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CMS Gives Providers More Elbow Room to Fight MA Denials in Update to Appeals Guidance

By Nina Youngstrom

In an Aug. 3 update to Chapter 13 of the *Medicare Managed Care Manual*, CMS has drawn new lines in the sand for appeals of denials by Medicare Advantage (MA) plans. This should help hospitals and other providers push back when they think they have grounds for authorization of inpatient admissions, for example, or claims for services have been inappropriately denied, experts say.

The changes to "Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance" affect enrollee appeals of services, peer-to-peer discussions and appeal rights for noncontracted providers.[1]

"In this area of member appeals and having member appeals being heard and adjudicated, it's a really big deal," said Edward Hu, M.D., system executive director of physician advisor services at UNC Health in Chapel Hill, North Carolina. Physicians (often at hospitals) typically request standard or expedited reconsiderations (appeals) on an enrollee's behalf when an MA denies payment.

"These are some of the most significant changes I have seen since 2016 for member protections," added Brian Moore, M.D., medical director of utilization management and physician advisor services at Atrium Health in North and South Carolina.

For one thing, CMS changed the language on reconsiderations of a denial of an enrollee's request for items or services. Until now, MA plans were required to dismiss the appeal if the enrollee received the services before the MA plan completed the appeal. That's no longer the case. "CMS is pretty clear you can't dismiss a case because the patient was discharged," Hu said at an Aug. 16 town hall sponsored by the American College of Physician Advisors. That opens a pathway for appeals of inpatient admission and skilled nursing facility denials, he said.

As CMS explains in Sec. 50.8 of the guidance, "If an enrollee requests a pre-service reconsideration but the MA plan becomes aware that the enrollee has received the requested item/service/Part B drug before the MA plan completes its reconsideration, the MA plan must process the request as a request for payment or dismiss the request if it is unable to obtain the information necessary to process a payment request."

Because of the new language, appeal rights won't vanish when MA plans delay admission decisions. "Plans can't dismiss appeals as easily anymore," Hu said. The new language applies to standard and expedited appeals.