SUBMITTING CASES TO ATTORNEY
FOR COMMERCIAL LITIGATION

MY CASE:

- ALL CASES TO LAWALL MITCHELL are to be set up in MYCase *THROUGH ALEX*
    - Once you have vetted and member/ first level appealed a case email the appeal and the packet with all information to Alex and she will set up a case and upload the documents to it.
    - Alex will then 'task" that file to Aaron and Dara (attorneys)
    - You can view the status of your case by going to: https://www.mycase.com/login

OLD AR

- Spreadsheet should exist with some data for old claims from clients (these are claims we don't submit originally but take over for a client as collections only.)
- Attorney will be provided with reports or spreadsheets and will select old cases they think are viable.

NEW CASES

- As you are working through AR you will identify new case and send them attorney as follows:

SPS CLAIMS TO ATTORRNEY (NEW & OLD ARs):

- SPS will:
    - Vet which cases are viable. "Viable" based on:
        - Is a commercial claim
        - Less than 50% of billed charges are paid
        - WITHIN 180 DAYS:
            - Must have DAR in place
            - Do first level member appeal-
                - If over $10K use guidelines that are provided on relevant templates and send to AM
                - If under $10K - no need to send to AM- use templates
            - If 1st level appeal is paid- enter payment on AM spreadsheet
                - If not paid at all OR not paid up to 50% of billed charges after that-send for second level member appeal - those will be on AM letterhead and must be run past AM!!
                    - At this point, AM will need in Sharefile

- EOB determination (initial EOB and additional payment if applies)
- Copy of Insurance Card
- DAR
- Written response from carrier
    - If NO RESPONSE (or request for more time) let AM know to say "failed to respond"
- HCFA
- Op report
- Authorization
- Eligibility and benefits verification notes- which show how plan pays

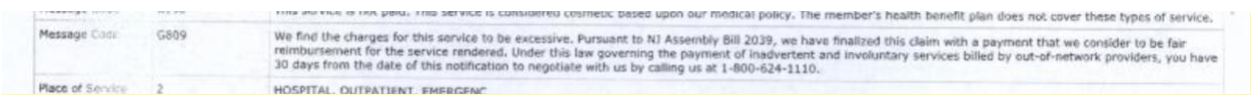
- If 1st level appeal DOES bring total paid over 50% (or use your judgement) of billed charges, post payment in AM spreadsheet and call it a day- COMPLETE

- NOT WITHIN 180 DAYS: if determination is NOT within 180 days (BUT within 2 years):
    - Try to send member appeal anyway (per above workflow) send response to AM regardless of that response. (Carrier may not raise the timely issue- which is good!)
        - If they address the issue and DO NOT say "appeal not within 180 days" they've waived the 180 day constraint. AM can argue this.
        - If they do address the 180 days:
            - Go to the next workflow (over 2 years)
- OVER 2 YEARS (or appeal deemed untimely):
    - Make sure you enter on AM Appeals spreadsheet
    - Send AM necessary documentation in Sharefile (per above)
    - AM will send out a demand for payment
    - Just provide documentation or information as requested from AM throughout process.

- IF you submit an appeal to Aaron for review, and he doesn't get back to you, follow up with him in **within one week.**

SURPRISE MEDICAL BILLS:

- IF a provider is an "inadvertent provider" meaning patient admitted through ER or inpatient consult, didn't choose or elect surgery, MUST make sure
    - IF it references…"pursuant to A2039" but can be any code (usually G code, i.e., G807, G809)



- ELIGIBLE:
  - Was NOT elective and was ER or inpatient consult
  - If they don't pay 100% of billed charges
  - Only fully insured plans are eligible (carrier supposed to be indicating this status on insurance card.)
- You have 30 days to negotiate from determination- CALL carrier within that timeframe to try to get a negotiate a rate- **SHOULD get 80% of Fair Health** (USE 80th percentile of OPTUM, as found in fee analyzer, make sure the area is correct)
  - SEND IMMEDIATELY TO AM because 30 DAYS is all he has to file: if NOT paid or negotiated, **prepare file for AM:**
    - Give AM all the usual back up info in Sharefile
      - MAKE SURE you name share file folder, i.e., "SURPRISE BILL- JOHN SMITH"
    - EMAIL AM to make sure he gets it timely put "Surprise Bill" in subject line
- YOU WILL NOT SEE THIS ON ERA's – you have to check NAVINET to see the real EOB for these denials. Please be careful to catch all of them.
- IF it's not appropriate to have the surprise bill invoked (i.e.,the provider didn't go to the ER and it was elective surgery) AND if it was underpaid, then submit an appeal:
  - "This was not a surprise bill as it was elective, please reconsider this see
    - attached op report
    - elective form stating "we are OON"
    - Authorization #
- If it's a VALID SURPRISE BILL: you cannot bill patient for more than the in network liability. We will determine on a case by case basis.