Payer's (Still) Going WILD

Medicare Advantage + Welcome to the 2 MN rule

AR Systems, Inc.

Day Egusquiza, President
AR Systems, Inc. & Patient Financial Navigator Foundation, Inc.

Day's Revenue Cycle Motto:

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

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AND START WITH A LITTLE "PAYER FUN"

THANKS, WARREN K/REGION 8 HFMA MEETING, 2022

U	usually	C	called
N	nine	I	in
I	in	G	got
T	ten	N	no
E	experience	A	answer
D	denials…..	++All time favorite: Singing the"Blues "	

Medicaid Redetermination

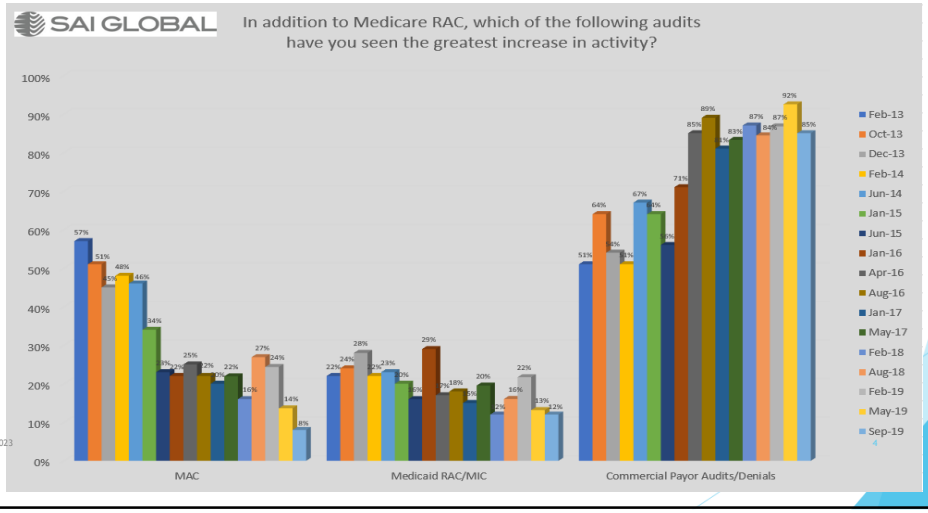
2023 2

Mgd Care Anguish-
A Brave New World Required-

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

8 year history with Compliance 360/SAI

AHA survey: 78% of hospitals =payer relationships are getting worse. 84% said the cost of complying with payer policies is increasing; 95% saw increase in staff time spent trying to get prior authorization. 11-22 Win/Lose!



"Most Medicare Advantage/MA Enrollees Are Satisfied with their coverage."

A Retirement Living Survey found that 71% of Medicare Advantage enrollees are satisfied with their coverage, and many respondents cited as their chief reasons:

1. Affordability
2. Prescription drug coverage
3. The ability to choose providers
4. Medical and preventive care options

61% said their current MA plans performed better than their previous coverage plan but only 44% said they full understand their MA coverage. (Fierce Healthcare 8-23)

How has 50% of all enrollees ended up in MA plans? A common practice:

If the Employer has an insurance and the insurance also has a MA plan-- the retirees are auto rollover to MA

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Medicare Advantage/MA Landscape Updates 2024

- Total Medicare Beneficiaries as of 12-23
- 65 Million. Over 100,000 new since 9-23.
- Of the 65M, 33 Million are Medicare Advantage

MA spending to outstrip traditional Medicare by $88B this yar: MedPAC. 1-16-24 (Dive Brief)

- The federal govt could pay MA plans $88B more this year than it would be spending if those seniors were in traditional Medicare, according to new data from MedPAC.
- That's because MA insurers attract healthier and therefore lower-cost individuals into their plans, and aggressively code the medical needs of their benes to recoup higher reimbursement from the govt.
- MA programs are growing but has also snowballing spending.
- In the report, MedPAC staff analyzed fed eral data and found overpayments to the MA plans have grown to $350B since 2020.

2023

- Favorable selection and diagnostic coding are spurring MA spending way beyond traditional Medicare.
- MedPAC also said the program's quality bonus system isn't a good measure of plan quality, joining other research groups who say the program needs reform.

Data Elements in 2024

- 47% say they are in excellent or very good health compared to 53% of traditional Medicare /TM enrollees.
- More than half of dually eligible for Medicaid benefits are enrolled in MA.
- About 38% of MA members have annual incomes of less than $25,000 compared to 23% of TM.
- Among those enrolled in MA, 54% are people of color.
- Four million people living in rural areas are enrolled in MA
- MA premiums and deductibles will increase of 5-12%
- 13 of the most popular supplemental benefits will be available to fewer enrollees in 2024.

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Hospitals at risk – **300+ rural hospitals at immediate risk of closure** –have lost $ on patient services with public assistance ending (PHE) and are not likely to receive sufficient funds to cover the losses. These hospitals have low reserves and more debt than assets. (Center for HealthCare Quality & Payment Reform 7-23) 37 have closed since 2020… WOW!

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

2021

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

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

- OIG completes audit of specific dx codes that Excellus Health Plan, Inc submitted to CMS. 7-2023
- Under the MA program, CMS makes monthly payments to MA organizations according to a system of risk adjustment that depends on the health status of each enrollee.
- MA are paid more for enrollees with dx associated with more intensive use of health resources.
- OIG audited 210 unique enrollee high-risk dx submitted that did NOT comply with federal requirements.
- Specifically 202 of 210 sampled, the medical record did not support the dx codes, resulting in $479K overpayments.
- Estimated Excellus received approx. $5.4M in overpayments 2017-2018. Too early to make them pay back which recently changed.

2023

- Excellus disagreed with all, but OIG confirmed

- **Cigna sued following ProPublica report on unreviewed batches of denied claims. 7-23**
- Two Cigna members have filed a class-action complaint against their insurer for allegedly denying large batches of member's claims without individual review- thereby denying them coverage for certain services.
- Many states require physicians to review pt files and coverage polices BEFORE denying claims for medical reasons.
- The suit alleges that Cigna has bypassed these steps by having an **Algorithm called " PXDX"** complete the review and then having physicians sign off on groups of denied claims.
- "Relying on the PXDX system, Cigna's doctors instantly reject claims on medical grounds (med necessity sound familiar?) without ever opening a pt file, leaving thousands of patients effectively without coverage and with unexpected bills. The scope of this problem is massive."
- Cigna denies.. For accelerating for low-cost screening…
- **HEY ELEVANCE HEALTH is seeing AI as a huge opportunity… quarterly earnings call… 7-23**

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

Know Traditional Regulations with references. Don't shoot from the hip.

WITH 10 YEARS OF NON-AUDITING OF A 2 MN PRESUMPTION STAY/FROM AND THRU DATES ON THE UB/BILLING DOCUMENT FOR TRADITIONAL MEDICARE, IT WILL BE THE FIRST TIME ROUTINE AUDITING CAN OCCUR ON 2 MN PRESUMPTION==FROM THE MEDICARE ADVANTAGE PLANS

BAD HABITS OF CHARTING: COPY FORWARD, COPY & PASTE – WILL BE EVIDENT IN THE NEW MA AUDITING WORLD.

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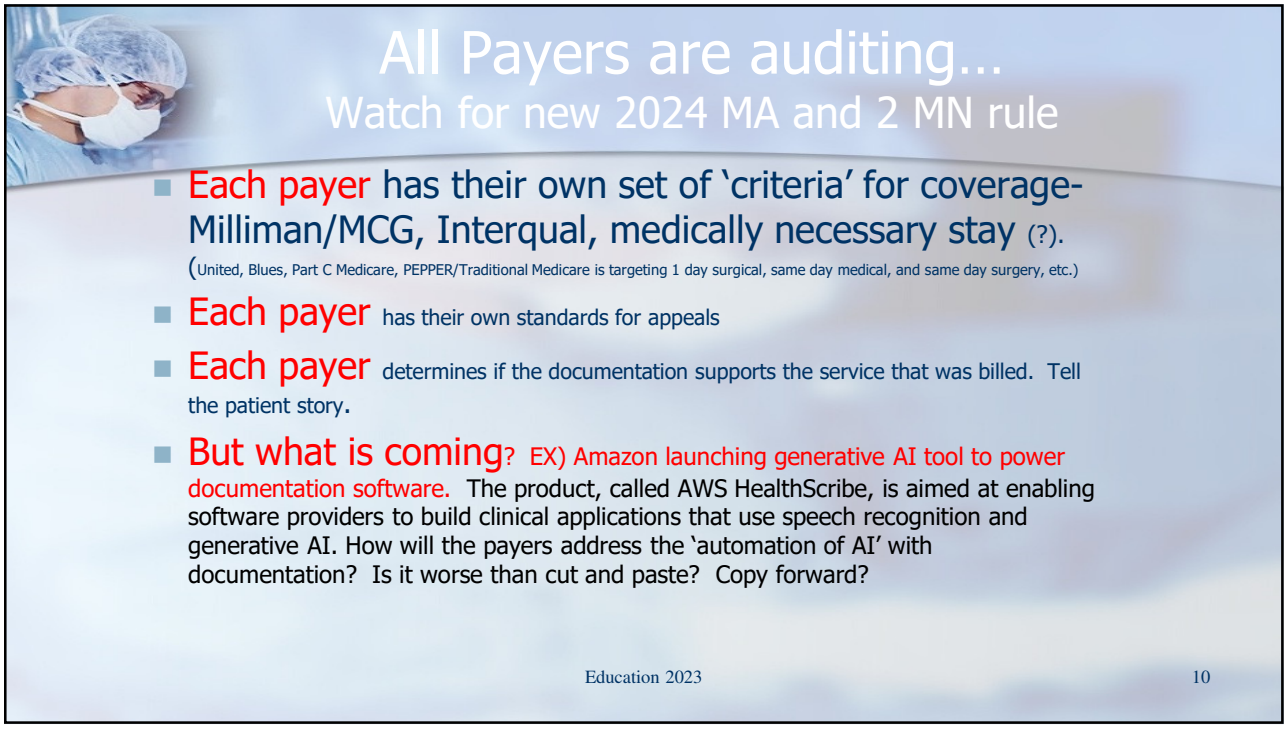

All Payers are auditing…

Watch for new 2024 MA and 2 MN rule

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

Education 2023

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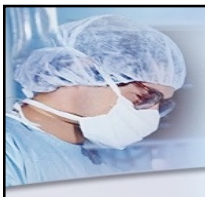
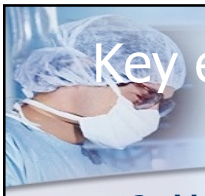


Why we LOVE the 2 MN Rule for Traditional Medicare?

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



Key elements of new Medicare inpt regulations – 2 methods

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

Pg 50959

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

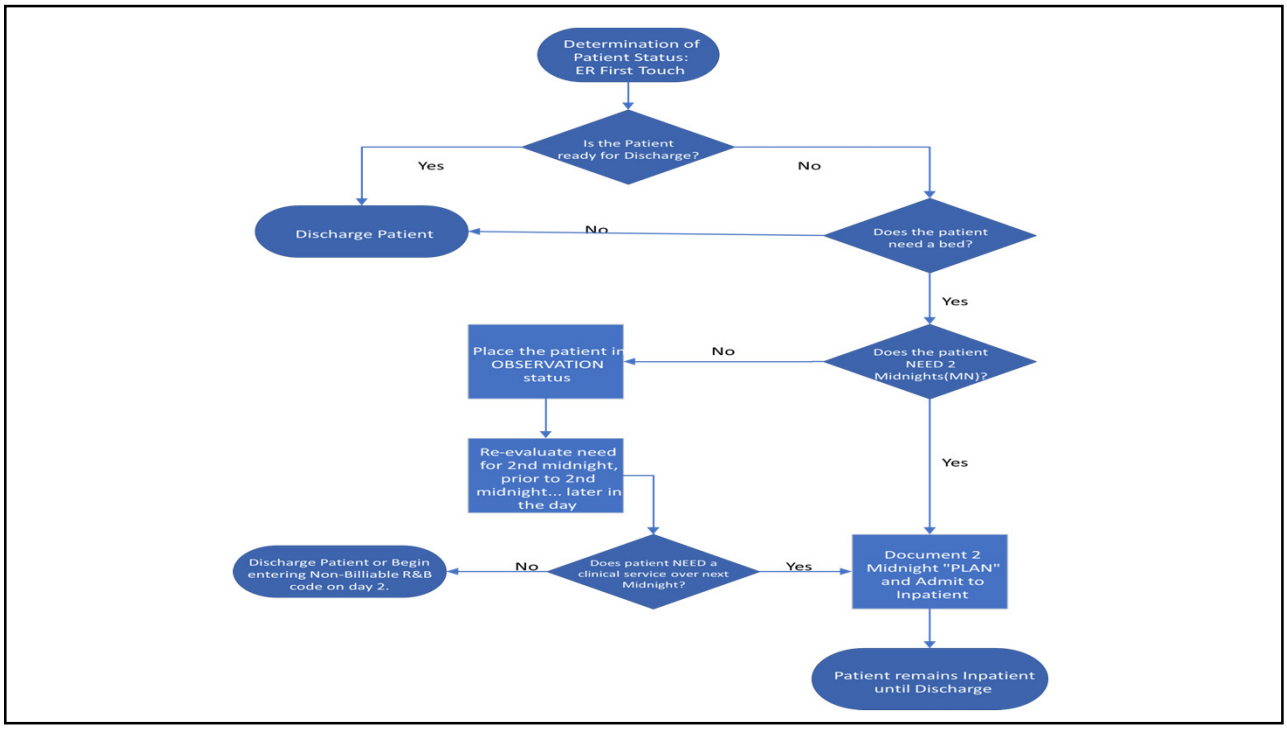
Pg 50956

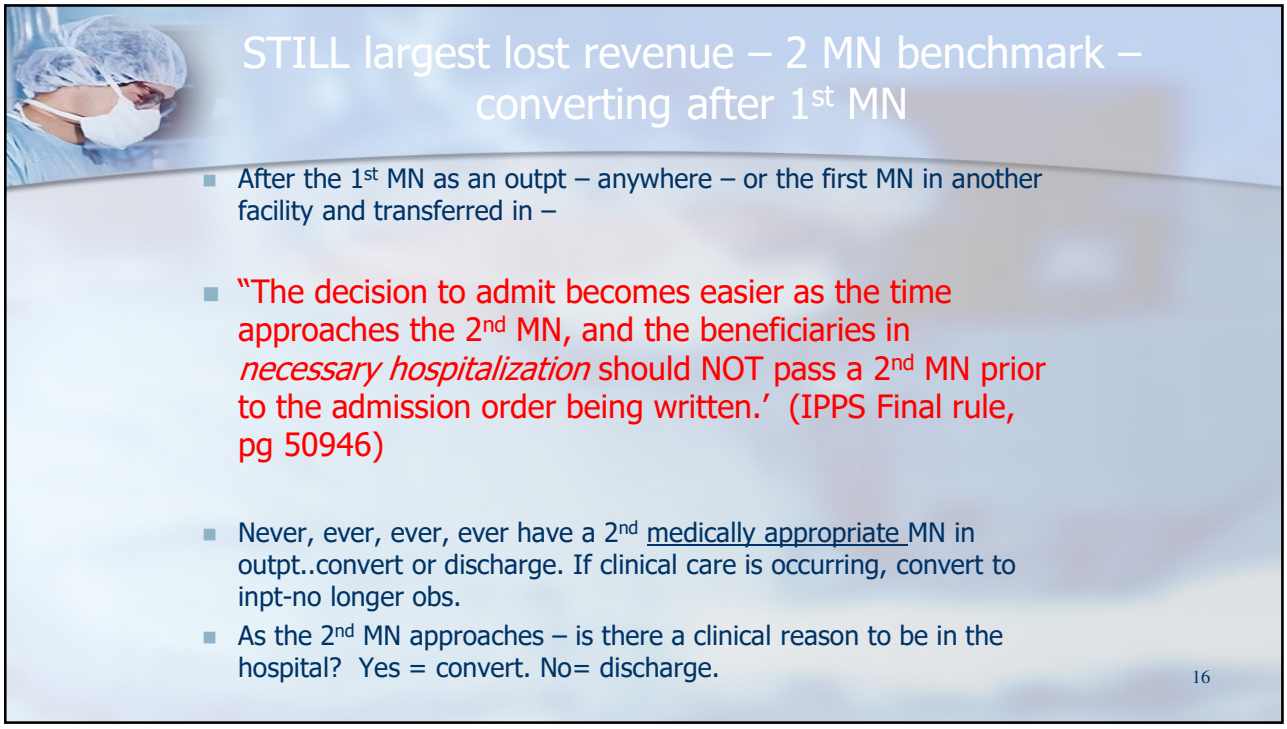
Understanding 2 MN Benchmark – 72 Occurrence Span MM8586 1-24-14

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

More on decision making-Inpt

- If the beneficiary has already passed the 1 midnight as an outpt, the physician should consider the 2nd midnight benchmark met if he or she expects the beneficiary to require an additional midnight in the hospital. (MN must be documented and done)
- Note: presumption = 2 midnights AFTER obs. 1 midnight after 1 midnight OBS = at risk for inpt **audit but still an inpt.**
- Pg 50946
- **..**the judgment of the physician and the physician' s order for inpt admission should be based on the expectation of care surpassing the 2 midnights with **BOTH** the expectation of time and the underlying need for medical care supported by complex medical factors **such as history and comorbidities, the severity of signs and symptoms , current medical needs and the risk of an adverse event.** Pg 50944


Determination of Patient Status: ER First Touch
Is the Patient ready for Discharge?
Yes
No
Discharge Patient
No
Does the patient need a bed?
Yes
Place the patient in OBSERVATION status
No
Does the patient NEED 2 Midnights(MN)?
Yes
Re-evaluate need for 2nd midnight, prior to 2nd midnight... later in the day
Discharge Patient or Begin entering Non-Billiable R&B code on day 2.
No
Does patient NEED a clinical service over next Midnight?
Yes
Document 2 Midnight "PLAN" and Admit to Inpatient
Patient remains Inpatient until Discharge


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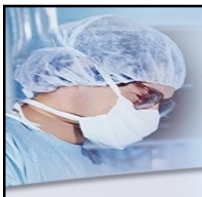
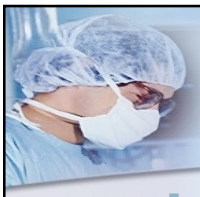


"Meeting Criteria" – means Traditional Medicare ?

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

More on clinical guideline clarifications/CMS

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



And more update - Transfers

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

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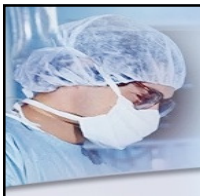


Tough Limitation –document
NOT BEEN AUDITED BY CMS

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

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

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

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 t**o, or for evaluation and management of, the prior stay's medical condition, hospitals will adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim. Chpt 3 Sec 40 2.5

Please be aware that services rendered by other institutional providers during a combined stay must be paid by the acute care PPS hospital as per common Medicare practice. 1 Single payment with same day readmission

Becker Report 11-23. MA plans have less readmissions than Traditional Medicare…that is because they don't APPROVE any readmit w/in 30 days!! WRONG

Ensure all 'chronic conditions' are excluded from usage in determinations/MA

2023 21

30-Day Readmission Traditional CMS

Yearly penalties, not each case as MA Plans are doing

CMS Hospital Readmissions Reduction Program (HRRP)

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

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

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

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

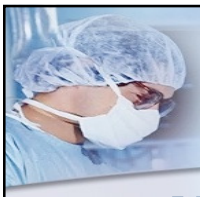
(1) patients admitted for an acute exacerbation of **chronic obstructive pulmonary disease (COPD);** and

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

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

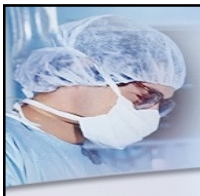
READMISSION PENALTIES: CMS FINES 2545 HOSPITAL FOR HIGH READMISSION RATES.

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



When an inpt is not appropriate, but not safe to be discharged – think Observation/outpt and watch closely

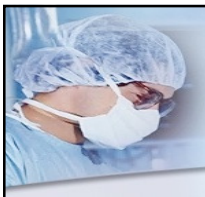
BILLABLE HRS VS. HRS IN A BED



What is OBS? Medicare Guidelines

- **APC regulation (FR 11/30/01, pg 59881)**
  "Observation is an active treatment to determine if a patient's condition is going to require that he or she be admitted as an inpatient or if it resolves itself so that the patient may be discharged."

- **Medicare Hospital Manual (Section 455)**
  "Observation services are those services furnished on a hospital premises, including use of a bed and periodic monitoring by nursing or other staff, which are reasonable and necessary to evaluate an outpatient condition or determine the need for a possible as an inpatient."



Expanded 2006 Fed Reg

Note: Use documentation guidelines for all payers/consistency

- **Observation** is a well defined set of specific, **clinically appropriate services, which include ongoing short-term treatment, assessment and reassessment**, before a decision can be made regarding whether a pt will require further treatment as hospital inpts or if they are able to be discharged from the hospital.
- *Note: No significant 2007, 08 ,09 , 10 , 11, 12, 13,14, 15, 16 and forward – no significant changes*

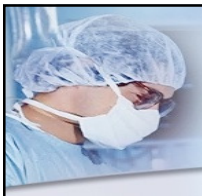
More on observation Medicare regulations

- Observation services are covered only when provided by the order of a physician another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or to order outpt tests. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpt can be made in less than 48 hours, usually in less than 24 hours.
- In only rare and exceptional cases do reasonable and necessary outpt observation services span more than 48 hrs (Never 48 hrs since 2014/2 MN benchmark)

Publication 100-2; Chapter 6, 220.5 (prior to 2 MN rule but still good)

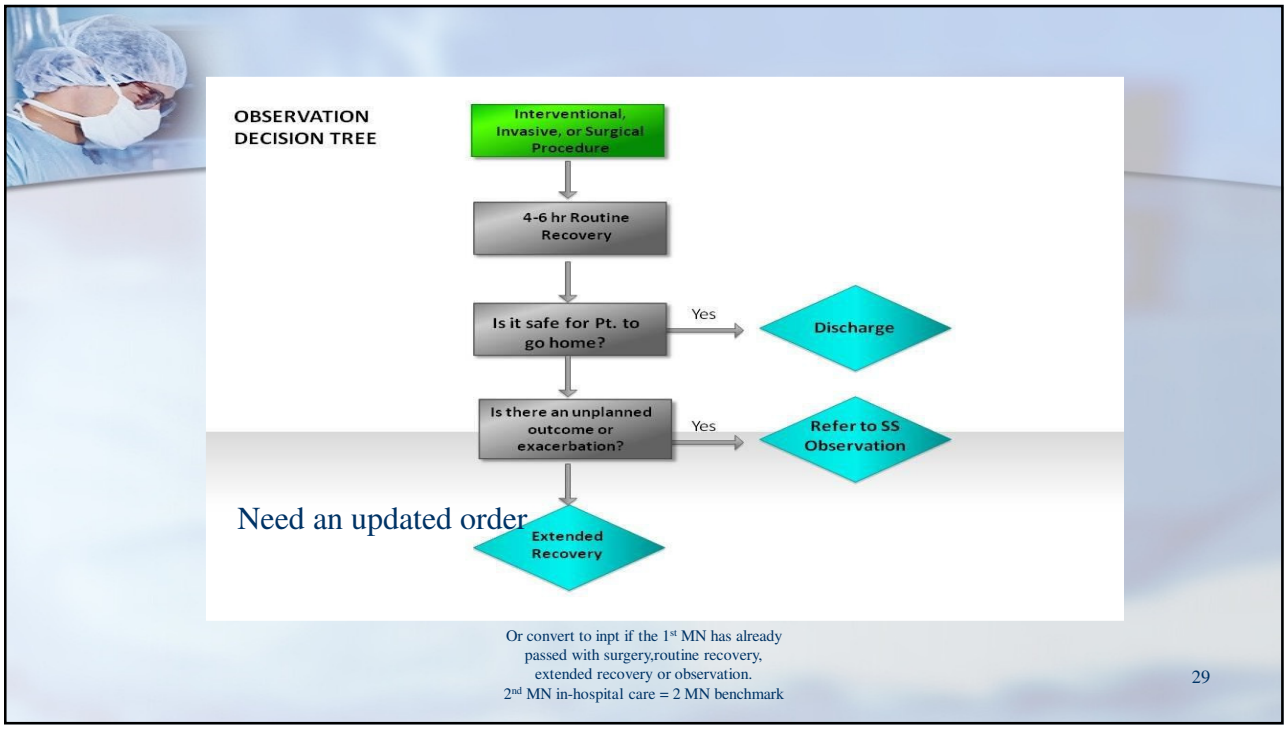
More 2006 Regulations

Observation status is commonly assigned to pts with **unexpectedly** prolonged recovery after surgery and to pts who present to the emergency dept and who then require a significant period of treatment or monitoring before a decision is made concerning their next placement. (Fed Reg, 11-10-05, pg 68688)



Recovery Guidance

- Services that are covered under Part A, such as a medically appropriate inpt admission or as part of another Part B service, such as postoperative monitoring during a standard recovery period (e.g.4-6 hrs) which should be billed as recovery room services. Similarly, in the case of pts who under diagnostic testing in a hospital outpt dept, routine preparation services furnished prior to the testing and recovery afterwards are included in the payment for those dx services. Obs should not be billed concurrently with therapeutic services such as chemotherapy. (Pub 100-02, Ch 6, Sec 70.4)



Or convert to inpt if the 1st MN has already passed with surgery,routine recovery, extended recovery or observation.
2nd MN in-hospital care = 2 MN benchmark

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More on Extended Recovery

- Use when the pt has a clinical reason to stay beyond the routine recovery, usually defined as 4-6 hrs. Can be doctor-specific –but wow! How to operationalize that? Nuts!
- Order extended recovery with a plan for a 'safe discharge trigger.' Billable until the safe discharge is met.
- Observation is for an unplanned event. Extended recovery is expected, with an ongoing recovery plan. (Can bill different levels of recovery: phase 1, 2, extended)

Education 2023

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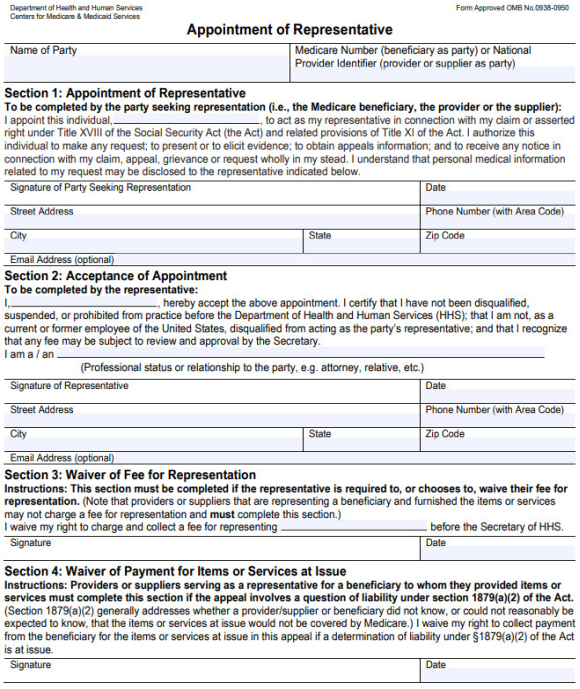
And more from Medicare Managed Care Manual – Post stabilization & Post acute care. *Most MA plans do not have 3 day qualifying stay. Can be a direct admit to SNF*

- 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**. (Think $500 per day)
- HUGE! The MA plan has to have a SNF provider network to sell in your community. The pt has to be placed in an in-network SNF facility. If no in-network plan, then file complaint with CMS. Track and trend. But also get payment for the delayed 'days' while awaiting placement. HUGE!

CMS FORM 1696 Appointment of Representative (AOR)

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



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.)

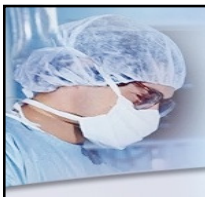
I waive my right to charge and collect a fee for representing _____ before the Secretary of HHS.

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



Hot off the press- Auditing Traditional Medicare

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

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

- On April 5, 2023, CMS issued a final rule /2024 that revises the MA /Part C, Part D , Medicare Cost Plan and Programs of all-inclusive Care for the Elderly (PACE) regulations to implement changes related to:
  - Star Ratings
  - Marketing and Communication
  - Health Equity
  - Provider Dictionaries
  - Coverage Criteria **
  - Prior Authorization **
  - Network Adequacy
  - And other programmatic areas.

- Ensuring timely access to care: Utilization Mgt

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

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

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

More Final Rule impacts – More UR And Prior Authorization

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

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

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

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

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

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

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

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

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

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

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

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

- Effective Date

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

- Payer situation

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

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

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

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

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

Traditional Medicare 2 MN – from 10 years ago

MA law since 1-1-24. Tie together…always!

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

- MA enrollment is up by 2.7M.
- Now totals 30.7 M of the 65 M Medicare beneficiaries.
- 46% -50% are now enrolled in MA plans
- Traditional Medicare is down by 4M since 2019.
- MA plans were to have a cut in payments in 2024. AHIP (Health Plan group) stated benefits would be impacted to the MA clients. In lieu of the cut,

  MA Rates WERE INCREASED 3.32% for 2024.
- ***In Feb, CMS finalized a rule to start recovering improper payments made to MA plans thru audits for the first time since 2007. Recovering is the key.*** **Humana has sued 8-23**
- United Health Care Announces it will reduce its prior authorization by 20% and implement a Gold-Card program. 3-23 (Now prior for anything but screening colonoscopies.)
- Reductions will begin this summer for all Medicaid, MA plans and commercial plans.
- The national gold-card program will be implemented in early 2024.
- Qualifying providers will follow a simple notification process for most procedure codes rather than the prior authorization process.
- Both AHA and AMA are cautious to see if this really does remove unnecessary barriers to care and wasteful administrative burden on providers.
- Concern: How is this really done? Some states/Texas have had limited Gold Card activity and stated it was not what they had hoped for. More post payment audits?
- Concern: This is primarily for physician practices Not the hospital challenges with inpt vs obs.

Colorado MA payer: The 2 MN rule does not apply to the MA plans. **Here we go!

- MA plan sent the following:

As noted in 2024 Final Rule CMS states that the 'two midnight presumption does not apply to Medicare Advantage plans' …and that plans 'may still use prior authorization or concurrent case management review of inpatient admissions based on whether the complex medical factors determined in the medical record support medical necessity of the inpt admission, under either the two-midnight benchmark or the case-by-case exception. (pg 225 if the FR)

"It is important to clarify that the 'two-midnight presumption; (the presumption that all inpt claims that cross two midnights following the inpt admission order are 'presumed' appropriate for payment and are not the focus of medical review absent other evidence) DOES NOT APPLY TO MA PLANS.

They will continue to use Interqual when evaluating an inpt vs observation level of care.

- **Ok-let's get our A++ game on as this could easily be the position of many MA plans.**
- Traditional Medicare HAS NOT audited any 2 MN LOS for the past 10 years. The 'presumption' is that if the LOS is 2 or more MNs, then the facility has followed the guidelines and is auto PAID WITHOUT AUDIT –unless patterns are identified. (Rare)
- The 2024 regulations state that the MA plans DO NOT have to 'presume' the 2MN inpt is appropriate. They can audit.
- WOW! Yes, it applies..
- All facilities MUST know the new 2024 regs…and Traditional Medicare 2 MN rules..
- BUT – huge risk for providers.
  - What does your PLAN for 2 MN presumption say? Does the provider clearly state why 2 MN?
  - Or 1 outpt MN plus the plan for the 2nd MN benchmark – clearly provider outlines why a 2nd 'in-hospital' MN is needed.

Humana reply to hospital's request to meet and they received the following reply. 11-23

- *"Second is a request made by our Utilization Management physician leadership to have a discussion with Humana physician leaders about application of the 2-midnight rule at the Managed Medicare Advantage plan starting 1-1-24? This is a concern that has been under scrutiny by our teams for a long while and CMS has pledged to keep an eye on appropriate application beginning in 2024 so we are hoping to have a discussion with the Humana team on ensuring this rule is being adhered to. Is this a meeting you can assist me in coordinating?"*

- ***REPLY:*** **Humana is currently working on a plan for Provider outreach/meetings before Jan 1, 2024. There has been a great deal of work going on here since the April letter and we are working on finalizing material to share. We will be in compliance with CMS's expectation. We will be doing our concurrent review process, as the guidance for MA Plans is not solely time dependent but also requires complex medical factors. (Thanks, R Greiner, RAC Relief for sharing.**

Another MA plan comments on 2 MN compliance- **United** - Missouri, Kansas, Nebraska 10-9-23 reply

- *Thank you for your email of Sept 9, 2023 when you requested confirmation that UnitedHealhcare is aware of and intends to comply with the Final Rule.*
- *To clarify the information sheet you shared from the AHA, the 2024 Final Rule expressly allows MA plans to adopt internal coverage criteria when the applicable coverage in Traditional Medicare Laws, NCD, & LCD are not fully established (42 CFR 422.101 (b) (6).*
- *Coverage criteria are not full established when, for example, 'additional unspecified criteria are needed to interpret or supplement general provisions in order to determine the medical necessity consistency. ((6) (i) A) Coverage criteria are not fully established under the Two-Midnight Rule.*
- **CMS guidance confirms that the Two-Midnight Rule contains a number of general provisions and that additional criteria are needed to make appropriate coverage determination.**
- CMS explains, first and foremost, that the medical record must indicate hospital care was 'medically necessary, reasonable and appropriate' at all times during the stay.(Program Integrity Manual, Ch 6, 6.5.2)
- Further, the Two-MN benchmark (412.3 (d)(1) requires a determination of whether the information in the medical record supports a 'reasonable expectation' at the time of admission that the beneficiary would require a hospital stay crossing at least two MNs.

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UHC publication: effective 1-1-24

www.uhcprovider.com/content/dam/provider/docs/public/policies/index/macs/hospital-services-010124.pdf. Important Reading. Meet with each payer - review YOUR Plan for TELLING the payer it is an inpt and here is the Plan - intensity and severity. Pd at DRG,not per day. (pg 2)

- *Whether the admitting physician has a reasonable expectation' depending on whether the complex medical factors documented in the medical record supports both the decision to keep the beneficiary in the hospital and the expected length of stay. (6.5.2 (A) (l) B).*
- ***Given these and other general provisions of the Two-MN rule, CMS requires its reviewers to use a screening tool as part of acute inpatient hospital coverage reviews. (6.5.1)***
- ***Thus, Medicare Advantage plans may appropriately adopt internal coverage criteria for use in making medical necessity determinations under the Two-MN rule.***

****

What does "Medical Necessity mean" - THE PLAN for an estimated 2 MN that includes the 'severity of illness and intensity of service". Build a template with the order set. UR and CDI are engaged to ensure the record is ready to be submitted. (CDI MA first)

If the hospital has a physician generated plan for an estimated 2 MN stay, and submits it with the prior auth documentation, what more is needed? A PLAN for Estimated 2 MN -at first touch= Presumption. Early, unexpected discharge = 1 MN. A PLAN for 1 outpt MN plus one more MN for in-hospital care = Inpt under 2 MN benchmark. STILL TRYING TO DEFINE MEDICAL NECESSITY/per United. IT IS THE PLAN FOR 2 MN OR 1+1 PLAN

And then we hear from Aetna- letter 11-23

- Aetna seeks to provide you with some information on how Aetna's MA Plans complies with the Two Midnight Rule.
- We will follow the Two Midnight Benchmark.
- Under the Two Midnight Benchmark, surgical procedures, diagnostic tests and other treatments will generally be considered appropriate for inpatient hospital admission and payment under Medicare when the physician expects the patient, based on specific complex medical factors documented in the medical record (such as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of adverse event), to require a hospital stay that crosses at least two midnights and admits the member to the hospital based upon that expectation.
- **Our MA Plans are not required to follow the Two Midnight Presumption**

- **Our Medical Necessity reviews**
- **Our MA Plans can use Internal Coverage Criteria to determine Medical Necessity**
- We have created publicly accessible internal coverage criteria when coverage criteria are not fully established under the Medicare statute, regulation, national coverage determinations (NCD), or local coverage determinations (LCD).
- **Our internal coverage criteria are based on current evidence in widely used treatment guidelines or clinical literature and comply with CMS requirements.**
- These criteria will be available soon on https://go.aetna.com/aetnamedicareguidance. (Thanks, B. Fiser, NC system) They are now available 1-24

Prior Authorization Request for Inpatient

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

Patient Name DOB:

Insurance name: Subscriber #: (SAMPLE FOR SUBMISSION WITH RECORDS TO PAYER/UR)- Access to EMR is problematic – how can they see the PLAN? How can you guide them as to what the plans says and record supporting the PLAN?

Records sent /attached to support inpt request:
- ER physician
- ER nursing notes
- Lab results
- Imaging results
- H&P
- Other _____

Additional justification to support inpt request:

TELL THE PAYER: The plan for an estimated 2 MN stay is: (Comes from the physician's PLAN that accompanies the admit order)

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

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

Based on the attached and the above additional justification:

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

Respectfully submitted,

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

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

More Federal "Concerns" with the MA plans

Medicare Advantage collected $12B in 'excess payment' – watchdog report says 3-22 **Directly tied to 2024 MA final rule.

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

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

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

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

- 42 CFR 422.101 states:
- "…each MA organization must meet the following requirements:
- (a) Provide coverage of, by finishing, arranging for, or making payment for, all services that are covered by Part A and Part B of Medicare…that are available to beneficiaries residing in the plan's service area…
- (b) Comply with-
- (1) CMS's national coverage determinations
- (2) General coverage guidelines included in original Medicare manuals and instructions unless superseded by regulations…"

- This regulation essentially states that MAO's may not be more restrictive than Medicare FFS/Traditional Medicare.

- Questions: Inpt only list? 2 MN rule? Prior auth? CHECK THE CONTRACT!

"Payers Gone Wild" -understanding the contract, website posted policy updates, appeal language and when to just say 'heck no" ****EVERYTHING IS AN INPT…UNTIL IT ISN'T.***

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.)*

More Denial Reasons & Action Items – Ex Humana

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

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

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

Patterns from payer determination letters: Aetna (ex) **No longer allowed with final rule 2024!!*

Aetna: MA account. Using clinical guidelines.

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

- We used inpt and surgical care MCG guidelines. The requirements for coverage are: (1) active bleeding w or w/o high-risk endoscopic features; (2) hemodynamic instability; (3)severe anemia causing heart failure, cardiopulmonary symptoms and /or cognitive impairment; (4) severe liver disease or abnormal coagulation; (5) treatment intensity or monitoring that requires inpatient treatment; (6) severe thrombocytopenia; (7) inability to tolerate oral hydration; (8) previous aortic graft placement or known aortic aneurysm; or (9) documentation of significant active comorbid conditions requiring hospitalization. The member did not meet any of these requirements.

- PLUS: Peer to peer: 'It you are a treating practitioner and you disagree with a coverage denial, you may request a peer to peer with the Medical Director who made the decision. Follow fax: Scheduled P2P call within 14 days to speak to Med Director. (**DOS: 5-18 Rec Ltr: 5-24. 6 days)**

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

*****Now present this case as a Plan for 2 MN from the initial ER visit*** Plan for 2 Mn presumption ***

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

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

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

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

*****Now present this case as a Plan for 2 MN from the initial ER visit*** Plan for 2 Mn presumption ***

- HUMANA: what guidelines are they using? Letter was written to the pt, copied to the hospital (DOS 4-4; letter recd 4-8. 4 days) **Look to 2024 final regs. Now re-present this case***

- '***Based on Medicare guidelines, the services your provider is requesting do not meet the requirements for approval***. We reviewed your records and they show you were admitted to the hospital with stroke-like problems that went away quickly. You got blood tests. You had special pictures of your brain and heart taken. You got extra fluids and medicine by mouth.
- In order for the requested services to be an inpt, you would have to have:
  - Abnormal blood pressure or heartbeats that do not get better with treatment (hemodynamic instability.
  - Weakness in one area of the body that keeps happening (recurrent focal neurological signs)
  - Finding on brain imaging that requires inpt level of care (eg mass)
  - Trouble thinking clearly which is new alerted mental status.
  - Dangerous heartbeats (cardiac arrhythmias of immediate concern)
  - Urgent inpt procedure is needed (eg carotid endarterectomy, carotid artery stenting)

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

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

Decision was based on Medicare Benefit Policy Manual, Chpt 1, Section 10. (Severity/intensity) THESE ARE CLINICAL GUIDELINES –their own? MCG? IQ?

Timing of Determination Letters Contract language on timelines (ex)

- UHC: Faxed

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

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

- Humana: Faxed

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

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

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

- **Humana - Claims Payment Policy**
- Subject: Inpt to outpt Rebilling
- Published: 9-2016 Policy # CP2015018
- Claim for inpt services when an inpt admission was not medically necessary. ***(PS Based on their decision and guidelines. Do you know it?)***
- ***Humana's Medicare Advantage plans follow the CMS guidelines for inpatient Part B rebilling. (PS- they do not use the 2MN rule, they require records sent for prior auth, delays in replying)***
- When an acute care hospital determines **BEFORE discharge t**hat the pt should not have been admitted as an inpt, Humana will ONLY accept services submitted on an appropriate outpt bill type (131) or 85X and will allow the provider to submit all codes for a normal outpt situation and required Condition code 44. (Again, not following TM rules but applying CC here. Even with this ruling, delays in ruling and time to get CC 44 done, which means pt notified, UR committee done, attending doc/notified and order changed – then can bill obs. UG!)
- When an acute care hospital or Humana determines **AFTER discharge** that the pt should not have been an inpt, Humana will only accept inpt bill type 121. This billing should reflect the reasonable and necessary Part B services and provide CPT codes where appropriate. Report condition code W2 to indicate this is a Part B claim and include "A/B Rebilling" in the treatment authorization field.
- For pre-admission services in the 3-day payment window, the hospital may separately bill for services prior to an inpt admission and should report "A/B Rebilling" in the treatment authorization field of the appropriate outpt TOB 131 or 851.

WOW and DOUBLE WOW! Additional Thoughts:

Did contracting know of this clause? Why allowed?

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

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

Order says inpt? How did the provider bill?

2023

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DRG = 1 payment for the entire stay

- Traditional Medicare for larger facilities = DRG. Each DRG has a mean LOS that the payment is based on. The diagnosis and inpt procedures are grouped into a single DRG payment. Some DRGs have higher payments based on co-morbid conditions. There is a small variation for each site but: **1 stay = 1 $.** (CAH, pd differently)
- Medicare Advantage pays= same DRG methodology –with coding rules controlled by the HIPAA Standard Transactions 2003. 1 stay = 1 pre-determined payment for the dx and procedures done.
- Re-evaluate – why battling for additional 'days' when the inpt has already been confirmed? Exception – need for SNF/if qualifying stay is requiredcand 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***?
- **Why are the hospitals 'fighting over additional days' when the payment is a single DRG? No payment by days**.

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

**Look at 2024 Final regs..

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

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

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

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

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

§ 422.214 Special rules for services furnished by noncontract providers.

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

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

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

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

Medicare Advantage – Provider WINS – no post d/c
Use Regulations. Have legal letter ready to send to the payer if post-request for records/MA

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

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

Medicare Advantage – Provider WINS –

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

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

- **New process: With each request for records from the MA plans, leadership reviews: was this already prior approved? Yes. Send attorney letter telling the MA plan/or their representative they are in violation of the above section. Discontinue requesting and any subsequent denials or recoupments or a formal complaint will be filed with CMS. Track and trend by payer. DO NOT SEND RECORDS - send letter instead.**

- Idea: Create attorney template letter to send with each MA request when a prior authorization was received..and due to the delay, payment made.
- Upon receipt of record request, do not send. Instead send the template letter/attorney signature.
- Track to ensure no recoupment occurs. Send formal compliant if needed.

Operational Addendums for Contracts

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Operational Elements directly relate to:

Cost of collection

Disputed claims at time of prior auth

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

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

Reducing the administration cost – to both they payer and the provider.

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

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

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

2023

Site filed a complaint/Region 2. Prior authorized, approved and then denied later after admission

Thank you for contacting us concerning MAO denial of pre-authorized services. If your organization is a non-contracted provider, CMS outlines that MA or Part D plans are required to reimburse noncontracted providers for services provided at no less than the amount that would be paid under Original Medicare. Providers should follow and exhaust the MA or Part D's plan established dispute process. Please see Managed Medicare Chapter 13

If your organization is a contracted provider, please remember that CMS is not a signed party to any CONTRACT that may exist between your organization and the plan; therefore, we cannot intervene or enforce the contract. CMS attempts to facilitate a discussion between plans and providers by forwarding provider communications (inquiries, complaints) we receive directly to the MAO for response by entering your inquiry into our complaint tracking system to notify the MA, PACE or Part D plan.

CMS, office of operations and local engagement. 10-23-23

CMS is not declaring a violation of the reg as their part – they will always reference the contract – payment they cannot intervene.

But what if the MA plans are not complying as outlined by the law or as interpreted by the provider? What recourse does the provider have?

- **American Hospital Association/AHA**, letter to CMS, Oct 13, 2023 (references a previous letter on MA issues in Aug 22 and Feb 23)
- "We urge the Agency to rigorous oversight to enforce the policies and safeguards included in the rule and to ensure that appropriate action is taken in response to any violations." Providers/many examples
- CMS is prohibited from doing intervention with Contracting Payment issues.
- A) MAO are retroactively reviewing inpt stays that received prior auth citing that they are NOT doing so as a medically necessary audit but rather under a SHORT STAY audit that is performed on any Medicare stay that is less than two days. We understand that the 2 MN presumption does not apply, but the criteria by which the plan is required to review the inpt stay (specifically the 2 MN rule)- NOT THE CRITERIA OF A SHORT STAY POLICY OF THE PLAN's OWN MAKING!
- Focus on the payers - known bad actors.
- Presents Recommendations: Data collection & reporting, Routine auditing, Pathways to report suspected violations, Enforce penalties.

- B) In other cases, the terminology stating that denials of inpt care are **PAYMENT REVIEWS**, and not level of care reviews, medical necessity audits or organizational determinations - even when the audit is EXPLICITLY evaluating whether the inpt level of car was appropriate and results in care delivered being downgraded to observation status and payment.
- A 3rd party vendor, for a short stay audit-noting that they were conducting a '**payment integrity administrative review,** not a level of care or a medically necessary review, focused on payment of services.
- **"We urge CMS to issue clarifying directives to MAOs regarding the applicability of the Two-MN rule and the obligations for MAOs to provide PAYMENT for covered services. We also urge CMS to close loopholes in terminology or practice that allow MAOs to deny services or payment in a way that circumvents establish processes for adjudicating adverse organizational determinations."**

Mmillerick@aha.org **No reply as of 11-11-23**

Full report aha.org

CMS 2024 Oversight Activities 10-24-23
Medicare Part C & D Oversight & Enforcement Group

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

Another CMS communication 2024 Oversight

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

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

Thank You for Joining Us in this Educational Journey

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