Tips to obtain payment, despite plan denials

Sometimes, a plan will mistakenly verify coverage or preauthorize a service, and later refuse to pay for the procedure.

For example, a plan may verify that a patient is covered for a follow-up CT scan but later deny payment, which is unfair to your practice.

You’ve contacted the plan to make sure the service is covered and followed the utilization management rules, so you should receive payment in a timely manner.

You don’t have to accept the plan’s payment denial, experts say. You may be legally entitled to payment for claims mistakenly verified or preauthorized. Simply sending a letter that says the denial is unacceptable will cause many plans to reverse the denial, says Randal L. Payne, Esq., at Sullins, Johnston, Rohrbach, and Mager in Houston.

Payne frequently drafts challenge letters for his provider clients to send to plans.

Why mistakes happen

The employee who takes your precertification call may only check whether the member generally has that service as a covered benefit.

After you’ve provided the service and the plan reviews the claim, it may discover other information, such as the member’s employer canceled the employee’s health insurance.

At that point, the plan will often refuse to pay the claim, says Lisa Manziel, Esq., at Manziel Law Offices in Dallas. “There has been a big increase in this type of denial,” Manziel says.

Some physicians don’t even realize when a plan has denied a claim for this reason. “The denials sometimes aren’t that specific, and the physician’s billing department writes off the claim when it really isn’t necessary,” explains John Clark, Esq., at Clark, Mascaro, and Aziz, PC, in Atlanta.

Most plans refer to the contract to justify their denials in this situation. In particular, they may note that the contract contains a disclaimer that “any preauthorization or verification of coverage is not a guarantee of payment.”

Even if the contract doesn’t have this disclaimer, the plan may have used disclaimer language when initially verifying coverage or giving preauthorization. Or the plan may include such language as a justification in its denial letter.

Some plans also try to justify their right to deny these claims by telling the provider that the Employee Retirement Income Security Act (ERISA)—which may bar lawsuits pertaining to denials of benefits—governs the plan.

“If a plan is going to give a physician verification or preauthorization, it has a duty to do it in good faith and with due care.”

—Lisa Manziel, Esq., at Manziel Law Offices in Dallas.

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How to overturn denials

To reverse these denials, send the plan a letter challenging the denial. Address the letter to the individual who sent the denial or to the head of the plan’s claims department.

This works when you have the law on your side, explains Manziel.

“If a plan is going to give a physician verification or preauthorization, it has a duty to do it in good faith and with due care,” she says. “The practice relies on that verification or preauthorization when it provides services to the member.”

And any disclaimer in the contract isn’t automatically enforceable, says Payne.

“Pro-plan language won’t affect your legal claim that the plan deceived you,” he explains.

“Having the disclaimer doesn’t give plans a license to lie,” notes Clark. “These disclaimers probably won’t hold up in court.”

In many states, laws or court decisions specifically protect physicians from this type of payment denial. These protections vary widely.

For example, some states say a plan can’t retroactively deny payment for preauthorized services.

Other states don’t automatically bar plans from retroactively denying payment, but their courts have rules that ERISA doesn’t bar the provider from suing the plan for payment.

There’s no downside to sending a letter challenging the payment denial. “Providers have nothing to lose,” says Tammy Tipton, president of Appeal Solutions in League City, TX. “Often, the letter itself is enough for the plan to reverse the denial.”

What to include in the letter

“Model letter,” which can be found on p. 3, is a letter drafted by Tipton.

The letter acknowledges the denial, states that it is not acceptable, and includes specifics about the practice’s contract with the plan.

Should you need to write a challenge letter, make sure to show the letter to your attorney for approval first. If you already have such a letter, compare it to the sample letter and add any needed improvements or clarifications.

If the plan ignores your letter, send a second letter, copying the plan’s CEO and medical director. It pays to be persistent, Tipton says.

If the plan still doesn’t respond or refuses to pay you, you may want to consider taking legal action.

“Sometimes, suing may be the physician’s best course of action,” says Clark.
Providers should negotiate contract terms that state that the carrier can deny only precertified treatment under agreed-upon circumstances, says Tipton. “Contract language can also clarify that the precertification is binding if it was extended, due to the carrier’s error in applying the policy terms,” she says. “If the carrier is reluctant to such terms, your office may need to decrease the exposure related to poor verification by submitting a written pretreatment request for benefit disclosure.” Phone verification is provided as a courtesy, she adds.

However, if the provider submits a written request and establishes the right to benefit information, the carrier is under more legal obligation to respond.

“Under the ERISA Claim Procedure Regulation applicable to many group health plans, fines can actually apply if the carrier ignores a request from a qualified party,” Tipton notes.

**Model letter**

Tammy Tipton, reimbursement specialist at Appeal Solutions in League City, TX, developed the following sample letter, which refers to a denial made by a healthcare plan and tells the plan that the denial is not acceptable.

Show this letter to your attorney and get his or her approval before using it. If you already use a similar letter, compare it to this one and add any improvements or clarifications.

January 1, 2009
Re: Claim #123

Dear Ms. Doe:

We have received your denial of the above claim. This denial is unacceptable. We properly obtained preauthorization for the procedure and relied on that preauthorization when we performed the procedure.

We called and spoke to Mr. Smith in your office at 2 p.m., June 22. Mr. Smith confirmed that the member was covered, that the procedure was a covered benefit, and that the coverage was not exclusively contracted to any specialty provider.

We acted in good faith and had no knowledge that ABC HMO would find that it had made a mistake.

Under general principles of law and equity, plans must act in good faith and with due care.

Once you preauthorize a procedure and we perform it, you cannot deny coverage.

As you know, any disclaimer that states “preauthorization or verification does not guarantee payment” is not automatically or necessarily legally enforceable.

In addition, our contract states that ABC HMO agrees to perform in good faith. We believe that the denial of this claim is not in good faith and that it is a violation of our contract.

We hereby request that you reverse the denial and pay the claim in full within 30 days of this letter.

If you do not, we may have to take further action to protect our interests.

Yours truly,
Jim James, Office Manager
Random Radiology Group

**Insider sources**

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Four pitfalls to avoid when interpreting films off-site

Many radiology practices review and interpret images taken by family practices, IDTFs, or other practices or facilities. But be careful—you may face several compliance and clinical hazards under such arrangements.

For example, these off-site arrangements may not comply with the new antimarkup rule. In addition, such arrangements may also expose facilities to malpractice risks, says Matthew Kupferberg, Esq., at Medco Health Solutions, Inc., in Franklin Lakes, NJ.

For example, a patient with a bad outcome can sue the treating physician and the practice or facility that took the image. The insurer for the practice or facility could bring the interpreting radiologist into the suit.

When interpreting off-site films, make sure to avoid the following compliance and clinical hazards:

➤ **Antimarkup violations.** “Interpretative services for Medicare and Medicaid patients must comply with Stark,” says Thomas W. Greeson, Esq., at Reed Smith, LLP, in Falls Church, VA. But even if the contractual arrangement complies with Stark Law, it may trigger the antimarkup restriction contained in the 2008 Medicare Physician Fee Schedule (MPFS).

“The rule was adopted, but the effective date was delayed by CMS until January 1, 2009,” says Greeson.

For example, if an orthopedic group pays a radiology group $300 to read a CT scan for a Medicare patient, and the contractor reads it remotely from the referring physician’s practice, CMS could treat the arrangement as a purchased interpretation.

This means that the referring physician’s group could bill for the interpretation service but could not mark it up and bill Medicare any more than the $300 charge for the professional component.

“Facilities that currently provide off-site interpretations and providers that use such services need to review these arrangements in light of the 2009 MPFS final rule,” says Greeson. CMS had not finalized the proposed MPFS rule at the date of RACRI’s publication, so check with your attorney about the final effect of the rules.

➤ **Quality checks for referring practices.** Interpreting images off-site is riskier than interpreting images on-site because the radiologist has less control. If a referring practice has inferior equipment, it influences the quality of the images and can affect your interpretation, says Kupferberg.

To avoid this situation, don’t enter into an agreement to provide interpretations if the equipment is inferior. Retain the right to terminate an agreement if the referring practice provides the radiologist with poor images.

➤ **Untrained personnel.** The radiologist depends on the referring practice to acquire appropriate images and to act prudently and promptly in response to the radiologist’s report, says Kupferberg.

A less competent technologist may take fewer views, which may increase the likelihood that the radiologist will miss a significant finding.

If an off-site radiologist reports a significant finding and reports it to the referring facility, such information and follow-up care must be promptly provided to the patient.

So check technologists’ credentials, and establish policies and protocols to document how and when you communicate findings to the referring facility.

➤ **No access to prior films or images.** Failure to compare prior images is a major reason radiologists can lose malpractice suits, says Kupferberg.

Make sure you establish procedures and protocols that require the referring facility to provide all the patient’s prior images. In your agreement, make the referring facility responsible for tracking prior images and forwarding them along with the image it wants interpreted.

Insider sources

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Update RIS/PACS to improve patient outcomes

If your facility has updated to a full radiology information system (RIS) and integrated a PACS, it’s time to check whether that system does all it should to improve your practice, efficiency, and patient care, says Karen Graham, chief information officer at Cooper University Hospital in Camden, NJ.

The following four steps will help you analyze and update your system:

1. **Analyze practice needs.** Examine your RIS/PACS. Analyze your people, processes, and culture, says Graham. No administrator advances any project without the support of staff members and superiors. For example, radiologists determined to continue reading film will ensure that the PACS implementation process fails.

   Evaluate the patient experience from the time the appointment is set to the time he or she receives results, and document any problems. For example, determine whether the image reading turnaround is too long. Examine the various levels of reading redundancy and map the workflow of your institution.

   This analysis is necessary, says Daniel Ireland, vice president of clinical support at United Memorial Medical Center in Batavia, NY.

   Once you understand your challenges, evaluate your current technology and determine how you should update the RIS/PACS system. In many cases, you need to change modalities and equipment, says Graham, adding that you should also look at your culture. You may find that updates to the RIS/PACS will invigorate and improve your culture and care to patients.

2. **Question your budget.** You must project costs for your improved system, but also make sure you document the costs of inefficiencies to your current system. If radiologists are more efficient, you’ll find that you’ll quickly recap the initial expenditures for an updated RIS/PACS. A PACS doesn’t generate revenue. It simply stores and retrieves data. Updating a RIS/PACS system costs money, but it may not be as substantial as you think. It may not cost millions of dollars. Do your homework and determine the cost/benefit before you buy into a new system.

3. **Make site visits.** Visit other facilities that have updated a RIS/PACS to see the most recent features and gain new, invaluable perspective on potential integration options, says Ireland. Ask other facilities whether you can observe various phases of the systems’ implementation. Remember, sales staff members generally promise excellent products, but it’s up to you to perform due diligence to make sure those products meet your facility’s needs.

4. **Research vendors for updates.** You’ll need to research the cost and offerings of vendors, says Graham. But keep in mind that you can also use different vendors for RIS/PACS, and you may want to keep your options open, says Ireland.

**Insider sources**

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Illustration by David Harbaugh

“The PACS committee members found out implementing PACS would cost $2–$5 million, so they delegated you to fund it while they’re under restraint and seclusion.”
CMS issues test order signature clarification

CMS recently released an update to the Medicare Benefit Policy Manual, clarifying physician signature requirements for clinical diagnostic tests. Specifically, the update (Change Request 6100, Transmittal 94) stated that physician signatures are not required on orders for diagnostic tests paid based on the Clinical Laboratory Fee Schedule, the Medicare Physician Fee Schedule, or for physician pathology services. CMS accidently left the stipulation out of the manual when it was originally published.

Before CMS issued the August revision, Medicare contractors were routinely rejecting claims that lacked a physician signature. The clarification means one less arduous task for radiologists, says Jean Acevedo, LHRM, CPC, CHC, PCS, president and senior consultant at Acevedo Consulting in Delray Beach, FL. However, they still need to make sure the intent of the ordering physician is clear, Acevedo says.

“The good news for radiologists is they no longer have to track down physicians and ask them to fax over signatures,” she explains. “We conduct compliance auditing of several different radiology groups and, up until now, we have always required the code and the signed order. Now we won’t be looking for any physician signature—just documentation that the order is there.”

It isn’t likely to alter practice operations much, says Stacy Gregory, RCC, CPC, owner and senior consultant at Gregory Medical Consulting Services in Tacoma, WA. However, radiologists can breathe a sigh of relief regarding the time saved from searching for physician signatures, she says.

Confusion regarding signature requirements

Some providers are still unsure about when it is necessary to verify signatures. This is especially true as CMS recently passed another rule stating it will no longer accept medical records with a physician signature stamp, says Veronica Marsich, Esq., at Smith Haughey Rice and Roegge in Ann Arbor, MI.

That rule modified CMS’ Medicare Program Integrity Manual and mandated the use of handwritten or electronic signatures in documentation in lieu of a signature stamp. It’s no surprise that providers may not know what to do, particularly because these two changes came out so close to one another, Marsich says.

“Radiologists need to make sure their intake scheduling person has enough education and is able to document orders correctly when they come in over the phone.”

—Jean Acevedo, LHRM, CPC, CHC, PCS
“It has created some confusion in the sense that there are other components of the manuals that say when a signature is required, it has to be original,” she says. “The point is, if the documentation requires a signature, make sure it doesn’t have a stamp. But in the case of diagnostic tests, they don’t need it at all.”

“I tell them they don’t have to do anything except make sure the order is clear,” says Acevedo, who has already received questions from imaging centers.

Marsich says she is also optimistic that the revision will stop contractors from returning claims and refusing payment because of physician signature. “I really don’t think there will be any delay in payment on the contractor side of things,” she says. “Now that the revision is clearly stated in the manual, they don’t have any room to disregard it.”

**Items to watch**

Although the transmittal alleviates some burden from providers, it’s important to look closely at the language of the revision, says Acevedo. In addition to stating that no signature will be required for diagnostic tests, CMS also states that “while a physician order is not required to be signed, the physician must clearly document, in the medical record, his or her intent that the test be performed.”

It is important to note that even though radiologists don’t have to look for a signature, they still have to make sure that intent to perform the test is well documented, Acevedo says. “What that means, essentially, is that radiologists need to make sure their intake scheduling person has enough education and is able to document orders correctly when they come in over the phone,” she says. “They need to be able to clearly understand the ordering physician’s intent.”

Providers should remember that this revision does not change any prior CMS directives regarding ordering requirements for interpreting physicians, Acevedo says. Specifically, interpreting physicians still cannot step outside the bounds of an order without having a discussion with the ordering physician and requesting a new test order, if needed, she explains. (See “What CMS says about signature changes” at right for the official language.)

The absence of a physician signature does not nullify those ordering requirements, Acevedo says, and adds, “I would really stress that because it can be very easy to forget.”

**Physicians’ signing rules**

As a general practice, physicians are often advised to sign any requisition for service, so radiologists may see no difference at all, says Marsich. In fact, it would be ideal if the clarification served as protection from contractors in potential disputes, rather than triggering a big change in protocol, she says.

“Physicians have in the back of their mind that signatures are important,” Acevedo says. “And, of course, they protect radiologists, too. I wouldn’t suggest that any radiology practice discourage treating physicians from signing orders. Still, it’s a nice thing that radiologists don’t have to search them out anymore.”

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**What CMS says about signature changes**

CMS’ Medicare Benefit Policy Manual states the following regarding signature requirements on diagnostic test orders:

> When an interpreting physician (e.g., radiologist, cardiologist, family practitioner, general internist, neurologist, obstetrician, gynecologist, ophthalmologist, thoracic surgeon, vascular surgeon) at a testing facility determines that an ordered diagnostic radiology test is clinically inappropriate or suboptimal, and that a different diagnostic test should be performed (e.g., an MRI should be performed instead of a CT scan because of the clinical indication), the interpreting physician/testing facility may not perform the unordered test until a new order from the treating physician/practitioner has been received.

> Similarly, if the result of an ordered diagnostic test is normal and the interpreting physician believes that another diagnostic test should be performed (e.g., a renal sonogram was normal and based on the clinical indication, the interpreting physician believes an MRI will reveal the diagnosis), an order from the treating physician must be received prior to performing the unordered diagnostic test.
Time to review, adapt to the new ABN process

CMS issued a new “Advance Beneficiary Notice of Noncoverage” form in March 2007. The form replaced the general and laboratory-specific Advance Beneficiary Notice (ABN) used in recent years, says Robert E. Mazer, Esq., at Ober Kaler in Baltimore. But many radiology practices and facilities still have questions about the new form.

ABNs document a Medicare beneficiary’s recognition that Medicare is unlikely to pay for an item or service based on medical necessity and other specified reasons, says Mazer.

“The date was originally September 2008 but now is March 1, 2009,” says Jackie Miller, RHIA, CCS-P, CPC, vice president of product development at Coding Metrix, Inc., in Powder Springs, GA.

The new form is for physicians, providers, practitioners, and suppliers paid under Medicare Part B, as well as hospices and religious nonmedical healthcare institutions paid under Medicare Part A. It may not be used for inpatient hospital services, by skilled nursing facilities, or home health agencies, notes Mazer.

The new ABN combines the general ABN (ABN-G) and the laboratory ABN (ABN-L) into one notice, making the process simpler for patients. Mazer says the new ABN form continues to require the:

- Identification of the item or service to which it relates
- Reason Medicare is not expected to pay for the item or service
- Estimated cost of the item or service

Beneficiaries now have three possible choices when they fill out an ABN:

- Obtain the item or service, but agree that they will not submit a Medicare claim or expect that Medicare will pay. In other words, the patient will pay for the service. This is a new option.

- Obtain the item or service and require submission of a Medicare claim.

- Refuse the item or service. According to CMS, “if the beneficiary cannot or will not make a choice, the notice should be annotated, for example: ‘Beneficiary refused to choose an option.’ ”

If the patient refuses to sign and demands service, the facility can note that the patient refused to sign. Two witnesses should sign a document stating that the patient refused to sign, despite medical advice. Under such circumstances, the patient may be held responsible, says Stacie L. Buck, RHIA, CCS-P, LHRM, RCC, CIC, vice president of Southeast Radiology Management in Stuart, FL.

Form incorporates informed consent

CMS blended concepts from informed consent forms into the ABN process, says Mazer. CMS requires that:

- The ABN be verbally reviewed with the patient or his or her representative

- Answers be provided to any patient questions

- The ABN be delivered sufficiently in advance of the provision of the item or service, so that the patient can consider all the available options

Insider sources

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Insider tip

You can get information on the new Advance Beneficiary Notice (ABN) form at www.cms.hhs.gov/BNI/02_ABNGABNLA.asp#TopOfPage. Click on the first item on the list, “Revised ABN CMS-R-131 Form and Instructions.” This should download a zip file to your computer that contains the new form in English and Spanish. The customizable form is “ABN-custom-L 3-6-08.doc.”