

Appealing Claim Denials

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Today's Agenda

- How to Respond to Health Plan Denials
- Understanding Medical Necessity
- Documentation Needed
- Sample Appeal Letters

Prepare A Claim

- Provide patient information
- Provide a diagnosis using ICD-9 codes
- Provide a treatment code using CPT codes
- Be able to support code assignments with patient history, physician referral notes and evaluation notes
- Obtain patient permission to supply health plan with information

Waiting For A Decision.....

- Most states require health plans to pay or deny a claim within 30 to 60 days
- Notify the state insurance commission if health plans fail to make timely decisions (www.naic.org)

Claim Denied....Now What?

- If you don't agree with the decision, consider appealing the denial.

Appeal A Claim: Step 1

- Review the patient's insurance policy for coverage information. Does coverage support payment?
- Review the explanation of benefits (EOB) for denial status and reason.

Appeal A Claim: Step 2

- If coverage language supports payment, write an appeal letter describing the disorder, its medical nature, and reference the coverage policy paragraph that shows how your treatment fits coverage criteria.
- Sample appeal letters available at <http://www.asha.org/members/issues/reimbursement/private-plans/appeals.htm>

Reasons For Denial

- Not medically necessary
- Treatment is investigational
- Not a covered service
- Local public school provides treatment
- Provider status not recognized
- Treatment is educational/developmental in nature

Health Plan Disputes by Type

- Medical necessity disputes accounted for 37% of appeals
- Contractual limits of coverage accounted for 36% of appeals
- Disputes over access to out-of-network services accounted for 19% of appeals

(Journal of the American Medical Association; February 2003)

Health Plan Disputes by Type

Among disputes over contractual limits of coverage, **61%** of the cases focused on **speech therapy**, physical therapy, foot orthotics, dental care, alternative medicine, investigational therapies, and infertility.

Rate of Overturn of Disputes

- Contractual disputes were overturned 33% of the time
- Out-of-network disputes had a 35% rate of overturn
- Medical necessity disputes had the highest rate of overturn at 52%

Medical Necessity Disputes

- However, these medical necessity disputes were concentrated on relatively few services, such as surgery for obesity and breast alterations. These disputes highlight the need for more frankness about health care that is medically necessary and the role of health insurance.

Medical Necessity

- Speech-language pathology and audiology services must be viewed as treatment of impairments, and not as a quality of life issue. Treating an individual's speech-language, hearing, or swallowing disorder improves health status, and therefore, is medically necessary.

Medical Necessity

- Definition is often vague
- Each health plan defines medical necessity

Medical Necessity Defined

Medicare defines medical necessity as: “a service that is reasonable and necessary for the diagnosis or treatment of an illness or injury, or to improve the functioning of a malformed body member.” The service must be provided within generally acceptable professional medical standards.

Why Speech-Language and Audiology Services Meet the Definition of Medical Necessity

These services are medically necessary to treat speech-language, swallowing, hearing and balance disorders, many of which have a neurological basis and result from injury, illness, or disease. Medical necessity takes into consideration whether a service is essential and appropriate to the diagnosis and/or treatment of disease or injury.

Speech-Language and Audiology Services Are Medically Necessary (con't)

Stedman's Medical Dictionary, 24th Edition, defines illness and disease as “a disorder of body functions.” Loss of hearing, impaired speech and language, and swallowing difficulties all reflect a loss of body functions and services to treat such impairments must be regarded as meeting medical necessity.

Appealing a Verbal Apraxia Denial: Establishing Medical Necessity

Case Study

Provide Supporting Evidence

- Verbal apraxia is not a developmental delay, but rather an issue of health and normal physiological function
- It is a speech disorder that is neurologically based
- Child has limited control of speech muscles

Provide Supporting Evidence

Recent scientific findings shed light on the cause of pediatric verbal apraxia. British neurogeneticists identified a gene mutation that appears responsible for verbal apraxia (Nature, 413, 519-523; 2001). Studies suggest basal ganglia, a brain region that controls movement, may be different for those with verbal apraxia.

Appealing a Cognitive Rehabilitation Denial: Treatment Is “Investigational”

Case Study

Why Do Health Plans Say Cognitive Rehab is “investigational?”

BlueCross BlueShield Association Technology Evaluation Center issued a report in Dec. 2002 stating cognitive rehab services were “investigational” and therefore not covered. Other independent BCBS’s adopted this policy.

Challenging A Health Plan

- ASHA provides support for cognitive rehab (NOMS data, letters to BCBS)
- Treatment efficacy reports
- Medicare recognizes SLP's role
- NIH consensus statement supports cognitive rehab
- Recent independent review of denial in MT supports cognitive rehab

ASHA NOMS Data

- A large percentage of patients with TBI who received speech-language pathology services made significant gains on the Functional Communication Measures (FCMs).
- FCMs are 7-point rating scales ranging from least functional (Level 1) to most functional (Level 7) that measure improvement.

ASHA NOMs

Functional gains were demonstrated by:

- 81% of patients treated for memory
- 82% of patients treated for attention
- 83% of patients treated for pragmatics
- 80% of patients treated for problem solving

Research Supports Cognitive Rehab

- In an article entitled “Evidence-based Cognitive Rehab: Updated Review of the Literature From 1998-2002,” published in *Archives of Physical Medicine & Rehabilitation* (Aug. 2005), the authors report “substantial evidence to support cognitive-linguistic therapies for people with TBI or stroke.”

NIH Support

- Cognitive rehab is endorsed by the National Institutes of Health (NIH) consensus panel, which notes existing studies that support this treatment, even though research in this area is “exceedingly difficult to conduct.”

Support From U.S. Dept. of Defense & Dept. of Veterans Administration

- Together form the Defense & Veterans Brain Injury Center (DVBIC)
- DVBIC actively engaged in innovative/cutting edge rehab of brain injured veterans
- Conducts clinical research
- Brain injury becoming “signature wound of Iraq war”

Why Is Research Lacking for Cognitive Rehab?

- Only controlled research can sort out the impact of treatment vs. spontaneous recovery, but it is complex and costly
- It is a challenge to define the “active ingredients” of an interactive therapy provided by a clinician and the most appropriate control or comparison condition
- Gathering a sufficient # of patients with similar cognitive characteristics is difficult

However.....

The absence of firm efficacy data is not evidence of the ineffectiveness of cognitive rehab.

John Whyte, MD, PhD, “Promoting Research in Cognitive Neuroscience and Cognitive Rehabilitation” (*Health Policy Newsletter, Vol. 18, #3, Sept. 2005*).

Cognitive Rehab Denial Overturned

- You and your patient can win!
- An Independent Review Organization overturned a BCBS of Montana denial for cognitive rehab services for a 38 y/o patient with head injury as the result of a car accident.

Denial Overturned....

- After a year of denials and appeals, the independent reviewer concurred with ASHA's position and required BCBS of MT to pay for patient's treatment.

Health Plan Says: Get Speech Therapy from the Local Public Schools

Q. Can a health plan say this?

A. Probably. Health plans often have a government agency exclusion clause in the contract. If a state/federal government agency provides the needed treatment (schools), then that treatment is excluded from coverage.

ASHA is developing a strategy to prevent health plans from doing this. It will be aimed at state legislative efforts.

Documentation Needed

Q. What documentation must I provide the health plan?

A. Whatever is necessary and reasonable to review a claim. Documentation requirements can vary and each plan may specify unique data. Typically, health plans request only minimum information. Evaluation reports and weekly notes are reasonable.

Documentation

- Always link the communication disorder to a medical diagnosis when appropriate, including remarkable medical history. This helps establish medical necessity.

Appealing Beyond the Health Plan: External Claim Review

- Consider external claim review (independent review) after exhausting all appeal levels of health plan
- If a patient prevails at the external claim review level, health plans must pay for the treatment, and a precedent is established.

External Claim Review

- ASHA strongly promotes the use of the external claim review process
- 42 states have an external review process
- Go to www.kff.org/consumerguide to get information about each state's procedure and contact points.

Payment Tips

- Review the patient's policy for coverage
- Use terms that are medically oriented (evaluation, diagnosis, treatment, condition)
- Submit correct ICD-9 and CPT codes, physician referral, progress notes, goals and discharge plans
- Educate payers about your services and new procedures

Appealing A Claim

- Questions?
- Do you have a specific case to present?
- Successful appeal to share?