MAXIMUS
Federal Services

Medicare
Managed Care & PACE
Reconsideration Project

Reviewing Medicare Appeals

MAXIMUS Federal Services
Medicare Part C QIC
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Who We Are

We are MAXIMUS Federal Services. We are experts on appeals. Medicare hired us to review the file and decide if the health plan made the correct decision. We work for Medicare. We do not work for the health plan.

Cathleen MacInnes
Project Director
Medicare Managed Care & PACE Reconsideration Project

Do you need help?

Call 1-800-MEDICARE (1-800-633-4227) for help or more information about what you can do in this case. TTY users should call 1-877-486-2048.

The Appeal Number is: 1-4513360516

July 25, 2016

ROSE HOCKETT DIR OF BUSINESS SVC
ST LUKES HOSPITAL
915 E 1ST STREET
DULUTH, MN 55805

RE: Enrollee: T. Connor
Medicare Number:
Date(s) of Service: November 21, 2015 to December 9, 2015

Dear ROSE HOCKETT DIR OF BUSINESS SVC:

This letter is about our decision in your appeal to UPPER PENINSULA HEALTH PLAN, LLC (UPHP). You asked UPHP to pay for the inpatient hospital services provided from November 21, 2015 to December 9, 2015.

Our decision

We agree with you. This means that we will tell UPHP to pay for these services. To learn more about how we made our decision, read the following pages of this letter.

What you have to do

We sent UPHP a copy of this letter, so they know they have to pay for these services.

UPHP has to pay for the item or service within 30 days. If UPHP does **not** do so within 30 days, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

cc: H1977: UPPER PENINSULA HEALTH PLAN, LLC, c/o Nicole Sandstrom
Chicago CMS Regional Office

How we made our decision

1. We read all the papers in the file.
2. We checked Medicare rules.
3. We checked the contract with UPHP.

To make our decision we read all the papers in the file very carefully. We used the Medicare rules. We looked to see if UPHP correctly followed Medicare rules and regulations.

Medicare rules say that the health plan must give the member a subscriber agreement. It is a contract between the health plan and the member. It is usually called the "Evidence of Coverage" (EOC) or "Member Agreement." We read this contract carefully to see what UPHP is supposed to cover.

Medicare rules

The rules say that health plans must pay for a medical service or item if regular Medicare would pay for it in this case. You can find this rule at 42 CFR §422.101.

The rules say that a Medicare health plan may restrict members to a network of providers as long as medically necessary covered care is accessible and available through this network. The rules say that the health plan must arrange for specialty care outside of the plan provider network when network providers are unavailable or inadequate to meet a member's medical needs. You can find this rule at 42 CFR §422.112.

The rules say that a Medicare Health Plan is financially responsible for emergency services regardless of whether the services are obtained within or outside the Health Plan. Emergency services are covered whether there is prior authorization for the services. An emergency is defined as when a person would believe that without immediate medical attention there would be serious jeopardy to his or her health. You can find this rule at 42 CFR §422.113.

The rules say that a contract plan provider is an agent of the plan. Services and referrals obtained from a plan provider are viewed as plan-approved unless notice is given that the services will not be covered. When a plan provider gives, or refers an enrollee for, a service that the enrollee reasonably believes is covered by the plan, the enrollee is held harmless and need not pay more than the plan-allowed cost-sharing for that service. You can find this rule at Medicare Managed Care Manual Ch. 4 §170.

If you want to read these Medicare rules, you can go to this web site www.medicareappeal.com.

The health plan contract

The health plan contract says that UPHP covers items and services in accordance with Medicare rules. The health plan contract says that members must use network (contract) providers to get their covered services. The only exceptions are emergencies, urgently needed care when contract

admission to St. Luke's Hospital was emergent, the health plan would have to show that the emergency care ended at some point prior to discharge. The health plan has made no argument that T. Connor was stable for discharge or transfer at any time between his emergency admission to St. Luke's Hospital on November 21, 2015 and his discharge on December 9, 2015.

Even if we assume that UPHP was incorrect in its determination that the admission to St. Luke's Hospital was emergent or that T. Connor received post-stabilization care at St. Luke's Hospital prior to discharge, we find that the transfer to St. Luke's Hospital was plan directed care. T. Connor was transferred to St. Luke's Hospital at the request of the plan contract hospital, Aspirus Grand View Hospital, because the plan contract hospital did not have adequate facilities to meet T. Connor's medical needs. The file does not show that UPHP's contract provider, Aspirus Grand View Hospital, requested prior authorization of this referral, advised you that T. Connor was a UPHP enrollee, or informed you of the need to notify UPHP of this transfer. However, under Medicare rules, referrals given by a contract provider are considered approved by the plan unless notice is provided that the services will not be covered. Since neither Aspirus Grand View Hospital nor UPHP advised you that these services would not be covered, this transfer is considered plan-approved.

Therefore, we decided that UPHP has to pay for the inpatient hospital services provided from November 21, 2015 to December 9, 2015.

If UPHP does not agree with our decision, they can ask us to open a case again. We only open a case again if we believe there was a mistake or if there is new information to review. The health plan has to show us the mistake and/or send us the new information. **This does not happen often.** If we decide to open the case again, we will send you a letter.


ERN
NCRA
CAN I PROCESS
THIS?

WHAT IF YOU COULD PREVENT DENIALS?

We created a Clinical Denial Prevention Unit to work in concert with our Case Managers (before bill drop) to:

- Convert tracking and reference numbers to authorization numbers prior to billing to avoid backend denials.
- Challenge improper requests for medical records to review services prior to the issuance of an authorization.
- Fight concurrent or continuity of care denials and initiate a notice of disagreement of care to trigger the plan's responsibility to assume care for patient under State law and 42 CFR Part 422.
- Expedite transfer of a patient to ensure continuity of care.
- Challenge a plan's refusal to conduct retrospective review for unauthorized medically necessary services (provided after normal business hours, or when the patient's insurance information was not provided, etc.)
- Challenge improper denials of care after patient is discharged under Title 28, Part 422 or any other applicable regulation.
- Challenge medical necessity, reductions of level of care and disputed health care services under state and federal laws
- Fight prospective care (pre-certification) denials.

We fight health plan unfair payment practices and deploy the company's renown, Web-based proprietary denial prevention and management program (REVAssurance) to:

Obtain Timely Authorizations | Accelerate Revenue Capture | Overturn Improper Denials | Decrease Bad Debt | And Improve Operating Margin And Cash Flow.

www.erntraf.org

CASE STUDY

OBTAINING AUTHORIZATION AFTER PATIENT DISCHARGES (ERISA)

CONFIDENTIAL FACSIMILE TRANSMITTAL SHEET

TO:	FROM:
Medical Management	*Inez Villalobos*
COMPANY:	DATE:
Blue Cross Blue Shield of Illinois	*WEDNESDAY, MARCH 23, 2022*
FAX NUMBER:	TOTAL NO. OF PAGES INCLUDING COVER:
312-233-4060	4
PHONE NUMBER:	SENDER'S REFERENCE NUMBER:
	TRAF#81217
RE:	
Request for Retro-Authorization for Inpatient Admission	

X URGENT ☒ FOR REVIEW ☐ PLEASE COMMENT ☒ PLEASE REPLY ☐ PLEASE RECYCLE

PLEASE ACCEPT THIS AS A RETRO AUTHORIZATION REQUEST AND PROVIDE A HARD COPY AUTHORIZATION FOR THE SERVICES PROVIDED.

29 U.S.C. § 2560.503-1(b)(5) addresses claim procedure and mandates that:

> ***The claims procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants.***

According to the above your determination must be made in accordance to the Summary Plan Description or any governing plan document.

Best,

Inez Villalobos
Claims Compliance Auditor III
Tel: (714) 820-6960 Fax: (714) 995-6901
Email: inezvillalobos@ernenterprises.org

ERN
TRAF

REQUEST FOR RETRO AUTHORIZATION
Submitted via Fax

March 23, 2022

Blue Cross Blue Shield of Illinois
Attn: Medical Management
P.O Box 3418
Scranton, PA 18505

Fax: 1-312-233-4060

Our client: St. Charles Health System
Tax ID:
Patient: White,

DOS: 12/22/21-03/11/22

This office represents St. Charles Health System and has been asked to request a retro authorization for the services referenced above.

Please note these services have been partially authorized through the employer's previous third-party administrator (Meritain Health) under **authorization #3791712**. Patient has health insurance coverage through employer Cushman and Wakefield, a self-funded ERISA plan. On 01/01/22, Cushman and Wakefield change third party administrators from Meritain Health to Blue Cross Blue Shield of Illinois, making it almost impossible to secure continue authorization for the inpatient admission.

The change in third-party administration is truly concerning as the patient was receiving inpatient services during the change.

Upon our investigation, we have come to the following understanding of our client's position in this matter:

- On 12/22/21, the patient presented to St. Charles with intra-abdominal and pelvic swelling. The same day St. Charles notified Meritain Health of patient admission and requested authorization. Hailey with Summit provided authorization #3791712 for exploration laparotomy.
- On 12/29/21, St. Charles submitted clinicals to Meritain Health.
- On 12/30/21, St. Charles received continued stay authorization from Meritain Health.
- On 01/04/22, St. Charles submitted clinicals to Meritain Health.
- On 01/17/22, St. Charles submitted clinicals to Meritain Health.
- On 01/20/22, St. Charles submitted clinicals to Meritain Health.
- On 01/28/22, the patient suffered from recurrent respiratory failure and St. Charles submitted clinicals to Meritain Health.
- On 02/21/22, Husband called St. Charles to verify Meritain Health insurance is responsible for DOS 12/22/21-12/31/21 and Blue Cross is responsible for DOS 01/01/22-discharge.

- On 03/17/22, St. Charles called Blue Cross and Kelly stated Blue Cross provides no retro authorizations for encounters past 7 days (call ref# U22076BIJB).
- To date, Blue Cross has failed to review this case and provide a written determination as required under federal law.

PLEASE ACCEPT THIS AS A RETRO AUTHORIZATION REQUEST AND PROVIDE A HARD COPY AUTHORIZATION FOR THE SERVICES PROVIDED.

Under ERISA law, a plan administrator must provide a claimant with written or electronic notification of any adverse benefit determination consistent with **29 CFR 2560.503-1(g)(1)**, which states:

> ***The notification shall set forth, in a manner calculated to be understood by the claimant --(i) The specific reason or reasons for the adverse determination; (ii) Reference to the specific plan provisions on which the determination is based; (iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; (iv) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review;***

Furthermore, it adds:

> ***(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request.***

Lastly, **29 U.S.C. § 2560.503-1(b)(5)** addresses claim procedure and mandates that:

> ***The claims procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants.***

Here, on 03/17/22, Kelly with Blue Cross stated they cannot provide retro authorization for this case (call ref#U22076BIJB). However, Blue Cross has failed to provide any a summary plan description or any governing plan document that shows retro-authorization requests are not allowed under the member's plan.

Accordingly, this office requests the following pursuant to **29 U.S.C. § 1024(b)(4):**

- ❑ *An electronic written copy of the section of the summary plan description that instructs claims processing.*
- ❑ *An electronic written copy of the section of the summary plan description that describes retro-authorization request*

- ❑ *A copy of all plan documents and summary plan descriptions that have existed during the time of the participant's coverage policy.*
- ❑ *Your client's employer identification and 3-digit plan number.*
- ❑ *A copy of the updated summary plan descriptions in effect for the last three years.*
- ❑ *A copy of the summary annual reports for the last three years.*
- ❑ *A copy of the bargaining agreement, trust agreement, contract, or other instrument under which the plan was established and all amendments since the establishment date until the present.*
- ❑ *A copy of all written polices, memoranda, minutes of meetings and any other written documentation addressing reimbursement timeframes, emergency services and care, authorizations, and retro-authorization.*

As you know, **29 U.S.C. § 1132(c)** requires ERISA plan information to be provided within thirty days from the receipt of the request. Failure to supply the above requested information within thirty days of date of this letter may subject you to a penalty of **$110.00 per day** and other costs, including attorney's fees if we seek review from our legal counsel.

As Blue Cross acting as the third-party administrator for self-funded employer plan failed to provide a hard copy authorization or proper determination, we are requesting that your office expedite a review and provide authorization by **end of day, March 24, 2022**, to avoid any unnecessary regulatory filing action with the **U.S Department of Labor**.

It is our sincere hope it does not come to this point.

Respectfully,

Inez Villalobos

Inez Villalobos
Claims Compliance Auditor III
ERN/TRAF – The Reimbursement Advocacy Firm

Tel: (714) 995-6900 Ext. 6920 Fax: (714) 995-6901

2000–INSURANCE PAYMENT

Dep Dt: 6/1/2022 Post Dt: 6/2/2022

Automated Clearing House Payment posted from Electronic Remittance

-151,84...

View History

Summary

Payer on Payment
MERITAIN HEALTH [300]

Posted To
Primary Insurance - MERITAIN HEALTH [300]

Payment Invoice #
H2000368007700

Bucket Invoice #
H2000368007700

Total Check Amount
165,245.55

Reference #
1036758065

ICN #
EX9MA13

Account
20003680077-

Comment
Electronic Remittance Run 851478

Payment Amounts

Billed	Allowed	Not Allowed	Denied	Ins Write-off
387,429.03	151,848.02	235,581.01	—	—

Deductible	Coinsurance	Copay	Non Covered	Patient Responsibility
0.00	0.00	0.00	0.00	0.00

Remit Codes

Remit Code	Actions	Amount
CO 45 - Chgs excd fee sch/max allowable	1	235,581.01

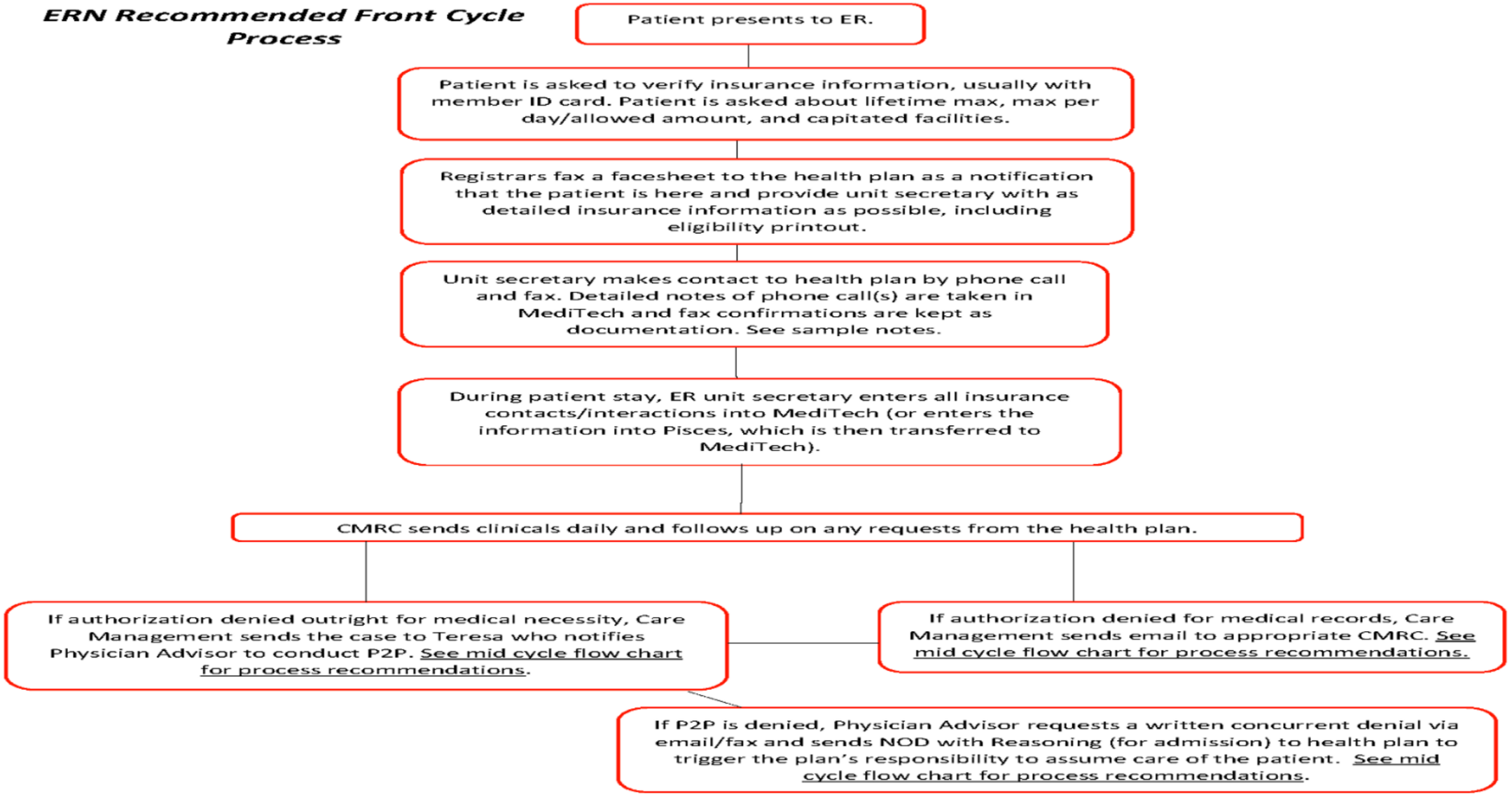
Action	Adjustment Code
1-Not Allowed Adjustment	3000-PAYOR CONTRACTUAL ADJUSTMENT

HAVE YOU CREATED:

- [ ] Letter Libraries
- [ ] Law Libraries
- [ ] Blurb Libraries
- [ ] Letter Libraries
- [ ] Fax Cover Sheets with Laws
- [ ] Registration Forms with Laws
- [ ] Policies, Procedures, and Checklists
- [ ] KPIs & Metrics (e.g. El Pollo Loco)

3. Flow Charts and Processes

ERN Recommended Front Cycle Process



4. Documentation & Rebuttal Guidelines for Front (F) & Mid cycle (M)

	Scenario	ERN Recommended Note/Rebuttal
F	**POSTSTABILIZATION NOTIFICATION NOTES** (by ED personnel)	Health Plan contacted: [NAME OF PLAN OR CONTRACTED PROVIDER e.g. Health Net of California, Inc.] Title/Department contacted: [PLAN OR CONTRACTED PROVIDER e.g. Health Net] Hospital Notification Unit Name of person spoke with (First & Last): John Doe Phone number first dialed: 800-995-7890 Phone number of last person spoke with/call back number/extension: [PHONE NUMBER AND EXTENSION] Date, start and end time of call: 2/26/2019, 10:32 AM-10:50 AM Authorization/tracking/reference number (if not given, then note): no authorization/tracking/reference number received. IF AUTHORIZATION WAS RECEIVED: How many days is this authorization for? What exactly is being authorized (e.g., emergency admission, appendectomy). Notes from call: Notified [NAME OF REPRESENTATIVE] at [NAME OF PLAN/CONTRACTED PROVIDER] of patient presenting to the ED, needing emergency admission and requested authorization as patient cannot be discharged safely.
F	**NO HMO AUTHORIZATION WAS GIVEN** (by ED and IV Personnel)	HMO: ____ Informed representative that under state law, they have 30 minutes from this call to make a decision to authorize care or arrange for transfer to another facility. No authorization/tracking/reference number was given during call (See 28 CCR §1300.71.4 (b)(1).) **READ DISCLAIMER**: "Please note that while you have issued a tracking/reference number for your patient, under existing CA law, plans are required, within 30 minutes from initial contact, to authorize poststabilization care or arrange for the prompt transfer of the enrollee to another hospital. This tracking/reference # does not satisfy your requirements under the law but constitutes that contact was made in the event we do not receive an authorization number from you within a half hour of this request. All services afterwards are deemed authorized (See 28 CCR 1300.71.4 (a-c), H&S 1262.8 (d)." **REFERENCE UR FAX COVER SHEET/HMO/MAO CONTINUED FAILURE TO RESPOND FAX COVER SHEET FOR CMRC**
F	**NO MAO AUTHORIZATION WAS GIVEN** (by ED AND IV Personnel)	MAO: ____ Informed representative that under federal law, they have sixty (60) minutes from this call to approve/disapprove care or arrange for transfer to another facility. No authorization/tracking/reference number was given during call (See 42 CFR 422.113 (c)(2)(iii)(C)). **READ DISCLAIMER:** Please note that while you have issued a tracking/reference number for your patient, under existing Medicare law, plans are required, within 60 minutes from initial contact, to pre-approve poststabilization care or assume care of the beneficiary (via transfer, or at our hospital if privileged). This tracking/reference # does not satisfy your requirements under the law but constitutes that contact was made in the event we do not receive an authorization number from you within one hour of this request. Your financial responsibility for post-stabilization care services it has not pre-approved ends when you assume care of the patient, reach an agreement with our treating physician/PA or the enrollee is discharged (See 42 CFR 422.113 (c)(3)).

REQUEST FOR AUTHORIZATION TO PROVIDE POSTSTABILIZATION SERVICES

TO:	FROM: JOE COMPLIANCE
FAX:	PAGES:
PHONE:	DATE:
RE: **REQUEST FOR AUTHORIZATION TO PROVIDE POSTSTABILIZATION SERVICES**	CC:

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

At this time we are requesting authorization to provide post-stabilization services to your insured. **As the contracting medical provider or health care service plan, you have 30 minutes (60 minutes if you are an MA plan pursuant to 42 CFR §422.113) from receipt of this notification to provide an authorization, or make a decision to arrange transfer of the patient.** If you do not respond to this notification, or communicate an intent to transfer the patient and do not effectuate a transfer within a reasonable time, the post stabilization services shall be deemed authorized and shall be paid in accordance with the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2) and any regulation adopted thereunder or 42 CFR Part 422 and any regulation adopted thereunder. Please be advised that due to ER overflow concerns, **plans must effectuate transfer within 2 hours of notifying us of its intent to do so, or the patient will be admitted** and the plan will be responsible to reimburse for all services up to the time that transfer is effectuated pursuant to 28 CCR §1300.71.4(2).

Contact one of the following Case Managers to provide authorization for the statutorily deemed authorized services.

NAME (XXX) XXX-XXXX **NAME (XXX) XXX-XXXX** **NAME (XXX) XXX-XXXX**

Comments: PLEASE FAX AUTHORIZATION NUMBER TO (xxx) xxx-xxxx

If you need any further information, please contact: Care Coordination Department @ (xxx) xxx-xxxx or Fax (xxx) xxx-xxxx.
Insert confidentiality/HIPAA statement here -

NOTIFICATION OF MAO DISAGREEMENT OF CARE

TO:	FROM: JOE COMPLIANCE
FAX:	PAGES:
PHONE:	DATE:
RE: **NOTIFICATION OF MAO DISAGREEMENT OF CARE**	CC:

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Patient Admitted On (date/time), XXXXXX ("Health Plan") was notified that the above patient is stable after being treated in the ER and requires post-stabilization care. On (date/time) (Doctor Name) at Health Plan informed our physician during peer to peer review that Health Plan has denied further poststabilization care at our hospital. This notice serves as a formal **NOTICE OF DISAGREEMENT OF CARE under 42 CFR 422.113 (c)(3) which outlines the** *"End of MA organization's financial responsibility" and states: The MA organization's financial responsibility for post-stabilization care services it has **not pre-approved ends** when--*

*(i) A plan physician with privileges at the treating hospital **assumes** responsibility for the enrollee's care;*

*(ii) A plan physician **assumes** responsibility for the enrollee's care through transfer;*

*(iii) An MA organization representative and the treating physician **reach an agreement** concerning the enrollee's care; or*

*(iv) The enrollee is **discharged**.*

Under existing federal law, Medicare Advantage Plans are required to pay for all care up until they assume care of the patient, reach a peer to peer agreement, or the patient is discharged. Any peer to peer review denial of poststabilization services is an automatic decision/election to assume care of, or transfer the patient as soon as possible **pursuant to 42 CFR §422.113 (c) above.**

As of the above (date/time), Health Plan has failed to initiate assuming care of or transferring the patient. (Please be advised that for patients pending admission, if Health Plan fails to assume care of or transfer the patient within a reasonable time, the patient will be admitted to limit overflow and delays in our ER).

Contact one of the following Case Managers to effectuate transfer immediately and/or provide authorization for.

NAME (XXX) XXX-XXXX **NAME (XXX) XXX-XXXX** **NAME (XXX) XXX-XXXX**

Comments: PLEASE FAX AUTHORIZATION NUMBER TO (xxx) xxx-xxxx

If you need any further information, please contact: Care Coordination Department @ (xxx) xxx-xxxx or Fax (xxx) xxx-xxxx.
Insert confidentiality/HIPAA statement here -

2/27/19

BLURB CREATION 1

As you know, CMS recently announced an expansion of the Accelerated and Advanced Payment Program to a broader group of Medicare Part providers and Part B suppliers during the duration of the public health emergency declared by HHS Secretary Alex Azar in January.

In that press release, CMS Administrator Seema Verma stated, **“With our nation’s health care providers on the front lines in the fight against COVID-19, dollars and cents shouldn’t be adding to their worries. Unfortunately, the major disruptions to the healthcare system caused by COVID-19 are a significant financial burden on providers. Today’s action will ensure that they have the resources they need to maintain their all-important focus on patient care during the pandemic.”**

During the COVID-19 crisis, [PROVIDER MEMBER] relies on timely authorizations and reimbursement by MA Plans to treat beneficiaries at high risk in the pandemic.

[ADD END].

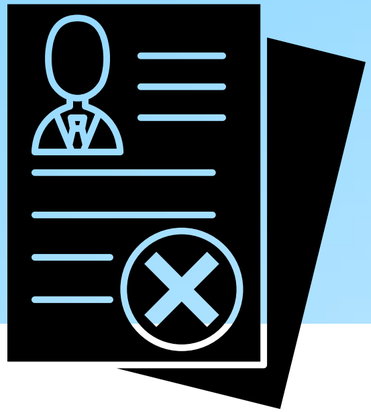
Medicare Advantage Appeals Timeline

To protect your rights, make sure to escalate your cases to ERN/The Reimbursement Advocacy Firm (TRAF) within the following timeframes.

YOU

60 Days
To request a reconsideration

Source: **42 CFR 422.582(a-b)**



PAYOR

30 Days
To uphold the service denial and send to an IRE

42 CFR 422.590(a)(2)

PAYOR

60 Days
To effectuate a payment reconsidered determination

42 CFR 422.590(b)
42 CFR 422.618(a)

MANAGING DENIALS

Code	Description
100	HMO Appeal Acknowledgment Vio.
101	HMO Timely Appeal Vio.
102	HMO Untimely Payment Vio.
103	HMO ER Non Payment Vio.
104	HMO Misdirected Claim Vio.
105	HMO No Claim On File Vio.
106	HMO Paid ER-Post-Stab Dnl.
107	HMO Pre-Existing Vio.
108	HMO UCR Reduction-OSHPD Recvd
109	HMO Req for Unnecessary Info
110	HMO Retro Denial After Auth
111	HMO Untimely Filing Vio.
112	HMO Unauthorized Treatment Dnl
113	HMO Underpayment Vio.
114	HMO COB Vio.
115	HMO Medical Necessity Dnl.
116	HMO Unlawful Refund Request
117	HMO Unlawful Refund Offset
118	HMO UCR Underpayment
119	HMO Incorrect Coding Dnl.
120	HMO Hospice Dnl.
121	HMO PDR Untimely Determination
122	HMO TPL Dnl.
123	HMO ER Not Paid-Post-Stab Dnl.
124	HMO AOB Payment Sent to Pat.
125	HMO Pd-UCR-Provider Contracted
126	HMO UCR Reduction-OSHPD Compl.
127	HMO Improper Refund Request
128	HMO Rebill As Observation Dnl.
129	HMO L&D Not Paid-Post-Stab Dnl
130	HMO Patient Not Eligible
131	HMO Req for Unnec. Info - Auth
132	HMO Req for Unnec. Info - MR's
133	HMO Misdirected-DOFR
134	HMO DHS Recoupment
135	HMO DHS-Timely Filing
136	HMO DHS-Not Eligible on DOS
137	HMO DHS-Not Covered Benefit
138	HMO DHS-Not Authorized
139	HMO Underpayment-No Contract
140	HMO Not A Covered Benefit
141	HMO Fail. to Conduct Retro Rvw
142	HMO UCR Underpayment Complete
143	HMO Split ER&PostStab Charges
144	HMO Underpaid-Verify Contract
145	HMO PostStab Transf. Auth Den
146	HMO Lower Level of Care Und.
147	HMO Line Item Denial Underpay
148	HMO ER Paid-Notification-PS
149	HMO ER Paid-No Notification-PS
150	HMO ER No Pay-Notification-PS
151	HMO ER No Pay-No Notific.-PS
152	HMO CC Underpay-No Contract
153	HMO Non-Emergent Denial
154	HMO ER Underpay CT Scan Den.
155	HMO Interqual & Milliman Dnl

Code	Description
200	PPO UCR Reduction-OSHPD Recvd
201	PPO UCR Underpayment
202	PPO Untimely Appeal Vio.
203	PPO AOB Denial-Strong St. Law
204	PPO AOB Denial-Weak/No St.Law
205	PPO Underpayment Vio.
206	PPO Untimely Payment Vio.
207	PPO Unauthorized Treatment
208	PPO Retro Denial after Auth
209	PPO Untimely Filing Vio.
210	PPO PDR Untimely Determination
211	PPO COB Vio.
212	PPO TPL Dnl.
213	PPO Misdirected Claim Vio.
214	PPO Non Payment Vio.
215	PPO No Claim On File Vio.
216	PPO Medical Necessity Dnl.
217	PPO Incorrect Coding Dnl.
218	PPO Paid ER-Post-Stab Dnl.
219	PPO ER Not Paid-Post-Stab Dnl.
220	PPO Appeal Acknowledgment Vio
221	PPO Req for Unnecessary Info
222	PPO AOB Payment Sent to Pat.
223	PPO Pd-UCR-Provider Contracted
224	PPO UCR Reduction-OSHPD Compl.
225	PPO DOI UCR
226	PPO Rebill As Observation Dnl.
227	PPO Unlawful Refund Request
228	PPO Unlawful Refund Offset
229	PPO Patient Not Eligible
230	PPO Req for Unnec. Info - Auth
231	PPO Req for Unnec. Info - MR's
232	PPO Misdirected-DOFR
233	PPO DHS Recoupment
234	PPO DHS-Timely Filing
235	PPO DHS-Not Eligible on DOS
236	PPO DHS-Not Covered Benefit
237	PPO DHS-Not Authorized
238	PPO Underpayment-No Contract
239	PPO TPL Primary Payor
240	PPO UCR Underpayment Complete
241	PPO Split ER&PostStab Charges
242	PPO Underpaid-Verify Contract
243	PPO Lower Level of Care Under.
244	PPO Line Item Denial Underpay
245	PPO ER-Paid per OON Copay/Ded.
246	PPO ER Paid-Notification-PS
247	PPO ER Paid-No Notification-PS
248	PPO ER No Pay-Notification-PS
249	PPO ER No Pay-No Notific.-PS
300	MCal Incorrect Coding Dnl.
301	MCal ER Paid-Post-Stab Dnl.
302	MCal ER Not Paid-Post-Stab Dnl
303	MCal Appeal Acknowledgment Vio
304	MCal Req for Unnecessary Info
305	MCal Untimely Appeal Vio.

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CAN I AUTOMATE THIS?

REVASSURANCE 4.0 KNOWLEDGE BASE

(FOR INTERNAL USE)

TOP 10 LAW TOPICS OR DENIAL REASONS - MEDICARE ADVANTAGE (MA)

Denial	Law
AUTHORIZATION TIMEFRAMES - NON-URGENT	42 CFR § 422.568 (b)
INTEREST OWED ON LATE CLAIMS	42 CFR § 422.520 (a)(2)
MATERNITY COVERAGE	45 CFR § 146.130 (a)
MEDICAL NECESSITY - QUALIFIED REVIEWERS	42 CFR § 422.590 (g)(2)
NO AUTHORIZATION FOR ER	42 CFR § 422.113 (b)(2)
NOTICE REQUIREMENTS FOR ADVERSE DETERMINATIONS	42 CFR § 422.568 (d-f)
RECOUPMENT	42 U.S.C 1395ddd (f)(2)
RETROACTIVE DENIALS FOR AUTHORIZED CARE	42 CFR § 422.752 (a)(5)
TIMEFRAMES FOR POST-STABILIZATION DENIALS OR AUTHORIZATIONS	42 CFR § 422.113 (c)(2)(ii-iii); (c)(3)
TIMELY PAYMENT - DEFINITION OF A CLEAN CLAIM	42 CFR § 422.520 (a)(1,3)

ADDITIONAL LAW TOPICS OR DENIAL REASONS

DEFINITIONS	42 CFR § 422.2
NO CLAIM ON FILE	Mailbox Rule [Case Law]
FREEDOM OF CHOICE	42 CFR § 422.114 (b)
WRITTEN STANDARDS REQUIREMENTS	42 CFR § 422.112 (6)(i-ii)
REQUIREMENTS RELATING TO BASIC BENEFITS	42 CFR § 422.101 (a)

LEGEND

[FED. MEDICAID]	Federal Medicaid Law
[Medicaid Managed Care]	Law only applies to Medicaid claims
[PPO]	Law only applies to PPO claims
[HMO]	Law only applies to HMO claims
(Medical necessity)	Law only applies to medical necessity claims
[FED.]	Federal Law
[Medicaid]	State Medicaid Law

Tip: If you wish to view a law longer without hovering over it, you can right click on the law and select "Show/Hide Note."

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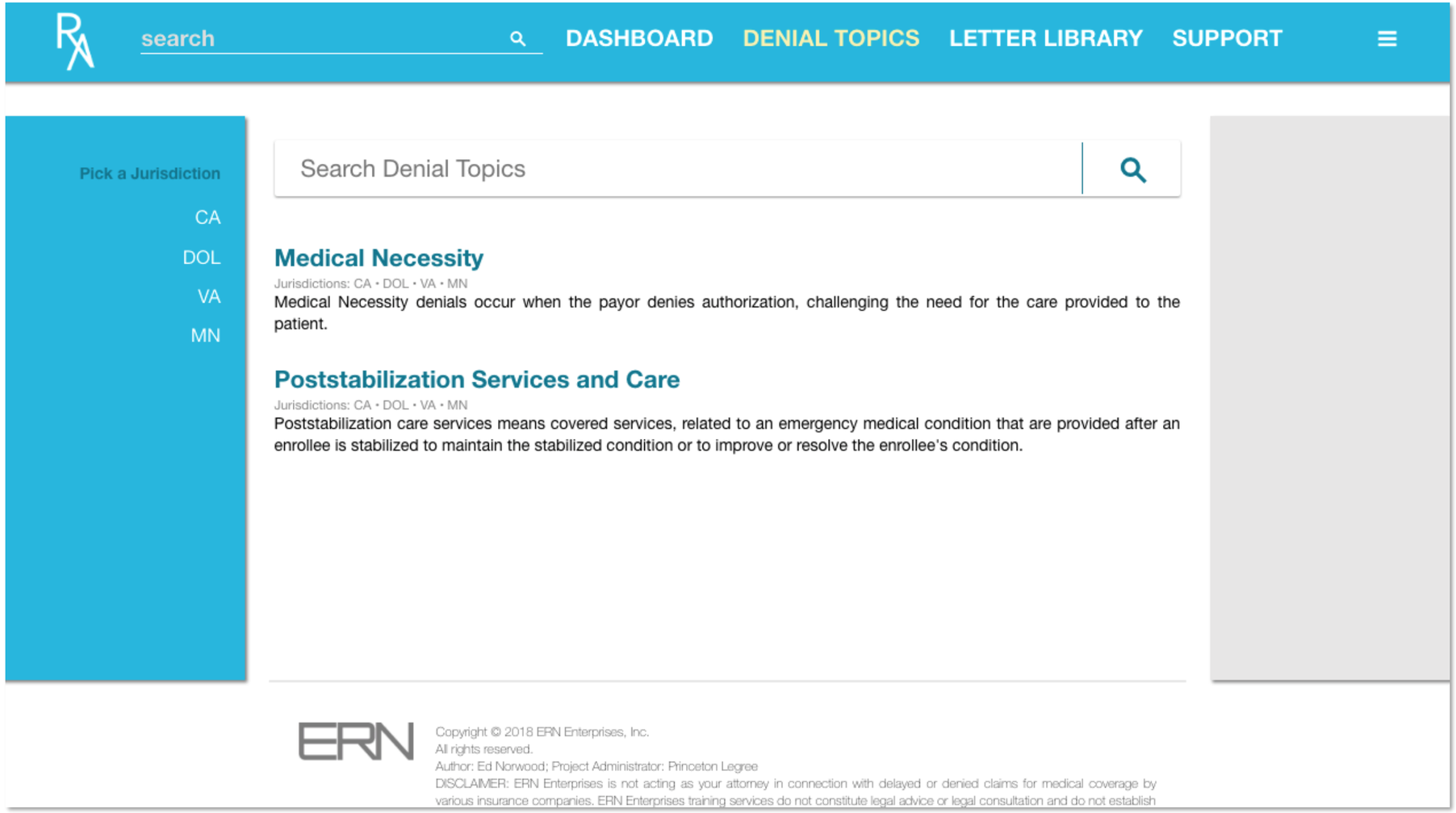
REVASSURANCE ONLINE

REVAssurance Online



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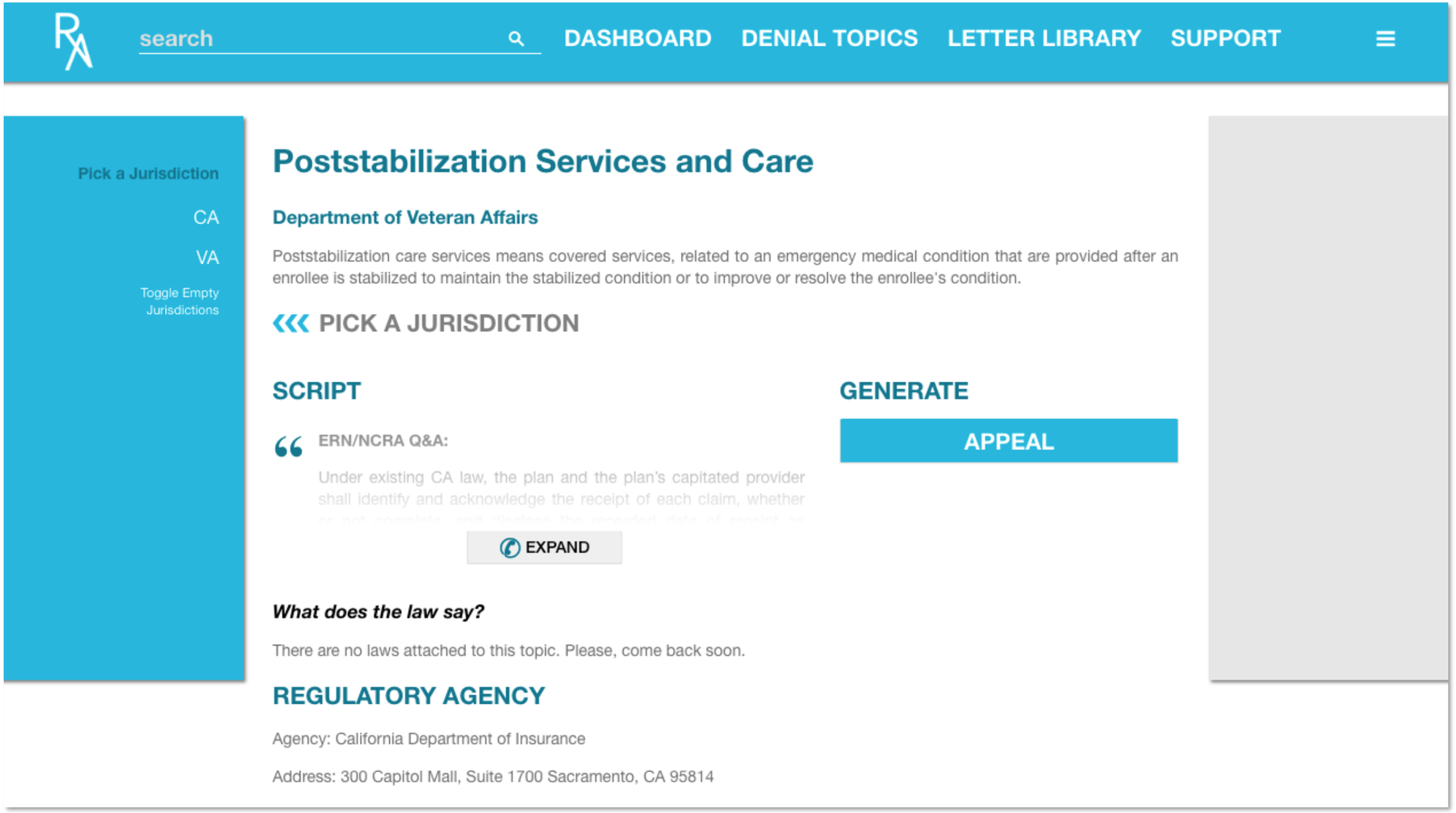

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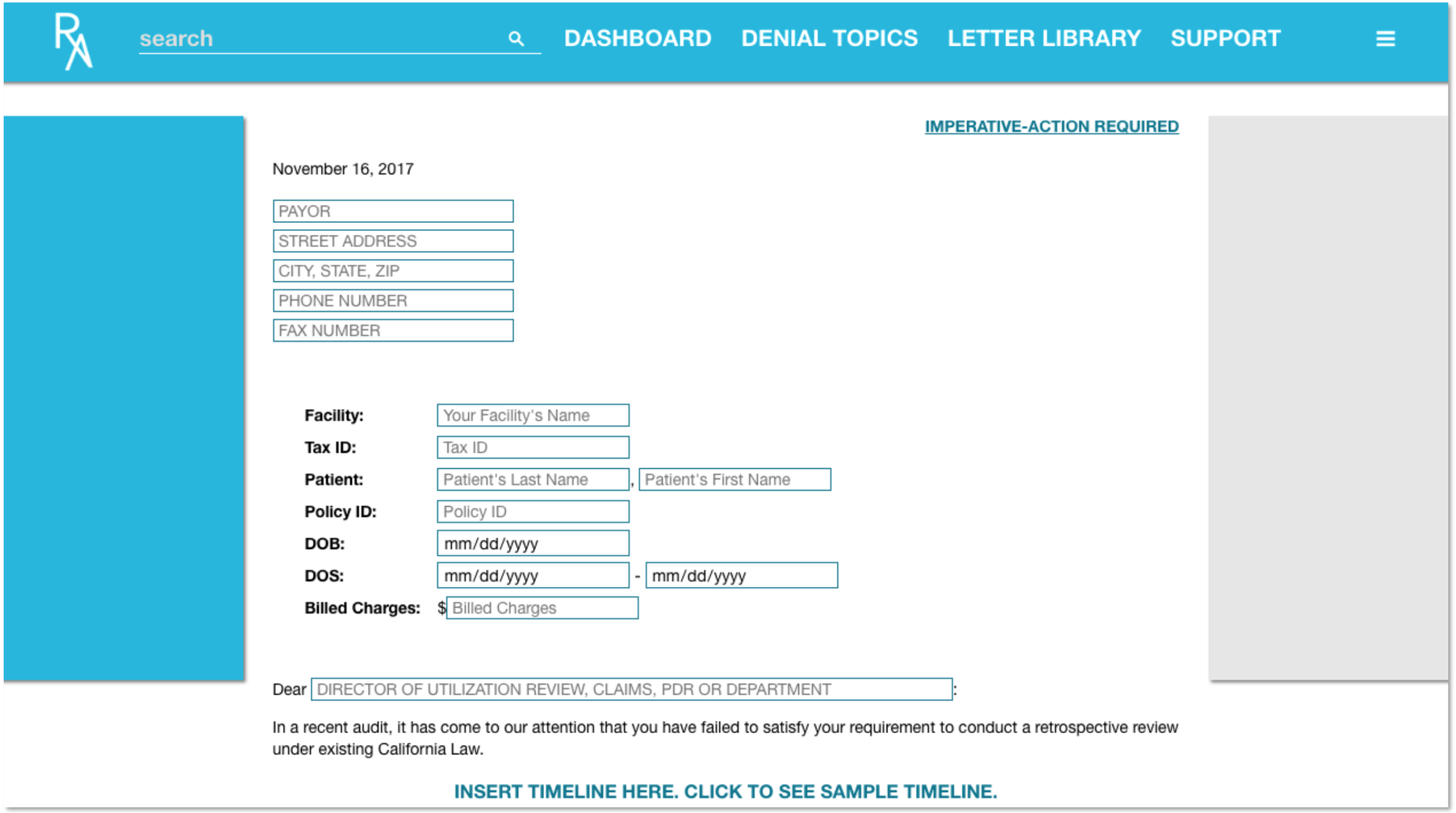

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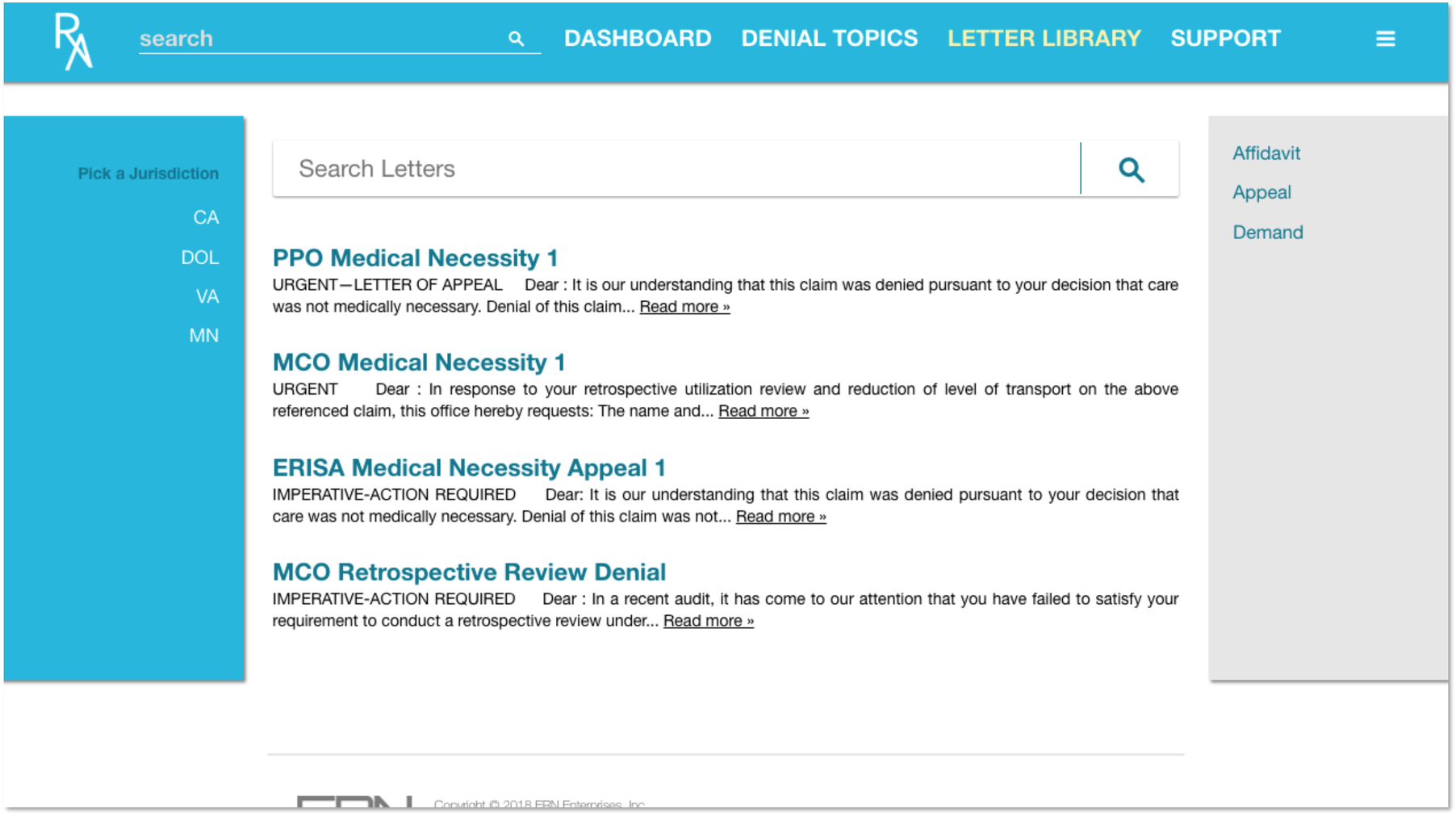

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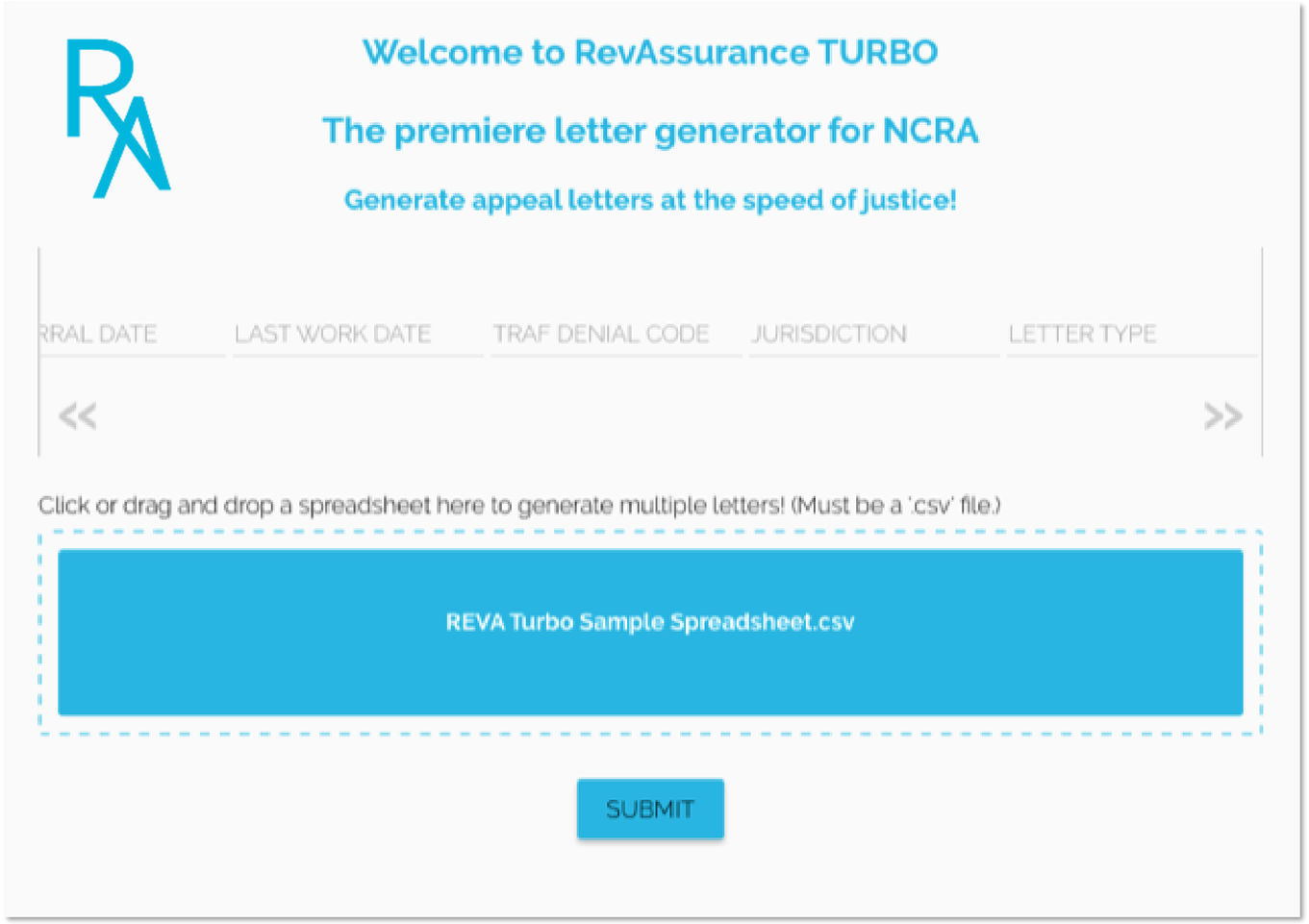

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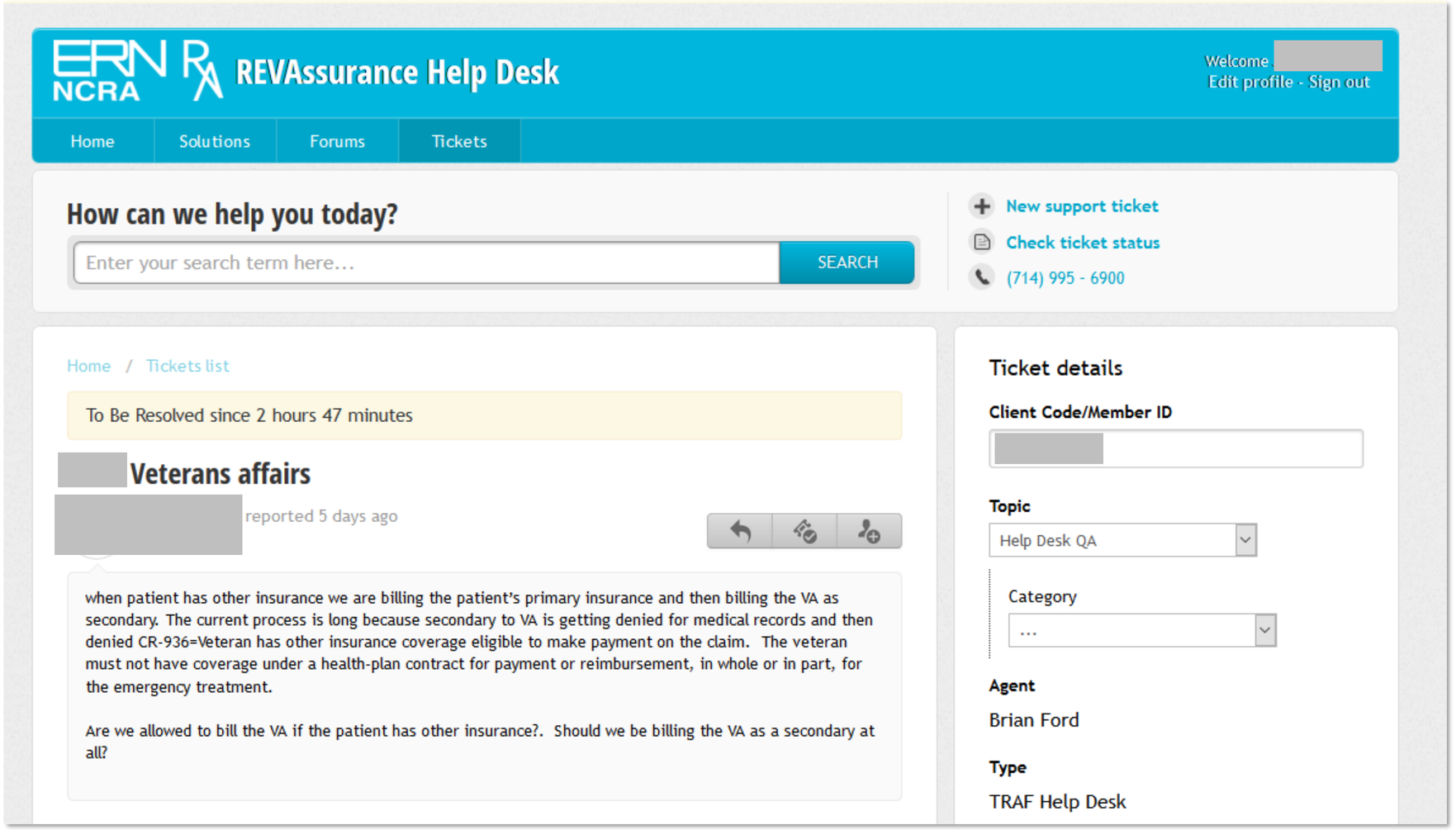


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CAN I BEAT THIS?


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THE POWER OF ASKING QUESTIONS
IN THE APPEAL PROCESS

WHEN PAYORS WON'T LISTEN

The Power of Asking Questions in the Appeal Process

DENIAL DETERMINATION EXERCISE:

The following is a sample timeline of a common denial.
Use the facts below to complete this worksheet, and use it as a model in crafting your own questions:

- On 11/1/15, the patient presented to the emergency department of Hospital with severe crushing chest pains.
- On 11/1/15, Hospital called Careless Sr. Plan and Representative stated that the patient was eligible, effective 5/1/12 to current, and issued a tracking number (See Exhibit A – Hospital Records*).
- On 11/2/15, Hospital faxed a face sheet to Careless Sr. Plan notifying of the patient's admission and requesting authorization per: _____.
- On 11/5/15, patient discharged without any disapproval from Careless Sr. Plan.
- On 11/8/15, Hospital submitted the claim to Careless Sr. Plan electronically.
- On 2/5/16, Hospital called Careless Sr. Plan and Representative stated the claim was denied as not medically necessary, requesting medical records. (See Exhibit B – Explanation of Benefits*).
- To date, payment has not been released.

WHAT IS WRONG WITH THIS REQUEST?

WHEN PAYORS WON'T LISTEN

The Power of Asking Questions in the Appeal Process

1) WHAT IS THE DENIAL? _____

2) JURISDICTION: [ ] STATE [ ] HMO[ ] MA [ ] VA [ ] ERISA

3) EXCEPTION/EXEMPTION BOP SAMPLE QUESTION:

Please provide the statutory authority [PLAN:_____] relies upon to request _____ for statutorily deemed authorized services?

4) EXCEPTION/EXEMPTION BOP SAMPLE ARGUMENT:

As you know, contact was made with the plan on _____ and [PLAN:_____] issued a tracking/reference number (#_____). HERE, [PLAN:_____] failed to approve care within one (1) hour of the request, failed to assume care via a physician with treating privileges at our hospital or transfer, failed to enter into an agreement with the treating physician, therefore your financial responsibility ended upon patient discharge. Please release the federal funds due the Medicare beneficiary.

WHEN PAYORS WON'T LISTEN

The Power of Asking Questions in the Appeal Process

SAMPLE DENIAL SCENARIOS – QUESTION SCRIPTS:

1) THE ER CT SCANS WERE DENIED AS NOT AUTHORIZED (42 CFR §422.113 (b)(2)(ii)).

2) OUR PHYSICIAN DETERMINED THE PATIENT WAS STABLE FOR TRANSFER OR DISCHARGE TWO DAYS PRIOR TO [DATE] (42 CFR §422.113 (b)(3)).

3) WE DON'T DO PEER TO PEER REVIEWS CONCURRENTLY, ONLY RETROSPECTIVELY (42 CFR §422.113 (c)(3)(iii)(C)).

4) WE NEED MEDICAL RECORDS FOR THE POSTSTABILIZATION SERVICES AND CARE—THE TRACKING/REFERENCE NUMBER IS NOT A GUARANTEE OF PAYMENT (42 CFR §422.113 (c)(3)(iii)(A)).

5) WE UPHELD OUR DRG DOWNCODE/VALIDATION.THERE ARE NO MORE APPEAL PROCEDURES FOR NON-CONTRACTED PROVIDERS (42 CFR §§422.590 (c)(3) and 422.592)).

WHEN PAYORS WON'T LISTEN

The Power of Asking Questions in the Appeal Process

EXCEPTION/EXEMPTION BOP QUESTION CREATION:

Please provide the statutory authority [PLAN:_____] relies upon to

_____

_____

EXCEPTION/EXEMPTION BOP ARGUMENT CREATION:

As you know,

_____

_____

_____

_____

Please release the _____ federal funds due the Medicare beneficiary.

As advocates:

We don’t show partiality.
We work both small and big cases alike.
We collaborate when cases are too hard for us.
We aren’t afraid of anyone AND
WNITTF: WE’RE NOT IN THIS TO FAIL.

You fight for their lives.

We fight for you.

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