

Appealing Treatment / Reimbursement Denials

The ability to make a successful clinical appeal when requested treatment services are denied by an MCO is an important skill for psychiatrists to have in today's environment. No one strategy will prove successful at all times and in all situations; often success will lie in a combination of approaches, depending on the case at hand.

APPEAL STRATEGIES

The APA's Office of Healthcare Systems and Financing recommends the following:

1. Request and review a copy of the MCO's appeals procedures and utilization review (UR) criteria before initiating any appeals.
2. Ask for the case manager's credentials. **Denials of psychiatrists' services should be made only by psychiatrists.**
3. Request written notification of the reasons for denial and a description of the information required for approval. This will ensure that subsequent submissions "fit the bill."
4. Request names and addresses of the people who should receive applications for an appeal and find out the MCO's deadline for appeals.
5. Meet all UR and appeal deadlines. If you do not, the merits of your case may not matter. Certification denials due to "administrative noncompliance" are rarely overturned. If the case is denied on an administrative basis (i.e., a request for continued certification was not made within the specified time, precertification procedures were not followed, or there were benefit coverage exclusions), you'll need to explain any extenuating circumstances in your appeal.
6. If your appeal is denied, appeal again. Many companies offer three or four levels of appeal. It is advisable to exhaust all levels of appeal before initiating litigation, should you be forced to proceed that way.
7. Be concise. Don't send more information than necessary and be sure to get permission from your patient to release that information.
8. Request peer review with a psychiatrist trained in the same subspecialty who has experience in the treatment requested.
9. In an emergency situation, request an "expedited appeal" over the telephone with the consulting psychiatrist. Most MCOs have such services.
10. If applicable, ask the patient to enlist the support of his or her Personnel/ Human Resources Department. MCOs are often more responsive to their paying clients' complaints than to complaints from physicians.
11. In cases that are slow to respond to standard treatments, ask the company to "flex benefits" by working with you to find a cost-effective, alternative treatment approach.
12. If coverage is denied after appealing, some companies may allow you to request an external review of the case with or without some cost-sharing.
13. In truly egregious cases, copy your appeal to the state insurance commissioner. Seeing such a "cc" may elicit a more rapid and favorable response.

14. Contact any professional association you belong to and any consumer advocacy groups that may be helpful. A complaint lodged by several parties will be stronger.

LETTER OF APPEAL

The following are some suggestions for inclusion in a letter of appeal:

- Include any literature that supports your case, including references to the APA's practice guidelines. This may help convince the reviewer that the proposed treatment will result in the desired outcome.
- Be candid about the patient's condition. Describe any changes in diagnosis, comorbidities, progression, or regression of the patient's condition; special treatments such as suicide restraints and seclusion; neurological testing and other medical tests; medications; and any self-injury or assaultive behavior.
- Clearly relate the level of care requested to the patient's condition. Information should be based on objective reasoning, not just opinion.
- Describe the next step of treatment, providing goals and an approximate time frame for the completion of treatment. This will promote the idea that you have an action-oriented approach.
- If applicable, recommend alternative treatments for the patient.
- Present evidence of similar cases where the care was approved by the same plan.
- Appeal with a collaborative spirit.

If you need further assistance, call the APA Practice Management HelpLine at (800) 343-4671.

INDEPENDENT REVIEW ORGANIZATIONS (IROs)

Currently 44 states and the District of Columbia have enacted independent review laws that require disagreements over what constitutes a health plan coverage to be decided by a review done by a medical expert or panel of medical experts who have no affiliation with the health plan. Laws vary from state to state as to whether the review decisions are binding, but they are in most states. Currently, approximately 50 percent of the disputes taken to independent review result in the reversal of a coverage denial. An independent, external review, however, can only be accessed after the internal appeals process established by individual MCOs has been completely exhausted.

Although independent reviews have been around for years, there is still a lack of public awareness about the process, and patients generally do not take advantage of the reviews despite claims denial letters that inform them about their availability. In 2005 the Kaiser Family Foundation published a guide to handling health plan disputes that provides specific information about how to access the independent review organizations in each state that has mandated the independent review process. This document can be downloaded at <http://kff.org/health-costs/report/a-consumer-guide-to-handling-disputes-with-your-employer-or-private-health-plan/>.

The Office of Healthcare Systems and Financing encourages patients, and their physicians, to take advantage of this vehicle for resolving disputes that arise in obtaining appropriate mental health care.