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Faxing One-Page Expedited Appeals to MA Plans Is New Strategy for PA

By Nina Youngstrom

Although CMS has been talking about making fax machines obsolete in Medicare, they're turning out to be useful for filing expedited appeals of pre-service benefit denials by Medicare Advantage (MA) plans. Time is of the essence with expedited appeals, and fax machines are a fast and less torturous way to move them forward, a physician advisor says.

"I no longer ever call the plans," says Brian Moore, M.D., medical director of utilization management and physician advisor services at Atrium Health in North and South Carolina. It's a new posture in his appeals of denials, which initially include fewer medical records.

Moore is an advocate of expedited appeals, which allow physicians and other clinicians to fast-track appeals on behalf of certain patients while shifting the burden to MA plans to justify denials. He thinks expedited appeals are a game-changer for appealing MA denials, but they are underused by hospitals, possibly because patients and physicians may not know about this pathway ("Expedited Appeals of MA Benefit Denials Could Be 'Game-Changer' for Hospitals," *RMC* 28, no. 11).

Although he used to submit them by phone and send in a full copy of the medical records, that's changed. CMS regulations require MA plans to accept appeals in writing, and "every plan has a fax line dedicated to the process," Moore says. MA plans "must submit an efficient and convenient means for individuals to submit oral and written requests," according to the regulation 42 C.F.R. § 422.570 (2018).

In Writing, Rules 'More Likely To Be Followed'

CMS established expedited appeals as an alternative to regular appeals when physicians and patients believe that waiting for the MA plan to decide on the appeal in the usual way, which takes up to 14 days, "could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function," the regulation states.

Because physicians and patients request expedited determinations from MA plans before claims are paid, Moore says they're particularly useful for pending admissions to post-acute care—skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospital admissions—from acute-care hospitals. Patients (enrollees) or physicians may file expedited appeals directly. Other hospital clinicians, such as case managers (who are usually nurses), also may file expedited appeals on their behalf when enrollees sign appointment of representative (AOR) forms. "If someone who is not a physician is initiating this, a supporting statement from a physician is needed," says Moore, who is chairman of the American College of Physician Advisors' government affairs committee. Moore also files grievances with CMS when MA plans don't comply with regulations on expedited appeals. For example, Moore says MA plans sometimes refuse expedited appeals because there's no AOR even when they're not required, so he's been filing grievances. "We have case files opened with all the big plans," he notes.

When hospitals file expedited appeals, they're required to submit demographic and clinical information about the patient, including why the appeal is being expedited. Then MA plans must respond in 72 hours, either explaining why they denied authorization or approving and overturning the denial. When MA plans uphold the denial, it's automatically forwarded (by FedEx overnight) to Maximus Federal, the independent review entity for Part C, which also has 72 hours to affirm the denial or reverse it. "Maximus can overturn the denial if the plan can't demonstrate there were significant attempts to get the clinical information," he explains. When Maximus sides with the enrollee/hospital, it's reported to CMS, which tracks denials.

So far, Moore has overturned 50 denials with expedited appeals, but the process is "soul sucking." There are long phone calls, and he has to submit stacks of medical records. That's why he looked for a better method and turned to the fax machine. He notes that expedited appeals cannot be used after a service has been or is being received. "The key is for physicians and patients to know their rights when speaking with an MA plan regarding a denial. If able to handle this in writing, the rules are more likely to be followed."