in sending your all of your member’s claims. I will enforce your member’s contract by requiring your member to pay me at the time of service and they can send their own claim. In the event my courtesy is revoked, and your company sends a request for a claim, I have the option of denying your request or you can pay my administrative fee of $125 for processing a claim. A copy of this letter is being sent to your member. I will allow you fourteen business days to respond.

Very Truly Yours,

Name of Provider
Name of Practice
Address
City, State ZIP
Phone

Date

SENT CERTIFIED MAIL/RETURN RECEIPT

Name of Insurance Company
Attn: CEO
Corporate Address
City, State ZIP

Subject: Timely Filing Denial

Dear CEO,

On (Date), I provided medical care to your member (Name of patient) pursuant to a contract between your company and me. Per the terms of that contract, I have performed my contractual obligation to provide covered services, CPT and ICD-9-CM code a claim and to submit that claim within (days) from the date of service. As you can see from the attached printout from my billing software, I submitted the claim on (date). The claim was submitted in a timely manner, well within the timeframes outlined on page (Page Number) of our agreement. I have no reason to withhold claims because to do so benefits no one.

As you can see, from your EOB, dated (Date), your company denied my claim by stating the claim was received in an untimely manner. The claim was submitted in a timely manner, therefore your company has a contractual requirement to reimburse me per the fee schedule outlined in the contract. Please understand that my being contracted with your company is a courtesy I extend to you and your members. This courtesy can be revoked at any time.

Your company has fourteen (14) days from the date of this letter to reconsider your denial. If you elect to pay this claim, it will show that you have respect for the contract we worked hard to develop. If you elect not to pay this claim, I will deem this as a breach of the agreement, which will force me to submit my letter of termination and consider legal action to protect my interests. You do understand that if I terminate my agreement, I will have no obligation to send claims for your member and I can require your member to pay 100% of my usual and customary charges at the time of service. I will also inform the Hospital CEO of your actions so that if I terminate, you cannot use outside pressure to have me contract with your company again. I will also deem the denial to imply that the service I rendered is not a covered service which allows me to bill your member for my full usual and customary charges.

I hope your company will reconsider these frivolous denials. I could keep my medical expenses down if I didn’t have to devote extra time and money to get your company to abide by it’s contractual requirements. If you wish that I not terminate my contract, I may have no recourse but to renegotiate my agreement and I will require a higher reimbursement to recoup my losses. I look forward to your complete cooperation and reimbursement of this covered service.

Very Truly Yours,

Name of Provider
Dear CEO,

Attached to this letter, is a demand from a debt collection company that states it is attempting to collect an alleged debt owed to your company, because your company states it performed a retroactive denial of your member’s claim. I wish to inform you that I am not contracted with your company and I do not appreciate letters from debt collection companies without due process of law. Your company never sent me any correspondence regarding this matter. Had you sent me a letter regarding this matter, I would have responded to you, by informing you that I owe you nothing in return. The claim I sent you was your member’s claim to have their benefit paid. I have no claim with your company. Your member asked you to take the payment of their benefit and send it to me via an Assignment of Benefit form. This form does not imply that any relationship exists between your company and me. Once I received the payment of your member’s benefit, I applied it to the debt your member owed me and if there were any balances, I collect that from your member as well.

If you state that you retroactively denied your member their benefits, then this is an issue between you and your member, not me. It is your member that benefitted from your payment of their benefit, not me. You will inform your debt collection agency to cease any and all communication with me regarding this matter. If I find that your collection agency has listed this debt with any credit bureau or if it shows on my credit report, you will leave me no choice but to take legal action to protect my name and reputation.

You are hereby informed that you will make every effort to recoup this from your member. Your threat that you will offset this against any claim currently in your system is a veiled threat. I have no claims with you. Your members do. All you have done is to force me to change my policy of helping your members. You can consider my courtesies to your members, revoked. From this day forward, I will no longer code and submit claims as a courtesy to your member. I will now enforce the contract you have with your members. Your members will be required to pay me at the time of service for my services. It will be your member’s responsibility to submit and code their own claims for reimbursement. For those members whose claims I sent as a courtesy, I will now bill your members for 100% of my charges rather than wait for you to pay their claim. This will now force you to recoup from your member in the future. If your members have a complaint, I will refer them to you for answers.

Your demand for the return of funds is hereby denied and I consider this matter closed.

Very Truly Yours,

Name of Provider
On (Date), your member presented themselves to my practice, asking me to provide them with medical care that both your member and I deemed to be medically necessary. As a contracted provider, I rendered the service per the terms of my agreement with your company. The claim I sent on (date) was coded properly per the American Medical Association's CPT-4 coding guidelines and National Correct Coding Initiative (CCI) edits standards and guidelines. You will note that the AMA approves the CMS’s CCI edits as the industry standards for coding and reporting of multiple codes. You will also note that my claim was sent in a timely manner, well within the timeframe listed in our Agreement.

On (Date), your company denied CPT Code (XXXXX), by stating that CPT (XXXXX) is included or bundled with CPT (YYYYY). I am sure you can understand how confused and disturbed I am considering that your denial is the exact opposite of the CCI edits that physicians are required to follow when coding a claim. I take pride in the fact that I take the time to make sure that my claim is 100% complete, accurate and correct with the codes I select and place on my claim. If the services I rendered were deemed to be inclusive per the industry coding standards, then I would not place them on my claim.

Based on the Rules of Discovery, I hereby demand the following from your company:

1. Any and all documents that your company uses to create your CCI edits. This documentation must come from an accredited source such as the American Medical Association or an accredited medical society. If your company has used a consultant, we make the demand for the name and address of the consultant, the consultant’s credentials, as well as any and all documentation provided to you and used by the consultant.

2. A copy of the member’s health benefit plan. The health benefit plan will provide me with the information I need to enter into the appeals/legal process. I believe that the denied procedure may be a covered service.

Your company has 30 days from the date of this letter, to provide this information. Your failure to respond with these demands will require me to imply the denied service to be a non-covered service which will allow me to bill the member. It will also allow the member to appeal a possible benefit denial which could also lead to possible legal action taken by your member.

If I am required to code my claims, per acceptable industry coding guidelines, I expect your company to do the same. If I am required to show the foundation behind my coding decisions, your company is obligated to do the same. When I provide a service, I expect to be paid. When I agree to contract with a health insurance company, I have agreed to take a considerable discount to my services as a courtesy to you and your members. These frivolous denials are causing me to expend money in administrative expenses and to lose revenue needlessly. These denials will require me to re-negotiate my contract with you, to add language that will stop these denials, and demand that you increase my payment to offset my losses. It could also cause me to terminate my current agreement with your company. If I elect to terminate, a copy of my termination and the documentation causing the termination, will be sent to the Hospital CEOs where I have privileges, so that your company cannot influence the hospital to re-contract with your company.

I look forward to your cooperation in this matter.

Very Truly Yours,

Name of Physician
Name of Practice  
Address  
City, State ZIP  
Phone

Date

SENT CERTIFIED MAIL/RETURN RECEIPT

Name of Insurance Company
Attn: CEO  
Address  
City, State ZIP

RE: Inclusive denial

Dear Name of CEO;

On (Date), your member presented themselves to my practice, asking me to provide them with medical care. Your member was fully aware that I am not contracted with your company, therefore, when continuing with the medical care, your member did so as a freedom of choice decision. As a non-contracted provider, I have no requirement to code or submit any claim. This is a courtesy I extend to your members that can be revoked at any time. The claim I sent on (date) was coded per industry accepted coding guidelines and National CCI edit standards and guidelines. My sending this claim did not establish any contractual relationship between us. I am sure you know that when your member seeks care from an out of network provider, it is your member that has the responsibility to code and submit their own claim.

On (Date), your company denied CPT Code (XXXXX), by stating that CPT (XXXXX) is included or bundled with CPT (YYYYY). This letter is not an appeal, but informs you that your member must appeal this themselves. If you wish to review your denial because you feel your denial was a mistake, please feel free to issue payment of your member’s health benefit to me, per your member’s Assignment of Benefit request, so that I can apply the payment to the debt your member owes me.

If you wish to continue with your coding decision to deny the claim, then I must inform you that I will make immediate changes to my policy as it regards non-contracted patients. Your actions will cause me to revoke my courtesy to code and send claims. I can demand that your members pay for their medical care at the time of service. Your members will be required to code and submit their own claim, per their contract with you. I will give your member’s a receipt to use for reimbursement. Naturally, if your company asks me for a coded claim, your request will be denied and referred to your member or your company can pay my administrative fee of $125 for coding and processing a claim.

Again, no one forces your members to seek care from me. They do so as a freedom of choice. Your members are always free to seek care from any network provider they choose. However, I have the freedom of choice to choose how I wish to be paid and whether I wish to provide claims assistance as a courtesy to your member. I hope you will reconsider your decision, for your member’s sake.

Very Truly Yours,

Name of Physician
Name of Practice  
Address  
City, State  ZIP  
Phone

Date

SENT CERTIFIED MAIL/RETURN RECEIPT

Name of Insurance Company
Attn: CEO  
Address  
City, State ZIP

RE: Untimely Refund Demand

Dear Name of CEO:

Attached to this letter, is a demand by your company, dated (Date), where you are asking for the return of a health benefit payment, for services rendered on (date). As you can see, your refund demand is presented more than (number) months from when the patient was treated. First, as a non-contracted provider, I do not have to respond to this untimely demand because you want the payment of the health benefit returned to you. For this, you must contact your member to have them repay you the payment of their benefit.

Your refund demand is being denied for the following reasons:

(1) Your demand was sent in an untimely manner. Waiting this long to submit a claim places everyone into an undue prejudicial position from trying to collect any reimbursement. If we sent you a claim this late, you would deny it for untimeliness.

(2) Based on the Doctrine of Laches, we should not have to wait forever for your company to decide to request the return of monies allegedly owed to you. Your request should have been sent, to your member, within a reasonable timeframe.

Please do not threaten us with attempting to offset this money against any claims you have in your system. As a non-contracted provider, we have no claims with you. The claims we sent were your member’s claims and they were sent as a courtesy to assist your member with the debt with us. You would only be harming your members because we would immediately revoke our courtesy of sending claims. We would also start billing every patient of yours that we treated and demand they pay us immediately, for the full amount of our usual and customary charges. Any patient complaints will be sent to you. If you send us to your collection agency, we will be forced to take any and all actions to protect our interests. Again, please contact your member for the return of their health benefit payment.

Sincerely,

Name of Provider
Dear [Name of CEO];

On Date, your company asked me to become contracted with you, as a courtesy to your members. In exchange for accepting a reimbursement for a lesser amount than my usual and customary charges, I agreed to be contracted. If you look on Page (Number) of the Agreement, my obligation, in addition to providing covered services, is to submit my claims within (timeframe). Your company agreed to pay my claims within (timeframe).

The claims that are attached to this letter were submitted to your company according to the terms of the Agreement. As of this date, these claims remain unadjudicated. I had hoped that your company would honor your part of the agreement and pay me for the covered services I rendered. Chasing down payments of unpaid claims adds to my administrative costs and decreases the already low reimbursement you are supposed to pay me.

I am allowing you thirty (30) calendar days to reimburse me for these services. If you decide to ignore this letter or refuse to honor payment, I will have no choice but to consider your refusal as a possible breach of our agreement which could force me to terminate my contract. This could also force me to seek a cure through the legal system, which neither of us wishes to pursue because we all know how expensive that can be. If termination is not an option to consider, then I will have to renegotiate my reimbursement to offset the administrative costs of trying to collect a contractual payment. In addition, I could consider the non-payment to mean the services were not covered, thereby allowing me to bill your member.

You do know that if I am not contracted, I have no requirement to send claims for your members and your members, if they make a freedom of choice decision to seek care from me, will have to pay extra out of pocket expenses by paying my charges in full and your member will have to code and submit their own claims per their contract with you. As a non-contracted provider, my administrative fee for coding and submitting a claim is $125. I wish for our relationship to continue, but if your company wishes to ignore it’s contractual responsibilities, then our relationship is in jeopardy. Your cooperation in this matter is greatly appreciated.

Sincerely,

[Name of Provider]
Name of Practice
Address
City, State ZIP
Phone

Date

SENT CERTIFIED MAIL/RETURN RECEIPT

Name of Insurance Company
Attn: CEO
Address
City, State ZIP

RE: Unpaid Claim

Dear Name of CEO;

On (date), your member presented themselves for medical care, with the full knowledge that I am not a contracted provider. Your member made a freedom of choice decision to continue with the medical care. As a courtesy to your member, which I can revoke at any time, I send your member’s claim on (Date). As of this date, neither a payment or denial has been received.

This letter is not an appeal of the non-payment. It is simply a courtesy letter to let you know that I cannot continue to provide assistance to your member regarding their claims issues if I am not being paid. I could have demanded your member pay for the care at the time of service, but I showed compassion by helping your member with their claims.

If you sent payment to your member, please let me know this so that I can report your member to the Internal Revenue Service for keeping the health benefit payment and not using it to pay their debt to me. This money may be considered as income and must be reported according to IRS Laws.

If you did not send the member the payment, then please issue payment to me, per the Assignment of Benefit form, signed by your member at the time of service. I can then take the payment of their health benefit, apply it to their debt and then have the patient pay any remaining balances.

Again, my sending a claim is a courtesy that I can revoke at any time, thus having each of your members pay for the medical care at the time of service and have them send their own claim per the terms of their contract with you. If I receive a request for a claim, my administration fee for coding and processing a claim is $125.

Your cooperation in this matter is greatly appreciated.

Sincerely,

Name of Provider
Dear Name of CEO;

On (Date), your company and I entered into an agreement, where your company asked me to provide covered services to your member in return for my taking a considerable discount to my reimbursement fee. If you look at Page (number) of the Agreement, I am to be reimbursed (amount of reimbursement), for my services.

On (Date), your member received covered services from me. Per the terms of the Agreement, those services were rendered and a claim was submitted on (date), well within the timely filing limits of the Agreement. If you look at the attached EOB, your company was supposed to reimburse me ($X.XX). Instead, your company paid ($Y.YY), which is considerably less than the contracted amount.

I agreed to lower my reimbursement fee to assist your members and to help you keep the costs of medical care down. My paying me less than what was agreed, your company forces me to expend additional operational costs that were not taken into consideration during the contract negotiations. I should not have to appeal the payment of a claim. Instead, your company should honor the contract you signed.

I am allowing you thirty (30) calendar days, from the date of the receipt of this letter, to cure this problem and make the claim whole. Your refusal to do so could cause me to reconsider whether I should be contracted or not. It could also cause me to consider legal action to enforce the contract, and I am willing to proceed down that road if we come to that. You do know, as a non-contracted provider, I am under no obligation to send claims for your members. That is a contractual requirement of your member I have no problem in enforcing. Also, I am entitled to collect my full charges from the member at the time of service, thus causing your members to expend more in out of pocket expenses.

If termination or legal action is an option we wish to avoid, then I may have to renegotiate my contract to demand a higher reimbursement to offset these unwarranted extra expenses. Your decision in this matter will decide how I wish to pursue this. Your cooperation is greatly appreciated.

Sincerely,

Name of Provider
Dear Name of CEO;

As you are aware, I am not contracted with your company, by choice. When your members seek care from me, they do so making a freedom of choice decision to be treated by an out of network provider. As a non-contracted provider, I am under no obligation to send a claim for your member. I am sure you know this is your member’s contractual responsibility. I do this, merely as a courtesy which I can revoke at any time. My sending a claim does not establish any relationship with your company. Again, this is your member’s claim I am sending.

Attached to this courtesy letter, is an EOB, for your patient (Name of Patient), who was seen on (Date). When looking at the EOB, you paid the claim, in the amount of ($X.XX). As a non-contracted provider, I am entitled to receive the full amount of my charges, either from you, your member, or both. The EOB states I cannot bill the member for the balance. As a non-contracted provider, your policies and procedures have no jurisdiction on me, therefore, you have no authority to dictate what I can and cannot do with balances that are due to me.

If the amount that you paid is all you are required to pay, per the terms of your contract with your member, then I have no issues with that. I will collect the balance from your member. If, however, your contract with your member demands that you pay the benefit in full, then it appears that your company may not be performing your fiduciary duties under the terms of your contract. This, however, will be your member’s responsibility to appeal, not mine. If you feel you made a mistake and you wish to resolve this without involvement of your member, you are free to issue payment of the remainder of the benefit and I will apply the benefit payment to the debt your member owes me. I will allow you thirty (30) days from the date of the receipt of this letter to make your decision. If I do not receive payment by that time, I will contact your member for payment and revoke my courtesy assistance. If your company asks for a claim, my fee for coding and processing a claim is $125. Your cooperation is greatly appreciated.

Sincerely,

Name of Provider.
Dear [Name of Patient];

On [date], you presented yourself, asking us to provide you with medical care. As of this date, you have not filed any complaints regarding the medical care you received. As a courtesy to you, we filed a claim with your health insurance company, even though it is your contractual responsibility to do so. After speaking with your health insurance company, we have found that your insurance company sent you payment for the services you received from us.

Your debt with the doctor is seriously delinquent and there should be no reason for it to be that way due to the fact that you received the money to pay for your medical care. You do understand that you have a responsibility to pay for the medical care you receive. If you decide to make a freedom of choice decision to refuse to pay for your medical care, we will have no choice but to do the following:

1. We will send your account to our debt collection agency. They will have orders from us to report your delinquent debt to the national credit bureaus. Once this happens, you may not be able to obtain credit for many years. The collection agency will remind you of this. It is not a threat, it is merely a statement of fact.

2. We will contact your insurance company and require them to send you a 1099-MISC form showing you received payment of the claim. You will need to take that form and report the money you received, to the Internal Revenue Service, on your income tax return. You do understand that failure to report money you receive and pay taxes on that money could be considered as tax evasion.

3. We will contact the Internal Revenue Service and inform them you received money that you might not have reported. We will ask the IRS to audit your tax return to ensure you have reported the money you received.

Any future care you elect to receive from us must be paid in advance, before you are seen, this includes any and all balances due. In addition, in compliance with your contract with your company, you will be responsible for submitting your own claim. We will not provide you with a claim. All we will give you is a receipt for the medical care.

You may contact us at [number] to discuss your debt. Unfortunately, we will not accept time payments.

Sincerely,

[Name of Physician]
RE: Name of Patient

Dear (Name of CEO);

On (date), your member (Name of member) (Policy Number) presented themselves, asking us to provide them with medical care. We are not contracted with your company for various reasons. As a courtesy to your member, we filed a claim with your company, even though it is your member’s contractual responsibility to do so. Rather than send us the payment of the benefit, your company elected to send the payment to your member. We understand that you have the right to do this.

Your member has made a freedom of choice decision to keep the payment of the benefit and to allow their debt with us to become seriously delinquent. By doing this, their actions seriously affect the way we will conduct business with every other patient of yours from now on. Effective immediately, we will inform you and your members of our current policy regarding medical care your members ask us to provide:

(1) We will no longer send claims as a courtesy to your member. That is a contractual requirement that your member has with you and we will enforce it to the letter. Your member must pay us first, before they are seen. We will provide your member with a receipt that they can use to be reimbursed. If you request a coded claim from us, our fee is $125.00, payable in advance.

(2) Your company must send your member a 1099-MISC form showing that your member received payment of their claim. If you send us a 109-MISC form, we will file a complaint with the Internal Revenue Service because your company did not issue payment to us. You will need to inform your members that when they keep their benefit payment, rather than pay their medical bills, they need to report the money they received, to the Internal Revenue Service, on their income tax return.

(3) We will contact the Internal Revenue Service and inform them that your members received money from your company that they might not have reported. We will ask the IRS to audit their tax return to ensure your members have reported the money they received from you.

Sincerely,

Name of Physician
ASSIGNMENT OF BENEFIT AND REPRESENTATIVE AUTHORIZATION

Date:________________________

Patient Name:______________________________________________________________

Patient Address_____________________________________________________________

Patient City________________________________________________________________

Patient State_____________            Patient Zip Code_______________________________

Patient Phone:______________________________________________________________

Patient Cell Phone:__________________________________________________________

Patient E-Mail Address:______________________________________________________

Emergency Name and Phone Number:___________________________________________

Employer:__________________________________________________________________

SS#/ID#:___________________________________________________________________

I hereby certify that the insurance information that I have provided XXX Provider (Doctor), on the Insurance Affidavit (Affidavit) form, is true and accurate as of the date of service. I have made sure that if I have more than one insurance policy, all carriers have been contacted under the NAIC Coordination of Benefit Rules and applicable State Laws regarding Coordination of Benefits. I certify that benefits, to pay any and all medical claims, are available from any and all of the insurance companies on the Affidavit, as of the date of service. If authorization is needed to provide me with medical care, I certify that I have obtained said authorization, from my Primary Care Provider or Health Insurance Company, in order to seek medical care from Doctor.

I understand that intentionally providing false insurance information may be considered as fraud. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my medical bill is paid in full. I also understand that my insurance company may not pay 100% of the amount of the medical claim and I may be responsible for any and all amounts not payable by my insurance company. I also understand that in the event that my insurance company performs a retroactive denial of my benefits, I am responsible for reimbursing the insurance company and not the Doctor.

Page 1 of 3

I hereby authorize Doctor to submit my claims for health benefits, on my behalf, to the insurance company listed on the copy of the current insurance card I have provided Doctor, in good faith. I fully agree and understand that the submission of a claim does not absolve me of my responsibility to ensure the claim is paid in full and that this courtesy can be revoked at any time.

I hereby instruct and direct_________________________________________________ my health insurance company, pay my health benefits, in full, and to make payment of my health benefits, by check, made out and mailed to: XXX Provider 123 Main Street, Anywhere, USA 12345-1234.

If my current policy prohibits the assignment of my health benefits by making direct payment to (Doctor), I also instruct and direct ___________________________________________ Insurance Company to make out the check to me and mail it as follows: XXX Provider, 123 Main Street, Anywhere, USA 12345-1234, for the full and complete payment of my health benefits, and otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered.

This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to (Doctor), and I have agreed to pay Doctor, any balance of professional service charges over and above this insurance payment. Upon receipt of said check, I authorize Doctor to deposit checks received on my account when made out to me. I authorize Doctor to make deposit into the account
of XXX Provider on my behalf.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize Doctor to be my personal representative, which allows Doctor to: (1) submit my claims for health benefit, (2) submit any and all appeals when my insurance company denies me benefits to which I am entitled, (3) submit any and all requests for benefit information; insurance company policies and procedures; names and specialty of insurance company representatives that denied my health benefit; names, credentials and documents from any outside consultants or medical societies that had any part to the denial of my health benefit; and (4) initiate formal complaints to any State or Federal agency that has jurisdiction over my benefits. I fully understand and agree that I am responsible for full payment of the medical debt if my insurance company has refused to pay 100% of my benefits, within ninety (90) days of any and all appeals or request for information. I also agree that any fines levied against my insurance company will be paid to Doctor for acting as my personal representative.

Page 2 of 3

A photocopy of this Assignment shall be considered as effective and valid as the original.

________________________________________________
Signature of Patient or Policy Holder

________________________________________________
Date

________________________________________________
Witness

________________________________________________
Date

________________________________________________
Witness

________________________________________________
Date

________________________________________________
Signature of Claimant if other than Policy Holder

Page 3 of 3