AHCA/NCAL Checklist for Addressing Medicare Advantage Organization (MAO) Denials

Developed in partnership with Hooper, Lundy & Bookman

Did the MAO Adhere to Prior Authorization (PA) Requirements? *[42 CFR 422.138, 422.112(b)(8)]*

- Is it for a Permissible Purpose? PA can only be used to:
  - Confirm the presence of diagnoses or other medical criteria that are the basis for coverage determinations for the specific item or service
  - *[For basic benefits]* Ensure an item or service is medically necessary
  - *[For supplemental benefits]* Ensure that the furnishing of a service or benefit is clinically appropriate

  Note: Where MAOs cover more SNF days than are covered by Traditional Medicare, these days are considered a supplemental benefit
- What is the Effect of PA? Once PA is granted, the MAO:
  - "May not deny coverage later on the basis of lack of medical necessity"
  - May not reopen the decision except for "good cause" or in case of fraud or similar fault
- Continuity of Care & Active Course of Treatment:
  - The PA for an active course of treatment that is a basic benefit must remain in place for entire course of treatment "as long as medically necessary to avoid disruptions in care" in accordance with applicable coverage criteria, the patient's medical history, and the treating provider's recommendation
  - When a patient changes plans, the MAO must provide minimum 90-day transition period for active course(s) of treatment without requiring a new PA (basic benefits only)

Was the Medical Necessity Determination Proper? *[42 CFR 422.101(c)]*

- Medical necessity determinations (for admission and length of stay) must be based on:
  - Coverage criteria (see below)
  - "Reasonable and necessary" requirement
  - Enrollee's medical history, physician recommendations, and clinical notes
  - Involvement of the MAO's medical director where appropriate

Did the MAO Apply Appropriate Coverage Criteria? *[42 CFR 422.101(b)]*

- Traditional Medicare Criteria: MAOs must comply with NCDs, LCDs, and general coverage and benefit conditions in Traditional Medicare laws, unless superseded by laws applicable to MA plans
- Internal Coverage Criteria requirements:
  - Only permitted if Medicare coverage criteria are not fully established (e.g., if additional criteria are needed to supplement coverage criteria for consistency);
  - Must be based on current evidence in widely used treatment guidelines or clinical literature
  - Must be publicly accessible (including summary of evidence, list of sources, and explanation of rationale that supports the adoption of the coverage criteria)
- InterQual/MCG: MAOs "may not use InterQual or MCG criteria, or similar products, to change coverage or payment criteria already established under Traditional Medicare laws." (If used to supplement, must comply with internal coverage criteria requirements, e.g., public accessibility)
- Other Clinically Appropriate Settings: An MAO cannot deny coverage of a service (e.g. of a SNF admission) that meets coverage criteria based on the availability of another clinically appropriate care setting (e.g., home health), unless the care is not medically necessary
- Step Therapy for Non-Drug Items/Services: Only permitted as part of internal coverage criteria

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Was the Denial Timely, Properly Noticed, and Reviewed? *[42 CFR 422.566, 422.568, 422.570, 422.571]*

- Timing: Organization determinations (including denial of prior authorization) must be made timely, and the failure to do so is an adverse determination that can be appealed
  - Regular requests: 14 calendar days
  - Expedited requests: "as expeditiously as the enrollee's health condition requires" but no more than 72 hours after the request
- Content: A denial notice must state the *"specific reasons* for the denial"
  - This includes: "a description of the applicable coverage rule or applicable plan policy (for example, Evidence of Coverage provision) upon which the action was based, and a specific explanation about what information is needed to approve coverage must be included, if applicable"
- Medical Reviewer: A denial based on medical necessity must have been reviewed by a physician or other appropriate health professional with expertise in the relevant specialty

Is the MAO Network Adequate? *[42 CFR 422.112(a)]*

- MAO must maintain and monitor a network of appropriate providers (including SNFs) sufficient to provide adequate access to covered services to meet the needs of the population served.
- MAO must "arrange for and cover any medically necessary covered benefit outside the plan provider network" at in-network cost-sharing when in-network provider or benefit is unavailable or inadequate to meet enrollee's medical needs

Who Can Challenge the MAO's Denial? *[42 CFR 422.560 et seq.]*

- MAO Dispute. Review your contract with the MAO to identify the dispute resolution process
- Beneficiary Appeal. The beneficiary has multiple levels of appeal available, as illustrated here: https://www.cms.gov/medicare/appeals-and-grievances/mmcag/downloads/managed-care-appeals-flow-chart-.pdf
  - With authorization from the beneficiary, a representative (such as a provider authorized by the beneficiary) can carry out appeals on his or her behalf
  - Beneficiaries may also fast-track an appeal of non-coverage of SNF services to the Quality Improvement Organization (QIO) if they file by noon the first day after the Notice of Medicare Non-Coverage (NOMNC)
  - Beneficiary assistance is available from 1-800-MEDICARE, the local SHIP program, or the Medicare ombudsman