



Dinsmôre

Navigating Payor Disputes and Litigation

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Today's Presenters



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Today's Agenda

- ▶ **Denials**
- ▶ **Audits/Overpayments**
- ▶ **Payor Disputes**
- ▶ **Takeaways**

Disclaimer

We have no real or perceived conflicts of interest that relate to this presentation.

Why is this Topic Important?

- Payors are increasingly finding ways to recoup payments.
- Have to be diligent.
- Develop a strategy for identifying and disputing denials and overpayments.
- Need to play the game.



Denials



First Steps - Payor Types

- The very first step to take
- Distinct paths
- Who is the decision maker?
- Who has the obligation to pay?
- Different rules apply

First Steps – ERISA Claims

- Insurance card: Benefits are not insured by Payer.
- The players:
 - Plan Sponsor
 - Plan Administrator
 - Claims Supervisor/Administrator
 - Network

First Steps – Document Requests

- Request copy of the Summary Plan Description/Plan Document
- Complete Authorized Representative Form
- Develop timeline for appeal deadlines and levels of appeal
- Send “104(b)” letter to Plan Administrator requesting information owed under law

Claim Denials

- Important to pay attention to timelines to dispute adjudication of a claim.
- Has the Payor properly adjudicated the claim within the required timeframe in the Payor agreement?
- Claim adjudication rationale (such as denials) are detailed in Explanation of Payment (“EOP”) – for providers or Explanation of Benefits (“EOB”) - patients.
 - Also referred to claims remittance or 835 electronic remittance advice (“ERA”).
- EOP or Remittance will detail how the claim was adjudicated by the Payor.
- An EOP includes information about the claim's adjudication, payment or reduction, adjustments, denials, and uncovered charges.

Claim Denials and Other Adjudication Rationale

- EOP or Remittance will include specific codes related to the claim adjudication decisions. Examples include of Remark Codes:
 - N382 - Missing/incomplete/invalid patient identifier.
 - M62 - Missing/incomplete/invalid treatment authorization code.
 - CO45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- General denial rationale related to claim adjudications:
 - Claims not being paid pursuant to the correct contractual rate.
 - Claims denying for facilities or providers not properly added to the underlying agreement.
 - Separately reimbursable issues for specific types of services Payor requires to be billed on a line item basis.

Claim Denials and Other Adjudication Rationale

- Further claim denial rationale:
 - Missing authorizations.
 - Duplicate claim submissions.
 - Proper Payor claims.
 - Coordination of benefits issues related to primary and secondary claims.
 - Allowable amounts based upon contractual or government regulations.
 - Timely filing disputes.
 - Payor fails to respond or adjudicate a claim submission
 - Pay attention to the timeframe related for claim adjudication or prompt guidelines. May be able to assess interest or other contractual/regulatory remedies (i.e., liquidated damages provisions).

Appeals



Appeals – Foundational Issues

- When there is a claim dispute need to determine what the remedy is to resolve the dispute.
- It is paramount to timely file appeals and follow the criteria to doing so. The requirements may also be in a Provider Manual. Not in the actual four corners of the document.
- Want to appeal the claim as far as the Payor will allow you to appeal in order to preserve your administrative rights in future arbitration or litigation proceedings.
- Appeals sometimes seem fruitless, however, the most important aspect of the appeal is to preserve rights for future challenges down the line.
- Case law suggests that failure to exhaust administrative remedies with the Payor may result in the inability to challenge the adjudication decision later on.

Appeals – Foundational Issues

- **Exhaustion of Administrative Remedies** – A Legal Doctrine that requires a plaintiff to use all available administrative remedies before seeking judicial review.
 - What appeals process is required?
 - Does our claim (ex., a State breach of contract claim) have to follow federal rules?
- *Prime Healthcare Huntington Beach, LLC vs. SCAN Health Plan*, 210 F. Supp. 3d 1225 (C.D. Cal. 2016) – Non-Contracted provider claims under State law need to follow Federal Medicare appeal process
- *RenCare, Ltd. V. Humana Health Plan of Tex., Inc.*, 395 F.3d 555, 556 (5th Cir. 2004) – contracted provider claim for payment under state law is not “inextricably intertwined” with Medicare rules.

Appeals – Foundational Issues

▪ Exhaustion of Administrative Remedies

- Courts/Arbitrators can and do waive exhaustion requirements, but are usually reluctant to do so:

- *Eldridge Factors*:

- Claim must be collateral to substantive claim of entitlement
- Denial of relief must result in irreparable harm; and
- Resolution will not serve the purposes of exhaustion.

- *Purpose of Exhaustion* – (Supreme Court suggested this is most important)

- Is there a benefit to requiring exhaustion such as ensuring agency expertise is used and developing a record?
- Would imposing the requirement conserve judicial resources?





Appeals – Foundational Issues

- First step is to analyze the claim EOP along with provider manuals, billing policies, coverage criteria or other Payor policies to assess if an appeal would be viable (i.e., “Rules of the Game”).
- Next, assess claim appeal requirements such as timelines, claim form to utilize, documentation required, and where to file the appeal.
 - These requirements are almost always in the Provider Manual or Provider Agreement.
- Submit the appeal to the correct address.
- Once the appeal is decided on, determine if there are further appeal rights contractually or through regulatory process.
- If this is the final appeal process with the Payor then assess requirements for further dispute resolution procedures.




Section 9: Reconsiderations (Appeals)

Provider Retrospective Appeals Overview

This Section 9 applies to Provider issues concerning the Provider's dissatisfaction with denial of payment, where a denial has been issued for reasons such as: no prior authorization, benefits exhausted, service exceeds authorization, days billed exceed authorization, nursery days exceed mother's stay, payment error/not authorized, authorization denied, authorization expired, requires authorization, or lack of medical information.

A Provider may appeal a claim or utilization review denial on their own behalf by mailing or faxing  a letter of appeal or an appeal form with supporting documentation such as medical records. Appeal forms are at  Select the appropriate state from the drop-down menu and click on *Forms* under *Medicare* in the *Providers* drop-down menu. Providers have 90 calendar days from  original utilization management review decision or claim denial to file a Provider appeal. Appeals after that time will be denied for untimely filing. If the Provider feels that the appeal was filed within the appropriate timeframe, the Provider may submit documentation showing proof of timely filing. Examples of acceptable proof include, but are not limited to: registered postal receipt signed by a representative of  a similar receipt from other commercial delivery services, or a fax submission confirmation.

Participating Provider Reconsideration Request Form

Visit our Provider Portal  to submit your request electronically. Send this form with all pertinent medical documentation to support the request to  **Attn: Appeals Department** at P.O. Box 31368  You may also fax the request to **1-866-201-0657**. Your reconsideration will be processed once all necessary documentation is received and you will be notified of the outcome. Please fill in all provider and patient information fields below as they are **required to complete your request**.

Request Date:

*Only use this form if service has been rendered. Please go to the Member portal for submission and appeal form for services that have not been rendered.

Provider/Facility Information

Name:

Provider ID on Billed Claim:

NPI:

Tax ID Number:

Address:

City:

State: Zip Code:

Telephone:

Fax:

Contact Person:

Patient Information

Name:

ID Number:

Date of Birth:

Service Provided Information:

Date(s) of Service:

Place of Service Code:

Claim #:

Authorization #:

If you are a Participating Provider with an appeal reconsideration, please submit your request on the Participating Provider Appeal Reconsideration Form, along with supporting documentation.

Filing on Member's Behalf Member appeals for medical necessity, out-of-network services, or benefit denials, or services for which the member can be held financially liable for services must be accompanied by an Appointment of Representation form or other office documentation signed and dated by the member you are appealing on behalf of, unless you are an attorney, power of attorney, court appointed guardian or health care proxy agent with associated documentation.

Disputed Service – Please provide service type/code(s):

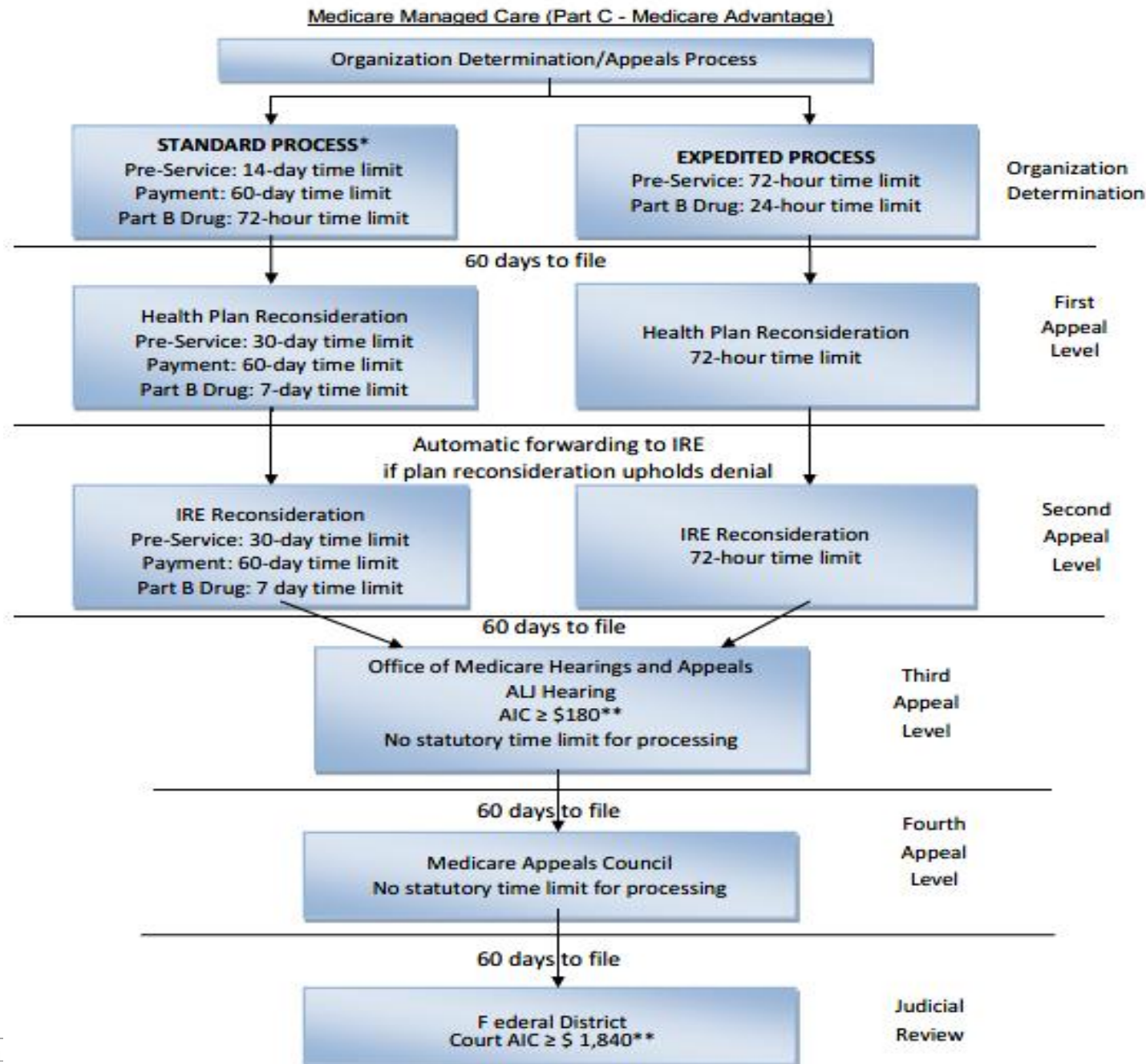
Signature: Date:

***See below for additional information**

Documentation Needed: All Medical Information Needed to Determine Medical Necessity

Examples:

- **Inpatient or Observation stays** – doctor orders, progress notes, ER notes, medication record, lab reports, nurse's notes, consultation reports, PT/OT/ST notes (if applicable)
- **Procedures** – procedure report, supporting consultation reports, PCP progress notes, referring MD script
- **Consultations** – consultation report, referring MD script
- **PT, OT, ST** – progress notes, evaluations, summaries, referring MD script
- **Radiology** – reports, referring MD script
- **Initial Authorization Determination Letter** (if applicable)



Appeal Best Practices

- Follow the steps in the provider manual.
- Provide justification for appeal based upon Payor requirements. Not enough to just demand payment for disputed claim.
- When filing an appeal pay attention to documents required specifically related to medical necessity.
- Keep documentation on file related to appeals as you move towards a dispute resolution procedure.

Audits/Overpayments



Audits/Overpayments

- Payors may audit claims after the claims are paid.
- Audits are different than denials, as the Payor is looking at claims after adjudication to determine if documentation supports the service to be billed or other criteria is lacking.
 - In some cases Special Investigation Units may do pre-payment reviews.
- Important for the provider to pay attention to the requirements of an audit request letter or terms dictated in the Payor agreement or provider manual.
- Deadlines on audits and overpayments.
 - Ohio law has a lookback period of two years on overpayments. R.C. 3901.388. Exceptions for cases of fraud by the Payor.



Recoupment Rights

- If there is an overpayment is the Payor permitted to offset against future amounts due or does the provider have to pay back the amounts separately?
- What are the recoupment provisions? Many Payor contracts allow offsetting of claims that they believe to be overpayment against amount due. The agreement may require advance notice from the Payor, or little notice at all.
- Providers should request that notice be provided of the attempted recoupment action, with an attempt to appeal the recoupment and only then can any claims be offset.

Payor Disputes



Payor Disputes

- **Baseline Facts and Case Assessment**
- **Identifying the Appropriate Processes**
- **Foundational Issues to Consider**
 - Timing Limitations
 - Prompt Pay Statutes and other laws/regulations
- **What to expect in Arbitration and Litigation**

Payor Disputes – Baseline Facts/Assessment

- **Issue identification:** Underpayment, Coding, Medical Necessity, Prior Authorization, “Crossover” Claims, Sequestration, Recoupment/Overpayment, Audit. . .
- **Plan type(s):** Medicare Advantage, Medicaid MCO, Duals, Commercial, etc.
- **Provider status:**
 - Contracted (In-Network, Participating, Par, INN)
 - Non-Contracted (Out-of-Network, Non-Participating, Non-Par, OON)
 - Authorizations? May only have quasi-contract theories.
 - Single Case/Patient Agreement (SPA)
- **What laws/regulations apply?:**
 - ERISA, Medicare/Medicaid Statutes, State Laws/Regulations
 - Prompt Pay, Bad Faith, Unfair/Deceptive Trade Practices, Network Adequacy Rules, Any Willing Provider (AWP), etc.

Payor Disputes – Baseline Facts/Assessment

▪ **Payor status:**

- Primary, Secondary, Tertiary?
- Government Fee-Schedule Applicable?
- Third Party Administrator/Re-Pricer?

▪ **Amount in dispute:**

- What is the contract payment rate?
- What is the applicable fee-schedule rate?
- How are these rates calculated? (ex. pricing tools)
- Do we have documentation for rates/payment terms?
- Are other parts contracts (ex., performance incentives) affected by dispute?

Payor Disputes – Baseline Facts/Assessment

- **What is the current relationship with the Payor?**
 - Active contract negotiations? Recent increase/decrease?
 - Other active/known issues with Payor? (ex. two-midnight rule)
 - Active audits, overpayment requests, etc.?
- **Could we be subject to cross claims?**
 - Currently under prepayment review?
 - Aware of ongoing coding/documentation issues?
 - Is there anything unique about our claims/documentation?

Payor Disputes – Identifying Processes

- **Procedure Identification:** The applicable dispute resolution process is usually determined by Payor Type and Provider Status (ex., Contracted MA vs. Non-Contracted MA)
- **Available Processes:**
 - Internal/External Appeals and Agency Complaints
 - Alternative Dispute Resolution (ex., Arbitration, Mediation, etc.)
 - State/Regulator-Facilitated Resolution
 - ODI Arbitration Portal
 - CMS Provider Reimbursement Review Board (PRRB))
 - Litigation

Payor Disputes – Identifying Processes

- **Consider a contracted provider:**
- **What should we ask while reviewing our contract?:**
 - Is our claim for damages, equitable/injunctive relief, or both?
 - Does the Provider Appeal process apply?
 - What timing considerations apply?
 - Claims submission deadline
 - Dispute notice deadline
 - Arbitration/Mediation filing deadline
 - Statute of Limitations
 - Are we required to negotiate with the Payor or use a specific ADR process (arbitration/mediation)?

Payor Disputes – Foundational Issues

■ Limitations Periods

■ Contractual Limitations

- Dispute Submission Time Period
- Negotiation Process Time Period
- Arbitration Time Period

■ Statutes of Limitation

- Written Contract vs. Verbal Contract

■ Appeal/Third Party Review Timing

- Note: Use Tolling Agreements as they enable negotiation.

Payor Disputes – Related Laws

■ Prompt Pay Laws

- State and Federal Versions
- Interest penalties where timing components are not met.
- Can apply to both payment and overpayment recovery.
- May have unique timing components related to payment/overpayment and dispute notification.
- May contain tolling terms that delay timing while requests for additional information are being processed
- May only apply to certain types of insurance
 - ORC 3901.381 does not apply to Medicare, Medicaid, or self-insured ERISA Plans (but there are federal rules)
- May not be privately enforceable

Payor Disputes – Related Laws

■ Any Willing Provider (AWP) Laws

- Must allow providers in network if willing to accept reasonable terms and conditions
- Federal and State Versions available
- Can be very helpful for network/termination disputes
- Have been used to argue that payors must have cause to terminate provider agreements.
- May not be privately enforceable

■ Payment Limitation Rules.

- State laws prohibiting payment above thresholds. (ex., may an MCO pay greater than 120% of Medicaid FFS?)
- Secondary coverage limits – Medicaid MCOs are typically not required to pay higher than what Medicaid FFS would have covered.

Payor Disputes – Related Laws

■ Network Adequacy Standards

- Payors are required to maintain specific numbers of providers in network based upon geographic and/or travel times.
- Vary in application based on urban/rural patient populations.
- Federal and State Versions available.
- Can be very helpful for network/termination disputes.
- May not be privately enforceable.

■ Benefits Parity Rules

- Payors are required to cover certain benefits in parity with other benefits
- Does the payer's payment practice result in systematic under coverage of a particular benefit?
- Claims typically tie into Deceptive Trade Practices Acts that are privately enforceable. (Note: May need to consider patient co-plaintiff).

Payor Disputes – What to Expect

■ Arbitration

- Required Entities and Rules (ex., AAA Commercial Rules)
- May need to happen in another City/State
- More than one Arbitrator depending on amount in dispute.
- Costs can be substantial
 - Note: filing fees, arbitrator fees, class-based action unlikely.
- Contract-based, but may not be more efficient
- Need to identify a qualified arbitrator(s)
 - Note: Is the Arbitrator Plan or Provider friendly?
- Confidential
- Limited Discovery
- Limited Appellate Review

Payor Disputes – What to Expect

▪ **Litigation**

- Consider whether Federal or State Court is best.
 - Note: That removal to Federal Court may happen
- Clearer rules base on where filed (i.e., Federal or State Court)
- Unable to select Judge
- Costs can be substantial
- The only avenue for Injunctive Relief/Equitable Relief
 - Note: Cases involving contract termination may be more amenable to Litigation.
- Public Proceeding

Payor Disputes – What to Expect

▪ Arbitration/Litigation

- Costly
 - Filing fees, legal costs, time/resource expenditure, document production, etc.
 - Fee-shifting provisions where prevailing party is entitled to fees.
- “Battle of the Spreadsheets”
 - Most disputes require identification of disputed claim population and can involve thousands and thousands of claims, procedures, patients, etc.
- Statistical Sampling/Extrapolation
 - Is it economical to litigate all claims?
- Binding

Takeaways



Takeaways/Practice Tips

- Know which “rules” apply
- Track deadlines for appeals, dispute resolution notices, lawsuits, etc. early on
- Make your appeals count
- Keep a record of what was sent for the appeal
- Engage legal early on in the process for options on how to navigate denials and disputes, especially involving large dollar amounts
- Develop an approach for disputing appeals, overpayments, and disputes



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