Best Practices for Ensuring Patient Access to Care: Appeals and Authorizations

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Prior Authorization

- Mandatory
  - Contracted provider; required in order for you to be paid or a service to be covered.
- Voluntary
  - May be contracted or non-contracted; allows you to determine whether you will be paid before you provide a service
  - In the case of non-contracted providers, protects the beneficiary from an unforeseen bill.

Prior Authorization

- Look at the insurers for which you tend to file the most prior authorization requests. Make sure you understand all the mechanisms you can use for making a request. Choose the mechanism that is easiest for your practice to utilize. Could be fax, standard electronic transaction, health plan specific portals, etc…
- Set up any procedures or protocols to make it more convenient to file requests.
- Before providing services or sending prescriptions to the pharmacy, check the prior authorization requirements for the patient's plan.

Prior Authorization

- Establish a protocol to consistently document data required for prior authorization in the medical record
- Promptly reply to any requests for additional documentation. In some instances, plans will deny the request if they have not received the information necessary to make the decision in the timeframe required by law. Failure may result in the hassle of filing an appeal.

Prior Authorization

- Track your requests, and follow up to ensure the decision is made within the required time frame and to prevent any delays if you see that information is lost or not received by the health plan.

Prior Authorization

- Timelines for making decisions are generally regulated under applicable law. For example:
- Medicare Advantage – Generally 14 days standard/72 hour expedited.
- ERISA/ACA -- Generally 14 days standard/72 hour expedited.
  - State law may set forth shorter standards for plans subject to state law.
- Part D (Medicare drug requests) – Generally 72 hours standard /24 hours expedited

Appeals

- May appeal:
  - Denied prior authorization requests
  - Denied/downcoded requests for payment

Appeals

- Number 1 rule: If you feel your claim was improperly denied/downcoded or requested coverage was denied: DO IT.
- Failure to appeal can:
  - Result in a patient's financial responsibility for a claim.
  - Decrease patient access to services.
  - Result in a lost opportunity to get a payor's systems issue fixed in a timely manner.
  - Reinforce a payor's belief that the practice is acceptable.
  - Deprive APMA or other advocates of evidence to identify systematic practices and bring them to the attention of payors.
- Successfully appealing may get you on an exclusion list for a payor's claim review process.

Review Denials

- Review each denial for prior authorization to see if you agree with the rationale.
- Review each claim for which you do not receive the expected payment amount. Determine the reason it was denied, downcoded or not paid in full.
  - This exercise serves two purposes:
  (1) if you are doing something wrong that is causing the issue, it allows you to change your policies to avoid problems in the future; or
  (2) if the payor has made a mistake, it allows you to identify decisions you wish to appeal.

Understand Your Rights

- Your rights will generally depend upon two factors:
  - if the patient is enrolled in a health plan with which you have a contract, you rights will depend, in part, on the contract;
  - your rights may also depend upon the laws regulating the particular line of business in which the patient was enrolled.
- The contract and the law regulate a number of issues that are key to your appeal:
  - amounts the payor is obligated to pay.
  - right to retroactively recoup amounts previously paid and timeframe for such recoupments.
  - your rights regarding appeals.

Understand the Process

- The process will vary depending on the line of business and payor.
- May vary based on whether you are a contracting provider.

Identify the Correct Process

- Employer group and individual health plans (ERISA/Affordable Care Act/state rules – or plan rules)
  - Appeals as contracted provider
  - Appeal as authorized representative
- Medicaid
  - Plans
  - FFS
- Medicare-Medicaid Plans (MMPs)

Identify the Correct Process

- Medicare
  - FFS
  - Medicare Advantage
    - Contracting provider
    - Non-contracting provider
  - Medicare Cost (certain states including MN, IA, WI, TX, MD, VA, ND, SD…)

Understand the Process

- Most state laws address member appeals or non-contracting provider appeals: few prescribe a process for contracting providers.
- Same is true for Federal laws.
- However, denial notices are often regulated and directions on how to appeal are required.
- Some state/Federal laws also require websites to include explanations of how to appeal.

Understand the Process: Example – ACA/ERISA

- Regulations serve as a floor. State law can be more stringent (but would only apply to plans regulated by state law).
- Specifies requirements such content of adverse determination notices, timelines for review and appeal process.
- Notice of adverse decision has to include certain information.
- Claimant has up to 180 days to appeal
- Health Plan must have health professional with appropriate training and experience if issue is medical necessity.

Understand the Process: Example – ACA/ERISA

- Claimant has the right to access information relating to the appeal/grounds for decision.
- Plan can have one or two levels of appeal but both must be resolved within 60 days.
- Medical Necessity issues are appealable to external review entity with maximum of $25 refundable fee.
- May be federal or state external review entity.

Understand the Process: Example – Medicare Advantage

- Contracting providers: Subject to plan process (with limited exception for prior authorization requests).
- Non-contracting providers
  - Must sign a waiver of liability
  - Must appeal within 60 days
  - Plan has 30 days to resolve requests for services (72 hours for expedited requests)/60 days for requests for payment; if decision is still adverse, it is automatically forwarded to an independent review entity.
  - If not satisfied, provider has 60 days at appeal to Administrative Law Judge and further appeals opportunities consistent with Medicare FFS.

Appeals: Best Practices

- Evaluate the denial: Take a close look and make sure your claim was submitted correctly and appropriately.
  - If not, ask for a reopening or otherwise file a corrected claim.
- Submitting your appeal
  - Submit a timely appeal; know how long you have
  - Send it to the appeals department as directed
  - Do not include legal accusations
  - Include a straight-forward explanation
    - Appeals reviewers are often nurses or coding experts
    - In order to deny, the law may require review by a physician or health care professional with appropriate training and experience in the field of medicine involved in the medical judgment.

Submitting Your Appeal

- Include relevant evidence:
  - For Medicare Advantage appeals, include FFS EOBs that show that the claims was paid/service was covered under FFS.
  - Include EOBs showing the claim has been paid in the past.
  - For Medicare, NCDs or LCDs.
  - Include any past appeal overturns on the same issue (blinded to avoid HIPAA issues).
  - Include any relevant portions of the medical record.
  - For medical necessity, may include medical articles.
  - May include coding guidance.

Keep Appealing!

- If your appeal is denied, determine whether there are additional levels of appeal.
  - Under the ACA (member process), Medicare FFS, Medicare Advantage (non-contracting providers) and Medicaid there are additional levels
  - Under these programs, you can obtain review by an external, independent entity
  - Under Medicare Advantage, if you are a non-contracting provider and the plan wishes to affirm its denial, it must automatically send the appeal to an independent entity for review. No action is necessary from the provider.

Develop Appeals Processes

- For each payor under which you appeal, you should maintain a file, which includes:
  - The appeals procedures for the payor to make them easy for you or your office staff to find.
  - A copy of any contract you have with that payor, so that your rights are easily identifiable.
  - Every appeal you have submitted and the response to each appeal. This allows you to track your appeals. It also gives you important information for future appeals and adjusting practice policies.
  - A page for notes. On this page you can include any individuals with whom you have had discussions or whose assistance you have found particularly helpful.

Develop Appeals Processes

- If you provide services under different lines of business for the payor, you may want to keep different files.

For ERISA/ACA: Set the Stage

- The statutorily prescribed process applies to claimants (i.e., members and their dependents) which includes plan beneficiaries and their AUTHORIZED REPRESENTATIVES.
- Becoming an authorized representative essentially allows the physician to stand in the shoes of the beneficiary in order to use the member appeal process.
- APMA has a model form to be appointed as an authorized representative.

APMA Resources:

- Chapter of the Private Insurance Resource Guide on Appeals
- Model Authorized Representative Forms for ERISA/ACA