
Presenter: Ed Norwood
DISCLAIMER: The intent of this program is to present accurate and authoritative information in regard to the subject matter covered. It is presented with the understanding that ERN/NCRA is not engaged in the rendition of legal advice. This presentation is intended for educational and informational purposes only. If legal advice or other expert assistance is required, you should seek the counsel of your own attorney with the expertise in the area of inquiry.
HFMA SUMMER CONFERENCE 2022
MAXIMIZING THE HUMAN EXPERIENCE IN A POST PANDEMIC WORLD
Champions for MEDICALLY APPROPRIATE HEALTHCARE.
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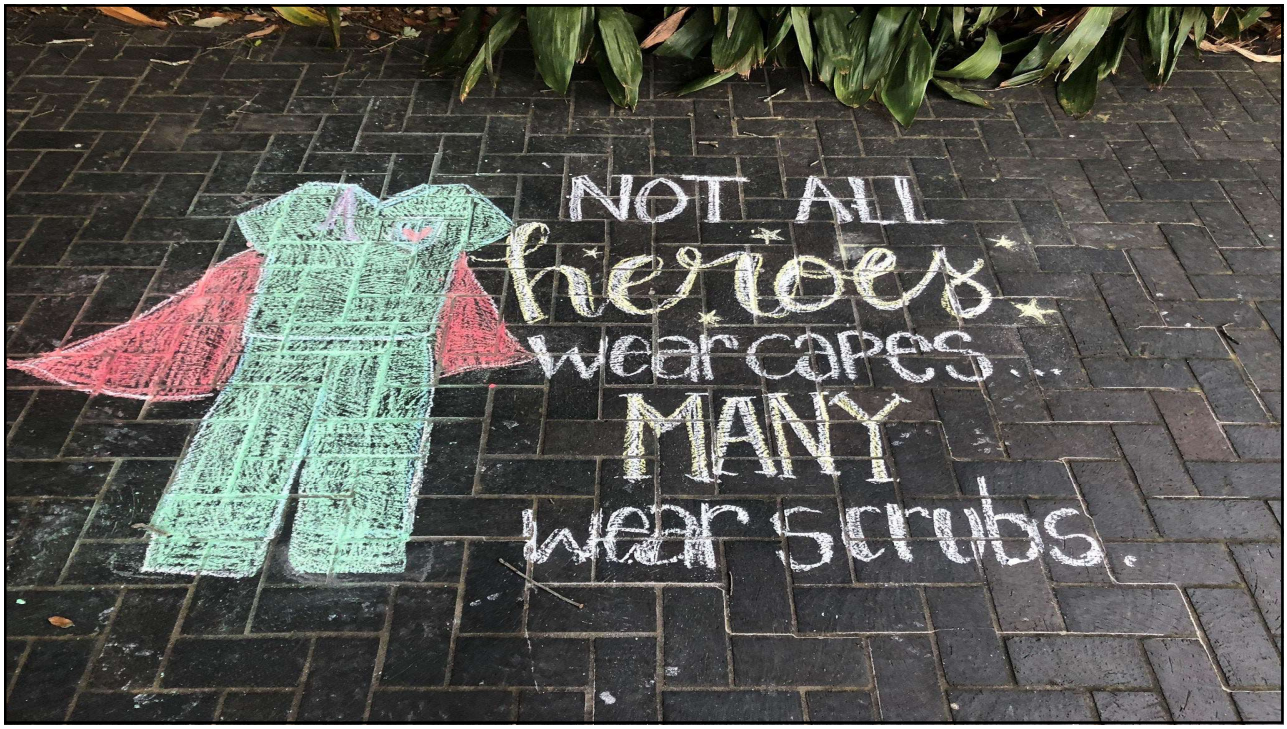

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WHY WE EXIST

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.

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WE ADVOCATE

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

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As our hearts and healthcare delivery system have been tested, we have seen some shining stars (and heroes) emerge.

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- States have introduced emergency regulations mandating certain coverage for COVID RELATED CARE.

In the interest of public safety and the protection of residents, State Departments of Insurance ("Department" or "DOI") have issued special rules, regulations, and guidance for insurers related to the COVID-19 pandemic.

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On March 17, 2020, Governor Asa Hutchinson issued Executive Order **20-06 (which renewed several times: 20-16, 20-48, 20-51, 20-53, 21-03) and ended 5/30/21. The Delta Variant triggered EO 21-14 issued 7/29/21-9/29/21** and ordered state agencies to "identify provisions of any regulatory statute, agency order or rule that in any way prevents, hinders, or delays the agency's ability to render maximum assistance" to Arkansans during the COVID-19 health emergency.

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PRIOR AUTHORIZATION PRACTICES AND PROTOCOLS BY HEALTHCARE INSURERS AND HMO'S

Prior Authorization Transparency Act (Ark. Code Ann. § 23-99-1101 et seq.)

For cases involving COVID-19 patients, the prior authorization requirements found in Ark. Code Ann. §§ 1105, 1106, and 1107, are suspended.

AID Rule 115 – Prior Authorization Transparency Act

For cases involving COVID-19 patients, § 8 of AID Rule 115 relative to the requirements of Ark. Code Ann. § 23-99-1109(b)(1) is suspended.

With this action, the Arkansas Insurance Commissioner is temporarily prohibiting a healthcare insurer's or HMO's prior authorization or step therapy practices or protocols which are referenced and regulated **under the Prior Authorization Transparency Act and Section Eight of AID Rule 115 for cases involving COVID-19 patients.**

BETWEEN THE TIME FRAME OF 3/17/20 AND 9/29/21, DID YOU SEE DENIALS FOR LACK OF AUTHORIZATION INVOLVING COVID PATIENTS?

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EMERGENCY RULE 122

PRIOR AUTHORIZATION WAIVERS FOR POST-ACUTE TRANSFERS

SECTION 2. STATEMENT OF EMERGENCY

The Arkansas Insurance Commissioner ("Commissioner") finds that insurance barriers exist causing unnecessary hospitalizations and hospital resource costs due to health plans applying prior authorization protocols for patients transferring from hospitals to **post-acute facilities, skilled nursing facilities, and acute inpatient rehabilitation facilities**. The Commissioner finds that a public emergency exists **to temporarily eliminate prior authorization requirements that** are burdening hospital occupancy and resources **as patients wait on authorizations from an insurer, HMO, or Medicare Advantage organization before transitioning to a post-acute care facility from the hospital**.

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EMERGENCY RULE 122

PRIOR AUTHORIZATION WAIVERS FOR POST-ACUTE TRANSFERS

SECTION 3. AUTHORITY

Pursuant to Ark. Code Ann. §23-99-1118, the State Insurance Department may promulgate rules for the implementation of this subchapter governing the "Prior Authorization Transparency Act." Ark. Code Ann. §25-15-204 (b) (1) states that if an agency finds that **imminent peril to the public health, safety, or welfare or compliance with federal laws or regulations** requires adoption of a rule upon less than thirty (30) days' notice and states in writing its reasons for that finding, it may proceed without prior notice or hearing, or upon any abbreviated notice and hearing that it may choose, to adopt an emergency rule. The rule may be effective for no longer than one hundred twenty (120) days.

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EMERGENCY RULE 122

PRIOR AUTHORIZATION WAIVERS FOR POST-ACUTE TRANSFERS

SECTION 4. DEFINITIONS

Unless otherwise stated in this Rule, the definitions in Ark. Code Ann. § 23-99-1103 shall apply to the provisions or sections of this Rule.

SECTION 5. PRIOR AUTHORIZATION WAIVERS FOR POST-ACUTE TRANSFERS

No health benefit plan, or Utilization Review entity, **shall impose a prior authorization protocol, pre-certification requirement, or step therapy procedure for, or upon, transfers of insured patients from hospitals to a post-acute setting or facility** which includes but is not limited to skilled nursing facilities, or acute inpatient rehabilitation facilities during the effective time period of this Rule.

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AR Title § 23-99-1103. Definitions

(2) "Authorization" means that a utilization review entity has:

(A) Reviewed the information provided concerning a healthcare service furnished or proposed to be furnished;

(B) Found that the requirements for medical necessity and appropriateness of care have been met; and

(C) Determined to pay for the healthcare service according to the provisions of the health benefit plan;

AN AUTHORIZATION CREATES A CONTRACT.
WHAT IS THE PURPOSE OF A TRACKING/REFERENCE NUMBER?

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AR Title § 23-99-1103. Definitions

(4)(A) **"Emergency healthcare service"** means a healthcare service provided in a fixed facility in **the first few hours** after an injury or after the onset of an acute medical or obstetric condition that manifests itself by one (1) or more symptoms of such severity, **including severe pain**, that in the absence of immediate medical care, the injury or medical obstetric condition would reasonably be expected to result in:

(A) Serious impairment of bodily function;
(B) Serious dysfunction of or damage to any bodily organ or part; or
(C) Death or threat of death;

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AR Title § 23-99-1103. Definitions

(4)(B) **"Emergency healthcare service"** includes the medically necessary surgical treatment of a condition discovered **in the course of a surgical procedure originally intended for another purpose**, so long as the subsequent surgical procedure is a covered benefit under the healthcare plan, and whether or not the originally intended surgical procedure or the subsequent surgical procedure for the condition discovered during surgery is subject to a prior authorization requirement;

EMERGENCY SERVICES INCLUDES SURGICAL TREATMENT OF A CONDITION DISCOVERED WHILE TREATING A PREVIOUS CONDITION, REGARDLESS OF IF IT IS SUBJECT TO PRIOR AUTHORIZATION REQUIREMENT.

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§ 23-99-1107. Prior authorization -- Emergency healthcare service

(a) A utilization review entity **shall not require prior authorization** for prehospital transportation **or for provision of an emergency healthcare service**.

(b)(1) A utilization review entity shall allow a subscriber and the subscriber's healthcare provider **a minimum of twenty-four (24) hours following an emergency admission** or provision of an emergency healthcare service for the subscriber or healthcare provider **to notify the utilization review entity** of the admission or provision of an emergency healthcare service.

(2) If the admission or emergency healthcare service occurs on a holiday or weekend, a utilization review entity **shall not require notification until the next business day after the admission** or provision of the emergency healthcare service.

WHAT ARE SOME SCENARIOS THAT WOULD IMPEDE YOU FROM MEETING THIS TIMEFRAME?

(See Sec. 1105 and 1106 for Non urgent & urgent Timeframes)

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Ed Norwood

From: Sherri Harville <s
Sent: Monday, Februa
To: Ed Norwood
Subject: Arkansas HFMA

Good morning Ed,

It was a pleasure to hear you speak on When Payors Won't Listen yesterday at the Arkansas HFMA Revenue Cycle Seminar. I love your enthusiam for this. I approached you afterwards on a couple of questions and you requested that I email these to you.

I have sent the following question to a couple of my largest payers. AR Blue Cross Blue Shield has not responded but I did receive a response from Qualchoice (QCA). QCA has advised that as long as the patient is still admitted and has not been discharged we can and should be able to obtain an authorization regardless of any 24 hr notification rule. We spoke briefly and you asked that I send you my scenario so that you could research.

1) I have been looking at a specific scenario revolving around authorizations, really lack of authorizations, in situations where a member arrives to us unconscious or unable to communicate. We sometimes have issues of not being able to obtain authorizations simply because the patient does not have medical ID cards on them and we can not get reliable information to begin our normal processes. These situations revolve around patient's who have sustained injuries or medical conditions that render them unable to cooperate or speak. Sometimes the issue might also center around a patient that is not reliable due to mental health issues or drug/alcohol intoxication. There are times that we can get the information before the patient discharges but we are outside of the window to get authorization.

We have come across this scenario and it can result in advisament for appeal. In cases such as mentioned above, do your plans have an administrative process where we can send clinical documentation to prove, that of not fault of our own, there really was no opportunity to follow normal process because of the specific limitations on us. If we could provide medical records that support our inability to effectively communicate with a patient couldn't we begin working towards an authorization rather than spending time filing the bill and waiting for the denial to appeal on an administrative issue like this? If we could provide documents for UR to include with clinical would we be able start authorizations before a patient discharges?

2) You stated that you could provide the wording or backing to using Account Notes for appeal letters. Can you send me the information that supports this?

I will likely have a couple of other questions but I wanted to get this to you quickly based on the #1 item that I listed above. Baptist Health has 11 facilities and this is a recent concern that has popped up.

Thank you,
Sherri Harville

Sherri Harville
Denials Supervisor
Patient Financial Services

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Ed Norwood

From: Melissa Grisham <Melissa.Grisham@arkansas.gov>
Sent: Tuesday, April 09, 2019 9:10 AM
To: Ed Norwood
Cc: Booth Rand; Allen Kerr; Jimmy Harris; Daniel Muhlbach
Subject: RE: Arkansas Prior Authorization Transparency Act

Mr. Norwood,

Arkansas does not have any statutory authority or policy that address a situation of a provider not being able to ascertain insurer information from an incapacitated insured. These situations would probably be reviewed on a case-by-case basis after the appeal process is complete.

Thank you,

Melissa Grisham
Market Analysis Chief
Associate Counsel
Arkansas Insurance Department
1200 W. 3rd St.
Little Rock, AR
(501) 371-2841

From: Ed Norwood <ednorwood@ernenterprises.org>
Sent: Monday, April 8, 2019 11:08 AM
To: Allen Kerr <Allen.Kerr@arkansas.gov>
Cc: Booth Rand <booth.rand@arkansas.gov>; Melissa Grisham <Melissa.Grisham@arkansas.gov>
Subject: Re: Arkansas Prior Authorization Transparency Act

Commissioner Kerr,

Thanks for your prompt response to our emergence provider membership concerns in Arkansas.

I will await their response Wednesday.

Best,

Ed Norwood
Sent from my T-Mobile 4G LTE Device

-------- Original message --------
From: Allen Kerr <Allen.Kerr@arkansas.gov>
Date: 4/8/19 8:55 AM (GMT-08:00)
To: Ed Norwood <ednorwood@ernenterprises.org>
Cc: Booth Rand <booth.rand@arkansas.gov>, Melissa Grisham <Melissa.Grisham@arkansas
Subject: RE: Arkansas Prior Authorization Transparency Act

How are we going to trend this denial for escalation?

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5:50 PM Thu Apr 11 LTE 64%

Booth rand Cancel

Search for "Booth rand"

Top Hits

Booth Rand Yesterday
RE: Arkansas Prior Authorization Trans...
We are looking into this, and I will visit...

People

Booth Rand

Sender contains: Booth rand

Subjects

[redacted]

Done 21 of 24

On Apr 9, 2019, at 7:33 PM, Booth Rand <booth.rand@arkansas.gov<mailto:booth.rand@arkansas.gov>> wrote:

I think we have some power in rules or in negotiation with our licensees to limit carrier time limits cutoffs for authorization requirements for enrollees who do not present or who cannot supply carrier information at the hospital for benefit status, prospective or current in force status.

In fact I'm copying our hospital association on this.

Elisa/Jodiane. See full thread..

Is this an issue for our hospitals?

On Apr 9, 2019, at 7:21 PM, Ed Norwood <ednorwood@ernenterprises.org<mailto:ednorwood@ernenterprises.org>> wrote:

Ms. Grisham,

Thank you for your email.

I will determine how large of an issue this is on Friday for our emergency provider membership.

We'll talk soon.

Best,

Ed Norwood
President
<image003.jpg>
ERN/The National Council of Reimbursement Advocacy
714-995-6900 ext. 6926 bus 714-995-6901 fax

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CASE STUDY

- OBTAINING AUTHORIZATION WHILE PATIENT IS IN-HOUSE.

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Obtaining Authorization While Patient Is In House

Case Study: Denial Prevention

Provider Profile

A large 11 trauma hospital provider member recently submitted a complaint to ERN/TRAF against a health plan who:

- Failed to approve or disapprove authorization within one (1) hour of contact being made
- Denied the claim stating the provider had notified them 23 days after patient admission and instructed the provider to bill the claim with clinical documentation after patient discharge. This would have resulted in an immediate backend denial and delayed revenue capture through the reconsideration process.

Results

Pursuant to 42 CFR 422.113 (C)(2)(iii), the health plan is ultimately responsible for the timely reimbursement of this claim as they failed to issue a timely organization determination within (1) hour either approving or disapproving services and assuming care of the patient. Thus, these post-stabilization services were deemed authorized after they failed to authorize or assume care of the patient and arrange for transfer within one (1) hour from the time the emergency provider submitted inpatient authorization requests and clinicals.

ERN TRAF Success

8 Days to secure authorization for all dates of service (11/22/2021 - 4/22/2022) .

In the first sixty-one (61) days the patient was in house, the health plan denied services that were rendered. With ERN's help, an authorization was secured in just eight (8) days.

You fight for them. We fight for you.
Contact julianatrang@ernenterprises.org or call (714) 995-6917.

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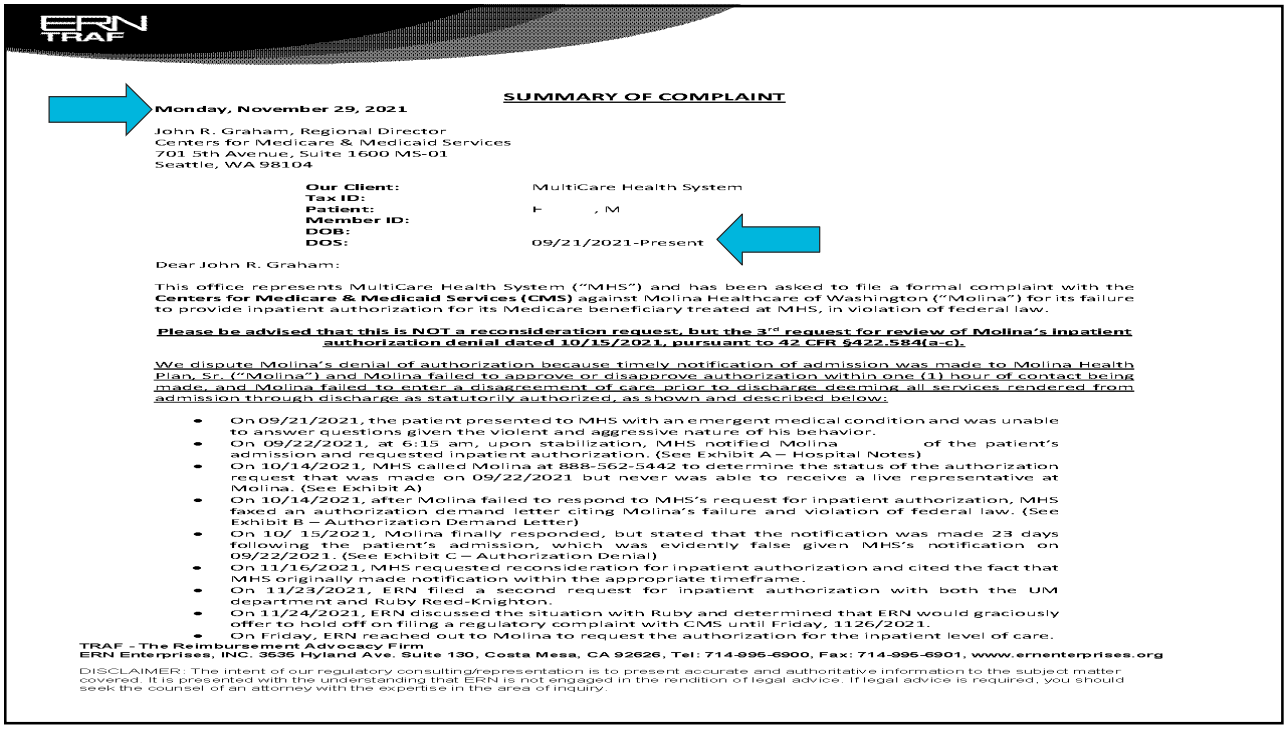

SUMMARY OF COMPLAINT

Monday, November 29, 2021

John R. Graham, Regional Director
Centers for Medicare & Medicaid Services
701 5th Avenue, Suite 1600 MS-01
Seattle, WA 98104

Our Client:	MultiCare Health System
Tax ID:	
Patient:	, M
Member ID:	
DOB:	
DOS:	09/21/2021-Present

Dear John R. Graham:

This office represents MultiCare Health System ("MHS") and has been asked to file a formal complaint with the **Centers for Medicare & Medicaid Services (CMS)** against Molina Healthcare of Washington ("Molina") for its failure to provide inpatient authorization for its Medicare beneficiary treated at MHS, in violation of federal law.

Please be advised that this is NOT a reconsideration request, but the 3rd request for review of Molina's inpatient authorization denial dated 10/15/2021, pursuant to 42 CFR §422.584(a-c).

We dispute Molina's denial of authorization because timely notification of admission was made to Molina Health Plan, Sr. ("Molina") and Molina failed to approve or disapprove authorization within one (1) hour of contact being made, and Molina failed to enter a disagreement of care prior to discharge deeming all services rendered from admission through discharge as statutorily authorized, as shown and described below:

- On 09/21/2021, the patient presented to MHS with an emergent medical condition and was unable to answer questions given the violent and aggressive nature of his behavior.
- On 09/22/2021, at 6:15 am, upon stabilization, MHS notified Molina of the patient's admission and requested inpatient authorization. (See Exhibit A – Hospital Notes)
- On 10/14/2021, MHS called Molina at 888-562-5442 to determine the status of the authorization request that was made on 09/22/2021 but never was able to receive a live representative at Molina. (See Exhibit A)
- On 10/14/2021, after Molina failed to respond to MHS's request for inpatient authorization, MHS faxed an authorization demand letter citing Molina's failure and violation of federal law. (See Exhibit B – Authorization Demand Letter)
- On 10/ 15/2021, Molina finally responded, but stated that the notification was made 23 days following the patient's admission, which was evidently false given MHS's notification on 09/22/2021. (See Exhibit C – Authorization Denial)
- On 11/16/2021, MHS requested reconsideration for inpatient authorization and cited the fact that MHS originally made notification within the appropriate timeframe.
- On 11/23/2021, ERN filed a second request for inpatient authorization with both the UM department and Ruby Reed-Knighton.
- On 11/24/2021, ERN discussed the situation with Ruby and determined that ERN would graciously offer to hold off on filing a regulatory complaint with CMS until Friday, 1126/2021.
- On Friday, ERN reached out to Molina to request the authorization for the inpatient level of care.

TRAF - The Reimbursement Advocacy Firm
ERN Enterprises, INC. 3535 Hyland Ave. Suite 130, Costa Mesa, CA 92626, Tel: 714-996-6900, Fax: 714-996-6901, www.ernenterprises.org

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- On 11/29/2021, ERN called Ruby who noted that her counterparts have not reached a determination on issuing authorization or determining placement for this patient after the patient has been in the inpatient level of care for sixty-nine (69) days.
- To date, Molina has failed to properly address a timely submitted inpatient admission notification and request for authorization and has further failed to assume care of the patient.

Pursuant to **42 CFR §422.584(a-c):**

*(a) **Who may request an expedited reconsideration.** An enrollee or a physician (regardless of whether he or she is affiliated with the MA organization) may request that an MA organization expedite a reconsideration of a determination that involves the issues described in § 422.566(b)(3) and (b)(4). (This does not include requests for payment of services already furnished.)*

*(b) **How to make a request.***

(1) To ask for an expedited reconsideration, an enrollee or a physician acting on behalf of an enrollee must submit an oral or written request directly to the MA organization or, if applicable, to the entity responsible for making the reconsideration, as directed by the MA organization.

(2) A physician may provide oral or written support for a request for an expedited reconsideration.

*(c) **How the MA organization must process requests.** The MA organization must establish and maintain the following procedures for processing requests for expedited reconsiderations:*

*(1) **Handling of requests.** The MA organization must establish an efficient and convenient means for individuals to submit oral or written requests, document all oral requests in writing, and maintain the documentation in the case file.*

*(2) **Prompt decision.** Promptly decide on whether to expedite the reconsideration or follow the timeframe for standard reconsideration based on the following requirements:*

(i) For a request made by an enrollee, the MA organization must provide an expedited reconsideration if it determines that applying the standard timeframe for reconsidering a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

(ii) For a request made or supported by a physician, the MA organization must provide an expedited reconsideration if the physician indicates that applying the standard timeframe for conducting a reconsideration could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Moreover, **42 CFR §422.566(b)(3-4)** states:

***Actions that are organization determinations.** An organization determination is any determination made by an MA organization with respect to any of the following:*

(3) The MA organization's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the MA organization.

(4) Reduction, or premature discontinuation, of a previously authorized ongoing course of treatment.

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I. MOLINA IS REQUIRED TO REIMBURSE ALL POST-STABILIZATION SERVICES RENDERED UP UNTIL DISCHARGE AS IT FAILED TO ISSUE A TIMELY ORGANIZATION DETERMINATION.

MHS properly notified Molina of its request for inpatient authorization via fax, which MOLINA acknowledged. Molina was required to respond with approval within one (1) hour or disapproval and assume care of the patient as required by federal law. As this did not occur, MHS's treating physicians had the right to continue to treat the patient, and Molina is financially responsible for all services rendered from admission through discharge under federal law.

As you may know, **42 CFR §422.113(c)(2)(iii)** states:

> *(2) MA organization financial responsibility.* The MA organization –
>
> *(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.* (Emphasis added.)

Pursuant to the above-cited regulations, Molina is ultimately responsible for the timely reimbursement of this claim as it failed to issue a timely organization determination within (1) hour either approving services or disapproving services and assuming care of the patient. Thus, these post-stabilization services were deemed authorized after Molina failed to authorize or assume care of the patient and arrange for transfer within one (1) hour from the time MHS submitted inpatient authorization requests and clinicals.

Please note, with Traditional Medicare, a prior 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. However, Molina is an MAO, and its right to conduct a retrospective medical review, as Traditional Medicare would have, is superseded by **42 CFR §422.113(c)** which requires Molina to issue a timely organization determination within one (1) hour of receiving inpatient notice.

The CMS publication titled "*Improper Use of Advance Notices of Non-coverage*" dated May 5, 2014, provides further evidence that Molina's failure to approve or disapprove authorized within the statutory timeframes has deemed such requested inpatient post-stabilization services authorized.

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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."

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 Molina, an MAO, 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.

As Molina failed to respond or assume care of its enrollee within the required timeframe, the treating physicians at MHS had the right to continue to treat the beneficiary until one of the criteria in **42 CFR §422.113 (c)(3)** were met, as shown below:

> *(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.)

Per **42 CFR §422.113(c)(3)**, Molina's responsibility would end when, (i) a plan physician assumed care of the enrollee, (ii) the enrollee was transferred, (iii) the treating physician and Molina reached an agreement concerning the enrollee's care, (iv) or when the enrollee was discharged. As (i-iii) did not occur, Molina's responsibility ended when the enrollee was discharged. Therefore, Molina remains financially responsible for all post-stabilization services and care rendered to its Medicare beneficiary.

Additionally, as you know, the **Molina Healthcare Provider Manual (Pgs. 45-46)** states:

> ***Molina or its delegated entity arranges for poststabilization services to ensure that the patient remains stabilized from the time the treating hospital requests authorization until the time the patient is discharged or a contracting medical Provider agrees to other arrangements.***
>
> ***After stabilization of the Member, Molina requires preapproval of further post-stabilization services by a participating Provider or other Molina representative. Failure to review and render a decision on the post-stabilization preservice request within one hour of receipt of the call shall be deemed an authorization of the request.***
>
> ***Molina or its delegated entity is financially responsible for these services until Molina or its delegated entity becomes involved with managing or directing the Member's care.***

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As MHS properly notified Molina of its request for inpatient authorization on 09/22/2021, Molina was required to respond within one hour of the request. After Molina failed to respond for the duration of twenty-two (22), MHS resorted to submitting an authorization demand letter outlining Molina's Failure. Molina responded to the authorization demand letter only stating that notification was not made in the required timeframe. Additionally, upon denying the authorization request, Molina failed to assume care of the patient as required above. Nevertheless, Molina remains financially responsible for this claim as they failed to respond within the required timeframe of one hour from the request made on 09/22/2021, establishing the inpatient post-stabilization care statutorily authorized.

For these reasons, we ask that the Centers for Medicare & Medicaid Services (CMS) review this matter and ensure Molina's compliance in the timely and proper adjudication of this claim involving placement for the patient following discharge and authorization for inpatient services rendered in good faith to the Medicare beneficiary.

Respectfully,

Cheyne W. Parkinson
Claims Compliance Auditor I
ERN/TRAF — The Reimbursement Advocacy Firm

Tel: 714-995-6900 ext. 6961 **Fax:** (714) 995-6901
Email: cheyneparkinson@ernenterprises.org

Enclosure: Exhibit A — Hospital Notes
Exhibit B — Authorization Demand Letter
Exhibit C — Authorization Denial

TRAF # 79472

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Cheyne Parkinson

From: Cheyne Parkinson
Sent: Tuesday, November 30, 2021 10:47 AM
To: 'Bennett, Kimberly'; 'charlie.galicia@
Cc: 'Reed-Knighton, Ruby'; Ed Norwood; Daniel Muhlbach
Subject: RE: Your request (Auth Received # 2128701395)

Importance: High

Tracking:

Recipient	Read
'Bennett, Kimberly'	
'charlie.galicia@	
'Reed-Knighton, Ruby'	
Ed Norwood	Read: 12/1/2021 1:29 PM
Daniel Muhlbach	Read: 11/30/2021 10:53 AM

Hello Charlie,

Thank you for your leadership and serious attention to this matter. I am e-mailing you to confirm that we have received notification of **authorization # 2128701395** for **DOS 09/21/2021-11/30/2021.**

As a result, we have withdrawn **CTM # C2103047024** upon Molina's diligence in redressing the issue we have outlined. As the patient remains in-house at the acute inpatient level of care, please be advised that we are continuing to monitor the situation very closely to ensure that MHS has the resources needed to render inpatient services to the Medicare beneficiary.

In addition, please note that CMS has been notified of the authorization issued for **the full DOS to date**, but I have also indicated that we will continue to keep them abreast of any changes in authorized care as MHS continues to treat this patient.

To document your leadership and role in redressing this matter, please provide your title for our compliance records.

Thank you again for your due diligence that has enriched MHS's ability to continue rendering high-quality care for this patient, as well as others, particularly during this volatile pandemic.

Best,
CWP

Cheyne W. Parkinson
Claims Compliance Auditor I | ERN | The Reimbursement Advocacy Firm
Office:714-995-6900 ext. 6961 | Direct Line 714-820-6961 | Fax:714-995-6901

www.ernenterprises.org

"And though your beginning was small, yet your latter end would greatly increase."
The Greatest Book Ever Written

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HOW DID WE DO THIS?

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CMS CENTERS for MEDICARE & MEDICAID SERVICES

TIMELY DETERMINATIONS
MAOs –42 CFR §422.566 (a)

(a) Responsibilities of the MA organization. Each MA organization **must have a procedure for making timely organization determinations** (in accordance with the requirements of this subpart) regarding the benefits an enrollee is entitled to receive under an MA plan, including basic benefits as described under § 422.100(c)(1) and mandatory and optional supplemental benefits as described under § 422.102, and the amount, if any, that the enrollee is required to pay for a health service. (Emphasis added.)

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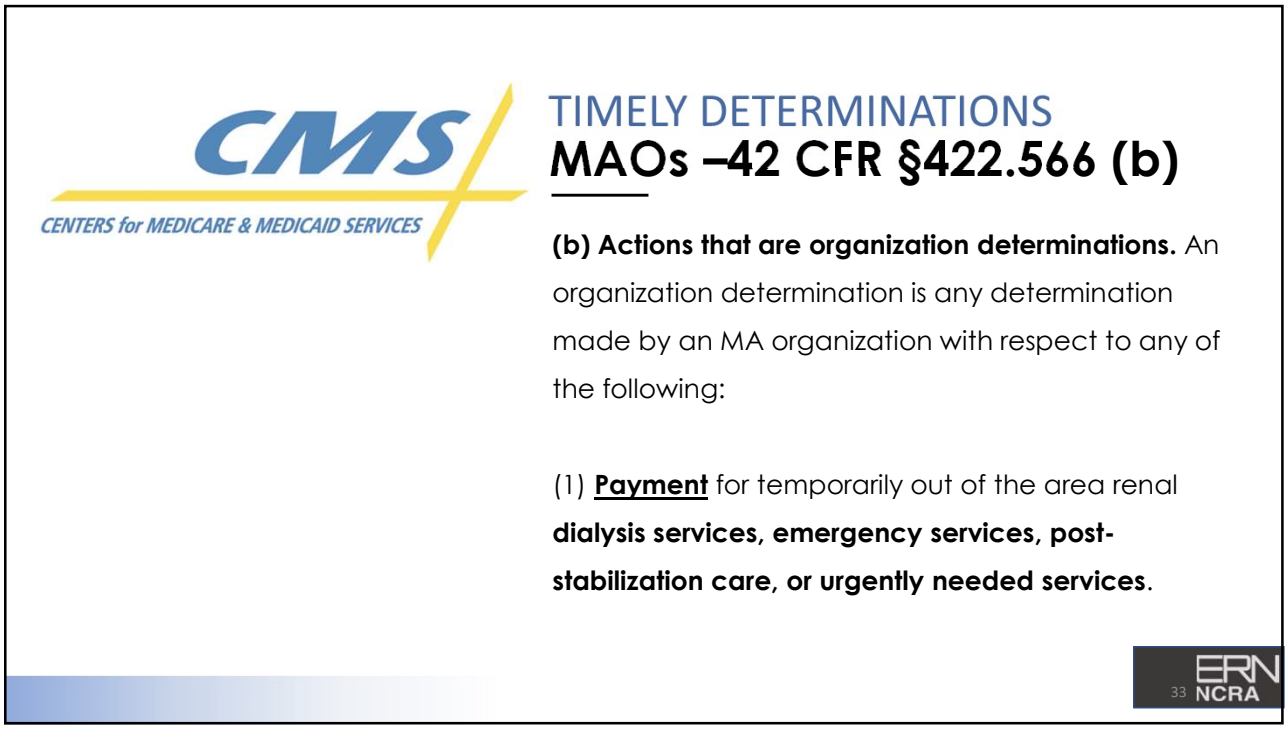
CMS
CENTERS for MEDICARE & MEDICAID SERVICES
TIMELY DETERMINATIONS
MAOs –42 CFR §422.566 (b)
(b) Actions that are organization determinations. An organization determination is any determination made by an MA organization with respect to any of the following:
(1) Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services.
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ERN NCRA

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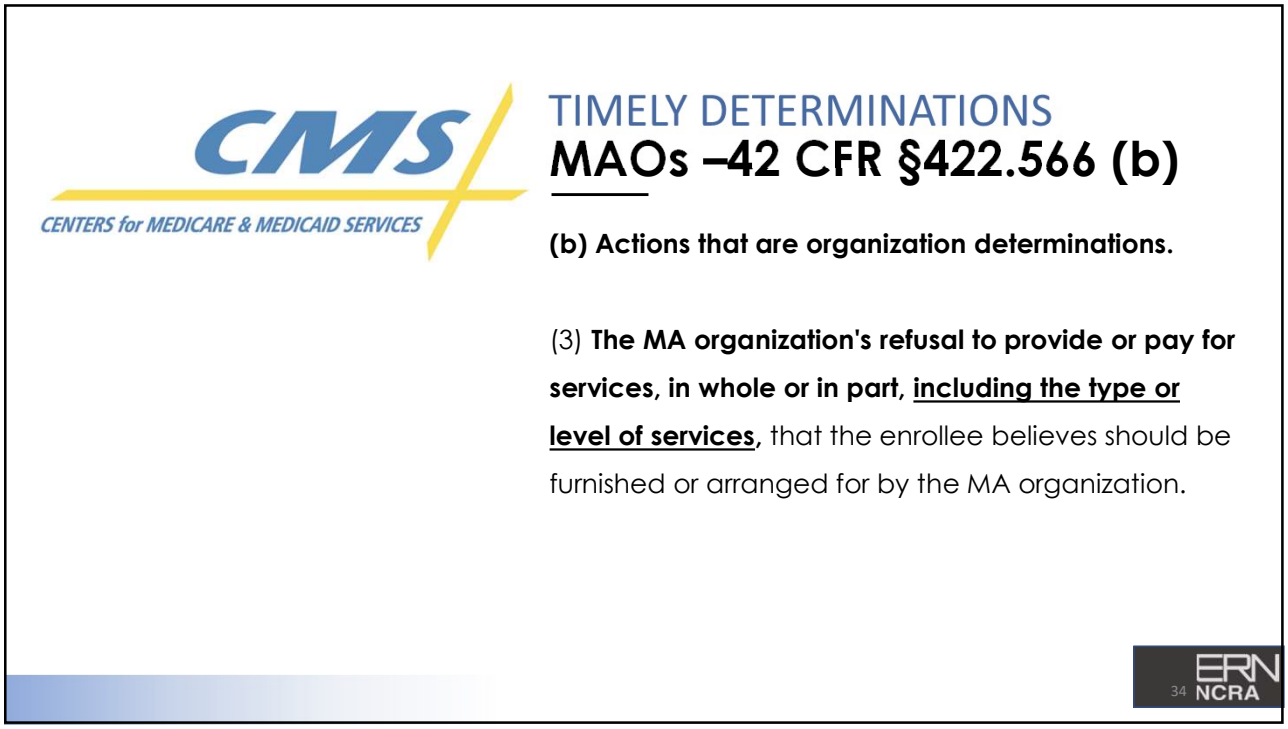
CMS
CENTERS for MEDICARE & MEDICAID SERVICES
TIMELY DETERMINATIONS
MAOs –42 CFR §422.566 (b)
(b) Actions that are organization determinations.
(3) The MA organization's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the MA organization.
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ERN NCRA

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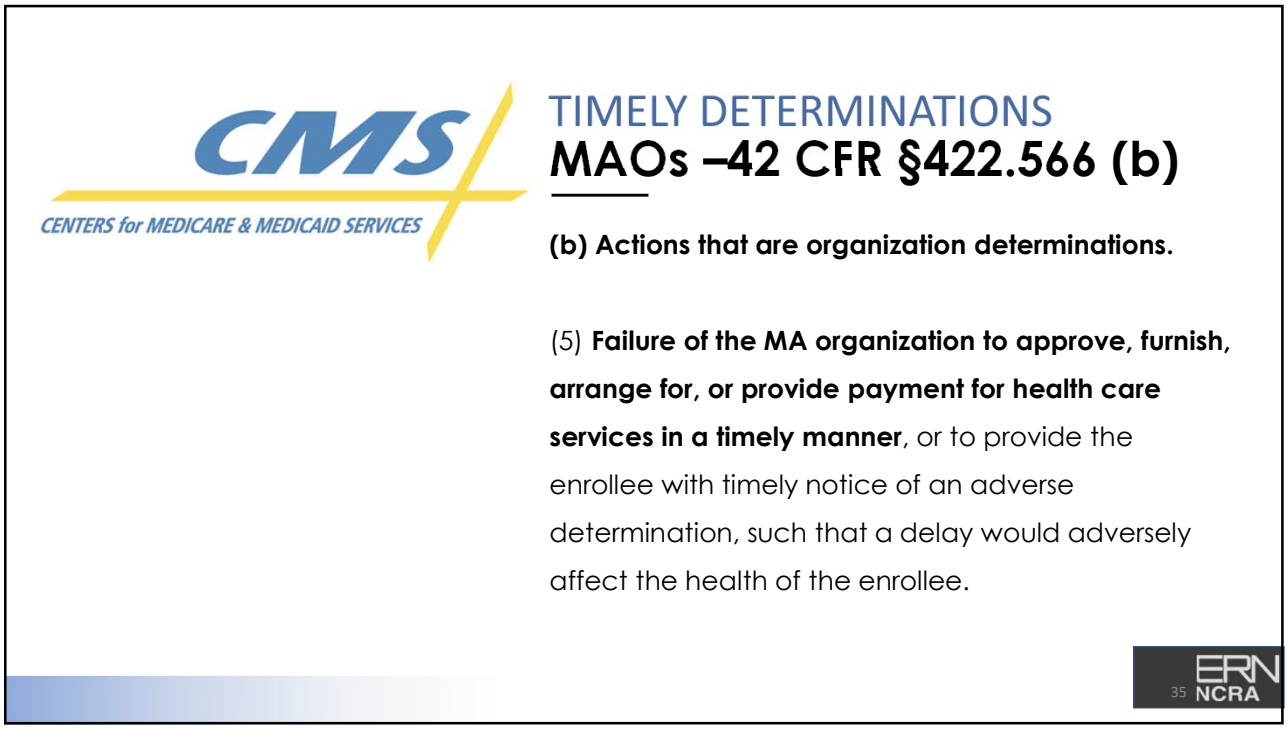
CMS
CENTERS for MEDICARE & MEDICAID SERVICES
TIMELY DETERMINATIONS
MAOs –42 CFR §422.566 (b)
(b) Actions that are organization determinations.
(5) Failure of the MA organization to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.
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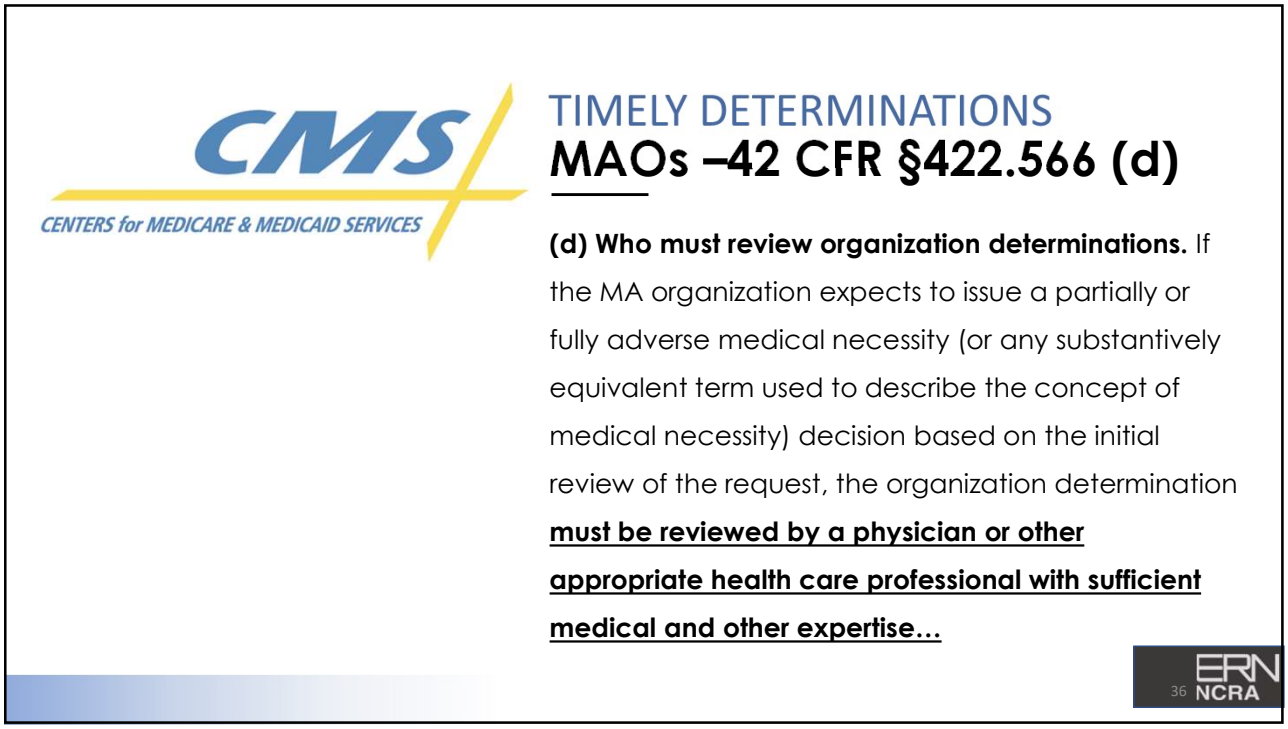
CMS
CENTERS for MEDICARE & MEDICAID SERVICES
TIMELY DETERMINATIONS
MAOs –42 CFR §422.566 (d)
(d) Who must review organization determinations. If the MA organization expects to issue a partially or fully adverse medical necessity (or any substantively equivalent term used to describe the concept of medical 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…
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CMS CENTERS for MEDICARE & MEDICAID SERVICES

TIMELY DETERMINATIONS
MAOs –42 CFR §422.566 (d)

(d) Who must review organization determinations.
…including knowledge of Medicare coverage criteria, before the MA organization 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. (Emphasis added.)

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CMS CENTERS for MEDICARE & MEDICAID SERVICES

POSTSTABILIZATION
MAOs –42 CFR §422.113

(c)(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;**

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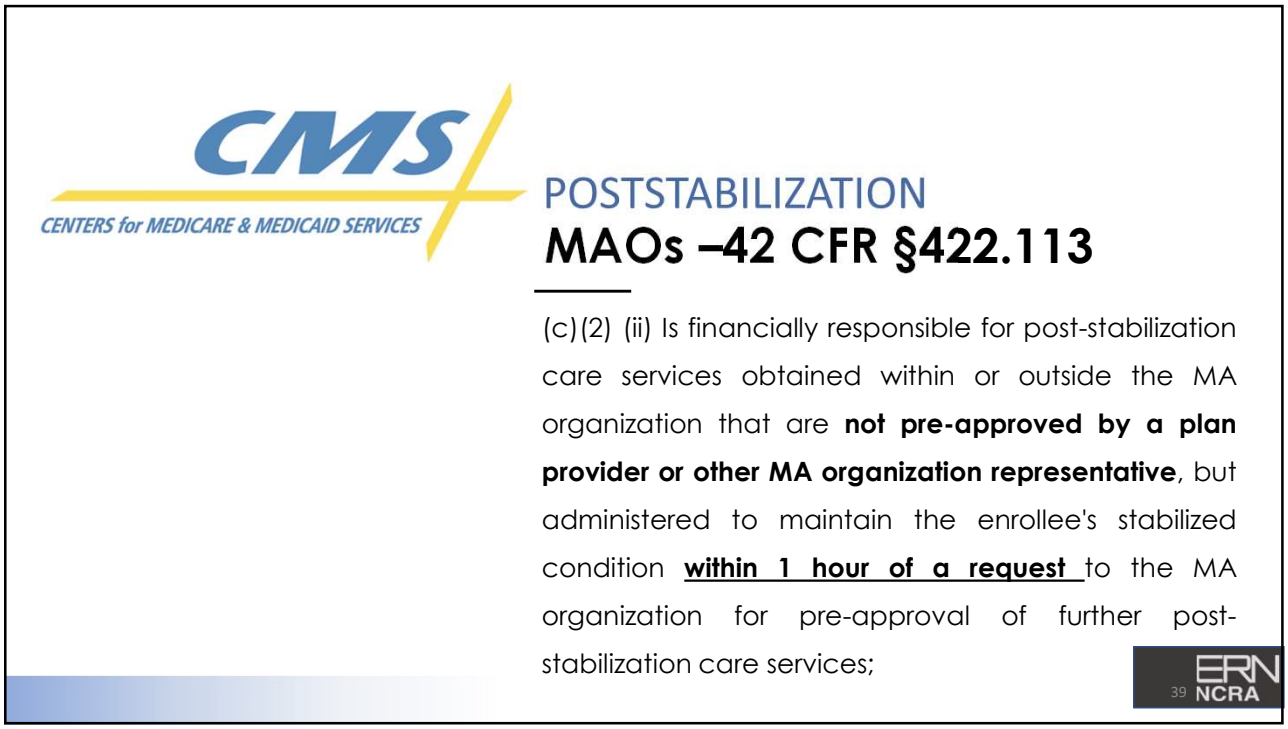
CMS
CENTERS for MEDICARE & MEDICAID SERVICES
POSTSTABILIZATION
MAOs –42 CFR §422.113
(c)(2) (ii) Is financially responsible for post-stabilization care services obtained within or outside the MA organization that are **not pre-approved by a plan provider or other MA organization representative**, but 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;
39
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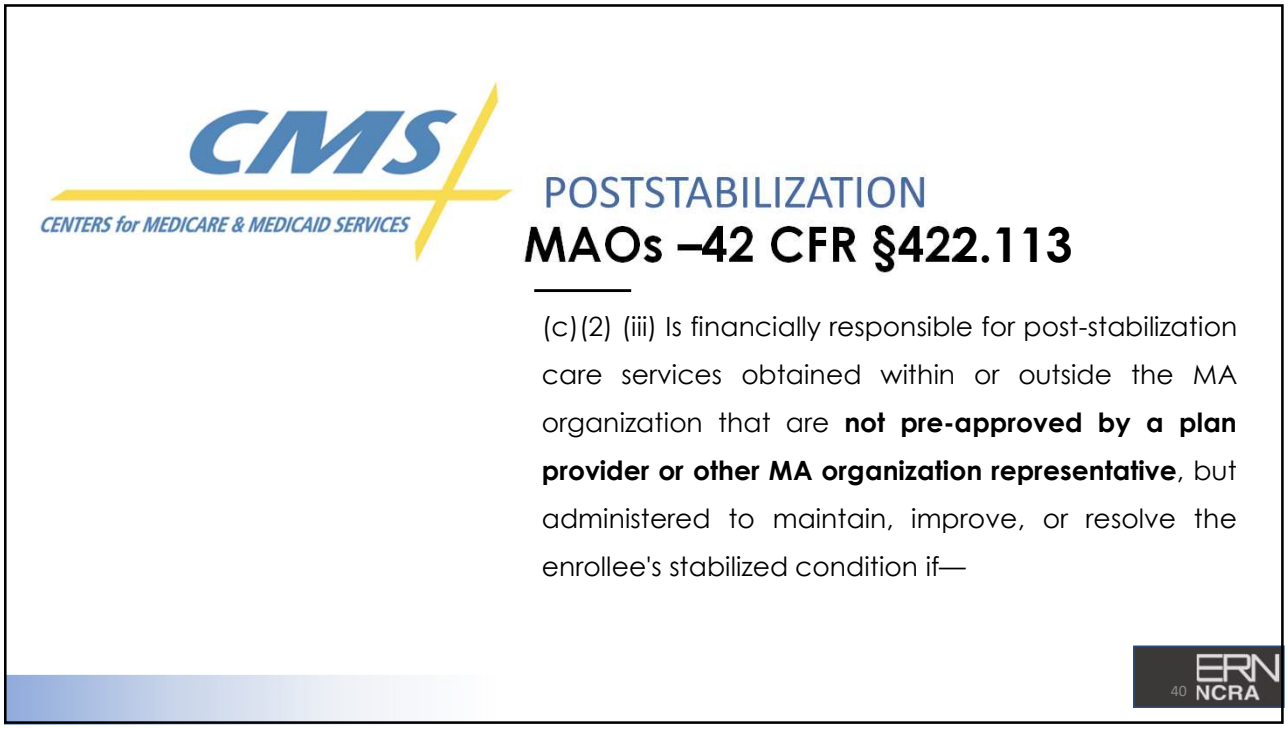
CMS
CENTERS for MEDICARE & MEDICAID SERVICES
POSTSTABILIZATION
MAOs –42 CFR §422.113
(c)(2) (iii) Is financially responsible for post-stabilization care services obtained within or outside the MA organization that are **not pre-approved by a plan provider or other MA organization representative**, but administered to maintain, improve, or resolve the enrollee's stabilized condition if—
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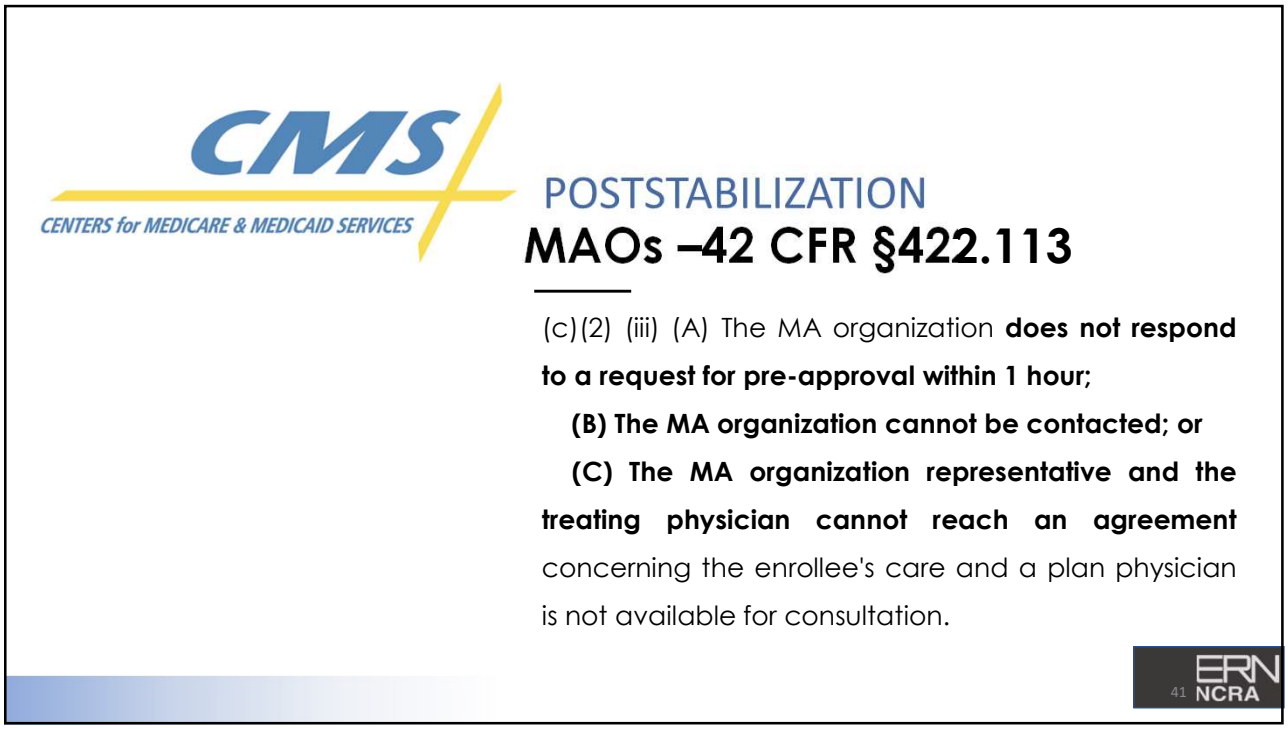
CMS
CENTERS for MEDICARE & MEDICAID SERVICES
POSTSTABILIZATION
MAOs –42 CFR §422.113
(c)(2) (iii) (A) The MA organization **does not respond to a request for pre-approval within 1 hour;**
(B) The MA organization cannot be contacted; or
(C) The MA organization representative and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultation.
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CMS
CENTERS for MEDICARE & MEDICAID SERVICES
POSTSTABILIZATION
MAOs –42 CFR §422.113
(c)(2) (iii) (C) 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;**
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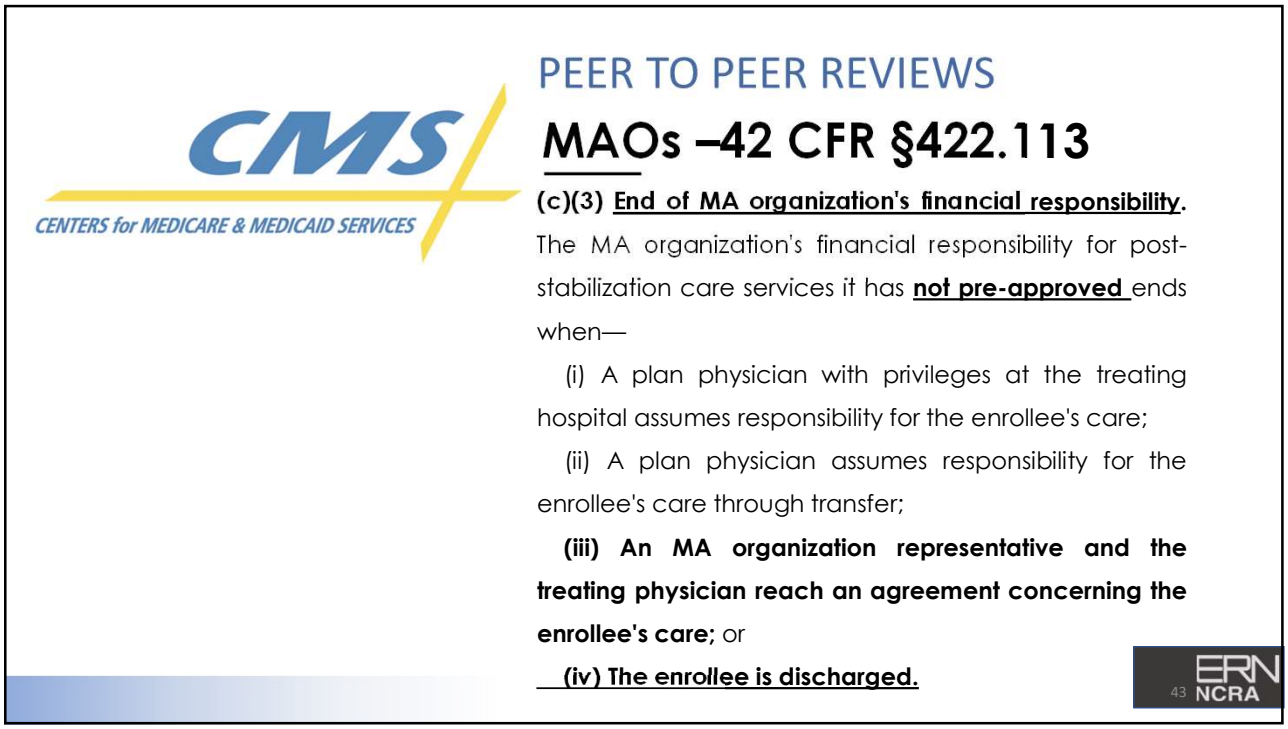
CMS
CENTERS for MEDICARE & MEDICAID SERVICES
PEER TO PEER REVIEWS
MAOs –42 CFR §422.113
(c)(3) End of MA organization's financial responsibility.
The MA organization's financial responsibility for post-stabilization care services it has not pre-approved ends when—
(i) A plan physician with privileges 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.
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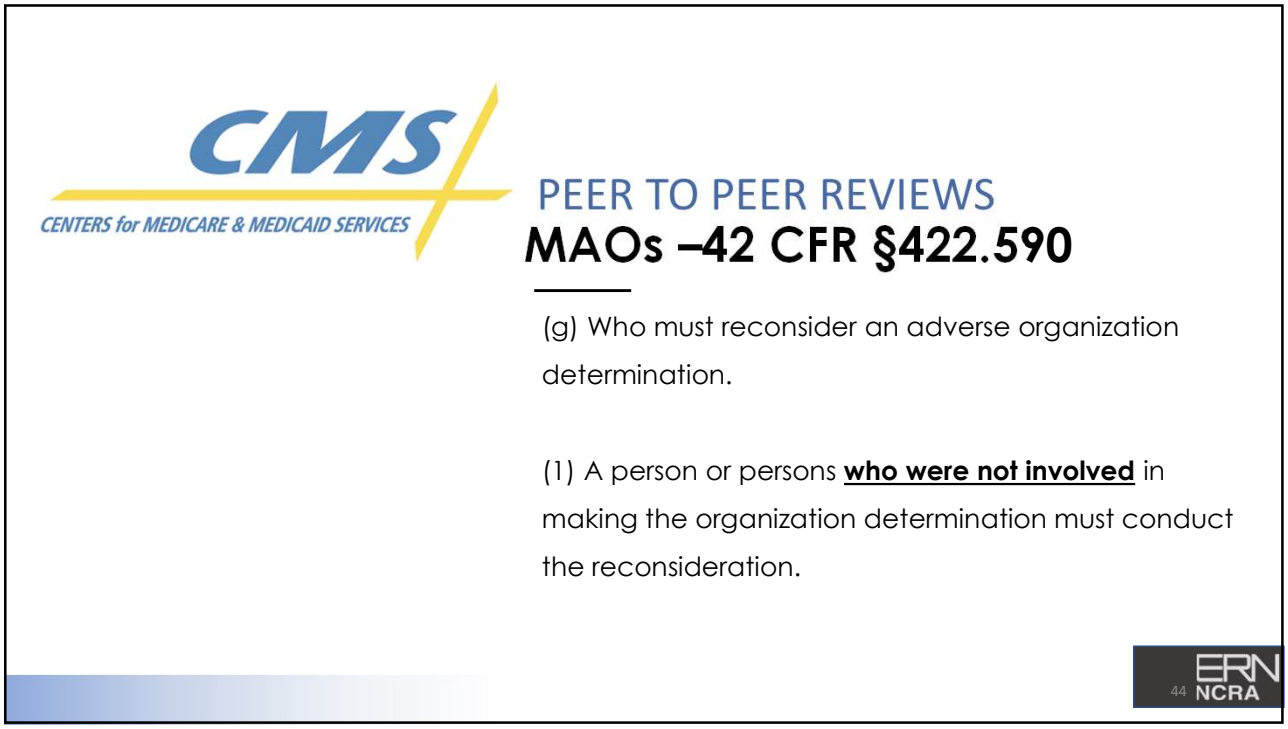
CMS
CENTERS for MEDICARE & MEDICAID SERVICES
PEER TO PEER REVIEWS
MAOs –42 CFR §422.590
(g) Who must reconsider an adverse organization determination.
(1) A person or persons who were not involved in making the organization determination must conduct the reconsideration.
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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

PEER TO PEER REVIEWS
MAOs –42 CFR §422.590

(g)(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.

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CASE STUDY

- NO RECORDS OR CLAIM ON FILE.

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ERN NCRA presents

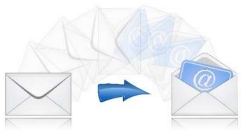
No Claim or Records on File

When a plan states NO CLAIM (OR RECORDS) ARE ON FILE, tell the plan:

(1) The claim/records are presumed to be received !

"This claim was submitted to you through our claims clearing house and not rejected OR The records were faxed on a secure line successfully with a fax confirmation sheet.

Under the common law Mailbox Rule, "proper and timely mailing of a document [properly addressed and deposited in the USPS] raises a rebuttable presumption that it is received by the addressee." Anderson v. United States, 966 F. 2d 487, 491 (9th Cir. 1992)



(2) The claim is beyond the statutory timeframes for prompt payment (if applicable.)

(3) If you have lost the claim (or records), you have mishandled PHI; I will fax you a copy of the claim (or records) you lost !

"You are reminded that this office is monitoring any possible Health Insurance Portability and Accountability Act (HIPAA) violations that may have occurred due to the mishandling and possible loss of claims and/or medical records. The HIPAA Privacy Rule requires a covered entity to maintain reasonable and appropriate administrative, technical, and physical safeguards to prevent intentional or unintentional use or disclosure of protected health information in violation of the Privacy Rule. PLEASE PROCESS THIS CLAIM ON A RUSH BASIS." 45 C.F.R. §164.530(c)

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Ed Norwood

From: Solomon, Frankie J [redacted]
Sent: Thursday, April 11, 2
To: Ed Norwood
Subject: HIPAA Testimonial

My VP and myself attended one of Ed's talks last year and were very excited about the things that we learned. The one with the biggest impact for our hospitals has been his HIPAA terminology. I must say that I was skeptical when Ed shared the idea of utilizing the HIPAA terminology with payors that claimed to not have received clinicals. I assumed that the payors would ignore this and continue to play the games that they had been playing. I WAS WRONG! I shared the technique with the Case Management Directors at our hospitals and within days I was receiving emails singing the praises of this. The Directors were amazed at how quickly the payors were changing their story and authorizing all days once they were notified that we were going to report the HIPAA violation to the OIG. It has definitely been a great piece of leverage for our hospitals. Thanks Ed!

Thanks- Frankie

Frankie Solomon, BSN, CCM, IQCI
Director of Denial Prevention & Recovery
[redacted]

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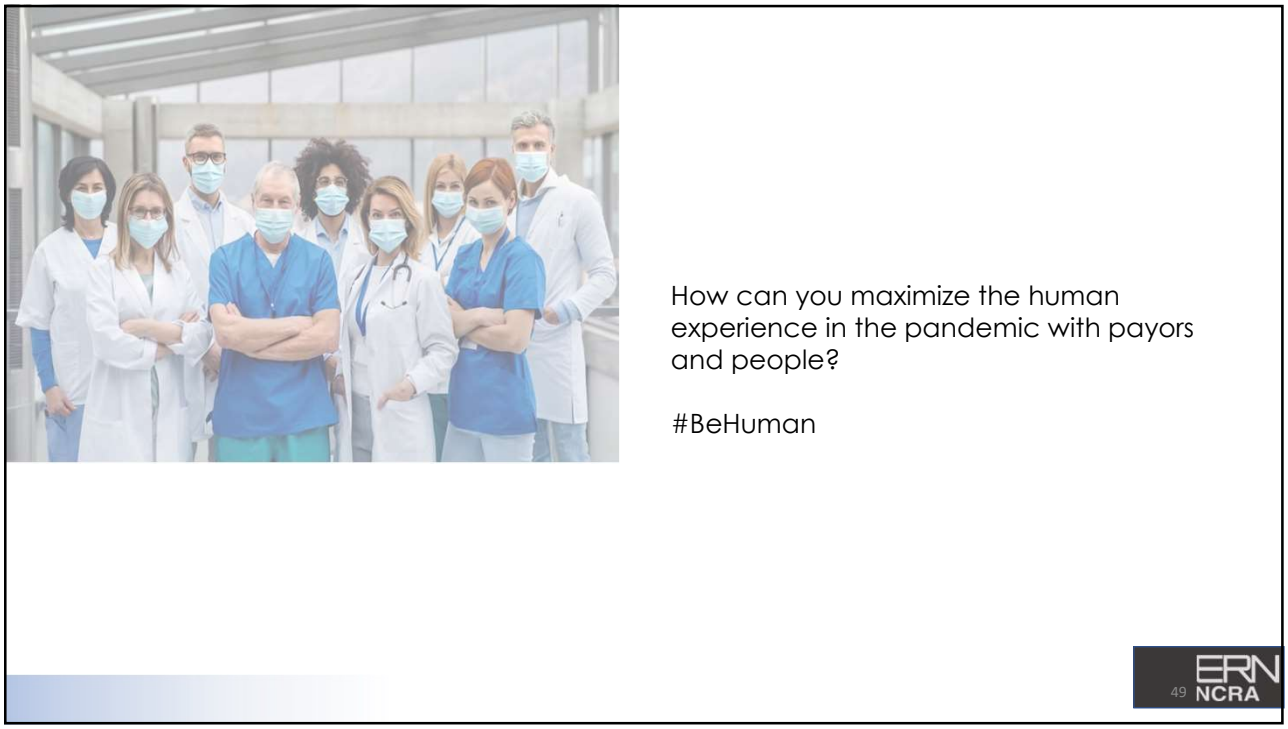
How can you maximize the human experience in the pandemic with payors and people?
#BeHuman
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ERN NCRA

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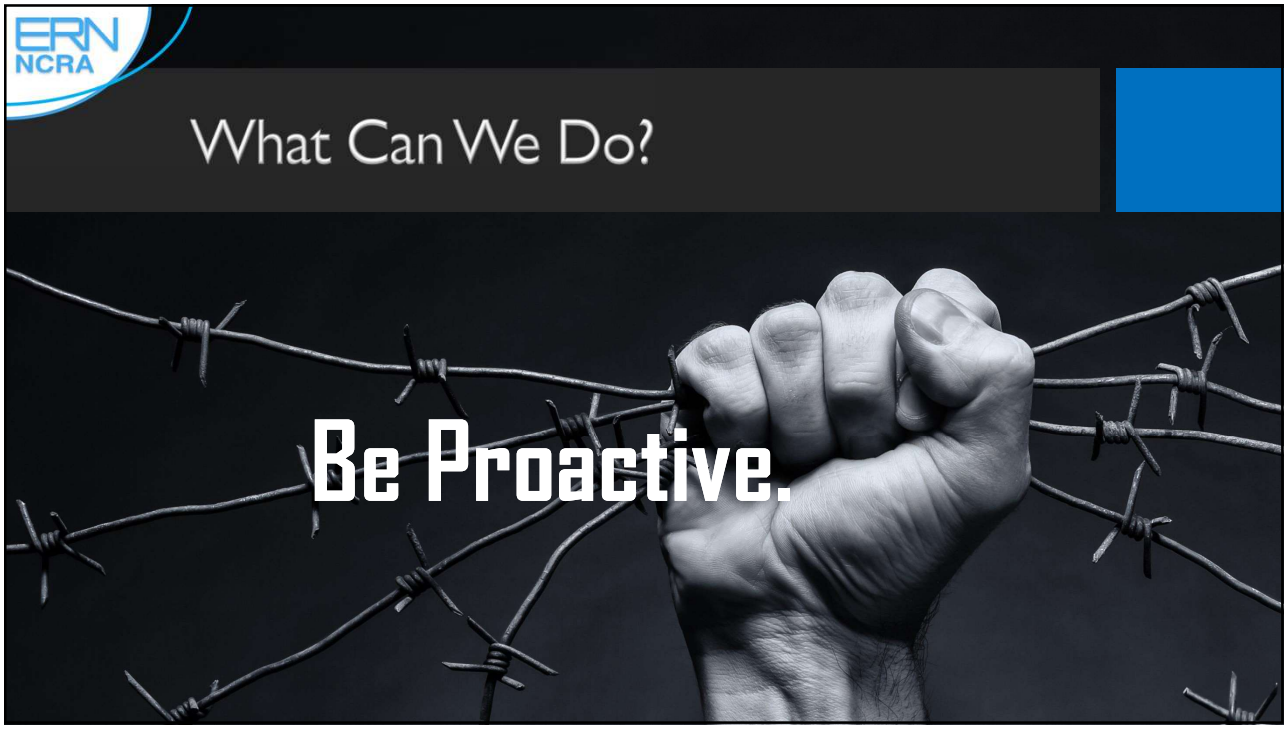
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What Can We Do?
Be Proactive.

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TRAF CLINICAL DENIAL PREVENTION

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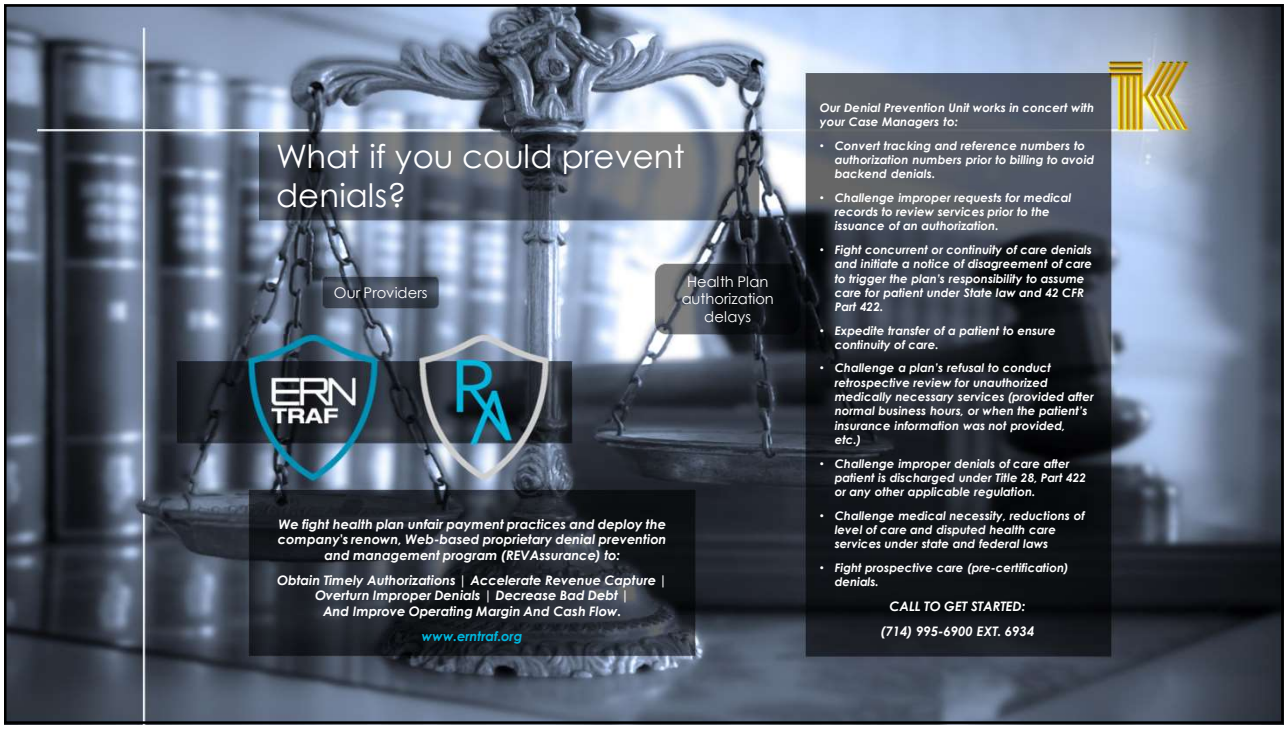
What if you could prevent denials?
Our Providers
Health Plan authorization delays
ERN TRAF
RA
We fight health plan unfair payment practices and deploy the company's renown, Web-based proprietary denial prevention and management program (REVAssurance) to:
Obtain Timely Authorizations | Accelerate Revenue 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 State law 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

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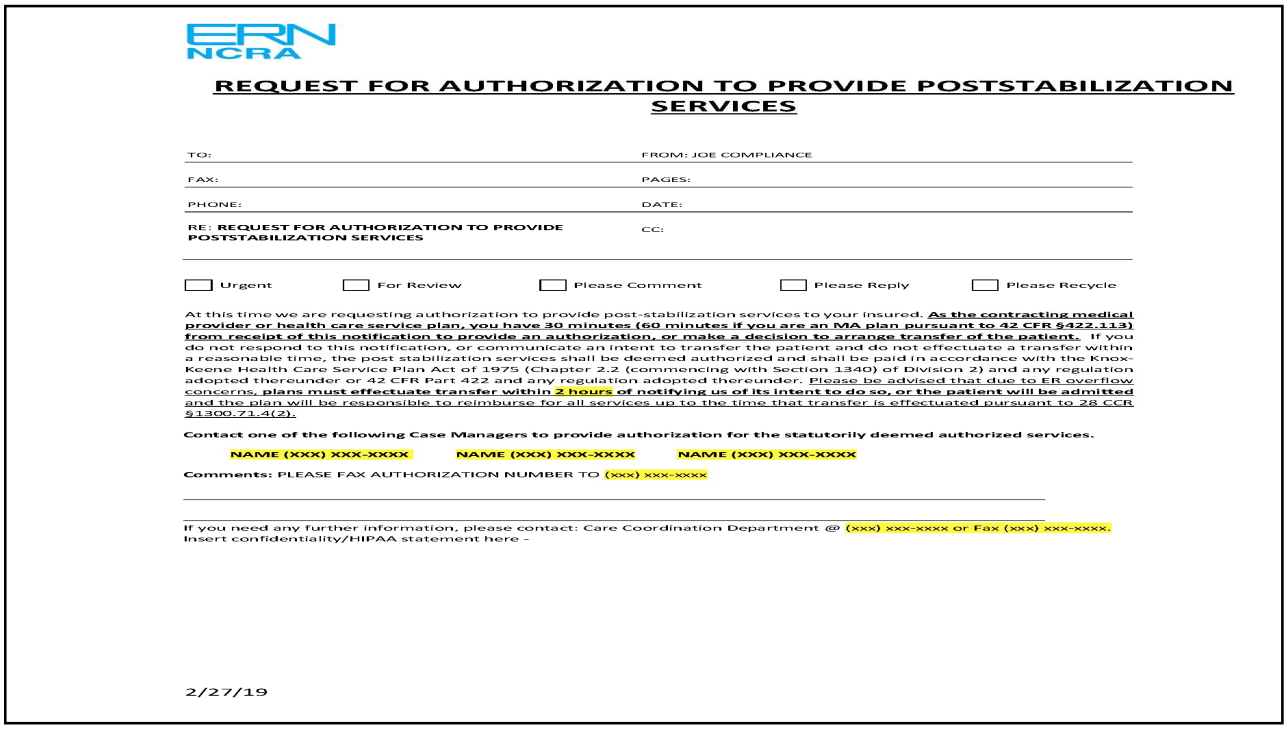

ERN NCRA

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 -

2/27/19

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ERN NCRA

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 -

2/27/19

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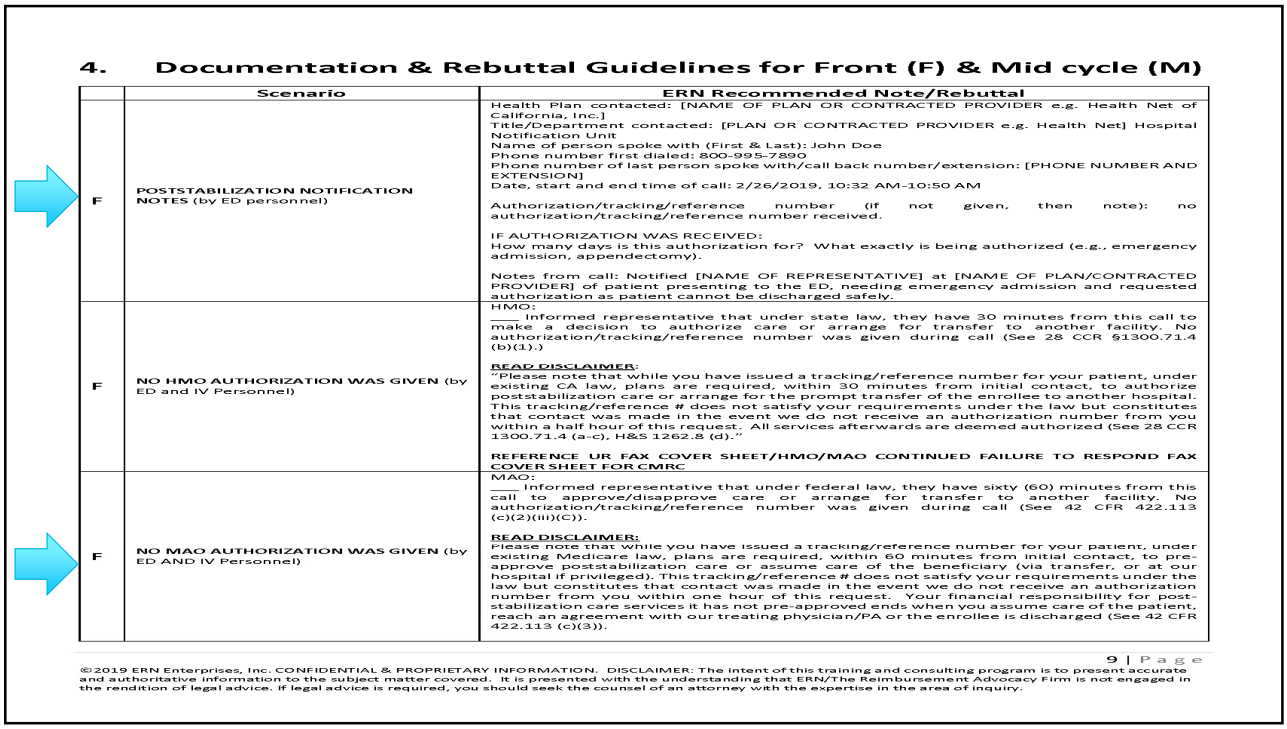

4. Documentation & Rebuttal Guidelines for Front (F) & Mid cycle (M)

	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)).

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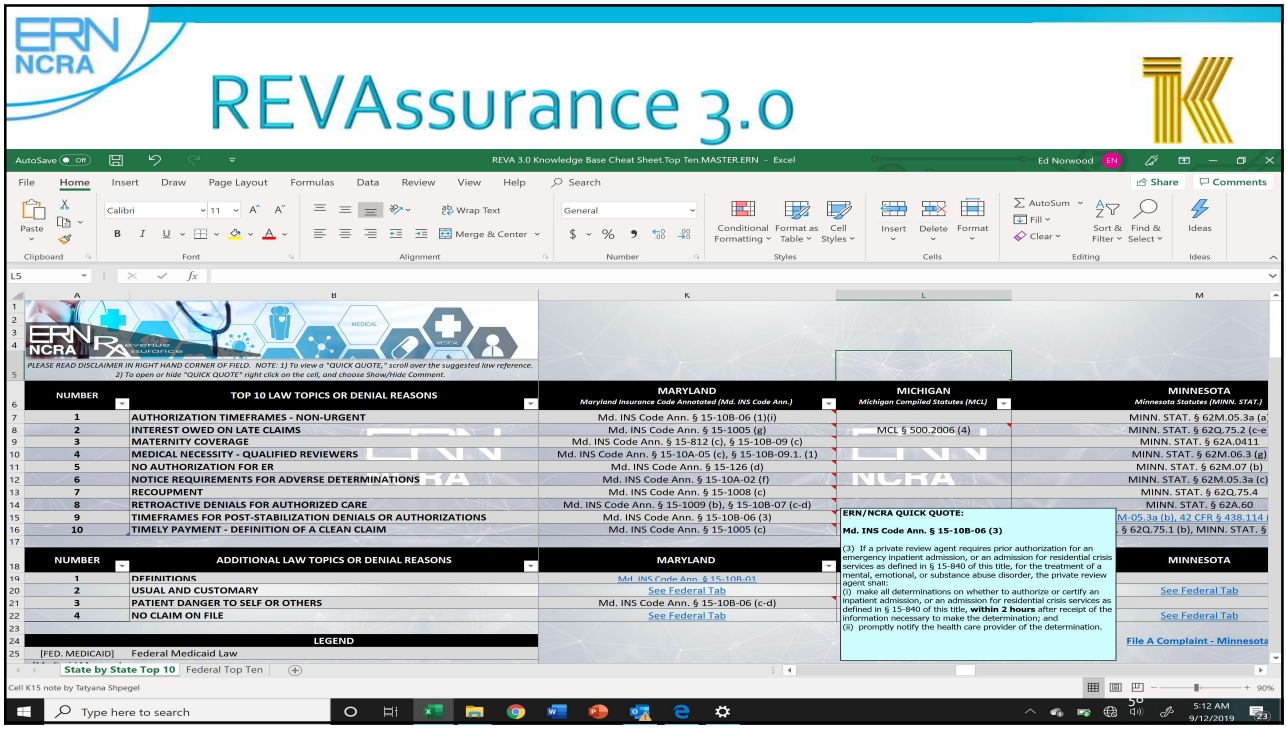

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RevAssurance Online

Programs

- Federal
  - Includes Federal resources for MA, ERISA, VA
- Professional
  - Includes resources for Federal and CA (HMO and PPO)
- Enterprise
  - Includes Federal resources and allows you to add any number of state components

Support

- Bronze
  - Online Support & Appeal Letter Review
- Silver
  - Everything in Bronze
  - Letter Customization
  - Monthly Representation Calls
- Gold
  - Everything in Silver
  - ON DEMAND Consulting

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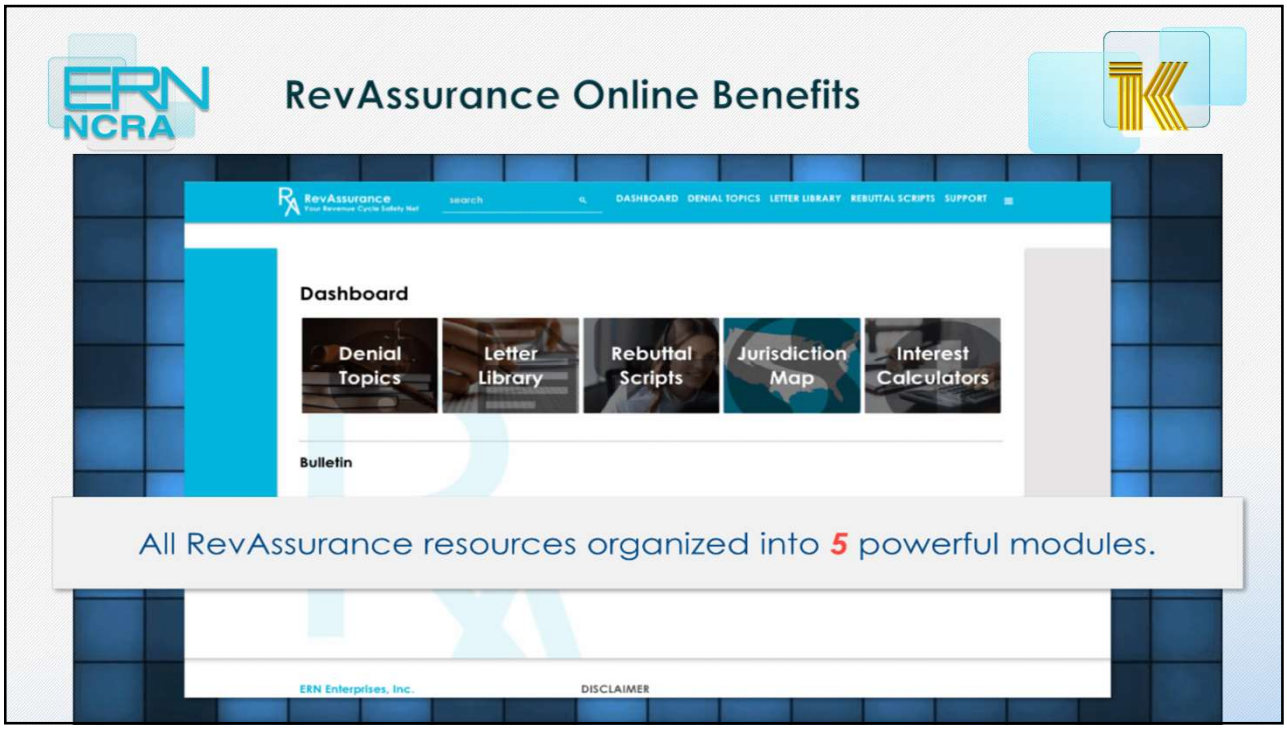
ERN
NCRA
RevAssurance Online Benefits
RevAssurance
DASHBOARD DENIAL TOPICS LETTER LIBRARY REBUTTAL SCRIPTS SUPPORT
Dashboard
Denial Topics
Letter Library
Rebuttal Scripts
Jurisdiction Map
Interest Calculators
Bulletin
All RevAssurance resources organized into 5 powerful modules.
ERN Enterprises, Inc.
DISCLAIMER

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ERN
NCRA
TRAF HELP DESK

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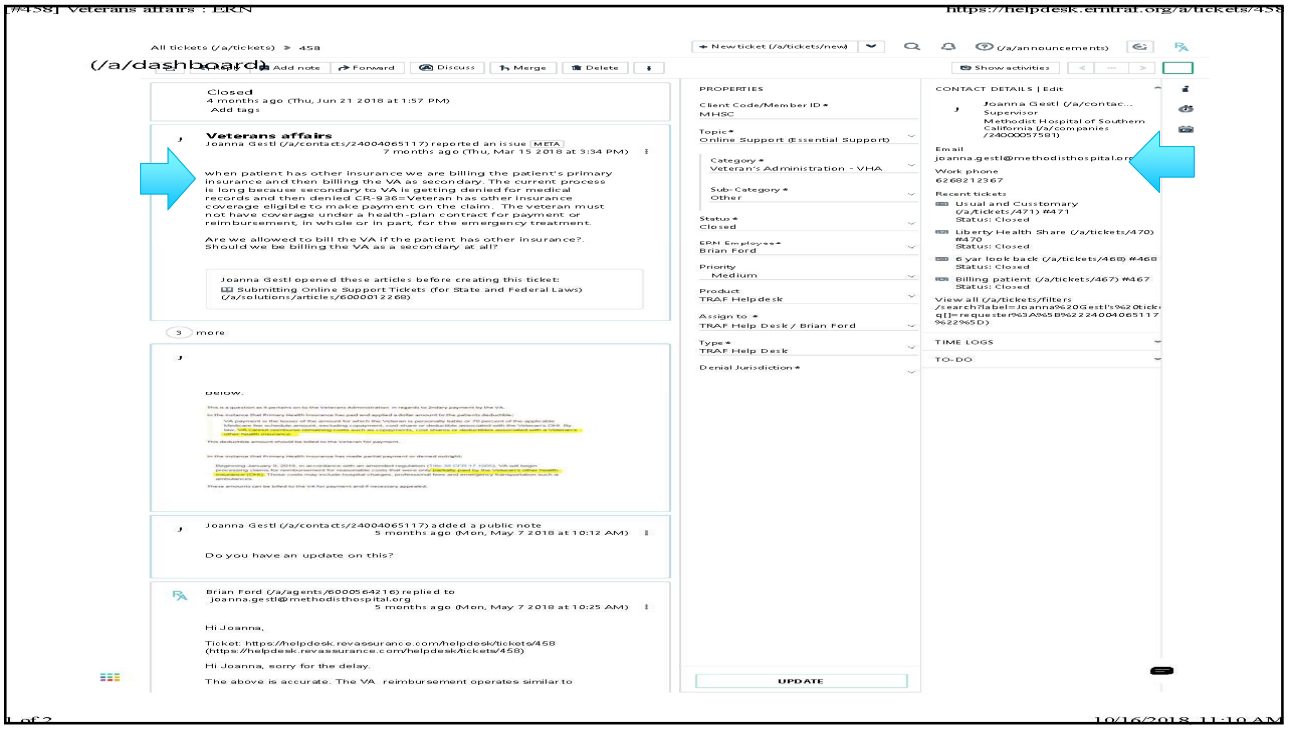
Veterans affairs
Joanna Gestl reported an issue
when patient has other insurance we are billing the patient's primary insurance and then billing the VA as secondary. The current process is long because secondary to VA is getting denied for medical records and then denied CR-9365 Veteran has other insurance coverage eligible to make payment on the claim. The veteran must not have coverage under a health-plan contract for payment or reimbursement, in whole or in part, for the emergency treatment.
Are we allowed to bill the VA if the patient has other insurance? Should we be billing the VA as a secondary at all?
Joanna Gestl opened these articles before creating this ticket:
Submitting Online Support Tickets (for State and Federal Laws)
Joanna Gestl added a public note
Do you have an update on this?
Brian Ford replied to joanna.gestl@methodisthospital.org
Hi Joanna,
Hi Joanna, sorry for the delay.
The above is accurate. The VA reimbursement operates similar to
UPDATE

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Presenter: Ed Norwood
www.ernenterprises.org
CLINICAL DENIALS COURSE (CDCC):
CONTACT US:
Ed Norwood, President
ERN/The National Council of Reimbursement Advocacy
ednorwood@ernenterprises.org
(714) 995-6900 ext. 6926
YOU FIGHT FOR THEM
WE FIGHT FOR YOU
Champions for MEDICALLY APPROPRIATE HEALTHCARE.
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