AHDAM | Association for Healthcare Denial & Appeal Management

July 2023 Webinar: Successfully Defending Inpatient Authorization Denials

Questions and Answers

Question: Under the affordable care act.....what would be considered "emergency services"? just the ED visit, or let's say an urgent visit to the ED for a needed procedure (PICC line placement for chemo)?

Answer from Denise Wilson: "**(i)** ***Emergency medical condition.*** The term *emergency medical condition* means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). (In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.)

(ii) ***Emergency services.*** The term *emergency services* means, with respect to an emergency medical condition—

(A) A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

(B) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

(iii) ***Stabilize.*** The term *to stabilize,* with respect to an emergency medical condition (as defined in paragraph (b)(4)(i) of this section) has the meaning given in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3))."

https://www.law.cornell.edu/cfr/text/29/2590.715-2719A

Question: We are seeing a change in verbiage by one of our MA's for our auth that the DRG is approved... if the final DRG winds up being different from the initial IP request, will that allow the MA to get around the "prior auth" rule?

Answer from Denise Wilson: Here are my thoughts. The deal is, they are supposed to authorize admission based on information known at the time the decision is made to admit. A DRG isn't final until after the patient is discharged and the medical record documentation is complete. So, it doesn't make sense the payer could deny based on a final DRG different from the working DRG provided at the time authorization was requested.

This is similar to payers wanting to deny emergency care when the patient is in obvious distress with anginal symptoms and cardio dynamic symptoms, but eventually the final diagnosis is acid reflux. The final diagnosis doesn't negate the fact that the patient presented to the ED with signs and symptoms that represented what appeared to be an emergent condition.

Question: Are Ambulance services included in the term "emergency services" mentioned on the Affordable Care Act slide?

Answer from Denise Wilson: No

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Question: The payer is authorizing, reviewing the case and approving, then the claim gets paid and 3rd party auditor hired by payer denies for level of care and takes money back. How can we best defend?

Answer from Denise Wilson: I believe this happens when the payer and contractor do not have good processes or communication in place to carve out the claims that were already approved and paid. You really should have some protections in place through your contract with the payer to disallow this practice through third-party auditors. For Managed Medicare payers, we have the new regulation at 42 CFR 422.138, https://www.ecfr.gov/current/title-42/section-422.138

(c) ***Effect of prior authorization or pre-service approval.*** If the 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 § 405.986 of this chapter) or if there is reliable evidence of fraud or similar fault per the reopening provisions at § 422.616. The definitions of the terms "reliable evidence" and "similar fault" in § 405.902 of this chapter apply to this provision.

Question: With payers like Wellcare, they will not provide written overturned decisions a lot of the time but only provide verbal notification. Then they will audit for lack of auth. How should we approach this noncontracted payer?

Answer from Denise Wilson: Since Wellcare is a managed Medicare payer, you can lodge a complaint with your regional Medicare office, ROCHIORA@cms.hhs.gov.

Question: We have our teams set up as denial prior to billing review, recon, P2P. Then post billing clinical appeals and technical appeals. Are you saying technical should also provide a clinical perspective?"

Answer from Karla Hiravi: Best practice is to include some clinical perspective to help prevent the decision coming back as newly denied for medical necessity. Example: denial for inpatient LOC received for late authorization. Extenuating circumstances existed. We recommend explaining the extenuating circumstances thoroughly and then also explain why the inpatient setting was necessary.

Question: I am having issues locating the handouts for today's webinar. I do not see a Handout section on the GTW console or any link to download on the AHDAM website."

Answer from Karla Hiravi: The handouts can always be downloaded from the "control panel" when you are attending the webinar live. We do not yet have the webinar and handouts on the website but will have them there soon.

Question: We are seeing an increase in denials for notification however in our notification process we are being told or their portal indicates prior auth not required. We appeal showing this information and medical necessity however they are upholding these denials based on "notification" requirements not followed."

Answer from Karla Hiravi: I suggest that you collect some good examples and present them to your payer representative(s). If that does not work, follow the chain of command for the payer and present the info at higher levels.

Question: Do you recommend admission for an IPO procedure such as an intra-aortic balloon pump when the patient is to be transferred within a few hours."

Answer from Karla Hiravi: Yes. Please reference the below that lists IPO procedures as an exception to the 2 midnight rule.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10080.pdf

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Question: Can a denial be appealed based on acute care needs and expected transfer from the cath lab without an actual admission?"

Answer from Karla Hiravi: Please reference https://racmonitor.medlearn.com/a-call-to-order/ as this explains differences between Medicare cases and commercial.

Question: When will Medicare Advantage Plans be required to follow the Medicare IP only list?"

Answer from Karla Hiravi: Our understanding is that January 1, 2024 is applicable to your question.

Question: What about Overpayment/Recoupment that was approved and insurance is taking money back after 6 mos or even 1 yr?

Answer from Reggie Allen: Overpayment and recoupments are not medical necessity denials, these are **audits.** Audits by an insurance payer is a fundamental aspect of any health plan's payment integrity operations. Health insurance payers monitor health care providers' billing, coding, and documentation practices billing, coding, and documentation practices of health care providers to determine the correct party, membership eligibility, and contractual compliance, as well as to detect and prevent fraud, waste, and abuse. Payers frequently conduct pre- and post-payment audits or retrospective reviews of claims. Depending on the payer, audits typically occur one to five years after a claim has been paid. Without a specific deadline, each state has a statute of limitations for audits.

Question: Please explain the good faith statement again.

Answer from Reggie Allen: Most states in the US recognize an implied covenant of good faith and fair dealing (or just "good faith") that requires every party in a contract to implement the agreement as intended, not using means to undercut the purpose of the transaction. This applies to the performance of a contract, not the negotiation, and the covenant applies to contracts automatically without being stated in the agreement.

The specific legal definition will vary from state to state, but the key parts of understanding a good faith argument are honesty and fairness. If you have evidence that a payer is not acting honestly or fairly on their side of an agreement, then you can make a good faith argument.

An example to this would be a payer denying the medical necessity of a claim with no evidence or explanation, but clear evidence of medical necessity exists in the medical record. This shows a lack of good faith because the payer could only deny the claim by ignoring the clear evidence on review of the medical record, or not reading the record at all.

Question: Should the payor have access to the EMR and if they do should you send them clinical?

Answer from Reggie Allen: This can occur if the Utilization Management Department has a collaborative relationship with the payer. However, if physician documentation is not timely or incomplete at the time it is reviewed by the payer, it will generate a denial. If the payer has access and is using the EMR for medical necessity reviews, the hospital should discuss not having to send in these reviews. I would refer to the UM manual of the payer regarding your contractual obligations.

Question: How can commercial payers deny at the time of claims after they have given full authorization via live reviews at the time of services?

Answer from Reggie Allen: This is a contractual language issue. Most commercial contracts state that authorization is not a guarantee of payment. This language is used to reserve the payers right to review the medical record after the care has been rendered. This does not apply to Medicare Advantage claims where the claim must be paid if authorization was given.

Question: Reggie mentioned the Medicare inpatient only list. If we have a scenario where the patient came from the ED, had surgery, but the team was not aware the code/procedure performed was in the list and the patient was admitted/discharged under observation status.

Answer from Reggie Allen: It's important that the surgery staff is aware of those procedures on the inpatient only list. It could possibly be built in the surgical scheduling system and the surgery team need education on the type of cases that are on this list. For example, these procedures tend to be more complex and have a higher risk for complications. They are also likely to need post-operative monitoring overnight and often have a long recovery time.

There are two exceptions to the policy of not paying for outpatient services rendered on the same day as an "inpatient-only" service paid under OPPS if the inpatient service had not been furnished. There are two exceptions:

- **Exception 1 –** there are other procedures both and inpatient only and outpatient procedures on the claim. The "in-patient only" service is denied, but payment is made for the separate procedure and any remaining payable outpatient services.
- **Exception 2** – the patient dies before the inpatient admission or transfer to another hospital. The hospital will report the "inpatient only" services with modifier "CA." This modifier stands for a procedure payable only in the inpatient setting when performed emergently on an outpatient who expires prior to admission. A single payment is made for all services reported on the claim, including the "inpatient only" procedure.

Question: Reggie mentioned good faith clause can you share an example?

Answer from Reggie Allen: Below is information that was written in a letter and the case was overturned.

"Based on the information, we respectfully request that you reconsider your previous decision and allow coverage for this inpatient stay as outline above. When Mr. XXX came to the hospital, he was seen emergently without paperwork. He was disoriented and confused and unable to provide information. We provided the highest level of care to your beneficiary. We conducted due diligence to obtain the information by contacting his family members and using external insurance verification systems. When the facility was able to obtain and verify insurance information, efforts were made to notify Blue Cross."

Question: What is the facility's obligation re: Medicare Messages when the insurance changes the pt to OBS (or says that is what they are paying for). We know these notices are to be given prior to discharge.

Answer from Reggie Allen: The Important Message from Medicare should be given to all patients within

two days of being admitted as an inpatient, this includes Medicare Advantage Plans. If the patient is converted to observation the patient should be made aware. The MOON notice should be given if the patient receives observation services for more than 24 hours, the reason for the status, and must be delivered no later than 36 hours after observation services begin.

Question: When we appeal for untimely notification payers upheld as administratively denied . What would be the next step ?

Answer from Reggie Allen: The next step would be a good faith argument.

Most states in the US recognize an implied covenant of good faith and fair dealing (or just "good faith") that requires every party in a contract to implement the agreement as intended, not using means to undercut the purpose of the transaction. This applies to the performance of a contract, not the negotiation, and the covenant applies to contracts automatically without being stated in the agreement.

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