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CMS Position on MA Appeals Works Against 'Rings of Power' Protecting Providers, PAs Say

By Nina Youngstrom

Layers of regulatory and subregulatory guidance culminating in the 2024 policy and technical changes to Medicare Advantage (MA) should protect hospitals from what they consider improper payment denials and appeals, except that a certain CMS policy is getting in the way, according to two physician advisors.[1]

"We know that even with all these protections, appeals are still denied and payments are still blocked," said Edward Hu, M.D., system executive director of physician advisor services at UNC Health in North Carolina. A big reason is a CMS requirement that its independent review entity (IRE) turn away appeals of MA denials if the enrollee's services are completed and the enrollee doesn't owe any money, Hu said April 18 at the National Physician Advisor Conference (NPAC). "Those are not hard things for MA plans to meet" if they're trying to avoid payments and appeals, especially for the many hospital stays that begin as emergencies, he said. "CMS is aware of this, and I don't know what they plan to do about it. I believe some in CMS are evaluating this."

But hospitals may have success concurrently appealing denials of MA plan "organization determinations," said Chris Caulfield, M.D., medical director of care management at UNC Hospitals, at NPAC. Despite what hospitals may think, they're allowed to appeal on behalf of enrollees without an appointment of representative (AOR) form.

In terms of the regulatory and subregulatory guidance, Hu used a "Lord of the Rings" analogy to walk through the "rings of power" protecting MA enrollees (and providers). A big one empowers enrollees to appeal adverse organization determinations (also known as denials), as spelled out in the subpart M regulation and the Medicare Advantage manual section on Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance (what used to be called Chapter 13).[2]

Hu said CMS defined an organization determination as the failure to authorize, provide or pay for a service, including the type or level of service. "If a payer decides something should be paid as observation and not inpatient, that's an organization determination," he said. CMS then defines an appeal as the MA enrollee's right to challenge the plan's adverse organization determination or cost sharing. "It's dual purpose," Hu explained.

There's another ring of power in "regulations that protect the services that don't have time for prior authorization" because CMS said MA plans are financially responsible for emergency services and post-stabilization according to the prudent layperson standard in 42 C.F.R. § 422.113(b)(2)(iii). CMS reinforced this in the 2024 MA rule (4201-F), which stated that "emergency services must be covered regardless of the final diagnosis, consistent with § 422.113(b)(2)(iii)" and "may not be retrospectively denied payment by the MA plan." The 4201-F rule also applies the two-midnight rule to MA plans.