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COMMERCIAL AUDITS AND APPEALS WHITE PAPER
STATE BAR OF MICHIGAN HEALTH LAW SECTION

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CONTENTS

Introduction.....	3
Blue Cross Blue Shield of Michigan Audits and Appeals Process	3
I. BCBSM Audit Overview	4
II. BCBSM Appeals Process.....	4
A. Step One: Written Complaint	4
B. Step Two: Informal Conference.....	5
C. Step Three: Independent Third Party Determination	5
III. Blue Care Network Health Maintenance Organization Appeals Process	6
PATIENT’S RIGHT TO INDEPENDENT REVIEW ACT.....	9
I. Covered Person’s Right to Request External Review	9
II. The External Review Process	12
III. Special Circumstances Recognized by PRIRA: Experimental or Investigational Services or Treatments.....	13
IV. Special Circumstances Identified by PRIRA: Expedited External Review Process	15
V. Appeal Rights Following External Review	16
Strategic Approaches for Commercial Audits and Appeals	17
I. Payor Documentation Criteria for Defending Claims	18
II. Responding to Audits and Defending Claims through Commercial Payors’ Appeals Processes ...	20
III. Prospective Compliance with Providers Following Audits	22
CONCLUSION.....	23

INTRODUCTION

Michigan healthcare providers and their legal counsel must be prepared to address audits and appeals initiated by commercial payors. Although healthcare compliance often focuses on state and federal regulatory authorities and audits, commercial payor audits may seriously affect a provider's ability to continue providing services to patients and have a detrimental impact on the provider's practice. Therefore, understanding potential commercial payor audits, steps to respond to audits, and challenge improper denials and appeals strategies are all critical skills that healthcare providers and their legal counsel should develop.

The following outlines the key types of commercial audits and the corresponding appeals processes that Michigan healthcare providers often encounter. In addition, the following addresses key strategies for preparing for an audit, responding to an audit and strategic tactics to employ in the event of unfavorable claim denials. While every audit and subsequent appeal will have a unique set of circumstances understanding the basic strategies is important for both healthcare providers and their legal counsel.

BLUE CROSS BLUE SHIELD OF MICHIGAN AUDITS AND APPEALS PROCESS

A healthcare provider's claims for medical services may be audited by Blue Cross Blue Shield of Michigan ("BCBSM") for a number of reasons. Some audits are a result of random selection. Others result from data analysis that reflects that the provider may be outside the norm among their peers in the provision of services. Audits may also arise from complaints by individuals including patients, disgruntled employees, and competitors about the provider's billing practices. Regardless of the initial reason for the audit, it is very important for the provider to appeal the audit results in conformance with the BCBSM Disputes and Appeals process. This process is currently contained in addendums to BCBSM's practitioner participation agreements made publically available on BCBSM's website as well

as in policy materials accessed through BCBSM's provider portal (more commonly known as "web-DENIS"). Failure to adhere to this contractually set forth process can lead to unnecessary overpayments, continuing problems with the ongoing submission of claims, subsequent audits, placement on pre-payment utilization review, or termination/disaffiliation from BCBSM programs.

I. BCBSM Audit Overview

In typical cases, the provider becomes aware of a BCBSM audit through notification requesting that the provider send copies of identified medical records to BCBSM or through notification that BCBSM will be performing an on-site review of medical records (which may or may not be identified beforehand). Upon completion of the record review, BCBSM will notify the provider that the claims are either payable, partially payable, or denied. The most common denials, by way of example, are denials based on lack of medical necessity to support the claim, pre-certification program rejections relating to length of stay or appropriateness of treatment setting, and recovery demands involving requests for repayment related to services unsupported by the documented medical record.

II. BCBSM Appeals Process¹

A. Step One: Written Complaint

When BCBSM sends a provider a post-payment audit denial letter, the letter will make an overpayment demand and provide a time frame for recovery of the overpayment. After receiving the audit results, providers must be careful to timely exercise their contractual appeal rights. The provider must begin this process by submitting a Written Complaint to BCBSM regarding the nature of the dispute.

In addition to defending the audit on the substantive merits in the Written Complaint, which may include providing written medical summaries of the claims at issue focusing on the services that were denied and the medical explanation for why the services were medically necessary (this may involve retaining a physician expert in some cases), providers may also take advantage of other legal defenses

including: challenging the statistical sampling in audits involving extrapolation (this will usually entail retention of a statistical expert); arguing that BCBSM violated various provisions of PA 350 of 1980 and the accompanying administrative code regulations in conducting the audit and in making its denials (this law is BCBSM's enabling legislation and sets forth many prohibitions and mandatory requirements that BCBSM must follow); and challenging denials based on lack of BCBSM policies or notice to the provider community or failure of BCBSM to follow its' own published policies.

B. Step Two: Informal Conference

BCBSM must then issue a Written Response to the provider within 30 days from the Written Complaint that details all of the reasons for BCBSM's decision. Providers that are dissatisfied with the explanation in BCBSM's Written Response must submit a Notice of Dispute requesting an informal conference within 60 days of receiving that written response. Within 30 days from the provider's request, BCBSM will schedule an informal conference. This conference may be held in-person or over the telephone. The purpose of the informal conference is to discuss the audit results in an informal setting and to explore a possible resolution of the dispute. If the dispute involves medical-related matters then a BCBSM consulting doctor will participate in the conference. Likewise, if the dispute is non-medical in nature, other appropriate BCBSM employees will attend.

Within 10 days following the conclusion of the informal conference, BCBSM will issue the provider with a decision. This decision or "Post-Conference Statement" must include a proposed resolution, the facts and supporting documentation on which the proposed resolution is based, and the specific section or sections of the law, contract, or other written policy or documented on which the proposed resolution is based.

C. Step Three: Independent Third Party Determination

Within 120 days after receipt of BCBSM's Post-Conference Statement, the provider will have the right to appeal BCBSM's proposed resolution to an external review body. The provider has the right to

appeal BCBSM's decision by either submitting a Request for Review by an External Peer Review Organization or initiating litigation and seeking judicial review of the dispute. Importantly, if the provider elects judicial review for resolution of the dispute then any right to review by an External Peer Review Organization is waived.

1. Review by External Peer Review Organization

Review by an External Peer Review Organization is an alternative to judicial resolution. However, once a provider initiates this external review process, the provider is required to complete it prior to seeking judicial resolution. An External Peer Review Organization includes Physician's Review Organization of Michigan ("PROM") or any other independent review organization ("IRO") approved by the Director of the Michigan Department of Insurance and Financial Services as eligible to be assigned to conduct external reviews for members under the Patient's Right to Independent Review Act (PRIRA).²

The Review Organization will base its decision upon written materials and any records submitted by the parties. Within thirty (30) days of the receipt of the written materials the Review Organization must issue its determination.

2. Judicial Resolution

If either the provider or BCBSM is dissatisfied with the Review Organization's determination, they may then seek judicial review of the dispute. As stated above, the provider may also seek judicial review at the conclusion of Step Two in this contractual process in lieu of the Review Organization stage. In making that decision, the provider should be aware that a finding or determination by PROM/IRO on an issue of medical necessity is given due deference and a court may not substitute its judgment for that of the PROM/IRO, if it is reasonable and absent credible conflicting evidence.

III. Blue Care Network Health Maintenance Organization Appeals Process

Blue Care Network ("BCN"), a subsidiary of BCBSM, provides different appeals processes for certain types of claim denials for health maintenance organization ("HMO") plans. The appeals process

for claim denials under BCN's HMO commercial plans are more plan-friendly in that providers are not afforded an external appeal level. Furthermore, a provider's appeal rights vary depending on whether the provider is appealing care management decision (medical necessity or administrative denials) or clinical editing denials, as outlined below.

A. Appealing Medical Necessity Denials

Medical necessity denials are made by plan medical directors based on medical record reviews, information from the attending and primary care physicians, clinical judgement of the medical director, and the member's benefit coverage considerations. The process for appealing care management decisions is a two-step process, both of which are internal.

"Level One" appeals must be submitted in writing to BCN within 45 calendar days from the date of the written denial notification and should include any additional clarifying clinical information to support the denial being overturned. Once the appeal request and supporting documentation are received, BCN has 30 calendar days to notify the provider of its decision.³

If the Level One decision is unfavorable, the provider may submit a "Level Two" appeal request within 21 calendar days from the date of the Level One appeal decision.⁴ Similar to Level One, Level Two is conducted as a written internal appeal. A Level Two appeal enables the provider another opportunity to submit new or clarifying clinical information. In addition, providers have the option to request that the Level Two appeal be performed by a different BCN physician reviewer from the physician who reviewed the appeal at Level One.⁵ Providers seeking a different physician reviewer must include a clear statement in the written appeal indicating such request.⁶ Following receipt of the provider's Level Two appeal submission, BCN has 45 calendar days to issue its Level Two decision. Once issued, the Level Two decision is final, and the provider has no further appeal rights.⁷

B. Appeal Administrative Denials

Administrative denials are not based on the medical necessity of care, and can be issued by BCN without the need for review by a plan medical director.⁸ Rather, BCN makes administrative denial determinations pursuant to administrative policies and/or contract language (e.g., noncompliance with clinical review requirements for elective procedures requiring pre-approval by BCN).⁹ For administrative denials, providers are only afforded one level of appeal, which is conducted as an internal written appeal. Providers must submit the written appeal request within 45 calendar days of receiving the denial.¹⁰ BCN will review the information submitted and issue its decision within 30 calendar days of receiving the written appeal request.¹¹ Once issued, the decision is final, and the provider has no further appeal rights except in cases where the administrative denial is overturned but a subsequent determination is made whereby BCN denies the claim based on medical necessity-related grounds. In this case, the provider would be eligible to appeal under the process described in the previous section.¹²

C. Appealing Clinical Editing Denials

Additional claim denials are made by BCN on an automated basis through the use of clinical editing software that compares the procedures codes billed by providers against nationally accepted coding and billing standards to verify clinical appropriateness and data accuracy.¹³ Common reasons for which providers receive clinical editing denials include, but are not limited to, unbundling of services, duplicate claims, unlisted codes, invalid modifiers, incidental or mutually exclusive procedures, and up-coding.¹⁴

Similar to administrative denial appeals discussed in the previous section, BCN only provides one level of appeal in connection with clinical editing denials.¹⁵ However, prior to initiating the appeals process, BCN recommends that providers should first review the denial code listed on the denied claim because in some cases BCN will indicate on the claim that the provider needs to correct the applicable defects and resubmit the claim.¹⁶ If correcting and resubmitting the claim is not an available option, providers have 180 days from the date of the claim denial to submit a written appeal using BCN's

“Clinical Editing Appeal Form.”¹⁷ BCN will review the information submitted and issue a final decision within 30 days of receiving the appeal request.¹⁸

PATIENT’S RIGHT TO INDEPENDENT REVIEW ACT

Another avenue to pursue a commercial appeal is to make use of Michigan’s Patient’s Right to Independent Review Act (“PRIRA”).¹⁹ A statute originally enacted in 2000, PRIRA affords a “covered person,”²⁰ defined as a policyholder, subscriber, member, enrollee, or other individual participating in a health benefit plan,²¹ the right to request an external review of an adverse determination²² by a commercial carrier, referred to as a “health carrier” in PRIRA.²³ PRIRA provides the covered person the opportunity for review of the written record by an independent review organization (“IRO”), which makes a recommendation to the Director of the Department of Insurance and Financial Services.²⁴ While the external review is on a written record and does not allow an opportunity for oral advocacy to the IRO or the Director, it provides essentially a *de novo* review since by statute the reviewing entity is not bound by any decisions or conclusions of the health carrier’s utilization review process or internal grievance process.²⁵

I. Covered Person’s Right to Request External Review

PRIRA requires that a commercial carrier give proper notice to a covered person of his right to request external review. At the time the commercial carrier sends written notice of the adverse determination to the covered person, it must provide written notice of the internal grievance and external review processes.²⁶ The written notice of the right to request an external review of an adverse determination issued before the service is provided must include several elements.²⁷ For example, the notice must inform the covered person of the ability under certain conditions to file a request for expedited external review at the same time the covered person files a request for expedited internal grievance.²⁸ It also has to inform the covered person that if the health carrier has not timely issued a written decision or agreed to a delay, the covered person may file the request for external review and be

considered to have exhausted the internal grievance process.²⁹ Third, the covered person must be notified that the health carrier may waive its internal grievance process and the exhaustion requirement.³⁰ Fourth, the notice must state that the internal grievance process is considered exhausted if the health carrier fails to comply with the requirements of the process, unless that failure are based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the covered person. MCL 550.1907(3)(a)(iv). In addition to this information, the written notice must include a copy of the description of both the standard and expedited external review procedures that highlights the covered person's opportunity to submit additional information in the external review process and includes any forms used to process and external review.³¹ Included with any forms provided with the written notice must be an authorization form or other document approved by the Director that allows the covered person to authorize the health carrier and health care provider to disclose protected health information³² and medical records that are pertinent to the external review.³³

PRIRA grants a cover person the right to request external review of an adverse determination if the covered person has exhausted the health carrier's internal grievance process or if the exhaustion requirement is waived under circumstances outlined in PRIRA.³⁴ After December 31, 2016, within 120 days after date of receipt of a notice of an adverse determination, the covered person may file the request for external review.³⁵ Except for requests for expedited review, all external review requests must be made in writing.³⁶ The Director must conduct a preliminary review of the request within 5 business days of receiving the request.³⁷ This preliminary review confirms: (1) whether the individual is or was a covered person in the health benefit plan at the time the health care service³⁸ was requested or, if the request involves a retrospective review, was a covered person at the time the health care service was provided; (2) whether the health care service reasonably appears to be a covered service under the health benefit plan; (3) whether the covered person has exhausted the internal grievance process, unless exhaustion is not required; (4) whether the covered person has provided all the information and forms required by the

Director that are necessary to process an external review, including a health information release form; and (5) whether the health care service appears to involve issues of medical necessity or clinical review criteria.³⁹

After conducting the preliminary review, the Director must immediately provide written notice to the covered person whether the request is complete and whether it has been accepted for external review.⁴⁰ If the request is accepted, the written notice to the covered person must include a statement that the covered person has 7 business days following the date of the notice to submit any additional information and supporting documentation that the reviewing entity will consider during the external review.⁴¹ The Director must also immediately notify the health carrier in writing of the acceptance of the request for external review.⁴² If the request is not accepted due to incompleteness, the Director is required to notify the covered person of the information needed to complete the request, and the covered person has 30 days from the date of receipt of the notification to provide the needed information.⁴³ If the Director does not accept the request, the written notice rejecting the request must state the reasons it was not accepted.⁴⁴

Depending on the nature of the adverse determination, it will be reviewed either by an IRO or by the Director.⁴⁵ Where the request for external review appears to involve issues of medical necessity or clinical review criteria, the Director must assign review to an approved IRO at the time the request is accepted for external review.⁴⁶ The IRO will provide the Director with a written recommendation whether to uphold or reverse the adverse determination, in accordance with the process outlined below.⁴⁷

If the Director accepts the request and it appears to only involve purely contractual provisions such as covered benefits or accuracy of coding and not issues of medical necessity, the Director may at her option, assign an IRO or keep the request and conduct the external review herself.⁴⁸ If the latter, the Director is required to follow the same statutory time frames and procedural requirements imposed on the IRO.⁴⁹ The Director is required to assign the request immediately to an IRO, even if she initially decided

to review the request, if at any time during her review she determines that the request involves issues of medical necessity.⁵⁰

Within 7 business days of the health carrier receiving the notice of acceptance of a request for external review referred to above, the health carrier or its designee utilization review organization⁵¹ is required to provide the reviewing entity the documents and any information that was considered in making the adverse determination.⁵² Failure to timely provide this information will not delay the external review.⁵³ If the IRO notifies the Director that the health carrier or its designee utilization review organization has failed to timely provide this information, the Director may terminate the external review and make a decision to reverse the adverse determination and immediately notify the IRO, the covered person, and the health carrier of the decision.⁵⁴ At any time during the external review process, the health carrier is permitted to reconsider its adverse determination.⁵⁵ Its reconsideration will not delay or terminate the external review process.⁵⁶ If the health carrier decides to reverse its decision, it must immediately notify in writing the covered person, the IRO, and the Director of its decision, and upon receipt of the notice the reviewing entity will terminate its review.⁵⁷

II. The External Review Process

In the review process, the reviewing entity is required to review all of the information received from the health carrier and any information provided by the covered person.⁵⁸ As noted earlier, it is not bound by any decisions or conclusions of the health carrier's utilization review process or internal grievance process.⁵⁹ It may also consider, if appropriate and available, other sources of information.⁶⁰ This includes (1) the covered person's pertinent medical records, (2) the attending health care professional's recommendation, (3) consulting reports from appropriate health care professionals and other documents submitted by the health carrier or the covered person, (4) the terms of coverage under the covered person's health benefit plan, (5) the most appropriate practice guidelines, such as generally accepted practice guidelines, evidence-based practice guidelines, or any other practice guidelines

developed by the federal government or national or professional medical societies, boards, and associations, and (5) any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization.⁶¹

The IRO must provide its recommendation to the Director within 14 days after its assignment by the Director.⁶² The recommendation must include a number of required elements, including (1) a general description of the reason for the request for external review; (2) the date the IRO received the assignment from the director to conduct the external review; (3) the date the external review was conducted; (4) the date of the IRO's recommendation; (5) the principal reason or reasons for its recommendation; (6) the rationale for its recommendation; (7) references to the evidence or documentation, including the practice guidelines, considered in reaching the recommendation.⁶³ Immediately upon receipt of the IRO's recommendation, the Director will review the recommendation to ensure it is not contrary to the terms of coverage under the health benefit plan.⁶⁴

The Director, within 7 business days of receipt of the IRO's recommendation, must also provide written notice to the covered person of her decision to uphold or reverse the adverse determination.⁶⁵ Included in the notice must be the principal reason or reasons for the decision along with the information provided by the IRO in its recommendation.⁶⁶ If relevant, the notice must articulate the principal reason or reasons why the director did not follow the IRO's recommendation.⁶⁷ The health carrier must immediately approve coverage upon receipt of the Director's written notice, if the Director's notice reversed the adverse determination.⁶⁸

III. Special Circumstances Recognized by PRIRA: Experimental or Investigational Services or Treatments

PRIRA gives special attention to requests for external review that involve issues of experimental or investigational services or treatments.⁶⁹ For requests for external review involving these issues, during the preliminary review process the Director must make a number of important determinations.⁷⁰ In

addition to the general considerations discussed earlier, she must consider whether the service is a covered benefit under the health benefit plan except for the health carrier's determination that the service or treatment is experimental or investigational.⁷¹ The Director must determine that the service is not explicitly listed as an excluded benefit under the health benefit plan.⁷² Next, she will evaluate whether the covered person's treating provider has certified one or more of the following: (1) that standard health care services or treatments have not been effective in improving the condition of the covered person; (2) that standard services or treatments are not medically appropriate, or (3) there is no available standard health care service or treatment covered by the health carrier that is more beneficial than the recommended or requested health care service.⁷³ The request also must include evidence that the treating provider has either: (1) recommended a health care service or treatment that the treating provider certifies in writing is likely to be more beneficial to the covered person, in the provider's opinion, than any available standard service or treatment, or (2) if the treating provider is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat the covered person's condition, certified in writing that scientifically valid studies using accepted protocols demonstrate that the service or treatment is likely to be more beneficial than any available standard service or treatment.⁷⁴

When the IRO provides its written recommendation involving issues of experimental or investigational services or treatments, there are items it must additionally consider under PRIRA.⁷⁵ It must consider if the FDA has approved the requested or recommended service or treatment for the condition.⁷⁶ It must also consider if medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested service or treatment "are more likely than not to be more beneficial to the covered person" than the benefits of any available standard health care service or treatment, and that the adverse risks of the recommended or requested service or treatment would not be substantially increased over those of available standard health care services or treatments.⁷⁷ "Medical or scientific evidence" and "evidence-based standards" are both terms defined by

PRIRA. The former definition contains an extensive list of categories of acceptable sources that includes evidence found in sources such as published peer-reviewed scientific studies, peer-reviewed medical literature, and standard reference compendia.⁷⁸ The latter is defined as “the conscientious, explicit, and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients.”⁷⁹ When framing a request for external review involving an issue of experimental or investigational service, it is important to consider what evidence can be compiled to support the services and whether it satisfies these statutory standards.

IV. Special Circumstances Identified by PRIRA: Expedited External Review Process

In addition to the standard process discussed above, PRIRA also offers an expedited external review process for situations where (1) the normal time frame for review “would seriously jeopardize the life or health of the covered person or would jeopardize the covered person’s ability to regain maximum function as substantiated by a physician either orally or in writing,” and (2) the covered person has filed a request for an expedited internal grievance.⁸⁰ The request for expedited external review must be made within 10 days of receiving the adverse determination.⁸¹ Although the standards are substantially similar to the normal review process, the time frames for processing the expedited review are significantly compressed.⁸² The Director is required to give immediate notice to the health carrier, and assign an IRO if it determines the reviewability requirements, discussed above, are met.⁸³ The health carrier has 12 hours to provide the necessary documents and information to the assigned IRO, which it can accomplish by any expeditious method including by telephone, fax or e-mail.⁸⁴ The IRO may consider the same additional categories of information as in the standard external review process if that information is available and appropriate, including cases that involve issues of experimental or investigational services or treatment.⁸⁵ The IRO must deliver its recommendation to the Director no later than 36 hours from the date the Director received the request for expedited review.⁸⁶ As with the standard external review process, the IRO is not bound by any decisions or conclusions of the health carrier’s utilization review

process or internal grievance process.⁸⁷ After immediately reviewing the recommendation to ensure that it is not contrary to the terms of coverage under the health benefit plan, the Director then has no more than 24 hours to complete her review of the IRO's recommendation and notify the covered person whether to uphold or reverse the adverse determination.⁸⁸ The health carrier must immediately approve coverage upon receipt of the Director's written notice, if the Director's notice reversed the adverse determination.⁸⁹

V. Appeal Rights Following External Review

Although the Director's decision is the final administrative remedy available under PRIRA, a person aggrieved by the decision may seek judicial review no later than 60 days from the date of the decision.⁹⁰ The appropriate venue for appealing the decision is the circuit court where the covered person resides or in Ingham County Circuit Court.⁹¹ As the decision is a final decision of an agency, the aggrieved party may file a claim of appeal as of right.⁹² Because the time limit for filing an appeal of right is jurisdictional, it is critical to be aware of and meet the 60 day deadline.⁹³ The aggrieved party must timely file an appeal of right in the form and content prescribed by the Michigan Court Rules and include all other required documents.⁹⁴ In addition to considering the general requirements of MCR 7.104, the appealing party should consult Subchapter 7.100 of the Michigan Court Rules, which contains specific provisions governing circuit court appeals of final agency decisions.⁹⁵ The Director will be required to file the administrative record with the circuit court.⁹⁶ Once the claim of appeal is filed, the Court Rules will dictate the time frame for briefing and argument.⁹⁷ Notably, the Director's decision does not preclude the health carrier from seeking other remedies under applicable state law, or the covered person from seeking other remedies under applicable federal or state law.⁹⁸ Review of a final decision by the Director is limited to determining whether the decision was authorized by law, which the Michigan Court of Appeals has held would exist when the decision is "in violation of statute [or constitution], in

excess of the statutory authority or jurisdiction of the agency, made upon unlawful procedures resulting in material prejudice, or is arbitrary and capricious.”⁹⁹

Strategically, there are some limitations to PRIRA, but also some advantages that a provider or its counsel should weigh. As mentioned, the external review is on a written record and does not allow an opportunity for oral advocacy to the IRO or the Director. Because the statute gives the right to request external review to the covered person, it is not a right directly given to the provider. There would need to be some coordination between the covered person and the provider to use PRIRA as a vehicle to challenge an adverse determination. Judicial review of the Director’s decision is limited and not under a de novo standard, so any appeal of the decision must consider the strength of the record developed in the external review process and evaluation whether the decision was in some other way not authorized by law.

The advantages of PRIRA are several. PRIRA operates under strict deadlines and time frames that can lead to a relatively swift decision by the Director. Further, if some thought is given to using PRIRA, the requesting party can take the opportunity to assemble all of the relevant information and documentation, as well as supporting medical or scientific evidence, to build an effective and persuasive case for the IRO, and the Director. This evidence could include declarations from medical experts, peer-reviewed scientific studies and medical literature, medical journals, and applicable standard reference sources. PRIRA also provides essentially a de novo review since by statute the reviewing entity is not bound by any decisions or conclusions of the health carrier’s utilization review process or internal grievance process. Thus, there is no deference owed to the health carrier. Finally, exercising rights under PRIRA does not prohibit the pursuit of other remedies available under state and federal law.

STRATEGIC APPROACHES FOR COMMERCIAL AUDITS AND APPEALS

Regardless of the commercial payor or the avenues for challenging claim denials there are important strategic approaches that all providers facing a commercial audit must consider when preparing

for a commercial audit and appealing subsequent denials. Providers challenging adverse determinations from audits must take into account the payor's contractual language and published guidelines. Furthermore, various state statutory bases may also be applicable to defend the denied claims. Finally, it is essential that providers consider retention of independent experts to provide additional support throughout the appeals process for the claims that are subject to an audit and any claims that are subsequently denied by the payor.

I. Payor Documentation Criteria for Defending Claims

There are a variety of documentation requirements that providers should consider and incorporate into the audit and appeals process. For example, providers that are in-network with the commercial payor either requesting the medical records or denying the claims at issue must consider the in-network contractual language and any additional administrative guides or documentation incorporated by reference into the provider's contract with the payor. For example, many in-network contracts will outline the audit and appeals process or at least reference additional materials that contain essential information regarding the audits and appeals process. It is crucial that providers familiarize themselves with the content of this information as it will include important information regarding deadlines and the appeals process. Appeals processes will differ depending upon the commercial payor and, thus, deadlines will differ as well. A thorough understanding of the audit and appeals process will serve providers well in being thoroughly prepared in the event of an audit and subsequent adverse determinations. In some cases, the information regarding deadlines and the appropriate appeals process may not be clearly outlined and providers should work with legal counsel to contact the commercial carrier to obtain this information. Only with the appropriate information will a provider know (a) its responsibilities pertaining to audit and appeal deadlines and (b) whether the commercial payor audit and appeals process complies with the contractual requirements outlined in the provider's contract or other relevant material.

In addition to the audit and appeals process deadlines and procedures binding contractual language is important for in-network providers regarding specific audit procedures such as statistical extrapolation and sampling criteria. In-network contractual language and/or policies incorporated by reference in the contract should provide the criteria by which the statistical extrapolation and sampling is conducted by the commercial payor. This information is very important for reviewing whether the commercial payor properly executed the statistical extrapolation and sampling and to hold the commercial carrier accountable to these standards.

Documentation requirements outlined in the contractual language also provide important substantive information regarding the criteria for providing services to patients and which will be the guiding principles for evaluating the substantive issues involved in the claims. In addition to contractual language for in-network providers, other important documentation guidelines include policies made available through the websites and provider portals. The guidelines will apply to any provider billing the commercial payor, whether they are in-network or out of network. As will be discussed in more detail below, it is important for providers to be aware of these policies as part of their compliance processes. However, the policies are integral aspects to respond to an audit and preparing appeals of denied claims. Types of policies that providers should take into consideration include service-specific policies that address the documentation and other requirements for rendering a specific service. These policies would likely include information regarding accepted indications for a service, medical necessity requirements and documentation requirements to demonstrate that the services provided were appropriate pursuant to the language in the policy. In addition to knowing the substance of the policy, it is critical for providers to also take into consideration the effective dates of policies and their revision history. In our experience, commercial payors may attempt to apply policies that were in effect after the services at issue were provided or apply outdated policies. Being attentive to effective and revision dates is an essential strategy

for providers to take into account when responding to an audit and defending claims denied through an appeals process.

In addition to policies, other important documentation elements that providers should consider include any published materials made available by the commercial payor. For example, commercial payors often publish regular newsletters or bulletins that outline updates to policies. In representing providers through commercial audits and appeals processes we have utilized these newsletters and bulletins to effectively argue improper application of policies due to the effective date of the policies or revisions. Furthermore, newsletter and bulletins are valuable tools for providers to remain informed regarding notice of new policies or revisions to existing policies that may alter providers' practices for rendering services or documenting the medical necessity of services.

Finally, commercial payors may also have provider manuals that outline general information applicable to all provider-types and services. Providers should also be aware of these general provider manuals to incorporate into their preparation of audits and appeals documentation.

II. Responding to Audits and Defending Claims through Commercial Payors' Appeals Processes

While a thorough understanding of the various contractual and non-contractual language is essential for any provider to effectively respond to a commercial payor's audit and proceed through the appeals process, there are also important tools that are helpful strategic methods for preparing an audit and/or appeal.

Providers should respond to audit requests as thoroughly as possible with a goal to presenting the documentation in a manner that renders it as easy as possible for the commercial payor to review and agree that the services were provided appropriately. With this goal in mind, there are specific strategies that providers may consider in responding to an audit. For example, upon receipt of an audit request from a commercial payor a provider should carefully review the claims requested and consider retaining an

independent expert to review the claims to provide narrative support for submission with the documentation to the commercial payor. The type of expert will depend upon the claims at issue. For example, if evaluation and management (“E/M”) codes are the focus of the audit request the provider may consider retaining a coding expert to review the claims and provide an independent report outlining that the services were properly coded. Other experts that a provider may consider retaining are those with expertise in the specific field to review the provider’s services and draft narrative reports outlining the support for the services provided. Expert support is an important component to responding to an audit as it often provides the reviewer with a “roadmap” to reviewing the medical documentation requested and correctly concluding that a service was provided appropriately. Furthermore, in the event of a claim denial already having an expert involved in the case is helpful for proactively preparing for the appeals process.

Another expert to consider retaining in the event of claim denials that result in a statistical extrapolation is a statistician to review the commercial payor’s documentation pertaining to the statistical sampling and extrapolation. A statistical sampling and extrapolation over a universe of claims during a specific period of time often significantly changes the impact an audit may have on an individual provider. While the sample actual denial amount may be bearable, if extrapolated over a significant period of time it could have devastating impact on a provider’s practice. As such, retaining a qualified statistician to review the commercial payor’s data and statistical extrapolation methods is an essential component to the appeals process. At times, commercial payors may insist that the statistical sampling and extrapolation is outside the scope of the “substantive appeals process” that only addresses the specific claim denial issues (e.g. medical necessity or coding). However, statistical extrapolation has a profound impact on the ultimate amount at issue in an audit and unless the commercial payor is willing to drop the extrapolation, the commercial payor must provide all relevant information to the provider pertaining to the statistical extrapolation so that it may be independently analyzed and tested by the provider’s expert.

Although the statistician's challenges may not result in the commercial payor reversing its findings during the internal appeals process, an analysis challenging extrapolation and sampling methods may be very effective before an independent appeals reviewer and/or a judge.

In addition to addressing the merits of the audit denials through expert reports, it is also appropriate strategy to submit a substantive position paper or brief that outlines general arguments defending the claims as billed and challenging any denials. The position paper should summarize the provider's positions challenging the audit claim denial. In appeals where there are several claims at issue, the position paper may address the general substantive issues and refer to exhibits where the specific claims are addressed in greater detail. Alternatively, a position paper could be drafted for each specific claim with the issues of each claim addressed in detail.

While a position paper is a beneficial tool for outlining support for the claims at issue, it is also an important tool for outlining any available legal arguments for challenging the claim denials. For example, there are state law challenges that may be helpful to outline in a position paper to fortify the other substantive challenges to the claim denials. A thorough understanding and research into applicable state law could be beneficial to a fully developed position paper.

III. Prospective Compliance with Providers Following Audits

While providers should be engaged in prospective compliance on a regular basis regardless of audit activity from commercial payors following an audit providers should consider engaging in additional compliance. Where an audit results in adverse claim denials a provider may disagree with the auditor's findings and determine that appealing the denials is an appropriate next step. However, even if a provider disagrees with the claim denials prospective compliance is still a worthwhile next step to consider.

Prospective compliance includes a number of actions that providers should consider instituting in their regular compliance programs. For example, as discussed above in reference to responding to or

appealing an audit, as part of compliance programs a provider should regularly gather, review and maintain commercial payor policies and guidelines that relate to the provider's practice. The provider's compliance program should identify regular intervals for the policies to be reviewed to determine if the payor has made any changes and update the provider's practices accordingly.

In addition to regularly reviewing policies and other materials published by commercial payors, an audit as an excellent opportunity for providers to consider retaining independent experts to engage in a pre-billing prospective educational audit. Depending upon the volume of the provider's practice, an appropriate and representative number of claims should be selected for review by the independent expert before the claims are submitted for payment. We recommend that our clients work with legal counsel in retaining independent experts and maintain that all communication with independent experts occur within the attorney-client relationship.

Prospective compliance should be integrated in all providers' normal policies and procedures, but experiencing an audit reaffirms the importance of regular compliance activities. A thorough compliance program that includes, but is not limited, to the suggestions discussed herein is a critical component to the provider's practice that should not be overlooked or ignored.

CONCLUSION

Michigan healthcare providers and their legal counsel are tasked with the responsibility of remaining up to date on the evolving commercial audit and appeals processes. Providers should be aware of the various components to different payor's auditing processes and implement proactive strategies to be prepared when presented with a commercial audit. Furthermore, provider's proactive readiness for commercial audits will also likely increase their ability to withstand an audit and preserve through appeals of any denied claims. Being well informed of the various appeals options and critical strategies in approaching an audit or an appeal will help providers successfully withstand a commercial audit and the subsequent appeals process.

¹ The information contained in this section is set forth in BCBSM's Provider Participation Agreement, Addendum E. *See also*, BCBSM Provider Manual Chapter: Appeals and Problem Resolution (April 2, 2017).

² MCL 550.1901 *et seq.*

³ BCN Provider Manual, Chapter 8 (Care Management), at 71 (January 2017).

⁴ *Id.*

⁵ *Id.*

⁶ *Id.*

⁷ *Id.*

⁸ *Id.* at 72.

⁹ *Id.*

¹⁰ *Id.*

¹¹ *Id.*

¹² *Id.*

¹³ BCN Provider Manual, Chapter 14 (Claims), at 71 (January 2017).

¹⁴ *Id.* at 71-73.

¹⁵ *Id.* at 75.

¹⁶ *Id.* at 74.

¹⁷ *Id.* at 75.

¹⁸ *Id.* at 74.

¹⁹ MCL 550.1901 *et seq.* Excluded from the scope of PRIRA are, for example, policies that provide coverage only for specified accident or accident-only coverage, credit, disability income, hospital indemnity, long-term care insurance, or any other limited supplemental benefit other than specified disease, dental, vision care, or care provided pursuant to a system of health care delivery and financing operating under section 3573 of the insurance code of 1956, Medicare supplemental policies, coverage under a Medicare plan, the federal employees health benefits program, worker's disability compensation, or automobile medical-payment insurance. MCL 550.1905.

²⁰ MCL 550.1903(i). Throughout, PRIRA extends the right to an external review to the covered person or the covered person's authorized representative. An "authorized representative" means (1) a person to whom a covered person has given express written consent to represent the covered person in an external review; (2) a person authorized by law to provide substituted consent for a covered person, or (3) if the covered person is unable to provide consent, a family member of the covered person or the covered person's treating health care professional. MCL 550.1903(c). In the interest of clarity, this white paper will refer generally to the "covered person" as inclusive of both the covered person and any authorized representative, where applicable.

²¹ A health benefit plan is a "policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of covered health care services." MCL 550.1903(r).

²² PRIRA uses the terms "adverse determination" and "final adverse determination." An adverse determination is "a determination by a health carrier that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and, based on the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness," and that results in the denial, reduction, or termination of that requested service. MCL 550.1903(a). The health carrier's failure to respond to a request for a determination in a timely manner is considered an adverse determination. *Id.* A final adverse determination is simply an adverse determination that has been upheld through the health carrier's internal grievance process. MCL 550.1903(q).

²³ A health carrier is a person, which is a general term defined to include a corporation, partnership, or similar entity, that is subject to Michigan's insurance law and regulations or the jurisdiction of the Director that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. MCL 550.1903(v).

²⁴ PRIRA gives the Director the responsibility to approve IROs who are eligible to conduct external reviews, with each approval period to be effective for 2 years. See MCL 550.1917. PRIRA also establishes minimum standards

that an IRO must satisfy in order to be approved by the Director. See MCL 550.1919. An IRO and the clinical peer reviewer is shielded from damages for any opinions rendered during or upon completion of an external review conducted under PRIRA, unless the opinion was rendered in bad faith or involved gross negligence. MCL 550.1921. PRIRA also imposes timeframes on the IRO for maintaining records. MCL 550.1923.

²⁵ MCL 550.1911(9). The Michigan Court of Appeals has upheld challenges to PRIRA and held that it satisfies due process requirements. See *English v. Blue Cross Blue Shield*, 263 Mich. App. 449, 688 N.W.2d 523 (2004).

²⁶ MCL 550.1907(1). Any written notice required under PRIRA must be provided in a culturally and linguistically appropriate manner, as required by 45 CFR 147.136(b)(2)(ii)(E). These federal regulations require, for applicable non-English languages, providing (1) oral language services, such as a telephone customer assistance hotline that includes answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including external review) in any applicable non-English language; (2) upon request a notice in any applicable non-English language; and (3) include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services. See 45 CFR 147.136(e). Federal regulations define an “applicable non-English language” as a non-English language if ten percent or more of the population residing in the United States county is literate only in the same non-English language, as determined in guidance published by the Secretary of HHS. 45 CFR 147.136(e)(3). A health carrier may satisfy delivery of notice to a covered person using electronic media that complies with federal regulations found at 29 CFR 2520.104b-1(c). MCL 550.1909(3). A description of the internal grievance and external review procedures must also be included in or attached to the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage it provides to the covered person. MCL 550.1925(1). This description must include a statement informing the covered person of the right to request the grievance or review, the Director’s toll-free telephone number and address, and a statement that when filing the request for external review the covered person will be required to authorize the release of any medical records that may be required in order to reach a decision on the review. MCL 550.1925(2).

²⁷ MCL 550.1907(3). For an adverse determination issued after the service was provided, the written notice of the right to request an external review must include the standard external review procedures information required under MCL 550.1907(3) and be provided in the manner prescribed by the Director. MCL 550.1907(4).

²⁸ MCL 550.1907(3)(a)(i).

²⁹ MCL 550.1907(3)(a)(ii).

³⁰ MCL 550.1907(3)(a)(iii).

³¹ MCL 550.1907(3)(b).

³² PRIRA includes its own definition of protected health information, which it defines, in terms conceptually similar to HIPAA, as “health information that identifies an individual who is the subject of the information or with respect to which there is a reasonable basis to believe that the information could be used to identify an individual.” MCL 550.1903(bb). “Health information” is “information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to 1 or more of... (i) the past, present, or future physical, mental, or behavioral health or condition of an individual or a member of the individual’s family; (ii) the provision of health care services to an individual; (iii) payment for the provision of health care services to an individual.” MCL 550.1903(w).

³³ MCL 550.1907(3)(c).

³⁴ MCL 550.1907(2).

³⁵ MCL 550.1911(1).

³⁶ MCL 550.1909(1).

³⁷ MCL 550.1911(2).

³⁸ A “health care service” is a service “for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.” MCL 550.1903(u).

³⁹ MCL 550.1911(2)(a)-(e).

⁴⁰ MCL 550.1911(4).

⁴¹ MCL 550.1911(5)(a).

⁴² MCL 550.1911(5)(b).

⁴³ MCL 550.1911(6).

⁴⁴ *Id.*

⁴⁵ MCL 550.1911(7).

⁴⁶ MCL 550.1911(7).

⁴⁷ *Id.*

⁴⁸ MCL 550.1911(8).

⁴⁹ MCL 550.1911(8).

⁵⁰ *Id.*

⁵¹ A utilization review organization is a person that conducts utilization review. MCL 550.1903(ff). Utilization review is defined as “a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings.” MCL 550.1903(ee). Formal techniques can include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review. *Id.* Each of these latter terms is separately defined by PRIRA. See MCL 550.1903(b), (d), (e), (g), (l), (aa), (cc), (dd).

⁵² MCL 550.1911(10).

⁵³ MCL 550.1911(10).

⁵⁴ MCL 550.1911(11).

⁵⁵ MCL 550.1911(13).

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ MCL 550.1911(12).

⁵⁹ MCL 550.1911(9).

⁶⁰ MCL 550.1911(14).

⁶¹ MCL 550.1911(14).

⁶² MCL 550.1911(16).

⁶³ MCL 550.1911(16)(a)-(g).

⁶⁴ MCL 550.1911(17).

⁶⁵ MCL 550.1911(18). If the Director kept the request and did not assign it to an IRO, the written notice to the covered person must be provided within 14 days of the decision to keep the request. *Id.* The Michigan Supreme Court has clarified that an IRO’s recommendation is not binding on the Director. See *Ross v. Blue Care Network*, 480 Mich. 153, 747 N.W.2d 828 (2008).

⁶⁶ MCL 550.1911(18)(a).

⁶⁷ MCL 550.1911(18)(b).

⁶⁸ MCL 550.1911(19).

⁶⁹ See MCL 550.1911(3). In PA 274 of 2016, the Michigan Legislature amended PRIRA, effective September 29, 2016. One of the substantive amendments to PRIRA in this legislation was the addition of sections addressing review of adverse determinations involving experimental or investigational services.

⁷⁰ MCL 550.1911(3).

⁷¹ MCL 550.1911(3)(b)(i).

⁷² MCL 550.1911(3)(b)(ii).

⁷³ MCL 550.1911(3)(c).

⁷⁴ MCL 550.1911(3)(d).

⁷⁵ MCL 550.1911(15).

⁷⁶ MCL 550.1911(15)(a).

⁷⁷ MCL 550.1911(15)(b).

⁷⁸ MCL 550.1903(y).

⁷⁹ MCL 550.1903(n).

⁸⁰ MCL 550.1913(1). This process is not available for retrospective adverse determinations or retrospective final adverse determinations. MCL 550.1913(12).

⁸¹ *Id.* If the covered person has not completed the health carrier's expedited internal grievance process, the IRO must determine immediately after it receives the assignment from the Director whether the covered person will be required to complete the expedited internal grievance before conducting expedited external review. MCL 550.1913(3). If the IRO determines that the expedited internal grievance process must be completed first, the IRO must immediately notify the covered person that it will not proceed with the expedited external review until the internal grievance process is completed. *Id.*

⁸² See generally MCL 550.1913.

⁸³ MCL 550.1913(2).

⁸⁴ MCL 550.1913(5).

⁸⁵ See MCL 550.1913(6), (7).

⁸⁶ MCL 550.1913(8).

⁸⁷ MCL 550.1913(4).

⁸⁸ MCL 550.1913(9), (10).

⁸⁹ MCL 550.1913(11).

⁹⁰ MCL 550.1915(1). By its own terms, PRIRA does not preclude the seeking of other available remedies under applicable state or federal law. MCL 550.1915(2), (3); see also *William Beaumont Hosp. v. Wass*, 315 Mich. App. 392, 397; 889 N.W.2d 745 (2016) (holding that "subsection (3) plainly provides that subsection (1) does not preclude an aggrieved party from pursuing other remedies under state and federal law, which would include the right to bring an original and separate action in circuit court for breach of contract."). Subsection (4) precludes the covered person from filing a subsequent request for external review involving the same adverse determination for which a decision has been received. MCL 550.1915(4).

⁹¹ MCL 550.1915(1).

⁹² MCR 7.103(A).

⁹³ MCR 7.104(A), MCR 7.103(A).

⁹⁴ See MCR 7.104.

⁹⁵ See MCR 7.123.

⁹⁶ MCR 7.109.

⁹⁷ See, e.g., MCR 7.111, MCR 7.212.

⁹⁸ MCL 550.1915(2)-(3). In addition to the Director's role in the external review process, PRIRA also gives the Director authority to punish persons for violations of PRIRA, depending on the nature and gravity of the violations, through the issuance of a cease and desist order, imposition of civil fines, the suspension, limitation or revocation of a license or certificate of authority, and petitioning the circuit court for injunctive relief. See generally MCL 550.1929.

⁹⁹ *English*, 263 Mich App at 455, quoting *Northwestern Nat'l Cas Co v Comm'r of Ins*, 231 Mich App 483, 487-488; 586 NW2d 563 (1998).