Giant Killers

“No matter what state you work in, there will be giants.”

- Ed Norwood
THE PURPOSE OF THE LAW IS TO BRING ME TO A PLACE OF RECOVERY.
ERN/The Reimbursement Advocacy Firm (TRAF) is the representation arm of ERN/National Council of Reimbursement Advocacy (NCRA), a for profit California corporation and provider membership organization, whose mission is to provide regulatory claims representation, training and patient advocacy that restricts third-party payors from making improper denials or medically inappropriate decisions.

At ERN, we understand the significance of quality health care and its reliance on financial viability. With the support of Wickline v. State, our primary goal is to advocate for medically appropriate health care and to ensure the faithful and ardent enforcement of all public health and safety laws for the protection of patients, physicians, hospitals and other emergency providers; because ultimately, we recognize that every case represents a human life.
The Sign of the Times.

Healthcare is a law to be defended.

The Sign of the Times.

Public policy and prompt payment laws are enacted for public good. They ensure patient access to medically necessary care when needed.
Title 6 §843.281 (b) A health maintenance organization may not engage in retaliatory action, including refusal to renew or termination of a contract, against a physician or provider because the physician or provider has, on behalf of an enrollee, reasonably filed a complaint against the health maintenance organization or appealed a decision of the health maintenance organization.

To “advocate for medically appropriate healthcare,“ you must MASTER three key objectives:

✓ 1st Objective:
You must learn how to connect your payment concerns to level of care.

✓ 2nd Objective:
You must learn how to audit cases and determine if non-compliance of administrative laws is indicated. (42 CFR Part 422, 29 CFR §2560.503-1, 38 USC §1725, etc.)

✓ 3rd Objective:
You must learn how to identify unfair payment and denial trends.
The power inequities that exist between health plans and providers demand we create a "culture of compliance" to challenge and protest any practice, policy or decision that impairs our ability to render quality care to our patients.

Unfair Payment Practices

ACCESS TO CARE DENIALS

Profit
Revenue
Finance
Product
Teamwork
Service
Title 6 § 843.002 Definitions

(7) "Emergency care" means health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the individual's condition, sickness, or injury is of such a nature that failure to get immediate medical care could:

(A) place the individual's health in serious jeopardy;
(B) result in serious impairment to bodily functions;
(C) result in serious dysfunction of a bodily organ or part;
(D) result in serious disfigurement; or
(E) for a pregnant woman, result in serious jeopardy to the health of the fetus.
Failure to pay for emergency services and care exacerbates an already fragile healthcare delivery system.

TX HMO POSTSTABILIZATION SERVICE DENIALS.
28 TAC §19.1723 – Preauthorization

(d)(3) If the proposed medical care or health care services involve post-stabilization treatment, or a life-threatening condition as defined in §19.1703 of this title (relating to Definitions), the HMO or preferred provider carrier shall issue and transmit a determination indicating whether proposed services are preauthorized within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no case to exceed one hour from receipt of the request. If the request is received outside of the period requiring the availability of appropriate personnel as required in subsections (e) and (f) of this section, the determination must be issued and transmitted within one hour from the beginning of the NEXT TIME PERIOD requiring such personnel. In such circumstances, the determination shall be provided to the treating physician or health care provider.

(e) A preferred provider may inquire via telephone as to the HMO or preferred provider carrier's preauthorization determination. An HMO or preferred provider carrier shall have appropriate personnel as described in §19.1706 of this title (relating to Personnel) reasonably available at a toll-free telephone number to provide the determination between 6:00 a.m. and 6:00 p.m. central time Monday through Friday on each day that is not a legal holiday and between 9:00 a.m. and noon central time on Saturday, Sunday, and legal holidays. An HMO or preferred provider carrier must have a telephone system capable of accepting or recording incoming inquiries after 6:00 p.m. central time Monday through Friday and after noon central time on Saturday, Sunday, and legal holidays and must acknowledge each of those calls not later than 24 hours after the call is received. An HMO or preferred provider carrier providing a preauthorization determination under subsection (d) of this section shall, within three calendar days of receipt of the request, provide a written notification to the preferred provider.
Under existing Texas law, if the HMO or preferred provider carrier issues an adverse determination in response to a request for post-stabilization treatment or a request for treatment involving a life-threatening condition, the HMO or preferred provider carrier shall provide to the enrollee or person acting on behalf of the enrollee, and the enrollee's provider of record, the notification required by §19.1721(c) of this title (relating to Independent Review of Adverse Determinations).

A preauthorization is not a guarantee of payment but once authorized, carriers cannot reduce or deny the claim on the basis that the services were not medically necessary or appropriate. The carrier may reduce or deny payment for other contractual reasons so long as a verification was not obtained in conjunction with the preauthorization.
Title 6 843.258– Appeal Involving Ongoing Emergency or Continued Hospitalization

(a) The investigation and resolution of an appeal of a complaint relating to an ongoing emergency or denial of continued hospitalization shall be concluded:

(1) in accordance with the medical or dental immediacy of the case; and
(2) not later than one business day after the complainant's request for appeal is received.

(b) Because of the ongoing emergency or continued hospitalization and at the request of the complainant, the health maintenance organization shall provide, instead of a complaint appeal panel, a review by a physician or provider who:

(1) has not previously reviewed the case; and
(2) is of the same or a similar specialty as the physician or provider who would typically manage the medical condition, procedure, or treatment under consideration for review in the appeal.

(c) The physician or provider reviewing the appeal may interview the patient or the patient's designated representative and shall decide the appeal.
When Payors Won’t Listen...

Denials: Prevention and Correcting Issues stemming from the Insurance Side.

What are payors looking for in an appeal letter?

1. Identify the denial reason.
2. Determine the jurisdiction.
   - Examples: MA, ERISA, State sponsored HMO.
3. Create transition statement of facts to ensure a clear explanation of the disputed item, including the provider’s position is contained in appeal letters.
   - ER No Pay: Postabilization: “We dispute [Payor’s name] denial of this claim as not medically necessary, because [Payor’s name] was notified of the patient’s admission and failed to disapprove of care prior to the patient’s discharge as shown and described below.”
   - No Claim on File: “We dispute [Payor’s name] denial of this claim as no claim on file, because [Client’s name] billed the claim to [Payor’s name] on [date] as shown and described below.”
4. Attach exhibits to document each fact.
   - Example:
     - On 9/23/15, the patient presented to the emergency department of [PROVIDER] with severe crushing chest pains.
     - On 10/3/15, MHG submitted the claim to Blue Cross (See Exhibit A – Hospital UB04 and Claims Clearing house receipt).
     - On 4/20/16, Blue Cross denied the claim for untimely filing (See Exhibit B – BX EOB).
5. Locate administrative laws to support each argument.
6. Apply the law.
   - Don’t just don’t copy and paste laws, hoping they will scare the Payor. Know your position.
7. Land the plane (Impose deadlines.)
   - “Please release the federal funds intended for the Medicare beneficiary on or before [deadline date] to prevent any unnecessary regulatory complaint action.”
Laws and Regulations

MCO-MEDICAID POSTSTABILIZATION SERVICE DENIALS.
MCO-Medicaid Definitions

**Post-Stabilization Care Services**: Medically necessary covered services, related to an emergency medical condition, that are provided after an enrollee is stabilized, in order to maintain the stabilized condition, and for which the MCO is responsible when: (i) the services are service authorized; (ii) the services are provided to maintain the enrollee's stabilized condition within 1 hour of a request to the MCO for service authorization of further post-stabilization care services; (iii) the MCO could not be contacted; (iv) the MCO did not respond to a service authorization within an hour; or (v) the MCO and treating provider are unable to reach agreement regarding the enrollee's care (42 CFR 438.114(e), and 422.214).
**MEDICARE HMO – 42 CFR § 422.113 (b)(2)** The MA organization is financially responsible for emergency and urgently needed services—

(i) Regardless of whether the services are obtained within or outside the MA organization;

(ii) Regardless of whether there is prior authorization for the services.

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(3) **Stabilized condition.** The physician treating the enrollee must decide when the enrollee may be considered stabilized for transfer or discharge, and that decision is binding on the MA organization.
**MEDICARE HMO - 42 CFR 422.113 (c)(2)** MA organization financial responsibility. The MA organization—
(i) Is financially responsible (consistent with Sec. 422.214) for post-stabilization care services obtained within or outside the MA organization that are pre-approved by a plan provider or other MA organization representative;

(ii) Is financially responsible for post-stabilization care services obtained within or outside the MA organization that are not pre-approved by a plan provider or other MA organization representative, but administered to maintain the enrollee's stabilized condition within 1 hour of a request to the MA organization for pre-approval of further post-stabilization care services;
(iii) Is financially responsible for post-stabilization care services obtained within or outside the MA organization that are not pre-approved by a plan provider or other MA organization representative, but administered to maintain, improve, or resolve the enrollee's stabilized condition if—

(A) THE MA ORGANIZATION DOES NOT RESPOND TO A REQUEST FOR PRE-APPROVAL WITHIN 1 HOUR;

(B) The MA organization cannot be contacted; or

(C) The MA organization representative and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultation. In this situation, the MA organization must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in Sec. 422.113(c)(3) is met;
(3) End of MA organization's financial responsibility. The MA organization's financial responsibility for post-stabilization care services it has not pre-approved ends when—

(i) A plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care;
(ii) A plan physician assumes responsibility for the enrollee's care through transfer;
(iii) An MA organization representative and the treating physician reach an agreement concerning the enrollee's care; or
(iv) The enrollee is discharged.

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Dear Business Office Manager,

Your correspondence was received in our office in regards to an inquiry for additional payment of healthcare services provided by your company. After careful consideration of the case and all supporting documentation, a decision has been made to uphold the initial determination.

The payment is based on the terms and reimbursement rate(s) outlined in Medicare's policy. The claim was processed appropriately in accordance to the terms and conditions of Medicare.

The basis for the decision is as follows:

This claim has been denied per the utilization review team. A letter was sent to the provider on 10/29/2013 and 1/17/2014. The provider will need to send an appeal for further claims review. Therefore, no additional benefits are due at this time.

Per your contractual agreement and/or the Knox-Keene language, you may not bill the member.

UnitedHealthcare, a Medicare Advantage Organization, and its contracting providers are obligated to reimburse non-contracting provider at the same rate a provider would collect if the patient were enrolled in original Medicare. According to Part 42 of the Code of Federal Regulations, Section 422.214, any non-contracted provider must accept as payment in full the amounts that it could collect if the beneficiary were enrolled in original Medicare.

If you have any questions or concerns, please call (800) 342-8789 and select the claims option.

Sincerely,

[Claim Details and Address]
It is our understanding that United had no record of having received an appeal request from Memorial Hospital of Gardena in response to denying the claim. United has since opened an appeal; I believe the plan is awaiting receipt of the Waiver of Liability from the hospital.

If you can provide evidence to CMS that Memorial Hospital did file a reconsideration request and the required documentation within 60 days of the remittance notification (per the Medicare Managed Care Manual, Chapter 13), please submit that to us.

40.2.3 - Notice Requirements for Non-contract Providers
(Rev. 105, Issued: 04-20-12, Effective: 04-20-12, Implementation: 04-20-12)

If the Medicare health plan denies a request for payment from a non-contract provider, the Medicare health plan must notify the non-contract provider of the specific reason for the denial and provide a description of the appeals process. Plans must deliver either a remittance advice/notice or other similar notification that includes the following information:

- Non-contract providers have the right to request a reconsideration of the plan’s denial of payment;
- Non-contract providers have 60 calendar days from the remittance notification date to file the reconsideration;
- Non-contract providers must include a signed Waiver of Liability form holding the enrollee harmless regardless of the outcome of the appeal (include either the form or a link to the form);
- Non-contract providers should include documentation such as a copy of the original claim, remittance notification showing the denial, and any clinical records and other documentation that supports the provider’s argument for reimbursement; and

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Dear Ms. Duarte,

I am responding to your email sent yesterday to Rose Trochez.

Attached are United’s denials and Memorial Hospital of Gardena’s hospital remote notes with pertinent dates highlighted as proof that Memorial Hospital submitted an appeal request within the 60 day timeframe for reconsideration, orally and in writing pursuant to 42 CFR §422.582(a).

Based on our investigation, we have found:

- On 06/06/13, patient was presented to the emergency room at Memorial Hospital. (See Remote Notes)
- On 06/07/13, Memorial Hospital called Secure Horizons and received authorization for patient from Amanda, authorization #13109-0582. (See Remote Notes)
- On 07/19/13, patient was discharged from Memorial Hospital.
- On 07/31/13, claim was billed to Secure Horizons electronically. (See Remote Notes)
- On 08/01/13, Memorial Hospital placed a phone call to Secure Horizons and spoke with Cory who stated claim was denied on 08/29/13 pending medical records. (See Remote Notes)
- On 09/10/13, Memorial Hospital sent the medical records by certified mail to support their reason for denial on REA FORM. (See Remote Notes)
- On 12/30/13, per Natalie, claims supervisor at Secure Horizons, claim was denied as not medically necessary, and submitted information to support denial of stay for number of services. (See Remote Notes)
- On 02/04/14, Memorial Hospital called Secure Horizons and spoke to Terrance, stating that claim should be sent back for review. (Oral appeal) (See Remote Notes)
- On 02/18/14, Memorial Hospital received correspondence from United stating the claim was denied per readmission review team. (See United’s Denial Letter)
- On 04/02/14, Memorial Hospital sent two boxes of additional medical records to Secure Horizons for review of denied claim. (See Remote Notes)
- On 04/04/14, Memorial Hospital called Secure Horizons to check on status of medical record review. Terrance stated they are not showing the records having been received; however, USPS website shows records as being delivered. (See Remote Notes)
- On 08/27/14, United sent Memorial Hospital a letter stating that “claim remains denied as no formal request for reconsideration/appeal was received to warrant further review.” (See attachment of letter)
- On 06/12/14, ERN/TRAFF sent an Appeal and Request for Reconsideration review to Secure Horizons for failure to review medical records per conversation on 04/04/14, and reconsideration review. (See attachment of letter)
- On 07/25/14, United sent ERN the Waiver of Liability forms. The forms were signed and faxed back to United and were forward to Ms. Duarte. (See WOL’s attached)
As the evidence will prove, Secure Horizons denied the claim on 08/29/13, and on 09/10/13 Memorial Hospital sent an appeal with medical records to Secure Horizons, requesting reconsideration of the claim. When Secure Horizons denied the claim again on 11/01/13, the provider advised Memorial Hospital that they could have sought clarification from Memorial Hospital or sent a letter stating their appeal was not a reconsideration. Instead they conducted a reconsideration review and denied it on 11/30/13. At that time they failed to send the claim to the IRE, pursuant to 42 CFR 442.590(b)(2).

Furthermore, patient was admitted through the emergency room and Memorial Hospital was given authorization by Secure Horizons to admit the patient. Pursuant to 42 CFR §442.113(b)(2)(i) an MA organization is financially responsible for emergency and urgently needed services regardless of whether there is prior authorization. However, since authorization was given in this case, according to 42 CFR §442.113(c)(3)(i), the MA organization is also financially responsible for services covered under the HCP. The HCP is a plan provider or other MA organization representative. Therefore, United is liable for the entire amount of the patient’s stay as patient was admitted with authorization through the emergency room per authorization #13168-0582.

The authorization demonstrates that UHC was aware of the beneficiary’s admission. Even if UHC did not issue an authorization, they were given an opportunity to assume care via:
(i) A plan physician with privileges at the treating hospital assuming responsibility for the enrollee’s care;
(ii) A plan physician assuming responsibility for the enrollee’s care through transfer or
(iii) An MA organization representative and the treating physician reaching an agreement concerning the enrollee’s care prior to discharge;

Since that did not occur, UHC’s financial responsibility ended when:
(iv) The enrollee was discharged. (See 42 CFR §442.113(c)(4))

In reference to the Waiver of Liability form, Secure Horizons failed to make reasonable efforts to secure the form if an appeal was forwarded to them without one. Since your involvement, they have sent forms to our office and we have forwarded sign copies for their reconsideration review. (See attached)

Please be advised that the information enumerated above was recorded in notes made by Memorial Hospital’s staff members. These notes constitute “hospital records” and the Federal Business Records Act may be invoked to offer hospital records as a reliable source of information to prove the truth of the matter asserted. Under 28 U.S.C.A. §1732(a), characterizing information as hospital records is predicated upon satisfying two requirements: the record must have been made in the regular course of business, and it must have been the regular course of the business to make such record contemporaneously or within a reasonable time. It has been held that when these two requirements are satisfied with respect to a hospital record, the entire document is deemed reliable.

The Memorial Hospital notes are used to keep records of all transactions in the regular course of business. Further, all Memorial Hospital notes are recorded contemporaneously or within a reasonable time. The Memorial Hospital notes are therefore properly characterized as hospital records under the Federal Business Records Act.

The attached exhibits are patient protected and the password will be sent immediately following this email. If you need any more information to help this investigation into United/Secure Horizon’s unlawful denial, please do not hesitate to contact our office.

We thank you for all your tireless advocacy for Medicare beneficiaries.

Best regards,
Dali Haley, Esq.
Claims Compliance Auditor II

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Dali Haley
From: Duarte, A
To: Trochez, R
Cc: Ed Norwood; Dali Haley
Subject: RE: ERN/TRAES Summary of Complaint/ Memorial Hospital of Gardens/ Password to follow

Ms. Trochez,

Thank you for your continued patience as we work on this case. It does appear, based upon the Information that Ms. Haley provided and some additional details from United, that they should have addressed the providers’ appeal in September 2013. CMS will follow up with United on this issue.

In the meantime, as I indicated previously, United is now addressing the appeal and they have the Waiver of Liability to accompany it. We intend to allow United to carry out this process and will track the outcome.

Respectfully,

Ann M. Duarte | Associate Regional Administrator | Division of Medicare Health Plans Operations | ECXNAEPE
Fax Server 8/14/2014 9:47:49 AM PAGE 5/003 Fax Server

August 14, 2014

ERN TARB
Ann: Rosa Trochez
1143 W Badondo Beach Blvd.
Gardena, CA 90247

Member ID #: M
Member Name: Hart

Dear Ms. Trochez:

We received your request for an appeal on July 08, 2014 about the denial of an inpatient claim for services provided at Memorial Hospital Gardens on June 6, 2013 through July 19, 2013.

Thank you for bringing this to our attention. We will pay for June 6, 2013 through July 19, 2013.

Based on the records, there was documentation of adequate treatment during the first admission and stability at discharge, the re-admission is not related directly to the first admission. The re-admission denial for dates of service June 6, 2013 through July 19, 2013 is being overturned.

What happens next?
- We changed the refusal of payment for June 6, 2013 through July 19, 2013 and your claim has been sent to the Claims Department to be paid within sixty (60) calendar days.

You have the right to:
- Ask for a copy of your case file and the criteria that we used to decide your case.
- To request a copy of your file, please contact us at:
  UnitedHealthcare
  PO BOX 6106
  MailStop M1377
  Cypress, CA 90630-6106
  Phone: 1-951-786-9638 TTY: 711
- Send additional information about your appeal

Y0966-130906-093818A CMS Approved 09122013
AG02_Appeal_Overtturn_Decision_09132013Update

Dali Haley

From: Dali Haley
Sent: Thursday, August 14, 2014 12:54 PM
To: Duarte, A

Subject: RE: ERN/TRAIR Summary of Complaint/ Memorial Hospital of Gardena

Ms. Duarte,

We thank you for your aggressive oversight over the UHIC complaint submitted to your office on July 8, 2014. Today we received correspondence from UHIC stating that the readmission of the beneficiary was not related directly to the first admission. Therefore, the denial for dates of service June 6, 2013 to July 19, 2013 is being overturned.

UHIC has notified this office that the claim has been sent to the Claims Department to be paid within 60 calendar days.

While we appreciate UHIC's partial compliance in this matter, the provider's first request for a standard reconsideration was on September 10, 2013. The provider again requested reconsideration on April 16, 2014, and after UHIC failed to adjudicate the claim in accordance with Medicare law and forward the claim to us, our office sent another request on June 12, 2014. Per 42 CFR §422.618(a)(2), "If, on reconsideration of a request for payment, the MA organization completely rescinds or reorganization determination, the organization must pay the service no later than 60 calendar days after the date the reconsideration is requested that resulted in a favorable decision, which was June 12, 2014.

UHIC should have remitted payment by August 11, 2012, and they are in non-compliance by stating that the claim shall be paid within 60 days of reprocessing the payment through their Claims Department. Please order your MAG or release payment forthwith in compliance with 42 CFR §422.618(a)(2).

We thank you for your tireless advocacy for Medicare beneficiaries.

Respectfully,

Dali Haley, Esq.
Claims Compliance Auditor II
ERN / The Reimbursement Advocacy Firm
714 995-6900 Ext. 6900 Fax 714 995-6901

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Ed Norwood Boot Camp: PCCP Federal ACC
Track A-Access to Care

Dalli Haley

Subject: ERN/TRAF Summary of Complaint/ Memorial Hospital of Gardena

From: Duarte, A
Sent: Friday, August 15, 2014 11:18 AM
To: Dalli Haley
Cc: Ed Norwood, Rose Trochez

Subject: RE: ERN/TRAF Summary of Complaint/ Memorial Hospital of Gardena

Ms. Haley,

I appreciate you sharing the news that UHC has reconsidered its denial and will pay the claim. Our office will address the organization's improper handling of the original request from Memorial Hospital of Gardena. Such actions, however, will not include instructing UHC to pay the claim quicker than within the 60-day established timeframe.

If UHC fails to pay Memorial Hospital within 60 days, please let me know so that we can take further action.

Respectfully,

Ann M. Duarte (Associate Regional Administrator) Division of Medicare Health Care Operations Region 9 DRG 1995

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Dalli Haley

From: Ed Norwood <ednorwood@ernenterprises.org>
Sent: Friday, August 15, 2014 12:52 PM
To: 'Table-Bedward, Arrath A. (CMS/CM)
Cc: 'Akinrin, Mary G. (CMS/CM)'; Dalli Haley, Rose Trochez; 'Duarte, Ann M. (CMS/CMHPO)

Subject: FW: ERN/TRAF Summary of Complaint/ Memorial Hospital of Gardena

Ms. Table-Bedward:

In the past, we have discussed the importance of reporting issues to you that have not been handled by your Regional Offices (RO), the MA or contractor consistent with Medicare Rules and Regulations.

Below is an example of the same.

While we appreciate Ms. Duarte's oversight in this matter, you will find below a glaring concern we have of the RO's ability to enforce the compliance of it's MAOs.

We trust you will intervene in this matter to prevent any unnecessary regulatory complaint action with Ms. Marilyn Tavenner's office by ensuring the federal funds intended for the Medicare beneficiary are released forthwith.

THIS IMPROPERLY DENIED CLAIM IS 349 DAYS BEYOND THE STATUTORY TIMEFRAME FOR REIMBURSING CLAIMS (PER 42 CFR SEC. 422.520.)

If not, we would appreciate an electronic written copy of any CMS Manual, Handbook, SOP or statutory authority that permits MAOs to reverse its organization determination (upon reconsideration) and pay for the service LATER than 60 calendar days after the date the MA organization receives the request for reconsideration (See 42 CFR §422.618(a)(2) AND EMAIL STRING BELOW.)

Best,

Ed Norwood
Chief Compliance Officer
ERN / The Reimbursement Advocacy Firm
714 955-6900 ext. 6926 Fax 714 995-6901

www.ernenterprises.org

“Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed it is the only thing that ever has.” - Margaret Mead
MA Organizations: Their Responsibility To You

MA Organizations are financially responsible for poststabilization care services when...

1. They have been pre-approved
2. You render services within 1 hour of your request
3. They did not respond to your request after one hour, they cannot be contacted and the plan physician cannot reach an agreement about the enrollee's care

MA Organizations’ financial responsibility ends when...

1. A plan physician assumes responsibility for the enrollee's care...
   - At the treating facility
   - OR through transfer
2. OR the enrollee is discharged
3. An MA organization representative and the treating physician reach an agreement about the enrollee's care

Source: 42 CFR §422.113 (c)(2, 3)
Laws and Regulations

ASK YOURSELF:

• Has the plan issued a tracking number versus an authorization?
• Did the plan receive faxed clinicals to conduct concurrent reviews while the patient was still hospitalized?
• Did the plan fail to notify the hospital of any disagreements prior to the commencement of poststabilization services and care or during the continuation of the same?

Any failure to issue an authorization within 60 minutes of the initial call deems the services authorized and payment cannot be denied.

Unfair Payment Practices

MA OBSERVATION VS. INPATIENT
Ed Norwood Boot Camp: PCCP Federal ACC
Track A - Access to Care

Laws and Regulations

**42 CFR § 422.504**

(i) MA organization relationship with first tier, downstream, and related entities.

(3) All contracts or written arrangements between MA organizations and first tier, downstream, and related entities must contain the following:

(i) Enrollee protection provisions that provide, consistent with paragraph (g)(1) of this section, arrangements that prohibit providers from holding an enrollee liable for payment of any fees that are the obligation of the MA organization.

We must protect the beneficiary from any improper rise in liability.

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The Medicare Benefit Policy Manual (Chapter 6-Hospital Svcs Covered Under Pt. B) defines observation care as:

“...a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation status is commonly assigned to patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge.”
Observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours.

· Section 50.3.1 of the Medicare Claims Processing Guide (Chapter 1) states:
Under the hospital Condition of Participation (CoP) at 42 C.F.R. §482.12(c), patients are admitted to the hospital or CAH as inpatients only on the recommendation of a physician or licensed practitioner permitted by the State to admit patients to a hospital. In addition, every Medicare patient must be under the care of a physician or other type of practitioner listed in the regulation (“the practitioner responsible for care of the patient”). In some instances, a practitioner may order a beneficiary to be admitted as an inpatient, but upon reviewing the case, the hospital’s utilization review (UR) committee determines that an inpatient level of care is not medically necessary.
Taking this into consideration, CMS obtained a condition code from the National Uniform Billing Committee (NUBC), effective April 1, 2004, that specifies:

- **Condition Code 44** - Inpatient admission changed to outpatient – For use on outpatient claims only, when the physician ordered inpatient services, but upon internal utilization review performed before the claim was originally submitted, the hospital determined that the services did not meet its inpatient criteria.

The State Operations Manual states that in no case may a non-physician make a final determination that a patient’s stay is not medically necessary or appropriate (see Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals).
Use of Condition Code 44 is not intended to serve as a substitute for adequate staffing of utilization management personnel or for continued education of physicians and hospital staff about each hospital’s existing policies and admission protocols. As education and staffing efforts continue to progress, the need for hospitals to correct inappropriate admissions and to report Condition Code 44 should become increasingly rare.

Section 50.3.2 adds:
In cases where a hospital or a CAH’s UR committee determines that an inpatient admission does not meet the hospital’s inpatient criteria, the hospital or CAH may change the beneficiary’s status from inpatient to outpatient and submit an outpatient claim (bill type 13x or 85x) for medically necessary Medicare Part B services that were furnished to the beneficiary, provided all of the following conditions are met:
Laws and Regulations

1. The change in patient status from inpatient to outpatient is made prior to discharge or release, while the beneficiary is still a patient of the hospital;
2. The hospital has not submitted a claim to Medicare for the inpatient admission;
3. The practitioner responsible for the care of the patient and the UR committee concur with the decision; and
4. The concurrence of the practitioner responsible for the care of the patient and the UR committee is documented in the patient's medical record.

APPLICATION FOR YOUR FACILITY:

• Ask your payor to provide the statutory authority they rely upon to request the patient’s inpatient stay be changed to observation:
  1. Reflecting a change in what the treating physician ordered and
  2. After the patient has been discharged.
VA ER REIMBURSEMENT LAWS

1. The VA has thirty (30) days under the prompt payment act to reimburse non-VA care to an emergency provider.
   (38 U.S. CODE § 3903)
   
2. If the VA makes an adverse benefit decision on non-VA care, the provider or representative must send a written Appeal (or Notice of Disagreement) within one (1) year.
   (38 U.S. CODE § 7105)
   NOTATION: IF Agency of Jurisdiction (AOJ) cannot clearly identify that communication as expressing an intent to appeal, the AOJ must contact the provider in writing.
   (38 CFR § 19.26)

3. The provider or representative must respond to the AOJ's request for clarification within one of the following dates:
   (i) 60 days after the date of the AOJ's clarification request;
   (ii) One year after the date of mailing of notice of the adverse decision being appealed (60 days for simultaneously contested claims).
   (38 CFR § 19.32)

4. Upon receiving a Notice of Disagreement, the AOJ must reexamine the claim and determine whether additional review or development is warranted. If the review upholds the denial, then they must prepare a Statement of Case (SOC), VA Form 9 and other notices and forward the veteran or their representative.
   (38 CFR § 19.29)
   (38 CFR § 19.30)

5. The Provider can then file a formal substantive appeal with the Board of Veteran Appeals (BVA) by filing VA Form 9 (and a narrative) within sixty (60) days from receipt of the Statement of Case; this timeframe may be extended with good cause. (You may have more time if you have any remaining portion of the one year period after the VA’s initial notice of its decision that prompted the NOD.) Also, if your appeal is untimely, timeliness or adequacy of response must be determined by the BVA, not the VA.
   (38 U.S. CODE § 7105 (d)(3))

6. AOJ must certify formal appeal for Board review at which time, the claimant or representative will be notified of their hearing and representation rights.
   (38 U.S. CODE § 19.24 (c)(2))
August 10, 2015

STATEMENT OF THE CASE
IN THE APPEAL
OF
St. Mary Medical Center for
FROM THE DECISION OF THE
DEPARTMENT OF VETERANS AFFAIRS

NOTICE TO APPELLANT:
This is a decision on the appeal you have initiated. It is a "Statement of the Case" which the law requires us to furnish to you in completing your appeal.

Please read the forwarding letter carefully, as well as the instructions on the enclosed appeal form. These explain your appeal rights and tell you what you must do to complete your appeal.

A copy of this "Statement of the Case" has been furnished to your representative: ERN The Reimbursement Advocacy Firm (TRAF)

ISSUE: APPEAL OF ALLEGED NON EMERGENT DENIAL
A timely claim presented the question of denial of entitlement because in order to be eligible for consideration of payment, specific provisions under the Millennium Health Care and Benefits Act Public Law 106-117, has to be met.

<table>
<thead>
<tr>
<th>Department of Veterans Affairs</th>
<th>APPEAL TO BOARD OF VETERANS' APPEALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Name of Veteran</td>
<td>(Last, First, Middle Initial)</td>
</tr>
<tr>
<td>2. Date of Birth</td>
<td></td>
</tr>
<tr>
<td>3. Address</td>
<td></td>
</tr>
<tr>
<td>4. Telephone Number</td>
<td></td>
</tr>
<tr>
<td>5. ZIP Code</td>
<td></td>
</tr>
<tr>
<td>6. Home Address</td>
<td></td>
</tr>
<tr>
<td>7. ZIP Code</td>
<td></td>
</tr>
<tr>
<td>8. If the veteran is deceased, who is the representative?</td>
<td></td>
</tr>
<tr>
<td>9. What are the issues you want to appeal to the Board? (Be sure to state the issue or issues set forth in Paragraph (ii) of the initial decision.)</td>
<td></td>
</tr>
<tr>
<td>10. I want to appeal all of the issues listed in the Statement of the Case and any supplemental statement of the case.</td>
<td></td>
</tr>
<tr>
<td>11. I want to appeal this appeal.</td>
<td></td>
</tr>
<tr>
<td>12. I want to appeal this decision.</td>
<td></td>
</tr>
<tr>
<td>13. I want to appeal the VA to make this appeal.</td>
<td></td>
</tr>
<tr>
<td>14. Date</td>
<td></td>
</tr>
</tbody>
</table>

(Please note: all boxes must be checked, including the one that applies in your case.)
The Freedom of Information Act (FOIA) is a law that gives you the right to access information from the federal government. It is often described as the law that keeps citizens in the know about their government.

There is no specific form that must be used to make a request. The request simply must be in writing, reasonably describe the information you seek, and comply with specific agency requirements. Most federal agencies now accept FOIA requests electronically, including by web form, e-mail or fax.

What can you ask for?

A FOIA request can be made for any agency record. You can also specify the format in which you wish to receive the records. You should be aware that the FOIA does not require agencies to do research for you, to analyze data, to answer written questions, or to create records in response to a request.
VHA DIRECTIVE 2010-008
January 27, 2010

TIMELINESS STANDARDS FOR PROCESSING NON-VA PROVIDER CLAIMS

1. PURPOSE. This Veterans Health Administration (VHA) Directive establishes policy standards for the processing of non-VA health care claims from non-Department of Veterans Affairs (VA) providers.

2. BACKGROUND

a. Timely processing of claims for hospital care and medical services ensures improved provider relations and increased Veteran access to supplemental community health care services. This policy applies to the traditional fee program as well as any claims for service provided to a Veteran outside a VA medical facility, including community-based Outpatient Clinics (CBOCs).

b. Non-VA health care claims are submitted for services purchased in accordance with the Federal Acquisition Regulation (FAR) and Veterans Affairs Acquisition Regulation (VAAR) (including individual authorizations and sharing agreements) and authorized under Title 38, United States Code (U.S.C.) §§ 1703, 1720, 1730C, 1725, 1728, 7409, or 8155. NOTE: Non-VA health care claims authorized by 38 U.S.C. §§ 1720 and 1720c include community nursing home, community adult day health care, home health care services, respite care, and hospice care.

c. For the purposes of this policy, a claim is considered processed upon the date:

(1) The batch is finalized;

(2) The claim is denied or disapproved; or

(3) The claim is returned to the provider as incomplete.

3. POLICY. It is VHA policy that 90 percent of all non-VA health care claims are processed within 30 days of the date the claim is received by the facility.

4. ACTION

a. **Veterans Integrated Service Network (VISN) Director.** The VISN Director is responsible for:

(1) Ensuring that standards are met with regard to where the claims for purchased non-VA health care are processed. For example, the VISN Director must ensure that standards are met by the centralized network function when claims processing has been centralized in a VISN, or by staff processing claims in a clinical service line (e.g., radiology).

(2) Ensuring development of claims processing tracking tools are used within the VISN.

**THIS VHA DIRECTIVE EXPIRES JANUARY 31, 2015**

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VHA DIRECTIVE 2010-008
January 27, 2010

(3) Submitting VISN specific data for all non-VA health care claims in a monthly performance tool housed on the National Fee Program Office Intranet Web site at: http://vhahscony.va.med.va.gov/default/default.asp.

(4) Ensuring that a copy of any VA facility or VISN contract for the payment or purchase of non-VA health care services from health care vendors in a VISN facility, geographical area, or patient referral area is given to all managers at the appropriate facility assigned responsibility for the payment of those purchased non-VA health care services.

b. **Facility Director.** The Facility Director is responsible for ensuring that:

(1) Each employee in the facility who processes non-VA health care claims for payment receives VHA Chief Business Office (CBO) standardized mandatory Veterans Health Information Systems and Technology Architecture (Vista) Fee and Claims Processing training, including application of contracted care rates to accurately pay services purchased by contract.

(2) A copy of any VA facility or VISN contract for the payment or purchase of non-VA health care services from health care vendors in a VISN facility, geographical area or patient referral area is given to all managers at the appropriate facility assigned responsibility for the payment of those purchased non-VA health care services.

(3) All non-VA health care claims, including claims that are denied for administrative or clinical reasons, are processed using the Vista Fee system, unless it is not possible to process the claim within Vista. (i.e., claims requiring paper or electronic processing, claims requiring prior authorization or contracts with health care vendors who do not use Vista Fee software must be documented in writing and approved by the facility Director. Workload capture for payments processed out of the Vista Fee system must be accomplished through other credible VA workload applications, such as the Vista Scheduling package.

(4) Claims processing timeliness standards are met with regard to where the VA medical facility chooses to process the non-VA health care claim.

(5) Non-VA health care claims requiring transfer to another fee site for processing are forwarded within 3 business days of receipt of the claim.

(6) Ninety percent of all non-VA health care claims are processed within 30 days of receipt of the claim at the fee claims processing site. All claims are to be date stamped with the date the claim is received at the facility and in those instances when the date of claim receipt is unknown, the postmark date or date of invoice, whichever is later, is to be used as the receipt date.

(7) Claims processing and status date, i.e., monthly performance reports, are submitted by using the monthly performance tracking tool housed on the VHA National Fee Program Office Intranet Web site at: http://vhahscony.va.med.va.gov/default/default.asp. The monthly report includes the following:

(a) All non-VA health care claims, including pended and denied claims, are counted in the statistics for claims processing timeliness reports.
VIA DIRECTIVE 2010-005
January 27, 2010

(6) Claims requiring additional information must be set to incomplete status in VistA Fee. These claims may be considered pended. The time from date of receipt to date additional information is received at the Stoplight Report. The time from date of receipt to date additional information is received at the Stoplight Report. The time from date of receipt to date additional information is required by the claimant is not included in the claim processing statistics. Upon receipt of the requested information, the processing cycle for the claim begins anew.

1. The claim is received on July 1. On July 6, it is determined that the Veteran meets administrative eligibility for VA payment; however, additional information is needed to adjudicate the claim. The claim is pended, set to incomplete status, and a letter is mailed to the claimant on July 8 requesting the needed information. The provider submits the additional information received at the VA facility on August 1. The claim is processed and dispositioned on August 15.

NOTE: If the VistA system site parameters are properly set, the system automatically begins tracking the time start of pended unauthorized claims. The system will display an alert message identifying claims due to be abandoned so that appropriate follow-up action may be taken. The system is also designed to automatically disposition the claim and print an abandonment letter when a claim entered under 38 U.S.C. 1723 is pended 90 days or 365 days for claims pended under 38 U.S.C. 1728.

2. The claim would be counted as follows:

<table>
<thead>
<tr>
<th>Action</th>
<th>Date</th>
<th>Calendar Days</th>
<th>Processing Days for Reporting Purposes</th>
<th>Stoplight Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim Receipt</td>
<td>July 1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Claim Pended and Closed</td>
<td>July 8</td>
<td>9</td>
<td>9</td>
<td>Counted as New Claim Received</td>
</tr>
<tr>
<td>Claim Receipt</td>
<td>August 1</td>
<td>32</td>
<td></td>
<td>Counted as New Claim Received</td>
</tr>
<tr>
<td>Claim Dispositioned and Closed</td>
<td>August 13</td>
<td>46</td>
<td>13</td>
<td>Claim Counted as Processed</td>
</tr>
</tbody>
</table>

3. When a claim is forwarded by another VA facility, the receiving facility must date stamp the date the claim is received as the start date for counting claims processing timeliness.

(8) Non-VA health care claims, including Electronic Data Interchange (EDI) claims, received in the Fee Site Fee Payment Processing System (FPFS), are opened and initial adjudication action begins within 3 business days of receipt of the claim at the Fee claims processing site.

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VIA DIRECTIVE 2010-005
January 27, 2010

(9) A non-VA health care claim is not considered for payment until all the information needed to make a decision is received by the processing VA facility. Claims requiring additional information must be returned to the claimant with a request for the additional information within 30 days from the date of VA receipt of the claim at the Fee claims processing site. Such claims returned to the claimant are considered "pended," and the following applies:

(a) A pended claim is neither a denial of the claim nor abandonment of the claim. Reasons for return may include, but are not limited to, the need for additional supporting documentation, or correction of medical coding discrepancies on the claim. Processing of a pended claim in accordance with established regulations resumes upon receipt of the requested information.

(b) VA medical facility correspondence notifying claimants of pended non-VA health care claims considered under 38 U.S.C. § 1723 (payment for emergency treatment not authorized by VA in advance for certain service-connected Veterans) must advise the claimant that the claim has not been denied, but that failure to submit requested information within 1 year from the date of request will result in the claim being abandoned.

(c) VA medical facility correspondence notifying claimants of pended non-VA health care claims considered under 38 U.S.C. § 1723 (payment for emergency treatment not authorized by VA in advance for non service-connected conditions) must advise the claimant that the claim has not been denied, but that failure to submit requested information within 30 days from date of request will result in the claim being abandoned.

An extension of time may be granted upon request by the claimant, not to exceed 30 days from the date the claim is returned. In the event the VA does not receive the additional information within the 30-day period or the requested extension, an extension within the 30-day period. In that case, an extension may be granted for what VA deems a reasonable time period.

5. REFERENCES
   b. Title 38 CFR §§ 17.52 – 17.56, 17.120 - 17.142, and 17.1000-17.1008.
   c. MP-4 Part III, Chapter 3.
   d. MP-4 Part III, Chapter 3.
   e. M-1 Part I, Chapter 18, Appendix A Section VI b (1) b.
   f. M-1 Part I, Chapter 19, Section 19.14C.

6. FOLLOW-UP RESPONSIBILITY: The Chief Business Officer (16) is responsible for the contents of this Directive. Questions should be referred to the National Fee Program Office at (302) 598-5160.

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Ed Norwood Boot Camp: PCCP Federal ACC
Track A - Access to Care

From: Ed Norwood <ehnorwood@ernenterprises.org>
To: Ms. Nelson and Ms. Romero:
Cc: Ed Norwood <ehnorwood@ernenterprises.org>
Subject: For Your Review - VHA Directive 2010-005 TIMELINESS FOR PROCESSINGVA CLAIMS
Attachments: VHA Directive 2010-005 TIMELESS FOR PROCESSINGVA CLAIMS.pdf

Tracking:

Recipient: Read

Ms. Nelson and Ms. Romero:

This office represents East Los Angeles Doctor’s Hospital (ELA) and has been asked to file a formal complaint with VISN 22 and the Office of the Assistant Secretary of Defense (Health Affairs) for the Sepulveda GLA’s improper denial of emergency and post stabilization care for the below veteran of the U.S. Armed Forces.

In its advisory role to healthcare providers that provide emergency and medically necessary services to VA beneficiaries, the Reimbursement Advocacy Firm (TRAF) periodically brings to your attention non-compliance issues related to—

1. A veteran’s timely access to emergency and post stabilization services in non-VA facilities.
2. Provider reimbursement for emergency or urgently needed services in non-VA facilities.
3. Any other health services furnished by a non-VA provider or supplier that are reimbursable under 38 CFR Part 17, 31 USC 3902 and 3903, 38 USC 1725 or any rule adopted pursuant thereto.

In the case of veteran Torner, we have determined the following payment failures by Sepulveda GLA

- On 8.25.11, the veteran was admitted into ELA through the emergency room.
- On 8.29.11, ELA called the VA and spoke with Emma who stated the veteran was eligible for VA benefits; on the same date, ELA faxed a face sheet of admission to Sepulveda VA constituting an informal/informal application per 38 CFR §17.54 to request authorization.
- On 9.13.11, ELA called VA and Emma confirmed again that patient is eligible for VA benefits for ER acute hospital care, but no benefits if veteran is transferred to a nursing home.
- On 11.8.11, the veteran was discharged.
- On 11.8.11 (7 days later), ELA submitted claim to Sepulveda VA.
- On 11.12.11 (93 days later), ELA called VA and Janice stated that the claim was still in process under claim #115997.
- On 3.12.12 and 3.13.12, ELA called VA and received no answer with the phone ringing continuously.
- On 3.14.12 (143 days later), ELA called VA and Fariba stated the claim was still processing.

- On 3.23.12 (152 days later), ELA called VA and Maria stated the claim was still processing as they are backlogged 3-4 months.
- On 4.3.12, ELA called VA and Fariba stated the claim was denied 3.24.12 (166 days later) for medical records.
- On 4.19.12 (15 days later), ELA confirmed that medical records were delivered to Sepulveda VA via FedEx #846366115000653 and signed for by D. Ortiz.
- On 6.11.12, ELA called VA and Lucy stated the claim was sent for pricing on 5.8.12.
- On 9.28.12, ELA called VA and automated service stated VA was not taking calls. Faxed request for claim status to the VA.
- On 10.30.12, ELA called VA and Lucy stated the claim was denied for untimely filing.
- On 11.2.12, ELA submitted timely filing appeal via certified mail #70101060000203147620.
- On 11.3.12, ELA called VA and Lucy stated she could not locate the appeal. Faxed the appeal to her attention.

We refute the VA’s legal premise for this denial as it is unsupported by any existing cases, statutes or regulations.

As you know, it is VHA policy that 90 percent of all non-VA health care claims are processed within 30 days of the date the claim is received by the facility (see attached VHA Directive 2010-005) consistent with 31 USC Sec. 3903 which provides that:

“...the required payment date is the date payment is due under the contract for the item of property or service provided or 30 days after a proper invoice for the amount due is received if a specific payment date is not established by contract.” 31 USC 3903(1)(A)(ii).

31 USC Section 3902 adds “that interest must be paid for late claims beyond 30 days.” 31 USC 3902(a).

When this claim was billed on 11.8.11, a claim number was assigned (#115997), yet a denial was not generated until 166 days later in violation of the applicable code section.

When medical records were requested by the VA, the request was governed by 38 CFR §17.1004(c) which states:

If after reviewing a claim the decisionmaker determines that additional information is needed to make a determination regarding the claim, such official will contact the claimant in writing and request additional information. The additional information may be submitted to the decisionmaker within 30 days of receipt of the request or the claim will be treated as abandoned, except that if the claimant within the 30-day period requests in writing additional time, the time period for submission of the information may be extended as reasonably necessary for the requested information to be obtained.

As you know, medical records were not requested in writing on 3.24.12 and once notified verbally, medical records were submitted via FedEx and received by the VA on 4.19.12 within the thirty day timeframe. Since receiving the medical records on that date, the VA actions included sending the claim for pricing and then denying it improperly for untimely filing.

THIS CLAIM IS NOW 360 DAYS BEYOND THE TIMEFRAME FOR PROCESSING CLAIMS.
We hereby request immediate release of the federal funds intended for the veteran. Please prevent any unnecessary regulatory complaint action by processing this claim on a rush basis and submitting payment details on or before Friday, April 26, 2013 along with:

- The date GLA approved payment and created a payment file for VA Automation and an ACE CONTROL NUMBER.

We appreciate your compliance.

Very Truly Yours,

Ed Norwood
Chief Compliance Officer
ERN / The Reimbursement Advocacy Firm
714 995-6900 ext. 6926 Fax 714 995-6501

www.ernenterprises.org

"Never doubt that a small group of thoughtful committed citizens can change the world. Indeed, it is the only thing that ever has." - Margaret Mead

Confidentiality Notice: MISUSE OF THIS INFORMATION IS A FEDERAL CRIME. The information contained in this Transmission is confidential, proprietary or privileged and may be subject to protection under the law, including the Health Insurance Portability and Accountability Act (HIPAA). This e-mail message, including all attachments, is intended for the use of the intended recipient(s). If you are not the intended recipient, you may NOT use, disclose, copy or disseminate this information. Please contact the sender by reply e-mail immediately and destroy all copies of the message and any accompanying attachments. Your cooperation is greatly appreciated. ERN/The Reimbursement Advocacy Firm.

Ed Norwood

From: Ed Norwood <ednorwood@ernenterprises.org>
Sent: Thursday, April 25, 2013 6:30 PM
Subject: Re: For your Review - URGENT Time Sensitive Matter

Tracking:
Recipient Recipient
'денисгрифин'@ernenterprises.org Read 4/26/2013 9:00 AM
Read 4/26/2013 9:45 AM
Ed Norwood Read 4/26/2013 9:42 PM

Ms. Nelson:

I appreciate your aggressive oversight over your claims processing unit to redress this matter. I have postponed our regulatory complaint filing one (1) week pending your response.

As this matter is now 371 days in violation of VHA Directive 2010-005 and applicable federal laws, please confirm:

1. All inpatient days (emergency and poststabilization services) have been approved.
2. A payment file has been created for VA Automation.
3. What the ACE Control number is.

This will enable us to determine:

- The date VA Automation/Austin entered the payment file into the US Treasury Mainframe System.
- If the payment file was certified the following morning.
- If a pre edit acknowledgement was sent to VA Austin (to release payment in 24 hours) to ensure their compliance.

If payment details have been released, please disregard this email and provide payment details (check#, check date, check amount, etc.)

On a final note, I heard a great quote recently regarding our duty to veterans and thought of you and Ms. Romero:

"We owe our World War II veterans - and all our veterans - a debt we can never fully repay."
- Doc Hastings

Thank you for doing your best to ensure this happens.

Best,

Ed Norwood
Chief Compliance Officer
Ed Norwood, SA

From: Nelson
Sent: Thursday, May 31, 2013 3:44 PM
To: Ed Norwood
Cc: "Ed Norwood"
Subject: RE: Second Request

Hello,

The claim was paid on 5/16/2013 with check number 21718729.

Thanks,
Eh

From: Denise Griffith [mailto:denisegriffith@ernenterprises.org]
Sent: Tuesday, May 21, 2013 3:41 PM
To: "Ed Norwood"
Cc: Romero, Debbie; Denise Griffith, Esq
Subject: RE: Second Request

Hi,

I am following up on your email below. Can you please advise of the check # and pay date?

Thank you,

From: Nelson
Sent: Monday, May 13, 2013 1:49 PM
To: "Ed Norwood"
Cc: Romero, Debbie; Denise Griffith, Esq
Subject: RE: Second Request

Hello Mr. Norwood,

- OLA will be paying $80,736.12 (70% of DRG price).
- I will reply with all check number and the date funded as soon as I have it.
- I left a voicemail for Christina Moreno at ELA Doctors Hospital today notifying her of the payment amount and timeframe to expect the funds.

Thank you,

Nelson, M.P.P.
Non-VA Medical Care
Acting Appeals / Customer Service Supervisor
VA Greater Los Angeles Healthcare System

From: Ed Norwood [mailto:ednorwood@ernenterprises.org]
Sent: Monday, May 06, 2013 5:17 PM
To: "Ed Norwood"

www.ernenterprises.org
Laws and Regulations

Under existing federal law, 38 CFR § 17.52(a) states: When VA facilities or other government facilities are not capable of furnishing economical hospital care or medical services because of geographic inaccessibility or are not capable of furnishing care or services required, VA may contract with non-VA facilities for care in accordance with the provisions of this section. When demand is only for infrequent use, individual authorizations may be used.

Care in public or private facilities, however, subject to the provisions of §§17.53, 17.54, 17.55 and 17.56, will only be authorized, whether under a contract or an individual authorization, for—

(3) Hospital care or medical services for the treatment of medical emergencies which pose a serious threat to the life or health of a veteran receiving hospital care or medical services in a facility over which the Secretary has direct jurisdiction or government facility with which the Secretary contracts, and for which the facility is not staffed or equipped to perform, and transfer to a public or private hospital which has the necessary staff or equipment is the only feasible means of providing the necessary treatment, until such time following the furnishing of care in the non-VA facility as the veteran can be safely transferred to a VA facility;
38 CFR § 17.54 adds: (a) The admission of a veteran to a non-Department of Veterans Affairs hospital at Department of Veterans Affairs expense must be authorized in advance. IN THE CASE OF AN EMERGENCY WHICH EXISTED AT THE TIME OF ADMISSION, AN AUTHORIZATION MAY BE DEEMED A PRIOR AUTHORIZATION if an application, whether formal or informal, BY TELEPHONE, telegraph or other communication, made by the veteran OR BY OTHERS IN HIS OR HER BEHALF is dispatched to the Department of Veterans Affairs...

...(1) for veterans in the 48 contiguous States and Puerto Rico, WITHIN 72 HOURS AFTER THE HOUR OF ADMISSION, including in the computation of time Saturday, Sunday and holidays, or (2) for veterans in a noncontiguous State, territory or possession of the United States (not including Puerto Rico) if facilities for dispatch of application as described in this section are not available within the 72-hour period, provided the application was filed within 72 hours after facilities became available.
(b) When an application for admission by a veteran in one of the 48 contiguous States in the United States or in Puerto Rico has been made more than 72 hours after admission, or more than 72 hours after facilities are available in a noncontiguous State, territory of possession of the United States, authorization for continued care at Department of Veterans Affairs expense shall be effective as of the postmark or dispatch date of the application, or the date of any telephone call constituting an informal application.
Ed Norwood Boot Camp: PCCP Federal ACC
Track A - Access to Care

Hi Denise,

Attached please find a copy of the EOR that was sent to the provider on 9/13/13. VA paid this claim according to Millennium bill payment methodology which is 70% of the DRG for the approved period. A VA physician determined the patient to be stable for transfer on 12/12/13, therefore no payment can be made beyond that point.

Thanks,
Erin N
Acting Administrative Officer
Health Administration Service

Respectfully,
Denise Griffith, J.D.
Claims Compliance Auditor
6901 / The Reimbursement Advocacy Firm
714-994-6900 Ext. 6924 Fax 714-994-6901

From: Erin B. <Erin.B@va.gov>
Sent: Wednesday, August 07, 2013 12:05 PM
To: Denise Griffith
Cc: Debbie

Hi Denise,

Preliminary Fee Remittance Advice Report

VA Greater Los Angeles
1111 Plummer Street
North Hills, CA 91342
Mail Code: 166C/036

EAST LOS ANGELES DOCTORS
PO BOX 63016
LOS ANGELES, CA
90060

Provider: EAST LOS ANGELES DOCTORS
Page 1 of 2
Ed Norwood, SA

From: N. Erin <Erin.N - =
Sent: Thursday, October 10, 2013 8:03 AM
To: Denise Griffith
Cc: R - George
Subject: RE: [WARNING : MESSAGE ENCRYPTED] Notice Of Disagreement

Ms. N,

As you know, 38 CFR §17.54(a) states:

"The admission of a veteran to a non-Department of Veterans Affairs hospital at the Department of Veterans Affairs expense must be authorized in advance. In the case of an emergency which existed at the time of admission, an authorization may be deemed a prior authorization if an application, whether formal or informal, by telephone, telegram or other communication, made by the veteran or by others in his or her behalf is dispatched to the Department of Veterans Affairs (1) for veterans in the 48 contiguous states within 24 hours after the hour of admission, including the computation of time on Saturday, Sunday and holidays..."

The VA was notified of the patient’s admission on 12/19/10 as shown by the remote hospital records provided in my previous email. Therefore, it appears the VA was notified of the patient’s admission to FVA within 72 hours of being admitted on 12/12/10 and post-stabilization should have been paid. Please advise if you need me to resubmit the hospital records that were submitted in my previous email.

Respectfully,

Denise Griffith

From: N. Erin <Erin.N - =
Sent: Thursday, September 26, 2013 10:08 AM
To: Denise Griffith
Cc: R - Debbie
Subject: RE: [WARNING : MESSAGE ENCRYPTED] Notice Of Disagreement

Hi Denise,

Good Morning Denise,

Your proof of VA notification was accepted and the claim will be reprocessed for additional payment ASAP.

Thanks,

Erin N
Acting Administrative Officer
Health Administration Service

www.ernenterprises.org
38 CFR § 17.121 Limitations on payment or reimbursement of the costs of emergency treatment not previously authorized:

(a) Emergency Treatment. Except as provided in paragraph (b) of this section, VA will not approve claims for payment or reimbursement of the costs of emergency treatment not previously authorized for any period beyond the date on which the medical emergency ended. For this purpose, VA considers that an emergency ends when the designated VA clinician at the VA facility has determined that, based on sound medical judgment, the veteran who received emergency treatment:

1. Could have been transferred from the non-VA facility to a VA medical center (or other Federal facility that VA has an agreement with to furnish health care services for veterans) for continuation of treatment, or

2. Could have reported to a VA medical center (or other Federal facility that has an agreement with to furnish health care services for veterans) for continuation of treatment.

[From that point on, no additional care in a non-VA facility will be approved for payment by VA.]
38 CFR § 17.121:

(b) Continued non-emergency treatment. Claims for payment or reimbursement of the costs of emergency treatment not previously authorized may only be approved for continued, non-emergency treatment, if:

1. The non-VA facility notified VA at the time the veteran could be safely transferred to a VA facility (or other Federal facility that VA has an agreement with to furnish health care services for veterans), and the transfer of the veteran was not accepted; and

2. The non-VA facility made and documented reasonable attempts to request transfer of the veteran to a VA facility (or to another Federal facility that VA has an agreement with to furnish health care services for veterans), which means the non-VA facility contacted either the VA Transfer Coordinator, Administrative Officer of the Day, or designated staff responsible for accepting transfer of patients, at a local VA (or other Federal facility) and documented such contact in the veteran's progress/physicians' notes, discharge summary, or other applicable medical record.
38 CFR § 17.121:

(c) **Refusal of transfer.** If a stabilized veteran who requires continued non-emergency treatment refuses to be transferred to an available VA facility (or other Federal facility that VA has an agreement with to furnish health care services for veterans), VA will make payment or reimbursement only for the expenses related to the initial evaluation and the emergency treatment furnished to the veteran **up to the point of refusal of transfer by the veteran.**

(Authority: 38 U.S.C. 1724, 1728, 7304)

Also see 38 CFR §17.1005 (b)-(d).
How do your physicians document when the patient is stable for transfer?

How do you communicate that to the VA?
Veteran Affairs: Their Responsibility To Veterans And You

The VA is financially responsible for poststabilization care services when...

1. The closest VA hospital is not geographically accessible.
   NOTE: Individual infrequent authorizations may be used (e.g., when no beds are available and the VA cannot furnish care.)
   (38 CFR § 17.52)

2. VA facilities are not staffed or equipped to give hospital care or medical services.
   (38 CFR § 17.52(a)(3))

3. The VA fails to respond to your informal application for authorization made within 72 hours of admission.
   NOTE: Telephone calls constitute a valid informal application.
   (38 CFR § 17.54)

Documentation is key.

- Transfer requests must be documented using the VA 10-2649A or its equivalent.
- Write name of the VA official who rejected your transfer request and specify the reason.

(No patient is transferred to the VA facility without the prior approval of a credentialed VA staff physician or designee.)
(VA Directive 2007-015)

The non-VA facility must make or document reasonable attempts to request transfer of the veteran to a VA facility to be paid beyond the point of stabilization (which means the non-VA facility contacted the VA Transfer Coordinator, Administrative Officer of the Day, or other designated staff. Make a note of your contact in the medical record.)
(38 CFR § 17.521(b)(2))

Unfair Payment Practices

HMO AND PPO MEDICAL NECESSITY DENIALS
“Never let anyone tell you NO that does not have the power to say YES.” - Eleanor Roosevelt
HMOs & PPOs:  Medical Necessity Denials

Utilization Review

(a) A health maintenance organization shall include in a notice of the final decision on an appeal a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision.

(b) The notice must include the toll-free telephone number and address of the department.

(c) A health maintenance organization shall have appropriate personnel reasonably available at a toll-free telephone number to provide a verification under this section between 6 a.m. and 6 p.m. central time Monday through Friday on each day that is not a legal holiday and between 9 a.m. and noon central time on Saturday, Sunday, and legal holidays. A health maintenance organization must have a telephone system capable of accepting or recording incoming phone calls for verifications after 6 p.m. central time Monday through Friday and after noon central time on Saturday, Sunday, and legal holidays and responding to each of those calls on or before the second calendar day after the date the call is received.

HMOs & PPOs:  Medical Necessity Denials

Utilization Review

(g) If a health maintenance organization has provided a verification for proposed health care services, the health maintenance organization may not deny or reduce payment to the physician or provider for those health care services if provided to the enrollee on or before the 30th day after the date the verification was provided unless the physician or provider has materially misrepresented the proposed health care services or has substantially failed to perform the proposed health care services.

(a) In this section, "preauthorization" means a determination by a health maintenance organization that health care services proposed to be provided to a patient are medically necessary and appropriate.

(b) A health maintenance organization that uses a preauthorization process for health care services shall provide each participating physician or provider, not later than the 10th business day after the date a request is made, a list of health care services that do not require preauthorization and information concerning the preauthorization process.

(d) On receipt of a request from a participating physician or provider for preauthorization, the health maintenance organization shall review and issue a determination indicating whether the health care services are preauthorized. The determination must be issued and transmitted not later than the third calendar day after the date the request is received by the health maintenance organization.
HMOs & PPOs: Medical Necessity Denials

Utilization Review

(g) If necessary to verify proposed medical care or health care services, an HMO or preferred provider carrier may, within one day of receipt of the request for verification, request information from the preferred provider in addition to the information provided in the request for verification. An HMO or preferred provider carrier may make only one request for additional information from the requesting preferred provider under this section.

(h) A request for information under subsection (g) of this section must:
1. be specific to the verification request;
2. describe with specificity the clinical and other information to be included in the response;
3. be relevant and necessary for the resolution of the request; and
4. be for information contained in or in the process of being incorporated into the enrollee’s medical or billing record maintained by the preferred provider.

(m) The provisions of this section may not be waived, voided, or nullified by contract.

28 TAC § 19.1724 Requests for Information

Unfair Payment Practices

ERISA MEDICAL NECESSITY LAWS
Concurrent Care Decisions

If a group health plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, then...

(A) ...any reduction or termination by the plan of such course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments constitutes an adverse benefit determination.

(The plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.)

(B) ...any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and the plan administrator shall notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the plan, provided that any such claim is made to the plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

29 CFR § 2560.503-1 (f)(2)(ii)

Adverse Benefit Determination Notifications

Manner and content of notification of benefit determination.

(i) The plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination.

The notification shall set forth, in a manner calculated to be understood by the claimant—

(ii) The specific reason or reasons for the adverse determination;

(iii) Reference to the specific plan provisions on which the determination is based;

(iv) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(v) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review;

In the case of an adverse benefit determination by a group health plan or a plan providing disability benefits,

(A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such a rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or

(B) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement of such explanation will be provided free of charge upon request.

In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.

29 CFR § 2560.503-1(g)
Full and Fair Review

Group health plans. The claims procedures of a group health plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless, in addition to complying with the requirements of paragraphs (h)(2)(i) through (iv) of this section, the claims procedures—

(i) Provide claimants at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(ii) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(iii) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(iv) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant’s adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

(v) Provide that the health care professional engaged for purposes of a consultation under paragraph (h)(3)(iii) of this section shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and (vi) Provide, in the case of a claim involving urgent care, for an expedited review process pursuant to which—(A) A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and (B) All necessary information, including the plan’s benefit determination on review, shall be transmitted between the plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

29 CFR § 2560.503-1 (h)(3)
(g) If a health maintenance organization has provided a verification for proposed health care services, the health maintenance organization may not deny or reduce payment to the physician or provider for those health care services if provided to the enrollee on or before the 30th day after the date the verification was provided unless the physician or provider has materially misrepresented the proposed health care services or has substantially failed to perform the proposed health care services.

(5) Misrepresents or falsifies information that it furnishes--
(i) To CMS; or
(ii) To an individual or to any other entity.
(6) Fails to comply with the requirements of Sec.422.206, which prohibits interference with practitioners’ advice to enrollees.

What is Negligent Misrepresentation?
Mr. Ehbar:

I trust your Thanksgiving was well.

Can you confirm if you or Mickey J. Adams are the employer-fiduciary for the Operating Engineers Trust Funds Local 12 (hereinafter referred to as OE)?

I need to forward a copy of a regulatory complaint that we are preparing to send to the U.S. Department of Labor for OE’s failure to release trust funds to reimburse emergency and authorized post stabilization services for one of its participants (We are also preparing to release a media advisory to see if similarly situated individuals exist.)

As you know, under Section 502 of the Act, a plan participant, beneficiary or an authorized representative with standing may bring a civil action in court to:

- Recover benefits due and enforce rights under the plan.
- Clarify rights to future benefits.
- Get appropriate relief from a breach of fiduciary duty.
- Enjoin any person who violates the terms of the plan or any provision of Title I of ERISA, such as the reporting and disclosure, participation, vesting or funding, and fiduciary provisions, to obtain other equitable relief.
- Obtain review of a final action of the Secretary of Labor to restrain the Secretary from taking action contrary to ERISA, or compel the Secretary to take action.

July 18, 2016, Maria Sandow in your Pasadena Office sent a letter stating:

“A claim has been received which cannot be paid. The charge is for a service that is not covered by the plan. Person was not eligible at date of service (See OE Ref. #: 201516100718.)”

However:

- On 05/05/15, the patient arrived at PHH for emergency services and care. PHH called Blue Cross to obtain insurance information and PHH spoke with Jesse B. at Blue Cross who stated that the patient had Blue Cross coverage effective 09/01/14. He also stated the plan pays 100% with no deductible and issued a call reference # 2015125120246. PHH also requested an authorization to the PCC, Dr. Panse, by fax.

- On 05/05/15, PHH called Dr. Panse’s office for authorization to admit the patient as patient underwent surgery that Monday.
- On 05/11/15, PHH received HCMG authorization for OP’s 32015150508720000200059 expiring 08/08/15.
- On 05/15/15, PHH faxed a face sheet to Blue Cross.

As the evidence will show, at no time while the patient was hospitalized did OE through its delegatee Blue Cross state “The member was not eligible.”

Please be advised that OE’s failure to ensure payment through their TPA is a breach of fiduciary duties and contrary to federal law. In the case of The Meadows v. Employers Health Insurance 9th Cir, 1995 47 F.3d 1006, an ERISA plan denied coverage to a drug treatment facility after previously verifying eligibility. The court allowed a suit to be brought against the plan for breach of contract and negligent misrepresentation, among other things. The court stated that if eligibility is verified, such verification cannot later be rescinded as plans are not insulated “from the consequences of their own misrepresentations” to providers.

Therefore, since the care referenced above was authorized, OE must pay CHLB, even if the Blue Cross employee made a mistake and the patient was not covered for the date of service.

Our provider member, PHH, treated the above enrollee/beneficiary in good faith, pursuant to OE/BX’s authorization and verification. Federal and State law states that the provider must be able to conclusively rely on the business entity’s verification. PHH is not at risk to receive payment because of a mistake made by OE/Blue Cross or one of its members.

You are reminded that the Employee Benefits Security Administration is imposed by the Employee Retirement Income Security Act to enforce violations such as:

- Failing to operate the plan prudently and for the exclusive benefit of participants;
- Using plan assets to benefit certain related parties to the plan, including the plan administrator, the plan sponsor, and parties related to these individuals;
- Failing to follow the terms of the plan (unless inconsistent with ERISA);
- Taking any adverse action against an individual for exercising his or her rights under the plan (e.g. being fired, fined, or otherwise being discriminated against);
- Failing to comply with ERISA Part 7 and the Affordable Care Act (welfare plans only).

Further, of the six forms of deceit recognized in California, only one—negligent misrepresentation—does not require the maker of a misrepresentation to know that the representation is false. As defined
by statute, negligent misrepresentation is "[t]he assertion, as a fact, of that which is not true, by one who has no reasonable ground for believing it to be true". California Civil Code, section 1710(2).

To prove a claim for negligent misrepresentation, the provider must show:

1. The defendant must have made a representation as to a past or existing material fact;
2. The representation must have been untrue;
3. Regardless of his actual belief the defendant must have made the representation without any reasonable ground for believing it to be true;
4. The representation must have been made with the intent to induce plaintiff to rely upon it;
5. The plaintiff must have been unaware of the falsity of the representation; and
6. And, finally, as a result of the reliance upon the truth of the representation, the plaintiff must have sustained damage.

This claim does not rely on the existence or validity of either the individual’s insurance contract or a managed care contract. A claim for negligent misrepresentation looks to whether the insurance company or its representative exercised reasonable professional competence in verifying coverage. The insurance company need not know that statements made are false when made.

In conclusion, by verifying that the patient was a member with OE/Blue Cross and pre-authorizing the participant’s "services", OE/Blue Cross made a false statement to induce PHI to provide health care services to the patient. Since Blue Cross is the TPA for OE, the burden of oversight and responsibility to insure that the TPA is adhering to the laws that govern ERISA claims is ultimately the responsibility of OE and they have a duty to act with integrity and in the "interest of the participants and beneficiaries."

Please make any further action unnecessary by remitting payment in the amount of $80,400.80 on or before Friday, December 2, 2016. I appreciate your response and assistance in this matter.

Best,

Ed Norwood
Chief Compliance Officer
ERN / The Reimbursement Advocacy Firm
714 995-6900 ext. 6926 Fax 714 995-6901

www.erntraf.org
www.ernenterprises.org

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Ed Norwood

From: Ed Norwood
Sent: Monday, December 05, 2016 4:33 PM
Ce: Cathy@oefi.org; mferieg@oefi.org; ckillian@oefi.org; mkleed@oefi.org; madama@oefi.org; mjmadams@oefi.org
Subject: RE: Notice of Intent to File Complaint with the U.S. Department of Labor

Mr. Ehrbar:

Please provide Mr. Mickey J. Adam’s email address and/or payment details to the undersigned regarding the demand of OE’s trust sent 11/28/16.

We expect your compliance.

Ed Norwood
Chief Compliance Officer
ERN / The Reimbursement Advocacy Firm
714 995-6900 ext. 6926 Fax 714 995-6901

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From: Ed Norwood
Sent: Monday, November 28, 2016 4:00 PM
Ce: Cathy@oefi.org; cathy@oefi.org; mferieg@oefi.org; ckillian@oefi.org; ckillian@oefi.org; cmkleed@oefi.org; mkleed@oefi.org; madama@oefi.org; madams@oefi.org
Subject: Notice of Intent to File Complaint with the U.S. Department of Labor

Mr. Ehrbar:
Ed Norwood

From: Joseph Ehrbar
Sent: Monday, December 05, 2016 4:39 PM
CC: Cathy Vitali; Matt Eregi; Chuck Killian; Mike DeChellis; madama@oef.org; mjadams@oef.org
Subject: Notice of Intent to File Complaint with the U.S. Department of Labor

Can you believe this?

Joseph R. Ehrbar
Fund Manager
Operating Engineers Trust Funds
610 W. 1st Street
(626) 356-3585
100 Corson Street
Pasadena CA 91103
jehrbar@oef.org
Website: OEF.org

From: Ed Norwood [mailto:ednorwood@ernenterprises.org]
Sent: Monday, December 05, 2016 4:56 PM
CC: Cathy Vitali; Matt Eregi; Chuck Killian; Mike DeChellis; madama@oef.org; mjadams@oef.org
Subject: Notice of Intent to File Complaint with the U.S. Department Labor

Mr. Ehrbar:

Please provide Mr. Mickey J. Adams's email address and/or payment details to the undersigned regarding the defraud of OIC's trust sent 11/28/16.

We expect your compliance.

Ed Norwood
Chief Compliance Officer
ERN / The Reimbursement Advocacy Firm
714 995-6900 ext. 6926 Fax 714 995-6901
www.erntraf.org
www.ernenterprises.org

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Ed Norwood

From: Ed Norwood
Sent: Monday, December 05, 2016 4:56 PM
CC: Cathy Vitali; Matt Eregi; Chuck Killian; Mike DeChellis; madama@oef.org; mjadams@oef.org
Subject: Notice of Intent to File Complaint with the U.S. Department of Labor

Mr. Ehrbar:

Your response is troubling.

Please confirm if you are the plan administrator and fiduciary for Operating Engineers Local 12.

As you may know, 29 U.S.C. § 1002(21)(A) defines a fiduciary as anyone who... [3] has any discretionary authority or discretionary responsibility in the administration of such plan.”

Under ERISA, a fiduciary has a duty to act “solely in the interest” and “for the exclusive purpose of providing benefits to participants and their beneficiaries [ERISA § 404(3)(a)(1)(A)].” Further, a fiduciary who does not administer the plan properly, and breaches the covenant created in Title 29 U.S.C. § 1104 & 1109, is held personally liable for the losses incurred (i.e. for the amount of the claims).

According to 29 U.S.C. § 1105(a)(2) (see infra § 4.04[C]), when a fiduciary delegates responsibility to a co-fiduciary (e.g. Anthem), prudence requires the fiduciary to take certain efforts to keep abreast of the activities on a day to day basis in the management of trust funds (See. Barker v. American Mobil Power Corp., 64 F.3d 1397, 1403 (9th Cir. 1995)). Further, in the case of Harris Trust & Sav. Bank v. John Hancock Mut. Life Ins. Co., 122 F. Supp. 2d 444 (S.D.N.Y. 2000), modified in part, 137 F. Supp. 2d 751 (S.D.N.Y. 2001), aff’d in part, vacated in part and rev’d in part by 302 F.3d 18 (2d Cir. 2002), the courts concluded the plan, who hired an insurer to manage free funds, placed its own interests and cash flow needs ahead of interests of plan participants. In Whitfield v. Tomasso, 682 F. Supp. 1287, 1302-03 (E.D.N.Y. 1980), plan trustees were liable for their failure to act competently in selecting, retaining, monitoring, and compensating third party administrator that rendered inadequate services to the plan.

It appears that Anthem may have engaged in claims processing that violated Operating Engineer fiduciary responsibility rules by failing to reimburse the emergency and authorized poststabilization services and care timely.

Again, this is a third request for the email address for Mickey J. Adams to redress the ERISA violations and defraud of trust cited in this email below prior to the filing of a regulatory complaint with the U.S. Department of Labor, and media advisory release to see if similarly situated participants exist.

Our complaint is scheduled for Tuesday, December 6, 2016.

As you consider your next move, please be reminded of your personal liability to act under CA Penal Code § 550 which states:

(b) It is unlawful to do, or to knowingly assist or conspire with any person to do, any of the following:
(1) Present or cause to be presented any written or oral statement as part of, or in support of or in opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact.

(2) Prepare or make any written or oral statement that is intended to be presented to any insurer or any insurance claimant in connection with, or in support of or in opposition to, any claim or payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact.

(3) Cause or knowingly fail to disclose the occurrence of an event that affects any person's initial or continued right or entitlement to any insurance benefit or payment, or the amount of any benefit or payment to which the person is entitled.

We appreciate and expect your compliance.

Best,

Ed Norwood
Chief Compliance Officer
ERN / The Reimbursement Advocacy Firm
714 995-6906 ext. 6926 Fax 714 995-6901
www.erntraf.org
www.ernenterprises.org

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Indeed, it is the only thing that ever has." - Margaret Mead

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From: Joseph Elbar <jelbar@oefi.org>
Sent: Monday, December 05, 2016 4:39 PM
To: Ed Norwood <ednorwood@ernenterprises.org>
Cc: Cathy Vitali <Cathy@oefi.org>; Matt Ereg <MFEreg@oefi.org>; Chuck Killian <ckillian@oefi.org>; Mike DeChellis <mdechellis@oefi.org>; mradams@oefi.org; mjadams@oefi.org
Subject: RE: Notice of Intent to File Complaint with the U.S. Department of Labor

No.

Ed Norwood
From: Joseph Elbar
Sent: Monday, December 05, 2016 4:58 PM
To: Joseph Elbar
Cc: Cathy Vitali; Matt Ereg; Chuck Killian; Mike DeChellis; mradams@oefi.org; mjadams@oefi.org
Subject: RE: Notice of Intent to File Complaint with the U.S. Department of Labor

Mr. Norwood,

We are reviewing the claim with Anthem and will get back to you.

Joseph R. Elbar
Fund Manager
Operating Engineers Trust Funds
(Local 12)

Website: OEF1.org

From: Ed Norwood <mailto:ednorwood@ernenterprises.org>
Sent: Monday, December 06, 2016 8:47 AM
To: Joseph Elbar
Cc: Cathy Vitali; Matt Ereg; Chuck Killian; Mike DeChellis; mradams@oefi.org; mjadams@oefi.org
Subject: RE: Notice of Intent to File Complaint with the U.S. Department of Labor

Mr. Elbar;

Your response is troubling.

Please confirm if you are the plan administrator and fiduciary for Operating Engineers Local 12.

As you may know, 29 U.S.C. §1002(21)(A) defines a fiduciary as anyone who..."[3] has any discretionary authority or discretionary responsibility in the administration of such plan."

Under ERISA, a fiduciary has a duty to act "solely in the interest of..." and "for the exclusive purpose of providing benefits to participants and their beneficiaries (ERISA § 404(a)(1)(A)."

Further, a fiduciary who does not administer the plan properly, and breaches the covenant created in Title 29 U.S.C. §§1104 & 1109, is held personally liable for the losses incurred (i.e. for the amount of the claims).

According to 29 U.S.C. §1105(a)(2) (sec infra §4.04[C]), when a fiduciary delegates responsibility to a co-fiduciary (e.g., Anthem), prudence requires the fiduciary to take certain efforts to keep abreast of the action taken by any claim fiduciary, including investigating possible mismanagement of trust funds (Sec. Barker v. American Mobil Power Corp., 64 F.3d 1397, 1403 (9th Cir. 1995).)

Ed Norwood

From: Ed Norwood
Sent: Thursday, December 07, 2016 12:16 PM
Ce: Matt Ehrbar; Chuck Killian; Mike DeCerio; Cathy Vitz
Subject: RE: Notice of Intent to File Complaint with the U.S. Department of Labor

Mr. Ehrbar,

Just a note as you review this matter. Your TPA, Anthem, was recently fined $650,000.00 for failing to fully and timely provide information to the DMHC during their investigation of complaints:

http://www.dmhc.ca.gov/Portals/0/AbouttheDMHC/NewsRoom/pr111016.pdf?ver=2016-11-10-112925-220

Needless to say, we anticipate the prudence from your department to take certain efforts to keep abreast of the activities of Anthem, including investigating and redressing claims processing deficiencies, and the possible mismanagement of trust funds.

We appreciate all you do to protect the over 20,000 members of the International Union of Operating Engineers (I.U.O.E.) Local 12, and their dependents and beneficiaries.

Best,

Ed Norwood
Chief Compliance Officer
ERN / The Reimbursement Advocacy Firm
714 995-6900 ext 6926 Fax 714 995-6901

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Ed Norwood

From: Joseph Ehrbar
Sent: Thursday, December 08, 2016 7:27 AM
Subject: Claim

Mr. Norwood,

We still haven’t heard back from Anthem but nevertheless, once we receive the information we cannot, by law, discuss it with you unless you provide us with a designation from the patient authorizing us to discuss it with you. We can accept an email form followed up with the mailed version.

Joseph R. Ehrbar
Fund Manager
Operating Engineers Trust Funds
(Local 12)

Website: OEFI.org

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Ed Norwood

From: Ed Norwood
Sent: Tuesday, December 08, 2016 1:34 PM
To: [Redacted]
Cc: M Releg; Chuck Killian; Mike DeChelle; Cathy Vitali
Subject: PCCP Notice of intent to File Complaint with the U.S. Department of Labor
Attachments: PCHL ADR - 13043.pdf

Mr. Ehrbar:

Thank you for your update.

Please be advised that under existing federal law, a health plan may not condition treatment, payment, continued enrollment in the health plan or eligibility for benefits on a patient providing individual authorization to a Business Associate of covered entity (HIPAA Privacy Rule § 164.506).

As you know, HIPAA Privacy Rule § 164.514 (d)(3) states:

(iii) A covered entity may rely, if such reliance is reasonable under the circumstances, on a requested disclosure as the minimum necessary for the stated purpose when:
(A) Making disclosures to public officials that are permitted under § 164.512, if the public official represents that the information requested is the minimum necessary for the stated purpose(s);
(B) The information is requested by another covered entity;
(C) The information is requested by a professional who is a member of its workforce or is a business associate of the covered entity for the purpose of providing professional services to the covered entity, if the professional represents that the information requested is the minimum necessary for the stated purpose(s) (Emphasis added.)

Section 164.514 (b)(1) states:

Prior to any disclosure permitted by this subpart, a covered entity must:

(i) Except with respect to disclosures under § 164.510, verify the identity of a person requesting protected health information, and the authority of any such person to have access to protected health information under this subpart, if the identity or any such authority of such person is not known to the covered entity; and
(ii) Obtain any documentation, statements, or representations, whether oral or written, from the person requesting the protected health information when such documentation, statement, or representation is a condition of the disclosure under this subpart (Emphasis added.)

(2) Implementation specifications:

Verification. (i) Conditions on disclosures. If a disclosure is conditioned by this subpart on particular documentation, statements, or representations from the person requesting the protected health information, a covered entity may rely, if such reliance is reasonable under the circumstances, on documentation, statements, or representations that, on their face, meet the applicable requirements (Emphasis added.)

Sec. 164.512 adds:

A covered entity may use or disclose protected health information without the written authorization of the individual, as described in Sec. 164.508, in the situations covered by this section, subject to the applicable requirements of this section. When the covered entity is required by this section to inform the individual of, or when the individual may agree to, a use or disclosure permitted by this section, the covered entity’s information and the individual’s agreement may be given orally. (Emphasis added.)

As such, our letter of representation and the attached signed statement of representation, are reasonable on face, that our office is a business associate representing PIIH.

If you disagree, please provide the statutory authority that states a patient’s authorization is a condition or requirement of disclosure.

To forego any further argument and expedite this matter, I draw your attention to the following cases:

In Connecticut State Dental Ass’n v. Anthem Health Plans, Inc, 591 F.3d 1337, 1352-53 (11th Cir. 2009), the court held that claim forms subjected by health care providers to administrator demonstrated an assignment of benefits by the patient, thus establishing standing for providers.

In Transp. V. Healthcare Fin. Servs., 322 F.3d 888, 893-94 (5th Cir. 2003), the Court of Appeals for the Fifth Circuit held that a third party collection agency possessed derivative standing as an assignee of a healthcare provider, who itself possessed derivative standing as an assignee of the beneficiary of the ERISA plan.

In Tango, the Court of Appeals cited Masic v. Bldg. Serv. Employees Health & Welfare Trust, 789 F.2d 1373, 1378 (9th Cir. 1986), "noting that extending derivative standing to health care providers ‘results in precisely the benefit the trust is designed to provide, and the statute is designed to protect,’ while also ‘making it unnecessary for health care providers to evaluate the correctness of a ‘pay before commencing medical treatment’ or forcing patients to ‘pay potentially large medical bills and await compensation from the plan.’”

As PIIH is an assignee of the patient (through its claim form and/or assignment of benefits), PIIH and this office (through the attached signed statement of representation) asserts derivative standing to appeal this matter.
Please make any further action unnecessary by remitting payment in the amount of $80,400.00 on or before Friday, December 9, 2016. 

I appreciate your compliance.

Best,

Ed Norwood
Chief Compliance Officer
ERN / The Reimbursement Advocacy Firm
714 995-6900 ext. 6926 Fax 714 995-6901

www.centralf.org
www.ernenterprises.org

"Never doubt that a small group of thoughtful committed citizens can change the world. Indeed, it is the only thing that ever has." - Margaret Mead

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From: Joseph Ehrbar [mailto:JeffEhrbar@oefi.org]
Sent: Thursday, December 08, 2016 7:27 AM
To: Ed Norwood <ednorwood@ernenterprises.org>
Subject: claim

Mr. Norwood,

We haven’t heard back from Anthem, but nevertheless, once we receive the information we cannot, by law, discuss it with you unless you provide us with a designation from the patient authorizing us to discuss it with you. We can accept an email form followed up with the mailed version.

Joseph R. Ehrbar
Fund Manager
Operating Engineers Trust Funds
(Local 12)

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Ed Norwood

From: Joseph Ehrbar
Sent: Friday, December 09, 2016 7:12 AM
To: Ed Norwood
Cc: Matt Ehrig; Chuck Killian; Mike DeChellis; Cathy Vital
Subject: RE: Notice of Intent to File Complaint with the U.S. Department of Labor

Mr. Norwood. We have received the info from Anthem. The patient was a member of the Anthem HMO, one of the plans we offer. As an HMO facility, your client would have been paid $58,273 by Anthem. That is the amount we will pay due to the confusion.

Joseph R. Ehrbar
Fund Manager
Operating Engineers Trust Funds
(Local 12)

Website: OEFI.org

From: Ed Norwood <mailto:ednorwood@ernenterprises.org>
To: Joseph Ehrbar
Cc: Matt Ehrig; Chuck Killian; Mike DeChellis; Cathy Vital
Subject: RE: Notice of Intent to File Complaint with the U.S. Department of Labor

Mr. Ehrbar:

Thank you for your update.

Please be advised that under existing federal law, a health plan may not condition treatment payment, continued enrollment in the health plan or eligibility for benefits on a patient providing individual authorization to a Business Associate of covered entity (HIPAA Privacy Rule § 164.508.)

As you know, HIPAA Privacy Rule § 164.514 (d)(3) states:

(iii) A covered entity may rely, if such reliance is reasonable under the circumstances, on a requested disclosure as the minimum necessary for the stated purpose when:
(A) Making disclosures to public officials that are permitted under § 164.512, if the public official represents that the information requested is the minimum necessary for the stated purpose(s);
(b) The information is requested by another covered entity;
(C) The information is requested by a professional who is a member of its workforce or is a business associate of the covered entity for the purpose of providing professional services to the covered entity, if the professional represents that the information requested is the minimum necessary for the stated purpose(s) (Emphasis added.)
Unfair Payment Practices

TIMELY APPEAL TIMEFRAMES

APPEAL SUBMISSION TIMEFRAME MATRIX

To protect your rights, make sure to escalate your cases to ERN/The Reimbursement Advocacy Firm (TRAF) within the following timeframes.

JURISDICTION:

- Medicare Advantage
- VA
- ERISA

TIMEFRAME:

- 60 DAYS from the date of the notice of the organization determination
- 1 YEAR of an adverse benefit decision
- 180 DAYS following receipt of a notification of an adverse benefit determination

SOURCE:

- 42 C.F.R. § 422.502(b)
- 38 U.S. CODE § 7105
- 29 C.F.R. § 2560.503-1(h)(3)
It can be difficult to find a passionate claims representation and training partner that reflect your corporate values and remain on the cutting edge of Federal and State prompt payment laws to stimulate cash flow.

When you use administrative laws in the revenue and appeal cycle:
• You strengthen your state’s healthcare delivery system
• You defend public health and safety
• You keep your doors open.
Together, we will build an enforcement program in the State of Texas and Oklahoma that works.

Call us to report unfair payment practices or concurrent denials of medically necessary care.

- **Patient Advocacy Hotline:**
  - (714)995-6900 Ext 6921
  - Email: pa@ernenterprises.org

- **Claim Representation Helpdesk:**
  - (714)995-6900 Ext 6935
  - Email: cr@ernenterprises.org

- **Member Services Helpdesk:**
  - (714)995-6900 Ext 6913
  - Email: ms@ernenterprises.org
What people are saying...

“ERN/TRAF is an amazing company; after partnering with them for a few months, I have never seen so many insurance companies willing to work with me directly to resolve their issues when they wouldn’t even answer my calls in the past. Way to go!” - J. Cummings, Valley Health Sys.

“This is so great. It didn’t take but what, 3 days for them to pay?” – Z. Aflak, CFO, Kindred SF

“I have had numerous occasions over the last several years to refer claims to ERN/TRAF. I chose TRAF over other vendors because I know that they are extremely knowledgeable about the statutes that apply to every payer type. They are true professionals and have been so successful with even the most difficult cases. I know that TRAF will always go the distance for us and when we’re really in trouble, I always think of Ed and his gang to help us out.” – D. Esparza, CHW

“Your company has really gotten the log jam of payments loosened up these days; we really appreciate your help and support.” - Reno CHW Member (VA outstanding A/R was reduced from 4.3 million to $196,038.37 in just 30 days!!)

QUESTIONS? NEED MORE INFORMATION?

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