SAMRA PLASTIC & RECONSTRUCTIVE SURGERY
1 Harmon Plaza, Suite 800
Secaucus, NJ 07094
W (855) 777-1056 ext 211 F (201) 616-7929

FIRST LEVEL MEMBER APPEAL
WARNING: IMPORTANT CONFIDENTIAL PROTECTED HEALTH INFORMATION ENCLOSED.

January 13, 2020

Via Certified R.R.R.
United Heatlhcare
Central Escalation Unit
PO Box 30573
Salt Lake City UT 84130-0573
Fax 801.938.2109
Attn: Member Appeals

Re: Appeal from Denial and/or Underpayment of Claim and Request for Plan Documents

Patient Name: [redacted]
Insured Name: [redacted]
Billed Charges: $1,880.00
Insured ID: [redacted]
Date of Service: 07/17/2019
Claim Number: [redacted]

Dear Member Appeals/Plan Administrator[1],

This letter shall serve as a first level member appeal on behalf of Dr. Samra of Samra Plastic & Reconstructive Surgery (the "Providers"). Please be advised that Dr. Samra is both an assignee and the designated authorized representative of patien[redacted] Attached is a designation as authorized representative and/or assignment of benefits fro[redacted] [redacted]to the Providers authorizing them, among other things, to pursue all rights on behalf of the member. The form clearly identifies the appointment of the Providers or anyone acting under their authority to act as assignees and designated authorized representatives of the Patient. In compliance with HIPAA regulations, enclosed is Strategic Practice Solutions' HIPAA-compliant Business Associate Agreement with Dr. Samra.

[1] This appeal is filed with the Plan Administrator of the above captioned plan, or appropriate named fiduciary or insurer of the plan. Any individual receiving this appeal is required to forward this document to the appropriate individual.

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Operative History

[redacted], a member of United Healthcare was diagnosed with chronic venous hypertension with inflammation. On July 17, 2019, at Bayshore Community Hospital-Wound care, Dr. Samra performed subcutaneous debridement. The procedures are detailed more fully in the report attached hereto.

Procedural History

The procedures were billed and paid by United Healthcare as follows:

CPT	Billed Amount	Paid Amount
99203-25	$480.00	$0.00
11042	$1,400.00	$65.50
Totals	$1,880.00	$65.50

As you can see from the above, only 3% of the billed charges were paid by [redacted] health insurance plan through United Healthcare. The member has been left with the financial responsibility for the remaining $1,814.50.

Dr. Samra is board certified in plastic surgery by the American Board of Plastic Surgery. Dr. Samra is not just any surgeon, but rather, an expert in his field. He has performed hundreds, if not thousands, of debridement cases.

Inadequate Network

Federal and State laws require that networks must include a sufficient number and type of provider to ensure that all medical care is available without unreasonable delay. Under New Jersey law, N.J.S.A. 26:2S, a health plan must maintain a provider network that meets certain standards, largely based upon service type and geographic accessibility, to ensure that covered members are able to access in-network medical specialists to meet their medical needs. State network adequacy laws have been found to apply to ERISA plans. Insco v. Aetna Health & Life Ins. Co., 673 F. Supp. 2d 1180 (D. Nev. 2009).

Over the last several years, insurers have been narrowing networks for covered benefits at the expense of their members/insureds, depriving them of both practical and timely access to critical medical care. The inclusion of the same provider in multiple plans magnifies access issues, as participating providers are unavailable to provide services on a timely basis.

In this case, the surgery was authorized as medically necessary and an in-network exception should have been granted because United Healthcare did not have a qualified provider in their network to trea[redacted] had no alternative but to use Dr.

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Samra. With an in-network exception, [redacted] should have received not only the cost-sharing benefit of using an in-network provider, but United Healthcare should have paid the provider's billed charges in full or given the provider an opportunity to negotiate his fees. United Healthcare abused its discretion in failing to give the provider an opportunity to negotiate a mutually agreed upon reimbursement rate prior to the surgery being rendered. Instead, United Healthcare made a unilateral decision as to what the rate would be, reimbursing the provider a fraction of the provider's billed charges. That unilaterally determined reimbursement rate is arbitrary and capricious.

Because of the inadequate network, [redacted] had no alternative, but to use the treating surgeons for the procedures at issue in this case. United Healthcare should not be permitted to circumvent the intent of Federal and State laws by maintaining an inadequate network in order to shift the cost of the medically necessary procedures onto. At a minimum, Dr. Samra should have been granted an opportunity to negotiate rates to provide your member with these authorized, medically necessary services. Instead, in violation of applicable law, the patient is now left with an out of pocket responsibility in excess of $1,814.50.

Holding the member responsible as if they opted for out-of-network benefits (i.e. leaving them with the billed balance) is grossly unjust and a breach of the insurance contract – not to mention deceptive in nature. Since United Healthcare's network was inadequate, United Healthcare is wholly responsible for payment to Dr. Samra. As an act of good faith, Dr. Samra is willing to negotiate a fair settlement in lieu of balance billing the member. Therefore, we expect to be contacted to negotiate his rates, which are the usual and prevailing rates for these procedures in the geographic area.

The Rate Of Reimbursement In This Case Is Artificially Low And Has No Reality In The Marketplace

The rate of reimbursement in this case was not reasonable for the complex surgical procedure performed. This was not a cosmetic procedure. From the credentials listed above, it is obvious that Dr. Samra is not just a general surgeon. Dr. Samra is a highly trained and skilled surgeon. Dr. Samra's fees reflect the complexity of the surgery, highly specialized skill set, years of training, practice and education. Dr. Samra fees are well within the usual and prevailing rates in the geographic area practiced by physicians of his stature. Dr. Samra's fees are also supported by numerous payments made by other payers in the area and supported by Physician Fee publications from multiple industry commercial publishers.

Therefore, the amount reimbursed by United Healthcare for this procedure has no reality in the marketplace and it seems unreasonable that [redacted] should be held responsible for a bill in the amount of $1,814.50. We are confident tha[redacted] could not have intended that the Plan would shift nearly all financial responsibility onto the member. For the foregoing

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reasons, reimbursement should be paid at a higher level of benefits and we are now seeking additional payment.

The Claims Must Be Paid With Interest

Any additional payments (or prior late payments) made on these claims must include late interest beginning thirty (30) days from the date all information and documentation required to process the claim was received.

We Hereby Demand A Copy Of All Plans/Documents/Fee Schedules Related To The Denial Of Claims In This Matter

Upon request and pursuant to state law, you are required to provide, within 30 days, a plan, handbook, certificate or other evidence of coverage designed for the claimant describing the services or benefits therefore to which the covered person is entitled under the policy or contract including but not limited to:

a. All exclusions and limitations;
b. All restrictions on accessing covered services, such as the requirement to obtain prior authorization, preadmission certification or periodic review of on-going treatment;
c. A full and clear description of the carrier's policies and procedures governing the provision of emergency and urgent care services or the payment of benefits therefore;
d. The responsibility of the covered person to pay deductibles, coinsurance or copayment as appropriate distinguishing any differences in the covered person's financial responsibility for accessing services within and outside of a carrier's network, when applicable;
e. A written explanation of how the carrier determines what is reasonable and customary or usual and customary under the plan and the covered person's responsibility to pay for charges that exceed what is reasonable and customary;
f. Fee Schedules or other documents that are relied on as to what is reasonable and customary;

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g. The right of the covered person to obtain information concerning the carrier's policies and procedures; and
h. The right of the covered person to understand where and in what manner covered services may be obtained.

Conclusion

As stated above, the Plan herein is subject to state regulations and you have 30 days to respond to this appeal. If you fail to respond, the provider reserves their right to pursue all available remedies, including bringing a lawsuit on the basis that the plan has failed to provide a reasonable claim procedure that would afford them a fair evaluation and ability to respond to the claim based on its merits.

If you have any questions, do not hesitate to contact me.

Sincerely,

Mayra Lewis

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w/ enc.