Current Managed Care Collection & Follow-up Techniques and Tips

AAHAM

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ALAN M. FISHER, P.A.

818 A1A North
Suite 303
Ponte Vedra Beach, Florida 32082
Tel: (904) 285-0070
Fax: (904) 245-1945

601 Heritage Drive
Suite 156a
Jupiter, Florida 33458
Tel: (561) 743-0745
Fax: (561) 743-2414

Toll Free (888) 868-1926
Amfpalegal@aol.com

Rejected

Denied

Under Paid

What Next?

- Call
- Appeal
- Reconsideration
- Be aware of Time Limits

Appeal the Issue

- Authorization / Pre-Certification
- Notification
- Timeliness
- ER Reimbursement
- Sequestration
- Medical Necessity/Level of Care
- Experimental Procedure

Why Appeal the Issue?

- Assume a claim is denied for no authorization.
- What should your appeal say?
- Why?

Authorization / Pre-Certification

- What harm was done?
- If an ER admission: Florida Law does not require authorization for emergency services.
  - *Florida Statute § 641.513 (1)(d)*
  - *Florida Statute § 627.64194 (2)(a) (effective July 1, 2016)*
  - *WHAT ABOUT THE ACA?*
  - *42 U.S.C. § 18022(b)(1)(B)(E)(i) – ACA-for emergency department*
- Doctors (Par & Non-Par)
  - *Florida Statute § 627.64194 (3) (effective July 1, 2016)*
    - *Emergency and Non-Emergency- Payment under certain conditions*

Standard for Authorization Requests

- The Florida Legislature added *Florida Statute § 627.42392(2)-standards*
- *Florida Statute § 641.3154(2)- HMO could be liable*
- The request cannot be longer than two pages.
- Specifies minimum information that must be included.

Notification

- Are Notification denials enforceable?
  - Depends on denied amount.
  - Cannot be arbitrary
- Possibly not incorporated in contract.

Notification

- This type of contract provision is often referred to as Liquidated Damages.
- Liquidated Damages provisions, to be enforceable, cannot be an arbitrary amount and must bear some relationship to the actual damages suffered. Otherwise it is a penalty and therefore unenforceable.

Timeliness

- Statute gives six months to file a claim from date of discharge or when the name or address of the primary insurer is received.
  - *Florida Statute § 641.3155*
  - *Florida Statute § 627.6131*
- No stated penalty if claim is filed late.
- Law abhors forfeiture.

Non-Par ER Reimbursement

- Some Insurers are only paying the 450 code
- Most are paying less than charges
- What they are obligated to pay?
- Ancillary charges;
- Stabilization charges.
- How Much?
- 29 CFR Sec 2590.715-2719A,(b), ACA regarding possibly only group policies
- Greater of
  - Median payment to par facilities for same services
  - The amount the plan would generally pay for out of network services
  - The amount Medicare would pay
  - Contract amount
- FL Statute § 641.513(5) states that reimbursement for a Non-Par provider is to be the lesser of:
  - As of July 1, 2016 this will apply to all insurance plans, see Fl Statute 627.64194 (4)
  - The provider's charges;
  - The usual and customary provider charges for similar services in the community where the services were provided; or
  - The charge mutually agreed to by the health maintenance organization and the provider within 60 days of the submittal of the claim.
- SO how much is to be paid?

Sequestration

- Following Sequestration in 2013, Carriers began reducing payments following Medicare's 2% payment reduction.
- At times these reductions can be hard to spot because many Carriers do not use an adjustment code for sequester.
- What do you do?
- It's all about the contract
  - April 17,2014 CMS Letter to the American Hospital Association
    - CMS, by statute, does not interfere in Private Insurance contracts
    - Payors must follow contractual fee arrangements and prompt pay
  - As clarified by CMS, Sequester only effects private insurance reimbursement if the contract language allows it to.

Medical Necessity/Level of Care

- What is the basis?
- Why?
- Who determines the standard?
- Medical Review

Experimental Procedure

- The definition of "Experimental" is not always clear.
- HMO's are required to explain their reasoning behind calling a treatment "Experimental."
  - *Florida Statute § 641.54(5)(d)*
- Medical Review by ARNP or M.D. can help:
  - Show treatment is effective.
  - Show treatment is in common use.

Conclusion

- Identify the Issue
- Appeal the Issue
- Establish a Record
- Watch for Time Limits

New Florida Legislation

- House Bill No. 1175 adds new requirements for providers.
  - Must post average cost of service bundles
  - Must provide patient an estimated cost of non-emergency services on request
  - Provide an itemized bill to patient within 7 days of discharge or request.
    - Per AHCA "The initial statement or bill must be made available upon request. The statement or bill must be provided within 7 days of discharge or release or 7 days of request, whichever is later.
  - Must detail where each cost comes from in language a layperson would understand.