

Navigating Medical Necessity in Three Acts

Medical Necessity Webinar Series Part 3

Appeals and Denials

.... And a few other important related topics

June 29, 2022

Catalyst Center Funding Acknowledgement

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Educational CME Information

ACMG Education
acmgeducation.net

**Financial Disclosure
& Mitigation**



All relevant financial relationships listed have been mitigated.

Name	Program Committee Member	Presenter Panelist Moderator	Peer Reviewer	Financial Disclosure Relationship/Company
Baughman, Allyson	X			Nothing to disclose
Beaver, Erin	X	X		Nothing to disclose
Caisse, Molly	X			Nothing to disclose
Comeau, Meg	X			Nothing to disclose
Ginsburg, Susanna	X			Nothing to disclose
Guysi, Nicole	X	X		Nothing to disclose
Jones, Tammy	X	X		Nothing to disclose
Kaylor, Julie	X	X		Employment and Stock, Guardant Health
Lyon, Megan	X		X	Nothing to disclose
Nance, Demeatrice	X	X		Nothing to disclose
Schiff, Jeff	X	X		Nothing to disclose



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Learning Objectives

At the conclusion of this activity, participants should be able to:

1. Explain what it means when a prior authorization is denied
2. Identify where to begin the appeal process
3. List the steps in the process for an appeal
4. Describe options if an appeal is denied

Our team of presenters



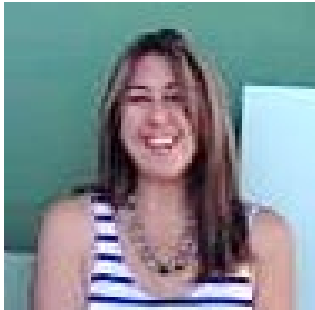
Dr. Jeff Schiff
Senior Scholar
Academy Health



Julie Wiedower Kaylor, MS
CGC



Demeatrice Nance CCHW
Ohio Sickle Cell Health Associates
Family Leader



Nicole Guysi
Family Leader
Arizona




Erin Beaver, MS CGC
License Certified Genetic Counselor
Missouri Baptist Medical Center




Tammy Jones
Program Coordinator
Genetic Metabolic Nutrition Research &
MNT4P Program, Emory University


Session 1 and 2 recording now available!

**The Catalyst Center**
School of Social Work
Center for Innovation in Social Work & Health

Medical Necessity Webinar Series

**NCC**
National Coordinating Center
for the Regional Genetics Networks


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**2022 Medical Necessity Webinar Series - OnDemand**


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Description

**The Catalyst Center**
School of Social Work
Center for Innovation in Social Work & Health

Medical Necessity Webinar Series

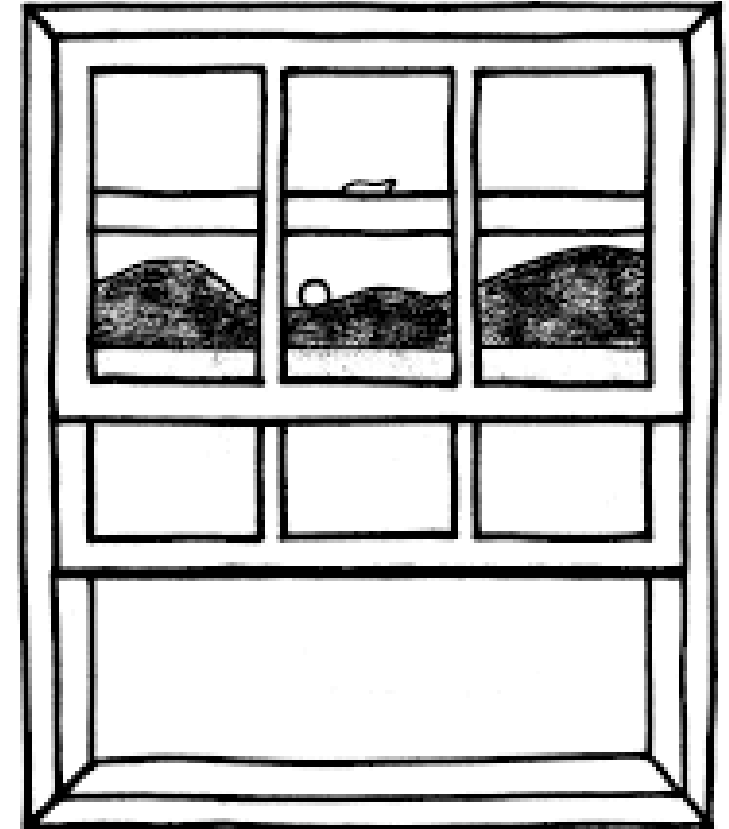
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Course Description:

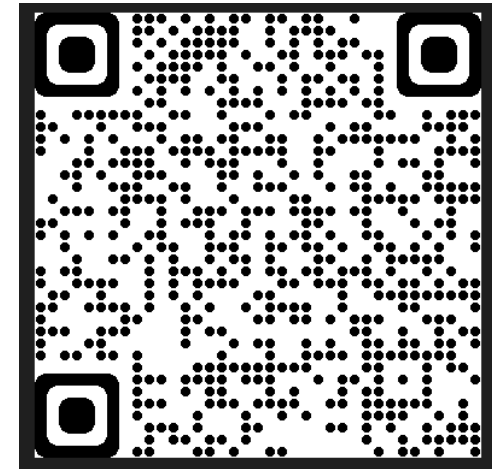
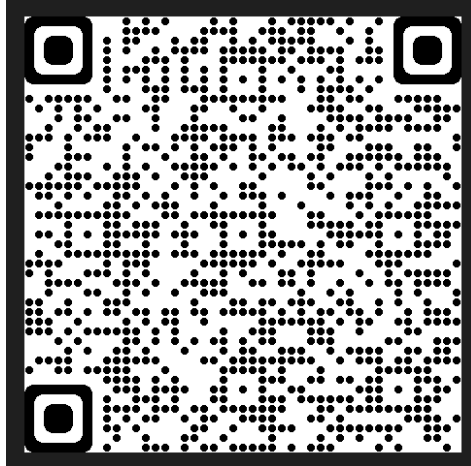
The Catalyst Center and the National Coordinating Center for the Regional Genetics Networks, two programs supported by the Health Resources and Services Administration, are pleased to announce a three-part webinar series to help the genetics community better understand how they can navigate medical necessity. This webinar series will provide information about medical necessity through the lens of genetic cases.

Approved !!

- Window of Time –
 - Prior authorization approved but only “good” for a certain period of time



Co-Pay/Co-insurance Relief



Denied

- Learning that the authorization was denied – your health plan requirements
 - Within 15 days if you're seeking prior authorization for a treatment
 - Within 30 days for medical services already received
 - Within 72 hours for urgent care cases
- Denial letter – to families, not providers
 - Includes appeal rights
 - and time frames for appeal

<https://www.healthcare.gov/appeal-insurance-company-decision/internal-appeals/>

National Association of Insurance Commissioners site <https://content.naic.org/article/consumer-insight-health-insurance-claim-denied-how-appeal-denial>

Terminology related to Denials

- Denial, termination and reduction of services or payment (DTRs): A DTR is an MCO's denial, termination or reduction of a healthcare service or payment of a claim.
- Federal and state law, and the DHS managed care contracts, requires MCOs to send members a Notice of Action, which is a DTR letter, anytime a MCO denies, terminates or reduces a service or claim.
- This is to ensure that members are educated about their right to file an appeal if members disagree with the MCO's decision.

Terms common in letters

- Not medically necessary
- Experimental or investigational
- For research purposes
- Incorrect level of service
- Administrative denials- inadequate information

Who can help (with understanding denials; with navigating appeals)?

Ombudsman –

someone appointed to **investigate complaints against an institution and seek resolutions to those complaints.**

The essential characteristics of an Ombudsman's Office are **independence, the ability to investigate complaints which often includes subpoena power, the ability to criticize government agencies and to recommend changes that may be issued in public reports.** An Ombudsman, however has no enforcement or disciplinary powers.

www.usombudsman.org

Ombudsman in health care insurance

- States are required to have managed care ombudsmen:
 - A problem solver
 - A neutral investigator
 - An advocate for fair and equal treatment
 - Confidentiality with Ombudsman

What help?

- Ombudsman:
 - To help beneficiaries with MCO issues:
 - Help you identify issues and possible solutions
 - Help you know your rights
 - Investigate complaints
 - Negotiate with your health plan to help you get the care you need
 - Resolve billing issues
 - Explain how to file a grievance, appeal or state fair hearing
 - Help you navigate the health care system

Who can assist within commercial payors?

- **Care Managers/Case Managers:**
 - Professionals who are assigned to and assist members navigating complex medical conditions.
- **Health Care Advocate/Member Advocate:**
 - Professionals who are available at a health plan to explain and assist with issues
- **Your Employer HR:**
 - These professionals select the benefits of the workplace. If you have a necessary procedure denied, they can sometimes provide alternate pressure.
- **Concierge Services:**
 - Subscription services to access professionals who will navigate this for a member. Often cost prohibitive, but in cases where medical needs and encounters are vast, there may be opportunity to streamline access. *may be a use of foundation funds

Under the hood of the appeals process

- Appeal comes into system at MCO (public or private) or Medicaid
- Reviewed at some level by nurse or physician
- Usually but not always specialist (required by law to be a specialist-specialist can be a relative term)
- Consideration of total cost to the system can occur here – ‘If we cover this one, who else will be knocking at the door’



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The Appeal Process – Step 1 – Internal review

- Appeal: Members can ask their MCO to review and overturn a decision. By filing an appeal, members have the potential to receive services they were initially denied. Members can file an appeal with the MCO by telephone or in writing.
 - Appeals categories
 - Billing & Financial Issues
 - Out-of-Network Service Denial
 - **Services & Benefits**
 - Timeliness of Service Delivery
- 90+ % service and benefits

Step 1: Appeal time frames

- Internal appeal must be completed within 30 days if your appeal is for a service you haven't received yet.
- Internal appeals must be completed within 60 days if your appeal is for a service you've already received.

Your request needs:

- You and your child's first and last name
- Your signature
- Date
- Your child's Member ID number which can be found on the front of their member ID card
- Your address and telephone number
- Your PCP's name and telephone number
- A description of the issue
- Any records related to your request- letter from the provider

Steps in gathering data and investigating the process:

- Check your content against printed criteria- must be provided, but might be vague
- Check or try to find out who manages appeals and who reviews them (their credentials), what can be known by the web.
- Understand if you are FFS or MCO (or administrative service provider)

An Appeal - Step 2: External review –

State fair hearing (SFH) (for Medicaid) : A state fair hearing (also known as a state appeal) is a member's request to have a judge (process, department, and names of "judges" varies by state) conduct an independent review of the MCO's decision. The member has the opportunity to present evidence to support his or her case.

- Federal law requires external review for most insurance
 - Medicaid
 - Insurance exchange plans
 - ERISA (employer self insured – except grandfathered plans)
- <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6178G-ENG>

Step 2: External review time frames

- Standard external reviews are decided as soon as possible – no later than 45 days after the request was received.
- Expedited external reviews are decided as soon as possible – no later than 72 hours, or less, depending on the medical urgency of the case, after the request was received.

<https://www.healthcare.gov/appeal-insurance-company-decision/external-review/>
https://www.cms.gov/CCIIO/Resources/Files/Downloads/appeals_srg_update.pdf

Consider the perspective of the MCO

- From the MCO/ state perspective
 - MCOs – good and bad - are in a bind – if they cover and another does not will beneficiaries switch?
 - Significant time on their side as well
 - FFS Medicaid will have a review process as well – MMD or pharmacy or vendor

Ask for single point of review – Medical Director, Policy Staff



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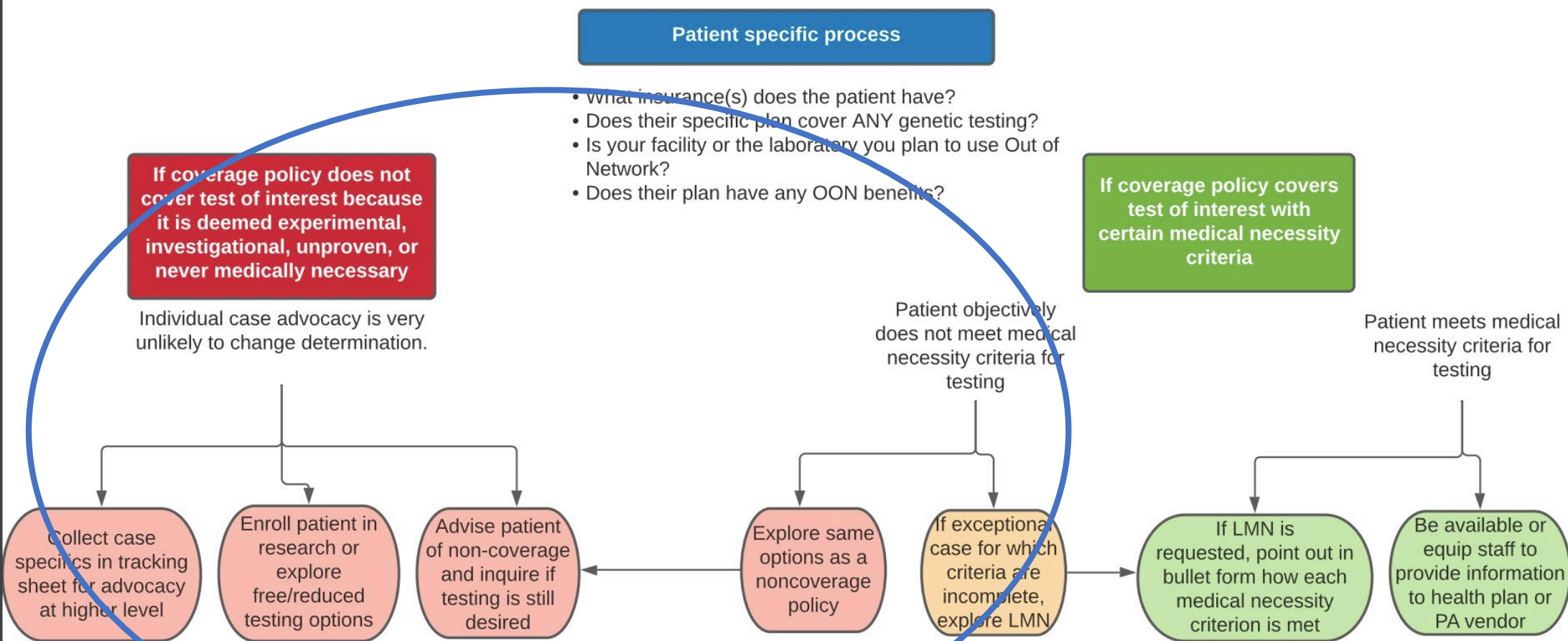
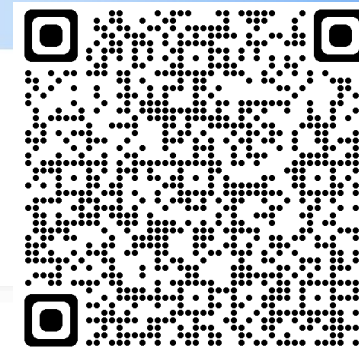
Building a bridge

- Relationship with health plan medical necessity reviewers
 - Credibility of the provider in the community is important including any conflicts, practice history, etc.
- Meeting
 - Respect, but ask for alterations in process – know or ask about the limitations of the state official either by statute Document decisions and assignments from meetings
 - Document expertise
 - Request fast track for genetics provider
 - Offer/ plan to share data back with MCO(s)

What are the options after a denial outside of appeals?

Prior Authorization process – Heartland RGN

<https://www.heartlandcollaborative.org/educational-resources/genetic-testing-toolkit/>



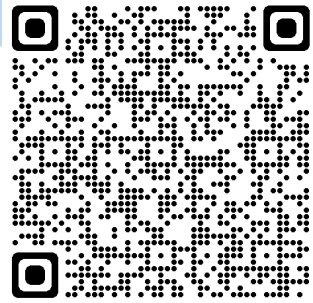
Other options within insurance and state services

- Individual state's Bureau of Special Healthcare Needs
- Case manager within insurance
- Single Case Agreement request
- Employee Emergency Funds
- Condition Specific Support Foundations

Financial Assistance Programs

- Know what patient financial assistance programs are available at your own health center.
- Ask the lab you are working with about patient financial assistance programs.
 - Application process
 - Most sliding scale
 - May or may not need financial documents to support application

Slide on sponsored testing links



PH: 405.271.2370 | F: 405.271.2784 | E: heartlandgenetics@outlook.com



[ABOUT](#) [FOR FAMILIES](#)

Please visit the recording of “*Getting the best out of prior authorizations and letter’s of medical necessity*” provided by Julie Kaylor and Erin Beaver. (Note you will have to fast forward to 15 minutes for it to begin)

Julie is a certified genetic counselor and has over 9 years of experience in genetics services in a laboratory, hospital, and health plan vendor setting. She is specialized in utilization management to increase access to appropriate genetic testing across health care. Her passion lies in speaking enthusiastically and effectively to multiple stakeholders while advocating for increased access to quality genetics care and forming partnerships between providers, institutions, health plans, and laboratories.

Erin is a genetic counselor with 1 year of industry experience and over 9 years of clinical experience in the St. Louis, MO area. She is the founder of inGENEuity, LLC, a genetic genealogy and counseling company. Erin currently works as a full time clinical genetic counselor in oncology at BJC Healthcare, Missouri Baptist Medical Center Breast Healthcare Center. Previous to this position, she held an industry genomic testing consultant position with PerkinElmer Genomics, a clinical genetic counselor and genetic counseling supervisor position at Mercy Hospital in St. Louis, and a clinical genetic counselor position in Fetal Care at Washington University in St. Louis. In her free time, Erin teaches at the Washington University in St. Louis Genetic Counseling Program and advises thesis students at the UAMS genetic counseling program. Erin’s research interests include development of innovative models of care in genetics, public health communications, and addressing inequities and disparities in healthcare especially as it relates to genetic services.

Genetic Testing Toolkit Resources:

[Patient glossary for terms related to insurance coverage](#)

[Sponsored Testing List](#) 




[Prior Authorization Information](#) 

[How to do a Prior Authorization](#) 

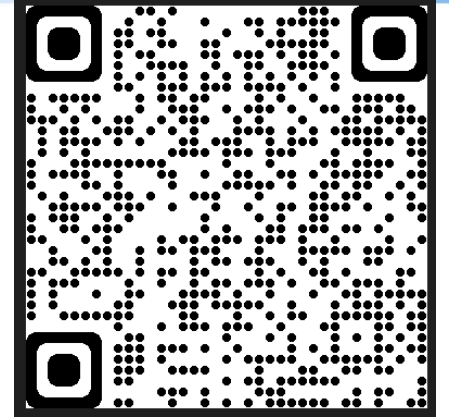
[What needs to be in a Letter of Medical Necessity](#) 

[Letter of Medical Necessity General Template](#) 

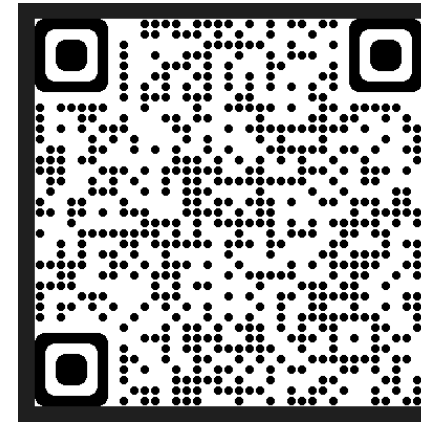
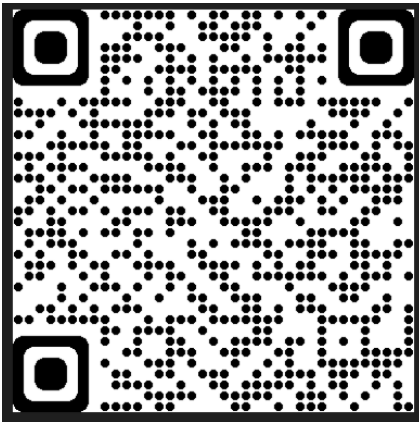
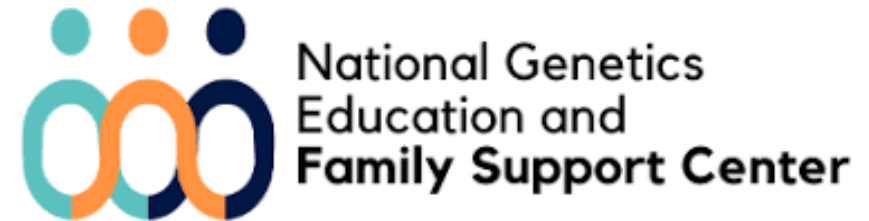
[Letter of Medical Necessity Template for Whole Exome Sequence \(WES\)](#) 

[Letter of Medical Necessity Template for WGS + WES](#) 

Research opportunities



Other helpful resources



Special Topic: Medical Nutrition Shortage

February 2022- recall of Abbott's Elecare, and a variety of powdered infant formulas produced at the Abbott plant in Sturgis, Michigan.

Four cases of *Cronobacter* infection infants led to the recall.

Due to the recall of certain products, patients who normally use those products are having to utilize alternative formulas. The increased demand has caused a shortage in stock of alternative products available in the supply chain, including metabolic formulas.

Manufacturers are increasing their production as best they can to keep up with demand. Currently demand is exceeding production capacity, which results in interruptions in availability. Because some manufacturers prioritize hospital and retail supply, DME companies may experience a supply interruption while a hospital or retail store may not.

<https://www.fda.gov/consumers/powdered-infant-formula-recall-what-know>

Special Topic: Medical Nutrition shortage

What are the options for individuals and families?

- Change prescription to an alternative that is available
 - Usually requires actions by individual/family and metabolic nutritionist at a minimum
- Contact Medical Food Company Insurance Navigation Assistance Programs
 - Nutricia, <https://nutricia-na.com/nutricianavigator/>
 - Vitaflo, <https://vitaflo4success.com/enroll-online/>
 - Cambrooke, <http://cambrookecare.com/>
- Investigate Local Support Programs
 - MNT4P at Emory University is an example, <https://mnt4p.org/about-mnt4p/>
 - WIC programs

Closing thoughts/ perspectives from our family colleagues

Three webinars

- Medical Necessity definition and use of evidence to create policy
- Medicaid and EPSDT and collaborative agreements (the Title V and Medicaid relationship)
- The practical application of Medical Necessity –
 - Understanding payer authorization processes
 - Requesting authorization
 - Denials and appeals

Wrap-up

- Webinar series available
- Heartland Regional Genetics Network (RGN) Genetic Testing Toolkit

<https://www.heartlandcollaborative.org/educational-resources/genetic-testing-toolkit/>

- Heartland RGN soliciting suggestions for additions to the Toolkit

