
ERN
NCRA
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.

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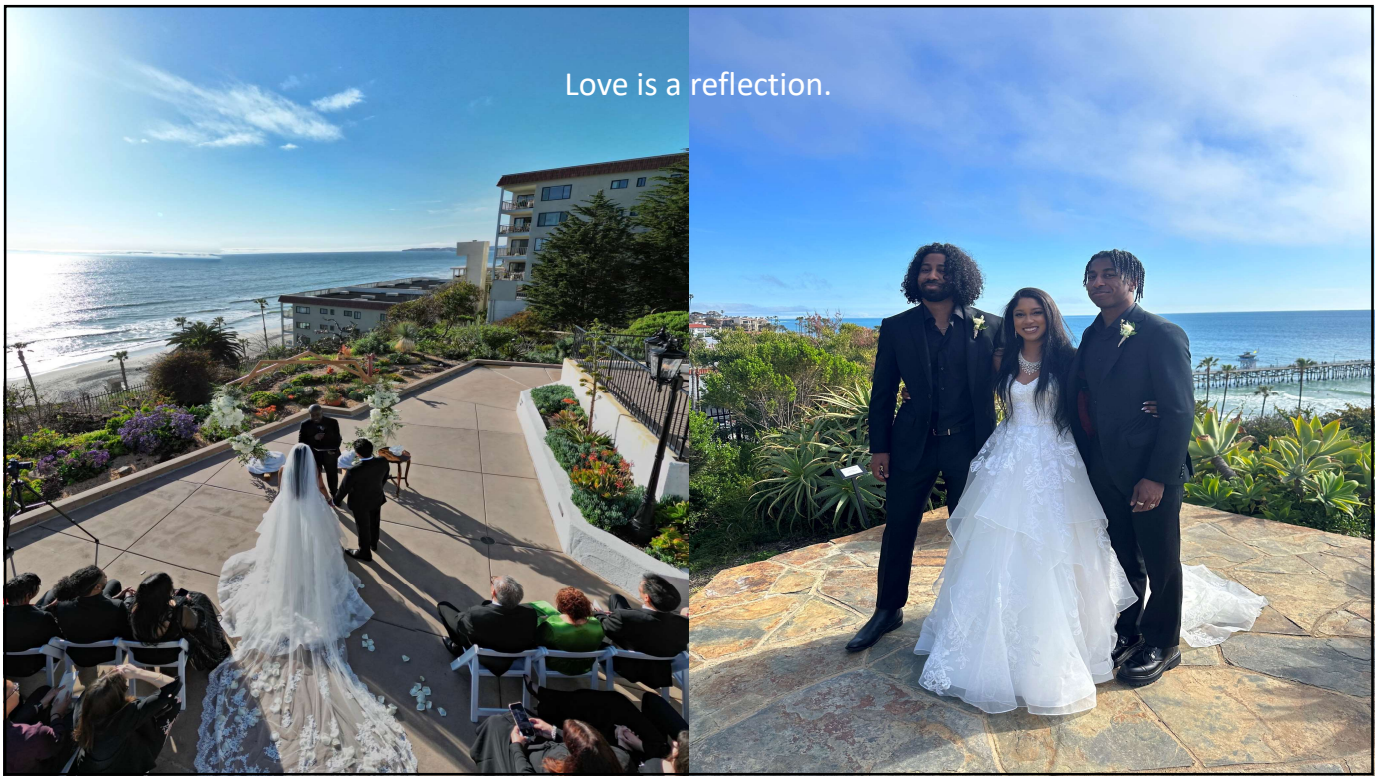
Love is a reflection.

2

Sign of the Times

No matter what state you work in, there will be giants.

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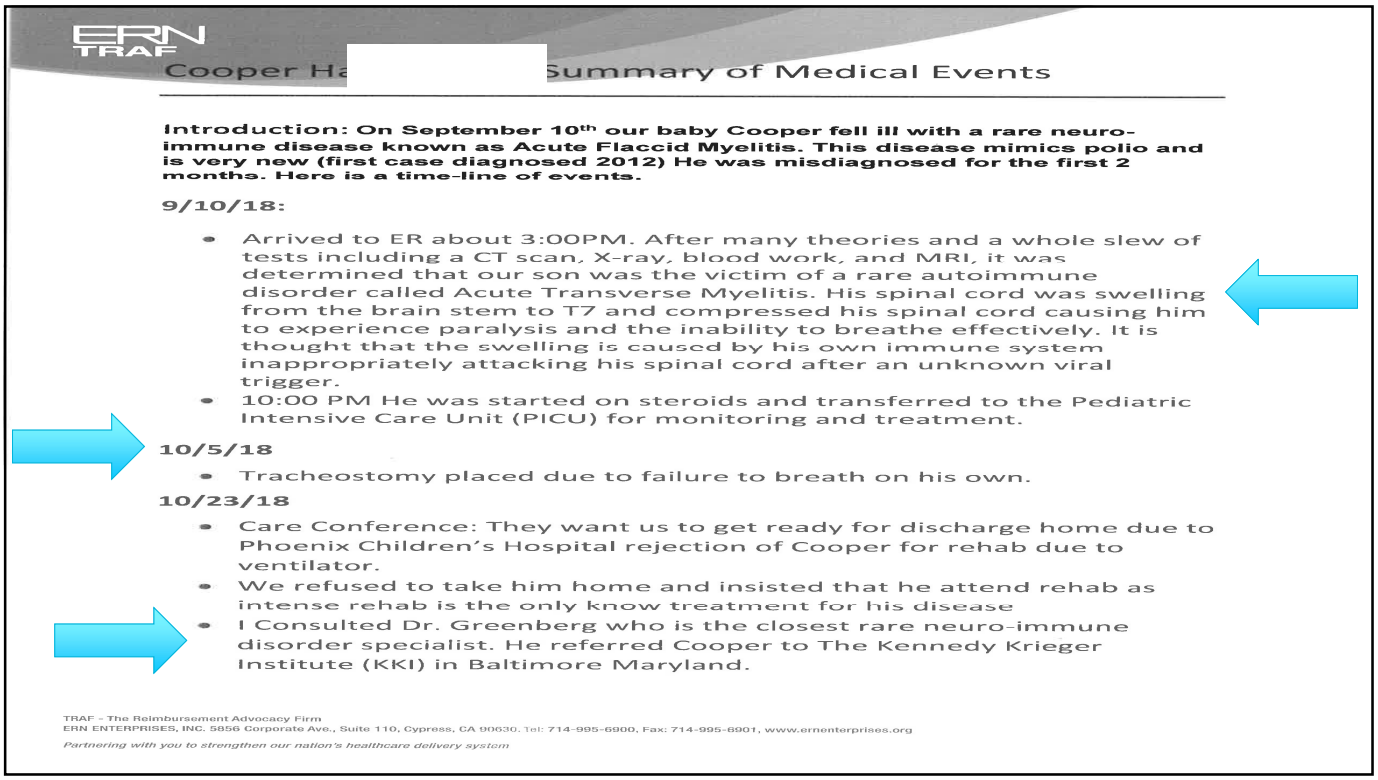

ERN TRAF

Cooper Ha[redacted] Summary of Medical Events

Introduction: On September 10th our baby Cooper fell ill with a rare neuro-immune disease known as Acute Flaccid Myelitis. This disease mimics polio and is very new (first case diagnosed 2012) He was misdiagnosed for the first 2 months. Here is a time-line of events.

9/10/18:

- Arrived to ER about 3:00PM. After many theories and a whole slew of tests including a CT scan, X-ray, blood work, and MRI, it was determined that our son was the victim of a rare autoimmune disorder called Acute Transverse Myelitis. His spinal cord was swelling from the brain stem to T7 and compressed his spinal cord causing him to experience paralysis and the inability to breathe effectively. It is thought that the swelling is caused by his own immune system inappropriately attacking his spinal cord after an unknown viral trigger.
- 10:00 PM He was started on steroids and transferred to the Pediatric Intensive Care Unit (PICU) for monitoring and treatment.

10/5/18

- Tracheostomy placed due to failure to breath on his own.

10/23/18

- Care Conference: They want us to get ready for discharge home due to Phoenix Children's Hospital rejection of Cooper for rehab due to ventilator.
- We refused to take him home and insisted that he attend rehab as intense rehab is the only know treatment for his disease
- I Consulted Dr. Greenberg who is the closest rare neuro-immune disorder specialist. He referred Cooper to The Kennedy Krieger Institute (KKI) in Baltimore Maryland.

TRAF - The Reimbursement Advocacy Firm
ERN ENTERPRISES, INC. 5856 Corporate Ave., Suite 110, Cypress, CA 90630. Tel: 714-995-6900, Fax: 714-995-6901, www.ernenterprises.org
Partnering with you to strengthen our nation's healthcare delivery system

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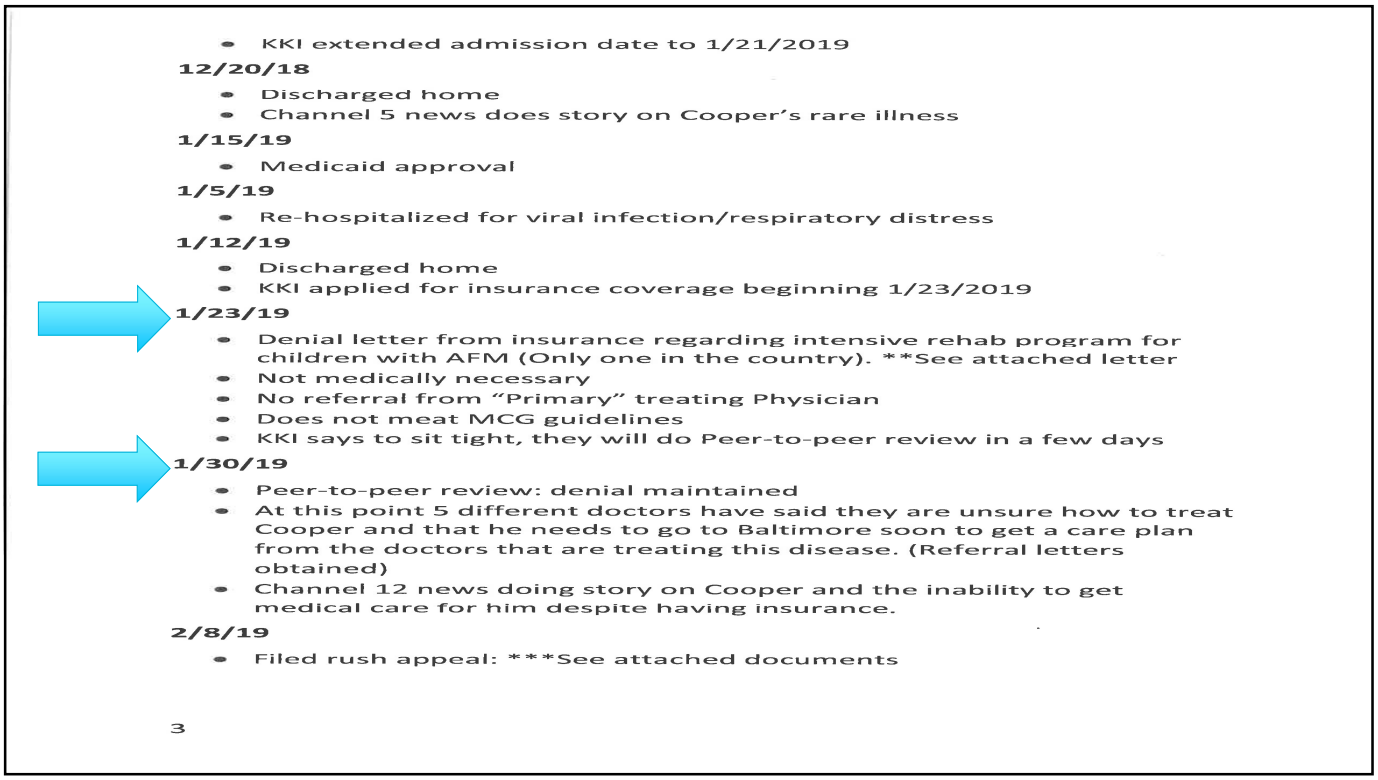

- KKI extended admission date to 1/21/2019

12/20/18

- Discharged home
- Channel 5 news does story on Cooper's rare illness

1/15/19

- Medicaid approval

1/5/19

- Re-hospitalized for viral infection/respiratory distress

1/12/19

- Discharged home
- KKI applied for insurance coverage beginning 1/23/2019

1/23/19

- Denial letter from insurance regarding intensive rehab program for children with AFM (Only one in the country). **See attached letter
- Not medically necessary
- No referral from "Primary" treating Physician
- Does not meat MCG guidelines
- KKI says to sit tight, they will do Peer-to-peer review in a few days

1/30/19

- Peer-to-peer review: denial maintained
- At this point 5 different doctors have said they are unsure how to treat Cooper and that he needs to go to Baltimore soon to get a care plan from the doctors that are treating this disease. (Referral letters obtained)
- Channel 12 news doing story on Cooper and the inability to get medical care for him despite having insurance.

2/8/19

- Filed rush appeal: ***See attached documents

3

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MCKESSON

InterQual® Level of Care Criteria
Acute Criteria

Review Process

Introduction

InterQual® Acute Level of Care Criteria provide support for determining the medical appropriateness of hospital admission, continued stay, and discharge. Acute Adult Criteria address the Observation, Acute, Intermediate, and Critical levels of care. Acute Pediatric Criteria include these levels of care and five additional levels of nursery care (Transitional Care, Newborn Level I, Special Care Level II, Neonatal Intensive Care Level III, and Neonatal Intensive Care Level IV).

Adult criteria are for review of patients ≥ 18 years of age. Pediatric criteria are for review of patients < 18 years of age.

Important: The Criteria reflect clinical interpretations and analyses and cannot alone either resolve medical ambiguities of particular situations or provide the sole basis for definitive decisions. The Criteria are intended solely for use as screening guidelines with respect to the medical appropriateness of healthcare services and not for final clinical or payment determinations concerning the type or level of medical care provided, or proposed to be provided, to a patient.

When evidence in the medical literature to support the efficacy and effectiveness of the intervention or service is absent, mixed, or unclear, criteria reflect the opinion of McKesson's expert clinical consultants. It is based upon current best practice and is the product of an iterative process involving multiple clinicians with diverse expertise in varied practice and geographic settings.

Reference materials

Reference materials are provided with the criteria and should be used to assist in the correct interpretation of the criteria.

- **Abbreviations and Symbols List**: Defines acronyms, abbreviations, and symbols used in the criteria.
- **Alcohol Withdrawal Assessment tool:** A worksheet to document a patient's CIWA-Ar score for alcohol withdrawal.
- **Bibliography**: References cited in the clinical content.
- **Clinical Revisions**: Provide details of changes to InterQual Clinical Criteria.
- **Drug List**: Categorizes drug names and classes mentioned within the criteria.

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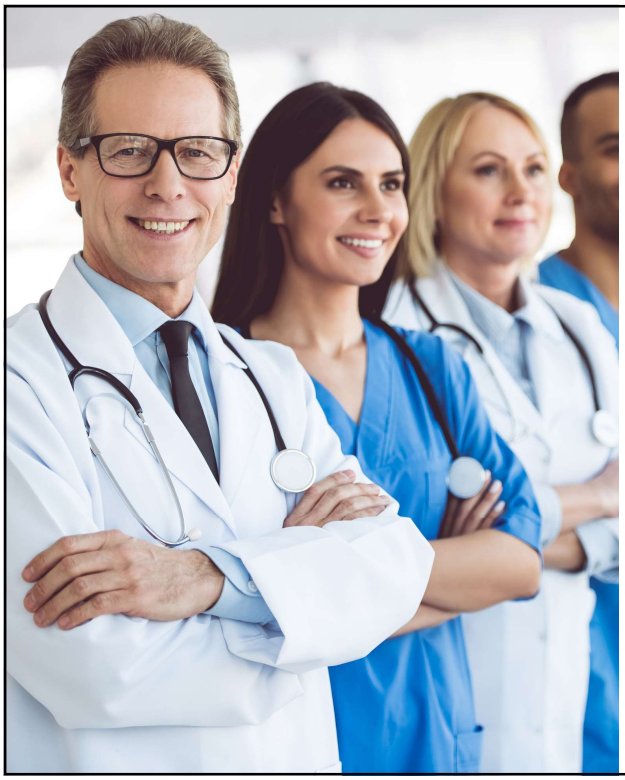

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InterQual Disclosure Updated 10/2019

Per the Change Healthcare Disclaimer (shown on their website), InterQual® is not intended to be used for **final clinical or payment determinations concerning the type or level, or medical care provided or proposed to be provided to a patient.** It reads in pertinent part:

"The Clinical Content reflects clinical interpretations and analyses and **cannot alone** either resolve medical ambiguities of particular situations **or provide the sole basis for definitive decisions.** The Clinical Content is intended solely for use as screening guidelines with respect to the medical appropriateness of healthcare services **and not for final clinical or payment determinations concerning the type or level of medical care provided, or proposed to be provided, to a patient."**.... (Emphasis Added)

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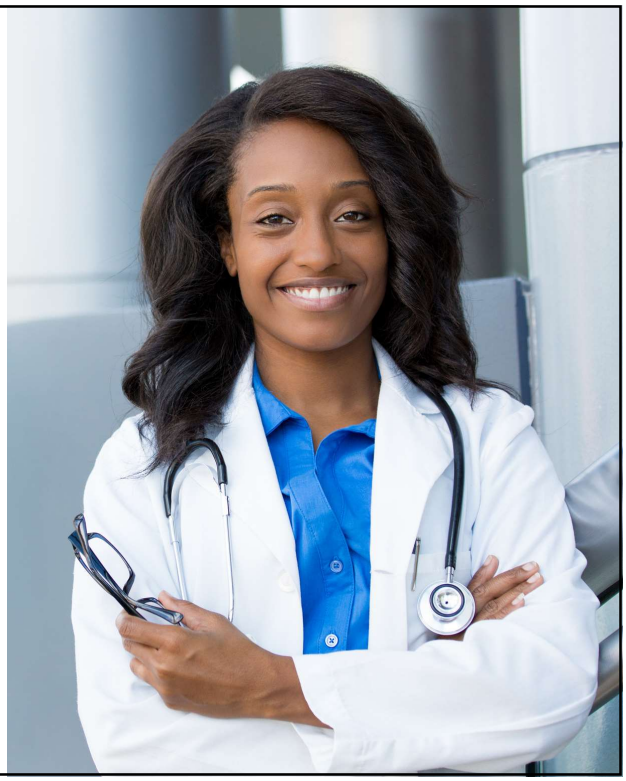
MCG Disclaimer (shown on their website)

Per the Milliman Care Guidelines Disclaimer (shown on their website):

"This Web site and the Content are for information and education purposes only. The Content should not be used to replace any written reports, statements, or notices provided by MCG. **Professionals and other persons should use the Content in the same manner as any other educational medium and should not rely on the Content to the exclusion of their own professional judgment.** MCG does not warrant the accuracy or completeness of the Content or the reliability of any statement or other information displayed or distributed through the site.



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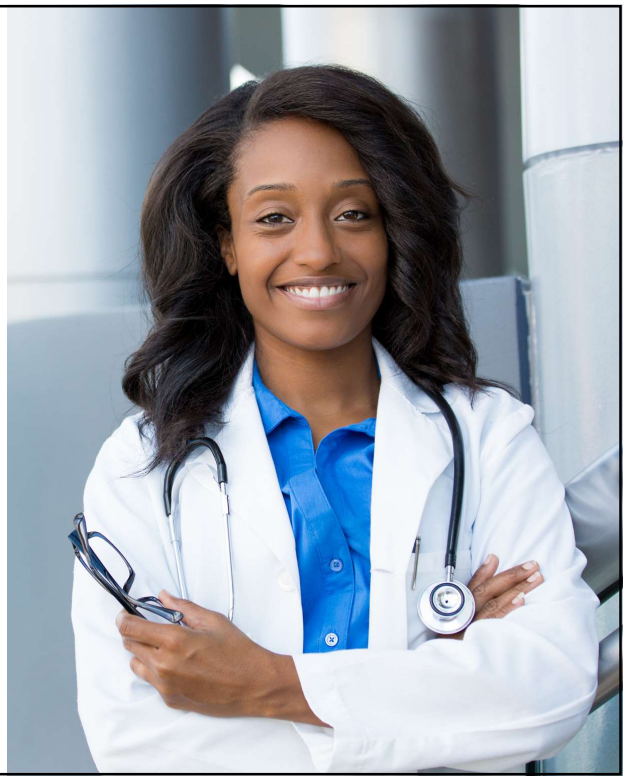
MCG Disclaimer (shown on their website)

…The care guidelines are not intended to be used **without the judgment of a qualified healthcare provider with the ability to take into account the individual circumstances of each patient's case.** In exchange for using this site, you agree not to hold MCG liable for any possible claim for damages arising from any decision you make based on information made available to you or obtained through the site." (Emphasis Added)



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ERN TRAF

SUMMARY OF COMPLAINT — ARIZONA MEDICAL BOARD

February 19, 2019

Patricia McSorley, Executive Director
Arizona Medical Board
1740 W. Adams St. Suite 4000
Phoenix, AZ 85007

Physician: Tolson, M.D.
License Number:
Board Certified: esiology

Patient: Cooper
ID:
DOB:
Denied Service: evel 1

Dear Ms. McSorley:

This office represents Cooper Le ind has been asked to file a formal complaint with the **Arizona Medical Board** against Dr. Jefi Tolson, M.D. for his negligent medical decision resulting in Cooper's delayed treatment fo ute Flaccid Myelitis, a rare neurological immune disease that mimics polio.

In its advisory role to healthcare providers that provide medically necessary services to ERISA participants, the National Council of Reimbursement Advocacy (NCRA) and the Reimbursement Advocacy Firm (TRAF) periodically brings to your attention non-compliance issues related to—

(1) Access to medically appropriate healthcare services consistent with clinical review requirements under Arizona Statutes, Title 20, §20-1057.06, §20-2501, §20-2532 and §20-2533 or any rule adopted pursuant thereto.
(2) Breach of fiduciary duties under 29 U.S.C. 1104 & 1109 including full and fair review requirements under ERISA law.
(3) Any other health services furnished by a provider or supplier that are reimbursable under 29 CFR section 2560.503-1 or any rule adopted pursuant thereto.

We dispute Dr. Tolson's decision to deny authorization for inpatient rehabilitation services based on lack of authorization, because two of Cooper's treating physicians with expertise in this field have documented the medical necessity of this requested service and Dr. Tolson does not have the clinical expertise to make an appropriate medical decision in this matter, as shown and described below and on the attached exhibits:

- On 09/10/2018 at 3:00PM, Cooper presented to an emergency room; multiple tests were performed including a CT scan, X-ray, blood work, and an MRI. It was determined that Cooper had developed a rare autoimmune disorder called Acute

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In 2003, Dr. Narayanan moved to Phoenix as a member of the Child Neurology division at Barrow Neurological Institute.

Dr. Narayanan has a special interest in the genetic basis of neurological disorders. Dr. Narayanan's research efforts focus on the neurobiology of genetic disorders (genes to pathogenesis), cell adhesion molecules and synapse formation. **(See Exhibit F — Dr. Narayanan Biography.)**

III. DR. TOLSON IS NOT QUALIFIED TO DETERMINE THE MEDICAL NECESSITY OF RARE NEUROLOGICAL AUTOIMMUNE DISORDERS.

In Dr. Tolson's denial dated January 23, 2019, he states "Request is denied for the following reasons. There is no referral from treating physician. There is no documentation by referring provider of medical necessity for second acute rehab admission. There is no documentation of functional improvement anticipated to be practical, ongoing, and sustainable. Request does not meet criteria for Inpatient Acute Rehabilitation in MCG guidelines. MCG is used for its guidelines to decide if criteria is met." **(See Exhibit B — Banner/Aetna Denial.)**

As you know, **29 CFR §2560.503-1(h)(2)** details the requirements of an employee benefit plan when conducting full and fair medical reviews, stating:

> ***The claims procedures of a group health plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless, in addition to complying with the requirements of paragraphs (h)(2)(ii) though (iv) of this section, the claims procedure —***
>
> ***(i) Provide claimants at least 180 days following the receipt of a notification of an adverse benefit determination within which to appeal the determination;***
> ***(ii) Provide for a review that does not afford deference to the initial adverse benefit determination that is conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;***
> ***(iii) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgement, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgement;***
> ***(iv) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;***
> ***(v) Provide that the healthcare professional engaged for purposes of consultation under paragraph (h)(3)(iii) of this section shall be an individual who is neither an individual consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.*** **(Emphasis added.)**

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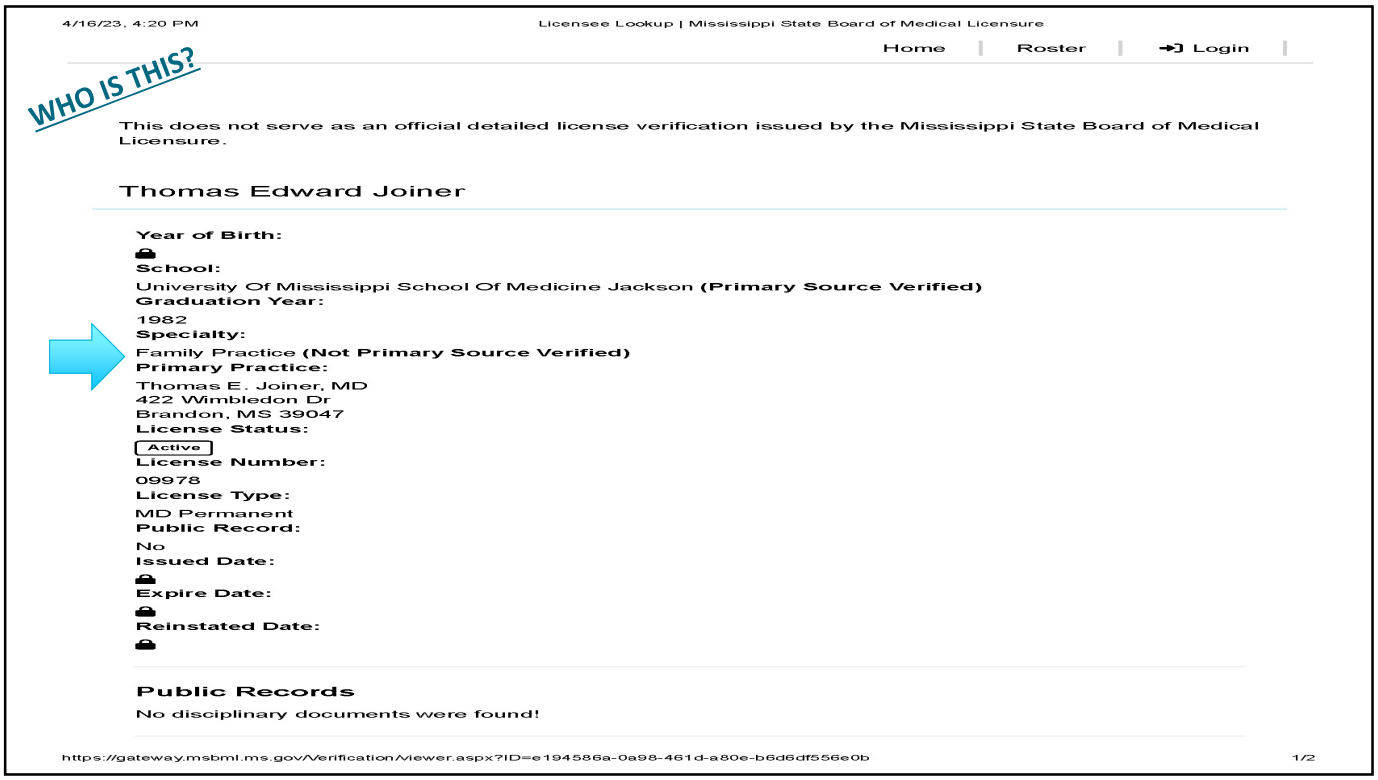

4/16/23, 4:20 PM Licensee Lookup | Mississippi State Board of Medical Licensure

Home | Roster | Login

WHO IS THIS?

This does not serve as an official detailed license verification issued by the Mississippi State Board of Medical Licensure.

Thomas Edward Joiner

Year of Birth:

School:

University Of Mississippi School Of Medicine Jackson **(Primary Source Verified)**

Graduation Year:

1982

Specialty:

Family Practice **(Not Primary Source Verified)**

Primary Practice:

Thomas E. Joiner, MD
422 Wimbledon Dr
Brandon, MS 39047

License Status:

Active

License Number:

09978

License Type:

MD Permanent

Public Record:

No

Issued Date:

Expire Date:

Reinstated Date:

Public Records

No disciplinary documents were found!

https://gateway.msbml.ms.gov/Verification/Viewer.aspx?ID=e194586a-0a98-461d-a80e-b6d6df556e0b 1/2

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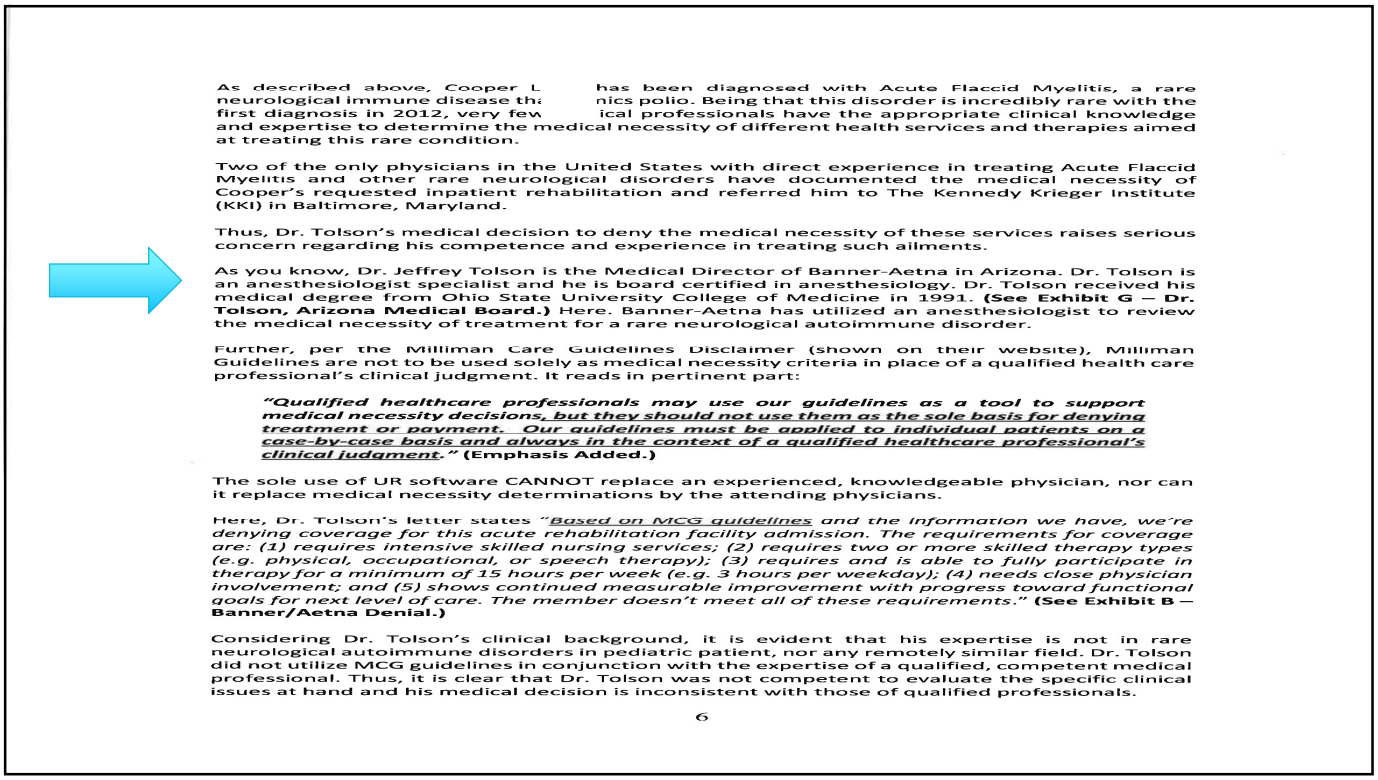

As described above, Cooper L has been diagnosed with Acute Flaccid Myelitis, a rare neurological immune disease th nics polio. Being that this disorder is incredibly rare with the first diagnosis in 2012, very few ical professionals have the appropriate clinical knowledge and expertise to determine the medical necessity of different health services and therapies aimed at treating this rare condition.

Two of the only physicians in the United States with direct experience in treating Acute Flaccid Myelitis and other rare neurological disorders have documented the medical necessity of Cooper's requested inpatient rehabilitation and referred him to The Kennedy Krieger Institute (KKI) in Baltimore, Maryland.

Thus, Dr. Tolson's medical decision to deny the medical necessity of these services raises serious concern regarding his competence and experience in treating such ailments.

As you know, Dr. Jeffrey Tolson is the Medical Director of Banner-Aetna in Arizona. Dr. Tolson is an anesthesiologist specialist and he is board certified in anesthesiology. Dr. Tolson received his medical degree from Ohio State University College of Medicine in 1991. **(See Exhibit G – Dr. Tolson, Arizona Medical Board.)** Here. Banner-Aetna has utilized an anesthesiologist to review the medical necessity of treatment for a rare neurological autoimmune disorder.

Further, per the Milliman Care Guidelines Disclaimer (shown on their website), Milliman Guidelines are not to be used solely as medical necessity criteria in place of a qualified health care professional's clinical judgment. It reads in pertinent part:

> ***"Qualified healthcare professionals may use our guidelines as a tool to support medical necessity decisions, but they should not use them as the sole basis for denying treatment or payment. Our guidelines must be applied to individual patients on a case-by-case basis and always in the context of a qualified healthcare professional's clinical judgment."*** **(Emphasis Added.)**

The sole use of UR software CANNOT replace an experienced, knowledgeable physician, nor can it replace medical necessity determinations by the attending physicians.

Here, Dr. Tolson's letter states *"Based on MCG guidelines and the information we have, we're denying coverage for this acute rehabilitation facility admission. The requirements for coverage are: (1) requires intensive skilled nursing services; (2) requires two or more skilled therapy types (e.g. physical, occupational, or speech therapy); (3) requires and is able to fully participate in therapy for a minimum of 15 hours per week (e.g. 3 hours per weekday); (4) needs close physician involvement; and (5) shows continued measurable improvement with progress toward functional goals for next level of care. The member doesn't meet all of these requirements."* **(See Exhibit B – Banner/Aetna Denial.)**

Considering Dr. Tolson's clinical background, it is evident that his expertise is not in rare neurological autoimmune disorders in pediatric patient, nor any remotely similar field. Dr. Tolson did not utilize MCG guidelines in conjunction with the expertise of a qualified, competent medical professional. Thus, it is clear that Dr. Tolson was not competent to evaluate the specific clinical issues at hand and his medical decision is inconsistent with those of qualified professionals.

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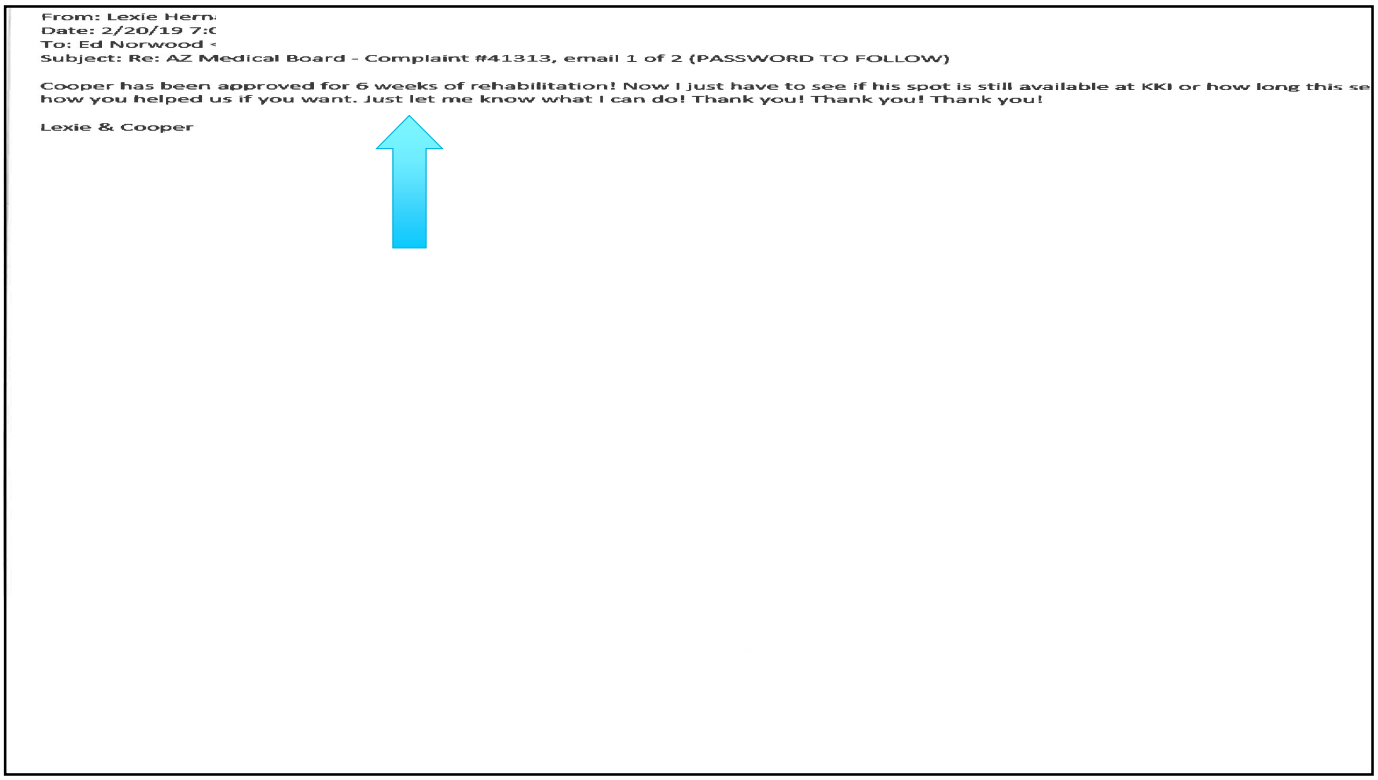

From: Lexie Hern
Date: 2/20/19 7:(
To: Ed Norwood <
Subject: Re: AZ Medical Board - Complaint #41313, email 1 of 2 (PASSWORD TO FOLLOW)

Cooper has been approved for 6 weeks of rehabilitation! Now I just have to see if his spot is still available at KKI or how long this se
how you helped us if you want. Just let me know what I can do! Thank you! Thank you! Thank you!

Lexie & Cooper

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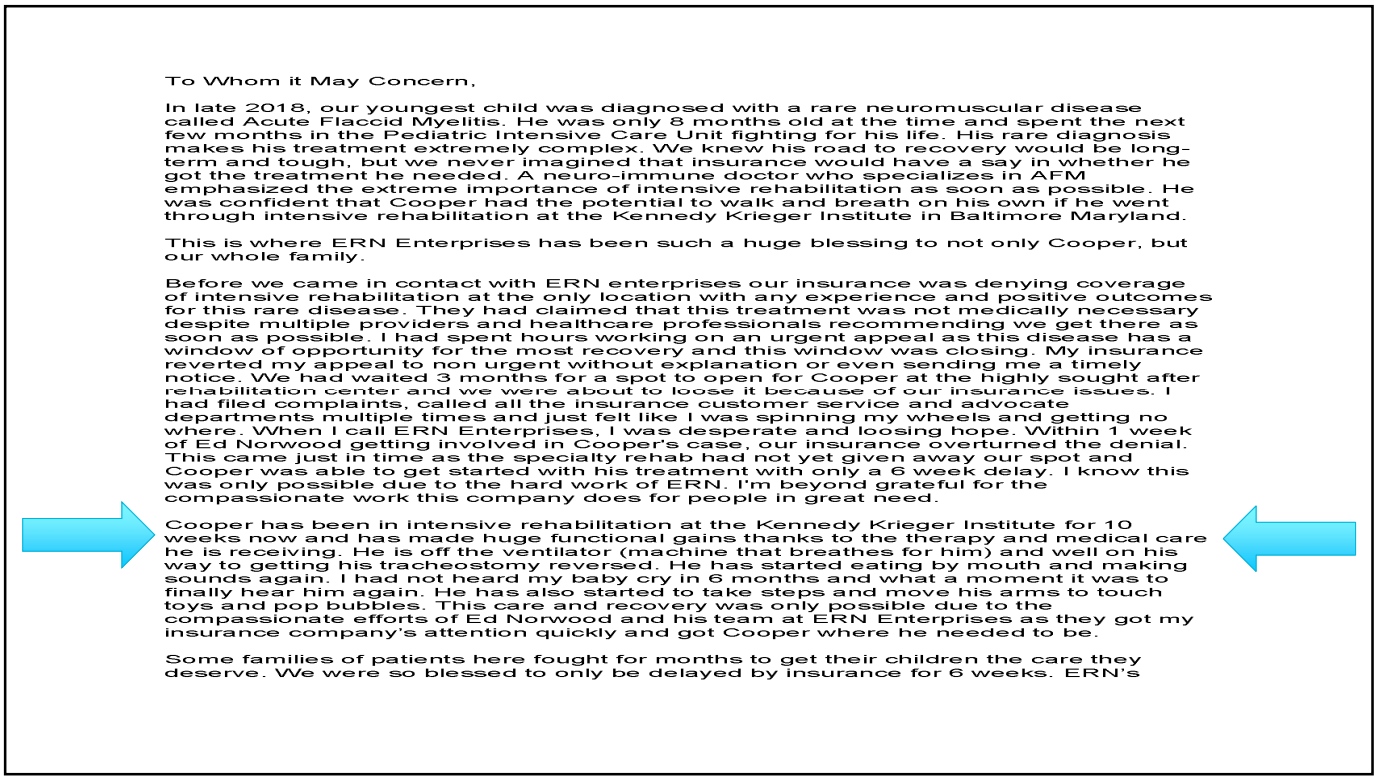

To Whom it May Concern,

In late 2018, our youngest child was diagnosed with a rare neuromuscular disease called Acute Flaccid Myelitis. He was only 8 months old at the time and spent the next few months in the Pediatric Intensive Care Unit fighting for his life. His rare diagnosis makes his treatment extremely complex. We knew his road to recovery would be long-term and tough, but we never imagined that insurance would have a say in whether he got the treatment he needed. A neuro-immune doctor who specializes in AFM emphasized the extreme importance of intensive rehabilitation as soon as possible. He was confident that Cooper had the potential to walk and breath on his own if he went through intensive rehabilitation at the Kennedy Krieger Institute in Baltimore Maryland.

This is where ERN Enterprises has been such a huge blessing to not only Cooper, but our whole family.

Before we came in contact with ERN enterprises our insurance was denying coverage of intensive rehabilitation at the only location with any experience and positive outcomes for this rare disease. They had claimed that this treatment was not medically necessary despite multiple providers and healthcare professionals recommending we get there as soon as possible. I had spent hours working on an urgent appeal as this disease has a window of opportunity for the most recovery and this window was closing. My insurance reverted my appeal to non urgent without explanation or even sending me a timely notice. We had waited 3 months for a spot to open for Cooper at the highly sought after rehabilitation center and we were about to loose it because of our insurance issues. I had filed complaints, called all the insurance customer service and advocate departments multiple times and just felt like I was spinning my wheels and getting no where. When I call ERN Enterprises, I was desperate and loosing hope. Within 1 week of Ed Norwood getting involved in Cooper's case, our insurance overturned the denial. This came just in time as the specialty rehab had not yet given away our spot and Cooper was able to get started with his treatment with only a 6 week delay. I know this was only possible due to the hard work of ERN. I'm beyond grateful for the compassionate work this company does for people in great need.

Cooper has been in intensive rehabilitation at the Kennedy Krieger Institute for 10 weeks now and has made huge functional gains thanks to the therapy and medical care he is receiving. He is off the ventilator (machine that breathes for him) and well on his way to getting his tracheostomy reversed. He has started eating by mouth and making sounds again. I had not heard my baby cry in 6 months and what a moment it was to finally hear him again. He has also started to take steps and move his arms to touch toys and pop bubbles. This care and recovery was only possible due to the compassionate efforts of Ed Norwood and his team at ERN Enterprises as they got my insurance company's attention quickly and got Cooper where he needed to be.

Some families of patients here fought for months to get their children the care they deserve. We were so blessed to only be delayed by insurance for 6 weeks. ERN's

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Ed Norwood

From: Lexie Hernandez
Sent: Sunday, May 05, 2
To: Ed Norwood
Subject: Re: Testimonial

Cooper is making so much progress. It's truly incredible. I watched him take his first steps a few days ago. Something I wasn't sure I would ever see. I can't even explain how incredible this place is at what they do for children with spinal cord injuries. Thank you again for getting us here.

Lexie

On Sun, May 5, 2019 at 7:16 PM Ed Norwood <ednorwood@ernenterprises.org> wrote:
So moved. So touched by your words Lexie.

Thank you.

How is Cooper doing?

Best,

Ed Norwood

Sent from my T-Mobile 4G LTE Device

-------- Original message --------
From: Lexie Hernandez <arharri1@gmail.com>
Date: 5/5/19 11:21 AM (GMT-08:00)
To: Ed Norwood <ednorwood@ernenterprises.org>
Subject: Testimonial

I am so sorry that this took me so long but I wanted to be able to share how much Cooper has benefitted from the treatment that was only made possible from your efforts.

Thank you again for everything!

Lexie

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WHO WE ARE

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

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WHAT WE DO

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

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HEALTHCARE IS A LAW TO BE DEFENDED.

WE EXIST TO FACE GIANTS. TO "ADVOCATE FOR MEDICALLY APPROPRIATE HEALTHCARE PURSUANT TO WICKLINE VS. STATE"

21

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

22

FOUR WAYS TO BE A CHAMPION FOR MEDICALLY APPROPRIATE HEALTHCARE

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ERN
NCRA

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THE FREEDOM OF INFORMATION ACT

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THE FREEDOM OF INFORMATION ACT

The Freedom of Information Act (FOIA) is a law that gives you the right to access information from the federal government. It is often described as the law that keeps citizens in the know about their government.

There is no specific form that must be used to make a request. The request simply must be in writing, reasonably describe the information you seek, and comply with specific agency requirements. Most federal agencies now accept FOIA requests electronically, including by web form, e-mail, or fax.

Source: 5 USC § 552

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THE FREEDOM OF INFORMATION ACT
WHAT CAN YOU ASK FOR?

A FOIA request can be made for any agency record. You can also specify the format in which you wish to receive the records. You should be aware that the FOIA does not require agencies to do research for you, to analyze data, to answer written questions, or to create records in response to a request (e.g. "No records responsive."

Source: 5 USC § 552

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U.S. Department of Labor Employee Benefits Security Administration
Washington, D.C. 20210

FEB 13 2017

Brian Ford
ERN/TRAF Enterprises
5856 Corporate Avenue
Suite 110
Cypress, CA 90630

Re: Freedom of Information Act Request #F2016-803561

Dear Mr. Ford:

This letter is in response of your Freedom of Information Act (FOIA) request dated April 29, 2016 addressed to the U.S. Department of Labor's (DOL) FOIA email address. Your request was forwarded to the Employee Benefits Security Administration (EBSA) for direct response to you. You requested records relating to EBSA's PBA program.

Your request for assistance with collection of monies has been addressed in the enclosed letter, dated February 8, 2017.

An interim response, dated May 13, 2016 provided the Benefits Advisor's GS-301-12 Position Descriptions.

EBSA's National Office has located the following Standard Operating Procedures (SOPs) and the EBSA Benefits Advisor Training Material responsive to your request. These records are enclosed herewith and have been redacted to effect Exemption 6. Exemption 6 (U.S.C 522(b)(6)) permits the withholding of information that would constitute an invasion of personal privacy. In accordance with the Department regulation 29 CFR 70.40(c)(l), dated May 30, 2006, requestors are charged for search, review, and reproduction costs. However, the fee is being waived since the total is under the de minimis costs threshold of $15.00 (29 CFR 70.43(a)):

SOPs

- SOP 03 Guidelines for Identifying, Recording, Calculating, Documenting, and Submitting Benefit Recoveries

  Attachments:
  1. Annuity Calculation Table
  2. Medical Benefits Calculation Table
  3. Recoveries Quick Review Sheet
  4. June 2016 Memorandum from EBSA's Office of Policy and Research (OPR) concerning the actuarial and economic assumptions underlying use of the Annuity Calculation Table
  5. June 2016 Memorandum from OPR concerning the actuarial and economic assumptions underlying use of the Medical Benefits Calculation Table

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- SOP #05 Guidelines for Providing Quality Technical Assistance

  Attachments:
  1. Standard Language Inserts to Make Requests for Information or to Obtain Documents

- SOP #06 Procedures for Inquiry and Complaint Referrals to Other EBSA Offices

  Attachments:
  1. Zip Codes by Region

- SOP #07 Guidelines for Providing Assistance to Third Parties With Respect to ERISA-Covered Benefit Claims, and for Referring Plan Participants and Beneficiaries to Outside Organizations and Advisors

  Attachments:
  1. March 2006 Memorandum

- SOP #08 Guidance for Handling Inquiries on Pension Calculations

- SOP #10 Procedures for referring potential violations of the plan-related document disclosure requirements contained in ERISA section 104(a)(6) and 29 CFR §2520.104a-8 to the Office of the Chief Accountant

  Attachments:
  1. Sample Participant Request for Information Letter
  2. Field Office Referral Memorandum to OCA

- SOP #12 Outreach, Education and Assistance Records Management

  Attachments:
  1. General Records Schedule 14
  2. General Records Schedule 16

- SOP #13 Reporting Referrals being Reviewed as Possible Leads for Enforcement
-
- SOP #14 Procedures to Follow in Requesting Health Information Protected Under the HIPAA Privacy Rules

  Attachments:
  1. Authorized Release
  2. EO 13181
  3. Privacy Rules Regulation
  4. Excerpt from Preamble of Final Rule

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U. S. DEPARTMENT OF LABOR
EMPLOYEE BENEFITS SECURITY ADMINISTRATION (EBSA)
Office of Outreach, Education and Assistance
Washington, D.C.

OUTREACH, EDUCATION, AND ASSISTANCE (OEA) **January 9, 2017**
STANDARD OPERATING PROCEDURE NO. 07-17

SUBJECT: ***Guidelines for Providing Assistance to Third Parties With Respect to ERISA-Covered Benefit Claims, and for Referring Plan Participants and Beneficiaries to Outside Organizations and Advisors.***

1. Purpose

The purpose of this Standard Operating Procedure, 07-17 (which supersedes SOP 07-06), is to provide EBSA's Benefits Advisors with uniform guidelines for (1) assessing and handling requests for Agency assistance made by third parties with respect to ERISA-covered benefit claims, and for (2) referring plan participants and beneficiaries, in appropriate situations, to non-profit organizations, counseling and advocacy organizations, or pro bono programs in order to pursue an unresolved claim for pension or welfare benefits.

2. Background and Policy Concerning Requests for Agency Assistance by Third Parties

EBSA's Benefits Advisors receive thousands of inquiries each year from plan participants and beneficiaries seeking assistance in understanding their rights under ERISA-covered pension and welfare benefit plans. In discharging their duties, Benefits Advisors endeavor to provide these individuals with general information about how certain provisions of ERISA may apply to their situation, and to provide them with information or assistance in securing the payment or protection of any benefits or rights to which they may be entitled under the ERISA statute, regulations, or the terms of the plan. In some instances, the Agency is contacted by individuals or entities who state that they are acting as an *authorized representative* on behalf of a plan participant or beneficiary, or that they have received an *assignment of benefits* from the participant or beneficiary enabling them to pursue unpaid claims in place of that individual. In other instances, the Agency is contacted by agents or assignees of medical providers. The following discussion is intended to provide Benefits Advisors with guidance in handling these types of inquiries that originate from third parties on behalf of a benefit claimant.

(a) Requests for Agency Assistance by Medical Providers or Their Agents to Collect Unpaid Claims -- EBSA regularly receives inquiries from third-parties requesting EBSA's assistance in facilitating the payment of certain claims from ERISA-covered plans. Most frequently, these inquiries originate with health care providers (or organizations acting on

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behalf of health care providers) seeking to obtain the reimbursement of outstanding claims from ERISA-covered group health plans arising from services that were rendered to patients covered by such plans.

In keeping with our Agency's commitment to provide plan participants and beneficiaries with information and practical guidance about their benefit rights under ERISA on a direct and personalized basis (see e.g., ERISA section 102(b)) Benefits Advisors should provide education about the ERISA claims and appeals process to third-party medical providers, collection agencies, and other similar entities who lodge complaints about unpaid medical claims. A Benefits Advisor is not obligated to provide assistance, beyond education and publications about ERISA, to an individual or entity that has been retained by a medical provider for the purpose of pursuing denied or unpaid medical claims. Instead, the Benefits Advisor will advise such individuals or entities that we will assist further if the participant or beneficiary contacts us directly.

(b) General Applicability of the ERISA Claims Procedure to Requests for Assistance from Bona-Fide Authorized Representatives of Plan Participants and Beneficiaries -- It is important to note that the Claims Procedure Regulation **does not** preclude the *authorized representative* of a participant or beneficiary (such as an attorney, legal guardian, medical provider or family member) from acting on behalf of that claimant with respect to claims for benefits and/or adverse benefit determinations. Generally, EBSA employees should provide a bona-fide authorized representative with the same level of assistance that they would otherwise offer directly to the plan participant or beneficiary. A Benefits Advisor is nevertheless permitted to request documentary evidence demonstrating that that person was, in fact, retained directly by the participant or beneficiary as an authorized representative (e.g., requesting a copy of a power of attorney or other appropriate documentation).[1] A mere assignment of benefits by a claimant to a healthcare provider will not be sufficient in this regard. Rather, the individual or entity must have been appointed directly and specifically by the claimant as an authorized representative for the purpose of claiming a benefit or appealing an adverse benefit determination. Furthermore, in most situations, the Benefits Advisor should speak directly with the plan participant or beneficiary before contacting a plan sponsor or service provider on that person's behalf.

(c) Credible Allegations by Medical Service Providers (or Other Third Parties) of Mismanagement or Abuse by Group Health Plan Fiduciaries -- In some instances, a health care provider or other entity may contact EBSA with a credible allegation that an ERISA-covered group health plan (or an outside insurance company retained by one or more such plans to adjudicate medical claims) has systematically failed to resolve or pay claims involving multiple plan participants (i.e., allegations not involving a stand-alone dispute over the plan's failure to pay an individual's specific benefit claim). If such a systemic allegation is raised by a provider or other entity, the Benefits Advisor should educate the

[1] As a general matter, it should be noted that, under the Claims Procedure Regulation, the final determination of whether a particular individual is a bona-fide authorized representative ordinarily rests with the plan administrator, and not with the Department of Labor. The Claims Procedure Regulation also permits plans to establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a claimant; accordingly, the validity of a designation of an authorized representative will usually depend on whether the designation has been made in accordance with the procedures established by the plan (if any). It is important that both claimants and plans make clear the extent to which an authorized representative will be acting on behalf of the claimant.

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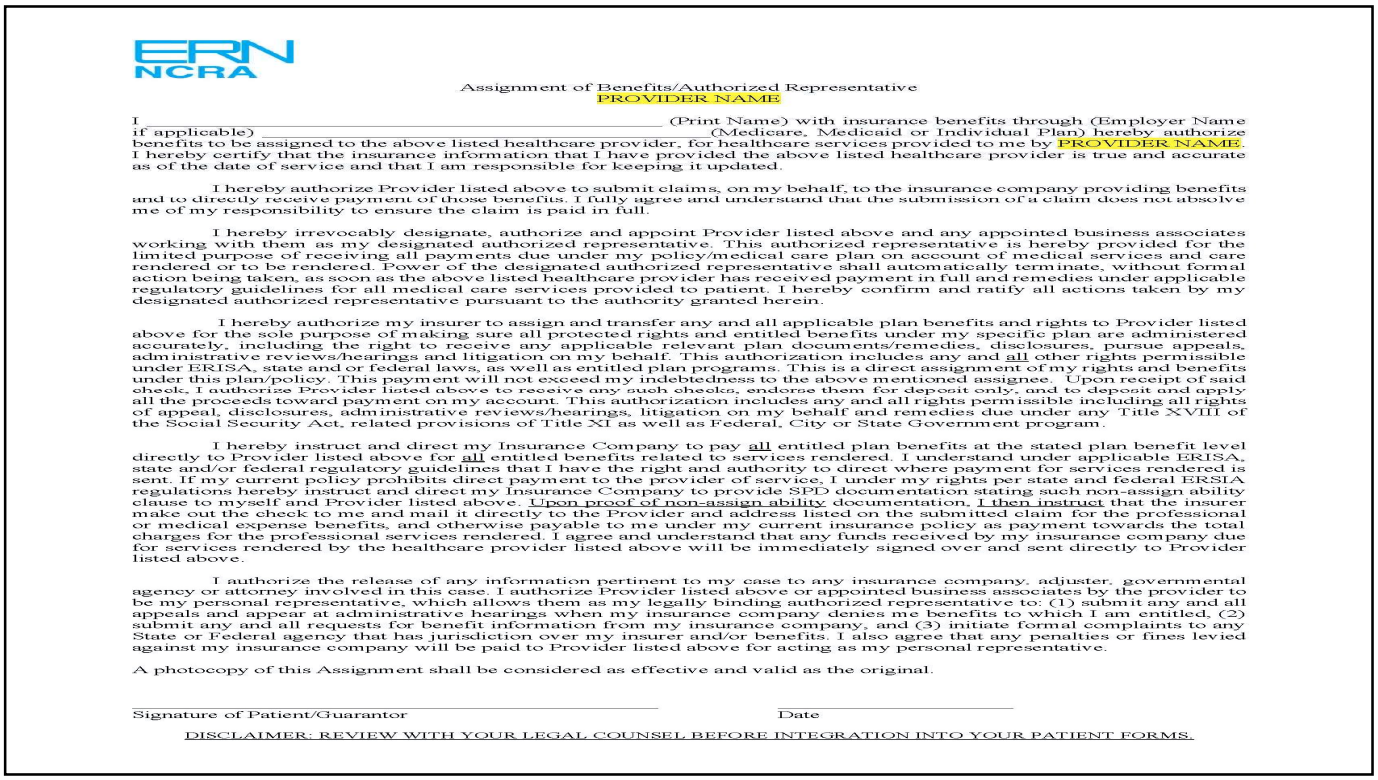

ERN NCRA

Assignment of Benefits/Authorized Representative
PROVIDER NAME

I _____ (Print Name) with insurance benefits through (Employer Name if applicable) _____ (Medicare, Medicaid or Individual Plan) hereby authorize benefits to be assigned to the above listed healthcare provider; for healthcare services provided to me by PROVIDER NAME. I hereby certify that the insurance information that I have provided the above listed healthcare provider is true and accurate as of the date of service and that I am responsible for keeping it updated.

I hereby authorize Provider listed above to submit claims, on my behalf, to the insurance company providing benefits and to directly receive payment of those benefits. I fully agree and understand that the submission of a claim does not absolve me of my responsibility to ensure the claim is paid in full.

I hereby irrevocably designate, authorize and appoint Provider listed above and any appointed business associates working with them as my designated authorized representative. This authorized representative is hereby provided for the limited purpose of receiving all payments due under my policy/medical care plan on account of medical services and care rendered or to be rendered. Power of the designated authorized representative shall automatically terminate, without formal action being taken, as soon as the above listed healthcare provider has received payment in full and remedies under applicable regulatory guidelines for all medical care services provided to patient. I hereby confirm and ratify all actions taken by my designated authorized representative pursuant to the authority granted herein.

I hereby authorize my insurer to assign and transfer any and all applicable plan benefits and rights to Provider listed above for the sole purpose of making sure all protected rights and entitled benefits under my specific plan are administered accurately, including the right to receive any applicable relevant plan documents/remedies, disclosures, pursue appeals, administrative reviews/hearings and litigation on my behalf. This authorization includes any and all other rights permissible under ERISA, state and or federal laws, as well as entitled plan programs. This is a direct assignment of my rights and benefits under this plan/policy. This payment will not exceed my indebtedness to the above mentioned assignee. Upon receipt of said sheek, I authorize Provider listed above to receive any such sheeks, endorse them for deposit only, and to deposit and apply all the proceeds toward payment on my account. This authorization includes any and all rights permissible including all rights of appeal, disclosures, administrative reviews/hearings, litigation on my behalf and remedies due under any Title XVIII of the Social Security Act, related provisions of Title XI as well as Federal, City or State Government program.

I hereby instruct and direct my Insurance Company to pay all entitled plan benefits at the stated plan benefit level directly to Provider listed above for all entitled benefits related to services rendered. I understand under applicable ERISA, state and/or federal regulatory guidelines that I have the right and authority to direct where payment for services rendered is sent. If my current policy prohibits direct payment to the provider of service, I under my rights per state and federal ERSIA regulations hereby instruct and direct my Insurance Company to provide SPD documentation stating such non-assign ability clause to myself and Provider listed above. Upon proof of non-assign ability documentation, I then instruct that the insurer make out the check to me and mail it directly to the Provider and address listed on the submitted claim for the professional or medical expense benefits, and otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered. I agree and understand that any funds received by my insurance company due for services rendered by the healthcare provider listed above will be immediately signed over and sent directly to Provider listed above.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, governmental agency or attorney involved in this case. I authorize Provider listed above or appointed business associates by the provider to be my personal representative, which allows them as my legally binding authorized representative to: (1) submit any and all appeals and appear at administrative hearings when my insurance company denies me benefits to which I am entitled, (2) submit any and all requests for benefit information from my insurance company, and (3) initiate formal complaints to any State or Federal agency that has jurisdiction over my insurer and/or benefits. I also agree that any penalties or fines levied against my insurance company will be paid to Provider listed above for acting as my personal representative.

A photocopy of this Assignment shall be considered as effective and valid as the original.

_____ _____
Signature of Patient/Guarantor Date

DISCLAIMER: REVIEW WITH YOUR LEGAL COUNSEL BEFORE INTEGRATION INTO YOUR PATIENT FORMS.

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PREVENTING SURPRISE MEDICAL BILLS FOR EMERGENCY SERVICES– 29 CFR § 2590.716-4 (b)

Coverage requirements. A plan or issuer described in paragraph (a) of this section must provide coverage for emergency services in the following manner— (1) Without the need for any prior authorization determination, even if the services are provided on an out-of-network basis. (2) Without regard to whether the health care provider furnishing the emergency services is a participating provider or a participating emergency facility, as applicable, with respect to the services. (3) If the emergency services are provided by a nonparticipating provider or a nonparticipating emergency facility— (i) Without imposing any administrative requirement or limitation on coverage that is MORE RESTRICTIVE than the requirements or limitations that apply to emergency services received from participating providers and participating emergency facilities.

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PREVENTING SURPRISE MEDICAL BILLS FOR EMERGENCY SERVICES– 29 CFR § 2590.716-4 (c)

(2) Emergency services means, with respect to an emergency medical condition -
(i) In general.
(A) An appropriate medical screening examination (as required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
(B) Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

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PREVENTING SURPRISE MEDICAL BILLS FOR EMERGENCY SERVICES– 29 CFR § 2590.716-4 (c)

(2) Emergency services means, with respect to an emergency medical condition -
(ii) Inclusion of additional services. (A) Subject to paragraph (c)(2)(ii)(B) of this section, items and services— (1) For which benefits are provided or covered under the plan or coverage; and (2) That are furnished by a nonparticipating provider or nonparticipating emergency facility (regardless of the department of the hospital in which such items or services are furnished) after the participant or beneficiary is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the services described in paragraph (c)(2)(i) of this section are furnished.
(3) To stabilize, with respect to an emergency medical condition, has the meaning given such term in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

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PREVENTING SURPRISE MEDICAL BILLS FOR EMERGENCY SERVICES

Under 42 U.S.C. 1395dd (b), for necessary stabilizing treatment for emergency conditions, the hospital must provide:

Within their capabilities for such further medical examination and such treatment required to stabilize the medical condition.

For the transfer of the individual to another medical facility in accordance with section (c) when the facility doesn't have the appropriate facilities or personnel (SECTION (c) OUTLINES RESTRICTING TRANSFER RULES UNTIL STABILIZATION).

ER to ER transfers (for services that originate in the emergency room and do not result in stabilization), poststabilization services and care (PS), AND Higher LOC PS transfers by noncontracting providers fall under the definition of emergency services that don't require authorization.

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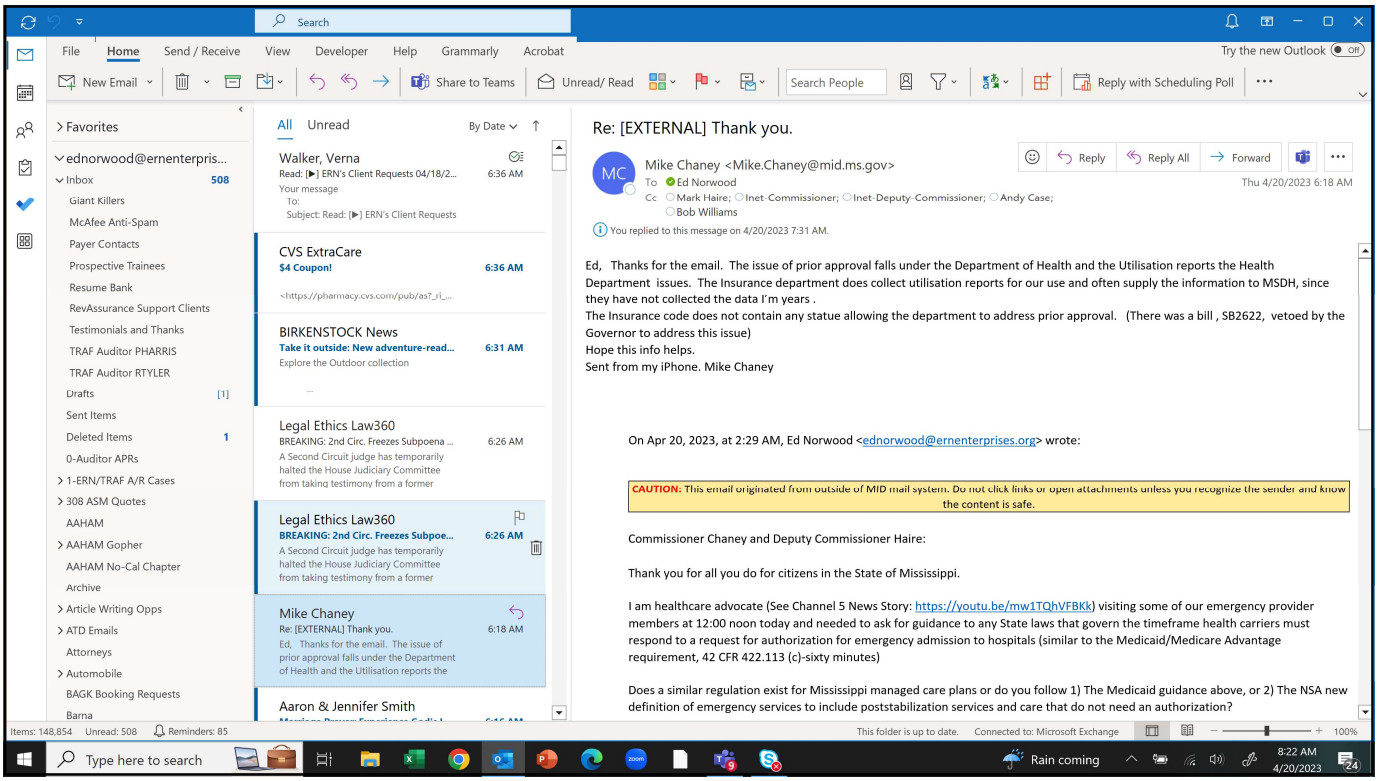
Re: [EXTERNAL] Thank you.
Mike Chaney <Mike.Chaney@mid.ms.gov>
Ed, Thanks for the email. The issue of prior approval falls under the Department of Health and the Utilisation reports the Health Department issues. The Insurance department does collect utilisation reports for our use and often supply the information to MSDH, since they have not collected the data I'm years .
The Insurance code does not contain any statue allowing the department to address prior approval. (There was a bill , SB2622, vetoed by the Governor to address this issue)
Hope this info helps.
Sent from my iPhone. Mike Chaney
On Apr 20, 2023, at 2:29 AM, Ed Norwood <ednorwood@ernenterprises.org> wrote:
CAUTION: This email originated from outside of MID mail system. Do not click links or open attachments unless you recognize the sender and know the content is safe.
Commissioner Chaney and Deputy Commissioner Haire:
Thank you for all you do for citizens in the State of Mississippi.
I am healthcare advocate (See Channel 5 News Story: https://youtu.be/mw1TQhVFBKk) visiting some of our emergency provider members at 12:00 noon today and needed to ask for guidance to any State laws that govern the timeframe health carriers must respond to a request for authorization for emergency admission to hospitals (similar to the Medicaid/Medicare Advantage requirement, 42 CFR 422.113 (c)-sixty minutes)
Does a similar regulation exist for Mississippi managed care plans or do you follow 1) The Medicaid guidance above, or 2) The NSA new definition of emergency services to include poststabilization services and care that do not need an authorization?

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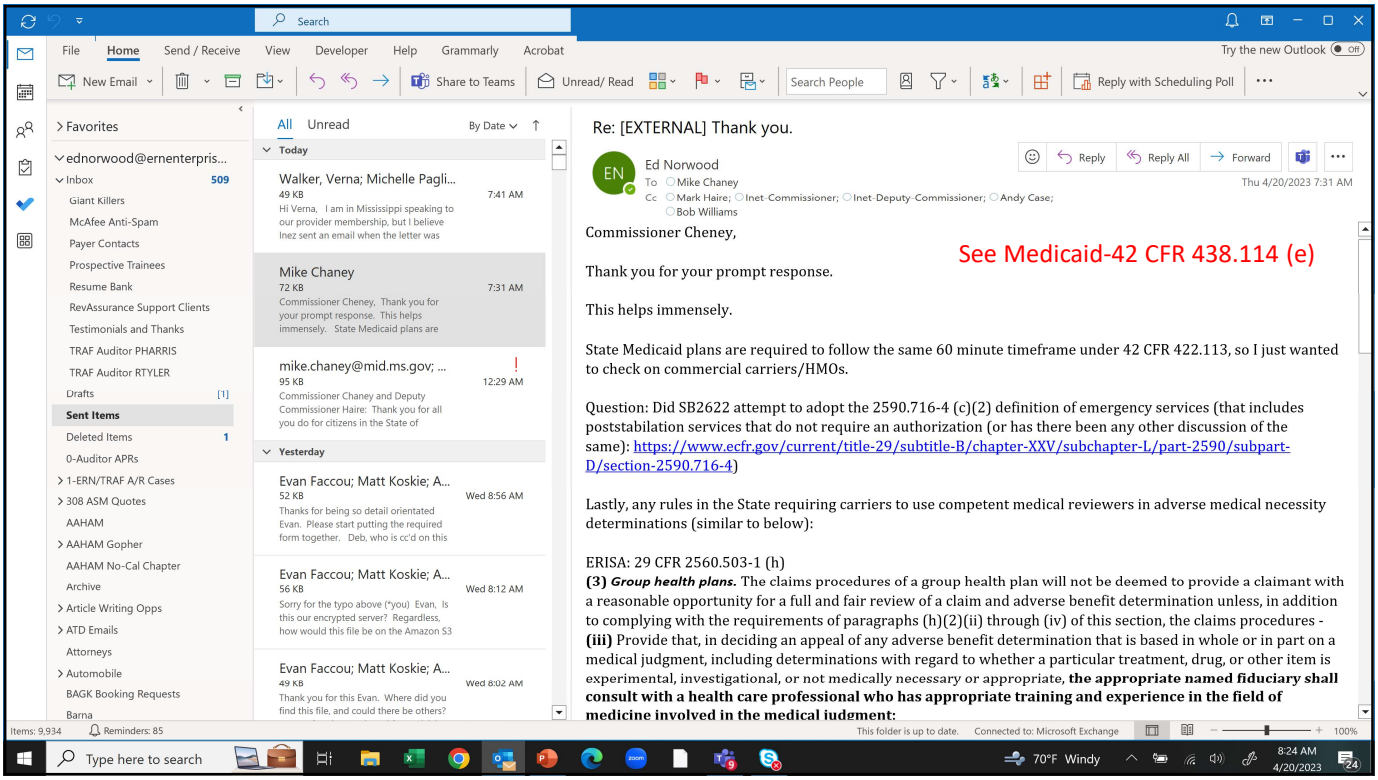
Re: [EXTERNAL] Thank you.
Ed Norwood
Commissioner Cheney,
See Medicaid-42 CFR 438.114 (e)
Thank you for your prompt response.
This helps immensely.
State Medicaid plans are required to follow the same 60 minute timeframe under 42 CFR 422.113, so I just wanted to check on commercial carriers/HMOs.
Question: Did SB2622 attempt to adopt the 2590.716-4 (c)(2) definition of emergency services (that includes poststabilation services that do not require an authorization (or has there been any other discussion of the same): https://www.ecfr.gov/current/title-29/subtitle-B/chapter-XXV/subchapter-L/part-2590/subpart-D/section-2590.716-4)
Lastly, any rules in the State requiring carriers to use competent medical reviewers in adverse medical necessity determinations (similar to below):
ERISA: 29 CFR 2560.503-1 (h)
(3) Group health plans. The claims procedures of a group health plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless, in addition to complying with the requirements of paragraphs (h)(2)(ii) through (iv) of this section, the claims procedures -
(iii) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

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ERISA PLANS ARE FINANCIALLY RESPONSIBLE FOR POSTSTABILIZATION CARE SERVICES…

- Without the need for prior authorization determination.
- Without regard to whether the health care provider furnishing the emergency services is a participating provider or participating emergency facility.

ERISA PLANS MUST ALSO PERMIT TREATING PHYSICIANS TO DETERMINE IF A CLAIM INVOLVES URGENT CARE.

- (i) A "claim involving urgent care" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations— (A) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, (B) In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. **(29 CFR 2560.503-1 (m)(1)(i))**

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ERISA PLANS MUST PERMIT TREATING PHYSICIANS TO DETERMINE IF A CLAIM INVOLVES URGENT CARE.

- (ii) Except as provided in paragraph (m)(1)(iii) of this section, whether a claim is a "claim involving urgent care" within the meaning of paragraph (m)(1)(i)(A) of this section is **to be determined by an individual acting on behalf of the plan** applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

- (iii) Any claim **that a physician with knowledge of the claimant's medical condition** determines is a "claim involving urgent care" within the meaning of paragraph (m)(1)(i) of this section **shall be treated as a "claim involving urgent care" for purposes of this section**. **(29 CFR 2560.503-1 (m)(1)(ii-iii))**

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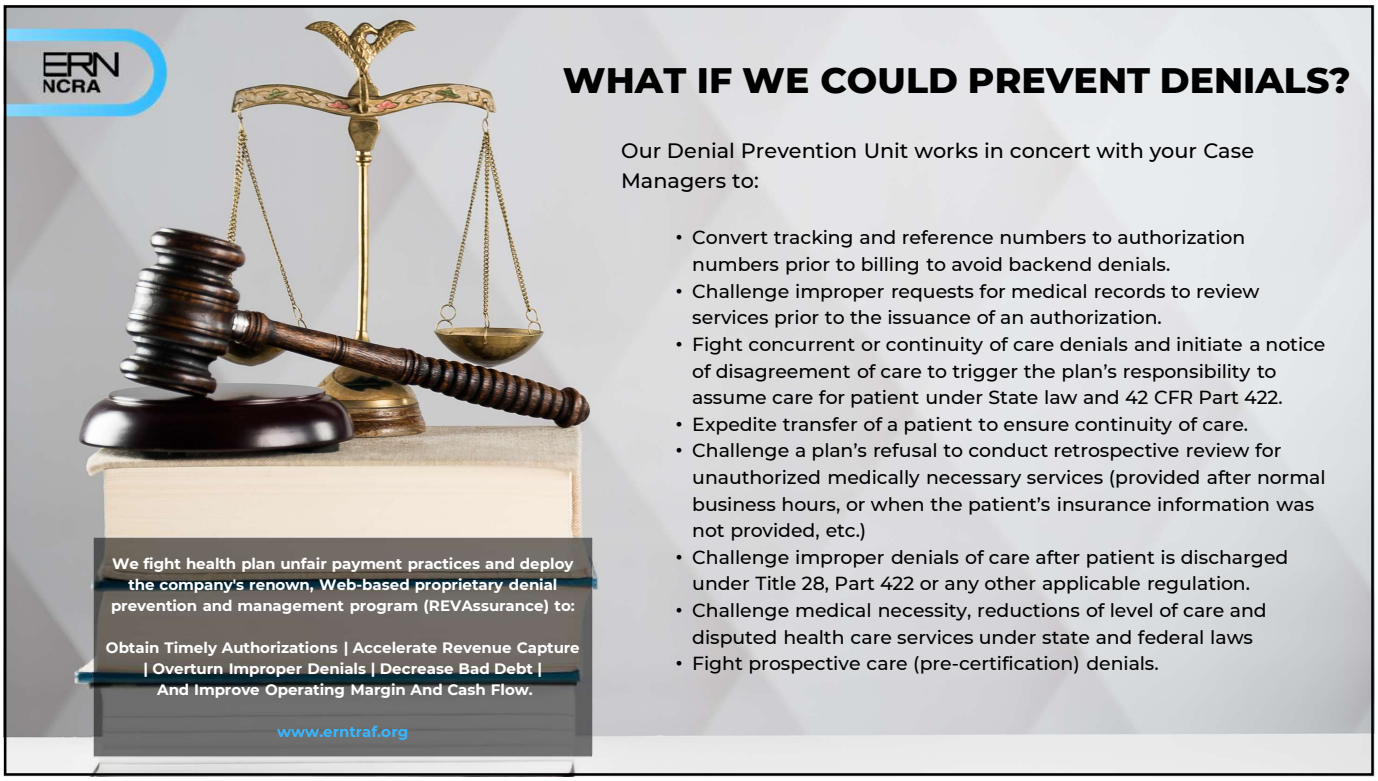
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WHAT IF WE COULD PREVENT DENIALS?
Our Denial Prevention Unit works in concert with your Case Managers to:
• Convert tracking and reference numbers to authorization numbers prior to billing to avoid backend denials.
• Challenge improper requests for medical records to review services prior to the issuance of an authorization.
• Fight concurrent or continuity of care denials and initiate a notice of disagreement of care to trigger the plan's responsibility to assume care for patient under State law and 42 CFR Part 422.
• Expedite transfer of a patient to ensure continuity of care.
• Challenge a plan's refusal to conduct retrospective review for unauthorized medically necessary services (provided after normal business hours, or when the patient's insurance information was not provided, etc.)
• Challenge improper denials of care after patient is discharged under Title 28, Part 422 or any other applicable regulation.
• Challenge medical necessity, reductions of level of care and disputed health care services under state and federal laws
• Fight prospective care (pre-certification) denials.
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

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NCRA
CASE STUDY
OBTAINING AUTHORIZATION AFTER PATIENT DISCHARGES (ERISA)

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*A DIVISION OF ERN ENTERPRISES

CONFIDENTIAL FACSIMILE TRANSMITTAL SHEET

TO:	FROM:
Medical Management	*Inez Villalobos*
COMPANY:	DATE:
Blue Cross Blue Shield of Illinois	*WEDNESDAY, MARCH 23, 2022*
FAX NUMBER:	TOTAL NO. OF PAGES INCLUDING COVER:
312-233-4060	4
PHONE NUMBER:	SENDER'S REFERENCE NUMBER:
	TRAF#81217

RE:
Request for Retro-Authorization for Inpatient Admission

X URGENT ☒ *FOR REVIEW* ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

PLEASE ACCEPT THIS AS A RETRO AUTHORIZATION REQUEST AND PROVIDE A HARD COPY AUTHORIZATION FOR THE SERVICES PROVIDED.

29 U.S.C. § 2560.503-1(b)(5) addresses claim procedure and mandates that:

> ***The claims procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants.***

According to the above your determination must be made in accordance to the Summary Plan Description or any governing plan document.

Best,

Inez Villalobos
Claims Compliance Auditor III
Tel: (714) 820-6960 Fax: (714) 995-6901
Email: inezvillalobos@ernenterprises.org

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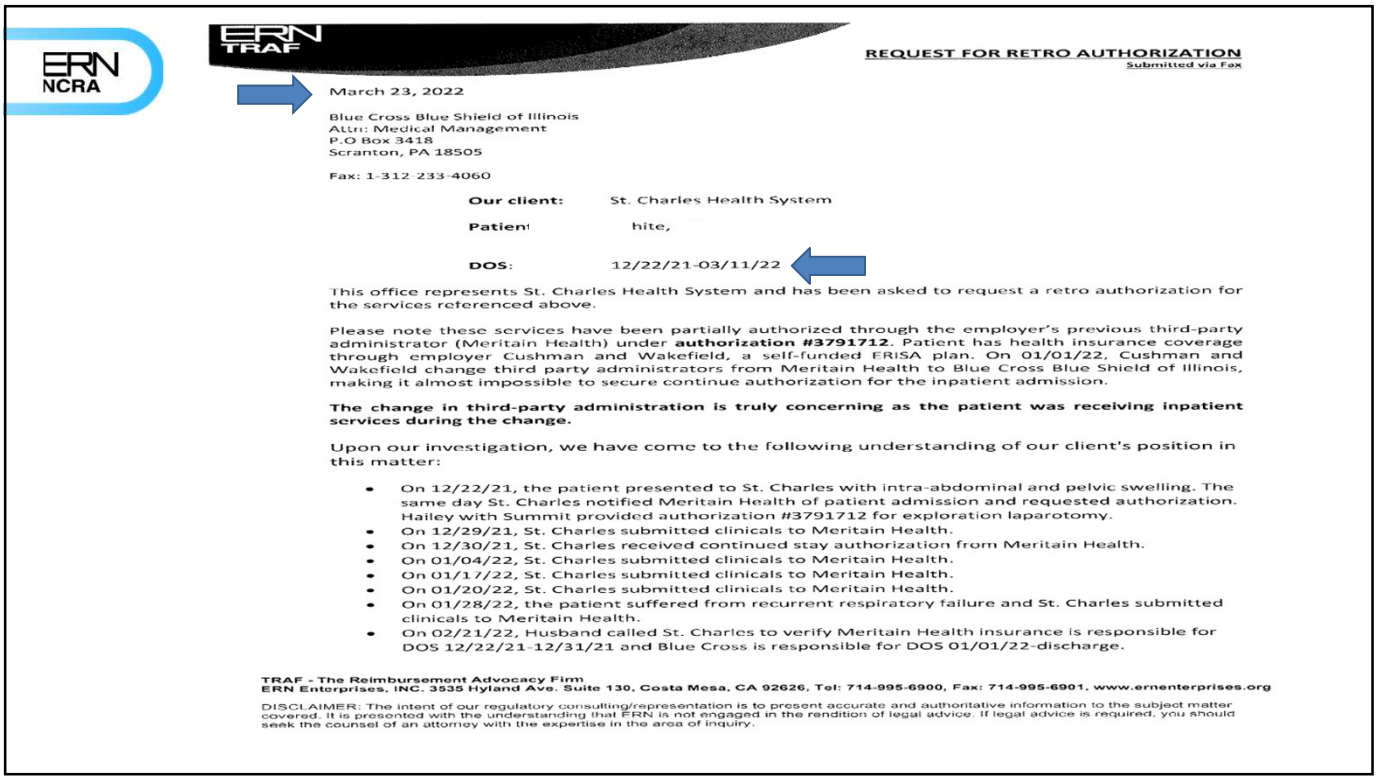

REQUEST FOR RETRO AUTHORIZATION
Submitted via Fax

March 23, 2022

Blue Cross Blue Shield of Illinois
Attn: Medical Management
P.O Box 3418
Scranton, PA 18505

Fax: 1-312-233-4060

Our client: St. Charles Health System

Patient: hite,

DOS: 12/22/21-03/11/22

This office represents St. Charles Health System and has been asked to request a retro authorization for the services referenced above.

Please note these services have been partially authorized through the employer's previous third-party administrator (Meritain Health) under **authorization #3791712**. Patient has health insurance coverage through employer Cushman and Wakefield, a self-funded ERISA plan. On 01/01/22, Cushman and Wakefield change third party administrators from Meritain Health to Blue Cross Blue Shield of Illinois, making it almost impossible to secure continue authorization for the inpatient admission.

The change in third-party administration is truly concerning as the patient was receiving inpatient services during the change.

Upon our investigation, we have come to the following understanding of our client's position in this matter:

- On 12/22/21, the patient presented to St. Charles with intra-abdominal and pelvic swelling. The same day St. Charles notified Meritain Health of patient admission and requested authorization. Hailey with Summit provided authorization #3791712 for exploration laparotomy.
- On 12/29/21, St. Charles submitted clinicals to Meritain Health.
- On 12/30/21, St. Charles received continued stay authorization from Meritain Health.
- On 01/04/22, St. Charles submitted clinicals to Meritain Health.
- On 01/17/22, St. Charles submitted clinicals to Meritain Health.
- On 01/20/22, St. Charles submitted clinicals to Meritain Health.
- On 01/28/22, the patient suffered from recurrent respiratory failure and St. Charles submitted clinicals to Meritain Health.
- On 02/21/22, Husband called St. Charles to verify Meritain Health insurance is responsible for DOS 12/22/21-12/31/21 and Blue Cross is responsible for DOS 01/01/22-discharge.

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- On 03/17/22, St. Charles called Blue Cross and Kelly stated Blue Cross provides no retro authorizations for encounters past 7 days (call ref# U22076BIJB).
- To date, Blue Cross has failed to review this case and provide a written determination as required under federal law.

PLEASE ACCEPT THIS AS A RETRO AUTHORIZATION REQUEST AND PROVIDE A HARD COPY AUTHORIZATION FOR THE SERVICES PROVIDED.

Under ERISA law, a plan administrator must provide a claimant with written or electronic notification of any adverse benefit determination consistent with **29 CFR 2560.503-1(g)(1)**, which states:

> ***The notification shall set forth, in a manner calculated to be understood by the claimant --(i) The specific reason or reasons for the adverse determination; (ii) Reference to the specific plan provisions on which the determination is based; (iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; (iv) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review;***

Furthermore, it adds:

> ***(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request.***

Lastly, **29 U.S.C. § 2560.503-1(b)(5)** addresses claim procedure and mandates that:

> ***The claims procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants.***

Here, on 03/17/22, Kelly with Blue Cross stated they cannot provide retro authorization for this case (call ref#U22076BIJB). However, Blue Cross has failed to provide any a summary plan description or any governing plan document that shows retro-authorization requests are not allowed under the member's plan.

Accordingly, this office requests the following pursuant to **29 U.S.C. § 1024(b)(4):**

- ❑ *An electronic written copy of the section of the summary plan description that instructs claims processing.*
- ❑ *An electronic written copy of the section of the summary plan description that describes retro-authorization request*

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- ❑ *A copy of all plan documents and summary plan descriptions that have existed during the time of the participant's coverage policy.*
- ❑ *Your client's employer identification and 3-digit plan number.*
- ❑ *A copy of the updated summary plan descriptions in effect for the last three years.*
- ❑ *A copy of the summary annual reports for the last three years.*
- ❑ *A copy of the bargaining agreement, trust agreement, contract, or other instrument under which the plan was established and all amendments since the establishment date until the present.*
- ❑ *A copy of all written polices, memoranda, minutes of meetings and any other written documentation addressing reimbursement timeframes, emergency services and care, authorizations, and retro-authorization.*

As you know, **29 U.S.C. § 1132(c)** requires ERISA plan information to be provided within thirty days from the receipt of the request. Failure to supply the above requested information within thirty days of date of this letter may subject you to a penalty of **$110.00 per day** and other costs, including attorney's fees if we seek review from our legal counsel.

As Blue Cross acting as the third-party administrator for self-funded employer plan failed to provide a hard copy authorization or proper determination, we are requesting that your office expedite a review and provide authorization by **end of day, March 24, 2022**, to avoid any unnecessary regulatory filing action with the **U.S Department of Labor**.

It is our sincere hope it does not come to this point.

Respectfully,

Inez Villalobos
Claims Compliance Auditor III
ERN/TRAF – The Reimbursement Advocacy Firm

Tel: (714) 995-6900 Ext. 6920 Fax: (714) 995-6901

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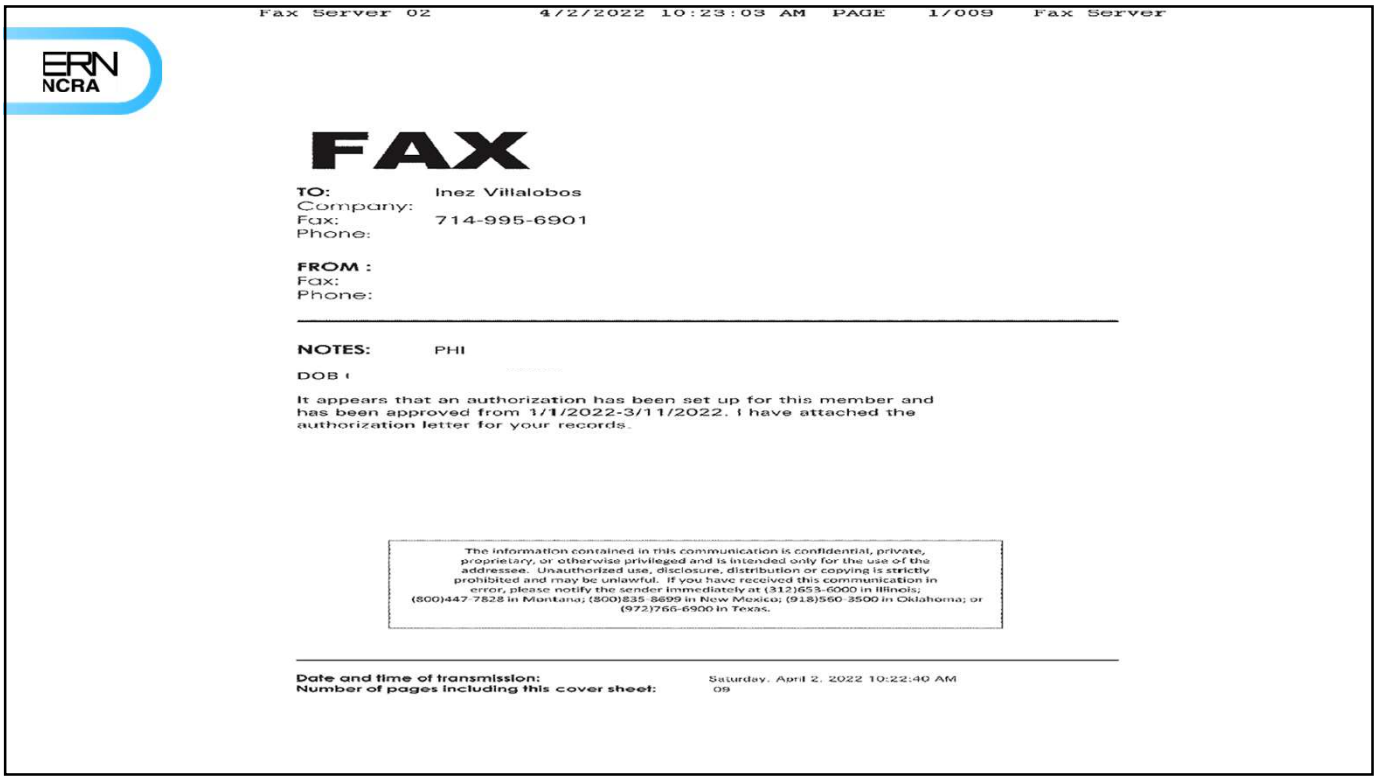


Fax Server 02 4/2/2022 10:23:03 AM PAGE 1/009 Fax Server

ERN NCRA

FAX

TO: Inez Villalobos
Company:
Fax: 714-995-6901
Phone:

FROM :
Fax:
Phone:

NOTES: PHI

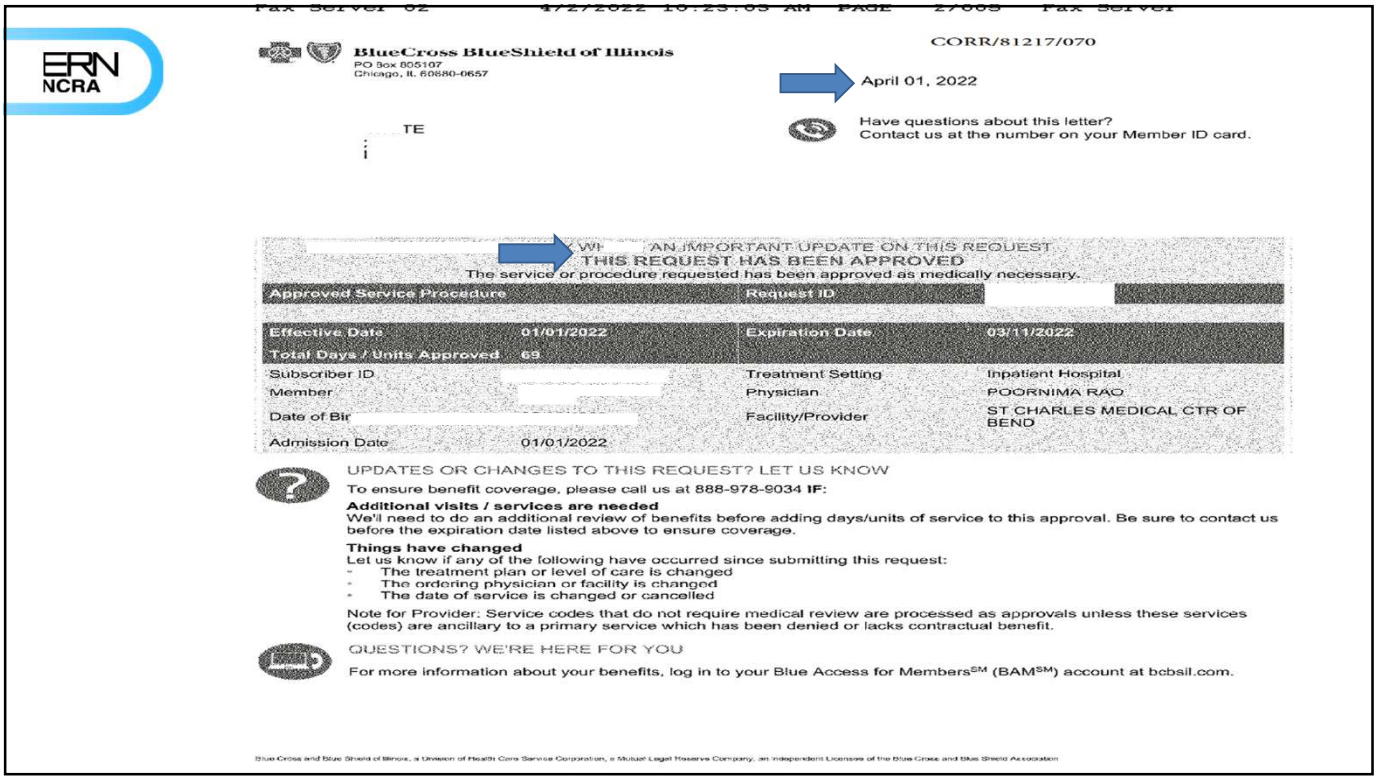
DOB

It appears that an authorization has been set up for this member and has been approved from 1/1/2022-3/11/2022. I have attached the authorization letter for your records.

The information contained in this communication is confidential, private, proprietary, or otherwise privileged and is intended only for the use of the addressee. Unauthorized use, disclosure, distribution or copying is strictly prohibited and may be unlawful. If you have received this communication in error, please notify the sender immediately at (312)653-6000 in Illinois; (800)447-7828 in Montana; (800)835-8699 in New Mexico; (918)560-3500 in Oklahoma; or (972)766-6900 in Texas.

Date and time of transmission: Saturday, April 2, 2022 10:22:40 AM
Number of pages including this cover sheet: 09

49



ERN NCRA

BlueCross BlueShield of Illinois
PO Box 805107
Chicago, IL 60680-0657

CORR/81217/070

April 01, 2022

TE

Have questions about this letter?
Contact us at the number on your Member ID card.

AN IMPORTANT UPDATE ON THIS REQUEST
THIS REQUEST HAS BEEN APPROVED
The service or procedure requested has been approved as medically necessary.

Approved Service Procedure		Request ID	
Effective Date	01/01/2022	Expiration Date	03/11/2022
Total Days / Units Approved	69		
Subscriber ID		Treatment Setting	Inpatient Hospital
Member		Physician	POORNIMA RAO
Date of Bir		Facility/Provider	ST CHARLES MEDICAL CTR OF BEND
Admission Date	01/01/2022		

UPDATES OR CHANGES TO THIS REQUEST? LET US KNOW

To ensure benefit coverage, please call us at 888-978-9034 **IF:**

Additional visits / services are needed
We'll need to do an additional review of benefits before adding days/units of service to this approval. Be sure to contact us before the expiration date listed above to ensure coverage.

Things have changed
Let us know if any of the following have occurred since submitting this request:
- The treatment plan or level of care is changed
- The ordering physician or facility is changed
- The date of service is changed or cancelled

Note for Provider: Service codes that do not require medical review are processed as approvals unless these services (codes) are ancillary to a primary service which has been denied or lacks contractual benefit.

QUESTIONS? WE'RE HERE FOR YOU

For more information about your benefits, log in to your Blue Access for Members℠ (BAM℠) account at bcbsil.com.

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

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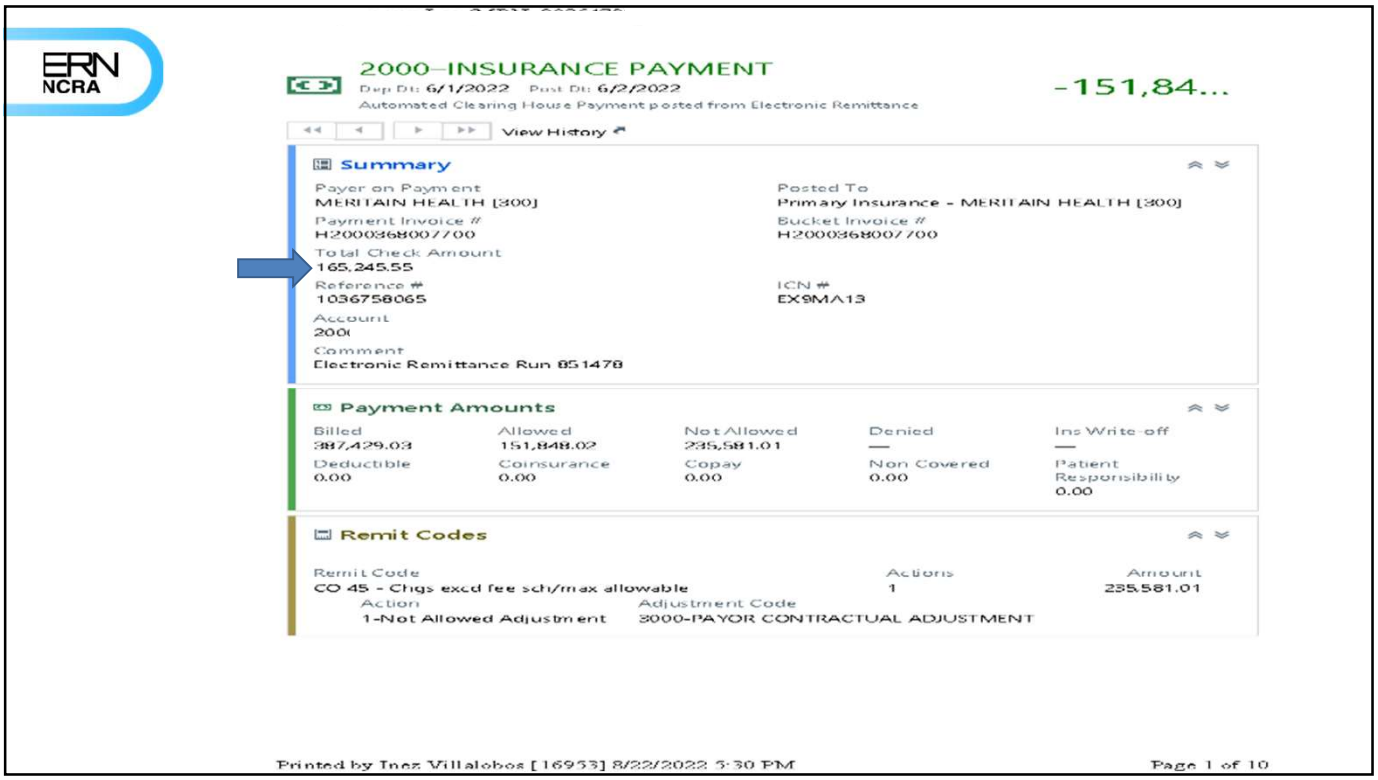


51

3

NO MORE AOB DENIALS AND PAYMENTS TO THE PATIENT.

52

PREVENTING SURPRISE MEDICAL BILLS FOR EMERGENCY SERVICES– 29 CFR § 2590.716.4 (b)

(3) If the emergency services are provided by a nonparticipating provider or a nonparticipating emergency facility -
(iv) The plan or issuer -
(A) **Not later than 30 calendar days after the bill for the services is transmitted by the provider or facility** (or, in cases where the recognized amount is determined by a specified State law or All-Payer Model Agreement, such other timeframe as specified by the State law or All-Payer Model Agreement), determines whether the services are covered under the plan or coverage **and, if the services are covered, sends to the provider or facility, as applicable, an initial payment or a notice of denial of payment**. For purposes of this paragraph (b)(3)(iv)(A), **the 30-calendar-day period begins on the date the plan or issuer receives the information necessary to decide a claim for payment for the services.**

53

PREVENTING SURPRISE MEDICAL BILLS FOR EMERGENCY SERVICES– 29 CFR § 2590.716.4 (b)(3)

(3) If the emergency services are provided by a nonparticipating provider or a nonparticipating emergency facility -
(iv) The plan or issuer -
(B) **Pays a total plan or coverage payment directly to the nonparticipating provider or nonparticipating facility that is equal to the amount by which the out-of-network rate** for the services exceeds the cost-sharing amount for the services (as determined in accordance with paragraphs (b)(3)(ii) and (iii) of this section), less any initial payment amount made under paragraph (b)(3)(iv)(A) of this section. **The total plan or coverage payment must be made in accordance with the timing requirement described in section 716(c)(6) of ERISA**, or in cases where the out-of-network rate is determined under a specified State law or All-Payer Model Agreement, such other timeframe as specified by the State law or All-Payer Model Agreement

NO AOB DENIALS OR SENDING CHECKS TO THE PATIENT IF YOU ARE NON-CONTRACTED.

54

4

BENEFIT DETERMINATION ON REVIEW TIMEFRAMES.

55

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW– 29 CFR § 2560.503-1 (i)(2)(iii)

(See subsection (f) for timing of notification of initial benefit determination.)

(2) Group health plans. In the case of a group health plan, the plan administrator shall notify a claimant of the plan's benefit determination on review in accordance with paragraphs (i)(2)(i) through (iii), as appropriate.

(i) Urgent care claims.
In the case of a claim involving urgent care, the plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the plan's benefit determination on review **as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination by the plan.**

56

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW– 29 CFR § 2560.503-1 (i)(2)(iii)

(See subsection (f) for timing of notification of initial benefit determination.)

(2) Group health plans. In the case of a group health plan, the plan administrator shall notify a claimant of the plan's benefit determination on review in accordance with paragraphs (i)(2)(i) through (iii), as appropriate.

(ii) Pre-service claims.
In the case of a pre-service claim, the plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the plan's benefit determination on review **within a reasonable period of time appropriate to the medical circumstances**. In the case of a group health plan that provides **for one appeal** of an adverse benefit determination, **such notification shall be provided not later than 30 days after receipt by the plan of the claimant's request for review of an adverse benefit determination**. In the case of a group health plan that provides **for two appeals** of an adverse determination, such notification shall be provided, with respect to any one of such two appeals, **not later than 15 days after receipt by the plan of the claimant's request for review of the adverse determination.**

57

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW– 29 CFR § 2560.503-1 (i)(2)(iii)

(See subsection (f) for timing of notification of initial benefit determination.)

(2) Group health plans. In the case of a group health plan, the plan administrator shall notify a claimant of the plan's benefit determination on review in accordance with paragraphs (i)(2)(i) through (iii), as appropriate.

(iii) Post-service claims.
(A) In the case of a post-service claim, except as provided in paragraph (i)(2)(iii)(B) of this section, the plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the plan's benefit determination on review within a reasonable period of time. In the case of a group health plan that provides **for one appeal** of an adverse benefit determination, **such notification shall be provided not later than 60 days after receipt by the plan of the claimant's request for review of an adverse benefit determination**. In the case of a group health plan that provides **for two appeals** of an adverse determination, such notification shall be provided, with respect to any one of such two appeals, **not later than 30 days after receipt by the plan of the claimant's request for review of the adverse determination**.

How do you track this?

58

DEFINITIONS
– 29 CFR § 2560.503-1 (m)(4)

(m) Definitions. The following terms shall have the meaning ascribed to such terms in this paragraph (m) whenever such term is used in this section:

(4) The term "adverse benefit determination" means

(i) Any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate;

59

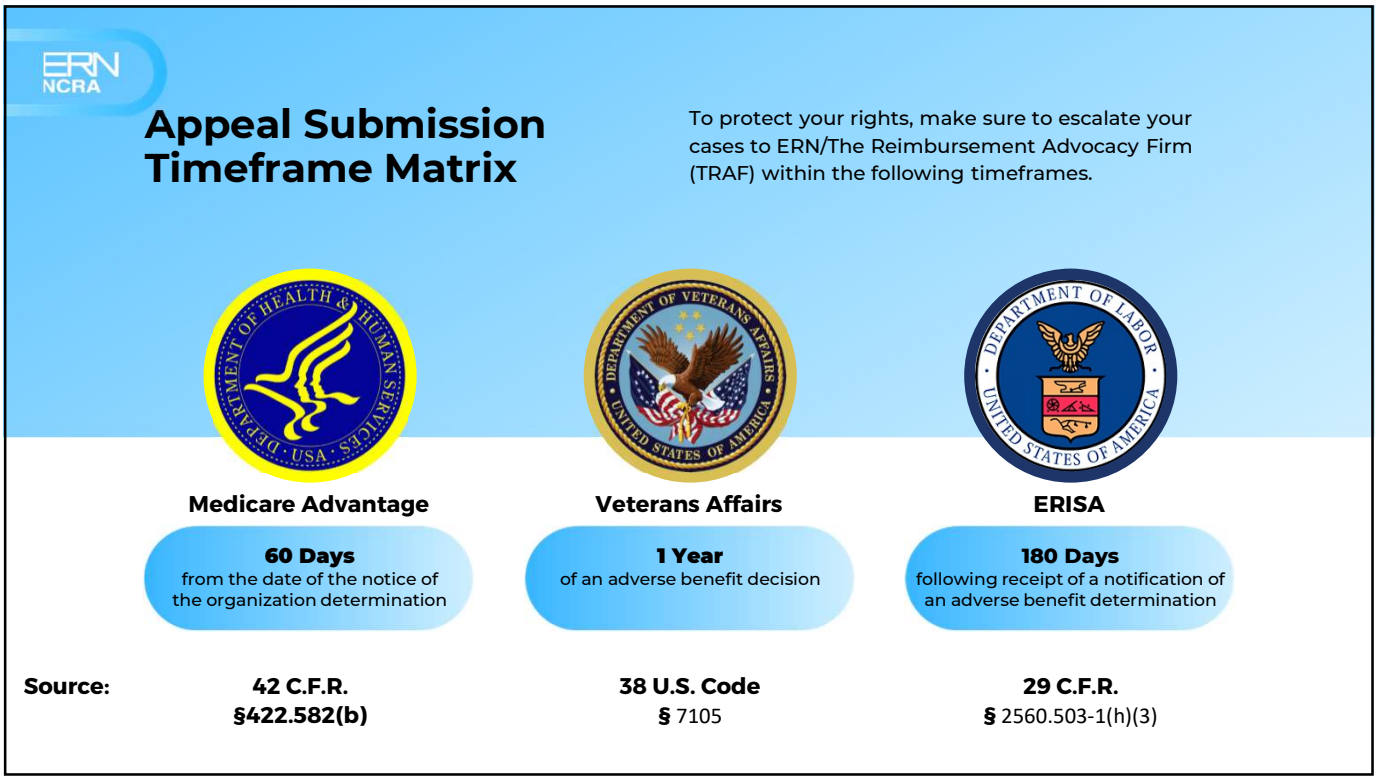
FULL AND FAIR REVIEW
– 29 CFR § 2560.503-1 (h)(3)

(3) Group health plans. The claims procedures of a group health plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless, in addition to complying with the requirements of paragraphs (h)(2)(ii) through (iv) of this section, the claims procedures—

(iii) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
(iv) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

Inspect what you expect.

60


ERN
NCRA
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.
Medicare Advantage
60 Days
from the date of the notice of the organization determination
Veterans Affairs
1 Year
of an adverse benefit decision
ERISA
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)

61


ERN
NCRA
5
PLANS FAILURE TO NEGOTIATE CONTRACTS CAN IMPACT IDR DECISIONS

62

INDEPENDENT DISPUTE RESOLUTION PROCESS. – 29 CFR § 2590.716-8

(a) (1) Scope. This section sets forth requirements with respect to the independent dispute resolution (IDR) process (referred to in this section as the Federal IDR process) **under which a nonparticipating provider, nonparticipating emergency facility, or nonparticipating provider of air ambulance services (as applicable), and a group health plan or health insurance issuer offering group health insurance coverage completes** a requisite open negotiation period and at least one party submits a notification **under paragraph (b)** of this section to initiate the Federal IDR process **under paragraph (c)** of this section, **and under which an IDR entity (as certified under paragraph (e) of this section) determines the amount of payment under the plan or coverage for an item or service furnished by the provider or facility.**

63

INDEPENDENT DISPUTE RESOLUTION PROCESS. – 29 CFR § 2590.716-8

(b) Determination of payment amount through open negotiation and initiation of the Federal IDR process -

(1) Determination of payment amount through open negotiation -
(i) In general. With respect to an item or service that meets the requirements of paragraph (a)(2)(xii)(A) of this section, **the provider, facility, or provider of air ambulance services or the group health plan or health insurance issuer offering group or individual health insurance coverage may, during the 30-business-day period beginning on the day the provider, facility, or provider of air ambulance services receives an initial payment or notice of denial of payment regarding the item or service, initiate an open negotiation period for purposes of determining the out-of-network rate for such item or service. To initiate the open negotiation period, a party must send a notice to the other party (open negotiation notice) in accordance with paragraph (b)(1)(ii) of this section.**

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INDEPENDENT DISPUTE RESOLUTION PROCESS. – 29 CFR § 2590.716-8

(b) Determination of payment amount through open negotiation and initiation of the Federal IDR process -

(1) Determination of payment amount through open negotiation -
(ii) Open negotiation notice -
(B) Manner. The open negotiation notice must be provided, using the standard form developed by the Secretary, in writing within 30 business days beginning on the day the provider, facility, or provider of air ambulance services receives an initial payment or a notice of denial of payment from the plan or issuer regarding the item or service. The day on which the open negotiation notice is first sent by a party is the date the 30-business-day open negotiation period begins.

65

OMB Control No. 1210-0136
Expiration Date: 06/30/2025

Information on the Parties and Item(s) and/or Service(s)

[*Enter name of party initiating negotiations*] is initiating an open negotiation period with [*enter name of the non-initiating party*] for the out-of-network rate of the following item(s) and/or service(s). To negotiate, please contact me (the representative of the initiating party) at the e-mail address or telephone number below:

Item(s) and/or service(s) [insert additional rows as appropriate]

	Description of item(s) and/or service(s)	Claim Number	Name of provider, facility, or provider of air ambulance services, and National Provider Identifier (NPI)	Date provided	Service code	Initial payment *(if no initial payment amount, write N/A)*	Offer for total out-of-network rate (including any cost sharing)
1.							
2.							
3.							
4.							
5.							

Signature _____ Date _____

Print Name _____ Relationship to person(s) or entity listed above _____

Mailing Address _____ Telephone number _____

Email Address _____

Please keep a copy of this notice for your records.

4

66

INDEPENDENT DISPUTE RESOLUTION PROCESS. – 29 CFR § 2590.716-8

(b) Determination of payment amount through open negotiation and initiation of the Federal IDR process -

(1) Determination of payment amount through open negotiation -
(ii) Open negotiation notice -
(B)(2) Initiating the Federal IDR process -

(i) In general. With respect to an item or service for which the parties do not agree upon an out-of-network rate by the last day of the open negotiation period under paragraph (b)(1) of this section, either party may initiate the Federal IDR process. To initiate the Federal IDR process, a party must submit a written notice of IDR initiation to the other party and to the Secretary, using the standard form developed by the Secretary, during the 4-business-day period beginning on the 31st business day after the start of the open negotiation period.

67

INDEPENDENT DISPUTE RESOLUTION PROCESS. – 29 CFR § 2590.716-8

(c) Federal IDR process following initiation -
(4)(iii) Considerations in determination. In determining which offer to select, the certified IDR entity must consider:

(C) Additional information submitted by a party, **provided the information is credible and relates to the circumstances** described in paragraphs (c)(4)(iii)(C)(1) through (5) of this section, with respect to a qualified IDR item or service of a nonparticipating provider, facility, group health plan, or health insurance issuer of group or individual health insurance coverage that is the subject of a payment determination. This information must also clearly demonstrate that **the qualifying payment amount is materially different from the appropriate out-of-network rate.**

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INDEPENDENT DISPUTE RESOLUTION PROCESS. – 29 CFR § 2590.716-6

Plan must pay provider the Qualifying Payment Amount ("QPA") within 30 days
The QPA is defined as:

- The median of the contracted (in-network) rates recognized by the plan in the same insurance market on 1/31/2019,
- For the same or similar item or service that is provided by a provider
- In the same or similar specialty or facility of the same or similar facility type, and
- In same geographic region, increased for inflation (annual CPI-U adjustment)

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INDEPENDENT DISPUTE RESOLUTION PROCESS. – 29 CFR § 2590.716-8

(c) Federal IDR process following initiation -
(4)(iii) Considerations in determination. In determining which offer to select, the certified IDR entity must consider:

(1) The level of training, experience, and quality and outcomes measurements of the provider or facility that furnished the qualified IDR item or service (such as those endorsed by the consensus-based entity authorized in section 1890 of the Social Security Act).

(2) The market share held by the provider or facility or that of the plan or issuer in the geographic region in which the qualified IDR item or service was provided.

(3) The acuity of the participant, or beneficiary, receiving the qualified IDR item or service, or the complexity of furnishing the qualified IDR item or service to the participant or beneficiary.

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INDEPENDENT DISPUTE RESOLUTION PROCESS. – 29 CFR § 2590.716-8

(c) Federal IDR process following initiation -
(4)(iii) Considerations in determination. In determining which offer to select, the certified IDR entity must consider:

(4) The teaching status, case mix, and scope of services of the facility that furnished the qualified IDR item or service, if applicable.

(5) Demonstration of good faith efforts (or lack thereof) made by the provider or facility or the plan or issuer to enter into network agreements with each other, and, if applicable, contracted rates between the provider or facility, as applicable, and the plan or issuer, as applicable, during the previous 4 plan years.

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From: Denise Griffith
Sent: Friday, December 17, 2021 3:33 PM
To: ian.bautista@
Cc: Ed Norwood <ednorwood@ernenterprises.org>
Subject: FW: ProTransport-1 Contract Proposal

Dear Mr. Bautista,

I hope you and your family are doing well.

On behalf of Covalent Health, we are excited to reach out to you regarding partnering with Blue Shield to provide ambulance services in the Northern California region. Attached is some documentation on Covalent Health/ProTransport-1 and the mutual benefits that would result from Blue Shield and Covalent Health partnering to provide ambulance services to Blue Shield members. Also attached is the Blue Shield contract you previously provided with some changes for your review.

We look forward to working with Blue Shield and would love to finalize a contract within the next couple of weeks. Please let me know if you have any questions.

Best,

Denise Griffith, Esq. (CA)
Director, Regulatory Affairs & Compliance | ERN
Office:714-995-6900 ext. 6924 | Direct:714-995-6914 | Fax

Reply | Reply All | Forward
Mon 8/22/2022 8:42 AM

Bautista, Ian
To Denise Griffith
Cc Safran, Joseph

Hi Denise,

Good Morning. Thanks for the follow-up.

I just returned from sabbatical, today and am playing catch-up. I will address this issue at my earliest available opportunity.

Thank You,

Ian Bautista
Network Manager – Ancillary & Specialty Networks
Email: ian.bautista
Ph:
Fax:

blue california

From: Denise Griffith <denisegriffith@ernenterprises.org>
Sent: Friday, August 5, 2022 8:59 AM

72

73

ERN
NCRA

MA ORGANIZATIONS ARE FINANCIALLY RESPONSIBLE FOR POSTSTABILIZATION CARE SERVICES WHEN...

- They have been approved
- You render services within 1 hour of your request
- They did not respond your request after one hour, they cannot be contacted, and the plan physician cannot reach an agreement about the enrollee's care

MA ORGANIZATIONS ARE FINANCIALLY RESPONSIBLE FOR POSTSTABILIZATION CARE SERVICES WHEN...

- A plan physician assumes responsibility for the enrollee's care at the treating facility OR through transfer
- An MA organization representative and the treating physician reach an agreement about the enrollee's care
- OR the enrollee is discharged

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POLICY CHALLENGE:
CENTER FOR MEDICARE AND MEDICAID SERVICES

DID YOU KNOW?

MA plans are failing to preapprove care within the statutorily required one (1) hour and then denying claims for medical necessity—**even if ordered by a plan provider**.

Authority: 42 CFR §422.113 (See 42 CFR 438.114(e) for Medicaid)

FEDERAL REGISTER VOLUME 63, NUM 123:

"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. 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."

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POLICY CHALLENGE:
CENTER FOR MEDICARE AND MEDICAID SERVICES

WHAT CAN YOU DO?

Once the beneficiary is admitted and the 1-hour time for the MA to respond has lapsed, the continuity of the patient's care is the utmost concern, and the MA plan is discouraged from disrupting care that could have an adverse impact to the beneficiary.

- Vigorously defend retrospective denials after patient discharge in light of 422.113 (c)(3), which states: The MA organization's financial responsibility for post-stabilization care services it has not **pre-approved ends when - (iv) The enrollee is discharged.**
- Flag all MA plans conducting retrospective medical reviews and conducting post discharge medical necessity denials, and run a report showing (by Plan), # of beneficiary claims denied improperly, and # of uncompensated dollars effected.
- Notify ERN to determine next steps for escalation to the appropriate plan and/or regulatory agency.

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when:

- The MAO does not respond to a request for pre-approval within one hour;
- The MAO cannot be contacted; or
- The MAO 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 MAO must give the treating physician the opportunity to consult with a plan physician. The treating physician may continue with care of the patient until a plan physician is reached or one of the criteria below is met.)

20.5.3 – End of Post-Stabilization

The MAO's financial responsibility for post-stabilization care services it has not pre-approved ends when:

- A plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care;
- A plan physician assumes responsibility for the enrollee's care through transfer;
- An MAO representative and the treating physician reach an agreement concerning the enrollee's care; or
- The enrollee is discharged.

When a treating physician is contracted with the plan, CMS views him or her as a the plan for purposes of our rules and guidance. The rules above are intended for enrollee protection and guidance to plans for working with out-of-network providers. When we address "financial responsibility," we are referring to a plan's obligation to pay for (cover) the enrollee's services. That includes out-of-network providers, because those providers can bill enrollees if the plan denies their coverage/billing.

ABN(?)

Except under very limited circumstances, enrollees cannot be liable for in-network services, and therefore would not otherwise have an appealable interest – see 42 C.F.R. 422.562(c)(2). A network provider may not "stand in the shoes" of an enrollee by signing a waiver of liability (WOL) under the subpart M appeals process, but rather must follow the terms of his or her provider/plan contract.

individual physician contracted w/ SCAN (MA)

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- *Temporarily reduce plan-approved out-of-network cost-sharing to in-network cost-sharing amounts; and*
- *Waive the 30-day notification requirement to enrollees as long as all the changes (such as reduction of cost-sharing and waiving authorization) benefit the enrollee.*

Typically, the source that declared the disaster will clarify when the disaster or emergency is over. If, however, the disaster or emergency timeframe has not been closed 30 days from the initial declaration, and if CMS has not indicated an end date to the disaster or emergency, plans should resume normal operations 30 days from the initial declaration. MAOs not able to resume normal operations after 30 days should notify CMS.

MAOs must disclose their policies about providing benefits during disasters on their plan websites.

If the President has declared a major disaster or the Secretary has declared a public health emergency, MAOs must follow the guidance in chapter 5 of the Prescription Drug Benefit Manual, regarding refills of Part D medications. The Prescription Drug Benefit Manual may be found at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/Pub100_18.pdf.

160 – *Beneficiary Protections Related to Plan-Directed Care*
(Rev. 121, Issued: 04-22-16, Effective: 04-22-16, Implementation: 04-22-16)

Organization Determinations: An enrollee, or a provider acting on behalf of the enrollee, always has the right to request a pre-service organization determination if there is a question as to whether an item or service will be covered by the plan. If the plan denies an enrollee's (or his/her treating provider's) request for coverage as part of the organization determination process, the plan must provide the enrollee (and provider, as appropriate) with the standardized denial notice (Notice of Denial of Medical Coverage (or Payment)/CMS-10003). For the requirements related to organization determinations and issuance of the standardized denial notice (CMS-10003), see chapter 13 of the MMCM located at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c13.pdf.

Limitations on Enrollee Liability: CMS considers a contracted provider an agent of the MAO offering the plan. As stated in the preamble to the January 28, 2005 final rule (CMS-4069-F):

"MA organizations have a responsibility to ensure that contracting physicians and providers know whether specific items and services are covered in the MA plan in which their patients are enrolled. If a network physician furnishes a service or directs an MA beneficiary to another provider to receive a plan-covered service without following the plan's internal procedures (such as obtaining the appropriate plan pre-authorization),

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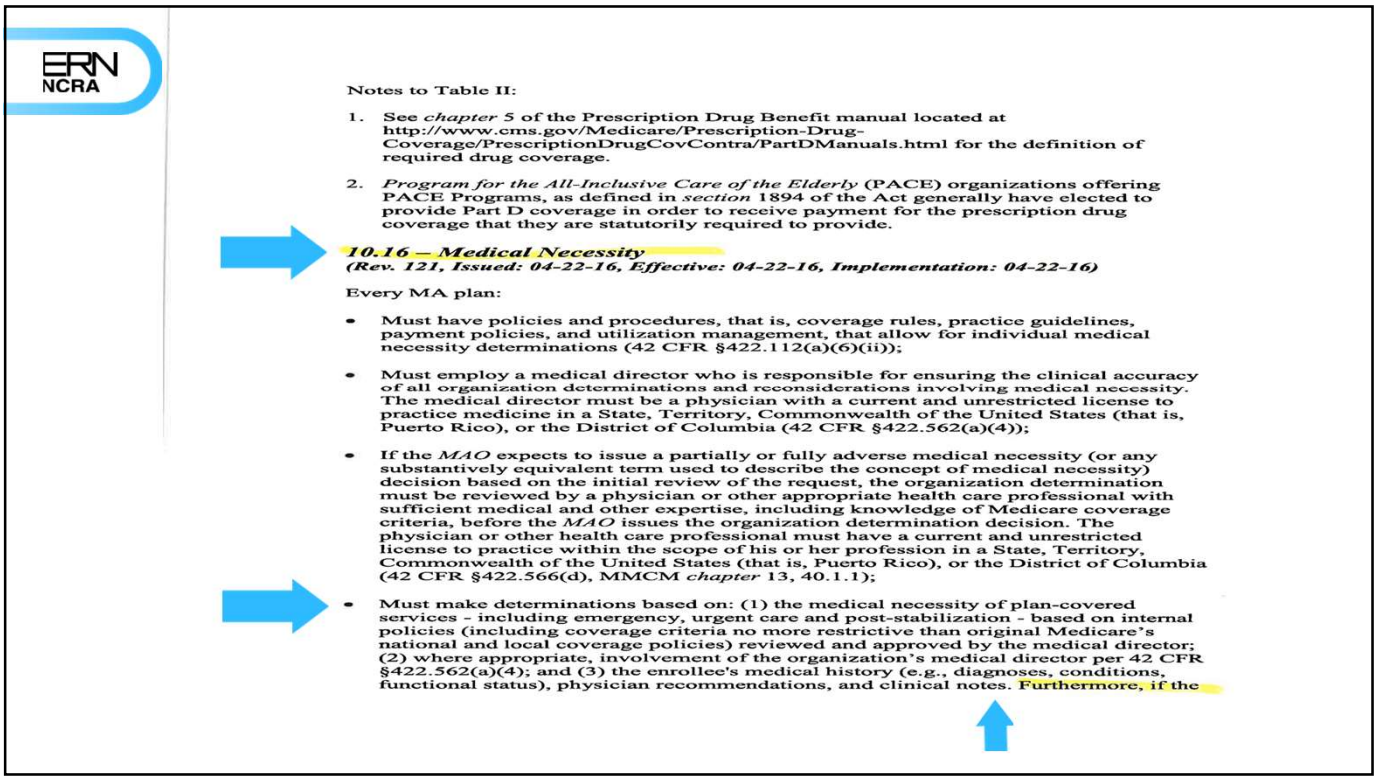

Notes to Table II:

1. See *chapter* 5 of the Prescription Drug Benefit manual located at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartDManuals.html for the definition of required drug coverage.

2. *Program for the All-Inclusive Care of the Elderly* (PACE) organizations offering PACE Programs, as defined in *section* 1894 of the Act generally have elected to provide Part D coverage in order to receive payment for the prescription drug coverage that they are statutorily required to provide.

10.16 – Medical Necessity
(Rev. 121, Issued: 04-22-16, Effective: 04-22-16, Implementation: 04-22-16)

Every MA plan:

- Must have policies and procedures, that is, coverage rules, practice guidelines, payment policies, and utilization management, that allow for individual medical necessity determinations (42 CFR §422.112(a)(6)(ii));
- Must employ a medical director who is responsible for ensuring the clinical accuracy of all organization determinations and reconsiderations involving medical necessity. The medical director must be a physician with a current and unrestricted license to practice medicine in a State, Territory, Commonwealth of the United States (that is, Puerto Rico), or the District of Columbia (42 CFR §422.562(a)(4));
- If the *MAO* expects to issue a partially or fully adverse medical necessity (or any substantively equivalent term used to describe the concept of medical necessity) decision based on the initial review of the request, the organization determination must be reviewed by a physician or other appropriate health care professional with sufficient medical and other expertise, including knowledge of Medicare coverage criteria, before the *MAO* issues the organization determination decision. The physician or other health care professional must have a current and unrestricted license to practice within the scope of his or her profession in a State, Territory, Commonwealth of the United States (that is, Puerto Rico), or the District of Columbia (42 CFR §422.566(d), MMCM *chapter* 13, 40.1.1);
- 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; (2) where appropriate, involvement of the organization's medical director per 42 CFR §422.562(a)(4); and (3) the enrollee's medical history (e.g., diagnoses, conditions, functional status), physician recommendations, and clinical notes. Furthermore, if the

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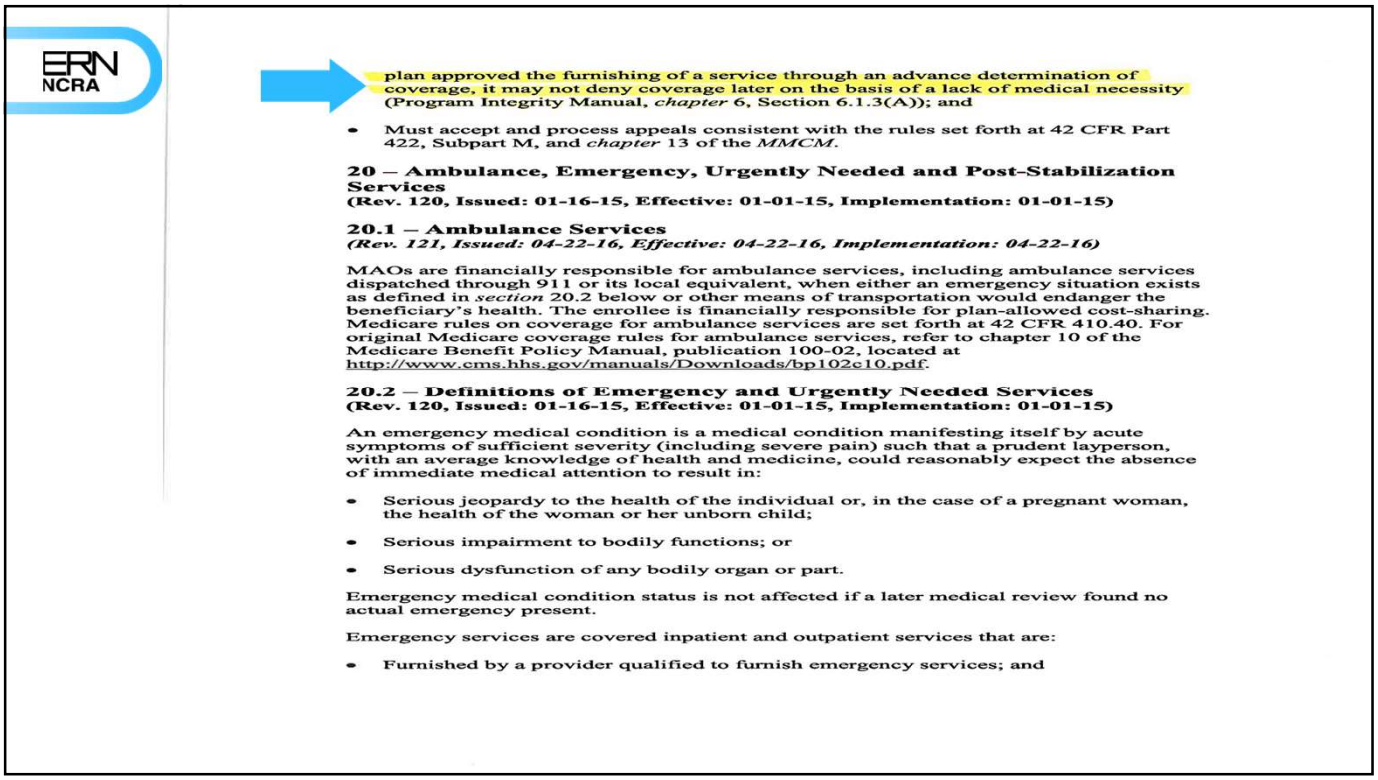

plan approved the furnishing of a service through an advance determination of coverage, it may not deny coverage later on the basis of a lack of medical necessity (Program Integrity Manual, *chapter* 6, Section 6.1.3(A)); and

- Must accept and process appeals consistent with the rules set forth at 42 CFR Part 422, Subpart M, and *chapter* 13 of the *MMCM*.

20 – Ambulance, Emergency, Urgently Needed and Post-Stabilization Services
(Rev. 120, Issued: 01-16-15, Effective: 01-01-15, Implementation: 01-01-15)

20.1 – Ambulance Services
(Rev. 121, Issued: 04-22-16, Effective: 04-22-16, Implementation: 04-22-16)

MAOs are financially responsible for ambulance services, including ambulance services dispatched through 911 or its local equivalent, when either an emergency situation exists as defined in *section* 20.2 below or other means of transportation would endanger the beneficiary's health. The enrollee is financially responsible for plan-allowed cost-sharing. Medicare rules on coverage for ambulance services are set forth at 42 CFR 410.40. For original Medicare coverage rules for ambulance services, refer to chapter 10 of the Medicare Benefit Policy Manual, publication 100-02, located at http://www.cms.hhs.gov/manuals/Downloads/bp102c10.pdf.

20.2 – Definitions of Emergency and Urgently Needed Services
(Rev. 120, Issued: 01-16-15, Effective: 01-01-15, Implementation: 01-01-15)

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency medical condition status is not affected if a later medical review found no actual emergency present.

Emergency services are covered inpatient and outpatient services that are:

- Furnished by a provider qualified to furnish emergency services; and

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- Internal CMS communication between Kimberly August, Tamara Harvey, and Aimee Reich regarding the applicability of the Medicare Managed Care Manual for contracted versus non-contracted providers.

In addition to the substantial delay in responding to this FOIA request consistent with **45 CFR Part 5 (Freedom of Information Regulations)**, CMS did not provide any documentation that satisfies the above requests. Further, pertaining to items I-IV, CMS did not indicate which documents relate to the above requests, nor did they state to those unanswered, "No records responsive to this request." (See Exhibit A – FOIA Response Letter.)

As you know, federal law requires FOIA requests to be fulfilled within 20 business days. As it appears that none of the provided documents address the requested information, this FOIA request has not been concluded and is now **120 business days past due.**

II. THE REGULATIONS PRESCRIBED UNDER 42 CFR PART 422 APPLY TO BOTH CONTRACTED AND NON-CONTRACTED PROVIDERS.

Included in CMS' response to our July 9, 2018 FOIA request is an internal CMS email which attempts to misconstrue a contracted provider's rights prescribed under **42 CFR Part 422, Subpart C, Sections 100 - 134**. As stated in this email, CMS maintains the position that "these rules and appeal rights are for enrollees and out-of-network providers – not ***contracted*** providers."

While Subpart M Appeal rights (422 CFR §560-626) may not apply to contracted providers, the legislative intent of **42 CFR Part 422, Subpart C - Benefits and Beneficiary Protections (§§ 422.100 - 422.134)** (which includes §422.113) does, as this Subpart includes specific details governing the role of contracted providers within a MAO. For instance, **42 CFR §422.112(a)(1)(i)** states that Medicare Advantage Organizations must "*maintain and monitor a network of appropriate providers that is **supported by written agreements** and is sufficient to provide adequate access to covered services to meet the needs of the population served.*" Further, **42 CFR §422.112(a)(9)** states the MAOs must also "*provide coverage for ambulance services, emergency and urgently needed services, and **post-stabilization care services in accordance with §422.113***."

As the above cited regulations expressly define the relationship between MAOs and contracted providers, including the provision of statutory payment obligations pursuant to **42 CFR §422.133**, it is improbable that this section of law is only intended to apply to non-contracted providers.

In addition, SCAN's application of Traditional Medicare regulations to support payment of claims for Medicare Advantage claims is inappropriate. Please note, with Traditional Medicare an authorization is not required and if there is any retrospective review, the provider protects themselves by informing the patient prior to services that Medicare may not cover a service and not pay for that service and have the patient sign an Advanced Beneficiary Notice of Non-coverage ("ABN") protecting the hospital if Medicare should deem an inpatient admission or post-stabilization services not medically necessary.

The CMS publication titled "*Improper Use of Advance Notices of Non-coverage*" dated May 5, 2014 provides further evidence that the statutory timeframes to approve or deny post-stabilization services apply to both contracted and non-contracted providers.

In its guidance, CMS states that an Advance Beneficiary Notice of Non-coverage (ABN) is not to be used by MAOs because "a Medicare Advantage enrollee has always had the right under the statute and regulations to an advance determination of whether services are covered prior to receiving such services." (See Exhibit B – Improper Use of ABNs.) From this verbiage and in the context of post-stabilization services, a logical inference would be that the right to an advance determination (e.g. pre-approval) of covered services is prescribed and protected by **42 CFR 422.113(c)(2)**. If these regulations did not apply to contracted MA providers, there would be no way of obtaining an advance determination of covered services prior to rendering care, and thus eliminating a provider's ability to notify MA beneficiaries receiving post-stabilization services of potential financial liability.

III. PER CMS POLICY, CONTRACTED PROVIDERS ARE CONSIDERED AGENTS OF THE PLAN.

Per CMS commentary included in its response to our July 9, 2018 FOIA request, "When a treating physician is contracted with the plan, CMS views him or her **as the plan** for purposes of our rules and guidance." (See Exhibit C – FOIA Response, pg. 2) Thus, as CMS considers a contracted provider to be a plan provider, the contracted provider's determination constitutes a "favorable organization decision."

This premise is supported through various CMS publications and opinions. For example, the CMS CDAG/ODAG guidance published September 4, 2013 (See Exhibit D – CDAG/ODAG Updates.) states that "The provision of an item or service by a **contract provider constitutes a favorable organization determination**."

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SOFFER, MICHAEL J MD

Provider data updated on 12-31-2018

Email Results Download Print

Specialty(s): PULMONOLOGY

Provider ID: 26042

Gender: Male

9001 WILSHIRE BLVD
STE 100
BEVERLY HILLS, CA 90211
310-691-1138

+ HERITAGE PROVIDER NETWORK REGAL MEDICAL GROUP LOS ANGELES
#0449 0 Network Hospitals 11 Plans 1 Specialty

TUN, TIN MD

Provider data updated on 12-31-2018

Email Results Download Print

Specialty(s): INTERNAL MEDICINE

Provider ID: 30750

Language(s): Burmese

Gender: Male

1031 E LATHAM AVE
STE 1
HEMET, CA 92543
951-929-3987

+ PRIMECARE HEMET
#0701 0 Network Hospitals 11 Plans 1 Specialty

Who are the treating physicians or provider - are they contracted with the MAO?

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CASE STUDY
CONTRACTED PROVIDERS AGENTS OF THE PLAN

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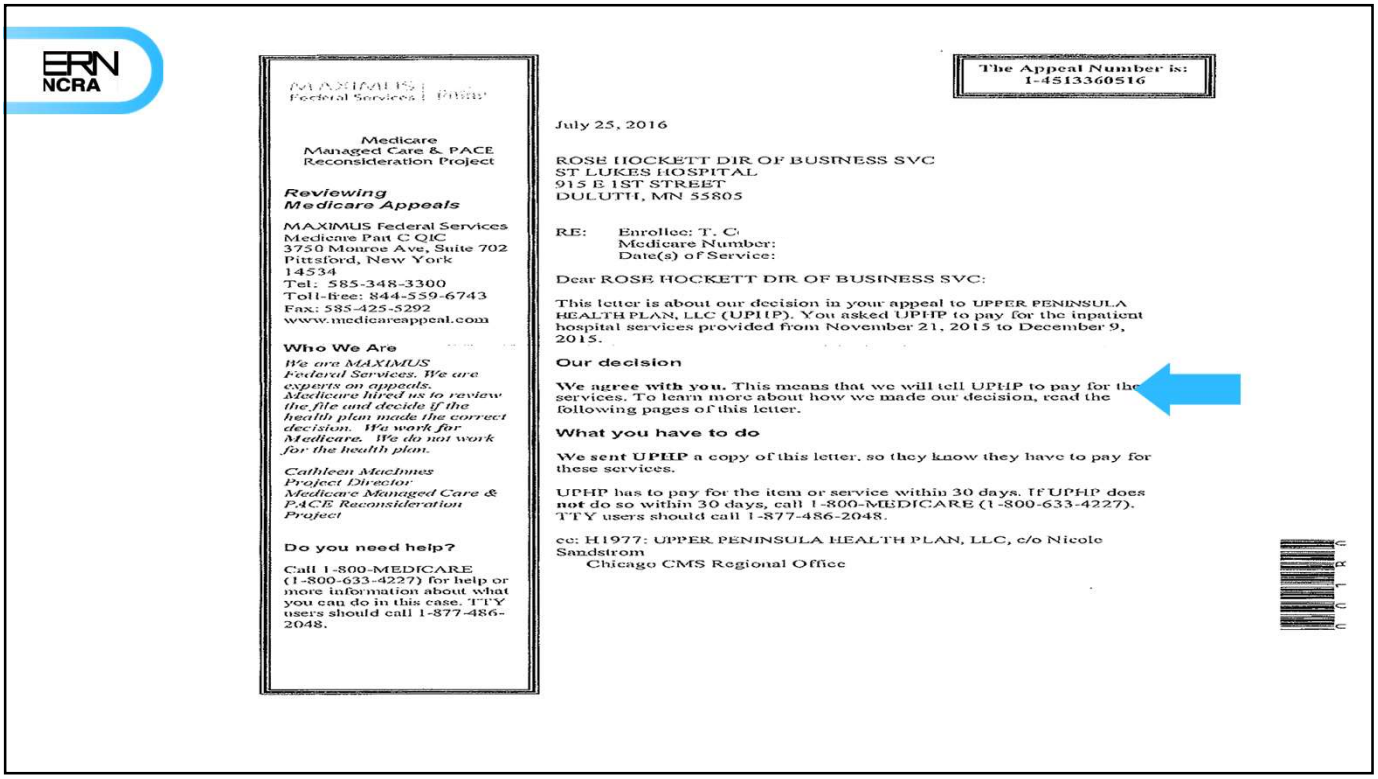
ERN
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Medicare
Managed Care & PACE
Reconsideration Project
Reviewing
Medicare Appeals
MAXIMUS Federal Services
Medicare Part C QIC
3750 Monroe Ave, Suite 702
Pittsford, New York
14534
Tel: 585-348-3300
Toll-free: 844-559-6743
Fax: 585-425-5292
www.medicareappeal.com
Who We Are
We are MAXIMUS Federal Services. We are experts on appeals. Medicare hired us to review the file and decide if the health plan made the correct decision. We work for Medicare. We do not work for the health plan.
Cathleen Mechmes
Project Director
Medicare Managed Care & PACE Reconsideration Project
Do you need help?
Call 1-800-MEDICARE (1-800-633-4227) for help or more information about what you can do in this case. TTY users should call 1-877-486-2048.
The Appeal Number is:
1-4513360516
July 25, 2016
ROSE HOCKETT DIR OF BUSINESS SVC
ST LUKES HOSPITAL
915 E 1ST STREET
DULUTH, MN 55805
RE: Enrollee: T. C
Medicare Number:
Date(s) of Service:
Dear ROSE HOCKETT DIR OF BUSINESS SVC:
This letter is about our decision in your appeal to UPPER PENINSULA HEALTH PLAN, LLC (UPHP). You asked UPHP to pay for the inpatient hospital services provided from November 21, 2015 to December 9, 2015.
Our decision
We agree with you. This means that we will tell UPHP to pay for the services. To learn more about how we made our decision, read the following pages of this letter.
What you have to do
We sent UPHP a copy of this letter, so they know they have to pay for these services.
UPHP has to pay for the item or service within 30 days. If UPHP does not do so within 30 days, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
cc: H1977: UPPER PENINSULA HEALTH PLAN, LLC, c/o Nicole Sandstrom
Chicago CMS Regional Office

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How we made our decision

1. We read all the papers in the file.
2. We checked Medicare rules.
3. We checked the contract with UPHP.

To make our decision we read all the papers in the file very carefully. We used the Medicare rules. We looked to see if UPHP correctly followed Medicare rules and regulations.

Medicare rules say that the health plan must give the member a subscriber agreement. It is a contract between the health plan and the member. It is usually called the "Evidence of Coverage" (EOC) or "Member Agreement." We read this contract carefully to see what UPHP is supposed to cover.

Medicare rules

The rules say that health plans must pay for a medical service or item if regular Medicare would pay for it in this case. You can find this rule at 42 CFR §422.101.

The rules say that a Medicare health plan may restrict members to a network of providers as long as medically necessary covered care is accessible and available through this network. The rules say that the health plan must arrange for specialty care outside of the plan provider network when network providers are unavailable or inadequate to meet a member's medical needs. You can find this rule at 42 CFR §422.112.

The rules say that a Medicare Health Plan is financially responsible for emergency services regardless of whether the services are obtained within or outside the Health Plan. Emergency services are covered whether there is prior authorization for the services. An emergency is defined as when a person would believe that without immediate medical attention there would be serious jeopardy to his or her health. You can find this rule at 42 CFR §422.113.

The rules say that a contract plan provider is an agent of the plan. Services and referrals obtained from a plan provider are viewed as plan-approved unless notice is given that the services will not be covered. When a plan provider gives, or refers an enrollee for, a service that the enrollee reasonably believes is covered by the plan, the enrollee is held harmless and need not pay more than the plan-allowed cost-sharing for that service. You can find this rule at Medicare Managed Care Manual Ch. 4 §170.

If you want to read these Medicare rules, you can go to this web site www.medicareappeal.com.

The health plan contract

The health plan contract says that UPHP covers items and services in accordance with Medicare rules. The health plan contract says that members must use network (contract) providers to get their covered services. The only exceptions are emergencies, urgently needed care when contract

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admission to St. Luke's Hospital was emergent, the health plan would have to show that the emergency care ended at some point prior to discharge. The health plan has made no argument that T. C r was stable for discharge or transfer at any time between his emergency admission to St. Luke's Hospital on November 21, 2015 and his discharge on December 9, 2015.

Even if we assume that UPHP was incorrect in its determination that the admission to St. Luke's Hospital was emergent or that T. C received post-stabilization care at St. Luke's Hospital prior to discharge, we find that the transfer to St. Luke's Hospital was plan directed care. T. C was transferred to St. Luke's Hospital at the request of the plan contract hospital, Aspirus Grand View Hospital, because the plan contract hospital did not have adequate facilities to meet T. C r's medical needs. The file does not show that UPHP's contract provider, Aspirus Grand View Hospital, requested prior authorization of this referral, advised you that T. C was a UPHP enrollee, or informed you of the need to notify UPHP of this transfer. However, under Medicare rules, referrals given by a contract provider are considered approved by the plan unless notice is provided that the services will not be covered. Since neither Aspirus Grand View Hospital nor UPHP advised you that these services would not be covered, this transfer is considered plan-approved.

Therefore, we decided that UPHP has to pay for the inpatient hospital services provided from November 21, 2015 to December 9, 2015.

If UPHP does not agree with our decision, they can ask us to open a case again. We only open a case again if we believe there was a mistake or if there is new information to review. The health plan has to show us the mistake and/or send us the new information. **This does not happen often.** If we decide to open the case again, we will send you a letter.

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TIMELY DETERMINATIONS
MAOs –42 CFR §422.566

(a) Responsibilities of the MA organization.

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

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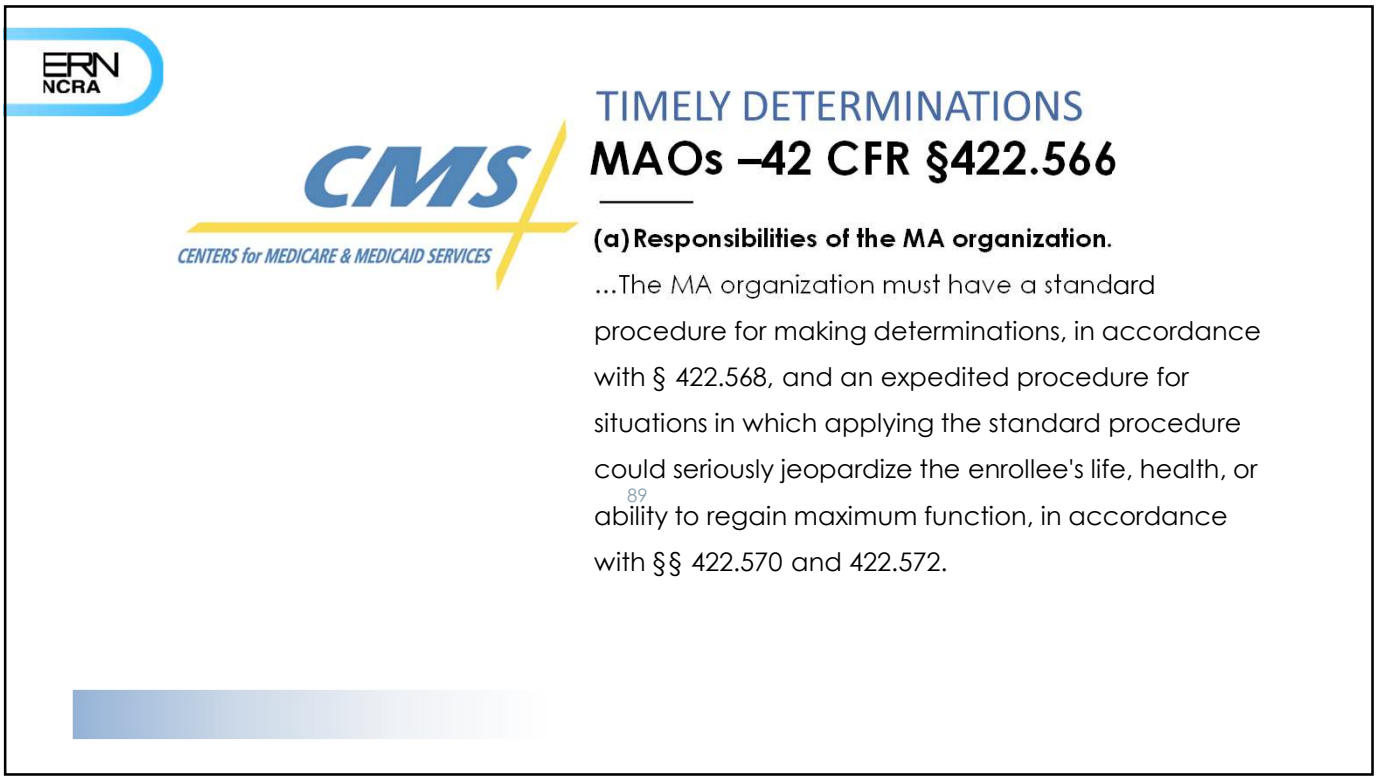
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TIMELY DETERMINATIONS
MAOs –42 CFR §422.566
(a) Responsibilities of the MA organization.
...The MA organization must have a standard procedure for making determinations, in accordance with § 422.568, and an expedited procedure for situations in which applying the standard procedure could seriously jeopardize the enrollee's life, health, or ability to regain maximum function, in accordance with §§ 422.570 and 422.572.
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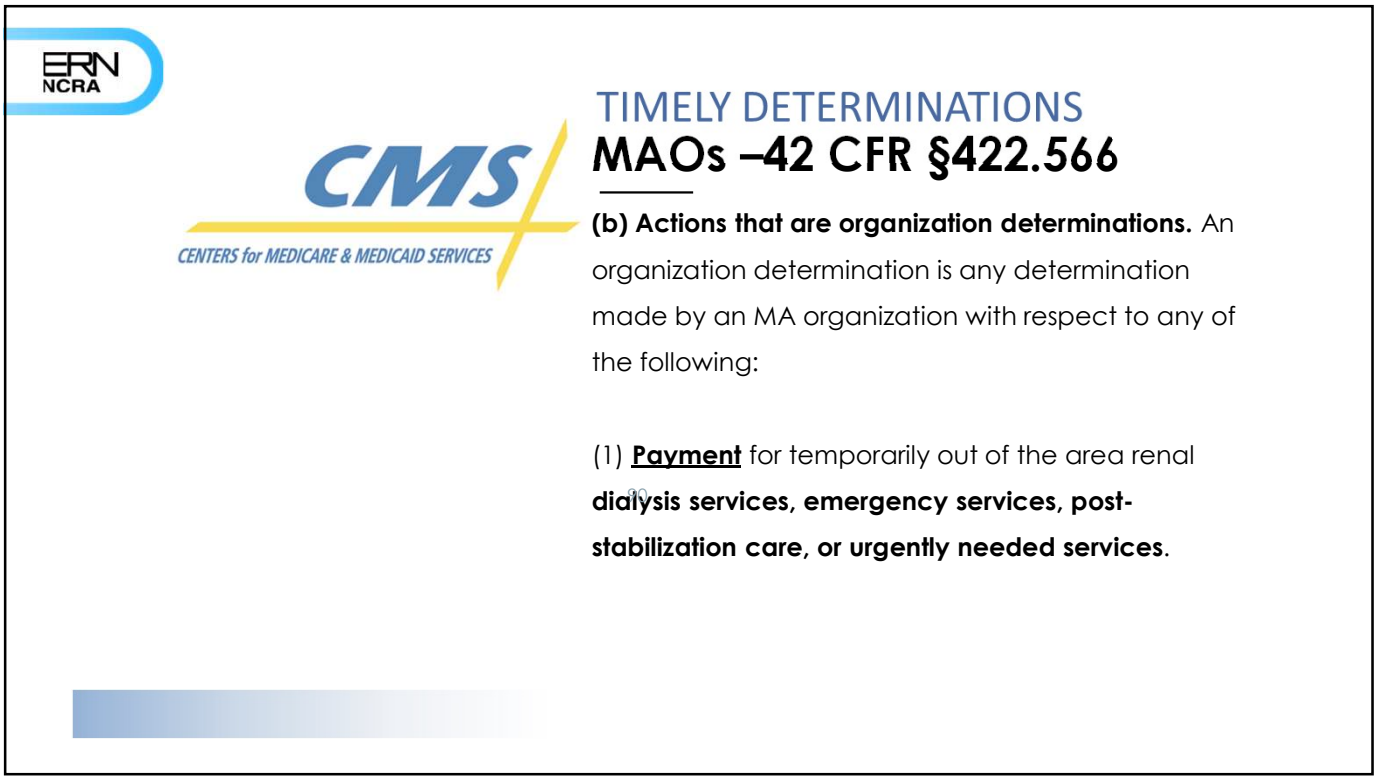
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TIMELY DETERMINATIONS
MAOs –42 CFR §422.566
(b) Actions that are organization determinations. An organization determination is any determination made by an MA organization with respect to any of the following:
(1) Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services.
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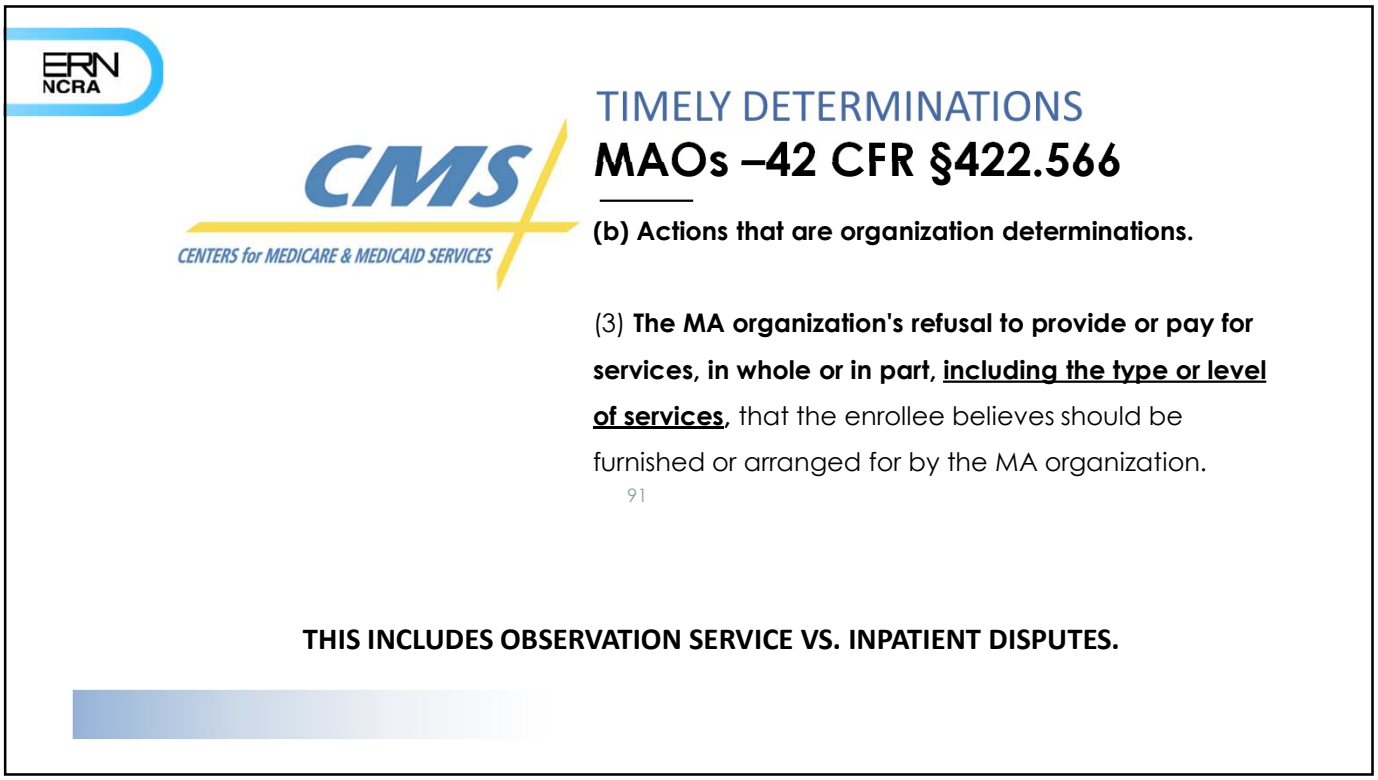
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TIMELY DETERMINATIONS
MAOs –42 CFR §422.566
(b) Actions that are organization determinations.
(3) The MA organization's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the MA organization.
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THIS INCLUDES OBSERVATION SERVICE VS. INPATIENT DISPUTES.

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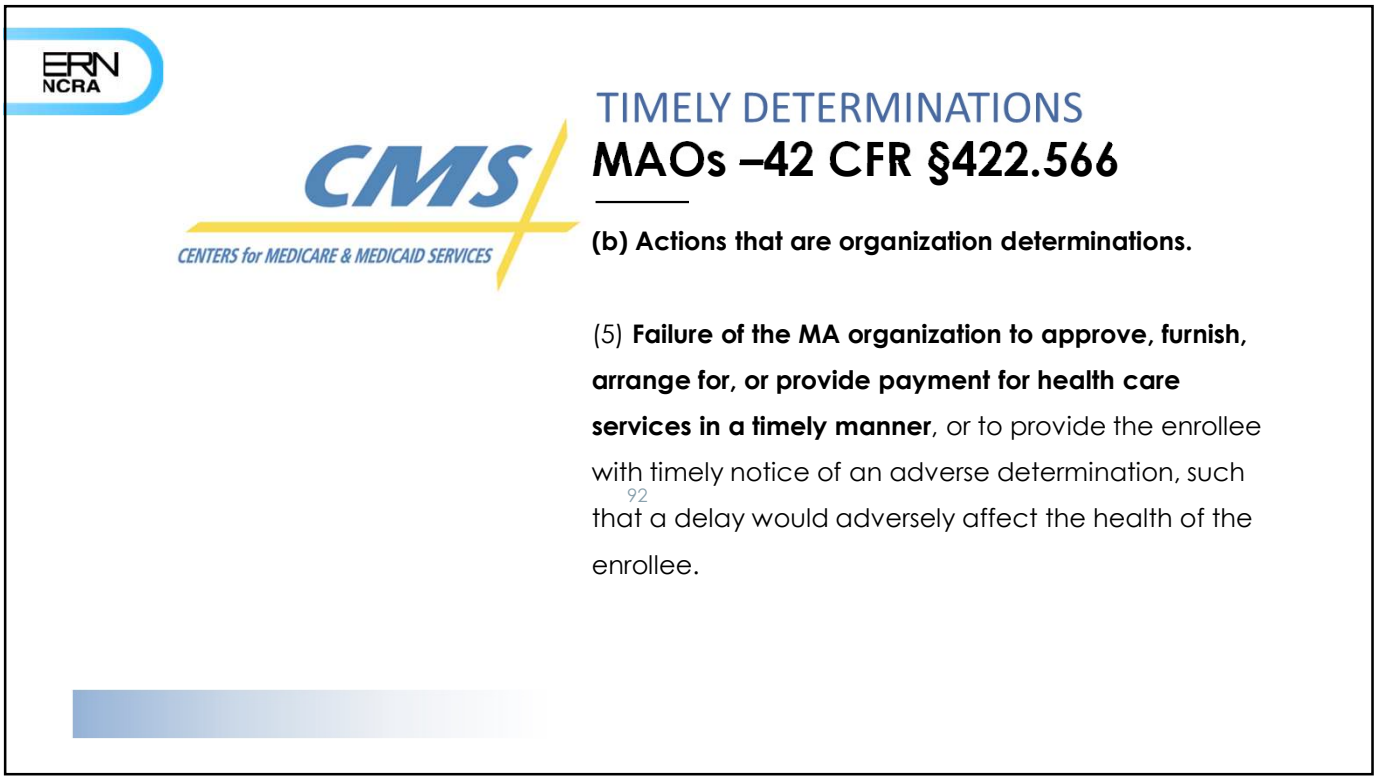
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CENTERS for MEDICARE & MEDICAID SERVICES
TIMELY DETERMINATIONS
MAOs –42 CFR §422.566
(b) Actions that are organization determinations.
(5) Failure of the MA organization to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.
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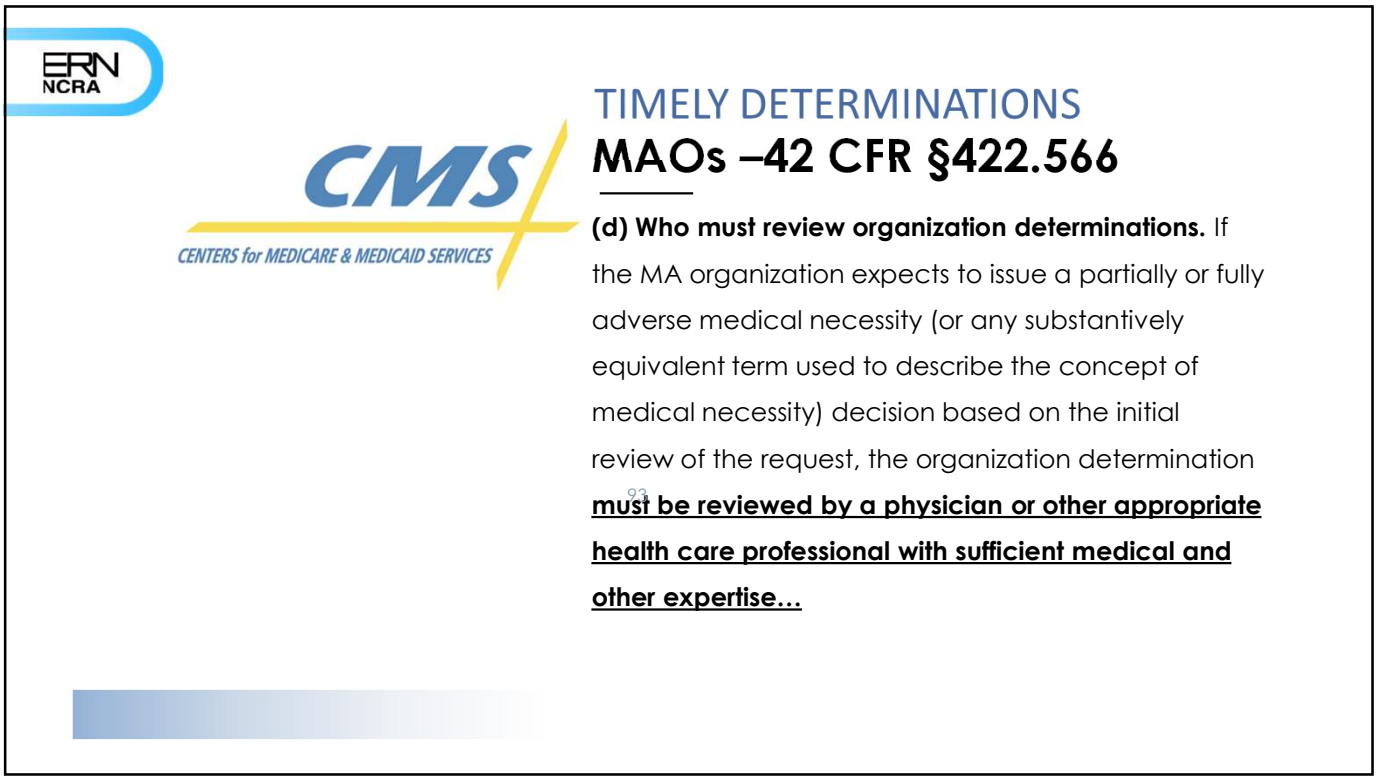
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CENTERS for MEDICARE & MEDICAID SERVICES
TIMELY DETERMINATIONS
MAOs –42 CFR §422.566
(d) Who must review organization determinations. If the MA organization expects to issue a partially or fully adverse medical necessity (or any substantively equivalent term used to describe the concept of medical necessity) decision based on the initial review of the request, the organization determination must be reviewed by a physician or other appropriate health care professional with sufficient medical and other expertise…
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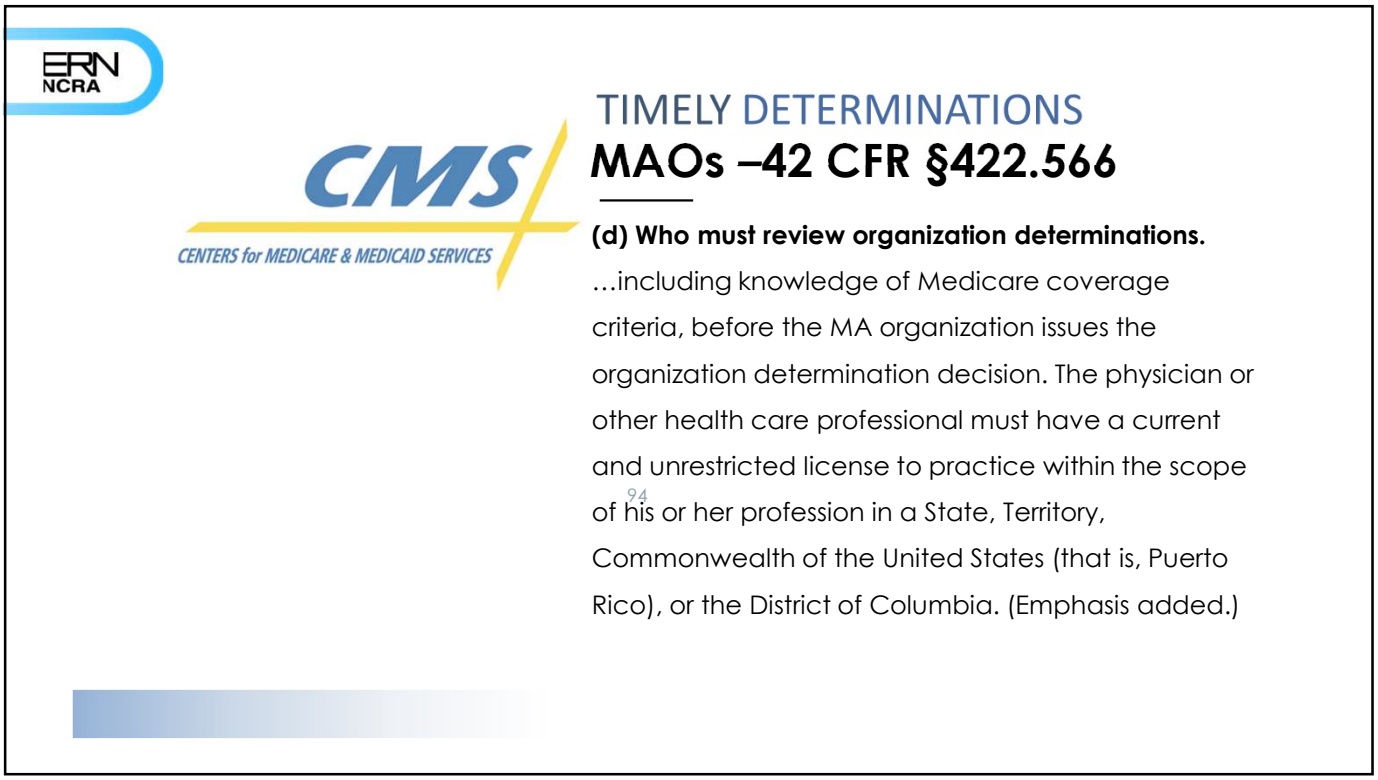
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TIMELY DETERMINATIONS
MAOs –42 CFR §422.566
(d) Who must review organization determinations.
…including knowledge of Medicare coverage criteria, before the MA organization issues the organization determination decision. The physician or other health care professional must have a current and unrestricted license to practice within the scope of his or her profession in a State, Territory, Commonwealth of the United States (that is, Puerto Rico), or the District of Columbia. (Emphasis added.)
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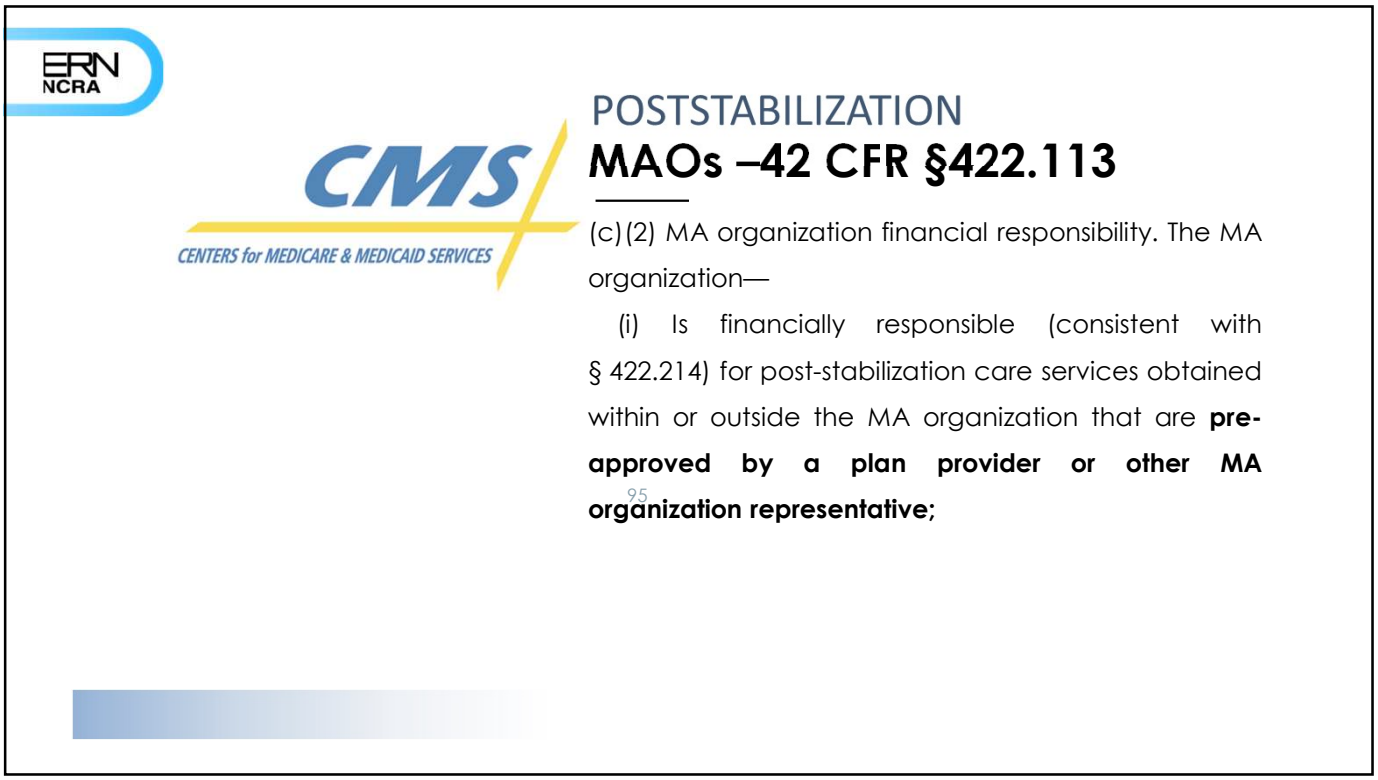
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CENTERS for MEDICARE & MEDICAID SERVICES
POSTSTABILIZATION
MAOs –42 CFR §422.113
(c)(2) MA organization financial responsibility. The MA organization—
(i) Is financially responsible (consistent with § 422.214) for post-stabilization care services obtained within or outside the MA organization that are **pre-approved by a plan provider or other MA organization representative;**
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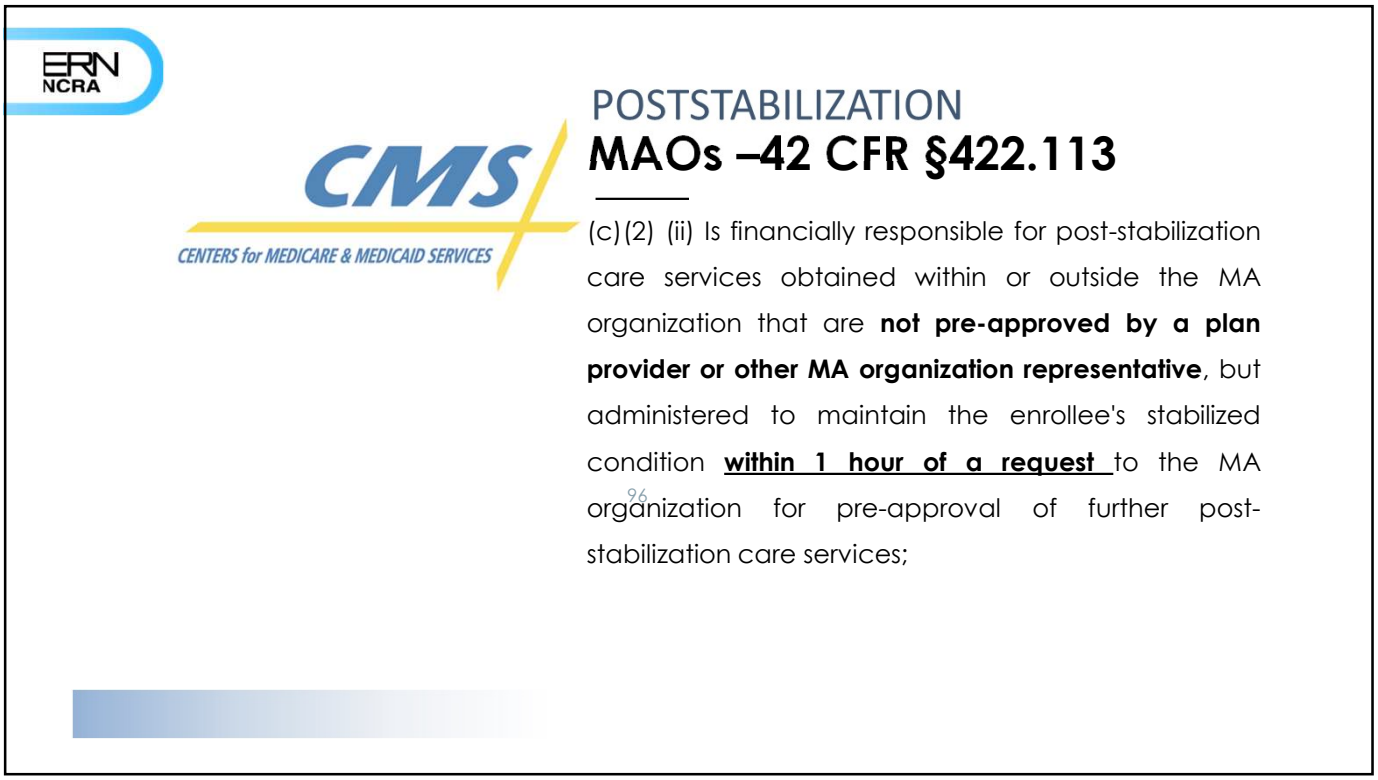
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CENTERS for MEDICARE & MEDICAID SERVICES
POSTSTABILIZATION
MAOs –42 CFR §422.113
(c)(2) (ii) Is financially responsible for post-stabilization care services obtained within or outside the MA organization that are **not pre-approved by a plan provider or other MA organization representative**, but administered to maintain the enrollee's stabilized condition **within 1 hour of a request** to the MA organization for pre-approval of further post-stabilization care services;
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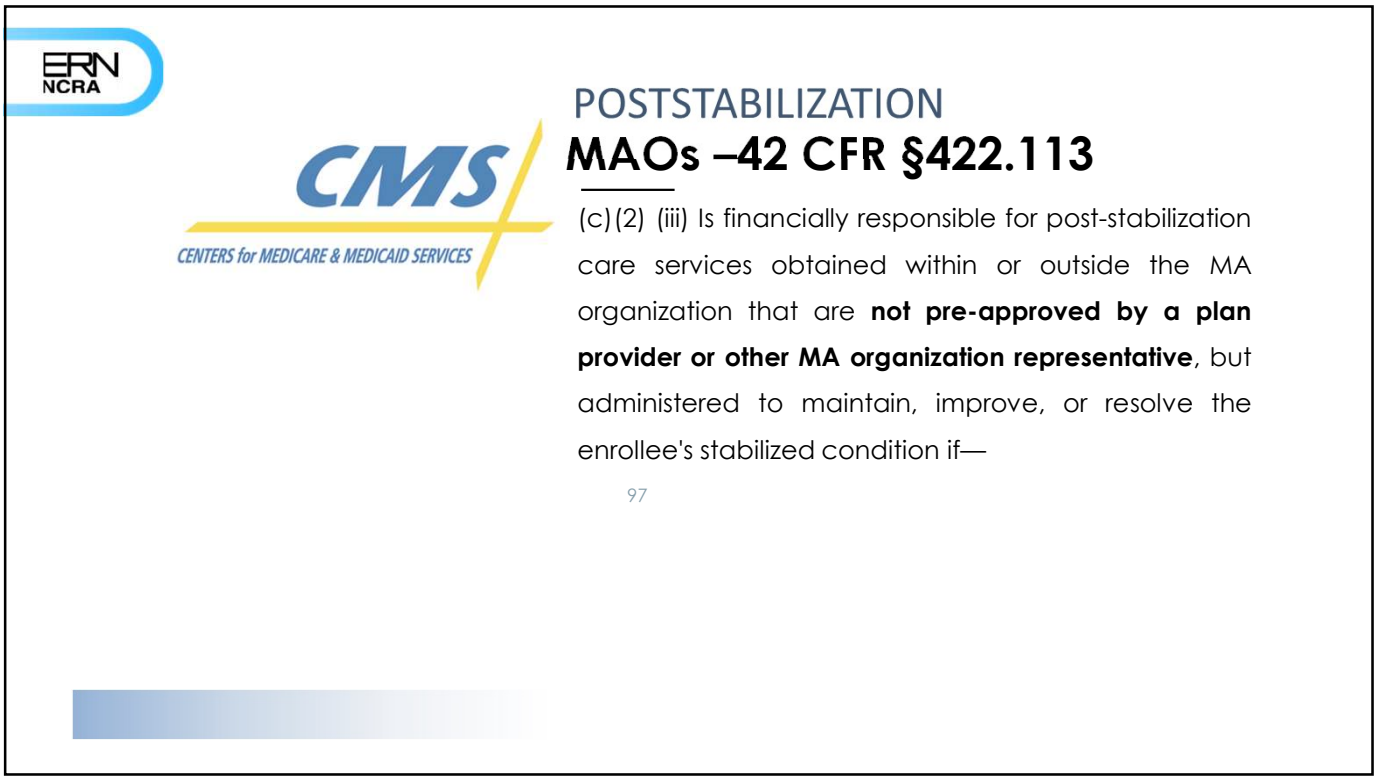
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CENTERS for MEDICARE & MEDICAID SERVICES
POSTSTABILIZATION
MAOs –42 CFR §422.113
(c)(2) (iii) Is financially responsible for post-stabilization care services obtained within or outside the MA organization that are **not pre-approved by a plan provider or other MA organization representative**, but administered to maintain, improve, or resolve the enrollee's stabilized condition if—
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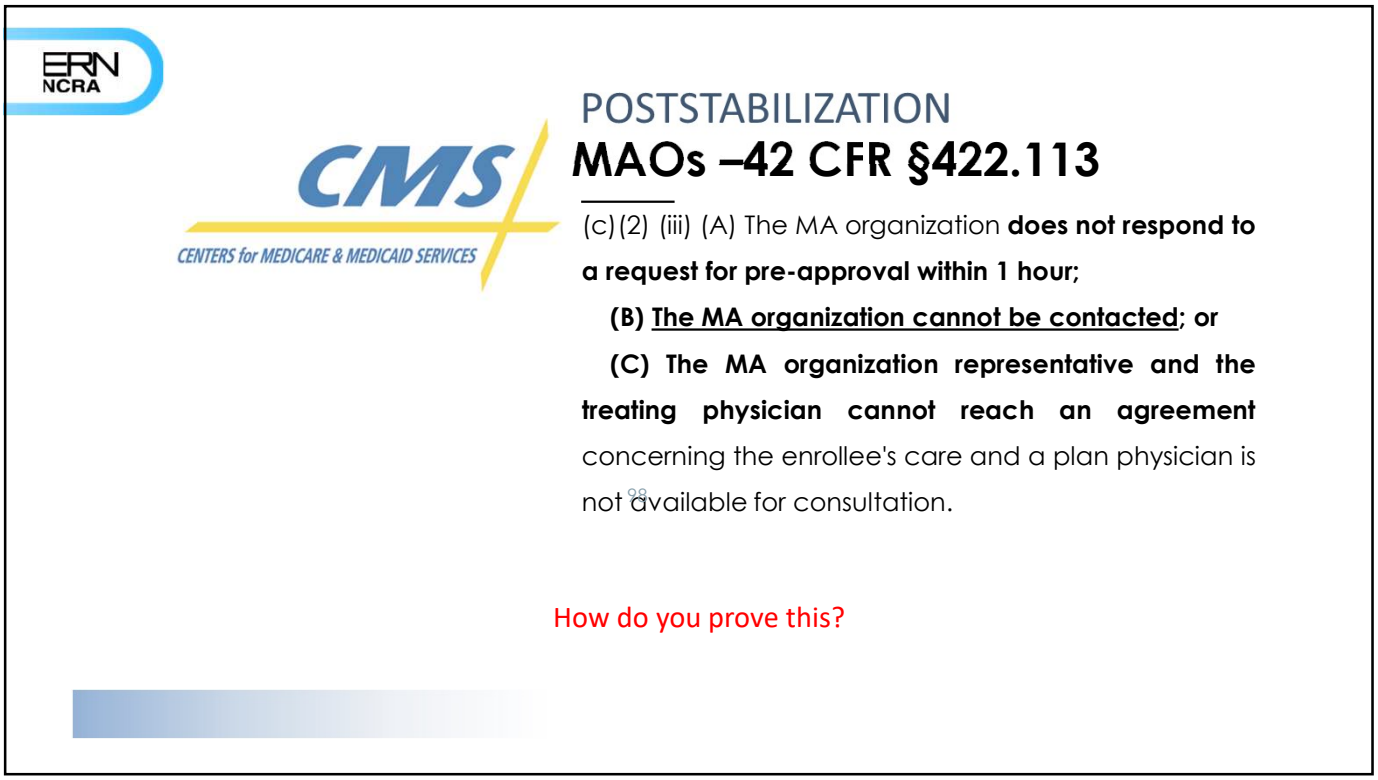
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POSTSTABILIZATION
MAOs –42 CFR §422.113
(c)(2) (iii) (A) The MA organization **does not respond to a request for pre-approval within 1 hour;**
(B) The MA organization cannot be contacted; or
(C) The MA organization representative and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultation.
98
How do you prove this?

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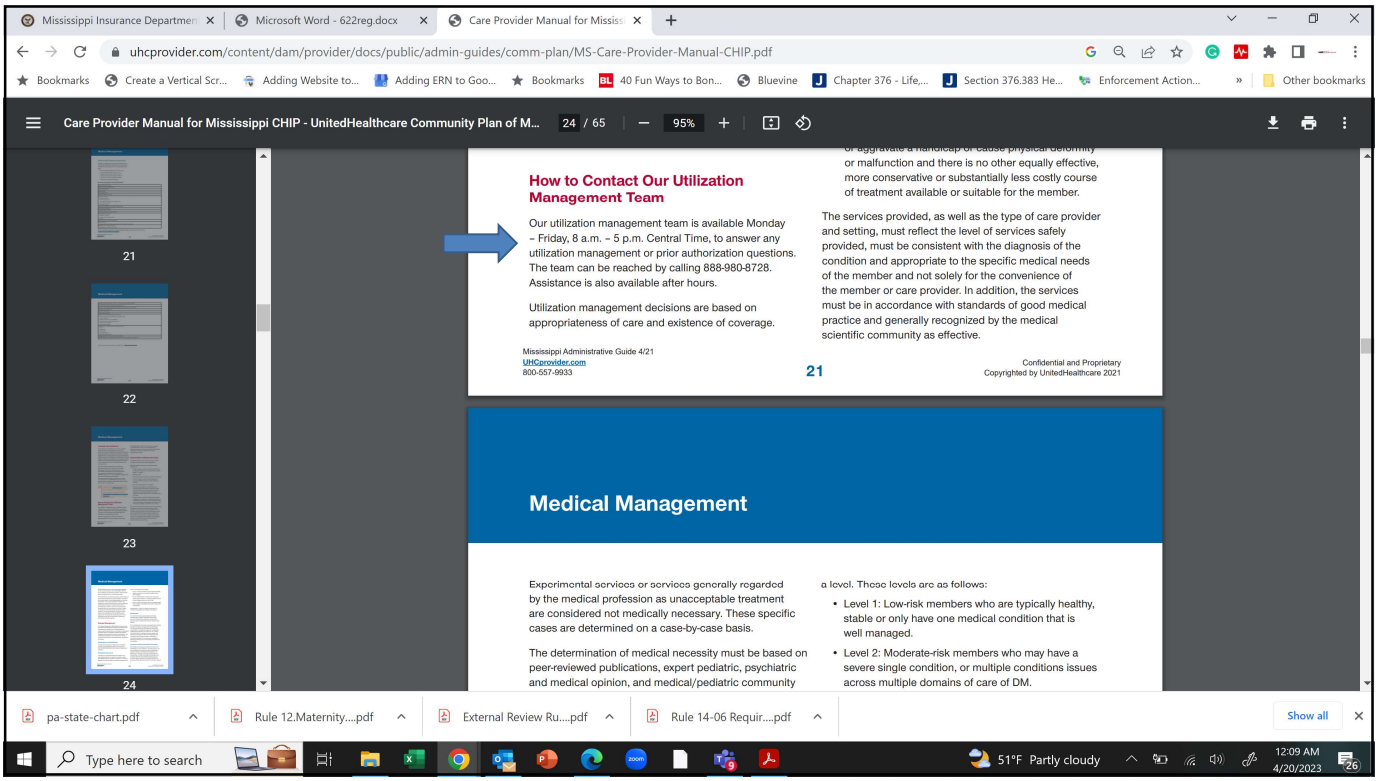

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CMS CENTERS for MEDICARE & MEDICAID SERVICES

POSTSTABILIZATION

MAOs –42 CFR §422.113

(c)(2) (iii) (C) In this situation, the MA organization must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient **until a plan physician is reached or one of the criteria in § 422.113(c)(3) is met**;

100

100

PEER TO PEER REVIEWS
MAOs –42 CFR §422.113

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

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

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

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

(iv) The enrollee is discharged.

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101

PEER TO PEER REVIEWS
MAOs –42 CFR §422.590

(h) Who must reconsider an adverse organization determination.

(1) A person or persons **who were not involved** in making the organization determination must conduct the reconsideration.

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PEER TO PEER REVIEWS
MAOs –42 CFR §422.590

(h)(2) When the issue is **the MA organization's denial of coverage based on a lack of medical necessity** (or any substantively equivalent term used to describe the concept of medical necessity), **the reconsidered determination must be made by a physician with expertise in the field of medicine that is appropriate for the services at issue**. The physician making the reconsidered determination need not, in all cases, be of the same specialty or subspecialty as the treating physician.

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HAVE YOU CREATED:

- Letter Libraries ☐
- Law Libraries ☐
- Blurb Libraries ☐
- Letter Libraries ☐
- Fax Cover Sheets with Laws ☐
- Registration Forms with Laws ☐
- Policies, Procedures, and Checklists ☐
- KPIs & Metrics (e.g. El Pollo Loco) ☐

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3. Flow Charts and Processes

ERN Recommended Front Cycle Process

Patient presents to ER.

Patient is asked to verify insurance information, usually with member ID card. Patient is asked about lifetime max, max per day/allowed amount, and capitated facilities.

Registrars fax a facesheet to the health plan as a notification that the patient is here and provide unit secretary with as detailed insurance information as possible, including eligibility printout.

Unit secretary makes contact to health plan by phone call and fax. Detailed notes of phone call(s) are taken in MediTech and fax confirmations are kept as documentation. See sample notes.

During patient stay, ER unit secretary enters all insurance contacts/interactions into MediTech (or enters the information into Pisces, which is then transferred to MediTech).

CMRC sends clinicals daily and follows up on any requests from the health plan.

If authorization denied outright for medical necessity, Care Management sends the case to Teresa who notifies Physician Advisor to conduct P2P. See mid cycle flow chart for process recommendations.

If authorization denied for medical records, Care Management sends email to appropriate CMRC. See mid cycle flow chart for process recommendations.

If P2P is denied, Physician Advisor requests a written concurrent denial via email/fax and sends NOD with Reasoning (for admission) to health plan to trigger the plan's responsibility to assume care of the patient. See mid cycle flow chart for process recommendations.

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

	Scenario	ERN Recommended Note/Rebuttal
F	POSTSTABILIZATION NOTIFICATION NOTES (by ED personnel)	Health Plan contacted: [NAME OF PLAN OR CONTRACTED PROVIDER e.g. Health Net of California, Inc.] Title/Department contacted: [PLAN OR CONTRACTED PROVIDER e.g. Health Net] Hospital Notification Unit Name of person spoke with (First & Last): John Doe Phone number first dialed: 800-995-7890 Phone number of last person spoke with/call back number/extension: [PHONE NUMBER AND EXTENSION] Date, start and end time of call: 2/26/2019, 10:32 AM-10:50 AM Authorization/tracking/reference number (if not given, then note): no authorization/tracking/reference number received. IF AUTHORIZATION WAS RECEIVED: How many days is this authorization for? What exactly is being authorized (e.g., emergency admission, appendectomy). Notes from call: Notified [NAME OF REPRESENTATIVE] at [NAME OF PLAN/CONTRACTED PROVIDER] of patient presenting to the ED, needing emergency admission and requested authorization as patient cannot be discharged safely.
F	NO HMO AUTHORIZATION WAS GIVEN (by ED and IV Personnel)	HMO: ___ Informed representative that under state law, they have 30 minutes from this call to make a decision to authorize care or arrange for transfer to another facility. No authorization/tracking/reference number was given during call (See 28 CCR §1300.71.4 (b)(1).) READ DISCLAIMER: "Please note that while you have issued a tracking/reference number for your patient, under existing CA law, plans are required, within 30 minutes from initial contact, to authorize poststabilization care or arrange for the prompt transfer of the enrollee to another hospital. This tracking/reference # does not satisfy your requirements under the law but constitutes that contact was made in the event we do not receive an authorization number from you within a half hour of this request. All services afterwards are deemed authorized (See 28 CCR 1300.71.4 (a-c), H&S 1262.8 (d)." REFERENCE UR FAX COVER SHEET/HMO/MAO CONTINUED FAILURE TO RESPOND FAX COVER SHEET FOR CMRC
F	NO MAO AUTHORIZATION WAS GIVEN (by ED AND IV Personnel)	MAO: ___ Informed representative that under federal law, they have sixty (60) minutes from this call to approve/disapprove care or arrange for transfer to another facility. No authorization/tracking/reference number was given during call (See 42 CFR 422.113 (c)(2)(iii)(C)). READ DISCLAIMER: Please note that while you have issued a tracking/reference number for your patient, under existing Medicare law, plans are required, within 60 minutes from initial contact, to pre-approve poststabilization care or assume care of the beneficiary (via transfer, or at our hospital if privileged). This tracking/reference # does not satisfy your requirements under the law but constitutes that contact was made in the event we do not receive an authorization number from you within one hour of this request. Your financial responsibility for post-stabilization care services it has not pre-approved ends when you assume care of the patient, reach an agreement with our treating physician/PA or the enrollee is discharged (See 42 CFR 422.113 (c)(3)).

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REQUEST FOR AUTHORIZATION TO PROVIDE POSTSTABILIZATION SERVICES

TO: FROM: JOE COMPLIANCE

FAX: PAGES:

PHONE: DATE:

RE: **REQUEST FOR AUTHORIZATION TO PROVIDE POSTSTABILIZATION SERVICES** CC:

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

At this time we are requesting authorization to provide post-stabilization services to your insured. **As the contracting medical provider or health care service plan, you have 30 minutes (60 minutes if you are an MA plan pursuant to 42 CFR §422.113) from receipt of this notification to provide an authorization, or make a decision to arrange transfer of the patient.** If you do not respond to this notification, or communicate an intent to transfer the patient and do not effectuate a transfer within a reasonable time, the post stabilization services shall be deemed authorized and shall be paid in accordance with the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2) and any regulation adopted thereunder or 42 CFR Part 422 and any regulation adopted thereunder. Please be advised that due to ER overflow concerns, **plans must effectuate transfer within 2 hours of notifying us of its intent to do so, or the patient will be admitted** and the plan will be responsible to reimburse for all services up to the time that transfer is effectuated pursuant to 28 CCR §1300.71.4(2).

Contact one of the following Case Managers to provide authorization for the statutorily deemed authorized services.

NAME (XXX) XXX-XXXX **NAME (XXX) XXX-XXXX** **NAME (XXX) XXX-XXXX**

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

If you need any further information, please contact: Care Coordination Department @ (xxx) xxx-xxxx or Fax (xxx) xxx-xxxx.
Insert confidentiality/HIPAA statement here -

2/27/19

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ERN NCRA

NOTIFICATION OF MAO DISAGREEMENT OF CARE

TO: FROM: JOE COMPLIANCE

FAX: PAGES:

PHONE: DATE:

RE: **NOTIFICATION OF MAO DISAGREEMENT OF CARE** CC:

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

Patient Admitted On (date/time), XXXXXX ("Health Plan") was notified that the above patient is stable after being treated in the ER and requires post-stabilization care. On (date/time) (Doctor Name) at Health Plan informed our physician during peer to peer review that Health Plan has denied further poststabilization care at our hospital. This notice serves as a formal **NOTICE OF DISAGREEMENT OF CARE under 42 CFR 422.113 (c)(3) which outlines the** *"End of MA organization's financial responsibility" and states: The MA organization's financial responsibility for post-stabilization care services it has* ***not pre-approved ends*** *when—*

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

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

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

(iv) The enrollee is ***discharged****.*

Under existing federal law, Medicare Advantage Plans are required to pay for all care up until they assume care of the patient, reach a peer to peer agreement, or the patient is discharged. Any peer to peer review denial of poststabilization services is an automatic decision/election to assume care of, or transfer the patient as soon as possible **pursuant to 42 CFR §422.113 (c) above.**

As of the above (date/time), Health Plan has failed to initiate assuming care of or transferring the patient. (Please be advised that for patients pending admission, if Health Plan fails to assume care of or transfer the patient within a reasonable time, the patient will be admitted to limit overflow and delays in our ER).

Contact one of the following Case Managers to effectuate transfer immediately and/or provide authorization for.

NAME (XXX) XXX-XXXX **NAME (XXX) XXX-XXXX** **NAME (XXX) XXX-XXXX**

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

If you need any further information, please contact: Care Coordination Department @ (xxx) xxx-xxxx or Fax (xxx) xxx-xxxx.
Insert confidentiality/HIPAA statement here -

2/27/19

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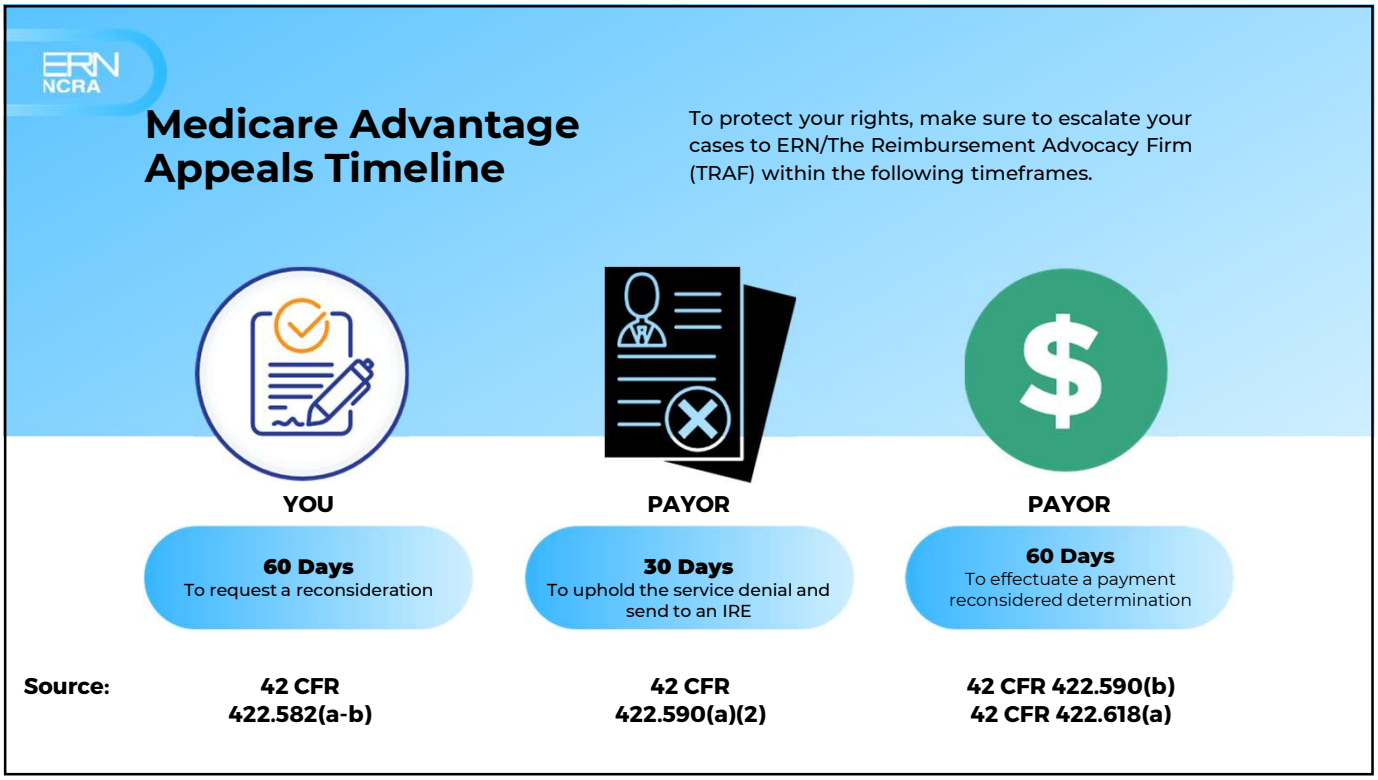

ERN NCRA

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.

	YOU	PAYOR	PAYOR
	60 Days To request a reconsideration	**30 Days** To uphold the service denial and send to an IRE	**60 Days** To effectuate a payment reconsidered determination
Source:	**42 CFR 422.582(a-b)**	**42 CFR 422.590(a)(2)**	**42 CFR 422.590(b) 42 CFR 422.618(a)**

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Date: 10/04/16 11:04:06 Debtor Category List Page 1

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

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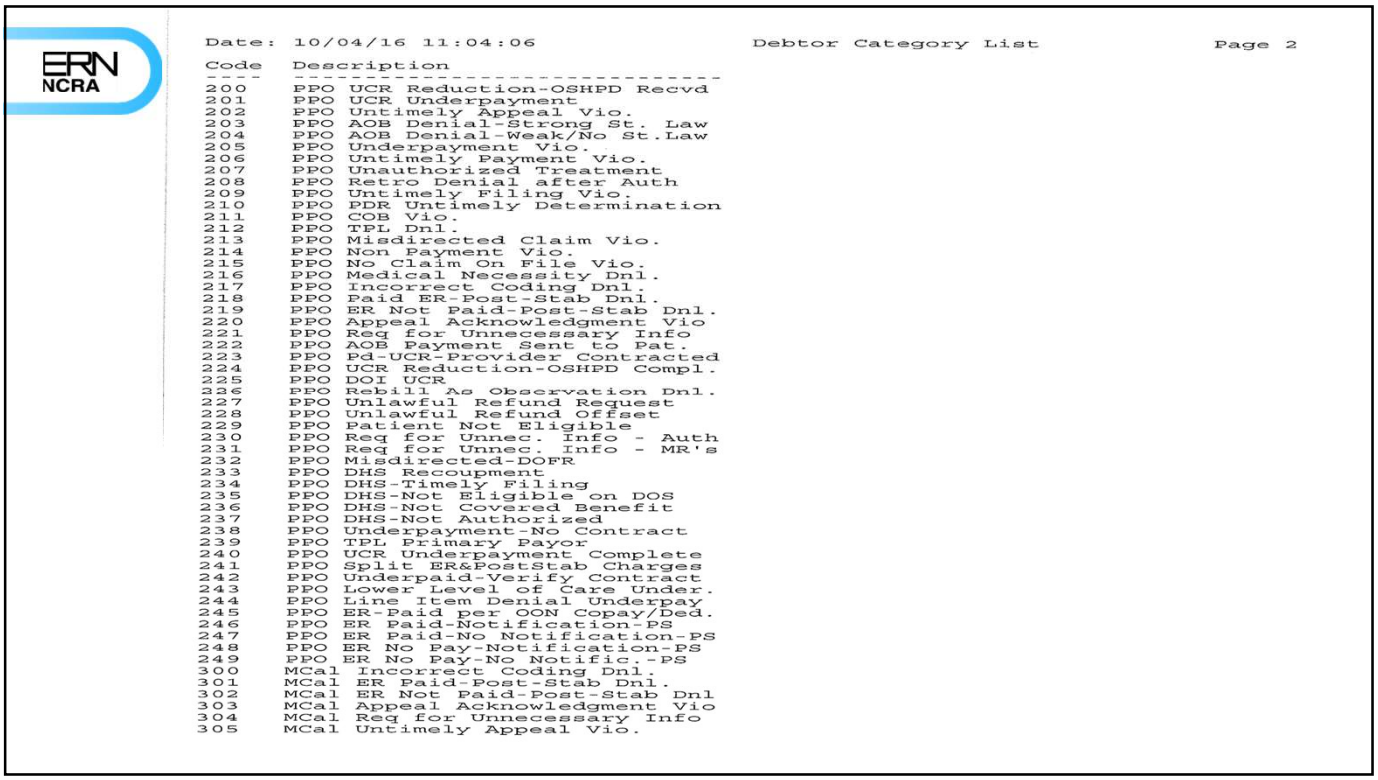

Date: 10/04/16 11:04:06 Debtor Category List Page 2

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.

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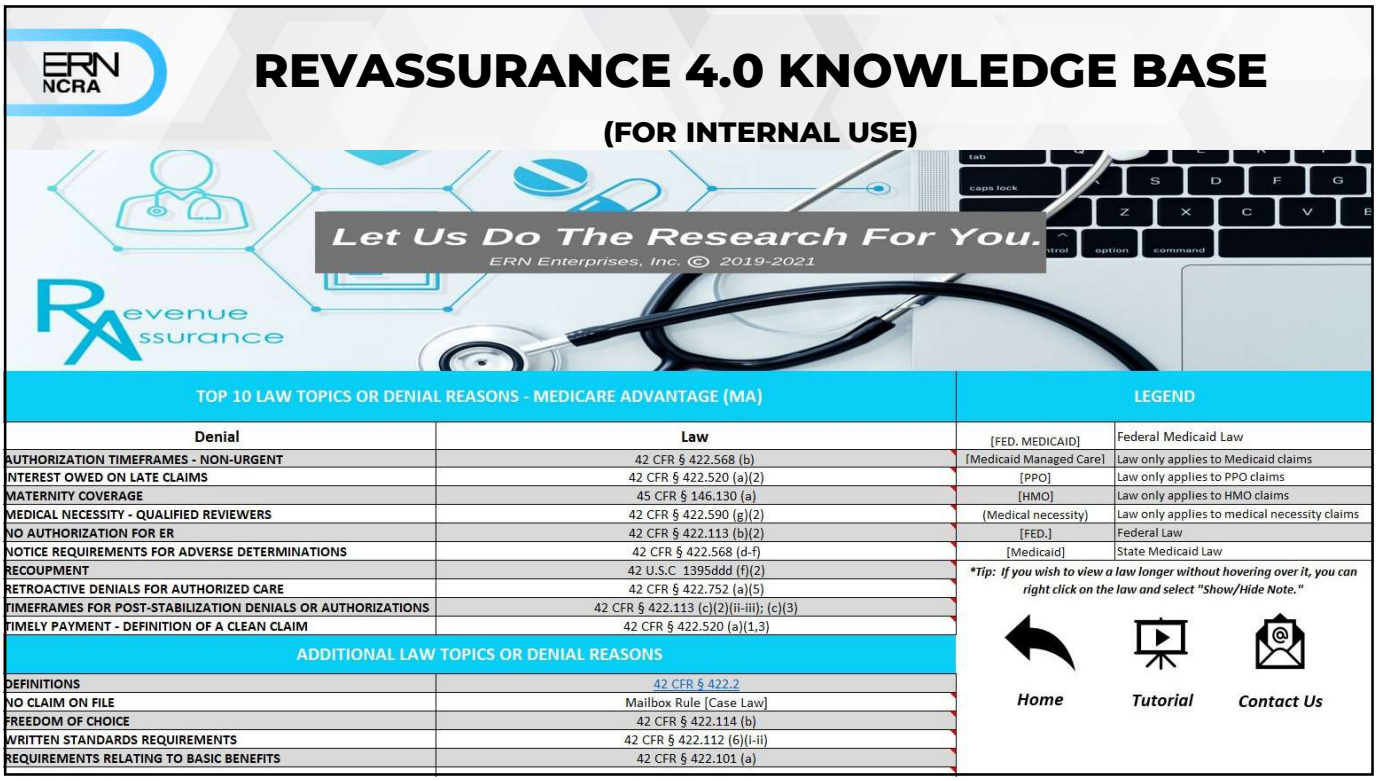

TOP 10 LAW TOPICS OR DENIAL REASONS - MEDICARE ADVANTAGE (MA)	
Denial	**Law**
AUTHORIZATION TIMEFRAMES - NON-URGENT	42 CFR § 422.568 (b)
INTEREST OWED ON LATE CLAIMS	42 CFR § 422.520 (a)(2)
MATERNITY COVERAGE	45 CFR § 146.130 (a)
MEDICAL NECESSITY - QUALIFIED REVIEWERS	42 CFR § 422.590 (g)(2)
NO AUTHORIZATION FOR ER	42 CFR § 422.113 (b)(2)
NOTICE REQUIREMENTS FOR ADVERSE DETERMINATIONS	42 CFR § 422.568 (d-f)
RECOUPMENT	42 U.S.C 1395ddd (f)(2)
RETROACTIVE DENIALS FOR AUTHORIZED CARE	42 CFR § 422.752 (a)(5)
TIMEFRAMES FOR POST-STABILIZATION DENIALS OR AUTHORIZATIONS	42 CFR § 422.113 (c)(2)(ii-iii); (c)(3)
TIMELY PAYMENT - DEFINITION OF A CLEAN CLAIM	42 CFR § 422.520 (a)(1,3)
ADDITIONAL LAW TOPICS OR DENIAL REASONS	
DEFINITIONS	42 CFR § 422.2
NO CLAIM ON FILE	Mailbox Rule [Case Law]
FREEDOM OF CHOICE	42 CFR § 422.114 (b)
WRITTEN STANDARDS REQUIREMENTS	42 CFR § 422.112 (6)(i-ii)
REQUIREMENTS RELATING TO BASIC BENEFITS	42 CFR § 422.101 (a)

LEGEND	
[FED. MEDICAID]	Federal Medicaid Law
[Medicaid Managed Care]	Law only applies to Medicaid claims
[PPO]	Law only applies to PPO claims
[HMO]	Law only applies to HMO claims
(Medical necessity)	Law only applies to medical necessity claims
[FED.]	Federal Law
[Medicaid]	State Medicaid Law

**Tip: If you wish to view a law longer without hovering over it, you can right click on the law and select "Show/Hide Note."*

Home Tutorial Contact Us

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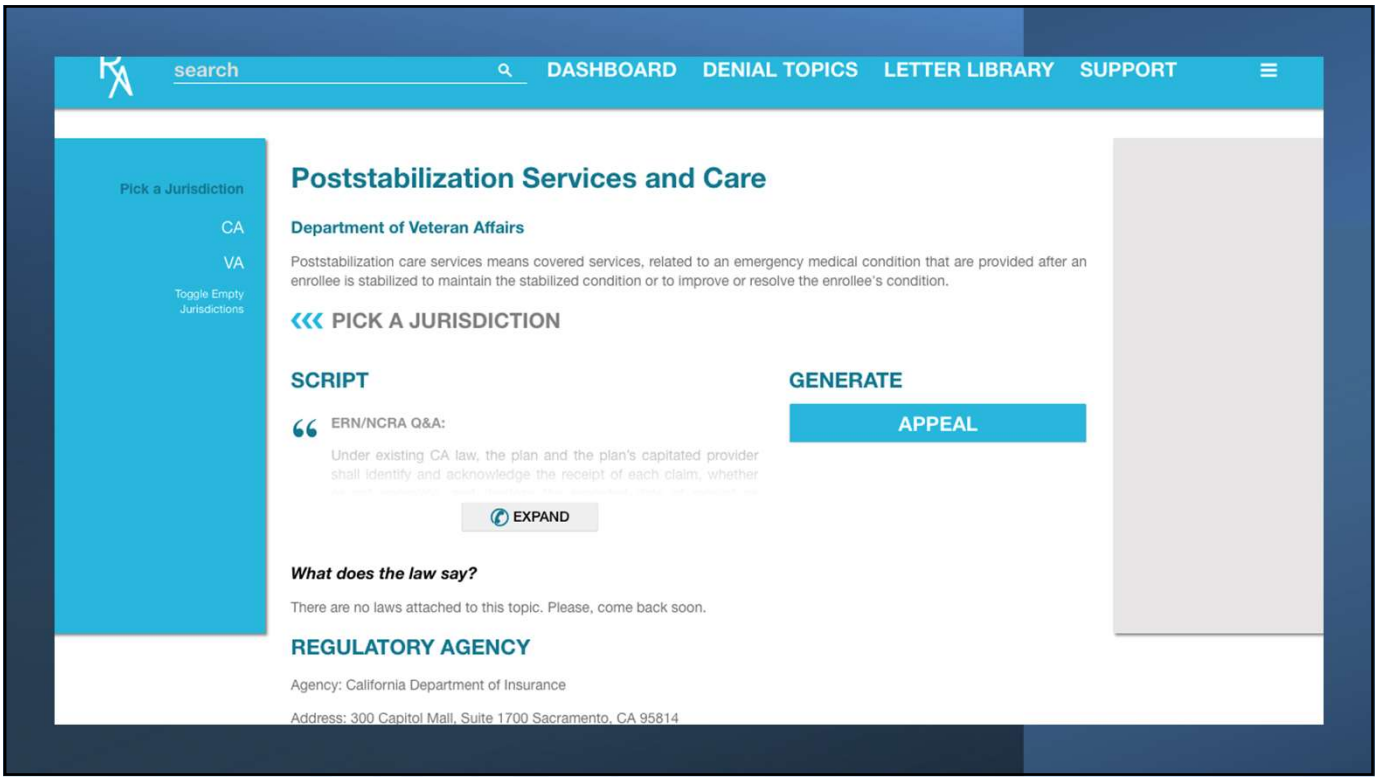
search
DASHBOARD
DENIAL TOPICS
LETTER LIBRARY
SUPPORT
Pick a Jurisdiction
CA
VA
Toggle Empty Jurisdictions
Poststabilization Services and Care
Department of Veteran Affairs
Poststabilization care services means covered services, related to an emergency medical condition that are provided after an enrollee is stabilized to maintain the stabilized condition or to improve or resolve the enrollee's condition.
PICK A JURISDICTION
SCRIPT
ERN/NCRA Q&A:
Under existing CA law, the plan and the plan's capitated provider shall identify and acknowledge the receipt of each claim, whether
EXPAND
GENERATE
APPEAL
What does the law say?
There are no laws attached to this topic. Please, come back soon.
REGULATORY AGENCY
Agency: California Department of Insurance
Address: 300 Capitol Mall, Suite 1700 Sacramento, CA 95814

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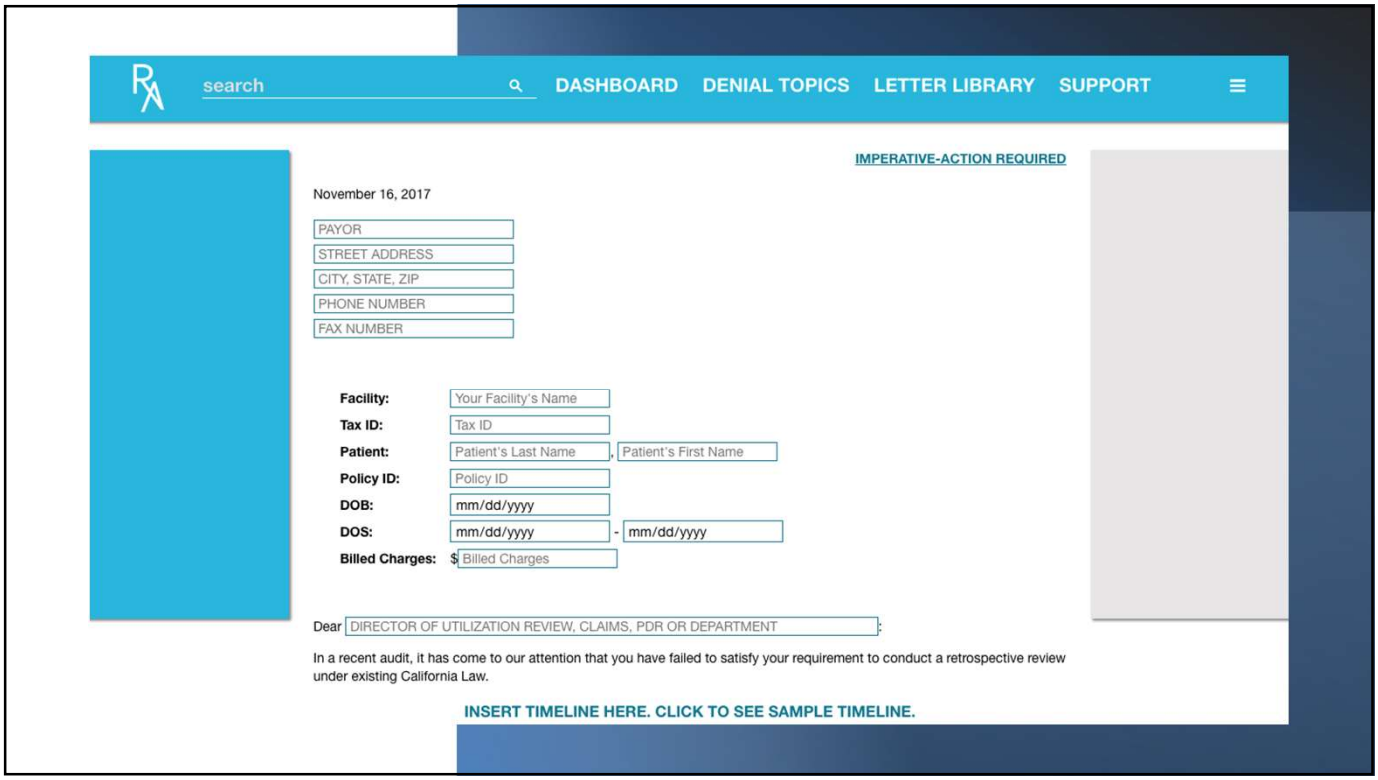
search
DASHBOARD
DENIAL TOPICS
LETTER LIBRARY
SUPPORT
IMPERATIVE-ACTION REQUIRED
November 16, 2017
PAYOR
STREET ADDRESS
CITY, STATE, ZIP
PHONE NUMBER
FAX NUMBER
Facility: Your Facility's Name
Tax ID: Tax ID
Patient: Patient's Last Name, Patient's First Name
Policy ID: Policy ID
DOB: mm/dd/yyyy
DOS: mm/dd/yyyy - mm/dd/yyyy
Billed Charges: $ Billed Charges
Dear DIRECTOR OF UTILIZATION REVIEW, CLAIMS, PDR OR DEPARTMENT:
In a recent audit, it has come to our attention that you have failed to satisfy your requirement to conduct a retrospective review under existing California Law.
INSERT TIMELINE HERE. CLICK TO SEE SAMPLE TIMELINE.

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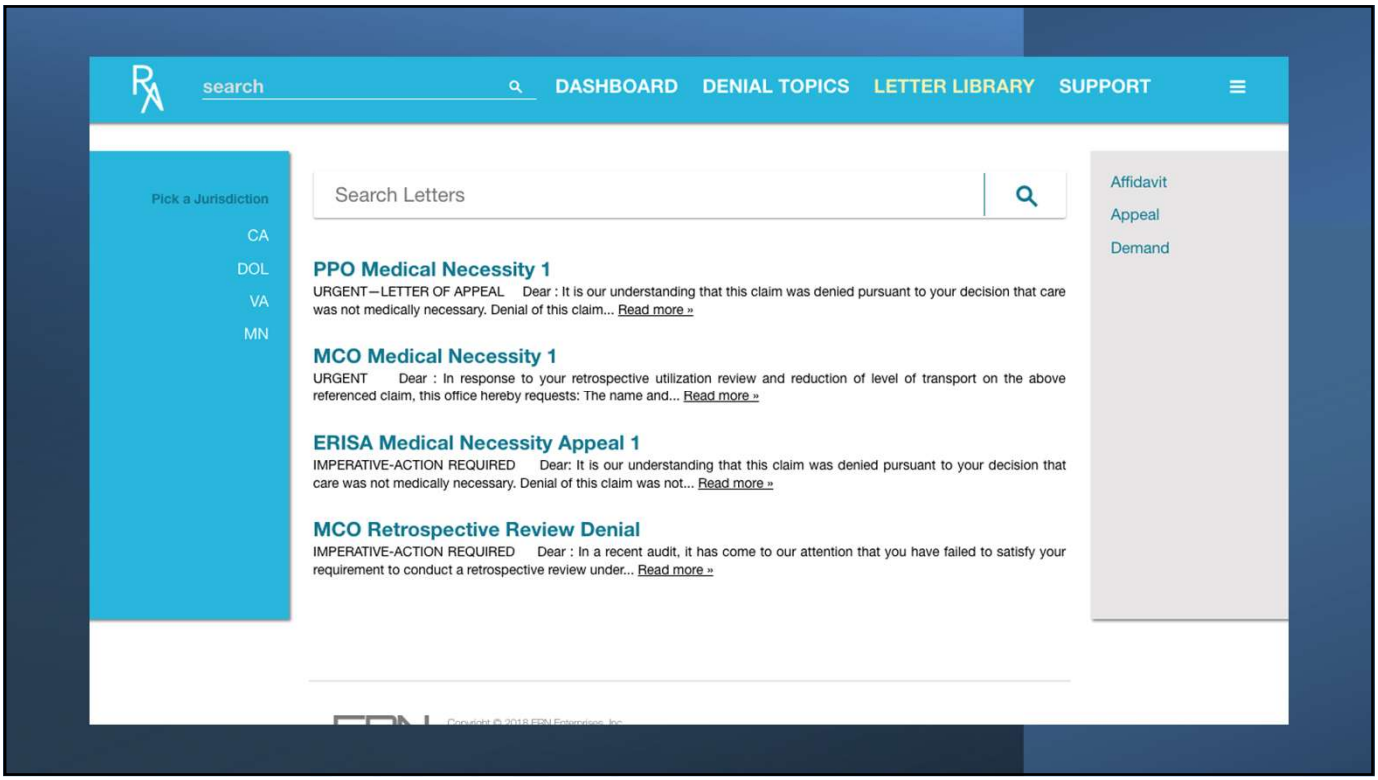
search
DASHBOARD
DENIAL TOPICS
LETTER LIBRARY
SUPPORT
Pick a Jurisdiction
CA
DOL
VA
MN
Search Letters
PPO Medical Necessity 1
URGENT—LETTER OF APPEAL Dear : It is our understanding that this claim was denied pursuant to your decision that care was not medically necessary. Denial of this claim... Read more »
MCO Medical Necessity 1
URGENT Dear : In response to your retrospective utilization review and reduction of level of transport on the above referenced claim, this office hereby requests: The name and... Read more »
ERISA Medical Necessity Appeal 1
IMPERATIVE-ACTION REQUIRED Dear: It is our understanding that this claim was denied pursuant to your decision that care was not medically necessary. Denial of this claim was not... Read more »
MCO Retrospective Review Denial
IMPERATIVE-ACTION REQUIRED Dear : In a recent audit, it has come to our attention that you have failed to satisfy your requirement to conduct a retrospective review under... Read more »
Affidavit
Appeal
Demand

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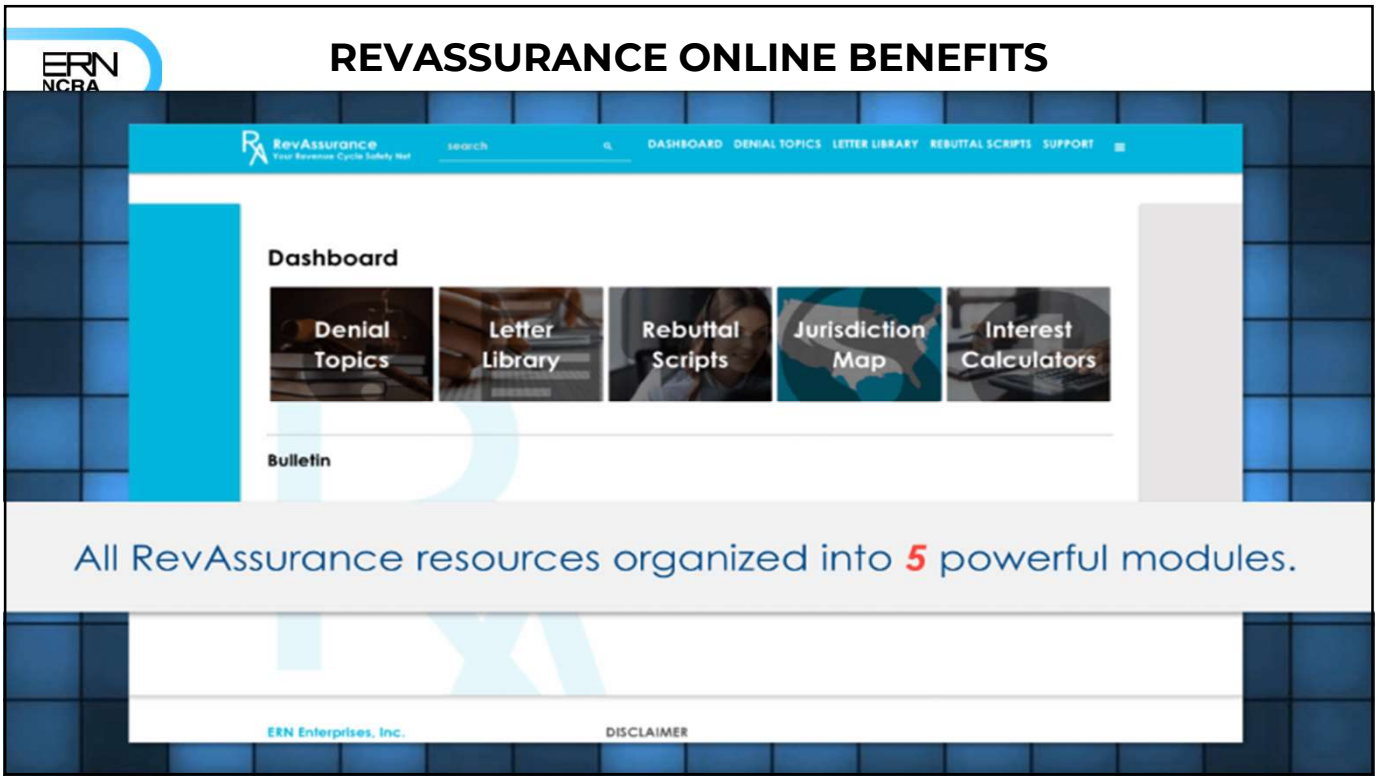
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REVASSURANCE ONLINE BENEFITS
RevAssurance
search
DASHBOARD
DENIAL TOPICS
LETTER LIBRARY
REBUTTAL SCRIPTS
SUPPORT
Dashboard
Denial Topics
Letter Library
Rebuttal Scripts
Jurisdiction Map
Interest Calculators
Bulletin
All RevAssurance resources organized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

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CAN I BEAT THIS?

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APPEAL LETTER WRITING WORKSHOP
WRITING THE APPEAL

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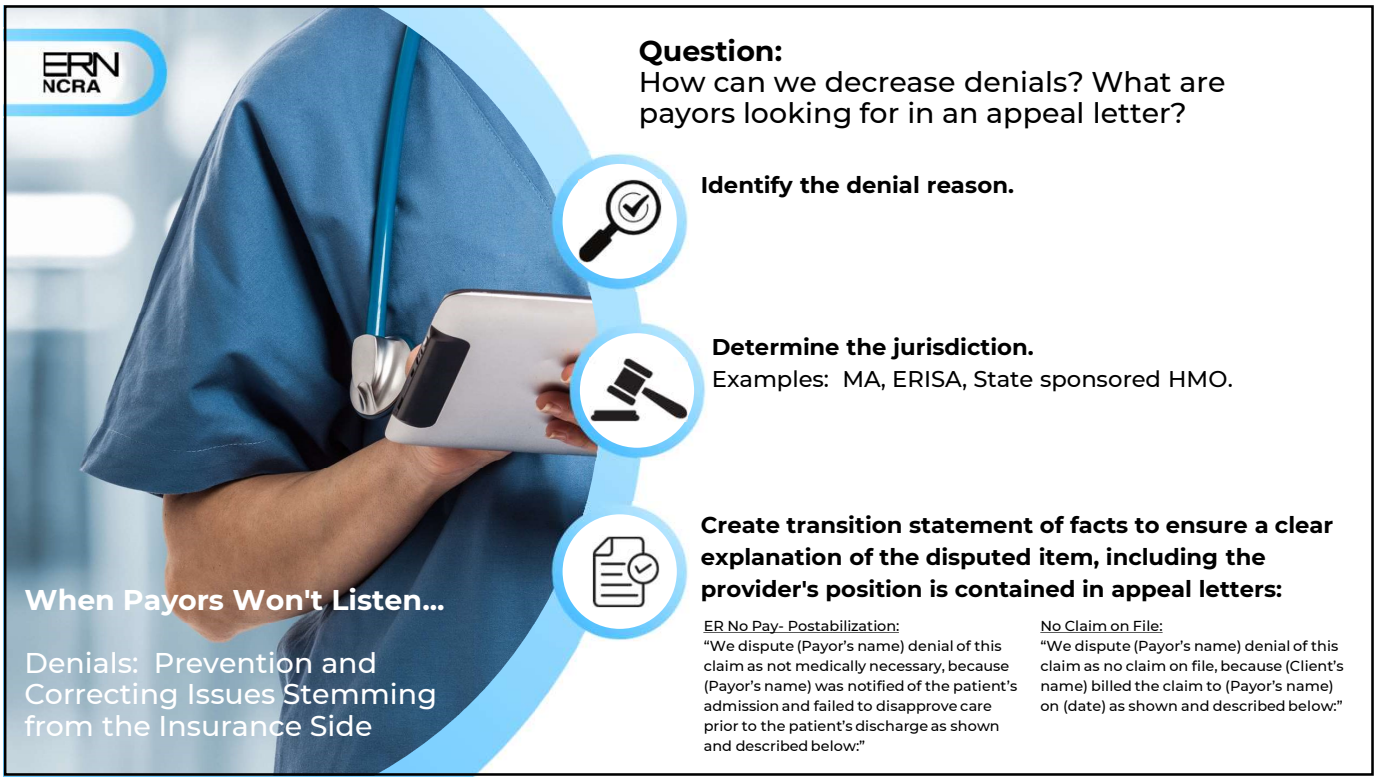
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When Payors Won't Listen...
Denials: Prevention and Correcting Issues Stemming from the Insurance Side
Question:
How can we decrease denials? What are payors looking for in an appeal letter?
Identify the denial reason.
Determine the jurisdiction.
Examples: MA, ERISA, State sponsored HMO.
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:"

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NCRA
When Payors Won't Listen...
Denials: Prevention and Correcting Issues Stemming from the Insurance Side
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)
Locate administrative laws to support each argument.
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."
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."

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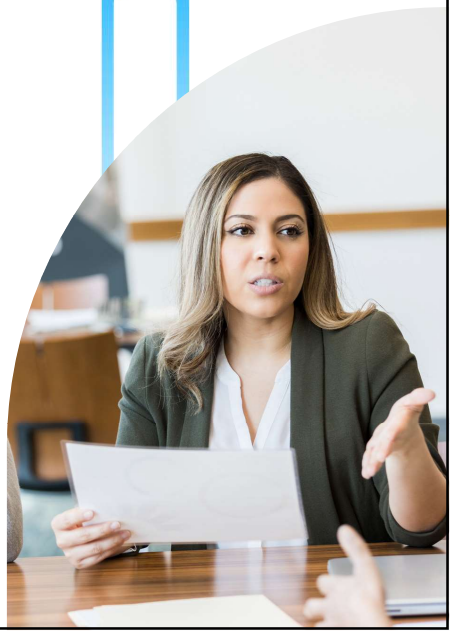
"WE DISPUTE..."
"...BECAUSE..."
"...AS SHOWN AND DESCRIBED BELOW:"



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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.

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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.

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WHEN PAYORS WON'T LISTEN

Denials: Prevention and Correcting Issues Stemming From the Insurance Side

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._____
_____

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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:

_____
_____
_____
_____

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YES, WE CAN!

BUILDING A CULTURE OF COMPLIANCE (A SYSTEM THAT ALL COMES TOGETHER) REQUIRES WE BUILD THREE SKILLS:

- Find success and failures (review data).
- Devise solutions for more efficient workflows. (we could do more training, install technology, hire more specialists, but we've done that).
- Create checklists and powerful stories.

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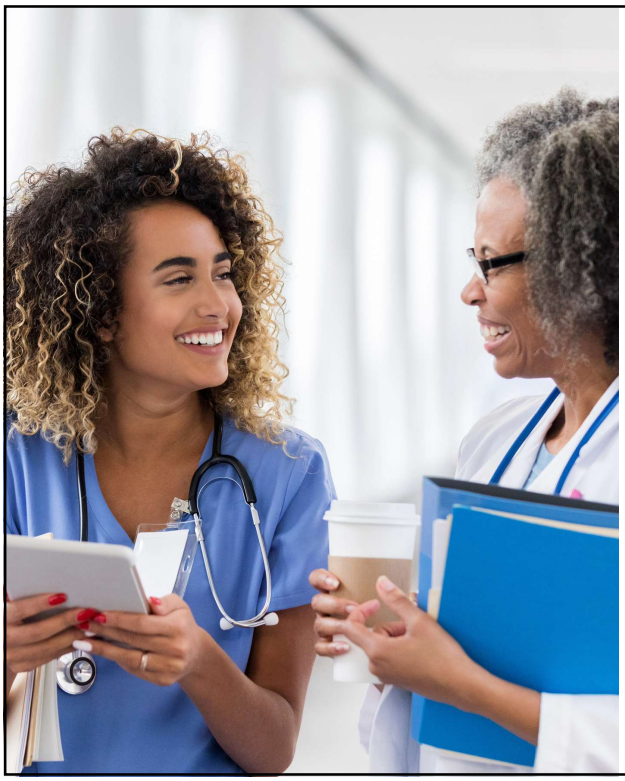

As advocates:

We collaborate
We are powerful storytellers
We pay attention to details
We are not victims and
We work each case as if we had never lost.

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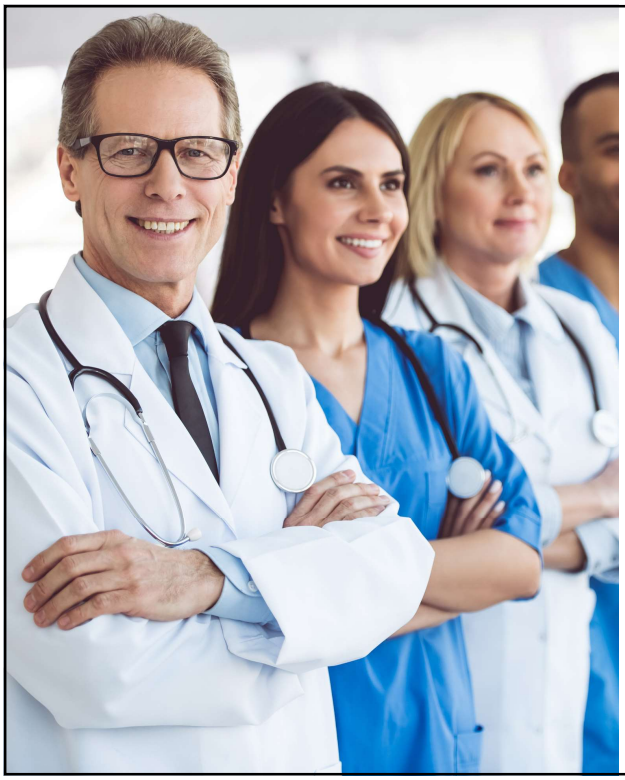

You fight for their lives.

We fight for you.

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ERN/The National Council of Reimbursement Advocacy
ednorwood@ernenterprises.org
(714) 995-6900 ext. 6926

www.ernenterprises.org

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