No matter what state you work in, there will be giants.”

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

At ERN, we understand the significance of quality health care and its reliance on financial viability. With the support of Wickline v. State, our primary goal is to advocate for medically appropriate health care and to ensure the faithful and ardent enforcement of all public health and safety laws for the protection of patients, physicians, hospitals and other emergency providers; because ultimately, we recognize that every case represents a human life.
Healthcare is a law to be defended.

Public policy and prompt payment laws are enacted for public good. They ensure patient access to medically necessary care when needed.
It is the public policy in the State of Arkansas that a physician/provider-patient relationship is paramount and should not be subject to third-party intrusion;

(Arkansas Code Title 23 § 23-66-802.)

THE PURPOSE OF THE LAW IS TO BRING ME TO A PLACE OF RECOVERY.
To “advocate for medically appropriate healthcare,” you must MASTER three key objectives:

✓ 1st Objective:
You must learn how to connect your payment concerns to level of care.

✓ 2nd Objective:
You must learn how to audit cases and determine if non-compliance of administrative laws is indicated. (42 CFR Part 422, 29 CFR §2560.503-1, 38 USC §1725, etc.)

✓ 3rd Objective:
You must learn how to identify unfair payment and denial trends.

The power inequities that exist between health plans and providers demand we create a “culture of compliance” to challenge and protest any practice, policy or decision that impairs our ability to render quality care to our patients.
Unfair Payment Practices

ACCESS TO CARE DENIALS

Unfair Payment Practices

HMO EMERGENCY SERVICE DENIALS.
(4) "Emergency healthcare service" means a healthcare service provided in a fixed facility in the first few hours after an injury or after the onset of an acute medical or obstetric condition that manifests itself by one (1) or more symptoms of such severity, including severe pain, that in the absence of immediate medical care would reasonably be expected to result in:

(A) Serious impairment of bodily function;
(B) Serious dysfunction of or damage to any bodily organ or part; or
(C) Death or threat of death;

(6)(A) "Healthcare service" means a healthcare procedure, treatment, or service:

(i) Provided by a facility licensed in this state; or
(ii) Provided by a doctor of medicine, a doctor of osteopathy, or by a healthcare professional within the scope of practice for which the healthcare professional is licensed in this state.

(B) "Healthcare service" includes the provision of pharmaceutical products or services or durable medical equipment;
Laws and Regulations


(a) A utilization review entity shall not require prior authorization for prehospital transportation or for provision of an emergency healthcare service.

(b)(1) A utilization review entity shall allow a subscriber and the subscriber's healthcare provider a minimum of twenty-four (24) hours following an emergency admission or provision of an emergency healthcare service for the subscriber or healthcare provider to notify the utilization review entity of the admission or provision of an emergency healthcare service.

(b)(2) If the admission or emergency healthcare service occurs on a holiday or weekend, a utilization review entity shall not require notification until the next business day after the admission or provision of the emergency healthcare service.

(c)(1) A utilization review entity shall cover emergency healthcare services necessary to evaluate and assess the health condition of a subscriber to stabilize a subscriber.

WHAT IF YOU CANNOT STABILIZE?

Dear Mr. Norwood,

November 8th, 2009
Ed Norwood, Pres
RNHA
ednorwood@ernenterprises.org

My husband and I would like to thank you for your time and help with our ongoing issue with our insurance company.

I was taken to our small rural community hospital on Friday, January 10th, 2009 for severe abdominal pain and vomiting, after about 6 hours in Tehachapi Hospital and after lab work and a cat scan the ER doctor came in and said I had a large ovarian cyst and acute appendicitis and needed to go to another hospital via an ambulance. By the time I was transported it was 4am Saturday morning. I arrived at Bakersfield Heart Hospital and was promptly taken for surgery. We decided not to have the appendix removed just yet and had the cyst removed. We came home on Sunday afternoon and I was then wheeled into surgery. I spent from Saturday to Monday in Bakersfield Heart Hospital.

Then in August of 2009 we received a bill from Bakersfield Heart Hospital in the amount $9,749.00. I then promptly started making phone calls. I called Bakersfield Heart Hospital and that is when I found out they are an out of network hospital. I then called my insurance company that I could contact Management Healthcare of California. They also filed an appeal and was also denied. I also spoke with Tehachapi Hospital several times. I explained to all parties that had known that I was being sent to an out of network hospital that I was 22 weeks pregnant and if I would have had the baby in Bakersfield Heart Hospital I would have ended up in the NICU.

I then called Agua Caliente as well as the AGWAwhich is the underwrites of our insurance company. I had been given the run around, everyone I was told to call would tell me they could not help me. I finally was able to get to the AGWA. She put me in contact with Mr. Norwood and this proved to be a very happy solution. Mr. Norwood made a few phone calls and by the end of the week this situation was resolved.

My husband and I are even getting our co-pay back.

Sincerely,

Mrs. Lisa A.
(d)(1) The determination by a utilization review entity of medical necessity or medical appropriateness of an emergency healthcare service shall not be based on whether the emergency healthcare service was provided by a participating or a nonparticipating healthcare provider.

(2) Restrictions on coverage for an emergency healthcare service provided by a nonparticipating healthcare provider shall not be greater than restrictions that apply on coverage for an emergency healthcare service provided by a participating healthcare provider.

Under existing federal and state law, at a minimum, plans shall pay for those services provided by an emergency department, including, at a minimum, a medical screening, examination and evaluation to determine if an emergency medical condition exists. At a minimum, the plan must reimburse the emergency department and, if applicable, its affiliated providers for Physician services at the lowest level of evaluation and management CPT (Physician's Current Procedural Terminology) codes (unless a higher level is clearly supported by documentation), and for the Facility fee and diagnostic services such as laboratory and radiology.
Failure to pay for emergency services and care exacerbates an already fragile healthcare delivery system.

HMO POSTSTABILIZATION SERVICE DENIALS.
Laws and Regulations

(e)(1) If a subscriber receives an emergency healthcare service that requires an immediate post-evaluation or post-stabilization healthcare service, a utilization review entity shall make an authorization within sixty (60) minutes of receiving a request.

(2) If the authorization is not made within sixty (60) minutes, the emergency healthcare service shall be approved.

Trend Denial Workshop

• CONSTRUCTING THE APPEAL
• DENIAL REASON CODES
When Payors Won’t Listen…

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

What are payors looking for in an appeal letter?

1. Identify the denial reason.

2. Determine the jurisdiction.
   Examples: MA, ERISA, State sponsored.

3. Create transition statement of facts with a clear explanation of the disputed item, including the provider's position is contained in the appeal letter.

   ER No Pay, Postabilization:
   "We dispute (Payor's name) denial of (Client's name) on (date) as shown and described below."

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

4. Attach exhibits to each fact.
   Example:

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

5. Locate administrative laws to support each argument.

   Don't just don't copy and paste laws, hoping they will scare the Payor. Know your position.

6. Land the plane (impose deadlines.)
   "Please release the federal funds intended for the Medicare beneficiary on or before (deadline date) to prevent any unnecessary regulatory complaint action."
MCO-Medicaid Poststabilization Service Denials.

MCO-Medicaid Definitions

Post-Stabilization Care Services: Medically necessary covered services, related to an emergency medical condition, that are provided after an enrollee is stabilized, in order to maintain the stabilized condition, and for which the MCO is responsible when: (i) the services are service authorized; (ii) the services are provided to maintain the enrollee's stabilized condition within 1 hour of a request to the MCO for service authorization of further post-stabilization care services; (iii) the MCO could not be contacted; (iv) the MCO did not respond to a service authorization within an hour; or (v) the MCO and treating provider are unable to reach agreement regarding the enrollee's care (42 CFR 438.114(e), and 422.214).
MEDICARE ADVANTAGE ER AND POSTSTABILIZATION SERVICES AND CARE LAWS

MEDICARE HMO – 42 CFR § 422.113 (b)(2) The MA organization is financially responsible for emergency and urgently needed services—
(i) Regardless of whether the services are obtained within or outside the MA organization;
(ii) Regardless of whether there is prior authorization for the services.
(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.

**MEDICARE HMO - 42 CFR 422.113 (c)(2)** MA organization financial responsibility. The MA organization—
(i) Is financially responsible (consistent with Sec. 422.214) for post-stabilization care services obtained within or outside the MA organization that are pre-approved by a plan provider or other MA organization representative;
(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 Sec. 422.113(c)(3) is met;

(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.
Dear Business Office Manager,

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

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

The basis for the decision is as follows:

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

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

UnitedHealthcare, a Medicare Advantage Organization, and its contracting providers are obligated to reimburse non-contracting providers at the same rate a provider would be paid if the patient were enrolled in original Medicare. According to Part 42 of the Code of Federal Regulations, Section 422.314, any non-contracted provider must accept as payment in full the amount it would collect if the beneficiary were enrolled in original Medicare.

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

Sincerely,

From: "Duarte, Ana M (CMS/CMSPO)" <ana.m.duarte@hrsa.gov>
Date: 07/24/2014 10:52 AM (GMT-08:00)
To: Ros E. Trochez <rosetrochez@ernenterprises.org>
Cc: Ed Norwood <ednorwood@ernenterprises.org>
Subject: ERN/TRAF - Summary of Complaint/ Memorial Hospital of Gardena/ Password to follow

Ms. Trochez,

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

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

40.2.3 - Notice Requirements for Non-contract Providers
(Rev. 185, Issued: 04-20-12, Effective: 04-20-12, Implementation: 04-20-12)

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

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

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

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

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

From: Dalli Haley
Sent: Friday, Jul 25, 2014 2:14 PM
To: Cc: E:
Subject: RE: RE: ERN/TSF/Summary of Complaint/ Memorial Hospital of Gardena/ Password to follow
Attachments: 3640-mbg cms exhibits 072514.pdf; 36460-mbg wol 072514.pdf

Dear Ms. Duarte,

I am responding to your email yesterday to Rose Trochez.

Attached are United's denials and Memorial Hospital of Gardena's hospital remote notes with pertinent dates highlighted as proof that Memorial Hospital submitted an appeal request within the 60 day timeframe for reconsideration, orally and in writing pursuant to 42 CFR §422.622(a).

Based on our investigation, we have found:

- On 06/06/13, patient was presented to the emergency room at Memorial Hospital.
- On 06/07/13, Memorial Hospital called Secure Horizons and received authorization for patient from Amanda, authorization #33136-0562. (See Remote Notes)
- On 07/18/13, patient was discharged from Memorial Hospital.
- On 08/09/13, claim was billed to Secure Horizons electronically. (See Remote Notes)
- On 09/10/13, Memorial hospital placed a phone call to Secure Horizons and spoke with Cory who stated claim received and denied on 09/09/13.
- On 09/10/13, Memorial hospital sent the medical records by certified mail to support their reason for readmission in APPEAL FORM. (See Remote Notes)
- On 12/10/13, per Natalie, claims supervisor at Secure Horizons, claim was denied as not medically necessary, and with no added documentation the claim will not be submitted to Tantrum.
- On 02/21/14, Memorial Hospital called Secure Horizons and spoke to Terrance, stating that claim should be sent back for review. (oral appeal) (See Remote Notes)
- On 03/03/14, Notice from United stating the claim was denied per readmission review team. (See United's denial letter)
- On 04/02/14, Memorial Hospital sent two boxes of additional medical records to Secure Horizons for review of denial of claim. (See Remote Notes)
- On 04/04/14, Memorial Hospital/ Mem/Hospital/ were not making the decisions having been reached, however, United/BlueCross shares records as being delivered.
- On 05/07/14, United sent Memorial Hospital a letter stating that "claim remains denied as no formal request for reconsideration/appeal was received to warrant further review."
- On 06/05/14, United sent an Appeal and Request for Reconsideration review to Secure Horizons for failure to review medical records per conversation on 04/16/14, and reconsider readmission review. (See attachment of letter)
- On 06/04/14, United sent ERN the Waiver of Liability forms. The forms were signed and faxed back to United and we forward to Ms. Duarte. (See WOL's attached)

As the evidence will prove, Secure Horizons denied the claim on 08/25/13, and on 09/10/13 Memorial Hospital sent an appeal with medical records to Secure Horizons, requesting reconsideration of the claim. When Secure Horizons received the medical records with cover letter, if they needed clarification if it was a request for reconsideration they could have sought clarification from Memorial Hospital or sent a letter stating their appeal was not a reconsideration as they instead conducted a reconsideration review and denied it on 09/10/13. At that time they failed to send the claim to United for a formal request for reconsideration/appeal.

Furthermore, patient was admitted through the emergency room and Memorial Hospital was given authorization by Secure Horizons to admit the patient. Pursuant to 42 CFR §422.113(b)(3) if an MA organization is financially responsible for emergency and urgently needed services regardless of whether there is prior authorization. However, since Secure Horizons was given in this case, according to 42 CFR §422.113(c)(2)(i), the MA organization is also financially responsible for the inpatient care services rendered within or outside the MA organization that are pre-approved by the MA organization. Consequently the denial of the claim was not due to a lack of financial responsibility.

The authorization demonstrates that UHC was aware of the beneficiary's admission. Even if UHC did not issue an authorization, they were given an opportunity to assume care as per the Payor's responsibility for the enrollee's care under the Payor's contract with the MA Organization. The Payor was the only one to lose their right to follow up on the enrollee's care prior to discharge.

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

(i) The enrollee was discharged. (See 42 CFR §422.113(c)(3))
(ii) The enrollee or the enrollee's representative notified the MA organization that care was no longer being provided by the enrollee.

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

Please be informed that the information enumerated above was records made by Memorial Hospital's staff members. These notes contain hospital records and the Federal Business Records Act may be invoked to offer hospital records as evidence for any purpose. Section 3772a(a) characterizing information as hospital records is predicated upon satisfying two requirements: the record must have been made in the regular course of business, and it must have been the regular course of the business to make such record contemporaneously or within a reasonable time. It has been held that when these two requirements are satisfied with respect to a hospital record, the entire document is deemed reliable.

Further, all Memorial Hospital notes are to be read to include all records in the regular course of business. The Memorial Hospital notes are therefore properly characterized as hospital records under the Federal Business Records Act.

The attached exhibits are assumed authenticated and the password will be sent immediately following this email. If you need any more information to help this investigation (United/Secure Horizons' unlawful denial, please do not hesitate to contact our office.

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

Best regards,

Dalli Haley, Esq.
Claims Compliance Auditor II
Dear Ms. Trochez,

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

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

Respectfully,

Ann M. Duarte | Associate Regional Administrator | Medicare/Medicaid

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Fax Server  8/14/2014 8:47:40 AM  PAGE 2/003  Fax Server

August 14, 2014

ERN TARP
Allene Rose Torches
4740 W. Foothill Blvd.
Gardena, CA 90247

Member ID #: 123456
Member Name: Rose Torches

Case Number: 1234567

Dear Ms. Torches:

We received your request for an appeal on July 14, 2014 about the denial of an inpatient claim
for services provided at Memorial Hospital Gardena on June 6, 2013 through July 19, 2013.

Thank you for bringing this to our attention. We will pay for June 6, 2013 through July 19, 2013 based on the records, there was documentation of adequate treatment during the first admission and indicated the re-admission is not related strictly to the first admission. The re-admission denial for dates of service June 6, 2013 through July 19, 2013 is overturned.

What happens next?

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

You have the right to:

* Ask for a copy of your case file and the criteria that we used to decide your case
  - To request a copy of your file, please contact us at: UnitedHealthcare
    - PO BOX 6106
    - Garland, TX 75001-6106
    - Phone: 1-877-786-9638, TTY: 711
  - Send additional information about your appeal

Y0006_130806_093816A CMS Approved 09132013
AGS02_Appeal_Ovetime_Decision_09132013Update
Dear Mr. Duarte,

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

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

While we appreciate UHC's partial compliance in this matter, the provider's first request for a standard reconsideration was on September 7, 2013. The provider again requested reconsideration on April 16, 2014, and after UHC failed to adjudicate the claim in accordance with Medicare law and forward the claim to Maximus, our office sent another request for reconsideration on May 16, 2014. Despite our request, the claim was not sent to Maximus for review. The UHC representative completely reserves its organizational determination, the organization must pay for the service no later than 60 calendar days after the date the MA organization receives the request for reconsideration. Therefore, UHC has 60 calendar days to remit payment from the date the reconsideration was requested that resulted in a favorable decision, which was June 12, 2014.

UHC should have remitted payment by August 11, 2014, and are in non-compliance by stating that the claim shall be paid within 60 days of remitting the payment through their Claims Department. Please order your MAC to release payment in full in compliance with 42 CFR §422.610(b)(3).

We thank you for your tireless advocacy for Medicare beneficiaries.

Respectfully,

Dalli Haley, Esq.
Claims Compliance Analyst II
ERN / The Reimbursement Advocacy Firm
714-995-6000 Ext. 8905 Fax 714-995-6001

"And though your beginning was small, yet your latter end would greatly increase."

The Greatest Book Ever Written

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From: Dalli Haley
Sent: Monday, August 15, 2014 11:18 AM
To: Dalli Haley
Cc: Ed Norwood; Rose Trochez

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

Mr. Haley,

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

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

Respectfully,

Ann M. Duarte | Associate Regional Administrator | Division of Medicare Health Plans Operations | Southern California |
Dalli Haley
From: Ed Norwood <ednorwood@ernenterprises.org>
Sent: Friday, August 15, 2014 12:45 PM
To: "Tabe-Bedward, Arrah A. (CMS/CMP); Dalli Haley; Rose Trochez; Duarte, Ann M. (CMS/CMHP)"
Cc: FW; ERN/TRAFL Summary of Complaint/ Memorial Hospital of Gardena
Subject: FW: ERN/TRAFL Summary of Complaint/ Memorial Hospital of Gardena

Ms. Tabe-Bedward:

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

Below is an example of the same.

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

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

THIS IMPROPERLY DENIED CLAIM IS 349 DAYS BEYOND THE STATUTORY TIMEFRAME FOR REIMBURSING CLAIMS (PER 42 CFR SECT. 422.300.)

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

Best,

ED Norwood
Chief Compliance Officer
ERN / The Reimbursement Advocacy Firm
714 995-6903 ext. 6926 Fax 714 995-6903
www.ernenterprises.org

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

Dalli Haley
From: Duarte, Ann M. (CMS/CMHP) [mailto:ann.duarte@cms.hhs.gov]
Sent: Wednesday, August 20, 2014 3:33 PM
To: Ed Norwood
Cc: Abel, Mary O. (CMS/CMP); Dalli Haley; Rose Trochez; Tabe-Bedward, Arrah A. (CMS/CMP)
Subject: RE: ERN/TRAFL Summary of Complaint/ Memorial Hospital of Gardena

Mr. Norwood,

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

Ann M. Duarte | Associate Regional Administrator | Division of Medicare Health Plans Operations | Center for Medicare &
MA Organizations are financially responsible for poststabilization care services when...

1. They have been pre-approved
2. You render services within 1 hour of your request
3. They did not respond to your request after one hour, they cannot be contacted, and the plan physician cannot reach an agreement about the enrollee's care

MA Organizations' financial responsibility ends when...

1. A plan physician assumes responsibility for the enrollee's care...
2. At the treating facility
3. OR through transfer
4. OR the enrollee is discharged

MA Organizations' financial responsibility ends when...

1. A plan physician assumes responsibility for the enrollee's care...
2. At the treating facility
3. OR through transfer
4. OR the enrollee is discharged

Source: 42 CFR §422.113 (c)(2-3)

Laws and Regulations

ASK YOURSELF:

• Has the plan issued a tracking number versus an authorization?
• Did the plan receive faxed clinicals to conduct concurrent reviews while the patient was still hospitalized?
• Did the plan fail to notify the hospital of any disagreements prior to the commencement of poststabilization services and care or during the continuation of the same?

Any failure to issue an authorization within 60 minutes of the initial call deems the services authorized and payment cannot be denied.
MA OBSERVATION VS. INPATIENT

42 CFR § 422.504

(i) MA organization relationship with first tier, downstream, and related entities.

(3) All contracts or written arrangements between MA organizations and first tier, downstream, and related entities must contain the following:

(i) Enrollee protection provisions that provide, consistent with paragraph (g)(1) of this section, arrangements that prohibit providers from holding an enrollee liable for payment of any fees that are the obligation of the MA organization.

We must protect the beneficiary from any improper rise in liability.
The Medicare Benefit Policy Manual (Chapter 6-Hospital Svcs Covered Under Pt. B) defines observation care as:

“...a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation status is commonly assigned to patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge.”

Observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours.
Section 50.3.1 of the Medicare Claims Processing Guide (Chapter 1) states:

Under the hospital Condition of Participation (CoP) at 42 C.F.R. §482.12(c), patients are admitted to the hospital or CAH as inpatients only on the recommendation of a physician or licensed practitioner permitted by the State to admit patients to a hospital. In addition, every Medicare patient must be under the care of a physician or other type of practitioner listed in the regulation ("the practitioner responsible for care of the patient"). In some instances, a practitioner may order a beneficiary to be admitted as an inpatient, but upon reviewing the case, the hospital's utilization review (UR) committee determines that an inpatient level of care is not medically necessary.

Taking this into consideration, CMS obtained a condition code from the National Uniform Billing Committee (NUBC), effective April 1, 2004, that specifies:

Condition Code 44—Inpatient admission changed to outpatient – For use on outpatient claims only, when the physician ordered inpatient services, but upon internal utilization review performed before the claim was originally submitted, the hospital determined that the services did not meet its inpatient criteria.
The State Operations Manual states that in no case may a non-physician make a
final determination that a patient’s stay is not medically necessary or
appropriate (see Appendix A - Survey Protocol, Regulations and Interpretive
Guidelines for Hospitals).

Use of Condition Code 44 is not intended to serve as a substitute for adequate
staffing of utilization management personnel or for continued education of
physicians and hospital staff about each hospital’s existing policies and admission
protocols. As education and staffing efforts continue to progress, the need for
hospitals to correct inappropriate admissions and to report Condition Code 44
should become increasingly rare.
Section 50.3.2 adds:
In cases where a hospital or a CAH's UR committee determines that an inpatient admission does not meet the hospital's inpatient criteria, the hospital or CAH may change the beneficiary's status from inpatient to outpatient and submit an outpatient claim (bill type 13x or 85x) for medically necessary Medicare Part B services that were furnished to the beneficiary, provided all of the following conditions are met:

1. The change in patient status from inpatient to outpatient is made prior to discharge or release, while the beneficiary is still a patient of the hospital;
2. The hospital has not submitted a claim to Medicare for the inpatient admission;
3. The practitioner responsible for the care of the patient and the UR committee concur with the decision; and
4. The concurrence of the practitioner responsible for the care of the patient and the UR committee is documented in the patient's medical record.
APPLICATION FOR YOUR FACILITY:

• Ask your payor to provide the statutory authority they rely upon to request the patient’s inpatient stay be changed to observation:

  1.) Reflecting a change in what the treating physician ordered and
  2.) After the patient has been discharged.
Path to Recovery: Non-VA Care Emergency Reimbursement and Appeals Process

"Restoring responsibility and accountability is essential to the economic and fiscal health of our nation." – Carl Levin

1. The VA has thirty (30) days under the prompt payment act to reimburse non-VA care to an emergency provider.

2. If the VA makes an adverse benefit decision on non-VA care, the provider or representative must send a written Appeal (or Notice of Disagreement) within one (1) year.

3. Upon receiving a Notice of Disagreement, the AOJ must reexamine the claim and determine whether additional review or development is warranted. If the review upholds the denial, then they must prepare a Statement of Case (SOC), VA Form 9 and other notices and forward the veteran or their representative.

4. The Provider can then file a formal substantive appeal with the Board of Veteran Appeals (BVA) by filing VA Form 9 (and a narrative) within sixty (60) days from receipt of the Statement of Case; this timeframe may be extended with good cause. You may have more time if you have any remaining portion of the one year period after the VA’s initial notice of its decision (that prompted the NOD). Also, if your appeal is untimely, timeliness or adequacy of response must be determined by the BVA, not the VA.

5. AOJ must certify formal appeal for Board review at which time, the claimant or representative will be notified of their hearing and representation rights.

DEPARTMENT OF VETERANS AFFAIRS
VA Long Beach Healthcare System
Long Beach, California 90822

August 10, 2015

In Reply Refer To:

STATEMENT OF THE CASE
OF
St. Mary Medical Center for
FROM THE DECISION OF THE
DEPARTMENT OF VETERANS AFFAIRS

NOTICE TO APPELLANT:

This is not a decision on the appeal you have initiated. It is a "Statement of the Case" which the law requires us to furnish to help you in completing your appeal.

Please read the forwarding letter carefully, as well as the instructions on the enclosed appeal form. These explain your appeal rights and tell you what you must do to complete your appeal.

A copy of this "Statement of the Case" has been furnished to your representative:
ERN The Reimbursement Advocacy Firm (TRAF)

ISSUE: APPEAL OF ALLEGED NON EMERGENCY DENIAL
A timely claim presented the question of denial of entitlement because in order to be eligible for consideration of payment, specific provisions under the Millennium Health Care and Benefits Act Public Law 106-117, has to be met.
### SUMMARY OF EVIDENCE:

<table>
<thead>
<tr>
<th>Date</th>
<th>Event/Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 26, 2011</td>
<td>Unauthorized medical claim was presented by St. Mary Medical Center for date of care.</td>
</tr>
<tr>
<td>October 12, 2011</td>
<td>Veteran is service connected, treatment was for non-service connected injuries as determined by medical staff.</td>
</tr>
<tr>
<td>November 08, 2011</td>
<td>Medical review was requested.</td>
</tr>
<tr>
<td>November 28, 2011</td>
<td>Medical review was completed. Episode of care was denied as non-emergent care. VA Medical Center feasibility available.</td>
</tr>
<tr>
<td>November 29, 2011</td>
<td>Preliminary Fee Remittance Advice Report printed and sent to St. Mary Medical Center stating reason for denial. Non-emergent, VA feasibility available.</td>
</tr>
<tr>
<td>January 30, 2012</td>
<td>Veteran letter printed and sent to stating reason for denial.</td>
</tr>
<tr>
<td>August 14, 2012</td>
<td>Notice of denial from CAG (the Reimbursement Advocacy Firm (TARF) for St. Mary Medical Center) for date of care.</td>
</tr>
<tr>
<td>September 27, 2014</td>
<td>Statement of the Case prepared.</td>
</tr>
</tbody>
</table>

### ADJUDICATIVE ACTION:

Claimant has no adjudicated service-connected disabilities and is not in receipt of VA compensation.

### PERTINENT LAWS, VA REGULATIONS AND PRECEDENTS:

- Millennium Health Care Benefits Act, Title 38, Code of Federal Regulations 1725, Public Law 103-117
- CER 4736 Millennium Health Care Benefits Act Public Law 106-147

Emergency treatment furnished to veterans by Non-VA facilities:

- To the extent allowable, payment or reimbursement of the expenses of care, not previously authorized, in a private or public (or Federal) hospital not operated by the VA, and any medical services (not previously authorized including transportation, supplies, appliances, similar devices and repairs) may be paid on the basis of a claim timely filed, under the following circumstances:
  1. You are enrolled in the VA Health Care System.
  2. You have been provided care by a VA clinician or provider within the last 24 months.
  3. You were provided care in a hospital emergency department or similar facility providing emergency care.
  4. You have no other form of health insurance.
  5. You do not have coverage under any other VA program.
  6. Department of Veterans Affairs or other Federal facilities are not feasibly available at the time of the emergency event.
  7. A reasonable lay person would judge that any delay in medical attention would endanger your health or life.
  8. You are financially liable to the provider of the emergency treatment for that treatment.
  9. You have no other contractual or legal recourse against a third party that will pay all or part of the bill.

# Signature

Ward, Charles Frank
**DECISION:**

In order to be entitled for payment of the cost of millennium health care medical expenses, all of the above requirements must have existed and in the absence of any one condition the Department of Veterans Affairs cannot accept the financial responsibility. It was determined the claimant did not meet the criteria for payment.

**REASON FOR DECISION:**

In considering a claim for payment of the cost of Millennium health care non-VA medical expenses, the responsible officials must determine if the claim received meets all circumstances listed in the Millennium Health Care Act Code of Regulations 1725.

**Prepared by:**

[Signature]
Date: August 10, 2015
Carolyn D. Hayes, Supervisory Program Specialist, VA Care in the Community

**Approved by:**

[Signature]
Date: August 10, 2015
Willie J. Moore, VISN 22 VA Care in the Community, Fee Manager, CBC PC, LB

---

**Department of Veterans Affairs**

**APPEAL TO BOARD OF VETERANS' APPEALS**

<table>
<thead>
<tr>
<th>Form</th>
<th>Name</th>
<th>Address</th>
<th>ZIP Code</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

**IMPORTANT:** Read the attached instructions before you fill out this form. VA also encourages you to get assistance from your representative in filling out this form.

**Page 1**

- **NAME OF VETERAN:**
- **CLAIM FILE NO.**
- **INSURANCE FILE NO.**

**Page 2**

- **VETERAN**
- **VETERAN'S WIDOW/ER**
- **VETERAN'S UPLIFER**
- **VETERAN'S PARENT**

---

**Signature:**

[Signature]
Date: [Date]

[Additional instructions and fields for signature and date]

---

**Page 3**

[More fields and instructions related to the appeal process]
The Freedom of Information Act (FOIA) is a law that gives you the right to access information from the federal government. It is often described as the law that keeps citizens in the know about their government.

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

What can you ask for?

A FOIA request can be made for any agency record. You can also specify the format in which you wish to receive the records. You should be aware that the FOIA does not require agencies to do research for you, to analyze data, to answer written questions, or to create records in response to a request.
## Emergency non-VA Care for Service-connected Veterans (38 U.S.C. §1728)

<table>
<thead>
<tr>
<th>Introduction</th>
<th>VA is authorized under 38 U.S.C. §1728 to make payment or reimbursement to a claimant for non-VA emergency care provided to certain service-connected veterans.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility</td>
<td>Payment for an unauthorized claim may be made when the following administrative and clinical criteria are met:</td>
</tr>
<tr>
<td></td>
<td>- Care or services must have been rendered to a Veteran for:</td>
</tr>
<tr>
<td></td>
<td>- An adjudicated service-connected disability</td>
</tr>
<tr>
<td></td>
<td>- A non-service-connected disability associated with and held to be aggravating a service-connected disability</td>
</tr>
<tr>
<td></td>
<td>- A non-service-connected disability</td>
</tr>
<tr>
<td></td>
<td>- For any disability of a Veteran rated permanently and totally disabled (P&amp;T) due to a service-connected disability</td>
</tr>
<tr>
<td></td>
<td>- For any illness, injury, or dental condition of a Veteran resulting in the Chapter 51 Vocational Rehabilitation Program for the reasons enumerated under 38 CFR 17.47(f), and</td>
</tr>
<tr>
<td>Administrative Criteria</td>
<td>- When such care or services are rendered in a medical emergency of such nature that a prudent layperson under the circumstances would reasonably expect that delay would be hazardous to life or health</td>
</tr>
<tr>
<td>Clinical Criteria</td>
<td>- VA or other Federal facilities were not feasibly available to provide the needed care</td>
</tr>
<tr>
<td>Note:</td>
<td>VA or other Federal facilities unavailable means that VA, or other Federal facility with which VA has an agreement to furnish emergency care for Veterans, could not provide the care due to the urgency of the condition and Veteran’s geographical location, or unavailability of services.</td>
</tr>
</tbody>
</table>

### Establishing Eligibility

Verify Veteran status by reviewing the following, as applicable:

- VA EDA (Electronic Disability Assessment) Inquiry
- KLF Menu for national activity
- VHA Enterprise EHR GW (Legacy) (https://mychart.va.gov/Services/BeginParsed.ascx)
- VHA Enterprise EHR GW (Alternate Data)
- HIN (Hospital Inquiry)
- VIS (Veteran Information Solution)

### Timely Filing of Claims

Claims must be filed within 2 years after the date of service or discharge (38 CFR 17.126).

The date of filing any claim for payment or reimbursement of expenses is the postmark date of a formal claim, the EDI claim receipt date, or the date of any preceding telephone call, telegram, or letter in which a formal claim is implied.

When a claim for payment or reimbursement of expenses of services not previously authorized has not been timely filed the expenses of any care or services rendered prior to the date of filing the claim will not be paid or reimbursed except:

- In the case of care or services rendered prior to VA adjudication allowing service connection:
  - The claim must be filed within 2 years of the date the Veteran was notified by VA of the allowance of the award of service-connected disability
  - The claim must include evidence for care related to the service-connected disability received within a 2-year period prior to the date the Veteran filed the original or reopened claim which resulted in the award of
Under existing federal law, 38 CFR § 17.52(a) states: When VA facilities or other government facilities are not capable of furnishing economical hospital care or medical services because of geographic inaccessibility or are not capable of furnishing care or services required, VA may contract with non-VA facilities for care in accordance with the provisions of this section. When demand is only for infrequent use, individual authorizations may be used.
Care in public or private facilities, however, subject to the provisions of §§17.53, 17.54, 17.55 and 17.56, will only be authorized, whether under a contract or an individual authorization, for—

(3) Hospital care or medical services for the treatment of medical emergencies which pose a serious threat to the life or health of a veteran receiving hospital care or medical services in a facility over which the Secretary has direct jurisdiction or government facility with which the Secretary contracts, and for which the facility is not staffed or equipped to perform, and transfer to a public or private hospital which has the necessary staff or equipment is the only feasible means of providing the necessary treatment, until such time following the furnishing of care in the non-VA facility as the veteran can be safely transferred to a VA facility;

38 CFR § 17.54 adds: (a) The admission of a veteran to a non-Department of Veterans Affairs hospital at Department of Veterans Affairs expense must be authorized in advance. IN THE CASE OF AN EMERGENCY WHICH EXISTED AT THE TIME OF ADMISSION, AN AUTHORIZATION MAY BE DEEMED A PRIOR AUTHORIZATION if an application, whether formal or informal, BY TELEPHONE, telegraph or other communication, made by the veteran OR BY OTHERS IN HIS OR HER BEHALF is dispatched to the Department of Veterans Affairs...
...(1) for veterans in the 48 contiguous States and Puerto Rico, WITHIN 72 HOURS AFTER THE HOUR OF ADMISSION, including in the computation of time Saturday, Sunday and holidays, or (2) for veterans in a noncontiguous State, territory or possession of the United States (not including Puerto Rico) if facilities for dispatch of application as described in this section are not available within the 72-hour period, provided the application was filed within 72 hours after facilities became available.

(b) When an application for admission by a veteran in one of the 48 contiguous States in the United States or in Puerto Rico has been made more than 72 hours after admission, or more than 72 hours after facilities are available in a noncontiguous State, territory of possession of the United States, authorization for continued care at Department of Veterans Affairs expense shall be effective as of the postmark or dispatch date of the application, or the date of any telephone call constituting an informal application.
38 CFR § 17.121 Limitations on payment or reimbursement of the costs of emergency treatment not previously authorized:

(a) Emergency Treatment. Except as provided in paragraph (b) of this section, VA will not approve claims for payment or reimbursement of the costs of emergency treatment not previously authorized for any period beyond the date on which the medical emergency ended. For this purpose, VA considers that an emergency ends when the designated VA clinician at the VA facility has determined that, based on sound medical judgment, the veteran who received emergency treatment:

1. Could have been transferred from the non-VA facility to a VA medical center (or other Federal facility that VA has an agreement with to furnish health care services for veterans) for continuation of treatment, or

2. Could have reported to a VA medical center (or other Federal facility that has an agreement with to furnish health care services for veterans) for continuation of treatment.

[From that point on, no additional care in a non-VA facility will be approved for payment by VA.]
38 CFR § 17.121:

(b) Continued non-emergency treatment. Claims for payment or reimbursement of the costs of emergency treatment not previously authorized may only be approved for continued, non-emergency treatment, if:

(1) The non-VA facility notified VA at the time the veteran could be safely transferred to a VA facility (or other Federal facility that VA has an agreement with to furnish health care services for veterans), and the transfer of the veteran was not accepted; and

(2) The non-VA facility made and documented reasonable attempts to request transfer of the veteran to a VA facility (or to another Federal facility that VA has an agreement with to furnish health care services for veterans), which means the non-VA facility contacted either the VA Transfer Coordinator, Administrative Officer of the Day, or designated staff responsible for accepting transfer of patients, at a local VA (or other Federal facility) and documented such contact in the veteran's progress/physicians' notes, discharge summary, or other applicable medical record.
38 CFR § 17.121:

(c) Refusal of transfer. If a stabilized veteran who requires continued non-emergency treatment refuses to be transferred to an available VA facility (or other Federal facility that VA has an agreement with to furnish health care services for veterans), VA will make payment or reimbursement only for the expenses related to the initial evaluation and the emergency treatment furnished to the veteran up to the point of refusal of transfer by the veteran.

(Authority: 38 U.S.C. 1724, 1728, 7304)

Also see 38 CFR §17.1005 (b)-(d).
How do your physicians document when the patient is stable for transfer?

How do you communicate that to the VA?
The VA is financially responsible for poststabilization care services when...

1. The closest VA hospital is not geographically accessible.
   NOTE: Individual infrequent authorizations may be used (e.g., when no beds are available and the VA cannot furnish care.)
   (38 CFR § 17.52(a)(3))

2. VA facilities are not staffed or equipped to give hospital care or medical services.
   (38 CFR § 17.52(a)(3))

3. The VA fails to respond to your informal application for authorization made within 72 hours of admission.
   NOTE: Telephone calls constitute a valid informal application.
   (38 CFR § 17.54)

HMO and PPO Medical Necessity Denials
“Never let anyone tell you NO that does not have the power to say YES.” - Eleanor Roosevelt

HMOs & PPOs: Medical Necessity Denials

Utilization Review

(a) The General Assembly finds that:
   (1) A physician-patient relationship is paramount and should not be subject to third-party intrusion; and
   (2) Prior authorizations can place attempted cost savings ahead of optimal patient care.

(b) The General Assembly intends for this subchapter to:
   (1) Ensure that prior authorizations do not hinder patient care or intrude on the practice of medicine; and
   (2) Guarantee that prior authorizations include the use of written clinical criteria and reviews by appropriate physicians to secure a fair authorization review process for patients.

(c) “Expeditied prior authorization” means prior authorization and notice of that prior authorization for an urgent healthcare service to a subscriber or the subscriber’s healthcare provider within one (1) business day after the utilization review entity receives all information needed to complete the review of the requested urgent healthcare service.
HMOs & PPOs: Medical Necessity Denials

Utilization Review

(7) "Medically necessary healthcare service" means a healthcare service that a physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, or disease or the symptoms of an illness, injury, or disease in a manner that is:

(A) In accordance with generally accepted standards of medical practice;

(B) Clinically appropriate in terms of type, frequency, extent, site, and duration and

(C) Not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other healthcare provider;

(8)(A) "Prior authorization" means the process by which a utilization review entity determines the medical necessity and medical appropriateness of a covered healthcare service before the healthcare service is rendered, including without limitation preadmission review, pretreatment review, utilization, and case management.

(B) "Prior authorization" may include the requirement by a health insurer or a utilization review entity that a subscriber or healthcare provider notify the health insurer or utilization review entity of the subscriber's intent to receive a healthcare service before the healthcare service is provided;

(9) "Urgent healthcare service" means a healthcare service for a non-life-threatening condition that, in the opinion of a physician with knowledge of a subscriber's medical condition, requires prompt medical care in order to prevent:

(i) A serious threat to life, limb, or eyesight;

(ii) Worsening impairment of a bodily function that threatens the body's ability to regain maximum function;

(iii) Worsening dysfunction or damage of any bodily organ or part that threatens the body's ability to recover from the dysfunction or damage; or

(iv) Severe pain that cannot be managed without prompt medical care.

(B) The rendering of an urgent healthcare service requires expedited prior authorization only, as provided under § 23-66-806, and

"Utilization review" (11)(A) "Utilization review entity" means an individual or entity that performs prior authorization for one (1) or more of the following:

(i) An employer with employees in this state who are covered under a health benefit plan or health insurance policy;

(ii) An insurer that writes health insurance policies;

(iii) A preferred provider organization or health maintenance organization; or

(iv) Any other individual or entity that provides, offers to provide, or administers hospital, outpatient, medical, or other health benefits to a person treated by a healthcare provider in this state under a policy, plan, or contract.

(B) A health insurer is a utilization review entity if it performs prior authorization.

Utilization Review

(a) If a utilization review entity requires prior authorization of a nonurgent healthcare service, the utilization review entity shall make a prior authorization or adverse determination and notify the subscriber and the subscriber's nonurgent healthcare provider of the prior authorization or adverse determination within two (2) business days of obtaining all necessary information to make the prior authorization or adverse determination.

(b) For purposes of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required.

A utilization review entity shall render an expedited prior authorization or an adverse determination concerning an urgent healthcare service and notify the subscriber and the subscriber's healthcare provider of that expedited prior authorization or adverse determination not later than one (1) business day after receiving all information needed to complete the review of the requested urgent healthcare service.

The purpose of this section is to define certain minimum standards for insurers utilizing pre-certification or pre-authorization reviews to ensure that such cost-containment procedures of disability insurers and health care plans are reasonable and do not unduly delay, or interfere with or impede the authorized practice of medicine and delivery of reasonable medical care. For purposes of this rule, acts of the claims administrator in performing pre-certification reviews shall be deemed to be acts of the insurer.

(c) Provide for reconsideration or medical reviews following disapproval or denial of pre-certification requests of insureds and claimants; and

(d) Provide for prompt peer medical review following disapproval or denial of pre-certification requests of insureds or claimants as to medically-necessary and/or life-threatening major surgical procedures.
Concurrent Care Decisions

If a group health plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, then...

(A) any reduction or termination by the plan of such course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments constitutes an adverse benefit determination...

(The plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefits are reduced or terminated.)

(B) any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and the plan administrator shall notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the plan, provided that any such claim is made to the plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.
Adverse Benefit Determination Notifications
Manner and content of notification of benefit determination.

1. The plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination.

The notification shall set forth, in a manner calculated to be understood by the claimant—

(i) The specific reason or reasons for the adverse determination;
(ii) Reference to the specific plan provisions on which the determination is based;
(iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
(iv) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review;

In the case of an adverse benefit determination by a group health plan or a plan providing disability benefits,

(A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that such rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request; or
(B) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement of such explanation will be provided free of charge upon request.

In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.

Full and Fair Review
Group health plans. The claims procedures of a group health plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless, in addition to complying with the requirements of paragraphs (h)(2)(ii) through (h)(2)(iv) of this section, the claims procedures—

(i) Provide claimants at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;
(ii) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
(iii) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and/or (iv) Provide for a consultation by the appropriate named fiduciary with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

In the case of an adverse benefit determination by a group health plan or a plan providing disability benefits,

(A) A request for a full and fair review of an adverse benefit determination may be submitted orally or in writing by the claimant; and (B) All necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

29 CFR § 2560.503-1(g)

29 CFR § 2560.503-1(h)(3)
For the violations listed in this paragraph (a), we may impose one, or more, of the sanctions specified in Sec. 422.750(a)(2), (a)(3), or (a)(4) on any MA organization that has a contract in effect. The MA organization may also be subject to other applicable remedies available under law.

Fails substantially to provide, to an MA enrollee, medically necessary services that the organization is required to provide (under law or under the contract) to the enrollee, and that failure adversely affects (or is substantially likely to adversely affect) the enrollee.

(5) Misrepresents or falsifies information that it furnishes—
   (i) To CMS; or
   (ii) To an individual or to any other entity.

(6) Fails to comply with the requirements of Sec. 422.206, which prohibits interference with practitioners' advice to enrollees.

What is Negligent Misrepresentation?
Ed Norwood

From: Ed Norwood

To: Cathy@oefi.org; ‘mferleg@oefi.org’; ‘ckillian@oefi.org’; ‘miked@oefi.org’; “madama@oefi.org”

Subject: Notice of Intent to File Complaint with the U.S. Department of Labor

Mr. Ehbar:

I trust your Thanksgiving was well.

Can you confirm if you or Mickey J. Adams are the employer-fiduciary for the Operating Engineers Trust Funds Local 12 (hereinafter referred to as OE)?

I need to forward a copy of a regulatory complaint that we are preparing to send to the U.S. Department of Labor for OE’s failure to release trust funds to reimburse emergency and authorized post-stabilization services for one of its participants. (We are also preparing to release a media advisory to see if similarly situated individuals exist.)

As you know, under Section 502 of the Act, a plan participant, beneficiary or an authorized representative with standing may bring a civil action in court to:

• Recover benefits due and enforce rights under the plan.
• Clarify rights or future benefits.
• Get appropriate relief from a breach of fiduciary duty.
• Enjoin any act or practice that violates the terms of the plan or any provision of Title I of ERISA, such as nonreporting and disclosure, participation, vesting or funding, and fiduciary provisions, as to obtain other equitable relief.
• Obtain review of a final action of the Secretary of Labor to restrain the Secretary from taking action contrary to ERISA, or compel the Secretary to take action.

On July 18, 2016, Maria Sandow in your Pasadena Office sent a letter stating:

“A claim has been received which cannot be paid. The charge is for a service that is not covered by the plan. Member was not eligible at date of service. (See OE Ref. # 2015161007183.)”

However:

• On 05/05/15, the patient arrived at PHH for emergency services and care. PHH called Blue Cross to obtain insurance information and PHH spoke with Jesse III at Blue Cross who stated that the patient had Blue Cross coverage effective 09/01/14. He also stated the plan pays #100% with no deductible and issued a call reference # 2015125120246. PHH also requested an authorization to the PCP, Dr. Panse, by fax.

• On 05/08/15, PHH called Dr. Panse’s office for authorization to admit the patient as patient underwent surgery that Monday.
• On 08/11/15, PHH received HCMG authorization for OBS 32015005082001000200099 expiring on 09/09/14.
• On 05/19/15, PHH faxed a face sheet to Blue Cross.
• On the same day, PHH attempted to obtain a tracking number from Blue Cross, but Blue Cross stated that no tracking is required and the participant was discharged.

As the evidence will show, at no time while the patient was hospitalized did OE through its delegate Blue Cross state “The member was not eligible.”

Please be advised that OE’s failure to ensure payment through their FPA is a breach of fiduciary duties and contrary to federal law. In the case of The Meadows v. Employers Health Insurance 9th Cir. 1995 47 F.3d 1706, an ERISA plan denied coverage to a drug treatment facility after previously covering the particular drug treatment service. The case was brought against the plan for breach of contract and negligent misrepresentation, among other things. The court stated that if eligibility is verified, such verification cannot later be rescinded as plans are not insulated “from the consequences of their own misrepresentations” to providers.

Therefore, since the care referenced above was authorized, OE must pay CHLB, even if the Blue Cross employee made a mistake and the patient was not covered for the date of service.

Our provider member, PHH, treated the above enrollee/beneficiary in good faith, pursuant to OE/BX’s authorization and verification. Federal and State law states that the provider must be able to conclusively rely on the business entity’s verification. **PHH is not at risk to receive payment because of a mistake made by OE/Blue Cross or one of its members.**

You are reminded that the Employee Benefits Security Administration is imposed by the Employee Retirement Income Security Act to enforce violations such as:

• Failing to operate the plan prudently and for the exclusive benefit of participants
• Using plan assets to benefit certain related parties to the plan, including the plan administrator, the plan sponsor, and parties related to these individuals;
• Failing to follow the terms of the plan (unless inconsistent with ERISA);
• Failing to properly select and monitor service providers (third party administrators)
• Taking any adverse action against an individual for exercising his or her rights under the plan (e.g., being fired, fined, or otherwise being discriminated against);
• Failure to comply with ERISA Part 7 and the Affordable Care Act (welfare plans only).

Furthermore, one of the six forms of deceit recognized in California, only one—negligent misrepresentation—does not require the maker of a misrepresentation to know that the representation is false. As defined
by statute, negligent misrepresentation is "[t]he assertion, as a fact, of that which is not true, by one who has no reasonable ground for believing it to be true". California Civil Code, section 1710(2).

To prove a claim for negligent misrepresentation, the plaintiff must show:

1. The defendant must have made a representation as to a past or existing material fact;
2. The representation must have been untrue;
3. Regardless of his actual belief the defendant must have made the representation without any reasonable ground for believing it to be true;
4. The representation must have been made with the intent to induce plaintiff to rely upon it;
5. The plaintiff must have been unaware of the falsity of the representation; must have acted in reliance upon the truth of the representation and must have been justified in relying upon the representation;
6. And, finally, as a result of the reliance upon the truth of the representation, the plaintiff must have sustained damage.

This claim does not rely on the existence or validity of either the individual’s insurance contract or a managed care contract. A claim for negligent misrepresentation looks to whether the insurance company or its representative exercised reasonable professional competence in verifying coverage. The insurance company need not know that statements are false when made.

In conclusion, by verifying that the patient was a member with OE/Blue Cross and pre-authorizing the participant’s “services”, OE/Blue Cross made a false statement to induce PPH to provide health care services to the patient. Since Blue Cross is the TPA for OE, the burden of oversight and responsibility to insure the TPA is adhering to the laws that govern ERISA claims is ultimately the responsibility of OE and they have a duty to act with integrity and in the “interest of the participants and beneficiaries.”

Please make any further action unnecessary by remitting payment in the amount of $80,400.80 on or before Friday, December 5, 2016. I appreciate your response and assistance in this matter.

Best,
Ed Norwood
Chief Compliance Officer
ERN / The Reimbursement Advocacy Firm
714 995-6900 ext. 6926 Fax 714 995-6901
www.erntraf.org
www.ernenterprises.org

---

From: Ed Norwood
Send: Monday, December 08, 2016 4:33 PM
To: ‘Cathy@oeif.org’; ‘mferieg@oeif.org’; ‘ckillian@oeif.org’; ‘mkeresz@oeif.org’; ‘madame@oeif.org’;
Subject: notice of intent to file complaint with the U.S. Department of Labor

Mr. Ehbar:

Please provide Mr. Mickey J. Adam’s email address and/or payment details to the undersigned regarding the defraud of OE’s trust sent 11/28/16.

We expect your compliance.

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

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

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From: Ed Norwood
Send: Monday, November 28, 2016 4:09 PM
To: ‘jehbar@oeif.org’; ‘cathy@oeif.org’; ‘mferieg@oeif.org’; ‘ckillian@oeif.org’; ‘mkeresz@oeif.org’; ‘madame@oeif.org’; ‘mikee@oeif.org’; ‘mikeler@oeif.org’; ‘maxarias@oeif.org’
Subject: Notice of intent to file complaint with the U.S. Department of Labor

Mr. Ehbar:
Can you believe this?

Ed Norwood
From: Joseph Ehrbar
Sent: Monday, December 05, 2016 4:33 PM
to: Ed Norwood
抄送: Cathy Vitali, Matt Enrig, Chuck Killian; Mike DeChellis; madams@oefi.org; mjadams@oeefi.org
Subject: RE: Notice of Intent to File Complaint with the U.S. Department of Labor

Mr. Ehrbar:

Please provide Mr. Mickey J. Adam’s email address and/or payment details to the undersigned regarding the defraud of O’S trust sent 11/28/16.

We expect your compliance.

Ed Norwood
Chief Compliance Officer
ERB / The Reimbursement Advocacy Firm
714 956-6900 ext. 6926 Fax 714 996-6901
www.ernenterprises.org
www.ernenterprises.org

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

Ed Norwood
From: Ed Norwood
Sent: Monday, December 05, 2016 4:48 PM
to: Joseph Ehrbar
抄送: Cathy Vitali, Matt Enrig, Chuck Killian; Mike DeChellis; madams@oefi.org; mjadams@oeefi.org
Subject: RE: Notice of Intent to File Complaint with the U.S. Department of Labor

Mr. Ehrbar:

Your response is troubling.

Please confirm if you are the plan administrator and fiduciary for Operating Engineers Local 12.

As you may know, 29 U.S.C. § 1002(21)(A) defines a fiduciary as anyone who...[3] has any discretionary authority or discretionary responsibility in the administration of such plan

Under ERISA, a fiduciary has a duty to act "solely in the interest of..." and "for the exclusive purpose of providing benefits to participants and their beneficiaries. (ERISA § 404(a)(1)(A))

Further, a fiduciary who does not administer the plan properly, and breaches the covenant created in Title 29 U.S.C. §§ 1104 & 1109, is held personally liable for the losses incurred (i.e. for the amount of the claim).

According to 29 U.S.C. § 1105 (a)(2) [see infra §4-04(C), when a fiduciary delegates responsibility to a co-fiduciary (e.g. Anthem), prudence requires the fiduciary to take certain efforts to keep abreast of the management of trust funds (See. Barker v. American Power Corp., 64 F.3d 1397, 1403 (9th Cir. 1995).


It appears that Anthem may have engaged in claims processing that violated Operating Engineer fiduciary responsibility rules by failing to reimburse the emergency and authorized post-stabilization services and care timely.

Again, this is a third request for the email address for Mickey J. Adams to redress the ERISA violations and defraud of trust cited in my email below prior to the filing of a regulatory complaint with the U.S. Department of Labor, and media advisory release to see if similarly situated participants exist.

Our complaint is scheduled for Tuesday, December 6, 2016.

As you consider your next move, please be reminded of your personal liability to act under CA Penal Code § 447.1.

(b) It is unlawful to do, or to knowingly assist or conspire with any person to do, any of the following.

1
(1) Present or cause to be presented any written or oral statement as part of, or in support of, or in opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact.
(2) Prepare or make any written or oral statement that is intended to be presented to any insurer or any insurance claimant in connection with, or in support of, or in opposition to, any claim or payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact.
(3) Conceal, or knowingly fail to disclose the occurrence of, an event that affects any person’s initial or continued right or entitlement to any insurance benefit or payment, or the amount of any benefit or payment to which the person is entitled.

We appreciate and expect your compliance.

Best,
Ed Norwood
Chief Compliance Officer
ERN Reimbursement Advocacy Firm
714 995-6900 ext. 6926 Fax 714 995-6901
www.ernenterprises.org
www.ERNTRAFTA.org

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From: Joseph Elhrbar <maleto.jehrbar@oefl.org>
Sent: Monday, December 05, 2011 10:26 AM
To: Ed Norwood <ejnorwood@ernenterprises.org>
Cc: Cathy Vitali <Cathy.vitali@oefl.org>, Matt Erleg <mterleg@oaei.org>, Chuck Kilian <ckillian@oefl.org>, Mike DeChells <mdechells@oefl.org>, mjdams@oefl.org
Subject: Notice of Intent to File Complaint with the U.S. Department of Labor

Mr. Norwood,

We are reviewing the claim with Anthem and will get back to you.

Joseph R. Elhrbar
Fund Manager
Operating Engineers Trust Funds
(Local 12)

Website: OEF.org

From: Ed Norwood [mailto:ejnorwood@ernenterprises.org]
Cc: Cathy Vitali <Cathy.vitali@oefl.org>, Matt Erleg <mterleg@oaei.org>, Chuck Kilian <ckillian@oefl.org>, Mike DeChells <mdechells@oefl.org>, mjdams@oefl.org

Subject: Notice of Intent to File Complaint with the U.S. Department of Labor

Mr. Elhrbar,

Your response is troubling.

Please confirm if you are the plan administrator and fiduciary for Operating Engineers Local 12.

As you may know, 29 U.S.C. § 1002(21)(A) defines a fiduciary as anyone who "has any discretionary authority or discretionary responsibility in the administration of such plan."

Further, a fiduciary who does not administer the plan properly, and breaches the covenant created in Title 29 U.S.C. §§ 1104 & 1109, is held personally liable for the losses incurred (i.e., for the amount of the claim). According to 29 U.S.C. § 1105(a)(2) (see infra §4.04[C]), when a fiduciary delegates responsibility to a co-fiduciary (e.g., Anthem), prudence requires, the fiduciary to take certain efforts to keep abreast of the activities of a co or claim fiduciary, including investigating possible mismanagement of trust funds (See. Power Corp., 64 F.3d 1397, 1401 (9th Cir. 1995).)

Further, in the case of Harris Trust & Sav. Bank v. John Hancock Mut. Life Ins. Co., 122 F. Supp. 2d 444 (N.D. Ill. 2000), the court concluded that a plan participant who instructed his insurer to hire an insurance company to manage the plan, lacked fiduciary status because he did not assume any responsibility for the actions of the insurer. In part by 302 F.3d 18 (2d Cir. 2002), the courts concluded the plan, who hired an insurer to manage free funds, placed its own interests and cash flow needs ahead of interests of plan participants. In Whitfield v.
Ed Norwood

From: Ed Norwood

To: "Joseph Ehbar"

Cc: Matt Eng, Chuck Killian, Mike DeChello, Cathy Vital

Subject: RE: Notice of Intent to File Complaint with the U.S. Department of Labor

Mr. Ehbar:

Just a note as you review this matter. Your TPA, Anthem, was recently fined $650,000.00 for failing to fully and timely provide information to the DMHC during their investigation of complaints:

http://www.dmhc.ca.gov/Portals/0/AbouttheDMHC/NewsRoom/pr111016.pdf?ver=2016-11-10-112923-220

Needless to say, we anticipate the prudence from your department to take certain efforts to keep abreast of the activities of Anthem, including investigating and redressing deficiencies processing deficiencies, and the possible mismanagement of trust funds.

We appreciate all you do to protect the over 20,000 members of the International Union of Operating Engineers (I.U.O.E.) Local 12, and their dependents and beneficiaries.

Best,

Ed Norwood
Chief Compliance Officer
ERN / The Reimbursement Advocacy Firm
714 995-9900 ext. 6926 Fax 714-995-6901
www.erntraf.org

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How would you respond to this?
Ed Norwood

From: Ed Norwood
To: Joseph Ehrbar
Cc: Matt Emel; Chuck Killian; Mike DeChellea; Cathy Vital
Subject: Request to File Complaint with the U.S. Department of Labor
Attachments: PIIH SOR.pdf

Mr. Ehrbar:

Thank you for your update.

Please be advised that under existing federal law, a health plan may not condition treatment, payment, continued enrollment in the health plan or eligibility for benefits on a patient providing individual authorization to a business associate of covered entity (HIPAA Privacy Rule § 164.508).

As you know, HIPAA Privacy Rule § 164.514 (d)(3) states:

(ii) A covered entity may rely, if such reliance is reasonable under the circumstances, on a requested disclosure as the minimum necessary for the stated purpose when:
(A) Making disclosures to public officials that are permitted under § 164.312, if the public official represents that the information requested is the minimum necessary for the stated purpose(s); and
(B) The information is requested by another covered entity.

(C) The information is requested by a professional who is a member of its workforce or is a business associate of the covered entity for the purpose of providing professional services to the covered entity, if the professional represents that the information requested is the minimum necessary for the stated purpose(s) (Emphasis added.)

Section 164.514 (b)(3) states:

(i) Except with respect to disclosures under § 164.530, verify the identity of a person requesting protected health information and the authority of any such person to have access to protected health information under this subpart, if the identity or any such authority of such person is not known to the covered entity.

(ii) Obtain any documentation, statements, or representations, whether oral or written, from the person requesting protected health information and the identity or such authority of such person.

(iii) A covered entity may rely, if such reliance is reasonable under the circumstances, on documentation, statements, or representations that, on their face, meet the applicable requirements (Emphasis added.)

Health information, a covered entity may rely, if such reliance is reasonable under the circumstances, on documentation, statements, or representations that, on their face, meet the applicable requirements (Emphasis added.)

Sec. 164.512 adds:

A covered entity may use or disclose protected health information without the written authorization of the individual, as described in Sec. 164.508, or the opportunity for the individual to agree or object as described in Sec. 164.510, in the situations covered by this section, subject to the applicable requirements of this section. When the covered entity is required by this section to inform the individual of, or when the individual may agree to, a use or disclosure permitted by this section, the covered entity’s information and the individual’s agreement may be used as evidence (Emphasis added.)

As such, our letter of representation and the attached signed statement or representation, are reasonable on face, that our office is a business associate representing PHH.

If you disagree, please provide the statutory authority that states a patient’s authorization is a condition (or requirement) of disclosure.

To forego any further argument and expedite this matter, I draw your attention to the following cases:

In Connecticut State Dental Ass’n v. Anthem Health Plans, Inc., 991 F.3d 1337, 1352-53 (11th Cir. 2009), the court held that claim forms subjected by health care providers to administrator demonstrated an assignment of benefits by the patient, thus establishing standing for providers.

In Tango Transp. v. Healthcare Fin. Servs., 322 F.3d 886, 893-94 (5th Cir. 2003), the Court of Appeals for the Fifth Circuit held that a third party collection agency possessed derivative standing as an assignee of a healthcare provider, who itself possessed derivative standing as an assignee of the beneficiary of the ERS plan.

In Tango, the Court of Appeals cited Misic v. Bldg. Serv. Employees Health & Welfare Trust, 789 F.2d 1374, 1378 (9th Cir. 1986), “noting that extending derivative standing to health care providers ‘results in precisely the benefit the trust is designed to provide and the statute is designed to promote’...making it unnecessary for health care providers to evaluate the solvency of patients before commencing medical treatment’ or forcing patients to ‘pay potentially large medical bills and await compensation from the plan.’”

As PHH is an assignee of the patient (through its claim form and/or assignment of benefits), PHH and this office (through the attached signed statement of representation) asserts derivative standing to appear this manner.
Please make any further action unnecessary by remitting payment in the amount of $90,400.80 on or before Friday, December 9, 2016.

I appreciate your compliance.

Best,

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

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From: Joseph Ehrbar [mailto:Jehrbare@oeifi.org]
Sent: Thursday, December 08, 2016 7:27 AM
To: Ed Norwood <ednorwood@ernenterprises.org>
Subject: claim

Mr. Norwood,

We still haven’t heard back from Anthem but nevertheless, once we receive the information we cannot, by law, discuss it with you unless you provide us with a designation from the patient authorizing us to discuss it with you. We can accept an email form followed up with the mailed version.

Joseph R. Ehrbar
Fund Manager
Operating Engineers Trust Funds
(Local 12)

Ed Norwood

From: Joseph Ehrbar
Sent: Friday, December 09, 2016 7:12 AM
To: Ed Norwood
Cc: Matt Eried; Chuck Killian; Mike DeChellis; Cathy Vital
Subject: RE: Notice of Intent to File Complaint with the U.S. Department of Labor

Mr. Norwood, We have received the info from Anthem. The patient was a member of the Anthem HMO, one of the plans we offer. As an HMO facility, your client would have been paid $8,723 by Anthem. That is the amount we will pay due to the confusion.

Joseph R. Ehrbar
Fund Manager
Operating Engineers Trust Funds
(Local 12)

Website: OEIFI.org

From: Ed Norwood [mailto:ednorwood@ernenterprises.org]
Sent: Thursday, December 08, 2016 1:34 PM
To: Joseph Ehrbar
Cc: Matt Eried; Chuck Killian; Mike DeChellis; Cathy Vital
Subject: RE: Notice of Intent to File Complaint with the U.S. Department of Labor

Mr. Ehrbar,

Thank you for your update.

Please be advised that under existing federal law, a health plan may not condition treatment, payment, continued enrollment in the health plan or eligibility for benefits on a patient providing individual authorization to a Business Associate of covered entity (HIPAA Privacy Rule § 164.308.)

As you know, HIPAA Privacy Rule § 164.514 (d)(3) states:

(iii) A covered entity may rely, if such reliance is reasonable under the circumstances, on a requested disclosure as the minimum necessary for the stated purpose when:

(A) Making disclosures to public officials that are permitted under § 164.212, if the public official represents that the information requested is the minimum necessary for the stated purpose(s);

(B) The information is requested by another covered entity;

(C) The information is requested by a professional who is a member of its workforce or is a business associate of the covered entity for the purpose of providing professional services to the covered entity, if the professional represents that the information requested is the minimum necessary for the stated purpose(s) (Emphasis added.)
Unfair Payment Practices

**TIMELY APPEAL TIMEFRAMES**

**APPEAL SUBMISSION TIMEFRAME MATRIX**

To protect your rights, make sure to escalate your cases to ERN/The Reimbursement Advocacy Firm (TRAF) within the following timeframes.

**JURISDICTION:**
- Medicare Advantage
- VA
- ERISA

**TIMEFRAME:**
- **60 DAYS** from the date of the notice of the organization determination
- **1 YEAR** of an adverse benefit decision
- **180 DAYS** following receipt of a notification of an adverse benefit determination

**SOURCE:**
- 42 C.F.R. § 422.582(b)
- 38 U.S. CODE § 7105
- 29 C.F.R. § 2560.503-1(h)(3)
SUMMARY OF COMPLAINT

Submitted via Email

May 28, 2018
Arnell Tabor-Bedward
8TH FLOOR, 400 W. DUKE STREET, APT 3005

St. Luke’s Hospital
Center for Medicare & Medicaid Services

Provider:
Tax ID:
Payer:
DOB:
Billed Charges:

Dear Ms. Tabor-Bedward:

This office represents St. Luke's Hospital ('"SLH") in regards to an incorrectly denied claim by Upper Peninsula Health Plan. I received your contact information from Ed Norwood, my Chief Compliance Officer. I wanted to reach out to clarify the situation around the denial of claim 13-1273 in the amount of $5,945.77.

In its advisory role to healthcare providers that provide medically necessary services to Medicare beneficiaries, the National Council of Reimbursement Advocacy ('"NCRA") and the Reimbursement Advocacy Firm ('"RAF") periodically brings to your attention non-compliance issues related to...

We dispute UPHP's denial of this claim for emergency and post-stabilization services and care for lack of authorization, because emergency services do not require prior authorization and in regards to prior stabilization services and care that are denied at the non-emergency level, therefore it was incorrect for UPHP to deny this care with the following evidence:

- On 1/1/15, the patient presented to Aspirus Grand View Hospital and was then transferred via Medevac to SLH for further treatment and care. Coverage was verified with Medicare. As the patient presented SLH with the Medicare ID. (Exhibit A: Hospital Remote Record)
- On the same date, verbal authorization to transfer the patient was obtained from the patient's next of kin, then treating physician and from the physician at SLH. There was diagnosed with acute vascular insufficiency. (Exhibit B: Reimbursement Advice)
- On 1/12/15, the patient expired. (Exhibit C: Claim RD)

RAF - The Reimbursement Advocacy Firm
8TH FLOOR, 400 W. DUKE STREET, APT 3005

FILED-05/25/16
SUMMARY OF COMPLAINT
Supporting Exhibits Submitted via Email

- On 12/22/15, SLH billed the claim to Medicare and the claim was denied, making the patient eligible with Medicare Advantage Plan UPHP. (Exhibit D: Medicare RA)
- On 12/22/15, SLH verified the patient's insurance coverage with UPHP. (Exhibit A: Hospital Remote Record)
- On 01/04/16, SLH billed the claim to UPHP.
- On 01/05/16, SLH submitted a retro-authorization appeal to UPHP. (Exhibit G: Hospital Remote Record)
- On or around the same date, SLH contacted UPHP and became aware there was no claim or retro-authorization appeal on file.
- On 02/08/16, SLH submitted a retro-authorization appeal to UPHP. (Exhibit F: Hospital Remote Record)
- On 03/31/16, SLH submitted a retto-authorization appeal to UPHP. (Exhibit E: Hospital Remote Record)
- On 04/05/16, SLH submitted the claim the UPHP and the claim was rejected.
- On 05/03/16, SLH submitted a letter stating there was no notification of admission within one business day. (Exhibit F: Hospital Remote Record)

As you know, 42 C.F.R. 422.110(h)(v) states:

(a) Rules for coordinated care plans. An MA organization that offers an MA coordinated care plan must develop and implement procedures and standards. Each MA organization ensures that all covered services, including supplemental services contracted for by the plan on behalf of the Medicare enrollee, are available and accessible under the plan. To accomplish this, the MA organization must meet the following requirements:

(1) The MA organization must establish written policies and procedures that:

(A) Ensure that all covered and noncovered services are accessible under the plan.
(B) Ensure that all services are made available at the level or exceed standards established by CMS. Timely access to care and member services within a plan's provider network must be continuously monitored to ensure compliance with these standards, and the MA organization must develop policies and procedures to ensure that providers are not denied the opportunity to receive payment for covered services.
(2) Policies and procedures (coverage rules, practice guidelines, payment notices, and utilization management) that allow for individual medical necessity determinations.
(3) Provider consideration of beneficiary input into the provider's proposed treatment plan.

Our records show, SLH submitted medical records for a retro-authorization review. UPHP then improperly denied the claim and this denial is not consistent with the CMS policy. UPHP did not communicate the denial of the claim to SLH. In response to our provider member's request for retro-authorization is unsubstantiated. UPHP must provide the policies and procedures utilized for a decision based upon medical necessity.

II. UPHP FAILED TO REIMBURSE MEDICALLY NECESSARY POST STABILIZATION SERVICES AND CARE.

In regards to post stabilization services and care, 42 C.F.R. 422.110(h)(v) states:

1.

2.

3.
FILED:05/26/16
SUMMARY OF COMPLAINT
Supporting Exhibits Submitted via Email

I. Services of noncontracting providers and suppliers. (1) An MA organization must make timely and proper payment for delivery of the plan services. For the following services delivery of the plan requires prior authorization that does not result in a MA organization to provide services covered by the MA plan:

- Ambulance services dispatched through 911 or its local equivalent as provided in Sec. 422.113.
- Emergency and urgently needed services as provided in Sec. 422.113.
- Maintenance and post-stabilization care services as provided in Sec. 422.113.
- Preventative services covered under PCCP/MA, AC and AMI．
- Services for which coverage has been denied by the MA organization and found upon appeal under subject M of this part to be services the enrollee was entitled to have furnished, or paid for, by the MA organization.

Alternatively, UHP is financially responsible for post-stabilization services in accordance with 42 CFR 422.113 (c)(2), which states:

(1) Maintenance care and post-stabilization care services (hereafter together referred to as “post-stabilization care services”).

(i) MA organization financial responsibility. The MA organization—

- Is financially responsible for post-stabilization care services obtained within or outside the MA organization that are pre-approved by a plan provider or other MA organization representative.
- 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.
- Is financially responsible for post-stabilization care services obtained within or outside the MA organization for pre-approval of further post-stabilization care services.
- Is financed 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.

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

(3) The enrollee is at risk of harm if the enrollee does not receive the post-stabilization care necessary for the enrollee’s condition, or, under the circumstances described in paragraph (c)(2)(iii) of this section, to improve or resolve the enrollee’s condition.

As shown in the remote notes, when SLH attempted to speak with the beneficiary, the patient was intubated. Therefore, as SLH did not know the MA plan representative for the beneficiary’s services, UHP could not be contacted timely to request pre-authorization for post-stabilization services.

Post stabilization services and care is defined under 42 CFR 422.113 (c) (1) which states:

| 3 |
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FILED:05/26/16
SUMMARY OF COMPLAINT
Supporting Exhibits Submitted via Email

(c) Maintenance care and post-stabilization care services (hereafter together referred to as “post-stabilization care services”).

(1) MA organization financial responsibility. The MA organization—

(ii) Maintenance care and post-stabilization care services means covered services related to an emergency not otherwise covered by this section provided after an enrollee is stabilized in order to maintain the enrollee’s condition, or, under the circumstances described in paragraph (c)(2)(iii) of this section, to improve or resolve the enrollee’s condition.

The patient presented to SLH to receive emergency services and care. Pursuant to the above law, UHP’s enrollee maintained the right to the freedom of choice to use any Medicare provider. Thus, this claim cannot be denied based on the grounds of the services were rendered by a non-contracted hospital.

III. UHP failed to reimburse services that otherwise would have been reimbursed by Medicare.

42 CFR 422.101(a)(b) states:

- Except as specified in Sec. 422.318 (for entitlement that begins or ends during a hospital stay) and Sec. 422.320 (with respect to hospice care), each MA organization must meet the following requirements:
- MA organizations must do one of the following:
- Pay all amounts, by furnishing, assigning, or making payment for, all services that are covered by Part A and Part B of Medicare (if the enrollee is entitled to benefits under both parts) or by Medicare Part B (if entitled only under Part B) and that are available to beneficiaries residing in the geographic area in which the enrollee is residing and outside of the service area of the plan if the services are accessible and available to enrollees.

(3) (a) CMS’s national coverage determinations.

(1) Except as specified in original Medicare manuals and instructions unless revised to reflect changes in Medicare instructions and instructions and

(2) Written coverage decisions of local Medicare contractors with jurisdiction for claims in the geographic area in which services are covered under the MA plan, if an MA plan covers geographic areas encompassing more than one local coverage policy area, the MA organization offering such plan must ensure that each area of the plan area that has a local contractor is selecting the area’s local contractor policy that is most beneficial to enrollees.

(3) Written coverage decisions taken by local Medicare contractors with jurisdiction for claims in the geographic area in which services are covered under the MA plan, if the enrollee is entitled to benefits under both parts) or by Medicare Part B (if entitled only under Part B) and that are available to beneficiaries residing in the geographic area in which the enrollee is residing and outside of the service area of the plan if the services are accessible and available to enrollees.

- CMS will review notices provided under paragraph (b)(3)(ii) of this section, evaluate the selected local coverage policy or policies based on such factors as easy access, geographic

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distribution of enrollees, and health status of enrollees, and notify the MA organization of its
intention to file a claim for compliance with the requirements of the selected uniform local coverage
policy area or plan. If the MA organization does not file an appeal, the provider may submit an
explanation of medical necessity for the item or service to the MA organization. If the
explanation is not accepted, the provider may submit an advance payment request to the MA
organization. If the MA organization does not file an appeal, and the advance payment request
is not accepted, the provider may submit a report of non-compliance to the CMS.

If an MA organization offering an MA local plan elects to exercise the option in paragraph (h)(3)
of this section related to a local MA plan, or if an MA organization offering an MA regional plan
fails to file a request to the CMS within 30 days of when the provider submitted the advance
payment request, the provider may submit a report of non-compliance to the CMS. The report of
non-compliance must include the provider's address and date, the date the provider submitted the
advance payment request, and the name of the provider.

If an MA organization offering an MA regional plan fails to file a request to the CMS within
30 days of when the provider submitted the advance payment request, the provider may file a
claim for reimbursement for the item or service with the MA organization. If the MA
organization does not file an appeal, the provider may submit an explanation of medical necessity
for the item or service to the MA organization. If the explanation is not accepted, the provider may
submit an advance payment request to the MA organization. If the MA organization does not
file an appeal, and the advance payment request is not accepted, the provider may submit a
report of non-compliance to the CMS. The report of non-compliance must include the provider's
address and date, the date the provider submitted the advance payment request, and the name of the
provider.

Here, UHP is financially responsible for the reimbursement of this claim, as the services rendered to
your enrollee were covered by Medicare as would have been covered.

IV. UHP FAILED TO REQUEST A WAIVER OF LIABILITY PRIOR TO THE INITIAL PROCESSING OF THIS CLAIM.

As you are aware, the claim is for services rendered to a beneficiary who is not enrolled in Medicare.

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-contracted provider completes a waiver of liability statement.

Physicians and suppliers who have executed a waiver of beneficiary liability are NOT REQUIRED TO
COMPLETE THE CMS-1500, APPOINTMENT OF REPRESENTATION FORM. In this case, the physician or
supplier is NOT REPRESENTING THE BENEFICIARY, AND THIS DOES NOT NEED A WRITTEN
APPOINTMENT OF REPRESENTATION.

Attached to my last email (Exhibit 6: Email Sending) was the signed Waiver of Liability which was necessary to be
obtained on behalf of our claim to process. However, UHP has failed to submit the signed Waiver of Liability
for the claim.

V. UHP FAILED TO SUBMIT THIS CASE TO MAXIMUM UPON THEIR FIRST ADVERSE DETERMINATION.

Our office is also concerned with UHP’s failure to forward its adverse organization determination to the IBE within
30 calendar days from the date the IBE received the request for a standard reconsideration. As you know, 42 CFR §422.590
states:

(3) If the MA organization allows, its adverse organization determination, it must prepare a
written explanation and send the case file to the independent entity contracted by CMS no later
than 60 calendar days from the date it receives the request for a standard reconsideration.

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

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

Further 42 CFR §422.590 (g) states:

(1) A person or persons who were not involved in making the organization determination must
conduct the reconsideration.

(2) When the issue is the MA organization's denial of coverage based on a lack of medical
necessity, the reconsideration may re-consider the issue of medical necessity, and it is not necessary
for the reconsideration to be conducted by a person or persons other than those who made the
original determination.

Our provider member requested a standard reconsideration on 01/29/16 and submitted evidence, i.e., medical
records, certification of contract made, etc. to overturn the MAO's improper denial. If the MAO affirmed in whole
or in part the adverse organization determination, the provider member must prepare a written explanation of their
adverse organization determination and send the case file to the IBE (Independent entity contracted by CMS) within
60 calendar days from the date the IBE received the reconsideration request.

This non-compliance issue has been previously addressed in the Best Practices and Common Findings Memos #3,
from the 2012 Program Audit. In that audit, denied Muscular, Director of the Medicare Parts C and D Oversight and
Enforcement Group stated:

In the area of Part C Organization Determinations, Appeals, and Waivers, Medicare Advantage Organizations often continue to be noncompliant, predominantly in the areas of clinical decision making, timely processing and notification of decisions, and in classification and
processing of grievances. Organizations must ensure coverage decisions, appeals, and grievances are handled appropriately in order to avoid beneficiary harm due to delayed or
improper coverage determinations or improper treatment of grievances.

Sponsors continue to be inaccurate and unclear in the communication of their coverage decisions. It is critical that Sponsors clearly and accurately communicate their decisions.

We observed the following: Upon receiving a request for reconsideration of a denied claim from a non-contract provider without the waiver of liability (WoL), there was a failure to make, and document, reasonable efforts to secure the necessary form.

Sponsors continue to be untimely and/or improperly processing organization determinations, reconsiderations, and payments. Timeliness is imperative in ensuring beneficiaries receive
access to care.

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

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Here, it does not appear that the MAC contacted the provider to make a request for the WO, and/or document reasonable offers to resolve the dispute that the provider has received. It also appears that the provider is unable to obtain the necessary documents in a timely manner. As such, the Medicare Advantage Organization is attempting to withdraw the Federal funds due the Medicare beneficiary. As such, we are requesting that CMS investigate this matter.

Respectfully,

Fantasia Washington
Claim Compliance Editor
Phone: 313-821-5420, ext. 9907
e-mail: fwa@ernenterprises.org

Enclosure:
Exhibit A: Hospital Remote Records
Exhibit B: Vendor Document
Exhibit C: Claim/DE
Exhibit D: Medicare RA
Exhibit E: SDR Appeal
Exhibit F: Claim Correspondence
Exhibit G: Email String

FP: Appeal #: 1-45334880166; Email 1 of 2
000547344-uj.php stt horrible 0909416.pdf

Fantasia Washington

Subject: FP: Appeal #: 1-45334880166; Email 1 of 2
Attachments: 000547344-uj.php stt horrible 0909416.pdf

From: Fantasia Washington
Sent: Tuesday, June 14, 2016 1:42 PM
To: Janice Eldem
Cc: Ed Norwood <ednorwood@ernenterprises.org>

Dear Ms. Eldem,

I hope this message finds you well.

I received your contact information from my Chief Compliance Officer, Ed Norwood and I wanted to reach out to you in regards to the appeal number mentioned above. Your company has filed a complaint with CMS for Upper Peninsula Health Plan's failure to request a waiver of liability, failure to forward this case to the IRE upon upholding their initial benefit decision and finally, Upper Peninsula Health Plan has now submitted this matter to MAXIMUM.

In our complaint/ appeal, ERN/TRAIC cited Upper Peninsula Health Plan with an aggregate number of violations including their failure to request medical records for a proper medical review to determine medical necessity. (Has attached copy of summary of complaint)

As you know, the covenant of good faith and fair dealing in all contracts requires each contracting party to refrain from doing anything to impair "the right of the other to receive the benefits of the agreement." (Murphy v. Allstate Ins. Co. (1976) 17 Cal.3d 937, 940 (132 Cal.Rptr. 594, 553 P.2d 584).)

As applied to insurance contracts, it does not merely "connotate the absence . . . of positive misconduct of a malicious or immoral nature . . . ." (Neal v. Farmers Ins. Exchange (1978) 21 Cal.3d 910, 922, fn. 5 (148 Cal.Rptr. 889, 582 P.2d 980)); it demands that the insurer act reasonably. (Id. at p. 925.)

In a medical insurance policy, the insured's expectation of security is relevant to the interpretation of medical necessity. The Supreme Court has held "that an insurer may breach the covenant of good faith and fair dealing when it fails to properly investigate its insured's claim." (Egen v. Mutual of Omaha Ins. Co., supra, 24 Cal.3d 809, 817.)

In reviewing the medical necessity of hospitalization, this duty of investigation surely entails an obligation to make reasonable efforts to obtain all medical records relevant to the hospitalization.

Therefore, the covenant of good faith and fair dealing places the burden on the insurer to seek information relevant to the claim.

This office, hereby requests MAXIMUM to review the copy of the complaint submitted to CMS and forward the medical records, which will be sent via USPS Priority mail, (Tracking number: 9408 5059 9930 0341 51) to a medical reviewer.

Note: The attachment is password protected, a password will follow.

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Traff 47744
7/25/2016

Rosh Rockett Dir of Business SVC
ST Luke’s Hospital
341 N. 1st Ave
Minneapolis, MN 55405

RE: Preliminary: T. Conover Medicare Number: Date(s) of Service: November 31, 2015 to December 9, 2015

Dear Rosh Rockett Dir of Business SVC:

This letter is about our decision to appeal to Upper Peninsula Health Plan, LLC (UPHP). You asked UPHP to pay for the hospital services provided from November 31, 2015 to December 9, 2015.

Our decision
We agree with you. This means that we will tell UPHP to pay for these services. Below is more about how we made our decision, read the following pages of this letter.

What you have to do
We sent UPHP a copy of this letter, so they know they have to pay for these services.

UPHP has 30 days to pay for the item or service within 30 days. If UPHP does not pay within 30 days, call 1-800-MEDICARE (1-800-633-4227). 11/15/15.

cc: J. H. 149/97: Upper Peninsula Health Plan, LLC, 600 Nicola Sandstrom
Chicago CMS Regional Office

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How we made the decision

1. We read all the papers in the file.
2. We checked Medicare rules.
3. We decided to appeal to UPHP.

To make our decision we read all the papers in the file very carefully. We used the Medicare rules. We looked to see if UPHP correctly followed Medicare rules and regulations.

Medicare rules say that the health plan must give the member a subscriber agreement. It is a contract between the health plan and the member. It is usually called the “Certificate of Coverage” (CoC) or “Member Agreement.” We read this contract carefully to see what UPHP is supposed to cover.

Medicare rules

The rules say that health plans must pay for a medical service or item if regular Medicare would pay for it in this case. You can find this rule at 42 CFR §482.101.

The rules say that a Medicare health plan may require members to a network of providers as long as medically necessary covered care is accessible and available through this network. The rule say that the health plan must arrange for specialty care outside of the plan provider network.

The rules also say that Medicare would pay for inpatient hospital care or inpatient hospital services without a prior authorization. The rule requires the hospital to report to Medicare if a patient needs care beyond the original hospital stay. You can find this rule at 42 CFR §482.113.

The rules say that the Medicare Health Plan is financially responsible for emergency services without the members having to make any payment.

If you want to read these Medicare rules, you can go to this website: www.medicare.gov.

The health plan contract

The health plan contract says that UPHP covers items and services in accordance with Medicare rules. The health plan contract says that members must use network (contract) providers to get their covered services. The only exceptions are emergencies, urgent needed care when contract

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www.ernenterprises.org
Explanation of decision

We decided that UPHP has to pay for the inpatient hospital services provided from November 21, 2015 to December 9, 2015.

You asked UPHP to pay for these services. You say that you were not aware that T. Connor was enrolled in UPHP at the time of admission; therefore, you were not aware that prior authorization was required. UPHP denied your request. UPHP says that UPHP requires notification of all admissions within 1 business day of admission. UPHP says that, because you failed to notify the health plan of T. Connor's admission within 1 business day, these services are not payable.

UPHP must follow Medicare rules. The rules say that health plans must cover emergency services and urgently needed services even if the services are provided out of network or without prior authorization. Medicare rules say that the health plan must arrange for specialty care services if the enrollee's primary care doctor or health care provider requests it. U.S. Department of Health and Human Services, Department of Justice, Office of the Inspector General, Advisory Opinion 97-8,June 18, 1997. Medicare rules say that a preferred provider is an agent of the plan. Services and referrals given by a preferred provider are considered approved by the plan unless notice is provided that the services will not be covered.

In this case, the record shows that T. Connor was originally seen at Aspirus Grand View Hospital, a UPHP plan contract provider, for pneumonia and possible bowel ischemia. Aspirus Grand View Hospital determined that they could not appropriately treat T. Connor or this problem. T. Connor was then transferred to St. Luke's Hospital. Although UPHP has an agreement with Aspirus Grand View Hospital, they do not provide critical care. So T. Connor was transferred to St. Luke's Hospital and arranged for ambulances to bring him to that hospital. The record shows that this transferring hospital does not have adequate facilities to provide the medical services needed by the patient. UPHP covered the ambulance services to transfer T. Connor from Aspirus Grand View Hospital to St. Luke's Hospital. According to the UPHP panel review form, T. Connor was emergently admitted to St. Luke's Hospital.

In making its decision, UPHP has relied on an internal policy requiring notification of all admissions within 1 business day of admission. However, the plan must comply with Medicare rules to cover the services. UPHP must have adequate procedures and policies to ensure that the enrollee's primary care doctor or health care provider requests it. U.S. Department of Health and Human Services, Department of Justice, Office of the Inspector General, Advisory Opinion 97-8, June 18, 1997. UPHP's internal medical panel review form states that T. Connor was emergently admitted to St. Luke's Hospital. As such, prior authorization was not needed for this admission. Emergency care must when the patient is stabilized. Post stabilization care is care that is administered to stabilize, improve, or maintain the patient's condition. Although UPHP never made an explicit argument that some of the care provided to T. Connor was post stabilization care nor did the health plan attempt to indicate when T. Connor's emergency admission to St. Luke's Hospital became post stabilization care, UPHP says that T. Connor was post stabilization care prior to being transferred to St. Luke's Hospital. However, because the health plan has determined T. Connor's admission to St. Luke's Hospital was emergent, the health plan would have to show that the emergency care ended at some point prior to discharge.

Even if we assume that UPHP was incorrect in its determination that the admission to St. Luke's Hospital was emergent or that T. Connor's emergency admission to St. Luke's Hospital prior to discharge, we find that the transfer to St. Luke's Hospital was planned care. T. Connor was seen at St. Luke's Hospital and then transferred to St. Luke's Hospital. The record shows that T. Connor's condition was critical care and that he was transferred to St. Luke's Hospital for further treatment. The record shows the need to stabilizing T. Connor's medical needs. The file does not show that UPHP's contract provider, Aspirus Grand View Hospital, requested prior authorizations of this referral. Indeed, as noted above, T. Connor was a UPHP enrollee, and informed you of the need to notify UPHP of this transfer. However, under Medicare rules, referrals given by a contract provider are considered approved by the plan unless notice is provided to the health plan that these services will not be covered. UPHP advised you that these services would not be covered, this transfer is consistent plan-approved.

Therefore, we decided that UPHP has to pay for the inpatient hospital services provided from November 21, 2015 to December 9, 2015.

If UPHP does not agree with our decision, they can ask us to open a case again. We only open a case again to resolve issues of misunderstanding or if there is new information to review. The health plan has to show us the information you don't have or new information. This does not happen often. If we decide to open the case again, we will send you a letter.
It can be difficult to find a passionate claims representation and training partner that reflect your corporate values and remain on the cutting edge of Federal and State prompt payment laws to stimulate cash flow.

When you use administrative laws in the revenue and appeal cycle:
• You strengthen Arkansas’ healthcare delivery system
• You defend public health and safety
• You keep your doors open.
Together, we will build an enforcement program in the State of Arkansas that works.

- Patient Advocacy Hotline: (714)995-6900 Ext 6921
  Email: pa@ernenterprises.org

- Claim Representation Helpdesk: (714)995-6900 Ext 6935
  Email: cr@ernenterprises.org

- Member Services Helpdesk: (714)995-6900 Ext 6913
  Email: ms@ernenterprises.org

Call us to report unfair payment practices or concurrent denials of medically necessary care.
What people are saying...

“ERN/TRAF is an amazing company; after partnering with them for a few months, I have never seen so many insurance companies willing to work with me directly to resolve their issues when they wouldn’t even answer my calls in the past. Way to go!” - J. Cummings, Valley Health Sys.

“This is so great. It didn’t take but what, 3 days for them to pay?” – Z. Aflak, CFO, Kindred SF

“I have had numerous occasions over the last several years to refer claims to ERN/TRAF. I chose TRAF over other vendors because I know that they are extremely knowledgeable about the statutes that apply to every payer type. They are true professionals and have been so successful with even the most difficult cases. I know that TRAF will always go the distance for us and when we’re really in trouble, I always think of Ed and his gang to help us out.” – D. Esparza, CHW

“Your company has really gotten the log jam of payments loosened up these days; we really appreciate your help and support.” - Reno CHW Member (VA outstanding A/R was reduced from 4.3 million to $196,038.37 in just 30 days!!)

QUESTIONS? NEED MORE INFORMATION?

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ERN/NCRA/TRAF
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Cypress, CA 90630
(714) 995-6900 ext. 6926