ERN NCRA

You fight for their lives.

WE FIGHT FOR YOU.

HEALTH LAWS

2018

When Payors Won't Listen:

The Law, Denial Management and Appeal Letter Writing

DISCLAIMER: The intent of this program is to present accurate and authoritative information in regard to the subject matter covered. It is presented with the understanding that ERN/NCRA is not engaged in the rendition of legal advice. This presentation is intended for educational and informational purposes only. If legal advice or other expert assistance is required, you should seek the counsel of your own attorney with the expertise in the area of inquiry.

We Advocate.

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

What We Do.

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

The Sign of the Times

At ERN, we understand the significance of quality health care and its reliance on financial viability. With the support of *Wickline v. State*, our primary goal is *to advocate for medically appropriate health care* and to ensure the faithful and ardent enforcement of all public health and safety laws for the protection of patients, physicians, hospitals and other emergency providers; because ultimately, we recognize that every case represents a human life.

The Sign of the Times

One of the most cited cases regarding managed care liability is **Wickline vs. State of California** (November 1986)

The Sign of the Times

The Court of Appeal held that:

(1) Patient who is harmed when care which should have been provided is not provided should recover from all responsible for deprivation of care, including when appropriate health care payors;

The Sign of the Times

(2) Third-party payors of health care services can be held legally accountable when medically inappropriate decisions result from defects or designs or implementation of cost containment mechanisms;

The Sign of the Times

(3) Physician who complies without protest with limitations imposed by third-party payors cannot avoid ultimate responsibility for patient's care; and

(4) Medi-Cal was not liable for discharge decision"(Emphasis added.)

Ed Norwood

Subject: FW: Dr. Hosalkar info

From: Lisa Townsend [mailto:
Sent: Monday, April 17, 2017 10:53 PM
To: Ed Norwood <ednorwood@ernenterprises.org>
Subject: Re: Dr. Hosalkar info

My Son had two failed limb lengthening surgeries with two different doctors in the state of California. With each surgery he suffered many years of pain and extensive rehabilitation. After each surgery failed I was approached by each doctor and was told that the only option left would be to amputate his leg. I also knew that would never be an option and I would make sure to exhaust every resource to find a doctor that could fix my Son.

Through my son's physical therapy I was given the name of a limb lengthening specialist in Florida. I then notified my son's insurance to find out how to get approval to go to Florida to see this doctor. I did everything they told me to do and then submitted my paperwork, after 4 days they had notified me and told me his case had been denied. They said as long as there was a doctor in California who could fix him he could not go out of state for surgery.

I was then introduced to Ed and his amazing staff at ERN who took our case and fought for us to get medical treatment in Florida.
My Son has now had two successful lengthening surgeries in Florida and we are leaving soon to have another.

I know if I had never met Ed my Son and I would still be fighting to get approval to get him to a specialist. I am thankful everyday that we found ERN, they have certainly changed our lives.

Sent from my iPhone

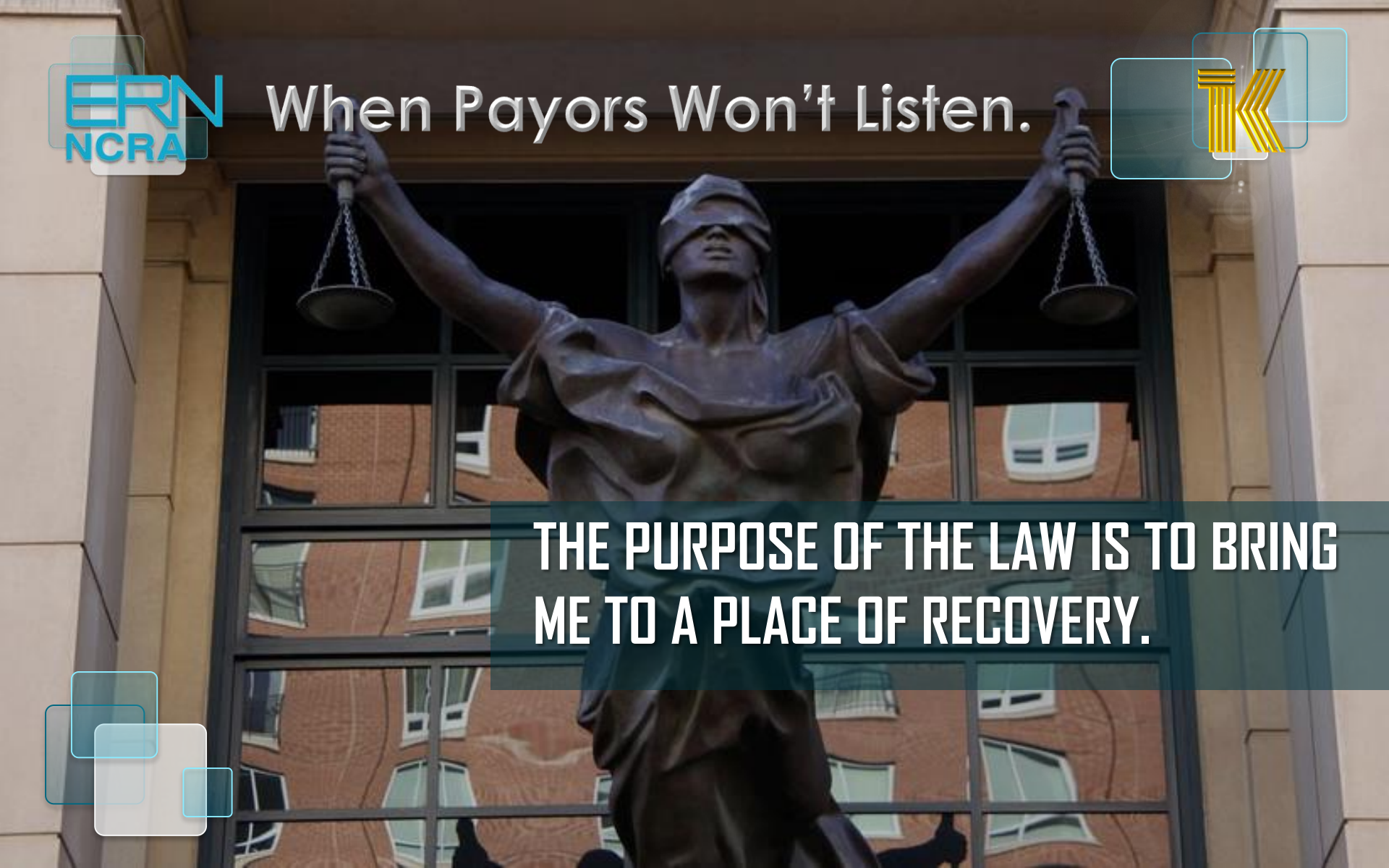
FOUR WAYS TO BE A

Champion

FOR MEDICALLY APPROPRIATE HEALTHCARE

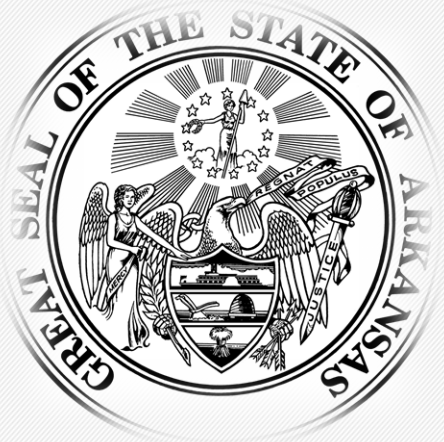

ERN
NCRA
Can I do this?

When Payors Won't Listen.



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

The Law



AR EMERGENCY AND POSTSTABILIZATION

Emergency Services

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

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

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

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

Poststabilization Services

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

(e)(1) If a subscriber receives an emergency healthcare service that requires an immediate **post-evaluation or post-stabilization healthcare service**, a utilization review entity shall make an authorization **within sixty (60) minutes** of receiving a request.

(2) If the authorization is not made **within sixty (60) minutes**, the emergency healthcare service shall be approved.

LA EMERGENCY AND POSTSTABILIZATION

Emergency Services

LA Revised Statutes §1821. Payment of claims; health and accident policies; prospective review; penalties; self-insurers; telemedicine reimbursement by insurers

D(2)(b) Every insurer, health maintenance organization, preferred provider organization, or other managed care organization which includes emergency medical services as part of its policy or contract, shall provide coverage **and shall subsequently pay providers for emergency medical services provided to an insured, enrollee, or patient who presents himself with an emergency medical condition.**

(c) An insurer, health maintenance organization, preferred provider organization, or other managed care organization **shall not retrospectively deny or reduce payments to providers for emergency medical services of an insured, enrollee, or patient even if it is determined that the emergency medical condition, initially presented is later identified through screening not to be an actual emergency**…

MS EMERGENCY AND POSTSTABILIZATION

Emergency Services

Title 15 Rule 82.7.6

Notwithstanding language to the contrary elsewhere contained herein, if a licensed physician certifies in writing to an insurer **within seventy-two (72) hours of an admission** that the insured person admitted was in need of emergency admission to hospital care, **such shall constitute a prima facie case of the medical necessity of the admission**. An emergency admission results from sudden onset of a medical condition manifested by acute symptoms of sufficient severity that absence of immediate inpatient hospitalization could reasonably result in:

1. Permanently placing the patient's health in jeopardy;

2. Serious impairment to bodily functions; or

3. Serious and permanent dysfunction of any bodily organ or part, or other serious medical consequences.

Source: Miss. Code Ann. §41.83.1

The Law

OK EMERGENCY AND POSTSTABILIZATION

Emergency Services

Title 36 §36-6907 Emergency Services

L. Decisions by a health maintenance organization to authorize or deny coverage for an emergency service **shall be based on the patient presenting symptoms** arising from any injury, illness, or condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a reasonable and prudent layperson could expect the absence of medical attention to result in serious:

1. Jeopardy to the health of the patient;
2. Impairment of bodily function; or
3. Dysfunction of any bodily organ or part.

Plans cannot deny emergency services solely based on a retrospective analysis or final discharge of the services provided.

Emergency Services

Title 36 §36-6907 Emergency Services

M. Health maintenance organizations shall not deny an otherwise covered emergency service **based solely** upon lack of notification to the HMO.

N. Health maintenance organizations shall compensate a provider for **patient screening, evaluation, and examination services that are reasonably calculated to assist the provider in determining whether the condition of the patient requires emergency service**. If the provider determines that the patient does not require emergency service, coverage for services rendered **subsequent to that determination shall be governed by the HMO contract** *(See Title 36 §36-6055 (L –N for PPO.)*

Plans must pay for the patient screening, evaluation and examinations services required to rule out an emergency.

APPENDIX G. PROMPT PAY FORM

PROMPT PAY FORM

Oklahoma Insurance Department
Five Corporate Plaza
3625 NW 56th Street, Suite 100
Oklahoma City, Ok 73112-4511
(405) 521-2828
(800) 522-0071 Toll Free (In State Only)
(405) 521-6632 Fax

NOTE:
ENTITIES ACCUSED OF PROMPT PAY VIOLATIONS ARE REQUIRED TO SUBMIT DOCUMENTATION SUPPORTING THE REASON FOR DELAY IN PAYMENT OR PROOF OF PAYMENT TO THE OKLAHOMA INSURANCE DEPARTMENT WITHIN TEN (10) DAYS.

FROM: _____ **Telephone:** _____

Address: _____ **City & State:** _____ **Zip:** _____

Name of insured or member: _____ **Telephone:** _____

Address: _____ **City & State:** _____ **Zip:** _____

Full Name of Entity accused of prompt pay violations: _____

Address: _____ **City & State:** _____ **Zip:** _____

Policy/Contract/Group Number or Name: _____

Dates Claims Originally Submitted: _____

Please give as detailed information as possible including dates and explain what solution you feel is correct. Attach copies of all correspondence relating to the inquiry. Include the following information if available: 1) Provider PIN such as health plan/company ID/tax ID; 2) Member ID number; 3) Date of original claim filing; 4) Date of service; 5) Billed amount for the service; and 4) description of the service or CPT code involved.

_____

_____

_____

_____

(Continue on the back)

COMPLAINANT MUST PROVIDE A COPY OF THIS COMPLETED FORM TO THE ENTITY ACCUSED OF PROMPT PAY VIOLATIONS AND THE OKLAHOMA INSURANCE DEPARTMENT SIMULTANEOUSLY.

The Law

TX EMERGENCY AND POSTSTABILIZATION

Poststabilization Services

28 TAC §19.1718 – Poststabilization Treatment

(d)(3) If the proposed medical care or health care services involve **post-stabilization treatment, or a life-threatening condition as defined in §19.1703 of this title (relating to Definitions)**, the HMO or preferred provider benefit plan must issue and transmit a determination indicating whether proposed services are preauthorized **within the time appropriate to the circumstances relating to the delivery of the services and the condition of the enrollee, but in no case to exceed one hour from receipt of the request**. If the request is received outside of the period requiring the availability of appropriate personnel as required in **subsections (e) and (f)** of this section, the determination must be issued and transmitted **within one hour from the beginning of the next time period requiring appropriate personnel**.

The Law

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

MA EMERGENCY AND POSTSTABILIZATION

Emergency Services

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

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

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

Emergency Services

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

Poststabilization Services

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

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

Poststabilization Services

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

Poststabilization Services

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

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

(B) The MA organization cannot be contacted; or

Poststabilization Services

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

Poststabilization Services

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

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

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

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

(iv) The enrollee is discharged.

MA Organizations: Their Financial Responsibility to You

Source:
42 CFR §422.113 (c)(2-3)

MA Organizations are financially responsible for poststabilization care services when…

1. …they have been pre-approved

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

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

MA Organizations' financially responsibility ends when…

1. …a plan physician assumes responsibility for the enrollee's care…
   - …at the treating facility
   - …OR through transfer

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

3. …OR the enrollee is discharged

Ed Norwood

From: Brian Ford
Sent: Friday, May 04, 2018 5:02 PM
To: Duarte, Ann M. (CMS/CMHPO)
Cc: August, Kimberly J. (CMS/CM); Smith, Jennifer M. (CMS/CM); Ed Norwood;
Subject: RE: CMS Correspondence
Attachments: Establishment of M+C Program 6.26.98.00-15648.pdf; Establishment of MA Program 6.29.2000.00-15648.pdf

Good afternoon Ms. Duarte and Ms. Coleman,

Thank you both very much for your responses and guidance into our inquiry. The email provided below is concerning as it does not parallel the written intent of CMS when drafting sections 422.100 and 422.113. In fact, our findings shows CMS's intent of the law to be the complete opposite of what is provided below. I have attached all of the following information above for your review.

1.) **According to Federal Register Volume 63, Number 123, MAO's are prohibited from avoiding liability when an MAO fails to respond to the provider within 1 hour of the provider notifying the MAO of the members stabilized condition.**

The Federal Register attached above is provided to clarify the Medicare law and how it is applied. The Federal register states:

> ***"We agree that the issue of when the M+C organization's financial responsibility ends needs further clarification. We also agree that the physician should not have to arrive in person at the hospital in order to assume responsibility for his or her patient. Therefore, we are incorporating the following language into § 422.113(c)(3): "The M+C organization's financial responsibility for post-stabilization care services it has not pre-approved ends when—(i) A plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care; (ii) A plan physician assumes responsibility for the enrollee through transfer; (iii) An M+C organization representative and the treating physician reach an agreement concerning the enrollee's care; or,(iv) The enrollee is discharged."***
>
> ***We do not agree that the M+C organization should have the absolute right to control the care that is given to the member when it does eventually respond and the one hour time period has elapsed. For example, a late response could result in a scenario where post-stabilization care services may have already started, and in such a situation, we believe that interruption of a procedure in progress in order to transfer the enrollee to another facility could be harmful to the member. The M+C organization is financially responsible for post-stabilization services until the M+C organization and the treating physician execute a plan for safe transfer of responsibility. Safe transfer of responsibility should occur with the needs and the condition of the patient as the primary concern, so that the quality of care the patient receives is not compromised."*** (See Pages 40201-40204)

The above is logical as allowing an MAO to deny an inpatient claim as not medically necessary would permit the MAO from escaping financial liability for inpatient services when they failed to respond to the provider within 1 hour, thus losing their absolute right to control the care given to the member.

As such, SCAN may do a medical necessity review, but it may not deny the inpatient care on that basis as they do not have the right to control the care that was given to the member after they failed to respond to our provider member within 1 hour.

To further this position, the Register also states:

> ***By post-stabilization care services, we generally mean covered services, related to an emergency episode, provided after the enrollee is considered to be stable (see new § 422.113(c)). Under the post-stabilization provisions set forth in the interim final rule, "post-stabilization" services were limited to services authorized by the M+C organization or services furnished when the organization cannot be reached, or fails to respond to a request for authorization within an hour. This definition did not address services that may be required during that hour to keep the patient stabilized. We believe that it is necessary to ensure that the patient continues to receive necessary treatment during the 1-hour time frame when the provider waits for the organization to respond. These services consist of those necessary to maintain the stable condition achieved through previously administered emergency services. Any period of instability that rises to the level of an emergency medical condition that occurs during this time would be covered under § 422.113(b).***
>
> ***Section 422.113(c) also establishes that if the M+C organization does not respond within the 1-hour time frame, the M+C organization cannot be reached, the treating physician can proceed with post-stabilization services that are administered not only to ensure stability, but also to improve or resolve the patient's condition. When an M+C organization representative who is a non-physician and the treating physician cannot reach agreement on a course of treatment, the M+C organization must allow the treating physician to speak with a plan physician. By allowing the treating physician to proceed with care of the patient in these cases, we are ensuring that M+C enrollees receive the same standard of timely care as beneficiaries under original Medicare.*** (See pages 40201-40204)

The section above demonstrates that the treating physician has the ultimate and final say of the members treatment and services to be rendered to improve or resolve the members condition in the event the MAO fails to respond within 1 hour to the provider. Therefore, this would preclude the use of any medical review by the MAO if the treating physicians determination stands.

Here, there was no dispute of treatment, SCAN simply failed to respond leaving the treating physician to determine the course of further treatment. Logically, SCAN may not challenge the decision of the treating physician. Any medical necessity review is useless.

Additionally, the care and treatment during the 1 hour waiting period performed to maintain the stable condition are considered emergency services and must not be medically reviewed and must be analyzed in accordance with the prudent layperson standard, which brings me to my next concern.

2.) **Medicare Managed Care Manual Chapter 4, Section 10.16 is in direct violation of federal law regarding emergency services.**

Medicare Managed Care Manual Chapter 4, Section 10.16 states:

> **Every MA plan:**
>
> **Must make determinations based on: (1) the medical necessity of plan-covered services - including emergency, urgent care and post-stabilization - based on internal policies (including coverage criteria no more restrictive than original Medicare's national and local coverage policies) reviewed and approved by the medical director;**

According to this provision in the manual, Medicare is requiring every MA plan to make medical necessity determinations based on medical necessity for emergency services. This alone is completely prohibited in EMTALA as well as federal CMS law.

According to the Federal Register which states:

Consistent with the new definition of ``emergency medical condition'' in section 1852(d)(3)(B), we are codifying longstanding HMO/CMP Manual policy (Sec. 2104) of prohibiting retrospective denial for services which appeared, to the prudent layperson, to be emergencies, but which turn out to be nonemergency in nature. (See Pages 34985-34986)

The above entry was strengthened by **422.113(b)(2)(iii)** which states:

(2)MA organization financial responsibility. The MA organization is financially responsible for emergency and urgently needed services —
(iii) In accordance with the prudent layperson definition of emergency medical condition regardless of final diagnosis;

Therefore, section 10.16 appears to be in conflict with the requirements for emergency services under federal law and the standard for review.

3.) CMS may not refuse to resolve a complaint solely because the provider is contracted with the MAO.

We understand that the MAO and the provider are encouraged to settle disputes via the contract, but this does not prohibit the provider from submitting complaints in the CTM nor does it permit CMS to refuse to adjudicate a complaint that was filed in the CTM. As you know, 422.504 requires the MAO to abide by certain rules and regulations. If one of these rules or regulations may have been violated, CMS has a duty to investigate and resolve the matter.

The Federal Register stated in pertinent part:

Complaints and disputes are addressed in the HCFA monitoring process, and resolution would depend on the circumstances encountered. Ultimately, if agreement cannot be reached, a dispute over whether the conditions for M+C coverage for post-stabilization care services under § 422.100 and § 422.113 have been met could be resolved in an enrollee's appeal of the M+C organization's denial of payment for post-stabilization services, or an appeal by a provider if the provider agrees not to charge the enrollee. (We note that the rules governing payment for services furnished by no contracting providers would apply in post-stabilization cases, as set forth in § 422.214 and discussed in detail in section II.E of this preamble.

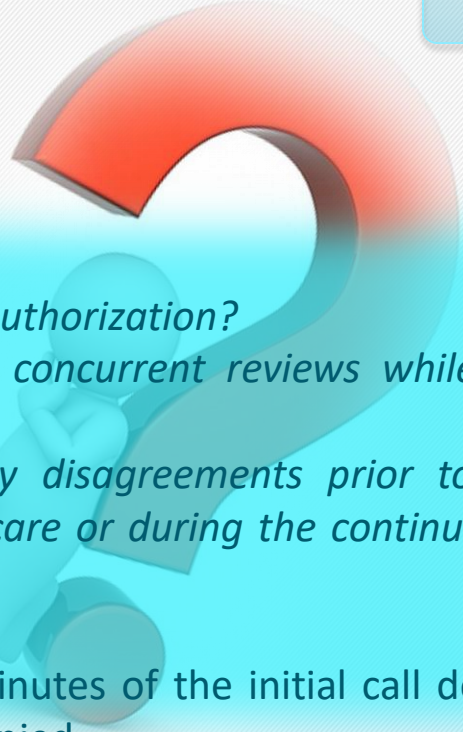
The only way that CMS may be able to resolve a possible breach of 422.504 is through the CTM and the complaint process. Here, there is a clear violation of federal law and a breach of the MAO's duties under 422.504 are apparent by denying services that the MAO has financial responsibility for. Regardless of whether there is a contract, CMS must resolve this complaint.

It is very clear then that the entire purpose of 422.113 is to prevent the MAO from having the ability to control the patient's care when the MAO has failed to respond within 1 hour. Please also note the detail and depth the Federal Register goes into in explaining and clarifying the federal law and how it may be interpreted. The purpose of the 1 hour rule is to protect the beneficiary as well as the provider of care and services, so logically it should be read in terms most favorable to the beneficiary and provider.

Lastly, the Medicare Managed Manual section 10.16 is silent to the 1 hour requirement and I suspect that its absence is for a reason. The terms in the manual may be true, but according to the Federal Register above, that section becomes inapplicable when the MAO fails to respond to the provider within 1 hour, as was the case here with SCAN.

If you disagree with our findings, please provide written authority that would supersede this Federal Register in the interpretation of 422.113.

Questions



ASK YOURSELF:

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

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

RECONSIDERATIONS

Medicare Advantage Appeals Timeline

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

To request a reconsideration

42 CFR 422.582(a-b)

To uphold the service denial and send to an IRE

42 CFR 422.590(a)(2)

To effectuate a payment reconsidered determination

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

MA Reconsideration Process

42 CFR §422.586 The MA organization must provide the parties to the reconsideration with a reasonable opportunity to present **evidence and allegations of fact or law, related to the issue in dispute, in person as well as in writing.** In the case of an expedited reconsideration, the opportunity to present evidence is limited by the short timeframe for making a decision. Therefore, the MA organization must inform the parties of the conditions for submitting the evidence.

POLICY CHALLENGE:
CENTER FOR MEDICARE AND MEDICAID SERVICES

DID YOU KNOW?

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

Authority: **42 CFR §422.590 (b)(2)**

CARELESS HEALTH PLAN

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

WHAT CAN YOU DO?

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

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

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

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


ERN
NCRA
Can I
process this?

What if you could prevent denials?

Our Providers

Health Plan authorization delays

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

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

www.erntraf.org

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

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

CALL TO GET STARTED:

(714) 995-6900 EXT. 6934

METHODIST HOSPITAL – INSURANCE VERIFICATION WORKSHEET

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

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

PATIENT INFORMATION

Patient Name _____

D.O.B. _____ SSN _____

Admit Date _____

Account # _____ MRUN _____

PATIENT TYPE

MED_____ SURG_____ TCU _____ REHAB_____ OB_____

SSO _____ SSP _____ OPS_____

Scheduled/Elective _____ ER _____ Direct/Urgent_____

DX_____

INSURANCE/HOME PLAN

Insurance Name _____

IPA _____

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

If Self-funded, Employer Name _____

PPO _____ EPO _____ HMO _____ POS _____

Effective Date _____ Subscriber _____

ID# _____ Group # _____

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

PROCEDURE _____

Capitated Hospital _____

CLAIMS ADDRESS

Name _____

Address _____

City _____

BENEFITS

VERIF W/ _____ PHONE # _____

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

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

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

HMO – PLAN/IPA AUTH#_____ Per _____

PHONE # _____ FAX # _____

INS TRACKING # _____ PER _____ @ (_____) _____

WORKERS COMP

Date of Injury _____ Claim # _____

ADJ _____ Phone # _____

PPO – PRE-CERT REQUIRED? YES / NO

Spoke With _____

Reference # _____

Case Manager Name _____

Notes/Comments _____

PRE-CERT UR NAME _____

Pre-Cert Phone# _____

Days Allowed _____

Phone # _____

VERIFIED BY & DATE: _____

ERN
NCRA

fax

TO:	FROM: ED NORWOOD
FAX:	PAGES:
PHONE:	DATE:
RE: **FACESHEET OF MA ENROLLEE ADMISSION**	CC:

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

At this time, we are requesting authorization to provide post-stabilization services to the attached **Medicare Advantage (MA) Enrollee**. Please be advised that as the MA Plan provider or MA organization representative, you have **one (1) hour** to preapprove poststabilization care services from receipt of this notification, or make a decision to arrange transfer of the enrollee. If you do not respond with preapproval or communicate an intent to transfer the beneficiary within **one (1) hour**, or effectuate a transfer within a reasonable time, the post stabilization services shall be deemed authorized and paid in accordance with **42 CFR §422.113 (c)(2)** and any regulation adopted thereunder. Further, please be advised that due to ER overflow concerns, transfers must be effectuated within ___ hours of notifying us of the intent to assume management of the enrollee's care, or the patient will be admitted and the MA plan will be responsible to reimburse for all services up to the time that transfer is effectuated, or the enrollee is discharged **(See 42 CFR §422.113 (c)(3)**.

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

If you need any further information, please contact: Care Coordination Department @ (xxx) xxx-xxxx or Fax (xxx) xxx-xxxx.

Insert confidentiality/HIPAA statement here -

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

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

Procedure

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

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

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

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

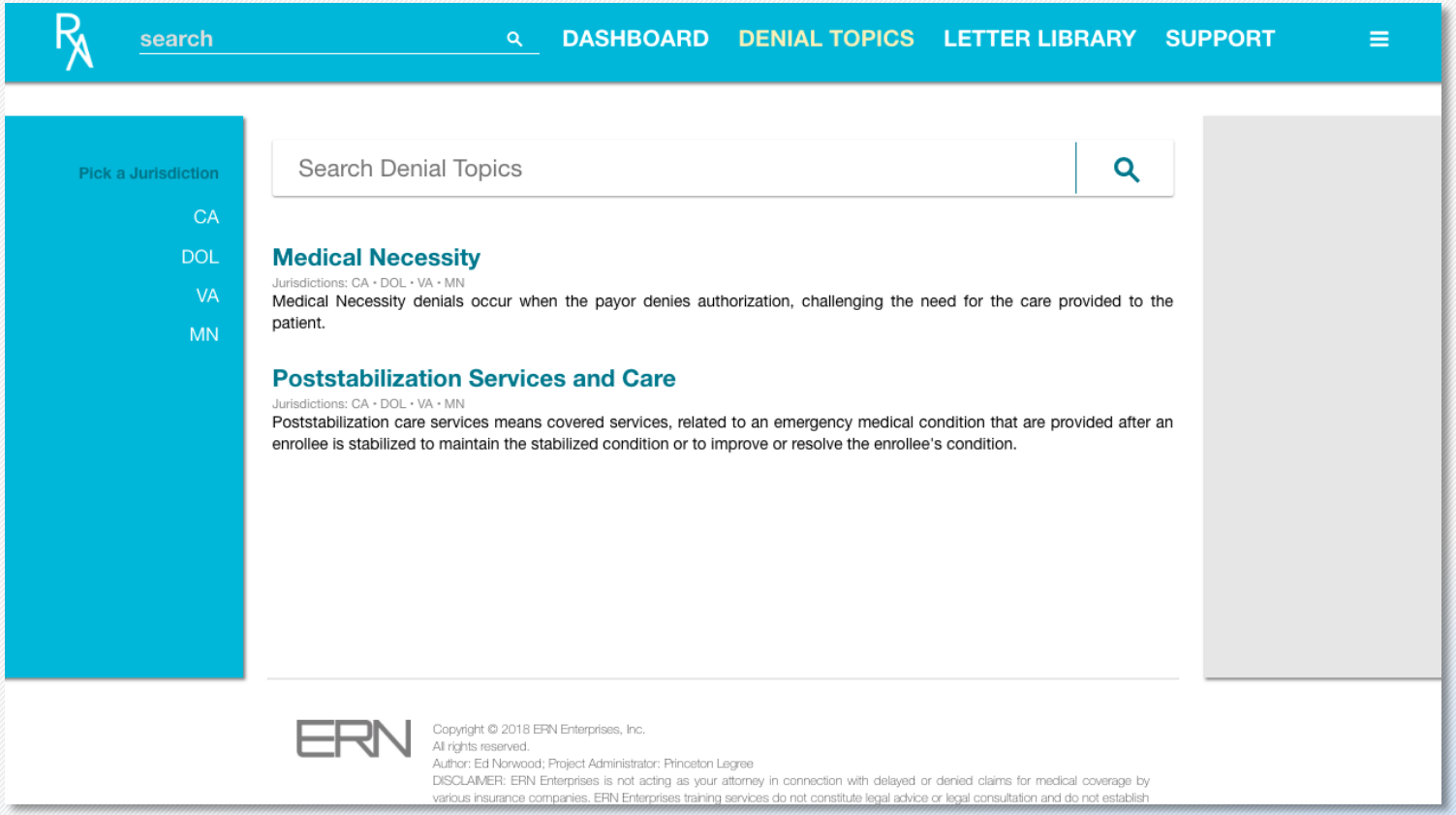
Challenge Everything

Have you created:

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


ERN
NCRA
Can I automate this?

REVAssurance Online



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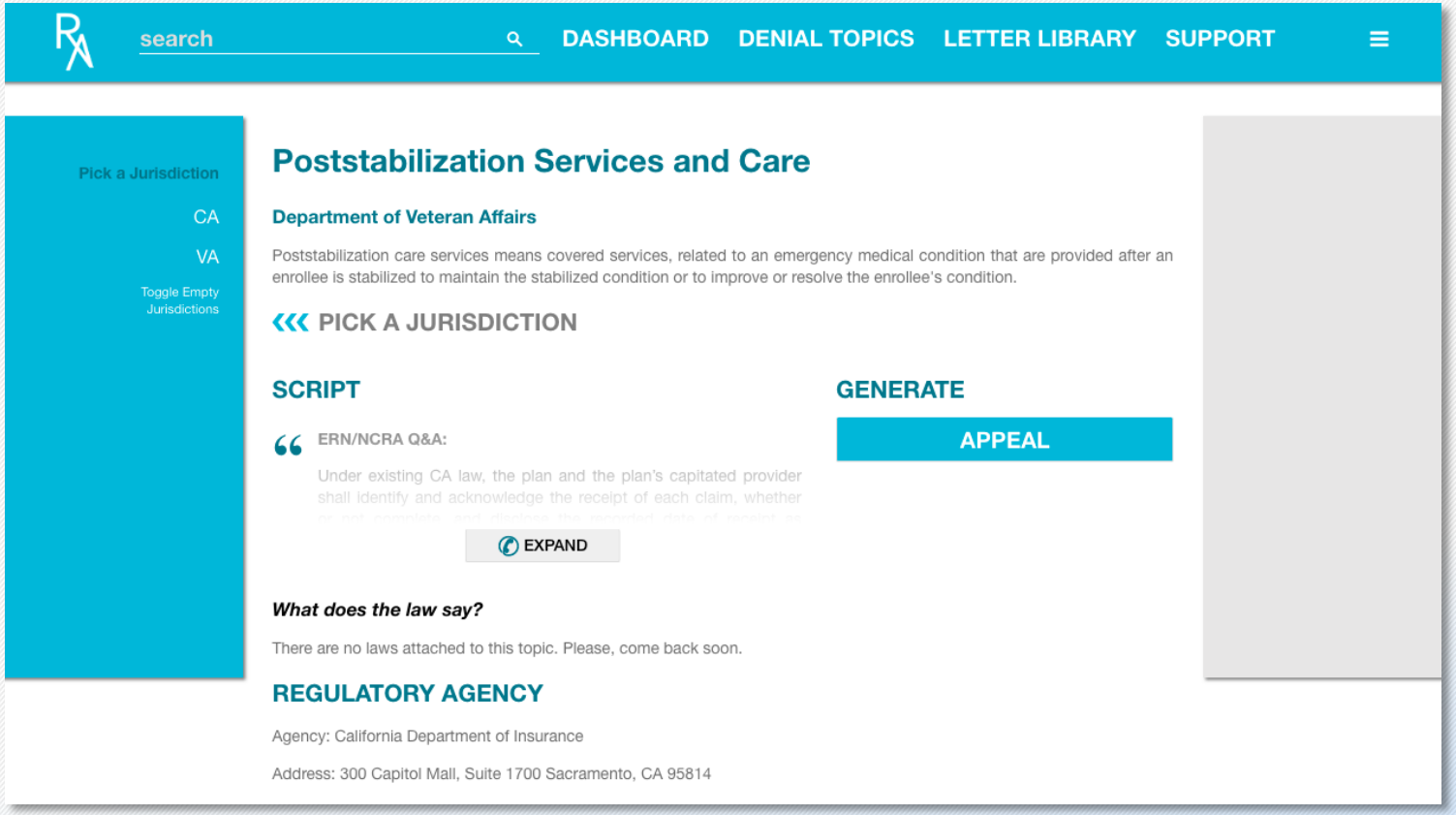

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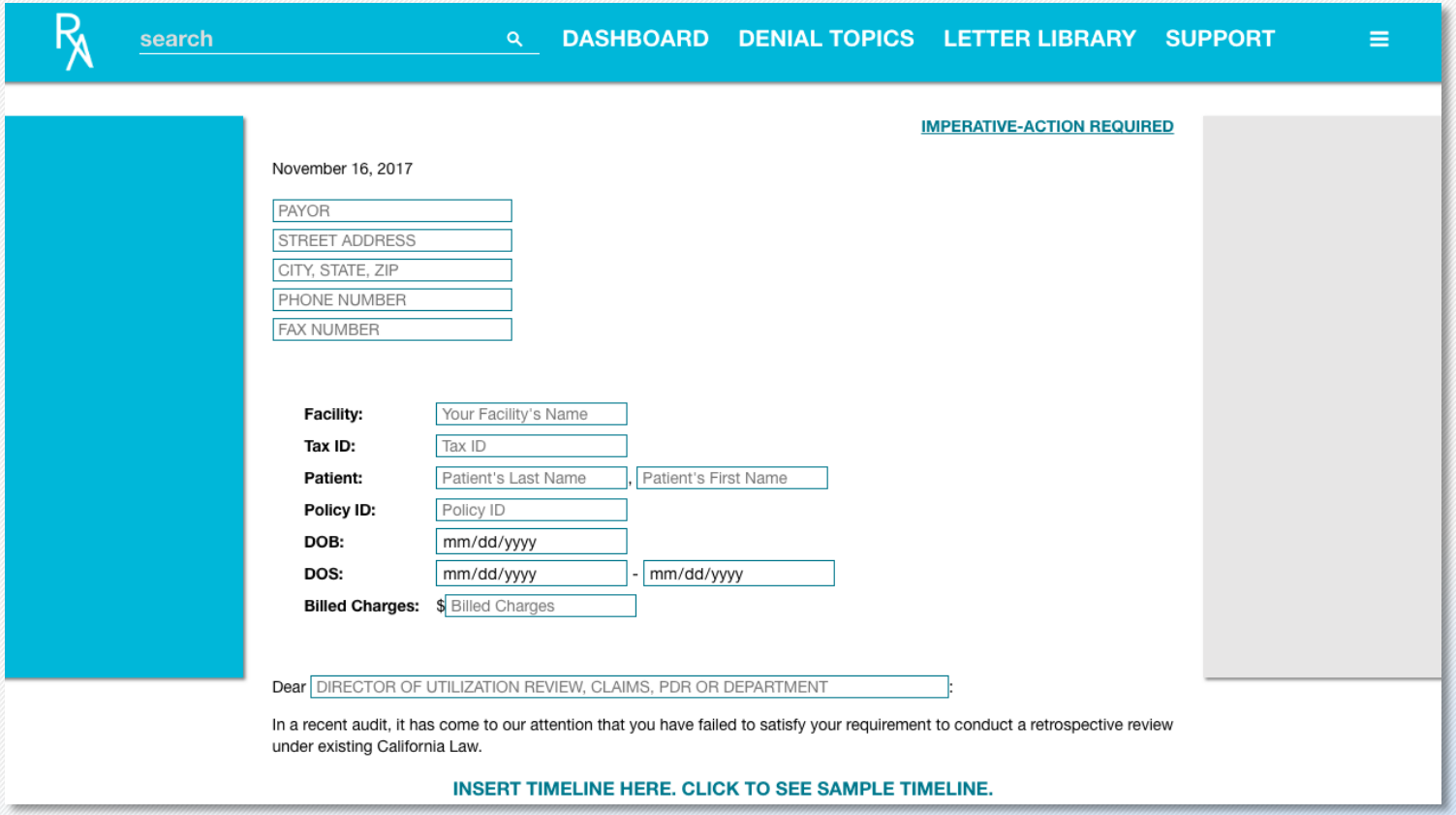

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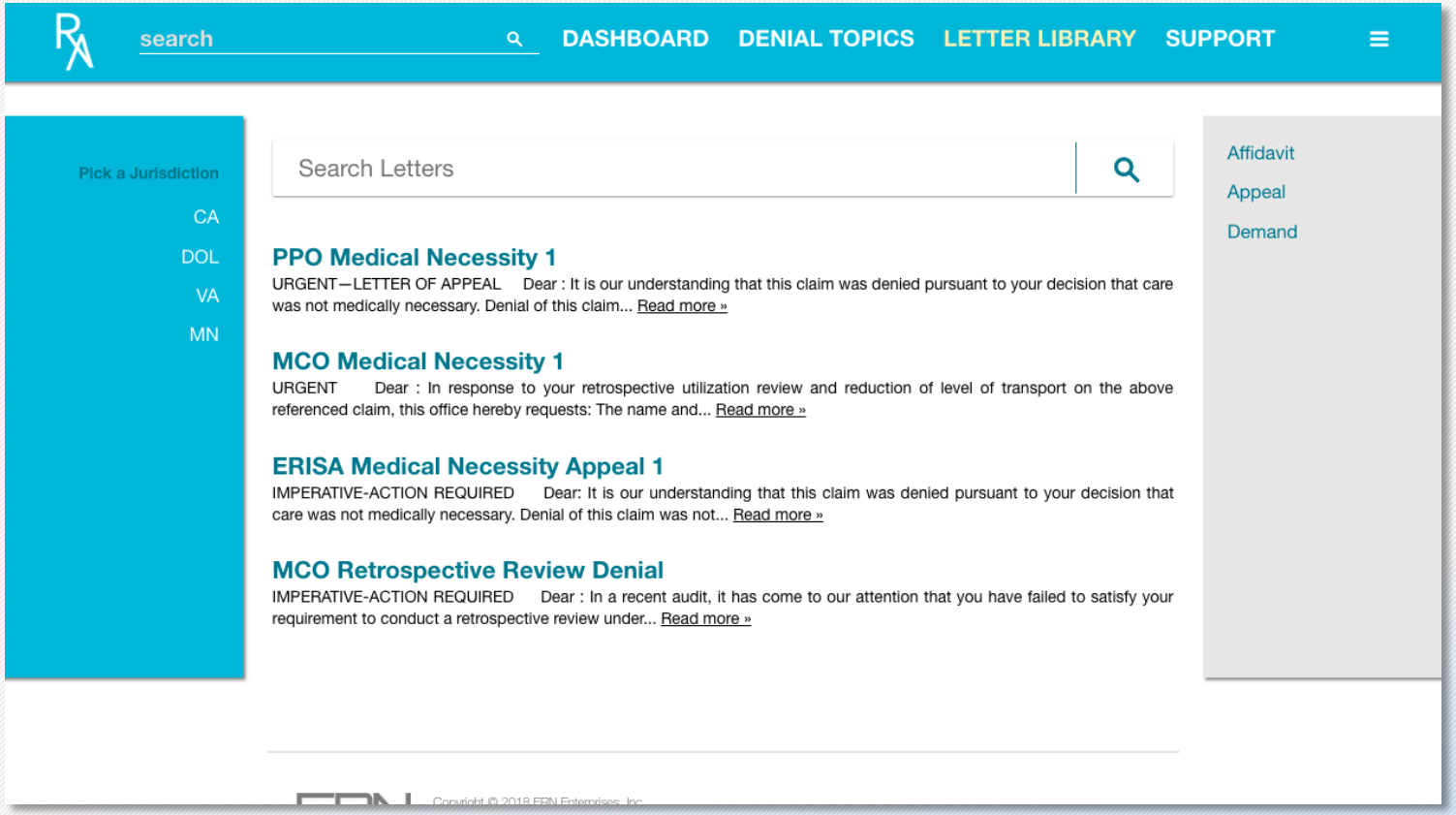
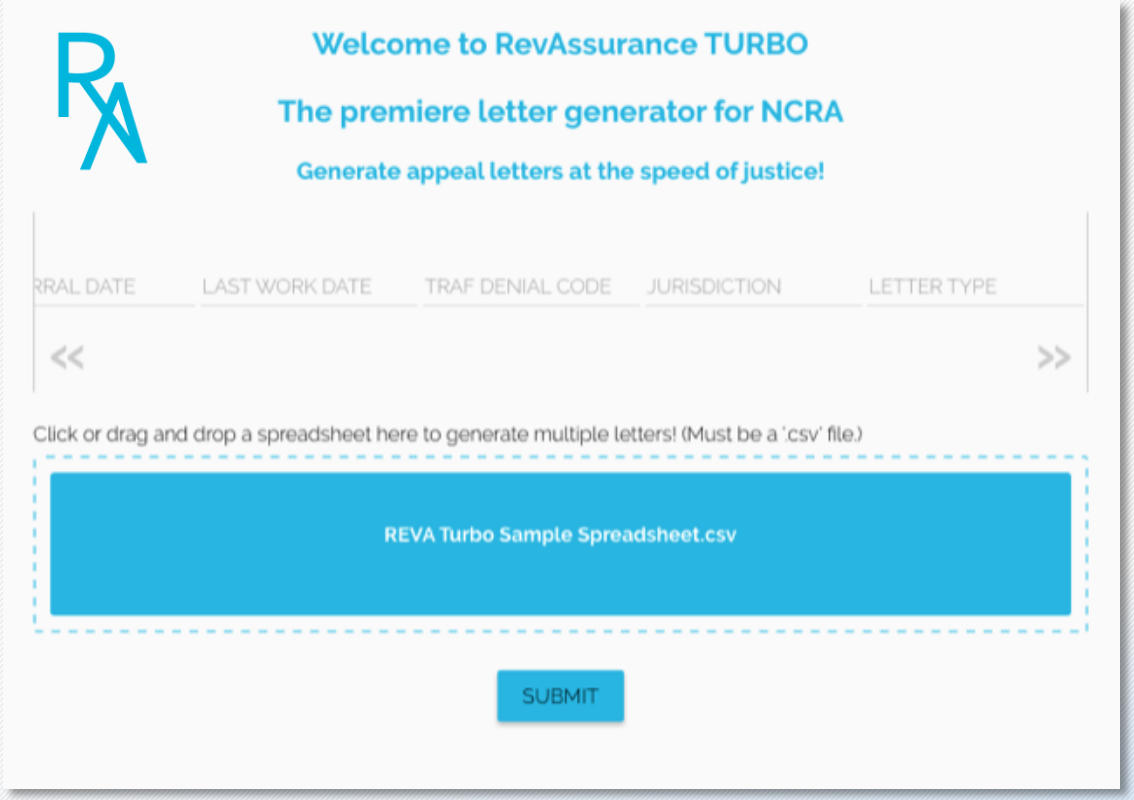
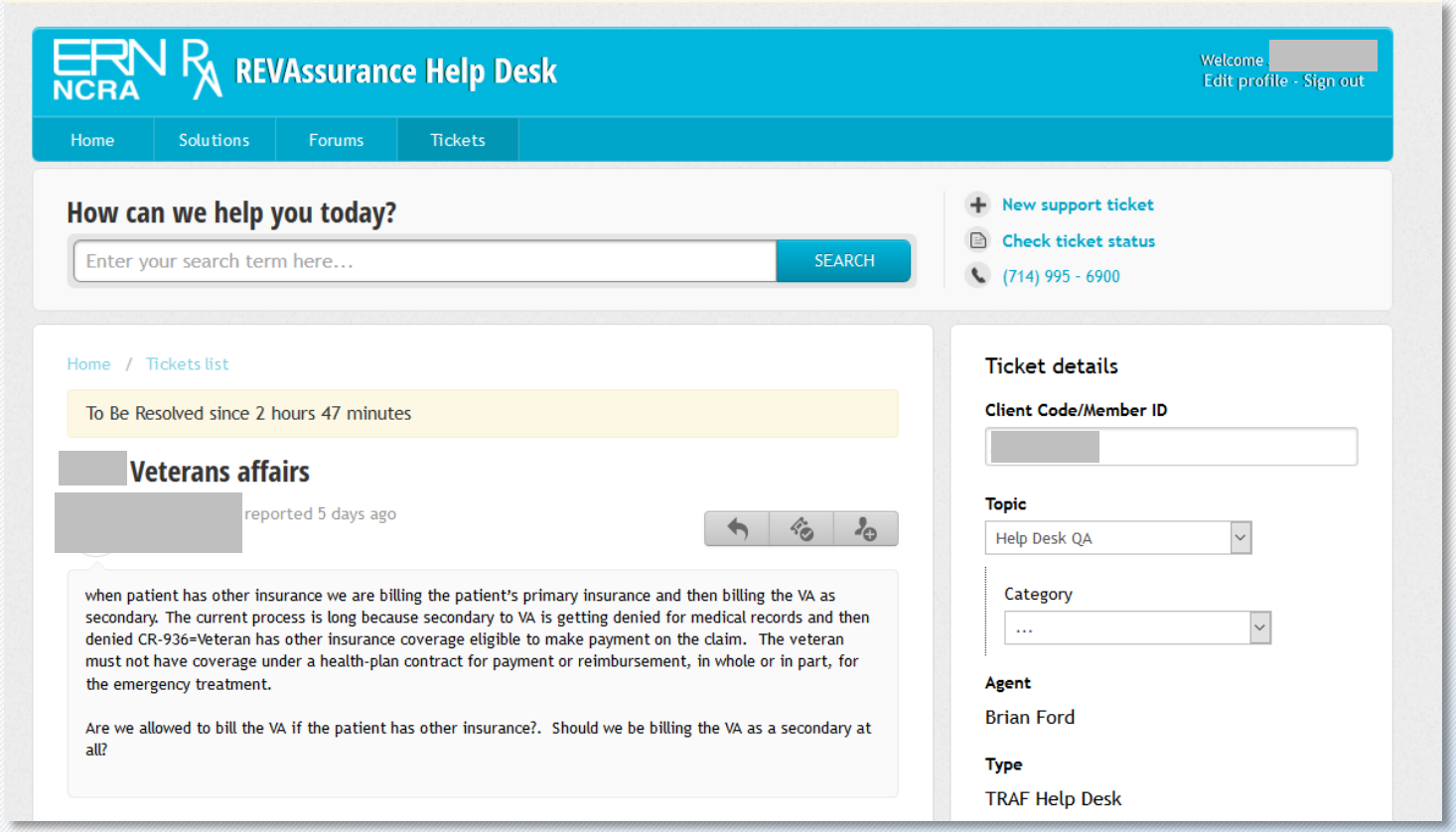


REVAssurance *TURBO*



REVAssurance Support



REVAssurance Support

Thank you for your inquiry. The VA has, for a long time, used the denial you refer to above to deny veteran claims if the veteran had any primary coverage. However this all changed very recently in 2017 with the Staab case (https://www.westdunn.com/news/2017/3/12/the-staab-case-the-tension-between-congressional-mandate-and-funding-of-veterans-benefits). Recently, the U.S. Secretary of Veteran Affairs, Dr. David Shulkin, voluntarily dropped their appeal to the case which means that the original decision in the Staab case will control.

What this means is that the VA is required to reimburse veterans for any portion of the claim not covered or reimbursed by the primary carrier. So, to answer your question, you should absolutely bill the VA as secondary after the Primary has either paid or denied and bill your claim as such. Since the VA is currently drafting a regulation for these types of claims, it is important that you engage fully in the appeals process to ensure your claim will be reimbursed should it be denied during this period.

Best,
Brian Ford
Claims Compliance Auditor II
ERN / The National Council of Reimbursement Advocacy
714-995-6900 Ex. 6913 Fax 714 995-6901


Can I beat this?

Appeal Submission Timeframe Matrix

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

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

APPEAL LETTER WRITING WORKSHOP

DENIAL MANAGEMENT

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

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

APPEAL LETTER WRITING WORKSHOP

WRITING THE APPEAL

When Payors Won't Listen…

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

QUESTION: *How can we decrease denials?*

What are payors looking for in an appeal letter?

1. **Identify the denial reason.**

2. **Determine the jurisdiction.**

   Examples: MA, ERISA, State sponsored HMO.

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

ER No Pay- Postabilization:

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

No Claim on File:

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

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

   Example:

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

   (HEALTH NET PAYOR PANEL ATTORNEY COMMENTS)

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

6. **Apply the law.**

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

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

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

When Payors Won't Listen

"WE DISPUTE..."

"...BECAUSE..."

"...AS SHOWN AND DESCRIBED BELOW:"

When Payors Won't Listen…

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

DIRECTIONS:

The following is a sample timeline of a common denial.

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

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

When Payors Won't Listen…

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

1) WHAT IS THE DENIAL? _____

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

3) TRANSITIONAL STATEMENT OF FACT:

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

_____

_____

_____ **as shown and described below**:

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

See directions above.

5) APPLICABLE LAWS:

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

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

5) APPLY THE LAW:

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

1. _____

   _____

2. _____

   _____

3. _____

   _____

When Payors Won't Listen…

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

6) CONCLUSION (LAND THE PLANE):

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

_____

_____

_____

_____

When Payors Won't Listen

As advocates:

We don't show partiality.

We work both small and big cases alike.

We collaborate when cases are too hard for us.

We aren't afraid of anyone AND

WNITTF: WE'RE NOT IN THIS TO FAIL.

We fight for you.

CONTACT US:
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(714) 995-6900 ext. 6926