BMD

Brennan Manna Diamond

Negotiating Settlements for Out-of-Network and High Dollar Claims

Moderator: Bryan E. Meek, Esq.

Panel Presenters: Jami Offenberger & Colleen Stone

LISTEN. SOLVE. EMPOWER.

Topics for Discussion

- Out-of-Network Claim Denials
- Using Settlement Negotiations to Resolve Out-of-Network Disputes
- Patients' Refusal to Pay Balance Bill

Out-of-Network Claim Denials

- Private payers are increasing their numbers of out-of-network claim denials as a way to contain costs or otherwise increase revenue.

- These denials typically arrive from audits performed by the payer (e.g. UHC), one of its subsidiaries (e.g. Optum), or its Special Investigations Unit (e.g. UHC's SIU).
  - These audits may begin with a medical record request prior to payment decisions being rendered, or
  - The payer may outright deny the claims without reviewing the medical records or otherwise seeking a statement or narrative from the provider.

Out-of-Network Claim Denials

- Common Denial Reasons:
  - Exceeds Reasonable & Customary Rates
  - Evidence of Medical Necessity Not Provided
  - Waiver of Co-payments and Deductibles

- Payer Actions for Recovery
  - Recoupment (assuming provider submits sufficient claims to the payer)
  - Repeated Demands for Payment
  - Refusal to Process Subsequent Claims
  - Litigation

Case Study

- Panel Member: **Colleen Stone**
  - Manager of Internal Audit & Analysis at Lake Health in Lake County, Ohio
- Lake Health is a private, not-for-profit leader in healthcare in Northeast Ohio.
  - 600 physicians
  - 2,900 healthcare professionals
  - 1000 volunteers
  - 2 hospital locations (Tri-Point Medical Center & West Medical Center)
  - 17 up-to-date, hi-tech facilities.

Negotiating a Settlement

- Typically requires the submission of a well-crafted position statement attacking both the payer's findings as well as highlighting the violations of state and federal law.
  - Look to: a state's prompt pay laws, provider manuals, Medicare guidance
  - For example: Ohio Revised Code §3901.381
    - A third-party payer has fifteen (15) days from receipt to notify a provider when a materially deficient claim is received.
    - A third-party payer has thirty (30) days to process a claim if no supporting documentation is needed.
    - A third-party payer has forty-five (45) days to process a claim if the third-party payer requests additional supporting documentation. However, third-party payers must request supporting documentation within thirty (30) days of the initial receipt of the claim. The time period of forty-five (45) days is suspended until the third-party payer receives the last piece of information requested in the initial thirty (30) day period.
- Use the patient to your advantage.

Non-Payment of Balance Bills

- Pursuant to a 2017 study, 70% of patients with hospital bills less than $500 did not pay off the full balance in 2016.
  - This number is a significant increase from 2015 (53%) and 2014 (49%)
- 10% of hospital bills were $500 to $1000, and 85% were not paid in full in 2016.
- Balance bills are typically seen with emergency room treatment.

Non-Payment of Balance Bills

- Obtaining payment:
  - Ensure patients sign a form indicating that they are responsible for balance bills
  - Ensure compliance with state laws. Some states have laws governing balance billing.
    - Ohio law permits out-of-network balance billing on private (non-government) payer plans.
  - Collections/lawsuits

- Send collection letters to patients that includes EOBs and explanation for why they are responsible for payment.
  - Strategic submission of letters (15 days post D/O/S, 45 days post D/O/S, and 75 days post D/O/S, for example)
  - 75% of best performing collection employees start the collection follow-up process less than 30 days from discharge.
    - "People pay their bills emotionally, and will prioritize the bills that are most important to them at the time."
- Balance bills are easy money that is available for grabs, especially from one-time patients.
- Negotiate appropriate settlements with each individual patient. Make sure that a statement is made to the effect that payment is only being reduced to avoid the cost of litigation or further collection attempts.

Case Study

- Panel Member: **Jami Offenberger**
  - Collection Manager, Patient Financial Services at Mercy Medical Center, Canton, Ohio
- Mercy Medical Center is a private, not-for-profit leader in healthcare in Northeast Ohio.
  - 620 members on its medical staff and employs 2,500 people
  - 10 up-to-date, hi-tech locations around the Stark and Tuscarawas County areas.

What steps are you taking to identify risks and liabilities?

- Are you conducting routine interviews with hospital executives and employees to discover risk areas?
- Are you utilizing data-mining software to locate and spot consistent billing errors/trends?
- Are you researching external resources such as articles written by attorneys, OIG, and the Dept. of Justice to identify key areas of concern?
- Are you analyzing financial data to evaluate past and predict future reimbursement trends?
- Are you developing best practices and workflow policies?
- Are you seeking legal and peer review of current and future operations?

Questions?

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