Wolters Kluwer

Reimbursement Advisor

Editors: Christopher Kenny and Mark Polston

Volume 35, Number 1, September 2019

Strategies to Prevent Line Item Denials

Best practices to understand and avert or challenge line item denials

By Leslie Murphy and Amy O'Neill

Line item denials are one of the most common methods health plans use to reduce payment to providers. Line item denials occur when a health plan unilaterally excludes from payment certain billed charges on a hospital bill, which can significantly impact hospital reimbursement.

The process of challenging health plan line item denials often requires significant administrative resources to recover the proper reimbursement amount. This article addresses best practices for understanding, addressing and preventing line item denials.

This article will begin with a brief overview of how understanding hospital charges and billing practices assists with analyzing line item denials. Next, this article will discuss typical line item denials, strategies for understanding and challenging line item denials, and steps hospital providers can take to reduce future line item denials.

Understanding Your Hospital's Charges and Billing Practices

All hospitals have a charge description master (CDM), which is a comprehensive list of all care services and items provided by a hospital to a patient. Each service and supply listed in the CDM includes a unique item code identifier, a description of the service or item, the department to which the charge corresponds, the associated charge amount, the revenue code to which the charge corresponds, and a corresponding current procedural terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code, if applicable.

There is not a standard CDM for all hospitals, and the Centers for Medicare & Medicaid Services does not dictate how hospitals construct their CDMs. [*See* Medicare Provider Reimbursement Manual, Part 1, CMS Pub. 15-1, Ch. 22, § 2203.] Every hospital creates and maintains its own CDM that includes thousands of individual entries intended to capture the costs of each procedure, service, supply item, prescription drug, diagnostic test, room charge or anything else that could be provided by the hospital to a patient.

Each hospital's CDM is unique and tailored to the specific resources and costs of that facility. For example, CDMs will have distinct differences depending on whether the facility is a small community hospital, large tertiary hospital, academic medical center or other type of facility. For reference, a CDM excerpt is shown in Exhibit 1.

The hospital uses the CDM to create an itemized bill for each patient that details every service and supply provided to that patient. The CDM also directly links to a hospital's revenue cycle because each unique revenue charge is linked to a specific revenue code for billing purposes. Revenue codes aggregate the charges incurred for hospital services into categories, such as

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Exhibit 1—Sample Chargemaster Extract

Item Code	Item Description	Dept Num	Standard Price	Revenue Code	HCPCS
3023001	DAILY CARE FOURTH NORTH	13030	$665.50	111	
3120000	DAILY CARE ICU	13120	1,172.50	200	
4156159	MINERAL OIL 30ML	13190	11.50	250	
4400206	SINGLE TOWEL	14430	2.25	270	
4440302	HEP C ANTIBODIES-0288	14440	53.50	300	86803
4470220	HAND XRAY-0183	14470	102.50	320	73130
4472538	C/T PELVIS W & W/O ENHANCEMENT	14302	1,069.75	350	72194
4416000	LASIK SURGERY - PER EYE	13190	2,105.25	360	66999

radiology, emergency department or pathology. The various charges on the itemized bill are summarized by revenue codes and submitted to a health plan for reimbursement.

Form CMS-1450, also known as the UB-04 form, is the standard claim form for billing health plans. Accordingly, all individual charge details reported on the itemized bill that are summarized by revenue code on the UB-04 for billing purposes come directly from the hospital's CDM.

Health Plans' Use of Line Item Denials to Reduce Payments

Line item denials occur when a health plan denies a specific line item, or multiple line items, on a hospital bill. For inpatient claims, the individual itemized charges are not listed on the UB-04 because they are summarized at the revenue code level. Because itemized bills are not submitted electronically with the UB-04, health plans often will deny the entire claim and request a copy of the itemized bill to allow the plan to review for potential line item denials before making payment. For outpatient claims, the itemized bill is not always necessary because certain individual HCPCS codes must be reported on the UB-04 form from which the health plans can perform line item denials.

Health plans most frequently perform line item denials when the payment methodology is based on a

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Reimbursement *Advisor*

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Reimbursement Advisor
(ISSN: 0884-2795 USPS 770-190) is published monthly for $869 per year by Wolters Kluwer at 28 Liberty Street, New York, NY 10005.

POSTMASTER: Send address changes to *Reimbursement Advisor*, 7201 McKinney Circle, Frederick, MD 21704.

Business and circulation:
Fulfillment Operations, Wolters Kluwer, 7201 McKinney Circle, Frederick, MD 21704.

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CMS Releases Proposed Rule That Would Require Hospitals to Disclose Negotiated Rates

Advancing price transparency replete with complexities

By Joel McElvain

The Department of Health and Human Services (HHS) has made the promotion of price transparency one of the central features of its health policy agenda.

HHS has relied primarily on a provision of the Patient Protection and Affordable Care Act that requires hospitals to make public a list of their "standard charges." HHS, through the Centers for Medicare & Medicaid Services, initially issued guidance applying that statute to encourage hospitals to post their chargemasters online. Another component of HHS, the Office of the National Coordinator for Health Information Technology (ONC), recently issued a request for information to inform the public that the agency was exploring the possibility of requiring hospitals to publicly disclose payer-specific pricing data.

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CMS has now published a proposed rule that would rely on the "standard charges" statute to impose a dramatically more onerous requirement on hospitals to publish multiple lists, not only of their standard charges, but also of the specific rates that they negotiate for items and services with particular payers. The proposed rule, if adopted, appears to be highly vulnerable to a legal challenge, as the new obligation that the agency seeks to impose on hospitals seems difficult to square with the statutory language.

Background

In 2010, as part of the Patient Protection and Affordable Care Act, Congress enacted Section 2718(e) of the Public Health Service Act, which specifies that:

> Each hospital operating within the United States shall for each year establish (and update) and make public … a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act. [42 U.S.C. § 1395ww(d)(4)]. [42 U.S.C. § 300gg-18(e).]

The statute charged the HHS secretary with the task of developing guidelines to govern the manner in which a hospital makes its standard charges public. [*Id.*] CMS first took up this task in its fiscal year (FY) 2015 inpatient prospective payment system (IPPS) final rule. At that time, the agency proceeded with a light touch, declaring that hospitals could comply with the statute by making public either "a list of the standard charges (whether that be the chargemaster itself or in another form of their choice)," or "their policies for allowing the public to view a list of those charges in response to an inquiry." [79 Fed. Reg. 49854, 50146 (Aug. 22, 2014).]

As CMS explained the issue at the time, although "MedPAC [had] suggested that hospitals be required to post the list on the Internet, and while we agree that this would be one approach that would satisfy the guidelines," the agency chose instead to defer to the judgment of hospitals as to how to make their standard charges available to the public: "[W]e believe hospitals are in the best position to determine the exact

manner and method by which to make the list public in accordance with the guidelines." [*Id.*]

The proposed rule, if adopted, appears to be highly vulnerable to a legal challenge.

So matters remained until CMS revisited the issue in its FY 2019 IPPS rulemaking. The agency expressed its concern "that challenges continue to exist for patients due to insufficient price transparency" and noted that "chargemaster data are not helpful to patients for determining what they are likely to pay for a particular service or hospital stay." [83 Fed. Reg. 20,164, 20,549 (May 7, 2018).] CMS noted that it is "considering ways to improve the accessibility and usability of the charge information" that hospitals are required to disclose. [*Id.*]

As one step in that effort, the agency revised its guidelines to specify that it would require hospitals to make a list of their standard charges available via the internet in a machine-readable format. The agency specified that a hospital could publish this data "in the form of the chargemaster itself or another form of the hospital's choice." [*Id.*]

At the same time, the agency acknowledged the ambiguity in the statutory phrase "standard charges" and sought public comment on several possible definitions for that phrase, including "average or median rates for items on the chargemaster," "average or median rates for groups of services commonly billed together (such as for an MS-DRG)," and "the average discount off the chargemaster amount across all payers." [*Id.*] The agency further asked for comments on whether it should require hospitals to tell patients their expected out-of-pocket charges. [*Id.*]

CMS reiterated its approach to the statute in its final FY 2019 IPPS rule, declaring that it would require, as of Jan. 1, 2019, "that hospitals' list of standard charges be made available to the public via the internet in a machine readable format and that hospitals update this information at least annually, or more often as appropriate." [83 Fed. Reg. 41114, 41686 (Aug. 17, 2018).] The agency did not attempt to provide a more detailed definition of the phrase "standard charges," other than to reiterate that hospitals could choose to publish data "either in the form of the chargemaster itself or another form of the hospital's choice, as long as the information is in machine readable format." [*Id.*]

The agency declared that it would not require "at this time" that hospitals publish payer-specific data, hinting that it may choose to impose that requirement in the future. Earlier this year, CMS' sister agency, ONC, expanded on that hint by issuing a request for information seeking the public's views on way in which the agency could require hospitals to disclose payer-specific pricing data. [84 Fed. Reg. 7424, 7508-7553 (Mar. 4, 2019).]

The Proposed Rule

After taking comments on the request for information, CMS recently issued a proposed rule that declares the agency's intention to reinterpret Section 300gg-18(e). In particular, the agency proposes to define the phrase "standard charges" to mean not only the hospital's chargemaster but also "payer-specific negotiated charges," meaning the particular rates that a hospital has negotiated with third-party payers. [84 Fed. Reg. 39,398, 39,571 (Aug. 9, 2019).]

The agency proposes to define the phrase "standard charges" to mean not only the hospital's chargemaster but also "payer-specific negotiated charges," meaning the particular rates that a hospital has negotiated with third-party payers.

Because the agency proposes to issue its rule under a provision of the Public Health Service Act, rather than the Medicare statute, the new requirement would apply not only to Medicare-enrolled hospitals but to any state-licensed hospital in the United States. [84 Fed. Reg. at 39,575.] The agency would, however, except federally owned or operated hospitals from the proposed rule's requirements. [*Id.*]

A hospital that is subject to the rule would be required to publish information with regard to all of its "items and services," which the proposed rule would define as all individual items and services, or service packages, that could be provided by a hospital to a patient in connection with an inpatient admission or an outpatient department visit for which the hospital has established a standard charge. [84 Fed. Reg. at 39,576.] For this purpose, "service packages" could refer to Medicare diagnosis-related group classifications or any other grouping that the hospital uses for billing purposes. [*Id.*]

The disclosure requirement would also extend to items and services furnished by physicians and nonphysician practitioners who are employed by the hospital, but would not include items or services provided by physicians or practitioners who are not employed by the hospital (such as anesthesiologists who perform services at a hospital but who practice independently). [*Id.* at 39,577.]

Charges to self-pay patients would be excluded under this definition.

The proposed rule would require hospitals to disclose their standard charges for these items and services. Controversially, the proposed rule would redefine the statutory phrase standard charges to mean both "gross charges"—that is, the charges listed by the hospital on its chargemaster—and "payer-specific negotiated charges," meaning the charge that the hospital has negotiated with a third-party payer for an item or service. [84 Fed. Reg. at 39,578-79.] Charges to self-pay patients would be excluded under this definition, as would charges that are not negotiated (such as Medicare fee-for-service rates or Medicaid fee-for-service rates). [*Id.* at 39,579.]

CMS does not at this time propose additional types of disclosures, but it is seeking public comment on whether it should further expand the definition of standard charges to include additional information, such as the hospital's minimum, median and maximum negotiated charges, or discounted cash prices for uninsured individuals. [*Id.*]

The proposed rule would require hospitals to disclose their standard charges in two ways:

- First, for all of the hospital's items or services, as that phrase is defined earlier in this article, the hospital would be required to make public a comprehensive machine-readable file with all the standard charges for those items and services. [84 Fed. Reg. at 39,582.] The proposed rule would require a standardized format for this file, listing a description of the item or service, the gross charge for the item, any payer-specific negotiated charges for the item, billing codes and revenue codes. [*Id.*] The file would need to be published on the internet without any password or other barriers to public access to the file. [*Id.*]
- Second, the hospital would also be required to publish a consumer-friendly display of its charges for certain common "shoppable" services, meaning services that can be scheduled by a health care consumer in advance. [84 Fed. Reg. at 39,585.] The consumer-friendly display would group primary services together with ancillary items and services that are customarily furnished in conjunction with the primary service. [*Id.*]

  The display would need to include a plain-language description of services. [*Id.*] The display would need to include as many of the 70 specific services that CMS lists in the proposed rule that are provided by the hospital, as well as any additional "shoppable" services that the hospital provides, so that the hospital lists a total of at least 300 such services. [*Id.* at 39,586-89.]

  The display would need to list the particular locations or campuses at which the service is available. [*Id.* at 39,590.] If the standard charge for the service varies by inpatient or outpatient setting, the display would need to identify the charge in both settings. [*Id.*] The information must be also in a paper copy, such as a brochure or booklet, for consumers who request it. [*Id.*]

CMS would enforce the new rule initially by relying on consumer complaints but may also initiate audits of hospitals' compliance with the rule. [84 Fed. Reg. at 39,591.] If a hospital is found to be out

of compliance, CMS generally would first provide a written warning notice to the hospital of the violation, then require the hospital to submit a corrective action plan for the agency's approval, and finally impose a civil monetary penalty; CMS would retain discretion to depart from this sequence, however. [*Id.* at 39,592.]

The civil monetary penalty for a violation would be a maximum of $300 per day and would not be aggregated (*i.e.*, even if a hospital is found to have committed multiple violations, the penalty would not exceed $300 per day). [*Id.*] Any penalties that are imposed would be publicized on CMS' website. [*Id.* at 39,593.] A hospital that receives a penalty would have the right to an administrative appeal. [*Id.*]

If CMS does intend to finalize this proposal with the rest of the OPPS rule, a final rule would likely be issued by November.

The proposed rule does not list an effective date for the new disclosure requirements. Given that the proposal was included in the agency's proposed rule for the outpatient prospective payment system (OPPS) for calendar year 2020, however, it is reasonable to infer that the agency intends for the new requirements to become effective with the rest of the OPPS rule on Jan. 1, 2020. Given the technical challenges that hospitals would face in complying with these new disclosure requirements, it may be anticipated that commenters will object to this timeline, and the agency will need to address the timing issue before it issues a final rule.

This proposed rule appears to be quite vulnerable to a legal challenge.

Comments are due on the proposed rule by Sept. 27, 2019. If CMS does intend to finalize this proposal with the rest of the OPPS rule, a final rule would likely be issued by November.

Conclusion

If this CMS proposed rule is finalized, it would, for the first time, require hospitals to disclose confidential prices that they have negotiated with particular payers. This proposed rule appears to be quite vulnerable to a legal challenge.

The statute on which the agency relies simply requires hospitals to disclose "a list" of their "standard charges," but the agency intends now to require hospitals to publish multiple lists, not of standard charges that would apply across the board, but of payer-specific charges. The agency's legal authority for its new proposal is this open to question.

If finalized, compliance with a broad disclosure requirement may put providers or other entities in legal jeopardy under contractual confidentiality provisions or under state trade secrets laws.

The proposal, if finalized, also holds the potential to place hospitals in a legal dilemma. Compliance with a broad disclosure requirement may put providers or other entities in legal jeopardy under contractual confidentiality provisions or under state trade secrets laws. Moreover, providers may face antitrust exposure if they were to widely disseminate their contractual pricing arrangements; the Department of Justice and the Federal Trade Commission has indicated that such a practice might draw antitrust scrutiny. [U.S. Department of Justice and Federal Trade Commission, *Statements of Antitrust Enforcement Policy and Health Care* at 49–51 (August 1996).] Hospitals would be well advised to prepare comments during the rulemaking process to inform the agency of these practical and legal barriers to full compliance with the proposed rule.

CMS also should give thought to whether its proposal would actually achieve its goals of lowered medical prices. Its premise appears to be that patients, armed

with comprehensive pricing data for medical services, will comparison shop and seek out the medical services that provide the best value. But a broad requirement of disclosure may have the opposite effect, as patients with access to pricing information, but lacking further context, may consider higher prices to be evidence of the greater quality of a provider's medical services, leading to higher overall prices. In sum, HHS should proceed with caution before it attempts to impose a wide-sweeping price disclosure rule with uncertain consequences. ■

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percentage of billed charges. By unilaterally removing individual charges, the health plan reduces the total billed charges amount used to calculate expected claim reimbursement.

For example, if a hospital submits an outpatient claim for $10,000 and the payment methodology is 50% of billed charges, the expected reimbursement is $5,000. If the health plan performs a line item review of the claim and identifies $2,000 in billed charges to exclude as line item denials, the health plan will remove those billed charges before applying the payment methodology. In this example, the health plan would pay 50% of the lesser billed charges amount of $8,000, which reduces hospital reimbursement to $4,000.

Line item denials are particularly effective to reduce payments made to hospital providers when the hospital reimbursement methodology includes a stop-loss provision. Stop-loss provisions are designed to set a different reimbursement methodology for certain higher-cost patients.

Generally, a stop-loss payment methodology reimburses a hospital a certain amount (*e.g.*, per diem) until the total billed charges reach a specified dollar threshold, referred to as the stop-loss threshold. Once billed charges reach the stop-loss threshold, the payment methodology changes to a percentage of billed charges. Health plans often use line item denials to reduce the billed charges to an amount below the stop-loss threshold, often resulting in dramatically reduced payments to providers—oftentimes reducing payment by thousands of dollars.

For example, a hospital's intensive care unit (ICU) payment rate is $10,000 per diem but includes a stop-loss provision that sets reimbursement at 50% of billed charges when billed charges exceed $300,000. If the bill for a health plan member admitted to an ICU for five days reaches $302,000, the claim is payable at the stop-loss rate totaling $151,000. If a health plan performs a line item review and identifies $2,000 in charges to exclude from payment, the health plan will remove those charges and instead pay the bill at the per diem rate because the bill no longer exceeds the stop-loss threshold. Thus, $2,000 in line item denials reduces the health plan's payment from $151,000 ($302,000 × 50% of billed charges) to $50,000 ($10,000 per diem × 5 days).

A common line item denial is a charge that a plan states was improperly unbundled or included in the cost of a different charge (*e.g.*, routine charges included in a room and board charge). Health plans often cite Medicare or its internal policies as the authority for line item denials. For example, a health plan might deny services performed by an ancillary department (*e.g.*, respiratory therapy) as a routine service included in the room and board charge and not separately billable under Medicare. Section 2202.6 of the Medicare Provider Reimbursement Manual (PRM) provides, in pertinent part:

> "[i]ncluded in routine services are the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made."

In the example provided, the ancillary department performed the service, not the nursing staff, and Medicare expressly provides that ancillary services may also be billed "in addition to a routine service charge." [*See* PRM § 2202.8 (Ancillary Services).] In this example, the Medicare guidelines support separately billing the ancillary services and the health plan's authority does not support the denial. Accordingly, the hospital should fully analyze the applicable guidelines a health plan relied upon in performing the line item denials to ensure the health plan is correctly applying them.

When a health plan engages a vendor to perform sweeping line item denials electronically, the impact of the denials in the aggregate can result in substantial underpayments and can be difficult for hospitals to appeal.

In addition, health plans often hire private vendors that develop and apply proprietary algorithms to electronically perform line item denials on a large-scale basis on the health plan's behalf. The electronic algorithms can pre-identify certain charges to automatically deny when billed at a certain frequency or when billed in conjunction with other services.

For example, the vendor algorithm might deny all venipuncture charges on a particular day on the basis that the patient should have had a peripherally inserted central catheter instead of multiple venipunctures. When a health plan engages a vendor to perform sweeping line item denials electronically, especially on smaller charges, the impact of the denials in the aggregate can result in substantial underpayments and can be difficult for hospitals to appeal.

Health plans perform line item denials by using a variety of methods. Often, the line item denials are not justified based on the authority cited by the health plan. As discussed in the next section, hospitals must diligently develop a method to identify and determine the reasons for line item denials so that they can develop strategies to address line item denials.

Strategies to Understand, Prioritize and Address Line Item Denials

Best practices for addressing line item denials begins with identifying billed charges denied by health plans and then developing an efficient process to obtain full reimbursement. When a hospital determines that a health plan underpays a claim, the hospital should review the remittance advice (RA) to determine if the RA identifies the specific charges denied by the health plan or why charges were denied.

Hospitals must diligently develop a method to identify and determine the reasons for line item denials so that they can develop strategies to address line item denials.

A manual process of researching line item denials can create a significant administrative burden on hospital providers, which requires working with the health plan to understand how the claim was processed and obtaining information necessary to understand the basis for the denial. The following three steps are suggested to analyze and resolve line item denial disputes with health plans.

Step 1: Understand reasons for line item denials

One challenging aspect of line item denials is identifying exactly which billed charges were denied based on the health plan's RA. The RA provided by the health plan provides an explanation of reasons for payment, adjustment and denial of a claim. The Health Insurance Portability and Accountability Act (HIPAA) standard file for an electronic RA (ERA) is the 835I for hospital claims, which requires the use of standard remittance advice remark codes (RARC) and claims adjustment reason codes (CARC).

CARCs communicate why the plan's payment differs from the amount billed by the provider. Some examples of common CARCs that indicate line item denials include:

- 45: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement

- 96: Noncovered charge(s)
- 97: The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 234: This procedure is not paid separately.

RARCs provide additional explanation for an adjustment already described by a CARC. Examples of RARCs that may indicate a line item denial are:

- N56: Separately billable services/tests have been bundled as they are considered components of the same procedure; separate payment not allowed.
- M86: Service denied because payment already made for same/similar procedure within set time frame.
- M15: Separately billed services/tests have been bundled as they are considered components of the same procedure; separate payment not allowed.

For reference, a list of all CARCs and RARCs and descriptions are available at *http://www.wpc-edi.com/reference/*.

Health plans may apply one or more CARC and/or RARC on an ERA, which can cause confusion as to the denial reason. For example, the ERA could include billed charges of $20,000 under revenue code 25X (pharmacy), yet pharmacy charges listed on the itemized bill are aggregated under a single revenue code. As previously discussed, the pharmacy charges listed on the itemized bill are aggregated under a single revenue code. If the hospital is expecting 50% of billed charges and the ERA lists CARC code 96 (noncovered charges) and an allowed amount of $5,000, instead of the $10,000 as expected, the provider cannot determine which of the individual pharmacy charges under revenue code 25X were denied or the substantive reason why.

When a health plan applies multiple CARCs and/or RARCs to a single line item or revenue code, the additional codes do not always help clarify which charges the health plan denied. For instance, the health plan might apply both CARC 45 ("Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement") and RARC N56 ("Separately billable services/tests have been bundled as they are considered components of the same procedure, separate payment is not allowed") to a single revenue code. While these codes put the hospital on notice that a line item denial was performed, the hospital still does not know the specific individual charges underlying the revenue code that were denied.

If a hospital provider suspects that line item denials occurred and cannot determine from the ERA what specific items were denied, the first step is to contact the health plan and ask for an explanation of what charges were denied and the reason(s) for the denial. Health plans often prepare a summary or chart of individual denied charges, a specific reason for the denial, and the authority relied upon to perform the line item denial (*e.g.*, internal health plan policies or Medicare guidelines). The detailed information prepared with a denial summary chart is not sent with the ERA but may be provided by the health plan in a separate communication.

The detailed summary of denials, if provided, significantly reduces the administrative burden of determining what specific charges were denied and the reason for the denial. Moreover, if the chart includes citations to the health plan's authority for the denial, the hospital can quickly and easily review these authorities to determine whether the authority supports the denial.

Step 2: Determine which line item denials have the greatest impact on revenue

Once a provider understands the specific charges that trigger line item denials, the provider can next focus on identifying its highest priority denials. To begin, a hospital should identify high-dollar charges that are consistently denied.

If the hospital can identify a health plan's pattern of denying these high-cost charges, all similar denials could be gathered and challenged as a group to improve efficiency and reduce cost.

For example, certain types of implants can have billed charge amounts of $10,000 or more. These individual high-cost denials are worth the effort and expense of challenging on an individual basis. If the

hospital can identify a health plan's pattern of denying these high-cost charges, all similar denials could be gathered and challenged as a group to improve efficiency and reduce cost.

In addition to reviewing high-cost charges, a hospital should also consider identifying lower-cost line item denials that, when reviewed in the aggregate, involve a significant amount of lost revenue. Venipuncture is a good example. The billed charge for a single venipuncture is often $10 to $20. While it may not make financial sense to individually appeal denied venipuncture claims to recover a few dollars, if a hospital gathers all venipunctures denied by a particular health plan over a period of time, the hospital can more efficiently appeal those denials as a group. This approach redirects resources from appealing multiple individual claims to appealing systemic denials on an aggregate basis.

Step 3: Communications to resolve disputed line item denials

If individual claim appeals are unsuccessful, the next step is for the hospital provider to reach out to the health plan operations team. The hospital provider should focus on reimbursement of past improper line item denials and resolution of the health plan's line item denial practices going forward.

Hospitals and health plans have an ongoing business relationship that often involves regular operations team meetings to discuss reimbursement disputes or other issues. During these meetings, the hospital can identify examples of line item denial cases, explain why the hospital believes the denials were improper, and discuss how to avoid similar denials going forward. If the operations teams are unsuccessful in full resolution, the next option is likely to request a meeting and confer with the appropriate leadership before moving to formal dispute resolution.

Importantly, when a hospital identifies a line item denial dispute, the hospital should understand the applicable statutory or contractual limitations periods that may impact the denied claim(s). Statutes of limitations are variable by state but generally range from three to 10 years. There may also be state-specific regulatory limitations periods based on payer types (*e.g.*, preferred provider or health maintenance organizations).

Additionally, the contract between a hospital provider and health plan may include a separate contractual limitations period. For example, many provider contracts limit a party's ability to recover underpayments two to three years from the date of the health plan's payment of the claim. In this situation, even if the state statute of limitations is four years, the hospital provider cannot seek recovery on an improper line item denial due to contractual restrictions provided in the parties' contract. Sometimes the contractual limitations period may run from the date of the claim denial, the date of appeal or the plan's response to an appeal. Given the potential variables, hospitals should understand the applicable limitations periods for each health plan.

Hospitals should understand the applicable limitations periods for each health plan.

To avoid a potential statutory or contractual bar to recovery, a hospital provider may also consider seeking a tolling agreement with the health plan. The tolling agreement should identify the specific disputed issues, a specific time frame, and expressly state that all of the statutory and contractual limitations periods are tolled as of a date certain and until a party terminates the agreement by written notice.

If informal dispute resolution is unsuccessful, the parties' contract will generally determine the process for formal dispute resolution. Hospital contracts typically include a confidential, private arbitration provision that specifies the process for initiating arbitration. Examples of processes that promote efficiency in arbitration include: a detailed provision regarding the meet and confer process required before filing an arbitration, specification of the number of arbitrators required for appointment, and the scope of discovery.

Arbitration provisions may also include agreed upon arbitration procedures geared toward claims payment disputes, such as an agreement to exchange claims spreadsheets early in the proceedings. More detailed arbitration provisions generally ensure a smoother and more efficient arbitration process.

Strategies to Prevent Line Item Denials

Even better than understanding and resolving line item denials is preventing line item denials. There

are several ways providers can proactively prevent line item denials, including by sharing the hospital CDM during contract negotiations and negotiating contract language that helps to prevent or reduce line item denials.

Share CDM in Contract Negotiations

When sharing the hospital's CDM with a health plan during contract negotiations, the hospital can directly ask the health plan about specific charges on the CDM that are being denied and allow the health plan to voice any concerns about the CDM and to work through those concerns. Even if the health plan does not engage, once the provider has asked the health plan to discuss and address the issue, the health plan will be in a difficult position if it continues to deny charges on the CDM after being given a specific opportunity to discuss and address the CDM and raise any concerns.

The health plan will be in a difficult position if it continues to deny charges on the CDM after being given a specific opportunity to discuss and address the CDM and raise any concerns.

In years past, hospitals were sometimes reluctant to share their CDMs with health plans. Today, federal law requires hospitals to make their CDM publicly available. Specifically, Section 2718(e) of the Public Health Service Act, as amended by the Patient Protection and Affordable Care Act, requires all hospitals in the United States to annually publish a list of their standard charges in a manner specified by the Department of Health and Human Services.

CMS originally permitted hospitals to post only their charge-making policy for public review, but, effective Jan. 1, 2019, CMS now require hospitals to make their CDM publicly available via the internet in a machine-readable format and to update this information at least annually, or more often as appropriate. [*See* https://www.federalregister.gov/documents/2018/08/17/2018-16766/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the.]

There are also several state-specific requirements for public disclosure of all or portions of CDMs. For example, California has, for many years, required hospitals to file a copy of their CDM with the Office of Statewide Health Planning and Development and to estimate future charge increases for patient services. [Cal. Health & Safety Code § 1339.55.]. The compiled list of CDMs published by OSHPD can be found at *https://oshpd.ca.gov/data-and-reports/cost-transparency/hospital-chargemasters/*.

New Hampshire has a searchable public website that identifies each hospital's charges and expected patient payment amounts by facility and procedure type for most common inpatient and outpatient procedures. This information can be found at *https://nhhealthcost.nh.gov/costs/select*.

Negotiate Contract Language That Prevents, Reduces Line Item Denials

The most effective method to prevent line item denials is contract language reform. The key to contract language reform requires hospitals analyze health plan line item denials to identify the specific charges denied, denial reasons and the financial impact of the denials. With this information, a hospital is well equipped to discuss the CDM with the health plan and explain why the hospital believes the health plan's practice of performing line item denials is not appropriate.

For example, contract negotiators can explain in detail why certain charges are not included in room and board charges, the hospital's charging and billing practices for ancillary staff, the authority for the hospital's position, and any other topics identified by the hospital during its analysis of the denied charges. This type of exchange during negotiations can lead to a better mutual understanding between the parties regarding their respective practices.

After establishing the hospital's position on line item denials and the basis for the hospital's position, the hospital is in a good position to propose contract language that prohibits prepayment line item denials with limited exceptions (*e.g.* duplicate charges).

Another option is for the parties to negotiate a specific list of items or services by CPT/HCPCS code

that the provider agrees the health plan can deny in a prepayment audit. The list will provide certainty for the hospital provider and the health plan as to which charges can be denied. Additionally, the list is evidence of the health plan's agreement that charges not on the exclusion list are appropriate charges that are not subject to denial. This approach can significantly reduce the administrative burden associated with denials for both parties.

While not all providers are able to obtain line item denial prohibitions in their contracts to the full extent desired, there are other contract provisions that can assist the hospital provider with line item denials. For instance, the hospital provider can propose a contract provision that requires notice to the hospital before a health plan performs line item denials on specific charges that were previously paid during the line item denial process. The provision will also facilitate discussions between the parties early on to help resolve disputes before significant financial or administrative burdens are incurred.

If the hospital provider cannot contractually prohibit or limit line item denials, the hospital may consider adding a contractual provision that requires the health plan to provide specific information on every claim on which a line item denial is performed. The specific information should include identification of every denied charge and the authority relied upon for the denial. Contractually requiring this additional information from the plan can help alleviate the hospital provider's administrative burden to research denials, place responsibility on the health plan to affirmatively provide its reasoning for denials, and may help reduce the frequency of unjustified denials. Health care attorneys experienced in this area can provide significant value during contract negotiations to help draft provisions that will work for the provider and the health plan, and accomplish the goal of reducing line items denials and the administrative burden associated with them.

Conclusion

Addressing and preventing line item denials is not a perfect science, but it starts with gaining a solid understanding of what line item denials look like and how to determine when and why they occur. Best practices include maintaining open lines of communication between the hospital provider and health plan to address any charging concerns or disputes upfront and to continue addressing any concerns though regular operational practices.

The hospital provider should prioritize which denials most affect the provider's bottom line and make a concerted effort to address those denials with the health plan.

When a problem arises, the hospital provider should prioritize which denials most affect the provider's bottom line and make a concerted effort to address those denials with the health plan through informal efforts and, if needed, through a formal meet and confer process. If the parties are unable to reach an agreement, legal action or escalation to regulators may be necessary. Of course, the key to preventing line item denials is contract language reform that prohibits or tends to reduce a health plan's ability to perform large-scale, prepayment line item denials. ■

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