TN Department of Commerce & Insurance

TennCare Oversight Division

Provider Complaint Process

A Summary for Providers of Services to TennCare, CoverKids, CoverRx & MA SNP/FIDE Enrollees

RDA 11278 October 2021

What is the TennCare Oversight Division?

- We are the State agency that regulates the TennCare and CoverKids programs' managed care companies.
  - We are not part of the Tennessee Department of Finance and Administration (TDFA), Division of TennCare (Bureau).
  - We are located within the Department of Commerce & Insurance (TDCI).
- We assist in the regulatory oversight of the Medicare Advantage Special Needs Plans for Medicare/Medicaid Dual Eligibles (MA SNPs and/or D-SNPs) operating in Tennessee.

What is the TennCare Oversight Division's authority to do this?

- The Tennessee HMO law (T.C.A.§ 56-32-101 et seq);
- The Contracts between the Division of TennCare and the Managed Care Companies (MCCs);
- The Medicare Improvement for Patients and Providers Act of 2008 (MIPPA); and
- The Contracts between the Division of TennCare and the Tennessee Medicare Advantage Special Needs Plans (MA SNPs).

What does the Division do?

- Review and approve/disapprove provider agreement templates, unique provider agreements, and provider manuals for TennCare, CoverKids, and MA SNP/FIDE MCCs.
- Review and approve TennCare and CoverKids subcontractor agreements and operational relationships.
- Oversee financial solvency of the MCCs.
- Examine, review, and test for TennCare and CoverKids claims payment promptness and accuracy.

What does the Division do? (continued)

- Process Provider Complaints from providers of services delivered to TennCare, CoverKids and CoverRx enrollees to facilitate complaint resolution in an informal setting.

- Process Provider Complaints from providers of services delivered to TennCare/Medicare dual eligible enrollees to facilitate complaint resolution in an informal setting.

What does the Division do? (continued)

- Provide administrative support for the Independent Review Process of provider claims for services delivered to TennCare and CoverKids enrollees.

- Process Enrollee and Applicant Requests for Assistance with the Division of TennCare, TennCare MCOs, CoverKids MCOs and MA SNP/FIDE MCOs.

What is the TennCare Oversight Division Provider Complaint Process?

- A process available to providers of services delivered to TennCare, CoverKids, or MA/MA SNP enrollees who have a complaint about the Division of TennCare or an MCC.
- This process is free.
- The TennCare Oversight Division requires MCCs to respond to complaints from providers concerning operational and claims disputes in a timely manner.
- The TennCare Oversight Division uses information regarding disputed claims and other MCC operations to monitor, examine, and enforce MCC compliance.

Why submit a payment dispute Provider Complaint rather than an Independent Review Request?

- It is free. There is no fee to file a complaint.
- The Provider Complaint process is faster than Independent Review.
- The Provider Complaint process is not limited to 365 days from the date of the initial denial or recoupment.
- If you think the response is incorrect or insufficient, you can submit additional information or otherwise challenge the result. (I.e., you get a second bite of the apple.)

(Independent Review remains available so long as you submit your IR Request prior to 365 days from the date of the initial denial or recoupment.)

Other Reasons for Submitting a Provider Complaint

- Provider Agreement contract changes
- TennCare/MCO policies/procedures
- TennCare Crossover claims
- Payment delays
- Credentialing problems
- Other MCC operational problems

MA SNP Plans in Tennessee

TennCare HMO MA SNP Plans:

- Amerigroup/Amerivantage Speciality +
- UnitedHealthcare of the River Valley/UnitedHealthcare Dual Complete
- Volunteer State Health Plan/BlueCare Plus

Non-TennCare HMO MA SNP Plans

- Cigna-HealthSpring TotalCare (HMO SNP)
- Humana Gold Plus
- Windsor/WellCare Comp Access

What kinds of Provider Complaints can be sent?

Complaints may involve, but are not limited to:

- Claims denials
- Claims payment accuracy
- Claim processing timeliness
- Credentialing procedures
- Inability to obtain assistance from the MCC
- Questions about MCC policy and procedures

Claim Denial Examples
(Not Comprehensive)

- ASH Form
- Coding Disputes
- Lack of Authorization
- Medical Necessity
- Non-Par Provider
- TPL
- Untimely Filing
- Readmissions within 30 days
- Enrollee not eligible on DOS
- Claim paid incorrectly

Provider Complaint Tracking Trends and Behaviors

TennCare Oversight uses an electronic tracking system/database that shows trends and behaviors.

- ASH Forms
  - Typed vs. Handwritten
- Acute to Post-Acute Care Pre-Auth Waiver
  - Discharge Coordination with DSNP

What about non-TennCare Program Provider Complaints?

- Complaints about commercial health plans should be directed to the TDCI Insurance Division Consumer Insurance Services Section at:

  Consumer Insurance Services Section – Vickie Trice, Director
  500 James Robertson Parkway
  Nashville, TN 37243-0574
  800-342-4029 | (615) 741-2218
  Fax: (615) 532-7389

  https://www.tn.gov/commerce/insurance/consumer-resources.html

  Consumer Insurance Services exists to educate consumers and mediate insurance-related disputes.

  Remember, complaints about payment disputes for services rendered to Medicare dual eligible TennCare members (including complaints about MA and MA SNP/FIDE plans) should be directed to the TennCare Oversight Division.

TennCare Oversight has website information about the Provider Complaint Process

- Information about the Provider Complaint process is located at: https://www.tn.gov/commerce/tenncare-oversight/mco-dispute-resolution.html

- This website has Provider Complaint forms to assist providers in submitting a complaint. Use of these forms is not mandatory. There are 3 forms:
  - TennCare/CoverKids Provider Complaint Form
  - MA-SNP Provider Complaint Form
  - TennCare Provider Episode of Care Report Provider Complaint Form[1]

[1]Episode-based payment seeks to align provider incentives with successfully achieving a patient's desired outcome during an “episode of care,” which is acute or specialist-driven health care delivered during a specified time period to treat a physical or behavioral condition. Ultimately the provider gets a “report”. If a provider disagrees with the report, use the Episode of Care Report Provider Complaint form.

How does the Provider Complaint Process work?

- When a Complaint is received, the TennCare Oversight Division forwards it to the MCC for investigation and response.
- The TennCare Oversight Division will send the Provider written notification of this referral.
- The MCC must respond in writing to both the Provider and the TennCare Oversight Division by a set deadline to avoid assessment of Liquidated Damages or other appropriate penalties.
- If a Request for Independent Review is received that is not eligible for Independent Review, the Request will be processed as a Provider Complaint.

How can a Provider submit a Complaint about an MCC?

- Submit a written complaint by facsimile or secure/encrypted email delivery. If you must send by surface delivery, please send an encrypted CD or thumb drive by U.S.P.S, FedEx, UPS. etc. and email or fax the password. Or, use an SFTP account.

- Provide a summary of the problem. Include as much supporting information as possible, including copies of claims and remittance advices and other denial correspondence from the MCC.

How can a Provider submit a Complaint about an MCC?
(continued)

If a Complaint concerns claims regarding multiple enrollees, the claims should be listed on an Excel spreadsheet with identification of the enrollee by name, date of birth or SSN, and the date of service. The Excel spreadsheet should be submitted in electronic format.

How can a Provider submit a Complaint about an MCC? (continued)

If a Complaint contains Protected Health Information ("PHI"), send it by surface or fax delivery, unless the Provider has HIPAA compliant securely encrypted email delivery system.

PHI includes any patient identifying information or protected health information, including the patient's name and address.

The link to the TennCare Oversight Division's email address can be found at:

https://www.tn.gov/commerce/tenncare-oversight/contact.html

What can a Provider do if not satisfied with the response to the Provider Complaint?

- If you think the PC Response is incorrect or insufficient, send an email stating why.
- Providers may seek other legal or contractual remedies; or,
- Request Independent Review if it is claims payment concerning TennCare or CoverKids services.

What can a Provider do if the MCC fails to do what it promises?

The Provider should notify the TennCare Oversight Division in writing if the MCC sends a satisfactory response promising to pay a claim or promising some other relief and then fails to do as represented.

The TennCare Oversight Division will require the MCC to show proof that the MCC has done what it promised to avoid assessment of liquidated damages or other appropriate penalty.

Where do I send the Provider Complaint?

You can send electronically to the TennCare Oversight Division by:
Fax: 615-401-6834
Email TennCare.Oversight@tn.gov

If you have questions, you may call 615-741-2677 for assistance.

More information about the Provider Complaint process can be found at:

https://www.tn.gov/commerce/tenncare-oversight/mco-dispute-resolution/provider-complaint-process.html

Where do I send the Provider Complaint?
(continued)

A surface delivery Complaint can be submitted to:

Compliance Office
TennCare Oversight Division
TN Department of Commerce & Insurance
Nashville, TN 37243-1169

Department of Commerce and Insurance, Authorization No. 335508 October 2020, this public document is electronic only and was promulgated at a cost of $0.00 per copy.

Provider Independent Review for TennCare & CoverKids

Information Guide for Providers
TennCare or CoverKids

Claims Payment Disputes

October 2021

What is Independent Review?

Independent Review is a process administered by the TennCare Oversight Division available for Providers to resolve TennCare services claims payment disputes.

T.C.A. § 56-32-126(b) governs the TennCare Program Independent Review process.

Effective 1/1/2021, the Contractor Risk Agreement also makes the Independent Review process available to CoverKids Program disputed claims.

How do I submit a Request?

Submit a written request to the Commissioner of Commerce & Insurance c/o TennCare Oversight Division.

A suggested Independent Review Request form can be found on the TennCare Oversight Division website at:

https://www.tn.gov/commerce/tenncare-oversight/mco-dispute-resolution/independent-review-process.html

The form is titled:

Request to Commissioner for Independent Review of Disputed Provider Claim

What health plans are included?

The TennCare/CoverKids MCCs:

- the 3 TennCare HMOs;
- the Dental Benefits Manager (DBM); and
- the Pharmacy Benefit Manager (PBM).

Who are the Independent Reviewers?

They are persons selected by a panel to hear disputes between TennCare MCCs and Providers. They act like judges in that they make decisions on claims disputes.

- Pursuant to T.C.A. § 56-32-126(b)(4), the Selection Panel for TennCare Reviewers selects the Independent Reviewers.

- The Panel consists of two Provider representatives, one representative from each of the two largest TennCare HMOs, and the Commissioner of the Tennessee Department of Commerce & Insurance or the Commissioner's designated representative. *See* T.C.A. § 56-32-126(b).

Who pays the Independent Reviewers?

- The MCCs pay the Independent Reviewers the fee amount set by the Selection Panel for TennCare Reviewers pursuant to T.C.A. § 56-32-126(b).

- However, if the Provider does not prevail in the independent review, the Provider is required to reimburse the MCC for the fee.

- So, it is the party that does not prevail that is ultimately responsible for paying the Reviewer.

What makes an Independent Reviewer "Independent"?

- Reviewers are not selected by the MCC, the Provider, the Department of Commerce & Insurance (TDCI) or the TDFA Division of TennCare (Bureau).
- Reviewers' compensation is not connected to the outcome of the reviews performed.
- Independent Reviewers are selected by the independent Selection Panel for TennCare Reviewers.

Types of disputes can be sent to Independent Review

1) TennCare and CoverKids Services Claim Denials or Recoupments

- **TennCare Program service** rendered to a TennCare* enrollee; **and**
- MCC partially or totally denied/recouped the claim *(or the MCC failed to respond to the claim by issuing an RA within 60 calendar days)*; **and**
- Provider requested reconsideration of the denial or recoupment in writing; **and**
- 30 days have passed since the MCC received the reconsideration request.

Two types of disputes can be sent to Independent Review (continued)

2) Episode of Care Annual Report Disputes

- Episode-based payment seeks to align provider incentives with successfully achieving a patient's desired outcome during an “episode of care,” which is acute or specialist-driven health care delivered during a specified time period to treat a physical or behavioral condition. Ultimately, the provider gets an annual “report”.

- If a provider disagrees with the report, use the suggested form titled:

  Request to Commissioner for Independent Review of Disputed TennCare Episode of Care Cycle Provider Gain/Risk Share Total

This form can be found at:

https://www.tn.gov/commerce/tenncare-oversight/mco-dispute-resolution/independent-review-process.html

What are the eligibility limitations for Independent Review?

- Request must be received by the TennCare Oversight Division within 365 days of the initial denial or recoupment.
- Request must include a copy of the Provider's request for reconsideration of the denial or recoupment.
- Non-contracted Providers must submit a check for $750.00 with the Request.
- The claim(s) must not be involved in arbitration or litigation.

What happens when the TennCare Oversight Division receives an Independent Review Request?

The TennCare Oversight Division conducts a preliminary eligibility review to ascertain the following:

- Was the Request received within 365 days of the initial denial or recoupment?
- Whether the Provider is network contracted. If not contracted, was the required fee submitted?
- Does the dispute involve TennCare or CoverKids services claim(s)?

(Continued on next page.)

What happens when the TennCare Oversight Division receives an Independent Review Request?
(continued)

- Is there documentation that a claim was denied or recouped in whole or in part?
- Is there documentation of Provider's Reconsideration Request of the denial/recoupment?
- Are the materials submitted legible?
- Does the submission appear to be complete?

If the submission is eligible, the Division refers the Request to an Independent Reviewer.

What happens if my request is not eligible for Independent Review?

- When a Request does not meet eligibility requirements required by T.C.A. § 56-32-126(b), the TennCare Oversight Division will generally process the Request as a Provider Complaint.

- The Division will send written notice to the Provider saying why the Request is not eligible for Independent Review and whether the Request is being processed as a Provider Complaint.

Can I aggregate multiple claims disputes into one Independent Review Request?

YES, if there is one specific claims denial reason involving one "common" question of fact or law and the Request does not involve more than one Episode of Care Report.

- Can a Reviewer decide one claim and apply that decision to all claims?
- The mere fact that claims are not paid does not create a common substantive question of fact or law.
- The Reviewer makes the final determination as to whether claims are eligible for aggregation.

What happens if I request claims be aggregated when they are not eligible for aggregation?

- If a Reviewer determines that claims should not have been aggregated, a fee will be assessed for each claim that cannot be aggregated with another claim.

- The Reviewer will explain the reason for this determination.

Aggregated request issues

- Multiple claims denied/recouped for Medical Necessity are not eligible for aggregation.

- When an aggregated request contains claims for multiple enrollees (>5), the provider should submit electronic Excel Spreadsheets listing all enrollees with appropriate demographic data, including Name, DOB, SSN, and DOS.

Who pays for the review?

Contracted Providers (Par-Providers)

- The MCC always pays the Reviewer.
- If a contracted Provider loses the Independent Review, the Provider must reimburse the MCC the fee.
- If a losing Provider does not refund the MCC the fee, the TennCare Oversight Division may prohibit that Provider from future participation in the Independent Review process.

Who pays for the Independent Review?

Non–Contracted Providers (Non-Par Providers)

- The MCC always pays the Reviewer.
- Non-contracted Providers must submit the Reviewer fee to the TennCare Oversight Division with the Request for Independent Review.
- If the non-contracted Provider wins the review, TDCI will return the money held to the Provider.
- If the MCC wins, TDCI will pay the MCC.

(If the claim is not eligible for Independent Review, the fee will be returned to the non-contracted Provider.)

How much is the Independent Review fee?

- The Independent Reviewer fee is $750.00 per Independent Review Request. ($450.00 if settled prior to Decision.)

- If claims are “aggregated” into one Independent Review Request, there is only one fee of $750.00.

(Remember that the Independent Reviewer makes the final determination of whether requests are appropriately aggregated. Therefore, the final amount of fees per submitted request may increase.)

How can I request an Independent Review?

Fill out the information requested on the Request for Independent Review form and attach or enclose supporting documents. Please submit in electronic format.

- Always include documentation that the claim was denied, and you requested reconsideration of the denial.
- Include everything supporting your position. You may include a narrative letter explaining why you think the MCC was wrong.
- If you are relying on MCG standards or other guidelines, include a copy.

(continued)

How can I request an Independent Review?
(continued)

- Always include your email address and fax number.

- If you submit by surface delivery, please send an encrypted CD or thumb drive. Send the password by separate email.

Where do I send the request?

Send the Request to:

Fax: 615-401-6834

Email: TennCare.Oversight@tn.gov

Surface Delivery:

Compliance Office, TennCare Oversight Division
TN Dept of Commerce & Insurance
500 James Robertson Parkway
Nashville, TN 37243-1169

Where can I get the request for Independent Review form?

- The Independent Review Request Forms are located on our website at:

  https://www.tn.gov/commerce/tenncare-oversight/mco-dispute-resolution/independent-review-process.html

- A provider may also call 615-741-2677 to request the form.

Will I be contacted by the Reviewer?

- Yes. The Reviewer will contact the Provider and the MCC by certified mail, return receipt requested, or by date and time marked facsimile.

The Reviewer will ask the Provider and the MCC to provide any additional written information and documentation that the Provider or MCC wants the Reviewer to consider.

Independent Review Tracking Trends and Behaviors

Hospital Requests for Independent Review

– Inpatient vs Observation is most common

- Medical Necessity
- Provider Agreement/Medical Policies – MCG (f/k/a Milliman Care Guidelines) or InterQual or both

It is the Independent Reviewer's position that the Agreement between the Provider and MCC is the basis on which both parties should follow.

Independent Reviewer

How will I know who wins the Independent Review?

- The Reviewer will tell you.
- The Reviewer will write a decision and send a copy to the Provider, MCC, and the TennCare Oversight Division.

Can I appeal the Independent Reviewer decision ?

Not exactly. T.C.A. § 56-32-126(b)(3)(D) states either party may file suit against the MCC and Provider, but not the Independent Reviewer, in any court having jurisdiction to review the Reviewer's decision. The suit must be filed within 60 days of the Reviewer's decision.

Any claim concerning a Reviewer's decision not brought within sixty (60) calendar days of the Reviewer's decision will be forever barred.

If I win, when will I get my money?

The MCC must pay the Provider within 20 days of receipt of the Reviewer's decision.

What if the MCC does not pay when I win?

The Provider should contact TDCI by secure/encrypted email, facsimile, or surface mail if payment is not received within 20 days of receipt of the Reviewer's decision.

- An email should be sent to: TennCare.Oversight@tn.gov
- A facsimile should be sent to: 615-401-6834
- If your email (or any email attachment) contains any PHI, the email must be sent by HIPAA compliance secure email.

What will the TennCare Oversight Division do if the MCC does not pay as decided?

The Division will require the MCC to show proof that the MCC has done what the Reviewer decided to avoid assessment of liquidated damages.

Department of Commerce and Insurance, Authorization No. 335505 October 2020, this public document is electronic only and was promulgated at a cost of $0.00 per copy.

INDEPENDENT REVIEW

- The Process
- Case Example

Dianne Llanes, RN Appeals Coordinator
Memphis TN

Methodist Le Bonheur Healthcare

THE PROCESS

- Analyze the denial
- Research the history and details
- Gather the documentation
- Prepare the packet
- Send to Tenncare Oversight Division

Methodist Le Bonheur Healthcare

ANALYZE THE DENIAL

- Is it medical necessity or technical denial?
- Are all levels of appeal exhausted?
- What was the reason for the denial?

Methodist Le Bonheur Healthcare

RESEARCH THE HISTORY AND DETAILS

- What is the date of the initial claim denial? (we have 365 days from this date to submit an Independent Review)

- Review: claim details, billing notes, utilization review notes, case management notes, and if medical necessity denial medical record and criteria guidelines

Methodist Le Bonheur Healthcare

GATHER THE DOCUMENTATION

- Copy of provider reconsideration is required
- Preferable to send denial letter from MCO
- Proof of auth if denied for no auth
- Proof of timely filing if denied for PTF
- Copy of medical record, EMR if using encrypted email
- Any other pertinent info such as a previously written appeal letter

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PREPARE THE PACKET

- “Independent Review Form” is required
- Narrative letter is advised
- Supporting documents such as claim, remittance advice, billing notes, utilization review screenshot, possibly itemized bill and any information that supports your position
- Milliman criteria if medical necessity denial and payer uses this criteria
- Medical record if med necessity denial

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SEND THE DOCUMENTATION TO TENNCARE OVERSIGHT DIVISION

- Encrypted email
- Fax with HIPAA statement
- Request access to File Share
- USPS certified mail

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CASE EXAMPLE

- Precert was obtained for outpatient procedure
- Patient had the procedure
- Claim denied for Anthem CG Surg 63
- Appeal sent contending that patient met criteria for Anthem CG Surg 97
- Appeal denied
- Independent Review was sent

Methodist Le Bonheur Healthcare

IR packet included:

- IR Form
- Narrative letter
- Copy of preauthorization
- Copy of reconsideration request
- Copy of denial letter
- Clinical guidelines (the one denial based upon and the one criteria was met)
- Medical record

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Only claims which meet ALL the requirements set forth in T.C.A. § 56-32-126(b) (2) (A) thru (D) are eligible for Independent Review. Claims payment disputes involved in litigation, arbitration or not associated with a TennCare member are not eligible.

Please give a written description of the problem: (Attach additional pages if needed)

- **Description may include, but not limited to: reason given for denial and your position explaining why the MCO should pay the claim. Include all pertinent information**
- **Attach copies of pertinent documentation, including any correspondence from the plan and remittance advices.**

mco denied "did not meet criteria".
Facility position: pre-authorization was received + procedure was approved.
mco denial was based on "Anthem SURG 00033H: Cardioverter Defibrillators."
That is not the procedure performed. Patient met criteria for "GG-SURG-97"
which describes the correct procedure. Request payment of claim.
SEE ATTACHED LETTER

Do you want your claims aggregated? N/A ☐ Yes ☐ No

Methodist Le Bonheur Healthcare
1350 Concourse Avenue, Suite 664
Memphis, TN 38104
Jan. 24, 2020

To whom it may concern,

Please accept a request for an Independent Review. We are asking for a specialist who is board certified in cardiology to review for medical necessity. The patient is Xxxxx Xxxxx, Amerigroup ID #XXXXXXX, with DOS 6/13/19-6/14/19. The procedure was: "Single chamber implantable cardioverter defibrillator implant".

The timeline is as follows:

A precert was obtained on 6/12/19 for procedure code 33249.
Surgery completed on 6/13/19 for procedure code 33249.
Claim filed 6/25/19.
Claim denied 7/16/19.
Facility appeal has denied.

It is the facility's contention that this patient met medical necessity criteria under "Guideline #CG-SURG-97". (Guideline is enclosed. Patient History and Physical is attached and documents that criteria is met). This guideline is for "implantable transvenous and subcutaneous cardioverter-defibrillator devices to monitor the heart rhythm and deliver an electrical shock when a life-threatening ventricular arrhythmia is detected".

The denial from Amerigroup was based on "Criteria: Anthem SURG: 00033H: Cardioverter Defibrillators". Our hospital staff has reviewed Amerigroup website and found that CG-SURG-63 is for "biventricular cardiac pacing to deliver cardiac resynchronization (CRT) to alleviate the symptoms of moderate to severe congestive heart failure associated with left ventricular dyssynchrony. It also addresses a hybrid device that combines CRT with an implantable cardioverter defibrillator (ICD). In the combined device (CRT/ICD), the CRT component promotes coordinated contraction of both ventricles, while the ICD portion detects dangerous arrhythmias and shocks the heart back into a normal rhythm. THIS IS NOT THE DEVICE THAT WAS USED FOR THIS PATIENT.

Dr. Yosef Kahn completed the History and Physical on 6/12/19 performed Ms. Xxxx's surgery on 6/13/19. He attended medical school in Philadelphia PA, had advanced training in each Boston, MA, Tucson AZ and New York City, NY. He is board certified in three areas: Cardiac Electrophysiology, Cardiovascular Diseases and Internal Medicine. It is certain that he was confident the patient met national criteria before the procedure was scheduled.
Amerigroup has denied paying for the procedure based on using a criteria which was not performed on this patient. The patient did meet criteria for a different procedure. The procedure was pre-authorized. The facility followed all of the proper guidelines. Payment is requested.

Once a determination is made, or if other information is needed, please contact directly:

Dianne Llanes, RN
Patient Financial Services
1350 Concourse Avenue, Suite 664
Memphis, TN 38104
Phone #901-516-1138
Fax #901-266-6619

Your assistance in this matter is greatly appreciated.

Sincerely,

Dianne Llanes, RN BSN
Appeals Coordinator

Enclosures: "Request…for Independent Review" form, UB, RAs, copy of 8/1/19 reconsideration request, 10/31/19 Amerigroup denial letter, Amerigroup Clinical Guidelines (patient met guidelines for CG-SURG-97 Cardioverter Defibrillators NOT CG-SURG 63 which Amerigroup based denial), printout showing "Request approved"…. "code 33249", medical record

Medical Policies and Clinical UM Guidelines Search

Prescription Drug Documents
The pharmacy clinical criteria for injectable, infused, or implanted prescription drugs and therapies covered under the medical benefit may be accessed at the following websites for certain Medicare/Medicaid markets.

- Medicare/Medicaid (https://www11.anthem.com/pharmacyinformation/clinicalcriteria/home.html)

AIM Specialty Health (AIM)
Health Plans may use guidelines developed by AIM Specialty Health (AIM), a separate company, to perform utilization management services for some procedures for certain health plan members. If you are searching for information related to Cardiology, Musculoskeletal, Radiation Oncology, Radiology, and Sleep, please also see the link below.
By clicking on the link to AIM below, you are now leaving our site and linking to a site created and/or maintained by AIM ("External Site"). Upon linking you are subject to the terms of use, privacy, copyright and security policies of the External Site. We provide this link solely for your information and convenience. We encourage you to review the privacy practices of the External Site. The information contained on the External Site should not be interpreted as medical advice or treatment provided by us.
http://www.aimspecialtyhealth.com/marketing/guidelines/185/index.html
(https://www.aimspecialtyhealth.com/marketing/guidelines/185/index.html)

Search: ICD

Results per page 10 1 - 10 of about 456.

Narrow Your Search:

File Type
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Category [Top 10]
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- REHAB (6)
- DME (49)
- GENE (47)
- LAB (24)
- TRANS (22)
- RAD (17)
- SURG (156)
- MED (102)
- Show All

Policy Number [Top 10]
- ANC.00006 (1)
- ANC.00007 (1)
- ANC.00008 (1)

CG-SURG-07 Cardioverter Defibrillators
(https://medicalpolicies.amerigroup.com/medicalpolicies/guidelines/gl_pw_d092851.htm)
https://medicalpolicies.amerigroup.com/medicalpolicies/guidelines/gl_pw_d092851.htm
Index Automatic Defibrillator Cardioverter Defibrillator EMBLEM S-ICD System *ICD* Implantable Cardioverter-Defibrillator S-*ICD* System Subcutaneous *ICD* The use of specific product names is illustrative only. It is not intended to be a recommendation of one product over another, and is not intended to represent a complete listing of all products available.

this should have been used for claim rejection by Amerigroup.

CG-SURG-63 Cardiac Resynchronization Therapy with or without an Implantable Cardioverter Defibrillator for the Treatment of Heart Failure
(https://medicalpolicies.amerigroup.com/medicalpolicies/guidelines/gl_pw_d055824.htm)
https://medicalpolicies.amerigroup.com/medicalpolicies/guidelines/gl_pw_d055824.htm
In the *ICD*–CRT group, 188 subjects died, as compared with 236 in the *ICD* group (HR, -0.75; 95% CI, 0.62 to 0.91; p=0.003), and 174 were hospitalized for HF, as compared with 236 in the *ICD* group (HR, -0.68; 95% CI, 0.56 to 0.83; p<0.001). However, at 90 days after device implantation, adverse events had occurred in 124 subjects in the *ICD*-CRT group, as compared with 58 in the *ICD* group (p<0.001).

Denial based on . . .

MED.00055 Wearable Cardioverter Defibrillators
(https://medicalpolicies.amerigroup.com/medicalpolicies/policies/mp_pw_a050505.htm)
https://medicalpolicies.amerigroup.com/medicalpolicies/policies/mp_pw_a050505.htm
Therefore, an implantable cardiac defibrillator (*ICD*) is considered the gold standard and, as such, a WCD would be considered an alternative to an *ICD* only in the small subset of individuals that have co-morbidities or other contraindications for an *ICD*

RESULT: CLAIM WAS PAID (28K)

Thank You and Wish You Success with your Independent Reviews!

Methodist Le Bonheur Healthcare


erlanger
Health System

Preparing an Excellent Independent Review, a Case Study

Jill S. Forgey, RN BSN MBA
Revenue Integrity Director

To Send or Not to Send, *that* is the Question

Recognize what accounts are appropriate for Independent Review (IR), and which are not.

- Review TDCI rules for filing IR. Determine if the IR timeframe is met.
- Review the payer contract and Provider Administration Manual and know the rules, (i.e. what is their policy on readmission? Is there a circumstance that readmission denials will be considered on appeal, what evidence based criteria do they use, etc.).
- Prioritize those accounts that are eligible for IR and have a higher expectation of being reviewed in your favor.

Example of IR finding in readmission case

The MCC has a specific 14 day re-admission payment policy. If the Provider wishes to challenge a payment denial under the policy, they have an adequate procedure to do so. Nevertheless it is the responsibility of the Provider to present the documents and arguments that clearly support the challenge. The MCC is not obligated to defend its policy. If the denial is successfully challenged, then it must defend the denial.

Even if this case illustrates an unfair and unjust application of the policy, the Independent Reviewer does not find sufficient argument from the Provider to demonstrate an improper application of the 14 day policy. The Independent Reviewer Upholds the MCC's Denial.

Know the Rules

Claims for patients at either a DRG or Per Diem facility that are re-admitted for a condition other than those specified in this policy are not eligible for multiple payments. Only a single payment will be made by BlueCare Tennessee. These guidelines are subject to the Provider's contract and retrospective claims review and recovery.

Some examples of readmissions that MAY NOT be authorized are:

- respiratory admissions, e.g., COPD;
- complications from surgical procedures; or
- congestive heart failure (CHF)

Some examples of readmissions that MAY be authorized are:

- NICU admissions;
- planned admissions;
- cancer diagnoses for chemotherapy;
- complications of pregnancy;
- admissions for coronary artery bypass surgery following an admission for chest pain;
- children 21 years and under admitted to any facility; or
- admissions for complication due to rejection of transplant/implant surgery.

According to the Bureau of TnCare

http://publications.tnsosfiles.com/rules/1200/1200-13/1200-13-16.20111128.pdf

http://publications.tnsosfiles.com/rules/1200/1200-13/1200-13.htm
(click on 1200-13-16 for medical necessity)

Review 1200-13-16-.05:
1200-13-16-.05 MEDICAL NECESSITY CRITERIA.

(1) To be medically necessary, a medical item or service must satisfy each of the following criteria:

(a) It must be recommended by a licensed physician who is treating the enrollee or other licensed healthcare provider practicing within the scope of his or her license who is treating the enrollee;
(b) It must be required in order to diagnose or treat an enrollee's medical condition;
(c) It must be safe and effective;
(d) It must not be experimental or investigational; and
(e) It must be the least costly alternative course of diagnosis or treatment that is adequate for the enrollee's medical condition.

(5) Safe and effective.

(a) To qualify as being safe and effective, the type, scope, frequency, intensity, and duration of a medical item or service must be consistent with the symptoms or confirmed diagnosis and treatment of the particular medical condition. The type, scope, frequency, intensity, and duration of a medical item or service must not be in excess of the enrollee's needs.

(b) The reasonably anticipated medical benefits of the item or service must outweigh the reasonably anticipated medical risks based on:

1. The enrollee's condition; and

2. The weight of medical evidence as ranked in the hierarchy of evidence in rule 1200-13-16-.01(21) and as applied in rule 1200-13-16-.06(6) and (7).

Ok, so what is the hierarchy of evidence?
(21) HIERARCHY OF EVIDENCE shall mean a ranking of the weight given to medical evidence depending on objective indicators of its validity and reliability including the nature and source of the medical evidence, the empirical characteristics of the studies or trials upon which the medical evidence is based, and the consistency of the outcome with comparable studies.
The hierarchy in descending order, with Type I given the greatest weight is:

(a) Type I: Meta-analysis done with multiple, well-designed controlled clinical trials;

(b) Type II: One or more well-designed experimental studies;

(c) Type III: Well-designed, quasi-experimental studies;

(d) Type IV: Well-designed, non-experimental studies; and

(e) Type V: Other medical evidence defined as evidence-based

1. Clinical guidelines, standards or recommendations from respected medical organizations or governmental health agencies;

2. Analyses from independent health technology assessment organizations; or

3. Policies of other health plans.

Making your argument

- Medical necessity (continued stay)
- Inpatient versus observation (most common)
- Contractual
- Auditing a previously prior approved claim when contract prohibits
- Medical Policy (investigational)
- Did not meet the policy definition of readmission
- Coding
- Removal of CC or MCC (DRG clinical validation)
- Validity of inpatient order

Compare these clinical explanations

For a clinical reviewer

Mr X is a 38-year-old male who presented in acute respiratory failure requiring mechanical ventilation, had sepsis, required pressor support, was febrile (102) and tachycardic (115). He was admitted to the ICU on an IV flouroquinolone after pan cultures were obtained. Auscultation of lungs was suspicious for silent aspiration.

For a non-clinical reviewer

Mr X is a 38-year-old male brought to the ER by ambulance after he was found by family having a hard time breathing. He was unable to breathe on his own so was placed on a ventilator. He had been sick for a few days at home and was found to have a very low blood pressure, so low that medication was required IV to raise it so his organs received the needed oxygen. He was running a fever of 102, and his heart was beating very fast (115, should be 60-100). The doctor diagnosed him with shock and placed him in intensive care on strong IV antibiotics. When he listened to his chest, he was worried he had inhaled liquid into his lungs, a concerning finding.

Payer vs Hospital

How the MCO sees it:

7 month old male fell and hit head. Brought to ER with swelling on side of head. Happy. Afebrile, VSS, CT ordered, neurology consult placed. No neuro deficits. Neuro states doing well, taking po, can be discharged. CT exam showed nondisplaced skull fracture, likely small volume epidural hemorrhage, no mass effect.

How (we) the Hospital sees it:

7 month old infant boy fell from crib and struck head, was brought to ER where on exam there was swelling and tenderness with scalp injury to the left parietal area. CT exam showed a linear left parietal nondisplaced skull fracture with associated acute intracranial extra-axial hemorrhage and likely an epidural hemorrhage.

How we want the Independent Reviewer to see it:

This is a little 7 month old baby who was brought to our emergency room, his mother distraught after finding the baby passed out beside his crib at home. She noticed he had a huge lump on the side of his head, with broken skin and blood dripping out. She had trouble waking him up, so called 911. When they got to the ER, the doctor noted he was worried about a skull fracture, and since the baby couldn't talk to tell him if he was dizzy or had other symptoms like blurred vision, or possibly even a seizure, he performed a cat scan to look for internal injuries. This showed not only a skull fracture but also an area of bleeding around the brain. Knowing all the things that can be associated with this, he ordered a neurologist to evaluate the baby, and to admit him for neurological exams every four hours. They lived in a very rural area so if he sent them home, he was very concerned about something happening and not having access to care.

The Criteria

- Observation criteria for this condition is appropriate, based on the presence of head trauma with skull fracture, but the intracranial pathology is not addressed

- Inpatient criteria is appropriate, based on the presence of intracranial pathology on imaging. Safe outpatient care by the parents cannot be established.

- Which is most appropriate?

We believe inpatient admission criteria is the most appropriate level of care because this infant did have evidence of bleeding in the brain, the doctor didn't feel the parents could safely take care of him and they lived in a rural area, so if he was sent home and had a seizure or increased bleeding, he could not get back to the hospital in a timely manner. This is in alignment with inpatient care.

Supporting your argument with evidence

Use the applicable evidence based guidelines to support your clinical argument.

- Print a copy of the clinical criteria to include with your submission and point the reviewer to the appropriate sections.
- Point out clinical information that was originally provided to the MCO and the criteria used and if applicable explain why you are using the same or different criteria.
- Provide a copy of any certifications you may hold that show your expertise with understanding and interpreting the guidelines.

6.3 *Final Decision and Explanation of Reasons for Final Decision.*

6.3.1 The Independent Reviewer reverses the MCO's Decision.

6.3.2 At the outset, the Independent Reviewer notes that both the Provider and the MCO have done an excellent job explaining their positions and providing support for their respective arguments. Your efforts in this regard are greatly appreciated.

The parties agree on one point: That the *Milliman Care Guidelines* are applicable. Unfortunately, that is about the extent of the parties' agreement.

The MCO contends that in making its medical necessity determination, it need look no further than *Milliman Care Guideline "Drug Ingestion or Overdose: Observation Care"* - OCG:OC-017 (ISC). It argues that the reason for Mr. [redacted] admission was overdose, not aspiration pneumonia, and accordingly, the guideline for drug ingestion/overdose was the appropriate reference for this case. It asserts that Mr. [redacted] case met these "observation care" criteria at the time of admission to Erlanger. It further asserts that Mr. [redacted] case met the "Observation Care Discharge Criteria" in less than 24 hours after admission to Erlanger.

Provider, on the other hand, contends that Mr. [redacted] met the clinical criteria for *Milliman* ICU admission on a number of fronts. Provider points out that consistent with *Milliman Care Guideline "Intensive Care Guidelines"* - LOC:LOC-001(ISC), ICU admission may be indicated when need is demonstrated by respiratory failure with the need for invasive or noninvasive mechanical ventilation and when need is demonstrated by physical findings including threatened airway, sudden altered mental status, repeated or prolonged seizures, or coma (Glasgow coma scale) score of 8 or less. In addition, consistent with *Milliman Care Guideline "Pneumonia Due to Aspiration"* - ORG:M-283 (ISC), admission is indicated for "aspiration pneumonitis associated with an acute event (eg, neurologic change, massive emesis, drug overdose)." Each of these criteria, Provider asserts, were present in Mr. [redacted]s case.

Based on the records submitted for review, as asserted by the MCO, it is true that the criteria in the *Milliman Care Guidelines "Drug Ingestion or Overdose: Observation Care"* was met; however, not to the exclusion of [redacted] other medical conditions present at admission. I see nothing in the record to suggest that the overdose criteria guideline should somehow "trump" the ICU guideline or any other applicable guideline. The frontline admitting physicians must make decisions based on the evidence before them. [redacted] presented with respiratory failure, required intubation prior to his

emergency arrival, suffered from a seizure disorder - having one or more prior to arrival, his GCS was 3, he continued to require mechanical ventilation and the physician suspected the patient had aspirated. This is a patient who clearly met admission criteria at the time he presented.

The fact that [redacted] quickly responded to the care he was given by the Provider is a credit to the Provider and a positive outcome for the patient that we all wish could be experienced by all Tenncare enrollees. The fact that [redacted] case met the *Milliman Care Guideline "Observation Care Discharge Criteria"* in less than 24 hours after admission to Erlanger is not evidence that his case did not meet inpatient admission criteria when presented.

For all of the foregoing reasons, the Independent Reviewer reverses the denial of the MCO and finds in favor of the Provider.

Organize

Begin to compile and organize your Independent Review submission:

- Position Statement with list of exhibits (Include why MCO is wrong)
- Request for Independent Review Letter (and criteria)
- Claim Form
- Any Paid or Denial EOB
- Denial or Audit Findings Letter (Can be pre-pay or post-pay audit)
- Appeal Letter (Email may also be relevant)
- Appeal Findings Letter
- Medical Record (Send what is needed to support your position)
- Contract signature page or applicable sections

The Cost of the Independent Review (IR) Process

- Knowing the cost of going through the IR helps the hospital select their cases strategically
- Erlanger recently studied the cost of appealing a denied case through the Independent Review process.
  - **Key Takeaways:**
    1. Sometimes IR cases might have a monetary net loss when going through the process, but that can still serve as a type of “denials deterrence”
    2. The Independent Review process isn’t perfect, which further highlights the importance of selecting strong cases and presenting with the audience in mind

How Less Than a Half of an Inch Cost a Hospital > $1,700 in Denied Payment

by Denise Wilson | Nov 14, 2018 | Appeals, Insurance Denials

Reproduced with permission of ACPA

A large national insurance carrier, offering managed Medicaid plans, recently denied the inclusion of ICD-10-CM codes Z68.41, body mass index (BMI) 40.0-44.9, and E66.01, morbid obesity due to excess calories, as secondary diagnoses on an inpatient claim for a large health system in Tennessee. The deletion of said codes resulted in a down coding of the originally billed DRG 086, Traumatic stupor & coma, coma <1 hr w CC to DRG 087, Traumatic stupor & coma, coma <1 hr w/o CC/MCC. The down coding resulted in a loss of dollars in the amount of $1,717 in reduced payment for the provider hospital.

The Back Story. A 61 year-old patient on aspirin and Plavix presented to the hospital emergency department after falling at home and suffering a severe headache immediately after. The CT indicated multiple areas of subarachnoid hemorrhage. The patient was declared a trauma and admitted to the ICU. A Neurology consult confirmed the diagnosis of subarachnoid hemorrhage. Fortunately, the patient's hospital course was uneventful and the patient was able to be discharged home after a few days.

As the provider coded the chart for billing, codes that were included as secondary diagnoses were ICD-10-CM codes Z68.41, body mass index (BMI) 40.0-44.9, and E66.01, morbid obesity due to excess calories. After all, this patient's body weight as recorded on the bed scale was 123.1 kg and the patient's height as reported by the patient was 170.1 cm for a calculated BMI of 42.5 (click here for the page). The treating physician included the diagnosis of morbid obesity in the medical history section of the patient's history and physical.

Cost Summary

Expected Payment:	**$5,861.09**
Cost of Care:	$ 6,776.23
Unreimbursed cost before Dispute Resolution:	$ (915.14)
Administrative Cost of Level One:	$ 173.31
Administrative Cost of Level Two:	$ 90.95
Administrative Cost of Independent Review:	$ 648.42
Administrative Cost of Arbitration Prep:	$ 5,728.72
Total Unreimbursed Cost:	$ (7,556.54)

Takeaways from the Study

1. **IR appeals might have a monetary net loss, but they can still serve as a type of "denials deterrence"**
    - In the study, even if the denied payment had been overturned at the Independent Review, Erlanger would have spent $7,688.91 to receive a $5,861.09: a $1,827.82 net loss.
    - Because Erlanger was confident about the case, Erlanger chose to dispute the down coding all the way to arbitration to as a way to deter MCOs from egregiously denying payment. The MCO paid prior to the start of arbitration
2. **The Independent Review process isn't perfect, and who exactly is reviewing can affect decision outcomes.**

Comparing Independent Review to Complaint
What to expect in response

2021.0427 Provider Complaint Referral to VSHP SNP [secure email] Erlanger Medical Center

KM Kim Mangrum <Kim.Mangrum@tn.gov> Reply all |
Today, 9:51 AM
BlueCare_Oversight_GM@bcbst <BlueCare_Oversight_GM@bcbst.c+13 more

Provider Complaint # 2021.0427
Provider: Erlanger Medical Center
DOS: [redacted]
Denial Reason: MN-IP/OS
Patient: [redacted]
Compliance Officer: CLS

Provider Rep: Jill Forgey, RN BSN
Prov Reg Email: jill.forgey@erlanger.org
Prov Rep Fax: (423)778-4891

This email is addressed to VSHP SNP Managed Care Company/Healthplan.

The captioned Provider Complaint against VSHP SNP concerning services for the referenced patient has been placed on the SFTP server. This provider complaint correspondence consists of disputed claims information from the captioned Provider (Erlanger Medical Center).

Please respond to the Provider and send a copy to the TennCare Oversight Division by no later than 30 calendar days from the date of this email. In order for the response to be acceptable to the Department of Commerce & Insurance and not subject to a civil penalty, you must send your response to the Provider and a copy of the response to the TennCare Oversight Division of the Department of Commerce & Insurance on or before the due date. A copy of the letter may be sent to me and to TennCare.Oversight@tn.gov

Please use our Provider Complaint Number on any correspondence with this office.

This request is made pursuant to T.C.A. 56-1-106, which states in pertinent part:

(a)(1) Notwithstanding any other provision of law or rules to the contrary, if the department makes a request for information from an entity or individual licensed under this title, or required to be licensed under this title, concerning a complaint filed against the entity or individual, and the request requires a response, the entity or individual must respond to the request within a reasonable time.
(2)(A)As used in this section, "reasonable time" means a period of time not to exceed thirty (30) days from the date the request is received by the entity or individual.

Comparing Independent Review to Complaint
What to expect in response

Amerigroup

(1) OTA TD/RT

October 1, 2021

RECEIVED
OCT 01 2021
REVENUE INTEGRITY DEPT.

Jill Forgey, RN BSN
975 East Third Street
Chattanooga, TN 37403
jill.forgey@erlanger.org
(423)778-4891

RE: Provider Complaint 2021.0379
Provider: Erlanger
Member: [redacted]
DOS:
LOB: Medicaid

To Whom It May Concern:

Thank you for contacting Amerigroup. We have reviewed complaint 2021.0379 from provider group Erlanger Hospital, (NPI#1639264575), regarding the recoupment of an overpayment for the claim [redacted]

A brief summary of the claim activity to date;

- On 12/05/2018 Amerigroup received the claim 161339041400. On 12/19/2018 the claim was paid in the amount of $9,079.64.
- On 06/21/2021 Amerigroup recouped an overpayment of $2,677.74 due to a change in the DRG that resulted in a lesser payment that what was originally paid.
- On 09/03/2021 Amerigroup received the provider state complaint. No prior appeals received

Determination: Overturn

Rationale: [redacted] with medical history significant for chronic pain of right shoulder/back, hypertension and current smoker. The patient had been involved in an ATV accident on 09/16/2018 that resulted in a clavicle fracture as well as a tension pneumothorax requiring chest tube placement. He was seen by orthopedics at that time, and it was felt that nonoperative intervention would be done at that time. Due to substantial displacement and substantial discomfort with movement, the patient subsequently went to the operating room on 10/29/2018 for an open reduction internal fixation (ORIF) of the right clavicle. He later noted some erythema around the area and was prescribed oral antibiotics in