New Jersey Orthopaedic Society
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Monthly Report

August 2015

In this issue

From The Statehouse

AJ Sabath, Lynn Haynes, and Charles Burton

Summer Recess

Following enactment of the Fiscal Year 2016 budget at the end of June, the Senate and Assembly took a break for the summer. However, the Legislature has not officially recessed and the Senate has been holding pro forma sessions to prevent the Governor from making recess appointments. They will not be voting on anything substantive or controversial because of the election. All eighty seats of the Assembly are up for election in November and as a result of this they are not expected to meet again until mid-November. At that time the Legislature will hold its lame duck session in the remaining weeks of the current legislative term, which will end in mid January 2016.

Out-of-Network Update:

There has been a break in the silence during the Legislature's summer regarding the Out-of-Network (OON) issue. After slowing down the OON bill's progress in June, we have been contacted by Senator Vitale, Assemblyman Coughlin, Assemblyman Schaer and Assemblyman Singleton with a request to provide specific changes to the (OON) committee substitute and then to participate in a stakeholders meeting at the end of August. In response to this request, we have been working with the Board and the Advocacy Committee, along with our allies from the Access to Care Coalition, the large coalition of providers including hospitals and the Medical Society of New Jersey as well as a host of other surgical specialties and physician organizations that work in a hospital setting and/or Ambulatory Surgery Centers.

You may recall that after months of behind the scenes wrangling and upon completion of two lengthy "discussion only" legislative hearings in the State Senate and General Assembly in June, the New Jersey Legislature took a break this Summer before enacting any significant Out-of-Network (OON) reform and will return to usual business after the 2015 Legislative Elections in November. As a reminder, the "discussion only" hearing in the Assembly Financial Institutions Committee in early June and a subsequent attempt to pass the bill out of the Senate Commerce Committee failed. Amendments were made public but not adopted that scaled back the legislation, but not enough to limit the tremendous opposition from the provider community. As a result of the continued opposition, the Senate Commerce Committee ultimately only discussed the bill and did not vote to release it because there were not enough votes to pass it out of Committee. The sponsors now want recommendations on the scaled-back version of the bill that was never voted on.

We have been working independently meeting with legislators, key staff and other pertinent officials in the Governor's office. We have also been attending fundraisers on your behalf and continue to communicate your concerns with the OON bill to important decision makers. We will also begin implementing on your behalf a strategy to further educate legislators and staff on any new developments or existing concerns. We will also continue to work to replenish our political war chest to enable us to maintain an active presence at political fundraisers.

Virtua Health Lawsuit

In July, Virtua Health and Capital Health System filed a lawsuit against the State of New Jersey seeking to stop the implementation of a recently-enacted emergency medical services (EMS) law that allows Level 1 trauma centers Cooper University Hospital (Cooper) in Camden, Robert Wood Johnson University Hospital (RWJ) in New Brunswick and University Hospital in Newark to take over paramedic services in their regions by January 2016. Cooper and RWJ are expected to take over these services in Camden and Hamilton, respectively. RWJ and University Hospital already provide EMS services in this municipality so this legislation is perceived to be more of a benefit to Cooper Hospital.

A special provision of the law will allow RWJ to take over EMS services in Hamilton. Virtua has been providing the Advanced Life Support (ALS) to the City of Camden for 38 years and Capital Health has provided ALS services since 1977. Virtua and Capital Health System contended in court documents that this new law violates the New Jersey Constitution's clause against special legislation. This new law allows Cooper Hospital to bypass a state Department of Health (DOH) process that requires a hospital system seeking to provide EMS service in a region to submit a comprehensive certificate of need application to the DOH.

This law was fast-tracked in the Legislature as it was introduced in early June, passed by both the Senate and the Assembly by the end of that month and was signed into law by the Governor in early July. We opposed this legislation all throughout the process and will continue to monitor the lawsuit.

Regulating One-Room Surgery Centers

On June 25, 2015, Senator Joseph Vitale, Chairman of the Senate Health, Human Services and Senior Citizens Committee introduced S3051 (Vitale/Addiego) which would strengthen the requirements for accreditation, inspection, and general oversight of "surgical practices."

The bill would require surgical practices, as a condition of their registration with the Department of Health (DOH), to: (1) obtain ambulatory care accreditation from an accrediting body recognized by the Centers for Medicare and Medicaid Services (CMS), in addition to obtaining certification from CMS as an ambulatory surgery center provider; and (2) provide the DOH with proof of such accreditation and certification. Current law requires a surgical practice registrant to obtain, and provide proof of, either accreditation or certification, but not both.

The bill would also provide that, whenever the DOH conducts an inspection of a surgical practice, it will be required to post, at a publicly-accessible location on its Internet website, the results of the inspection; and whenever a complaint is filed against a surgical practice that does not accept Medicare, the DOH will be required to post, at a publicly-accessible location on its Internet website, the facility's plan of correction.

In each legislative session Senator Vitale introduces a bill that would regulate one-room surgery centers. There is no Assembly companion bill yet. The Assembly will not return until after the November election so no bills will be voted on until after the Legislature reconvenes in mid-November. The Senate is not expected to vote on anything substantive or controversial because of the election. We will continue to monitor this bill and track any new developments.

SAVE THE DATE

April 1 & 2, 2016

NJOS 41st Annual Symposium

and

49th Annual Northeastern Mid-Atlantic Orthopaedic Residents' and Research Conference

The Heldrich Hotel

New Brunswick, NJ

Legal Update

Mark E. Manigan, Esq.

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National Update at-a-Glance

CMS Proposes Several Important Changes in the 2016 Medicare Physician Fee Schedule Rule

On July 15, 2015, the Centers for Medicare & Medicaid Services (CMS) published its 2016 Physician Fee Schedule Proposed Rule. CMS proposes to finalize changes to the Physician Quality Reporting System (PQRS) and the Physician Value-Based Payment Modifier (Value Modifier), and also proposes new physician payment and quality monitoring policies. The proposal contains certain clarifications and new exceptions to the federal law that prohibits self referrals (known as the Stark Law).

Under the proposal, 2016 will be used as the reporting period for 2018, and CMS proposes a 2% payment reduction for individual eligible providers or group practices that do not satisfactorily report data on PQRS quality measures, or in lieu of reporting, participate in a qualified clinical data registry. The Rule proposes the addition and elimination of certain quality measures, equaling a total of 300 measures in the PQRS set for 2016 if all proposals are finalized.

Consistent with past years, the 2018 Value Modifier will be applied based on PQRS participation by individual providers and group practices. The maximum upward and downward adjustment factors remain at 4.0% for groups of 10 or more eligible providers and 2.0% for groups of fewer than 10 as well as solo practitioners.

Additionally, CMS proposes to establish a new exception to the Stark Law for certain timeshare arrangements between physicians and hospitals. To qualify (i) a licensee would be required to use the licensed premises, equipment, personnel, items, supplies and services predominantly to furnish evaluation and management services to patients of the licensee, and (ii) the arrangement could not involve advanced imaging equipment, radiation therapy equipment or clinical or pathology laboratory equipment. The exception would be limited to timeshare arrangements in which hospitals and physician organizations are the licensors. It would not protect timeshare arrangements offered by other types of health care organizations, including clinical laboratories. The proposed exception would not be available to protect part-time and exclusive leases of office

space, which would continue to be measured under the current exception for real property leases.

CMS also proposes to establish another new exception to the Stark Law for payments made by a hospital, Federally Qualified Health Center or Rural Health Center to a physician to assist the physician in employing a non-physician practitioner (NPP) in the donor's geographic service area. NPPs would include physician assistants, nurse practitioners, clinical nurse specialists and certified nurse midwives. The proposed exception would apply only to situations in which the NPP is a bona fide employee of the physician or physician practice receiving the support, and the purpose of the employment is to provide primary care services to patients of the physician practice. The proposed exception includes a cap on the amount of remuneration and a two-year limit on assistance.

According to CMS, the requirement of many Stark Law exceptions for a "writing" or "written agreement" need not be satisfied by evidence of a single contract. Instead, depending on the facts and circumstances, a collection of contemporaneous documents, including documents evidencing the course of the parties' conduct, may suffice. As a result, the Rule proposes to clarify that Stark exceptions conditioned on a term of at least 1 year do not require a written contract or other document with an explicit provision identifying the term of the arrangement. Rather, an arrangement that lasts at least 1 year satisfies this requirement. In addition the Rule proposes to allow parties 90 days (instead of 30) to obtain required signatures to an agreement, irrespective of whether the failure to secure a timely signature is knowing or inadvertent.

CMS and AMA Attempt to Ease Transition to ICD-10

On July 6, 2015, CMS and the American Medical Association (AMA) announced joint efforts to prepare providers for the transition from ICD-9 to ICD-10 coding for medical diagnoses and inpatient hospital procedures, including educating providers through webinars, on-site training, educational articles and national provider calls.

ICD-10 is set to begin on October 1 and is required for everyone covered by HIPAA. According to CMS, ICD-10 will help to better identify illnesses, early warning signs of disease outbreaks and adverse drug events. Some of the major differences between ICD-9 and ICD-10 are as follows:

- Codes are grouped by anatomical site rather than by injury.
- Change from 14,000 codes to 69,000 codes.
- Extensive combination codes to better capture complexity.

An ICD-10 Ombudsman will be named to triage and answer questions about claims submissions.

U.S. Department of Health & Human Services Required to Better Justify "Per-Click" Medicare Rule

In June 2015, in Council for Urological Interests v. Burwell, No. 13-5235 (D.C. Cir. June 2015),the District of Columbia Federal Court of Appeals determined that the U.S. Department of Health & Human Services (DHHS) must develop a better rationale on whether a "per-click" ban on equipment leases is consistent with the purpose and language of 42 C.F.R. § 411.351 and the 1993 House of Representatives Conference Report on the Stark law. A "per click" basis is a fee arrangement whereby the hospital utilizing the equipment is charged for each use of the equipment.

DHHS interprets 42 C.F.R. § 411.351 to ban physician-owned entities from leasing equipment to a hospital on a "per-click" basis and then referring patients to that hospital for treatment on the leased equipment because the lease fees fluctuate by the volume or value of referrals, one of the main prohibitions of compensation arrangements under Stark. The D.C. Circuit acknowledged that the legislation at issue is ambiguous and determined that the DHHS's interpretation does not resolve the ambiguity. Therefore, the court remanded the case to have the DHHS more clearly devise a rationale on why a "per-click" arrangement is impermissible.

Final Rule for Updating the Medicare Shared Savings Program
CMS issued its final rule updating the Medicare Shared Savings Program (MSSP) on June 4, 2015 (CMS-1461-F). CMS stated that it is implementing the rule to enhance focus on primary care services and provide additional flexibility to providers. Functionally, the rule clarifies and codifies existing guidance in a number of areas, and introduces new aspects to the MSSP in response to comments from stakeholders. Among other provisions, the rule:

- creates a new track (Track 3) for Accountable Care Organizations (ACOs), based on the Pioneer ACO Model, which includes higher rates of shared savings and options to use new care coordination tools;
- revises eligibility, application and other requirements relating to ACO participants, providers and suppliers;
- streamlines data-sharing requirements, facilitating better communication between CMS and ACOs;
- provides for a waiver of the 3-day stay Skilled Nursing Facility rule for certain beneficiaries;
- addresses the beneficiary assignment methodology;
- refines the methodology for determining ACO financial performance and the policies for resetting financial benchmarks in the future; and
- resolves issues relating to program integrity and transparency, such as public reporting, terminations and reconsideration review.

CMS stated it will provide additional information, online webinars and question and answer sessions with CMS staff for anyone interested in learning more about the affects of the final rule.

OIG Alert: State Health Insurance Marketplaces at Risk of Misusing Federal Funds Without Further Guidance from CMS
The U.S. Department of Health & Human Services, Office of Inspector General (OIG) recently issued a memorandum addressed to CMS warning that state-based health insurance marketplaces (SBMs) developed pursuant to the Affordable Care Act are at risk of misusing federal grant money without further guidance from CMS as to how they may use the funds. The states at issue were granted funds to assist them in developing and implementing their health insurance marketplaces. However, the Affordable Care Act required that the SBMs be self-sustaining by January 1, 2015 and prohibits the SBMs from using the establishment grant money to pay for ongoing operations. Current CMS guidance only describes broad categories of operating costs which the SBMs may not pay using establishment grant money after January 1, 2015, including rent, software maintenance, telecommunications, utilities and base operational personnel and contractors. In the memorandum, the OIG warns that neither the law nor CMS guidance adequately delineates between development costs and operational expenses in the context of other examples of actual costs the SBMs incur.

The OIG based its assessment of risk on its review of SBM budget information and audits of the establishment grants, finding that a number of the SBMs are expected to receive relatively little or no revenues to offset operating expenses in 2015 and future years. To avoid the prospect of SBMs improperly using establishment grants to fund operations, the OIG proposes that CMS develop and publish guidance with more detailed definitions of design, development and implementation expenses, using real world examples such as call centers, in-person assisters, bank fees, and printing and postage costs.

Focus on the States

Morristown Medical Center Campus No Longer Tax-Exempt
In June 2015, Judge Bianco of the Tax Court of New Jersey ruled in favor of the Town of Morristown concerning property owned by AHS Hospital Corp. d/b/a Morristown Memorial Hospital (now known as Morristown Medical Center) (MMC). This decision, which could have

enormous ripple effects both inside and outside of New Jersey, concluded that MMC's 1.1-million-square-foot campus would no longer be entitled to its New Jersey property tax exemption because its charitable and profit driven endeavors were wound too tightly together to qualify for the tax-benefit. Judge Bianco found that MMC "entangled its activities and commingled its efforts" with "for-profit" operations after examining in great detail how the work was carried out by all affiliates operating on the campus, with specific attention paid to the number of private practice physicians, investment and insurance affiliates and other factors.
Subsequent to the decision, the Town and MMC jointly announced that they would engage in talks to end the legal battle, which would preclude a further challenge in New Jersey. In any event, the groundwork for local, state and federal challenges to entities' "not-for-profit" status has been laid. Given the possibility of these challenges, it behooves health systems and other medical providers to review their operations and structure to confirm that their "for-profit" and "not-for-profit" organizations and/or activities are properly delineated.

Telemedicine Company Sues Texas Medical Board
Teledoc, Inc., a large telehealth service of approximately 700 board-certified, state-licensed physicians, recently sued the Texas Medical Board (Texas Board) for anti-trust violations. This lawsuit is the most recent in a series of lawsuits between the Texas Board and Teledoc.

The Texas Board introduced a new rule that would require Texas physicians to form a doctor-patient relationship through the use of a physical exam regardless of the physician's opinion as to whether such an exam is needed. In the complaint filed in the action, Teledoc alleges that the Texas Board's actions are an illegal attempt to block competition from Teledoc, which according to Teledoc, has enjoyed "explosive" growth in recent years. Teledoc argues that the Texas Board is inappropriately acting on concerns that Teledoc takes business away from local physicians.

In New Jersey, proposed bills in the Senate and Assembly are attempting to expressly permit the practice of telemedicine and would require managed care plans, Medicaid, the State Health Benefit Commission's and the School Employees Health Benefit Commission's health care plans to pay for medical services provided via telemedicine at a rate equal to the reimbursement rate provided for in-person services.

Bill Introduced to Limit Payment for Out-of-Network Medical Services
In May 2015, Senate Bill S20 (A4444), entitled the "Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act," was introduced into the New Jersey State Senate. The bill, if passed into law, would, among other things:

- Require health care facilities and health care professionals to provide written disclosures to patients at least 30 days prior to their non-emergency or elective procedures, the facility's and the health care professional's network status, the patient's personal financial responsibility based upon that status, and a description of the procedure.
- Require carriers to disclose in writing a list of providers that are in-network, to be updated at least every 20 days, and to disclose whether in-network providers become out-of-network providers.
- Prohibit health care facilities and health care professionals from billing patients for emergency or urgent care services beyond the covered person's deductible, copayment or coinsurance responsibilities.
- Establish a binding arbitration process between health care providers and carriers.

A provision of the original form of the bill that would have capped the price of out-of-network services was eliminated from the present form of the bill. The bill is also expected to undergo additional amendments as it winds its way through the legislative process. The bill was most recently reviewed by the Pension and Health Benefits Commission on July 31, 2015.

Proposed Bill to Reduce ASC Assessment Fee

Senate Bill 3047, and its Assembly counterpart, Bill 4588, introduced on June 22, 2015, if approved, would reduce the annual assessment fee on ambulatory care facilities. Currently, ambulatory care facilities with gross receipts of $300,000 or more are required to pay an assessment of 2.95% of its gross receipts, the total amount of the assessment not to exceed $350,000. This change, to take effect beginning in 2016, would reduce the assessment to 2.28% of the facility's annual gross receipts, the total amount of the assessment not to exceed $300,000. The reduction from 2.95% to 2.25% will result in a proportionate 22.7% reduction in total assessment collections.

Proposed Bill Would Revise Exception Permitting Hospitals and Medical Schools to Establish New Surgical Practices and ASCs

On June 29, 2015, Senate Bill S2876 (A4476) was passed by the New Jersey State Senate. The Assembly Bill was passed by the New Jersey State Assembly on June 25, 2015. The bill, if signed into law, would, among other things, amend the exception under New Jersey law that permits hospitals and medical schools to establish new surgical practices and ambulatory surgical centers. The bill provides that for the exception to apply, the new surgical practices and ambulatory surgery centers may be established only if they are (i) owned by a general hospital or medical school that is licensed in New Jersey as of March 1, 2015; (ii) owned by a hospital that had applied to become approved to provide ambulatory surgery services in New Jersey on or before March 1, 2015, so long as the hospital is later approved to provide the ambulatory surgery services at the facility; or (iii) if the facility is owned by a hospital that is approved to provide ambulatory surgery services at another facility in New Jersey. However, the changes proposed by the bill do not alter the exception that permits a new facility license or surgical practice registration to be issued to a new facility provided that such facility is jointly owned by a general hospital in the State of New Jersey and one or more other parties.

A 'REVIVIAL' PRODUCTION ON 44TH STREET

Join us for a second ICD-10 coding workshop in New York City on September 10!

Attend the AAOS/KZA ICD-10 coding and reimbursement course in NYC on Thursday, September 10 at the Cornell Club in Midtown Manhattan. Demand for ICD-10 education is high. The May 8th course sold-out. Many physicians and staff requested this second training date. There are only 75 seats in the September meeting room. Margi Maley, BSN, MS is the instructor. Read some of her recent reviews:

"The course left me feeling empowered to meet the challenge of ICD-10. I received excellent tools, including the flashcards, IZD-10 Slim Guide, and tips from the workbook. I now possess a solid strategy to emphasize the diagnosis codes, which account for the majority of my collections." --Sylvia Hesse, MD, New York, NY

"The time and effort that KZA put into developing a system to help coders with orthopaedic coding is so greatly appreciated. The tools that you have created are worth every penny we spent for this workshop. We can only express our thanks for all of your hard work. See you next year!" --Yvonne Currie, COO,

Casper, WY

"A truly outstanding course!" --Anthony Sanzone, MD, Chula Vista, CA
Send new doctors and staff to this seminar to prepare for ICD-10 on October 1, 2015. No more delays. No more reprieves. It's happening, and your practice needs to be ready for it.

98% OF 2015 ATTENDEES WOULD RECOMMEND AAOS/KZA TRAINING TO A COLLEAGUE.

With less than 100 days until the implementation of the ICD-10 coding system, time is running out.

Register TODAY at www.karenzupko.com/workshops or call 312-642-8310

Need more information? Want to see the full agenda? Check out our 2015 e-brochure:
http://www.karenzupko.com/downloads/2015_AAOS_Ebrochure.pdf

Cyber Shield and Billing E&O Insurance: PriMed Consulting
Gabrielle Lamb

Cyber Shield and Billing E&O are two issues getting increased attention these days. Medical malpractice carriers like **Princeton & MDAdvantage** offer this coverage with basic limits at no charge as a supplement to the malpractice policy.

While MDAdvantage offers higher limits for an additional premium, Princeton Insurance announced last week that they will be offering higher limits for these two coverages, with limits of $500,000 and $1 Million.

Princeton CyberShield and Princeton CyberShield PLUS include coverage for the following risks:

Network Security and Privacy Insurance*
Includes third-party liability coverage for allegations of privacy violations and network security failures.
Regulatory Fines and Penalties Insurance
Includes coverage for fines/penalties for violations of privacy regulations including but not limited to HIPAA, Gramm Leach Bliley and HITECH.
Patient Notification and Credit Monitoring Costs Insurance
Includes all reasonable legal, public relations, advertising, IT forensic, credit monitoring and postage expenses incurred by the insured for notifying a third party of a privacy breach.
Data Recovery Costs Insurance
Includes all reasonable and necessary sums required to recover and/or replace data that is compromised, damaged, lost, erased or corrupted by non-property perils.

*Defense costs are paid within the limits of liability unless prohibited by law.

First, insured physicians will have the option of purchasing increased limits of either $500,000 or $1,000,000 for Princeton's CyberShield coverage. $50,000 in CyberShield protection is currently provided to all physician policyholders at no additional cost. Policyholders purchasing increased CyberShield limits will be protected by the same coverage form as is used for the base coverage amount. If purchased, the endorsement referencing the higher limits will be placed on the entity, unless the policyholder is a solo practitioner, in which case the endorsement will be added to their individual policy.

Physician policyholders may also purchase additional coverage and limits for Billing E&O exposure.

If you would like further information or obtain quotes, please call PriMed Consulting at 800.528.3758. Or email: glamb@primedconsulting.com

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Leveling the playing field between out of network providers and insurance companies

Leslie Howards, Esq.
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By definition, a "level playing field" is a concept about fairness where all players play by the same set of rules. The underlying assumption is transparency and consistency of the rules, their definition, and their interpretation. In other words, a playbook that all players have access to and understand. Unfortunately, in today's reimbursement world for out of network providers (OON), the field is sorely off balance leading to potentially hundreds of thousands of dollars unclaimed and uncollected.

The Players

Insurance Companies - For the most part, insurers are corporate giants with deep pockets that have mastered the art of creating processes on top of processes. A web of red tape at every turn causes members and providers alike to feel stuck and out of control. This is the image of today's insurers. An exaggeration? You be the judge.

Out of Network Providers - Long gone are the days of private practice physicians seeing patients with little concern about insurance reimbursements. Today, being in private practice, and one who is an out of network provider, carries with it huge risks and daily unknowns. Professionals, who were trained to treat patients, but not necessarily run a business, are forced to face-off daily with their large-scale counterparts on matters directly affecting the bottom line. The result? Physicians must manage the rising costs of business in a medical climate they have very little control over. The claims auditing and appeals process itself gets overburdening, and without knowing the specific plan outlined in a patient's Summary Plan Description, providers are unable to take action against claims offers that are unfair and sometimes even downright insulting. Even a large practice rarely has the internal ability and resources to effectively manage this process.

The Playbook

Summary Plan Description - For every health insurance plan that is written there is a Summary Plan Description (SPD) that goes along with it and is given to the member when he/she enrolls. In most cases, it is solely the insurer who interprets and executes the terms in the Summary Plan Description, and controls the claims process every step of the way. Therefore, it is ultimately up to them to determine the level of difficulty, clarity, and consistency of each claim handled.

The language in an SPD is typically ambiguous, unclear, and wide open to interpretation. Terms such as "usual and customary," and "allowable amount," are examples of ways insurers keep control of specific claims. The ambiguity allows for interpretation, and usually this interpretation is done solely on the insurer side. For example, what is usual and customary, and who determines that? Further, who determines the allowable amount and when can it change?
Why does this keep the claim negotiations one-sided? Because the member rarely keeps or reads the SPD and the provider only has access to it if the member gives him the right. If the provider does not see the SPD they are unable to determine if what the insurer is offering is outside the scope of what is fair for each claim.

The Answer?

With Knowledge Comes Power

ERISA- Most insurance policies are governed under ERISA (Employee Retirement Income Security Act), and therefore have strict regulations regarding disclosure of terms and administration of policies. Specifically, ERISA guarantees each member a full and fair review of plan documents and all evidence, methodology and fee schedules relied upon to determine the reimbursement amount. The key to OON providers receiving more, if not all, of the reimbursement in accordance with each member's policy, is to take a systematic approach and work with the law under ERISA for each claim.

Leveling the Field

Ensure all patients sign a DAR (Designated Authorized Representative) form on initial visit. A critical starting point as this allows the providers to "step into the shoes" of the patient. Without a DAR providers have NO rights, as health insurance is a contractual agreement between the MEMBER and the insurance company. Once signed, however, the provider has all the rights and protections afforded under the patient's policy and the law. By exercising the member's rights under ERISA, providers are able to appeal, negotiate directly, clarify terms, and ultimately hold the insurance companies to the fairest interpretation of the SPD possible under the law.

Exhaust the written appeals process. This process includes all the administrative remedies required before a claim can move on to litigation. It is a tedious process complete with red tape, denials, and delays, and can take six months or longer. Many providers and members give up and accept whatever they are offered at this point - usually well below what they are entitled to.

Request a Summary Plan Description (SPD) - Legal intervention begins with a request for a Summary Plan Description. Providing the SPD is required under ERISA, and a refusal or a delay in doing so has severe fines.

Take Legal Intervention and Action - Once the member's SPD is received, a careful analysis can identify language to be challenged and proven inconsistent. It is these inconsistencies, ambiguities, or buried promises that can lead to a clarification of the terms, a re-evaluation of the current payment, and ultimately a favorable result. Many times claims can be settled prior to litigation with demand letters. However, as a last resort insurers will be taken to court, many times resulting in a settlement in the early stages of litigation.

No Pain No Gain

Obviously, this sounds simple but can be difficult and sometimes impossible for busy medical practices to implement. Historically, insurers have realized this too and brought in outside help. In many cases it is beneficial for providers to consider doing the same. A designated resource that works specifically on the claims auditing and appeals process and insurer negotiations can keep the process moving to a favorable outcome - ultimately leaving much less money on the table. These resources can work on one or several parts of the process, on current claims, or provide a complete analysis of historical claims with potential benefits.

The only constant in today's medical climate is that things continue to change. Keeping up with the changes, and staying on top of claims processes are critical to maintaining a successful practice. It might be a difficult and sometimes painful part of business, but one that is not going away. The positive impact on the bottom line can be a constant reminder that it is a long-term investment in a difficult business.