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Lab Stewardship Hot Topic: Helping patients win insurance appeals for medically necessary testing

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Objectives

- Explain why insurance companies deny “medically necessary” claims
- Understand what information is needed to appeal these claims
- Understand the general process for appealing these claims

The Health Care Business

- Health insurance - protect from high cost medical care
- Insurance company- paid a certain amount of money per member. Cost per member is dependent on several factors.
- Insurance companies have processes in place in order to control costs (CM, UR/UM, prior auth, referrals)
- Insurance companies report to their stakeholders
  - Big 5 companies reported $4.5 billion in net earnings in first quarter 2017

The Health Care Business

- OIG report “Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns about Service and Payment Denials – September 2018
  - CMS cited 56% of audited Medicare Advantage Organizations (MAO) contracts for making inappropriate denials in 2015
  - CMS cited 45% MAO provided denial letters that contained insufficient information to properly explain why claims were denied.
  - 1% of MAO beneficiaries utilized the appeal process

Why do insurance companies deny claims?

- Provider error
  - Wrong insurance, ID, DOB, or code
  - Provider Credentials
  - Lack of prior auth
- Payer error
  - Human error for unlisted codes, poor process
- Lack of clinical documentation
- Lack of understanding of what is being ordered
- Disagreement about what is medically necessary (Hayes, ECRI)
- Remember - 1% of MAO beneficiaries utilized the appeal process

What information is needed to appeal?

- EOB/Claim number
- Denial Letter with reason for denial
- Appropriate appeal form, if available
- Authorized representative form
- Statement of medical necessity form ordering MD – why was the test/procedure ordered and what was done with the results
- Member Letter
- Explanation of services provided

Process for Appealing Claims

- Denial reasons vary so verify you have to know the correct reason in order to follow the correct appeal process
- Contact your payer to determine all levels of appeal
- Verify timelines for appeal – don't lose a case because of timely filing
- Follow-up on the appeal – don't depend on the payer
- Fax when possible – avoid mailing

Process for Appealing Claims

- Commercial
  - Appeals vary by company
  - Call to verify both provider appeal process and member process. Determine if employer appeals are an option
  - Obtain appeal phone and fax numbers
  - Obtain appeal forms specific for payer or IRO
  - Determine if a peer to peer is an option
  - Use the external review process to influence individual case determination and medical coverage
    - “like kind”
    - Standard of care

Process for Appealing Claims

- Medicare
  - First Level: Redetermination by a Medicare Administrative Contractor (MAC)
  - Second Level: Reconsideration by a Qualified Independent Contractor (QIC)
  - Third Level: Decision by the Office of Medicare Hearings and Appeals (OMHA)
  - Fourth Level: Review by a Medicare Appeals Council (MAC)
  - Fifth Level: Judicial Review in Federal District Court
- Medicaid

Final Thoughts

- Consider prioritization of appeals
- Don’t quit- appeals impact coverage decisions and contracts
- Collect all external review letters to influence coverage decision
- Involve your patients and KOL

Questions?

Thank you for your time!

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