Health Laws

Regulatory

Complaint Process with CMS

ED NORWOOD, CCO

You fight for their lives **We fight for you**

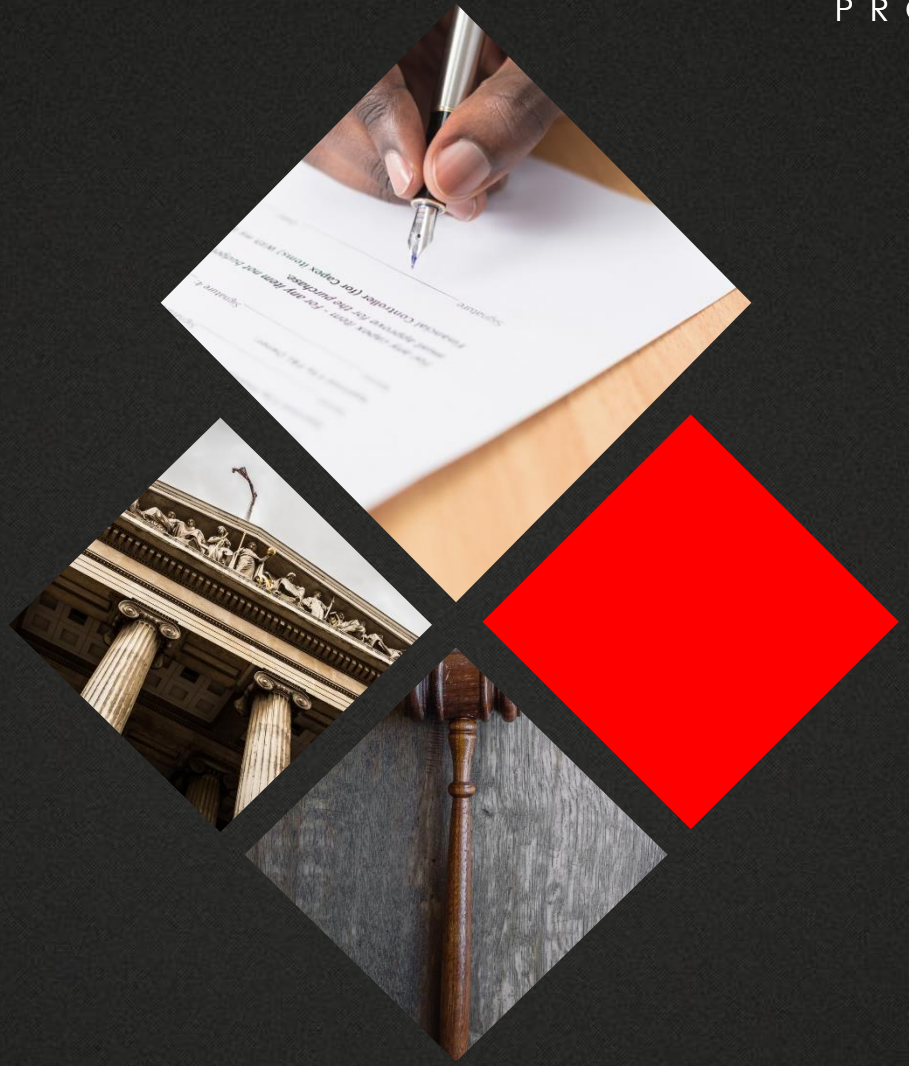
ERN
NCRA

She quoted

"Never let anyone tell you NO that does not have the power to say YES." - Eleanor Roosevelt

REGULATORY COMPLAINT
PROCESS **WITH CASE STUDIES**

Medicare Advantage



APPEALS STRATEGY

I. Original Determination

A. Review denial or payment of claim by the Medicare Advantage Plan.

II. 1st Level of Appeal

A. The first level of appeal must be submitted to the Plan who made the original determination.

IMPORTANT

ALL 1ST LEVEL APPEALS TO THE PLAN MUST BE SUBMITTED WITHIN 60 DAYS FROM DATE OF ORIGINAL DETERMINATION.

B. A signed Waiver of Liability ("WOL") must be submitted with the 1st level of appeal for non-contracted providers only.
   - See **§60.1.1 Ch. 13, Medicare Managed Care Manual;** "*A non-contracted provider, on his or her own behalf, is permitted to file a standard appeal for a denied claim only if the non-contract provider completes a waiver of liability statement…*"**.** (Non-contracted providers only.)

Waiver of Liability

Appendix 7 - *Waiver of Liability Statement*
(Rev. 105, Issued: 04-20-12, Effective Date: 04-20-1; Implementation Date: 04-20-12)

WAIVER OF LIABILITY STATEMENT

_____
Medicare/HIC Number

_____
Enrollee's Name

_____ _____
Provider *Dates of Service*

_____
Health Plan

I hereby waive any right to collect payment from the above-mentioned enrollee for the aforementioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR 422.600.

_____ _____
Signature *Date*

III. Plan Submission of the Claim to the Independent Review Entity ("IRE"). (Non-contracted providers only)

A. If a Plan denies the appeal and upholds their original determination, per **42 CFR 422.590(b)(2)**, *the Plan must submit the claim and case file to Maximus*, the Medicare contracted IRE.

IV. Denial or Dismissal by the IRE

A. If Maximus DENIES the claim and agrees with the Plan, Maximus will send a written denial to you.

1. Review the denial and discuss the merits of the case and if additional appeals are warranted.
2. **IMPORTANT** – If claim was denied for "**not medically necessary**" and ER services HAVE NOT been paid, look to see if provider contacted MA Plan upon admission as follows:
   a. If there **WAS** a phone call/ contact upon admission, seek a third level of appeal with ALJ.
   b. If there **WAS NOT** a phone call/ contact upon admission, the MA Plan has an afterhours/ weekend contact line, and there was no admission order on file from the treating provider, **request a split rebill from provider for ER/ Outpatient services and have provider submit rebill to MA Plan for payment of ER services.**
      - Inpatient services will remain denied.

IV. Denial or Dismissal by the IRE Cont.

B. If Maximus DISMISSES the appeal, find the dismissal reason.

1. Often the appeal was not filed within 60 days or a WOL was not submitted with the appeal.

a. If the appeal was dismissed for untimely filing, research the claim to figure out if good cause for the untimely filing exists and if so, submit a Good Cause Exception/ Request to the Plan and state good cause for untimely filing of the appeal along with grounds for the appeal.

2. If the appeal was dismissed for lack of WOL, research the claim to see if the Plan made and documented attempts to recover the WOL from the provider.

a. If not, sign a WOL and send to Maximus along with an appeal letter stating the Plan failed to recover and document attempts to recover a WOL from the plan.

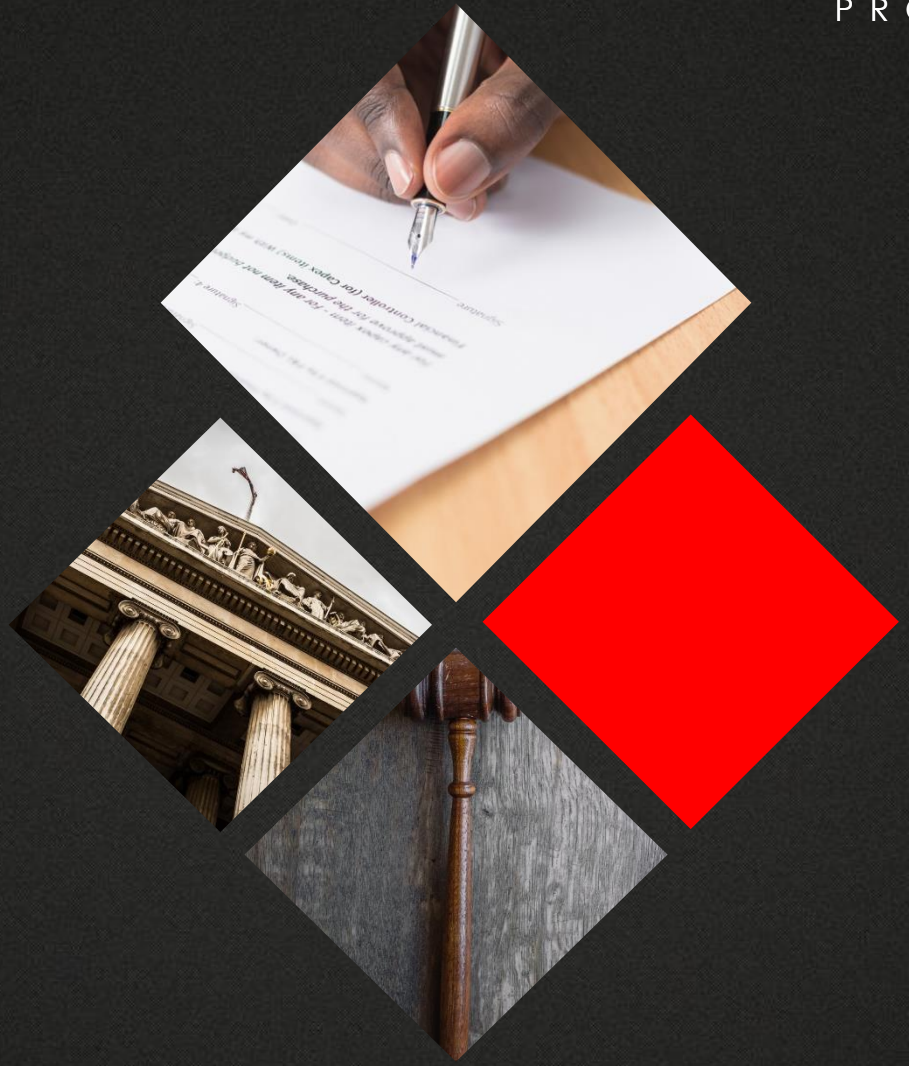
- See 2012 Program Audits

V. Seeking an ALJ Hearing

A. If Maximus has DENIED the appeal and agreed with the Plan, a request for an ALJ hearing may be made.
B. The form will be included with Maximus's denial.
C. Fill out the form and submit to the address provided on the form **NO LATER THAN 60 DAYS FROM THE DATE OF MAXIMUS'S DENIAL.**
D. Await the response of hearing date from the Department of Health and Human Services, Office of Medicare Hearings and Appeals Centralized Docketing Office.

REGULATORY COMPLAINT PROCESS **WITH CASE STUDIES**

Medicare Advantage



REGULATORY COMPLAINT FILING STRATEGY

The **CMS Regional Office Account Management "Standard Operating Procedure" ("AM SOP 3.0"), Section 5.2. states:**

Because of the size of the Part C and D programs and the number of issues CMS monitors, **it is important to use complaints data as a source of information to gain insights into account compliance**. The **Complaints Tracking Module (CTM)** provides valuable insights into system issues and/or areas of poor performance associated with a particular account. CTM complaints are received by CMS through a variety of sources including: 1-800 MEDICARE (primarily), CMS Regional Offices, State Health Insurance Assistance Program (SHIPs), Department of Insurance (DOIs), Senior Medicare Patrols (SMPs), SAAs, written correspondence, , congressional offices and others. **REGARDLESS OF WHO RECEIVES THE COMPLAINT, ALL BENEFICIARY AND PROVIDER COMPLAINTS ARE REQUIRED TO BE RECORDED IN THE CTM.**

The CMS AM SOP section 5.3.2 in part, adds:

"Provider complaints should be tracked and resolved via the CTM, and AMs who are contacted directly by providers or referred complaints from elsewhere in CMS should make sure these complaints **are accurately recorded in CTM for trending and aggregation.** Providers may contact the AM, plan specialist, or other RO staff person in accordance with RO procedures when they have various claims payment problems, **which might include claims payment timeliness, unpaid claims, claims inappropriately denied, appeals of claims payment denials, or incorrectly paid claims**. Per the Complaint Management Protocol the AM or plan specialist should enter the complaint into the CTM.

The CMS AM SOP section 5.3.2 in part, adds:

The number of claims, incidents, or providers involved in any one (or other) of these problems can point to a possible compliance problem. If the caseworkers are getting calls from several different providers about the same type of problem, calls about many different types of claims, or chronic calls about the same unresolved problem, further investigation with the account is certainly warranted and may indicate a systemic problem and support the need for a compliance action.

If it appears that the account's actions do not adhere to CMS requirements, as a first step, the AM could request the account's policies and procedures to assess whether these documents adhere to CMS requirements. An audit may be needed if an account's policies and procedures are correct, but the account's actions are different.

The CMS AM SOP section 5.3.2 in part, adds:

A non-contracted provider, on his or her own behalf, is permitted to file a standard appeal for a denied claim (generally Part C) only if the provider completes a waiver of liability statement, which states that the provider will not bill the enrollee regardless of the outcome of the appeal. See Chapter 13 of the Medicare Managed Care Manual for more information. **AMs should confirm that non-contracted providers with claims payment complaints are aware of and have used the account's appeals process before CMS becomes involved in the dispute.**

Ed Norwood

Subject: FW: Please Temporarily Hold All MA Complaints
Attachments: Provider Dispute Instructions and Cover Sheet.docx

From: Duarte, Ann M. (CMS/CMHPO)
Sent: Friday, March 24, 2017 1:34 PM
To: Charisma Franklin <charismafranklin@ernenterprises.org>; Brian Ford <brianford@ernenterprises.org>; Rose Trochez <rosetrochez@ernenterprises.org>
Subject: RE: Please Temporarily Hold All MA Complaints

Good afternoon.

Thank you for your patience as CMS developed a new streamlined approach for ERN/TRAF to submit providers' concerns and for CMS staff to investigate them without changing the goal: open communication between the Medicare Advantage Organization and the provider toward a resolution.

Please review the attached instructions and let me know if you have any questions about them. We expect ERN/TRAF to follow the new procedures immediately, so it will be important for you to ask for clarification if you need it.

Respectfully,

Ann M. Duarte | **Associate Regional Administrator** | Division of Medicare Health Plans Operations | Centers for Medicare & Medicaid Services | CMS San Francisco Regional Office | 90 7th Street, 5-300 (5W) | San Francisco, CA 94103-6708 | ☎: 415-744-3770 | 🖷: 443-380-8889 | ✉: ann.duarte@cms.hhs.gov

INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW:
This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law. If you are the unintended recipient of this information please notify the sender.

From: Duarte, Ann M. (CMS/CMHPO)
Sent: Friday, February 17, 2017 9:24 AM
To: 'Charisma Franklin' <charismafranklin@ernenterprises.org>; 'Brian Ford' <brianford@ernenterprises.org>; 'Rose Trochez' <rosetrochez@ernenterprises.org>
Subject: Please Temporarily Hold All MA Complaints
Importance: High

ERN/TRAF —

CMS is currently formulating new procedures for handling some provider complaints against MAOs, including those you send on behalf of the providers that you represent. Please hold all new requests, including the one that just now came in from Ms. Franklin, until I issue new guidance to you and to CMS staff. The new process will simplify the roles that each of us play in assuring that CMS' contracted MAOs are meeting their obligations to their contracted providers and to the non-contracted providers who deliver services to their members.

I hope to issue new guidance by the end of this month, so I ask that you hold your inquiries until that time.

INSTRUCTIONS FOR SUBMITTING PROVIDER COMPLAINTS RELATED TO MEDICARE ADVANTAGE ORGANIZATION (MAO) APPEALS ISSUES OR CLAIMS PAYMENT DISPUTES TO CMS

Medicare providers (including organizations representing them and intervening on their behalf) seeking assistance from CMS in resolving Medicare Advantage (MA) claims issues **must adhere to the following instructions and complete the attached cover sheet for each complaint** (i.e., one cover sheet for each beneficiary case). CMS will act upon the case if (and only if):

1. The provider submits the cover sheet and documentation requested on the cover sheet;
2. The provider does **not** submit documentation **not** listed on the cover sheet; and
3. The provider and representing organization (if applicable) indicate prior communication with the MAO in attempt to resolve the issue.

If the provider meets the above requirements, CMS staff will direct the MAO to investigate the case and to work directly with the provider toward resolution. If the provider does not meet these requirements, CMS will return the case(s) for correction before taking further action.

In general, CMS' role in these matters is to facilitate communication between the MAO and the provider. ***It is not CMS' role to determine medical necessity for an appeal case nor to determine appropriate claims payment amounts for payment disputes.*** Should CMS identify a trend in provider complaints, staff will investigate the matter further and work with the MAO to address the broader issue.

CMS allocates its MAO oversight responsibilities across all ten Regional Offices (RO). To ensure the appropriate RO receives the case, providers not already familiar with the MAO's CMS account manager should submit their complaints (including cover sheets) to Ann Duarte, Associate Regional Administrator, via e-mail (ann.duarte@cms.hhs.gov) in ***password protected files***. Ms. Duarte will distribute the complaints to the appropriate CMS RO to investigate and refer to the appropriate MAO.

WHAT IS AN APPEAL COMPLAINT?

For these purposes, CMS defines an appeal complaint to be a complaint alleging an MAO's failure to follow the applicable appeals process, whether for contracted or non-contracted providers. Note that an appeal could include an MAO's denial of specific line item within a claim. Examples of non-compliance could include an MAO's failure to notify the provider of the available appeal process or failure to act upon an appeal appropriately submitted by a provider.

CMS defines the non-contracted provider appeals process in the Medicare Managed Care Manual, Chapter 13. That process includes the requirement that the MAO auto-forward an upheld denial to the Independent Review Entity (IRE).

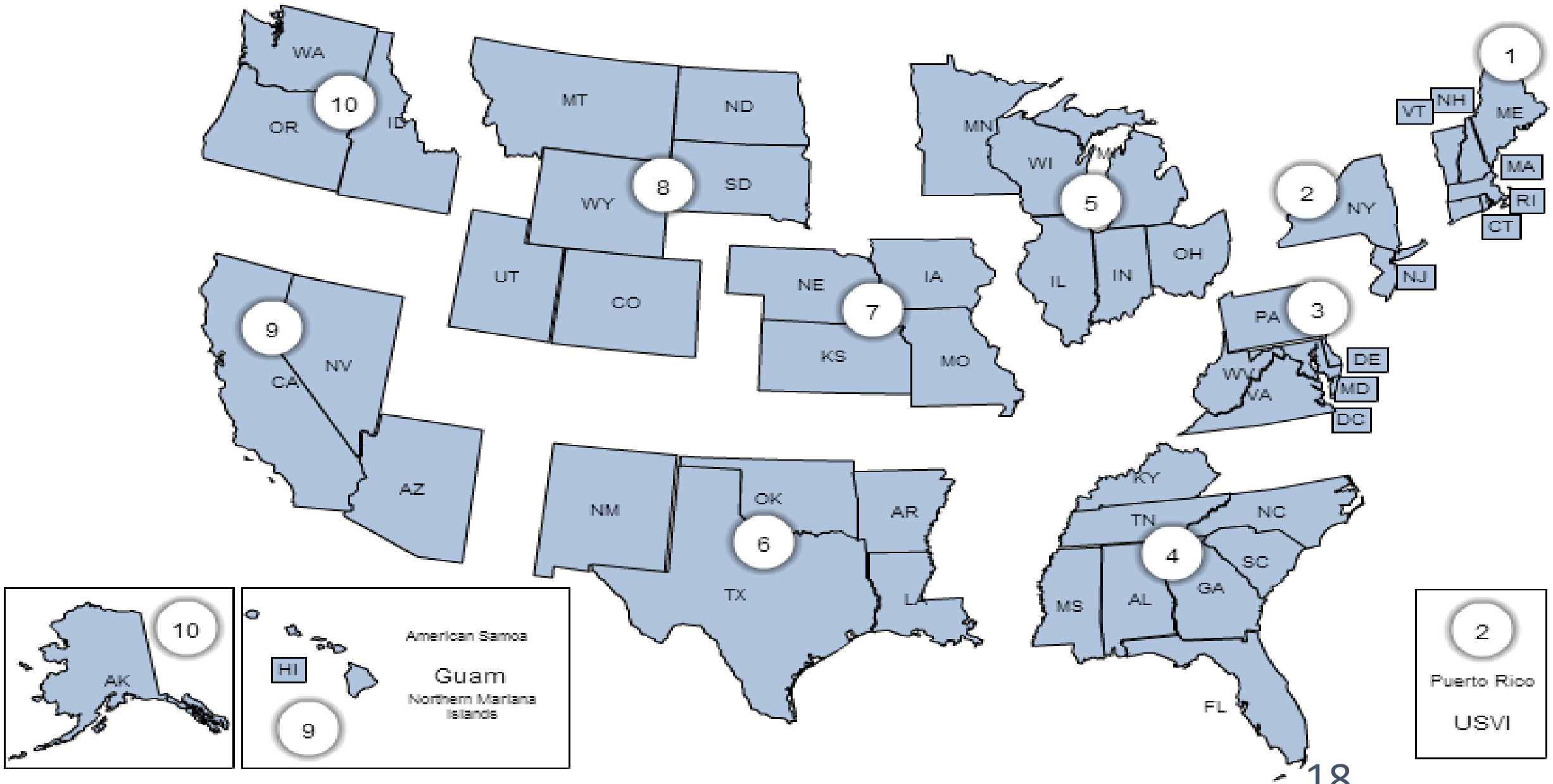
The MAO is responsible for defining and adhering to an appeals process for contracted providers as elaborated in the provider's contracts.

WHAT IS A CLAIMS PAYMENT DISPUTE?

For these purposes, a claims payment dispute is a provider's dispute over the *amount* that the MAO paid on a particular claim, including the MAO's decision to down-grade a claim to lower level of service and corresponding lower reimbursement amount.

03/23/2017 FINAL

CMS REGIONAL OFFICE MAP



APPEALS / 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	
1.2	Entity Submitting Complaint	____ Provider ____ 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	
1.3	Submitter's Name	
	E-mail Address	
	Telephone Number	
1.4	Beneficiary Name	
1.5	Beneficiary Health Insurance Claim Number (HICN)	
1.6	Provider Name	
1.7	Medicare Advantage Organization	
1.8	Claim Number	
1.9	Date(s) of Service	
1.10	Provider Contract Status	____ Provider Contracted with MAO during Date(s) of Service ____ Provider NOT Contracted with MAO during DOS
1.11	Complaint Type	____ Contracted Provider Appeal ____ Non-Contracted Provider Appeal ____ Contracted Provider Claims Payment Dispute ____ Non-Contracted Provider Claims Payment Dispute ____ Other
	Brief Summary of Complaint (not to exceed 50 words)	
1.12	Provider has Communicated with MAO in Attempt to Resolve Issue	____ 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	
1.13	Organization Representing Provider has Communicated	____ Yes

	with MAO in Attempt to Resolve Issue	____ No *(NOTE: CMS will only review this case if the intervening organization has already attempted to resolve it by working directly with the MAO.)* ____ N/A (No intervening organization involved.)
	If Yes, Name(s) of Individual(s) at MAO.	

Ed Norwood

From: CMS ROSFODHPP <ROSFODHPP@cms.hhs.gov>
Sent: Tuesday, July 09, 2019 3:52 PM
To: Daniel Muhlbach
Cc: CMS ROSFODHPP
Subject: CMS Complaint - Promise Health Plan's Failure to Reimburse Emergency and Post-Stabilization Services (OMC), email 1 of 2

This email is to confirm receipt of your inquiry/complaint on behalf of the provider. We entered it into our complaint tracking system to notify the Medicare Advantage or Part D plan addressed in your inquiry/complaint. The provider will receive a call from the plan within 30 days. CMS is not a signed-party on the contract between the provider and the Medicare Advantage or Part D plan, therefore, we cannot intervene or enforce the contract. Please direct the provider to refer to his/her contract with the Medicare Advantage or Part D plan, or the appropriate department within their organization, to determine how to follow up with the plan should they not respond to claims according to the timeframes specified in the contract. If you have any questions regarding the status of this complaint, please contact the plan directly. If the plan is not responsive you may reach out to this office at ROSFODHPP@CMS.HHS.GOV and refer to the complaint ID C1902827854.

From: Daniel Muhlbach <danielmuhlbach@ernenterprises.org>
Sent: Monday, July 8, 2019 9:42 AM
To: CMS ROSFODHPP <ROSFODHPP@cms.hhs.gov>
Subject: [WARNING : MESSAGE ENCRYPTED] CMS Complaint - Promise Health Plan's Failure to Reimburse Emergency and Post-Stabilization Services (OMC), email 1 of 2
Importance: High

Good morning:

Please find the attached Summary of Complaint and corresponding spreadsheet filed on behalf of Olympia Medical Center citing Blue Shield of California — Promise Health Plan's failure to reimburse emergency and statutorily authorized post-stabilization services rendered in good faith to four Medicare beneficiaries.

The password to these documents will follow in a separate email.

Thank you in advance for ensuring Promise Health Plan's compliance in the timely and proper adjudication of these claims.

Respectfully,

Daniel Muhlbach
Claims Compliance Auditor I | ERN | The Reimbursement Advocacy Firm
Office:714-995-6900 ext. 6970 | Direct:714-820-6970 | Fax:714-995-6901

https://protect2.fireeye.com/url?k=b4021d39-e8560445-b4022c06-0cc47adc5fa2-f1949f8b8b4b7a1e&u=http://www.ernenterprises.org/

The CMS AM SOP section 5.3.2 in part, states:

Provider Contracting Disputes

Except as noted below, the account agrees to take ultimate responsibility for all services provided to enrollees and terms of the contract and otherwise fulfill all terms and conditions of its contract with CMS regardless of any relationships that the account may have with entities, contractors, subcontractors, first-tier or downstream entities. As such, it is CMS policy that the execution of a contract between an account and a provider is between those parties and CMS will not intervene **unless it can be proven that beneficiary access is being impacted as a result**. If a contracted provider contacts the AM directly, the AM may submit a request to the account to investigate the complaint **and report back to the AM on the resolution.**

CASE STUDY

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	7.25.17
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
1.3	Submitter's Name	Rose Trochez
	E-mail Address	rosetrochez@ernenterprises.org
	Telephone Number	714.995.6900 ext 6939
1.4	Beneficiary Name	MARTINEZ,C
1.5	Beneficiary Health Insurance Claim Number (HICN)	
1.6	Provider Name	Hemet Valley Medical Ctr.
1.7	Medicare Advantage Organization	MOLINA SR
1.8	Claim Number	Not listed
1.9	Date(s) of Service	
1.10	Provider Contract Status	__x__ Provider Contracted with MAO during Date(s) of Service ____ Provider NOT Contracted with MAO during DOS
1.11	Complaint Type	__x__ Contracted Provider Appeal ____ Non-Contracted Provider Appeal ____ Contracted Provider Claims Payment Dispute ____ Non-Contracted Provider Claims Payment Dispute ____ Other
	Brief Summary of Complaint	Patient arrived at the ER, Hemet attempted to make notification to Molina SR. of a possible inpatient admission. Molina failed to respond to the 1 hour allotted per Title 42. 422.113, patient was admitted due to no response from Molina.
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	GENERIC RESPONSE
1.13	Organization Representing Provider has Communicated with MAO in Attempt to Resolve Issue	_x Yes ____ No *(NOTE: CMS will only review this case if the intervening organization has already attempted to resolve it by working directly with the MAO.)* ____ N/A (No intervening organization involved.)
	If Yes, Name(s) of Individual(s) at MAO.	GENERIC RESPONSE

Dr. James Cruz
Utilization Management
300 Ocean Gate # 200
Long Beach, CA 90802

August 11, 2017

Centers for Medicare & Medicaid Services (CMS)
90 – 7th St
Suite 5-300
San Francisco, CA 94103-6706

Re: CTM Complaint ID: C1702693818, HIC Number: 5

To Whom It May Concern:

The case has been reviewed. The following documents were reviewed for this case:

1. Member's medical record
2. CMS Complaint ID C1702693818
3. Provider Appeal/Claim Payment Dispute Cover Sheet dated 6/1/17
4. Hemet Valley Medical Center Medical Record (22 total pages, including member face sheet, admission history and physical, operative report, Lab test results, MD progress notes).

The Hemet Valley Medical Center has filed a grievance regarding this case. The hospital, in the Provider Appeal/Claim Payment Dispute Cover sheet, states the following:

Patient arrived at the ER, Hemet attempted to make notification to Molina SR. of a possible inpatient admission. Molina failed to respond to the 1 hour allotted per Title 42. 422.113. Patient was admitted due to no response from Molina.

Per the Provider Appeal/Claim Payment Dispute Cover sheet document, the hospital did not file a medical necessity complaint. Therefore, Molina concludes the facility does not dispute this case on the basis of medical necessity. Regarding the Title 42 422.113 regulation and the allegation by the hospital that Molina did not return the hospital's notification call within a one hour time frame, the medical records submitted by Hemet Valley Medical Center to Molina do not support the allegation. The medical records submitted to Molina did not show evidence of any attempted communication between Hemet Valley Medical Center and Molina prior to the member being admitted. The dispute by Hemet Valley Medical Center is without merit.

Sincerely,

Dr. James Cruz

ENCLOSURE

March 16, 2018

CASE SUMMARY

Provider; Hemet Valley Medical Center (HVMC)
Patient Name: **C Martinez**
D.O.B.:
Policy #:
D.O.S.:
Account #:

Dear Ms. Munoz:

Thank you for reaching out to my office regarding the above member.

I have reviewed the attached letter dated August 11, 2017, and signed by Dr. James Cruz.

We dispute the comments made by Dr. Cruz as his statements are inaccurate (We we will also forward our rebuttal to CMS.)

It is apparent Dr. Cruz was unaware of the events that had taken place prior to post-stabilization services requested by the Primary Treating Physician and provided at HVMC.

In Dr. Cruz's correspondence, he states *"Patient arrived at the ER, HVMC attempted to make inpatient notification to Molina Sr. of a possible inpatient admission and Molina failed to respond within 1 hour per CFR 422.113."*

Per his correspondence to CMS, he further states ***"There was nothing HVMC submitted to support the allegation of Molina's failure to respond*** *and Molina's violation of CFR 422.113."*

We respectfully dispute his response. Upon stabilization of the emergency service, HVMC faxed four requests for inpatient authorization for post-stabilization services to Molina and Vantage Medical.

- **On 3/29/16 Vantage responded with a tracking number #383316.**
- **On 3/29/16, Molina responded with a tracking# 1608902739**

At no time:

- **Did either entity authorize services within one hour of the request. (The tracking number constitutes that contact was made, even if it is not an authorization (See Attached-Fax confirmations).**
- **Did either entity request a transfer of the patient nor attempted to assume care of the patient/member.**

We are unsure what Molina assumed would happen to the patient without a timely response (especially since the PTP deemed the patient appropriate for admission in order to cure and relieve the medical issue.)

Here, Molina is attempting to act as traditional Medicare and perform retro reviews, yet they are a Medicare Advantage plan, and is governed by part 422 (which supersedes Medcare law.)

Molina is in violation of:

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) 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 § 422.113(c)(3) is met; and***
>
> ***(iv) Must limit charges to enrollees for post-stabilization care services to an amount no greater than what the organization would charge the enrollee if he or she had obtained the services through the MA organization. For purposes of cost sharing, post-stabilization care services begin upon inpatient admission.***
>
> ***(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.***

Please order them to release the federal funds due the Medicare beneficiary.

Respectfully,

Ryan Cauley
Utilization Management
300 Ocean Gate # 200
Long Beach, CA 90802

March 22, 2018

Centers for Medicare & Medicaid Services (CMS)
90 – 7th St
Suite 5-300
San Francisco, CA 94103-6706

Re: CTM Complaint ID: C18027171597, HIC Number: 5

To Whom It May Concern:

Molina Healthcare takes issue with the legal basis for HVMC's complaint. In their complaint, HVMC makes the very critical mistake of taking a portion of a regulation out of context to support their position. HVMC claims Molina is in violation of CFR 422.113 stating only "[t]he MA organization does not respond to a request for pre-approval within 1 hour [.]" Had HVMC included the entire citation it would become clear that this situation only applies to services that are "administered to **maintain, improve, or resolve** the enrollee's stabilized condition [.]"(Emphasis added). Please see the full citation below.

Per CFR 422.113 (c)(1), post-stabilization services are provided in order to either maintain the stabilized condition or improve/resolve the enrollee's condition. It is, and always has been, Molina's position that an inpatient admission was not necessary to either maintain or improve the enrollee's condition. Moreover, HVMC has not disputed Molina's decision by filing a medical necessity complaint, as is required to raise this issue. Therefore, since Molina determined the services were not medically necessary to maintain, improve, or resolve the enrollee's stabilized condition, the one-hour rule cited by HVMC would not apply here.

If HVMC's understanding of the law was correct then it would significantly undermine MAOs' ability to do their job effectively because they would no longer have much ability to control inpatient admissions following emergency room visits. One hour is hardly enough to receive a fax, perform a competent clinical review, and respond to the hospital. If the failure to respond within that timeframe meant that the hospital's determination was automatically correct it would very likely lead to abuses by hospitals. That is why Molina's interpretation of the law seems to align more closely with what we can reasonably assume the drafters intended, and what would make the best public policy. Nevertheless, Molina responded within only hours of HVMC's fax requesting clinical information, hardly an unreasonable amount of time.

Therefore, since HVMC is not disputing Molina's medical necessity determination, and since the "1 hour rule" referenced by HVMC would not apply to these circumstances given Molina's clinical review determination, there are no further issues that need to be considered. Accordingly, Molina respectfully requests that HVMC's claims be dismissed.

CFR 422.113

(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;

(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;

(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

(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 § 422.113(c)(3) is met; and

(iv) Must limit charges to enrollees for post-stabilization care services to an amount no greater than what the organization would charge the enrollee if he or she had obtained the services through the MA organization. For purposes of cost sharing, post-stabilization care services begin upon inpatient admission.

Sincerely,

RYAN T. CAULEY, ESQ.
ASSOCIATE COUNSEL
MOLINA HEALTHCARE INC.
200
LON
(562
(562
RYA

ENCLOSURE

March 28, 2018

Ryan Cauley
Utilization Management
300 Ocean Gate # 200
Long Beach, CA 90802

Re: CTM Complaint ID: C18027171597, HIC Number

Good morning Mr. Cauley:

We are in receipt of your correspondence dated March 22, 2018, addressed to Centers for Medicare & Medicaid Services (CMS) (a copy was forwarded to ERN).

In your correspondence you state: *"HVMC claims Molina is in violation of CFR 422.113" stating only "the MA organization does not respond to a request for pre-approval within 1 hour."*

You then state *"Molina responded within only hours of HVMC's fax requesting clinical information, hardly an unreasonable amount of time."*

Our position is clear. The one-hour timeframe is to benefit the patient, not the MAOs' nor the providers. Patients need access to care quickly, and this regulation holds both parties accountable ("hardly an unreasonable amount of time") to avoid catastrophic consequences.

HVMC' interpretation of the law is accurate, and ERN agrees. It appears Molina is interpreting the law to benefit the MAO. Even if Molina does not feel it provides enough time, there is no statutory authority that exempts Molina from adhering to it.

Molina must perform according to the requirements of the law which is "1 hour." This is also burdensome on the providers, yet they still send requests for authorizations diligently.

You next state; *"...Had HVMC included the entire citation it would become clear that this situation only applies to services that are "administered to **maintain, improve**, or **resolve** the enrollee's stabilized condition."*

Please advise why a Primary Treating Physician would admit a patient for poststabilization services and care other than **to maintain, improve or resolve the stabilized condition?**

If Molina disapproved of the care, Molina failed to attempt transfer prior to discharge of the patient. If Molina responded within hours, we are unaware of any intent to transfer the patient. The patient was admitted from 3/28-4/2/2018, and I do not see a transfer request or disapproval of care prior to discharge.

As you are aware under 42 CFR §422.113 states:

(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;

(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;

(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

(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 § 422.113(c)(3) is met; and

(iv) Must limit charges to enrollees for post-stabilization care services to an amount no greater than what the organization would charge the enrollee if he or she had obtained the services through the MA organization. For purposes of cost sharing, post-stabilization care services begin upon inpatient admission.

(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.

Here, Molina failed to assume care of the patient within one (1) hour, which means their financial responsibility ended when the beneficiary was discharged. Therefore, the federal funds are due to the emergency provider.

Please be advised that ERN represents many hospital facilities with similar failures by Molina who performs unlawful retro reviews as if they are Traditional Medicare which is improper.

A copy of this correspondence is being forwarded to CMS. If Molina would like to engage in a dialogue of how to resolve these claims where contact was made, and a response from Molina was not received or received untimely, we would be open for discussion.

Respectfully,

Rose Trochez, CMRS
Project Manager
714. 995.6900 Ext.6939
714.995.6901 Fax

Dr. Tyler Jung
Utilization Management
300 Ocean Gate # 200
Long Beach, CA 90802

April 9, 2018

Centers for Medicare & Medicaid Services (CMS)
90 — 7th St
Suite 5-300
San Francisco, CA 94103-6706

Re: CTM Complaint ID: CTM C18027171597, HIC Number: 5

To Whom It May Concern:

The case has been reviewed by the Molina Healthcare of California Chief Medical Officer, Dr Tyler Jung. After careful consideration and applying applicable clinical criteria and judgment the denial in question has been overturned. The following documents have been reviewed for this case:

1. CMS Provider Complaint C1802733144 dated 3/15/2018
2. Medical Records

This is a 74 year old Molina member with a history of hypertension, rheumatoid arthritis, who presented to the emergency department with a day history of vomiting and diarrhea. Her pain radiated to the back. Her vitals were stable; however, she did have a white count of 33.8, and renal insufficiency with creatinine of 2.79. Her CT scan showed diverticulosis. Our member was admitted and placed on antibiotics, kept without anything by mouth, and started on intravenous fluids.

By day 1 her white count was still 20.8, but her renal function was improving. She had one positive blood culture which later was thought to be a contaminant. Our member continued on antibiotics. Our member had an EGD which shoed ulcerative mid distal esophagitis, and erosive antral gastritis. Based on InterQual criteria of 2016 our member did fail to meet criteria for gastrointestinal bleeding and acute level of care; however, the composite of her symptoms and findings are open to medical judgment. Thus, after careful deliberation and reviewing medical records, I will overturn the denial for acute level of care based on medical judgment.

Sincerely,

Dr. Tyler Jung

ENCLOSURE

YOU FIGHT FOR THEIR LIVES

WE FIGHT FOR YOU

ERN

NCRA

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