Writing Effective Appeals

PayerWatch

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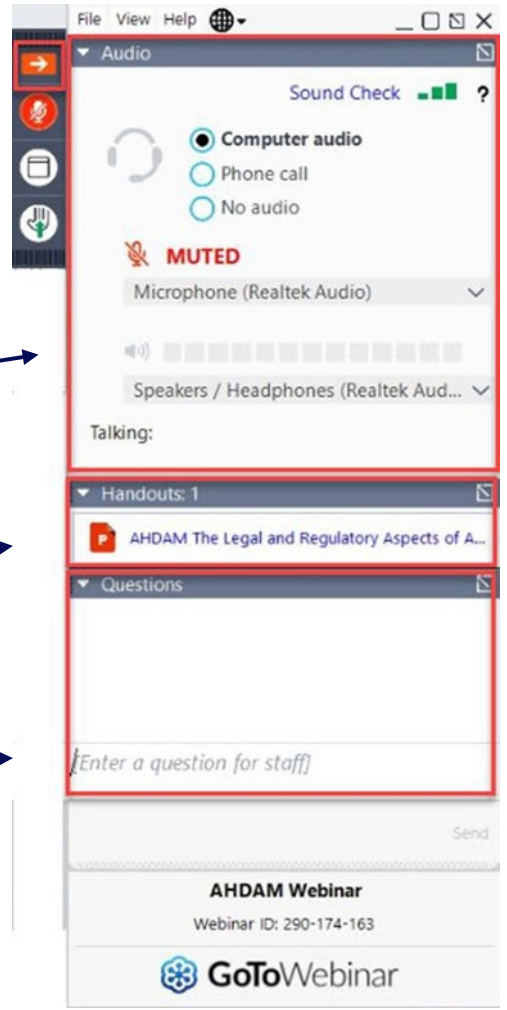

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There are no conflicts of interest to declare for any individual in a position to control the content of this presentation.

Presenter

Ryan O’Hara

Managing Principal, Denial Research Group

Ryan O’Hara is an accomplished healthcare executive with a wealth of experience in revenue cycle operations. Throughout his 20+ year career, Ryan has demonstrated a deep understanding of the complexities of healthcare financial management and has worked to develop strategies and solutions to drive efficiency, reduce costs, and improve patient outcomes.

He has spent the majority of his time on the healthcare provider side, working as a revenue cycle operations leader across many hospitals and health systems. He also has spent several years working on the EMR and 3rd party business partner side. This has provided for a diverse and rounded background; but one that is always rooted in being a trusted and value-add contributor for healthcare providers.

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Denial Research Group

Legal Arguments

- Administrative/Clerical Errors - Substantial Performance/Non-Material Breach
- Administrative/Clerical Errors - Medically Necessary Claims Cannot be Completely Denied Based on Clerical Errors
- Administrative/Clerical Errors - Medically Necessary Claims Cannot be Completely Denied Based on Network Status
- Dr./Patient relationship & Unforeseen Circumstances
- Coding – Little to No Explanation Provided for the Reason Code Denial
- Promissory Estoppel
- Unjust Enrichment
- Good Faith and Fair Dealing

Language that works

- Use their policy and SPD against them
  - *This appeal is based on substantial medical evidence supporting the long-term efficacy of {treatment/drug} in patients with {Diagnosis} and highlights the negligence inherent in your decision, given the outdated criteria currently employed by you*
  - *The insurance company's criteria for {treatment/drug} , as stated in your policy, which was last updated in 2020 is refuted by (Study #1) and previously referenced studies (Study #2) & (Study #3). As such, your policy does not reflect the most current and accepted medical practices. By failing to update your criteria to incorporate recent data and clinical guidelines, {Payer} is acting negligently. This negligence not only puts patients' health at risk but also fails to meet the standard of care required by contemporary medical practice.*
  - *Should {Patient} suffer adverse health consequences or death due to the denial of this essential treatment, we will consider filing a complaint alleging criminal negligence with the state attorney general's office. Additionally, complaints will be filed with the National Committee for Quality Assurance (NCQA) and the state department of insurance, highlighting {Payer's} failure to adhere to updated and accepted medical guidelines.*

Evidence-based/clinically supported language

Beneficiary Name	Mouse Minnie
Member ID or MBI Number	
Claim Dates of Service	01/01/2024 - 01/02/2024
Reason(s) for Denial	Allegation: Services provided not reasonable or medically necessary
Principal Diagnosis	
Comorbidities/Complicating Factors	
Procedures	

Clinical Justification for Inpatient Status

The facts will show that care provided to this patient was medically necessary considering the totality of the member's circumstances and was provided in accordance with appropriate clinical criteria, nationally recognized guidelines, and the payer's policies.

Mouse Minnie was a XX-year-old lady/gentleman (avoid using the words patient or beneficiary) with a medical history as outlined above.

Mouse Minnie presented to the hospital Emergency Department via ambulance/as a direct admit on mm/dd/yyyy at 00:00 AM/PM after experiencing (describe acute symptoms - avoid the words "complaining of" - use "suffering" or "experiencing". Continue describing the patient's presenting signs and symptoms, abnormal findings on physical exam, abnormal test results, treatments started in the ED and the outcome of those treatments, and any failure of outpatient treatment. Include the ED physician's presumed or admitting diagnoses, if documented). Mouse Minnie was admitted as an inpatient/initially placed in observation on mm/dd/yyyy at 00:00 AM/PM.

(Summarize the admitting physician's history and physical and plan of care documentation that supports how the patient was severely ill, at a high risk of death or further disability, required intensive medical care, services, testing, or monitoring to justify the physician's inpatient admission decision. Focus on what is known at the time of the decision to admit. Cite all relevant abnormal findings and explain their significance. Avoid using words like some, a little, minor, etc., while incorporating words like significant, severe, abnormal, elevated, decreased, or aberrant as long as that is supported in the medical record. Include the relevant specialty and interdisciplinary consultations ordered along with their findings. Review the discharge summary and summarize any major events that occurred during the hospitalization.)

(Establish in the summary how the clinical evidence supports the need for inpatient hospitalization.)

Acceptable Standards of Medical Care in the Community

Acceptable standards of medical care within the community should always be a consideration in any decision to admit a patient to inpatient status in a hospital. Evidence based guidelines support inpatient admission and/or indicate this patient was at high risk for adverse events and/or poor outcomes.

Justification of Treatment and Setting by Standards of Care

Source/Reference	**List of Medicare severity diagnosis-related groups (MS-DRGs) geometric mean length of stay – FY 2023 final rule. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2023-ipps-final-rule-home-page**
Evidence Based Guideline/Practice Guideline Recommendation	**DRG** / **Geometric Mean LOS** 308 / 3.4 309 / 2.3 310 / 1.8
Source/Reference	**January, C. T., Wann, L. S., Calkins, H., Chen, L. Y., Cigarroa, J. E., Cleveland, J. C., Jr, Ellinor, P. T., Ezekowitz, M. D., Field, M. E., Furie, K. L., Heidenreich, P. A., Murray, K. T., Shea, J. B., Tracy, C. M., & Yancy, C. W. (2019). 2019 AHA/ACC/HRS Focused Update of the 2014 AHA/ACC/HRS Guideline for the Management of Patients With Atrial Fibrillation: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines and the Heart Rhythm Society in Collaboration With the Society of Thoracic Surgeons. Circulation, 140(2), e125–e151. https://doi.org/10.1161/CIR.0000000000000665 https://www.jacc.org/doi/10.1016/j.jacc.2019.01.011**
Evidence Based Guideline/Practice Guideline Recommendation	For patients with [atrial fibrillation] AF and an elevated CHA2DS2-VASc score of 2 or greater in men or 3 or greater in women, oral anticoagulants are recommended. NOACs (dabigatran, rivaroxaban, apixaban, and edoxaban) are recommended over warfarin in NOAC-eligible patients with AF (except with moderate-to-severe mitral stenosis or a mechanical heart valve). Dabigatran and rivaroxaban were associated with a higher risk of hospitalization or death from bleeding than that of warfarin. Surgical occlusion of the LAA may be considered in patients with AF undergoing cardiac surgery, as a component of an overall heart team approach to the management of AF. AF catheter ablation may be reasonable in selected patients with symptomatic AF and HF with reduced left ventricular (LV) ejection

	fraction (HFrEF) to potentially lower mortality rate and reduce hospitalization for HF. Patients in the AF catheter ablation group had significantly reduced overall mortality rate, reduced rate of hospitalization for worsening HF, and improved LV ejection fraction as compared with the medical therapy group, and according to device interrogation, more patients in the AF catheter ablation group were in sinus rhythm. For patients with AF who have a CHA2DS2-VASc score of 2 or greater in men or 3 or greater in women and who have end-stage chronic kidney disease (CKD; creatinine clearance [CrCl] <15 mL/min) or are on dialysis, it might be reasonable to prescribe warfarin (INR 2.0 to 3.0) or apixaban for oral anticoagulation. In the Medicare population, AF is associated with increased in hospital mortality rate (25.3% with AF versus 16.0% without AF), 30-day mortality rate (29.3% versus 19.1%), and 1-year mortality rate (48.3% versus 32.7%).
Source/Reference	**Cummings ED, Swoboda HD. Digoxin Toxicity. [Updated 2023 Mar 4]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK470568/**
Evidence Based Guideline/Practice Guideline Recommendation	There is no specific arrhythmia for digoxin toxicity rather a range of arrhythmias can be present such as various degrees of AV block, premature ventricular contractions, bradycardia, and even ventricular tachycardia. EKG findings sometimes referred to as the digitalis effect may be seen. These changes commonly involve the T wave and include flattening, inversion, scooped appearance of ST-segment and ST depression in the lateral leads. Although guidelines are unclear, treatment with digoxin immune Fab is also known by the trade name Digibind, is considered first-line therapy for dysrhythmias including AV block and ventricular tachycardia caused by suspected digoxin toxicity. Most patients with digoxin toxicity are at risk for arrhythmias and need ICU monitoring.
Source/Reference	**Heidenreich PA, Solis P, Estes NAM 3rd, Konarow GC, Jurgens CY, Marine JE, McManus DD, McNamara RL. 2016 ACC/AHA clinical performance and quality measures for adults with atrial fibrillation or atrial flutter: a report of the American College of**

	Cardiology/American Heart Association Task Force on Performance Measures. *J Am Coll Cardiol* 2016;68:575–68. As found on: http://www.onlinejacc.org/content/68/5/525
Evidence Based Guideline/Practice Guideline Recommendation	AF is recognized as the most common cardiac arrhythmia in the United States and is associated with increased mortality rate for individuals who have other cardiovascular conditions and procedures, such as heart failure, myocardial infarction, coronary artery bypass graft, stroke and hypertension. Furthermore, AF is associated with a 4- to 5-fold increased

	Ventricular arrythmias (Vas) are common in patients after LVAD implantation, and it is important to first identify and treat reversible causes of VA including suction events and electrolyte disturbances. Current guidelines recommend ICD implantation and generator replacement in patients with LVADs with any prior history of VA, although a prospective, randomized study is needed.
Source/Reference	**Sandesara, C., Rottman, J., and Olshansky, B. (Updated 2017).**

	However, no strategy has presently been shown to prevent or reduce the incidence of TdP.
Source/Reference	**Al-Khatib, S. M. & Page, R. L. (2016). Acute Treatment of Patient With Supraventricular Tachycardia. JAMA Cardiology Clinical Guidelines Synopsis. *JAMA Cardiology*, *1*(4), 483-485. As found on: https://jamanetwork.com/journals/jamacardiology/fullarticle/2527088?alert=article**
Evidence Based	Vagal maneuvers and adenosine are recommended for the termination of

Denial Prevention

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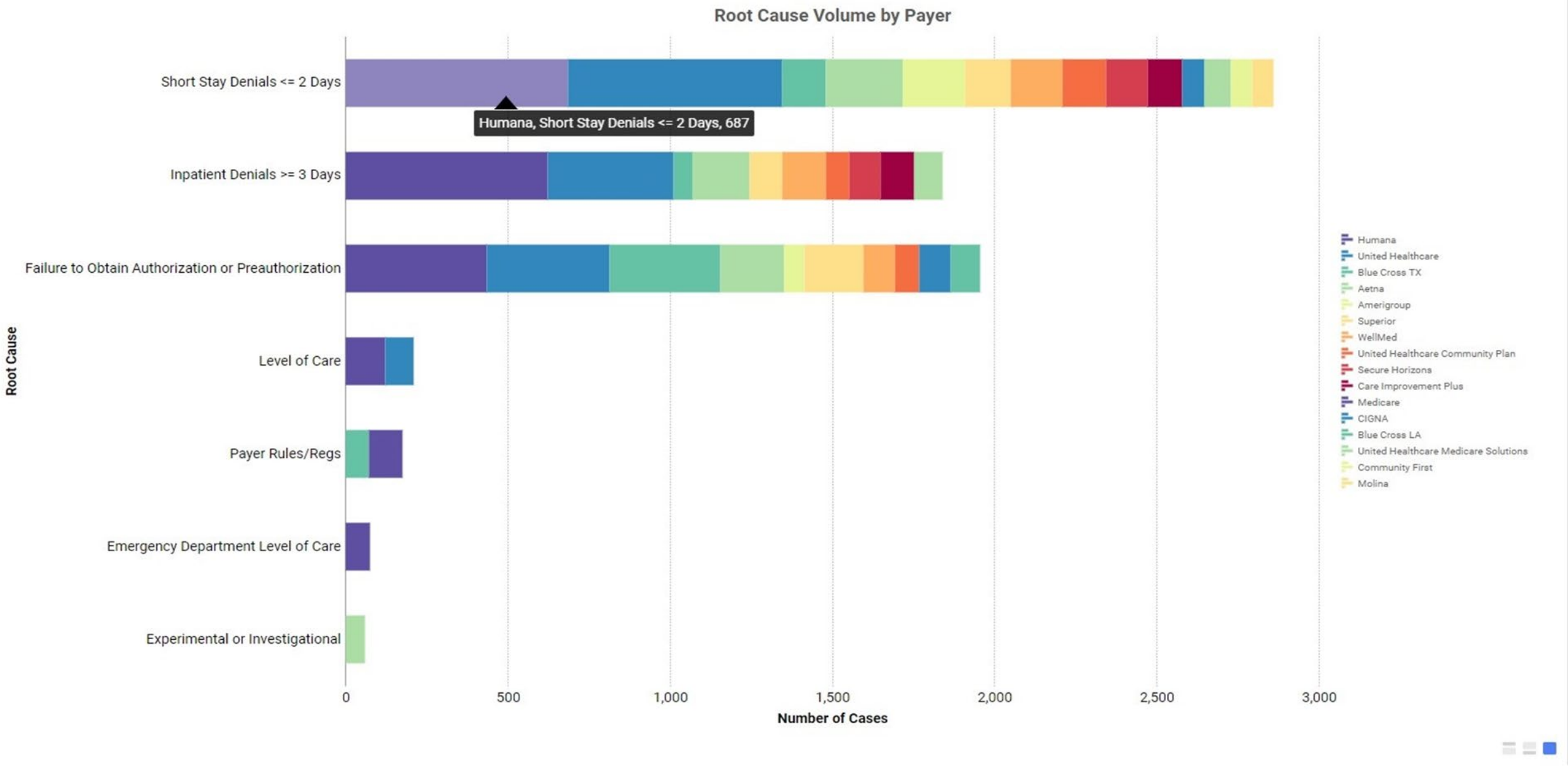
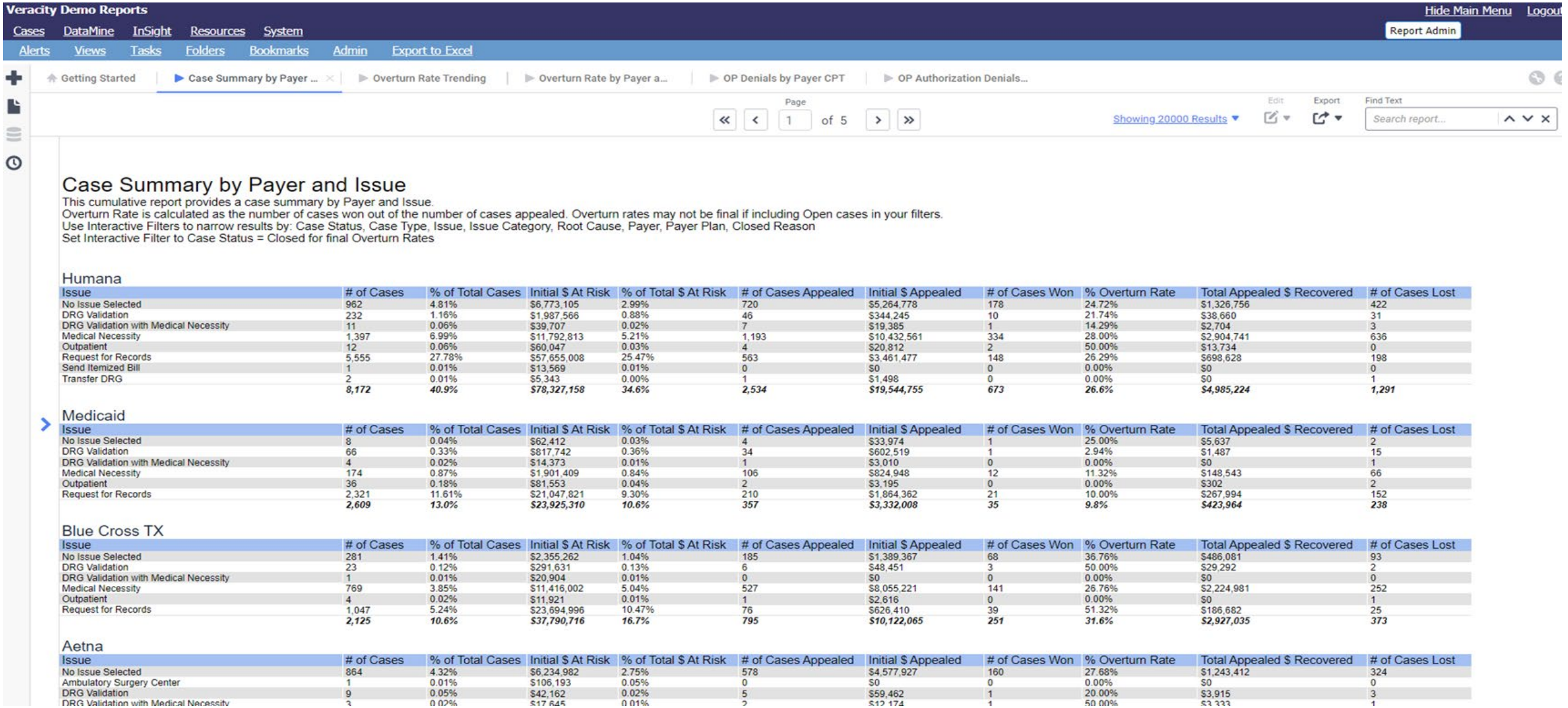
Payer Behaviors



Baseline Dashboarding



Case Summary by Payer and Issue

This cumulative report provides a case summary by Payer and Issue.
Overturn Rate is calculated as the number of cases won out of the number of cases appealed. Overturn rates may not be final if including Open cases in your filters.
Use Interactive Filters to narrow results by: Case Status, Case Type, Issue, Issue Category, Root Cause, Payer, Payer Plan, Closed Reason
Set Interactive Filter to Case Status = Closed for final Overturn Rates

Humana

Issue	# of Cases	% of Total Cases	Initial $ At Risk	% of Total $ At Risk	# of Cases Appealed	Initial $ Appealed	# of Cases Won	% Overturn Rate	Total Appealed $ Recovered	# of Cases Lost
No Issue Selected	962	4.81%	$6,773,105	2.99%	720	$5,264,778	178	24.72%	$1,326,756	422
DRG Validation	232	1.16%	$1,987,566	0.88%	46	$344,245	10	21.74%	$38,660	31
DRG Validation with Medical Necessity	11	0.06%	$39,707	0.02%	7	$19,385	1	14.29%	$2,704	3
Medical Necessity	1,397	6.99%	$11,792,813	5.21%	1,193	$10,432,561	334	28.00%	$2,904,741	636
Outpatient	12	0.06%	$60,047	0.03%	4	$20,812	2	50.00%	$13,734	0
Request for Records	5,555	27.78%	$57,655,008	25.47%	563	$3,461,477	148	26.29%	$698,628	198
Send Itemized Bill	1	0.01%	$13,569	0.01%	0	$0	0	0.00%	$0	0
Transfer DRG	2	0.01%	$5,343	0.00%	1	$1,498	0	0.00%	$0	1
	8,172	***40.9%***	***$78,327,158***	***34.6%***	***2,534***	***$19,544,755***	***673***	***26.6%***	***$4,985,224***	***1,291***

Medicaid

Issue	# of Cases	% of Total Cases	Initial $ At Risk	% of Total $ At Risk	# of Cases Appealed	Initial $ Appealed	# of Cases Won	% Overturn Rate	Total Appealed $ Recovered	# of Cases Lost
No Issue Selected	8	0.04%	$62,412	0.03%	4	$33,974	1	25.00%	$5,637	2
DRG Validation	66	0.33%	$817,742	0.36%	34	$602,519	1	2.94%	$1,487	15
DRG Validation with Medical Necessity	4	0.02%	$14,373	0.01%	1	$3,010	0	0.00%	$0	1
Medical Necessity	174	0.87%	$1,901,409	0.84%	106	$824,948	12	11.32%	$148,543	66
Outpatient	36	0.18%	$81,553	0.04%	2	$3,195	0	0.00%	$302	2
Request for Records	2,321	11.61%	$21,047,821	9.30%	210	$1,864,362	21	10.00%	$267,994	152
	2,609	***13.0%***	***$23,925,310***	***10.6%***	***357***	***$3,332,008***	***35***	***9.8%***	***$423,964***	***238***

Blue Cross TX

Issue	# of Cases	% of Total Cases	Initial $ At Risk	% of Total $ At Risk	# of Cases Appealed	Initial $ Appealed	# of Cases Won	% Overturn Rate	Total Appealed $ Recovered	# of Cases Lost
No Issue Selected	281	1.41%	$2,355,262	1.04%	185	$1,389,367	68	36.76%	$486,081	93
DRG Validation	23	0.12%	$291,631	0.13%	6	$48,451	3	50.00%	$29,292	2
DRG Validation with Medical Necessity	1	0.01%	$20,904	0.01%	0	$0	0	0.00%	$0	0
Medical Necessity	769	3.85%	$11,416,002	5.04%	527	$8,055,221	141	26.76%	$2,224,981	252
Outpatient	4	0.02%	$11,921	0.01%	1	$2,616	0	0.00%	$0	1
Request for Records	1,047	5.24%	$23,694,996	10.47%	76	$626,410	39	51.32%	$186,682	25
	2,125	***10.6%***	***$37,790,716***	***16.7%***	***795***	***$10,122,065***	***251***	***31.6%***	***$2,927,035***	***373***

Aetna

Issue	# of Cases	% of Total Cases	Initial $ At Risk	% of Total $ At Risk	# of Cases Appealed	Initial $ Appealed	# of Cases Won	% Overturn Rate	Total Appealed $ Recovered	# of Cases Lost
No Issue Selected	864	4.32%	$6,234,982	2.75%	578	$4,577,927	160	27.68%	$1,243,412	324
Ambulatory Surgery Center	1	0.01%	$106,193	0.05%	0	$0	0	0.00%	$0	0
DRG Validation	9	0.05%	$42,162	0.02%	5	$59,462	1	20.00%	$3,915	3
DRG Validation with Medical Necessity	3	0.02%	$17,645	0.01%	2	$12,174	1	50.00%	$3,333	1

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Improvement Dashboarding

	Top 10 Payers*	Humana	United Healthcare	Blue Cross TX	Medicare	Aetna	Superior	Medicaid	Choicecare Network	Cigna	Blue Cross LA	All Payers
Success Rate/Closed Cases	Current Month All Cases Success Rate	31%	42%	36%	41%	40%	13%	12%	30%	39%	30%	33%
	Current Month Denial Success Rate	36%	42%	41%	17%	45%	12%	42%	0%	39%	32%	36%
	Current Month Audits Success Rate**	19%	40%	22%	55%	14%	17%	3%	33%	33%	0%	24%
	FY2025 All Cases Success Rate	36%	47%	35%	59%	40%	20%	7%	23%	39%	38%	37%
	FY2025 Closed Cases Vol (for Success Rate)	760	970	390	158	170	230	106	13	155	50	3,771
	FY2025 Closed Cases Vol Favorable Outcome	277	452	135	94	68	47	7	3	60	19	1,396
	FY2025 Closed Cases Vol Unfavorable Outcome	483	518	255	64	102	183	99	10	95	31	2,375
	FY2025 Denial Success Rate	41%	46%	39%	24%	42%	17%	28%	0%	39%	40%	38%
	FY2025 Audits Success Rate**	22%	48%	20%	76%	25%	31%	2%	27%	25%	20%	32%
	FY2024 All Cases Success Rate	40%	55%	50%	51%	51%	26%	9%	48%	43%	47%	41%
	FY2024 Denial Success Rate	41%	57%	57%	30%	54%	22%	33%	65%	43%	50%	43%
	FY2024 Audits Success Rate **	32%	43%	15%	73%	39%	46%	7%	39%	36%	27%	32%
	FY2025 % of Audits Closed with No Findings	96%	96%	93%	91%	93%	59%	92%	99%	93%	96%	96%
	FY2025 % of Audits with Findings	4%	4%	7%	9%	7%	41%	8%	1%	7%	4%	4%
	FY2024 % of Audits with Findings	42%	80%	34%	50%	39%	45%	61%	44%	49%	72%	49%
	FY2024 % Audits Closed with "No Findings"	58%	20%	66%	50%	61%	55%	39%	56%	51%	28%	51%
	Current Month Total Cases Created	1,497	1,476	1,062	215	270	240	65	2	162	150	6,418
	Cases Created % of Total Discharges	7%	3%	2%	0%	2%	2%	2%		2%	2%	2%
	% of Total Veracity Cases Created in Current Month	23%	23%	17%	3%	4%	4%	1%	0%	3%	2%	100%
	Current Month Denial Cases Created	546	555	482	114	106	145	29	0	126	50	2,668
	Denial Cases Created % of Total Discharges	2%	1%	1%	0%	1%	1%	1%		2%	1%	1%
	Current Month Audit Cases Created	951	921	580	101	164	95	36	2	36	100	3,750
ed	Audit Cases Created % of Total Discharges	4%	2%	1%	0%	1%	1%	1%		1%	1%	1%

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Denials Prevention discipline

- Multi-disciplinary group driven by goals and measurement
  - Project Management
    - Organization and Task Management
  - Business Intelligence
    - Measurement, Dashboarding, and Prioritization
  - RCM Operations (Front, Middle, Back)
    - Process Improvement
  - Clinical leadership
    - Clinical “buy-in” and Quality Improvement
  - IT/Clinical Informatics
    - EMR support
  - Finance
    - Validation
  - Managed Care
    - Awareness and “Closing the loop”

Presenter

Brian McGraw
Founder & CEO, PayerWatch
Founder & Chairman, AHDAM

Brian McGraw is the founder and president of PayerWatch and the Association for Healthcare Denial & Appeal Management. He is a fierce advocate for hospitals and physicians in their right to be fully paid, and educates revenue cycle and clinical leaders throughout the U.S. on government and commercial claim dispute resolution management. He is a nationally recognized speaker and sought-after expert in payer denials and audits, regulatory audit management, and payer contracting.

Over the last 20 years, he has worked with hundreds of hospitals and many of the nation's largest healthcare systems to improve their denial and audit management programs, managed care reimbursements, denied claim recoveries, billing integrity, RAC/MAC audit management, and Medicare compliance.

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A Payer Content Strategy

PayerWatch

Next Webinar:
January 15th, 2025

AHDAM / PayerWatch

Joint Roundtable Discussion

Better Payer Data, Better Payer Denial Outcomes

An Instructional Session with Clinical and Revenue Cycle Leaders

PayerWatch

PayerWatch

Veracity

Denial | Audit |Appeal Management System

AppealMasters

Appeal Support Services

Denial Research Group

Denial/Audit Management Re-engineering

AHDAM

Association for Healthcare Denial & Appeal Management

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Knowledge Center

Resources focused on denial prevention and appeal success.

AHDAM.ORG Statement on the UnitedHealthcare CEO Incident and Public Sentiment Toward the Health Insurance Industry

90%

of denied claims are preventable

Firm Resolve Begins at the Top

- Every justifiable appeal shall proceed to its end point under the contract, under the applicable law, and under the patient's covered benefits. It's nothing personal, it's only business. Take it all the way.

- Every managed care contract shall be made available to operationally responsible parties in the organization **actually appealing and dealing daily with the payers— no exceptions.**

Payer Content?? Huh??

What is it? Where is it? How do I use it?

- Contract rules/communications
- Provider manual details
- Statutory regulations
- Evidence-based guidelines
- Payer policy bulletins
- Payer appeal rules matrix
- Active disputes
- Appeal-ready communication tools
- Dispute reporting

Administration | Payers | Configuration | Workflow | User Preferences

Payers | Plans | Timeframes | Contacts | Contractors | 835 Payer Administration | Contracts | State Info | Payer Policies

New Payer Policy

Columns

Actions	Name	Url
Properties		
Properties Download	Anthem Ambulance Transportation	https://www.anthem.com/docs/public/inline/C-19001-CA.pdf
Properties Download	Anthem Body Mass Index Coding and Billing Policy	https://providernews.anthem.com/georgia/article/body-mass-index-bmi-reimbursement-policy-facility
Properties Download	Anthem Bundled Services and Supplies Reimbursement Policy (Profession...	https://www.anthem.com/docs/public/inline/CA-08003CA.pdf
Properties Download	Humana Ablation Techniques and Extracorporeal Shock Wave Therapy for ...	https://apps.humana.com/tad/tad_new/Search.aspx?sortfield=name&policyType=medical
Properties Download	Humana Achalasia and Gastroesophageal Reflux Disease (GERD) Treatments	https://apps.humana.com/tad/tad_new/Search.aspx?sortfield=name&policyType=medical
Properties Download	Humana Acne Treatments	https://apps.humana.com/tad/tad_new/Search.aspx?sortfield=name&policyType=medical
Properties Download	Humana Air Ambulance	https://apps.humana.com/tad/tad_new/Search.aspx?sortfield=name&policyType=medical
Properties Download	Humana Bariatric Surgery	https://apps.humana.com/tad/tad_new/Search.aspx?sortfield=name&policyType=medical
Properties Download	Humana Cardiac Catheterization	https://apps.humana.com/tad/tad_new/Search.aspx?sortfield=name&policyType=medical
Properties Download	Humana Cardiac Electrophysiological Studies and Cardiac Catheter Abla...	https://apps.humana.com/tad/tad_new/Search.aspx?sortfield=name&policyType=medical
Properties Download	Humana Cardioverter Defibrillators/Cardiac Resynchronization Therapy	https://apps.humana.com/tad/tad_new/Search.aspx?sortfield=name&policyType=medical
Properties Download	Humana Coronary Stents and Angioplasty	https://apps.humana.com/tad/tad_new/Search.aspx?sortfield=name&policyType=medical

New Payer Policy

Columns

humana

Actions	Name	Url
Properties Download	Humana Ablation Techniques and Extracorporeal Shock Wave Therapy for ...	https://apps.humana.com/tad/tad_new/Search.aspx?sortfield=name&policyType=medical
Properties Download	Humana Achalasia and Gastroesophageal Reflux Disease (GERD) Treatments	https://apps.humana.com/tad/tad_new/Search.aspx?sortfield=name&policyType=medical
Properties Download	Humana Acne Treatments	https://apps.humana.com/tad/tad_new/Search.aspx?sortfield=name&policyType=medical
Properties Download	Humana Air Ambulance	https://apps.humana.com/tad/tad_new/Search.aspx?sortfield=name&policyType=medical
Properties Download	Humana Bariatric Surgery	https://apps.humana.com/tad/tad_new/Search.aspx?sortfield=name&policyType=medical
Properties Download	Humana Cardiac Catheterization	https://apps.humana.com/tad/tad_new/Search.aspx?sortfield=name&policyType=medical
Properties Download	Humana Cardiac Electrophysiological Studies and Cardiac Catheter Abla...	https://apps.humana.com/tad/tad_new/Search.aspx?sortfield=name&policyType=medical
Properties Download	Humana Cardioverter Defibrillators/Cardiac Resynchronization Therapy	https://apps.humana.com/tad/tad_new/Search.aspx?sortfield=name&policyType=medical
Properties Download	Humana Coronary Stents and Angioplasty	https://apps.humana.com/tad/tad_new/Search.aspx?sortfield=name&policyType=medical
Properties Download	Humana Knee Arthroplasty	https://apps.humana.com/tad/tad_new/Search.aspx?searchtype=beginswith&docbegin=K&policyType=me

1

1 of 1 pages (10 items)

Coding the Payer, the Contract and the Clinical Business Rules

PAYER BUSINESS RULES

- The Payer makes the rules and we have to follow them or risk not getting paid
- The three R's – right person, right documentation, right time

CONTRACT BUSINESS RULES

- Very few clinicians have immediate access to the Business Rules
- How does the contract tie back to Utilization Management?
- How does the contract tie back to Clinical Documentation Integrity?

CLINICAL BUSINESS RULES

- NCD's, LCD's
- Medical Policies
- Coverage Policy Bulletiins
- Third Party Guidelines
    - MCG, IQ, Evicore, et al.

Return to Payers Grid | Return to Payer of this Plan

Payer: Humana , Payer Plan: HUMANA CHOICE GOLD CHOICE MM

Info | Timeframes | Contacts | Links | Documents | Contract | Notes | Payer Policies

Save | Cancel | This plan has 3433 cases associated with it.

Payer:	HUM - Humana *	**Payer Grouping:**	
Plan Name:	HUMANA CHOICE GOLD CHOICE MM *	**Payer Parent Company:**	Humana, Inc.
Code:	PHUMGC *	**Payer ID:**	61101
Financial Class:	MC - Medicare Part A Modified New	**Primary State:**	State Info
Provider Portal:	*Provider Portal Url* Go	**Delegation:**	
Provider Manual:	https://apps.humana.com/marketing/documents.a Go	**Accreditation Agency:**	National Committee for Quality Assurance...
Medical Policy:	https://apps.humana.com/tad/tad_new/home.asp Go	**NAIC Group Name:**	
Timely Filing:	180	**NAIC Group Number:**	*Enter value* **ID Number:** *Enter value*
Active:	Yes	**Primary Send Method:**	USPS
In Network:	Yes	**Primary Follow-up Method:**	EDELIVERY
		Secondary Send Method:	

Internal Appeals & Audits

Appeal Type: Provider

Client Code: *Client Code*

Appeal Level Case Category: *Case Category*

Appeal Level Desc: Internal Appeal

Appeal Level Contact:

Appeal Level: 0

Appeal Submission Timeframe: 180

Appeal Decision Timeframe: 0

Claim Timely Filing: 180

Records Request Limit: 0

Desk Audit Notice Requirement: Yes | No | **Unknown**

Dispute Resolution

Cancel | Delete | Save

Case Escalation Step Description: Discussion Between Parties (Informal)

Case Escalation Step No: 1

Dispute Submission Timeframe: 0

Exchange of Evidence: Yes | **No** | Unknown

Witness Testimony: Yes | **No** | Unknown

Submission of Evidence: Yes | **No** | Unknown

…And UR/UM Has The First Point Of Contact Challenge…

- Who is the primary payer?
- What are their rules for inpatient?
- Is this payer contracted? What are the patient status contract terms? If not contracted, then what?
- What guidelines is the payer using to support /determine inpatient? Milliman? Interqual? Neither?
- Who is the provider who will write the inpatient order?
- What if the payer disputes the inpatient request?
- What are the payer's rules for resolving a patient status dispute?
- Does UR know any of the contract terms?
- If patient status changes are contractually limited for after discharge, then what?

Proactive Strategies

- Develop a template of terms for all payers, commercial and Medicare Advantage, beyond payment.
- Areas to include:
  - Timeline to submit clinicals—inpatient vs observation
  - Timeline for determination from the payer, within 12 hours
  - Immediate call/appeal including guarantee of a peer to peer call within 24 hours with clear time assigned and kept
  - Clearly outline criteria being used to determine inpatient status (beyond “medically necessary care”)
  - DRG: Ensure correct coding guidelines are applied to DRG assignment and selection of principal diagnosis vs. secondary diagnoses.
  - Re-admission guidelines.
  - Appeal rights – post discharge. Ensure all five levels with traditional Medicare are included for all Part C plans.
  - “Using traditional Medicare/CMS” rules, but what happens when they don’t?

The Provider Manual – Even Level Set

Generally, the purpose of the provider manual is to expand on the terms and conditions to which the parties have agreed. In contracts where the language incorporates the provider manual by reference, the provider manual is part of the contract and should be attached to the contract.

- The terms and conditions set forth in the provider manual can have significant impact on the denials received and the hospital's ability to successfully appeal those denials.
- Avoid language which permits the payer to modify any terms and conditions without the express written agreement of a designated hospital representative.

Contract and Manual Language Clearly Affect Denial and Appeal Management

- A well-negotiated payer contract will always take into consideration provider protections in the appeal and audit processes.
- External review and dispute resolution remedies should be accessible, affordable and mutual.
- Three examples of constantly missing audit/denial/appeal provisions:
  - Audit limits
  - E-communication
  - Decision timeframes

Medical Necessity Provisions: Purpose

- Generally, to define for both parties, hospital and payer, the services that will be covered or paid for by the payer.
  - All healthcare providers are required to provide medical services in accordance with accepted national standards of medical and surgical care.
  - The standard of care is what a reasonably competent hospital/practitioner would do in the same or similar circumstances.
  - The standard of care cannot necessarily be determined by a payer's medical director or designee under the control of the medical director.
  - Do not agree to language which allows the payer or the designee under its control to ultimately determine what "medically necessary services" are.

Medical Necessity - LANGUAGE TO AVOID!

- “Medically necessary” describes the use of a service or supply which is commonly and customarily recognized as appropriate in the treatment of a Member’s diagnosed illness or injury; appropriate with regard to standards of good medical practice; not solely for the convenience of the Member, his or her physician, Hospital or other health care provider; and the most appropriate supply or level of service which can be safely provided to the Member.

- **The decision as to whether a service or supply is Medically Necessary for the purposes of payment by the Corporation rests with the Corporation’s Medical Director of his or her designee, provided however, that such decision shall be based on standard criteria published by MCG, or such other reputable national guidelines as Corporation may in its sole discretion employ.** Such a decision will in no way affect the Hospital’s determination of whether medical treatment is appropriate as a matter of medical judgment.

Emergency Services: Purpose

The **E**mergency **M**edical **T**reatment **A**nd **L**abor **A**ct (EMTALA) imposes specific obligations on Medicare participating hospitals that offer emergency services. EMTALA provides the participation hospitals with emergency departments are required to provide an appropriate medical screening examination for any individual who requests it to determine whether an emergency medical condition exists or if the patient is in active labor.

- Avoid agreeing to language which allows the payer or its designee to determine whether emergency services were required.

Emergency Services - LANGUAGE TO AVOID!

"Emergency" means a serious health-threatening or disabling condition manifested by severe symptoms occurring suddenly and unexpectedly, which could reasonably be expected to result in serious physical impairment or loss of life if not treated immediately, and **which occurs under circumstances making it impossible for the ill or injured person to contact a Plan Provider for care, i.e., heart attacks, strokes, poisonings, and loss of consciousness or respiration.**

The Health Plan may determine that other similarly acute conditions are medical emergencies.

Emergency Services - LANGUAGE TO AVOID!

EMERGENCY SERVICES. Medical care is available through [Payer's] PCPs seven (7) days a week, twenty-four (24) hours a day. In the event of an emergency, the Member should seek to obtain treatment or approval for treatment from the PCP or the designated covering physician. If an Emergency Medical Condition results in the receipt of medical care without such approval, charges for such treatment will be covered, subject to Co-payments described in the applicable Schedule of Co-payments and Allowances, **if, in [Payer's] determination, Emergency Services were required.**"

The Managed Care Contract

A managed care contract is 1/4 arithmetic and 3/4 operational/administrative requirements.

Managed Care Department – Payer-by-Payer Strategies

- Schedule monthly CLINICAL meetings with the primary contracted payers for denial and audit review.
- Have examples of abuse and malfeasance with inpatient status, DRG, and readmission (the three hot spots).
- Involve contracting with all payer clinical/operational meetings and calls.
- Involve UM/PA with all payer operational meetings/calls.
- Involve coding leaders and CDI with all payer operational meetings/calls.

Treat the Contract as a Living document

- Ongoing consultation, communication, and education for appeal clinicians and their support staff by the organization's contracting staff will ensure success under the terms of contracts.
- Different staff members will need to understand different elements of contractual goals, based on their role/position.
- Appeal staff need to know precertification requirements, appeal rules, and medical criteria rules.

The devil is in the details

- Managed care provisions affect denials, retrospective audits, and the entire appeal/dispute resolution process. Providers need to understand contract language to fully exercise their rights in the appeal process.

- Initiate conversations with managed care about opportunities to change some of the language in contracts with payers. Given the traditional structure of contracts, the focus on medical records and audits has been lacking. Contracts are usually written in favor of payers. Meet with contracting to revise the language to support the provider appeal process.

Crafting Effective Audit Limits

- **Define Clear Parameters:** Specify the **maximum number of audits** allowed per year, the acceptable scope of each audit, and the timeframes within which audits must be conducted. Clear definitions prevent ambiguity and protect your hospital from potential overreach.

- **Establish Recoupment Thresholds:** **Set standards, thresholds and timelines for recoupment actions.** This ensures that minor discrepancies don't trigger significant financial repercussions. For instance, only discrepancies exceeding a certain dollar amount should warrant recoupment efforts. Recoupments should not be according to the payer or contractor, and not permitted until the entire appeal process is completed.

- **Include the Appeal Process:** Incorporate a robust appeals process. This enables your hospital to challenge unjust audit findings effectively. A well-defined appeals mechanism acts as a buffer against arbitrary decisions and ensures due process.

Audit Limits Matter

- Unpredictable revenue swings
- Strained resources
- Prolonged disputes

This isn’t a mere hypothetical; it’s a reality many healthcare providers face.

Audit limits serve as a:

- Protective barrier against excessive and arbitrary payer audits.
- Establish clear boundaries on the scope, frequency, and timelines of audits will safeguard your revenue streams.
- Being proactive in contracting ensures:
  - *financial stability*
  - *greater predictability and provider control*

Audit Limiits - Enhancing Negotiating Power

If payers know that your hospital insists on reasonable audit terms, they are more likely to respect your overall contract provisions (LOL).

This can leads to fairer agreements and set a positive precedent for future negotiations.

Take Command of Your Contracts

Audit limits aren't just a formality—they are a necessity. They provide predictability, reduce administrative burdens, and enhance your negotiating power. Most importantly, they protect your hospital’s bottom line, allowing you to focus on what truly matters—providing exceptional patient care.

Enforcing Your Entitled Rights

- With ERISA and Medicare Advantage***, your institution must enact the patient rights of appeal,*** otherwise you lose all leverage in the fight.
- Dispute resolution should be in every contractual agreement, and it should be utilized indiscriminately. It is YOUR RIGHT!
- Leverage other external resources as a standard part of your appeal process. Consider a centralized appeal management *SYSTEM* approach.
- When you inform the payer of your intent to pursue all avenues early on and then do it, the squeaky wheels will pay off over time.
- Know your levels: build an appeal matrix if you don’t already use one.

Recommendation - A Full Court Press

- **Harness your Contracts** – Appeal Timeframes, Decision Timeframes, Audit Limits, Recoupment Limits, Levels of Appeal, Independent Review, External Review Requirements, Policy Notification and Implementation, e-Communication, Auditor-Payer Rules, etc., etc., etc.,

- **Complete your Denial & Audit Response Scripts** – Automated Payer Automated Escalation, Automated Expedited Reviews, Dispute Resolution, Member Rights, Member Appeals, Automate Legal Argument inclusion (state-by-state)

Executive Buy-in Required

- Firm resolve to get paid begins at top, CEO, CMO, CFO, etc.
- Managed care (payer contracting) will be a help or a hindrance. Their marching orders have to come from the *C-suite.*
- C-suites, joint operating committees, and payer resolution meetings need:

THE DENIAL/AUDIT DATA!

- Pursuing full payment is responsibility. **Appeal specialists take it seriously and should be fully supported in their efforts.**

Questions and Answers

PayerWatch

PayerWatch Survey to Follow

Please complete the survey at the conclusion of this webinar.

We will be drawing a winner from those who complete it and donating a television and X-Box to the children's hospital or children's charity of your choice!

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Thank you for attending!

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