Denials, Denials, Denials Power Gap with payers & Strategies for MA plans

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

2

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Mgd Care Anguish-
A Brave New World Required-

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

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3

INSURERS CALL OIG MEDICARE ADVANTAGE AUDIT 'MISLEADING'

BECKER, 10-24 && NEW OIG FOCUS 4-25

In an audit published Oct. 24, the watchdog estimated Medicare Advantage companies received $7.5 billion through health risk assessments and chart reviews.

Around two-thirds of these payments are generated from in-home health risk assessments and chart reviews, the audit found. **The OIG wrote these tools may be more "vulnerable to misuse" because they are administered by MA plans or third-party organizations, not enrollees' providers.**

In a statement published Oct. 24, Mary Beth Donahue, president and CEO of the Bette Medicare Alliance, said the report "paints a misleading picture of in-home health assessments."

The Better Medicare Alliance is backed by major insurers.

"Medicare Advantage is designed to achieve a better overall understanding of individuals' health, and in-home assessments are a crucial part of this model," Ms. Donahue said. "This information ensures seniors get the resources they need. We have supported codified best practices for these assessments and will continue to do so."

Medicare Advantage is designed to achieve a better overall understanding of individuals' health, and in-home assessments are a crucial part of this model," Ms. Donahue said. "This information ensures seniors get the resources they need. We have supported codified best practices for these assessments and will continue to do so."

In an Oct. 24 statement, AHIP, the trade association representing insurers, said CMS did not concur with key recommendations in the OIG's report.

The agency did not concur with recommendations from the OIG to restrict payments for diagnoses found during in-home visits.

In its statement, AHIP said that health risk assessments are "one of many tools" MA plans use to identify chronic conditions and prevent these conditions from becoming more serious.

"Whether they occur in the patient's home or in a clinical office setting, the HRA offers an opportunity for the health plan and provider to obtain a complete evaluation of the patient's physical, behavioral, and mental health needs, medications, health risks, and environmental factors that affect health," the association said.

Medicare Advantage: Questionable Use of Health Risk Assessments Continues To Drive Up Payments to Plans by Billions OIG.HHS.GO

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4

AND MA PAYERS ARE EXITING THE MARKET..MAJOR DISRUPTION TO THE PATIENTS.

Eighteen insurers have exited Medicare Advantage markets for 2025, with more than 1.8 million people currently enrolled in plans that will not exist next year, according to OliverWyman.

Market exits by Humana, Aetna, and UnitedHealthcare collectively affect nearly 70% of those 1.8 million individuals. Beckers, 10-24

"It's important to highlight that these plan exits reflect members who will not be automatically moved into other products, even if one was available," OliverWyman analysts wrote. "While these plan exits may seem alarming, carriers in many of these markets have introduced new products or have other products that members can switch to for 2025."

Market exits causing the most disruption:

Humana: 28%

Aetna: 26%

UnitedHealthcare: 15%

Other: 15%

Centene: 4%

Guidewell: 3%

Cambia: 2%

Premera Blue Cross: 2%

BCBS Kansas City: 2%

Elevance Health: 1%

Bright Health: 1%

BCBS exiting contract with MD Anderson. Pts have to find other care/coverage

Idaho: Large commercial payer –only selling MA in specific low-risk counties

5

5

Payers ranked by Medicare Advantage enrollment in 2024/Beckers 1-24

United is still the larges MA carrier in the country while CVS Health /Aetna recorded 15% growth during open enrollment.

The analysis sourced CMS Medicare Advantage Enrollment data. Rate of Growth or Decline is included. 3.5-5 Star ratings can account for 6% of MA $

- **Top 10 payers by MA enrollment in 2024**

1) **United Healthcare Group: 9.5M +1% ****
2) **Humana: 5.9 M +2% ****
3) **CVS Health: 3.9M +15% (Aetna is owned)****
4) **Elevance Health: 2 M -1% (Anthem)**
5) **Kaiser Permanente: 1.9 M no change**
6) **Centene: 1.2 M -11%**
7) **BCBS Michigan: 696,000 =4%**
8) **Cigna 597,000 -1% ---Sold, eff 2025**
9) **Highmark Health: 417,000 +4%**
10) **Florida Blue: 332,000 no change**

****indicated OIG is looking at for questionable coding/new codes practices. 10-24**

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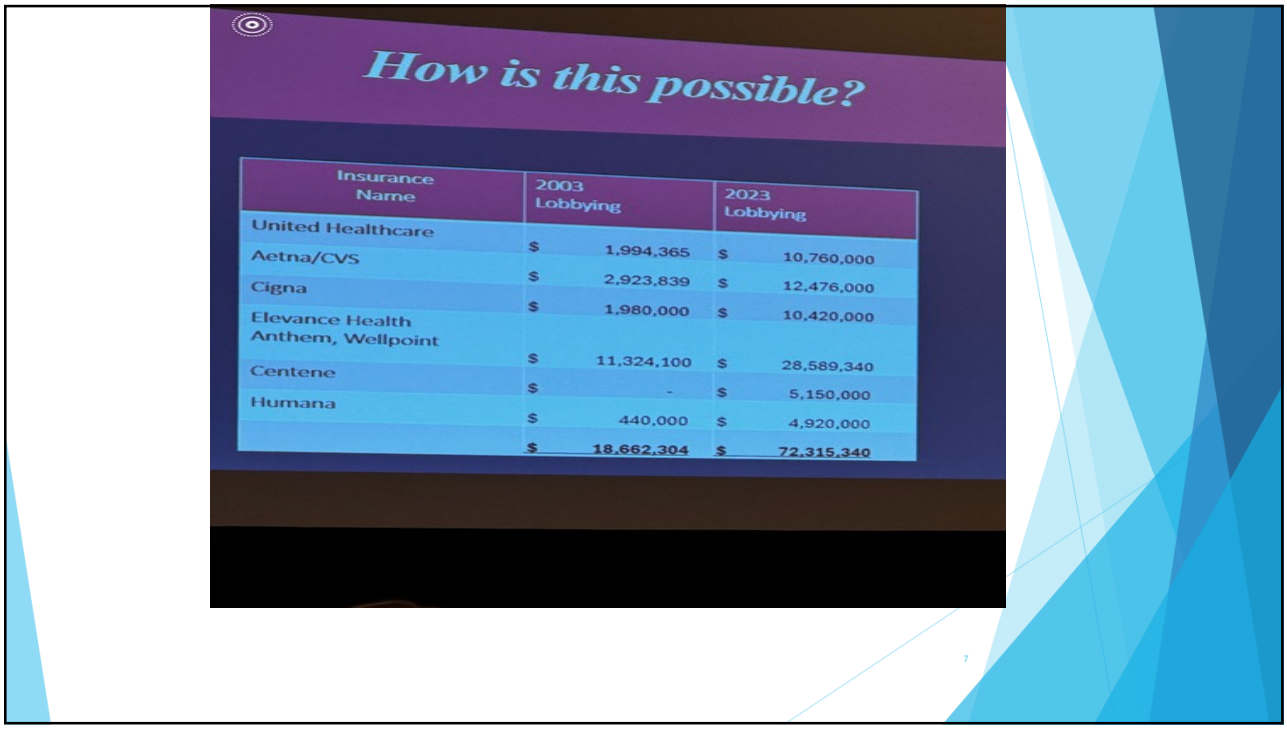
How is this possible?
Insurance Name
2003 Lobbying
2023 Lobbying
United Healthcare
$ 1,994,365
$ 10,760,000
Aetna/CVS
$ 2,923,839
$ 12,476,000
Cigna
$ 1,980,000
$ 10,420,000
Elevance Health
Anthem, Wellpoint
$ 11,324,100
$ 28,589,340
Centene
$ -
$ 5,150,000
Humana
$ 440,000
$ 4,920,000
$ 18,662,304
$ 72,315,340

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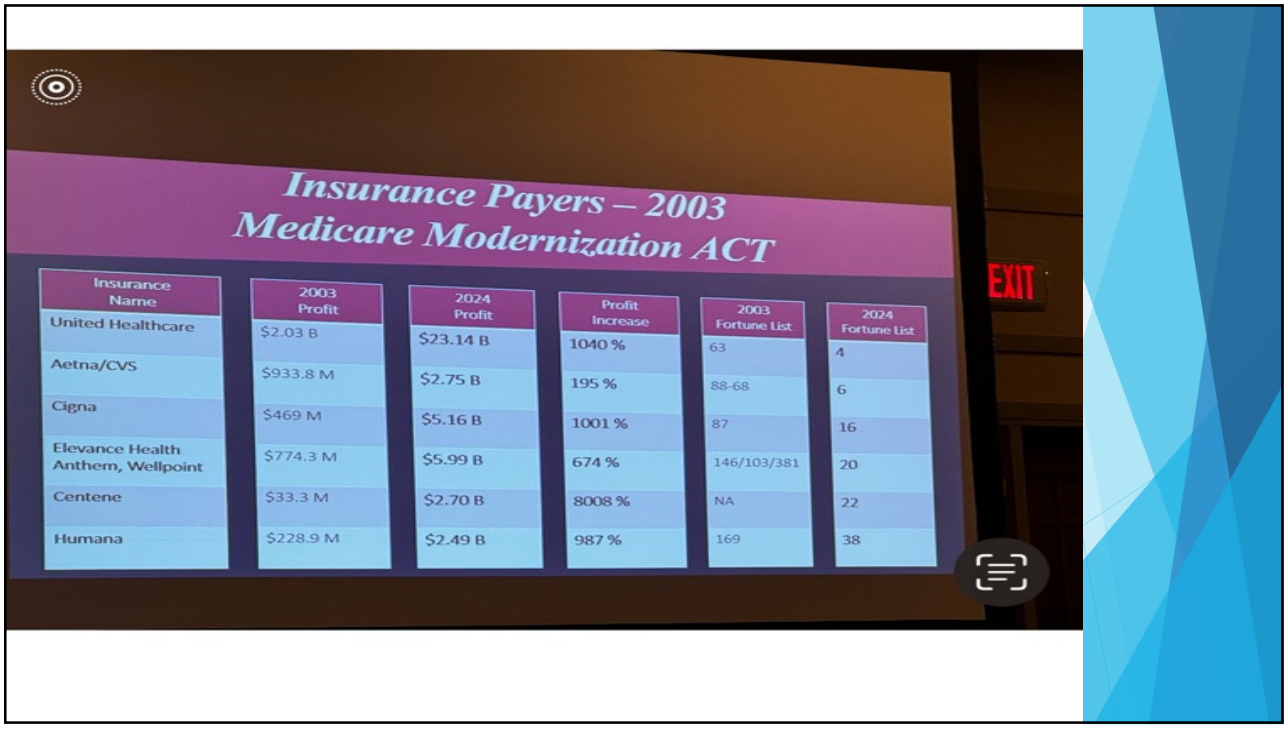
Insurance Payers – 2003
Medicare Modernization ACT
EXIT
Insurance Name
2003 Profit
2024 Profit
Profit Increase
2003 Fortune List
2024 Fortune List
United Healthcare
$2.03 B
$23.14 B
1040 %
63
4
Aetna/CVS
$933.8 M
$2.75 B
195 %
88-68
6
Cigna
$469 M
$5.16 B
1001 %
87
16
Elevance Health
Anthem, Wellpoint
$774.3 M
$5.99 B
674 %
146/103/381
20
Centene
$33.3 M
$2.70 B
8008 %
NA
22
Humana
$228.9 M
$2.49 B
987 %
169
38

8

Medicare Advantage/MA Landscape Updates 2024

- Total Medicare beneficiaries as of 8-24
- 67 Million. Medicare covers 18.7% of all Americans
- Of the 67M, 33M/54% are Medicare Advantage

MA spending to outstrip traditional Medicare by $88B this year: 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 federal data and found overpayments to the MA plans have grown to $350B since 2020.**
- 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.

9

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"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 ****This is the often the most critical piece when selecting Part D- separate or within Part C.
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 54% 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 notified and then they are auto rollover to MA

10

A CFO's Analysis of 'Long Length's of stay" with the Medicare Advantage plans. Real CASH opportunities Before 1-24 and post 1-24 Denials for inpt

- As all providers are hoping for a much smoother process to have an inpt approved with the MA plans due to the 1-24 implementation of the 2 MN rule – it is important to have historical information and then track and trend to see success with massive reduction in the long OBS stays.

Analysis of 2023.	Stays over 2MN 140 ADC
Medicare traditional	33 of 165 OBS pts stayed over 2 MN (did not covert to inpt as the 2nd MN approached and the pt needed necessary in-hospital care.)
Aetna MA	26 of 43 OBS patients stayed over 2 MN
BCBS MA	64 of 86 OBS pts stayed over 2 MN
Humana MA	180 of 251 OBS pts stayed over 2 MN
United Healthcare MA	285 of 389 OBS pts stayed over 2 MN
TOTAL MA MARKET	**588 of 934 OBS pts stayed over 2 MN. 63%**

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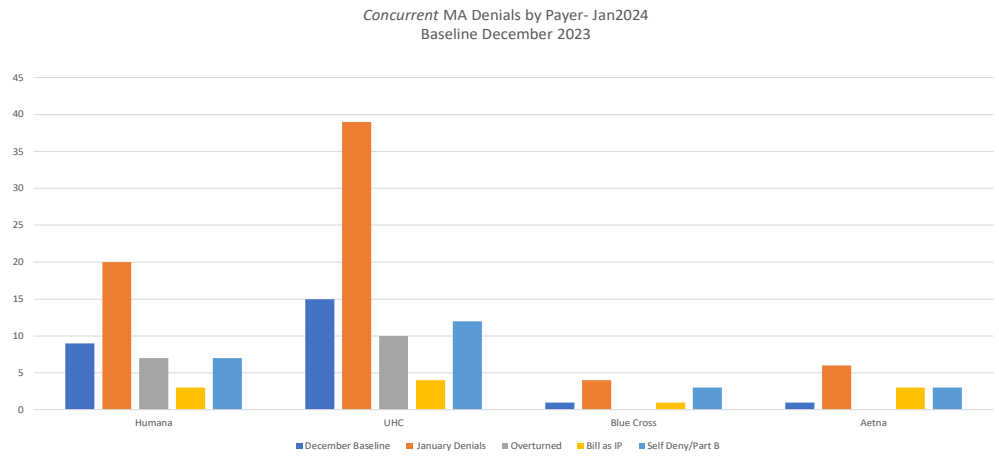
Managed Medicare Status Disputes January 2024



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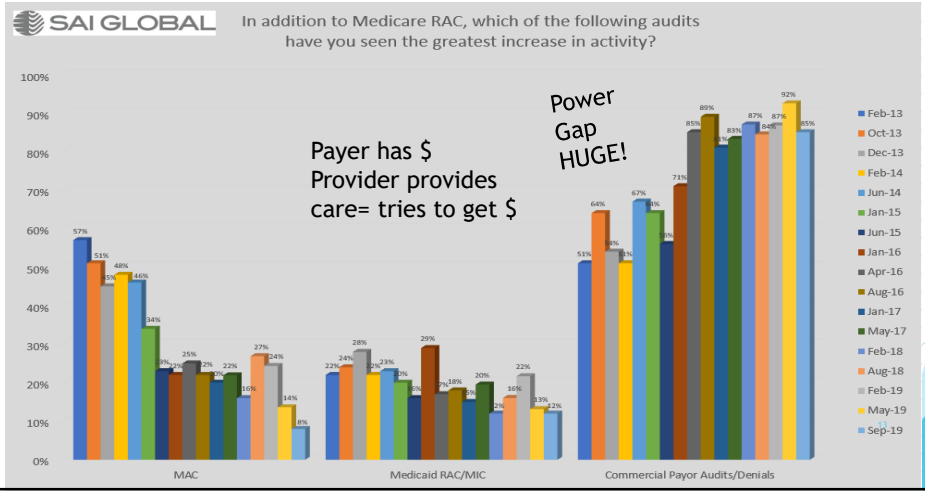
8 year history with Compliance 360/SAI

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!



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Payers have found a new way to deny services. Dreaded new phrase: **Provider is unbundling separate items that are included in the primary service provided. "Services are paid as part of another service"** **BUNDLING: Used for Inpt outlier "reviews/disallowed" & outpt procedures.**

Commercial and MA are the largest ones current doing this.

Where does it say in their CONTRACT that this is defined?

How can commercial, WC, & Medicaid contracted payers use Traditional Medicare language when these are not Traditional Medicare patients?

There is no Rule for your Rule - to the payers from the providers…

14

What are the most common examples that are occurring on the Remittances? Primarily -Medicare Advantage and Commercial

- Multiple outpatient procedures- only pay 1 of multiple CPT M15, CO 97, CO 45
  - Process: initial CPT codes prior authorization with payer. Contract unlikely to have a timeline to reply. Some say up to 14 days after request. If an additional CPT is done during an outpt procedure, the provider must notify the payer immediately (contracts have timelines –such as within 24 hrs) to get the additional CPT prior authorized. **If the provider fails to get the 2nd CPT prior authorized - the ENTIRE claim is denied.**
  - Outcome: If all the required prior auth occurs, and the provider bills multiple CPTs, there **is only a single CPT paid. The payer decides which CPT to pay with the allowable applied to the one CPT code. All** additional items: Multiple CPTS, implantables, anesthesia, imaging, recovery, lab tests, & observation are denied as one or all of the below denial codes.
  - Denied: Bundled into the primary service. C0 97 (Not all payers)
    Denied: Service is not payable separately as another service has been adjudicated/paid.
    Denied: Bundled as they are considered components of another procedure. M15 (From comparing UB to RA- line item)
    Denied: Chgs exceed fee schedule or contracted arrangement. C045 But there is No payment

Question: Why do the work to prior auth the additional CPTs? ***Where does it say in the contract that the payer gets to decide that all the services are not paid as they are part of another primary CPT/the only 1 paid.***

15

15

NEW WAYS TO DENY/DELAY/DISPUTE CLAIMS

1) Doctor is rejected/denied as not being on the payer rooster. Been a part of the hospital for multiple years.

Now the battle – provide proof, provide all the rooster updates. Claims continue to be denied. IF there are enough resources to keep doing this – happening with multiple payers. Race to try to keep more claims from denying.

Then the claims are to be 'found' and resubmitted and they will be paid in the normal timeline.

It is the payer's error. How can a provider protect against this?

2) Line item denials- stating that any service is a part of another service –and only pay the line the payer thinks is appropriate.

Based on what criteria? When asked where it says this is allowed – look to their webpage for updates.

Which are very general.

Each payer has their own definition of what's is part of another procedure.

Each payer has their own definition of what services cannot be paid separately.

16

16

Other outpt common patterns from the Remittance Advice comparison to the UB?

- Observation billed with any outpt claim – ER to OBS< invasive procedure, direct admit
  - No examples showed **any payment for Observation**. *All denied as Co97 or CO 45.*
  - Why is prior auth being done with additional UR work for a service that is never paid?
  - When the payer says: just leave them in observation and let's see how they do after 48 hrs – they love it because they are NOT going to pay anything for any obs hrs.
  - ***Where does it define what is part of another service? Who decides that? An unexpected event, or exacerbation of a condition = observation post procedure.*** **How is that of another primary service?**
  - All the UR work = $0

Other common areas of outpt line item denials:

- All recovery, anesthesia, supplies, implantables, multiple procedures are not paid
- **ER To observation** – ALL services done during the ER visit AND Observation – are paid under the SINGLE ER visit Level. (Now multiple payers are determining what they will require -how the facility ER E&M level is created. *Where does it say in the payer contract that they can create their own when the site is following CMS's guidance for all payers.)*
- **Percent of billed charges/Critical Access hospitals/MA plans &/or commercial** – *disallow same lines and pay the % of what is left.*
- *Cigna – denying revenue code 272 unless there is a HCPC. (Violates UB 04 guidelines, HIPAA Standard TX)*
- ***Anthem MA announces it will go to 100% prepayment review of all ER 4&5s. (Based on whose E&M leveling criteria)***

17

What about Inpatient denials? What about Outlier Payments? What about fee for service?

- Yes, paid under DRG for the stay.
  - Examples included DRGs where a list of services were denied – and deducted from the DRG payment. (more uncommon with DRG) "All inpt services are covered under the R&B….."
  - YES, under Inpt Outlier payment.
    - Common process of line item denials within the Outlier payment

    Ex) Multiple MA plans denied a full day of charges. Mostly on the 1st day of the admit stay; some randomly through the stay. Date of Service: 4-18 to 4-30. Full day of charges on 4-18 denied. Payment part of another service??

    Ex) Disallowed, as packaged with other primary services (i.e. R&B for ICU) – ventilator services, bedside procedures and any other ancillary testing during the stay on a given day or multiple days.

    Ex) Disallowed some of the ICU R&B and only allowed medical R&B rate..for many days.

    By doing these, the total billed charges are under the outlier threshold so only DRG is paid.

    - ***Yes, under fee for service on inpt accounts***

    Ex) The same rules of paid as part of another service – especially ICU or related services

    Critical access hospitals have not been exempt to this type of arbitrary line item denial.

Where does it say in the contract they can arbitrary make these line item denials on an inpt DRG account? Or fee for service/line item denials? It not contracted, Traditional Medicare rules apply.

18

18

When hospitals decide to appeal all the CO45 or CO97 or M15 line item denials – what will the denials be based on?

It is not a medically necessary denial.

- **It is a contract driven issue – as it is either SILENT on allowing this arbitrary decision or**
  - the provider/denial team is told it is allowed in the contract and since many denial teams do not know what the language of the contract is, they are left with limited appeal rights.

If you are appealing, based on? Always ask to see the language, from the payer, in the contract that allows for this. Track and trend. *Many state it is in their provider manual/online. It says what? MA plans are notorious for saying: same as Traditional Medicare"

If you are winning, which item? Outpt? Inpt?

What is the strategy –claim by claim – that is being used?

Another one: If you are paid a % of billed charges, with the line item denials, it is below the contracted amount. What is the contracted rate for outpts? Line item pays less

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There are no rules for your rule-reduction in payment, denial, debate.

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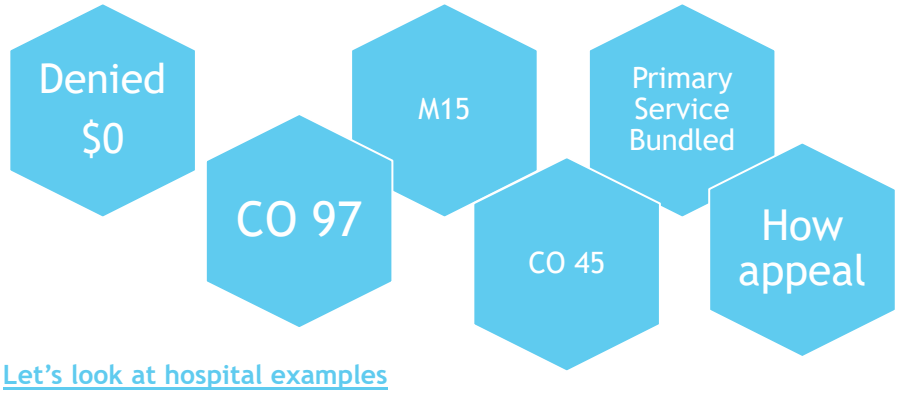

Let's look at hospital examples

Denied: Bundled into the primary service. C0 97 (Not all payers)
Denied: Service is not payable separately as another service has been adjudicated/paid.
Denied: Bundled as they are considered components of another procedure. M15 (From comparing UB to RA- line item)
Denied: Chgs exceed fee schedule or contracted arrangement. C045 But there is No payment

20

20

POWERFUL NEW DENIALS: OUTPT PAYMENTS CRITICAL ACCESS OR % OF BILLED CHARGES

Paid a % of billed charges?

Deadly line- item denials

Each payer is defining what is 'part of another procedure." C097

Based on? Some are using APC methodology

Some are using their own fee schedule; unknown to the sites

Method 2/CAH – MA plans are not paying; although required

Medicare Advantage-pay a % of billed charges. Same as Medicare's rate

Line item denials – stating broad reasons for denying – then paying the % of what is left.

One payer will declare charges exceed payment –always – and then pay $0.

Entire services are $0 /C045 with a single line actually getting paid. All the rest are $0 with C045/

21

21

Surgical procedures	Billed charges	Covred items	MA Covered Items	% of billed chrgs pd
1) Arthroscopy shoulder, debridement of 1 02 structures 29822	$5987	$2633	$2633	
Denied: 11042 Removal of devitalized tissue from the wound	$11,974	0	0	0
Denied: 36573 Insertion of a central venous cath	$3144	0	0	0
Denied all: Obs hrs/65, recovery, anethesia, all drugs, pulmonary function, all lab, all injection codes **2MN now Blue Medicare Adv	Full charges on claim: $37,630	$2633/ 1 CPT code	$2633 **Was this paid under OPPS + %? Who has done this type of comparison analysis?	**7% of billed charges** ***Contract rate is? Once they identify Covered services. How are the line items being determined as not separately billable?**

22

22

More Line item examples	Billed items	Covered Items Payer identifies the Primary Service/only line paid	% of billed charges
ER to obs **United MA**	$24,858	ER visit 99284 $1527/but payer had a higher allowable of $2236	
All obs hrs/72, 250 & 636 drugs, 73 hrs of IV infusion w/some hydration, 14 labs, 1 xray, 1 CT/351, 3 IM injections/940 **2MN now	ALL DENIED - C0 45 All services are included in the single payment for 99284 $23,331	$1527	**9% of billed charges**
OR outpt Carpel Tunnel Aetna MA	$11,377	Single CPT for Surgery 29848 $6197 Pd: $1059	
All J codes, 2nd procedure 20600XU, anesthesia and recovery	ALL DENIED-benefit not separate payable $10,318	$1059	**9% of billed charges**
Rt Cath procedure United Healthcare MA	$22,032	$15,754	
All obs hrs/17, all 250/drug, 636/drugs, lab, US/402, arteriography/323, C code implants, anesthesia, recovery.	ALL DENIED -C097 $52,522	$15,754	**30% of billed charges**
Cath w/Obs - BCBS comm All obs, additional cath procedure, C codes, all drugs, labs, no anesthesia or recovery 93460	$16, 738 Some J codes /636 were paid.	$6685 Used RA codes: 234= This procedure is not paid separately. M15: Separately billable have been bundled/part of another component N20: Not pd with other service	**40% of billed charges** ****What are they basing their 'rules' on as not Medicare?**

23

Chemo Therapy – Medicare Advantage Examples
Who determines the 'primary service/only line paid?

Payer	BilledChgs	AllowedAmt	Denied	Amt Paid	% of billed chg
Blue Adv HMO	$30,339	$7103 1 IV adm, 1 chemo inj, HBC visit Chemo Drug: C9399JZ $26,473 PD:	All other drugs, lab tests, IV solutions	$7103 C045: M15 $6486	23% including large contractual with Chemo drug
United MA	$4042	$304 HBC visit, J9395/drug	Chemo injection adm, all lab Denied. CO97 included in other payment	$304	9% pd of billed charges

24

24

And then there are Prior Authorization

D E N I A L S

- **"No Prior Auth Required.' On the portal**
- Track, by payer, which payer denials as PRIOR AUTH MISSING
- Now what? Reaching out to the payer to re-process - could work **HINT-**FIX THE PORTAL"**
- Primary payer in area: Portal requests
- Inquiry requests - wait to hear from the inquiry before anything else can be done.
- Payer states - taking ave 30 days to reply. Then work on what the reply takes. At least another 60 days to get paid.
- APPEAL - ***if you want faster, then appeal. But we will want the full record so we can see if the service was medically necessary.***
- PATTERN: High Priced IV medications

- **"Prior Auth was on the claim but denied as Prior Auth missing."**
- Track, by payer, which payer denials as PRIOR AUTH MISSING.
- When reaching out to a payer - same situation as not requested.
- Could do inquiry and WAIT.
- Or File an Appeal -but again want to see the medical records. AGAIN?
- IT IS THE PAYER's ERROR
- PATTERN: High priced IV medications
- Both of these are 'bad faith' with the contract
- Be ready to report your patterns.. Powerful

25

25

And Finally – just say "N N O O O"

- When we look at the cost of:
- Prior auth disallowed/lower level of care/dx would not endanger the pt,
- Claims submission/rejections,
- Line- item denials on the EOB,
- Post payment request for records,
- Post payment denials or reduction of service,
- Appeals filed within the same insurance plan,
- Delays in getting post-acute care referrals ……..

Time to just say NO! Why are you contracted? What is the benefit to the provider? The ongoing cost to the provider? What is the win for the provider? Contracting can easily be a win/lose for the payer/win and lose/provider. How can a collaborative environment exist in this setting?

26

26

Normal Contracting: Does not speak to the operational issues that add cost and end in denials or rejections of claims. Time to talk Addendums!

Where does it say the hospital agreed to that interp or denial or 'no cost?
What section are you using? Plz provide asap so we can 'see' it together?

Operational Elements directly relate to:

Cost of collection- Labor!! DRG downgrades, concurrent inpt attempts, appeals and more appeals.

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.

Disputed service at time of prior auth. When to add additional CPTs, value based means, delays

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

27

For every denial or dispute – Is the provider asking:

Where does it say in the contract that we agreed to this?

It Is all about additional of the **Operational Contract Addendum**

Items that are usually NOT included.

Let's Talk…….

- When trying to decipher the Operational aspects of the payer's uniform contract, it rapidly becomes apparent that the contract has all the provisions to protect the payer but very little reciprocal provisions for the provider.
- EX: ***PAYER:*** ***Days to notify of a pt in-house Penalty – denial of obs or inpt.***

  PROVIDER: There is no provision for timely reply to request.

- EX: ***PAYER:*** ***Prior authorization required for almost all outpt procedures and all inpts.***

PROVIDER: There is no requirement for rapid reply or justification. (Insurance directed care VS physician directed care. Who determines if the ordered care is 'medically necessary'; based on what knowledge of the pt?)

Payer is using an external contracted firm/pd by the insurance plan to review certain areas: Imaging, outpt procedures, etc. Did the provider realize that the decisions are made by a company who is paid by the insurance plan – not an indept review?

28

As we work thru each denial, what is the action plan with the payer to eliminate thru internal changes or clarification around what was agreed to within the contract? Maybe some of both. "

Let's talk. Build Addendums to Contracts

- New process to consider:

1. Every time there is a request for records – where in the contract does it say we will do this? Unlimited #? No cost to the payer? Why does the payer need these records? Data mining to find DX = $7B new money for MAs.
   - ACTION: Create a Operational Contract Addendum that addresses all requests for records. With limitations and payment. See Addendums that address volume of accounts, cost to send, onsite vs submission, never give access to payers to see records/always prepare the pt story,

2) Every Denial. Every down coding for 'validation DRG audits"
   - ACTION: Use the Correct Coding guidelines in addendum; define which sepsis will be used; include provider audit accuracy % and therefore, no records sent.

3) New denial reason. One payer is now denying readmission in 30 days if the patient ends up in any facility that is part of the same health system regardless of distance or reason. Where does it say this in the contract regarding readmissions?
   - ACTION: Readmissions like traditional Medicare which is NOT within 30 days but know. Traditional Medicare lookback rule with specific dx/readmissions in 30 days. Daily Traditional Medicare – same pt, same day, same hospital = roll into 1 bill. .

4. Policy changes without input from providers or just webpage notice of change. Wow! Most contracts have this provision that the payer can change anything or implement new rules by simply posting it on their webpage.
   - ACTION. Build an Addendum that no changes thru policy publication will not be accepted without prior approval by the site.

5) Each payer has published their own technical ER E&M leveling system. They will be using their own guidelines when auditing. Or their own 'criteria' to down grade on the EOB without any additional patient information
   - ACTION: State that the provider will be using CMS's 2000 guidelines for creating an ER E&M that will be used for all payers. No payer -specific E&M criteria will be used.

6) Line item denials with DRG outliers. Line item bundling into primary procedure as determined by the payer. Both are huge losses to the hospital
   - ACTION: Disallows all DRG payment reviews/outlier. Addendum that speaks to no auto-bundlingor assigning primary CPT code without methodology approved or do not allow it at all. Pay each CPT code.

6) Post acute care is ordered; prior auth requested; no timeline to reply while the pt is held with no additional reimbursement for the held days post d/c order. FEDERAL ACTION 10-24
   - ACTION: Addendum speaks to timeline for Reply and a per day payment for all held patients.

29

29

Operational Addendums for Contracts- Sample

- **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

30

30

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 & AG Tools: No payer shall use any AL or Algorirhm /AG 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

Prior Authorization vs Medical Necessity pre-screening: No priority software/company will be used to determine 'medical necessity' of a procedure. The use of this private screening tool is not allowed for any inpt or outpt procedures.

Site of service determinations: If the hospital or associated provider requests a procedure or test to be done at the hospital, then this will be the site of service. A referral or requirement that the patient have the procedure or test done at a different location – a non-provider related location – will not be allowed.

31

31

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.. **NOT FOR MA ISSUES /New one 8-24**

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

32

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**[33]

Full report aha.org

33

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.

THIS IS THE KEY PIECE OF DISPUTE WITH THE MA DENIALS. Complex medical factors -inpt defined in final 2014 regs.

34

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)

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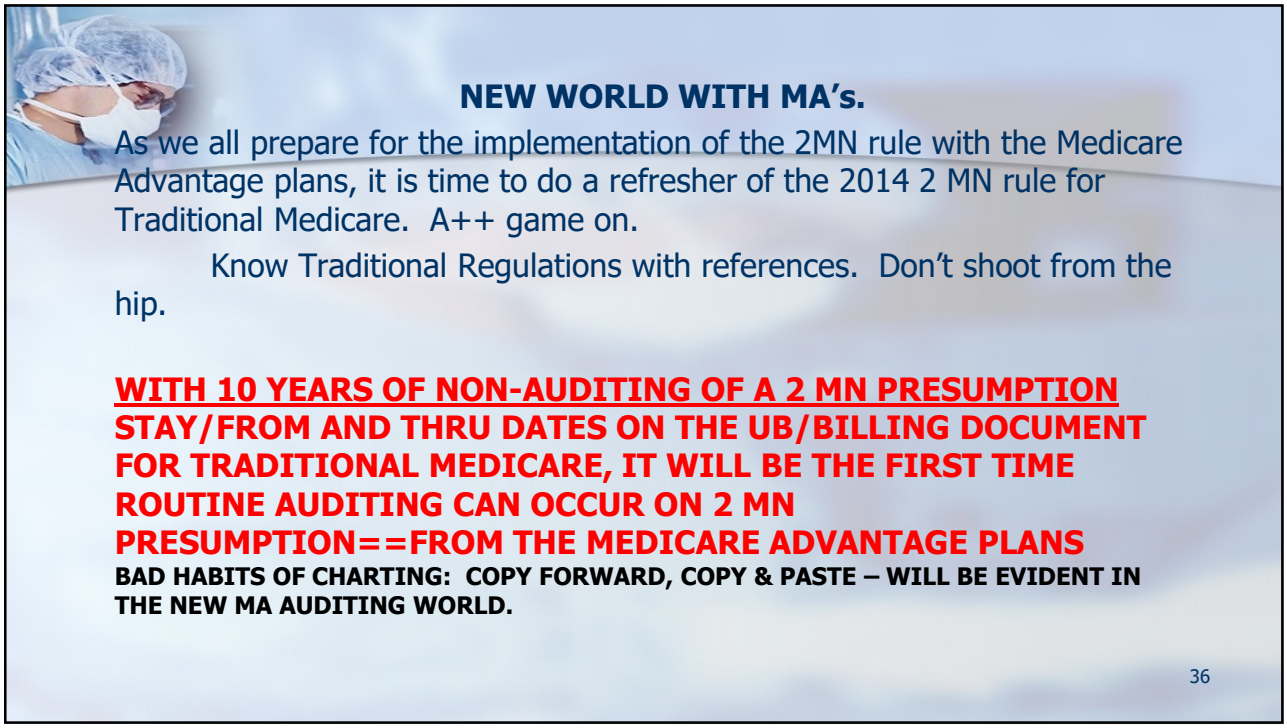

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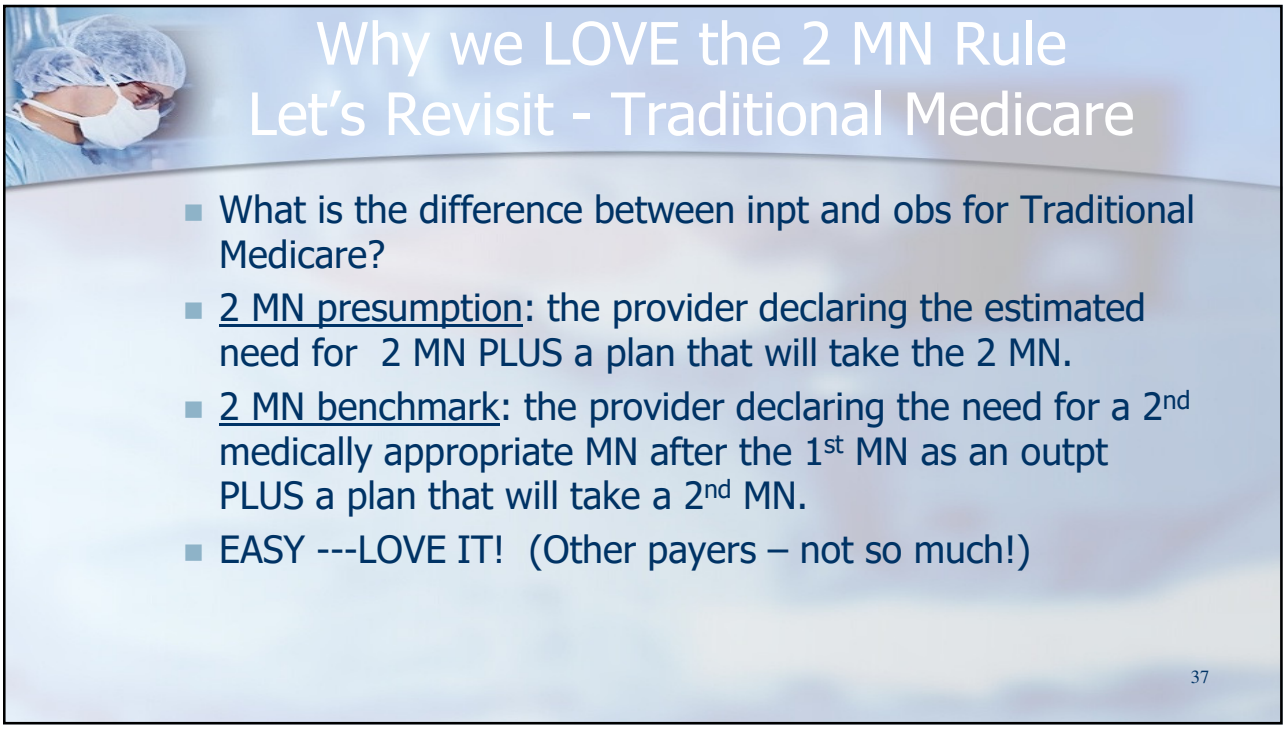
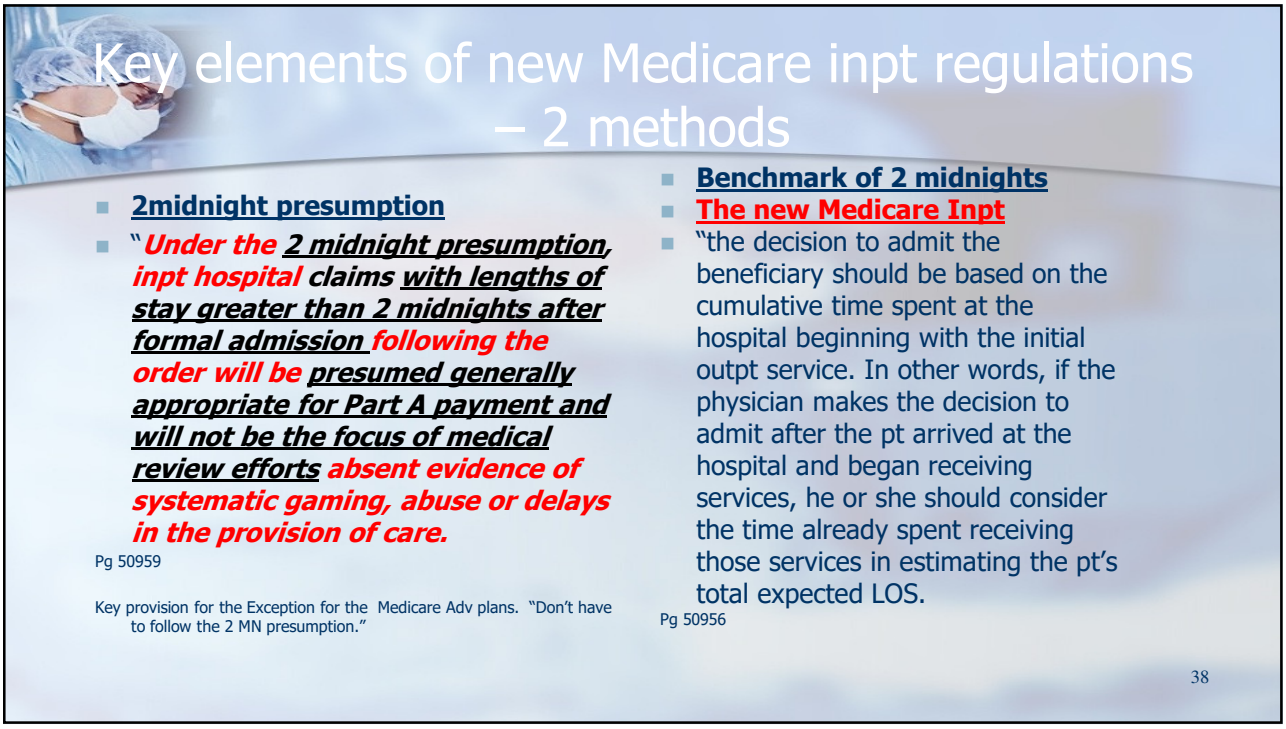

Why we LOVE the 2 MN Rule
Let's Revisit - Traditional Medicare
What is the difference between inpt and obs for Traditional Medicare?
2 MN presumption: the provider declaring the estimated need for 2 MN PLUS a plan that will take the 2 MN.
2 MN benchmark: the provider declaring the need for a 2nd medically 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!)
37

37


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
Key provision for the Exception for the Medicare Adv plans. "Don't have to follow the 2 MN presumption."
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
38

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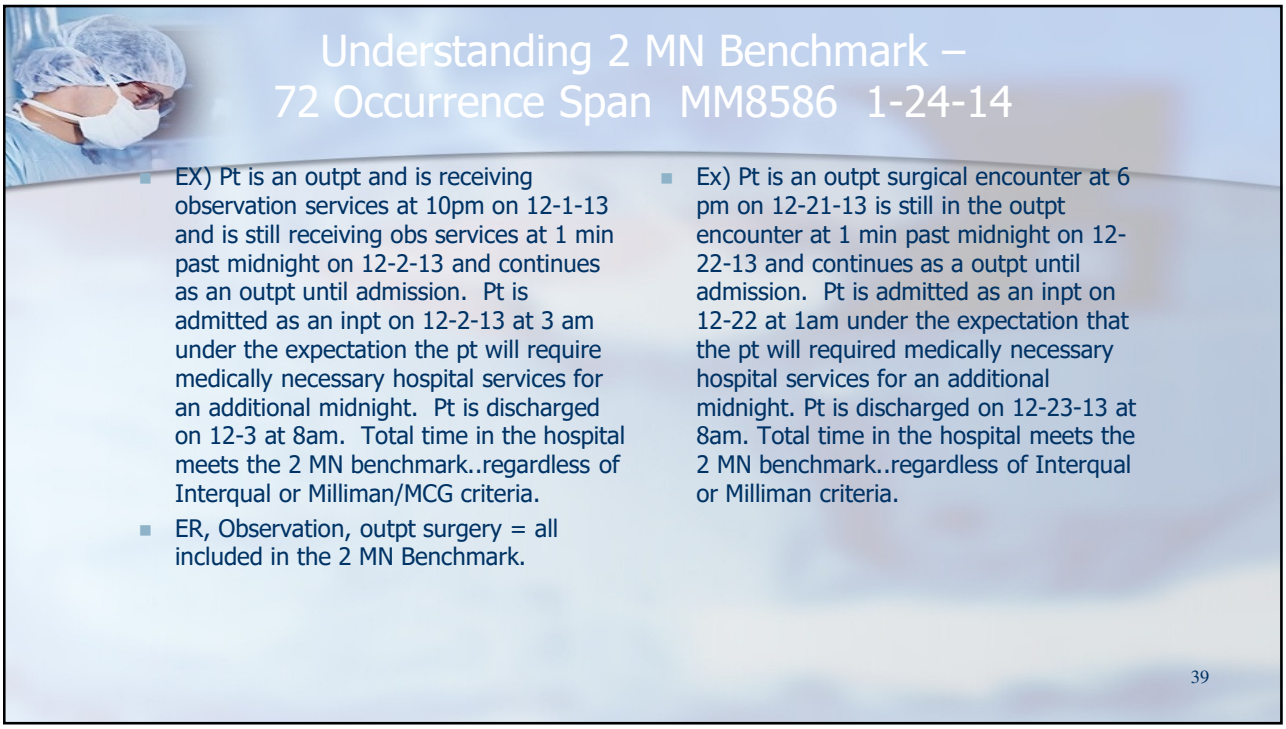
Understanding 2 MN Benchmark –
72 Occurrence Span MM8586 1-24-14
EX) Pt is an outpt and is receiving observation services at 10pm on 12-1-13 and is still receiving obs services at 1 min past midnight on 12-2-13 and continues as an outpt until admission. Pt is admitted as an inpt on 12-2-13 at 3 am under 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.
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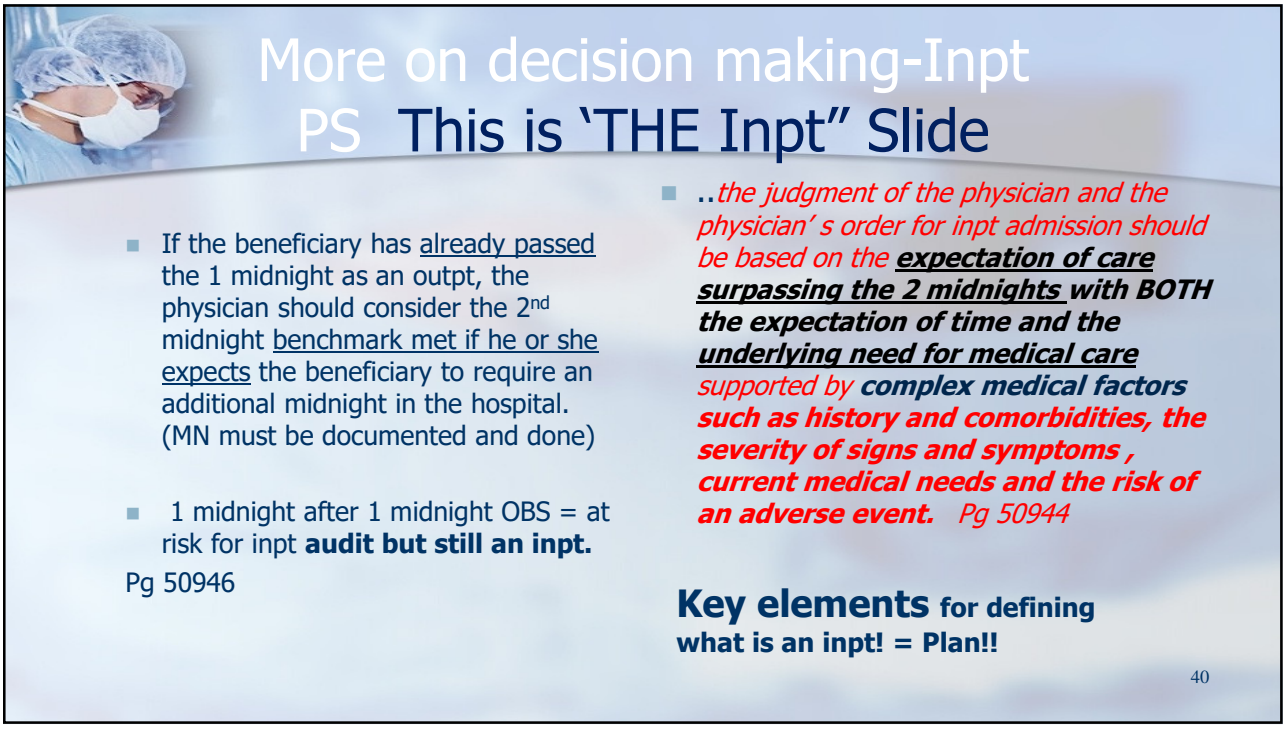
More on decision making-Inpt
PS This is 'THE Inpt" Slide
If the beneficiary has already passed the 1 midnight as an outpt, the physician should consider the 2nd midnight benchmark met if he or she expects the beneficiary to require an additional midnight in the hospital. (MN must be documented and done)
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
Key elements for defining what is an inpt! = Plan!!
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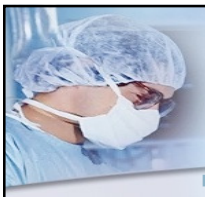


STILL largest lost revenue – 2 MN benchmark – converting after 1st MN

- 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 to inpt with a PLAN. No= discharge.

41

41

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!

42

42

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

43

43

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

44

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.)

45

45

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.

46

Medicare Advantage – Provider WINS –

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

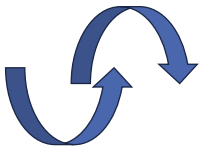
If the plan approved the furnishing of a service thru an advance determination of coverage, it MAY NOT deny coverage later on the basis of a lack of medical necessity." Medicare Mgd Care Manual/Medical Necessity, Chpt 4. Section 10.16.

- 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.

47

47

What is in the Provider's Tool Box ?



- Appt of a Representative
- Ensure there is easy access to the 2014 and 2024 inpt regulations
- "Plan" by the provider that is completed for ALL payers
- Tied to 2 MN presumption or 2 MN benchmark – done at the time of request for inpt. ***OUTLINES THE COMPLEX MEDICAL FACTORS!***
- Prior authorization new submission process – Tell the payer why an inpt using Medicare Guidelines from 2014. KNOW THE REGS!
- Operational Contractual Addendums – working on moving 100% of the power from the payer to a new provider-payer relationship with guidelines for the payers. Currently missing from most contracts.
- File Complaints with CMS. Track and trend violations by payer.

48

48

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

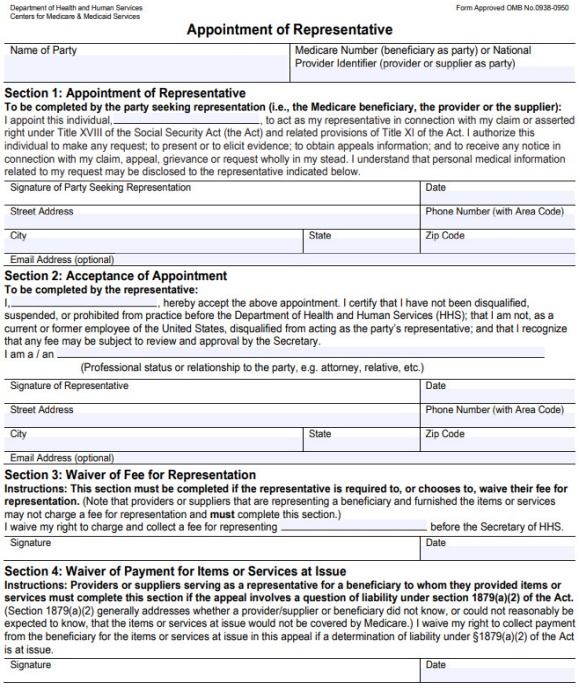
- 42 CFR 422.101 states:
- "…each MA organization must meet the following requirements:
- (a) Provide coverage of, by finishing, arranging for, or making payment for, all services that are covered by Part A and Part B of Medicare…that are available to beneficiaries residing in the plan's service area…
- (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. But What Does Your Contract State? Or is it 'silent'- 100% interp by the payer? See Addendums!

49

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**
- **Pt Involvement request**



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

50

What does a Plan for 2 MN presumption and/or the 2nd MN after an outpt 1st MN/Benchmark look like?

- Numerous references in the Traditional Medicare final regs from 2014
- Key elements –what the payers are also referencing in their denial letters:
  - Looking ***for FOUR Elements: Severity of illness, intensity of services, risk factors, and comorbid conditions that are outlined by the ordering physician. (COMPLEX MEDICAL FACTORS*** *(Final Regs 2014)*
  - Tie the plan to the expectation of 2 MN Presumption
  - Tie the plan to the plan for the 2nd MN after the 1st outpt MN= Benchmark
  - Reference exactly the language the payers are denying for in the site's plan
  - The MA should be told there is a plan/defined complex factors tied to 2MN; therefore, they don't get to use their own internal criteria.
  - Present the 2 MN case to the payer with the initial submission of records.

51

51

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)- Payer w/direct 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: **COMPLEX MEDICAL FACTORS TO SUPPORT INPT (From Final Regs 2014)**

TELL THE PAYER: The plan for an estimated 2 MN stay is: Presumption o r Benchmark (1 outpt MN = 1 more inhospital MN= 2 MN Inpatient) (Comes from the physician's PLAN that accompanies the admit order). The patient meets the Complex Medical factors as outlined in the final 2 MN rule, 2014 for inpatient..

1) Severity of illness 2) Intensity of services 3) known risk factors 4) Other co-morbid conditions that will impact the need for inpt level of care: (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,

52

52

Now we are live, what is happening when inpts are requested using the 2 MN rule? What type of 2 MN?

• Denial of inpt request: United

- *Determination rationale:*
- *This determination is based on Medicare and HEALTH PLAN criteria that states* ***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****. Please visit UHC.Provider..com/policies to review the UHC MA Coverage Summary for Hospital Services.*
- *Based on my review, these criteria may NOT have been met. To help you understand more about this determination, here is my medical rationale:*
- ***"This patient was admitted to the hospital on 1-9-24 with colitis. We reviewed the provided clinical information based on traditional Medicare and health plan criteria for inpt admission.***
- ***Our findings indicate that this stay does not meet criteria for inpt admission. The medical record does not document COMPLEX FACTORS that support an inpt admission is reasonable and necessary..***
- ***The reason is a 3-week hx of diarrhea with colitis noted on CT abdomen. CDiff negative. Responded to ER initiated ceftriaxone . No dehydration or electrolyte imbalance deny. Consequently, the admission does not meet criteria for inpt stay."***

• Denial of inpt request: Humana

- We denied the medical services/items . The request for inpt hospital level of service of care to be covered does not meet the requirements for approval. (Directed toward the pt)
- Humana has reviewed this request against its Inpt Hospital Medical Coverage Policy which can be found at www.humana.com/coverage policies, which includes the inpt admission criteria as outlined by CMS.
- In order for an inpt hospital admission to be appropriate for coverage under Medicare Part A, CMS requires that the admiitting physician **have a reasonable expectation that the pt requires medically necessary hospital care that crosses 2 MN, based on complex medical factors supported by the medical record documentation.**
- **The information in the medical record documentation does not** support the admitting physician's expectation , based on COMPLEX MEDICAL FACTORS, that your hospital stay will require 2 or more MNs.
- ***"Our physician reviewed your records, and they show you were admitted to the hospital with trouble breathing because of a lung problem (COPD-Chronic Obstruction Pulmonary Disease). You were evaluated for blood tests and pictures of your chest. You were treated with breathing medicine and medicines in your vein that fight infection and inflammation. Your records do not show that you have the complex medical conditions to support an inpt stay.***

53

53

Additional MA payer denials for inpt. Wow!

Aetna: A decision denying coverage. 4-6-24

"A physician with expertise in the field of medicine or health care that is appropriate for the services at issue reviewed the request taking account of appropriate coverage and benefit criteria, whether the requested item or service is reasonable and necessary as defined by Medicare, the Aetna policy stated below (speaks directly to clinical guide criteria) and the member's complex medical factors.

Denied for the below reasons: (A full page of narrative speaking to Medicare's rules; regs listed in many areas). "We used Medicare guidance and Aetna Supplemental guidance and Aetna Supplemental guidelines for General Recovery Care, Body System General Recovery Guidelines, Systemic or infections condition. (It goes on to outline all the 21 factors for coverage. Stating: The patient does meet any of these factors.

NO REFERENCE TO THE 2 MN RULE other than to list the 42 CFR

Humana- Denial of Medical Coverage 4-8-24

"Humana has reviewed this request against its Inpatient Hospital Services Medical Coverage Policy which can be found at www.Humana.Com/coveragepolicies which includes the inpt admission criteria outlined by CMS.

"The information in the medical record documentation does not support the admitting physician's reasonable expectation that the pt's care will cross two midnights, **based on complex medical factors that your hospital stay requires two or more midnights."**

'Your records do not show that you have the following signs, symptoms, comorbidities, complex medical condition or other factors that would require treatment in the inpt setting such as: (Lists 5 items –Their own clinical guidelines.)

"Based on the documentation provided, the request for an inpt **level of care is NOT MEDICALLY NECESSARY.**

You did not appear to have complex medical factors that would require a prolonged workup and tx in the hospital to support a reasonable expect you would require medically necessary hospital care that spans 2 MN.

NO REFERENCE TO THE 2MN RULE other than to list it as reference

54

54

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)

55

55

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 --

56

56

AHA Member Advisory: "New Medicare Advantage Question and Complaint Process for Provider Organizations." 8-20-24

- A new complaint form has been created with instructions on resolving MA claims issues.
- The complaint form is a cover pg to a password-protected file along with the requested documentation as indicated
- To the new CMS Drug & Health Plan Operations (DHPO) email at MedicarePartCDQuestions@CMS.hhs.gov**Needs form
- **ALL MA inquiries and complaints from providers thru this centralized email. NEW – not regional CMS offices**
- In addition to the DHPO email, hospitals and health systems may also send complaints ***about inappropriate utilization management criteria or claims processing approaches that they believe do not comply with CMS requirements*** to CMS Part Cand D audit email at: part_c_part_d_audit@cms.hhs.gov**No form required.
- This may include practices **related to prior authorization concurrent review or retrospective review to deny or downgrade coverage or payment that the provider believes is not permitted under CMS rules.**
- These complain types can be submitted to both the Part C & D Audit and the DHPO emails. Note there is no cover sheets required for Part C & D Audit email submission.

For CMS to act upon cases submitted thru the new email, the provider must:

- Include all information and documentation requested on the cover pg.
- Refrain from providing additional info not requested on the cover pg.
- Certify that an effort was made to resolve the issue with the MA plan before contacting CMS.
- CMS reminds providers that its role is not to determine medically necessity or payment amounts for disputed cases, CMS will seek to identify trends in provider complaints to investigate and address broader issues with MA plans where appropriate.
- Determine to add to CMS's Complaint Tracking Module.
- As appropriate – be sure to reference 42 CFR 422.101 (b) (2) and 42 CFR 412.3. (2 MN rule)

57

57

Hot off the press: AHA- "*New Medicare Advantage Question & Complaint process for Provider Organizations" 8-20-24*

		Fill in required information below. Indicate option selection with "X."
1.1	Date of Submission to CMS	
1.2	Entity Submitting Complaint	___ Provider ___Organization Representing Provider *(If indicated, complete the field below and submit evidence of the contractual relationship between the provider and the representing organization substantiating the organization's authority to investigate the case on behalf of the provider.)*
	Name of Organization Representing Provider	
1.3	Submitter's Name	
	E-mail Address	
	Telephone Number	
1.4	Beneficiary Name	
1.5	Beneficiary Health Insurance Claim Number (HICN) / Medicare Beneficiary Number (MBN)	
1.6	Provider Name	
1.7	Medicare Advantage Organization	
1.8	Claim Number	
1.9	Date(s) of Service	
1.10	Provider Contract Status	_____ Provider Contracted with MAO during Date(s) of Service _____ Provider NOT Contracted with MAO during DOS
1.11	Complaint Type	____ Contracted Provider Appeal ____ Non-Contracted Provider Appeal ____ Contracted Provider Claims Payment Dispute ____ Non-Contracted Provider Claims Payment Dispute _____ Other
	Brief Summary of Complaint	
1.12	Did MAO communicate your appeal rights.	__Yes __No
1.13	Have you exhausted all appeals rights per the noncontracted provider appeals or per contract w/MAO	__Yes __No
1.14	Provider has Communicated with MAO in Attempt to Resolve Issue	_____ Yes _____ No *(NOTE: CMS will only review this case if the provider has already attempted to resolve it by working directly with the MAO.)*

- **MA Plan Complaint Process for Violation of Two Midnight Rule Provisions**
- References: CMS instructions to encrypt documents

  Complaint Form

  Instructions to submit complaint - MUST READ
- If after appeals and dispute processes have been exhausted and you feel the issues remain, you may document the form for CMS' review. Please remember to provide the Medicare beneficiary's information on the provider claims and disputes form . A complaint will be filed for the plans' review if CMS agrees the matter appears to be unresolved. However, CMS cannot intervene in contractual disputes, disagreements for payment or related interpretations of the existing contract.
- **Big deal!!**
- **Hospitals and health systems may also send complaints about inappropriate utilization management criteria or claims processing approaches that they believe do not comply with CMS requirements to the CMS Part C and D Audit email at part_c_part_d_audit@cms.hhs.gov.**
- **This may include practices related to prior authorization, concurrent review or retrospective review to deny or downgrade coverage or payment that the provider believes is not permitted under CMS rules. These complaint types can be submitted to both the Part C and D Audit and the DHPO emails. Note that there is no cover sheets required for the Part C and D Audit email submission but must follow all PHI privacy rules.**

58

58


Thank You for Joining Us in this Educational Journey
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59

59