Mastering Medicare Advantage Plan Obstacles & Navigating the 2 Midnight Benchmark

Richelle Marting, JD, MHSA, RHIA, CPC, CENC, CPMA, CPC-I

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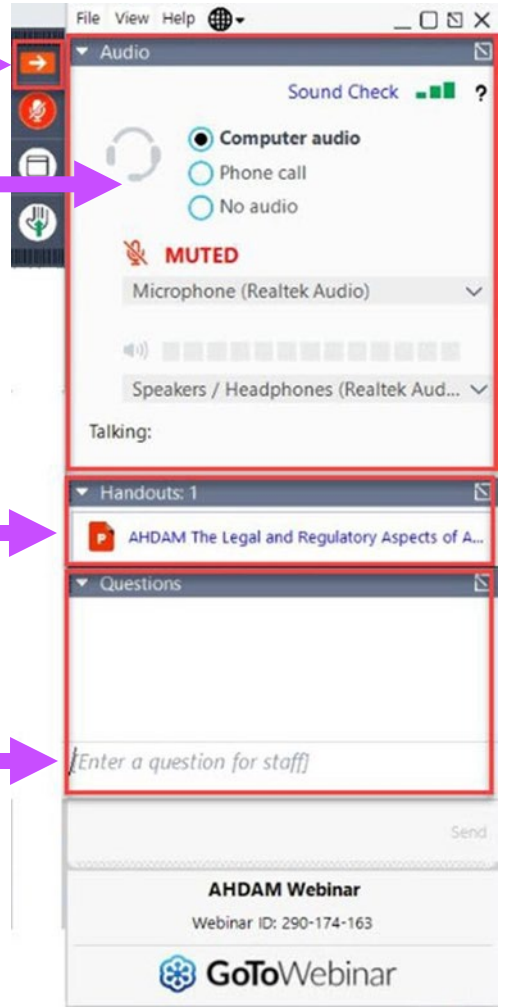

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The Association for Healthcare Denial and Appeal Management

- The nation's only association dedicated to Healthcare Denial and Appeal Management.
- Our mission is to support and promote professionals working in the field of healthcare insurance denial and appeal management through education and collaboration.
- Our vision is to create an even playing field where patients and healthcare providers are successful in persuading medical insurers to make proper payment decisions.

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AMEDCO: Learner Notification (for physicians)

Association for Healthcare Denial & Appeal Management

Mastering Medicare Advantage Plan Obstacles & Navigating the 2 Midnight Benchmark

May 28, 2025

Online

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No financial commercial support was received for this educational activity.

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CE Language (for physicians)

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AMEDCO: Learner Notification, continued (for physicians)

Karla Hiravi	NA
Richelle Marting	NA
Raymond Smith	NA
Jo Shultz	NA

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3. Evaluate the meeting.
4. Print, download, or save your certificate for your records.
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Objectives - After Attending This Program You Should Be Able To

1. Determine common Medicare Advantage plan challenges with the 2-midnight benchmark.
2. Identify strategies that work when responding to plan denials.
3. Determine when the CMS complaint process should be initialized.

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Learning Outcomes

Learning Outcomes: At the conclusion of the webinar, the learner will be able to:

- Determine common Medicare Advantage plan challenges with the 2-midnight benchmark.
- Identify strategies that work when responding to plan denials.
- Determine when the CMS complaint process should be initialized.

Richelle Marting, JD, MHSA, RHIA, CPC, CENC, CPMA, CPC-I

- Richelle Marting is an attorney, a registered health information administrator and certified professional coder. Her practice as an attorney has focused on defense of healthcare professionals and facilities on reimbursement related matters. She serves as the director of managed care contracting for a Kansas City area hospital and medical group, and has supported other attorneys during reimbursement related litigation as an expert witness. Richelle is on the Board of AHDAM, the Government Affairs Committee of the American College of Physician Advisors, the Payer Accountability Workgroup of the American Hospital Association, and the Insurance Advisory Committee of the Missouri Hospital Association. She is also on the Women's Leadership Council for the American Health Law Association. She brings the combination of her legal experience with understanding of medical coding and reimbursement systems to the denial and appeals areas of revenue cycle to help develop strategies for holding plans accountable in following the law and contract terms.

01 Coverage of Basic Medicare Benefits

02 MA Plan Rules for Coverage Criteria

03 Pre-Service Issues

04 Post-Claim Issues

05 Successful Appeal Strategies

Resources You Need On Hand

Managed Care Manual - IOM 100-16 https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms019033

2024Final Rule (4201) - https://www.federalregister.gov/documents/2024/04/23/2024-07105/medicare-program-changes-to-the-medicare-advantage-and-the-medicare-prescrip tion-drug-benefit

CMS Memo to MAOs - https://www.cms.gov/files/document/hpms-memo-faq-coverage-criteria-and-utilization-management-cms-4201-f-02-6-2024-pdf .pdf

01 Basic Medicare Benefits

Medicare Advantage plans must cover and pay for basic Medicare benefits in a manner that is no more restrictive than Traditional Medicare

Basic Medicare Benefits

Medicare Advantage plans provide coverage of basic Medicare benefits

by providing them directly, under arrangement ***or paying for*** *care*

Cite Your Sources

Social Security Act

- MA plans shall provide to members the benefits under traditional Medicare
- *42 U.S.C. 1395w–22*

Federal Regulation

- Each MA plan must cover all services covered by Part A and Part B
- *42 CFR 422.101*

Managed Care Act

- An MA plan must provide enrollees in that plan with all Part A and Part B original Medicare services
- *IOM 100-16, Ch 4, Section 10.2*

> An organization determination about coverage and payment of benefits includes both an MA organization's refusal to **provide or pay** for services, **in whole or in part**, including the type **or level of services**

Fully Established

Coverage Criteria

MA plans must comply with coverage and benefit conditions in Traditional Medicare, including:

- Inpatient only list (p. 22192)
- Inpatient criteria (p. 22194)
- SNF (p. 22194)
- Home health (p. 22194)
- Inpatient rehab (p. 22194)

Plans cannot have policies that change these rules.

02 Coverage Criteria

Coverage Criteria

MA plans can only apply coverage criteria if Traditional Medicare has not fully established coverage rules, and in those instances, must meet very stringent requirements

When Medicare Rules are not Fully Established

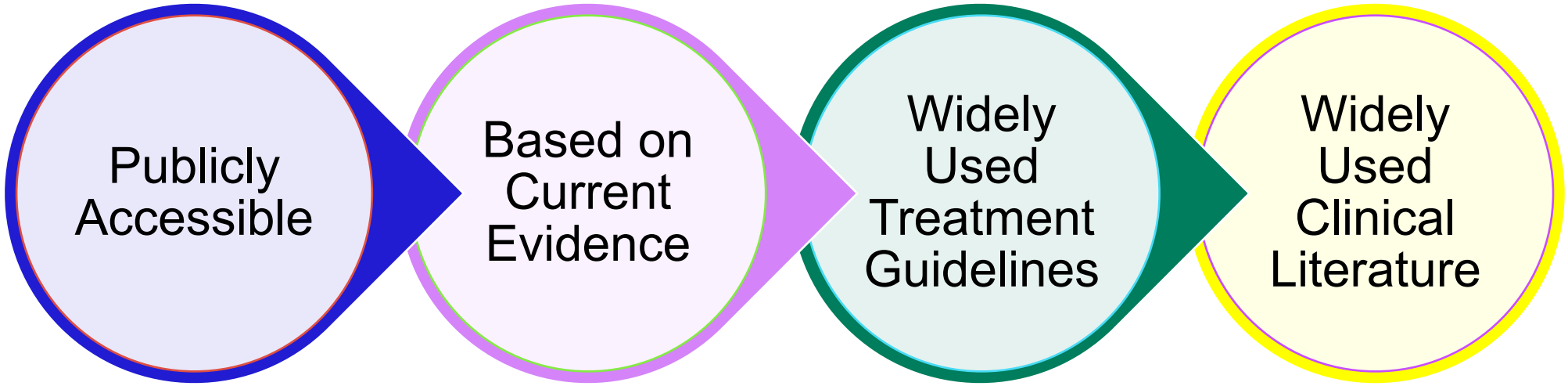
(i) *Coverage criteria not fully established.* Coverage criteria are not fully established when:

(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.

When Permitted, Coverage Criteria Must Be:



Coverage Criteria Versus Payment Policy

- Contracts between hospitals, professionals, and health plans often address policies and procedures
- Plan may develop rules in the form of policies (or similar terms)
- A decision related to coverage and payment can only be re-opened for good cause
- Includes any decision related to prior authorization
  - Inpatient admission
  - Post-acute admissions

CMS weighed in on post-claim reviews of services that were prior authorized

> *If an MA plan MA 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.*

03 Pre Service Issues: Prior Auth

- *CMS has clarified when prior authorizations can be used, what they can look for, and who must decide their outcome.*

Prior Authorizations

Only Two Permitted Uses -

1. confirm presence of a diagnosis or other medical criteria; or
2. ensure an item or service is medically necessary based on standards specified in the rule.

No Use for Emergencies - MA Plans cannot use prior authorizations for treatment of emergency medical conditions.

Inpatient Only Procedures - Cannot be denied for the inpatient setting.

Revocation - If approved by prior authorization, MA plan cannot deny coverage later **on the basis of lack of medical necessity.**

Who Decides?

Anyone Can Approve

Denials Must be Made by

A physician or other professional with expertise in the services at issue, including knowledge of Medicare rules

Two Midnight Rule

- **Basic Two-Midnight** - An inpatient admission is generally appropriate for payment under Medicare Part A when the admitting physician expects the patient to require hospital care that crosses two midnights
- **Unexpected Short Stay** - Unexpected death, other circumstances can still qualify; defer to initial expectation
- **Inpatient Only** - MA plans may permit *more* procedures as IOP, but not fewer, than Traditional Medicare's IOP list

Two Midnight Benchmark v Presumption

- Two-Midnight Benchmark Applies
- Two-Midnight Presumption is a medical review instruction from CMS to MACs, RACs, QIOs; does not apply to MA

Feb. 6, 2024 Memo from CMS to MA Plans:

"An MA organization may evaluate whether the admitting physician's expectation that the patient would require hospital care that crosses two-midnights was reasonable based on complex medical factors documented in the medical record. Consistent with § 412.3, that evaluation should defer to the judgment of the physician **as long as that judgment was reasonable** based upon the complex medical factors documented in the medical record. "

Post Claim Issues

Medicare Advantage plans that authorized inpatient status cannot reopen their decision without good cause

Post Claim Status Changes

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)?

- Subject to limitation
- **Limitation:** If 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
- **Good Cause:** Evidence of fraud or fault; ***new*** and material evidence that was not known or available to the plan at the time of its initial decision

> 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.

Medical Necessity v. Payment Policy

The Response Plans Give:

- This is not a medical necessity decision; this decision is based on our payment policy.

- CMS cannot interfere in private contracts.

> [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.**

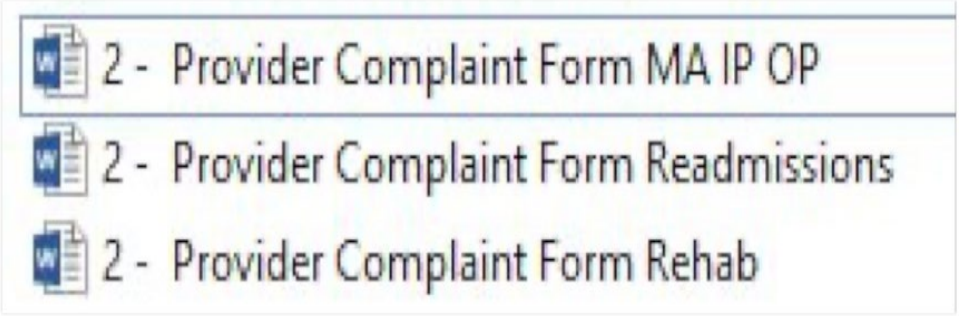
New CMS Complaint Process

		Fill in required information below. Indicate option selection with "X."
1.1	Date of Submission to CMS	
1.2	Entity Submitting Complaint	_X_ Provider ____ Organization Representing Provider _____Appointment of Representative (attach form) _____Other (Summarize)
	Name of Organization Representing Provider	
1.3	Submitter's Name	Richelle Marting
	E-mail Address	rmarting@richellemarting.com
	Telephone Number	123-456-7890
1.4	Beneficiary Name	
1.5	Beneficiary Health Insurance Claim Number (HICN) / Medicare Beneficiary Number (MBN)	
1.6	Provider Name, telephone number, E-Mail address	ABC Hospital, 098-765-4321, abchospital@abchospital.com
1.7	Medicare Advantage Organization	____ Aetna _____ Cigna _____ UHC ____ BCBSKS _____ Humana _____Other:
1.8	Claim Number	
1.9	Date(s) of Service	
1.10	Provider Contract Status	_X_ Provider Contracted with MAO during Date(s) of Service ____ Provider NOT Contracted with MAO during DOS
1.11	Complaint Type	_X_ Contracted Provider Appeal ____ Non-Contracted Provider Appeal _X_ Contracted Provider Claims Payment Dispute ____ Non-Contracted Provider Claims Payment Dispute ____ Other
	Brief Summary of Complaint	See page 2
1.12	Did MAO communicate your appeal rights.	_X_ Yes __No
1.13	Have you exhausted all appeals rights per the non-contracted provider appeals or per contract w/MAO	__Yes _X_ No
1.14	Provider or their representative has Communicated with MAO in Attempt to Resolve Issue	_X_ Yes ____ No *(NOTE: CMS will only review this case if the provider has already attempted to resolve it by working directly with the MAO.)*
	If Yes, Name(s) of Individual(s) at MAO	

New CMS Complaint Process

Tips:

- Submit concurrent with your P2P or other appeal
- Notify your contracting or provider rep of your concern with common issues such as IP status, post-acute care denials
- Include the plan number from the ID card
- Must be password protected
- Develop templates where page 2 outlines your argument



New CMS Complaint Process

Why Use This Process?

Table 7: 2021 - 2024 Average Star Rating by Part C Measure

Measure	2021 Average Star	2022 Average Star	2023 Average Star	2024 Average Star
Complaints about the Plan	4.8	4.7	4.3	3.9

What to Expect

- CMS will provide a CTM number
- You may be asked to send issues directly to the plan's complaints department; prepare a response
- Some plans won't contact you at all and will send a written letter, similar to an appeal decision letter

What to Expect

- Track Complaints and CTMs
- Track Issues (e.g. IP/OP Status, Readmission, Clinical Validation)
- Trend
- Report to Managed Care Contracting, Compliance, Legal, Physician Advisors, Revenue Cycle

What to Expect

- Notify CMS if you don’t have any response within 30 days.
- Notify CMS if the plan didn’t contact you promptly.
- Notify CMS if the plan’s decision continues to misconstrue the rules.
- You may quietly see payments or reversals.
- You may have plans agree to stop a particular type of post-claim audit.

Questions and Answers

Questions?

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Thank you for attending today's event!

For more information, please contact:

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