California HFMA

Emerging Third-Party-Payer Denials – Provider Defenses & Appeal Strategies

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Current Denial Trends

- Increase in Third-Party-Payer Audits
- Increase in Inappropriate Level of Care Denials
- Emergence of DRG *Validation* Audits
- Emergency Room Acuity Level Downgrades

Tactics to Address Emerging Issues

- Arguments & Resources for Appeal Letters
- Beneficial Managed Care Contract Language
- Targeted Education for Clinical Review Nurses
- Utilization of External Appeal with Independent Review Organization or Complaint to the California Department of Managed Healthcare
- Development of Inpatient to Outpatient Billing Protocol
- Implementation of Certain Front-End Processes

Resources

- Legal Principals & Concepts
- Case Law
- California Statutes
- Federal Regulations
- Contract Provisions
- Payer "Provider Manual" Language
- Medical Records
- Hospital Internal Policies & Procedures
- Hospital System Notes
- Summary Plan Description
- Industry Guidelines

Inappropriate Audit Tactics

Blue Cross – HDI Audit – Claims Previously Authorized

- Blue Cross certified the inpatient admissions during the preauthorization process and issued authorization numbers.
- Blue Cross's Audit Company, HDI, included the claims in an audit and requested medical records to review level of care. HDI physician determined the admissions didn't meet inpatient level of care.
- Blue Cross system notes indicate Blue Cross was aware admissions were pre-certified.

Recovery Notes:	Provider Billing Error
Crediting Notes:	Please rekey claim to deny with Not Covered Reason D1142 - Services not covered in an inpatient setting. See CSB 171-11. Clinical Operations has entered into a partnership with HealthDataInsights (HDI) to perform Retrospective Utilization Review Audits of inpatient admissions. While precerts may exist for these claims, it has been determined that they do not meet criteria for an inpatient admission. Claims should not be repaid or adjusted without approval from Audit Services. For

Inappropriate Audit Tactics

Blue Cross – HDI Audit – Claims Previously Authorized

- Hospital Appeals Should Cite:
  - Contract Language – "There shall be no retroactive denial of claims on the basis of medical necessity for claims which have been approved by the utilization review program."
  - State Statute – "A claim may not be denied if a provider follows the payer's authorization procedures and receives authorization for a covered service for an eligible subscriber."
  - Medicare Managed Care Manual – "If the 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."

California State Statutes

- Health plan shall not rescind or modify an authorization for services after the service is rendered.
- Health plan shall not deny payment of a claim on the basis that the plan did not provide authorization for health care services that were *related to* services that were previously authorized if it was medically necessary to provide the services at the time.

Cal. Health & Safety Code § 1371

Medicare Managed Care Manual

If the Medicare Advantage 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)

Managed Care Contract Provisions

Payor A

- PAYER shall not deny or reduce payment to Provider for any services provided by Provider to PAYER Beneficiaries once initially pre-certified or authorized provided that there was no material misrepresentation or fraud in the request for authorization.

Payor B

- Payor may deny payment of claims which have not been approved by its utilization review program. However, there shall be no retroactive denial of claims on the basis of medical necessity for claims which have been approved by the utilization review program.

Payor C

- Provider may ***conclusively*** rely on authorization obtained from plan or plan's agent for medically necessary covered services pursuant to State Statute.

Inappropriate Audit Tactics

Humana Audit – Claims Previously Adjudicated

- Humana denied an inpatient claim prior to payment for lack of authorization. Hospital submitted an appeal and Humana overturned the denial and issued payment.
- Months later, Humana's Audit Division included the claim in an audit and requested medical records to review level of care. Hospital submitted medical records and Humana's Audit Division determined the admission didn't meet inpatient level of care. Humana recouped payment.
- Accounts that are reviewed and adjudicated through the payer's appeals process should *not* be subject to a later retrospective audit.
  - Federal regulations do not allow multiple audits of a single account.
  - National Association of Insurance Commissioner's Audit Guidelines indicate audit results are "final."

Medicare Managed Care Manual

According to CMS, review entities must ***not*** review claims that were previously subjected to medical record review.

Program Integrity Manual, Chapter 3, Section 3.5.2

Healthcare Carrier Claim Audit Guidelines

- Drafted by the National Association of Insurance Commissioners.
- State and Federal Regulations and Managed Care Contract Language preempt these Guidelines.
- Carrier shall provide notice of audit within 6 months of receipt of claim and complete the audit within 12 months.
- Carriers shall make prompt payment of a bill and shall not delay payment for an audit process.
- Payment of 95% of the insurance liability shall be an acceptable payment amount prior to scheduling the audit.
- The medical record documents clinical data on diagnoses, treatments, and outcomes; it is not designed to be a billing document. Other documentation for services may exist.
- Once both Parties agree to the audit findings, **audit results are final**.

Inappropriate Audit Tactics

Anthem Blue Cross Audit – Improper Notice & Offset

- Anthem Blue Cross sent notice of audit to providers which only listed an aggregate dollar amount for reimbursement and vague findings of "upcoding and unbundling." None of the letters identified the claim, name of patient, or date of service; providers were required to contact Anthem for claim information.
- Anthem Blue Cross sent the recoupment notices more than one-year from the date of payment.
- Anthem Blue Cross recouped payment because of hospitals' failure to provide medical records / contest the recoupment.

California State Statutes

- A plan may only offset an uncontested notice of overpayment against a provider's current claim submission when: (i) the provider fails to reimburse the plan within 30 working days *and* (ii) contract between the provider and the plan specifically authorizes offset.

- A plan shall not request reimbursement for the overpayment of a claim unless the plan sends a written request for reimbursement to the provider within 365 days of the Date of Payment on the overpaid claim.

Cal. Health & Safety Code § 1371

Cease & Desist Order

- Anthem Blue Cross was ordered to cease attempts to obtain reimbursement from providers without notifying the provider in writing of the name and date of service of ***each*** claim and explanation of the reason for overpayment.
- Anthem Blue Cross was also ordered to cease all attempts to obtain reimbursement on claims greater than 365 days from the date of payment.

CA Department of Managed Healthcare Matter No. 11-366

Potential Provider Defenses

- Challenge a payer audit when the audit does not conform to audit parameters in the managed care contract and/or applicable California statutes.
  - The audit is beyond the applicable time frame.
  - Payer did not provide proper notice of the audit (*e.g.*, was correct hospital address used?).
  - The notice did not contain sufficient information regarding the identification of the account and/or the reason behind the denial.
  - The notice did not give the provider enough time to contest the recoupment.
  - Payer did not provide proof of relationship with audit company in violation of hospital's release of information policy.

Managed Care Contract Language

- Plan agrees that only Plan and its employees may conduct an audit. Third-parties (*i.e*. audit companies) are *not* entitled to conduct audits.
- If Plan's accounts receivable over 60 days exceeds "X," Plan shall forfeit its right to audit until such time as the A/R is at or below "X".
- Plan agrees that Payer's audit requests cannot exceed "X" Members for any given month.
- Plan shall not conduct an audit of a Member's medical and billing records unless payment of the entire amount due on the claim is made to Hospital.
- Accounts that have not been paid in accordance with State Prompt Payment Statute are not entitled to be audited.
- All audits must be conducted within 6 months of the date of service for outpatient services and date of discharge for inpatient services.

Managed Care Contract Language

- PAYER will conduct audits in accordance with the following guidelines:
  - Provision of documentation of audit company relationship with payer and copy of business associate agreement;
  - Provision of information to identify the claim (date of service, account number, patient name);
  - Provision of patient's authorization to release PHI to third-party;
  - Payment to Hospital for copies of medical records;
  - Audit personnel will identify to HOSPITAL any underpayments that are discovered during the audit.
  - Final letter documenting agreed upon audit results, terms for collections for overpayments, and action to be taken by PAYER or HOSPITAL for underpayments.

Enhanced Bill Review Audits

- Kaiser "pends" or denies high dollar claims for Itemized Statement.
- Upon receipt of Itemized Statement, Kaiser performs an audit of hospital charges.
- Kaiser denies charges as "Redundant," "Inclusive," "Routine", "Unbundled" and thus not separately payable.
- Sole purpose of audit is to decrease the "Total Charges" on the claim and, thus, the amount due to the hospital under the contract.

Enhanced Bill Review Audits

Commonly Denied Charges

- Diabetes Education
- Cardiac Patient Instructions
- Prolene
- Venipuncture Lab
- Heparin Flush
- Point of Care Lab Tests
- Blade Sternum
- Nasal Cannula
- Dextrose
- HC Magnesium
- NACL / Sodium Chloride

Enhanced Bill Review Audits

- Review managed care contract for relevant provisions (Audit, Billing & Coding, Adjustments).
  - Was notice of audit provided in the prescribed time period?
- Review Payer's Billing Guidelines and Claim Payment Policies.
  - If policy is not published on website or provider manual, request policy from Provider Relations Representative.
  - Argue unpublished policies are not "incorporated" into the contract, and thus, inapplicable to hospital.
- Review California statutes.
- Review CMS Guidelines.

Enhanced Bill Review Audits

Sample Contract Provision - *Aetna*

Hospital agrees to rebundle to the primary procedure those services considered part of, incidental to, or inclusive of the primary procedure and make other adjustments for inappropriate billing or coding (e.g., duplicative procedures or claim submissions, mutually exclusive procedures, gender/procedure mismatches, age/procedure mismatches). To the extent Hospital is billing on a CMS 1500, as of the Effective Date, in performing rebundling and making adjustments for inappropriate billing or coding, Company utilizes a commercial software package (as modified by Company for all Participating Providers in the ordinary course of Company's business) which commercial software package relies upon Medicare/Medicaid and other industry standards in the development of its rebundling logic. Company makes available on its password protected provider website (www.aetna.com) the current version of payment policy (i.e., rebundling) logic then in use for consideration of claims.

Enhanced Bill Review Audits

- "Billing Errors"
  - Audit alleges "Billing Error" for high dollar drug charge.
  - Example: CPT Code J2977 Alteplase
- Check CMS Medically Unlikely Edit ("MUE").
  - If units billed is acceptable under CMS guidelines, the denial of the charge as a "Billing Error" is completely inappropriate.
  - The appeal should include clinical support for the medically necessity of the drug *and* the units billed.
  - Include Print Out of CMS MUE for the CPT Code.
  - The medical record should be attached to the appeal.

Enhanced Bill Review Audits

- "Health Plan Exclusion"
  - Audit alleges charges removed due to health plan "Exclusion" such as an Experimental Denial.
  - Example: Inhaled Nitric Oxide ("INO")
- Deploy Approach used for Experimental Denials.
  - Obtain payer's clinical policy bulletin for the service, drug, or procedure.
  - Argue that the patient's condition met the criteria for coverage.
  - The medical record should be attached to the appeal.

Enhanced Bill Review Audits

- "Routine," "Unbundled," "Inclusive"
  - Obtain Speaking Points from Hospital Chargemaster contact for charges commonly denied as "Inclusive".
  - Maintain a document with arguments for each charge.
  - Example: Diluents denied as included in the underlying charge for medication.

"Diluents are items provided separately from the drugs administered. Per Medicare transmittal 1336, "Hospitals are strongly encouraged to report charges for all drugs, biologicals, and radiopharmaceuticals, regardless of whether the items are paid separately or packaged." Hospital also follows Medicare's 340B reporting and tracking requirements which mandate the hospital charge with this level of detail."

Enhanced Bill Review Audits

- Application of Outpatient Rules to Inpatient Claim
  - Audit Companies cite CMS & NCCI Rules that are applicable to *outpatient* claims.
  - Example: One Venipuncture Laboratory Charge Allowed Per Day

"Application of this coding edit is completely inappropriate because the Medicare rule is only applicable to *outpatient* coding of laboratory charges. The subject claim is an *inpatient* hospital claim. As you are aware, payment for inpatient care is based on a fixed fee determined for each diagnosis-related group ("DRG"). Laboratory tests performed for Medicare inpatients are considered a part of the DRG payment."

Inappropriate Audit Tactics

Aetna Audit – Failure to Forward Appeals to Maximus

- Aetna is non-participating with the hospital. Aetna failed to forward Medicare Advantage Plan audit appeals to Maximus after denial of second level appeal. Maximus refused to accept appeals directly from the hospital.
- Hospital aggregated claims and sent Notice of Dispute to Aetna. Hospital demanded that (i) claims be forwarded to Maximus with no timely filing implications and (ii) Aetna correct its appeal process.
- Hospital cited 42 CFR § 422.590(b): "If the Medicare Advantage Organization affirms, in whole or in part, its adverse organization determination, it must prepare a written explanation and send the case file to the independent entity contracted by CMS no later than 60 calendar days from the date it receives the request for a standard reconsideration. The organization must make reasonable and diligent efforts to assist in gathering and forwarding information to the independent entity."
- Hospital also cited Aetna's own website which indicated that if it upholds an initial determination, it will forward the case to Maximus.

Inappropriate Audit Tactics

Aetna Audit – Failure to Forward Appeals to Maximus

- Instead of reprocessing the claims, Aetna and Hospital agreed upon a settlement amount. Aetna corrected internal appeals process and assigned a representative for hospital to contact with future issues.
- Hospital made changes to its appeals processes;
  - Hospital ensured Medicare Advantage appeals submitted (i) to appropriate Aetna Appeal Address for Medicare Advantage claims (ii) without Aetna's *commercial* appeal cover form.
  - Hospital included the executed Waiver of Liability Form with every appeal.

Court Ruling – Exhaustion of Administrative Remedies in Medicare Advantage Disputes

- Non-contracted Medicare Advantage Plan initially paid the hospital's bills, but later "unilaterally recouped substantial sums" from hospital on post-payment audits.
- The plan refused to return the payments, and the hospitals sued for unjust enrichment and quantum meruit.
- The plan argued the claims should be dismissed because the hospital failed to exhaust their administrative remedies under the Medicare Act – the case was dismissed.
- Court held that **hospitals must exhaust their administrative remedies** before bringing their payment dispute with a Medicare Advantage Organization to court.

Emergency Department Denials

- Payers implementing policies to:
  - Deny emergency department ("ED") claims as "non-emergent" or
  - Downgrade ED Acuity Level.
- Denials are based on the coding of the claim; not on the medical record.
  - UHC utilizes Optum's tool; EDC Analyzer.
- High volume of low dollar denials.
  - ED Acuity Level Downgrade Average is $180.00.

Emergency Department Denials

- Denials involve clinical determination so each denial must be individually appealed with medical record.
- To pursue hearing or legal action, payer's internal appeal avenues must be exhausted.
- Create appeal letter templates and process to *efficiently* appeal downgrades.
- The are no regulatory guidelines for coding ED Level. MedPAC asked HHS to create a national guideline for coding all ED visits by 2022.
- *Would change to hospital's managed care contract reimbursement structure for ED visits help the issue*?

Clinical Review Nurse Training

- Improve success of clinical appeals by training Clinical Review Nurses to incorporate the following items into the appeal:
  - Procedural Arguments
  - Contract Language
  - California Statutes or Federal Regulations
- Provide Clinical Review Nurses with managed care contract provisions that are relevant to clinical denials.
- Provide Clinical Review Nurses with summary of California statutes applicable to clinical denials and appeals.
- Develop appeal letter templates for Clinical Appeal Nurses which contain the most common procedural arguments.
- Conduct "Persuasive Appeal Writing Workshops" for Nurses.

Clinical Review Nurse Training

Procedural Arguments

- Denied claims involve issues *in addition to* "lack of medical necessity" that must be addressed.
- The hospital could not request authorization because the hospital was not aware of the Patient's insurance coverage due to "Extenuating Circumstances":
  - The patient presented to the emergency department unconscious and could not communicate coverage information;
  - The patient did not have an insurance identification card upon presentation to the emergency department;
  - The patient indicated coverage under *traditional* Medicare.
- The hospital attempted to obtain authorization, however, when the hospital called the carrier, the carrier advised that authorization was *not* required.

Clinical Review Nurse Training

Contractual Arguments

- Managed care contract may contain language which requires coverage for medically necessary services *even though* the payer's notification procedure was not followed.
  - "In the event payment is denied for Hospital's failure to comply with a protocol regarding notification or authorization, Payer will reverse the denial if Hospital can show **Hospital's services were medically necessary."**
  - "In the event that a procedure is changed or added on the date of service to more appropriately treat the patient's condition, payment for those services cannot be denied based on lack of prior authorization alone."
    - Specific to Unplanned *Outpatient* Procedures – Physicians modify procedure *during* the procedure so the billed CPT Codes do not match the authorized CPT Codes.

Clinical Review Nurse Training

Failure to Respond to Authorization Request

- Patient presented to the Hospital Emergency Room was stabilized and admitted as an inpatient.
- Hospital requests authorization from patient's insurer. Insurer "pends" the authorization for clinicals. Hospital provides the clinicals.
- Hospital bills the claim and subsequently receives a letter from insurer indicating that the inpatient admission was denied as not meeting criteria at the time of the authorization request.

California State Statutes

A health plan must approve or disapprove a provider's request for authorization to provide necessary post-stabilization medical care within one half hour of the request, or the necessary post-stabilization medical care shall be **deemed authorized**.

Cal. Health & Safety Code § 1371.4(d); 28 CCR § 1300.71.4(b)

Level of Care Denials

Regulatory Arguments – Use of Incorrect Clinical Criteria

- HealthNet & UHC often use Milliman Care Guidelines ("MCG") to deny inpatient Medicare Advantage Plan claims.
- Inpatient admissions for Medicare Advantage beneficiaries must be reviewed under the two-midnight rule with deference to the physician's complex medical judgement.
  - According to CMS, criteria such as "InterQual and MCG are *just tools*, not Medicare policy."
- Medicare Advantage Plans may *not* restrict a patient's benefits beyond the limitations imposed by Traditional Medicare.

SECTION 10.2 MEDICARE MANAGED CARE MANUAL

Level of Care Denials

Regulatory Arguments – Use of Incorrect Clinical Criteria

Inpatient admissions are based on an *expectation* that a patient will require two midnights of inpatient care. CMS requires that reviewers evaluate the appropriateness of an admission based *solely* upon the information available at the time of admission.

- Medical reviewers must *only* consider the medical evidence that was available to the physician at the time he or she made the admission decision (*i.e.*, what is "known & knowable").
- Reviewers are instructed NOT to take into account other information, such as test results, that was *not* available to admitting physician unless it would support the admission decision.

BENEFITS POLICY MANUAL (CMS PUB. 100-02), CH. 1, § 10

Level of Care Denials

Regulatory Arguments – Use of Incorrect Clinical Criteria

- Under the 2-midnight benchmark, if a beneficiary refuses any additional care and is subsequently discharged, this will be considered similarly to departures against medical advice and could be considered an appropriate inpatient admission, so long as the expectation of the need for medically necessary hospital services spanning 2 or more midnights was reasonable at the time the inpatient order was written, and the basis for that expectation as well as the refusal or additional treatment, are documented in the medical record."

CMS FREQUENTLY ASKED QUESTIONS – TWO-MIDNIGHT RULE, Q12, A12

Level of Care Denials

Arguments Against Use of a Clinical Criteria

- Commercial Clinical Criteria are *just* Guidelines and should *not* be Used as a Substitute for a Physician's Independent Judgement.
  - Cannot "replace" a doctor's physical and visual assessment of a patient.
  - "There are very few cases in which the physician's judgment is so plainly unreasonable, or contrary to good medical practice, that coverage should be refused."
- MCG only considers the progress made by an "optimally responsive patient" and assumes each patient's care is going to progress with the best possible outcome.

Court Ruling – MCG Clinical Criteria used by BCBS More Restrictive than Generally Accepted Standards of Care

- BCBS health benefit plans defined "medically necessary" services as appropriate and consistent with accepted standards of medical practice in the state.
- Court held that the clinical criteria developed by MCG and used by BCBS were **much more restrictive** than those generally accepted standards.
- The driving factors in determining appropriate treatment level should be safety and effectiveness.
- When there is ambiguity as to the appropriate level of care, generally accepted standards call for erring on the side of caution by placing the patient in a higher level of care.

Smith v. HCSC Case No. 1:19-cv-07162

Level of Care Denials

Regulatory Arguments – Inpatient Only Procedure

- Molina often denies inpatient claims for failure to meet inpatient admission criteria when the hospitalization involves an "Inpatient Only Procedure."
- "Inpatient Only Procedures" are procedures that are only payable under Medicare when they are performed in the inpatient hospital setting.
- Medicare publishes a list of "Inpatient Only" CPT Codes annually in Addendum E to the OPPS Final Rule.

Level of Care Denials

Regulatory Arguments – Inpatient Only Procedure

- Appeal should state the procedure is on the "Inpatient Only" list.
  - Include the relevant code and code description in the appeal.
- If plan is a Medicare Advantage Plan, cite CMS regulations which state that Medicare Advantage Plans may not restrict benefits beyond the limitations imposed by Traditional Medicare.
- If plan is MediCal or Commercial, check the payer's clinical policy; many payers' own clinical policies indicate reimbursement at inpatient level of care for Inpatient Only Procedures.
- "Payer must cover services provided in accordance with generally accepted standards of medical practice. The country's ***largest*** payer of healthcare services (CMS) deemed these procedures so serious that they *must* be performed on an **inpatient** basis."

Coding Denials

DRG Downgrade

- Physician documentation of the condition is *not* contained in the appropriate sections of the medical record.

DRG Validation

- There is physician documentation of the condition in the record, however, the payer alleges the physician diagnosis is *not* accurate.

Coding Denials

Removed Secondary Diagnoses

N17.9 – Acute Kidney Failure, Unspecified
N17.0 - Acute Kidney Failure with Tubular Necrosis
N39.0 - Urinary Tract Infection, Site Not Specified
I13.0 - Hypertensive Heart & Chronic Kidney Disease with Heart Failure
J9601 – Acute Respiratory Failure
J96.00 - Acute Respiratory Failure, Unspecified with Hypoxia or Hypercapnia
J96.21 - Acute and Chronic Respiratory Failure with Hypoxia
Z68.41 - Body Mass Index 40.0 – 44.9
E66.01 - Morbid (Severe) Obesity
E43 - Unspecified Severe Protein-Calorie Malnutrition
E87.1 – Hypo-Osmolaity and Hyponatremia
P96.83 - Meconium Stain
P55.1 - ABO Isoimmunization of Newborn
A41.9 - Sepsis, Unspecified Organism
G92 - Toxic Encephalopathy
G93.41 - Metabolic Encephalopathy
G93.40 - Encephalopathy, Unspecified
D62 - Acute Posthemorrhagic Anemia

Coding Denials

DRG Validation – Commonly Removed Diagnoses

- Sepsis
- Acute Kidney Failure – Tubular Necrosis
- Malnutrition

Build a library of arguments, peer review articles, and appeal templates specific to your hospitals' most commonly denied conditions.

DRG Validation – Case Study

Sepsis-3 vs. SIRS

- The CMS has not adopted Sepsis-3.
- CMS published response to the Sepsis-3 Criteria:
  - "The existing sepsis definitions, including the use of SIRS criteria, have been instrumental in training clinicians and nurses on how to best identify patients in the early stages of sepsis."
  - "The Sepsis-3 definition structure does not clearly identify patients in the early stages of sepsis where rapid resuscitation provides the greatest patient benefit and improves survival. A change to the existing definition could disrupt the 15-year trend toward further reduction in sepsis mortality."
- CMS is the largest payer of healthcare services in the country so CMS guidelines can be used to establish "generally accepted medical practice."

DRG Validation – Case Study

Sepsis-3 vs. SIRS

- Arguments Against Application of Sepsis-3 Criteria:
  - Sepsis requires a high index of suspicion; definitions which narrow that scope of this clinical entity work against this need.
  - Criteria not prospectively studied to determine if use would introduce delay in treatment which would lead to increase in mortality/morbidity.
  - Physicians & nurses are not trained to identify sepsis based on SOFA.
  - Authors of Sepsis-3 continue to report that criteria is *not* an ideal screening tool.
  - No other American medical societies have endorsed Sepsis-3 criteria and the criteria has been specifically rejected by:
    - The American College of Chest Physicians,
    - The American College of Emergency Physicians, and
    - The Infectious Disease Society of America.

DRG Validation – Case Study

Sepsis-3 vs. SIRS

- Arguments Against Retroactive Diagnosis by Non-Treating Clinician
  - "Diagnosing a patient's condition is solely the responsibility of the provider. Only the physician, or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis, can "diagnose" the patient."
  - "While physicians may use a particular clinical definition or set of clinical criteria to establish a diagnosis, the code is based on his/her documentation, not on a particular clinical definition or criteria."

ICD-10 CM Coding Clinic, Fourth Quarter 2016 Pages 147-148

Complaints to CA DMHC

- Allows for submission of online complaints to the California Department of Managed Health Care ("DMHC") for most issues and a deadline of 4 years from the date of service.
- Before the DMHC can begin a review, provider required to submit the dispute to the payor's Provider Dispute Resolution ("PDR") mechanism for a minimum of 45 working days or until receipt of the payor's written determination, whichever period is shorter.
- Appropriate supporting documentation must be included.
  - UB04
  - EOBs
  - Provider Dispute Resolution Letter (*i.e.*, Appeal)
  - Provider Dispute Resolution Determination Letter

External Appeals with IRO

Incorporate Pursuing External Appeals with Independent Review Organization ("IRO") into Appeal Process.

- Affordable Care Act ("ACA") requires that payers offer external appeal avenue with an IRO upon exhaustion of internal payer appeal process.
- Clinical & Experimental Denials
- Payers interpret ACA provision as a "patient" right and require patient authorization to forward appeal to IRO. Difficult and time-consuming process to obtain patient authorization.
- Include provision in managed care contract that gives the "provider" the right to request review by an IRO.

External Appeals with IRO

Sample Contract Language:

"If Facility disagrees with Payer's final determination as rendered at the conclusion of the reconsideration and appeals process, Facility may request a review of Payer's final determination by an independent third-party reviewer mutually acceptable to Facility and Payer. Facility must make a written request for the third-party review of a claim within 12 months of the date of Payer's original claim denial or within 6 months of Payer's final determination, whichever is later.

Inpatient to Outpatient Billing

Develop Inpatient to Outpatient Rebill Protocol Which Outlines:

- Circumstances inpatient admissions will be re-billed as outpatient;
- Step by step instructions to re-bill the inpatient admission as outpatient;
- Tailor process by payer type (Medicare Advantage, Commercial);
- Define when Observation Units will be included in the new outpatient claim;
- Policy considers impact on patient's financial liability; and
- Policy should be reviewed by the Compliance Department.

Inpatient to Outpatient Billing

Common Outpatient Observation MS-DRGs :

- Chest Pain (MS–DRG 313);
- Syncope (MS–DRG 312);
- Esophagitis (MS–DRG 392);
- Cardiac Arrhythmia (MS–DRG 310);
- Disorders of Nutrition (MS–DRG 641);
- Circulatory Disorders except Acute Myocardial Infarction, with Cardiac Catheterization (MS–DRG 287).

According to Medicare Payment Advisory Commission ("Medpac")

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