HEALTHCARE REIMBURSEMENT LAW

INSURANCE OR EMPLOYER GROUP HEALTH PLAN REFUND REQUESTS AND RECOUPMENTS

- TGF routinely fights refund demands and protects providers' rights to keep money voluntarily paid by insurers and GHPs
- Often, refund requests and recoupment activities are based on illegal or incorrect retro-denials—TGF can persuade payers that requests are wrong and obtain retractions or cessation of collection efforts
    - Types of issues that may result in improper refund and recoupment activities are outlined below under the heading "Insurance or Group Health Plan Denials"
- Even when a payer had a legitimate reason to deny the claim at the time of payment, the provider is usually entitled to keep the voluntary payments under laws of restitution and equity
- Recoupments create accounting nightmares that cost providers time and money to decipher—TGF works to prevent recoupments before they happen and enforce providers' rights to avoid these expensive consequences

INSURANCE OR EMPLOYER GROUP HEALTH PLAN DENIALS

- Retro-terminations
    - Insurers and GHPs, often acting in concert, verify benefits and coverage prior to a procedure only to later deny claims because the patient's benefits were later terminated retroactive to a date before the service was performed
    - Providers are generally expected to bear the loss created by the failure of communication between the insurer and GHP
    - TGF works to ensure that providers who dutifully verified benefits and complied with all necessary formalities are not forced to bear the cost of these services—when providers do everything right, they should not lose money due to the carelessness of insurers and GHPs

- Usual, Customary, and Reasonable (UCR) Denials
  - When providers render "out of network" benefits, reimbursement is generally limited to the UCR charge
  - In an effort to limit benefits, strong arm providers into entering contracts for reduced reimbursement, and line the pockets of insurance company executives, insurers have **reduced** UCR rates despite increases in costs
  - Providers often accept incredibly low UCR determinations rather than disputing the insurer's partial denial because they can usually balance bill the patient and the insurer's appeals processes are time consuming and difficult to navigate
  - Insurers and GHPs are frequently engaging "expert" repricers and "cost containment" solution companies to determine UCR rates and discourage providers from challenging their conclusions
    - Incredibly, these repricers are often paid more for determining UCR than providers are paid for rendering services
  - TGF has the expertise and resources to appeal erroneous UCR determinations and obtain reimbursement at reasonable rates
  - Insurers and GHPs must follow the terms of their plan documents—and those terms rarely allow for exceptionally low UCR determinations. If the UCR rate seems too low, it probably is
  - TGF expertly enforces providers rights in this area whether the plan is governed by ERISA, state, or other law

- Silent PPOs
  - Silent PPOs are illegal reimbursement tools developed by payers to deceive providers into accepting improper discounts
  - Silent PPOs are often difficult to identify—TGF works with providers to identify these issues and pursue imprudent payers who employ these methods
  - The illegal methods of reimbursement are deserving of special attention because they are not merely abuses of a weakness, but intentionally fraudulent activity
  - TGF aptly turns the tables on these payers by treating the fraudulent "discount" as a UCR denial—which it actually is—creating balance billing liability for the patient
  - By leveraging patient's rights against the payer, TGF works to resolve silent PPO issues directly with the payer and avoids inefficiencies of third party administrators

- COBRA Issues
  - COBRA continuation coverage is governed by very detailed and complex regulations issued by a multitude of government agencies, including the Department of Labor and Internal Revenue Service
  - GHPs must do very specific things when dealing with COBRA beneficiaries
  - TGF stays up to date on these complex regulations and we use these regulations to benefit our clients
  - TGF can pursue balances or work to reinstate coverage when it was improperly terminated
  - We also provide guidance on practices to avoid common pitfalls of COBRA

- Emergency Medical Services
  - Of course, hospitals are required to provide emergency services to individuals who need those services
  - Most states also have laws that require insurers to pay for such services
  - However, because ER services are often expensive, insurers look for ways to deny payment
  - TGF forces insurers to comply with applicable laws and works on behalf of hospitals to prevent them from losing money on insured patients who need emergency care

- Coordination of Benefits
  - When coverage is available from more than one source, providers often feel a false sense of security that one source will surely pay
  - When multiple sources of coverage exist it is not uncommon for insurers to dispute primary liability—resulting in denials from both payers!
  - TGF will consult with both insurers and develop a solution after considering the insurers' COB provisions and applicable COB state laws

- Medicare as Secondary Payer
  - Medicare has specific, detailed provisions for determining when a GHP must pay its benefits primary to available Medicare benefits
  - Federal laws dictate that, in certain circumstances, GHPs cannot reduce benefits, pay secondary to Medicare, or terminate benefits based on availability of Medicare
  - These laws are designed to reduce government spending and preserve the fiscal integrity of the Medicare program
  - Nevertheless, GHPs persistently attempt to offload their responsibility on the federal government
  - TGF aggressively and vigorously pursues GHPs that violate these federal laws governing payment of benefits and forces GHPs to pay primary to the maximum extent of the law

- Utilization Review Programs
    - All insurers have utilization review or utilization management programs, which they spin as programs designed to insure quality of care, but in fact such programs are nothing more than rationing and limiting of care
    - Through these programs, insurers step between patients and physicians and seek to dictate the provision of medical care
    - TGF can assist in enforcing providers' rights during these programs in several ways, including advocating for changes in medical policies or appealing adverse decisions within existing policies
    - TGF firmly believes that providers—rather than insurers—should determine what care is appropriate and we fight passionately to achieve this result

- PPO Network Issues
    - Insurers have long engaged in abusive practices with PPO networks resulting in significant discounts to insurers to which they were not entitled
    - Many insurers are now even more blatantly abusing PPO network agreements by refusing to honor agreed upon network rates
    - This practice by insurers results in the provider receiving less reimbursement than promised and the patient being subject to unnecessary balance billing
    - TGF works with these imprudent payers and the applicable PPO networks to require adherence to the terms of PPO agreements

MEDICAL LIENS

- Many states allow certain types of providers to take a lien in their patients' causes of action when they treat patients for injuries caused by a third person
    - In Georgia, the statute authorizes such liens for hospitals, nursing homes, physician practices, and traumatic burn centers
- Hospital liens are critical in third party liability situations because many insurance policies exclude coverage when injuries were caused by another party
- Managing the process from timely and validly filing the lien to confirming a third party payment is complicated by shifty personal injury lawyers who attempt to maximize money in the pocket of their clients
- TGF effectively files hospital liens by determining who may be liable to the patient, providing all of the required notice, and then carefully monitoring the progress of insurance payments or other settlements and awards

MEDICARE ADVANTAGE PLANS

- Medicare Advantage plans are alternatives to original Medicare managed by private insurers, such as Blue Cross or Humana, and subsidized by the federal government
- MA plans are governed by the terms of their policies and federal regulations; however, private insurers that manage (and profit off of) these plans often use the badge of Medicare and CMS to frighten providers into complying with unreasonable medical record requests or accepting delayed and reduced payments
- TGF can help providers defeat abusive practices of insurers that run MA plans while complying with the federal regulations actually imposed by CMS on providers dealing with MA plans

MEDICARE DENIALS

- TGF assists providers whose Medicare claims are denied for various reasons
- Frequently, coverage decisions are made by intermediaries and appealed to contractors who apply local coverage determinations issued by the intermediary rather than CMS
- At higher levels of appeal, administrative law judges can disregard local coverage determinations and decide whether care provided was medically necessary
- TGF works with its clients to craft arguments throughout the Medicare appeals process to ensure that medically necessary care is properly reimbursed by the federal government

CRIME VICTIMS COMPENSATION ADVOCACY

- All states have implemented programs which provide victims of crime with financial assistance, including payment of medical expenses resulting from the crime
- These programs are governed by regimented procedures and rules implemented by state agencies—TGF's experience with these agencies allows it to navigate the system in a way that ensures government benefits are paid quickly and efficiently
- TGF works directly with providers' patients to make the system operate seamlessly

DIALYSIS PROVIDER SERVICES

- TGF has become a national leader in the fight to preserve provider and patients rights against ESRD related benefits violations. In *Bio-Medical Applications of Tenn., Inc. v. Cent. States, Se. & Sw. Areas Health & Welfare Fund, 648 F. Supp. 2d 988 (E.D. Tenn. 2009)* Attorney Doug Gibson secured the first favorable federal district court provider decision regarding group health plan ESRD Medicare Secondary Payer Act violations under ERISA.
- Medicare as Secondary Payer Act Violations — taking into account Medicare entitlement OR differentiating in benefits available to those with ERSD to reduce plan's financial obligations. These may manifest through any of the following schemes:
    - Converting enrollees to Medicare Advantage plans upon ESRD Medicare entitlement (or dual entitlement situations)
    - Reducing reimbursement (with or without justification in the plan document) after the first three months of service
    - Plan amendments that reduce benefits to those with ESRD, Medicare, or some equivalent therefore, such as "outpatient dialysis"
    - Plan use of "repricers" that specialize in "dialysis cost control" such as Dialysis (Defining) Cost Containment, Ethicare Advisors, and DialysisPPO.
    - Furthermore, many plans attempt to be less overt, utilizing "benefits limitations" that may manifest through many of the issues discussed in the Insurance or Employer Group Health Plan Denials section above.
- TGF works with dialysis providers to successfully resolve ESRD related claims denials without need for legal proceedings or litigation. TGF contested plan benefit denials involving Dialysis Cost Containment, Ethicare, and DialysisPPO, reaching favorable out of court settlements with the plans.
- TGF successfully contests refund demands when payers attempt to recoup or off-set voluntary payments made during or after the ESRD Medicare coordination of benefits period. TGF has found that payers will routinely discontinue the patient's benefits once it learns the patient has become eligible for Medicare, resulting in retro-denials and requests for refunds.