Payer's (Still) Going WILD

Medicare Advantage Challenges ++Attacking Operational Denial

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!

Objectives for this very fun class

1. Attendees will learn updates occurring with the Medicare Advantage plans

2. Attendees will identify strategies to address the payer's disputes, downgrades and denials.

3. Attendees will receive operational ideas to address the new 'attacks' from the payers

4. Attendees will look at new way to take their power back: Building Operational Contractual Addendums.

AND START WITH A LITTLE "PAYER FUN"

THANKS, WARREN K/REGION 8 HFMA MEETING, 2022

U	usually
N	nine
I	in
T	ten
E	experience
D	denials…..

Medicaid Redetermination

C	called
I	in
G	got
N	no
A	answer

++All time favorite: Singing the"Blues "

And did someone say : Supreme Court's Decision to overturn a 40 year process. Chevron vs NRDC. Impact to healthcare??

- On June 28, 2024, the US Supreme Court overturned its long-standing precedent in ***Chevron vs NRDC***. Under Chevron, courts were required to defer to an executive agency's reasonable interpretations of ambiguous statutory provisions.
- Under the new framework set out in ***Loper Bright vs Raimondo***, courts must instead consider statutory text on its own terms and evaluate agency action in light of the 'best reading' on the underlying statue.
- This new framework significantly shifts the balance in administrative litigation away from executive agencies like CMS and toward a more level playing field. (Day's note: Which court knows the workings of Medicare and the many regulatory impacts of every change? Cost will be high for the hospitals to litigate. Will CMS even issue FINAL RULES any longer on legislation? Will they still do it knowing they can and likely will be sued if there is disagreement over what it means or how it should roll out?)

- **Moody Report: Chevron ruling may spark lower hospital reimbursement. July 2024**
- Hospitals may see more lawsuits related to reimbursement regulations. The ratings agency released a report predicting litigation would 'almost certainly' increase and the heavily regulated healthcare industry would likely see litigation related to reimbursement, insurance eligibility and more. Insurers, pharmaceutical companies and patient advocacy groups could 'bring lawsuits that ultimately raise costs and reduce hospital reimbursement.'
- Hospitals won't likely see changes to their expenses and reimbursement right away since the federal govt can still develop rules and regulations, and lawsuits take time to move thru the court system and reach a conclusion. That doesn't mean the lawsuits challenging regulatory interpretation will be succeed.

And what else is happening in the payer world?

Court blocks Medicare Advantage broker fee caps. (Becker)

- Judge O'Conner /Texas judge put a 'pause' on the implementation of the CMS regulations capping the amount Medicare Advantage companies can pay their brokers that sell their plans.
- In April, CMS issued a final rule capping the total compensation MA plans can pay brokers at $611 for a new member, and $306 for a renewal. These caps include payments for administrative costs, which were previously excluded for limits.
- CMS raised the compensation limit by $100 to account for the removal of separate adm costs.
- Broker group sued and won/said they will be hurt with the arbitrary cap. It was intended to close any 'loophole' to get higher compensation from the plans and prevent 'anti-competitive and anti-consumer steering incentives.'
- Smaller plans have argued previous broker compensation made it difficult to compete with larger insurers that had a larger budget to pay brokers for enrolling beneficiaries.

Five payers recently fined by states. (Are you reporting them?)

- Payers have faced state penalties in 2024 for slow reimbursement, improper claims denials, or the sale of unapproved products.
- Anthem BCBS Virginia: will pay $3263,000 to settle allegations that it violated state law, including improper denial of claims and incorrect reimbursements
- Cigna was fined $600,000 by Texas in June for failing to comply with multiple independent claims dispute resolution requirement under state law.
- United Healthcare was fined $546,500 by Utah in May for selling unapproved health plans to state residents.
- Molina Healthcare of Washington was fined $100,000 for enrollment and billing errors in March.
- Anthem BC of CA was fined $690,000 in Jan for failure to reimburse providers and members in a timely manner. (Anthem is now Elevance Health/2022)

Labor intensive, but it is **critical to track and trend abuse by payer and report them accordingly.**

And a little bit more specifically for Medicare Advantage Plans

- **Insurers brought in $50Billion through 'questionable' Medicare Advantage coding: Wall Street Journal. July 2024**
- Think 'risk adjustment notices to facilities' that they need unlimited records 'per CMS'
- **HHS announces investigation of MA prior authorization use for post-acute care.** AHA

  The Dept of Health and Human Services is investigating MA organizations use of prior auth for post-acute care after hospital stays.

  The focus is on the authorization processes and the frequency of denied requests for care in long-term acute care hospitals, inpt rehab facilities, and skilled nursing facilities.
- **Footnote: Remember - Prohibit MA organizations from limiting or denying coverage when the item or service would be covered under TM. Applies to all, not just Inpt vs obs.**

- **CMS's 2024 MA rule brings some improvements but falls short of addressing all providers' concerns**. (Medicare payment & Reimbursement.)
- **Medicare Advantage Final Rule (CMS-4201-F)**. The rule represents CMS's efforts to refine the practice of MA organizations by placing limitations on prior authorization, elevating requirements for provider directories and making comprehensive adjustments to the MA and Part D quality rating systems.
- Nonetheless, some providers continue to express frustration with the challenges posed by MA and the final rule does not allay all of their concerns.
- Provider frustration has led to an appreciable shift in practice – with some hospitals opting to discontinue their participation in MA plans due to the adverse consequences on patient populations.
- Among the final rule's notable provisions, four most important with the determination around prior authorization having raised the most questions and concerns.
- Prior authorization, advancements in quality rating systems, promotion of health equity and applicability of the 2-midnight rule.

Mgd Care Anguish-
A Brave New World Required-

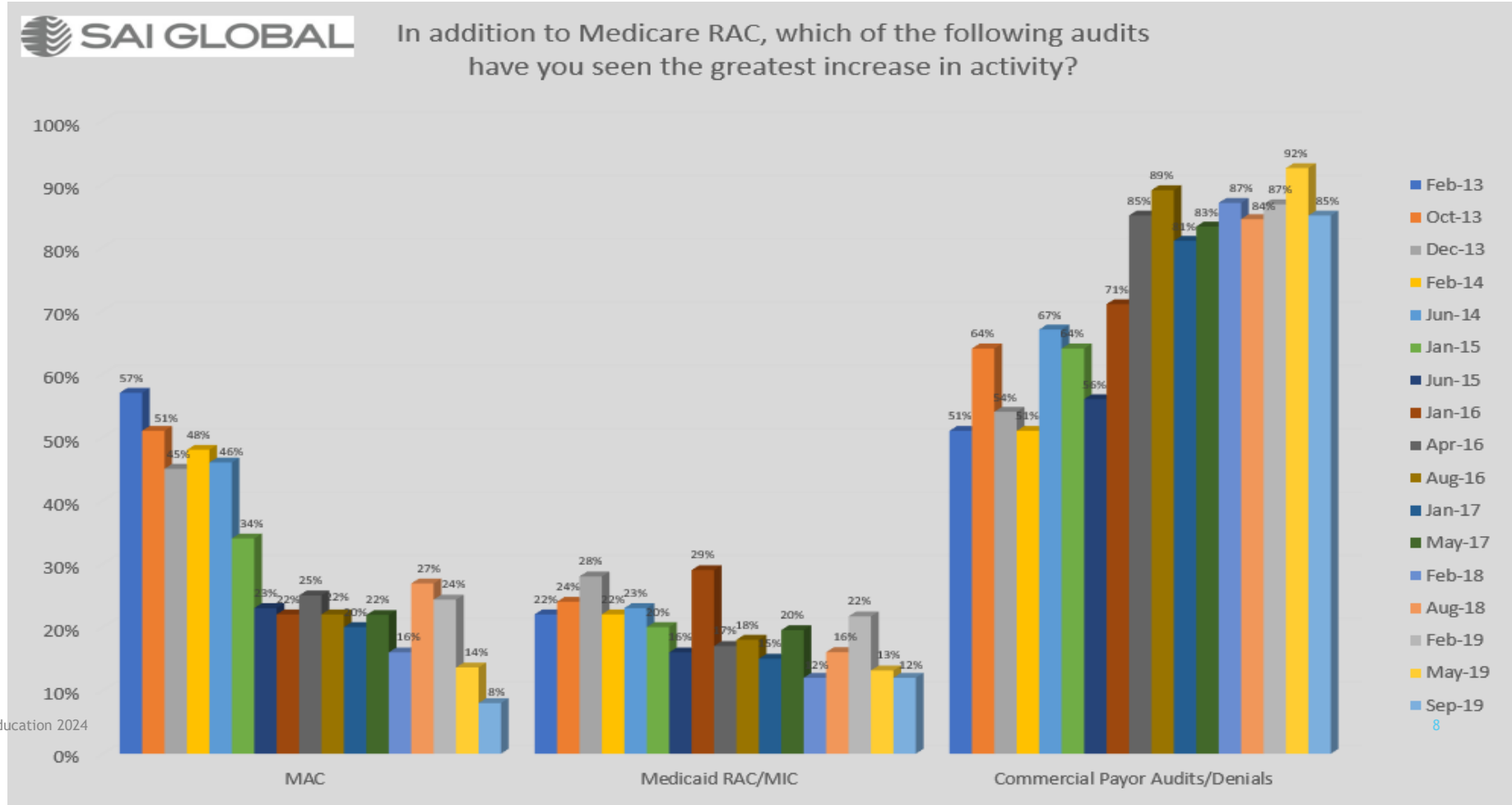
Payer Policy Changes/Outside the Contract

Significant Growth of Medicare Advantage Plans

= Financial Impact to Providers

8 year history with Compliance 360/SAI

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



Medicare Advantage/MA Landscape Updates 2024

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

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

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

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

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

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

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

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

If the Employer has an insurance and the insurance also has a MA plan-- the retirees are auto rollover to MA (State and govt employees-most states)

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

- OIG completes audit of specific dx codes that Excellus Health Plan, Inc submitted to CMS. 7-2023
- Under the MA program, CMS makes monthly payments to MA organizations according to a system of risk adjustment that depends on the health status of each enrollee.
- MA are paid more for enrollees with dx associated with more intensive use of health resources.
- OIG audited 210 unique enrollee high-risk dx submitted that did NOT comply with federal requirements.
- Specifically 202 of 210 sampled, the medical record did not support the dx codes, resulting in $479K overpayments.
- Estimated Excellus received approx. $5.4M in overpayments 2017-2018. Too early to make them pay back which recently changed.
- Beginning 2024, recoupment. Not since 2007.
- Excellus disagreed with all, but OIG confirmed

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

CMS: MA insurers can't use AI, algorithms to deny care

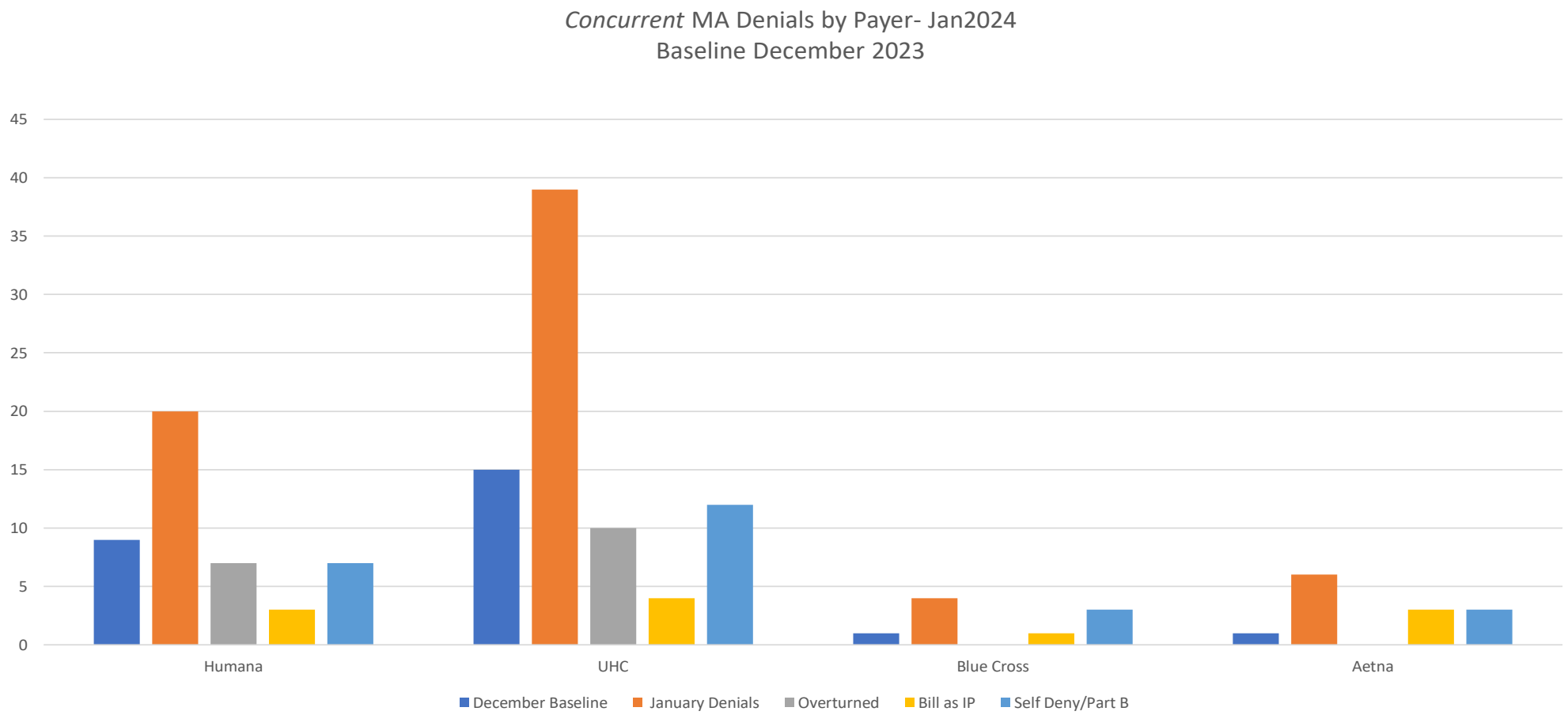
- ***The CMS sent a memo clarifying that Medicare Advantage insurers are not allowed to use algorithms or AI-powered tools as basis for denying care or coverage. Algorithms and AI tools can be used only to support coverage decisions, and insurers must ensure that the tools they are using comply with the CMS' coverage decision requirements. 2-24 ** see slide 52***

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%**

Managed Medicare Status Disputes January 2024



NEW WORLD WITH MA's.

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

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

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

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

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!)

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.***

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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.

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More on decision making-Inpt

- If the beneficiary has already passed the 1 midnight as an outpt, the physician should consider the 2nd midnight benchmark met if he or she expects the beneficiary to require an additional midnight in the hospital. (MN must be documented and done)
- 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!!

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

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

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

§ 422.214 Special rules for services furnished by noncontract providers.

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

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

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

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

Medicare Advantage – Provider WINS –

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.

More Denial Reasons & Action Items – Ex Humana

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

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

- Inpt denied as 'not medically necessary' for inpt level of care. SURPRISE
- UR and internal PA review the case. Decide to go to P2P to fight for inpt.
- Inpt continued to be denied. SURPRISE
- Now the hospital decided on one of the accounts to accept obs.
- They tell the payer they are going to downgrade to obs and bill
- Payer says: "You can't as you don't have an obs order" and the pt has gone home. (See previous note about no CC 44 with MA plans. Don't get it both ways)
- IDEA: Begin using a template for the medical record. It is telling the payer:

■ ***" Thru communication with *payer's name*, the inpt order is being changed to observation as the payer will not authorize inpt and the facility agrees not to appeal or challenge the change in status. The account will be changed to OBS for billing purposes." Signed by MD or Internal Physician Advisor. Order is now in the chart for obs.***

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.

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.

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)

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

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

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

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

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

Pg 1

UHC publication: effective 1-1-24

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

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

****

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

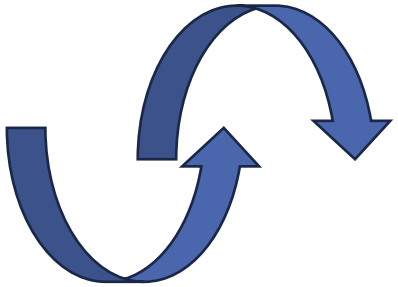
If the hospital has a physician generated plan for an estimated 2 MN stay, and submits it with the prior auth documentation, what more is needed? A PLAN for Estimated 2 MN -at first touch= Presumption. Early, unexpected discharge = 1 MN. A PLAN for 1 outpt MN plus one more MN for in-hospital care = Inpt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

And then we hear from Aetna- letter 11-23

- Aetna seeks to provide you with some information on how Aetna's MA Plans complies with the Two Midnight Rule.
- We will follow the Two Midnight Benchmark.
- Under the Two Midnight Benchmark, surgical procedures, diagnostic tests and other treatments will generally be considered appropriate for inpatient hospital admission and payment under Medicare when the physician expects the patient, based on specific complex medical factors documented in the medical record (such as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of adverse event), to require a hospital stay that crosses at least two midnights and admits the member to the hospital based upon that expectation.
- **UPDATE: Aetna – beginning 12-1-23, notify of all inpt admissions including thru the ED within two/2 business days of admission. (Vs 1)**

- **Our Medical Necessity reviews**
- **Our MA Plans can use Internal Coverage Criteria to determine Medical Necessity .Not required to follow 2 MN presumption. (2 MN = auto inpt)**
- We have created publicly accessible internal coverage criteria when coverage criteria are not fully established under the Medicare statute, regulation, national coverage determinations (NCD), or local coverage determinations (LCD).
- **Our internal coverage criteria are based on current evidence in widely used treatment guidelines or clinical literature and comply with CMS requirements.**
- These criteria will be available soon on https://go.aetna.com/aetnamedicareguidance. (Thanks, B. Fiser, NC system) They are now available 1-24

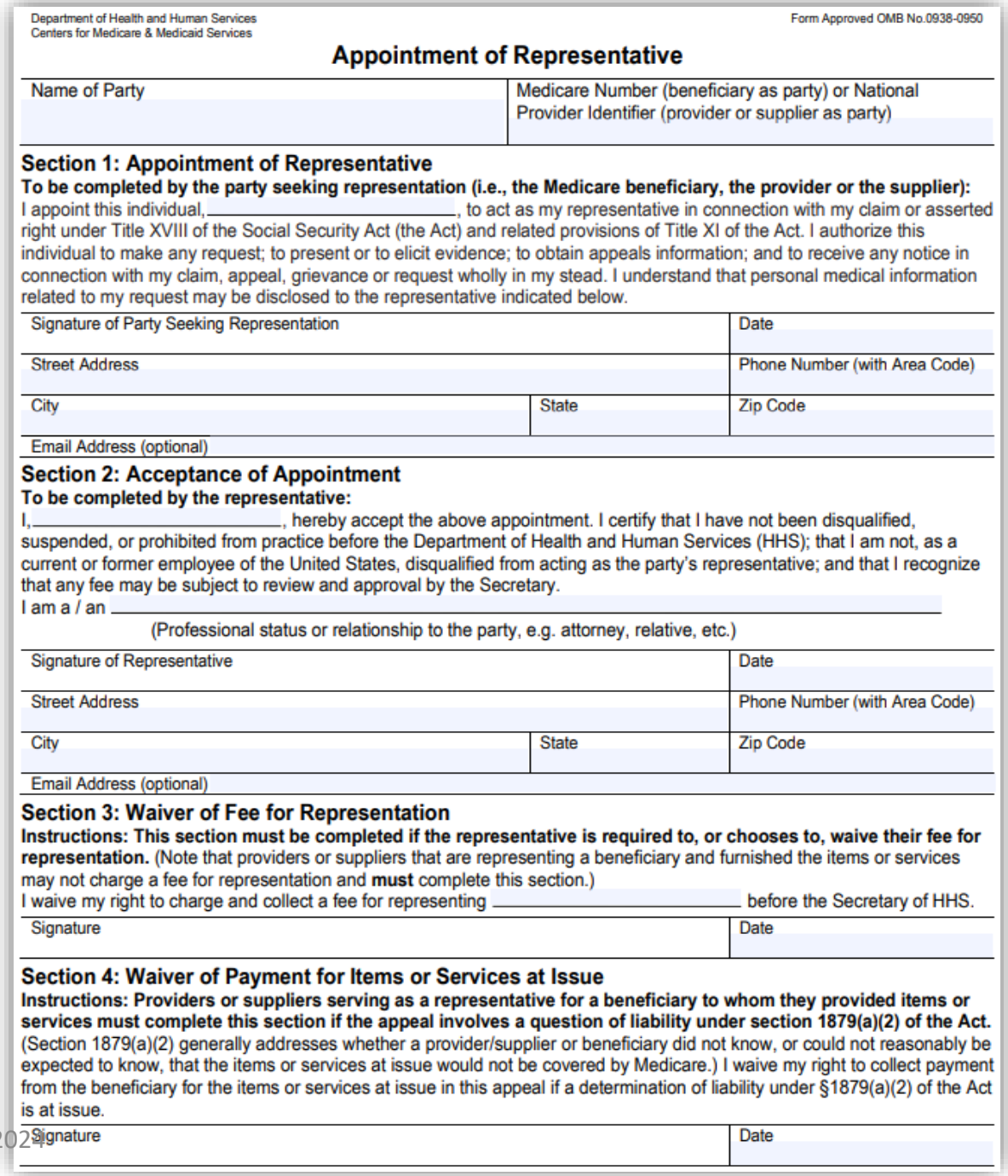
What is in the Provider's Tool Box ?



- Appt of a Representative
- "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.
- 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.

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

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.

Prior Authorization Request for Inpatient

DO FOR ALL PAYERS – Tell them why it is an inpt

SEND WITH THE INITIAL RECORD SUBMISSION

No direct access to records –Tell why an inpt, not letting the payer tell the provider

Change the way the provider speaks to the payer- both UR and PA

It is an inpt …until it isn't

Patient Name DOB:

Insurance name: Subscriber #: (SAMPLE FOR SUBMISSION WITH RECORDS TO PAYER/UR)- 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,

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.***

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.

More MA Denials. *What about 2 MN benchmark? 1 outpt MN = 1 more = 2 MN inpt. All same complex medical factors but as the 2nd MN approaches..new plan for why 2nd MN is clinically necessary 'in-hospital' and convert*

United Healthcare 2-27-24

"This is a follow-up to an inpt admission. Based on the clinical information provided, the member may not meet the criteria for an inpt stay."

"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 UHCProvider.com/policies to review the UHC Medicare Advantage Coverage Summaries for Hospital care."

This pt was admitted to the hospital on 2-20 with erythema intertrigo. We reviewed the provided clinical information based on Traditional Medicare and health plan criteria for admissions. The medical record does not document complex medical factors. The reason is patient had a clinical condition as indicated by the need to establish a dx and tx in a lower level of care."

NO REFERENCE TO THE 2MN rule..Not even as a reference.

United Healthcare 3-12-24

Same two initial statements. Part of template for all denials of inpt.

Still referencing Medicare Criteria but no mention of the care requiring a 2 MN or a 2 MN benchmark.

Short and sweet with the rationale:

'This pt was admitted to the hospital on 3-8-24 with cerebral infarction unspecified. We reviewed the provided clinical information based on Traditional Medicare and health plan criteria.

"Our findings indicate that this stay does not meet criteria for an inpt admission. The medical record does not document complex medical factors that support an inpt admission is reasonable and necessary.

"The reason is member stable and not hypoxic." Nothing more!

NO REFERENCE TO THE 2 MN RULE – not even as a reference.

More MA inpt Ideas and New CMS guidance – AI & Algorithms. 2-24

- <u>If denied inpt and P2P, action items could be:</u>
- Track and trend each case that violated the 2 MN rule. File Complaint
- Reach out to the payer to ensure they understand your next steps- reply:

"Thank you for your response but I disagree. The case meets the provisions of the 2 MN rule. I will be filing a complaint with CMS about your violation of fed regs found at 42 CFR 422.101 (b) (2). I will also request your name and your area of expertise to determine if you meet the standard set forth in CFR 422.629 (k) (3) for organization determinations?" (Thanks Dr Hirsch, R1 RCM)

- <u>CMS issues AI guidelines for MA plans</u> (Becker2-6-24)
- *"We are concerned that algorithms/AG & AI can exacerbate discrimination and bias. MA org should , prior to implementing AG or software tool, ensure that the tool is not perpetuating or exacerbating existing bias or introducing new bias."*
- *<u>Key takeaways</u>:*
- *CMS clarified the difference between AI and AG. Algorithms 'can imply a decisional flow chart of a series of it-then statements. AI is a 'machine – based system that can-for a given set of human-defined objectives – make predictions, recommendations or decisions influencing real or virtual environments.*
- *Ensure all AI & AG are complaint with CMS overage requirements. EX) MA must base a coverage decision on an individual member's medical history, physician recommendation or clinical notes – not on a larger data set.*

For every denial – Is the provider asking:

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

It Is all about 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 for reply.

- 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?

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. "Where in the contract does it say we agreed to this? Plz produce it so we can discuss."

Let's talk.

- 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 = $5B 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" 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? Operational addendum – Readmissions like traditional Medicare which is NOT within 30 days but know 30 Traditional Medicare lookback rule.

4) Policy changes without input from providers or 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. 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 Use Addendum to 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

7) By the payer. Both are huge losses to the hospital. Addendum that disallows all DRG payment reviews/outlier. Addendum that speaks to no auto-bundling or assigning primary CPT code without methodology approved or do not allow it at all. Pay each CPT code.

8) Definition of an inpt. Huge as each payer has their own criteria. Ensure it is agreed to but what

9) If they don't follow the Interqual or MCG? MA- must use the 2 MN as outlined with 2024 final regs. Addendum that the law will be followed including the elements to support inpt as outlined in the 2014 final regs.

10) 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. Addendum speaks to timeline for Reply and a per day payment for all held patients.

And on and on with each down grade or denial.

Operational Addendums for Contracts

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

AI & AG Tools: No payer shall use any AL or Algoririhm /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.

Operational Elements directly relate to:

Cost of collection

Disputed claims at time of prior auth

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

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

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

What to do to try to level the power position with the payer- provider relationship?

- Identifying the documents being sent to the payer – prepare the REASON for INPT. Complex Medical Factors/Plan
- Do not let the payers decide if they can FIND the complex factors in the initial clinical records sent or put in a secure portal. Tell them what it is!
- Absolutely control the flow of information. Tell the pt story – intensity of service, severity of illness, co-morbid conditions and risk factors..all tied to the doctor's plan for 2 MN. This is an inpt.
- Use the Final Regulations from 2014 to 'talk the new language' w/payers.
- Utilize the Operational Contractual Addendums to identify the key areas of broken payer relationships? Power is 100% with the payers.
- File complaints with CMS's regional reps. 1st: try to address with payer; then 2nd: file complaint and reference the regulations they have violated.. Can't file if not pd correctly. (CMS can't address payment/contract disputes.)
- Use of clinical standards (IQ, MCG) does not cover all situations. The PLAN for 2 MNs or 1 outpt = 1 more MN = 2 MN inpt
- Track and trend patterns by payers.

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

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

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

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

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

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

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

Full report aha.org

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

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

Another CMS communication 2024 Oversight

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

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

Thank You for Joining Us in this Educational Journey
Questions??

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