The Appeals Process For Medical Billing

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**What is an Appeal?**
An appeal is a legal process where you are asking the insurance company to review it’s adverse benefit determination with the patient’s claim for benefits or you are appealing a provider contract issue.

**What is an adverse benefit determination?**
According to Federal Regulation 29 CFR 2560.503-1, *The term “adverse benefit determination” means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.*

**When I send a claim, isn’t this the doctor’s claim?**
No. What you are doing is sending a claim to have the patient’s health benefit paid. This is why, when the insurance company doesn’t pay the benefit correctly, it is called an adverse benefit determination. The insurance company, when processing a claim, will send a document called an Explanation of Benefit form. If the doctor wishes to have the payment of the benefit sent to him/her, you have the patient sign a document called an Assignment of Benefit form. So, as you can see, everything relates to the patient’s benefit.

**What am I appealing with a doctor’s contract?**
There are many part of a contract that would be appealed. Examples are time limits to send claims, time limits to pay claims, the amount of reimbursement and more.

Appealing used to be simple, but today, appeals are very complex. You have many variables that must be considered when appealing. This manual will answer many of the questions you may have regarding appeals.
Step #1 – Understanding Your Rights:
Healthcare benefits are based on a legal and binding contract. The contract is established between the patient and the insurance company or the patient’s employer and the insurance company. If an employer signed a contract, then the health benefits are provided to an employee as a benefit of employment.

The appeal rights are clearly defined in the patient’s health benefit manual and under the ERISA law, 29 CFR 2560.503-1. First, the health benefit contract does not allow you, the provider or medical biller, the right to appeal an adverse benefit determination. The right of appeal rests with the patient.

When you look at 29 CFR 2560.503-1, it states as follows:
(4) The claims procedures do not preclude an authorized representative of a claimant from acting on behalf of such claimant in pursuing a benefit claim or appeal of an adverse benefit determination. Nevertheless, a plan may establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a claimant, provided that, in the case of a claim involving urgent care, within the meaning of paragraph (m)(1) of this section, a health care professional, within the meaning of paragraph (m)(7) of this section, with knowledge of a claimant's medical condition shall be permitted to act as the authorized representative of the claimant; and

(5) The claims procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants.

As you can see, before you can do anything regarding a patient’s health benefit determination, you must have written permission from the patient to do so. An Assignment of Benefit form is insufficient to place authorized representation to a provider or a provider’s representative such as a medical biller. You will need a separate document, signed by the patient, that authorizes you to legally represent the patient.
The Employee Benefits Security Administration, the enforcement agent of the Department of Labor, states the following on it’s website regarding questions related to the Employee Retirement Income Security Act (ERISA):

**B-1: May a plan require that a claimant complete and file a form identifying any person authorized to act on his or her behalf with respect to a claim?**

Yes, with one exception. The regulation provides that a reasonable claims procedure may not preclude an authorized representative of a claimant from acting on behalf of a claimant with respect to a benefit claim or appeal of an adverse benefit determination. The regulation also provides, however, that a plan may establish reasonable procedures for determining whether an individual has been authorized to act on behalf of the claimant. Completion of a form by the claimant identifying the authorized representative would be one method for making such a determination.

The one exception is where a claim involves urgent care. In such instances, a plan must, without regard to the plan’s procedures for identifying authorized representatives, permit a health care professional with knowledge of the claimant’s medical condition (e.g., a treating physician) to act as the authorized representative of the claimant. This exception is intended to enable a health care professional to pursue a claim on behalf of a claimant under circumstances where, for example, the claimant is unable to act on his or her own behalf. See § 2560.503-1(b)(4).

**B-2: Does an assignment of benefits by a claimant to a health care provider constitute the designation of an authorized representative?**

No. An assignment of benefits by a claimant is generally limited to assignment of the claimant’s right to receive a benefit payment under the terms of the plan. Typically, assignments are not a grant of authority to act on a claimant’s behalf in pursuing and appealing a benefit determination under a plan. In addition, the validity of a designation of an authorized representative will depend on whether the designation has been made in accordance with the procedures established by the plan, if any.

**B-3: When a claimant has properly authorized a representative to act on his or her behalf, is the plan required to provide benefit determinations and other notifications to the authorized representative, the claimant, or both?**

Nothing in the regulation precludes a plan from communicating with both the claimant and the claimant’s authorized representative. However, it is the view of the department that, for purposes of the claims procedure rules, when a claimant clearly designates an authorized representative to act and receive notices on his or her behalf with respect to a
claim, the plan should, in the absence of a contrary direction from the claimant, direct all information and notifications to which the claimant is otherwise entitled to the representative authorized to act on the claimant’s behalf with respect to that aspect of the claim (e.g., initial determination, request for documents, appeal, etc.). In this regard, it is important that both claimants and plans understand and make clear the extent to which an authorized representative will be acting on behalf of the claimant.

http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html

As I previously stated, the right of appeal rests with the member, not you and not the provider, unless you have been given written permission to appeal on behalf of the member. The following is from a member’s HMO benefit manual regarding the member’s appeal rights:

If a claim for payment or services is denied by the Plan, you must ask the Plan, in writing and within six months of the date of the denial, to reconsider its denial before you request a review by OPM. (This time limit may be extended if you show you were prevented by circumstances beyond your control from making your request within the time limit.) OPM will not review your request unless you demonstrate that you gave the Plan an opportunity to reconsider your claim. Your written request to the Plan must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided.

This right is available only to you or the executor of a deceased claimant’s estate. Providers, legal counsel, and other interested parties may act as your representative only with your specific written consent to pursue payment of the disputed claim. OPM must receive a copy of your written consent with their request for review.

So, your very first step is to ask yourself this question: Do I have the right to appeal the adverse benefit determination? As you can see, you do not have the right unless the patient gives you that right. If you make a freedom of choice decision to appeal without the patient’s written permission, the insurance company does not have to respond to you. The patient also has the right to file a lawsuit against you for taking their appeal rights away from them.

Once you have been given that right to appeal, you need to understand that the appeals process is very detailed and it has exact steps that must be taken and within specific timeframes. In addition, once you start the appeal
You (or a person acting on your behalf) may not bring a lawsuit to recover benefits on a claim for treatment, services, supplies or drugs covered by this Plan until you have exhausted the OPM review procedure, established at section 890.105, title 5, Code of Federal Regulations (CFR). If OPM upholds the Plan’s decision on your claim, and you decide to bring a lawsuit based on the denial, the lawsuit must be brought no later than December 31 of the third year after the year in which the services or supplies upon which the claim is predicated were provided. Pursuant to section 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management in Federal court. Federal law exclusively governs all claims for relief in a lawsuit that relates to this Plan’s benefits or coverage or payments with respect to those benefits. Judicial action on such claims is limited to the record that was before OPM when it rendered its decision affirming the Plan’s denial of the benefit. The recovery in such a suit is limited to the amount of benefits in dispute.

As you can see, this patient’s health benefits are under Federal Law. This particular HMO wants you to believe that State law has jurisdiction over the payment of the health benefits.

**Step #2 – Gathering Evidence**

When a lawyer goes into court, he/she does so with as much evidence as they can find. The prosecutor has evidence to show the court that a crime as been committed. The defense has the right to see this evidence and to produce evidence to dispute the prosecutor’s evidence. Providing the information to the defense is called disclosure. This is because there can be no surprises in a court of law. When there is an adverse benefit determination, the health insurance company must inform the member what was used to deny the payment of the benefit or why the benefit was not paid in full.
The following is from an HMO benefit manual:

If your claim to a benefit under the plan is denied in whole or in part, you (or your beneficiary) will be notified in writing by the claims administrator for the benefit plan within 90 days of the receipt of your claim (180 days if special circumstances apply; if special circumstances require an extension, you will be notified in writing prior to the termination of the initial 90-day period).

This written notice will include:

* The specific reason(s) for the denial

* References to the plan provision(s) on which the denial is based

* A description of any additional materials or information that is necessary to satisfy the claim and an explanation of why such materials or information is necessary

* The procedures for appealing the decision.

You or your authorized representative may review all documents related to any denial of benefits.

The disclosure of information requirement is also listed on the EBSA website:


B-5: For purposes of furnishing relevant documents to a claimant, what kind of disclosure is required to demonstrate compliance with the administrative processes and safeguards required to ensure and verify appropriately consistent decision making in making the benefit determination?

What documents will be required to be disclosed will depend on the particular processes and safeguards that a plan has established and maintains to ensure and verify appropriately consistent decision making. See 65 FR at 70252. The department does not anticipate new documents being developed solely to comply with this disclosure requirement. Rather, the department anticipates that claimants who request this disclosure will be provided with what the plan actually used, in the case of the specific claim denial, to satisfy this requirement. The plan could, for example, provide the specific plan rules or guidelines governing the application of specific protocols, criteria, rate tables, fee schedules, etc. to claims like the claim at issue, or the specific checklist or cross-checking document that served to affirm that the plan rules or guidelines were appropriately applied to the claimant’s claim. Plans are not required to disclose other claimants’
individual records or information specific to the resolution of other claims in order to comply with this requirement. See § 2560.503-1(m)(8)(iii). See question D-12.

**D-8: Does the regulation’s requirement of consultation with appropriate health care professionals limit the discretion of a plan fiduciary reviewing an adverse benefit determination with respect to the advice the fiduciary may seek in resolving the issues raised by the review?**

The regulation requires, for group health and disability claims, that the fiduciary deciding an appeal of an adverse benefit determination based in whole or in part on a medical judgment consult with an appropriate health care professional. This requirement of consultation is intended to ensure that the fiduciary deciding a claim involving medical issues is adequately informed as to those issues. The consultation requirement, however, is not intended to constrain the fiduciary from consulting any other experts the fiduciary considers appropriate under the circumstances. For example, in connection with the appeal of a denied disability claim, a fiduciary may consider it appropriate to consult with vocational or occupational experts. In all cases, a fiduciary must take appropriate steps to resolve the appeal in a prudent manner, including acquiring necessary information and advice, weighing the advice and information so obtained, and making an independent decision on the appeal. The regulation’s provision for consultation with a health care professional is not intended to alter the fiduciary standards that apply to claims adjudication.

**D-9: Under what circumstances must a group health plan (or disability benefit plan) disclose the identity of experts consulted in the course of deciding a benefit claim?**

The regulation provides that, in order to allow claimants a reasonable opportunity for a full and fair review of their claim, a plan’s claims procedures must provide for the identification of medical (or vocational) experts whose advice was obtained on behalf of the plan in connection with an adverse benefit determination, without regard to whether the advice was relied upon in making the determination. Under the rules, plans are not required to automatically provide, as part of a notice of an adverse benefit determination or otherwise, the identity of experts consulted during the claim determination process. Nor are plans required to disclose the name of experts in the absence of an adverse benefit determination. On the other hand, consistent with the procedural requirements of the regulation, the plan must provide the identity of any such experts when requested by a claimant in connection with an adverse benefit determination. See § 2560.503-1(h)(3)(iv) and (4).

**D-10: Upon receipt of a request from a claimant for the identity of experts consulted by the plan in connection with an adverse benefit determination, may a plan satisfy the requirements of the regulation by providing only the name of the company employing the expert or the qualifications of the expert, rather than the name of the expert?**
No. The regulation expressly requires that plans provide for the identification of the medical or vocational expert or experts whose advice was obtained on behalf of the plan in connection with the claimant's claim. Consequently, merely providing the name of the company employing the expert or the qualifications of the expert would not, in the department’s view, satisfy this requirement of the regulation. See § 2560.503-1(h)(3)(iv) and (4). See question D-7.

D-10: Upon receipt of a request from a claimant for the identity of experts consulted by the plan in connection with an adverse benefit determination, may a plan satisfy the requirements of the regulation by providing only the name of the company employing the expert or the qualifications of the expert, rather than the name of the expert?

No. The regulation expressly requires that plans provide for the identification of the medical or vocational expert or experts whose advice was obtained on behalf of the plan in connection with the claimant's claim. Consequently, merely providing the name of the company employing the expert or the qualifications of the expert would not, in the department’s view, satisfy this requirement of the regulation. See § 2560.503-1(h)(3)(iv) and (4). See question D-7.

D-11: Does the regulation require that a group health plan provide a claimant with copies of the claimant’s medical records relating to his or her benefit claim?

Yes. The regulation requires a plan to provide claimants, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to a claimant’s claim for benefits. Under the regulation, relevant documents include, among other things, documents or records relied upon in making a benefit determination and documents and records submitted in the course of making the benefit determination. Inasmuch as a claimant’s medical records relating to the benefit claim would be relevant documents, access to, and copies of, the claimant’s medical records would have to be provided upon the claimant’s request. The department notes, however, that if a plan has reason to believe that a claimant’s medical records contain information that should be explained or disclosed by the physician (or other health professional) who developed the information, it would not be inconsistent with the regulation to refer the claimant to the physician (or other health professional) for such information prior to providing the requested documents directly to the claimant. However, if the physician to whom the claimant was referred failed to provide the requested information to the claimant in a reasonable period of time and without charge, the plan itself would be required to honor the claimant’s request.

D-12: Does the regulation require that a plan provide claimants with access to or copies of files of other claimants?

No. The regulation requires that a claimant, have access to, and copies of, documents, records and other information relevant to the claimant’s claim. For this purpose, the regulation defines as relevant any document, record, or other information that:
Was relied upon in making the benefit determination

Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon

Demonstrates compliance with the plan’s administrative processes and safeguards for ensuring consistent decision making

Constitutes a statement of policy or guidance with respect to the group health plan concerning the denied treatment option or benefit for the claimant’s diagnosis, without regard to whether it was relied upon in making the benefit determination. See §§ 2560.503-1(h)(2)(iii) and 2560.503-1(m)(8)

While information and data from various claimants’ files may have been compiled for purposes of developing a plan’s criteria, standards, guidelines, or policies to be used in ensuring and demonstrating compliance with administrative processes and safeguards relating to consistent decision making, (see question B-5); or evaluating or assessing treatment options for benefit determinations, only the criteria, standards, guidelines, or policies themselves would have to be disclosed as information relevant to an individual claimant’s claim, not the various claimants’ files on which such criteria, standards, guidelines, or policies were based.

When you read 29 CFR 2560.503-1, you can see that it states the following:

(g) Manner and content of notification of benefit determination.

• (1) Except as provided in paragraph (g)(2) of this section, the plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv). The notification shall set forth, in a manner calculated to be understood by the claimant -
  o (i) The specific reason or reasons for the adverse determination;
  o (ii) Reference to the specific plan provisions on which the determination is based;
  o (iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
  o (iv) A description of the plan’s review procedures and the time limits applicable to such procedures, including a statement of the claimant’s right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review;
  o (v) In the case of an adverse benefit determination by a group health plan or a plan providing disability benefits,
    ▪ (A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse
determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or

- (B) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.
  
  - (vi) In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.

- (2) In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, the information described in paragraph (g)(1) of this section may be provided to the claimant orally within the time frame prescribed in paragraph (f)(2)(i) of this section, provided that a written or electronic notification in accordance with paragraph (g)(1) of this section is furnished to the claimant not later than 3 days after the oral notification.

(h) Appeal of adverse benefit determinations.

- (1) In general.

Every employee benefit plan shall establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and under which there will be a full and fair review of the claim and the adverse benefit determination.

- (2) Full and fair review.

Except as provided in paragraphs (h)(3) and (h)(4) of this section, the claims procedures of a plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures-

  - (i) Provide claimants at least 60 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

  - (ii) Provide claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

  - (iii) Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a
As you can see, the patient or the patient’s authorized representative is allowed full disclosure of any and all information that was used to make the adverse benefit determination and this information can be used when submitting an appeal. Therefore before you can submit any appeal, you need to see what the insurance company used to make the adverse benefit determination.

You will also need to review the patient’s health benefit manual because this is where most of your appeal information is located. The benefit manual will tell you the following:

* Health benefits the patient is entitled to receive
* Health benefits that are excluded and will not be paid.
* Coordination of Benefits.
* Claims submission timeframes.
* Care from out of network providers.
* Out of Pocket expenses.
* Benefit payment amounts.
* Appeals process.

You should never submit an appeal without having all of the evidence you must have to overturn the adverse benefit determination. For example, for timely filing denials, you need to see how long the patient has to submit their own claim. The insurance company may tell you that the time limit is ninety days, yet the patient’s benefit manual may allow the patient a whole year to submit the claim. The insurance company may pay a usual and customary amount, yet, the patient’s benefit manual may say that all benefits are paid in full. If the insurance company says the service is not a benefit, the patient’s
benefit manual may say that the service is a benefit the patient is contractually required to receive. The claim may have been denied saying that there are no benefits when the patient seeks care from an out of network provider, and when you look at the benefit manual, you may see that the insurance company is correct. If the insurance company denied the benefit based on an internal policy, or using documentation from a medical society or from information provided by an outside consultant, then you have every right to see this documentation. You should never accept a denial that is based on a personal opinion.

**Step #3: Preparing Your Appeal**

Now that you have permission to appeal and you have your evidence, now you have to put everything together and submit your appeal to the insurance company. The type of appeal will depend on why the adverse benefit determination happened.

1. Timely Filing
2. Inclusive Denial
3. No Benefits Denial
4. Payment Less Than Full Charges
5. Medically Necessary
6. Coordination of Benefits
7. Experimental Denial
8. No authorization or pre-certification

As with all denials, you need to tailor your appeal based on whether the provider is contracted or not.

**Non-Contracted Provider:**

To reiterate, as a non-contracted provider or a medical biller for a non-contracted provider, you have absolutely no rights at all. The non-contracted provider has no benefits to appeal and any claims issues rest with the patient.
When you submit the appeal, you must attach a copy of the document authorizing you to represent the patient.

**Contracted Provider:**

Most of the denials you will be appealing will be contract related. This means you must review the provider’s contract to see what the contract says about the specific issues you will be appealing.

**Timely Filing**

Time limits are established based on (a) State Law, (b) Contracts between the patient and insurance company, and (c) contracts between the provider and the insurance company. You need to know which has jurisdiction.

State Law: Some states have time limits to submit claims, some do not.

The time limit to submit a claim is based on the patient’s contract. Some have a 90 day time limit, some have one year, some have two years. The following is from an HMO Benefit Contract:

*Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.*

As you can see, this HMO contract requires the patient, not the provider or the medical biller, within 2 years from the date of service.