

Fighting For Your Patients

Best Practices to Reverse Insurance Coverage and Payment Denials



Fighting For Your Patients: Best Practices to Reverse Insurance Coverage and Payment Denials

Conflicts of Interest: The presenters have no conflict of interest to report

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Fighting For Your Patients: Best Practices to Reverse Insurance Coverage and Payment Denials

Objectives:

1. To learn about the legal and legislative foundation of patient appeals
2. To understand the process for elevating the appeal to an external appeal
3. To increase knowledge of best practices for external patient appeals to reverse denials



Fighting For Your Patients: Best Practices to Reverse Insurance Coverage and Payment Denials

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Fighting for Your Patients

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Utilization Management Snapshot (as of 3/22/21)

▶ Anthem

- ▶ Commercial States - CO, CT, GA, IN, KY, ME, MO, NH, NV, NY, OH, VA, WI
- ▶ Medicaid rollouts - NY, WI, IN, NE, MO
- ▶ Coding exclusions
 - ▶ Letter challenging codes: Gait Analysis Instrumented, Motion Analysis, Electrical Stimulation, Mechanical Traction for spinal lumbar disorders, Active Therapeutic Movements
 - ▶ APTA templates
- ▶ Site of service review (Anthem clinical guideline on HUB)



Utilization Management Snapshot (as of 3/22/21)

▶ Cigna

- ▶ “Patient review functionality will launch for all U.S. network- and non-network participating providers (except behavioral) starting on February 26, 2021.”

▶ eviCore

- ▶ Clinical Guideline review
- ▶ Continued provider issues
- ▶ APTA Action: Meeting with chapters to determine next steps.

Utilization Management Snapshot (as of 3/22/21)

▶ Humana/ Cohere

- ▶ Effective 1/1/21
- ▶ MSK prior auth across 12 states - AL, GA, IN, MI, OH, KY, NC, PA, SC, VA, TN, WV
- ▶ APTA Action: Setting up initial meeting



Utilization Management Snapshot (as of 3/22/21)

► Magellan

- Acquired by Centene
- Ambetter exchange plans - any reported issues?
- APTA Action: Quarterly meetings



Utilization Management Snapshot (as of 3/22/21)

▶ United HealthCare

- ▶ UHC West and WI (“written treatment plan by physician”)
- ▶ UHC WI: site of service reviews
- ▶ 1/1/21: UHCCP requires documentation for each billed CPT code
- ▶ APTA Action: Letter



Fighting for Your Patients

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Avenues for Advocacy

▶ New Materials for Members

- ▶ Resources: Introduction video
- ▶ Memo to “Interested Parties” re PPS Survey
- ▶ Talking Points
- ▶ Infographic
- ▶ PowerPoint
- ▶ Draft Appeals letter

Payment Resources

PPS provides payment tools and resources to guide you through the complicated payment environment. The material on this page is updated monthly and is a free benefit of your membership with PPS.



Value of Physical Therapy



Payer Contracts



Telehealth



Strategies to Maximize Revenue

State Payer Advocacy Network

Resources

Utilization Management, Internal Appeals and External Reviews

Bill and Bob's Intro to Utilization Management Resources Video



Interested Parties Memo

Fighting for Your Patients - PPS Payment Policy Committee Powerpoint Presentation

Sample External Review Request Letter

Sample Internal Appeal Letter for Services Denied as

Utilization Management Appeals and Review Talking Points

INSURANCE DENIALS

DENIALS ARE COMMONPLACE
At least 1/3rd of claims denied in 2019
<https://www.apta.org/press-releases/2020/01/08/claims-denials-and-appeals-in-2019>

UTILIZATION MANAGEMENT PROLIFERATING
Payers increasingly contract with utilization management programs, or "UMCs," to administer the rehabilitation benefit.
<https://www.apta.org/press-releases/2019/11/14/umc-contracting>

YOU CAN HELP PATIENTS APPEAL
Request an Appeal if Care is Denied - Don't waste time with peer-to-peer
<https://www.healthcare.gov/press-releases/2019/07/23/>

INTERNAL APPEALS ARE NOT THE LAST RESORT
External Review is also a patient's right in commercial, non-grandfathered insurance plans
<https://www.healthcare.gov/press-releases/2019/07/23/>

YOU ARE NOT ALONE
Consumer Assistance Programs
<https://www.healthcare.gov/press-releases/2019/07/23/>
<https://www.consumerhelpifihaveinsurance.com>
American Advocates Foundation
<https://www.governorsadvocates.org>

FIGHTING FOR YOUR PATIENTS CAN BOOST YOUR BOTTOM LINE

PPS



You are Not Alone!

- Consumer Assistance Programs
<https://www.healthcare.gov/how-can-i-get-consumer-help-if-i-have-insurance/>
- Patient Advocate Foundation -
<https://www.patientadvocate.org/>
- Research -
<https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/>
- PPS State Payer Advocacy Network

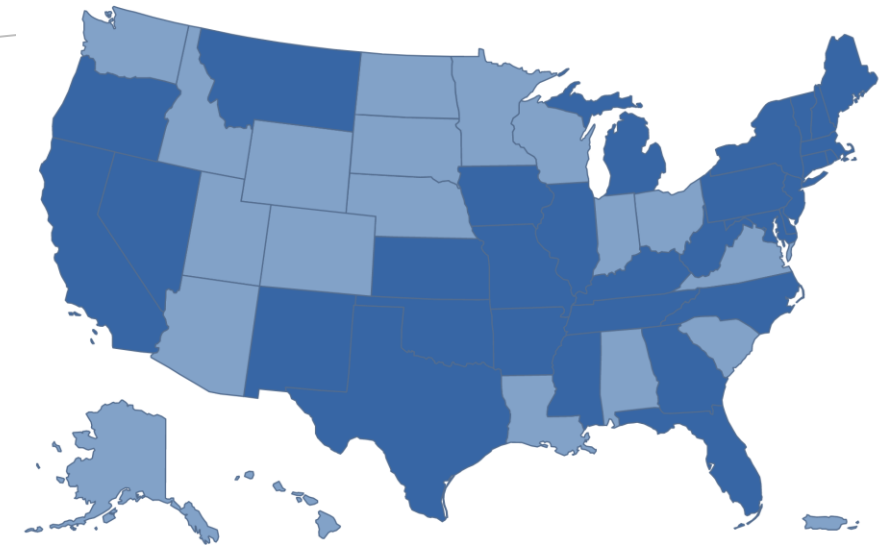
How can I get direct help with a problem or question?

The map below will help you find the contact information for your State's CAP. If your State doesn't have a CAP, the map will direct you to other possible resources – such as the State Department of Insurance and the US Department of Labor – including phone numbers, email addresses, direct mailing addresses, and websites.

[Skip To State Listing](#)

Consumer Assistance Programs Map

■ CAP in Operation with Federal Grant ■ CAP in Operation without Federal Grant ■ No CAP ■ No Resources Available



States

Connecticut	New Jersey
Delaware	Rhode Island
Massachusetts	Vermont
Maryland	District of Columbia
New Hampshire	

Territories & Commonwealths

American Samoa	Northern Mariana Islands
Federated States of Micronesia	Puerto Rico
Guam	Palau
Marshall Islands	Virgin Islands

Select a State

Go There





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Scope of this Appeals advice

- ▶ Commercial health plans regulated by the ACA.
- ▶ Medicare Advantage Plan appeals follow a different procedure (resources provided).
- ▶ For Medicaid appeals - consult your state laws.



Claims *Payment* Appeals - not covered

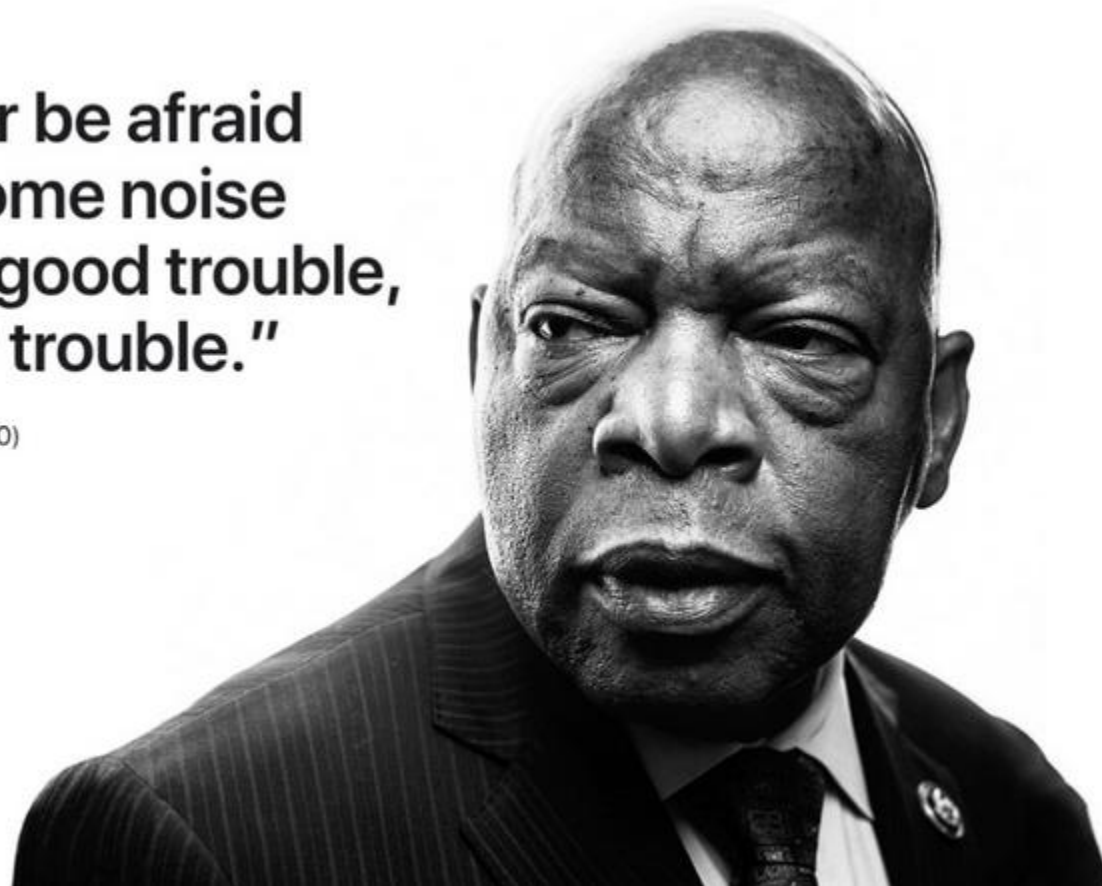
- ▶ Inadequate/No Payment for reasons *not* related to a UR process or medical necessity
- ▶ Examples:
 - ▶ Inadequate payment due to denial of multiple units of a code
 - ▶ Coding edits/incorrect coding, i.e. -59 modifier issues
 - ▶ Denials for inadequate documentation
- ▶ In-network provider needs to appeal these issues pursuant to the payer's provider manual.
- ▶ Process will likely be different than medical necessity appeals.
- ▶ Proceed to contract dispute if appeals process does not resolve issue.



Appeals as a Strategy

**"Never, ever be afraid
to make some noise
and get in good trouble,
necessary trouble."**

Rep. John Lewis (1940-2020)



Appeals

- ▶ Why appeal?
- ▶ What to appeal?
- ▶ Who should appeal?
- ▶ When should you appeal?
- ▶ How to appeal



Why Appeal?

- ▶ Provider Reconsideration/Appeal vs. Patient Appeal
- ▶ Federal and state laws apply when using the patient's appeal rights, including the right to a **“full and fair”** review
- ▶ Faster resolution *and* approval of more visits - saves future time
- ▶ Failure to appeal may result in provider having to hold the patient harmless of denied charges.



What to Appeal

- ▶ *Any*
 - ▶ denial,
 - ▶ reduction, or
 - ▶ termination of, or
 - ▶ failure to provide or make payment (*in whole or in part*) for a benefit
 - ▶ resulting from the application of any *utilization review* or treatment determined to be *experimental or investigational or not medically necessary or appropriate*.



Who should appeal?

Patient?

- ▶ State and federal appeals rules apply
- ▶ Patient can appoint an “Authorized Representative” - which can be the provider

Provider?

- ▶ State and federal appeals rules don't apply
- ▶ Terms of your provider agreement apply



When should you appeal?

- ▶ As soon as you get a verbal denial. Ask for the written decision by fax
- ▶ Before you get a denial if the payer/utilization review entity had an obligation to approve (or deny) authorization for visits within a particular time frame and didn't - for instance, the payer fails to respond to an expedited appeal in the required time-frame. (Failure to approve is a constructive denial.)



How to Appeal



Where to find the appeals procedure

- ▶ The denial letter - ask for it to be faxed on day you receive the verbal denial
- ▶ Certificate of Insurance or Summary Plan Description (“SPD”) - if health plan is provided by employer
 - ▶ Have the patient download a PDF of their plan document and send to you - do this in advance before you need it!



Appeals Levels

- ▶ Large health plans can only require a max of 2 internal appeals. Individual and Small Group plans can only have 1 internal appeal level.
- ▶ Last Level of Appeal - Independent External Review
- ▶ Expect to have to exhaust all appeals, so your goal should be to get to the independent external review as fast as possible.
- ▶ A “*Reconsideration*” is not an official appeal level in commercial plans. It is an extra voluntary level and only delays getting to the Independent External Review. (Does not apply to Medicare appeals.)



Reasons *not* to ask for a “Reconsideration”

- ▶ A “Reconsideration” is not a formal appeal under rules for private insurance. It is just an extra step to make it take longer to get to the External Appeal level.
- ▶ It will be done by the same entity that made first decision.
- ▶ Appealing directly to insurer will bring attention to the problem and make them review the claim they outsourced in the first place.

Important Note: The 1st level of appeal is called a “Reconsideration” in Medicare Advantage Plans, so the advice on this slide does NOT apply to MA Plan appeals.



Concurrent Care Claims

- ▶ When you are requesting additional visits under a plan of care already in progress, it is a “concurrent care claim” under federal law
- ▶ Requires a decision on appeal within 72 hours if it meets the requirements of an Urgent Care Claim
- ▶ If answer not received on time, you can jump to the next level of appeal



Request an *Expedited* Appeal for Urgent Care

“*Urgent care*” is defined under federal and state laws as:

- ▶ Treatment that, if delayed, could **seriously jeopardize** the life or **health** of the claimant to **regain maximum function**, or
- ▶ In the opinion of a **physician** with knowledge of the claimant’s medical condition, delayed treatment would subject the claimant to **severe pain** that could not be adequately managed without the care or treatment.
- ▶ Requires decision within 72 hours (ACA); state time limit may be less.



Denial Notice Requirements

- ▶ **Specific** reasons for the adverse determination
- ▶ Reference to specific plan provisions on which the determination is based
 - ▶ A **description of additional material or information necessary** for the claimant **to perfect the claim** *and* an **explanation of why such material or information is necessary**
 - ▶ Description of the plans review procedures and time limits and right to bring civil action



Denial Notice Requirements

- ▶ If an **internal rule, guideline, protocol, or other similar criteria** and was relied upon in making the adverse determination, copies **must be provided** free of charge to the claimant upon request, or
- ▶ If medical necessity is the issue, an explanation of the **scientific or clinical judgment for the determination**, applying the **terms of the plan to the claimant's medical circumstances**, or a statement that such explanation will be provided free of charge upon request.



Physician Attestation

- ▶ Get the referring physician to sign an attestation letter that the appeal needs to be expedited and send in with appeal request
- ▶ Look at your state's form to request an independent external review to see if it requires a physician statement. (See resources provided)



How to Appeal: Case Study

- ▶ Female patient s/p rotator cuff repair; referred for PT 9 days post-op in Dec. 2020.
- ▶ PT Plan of Care was for 8-12 weeks, 3x/wk; FOTO data indicated this patient could be expected to need 27 visits
- ▶ AIM approved 8 visits, then 1 visit, then 4 visits (13 total), then denied further visits despite fact that pt. had available covered visits, had not yet progressed to strengthening part of post-op protocol and risk of adhesive capsulitis was a concern.



Case study facts continued

- ▶ AIM denied further visits stating the patient was not making progress, which was NOT true.
- ▶ PT/office staff spent 1-2 hours/day for the next week trying to get through to AIM to get a reconsideration done (~7 hours of time)
- ▶ Patient finally proceeded with 1st level internal appeal - denial upheld
- ▶ Request for expedited independent external review - resulted in the patient being granted 17 additional visits!
- ▶ No further pre-auth from AIM required after this.



What to Expect



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Be an Appeals Superhero!



American Academy of Orthopaedic Physical Therapy Payment & Value Workgroup

Marcia Spoto PT, DC

Board-Certified Clinical Specialist in Orthopaedic Physical Therapy



History of Workgroup: Strategic Framework 2021-24

- ▶ **Diversity & Inclusion:** *Increase the diversity of members and leaders and engage in efforts to make AOPT a more inclusive organization.*
- ▶ **Evidence to Best Practice:** *Promote the development and implementation of evidence to best practice.*
- ▶ **Positioning & Public Awareness:** *Position members as experts in managing movement and functional performance impairments.*
- ▶ **Value & Payment:** *Enhance payment for services by demonstrating the value of physical therapy.*



APTA Public Policy Priorities

- ▶ Patient Access & Care

 - Ensure appropriate payment MPFS*

 - Increase Transparency on HC costs & financial interests (COI)*

- ▶ Value-Based Care and Practice

 - Promote APMs that improve cost efficiencies in care*

 - Reduce administrative burden*

- ▶ Research and Clinical Innovation

- ▶ Population Health & Social Determinants of Health



Initiatives

- ▶ Payment & Value Survey AOPT members
- ▶ Development of member resources
- ▶ Collaborate with PPS & APTA on payment
- ▶ Work with stakeholder groups on payment & value
- ▶ Better define value as it relates to PT services
- ▶ Inform development of VBP models in practice
- ▶ Build a payment presence for our members



Committee Members

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- ▶ Trevor Lentz PT, PhD, MPH
- ▶ Gwen Simmons Esq, PT, FAAOMPT
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Q&A

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