2019 HCCA Clinical Care Compliance Conference (Nashville, TN)
October 27, 2019

All About Appeals and Grievances:

Review of the Regulations and How to Navigate Your Way through these Processes at a Medicare and Medicaid Health Plan

Gail Kinkead, CHC
Director, Protiviti
New York, NY

Anthony H. Choe, JD
Counsel, Polsinelli, PC
Washington, DC

1

1

We Will Cover…

- Medicaid and Medicare Appeal and Grievance regulatory requirements, including how Plans are audited by CMS and Medicaid State Agencies on adhering to these rules.
- Discuss the Appeal and Grievance process and scenarios from both the Plan and Provider perspective: What are Best Practices?
- Explore options available to members after the Appeal or Grievance is upheld at the Health Plan level: What happens next?

2

2

Key Terms & Acronyms

- Medicaid Managed Care (MMC)
- Medicare Advantage (Part C or MA)
- Medicare Advantage Organization (MAO)
- Medicare Prescription Drug Program (Part D)
- Medicare Part D Plan (PDP or MA-PD)
- HHS Office of Inspector General (OIG)
- Qualified Health Plan (QHP)

3

3

What's At Stake

4

4

Growth of Managed Care - Medicare

- Why
  - Enrollee familiarity with managed care
  - Enhanced benefits

- As of October 2019
  - Part C
    - 733 contracts with payors
    - Over 22 million MA enrollees, of which 20 million have a Part D benefit
  - Part D
    - 63 standalone contracts with payors
    - Over 25 million with Part D only coverage

CMS Monthly Summary Report, October 2019

5

5

Growth of Managed Care - Medicaid

- Why
  - State budget pressures
  - ACA expansion
  - Triple aim

- For 2017:
  - Over 64 million enrolled in comprehensive, risk-based managed care plans
  - 283 Medicaid Managed Care plans
  - $263 billion spend on Medicaid managed care, 46% of total Medicaid spending

CMS Medicaid Managed Care Enrollment Reports, 2019; Urban Institute estimates based on FY 2017 data

6

6

Issues: High Rates of Denials

- For MA, 2016, MAOs denied:
  - **4%** of preauthorization requests
  - **8%** of payment requests
  - https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf
- MMC denial rate for Illinois 2018 hospital claims was **10.6%**
  - https://www.illinois.gov/hfs/SiteCollectionDocuments/Finalreporthospitalpayments.pdf
- For QHPs in 2017, Kaiser Family Foundation found:
  - 41.9 million of 232.9 million network claims were denied
  - **18%** overall denial rate
  - https://kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/

Issues: Denials Rarely Appealed

- https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf

	2014	2015	2016	Total
MAO contracts included in this analysis	**409**	**419**	**422**	**581***
Number of denials issued (full and partial)	28,907,329	35,662,934	36,565,990	101,136,253
Total number of first-level appeals	348,058	365,016	407,995	1,121,069
Number of appeals filed with MAOs for these contracts	*277,098*	*279,824*	*306,295*	*863,217*
Number of appeals filed with the Quality Improvement Organization for these contracts	*70,960*	*85,192*	*101,700*	*257,852*
Rate of first-level appeal	1.20%	1.02%	1.12%	1.11%

*This represents the total number of unique contracts included in our analyses.

Source: OIG analysis of 2014–16 annual performance data and Quality Improvement Organization data for contracts that reported validated data, 2018.

Issues: Inappropriate Denials

- MAOs reversed almost 75% of their own denials

	2014	2015	2016	Total
MAO contracts included in this analysis	**409**	**419**	**422**	**581***
Number of appeals filed with MAOs	277,098	279,824	306,295	863,217
Number of fully overturned denials	186,883	192,041	228,031	606,955
Number of partially overturned denials	20,495	18,858	2,594	41,947
Number of denials upheld	69,720	68,925	75,670	214,315
Rate of successful appeal (fully or partially overturned denials)	74.84%	75.37%	75.30%	75.17%
Rate of fully overturned denials	67.44%	68.63%	74.45%	70.31%
Rate of partially overturned denials	7.40%	6.74%	0.85%	4.86%
Rate of upheld denials	25.16%	24.63%	24.70%	24.83%

*This represents the total number of unique contracts included in our analyses.

Source: OIG analysis of 2014–16 annual performance data for contracts that reported validated data, 2018.

9

9

Issues: Inappropriate Denials

- Denials were overturned (completely or in-part) by independent reviewers at a high rate
  - 26% by QIO
  - 9% by IRE
  - 27% by ALJ
  - 23% by MAC

	2014	2015	2016	Total
Level 1: Quality Improvement Organization				
Number of appeal decisions issued	77,023	88,423	94,480	259,926
Number of denials overturned or partially overturned	*23,339*	*22,334*	*21,356*	*67,029*
Rate of denials overturned	**30.30%**	**25.26%**	**22.60%**	**25.79%**
Level 2: Independent Review Entity				
Number of appeal decisions issued	33,734	36,457	45,796	115,987
Number of denials overturned or partially overturned	*3,718*	*3,530*	*4,208*	*11,456*
Rate of denials overturned	**11.02%**	**9.68%**	**9.19%**	**9.88%**
Level 3: Administrative Law Judge				
Number of appeal decisions issued	1,145	1,515	1,632	4,292
Number of denials overturned or partially overturned	*251*	*481*	*430*	*1,162*
Rate of denials overturned	**21.92%**	**31.75%**	**26.35%**	**27.07%**
Level 4: Medicare Appeals Council				
Number of appeal decisions issued for cases brought by beneficiaries and providers	139	97	30	266
Number of denials overturned or partially overturned for these cases	*38*	*18*	*6*	*62*
Rate of denials overturned in favor of beneficiaries and providers	**27.34%**	**18.56%**	**20.00%**	**23.31%**

Source: OIG analysis of 2014–16 data from CMS, the Office of Medicare Hearings and Appeals, and the Departmental Appeals Board, 2018.

10

10

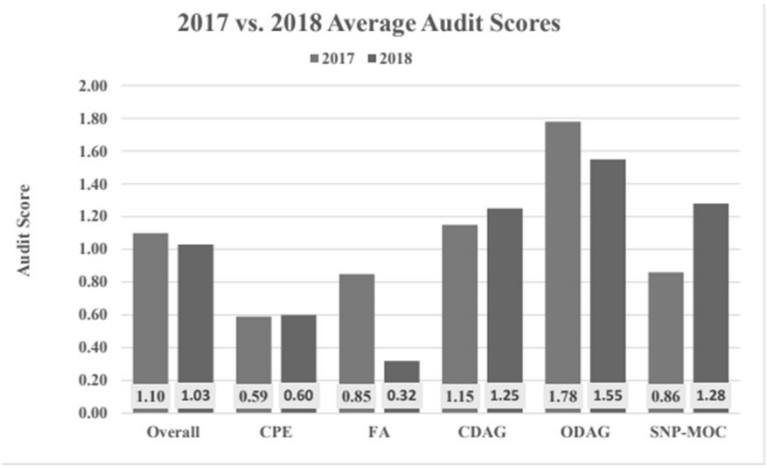
Issues: Regulators Are Watching

- **OIG**
  - April 2019, added MMC denials for prior authorizations for medical, dental and prescription drug services as an issue to their Work Plan (Report # W-00-19-31535), report expected in 2020
  - June 2019 announcement that it would review extent to which MMC denials were overturned on appeal (Report # OEI-09-19-00350), report expected in 2021
- **CMS**
  - MA Organization Determinations, Appeals, and Grievances (ODAG) and Part D Coverage Determinations, Appeals, and Grievances (CDAG) audits
  - Sanctions against MA and Part D plans often focused on appeals and grievance compliance deficiencies
  - See CMS sanctions against MAOs and Part D Sponsors at https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/PartCandPartDEnforcementActions-.html

11

11

CMS 2018 Program Audit



12

12

Examples of Deficiencies

- Failure to conduct required outreach to providers or to beneficiaries to obtain information necessary to make appropriate clinical decisions.
- Misclassifying Part C reconsiderations as organization determinations.
- Denial letters for Part C organization determinations, Part D coverage determinations and appeals did not include adequate rationales, contained incorrect/incomplete information specific to denials, or were written in a manner not easily understandable by beneficiaries
- Failure to auto-forward or timely auto-forward Part D coverage determinations and/or redeterminations to the Independent Review Entity (IRE) for review and disposition.
- Failure to provide accurate or complete information in Part C grievance resolution letters.
- Dismissed Part C cases prior to the conclusion of the appeal timeframe.
- Failure to properly oversee its delegated entities responsible for processing Part C organization determinations, appeals and grievances.

13

13

Why Compliance Should Care

- Declining revenue can incentivize improper conduct
- Denials and unsuccessful appeals may help you to identify fraud, waste or abuse, even outside of managed care claims
  - *60 overpayment rule requirements*
  - *Duty to investigate potential overpayments*
- A history of denied claims can raise audit flags for payers
  - HHS & DOJ Health Care Fraud and Abuse Control Program
- Relevant to assess that payers and providers are complying with applicable law and contract provisions
- Potential risk area for compliance training and oversight

14

14

Key Background

15

15

Trend: Convergence of MA & Part D

- In February 2019, CMS consolidated the MA and Part D appeal and grievance manuals into a single document.
  - https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf
- Governed by CMS regulations at 42 CFR Part 422 Subpart M for MA and 42 CFR Part 423 Subparts M and U for Part D.
- According to CMS: "The combining of these chapters will better align Part C and Part D appeals policy, identify key differences between the two, provide clearer interpretation of current policy, and update guidance based on the Part C and D 2019 regulation."

16

16

Trend: Convergence of MMC & MA

- Through the 2017 MMC final rule, CMS sought to align the MMC regulations with those of MA plans and QHPs. This included the MMC appeals and grievances rules, because:
  - "*the **existing differences** between the rules applicable to Medicaid managed care and the various rules applicable to MA, private insurance, and group health plans concerning grievance and appeals processes **inhibit the efficiencies that could be gained with a streamlined grievance and appeals process that applies across markets**. **A streamlined process would make navigating the appeals system more manageable for consumers who may move between coverage sources as their circumstances change**.*" 81 Fed. Reg. 27498, 27505 (May 6, 2016).
- MMC rule codified at 42 C.F.R. Part 438, Subpart F

17

17

What is an "Appeal"

Medicare Advantage & Part D

Appeal means any of the procedures that deal with the review of ***adverse organization determinations...***

42 C.F.R. 422.561 & 423.560

Medicaid Managed Care

Appeal means a review by an MCO, PIHP, or PAHP of an ***adverse benefit determination***.

42 C.F.R. 438.400(b)

18

18

What is an "Adverse Determination"

Medicare Advantage

42 C.F.R. 422.566(b)

An *organization determination* is any determination made by an MA organization with respect to any of the following:

(1) Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services.

(2) Payment for any other health services furnished by a provider other than the MA organization that the enrollee believes—

(i) Are covered under Medicare; or

(ii) If not covered under Medicare, should have been furnished, arranged for, or reimbursed by the MA organization.

(3) The MA organization's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the MA organization.

(4) Reduction, or premature discontinuation, of a previously authorized ongoing course of treatment.

(5) Failure of the MA organization to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.

Medicaid Managed Care

42 C.F.R. 438.400(b)

Adverse benefit determination means, in the case of an MCO, PIHP, or PAHP, any of the following:

(1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

(2) The reduction, suspension, or termination of a previously authorized service.

(3) The denial, in whole or in part, of payment for a service.

(4) The failure to provide services in a timely manner, as defined by the State.

(5) The failure of an MCO, PIHP, or PAHP to act within the timeframes…and (2) regarding the standard resolution of grievances and appeals.

(6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right…, to obtain services outside the network.

(7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

19

19

"Adverse Determination" – In Plain English

The denial, reduction or premature discontinuation by the managed care organization of benefits/rights an enrollee may be entitled to

20

20

A "Grievance" is Not an Appeal

Medicare Advantage & Part D

Grievance means any complaint or dispute, ***other than one that constitutes an organization determination***, expressing dissatisfaction with any aspect of an MA organization's or provider's operations, activities, or behavior, regardless of whether remedial action is requested.

42 C.F.R. 422.561 & 423.560

Medicaid Managed Care

Grievance means an expression of dissatisfaction about ***any matter other than an adverse benefit determination***. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision.

42 C.F.R. 438.400(b)

21

21

How Others View an Appeal

- **Members:**
  - Any Expression of Dissatisfaction with the denial of a Benefit of Service they believe they are entitled to.
  - Any Expression of Dissatisfaction with the payment for a service or benefit which has been received but was not paid in full
- **Industry:**
  - A Fair and Independent Review requested by a member or their authorized representative of a denial in full or part for services or benefits requested or payment of services or benefits rendered.

22

22

Who Can Appeal?

- **Provider on their own behalf**
- **Provider on behalf of the Member**
- **Member**
  - Parent or guardian of minor Member
- **"Authorized Representative" of the Member**
  - An individual appointed by an enrollee or other party, or authorized under state or other applicable law, to act on behalf of an enrollee or other party involved in a grievance, organization determination, or appeal. See 42 C.F.R. §§422.561 & 423.560.
- **Agents with a Power of Attorney**

23

23

MA & Part D Appeals Process

24

24

Life Cycle of a CMS Appeal

- Organization/coverage determination
- First Level Appeal – Internally managed by the Health Plan
- Second Level Appeal – Performed by the Independent Review Entity contracted by CMS to review denials upheld by the Health Plan and the First Level Appeal or Dismissed by the Health Plan
- Third Level Appeal – Administrative Law Judge Hearing
- Forth Level Appeal – Medicare Appeals Council
- Fifth Level Appeal – Judicial Review

25

25

What's in a Name?

- Medical Part C Appeals are also called **Reconsiderations**
- Pharmacy Part D Appeals are also called **Redeterminations**
- Member Appeals
- Non-Participating Provider Appeals are called **Provider Disputes**

26

26

First Level of Appeal: Plan

Part C Reconsideration

- Conducted at the plan
- 60 days to file appeal with plan from coverage determination
- Standard Process:
  - 30 day time limit for pre-service issue
  - 60 day time limit for payment issue
- Expedited Process:
  - 72 hour time limit
  - Payment requests not eligible

Part D Redetermination

- Conducted at the plan
- 60 days to file appeal with plan from coverage determination
- Standard Process:
  - 7 day time limit for benefits issue
  - 14 day time limit for payment issue
- Expedited Process:
  - 72 hour time limit

27

27

Second Level of Appeal: IRE

Part C IRE Reconsideration

- Appeal is automatically sent to Independent Review Entity (IRE) if plan upholds denial
- Standard Process:
  - 30 day time limit for pre-service issue
  - 60 day time limit for payment issue
- Expedited Process:
  - 72 hour time limit
  - Payment requests not eligible

Part D IRE Reconsideration

- 60 days to file appeal with IRE from plan decision
- Standard Process:
  - 7 day time limit for benefits issue
  - 14 day time limit for payment issue
- Expedited Process:
  - 72 hour time limit

28

28

Third Level of Appeal: OMHA

Part C: OMHA

- 60 days to file appeal with Office of Medicare Hearings and Appeal from IRE decision
- Must have an amount in controversy ≥ $160 (for 2019)
- No expedited process
- No statutory time limit for processing

Part D: OMHA

- 60 days to file appeal with Office of Medicare Hearings and Appeal from IRE decision
- Must have an amount in controversy ≥ $160 (for 2019)
- Standard Process:
  - 90 day time limit
- Expedited Process:
  - 10 day time limit

29

29

Fourth Level of Appeal: MAC

Part C: MAC

- 60 days to file appeal with Medicare Appeals Council from OMHA decision
- No expedited process
- No statutory time limit for processing

Part D: MAC

- 60 days to file appeal with Medicare Appeals Council from OMHA decision
- Standard Process:
  - 90 day time limit
- Expedited Process:
  - 10 day time limit

30

30

Fifth Level of Appeal: Federal Court

- Applies to both Parts C and D
- Within 60 days of the MAC decision, must file in federal district court
- Amount in controversy must be ≥ $1,630 (for 2019)

31

31

Commercial Appeals Process

32

32

Life Cycle of a Commercial Appeal

- Denial
- First Level Appeal – Internally Managed by the Health Plan
- Second Level Appeal – May be Internally Managed by the Health Plan or for Self Insured Employer Groups may be managed by the Employer Group
- Third Level Appeal – For Self Insured Employer Groups may be managed by the Employer Group

33

33

Pre-Service Appeals

- Must be submitted within 60 days of the notice of denial
- Will be dismissed if the services have already been provided

34

34

Member Post Service Appeals

- Must be submitted within 60 days of the denial
- If the provider, as the authorized representative of the member, is submitting a post service denial on behalf of the member it uses the members right of first level appeal. When the member is notified that the denial, which was submitted by the provider on the members behalf, is upheld their next step is to file an appeal with the IRE.

35

35

Provider Appeals

- Non-Participating/Non-Contracted providers appealing on their own behalf are subject to the Provider Dispute process defined by CMS.

36

36

Dismissals

A decision not to review a request for a grievance, initial determination, or appeal because it is considered invalid or does not otherwise meet Medicare Advantage or Part D requirements.

Grievances and coverage requests: May be dismissed on the grounds that a valid request was not received. The plan should notify the enrollee and the person asserting representative status of the dismissal in writing. The dismissal notice should explain the reason(s) for the dismissal, how the invalid request can be cured, and that the request will be processed if the enrollee or representative resubmits a properly executed form.

37

37

Withdrawals

An enrollee may submit a written withdrawal request for a grievance any time before the decision is mailed by the plan. The plan may accept verbal withdrawals for both written and verbal grievances received from an enrollee. The plan must clearly document in the system that the enrollee does not want to proceed with the grievance procedures. The plan should, but is not required to, send a written confirmation of that withdrawal to the enrollee within 3 calendar days of receiving the withdrawal request.

If the enrollee submits a quality of care grievance verbally or in writing, but later decides to withdraw the grievance, the plan is still required to investigate the quality of care grievance; however, the plan is not required to notify the enrollee of the outcome of the grievance since they decided not to pursue the grievance.

38

38

Timeliness, Accuracy and Completeness

- The medical exigency standard requires a plan and the independent review entity to make decisions as "expeditiously as the enrollee's health condition requires." This standard is set forth in regulations at Part 422 Subpart M and Part 423 Subpart M with respect to coverage requests and effectuation of favorable decisions.
- This standard was established by regulation to ensure that plans develop a standard for determining the urgency of coverage requests, triage incoming requests against established criteria, and prioritize each request according to these standards. Plans must treat each case in a manner that is appropriate for the facts and circumstances of the enrollee's medical condition. Plans should not routinely take the maximum time permitted for adjudicating coverage requests.

39

39

Grievances

An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan, its contacted providers or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, an appeal of a denial generated in making an organization determination or coverage determination or an Late Enrollment Penalty determination.

40

40

Life Cycle of a Grievance

Written or verbal expression of dissatisfaction which does not involve denial of services or benefits or reimbursement of a service or benefit which has been provided.

Investigation or verbal communication of the health plan approach or decision.

Written or verbal response which addresses all the issues raised.

If verbal response, confirmation with the caller that they are satisfied with the response provided.

41

41

First Call Resolution

Member Services may be granted the authority to resolve grievances while on the call with the member or their authorized representative.

All grievance documentation requirements must be met in the call documentation as well as confirming the caller grievance has been successfully resolved. Otherwise the grievance must be documented and sent to the Grievance Department for resolution and notification of the response.

42

42

Potential Quality of Care

A grievance related to whether the quality of covered services provided by a plan or provider meets professionally recognized standards of health care, including whether appropriate health care services have been provided or have been provided in appropriate settings.

43

43

Quality Improvement Organizations

- **Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO):**
  - Organizations comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare enrollees.
  - The BFCC- QIOs review enrollee complaints about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities (SNFs), home health agencies (HHAs), Medicare managed care plans, Medicare Part D prescription drug plans, and ambulatory surgical centers.
  - The BFCC-QIOs also review continued stay denials in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs, and comprehensive outpatient rehabilitation facilities (CORFs).
  - In some cases, the BFCC-QIO can provide informal dispute resolution between the health care provider (e.g., physician, hospital, etc.) and enrollee.

44

44

MMC Appeals Process

45

45

Federal MMC Appeals Standards

- CMS established new MMC appeals and grievances guidelines effective in 2017, and updated in 2019.
- Plans must provide information about the grievance and appeals system to all providers and subcontractors at the time of contracting
- States enjoy flexibility to customize their own guidelines, for Medicaid, within the boundaries of the federal standards.
  - So…guidelines vary by state for Medicaid but are consistent nationally for Medicare

46

46

Notice of Adverse Benefit Determination

Plan must give timely and adequate written notice to the Member that explains:

- The **rationale** for this determination
- The right to be furnished upon request, free of charge, **access to /copies of all documents and information relevant to the determination**
- **Right to an appeal**, including a right to request a State Fair Hearing
- When and how to seek an **expedited appeal**
- Rights to have **continued benefits** pending the appeal

47

47

Requirements for Initial Complaint

Appeals

- Within 60 calendar days of date on the adverse decision determination notice
- Form
  - In writing or orally (almost no plans allow oral)
  - Unless an expedited resolution is sought, an oral request must be followed by a written, signed appeal.
    - CMS requires a written response within 3 days when a verbal response has been provided to an expedited appeals

42 C.F.R. 438.403(2)

Grievances

- At any time
- Form
  - In writing or orally and as determined by CMS, the State and/or plan

48

48

Level 1 Plan Review

- An MMC plan may only have **one level of appeal**. 42 C.F.R. 438.402(b).
- Appeals timeframe for Plan decision:
  - **Standard: 30 calendar days** from receipt of appeal
  - **Expedited: 72 hours** from receipt of appeal
  - Extensions possible, when the delay is to the benefit of the member and the member agrees
- Grievances timeframe for Plan decision: **90 calendar days** from receipt of grievance
- If Plan fails to meet the appeals timeframes, the enrollee is deemed to have exhausted the appeals process and may initiate a State Fair Hearing
- Plans must consider all information submitted, regardless of whether this information was considered in the original decision

42 C.F.R. 438.408

49

49

State Fair Hearing

- Available only if:
  - Plan upholds an adverse benefit determination; **or**
  - Plan fails to meet appeals notice and timing requirements
- No requirement to proceed to a State Fair Hearing
- New rule requires exhaustion of internal plan appeals processes

50

50

External Medical Review

- Available only if Enrollee seeks it (optional)
- Must be requested within 120 calendar days from the Plan's notice of resolution
- No requirement to proceed to a State Fair Hearing first
- Conducted independent of both the state and Plan
- Offered without cost to the enrollee
- Review does not extend certain timeframes
- May not disrupt continuation of benefits during review period

51

51

Continuation of Benefits

- Plan must continue benefits to Member if:
  - the appeal request is made timely;
  - the appeal involves the termination, suspension or reduction of previously authorized services;
  - the services were ordered by an authorized provider;
  - the period covered by the authorization has not expired; **and**
  - the enrollee timely files for continued benefits (not automatic)
- Occurs while a Plan appeal, external review or State Fair Hearing is pending
- If Member fails to request a State Fair Hearing and continuation of benefits request within 10 calendar days, services can be stopped

52

52

Challenges & Best Practices

53

53

Frequent Areas of Scrutiny

- Members have a due process right if the plan intends to deny, stop or reduce services
- Did plan provide:
  - proper and timely notice of the denial
  - adequate reasons for the denial
  - references to policies and clinical facts
  - instructions on how to appeal, including how to keep services ongoing during pending appeal

54

54

Factors that Complicate Appeals

- In-Network vs. Out-of-Network providers
- Arbitration or other alternative dispute resolution clauses in contracts
  - Absence of binding case law
- Repricers
- PPO arrangements

55

55

Involvement of Providers

- Critical for medical necessity related denials
- Importance of accurate, complete and timely documentation
  - EHR challenges
- May need to be an advocate
  - Offer testimony (Peer to Peer) and other evidence
- Should be involved in the review of case file documentation and information furnished by the plan

56

56

Involvement of Compliance

- Tracking
  - Expected revenue vs. A/R
  - Denial codes (by category)
- Training
- Audits
  - Internal
  - External
- Validation of coding software
- Documentation standards
  - Accuracy
  - Timeliness
  - Completeness
  - Retention
- Implementing corrective actions
  - Future contracting

57

57

Involvement of Consultants & Attorneys

Pros

- Ability to get a gut check / independent, third-party judgment
- Specialized knowledge and experience
  - Coding
  - Statistical extrapolation
  - Strategies and tactics
- Insights on how to preserve appeal rights
- Ability to get attention of and responses from health plan

Cons

- Cost
- Time and staff resources to get consultants/attorneys up to speed
- Lack of familiarity with the specific issue
- Involvement can raise the temperature of discussions with health plans

58

58

War Stories / Case Studies

59

59

A Few Examples

I am appealing

I need this procedure you said no to

I am so mad you won't let me have

The motorized wheelchair I want

You to pay for my band aids

More days in the skilled nursing facility I am in, I don't want to go home

60

60

Questions

61