Best Practices in Patient Advocacy

by Daniel P. Lorence, PhD, and Harry Rhodes, MBA, RRA

When an insurance claim or treatment authorization is denied, where can patients turn? More frequently they are turning to patient advocates who understand the information contained in their claims and medical records. Here's a look at some opportunities for HIM professionals in this growing field.

Recent actions at both the federal and state levels reflect a growth of patient advocacy that continues to be a politically popular area of debate. Typically, proposed "health consumer bills of rights" involve patient-determined access to care and insurance coverage, such as for emergency care or specialty treatment.

Just how successful such advocacy will be against the considerable resources of global payer organizations remains to be seen, but the right to be heard is likely to be exercised by those in need. What's more, aside from the good feeling of helping patients get care, advocacy makes good business sense. Providers have little to gain and much to lose by denying medically appropriate treatment, most notably by risking expensive litigation arising from negligence, breach of the managed care contract, or overall bad faith. Furthermore, while denying needed treatment generates ill will, it also can result in sicker patients and more expensive care after an initial denial.

In this climate, patient advocates -- professionals who help consumers resolve problems related to medical insurance claims- are claiming a niche in the healthcare industry. For healthcare professionals versed in information management processes, the opportunities for advocates will grow.

What Does an Advocate Do?

Patient advocates are generally health professionals who have a background in operational healthcare delivery, insurance, health information management, or medical terminology and who understand the business side of healthcare.

Often, an insurance claim or treatment authorization is denied because the medical record contains ambiguous information on the needed diagnosis and treatment. The payer then has grounds to deny the sought-after approval based on a lack of documentation. A record-savvy advocate can often locate other language in the record suggesting the necessity of the treatment. Alternatively, an advocate can often make a strong case by comparing a coded or documented diagnosis with standardized treatment protocols that prescribe the needed treatment, even though not explicitly ordered in the record or highlighted as "medically necessary." Also, a patient may seek an advocate to review a claim or record simply to determine if it makes sense.

An advocate is also able to recognize and demonstrate "bad faith." Demonstrating bad faith in contract performance is one of the few bargaining tools that has proven effective in dealing with payers, since federal legislation and payer-friendly contract provisions make other types of litigation an expensive, and often unrealistic, uphill battle for patients. (See "Bad Faith," p. 60.)

A good advocate is able to understand the perspectives of patients, providers, and payers and how they interrelate. This multidimensional perspective becomes critical in deciphering the medical bill and its congruence with the healthcare record and how these both relate to the reimbursement process. More importantly, the advocate has the background to look for clues within medical documentation to assess, to some extent, treatment and coverage denials based on the two most common reasons reimbursement or coverage is denied to patients: that the treatment is deemed experimental in nature or lacks medical necessity.

Experimental Treatment

One problem the patient advocate must overcome is that there is no universal set of criteria that defines a given medical treatment as experimental. When applied with prudence, a payer clause that limits reimbursement for unproven or radical therapies was traditionally viewed as reasonable. Today, however, the classification of a given treatment as experimental, especially in the area of oncology, is increasingly being applied to procedures that show promise but as yet are not commonly practiced in a given specialty area.

Critics contend that few, if any, medical treatments can ever be proven as conclusively efficacious, since there are so many other undocumented variables in medical care that affect the outcome, including comorbidity, age, lifestyle, or treatment variation. Furthermore, it may take many years to accumulate data on a statistically significant patient population to move all aspects of a treatment definitively beyond the experimental stage. Denying reimbursement for early adopters of innovative treatment would also likely discourage any significant advance in medical research. Recognizing these limitations, regulatory bodies in a number of states have begun to restrict payers from arbitrarily labeling treatment as experimental, with proposed federal legislation including similar restrictions. [1]

Medical Necessity

There is likewise little agreement among insurance plans regarding when and where a given treatment should be approved as medically necessary. Traditionally, the individual provider had almost unlimited discretion in deciding whether a given treatment was necessary. More recently, managed care organizations (MCOs) and payers have attempted to set corporate standards of medical necessity, often with far more restrictive treatment options for providers of care. These standards are increasingly being viewed as unreasonable, resulting in intervention by regulators and the courts.

For example, home health care is an area that is considered one of the most easily justified for claims denial, based on a perceived history of industry-wide overcharging. Theoretically, this should result in most claims denials being upheld upon appeal. In fact, one recent study reported that 81 percent of challenges to denial of claims were successful in overturning the payer's denial decision, yielding reimbursement for the patient. [2] This suggests that insurance companies may be reluctant to vigorously contest persistent appeals from denial of care or are wrongfully denying care at an alarming rate.

In a more comprehensive study, the US Government Accounting Office, studying services across six carriers for 74 different services, found that medical necessity denial rates varied widely from zero to 100 denials per 1000 claims for certain types of treatment. This was believed to be the result of inconsistent use of computerized screening criteria for specific services among carriers. They also found that more than half of the denied claims originated from relatively few providers. Other explanations included varying interpretation of national coverage standards across carriers, differences in the way carriers treated claims with missing information, and reporting inconsistencies. [3] It seems likely, then, that such denials based on lack of medical necessity will continue to be applied with some inconsistency.

Small Practice Advocacy -- Claims Made Easy

Irene Porges, ART, professor of health information technology at Manhattan Community College, started her Brooklyn-based claims advocacy business from home under the name Claims Made Easy. The idea took root when Porges was forced to handle a number of complex claims disputes for her own family. Finding the task daunting, she quickly realized that the average person would find it almost impossible to challenge a payer without a working knowledge of ICD-9 and CPT coding, explanation of benefits (EOB) forms, co-pay calculations, and standard and reasonable fee schedules.

Porges, who specializes in post-treatment overbilling issues, emphasizes that everything is negotiable -- and that payers are almost universally interested in receiving a reduced payment in lieu of no payment at all. Knowledge of coding and medical terminology is a key source of leverage in this process. Since payers are often bound by local standard and reasonable fees and customary charges, an advocate can comb through billing information and seek inconsistencies between coded details in the bill and documentation in the medical record. While she seldom is forced to threaten a payer, Porges concedes that even the suggestion of possible fraud resulting from such an analysis can be a powerful motivator for payers to accede to consumers' wishes.

Knowing the language of healthcare also allows advocates to obtain information from the payer's own agents, which often works to the patient's benefit. Internal utilization review standards, for example, may call for a minimal length of hospital stay

often exceeding the patient's actual stay. An ongoing problem for many payers is having to justify a failure to meet their own established standard of care, which in litigation would likely be an indefensible action on their part. Further, the poor integration of information and billing systems found in many recently merged companies often results in communication with claims representatives who are unsure of their own internal policies and procedures.

Who is at fault?

Providers and payers are often at odds over who was at fault for inappropriate treatment denial or claims rejection. An advocate can often gain an ally by determining where liability lies and enlisting the support of the innocent party. What to look for:

- The treating physician's protest. A physician who complies without protest with payer's limitations, when good medical judgement dictates otherwise, cannot use the payer as a scapegoat when the patient is adversely affected.
- Unreasonable cost control mechanisms. A payer is liable when medically inappropriate decisions result from defects in the design of cost containment mechanisms, such as when adequate appeals process is lacking or ignored.
- Necessity determined by corporate standards. Large national payer corporations often dictate one corporate standard for determining medical necessity. Many courts, however, still mandate a more localized community medical standard.
- An attending provider's history. A patient who suffers at the hand of a habitually inept provider may have little recourse against a provider who is bankrupt or who disappears. In such a case the payer's duty to adequately screen and monitor their contractors becomes critical, and the payer can be held liable for the provider's error.

Reference

Schessler, Cheralyn. "Liability Implications of Utilization Review as a Cost Containment Mechanism." *Journal of Contemporary Health Law & Policy*, Spring 1992.

The Advocacy Corporation -- Claim Guard Plus

At the opposite end of the spectrum are multistate organizations that employ healthcare professionals as claims advocates. Claim Guard Plus of Indianapolis, IN, uses a structured, corporate-wide network to help patients through claims problems. Claims can often be settled for less than the full amount billed, company founder Tom Lopsiger says, but the advocate must ensure that an "accord and satisfaction" is reached. If payment is made to settle a dispute and is less than the amount due, it should be accompanied by some documentation identifying the payment as an accord and satisfaction, meaning it is not simply a partial payment on the full amount due. At the very least, the "accord" language should appear on the payment check (see "Settlement Terms").

In handling a claims dispute, Lopsiger believes that nothing beats a good record audit. His company facilitates thorough review of the patient chart by trained professionals who can quickly compare claims information with the medical record and identify erroneous information, such as medication charges, and can also spot omissions in the documentation (see "Record Auditing"). He also tends to avoid the use of attorneys, seeking instead to keep communication open between the parties involved.

Where there is a potential for a malpractice suit or other litigation, patients have the option of seeking an attorney or an unbiased external physician review -- in effect a second opinion based on review of information documented in the patient's chart. ECRI of Plymouth Meeting, PA, and Medical Care Management Corp. of Bethesda, MD, provide this service at low cost. If favorable to the patient, this review, in effect, acts as a pre-litigation expert opinion, demonstrating, at least, that the patient's claim has some merit.

Settlement Terms

Making a payment of less than the full amount owed, if done to settle any claim for the full amount, should be represented as an accord and satisfaction.

According to Black's Law Dictionary, 6th ed., an accord and satisfaction is a method of discharging a claim whereby the parties agree to give and accept something in settlement of the claim and perform the agreement (the "accord" being the agreement and the "satisfaction" its execution or performance) and it is a new contract substituted for an old contract which is thereby discharged, or for an obligation or cause of action which is settled, and must have all of the elements of a valid contract. An executory bilateral contract of "accord" is an agreement embodying a promise, express or implied, to accept at some future time a stipulated performance in satisfaction or discharge in whole or in part of any present claim, cause of action or obligation, and a promise express or implied to render such performance. Such arises where parties, by a subsequent agreement, have satisfied the former one, and the latter agreement has been executed. (For further examples, see Restatement 2d. of Contracts s. 281 [1990 App.].)

Ideally, the settlement is a contract drawn up by an attorney stipulating its terms. Otherwise, it can be a letter, form contract (available in most office supply and bookstores), or other document that clearly communicates that the consumer is paying less than the full amount owed to the insurer/payer, that the insurer/payer accepts this lesser amount and discharges any further debt the consumer owes at that time. Sometimes a statement on the payment check will suffice, stating "this payment is a full accord and satisfaction" or "this payment satisfies in full all amounts owed to this payee."

Advocacy in Risk Management -- MMI Co.

HIM opportunities are not limited to the advocate who confronts or contests payer organizations. Increasingly, treatment denials are being represented as medical malpractice, carrying the threat of litigation. In such cases the patient advocate's best ally can be found within the provider-payer network itself, most commonly within the risk management department.

Starr Lander, RRA, works for a risk management resource and malpractice insurer, MMI Companies of Deerfield, IL. While her job is to protect providers from malpractice risk, in her role as a risk manager she often serves as a patient advocate by settling minor disputes before they are litigated. Sometimes providers are not able to fully assess the potential risk involved in a patient dispute, even though the provider may not have been at fault. There may be incomplete or missing medical documentation, mishandled test results, or simple communication errors that, in a litigation setting, could prove disastrous to a provider. At this stage risk managers will often work to accommodate the patient's wishes in order to avoid a costly lawsuit. Other times, providers simply make mistakes, with the patient only seeking needed medical treatment rather than a large monetary award. Within this context, the risk manager must weigh the cost of accommodating the patient against the potential risk of turning them away, possibly to seek a remedy through the courts. Again, advocating the patient's side in such a case is often the most efficient resolution.

Lander, who has a background in hospital risk management, suggests that HIM professionals are well equipped to serve in expanding career tracks in this area. She found that her training in medical terminology, documentation, and hospital management provided a set of skills uniquely suited to this position (though she recommends that anyone interested in this area also acquire a working knowledge of insurance practices, legal procedure, and clinical guidelines). Lander also strongly recommends experience or advanced training in patient relations, since most litigation can be avoided by working with the patient within the healthcare delivery setting. Once a lawsuit is filed, any direct communication between a represented patient and provider is essentially prohibited.

Lander also notes the growing advocacy role of risk managers who are involved in disputes with payers. MCOs, in particular, are becoming more aggressive about dictating treatment protocols to providers and are willing to institute litigation against hospitals or individual providers for perceived overutilization of services. Essentially, this situation positions the patient, provider, and risk manager against the MCO in a struggle for clinical decision-making authority. In such a situation the patient gains the alliance of the provider network, potentially gaining access to the considerable resources and expertise of the network members.

Record Auditing

Denial of claims is not always the fault of the payer. Parties submitting claims often make mistakes. An advocate can often see trends within provider groups by auditing records for patterns of documentation problems. Donna Cronic, ART, a senior consultant at Healthcare Management Advisors, Atlanta, GA, offers some guidelines:

- Select a sample of claims and match them with the appropriate records and documentation. All pulled claims should be sorted with their EOB and other documentation pertinent to that claim.
- Assign codes and modifiers to the claims. If these are different from what was on the original claim, find out why. Include these reasons in your findings report.
- Check for medical necessity on the services performed.
- Be sure that all the tests ordered by the physician were actually performed.
- Make sure that there is documentation to support everything in the claims.
- Be sure all orders are written and signed by the doctor.
- Check for data entry errors.
- Review the EOBs in the claim. Determine why they're getting denied. Prepare the claims again for billing and follow up to see if your second submission gets through for reimbursement.
- Check your top 10 denials. Is there something in your encounter form that is incorrect, possibly a wrong code, or something that is not correct for your practice anymore which may be causing these denials? Review your encounter form carefully.
- Make sure you are using specific codes. Some codes are too general for medical necessity purposes.
- Make sure your encounter form lists all E&M level exams, even if your practice doesn't always provide all of them. You need the options to code every level available on your forms.

Opportunities for HIM Professionals

What are the common operational threads running through these practices? All practitioners agree that persistence is critical when dealing with the healthcare reimbursement system. Whether by design or default, most payer organizations are not perceived as user friendly, and assistance in getting claims paid is often inaccessible to all but the most persistent. Also, strong negotiation skills are critical, and the most successful advocate is usually one who can reach a compromise that benefits the patient and allows the payer representative to save face. Finally, development of a resource network is often necessary when contesting a large payer corporation. There are countless physicians, lawyers, claims experts, and health information professionals -- many of whom have experienced the pitfalls of the healthcare system firsthand -- who are sympathetic to the work of the advocate. A unified group of professionals can go a long way toward supporting the overall mission of the patient advocate-obtaining access to healthcare.

Had Faith

Providers and payers are required to act in good faith under a health plan contract. Good faith is open to the interpretation of a reviewer or court. Some signs of bad faith denial of care and reimbursement are:

- *Did the payer's medical director or appointed designee expressly deny the requested treatment or claim*? Look for a long list of approving authorities. If too many people are authorized to make denials, there's an increased chance of review inconsistency and questionable internal compliance. This helps the patient's case.
- *Was every detail of the patient's case thoroughly documented*? Even minor details missing from the physician notes and supporting documentation can be challenged as essential to the patient's treatment.
- *Are there ambiguities in the patient's contract regarding excluded services in the contract*? A clear list of excluded procedures or tests supports the payer's denial. However, once a provider begins treatment and stops short of a necessary test or procedure without a clear warning to the patient, there is potential for provider and/or payer

negligence. Also, broad categories of excluded services are vulnerable to attack by a patient as bad faith. Further, the payer's own utilization review procedures are often overlooked. Use them to the patient's advantage.

- *Did the decision maker adequately consult with the attending physicians*? If denial was based on an incomplete or sketchy record, without further consultation, it is often interpreted in favor of the patient.
- *Did the decision maker consult with experts in a relevant area of specialized care*? A primary care generalist is often unfamiliar with the local standard of specialty care, which is usually a standard defined by specialists. Alternatively, get a second opinion from a specialist outside the payer's network. This can be persuasive.
- *Was there a convincing lack of medical necessity*? The traditional measure of medical necessity was based on a "generally accepted standard of good medical practice in the community." As nationwide and even global databases become available to individual providers, there is a steady movement away from the local community standard to national aggregate standards. Data that supports your claim from other, larger "communities" is often persuasive.
- *Did the payers follow their own review policy*? Inadequate or defective utilization review for medical necessity works to the patient's advantage. Also, look closely for financial incentives to deny needed treatment, which courts and regulators often disfavor.
- *Is there clear indication of a treatment as experimental*? Payers will often rely on published practice guidelines or protocols that list a given treatment as experimental. These become dated very quickly, however, as the treatment diffuse across the industry. Find other providers or hospitals who have a track record of this treatment. Also, consider the impact of a given treatment. Regardless of contract terms, payers get little sympathy from outside reviewers or courts for denying life-saving or dramatic life-improving treatment.
- *Check the time limits on review and appeals*. Payers often promise a very short turnaround time to review complex treatment decisions. Delays favor the patient's right to seek care elsewhere and then claim reimbursement, especially for emergency situations.

Resource

Quinn, Campion. "Avoiding 'Bad Faith' Denials of Medical Claims." *Managed Care* 6, no. 4 (1997):79.

Notes

1. Friedman-Knowles Act, Ann. Cal. Health & Safety Code s. 1370.4.

2. "In Trend, Courts Nix Home Care Denials." *Hospitals & Health Networks* 72, no. 5 (1998): 47.

3. "Medicare Part B: Regional Variation in Denial Rates for Medical Necessity." *GAO Letter Report*. Washington, DC: December 19, 1994.

References

The Alliance of Claims Assistance Professionals (ACAP) is a professional society that certifies patient advocates through a national testing program. For more information, contact ACAP at 731 S. Naperville Rd., Wheaton, IL 60178; telephone (630) 588-1260.

Eddy, David. "Investigational Treatment: How Strict Should We Be?" *Journal of the American Medical Association* 278, no. 3, (1997): 179-185.

Daniel Lorence *is AHIMA's senior research analyst.* ***Harry Rhodes*** *is an AHIMA HIM practice manager.*

Article citation:
Lorence, Daniel P., and Harry Rhodes. "Best Practices in Patient Advocacy." *Journal of AHIMA* 69, no.8 (1998): 56-60.