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Reimbursement Roundup: Uncover Must-Know Appeals Changes Established By New Federal Law

Now's the time to find out how ERISA and PPACA impact your practice -- or you'll face major reimbursement losses.

New Federal claims appeals regulations went into full implementation in 2011, so if you haven't gotten to know the new law and honed your Employee Retirement Income Security Act (ERISA) knowledge, you could be costing your practice thousands. Read on for advice on how to master these rules.

Background: The Patient Protection and Affordable Care Act (PPACA), signed into law by President Obama Mar. 23, 2010, incorporates or adopts existing ERISA claim regulation in its entirety and adds on six to seven new standards/requirements as well.

Challenge: The new appeals regs will affect all your billing denials and appeals outside of Medicare and Medicaid, so your billing department will need to learn them to recoup deserved pay. The new regulations went into full implementation on July 1, 2011, so if you haven't gotten to know the new law and honed your Employee Retirement Income Security Act (ERISA) knowledge, you could be costing your practice thousands.

Problem: The provider side of the healthcare industry doesn't focus enough on the new appeals regulations, warns **Dr. Jin Zhou,** president of www.erisaclaim.com and national expert, speaker, consultant, author, and publisher of ERISA claim denials and appeals, regulation education, and compliance. "Healthcare providers should be informed of all specific and accurate statutory provisions on all new Obama health law mandates for claim appeals," he says. "The payer side of the industry talks about it all the time to make sure you don't get paid."

Learn Which Plans Are Affected

Under PPACA, ERISA now governs every group health plan and individual policy. This means that not only are self-funded and employer-provided plans under ERISA, but also "governmental plans, church plans, school plans, and individual policies," Zhou explains. "Everybody outside Medicare and Medicaid, PPACA and ERISA govern all of your claims."

Note that worker's compensation and personal injury claims do not fall under PPACA because they are not considered healthcare plans. "Worker's comp is a legal mandate," Zhou adds.

Exception: If a plan is part of a grandfathered health plan, it is not subjected to the PPACA requirements. "The grandfathered plan is the plan that's in existence on or before March 23 2010," Zhou says. "However, many plans have lost grandfathered status because of changes made to the plan, such as elimination of special treatment of a special condition or disease or change in copay or deductible."

Critical: Remember that PPACA is a Federal mandate, and is therefore not optional.

Get to Know New Internal/External Appeals Options

You now have both internal and external appeals options under PPACA. According to a June 22, 2010, press release from the U.S. Department of Labor, "The new appeals regulations were issued by the Departments of Health and Human Services (HHS), Labor, and the Treasury. Consumers ... will have the right to appeal decisions, including claims denials and rescissions ... This includes the right to appeal decisions made by a health plan through the plan's internal process and, for the first time, the right to appeal decisions made by a health plan to an outside, independent decision-maker ..."

"The appeals rules ... will extend important protections and simplify the system for consumers," said Labor Secretary **Hilda Solis** in the press release. "And they will ensure that consumers in new health plans have access to internal and external appeals processes that are clearly defined, impartial, and designed to ensure that, when health care is needed and covered, consumers get it."

Good news: For the internal appeals process, PPACA adopted ERISA claims regulations in their entirety, and added six to seven new requirements as well, Zhou says. The law provides the new external appeals option by adopting the National Association of Insurance Commissioners (NAIC) external appeal model.

Before, after you finished the internal appeals process, you had to move to Federal Court. "Now the Federal law says you have one more change before you sue each other; you can do external appeals," Zhou explains.

Faster payment: The decision of the external appeal is binding for both parties (the plan and the patient), and if the external appeal determines the insurance plan must pay the patient, payment is immediate.

Become the Patient's Authorized Representative

Important: You, as the practice or provider, have no claim with the insurance company, says coding, billing, and practice management consultant **Steven M. Verno, CMBS, CMSCS, CEMCS, CPM-MCS,** in Orlando, Fla.

The appeal rights belong to the patient, not your practice, so you need to get the patient's written permission to appeal a claim under ERISA. Under Federal Law, a provider or the provider's representative (medical biller) can appeal an adverse benefit determination without the written authorization by the member.

Now under PPACA, if you have "good assignment" from the patient, you as the healthcare provider will become a claimant during the appeals process, Zhou stresses. "By regulation you are now defined as a claimant, which means you are as good as the patient and your rights, even if you're out of network, are equal to the patient's. This dramatically enhances the provider's rights and is, therefore, is most significant change to providers."

You'll use the existing ERISA regulations for having the patient make your practice/ provider an authorized representative for billing and appeals. "Your traditional assignment is no good!" Zhou warns.

According to an FAQ answer on the Department of Labor Website, "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." (www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html)

Expect More Streamlined EOBs

The other big change your practice and your patients will see is that PPACA requires -- for the first time in history -- that there be one explanation of benefits (EOB) format for the entire industry. There will be three types of EOBs:

1. An EOB for initial denials called the adverse benefit determination
2. An EOB for final internal appeals denials called the final internal adverse benefit determination
3. An EOB for external appeals denials called the final external adverse benefit determination.

"The contents of the EOB got extended and are now standardized so the whole country has one format," Zhou explains. The EOB must contain clear diagnosis coding, clear procedure/service coding, the physician name, the reason for the denial, the appeal options, and more.

Resource: For further information, you can visit the labor department website at www.dol.gov/ebsa/healthreform/.

In addition to requiring a standardized explanation of benefits (EOB) and allowing the provider to become a claimant, the final PPACA regulations also set forth the following new requirements that your practice should be aware of:

- Clarification of the meaning of adverse benefit determination -- this means that rescission of coverage is

considered a denial and patients can use the entire ERISA appeals process to fight the denial/policy cancellation.

- Expedited urgent care determination -- this regulation stated that insurance companies had to determine benefits involving urgent care within 24 hours. This requirement was "cancelled," Zhouexplains. "The urgent care decision making now has to be as soon as possible, and goes back to the original ERISA regulation which is 72 hours," he adds.
- Full and fair review -- "The new regulation says that if you ever introduce new evidence (such as a pathology report that wasn't looked at before) or you employ a new rationale, you must make advance disclosure," Zhou explains. "That means the plan must tell the claimant far in advance so there's time to understand and appeal the new rationale or evidence."
- Avoid conflict of interest -- this means insurance companies can't use someone to do appeals that has a conflict of interest. For example, if Person A does the first level of appeal and Person B does the second level of appeals, but Person A is Person B's boss, that would be a conflict of interest, Zhou says.
- Code definitions on EOBs -- this regulation said that insurance companies had to put the ICD-9, CPT®, and HCPCS code definition on the EOB. "We knew this would not fly under HIPAA," Zhou laments. The regulation was eliminated as well. The codes will appear, but not the definitions.