ERN NCRA

You fight for their lives.

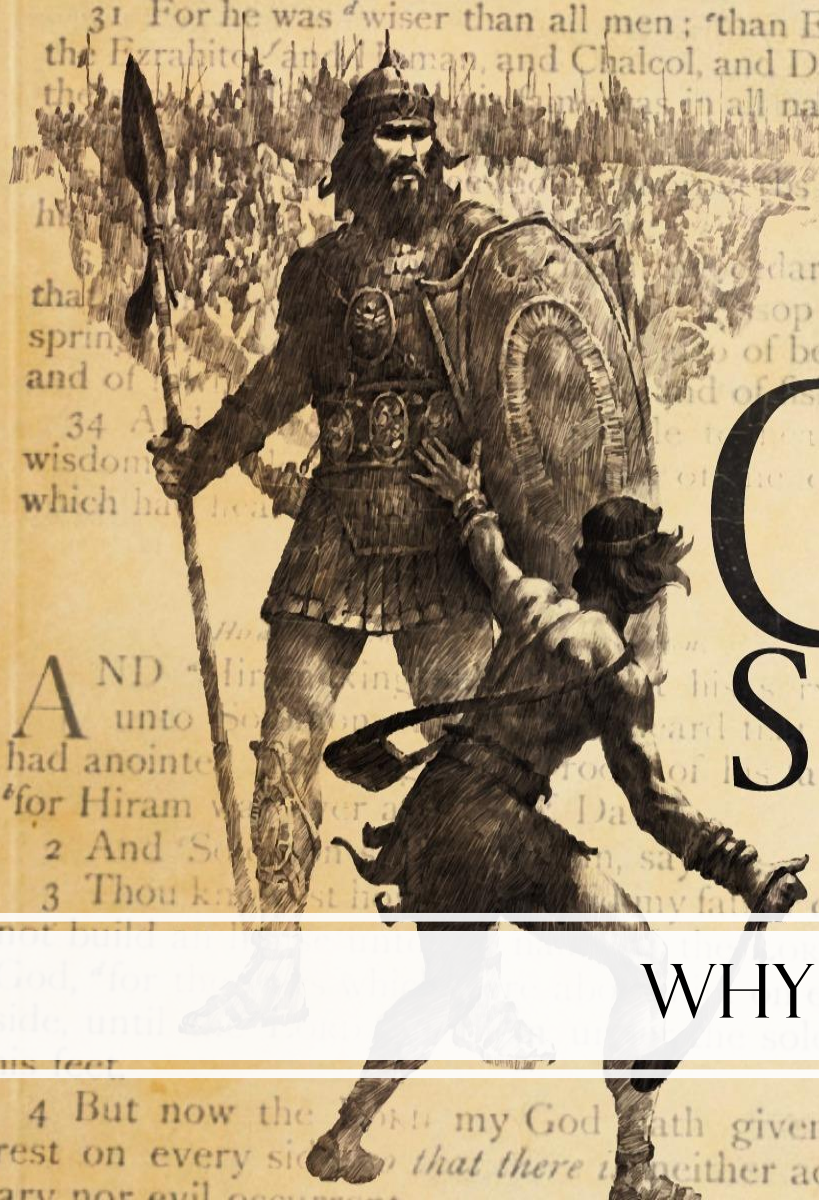
WE FIGHT FOR YOU.

HEALTH LAWS

2019

When Payors Won't Listen:

The Law, Denial Management and Appeal Letter Writing (MD)



GIANT SLAYERS

WHY WE EXIST.

To Whom it May Concern,

In late 2018, our youngest child was diagnosed with a rare neuromuscular disease called Acute Flaccid Myelitis. He was only 8 months old at the time and spent the next few months in the Pediatric Intensive Care Unit fighting for his life. His rare diagnosis makes his treatment extremely complex. We knew his road to recovery would be long-term and tough, but we never imagined that insurance would have a say in whether he got the treatment he needed. A neuro-immune doctor who specializes in AFM emphasized the extreme importance of intensive rehabilitation as soon as possible. He was confident that Cooper had the potential to walk and breath on his own if he went through intensive rehabilitation at the Kennedy Krieger Institute in Baltimore Maryland.

This is where ERN Enterprises has been such a huge blessing to not only Cooper, but our whole family.

Before we came in contact with ERN enterprises our insurance was denying coverage of intensive rehabilitation at the only location with any experience and positive outcomes for this rare disease. They had claimed that this treatment was not medically necessary despite multiple providers and healthcare professionals recommending we get there as soon as possible. I had spent hours working on an urgent appeal as this disease has a window of opportunity for the most recovery and this window was closing. My insurance reverted my appeal to non urgent without explanation or even sending me a timely notice. We had waited 3 months for a spot to open for Cooper at the highly sought after rehabilitation center and we were about to loose it because of our insurance issues. I had filed complaints, called all the insurance customer service and advocate departments multiple times and just felt like I was spinning my wheels and getting no where. When I call ERN Enterprises, I was desperate and loosing hope. Within 1 week of Ed Norwood getting involved in Cooper's case, our insurance overturned the denial. This came just in time as the specialty rehab had not yet given away our spot and Cooper was able to get started with his treatment with only a 6 week delay. I know this was only possible due to the hard work of ERN. I'm beyond grateful for the compassionate work this company does for people in great need.

Cooper has been in intensive rehabilitation at the Kennedy Krieger Institute for 10 weeks now and has made huge functional gains thanks to the therapy and medical care he is receiving. He is off the ventilator (machine that breathes for him) and well on his way to getting his tracheostomy reversed. He has started eating by mouth and making sounds again. I had not heard my baby cry in 6 months and what a moment it was to finally hear him again. He has also started to take steps and move his arms to touch toys and pop bubbles. This care and recovery was only possible due to the compassionate efforts of Ed Norwood and his team at ERN Enterprises as they got my insurance company's attention quickly and got Cooper where he needed to be.

Some families of patients here fought for months to get their children the care they deserve. We were so blessed to only be delayed by insurance for 6 weeks. ERN's

generosity demonstrates what a huge heart this company has for getting people the healthcare treatments that they need and deserve.

As our son continues to progress in his healing, I feel so grateful for the chance encounter I had with Ed Norwood and his team. Our family continues to feel the impact that ERN has made on our lives, as their generosity has provided one less problem to worry about. Instead, we can focus on what is truly important; Cooper and his recovery.

Best Regards,

Lexie Hernandez

Ed Norwood

From: Lexie Hernandez <arharri1@gmail.com>
Sent: Sunday, May 05, 2019 5:51 PM
To: Ed Norwood
Subject: Re: Testimonial

Cooper is making so much progress. It's truly incredible. I watched him take his first steps a few days ago. Something I wasn't sure I would ever see. I can't even explain how incredible this place is at what they do for children with spinal cord injuries. Thank you again for getting us here.

Lexie

On Sun, May 5, 2019 at 7:16 PM Ed Norwood <ednorwood@ernenterprises.org> wrote:

> So moved. So touched by your words Lexie.
>
> Thank you.
>
> How is Cooper doing?
>
> Best,
>
> Ed Norwood
>
> Sent from my T-Mobile 4G LTE Device
>
> -------- Original message --------
> From: Lexie Hernandez <arharri1@gmail.com>
> Date: 5/5/19 11:21 AM (GMT-08:00)
> To: Ed Norwood <ednorwood@ernenterprises.org>
> Subject: Testimonial
>
> I am so sorry that this took me so long but I wanted to be able to share how much Cooper has benefitted from the treatment that was only made possible from your efforts.
>
> Thank you again for everything!
>
> Lexie

ERN TRAF

Cooper [redacted]: Summary of Medical Events

Introduction: On September 10th our baby Cooper fell ill with a rare neuro-immune disease known as Acute Flaccid Myelitis. This disease mimics polio and is very new (first case diagnosed 2012) He was misdiagnosed for the first 2 months. Here is a time-line of events.

9/10/18:

- Arrived to ER about 3:00PM. After many theories and a whole slew of tests including a CT scan, X-ray, blood work, and MRI, it was determined that our son was the victim of a rare autoimmune disorder called Acute Transverse Myelitis. His spinal cord was swelling from the brain stem to T7 and compressed his spinal cord causing him to experience paralysis and the inability to breathe effectively. It is thought that the swelling is caused by his own immune system inappropriately attacking his spinal cord after an unknown viral trigger.
- 10:00 PM He was started on steroids and transferred to the Pediatric Intensive Care Unit (PICU) for monitoring and treatment.

10/5/18

- Tracheostomy placed due to failure to breath on his own.

10/23/18

- Care Conference: They want us to get ready for discharge home due to Phoenix Children's Hospital rejection of Cooper for rehab due to ventilator.
- We refused to take him home and insisted that he attend rehab as intense rehab is the only know treatment for his disease
- I Consulted Dr. Greenberg who is the closest rare neuro-immune disorder specialist. He referred Cooper to The Kennedy Krieger Institute (KKI) in Baltimore Maryland.

- KKI extended admission date to 1/21/2019

12/20/18

- Discharged home
- Channel 5 news does story on Cooper's rare illness

1/15/19

- Medicaid approval

1/5/19

- Re-hospitalized for viral infection/respiratory distress

1/12/19

- Discharged home
- KKI applied for insurance coverage beginning 1/23/2019

1/23/19

- Denial letter from insurance regarding intensive rehab program for children with AFM (Only one in the country). **See attached letter
- Not medically necessary
- No referral from "Primary" treating Physician
- Does not meat MCG guidelines
- KKI says to sit tight, they will do Peer-to-peer review in a few days

1/30/19

- Peer-to-peer review: denial maintained
- At this point 5 different doctors have said they are unsure how to treat Cooper and that he needs to go to Baltimore soon to get a care plan from the doctors that are treating this disease. (Referral letters obtained)
- Channel 12 news doing story on Cooper and the inability to get medical care for him despite having insurance.

2/8/19

- Filed rush appeal: ***See attached documents

InterQual® Level of Care Criteria
Acute Criteria

Review Process

Introduction

InterQual® Acute Level of Care Criteria provide support for determining the medical appropriateness of hospital admission, continued stay, and discharge. Acute Adult Criteria address the Observation, Acute, Intermediate, and Critical levels of care. Acute Pediatric Criteria include these levels of care and five additional levels of nursery care (Transitional Care, Newborn Level I, Special Care Level II, Neonatal Intensive Care Level III, and Neonatal Intensive Care Level IV).

Adult criteria are for review of patients ≥ 18 years of age. Pediatric criteria are for review of patients < 18 years of age.

Important: The Criteria reflect clinical interpretations and analyses and cannot alone either resolve medical ambiguities of particular situations or provide the sole basis for definitive decisions. The Criteria are intended solely for use as screening guidelines with respect to the medical appropriateness of healthcare services and not for final clinical or payment determinations concerning the type or level of medical care provided, or proposed to be provided, to a patient.

When evidence in the medical literature to support the efficacy and effectiveness of the intervention or service is absent, mixed, or unclear, criteria reflect the opinion of McKesson's expert clinical consultants. It is based upon current best practice and is the product of an iterative process involving multiple clinicians with diverse expertise in varied practice and geographic settings.

Reference materials

Reference materials are provided with the criteria and should be used to assist in the correct interpretation of the criteria.

- **Abbreviations and Symbols List**: Defines acronyms, abbreviations, and symbols used in the criteria.
- **Alcohol Withdrawal Assessment tool:** A worksheet to document a patient's CIWA-Ar score for alcohol withdrawal.
- **Bibliography**: References cited in the clinical content.
- **Clinical Revisions**: Provide details of changes to InterQual Clinical Criteria.
- **Drug List**: Categorizes drug names and classes mentioned within the criteria.

Laws and Regulations

InterQual Disclosure Updated 11/9/18

*"The Clinical Content reflects clinical interpretations and analyses and **cannot alone** either resolve medical ambiguities of particular situations **or provide the sole basis for definitive decisions**. The Clinical Content is intended solely for use as screening guidelines with respect to the medical appropriateness of healthcare services **and not for final clinical or payment determinations concerning the type or level of medical care provided, or proposed to be provided, to a patient**."…. (Emphasis Added)*

Per the Milliman Care Guidelines Disclaimer (shown on their website):

*"Qualified healthcare professionals may use our guidelines as a tool to support medical necessity decisions, **but they should not use them as the sole basis for denying treatment or payment**. Our guidelines must be applied to individual patients on a case-by-case basis and always in the context of a qualified healthcare professional's clinical judgment." (Emphasis Added) (See Attached)*

ERN
TRAF

SUMMARY OF COMPLAINT – ARIZONA MEDICAL BOARD

February 19, 2019

Patricia McSorley, Executive Director
Arizona Medical Board
1740 W. Adams St. Suite 4000
Phoenix, AZ 85007

Physician:	J Tolson, M.D.
License Number:	31688
Board Certified:	Anesthesiology
Patient:	Cooper
ID:	
DOB:	
Denied Service:	Inpatient Care, Rehabilitation Level 1

Dear Ms. McSorley:

This office represents Cooper Leigh and has been asked to file a formal complaint with the **Arizona Medical Board** against Dr. Jeffrey Tolson, M.D. for his negligent medical decision resulting in Cooper's delayed treatment for Acute Flaccid Myelitis, a rare neurological immune disease that mimics polio.

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

(1) Access to medically appropriate healthcare services consistent with clinical review requirements under Arizona Statutes, Title 20, §20-1057.06, §20-2501, §20-2532 and §20-2533 or any rule adopted pursuant thereto.
(2) Breach of fiduciary duties under 29 U.S.C. 1104 & 1109 including full and fair review requirements under ERISA law.
(3) Any other health services furnished by a provider or supplier that are reimbursable under 29 CFR section 2560.503-1 or any rule adopted pursuant thereto.

We dispute Dr. Tolson's decision to deny authorization for inpatient rehabilitation services based on lack of authorization, because two of Cooper's treating physicians with expertise in this field have documented the medical necessity of this requested service and Dr. Tolson does not have the clinical expertise to make an appropriate medical decision in this matter, as shown and described below and on the attached exhibits:

- On 09/10/2018 at 3:00PM, Cooper presented to an emergency room; multiple tests were performed including a CT scan, X-ray, blood work, and an MRI. It was determined that Cooper had developed a rare autoimmune disorder called Acute

In 2003, Dr. Narayanan moved to Phoenix as a member of the Child Neurology division at Barrow Neurological Institute.

Dr. Narayanan has a special interest in the genetic basis of neurological disorders. Dr. Narayanan's research efforts focus on the neurobiology of genetic disorders (genes to pathogenesis), cell adhesion molecules and synapse formation. **(See Exhibit F — Dr. Narayanan Biography.)**

III. DR. TOLSON IS NOT QUALIFIED TO DETERMINE THE MEDICAL NECESSITY OF RARE NEUROLOGICAL AUTOIMMUNE DISORDERS.

In Dr. Tolson's denial dated January 23, 2019, he states "Request is denied for the following reasons. There is no referral from treating physician. There is no documentation by referring provider of medical necessity for second acute rehab admission. There is no documentation of functional improvement anticipated to be practical, ongoing, and sustainable. Request does not meet criteria for Inpatient Acute Rehabilitation in MCG guidelines. MCG is used for its guidelines to decide if criteria is met." **(See Exhibit B — Banner/Aetna Denial.)**

As you know, **29 CFR §2560.503-1(h)(2)** details the requirements of an employee benefit plan when conducting full and fair medical reviews, stating:

> ***The claims procedures of a group health plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless, in addition to complying with the requirements of paragraphs (h)(2)(ii) though (iv) of this section, the claims procedure —***
>
> ***(i) Provide claimants at least 180 days following the receipt of a notification of an adverse benefit determination within which to appeal the determination;***
> ***(ii) Provide for a review that does not afford deference to the initial adverse benefit determination that is conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;***
> ***(iii) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgement, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgement;***
> ***(iv) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;***
> ***(v) Provide that the healthcare professional engaged for purposes of consultation under paragraph (h)(3)(iii) of this section shall be an individual who is neither an individual consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.*** **(Emphasis added.)**

As described above, Cooper Leigh has been diagnosed with Acute Flaccid Myelitis, a rare neurological immune disease that mimics polio. Being that this disorder is incredibly rare with the first diagnosis in 2012, very few medical professionals have the appropriate clinical knowledge and expertise to determine the medical necessity of different health services and therapies aimed at treating this rare condition.

Two of the only physicians in the United States with direct experience in treating Acute Flaccid Myelitis and other rare neurological disorders have documented the medical necessity of Cooper's requested inpatient rehabilitation and referred him to The Kennedy Krieger Institute (KKI) in Baltimore, Maryland.

Thus, Dr. Tolson's medical decision to deny the medical necessity of these services raises serious concern regarding his competence and experience in treating such ailments.

As you know, Dr. Jeffrey Tolson is the Medical Director of Banner-Aetna in Arizona. Dr. Tolson is an anesthesiologist specialist and he is board certified in anesthesiology. Dr. Tolson received his medical degree from Ohio State University College of Medicine in 1991. **(See Exhibit G – Dr. Tolson, Arizona Medical Board.)** Here. Banner-Aetna has utilized an anesthesiologist to review the medical necessity of treatment for a rare neurological autoimmune disorder.

Further, per the Milliman Care Guidelines Disclaimer (shown on their website), Milliman Guidelines are not to be used solely as medical necessity criteria in place of a qualified health care professional's clinical judgment. It reads in pertinent part:

> ***"Qualified healthcare professionals may use our guidelines as a tool to support medical necessity decisions, but they should not use them as the sole basis for denying treatment or payment. Our guidelines must be applied to individual patients on a case-by-case basis and always in the context of a qualified healthcare professional's clinical judgment."*** **(Emphasis Added.)**

The sole use of UR software CANNOT replace an experienced, knowledgeable physician, nor can it replace medical necessity determinations by the attending physicians.

Here, Dr. Tolson's letter states "*Based on MCG guidelines and the information we have, we're denying coverage for this acute rehabilitation facility admission. The requirements for coverage are: (1) requires intensive skilled nursing services; (2) requires two or more skilled therapy types (e.g. physical, occupational, or speech therapy); (3) requires and is able to fully participate in therapy for a minimum of 15 hours per week (e.g. 3 hours per weekday); (4) needs close physician involvement; and (5) shows continued measurable improvement with progress toward functional goals for next level of care. The member doesn't meet all of these requirements.*" **(See Exhibit B – Banner/Aetna Denial.)**

Considering Dr. Tolson's clinical background, it is evident that his expertise is not in rare neurological autoimmune disorders in pediatric patient, nor any remotely similar field. Dr. Tolson did not utilize MCG guidelines in conjunction with the expertise of a qualified, competent medical professional. Thus, it is clear that Dr. Tolson was not competent to evaluate the specific clinical issues at hand and his medical decision is inconsistent with those of qualified professionals.

From: Lexie Hernandez
Date: 2/20/19 7:02 AM
To: Ed Norwood <ednorwood@ernenterprises.org>
Subject: Re: AZ Medical Board - Complaint #41313, email 1 of 2 (PASSWORD TO FOLLOW)

Cooper has been approved for 6 weeks of rehabilitation! Now I just have to see if his spot is still available at KKI or how long this se
how you helped us if you want. Just let me know what I can do! Thank you! Thank you! Thank you!

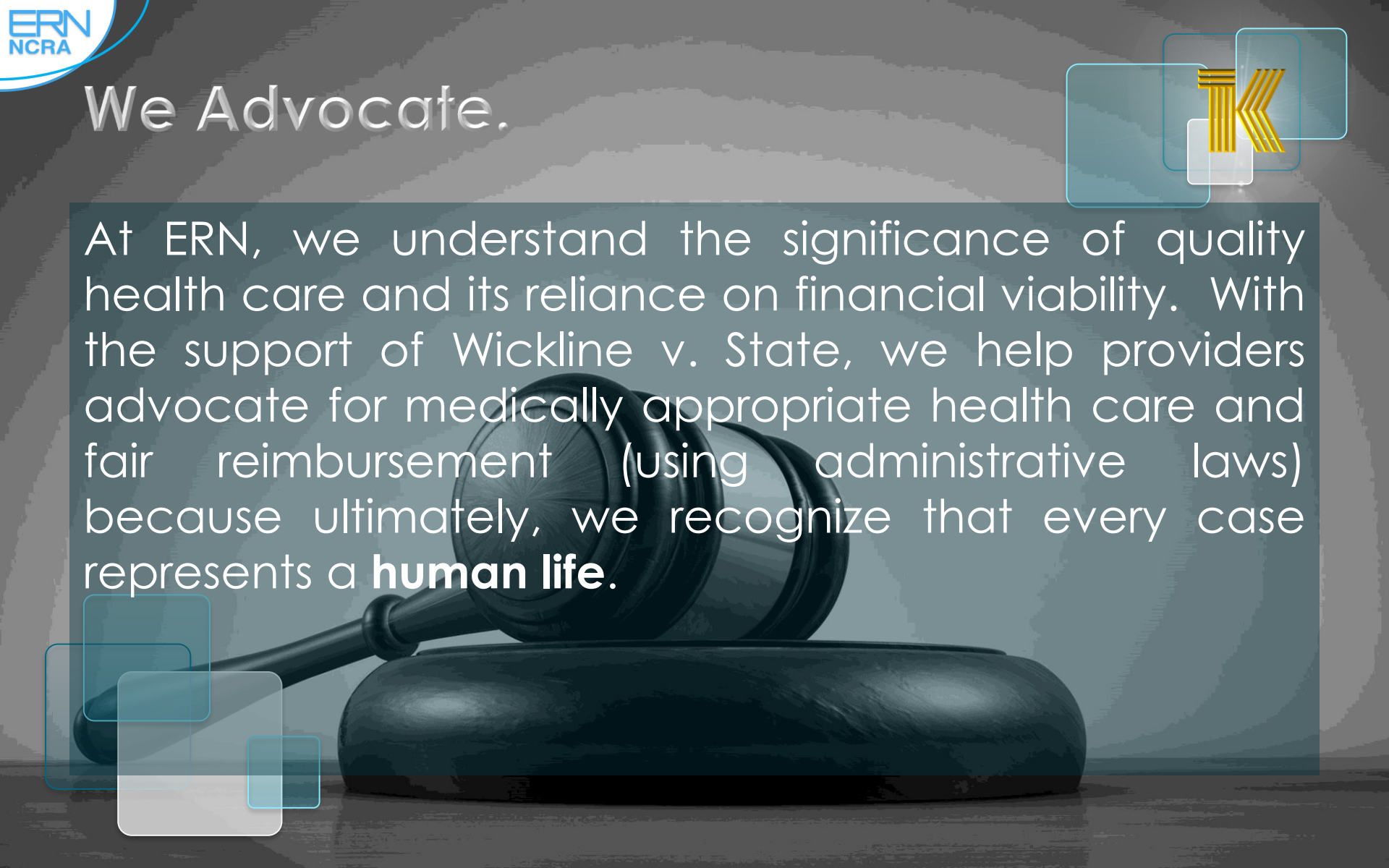
Lexie & Cooper

What We Do.

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

We Advocate.

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



FOUR WAYS TO BE A

Champion

FOR MEDICALLY APPROPRIATE HEALTHCARE


Can I do this?

When Payors Won't Listen.

THE PURPOSE OF THE LAW IS TO BRING ME TO A PLACE OF RECOVERY.

Maryland operates the nation's only all-payer hospital rate regulation system. This system is made possible, in part, by a 36-year-old Medicare waiver (codified in Section 1814(b) of the Social Security Act) that ***exempts Maryland from the Inpatient Prospective Payment System (IPPS) and Outpatient Prospective Payment System (OPPS) and allows Maryland to set rates for these services****. Under the waiver, all third parties pay the same rate.*

Ed Norwood

From: CMS ROSFODHPP <ROSFODHPP@cms.hhs.gov>
Sent: Thursday, August 22, 2019 10:52 AM
To: Tatyana Shpegel
Cc: CMS ROSFODHPP; Logue, Neal E. (CMS/CFMFFSO); Sadur, Kirk M. (CMS/CFMFFSO)
Subject: Maryland Medicare Advantage

Hi Tatyana,

We received a response back from CMS Baltimore regarding the State of Maryland's Medicare waiver. This waiver does not waive any MA laws or regulations. If you have any follow up questions regarding the waiver please submit them to the portal https://protect2.fireeye.com/url?k=16ce4b9b-4a9a52e7-16ce7aa4-0cc47adc5fa2-814694f2606ce549&u=https://dpap.lmi.org/dpapmailbox/ .

Thank you
Intake Unit

MD EMERGENCY AND POSTSTABILIZATION

Emergency Services

Md. INS Code Ann. § 15-126 (d)

(d) **Insurer prohibited from requiring insured to obtain prior authorization.** -- An entity subject to this section **may not require an insured or enrollee to obtain prior authorization** before accessing the 911 system or other State, county, or local government emergency medical services system **for an emergency medical condition**.

Poststabilization Services

§ Md. INS Code Ann. § 15-10B-06 (3)

(3) If a private review agent **requires prior authorization** for an emergency inpatient admission, or an admission for residential crisis services as defined in § 15-840 of this title, for the treatment of a mental, emotional, or substance abuse disorder, the private review agent shall:

(i) make all determinations on whether to authorize or certify an inpatient admission, or an admission for residential crisis services as defined in § 15-840 of this title, **within 2 hours after receipt of the information necessary to make the determination**; and

(ii) promptly notify the health care provider of the determination.

Competency Reviewers

Md. INS Code Ann. § 15-10B-09.1. (1)

A grievance decision shall be made based on the professional judgment of:

(1)

(i) a physician who is board certified or eligible **in the same specialty as the treatment under review;** or

(ii) a panel of other appropriate health care service reviewers with at least one physician on the panel who is board certified or eligible in the same specialty as the treatment under review;

(Also see MD. INS Code Ann. § 15-10A-05 (c) Minimum requirements for experts.)

HOW DO WE KNOW?

Maryland Board of Physicians Practitioner Profile System

General Disclaimer

This data was extracted on 08/21/2019

Winn, Daniel

License and Education

License No.:	D21250
Special License Category	
Accepts Medicaid:	No
Maintains Malpractice Ins:	No
Graduated:	1976
License Status:	**Active**
Date License Issued:	08/30/1977
License Expiration:	09/30/2021

Graduated from: UNIV OF MD SCH OF MED

Primary Practice Setting

Public Address

1501 S. Clinton Street

Baltimore
MD 21224

Postgraduate Training Program

Concentration

- Maryland General Hospital, Baltimore, MD — Internal Medicine

Specialty Board Certification

by ABMS, AOA, Royal College of Physicians and Surgeons of Canada, or the College of Family Physicians of Canada - as reported by licensee

- Internal Medicine

Self-Designated Practice Area

- Internal Medicine

Maryland Hospital Privilege Information- as reported by licensee

Licensee has not reported privilege information for the profile site.

Medical Licenses Held in Other States- as reported by licensee

- Virginia

Active Supervisee - Delegation Agreement For Core Duties

- None

Known Disciplinary Actions by any state medical board (within the past 10 years)

Summary: No actions reported during the last ten year period.

Download all Maryland Disciplinary Actions

None

Pending Board Charges

None

Malpractice (Information to be taken into consideration when reviewing a Licensee's profile)

Malpractice Judgments and Arbitration Awards (within the past 10 years)

None Reported

Malpractice Settlements

(If there are 3 or more settlements of $150,000 or greater within the past 5 years)

None Reported

Convictions for any crime involving moral turpitude

None reported by the courts

General Disclaimer

Glossary of Terms

Notice to Credential Verification Professionals

Return to Practitioners Profile Search

Medicare Advantage (Managed by the Center for Medicare & Medicaid Services)

POLICY CHALLENGES

CMS

POLICY CHALLENGE:
CENTER FOR MEDICARE AND MEDICAID SERVICES

DID YOU KNOW?

Some non-contracted MA plans are failing prepare a written explanation and send the case file to the IRE (Maximus) within 60 calendar days from the date it receives the request for a standard reconsideration.

Authority: **42 CFR §422.590 (b)(2)**

CARELESS HEALTH PLAN

See plan responsibilities per 422.590 (b)(2).

WHAT CAN YOU DO?

Vigorously defend MA plan usage of 3rd party vendors for overpayment recovery and failure to forward upheld denials to the IRE. This non-compliance issue has been previously addressed in the Best Practices and Common Findings Memo #2, from the 2012 Program Audits, where Gerard Mulcahy of CMS stated:

"We observed the following: Sponsors did not prepare a written explanation and send the case file to the IRE in a timely manner upon affirming its adverse organization determination."

Flag all MA plans failing to forward upheld denials to the IRE and run a report showing (by Plan), # of beneficiary claims where the failure occurred, and # of uncompensated dollars effected.

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

UnitedHealthcare
Medicare Solutions

EquiClaim

03/05/2018

BAXTER REGIONAL MEDICAL CENTER
624 HOSPITAL DR
MOUNTAIN HOME, AR 72653

RE: Finding for DRG Audit Review

Dear BAXTER REGIONAL MEDICAL CENTER:

As a UnitedHealthcare vendor, EquiClaim, a Change Healthcare Solution conducts reviews on their behalf, providing identification and recovery of claims overpayments. During a recent DRG Audit Review, we identified a claim that was paid incorrectly. The enclosed report outlines the specifics of our findings.

Please review the enclosed report within **30 business days** of this notice and:

- Indicate whether or not you agree with the findings.
- If you don't agree with the report findings, include documentation to substantiate the original inpatient designation.
- Sign the document.
- Return the signed document and any relevant documentation by mail to the return address listed above or fax it to (615) 238-9707.

If we don't hear from you within 30 days after the date of this letter, we'll reopen and adjust the claim. We'll provide information about your appeal and dispute rights on the Provider Remittance Advice (PRA) when the claim is adjusted.

If you have questions please contact:

Medical Review Unit
701 East 22nd Street, Suite 200
Lombard, IL 60148-5095
Phone: (868) 481-1479 Fax: (615) 238-9707
Email: equiclaim.support@changehealthcare.com

Thank you.

Sincerely,
Anthony L. Costello
Manager, Operations

Enclosure

REF NUM: URGU00567893

UnitedHealthcare
Medicare Solutions

EquiClaim

Findings Report for a Claim Review

Please review the following information about your claim and indicate whether you agree with our findings. Please return the form to us as soon as possible to the return address on the attached letter or fax it to (615) 238-9707. If you have any questions please contact EquiClaim Support at (866) 481-1479.

Patient Name: BELL,
Patient Control No:
Date of Service:
Date of Birth:
Claim Reference No:
Case ID:
Medical Record No:

HOSPITAL

Submitted DRG: 306 - CARDIAC CONGENITAL & VALVULAR DISORDERS W MCC

Principal Diagnosis Code: I350

Secondary Diagnosis Code: I5033, J449, E1151, N400, Z89611, Z7982, Z794, E785, I110, E1165

Principal Procedure Code:

Secondary Procedure Code:

CODING RECOMMENDATION

Recommended DRG: 293 - HEART FAILURE & SHOCK W/O CC/MCC

Principal Diagnosis Code: I5033

Secondary Diagnosis Code: I350, J449, E1151, N400, Z89611, Z7982, Z794, E785, I110, E1165

Principal Procedure Code:

Secondary Procedure Code:

Reviewer Rationale:

Resequence I50.33 Acute on chronic diastolic (congestive) heart failure as principal diagnosis. H&P states patient admitted for acute on chronic diastolic congestive heart failure. He has severe aortic stenosis that was previously documented in 2015. The plan was to continue with aggressive IV diuretics with Lasix, home medications. Discharge Summary states patient presented with increasing shortness of breath over last few days. When he tries to lay flat to sleep, he gets extremely short of breath and sleeps in a recliner. Past history states in 2005, he had an echocardiogram that showed severe aortic stenosis. Summary further states patient is admitted for congestive heart failure. An echocardiogram was repeated during this visit and revealed severe aortic stenosis. Patient was diuresed and his respiratory symptoms improved, however, given his significant aortic stenosis, this will continue to be a chronic issue unless intervention is performed. Cardiac enzymes were mildly elevated but was felt to be related to the congestive heart failure. Cardiology discussed aortic valve replacement and further outpatient evaluation would be performed. During the course of this hospitalization, the patient diuresed well and transitioned to oral diuretics.

Please see Official Coding Guidelines Section II for Selection of Principal Diagnosis which states the principal diagnosis is defined as that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.

Based on the physician documentation and the coding guideline, the more appropriate principal diagnosis would be I50.33 Acute on chronic diastolic (congestive) heart failure.

REF NUM: URGU00567893

UnitedHealthcare
Medicare Solutions

EquiClaim

Findings Report for a Claim Review

Patient Name: BELL
Patient Control No:
Date of Service:
Date of Birth:
Claim Reference No:
Case ID:
Medical Record No:

( ) The hospital agrees the claim didn't meet DRG 293 as determined by EquiClaim.

(X) The facility doesn't agree that the claim didn't meet DRG 293 as determined by EquiClaim and is submitting additional documentation to substantiate the coding details in the original claim.

Your signature on this form indicates you agree with our findings.

Allison Carter RN
Provider Representative Signature

3-16-2018
Date

Allison Carter
Provider Representative (print)

870-508-7414
Phone

REF NUM: URGU00567893

UnitedHealthcare
Medicare Solutions

EquiClaim

May 15, 2018

BAXTER REGIONAL MEDICAL CENTER
24 HOSPITAL DR
MOUNTAIN HOME, AR 72653

Patient Name : BELL.
Date of Service:
Date of Birth:
Case ID:

Dear Allison Carter

We are in receipt of your rebuttal letter dated April 06, 2018 regarding the recommendation to re-sequence I50.33 Acute on chronic diastolic (congestive) heart failure (CHF) as principal diagnosis. In your letter, you have indicated the principal diagnosis of Aortic Valve Stenosis I35.0 (Nonrheumatic aortic (valve) stenosis) is valid. After re-review of your rebuttal letter and supporting documentation, we are unable to revise our initial review findings. Please see below for additional rationale in supporting our initial revision.

Please note the circumstances of admission support the acute CHF as the condition chiefly responsible and focus of treatment during this admission. Although, there is known underlying severe aortic stenosis, this condition is not treated during admission but given the option to treat after discharge. This current admission focused on treating the acute CHF per admitting and discharge notes. The aortic stenosis is a chronic condition in this case and meets the definition of additional diagnosis.

Case synopsis; H&P states patient admitted for acute on chronic diastolic congestive heart failure. He has severe aortic stenosis that was previously documented in 2015. The plan was to continue with aggressive IV diuretics with Lasix, home medications. Discharge Summary patient is admitted for congestive heart failure. An echocardiogram was repeated during this visit and revealed severe aortic stenosis. Patient was diuresed and his respiratory symptoms improved, however, given his significant aortic stenosis, this will continue to be a chronic issue unless intervention is performed. Cardiac enzymes were mildly elevated but was felt to be related to the congestive heart failure. Cardiology discussed aortic valve replacement and further outpatient evaluation would be performed. During the course of this hospitalization, the patient diuresed well and transitioned to oral diuretics.

Please see Official Coding Guidelines Section II for Selection of Principal Diagnosis which states the principal diagnosis is defined as that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.

Based on the above supporting documentation and coding guidelines, our recommendation remains to re-sequence I50.33 Acute on chronic diastolic (congestive) heart failure as principal diagnosis, with a revised DRG 293.

EquiClaim appreciates your timely response and feedback in our collaborated efforts to achieve coding accuracy with compliance to nationally established coding guidelines. Please note this is a DRG validation audit, which authenticates code assignment. Coding Clinic 4th Quarter 2016 p. 147 states that clinical validation is beyond the scope of DRG (coding) validation, and the skills of a certified coder.

REF NUM: URGU00567893

UnitedHealthcare
Medicare & Retirement

EquiClaim

I am enclosing a DRG revision form for you to review and return to us. If you have any questions, please feel free to call me at 866-481-1479. You can email your response via secure email to: changehealthcare.support@changehealthcare.com or fax your response to 615-238-9707. You can also contact me directly via email at annwilliams@changehealthcare.com.

Sincerely,

Annie Williams, RHIT, CCS
DRG Field Analyst

Enclosure

REF NUM: URGU00567893

FINAL 06/01/2017

APPEAL / CLAIM PAYMENT DISPUTE COVER SHEET

Fill in the required information for each separate beneficiary case and submit the cover sheet for each case you submit. ***Do NOT submit any information outside what the cover sheet requests.*** The MAO will gather whatever additional information it needs during its efforts to investigate and resolve the case.

		Fill in required information below. Indicate option selection with "X."
1.1	Date of Submission to CMS	7/31/18
1.2	Entity Submitting Complaint	___ Provider _X_ Organization Representing Provider *(If indicated, complete the field below and submit evidence of the contractual relationship between the provider and the representing organization substantiating the organization's authority to investigate the case on behalf of the provider.)*
	Name of Organization Representing Provider	ERN/TRAF The Reimbursement Advocacy Firm
1.3	Submitter's Name	Brian Ford
	E-mail Address	brianford@ernenterprises.org
	Telephone Number	(714) 995-6900 ext. 6920
1.4	Beneficiary Name	See Attached
1.5	Beneficiary Health Insurance Claim Number (HICN)	See Attached
1.6	Provider Name	Baxter Regional Medical Center
1.7	Medicare Advantage Organization	United Healthcare
1.8	Claim Number	See Attached
1.9	Date(s) of Service	See Attached
1.10	Provider Contract Status	___ Provider Contracted with MAO during Date(s) of Service _X_ Provider NOT Contracted with MAO during DOS
1.11	Complaint Type	___ Contracted Provider Appeal _X_ Non-Contracted Provider Appeal ___ Contracted Provider Claims Payment Dispute ___ Non-Contracted Provider Claims Payment Dispute ___ Other
	Brief Summary of Complaint	UHC continuously failing to submit denied claim to Independent Review Entity within 60 days.
1.12	Provider has Communicated with MAO in Attempt to Resolve Issue	_X_ Yes ___ No *(NOTE: CMS will only review this case if the provider has already attempted to resolve it by working directly with the MAO.)*
	If Yes, Name(s) of Individual(s) at MAO	UHC provider dispute
1.13	Organization Representing Provider has Communicated	_X_ Yes

ERN
TRAF

SUMMARY OF COMPLAINT

We dispute UHC Sr.'s failure to reimburse Baxter Regional Medical Center (Baxter) for the attached claims because UHC Sr. failed to send the case to the independent entity contracted by CMS within 60 days from the date it received a request for a standard reconsideration.

- In all attached cases, Baxter timely billed UHC. Sr.
- In all attached cases, UHC Sr. denied the claim for medical necessity and lowered the level of care.
- In all attached cases, Baxter sent a reconsideration request to UHC sr.
- In all attached cases, UHC Sr. upheld their denial and failed to send the case to the IRE in accordance with **42 CFR §422.590.**

TO DATE, UHC SR. HAS FAILED TO FORWARD BAXTER'S CASES TO AN INDEPENDENT REVIEW ENTITY AS REQUIRED BY FEDERAL LAW.

The above referenced claims are for emergency or medically necessary post-stabilization care or both. In accordance with **42 CFR §422.590** which states:

> **(b)(2) If the MA organization affirms, its adverse organization determination, it must prepare a written explanation and sent the case file to the independent entity contracted by CMS no later than 60 calendar days from the date it receives the request for a standard reconsideration.**
>
> **(c) If the MA organization fails to provide the enrollee with a reconsidered determination within the timeframes specified in (b), this failure constitutes an affirmation of its adverse organization determination, and the MA organization must submit the file to the independent entity in the same manner as described under paragraph (b)(2).**

Under existing federal law, a reconsideration is defined by **42 CFR §422.580** as:

> **A review of an adverse organization determination, the evidence and finding upon which it was based, and any other evidence the parties submit.**

Further **42 CFR §422.590 (g)** states:

> **(1) A person or persons who were not involved in making the organization determination must conduct the reconsideration.**
> **(2) When the issue is the MA organization's denial of coverage based on a lack of medical necessity (or any substantively equivalent term used to describe the concept of medical necessity), the reconsidered determination must be made by a physician with expertise in the field of medicine that is appropriate for the services at issue. The physician making the reconsidered determination need not, in all cases, be of the same specialty or subspecialty as the treating physician.**

In all attached cases, Baxter received a denial on their claim from UHC Sr. which alleges that the Medicare beneficiary should or could have been treated at a lower level of care. In all attached cases, UHC recouped the amount UHC Sr. initially reimbursed to Baxter. In all attached cases, Baxter sent UHC Sr. a reconsideration request to reconsider and overturn their denial. In all attached cases, UHC Sr. upheld their denial for medical necessity and failed to send the case to the independent entity (IRE) contracted with Medicare for review within the 60 days. Instead, Baxter sent another appeal to UHC Sr. as a result of failing to send the cases to the IRE. In all attached cases, UHC Sr. improperly denied the second appeal as the case should been sent to the IRE for further review and currently remains non-compliant and violation of federal Medicare law.

We respectfully request CMS Region 6 to review this complaint against UHC Sr. and require their compliance in accordance with federal Medicare Advantage laws.

Respectfully,

Brian Ford, J.D.
Claims Compliance Auditor II
ERN/TRAF

Tel: (714) 995-6900 Ext. 6920 **Fax:** (714) 995-6901
Email: brianford@ernenterprises.org

Enclosure: Exhibit A — Claims Spreadhseet
Exhibit B — UHC initial and final determinations
Exhibit C — Baxter reconsideration

CISCO

Secured Message

Reply ReplyAll

From: Dobbins, Eric D
To: Brian Ford <brianford@ementerprises.org>
CC: Ed Norwood <ednorwood@ementerprises.org>
Date: 08/31/2018 11:20:12 AM PDT
Subject: Secure Message from eric.dobbins@uhc.com
Attachments: Baxter Claims Issue.xlsx

Hi Brian.

In regards to CMS case C18027585222, Optum Issue Management responded to me on 8/24/18 and attached you will find the list of claims with their new appeal numbers. Two of the claims already appear to have been paid and I included the dates. Two of the claims I had to send back to Optum Issue Management to review because they were missing the claims numbers. When I receive the new claim numbers for those, I will send to you. Please let me know if you have any questions.

Thanks so much,

Eric Dobbins | CTM Coordinator, M&R | UnitedHealth Group
eric.dobbins@uhc.com | Roanoke, Virginia

ServiceHEROES 2017

—SecureDelivery—

From: Brian Ford [mailto:brianford@ementerprises.org]
Sent: Wednesday, August 29, 2018 7:12 PM
To: Dobbins, Eric D
Cc: Ed Norwood
Subject: RE: Baxter UHC claims spreadsheet email 1 of 2

Good evening Mr. Dobbins,

As you continue reviewing our complaint, you are reminded that CMS requires their MAO's to resolve complaints within 20 business days in accordance with:

CMS Casework Management Protocol Section 1(E):

> The standard timelines and procedures for resolving Regional Office CMS Issue complaints are provided below. Complaints that have been: 1) automatically flagged in CTM as a CMS Issue as outlined in Section

Ed Norwood

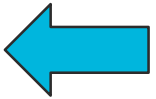
From: Dill, Gregory R. (CMS/CFMFFSO) <Gregory.Dill@cms.hhs.gov>
Sent: Tuesday, April 02, 2019 4:13 PM
To: Daniel Muhlbach
Cc: Kortzeborn, Catherine (CMS/CFMI
Subject: CMS Complaint - Baxter Regional

Dear Mr. Muhlbach:

Thank you for your organization's continued interest in ensuring that Medicare beneficiaries have access to Medicare Advantage benefits through the plan sponsors with which CMS contracts to deliver necessary and appropriate health care services.

CMS has investigated your concerns into UnitedHealthcare's (UHC) practices with respect to full and partial recoupment of claims paid to Baxter Regional Medical Center ("Baxter"), which ERN represents. After reviewing detailed documentation of these cases, CMS finds UHC to be in full compliance with CMS requirements for processing non-contracted provider appeals and non-contracted provider payment disputes.

Specifically, CMS staff reviewed the four Complaint Tracking Module (CTM) cases you brought to CMS's attention. They involved eight Medicare beneficiaries and ten Baxter claims. Of the ten claims, one was partially recouped (beneficiary initials: EF). UHC provided the appropriate provider dispute language to Baxter and has been in communication with the provider about that claim, which remains partially recouped. You may review CMS guidance on payment disputes to non-contracted providers, which is detailed in the 2015 update to the MA Payment Guide for Out of Network Payments: https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/providerpaymentdisputeresolution.html
UHC fully recouped the remaining nine claims and provided the required Medicare appeals language in each of the remittance notices. Baxter appealed all nine full recoupments. In two cases (RB and KW), Baxter filed its appeals late. In one cases (CW), Baxter failed to submit the required Waiver of Liability. UHC dismissed all three appeals, and the payments remain fully recouped. For the remaining six full recoupments (CB, HC, TC, TC, KW, and LWP), UHC processed Baxter's timely and complete appeals, reversed its recoupment, and paid the claims in full.



Again, CMS appreciates and shares you interest in the appropriate administration of the Medicare Advantage program. We believe that ERN can be a valuable partner in communicating Medicare Advantage rights and processes to the provider community. As you work with these entities, please ensure that they are aware of and then avail themselves of the appropriate appeals and payment dispute processes and work closely with the Medicare Advantage plan sponsor through those avenues available to them. Thank you for your collaboration on this.

Respectfully,

Greg Dill

Gregory R Dill, PharmD, MPH
CAPT, USPHS
Regional Administrator
San Francisco Regional Office
Centers for Medicare and Medicaid Services

POLICY CHALLENGE:
CENTER FOR MEDICARE AND MEDICAID SERVICES

DID YOU KNOW?

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

Authority: **42 CFR §422.113**

FEDERAL REGISTER VOLUME 63, NUM 123:

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

WHAT CAN YOU DO?

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

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

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

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

CHAPTER 4 MEDICARE MANAGED CARE MANUAL

when:

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

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

20.5.3 — End of Post-Stabilization

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

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

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

(WOL) under the subpart M appeals process, but rather must follow the terms of his or her provider/plan contract.

individual physician contracted w/ SCAN (MA)

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

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

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

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

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

160 — *Beneficiary Protections Related to Plan-Directed Care*

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

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

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

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

Notes to Table II:

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

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

10.16 – Medical Necessity

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

Every MA plan:

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

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

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

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

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

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

20 — Ambulance, Emergency, Urgently Needed and Post-Stabilization Services

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

20.1 — Ambulance Services

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

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

20.2 — Definitions of Emergency and Urgently Needed Services

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

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

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

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

Emergency services are covered inpatient and outpatient services that are:

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

- Internal CMS communication between Kimberly August, Tamara Harvey, and Aimee Reich regarding the applicability of the Medicare Managed Care Manual for contracted versus non-contracted providers.

In addition to the substantial delay in responding to this FOIA request consistent with **45 CFR Part 5 (Freedom of Information Regulations)**, CMS did not provide any documentation that satisfies the above requests. Further, pertaining to items I-IV, CMS did not indicate which documents relate to the above requests, nor did they state to those unanswered, "No records responsive to this request." (See Exhibit A – FOIA Response Letter.)

As you know, federal law requires FOIA requests to be fulfilled within 20 business days. As it appears that none of the provided documents address the requested information, this FOIA request has not been concluded and is now **120 business days past due.**

II. THE REGULATIONS PRESCRIBED UNDER 42 CFR PART 422 APPLY TO BOTH CONTRACTED AND NON-CONTRACTED PROVIDERS.

Included in CMS' response to our July 9, 2018 FOIA request is an internal CMS email which attempts to misconstrue a contracted provider's rights prescribed under **42 CFR Part 422, Subpart C, Sections 100 - 134**. As stated in this email, CMS maintains the position that "these rules and appeal rights are for enrollees and out-of-network providers – not ***contracted*** providers."

While Subpart M Appeal rights (422 CFR §560-626) may not apply to contracted providers, the legislative intent of **42 CFR Part 422, Subpart C - Benefits and Beneficiary Protections (§§ 422.100 - 422.134)** (which includes §422.113) does, as this Subpart includes specific details governing the role of contracted providers within a MAO. For instance, **42 CFR §422.112(a)(1)(i)** states that Medicare Advantage Organizations must "*maintain and monitor a network of appropriate providers that is **supported by written agreements** and is sufficient to provide adequate access to covered services to meet the needs of the population served.*" Further, **42 CFR §422.112(a)(9)** states the MAOs must also "*provide coverage for ambulance services, emergency and urgently needed services, and **post-stabilization care services in accordance with §422.113***."

As the above cited regulations expressly define the relationship between MAOs and contracted providers, including the provision of statutory payment obligations pursuant to **42 CFR §422.133**, it is improbable that this section of law is only intended to apply to non-contracted providers.

In addition, SCAN's application of Traditional Medicare regulations to support payment of claims for Medicare Advantage claims is inappropriate. Please note, with Traditional Medicare an authorization is not required and if there is any retrospective review, the provider protects themselves by informing the patient prior to services that Medicare may not cover a service and not pay for that service and have the patient sign an Advanced Beneficiary Notice of Non-coverage ("ABN") protecting the hospital if Medicare should deem an inpatient admission or post-stabilization services not medically necessary.

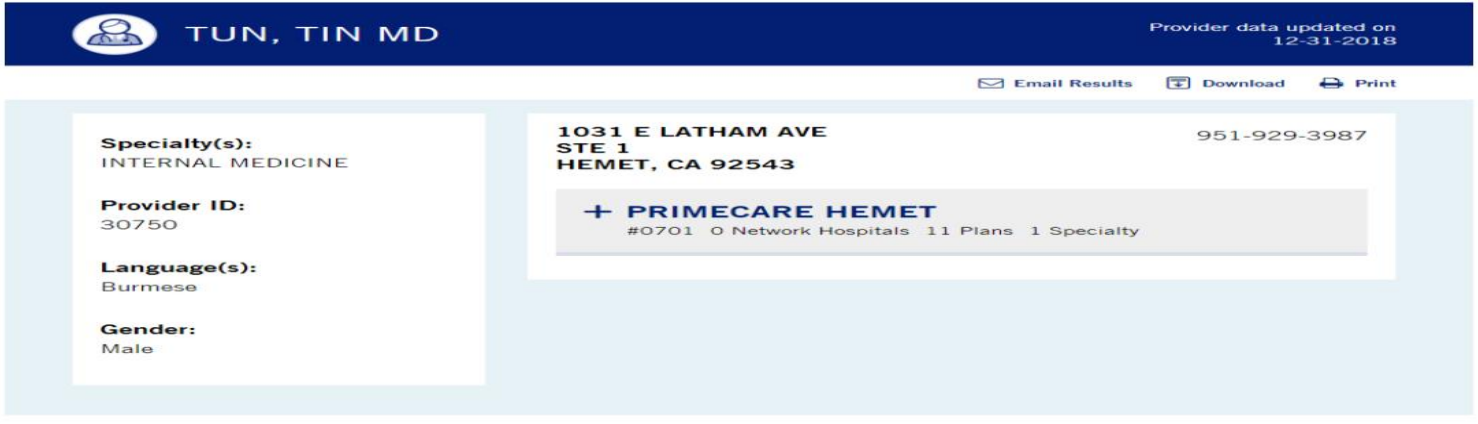
The CMS publication titled "*Improper Use of Advance Notices of Non-coverage*" dated May 5, 2014 provides further evidence that the statutory timeframes to approve or deny post-stabilization services apply to both contracted and non-contracted providers.

In its guidance, CMS states that an Advance Beneficiary Notice of Non-coverage (ABN) is not to be used by MAOs because "a Medicare Advantage enrollee has always had the right under the statute and regulations to an advance determination of whether services are covered prior to receiving such services." (See Exhibit B – Improper Use of ABNs.) From this verbiage and in the context of post-stabilization services, a logical inference would be that the right to an advance determination (e.g. pre-approval) of covered services is prescribed and protected by **42 CFR 422.113(c)(2)**. If these regulations did not apply to contracted MA providers, there would be no way of obtaining an advance determination of covered services prior to rendering care, and thus eliminating a provider's ability to notify MA beneficiaries receiving post-stabilization services of potential financial liability.

III. PER CMS POLICY, CONTRACTED PROVIDERS ARE CONSIDERED AGENTS OF THE PLAN.

Per CMS commentary included in its response to our July 9, 2018 FOIA request, "When a treating physician is contracted with the plan, CMS views him or her **as the plan** for purposes of our rules and guidance." (See Exhibit C – FOIA Response, pg. 2) Thus, as CMS considers a contracted provider to be a plan provider, the contracted provider's determination constitutes a "favorable organization decision."

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



Who are the treating physicians or provider—are they contracted with the MAO?

Emergency Services

MEDICARE HMO – ***42 CFR § 422.113 (b)(2)*** The MA organization is financially responsible for emergency and urgently needed services--

(i) Regardless of whether the services are obtained within or outside the MA organization;

(ii) Regardless of whether there is prior authorization for the services.

(A) Instructions to **seek prior authorization for emergency or urgently needed services may not be included** in any materials furnished to enrollees (including wallet card instructions), and enrollees must be informed of their right to call 911.

(B) Instruction to **seek prior authorization before the enrollee has been stabilized may not be included** in any materials furnished to providers (including contracts with providers);

(iii) In accordance with the prudent layperson definition of emergency medical condition **regardless of final diagnosis**;

Emergency Services

(3) Stabilized condition. The physician treating the enrollee must decide when the enrollee may be considered stabilized for transfer or discharge, **and that decision is binding on the MA organization**.

Poststabilization Services

MEDICARE HMO - 42 CFR 422.113 (c)(2) MA organization financial responsibility. The MA organization—

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

Poststabilization Services

(ii) Is financially responsible for post-stabilization care services obtained within or outside the MA organization that are not pre-approved by a plan provider or other MA organization representative, but administered to maintain the enrollee's stabilized condition **within 1 hour of a request** to the MA organization for pre-approval of further post-stabilization care services;

Poststabilization Services

(iii) Is financially responsible for post-stabilization care services obtained within or outside the MA organization that are not pre-approved by a plan provider or other MA organization representative, but administered to maintain, improve, or resolve the enrollee's stabilized condition if—

(A) THE MA ORGANIZATION DOES NOT RESPOND TO A REQUEST FOR PRE-APPROVAL WITHIN 1 HOUR;

(B) The MA organization cannot be contacted; or

Poststabilization Services

(c) The MA organization representative and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultation. In this situation, the MA organization must give the treating physician the opportunity to consult with a plan physician and **the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in Sec. 422.113(c)(3) is met**;

Poststabilization Services

(3) End of MA organization's financial responsibility. The MA organization's financial responsibility for post-stabilization care services **it has not pre-approved** ends when—

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

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

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

(iv) The enrollee is discharged (Emphasis added).

MA Organizations: Their Financial Responsibility to You

Source:
42 CFR §422.113 (c)(2-3)

MA Organizations are financially responsible for poststabilization care services when…

1. …they have been pre-approved by a plan provider or MAO.

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

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

MA Organizations' financially responsibility ends when…

1. …at the treating facility

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

…OR through transfer

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

3. …OR the enrollee is discharged

OBS VS. INPT. CASE STUDY

FINAL 06/01/2017

CASE STUDY

APPEAL / CLAIM PAYMENT DISPUTE COVER SHEET

Fill in the required information for each separate beneficiary case and submit the cover sheet for each case you submit. ***Do NOT submit any information outside what the cover sheet requests.*** The MAO will gather whatever additional information it needs during its efforts to investigate and resolve the case.

		Fill in required information below. Indicate option selection with "X."
1.1	Date of Submission to CMS	7.25.17
1.2	Entity Submitting Complaint	____ Provider _X___ Organization Representing Provider *(If indicated, complete the field below and submit evidence of the contractual relationship between the provider and the representing organization substantiating the organization's authority to investigate the case on behalf of the provider.)*
	Name of Organization Representing Provider	ERN/TRAF
1.3	Submitter's Name	Rose Trochez
	E-mail Address	rosetrochez@ernenterprises.org
	Telephone Number	714.995.6900 ext 6939
1.4	Beneficiary Name	MARTINEZ,C
1.5	Beneficiary Health Insurance Claim Number (HICN)	
1.6	Provider Name	Hemet Valley Medical Ctr.
1.7	Medicare Advantage Organization	MOLINA SR
1.8	Claim Number	Not listed
1.9	Date(s) of Service	
1.10	Provider Contract Status	___x_ Provider Contracted with MAO during Date(s) of Service ___ Provider NOT Contracted with MAO during DOS
1.11	Complaint Type	___x_ Contracted Provider Appeal ___ Non-Contracted Provider Appeal ____ Contracted Provider Claims Payment Dispute ____ Non-Contracted Provider Claims Payment Dispute ____ Other
	Brief Summary of Complaint	Patient arrived at the ER, Hemet attempted to make notification to Molina SR. of a possible inpatient admission. Molina failed to respond to the 1 hour allotted per Title 42. 422.113, patient was admitted due to no response from Molina.
1.12	Provider has Communicated with MAO in Attempt to Resolve Issue	_X_ Yes ____ No *(NOTE: CMS will only review this case if the provider has already attempted to resolve it by working directly with the MAO.)*

	If Yes, Name(s) of Individual(s) at MAO	GENERIC RESPONSE
1.13	Organization Representing Provider has Communicated with MAO in Attempt to Resolve Issue	_x Yes ____ No *(NOTE: CMS will only review this case if the intervening organization has already attempted to resolve it by working directly with the MAO.)* ____ N/A (No intervening organization involved.)
	If Yes, Name(s) of Individual(s) at MAO.	GENERIC RESPONSE

Dr. James Cruz
Utilization Management
300 Ocean Gate # 200
Long Beach, CA 90802

August 11, 2017

Centers for Medicare & Medicaid Services (CMS)
90 – 7th St
Suite 5-300
San Francisco, CA 94103-6706

Re: CTM Complaint ID: C1702693818,

To Whom It May Concern:

The case has been reviewed. The following documents were reviewed for this case:

1. Member's medical record
2. CMS Complaint ID C1702693818
3. Provider Appeal/Claim Payment Dispute Cover Sheet dated 6/1/17
4. Hemet Valley Medical Center Medical Record (22 total pages, including member face sheet, admission history and physical, operative report, Lab test results, MD progress notes).

The Hemet Valley Medical Center has filed a grievance regarding this case. The hospital, in the Provider Appeal/Claim Payment Dispute Cover sheet, states the following:

Patient arrived at the ER, Hemet attempted to make notification to Molina SR. of a possible inpatient admission. Molina failed to respond to the 1 hour allotted per Title 42. 422.113. Patient was admitted due to no response from Molina.

Per the Provider Appeal/Claim Payment Dispute Cover sheet document, the hospital did not file a medical necessity complaint. Therefore, Molina concludes the facility does not dispute this case on the basis of medical necessity. Regarding the Title 42 422.113 regulation and the allegation by the hospital that Molina did not return the hospital's notification call within a one hour time frame, the medical records submitted by Hemet Valley Medical Center to Molina do not support the allegation. The medical records submitted to Molina did not show evidence of any attempted communication between Hemet Valley Medical Center and Molina prior to the member being admitted. The dispute by Hemet Valley Medical Center is without merit.

Sincerely,

Dr. James Cruz

ENCLOSURE

ERN
TRAF

March 16, 2018

CASE SUMMARY

Provider; Hemet Valley Medical Center (HVMC)
Patient Name: **C** **Martinez**
D.O.B.:
Policy #:
D.O.S.:
Account #:

Dear Ms. Munoz:

Thank you for reaching out to my office regarding the above member.

I have reviewed the attached letter dated August 11, 2017, and signed by Dr. James Cruz.

We dispute the comments made by Dr. Cruz as his statements are inaccurate (We we will also forward our rebuttal to CMS.)

It is apparent Dr. Cruz was unaware of the events that had taken place prior to post-stabilization services requested by the Primary Treating Physician and provided at HVMC.

In Dr. Cruz's correspondence, he states *"Patient arrived at the ER, HVMC attempted to make inpatient notification to Molina Sr. of a possible inpatient admission and Molina failed to respond within 1 hour per CFR 422.113."*

Per his correspondence to CMS, he further states ***"There was nothing HVMC submitted to support the allegation of Molina's failure to respond*** *and Molina's violation of CFR 422.113."*

We respectfully dispute his response. Upon stabilization of the emergency service, HVMC faxed four requests for inpatient authorization for post-stabilization services to Molina and Vantage Medical.

- **On 3/29/16 Vantage responded with a tracking number #383316.**
- **On 3/29/16, Molina responded with a tracking# 1608902739**

At no time:

- **Did either entity authorize services within one hour of the request. (The tracking number constitutes that contact was made, even if it is not an authorization (See Attached-Fax confirmations).**
- **Did either entity request a transfer of the patient nor attempted to assume care of the patient/member.**

We are unsure what Molina assumed would happen to the patient without a timely response (especially since the PTP deemed the patient appropriate for admission in order to cure and relieve the medical issue.)

Here, Molina is attempting to act as traditional Medicare and perform retro reviews, yet they are a Medicare Advantage plan, and is governed by part 422 (which supersedes Medcare law.)

Molina is in violation of:

42 CFR 422.113 (c)

> (2)(iii) **(A) The MA organization does not respond to a request for pre-approval within 1 hour;**
>
> ***(B) The MA organization cannot be contacted; or***
>
> ***(C) The MA organization representative and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultation. In this situation, the MA organization must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in § 422.113(c)(3) is met; and***
>
> ***(iv) Must limit charges to enrollees for post-stabilization care services to an amount no greater than what the organization would charge the enrollee if he or she had obtained the services through the MA organization. For purposes of cost sharing, post-stabilization care services begin upon inpatient admission.***
>
> ***(3) End of MA organization's financial responsibility. The MA organization's financial responsibility for post-stabilization care services it has not pre-approved ends when –***
>
> ***(i) A plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care;***
>
> ***(ii) A plan physician assumes responsibility for the enrollee's care through transfer;***
>
> ***(iii) An MA organization representative and the treating physician reach an agreement concerning the enrollee's care; or***
>
> ***(iv) The enrollee is discharged.***

Please order them to release the federal funds due the Medicare beneficiary.

Respectfully,

Ryan Cauley
Utilization Management
300 Ocean Gate # 200
Long Beach, CA 90802

March 22, 2018

Centers for Medicare & Medicaid Services (CMS)
90 – 7th St
Suite 5-300
San Francisco, CA 94103-6706

Re: CTM Complaint ID: C18027171597

To Whom It May Concern:

Molina Healthcare takes issue with the legal basis for HVMC's complaint. In their complaint, HVMC makes the very critical mistake of taking a portion of a regulation out of context to support their position. HVMC claims Molina is in violation of CFR 422.113 stating only "[t]he MA organization does not respond to a request for pre-approval within 1 hour [.]" Had HVMC included the entire citation it would become clear that this situation only applies to services that are "administered to **maintain, improve, or resolve** the enrollee's stabilized condition [.]"(Emphasis added). Please see the full citation below.

Per CFR 422.113 (c)(1), post-stabilization services are provided in order to either maintain the stabilized condition or improve/resolve the enrollee's condition. It is, and always has been, Molina's position that an inpatient admission was not necessary to either maintain or improve the enrollee's condition. Moreover, HVMC has not disputed Molina's decision by filing a medical necessity complaint, as is required to raise this issue. Therefore, since Molina determined the services were not medically necessary to maintain, improve, or resolve the enrollee's stabilized condition, the one-hour rule cited by HVMC would not apply here.

If HVMC's understanding of the law was correct then it would significantly undermine MAOs' ability to do their job effectively because they would no longer have much ability to control inpatient admissions following emergency room visits. One hour is hardly enough to receive a fax, perform a competent clinical review, and respond to the hospital. If the failure to respond within that timeframe meant that the hospital's determination was automatically correct it would very likely lead to abuses by hospitals. That is why Molina's interpretation of the law seems to align more closely with what we can reasonably assume the drafters intended, and what would make the best public policy. Nevertheless, Molina responded within only hours of HVMC's fax requesting clinical information, hardly an unreasonable amount of time.

Therefore, since HVMC is not disputing Molina's medical necessity determination, and since the "1 hour rule" referenced by HVMC would not apply to these circumstances given Molina's clinical review determination, there are no further issues that need to be considered. Accordingly, Molina respectfully requests that HVMC's claims be dismissed.

CFR 422.113

(2)MA organization financial responsibility. The MA organization -

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

(ii) Is financially responsible for post-stabilization care services obtained within or outside the MA organization that are not pre-approved by a plan provider or other MA organization representative, but administered to maintain the enrollee's

stabilized condition within 1 hour of a request to the MA organization for pre-approval of further post-stabilization care services;

(iii) Is financially responsible for post-stabilization care services obtained within or outside the MA organization that are not pre-approved by a plan provider or other MA organization representative, but administered to maintain, improve, or resolve the enrollee's stabilized condition if -

(A) The MA organization does not respond to a request for pre-approval within 1 hour;

(B) The MA organization cannot be contacted; or

(C) The MA organization representative and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultation. In this situation, the MA organization must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in § 422.113(c)(3) is met; and

(iv) Must limit charges to enrollees for post-stabilization care services to an amount no greater than what the organization would charge the enrollee if he or she had obtained the services through the MA organization. For purposes of cost sharing, post-stabilization care services begin upon inpatient admission.

Sincerely,

RYAN T. ESQ.

ENCLOSURE

ERN
TRAF

March 28, 2018

Ryan Cauley
Utilization Management
300 Ocean Gate # 200
Long Beach, CA 90802

Re: CTM Complaint ID: C18027171597,

Good morning Mr. Cauley:

We are in receipt of your correspondence dated March 22, 2018, addressed to Centers for Medicare & Medicaid Services (CMS) (a copy was forwarded to ERN).

In your correspondence you state: *"HVMC claims Molina is in violation of CFR 422.113" stating only "the MA organization does not respond to a request for pre-approval within 1 hour."*

You then state *"Molina responded within only hours of HVMC's fax requesting clinical information, hardly an unreasonable amount of time."*

Our position is clear. The one-hour timeframe is to benefit the patient, not the MAOs' nor the providers. Patients need access to care quickly, and this regulation holds both parties accountable ("hardly an unreasonable amount of time") to avoid catastrophic consequences.

HVMC' interpretation of the law is accurate, and ERN agrees. It appears Molina is interpreting the law to benefit the MAO. Even if Molina does not feel it provides enough time, there is no statutory authority that exempts Molina from adhering to it.

Molina must perform according to the requirements of the law which is "1 hour." This is also burdensome on the providers, yet they still send requests for authorizations diligently.

You next state; *"...Had HVMC included the entire citation it would become clear that this situation only applies to services that are "administered to **maintain, improve**, or **resolve** the enrollee's stabilized condition."*

Please advise why a Primary Treating Physician would admit a patient for poststabilization services and care other than **to maintain, improve or resolve the stabilized condition?**

If Molina disapproved of the care, Molina failed to attempt transfer prior to discharge of the patient. If Molina responded within hours, we are unaware of any intent to transfer the patient. The patient was admitted from 3/28-4/2/2018, and I do not see a transfer request or disapproval of care prior to discharge.

As you are aware under 42 CFR §422.113 states:

(2)MA organization financial responsibility. The MA organization -

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

(ii) Is **financially responsible** for post-stabilization care services obtained within or outside the MA organization **that are not pre-approved by a plan provider or other MA organization representative**, but administered to maintain the enrollee's stabilized condition within 1 hour of a request to the MA organization for pre-approval of further post-stabilization care services;

(iii) Is financially responsible for post-stabilization care services obtained within or outside the MA organization that are not pre-approved by a plan provider or other MA organization representative, but administered to maintain, improve, or resolve the enrollee's stabilized condition if -

(A) The MA organization does not respond to a request for pre-approval within 1 hour;

(B) The MA organization cannot be contacted; or

(C) The MA organization representative and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultation. In this situation, the MA organization must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in § 422.113(c)(3) is met; and

(iv) Must limit charges to enrollees for post-stabilization care services to an amount no greater than what the organization would charge the enrollee if he or she had obtained the services through the MA organization. For purposes of cost sharing, post-stabilization care services begin upon inpatient admission.

(3)End of MA organization's financial responsibility. The MA organization's financial responsibility for post-stabilization care services it has not pre-approved ends when -

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

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

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

(iv) The enrollee is discharged.

Here, Molina failed to assume care of the patient within one (1) hour, which means their financial responsibility ended when the beneficiary was discharged. Therefore, the federal funds are due to the emergency provider.

Please be advised that ERN represents many hospital facilities with similar failures by Molina who performs unlawful retro reviews as if they are Traditional Medicare which is improper.

A copy of this correspondence is being forwarded to CMS. If Molina would like to engage in a dialogue of how to resolve these claims where contact was made, and a response from Molina was not received or received untimely, we would be open for discussion.

Respectfully,

Rose Trochez, CMRS
Project Manager
714. 995.6900 Ext.6939
714.995.6901 Fax

Dr. Tyler Jung
Utilization Management
300 Ocean Gate # 200
Long Beach, CA 90802

April 9, 2018

Centers for Medicare & Medicaid Services (CMS)
90 – 7th St
Suite 5-300
San Francisco, CA 94103-6706

Re: CTM Complaint ID: CTM C18027171597,

To Whom It May Concern:

The case has been reviewed by the Molina Healthcare of California Chief Medical Officer, Dr Tyler Jung. After careful consideration and applying applicable clinical criteria and judgment the denial in question has been overturned. The following documents have been reviewed for this case:

1. CMS Provider Complaint C1802733144 dated 3/15/2018
2. Medical Records

This is a 74 year old Molina member with a history of hypertension, rheumatoid arthritis, who presented to the emergency department with a day history of vomiting and diarrhea. Her pain radiated to the back. Her vitals were stable; however, she did have a white count of 33.8, and renal insufficiency with creatinine of 2.79. Her CT scan showed diverticulosis. Our member was admitted and placed on antibiotics, kept without anything by mouth, and started on intravenous fluids.

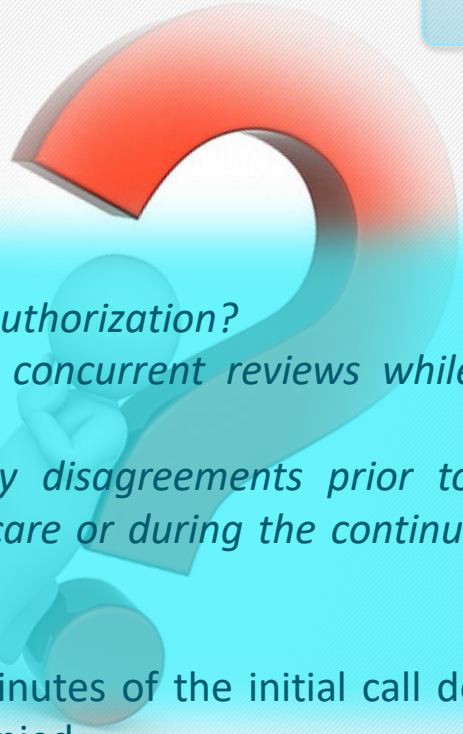
By day 1 her white count was still 20.8, but her renal function was improving. She had one positive blood culture which later was thought to be a contaminant. Our member continued on antibiotics. Our member had an EGD which shoed ulcerative mid distal esophagitis, and erosive antral gastritis. Based on InterQual criteria of 2016 our member did fail to meet criteria for gastrointestinal bleeding and acute level of care; however, the composite of her symptoms and findings are open to medical judgment. Thus, after careful deliberation and reviewing medical records, I will overturn the denial for acute level of care based on medical judgment.

Sincerely,

Dr. Tyler Jung

ENCLOSURE

Questions



ASK YOURSELF:

- *Has the plan issued a tracking number versus an authorization?*
- *Did the plan receive faxed clinicals to conduct concurrent reviews while the patient was still hospitalized?*
- *Did the plan fail to notify the hospital of any disagreements prior to the commencement of poststabilization services and care or during the continuation of the same?*

Any failure to issue an authorization within 60 minutes of the initial call deems the services authorized and payment cannot be denied.


ERN
NCRA
Can I
process this?

PREVENTING
DENIALS

What if you could prevent denials?

Our Providers

Health Plan authorization delays

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

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

www.erntraf.org

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

- ***Convert tracking and reference numbers to authorization numbers prior to billing to avoid backend denials.***
- ***Challenge improper requests for medical records to review services prior to the issuance of an authorization.***
- ***Fight concurrent or continuity of care denials and initiate a notice of disagreement of care to trigger the plan's responsibility to assume care for patient under Health and Safety Code §1371.4 (d) and 42 CFR Part 422.***
- ***Expedite transfer of a patient to ensure continuity of care.***
- ***Challenge a plan's refusal to conduct retrospective review for unauthorized medically necessary services (provided after normal business hours, or when the patient's insurance information was not provided, etc.)***
- ***Challenge improper denials of care after patient is discharged under Title 28, Part 422 or any other applicable regulation.***
- ***Challenge medical necessity, reductions of level of care and disputed health care services under state and federal laws***
- ***Fight prospective care (pre-certification) denials.***

CALL TO GET STARTED:

(714) 995-6900 EXT. 6934

Appeal Submission Timeframe Matrix

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

JURISDICTION:	Medicare Advantage	VA	ERISA
TIMEFRAME:	**60 DAYS** from the date of the notice of the organization determination	**1 YEAR** of an adverse benefit decision	**180 DAYS** following receipt of a notification of an adverse benefit determination
SOURCE:	42 C.F.R. §422.582(b)	38 U.S. CODE § 7105	29 C.F.R. § 2560.503-1(h)(3)

Medicare Advantage Appeals Timeline

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

To request a reconsideration

42 CFR 422.582(a-b)

To uphold the service denial and send to an IRE

42 CFR 422.590(a)(2)

To effectuate a payment reconsidered determination

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

METHODIST HOSPITAL – INSURANCE VERIFICATION WORKSHEET

*****PLANS HAVE 30 MINUTES (CA-HMOS-H&S CODE 1262.8/1371.4 (j)) AND 60 MINUTES (MA-42 CFR 422.113) TO RESPOND TO A REQUEST FOR AUTHORIZATION.*****

PRE-ADMIT _____ IN-HOUSE ROOM# _____ PRIMARY _____ SECONDARY _____

PATIENT INFORMATION

Patient Name _____

D.O.B. _____ SSN _____

Admit Date _____

Account # _____ MRUN _____

PATIENT TYPE

MED_____ SURG_____ TCU _____ REHAB_____ OB_____

SSO _____ SSP _____ OPS_____

Scheduled/Elective _____ ER _____ Direct/Urgent_____

DX_____

INSURANCE/HOME PLAN

Insurance Name _____

IPA _____

State _____ Self-funded ERISA Plan **YES/NO**

If Self-funded, Employer Name _____

PPO _____ EPO _____ HMO _____ POS _____

Effective Date _____ Subscriber _____

ID# _____ Group # _____

Need LOA for non-contracted plan? **YES/NO**

PROCEDURE _____

Capitated Hospital _____

CLAIMS ADDRESS

Name _____

Address _____

City _____

BENEFITS

VERIF W/ _____ PHONE # _____

Deductible $_____ Co-Pay $ _____ Ins Pays _____%_ C/R to $ _____ Out of Pocket Max then _____%

In Network Deductible Met? **YES/NO** Remaining Ded $ _____ Lifetime Max $ _____

Out of Network Deductible Met? **YES/NO** Remaining Ded $ _____ Lifetime Max $ _____

HMO – PLAN/IPA AUTH#_____ Per _____

PHONE # _____ FAX # _____

INS TRACKING # _____ PER _____ @ (_____) _____

WORKERS COMP

Date of Injury _____ Claim # _____

ADJ _____ Phone # _____

PPO – PRE-CERT REQUIRED? YES / NO

PRE-CERT UR NAME _____

Spoke With _____ Pre-Cert Phone# _____

Reference # _____ Days Allowed _____

Case Manager Name _____ Phone # _____

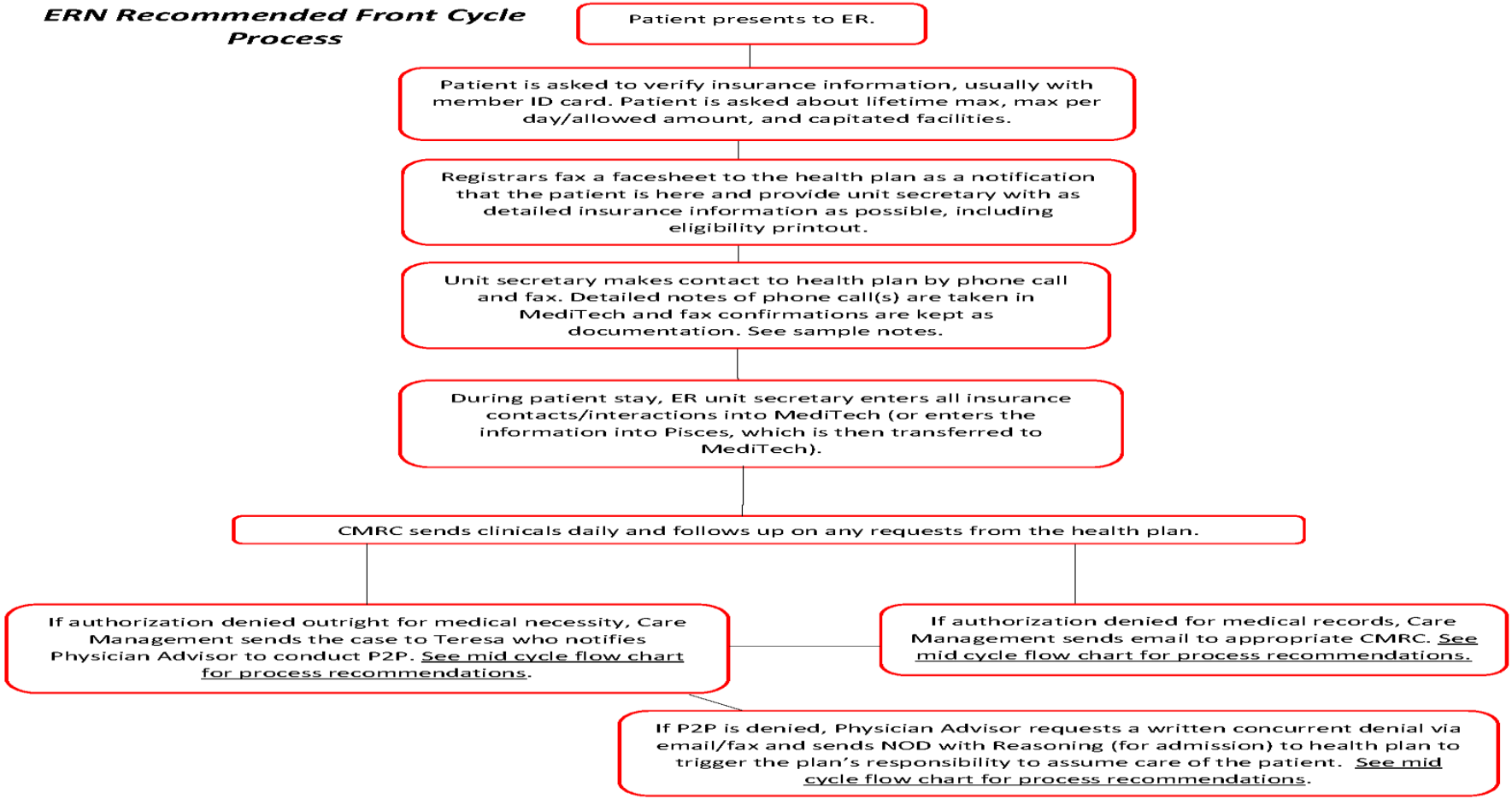
Notes/Comments _____

VERIFIED BY & DATE: _____

Table of Contents

3. Flow Charts and Processes

ERN Recommended Front Cycle Process



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

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

ERN
NCRA

REQUEST FOR AUTHORIZATION TO PROVIDE POSTSTABILIZATION SERVICES

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

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

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

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

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

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

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

MAO CONTRACTED WITH TREATING PHYSICIAN

TO:	FROM: JOE COMPLIANCE
FAX:	PAGES:
PHONE:	DATE:
RE: **MAO CONTRACTED WITH TREATING PHYSICIAN**	CC:

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

Patient Admitted On (date/time), XXXXXX ("Health Plan") was notified that the above patient is stable after being treated in the ER and requires post-stabilization care. On (date/time) we received a denial from Health Plan stating that further poststabilization care at our hospital has been denied. **However, it has come to our attention that the treating physician is contracted with your plan**. Please be advised that when a treating physician is contracted with an MAO, CMS views him or her "as the plan" for the purposes of their rules and guidance. Here, the inpatient admission order by your contracting treating physician constitutes a favorable determination. Please issue immediate authorization to our hospital within sixty (60) minutes as required by 42 CFR §422.113 (c)(2) to preserve the beneficiary's continuity of care.

Please contact one of the following Case Managers to issue immediate authorization.

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

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

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

NOTIFICATION OF MAO DISAGREEMENT OF CARE

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

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

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

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

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

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

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

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

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

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

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

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

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

patient in person by a Specialty Physician who is qualified to give an opinion or render the necessary treatment in order to stabilize the patient.

Reasonable means the amount of time allowable for a healthcare service plan or medical group provider to take over management of a patient's care through arrangement and effectuation of transfer to a contracted facility. A reasonable period of time is based upon many factors unique to Avanti Hospitals, and to individual patient circumstances, including *a) ED volume, b) number of patients in the waiting room waiting to be seen, c) number of paramedics waiting to off load critical patients, d) patient comfort and satisfaction, e) CMS quality measure regarding ED length of stay for admitted patients, f) and most importantly patient safety*. Under most all circumstances, and based upon unique factors to southern Californian emergency care and Avanti Hospitals, reasonable shall mean no more than ninety (90) minutes.

Procedure

1. A patient who presents to the Emergency Room will be triaged according to existing policy.

2. A Medical Screening Exam will be completed to determine if an Emergency Medical Condition or active labor exists per existing policy.

3. If an Emergency Medical Condition exists, the care, treatment or surgery will be provided to the point of stabilization:

    a) If stabilization occurs in the Emergency Room and the patient can be discharged from the Emergency Room, there is no need to contact the health care service plan for authorization.
    b) If stabilization occurs in the Emergency Room but the Treating Provider believes that the enrollee requires medically necessary health care services and may not be discharged safely:
        i. The hospital shall seek to obtain the name and contact information of the patient's health care service plan. The hospital shall document its attempt to ascertain this information in the patient's medical record, which includes requesting the patient's health care service plan member card or asking the

Challenge Everything

Have you created:

- **Letter Libraries**
- **Law Libraries**
- **Fax Cover Sheets with laws**
- **Registration Forms with laws**
- **Policies, Procedures and Checklists**
- **Blurb Libraries**

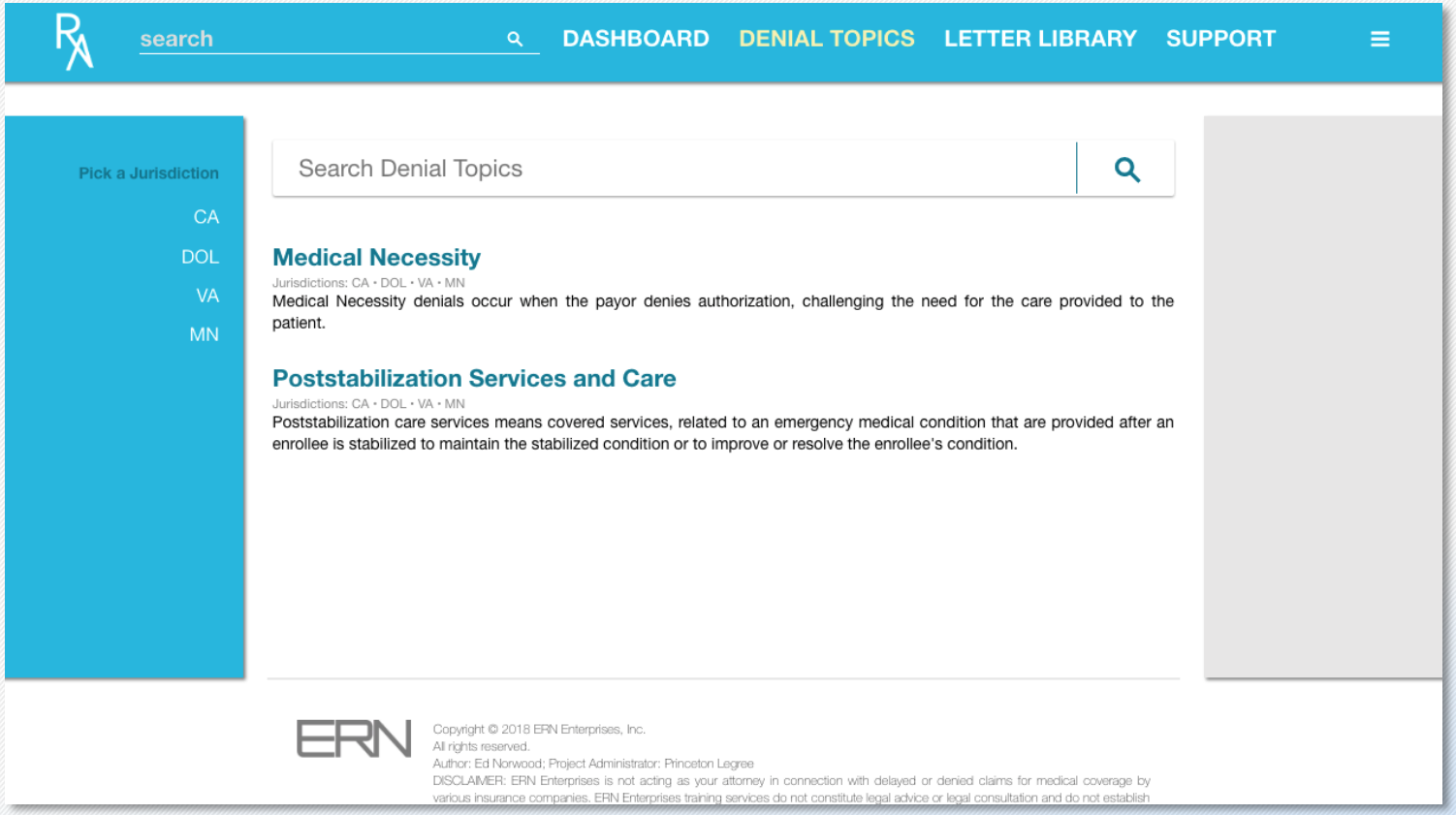
MANAGING DENIALS

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

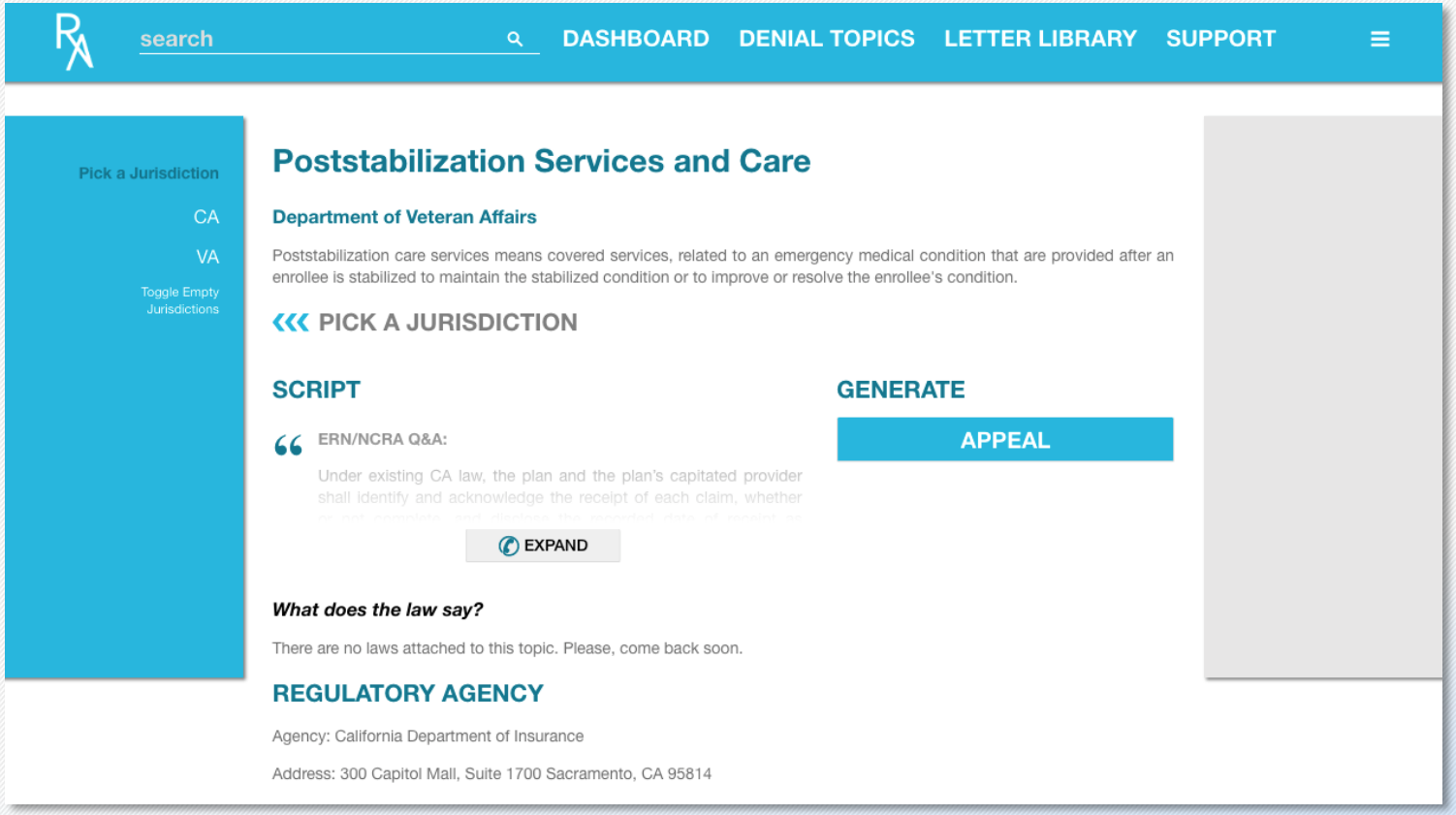
Code	Description
200	PPO UCR Reduction-OSHPD Recvd
201	PPO UCR Underpayment
202	PPO Untimely Appeal Vio.
203	PPO AOB Denial-Strong St. Law
204	PPO AOB Denial-Weak/No St.Law
205	PPO Underpayment Vio.
206	PPO Untimely Payment Vio.
207	PPO Unauthorized Treatment
208	PPO Retro Denial after Auth
209	PPO Untimely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


ERN
NCRA
Can I automate this?

REVAssurance Online



REVAssurance Online



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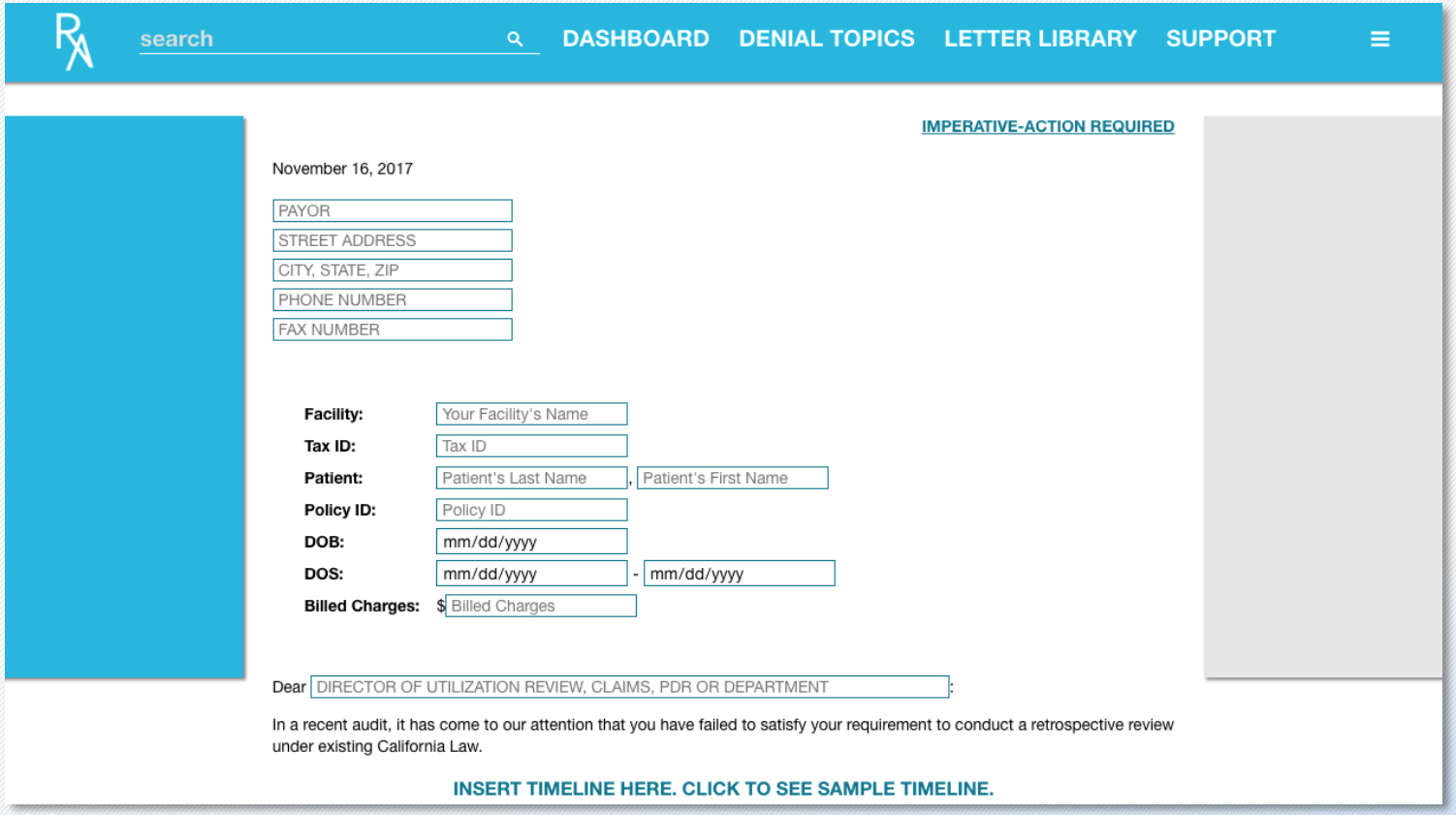

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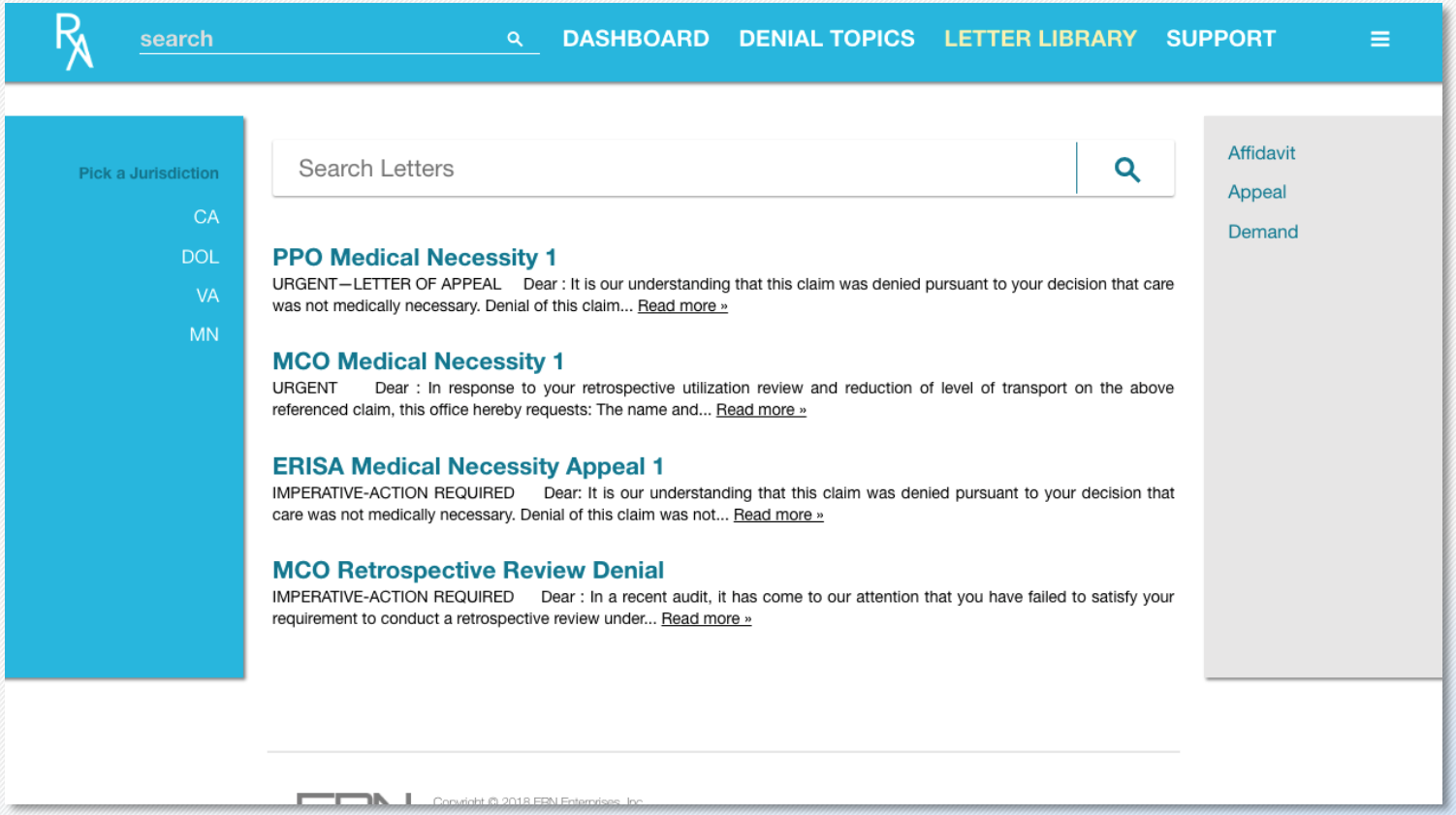

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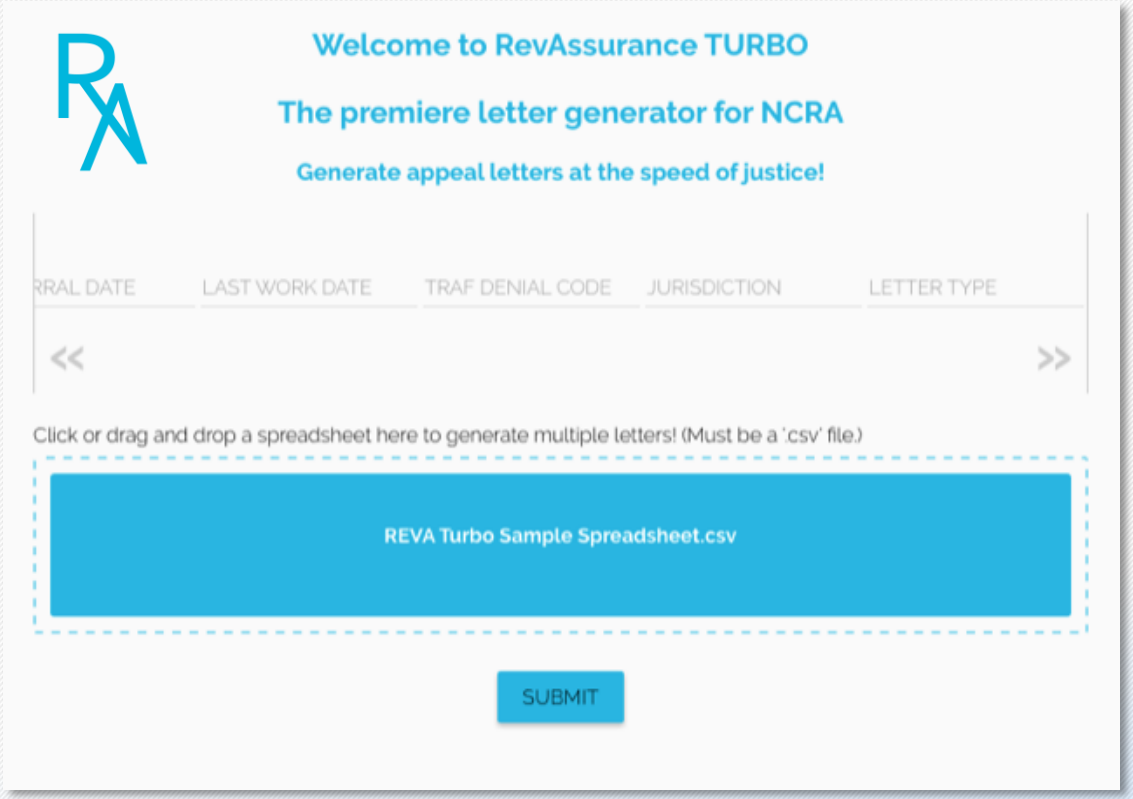
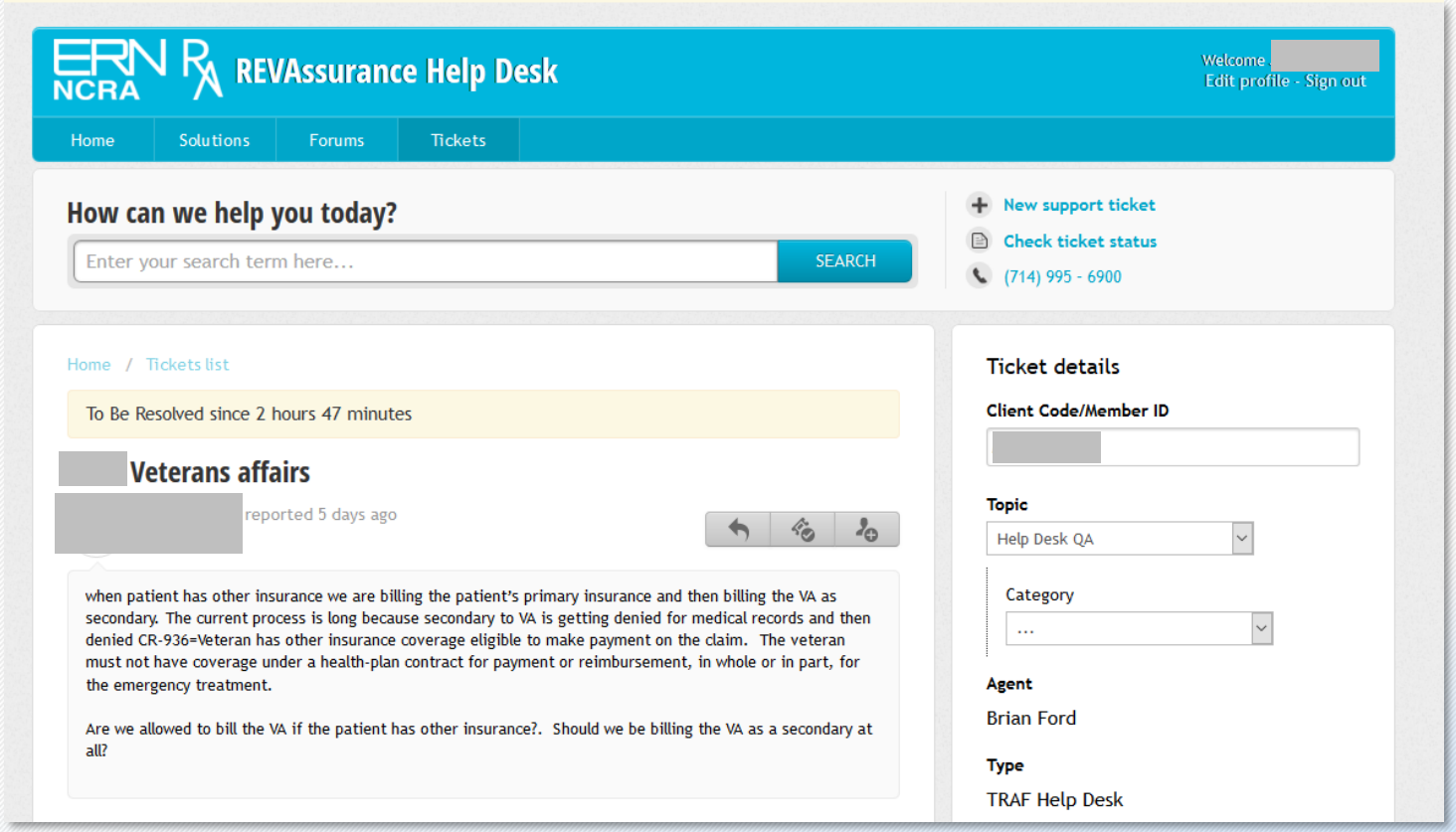


REVAssurance Support




Can I beat this?

APPEAL LETTER WRITING WORKSHOP

WRITING THE APPEAL

ERN NCRA

When Payors Won't Listen…

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

QUESTION: *How can we decrease denials?*

What are payors looking for in an appeal letter?

1. **Identify the denial reason.**

2. **Determine the jurisdiction.**

   Examples: MA, ERISA, State sponsored HMO.

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

ER No Pay- Postabilization:

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

No Claim on File:

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

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

   Example:

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

   (HEALTH NET PAYOR PANEL ATTORNEY COMMENTS)

5. **Locate administrative laws to support each argument.**

6. **Apply the law.**

   "Here, [Payor] was notified on [DATE], but failed to assume responsibility of the patient, within 60 minutes, prior to the patient's discharge, deeming the services statutorily authorized."

7. **Land the plane (Impose deadlines.)**

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

When Payors Won't Listen

"WE DISPUTE..."

"...BECAUSE..."

"...AS SHOWN AND DESCRIBED BELOW:"

When Payors Won't Listen…

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

DIRECTIONS:

The following is a sample timeline of a common denial.

Use the facts below to complete this worksheet, and use it as a model in crafting your own letters:

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

When Payors Won't Listen…

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

1) WHAT IS THE DENIAL? _____

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

3) TRANSITIONAL STATEMENT OF FACT:

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

_____

_____

_____ **as shown and described below**:

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

See directions above.

5) APPLICABLE LAWS:

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

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

5) APPLY THE LAW:

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

1. _____

   _____

2. _____

   _____

3. _____

   _____

6) CONCLUSION (LAND THE PLANE):

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

_____

_____

_____

_____

When Payors Won't Listen

As superheros:

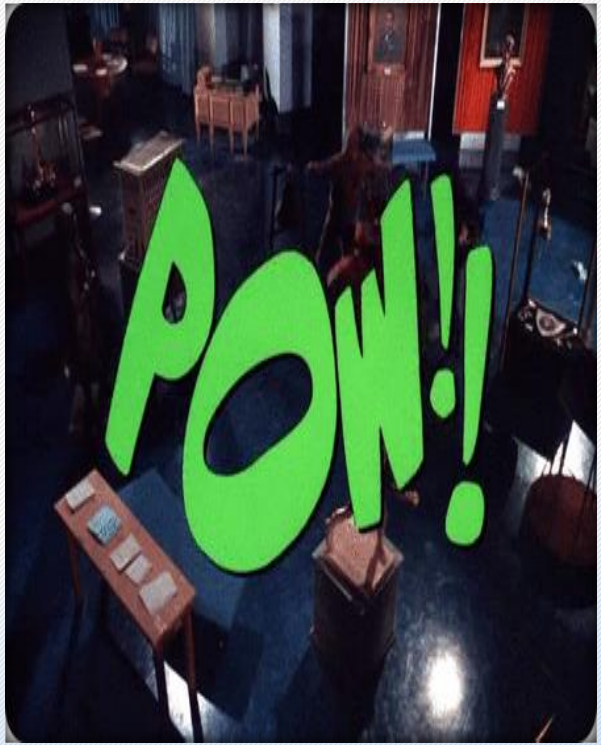
We are no respector or payors.

We work both small and big cases alike.

We collaborate when cases are too hard for us.

We aren't afraid of anyone AND

We fight every giant as if we had never failed.



We fight for you.

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