Best Practices in 2025 for Successful Appeal of Medicare Advantage Inpatient Post-Acute Denials!

June Stark, RN, BSN, MEd
Joanne Kinlay, RN, BSN, MMSc

Purpose

To present the Appeal Evidenced Based Protocol, created over a 3-year period, which consistently provided an approach, including strategies for overturning a Medicare Advantage post-acute denial, ensuring a patient's healthcare coverage rights, decreasing length of stay and maximizing hospital throughput.

Lecture Objectives

- Discuss the legal, ethical and health disparity concerns of the Medicare Advantage Denials for a patient's post-acute stay and the case manager's role in appeal (CCMC-Principle 2 – CM will respect the rights and inherent dignity of all of their clients)
- Explain the benefits of overturning denials in your facility, including decreased LOS, hospital throughput and financial benefits.
- Design a plan for how to implement the Successful Appeal EBP Protocol in your own practice, and in your department

Disclaimer

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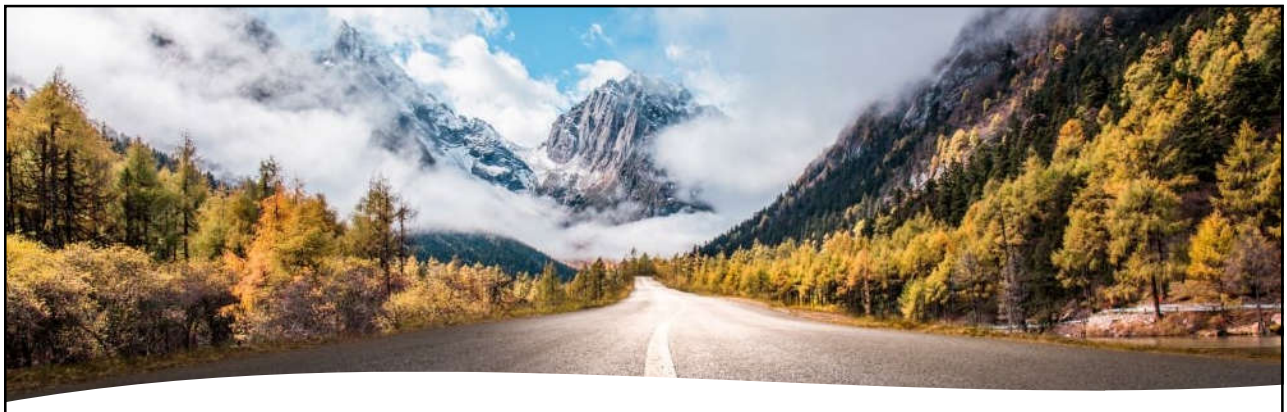


Started our 3-year journey for EBP Appeal, a long rewarding road.....

.....resulting in significant outcomes important for patients and their families!

The Case Study that started this.....

- A seriously ill patient from out of state, gained insurance pre-admission authorization for a hospital stay, because the surgical care required, was not available in her state.
- Prior to this admission, her husband had used an “insurance broker” to purchase what he was told was the best insurance for his wife’s complex condition. It was a Medicare Advantage (MA) plan. After a 30-day LOS, the patient’s physician said she needed LTACH for rehab.
- The LTACH accepted the patient, but the MA insurance company denied her the LTACH stay. Denied her post-acute Medicare rights.

The Case Study that started this, continued.

- CMS/Medicare has made it clear all Medicare Patients must be treated the same. A traditional Medicare patient doesn't need a pre-auth for post-acute discharge from hospital care. They need an MD order and have the ability to meet the rehab/Home care review criteria
- The husband appealed the Medicare Advantage Plan decision and lost. He was given no other options. He was desperate and distraught; he turned to the case manager to help navigate.
- The Case Manager, wanted to support the patient and her hospital throughput. **The patient had no other option that would return her to a meaningful level of functioning**.

The Case Study that started this, continued.

- The Case Manager called her Educator for advice.
- The Educator heard the urgency of an intervention for all involved. As the Case Manager described the situation, she heard the standards of professional Case Management conveyed by the Case Manager. Advocacy, ethical principles, high practice standards. ***(Principle #2 CCMC Code of Conduct-respect dignity and inherent rights of clients***)
- Together the Case Manager and Educator (who had a strong UM appeal background), worked on this case every day.
- The husband reported the denial to the Department of Insurance in both states and to the Attorney General in his home state. He also issued a complaint of dissatisfaction to the MA plan.

The Case Study that started this, continued.

- The turning point occurred through the collaboration and determination of the Case Manager and Educator.
- Researching every opportunity, they learned that a MA insured patient **is already enrolled in Medicare** and a request by the patient or her spokesperson to cancel her MA plan and switch to traditional Medicare resulted in a switch on the first day of the next month.
- The husband agreed and the patient he switched back to Traditional Medicare and the patient was transferred to LTACH.
- The positive outcomes of their work together incentivized them to continue their collaboration resulting in the EBP Appeal Protocol.

Case Study Outcome:

The development of the Appeal EBP Protocol emerged from this case increasing from one patient to 83 patients. Case managing these patients led to the establishment of successful appeal approaches for overturning denials and when unable to overcome barriers, then implementing strategic interventions resulting in a safe discharge alternative.

Reasons Why to Appeal Denials

- Case Manager's standards of practice promote advocacy and participation in appeals. Plus, hold to safe discharge plans by professional standards and COPs.
- Healthcare is a patient's right. Case Managers maximize a patient's healthcare benefits.
- CMS states that Traditional or Original Medicare and the Medicare Advantage patient must be treated the same, but limited guardrails to ensure care equity.
- MA Plans deny care...CMS states when appeal likely will overturn, but most denials are not appealed (approximately 10% appealed).

Case Management Society of America (CMSA) Standards of Practice

The Case Management Society of America (CMSA) has established Standards of Practice that emphasize the case manager's role as a client advocate. **These standards clearly state that when conflicts arise, the needs of the client must take priority over other considerations.**

Commission for Case Manager Certification (CCMC) Code of Conduct

Principle 2: respect the rights and inherent dignity of all clients

The American Association of Case Management (ACMA)-Scope of Practice

Case Management will:

- **proactively prevent medical necessity denials** by providing education to physicians, staff and patients, interfacing with payers and documenting relevant information.
- **provide the clinical information necessary for the appeals process of cases for which a denial of care or services has been received.**
- **utilize a process to escalate and resolve a denial to secure payment for the necessary care and services provided to the patient.**

As a reminder...COP for Discharge

CMS – conditions of participation § 482.43 Condition of participation: Discharge planning.

"...**The hospital must have an effective discharge planning process that focuses on the patient's goals and treatment preferences** and includes the patient and his or her caregivers/support person(s) as active partners in the discharge planning for post-discharge care.

The discharge planning process and the discharge plan must be consistent with the patient's goals for care and his or her treatment preferences, ensure an effective transition of the patient from hospital to post-discharge care, and reduce the factors leading to preventable hospital readmissions...."

Healthcare is a Right: A Brief Medicare Review Moment

- The right to health is recognized in the Universal Declaration of Human Rights (1948) and the World Health Organization (WHO) Constitution (1948).
- US Healthcare Rights include appropriate access to Medicare, Medicaid, CHIP which are regularly navigated by case managers especially at d/c
- Eligible for Medicare = worked 40 work quarters or 10 years, paying Federal Insurance Contributions Act (FICA), for example in 2025 1.5% of our taxes contributes to Medicare.

A Brief Medicare Review Moment, continued

- Our FICA Taxes pay for Medicare and Social Security: not an entitlement.
- Approximately 1.45% of your earnings go to FICA Taxes which pays for Medicare
- Total FICA payment for Medicare and Social Security average is $100,000 and the longer worked the higher FICA payments

Traditional Medicare vs MA Plans.

- Traditional Medicare started in 1965 by President Lyndon Johnson secures for patient's healthcare rights, including the post-acute benefits without pre-authorization.
- President Clinton in 1977 started Medicare Advantage (MA) Plans which used Medicare dollars to contract with Commercial Insurance Companies.

CMS and other Government Rules and Regulations: The Final Rule 2024

- The CMS Final Rule states: MA Plans must cover the same benefits as Fee-For-Service (FFS) Medicare, including, Part A (hospital insurance) and Part B (medical insurance) benefits.
- The CMS FAQ's for Medicare Advantage Final Rule 2024: An MA organization cannot deny admission to a post-acute setting and/or redirect care to another setting, if the patient is being discharged from an acute hospital meets criteria, with a physician order and would be covered under Traditional Medicare (i.e., Skilled Nursing Facility, Acute or Long-Term Care Hospital).

Why CMS Changed the Medicare Advantage Rules?

- Reported on Feb 20, 2024- Approximately **33.4 million people** (51% of those eligible for Medicare) were enrolled in a Medicare Advantage plan .....this is increased from 47% in 2021.
- CMS/Government aware of the MA inequities compared to Traditional Medicare...restrictions placed but largely ignored by MA plans.

Medicare Advantage Denials Jump 56%, Commercial Denials 20%

- Patients on MA plans are often denied care at above-average rates. Between 2022 and 2023, denials rose more than 20 percent for private, commercial claims **and nearly 56 percent for MA claims**, the American Hospital Association reported in September (Newsweek)

- In 2023, the government paid $462 billion to Medicare Advantage plans, which is 45% of total Medicare spending. This is an increase from 29% in 2017

The Facts: most do not appeal, but overturn rates are high!!!

Low appeal rate:

CMS Studies show that only a small percentage of denied claims are actually appealed by providers, indicating a potential issue with awareness of the appeals process or the perceived difficulty in successfully overturning a denial.

The majority of the 3.4 million denied prior authorization requests were not appealed, similar to previous years. In 2019, just 7.5% of all denials were appealed. That share increased somewhat in 2020 to 10.2% and was relatively stable in 2021 (10.6%) and 2022 (9.9%) (Figure 4).Aug 8, 2024

The Facts: most do not appeal, but overturn rates are high!!! continued

Reasons for not appealing:

Some possible reasons why providers might not appeal denials include the administrative burden involved, uncertainty about the chances of success, or concerns about further frustrating patients.

Impact on patient care:

When denials are not appealed, it can potentially lead to patients being denied necessary care or facing unexpected out-of-pocket costs.

Family Appeals

Consumers are not provided any information about how reliably marketplace plan options pay claims and plans reporting high claims denial rates do not appear to face any consequences.

How often are family appeals successful?

- In 2023, insurers overturned 56% of family appeals

Report on Medicare Advantage plans.

Office of Inspector General report on MA denials: Appeal outcomes from 2014-2016

"...Although there are resources available to help beneficiaries navigate the appeals process, advocacy groups report that **the process is often confusing and overwhelming for beneficiaries, particularly those struggling with critical medical issues.**

Although overturned denials do not necessarily mean that MAOs inappropriately denied the initial request, each overturned denial represents a case in which beneficiaries or providers had to file an appeal to receive services or payment that are covered by Medicare. **This extra step creates friction in the program and may create an administrative burden for beneficiaries, providers, and MAOs. This may be especially burdensome for beneficiaries with urgent health conditions.**

Report on Medicare Advantage plans, continued.

"…Further, although overturned payment denials do not affect access to services for the associated beneficiaries, the denials may impact future access.

Providers may be discouraged from ordering services that are frequently denied—even when medically necessary—to avoid the appeals process…"

The Expedited "Fast" Appeal. Who should appeal? The Provider or the Family?

Limitations of a Family Appeal:

- Family does not have access to supporting, up to date clinical documents to send. (*Insurance asks for evaluations to be within 48 hours)
- English is not always their first language, so they are at a disadvantage in navigating the obstructive appeal process.
- Family rarely has medical knowledge.
- Family does not know about different rehab levels of care.
- Some family's hire legal representation to assist them in their family appeal. Who should pay for that? This is not health-equity!

Why do insurance companies deny post-acute rehab?

- Most Payors reimburse by a Diagnosis Related Group (DRG) which is a flat rate for the hospital stay. By denying an appropriate rehabilitation stay, the patient usually remains in the hospital longer and the additional cost of the rehab is avoided by the Insurance company.
- MedPAC estimates that Medicare Advantage plans were overpaid by $27 billion (6%) in 2023, and, also estimated that MA beneficiaries had significantly lower expenditures than patients remaining in Traditional Medicare with similar risk factors.

Be Aware Using Ai for authorizations

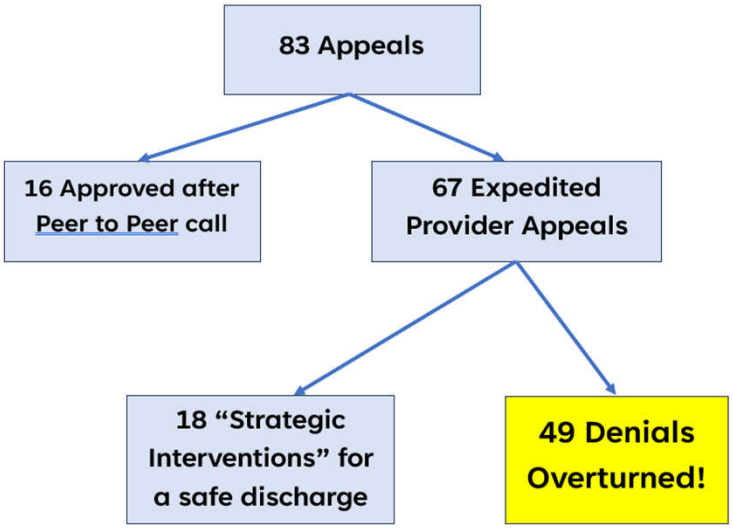
Newsweek Magazine 11/23/24

Initial decisions on authorization approvals are often being made by Artificial Intelligence programs.

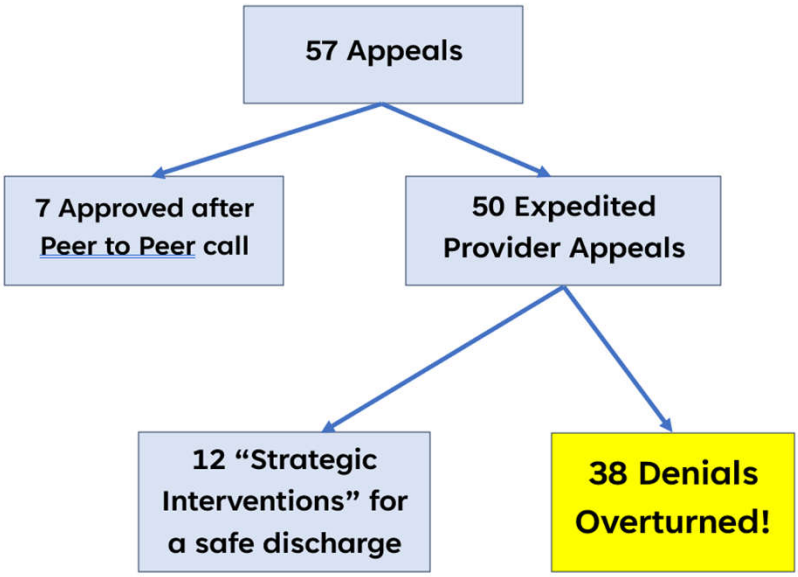
"...In July 2023, Cigna was hit with a class action lawsuit over an algorithm that reportedly rejected more than 300,000 claims in two months—spending **about 1.2 seconds on each**.....

.....In November 2023, a lawsuit against UnitedHealthcare claimed that the company deployed an AI tool developed by NaviHealth (itself an arm of the company's health services business, Optum) to deny care to elderly Medicare Advantage (MA) beneficiaries. Weeks later, Humana was served papers for allegedly utilizing the same NaviHealth tool**, which had a known 90 percent error rate**, according to the initial lawsuit...."

Evidence Based Practice– All InsurancePlans



Results of Appeals for Patients with Medicare Advantage Plans



Which levels of rehab did we get all patients to after a successful P2P call?

We moved 16 patients to:

- 6 patients to LTACH
- 3 to Acute level (2MA)
- 7 to Skilled Nursing Facility (5MA)

Which levels of rehab did we get all patients to after a successful Expedited Provider Appeal?

We moved 49 patients to:

- 14 to LTACH (10 MA)
- 14 to Acute (11MA)
- 21 to SNF (17MA)

Strategic Interventions- When the Appeal Fails

COMPLEX CASE MANAGEMENT

Requires in some circumstances, extreme measures prior to discharge, in effort to capture the highest quality of patient care possible.

Examples of Strategic Interventions:

- Sent patient to a lower level of care.
- Increased therapies while inpatient, then home with services
- Encouraged family to change insurance back to traditional Medicare with a secondary insurance, to take effect the first day of the next month.

Length Of Stay after authorization was submitted. Appeals increase LOS, but not appealing increases it more!!!!

Patient was ready for rehab- average number of days

• Peer to Peer Calls	3.6 days
• Expedited Provider Appeal	7.6 days
• Strategic Interventions	18.2 days

Length of Stay – Medicare Advantage plans (n=57)

Patient was ready for rehab - average number days
We were appealing for these levels:

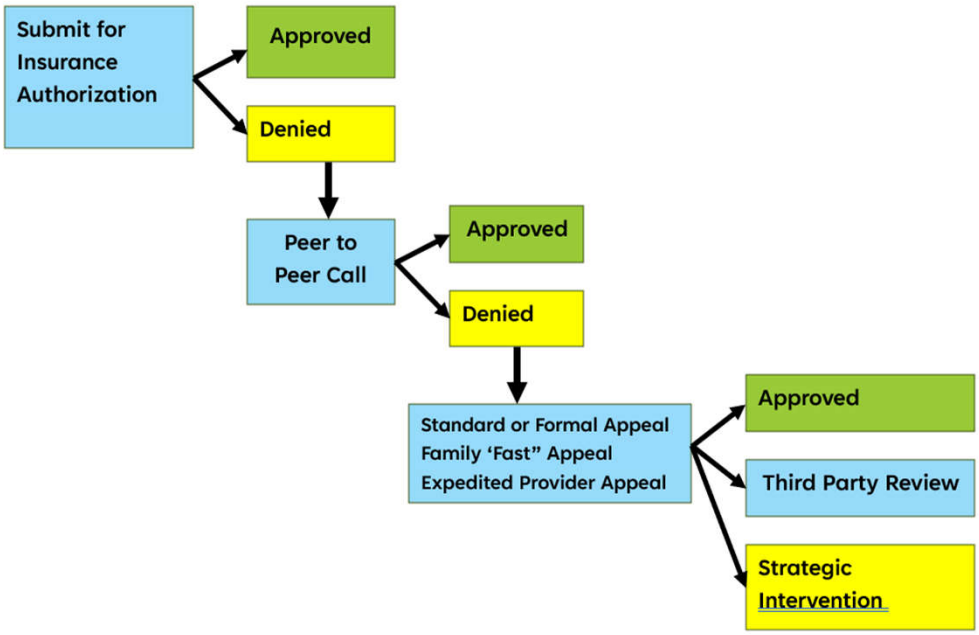
- LTAC (n=18) 12.6 days 8=SI **8.7 adj.**
- Acute (n=16) 6.5 days 3=SI **6.6 adj.**
- SNF (n= 23) 6.7 days 1=SI **5.8 adj.**

Consider……if the patients had traditional Medicare, these extra nights would have been avoided!

MA Plans – Timeline for the Appeal with the 2024 Final Rule? (SI data excluded n=12)

	Pre 2024 SI=4		2024 *After CMS Final Rule SI=8	
Level of Care Requested	Total patients	Average LOS	Total Patients	Average LOS
LTACH	**6**	**9.8**	**4**	**7**
Acute	**7**	**6.8**	**4**	**7**
SNF	**12**	**4**	**8**	**7.7**

The Post Acute Appeal Process



The Steps of the Appeal EBP Protocol

- Be Proactive- anticipate risk of denial
- Identify Insurance Company Appeals Processes and anticipate frequent appeal process changes
- Peer to Peer Practices
- Request Expedited Appeal
- Components of Successful Appeal Letter
- Incorporate CMS Final Rules and Regulations to hold Insurances Accountable
- Plan Post-Shift (24/7) Case Manager/UM Coverage to be available for Insurance Provider (can loose appeal right, loose case and decrease hospital throughput)
- Implement Strategic Case Management Planning if lose appeal—this is an alternative case management plan
- Create pathways to government and national organizations to facilitate appeal in real times and to promote insurance provider compliance

7 Steps to Peer to Peer Calls

Step 1 - Be Proactive

- On admission – look at the patient's insurance and anticipate the patient's discharge needs.
- If the authorization is denied, be committed to the appeal process; be determined to overturn denial and passionate in pursuit of the outcome!

Rationale:

- You may need to reach out to your financial department to verify the insurances are listed correctly.
- Anticipate a need for a Peer to Peer (P2P) Appeal, and the potential need for an Expedited Provider Appeal.

Step 2 – Be Vigilant!

- Once the facility has gone for authorization, be vigilant for the need to do a P2P call.

Rationale:

- Rehab facility gets notified by the Payor with critical information and may not promptly let you know. Keep asking them if they have heard anything and make sure they have your contact details.
- There can be unrealistic deadlines set by Payor for the Peer-to-Peer call (e.g. a 3 hour window), that gets overlooked during a busy day.
- Some Payors are not open over the weekend. We have been told on a Friday

  "...You can do a Peer to Peer call on Monday..."
- Even after the call, some Payors claim they need up to 72 hours to make a decision.

Step 3 - Choose the right Clinician.

- Be selective about choosing an effective Clinician.
- Ask a Clinician on the team with a positive overturn track record, who is also familiar with the patient.
- Make sure they willingly agree to participate. Avoid using those who are reluctant to make the call!

Rationale:

- If the clinician is not confident going into the call, it will likely not be successful.
- Clinicians are rounding on their patients, or in clinic. It is inconvenient for them to be available to make the call and frustrating trying to get through to the Payor with their call back information.

Warning signs....

"....I never win these things!...."

"....I don't want to say something that is discoverable in court!...."

"....Your doctor didn't seem to want to talk about his patient!..."

Step 4 - Coach the Clinician

- Focus on the **Medical Necessity** of why this patient needs rehab.
- Do not deviate; stay focused on the patient's medical needs.
- Why is the rehab stay the only option for this patient?
- Do not suggest the patient needs rehab for social reasons.
- This is not the time to express personal opinions about the authorization process or the insurance industry.

Rationale:

- The Peer to Peer call is brief.
- Offending or attacking the MD representing the Payor will not help overturn the denial.

Step 5 - Educate the Clinician

- Use email and phone to encourage and coach the Clinician on the exact rehab levels of care (LTCH, IRF, SNF) that this patient needs.
- Email a brief summary of levels to the clinician.
- Empower the clinician to be confident in the level of care they are prescribing for the patient.

Rationale:

- Even the most experienced clinician is unaware of the rehab levels and requirements.
- Sometimes the MD is inexperienced with levels of care (e.g. approving a trach/vent patient for Acute level, instead of LTACH. Acute will not do vent weaning.)

"...I didn't know there were 3 levels of rehab..."

A Sample of Levels of Rehab for Clinician Coaching

- LTACH - average length of stay is 25+ days. The patient needs complex medical care and therapies up to 3 hours per day. 24/7 physician and nursing available.
- IRF – average length of stay is 15-21 days. The patient needs to actively participate in therapies for up to 3 hours per day
- SNF – average length of stay is 25 days. Therapies for 1-2 hours per day

Step 6 - Be Persistent!

- The P2P is the first step in the appeal process, but if it is not offered, you should request it. State that it is a patient's appeal right, especially if a Medicare Advantage plan.
- Persist! If the Payor continues to decline this Appeal option, they may change their decision and offer a P2P opportunity.

Rationale:

- We strongly recommend participating in the P2P if given the opportunity. If denial overturned, an immediate authorization for a post-acute discharge is provided. Do not skip the P2P step if it is offered
- Overturning the denial at the P2P stage will reduce the Length of stay

Step 7 - Act Fast! Do not give up!

- If the denial is overturned, move quickly to transfer the patient to rehab that day.
- If not overturned, call the Payor ASAP!
- Notify them you are going to file an **Expedited Provider Appeal.**
- Ask for the phone & fax number of their Appeals Department.
- Try to fax the Expedited Provider Appeal, the day the P2P is denied.
- Order expedited therapy evaluations if they are not within 48 hours.

Rationale:

- Every day you wait to appeal, adds an unnecessary night.
- Even though you provided therapy evaluations for the authorization, and it is the Payor's fault that the P2P process has postponed the discharge, they will likely ask for updated therapy evaluations.

7 Steps to the Expedited Provider Appeal

Step 1 - Cover Letter

- Write a cover letter to send with the clinical notes.
- Don't just send clinicals without an explanation of what you are asking for.

Rationale:

There must be no doubt about:

- the facility you are from, and which facility you are trying to send the patient to.
- the provider you are representing.
- the level of rehab you are asking for.

Step 2 – The Cover letter should include:

- **Write "Expedited Provider Appeal"** in bold, at the top.
- The NPI of both the provider and your facility.
- Patient's DOB and insurance ID

Rationale:

- If you do not specify that you are filing an Expedited Provider Appeal, it will be processed as a standard appeal.
- Avoid any reason for the appeal to stall. Provide them with all the details they will ask for. Otherwise, they will call after hours or over the weekend to confirm these details.

Step 3 - What should the cover letter say?

- Make it concise and personalize to the patient.
- Do not just copy and paste from the notes! Do not use "nursing short hand" and avoid acronyms and abbreviations.
- Be very clear about the level of care you are appealing for. Justify the level of care requested. Why does the patient need that level and why can't their needs be met at a lower level?

Rationale:

- Should be brief, to keep their attention.
- Your acronym is not my acronym! Do not assume they know what you are talking about or have your level of medical knowledge.
- The first representative is compiling a brief report for their MD.
- This is your chance to rationalize for the correct level of rehab.

Step 4 – Refer to Healthcare Policies

Medicare Advantage plans:

Medicare states, "*The federal government requires Medicare Advantage plans to cover everything that Medicare parts A and B covers*." If this patient had traditional Medicare, she could access a Long-Term Acute Level of Care (LTAC) immediately, without an authorization!

Non Medicare Advantage Plans:

CMS which sets the medical standards for healthcare in the US, established that hospital physicians are the decision-maker in a patients care, state that "*...all treatment decisions for beneficiaries are based on the medical judgment of physicians and other qualified practitioners. This CMS rule does not prevent the physician from providing any service at any hospital or facility, regardless of the expected duration of the service...*"

Step 5 - Choosing Clinical notes

- Depending on the Payor and plan, you may be asked to provide an "Appointment of Representative" (AOR) form (CMS #1696). *Fax it at the front of the notes, after the cover letter.
- Send PM&R (Physical Medicine & Rehabilitation Specialist) notes supporting level of care, if you have them.
- Only send relevant, supporting notes.- H&P, most recent physician's & therapy notes.
- List the notes that you are faxing to them.

Rationale:

- Make sure notes are in the most impactful order.
- If they requested the AOR, there will likely be a follow up call (after hours and weekends) to ask you about it.
- Don't send notes that do not support the level of care you are requesting!

Step 6 - Follow up!

- Call the Payor and confirm they received the faxed appeal.
- Try to get a confirmation number for all your conversations with the Payor.

Rationale:

- Did they give you the correct fax number for the appeal?
- Did it go to the correct department for that plan?
- Did the appeal get "wiped" from their system?

Step 7 - Be Accessible

- Be accessible! The Payor will call after hours and on weekends!
- They have a 72 hour turn around for a decision
  - If appeal is submitted Wednesday, the result is due by Sat;
  - Thur-→Sun;
  - Fri -→Mon.
- Consider giving your cell phone as the contact number, if there will not be a consistent person to take calls for the next 72 hours.

Rationale:

- They will always call on a Friday night or Saturday morning.
- One overturn decision was left on my desk phone Friday at 6:30pm.

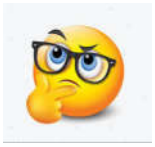
Be accessible, continued.

One of the larger Insurance companies was reading you a disclaimer when you submitted an appeal.

"...If you are submitting on a Friday or over the weekend and are not available for follow up questions or documentation

....this appeal will be denied..."

Since the 2024 MA Final Rule-



- Appeal Process feels even more aggressive since the Final Rule came into affect.
  "....this Medicare Advantage plan does not offer a Peer to Peer call opportunity..."
- Promoting the "Family Fast appeal" and not mentioning that a provider can appeal. Ask yourself...***why would they do that?***
- Sending the Expedited Provider Appeal to 3rd party reviewer as soon as we submit it, instead of having their MD review it.

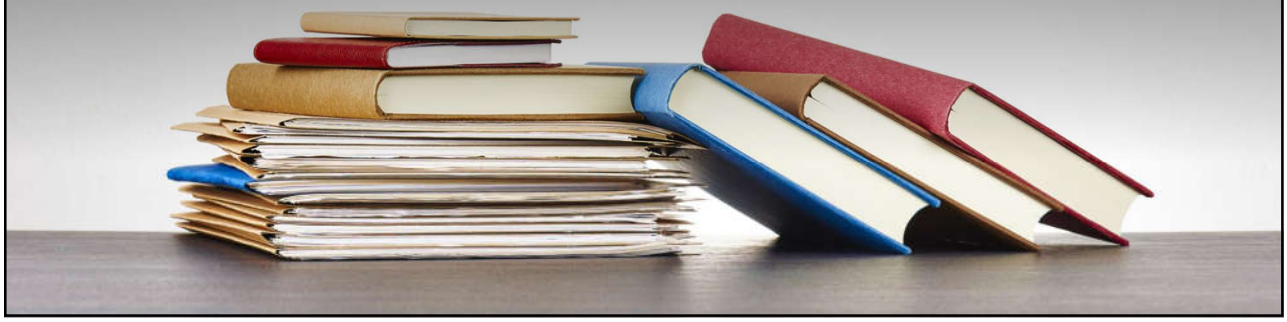
Be aware Payor Changes the Playing Field

In an effort, to be organized, a Case Manager may learn the rules and processes of a Payor.....but be aware the processes can at anytime suddenly change.

For the 1st few months of our project, the Appeal Overturn Rate was 100%, but often and frequently the Payors Appeal processes changed and when they did, our success rate fell as we needed to learn the new approach.

Anticipation of the appeal process steps is critical, because the Payor's timeline determines the availability of appeal rights. If late with P2P or Expedited Appeal response, the appeal rights are withdrawn.

3 Case Studies



Case Study 1 – Medicare Advantage Plan - 2024

- 65 year old lady with encephalopathy and epilepsy. **Denied for Acute level of rehab.**
- We were notified of the P2P opportunity at 4pm, however the message was missed by the Case Manager. P2P call was due by 10:30am next day.
- P2P called made - continued to be denied. Family and CM were told the family could file a "fast appeal". ***"…We will approve SNF level care, but only if the family request it within the next 24 hours…."***
- We filed an Expedited Provider Appeal.
- The Payor called to request an AOR form (Spanish speaking patient).
- Two days later, Easter Sunday, they called my cell to say the appeal for Acute rehab had overturned the denial.

Patient stayed an extra 5 nights after the rehab went for auth.

Case Study 2 – Medicare Advantage Plan - 2023

- Lung transplant patient, trached and vented. English was not family's first language.
- Authorization for LTACH was denied.
- P2P call – Attending was unaware of different rehab levels and agreed to Acute level of rehab. We filed an Expedited Provider Appeal.
- Payor sent case to a third party reviewer, who supported the denial.
- Team did not want her to go to Acute level of rehab- (*Acute rehab does not wean a ventilator!) No other level of rehab would have been appropriate for this patient.
- She stayed in our acute facility to rehab; was weaned off the ventilator and the trach was decannulated. She went home with services.
- Family then changed insurance from the Medicare Advantage plan back to Traditional Medicare, in the event she needed further hospitalizations (and rehab stays).

Patient stayed an extra 24 nights after the rehab went for auth.

Case Study 3 – Commercial Plan - 2024

- Patient in their 60's with Myasthenia Gravis; 2 week admission; PT/OT and Physicians recommended Acute rehab. **Denied for Acute rehab.**
- Family were told they could do a Family "Fast" Appeal. Hospital was in Code Capacity and the Case Manager felt pressure to discharge, and patient agreed to leave that day, while the family appeal was in process. The patient was discharged home with services.
- Patient was readmitted 6 days later to the ICU; requiring intubation. **Additional 20 night stay.**
- Then discharged to Acute rehab.

Our Final Goal now.....

- To share the Appeal EBP Protocol with our Case Management colleagues.
- We welcome you to contact us to support your efforts.

  junestark13@outlook.com
- This is our third presentation, we presented at ACMA Boston 2023, National CMSA 2024 in Providence RI and now CMSNE 2025

Q & A

We welcome your questions and comments!

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Helpful Resource: Contract Year 2025 Medicare Advantage and Part D Final Rule (CMS-4205-F)

Apr 04, 2024
Medicare Part D
Policy

https://www.cms.gov/newsroom/fact-sheets/contract-year-2025-medicare-advantage-and-part-d-final-rule-cms-4205-f

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