Mastering Federal Appeal Concepts (Clinical)

A Strategic MA Learning Session by ERN Enterprises by Ed Norwood

> **You fight for them. We fight for you.**

Learning Objectives

Identify Core Appeal Concepts

Master concepts relevant to medical necessity denials, statutory timeframe failures, improper reopenings, and post-acute care denials

Organize Around Denial Themes

Structure understanding around core denial patterns to increase authorization and revenue capture

Develop Team Capabilities

Build skills through jurisdictional trend analysis, root cause analysis training, and administrative law application


KTLA
5
WEATHER
Lake Isabella 45°
Hi:65°, Lo:44°
#ktla
Bishop 57°
Hi:68°, Lo:38°
60°
10:30

Yesterday 6:50 PM

❤️

Ed,

What a special day. I am sitting here reflecting and just want to extend my gratitude towards you and your staff. You guys are the real hero's in this whole journey. I am so incredibly blessed for you to say yes. I am also so blessed to have Denise be the one who represented us and make all of this possible! I am forever grateful for you and your team of rockstars! You guys are the reason the story is told the way it is. I wouldn't have it any other way. There will never be enough Thank you's to go around, but anything I can do to help just know I am always one call away! Next time I am in time, I would love to bring my Mom by to see both of you as well!

Thank you, thank you, thank you for changing my life forever.🫶

WHAT'S THE IMPACT BEHIND THE WORK YOU ARE DOING?

The Sign of the Times

Providers now find themselves in a new, *additional* role:

Patient advocate and intermediary

This dual responsibility requires healthcare providers to:

- Navigate complex insurance requirements
- Challenge inappropriate denials
- Document with both clinical and regulatory concerns in mind
- Understand payment rules as thoroughly as treatment protocols

Successful healthcare organizations recognize that patient advocacy is no longer optional—it's an essential component of providing comprehensive care in today's complex regulatory environment.

The Sign of the Times

Landmark Legal Precedent: Wickline vs. State (November 1986)

> One of the most cited cases regarding managed care liability is **Wickline vs. State** (November 1986)

This pivotal case established that:

- Third-party payors can be held legally accountable for medically inappropriate decisions
- Physicians cannot abdicate their responsibility to advocate for proper patient care
- Providers have a duty to appeal improper denials when patient welfare is at stake

The Wickline case fundamentally changed the relationship between providers and payors, establishing that financial considerations cannot override medical necessity and professional judgment.

We must advocate.

Healthcare advocacy is not just a professional responsibility—it is a moral imperative that protects patients' rights and ensures access to medically necessary care.

For Patient Rights

Every patient deserves access to medically appropriate care without inappropriate barriers or delays.

For Professional Integrity

Our commitment to patients requires us to challenge unfair practices and fight improper denials.

For System Accountability

Consistent advocacy instills preventive measures to help payors identify systemic failures, ameliorate harm to patients, and preclude future violations.

How do we advocate for medically appropriate healthcare?

This fundamental question drives our mission and defines our professional commitment to patients who depend on us for their care.

Document Everything

Maintain detailed records of all communications, authorization requests, and medical decisions. Proper documentation is your strongest weapon against improper denials.

Challenge Inappropriate Denials

Don't accept unfair payment practices or concurrent denials. Use the appeals process and engage with physician reviewers and ERN to fight for your patients.

Build Strategic Partnerships

Work with ERN and specialty RCM/legal experts to build strategic alliances, access intellectual property, technology, share resources, and strengthen your revenue cycle processes.

Speak Up for Patients

Use your professional voice to highlight systemic issues and advocate for policy changes that protect patient access to medically necessary care.

Remember: Advocacy is both a professional responsibility and law. When we fight for medically appropriate healthcare, we must become strategic in showing our staff how to defend our nation’s healthcare delivery system.

Don’t train OpenAI models to replace you.

States					Federal
A-G	H-Mar	Mas-NJ	NM-SC	SD-W	Jurisdictions
Alabama	Hawaii	Massachusetts	New Mexico	South Dakota	ERISA
Alaska	Idaho	Michigan	New York	Tennessee	Medicare Advantage (MA)
Arizona	Illinois	Minnesota	North Carolina	Texas HMO	Medicaid
Arkansas	Indiana	Mississippi	North Dakota	Texas PPO	Veterans Affairs (VA)
California HMO	Iowa	Missouri	Ohio	Utah	REVA Chart
California PPO	Kansas	Montana	Oklahoma	Vermont	
Colorado	Kentucky	Nebraksa	Oregon	Virginia	Non Federal
Connecticut	Louisiana	Nevada	Pennsylvania	Washington	Public Health Service Act
Delaware	Maine	New Hampshire	Rhode Island	West Virginia	
Florida	Maryland	New Jersey	South Carolina	Wisconsin	
Georgia				Wyoming	

Internal Comprehensive Knowledge Bases

We have created an unparalleled repository of insights, best practices, and regulatory intelligence. Our knowledge base provides the deep understanding our auditors need to navigate complex clinical appeal challenges and stay ahead of evolving payor tactics.

RevAssurance Cloud Platform

We have helped our provider members streamline their appeal processes with our state-of-the-art revenue cycle management appeal (RCMA) cloud platform. RevAssurance.org empowers our shareholders and providers with tools for efficient denial prevention and collaborative workflows-- optimizing their appeal success rates, authorization and revenue capture.


ERN
NCRA
THERE IS NO INTELLIGENCE AS GREAT AS HUMAN INTELLIGENCE.

Unlock the Power of Concepts to Combat Denials

As children, we were taught concepts—mental building blocks that help us understand and organize the world around us. What if those same building blocks held the key to winning Medicare Advantage appeals?

Grasp Universal Concepts

Learn timeless, actionable appeal concepts that successfully challenge payor misconduct

Organize Understanding

Structure knowledge around core denial themes to increase authorization and revenue capture

Build Team Depth

Transform your team's ability to spot, analyze, and combat improper payor denials and policies

Why Concepts Matter

Concepts are more than words—they're mental frameworks. When applied to clinical appeals, they help teams:

Break Down Complexity

Simplify complex regulations into manageable components

Respond Effectively

Counter evolving payor tactics with proven strategies

Communicate Powerfully

Deliver messages with clarity, precision, and impact

Write Winning Appeals

Solve payor problems and craft effective, successful appeals

con·cept /ˈkänˌsept/

A plan or intention; a conception.

Conception

When you think of the word "conception" we think of the act of something conceived. The moment an idea takes form.

Gestation

Once conception occurs, the process of gestation must carry what is conceived to birth. Ideas need nurturing to grow.

Planning

But conception also means the forming or devising of a plan or idea. The strategic **foundation** for action.

Medical Necessity Concepts: Creating an MOU

Authorization Status

Was there an authorization or tracking number issued for the stay? If so, was there an attempt to rescind or modify it? Can we constitute that contact was made to afford the plan an opportunity to assume care of the patient? *(MA – 42 CFR §422.113)*

Reviewer Competency

If no authorization was obtained or attempted, was the reviewer or decisionmaker competent? Can we challenge their knowledge, experience, expertise, training, and education in the field of medicine, compared to the treating physician or field of medicine/healthcare appropriate for the services at issue *(MA – 42 CFR §422.566(d) and 42 CFR §422.590(h)(2); ERISA – 29 CFR §2560.503-1 (h)(3)(iii-v).*

Physician Justification

Do we have a letter of medical justification by the treating physician to do a Clinical Appeal? Look for plan directed care, plan affiliated/approved care or treating physician preference supported laws to refer patients. *(MA -- 42 CFR §422.113 (b)(3)).*

Guideline Discrepancies

Use the payor guidelines against the payor, showing their policy is more restrictive than CMS policies, or challenge the use of MCG and InterQual guidelines solely without the independent review of a qualified physician. If ERISA is your jurisdiction, you may also challenge the plan's failure to make decisions consistent with the Summary Plan Description (SPD) to challenge the denial. *(MA -- Medicare Managed Care Manual Ch. 4 § 10.16; ERISA -- 29 CFR §2560.503-1 (b)(5) (g)(1)(ii) (j)(2).*

Notice Rule Failures

Use the medical necessity notice requirement failures against the plan – name and phone number of doctors, criteria used, legal rationale, etc. *(MA – 42 CFR § 422.568 (e), §422.572 (e); 42 CFR § 422.112 (6)(i); Medicare Managed Care Manual Ch. 4 § 10.16; ERISA – 29 CFR §2560.503-1 (g)(1)(i-vi) and (h)(3)(iv).*

Awaiting Placement

If a denied stay was due to waiting for post-discharge placement (SNF, hospice, home health), seek laws requiring reimbursement for the alternate placement days at inpatient level of care while patient awaits SNF placement *(MA -- Medicare Managed Care Manual Section 10.6 - Criteria for Continued Inpatient Hospital Stay (Rev. 94, Issued: 10-16-15, Effective: 11-16-15, Implementation: 11-16-15) and Section 10.7 - Utilization Review (UR) in Lieu of Separate Recertification Statement (Rev. 1, 09-11-02).*

Creating An MOU

Medical Necessity Appeal Concepts

Authorization Status	Reviewer Competency
Physician Justification	Guideline Discrepancies
Notice Rule Failures	Awaiting Placement

Authorization: Was there an authorization or tracking number issued for the stay?

Authorization Status

Determine if there was an authorization or tracking number issued for the stay. Document all communications and reference numbers provided by the plan.

Rescission or Modification Attempts

If an authorization was issued, investigate whether there was any attempt to rescind or modify it after the fact. Document timing and reasons provided.

Plan Contact Opportunity

Verify that contact was made to afford the plan an opportunity to assume care of the patient. This is crucial for establishing the plan's financial responsibility.

Key Documentation Points:

- All **authorization numbers** and tracking references
- Date and time of all communications with the plan
- Any attempts by the plan to modify or rescind authorizations
- Evidence of providing the plan opportunity to assume patient care

Proper documentation of these elements strengthens your position when challenging improper denials and establishes the legal foundation for the plan's financial responsibility.

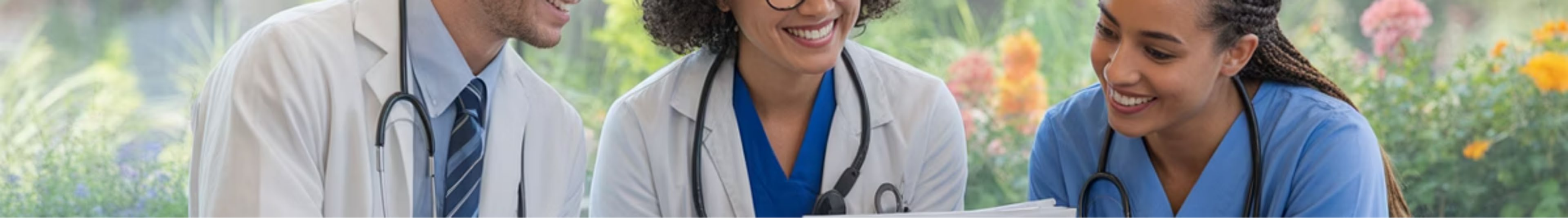
Regulatory Reference: MA – 42 CFR §422.113

Reviewer Competency: Challenging the Decision Maker

Challenge the qualifications and expertise of the individual making denial decisions. The reviewer's medical background must align with the treating physician's specialization and the specific medical field of the service provided.

> **A denial from an unqualified reviewer lacks clinical validity and can be overturned.**

Regulatory Reference: MA – 42 CFR §422.566(d) and 42 CFR §422.590(h)(2); ERISA – 29 CFR §2560.503-1 (h)(3)(iii-v).



Clinical Problems & Specialists

Understanding the right specialist for each clinical appeal, and verifying their competency through the State Medical Board website, are crucial for the competency argument:

> **A patient with cancer would never consult with an anesthesiologist for treatment. Why would a health plan do the same?**

Eczema

Specialist: **Dermatologist**

Kidney Disease

Specialist: **Nephrologist**

Cancer

Specialist: **Oncologist**

Heart Disease

Specialist: **Cardiologist**

Thyroid Conditions

Specialist: **Endocrinologist**

Anthem Blue Cross Life and Health Insurance Company
21215 BURBANK BOULEVARD
WOODLAND HILLS, CA 91367

32403

Anthem BlueCross

January 22, 2025

**********MIXED AADC 928
2435 2 MB 0.622 11

[redacted]

ELIJAH, we've reviewed your request

An experienced healthcare professional has reviewed the request for care that you or your doctor recently sent us.

Your request is important and personal to you and to us. Our decisions affect you. Because of that, our review included more than clinical guidelines and scientific data alone. Information about your health and your health plan were a part of it, too.

Results of the review

Our review showed that the care you've requested is Not Medically Necessary. We can't approve your request because your plan doesn't cover care that is Not Medically Necessary.

Details from the review (consider discussing with your doctor)

The request tells us your doctor wants to use a laser to destroy tumor tissue (laser ablation) in your brain. This procedure cannot be approved under the plan clinical criteria. For this reason, this request is denied as not medically necessary. It may help your doctor to know that we reviewed this request using the plan clinical guideline, Cryosurgical or Radiofrequency Ablation to Treat Solid Tumors Outside the Liver (CG-SURG-61).

Details about the review

Reference number
[redacted]

Care location
Inpatient Hospital

Doctor
SUMEET VADERA and UC IRVINE MEDICAL CENTER

Reason for denying your request
Not Medically Necessary

Do you have questions?

If you have questions about the information in this letter, please call (800) 274-7767

If you have questions about your benefits, please call the Member Services number on your ID card.

01078900101

Would you like to appeal?

By phone
Call the Member Services number on your ID card.

In writing
Review the enclosed appeals information for details.

CORRECTED EXPEDITED APPEAL AND NOTICE OF INTENT TO FILE COMPLAINT

Via Email and Fax

Sunday, February 02, 2025

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY
21215 BURBANK BLVD
WOODLAND HILLS, CA 91367

GREG MCCLELLAND, CHAIRMAN
DAVID OSBORNE, PLAN ADMINISTRATOR
CALIFORNIA IRONWORKERS
131 N. EL MOLINO AVE. STE. 330
PASADENA, CA 91101-1878
FAX: 626-792-7667

Plan Participant:
Patient:
Group #:
Plan Code:
DOB:
UM Reference #

RE: Improper denial by Anthem Blue Cross of laser ablation brain surgery scheduled Tuesday 02/04/25

Dear Mr. McClelland and Mr. Osborne,

This office represents participant Cornejo, and has been asked to file a formal complaint with the **U.S. Department of Labor, Employee Benefits Security Administration (EBSA)** and release a media advisory against the **California Ironworkers (CI)** for its TPA, **Anthem Blue Cross' (BC),** failure to authorize medically necessary brain surgery (laser ablation) to remove a tumor, as required by federal law.

In its advisory role to healthcare providers that provide medically necessary services to ERISA participants, The National Council of Reimbursement Advocacy (NCRA) and The Reimbursement Advocacy Firm (TRAF) periodically brings to your attention non-compliance issues related to—

(1) An ERISA participant's access to emergency and post-stabilization services and care.
(2) Breach of fiduciary duties under 29 U.S.C. §§ 1104, 1109 including full and fair review requirements under ERISA law.
(3) Any other health services furnished by a provider or supplier that are reimbursable under Title 29 Code of Federal Regulations, or any rule adopted pursuant thereto.

We dispute CI/BC's denial on 1/22,2025 (REF# UM73296092) that the laser ablation is not medically necessary, because CI through its delegate, BC, failed to establish and maintain reasonable claims procedures, and failed to meet manner, content, and notice requirements for a decision based upon medical necessity, as shown and described below:

Anthem Blue Cross Life and Health Insurance Company
Grievances and Appeals
P.O. Box 4310
Woodland Hills, CA 91365

Anthem

February 04, 2025

ELIJAH [redacted]

More Details

Member ID
[redacted]

Case Number
[redacted]

Date Request Received
02/02/2025

Confidential Health Plan Information for:
ELIJAH [redacted]

Important Information about your appeal.

Reviewed for your plan by AUMSI UM Services, Inc.

Dear ELIJAH [redacted],

Your appeal
We've reviewed a request from Ed Norwood Chief Compliance Officer for an appeal regarding the denial of a procedure, a laser to destroy tumor tissue (laser ablation) in the brain and a full hospital admission after the surgery, received on February 2, 2025. We understand an appeal was initiated on your behalf because this procedure and full hospital admission after the surgery is medically necessary.

Our decision
We've gone over your appeal and have decided to change our previous decision, as explained below.

Upon further review of the medical information provided, a health plan Physician Clinical Reviewer, an MD who is board certified and specializes in Neurological Surgery and our health plan Medical Director Reviewer, an MD who is board certified and specializes in General Surgery and Critical Care Medicine, has reviewed this appeal and overturned this denial to allow coverage for the following below:

- 61736 - LITT LES ICR SINGLE TRAJECTORY 1 SIMPLE LESION
- Level of Care - 1 day Inpatient Stay

Physician Justification: Empowering the Treating Doctor

Comprehensive Medical Justification

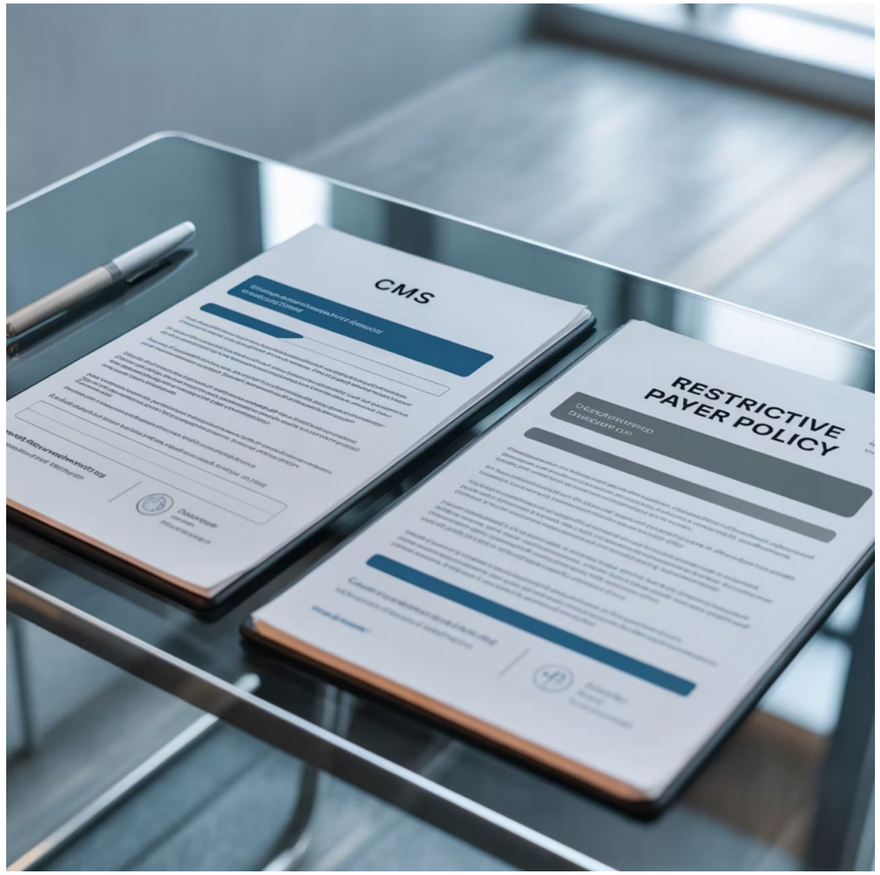
Obtain a detailed medical justification letter from the treating physician, outlining the necessity of the services provided based on the patient's condition.

Legal and Regulatory Support

Reference specific laws supporting plan-directed, plan-affiliated, or physician-preferred patient referrals to strengthen the argument for medically necessary care.

Regulatory Reference: MA - 42 CFR §422.113 (b)(3)).

Guideline Discrepancies: CMS vs. Payer Policies



Highlight instances where payer guidelines are more restrictive than established CMS policies. Challenge the sole use of proprietary criteria like MCG or InterQual without an independent physician's review.

⚠ Ensure compliance with the Summary Plan Description (SPD) for ERISA cases, as payer policies cannot supersede the SPD.

Regulatory Reference: MA - Medicare Managed Care Manual Ch. 4, §10.16; ERISA - 29 CFR §2560.503-1 (b)(5) (g)(1)(ii) (j)(2).

Notice Rule Failures: Holding Payers Accountable

Leverage Non-Compliance

Utilize any instances where the health plan failed to meet required medical necessity notice requirements as a strong basis for challenging denials. Strict adherence to notice periods is legally mandated.

Timely Notice

Did the plan provide notice of adverse decisions within the specified timeframes?

Content Requirements

Was the denial notice complete, including specific reasons and appeal rights?

Procedural Defects

Failure to meet notice rules can constitute a procedural defect leading to an automatic overturn.

(MA - 42 CFR § 422.568 (e), §422.572 (e); 42 CFR § 422.112 (6)(i); Medicare Managed Care Manual Ch. 4 § 10.16; ERISA – 29 CFR §2560.503-1 (g)(1)(i-vi) and (h)(3)(iv).

BN

Bates Nathan

Reply | Reply all | Forward

To: Ed Norwood

Fri 2/14/2025 10:29 AM

Cc: Hathi Sejal

Good morning Ed,

I don't work on administrative review anymore and I haven't since September 2024. That being said I would like to better understand your request so I can forward it to either the current administrative review employee or to our complaints and grievances team. Administrative review has a very narrow scope, so when we receive cases that can not be resolved by the power of administrative review we send it to the complaints and grievances team.

I do vaguely remember working with these individuals. As your message details, I recall we were sent 3 cases, then after a period of time a different employee from ERN followed up with those cases. At that time it was determined they did not provide the necessary information required in their original submission, and because of that we could not advance the case until we had received that information. Without medical records, the MDs that review administrative reviews for medical necessity don't have information to work off of.

Your next section dives into a CCO's requirement to provide notices. I have not previously reviewed this OAR as it has not been a part of the administrative review process. I would agree that CCOs need to provide notices. Are you stating that the CCO did not provide the notice *before* an administrative review was requested of OHA, thus preventing the provider from filing an admin review? If so, normal procedure would be for us to reach out to the CCO, mandating they provide that notice. When that notice is created, the provider would then be able to submit an administrative review. The 30-day window for a provider to submit a review request only starts when the CCO appeal process has ended. From our perspective, the CCO appeals process doesn't end until a notice is given to the provider.

Is this email to let us know that the CCO did not provide this? To ask OHA to connect with the CCO to provide this? Or, merely to let us know you'll be informing CMS that the CCO did not provide this notice?

From my perspective we were not done offering assistance, but if there have been further attempts to remedy this situation they have not been sent to my email. There really are a variety of directions we could go with this, and if you'd let me know what you're most interested I can start working towards that resolution. If you'd like us to connect with the CCO to get a notice out of them, any CCO communications you can provide between ERN/St. Charles and the CCO would be beneficial. I would be surprised and disappointed if you requested a notice from them and they refused, but I suppose that is possible.

Sincerely,
Nathan Bates
EDI Business Analyst
Oregon Health Authority

From: Murdock Marcy L
Sent: Tuesday, March 04, 2025 12:00 PM
To: Ed Norwood <ednorwood@ernenterprises.org>
Subject: Administrative Review Requests

Good afternoon Ed,
I have submitted the administrative review for Pendergrass to Acentra Health for their medical review. It is due back to us by 4/4/2025. That is the only one that we have received an EOB from to proceed.

I am working with one of my liaisons to get the EOBs from HealthShare for the other two cases. As soon as I receive those, I will send them for review as well. They were in a different system so it is taking additional steps to retrieve them.

We are working to get clarification on the adverse appeal determination letters for HealthShare of Oregon-CareOregon. Their current process is to only provide an EOB as their appeal determination. Until we get further clarification on these requirements, I am using these EOBs to proceed with these 3 cases.

Please let me know if you have any further questions or need any additional information.

Thank you for your patience with these.

Marcy Murdock
Project Coordinator, Operations & Policy Analyst 2
OREGON HEALTH AUTHORITY

From: Ed Norwood <ednorwood@ernenterprises.org>
Sent: Tuesday, March 04, 2025 5:21 PM
To: Murdock Marcy L
Subject: RE: Administrative Review Requests
Importance: High

Thank you Marcy.

However, that is concerning.

As you know, an EOB would not constitute an adverse appeal determination unless it met notice requirements under **OAR §410-141-3885** which states:

(1) When an MCE has made an adverse benefit determination, the MCE shall notify the requesting provider and give the member and the member's representative a written notice of action/adverse benefit determination notice. ***The notice shall:***
(b) For timing of notices, follow timelines required for the specific service authorization or type via oral and written mechanisms for any service request of the member or the member's provider outlined in OAR 410-141-3835 (MCE Service Authorization) MCE Service Authorization or otherwise specified in this rule;
(c) Meet the content notice requirements specified in 42 CFR § 438.404 and in the MCE contract, including the following information:
(A) Date of the notice;
(B) MCE's name, address, and telephone number;
(C) Name of the member's Primary Care Practitioner (PCP), Primary Care Dentist (PCD), or behavioral health professional, as applicable;
(D) Member's name, address, and member ID number;
(E) Service requested or previously provided and the adverse benefit determination the MCE made or intends to make, including whether the MCE is denying, terminating, suspending, or reducing a service or denial of payment;
(F) Date of the service or date service was requested by the provider or member;
(G) Name of the provider who performed or requested the service;
(H) Effective date of the adverse benefit determination if different from the date of the notice;
(I) Whether the MCE considered other conditions such as co-morbidity factors if the service was below the funding line on the Prioritized List of Health Services and other services pursuant to 410-141-3820 (Covered Services) and 410-141-3830 (Prioritized List of Health Services);
(J) Clear and thorough explanation of the specific reasons for the adverse benefit determination;
(K) A reference to the specific statutes and administrative rules to the highest level of specificity for each reason and specific circumstance identified in the ABD notice;
(L) The member's or, if the member provides their written consent as required under OAR 410-141-3890 (Grievances & Appeals: Appeal Process)(1), the provider's right to file an appeal of the MCE's adverse benefit determination with the MCE, including information on exhausting the MCE's one level of appeal, and the procedures to exercise that right;
(M) The member's or the provider's right to request a contested case hearing with the Authority only after the MCE's Appeal Notice of Resolution or where the MCE failed to meet appeal timelines in OAR 410-141-3890 (Grievances & Appeals: Appeal Process) and 410-141-3895 (Grievances & Appeals: Expedited Appeal), and the procedures to exercise that right;
(N) The circumstances under which an appeal process or contested case hearing can be expedited and how the member or the member's provider may request it;
(O) The member's right to have benefits continue pending resolution of the appeal or contested case hearing, how to request that benefits be continued, and the circumstances under which the member may be required to pay the cost of these services; and
(P) The member's right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination including any processes, strategies, or evidentiary standards used by the MCE in setting coverage limits or making the adverse benefit determination.

Again, it appears the CCO has failed to issue the legally required ABD/Notice of Action to exhaust the appeal process, thus barring the provider to respond with a review of the CCO's decision and posing a question as to whether a substantive review initially occurred of the claims.

From: Murdock Marcy L
Sent: Thursday, April 03, 2025 1:33 PM
To: Ed Norwood <ednorwood@ernenterprises.org>
Subject: RE: Administrative Review Requests

Ed,
First, I want to apologize for the delay. This issue with HealthShare/CareOregon has involved so many different people that I dropped the ball on re-review.

I sent the request over for Pendergrass today so it is due back to us by 5/3/25.

The request for Ritter is due back to us by 4/7/25.

I am also sending over the request for Bunnell today. I had noted that I was waiting for EOBs but I'm submitting the MR information you sent to me so we can get it rolling.

Again, my apologies. Also, for future reference, if all documentation is not included when the review is requested, it will not go out for Administrative Review. We don't typically do a second review so I'm making an exception in this case due to the issues with the CCO.

If documentation is not included, I will send a letter out indicating such so there is an opportunity to resubmit at that time.

Thank you for your understanding and patience on working through these cases.

Marcy Murdock
Project Coordinator, Operations & Policy Analyst 2
OREGON HEALTH AUTHORITY
Medicaid Division

Awaiting Placement: Reimbursement for Continued Stay

When a patient's inpatient stay is denied solely because they are awaiting post-discharge placement (e.g., SNF, hospice, home health), seek laws or regulations requiring reimbursement at inpatient rates for those days.

Advocate for appropriate payment when delays are beyond the hospital's control and continued inpatient care is medically appropriate.

Regulatory Reference: Medicare Managed Care Manual Section 10.6 - Criteria for Continued Inpatient Hospital Stay (Rev. 94, Issued: 10-16-15, Effective: 11-16-15, Implementation: 11-16-15) and Section 10.7 - Utilization Review (UR) in Lieu of Separate Recertification Statement (Rev. 1, 09-11-02).

Case Study: Authorization Challenges

OBTAINING AUTHORIZATION WHILE PATIENT IS AWAITING SNF OR POST ACUTE PLACEMENT

Common challenges healthcare providers face when seeking authorization for patients awaiting placement include:

- No appropriate facility available
- Appropriate facility found, but no bed available
- Patient acuity (e.g., vent dependent)
- Patient overstayed DRG and needs LTAC

Understanding your rights and the MAO's obligations is essential to successfully navigate these challenges and ensure proper reimbursement for necessary care.

Medicare Advantage Impact on Hospital Care

Extended Hospital Stays

Medicare Advantage beneficiaries are staying in hospitals longer than traditional Medicare patients, indicating potential barriers to appropriate discharge planning.

Limited Post-Acute Access

Reduced access to vital post-acute care services creates bottlenecks in the healthcare system and may compromise patient outcomes.

Research Findings

University of Chicago analysis reveals systemic issues in Medicare Advantage care coordination and service delivery.

> **WASHINGTON (June 17, 2025) — A new study from NORC, a nonpartisan research organization, highlights significant disparities in care access and hospital utilization patterns between Medicare Advantage and traditional Medicare beneficiaries. Among the most striking findings: Medicare Advantage patients had hospital stays that were 40% longer on average than those with Traditional Medicare, which comes to seven days versus five. In 2022, Medicare Advantage plans discharged fewer patients to post-acute care settings such as skilled nursing or home health compared to patients covered by Traditional Medicare. These disparities suggest that Medicare Advantage beneficiaries are more likely to face delays in recovery and reduced access to essential care following hospitalization.**

This research underscores the importance of proper authorization processes and the need for healthcare providers to advocate for appropriate post-acute care transitions. The findings support the critical need for challenging improper denials and ensuring Medicare Advantage organizations fulfill their obligations to provide timely, medically necessary services.

Federal Laws: Patient Transfers and DRG Overstays

Key Regulatory Protection

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

Legal Basis

This protection is grounded in federal regulations governing continuity of care and appropriate level of care transitions. **When DRG timeframes are exceeded, the clinical need for specialized care becomes evident, raising important considerations related to coverage, medical necessity, and patient well being (e.g., need for post acute care, complex health conditions, delays in care**).

Documentation Requirements

To ensure this protection applies, hospitals must maintain thorough documentation of the medical necessity for transfer, notification to the MAO, and the contracted status of the referring facility.

Enforcement Strategy

When MAOs attempt to deny these transfers, providers may reference the above key regulatory federal protection (if contracted), file an expedited reconsideration, or escalate the case to ERN for denial prevention.

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 Hospital Location: Palmetto** **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 & 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 Care-Palmetto**
Tax ID:
NPI:
Patient: [redacted]
Member ID: [redacted]
DOB:
DOS: **05/01/2023-Ongoing/Present**
Reference #: [redacted]

Dear United Healthcare Appeals Unit:

This office represents Continue Care Palmetto (CCP) **(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.

United Healthcare
CA124-0187, PO Box 6106, Cypress, CA 90630

The Case Number is: [redacted]

May 11, 2023

The Reimbursement Advocacy Firm
Attn: John Shen
Taylor At Marion St
Columbia, SC 29220

RE: Member Name: [redacted]McMichael
Member ID: [redacted]

Dear Mr. Shen :

We received your request for a fast appeal on May 09, 2023 about providing coverage for long term acute care. Thank you for bringing this to our attention. We decided our decision to deny coverage for the services is incorrect.

What happens next?

We will cover services until they are no longer medically needed, or the plan benefit limit is reached.

Authorization number [redacted] for Long Term Acute Care from Intermedical Hospital of South Carolina provider can be reached at (803)-296-5425

We have approved Authorization number [redacted] for Long Term Acute Care from Intermedical Hospital of South Carolina provider can be reached at (803)-296-5425. You may use authorization number [redacted] for the following date(s); Expected Admission Date: 05/11/2023.

You have the right to:

- Ask for a copy of your case file and the criteria that we used to decide your case
  - To request a copy of your file, please contact me at:

UnitedHealthcare
PO Box 6106
MS CA124-0187
Cypress, CA 90630-0016

[redacted]

MA Organizations: Their Responsibility To You

Pre-Approved Services

MA Organizations are financially responsible for poststabilization care services when they have been pre-approved at the treating facility.

Timely Service Provision

MA Organizations are financially responsible when you render services within 1 hour of your request for authorization.

Non-Response Situations

MA Organizations are financially responsible when they did not respond to your request after one hour, they cannot be contacted, and the plan physician cannot reach an agreement about the enrollee's care.

Physician Assumption

MA Organizations' financial responsibility ends when a plan physician assumes responsibility for the enrollee's care.

Care Agreement

MA Organizations' financial responsibility ends when an MA organization representative and the treating physician reach an agreement about the enrollee's care.

Patient Discharge

MA Organizations' financial responsibility ends when the enrollee is discharged from the facility.

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

Application to your Facility

Provider Status

Are you contracted or non-contracted? If contracted, did a contracted physician or provider furnish or refer the service?

Pre-Approval Attempts

Did you strengthen your contracted provider argument with an attempted request for preapproval?

Referral Documentation

If non-contracted, was the patient referred by a contracted provider? Did you attempt to notify the plan and request authorization?

Contact Methods

How was contact made and documented? Did the plan issue a tracking/reference number instead of an authorization?

Transfer Attempts

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?

Denial Review

If no attempt to obtain a preapproval was made, was the denial made by a competent physician with sufficient medical expertise?

Thorough documentation addressing these questions strengthens your position when challenging improper denials and pursuing appropriate reimbursement.

What if you could prevent denials?

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 authorization issuance
- Fight concurrent or continuity of care denials and initiate notice of disagreement
- Expedite patient transfers to ensure continuity of care
- Challenge plan's refusal to conduct retrospective review for unauthorized medically necessary services
- Fight prospective care (pre-certification) denials

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

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

We can help you do the same onsite.

ERN

DENIAL PREVENTION CASE STUDY

Q3 2024

Fighting the disease of improper medical necessity denials one human life at a time.

$8,967,214.16

Referred to ERN's Claims Representation Unit (CRU) for post discharge denied claims.

$2,865,462.36 (33%)

CR overturn success rate.

$10,088,431.76

Referred to ERN's Denial Prevention Unit (DPU) for concurrently denied stays.

$5,799,320.56 (67%)

DPU overturn success rate.

6 OUT OF 10

DPU patient cases overturned using the MA expedited reconsideration process (42 CFR 422.572 & 422.590 (e).

A 102% INCREASE!

This four (4) hospital system in Oregon dramatically increased it's ROI by initiating the appeal process while the patient was still in house, spending only $463k (8%) to recover 5.8 million, but $642k (22.43%) to recover 2.8 million.

HARD WORK IS GOOD WORK AND WE DO IT WITH JOY.

www.ernenterprises.org

The Sign of the Times

Healthcare is a law to be defended.

The increasing complexity of healthcare regulations has transformed medical care from purely clinical practice to a legally regulated environment. Healthcare providers must now understand not just medicine, but also the administrative law framework that governs every aspect of patient care.

This shift requires healthcare organizations to develop robust compliance programs and equip staff with knowledge of relevant healthcare laws and regulations to protect both patients and the organization.

Application

Identify the concept.

DIRECTIONS:

The following is a sample timeline of a common denial.

Use the facts below to identify the root concept to fight the below denial:

- On 11/1/20, the patient presented to the emergency department of *Hospital* with severe crushing chest pains.
- On 11/1/20, *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 11/2/20, *Hospital* faxed a face sheet to ***Careless Sr. Plan*** notifying of the patient's admission and requesting authorization per: _____.
- On 11/5/20, patient discharged without any disapproval from ***Careless Sr. Plan***.
- On 11/8/20, *Hospital* submitted the claim to ***Careless Sr. Plan*** electronically.
- On 2/5/21, *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 THE CONCEPT?

Why You Must Appeal

As advocates:

Impartiality

We don't show partiality. Every patient deserves equal access to medically necessary care regardless of complexity or financial impact.

Comprehensive Approach

We work both small and big cases alike. The principle matters more than the dollar amount at stake.

Collaboration

We collaborate when cases are too hard for us. No one should face these challenges alone.

Commitment

We aren't afraid of anyone-WE'RE NOT IN THIS TO FAIL (WNITTF).

Why You Must Appeal

Together

Appeals are more than just financial recovery efforts—they are essential components of an effective advocacy program that protects patients' rights and holds payers accountable.

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

When healthcare providers consistently challenge improper denials and unfair payment practices, they create a powerful incentive for payers to improve their processes and comply with legal requirements.

Your “YES” matters.

You fight for them.

We fight for you.

ERN/The National Council of Reimbursement Advocacy stands ready to support your organization in navigating the complex landscape of healthcare reimbursement and regulatory compliance.

CONTACT US:

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(714) 995-6926

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