



Take control of Medicare Advantage denial challenges

What's the difference between Medicare and Medicare Advantage? With more Medicare-eligible individuals signing up for Medicare Advantage plans, hospitals and patients are learning the difference—sometimes the hard way. Navigating Medicare Advantage denials can be a daunting endeavor, one that may lack clear rules and definitions. Faced with a time-consuming and complex appeals process, limited resources, and a lack of staff experienced in successfully negotiating Medicare Advantage, many organizations accept decreased reimbursement. But that's often a mistake.

As Medicare Advantage makes strides to becoming the new norm, revenue integrity needs to establish new processes, educate staff, and advocate for patients. Learn how your organization can keep pace with change before it's too late to catch up.

The risks of capitated payment

As Medicare Advantage has grown, patients and providers have faced an array of new challenges associated with these plans, including denials of medically necessary care, delayed authorizations, and a complex appeals process. In September 2018, the Office of Inspector General (OIG) released a [report](#) that affirmed, with surprising bluntness, what many providers and patients have experienced: Medicare Advantage Organizations (MAO) may be gaming the capitated payment system to inflate their profits by inappropriately denying medically necessary care.

The OIG study looked at data on denials, appeals, and appeal outcomes for 2014 to 2016 for each level of the Medicare Advantage appeal process. It also analyzed CMS' 2015 Medicare Advantage audit results and enforcement actions,

including star ratings data from 2016 to 2018. The findings strongly suggest that MAOs aren't playing fair. MAOs overturned 75% of their own denials at the first level of the appeals process, and additional denials were overturned by independent reviewers at higher levels. The large volume of successful appeals, particularly at the first level, raises concerns that MAOs were denying payment and authorization for services that should have been provided, the OIG said. And, even more concerning, beneficiaries and providers appealed only 1% of denials. Given the high rate of successful appeals, the low rate of appeals in general suggests that the Medicare Advantage appeals process is overly burdensome, particularly for beneficiaries.

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The OIG's report goes on to detail CMS' past audit results and enforcement actions. In 2015, CMS cited 56% of audited MAO contracts for inappropriately denying requests for preauthorization of services or payment. CMS found that some MAOs made the wrong clinical decision based on information submitted by the provider organization or the beneficiary, while other MAOs did not request all the necessary information before deciding to issue a denial. Also in 2015, CMS cited 45% of audited MAOs for sending insufficient denial letters,



meaning that provider organizations and beneficiaries may not have known exactly why authorization or payment was denied or how to appeal the decision. These findings are particularly troubling because by delaying payment or medically necessary care, MAOs are causing harm to beneficiaries who may already be critically ill.

But will the OIG's report lead to change? "I think at the very least the report has put MAOs on alert, especially those with high overturn rates and/or low appeal rates, and hopefully will lead to some reform in the future for the benefit of Medicare beneficiaries," says **Sarah L. Goodman, MBA, CHCAF, COC, CCP, FCS**, president/CEO and principal consultant for SLG, Inc., in Raleigh, North Carolina.

CMS has taken action against MAOs that don't follow regulations. After CMS' 2015 audit of MAOs, nine MAOs were fined a total of \$1.9 million for violations related to denials and appeals; CMS noted that some of these violations were common problems. The agency suspended new enrollment for two MAOs due to compliance violations that posed

a serious safety threat to the nearly half a million beneficiaries covered under the two organizations. However, even though CMS' own audits point to systemic noncompliance among MAOs, beginning in 2019, audit violations will no longer impact MAOs' star ratings.

Delays in medically necessary care and appropriate payment have far-reaching consequences, the OIG said. If care is delayed, a critically ill beneficiary may not receive treatment when it would have been most effective, leading to poorer outcomes and additional services. A beneficiary who has had to pay out of pocket for services that were inappropriately denied may be reluctant to seek care in the future. Provider organizations may opt to write off these denials rather than work through the complex appeals process. However, that decision will hurt the organization's bottom line and affect its ability to finance new services, existing services, and facility improvements—or even to stay open at all. In addition, the high volume of denials may deter provider

organizations from offering commonly denied services, the OIG said in its report.

It isn't surprising that MAOs are looking to make a profit; after all, they are private companies. But the implications of denying or delaying medically necessary treatment to cancer patients while offering benefits such as high-tech fitness trackers raises reasonable concerns about how some MAOs are using federal money, says **Timothy Brundage, MD, CCDS**, medical director of The Brundage Group in St. Petersburg, Florida. "They're promising all the bells and whistles. The only way you can provide bells and whistles is if you're actually saving cost, and the way to save cost is to have the care of the patient be lower than the expected cost of caring for the patient," he points out.

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In theory, MAOs will keep patients healthy by encouraging them to make use of lower-cost outpatient services such as regular primary care checkups. In turn, MAOs are encouraged to keep patients healthy and out of the hospital through risk-sharing and capitated payments. However, as the OIG report pointed out, that can incentivize MAOs to deny or delay medically necessary care that can only be provided in a hospital.

"The biggest-ticket item that you have as a risk dollar is an inpatient hospitalization. That's a super-expensive place to receive care, and obviously that patient is very sick if they get admitted to the hospital," Brundage says. "The managed Medicare folks do everything in their power to keep the patient in observation or outpatient so they're caring for their patient at the lowest cost possible."

Following the process

One of the key points of the OIG's report is that although most denials were overturned on a first-level appeal, only 1% of denied claims were appealed. The high rate of successful appeals suggests that the initial denials were inappropriate, but the extremely low number of denials that were brought through the appeals process supports comments from provider organizations and patients that the Medicare Advantage appeals process is overly complex and burdensome, the OIG said in its report.

But although experts agree that the appeals process is difficult to navigate, there are a number of factors at play that may have fallen outside the scope of the OIG's review. Significantly, MAOs, third-party auditors contracted by MAOs, and provider organizations may not be using the same definition of an appeal, says **Brian A. Moore, MD, FACEP, CHCQM-PHYADV**, medical director of utilization management and physician advisor services at Atrium Health in Charlotte, North Carolina. The traditional Medicare appeals process is well-defined, and provider organizations are generally familiar with its ins and outs. Medicare Advantage is a different story.

Traditional Medicare denials are retrospective; in contrast, Medicare Advantage denials, like most commercial payer denials, are concurrent. The formal Medicare Advantage appeal or reconsideration process is outlined in the [Maximus Federal Medicare Health Plan Reconsideration Process Manual](#), which describes the steps a patient or a patient representative (possibly the provider organization) can take to open a formal reconsideration if the patient feels his or her benefits are being inappropriately denied. These formal appeals are tracked by CMS and comprise the data that agencies such as the OIG can review, Moore says. But most Medicare Advantage denials never go through that process.

When an MAO notifies a hospital that it will not cover or pay for a patient's care, the attending physician or a physician advisor (PA) may engage the MAO's medical director in a peer-to-peer discussion. During this discussion, the physician or PA

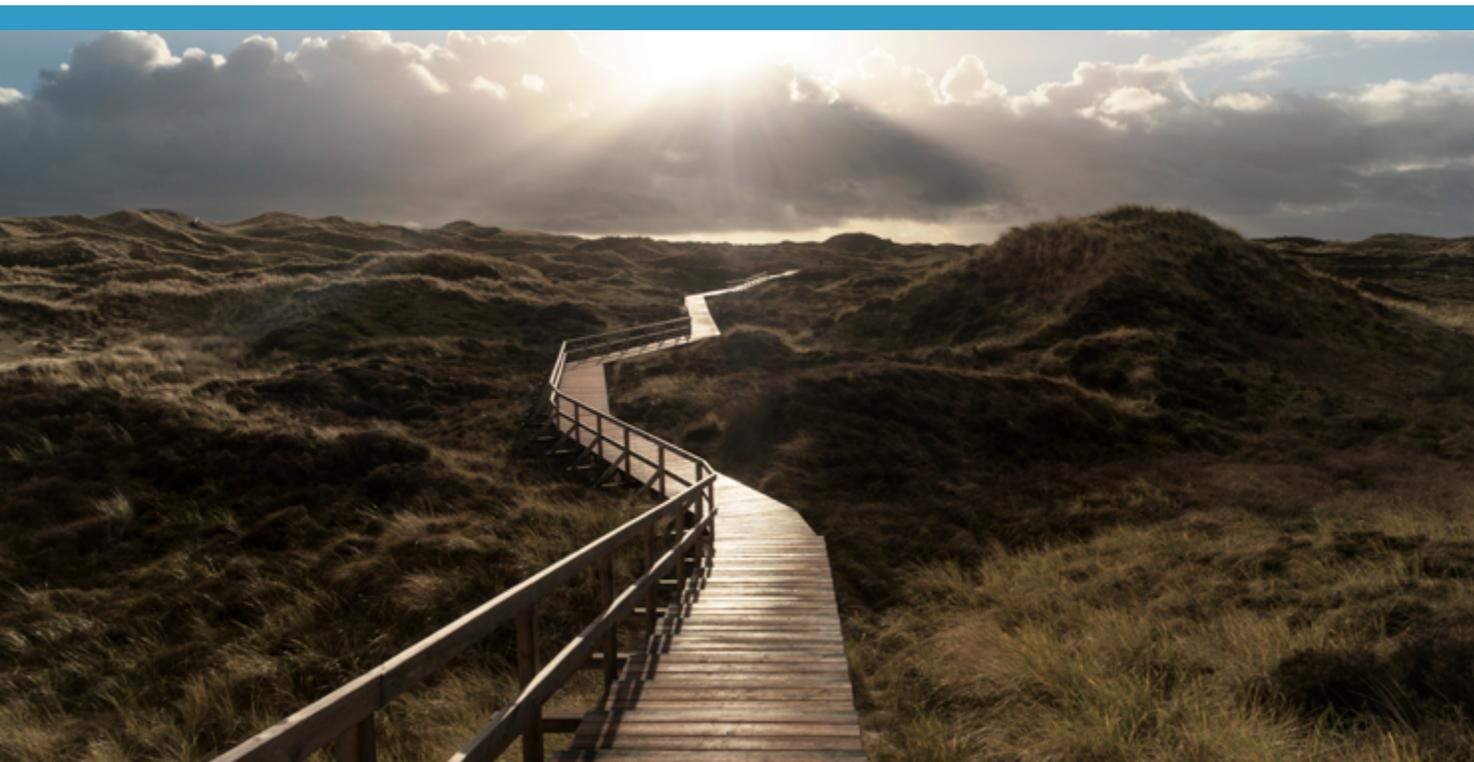
explains why he or she believes the denied service should be approved, supplying any additional documentation that confirms the service is covered and medically necessary. From the hospital's perspective, this may look like a denial, but that's generally not how the MAO defines it and not how it will be reported to CMS, Moore explains.

"All of the work we were doing and are doing currently in our peer-to-peer work, which is a very large volume and most hospitals are doing a large volume of these peer-to-peers, all of the cases that we get overturned don't flow into this. It's not even considered a denial," he says. "Because what happens is before you drop your bill, they rescind their denial and it's almost treated like a delayed authorization. My understanding is that it's not a reconsideration as outlined in the Maximus program and it doesn't make it into the Medicare appeals program. So, it doesn't really get reported as a denial."

For example, a Medicare Advantage beneficiary is admitted as an inpatient and is hospitalized for four days. During the stay, the MAO notifies the hospital that the care provided does not meet inpatient medical necessity criteria, and a peer-to-peer

may be scheduled to discuss the case. The MAO medical director will then call the attending physician, often during rounds, to inform him or her that the MAO has determined that inpatient care was not medically necessary, and the patient's status should be changed to outpatient with observation services. After speaking to the MAO's medical director, the attending physician may be persuaded that, in this case, the patient did not meet the plan's criteria for inpatient care and agree to change the status to outpatient. The physician may be too busy to have an in-depth discussion about details of plan coverage and definitions and, not unreasonably, may simply trust that the MAO understands its own plan. That interaction will not be tracked in the Maximus program and will not be considered a denial. It will appear to CMS as if the attending physician actually intended for the patient to be treated as an outpatient all along, Moore says. Failure to track and report this type of MAO influence can significantly underreport actual MAO plan denial activity.

"I think most of us in the industry are happy that the OIG pointed out that it appears that this denial



activity that's happening is significantly incented with profits, and unfortunately it's resulting in patients who are having benefits that we feel are denied inappropriately," Moore adds. "Until you really delve deep into what your options are, especially as a contracted provider, it's very hard to get outside of the contract or outside of the plan when you feel the benefits are being denied. You don't feel empowered by CMS to protect patients against these aggressive MAO plan denials identified by the OIG."

Clinical validation

Clinical validation denials are challenging regardless of the payer, and MAOs are no exception. MAOs essentially play by their own rules, says **James P. Fee, MD, CCS, CCDS**, CEO of Enjoin and practicing hospitalist in Baton Rouge, Louisiana. "Although it's Medicare beneficiaries and an MAO organization, those organizations don't necessarily follow guidance by traditional Medicare," he says.

That misalignment isn't limited to the appeals process—it extends to clinical criteria and issuing clinical validation denials, too. This has become particularly challenging for conditions such as sepsis where multiple clinical criteria and definitions exist, Fee says. Due to the clinical uncertainty of the definition of sepsis, CMS uses Sepsis-2, resulting in a decrease in the amount of clinical validation denials for sepsis under traditional Medicare. However, the pendulum has swung in the other direction for Medicare Advantage. Many MAOs use Sepsis-3 criteria and provider organizations have seen denials skyrocket, he says.

"Clinical validity is determined by reviewers who don't fully understand clinical medicine and certainly have difficulty applying clinical medicine to coding rules and guidelines," Fee says.

For example, an MAO or its auditors may have specific criteria for encephalopathy such as a mini mental status exam to validate the diagnosis. A patient is admitted with altered mental status. The physician documents the impaired function, diagnoses metabolic encephalopathy, and then documents the diagnosis and treatment. However, the

MAO issues a clinical validation denial because the physician did not administer a mini mental status exam.

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"The mini mental status exam is one mechanism to establish impaired neurologic function, but it's not an absolute requirement based upon evidence-driven definitions of encephalopathy," Fee says. "So once that denial is received, and you clinically validate that it was the correct diagnosis, validate and justify what you submitted on the claim and what was documented."

The attending physician can work with a PA to draft an appeal letter that establishes the diagnosis of encephalopathy without a mini mental status exam and that cites clinical evidence and *Coding Clinic* guidelines. The provider organization should have a system to track receipt of denials, when appeal letters are sent out, and any follow-up, he adds.

However, success may ultimately rest on the hospital's contract with the MAO. Although an MAO should cover all Medicare Part A and B benefits, like other commercial payers its contract terms may include varying criteria.

"Certain organizations within their contract with the MAO may have established definitions and criteria for the clinical validity of diagnoses. And if you sign that agreement, you're bound by

those definitions,” Fee says. “So that is what you need to establish encephalopathy. You have to apply that definition because contractually you’ve agreed to it.”

Getting ahead

A robust PA program is essential to managing Medicare Advantage denials, Moore and Brundage agree. These professionals are often best-suited to craft appeal letters and engage in peer-to-peer discussions with MAO medical directors or nurse auditors. Revenue integrity should work with PAs to track, report, and monitor Medicare Advantage denials, identify opportunities for improvement, and establish processes. (For more information on how to collaborate with PAs, see the article on p. 21.)

Staying on top of Medicare Advantage denials and appeals will be critical as that patient population grows. “The longer that we have managed Medicare and the savvier the insurance companies become, the more they understand the system, and the more they are able to take every advantage that they possibly can to pay as little as they possibly can for the patient who receives care,” Brundage says. “It’s hard to have an unbiased insurance company because it comes down to dollars and cents.”

Managing Medicare Advantage denials is a team sport, Moore says. Revenue integrity should find out who is receiving calls from the MAO or third-party

auditors and who is receiving the denial notifications. Depending on the size of the organization and whether it has a centralized structure, tracking down these notifications can be difficult.

“You have to get that streamlined to where you can capture all the peer-to-peers as early as possible so that you can review them,” Moore says. “The biggest thing is, I think, investing in the PA program who can then help organize and get these denials going to a centralized area. Then they can handle them on behalf of the attendings, allowing them to perform their clinical duties while we confront the denial activity.”

To help manage Medicare Advantage denials, organize the denial issues by plan and determine their dollar impact and volume, Goodman says. Some of the issues may repeat across plans. Be thorough and diligent—create a tracking spreadsheet or database to monitor progress.

Then, track the data and outcomes, Moore says. Revenue integrity can use tools such as payer scorecards to collect a holistic picture of each MAO their organization deals with. Take the time to investigate and understand CMS’ guidelines for inpatient care, such as the 2-midnight benchmark, but don’t neglect other tools, such as InterQual and Milliman, that MAO medical directors might be using.

Collect feedback from PAs and attending physicians after peer-to-peers with MAO medical directors. For example, during peer-to-peer discussions, it might become apparent that although the provider organization is sending all documentation, the complete record is not being passed on to the medical director. Organizations should document and track these instances and consider opportunities to address them with internal controls, contract terms, or direct advocacy with the MAO and CMS.

Lastly, when it comes to managing MAO plan relationships, make sure key individuals have knowledge about your contracts, Moore adds. Not infrequently, MAO plan denial practices are prohibited by your contract, and understanding how to use your contracts to reduce or counter these appeals is critical. **NJ**



Understanding Medicare Advantage

A Medicare Advantage plan, or Medicare Part C, is a Medicare plan offered by a private company that contracted with Medicare, according to CMS. In other words, it's a commercial plan that is funded by federal money. A Medicare Advantage payer organization is called a Medicare Advantage Organization (MAO). And while MAOs are expected to provide beneficiaries' full Part A and B benefits, the reimbursement system is very different than under traditional Medicare.

Medicare Advantage uses a capitated payment model. Under this model, beneficiaries enroll in a Medicare Advantage plan, and Medicare pays the MAO a risk-adjusted payment each month per beneficiary. In exchange, the MAO agrees to authorize all medically necessary care that is covered by Medicare and reimburse the provider organizations for their services. The monthly payments are risk-adjusted based on the beneficiaries' individual health status, chronic conditions, and other factors that may make care more resource-intensive and, therefore, expensive. A higher-risk patient is expected to require more care—and more expensive care—than a lower-risk patient, and therefore the MAO receives a higher payment for agreeing to manage that higher-risk patient. The benefit to the MAO is that if it is able to manage a patient's care at a lower than expected cost, it gets to keep the difference, says **Timothy Brundage, MD, CCDS**, medical director of The Brundage Group in St. Petersburg, Florida. For example, CMS pays an MAO \$7,000 in 2019 to manage the care for Mrs. Jones based on her 2018 risk score. If the MAO can do this for \$6,000, it makes a profit. However, if Mrs. Jones' care for the year costs \$9,000, the MAO faces a loss.

Risk is determined and calculated based on patients' risk scores—data based on Hierarchical Condition Categories (HCC). The HCC model categorizes specific ICD-10-CM diagnosis codes into groups that are determined to be similar both financially and clinically. Not all ICD-10-CM codes map to an HCC, and although it's obvious that certain chronic conditions such as diabetes map to HCCs, others are less apparent. Past health events such as a myocardial infarction or an amputation can fall into an HCC. Missing these diagnoses, whether through incomplete coding and documentation or neglecting to address them through routine care, can inappropriately lower a patient's risk score and ultimately reduce the resources available to provide care. On the other hand, inappropriately reporting codes to increase a patient's risk score is fraud and may be considered a criminal offense.

The Medicare Advantage population was relatively small several years ago, but it has experienced rapid growth. MAOs have begun to aggressively market their plans; some now offer lower premiums and expanded benefits, such as healthy groceries or expanded telehealth, that are not available under traditional Medicare. In addition, CMS itself encourages the growth of Medicare Advantage and *predicts* that enrollment will reach 22.6 million in 2019, up from 20.2 million in 2018. Industry analyst LEK Consulting *forecasts* that by 2025, 50% of Medicare-eligible individuals will be enrolled in a Medicare Advantage plan. [NJ](#)