AMRPA
AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

Advanced IRF Boot Camp

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Prior Authorization and Medicare Advantage Strategies to Succeed

Renee Alsop, PT, DPT, MRMC

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Objectives:

1. Identify the resource document, created by CMS, that provides specific guidance on MA prior authorizations and appeals.
2. Identify strategies that MA plans implement that are potential barriers to IRF care.
3. Identify strategies that IRF facilities may implement to decrease wait time for decisions and increase prior authorization approvals.

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Medicare Advantage Strategies to Succeed

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They can't do that!

Understanding and applying the regulations

Own it.

Benefits of owning the auth process

Consistency is key.

Define a standard process

Outsmart the AI.

Excellent documentation matters

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Understanding and Applying the Regulations

They can't do that!

- IRF Medicare Criteria – All members of team should know
- Medical necessity – Active, ongoing medical management
- Always submit an Expedited Auth
- Always submit an Expedited Appeal (if an appeal is appropriate)
- Grievances and complaints
  - To the Plan (Grievance with an AOR on behalf of patient) examples: noncompliant with regs, potential HIPAA violation for "losing" appeal requests
  - To Medicare (Part C Provider Complaint)

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Understanding and Applying the Regulations

IRF Medicare Criteria

1. Requires face to face visits with a rehab physician at least 3 days per week to be assessed both medically and functionally to modify the course of treatment.
2. Requires at least two therapies, one of which must be PT or OT. (Other can be ST or Prosthetist)
3. Requires and can take part in three hours of therapy a day at least 5 days a week or 15 hours per week.
4. Requires and can be reasonably expected to actively participate and benefit from an intensive interdisciplinary rehab program.
5. Reasonable expectation of a measurable, practical improvement in a reasonable amount of time.

They can't do that!

42 C.F.R. § 412.622(a)(3); *see also* Medicare Benefit Policy Manual (MBPM) Ch. 1, § 110.1. § 1862(a)(1)(A) of the Act

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Understanding and Applying the Regulations

Expedited Auth Request

42 C.F.R. § 422.570(c)(2)(ii).

§ 422.570 Expediting certain organization determinations.

(a) ***Request for expedited determination.*** An enrollee or a physician (regardless of whether the physician is affiliated with the MA organization) may request that an MA organization expedite an organization determination involving the issues described in § 422.566(b)(3) and (b)(4). (This does not include requests for payment of services already furnished.)

(b) ***How to make a request.***

(1) To ask for an expedited determination, an enrollee or a physician must submit an oral or written request directly to the MA organization or, if applicable, to the entity responsible for making the determination, as directed by the MA organization.

(2) A physician may provide oral or written support for a request for an expedited determination.

(2) Promptly decide whether to expedite a determination, based on the following requirements:

(i) For a request made by an enrollee the MA organization must provide an expedited determination if it determines that applying the standard timeframe for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

(ii) For a request made or supported by a physician, the MA organization must provide an expedited determination if the physician indicates that applying the standard timeframe for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

They can't do that!

"must provide"

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Understanding and Applying the Regulations

No answer on exp auth after 72 hours?

42 C.F.R. § 422.572(f)

(f) ***Effect of failure to provide a timely notice.*** If the MA organization fails to provide the enrollee and the physician or prescriber involved, as appropriate, with timely notice of an expedited organization determination as specified in this section, this failure itself constitutes an adverse organization determination and may be appealed.

They can't do that!

No response on an exp auth 72 hours after submission *is an adverse decision (denial) and may be appealed*

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Understanding and Applying the Regulations

Expedited Appeal Request

42 C.F.R. § 422.584(c)(2)(ii).

(c) *How the MA organization must process requests.* The MA organization must establish and maintain the following procedures for processing requests for expedited reconsiderations:

(1) ***Handling of requests.*** The MA organization must establish an efficient and convenient means for individuals to submit oral or written requests, document all oral requests in writing, and maintain the documentation in the case file.

(2) ***Prompt decision.*** Promptly decide on whether to expedite the reconsideration or follow t timeframe for standard reconsideration based on the following requirements:

(i) For a request made by an enrollee, the MA organization must provide an expedited reconsideration if it determines that applying the standard timeframe for reconsidering a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

(ii) For a request made or supported by a physician, the MA organization must provide an expedited reconsideration if the physician indicates that applying the standard timeframe for conducting a reconsideration could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

42 C.F.R. § 422.590 (e)(1)

They can't do that!

(e) *Expedited reconsideration —*

(1) ***Timeframe for services or items.*** Except as provided in paragraph (f) of this section, an MA organization that approves a request for expedited reconsideration must complete its reconsideration and give the enrollee (and the physician involved, as appropriate) notice of its decision as expeditiously as the enrollee's health condition requires but no later than 72 hours after receiving the request.

Exp reconsideration MUST be provided if physician attests

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Benefits of Owning the Auth/Appeal Process

Own it.

- Fewer degrees of freedom
  - One organization does all auths and appeals
  - Dedicated resource for auths and appeals
- Clinicals submission- Clinical expertise
- Updated clinical requests – Just because plans ask does not mean you have to provide
- Data tracking
  - Data-driven auth and appeal recommendations
  - Changes in plan behavior

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Define a Standard Process

Consistency is key.

- Process mapping – Not person dependent
- Templates for exp auth and exp appeals
- Dedicated VM lines
- NO Peer-to-Peers
- Keep your receipts!
  - Faxes, not phone calls
  - Reference numbers
  - Date, time, person, title, notes

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Define a Standard Process - Templates

Expedited Auth Request

Because I am a submitting this request, expedited processing is mandatory under 42 C.F.R. § 422.570(c)(2)(ii). I am a physician making this expedited request to approve coverage. I am familiar with this patient's clinical information and have concluded that this coverage request should be processed on an expedited basis because **application of the normal time frame could seriously jeopardize the patient's health and ability to regain maximum function**. ***(MD name, Signature)***

Consistency is key.

Expedited Appeal Request

Because I am submitting this request, expedited processing is mandatory under 42 C.F.R. § 422.584(c)(2)(ii). I am a physician requesting expedited processing of the request for reconsideration for this patient. I am familiar with this patient's health and have concluded that this reconsideration should be processed on an expedited basis because **application of the normal time frame could seriously jeopardize the patient's health and ability to regain maximum function**. ***(MD Name, signature)***

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The Importance of Excellent Documentation

Outsmart the AI.

- EMR smart phrases and templates - Use wording of five Medicare IRF criteria
- Pre Admission Screen – The why and how the patient meets all five Medicare criteria
- Acute care MD notes – Requires IRF not "IRF vs SNF"
- Acute care therapy notes – Requires and can tolerate 3 hours of therapy a day, all disciplines aligned
- Smart coding when entering ICD-10 codes to start an exp auth request

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Medicare Advantage

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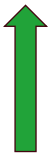
They can't do that!

Own it.

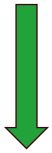
Consistency is key.

Outsmart the AI.

Understanding and applying the regulations + Benefits of owning the auth process + Define a standard process + Excellent documentation matters =



Efficiency
Approvals
Overturned
Appeals
Admissions



Denials
Time from Request to Decision
Frustration

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References and Links

Code of Federal Regulations Subpart M – Grievances, Organization Determinations and Appeals
https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-M

Medicare Managed Care Manual, Parts C&D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance
https://www.cms.gov/medicare/appeals-and-grievances/mmcag/downloads/parts-c-and-d-enrollee-grievances-organization-coverage-determinations-and-appeals-guidance.pdf

Medicare Managed Care (Part C – Medicare Advantage) Auth and Appeals Flowchart
https://www.cms.gov/medicare/appeals-and-grievances/mmcag/downloads/managed-care-appeals-flow-chart-.pdf

MAXIMUS – Federal CMS Independent Review Entity
http://www.medicareappeal.com/
https://www.cms.gov/medicare/appeals-grievances/appeals-decision-search-part-c-d

Medicare AOR Form – CMS1696
https://www.cms.gov/cms1696-appointment-representative

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Questions and Comments

Renee Alsop, PT, DPT, MRMC
Carolinas Rehabilitation – Atrium Health/Advocate Health

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