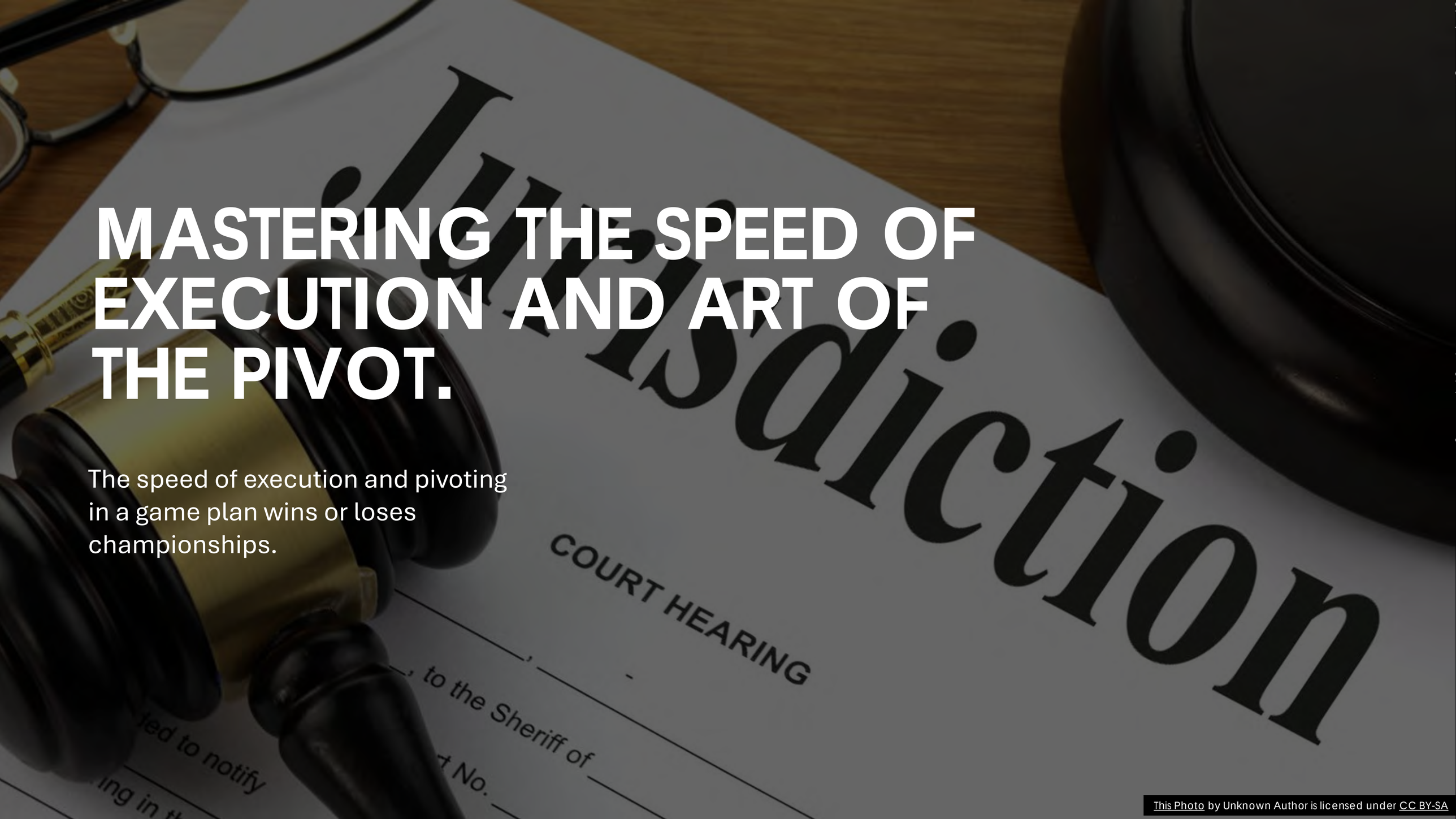
WHEN PAYORS WON'T LISTEN

Challenging Post Discharge and Post Acute Denials & Transfers

Faculty: Ed Norwood

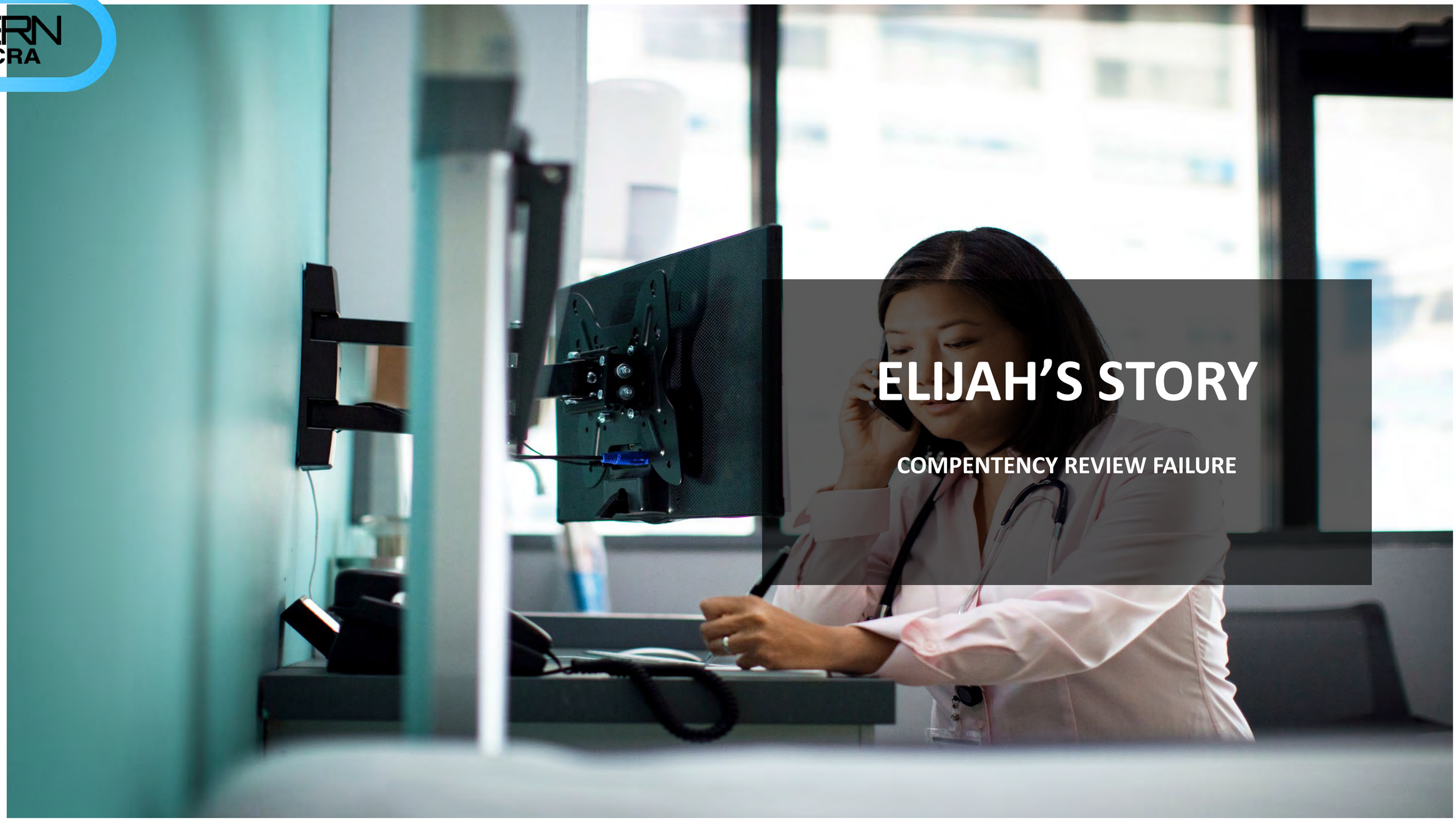
Learning Objectives:

1. Identify key CMS regulations and emerging state policies governing the use of AI and automation in medical necessity determinations.
2. Analyze how payer denial strategies are evolving through automation and where they may conflict with federal and state requirements.
3. Apply administrative law principles to strengthen appeal strategies against increasingly complex and automated denials.
4. Develop leadership approaches that build expertise, adaptability, and a culture capable of navigating continuous industry change.



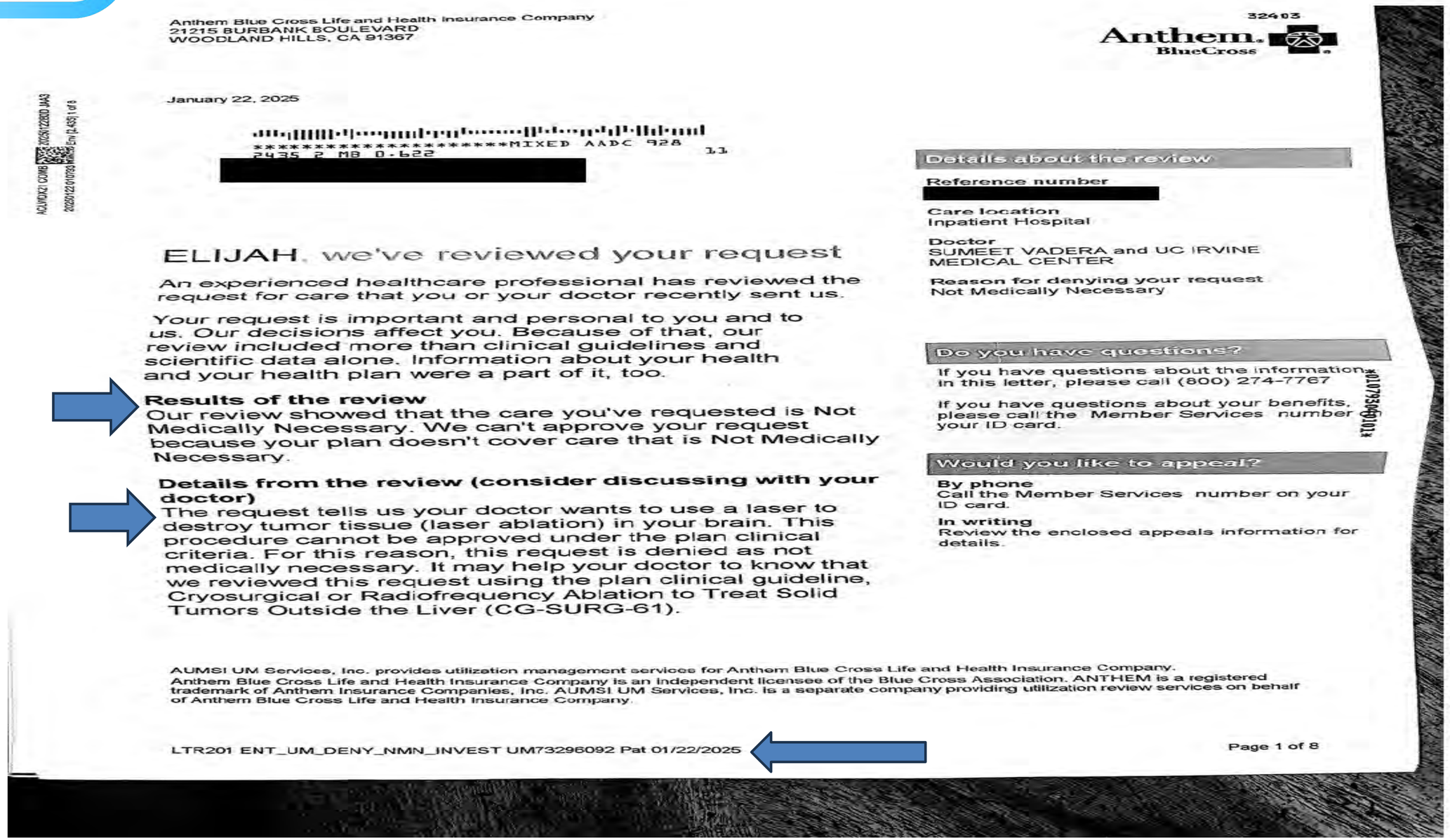
MASTERING THE SPEED OF EXECUTION AND ART OF THE PIVOT.

The speed of execution and pivoting in a game plan wins or loses championships.



ELIJAH'S STORY

COMPENTENCY REVIEW FAILURE



Anthem Blue Cross Life and Health Insurance Company
21215 BURBANK BOULEVARD
WOODLAND HILLS, CA 91367

32403

Anthem BlueCross

January 22, 2025

**********MIXED AADC 928
2435 2 MB 0.622 11

[redacted]

ELIJAH, we've reviewed your request

An experienced healthcare professional has reviewed the request for care that you or your doctor recently sent us.

Your request is important and personal to you and to us. Our decisions affect you. Because of that, our review included more than clinical guidelines and scientific data alone. Information about your health and your health plan were a part of it, too.

Results of the review
Our review showed that the care you've requested is Not Medically Necessary. We can't approve your request because your plan doesn't cover care that is Not Medically Necessary.

Details from the review (consider discussing with your doctor)
The request tells us your doctor wants to use a laser to destroy tumor tissue (laser ablation) in your brain. This procedure cannot be approved under the plan clinical criteria. For this reason, this request is denied as not medically necessary. It may help your doctor to know that we reviewed this request using the plan clinical guideline, Cryosurgical or Radiofrequency Ablation to Treat Solid Tumors Outside the Liver (CG-SURG-61).

Details about the review

Reference number
[redacted]

Care location
Inpatient Hospital

Doctor
SUMEET VADERA and UC IRVINE MEDICAL CENTER

Reason for denying your request
Not Medically Necessary

Do you have questions?

If you have questions about the information in this letter, please call (800) 274-7767

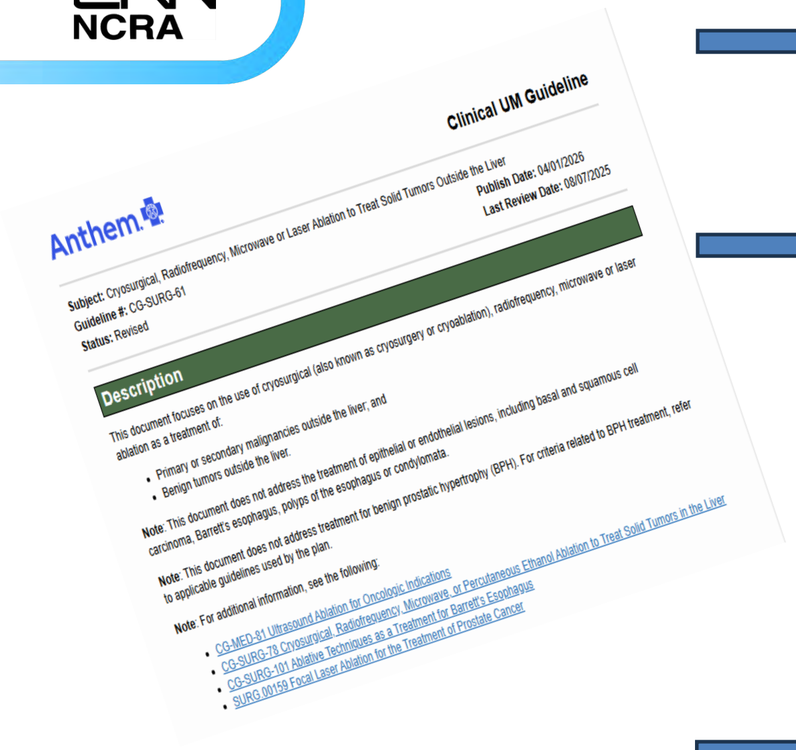
If you have questions about your benefits, please call the Member Services number on your ID card.

Would you like to appeal?

By phone
Call the Member Services number on your ID card.

In writing
Review the enclosed appeals information for details.

AUMSI UM Services, Inc. provides utilization management services for Anthem Blue Cross Life and Health Insurance Company. Anthem Blue Cross Life and Health Insurance Company is an independent licensee of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. AUMSI UM Services, Inc. is a separate company providing utilization review services on behalf of Anthem Blue Cross Life and Health Insurance Company.



Anthem

Clinical UM Guideline

Subject: Cryosurgical, Radiofrequency, Microwave or Laser Ablation to Treat Solid Tumors Outside the Liver
Guideline #: CG-SURG-61
Status: Revised
Publish Date: 04/01/2026
Last Review Date: 08/07/2025

Description

This document focuses on the use of cryosurgical (also known as cryosurgery or cryoablation), radiofrequency, microwave or laser ablation as a treatment of:

- Primary or secondary malignancies outside the liver; and
- Benign tumors outside the liver.

Note: This document does not address the treatment of epithelial or endothelial lesions, including basal and squamous cell carcinoma, Barrett's esophagus, polyps of the esophagus or condylomata.

Note: This document does not address treatment for benign prostatic hypertrophy (BPH). For criteria related to BPH treatment, refer to applicable guidelines used by the plan.

Note: For additional information, see the following:

- CG-MED-91 Ultrasound Ablation for Oncologic Indications
- CG-SURG-78 Cryosurgical, Radiofrequency, Microwave, or Percutaneous Ethanol Ablation to Treat Solid Tumors in the Liver
- CG-SURG-101 Ablative Techniques as a Treatment for Barrett's Esophagus
- SURG.00159 Focal Laser Ablation for the Treatment of Prostate Cancer

Clinical Indications

Medically Necessary:

Prostate Cancer

Whole-gland cryosurgical ablation of the prostate is considered **medically necessary** as a treatment of prostate cancer.

Non-small cell lung cancer (NSCLC)

Thermal ablation (radiofrequency ablation, cryoablation or microwave ablation) of NSCLC is considered **medically necessary** when all of the following criteria are met:

1. Surgical or radiation treatment with curative intent is considered appropriate based on stage of disease, however medical co-morbidity renders the individual unfit for those interventions; **and**
2. No tumor has a maximum diameter of greater than 3.0 cm; **and**
3. Tumors are located at least 1 cm from the trachea, main bronchi, esophagus, aorta, aortic arch branches, pulmonary artery and the heart.

Tumor(s) that have metastasized to the lung

Thermal ablation (radiofrequency ablation, cryoablation or microwave ablation) of malignant tumor(s) that have metastasized to the lung is considered **medically necessary** when *all* of the following criteria are met:

1. Surgical or radiation treatment is considered appropriate based on stage of disease, however medical co-morbidity renders the individual unfit for those interventions; **and**
2. There is no current active extra-pulmonary metastatic disease; **and**
3. There are no more than 3 tumors per lung; **and**
4. No tumor has a maximum diameter greater than 3.0 cm; **and**
5. Tumors are located at least 1 cm from the trachea, main bronchi, esophagus, aorta, aortic arch branches, pulmonary artery and the heart.

Osteoid osteomas

Radiofrequency ablation of osteoid osteomas is considered **medically necessary**.

Bone metastases

Thermal ablation (radiofrequency ablation, cryoablation or microwave ablation) of painful bony metastases is considered **medically necessary** in individuals who have failed or who are considered poor candidates for standard treatments such as opioids or radiation therapy.

Renal malignancy

Thermal ablation (radiofrequency ablation, cryoablation or microwave ablation) for clinically localized, suspected renal malignancy is considered **medically necessary** for individuals with peripheral lesions that are less than or equal to 4 cm in diameter.

Benign thyroid nodules

Thermal ablation (radiofrequency ablation, laser ablation or microwave ablation) is considered **medically necessary** when *either* criteria I or II are met:

I. Symptomatic nonfunctioning nodule when both of the following criteria (A and B) are met:
   A. Causing compressive symptoms (for example, pain, difficulty breathing or swallowing or hoarseness); **and**
   B. Confirmed to be benign as evidenced by *one* of the following (1 **or** 2):
      1. Benign cytology on two fine needle or core biopsies; **or**
      2. *Both* of the following criteria are met (a **and** b):
         a. Benign cytology on *one* fine needle or core biopsy; **and**
         b. Nodule is considered to be very low to intermediate risk based on the American College of Radiology Thyroid Imaging Reporting and Data Systems (ACR TIRADS) ultrasound risk stratification

II. Autonomously functioning thyroid nodule (AFTN) when **all** of the following criteria (A, B and C) are met:
   A. Subclinical or overt hyperthyroidism; **and**
   B. Radioactive uptake scan confirmation of a hyperfunctioning nodule; **and**
   C. Confirmed to be benign as evidenced by *one* of the following (1 **or** 2):
      1. Benign cytology on two fine needle or core biopsies; **or**
      2. *Both* of the following criteria are met (a **and** b):
         a. Benign cytology on *one* fine needle or core biopsy; **and**
         b. Nodule is considered to be very low to intermediate risk based on ACR TIRADS ultrasound risk stratification.

Not Medically Necessary:

Focal cryosurgical ablation of prostate tumors is considered **not medically necessary**.

Laser ablation, or laser interstitial thermal therapy is considered **not medically necessary** when the above criteria are not met.

Thermal ablation (radiofrequency ablation, cryoablation, or microwave ablation) of tumors outside the liver is considered **not medically necessary** when the above criteria are not met and for all other indications.

ERN
TRAF

CORRECTED EXPEDITED APPEAL AND NOTICE OF INTENT TO FILE COMPLAINT
Via Email and Fax

Sunday, February 02, 2025

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY
21215 BURBANK BLVD
WOODLAND HILLS, CA 91367

GREG MCCLELLAND, CHAIRMAN
DAVID OSBORNE, PLAN ADMINISTRATOR
CALIFORNIA IRONWORKERS
131 N. EL MOLINO AVE. STE. 330
PASADENA, CA 91101-1878
FAX: 626-792-7667

Plan Participant:
Patient:
Group #:
Plan Code:
DOB:
UM Reference #

RE: Improper denial by Anthem Blue Cross of laser ablation brain surgery scheduled Tuesday 02/04/25

Dear Mr. McClelland and Mr. Osborne,

This office represents participant Cornejo, and has been asked to file a formal complaint with the **U.S. Department of Labor, Employee Benefits Security Administration (EBSA)** and release a media advisory against the **California Ironworkers (CI)** for its TPA, **Anthem Blue Cross' (BC),** failure to authorize medically necessary brain surgery (laser ablation) to remove a tumor, as required by federal law.

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) An ERISA participant's access to emergency and post-stabilization services and care.
(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 Title 29 Code of Federal Regulations, or any rule adopted pursuant thereto.

We dispute CI/BC's denial on 1/22,2025 (REF# UM73296092) that the laser ablation is not medically necessary, because CI through its delegate, BC, failed to establish and maintain reasonable claims procedures, and failed to meet manner, content, and notice requirements for a decision based upon medical necessity, as shown and described below:

Anthem Blue Cross Life and Health Insurance Company
Grievances and Appeals
P.O. Box 4310
Woodland Hills, CA 91365

Anthem

February 04, 2025

ELIJAH [redacted]

More Details

Member ID
[redacted]

Case Number
[redacted]

Date Request Received
02/02/2025

Confidential Health Plan Information for:
ELIJAH [redacted]

Important Information about your appeal.

Reviewed for your plan by AUMSI UM Services, Inc.

Dear ELIJAH [redacted],

Your appeal
We've reviewed a request from Ed Norwood Chief Compliance Officer for an appeal regarding the denial of a procedure, a laser to destroy tumor tissue (laser ablation) in the brain and a full hospital admission after the surgery, received on February 2, 2025. We understand an appeal was initiated on your behalf because this procedure and full hospital admission after the surgery is medically necessary.

Our decision
We've gone over your appeal and have decided to change our previous decision, as explained below.

Upon further review of the medical information provided, a health plan Physician Clinical Reviewer, an MD who is board certified and specializes in Neurological Surgery and our health plan Medical Director Reviewer, an MD who is board certified and specializes in General Surgery and Critical Care Medicine, has reviewed this appeal and overturned this denial to allow coverage for the following below:

- 61736 - LITT LES ICR SINGLE TRAJECTORY 1 SIMPLE LESION
- Level of Care - 1 day Inpatient Stay

StandardApproval


ERN
NCRA
YOU ARE NOT AN IMPOSTER

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.

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.

HEALTHCARE IS A LAW TO BE DEFENDED.

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

HOW DO WE ADVOCATE FOR POST-ACUTE TRANSFERS?

ARGUE THE 1-HOUR FAILURE RULE

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.)

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.

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**.

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, <u>including the type or level of services</u>,** that the enrollee believes should be furnished or arranged for by the MA organization.

THIS INCLUDES OBSERVATION SERVICE VS. INPATIENT DISPUTES AND POST ACUTE DENIALS.

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.

RE: Amended FOIA Request Post-stabilization turnaround times (TAT) (Control Number 041420257006)

Ed Norwood
To CMS FOIA Request
Cc opolefoia@cms.hhs.gov; kenyetta.stringfellow@cms.hhs.gov; emmett.nicholson@cms.hhs.gov

Reply | Reply All | Forward

Wed 4/16/2025 7:32 PM

This message was sent with High importance.

Dear CMS FOIA Team:

Thank you for all you do for Medicare beneficiaries.

We have detected a disturbing trend of MAO plans asserting they do not have to abide by the authorization requirements for post-stabilization admissions following an ER visit (instead requiring notification within 24 hours of admission), and thereby eliminating the relevancy of the one (1) hour response timeframes delineated under **42 CFR § 422.113(c)(2)** and **Medicare Managed Care Manual Ch. 4, §20.5.2.**

Specifically, the plans assert the following:

*Because MAO does not require prior authorization **for post-stabilization care**, the regulations and turnaround time ("TAT") regarding prior authorizations are not relevant. Rather, the TATs that are relevant are those for standard authorization decisions. For Medicare members, federal regulations require that standard authorization decisions be made within 14 calendar days. 42 CFR § 422.568(b). Expedited decisions must be made within 72 hours. 42 CFR § 422.572(a)(1). Notably, these regulations do not require a health plan to pay all hospital charges if the stated turnaround times are missed.*

As you know:

- **42 CFR §422.113(c)(1)** states: Post-stabilization care services means covered services, related to an emergency medical condition, that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or, under the circumstances described in paragraph (c)(2)(iii) of this section, to improve or resolve the enrollee's condition.
- **42 C.F.R. §422.113(b)(2)(ii)** requires MA plans to cover emergency services "regardless of whether there is prior authorization for the services," making denial of entire Claims (including the emergency portion of the claim) unlawful;
- **42 C.F.R. §422.113(c)(2)(iii)(B)** requires MA plans to cover post-stabilization services where the MA plan "cannot be contacted," making denials on Claims where notification was impossible until after the fact unlawful.
- **MMCM Ch 4. §20.5.3, 42 C.F.R. §422.113(c)(2)(iii)(C) and 42 C.F.R. §422.113(c)(3)** requires MA plans to cover post-stabilization services where the MA plan does not preapprove the hospital to provide post-stabilization services, within one (1) hour, and does not assume responsibility for the enrollee's care through transfer. This provision makes denials of charges for services rendered **after** the plan was notified of its patients' admissions and **after** the patient is discharged unlawful because the plan failed to assume responsibility for the care of its member despite its knowledge that such member was being treated at a facility.

RE: Amended FOIA Request Post-stabilization turnaround times (TAT) (Control Number 041420257006)

Ed Norwood
To CMS FOIA Request
Cc opolefoia@cms.hhs.gov; kenyetta.stringfellow@cms.hhs.gov; emmett.nicholson@cms.hhs.gov

Reply | Reply All | Forward

Wed 4/16/2025 7:32 PM

This message was sent with High importance.

Therefore, pursuant to the Freedom of Information Act, please provide:

- An electronic, written copy of any CMS Policy, Directive, Manual, Handbook, Standard Operating Procedure, Document, or Statutory Authority that permits MAOs to be exempt from the one (1) hour timeframe to respond to requests for post-stabilization preapprovals when they do not require authorization (or only require 24 notification from providers).
- An electronic, written copy of any CMS Policy, Directive, Manual, Handbook, Standard Operating Procedure, Document, or Statutory Authority that permits MAOs to apply standard authorization timeframes (14 calendar days under **§422.568 (b))** when a provider makes a request for preapproval for post-stabilization care services **(under §422.113 (c),** after an enrollee is stabilized, in order to maintain the stabilized condition, or under the circumstances described in **42 CFR §422.113 (c)(2)(iii),** or to improve or resolve the enrollee's condition.
- An electronic, written copy of any CMS Policy, Directive, Manual, Handbook, Standard Operating Procedure, Document, or Statutory Authority that permits MAOs to apply expedited authorization timeframes (72 hours under **§422.572 (a)(1))** when a provider makes a request for preapproval for post-stabilization care services **(under §422.113 (c)**, after an enrollee is stabilized, in order to maintain the stabilized condition, or under the circumstances described **in 42 CFR §422.113 (c)(2)(iii),** or to improve or resolve the enrollee's condition.
- An electronic, written copy of any CMS Policy, Directive, Manual, Handbook, Standard Operating Procedure, Document, or Statutory Authority that requires MAOs, whether in or out of network, to respond within one (1) to a request for preapproval for post-stabilization care services, after an enrollee is stabilized, in order to maintain the stabilized condition, or under the circumstances described in **42 CFR §422.113 (c)(2)(iii),** or to improve or resolve the enrollee's condition.
- An electronic, written copy of any CMS Policy, Directive, Manual, Handbook, Standard Operating Procedure, Document, or Statutory Authority that requires MAOs to be financially responsible for emergency services (furnished by a provider qualified to furnish emergency services; and needed to evaluate or stabilize an emergency medical condition—whether inpatient or outpatient), without requiring a split bill changing the UB 04 representation of services rendered, in the event MA organization refuses to provide or pay for post-stabilization care services, in whole or in part, including the type or level of services,

We appreciate all you do.

Best,

Ed Norwood
President

CMS RULING ON POSTSTABILIZATION TATs

A new response to the DPAP Mailbox ticket, Issue ID 9653 (CMS Tracking ID: 288467b7-8088-4d86-a43f-65a421823372) was sent on 9/30/2025 3:06:25 PM as follows:

Thank you for your inquiry.

If you would like CMS to look into a specific case, please provide supporting documentation, including if the case involves a contracted provider and whether the case has been fully appealed with the MA organization. Please redact protected health information before sharing any information with CMS.

Under CMS regulations at 42 CFR 422.113(c)(2), a Medicare Advantage (MA) organization becomes financially responsible only for post-stabilization care services that are furnished by a hospital if the MA plan has not responded within one hour of a request by the hospital to the MA organization for pre-approval of post-stabilization care services. These requirements apply to both contracted and non-contracted facilities.

As mentioned in previous correspondence, for contracted or non-contracted provider payment dispute matters, CMS encourages all providers to first engage in the plans' internal appeals and grievances process. Providers should follow the MA or Part D plan's established dispute process until exhausted.

Thank you,

CMS Policy Team.

Case Study: SNF Authorization Challenges

OBTAINING AUTHORIZATION WHILE PATIENT IS AWAITING SNF OR POST ACUTE PLACEMENT

Common challenges healthcare providers face when seeking authorization for patients awaiting placement include:

- No appropriate facility available
- Appropriate facility found, but no bed available
- Patient acuity (e.g., vent dependent)
- Patient overstayed DRG and needs LTAC

APPEAL OF DENIED AUTHORIZATION

Submitted via Fax

March 6, 2025

PacificSource Medicare
Grievance & Appeals Department
2965 NE Conners Ave
Bend, OR 97701
Fax: 541.322.6424

Our Client:	St Charles Bend Campus ("SCH")
TAX ID:	[redacted]
Patient:	[redacted] Hendricks
ID#:	[redacted]
DOB:	[redacted]
DOS:	[redacted]
Billed Charges:	$87,690.44

Dear Director of Appeals:

ERN Enterprises represents St. Charles Bend Campus **(See Attached Statement of Representation)** and has been asked to audit and investigate the above referenced claim for emergency and post-stabilization services that PacificSource has partially denied authorization for in possible violation of federal law.

We dispute PacificSource's denial of date of service 02/09/25-02/12/25 as not medically necessary, because the patient could not be safely discharged on 02/09/25 and required transfer to SNF level of care; Medicare requires PacificSource to continue approving and reimbursing alternate placement days at inpatient level of care until a bed is available at a participating SNF willing and able to accept the patient; and PacificSource failed to notify of its authorization denial that started on 02/09/25 until 3 days later on 02/12/25, as shown and described below:

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

(1) A Medicare Advantage Plan's failure to provide coverage of, by furnishing, arranging for, or making payment for, all services that are covered by Part A and Part B of Medicare.
(2) Any other health services furnished by a provider or supplier that are reimbursable under 42 CFR sections 422.100, 422.101, 422.112, 422.113, 422.216, 422.318, 422.510, 422.520, 422.570, 422.570, 422.580, 422.582, 422.586, 422.590, 422.592, 422.594 or any rule adopted pursuant thereto.

PacificSource
Medicare
PO Box 7469
Bend, OR 97708
ADDRESS SERVICE REQUESTED

April 1, 2025

Notice of Appeal Resolution

St Charles Medical Center Bend Hospital

Member: [redacted] Hendricks
PacificSource ID: [redacted]
DOB: [redacted]
Appeal #: [redacted]
Service Requested: Hospital Stay

Dear denise:

I am writing in response to your request for reconsideration of PacificSource Medicare's determination regarding the above service.

The information you provided in your appeal and your medical records were carefully reviewed, and resulted in a determination to approve your request. This letter serves as your authorization. A copy of this letter has also been sent to the member.

Authorization Reference Number: [redacted]
Approved Date Range: 1/27/2025 - 2/12/2025
Item/Service(s) Received:

The services were requested by the Facility St Charles Medical Center Bend Hospital. We have approved these services. These services may have limits. Please see your Medical Benefits Chart in your Evidence of Coverage (EOC) book. This chart will show services that are covered by you and what your cost may be.

Thank you for allowing us to review this issue for you. If you have any questions regarding this appeal, please contact us Monday – Friday, 8am-5pm at (541) 330-4992, or toll free at (888) 863-3637. Our fax Number is (541) 322-6424.

Sincerely,

Appeals & Grievance Team
PacificSource Community Solutions

PacificSource Community Health Plans is an HMO/PPO plan with a Medicare contract.


ERN
NCRA
DOCUMENT MEDICAL NECESSITY

MA PLANS MUST FOLLOW MEDICARE COVERAGE CRITERIA

Under CMS rules:

- MA plans **must cover services consistent with Traditional Medicare.**
- They cannot **deny a level of care if criteria are met (See attached CMS-4201-F and 42 CFR 422.101).**
- **MA plans must give a specific, detailed rationale for denial.**

Document Medical Necessity: State that the patient meets post-acute inpatient criteria using the enrollee's medical history (for example, diagnoses, conditions, functional status, physician recommendations, and clinical notes). Plans must justify their organization determination ("denial") with specific criteria and a review by a competent physician or health care professional with expertise in the field of medicine or health care that is appropriate for the services at issue, including knowledge of Medicare coverage criteria, before the MA organization issues the organization determination decision.


ERN
NCRA
CHECK THE COMPETENCY OF THE REVIEWER

COMPETENCY OF REVIEWERS

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 expertise in the field of medicine or health care that is appropriate for the services at issue**, **including knowledge of Medicare coverage criteria, before the MA organization issues the organization determination decision**. The physician or health care professional reviewing the request need not, in all cases, be of the same specialty or subspecialty as the treating physician or other health care provider. 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.

CITE BREACHES OF THE MEDICARE CONTRACT

POTENTIAL BREACHES OF THE MEDICARE CONTRACT

42 CFR 422.101 (a-b)

(a) Provide coverage of, by furnishing, arranging for, or making payment for, ALL SERVICES THAT ARE COVERED BY PART A AND PART B OF MEDICARE (if the enrollee is entitled to benefits under both parts) or by Medicare Part B (if entitled only under Part B) and that are available to beneficiaries residing in the plan's service area. Services may be provided outside of the service area of the plan if the services are accessible and available to enrollees.

(b) Comply with—

(1) CMS's national coverage determinations;

(2) **General coverage** and benefit conditions included in Traditional Medicare laws, **unless superseded by laws applicable to MA plans**. **This includes criteria for determining whether an item or service is a benefit available under Traditional Medicare**. For example, this includes **payment criteria for inpatient admissions at 42 CFR 412.3 (2MN)**, services **and** procedures that the Secretary designates as requiring inpatient care under 42 CFR 419.22(n), and requirements for payment of Skilled Nursing Facility (SNF) Care, Home Health Services under **42 CFR part 409**, and Inpatient Rehabilitation Facilities (IRF) at 42 CFR 412.622(a)(3) **(Emphasis added).**

Does the post-acute care meet the criteria for Medicare coverage and reimbursement?

POTENTIAL BREACHES OF THE MEDICARE CONTRACT

42 CFR 422.101(b)

(6) MA organizations **may create publicly accessible internal coverage criteria** that are based on current evidence in widely used treatment guidelines or clinical literature **when coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs**. Current, widely-used treatment guidelines are those developed by organizations representing clinical medical specialties, and refers to guidelines for the treatment of specific diseases or conditions. **Acceptable clinical literature includes** large, randomized controlled trials or prospective cohort studies with clear results, published in a peer-reviewed journal, and specifically designed to answer the relevant clinical question, or large systematic reviews or meta-analyses summarizing the literature of the specific clinical question.

A denial of post-acute authorization is a denial of coverage and potentially in violation of MA coverage requirements.

POTENTIAL BREACHES OF THE MEDICARE CONTRACT

42 CFR 422.101(b)

(i) Coverage criteria not fully established. Coverage criteria are not fully established when:

(A) additional, unspecified criteria are needed to interpret or supplement general provisions in order to determine medical necessity consistently. The MA organization must demonstrate that the additional criteria provide clinical benefits **that are highly likely to outweigh any clinical harms, including from delayed or decreased access to items or services**;

(B) NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD; or

(C) There is an absence of any applicable Medicare statutes, regulations, NCDs or LCDs setting forth coverage criteria.

Per CMS 4201-F, MA plans cannot invent or apply additional criteria (e.g. Sepsis 3) unless: (1) It is necessary to interpret Medicare rules, (2) It clearly benefits the patient, AND (3) It does not create harm—including delays or reduced access.

10+ Hospital System Secures Over $6 Million Settlement

Against a Non-Compliant Health Plan Payor

CLIENT SUCCESS | PAYOR DISPUTE RESOLUTION

300+	$6M+	25+	3
Clinics & Care Sites	Settlement Recovered	Policy Ammendments	Claim Types Resolved (HMO - Medicaid - Medicare)

The Situation

ERN was engaged to represent a 10+ trauma hospital system **facing persistent, unresolved disputes** with a major health plan payor **spanning multiple years.**

Despite repeated internal efforts to address the issues — including direct negotiations and formal outreach — **the payor failed to act in good faith.** Claims went unanswered, contractual obligations were ignored, and the administrative burden on the hospital system mounted steadily.

ERN/TRAF escalated reconsiderations, reopening requests, and CMS regulatory complaints, triggering settlement talks with the payer. After repeated lowball offers, the provider ultimately canceled its contract with the payor — a significant operational and financial disruption for a system of this scale.

ERN's Approcach

1. **Regulatory Pressure**
ERN aligned each category of disputed claims with the specific administrative laws and regulatory requirements governing payor behavior. This established a clear framework for evaluating compliance across all impacted lines of business.

2. **Strategy & Case Development**
ERN built a comprehensive case structure that connected payor actions directly to statutory obligations and contractual requirements. This included the development of a formal settlement demand supported by detailed documentation and legal positioning.

3. **Structured Escalation**
ERN advanced the matter through formal channels, including regulatory complaints and mediation, presenting a fully developed case, grounded in administrative law, outlining the payor's obligations and areas of non-adherence.

4. **Outcome Execution**
ERN maintained direct engagement to finalize terms, ensuring alignment with the framework established throughout the process. **The payor ultimately agreed to nearly all proposed terms.**

The Result

ERN's representation resulted in a **settlement over $6 million tied to improperly handled claims across commercial HMO, Medicaid, and Medicare.**

The agreement included **more than 25 policy and process amendments** that included alignment around key areas such as **medical necessity determinations, using sepsis 2 instead of sepsis 3 inpatient admission criteria, DRG-based reimbursement methodologies, and contract-based requirements for emergency and post-stabilization services (responding within one (1) hour of the authorization request).**

It also strengthened policies related to overpayments, recoupments, and audit practices, while introducing updates to internal platforms and operational workflows to **improve consistency and transparency in claim adjudication.**

The result was not only financial recovery, but **a structural shift to stem payor misconduct and instill preventative measures to preclude future violations.**

You Fight for Them, We Fight for You

Our Mission at ERN

We stand with providers in the fight for fair reimbursement, leveraging administrative law to hold payers accountable and protect the foundation of financial stability and patient care.

714-995-6900 | www. ernenterprises.org

POTENTIAL BREACHES OF THE MEDICARE CONTRACT

42 CFR 422.101(b)

(ii) Publicly accessible. For internal coverage policies, the MA organization must provide in a publicly accessible way the following:
(A) The internal coverage criteria in use **and a summary of evidence that was considered during the development of the internal coverage criteria used to make medical necessity determinations**;
(B) **A list of the sources of such evidence**; and
(C) An explanation of **the rationale** that supports the adoption of the coverage criteria used to make a medical necessity determination. When coverage criteria are not fully established as described in paragraph (6)(i)(A), the MA organization **must identify the general provisions that are being supplemented or interpreted and explain** how the additional criteria provide clinical benefits that are highly likely to outweigh any clinical harms, including from delayed or decreased access to items or services.

In addition to the clinical rationale, you can request a summary of the evidence and sources used to create/adopt internal coverage criteria.

POTENTIAL BREACHES OF THE MEDICARE CONTRACT

42 CFR 422.101(c)

(c) Medical necessity determinations and special coverage provisions—(1) Medical necessity determinations.
(i) MA organizations must make medical necessity determinations based on all of the following:

(A) Coverage and benefit criteria as specified at paragraphs (b) and (c) of this section and may not deny coverage for basic benefits based on coverage criteria not specified in paragraph (b) or (c) of this section.
(B) Whether the provision of items or services **is reasonable and necessary** under section 1862(a)(1) of the Act.
(C) The enrollee's medical history (for example, diagnoses, conditions, functional status), physician recommendations, and clinical notes.
(D) Where appropriate, involvement of the organization's medical director as required at **§ 422.562(a)(4)**.

MAOs must make medical necessity determinations based on Medicare coverage criteria and laws, not internal policies.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C4-21-26
Baltimore, Maryland 21244-1850

DATE: February 6, 2024

TO: All Medicare Advantage Organizations and Medicare-Medicaid Plans

SUBJECT: Frequently Asked Questions related to Coverage Criteria and Utilization Management Requirements in CMS Final Rule (CMS-4201-F)

On April 5, 2023, CMS issued the "Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly" final rule which included requirements and clarifications relating to Medicare Advantage (MA) coverage criteria for basic benefits, use of prior authorization, and the annual review of utilization management tools. The new regulatory provisions are applicable to coverage beginning January 1, 2024. Since the issuance of this rule, CMS has received questions about the application of these rules once they are effective. In this memo, we provide clarification about how we expect MA plans to comply with these new rules.

1. **Question: When are MA organizations able to use internal coverage criteria when making medical necessity determinations for basic Medicare benefits?**

   Answer: For Medicare basic benefits, MA organizations must make medical necessity determinations in accordance with all medical necessity determination requirements, outlined at § 422.101(c)[1]; based on the circumstances of each specific individual, including the patient's medical history, physician recommendations, and clinical notes; and in line with all fully established Traditional Medicare coverage criteria. This includes established criteria in applicable Medicare statutes, regulations, National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs). When Medicare coverage criteria are not fully established, MA organizations may create publicly accessible internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature, as permitted in § 422.101(b)(6).

[1] MA organizations must make medical necessity determinations based on all of the following:
(A) Coverage and benefit criteria as specified at § 422.101(b) and (c) and may not deny coverage for basic benefits based on coverage criteria not specified in § 422.101(b) or (c).
(B) Whether the provision of items or services is reasonable and necessary under section 1862(a)(1) of the Act.
(C) The enrollee's medical history (for example, diagnoses, conditions, functional status), physician recommendations, and clinical notes.
(D) Where appropriate, involvement of the organization's medical director as required at § 422.562(a)(4).

a measure of protection for enrollees and assurances that the coverage criteria are rational and supportable by current, widely used treatment guidelines and clinical literature.

4. **Question: What does the internal coverage criteria standard "based on current evidence in widely used treatment guidelines or clinical literature" mean as used in § 422.101(b)(6)?**

   Answer: In circumstances when Medicare Part A and B coverage criteria are not fully established and MA plan internal coverage criteria are permitted, CMS elaborated on the meaning of current, widely used treatment guidelines and clinical literature in the preamble of the final rule on pages 22189, 22196, and 22197. Current, widely used treatment guidelines are those developed by organizations representing clinical medical specialties and refers to guidelines for the treatment of specific diseases or conditions. Acceptable clinical literature includes large, randomized controlled trials or prospective cohort studies with clear results, published in a peer-reviewed journal, and specifically designed to answer the relevant clinical question, or large systematic reviews or meta-analyses summarizing the literature of the specific clinical question. MA organizations may not add coverage criteria that are not supported in such guidelines or literature, or change the substantive recommendations contained in such guidelines or literature to support coverage criteria. If the internal coverage criteria cannot be supported by current evidence in widely used treatment guidelines or clinical literature, publicly and in a way that meets the evidentiary standard in the final rule, plans should not develop internal coverage criteria even if the Traditional Medicare coverage criteria are not fully established. Referencing information, such as a book, website, or third-party criteria, without directly describing and referencing the requisite source citations from primary literature that are widely used treatment guidelines or clinical literature, would not comply with § 422.101(b)(6)(ii). These transparency measures will protect beneficiaries by ensuring that coverage criteria are rational and supportable by current, widely used treatment guidelines and clinical literature. This requirement provides further transparency into MA organizations' medical necessity decision making and is consistent with CMS's expectation that MA organizations develop and use coverage criteria in a way that aligns with Traditional Medicare.

7. **Question: Can an MA organization deny admission of a patient to a post-acute care facility from an acute care hospital if it's ordered by their physician and the patient meets the coverage criteria for admission into that facility?**

   Answer: No, if a patient is being discharged from an acute care hospital to a post-acute care facility that would be covered under Traditional Medicare and the patient's attending physician orders post-acute care in the specific type of facility (i.e., Skilled Nursing Facility (SNF), Long Term Care Hospital (LTCH)) and the patient meets all applicable Medicare coverage criteria for admission into that facility type, the MA organization cannot deny admission to that post-acute setting and/or redirect the care to a different setting. In the context of post-acute care services furnished in a particular setting, MA organizations may only deny a request for Medicare covered post-acute care services if the MA organization determines that the Traditional Medicare coverage criteria (e.g., for SNF care in §§ 409.30-409.36) or internal coverage criteria when applicable and

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C4-21-26
Baltimore, Maryland 21244-1850

authorized by § 422.101(b) for the services cannot be satisfied in that particular setting. We explained this clearly as part of the proposal that we adopted in the final rule. 88 FR 22189. We reiterate here that MA organizations may only deny a request for Medicare covered post-acute care services in a particular setting if the MA organization determines that the Traditional Medicare coverage criteria or internal coverage criteria (when applicable and authorized by § 422.101(b)) for the services cannot be satisfied in that particular setting. However, MA plans are permitted to offer coverage of alternatives to Medicare covered post-acute care services in a particular setting and an enrollee is permitted to elect different treatment. The requirement for MA plans to cover all basic benefits consistent with Traditional Medicare coverage criteria does not prohibit discussions with the enrollee of other treatment options that are covered by the MA plan. However, the flexibility for MA plans to cover and deliver care in cost-effective approaches does not replace the obligation for MA plans to cover all basic benefits consistent with the established coverage criteria for Traditional Medicare.

MA organizations may only terminate coverage for post-acute care services based on coverage criteria that are specified in § 422.101(b) or (c), which include medical necessity. An algorithm or software tool may be used to assist MA plans in predicting a length of stay, but that prediction alone must not be used as the basis to terminate post-acute care services; the patient must no longer meet the level of care requirements needed for the post-acute care at the time the services are being terminated, which can only be determined by re-assessing the individual patient's condition prior to issuing the notice of termination of services. An MA organization's decision to terminate post-acute care services and discharge a patient from a home health agency (HHA), skilled nursing facility (SNF), or comprehensive outpatient rehabilitation facilities (CORF) is an organization determination and is appealable in accordance with rules in §§ 422.624 and 422.626.[4] The specific expedited appeal process applicable to such terminations of provider services provides that the burden of proof rests with the MA organization to demonstrate that termination of coverage is the correct decision, either on the basis of medical necessity, or based on other Medicare coverage policies, and that the MA organization must supply a specific and detailed explanation why services are either no longer reasonable and necessary or are no longer covered, including a description of the applicable coverage criteria and rules. 42 CFR § 422.626(c) and (e).

See question #2 of CMS-4201-F for MAO use of AI and Algorithms in medical necessity determinations.

8. Question: Does the CY 2024 final rule mean that MA organizations must follow the Medicare "two-midnight rule"?

[4] Discharge from an inpatient hospital is appealable in accordance with §§ 422.620 and 422.622. In these expedited reviews by the QIO, the MA organization also bears the burden of proof that the discharge "is the correct decision, either on the basis of medical necessity, or based on other Medicare coverage policies." § 422.622(c).

DEPARTMENT OF HEALTH & HUMAN SERVICES
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9. **Question: Are plans able to do post-claim audits and deny payment and still be compliant with the effect of a prior authorization or pre-service approval rule at 422.138(c)?**

Answer: Plans can conduct post-claim reviews, but it must be compliant with reopening rules and only revised within specific parameters. Subject to the limitation in § 422.138(c), discussed below, a plan is permitted to conduct post-payment review on a selected claim, consistent with the reopening rules in § 422.616 and other applicable rules in Part 422, Subpart M.

If an organization determination is reopened and revised, the plan must notify the parties of its revised determination. If the revised determination is adverse, the notice to the parties must state the rationale and basis for the reopening and revision and any applicable right to appeal. However, the final rule codified at § 422.138(c) states that if an

MA organization approved the furnishing of a covered item or service through a prior authorization or pre-service determination of coverage or payment, it may not deny coverage later on the basis of lack of medical necessity and may not reopen such a decision for any reason except for good cause (as provided at 42 CFR § 405.986) or if there is reliable evidence of fraud or similar fault per the reopening provisions at § 422.616. This means that if the MA organization pre-authorized the inpatient admission, it would be a violation of § 422.138(c) to later deny payment based on a determination that the level of care was not medically necessary.

We have heard frequently that MA organizations utilize post-claim review audits and examinations that routinely result in the denial of payment for the inpatient care that was provided to the enrollee. Further, we have heard that MA organizations characterize these reviews as "payment" reviews and that these reviews are "not organization determinations" or "level of care or medical necessity reviews." We disagree with those characterizations of decisions that are denials of coverage or otherwise a 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. We reiterate here that the refusal to provide or pay for services, in whole or in part, including the type or level of services (e.g., inpatient services versus outpatient services) is an organization determination by the MA plan under § 422.566(b)(3). Therefore, if the MA organization expects to issue a partially or fully adverse decision about whether the services are or were medically necessary, that decision – meaning that organization determination - must be reviewed by a physician or other appropriate health care professional with expertise in the field of medicine or health care that is appropriate for the services at issue, including knowledge of Medicare coverage criteria, before the MA organization issues the organization determination decision. See 42 CFR § 422.566(d).

APPEAL AS PLAN DIRECTED CARE

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;**

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;

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—

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) <u>The MA organization cannot be contacted</u>; 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.

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."

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop N2-20-16
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES

Office of Strategic Operations and Regulatory Affairs/Freedom of Information Group
Refer to: Control Number 052220197010 and PIN Q2XA

7/8/2019

Daniel Muhlbach
The Reimbursement Advocacy Firm
5856 Corporate Avenue, Suite 110
Cypress, CA 90630

Dear Mr. Muhlbach:

This letter is in response to your Freedom of Information Act (5 U.S.C. § 552) request of March 15, 2019 which you sent to the Centers for Medicare & Medicaid Services (CMS). Within your correspondence, you requested the following:

1. ***An electronic, written copy of any CMS Policy, Directive, Manual, Handbook, Standard Operating Procedure, Federal Register or statutory authority that delineates how contracted, in-network providers function as agents of the plan.***

2. ***An electronic, written copy of any CMS Policy, Directive, Manual, Handbook, Standard Operating Procedure, Federal Register or statutory authority that describes how the provision of an item or service by a contracted, in-network provider constitutes a favorable organization decision.***

3. ***An electronic, written copy of any CMS Policy, Directive, Manual, Handbook, Standard Operating Procedure, Federal Register or statutory authority that permits a Medicare Advantage Organization from performing retroactive medical necessity reviews for health care services that are ordered and rendered by a contracted, in-network provider.***

4. ***An electronic, written copy of any CMS Policy, Directive, Manual, Handbook, Standard Operating Procedure, Federal Register or statutory authority that absolves a Medicare Advantage Organization's financial liability for health care services that are pre-approved by a contracted, in-network provider.***

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)

- *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),

I AM THE AGENT.

then the beneficiary should not be penalized to the extent the physician did not follow plan rules."

Consequently, when a contracted provider furnishes a service or refers an enrollee for a service that an enrollee reasonably believes is a plan-covered service, the enrollee cannot be financially liable for more than the applicable cost-sharing for that service. If a contracted provider believes an item or service may not be covered for an enrollee, or could be covered only under specific conditions, the appropriate process is for the enrollee or provider to request a pre-service organization determination from the plan.

If a contracted provider refers an enrollee to a non-contracted provider for a service that is covered by the plan upon referral, the enrollee is financially liable only for the applicable cost-sharing for that service. Contracted providers are expected to coordinate care or work with plans prior to referring an enrollee to a non-contracted provider to ensure, to the extent possible, that enrollees are receiving medically necessary services covered by their plan. Furthermore, plans are expected to work with their contracted providers to ensure that clear processes are in place and providers are educated about those processes, including appropriate documentation, to substantiate that a referral has been made.

If a service is never covered by the plan and the plan's Evidence of Coverage (EOC) provided to the enrollee is clear that the service or item is never covered, the plan is not required to hold the enrollee harmless from the full cost of the service or item. For a service or item that is typically not covered, but could be covered under specific conditions (e.g., dental care that is necessary to treat an illness or injury), the EOC, in and of itself, is not adequate notice of non-coverage for purposes of determining enrollee liability. In such instances, the appropriate process is for the enrollee, or the provider acting on behalf of the enrollee, to request a pre-service organization determination. If the plan denies the service, the plan must issue the standardized denial notice with appeal rights. The enrollee has the right to appeal any denial of a service or item. Plans also must educate their contracted providers about the limits of plan coverage and the need to correctly advise enrollees when providing referrals for covered services. This will prevent confusion related to plan coverage and enrollee financial liability as well as ensure coordination of the care furnished.

When the provider, or the plan acting on behalf of the provider, can show that an enrollee was notified (via a clear exclusion in the EOC or the standardized denial notice) prior to receipt of the item or service that the item or service is not covered by the plan or that coverage is available only if the enrollee is referred for the service by a contracted provider but the enrollee nonetheless receives that item or service in the absence of a referral, the regulation at §422.105(a) does not require the MA plan to hold the enrollee harmless from the full cost of the service or item charged by the provider.

170 — *Balance Billing*
(Rev. 121, Issued: 04-22-16, Effective: 04-22-16, Implementation: 04-22-16)

A contracted provider is an agent of the plan in both scenarios: 1) While furnishing a service or 2) Referring the enrollee to another physician or provider.

ERN
NCRA

CASE STUDY

CONTRACTED PROVIDERS AGENTS OF THE PLAN

ContinueCARE Appeal Form

CHC Community Hospital Corporation

Patient Name: [redacted] **Michael** DOB: [redacted] Insurance Company: UHC MCR Subscriber ID# [redacted] Submission Date: 5/5/23 Denial Date: 5/6/23 Denied by: MD Phone Number: 855-851-1127 Reference Number: None Provided	**ContinueCARE Hospital Location: Palmetto** **Denial Reason: PT did not have the complexity requiring the LTACH level of care and the care could be safely provided at a lower level of care.** **How long was given for P2P: 4 business hours** **P2P Phone Number: 855-851-1127, option 5** **Appeal Phone Number: 877-262-9203** **Appeal Fax Number: 866-373-1081**

Hospital Information: Name of referring hospital: Lexington Medical. Name & number of referring MD: Anthony Zamcho Name & number of case manager: Deana Sutton & number: Anthony Zamcho	**Brief Patient History:** [redacted]
Acute Diagnosis Code: [redacted] Description: [redacted]	**What services will be needed?** [redacted]

REQUEST FOR EXPEDITED RECONSIDERATION
AND/OR REOPENING OF A RECONSIDERED DETERMINATION
PURSUANT TO 42 CFR §422.584 and §422.590 (e) and §422.616

May 9, 2023

United Healthcare Appeals Unit
P.O. Box 30575
Salt Lake City, UT 84130-0575

Our Client: **Continue Care-Palmetto**
Tax ID:
NPI:
Patient: [redacted]
Member ID: [redacted]
DOB:
DOS: **05/01/2023-Ongoing/Present**
Reference #: [redacted]

Dear United Healthcare Appeals Unit:

This office represents Continue Care Palmetto (CCP) **(See Exhibit A: Statement of Representation, ERN is a business association representing the covered entity)** and has been asked to audit and investigate the attached denial of Medicare Long Term Acute Care inpatient covered services for possible complaint filing with **the Centers for Medicare and Medicaid Services (CMS)** for United Healthcare's possible violation of federal law and CMS guidelines.

Please be advised that this is an expedited reconsideration request (Per section 40.8 of the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance (Page 40)) of the improper authorization denial dated 05/06/2023.

We dispute UHC's denial of the patient's transfer to a long-term acute care hospital because the referring facility, Lexington Medical Center, is an in-network facility, therefore, any referrals for services are plan-directed care, pursuant to Chapter 4 Medicare Managed Care Manual §160, as the facility is an agent of the plan. Furthermore, MAOs must make determinations based on coverage criteria no more restrictive than original Medicare, CCP notified UHC of the inpatient transfer, and upon denial, UHC failed to assume care of the patient, as shown and described below:

- On 05/01/2023, the patient presented to the emergency room at Lexington Medical Center under the care of the hospitalist team for [redacted]
- On 05/05/2023, CCP prepared patient for transfer to long term acute care facility and notified United Healthcare SR of this and requested authorization.
- On 05/06/2023, United Healthcare SR denied the long-term acute care transfer request, stating the patient did not have the complexity requiring the transfer to long term acute care, and that the care could be safely provided at a lower level of care, but did not assume care of the beneficiary as required by **42 CFR §422.113(c)(3).**
- To date, United Healthcare SR has failed to provide hard copy authorization for medically necessary inpatient long term acute hospital care ordered by the treating physician.

United Healthcare
CA124-0187, PO Box 6106, Cypress, CA 90630

The Case Number is: [redacted]

May 11, 2023

The Reimbursement Advocacy Firm
Attn: John Shen
Taylor At Marion St
Columbia, SC 29220

RE: Member Name: [redacted]McMichael
Member ID: [redacted]

Dear Mr. Shen :

We received your request for a fast appeal on May 09, 2023 about providing coverage for long term acute care. Thank you for bringing this to our attention. We decided our decision to deny coverage for the services is incorrect.

What happens next?

We will cover services until they are no longer medically needed, or the plan benefit limit is reached.

Authorization number [redacted] for Long Term Acute Care from Intermedical Hospital of South Carolina provider can be reached at (803)-296-5425

We have approved Authorization number [redacted] for Long Term Acute Care from Intermedical Hospital of South Carolina provider can be reached at (803)-296-5425. You may use authorization number [redacted] for the following date(s); Expected Admission Date: 05/11/2023.

You have the right to:

- Ask for a copy of your case file and the criteria that we used to decide your case
  - To request a copy of your file, please contact me at:

UnitedHealthcare
PO Box 6106
MS CA124-0187
Cypress, CA 90630-0016

[redacted]

REQUEST A REOPENING

ERN NCRA

ERN TRAF

REOPENING REQUEST
Fact Sheet

Medicare Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance § 80

[§ 80] Reopening and Revising Determinations and Decisions

Pursuant to **42 CFR § 422.616(a)**, the reopening regulations in **Part 405** (i.e., **§§405.980 – 405.986**) are applicable to Part C, unless otherwise specified.

[§ 80.2] Reopenings Separate and Distinct from Appeals

The reopening process is separate and distinct from the appeals process.

[§ 80.3] Timeframes for Reopening

For MA plans, reopenings may be initiated:
- **(1)** within 1 year from the date of the initial determination or redetermination for any reason;
- **(2)** within 4 years from the date of the initial determination or redetermination for good cause; and
- **(3)** at any time for the purpose of correcting a clerical error or if the determination was procured by fraud.

For all other entities, reopenings may be initiated:
- **(1)** within 180 days from the date of the initial determination or redetermination for good cause; and
- **(2)** at any time if the decision was procured by fraud.

[§ 80.3.2] Timeframes for Processing a Reopening

MAOs must:
- **(1)** notify the requestor in writing of the decision not to reopen; or
- **(2)** issue a determination as to the administrative finality of the reopening action within:
  - **(a)** 60 days from the date of receipt of the party's reopening request; or
  - **(b)** 30 calendar days of receipt of the request for reopening, if at the IRE level.

[§ 80.5] Good Cause for Reopening

1) There is **new and material evidence** that was not available or known at the time of the determination or decision and may result in a different conclusion.
2) The evidence that was considered in making the determination or decision clearly shows on its face that an **obvious error** was made at the time of the determination or decision.

[§ 80.6] Notification Requirements for Reopenings

Written notification must:
- **(1)** state the rationale and basis for the reopening and revision;
- **(2)** state the specific reason for the revision or change in rationale; and
- **(3)** provide information on any appeal rights.

If a reopening results in issuance of payment to a provider, a revised remittance advice notice must be issued.

How do you handle "appeals exhausted" denials?

TRAF - The Reimbursement Advocacy Firm
ERN Enterprises, INC. 3535 Hyland, Suite 130, Costa Mesa, CA 92626. Tel: 714-935-6900. Fax: 714-935-6901. www.ernenterprises.org

Reopening Blurb and TRAF OTs

Trevor Clemente
To Ed Norwood

Reply | Reply All | Forward

Wed 9/17/2025 9:51 AM

Hey Ed, Here are the 2 most recent Reopening OT's and the Request for Reopening Blurb. Have a great class!

TRAF 91006: MHS / Aetna

ER-No Pay Notification – Amount paid: $15,894.12

- 1/6/25 Aetna denies MHS UB claim as unauthorized.
- 4/10/25 – ERN appeal submitted
- 5/1/25 – Aetna denies appeal as appeal rights exhausted.
-5/2/24 – Request to Reopen submitted
- 6/27/25 – Follow-Up Request to Reopen submitted.
- 7/18/25 – 2nd Follow-Up Request to Reopen submitted.
- 9/4/25 – Overturned denial and paid

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.

What questions do you have for me?

You fight for their lives.

We fight for you.

CONTACT US:
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