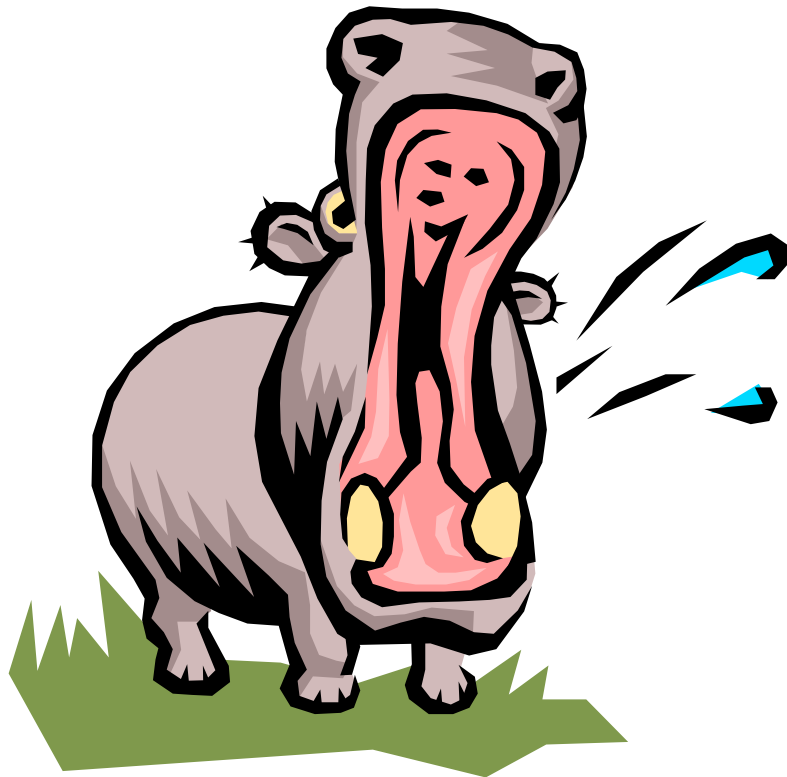




Denials, Denials, Denials- Strategies – Step 1 and Step 2

AR Systems, Inc.

Day Egusquiza, President

AR Systems, Inc. & Patient Financial Navigator Foundation,
Inc.

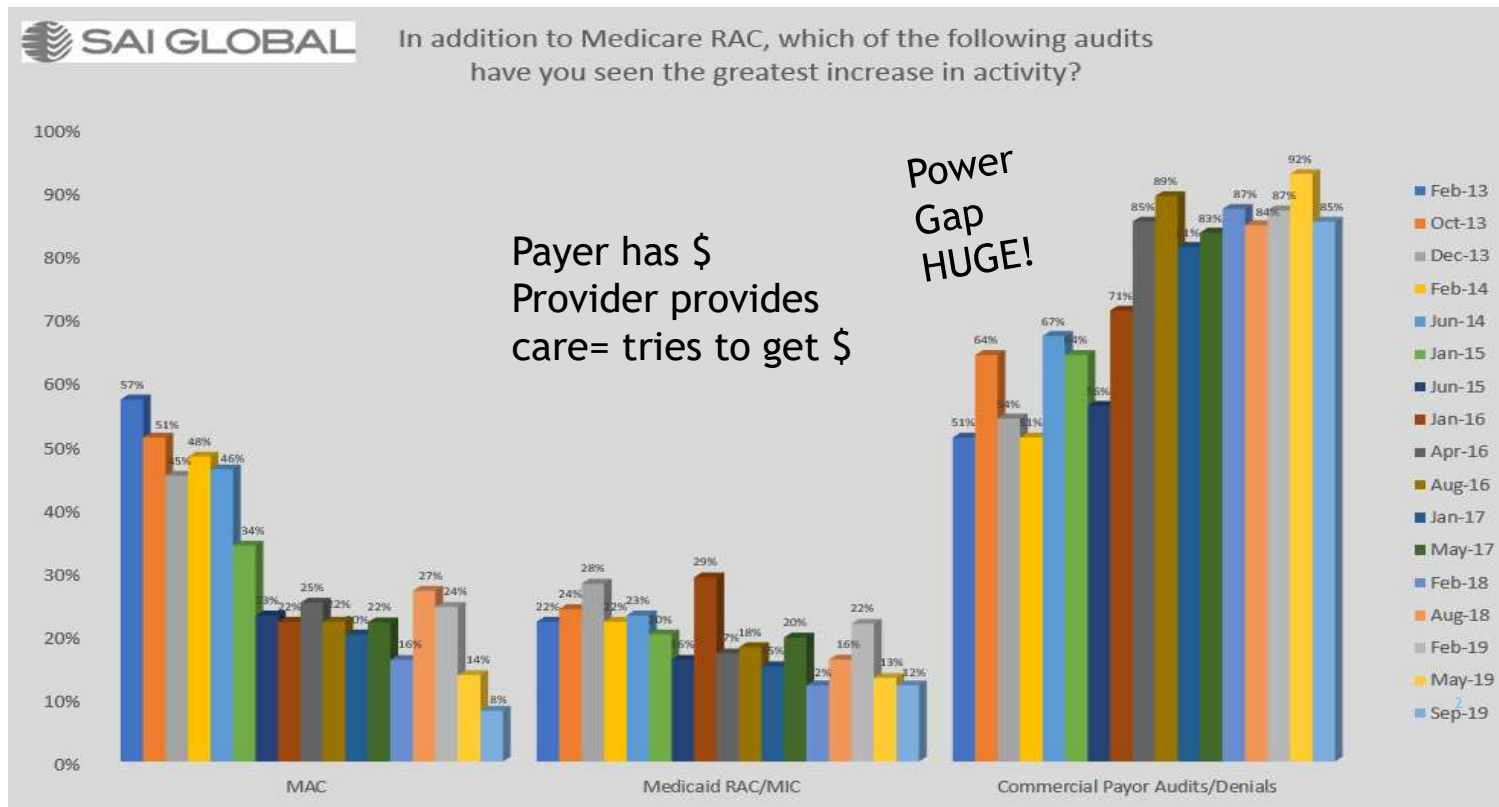
Day's Revenue Cycle Motto:

My patient did not ask to get sick. My patient did not ask to have their bill be so high. My patient did not ask for their insurance to pay so little or deny their claim. My patient did not ask to have their life disrupted by this unexpected illness. How can I help? You are scared and sick.

Let me be the Patient Financial Navigator!

10 year history with SAI 360

AHA survey: 78% of hospitals =payer relationships are getting worse. 84% said the cost of complying with payer policies is increasing; 95% saw increase in staff time spent trying to get prior authorization. 11-23 Win/Lose!



“CLAIMS DENIAL RATES UP, PRIOR AUTH DENIALS DOWN IN 2024” KODIAK SOLUTIONS 5-23-25

Five Notes from findings: 2100 hospitals; 300,000 physicians

Hospitals and medical practices faced slower payment processing from insurers in 2024 compared with 2023 even as prior auth denial rates fell.

- 1) Providers collected about \$3 less in 2024 for every \$100 that insured patients owed on their portion of medical bills.
- 2) The initial denial rate on claims in 2024 increased 2.4% to **11.81%**.
- 3) The initial denial rate increased even as providers cut the rate of initial denials related to prior auth issues by 7.7% in 2024. Denials related to questions of **medical necessity and requests for more information made up the difference**, with rates for both categories increase by 5% and 5.4% respectively.
- 4) True accounts receivable days increased 5.2% year-over-year.
- 5) Providers collected 34.5% of amounts owed by insured patients, down from 2023's self-pay rate for insured patients of 37.6%.

- **“AI ARMS RACE’ UNDERWAY AS PAYERS, PROVIDERS JOCKEY FOR UPPER HAND IN CLAIMS REVIEW.” HEALTHCARE DIVE 6-25 NEBRASKA & AZ NEW LAW: BARS AI FROM FINAL SAY IN DENIALS. CMS TELLS MA CAN’T USE AI ONLY FOR DENIALS. LEARY OF THE PAYER’S USE OF AI?**

Big Audits and Proposed Review “No Upcode Act” - Medicare Adv



- ▶ Proposal introduced on March 25th in an effort to find additional ways to reduce the \$2.4 Trillion to the national debt over the next decade (CBO). Senate Republicans are looking for cost-saving measures within Federal Health Programs. (This is beyond the huge Medicaid cuts.)
- ▶ “There is a lot of concern on Capital Hill about Medicare Advantage” -which is 55% of all Medicare. Legislation introduced, w/bipartisan support - aims to tighten DIAGNOSIS coding regulations and could yield up to \$275Billion in savings over 10 years.’
- ▶ Humana and United indicated support for increased auditing of accuracy of a NURSING’s home visit that adds diagnosis codes without physician involvement and must have any new DX code related to ongoing treatment.
- ▶ **PUT ON HOLD... No appetite to cut “Medicare”. *Will begin AGGRESSIVE MA audits/500 plans, to add 2000 coders/auditors**

The proposal seeks to:

- A. Use two years of diagnostic data in risk (payment) adjustment, rather than one.
- B. Limit use of outdated or unrelated conditions when assessing care costs.
- C. Ensure Medicare (Adv) only pays for treatments related to clinically relevant conditions.
- D. Align assessment methods between traditional Medicare and Medicare Advantage.

NEW COSTS TO PROVIDERS: Just say NO but be prepared

Ensure there is a contractual limit for # of records that will be sent for any request.

The MAs will continue to have to support their adding of a DX. Payers told: the correct DX codes were submitted with all claims. Use this history to find codes related to relevant care.

Medicare Advantage – Provider WINS – no post d/c

Use Regulations. Have legal letter ready to send to the payer if post-request for records/MA

**If the plan approved the furnishing
of a service thru an advance
determination of coverage,
it MAY NOT deny
coverage later on the basis of a lack
of medical necessity.” Medicare
Mgd Care Manual/Medical
Necessity, Chpt 4. Section 10.16.**

- ▶ Approved for inpt. 10-18-18. Resulted in 1 day stay. Hired company to audit - denied and told to downgrade to obs. Not medically necessary for inpt. 9-19. Nope.
- ▶ Approved for obs 8-8-19. Did P2Pcall. Overturned and approved for inpt. 8-12-19. Indept firm (paid to deny) audited and stated downgrade to obs -could be treated in a lower level of care. 2-1-20. Nope.
- ▶ Of course, payer says you understood that this prior authorization was not a ‘guarantee of payment’ thru the contract language. Same language with commercial prior authorizations. But Medicare Mgd Care Manual adds more strength to the provider.

Medicare Advantage – Provider WINS –

Use Regulations. Have legal letter ready to send to the payer if post-request for records/MA

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of medical necessity.” Medicare
Mgd Care Manual/Medical
Necessity, Chpt 4. Section 10.16.**

- ▶ New process: With each request for records from the MA plans, leadership reviews: was this already prior approved? Yes. Send attorney letter telling the MA plan/or their representative they are in violation of the above section. Discontinue requesting and any subsequent denials or recoupments or a formal complaint will be filed with CMS. Track and trend by payer. **DO NOT SEND RECORDS - send letter instead.**
- ▶ Idea: Create attorney template letter to send with each MA request when a prior authorization was received..and due to the delay, payment made.
- ▶ Upon receipt of record request, do not send. Instead send the template letter/attorney signature.
- ▶ Track to ensure no recoupment occurs. Send formal compliant if needed.

SO WHAT NOW?

Denials are getting much worse. Ex) Post payment reviews, after initial approval for inpt. Contract companies auto down code to obs for most short stays, but even ones won in P2P are down coded. The provider starts over – but at what costs? Massive administrative costs.

Medicare Advantage payer –Aetna – is creating their own process for determining an inpt. Moving to post-status review – no consideration for 2 MN rule.

Must meet MCG to be an inpt. If not, auto move to lesser payment, like obs. No denials, no P2P challenges. The payer is doing what they want to – regardless of the 2024 regulations. But what can a single provider do?

Each denial is tracked, by payer, by reason

Internal review of each –looking for patterns – with Payment %/billed charges – with DRG assignment with challenges of comorbidities- with line-item denials....and other creative ways to reduce payment.

WHY HOSPITALS ARE DOUBLING DOWN ON 'PAYER SCORECARDS.'

BECKER HOSPITAL REVIEW

'As hospitals and health systems face increasing pressure to maintain margins and secure sustainable reimbursement, a growing number of leaders are turning to an old business truth: **What gets measured, gets managed.**

1. Payer "scorecards" are gaining traction **as hospitals seek to hold insurers accountable, reduce administrative friction and strengthen their negotiating position.**
2. **By systematically tracking performance metrics such as denial rates, response times, and contract compliance, providers aim to shift the balance at the negotiating table.**

Ensemble VP of payer strategies, Brad Gingerich –

- Scorecards are gaining traction to hold insurers accountable, reduce administrative friction and strengthen their negotiating position.
- By systematically tracking performance metrics such as denial rates, response times and contract compliance, providers aim to shift the balance at the negotiating table.
- Emphasize that data is the provider's leverage.

*****How does the leverage work if the payer is not willing to make a change based on the scorecard? How do the individual sites create and maintain their payer scorecard? How is it used in ongoing denials-weekly?****

STEP 1: DATA-DRIVEN DENIAL MANAGEMENT

1. Discover the power of Comprehensive Payer Analytics – in all size hospitals.
2. Learn techniques to monitor and evaluate denial patterns, accuracy rates, and processing timeliness from the different payers
3. What are the State laws around timeliness of payer payment for ‘clean claims?’
4. This intelligent-gathering approach provides the foundation for effective denial Prevention and Management.

Let's look at an example of an initial Payer Matrix – recorded from the EOBs.

Then we will discuss how the Payer Matrix led to the next step of researching **actual line item denials** or **DRG Outlier denials** or **Grouping as ‘unbundled like services’** or **just denied a CPT code with no explanation.**

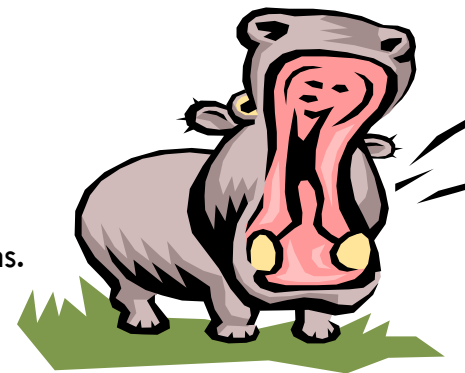
Then look at a new tool: Tracking and Trending Prior Auth ‘Denials’ – after

Approval of CPT code or included on the UB but denial said it wasn't there.

Moves to Denial Prevention- once patterns are known...

Create a Payer Scorecard with all the pertinent pieces of contractual ‘costs’, incorrect payments.

Compliance issues within the contract, Silent issues/all interps./no language; delays; denial patterns.



BASIC DATA ELEMENTS FROM WITHIN A PAYER CONTRACT. PART OF THE INITIAL MATRIX

1) Days to submit a claim. hospital1, RHC, all provider-based clinics. Usually in the contract.

#2-8 are not usually included-just the payer's side.

2) Days to receive a reply for all prior auth requests – including inpt, outpt, procedures. Uncommon to see but needs added. (National legislation as well as some states. Currently can have 14 days. Moving to 72 hrs for urgent; 7 days for non- waiting for final rollout)

3) Days to schedule a TIMELY peer to peer call – within 24 hrs of receiving TIMELY reply for request for prior auth.

4) Days to file an appeal. Days to file a re-determination for MA plans. Ensure where the appeal actually goes. Days to receive payment once the appeal or redetermination is overturned.

5) United – IMPLIED that Optum is part of their contract thru a single section – ‘affiliated groups’ – with no mention of who or what this actually means. Non-Contracted MA plans – much more power for the provider to aggressively work with CMS if non-compliant with the non-contracted regulations.

6. Inpt clinical guidelines for all NON-Medicare Adv plans. Which guideline used? If payer is using IQ- Provider must have access...by the payer. Contract issue.

7. Which Sepsis guideline is being used? Hospitals historically follow Traditional Medicare but no national standard.

8. Days to receive a reply from a Prior auth for placement to a SNF, SWING, or Rehab. Same potential changes coming.

*Look to a type of **Contract Addendum** to clarify many of the operational At- Risk elements – that are beyond the rate. Timelines for the payer to reply to All transactions equal to or faster than the payer requires of the facility. **In class**

WHEN REQUESTING PRIOR AUTH - IDENTIFIED

Prior authorization for Imaging.

- PA department did receive PA for the service
- But the referral was for a free-standing imaging center, not the hospital
- When challenging the payer- THIS IS SITE OF SERVICE REFERRAL.
- Said they told the providers thru their webpage update that each pt will be told where to look for CHEAPER services.
- Hospitals will likely never meet this threshold (due to ER, inpts, bad debt, etc.)

Prior authorization for outpt procedure – Colonoscopy.

- PA denied –pt must go to Free-standing Ambulatory Surgery center. There is none in the area – within 50 miles.
- Payer – now denied as not medically necessary. GAMES! Pt refused to have.

CONTRACT: When providers give a reduction off billed charges – it is done in Good Faith that the payer will not refer services away from the provider. What is the win for the provider to give a discount?

MORE PROBLEMATIC RA EXAMPLES

IV Therapy. A growing area of treatment for rheumatoid arthritis – significant growth.

Outcome: Payer denied the DRUG as a component of the IV 1 hr infusion.
Cost of the \$10K medication is unpaid as it is combined into the \$280 1hr infusion.
How does the provider challenge this?

This procedure was prior authorized and approved for 3 treatments.

How is the care area being kept aware of the ongoing payer reductions?

CREATE: A Pharmacy Payer Challenge Work Team. Maintain a log of all patients, by payer, billed charges PLUS cost of the medication. Did the actual payment cover the cost of the drug? Then the additional overhead costs?

Physicians should be kept in the loop as these denials continue as Patient Care is absolutely being impacted. Can the provider absorb the cost of the medication? Or does patient care continue with no payment source? What business model can sustain this ?

New ways to Deny/Delay/dispute claims

- 1) Doctor is rejected/denied as not being on the payer rooster. Been a part of the hospital for multiple years.

- Now the battle – provide proof, provide all the rooster updates. Claims continue to be denied. IF there are enough resources to keep doing this – happening with multiple payers. Race to try to keep more claims from denying.

Then the claims are to be ‘found’ and resubmitted and they will be paid in the normal timeline.

It is the payer’s error. How can a provider protect against this?

- 2) Govt Payer indicated that all Medicaid claims for the provider were rejected.

- States- paperwork is not completed properly. WHAT? Been a hospital with Medicaid for 40+ years
- New Coordination of Benefit contract. New update to ‘correct claim’ submission edits.
- All claims for Medicaid – 2nd largest payer in rural hospital – were denied. Approx \$700K in chgs. Very difficult to find the right people to advise how to fix.
- Had to complete new Application

MORE EXAMPLES OF NON-PAYMENT ON RA- LINE ITEM DENIALS. KEEP SQUEEZING...



Payer denied 3 imaging services

- Said was included in the primary service
- No other service to combine into – ER visit with observation.
- Observation was not paid as bundled into??
- Very hard to follow logic of the bundling and not paid separately.
- What logic is being used?
- Without a contract reference, the payers are arbitrarily denying – with the providers left trying to challenge a payment system that was not included –except “only pay medically necessary services.”

Payer denied all additional CPTs for Surgeries

- Two CPTs were prior authorized as part of an outpt invasive procedure.
- A 3rd one was authorized immediately/within 24 hrs of being done during the surgical procedure.
- Denied a separate payment for 2 of the 3 CPT codes. They are bundled. 2 into the 3rd one and the payer determined which CPT code they would pay.
- What logic is being used to do this type of bundling? This is a huge win for the payers –even after prior authorization was received. (Pre/OK; payment/denied all but 1.)

WHAT ARE THE MOST COMMON OUTPATIENT DENIAL/REDUCTION EXAMPLES THAT ARE OCCURRING ON THE REMITTANCES? PRIMARILY - MEDICARE ADVANTAGE AND COMMERCIAL

Multiple outpatient procedures- only pay 1 of multiple CPT M15, CO 97, CO 45

- **Process:** initial CPT codes prior authorization with payer. Contract unlikely to have a timeline to reply. Some say up to 14 days after request. If an additional CPT is done during an outpt procedure, the provider must notify the payer immediately (contracts have timelines –such as within 24 hrs) to get the additional CPT prior authorized. **If the provider fails to get the 2nd CPT prior authorized – the ENTIRE claim is denied.**
 - **Outcome:** If all the required prior auth occurs, and the provider bills multiple CPTs, there **is only a single CPT paid. The payer decides which CPT to pay with the allowable applied to the one CPT code. All** additional items: Multiple CPTS, implantables, anesthesia, imaging, recovery, lab tests, & observation are denied as one or all of the below denial codes.
 - **Denied:** Bundled into the primary service. CO 97 (Not all payers)
Denied: Service is not payable separately as another service has been adjudicated/paid.
Denied: Bundled as they are considered components of another procedure. M15 (From comparing UB to RA- line item)
Denied: Chgs exceed fee schedule or contracted arrangement. C045 But there is No payment
- Question:** Why do the work to prior auth the additional CPTs? *Where does it say in the contract that the payer gets to decide that all the services are not paid as they are part of another primary CPT/the only 1 paid.*

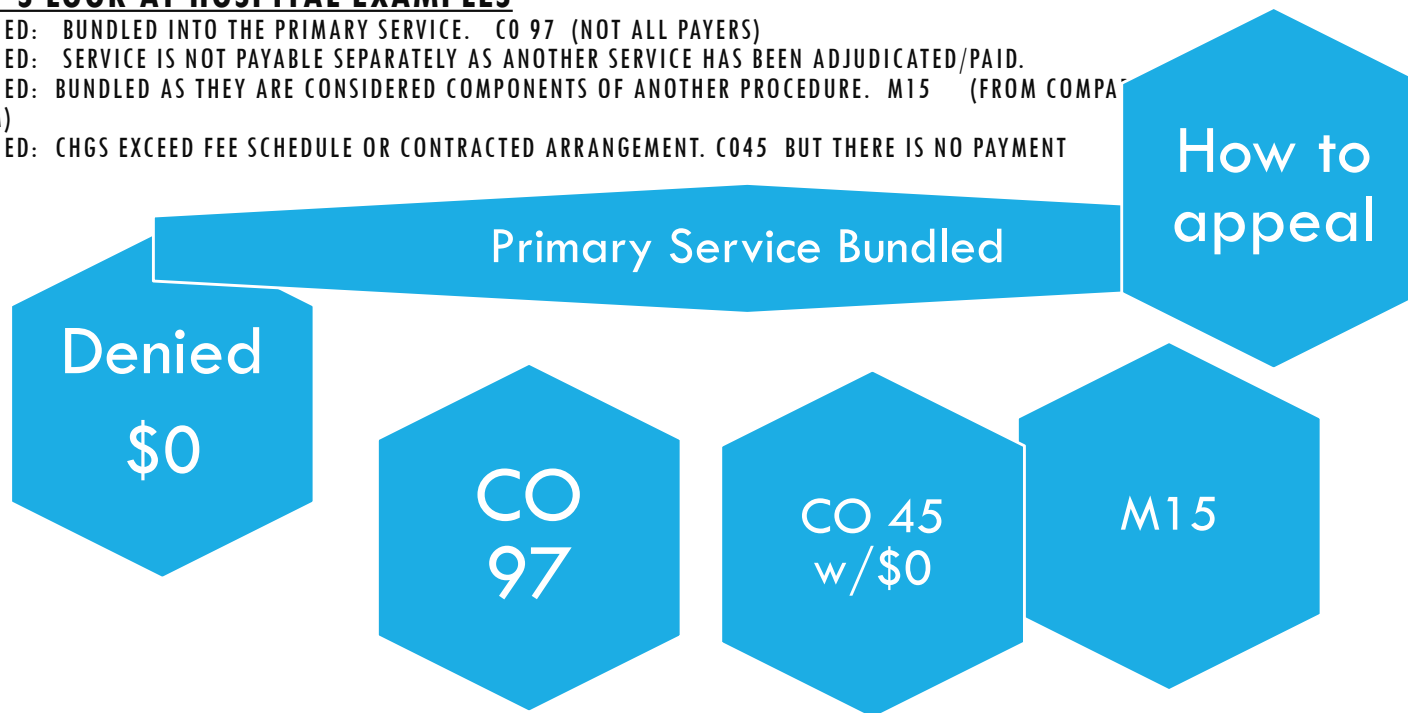
LET'S LOOK AT HOSPITAL EXAMPLES

DENIED: BUNDLED INTO THE PRIMARY SERVICE. CO 97 (NOT ALL PAYERS)

DENIED: SERVICE IS NOT PAYABLE SEPARATELY AS ANOTHER SERVICE HAS BEEN ADJUDICATED/PAID.

DENIED: BUNDLED AS THEY ARE CONSIDERED COMPONENTS OF ANOTHER PROCEDURE. M15 (FROM COMPATIBLE ITEM)

DENIED: CHGS EXCEED FEE SCHEDULE OR CONTRACTED ARRANGEMENT. C045 BUT THERE IS NO PAYMENT



OTHER OUTPT COMMON PATTERNS FROM THE REMITTANCE ADVICE COMPARISON TO THE UB?

Observation billed with any outpt claim – ER to OBS< invasive procedure, direct admit *hospital sample

- No examples showed **any payment for Observation**. *All denied as Co97 or CO 45.*
- Why is prior auth being done with additional UR work for a service that is never paid?
- When the payer says: just leave them in observation and let's see how they do after 48 hrs – they love it because they are NOT going to pay anything for any obs hrs.
- **Where does it define what is part of another service? Who decides that? An unexpected event, or exacerbation of a condition = observation post procedure. How is that of another primary service?**
- All the UR work = \$0

Other common areas of outpt line item denials:

- All recovery, anesthesia, supplies, implantables, multiple procedures are not paid
- **ER To observation** – ALL services done during the ER visit AND Observation – are paid under the SINGLE ER visit Level. (Now multiple payers are determining what they will require -how the facility ER E&M level is created. *Where does it say in the payer contract that they can create their own when the site is following CMS's guidance for all payers.*)
- **Percent of billed charges/Critical Access hospitals/MA plans &/or commercial** – disallow same lines and pay the % of what is left.
- Cigna – denying revenue code 272 unless there is a HCPC. (Violates UB 04 guidelines, HIPAA Standard TX)
- **Anthem MA announces it will go to 100% prepayment review of all ER 4&5s. (Based on whose E&M leveling criteria)**

Surgical procedures	Billed charges	Covred items	MA Covered Items	% of billed chrgs pd
1) Arthroscopy shoulder, debridement of 1 02 structures 29822	\$5987	\$2633	\$2633	
Denied: 11042 Removal of devitalized tissue from the wound	\$11,974	0	0	0
Denied: 36573 Insertion of a central venous cath	\$3144	0	0	0
Denied all: Obs hrs/65, recovery, anesthesia, all drugs, pulmonary function, all lab,	Full charges on claim: \$37,630	\$2633/ 1 CPT code	\$2633 **Was this paid under OPPS + %? Who has done	7% of billed charges * Contract rate is? Once they

More Line item examples	Billed items	Covered Items Payer identifies the Primary Service/only line paid	% of billed charges
ER to obs United MA	\$24,858	ER visit 99284 \$1527/but payer had a higher allowable of \$2236	
All obs hrs/72, 250 & 636 drugs, 73 hrs of IV infusion w/some hydration, 14 labs, 1 xray, 1 CT/351, 3 IM injections/940 **2MN now	ALL DENIED – C0 45 All services are included in the single payment for 99284 \$23,331	\$1527	9% of billed charges
<u>OR outpt</u> <u>Carpel Tunnel</u> <u>Aetna MA</u>	\$11,377	Single CPT for Surgery 29848 \$6197 Pd: \$1059	
All J codes, 2 nd procedure 20600XU, anesthesia and recovery	ALL DENIED-benefit not separate payable \$10,318	\$1059	9% of billed charges
Rt Cath procedure United Healthcare MA	\$22,032	\$15,754	
All obs hrs/17, all 250/drug, 636/drugs, lab, US/402, arteriography/323, C code implants, anesthesia, recovery.	ALL DENIED -C097 \$52,522	\$15,754	30% of billed charges
Cath w/Obs – BCBS comm All obs, additional cath	\$16,738 Some J codes /636 were paid.	\$6685 Used RA codes: 234= This procedure is not paid separately. M15: Separately billable have been	40% of billed charges **What are they basing their 'rules' on as not

WHAT ABOUT INPT DENIALS? OUTLIERS

Yes, paid under DRG for the stay.

- Examples included DRGs where a list of services were denied – and deducted from the billed charges for the Outlier case. “All inpt services are covered under the R&B.....
 - HIT: **OUTLIER CASES.** Payer does Arbitrary denials to reduce charges enough to get under the Charge Outlier threshold; only pay DRG.
 - Ex) \$310K 17 days. Disallowed 3 days of charges, middle of the stay/high dollar days. ICU case. Only paid DRG \$. What allows for this logic? DRG is not a per-day payment. It is a per-stay payment.
 - Ex) Multiple MA plans denied a full day of charges. Mostly on the 1st day of the admit stay; some randomly through the stay. Date of Service: 4-18 to 4-30. Full day of charges on 4-18 denied. Payment part of another service??
 - Ex) Disallowed, as packaged with other primary services (i.e. R&B for ICU) – ventilator services, bedside procedures and any other ancillary testing during the stay on a given day or multiple days.
 - Ex) Disallowed some of the ICU R&B and only allowed medical R&B rate..for many days.
- By doing these, the total billed charges are under the outlier threshold so only DRG is paid.

Where does it say in the contract they can arbitrary make these line item denials on an inpt DRG account? Or fee for service/line item denials? Also, if not contracted, Traditional Medicare rules apply.



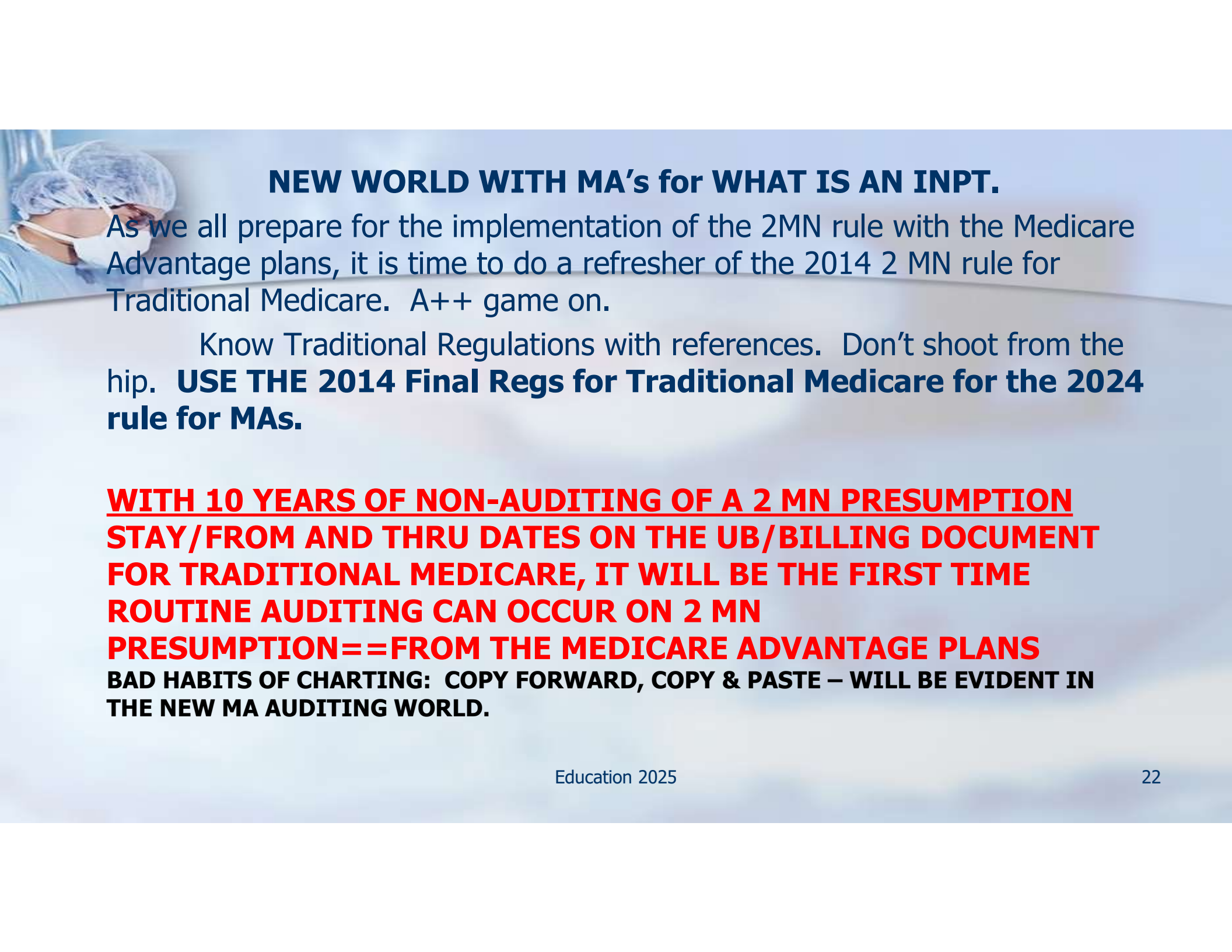
More Denial Reasons & Action Items – Ex Humana

Normal course of Inpt Request with payer. (Let's use Humana for teaching ex)

****Look to 2024 final rule – all using same inpt definition – 2 MN rule****

- Inpt denied as 'not medically necessary' for inpt level of care. SURPRISE
- UR and internal PA review the case. Decide to go to P2P to fight for inpt.
- Inpt continued to be denied. SURPRISE
- Now the hospital decided on one of the accounts to accept obs.
- They tell the payer they are going to downgrade to obs and bill
- Payer says: "You can't as you don't have an obs order" and the pt has gone home. (See previous note about no CC 44 with MA plans. Don't get it both ways)
- IDEA: Begin using a template for the medical record. It is telling the payer:
 - ***" Thru communication with *payer's name*, the inpt order is being changed to observation as the payer will not authorize inpt and the facility agrees not to appeal or challenge the change in status. The account will be changed to OBS for billing purposes." Signed by MD or Internal Physician Advisor. Order is now in the chart for obs.***





NEW WORLD WITH MA's for WHAT IS AN INPT.

As we all prepare for the implementation of the 2MN rule with the Medicare Advantage plans, it is time to do a refresher of the 2014 2 MN rule for Traditional Medicare. A++ game on.

Know Traditional Regulations with references. Don't shoot from the hip. **USE THE 2014 Final Regs for Traditional Medicare for the 2024 rule for MAs.**

WITH 10 YEARS OF NON-AUDITING OF A 2 MN PRESUMPTION STAY/FROM AND THRU DATES ON THE UB/BILLING DOCUMENT FOR TRADITIONAL MEDICARE, IT WILL BE THE FIRST TIME ROUTINE AUDITING CAN OCCUR ON 2 MN PRESUMPTION==FROM THE MEDICARE ADVANTAGE PLANS
BAD HABITS OF CHARTING: COPY FORWARD, COPY & PASTE – WILL BE EVIDENT IN THE NEW MA AUDITING WORLD.



Key elements of new Medicare inpt regulations – 2 methods

- **2midnight presumption**
- ***"Under the 2 midnight presumption, inpt hospital claims with lengths of stay greater than 2 midnights after formal admission following the order will be presumed generally appropriate for Part A payment and will not be the focus of medical review efforts absent evidence of systematic gaming, abuse or delays in the provision of care."***

Pg 50959

Key provision for the Exception for the Medicare Adv plans. "Don't have to follow the 2 MN presumption."

- **Benchmark of 2 midnights**
- **The new Medicare Inpt**
- "the decision to admit the beneficiary should be based on the cumulative time spent at the hospital beginning with the initial outpt service. In other words, if the physician makes the decision to admit after the pt arrived at the hospital and began receiving services, he or she should consider the time already spent receiving those services in estimating the pt's total expected LOS."

Pg 50956



More on decision making-Inpt

- If the beneficiary has already passed the 1 midnight as an outpt, the physician should consider the 2nd midnight benchmark met if he or she expects the beneficiary to require an additional midnight in the hospital. (MN must be documented and done)
- 1 midnight after 1 midnight OBS = at risk for inpt **audit but still an inpt.**

Pg 50946

- .. *the judgment of the physician and the physician's order for inpt admission should be based on the expectation of care surpassing the 2 midnights with **BOTH the expectation of time and the underlying need for medical care supported by complex medical factors such as history and comorbidities, the severity of signs and symptoms, current medical needs and the risk of an adverse event.*** Pg 50944

Key elements for defining what is an inpt! = **Plan!!**



STILL largest lost revenue – 2 MN benchmark – converting after 1st MN

- After the 1st MN as an outpt – anywhere – or the first MN in another facility and transferred in –
- “The decision to admit becomes easier as the time approaches the 2nd MN, and the beneficiaries in *necessary hospitalization* should NOT pass a 2nd MN prior to the admission order being written.’ (IPPS Final rule, pg 50946)
- Never, ever, ever, ever have a 2nd medically appropriate MN in outpt..convert or discharge. If clinical care is occurring, convert to inpt-no longer obs.
- As the 2nd MN approaches – is there a clinical reason to be in the hospital? Yes = convert to inpt with a PLAN. No= discharge.



“Meeting Criteria” – means Traditional Medicare ?

- It never has and never will mean – “meeting clinical guidelines” (Interqual or MCG/Milliman)
- It has always meant – the physician’s documentation to support inpt level of care in the admit order or admit note.
- SO –if UR says: Pt does not meet “Criteria”/Medical necessity not met – this means: Doctor cannot attest to a medically appropriate 2 midnight stay with a plan for 2 MN or additional 2nd MN after a 1st outpt MN– right?
- **11/1/2013 Section 3, E. Note: “It is not necessary for a beneficiary to meet an inpatient “level of care” by screening tool, in order for Part A payment to be appropriate”**
- **Hint: 1st test: Can provider attest/certify estimated LOS of 2 midnights? THEN check clinical guidelines to help clarify any medical qualifiers... but the physician’s order with PLAN – trumps any Clinical Guideline criteria.**

Wow! Hot off the press - CMS Final rule with regard to Medicare Advantage Prior Authorization, Utilization Management, Traditional Medicare Coverage, etc.
Effective 1-2024 WELCOME TO THE 2 MN RULE, MA plans!!

- ▶ On April 5, 2023, CMS issued a final rule /2024 that revises the MA /Part C, Part D , Medicare Cost Plan and Programs of all-inclusive Care for the Elderly (PACE) regulations to implement changes related to:

- ▶ Star Ratings
- ▶ Marketing and Communication
- ▶ Health Equity
- ▶ Provider Dictionaries
- ▶ Coverage Criteria **
- ▶ Prior Authorization *
- ▶ Network Adequacy
- ▶ And other programmatic areas.

- ▶ Ensuring timely access to care: Utilization Mgt

This final rule clarifies clinical criteria guidelines to ensure people with MA receive access to the same medical necessary (subjective) care they would receive in Traditional Medicare/TM

CMS clarifies- MA plans must comply with national coverage determinations/NCD and LCD and general coverage and benefit coordination included in TM.

When applicable criteria are not fully established, a MA may create internal criteria based on current evidence in widely used treatment guidelines. Coverage not explicitly when MA use publicly accessible internal coverage criteria IN LIMITED circumstances is necessary to promote transparent, and evidence-based clinical decisions by MA plans that are consistent with TM. Must disclose what was used.

THIS IS THE KEY PIECE OF DISPUTE WITH THE MA DENIALS. Complex medical factors -inpt defined in final 2014 regs.

MA Plans can offer more than Traditional Medicare, not less! *2024 Final Rule is even more clear.**

- ▶ 42 CFR 422.101 states:
- ▶ “...each MA organization must meet the following requirements:
- ▶ (a) Provide coverage of, by finishing, arranging for, or making payment for, all services that are covered by Part A and Part B of Medicare...that are available to beneficiaries residing in the plan’s service area...
- ▶ (b) Comply with-
- ▶ (1) CMS’s national coverage determinations
- ▶ (2) General coverage guidelines included in original Medicare manuals and instructions unless superseded by regulations...”
- ▶ This regulation essentially states that MAO’s may not be more restrictive than Medicare FFS/Traditional Medicare.

Payer	Patient Name	DOB	DOS	Subscriber ID	Billed Amount	Allowed	Amount Paid	# of days for payment	
Medicare of Idaho (H)	#NAME?				\$ 468.00	\$ 468.00	\$ 220.15	4	
Medicare of Idaho (H)					\$ 740.00	\$ 740.00	\$ 348.10	4	
Medicare of Idaho (H)					\$ 1,740.00	\$ 1,740.00	\$ 818.50	4	
Medicare of Idaho (H)					\$ 412.00	\$ 412.00	\$ 193.80	14	
Medicare of Idaho (H)					\$ 399.00	\$ 399.00	\$ 158.51	14	
Medicare of Idaho (H)					\$ 559.00	\$ 559.00	\$ 296.04	14	
Medicare of Idaho (H)					\$ 176.00	\$ 60.28	\$ -	10	
Medicare of Idaho (H)					\$ 513.00	\$ 313.00	\$ 160.05	10	
Medicare of Idaho (H)					\$ 176.00	\$ 60.28	\$ -	15	
Medicare of Idaho (H)					\$ 380.00	\$ 121.46	\$ -	10	
Medicare of Idaho (H)					\$ 726.00	\$ -	\$ -	8	
Medicare of Idaho (H)					\$ 787.00	\$ 493.21	\$ 273.39	14	
Medicare of Idaho (H)					\$ 583.00	\$ 583.00	\$ 274.24	14	
Medicare of Idaho (H)					\$ 251.00	\$ 88.72	\$ -	15	
Medicare of Idaho (H)					\$ 312.00	\$ 312.00	\$ 146.77	14	
Medicare of Idaho (H)					\$ 251.00	\$ 88.72	\$ -	15	
Medicare of Idaho (H)					\$ 1,825.00	\$ 1,825.00	\$ 528.22	14	
Medicare of Idaho (H)					\$ 11,882.89	\$ 11,117.50	\$ 3,560.13	14	
Medicare of Idaho HNC (H)					\$ 251.00	\$ 251.00	\$ 144.79	14	
Medicare of Idaho HNC (H)					\$ 251.00	\$ 251.00	\$ 17.88	14	
Medicare of Idaho HNC (H)					\$ 176.00	\$ 176.00	\$ 214.66	14	
Medicare of Idaho HNC (H)					\$ 176.00	\$ 176.00	\$ 126.07	14	
Medicare of Idaho HNC (H)					\$ 251.00	\$ 251.00	\$ 214.66	25	
Medicare of Idaho HNC (H)					\$ 176.00	\$ 176.00	\$ 214.66	14	
Medicare of Idaho HNC (H)					\$ 320.00	\$ 320.00	\$ 13.17	14	
Medicare of Idaho HNC (H)					\$ 79.00	\$ 79.00	\$ -	19	
Medicare of Idaho HNC (H)					\$ 79.00	\$ 79.00	\$ -	19	
Medicare of Idaho HNC (H)					\$ 251.00	\$ 251.00	\$ 17.88	24	
Medicare of Idaho HNC (H)					\$ 79.00	\$ 79.00	\$ -	14	
Medicare of Idaho HNC (H)					\$ 251.00	\$ 251.00	\$ 17.88	14	
Medicare of Idaho HNC (H)					\$ 176.00	\$ 176.00	\$ 76.88	14	
Medicare of Idaho HNC (H)					\$ 1,836.00	\$ 1,836.00	\$ 429.12	14	
Medicare of Idaho (H)					\$ 1,133.00	\$ 416.43	\$ 397.62	14	
Medicare of Idaho (H)					\$ 636.76	\$ 230.62	\$ 180.81	29	
Medicare of Idaho (H)					\$ 380.00	\$ 152.59	\$ 119.63	16	
Medicare of Idaho (H)					\$ 339.00	\$ 153.29	\$ 120.17	26	
Medicare of Idaho (H)					\$ 636.76	\$ 230.62	\$ 180.81	26	
Medicare of Idaho (H)					\$ 251.00	\$ 117.21	\$ 91.89	26	
Medicare of Idaho (H)					\$ 493.00	\$ 183.38	\$ 115.17	15	
Medicare of Idaho (H)					\$ 251.00	\$ 117.21	\$ 91.89	15	
Medicare of Idaho (H)					\$ 176.00	\$ 83.19	\$ 93.64	15	
Medicare of Idaho (H)					\$ 251.00	\$ 117.21	\$ 91.89	15	
March 3 Forward									
Medicare of Idaho (H)					\$ 3,408.36	\$ 3,002.30	\$ 799.18	16	
Medicare of Idaho (H)					\$ 251.00	\$ 251.00	\$ 214.66	14	
Medicare of Idaho (H)					\$ 449.01	\$ 449.01	\$ 13.17	14	
Medicare of Idaho (H)					\$ 3,408.36	\$ 3,002.30	\$ 799.18	16	
Medicare of Idaho (H)					\$ 380.00	\$ -	\$ -	7	
Medicare of Idaho (H)					\$ 251.00	\$ 251.00	\$ 214.66	14	
Medicare of Idaho (H)					\$ 176.00	\$ 176.00	\$ 214.66	14	

Payer Matrix:

Timely \$

Allowed Amt VS

Billed Amt

Paid Amt

Why didn't all pay

the Interim

Rate/CAH

Payer Rate 46%	Patient Name	DOS	Subscriber ID	Billed Amount	Allowed	Amount Paid	# of days for payment Contract Amount= 90	Percent Paid	Self-Pay	Comments/Discoveries
Optum MA		1/3/2025		6,817.11	2,815.71 \$	2,651.09	33	39% \$	114.36	
Optum MA		11/12/2024		4,120.43	3,427.00 \$	3,069.36	21	75%		
Optum MA		1/7/2025		690.00	183.92 \$	92.04	4	13%		
Optum MA		1/8/2025		250.00	\$	-	3	0%		CO45 (Charge exceeds fee schedule)
Optum MA		1/6/2025		1,192.00	524.48 \$	513.99	4	43%		
Optum MA		1/6/2025		787.00	262.49 \$	257.24	5	33%		
Optum MA		1/5/2025		3,035.33	1,130.51 \$	985.41	5	33%		
Optum MA		6/30/2024		1,026.27	451.56 \$	27.57	71	0%		CO45, CP253, OA23, PR3
Optum MA		1/2/2025		110.00	48.40 \$	47.43	5	42%		
Optum MA		1/4/2025		4,582.85	1,896.77 \$	1,770.64	5	39%		
Optum MA		4/1/2024		3,338.55	\$	-	0	No covered		CO29 (Time limit for filing expired) Epic now says that she is covered under Blue Cross 3.10.25
Optum MA		12/28/2024		6,603.00	2,905.32 \$	2,690.43	2/13	41%		Check came through 1/17/25, but this one was wrote off due to CO29 so bill date is 2/13/25 in EPIC
Optum MA (HB)					\$	2,988.01	billed 01/06/25- in process	42% \$	100.00	
Optum MA (HB)					\$	15,483.42	67	\$2626.01 (Disallowed drugs = 35%\$340.89)		ADT (DRG prepay medical records not received)
Optum MA (HB)					\$	-	69	0%		
Optum MA (HB)					\$	-	99	0%		OFV (Prior auth not obtained)-Note: Billed date to processed date, even though no pmt rec. and still no pmt.
Optum MA (PB)		9/15/2023		29,855.17	- \$	-	15	0%		OFV (Prior auth not obtained)
Optum MA (HB)										
March 3 Forward- NEW RATE AJUSTEMENT – Tracking to ensure paid accuracy. Fee for service										

KNOW THE PAYER CONTRACTED AMOUNT. RESEARCH EVERY ACCT WHERE IT WAS BELOW THE AMT. PS WHY ARE PROVIDERS ACCEPTING THE MEDICARE INTERIM RATE FOR THE MA PLANS — THERE IS NO COST REPORT TO BE MADE 'WHOLE'?' ESPECIALLY A CONCERN WITH CRITICAL ACCESS HOSPITALS

SO WHAT DID WE 'SEE' AND WHAT IS READY TO BE COMMUNICATED TO THIS PAYER- OPTUM



- 1) Payment rate is 46% of billed charges. They are a Medicare Advantage payer
- 2) The Payer Matrix shows:

Medicare rate to pay should be 14 days from submission

Payer is not paying 46% on all claims. *The Traditional Medicare rate as agreed in contract

- 3) Then look at the actual remittances - what is present that is moving the payment BELOW 46%?

Remittances had contractual codes – C097/bundled and CO45/said paid less than billed but no payment is present. Or arbitrary stating – non covered when Traditional Medicare does . LINE ITEM DENIAL.

- 4) Once Payer has taken all their reductions – which were present on all remittances over 4-month focused review period – **the payments were then determined from the remaining payers' COVERED charges.**

5. **Payer produced their data – they are paying according to contract- 46% of billed- AFTER deductions.**

NOW ON TO RESEARCHING ANOTHER REASON FOR A REDUCTION IN PAYMENT — **PRIOR AUTH/PA**

1. Each department doing their own PA or a centralized department doing PA asked to keep a log – for 2 weeks – of all PAs that were denied AT THE POINT OF REQUEST – by payer, by reason
2. Each Denial team member was asked to keep a MONTHLY log of all denials that were based on No Prior Auth from the remittances.

OUTCOME: Discussion with Contracting on “Good faith reductions off billed charges-Not ok”

Prior Authorizations were completed – using the online payer portal- which indicated if a PA was required or not. Less than 1% were missed.

Patterns: Payer online portal said – no PA required – and then denied for no prior auth. With denial follow up with the payer – said ‘have to appeal and send full records.’ What – this is your error. Just update your portal.’ Nope- Track and Trend.

Patterns: Identified MANY PA denials when the PA authorization # was present on the UB. Tracked and trended by payer. Must appeal and send full records.Brought to Contracting as abuse of the contract.

All examples resulted in major delays in payment. Considerable lost staff time researching and submitting appeals. PLUS the payers could then also do a Line-Item Audits for % of billed charges payer.

More Denial Reasons & Action Items – Ex Humana

Normal course of Inpt Request with payer. (Let's use Humana for teaching ex)

****Look to 2024 final rule – all using same inpt definition – 2 MN rule****

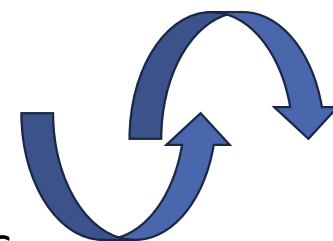
- Inpt denied as 'not medically necessary' for inpt level of care. SURPRISE
- UR and internal PA review the case. Decide to go to P2P to fight for inpt.
- Inpt continued to be denied. SURPRISE
- Now the hospital decided on one of the accounts to accept obs.
- They tell the payer they are going to downgrade to obs and bill
- Payer says: "You can't as you don't have an obs order" and the pt has gone home. (See previous note about no CC 44 with MA plans. Don't get it both ways)
- IDEA: Begin using a template for the medical record. It is telling the payer:
 - ***" Thru communication with *payer's name*, the inpt order is being changed to observation as the payer will not authorize inpt and the facility agrees not to appeal or challenge the change in status. The account will be changed to OBS for billing purposes." Signed by MD or Internal Physician Advisor. Order is now in the chart for obs.***



Step 2-**Move Beyond Acceptance of Routine Denials by Reframing Payer Discussions**

- Doable in all size hospitals. Can do manually and automated but don't let the 'need to have this automated within E HR' delay the 'Let's Get Going Now.'
- As outlined in Step 1 – Actionable Data is being Tracked and trended payer specific.
- Ongoing feedback from the Action Teams that identify the Operational Costs, Denial Costs, and Challenge of payment costs: prior auth, inpt UR team, PFS/BO, HIM & the internal denial team.
- Explore strategies for addressing the Contract Costs.
- Identify hidden Line-Item denials/CO codes within a remittance.
- Challenging the unilateral webpage updates
- Questioning the fundamental value of payer relationships. Is it a partnership or a win/lose?

What is in the Provider's Tool Box ?



- Appt of a Representative
- Ensure there is easy access to the 2014 and 2024 inpt regulations
- “Plan” by the provider that is completed for ALL payers
- Tied to 2 MN presumption or 2 MN benchmark – done at the time of request for inpt. ***OUTLINES THE COMPLEX MEDICAL FACTORS!***
- Prior authorization new submission process – Tell the payer why an inpt using Medicare Guidelines from 2014. **KNOW THE REGS!**
- Operational Contractual Addendums – working on moving 100% of the power from the payer to a new provider-payer relationship with guidelines for the payers. Currently missing from most contracts.
- File Complaints with CMS. Track and trend violations by payer.

CMS FORM 1696

Appointment of Representative (AOR)

- Must be accepted by all Medicare Advantage plans – cannot require a different form
- Sections 4 not applicable to Medicare Advantage because the Plan's Evidence of Coverage dictates any cost-sharing responsibility, unchanged by this form
- Providers cannot charge a fee for representing enrollee
- Valid for 1 year, and for life of an appeal
- Use when a payer says – we will only speak to the ATTENDING! NOPE!
- USE THE FORM TO BE PRO-ACTIVE
- Pt Involvement request

Appointment of Representative

Name of Party	Medicare Number (beneficiary as party) or National Provider Identifier (provider or supplier as party)
---------------	--

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):
I appoint this individual, _____, to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the Act) and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my claim, appeal, grievance or request wholly in my stead. I understand that personal medical information related to my request may be disclosed to the representative indicated below.

Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)		

Section 2: Acceptance of Appointment

To be completed by the representative:

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____
(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)		

Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to, waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of HHS.

Signature	Date
-----------	------

Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.) I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature	Date
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What does a Plan for 2 MN presumption and/or the 2nd MN after an outpt 1st MN/Benchmark look like?

- Numerous references in the Traditional Medicare final regs from 2014
- Key elements –what the payers are also referencing in their denial letters:
 - Looking **for *FOUR Elements: Severity of illness, intensity of services, risk factors, and comorbid conditions that are outlined by the ordering physician. (COMPLEX MEDICAL FACTORS (Final Regs 2014)***
 - Tie the plan to the expectation of 2 MN Presumption
 - Tie the plan to the plan for the 2nd MN after the 1st outpt MN= Benchmark
 - Reference exactly the language the payers are denying for in the site's plan
 - The MA should be told there is a plan/defined complex factors tied to 2MN; therefore, they don't get to use their own internal criteria.
 - Present the 2 MN case to the payer with the initial submission of records.

~~Initial Authorization Request for Inpatient~~
DO FOR ALL PAYERS – Tell them why it is an inpt
SEND WITH THE INITIAL RECORD SUBMISSION
No direct access to records –Tell why an inpt, not letting the payer tell the provider
Change the way the provider speaks to the payer- both UR and PA
It is an inpt ...until it isn't

Patient Name

DOB:

Insurance name:

Subscriber #:

(SAMPLE FOR SUBMISSION WITH

RECORDS TO PAYER/UR)- Payer w/direct access to EMR is problematic – how can they see the PLAN? How can you guide them as to what the plans says and record supporting the PLAN?

Records sent /attached to support inpt request:

ER physician

ER nursing notes

Lab results

Imaging results

H&P

Other _____

Additional justification to support inpt request: **COMPLEX MEDICAL FACTORS TO SUPPORT INPT (From Final Regs 2014)**

TELL THE PAYER: The plan for an estimated 2 MN stay is: **Presumption** o r **Benchmark** (1 outpt MN = 1 more inhospital MN= 2 MN Inpatient) (Comes from the physician's PLAN that accompanies the admit order). The patient meets the Complex Medical factors as outlined in the final 2 MN rule, 2014 for inpatient..

1) Severity of illness 2) Intensity of services 3) known risk factors 4) Other co-morbid conditions that will impact the need for inpt level of care: (List)

Based on the attached and the above additional justification:

Inpatient patient status is requested. _____

If inpt is denied, we would request the justification for same to be included in the decision letter. A Peer-to-Peer call will be immediately scheduled as necessary. (CMS Form 1696/Appointment of a Representative has been completed by the patient.)

Respectfully submitted,

Now we are live, what is happening when inpts are requested using the 2 MN rule? What type of 2 MN?

• Denial of inpt request: United

- *Determination rationale:*
- *This determination is based on Medicare and HEALTH PLAN criteria that states **a member must show signs and/or symptoms severe enough to need services that can only be provided safely and effectively on an inpt basis.** Please visit UHC.Provider.com/policies to review the UHC MA Coverage Summary for Hospital Services.*
- *Based on my review, these criteria may NOT have been met. To help you understand more about this determination, here is my medical rationale:*
- ***“This patient was admitted to the hospital on 1-9-24 with colitis. We reviewed the provided clinical information based on traditional Medicare and health plan criteria for inpt admission.***
- ***Our findings indicate that this stay does not meet criteria for inpt admission. The medical record does not document COMPLEX FACTORS that support an inpt admission is reasonable and necessary..***
- ***The reason is a 3-week hx of diarrhea with colitis noted on CT abdomen. CDiff negative. Responded to ER initiated ceftriaxone . No dehydration or electrolyte imbalance deny. Consequently, the admission does not meet criteria for inpt stay.”***

• Denial of inpt request: Humana

- *We denied the medical services/items . The request for inpt hospital level of service of care to be covered does not meet the requirements for approval. (Directed toward the pt)*
- *Humana has reviewed this request against its Inpt Hospital Medical Coverage Policy which can be found at www.humana.com/coverage policies, which includes the inpt admission criteria as outlined by CMS.*
- *In order for an inpt hospital admission to be appropriate for coverage under Medicare Part A, CMS requires that the admitting physician **have a reasonable expectation that the pt requires medically necessary hospital care that crosses 2 MN, based on complex medical factors supported by the medical record documentation.***
- ***The information in the medical record documentation does not support the admitting physician’s expectation , based on COMPLEX MEDICAL FACTORS, that your hospital stay will require 2 or more MNs.***
- ***“Our physician reviewed your records, and they show you were admitted to the hospital with trouble breathing because of a lung problem (COPD-Chronic Obstruction Pulmonary Disease). You were evaluated for blood tests and pictures of your chest. You were treated with breathing medicine and medicines in your vein that fight infection and inflammation. Your records do not show that you have the complex medical conditions to support an inpt stay.***

Normal Contracting: Does not speak to the operational issues that add cost and end in denials or rejections of claims. Time to talk Addendums!

Where does it say the hospital agreed to that interp or denial or 'no cost? What section are you using? Plz provide asap so we can 'see' it together?

Operational Elements directly relate to:

Cost of collection- Labor!! DRG downgrades, concurrent inpt attempts, appeals and more appeals.

Denials or partial denials due to variety of reasons: Line item audits/unbundled, experimental drugs, multiple surgery CPTs when only 1 was approved; timely; coding validation

Payer responsibilities and limitations on 'silent' issues within the contract. Such as: timelines to reply, timelines for P2P, timelines to reply to appeals/levels, limits on request for records, readmission rules, and other ties to Traditional Medicare.

Disputed service at time of prior auth. When to add additional CPTs, value based means, delays

Reducing the administration cost - to both the payer and the provider.

For every denial or dispute - Is the provider asking:

Where does it say in the contract that we agreed to this?

It is all about additional of the **Operational Contract Addendum** Items that are usually NOT included.

Let's Talk.....

- ▶ When trying to decipher the Operational aspects of the payer's uniform contract, it rapidly becomes apparent that the contract has all the provisions to protect the payer but very little reciprocal provisions for the provider.

▶ EX: PAYER: *Days to notify of a pt in-house Penalty - denial of obs or inpt.*

PROVIDER: There is no provision for timely reply to request.

▶ EX: PAYER: *Prior authorization required for almost all outpt procedures and all inpts.*

PROVIDER: There is no requirement for rapid reply or justification. (Insurance directed care VS physician directed care. Who determines if the ordered care is 'medically necessary'; based on what knowledge of the pt?)

Payer is using an external contracted firm/pd by the insurance plan to review certain areas: Imaging, outpt procedures, etc. Did the provider realize that the decisions are made by a company who is paid by the insurance plan - not an indept review?



As we work thru each denial, what is the action plan with the payer to eliminate thru internal changes or clarification around what was agreed to within the contract? Maybe some of both. “

Let's talk. Build Addendums to Contracts



► New process to consider:

1. Every time there is a request for records - where in the contract does it say we will do this? Unlimited #? No cost to the payer? Why does the payer need these records? Data mining to find DX = \$7B new money for MAs.
► **ACTION:** Create a Operational Contract Addendum that addresses all requests for records. With limitations and payment. See Addendums that address volume of accounts, cost to send, onsite vs submission, never give access to payers to see records/always prepare the pt story,
- 2) Every Denial. Every down coding for 'validation DRG audits'
► **ACTION:** Use the Correct Coding guidelines in addendum; define which sepsis will be used; include provider audit accuracy % and therefore, no records sent.
- 3) New denial reason. One payer is now denying readmission in 30 days if the patient ends up in any facility that is part of the same health system regardless of distance or reason. Where does it say this in the contract regarding readmissions?
► **ACTION:** Readmissions like traditional Medicare which is NOT within 30 days but know. Traditional Medicare lookback rule with specific dx/readmissions in 30 days. Daily Traditional Medicare - same pt, same day, same hospital = roll into 1 bill. .

4. Policy changes without input from providers or just webpage notice of change. Wow! Most contracts have this provision that the payer can change anything or implement new rules by simply posting it on their webpage.

- **ACTION.** Build an Addendum that no changes thru policy publication will not be accepted without prior approval by the site.

- 5) Each payer has published their own technical ER E&M leveling system. They will be using their own guidelines when auditing. Or their own 'criteria' to down grade on the EOB without any additional patient information

- **ACTION:** State that the provider will be using CMS's 2000 guidelines for creating an ER E&M that will be used for all payers. No payer -specific E&M criteria will be used.

- 6) Line item denials with DRG outliers. Line item bundling into primary procedure as determined by the payer. Both are huge losses to the hospital

- **ACTION:** Disallows all DRG payment reviews/outlier. Addendum that speaks to no auto-bundling or assigning primary CPT code without methodology approved or do not allow it at all. Pay each CPT code.

- 6) Post acute care is ordered; prior auth requested; no timeline to reply while the pt is held with no additional reimbursement for the held days post d/c order. **FEDERAL ACTION 10-24**

- **ACTION:** Addendum speaks to timeline for
Reply and a per day payment for all held patients.

Operational Addendums for Contracts- Sample

- ▶ **Hospital name**
- ▶ **Operational Addendum to the Contract**
- ▶ **Will function as part of /extension of the Contract**
- ▶ This **(Add Payor Here)** Addendum (“Addendum”) is incorporated by reference into the Agreement between **(Add Payor Here)** and (hospital name) and describes operational protocols designed to enhance the workflow involved in providing Covered Services to all **(Add Payor Here)** eligible Medicare Advantage members.
- ▶ This Addendum supersedes any prior (Hospital name) operational protocols set forth between the parties. Should there be a conflict between the Agreement and this Addendum, this Addendum will control as it relates to (Hospital name) operational protocols.

Contract Interpretations: As stated in **Section 5, Paragraph 3** (or specific page of each contract) of the original Medicare Advantage Agreement executed on January 1, 2023; both parties shall, at all times, follow Medicare state and federal rules as set forth in the Agreement and prescribed by Medicare.

Prior Authorizations- Invasive procedures: In cases where an initial authorization is granted for an inpatient or outpatient surgical/invasive procedure, for example, and during the initial procedure, another medically appropriate related procedure is also done by the surgeon – both procedures are covered under the initial prior authorization and reimbursed accordingly -for both the hospital and the provider.

Inpatient Stays with procedures. Inpatient stays are approved and paid by the per-stay DRG. Therefore, no additional prior authorization is required for any procedures done during the inpatient stay.

Claims Denied for Timely Filing: A pre-determined # of days will be allowed for initial claim submission. If an initial claim is submitted and further work, partial denial, or full denial is identified – the timely filing requirement will have been met with the initial claim submission.

Experimental Drugs: In cases where drugs are denied by the Payor because they deemed experimental, the Payor must provide the definition they are using to make this determination. In addition, if the drugs are used as part of the standard of care for the treatment, those drugs should be covered as well.

Line-Item/Forensic Audits & Bundles The Payor will not conduct line-item audits without a defined agreement on what is included in the primary service. This applies to all nursing services, OR, ER, diagnostic services

Denial of Services: No Commercial Plan shall use Medicare guidelines to support their denial of services. All denials will included a detailed explanation of why the request was denied – ‘not medically necessary’ will not be allowed.

Patient Placement after Discharge: For Medicare Advantage plans – once a patient is approved for discharge, if there is no placement found within the Medicare Advantage network, a per diem rate of \$500 will be charged while the hospital holds the patient. Per CMS guidelines, the Medicare Advantage plan is responsible for post-acute transfers to in-network providers.

Patient Transfer: If a prior authorization is requested by the Hospital for a patient transfer to a post-acute setting, a per diem rate of \$500 will be charged per day to cover the cost of holding the insurance’s patient. This standard is used for Managed Medicaid, Medicare Advantage, and other plans.

Two (2) Midnights Rule - Request for Medical Records: In accordance with the 2 Midnight Rule, effective 1-1-24 for Medicare Advantage plans, (Hospital name) agrees to provide initial records along with a physician plan for 2 midnight presumption (expected 2 MN stay) or a 2nd in-hospital midnight after the 1st outpatient midnight to the MA plan at the initiation of care. The inpatient will be confirmed according to the intensity of services, severity of illness, acute level of care, risk factors and co-morbid conditions as outlined by the admitting/treating physician. No additional records will be requested as the payment is per stay – a DRG payment, not a per day payment.

Request for Medical Records: Payors must conduct chart reviews on-site at the hospital. No records will be sent as the cost to prepare and send the charts is cost prohibitive. In the event the hospital agrees to send a patient’s medical record, a charge of \$150 per chart is pre-paid by the requesting party – with only the minimum necessary information sent. Access to the hospital’s EMR is also not allowed. Records can be put in a secure portal after being prepared.

Limit on Request for Records: The payer shall provide justification for any record request that aligns with the thresholds established. CMS requesting records from the MA plan to justify the diagnoses submitted does not required the hospital to submit any records to the MA plan. The threshold for each approved justification for records is 25 records with a pre-paid payment of \$150 per record. Only elements of the record allowed by the HIPAA Privacy Law (minimally necessary information) will be submitted- in person or via secure portal

Condition Code 44 – Applicable to Medicare Advantage: As MA plans require an external review of records prior to approval of an inpatient patient status, condition code 44 will not apply. It only applies to Traditional Medicare.

Timelines for payer responses: When not specifically addressed in the Contract, the timelines for response by the payer will be: Initial response for inpt status = 1 day, Peer to Peer call with the payer= scheduled within 24 hrs of request with the appropriate specialty in accordance with the Jan 1, 2024 regulations. Prior authorization requests = within 24 hrs of request or sooner.

Prior authorization requirements: As the physician is directing the patient care and has the complete knowledge of the type and level of care the patient may need, no prior authorization of the following will occur:

► **Chemo therapy drugs & Multiple surgeries when initial surgery was approved (More?)**

Direct access to EMR: Due to the changing environment, all payer requests for records -including initial submission – will be prepared by the hospital and submitted according to the timelines for submission. With all DRG payers, no concurrent review will be required or allowed.

Coding Clinic /Adherence to the HIPAA Standard Transaction Law: Any coding validation audits done by the payer will follow the above referenced guidance. For any coding conflicts, the correct coding guidelines will be used as the final reference to support the codes submitted. For Sepsis, (hospital name) will use CMS definition- Sepsis 4 (?) – for all payers. No denials will be based on any other sepsis definition.

Re-admissions: To ensure consistency with Traditional Medicare guidelines for separate payment for 2nd admit – the following guidance will be used for all Medicare Advantage plans. A 2nd payment will be made for any readmission beyond the same day, same hospital, similar symptoms will be made. There is no 30-day Re-admission rule per patient stay. Traditional Medicare has the Re-Admission Reduction Program that targets specific diagnosis and does a complete yearly look back for excessive readmissions.. not case specific. Identified chronic conditions will be omitted from dx when determining dx limitations.

Changes to the contract posted on payer’s webpage or thru announcement: Any changes to the contract or the Operational Addendum that are impacted by post-signature or during the period of coverage with the contract will not be effective unless agreed to, in writing, by the site.

AI & AG Tools: No payer shall use any AL or Algorihm /AG tool (Ex: nHPredict) for any screening or use with approving or denying care without a physician review. Any AI tools will be approved prior to use

Prior Authorization vs Medical Necessity pre-screening: No priority software/company will be used to determine ‘medical necessity’ of a procedure. The use of this private screening tool is not allowed for any inpt or outpt procedures.

Site of service determinations: If the hospital or associated provider requests a procedure or test to be done at the hospital, then this will be the site of service. A referral or requirement that the patient have the procedure or test done at a different location – a non-provider related location – will not be allowed.

CMS Contacts for Regions 1-10 (7-21)

File complaints – squeak – with excellent examples of abuse. IT CANNOT BE FOR A PAYMENT/CONTRACTUAL ISSUE
Will require the provider try to work it out with the payer first. Then file.. NOT FOR MA ISSUES /New one 8-24

Region 1	Robosora@cms.hhs.gov	CT, ME, MA, NH, RI, VT
Region 2	Ronycora@cms.hhs.gov	NJ, NY, Puerto Rico, Vir Islands
Region 3	Rophiora@cms.hhs.gov	DE, Dis of CO, MD, PA, VA, WV
Region 4	Roatlora@cms.hhs.gov	AL, FL, GA, KY, MS, NC, SC, TN
Region 5	Rochiora@cms.hhs.gov	Ill, IN, MI, MN, OH, WI
Region 6	Rodalora@cms.hhs.gov	Ark, LA, NM, OK, TX
Region 7	Rokcmora@cms.hhs.gov	IA, KS, MO, NE
Region 8	Roreaora@cms.hhs.gov	CO, MT, ND, SD, UT, WY
Region 9	Rosfoora@cms.hhs.gov	AZ, CA, HI, NV, Pacific Territories
Region 10	Rosea_ora2@cms.hhs.gov	AK, ID, OR, WA



Another CMS communication 2024 Oversight

- CMS has sent a memo to all MA plans announcing its plan to use audits to ensure compliance with the new requirements under the 2024 MA final rule. Issued in April, the rule includes new requirements concerning coverage criteria, the use of prior authorization and other utilization management techniques.
- Specific provisions:
 - Prohibit plans from limiting or denying coverage for a Medicare-covered service based on their own internal or proprietary criteria if such restrictions do not exist in traditional Medicare.
 - Requires adherence to the '2 MN Rule' for coverage of an inpt admission
 - Limits plan's ability to apply service restrictions not found in Traditional Medicare.

Beginning in Nov, CMS will conduct strategic conversations w/MA plans to ensure they have a comprehensive understanding and implementing pf coverage criteria. (Thanks, E Sullivan,

RAC Relief for sharing)

CMS 2024 Oversight Activities 10-24-23

Medicare Part C & D Oversight & Enforcement Group

- *On April 12, 2023, CMS issued a final rule that included new requirements about coverage criteria and the use of utilization management (UM) required in the MA program.*
- *Strategic Conversations: CMS account mgrs. will be conducting strategic conversations with MAOs to ensure their understanding and implementation of these coverage criteria and UM requirements. The strategic conversations will begin in Nov 2023. We strongly encourage each organization to take advantage of this opportunity so you can confirm your compliance before CMS begins auditing the requirements in 2024.*
- *Program Audits: Starting in Jan 2024, the Medicare Part C & D Oversight and Enforcement Group will begin conducting both routine and focused audits of organizations to assess compliance with the UM requirements finalized in CMS-4201-F. Routine program audits will be conducted as we have conducted them in the past. Focused audits will be limited in scope and duration. CMS will provide organizations that are selected for a focused audit with additional instructions and guidance after CMS initiates the focused audit.*
- Please note, organizations offering MA and MA-Part D plans (MAPD) may be subject to a focused audit even if the organization completed a 2021 or 2022 routine program audit. Further, organizations that were audited in 2023 and will undergo a CMS-led audit validation may be subject to a review of the new UM requirements during your validation audit.
- AND THE FUN BEGINS!! More 'wasted' man hrs and losses --

AHA Member Advisory: “New Medicare Advantage Question and Complaint Process for Provider Organizations.” 8-20-24

- A new complaint form has been created with instructions on resolving MA claims issues.
- The complaint form is a cover pg to a password-protected file along with the requested documentation as indicated
- To the new CMS Drug & Health Plan Operations (DHPO) email at MedicarePartCDQuestions@CMS.hhs.gov**Needs form
- **ALL MA inquiries and complaints from providers thru this centralized email. NEW – not regional CMS offices**
- In addition to the DHPO email, hospitals and health systems may also send complaints ***about inappropriate utilization management criteria or claims processing approaches that they believe do not comply with CMS requirements*** to CMS Part C and D audit email at: part_c_part_d_audit@cms.hhs.gov**No form required.
- This may include practices **related to prior authorization concurrent review or retrospective review to deny or downgrade coverage or payment that the provider believes is not permitted under CMS rules.**
- These complain types can be submitted to both the Part C & D Audit and the DHPO emails. Note there is no cover sheets required for Part C & D Audit email submission.

For CMS to act upon cases submitted thru the new email, the provider must:

- Include all information and documentation requested on the cover pg.
- Refrain from providing additional info not requested on the cover pg.
- Certify that an effort was made to resolve the issue with the MA plan before contacting CMS.
- CMS reminds providers that its role is not to determine medically necessity or payment amounts for disputed cases, CMS will seek to identify trends in provider complaints to investigate and address broader issues with MA plans where appropriate.
- Determine to add to CMS’s Complaint Tracking Module.
- As appropriate – be sure to reference 42 CFR 422.101 (b) (2) and 42 CFR 412.3. (2 MN rule)

AND FINALLY — MAYBE -JUST SAY “N N O O O”

When we look at the cost of:

Prior auth disallowed/lower level of care/dx would not endanger the pt,
Claims submission/rejections,
Line- item denials on the EOB,
PRE/Delay in initial payment & Post payment request for records,
Post payment denials or reduction of service,
Appeals filed within the same insurance plan,
Delays in getting post-acute care referralson and on



Time to just say NO! Why are you contracted? What is the benefit to the provider? The ongoing cost to the provider? What is the win for the provider? Contracting can easily be a win/lose for the payer/win and lose/provider. How can a collaborative environment exist in this setting? Why not join with other healthcare providers – no more.

**MOVE FROM DENIAL MANAGEMENT TO DENIAL PREVENTION— THRU ACTIONABLE DATA,
PAYER CHALLENGING OF ARBITRARY ITEMS, ONGOING CONTRACT TEAM WORK,
TRACKING AND TRENDING ALL DATA BY PAYER. THEN ACT!**

THANK YOU FOR JOINING US IN THIS EDUCATIONAL JOURNEY



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