ERNEST HEALTH
We are passionate patient caregivers

Right Patient, Right Place…On Time

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- Garner an understanding of the payer landscape and changes over past several years, as well as the trajectory for the future
- Learn about optimum management of managed care beneficiaries
- Understand how to maximize data analyzation/use for development of future best practices
- Establish an optimal workflow within your PAC setting to maximize accessibility and outcomes

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Medicare Replacement – The Numbers.

2014: 31% (15M)
2015: 32% (16M)
2016: 33% (17M)
2017: 35% (18M)
2018: 37% (20M)
2019: 39% (22M)
2020: 42% (24M)
2021: 46% (26M)
2022: 48% (28M)
2023: 51% (31M)

- **2024: 54%**
  - 32.8 million Medicare Advantage enrollees in 43 different plans
  - 119% increase over last 10 years
  - UnitedHealthcare & Humana (47%)
  - CVS/Kaiser/Centene/Cigna (23%)
  - BCBS plans (14%)
  - AL, CT, MI, HI, ME, FL, RI: over 60% of Medicare beneficiaries are enrolled in MA
  - Estimated by 2034, 64% of eligible enrollees will be in MA plans
- MA plans pay like Traditional Medicare, but they "play" like insurance
  - Prior auth for PAC, Part B Drugs

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Source: KFF analysis of CMS Medicare Advantage Enrollment Files, 2010-2024; Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2010-2016; CCW data from 20 percent of beneficiaries, 2017-2020; CCW data from 100 percent of beneficiaries, 2021-2022, and Medicare Enrollment Dashboard 2023-2024. Enrollment numbers from March of the respective year. Projections for 2025 to 2034 are from the June Congressional Budget Office (CBO) Medicare Baseline for 2024.

Not-So-Fun Facts…

- Medicare Advantage insurers made nearly 50 million prior authorization determinations in 2023, reflecting steady year-over-year increases since 2021 (37 million) and 2022 (42 million) as the number of people enrolled in Medicare Advantage has grown.
- In 2023, insurers fully or partially denied 3.2 million prior authorization requests, which is a somewhat smaller share (6.4%) of all requests than in 2022 (7.4%).
- A small share of denied prior authorization requests was appealed in Medicare Advantage (11.7% in 2023).
- Though a small share of prior authorization denials were appealed to Medicare Advantage insurers, most appeals (81.7%) were partially or fully overturned in 2023.
- More than half (54%) of eligible Medicare beneficiaries are enrolled in Medicare Advantage in 2024.
- More than one-third (37%) of Medicare beneficiaries live in a county where at least 60 percent of all Medicare beneficiaries are enrolled in Medicare Advantage plans.
- Medicare Advantage enrollment is highly concentrated among a small number of firms, with UnitedHealthcare and Humana accounting for nearly half (47%) of all Medicare Advantage enrollees nationwide.

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https://www.kff.org/medicare/issue-brief/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-in-2023/

https://www.kff.org/medicare/press-release/nearly-7-in-10-medicare-beneficiaries-do-not-compare-coverage-options-during-open-enrollment/

https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-enrollment-update-and-key-trends/

Advocacy

AMRPA conducted a nationwide survey in July/August 2024 of freestanding IRFs and IRUs to determine how frequently prior auth for admission to an IRF was denied, how timely decisions were, and consequences for these beneficiaries.

Results:

Nearly 60% of initial auths were denied, resulting in nearly 67k unnecessary days waiting for a decision, discharge, or appeal across the two-month time span

AMRPA Prior Authorization Survey, 2024

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AMRPA
AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

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How do we stack up to the industry?

- 57.4% denial rate on initial auth
  - UHC 66%
  - Humana 65%
  - Aetna 57.7%
- 34% overturned on appeal
- Average wait time to initial decision is 2.5 days
- A total of 67,247 reported acute hospital days were spent waiting for an initial determination (extrapolated for year would have been over 400,000 days)
- ***Overall, 44% of MA prior auths attempted were approved by all payors***

- Ernest Average Conversions 2025 (of attempted):
  - ***59.4%***
  - Running approximately 15% higher than industry average!

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How to Get an Advantage on the Disadvantages

Right level of care & access to care

- Referral
- Admission
  - Initial Auth
  - P2P
  - Expedited appeal
- Understanding payment
  - PPS vs. per diem
- Maximizing POC/Continued auth
- Courtesy updates – Medicare Advantage
- CMS regs/tools
- Programming – Payor Relations Specialist & Medicare Replacement Risk Strategy Approach

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The Challenge..

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Tell the Story

ERNEST HEALTH	MANAGED CARE: SPEAKING THE LANGUAGE
"RED FLAG" LANGUAGE	"GREEN LIGHT" LANGUAGE
Patient lives alone.	Patient was independent at home prior to this event, and there is expectation of returning to prior level of function to maintain independence, avoiding a readmission.
Patient can benefit from rehab.	Patient's clinical condition meets full Inpatient Acute Rehab criteria; the lower level of care site (define care site) cannot provide total IDT approach needed; and patient's anticipated d/c care site following inpatient rehabilitation is (define care site).
Patient is fearful of going home.	Patient is at high risk of unplanned readmission due to (... fall risk, inability to self-administer medication, lack of 24 hr caregiver in prior setting, etc.)
Current diagnosis of Anxiety or Dementia.	Despite co-morbid diagnosis of (Anxiety or Dementia), patient was performing all ADLs (and name IADLs if applicable) independently prior to admission.
Current diagnosis of "Failure to Thrive."	Patient has signs and symptoms of depression, protein calorie malnutrition and muscle wasting. Robust IDT plan and clinical services planned to improve these conditions.
Patient requires ongoing inpatient level of care.	Patient's co-morbid acute (list) and chronic (list) medical conditions require daily, medically necessary oversight by a Physician to monitor and manage medication changes, treat pain, and (other list)

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Engage & educate your liaisons AND your referral sources!

Key phrases and verbiage for referral sources:

1. The patient requires active and ongoing therapeutic intervention of multiple therapy disciplines that can only be offered in an inpatient rehab facility.

2. The patient's medical complexity cannot safely be managed in a lower level of care such as SNF.

3. For any chance to return to their prior level of function and a community setting, the pt. requires an intense multi-disciplinary program.

4. The patient's medical and functional needs cannot be managed safely in a skilled nursing facility for many reasons:

    1. SNF staffing ratios 1:20; IRF staffing ratios 1:6 or 1:7

    2. SNF physician requires monthly visits; IRF physicians visit 3-5x/week

5. If the patient is at high risk for medical complications and requires close medical supervision to optimize their recovery and allow for a safe return to prior living situation/community living, IRF is the best option for this pt.

6. If the pt. requires the interdisciplinary services that can only be provided in an inpatient rehab setting; 24-hour RN/rehab nursing, 3 hours of multi-discipline therapy, close medical supervision, Nutritional services, Pulmonary services, IRF is the best option for this pt.

7. If the pt. is able to tolerate being up out of bed or in a chair for 30 minutes at a time, our therapy can be modified to meet their needs.

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Restate the Rules

Beginning January 1, 2024, CMS is providing important protections regarding utilization management policies and coverage criteria that ensure that Medicare Advantage (MA) enrollees receive the same access to medically necessary care that they would receive in Traditional Medicare.

HOW DOES THIS IMPACT MY PATIENTS THAT REQUIRE AN INPATIENT REHABILITATION OR LONG-TERM ACUTE CARE HOSPITAL ADMISSION FOR RECOVERY?

- The new rule indicates that the MA plan may direct a patient to an alternative setting only if the setting or services ordered by the clinician fail to meet FFS Medicare regulatory criteria
    - *If your physician(s) & clinicians directly recommend Inpatient Rehabilitation or Long-Term Acute (NOT SNF), the MA plan cannot DENY unless the beneficiary does not meet FFS Medicare regulatory criteria*

- Medicare Advantage plans cannot limit or deny coverage for a Medicare-covered service based on their own internal or proprietary criteria if such restrictions don't exist in traditional Medicare
    - *MA plans MUST follow regulatory coverage criteria in FFS Medicare for admission into Inpatient Rehabilitation or Long-Term Acute Hospitals, they are restricted from utilizing internal cr as Interqual or Milliman*

- Medicare Advantage plans can no longer apply site of service restrictions not found in traditio Medicare
    - *If a patient meets qualifications for Inpatient Rehabilitation or Long-Term Acute Hospita per the Medicare Benefit Policy Manual, they also qualify as a beneficiary of their MA plar*

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Source documentation from CMS: Social Security Act, Code of Federal Regulations (CFR), Managed Medicare Manual, Medicare Managed Care Manual to Parts C &D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance

- Anyone from the MA plan reviewing admission authorization requests must have expertise in the relevant medical discipline for the service being requested
    - *The clinicians or practitioners overseeing authorizations to Inpatient Rehabilitation or Long-Term Acute Hospitals cannot be from a field not relevant (ie pediatrician, oncology, etc)*

- Prior Auths must stay valid for an entire course of approved treatment
    - *You may send the referral and we may begin authorization process right away, as the auth will not expire – it will remain valid for as long as medically necessary*

- Establish additional processes to oversee MA plan utilization management programs including an annual review of policies to ensure consistency with federal rules;
    - *Regular oversight of MA plan utilization moving forward.*

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Restate the Rules

Please call if there are any questions. Admit Date: _____

The Centers for Medicare and Medicaid Services requires that all Medicare Managed Care Plans "have processes in place to accept requests (grievance, coverage, and appeal requests) 24 hours a day, 7 days a week (including holidays)" as outlined in section 10.5.2 of "Parts C & D Enrollee Grievances, Organization/Coverage Determination, and Appeals Guidance" published August 3, 2022. (www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG)

*Additionally, they must "expedite the determination or reconsideration if the request shows the normal timeframe for decision making a determination or reconsideration could seriously jeopardize the enrollee's life, health, or ability to regain maximum function. The organization must notify the enrollee, and physician as appropriate, **no later than 72 hours after the receipt of the request.**" as outlined in Social Security Act Sec. 1852. [42 U.S.C. 1395w–22] (a) Basic Benefits. (G) Coverage Determinations, Reconsiderations, and Appeals Social Security Act §1852 (ssa.gov)*

☐ Expedited Appeal

This patient meets medical necessity defined by Medicare guidelines for admission to an inpatient rehabilitation facility (IRF) based on the documentation meeting IRF criteria as outlined below:

☐ Patient generally requires an intense rehabilitation therapy program _____

☐ The patient is reasonably expected to actively participate in, and benefit significantly from, the intensive rehabilitation therapy program

☐ The patient requires physician supervision by a rehabilitation physician _____

☐ The patient requires an intensive and coordinated interdisciplinary approach to rehabilitation _____

We use a collaborative, interdisciplinary approach to provide early identification and assistance and mitigation of the high risk issues for readmission and follow the transitional needs of our patients post-discharge as patient's care needs change.

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Restate the Rules

ERNEST HEALTH **MEDICARE REPLACEMENT RISK STRATEGY PROGRAM**

SITUATION:

Plan administers an administrative denial (potentially because you took the patient prior to auth)

Answer:
July 2024, CMS made it clear that administrative denials are no longer valid even if treatment/ care has commenced:

Source documentation: Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance was updated: **"40.4 Prior Authorization and Other Utilization Management Requirements** – states that an enrollee, an enrollee's representative, or a provider on behalf of the enrollee has the right to voluntarily request plan approval (either pre-service or concurrent to receiving services) in circumstances where there is a question whether the plan will cover a service, item, or Part B drug. An enrollee's right to voluntarily receive plan approval extends to any service, item, or Part B drug which the enrollee believes is or should be covered by the plan (this includes non-covered services, items, or Part B drugs and those for which the plan does not require Prior Authorization (PA) as a condition for coverage in its annual Evidence of Coverage)."

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Restate the Rules

SITUATION:

Payor asks why you have taken a patient without prior auth, or pushes back during P2P

Answer:
For all patients requiring post-acute care, it is imperative that these beneficiaries receive the level of care they deserve depending on their condition, as those with traditional Medicare FFS would. When our hospital determines that a patient qualifies for IRF level of care through the conditions of participation, functional, and medical needs we submit for prior auth. If a decision takes an unreasonable amount of time and that beneficiary's condition is deteriorating or facing more unfavorable outcomes (example not receiving any therapies in acute care) by not being allowed to transition to the appropriate next level of care in timely manner, we have, on occasion, expedited this process of admission to IRF.

Source documentation: Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance 10.4.1 – **Medical Exigency Standard The medical exigency standard requires a plan and the independent review entity to make decisions as "expeditiously as the enrollee's health condition requires."** This standard is set forth in regulations at Part 422 Subpart M and Part 423 Subpart M with respect to coverage requests and effectuation of favorable decisions. This standard requires that the plan or the independent review entity apply, at a minimum, established accepted standards of medical practice in assessing an individual's medical condition. Evidence of the individual's condition can be obtained from the treating provider or from the individual's medical record (e.g., diagnosis, symptoms, or test results). This standard was established by regulation to ensure that plans develop a standard for determining the urgency of coverage requests, triage incoming requests against established criteria, and prioritize each request according to these standards. **Plans must treat each case in a manner that is appropriate for the facts and circumstances of the enrollee's medical condition.** Plans should not routinely take the maximum time permitted for adjudicating coverage requests.

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Show Value to Payors

- Penny-wise, pound-foolish
  - Right setting, right time
- Value of programming
  - Post discharge
  - Pt education/empowerment
  - Reduction of readmission
- Contract negotiation

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Don't Give Up. Don't Fold.

Speak the language.
Be innovative.
Be relentless.

relentless

persistent, continuing, constant, continual, continuous, nonstop, never-ending, unabating, interminable, incessant, unceasing, endless, unending, unremitting, unrelenting, unfaltering, untiring, unwavering, dogged, tenacious, single-minded, tireless, indefatigable, **unstoppable**

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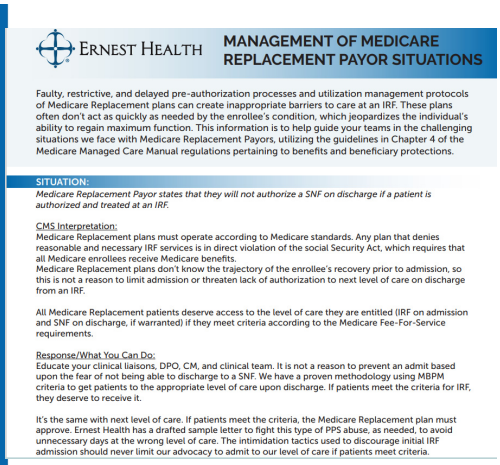
Engage & Empower Your Team



ERNEST HEALTH

MANAGEMENT OF MEDICARE REPLACEMENT PAYOR SITUATIONS

Faulty, restrictive, and delayed pre-authorization processes and utilization management protocols of Medicare Replacement plans can create inappropriate barriers to care at an IRF. These plans often don't act as quickly as needed by the enrollee's condition, which jeopardizes the individual's ability to regain maximum function. This information is to help guide your teams in the challenging situations we face with Medicare Replacement Payors, utilizing the guidelines in Chapter 4 of the Medicare Managed Care Manual regulations pertaining to benefits and beneficiary protections.

SITUATION:

Medicare Replacement Payor states that they will not authorize a SNF on discharge if a patient is authorized and treated at an IRF.

CMS Interpretation:
Medicare Replacement plans must operate according to Medicare standards. Any plan that denies reasonable and necessary IRF services is in direct violation of the social Security Act, which requires that all Medicare enrollees receive Medicare benefits.
Medicare Replacement plans don't know the trajectory of the enrollee's recovery prior to admission, so this is not a reason to limit admission or threaten lack of authorization to next level of care on discharge from an IRF.

All Medicare Replacement patients deserve access to the level of care they are entitled (IRF on admission and SNF on discharge, if warranted) if they meet criteria according to the Medicare Fee-For-Service requirements.

Response/What You Can Do:
Educate your clinical liaisons, DPO, CM, and clinical team. It is not a reason to prevent an admit based upon the fear of not being able to discharge to a SNF. We have a proven methodology using MBPM criteria to get patients to the appropriate level of care upon discharge. If patients meet the criteria for IRF, they deserve to receive it.

It's the same with next level of care. If patients meet the criteria, the Medicare Replacement plan must approve. Ernest Health has a drafted sample letter to fight this type of PPS abuse, as needed, to avoid unnecessary days at the wrong level of care. The intimidation tactics used to discourage initial IRF admission should never limit our advocacy to admit to our level of care if patients meet criteria.

As you experience challenges & trends across your organization with payers, situations, and patients, develop your arsenal to fight back!

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Engage & Empower Your Team

APPEAL / CLAIM PAYMENT DISPUTE COVER SHEET

		Fill in required information below. Indicate option selection with "☑."
1.1	Date of Submission to CMS	
1.2	Entity Submitting Complaint	☑ Provider ☐ Organization Representing Provider ☐ Appointment of Representative (attach form) ☐ Other (Summarize)
	Name of Organization Representing Provider	***Individual Hospital
1.3	Submitter's Name	Melissa Eder
	E-mail Address	melissaeder@ernesthealth.com
	Telephone Number	864-378-2888
1.4	Beneficiary Name	****
1.5	Beneficiary Health Insurance Claim Number (HICN) / Medicare Beneficiary Number (MBN)	***
1.6	Provider Name, telephone number, E-Mail address	***Individual Hospital;
1.7	Medicare Advantage Organization	United Healthcare
1.8	Claim Number	***
1.9	Date(s) of Service	***
1.10	Provider Contract Status	☑ Provider Contracted with MAO during Date(s) of Service ☐ Provider NOT Contracted with MAO during DOS
1.11	Complaint Type	☑ Contracted Provider Appeal ☐ Non-Contracted Provider Appeal ☑ Contracted Provider Claims Payment Dispute ☐ Non-Contracted Provider Claims Payment Dispute ☐ Other
	Brief Summary of Complaint	[illegible]
1.12	Did MAO communicate your appeal rights.	☐ Yes ☑ No
1.13	Have you exhausted all appeals rights per the non-contracted provider appeals or per contract w/MAO	☐ Yes ☑ No
1.14	Provider or their representative has Communicated with MAO in	☑ Yes ☐ No *(NOTE: CMS will only review this case if the provider has already attempted to resolve it by working directly with*

Complaint Process

Utilize the CMS process allowing providers/hospitals to complain in the pre-auth, concurrent, or post stay claims

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Engage & Empower Other Levels of Care and Beneficiaries

MEDICARE REPLACEMENT ADVOCACY FORM

Plan: _____ Plan Phone #: _____

• My doctor _____ (NAME PHYSICIAN), recommended IRF/LTACH level of care. Per the Medicare Replacement Final Rule, published by Centers for Medicare & Medicaid Services (42 CFR Parts 417, 422, 423, 455, and 460), since they meet regulatory criteria, you (Medicare Replacement Company) cannot deny their admission to _____ (FILL IN HOSPITAL).

• By denying reasonable and necessary IRF/LTACH services, you (Medicare Replacement Company) are in direct violation of the Social Security Act, which requires provision of all Medicare benefits to your (their) members.

• Per the Medical Exigency standard, you (Medicare Replacement Company) are required to make decisions as expeditiously as _____ (NAME PATIENT) health condition requires. Currently, my doctor says that I am/ They are ready for IRF/LTACH level of care and I am not receiving that in _____ (NAME REFERRING HOSPITAL/ENTITY).

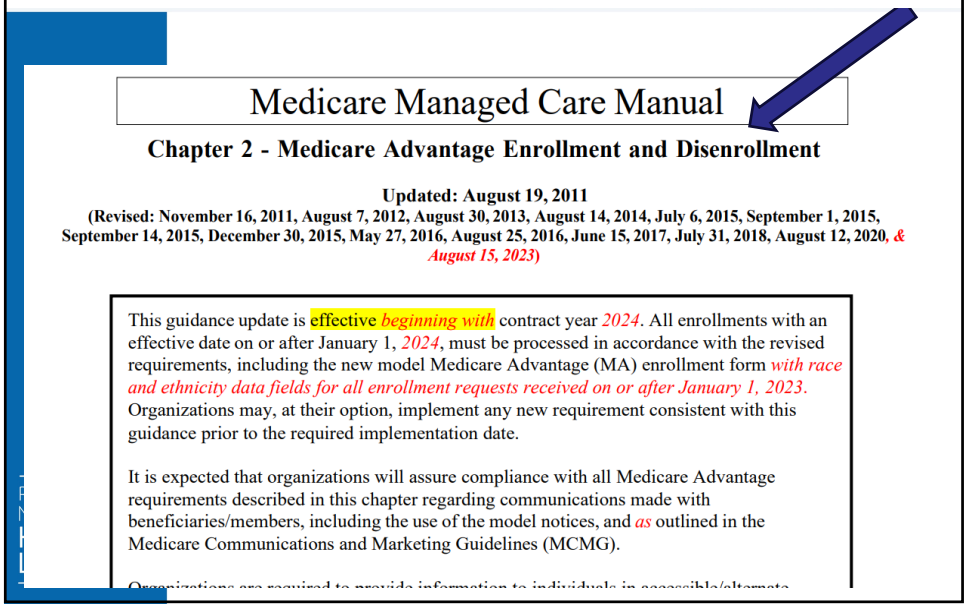
• I have a choice in my medical coverage and will be researching competitors or traditional Medicare that will better serve my healthcare needs.

Peer-to-Peer Reviews

The following is a quick reference for patient information to consider when participating in a peer-to-peer review:

- New medical condition requiring acute care has presented.
- List the acute medical conditions that require 24-hour care from a physician and a registered nurse that cannot be managed in a lower level of care. Define why the patient could not have their needs met in a skilled nursing facility.
- Medical condition requires coordinated, interdisciplinary rehabilitation program, which cannot be provided in a less intensive setting.
- Patient has significant impairment, such as paresis, ataxia, cognition or other safety issues.
- Patient has had a functional decline and requires inpatient therapy to reach prior level of function.
- Patient's condition has potential for significant practical improvement with inpatient rehabilitation with an average LOS of 10 - 14 days.
- Patient is motivated and able to participate in a minimum of 3 hours of therapy daily, five days a week (or 15 hours a week).

When All Else Fails...Educate!



Medicare Managed Care Manual

Chapter 2 - Medicare Advantage Enrollment and Disenrollment

Updated: August 19, 2011
(Revised: November 16, 2011, August 7, 2012, August 30, 2013, August 14, 2014, July 6, 2015, September 1, 2015, September 14, 2015, December 30, 2015, May 27, 2016, August 25, 2016, June 15, 2017, July 31, 2018, August 12, 2020, & August 15, 2023)

This guidance update is effective *beginning with* contract year *2024*. All enrollments with an effective date on or after January 1, *2024*, must be processed in accordance with the revised requirements, including the new model Medicare Advantage (MA) enrollment form *with race and ethnicity data fields for all enrollment requests received on or after January 1, 2023.* Organizations may, at their option, implement any new requirement consistent with this guidance prior to the required implementation date.

It is expected that organizations will assure compliance with all Medicare Advantage requirements described in this chapter regarding communications made with beneficiaries/members, including the use of the model notices, and *as* outlined in the Medicare Communications and Marketing Guidelines (MCMG).

Innovative Programming

- **Payor Relation Specialist** – Work Smarter, Not Harder!
- **Medicare Replacement Risk Strategy Program** – Do the Right Thing!

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Payor Relation Specialist (PRS)

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- Realignment of existing duties of various departments to enhance:
  - Efficiency
  - Quality
  - Consistency of entire Auth/Continued Stay Process for Marketing, Admissions, Case Management, and our Patients
- Primary goals/Objectives
  - Maximize POC for younger patients
  - Increase Medicare Advantage conversions
  - Increase other Non-MCR payer conversions
- Secondary goals
  - Relationships

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Medicare Replacement Risk Strategy Approach

DENVER REGIONAL REHABILITATION HOSPITAL

RIGHT PATIENT, RIGHT PLACE...ON TIME!

OUTCOMES

Success Rate/Authorizations

- On initial authorization: **61%**
- On cases that advance to P2P: **82%**
- On cases that advance to Expedited Appeal: **77%**
- On cases that advance to ALJ: **100%**
- Overall success rate: **96%**

*It is estimated that the Medicare Replacement Admission Risk has saved our short-term hospital partners more than **875** unnecessary STAC hospital days thus far.*

8451 Pearl St #101,
Thornton, CO 80229
DRRH.ernesthealth.com

PURPOSE

Provide enhanced advocacy and action to apply the right level of care at the right time to Medicare Replacement beneficiaries.

HOW

Once a patient is referred and determined to meet inpatient rehabilitation criteria by our clinical liaisons and medical director, a request for "At-Risk Admission" is requested by the Ernest Health facility to Ernest Health's Corporate Risk team. Insurance authorization is submitted to the insurance provider by Ernest Health's Payor Relations Specialist (PRS). After authorization has been submitted, and if approved by Ernest Health's Corporate Risk team, the patient can be admitted once medically ready ***while still pending prior authorization.***

- If the Medicare Replacement plan denies the initial authorization that was pending, Denver Regional Rehabilitation Hospital's medical director/internal team will handle the P2P, Expedited appeal, QIO, and ALJ as needed.

WHAT IF THE DECISION FOR DENIAL IS UPHELD, WILL THE PATIENT BE BILLED?

No! The patient is not at any financial risk for the stay. Ernest Health accepts all risk for the Medicare Replacement Risk admission in this program.

WHO IS ELIGIBLE?

Currently, eligible patients include those with Medicare Replacement plans who have a strong rehabilitation diagnosis (CMS-13) and are identified by our clinical liaisons and medical directors as meeting the criteria for inpatient rehabilitation admission and the conditions of participation.

WHAT IS THE BENEFIT?

This program is designed to avoid unnecessary delays and assure patients who meet criteria are able to initiate their inpatient rehabilitation to begin the road to recovery ON TIME, when their treatment team says they are ready.

Benefits:

- Short Term Acute Care (STAC) Hospitals avoiding unnecessary longer stays than medically required
  - It is estimated that through the MRRSA, Ernest has saved local STACs ***over 1200 Unnecessary STAC days thus far***
- Expeditious access to Medical/Therapeutic care following acute neuro impact, supporting and enhancing neuroplasticity – Right patient, right place, ON TIME
- Onset days reduced, increased medical/functional complexity of patient population for rehab/LTACH
- Increased likelihood of authorization due to Rehab/LTACH Medical professionals completing Peer2Peer. Also, chance that pt has already completed/tolerated part of rehab/Medical programming prior to P2P, further reinforcing appropriateness for level of care.

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Medicare Replacement Risk Strategy Approach

How it's going (Oct 17, 2024 – July 13, 2025)….

- **476** Cases Approved for Risk; **407** Patients *actually* admitted
  - 244/407 Approved in Initial Auth = **60%** Success at this level
  - 85/150 Approved in P2P = **57%** Success at this level
  - 59/94 Approved in Facility Driven Expedited Appeal = **63%** Success at this level
  - 5/7 Approved at ALJ (12 cases pending hearing or decision) = **71%** Success at this level
- ***Overall Denial Rate so far: 0.98%***

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Do the Right Thing.

- Right setting, right time
- Constantly develop strategy
- Reduction of readmissions
- Show value to the payors
- Never give up fighting!

- Questions?

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Thank You.

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