ERN NCRA

You fight for their lives.

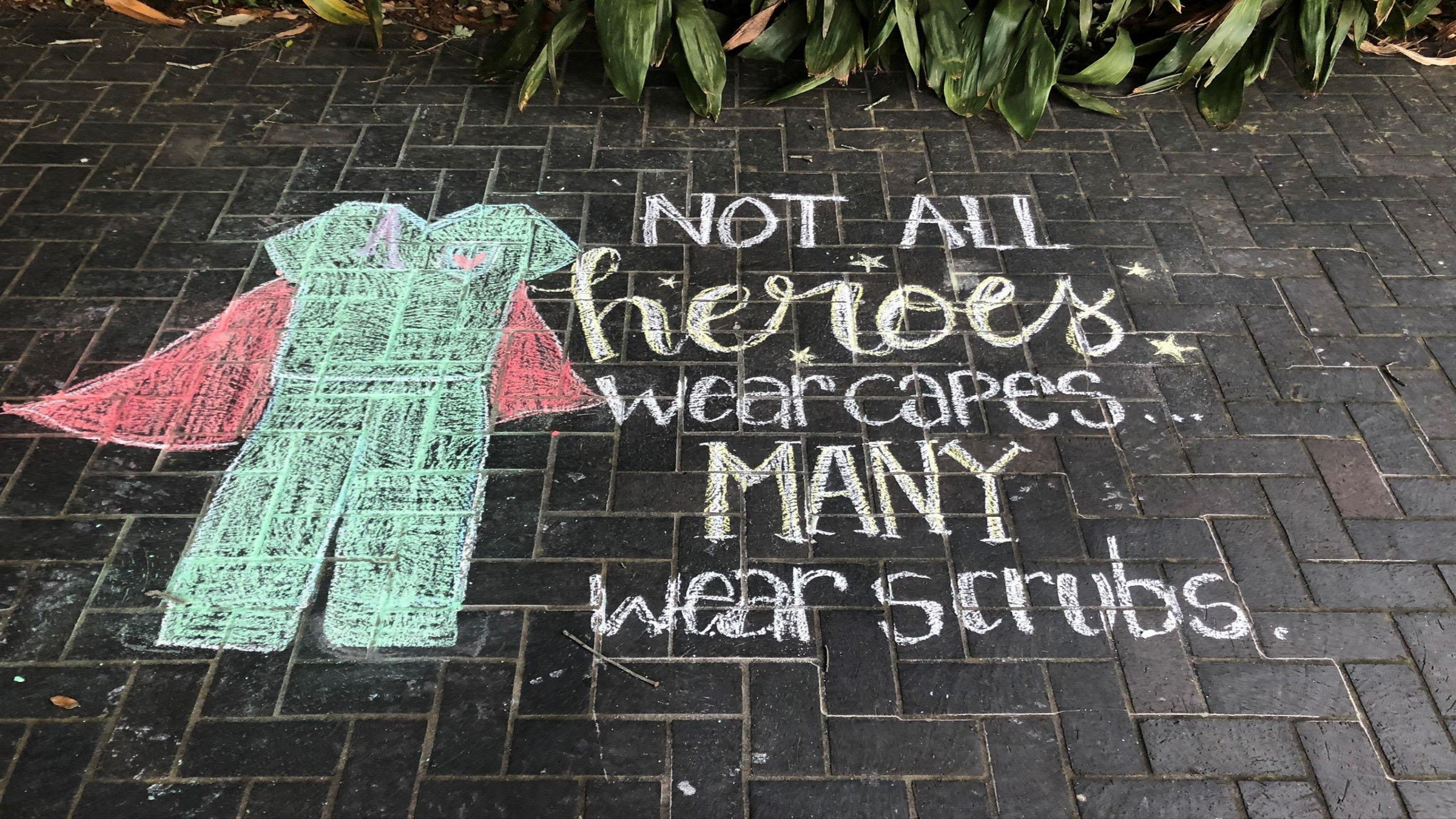
WE FIGHT FOR YOU.

HEALTH LAWS

2023

When Payors Won't Listen:

The Law, Denial Management and Appeal Letter Writing (Post Acute)


NOT ALL
heroes
wear capes...
MANY
wear scrubs.

ContinueCARE Appeal Form

CHC Community Hospital Corporation

Patient Name: [redacted] **Michael** DOB: [redacted] Insurance Company: UHC MCR Subscriber ID# [redacted] Submission Date: 5/5/23 Denial Date: 5/6/23 Denied by: MD Phone Number: 855-851-1127 Reference Number: None Provided	**ContinueCARE** **Denial Reason: PT did not have the complexity requiring the LTACH level of care and the care could be safely provided at a lower level of care.** **How long was given for P2P: 4 business hours** **P2P Phone Number: 855-851-1127, option 5** **Appeal Phone Number: 877-262-9203** **Appeal Fax Number: 866-373-1081**
Hospital Information: Name of referring hospital: Lexington Medical. Name & number of referring MD: Anthony Zamcho Name & number of case manager: Deana Sutton ContinueCARE MD & number: Anthony Zamcho	**Brief Patient History:** [redacted]
Acute Diagnosis Code: [redacted] Description: [redacted]	**What services will be needed?** [redacted]

REQUEST FOR EXPEDITED RECONSIDERATION
AND/OR REOPENING OF A RECONSIDERED DETERMINATION
PURSUANT TO 42 CFR §422.584 and §422.590 (e) and §422.616

May 9, 2023

United Healthcare Appeals Unit
P.O. Box 30575
Salt Lake City, UT 84130-0575

Our Client: **Continue**
Tax ID:
NPI:
Patient: **Michael,** [redacted]
Member ID: [redacted]
DOB:
DOS: **2023-Ongoing/Present**
Reference #: [redacted]

Dear United Healthcare Appeals Unit:

This office represents Continue **(See Exhibit A: Statement of Representation, ERN is a business association representing the covered entity)** and has been asked to audit and investigate the attached denial of Medicare Long Term Acute Care inpatient covered services for possible complaint filing with **the Centers for Medicare and Medicaid Services (CMS)** for United Healthcare's possible violation of federal law and CMS guidelines.

Please be advised that this is an expedited reconsideration request (Per section 40.8 of the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance (Page 40)) of the improper authorization denial dated 05/06/2023.

We dispute UHC's denial of the patient's transfer to a long-term acute care hospital because the referring facility, Lexington Medical Center, is an in-network facility, therefore, any referrals for services are plan-directed care, pursuant to Chapter 4 Medicare Managed Care Manual §160, as the facility is an agent of the plan. Furthermore, MAOs must make determinations based on coverage criteria no more restrictive than original Medicare, CCP notified UHC of the inpatient transfer, and upon denial, UHC failed to assume care of the patient, as shown and described below:

- On 05/01/2023, the patient presented to the emergency room at Lexington Medical Center under the care of the hospitalist team for [redacted]
- On 05/05/2023, CCP prepared patient for transfer to long term acute care facility and notified United Healthcare SR of this and requested authorization.
- On 05/06/2023, United Healthcare SR denied the long-term acute care transfer request, stating the patient did not have the complexity requiring the transfer to long term acute care, and that the care could be safely provided at a lower level of care, but did not assume care of the beneficiary as required by **42 CFR §422.113(c)(3).**
- To date, United Healthcare SR has failed to provide hard copy authorization for medically necessary inpatient long term acute hospital care ordered by the treating physician.

Here, it is evident the patient requires ongoing prolonged hospitalization and close physician monitoring. Despite services currently being provided [redacted] Medical doctor consulted the patient and [redacted] This patient is not eligible for any other level of care at this time other than LTAC. He requires [redacted]

We hereby request immediate beneficiary authorization for long-term acute care as it is the only appropriate level of care at this time that can optimally achieve the above-said outcomes.

I. LEXINGTON MEDICAL CENTER IS A CONTRACTED FACILITY REFERRING THE PATIENT TO CCP FOR LONG-TERM ACUTE CARE INPATIENT SERVICES WHICH CONSTITUTES A FAVORABLE ORGANIZATION DETERMINATION.

It has been a longstanding rule that contracted plan providers are agents of the plan. ALJ case law decisions have consistently held that if contracted providers are qualified enough to perform life-saving and sustaining treatments, they are qualified to determine hospitalization, and where they receive treatment.

Even if Community Health had not contacted the plan for preapproval and services were denied as not medically necessary, **42 CFR § 422.113(c)(2)** outlines the MA organization's financial responsibility and states:

The MA organization –
(i) Is financially responsible (consistent with § 422.214) for post-stabilization care services obtained within or outside the MA organization that are pre-approved by a plan provider or other MA organization representative.

Pursuant to **Chapter 4 Medicare Managed Care Manual § 160:**

CMS considers a contracted provider an agent of the MAO offering the plan. As stated in the preamble to the January 28, 2005 final rule (CMS-4069-F):

"MA organizations have a responsibility to ensure that contracting physicians and providers know whether specific items and services are covered in the MA plan in which their patients are enrolled. **If a network physician furnishes a service or directs an MA beneficiary to another provider to receive a plan-covered service without following the plan's internal procedures (such as obtaining the appropriate plan pre-authorization), then the beneficiary should not be penalized to the extent the physician did not follow plan rules."**

If a contracted provider refers an enrollee to a non-contracted provider for a service that is covered by the plan upon referral, the enrollee is financially liable only for the applicable cost-sharing for that service. Contracted providers are expected to coordinate care or work with plans prior to referring an enrollee to a non-contracted provider to ensure, to the extent possible, that enrollees are receiving medically necessary services covered by their plan. Furthermore, plans are expected to work with their

contracted providers to ensure that clear processes are in place and providers are educated about those processes, including appropriate documentation, to substantiate that a referral has been made.

When UHC's contracted facility, Lexington Medical Center referred the patient to be transferred to CCP for long-term acute care, it constituted a favorable organization determination on behalf of UHC (See Exhibit D: Lexington Medical Center Contracted Status). Therefore, UHC's denial of this pre-service authorization as unauthorized/not medically necessary was improper.

This premise is supported through various CMS publications and opinions. For example, the CMS CDAG/ODAG guidance published September 4, 2013 states that **"The provision of an item or service by a contract provider constitutes a favorable organization determination."**

In addition, the Inspector General Christi A. Grimm released a Report in Brief, April 2022, OEI-09-18-00260, outlining when MAO reviewers are unfamiliar with network coverage rules. In her report, Ms. Grimm stated: **"In most cases, a beneficiary needs prior authorization to receive care from a noncontracted provider. However, the skilled nursing facility was an in-network facility. This qualified the claim as "plan-directed care," and therefore no prior authorization was required. The MAO attributed the denial to human error."**

Please be reminded we have a right to a reconsideration **pursuant to 42 CFR § 422.578 which states:**

Any party to an organization determination (including one that has been reopened and revised as described in § 422.616) may request that the determination be reconsidered under the procedures described in § 422.582, which addresses requests for a standard reconsideration. A physician who is providing treatment to an enrollee may, upon providing notice to the enrollee, request a standard reconsideration of a pre-service request for reconsideration on the enrollee's behalf as described in § 422.582.

II. THE TREATING PHYSICIAN MUST DECIDE WHEN THE MEDICARE BENEFICIARY MAY BE CONSIDERED STABILIZED FOR TRANSFER OR DISCHARGED, AND THE DECISION IS BINDING ON THE MAO.

As you know, the above Medicare beneficiary is currently hospitalized and receiving inpatient post-stabilization services and care at Lexington.

Pursuant to the **Medicare Managed Care Manual, Chapter 4,** post-stabilization care services are covered services that are related to an emergency medical condition, **provided after the beneficiary is stabilized.** These services are provided to **maintain the stabilized condition**, or under certain circumstances to improve or resolve the beneficiary's condition.

The denial stating the beneficiary is unstable for long-term acute care is improper because only **the beneficiary's treating physician may decide when the beneficiary may be considered stabilized for transfer or discharged from care. This decision is then binding on the MAO.** Here, the treating physician Dr. Anthony Zamcho M.D. at CCP has recommended for the patient to be transferred to a long term acute care facility.

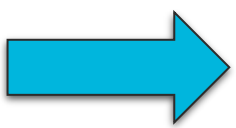
Short-term acute care and long-term acute care are a continuance of care for post-stabilization services because the services were initiated in the emergency department. Short-term acute care is very goal-oriented towards helping the patient return home or resume their normal activities and function. The goal of long-term acute care is typically to **preserve** the patient's **quality** of life and health as much as possible, in addition to having an average length of stay that is greater than 25 days.

III. MA ORGANIZATIONS MAY NOT DENY MEDICALLY NECESSARY LONG-TERM ACUTE CARE AS THEY MUST PROVIDE COVERAGE FOR ALL THE SERVICES THAT ARE COVERED BY MEDICARE PART A AND PART B.

As you may know, **42 CFR §422.101** states:

> Except as specified in 42 CFR §422.318 (for entitlement that begins or ends during a hospital stay) and 42 CFR §422.320 (with respect to hospice care), **each MA organization must meet the following requirements:**
>
> **(a) Provide coverage of, by furnishing, arranging for, or making payment for, all services that are covered by Part A and Part B of Medicare (if the enrollee is entitled to benefits under both parts) or by Medicare Part B (if entitled only under Part B) and that are available to beneficiaries residing in the plan's service area. Services may be provided outside of the service area of the plan if the serviecs are accessible and available to enrollees.**
> **(b) Comply with —**
> **(1) CMS's national coverage determinations;**
> **(2) General coverage guidelines included in original Medicare manuals and instructions unless superseded by regulations in this part or related instructions; and**
> **(3) Written coverage decisions of local Medicare contractors with jurisdiction for claims in the geographic area in which services are covered under the MA plan.** If an MA plan covers geographic areas encompassing more than one local coverage policy area, the MA organization offering such an MA plan may elect to apply to plan enrollees in all areas uniformly the coverage policy that is the most beneficial to MA enrollees. MA organizations that elect this option must notify CMS before selecting the area that has local coverage policies that are most beneficial to enrollees as follows.

Here, the MAO must provide coverage and pay for all services that are covered by Part A and Part B of Medicare, and because Part A and Part B covers long-term acute care, MAOs are required to provide the same services covered under original Medicare **(See Exhibit E: CMS Medicare policy).**



IV. EVEN IF THE REFERRING FACILITY, LEXINGTON MEDICAL CENTER, IS NOT AN AGENT OF THE PLAN, A COMPETENT PHYSICIAN WITH EXPERTISE IN THE SAME AREA AS THE PATIENT'S CONDITION IS REQUIRED TO REVIEW THE MAO'S DETERMINATION OF PARTIAL OR FULL ADVERSE MEDICAL NECESSITY DETERMINATIONS.

The Medicare Managed Care Manual, Chapter 4, Section 10.16 outlines the MAO's "medical necessity" review decisions criterion, and states:

Every MA plan:

- **If the MAO expects to issue a partially or fully adverse medical necessity (or any substantively equivalent term used to describe the concept of medical necessity) decision based on the initial review of the request, the organization determination must be reviewed by a physician or other appropriate health care professional with sufficient medical and other expertise, including knowledge of Medicare coverage criteria, before the MAO issues the organization determination decision. The physician or other health care professional must have a current and unrestricted license to practice within the scope of his or her profession in a State, Territory, Commonwealth of the United States (that is, Puerto Rico), or the District of Columbia (42 CFR §422.566(d), MMCM chapter 13, 40.1.1);**
- **Must make determinations based on: (1) the medical necessity of plan-covered services – including emergency, urgent care and post-stabilization – based on internal policies (including coverage criteria no more restrictive than original Medicare's national and local coverage policies) reviewed and approved by the medical director; (2) where appropriate, involvement of the organization's medical director per 42 CFR §422.562(a)(4); and (3) the enrollee's medical history (e.g., diagnoses, conditions, functional status), physician recommendations, and clinical notes. Furthermore, if the plan approved the furnishing of a service through an advance determination of coverage, it may not deny coverage later on the basis of a lack of medical necessity**

Here, approvals and denials of coverage of medical services rendered to the patient must be made by a physician with sufficient medical expertise in the same medical field as the one that the patient's treating condition is in. It would be neither right nor prudent for a MAO physician outside the realm of the patient's condition to be offering medical advice, review, or engaging in peer-to-peer conversation with the patient's treating physician, especially when it is in direct relation to the important and life-altering medical decisions concerning the patient's medical treatment. However, this is a moot point as Lexington Medical Center is contracted with UHC. Here, UHC appears to be unfamiliar with network facility coverage rules as this transfer to a long-term care acute facility falls under "plan-directed care" and therefore no prior authorization was required.

V. ANY MAO DIRECT OR INDIRECT INTERFERENCE WITH HEALTH CARE PROFESSIONALS' ADVICE TO THEIR PATIENTS IS STRICTLY PROHIBITED.

Pursuant to **42 CFR §422.206**, in pertinent part:

> **(a) General rule. (1) An MA organization may not prohibit or otherwise restrict a health care professional, acting within the lawful scope of practice, from advising, or advocating on behalf of, an individual who is a patient and enrolled under an MA plan about —**
>
> **(i) The patient's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to the individual to provide an opportunity to decide among all relevant treatment options;**
>
> **(ii) The risks, benefits, and consequences of treatment or non-treatment; or**
>
> **(iii) The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.**

This law is further strengthened and reinforced by recent case law addressing the fact that physicians at referring hospitals should challenge the MAO's denial of the treating physician's recommended treatment

options on the grounds that such adverse and intimidating actions and behavior from the MAO vigorously interfere with, and effectively erode, the patient-provider relationship.

In the case of *Murphy v. Board of Medical Examiners of the State of Arizona* (citation: Court of Appeals of Arizona, Division 1, Department A, Nos. 1 CA-CV 95-0327, 1 CA-CV 96-0182, Decided: July 15, 1997), the medical director of a MAO refused to authorize a patient's gallbladder surgery, unilaterally deeming it to be not "medically necessary," which was in direct contradiction to the advice given by the patient's treating surgeon. The patient's physician filed a complaint again the MAO medical director with the Arizona Board of Medical Examiners, stating that the medical director's coverage denial constituted "unprofessional conduct" and "medical incompetence" that interfered with the physician-patient relationship and effectively eroded the patient's trust in his surgeon and in the surgery that was recommended for him to undergo.

VI. THE MAO OFFERING PRIVATE FEE-FOR-SERVICE PLANS TO PATIENTS MUST DEMONSTRATE THAT IT OFFERS SUFFICIENT ACCESS TO CARE AND FREEDOM OF CHOICE CAPABILITIES.

Pursuant to 42 CFR §422.114, in pertinent part:

> **(a) Sufficient access.**
> **1. An MA organization that offers an MA private fee-for-service plan must demonstrate to CMS that it has sufficient number and range of providers willing to furnish services under the plan.**
>
> **(i) Payment rates that are not less than the rates that apply under original Medicare for the provider in question;**
>
> **(ii) Subject to paragraph (A) of section (a)(2)(ii), contracts or agreements with a sufficient number and range of providers to furnish the services covered under the MA private fee-for-service plan;**
>
> **(b) Freedom of choice. MA fee-for-service plans must permit enrollees to obtain services from any entity that is authorized to provide services under Medicare Part A and Part B and agrees to provide services under the terms of the plan.**

Here, it is important to note that the MAO offering the private fee-for-service plans to the patient who is in short-term acute care must ensure that the patient is receiving the full and proper access to the number and range of providers willing to furnish these services under the MAO plan.

Furthermore, it is the patient's prerogative to seek the obtainment of services from **any** entity that is authorized to provide these services under Medicare Part A and B. That is to say, if and when the MAO wants to direct the patient's treatment to services, it is fully within the patient's choice to refuse such treatment direction and to request for any and all of their own treatment designations and requests, insofar as their designations and requests fall within the provided services outlined under Medicare Part A and Part B.

If you disagree, you're reminded that with any potential disagreement of care, you're required to assume care of the patient, pursuant to **42 CFR §422.113(c)(3).**

If United Healthcare SR fails to respond or assume care of its enrollee within the required timeframe, the treating physicians at CCP and Community Health Care have the right to continue to treat the beneficiary until one of the criteria in **42 CFR §422.113 (c)(3)** were met, as shown below:

> *(3) End of MA organization's financial responsibility. 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.* (Emphasis added.)

Per **42 CFR §422.113(c)(3)**, Payor's responsibility would end when, (i) a plan physician assumed care of the enrollee, (ii) the enrollee was transferred, (iii) the treating physician and Payor reached an agreement concerning the enrollee's care, (iv) or when the enrollee was discharged. If (i-iii) does not occur, the MAO's responsibility ends when the enrollee is discharged. Therefore, the MAO remains financially responsible for all post-stabilization services and care, including any transfers to CCP rendered to its Medicare beneficiary.

To ensure continued access to quality healthcare for the Medicare beneficiary enrolled under your MA plan, we ask that your office provide immediate authorization to the undersigned for transfer to the long-term acute care facility on or before **May 10, 2023,** to prevent further escalation with CMS.

We appreciate your leadership.

Respectfully,

John Shen
Claims Compliance Auditor II
ERN/The Reimbursement Advocacy Firm

Tel: (714) 820-6961 **Fax:** (714) 995-6901
Email: johnshen@ernenterprises.org

Enclosed:
Exhibit A — ERN Statement of Representation
Exhibit B — Continue Care Appeal Form and Medical Records
Exhibit C — Dr. Anthony Zamcho, MD Profile
Exhibit D — Lexington Medical Center Contracted Status
Exhibit E — CMS Medicare Policy
Exhibit F — Signed Waiver of Liability

THE REIMBURSEMENT ADVOCACY FIRM*

*A DIVISION OF ERN ENTERPRISES

CONFIDENTIAL FACSIMILE TRANSMITTAL SHEET

TO:	FROM:
United Healthcare Expedited Appeals	**John Shen**
COMPANY:	DATE:
United Healthcare SR	*FRIDAY, MAY 12, 2023*
FAX NUMBER:	TOTAL NO. OF PAGES INCLUDING COVER:
1-888-517-7113	1
PHONE NUMBER:	SENDER'S REFERENCE NUMBER:
1-800-322-2758	TRAF# 86281, Patient: [redacted] McMichael

RE:

This office received a phone call from Crystal from UHC SR on 5/11/23 at 8:48 PM PST. Crystal verbally stated that the 5/6/23 denial for this patient's transfer request to Long Term Acute Care was overturned. The Authorization Number is A197320642.

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

Dear UHC SR Expedited Appeals,

This office represents Continue and has been asked to audit and investigate the denial of Medicare Long Term Acute Care inpatient covered services for possible complaint filing with the **Centers for Medicare and Medicaid Services (CMS)** for UHC SR's possible violation of federal law and CMS guidelines.

Please be advised that this office received a phone call from Cystal from UHC SR on 5/11/23 at 8:48 PM PST. Crystal verbally stated that the 5/6/23 denial for this patient's transfer request to Long Term Acute Care was overturned. The Authorization Number is A197320642.

Please provide a printed copy of the overturn let

Respectfully,

John Shen
Email: johnshen@ernenterprises.org Phone: 714-820-6961 Fax: 714-995-6901

Federal Laws

If a patient has overstayed the DRG, is at a contracted short term acute care hospital who requests transfer to a non-contracted LTAC, it is considered plan approved care.

Who We Are.

ERN/The Reimbursement Advocacy Firm (TRAF) is the representation arm of ERN/National Council of Reimbursement Advocacy (NCRA), a for profit California corporation and provider membership organization, whose mission is to provide regulatory claims representation, training and patient advocacy that restricts third-party payors from making improper denials or medically inappropriate decisions.

What We Do.

At ERN, we understand the significance of quality health care and its reliance on financial viability. With the support of Wickline v. State, we help providers advocate for medically appropriate health care and fair reimbursement (using administrative laws) because ultimately, we recognize that every case represents a **human life**.

The Sign of the Times.

Healthcare is a law to be defended.

The Sign of the Times.

We exist to face giants.
To "advocate for medically appropriate healthcare pursuant to Wickline vs. State."

The Sign of the Times.

Public policy and prompt payment laws are enacted for public good. They ensure patient access to medically necessary care when needed.

The Sign of the Times.

The power inequities that exist between health plans and providers demand providers create a **"enforcement program"** to do the following:

- **Draw a narrative thread of administrative laws throughout the entire revenue cycle.**
- **Challenge and protest any practice, policy or decision that impairs their ability to render quality care to patients.**

It is a must you preserve patient access to care by these rules. We live by regulations in every other area except the revenue cycle (e.g. JCAHO, credentialing).


Can I do this?

LEGISLATIVE UPDATE

OIG POST ACUTE REPORT

LEGISLATIVE UPDATE

OIG POST-ACUTE REPORT

Medicare Advantage enrollment has continued an increasing trend within the last decade. It is predicted by The Congressional Budget Office that relative to all Medicare beneficiaries, those enrolled in Medicare Advantage plans would account for 51% by 2030. Medicare Advantage abides with the services of Original Medicare, with the additional responsibility of care coordination. Managing this means that Medicare Advantage Organizations (MAO) may urge for additional requirements: beneficiaries using in-network providers for specific services; **prior authorization before specific services can be provided**; or referrals for specialty care services.

With the requirement of prior authorization in mind, **MAOs are responsible for delaying and even inappropriately denying access to medically necessary care and payment, denying millions of requests annually.**

Based on the OIG report, MAOs tend to validate their denials on the basis that requests do not meet Medicare coverage rules. In stating so, **they resort to creating clinical criteria that are not otherwise contained in Medicare coverage rules**. (Not to be mistaken: MAOs are permitted to implement additional clinical criteria within their determinations; however, **such criteria should not be more restrictive than that of its original national and local policies** (See Medicare Manual Chapter 4, Section 10.16.))

Three Key Takeaways From The Report

MAO denials are:

- Using MAO clinical criteria that are not contained in Medicare coverage rules.
- Requesting unnecessary documentation
- Making human review errors and system errors

(Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care, OIG [2022])

LEGISLATIVE UPDATE

THE SENATE HOMELAND SECURITY HEARING

The Senate Homeland Security and Governmental Affairs Permanent Subcommittee on Investigations conducted a hearing **on Wednesday 5/17/23 to learn how and why Medicare Advantage (MA) plans have routinely denied care of covered services**.

MA continues to grow in popularity and the private plans now provide Medicare coverage for 30 million seniors, more than half of eligible beneficiaries. But Blumenthal said that the major insurance companies who run the plans are making record profits in part because of the denials or delays in care. He warned insurers that lawmakers won't allow this practice to continue.

Bipartisan lawmakers have sent letters to MA's biggest insurers—UnitedHealth, Humana and CVS Aetna, which collectively cover 50 percent of MA beneficiaries—**asking for internal documents that show how decisions are made to grant or deny access to care, including how they use AI.**

"If you deny lifesaving coverage for seniors, we are watching. We will expose you. We will demand better. We will pass legislation, if necessary, but action will be forthcoming," Blumenthal said.

OIG Chief of Staff Megan Tinker, chief of staff, provided testimony that the OIG has found that MA organizations have denied coverage to services that would have been approved had the members been enrolled in Medicare. In some cases, MA plans have denied payments to providers for services already delivered to patients even though the requests met Medicare coverage rules and the plans' own billing rules. She pointed to an **April 2022 investigation that found in 2021, MA organizations denied 2.2 million prior authorization requests and more than 56 million payment requests overall**. Thirteen percent of the prior authorization denials were for services that met Medicare coverage rules. "Plans make more money by providing fewer services," she told the committee.

(Ilene MacDonald, Rise, May 19, 2023)

LEGISLATIVE UPDATE

2024 MEDICARE ADVANTAGE FINAL RULE

On April 5, 2023, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that revises the Medicare Advantage (MA or Part C), Medicare Prescription Drug Benefit (Part D), Medicare Cost Plan, and Programs of All-Inclusive Care for the Elderly (PACE) regulations.

Enhancements to Medicare Advantage and Medicare Part D:
Ensuring Timely Access to Care: Utilization Management Requirements

- **Clarifying clinical criteria guidelines to ensure people with MA receive access to the same medically necessary care they would receive in Traditional Medicare**
- **Defines when applicable Medicare coverage criteria are not fully established by explicitly stating the circumstances in which MA plans may apply internal coverage criteria.**
- **Streamlines prior authorization requirements, including adding continuity of care requirements and reducing disruptions for beneficiaries**
  - Requires that coordinated care plan prior authorization policies may only be used to confirm the presence of diagnoses or other medical criteria and/or ensure that an item or service is medically necessary
  - **Requires coordinated care plans to provide a minimum 90-day transition period when an enrollee currently undergoing treatment switches to a new MA plan, during which the new MA plan may not require prior authorization for the active course of treatment**
  - Requires all MA plans to establish a Utilization Management Committee to review policies annually and ensure consistency with Traditional Medicare's national and local coverage decisions and guidelines.
  - **Requires that approval of a prior auth. request for a course of treatment must be valid for as long as medically reasonable/necessary to avoid disruptions in care in accordance with applicable coverage criteria, the patient's medical history, and the treating provider's recommendation.**

(2024 Medicare Advantage and Part D Final Rule [CMS-4201-F], CMS)

CONTRACTED PROVIDERS

MA Timely Prior Authorizations

Federal Laws

As contracted providers, you don't have Medicare Appeal and Hearing rights, but you are treated as an agent of the plan to preserve beneficiary access to care.

Federal Laws

42 CFR § 422.152(b)(1)

(b) Requirements for **MA coordinated care plans** (except for regional MA plans) and including local PPO plans that are offered by organizations that are licensed or organized under State law as HMOs.

An **MA coordinated care plan's** (except for regional PPO plans and local PPO plans as defined in paragraph (e) of this section) **quality improvement program must** -

(1) In processing requests for initial or continued authorization of services, **follow written policies and procedures that reflect current standards of medical practice**.

Federal Laws

42 CFR § 422.202(b)(1) and 42 CFR 422.202(b)(3)

(b) Consultation. The MA organization must establish a formal mechanism to consult with the physicians who have agreed to provide services under the MA plan offered by the organization, regarding the organization's **medical policy**, **quality improvement programs and medical management procedures** and ensure that the following standards are met:

(1) Practice guidelines and utilization management guidelines -

(i) Are based on reasonable medical evidence or a consensus of health care professionals in the particular field;

Federal Laws

42 CFR § 422.202(b)(1) and 42 CFR 422.202(b)(3)

(ii) Consider the needs of the enrolled population;

(iii) Are developed in consultation with contracting physicians; and

(iv) Are reviewed and updated periodically.

(2) The guidelines are communicated to providers and, as appropriate, to enrollees.

(3) Decisions with respect to utilization management, enrollee education, coverage of services, and other areas in which the guidelines apply are consistent with the guidelines.

Federal Laws

Chapter 4, § 50.6 – Cost Sharing for Dual-Eligible Enrollees Requiring an Institutional Level of Care (also Chapter 16B, § 20.2.4.3 – Cost Sharing for Dual Eligibles Requiring an Institutional Level of Care)

§ 110.1.1 – Provider Network Standards

Plans may not implement utilization management protocols that create inappropriate barriers to needed care. **Prior authorization** and **referral** are two utilization management approaches frequently used by plans and are entered in the PBP; the following definitions and requirements clarify the meaning and appropriate use of these two approaches:

- **Prior Authorization:** A process through which the physician or other health care provider is required to obtain **advance approval from the plan** that payment will be made for a service or item furnished to an enrollee. Unless specified otherwise with respect to a particular item or service, the enrollee is not responsible for obtaining (prior) authorization.

Federal Laws

Chapter 4, § 50.6 – Cost Sharing for Dual-Eligible Enrollees Requiring an Institutional Level of Care (also Chapter 16B, § 20.2.4.3 – Cost Sharing for Dual Eligibles Requiring an Institutional Level of Care)

§ 110.1.1 – Provider Network Standards

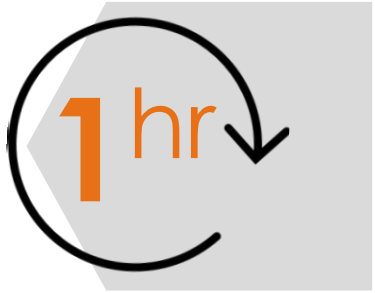
- **Referral:** A process through which the **enrollee's primary care physician or other network physician (depending on the plan policy) permits or instructs the enrollee to obtain an item or service from another physician or other provider type**.

Who is this?

POLICY CHALLENGE:
CENTER FOR MEDICARE AND MEDICAID SERVICES

DID YOU KNOW?

MA plans are failing to preapprove care within the statutorily required one (1) hour and then denying claims for medical necessity—**even if ordered by a plan provider**.



Authority: **42 CFR §422.113 (See 42 CFR 438.114(e) for Medicaid)**

FEDERAL REGISTER VOLUME 63, NUM 123:

"We do not agree that the M+C organization should have the absolute right to control the care that is given to the member when it does eventually respond and the one hour time period has elapsed. Safe transfer of responsibility should occur with the needs and the condition of the patient as the primary concern, so that the quality of care the patient receives is not compromised."

WHAT CAN YOU DO?

Once the beneficiary is admitted and the 1 hour time for the MA to respond has lapsed, the continuity of the patient's care is the utmost concern and the MA plan is discouraged from disrupting care that could have an adverse impact to the beneficiary.

Vigorously defend retrospective denials after patient discharge in light of 422.113 (c)(3), which states: The MA organization's financial responsibility for post-stabilization care services it has **not pre-approved ends when - (iv) The enrollee is discharged.**

Flag all MA plans conducting retrospective medical reviews and denying for medical necessity, and run a report showing (by Plan), # of beneficiary claims denied improperly, and # of uncompensated dollars effected.

Notify your RAC leader and Ed Norwood to determine next steps for escalation to the appropriate plan and/or regulatory agency.

CHAPTER 4 MEDICARE MANAGED CARE MANUAL

when:

- The MAO does not respond to a request for pre-approval within one hour;
- The MAO cannot be contacted; or
- The MAO representative and the treating physician cannot reach an agreement concerning the enrollee's care, and a plan physician is not available for consultation.

(In this situation, the MAO must give the treating physician the opportunity to consult with a plan physician. The treating physician may continue with care of the patient until a plan physician is reached or one of the criteria below is met.)

20.5.3 — End of Post-Stabilization

The MAO's financial responsibility for post-stabilization care services it has not pre-approved ends when:

- A plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care;
- A plan physician assumes responsibility for the enrollee's care through transfer;
- An MAO representative and the treating physician reach an agreement concerning the enrollee's care; or
- The enrollee is discharged.

When a treating physician is contracted with the plan, CMS views him or her as a the plan for purposes of our rules and guidance. The rules above are intended for enrollee protection and guidance to plans for working with out-of-network providers. When we address "financial responsibility," we are referring to a plan's obligation to pay for (cover) the enrollee's services. That includes out-of-network providers, because those providers can bill enrollees if the plan denies their coverage/billing.

ABN (?)

Except under very limited circumstances, enrollees cannot be liable for in-network services, and therefore would not otherwise have an appealable interest — see 42 C.F.R. 422.562(c)(2). A network provider may not "stand in the shoes" of an enrollee by signing a waiver of liability (WOL) under the subpart M appeals process, but rather must follow the terms of his or her provider/plan contract.

individual physician contracted w/ SCAN (MA)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop N2-20-16
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES

Office of Strategic Operations and Regulatory Affairs/Freedom of Information Group
Refer to: Control Number 052220197010 and PIN Q2XA

7/8/2019

Daniel Muhlbach
The Reimbursement Advocacy Firm
5856 Corporate Avenue, Suite 110
Cypress, CA 90630

Dear Mr. Muhlbach:

This letter is in response to your Freedom of Information Act (5 U.S.C. § 552) request of March 15, 2019 which you sent to the Centers for Medicare & Medicaid Services (CMS). Within your correspondence, you requested the following:

1. ***An electronic, written copy of any CMS Policy, Directive, Manual, Handbook, Standard Operating Procedure, Federal Register or statutory authority that delineates how contracted, in-network providers function as agents of the plan.***

2. ***An electronic, written copy of any CMS Policy, Directive, Manual, Handbook, Standard Operating Procedure, Federal Register or statutory authority that describes how the provision of an item or service by a contracted, in-network provider constitutes a favorable organization decision.***

3. ***An electronic, written copy of any CMS Policy, Directive, Manual, Handbook, Standard Operating Procedure, Federal Register or statutory authority that permits a Medicare Advantage Organization from performing retroactive medical necessity reviews for health care services that are ordered and rendered by a contracted, in-network provider.***

4. ***An electronic, written copy of any CMS Policy, Directive, Manual, Handbook, Standard Operating Procedure, Federal Register or statutory authority that absolves a Medicare Advantage Organization's financial liability for health care services that are pre-approved by a contracted, in-network provider.***

- *Temporarily reduce plan-approved out-of-network cost-sharing to in-network cost-sharing amounts; and*

- *Waive the 30-day notification requirement to enrollees as long as all the changes (such as reduction of cost-sharing and waiving authorization) benefit the enrollee.*

Typically, the source that declared the disaster will clarify when the disaster or emergency is over. If, however, the disaster or emergency timeframe has not been closed 30 days from the initial declaration, and if CMS has not indicated an end date to the disaster or emergency, plans should resume normal operations 30 days from the initial declaration. MAOs not able to resume normal operations after 30 days should notify CMS.

MAOs must disclose their policies about providing benefits during disasters on their plan websites.

If the President has declared a major disaster or the Secretary has declared a public health emergency, MAOs must follow the guidance in chapter 5 of the Prescription Drug Benefit Manual, regarding refills of Part D medications. The Prescription Drug Benefit Manual may be found at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/Pub100_18.pdf.

160 — Beneficiary Protections Related to Plan-Directed Care
(Rev. 121, Issued: 04-22-16, Effective: 04-22-16, Implementation: 04-22-16)

Organization Determinations: An enrollee, or a provider acting on behalf of the enrollee, always has the right to request a pre-service organization determination if there is a question as to whether an item or service will be covered by the plan. If the plan denies an enrollee's (or his/her treating provider's) request for coverage as part of the organization determination process, the plan must provide the enrollee (and provider, as appropriate) with the standardized denial notice (Notice of Denial of Medical Coverage (or Payment)/CMS-10003). For the requirements related to organization determinations and issuance of the standardized denial notice (CMS-10003), see chapter 13 of the MMCM located at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c13.pdf.

Limitations on Enrollee Liability: CMS considers a contracted provider an agent of the MAO offering the plan. As stated in the preamble to the January 28, 2005 final rule (CMS-4069-F):

"MA organizations have a responsibility to ensure that contracting physicians and providers know whether specific items and services are covered in the MA plan in which their patients are enrolled. If a network physician furnishes a service or directs an MA beneficiary to another provider to receive a plan-covered service without following the plan's internal procedures (such as obtaining the appropriate plan pre-authorization),

(See Organization Determinations – Sub part M, 42 CFR 422.566)

then the beneficiary should not be penalized to the extent the physician did not follow plan rules."

Consequently, when a contracted provider furnishes a service or refers an enrollee for a service that an enrollee reasonably believes is a plan-covered service, the enrollee cannot be financially liable for more than the applicable cost-sharing for that service. If a contracted provider believes an item or service may not be covered for an enrollee, or could be covered only under specific conditions, the appropriate process is for the enrollee or provider to request a pre-service organization determination from the plan.

If a contracted provider refers an enrollee to a non-contracted provider for a service that is covered by the plan upon referral, the enrollee is financially liable only for the applicable cost-sharing for that service. Contracted providers are expected to coordinate care or work with plans prior to referring an enrollee to a non-contracted provider to ensure, to the extent possible, that enrollees are receiving medically necessary services covered by their plan. Furthermore, plans are expected to work with their contracted providers to ensure that clear processes are in place and providers are educated about those processes, including appropriate documentation, to substantiate that a referral has been made.

If a service is never covered by the plan and the plan's Evidence of Coverage (EOC) provided to the enrollee is clear that the service or item is never covered, the plan is not required to hold the enrollee harmless from the full cost of the service or item. For a service or item that is typically not covered, but could be covered under specific conditions (e.g., dental care that is necessary to treat an illness or injury), the EOC, in and of itself, is not adequate notice of non-coverage for purposes of determining enrollee liability. In such instances, the appropriate process is for the enrollee, or the provider acting on behalf of the enrollee, to request a pre-service organization determination. If the plan denies the service, the plan must issue the standardized denial notice with appeal rights. The enrollee has the right to appeal any denial of a service or item. Plans also must educate their contracted providers about the limits of plan coverage and the need to correctly advise enrollees when providing referrals for covered services. This will prevent confusion related to plan coverage and enrollee financial liability as well as ensure coordination of the care furnished.

When the provider, or the plan acting on behalf of the provider, can show that an enrollee was notified (via a clear exclusion in the EOC or the standardized denial notice) prior to receipt of the item or service that the item or service is not covered by the plan or that coverage is available only if the enrollee is referred for the service by a contracted provider but the enrollee nonetheless receives that item or service in the absence of a referral, the regulation at §422.105(a) does not require the MA plan to hold the enrollee harmless from the full cost of the service or item charged by the provider.

170 — *Balance Billing*
(Rev. 121, Issued: 04-22-16, Effective: 04-22-16, Implementation: 04-22-16)

A contracted provider is an agent of the plan in both scenarios: 1) While furnishing a service or

2) Referring the enrollee to another physician or provider

CASE STUDY

- **CONTRACTED PROVIDERS AGENTS OF THE PLAN**

MAXIMUS
Federal Services

Medicare
Managed Care & PACE
Reconsideration Project

Reviewing Medicare Appeals

MAXIMUS Federal Services
Medicare Part C QIC
3750 Monroe Ave, Suite 702
Pittsford, New York
14534
Tel: 585-348-3300
Toll-free: 844-559-6743
Fax: 585-425-5292
www.medicareappeal.com

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:

July 25, 2016

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

RE: Enrollee: 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

providers are not available, out of area dialysis, and pre-approved care. You can find this information on page 8 of the 2016 Evidence of Coverage.

Explanation of decision

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

You asked UPHP to pay for these services. You say that you were not aware that T. Connor was enrolled in UPHP at the time of admission; therefore, you were not aware that prior authorization was required. UPHP denied your request. UPHP says that UPHP requires notification of all admissions within 1 business day of admission. UPHP says that, because you failed to notify the health plan of T. Connor's admission with 1 business day, these services are not payable.

UPHP must follow Medicare rules. The rules say that health plans must cover emergency services and urgently needed services even if the services are provided out of network or without prior authorization. Medicare 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. Medicare rules say that a contract provider is an agent of the plan. Services and referrals given by a contract provider are considered approved by the plan unless notice is provided that the services will not be covered.

In this case, the record shows that T. Connor was originally seen at Aspirus Grand View Hospital, a UPHP plan contract provider, for pneumonitis and possible bowel ischemia. Aspirus Grand View Hospital determined that they could not appropriately treat T. Connor at this hospital due to his multiple medical co-morbidities. Aspirus Grand View Hospital then referred T. Connor to St. Luke's Hospital and arranged for ambulance transfer. Medicare rules say that ambulance transport is covered for transfer of a patient from one hospital to another only if the transferring hospital does not have adequate facilities to provide the medical services needed by the patient. UPHP covered the ambulance services to transfer T. Connor from Aspirus Grand View Hospital to St. Luke's Hospital. According to UPHP's panel review form, T. Connor was emergently admitted to St. Luke's Hospital.

In making its decision, UPHP has relied on an internal policy requiring notification of all admissions within 1 business day of admission. However, the plan must comply with Medicare rules which state that health plans must cover emergency services and urgently needed services even if the services are provided out of network or without prior authorization. UPHP's internal medical panel review form states that T. Connor was emergently admitted to St. Luke's Hospital. As such, prior authorization was not needed for this admission. Emergency care ends when the patient is stabilized. Post-stabilization care is care that is administered to maintain, improve, or resolve the enrollee's stabilized condition. Health plans may require providers to request authorization for post-stabilization care. Although UPHP never made an explicit argument that some of the care provided to T. Connor was post-stabilization care nor did the health plan attempt to indicate when T. Connor's emergency admission to St. Luke's Hospital became post-stabilization care, UPHP says that T. Connor was hemodynamically stable prior to being transferred to St. Luke's Hospital. However, because the health plan has determined T. Connor's

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.

NON-CONTRACTED PROVIDERS

MA Timely Prior Authorizations

Federal Laws

Chapter 4, § 110.4 – Preferred Provider Organization (PPO) Coverage and Access

(Rev. 121, Issued: 04-22-16, Effective: 04-22-16, Implementation: 04-22-16)

PPOs must furnish all services in-network and out-of-network, but may charge higher cost-sharing for plan covered services obtained out-of-network. The following rules apply to PPO coverage outside the service area:

- **PPO plans must provide reimbursement for all plan-covered medically necessary services received from non-contracted providers without prior authorization requirements.** However, both enrollees and providers have the right to request a prior written advance determination of coverage from the plan prior to receiving/providing services;

Timely Determinations

▶ **Subpart M** Grievances, Organization Determinations and Appeals 422.560 – 422.634

MEDICARE HMO – 42 CFR § 422.566 (a) Responsibilities of the MA organization. **Each MA organization must have a procedure for making timely organization determinations** (in accordance with the requirements of this subpart) regarding the benefits an enrollee is entitled to receive under an MA plan, including basic benefits as described under § 422.100(c)(1) and mandatory and optional supplemental benefits as described under § 422.102, and the amount, if any, that the enrollee is required to pay for a health service. (Emphasis added.)

Timely Determinations

MEDICARE HMO – 42 CFR § 422.566 (b) **Actions that are organization determinations.** An organization determination is any determination made by an MA organization with respect to any of the following:

(1) **Payment** for temporarily out of the area renal dialysis services, **emergency services, post-stabilization care, or urgently needed services.**

Timely Determinations

MEDICARE HMO – 42 CFR § 422.566 (b) Actions that are organization determinations.

(3) **The MA organization's refusal to provide or pay for services, in whole or in part, including the type or level of services**, that the enrollee believes should be furnished or arranged for by the MA organization.

How would you fight inpatient to observation denials if contracted?

Timely Determinations

MEDICARE HMO – 42 CFR § 422.566 (d) Who must review organization determinations. If the MA organization expects to issue a partially or fully adverse medical necessity (or any substantively equivalent term used to describe the concept of medical necessity) decision based on the initial review of the request, the organization determination **must be reviewed by a physician or other appropriate health care professional with sufficient medical and other expertise…**

Timely Determinations

MEDICARE HMO – 42 CFR § 422.566 (d) Who must review organization determinations.

…including knowledge of Medicare coverage criteria, before the MA organization issues the organization determination decision. The physician or other health care professional must have a current and unrestricted license to practice within the scope of his or her profession in a State, Territory, Commonwealth of the United States (that is, Puerto Rico), or the District of Columbia. (Emphasis added.)

Notes to Table II:

1. See *chapter* 5 of the Prescription Drug Benefit manual located at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartDManuals.html for the definition of required drug coverage.

2. *Program for the All-Inclusive Care of the Elderly* (PACE) organizations offering PACE Programs, as defined in *section* 1894 of the Act generally have elected to provide Part D coverage in order to receive payment for the prescription drug coverage that they are statutorily required to provide.

10.16 – Medical Necessity

(Rev. 121, Issued: 04-22-16, Effective: 04-22-16, Implementation: 04-22-16)

Every MA plan:

- Must have policies and procedures, that is, coverage rules, practice guidelines, payment policies, and utilization management, that allow for individual medical necessity determinations (42 CFR §422.112(a)(6)(ii));

- Must employ a medical director who is responsible for ensuring the clinical accuracy of all organization determinations and reconsiderations involving medical necessity. The medical director must be a physician with a current and unrestricted license to practice medicine in a State, Territory, Commonwealth of the United States (that is, Puerto Rico), or the District of Columbia (42 CFR §422.562(a)(4));

- If the *MAO* expects to issue a partially or fully adverse medical necessity (or any substantively equivalent term used to describe the concept of medical necessity) decision based on the initial review of the request, the organization determination must be reviewed by a physician or other appropriate health care professional with sufficient medical and other expertise, including knowledge of Medicare coverage criteria, before the *MAO* issues the organization determination decision. The physician or other health care professional must have a current and unrestricted license to practice within the scope of his or her profession in a State, Territory, Commonwealth of the United States (that is, Puerto Rico), or the District of Columbia (42 CFR §422.566(d), MMCM *chapter* 13, 40.1.1);

- Must make determinations based on: (1) the medical necessity of plan-covered services - including emergency, urgent care and post-stabilization - based on internal policies (including coverage criteria no more restrictive than original Medicare's national and local coverage policies) reviewed and approved by the medical director; (2) where appropriate, involvement of the organization's medical director per 42 CFR §422.562(a)(4); and (3) the enrollee's medical history (e.g., diagnoses, conditions, functional status), physician recommendations, and clinical notes. Furthermore, if the

plan approved the furnishing of a service through an advance determination of coverage, it may not deny coverage later on the basis of a lack of medical necessity (Program Integrity Manual, *chapter* 6, Section 6.1.3(A)); and

- Must accept and process appeals consistent with the rules set forth at 42 CFR Part 422, Subpart M, and *chapter* 13 of the *MMCM*.

20 — Ambulance, Emergency, Urgently Needed and Post-Stabilization Services
(Rev. 120, Issued: 01-16-15, Effective: 01-01-15, Implementation: 01-01-15)

20.1 — Ambulance Services
(Rev. 121, Issued: 04-22-16, Effective: 04-22-16, Implementation: 04-22-16)

MAOs are financially responsible for ambulance services, including ambulance services dispatched through 911 or its local equivalent, when either an emergency situation exists as defined in *section* 20.2 below or other means of transportation would endanger the beneficiary's health. The enrollee is financially responsible for plan-allowed cost-sharing. Medicare rules on coverage for ambulance services are set forth at 42 CFR 410.40. For original Medicare coverage rules for ambulance services, refer to chapter 10 of the Medicare Benefit Policy Manual, publication 100-02, located at http://www.cms.hhs.gov/manuals/Downloads/bp102c10.pdf.

20.2 — Definitions of Emergency and Urgently Needed Services
(Rev. 120, Issued: 01-16-15, Effective: 01-01-15, Implementation: 01-01-15)

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency medical condition status is not affected if a later medical review found no actual emergency present.

Emergency services are covered inpatient and outpatient services that are:

- Furnished by a provider qualified to furnish emergency services; and

The MAO is not responsible for the care provided for an unrelated non-emergency problem during treatment for an emergency situation. For example, if the attending physician is treating a fracture, the plan is not responsible for any costs connected with a biopsy of skin lesions performed while treating the facture.

20.4 — Stabilization of an Emergency Medical Condition

(Rev. 121, Issued: 04-22-16, Effective: 04-22-16, Implementation: 04-22-16)

The physician treating the enrollee must decide when the enrollee may be considered stabilized for transfer or discharge, and that decision is binding on the MAO. Refer to *section* 20.5 below for the MAO's obligations regarding services provided following stabilization. Chapter 13 of the *MMCM*, "MA Beneficiary Grievances, Organization Determinations, and Appeals," addresses the enrollee's right to request a Quality Improvement Organization review of hospital discharges to a lower level of care. For transfers from one inpatient setting to another inpatient setting, an enrollee or person authorized to act on his or her behalf who disagrees with the decision and believes the enrollee cannot safely be transferred may request that the organization pay for continued out-of-network services. If the MAO declines to pay for the services, appeal rights are available to the enrollee.

20.5 — Post-Stabilization Care Services

(Rev. 120, Issued: 01-16-15, Effective: 01-01-15, Implementation: 01-01-15)

20.5.1 — Definition of Post-Stabilization

(Rev. 120, Issued: 01-16-15, Effective: 01-01-15, Implementation: 01-01-15)

Post-stabilization care services are covered services that are:

- Related to an emergency medical condition;
- Provided after an enrollee is stabilized; and
- Provided to maintain the stabilized condition, or under certain circumstances (see below), to improve or resolve the enrollee's condition.

20.5.2 — MAO Financial Responsibility

(Rev. 120, Issued: 01-16-15, Effective: 01-01-15, Implementation: 01-01-15)

The MAO is financially responsible for post-stabilization care services obtained within or outside the MAO that:

- Are pre-approved by a plan provider or other MAO representative;

- Although not pre-approved by a plan provider or other MAO representative, are administered to maintain the enrollee's stabilized condition within one hour of a request to the MAO for pre-approval of further post-stabilization care; or
- Although not pre-approved by a plan provider or other MAO representative, are administered to maintain, improve, or resolve the enrollee's stabilized condition when:
  - The MAO does not respond to a request for pre-approval within one hour;
  - The MAO cannot be contacted; or
  - The MAO representative and the treating physician cannot reach an agreement concerning the enrollee's care, and a plan physician is not available for consultation.

(In this situation, the MAO must give the treating physician the opportunity to consult with a plan physician. The treating physician may continue with care of the patient until a plan physician is reached or one of the criteria below is met.)

20.5.3 — End of Post-Stabilization
(Rev. 120, Issued: 01-16-15, Effective: 01-01-15, Implementation: 01-01-15)

The MAO's financial responsibility for post-stabilization care services it has not pre-approved ends when:

- A plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care;
- A plan physician assumes responsibility for the enrollee's care through transfer;
- An MAO representative and the treating physician reach an agreement concerning the enrollee's care; or
- The enrollee is discharged.

20.5.4 — Cost-Sharing
(Rev. 120, Issued: 01-16-15, Effective: 01-01-15, Implementation: 01-01-15)

Enrollee charges for post-stabilization care services may not be greater than what the organization would charge the enrollee if s/he had obtained the services through a contracted provider of the MAO. For purposes of cost-sharing, post-stabilization care services begin when the patient is stabilized and the emergency ends.

30 — Supplemental Benefits
(Rev. 120, Issued: 01-16-15, Effective: 01-01-15, Implementation: 01-01-15)

MA Organizations: Their Responsibility To You

MA Organizations are financially responsible for poststabilization care services when…

1. …they have been pre-approved

2. …you render services within 1 hour of your request

3. …they did not respond your request after one hour, they cannot be contacted and the plan physician cannot reach an agreement about the enrollee's care

MA Organizations' financial responsibility ends when…

1. …a plan physician assumes responsibility for the enrollee's care…

…at the treating facility

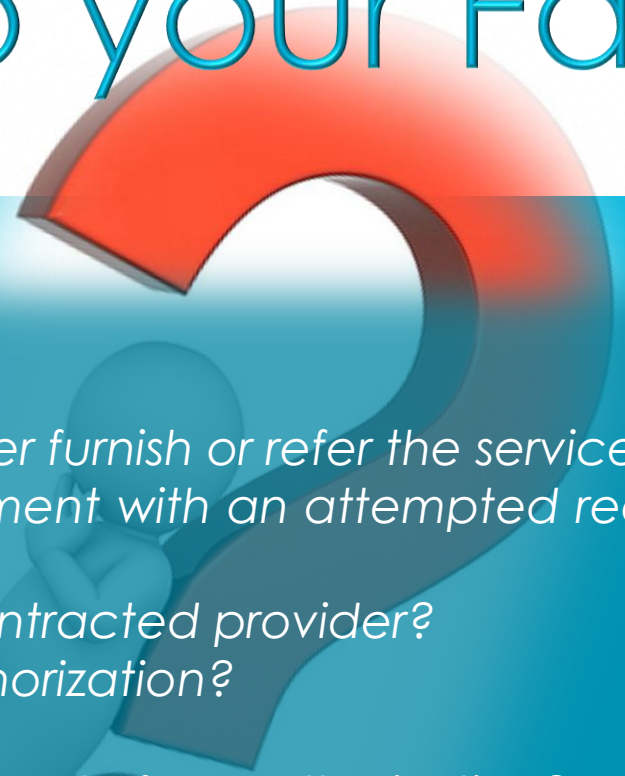
…OR through transfer

2. …an MA organization representative and the treating physician reach an agreement about the enrollee's care

3. …OR the enrollee is discharged

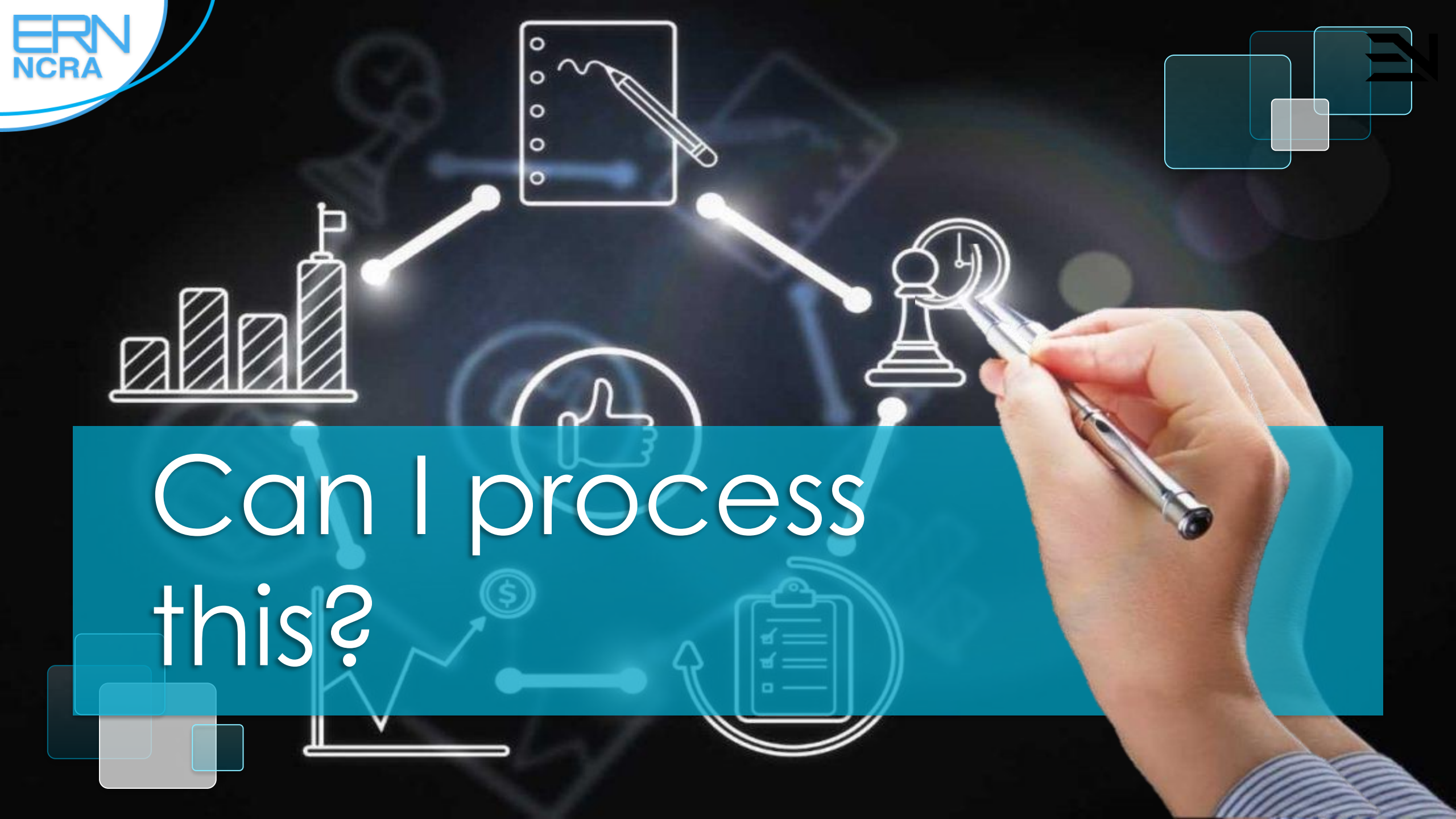
Source: MCMM Ch. 4, SEC. 20.5.2, 50.5.3
42 CFR §422.113 (c)(2-3)

Application to your Facility



QUESTIONS:

- *Are you contracted or non-contracted?*
- *If contracted, did a contracted physician or provider furnish or refer the service?*
- *Did you strengthen your contracted provider argument with an attempted request for preapproval?*
- *If non-contracted, was the patient referred by a contracted provider?*
- *Did you attempt to notify the plan and request authorization?*
- *How was contact made and documented?*
- *Did the plan issue a tracking/reference number instead of an authorization?*
- *Did the plan attempt to transfer the patient while still in house?*
- *Did the plan fail to notify the hospital of any disagreements prior to the commencement of poststabilization services and care or during the continuation of the same?*
- *If no attempt to obtain a preapproval was made, was the denial made by a competent physician with sufficient medical expertise?*


ERN
NCRA
Can I process this?

What if you could prevent denials?

Our Providers

Health Plan authorization delays

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

Our Denial Prevention Unit works in concert with your Case Managers to:

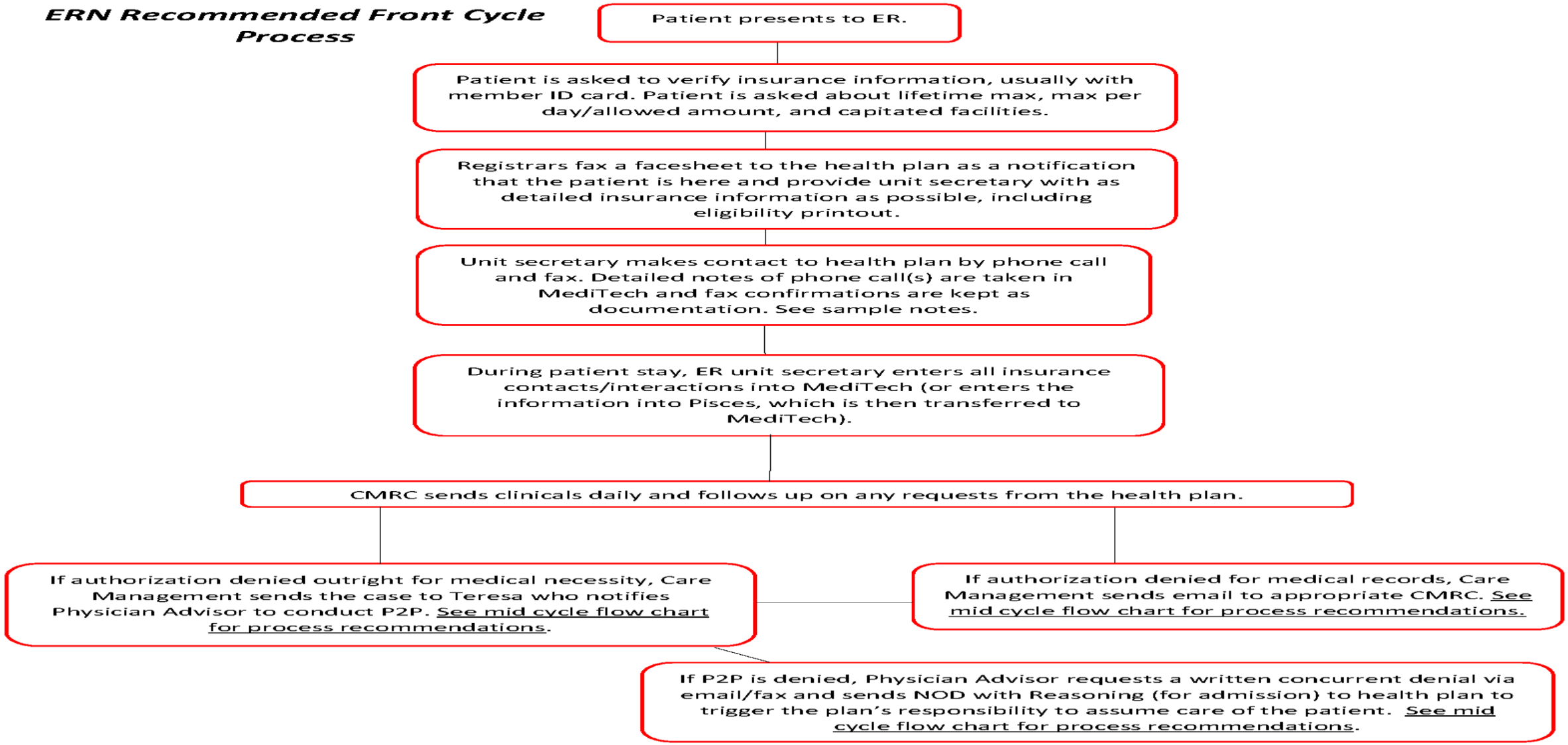
- *Convert tracking and reference numbers to authorization numbers prior to billing to avoid backend denials.*
- *Challenge improper requests for medical records to review services prior to the issuance of an authorization.*
- *Fight concurrent or continuity of care denials and initiate a notice of disagreement of care to trigger the plan's responsibility to assume care for patient under Health and Safety Code §1371.4 (d) 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.*

CALL TO GET STARTED:

(714) 995-6900 EXT. 6934

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

Medicare Advantage Appeals Timeline

To protect your rights, make sure to ensure your and the payor's compliance within the following timeframes…

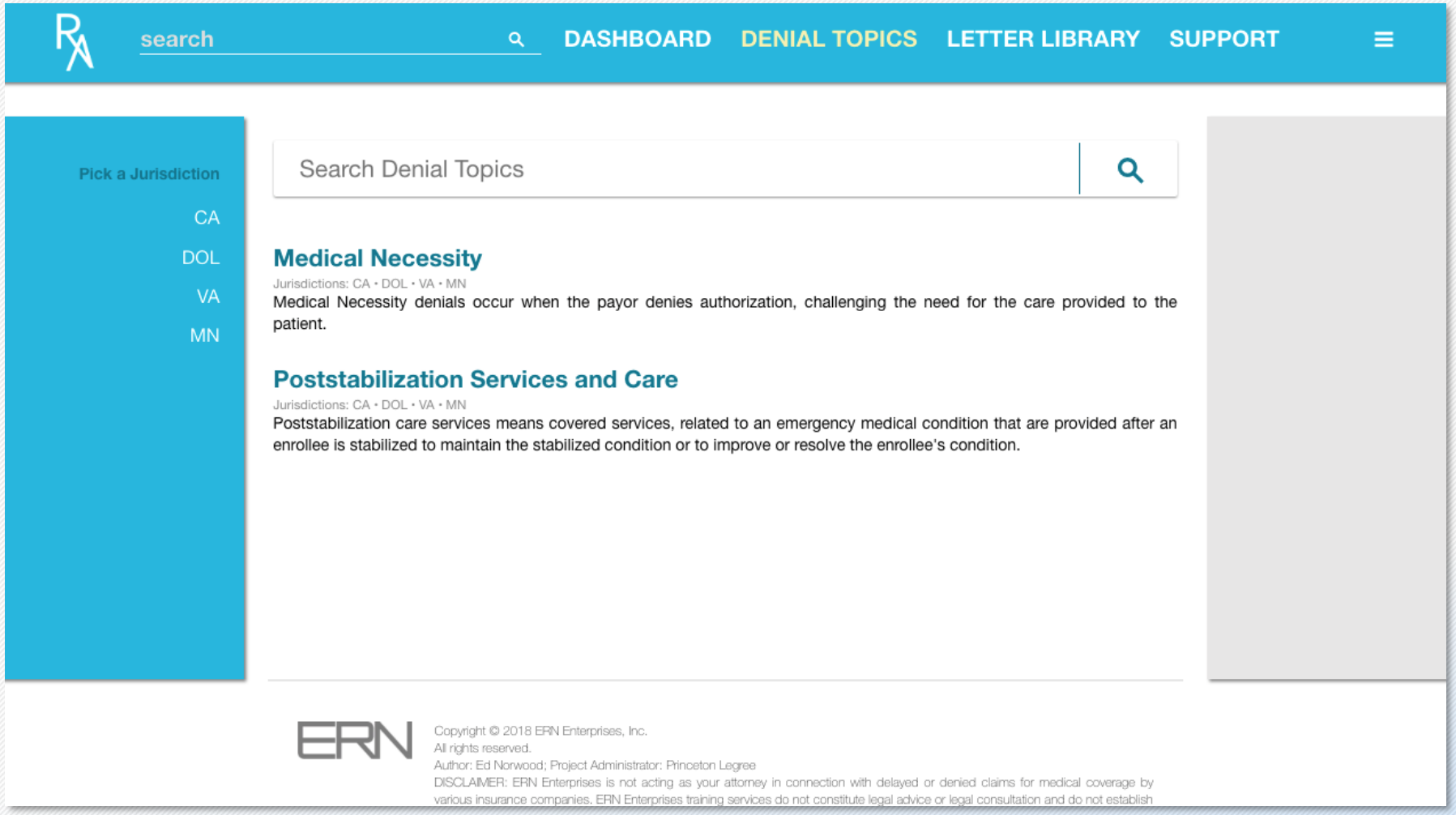
MANAGING
DENIALS

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

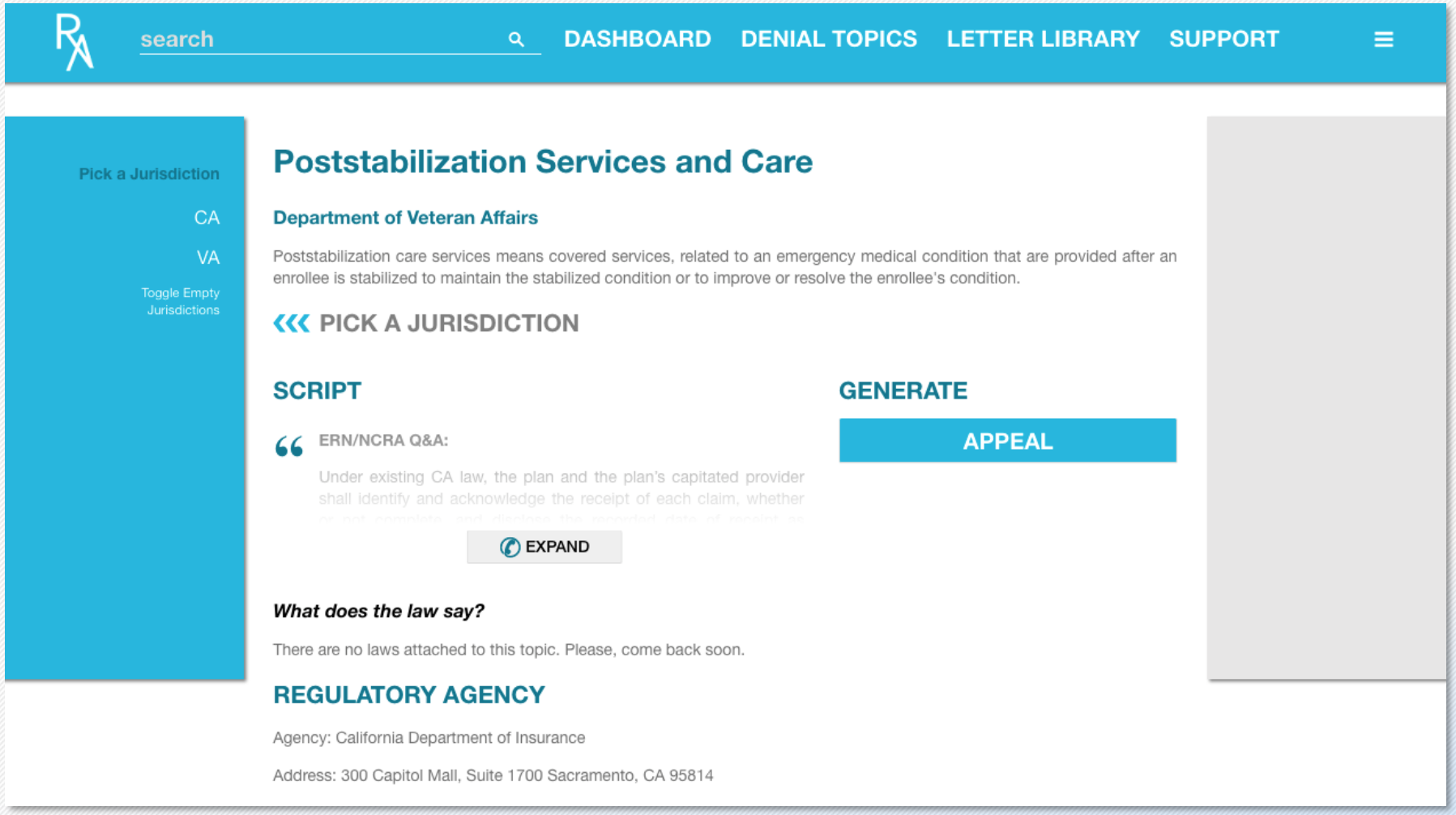
Code	Description
200	PPO UCR Reduction-OSHPD Recvd
201	PPO UCR Underpayment
202	PPO Untimely Appeal Vio.
203	PPO AOB Denial-Strong St. Law
204	PPO AOB Denial-Weak/No St.Law
205	PPO Underpayment Vio.
206	PPO Untimely Payment Vio.
207	PPO Unauthorized Treatment
208	PPO Retro Denial after Auth
209	PPO Untimely 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.


ERN
NCRA
Can I automate this?

REVAssurance Online



REVAssurance Online



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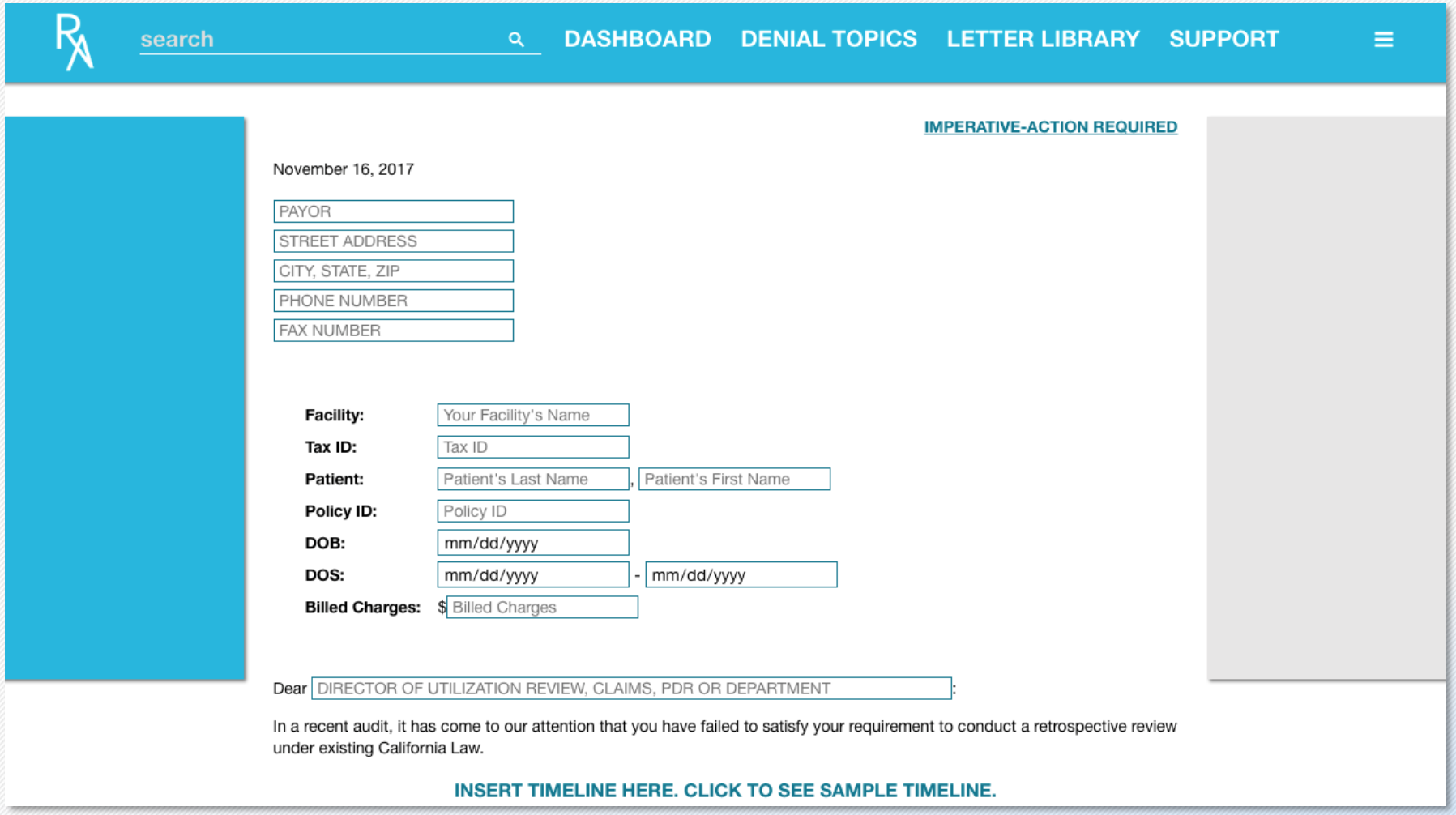
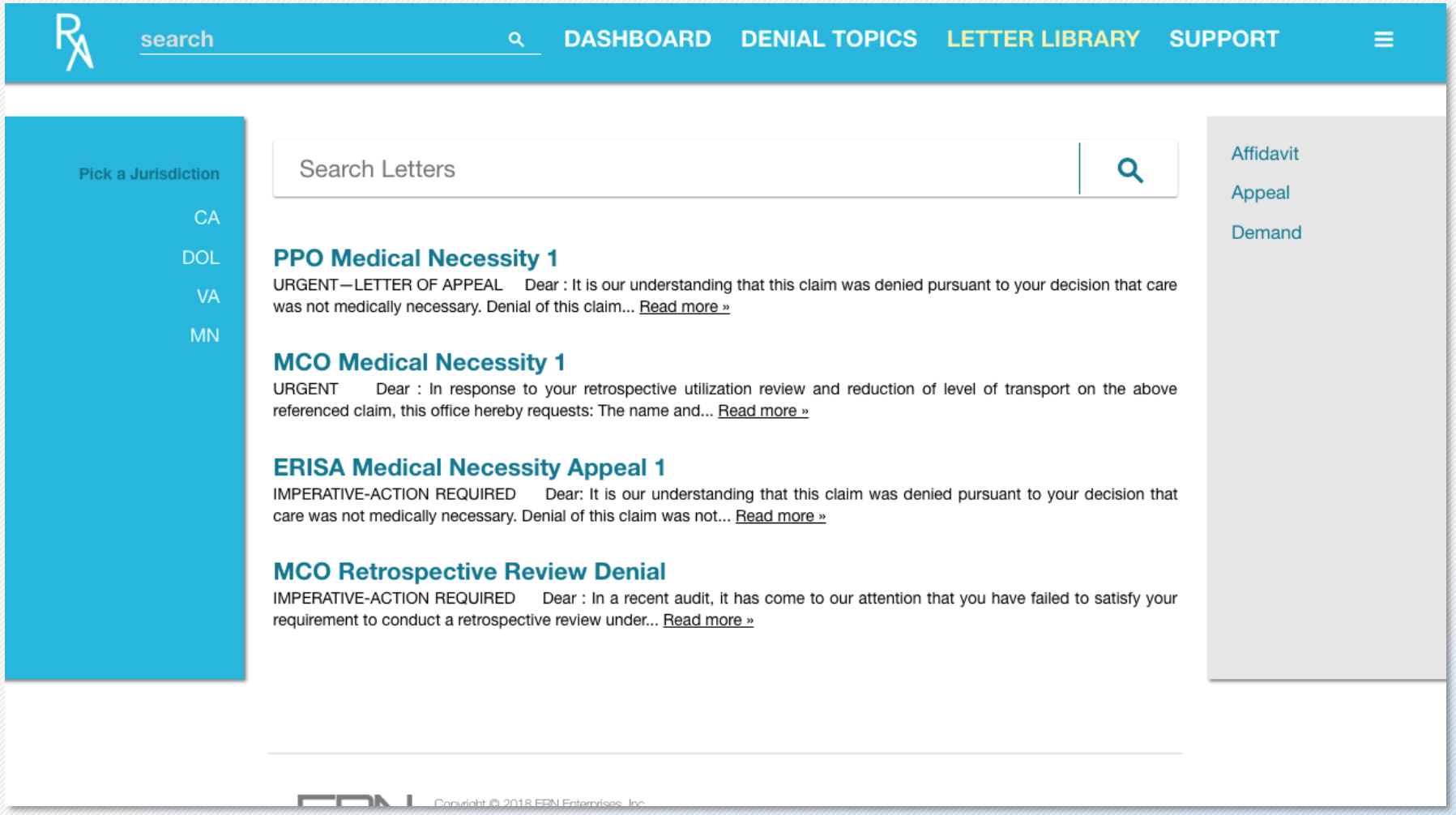
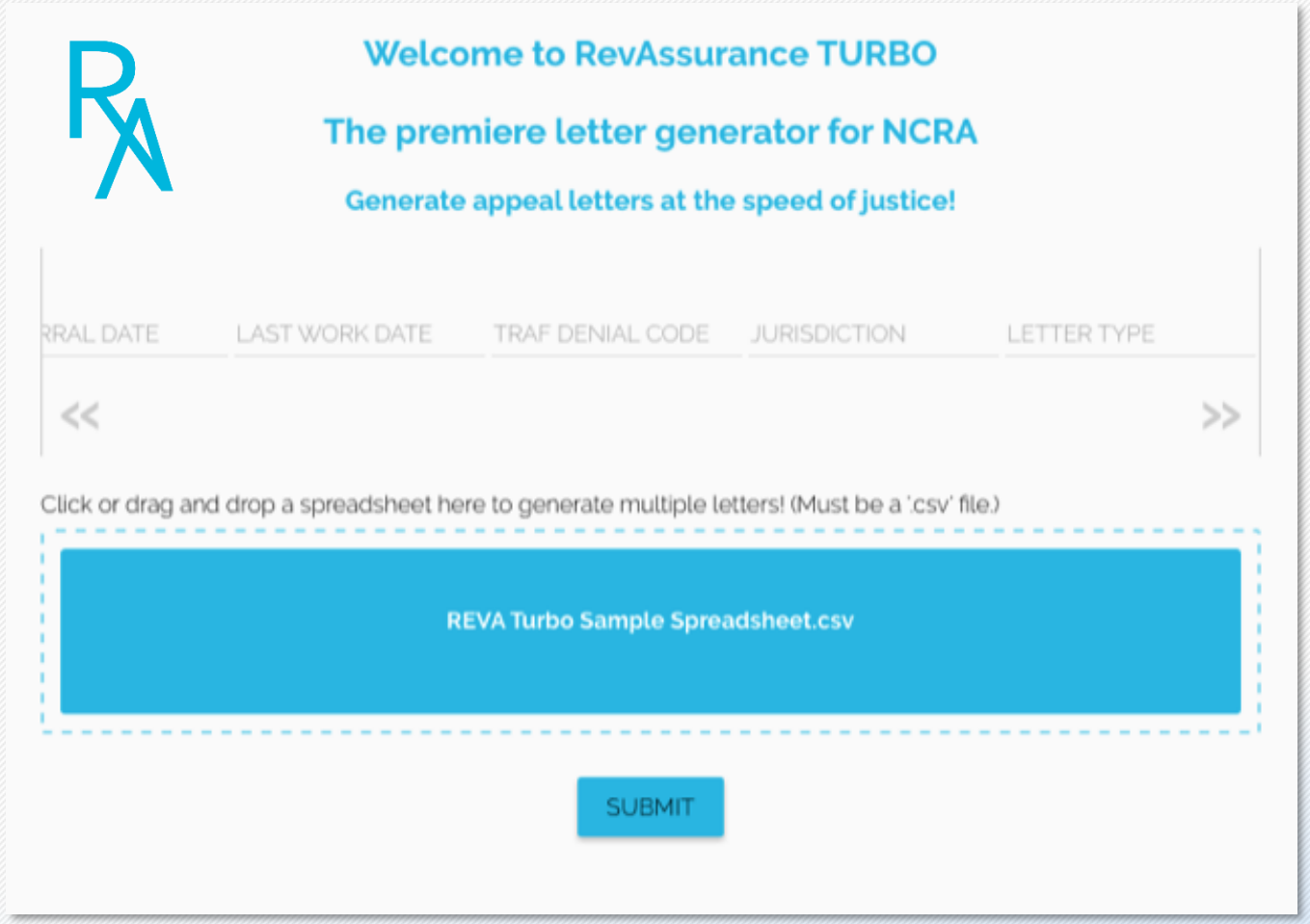


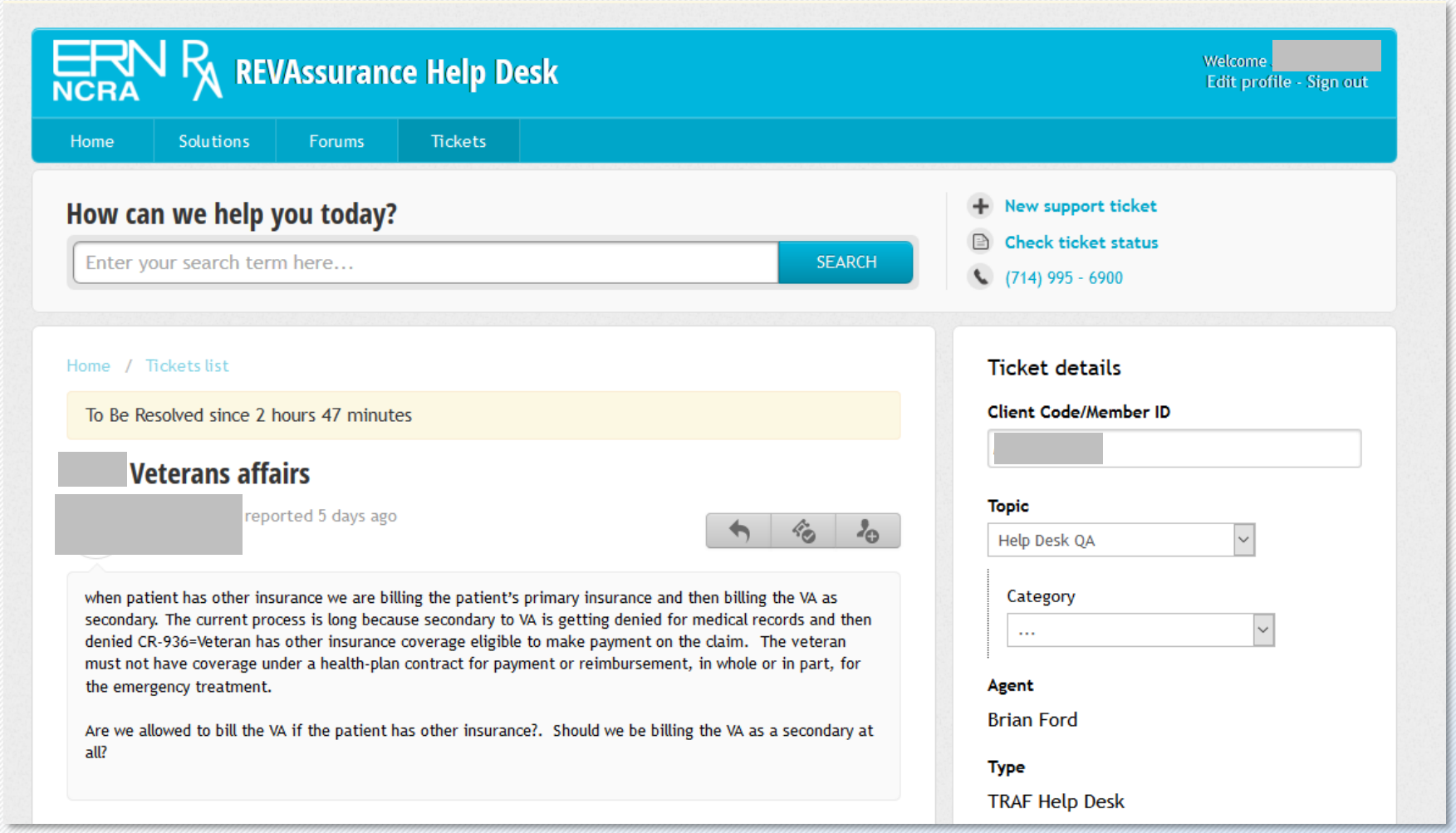
REVAssurance Online



REVAssurance *TURBO*



REVAssurance Support



APPEAL LETTER WRITING WORKSHOP

WRITING THE APPEAL

When Payors Won't Listen…

Denials: Prevention and Correcting Issues stemming from the Insurance Side.

QUESTION: *How can we decrease denials?*

What are payors looking for in an appeal letter?

1. **Identify the denial reason.**
2. **Determine the jurisdiction.**

   Examples: MA, ERISA, State sponsored HMO.
3. **Create transition statement of facts to ensure a clear explanation of the disputed item, including the provider's position is contained in appeal letters:**

ER No Pay- Postabilization:

"We **dispute** (Payor's name) denial of this claim as not medically necessary, **because** (Payor's name) was notified of the patient's admission and failed to disapprove care prior to the patient's discharge **as shown and described below**:"

No Claim on File:

"We **dispute** (Payor's name) denial of this claim as no claim on file, **because** (Client's name) billed the claim to (Payor's name) on (date) **as shown and described below**:"

4. **Attach exhibits to document each fact.**

   Example:

   - ❑ On 9/23/15, the patient presented to the emergency department of (PROVIDER) with severe crushing chest pains.
   - ❑ On 10/3/15, MHG submitted the claim to Blue Cross **(See Exhibit A – Hospital UB04 and Claims Clearing house receipt)**.
   - ❑ On 4/20/16, Blue Cross denied the claim for untimely filing **(See Exhibit B – BX EOB)**.

   (HEALTH NET PAYOR PANEL ATTORNEY COMMENTS)
5. **Locate administrative laws to support each argument.**
6. **Apply the law.**

   "Here, [Payor] was notified on [DATE], but failed to assume responsibility of the patient, within 60 minutes, prior to the patient's discharge, deeming the services statutorily authorized."
7. **Land the plane (Impose deadlines.)**

   "Please release the federal funds intended for the Medicare beneficiary on or before (deadline date) to prevent any unnecessary regulatory complaint action."

When Payors Won't Listen

"WE DISPUTE..."

"...BECAUSE..."

"...AS SHOWN AND DESCRIBED BELOW:"

When Payors Won't Listen…

Denials: Prevention and Correcting Issues stemming from the Insurance Side.

DIRECTIONS:

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 letters:

- 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.

When Payors Won't Listen…

Denials: Prevention and Correcting Issues stemming from the Insurance Side.

1) WHAT IS THE DENIAL? _____

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

3) TRANSITIONAL STATEMENT OF FACT:

We **dispute** _____'s denial of this claim, **because**

_____

_____

_____ **as shown and described below**:

4) *CREATE A TIMELINE FOR YOUR APPEAL AND ATTACH SUPPORTING EXHIBITS TO EACH FACT.

See directions above.

When Payors Won't Listen…

Denials: Prevention and Correcting Issues stemming from the Insurance Side.

5) APPLICABLE LAWS:

Reference the laws relevant to this denial and cite them, in full:

1. Please, be advised that _____ states…
2. Further, _____ states…
3. Finally, _____ states…

5) APPLY THE LAW:

Apply the laws, above, to the facts outlined in the timeline. Explain how the payor's actions violate the law:

1. _____

   _____

2. _____

   _____

3. _____

   _____

When Payors Won't Listen…

Denials: Prevention and Correcting Issues stemming from the Insurance Side.

6) CONCLUSION (LAND THE PLANE):

End the letter by demanding payment compliance and imposing deadlines. If the law stipulates a reimbursement deadline, evoke it here:

_____

_____

_____

_____

When Payors Won't Listen

As advocates:

We collaborate.

We are no respecter of payors.

We work both small and big cases alike.

We aren't afraid of anyone AND

We may not win 100% of the time, but we work each case as if we had never lost.

Why You Must Appeal

Together, we will build an enforcement program in the Nation that works.

We fight for you.

CONTACT US:
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ednorwood@ernenterprises.org
(714) 995-6926