ERN NCRA

You fight for their lives.

WE FIGHT FOR YOU.

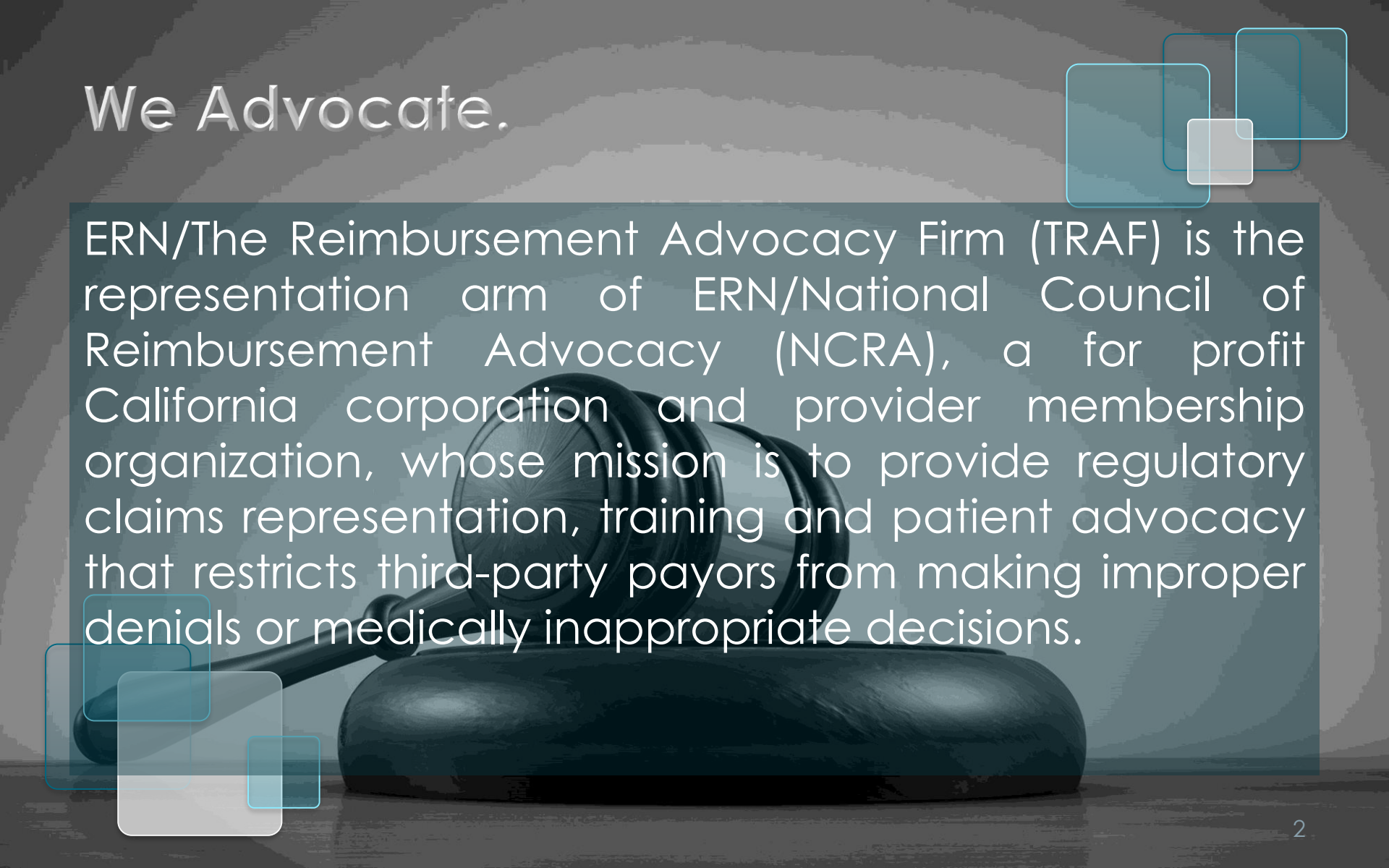
HEALTH LAWS

Three (3) Things Medicare Advantage Plans Don't Want You To KNOW.

Ed Norwood, President/CCO

We Advocate.

ERN/The Reimbursement Advocacy Firm (TRAF) is the representation arm of ERN/National Council of Reimbursement Advocacy (NCRA), a for profit California corporation and provider membership organization, whose mission is to provide regulatory claims representation, training and patient advocacy that restricts third-party payors from making improper denials or medically inappropriate decisions.



Healthcare is a law to be defended.

3 THINGS MEDICARE ADVANTAGE PLANS DON'T WANT YOU TO KNOW

Change the Rules of the Game.

The

FREEDOM OF INFORMATION ACT

The Freedom of Information Act

If you are having difficulty getting government claims paid, more than likely it's something you didn't do.

Health insurance is something of an opaque industry.

As a consumer, we know we have to pay the premium in full (no partial or UCR payments), we just have no clue how the payor arrived at that rate.

The Freedom of Information Act

In contrast, when a provider bills, payors often want: ***itemized statements, original invoices for implants or supplies, etc.*** to substantiate what is being charged.

As advocates, we have a right to demand substantiation of payor actions or inaction.

Ed Norwood

From: Christy Cundiff
Sent: Monday, March 27, 2017 9:43 AM
To: Denise Griffith
Subject: RE: Failure To Reimburse Authorized Services

Denise,
Due to HIPAA laws, I cannot send an EOB/EOR. I can confirm that the claim was processed and paid on 3/23/17. You can check with the provider to ensure they received payment for the claim.

Thanks,
Christy Cundiff, CPC
Retail Service Operations Compliance

Humana
101 E Main | Louisville, KY 40202

From: Denise Griffith [mailto:denisegriffith@ernenterprises.org]
Sent: Friday, March 24, 2017 1:28 PM
To: Christy Cundiff
Subject: RE: Failure To Reimburse Authorized Services

Thank you for promptly resolving this issue. Can you please send me a copy of the payment EOB, so I can close this case out?

Thanks,

Denise Griffith, Esq.
Director, Regulatory Affairs & Compliance
ERN / The Reimbursement Advocacy Firm
714 995-6900 Ext. 6924 Fax 714 995-6901

Ed Norwood

From: Ed Norwood
Sent: Monday, March 27, 2017 11:07 AM
To: 'Christy Cundiff'
Cc: Denise Griffith
Subject: RE: Failure To Reimburse Authorized Services

Follow Up Flag: Follow up
Due By: Friday, April 07, 2017 12:30 PM
Flag Status: Flagged

Tracking:

Recipient	Read
'Christy Cundiff'	
Denise Griffith	
Ed Norwood	Read: 3/27/2017 12:41 PM

Ms. Cundiff,

Please provide the HIPAA Privacy Rule you rely upon that prohibits you from sending an EOR/EOB to a business associate of a covered entity.

Respectfully,

Ed Norwood
Chief Compliance Officer
ERN / The Reimbursement Advocacy Firm
714 995-6900 ext. 6926 Fax 714 995-6901

www.erntraf.org
www.ernenterprises.org

ERN
TRAF

"Never doubt that a small group of thoughtful committed citizens can change the world. Indeed, it is the only thing that ever has." - Margaret Mead

From: Christy Cundiff
Sent: Monday, March 27, 2017 9:43 AM

Ed Norwood

From: Christy Cundiff
Sent: Monday, April 03, 2017 4:01 AM
To: Ed Norwood
Cc: Denise Griffith
Subject: RE: Failure To Reimburse Authorized Services

Ed,
I sent you and Denise a copy of the EOB on 3/28/17 via secure email.

Thanks,
Christy Cundiff, CPC
Retail Service Operations Compliance

Humana
101 E Main | Louisville, KY 40202

From: Ed Norwood [mailto:ednorwood@ernenterprises.org]
Sent: Friday, March 31, 2017 7:47 PM
To: Christy Cundiff
Cc: Denise Griffith
Subject: RE: Failure To Reimburse Authorized Services

Ms. Cundiff:

I trust you are well.

This is a *second* request for the HIPAA Privacy Rule you rely upon that prohibits you from sending an EOR/EOB to a business associate of a covered entity.

We would appreciate a secure copy of the EOR/EOB requested by Ms. Griffith below to document your compliance in this matter.

Respectfully,

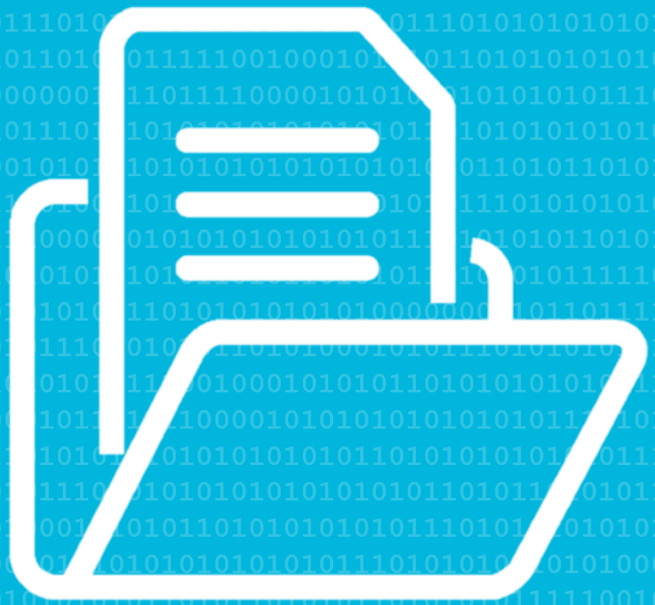
Ed Norwood
Chief Compliance Officer
ERN / The Reimbursement Advocacy Firm
714 995-6900 ext. 6926 Fax 714 995-6901

www.erntraf.org
www.ernenterprises.org

Freedom of Information Act

The Freedom of Information Act (FOIA) is a law that gives you the right to access information from the federal government. It is often described as the law that keeps citizens in the know about their government.

There is no specific form that must be used to make a request. The request simply must be in writing, reasonably describe the information you seek, and comply with specific agency requirements. Most federal agencies now accept FOIA requests electronically, including by web form, e-mail or fax.



What can you ask for?

A FOIA request can be made for **any** agency record. You can also specify the format in which you wish to receive the records. You should be aware that the FOIA does not require agencies to do research for you, to analyze data, to answer written questions, or to create records in response to a request.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C4-26-05
Baltimore, Maryland 21244-1850

Office of Strategic Operations and Regulatory Affairs

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

HCDI-(SBJ)

Refer to: 061020117044

NOV 30 2012

Ed Norwood [eajjjn@spamarrest.com]
ERN/The National Council of Reimbursement
Advocacy
4552 Lincoln Avenue, Suite 105
Cypress, CA 90630

Dear Mr. Norwood:

This is a follow-up response to your June 9, 2011 Freedom of Information Act request electronically submitted to the Centers for Medicare & Medicaid Services. By letter dated July 1, 2011, this agency's San Francisco Regional Office responded to this request and informed you that the documents that may respond to items 2, 3, and 4 of your request would be forwarded to my office for processing. The documents forwarded pertain to items 2, 3, 4, and 6 of your request and are enclosed in their entirety.

2. any written CMS policy, procedure, manual or document that directs CMS regional offices how to review and investigate complaints against MA plans that contract with Medicare Providers. ***AM SOP (Section 5.3.2) enclosed***.

3. any written CMS policy, procedure, manual or document that directs CMS Regional Offices how to review and investigate patient grievances against MA plans that contract with Medicare Providers. ***CMP enclosed***.

4. the written CMS policy, procedure, manual or document that explains the process how CMS Regional Offices oversee MA plan contracts to ensure they are consistent with Medicare regulation imposed upon the MA plan. ***AM SOP (Section 5.3.2) enclosed***.

6. any written CMS policy, procedure, manual or document that informs healthcare providers that CMS does not have regulatory oversight of MA plans they may contract with and that the provider contract will control: the scope of the services to be provided by providers to MA plans, the payment MA plans will make to providers for those services, and the conditions under which the MA plan will pay the contract provider for those services if they sign. ***Part C MA APP/Chap. 6 enclosed***.

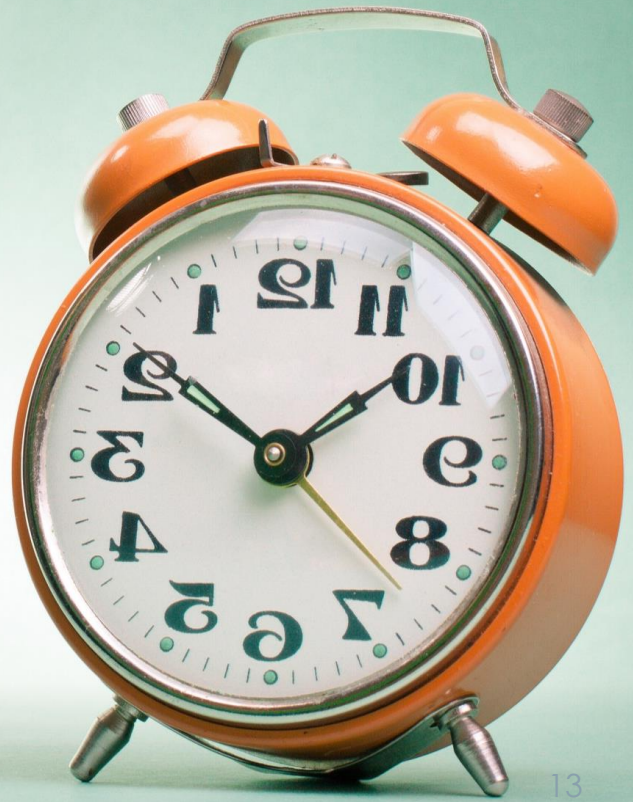
Sincerely,

Michael Marquis
Director
Division of Freedom of Information

Enclosure: Email

You are not a Victim.

TIMEFRAMES TO AUTHORIZE POSTABILIZATION SERVICES



Timeframe to Authorize Poststabilization Services

Medicare Advantage (managed by the Center for Medicare & Medicaid Services)

Timeframe to Authorize Poststabilization Services

MEDICARE HMO – *42 CFR § 422.113 (b)(2)* *The MA organization is financially responsible for emergency and urgently needed services--*

(i) Regardless of whether the services are obtained within or outside the MA organization;

(ii) Regardless of whether there is prior authorization for the services.

Timeframe to Authorize Poststabilization Services

(3) Stabilized condition. The physician treating the enrollee must decide when the enrollee may be considered stabilized for transfer or discharge, and that decision is binding on the MA organization.

Timeframe to Authorize Poststabilization Services

MEDICARE HMO - 42 CFR 422.113 (c)(2) MA organization financial responsibility. The MA organization—

(i) Is financially responsible (consistent with Sec. 422.214) for post-stabilization care services obtained within or outside the MA organization that are pre-approved by a plan provider or other MA organization representative;

Timeframe to Authorize Poststabilization Services

(ii) Is financially responsible for post-stabilization care services obtained within or outside the MA organization that are not pre-approved by a plan provider or other MA organization representative, but administered to maintain the enrollee's stabilized condition **within 1 hour of a request** to the MA organization for pre-approval of further post-stabilization care services;

Timeframe to Authorize Poststabilization Services

(iii) Is financially responsible for post-stabilization care services obtained within or outside the MA organization that are not pre-approved by a plan provider or other MA organization representative, but administered to maintain, improve, or resolve the enrollee's stabilized condition if—

(A) THE MA ORGANIZATION DOES NOT RESPOND TO A REQUEST FOR PRE-APPROVAL WITHIN 1 HOUR;

(B) The MA organization cannot be contacted; or

Timeframe to Authorize Poststabilization Services

(c) The MA organization representative and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultation. In this situation, the MA organization must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in Sec. 422.113(c)(3) is met;

Timeframe to Authorize Poststabilization Services

(3) End of MA organization's financial responsibility. The MA organization's financial responsibility for post-stabilization care services it has not pre-approved ends when—

(i) A plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care;

(ii) A plan physician assumes responsibility for the enrollee's care through transfer;

(iii) An MA organization representative and the treating physician reach an agreement concerning the enrollee's care; or

(iv) The enrollee is discharged.

2014190-EVACM1A-00205-01

UnitedHealthcare
PO Box 30968
Salt Lake City, UT 84130

July 8, 2014

364460 | 37

ROSE TROCHEZ
5856 CORPORATE AVE., SUITE 110
CYPRESS, CA 90630

Member Name: M Hart
Member ID/Claim:
DOS: 6/6/2013-7/19/2013
Billed Charges: $542,657.80
Account/PCN:
Request ID:

Dear Business Office Manager,

Your correspondence was received in our office in regards to an inquiry for additional payment of healthcare services provided by your company. After careful consideration of the case and all supporting documentation, a decision has been made to uphold the initial determination.

The payment is based on the terms and reimbursement rate(s) outlined in Medicare's policy. The claim was processed appropriately and in accordance to the terms and conditions of Medicare.

The basis for the decision is as follows:

This claim has been denied per the readmission review team. A letter was sent to the provider on 10/29/2013 and 1/17/2014. The provider will need to send an appeal for further claims review. Therefore, no additional benefits are due at this time.

Per your contractual agreement and/or the Knox-Keene language, you may not bill the member.

UnitedHealthcare, a Medicare Advantage Organization, and its contracting providers are obligated to reimburse non-contracting providers at the same rate a provider would collect if the patient were enrolled in original Medicare. According to Part 42 of the Code of Federal Regulations, Section 422.214, any non-contracted provider must accept as payment in full the amounts that it could collect if the beneficiary were enrolled in original Medicare.

If you have any questions or concerns, please call (800) 542-8789 and select the claims option.

Sincerely,

From: "Duarte, Ann M. (CMS/CMHPO)" <
Date: 07/24/2014 10:52 AM (GMT-08:00)
To: Rose Trochez <rosetrochez@ernenterprises.org>
Cc: Ed Norwood <ednorwood@ernenterprises.org>
Subject: RE: ERN/TRAF Summary of Complaint/ Memorial Hospital of Gardena/ Password to follow

Ms. Trochez,

It is our understanding that United had no record of having received an appeal request from Memorial Hospital of Gardena in response to denying the claim. United has since opened an appeal; I believe the plan is awaiting receipt of the Waiver of Liability from the hospital.

If you can provide evidence to CMS that Memorial Hospital did file a reconsideration request and the required documentation within 60 days of the remittance notification (per the Medicare Managed Care Manual, Chapter 13), please submit that to us.

40.2.3 - Notice Requirements for *Non-contract* Providers

(Rev. 105, Issued: 04-20-12, Effective: 04-20-12, Implementation: 04-20-12)

If the Medicare health plan denies a request for payment from a *non-contract* provider, the Medicare health plan must notify the *non-contract* provider of the specific reason for the denial and provide a description of the appeals process. *Plans must deliver either a remittance advice/notice or other similar notification that includes the following information:*

- *Non-contract providers have the right to request a reconsideration of the plan's denial of payment;*

- *Non-contract providers have 60 calendar days from the remittance notification date to file the reconsideration;*

- *Non-contract providers must include a signed Waiver of Liability form holding the enrollee harmless regardless of the outcome of the appeal [include either the form or a link to the form];*

- *Non-contract providers should include documentation such as a copy of the original claim, remittance notification showing the denial, and any clinical records and other documentation that supports the provider's argument for reimbursement; and*

Rose Trochez

From: Dalli Haley
Sent: Friday, July 25, 2014 2:14 PM
To: ann.
Cc: Ed Norwood; Rose Trochez
Subject: RE: RE: ERN/TRAF Summary of Complaint/ Memorial Hospital of Gardena/ Password to follow
Attachments: 36460-mhg cms exhibits 072514.pdf; 36460-mhg wol 072514.pdf

Dear Ms. Duarte,

I am responding to your email sent yesterday to Rose Trochez.

Attached are United's denials and Memorial Hospital of Gardena's hospital remote notes with pertinent dates highlighted as proof that Memorial Hospital submitted an appeal request within the 60 day timeframe for reconsideration, orally and in writing pursuant to 42 CFR §422.582(a).

Based on our investigation, we have found:

- On 06/06/13, patient was presented to the emergency room at Memorial Hospital.
- On 06/07/13, Memorial Hospital called Secure Horizons and received authorization for patient from Amanda, authorization #13158-0582. (See Remote Notes)
- On 07/19/13, patient was discharged from Memorial Hospital.
- On 07/31/13, claim was billed to Secure Horizons electronically. (See Remote Notes)
- On 09/10/13, Memorial Hospital placed a phone call to Secure Horizons and spoke with Cory who stated claim was denied on 08/29/13 pending medical records. (See Remote Notes)
- On 09/10/13, Memorial Hospital sent the medical records by certified mail to support their reason for readmission IN APPEAL FORM. (See Remote Notes)
- On 12/10/13, per Natalie, claims supervisor at Secure Horizons, claim was denied as not medically necessary, and submitted information does not support length of stay nor number of services. (See Remote Notes)
- On 02/04/14, Memorial Hospital called Secure Horizons and spoke to Terrance, stating that claim should be sent back for review. (Oral appeal) (See Remote Notes)
- On 02/18/14, Memorial Hospital received correspondence from United stating the claim was denied per readmission review team. (See United's Denial Letter)
- On 04/02/14, Memorial Hospital sent two boxes of additional medical records to Secure Horizons for review of denied claim. (See Remote Notes)
- On 04/16/14, Memorial Hospital called Secure Horizons to check on status of medical record review. Terrance stated they are not showing the records having been received, however, USPS website shows records as being delivered.
- On 05/27/14, United sent Memorial Hospital a letter stating that "claim remains denied as no formal request for reconsideration/ appeal was received to warrant further review."
- On 06/12/14, ERN/TRAF sent an Appeal and Request for Reconsideration review to Secure Horizons for failure to review medical records per conversation on 04/16/14, and reconsider readmission review. (See attachment of letter.)
- On 07/25/14, United sent ERN the Waiver of Liability forms. The forms were signed and faxed back to United and were forward to Ms. Duarte. (See WOL's attached)

As the evidence will prove, Secure Horizons denied the claim on 08/29/13, and on 09/10/13 Memorial Hospital sent an appeal with medical records to Secure Horizons, requesting reconsideration of the claim. When Secure Horizons received the medical records with cover letter, if they needed clarification if it was a request for reconsideration they could have sought clarification from Memorial Hospital or sent a letter stating their appeal was not a reconsideration. Instead they conducted a reconsideration review and denied it on 12/10/13. At that time they failed to send the claim to the IRE, pursuant to 42 CFR §422.590(b)(2).

Furthermore, patient was admitted through the emergency room and Memorial Hospital was given authorization by Secure Horizons to admit the patient. Pursuant to 42 CFR §422.113(b)(2)(ii) an MA organization is financially responsible for emergency and urgently needed services regardless of whether there is prior authorization. However, since authorization was given in this case, according to 42 CFR §422.113(c)(2)(i), the MA organization is also financially responsible for post-stabilization care services obtained within or outside the MA organization that are pre-approved by a plan provider or other MA organization representative. Therefore, United is liable for the entire amount of the patient's stay as patient was admitted with authorization through the emergency room per authorization #13158-0582.

The authorization demonstrates that UHC was aware of the beneficiary's admission. Even if UHC did not issue an authorization, they were given an opportunity to assume care via:

(i) A plan physician with privileges at the treating hospital assuming responsibility for the enrollee's care;
(ii) A plan physician assuming responsibility for the enrollee's care through transfer or
(iii) An MA organization representative and the treating physician reaching an agreement concerning the enrollee's care prior to discharge;

Since that did not occur, UHC's financial responsibility ended when:

(iv) The enrollee was discharged. (See 42 CFR §422.113(c)(3))

In reference to the Waiver of Liability form, Secure Horizons failed to make reasonable efforts to secure the form if an appeal was forwarded to them without one. Since your involvement, they have sent forms to our office and we have forwarded sign copies for their reconsideration review. (See attached)

Please be advised that the information enumerated above was recorded in notes made by Memorial Hospital's staff members. These notes constitute "hospital records" and the Federal Business Records Act may be invoked to offer hospital records as a reliable source of information to prove the truth of the matter asserted. Under 28 U.S.C.A. § 1732(a), characterizing information as hospital records is predicated upon satisfying two requirements: the record must have been made in the regular course of business, and it must have been the regular course of the business to make such record contemporaneously or within a reasonable time. It has been held that when these two requirements are satisfied with respect to a hospital record, the entire document is deemed reliable.

The Memorial Hospital notes are used to keep records of all transactions in the regular course of business. Further, all Memorial Hospital notes are recorded contemporaneously or within a reasonable time. The Memorial Hospital notes are therefore properly characterized as hospital records under the Federal Business Records Act.

The attached exhibits are password protected and the password will be sent immediately following this email. If you need any more information to help this investigation into United/ Secured Horizon's unlawful denial, please do not hesitate to contact our office.

We thank you for all your tireless advocacy for Medicare beneficiaries.

Best regards,

Dalli Haley, Esq.
Claims Compliance Auditor II

Dalli Haley

From: Duarte, A
Sent: Wednesday, July 30, 2014 1:41 PM
To: Rose Trochez
Cc: Ed Norwood; Dalli Haley
Subject: RE: ERN/TRAF Summary of Complaint/ Memorial Hospital of Gardena/ Password to follow

Ms. Trochez,

Thank you for your continued patience as we work on this case. It does appear, based upon the information that Ms. Haley provided and some additional details from United, that they should have addressed the provider's appeal in September 2013. CMS will follow up with United on this issue.

In the meantime, as I indicated previously, United is now addressing the appeal and they have the Waiver of Liability to accompany it. We intend to allow United to carry out this process and will track the outcome.

Respectfully,

Ann M. Duarte | Associate Regional Administrator | Division of Medicare Health Plans Operations | Centers for Medicare &

MedicareComplete
UnitedHealthcare

CA124-0157, PO Box 6106, Cypress, CA 90630

August 14, 2014

ERN TARF
Attn: Rose Torchez
1145 W Redondo Beach Blvd.
Gardena, CA 90247

Member ID #:
Member Name: M Hart

Case Number:

Dear Ms. Torchez:

We received your request for an appeal on July 08, 2014 about the denial of an inpatient claim for services provided at Memorial Hospital Gardena on June 6, 2013 through July 19, 2013. Thank you for bringing this to our attention. We will pay for June 6, 2013 through July 19, 2013.

Based on the records, there was documentation of adequate treatment during the first admission and stability at discharge, the re-admission is not related directly to the first admission. The re-admission denial for dates of service June 6, 2013 through July 19, 2013 is overturned.

What happens next?

- We changed the refusal of payment for June 6, 2013 through July 19, 2013 and your claim has been sent to the Claims Department to be paid within sixty (60) calendar days.

You have the right to:

- Ask for a copy of your case file and the criteria that we used to decide your case
  - To request a copy of your file, please contact me at:

UnitedHealthcare
PO BOX 6106
Mailstop CA 124-0157
Cypress, CA 90630-9948
Phone: 1-951-786-9638, TTY: 711

- Send additional information about your appeal

Y0066_130806_093816A CMS Approved 09132013
AG502_Appeal_Overturn_Decision_v09132013Update

Dalli Haley

From: Dalli Haley
Sent: Thursday, August 14, 2014 12:54 PM
To: 'Duarte, A :MHPO)'
Cc: Ed Norwood; Rose Trochez
Subject: RE: ERN/TRAF Summary of Complaint/ Memorial Hospital of Gardena

Ms. Duarte,

We thank you for your aggressive oversight over the UHC complaint submitted to your office on July 8, 2014. Today we received correspondence from UHC stating that the readmission of the beneficiary was not related directly to the first admission, therefore, the denial for dates of service June 6, 2013 to July 19, 2013 is being overturned. (Case #: ST000867GN)

UHC has notified this office that the claim has been sent to the Claims Department to be paid within 60 calendar days.

While we appreciate UHC's partial compliance in this matter, the provider's first request for a standard reconsideration was on September 10, 2013. The provider again requested reconsideration on April 16, 2014, and after UHC failed to adjudicate the claim in accordance with Medicare law and forward the claim to Maximus, our office sent another request to UHC on June 12, 2014. Per **42 CFR §422.618(a)(2),** *"if, on reconsideration of a request for payment, the MA organization completely reverses its organization determination, the organization must pay for the service no later than 60 calendar days after the date the MA organization receives the request for reconsideration."* Therefore, UHC has 60 calendar days to remit payment from the date the reconsideration was requested that resulted in a favorable decision, which was June 12, 2014.

UHC should have remitted payment by August 11, 2012, and they are in non-compliance by stating that the claim shall be paid within 60 days of reprocessing the payment through their Claims Department. Please order your MAO to release payment forthwith in compliance with **42 CFR §422.618(a)(2).**

We thank you for your tireless advocacy for Medicare beneficiaries.

Respectfully,

Dalli Haley, Esq.
Claims Compliance Auditor II
ERN / The Reimbursement Advocacy Firm
714 995-6900 Ex. 6906 Fax 714 995-6901

"And though your beginning was small, yet your latter end would greatly increase."
The Greatest Book Ever Written

Dalli Haley

Subject: ERN/TRAF Summary of Complaint/ Memorial Hospital of Gardena

From: Duarte, A)
Sent: Friday, August 15, 2014 11:18 AM
To: Dalli Haley
Cc: ; Ed Norwood; Rose Trochez
Subject: RE: ERN/TRAF Summary of Complaint/ Memorial Hospital of Gardena

Ms. Haley,

I appreciate you sharing the news that UHC has reconsidered its denial and will pay the claim. Our office will address the organization's improper handling of the original request from Memorial Hospital of Gardena. Such actions, however, will not include instructing UHC to pay the claim quicker than within the 60-day established timeframe.

If UHC fails to pay Memorial Hospital within 60 days, please let me know so that we can take further action.

Respectfully,

Ann M. Duarte | Associate Regional Administrator | Division of Medicare Health Plans Operations | Centers for Medicare &

Dalli Haley

From: Ed Norwood <ednorwood@ernenterprises.org>
Sent: Friday, August 15, 2014 12:45 PM
To: 'Tabe-Bedward, Arrah A. (CMS/CM)'
Cc: 'Abeln, Marty O. (CMS/CM)'; Dalli Haley; Rose Trochez; 'Duarte, Ann M. (CMS/CMHPO)'
Subject: FW: ERN/TRAF Summary of Complaint/ Memorial Hospital of Gardena

Ms. Tabe-Bedward:

In the past, we have discussed the importance of reporting issues to you that have not been handled by your Regional Offices (RO), the MAO or contractor consistent with Medicare Rules and Regulations.

Below is an example of the same.

While we appreciate Ms. Duarte's oversight in this matter, you will find below a glaring concern we have of the RO's ability to enforce the compliance of it's MAOs.

We trust you will intervene in this matter to prevent any unnecessary regulatory complaint action with Ms. Marilyn Tavenner's office by ensuring the federal funds intended for the Medicare beneficiary are released forthwith.

THIS IMPROPERLY DENIED CLAIM IS 349 DAYS BEYOND THE STATUTORY TIMEFRAME FOR REIMBURSING CLAIMS (PER 42 CFR SEC. 422.520.)

If not, we would appreciate an electronic written copy of any CMS Manual, Handbook, SOP or statutory authority that permits MAOs to reverse its organization determination (upon reconsideration) and pay for the service LATER than 60 calendar days after the date the MA organization receives the request for reconsideration **(See 42 CFR §422.618(a)(2) AND EMAIL STRING BELOW.)**

Best,

Ed Norwood
Chief Compliance Officer
ERN / The Reimbursement Advocacy Firm
714 995-6900 ext. 6926 Fax 714 995-6901

www.ernenterprises.org

ERN
TRAF

"Never doubt that a small group of thoughtful committed citizens can change the world. Indeed, it is the only thing that ever has." - Margaret Mead

Dalli Haley

Subject: FW: ERN/TRAF Summary of Complaint/ Memorial Hospital of Gardena

From: Duarte, Ann M. (CMS/CMHPO) [mailto:ann.duarte@cms.hhs.gov]
Sent: Wednesday, August 20, 2014 3:13 PM
To: Ed Norwood
Cc: Abeln, Marty O. (CMS/CM); Dalli Haley; Rose Trochez; Tabe-Bedward, Arrah A. (CMS/CM)
Subject: RE: ERN/TRAF Summary of Complaint/ Memorial Hospital of Gardena

Mr. Norwood,

Memorial Hospital of Gardena can anticipate payment by the end of next week.

Ann M. Duarte | **Associate Regional Administrator** | Division of Medicare Health Plans Operations | Centers for Medicare &

MA Organizations: Their Financial Responsibility to You

Source:
42 CFR §422.113 (c)(2-3)

MA Organizations are financially responsible for poststabilization care services when…

1. …they have been pre-approved

2. …you render services within 1 hour of your request

3. …they did not respond to your request after one hour, they cannot be contacted and the MA plan/plan physician and treating physician cannot reach an agreement about the enrollee's care

MA Organizations' financially responsibility ends when…

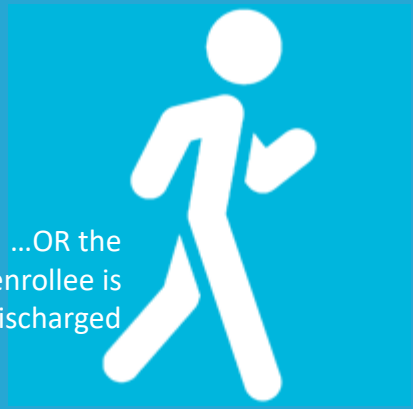
1. …at the treating facility

…a plan physician assumes responsibility for the enrollee's care…

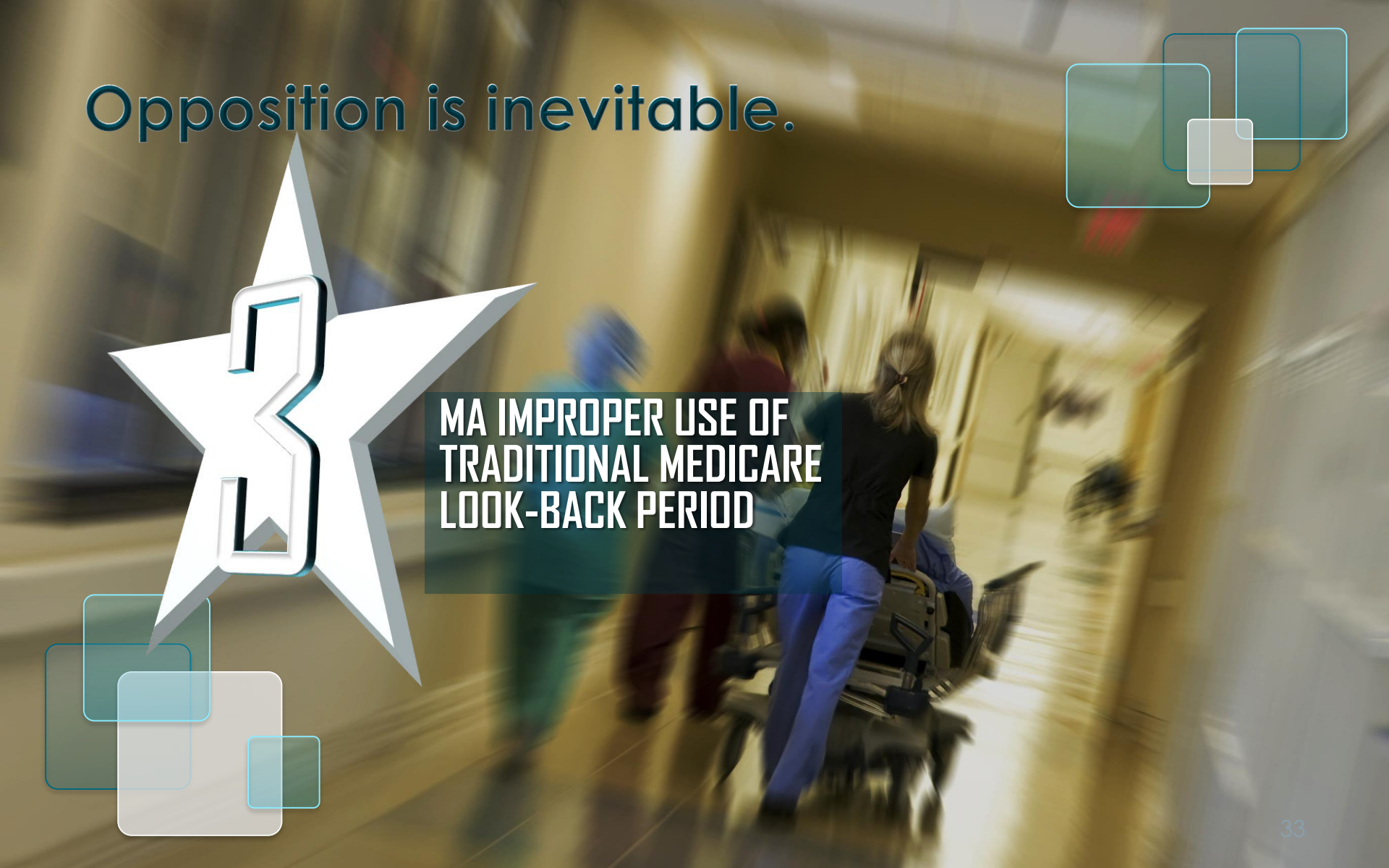
…OR through transfer

2. …an MA organization representative and the treating physician reach an agreement about the enrollee's care

3. …OR the enrollee is discharged



Opposition is inevitable.



MA IMPROPER USE OF TRADITIONAL MEDICARE LOOK-BACK PERIOD

WellCare Health Plans
Stephanie Papoulis
Senior Corporate Counsel

VIA OVERNIGHT DELIVERY

June 28, 2018

Christine Babu
The Reimbursement Advocacy Firm
980 9th Street Suite 500
Sacramento, California 95814
(714) 995-6900, ext 6970

Re: Harmony Health Plan, Inc. ("Harmony")

Dear Ms. Babu:

I received your letter dated June 25, 2018. I have reviewed the Arkansas statutes referenced in your request. I assume there has been some confusion as it pertains to the applicability of these statutes on Harmony's line of business. Harmony provides its benefits through a Medicare Part C plan. The applicable statutes referenced would not apply to Medicare Part C plans pursuant to 42 U.S.C. §1395w-26(b)(3), the provisions of state law regarding specific requirements on recoupment are preempted and inapplicable by federal law.

42 U.S.C. §1395w-26(b)(3) specifically states that law and regulations relating to Medicare Parts C and D "shall supersede any State law or regulation (other than State licensing laws or State law relating to plan solvency) with respect to MA organizations..." In interpreting the preemption provision, The Centers for Medicare and Medicaid Services ("CMS"), which administers Medicare Parts C and D, have stated that "all state standards, including those established through case law, are preempted to the extent they specifically would regulate MA plans, with exceptions of State licensing and solvency laws." 70 Fed.Reg. at 4665.

When state laws purporting to regulate Medicare Advantage plans do not relate to the narrow exceptions of licensing and solvency of those plans, but instead relate to the payment of claims or other obligations, courts have uniformly held such laws to be preempted. *Uhm v. Humana, Inc.*, 620 F.3d 1134 (9th Cir. 2010); *Meek-Horton v. Trover Solutions, Inc.*, 915 F.Supp.2d 486 (S.D.N.Y. 2013); *Potts v. Rawlings Co.*, 897 F.Supp.2d 185 (S.D.N.Y. 2012).

Based on the above federal statutes and caselaw, Harmony follows the CMS guidelines on recoupment pursuant to 42 CFR §405.350 to 379. Further, in reviewing the Letter of Agreement entered into by Baxter Regional PHO, Ltd ("Baxter") on or about March, 2008, I see no reference to audit rights held by Baxter. The documentation on overpayments should already be in Baxter's files along with Harmony's explanation for the recoupment.

Office Address: 8735 Henderson Road | Renaissance 1 | Tampa, Florida 33634
Mailing Address: 8725 Henderson Road | Tampa, Florida 33634
Telephone: 1-813-206-5582| Fax: 1-813-206-6210| **E-mail:** Stephanie

Ed Norwood

From: Ed Norwood
Sent: Friday, June 29, 2018 7:19 PM
To: 'Stephanie
Cc: Prather, Saylor W; 'Stone, Dianna'; Christine Babu; Denise Griffith
Subject: RE: WellCare/Harmony Recoupments Compliance Audit
Attachments: FR - 2016-

Tracking:

Recipient	Read
'Stephanie	
Prather, Saylor W	
'Stone, Dianna'	
Christine Babu	
Denise Griffith	
Ed Norwood	Read: 6/29/2018 7:44 PM

IMPERATIVE—ACTION REQUIRED

June 29, 2018

Stephanie Papoulis
8735 Henderson Road
Renaissance, FL. 33634

Dear Ms. Papoulis:

I am the Chief Compliance Officer at ERN/TRAF and am writing on behalf of Ms. Babu who was in meetings today.

Thank you for the clarification we received via your letter dated **June 28th, 2018** which clarified the line of business impacted by this specific recovery attempt by WellCare/Harmony, communicated via email to BRMC on **March 7th, 2018, March 19th, 2018** and **March 26th, 2018 (See Attached Email).** We have changed the jurisdiction of any potential complaint to the **Centers for Medicare and Medicaid (CMS).**

In your letter, you stated:

"Based on the above federal statutes and case law, Harmony follows the CMS guidelines on recoupment pursuant to 42 CFR §405.350 to 379."

Please provide:

- **The specific section of §405.350-359 or §405.370-379 that delineates a recoupment process for Medicare Advantage plans and their providers.**
- **The statutory authority WellCare/Harmony, a Medicare Advantage Plan relies upon to conduct a recoupment under 42 CFR §405.350-379 which applies to Medicare Part A and B fee for service providers.**

- **The statutory authority WellCare/Harmony relies upon to claim a definition as a Medicare Contractor under §405.370.**

As you know, Medicare Advantage Plans are governed by 42 CFR Part 422 and contracted providers do not have ALJ hearing rights as outlined in §405.373. Further, appeal rights for Medicare Advantage plans are in Part 422, not 401 and 405 as stated in 42 CFR §405.379. Upon reviewing your letter, it appears WellCare/Harmony is improperly attempting to utilize CMS/Medicare guidelines and look-back laws to justify recouping money from BRMC.

Please be advised that the look-back period in *The Federal Register document Vol. 81, No. 29: 42 CFR Parts 401 and 405; Reporting and Returning of Overpayments; Final Rule (February 12, 2016), page 7655 states:*

> ***"Commenters stated that CMS did not articulate any statutory authority or rationale for creating this distinction and narrowing the scope of the proposed rule to Medicare Part A and Part B providers and suppliers. According to commenters, the Medicare payment rules do not create any analytically distinct issues for Medicare Part A and Part B providers and suppliers over other categories of ''persons'' as defined under the proposed rule, thus commenters believed that the rule should similarly apply equally to all categories of persons as they relate to Medicare. Commenters noted that many providers or suppliers who submit claims to Medicare Part A or B also submit claims to managed care plans under Part C, plan sponsors under Part D, and Medicaid.***
>
> ***..... "We appreciate commenters' concerns, but will finalize this rule as proposed to* apply to Medicare Parts A and B only." (See Attached).**

As you can see, CMS and HHS agree that the Medicare six year look-back period does not apply to Part C (i.e., Medicare Advantage plans.) In an email to me dated December 13, 2017, CMS wrote:

"If Medicare Advantage Plans identify an overpayment, they have to report and return in the timeframe outlined in the attached HPMS memo and regulations. We do not dictate how they should deal with their providers- they should consult with their legal counsel."

Here, there is a big difference here when the Federal law provides Medicare with the right to recoup money paid to a fee for service Medicare provider, or to a Medicare Advantage Plan. They are not the same.

Here, WellCare/Harmony may have misrepresented to BRMC that they have a six year look back period and right to recoup payments made for Medicare Advantage beneficiaries under 42 CFR Part 405, that WellCare/Harmony knows or should have known was false.

Moreover, even if federal law did provide such a right, there is no guidance under federal law as to the process the MAO must adhere to in requesting such a recoupment. Since Part 422 is silent on this matter, and Part 405 does not apply to Medicare Part C, Arkansas state law may govern as WellCare/Harmony is a State sponsored plan.

This is a **second request** that your office review this matter for any unlawful refund recoupments while we prepare a potential regulatory complaint where non-compliance is indicated. As a clarification to your letter, Ms. Prather's email to BRMC on **March 9th, 2018**, did not identify what line of business is impacted by WellCare/Harmony's overpayment recovery efforts. Additionally, Ms. Prather's email did not provide BRMC

with any documentation on the overpayments, or an explanation for the recoupment efforts being enforced by WellCare/Harmony. In her email to BRMC on **March 26th, 2018**, she indicated that the provider notifications were forthcoming.

Please be advised that as a Medicare and Arkansas emergency safety net provider, BRMC reserves the right to audit and investigate overpayment recovery attempts, to aide in any dispute resolution steps needed, and allowed by Federal law. If you disagree with BRMC's standing on this matter, please provide the statutory authority you are relying upon to preclude BRMC from performing necessary audits and investigations of WellCare/Harmony's determinations to recoup overpaid monies.

Please consider this a **second request** to obtain the original written overpayment notifications to BRMC for all files attached. In addition, please indicate the claim paid date for each claim on the attached excel file provided to BRMC by Ms. Prather. In addition, as you review your claims processing logs, please indicate if:

- **Any exercise of recoupment has occurred on claims that were verified and or authorized, and later denied in violation of 42 CFR §422.113(c)**
- **Any exercise of recoupment has occurred on claims where contact was made for an emergency admission preapproval, and WellCare/Harmony failed to respond within one hour or before the enrollee discharged to approve care in violation of 42 CFR §422.113(c).**
- **Any exercise of recoupment has occurred on claims initially paid late without the required interest in violation of 42 CFR §422.520.**

Please be advised that any overpayment recovery attempts initiated by WellCare/Harmony and is found non-compliant through this compliance audit, will be defended vigorously under Federal law.

If WellCare/Harmony elects to **deduct** the alleged overpayment from future benefits to be paid and we find that WellCare/Harmony did so in violation of any of the above regulations, we will draft a formal complaint to the CMS to ensure that our provider member's rights are preserved.

If WellCare/Harmony can't produce the written notification clearly identifying the claim to be reimbursed, and supporting evidence showing that the recoupment was initiated consistent with the above Federal laws, our office urges WellCare/Harmony to expeditiously reimburse our provider member (if payment was already recouped); including payment of penalty and interest as mandated by Federal law, or provide a letter indicating that an overpayment no longer exists.

We ask that you cease and desist from any illegal and insufficient request for recoupment that WellCare/Harmony has no right to perform. Please provide written confirmation WellCare/Harmony is ceasing this recoupment activity within 10 days.

Failure to do so may result in a formal complaint filed with CMS for your failures.

Needless to say, it is our sincere hope that it will not have to come to this point.

Best,

Ed Norwood
Chief Compliance Officer

Ed Norwood

From: Roy Nichols <
Sent: Tuesday, July 17, 2018 7:00 AM
To: Allison Carter; Kattie Laney; Roger Paulson; Ed Norwood
Subject: RE: WellCare/Harmony Recoupments Compliance Audit

> > > Kattie Laney 7/17/2018 8:51 AM > > >
Ed,

I have went through these accounts an on the majority of these accounts we were not in appeal and cannot find notification of denial or a notice of why they were recouping. We had reached out to our old rep Saylor Prather and was told that when Wellcare does their recoupments on a remit, they do not tell providers which accounts they are recouping from to pay the others. Instead she said all she could sent us was what she called an F status report that contained the recoupment amounts and patient account numbers but the F Status does not tell you when they would recoup or our appeal rights. It has became a balancing nightmare since on the remits they were recouping money but not tying it to a patient account. Saylor Prather said that she had received several complaints from other providers because we could not balance our recoupments against the new remittances. We had to create an account on our side as a placeholder for these recoupments since they could not provide us with patient accounts that the recoupments belonged to.

I think you have scared the daylights out of them because it appears that they are now repaying us money on several of these accounts on our last 2 remittances from them! Now that they have started paying us back on several of these accounts, these accounts are showing false credit balances in our system because the recoupment amount is sitting in a placeholder account since they did not provide us with account numbers when the recoupments were taking place. I will need to have my posters move some of these recoupments to the patient accounts to resolve the credit balances and this may take some time for us to accomplish. I am noticing that they are also reprocessing and paying the original payment amount but I still am not seeing us being paid back for the amount they recouped on a separate remit, I believe that is what was happening with the one that Allison Carter had appealed with EHR, I am still showing they owe us $2,345.09 that they recouped from us.

Could you please share this information with Debbie at ERN also? She left me a voice-mail and I have not had a chance to call her back yet.

Thanks!

Kattie Laney
Patient Financial Services
870-508-7052

Ed Norwood

From: Roy Nichols
Sent: Tuesday, July 17, 2018 7:00 AM
To: Allison Carter; Kattie Laney; Roger Paulson; Ed Norwood
Subject: RE: WellCare/Harmony Recoupments Compliance Audit

Good morning Ed,

Please give us time to work the current payments and reconcile with our "Unapplied Activity account". Once we have balanced the current activity, we will determine our next steps.

Thank you for your help. Wellcare was driving us crazy!! Look forward to seeing you in New Orleans!!

Yes We Can

YOU ARE NOT POWERLESS TO INITIATE CHANGE IN YOUR GOVERNMENT CRISIS.

CHALLENGE THE SYSTEM TO CHANGE IT.

We fight for you.

CONTACT US:
Ed Norwood, President
ERN/The National Council of Reimbursement Advocacy
ednorwood@ernenterprises.org
(714) 995-6900 ext. 6926