Report on Medicare Compliance Volume 30, Number 26. July 19, 2021 Surprise Billing Rule Bans ER Denials Based on Final Diagnosis Codes

By Nina Youngstrom

Hospitals have two powerful weapons, one new and one old, to thwart unreasonable claim denials by Medicare Advantage (MA) and/or commercial plans, an expert said. One comes from an interim final rule on surprise billing[1] announced July 2 and the other from the *Medicare Managed Care Manual*.

To start in reverse, chapter four of the *Medicare Managed Care Manual* (Sec. 10.16)[2] states that "if the plan approved the furnishing of a service through an advance determination of coverage, it may not deny coverage later on the basis of a lack of medical necessity." People at hospitals may not be aware of this provision, said Day Egusquiza, president of AR Systems Inc., at SAI Global's Revenue Integrity Summit July 13.[3] "You will always have cases disputed after Grandma goes home," she noted. But according to the manual provision, "Medicare Advantage plans can't deny after the fact if they have authorized an admission."

Before responding to medical record requests from MA plans, hospitals should determine if they fall under the manual provision. When that's the case, Egusquiza suggested hospitals have their legal counsel send a letter cautioning the MA plan to back off or the hospital will file a complaint with CMS. Hospitals can prepare a form letter to use every time they receive documentation requests for authorized services, she said. "You shouldn't have to appeal these."