

AR Systems, Inc Training Library Presents



Attacking Medicare Advantage Denials - Taking Your Power Back PLUS WELCOME TO THE 2 MN RULE!

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!

Instructor:



Day Egusquiza, President

“Hi everybody. Love being with you in our virtual & face to face world. Mask on, smiling underneath, staying safe while we all stay connected. **Perfect!**”



Make up on, hair done, business.

Vs.

no make up, workout sweats...LOL

New definition of 'business casual'

Most common phrases from 2020:

“Can you hear me?”

and the favorite, as we talk up a storm:

“You are still on mute.”



David Johnson: Cracks in the Foundation (Part 6) – Overcoming inadequate leadership (hfm/9-22)

The American Hospital Association's (AHA) April 2022 [Cost of Caring](#) report pleads for more funding to offset double-digit increases in labor, supply and drug costs. Meanwhile, the latest West Health-Gallup [Healthcare Value Index](#) found that 95% of American adults find the perceived value of the healthcare they receive is “inconsistent” or “poor.” Healthcare’s leaders, including board leadership, should sit up and take notice.

A failure of healthcare leadership

- ▶ The economic principle is not complicated and applies to all industries. Demanding more money for overpriced services is no way to win consumers’ hearts, minds and wallets. Warren Buffett famously observed, “**Price is what you pay. Value is what you get.**”

7 strategies for health systems to apply (Day’s Hint: Be the patient!)

- ▶ Here are seven strategies that health systems can apply to create inspired leadership for advancing transformative change:
 1. Have the courage to lead revolutionary transformation.
 2. Streamline organizational governance.
 3. Determine and articulate the “just cause” that will guide organizational strategy.
 4. Undertake comprehensive culture change to educate and engage employees.
 5. Tap the community for support and inspiration.
 6. Remember that sacred cows make the best hamburger.
 7. Start yesterday.

AND START WITH A LITTLE “PAYER FUN”

THANKS, WARREN K/REGION 8 HFMA MEETING, 2022



U usually
N nine
I in
T ten
E experience
D denials.....

C called
I in
G got
N no
A answer

++All time favorite: Singing the “Blues “



Mgd Care Anguish-
A Brave New World Required-
Payer Policy Changes/Outside the Contract
Significant Growth of Medicare Advantage Plans
= Financial Impact to Providers

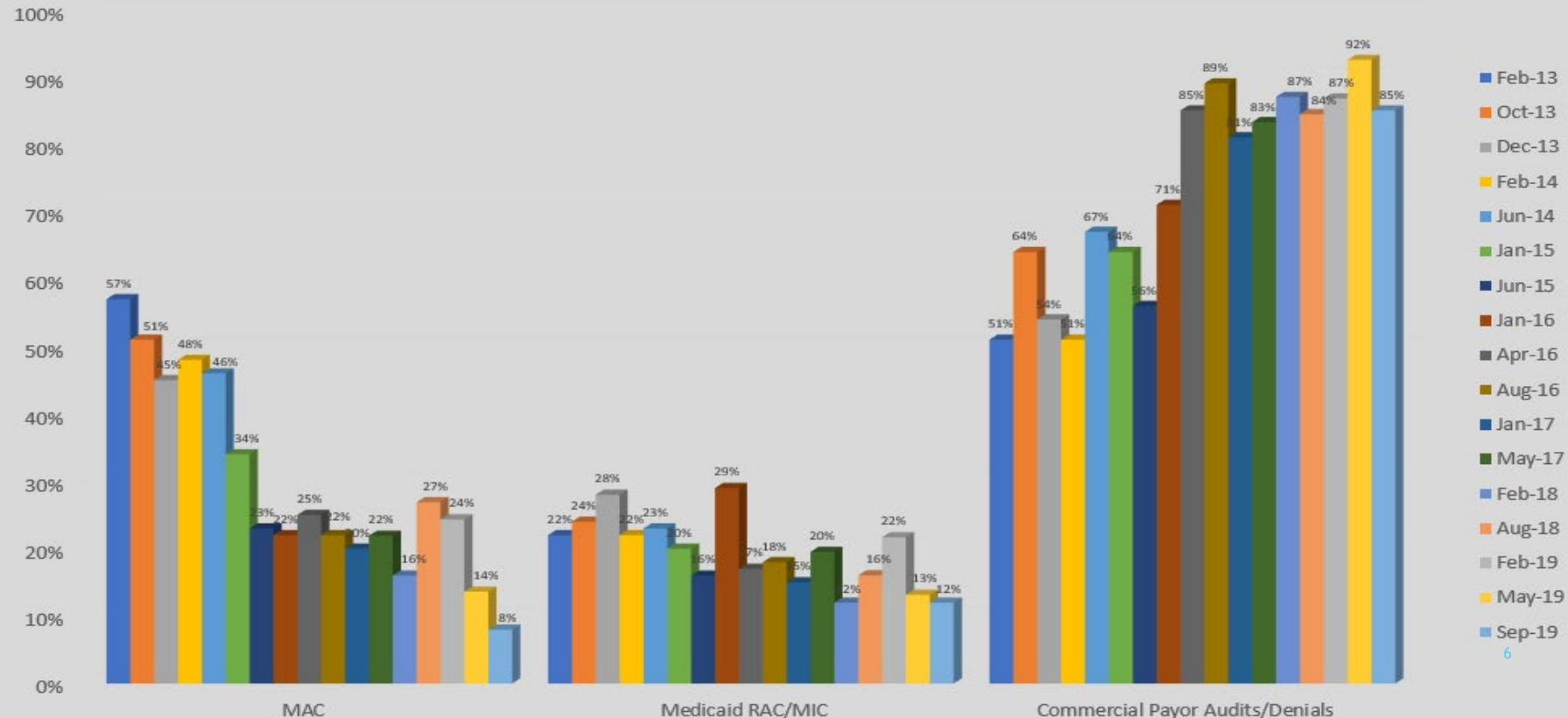


8 year history with Compliance 360/SAI

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. 11-22 Win/Lose!



In addition to Medicare RAC, which of the following audits have you seen the greatest increase in activity?



Hospitals at risk - **300+ rural hospitals at immediate risk of closure** -have lost \$ on patient services with public assistance ending (PHE) and are not likely to receive sufficient funds to cover the losses. These hospitals have low reserves and more debt than assets. (Center for HealthCare Quality & Payment Reform 7-23)

Stats from AHA	2023	
Total hospitals in all US	6129	
# of community hospitals	5157	84%
Of these, # of nongovt not-for-profit com hosp	2978	58%
# of owner investor-owned, for profit	1235	20%*
# of State & local govt community hospital	944	15%
Additional: # of Fed Govt hospitals	206	3%
# of nonfed psych hosp	659	11%
Other hospitals	107	2%

2021

By state - sample	# at risk of total # hosp
Kansas	29 Of 169 *34 private
Mississippi	25 of 128 *36 private
Oklahoma	24 of 165 *61 private
Alabama	19 of 133 *62 private
California	9 Of 570 *148 private
Iowa	7 Of 145 *5 private
Idaho	2 of 55 *13 private
Nevada	2 of 76 *37 private
As we carefully watch multiple small rural hospitals close , many are tied to Private for-profit investor owned.	Communities without a hospital - also means providers too. 7

OIG Auditing MA plans PLUS AI payer concerns ++ MA enrollment has exploded by 337% from 2006-2022.

- ▶ OIG completes audit of specific dx codes that Excellus Health Plan, Inc submitted to CMS. 7-2023
 - ▶ Under the MA program, CMS makes monthly payments to MA organizations according to a system of risk adjustment that depends on the health status of each enrollee.
 - ▶ MA are paid more for enrollees with dx associated with more intensive use of health resources.
 - ▶ OIG audited 210 unique enrollee high-risk dx submitted that did NOT comply with federal requirements.
 - ▶ Specifically 202 of 210 sampled, the medical record did not support the dx codes, resulting in \$479K overpayments.
 - ▶ Estimated Excellus received approx. \$5.4M in overpayments 2017-2018. Too early to make them pay back which recently changed.
 - ▶ Excellus disagreed with all, but OIG confirmed
- ▶ Cigna sued following ProPublica report on unreviewed batches of denied claims. 7-23
 - ▶ Two Cigna members have filed a class-action complaint against their insurer for allegedly denying large batches of member's claims without individual review- thereby denying them coverage for certain services.
 - ▶ Many states require physicians to review pt files and coverage polices BEFORE denying claims for medical reasons.
 - ▶ The suit alleges that Cigna has bypassed these steps by having an Algorithm called "PXDX" complete the review and then having physicians sign off on groups of denied claims.
 - ▶ "Relying on the PXDX system, Cigna's doctors instantly reject claims on medical grounds (med necessity sound familiar?) without ever opening a pt file, leaving thousands of patients effectively without coverage and with unexpected bills. The scope of this problem is massive."
 - ▶ Cigna denies.. For accelerating for low-cost screening...
 - ▶ **HEY ELEVANCE HEALTH is seeing AI as a huge opportunity... quarterly earnings call... 7-23**



All Payers are auditing...

Watch for new 2024 MA and 2 MN rule

- **Each payer** has their own set of 'criteria' for coverage- Milliman/MCG, Interqual, medically necessary stay (?). (United, Blues, Part C Medicare, PEPPER/Traditional Medicare is targeting 1 day surgical, same day medical, and same day surgery, etc.)
- **Each payer** has their own standards for appeals
- **Each payer** determines if the documentation supports the service that was billed. Tell the patient story.
- **But what is coming?** EX) Amazon launching generative AI tool to power documentation software. The product, called AWS HealthScribe, is aimed at enabling software providers to build clinical applications that use speech recognition and generative AI. How will the payers address the 'automation of AI' with documentation? Is it worse than cut and paste? Copy forward?



Why we LOVE the 2 MN Rule for Traditional Medicare?

- What is the difference between inpt and obs for Traditional Medicare?
- 2 MN presumption: the provider declaring the estimated need for 2 MN PLUS a plan that will take the 2 MN.
- 2 MN benchmark: the provider declaring the need for a 2nd medically appropriate MN after the 1st MN as an outpt PLUS a plan that will take a 2nd MN.
- EASY ---LOVE IT! (Other payers – not so much!)



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.
- **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 50959

Pg 50956



Understanding 2 MN Benchmark – 72 Occurrence Span MM8586 1-24-14

- EX) Pt is an outpt and is receiving observation services at 10pm on 12-1-13 and is still receiving obs services at 1 min past midnight on 12-2-13 and continues as an outpt until admission. Pt is admitted as an inpt on 12-2-13 at 3 am under the expectation the pt will require medically necessary hospital services for an additional midnight. Pt is discharged on 12-3 at 8am. Total time in the hospital meets the 2 MN benchmark..regardless of Interqual or Milliman/MCG criteria.
- ER, Observation, outpt surgery = all included in the 2 MN Benchmark.
- Ex) Pt is an outpt surgical encounter at 6 pm on 12-21-13 is still in the outpt encounter at 1 min past midnight on 12-22-13 and continues as a outpt until admission. Pt is admitted as an inpt on 12-22 at 1am under the expectation that the pt will required medically necessary hospital services for an additional midnight. Pt is discharged on 12-23-13 at 8am. Total time in the hospital meets the 2 MN benchmark..regardless of Interqual or Milliman criteria.



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)
- Note: presumption = 2 midnights AFTER obs. 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



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, 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 criteria.**



More on clinical guideline clarifications/CMS

- FAQ: Does the beneficiaries' hospital stay need to meet inpt level utilization review screening criteria to be considered reasonable and necessary for Part A Payment?
- A: if the beneficiary requires medically necessary hospital care that is expected to span 2 or more MN, then inpt admission is generally appropriate.. While UR committees may continue to use commercial screening tools to help evaluate the inpt admission decision, the **tools are not binding on the hospital** or CMS. (update 3-12-14)
- If it not necessary for a beneficiary to meet an inpt 'level of care' as may be defined by a commercial screening tool, in order for Part A payment to be appropriate. In addition, meeting an inpt LOC as may be defined by a commercial screening tool, does NOT make Part A payment appropriate in the absence of an expected LOS ..



And more update - Transfers

- **Transfer update:** During MedLearn call (2-26-14) CMS updated: receiving hospital CAN count time at a sending hospital toward their own 2 MN benchmark.
- Q2.2: How should providers calculate the 2-midnight benchmark when the beneficiary has been transferred from another hospital?
A2.2: The receiving hospital is allowed to take into account the pre-transfer time and care provided to the beneficiary at the initial hospital. That is, **the start clock for transfers begins when the care begins in the initial hospital.** Any excessive wait times or times spent in the hospital for non-medically necessary services shall be excluded from the physician's admission decision." Education 2023
- Sending hospital – if there is knowledge that the pt is being transferred/next day, the pt is obs as only 1 MN is appropriate in the sending hospital
- Use Occurrence Code Span 72/field to identify the date of the 1st MN/sending hospital.
- Place the date on the Inpt UB that may only have 1 additional MN for the receiving hospital.
- 2 MN Benchmark is now present on the 1 MN UB from the receiving hospital.
- Reference: SE1117revised MLNMatters
"Correct provider billing of admission date and statement covers period."



More Med Learn Updates

- National UB committee – **Occurrence code 72 MLN CR 8586, effective 12-13**
First /last visit dates
- *The from/through dates of outpt services. For use on outpt bills where the entire billing record is not represented by the actual from/through services dates of Form Locator 06 (statement covers period) AND*
- *On inpt bills to denote contiguous outpt hospital services that preceded the inpatient admission. (See NUBC minutes 11-20-13)*
- *CAH: Separate outpt from inpt when pt becomes an inpt. They do not combine into 1 acct.*

MLM SE1117 REVISED: Correct provider billing of admission date and statement covers period.

DOS after 10-1-11, admission date (FL 12) is the date the pt was admitted as an inpt to the facility. It is reported on all inpt claims regardless of whether it is an initial, or interim or final bill.

The statement covers period (from and thru dates/FL 6) identifies the span of service dates included in a particular bill. The 'from' date is the earliest date of service on the bill.



2 MN with a plan and then an early discharge..

- **2 MN presumption**: ALWAYS ensure there is a clinical plan for why the pt needs 2 MN at the first point of contact. **The plan is key!**

Ensure the ER provider and the Hospitalists or attending AGREE on the plan.. Handoffs need evaluated to ensure consistency. UR and PA involved.

The care is then documented – with nursing and the provider – documenting the course of treatment/progression of care as it relates to the plan.

SURPRISE: Clearly document the patient's unexpected recovery; unexpected transfer out; unexpected response to treatment. Then, a beautiful inpt.

- **2 MN benchmark**: ALWAYS ensure there is a clinical plan for why a 2nd MN was medically appropriate/in hospital care after an outpt 1st MN. **The plan is the key !**

The hospitalists/attending and UR need to communicate closely as the 2nd MN approaches... DO NOT WAIT UNTIL the am of the 3rd day.

CAREFUL not to convert early on the 2nd day and then discharge same day...no 2nd MN. What was the plan? Was it met early?

Note: Order takes effect when written. EX) Day 3 am, doctor converted to inpt. 10 mins later, discharged.

How was the plan met in 10 mins?

Education 2023



Tough Limitation –document

Delays in the Provision of Care.: FAQ 12-23-13 CMS

- *Q3.1: If a Part A claim is selected for Medical review and it is determined that the beneficiary remained in the hospital for 2 or more MN but was expected to be discharged before 2 MN absent a delay in a provision of care, such as when a certain test or procedure is not available on the weekend, will this claim be considered appropriate for payment under Medicare Part A as an inpt under the 2 MN benchmark?*

A3.1: Section 1862 a 1 A of the SS Act statutory limits Medicare payment to the provision of services that are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body. As such CMS ' longstanding instruction has been and continues to be that hospital care that is custodial, rendered for social purposes or reasons of convenience, and is not required for the diagnosis or treatment of illness or injury, should be excluded from Part A payment. Accordingly, CMS expects Medicare review contractors will exclude excessive delays in the provision of medically necessary services from the 2 MN benchmark. Medicare review contractors will only count the time in which the beneficiary received medically necessary hospital services."



Hot off the press- Auditing Traditional Medicare

- Livanta Claims Review Advisor Vol 1, Issue 18 7-23
- Does all short stay auditing for traditional Medicare nationwide.
- https://myemail.constantcontact.com/short-stay-review--The-inpatient-admission-decision.html?soid=1132747942080&aid=Wk7B_RLF2CM
- Plenty of case studies to use for teaching examples
- Medicare Program Integrity Manual Chapter 6- Medicare Guidelines which was revised 6-20.
- Includes key elements that need to be present to support inpt.
- Expectation of 2 MN in the record, inferred, transferring hospital, social, complex medical factors

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.

More Final Rule impacts - More UR And Prior Authorization



- ▶ Codify standards for coverage criteria to ensure *that basic benefit coverage for MA enrollees is NO MORE restrictive than Traditional Medicare.*
- ▶ Codify 422.101 (c)(1)(A) that MA organizations must make medically necessary determinations based on coverage and benefit criteria as specified at 422.101 (b) and (c) and may NOT DENY coverage for basic benefits based on coverage criteria that are not specified in 422.101 (b) or ©. **2 MN RULE is codified...
Presumption Vs Benchmark**

This means that when an MA organization is making coverage decisions on a Medicare covered item or service with full established coverage criteria, the MA organization CANNOT deny coverage of the item or service on the basis of internal, proprietary, or external clinical criteria that are not found in the TM coverage policies.

EX) Clinical criteria that restrict access to Medicare covered item or service UNLESS another service is done 1st, when not specifically required in the LCD or NCD, would be prohibited.

ex) 422.101 AND 412.3 (d) = using the 2 MN language to define an inpt. Benchmark. Rule prohibits MA from applying internal coverage criteria IN addition to TM statuses.

- ▶ **Streamlines Prior Authorization Requirements** including adding continuity of care requirements and reducing disruptions for beneficiaries.
- ▶ Coordinated care/CC plan prior authorization policies MAY ONLY be used to confirm the presence of a dx or other medical criteria and/or ensure that an item or service is medically necessary. (Subjective)
- ▶ Requires CC Plans to provide a minimum 90-day transition period when an enrollee currently undergoing tx switches to a new MA Plan , during which the new MA plan may NOT require prior auth for active course of tx.
- ▶ CMS is requiring all MA plans to have UM committee.
- ▶ More clarity around ‘course of treatment’ - must be valid for as long as medically necessary to avoid disruptions in care.
- ▶ **Prohibit MA organizations from limiting or denying coverage when the item or service would be covered under TM.**

MAAs must follow the 2-midnight rule, case-by-case exception and the inpt only list. **YAHOO! BABY Steps!**

- ▶ CMS explained under 422.101(b)(2),

“an MA plan must provide coverage, arranging for and paying for inpt admission when based on complex medical conditions in the record, the physician expects the pts care to cross two midnights (1+1/benchmark, 2 est at first touch /presumption) or admitting physician does not expect 2 MN but based on complex medical issues occurring that inpt is necessary (case-by-case exception) and when inpt is on the inpt only surgical list.”

DIFFERENT: Under presumption, 2 MN stay expected and billed 2 MN. Traditional Medicare = no routine auditing. Even if the pt only stays 1 MN, expectation and PLAN is present = TM pays inpt.

Now MA is expected to pay above example=1 & 2 MN.

BUT -MA plans can audit any 2 MN stays/presumptive of coverage for TM (use QIO, etc) Anything!!

EXPECT lots of debate of “medically necessary PLAN for 2 MN...with 1 MN...with a 2nd MN after the first outpt MN --why not obs?

- ▶ Effective Date

When it is effective? Rule references to a June 5, 2023 effective date with a Jan 1 2024 applicability date because CMS is codifying requirements rather than introducing new regulatory language. Gads.

- ▶ Payer situation

Spoke with a MA medical director. PA said this is a MA plan. Director - so? PA said 2 MN and she was very defensive. “Well we don’t follow that.” Asked if she was aware of the new Fed guidelines on this. “Well we don’t follow that and IF (she emphasized the IF) we decide to make any changes-it won’t take effect until 1-2024 and that’s all I am going to say about that.” She then proceeded to uphold a denial for seizure with a 5 day stay that met MCG criteria.

She stated he was back to baseline mental status on Day2. PA pointed out that he was delirious an in role vest per documentation and got anti-psychotics on day2. She said-you can appeal.”

NOW - 2 MN - how would this look? Doctor has a plan that would cover an estimated 2 MN stay. That plan is clearly outlined in the record/from the beginning. UM reads the plan. Now why denied? Much simpler but lots of documentation of PLAN that is full of medically necessary care. (Nursing adds to it too)

What's Going on with the MA payers in 2023?

- ▶ MA enrollment is up by 2.7M.
- ▶ Now totals 30.7 M of the 65 M Medicare beneficiaries.
- ▶ 46% -50% are now enrolled in MA plans
- ▶ Traditional Medicare is down by 4M since 2019.
- ▶ MA plans were to have a cut in payments in 2024. AHIP (Health Plan group) stated benefits would be impacted to the MA clients. In lieu of the cut,
MA Rates WERE INCREASED 3.32% for 2024.
- ▶ *In Feb, CMS finalized a rule to start recovering improper payments made to MA plans thru audits for the first time since 2007. Recovering is the key.*
- ▶ United Health Care Announces it will reduce its prior authorization by 20% and implement a Gold-Card program. 3-23 (Now prior for anything but screening colonoscopies.)
- ▶ Reductions will begin this summer for all Medicaid, MA plans and commercial plans.
- ▶ The national gold-card program will be implemented in early 2024.
- ▶ Qualifying providers will follow a simple notification process for most procedure codes rather than the prior authorization process.
- ▶ Both AHA and AMA are cautious to see if this really does remove unnecessary barriers to care and wasteful administrative burden on providers.
- ▶ Concern: How is this really done? Some states/Texas have had limited Gold Card activity and stated it was not what they had hoped for. More post payment audits?
- ▶ **Concern: This is primarily for physician practices Not the hospital challenges with inpt vs obs.**

And finally on 2024 Final Medicare Advantage and Part D (CMS-4201-F)

- ▶ Finally, MA organizations must comply with amended 422.566 (d) as in Section III.G of this Final Rule, which requires that a denial based on a medically necessity determination (subjective) must be reviewed by a physician or other appropriate health care professional with expertise in the field of medicine or healthcare that is appropriate for the service at issue.
- ▶ If I was being pessimistic, I might worry about:
 - ▶ **The Plan for 2 MNs or the 2nd MN after the first MN.** The pt story must be very clear!
 - ▶ It is critical that the UR nurses STOP using Interqual or MCG as CMS has never required or endorsed them. It is all about the 2 MN rule since 2014.
 - ▶ Learn and use the 2 types of 2 MN - TM and now all MA.
 - ▶ A+ Game must be on for all UR, Case Mgrs, Denial team and contracting. Track and Trend violations but be the one who knows! Not the payers.
- ▶ RELOOK AT EVERY LINE OF SERVICE When addressing the Medicare Advantage Patient.
- ▶ Assume all aspects of prior auth have been revised.
- ▶ Assume they can no longer deny a readmission within 30 days as TM only disallows a 2nd inpt payment for a) same day, b) same facility, c) similar dx. *Still discussing in new regs
- ▶ Assume they can no longer request records to prior auth a covered TM service. Clarify w/contract.
- ▶ Assume they must abide by the Inpt Only list, the 2 MN rule without adding their own criteria on top.
- ▶ Immediately re-assess all contracts to ensure they include the correct new language.

MA National Focus - More accountability? More focus on inappropriate prior auth denials?

Having 25th Anniversary!! ****= look for 2024 change

- ▶ **Star Ratings:** Huge financial benefit to the MA plans. 3.5 to 5 stars= large year end bonuses *****
- ▶ Fact sheet published on Oct 6,2022 by CMS - the average rating across all plans for 2023 is 4.15, down from 4.37 for 2022- highest ranking ever hit which translates into \$800M in revenue impacts to the plans . The average rating for 2021 was 4.06 and 4.16 in 2020. (Think COVID impact too)
- ▶ According to CMS, 72% of MA enrollees will be in contracts with four or more stars in 2023.
- ▶ The star ratings for MA plans with Part D/prescription drug coverage are derived from up to 38 quality measures.
- ▶ 57 MA plans received 5 stars, 67 earned 4.6 and 136 received a 4-star rating. Can yield up to 6% of revenue
- ▶ **Major Insurers Expand MA Footprint:** Plans to expand into hundreds of new counties next year following a record enrollment in 2022. Cigna plans to expand its MA geographic footprint by 22% to reach 582 new counties; while Humana will add 140 new counties and two states bringing its footprint to 91% of the country.
- ▶ **Enrollment:** as of 9-22, 48% of the entire Medicare population is in MA plans. That's up from 25% in 2020 and 39% in 2019. Projected to reach 61% by 2032 (per CBO) Hint: Many commercial plans are rolling over their retirees to the same payer's MA plan -automatically.

Medicare Advantage/Part C/MA -increase enrollments-

Each plan is different/unique in coverage. Approx 4800 plans.

- ▶ Significant changes were made to allow revision/expansion supplemental benefits -like hearing aides, health club memberships, in home visits, dental, delivered meals, glasses, and others ‘patient specific needs.’”
- ▶ Allows negotiation with pharmacy pricing
- ▶ Significant payments to plans for “Star Rating” (3.5 to 5) rated by pts.
- ▶ Limiting out of pocket yearly expense - \$6,700 currently/yearly *Some low as \$5,400
- ▶ *But not all plans are sold in all counties of the country/state.*
- ▶ Very limited ability to have a Medicare Supplemental - pt pays all out of pocket plus monthly premium. **MYMEDICARE.GOV****- can see all plans sold, county specific
- ▶ **MA IS NOT TRADITIONAL MEDICARE. Medicare ‘s rules do not apply if the hospital signs a contract. IF NOT CONTRACTED, Traditional Medicare rules apply. **Look at 2024**

Why would a patient select MA over Traditional Medicare?

- ▶ ALL have Part B = monthly premium/out of SS monthly Check. \$148/\$175 2022 monthly *income impact
- ▶ Part D = monthly premium/sold by insurance/but required. \$30/\$50 monthly*
- ▶ To cover co-pays and deductibles = Medicare Supplemental insurance. \$180 per person/insurance co (Total Monthly: \$372 ave)
- ▶ No cap on out of pocket costs with Traditional Medicare
- ▶ MA plans = collapse Part A,C, D into 1 monthly premium. Usually much less than Traditional fees. **BIG: Insulin capped at \$35 a month/2023. Some prices negotiated for free-standing Part D plans.**
- ▶ Some MA plans are not charging ANY Monthly premiums.(United/AARP) Each plan can develop their own package...
- ▶ MA plans are paid a per-member, per month for all signed up patients. Rate is set on risk, health factors, other/dx from submitted bills, formulas. No additional funds with inpts. Each MA plans has a separate contract with CMS.
- ▶ **AHIP -association for payers/healthplans = good to learn from their free webinars**

AARP United Healthcare Complete PPO - 2021 *Every year, new package

Medicare Advantage: Monthly premium is \$0 & \$144 Part B Medicare Premium & Part D/\$25.= \$169 (Immediate savings of approx. \$190 per month when had Traditional Medicare with supplemental insurance \$368) **Self discipline to save as there will be an out-of-pocket due.

******Hint: It is all about the money/1st, then access.******

- ▶ There is a copayment for all services as there is no ability to have a Medicare Supplement with MA plans. *Some are now offering.
- ▶ Copayment for drugs - \$0,\$3, or \$9 - depending on the drug tier. Some tier 2 drugs can be up to \$70
- ▶ Copayment for doctor appts- \$10 primary care, \$40 specialists.
- ▶ Lab tests are capped at \$5 each
- ▶ Outpt procedures are capped at \$295 each. Copayment for the doctor cap \$25. Pre-op testing cap \$5
- ▶ Allowance of \$60 monthly for over the counter meds. Order from United's website.
- ▶ VOLUME: Economies of Scale - huge power when negotiating with providers.
- ▶ **2022 & 2023: AARP UHC is now offering \$0 monthly premium & More options yearly.**

It is not the same cost in all areas of the country

- ▶ The MA plans are sold 'per county.'
- ▶ If there is a smaller population with less risk sharing to bring down costs to the MA plan, there could be higher costs or not sold at all.
- ▶ Choice is less with smaller counties/communities.
- ▶ Cost is different/could be higher in smaller populated areas.
- ▶ Out of network - significant as coverage is 'community/county' providers. (MyMedicare.gov)

2022 updates from Better Health Care Alliance - Medicare Advantage Advocates

- ▶ Annual notice to all plans to get new rates, program outlines , etc in April (8.5increase 4/22)
- ▶ Many new plans, smaller plans, grew in new enrollment period. Taking from the bigger plans
- ▶ Adding another focus point- Health Equity. Expect less out of pocket, higher quality requirements and more STAR focusing on customer experience.
- ▶ 28 M seniors enrolled in MA in 2021. 62M total on Medicare. (Double enrollment since 2000)
- ▶ 1 in 10 voluntary signed up for MA.
- ▶ 2022 Aver out of pocket in 2021 for MA pts: \$1640. NOTE: Usually a OOP for all services. Less than TM

For-Profit Medicare Advantage Plan Growth 2022

- ▶ United Health Group 765K new lives** Largest MA plan nationwide
- ▶ Centene Corporation 338K new lives
- ▶ CVS Health/Aetna 323K new lives **Hit from Opioid settlement
- ▶ Humana 315K new lives **Big movement to add lives**
- ▶ Bright Health 109K new lives** BIG: Losses 2nd & 3rd Q so cutting back on national focus and only doing CA and FL for MA plans.
- ▶ ++Have you monitored the new Great Resignation of patients moving from commercial to Medicare? WOW! How about from one MA plan to another during open enrollment! Double wow!
- ▶ No cost report or settlements with MA plans! Triple WOW for Critical access hospitals/CAHs

Mayo Clinic not accepting Medicare Advantage Out of network appts...while United Healthcare negotiates 2-15-22. 3-22/contract resolved...

- ▶ Originally no capacity to accept OON patients
- ▶ Now moving to no contract, therefore, they will only accept in-network MA patients
- ▶ Mayo indicates they end of up getting paid less when OON patients are seen and the administrative cost is high
- ▶ United HealthCare is working to get a contract with Mayo as their patients are not being scheduled.
- ▶ Remember - no MA plan can sale in a community without a provider network.. A bit more power

MedPAC: Overhaul MA payments and streamline CMMI Models Briefing held 6-16-21 (Healthcare Dive)

- ▶ Recommendations to Congress to revamp how health plans are paid in the lucrative Medicare Advantage program, culling how many models CMS tests and curbing high-cost drug approvals.
- ▶ Measures, the MA program is thriving.
- ▶ Despite relative efficiency, MA contracting isn't saving Medicare money; **--actually in 35 years, Medicare Managed care has been active, it has NEVER resulted in net savings for the cash-strapped program**", James Mathews, Executive Director of the Medicare Payment Advisory Commission.
- ▶ MedPaC estimates Medicare actually **spends 4% more** per capita for beneficiaries in MA plans than those in FFS under the existing benchmark policy.
- ▶ "Because the rebate \$ may be used to provide extra benefits, large rebates result in plans offering a disproportionate level of extra benefits.
- ▶ MA Plans can offer 'extra benefits' with the differences. (Hearing aids, dental, eye glasses, home delivered meals, transportation, gym membership.)
- ▶ Change formulas between bidding and geographic benchmark.
- ▶ **Former CMS Adm/Berwick, MD- MA surge offerings in recent years/Life valuations much higher- MAs are a money machine. 10-21**

More Federal “Concerns” with the MA plans Medicare Advantage collected \$12B in ‘excess payment’ - watchdog report says 3-22

final rule.

- ▶ MA Plans received \$12B in excess payments in 2020 according to the March 15th congressional report from the Medicare Payment Advisory Commission.
- ▶ The report says that MA’s RISK SCORES were nearly 10% higher than similar fee-for-service (Traditional Medicare) enrollees in 2020 due to higher diagnosis coding intensity.
- ▶ Though CMS does reduce MA risk scores to align closer with fee-for-service scores, they have never reduced lower than the minimum required by law. CMS reduced MA risk scores by 5.9% in 2020. The watchdog report says the scores “were about 3.6% HIGHER than they would have been IF MA patients had received fee-for-service care, leading to excess payments.
- ▶ Three previous risk adjustments recommendations from MedPAC:
 - ▶ Exclude diagnosis collected from health risk assessments. (IE. Tons of medical record requests from providers)
 - ▶ Use two years of dx data
 - ▶ Apply an adjustment to eliminate any residual impact of coding intensity.

The report says that chart reviews and health risk assessments are the MAIN factors causing coding differences between Medicare Advantage plans.

PROVIDER ALERT - where does it say, in your contract, that you have to send unlimited amt of records? What if you are not contracted with the MA plan? Traditional Medicare rules apply. No records?



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 MAOs may not be more restrictive than Medicare FFS/Traditional Medicare.
- Questions: Inpt only list? 2 MN rule? Prior auth? CHECK THE CONTRACT!

Inspector General Office: Addressing concerns about improper denials in Medicare Advantage/MA. 5-11-22

(Did focused audit)

- ▶ “A MA plan denied coverage for a walker a physician ordered for a 76-yr-old patient at risk of falling. The insurance company reported denying the walker because the pt received a cane in the past 5 years. A cane no longer provided the support the pt required to walk safely, and NO MEDICARE COVERAGE REQUIREMENT IMPOSES SUCH A FIVE-YEAR LIMIT.
- ▶ Another plan denied the MRI a physician ordered to assess why a 69-yr-old’s pain and weakness continued five months after a fall. The insurance company’s stated reason was that the patient did not first receive an X-ray. An X-ray could not detect the damage the physician suspected, and NO MEDICARE RULE MANDATES such an x-ray prior to MRI.
- ▶ Recently, OIG reported that some MA organization denials of prior authorization requests raise concerns about beneficiary access to medically necessary care. *We found that 13% of denied prior authorization requests and 18% of denied payment requests were for care that ACTUALLY MET Medicare coverage rules.*
- ▶ Sometimes insurers said the request lacked necessary information, but all necessary documentation was present. Some give up. Some seek alternative care or pay out of pocket. Some resubmitted repeatedly. Obtaining medically appropriate care should not require such resolve.
- ▶ Our recent study builds on prior OIG work. In 2018, we reported that MA appeal outcomes and audit findings raise concerns about service and payment denials. **The insurance companies running MA plans overturned 75% of their own prior authorization and payment denials upon appeal.** Essentially, beneficiaries or providers who persist were mostly successful. **BUT THESE INDIVIDUALS ONLY APPEALED ABOUT 1% OF DENIALS.**
- ▶ Providers can advise pts that they shouldn’t necessarily take an ‘initial no’ for a final answer and that they can consult appeal rights of MA beneficiaries on CMS’ webpage.” (Patients do this? Scary to them)

Prior Authorization/PA = Pending Legislation- focusing on MA ‘delays & denials” of care. 30 states working on their own.

- The Improving Seniors' Timely Access to Care Act would require CMS to report how often they use PA as well as the rate of approvals and denials, and would require HHS to set up a real time decision process for all services that are typically approved. The bill would also include an electronic PA processing system that health care organizations have wanted for years. (NOT APPROVED YET 4-23)

- In their Viewpoint, researchers from the University of Colorado and John Hopkins University called for 3 other ideas:

- The relative benefits and costs of PA should be reviewed by CMS at a procedure level. For instance, insisting on PA for high-cost chemotherapy when no other options exist will not reduce waste, but it will create additional administrative cost.
- MA payers should report approval and denial rates to the CMS based on sociodemographic characteristics and by procedure type in order to evaluate whether PA is increasing health care disparities.
- Based on what payers report to CMS about their denial rates, CMS should audit the PA denials of plans with high-denial rates and compare plans with high denials to other MA plans.

- In a [statement](#), lead author Kelly E. Anderson, PhD, MPP, assistant professor at the University of Colorado Skaggs School of Pharmacy and Pharmaceutical Sciences, addressed the need for improvements when utilizing PA.

Department of Justice - continuing to investigate “RISK ADJUSTMENT FRAUD CASES with MA PLANS”

- ▶ DOJ announces multiple actions over Medicare Advantage Risk Adjustment Fraud Cases.
- ▶ Issue: Submitting incorrect dx to increase the risk adjustment payment. “Knowingly”
- ▶ 6 Whistle blower cases. (Ex. Kaiser)
- ▶ Buffalo, NY MA plan: Independent Health. Had a specified billing company: DXID who alleges was knowing submitting false dx. Both the owner of Indp Health, and DXID are listed in the legal action.
- ▶ More fraud focus from the OIG in 2022...
- ▶ OIG 09-20-21 “Some MA companies leveraged chart reviews and health risk assessment to disproportionately drive payments.”
- ▶ **MUCH** discussion about changing the way MA plans are paid - Risk adj \$ for dx. as growth is now approx. 50% of the entire Medicare age pts. 7-23



Medical Record Review/Requests: Risk Adjustment!

- “UHC is committed to improving the quality of care provide. HHS to submit complete certain ACA-covered health plans. Accordingly, UHC is review of 2021 dates of service for certainly # of your patients. Engaged Optum and Ciox Health to conduct and retrieval options for the requested member from Jan 2021-Dec 31, 2021. Plz include all of the following medical record documentation. “(Essentially the full record.)
- ‘Aetna: As a MA organization, we are required to submit risk adjustment to CMS. We’re beginning our annual Medicare risk adjustment process. This is not a medical record review and not a claims payment audit. We are using Cotiviti..



And more Risk Adjustment hits/costs

- Amerigroup: Has initiated a program to better serve our Medicaid member and that more accurately reports health status and clinical risk profile. We are using EpiSource, specialize in data collection to increase accuracy of our Medicaid members. Please be assured this is not an audit. *CAH =130 records. (IA)

Obvious concerns: This is the MA plan requirements with CMS, not providers. Just say no!

- What new diagnosis will they find that was not already declared on the UB or 1500 billing form? The coders follow correct coding guidelines for assigning appropriate dx codes. Hospitals have coding accuracy audited thresholds.
- Massive cost to compile and send records. Time to bill the plan for the records:\$150 each
- The plans are paid based on dx codes, ie. risk factors. High incentive to 'find new dx' when they weren't declared on the UB. Medicaid Mgd Care – how are these plans paid for Medicaid patients?
- CONTRACT, CONTRACT, CONTRACT... The 'artificial' assigning of new dx codes and cost to compile and send – where does it say you will do it? Have you reported the plans for fraud and abuse violations if they are adding codes that are not supported by Correct Coding guidelines?

UR's role: First Touch

Key elements to success of UR:

1. **Understanding each payer's rules for determining an inpt status.**

Each payer has their own

Traditional Medicare does not use IQ or MCG. The 2 MN – presumption and benchmark

Develop a payer matrix that includes timelines for payer notification, type of payment from each payer/per day/DRG/% of billed charges, arbitrary guidelines, observation guidelines, etc.

2. Physician documentation will guide the supporting of inpt acuity.

3. Coordinate with providers, CDI and internal physician advisor for ongoing education.

UR's 2nd touch- Traditional Medicare

Traditional Medicare/TM – it is all done internally using the 2 MN rules.

2 MN presumption – anticipate the pt will need an estimated 2 MN to resolve care. What is the plan? (First touch)

2 MN benchmark – as the 2nd MN approaches in an outpt status (ER 1st MN/need 1 more to be an inpt or 2 MN in obs) –is there a clinical reason to be in a bed? Yes, what is the plan?

Is a 1 MN stay allowed under TM's 2 MN rule? Absolutely. If there was a plan for 2 and the pt had an early unexpected discharge = 1 MN inpt billable. If the pt had 1 outpt MN and then a 2nd medically appropriate midnight = 1 MN inpt billable.

Key- the plan outlined. Documented and met early or met the 2nd MN.

UR's 2nd Touch- Other payers

Other non-Traditional Medicare payers ***Look to 2024 Final rule for MA plans. Same regs..

1. Submission of records using the payer's KNOWN definition of inpt.
2. Reviewing the record – from the ED as all records from CDI or other interaction with the pt may not be available by the time records are due to the payer. Clarify internally
3. Outline WHY the pt is an inpt – using their criteria PLUS co-morbid conditions, risk factors, other documentation to support inpt.
4. Observation is a 'fall back position'. Doesn't meet, no other factors... but don't ASK for observation. ASK for inpt. Learn why the payer won't approve inpt.
5. Track and trend/TNT by payer.
6. Develop a payer matrix – all rules, timelines, etc tied to contract. Knowledge is power!

Strategies for “Demanding an inpt” and Keeping it - Crazy FUN (More Better Practice Ideas) **Impacted w/2024

- ▶ 1) Always know what clinical guidelines the payer is using. ALWAYS! (IQ, MCG)
- ▶ 2) When submitted records to ‘request’ inpt - a) include the clinical guidelines that clearly outline ‘why an inpt. b) a standard cover page that demands an inpt and why, c) if not clearly meeting inpt, the inpt cover page should also include additional justification. (co-morbid conditions, risk factors, etc)
- ▶ 3) The inpt started in the ER to an inpt bed. It does not start after the pt has been in a bed for a # of hrs. Huge !!
- ▶ 4) ER TO INPT - ER to Hospitalist/attending- UR outlines the reason why the pt is an inpt and the provider documents his plan for inpt in the patient record.
- ▶ 5) **Hint: CONCURRENT** review by payers during the stay. When will they give you the final INPT decision? Waiting until ‘days have passed’ = risk for obs inappropriately. Inpt happened at first touch... Lots to consider prior to allowing direct access/portal for designated records/decision timeline=w/in hrs

Non-Traditional Medicare/TM Payers (TM – we do our own/2 MN)

Patient Name

DOB:

Insurance name:
RECORDS TO PAYER/UR)

Subscriber #:

(SAMPLE FOR SUBMISSION WITH

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:

Meets clinical guidelines for the following diagnosis and course of treatment: (List)

IQ or MCG: (List their supporting info) (2024= WHAT TH E PLAN IS FOR 2 MN or the 2nd MN AFTER THE 1st OUTPT MN)

Other co-morbid conditions that will impact the need for inpt level of care: (List)

Known or suspected risk factors that further support inpt: (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.)

Outpt observation level of care, at the beginning of care, with the immediate intervention to move to inpt if the patient’s condition ‘rules in,’ or other clinical indicators are identified. _____ NOTE: Inpt will be requested immediately upon meeting inpt criteria.

Respectfully submitted,

Name, UR Team

Date /time sent to payer_____

UR's 3rd touch- No inpt? **2024

1. Don't agree with the payer's determination. Review case and hand off to the Physician advisor for a 2nd opinion. How to do a P2P call with the payer? TNT all reasons...
2. Traditional Medicare – have a 'short stay. Less than 2 MN. Review case and ensure a) the plan was clear for 2 MN and b) there was an unexpected early d/c. The initial review should be done at the point of admit and reviewed again as the early d/c occurs.
3. Traditional Medicare – 1 outpt MN + 1 more MN = inpt. Review case to ensure the PLAN for the 2nd MN is clearly outlined in the record.
4. Ensure the record is ready to support INPT. If deciding on OBS, there should be a PLAN for obs with TM – resolved home or converted prior to the 2nd MN. Aggressively resolve all TM accounts prior to the 2nd MN if 1st MN is outpatient.
5. If obvious ERROR as made with inpt order, then conditional code 44 must be done/followed prior to billing observation. (UR committee, attending, pt notified – then start the obs hrs) Very difficult to get done correctly.
6. NOPE WE WON'T BE BORED!!

Key Measures when beginning to work with ‘payers.’ Every payer has their own rules!

Medicare Advantage is Not Traditional Medicare!

- ▶ UR/Case Mgr and Physician Advisors have a working knowledge:
 - ▶ Payer Mix- Every payer has their own definition of inpt.
 - ▶ Observation rate/analysis - Every payer has their own determination of inpt vs obs.
EX) OBS RATE FY20: T Medicare 21.3% MA 28.6% All payer 25.0%
****2024 Final regs -all using same definition of inpt and obs- Traditional Med regs.****
- ▶ UR/Care Management Leaders Outline- includes Interqual or MCG or both that is being used. *Optum/UHC bought ChangeHealthCare which own IQ. SALE APPROVED 9-22. UHC using IQ.
- ▶ Census- volume of work is based on payer mix and average census of inpt and obs.
- ▶ P2P successes, attempts, negotiated-per payer
- ▶ Clinical denials, by payer, with overturns and reason
- ▶ Catch phrase: **Does not meet Medically Necessity. Means???**

Creating a Payer-Specific Matrix

Great tool in the toolbox



Key elements in having the inpatient vs outpt observation discussion with non-Traditional Medicare payers. (HINT: Better practice ideas)

- ▶ Each payer has their definition of ‘what is an inpt.’
- ▶ Each payer should have published what they are using in making that determination. (EX: Humana/MCG; United/MCG sort of/moving to IQ in May 2021; Indept BX plans/IQ- some moved to MCG)
- ▶ Each payer should have a way to request and complete a P2P challenge of patient status. (Contracted or within polices on webpage)
- ▶ Once this information is created as an internal matrix, now both the UR and the PA team know - what is this payer’s unique definition of an inpt.
- ▶ **Oh, not so simple -you say.** YEP - as there is unlikely anything tied directly to a contact payment or penalty if they don’t follow their own guidelines. BUT -it is the beginning step of a) requesting an inpt based on their own published clinical guidelines, b) UR’s efforts to confirm the inpt and c) talking points if a P2P call must occur.

PAYOR	HEALTH PLAN	PLAN TYPE	CONTRACT IN PLACE	UM CRITERIA	DRG	SURGICAL LIST REFERENCE	IP NOTIFICATION/ AUTHORIZATION	INTAKE-IP NOTIFICATION CONTACT
Who is the primary Insurance Payor?	What is the name of the Health Plan? UM should look at & start to think about what Payer and Plan Type does this patient have?	What type of plan is this? Knowing the type of plan can assist UM to think - Medicare regulation vs State Regulation vs Commercial contractual obligations vs. Corporate policy adherence in the absence of a contract	Is there a Contract with this payer/plan? A Yes vs No can prompt UM to think Contract specific rules at play vs. having to adhere to Plan's Corporate Policies	What UM Screening Tool does the Payer/Plan Use? Interqual, Millimen, CMS 2 MN Rule? Any other guidelines - IE: Medicare C list, Plan Specific Surgical Lists? Etc.	What DRG System is used - APR, MS, AP, Per Diem?	For Surgical Preadmissions - what does the plan reference for surgical bookings. EI: Medicare C-List, Medicaid IP Only list, Interqual, etc.	Who is responsible for the initial Notification of an IP Admission & Authorization Set-up? Financial Counseling, Patient Accounts, Business Office, Social Work, UM? *This information is important when retrospective denials occur for the technicality of "No Authorization Secured"; helps to get the visit back to the responsible party to attempt to rectify/update	If UM is responsible for any Inpatient Admission Notifications & Initial Auth Requests then who is the contact & how do they reach them?
MVP	MVP Gold MVP Medicare	Medicare	YES	Interqual	MS-DRG	Medicare C-List	Financial Counseling - responsible for Notification of all ED Inpatient Amissions. UM - responsible for Notification of all Obs to IP upgrades occurring on Floor Units	For Obs to IP upgrade occurring on a floor - UM to contact Lisa at MVP. Phone 518-234-5678 Fax 518-234-5679

“Payers Gone Wild” -understanding the contract, website posted policy updates, appeal language and when to just say ‘heck no’ ****Look to 2024 Final regs

- 1) “All stays under 48 hrs are observation.” Where does it say that in the contract? If not contracted, Traditional Medicare rules apply. What to do if continues to deny all inpt until more than 48 hrs has occurred?
- 2) “The patient can be treated in a lower level of care without endangering their health.or How long do you think they will need to be in the hospital?” Wow - that is tough as which UR nurse would say that the care is different in OBS vs inpt. But that is not the reason for inpt: The patient’s condition met their clinical guidelines. Not LOS; met clinical guideline +++
- 3) “If changes to pt status are made after d/c, the facility cannot bill anything. Provider liability and absorb. Just like traditional Medicare.” Nope!
- 4) “We only speak to the attending physician for P2P calls. CMS Form 1696
- 5) “We don’t do P2P. Just file an appeal.” Contracting.
- 6) “Let’s just access pertinent parts of your EHR so you don’t have to send us records.”
(Hint: When is the payer making the decision? ER to inpt = decision. The longer they ‘see’, the pt can recover and then obs.)

Hospital shall comply fully with the rules, policies and procedures that the Company has or will establish, including, but not limited to, those regarding utilization management including, but not limited to precertification of elective admissions and procedures, etc”

- “Hospital agrees to use best efforts to participate in, as required, and to abide by Company’s utilization review and decisions with respect to all members”
- “Hospital agrees to provide, when and to the extent possible, pre admission telephone notice to company of all members for whom admission through hospitals emergency room is contemplated.”
- “Hospital agrees to use best efforts to provide clinical data and information to company as is necessary to permit company to conduct utilization review.”
- “Hospital agrees to use best efforts to provide upon company’s request, and in accordance with hospital policy and State Law, complete copies of Member’s medical records.”

HUGE at risk ‘hidden’ in the language of the Payer Contracts. HUGE need to look beyond rates and at UR impact and other high cost issues –all records. Who is doing this? (Thanks, Stephani Daniels, PhoenixMed, retired)

Payer Uglies - In Contract. Watch and ensure there is an understanding prior to signing. HUGE! (NY 10-22)

▶ Humana - Claims Payment Policy

- ▶ Subject: Inpt to outpt Rebilling
- ▶ Published: 9-2016 Policy # CP2015018
- ▶ Claim for inpt services when an inpt admission was not medically necessary. *(PS Based on their decision and guidelines. Do you know it?)*
- ▶ *Humana's Medicare Advantage plans follow the CMS guidelines for inpatient Part B rebilling. (PS- they do not use the 2MN rule, they require records sent for prior auth, delays in replying)*
- ▶ When an acute care hospital determines **BEFORE discharge** that the pt should not have been admitted as an inpt, Humana will ONLY accept services submitted on an appropriate outpt bill type (131) or 85X and will allow the provider to submit all codes for a normal outpt situation and required Condition code 44. *(Again, not following TM rules but applying CC here. Even with this ruling, delays in ruling and time to get CC 44 done, which means pt notified, UR committee done, attending doc/notified and order changed - then can bill obs. UG!)*

- ▶ When an acute care hospital or Humana determines **AFTER discharge** that the pt should not have been an inpt, Humana will only accept inpt bill type 121. This billing should reflect the reasonable and necessary Part B services and provide CPT codes where appropriate. Report condition code W2 to indicate this is a Part B claim and include "A/B Rebilling" in the treatment authorization field.
- ▶ For pre-admission services in the 3-day payment window, the hospital may separately bill for services prior to an inpt admission and should report "A/B Rebilling" in the treatment authorization field of the appropriate outpt TOB 131 or 851.

WOW and DOUBLE WOW! Additional Thoughts:

Did contracting know of this clause? Why allowed?

How long is it taking to get initial decision? 3-5 days?

CONTRACT 1-2 DAYS. What are the chances of getting the P2P scheduled, done and decided PRIOR to the pt leaving?

Order says inpt? How did the provider bill?

Action items to get ready for the Medicare Advantage Plans to begin to use the 2 MN rule -with auditing! Tons of contracting and non-contracting work!

- ▶ Prior to 1-24, meet with the MA plans to discuss how you are going to tell them the PLAN FOR a) expected 2 MN presumption plan including signs & symptoms, acute LOC, complications, co-morbid conditions and b) 2 MN benchmark- 1 outpt MN including transfers in and 1 more in-hospital medically appropriate care = 1 MN = inpt. **New form after clarifying prior auth process.**
- ▶ What will PRIOR AUTHORIZATION Look like?
Present your form you will submit that outlines the above plan -in accordance with Fed regs.
- ▶ Clarify the 2 MN rollout -like Traditional Medicare. Outline that once an inpt is approved, the DRG is paid and there is no reason for concurrent review.
- ▶ As MA plans have to coordinate post discharge care thru one of their contracted care provider, and SNFs do not require a qualifying stay, coordinate how you will advise of pending d/c. Then work with them but ultimately MA's responsibility. Since there is no motivation to complete transfer, ensure the NEW LANGUAGE includes pre-diem payment for any delays.
- ▶ Ensure P2P communication is included as required in all contracting. New guidance is to have the same specialty at the payer as relative to type of case.
- ▶ Ensure CAH's are made whole... if not contracted, the Traditional Medicare rules apply-but what about the cost report at year end? Do the MA plans have to do them?and if contracted, same question as accepting TM rates is deadly as there is no cost report with the MA plans. **Must have a higher rate to offset the loss from the lack of the cost report.**
- ▶ Analysis of current LOS in obs with each MA plan. Track and trend changes with movement to 2 MN. Report abuses with CMS rep designated for your region.
- ▶ UR team, denial team and all interacting with the payers and providers: Do not use 'does not meet criteria. This patient's plan for an estimated 2MN is not clear. Query and clarify. Look to add order set questions: Admit to inpt. Plan for 2 MN: Free text. Plan for 2nd MN after 1 MN: Free text

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.***

Patterns from payer determination letters: Aetna (ex)

****No longer allowed with final rule 2024!!***

Aetna: MA account. Using clinical guidelines.

'We use national recognized clinical guidelines such as MCG, as well as ***clinical policy bulletins to support these coverage decisions***. Coverage has been denied for the following reasons:

- We used inpt and surgical care MCG guidelines. The requirements for coverage are: (1) active bleeding w or w/o high-risk endoscopic features; (2) hemodynamic instability; (3) severe anemia causing heart failure, cardiopulmonary symptoms and /or cognitive impairment; (4) severe liver disease or abnormal coagulation; (5) treatment intensity or monitoring that requires inpatient treatment; (6) severe thrombocytopenia; (7) inability to tolerate oral hydration; (8) previous aortic graft placement or known aortic aneurysm; or (9) documentation of significant active comorbid conditions requiring hospitalization. The member did not meet any of these requirements.
- PLUS: Peer to peer: 'It you are a treating practitioner and you disagree with a coverage denial, you may request a peer to peer with the Medical Director who made the decision. Follow fax: Scheduled P2P call within 14 days to speak to Med Director. (DOS: 5-18 Rec Ltr: 5-24. 6 days)

*****Change of internal request for inpt. Develop a payer matrix to know exactly what every payer is using. MA plans – use CMS form to create a representative for each MA pt/ internal PAs.**

Is patient still inhouse? (ex) ***Impacted w/2024**

- **United. MA plan.** Level of care determination/while in house.
Note: Moved from MCG to IQ, May 2021. Bought Optum who owns IQ.
- “Not met? My determination is based **on the health plans and Medicare criteria** that says 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.* (Major subjective!)
- Based on my review, these criteria haven’t been met. My rationale: this pt was admitted on 4-7-21 with sepsis unspecified organism. We reviewed the medical information made available to use, as well as the health plan criteria for admission to the hospital, and have determined that this does stay does not meet inpt admission.
- The reason is there was no hemodynamic instability. Hypoxemia, altered mental status, bacteremia, parenteral antimicrobial regimen that must be implemented on an inpt basis. Consequently, acute inpt hospital admission is not covered.” (IQ guidelines + UHC)
- What to do if disagree? You can request a P2P review. Send secure email or call #.
- Can a claim be submitted for this claim? If you submit an inpt claim, it will automatically be denied. You will received reconsideration process on your remittance. **DOS: 4-17 Ltr Rcd: 4-21 (4 days)**

You can still submit an output claim for all medically necessary services. Look to Medicare Claims Processing Manual, 100-04, Chapter 1, Section 50.3.2. (Condition code 44/TM)

WOW! UHC is using their own criteria, not the 2 MN rule, requiring hospitals to submit for review and then requiring the hospital to follow Traditional Guidelines/CC 44 when denying. WOW! NO WAY!

- **HUMANA:** what guidelines are they using? Letter was written to the pt, copied to the hospital (DOS 4-4; letter recd 4-8. 4 days) **Look to 2024 final regs. Must use the 2 MN rule

- ***'Based on Medicare guidelines, the services your provider is requesting do not meet the requirements for approval.*** We reviewed your records and they show you were admitted to the hospital with stroke-like problems that went away quickly. You got blood tests. You had special pictures of your brain and heart taken. You got extra fluids and medicine by mouth.

- In order for the requested services to be an inpt, you would have to have:

- Abnormal blood pressure or heartbeats that do not get better with treatment (hemodynamic instability).
- Weakness in one area of the body that keeps happening (recurrent focal neurological signs)
- Finding on brain imaging that requires inpt level of care (eg mass)
- Trouble thinking clearly which is new alerted mental status.
- Dangerous heartbeats (cardiac arrhythmias of immediate concern)
- Urgent inpt procedure is needed (eg carotid endarterectomy, carotid artery stenting)

Your records do not indicate the above problems. You had no trouble with.....

IF YOU HAVE NOT YET BEEN DISCHARGED FROM THE HOSPITAL, then we may be able to approve hospital observation services. Even if you stay in the hospital overnight or longer...

Decision was based on Medicare Benefit Policy Manual, Chpt 1, Section 10.

(Severity/intensity) THESE ARE CLINICAL GUIDELINES –their own? MCG? IQ?

Timing of Determination Letters

Contract language on timelines (ex)



- UHC: Faxed

DOS: 2-26	Received letter	3-1	
DOS: 4-17	Received letter	4-21	
DOS: 1-22	Received letter	1-25	
DOS: 5-12	Received letter	5-16	
DOS: 4-3	Letter dated:	4-6	Fax received: 4-8
DOS: 3-24	Received letter	3-28	AVE: 4 days

What if the pt has been discharged? Has the UB/claim already been sent as inpt? Was the PFS team told to hold these in a 'disputed status?' What is the timeline for the UR/Case Mgt team to submit original determination request?

- Humana: Faxed

DOS: 4-3	Received letter	4-6	
DOS: 5-8	Received letter	5-12	
DOS: 1-9	Received letter	1-13	AVE: 4 days

- “Cigna emphasized that its system does not prevent a patient from receiving care – it only decides when the insurer won’t pay. Reviews occur after the service has been provided to the patient and does not result in any denials of care.” **WOW – so they approve the care but not the payment. Who dreamed this up!** (ProPublica.1 min reviews)

The Anguish continues - Medicare Advantage is NOT Traditional Medicare

To Contract or not to Contract. What is the “win’ for the provider to contract? To not contract? Out of network penalties to the beneficiary...but what if you didn’t contract - where would the patient get their provider network?

The MA plan cannot sell without a provider network in your community.

Regulations 42 C.F.R. § 422.214

If non-contracting with a Medicare Advantage/MA plan....

§ 422.214 Special rules for services furnished by noncontract providers.

a) Services furnished by non-section 1861(u) providers.

1) Any provider (other than a provider of services as defined in section 1861(u) of the Act) that does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA coordinated care plan, an MSA plan, or an MA private fee-for-service plan must accept, as payment in full, the amounts that the provider could collect if the beneficiary were enrolled in original Medicare.

2) Any statutory provisions (including penalty provisions) that apply to payment for services furnished to a beneficiary not enrolled in an MA plan also apply to the payment described in paragraph (a)(1) of this section.

b) Services furnished by section 1861(u) providers of service. Any provider of services as defined in section 1861(u) of the Act that does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA coordinated care plan, an MSA plan, or an MA private fee-for-service plan must accept, as payment in full, the amounts (less any payments under §§ 412.105(g) and 413.76 of this chapter) that it could collect if the beneficiary were enrolled in original Medicare. (Section 412.105(g) concerns indirect medical education payment to hospitals for managed care enrollees. Section 413.76 concerns calculating payment for direct medical education costs.)

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

**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.**

- ▶ **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.

Payer 'mis-information' for Medicare Advantage plans

- ▶ “Recently we received a denial for a status 3 years after the encounter. The pt was here for an OP Hemorrhoid procedure developing vomiting with distension of a colonic ileus. History of Olgilvie syndrome failed 48 hrs of outpt treatment. Inpt was approved thru payer contact prior to billing/3 years ago. Now the 3rd party vendor is stating he did not meet inpatient criteria.”
- ▶ Medicare Managed Care Manual, Cpt 4, Section 10.16. Medical necessity applies:
- ▶ **“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.” YAHOO!**
- ▶ **Update: Some comments from CMS after filing complaint center around: What does your contract say about ability to look back for any period of time and audit with auto take back? Huge issue to look for asap. 8-23**

More payer anguish -Place of service Audits

- ▶ “One carrier has enlisted HDI to audit place of service. They sent us 10 cases, all Medicare Advantage, DOS vary from 2016-2018, only one case had a 1 day LOS and they all say the same thing: “The patient could have been safely and appropriately cared for in an outpt level of care.” Now that sounds like a medical necessity denial to me. The kicker? I have already been denied 4 of these cases (back in 2016 and 17) and one was overturned by peer to peer, the other three were overturned on written appeal. How can this be possible? “Western Conn. 8-18
- ▶ SEE PG 18. It can't! But think of the wasted administrative costs to continue to a) track, b) defend and c) repeat defend. Track and trend and turn all costs into Contracting.

And more from Medicare Managed Care Manual -
Post stabilization & Post acute care***See 2024/meets to go
to SNF per TM, then MA must accept.

- ▶ 42 CFR 422.113 . (2) The MA organization financial responsibility - the MA organization is financially responsible (consistent with 422.214) for post - stabilization obtained within or outside the MA organization that are pre- approved by a plan provider or other MA organization representative.
- ▶ If the pt is approved for post-acute care, the MA plan is responsible to find placement. They must have a post-acute care provider network.
- ▶ If they can't find placement, ensure there is contract language to pay a 'per diem/day' rate for any days beyond the safe discharge order.
- ▶ **HUGE!** The MA plan has to have a SNF provider network to sell in your community. The pt has to be placed in an in-network SNF facility. If no in-network plan, then file complaint with CMS. Track and trend. But also get payment for the delayed 'days' while awaiting placement. **HUGE!**

3 Legs of Anguish - Pt Status, DRG Downgrades, Re-Admissions

- ▶ DRG Downgrades - what documentation standards are required to allow all physician inclusion of ALL dx the pt has and are included in the thought process/not always the actual treatment?
- ▶ Pt Status Disputes- what is their definition of an inpt?
- ▶ Readmission Denials - Related means? 30 days when CMS does not use this standard. Preventable means?
- ▶ Hint - all must be in the contract! Usually silent.
- ▶ Look to operational addendums vs
- ▶ Payer -specific policies... UGLY
- ▶ Why are you contracting? No directing of patients. So what is the win for the provider? Payer win is discounting. Out of network, competition. MA plan cannot sell in your community without a provider network.



DRG Downgrades



- ▶ Lots of discussion regarding tying in the diagnosis outlined to the treatment. Simply listing dx is not sufficient to ‘earn the higher DRG payment.’
- ▶ Differing interpretations of ‘co-morbid’ conditions.
- ▶ Differing interpretations of ‘primary and secondary ...reasons for admit.’ Different DRG assigned.
- ▶ **DENIAL PREVENTION: The HIPAA standard transactions.. Required all covered entities/payers to follow the outlined coding rules. They have to follow correct coding rules; so quote HIPAA and share the coding rules that makes the dx code correct, order of dx codes, etc.**
- ▶ **Include Accuracy rate done by external validation auditor.**

DRG = 1 payment for the entire stay

- ▶ Traditional Medicare for larger facilities = DRG. Each DRG has a mean LOS that the payment is based on. The diagnosis and inpt procedures are grouped into a single DRG payment. Some DRGs have higher payments based on co-morbid conditions. There is a small variation for each site but: **1 stay = 1 \$**. (CAH, pd differently)
- ▶ Medicare Advantage pays= same DRG methodology -with coding rules controlled by the HIPAA Standard Transactions 2003. 1 stay = 1 pre-determined payment for the dx and procedures done.
- ▶ Re-evaluate - why battling for additional 'days' when the inpt has already been confirmed? Exception - need for SNF and Outlier \$/additional \$ based on very long LOS/outside the norm for the dx.
- ▶ **EX) Aetna approved 2 days. Hospital is pd DRG. They requested 3rd day. Denied. Aetna denied and reduced payment by \$1200. WHAT?**
- ▶ Final 2024 - must use TM Inpt only list. Also, DRGs not pd by days...

And more crazies...Non-traditional Medicare/Other payer surgical inpts

**Look at 2024 Final regs..

Inpt approved. DRG payer. Payer granted two days; a 3rd one was requested. Payer denied. Hospital bills as inpt with 3 days. Payer refuses to pay any charges. WHY? “Days’ does not equate DRG payment. (What if the hospital just bills with 2 days? Same DRG payment. Why anguish?) **Never should have been allowed!**

*Inpt approved. DRG payer. Procedure ordered was submitted. During the case, another procedure was conducted. Payer requires to be told of the additional procedure. If not, denied inpt. WHY? Inpt was already approved. ***2024 - was this on the inpt only list? Now auto covered as inpt, ordered as inpt, no LOS requirement.**

*Inpt requested. Inpt was denied. Hospital tries P2P call. Told can't bill outpt as inpt was denied. WHY? Absolutely a medically appropriate procedure. Pt status - inpt vs outpt - was in dispute. Hospital can a) accept the downgrade to outpt surgery and bill type 131/outpt or b) use a physician to appeal. Must always know what the payer is using to determine ‘inpt surgery’ - what clinical guidelines? ****MA plans must use TM inpt only***

*Inpt denied. But did approve 72 hrs of obs. What is the contract for payment for obs hrs and other related services? Does it equal an inpt surgery? Do not accept. ****Violation as doing less than traditional Medicare. Also on the inpt only list?**

Massive Requests for Records

- ▶ First: If contracted, what does the contract state regarding request? Volume? Frequency? Reason? ALWAYS validate with each request. (EX: NY health system)
- ▶ Second: If no contract, why send the records? If MA plan with no contract, what would 'traditional Medicare do' with the same issue? Threats to not pay or recoupment payment. IMMEDIATELY report to CMS /abuse.
- ▶ Third: Track and trend all requests. Why? What is the finding? Report to contract management ASAP.
- ▶ **DENIAL PREVENTION: HIPAA Standard Transaction and Privacy (2003ish) - only send 'minimally necessary information.' Never the full record. If prior authorized (all are) - then why do they need the record POST care? PS Some payers = "Pt signed document allowing us to request full record. " Ask to see it. PHI**

One RAC Relief User Issue- Lost Medical Records??

- ▶ Sending appeals and then following up to check the status only to learn they don't have any record of us filing an appeal and we will need to resend it to them.
- ▶ Suggested Response: “Would you like me to contact the Office of Civil Rights and file the HIPAA breach report for you since you lost PHI that I can prove was in your possession? **
- ▶ Track and trend patterns by payers.



Patient Status “Touches”-Revise for MA

1st touch: UR & Requests to payers

- ▶ UR in the ER
- ▶ Bed placement UR
- ▶ Pre-placement/pre-admission/pre-screening UR
- ▶ **Eliminate Place and Chase**
- ▶ Works to confirm inpt pt status with the payer or internally if Traditional Medicare/TM
- ▶ If starts as outpt, then condition meets a) 2 MN benchmark or b) Payer’s condition “rules in”/worsens = UR works with provider to write conversion order. 2 MN Benchmark = clinical reason to stay a 2nd MN . Other payers = work within their clinical guidelines and involve the PA with any payer (or ordering physician) dispute.
- ▶ Outpt surgeries- confusion over ‘moving to the floor to finish recovering’ including medically necessary extended recovery vs “observation/unplanned event” -with focus on moving to inpt per 2 MN benchmark or other payer’s rules/authorization. Can’t ‘pre-order outpt observation at the time ordering an outpt procedure. Forecasting an adverse event.
- ▶ Review all TM ‘inpt only’ prior to scheduling.**
- ▶ Outpt in a bed = nothing clinical = Free

2nd touch: Internal Physician Advisor

- ▶ Thru direct referrals from the UR
- ▶ Thru daily reports: 1 day stays/Traditional Medicare; 1 MN Traditional Medicare/TM = looking for potential conversions to INPT or timely discharge; 1 day stays with observation for other payers.
- ▶ Decision to move to P2P calls.

Then on to 3rd Touch: P2P call with non-Traditional Medicare payers. (Coordination)

Or the payer won’t allow a P2P, so another choice.

Decision: Move ahead and accept obs/Change to outpt/send bill. Move ahead and leave as an inpt disputed status/bill inpt anyway.

4th touch: Move to submission of the claim as the original order states/registered in the computer/inpt. Wait for the denial. File a formal appeal with the payer.

Hot spots: Communication of disputed status/claim⁷³
Communication of dialogue on appeal strategies from the PA advisor. Documentation of same.

Specifics – Disputes with payers. ***Look to 2024 Final Rule Internal MD/Physician Advisor with the Payer’s MD

- **What is a Peer to Peer call? Trained internal physician advisor speaking to the payer’s physician. Goal: Resolve dispute from initial request for inpt. All done prior to claim submission.**
- **Re-evaluate the initial ‘submission’ to the payer for prior authorization. *1st touch* Submit cover letter with initial submission – WHY an inpt!**
- **Payer’s use some type of clinical guideline to determine first decision: Inpt or Obs**
- **EX) Aetna denial letter/NC. ‘We reviewed information against MCG guidelines for inpt and surgical care. The requirements are ... The member doesn’t meet any of these requirements.’**
- **EX) If you are treating physician Or “if you are not discharged” – payer letters**
- **Important to a) Know what the individual payer is using. B) Present the case as it appears from the ER/Acute level including the ‘meet’ and other co-morbid conditions, risk factors as not all cases ‘fit’ into MCG or IQ.**
- **CDI work usually happens AFTER the records have been sent in the initial ask. How does this information get updated to the payer? Absolutely use in the P2P call. “New information!” Powerful.**



General Guidelines For Effective P2P Interaction with the Payer's MD (All non-T Medicare payers)

BE PREPARED. YOU ARE READY TO GO FOR INPT. That is the primary reason for the call.

Know the answers to the questions: Payer specific.

- ▶ **Why was the account denied?** What are the Clinical guidelines/CG for this case? Is it a 'gray' case or a CG slam dunk?
- ▶ **Who is payer?** What is the historical pattern with the MD? What is this payer's MD looking for to approve the INPT? Are there 'key words' this payer likes when looking for specific dx/courses of treatment? What are the 'hot words' NOT to use? (Observing for vs actively treating)
- ▶ **Place the request.** What are the contractual guidelines for a) scheduling a P2P, b) can the pt's status be changed post discharge with no aguish/bill type 131/obs from time of initial 'admit'?
- ▶ **Ensure there is clarity on when to schedule the call - time and date.** Again, very payer specific
- ▶ **Know the Levels the payer is using** Ex) Humana
-4 hrs from request; if missed, move to pre-dispute.

- ▶ **MA Plans-** Use of CMS form 1696/appointing of a representative. Submitted with the Request for P2P, if needed.
- ▶ **If not allowing P2P or a non-contracted payer, then what?** How can inpt be challenged without going to appeal/very costly/delays in payment? And if so, know the appeal rights/levels with each payer's contract.
- ▶ **Ensure timeline for DECISION on P2P if not done concurrently during the call.** Can post-discharge be done & concurrent? Get authorization #.
- ▶ **If the P2P call is attempted but missed/did not get scheduled well,** it is a '1x and done' -move to appeal or accept obs?
- ▶ **Bullet Highlights of the case.** Ex) MCG met/if it helps. Comorbid conditions. Updated issue since original request for inpt/UR 1st touch. Why inpt Level of care is necessary. If DRG payer, once approved for inpt. # of days is a mute issue. Same DRG payment.
- ▶ **Communicate with PFS/Rev Cycle on what is the final status of the account** -inpt or obs. Update medical record &/or AR file w/same

Peer to Peer Discussion: Preparation for the call & Outcome

Company: _____ Phone Number: _____ Date: _____

Name: _____ Date of Birth: _____

Insurance Number: _____ Chart Number: _____

Date of Admission: _____ Hospital: _____

Date of Discharge/if applicable: _____

Current Status: _____ Dx & Comorbid: _____

What does the payer use to define inpt? (IQ, MCG, other) _____ ***Watch for many disputes over caring needing 2 MN or 1+1 MN.* Plans will be huge!**

Medicare Advantage -CMS1696 Signed: _____ Yes _____ No

What was the justification for the dispute of inpt per the payer's response? (Review UR notes, meets clinical guidelines, co-morbid conditions, at risk issues, etc. Why can't this patient's condition be safely treated as obs?)

Clinical Presentation:

Pertinent Labs, other highlighted areas:

Changes since clinicals sent to payer?

Payer Medical Director: _____ Direct Phone Number if Given: _____

Outcome: _____ IP approved Authorization # _____ OBS approved.

Readmission issue? Yes _____ No _____ "Related issues" at risk? _____

Recommend Appeal: _____ Yes _____ No _____ N/A

Accept downgrade to obs? _____ Yes _____ No

If recommend Appeal: Basis for appeal _____

2023

Completed by:

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

Appointment of Representative

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

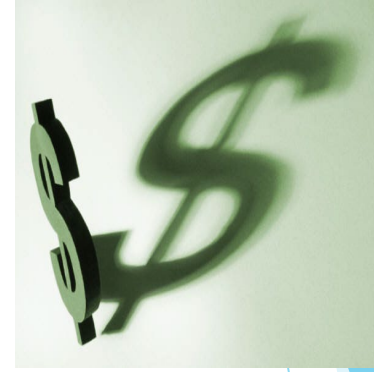
Signature	Date
-----------	------

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
-----------	------

It's all in the Contract or is it Policy-outside the contract?



- ▶ United Health Care **Policy Number: H-006**
- ▶ **Coverage Statement:** Hospital services (inpatient and outpatient) are covered when Medicare criteria are met.
****DANGER ZONE****
- ▶ For coverage to be appropriate under Medicare for an inpatient admission, the patient must demonstrate signs and/or symptoms severe enough to warrant then need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis. ****Now look at the 2 MN plan for care/2024 Final regs**

Update - United =25% market share Wow - big win under final rule 2024.

- ▶ As of Aug 2015, UHC no longer uses the CMS two-midnight standard to make inpt admission determination.
- ▶ UHC believes the best way to help UHC's members get access to the care they need is to relay on evidence-based guidelines and treatments. Evidence-based guidelines allow UHC to review a member's health condition based on the clinical documentation and provide consistent, clinically validated decisions for hospital admissions.
- ▶ **Sites should now consider: "If appeal results in an adverse decision, we request a copy of the individual criteria used to determine medical necessity be provided with the determination."**
- ▶ Per UHC 2016 Provider Manual - pp 113-114 Criteria for Determining Medical Necessity.
- ▶ May 2021- UHC moving to IQ/owns Optum which bought Change HealthCare which owns IQ. From UHC's MA policy #H-006. 2020 pg 2: "Physicians should use a 24-hr period as a benchmark, i.e. they should order admission for patients who are expected to need hospital care for 24 hrs other patients on a outpt basis." IQ= 48hrs in guidelines.
- ▶ Reported UHC IQ impact: much longer to get replies to 'disputed status' -P2P calls, etc. **UNITED/OPTUM now owns Change Healthcare which owns Interqual... SCARY!**

Readmission Denials- CMS Policy



When a patient is discharged/transferred from an acute care Prospective Payment System (PPS) hospital **and is readmitted to the same acute care PPS hospital on the same day for symptoms related to**, or for evaluation and management of, the prior stay's medical condition, hospitals will adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim. Chpt 3 Sec 40 2.5

Please be aware that services rendered by other institutional providers during a combined stay must be paid by the acute care PPS hospital as per common Medicare practice. **1 Single payment with same day readmission WOW ***2024 codified this for all MA plans too.**

30-Day Readmission Traditional CMS

Yearly penalties, not each case as MA Plans are doing

CMS Hospital Readmissions
Reduction Program (HRRP)

The Social Security Act establishes the Hospital Readmissions Reduction Program, which requires CMS to **reduce payments to IPPS hospitals with excess readmissions**, effective for discharges beginning on October 1, 2012. The regulations that implement this provision are in subpart I of 42 CFR part 412 (§412.150 through §412.154).

In the FY 2012 IPPS final rule, CMS finalized the following policies with regard to the readmission measures under the Hospital Readmissions Reduction Program:

- Defined readmission as an admission to a subsection (d) hospital **within 30 days of a discharge from the same or another subsection (d) hospital**;
- Adopted **readmission measures for the applicable conditions of acute myocardial infarction (AMI), heart failure (HF), and pneumonia (PN)**.

In the FY 2014 IPPS final rule, CMS finalized the expansion of the applicable conditions beginning with the FY 2015 program to include:

- (1) patients admitted for an acute exacerbation of **chronic obstructive pulmonary disease (COPD)**; and
- (2) patients admitted for elective **total hip arthroplasty (THA) and total knee arthroplasty (TKA)**.

In the FY 2015 IPPS final rule, CMS finalized the expansion of the applicable conditions beginning with the FY 2017 program to include patients admitted for **coronary artery bypass graft (CABG) surgery**.

READMISSION PENALTIES: CMS FINES 2545 HOSPITAL FOR HIGH READMISSION RATES.

83% OF 3080 HOSPITALS /2499 ANNOUNCED FINED (10-21) ²⁰²³ WOULD CUT UP TO 3% FROM EACH MEDICARE CASE DURING FISCAL YEAR 2021. PROGRAM IS 10 YEARS OLD

Sample Re-admission Denial - COVID involvement - 2 admissions within 30 day window. Denied\$ on 2nd. CT hospital 3-22

- ▶ Pt admitted in Jan and Feb 2020. (Vaccines??)
- ▶ The first admission: obese male with 2 weeks of SOB who was COVID positive and admitted for 5 days in late Jan.
- ▶ He was treated with PO steroids, remdesivir and discharged on high flow O2.
- ▶ The Discharge DRG was 177, Respiratory infection and inflammation w/MCC.
- ▶ Records requested.
- ▶ The 2nd admit was 22 days after the first admission's discharge day.
- ▶ He was admitted with post COVID-19 hypoxemia despite being on 3 L of O2 at home.
- ▶ A Chest Xray revealed bilateral infiltrates and the patient was treated for 8 days for possible aspiration PNA.
- ▶ He was discharged on a higher O2 to home. There was no clear dx of PNA.
- ▶ The coding was to DRG 189, Pulmonary edema and respiratory failure.
- ▶ **WHY DID IT DENY?**
- ▶ **Related? Which dx were the same on the 2 claims and what did it edit for?**
- ▶ **Grossly unfair with a totally new pandemic infectious agent with no clinical information.**



United Health Care Readmission- 30 days for any related reasons *common language
***Look to 2024 Final rule. Can't do !



- ▶ A LVN, LPN or RN will review the medical records and supporting documentation provided by the facility to determine whether the two admissions are related.
- ▶ If the subsequent admission is related to the initial admission and appears to have been preventable, the LVN, LPN or RN will submit the case to a medical director, who is a physician, for further review.
- ▶ The medical director will review the medical records to determine if the subsequent admission was preventable and/or there is an indication that the facility was attempting to circumvent the PPS system. **
- ▶ **Aetna MD/CA case in court: did not do review of case/just read recommendation by clinical team. AG's investigating**
- ▶ **FULL DENIALS of the 2nd admission by MA PLANS...and other COMMERCIAL PAYERS... Must be collapsed into the 1st admission. No 2nd admission allowed.**
- ▶ **Exclude ALL CHRONIC CONDITIONS from readmission penalties.**
- ▶ **Finalize which of the up to 10 dx/order of have to be 'same/similar' for rejection.**

Proactive Ideas for all non-Traditional Medicare/TM Contracting

Usually in Operational Addendum & Appeals

“Payers will do whatever you allow them to do.” Dr Hirsch, RAC RELIEF 7-23

Outline key elements prior to signing the contract. Re-visit throughout the contract year if concerns arise. **Rates are not included in this list.**

- 1. Timeline for submission of clinicals.** Week days, weekends, obs conversion request to inpt.
- 2. Clinical guidelines the payer is using making the inpt decision** along with required REASON for not approving inpt with decision.
- 3. Timelines for reply of request.** Weekends same as weekdays. 4-8 hrs maximum
- 4. Once inpt has been approved, no additional record requests** unless pt is a candidate to move to a post-acute level of care. Contract language must be known – i.e. qualifying stay. (DRG)
- 5. If granting access to the provider’s electronic medical record, critical to have a very limited review (ER if from the ER/labs/imaging/notes) with a firm timeline for decision. 4- 8 hrs maximum.** Continued delay yields risk of the pt ‘recovering in a lower level of care/obs.” If in obs, grant access when the pt’s condition needs reassessed. 8 hrs maximum.
- 6. DRG hot spots:** Sepsis, ensure there is adherence to the HIPAA Standard Transactions- all covered entities.
- 7. MA plans:** Ensure there is understanding that a disputed status may not resolved while the pt is in-house. TM rules do not apply. Status can be changed post discharge will full billing as inpt or outpt/131 bill type.
- 8. P2P:** Any provider may discuss the account on the patient’s behalf. All contracts allow both concurrent and post-discharge P2P. Once the request is made, a time is agreed to /recommended. Identify timeline with penalties if not adhered to. Agree to the qualifications of the payer MD. Outline the scope of the Payer MD can use –beyond meeting the clinical guidelines. No minimum LOS to be an inpt. (EX: all accts under 48 hrs are obs.)
- 9. Re-admission denials.** Outline exactly what is a ‘related’ case within 30 days. “Same as Medicare’ = same day, same facility, same dx. Chronic dx are excluded. Identify which dx must be the same and in which ‘spot’ of the up to 10 dx.

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

File complaints – squeak – with excellent examples of abuse

Will require the provider try to work it out with the payer first. Then file.. *Cannot be regarding rates*

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Operational Addendum's for Payer Contracts - All insurance types, all non-Traditional Medicare Payers.

- ▶ Many payer contracts are the same nationwide. (EX United)
- ▶ The challenge is to clarify OPERATIONAL Issues thru an Addendum to the contact.
- ▶ Operational issues are historically not addressed in the language of the contract. The key challenges adding cost to the contract are seldom known by the Contracting Department.
- ▶ Payers will direct providers to the Webpage for Policy Updates. (Who knows, who teaches, how are they rolled out, what if disputed. EX: (on hold now) United new mandatory United-specific lab codes, effective 1-1-22 for all contracted providers. Adding same special provision for Imaging. “Designated Diagnostic Provider’ status.
- ▶ Becoming a member of the Contracting Team, Care Mgt & PAs can interject factual data- tracking and trending of patterns, by payer - while outlining additional elements into the Operational Addendum while working closely with the back end/rejection/denial prevention team.
- ▶ **Per CMS: 75% of MA appeals are overturned. Games? But only 1% are appealed.**

Proactive Ideas for all non-Traditional Medicare/TM Contracting - usually in Operational Addendum & Appeals

Does directing of pts even occur? What is the win for the provider?

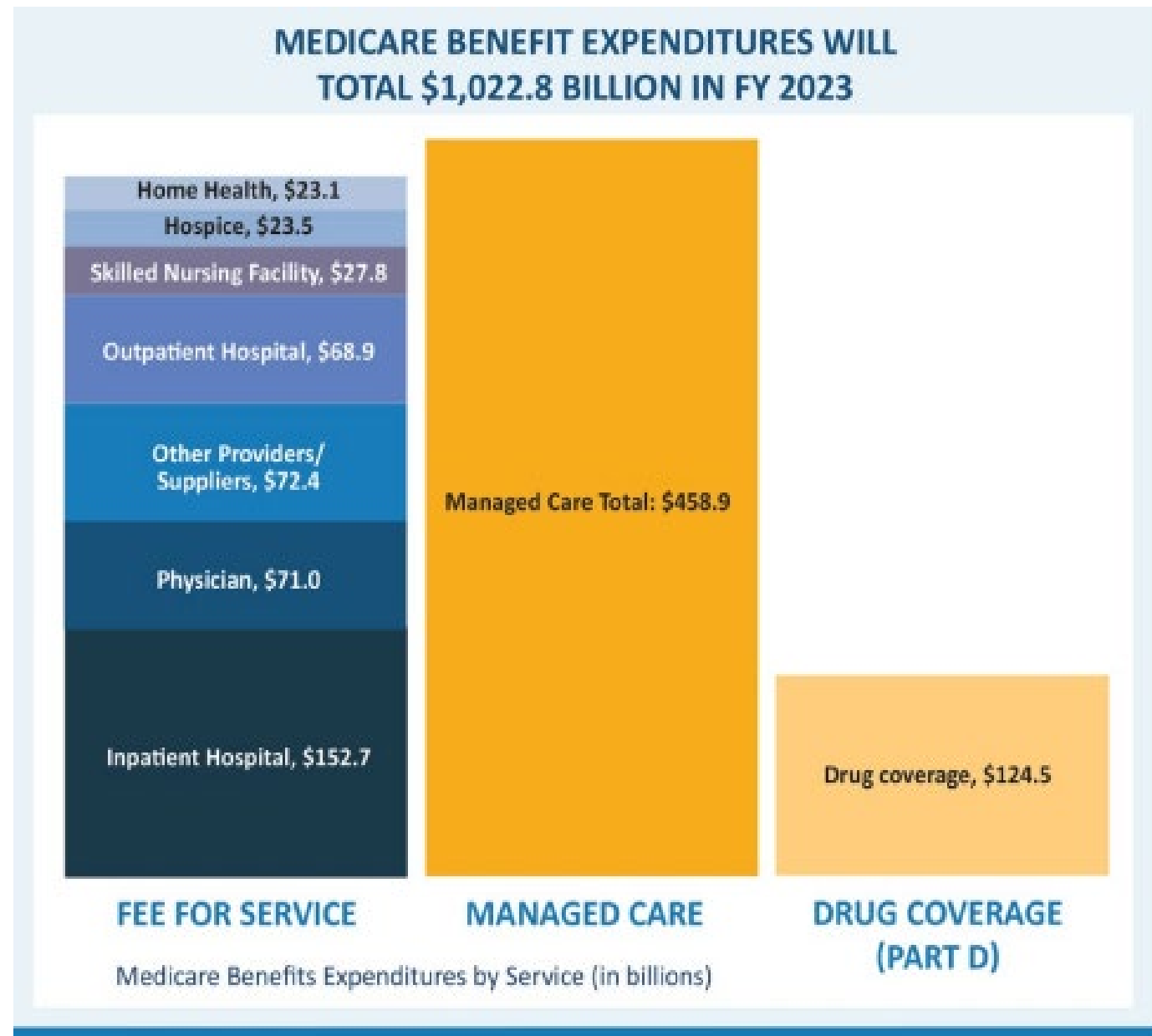
Outline key elements prior to signing the contract.

Re-visit throughout the contract year if concerns arise. (Rates are not included in this list)

1. **Timeline for submission of clinicals.** Week days, weekends, obs conversion request to inpt.
 2. **Clinical guidelines the payer is using making the inpt decision** along with required REASON for not approving inpt with decision.
 3. **Timelines for reply of request.** Weekends same as weekdays. 4-8 hrs maximum
 4. **Once inpt has been approved, no additional record requests** unless pt is a candidate to move to a post-acute level of care. Contract language must be known - i.e. qualifying stay. (DRG)
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Anticipated
\$27.1 billion
increase
over 2022

Traditional
Medicare spend
\$439.4 Billion



Source: *HHS FY2023 Budget in Brief-HHS.gov*

Background Story 2019 – 2022

Humana MA enrollment increased from 400 to 2200 attributed to Stillwater Medical providers

Zero premium PPO MA Plans increase in popularity with new retirees

Local Insurance Brokers increase MA Sales

Traditional Medicare Supplements enforce medical screening during open enrollment

- *Stillwater Medical Reimbursement drops to 95% of Medicare*
- *MA Denials = 22% of total MA claims for this period*
- *Traditional Medicare denials < 1% for the same period*
- *Cost to provide care increases 26%*

Oklahoma hospital terminates Medicare Advantage contracts amid financial challenges

Stillwater Medical Center in Oklahoma has ended all in-network contracts with Medicare Advantage plans amid financial challenges at the 117-bed hospital, the *Stillwater News Press* reported Oct. 14.

Humana and BCBS of Oklahoma were notified that their members will no longer receive in-network coverage after Jan. 1, 2023.

"BCBSOK is willing to work with Stillwater Medical Center in finding solutions that will allow Payne County residents continued local access to Medicare Advantage providers," a BCBS spokesperson told the newspaper.

The hospital said it made the decision after facing rising operating costs and a high prior authorization burden for the MA plans.

"This was a very tough financial decision for the Stillwater Medical leadership team. Our cost to operate has increased 26 percent over the past 2 years," Tamie Young, vice president of revenue cycle at SMC, told the *News Press*. "Financial challenges are increased by a 22 percent denial of service rate from Medicare Advantage plans. This is in comparison to a less than 1 percent denial rate from traditional Medicare."

The Real Transparency: Community and Patient Communication

- **Physician support and approval is key before providing notice to a payer**
- **Respond to the Press before they create their own story**
- **Provide reference points and key words to employees and providers**
- **Explain the “why” in easy-to-understand language**
- **Communicate Empathy, not Sympathy**
- **Reassure that physicians and hospitals are still here to provide care**
- **Teach about options and how out-of-network benefits work**
- **Use Videos and Q&A format for social media**
- **Publish contact information for State Medicare Assistance Programs**

Update- 6 months later. Multi-hospital rural

- Not contracted with any MA plans.
- The MA plans must use Traditional Medicare/TM rules for approving inpt/2 MN rule and other TM guidelines.
- But – instead of pre-payment disputes/denials – it has now moved to post-discharge/payment requests.
- Now inpt is paid – battle is post payment.
- Inpt only surgeries /list must be used; readmission rules; no prior auth for tests if TM did not require it. Never easy to do but must be done.
- Commercial large payer refuses to believe documentation of 26% increase in costs. Contract ‘talking’ not good.
- **BECKER REPORT: More providers are looking to terminate contracts-no wins.8-23**

Contract Checklist of Utilization Needs

Utilization Review Contract Checklist	
I. <u>Review Criteria</u>	
	Request: Interqual
	Request: If contract will not allow for exclusive use of Interqual then P2P Opportunity must be available when Criteria Conflict; P2P must then be based off of medical necessity & Provider input
II. <u>Concurrent Denials</u>	
	Request: Inpatient Hospitalization authorization can only be denied by a Medical Director/Physician Reviewer after it has failed to meet utilized criteria by the 1st level reviewer. A non-physician reviewer can not concurrently deny an Inpatient Hospitalization Authorization
	Request: Concurrent Denials due to failure of the payor's 1st level reviewer to provide the Medical Director with all pertinent chart documentation pertaining to the visit will be immediately overturned
	Request: P2P Opportunity available whenever the payor denies a visit concurrently. The P2P will be a review of the medical necessity of the cases; not how it does or does not meet criteria used
	Request: P2P should occur while the patient is in-house but must also be allowed up to 48hrs after discharge; P2P cannot be disallowed just because pt. was discharged. If the denial was received post discharge then the P2P shall be allowed & is to occur within 72 hrs of discharge
	Request: P2P can be conducted by the Attending Physician, Physician Advisor, CMO, &/or any applicable Consulting Physician pertinent to the hospitalization
	Request: Concurrently denied stays that are overturned on P2P appeal shall not be denied again post discharge upon retrospective review

Contract Checklist of Utilization Needs

Thanks, Ms Slavin/Strong Memorial, NY

III. <u>Elective Surgeries</u>
Request: Medicare lines follow the CMS Inpatient Only Surgical List Annually as CMS publishes
Request: Transparency of any internal Surgical Lists defining procedures as shrot stay 23 hrs, Ambulatory, or Inpatient designated
Request: Payor will not automatically deny procedure changes made during the time of surgery based on the new procedure was not pre-authorized. EI: Scheduled Short Stay 23 hrs lap spinal fusion that converts to open out of necessity
IV. <u>Readmissions</u>
Request: Clear & Transparent Readmissions Policy that clarifies when 2 Inpatient Hospitalizations will be combined by payor; limit to Same Day Returns for Same Condition/Diagnosis
Request: Payor will not automatically deny to combine return Inpatient Hospitalization Stays outside of the Same Day return policy. *In the event a premature discharge may have occurred the payor has the right to challenge/concurrently deny those 2 stays for combination to 1 continuous stay. Payor will not deny to combine 2 Inpatient stays on the sole basis that the patient returned to the hospital within a 30 day window of time
V. <u>Retrospective Denials</u>
Request: Payor shall not deny retrospectively any Inpatient visit they have already concurrently authorized & approved as Inpatient
Request: Appeal Responses - Failure of Payor to respond to appeal within the defined timeframe will result in automatic overturn of denial.
Request: If Denial is based off of internal medical policy as defined by payor then denial letter will explicitly state this including the link to the Policy resource utilized
Request: All appeals allowed an External Review Level of Appeal; Facility has the right to have the appeal reviewed by a 3rd party entity if the Payor upholds the denial at last level of appeal

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More filing of complaints - “Helping the contractor do the right thing.” 3-20

- ▶ To report issues to CMS. (Thanks, Dr Hirsch)
- ▶ MAC issues: CMSlistens@cms.hhs.gov
- ▶ QIO issues: QIOconcerns@cms.hhs.gov
- ▶ RAC issues: RAC@cms.hhs.gov
- ▶ Medicare Advantage issues: <https://appeals.lmi.org/DAPmailbox/mailbox?pageFilter=pca>

- ▶ Note - when ‘discussing’ issues with the MA plans - be very clear that you will report to CMS on behalf of the pt and will ensure it goes against their STAR Ratings... last major power statement.
- ▶ Ensure you have already tried to resolve with the payer.

Thank You for Joining Us in this Educational Journey



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