The Patriot Group

11 Tips to Receive Payment for Medical Claims Fairly & Quickly

Level The Playing Field With These Best Practices

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Introduction

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I have dedicated my career to advocating for the needs of the physician practice. This is a time when physicians and their practices are under siege by payors and government entities who aim to make it more and more difficult to operate a successful and profitable practice.

I founded The Patriot Group in 2008 because I am a passionate advocate of physician practices. I work very closely with the American Medical Association, several state Medical Societies, and other organizations, to insure that we have all the senior high level contacts that we need in all those organizations and in all the various insurance companies, so that we can provide the most effective results for our clients.

Nevertheless, all those contacts and relationships are not really our "secret sauce." We have to have them, certainly, and they certainly will benefit you, as one of our clients. Still, that's not why I wrote this report.

One of the things I have seen time and again is how so many providers are burdened with some misconceptions about fighting back, fighting to get paid right when they file a claim, and fighting to keep their payments when they are later denied and the payor takes back the money. All the payors want to hold the providers accountable, and that is as it should be. But the payors should also be held accountable. I have had fantastic success filing appeals for my clients, because I know how to ignore those misconceptions and hold payors accountable.

So let me share some things with you, so you can dispel any misconceptions you might have about appealing denials, and especially about where "the power" lies in healthcare.

Armed with what I'm about to tell you, then you can hopefully join me and hold the payors accountable, too.

What Do Payors Really Control?

Common Misconceptions

Most physicians and healthcare administrators believe that healthcare and particularly the "revenue cycle" are both controlled entirely by commercial insurers. They believe this because these companies are multi-million dollar conglomerates with seemingly endless streams of revenue. In addition, those same companies are the ones that draft the provider managed-care contracts that set the reimbursement rates for most practices.

Unless the health provider is a huge hospital network, there is generally very little room for negotiation as to the terms and rates for such contracts.

While this common belief is understandable, it simply is not true.

The fact is, the hospital system or medical practice and its consumer patients have much more "power" when it comes to the claims adjudication process than the insurance companies.

If the medical practice can learn to harness this power, its claims will be paid quickly and at fair reimbursement rates.

What Obligations Do The Payors Have?

Payors such as managed care companies, HMOs, PPOs and the like have many state and federal statutory and common law responsibilities with respect to the adjudication of medical claims. Providers simply do not have these obligations.

Managed care companies have to comply with the following:

State Prompt Payment Laws. (These state laws mandate)

- ☐ Payment of claims within a set time frame (i.e., Section 3224-a of NY Insurance Law requiring payment of electronically submitted claims within 30 days of receipt and 45 days of receipt for claim submitted on paper)
- ☐ Denial of claims within a set time frame in writing setting forth specific reasons for such denials (i.e., 30 days per Section 3224-a of NY Insurance Law)
- ☐ Payment of interest if claims are not paid within the statutory time frames set forth in the State Prompt Payment Law (i.e., at least 12 percent interest unless such interest would be less than $2.00 per Section 3224-a of NY Insurance Law)

Unfair claims settlement practices

- ☐ These acts and statutes prohibit insurer conduct that aims to avoid payment of clean claims when there is evidence of this as a general business practice (i.e. Section 2601 of NY Insurance Law)

Unfair and deceptive trade practices

- ▢ These acts and statutes prohibit deceptive and unfair advertising and marketing by insurers (i.e., New York Deceptive Trade Practices Laws – General Business Laws Section 349 – 350)

Federal ERISA laws are applicable when insurance companies administer self- funded plans

- ▢ (Federal Statute 29 CFR 2560.503-1 sets forth claim and appeal adjudication requirements for self-funded plans)

The Patient Protection and Affordable Care Act or "PPACA"

- ▢ Regulates time limits for insurers responding to appeals

Common law responsibilities.

- ▢ Common law assumes that inherent in every contract is the implied duty of good faith and fair dealings

- ▢ Certain common law responsibilities relate to the construction of managed care agreements (i.e., vague and ambiguous provisions are interpreted to the benefit of the non-drafter policyholder and healthcare provider and against the insurer – see Matter of United Community Ins. Co. v. Mucatel, 69 NY2d 777, 779, aff'd at 127 Misc.2d 1045; Hartol Products Corp. v. Prudential Ins. Co., 290 NY 44, 49)

Bad faith law

- ▢ Applicable to any insurer conduct that is so reckless and severe and creates severe civil and criminal sanctions against the insurer

Getting To The Tips!

In view of the many and varying obligations of the insurer in the claims adjudication process, it is incumbent upon the healthcare provider and medical practice to understand the law. Once the provider understands the law, it can effectively hold the insurance companies accountable to the law.

Knowledge of the law is the "power" that providers need to ensure that their claims are paid promptly, with interest if required by state law, and at fair reimbursement rates.

The following are the 11 tips that healthcare providers can utilize to ensure that their medical claims are paid quickly and fairly:

Tip #1

Can you prove that they received the claim you submitted?

Always obtain proof of the submission and receipt of claim

If the claims are submitted electronically, then your clearinghouse can provide validation reports that will prove delivery and receipt by the payor of any electronically submitted medical claims.

If the claims are submitted on paper via a CMS-1500 Claim Form:

- ▢ There is a presumption in the law that a properly addressed document, placed in the mail, is received by the intended recipient. Therefore, the intended recipient has the burden to prove that the mail was not actually received.
- ▢ Your practice should establish a written procedure for the mailing of paper claims and follow that procedure exactly. Paper claims can be mailed in bulk by certified mail, return receipt requested, and documented on a mail ledger of some sort to prove mailing of the claims to an insurer. The returned receipt is the proof of delivery to the insurer that is needed.

Tip #2

Is the payer adhering to applicable prompt payment laws and managed care agreements?

Keep Detailed Records Of Time Frames

It is important to know with certainty the time frames in which the insurer must pay claims, deny claims and/or request additional information to adjudicate a claim.

Tip #3

What part of a denial should you attack first, regardless of the merits of the denial?

Attack time frames before the merits of a denial

Before appealing a claim on the merits, determine if the statutory and contractual time frames were satisfied by the insurer.

- [ ] Example: Was the claim denied within 30 days of receipt? Was the payment made within 45 days?
- [ ] If not, was interest included in the payment?
- [ ] Was the denial set forth in writing and in plain language?
- [ ] Was the specific reason for the denial detailed?
- [ ] Was the insured and provider offered an opportunity to appeal and given appeal submission instruction?

Tip #4

Tip #4: Always include written explanations with appeals based on merit

Make sure you provide a written explanation in the form of a first level appeal or grievance as to the reasons it is believed that the denial is unfair and wrongful.

- [ ] Remind the insurer of its good faith obligations under the Unfair Claims Settlement Practices Act, the state's prompt payment law and managed care agreements
- [ ] Attach supporting documentations, including factual affidavits, medical records, photographs and CPT Code explanations as needed.
- [ ] Make sure the appeal is sent to the appeals and grievances department which may be different from the address for claims submissions.
- [ ] Always ensure that appeals are made within Appeals Submission deadlines set forth in the Managed Care Agreement.

Tip #5

File second level appeals

Many claims denied after first level appeal are paid after a second level appeal is filed. Thus, always file a second level appeal.

- [ ] First, determine whether the first appeal was sent within time frames set forth by applicable state and federal laws or the managed care agreement.

- [ ] Be mindful that certain states have different laws for medical necessity and cosmetic denials.

    - Example: New York affords an immediate right to an appeal review by an external appeals agent after a denial of a first level appeal for medical necessity or experiment reasons.

Tip #6

Utilize the state insurance department complaint procedure

- ☐ Violations of State Insurance Law are governed by the Commissioner of Insurance for the involved state.
- ☐ Self funded plans administered by insurance companies are governed by ERISA under the oversight of the US Department of Labor.
- ☐ A consumer or a healthcare provider may file a complaint with the regulatory authority when it is believed that an insurer (or administrator of a self funded plan) violated a law relating to claims adjudication such as the State Prompt Payment Law.

Tip #7

Utilize small claims lawsuits (under $5K)

Most states have courts of lesser jurisdiction that permit lawsuits against commercial entities such as insurance companies.

- [ ] Most of these courts permit lawsuits brought by non-lawyers where damages are less than $5,000. The costs for filing these lawsuits is usually nominal, less than $35.00 and the complaints are usually simplified, one page or less.

Tip #8

Ensure patients sign a proper Assignment of Benefits form

Make sure your AOBs include an authorization from the patient permitting the medical practice or its representatives to file appeals against their health insurers for denied claims.

Tip #9

Obtain patient email addresses and/or cell phone numbers

Obtaining patient email addresses and cell phone numbers for text messages is an easy and cost effective way to communicate with patients and especially useful when collecting deductibles, coinsurance, and non-covered services.

- [ ] The patient will have to sign a short consent to communications by email and text messages.

Tip #10

Create a easy to-do list for patients handling reimbursement checks from their insurance provider

Give patients self-addressed envelopes to use for returning claim checks to the practice.

- [ ] Where To Send Them
- [ ] How To Endorse Them

Tip #11

Keep track of payments by payers and the percentages of payments to charges

They can be used in appeal letters to establish a precedent for additional payment

- [ ] Example: Blue Cross's "YLK" Plan paid 80 percent of charges for patients Smith, Jones and Mann, thus they should pay 80 percent of charges for the appealed claims

Concluding Remarks

In summary, it is imperative that the healthcare system or medical practice, provider and revenue recycle administrators familiarize themselves with the various laws and other responsibilities of the various managed care organizations. Then hold these payors accountable to the law.

Remember, the "power" is with you.

Free Bonus Material

To learn more about how to maximize reimbursements, please refer to the following resources:

Watch the Webinar: "Nuts And Bolts Of Revenue Recovery"!

Watch the Webinar: "Everything the Out-of-Network Provider Needs to Know to Generate More Revenue"

*Both webinars are currently being sold for $240 (Good thing you came straight to the source!)

Next-Steps

Our team has revenue recovery down to a science. We make receiving payment feel like a breeze! Schedule a call today and let us know how we can help.

BOOK A FREE CONSULTATION