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Curb on MA Internal Coverage Criteria May Prevent Some Claim Denials

By Nina Youngstrom

When traditional Medicare has "fully established" coverage criteria, Medicare Advantage (MA) plans won't be able to use their own internal version to deny claims starting Jan. 1. That's one of the provisions in CMS's 2024 rule on policy and technical changes to MA that health care organizations hope will result in what they consider a fair shake in medical reviews.[1]

Although CMS has always required MA plans to provide at least the same coverage as traditional Medicare, it clarified they can't deny benefits based on coverage criteria that doesn't meet the updated language in the rule, said Richelle Marting, an attorney and certified coder in Olathe, Kansas. For example, MA plans aren't allowed to use internal coverage criteria to change the two-midnight rule or the requirement for a three-day qualifying stay before a skilled nursing facility admission. MA plans may be more generous (e.g., eliminating the qualifying stay) but not more restrictive (e.g., adding two days to it), she said.

As the rule explains, "when an MA organization is making a coverage determination on a Medicare covered item or service with fully established coverage criteria, the MA organization cannot deny coverage of the item or service on the basis of internal, proprietary, or external clinical criteria that are not found in Traditional Medicare coverage policies."

But Marting said the definition of "fully established" isn't elaborated on. "The interesting thing is the regulation doesn't define when coverage criteria are fully established," she said Nov. 28 at an HCCA webinar. "It defines when they're not fully established."

According to the rule, coverage criteria aren't fully established in Medicare statutes, regulations, national coverage determinations (NCDs) or local coverage determinations (LCDs) when:

- "[…] additional, unspecified criteria are needed to interpret or supplement general provisions in order to determine medical necessity consistently;
- "NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD, or
- "[…] there is an absence of any applicable Medicare statutes, regulations, NCDs or LCDs setting forth coverage criteria."

CMS added that "When additional, unspecified criteria are needed to interpret or supplement general provisions, the MA organization must demonstrate that the additional criteria provide clinical benefits that are highly likely to outweigh any clinical harms, including from delayed or decreased access to items or services."

That doesn't leave a lot of room for MA plans to develop their own internal coverage criteria, Marting said. "It's a fairly high burden for MA plans to meet before any internal criteria could be used." That's by design; CMS

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doesn't want them to deviate from traditional Medicare policies.

For example, Marting reviewed a denied claim for inpatient rehabilitation when an MA plan projected—based on its internal coverage criteria—that a patient coming out of the hospital would only require inpatient rehab for a certain number of days and therefore the claim was denied. The MA plan instead agreed to pay for a skilled nursing facility or home health services. Because that's more restrictive than traditional Medicare coverage, that kind of denial won't fly after Jan. 1 under the MA rule, she said.

No More Denials After Prior Authorization

The MA rule—which was published in the April 12 *Federal Register*—also tightens up prior authorization requirements: "Appropriate prior authorization should only be used to confirm the presence of diagnoses or other medical criteria and to ensure that the furnishing of a service or benefit is medically necessary or, for supplemental benefits, clinically appropriate and should not function to delay or discourage care." For example, MA plans can apply LCDs to prior authorization for radiofrequency ablation, which requires patients to have three months of moderate to severe pain; however, they can't use prior authorization for prerequisites that don't exist in the LCDs and are more restrictive than traditional Medicare's coverage policies "unless the coverage policy explicitly allows the MA plan to define different circumstances," Marting said.

CMS also prohibits MA plans from denying claims when they've given prior authorization. Chapter 4 of the *Medicare Managed Care Manual* already states that if MA plans "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." Denise Wilson, vice president of PayerWatch in Towson, Maryland, said, "A lot of folks in the industry were hanging their hat on that statement and trying to fight back MA plans. It was OK to have that in your appeal letter, but it didn't cause a lot of denials to get overturned." The MA rule's language is clearer: "Under the new provision we proposed at § 422.138(c), if an MA organization approved the furnishing of a covered item or service through a prior authorization or pre-service determination of coverage or payment, it may not deny coverage later on the basis of lack of medical necessity." Wilson said the new language clarifies that "advance determination of coverage" includes prior authorization of the coverage "and that it's not only coverage—it's also payment." She suggests providers include it in their denial letter template after Jan. 1. "You need to call them out on that in your appeal process."

A Medical Necessity Denial By Any Other Name

Hospitals should be on the lookout for MA claim denials and lost appeals based on medical necessity that are labeled something else, Wilson said at a Nov. 28 webinar sponsored by PayerWatch. MA plans may try to circumvent CMS expectations for inpatient versus outpatient coverage determinations by calling the reviews "billing validations" instead of medical necessity audits.

"It's unclear from the denial letter issued by third-party auditors employed by the MA plans how auditing of inpatient hospital claims suddenly transformed from a medical necessity issue to a billing issue," Wilson wrote in a June 2023 article for the Association for Healthcare Denial and Appeal Management.

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1 Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly, 88 Fed. Reg. 22,120 (April 12, 2023), https://bit.ly/3CH7TmX.

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