ERN NCRA

You fight for their lives.
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HEALTH LAWS

2019

When Payors Won't Listen:
Appeal Letter Writing 101

DISCLAIMER: The intent of this program is to present accurate and authoritative information in regard to the subject matter covered. It is presented with the understanding that ERN/NCRA is not engaged in the rendition of legal advice. This presentation is intended for educational and informational purposes only. If legal advice or other expert assistance is required, you should seek the counsel of your own attorney with the expertise in the area of inquiry.

WHAT

IF

Ed Norwood

From:
Sent: Monday, January 11, 2016 7:18 PM
To: Ed Norwood
Subject: RE: Today-Such a Gift!!

Hi Ed!
Thank you so much for checking in! I'm sorry I haven't written to update both you and Carol. It has been a whirlwind since I received my clear PET scan a couple of months ago! I was so excited I took a seasonal job at Nordstrom with 45 plus hours a week! Since that job is ending, and I will be getting back to school next week, this is perfect timing!
I didn't tell you of the details of my journey since I was approved for the drug you so graciously fought for me to receive. I had somewhat of a perfect storm of having just finished a bout of antibiotics for an infection when they started me on the Abraxane (I think late March/early April?) There was another drug that accompanied it called Perjeta that caused an intestinal infection called C-Diff due to it's occasional inherent diarrhetic effect for which I was hospitalized twice. Therefore, since I "failed" that treatment, they were then able to approve me for an even newer drug, Kadcyla, which I told you about in July that has very little side effects. To my knowledge, there was no resistance from Anthem in any way.
All this to say, I may not have really benefitted from the drug you helped me get approved for, however, I believe it was instrumental in leading (though somewhat precariously) to the treatment that would bring me into remission. Of course, this is all my interpretation of the events and my doctor would be the one to verify my perspective.
What this means to me and my family is that I don't think in terms of weeks or months anymore, but YEARS! I am finishing a credential program that I'd started and was half way through when I received my diagnosis and planning a trip to Europe to celebrate 25 years with my husband. I am ever so grateful for this gift of life that I've been given and I credit Sarah, you, Carol and Dr. Link for getting me here-thank you, Jesus!!

With overflowing gratitude,

Kristi

Sent from Mail for Windows 10

From: Ed Norwood
Sent: Monday, January 11, 2016 6:02 PM
To: Kristi Cooper
Subject: RE: Today-Such a Gift!!

Kristi,

Happy New Year.

Your overturn case has been nominated under our Humanitarian of the Year award and as consideration takes place, I just wanted to check in to see how you have been faring with the new drug(s.)

Are you having any additional problems with Blue Cross? What did this victory mean for you and your family? What impact has it made on your life?

Denise Griffith

From: Denise Griffith
Sent: Tuesday, April 14, 2015 5:16 PM
To: 'dan.southard@dmhc.ca.gov'
Cc: Ed Norwood
Subject: RE: Help with fighting insurance company for chemo treatments.
Attachments: Attachment 1.pdf; Attachment 2.pdf; Attachment 3.pdf

Tracking:

Recipient	Delivery	Read
'dan.southard@dmhc.ca.gov'		
Ed Norwood	Delivered: 4/14/2015 5:17 PM	Read: 4/14/2015 5:35 PM

Hi Dan,

Ed wanted me to give you some information that we found. In its denial, Blue Cross refers to the following policies as support for its denial:

http://www.anthem.com/medicalpolicies/policies/mp_pw_c155826.htm
http://www.anthem.com/medicalpolicies/policies/mp_pw_b087953.htm

A printed copy of the above policies is attached for your convenience (See Attached 1 and 2). The medical necessity requirements listed in policy # DRUG.00052 – Pertuzumab/Perjeta, which is the drug Blue Cross is denying, appear to have been met based on that policy. Additionally, in Blue Cross's denial, it states that they are denying the drug, because the patient had not been shown to have side effects/allergic reactions to the drug previously used, which is in direct contrast to the letter from the patient's doctor stating that the reason he prescribed the drug (and the reason Blue Cross initially approved it upon discussion with the patient's doctor) was due to the severe side effects/allergic reaction that the patient previously had to the other drug.

Also, Ed discovered that the doctor who made the determination to deny the drug had a malpractice award against him (See Attached 3). We are currently trying to obtain a copy of the enforcement that led to the malpractice award against the doctor to determine if it is relevant to this case.

Thank you for your help.

Best,

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

Department of Consumer Affairs
BREEZE

License Details

The Department of Consumer Affairs encourages you to verify the license statuses of any licensees that may appear in a 'Related License' section below. You can verify these licensees by selecting 'New Search' and conducting a new search using the 'Search by Personal or Business Name' option. Please note that the 'Related License' section will only appear below if this license is related to another license. Not all licensees have a related license.

If the License Details below include 'Date of Graduation', the month and date of g may not be available. In this instance it will be displayed as '01/01/YYYY' where YYYY represents the year of graduation. Please note that not all license ty 'Date of Graduation' on the License Details screen.

Press "Previous Record" to display the previous license.
Press "Next Record" to display the next license.
Press "Search Results" to return to the Search Results list.
Press "New Search Criteria" to do another search of this type.
Press "New Search" to start a new search.

License Number: 28021 *Current Date: 04/14/2015 11:52 AM*

Name:	MARGULES, EDWARD ROY
License Type:	Physician and Surgeon G
License Status:	License Renewed & Current
Secondary Status:	Malpractice Arbitration Award
Expiration Date:	11/30/2016
School Name:	DC001 - GEORGE WASHINGTON UNIVERSITY SCHOOL OF M
Date of Graduation:	01/01/1973
Original Issuance Date:	09/03/1974

Addresses

Address of Record (Required)	Address	17835 Ventura Blvd Ste 104 ENCINO , CA LOS ANGELES 91316-3639 US View on a map

Survey Information

The following information is self-reported by the licensee and has not been verified by the Board

Are you retired?	No
Activities in Medicine	Administration - 40+ Hours Other - None Patient Care - None Research - None Teaching - None Telemedicine - None
Patient Care Practice Location	Not Identified
Patient Care Secondary Practice Location	Not Identified
Telemedicine Practice Location	Not Identified
Telemedicine Secondary Practice Location	Not Identified
Current Training Status	Not In Training
Areas of Practice	General Surgery - Primary
Board Certifications	American Board of Surgery - Surgery
Postgraduate Training Years	6 Years Declined to Disclose

Anthem UM Services, Inc.
Grievances and Appeals
P.O. Box 4310
Woodland Hills, CA 91365

Anthem UM Services, Inc.

April 17, 2015

K[redacted] Cooper
[redacted]

Case number: 133[redacted]
Member name: K[redacted] Cooper
Member ID number: [redacted]
Date grievance received: April 14, 2015

Dear Mrs. Cooper:

Anthem UM Services, Inc., provides utilization management services for Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company. We've finished reviewing the grievance filed on your behalf by the Department of Managed Healthcare (DMHC) for the approval of Perjeta (also called pertuzumab), Herceptin (also called trastuzumab) and Abraxane (also called nab-paclitaxel). Based on the information we have, coverage is approved.

Your plan has reviewed your specific circumstances and health condition as documented in your appeal request and] in the medical records provided by John Link, M.D. The reviewers included an independent consultant who is a board-certified oncology and Anita Rajan, M.D., a health plan medical director who is board-certified in family medicine.

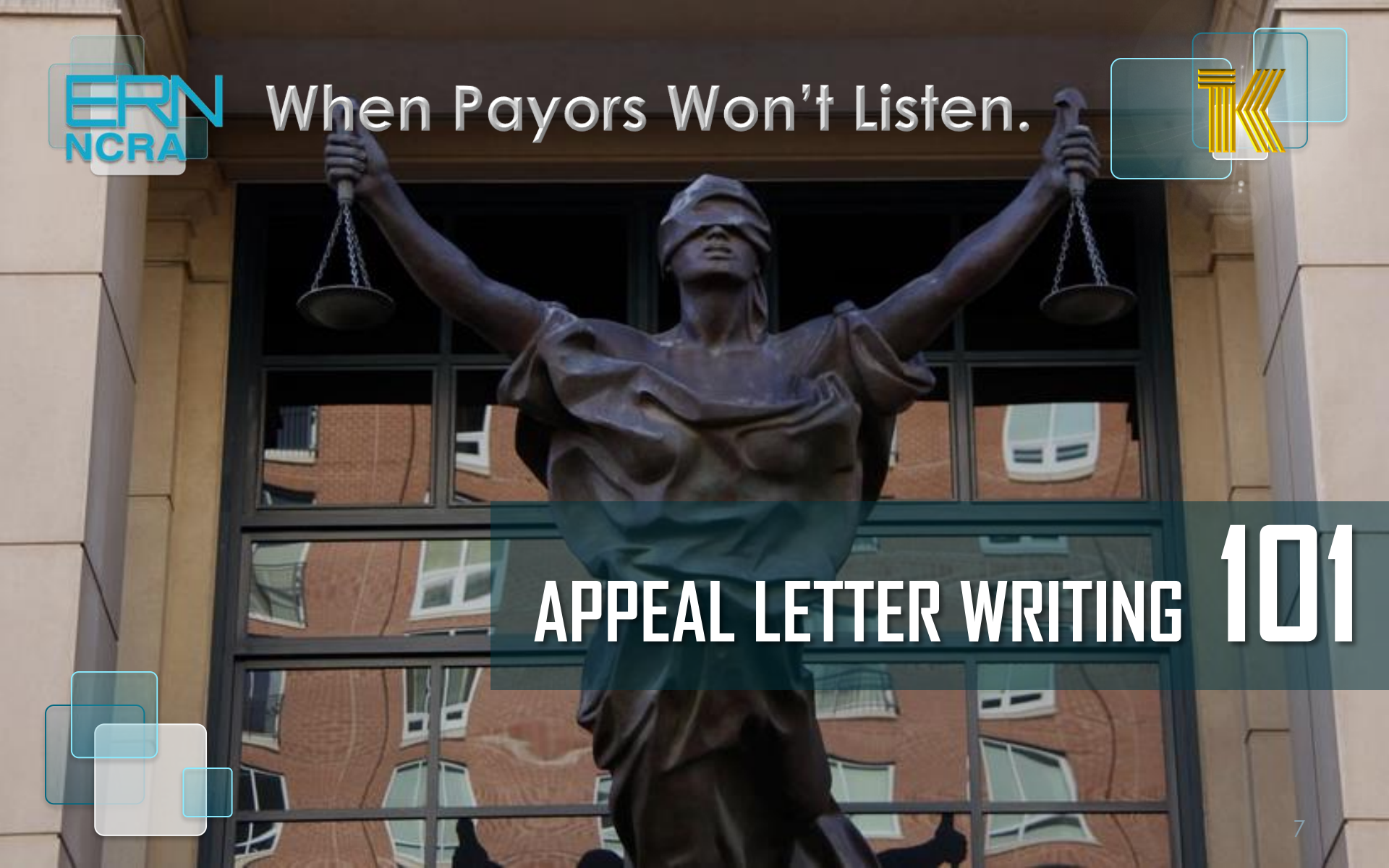
This authorization expires October 17, 2015 and is subject to your eligibility with your plan at the time of service.

Payment of claims depends on the terms of your plan. How much is covered will depend on any copays, deductibles, co-insurance and maximums you may have. The approval of the services doesn't change any benefits listed in your benefits booklet. Your benefits booklet explains what your plan covers in more detail.

Your coverage may change or renew. If it does, you should make sure your plan still covers the services that are approved. Coverage is subject to eligibility and what your plan says at the time you get services.

If you have any questions about this letter, call customer service toll-free at **1-800-365-0609** or **1-866-333-4823** our TDD line for the hearing and speech impaired.

When Payors Won't Listen.



APPEAL LETTER WRITING 101

PREVENTING
DENIALS

Medicare Advantage Appeals Timeline

To request a reconsideration

42 CFR 422.582(a-b)

To uphold the service denial and send to an IRE

42 CFR 422.590(a)(2)

To effectuate a payment reconsidered determination

42 CFR 422.590(b)
42 CFR 422.618(a)

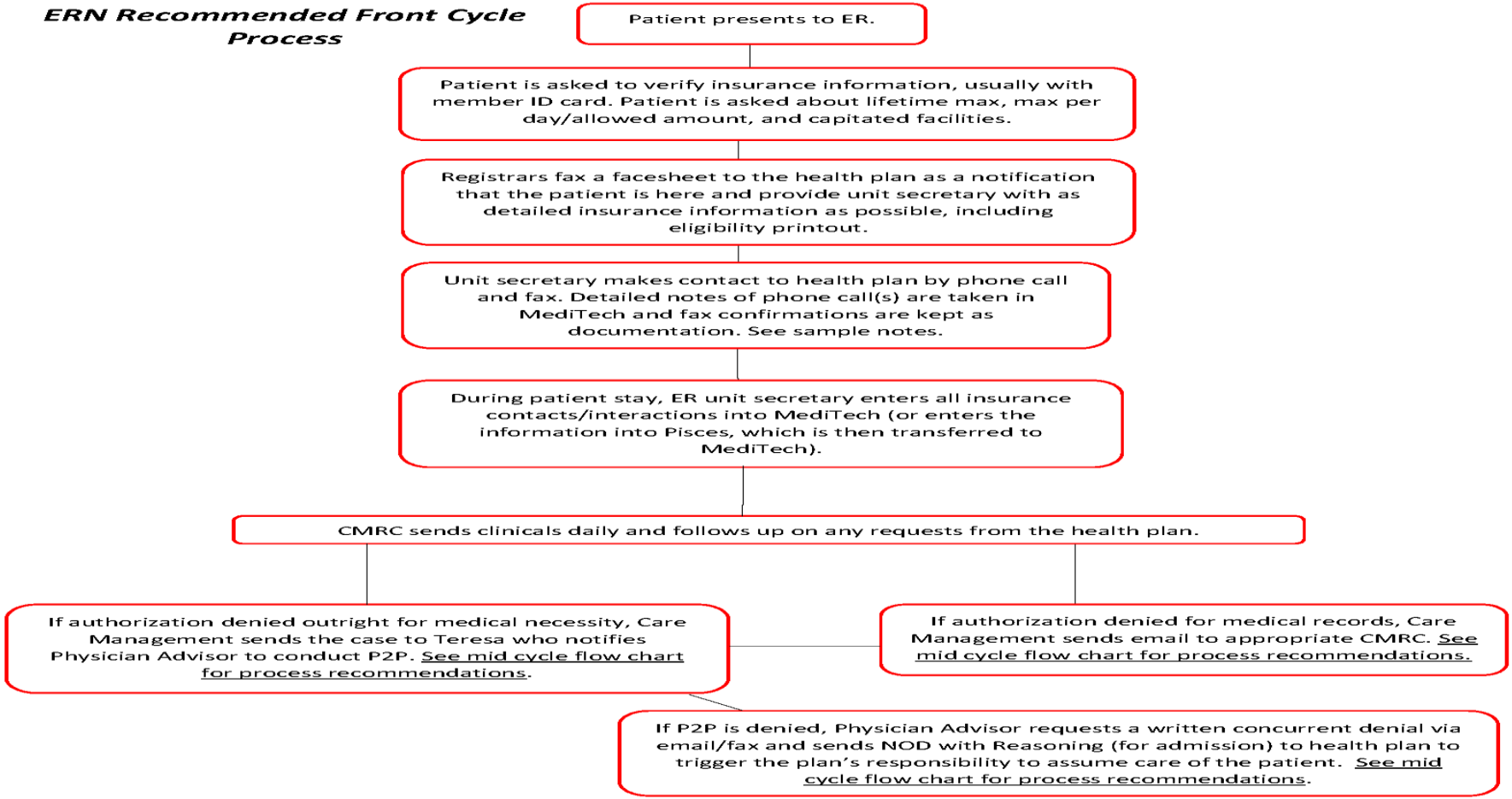
Challenge Everything

Back-end denial work requires the creation of:

- **Letter Libraries**
- **Law Libraries**
- **Fax Cover Sheets with laws**
- **Registration Forms with laws**
- **Policies, Procedures and Checklists**
- **Blurb Libraries**

3. Flow Charts and Processes

ERN Recommended Front Cycle Process



MANAGING DENIALS

Code	Description
509	MA Underpayment Vio.
510	MA ER Non Payment Vio.
511	MA Paid ER-Post-Stab Dnl.
512	MA Untimely Payment Vio.
513	MA Untimely Filing Vio.
514	MA Unauthorized Treatment
515	MA Hospice Dnl.
516	MA PDR Untimely Decision
517	MA Observation Dnl.
518	MA Negligent Misrepresentation
519	MA Req for Unnecessary Info
520	MA Unlawful Refund Request
521	MA Unlawful Refund Offset
522	MA Patient Not Eligible
523	MA Req for Unnec. Info - Auth
524	MA Req for Unnec. Info - MR's
525	MA Underpaid-No Contract
526	MA Waiver Not Received
527	MA Needs CWF Update
528	MA CWF - Incarcerated
529	MA CWF - Illegal
530	MA Split ER&PostStab Charges
531	MA Plan Failure to Request WOL
532	MA Underpaid-Per MCare Pricing
533	MA ER Paid-Notification-PS
534	MA ER Paid-No Notification-PS
535	MA ER No Pay-Notification-PS
536	MA ER No Pay-No Notific.-P
537	MA Unlawful Refund Post Stab
538	MA Underpaid-APC
539	MA Underpaid-ASC
540	MA Underpaid-Per Contract
541	MA Claim Sent, No Resp On File
542	MA Corr. Claim Sub. No Resp.
543	MA Underpaid-Implants
544	MA Underpaid-DRG
545	MA DRG Downcoding Recoupment
546	MA Sup.Max Amt.Paid By Primary
547	MA Underpaid-DRG Downcoding
548	MA CC-Untimely Filing
549	MA IPA Bankruptcy Denial
600	MC Medical Necessity Dnl.
601	MC Underpayment Vio.
602	MC Untimely Payment Vio.
603	MC Untimely Filing Vio.
604	MC Underpaid Per APC
605	MC Underpaid Per ASC
606	MC Underpaid Per Contract
607	MC Claim Submitted, No Resp.
608	MC Incorrect Coding Den.
702	VA Requested Docs Not Received
703	VA Payment taken as offset
704	VA Untimely Filing Vio.
705	VA Non Emergent Dnl.
706	VA Available Facility Dnl.
707	VA Untimely Payment Vio.

WRITING
THE APPEAL

When Payors Won't Listen…

Denials: Prevention and Correcting Issues stemming from the Insurance Side.

QUESTION: *What are payors looking for in an appeal letter?*

1. **Identify the denial reason.**

2. **Determine the jurisdiction.**

   Examples: MA, ERISA, State sponsored HMO.

3. **Create transition statement of facts to ensure a clear explanation of the disputed item, including the provider's position is contained in appeal letters:**

ER No Pay- Postabilization:

"We **dispute** (Payor's name) denial of this claim as not medically necessary, **because** (Payor's name) was notified of the patient's admission and failed to disapprove care prior to the patient's discharge **as shown and described below**:"

No Claim on File:

"We **dispute** (Payor's name) denial of this claim as no claim on file, **because** (Client's name) billed the claim to (Payor's name) on (date) **as shown and described below**:"

4. **Attach exhibits to document each fact.**

   Example:

   - ❑ On 9/23/15, the patient presented to the emergency department of (PROVIDER) with severe crushing chest pains.
   - ❑ On 10/3/15, MHG submitted the claim to Blue Cross **(See Exhibit A – Hospital UB04 and Claims Clearing house receipt)**.
   - ❑ On 4/20/16, Blue Cross denied the claim for untimely filing **(See Exhibit B – BX EOB)**.

   (HEALTH NET PAYOR PANEL ATTORNEY COMMENTS)

5. **Locate administrative laws to support each argument.**

6. **Apply the law.**

   "Here, [Payor] was notified on [DATE], but failed to assume responsibility of the patient, within 60 minutes, prior to the patient's discharge, deeming the services statutorily authorized."

7. **Land the plane (Impose deadlines.)**

   "Please release the federal funds intended for the Medicare beneficiary on or before (deadline date) to prevent any unnecessary regulatory complaint action."

When Payors Won't Listen

"WE DISPUTE..."

"...BECAUSE..."

"...AS SHOWN AND DESCRIBED BELOW:"

When Payors Won't Listen…

Denials: Prevention and Correcting Issues stemming from the Insurance Side.

DIRECTIONS:

The following is a sample timeline of a common denial.

Use the facts below to complete this worksheet, and use it as a model in crafting your own letters:

- On 11/1/15, the patient presented to the emergency department of *Hospital* with severe crushing chest pains.
- On 11/1/15, *Hospital* called ***Careless Sr. Plan*** and *Representative* stated that the patient was eligible, effective 5/1/12 to current, and issued a tracking number (See Exhibit A – Hospital Records*).
- On 11/2/15, *Hospital* faxed a face sheet to ***Careless Sr. Plan*** notifying of the patient's admission and requesting authorization per: _____.
- On 11/5/15, patient discharged without any disapproval from ***Careless Sr. Plan***.
- On 11/8/15, *Hospital* submitted the claim to ***Careless Sr. Plan*** electronically.
- On 2/5/16, *Hospital* called ***Careless Sr. Plan*** and *Representative* stated the claim was denied as not medically necessary, requesting medical records. (See Exhibit B – Explanation of Benefits*).
- To date, payment has not been released.

When Payors Won't Listen…

Denials: Prevention and Correcting Issues stemming from the Insurance Side.

1) WHAT IS THE DENIAL? _____

2) JURISDICTION: [ ] STATE [ ] HMO [ ] MA [ ] VA [ ] ERISA

3) TRANSITIONAL STATEMENT OF FACT:

We **dispute** _____'s denial of this claim, **because**

_____

_____

_____ **as shown and described below**:

4) *CREATE A TIMELINE FOR YOUR APPEAL AND ATTACH SUPPORTING EXHIBITS TO EACH FACT.

See directions above.

5) APPLICABLE LAWS:

Reference the laws relevant to this denial and cite them, in full:

1. Please, be advised that _____ states…
2. Further, _____ states…
3. Finally, _____ states…

5) APPLY THE LAW:

Apply the laws, above, to the facts outlined in the timeline. Explain how the payor's actions violate the law: ***(e.g. Here, Careless Sr. Plan was notified on [DATE], failed to preapprove care within 1 hour (or transfer the beneficiary while hospitalized), which means its financial responsibility ended on the date of discharge.]***

1. _____

   _____

2. _____

   _____

3. _____

   _____

6) CONCLUSION (LAND THE PLANE):

End the letter by demanding payment compliance and imposing deadlines. If the law stipulates a reimbursement deadline, evoke it here:

_____

_____

_____

_____

WHAT IS THE POWER OF A DEADLINE?

POLICY CHALLENGES

CMS

POLICY CHALLENGE:
CENTER FOR MEDICARE AND MEDICAID SERVICES

DID YOU KNOW?

Some non-contracted MA plans are failing prepare a written explanation and send the case file to the IRE (Maximus) within 60 calendar days from the date it receives the request for a standard reconsideration.

Authority: **42 CFR §422.590 (b)(2)**

CARELESS HEALTH PLAN

See plan responsibilities per 422.590 (b)(2).

WHAT CAN YOU DO?

Vigorously defend MA plan usage of 3rd party vendors for overpayment recovery and failure to forward upheld denials to the IRE. This non-compliance issue has been previously addressed in the Best Practices and Common Findings Memo #2, from the 2012 Program Audits, where Gerard Mulcahy of CMS stated:

"We observed the following: Sponsors did not prepare a written explanation and send the case file to the IRE in a timely manner upon affirming its adverse organization determination."

Flag all MA plans failing to forward upheld denials to the IRE and run a report showing (by Plan), # of beneficiary claims where the failure occurred, and # of uncompensated dollars effected.

Notify your RAC leader and Ed Norwood to determine next steps for escalation to the appropriate plan and/or regulatory agency.

UnitedHealthcare
Medicare Solutions

EquiClaim

03/05/2018

BAXTER REGIONAL MEDICAL CENTER
624 HOSPITAL DR
MOUNTAIN HOME, AR 72653

RE: Finding for DRG Audit Review

Dear BAXTER REGIONAL MEDICAL CENTER:

As a UnitedHealthcare vendor, EquiClaim, a Change Healthcare Solution conducts reviews on their behalf, providing identification and recovery of claims overpayments. During a recent DRG Audit Review, we identified a claim that was paid incorrectly. The enclosed report outlines the specifics of our findings.

Please review the enclosed report within **30 business days** of this notice and:

- Indicate whether or not you agree with the findings.
- If you don't agree with the report findings, include documentation to substantiate the original inpatient designation.
- Sign the document.
- Return the signed document and any relevant documentation by mail to the return address listed above or fax it to (615) 238-9707.

If we don't hear from you within 30 days after the date of this letter, we'll reopen and adjust the claim. We'll provide information about your appeal and dispute rights on the Provider Remittance Advice (PRA) when the claim is adjusted.

If you have questions please contact:

Medical Review Unit
701 East 22nd Street, Suite 200
Lombard, IL 60148-5095
Phone: (868) 481-1479 Fax: (615) 238-9707
Email: equiclaim.support@changehealthcare.com

Thank you.

Sincerely,
Anthony L. Costello
Manager, Operations

Enclosure

REF NUM: URGU00567893

UnitedHealthcare
Medicare Solutions

EquiClaim

Findings Report for a Claim Review

Patient Name: BEL
Patient Control No:
Date of Service: 09/24/2017 to 09/26/2017
Date of Birth: 11/23/[illegible]
Claim Reference No:
Case ID: URGU0056
Medical Record No:

( ) The hospital agrees the claim didn't meet DRG 293 as determined by EquiClaim.

(X) The facility doesn't agree that the claim didn't meet DRG 293 as determined by EquiClaim and is submitting additional documentation to substantiate the coding details in the original claim.

Your signature on this form indicates you agree with our findings.

Allison Carter RN
Provider Representative Signature

3-16-2018
Date

Allison Carter
Provider Representative (print)

870-508-1414
Phone

REF NUM: URGU00567893

UnitedHealthcare
Medicare & Retirement

EquiClaim

May 15, 2018

Allison Carter, Care Coordinator
BAXTER REGIONAL MEDICAL CENTER
624 HOSPITAL DR
MOUNTAIN HOME, AR 72653

Patient Name :	BELL, [redacted]
Date of Service:	09/24/
Date of Birth:	11/23
Case ID:	URGU

Dear Allison Carter

We are in receipt of your rebuttal letter dated April 06, 2018 regarding the recommendation to re-sequence I50.33 Acute on chronic diastolic (congestive) heart failure (CHF) as principal diagnosis. In your letter, you have indicated the principal diagnosis of Aortic Valve Stenosis I35.0 (Nonrheumatic aortic (valve) stenosis) is valid. After re-review of your rebuttal letter and supporting documentation, we are unable to revise our initial review findings. Please see below for additional rationale in supporting our initial revision.

Please note the circumstances of admission support the acute CHF as the condition chiefly responsible and focus of treatment during this admission. Although, there is known underlying severe aortic stenosis, this condition is not treated during admission but given the option to treat after discharge. This current admission focused on treating the acute CHF per admitting and discharge notes. The aortic stenosis is a chronic condition in this case and meets the definition of additional diagnosis.

Case synopsis; H&P states patient admitted for acute on chronic diastolic congestive heart failure. He has severe aortic stenosis that was previously documented in 2015. The plan was to continue with aggressive IV diuretics with Lasix, home medications. Discharge Summary patient is admitted for congestive heart failure. An echocardiogram was repeated during this visit and revealed severe aortic stenosis. Patient was diuresed and his respiratory symptoms improved, however, given his significant aortic stenosis, this will continue to be a chronic issue unless intervention is performed. Cardiac enzymes were mildly elevated but was felt to be related to the congestive heart failure. Cardiology discussed aortic valve replacement and further outpatient evaluation would be performed. During the course of this hospitalization, the patient diuresed well and transitioned to oral diuretics.

Please see Official Coding Guidelines Section II for Selection of Principal Diagnosis which states the principal diagnosis is defined as that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.

Based on the above supporting documentation and coding guidelines, our recommendation remains to re-sequence I50.33 Acute on chronic diastolic (congestive) heart failure as principal diagnosis, with a revised DRG 293.

EquiClaim appreciates your timely response and feedback in our collaborated efforts to achieve coding accuracy with compliance to nationally established coding guidelines. Please note this is a DRG validation audit, which authenticates code assignment. Coding Clinic 4th Quarter 2016 p. 147 states that clinical validation is beyond the scope of DRG (coding) validation, and the skills of a certified coder.

REF NUM: URGU00567893

UnitedHealthcare
Medicare & Retirement

EquiClaim

I am enclosing a DRG revision form for you to review and return to us. If you have any questions, please feel free to call me at 866-481-1479. You can email your response via secure email to: changehealthcare.support@changehealthcare.com or fax your response to 615-238-9707. You can also contact me directly via email at annwilliams@changehealthcare.com.

Sincerely,

Annie Williams, RHIT, CCS
DRG Field Analyst

Enclosure

REF NUM: URGU00567893

FINAL 06/01/2017

APPEAL / CLAIM PAYMENT DISPUTE COVER SHEET

Fill in the required information for each separate beneficiary case and submit the cover sheet for each case you submit. ***Do NOT submit any information outside what the cover sheet requests.*** The MAO will gather whatever additional information it needs during its efforts to investigate and resolve the case.

		Fill in required information below. Indicate option selection with "X."
1.1	Date of Submission to CMS	7/31/18
1.2	Entity Submitting Complaint	___ Provider _X_ Organization Representing Provider *(If indicated, complete the field below and submit evidence of the contractual relationship between the provider and the representing organization substantiating the organization's authority to investigate the case on behalf of the provider.)*
	Name of Organization Representing Provider	ERN/TRAF The Reimbursement Advocacy Firm
1.3	Submitter's Name	Brian Ford
	E-mail Address	brianford@ernenterprises.org
	Telephone Number	(714) 995-6900 ext. 6920
1.4	Beneficiary Name	See Attached
1.5	Beneficiary Health Insurance Claim Number (HICN)	See Attached
1.6	Provider Name	Baxter Regional Medical Center
1.7	Medicare Advantage Organization	United Healthcare
1.8	Claim Number	See Attached
1.9	Date(s) of Service	See Attached
1.10	Provider Contract Status	___ Provider Contracted with MAO during Date(s) of Service _X_ Provider NOT Contracted with MAO during DOS
1.11	Complaint Type	___ Contracted Provider Appeal _X_ Non-Contracted Provider Appeal ___ Contracted Provider Claims Payment Dispute ___ Non-Contracted Provider Claims Payment Dispute ___ Other
	Brief Summary of Complaint	UHC continuously failing to submit denied claim to Independent Review Entity within 60 days.
1.12	Provider 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	UHC provider dispute
1.13	Organization Representing Provider has Communicated	_X_ Yes

ERN
TRAF

SUMMARY OF COMPLAINT

We dispute UHC Sr.'s failure to reimburse Baxter Regional Medical Center (Baxter) for the attached claims because UHC Sr. failed to send the case to the independent entity contracted by CMS within 60 days from the date it received a request for a standard reconsideration.

- In all attached cases, Baxter timely billed UHC. Sr.
- In all attached cases, UHC Sr. denied the claim for medical necessity and lowered the level of care.
- In all attached cases, Baxter sent a reconsideration request to UHC sr.
- In all attached cases, UHC Sr. upheld their denial and failed to send the case to the IRE in accordance with **42 CFR §422.590.**

TO DATE, UHC SR. HAS FAILED TO FORWARD BAXTER'S CASES TO AN INDEPENDENT REVIEW ENTITY AS REQUIRED BY FEDERAL LAW.

The above referenced claims are for emergency or medically necessary post-stabilization care or both. In accordance with **42 CFR §422.590** which states:

> **(b)(2) If the MA organization affirms, its adverse organization determination, it must prepare a written explanation and sent the case file to the independent entity contracted by CMS no later than 60 calendar days from the date it receives the request for a standard reconsideration.**
>
> **(c) If the MA organization fails to provide the enrollee with a reconsidered determination within the timeframes specified in (b), this failure constitutes an affirmation of its adverse organization determination, and the MA organization must submit the file to the independent entity in the same manner as described under paragraph (b)(2).**

Under existing federal law, a reconsideration is defined by **42 CFR §422.580** as:

> **A review of an adverse organization determination, the evidence and finding upon which it was based, and any other evidence the parties submit.**

Further **42 CFR §422.590 (g)** states:

> **(1) A person or persons who were not involved in making the organization determination must conduct the reconsideration.**
> **(2) When the issue is the MA organization's denial of coverage based on a lack of medical necessity (or any substantively equivalent term used to describe the concept of medical necessity), the reconsidered determination must be made by a physician with expertise in the field of medicine that is appropriate for the services at issue. The physician making the reconsidered determination need not, in all cases, be of the same specialty or subspecialty as the treating physician.**

In all attached cases, Baxter received a denial on their claim from UHC Sr. which alleges that the Medicare beneficiary should or could have been treated at a lower level of care. In all attached cases, UHC recouped the amount UHC Sr. initially reimbursed to Baxter. In all attached cases, Baxter sent UHC Sr. a reconsideration request to reconsider and overturn their denial. In all attached cases, UHC Sr. upheld their denial for medical necessity and failed to send the case to the independent entity (IRE) contracted with Medicare for review within the 60 days. Instead, Baxter sent another appeal to UHC Sr. as a result of failing to send the cases to the IRE. In all attached cases, UHC Sr. improperly denied the second appeal as the case should been sent to the IRE for further review and currently remains non-compliant and violation of federal Medicare law.

We respectfully request CMS Region 6 to review this complaint against UHC Sr. and require their compliance in accordance with federal Medicare Advantage laws.

Respectfully,

Brian Ford, J.D.
Claims Compliance Auditor II
ERN/TRAF

Tel: (714) 995-6900 Ext. 6920 **Fax:** (714) 995-6901
Email: brianford@ernenterprises.org

Enclosure: Exhibit A — Claims Spreadhseet
Exhibit B — UHC initial and final determinations
Exhibit C — Baxter reconsideration

CISCO

Secured Message

Reply ReplyAll

From: Dobbins, Eric D
To: Brian Ford <brianford@ementerprises.org>
CC: Ed Norwood <ednorwood@ementerprises.org>
Date: 08/31/2018 11:20:12 AM PDT
Subject: Secure Message from eric.dobbins@uhc.com
Attachments: Baxter Claims Issue.xlsx

Hi Brian.

In regards to CMS case C18027585222, Optum Issue Management responded to me on 8/24/18 and attached you will find the list of claims with their new appeal numbers. Two of the claims already appear to have been paid and I included the dates. Two of the claims I had to send back to Optum Issue Management to review because they were missing the claims numbers. When I receive the new claim numbers for those, I will send to you. Please let me know if you have any questions.

Thanks so much,

Eric Dobbins | CTM Coordinator, M&R | UnitedHealth Group
eric.dobbins@uhc.com | Roanoke, Virginia

ServiceHEROES 2017

—SecureDelivery—

From: Brian Ford [mailto:brianford@ementerprises.org]
Sent: Wednesday, August 29, 2018 7:12 PM
To: Dobbins, Eric D
Cc: Ed Norwood
Subject: RE: Baxter UHC claims spreadsheet email 1 of 2

Good evening Mr. Dobbins,

As you continue reviewing our complaint, you are reminded that CMS requires their MAO's to resolve complaints within 20 business days in accordance with:

CMS Casework Management Protocol Section 1(E):

> The standard timelines and procedures for resolving Regional Office CMS Issue complaints are provided below. Complaints that have been: 1) automatically flagged in CTM as a CMS Issue as outlined in Section

How to Write a Statement of Fact

"WE DISPUTE..."

"...BECAUSE..."

"...AS SHOWN AND DESCRIBED BELOW:"

How to Write a Statement of Fact

DREAM TEAM - STATEMENT OF FACT:

*"**We dispute** your [DATE] denial of not receiving medical records, **because** medical records were faxed (or uploaded) with a fax (upload) confirmation and [PLAN] may be in violation of HIPAA Privacy Rule 164.530, mishanding PHI, as **shown and described below:***

We fight for you.

Thank you.