PayerWatch/AHDAM Legal Disclaimer:

The following is for informational and educational purposes only. The information contained in this document does not constitute legal advice and is not intended to create an attorney-client relationship.

If you need legal advice, contact your inhouse attorney.

- **Administrative/Clerical Errors - Substantial Performance/Non-Material Breach**
    - A purported breach is considered material when it is "so substantial and fundamental as to defeat the object of the contract," in other words, goes to the contract's root. Conversely, an incidental breach does not warrant contract termination or enforcement.
    - **Example:**
        - *When compared to {Facility}'s overall substantial performance in complying with {Payer}'s claim procedures, {Facility}'s mere technical denial is incidental when compared to the entirety of its submitted claim package. {Facility} made a good-faith effort to meet {Payer}'s guidelines. These small deviances can hardly be considered material in nature to warrant claim rejection let alone claim non-payment*

- **Administrative/Clerical Errors - Medically Necessary Claims Cannot be Completely Denied Based on Clerical Errors**
    - Both the federal and state "No Surprises Act" reject the notion that medically necessary services can be retrospectively denied based solely on mere administrative mistakes or errors
    - **Examples:**
        - *Both the federal and state "No Surprises Act" reject the notion that medically necessary services can be retrospectively denied based solely on mere administrative mistakes or errors…….*
        - *{Facility} provided medically necessary services that were warranted due to the circumstances surrounding admission and the patient's condition. Retrospective authorization and payment are appropriate based on the clinical merits.*

- **Administrative/Clerical Errors - Medically Necessary Claims Cannot be Completely Denied Based on Network Status**
    - No full, flat-out refusal to pay due to network status is acceptable; rather, a fair reimbursement plan should be established based on the claim's merits.
    - **Examples:**

- *Both the federal and state "No Surprises Act" reject the notion that medically necessary services can be retrospectively denied based solely on mere administrative mistakes or errors…….*
- *For emergency services, payers must pay for covered emergency medical services regardless of whether the facility is in or out of network. Likewise, for non-emergency medical services, a payer that provides any benefits to covered persons must pay for these services in the event they result in surprise bills regardless of the facility's participating provider status. No full, flat out refusal to pay due to network status is acceptable; rather, a fair reimbursement plan should be established based on the claim's merits.*
- *Here, regardless of {Facility}'s network status, {Facility} provided medically necessary services that were warranted due to the circumstances surrounding admission and the patient's condition. Retrospective authorization and payment are appropriate based on the clinical merits.*

- **Dr./Patient relationship & Unforeseen Circumstances**
  - Treating physician and Facility's support staff all operated under a reasonable degree of care and skill and should not be penalized for it
  - A physician-patient relationship is established when a physician takes an affirmative act to diagnose and/or treat a person
  - A hospital owes its patients a duty of care, skill, and diligence used by hospitals generally in its community
  - **Example:**
    - *{Facility} acted promptly and with ordinary care and diligence to mitigate the effects of deficient information from intake and to correct its medical claim. Therefore, given the paramount nature of the physician-patient relationship and the duty of care it imposes, and based on its obligation of good faith and fair dealing as an insurer, {Payer} should reverse its technical denial decision and review this claim based on its clinical merits.*

- **Coding – Little to No Explanation Provided for the Reason Code Denial**
  - Denial violates federal and state law by failing to provide a reasonable and accurate explanation for why the services provided should be denied based on the provider's assigned codes
  - **Example:**
    - *Likewise, according to the Code of {State} Annotated § XX-X-XX(XX), when denying claims it is an unfair claims practice to fail "to provide promptly a reasonable and accurate explanation of the basis for such actions." Here, {Payer}'s denial letter lacks a detailed explanation of why the provider's assigned code is incorrect as well as the reasoning behind its own assigned codes based on clinical validation. {Payer}'s denial letter violates {State} law by not including this information. Retrospective authorization is appropriate when*

{Payer}'s denial letter does not conform to the notice requirements set forth in {State} law.

- **Promissory Estoppel**
    - Detrimental reliance on a promise to pay given that services were rendered after obtaining that promise *(Pre-Authorization as an example)*
    - **Examples:**
        - *{State} law will enforce a promise with detrimental reliance when: a certain promise was made to a party, with a reasonable expectation that the party would rely on it, that party relied on the promise to their detriment, and injustice can only be avoided by enforcement of the promise. Here, {Payer}'s prior authorization of service(s)/procedure(s) on the above date, was a clear and unambiguous promise.*
        - *{Payer} should have known that {Facility} would rely on its promise, given the nature of their relationship. {Facility} rendered services only after obtaining the prior authorization from {Payer}. Denial of this claim breaks {Payer}'s enforceable promise.*

- **Unjust Enrichment**
    - A party is unjustly enriched when: a benefit is conferred upon the party by another and accepts the benefit under circumstances that make it unjust for the party to retain the benefit without payment.
    - **Examples:**
        - *Here, a physician-patient relationship was created when {Facility}'s physician treated {Patient}. At that time, {Patient}'s treating physician determined the medically necessary services provided satisfied their duty of care. {Payer} lacks firsthand knowledge to challenge this determination.*
        - *According to {State} law, a party is unjustly enriched when: a benefit is conferred upon the party by another and accepts the benefit under circumstances that make it unjust for the party to retain the benefit without payment.*
        - *Had {Patient}'s treating physician refused to provide medical services, {Payer} would be responsible for arranging such services, as well as paying any costs that arise from complications due to delay.*

- **Good Faith and Fair Dealing**
    - The law imposes an implied covenant of good faith and fair dealing on every contract.
    - Payer has a duty to act honestly and fairly when determining whether medical service(s)/procedure(s) rendered are necessary

- Concerning the services provided, Payer has failed to act honestly and fairly in its investigation by not considering the **circumstances & supporting documentation surrounding this patient during the dates of service**.
- **Examples:**
    - *{Payer} must act reasonably when investigating claims, only denying claims after a reasonable investigation discovers true facts which support denial.*
    - *Denial of this claim breaches {Payer}'s contractual obligation of good faith and fair dealing.*