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Revenue Assurance 4.5

Tutorial

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Letter From The President

The healthcare delivery system is in our hands only for a season. How we navigate in it determines the access to care we leave for our children and the next generation.

Physicians and healthcare practitioners who advocate for medically appropriate health care for their patients are protected from retaliation by third party payors. California law affords you rights to recover damages if a plan (or medical group, IPA, PPO, Foundation, hospital medical staff and governing body or payor) terminates an employment or other contractual relationship or otherwise penalizes you in retaliation against your efforts to challenge decisions, policies or practices which impair your ability to provide medically appropriate health care to patients. **(Business & Professions Code §2056)**

A violation of this law is grounds for disciplinary action against a plan's license. **(Health & Safety Code §1386; Insurance Code §10120.5)**

As you fight for your patients using REVAssurance, remember, it is the public policy of the State of California that a physician be encouraged **"to advocate for medically appropriate health care" for his or her patients**. "To advocate for medically appropriate health care" means, under the law, (1) to appeal a payer's decision to deny payment for a service pursuant to the plans grievance or appeal procedure or (2) to protest a decision or policy that the physician reasonably believes impairs the physician's ability to provide medically appropriate care to his or her patients. **(Business & Professions Code §510)**

Defend the emergency safety net well.

Respectfully,
Ed Norwood
President

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Main Menu & Site Navigation

- The Navigation Panel is the strip of links located on the left side of the site, just under our logo.
- It provides quick access to every page in the program, including the master letters, helpful links, the product license agreement, the ‘About’ page, and the tutorial you are now reading.

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Main Menu & Site Navigation

- The Main Menu is the first page you see upon entering the site.
- This page contains links to the four main sections of the website (Appeals, Demands, Affidavits, and Regulatory Links) and a link to this tutorial.

The Process

REVAssurance will help you attain proper reimbursement for the medical services you have rendered in good faith.

While the pathway to reimbursement varies case by case, the correspondence process can best be generalized in the following steps:

PROVIDER

- Step 1: Demand claims payment compliance → PAYOR
- Claim Denied ←
- Step 2: Appeal improper denials →
- No Reimbursement ←
- Step 3: Send an Affidavit →
- Still No Reimbursement ←

- Step 4: File a regulatory complaint →

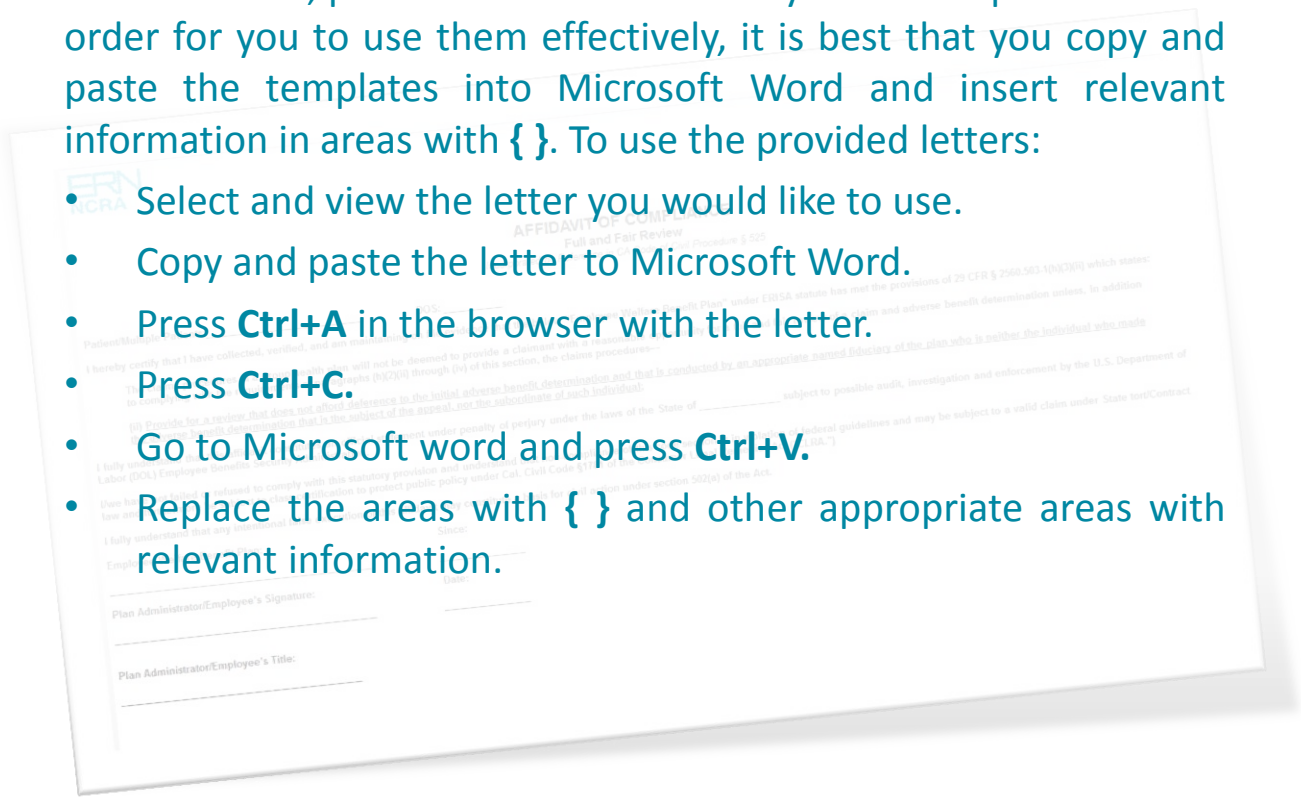
- (Contact ERN/The Reimbursement Advocacy Firm for assistance) →

The last three steps provide recourse if the payor denies reimbursement.

The Process

When you decide to call upon the letters presented by REVAssurance, please remember that they are in template form. In order for you to use them effectively, it is best that you copy and paste the templates into Microsoft Word and insert relevant information in areas with **{ }**. To use the provided letters:

- Select and view the letter you would like to use.
- Copy and paste the letter to Microsoft Word.
- Press **Ctrl+A** in the browser with the letter.
- Press **Ctrl+C.**
- Go to Microsoft word and press **Ctrl+V.**
- Replace the areas with **{ }** and other appropriate areas with relevant information.



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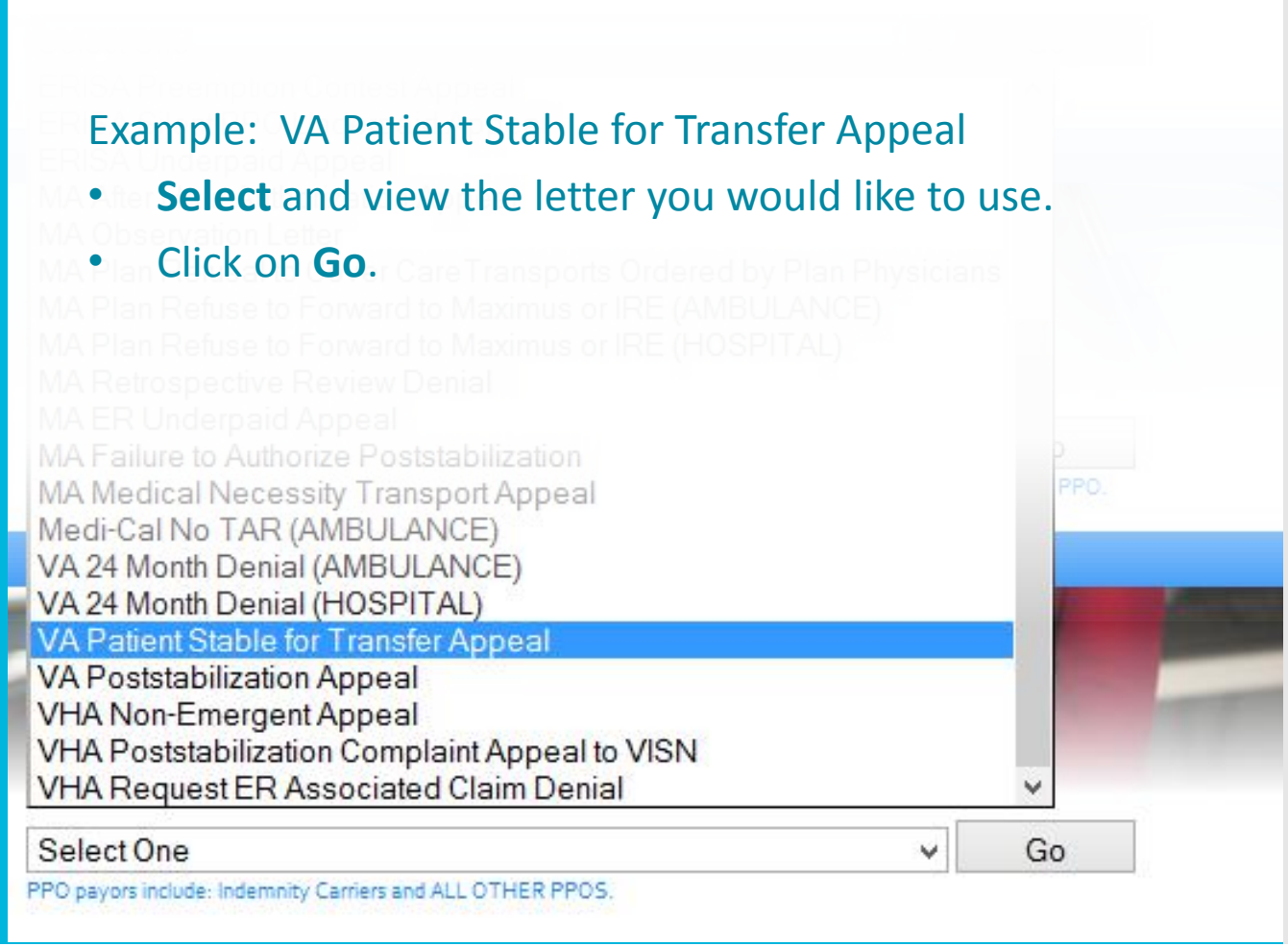
The Process

Example: VA Patient Stable for Transfer Appeal

- **Select** and view the letter you would like to use.
- Click on **Go**.



The Process

Example: VA Patient Stable for Transfer Appeal

- Copy and paste the letter to **Microsoft Word**.
- **Replace the blank spaces** and other appropriate areas with the relevant information.

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{Date}

IMPERATIVE ACTION REQUIRED

Dear Fee Basis Manager:

This office has been asked to file a formal complaint with VISN {NUMBER} for the {CITY} VA's failure to pay for emergency and poststabilization services and care as required by Federal law.

As you know, EMTALA imposes two duties on hospital emergency rooms: (1) a duty to screen a patient for an emergency medical condition, and, (2) once an emergency condition is found, a duty to stabilize the patient before transferring or discharging him. See 42 U.S.C. §1395dd, Jackson v. East Bay Hospital, 246 F.3d 1248, 1254-55 (9th Cir. 2001).

The statute requires the emergency department to "provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition . . . exists. " **42 U.S.C. §1395dd(a)**. If the hospital determines that an individual has an emergency medical condition, it must provide" within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition." **42 U.S.C. §1395dd(b)(1)(A)**.

38 CFR § **17.54(a)** adds:

> **"The admission of a veteran to a non-Department of Veterans Affairs hospital at Department of Veterans Affairs expense must be authorized in advance. In the case of an emergency which existed at the time of admiss**

Our office verified eligibility and notified the VA of the veteran's admission on {DATE} requesting authorization (or transfer) to no avail deeming these services authorized. Even if these services were not authorized, 38 CFR **§ 17.120** states:

> **To the extent allowable, payment or reimbursement of the expenses of care, not previously authorized, in a private or public (or Federal) hospital not operated by the Department of Veterans Affairs, or of any medical s**
>
> **(b) In a medical emergency.** Care and services not previously authorized were rendered in a medical emergency of such nature that delay would have been hazardous to life or health, and
> **(c) When Federal facilities are unavailable.** VA or other Federal facilities were not feasibly available, and an attempt to use them beforehand or obtain prior VA authorization for the services required would not have b

As you know, uunder existing Federal law, payment or reimbursement under **38 U.S.C. 1725 §17.1002** for emergency services may be made if all of the following conditions are met:

> **(a) The emergency services were provided in a hospital emergency department or a similar facility held out as providing emergency care to the public;**
> **(b) The claim for payment or reimbursement for the initial evaluation and treatment is for a condition of such a nature that a prudent layperson would have reasonably expected that delay in seeking immediate medica**
> **(c) A VA or other Federal facility/provider was not feasibly available and an attempt to use them beforehand would not have been considered reasonable by a prudent layperson (as an example, these conditions would**
> **(d) The claim for payment or reimbursement for any medical care beyond the initial emergency evaluation and treatment is for a continued medical emergency of such a nature that the veteran could not have been sa**
> **(e) At the time the emergency treatment was furnished, the veteran was enrolled in the VA health care system AND HAD RECEIVED MEDICAL SERVICES UNDER AUTHORITY OF 38 U.S.C. CHAPTER 17 WITHIN THE 24-MO**
> **(f) The veteran is financially liable to the provider of emergency treatment for that treatment;**
> **(g) The veteran has no coverage under a health-plan contract for payment or reimbursement, in whole or in part, for the emergency treatment (this condition cannot be met if the veteran has coverage under a health-p**
> **(h) If the condition for which the emergency treatment was furnished was caused by an accident or work-related injury, the claimant has exhausted without success all claims and remedies reasonably available to the**

IT IS OUR POSITION THAT THE VETERAN'S CLAIM HAS MET THE REQUIREMENTS OF 38 U.S.C. 1725 IN THIS CASE.

If you disagree, please provide this office with:

1. **A written explanation as to how these services did not meet the above requirements AND**
2. **A signed sworn affidavit from the fee service review physician or equivalent practitioner (at your VA) stating that the date of stabilization and requests to transfer the veteran to the VA was communicated to our**

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Master Demand Letters

There are 7 government payor demand letter templates.

There are 22 managed care organization demand letter templates.

There are 10 indemnity and PPO demand letter templates.

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Master Demand Letters

A demand is used when a claim has not been denied and is beyond the statutory time frame for reimbursement. These 39 templates are tools to enforce claims payment compliance and cite administration laws that govern the health care delivery process. Each template is customized according to the type of payor jurisdiction and denial type you face.

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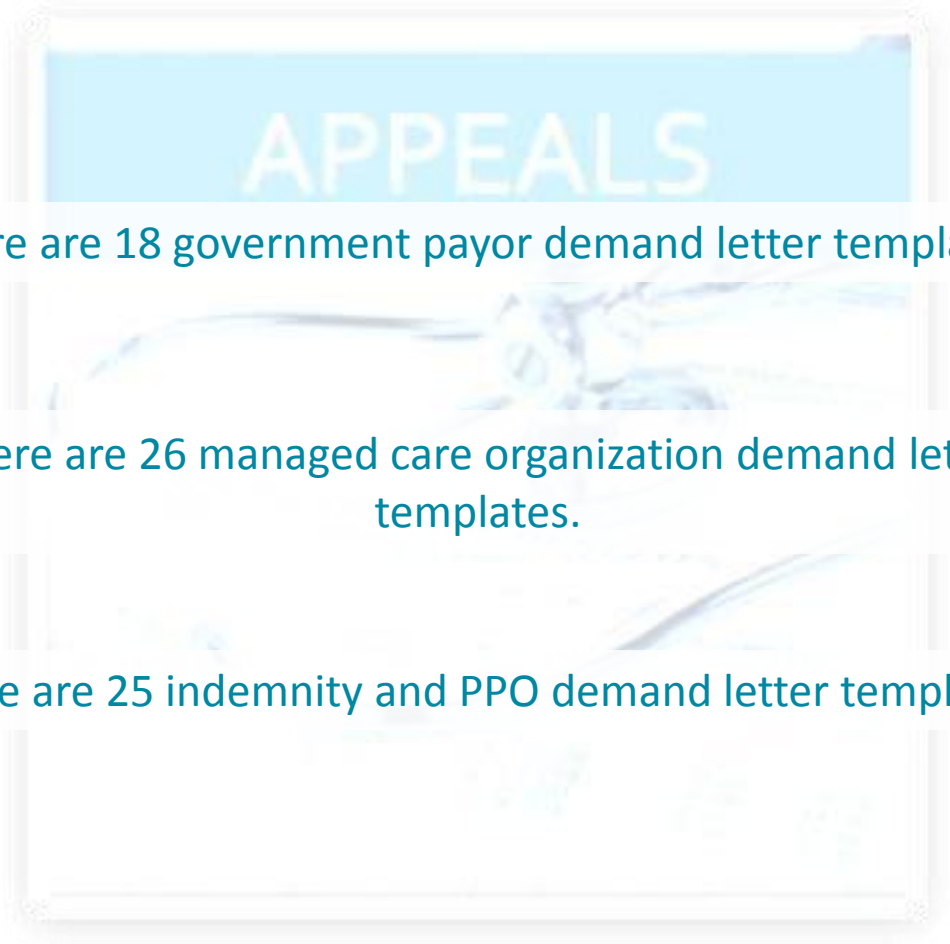
Master Appeal Letters



There are 18 government payor demand letter templates.

There are 26 managed care organization demand letter templates.

There are 25 indemnity and PPO demand letter templates.

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Master Appeal Letters

As stated earlier, the second step towards reimbursement is to appeal the payor's denial. This can be done using REVAssurance's appeal letters.

An appeal is a provider's written notice to the plan or the plan's capitated provider challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested or seeking resolution of a billing determination or other contract dispute.

If the payor chooses to deny a claim (either initially or after having sent a demand letter), send a letter to appeal their decision. The Master Appeal Letters page features 64 unique templates to assist you in appealing these denials.

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Affidavits & Forms

There are 8 government payor demand letter templates.

There are 9 managed care organization demand letter templates.

There are 11 indemnity and PPO demand letter templates.

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Affidavits & Forms

With regards to your reimbursement, affidavits serve a different purpose than appeal and demand letters. When you send an appeal or a demand letter, you are requesting claims payment and/or compliance from the plan to mitigate your loss and preclude future violations. However, an affidavit is a declaration under penalty of perjury that the plan is in compliance with the stated law cited in your letter. When you send an affidavit, you are sending a legal document for the payor to sign which states that they have indeed fulfilled their statutory obligation pursuant to all laws relevant to the case at hand.

REVAssurance provides 28 affidavits and forms as the final steps of persuading a health plan to comply before filing a complaint with a regulatory agency. They can be sent with:

- Appeal Letters
- Demand Letters
- Resubmission of Claims

They can also be sent in response to any questionable requests by a payor.

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Regulatory Links

There are 5 law dictionaries links.

There are 13 regulatory agency contact information links.

There are 4 links for regulatory claims representation help.

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Regulatory Links

REVAssurance is also linked with 5 law dictionaries for you to browse and search for the sections you need to reference in order to heighten the importance of your reimbursement and inform the payor of their responsibility as declared by law.

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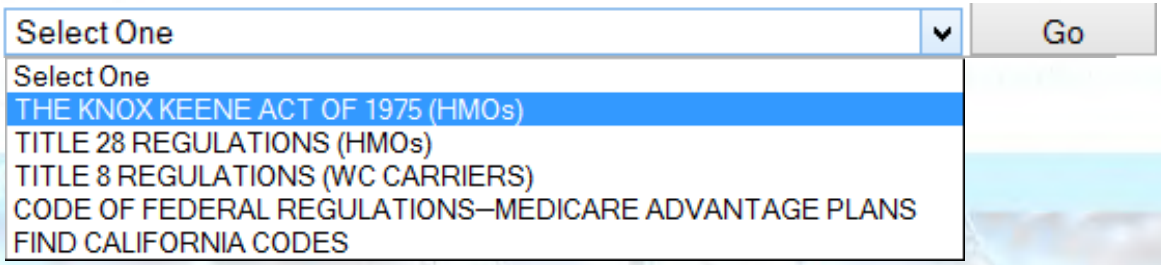
To give you an example of how they work, we will demonstrate the law dictionary of the entire Knox-Keene Act of 1975.

- Start by selecting **The Knox Keene Act of 1975 (HMOs)**.
- Then, click **Go**.



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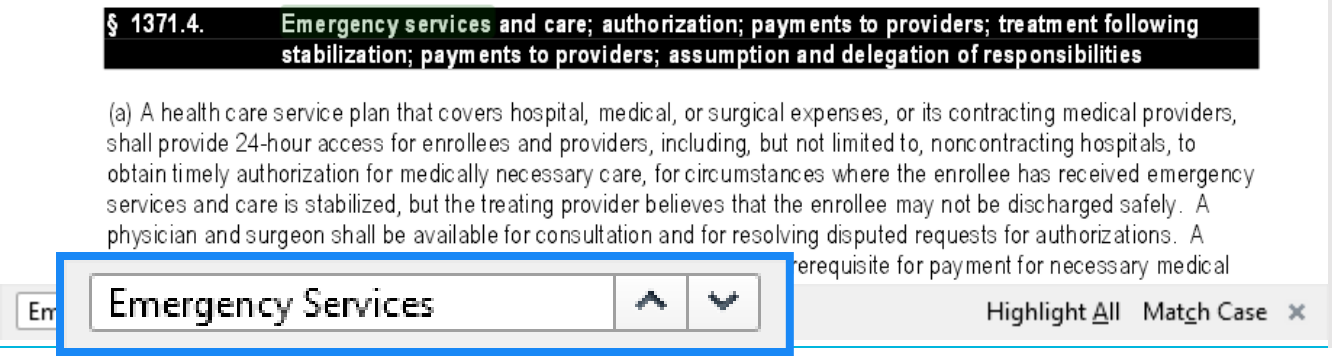
Regulatory Links

- If you wanted to search for laws pertaining to services rendered in emergencies press **Ctrl+F** and type "Emergency services" in the **Find** bar that appears at the very bottom of your browser. Then, press **Enter**.
- Then, **browse** among the sections that appear. If the section that appears is not the one you are looking for, simply press Enter or **Next** until you find the section you need.



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Regulatory Links

NOTE: Very often, you will need to look up laws regarding retroactive denials. Be mindful that in this database typing "Retroactive Denial" will not work as that is not the term used in laws. Instead policymakers use the term **Rescission.** The term Retroactive Denial is recognized by law as equating to a **Rescission**, but when searching, use the term **Rescission**.

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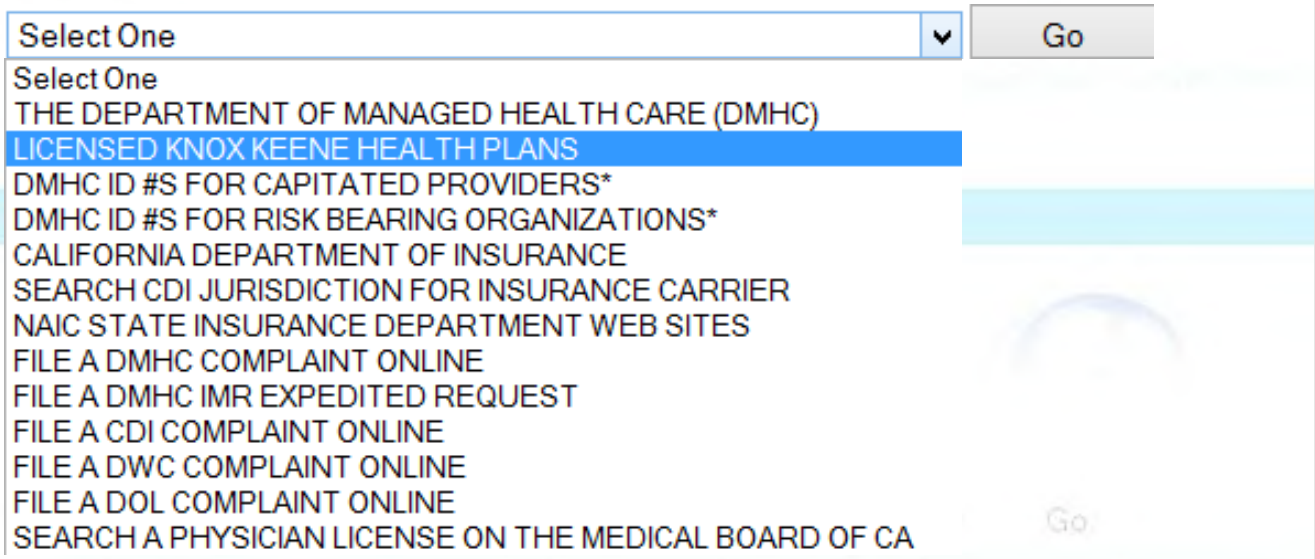
Using REVAssurance, you can also access contact information for 9 different Regulatory Agencies according to their jurisdiction.

- For an example, we will look up the contact info for filing complaints against health plans under the jurisdiction of the Knox-Keene Act.



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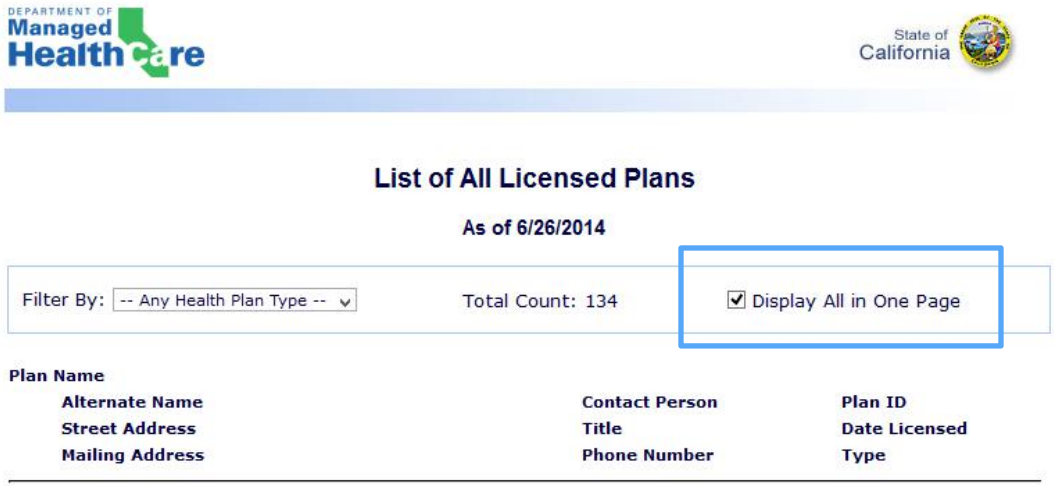

- To find the contact information for the proper regulatory agency, first check the box to **display all available contacts in one page**.
- Next, press **Ctrl+F** .

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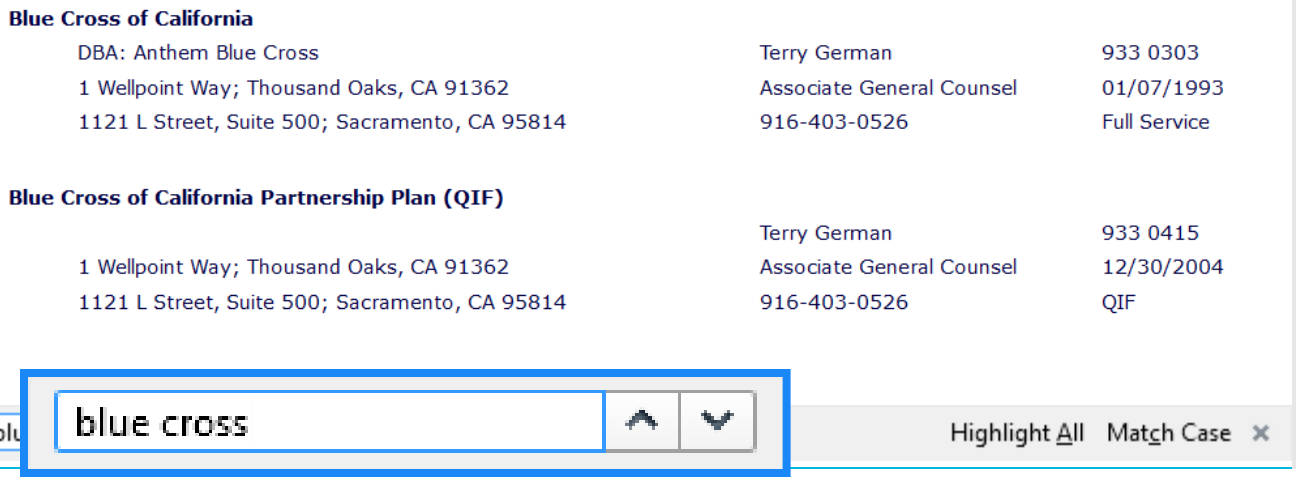
- locate the **Find** bar at the bottom of the browser menu bar.
- Type the name of the insurance company that you wish to file against and press **Enter**.
- (If the right company does not appear the first time, press Enter again until it does.)



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Some plans (such as United Health) are not Knox-Keene licensed and, as such, do not fall under this jurisdiction. Accordingly, you must find the proper jurisdiction and search under that database. For United Health, it's the California Department of Insurance, or CDI.

Begin your search by using a partial or full Company Name. From there you will be able to access information about a company's location, complaint history, and financial strength.

In addition to this service, you can review your agent's licensing history and gather basic pricing information.

Enter query criteria for Company Profiles

Company Name: United Health

Get Company | Reset

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And there it is!

CompanyList

For more information on any company, click the Company Name "Info" link. To view all companies in the same group, click the NAIC group number.

Company Name	State of Domicile	NAIC Number	NAIC Group Number	Name Type
UNITED HEALTHCARE INSURANCE COMPANY (Info)	CT	79413	0707	Old Name

Record 1

New Search

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Finally, in order to ensure that you are fully equipped to improve your hospital's cash flow, REVAssurance provides four different tools to guide you in pursuing your just reimbursement including:

- ERN/TRAF Claims Representation Approval Form: to fill out and forward to The Reimbursement Advocacy Firm if you desire the firm's direct service.
- A PDF document that highlights the help and support that ERN/TRAF can provide in your pursuit of fair and just reimbursement.
- The HMO interest calculator: to find out how much interest the health plan owes you pursuant to Health and Safety Code 1371.

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This concludes the tutorial!