Leveling the Playing Field Between Out of Network Providers and Insurance Companies

By Leslie Howard, Esq.

By definition, a "*level playing field"* is a concept about fairness where all players play by the same set of rules. The underlying assumption is transparency and consistency of the rules, their definition, and their interpretation. In other words, a playbook that all players have access to and understand. Unfortunately, in today's reimbursement world for out of network providers (OON), the field is sorely off balance leading to potentially hundreds of thousands of dollars unclaimed and uncollected.

The Players

Insurance Companies – For the most part, insurers are corporate giants with deep pockets that have mastered the art of creating processes on top of processes. A web of red tape at every turn causes members and providers alike to feel stuck and out of control. This is the image of today's insurers. An exaggeration? You be the judge.

Out of Network Providers – Long gone are the days of private practice physicians seeing patients with little concern about insurance reimbursements. Today, being in private practice, and one who is an out of network provider, carries with it huge risks and daily unknowns. Professionals, who were trained to treat patients, but not necessarily run a business, are forced to face-off daily with their large-scale counterparts on matters directly affecting the bottom line. The result? Physicians must manage the rising costs of business in a medical climate they have very little control over. The claims auditing and appeals process itself gets overburdening, and without knowing the specific plan outlined in a patient's Summary Plan Description, providers are unable to take action against claims offers that are unfair and sometimes even downright insulting. Even a large practice rarely has the internal ability and resources to effectively manage this process.

The Playbook

Summary Plan Description – For every health insurance plan that is written there is a Summary Plan Description (SPD) that goes along with it and is given to the member when he/she enrolls. In most cases, it is solely the insurer who interprets and executes the terms in the *Summary Plan Description*, and controls the claims process every step of the way. Therefore, it is ultimately up to them to determine the level of difficulty, clarity, and consistency of each claim handled.

The language in an SPD is typically ambiguous, unclear, and wide open to interpretation. Terms such as "usual and customary," and "allowable amount," are examples of ways insurers keep control of specific claims. The ambiguity allows for interpretation, and usually this interpretation is done solely on the insurer side. For example, what is *usual*

and customary, and who determines that? Further, who determines the *allowable amount* and when can it change?

Why does this keep the claim negotiations one-sided? Because the member rarely keeps or reads the SPD and the provider only has access to it if the member gives him the right. If the provider does not see the SPD they are unable to determine if what the insurer is offering is outside the scope of what is fair for each claim.

The Answer?

With Knowledge Comes Power

ERISA– Most insurance policies are governed under ERISA (Employee Retirement Income Security Act), and therefore have strict regulations regarding disclosure of terms and administration of policies. Specifically, ERISA guarantees each member a full and fair review of plan documents and all evidence, methodology and fee schedules relied upon to determine the reimbursement amount. The key to OON providers receiving more, if not all, of the reimbursement in accordance with each member's policy, is to take a systematic approach and work with the law under ERISA for each claim.

Leveling the Field

Ensure all patients sign a DAR (Designated Authorized Representative) form on initial visit. A critical starting point as this allows the providers to "step into the shoes" of the patient. Without a DAR providers have NO rights, as health insurance is a contractual agreement between the MEMBER and the insurance company. Once signed, however, the provider has all the rights and protections afforded under the patient's policy and the law. By exercising the member's rights under ERISA, providers are able to appeal, negotiate directly, clarify terms, and ultimately hold the insurance companies to the fairest interpretation of the SPD possible under the law.

Exhaust the written appeals process. This process includes all the administrative remedies required before a claim can move on to litigation. It is a tedious process complete with red tape, denials, and delays, and can take six months or longer. Many providers and members give up and accept whatever they are offered at this point – usually well below what they are entitled to.

Request a Summary Plan Description (SPD) - Legal intervention begins with a request for a Summary Plan Description. Providing the SPD is required under ERISA, and a refusal or a delay in doing so has severe fines.

Take Legal Intervention and Action – Once the member's SPD is received, a careful analysis can identify language to be challenged and proven inconsistent. It is these inconsistencies, ambiguities, or buried promises that can lead to a clarification of the terms, a re-evaluation of the current payment, and ultimately a favorable result. Many times claims can be settled prior to litigation with demand letters. However, as a last

resort insurers will be taken to court, many times resulting in a settlement in the early stages of litigation.

No Pain No Gain

Obviously, this sounds simple but can be difficult and sometimes impossible for busy medical practices to implement. Historically, insurers have realized this too and brought in outside help. In many cases it is beneficial for providers to consider doing the same. A designated resource that works specifically on the claims auditing and appeals process and insurer negotiations can keep the process moving to a favorable outcome – ultimately leaving much less money on the table. These resources can work on one or several parts of the process, on current claims, or provide a complete analysis of historical claims with potential benefits.

The only constant in today's medical climate is that things continue to change. Keeping up with the changes, and staying on top of claims processes are critical to maintaining a successful practice. It might be a difficult and sometimes painful part of business, but one that is not going away. The positive impact on the bottom line can be a constant reminder that it is a long-term investment in a difficult business.

Leslie Howard, Esq.

The Law Offices of Cohen & Howard, L.L.P.

Leslie Howard is a founding member of *The Law Offices of Cohen & Howard*, a New Jersey based firm who works with non-participating medical groups (out of network providers) to help drive up reimbursements from insurance companies by focusing on an underutilized area of the law (ERISA). Cohen & Howard has a proven track record of increasing reimbursements through the appeals process, negotiations, litigation, threat of litigation, and settlements, as well as through identifying and resurrecting "old claims" that have been written off. *For further information please contact our offices at: 732-747-5202 or email her directly at lhoward@cohenandhoward.com*