Presenter: Ed Norwood

CLINICAL DENIALS COURSE (CDC):

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.

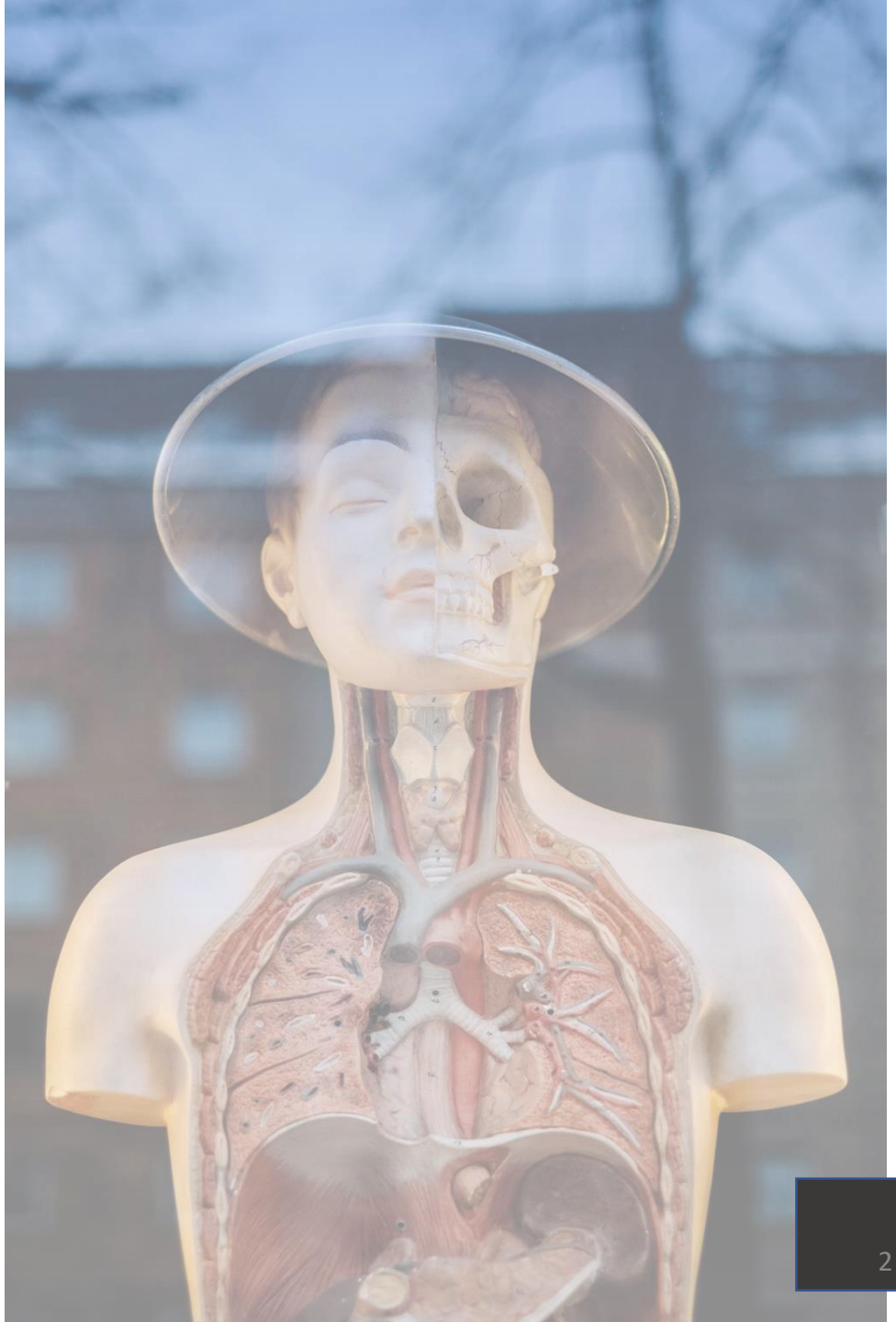
THREE THINGS MA PAYORS DON'T WANT YOU TO KNOW

Champions for MEDICALLY APPROPRIATE HEALTHCARE.

ERN NCRA

WE ADVOCATE FOR MEDICALLY APPROPRIATE HEALTHCARE

WHAT IS YOUR "WHY?"



WE EXIST TO DEFEAT GIANTS

CLINICAL DENIALS COURSE (CDC):

THREE THINGS:

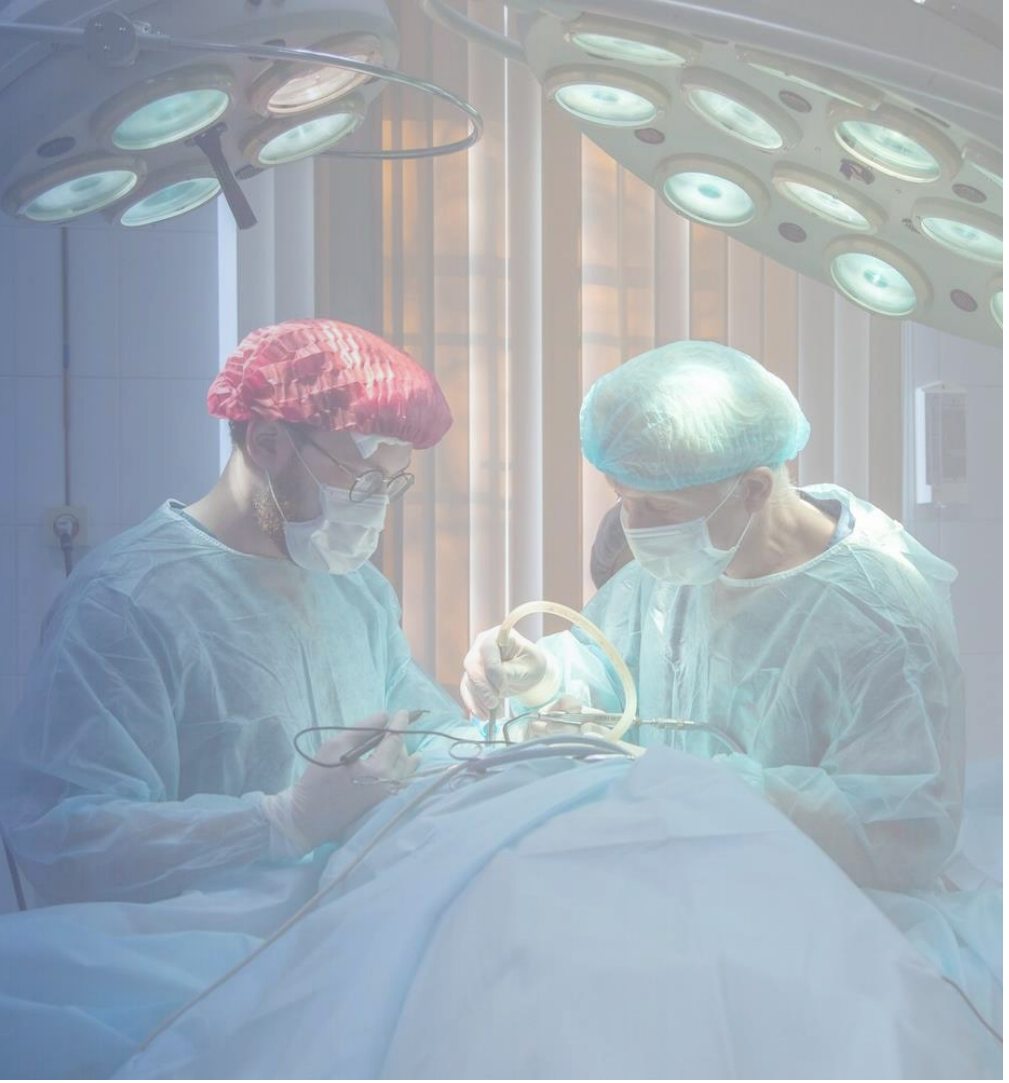
1.) CMS VIEWS TREATING DOCTORS AS THE PLAN.

2.) PEER TO PEER TIMEFRAMES.

3.) CONCURRENT PATIENT DENIALS MUST BE TRANSFERRED.

1.) CMS VIEWS TREATING DOCTORS AS THE PLAN.

MEDICARE ADVANTAGE



EMERGENCY OBSERVATION

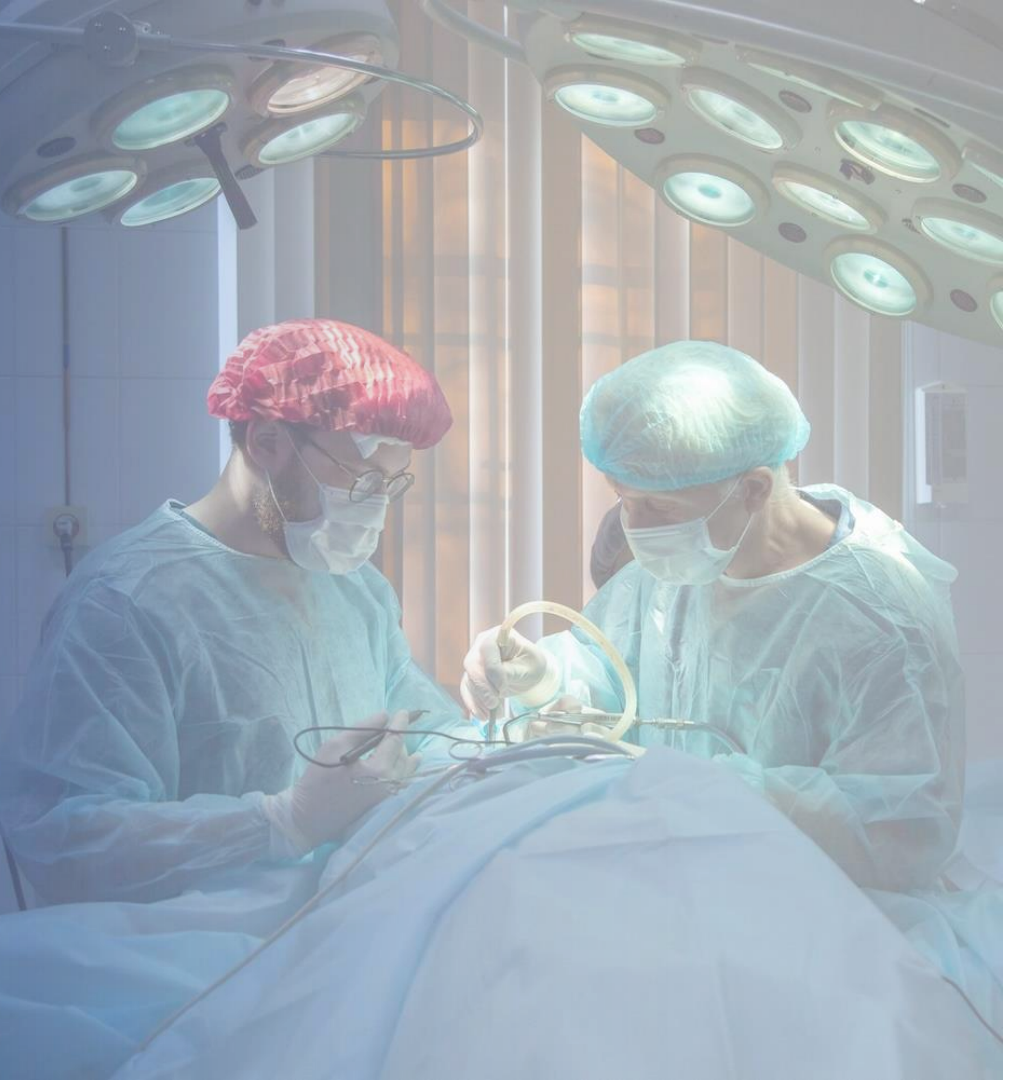
MAOs –42 CFR §422.113

(b)(2) MA organization financial responsibility. 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 <u>prior authorization</u> for the services.

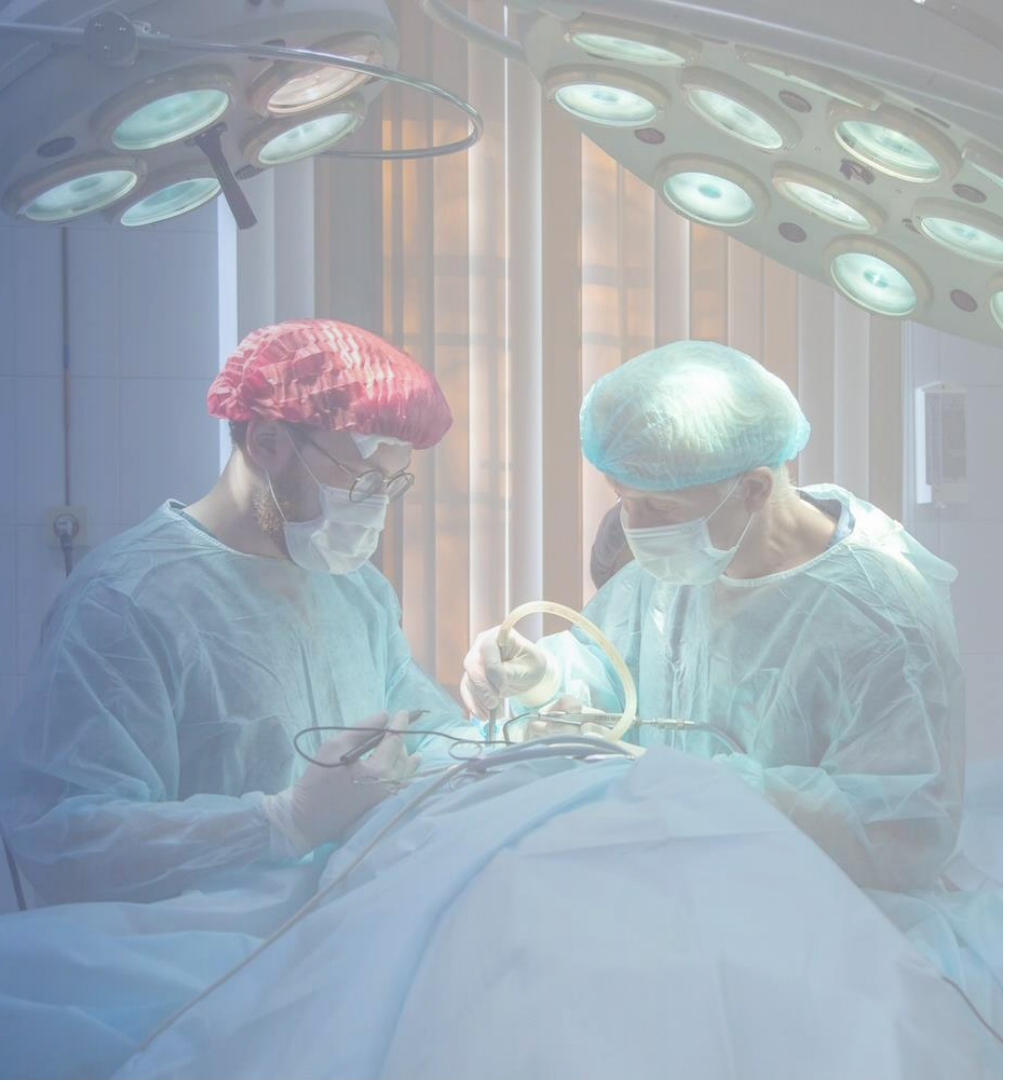
(iii) In accordance with the prudent layperson definition of emergency medical condition **<u>regardless of final diagnosis</u>**;



EMERGENCY OBSERVATION

MAOs –42 CFR §422.113

(b) (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.



POSTSTABILIZATION

MAOs –42 CFR §422.113

(c)(2) MA organization financial responsibility. The MA organization—

(i) Is financially responsible (consistent with § 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;**

CHAPTER 4 MEDICARE MANAGED CARE MANUAL

when:

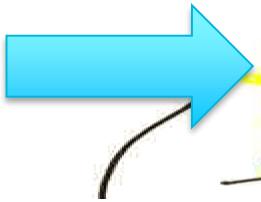
- The MAO does not respond to a request for pre-approval within one hour;
- The MAO cannot be contacted; or
- The MAO representative and the treating physician cannot reach an agreement concerning the enrollee's care, and a plan physician is not available for consultation.

(In this situation, the MAO must give the treating physician the opportunity to consult with a plan physician. The treating physician may continue with care of the patient until a plan physician is reached or one of the criteria below is met.)

20.5.3 — End of Post-Stabilization

The MAO's financial responsibility for post-stabilization care services it has not pre-approved ends when:

- A plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care;
- A plan physician assumes responsibility for the enrollee's care through transfer;
- An MAO representative and the treating physician reach an agreement concerning the enrollee's care; or
- The enrollee is discharged.



When a treating physician is contracted with the plan, CMS views him or her as a the plan for purposes of our rules and guidance. The rules above are intended for enrollee protection and guidance to plans for working with out-of-network providers. When we address "financial responsibility," we are referring to a plan's obligation to pay for (cover) the enrollee's services. That includes out-of-network providers, because those providers can bill enrollees if the plan denies their coverage/billing.

→ ABN(?)

provider/plan contract.

↓

individual physician
Contracted w/ SCAN (MA)

- *Temporarily reduce plan-approved out-of-network cost-sharing to in-network cost-sharing amounts; and*

- *Waive the 30-day notification requirement to enrollees as long as all the changes (such as reduction of cost-sharing and waiving authorization) benefit the enrollee.*

Typically, the source that declared the disaster will clarify when the disaster or emergency is over. If, however, the disaster or emergency timeframe has not been closed 30 days from the initial declaration, and if CMS has not indicated an end date to the disaster or emergency, plans should resume normal operations 30 days from the initial declaration. MAOs not able to resume normal operations after 30 days should notify CMS.

MAOs must disclose their policies about providing benefits during disasters on their plan websites.

If the President has declared a major disaster or the Secretary has declared a public health emergency, MAOs must follow the guidance in chapter 5 of the Prescription Drug Benefit Manual, regarding refills of Part D medications. The Prescription Drug Benefit Manual may be found at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/Pub100_18.pdf.

160 — Beneficiary Protections Related to Plan-Directed Care
(Rev. 121, Issued: 04-22-16, Effective: 04-22-16, Implementation: 04-22-16)

Organization Determinations: An enrollee, or a provider acting on behalf of the enrollee, always has the right to request a pre-service organization determination if there is a question as to whether an item or service will be covered by the plan. If the plan denies an enrollee's (or his/her treating provider's) request for coverage as part of the organization determination process, the plan must provide the enrollee (and provider, as appropriate) with the standardized denial notice (Notice of Denial of Medical Coverage (or Payment)/CMS-10003). For the requirements related to organization determinations and issuance of the standardized denial notice (CMS-10003), see chapter 13 of the MMCM located at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c13.pdf.

Limitations on Enrollee Liability: CMS considers a contracted provider an agent of the MAO offering the plan. As stated in the preamble to the January 28, 2005 final rule (CMS-4069-F):

"MA organizations have a responsibility to ensure that contracting physicians and providers know whether specific items and services are covered in the MA plan in which their patients are enrolled. If a network physician furnishes a service or directs an MA beneficiary to another provider to receive a plan-covered service without following the plan's internal procedures (such as obtaining the appropriate plan pre-authorization),

Notes to Table II:

1. See *chapter* 5 of the Prescription Drug Benefit manual located at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartDManuals.html for the definition of required drug coverage.

2. *Program for the All-Inclusive Care of the Elderly* (PACE) organizations offering PACE Programs, as defined in *section* 1894 of the Act generally have elected to provide Part D coverage in order to receive payment for the prescription drug coverage that they are statutorily required to provide.

10.16 – Medical Necessity

(Rev. 121, Issued: 04-22-16, Effective: 04-22-16, Implementation: 04-22-16)

Every MA plan:

- Must have policies and procedures, that is, coverage rules, practice guidelines, payment policies, and utilization management, that allow for individual medical necessity determinations (42 CFR §422.112(a)(6)(ii));

- Must employ a medical director who is responsible for ensuring the clinical accuracy of all organization determinations and reconsiderations involving medical necessity. The medical director must be a physician with a current and unrestricted license to practice medicine in a State, Territory, Commonwealth of the United States (that is, Puerto Rico), or the District of Columbia (42 CFR §422.562(a)(4));

- If the *MAO* expects to issue a partially or fully adverse medical necessity (or any substantively equivalent term used to describe the concept of medical necessity) decision based on the initial review of the request, the organization determination must be reviewed by a physician or other appropriate health care professional with sufficient medical and other expertise, including knowledge of Medicare coverage criteria, before the *MAO* issues the organization determination decision. The physician or other health care professional must have a current and unrestricted license to practice within the scope of his or her profession in a State, Territory, Commonwealth of the United States (that is, Puerto Rico), or the District of Columbia (42 CFR §422.566(d), MMCM *chapter* 13, 40.1.1);

- Must make determinations based on: (1) the medical necessity of plan-covered services - including emergency, urgent care and post-stabilization - based on internal policies (including coverage criteria no more restrictive than original Medicare's national and local coverage policies) reviewed and approved by the medical director; (2) where appropriate, involvement of the organization's medical director per 42 CFR §422.562(a)(4); and (3) the enrollee's medical history (e.g., diagnoses, conditions, functional status), physician recommendations, and clinical notes. Furthermore, if the

plan approved the furnishing of a service through an advance determination of coverage, it may not deny coverage later on the basis of a lack of medical necessity (Program Integrity Manual, *chapter* 6, Section 6.1.3(A)); and

- Must accept and process appeals consistent with the rules set forth at 42 CFR Part 422, Subpart M, and *chapter* 13 of the *MMCM*.

20 — Ambulance, Emergency, Urgently Needed and Post-Stabilization Services
(Rev. 120, Issued: 01-16-15, Effective: 01-01-15, Implementation: 01-01-15)

20.1 — Ambulance Services
(Rev. 121, Issued: 04-22-16, Effective: 04-22-16, Implementation: 04-22-16)

MAOs are financially responsible for ambulance services, including ambulance services dispatched through 911 or its local equivalent, when either an emergency situation exists as defined in *section* 20.2 below or other means of transportation would endanger the beneficiary's health. The enrollee is financially responsible for plan-allowed cost-sharing. Medicare rules on coverage for ambulance services are set forth at 42 CFR 410.40. For original Medicare coverage rules for ambulance services, refer to chapter 10 of the Medicare Benefit Policy Manual, publication 100-02, located at http://www.cms.hhs.gov/manuals/Downloads/bp102c10.pdf.

20.2 — Definitions of Emergency and Urgently Needed Services
(Rev. 120, Issued: 01-16-15, Effective: 01-01-15, Implementation: 01-01-15)

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency medical condition status is not affected if a later medical review found no actual emergency present.

Emergency services are covered inpatient and outpatient services that are:

- Furnished by a provider qualified to furnish emergency services; and

- Internal CMS communication between Kimberly August, Tamara Harvey, and Aimee Reich regarding the applicability of the Medicare Managed Care Manual for contracted versus non-contracted providers.

In addition to the substantial delay in responding to this FOIA request consistent with **45 CFR Part 5 (Freedom of Information Regulations)**, CMS did not provide any documentation that satisfies the above requests. Further, pertaining to items I-IV, CMS did not indicate which documents relate to the above requests, nor did they state to those unanswered, "No records responsive to this request." (See Exhibit A – FOIA Response Letter.)

As you know, federal law requires FOIA requests to be fulfilled within 20 business days. As it appears that none of the provided documents address the requested information, this FOIA request has not been concluded and is now **120 business days past due.**

II. THE REGULATIONS PRESCRIBED UNDER 42 CFR PART 422 APPLY TO BOTH CONTRACTED AND NON-CONTRACTED PROVIDERS.

Included in CMS' response to our July 9, 2018 FOIA request is an internal CMS email which attempts to misconstrue a contracted provider's rights prescribed under **42 CFR Part 422, Subpart C, Sections 100 - 134**. As stated in this email, CMS maintains the position that "these rules and appeal rights are for enrollees and out-of-network providers – not ***contracted*** providers."

While Subpart M Appeal rights (422 CFR §560-626) may not apply to contracted providers, the legislative intent of **42 CFR Part 422, Subpart C - Benefits and Beneficiary Protections (§§ 422.100 - 422.134)** (which includes §422.113) does, as this Subpart includes specific details governing the role of contracted providers within a MAO. For instance, **42 CFR §422.112(a)(1)(i)** states that Medicare Advantage Organizations must "*maintain and monitor a network of appropriate providers that is **supported by written agreements** and is sufficient to provide adequate access to covered services to meet the needs of the population served.*" Further, **42 CFR §422.112(a)(9)** states the MAOs must also "*provide coverage for ambulance services, emergency and urgently needed services, and **post-stabilization care services in accordance with §422.113***."

As the above cited regulations expressly define the relationship between MAOs and contracted providers, including the provision of statutory payment obligations pursuant to **42 CFR §422.133**, it is improbable that this section of law is only intended to apply to non-contracted providers.

In addition, SCAN's application of Traditional Medicare regulations to support payment of claims for Medicare Advantage claims is inappropriate. Please note, with Traditional Medicare an authorization is not required and if there is any retrospective review, the provider protects themselves by informing the patient prior to services that Medicare may not cover a service and not pay for that service and have the patient sign an Advanced Beneficiary Notice of Non-coverage ("ABN") protecting the hospital if Medicare should deem an inpatient admission or post-stabilization services not medically necessary.

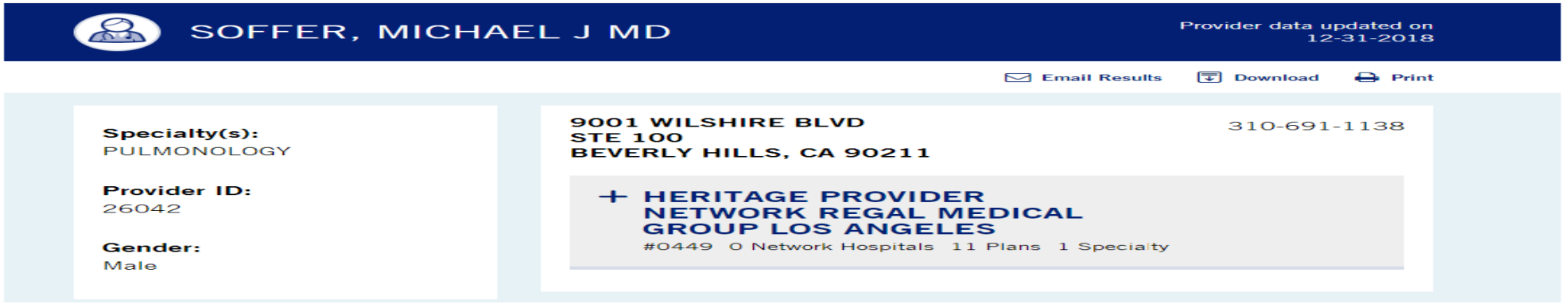
The CMS publication titled "*Improper Use of Advance Notices of Non-coverage*" dated May 5, 2014 provides further evidence that the statutory timeframes to approve or deny post-stabilization services apply to both contracted and non-contracted providers.

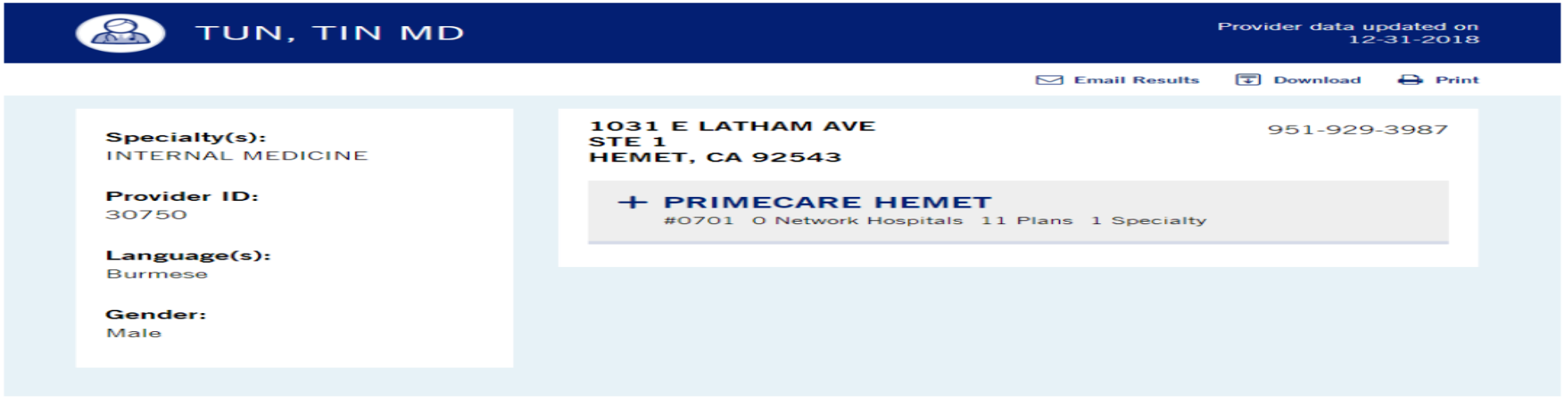
In its guidance, CMS states that an Advance Beneficiary Notice of Non-coverage (ABN) is not to be used by MAOs because "a Medicare Advantage enrollee has always had the right under the statute and regulations to an advance determination of whether services are covered prior to receiving such services." (See Exhibit B – Improper Use of ABNs.) From this verbiage and in the context of post-stabilization services, a logical inference would be that the right to an advance determination (e.g. pre-approval) of covered services is prescribed and protected by **42 CFR 422.113(c)(2)**. If these regulations did not apply to contracted MA providers, there would be no way of obtaining an advance determination of covered services prior to rendering care, and thus eliminating a provider's ability to notify MA beneficiaries receiving post-stabilization services of potential financial liability.

III. PER CMS POLICY, CONTRACTED PROVIDERS ARE CONSIDERED AGENTS OF THE PLAN.

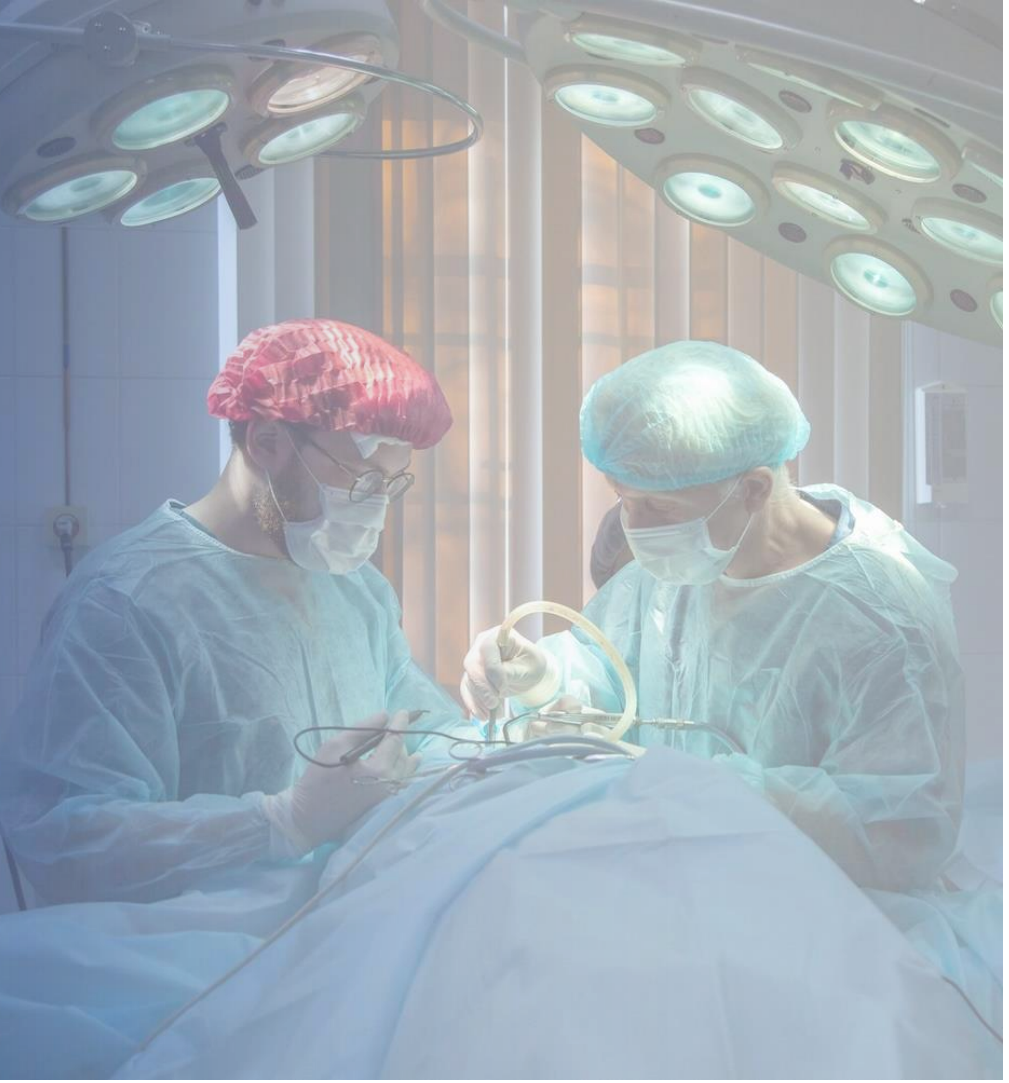
Per CMS commentary included in its response to our July 9, 2018 FOIA request, "When a treating physician is contracted with the plan, CMS views him or her **as the plan** for purposes of our rules and guidance." (See Exhibit C – FOIA Response, pg. 2) Thus, as CMS considers a contracted provider to be a plan provider, the contracted provider's determination constitutes a "favorable organization decision."

This premise is supported through various CMS publications and opinions. For example, the CMS CDAG/ODAG guidance published September 4, 2013 (See Exhibit D – CDAG/ODAG Updates.) states that "The provision of an item or service by a **contract provider constitutes a favorable organization determination**."





Who are the treating physicians or provider—are they contracted with the MAO?



POSTSTABILIZATION

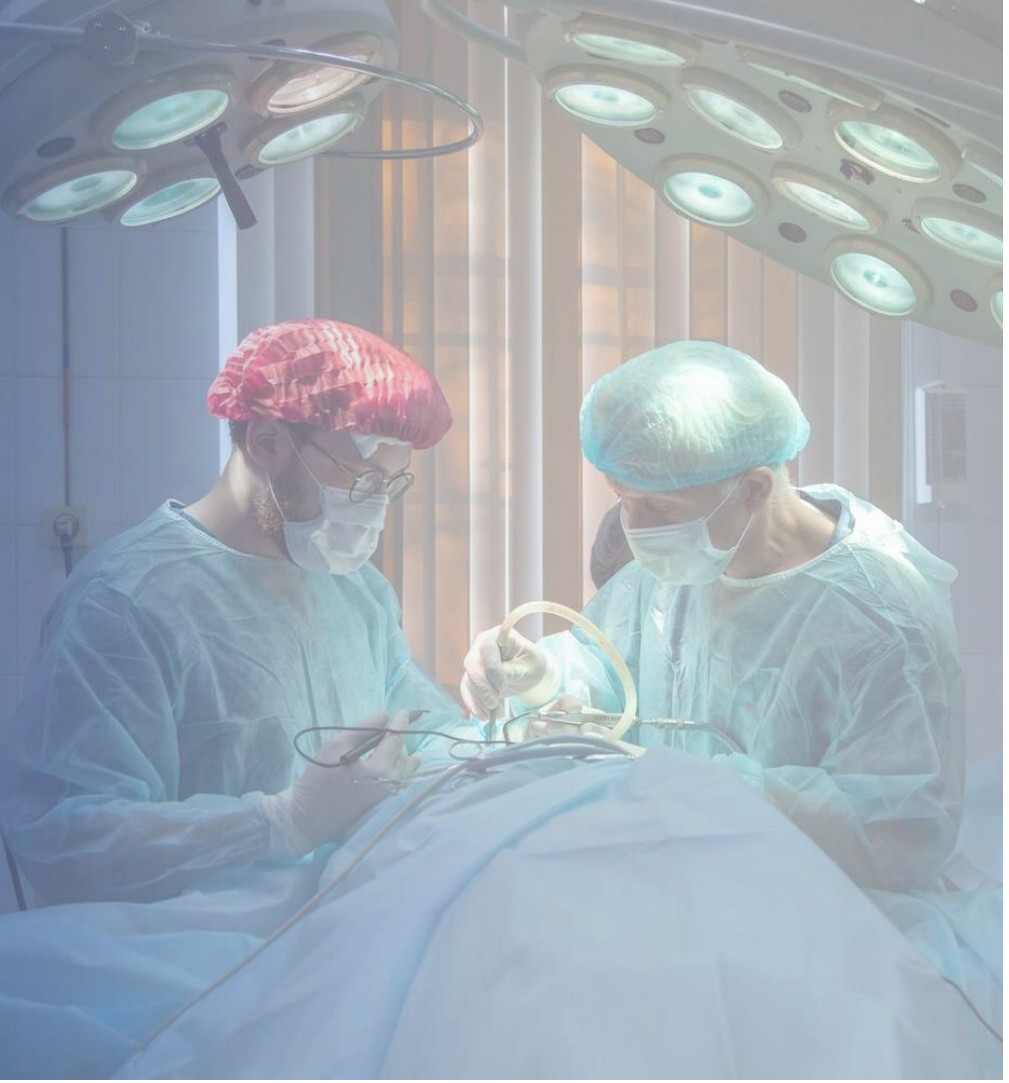
MAOs –42 CFR §422.113

(c)(2) MA organization financial responsibility. The MA organization—

(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;

2.) PEER TO PEER TIMEFRAMES.

MEDICARE ADVANTAGE

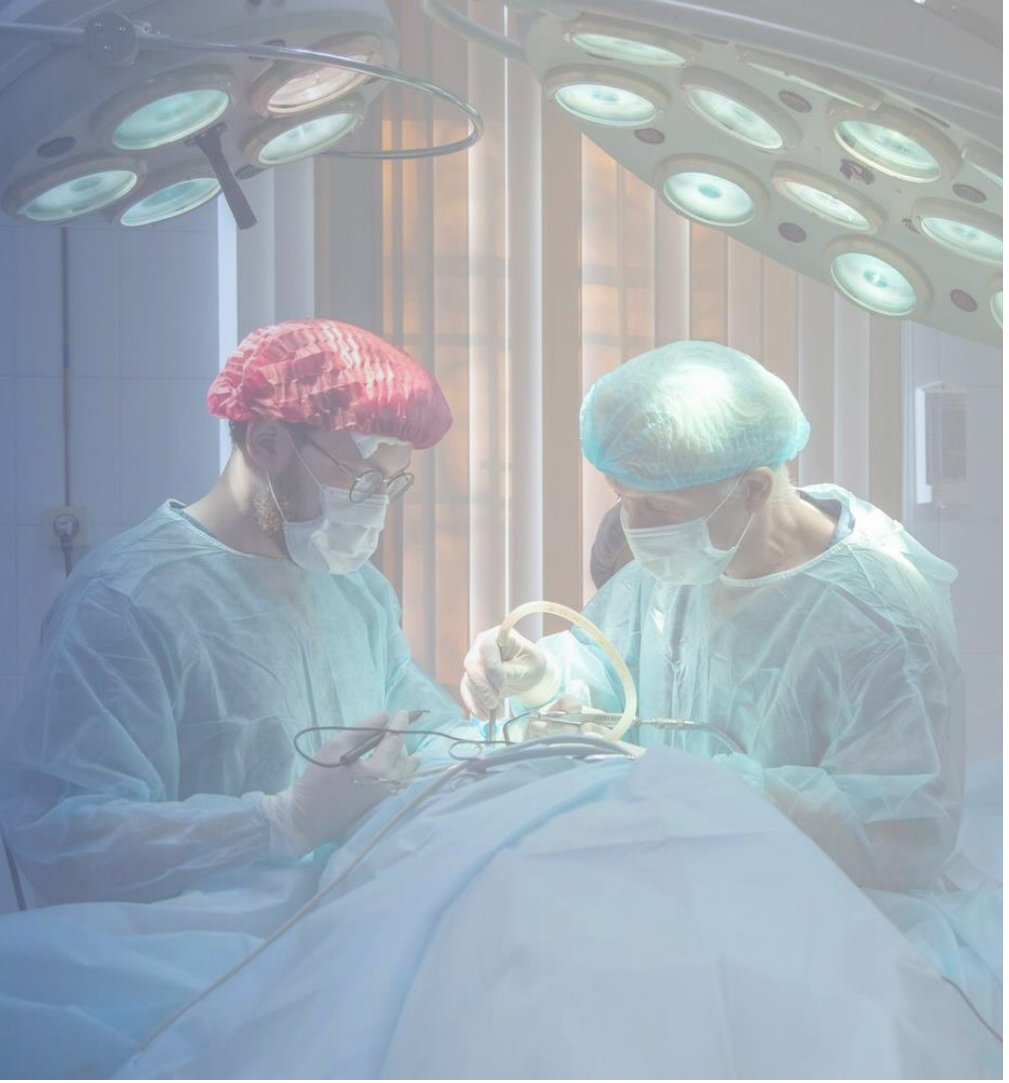


POSTSTABILIZATION

MAOs –42 CFR §422.113

(c)(2) MA organization financial responsibility. The MA organization—

(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—



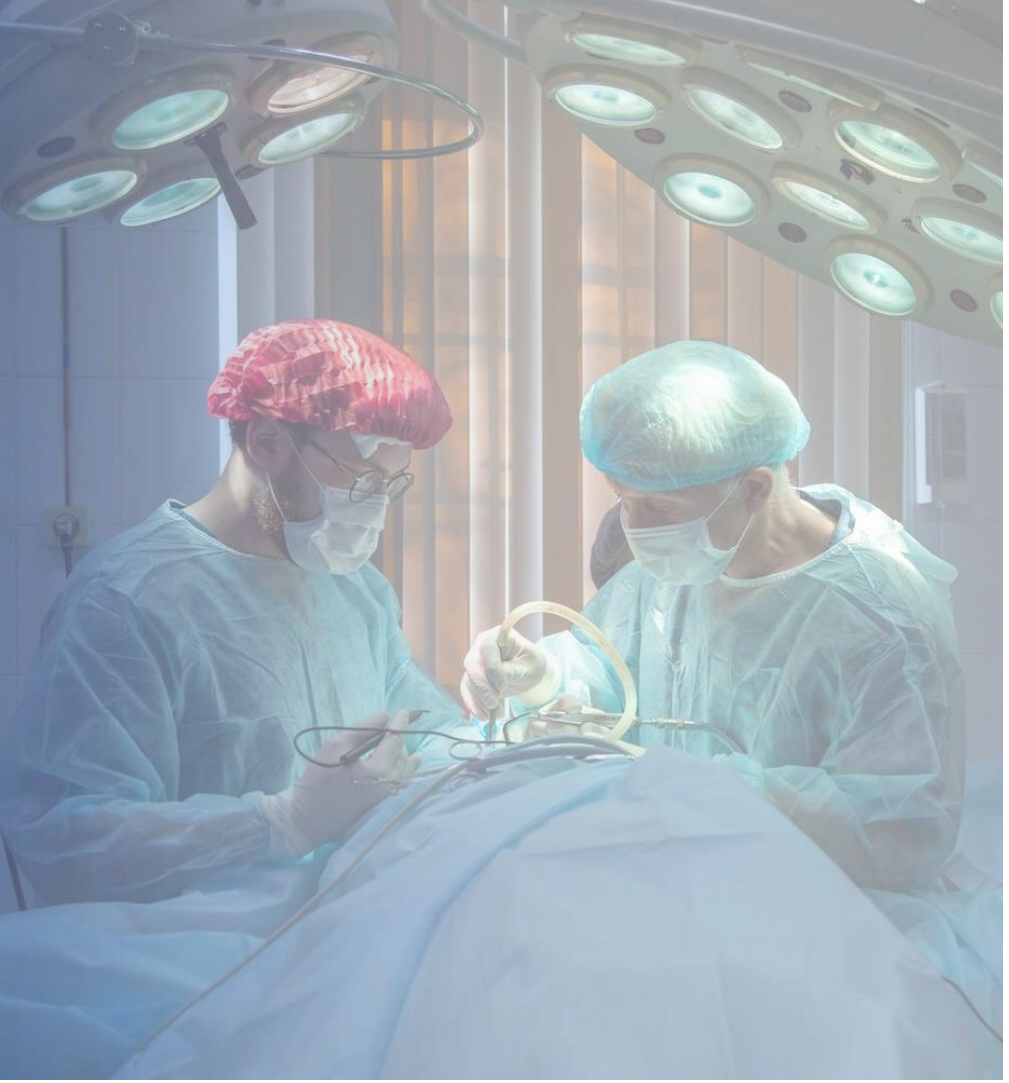
POSTSTABILIZATION

MAOs –42 CFR §422.113

(c)(2) (iii) (A) The MA organization **does not respond to a request for pre-approval within 1 hour;**

(B) The MA organization cannot be contacted; or

(C) <u>The MA organization representative and the treating physician cannot reach an agreement concerning the enrollee's care</u> and a plan physician is not available for consultation.



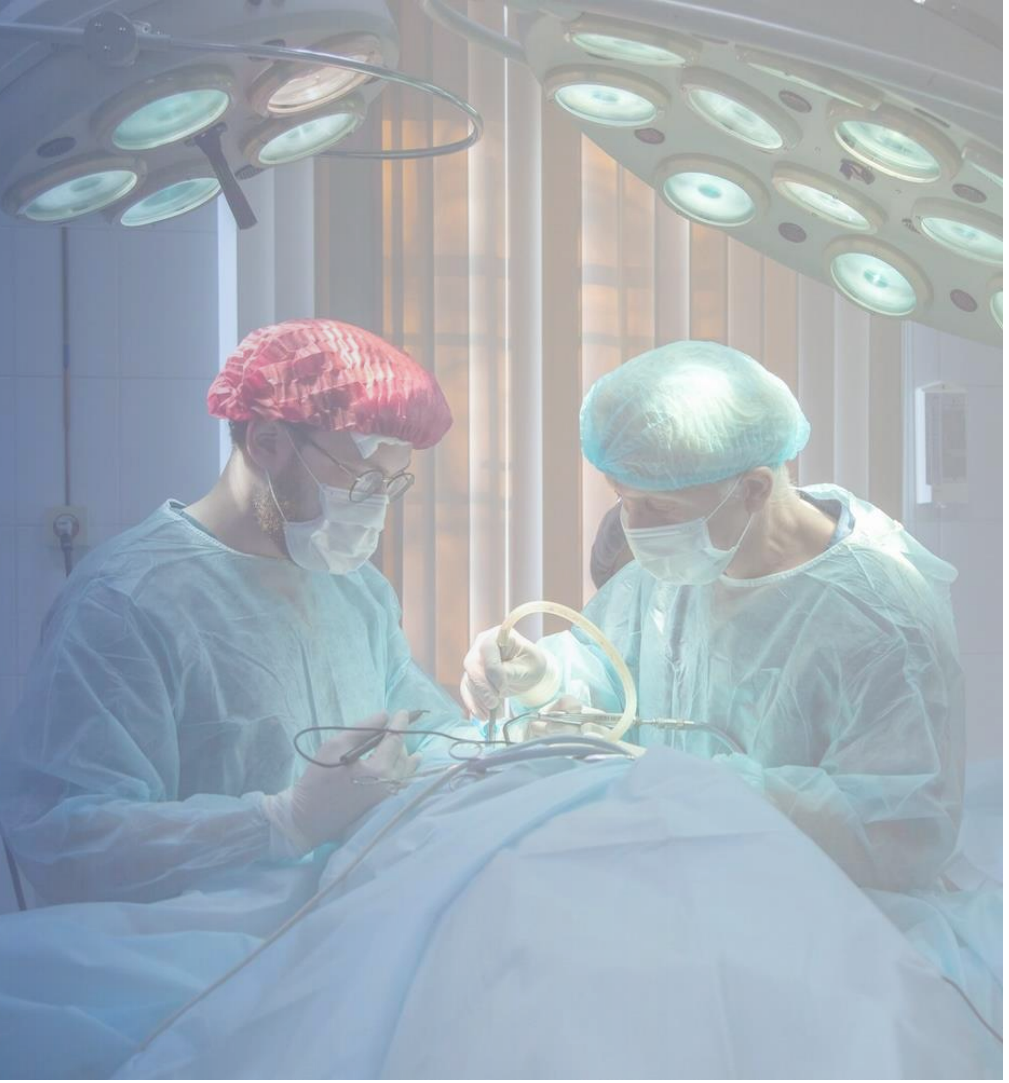
POSTSTABILIZATION

MAOs –42 CFR §422.113

(c)(2) (iii) (C) 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 § 422.113(c)(3) is met**;

3.) CONCURRENT PATIENT DENIALS MUST BE TRANSFERRED.

MEDICARE ADVANTAGE



PEER TO PEER REVIEWS

MAOs –42 CFR §422.113

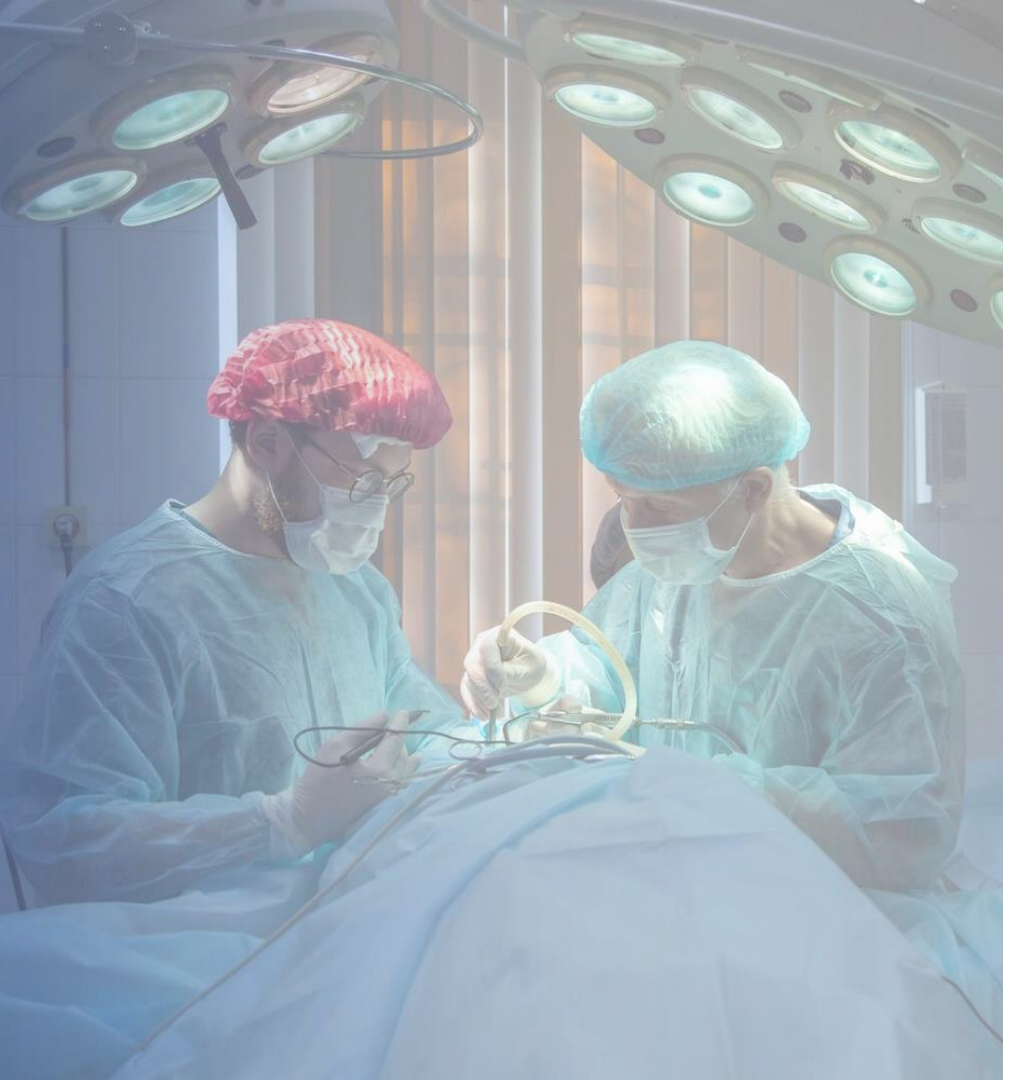
(c)(3) End of MA organization's financial responsibility. The MA organization's financial responsibility for post-stabilization care services it has **not pre-approved** ends when—

(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.



PEER TO PEER REVIEWS

MAOs –42 CFR §422.590

(g)(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.

ERN TRAF

Cooper [redacted]: Summary of Medical Events

Introduction: On September 10th our baby Cooper fell ill with a rare neuro-immune disease known as Acute Flaccid Myelitis. This disease mimics polio and is very new (first case diagnosed 2012) He was misdiagnosed for the first 2 months. Here is a time-line of events.

9/10/18:

- Arrived to ER about 3:00PM. After many theories and a whole slew of tests including a CT scan, X-ray, blood work, and MRI, it was determined that our son was the victim of a rare autoimmune disorder called Acute Transverse Myelitis. His spinal cord was swelling from the brain stem to T7 and compressed his spinal cord causing him to experience paralysis and the inability to breathe effectively. It is thought that the swelling is caused by his own immune system inappropriately attacking his spinal cord after an unknown viral trigger.
- 10:00 PM He was started on steroids and transferred to the Pediatric Intensive Care Unit (PICU) for monitoring and treatment.

10/5/18

- Tracheostomy placed due to failure to breath on his own.

10/23/18

- Care Conference: They want us to get ready for discharge home due to Phoenix Children's Hospital rejection of Cooper for rehab due to ventilator.
- We refused to take him home and insisted that he attend rehab as intense rehab is the only know treatment for his disease
- I Consulted Dr. Greenberg who is the closest rare neuro-immune disorder specialist. He referred Cooper to The Kennedy Krieger Institute (KKI) in Baltimore Maryland.

- KKI extended admission date to 1/21/2019

12/20/18

- Discharged home
- Channel 5 news does story on Cooper's rare illness

1/15/19

- Medicaid approval

1/5/19

- Re-hospitalized for viral infection/respiratory distress

1/12/19

- Discharged home
- KKI applied for insurance coverage beginning 1/23/2019

1/23/19

- Denial letter from insurance regarding intensive rehab program for children with AFM (Only one in the country). **See attached letter
- Not medically necessary
- No referral from "Primary" treating Physician
- Does not meat MCG guidelines
- KKI says to sit tight, they will do Peer-to-peer review in a few days

1/30/19

- Peer-to-peer review: denial maintained
- At this point 5 different doctors have said they are unsure how to treat Cooper and that he needs to go to Baltimore soon to get a care plan from the doctors that are treating this disease. (Referral letters obtained)
- Channel 12 news doing story on Cooper and the inability to get medical care for him despite having insurance.

2/8/19

- Filed rush appeal: ***See attached documents

InterQual® Level of Care Criteria
Acute Criteria

Review Process

Introduction

InterQual® Acute Level of Care Criteria provide support for determining the medical appropriateness of hospital admission, continued stay, and discharge. Acute Adult Criteria address the Observation, Acute, Intermediate, and Critical levels of care. Acute Pediatric Criteria include these levels of care and five additional levels of nursery care (Transitional Care, Newborn Level I, Special Care Level II, Neonatal Intensive Care Level III, and Neonatal Intensive Care Level IV).

Adult criteria are for review of patients ≥ 18 years of age. Pediatric criteria are for review of patients < 18 years of age.

Important: The Criteria reflect clinical interpretations and analyses and cannot alone either resolve medical ambiguities of particular situations or provide the sole basis for definitive decisions. The Criteria are intended solely for use as screening guidelines with respect to the medical appropriateness of healthcare services and not for final clinical or payment determinations concerning the type or level of medical care provided, or proposed to be provided, to a patient.

When evidence in the medical literature to support the efficacy and effectiveness of the intervention or service is absent, mixed, or unclear, criteria reflect the opinion of McKesson's expert clinical consultants. It is based upon current best practice and is the product of an iterative process involving multiple clinicians with diverse expertise in varied practice and geographic settings.

Reference materials

Reference materials are provided with the criteria and should be used to assist in the correct interpretation of the criteria.

- **Abbreviations and Symbols List**: Defines acronyms, abbreviations, and symbols used in the criteria.
- **Alcohol Withdrawal Assessment tool:** A worksheet to document a patient's CIWA-Ar score for alcohol withdrawal.
- **Bibliography**: References cited in the clinical content.
- **Clinical Revisions**: Provide details of changes to InterQual Clinical Criteria.
- **Drug List**: Categorizes drug names and classes mentioned within the criteria.

InterQual Disclosure Updated 11/9/18

"The Clinical Content reflects clinical interpretations and analyses and **cannot alone either resolve medical ambiguities of particular situations or provide the sole basis for definitive decisions**. The Clinical Content is intended solely for use as screening guidelines with respect to the medical appropriateness of healthcare services **and not for final clinical or payment determinations concerning the type or level of medical care provided, or proposed to be provided, to a patient."….** (Emphasis Added)

MCG Disclaimer (shown on their website)

"Qualified healthcare professionals may use our guidelines as a tool to support medical necessity decisions, **but they should not use them as the sole basis for denying treatment or payment**. Our guidelines must be applied to individual patients on a case-by-case basis and always in the context of a qualified healthcare professional's clinical judgment." (Emphasis Added) (See Attached)

ERN
TRAF

SUMMARY OF COMPLAINT – ARIZONA MEDICAL BOARD

February 19, 2019

Patricia McSorley, Executive Director
Arizona Medical Board
1740 W. Adams St. Suite 4000
Phoenix, AZ 85007

Physician:	J Tolson, M.D.
License Number:	31688
Board Certified:	Anesthesiology
Patient:	Cooper
ID:	
DOB:	
Denied Service:	Inpatient Care, Rehabilitation Level 1

Dear Ms. McSorley:

This office represents Cooper Leigh and has been asked to file a formal complaint with the **Arizona Medical Board** against Dr. Jeffrey Tolson, M.D. for his negligent medical decision resulting in Cooper's delayed treatment for Acute Flaccid Myelitis, a rare neurological immune disease that mimics polio.

In its advisory role to healthcare providers that provide medically necessary services to ERISA participants, the National Council of Reimbursement Advocacy (NCRA) and the Reimbursement Advocacy Firm (TRAF) periodically brings to your attention non-compliance issues related to—

(1) Access to medically appropriate healthcare services consistent with clinical review requirements under Arizona Statutes, Title 20, §20-1057.06, §20-2501, §20-2532 and §20-2533 or any rule adopted pursuant thereto.
(2) Breach of fiduciary duties under 29 U.S.C. 1104 & 1109 including full and fair review requirements under ERISA law.
(3) Any other health services furnished by a provider or supplier that are reimbursable under 29 CFR section 2560.503-1 or any rule adopted pursuant thereto.

We dispute Dr. Tolson's decision to deny authorization for inpatient rehabilitation services based on lack of authorization, because two of Cooper's treating physicians with expertise in this field have documented the medical necessity of this requested service and Dr. Tolson does not have the clinical expertise to make an appropriate medical decision in this matter, as shown and described below and on the attached exhibits:

- On 09/10/2018 at 3:00PM, Cooper presented to an emergency room; multiple tests were performed including a CT scan, X-ray, blood work, and an MRI. It was determined that Cooper had developed a rare autoimmune disorder called Acute

As described above, Cooper Leigh has been diagnosed with Acute Flaccid Myelitis, a rare neurological immune disease that mimics polio. Being that this disorder is incredibly rare with the first diagnosis in 2012, very few medical professionals have the appropriate clinical knowledge and expertise to determine the medical necessity of different health services and therapies aimed at treating this rare condition.

Two of the only physicians in the United States with direct experience in treating Acute Flaccid Myelitis and other rare neurological disorders have documented the medical necessity of Cooper's requested inpatient rehabilitation and referred him to The Kennedy Krieger Institute (KKI) in Baltimore, Maryland.

Thus, Dr. Tolson's medical decision to deny the medical necessity of these services raises serious concern regarding his competence and experience in treating such ailments.

As you know, Dr. Jeffrey Tolson is the Medical Director of Banner-Aetna in Arizona. Dr. Tolson is an anesthesiologist specialist and he is board certified in anesthesiology. Dr. Tolson received his medical degree from Ohio State University College of Medicine in 1991. **(See Exhibit G — Dr. Tolson, Arizona Medical Board.)** Here. Banner-Aetna has utilized an anesthesiologist to review the medical necessity of treatment for a rare neurological autoimmune disorder.

Further, per the Milliman Care Guidelines Disclaimer (shown on their website), Milliman Guidelines are not to be used solely as medical necessity criteria in place of a qualified health care professional's clinical judgment. It reads in pertinent part:

> ***"Qualified healthcare professionals may use our guidelines as a tool to support medical necessity decisions, but they should not use them as the sole basis for denying treatment or payment. Our guidelines must be applied to individual patients on a case-by-case basis and always in the context of a qualified healthcare professional's clinical judgment."*** **(Emphasis Added.)**

The sole use of UR software CANNOT replace an experienced, knowledgeable physician, nor can it replace medical necessity determinations by the attending physicians.

Here, Dr. Tolson's letter states *"Based on MCG guidelines and the information we have, we're denying coverage for this acute rehabilitation facility admission. The requirements for coverage are: (1) requires intensive skilled nursing services; (2) requires two or more skilled therapy types (e.g. physical, occupational, or speech therapy); (3) requires and is able to fully participate in therapy for a minimum of 15 hours per week (e.g. 3 hours per weekday); (4) needs close physician involvement; and (5) shows continued measurable improvement with progress toward functional goals for next level of care. The member doesn't meet all of these requirements."* **(See Exhibit B — Banner/Aetna Denial.)**

Considering Dr. Tolson's clinical background, it is evident that his expertise is not in rare neurological autoimmune disorders in pediatric patient, nor any remotely similar field. Dr. Tolson did not utilize MCG guidelines in conjunction with the expertise of a qualified, competent medical professional. Thus, it is clear that Dr. Tolson was not competent to evaluate the specific clinical issues at hand and his medical decision is inconsistent with those of qualified professionals.

From: Lexie Hernandez
Date: 2/20/19 7:02 AM (GMT-08:00)
To: Ed Norwood <ednorwood@ernenterprises.org>
Subject: Re: AZ Medical Board - Complaint #41313, email 1 of 2 (PASSWORD TO FOLLOW)

Cooper has been approved for 6 weeks of rehabilitation! Now I just have to see if his spot is still available at KKI or how long this se
how you helped us if you want. Just let me know what I can do! Thank you! Thank you! Thank you!

Lexie & Cooper

Ed Norwood

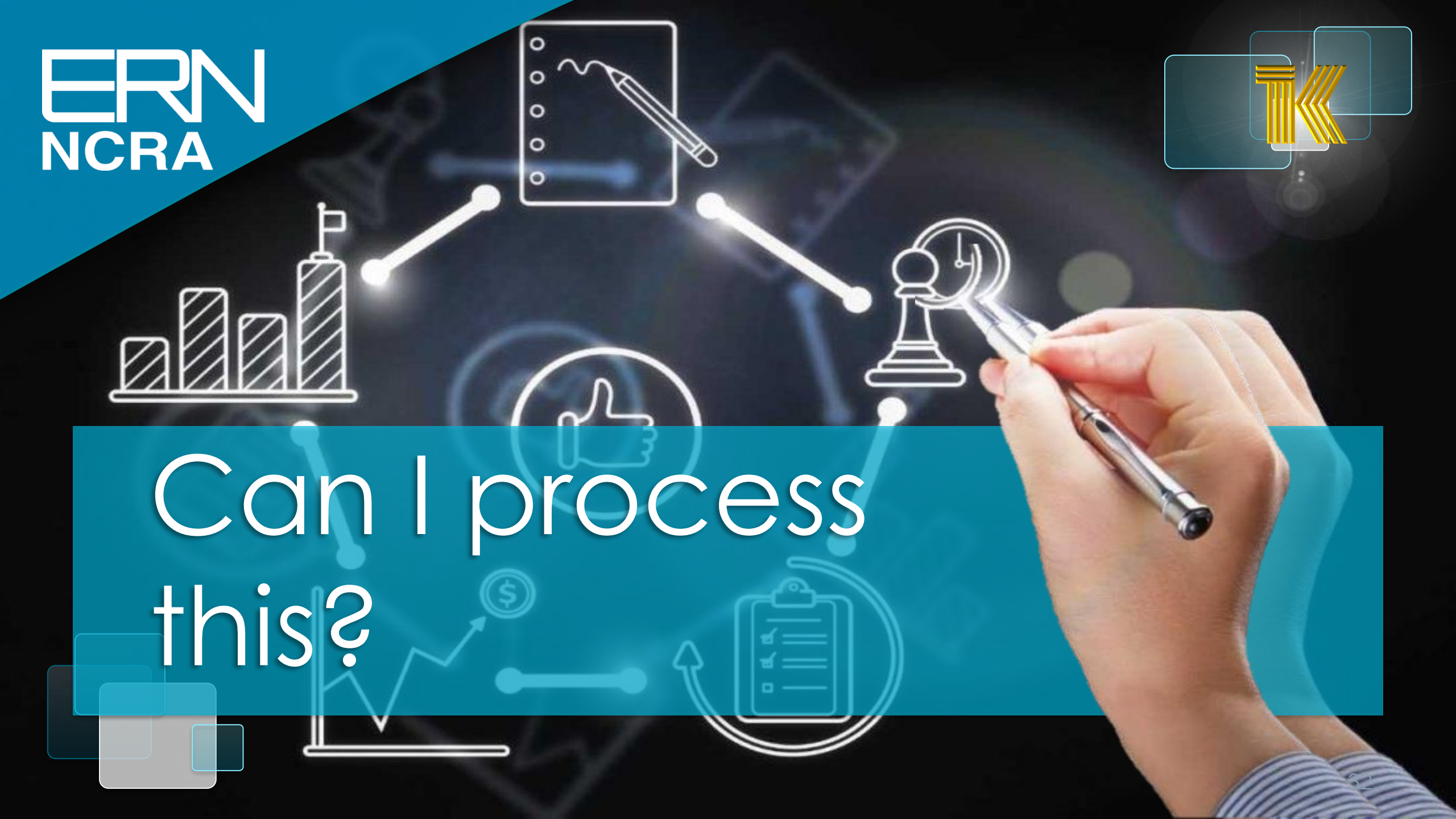
From: Lexie Hernandez
Sent: Sunday, May 05, 2019 5:51 PM
To: Ed Norwood
Subject: Re: Testimonial

Cooper is making so much progress. It's truly incredible. I watched him take his first steps a few days ago. Something I wasn't sure I would ever see. I can't even explain how incredible this place is at what they do for children with spinal cord injuries. Thank you again for getting us here.

Lexie

On Sun, May 5, 2019 at 7:16 PM Ed Norwood <ednorwood@ernenterprises.org> wrote:

> So moved. So touched by your words Lexie.
>
> Thank you.
>
> How is Cooper doing?
>
> Best,
>
> Ed Norwood
>
> Sent from my T-Mobile 4G LTE Device
>
> -------- Original message --------
> From: Lexie Hernandez <arharri1@gmail.com>
> Date: 5/5/19 11:21 AM (GMT-08:00)
> To: Ed Norwood <ednorwood@ernenterprises.org>
> Subject: Testimonial
>
> I am so sorry that this took me so long but I wanted to be able to share how much Cooper has benefitted from the treatment that was only made possible from your efforts.
>
> Thank you again for everything!
>
> Lexie


ERN
NCRA
Can I process this?

4. Documentation & Rebuttal Guidelines for Front (F) & Mid cycle (M)

	Scenario	ERN Recommended Note/Rebuttal
F	**POSTSTABILIZATION NOTIFICATION NOTES** (by ED personnel)	Health Plan contacted: [NAME OF PLAN OR CONTRACTED PROVIDER e.g. Health Net of California, Inc.] Title/Department contacted: [PLAN OR CONTRACTED PROVIDER e.g. Health Net] Hospital Notification Unit Name of person spoke with (First & Last): John Doe Phone number first dialed: 800-995-7890 Phone number of last person spoke with/call back number/extension: [PHONE NUMBER AND EXTENSION] Date, start and end time of call: 2/26/2019, 10:32 AM-10:50 AM Authorization/tracking/reference number (if not given, then note): no authorization/tracking/reference number received. IF AUTHORIZATION WAS RECEIVED: How many days is this authorization for? What exactly is being authorized (e.g., emergency admission, appendectomy). Notes from call: Notified [NAME OF REPRESENTATIVE] at [NAME OF PLAN/CONTRACTED PROVIDER] of patient presenting to the ED, needing emergency admission and requested authorization as patient cannot be discharged safely.
F	**NO HMO AUTHORIZATION WAS GIVEN** (by ED and IV Personnel)	HMO: ____ Informed representative that under state law, they have 30 minutes from this call to make a decision to authorize care or arrange for transfer to another facility. No authorization/tracking/reference number was given during call (See 28 CCR §1300.71.4 (b)(1).) **READ DISCLAIMER:** "Please note that while you have issued a tracking/reference number for your patient, under existing CA law, plans are required, within 30 minutes from initial contact, to authorize poststabilization care or arrange for the prompt transfer of the enrollee to another hospital. This tracking/reference # does not satisfy your requirements under the law but constitutes that contact was made in the event we do not receive an authorization number from you within a half hour of this request. All services afterwards are deemed authorized (See 28 CCR 1300.71.4 (a-c), H&S 1262.8 (d)." **REFERENCE UR FAX COVER SHEET/HMO/MAO CONTINUED FAILURE TO RESPOND FAX COVER SHEET FOR CMRC**
F	**NO MAO AUTHORIZATION WAS GIVEN** (by ED AND IV Personnel)	MAO: ____ Informed representative that under federal law, they have sixty (60) minutes from this call to approve/disapprove care or arrange for transfer to another facility. No authorization/tracking/reference number was given during call (See 42 CFR 422.113 (c)(2)(iii)(C)). **READ DISCLAIMER:** Please note that while you have issued a tracking/reference number for your patient, under existing Medicare law, plans are required, within 60 minutes from initial contact, to pre-approve poststabilization care or assume care of the beneficiary (via transfer, or at our hospital if privileged). This tracking/reference # does not satisfy your requirements under the law but constitutes that contact was made in the event we do not receive an authorization number from you within one hour of this request. Your financial responsibility for post-stabilization care services it has not pre-approved ends when you assume care of the patient, reach an agreement with our treating physician/PA or the enrollee is discharged (See 42 CFR 422.113 (c)(3)).

REQUEST FOR AUTHORIZATION TO PROVIDE POSTSTABILIZATION SERVICES

TO:	FROM: JOE COMPLIANCE
FAX:	PAGES:
PHONE:	DATE:
RE: **REQUEST FOR AUTHORIZATION TO PROVIDE POSTSTABILIZATION SERVICES**	CC:

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

At this time we are requesting authorization to provide post-stabilization services to your insured. **As the contracting medical provider or health care service plan, you have 30 minutes (60 minutes if you are an MA plan pursuant to 42 CFR §422.113) from receipt of this notification to provide an authorization, or make a decision to arrange transfer of the patient.** If you do not respond to this notification, or communicate an intent to transfer the patient and do not effectuate a transfer within a reasonable time, the post stabilization services shall be deemed authorized and shall be paid in accordance with the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2) and any regulation adopted thereunder or 42 CFR Part 422 and any regulation adopted thereunder. Please be advised that due to ER overflow concerns, **plans must effectuate transfer within 2 hours of notifying us of its intent to do so, or the patient will be admitted** and the plan will be responsible to reimburse for all services up to the time that transfer is effectuated pursuant to 28 CCR §1300.71.4(2).

Contact one of the following Case Managers to provide authorization for the statutorily deemed authorized services.

NAME (XXX) XXX-XXXX **NAME (XXX) XXX-XXXX** **NAME (XXX) XXX-XXXX**

Comments: PLEASE FAX AUTHORIZATION NUMBER TO (xxx) xxx-xxxx

If you need any further information, please contact: Care Coordination Department @ (xxx) xxx-xxxx or Fax (xxx) xxx-xxxx.
Insert confidentiality/HIPAA statement here -

MAO CONTRACTED WITH TREATING PHYSICIAN

TO:	FROM: JOE COMPLIANCE
FAX:	PAGES:
PHONE:	DATE:
RE: **MAO CONTRACTED WITH TREATING PHYSICIAN**	CC:

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Patient Admitted On (date/time), XXXXXX ("Health Plan") was notified that the above patient is stable after being treated in the ER and requires post-stabilization care. On (date/time) we received a denial from Health Plan stating that further poststabilization care at our hospital has been denied. **However, it has come to our attention that the treating physician is contracted with your plan**. Please be advised that when a treating physician is contracted with an MAO, CMS views him or her "as the plan" for the purposes of their rules and guidance. Here, the inpatient admission order by your contracting treating physician constitutes a favorable determination. Please issue immediate authorization to our hospital within sixty (60) minutes as required by 42 CFR §422.113 (c)(2) to preserve the beneficiary's continuity of care.

Please contact one of the following Case Managers to issue immediate authorization.

NAME (XXX) XXX-XXXX **NAME (XXX) XXX-XXXX** **NAME (XXX) XXX-XXXX**

Comments: PLEASE FAX AUTHORIZATION NUMBER TO (xxx) xxx-xxxx

If you need any further information, please contact: Care Coordination Department @ (xxx) xxx-xxxx or Fax (xxx) xxx-xxxx.
Insert confidentiality/HIPAA statement here -

NOTIFICATION OF MAO DISAGREEMENT OF CARE

TO:	FROM: JOE COMPLIANCE
FAX:	PAGES:
PHONE:	DATE:
RE: **NOTIFICATION OF MAO DISAGREEMENT OF CARE**	CC:

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Patient Admitted On (date/time), XXXXXX ("Health Plan") was notified that the above patient is stable after being treated in the ER and requires post-stabilization care. On (date/time) (Doctor Name) at Health Plan informed our physician during peer to peer review that Health Plan has denied further poststabilization care at our hospital. This notice serves as a formal **NOTICE OF DISAGREEMENT OF CARE under 42 CFR 422.113 (c)(3) which outlines the** *"End of MA organization's financial responsibility" and states: 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****.*

Under existing federal law, Medicare Advantage Plans are required to pay for all care up until they assume care of the patient, reach a peer to peer agreement, or the patient is discharged. Any peer to peer review denial of poststabilization services is an automatic decision/election to assume care of, or transfer the patient as soon as possible **pursuant to 42 CFR §422.113 (c) above.**

As of the above (date/time), Health Plan has failed to initiate assuming care of or transferring the patient. (Please be advised that for patients pending admission, if Health Plan fails to assume care of or transfer the patient within a reasonable time, the patient will be admitted to limit overflow and delays in our ER).

Contact one of the following Case Managers to effectuate transfer immediately and/or provide authorization for.

NAME (XXX) XXX-XXXX **NAME (XXX) XXX-XXXX** **NAME (XXX) XXX-XXXX**

Comments: PLEASE FAX AUTHORIZATION NUMBER TO (xxx) xxx-xxxx

If you need any further information, please contact: Care Coordination Department @ (xxx) xxx-xxxx or Fax (xxx) xxx-xxxx.
Insert confidentiality/HIPAA statement here -

www.ernenterprises.org

CLINICAL DENIALS COURSE (CDC):

CONTACT US:

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

YOU FIGHT FOR THEM
WE FIGHT FOR YOU

Champions for MEDICALLY APPROPRIATE HEALTHCARE.