Payer Relations Toolkit

A Guide to Help AAN Members Develop and Maintain Positive Working Relationships with Payer Medical Directors and Decision-makers

Available online at aan.com/view/payertoolkit

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Introduction

Health care provider advocacy is crucial at the federal, state, and payer levels to ensure fair reimbursement. The ability to efficiently and effectively address administrative, coverage/payment, quality and cost designations, and contractual issues with third-party payers has become crucial in neurologists’ quest to provide the highest quality care to their patients.

The Payer Relations Toolkit is designed by the American Academy of Neurology (AAN) Payment Policy Subcommittee. This subcommittee consists of a group of volunteer members who work to develop and maintain positive relationships with payers at a national level. The resources included in this toolkit will help neurologists and office administrators develop and maintain mutually rewarding relationships with decision-makers at private insurance companies at their own local level.

The mission of the AAN Payment Policy Subcommittee is to foster positive working relationships by working together with the health insurance industry toward high-quality patient-centered health care solutions. The group further strives to establish itself as a primary point of contact for members and payers seeking definition and development of medical policies that affect neurologic care. Specifically, the group maintains regular communication regarding neurology-focused concerns about covered services, plan policies, and administrative procedures that impact patient access, quality, efficiency of treatment, and reimbursement.

View the AAN's payer relations activities on the web at: aan.com/go/practice/private
Why You Need This Toolkit

Establish Productive Relationships with Payers
Physicians who have a process in place to contact payers find that issues are identified in a coordinated and consistent manner. Having a regular dialogue with insurance companies helps them understand the problems neurologists face and provides them with opportunities to correct and improve their policies and procedures. When neurologists understand and are able to positively influence payer decisions where appropriate, they are able to maximize time spent providing quality care to patients and reduce frustrations with the payer.

Build the Groundwork for Successful Appeals
One of the main reasons a physician might want to contact a payer is to appeal denied claims. The success of health coverage appeals provides the most compelling argument for pursuing them—very often, appeals of denials for coverage or reimbursement by health payers are ultimately successful in favor of the covered individual. However, success may not always be achieved at the first level of appeal, but is more likely with an established relationship built on trust as well as consecutive and polite persistence on the issue.

Make the Best Use of Your Time
The AAN Payer Relations Toolkit guides members toward their own optimal relationship with representatives from the private payers they work with on a regular basis. At some point in a physician's career he or she likely will face a coverage denial or adverse decision from a contracted payer. Use the contents of this toolkit to develop your own process for working with the payers to ease the burden so that you can get back to practicing the profession you love.

Receive Additional Assistance from the AAN
This toolkit also provides neurologists with the opportunity to contact the AAN directly for help with larger, more challenging issues or problems that may affect a large portion of the membership. The Payer Feedback Form can be filled out by a physician or office staff and alerts the AAN to the issue so it can be tracked at the national level. The AAN can leverage its national relationships with the payers where necessary to help solve issues in a timely manner.

Begin Using the Payer Relations Toolkit Today
Read through the toolkit and share it with your staff. There are tools and suggestions you can put into use immediately, such as using the template letter to set up a face-to-face meeting with payers with whom you do not already have relationships, or establishing an internal process that will help lead to a successful outcome in the face of an audit. Other information will be useful as situations arise, such as appealing a claims denial using the included template letter. The final section of the toolkit includes additional AAN resources and staff contacts for further assistance.
Case Study: Information Is Power

Knowing who to talk to at an insurance company, and what to say, can have a profound effect on patient care, as seen in this literal life-and-death true story of a neurologist with a dire need.

“I was unable to receive private insurer coverage for plasmapheresis for one of my patients. In fact, the insurer cited the AAN’s guideline as part of their rationale for non-coverage. They weren’t budging. The issue was time-sensitive: my patient would die if she did not receive this treatment.

“I turned to the AAN and, within two hours, staff members in the AAN guidelines and payer advocacy areas provided me with information about appropriate interpretation of guideline recommendations and specific language to use in my communications with the insurer. As a result, I requested to speak to a peer when I again contacted the insurer. Once dealing with a peer (physician in the same specialty), I explained the case and provided the information. I was able to break through the red tape. And, ultimately, I was successful in obtaining coverage. My patient lived.

“Had the AAN not stepped up to provide this information in a timely manner and given me the language/tools I needed to get to the right person at the insurer, my patient may not have survived.”

By using the recommendations in this toolkit to establish relationships with key payer staff (i.e., the “right people”) and knowing how to use AAN guidelines and resources to back up your claims, you will be better equipped to deal with urgent situations where life may be in the balance.
Get Paid on the First Claim Submission

The AAN payer relations team reached out to some of our medical director colleagues at various payers and received the following suggestions. Before contacting a payer about an issue, make sure you are able to answer the questions below and that contacting the payer is the most effective resolution. Many times, the answer to your issue lies in the details of the coverage or policy and can be answered after a little research, avoiding an unnecessary and potentially lengthy phone call.

- Is the patient eligible for this coverage under his or her health plan?
  - If so, does the patient have the applicable benefit? If not, there is little value in pursuing an appeal.
  - If it is not clear if the service or treatment is covered, an appeal is warranted.

- Does the payer make publicly available a current coverage or reimbursement policy that covers or excludes the requested service?*

- Is this service medically necessary?

- Are there any network constraints that are limiting the requested service?

- Was there any information missing from the claim?
  - Be sure to get the details of the denial in writing from the payer to help you review the claim for any clerical errors or missing information.

- Has the patient's co-payment or co-insurance amount for a covered service, drug, or item recently risen and become unaffordable to the patient?

*Finding publicly available payer coverage/reimbursement policies can be a challenge since private payers are not required to post the documents. The AAN provides information on how to locate private payer policies that are available online at aan.com/go/practice/private, under “Payers Web Sites.”
Tips from Insiders

This insiders’ look at ways to work effectively with payer representatives from the first point of contact includes tips provided by:

- AAN Payment Policy Subcommittee members
- State neurologic society leaders
- AAN Palatucci Advocacy Leadership Forum graduates
- AAN members via the AAN Practice Community Forum on AAN.com

Developing Positive Working Relationships

Successful payer advocacy starts by connecting with the right person (a peer, a medical director and/or other decision-maker).

- Develop and continually update a template to help you collect and organize key contact information for the third-party payers with whom you contract. Such information consists of names, titles and job responsibilities, phone numbers, email and mailing addresses, websites, coverage policy databases, and notes about any personal connections or information known about the individual.

- Set a goal to meet annually and in-person with a medical director or other decision-maker from each payer on your list. Face-to-face discussion is paramount in developing relationships with important individuals, providing an opportunity to build credibility and develop mutual trust. During in-person meetings, remind the payer that you are available and happy to help answer any questions that come up in their group about specific clinical topics within your area(s) of expertise.

- Conference calls are an acceptable way to communicate and nurture an already established relationship, but never underestimate the power of a face-to-face meeting and personal connection. Physicians report having the best relationships with third-party payers with whom they have met face-to-face.

“In our state [Indiana], the presidents of each specialty society meet a couple of times a year with insurance representatives. This group (mediated by the state medical society) meets regularly with the top four representatives for Medicaid in our state. This helps develop a working relationship.”
Effective Communication

When both parties are clear about expectations and timeline on specific requests, mutually satisfying work occurs quickly and you can get back to the important work of helping your patients. Efficiency is key. Time is valuable.

- Speak in a professional manner.
- Avoid inflammatory rhetoric.
- Document phone calls: to whom, when, and specific details of the conversation.
- Be prepared on the phone with all information readily accessible.
- Get to know the “buzzwords” that are frequently rejected—or approved—by the payer. For example, some payers automatically deny a claim when certain terminology is used (e.g., “rule out” on the basis of too little clinical support or approve when the indication is “pre-op” or “pre-chemo”).
- Be honest and do not waste time with language that is not supportive of your case.

“Yelling and threats distract from the situation and do not help in getting approval.”

Appealing Denials

Physicians should not be afraid to appeal inappropriate payer denials. Come prepared and confident in defending your decisions.

- State reasons for the service up front, particularly if you are aware that a payer consistently denies the service in specific instances. For example, document clearly in the medical record why the patient cannot receive a required step therapy (e.g., patient cannot have physical therapy because the patient is “too clinically unstable” or “too weak”).
- Sometimes when a payer denies approval, it is because the physician has missed the mark on describing in his/her note, or explicitly explaining the underlying reason for the service.
- In general, for those issues that are questionable or “touchy,” provide the payer with one peer-reviewed article supporting your point right along with the claim. With evidence, payers are quicker to approve the test or service.
- On clinical coverage decisions and requests for prior authorization, request to speak to a peer within the organization. A peer is defined as a physician of your same specialty.

Physicians legally have the right to challenge a coverage denial by a health insurance plan, guaranteed to all insured individuals. Every plan provides a process for reconsideration of any adverse determination. Appeals are most likely to be successful when presented in accordance with the plan’s appeals process and timeframe. The most effective appeals include very clear, factual statements about the purpose of the appeal. Most importantly, appeal letters must be tailored to the specific patient’s need(s) as documented in the medical record, and provide a clinical justification in support of the recommended treatment or service.

“For denials or peer-to-peer reviews, have information on hand to support your position. Be clear and concise, and do not argue or insult the medical director. If your claim is still denied and you feel strongly that it should not be, inquire about the next level of appeal.”
Coordinating Your Efforts with Other Neurologists

There is power in numbers. Work with other neurologists in your area to identify and overcome common issues.

- Join your state medical and/or state neurology society. Then, when other approaches fail, be vocal to the appropriate state medical committees with specific information: the company, the individual representatives, and the service, medication, or treatment in question—with all supporting documentation. Copy letters to appropriate higher level figures within the payer and possibly even your medical society president and legal affairs division.
- Complete the Payer Feedback Form.
- Contact your state neurology society about a recurring issue. Maybe others are experiencing the same issue(s).
- If you are struggling to make progress on an issue with the payer, consider contacting your state health insurance commissioner.

Spotlight: Trained Neuroimagers

These tips are of specific help to trained neurologists who order and/or interpret imaging studies.

- Order the tests that you feel are necessary at the same time. Ordering tests piecemeal inconveniences the patient and can be viewed as disingenuous. One member noted that ordering two MRIs at the same time requires more explanation and thought, which sometimes results in deciding that the second MRI is not really needed.
- Have one or two members of your office staff take care of all pre-authorizations so that the process becomes familiar to those individuals. This is much more efficient than reinventing the wheel or feeling intimidated each time you must seek prior approval.
- Always have your staff ask to speak to a physician—and insist on a specialist. You are a specialist and only a neurologist can understand your pre-authorization request. Never hesitate to appeal the decision if you think the test would be helpful.
- Get to know the names of a few physicians at the company who complete pre-authorizations for your patients. When you or your staff ask to speak to those specialists by name, they will view you as professional colleagues.
- Many requests are denied because the patient had the study approved by a different physician within the past month and forgot to tell the current physician. It is common in neurology. Remember to obtain as much information as you can from your patient to avoid this issue and get the results you want. Again, experienced staff will see this over and over again.
- If there is something unique or unusual about the case—such as “possible ALS” or “possible paraneoplastic syndrome”—point out right away that it is unusual and that it should be reviewed only by a neurologist. This will bypass review by others who are not familiar with unusual clinical neurology. If there is a treatment decision to be made (e.g., steroids vs. plasmapheresis), mention the urgency and make specific note that the decision must be made within a certain amount of time (e.g., 6 hrs, 12 hrs, 24 hrs).
- The ordering physician must provide a legitimate clinical indication for the performance of the study. This is NOT a clinical indication: “Patient called and asked for a brain MRI. Thinks she has MS because her neighbor has it, or she read about it in a magazine.”
Terms, Concepts, and Facts You Must Know in the Appeal Process

More than 50 percent of appeals of denials for coverage or reimbursement by payers are ultimately successful in favor of the covered individual. Success may not be achieved at the first level of appeal, and is more likely with consecutive, polite, persistent challenges. Appeals are most likely to be successful when presented in accordance with the payer’s appeals process and timeframe. Effective appeal letters are clear statements about the purpose of the correspondence, factual, and brief. Most importantly, appeal letters must be tailored to the specific patient’s need(s) as documented in the medical record, and provide a clinical, evidence-based justification in support of the recommended treatment or service.

The person designated to collect issues for your practice should be the person who handles and submits claims and appeals of denied claims to the payer on a regular basis.

Common Terms

**Adverse Determination:** Notification from the health plan or plan administrator advising the covered person of a reduction or denial of benefits

**Authorized Services:** Services which have been pre-certified when required under the terms of the contract

**Case Manager:** A nurse, doctor, or social worker who arranges all services that are needed to give proper health care to a patient or group of patients

**Carveout:** A portion of covered benefits which is set apart from the body of the health plan, such as mental health or substance abuse treatment, and subject to the advice of entities with specific expertise in the relevant specialized field or practice under contract with the health plan

**Claims Reviewer or Adjuster:** An employee of the health plan whose primary responsibility is to review claims for benefits before, during, or after services are provided

**Concurrent Review:** A coverage determination or appeal made during a course of treatment

**Evidence:** Generally referring to published studies and other credible documentation of the effect of a treatment, often used by doctors as proof that a treatment works or does not work

**Exception Request:** A term describing an appeal to a Medicare prescription drug plan requesting coverage for a drug not covered by the formulary, or for coverage of a “non-preferred drug” at a “preferred drug” cost

**Experimental or Investigational Treatment:** Treatment traditionally excluded from coverage by health insurance on the basis that 1) it is a drug not approved for marketing by the US FDA, including off-label indications of FDA-approved drugs; or 2) a procedure or therapy outside the scope of generally accepted medical practice
Expedited (Accelerated) Review: An appeal reviewed on a shortened timeframe provided when/if the provider believes a delay in treatment poses an imminent or serious threat to the patient’s health or ability to regain maximum function.

External Review: A determination of medical necessity conducted by neutral parties. If availability to an external appeal is a right established by state law (and therefore limited to plans subject to state law/regulation), the state’s Commissioner of Insurance is responsible and should be contacted for information regarding process, timeframes, and possible fees for the applicant.

Grievance: A request for reconsideration of an adverse determination concerning an administrative decision, rather than medical necessity, such as a dispute over a network pharmacy’s hours of operation, or timeliness of claims processing.

Health Plan: Commonly accepted term to describe the organizational schema of health insurance policies or contracts.

Internal Review: The formal process of appeal of an adverse determination at the first or second levels.

Medical Necessity: The determination of whether health services provided to a patient are required to maintain health according to accepted medical practice, current research and efficiency considerations.

Off-label Use: The use of a drug approved for marketing by the US FDA, but for a different indication than that described on the label.

Pharmacy and Therapeutics (P&T) Committee: A group of physicians, pharmacists or other health care providers who advise a health plan regarding safe and effective use of medications. The P&T Committee manages the formulary and acts as the organizational line of communications between the medical and pharmacy components of the health plan.

Pharmacy Benefit Manager (PBM): Organizations that contract with health plans (including risk and non-risk arrangements) for the purpose of administering prescription drug benefits to plan members.

Retrospective Review: A coverage determination or appeal made after a service or item is provided.

Step Therapy: A strategy used by health plans, particularly pharmacy benefit managers (PBMs), to manage costs. Step therapy requires that a particular therapy—generally one that is less costly—be tried first. Approval for coverage of a more costly therapy is only provided if the patient fails to respond to the first therapy.

Tier (as in Tiered Formularies): Level of cost-sharing that applies to specific drugs on a plan’s formulary. Plans generally have multiple cost-sharing tiers; tiers designated by smaller numbers (e.g., tiers 1 or 2) generally have lower cost-sharing than those designated by larger numbers (e.g., tiers 3 or 4).

Unlabeled Use: see “off-label use”
How Payer Physician Profiling/Tiering Programs Impact You

Proprietary programs by payers “rate” or “score” physicians according to cost and quality metrics. Some payers use the ratings to drive referral patterns by using lower co-pays, for example, for designated “cost-effective” or “higher quality” physicians.

The AAN seeks active involvement in the development, implementation, and evaluation of physician profiling/tiering programs that cover neurologists.

Neurologists should be aware of their ratings and be prepared to review and challenge the ratings, if needed.

The AAN signed on to an American Medical Association initiative to create guidelines to standardize reports used in physician profiling programs to ease the burden on physicians keeping track of their performance in different payer programs since they likely contract with many different payers.

For more information, visit aan.com/go/practice/policy, under “Physician Profiling.”
Thriving in the Face of an Audit...And Avoiding One in the Future

Regular internal auditing can help you identify incorrect billing patterns before claims are denied or outside auditors assess penalties. The AAN partnered with the AMA to develop an internal billing audit brochure to help you learn the steps to performing an internal audit in your office. The AAN and the AMA also partnered to create an external audit brochure guiding physicians through a retrospective health plan audit.

Reducing Your Risk of Audit
Audits do not typically happen by accident. Make sure you are not an outlier by checking your profile and the distribution of codes you use. You should prepare to explain why you may appear to be an outlier by identifying your unique circumstances:

- Regular use of “problem” or “abused” codes
- Consistent visits with more complex patients
- Billing abnormally high dollar amounts
- Aberrancy in billing patterns
- Use of add-on codes without the parent procedure code

In short, you must know how you compare with your peers. You can minimize your exposure by making sure you properly code and document your visits at all times. Remember that E/M and prolonged services are frequent targets for audits.

Tips to Effectively Manage an Audit
Physicians being audited should make sure that the sample requested is statistically valid. Claims are chosen based on known issues (e.g., problems known to RACs) as well as data mining by the payer (e.g., medically unlikely service provided).

- Read the request, citation, and demand (if any) carefully
- Contact the payer/requestor and ask to speak with someone directly
  - If they refuse, DOCUMENT IT IN WRITING.
- Check your contract for what you are obligated to provide
- Ask the same, experienced, staff member(s) to handle all audits
- Similarly, ask an experienced/expert staff member to pull the medical records
- Understand who is performing the audit:
  - Comprehensive Error Rate Testing (CERT)
  - Payment Error Rate Measurement (PERM)
  - Healthcare Fraud Prevention and Enforcement Action Team (HEAT)
  - State Medicaid Recovery Audit Contractor
• Recovery Audit Contractor (RAC)
• Private Payer (e.g., CPT and procedural audits, HEDIS audits)
• Other

Determine what the requestor wants

IF THE REQUESTOR HAS ACCESS TO ALL OF THE CLAIMS, DO NOT LET THEM EXTRAPOLATE CLAIMS FOR AN AUTOMATED REVIEW
Negotiating a Winning Contract with Your Payer

When engaging in negotiations with a payer, keep in mind that the payer is:

- Prepared – They are professional. This is their job.
- Talented – They contract all the time.
- Experienced – They have heard it all before. Know your practice data (e.g., total revenue, number of unique patients, number of visits per CPT code, RVU total by CPT, compute $/RVU by payer). Also, know your practice metrics (e.g., demographics, quality outcomes, patient satisfaction, referring physician satisfaction, investments in technology).

There are many ways physicians can influence success:

- Expectation – Know your goal and what you will settle for.
- Presentation – A good presentation is important: In writing, professional appearance, clear, concise, with relevant data.
- Attitude – Talk like a professional: Clear, concise, confident, reasoned.
- Know what you are signing! Read it. Understand terms and definitions. For payer contracts, utilize a lawyer or accountant if you have questions and/or it’s not a standard contract.
- During the negotiation itself, make sure you summarize responses in writing using respectful language and in a timely manner.
- Keep in mind what payers want: network, price advantage, case efficiency, quality care.
- Negotiations turn out better if: you have an established relationship with the payer, you are better prepared, there are limited alternatives for payers, you provide a unique service, or you accept patients using multiple payers.*

*Note: Negotiating contracts with payers, especially negotiation in collaboration with other physicians, may implicate antitrust laws. Neurologists who wish to explore negotiation strategies are encouraged to retain all legal advice from an experienced antitrust attorney. See page 18 for further guidance.

For more information on successful negotiations, consult The Physicians’ Comprehensive Guide to Negotiating, by Babitsky and Mangraviti, available to AAN members at a discount online at The AAN Store®.
Template Letter: Introduction to a Payer

Use this to establish a relationship with a private payer before a specific issue arises. Highlight the text below, copy, and paste into a word document.

[DATE]
[PAYER]
[ATTN:]
[ADDRESS 1]
[ADDRESS 2]
[PHONE]
[EMAIL]
RE: [PHYSICIAN/PRACTICE NAME] Letter of Introduction

Dear [DR./MR./MS./DIRECTOR OF CLAIMS NAME, IF AVAILABLE],

Please accept this letter as an introduction on behalf of my practice. My name is [NAME] and I am a practicing [NEUROLOGIST/PRACTICE MANAGER] for a neurology group at [EMPLOYER]. I currently accept patients insured by [PAYER]. Neurologists specialize in diseases of the brain and nervous system. These often complex and chronic diseases include Alzheimer’s disease, stroke, multiple sclerosis and epilepsy, amongst many others. Due to the nature of these diseases, neurologists typically have frequent and prolonged visits with their patients. Most neurological diseases additionally require coordination of care with other health care providers.

In today’s rapidly changing health care environment, frustrations often exist between physicians and payers. However, I believe that the ultimate goal of physicians and payers is the same: to provide the most appropriate care at the most appropriate time to ensure the best patient outcomes. Therefore, I am taking this first step in breaking down some of the barriers to create a strong working relationship with your organization. I look forward to collaborating with you to provide the highest-quality patient-centered health care solutions to patients.

I am writing to offer my assistance with any neurology-related questions that arise with [PAYER]. My practice specializes in [LIST ANY SPECIALTIES], and I am willing and able to act as a reliable data resource without obtruding in any manner with [PAYER] internal priorities and goal setting.

I would welcome an opportunity to meet with you and your staff and illustrate some of the ways that I can be helpful to [PAYER]. May we please set up a time to introduce ourselves? You may contact me by phone at [XXX-XXX-XXXX] or by email at [XXXX@XXXX.XXX]. I look forward to hearing from you soon.

Sincerely,
[NAME]
[MAILING ADDRESS]
[CITY, STATE, ZIP]
[DAYTIME PHONE]
[EVENING PHONE]
Template Letter: Appeal a Coverage Decision

Use this letter as a guide to help you submit a complete appeal. Highlight the text below, copy, and paste into a word document.

[DATE]
[PAYER]
[ATTN.]
[ADDRESS 1]
[ADDRESS 2]
[PHONE]
[EMAIL]

RE: Policy [INSURANCE POLICY NUMBER]
Insured [NAME OF PATIENT OR INSURED PERSON]
Treatment dates [ADMISSION DATE – DISCHARGE DATE, IF APPLICABLE]
Amount [TOTAL CHARGES]

Dear [DR./MR./MS./DIRECTOR OF CLAIMS NAME, IF AVAILABLE],

My name is [INSERT NAME] and I am a [NEUROLOGIST/PRACTICE MANAGER] at [EMPLOYER]. I currently accept patients insured by [PAYER].

Please accept this letter as [PATIENT'S NAME] appeal to [PAYER] decision to deny coverage for [NAME OF SPECIFIC PROCEDURE DENIED]. It is my understanding, based on your letter of denial dated [INSERT DATE], that this procedure has been denied because [QUOTE THE SPECIFIC REASON FOR THE DENIAL STATED IN THE DENIAL LETTER].

Currently, [I/ DR. XXXX] believe(s) that the patient will significantly benefit from [PROCEDURE]. You may not have had all of the necessary information at the time of your initial review. Please find additional details about the nature and effectiveness of [PROCEDURE] attached to this correspondence.

Based on this additional information, I hope that you will be able to provide a description of the records that would be necessary in order to approve the treatment, and reconsider your previous decision and allow coverage for [PROCEDURE] as outlined in this letter. Should you have questions about these materials or require anything further, please contact me by phone at [XXX-XXX-XXXX] or by email at [XXX@XXX.XXX].

Thank you for your prompt attention to this issue. I look forward to hearing back from you within 10 days of the receipt of this request.

Sincerely,

[NAME]
[MAILING ADDRESS]
[CITY, STATE, ZIP]
[DAYTIME PHONE]
[EVENING PHONE]
Escalate an Issue: Use the AAN Payer Feedback Form

For those payer and coverage issues that are persistent and/or challenging, the AAN provides members with an opportunity to submit feedback by contacting AAN staff through use of the Payer Feedback Form. The AAN may have additional resources to members struggling to resolve an issue. Alternatively, members may choose to contact AAN staff directly to discuss the issue.

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Antitrust Considerations

Neurologists may refer to the AAN Payer Relations Toolkit when contacting payers to express concerns with plan policies, covered services, and administrative hassles. The Toolkit may help neurologists in sharing information and building relationships with payers, and to strengthening established relationships.

The AAN Payment Policy Subcommittee’s efforts to improve payer policies and procedures, along with the AAN Payer Relations Toolkit, can facilitate better working relationships between neurologists and payers, and may lead to more efficient and timely payer practices concerning claims adjudication, as well as reasonable and appropriate payment for covered services.

As a word of caution, the strategies suggested in this Toolkit must be used by members in an appropriate manner and not for engaging in anti-competitive activities. The antitrust laws can involve complex legal and economic analysis beyond the scope of this Toolkit; but they are integral in the overall consideration of building payer relationships. The current antitrust landscape weighs heavily in favor of payers because of serious limitations placed on joint physician activity. Members are encouraged to retain legal advice from an experienced antitrust attorney in these situations.

Disclaimer

No material contained in the AAN Payer Relations Toolkit should be construed as legal advice. Neurologists are encouraged to seek advice from attorneys with expertise in payer relations.
Additional Resources

The AAN’s role in the development of health insurer coverage policy

The AAN’s role in the development of health insurer coverage policy
cp.neurology.org/content/2/2/139.full

AAN Practice Management Resources
Public & Private Insurer Relations Page aan.com/go/practice/policy
Private Insurer Relations Page aan.com/go/practice/private
Hard to Find Insurer Policy Links aan.com/go/practice/public/hardtofind
Payer Feedback Form aan.com/view/payerfeedback

AAN Position Statements
aan.com/go/about/position

AAN Guidelines
aan.com/go/practice/guidelines

AAN Measures
aan.com/go/practice/quality/measurements

AAN State and Local Advocacy
Includes state society development tools, events calendars, state-specific links, news, and more.
aan.com/go/advocacy/states
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References: