



## Maximizing Hospital Revenue and Productivity By Resolving Aged Third Party Denied and Unpaid Claims



Clark, Mascaro & Aziz, P.C. (CMA), formerly known as Clark & Mascaro, P.C. is a law firm that has been in existence for over 25 years. Our nationwide practice consists solely of helping hospitals resolve patient claims in which either no payment was made by a responsible third party or the claim was not properly paid by a third party. By exclusively focusing on this area, Clark, Mascaro & Aziz, P.C. has been able to develop a unique expertise and maintain an extraordinarily high level of success.

As a law firm designed to offer full services to their clients in this specialized area, Clark, Mascaro & Aziz, P.C. is able to handle client claims on a variety of levels. These levels range from acting as an extension of the hospital's business office all the way through the filing of suit when appropriate and authorized by the client. This allows clients to have the peace of mind of not having to worry about transferring the claim should legal action later be required. And by forwarding their difficult aged claims to Clark, Mascaro & Aziz, P.C. clients are able to more effectively concentrate their efforts on more current claims, thus increasing their revenue on both types of claims.



Our goal at Clark, Mascaro & Aziz, P.C. is to provide a level of performance and satisfaction that demonstrates to both clients and peers nothing less than the best legal service available. We are immensely proud of our accomplishments and invite you to learn more about who we are and the level of service we provide.



## Why CMA?

Clark, Mascaro & Aziz, P.C. offers nationwide innovative solutions to help manage and streamline your business office practices. Our goal is to assist with frustrating problems and aged claims so that the client's Business Office professionals can focus their time and efforts on more current claims, thus providing for maximum efficiency and effectiveness.

We offer a variety of options for claim assignment depending on the needs and desires of our clients. We can begin our resolution as an extension of the business office, with the option to be transferred to the law firm if later warranted, or we can begin claim resolution by the law firm only. We can provide insight and recommendations as to the benefits of each option and what may be best for the facility, but the ultimate decision is of course left to the client.

**Our Mission: To provide our clients with the most result-oriented, state-of-the-art insurance denial management solution in the marketplace today by utilizing our extensive industry experience.**

## Firm Resume

As an attorney in 1984 John Clark first had the challenge of attempting to overcome a third party insurance carrier's refusal to pay benefits on a claim. The hospital's staff had done everything possible from a lay perspective to force payment, but was stymied with improbable, indiscernible and changing reasons for denial based on seemingly whimsical reasoning. In that particular case, John could not accept the fact that the condition treated was preexisting, and as it turns out it was not. In addition, he determined that the preexisting exclusion period had passed. Thus, the groundwork for CMA's current specialized area of practice was laid at that time.

**CMA frees your staff to be more efficient and profitable with their inhouse and denial managements efforts.**

Upon further investigation and research, John discovered that hospitals and health care providers were quite often faced with stalling techniques and situations where specialized legal help is needed. John thus made the decision to steer his firm's focus towards hospital claims where third party payers had improperly denied coverage or forestalled payment. By resolving large aged third party denials, John's clients were able to concentrate their reimbursement efforts where they were

most effective, on less aged claims. Since that time, the firm has evolved into Clark, Mascaro & Aziz, P.C. and business has gradually grown. Third party reimbursement on a contingency basis is all that we do, and CMA has partnered with over 200 hospitals nationwide. Our Denial Specialists and attorneys have substantial experience and are specially trained in overturning improperly denied or stalled third party claims.

**Since our inception we have successfully represented our clients in all 3rd party payer arenas, including:**

- Managed Care
- ERISA plans
- Commercial Insurance
- Medicare
- Medicaid
- Municipal and Liability Claims
- Workers' Compensation

**For almost 20 years, we have also routinely handled difficult areas such as:**

- Mis-Verification of Eligibility
- Coordination of Benefits
- Failure to Pre-Certify Treatment
- Stop Loss Provisions
- Misconstrued Contractual Provisions
- Improper COBRA Notices



## Denials

The following list of denials are meant to be representative of the denial reasons handled by CMA, but as insurance companies are constantly striving to come up with new denial reasons, this list is not intended to be a complete list.

### **Not Medically Necessary**

When the insurance company feels that the specific treatment rendered was not required based on an alleged medical review of the file. However, often the individual that supposedly reviewed the claim is not a licensed physician or medical practitioner.

### **Denied For Preexisting Condition**

When a claim is denied because the policy language excludes medical conditions that the patient had during a defined period of time before the policy went into effect. The specific restrictions vary from policy to policy.

### **"Pended" For Preexisting Investigation**

When a claim is put on hold by the insurance company while they allegedly investigate whether or not the condition that was treated was a preexisting condition. The insurance company will usually require past medical information from the patient such as a list of doctors that the patient saw prior to the policy's effective date and those doctors' records.

### **Non-Covered Benefit**

Insurance policies usually contain a list and description of certain medical care and treatment that is specifically not covered under the policy.

### **Limited Benefits**

Similar to non-covered benefits, insurance policies usually contain a list and description of certain medical care and treatment that only have limited benefits (i.e. payment) under the policy.

### **Termination Of Coverage**

When a claim is denied as the insurance company is stating that the patient was not covered under the policy at the time of treatment. This often occurs even if the insurance company verified benefits to the hospital upon admission. (Sometimes the insurance company will completely rescind the policy, thus backdating the policy and treating it as if it never went into effect.)

### **Failure To Obtain Pre-Authorization**

Most insurance companies require either the individual or the medical care provider to call and obtain prior authorization of a particular treatment. If this is not done, the insurance company will deny a claim or assess a financial penalty.

### **Treatment Does Not Match The Authorized Days**

When the treatment is different than the days authorized, some insurance companies will deny the entire claim on the basis that the number of days authorized do not match the number of days on the hospital bill.



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### **Out-Of-Network Provider**

When a claim is denied or benefits are reduced because the patient did not seek treatment from a medical provider listed by the insurance company as part of their network of providers.

### **Treatment Could Have Been Provided At a Lesser Level Of Care**

When a third party reviewer, normally for the insurance company, feels that the treatment provided was excessive under the circumstances and that lesser treatment could have been provided.

### **Experimental/Investigational**

When the insurance company feels that the course of treatment was not sufficiently medically established to warrant coverage.

### **Work-Related/Workers' Compensation**

An insurance company will deny a claim if it suspects that the injury or illness may have been work-related. This would alleviate their financial responsibility by forcing workers' compensation insurance to cover the charges.

### **Pending Receipt Of Completed Claim Form**

This is a favorite tactic of many insurance companies. They will deny or pend the claim until a claim form is completed by the insured. They will often state that it is required that their members update their records and refuse to process the claim until such information is received.

### **Untimely Filing**

When an insurance company will deny a claim based on their time requirements for the filing of a claim after discharge. The time requirement may be in the patient's policy or in a contract the insurance company has with the hospital.

### **Appeal Time Expired**

For this denial, the insurance company refuses to consider a hospital or their representatives' appeal of an earlier denial as the insurance company is claiming that it was filed after the insurance company's appeal deadline. As with untimely filing, the time requirement may be in the patient's policy or in a contract the insurance company has with the hospital.

### **Denied For Alcohol Use Or Commission Of Crime**

When an insurance company denies a claim based on alleged language in the policy with their insured where it states that injuries resulting from certain type(s) of illegal activities are not covered. Exact language varies among insurance companies and even among policies, but what is consistent is that usually the denial is based on the patient's conduct at the time of injury.



## Miscellaneous Underpayments & Non-Payments

The following is a list of other miscellaneous scenarios where a claim is not paid or not fully paid that CMA can handle on your behalf. (These scenarios are simply representative and not meant to be exclusive by any means.)

### Coordination Of Benefits

When two or more insurance companies insure the same person and the companies are each disputing which one should pay first. In addition, occasionally an insurance company will withhold payment until they confirm that their insured was not covered under another insurance policy.

### Liability Of State, County, City Or Municipality For Treating Their Indigents

When a government entity brings an indigent to a hospital for treatment, often it is very difficult to get the government entity to admit financial responsibility for such treatment, but there are often specific statutes and/or case law that control such a situation.

### Payment For Prisoners Taken To A Hospital By Law Enforcement Officials

When a law enforcement agency brings an arrested individual or prisoner to a hospital for treatment, usually to the emergency room. Payment for such a situation often depends on the statutes and case law specific to the state and whether the patient is considered being in police "custody".

### Auto Accident Liability

When the patient was injured in an automobile accident where the patient was not at fault. Payment can often be obtained out of the settlement reached by the patient with the at-fault party. (Also see hospital liens below.)

### Hospital Liens

Related to auto accident liability cases set out above, many states have specific laws which enable a hospital to file a "lien" against any settlement proceeds of the patient from the patient's liability claim. Laws vary from state to state as to how a lien must be filed, the time requirements for filing such a lien, what protection a filed lien gives the hospital and what recourse a hospital has if the patient settles without resolving the lien.

### Usual And Customary Charges

Insurance companies often reduce payments based on what they allege should be the usual and customary charges for particular services for the area or region.

### Stalled Claims

Many times insurance companies will simply present excuse after excuse to not pay a claim. By itself each individual excuse may appear reasonable, but when the overall pattern is reviewed it becomes obvious that the insurance company is simply stalling.

### Refunds

When an insurance company asks for a refund of a payment previously made on a claim. CMA can handle these requests on a hospital's behalf, with no fees being due until the insurance company is no longer pursuing the refund request.



## Contract Interpretation & Enforcement

A denial is almost always based on a contract, whether it is a contract between the hospital and the insurance company or a contract between the patient/insured and their insurance company (i.e. the Insurance Plan). No matter what claim resolution option is chosen by a client, as a law firm CMA has the legal knowledge, expertise and experience to interpret the terms of a contract in such a manner as to fully maximize the hospital's benefits.



Whether it's on a claim by claim basis or for an in-depth project, CMA will ensure that you receive the greatest reimbursement legally possible under the contract.

## Special Projects

If a trend of an insurance company becomes apparent that results in a specific pattern of non-payments, slow/stalled payments or underpayments, CMA can handle the affected claims as a special project on the hospital's behalf.

By lumping together claims with similar insurance responses, a group resolution can often be achieved in an expedited fashion. Examples of such projects that have been handled by CMA are where a specific insurance company was consistently reducing bills by an arbitrary figure, and where certain types of claims were consistently not being paid correctly per the terms of the contract between the insurance company and the hospital.

## Bad Debt Review

CMA offers an extensive Bad Debt Review process whereby we evaluate accounts that are classified by a hospital as bad debt and uncollectible. We evaluate **all large, aged, unpaid claims** to ensure that all potentially recoverable monies from available third parties have actually been recovered. Many facilities opt for a periodic bad debt review to serve as a check and balance of their processes and procedures. We will review accounts even after other agencies have previously worked and closed the accounts.

## Aged Accounts Receivable Review

As an additional service available to our clients, CMA offers an A/R Snapshot Review. In this process, CMA will review a listing of the hospital's large and aged A/R accounts from any date of discharge, and will provide a list of claims which appear to still have potential third-party funds available.

In such a review, clients determine the specific categories of accounts (uninsured, commercial, etc.) for review. Clients always have the final decision regarding which files are assigned to CMA. Claims not identified as having remaining third party liability may still be pursued by traditionally utilized remedies. Depending on client preference, a snapshot can be a one time event or can be scheduled at regular intervals.

