AR Systems, Inc
Training Library Presents

Attacking Medicare Advantage Denials -
Taking Your Power Back
PS MA plans are primarily commercial plans

Instructor: Day Egusquiza, Pres
AR Systems, Inc

Education
Compliance
Commitment

HI everybody. Love being with you in our new virtual world. Mask on, smiling underneath, staying safe while we all stay connected. Perfect!

Make up on, Hair done, Business attire

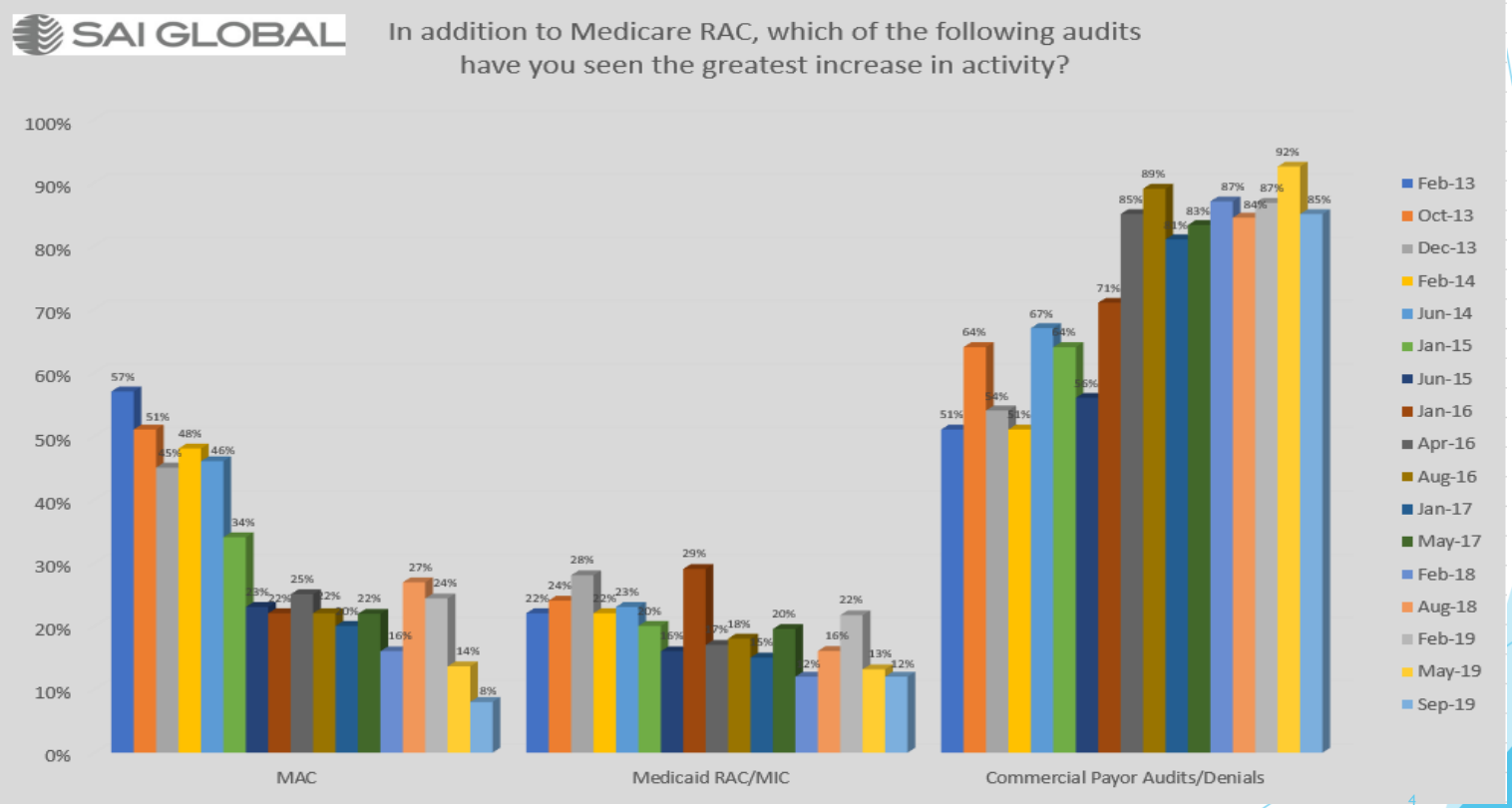
Vs no make up, workout sweats, loving the virtual moment.. LOL

Most common phrases from 2020: “Can you hear me?” and the favorite, as we talk up a storm: “You are still on mute.” LOL

Mgd Care Anguish-
A Brave New World Required-

Payer Policy Changes/Outside the Contract
Significant Growth of Medicare Advantage Plans
= Financial Impact to Providers

8 year history with Compliance 360 SAI Global – free webinars…



CMS: 2021 Medicare Advantage Premium Decrease 9-24-20. Plus Growth + Volume (Put your "A' game on!)

- 9-24-20 CMS stated that average Medicare Advantage premiums/monthly will decrease 11% to an estimated $21 from $23.63 this year.
- CMS estimates enrollment will increase 10% to 26.9 M in 2021, a rate that's on par with growth in 2021 to 40% of all Medicare enrollees.
- There will be 4,800 plans in the Medicare Advantage market, with an average of 47 plans per county – up from 39 plans this year. Medicare Advantage open enrollment begins 10-5 and ends 12-7, for coverage beginning Jan 1, 2021
- +++United accounted for 16x more inpt downgrades/denials than other payers. Humana 8x more. (SC hospital)
- +++Star program can yield up to a 6% bonus for the MA plans who have a 3.5-5 rating. Usually hundreds of millions of dollars..upward. (Pts scoring impacts start ratings.)

Medicare Advantage/Part C/MA –increase enrollments

- By 2021, it is forecast that Medicare Advantage/MA will constitute up to 40% of the Medicare market.
- Significant changes were made to allow revision/expansion supplemental benefits –like hearing aides, health club memberships, in home visits, home delivered meals, glasses, and others 'patient specific needs."
- Allows negotiation with pharmacy pricing
- Significant payments to plans for "Star Rating"(4&5) rated by pts.
- Limiting out of pocket yearly expense - $6,700 currently/yearly *Some low as $5,400
- But not all plans are sold in all counties of the country.
- No ability to have a Medicare Supplemental – pt pays all out of pocket plus monthly premium.
- MA IS NOT TRADITIONAL MEDICARE. Medicare 's rules do not apply if the hospital signs a contract. IF NOT CONTRACTED, Traditional Medicare rules apply.

Why would a patient select MA over Traditional Medicare?

- ALL have Part B = monthly premium/out of SS monthly Check. $148 monthly *income
- Part D = monthly premium/sold by insurance/but required. $40 monthly
- To cover co-pays and deductibles = Medicare Supplemental insurance. $180 per person/insurance co (Total Monthly: $372 ave)
- No cap on out of pocket costs with Traditional Medicare
- MA plans = collapse Part A,B, D into 1 monthly premium. Usually much less than Traditional fees.
- Some MA plans are not charging ANY Monthly premiums.(United/AARP) Each plan can develop their own package…
- **MA plans are paid a per-member, per month for all signed up patients. No additional funds with inpts.**

AARP United Healthcare Complete PPO - 2019

Medicare Advantage: Monthly premium is $38 & $144 Part B Medicare Premium & Part D/$25.= $207 (Immediate savings of approx. $150 per month when had Traditional Medicare with supplemental insurance $368)

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

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

- 2021: AARP United is offering $0 monthly premium.

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

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

Let’s look at Idaho:

- Populated areas can have multiple plans.
- Costs are approx. $285 per month for MA plans being sold- Part B & C which has D included. *AARP United now in Idaho/$0 so now $148 Part B only 2021.
- Some rural counties have no plans being sold.
- Less provider networks to use. HUGE For post acute care!!! Can’t sell in the community without a provider network…

Polling Question 1

Examples of why a patient would select a MA plan.

- Monthly premium –includes C&D
- Out-of-pocket expense can be lower than Traditional Medicare
- Additional coverage options can include eye glasses, dental, transportation, hearing aids.
- All the above

Key Measures when beginning to work with 'payers." Every payer has their own rules!
Medicare Advantage is Not Traditional Medicare!

- UR/Case Mgr and Physician Advisors have a working knowledge:
  - Payer Mix- Every payer has their own definition of inpt.
  - Observation rate/analysis – Every payer has their own determination of inpt vs obs.

  EX) OBS RATE FY20: T Medicare 21.3% MA 28.6% All payer 25.0%

  - UR/Care Management Leaders Outline- includes Interqual or MCG or both that is being used. *Optum/UHC bought ChangeHealthCare which own IQ. AHA asked to have reviewed.*
  - Census- volume of work is based on payer mix and average census of inpt and obs.
  - P2P successes, attempts, negotiated-per payer
  - Clinical denials, by payer, with overturns and reason
  - Catch phrase: Does not meet Medically Necessity. Means???

Creating a Payer-Specific Matrix

Great tool in the toolbox

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

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

Strategies for "Demanding an inpt" and Keeping it - Crazy FUN (More Better Practice Ideas)

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

"Payers Gone Wild" –understanding the contract, website posted policy updates, appeal language and when to just say 'heck no"

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

Polling Question 2

What is your experience with MA plans?

- Facility has over 10% penetration by MA plans
- Facility has more denials for inpt by MA plans than any other payer
- Facility has more requests for medical records for MA plans
- Facility has challenge determining what the payer has defined as ‘medically necessary’ denials.
- Facility has many new gray hairs thanks to MA plans

The Anguish continues - Medicare Advantage is NOT Traditional Medicare

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

Regulations 42 C.F.R. § 422.214
If non-contracting with a MA plan….

§ 422.214 Special rules for services furnished by noncontract providers.

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

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

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

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

Hot Off the Press!

MEDICARE ENROLLMENT & APPEALS GROUP

DATE: September 18, 2020

TO: All Medicare Advantage Organizations

FROM: Jerry Mulcahy

Director, Medicare Enrollment and Appeals Group

SUBJECT: Non-Contract Provider Access to Medicare Administrative Appeals Process

The purpose of this memorandum is to remind Medicare Advantage organizations (MAOs) of the applicability of the administrative appeals process at 42 C.F.R. Part 422 Subpart M if a non-contracted provider (NCP) who has furnished a service to an enrollee requests reconsideration of an organization determination.

Medicare Advantage – Provider WINS – use regulations

- "**If the plan approved the furnishing of a service thru an advantage determination of coverage, it MAY NOT deny coverage later on the basis of a lack of medical necessity." Medicare Mgd Care Manual/Medical Necessity, Chpt 4. PI manual, Cpt 6, Section 6.1.3.**

- Approved for inpt. 10-18-18. Resulted in 1 day stay. Hired company to audit – denied and told to downgrade to obs. Not medically necessary for inpt. 9-19. Nope.
- Approved for obs 8-8-19. Did P2Pcall. Overturned and approved for inpt. 8-12-19. Indept firm (paid to deny) audited and stated downgrade to obs –could be treated in a lower level of care. 2-1-20. Nope.

And more from Medicare Managed Care Manual – Post stabilization & Post acute care

- 42 CFR 422.113 . (2) The MA organization financial responsibility – the MA organization is financially responsible (consistent with 422.214) for post – stabilization obtained within or outside the MA organization that are pre-approved by a plan provider or other MA organization representative.
- If the pt is approved for post-acute care, the **MA plan is responsible to find placement**. They must have a post-acute care provider network.
- If they can't find placement, ensure there is contract language to pay a **'per diem/day' rate for any days beyond the safe discharge order.**

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

- DRG **Downgrades** – what documentation standards are required to allow all physician inclusion of ALL dx the pt has and are included in the thought process/not always the actual treatment?
- Pt Status **Disputes**– what is their definition of an inpt?
- Readmission **Denials** - Related means? 30 days when CMS does not use this standard. Preventable means?
- Hint – all must be in the contract! Usually silent.
- Look to operational addendums vs
- Payer –specific policies… UGLY

DRG Downgrades

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

DRG = 1 payment for the entire stay

- Traditional Medicare for larger facilities = DRG. Each DRG has a mean LOS that the payment is based on. The diagnosis and inpt procedures are grouped into a single DRG payment. Some DRGs have higher payments based on co-morbid conditions. There is a small variation for each site but: **1 stay = 1 $.**
- Medicare Advantage pays= same DRG methodology –with coding rules controlled by the HIPAA Standard Transactions 2003. 1 stay = 1 pre-determined payment for the dx and procedures done.
- Re-evaluate – why battling for additional 'days' when the inpt has already been confirmed? Exception – need for SNF and Outlier $/additional $ based on very long LOS/outside the norm for the dx.
- EX) Aetna approved 2 days. Hospital is pd DRG. They requested 3rd day. Denied. Aetna denied and reduced payment by $1200. WHAT?

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

Inpt approved. DRG payer. Payer granted two days; a 3rd one was requested. Payer denied. Hospital bills as inpt with 3 days. Payer refuses to pay any charges. WHY? "Days' does not equate DRG payment. (What if the hospital just bills with 2 days? Same DRG payment. Why anguish?)

*Inpt approved. DRG payer. Procedure ordered was submitted. During the case, another procedure was conducted. Payer requires to be told of the additional procedure. If not, denied inpt. WHY? Inpt was already approved.

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

*Inpt denied. But did approve 72 hrs of obs. What is the contract for payment for obs hrs and other related services? Does it equal an inpt surgery? Do not accept.

Polling Question 3

When the payer creates their own coding ‘rules’ what are they in violation of?

- HIPAA standard transaction law
- HIPAA privacy law
- Correct coding rules
- None, they can do what they want, when they want.
- None of the above

Massive Requests for Records

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

One RAC Relief User Issue- Lost Medical Records??

- Sending appeals and then following up to check the status only to learn they don't have any record of us filing an appeal and we will need to resend it to them.

- Suggested Response: “Would you like me to contact the Office of Civil Rights and file the HIPAA breach report for you since you lost PHI that I can prove was in your possession? **

Policy Alert –CMS /Advanced notice of change in methodology (MA plans) – IT IS FINAL FOR 2021

- Jan 6, 2020- CMS proposes changes in the Hierarchical Condition Categories (CMS-HCC)Risk Adjustment model for risk-adjusts payments to MA plans. FINAL!
- This year the Advance Notice will be released in 2 parts.
- For CY 2021, CMS proposes calculating risk scores using a 75% ENCOUNTER blend and a 25% Risk Adjustment Processing System (RAPS.) Over the last several years, CMS has been transitioning to greater use of encounter data by incrementally decreasing the weight of the RAPS.
- In CY 2018, CMS calculated risk scores using 25% encounter/75% RAPS
- In CY 2020, each data accounts for 50% of the risk score.
- The goal is to move use of the ENCOUNTER data and phase out the use of RACs entirely.
- Impact to providers? Data is from the UB, 1500 and yes, records!!! Watch for excessive requests of records- because "CMS wants us to.' Where does it say that? And if not contracted – why send any? Remember, the UB has the DX and all procedure codes.

Patient Status "Touches"

1st touch: UR

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

2nd touch: Physician Advisor

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

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

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

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

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

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

Specifics – Disputes with payers.
Internal MD/Physician Advisor with the Payer's MD

- **Do** more **Peer to Peer** calls- preferred Internal Physician
  - Get involved
  - Educate front line attending-documentation enhancements
  - Let them know what is in question
  - Share with all
  - Think internal Physician Advisor to effect change internally
  - **BIG: Healthplans (Humana) are including language about 'providers treating pt'**
  - **BIG: No longer do post-denial calls. Only concurrent.** 9-18 (POLICIES)

Polling Question 4

If the facility is not contracted with a MA plan, what are the rules?

- Abide by what you are told by the payers, per patient
- Look to their contract anyway for guidance
- Look to their webpage for guidance
- Following the Medicare Mgd Care Regs regarding the 2MN rule/other Traditional Medicare rules

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

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

Know the answers to the questions: Payer specific.

- **Why was the account denied** ? What are the Clinical guidelines/CG for this case? Is it a 'gray' case or a CG slam dunk?
- **Who is payer?** What is the historical pattern with the MD? What is this payer's MD looking for to approve the INPT? Are there 'key words' this payer likes when looking for specific dx/courses of treatment? What are the 'hot words' NOT to use? (Observing for vs actively treating)
- **Place the request.** What are the contractual guidelines for a) scheduling a P2P, b) can the pt's status be changed post discharge with no aguish/bill type 131/obs from time of initial 'admit?.
- **Ensure there is clarity on when to schedule the call - time and date.** Again, very payer specific
- **Know the Levels the payer is using** Ex) Humana -4 hrs from request; if missed, move to pre-dispute.
- **MA Plans-** Use of CMS form 1696/appointing of a representative. Submitted with the Request for P2P, if needed.
- **If not allowing P2P or a non-contracted payer, then what**? How can inpt be challenged without going to appeal/very costly/delays in payment? And if so, know the appeal rights/levels with each payer's contract.
- **Ensure timeline for DECISION on P2P if not done concurrently during the call.** Can post-discharge be done & concurrent? Get authorization #.
- **If the P2P call is attempted but missed**/did not get scheduled well, it is a '1x and done' -move to appeal or accept obs?
- **Bullet Highlights of the case.** Ex) MCG met/if it helps. Comorbid conditions. Updated issue since original request for inpt/UR 1st touch. Why inpt Level of care is necessary. If DRG payer, once approved for inpt. # of days is a mute issue. Same DRG payment.
- **Communicate with PFS/Rev Cycle on what is the final status of the account** -inpt or obs. Update medical record &/or AR file w/same

Peer to Peer Discussion: Preparation for the call & Outcome

Company: Phone Number: Date:

Name: Date of Birth:

Insurance Number: Chart Number:

Date of Admission: Hospital:
Date of Discharge/if applicable:

Current Status: Dx & Comorbid:

What does the payer use to define inpt? (IQ, MCG, other) _____

Medicare Advantage -CMS1696 Signed: ___Yes ___No

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

Clinical Presentation:

Pertinent Labs, other highlighted areas:

Changes since clinicals sent to payer?

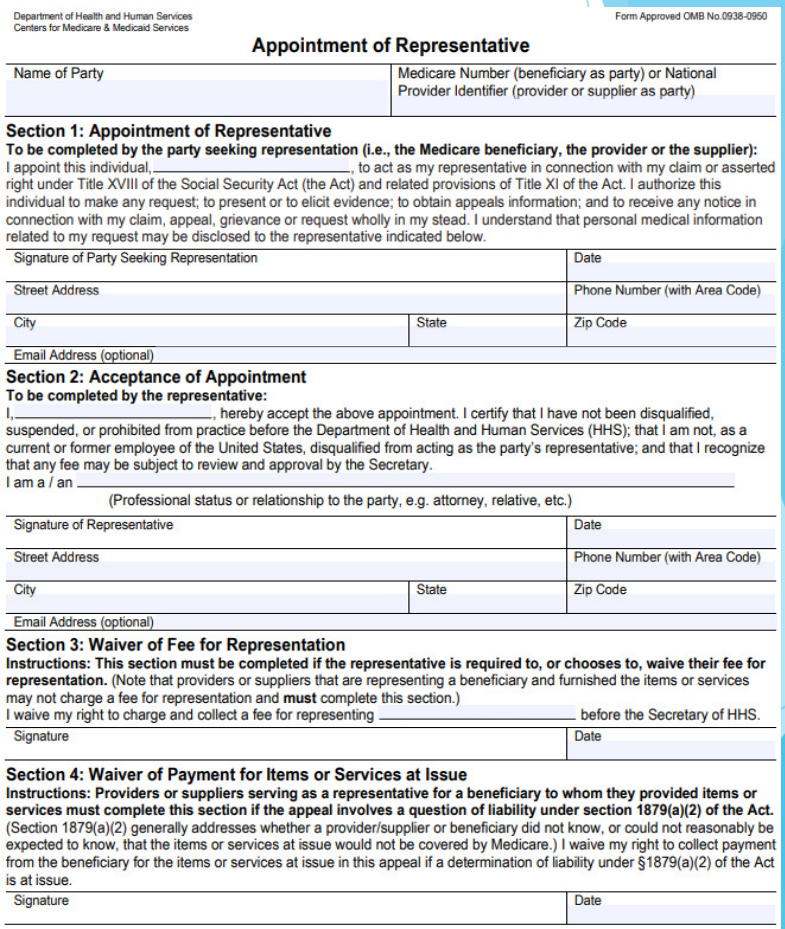
Payer Medical Director: _____ Direct Phone Number if Given: _____
Outcome: ___IP approved Authorization # _____ ___OBS approved.
Readmission issue? Yes ____ No____ "Related issues" at risk?_____

Recommend Appeal: ___ Yes ___ No ___N/A
Accept downgrade to obs? ____ Yes ____No
If recommend Appeal: Basis for appeal _____

Completed by:

CMS Form 1696 – formal representative

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



Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved OMB No.0938-0950

Appointment of Representative

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

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

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

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

Section 2: Acceptance of Appointment

To be completed by the representative:

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

I am a / an _____

(Professional status or relationship to the party, e.g. attorney, relative, etc.)

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

Section 3: Waiver of Fee for Representation

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

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

Signature	Date

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

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

Signature	Date

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

- United Health Care **Policy Number: H-006**
- **Coverage Statement:** Hospital services (inpatient and outpatient) are covered when Medicare criteria are met. **DANGER ZONE***

- For coverage to be appropriate under Medicare for an inpatient admission, the patient must demonstrate signs and/or symptoms severe enough to warrant then need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.

Update - United =25% market share

- As of Aug 2015, UHC no longer uses the CMS two-midnight standard to make inpt admission determination.
- UHC believes the best way to help UHC's members get access to the care they need is to relay on evidence-based guidelines and treatments. Evidence-based guidelines allow UHC to review a member's health condition based on the clinical documentation and provide consistent, clinically validated decisions for hospital admissions.
- More specifically, **United uses Milliman Care Guidelines (MCG) to determine** medical necessity and the appropriate level of care.
- UHC will also provide a copy of MCG criteria upon request before, during, or after a reconsideration request.
- **Sites should now consider: "If appeal results in an adverse decision, we request a copy of the individual criteria used to determine medical necessity be provided with the determination."**
- Per UHC 2016 Provider Manual – pp 113-114 Criteria for Determining Medical Necessity.
- May 2021- UHC moving to IQ/owns Optum which bought Change HealthCare which owns IQ.

Payer‘mis-information’ for Medicare Advantage plans

- “Recently we received a denial for a status 3 years after the encounter. The pt was here for an OP Hemorrhoid procedure developing vomiting with distension of a colonic ileus. History of Olgilvie syndrome failed 48 hrs of outpt treatment. Inpt was approved thru payer contact prior to billing/3 years ago. Now the 3rd party vendor is stating he did not meet inpatient criteria.”
- Medicare Managed Care Manual, Cpt 4, Section 10.16. And Program Integrity, Cpt 6, Section 6.1.3 Medical necessity applies:
- **“If the plan approved the furnishing of a service thru an advance determination of coverage, it may not deny coverage later on the basis of a lack of medical necessity.” YAHOO!**
- Turn in abuse to CMS – as oversight for all MA Plans.

More payer anguish -Place of service Audits

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

More payer anguish - Outpt

- "For the last month or so, we have been getting letters from UHC wanting the medical records on all our outpt services and even if they are the 2nd payer and owe us under $100, they want the records. They are asking for records for a simple CBC, strep test, drug screening, mammo,and colonoscopies. In many cases, it is costing us more to send them the medical record than what our actual reimbursement would be. I filed a complaint with our UHC Advocate and we have a phone call set up. They are calling it "pre-payment letters.' In many cases we have a prior authorization and they are still wanting the complete medical records. Now other payers are starting to do the same thing." Ill 80 bed hospital

- Most are commercial UHC and we are contracted..
- No idea why we would agree to this but under PROTOCOL, we have to respond.

Readmission Denials- CMS Policy

- When a patient is discharged/transferred from an acute care Prospective Payment System (PPS) hospital **and is readmitted to the same acute care PPS hospital on the same day for symptoms related to**, or for evaluation and management of, the prior stay's medical condition, hospitals will adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim. Please be aware that services rendered by other institutional providers during a combined stay must be paid by the acute care PPS hospital as per common Medicare practice.

30-Day Readmission CMS

CMS Hospital Readmissions Reduction Program (HRRP)

Section 3025 of the Affordable Care Act added section 1886(q) to the Social Security Act establishing the Hospital Readmissions Reduction Program, which requires CMS to **reduce payments to IPPS hospitals with excess readmissions,** effective for discharges beginning on October 1, 2012. The regulations that implement this provision are in subpart I of 42 CFR part 412 (§412.150 through §412.154).

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

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

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

(1) patients admitted for an acute exacerbation of chronic obstructive pulmonary disease **(COPD);** and

(2) patients admitted for elective **total hip arthroplasty (THA) and total knee arthroplasty (TKA).**

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

- READMISSION PENALTIES: CMS FINES 2545 HOSPITAL FOR HIGH READMISSION RATES. 83% OF 3080 HOSPITALS EVALUATED. COULD CUT UP TO 3% FROM EACH MEDICARE CASE DURING FISCAL YEAR 2021

United Health Care Readmission

- A LVN, LPN or RN will review the medical records and supporting documentation provided by the facility to determine whether the two admissions are related.
- If the subsequent admission is related to the initial admission and appears to have been preventable, the LVN, LPN or RN will submit the case to a medical director, who is a physician, for further review.
- The medical director will review the medical records to determine if the subsequent admission was preventable and/or there is an indication that the facility was attempting to circumvent the PPS system. **
- **Aetna MD/CA case in court: did not do review of case/just read recommendation by clinical team. AG's investigating**
- **FULL DENIALS of the 2nd admission by MA PLANS…and other COMMERCIAL PAYERS…**

Polling Question 5

What is the difference between Traditional Medicare's readmission rule and MA 's usual readmission rule?

- They both disallow any separate payment for readmissions during a 30 day period
- Traditional Medicare requires all similar dx be collapsed into 1 claim in a 30 day period.
- MA plans allow dispute on related readmission prior to claim submission – always
- Traditional Medicare will look at a given year/lookback for identified dx and determine volume of readmissions. If beyond threshold, can do up to 3% reduction in payments for the next year. It is not case per case.

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

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

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

<u>Outline key elements prior to signing the contract</u>. Re-visit throughout the contract year if concerns arise. (Rates are not included in this list)

1. **Timeline for submission of clinicals**. Week days, weekends, obs conversion request to inpt.
2. **Clinical guidelines the payer is using making the inpt decision** along with required REASON for not approving inpt with decision.
3. **Timelines for reply of request**. Weekends same as weekdays. 4-8 hrs maximum
4. **Once inpt has been approved, no additional record requests** unless pt is a candidate to move to a post-acute level of care. Contract language must be known – i.e. qualifying stay. (DRG)
5. **If granting access to the provider's electronic medical record**, critical to have a very limited review (ER if from the ER/labs/imaging/notes) with a firm timeline for decision. 4- 8 hrs maximum. Continued delay yields risk of the pt 'recovering in a lower level of care/obs." If in obs, grant access when the pt's condition needs reassessed. 8 hrs maximum.

- **DRG hot spots**: Sepsis, ensure there is adherence to the HIPAA Standard Transactions- all covered entities.
- **MA plans**: Ensure there is understanding that a disputed status may not resolved while the pt is in-house. TM rules do not apply. Status can be changed post discharge will full billing as inpt or outpt/131 bill type.
- **P2P:** Any provider may discuss the account on the patient's behalf. All contracts allow both concurrent and post-discharge P2P. Once the request is made, a time is agreed to /recommended. Identify timeline with penalties if not adhered to. Agree to the qualifications of the payer MD. Agree to have the same MD for all CHRISTUS accounts, per payer. Outline the scope of the Payer MD can use –beyond meeting the clinical guidelines. No minimum LOS to be an inpt. (EX: all accts under 48 hrs are obs.)
- **Re-admission denials**. Outline exactly what is a 'related' case within 30 days. "Same as Medicare' = same day, same facility, same dx. Chronic dx are excluded. Identify which dx must be the same and in which 'spot' of the up to 10 dx

CMS Contacts for Specific Plans and General Contact

File complaints – squeak – with excellent examples of abuse

- **Humana MED C Contact at Medicare:**
- Uvonda Meinholdt
  Health Insurance Specialist
  Kansas City Regional Office
  Phone: 816-426-6544
  FAX: 443-380-6020
  Uvonda.Meinholdt@cms.hhs.gov

- **UHC MED C Contact at Medicare:**
- Nicole Edwards
- Phone: 415-744-3672
- Nicole.edwards@cms.hhs.gov

- **Coventry Health Care Med C/Aetna Med C**
- Donald Marik
- Health Insurance Specialist
- Denver Regional Office
- Phone: 303-844-2646
- Donald.Marik@cms.hhs.gov

- Blue Cross Blue Shield Anthem Med C:
- Edgar Buyao
- Chicago Regional Office
- Phone: 312-353-5968
- Edgar.buyao@cms.hhs.gov
-
- **General CMS Contact:**
- Melanie Xiao
- Health Insurance Specialist
- Medicare Advantage Branch
- Division of Medicare Health Plans Operations
- Centers for Medicare & Medicaid Services
- CMS San Francisco Regional Office
- 90 7th Street, 5-300 (5W)
- San Francisco, CA 94103-6708
- Phone: 415-744-3613
- FAX: 443-380-6371
- melanie.xiao@cms.hhs.gov

More filing of complaints – "Helping the contractor do the right thing." 3-20

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

- Note – when 'discussing' issues with the MA plans – be very clear that you will report to CMS on behalf of the pt and will ensure it goes against their STAR Ratings… last major power statement.
- Ensure you have already tried to resolve with the payer. It is not about 'contract rates.'

AR Systems' Contact Info

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208 423 9036
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NEW EXPANDED WEBPAGE: http://arsystemsdayegusquiza.com