



**CMS 2010 BI-REGIONAL MEDICARE HEALTH PLAN COMPLIANCE
CONFERENCE**

Boston & New York – Serving Our Beneficiaries Together

Verbatim Transcript
Managed Care Appeals
Beverly Sgroi and Janice Eidem Esq.

>> OUR NEXT SESSION
IS MANAGED CARE APPEALS,

AND WE HAVE BEVERLY SGROI
AND JANICE EIDEM,

AND LET ME GIVE THEM A LITTLE
BIT OF AN INTRODUCTION.

BEVERLY IS
A HEALTH INSURANCE SPECIALIST.

SHE'S IN THE DIVISION
OF APPEALS POLICY,

WHICH IS IN OUR
BALTIMORE CENTRAL OFFICE.

BEVERLY SERVES AS
A SUBJECT MATTER EXPERT

REGARDING MEDICARE PART C
APPEALS, POLICY, AND OPERATIONS.

IN ADDITION, SHE'S
THE CONTRACTING OFFICER,

TECHNICAL REPRESENTATIVE,

C.O.T.R.,

FOR CMS'S MEDICARE PART C
INDEPENDENT REVIEW ENTITY,

THE I.R.E.

JANICE EIDEM IS
A PROJECT DIRECTOR

FOR MAXIMUS FEDERAL SERVICES.

PART C, WE CALL IT THE QIC.

YOU HEARD PAUL
REFER TO THE QIC.

THAT'S THE QIC--THE Q.I.C.

AND IS RESPONSIBLE FOR OVERSIGHT

OF MEDICARE PART C
RECONSIDERATIONS.

SHE IS A GRADUATE OF BRANDEIS

AND A GRADUATE OF THE DICKINSON
SCHOOL OF LAW.

PLEASE WELCOME
BEVERLY AND JANICE.

>> THANK YOU FOR INVITING

MAXIMUS FEDERAL SERVICES

TO PARTICIPATE
IN THIS CONFERENCE.

MY NAME IS JANICE EIDEM,
AND I AM THE PROJECT DIRECTOR

FOR QIC PART C.

WE SERVE AS THE INDEPENDENT
REVIEW ENTITY

FOR THE MANAGED CARE--MEDICARE
MANAGED CARE APPEALS PROGRAM.

FOR THOSE OF YOU WHO HAVE BEEN

WITH THE MEDICARE
MANAGED APPEAL--

MANAGED CARE APPEALS FIELD,

YOU ARE VERY FAMILIAR
WITH OUR ORGANIZATION.

WE HAVE BEEN HONORED TO SERVE

THE MEDICARE
MANAGED CARE PROGRAM

FOR MORE THAN 20 YEARS.

FOR THOSE OF YOU WHO ARE
NEWER TO OUR PROGRAM,

I WOULD LIKE TO SHARE
SOME INFORMATION ABOUT US.

AS THE SLIDE STATES,
OUR ADJUDICATION STAFF

INCLUDES NURSES
AND HEALTH CARE ATTORNEYS

WHOSE EXPERIENCE
WITH THE PROGRAM

RANGES FROM ONE TO 20--
OVER 20 YEARS

WITH AN AVERAGE
LENGTH OF SERVICE

OF MORE THAN 5 YEARS.

WE ALSO HAVE
AN EXPERIENCED, INDEPENDENT

MEDICAL REVIEW PANEL.

FOR THOSE DISPUTES THAT CENTER
ON MEDICAL NECESSITY,

WE OBTAIN OUR MEDICAL OPINIONS
FROM OUR EXPERIENCED PHYSICIANS,

WHO COMPRISE A PANEL
OF MORE THAN 400

GEOGRAPHICALLY DIVERSE,
BOARD-CERTIFIED PHYSICIANS

WHO ARE INDEPENDENT CONTRACTORS.

TODAY, I WOULD LIKE
TO TOUCH ON 4 TOPICS--

THE BEST PRACTICES
FOR SENDING CASES

TO MAXIMUS FEDERAL SERVICES;

STEPS TAKEN BY
MAXIMUS FEDERAL SERVICES

FOR CASE PROCESSING;

UNDERSTANDING
EFFECTUATION ISSUES,

WHICH I'M SURE IS VERY
NEAR AND DEAR TO MANY OF YOU;

AND FINALLY, WE WILL DISCUSS
A TECHNICAL ISSUE

OF WHAT CONSTITUTES
A VALID APPEAL.

SENDING CASES TO MAXIMUS
FEDERAL SERVICES.

ALL OF THE INFORMATION
DISCUSSED IN THIS--

DISCUSSED IN THIS PRESENTATION

CAN BE FOUND IN OUR
PROCESS MANUAL,

WHICH IS AVAILABLE ON OUR
QIC PART C WEB SITE,

AND THAT'S
WWW.MEDICAREAPPEAL.COM,

AND WE'LL HAVE THAT POSTED
A LITTLE LATER

IN THE PRESENTATION.

WE ARE AVAILABLE
TO RECEIVE CASES

MONDAY THROUGH SATURDAY
AND MOST HOLIDAYS.

OUR CASES COME DIRECTLY
FROM YOU, THE HEALTH PLAN,

NOT THE APPELLANT,

AND WE DO NOT ACCEPT
OUR CASES VIA FAX.

WE CONFIRM RECEIPT OF CASE--
THE CASE FILE USING 2 METHODS.

FOR EXPEDITED APPEALS,
WE ASK THAT YOU SEND

A NOTICE OF [INDISTINCT]
INTENT--EXCUSE ME--

PRIOR TO SENDING THE CASE.

THAT IS BASICALLY
INFORMATION TO US

IDENTIFYING KEY PIECES
ABOUT THE CASE

OR INFORMATION
ABOUT THE ENROLLEES

SO THAT WE KNOW TO BE ON
THE LOOKOUT FOR THAT CASE FILE.

WE WILL--IF WE DO NOT
RECEIVE THE CASE FILE

WITHIN ONE BUSINESS DAY
OF THE RECEIPT

OF THE NOTICE OF INTENT,

WE WILL CONTACT YOU IN ORDER
TO LET YOU KNOW THAT

WE HAVE NOT YET
RECEIVED THE CASE

AND ASK YOU TO RESEND IT.

FOR A STANDARD APPEAL,
WE SEND AN ACKNOWLEDGMENT LETTER

WITHIN 2 BUSINESS DAYS
OF RECEIPT OF THE CASE.

SO IF YOU DON'T RECEIVE
AN ACKNOWLEDGMENT LETTER FROM US

WITHIN ABOUT 5 TO 7
BUSINESS DAYS,

MOST LIKELY WE DID NOT RECEIVE
THAT PARTICULAR CASE.

WE ASK THAT YOU PLEASE CONTACT
OUR CUSTOMER SERVICE DEPARTMENT

TO CONFIRM,

AND WE CAN DETERMINE
WHETHER OR NOT

YOU SHOULD BE
RESENDING THAT CASE.

THERE ARE 3 BASIC COMPONENTS
TO A CASE FILE.

THERE IS THE RECONSIDERATION
BACKGROUND DATA FORM,

THE CASE NARRATIVE,
AND SUPPORTING DOCUMENTATION.

THE RECONSIDERATION BACKGROUND
DATA FORM

IS AVAILABLE ON OUR WEB SITE.

AND WHAT IS THIS FORM USED FOR?

THE INFORMATION
ON THE FORM IS USED

IN ORDER TO HELP US
INITIATE THE CASE FILE;

ADJUDICATE THE CASE FILE;

AND WE ALSO USE THE INFORMATION

ON THIS FORM

AS PART OF THE DATA COLLECTION,

WHICH INCLUDES THE PLAN LEVEL
REVIEW TIMELINESS,

AND AGAIN, I'M SURE THAT'S
SOMETHING VERY IMPORTANT--

VERY NEAR AND DEAR
TO YOUR HEARTS.

THE RECONSIDERATION BACKGROUND--
WHOOOPS, EXCUSE ME.

THE RECONSIDERATION BACKGROUND
DATA FORM AND CASE NARRATIVE

PROVIDES US THE INFORMATION
ON THE WHO, THE WHAT,

THE WHEN, AND THE WHY
OF AN APPEAL.

I'D LIKE TO EMPHASIZE
THAT IT IS VERY IMPORTANT

THAT THE INFORMATION IS ACCURATE
ON THE FORM AND THE NARRATIVE.

FOR EXAMPLE, PROVIDING
INCORRECT INFORMATION

ON THE "WHO" PORTION OF
THE RECONSIDERATION BACKGROUND

DATA FORM

DELAYS THE CASE
CREATION PROCESS,

BECAUSE WE NEED
TO GET BACK TO YOU

FOR THE PROPER INFORMATION,

SO IF YOU DON'T SUPPLY US WITH
THE CORRECT [INDISTINCT] NUMBER,

WE'RE GONNA NEED TO GET
BACK IN TOUCH WITH YOU

IN ORDER TO GET THE CORRECT
[INDISTINCT] NUMBER.

THAT'S GOING TO DELAY
THE CASE FILE INITIATION

AND THE CASE FILE PROCESSING.

ONE OF THE CONCERNS,
I THINK, THAT--

ONE OF THE MORE IMPORTANT
CONCERNS FOR YOU,

FOR REPORTING CONCERNS,

WE ENTER INFORMATION FROM

THE RECONSIDERATION BACKGROUND
DATA FORM

DIRECTLY INTO THE MEDICARE--
CMS'S MEDICARE APPEALS SYSTEM,

AND WE--WE ENTER IT
AS IT APPEARS

ON THE RECONSIDERATION
BACKGROUND DATA FORM.

CMS PERIODICALLY RUNS A REPORT

FROM "MAS," AND THAT'S
THE MEDICARE APPEALS SYSTEM,

TO MONITOR
THE HEALTH PLAN'S TIMELINESS

OF ITS
INTERNAL APPEALS PROCESSING.

SO IF YOU HAVE INCORRECT
OR INCOMPLETE INFORMATION

ABOUT THE DATES OF YOUR
APPEALS PROCESSING,

IT COULD NEGATIVELY IMPACT YOU

ON THE APPEALS
TIMELINESS REPORT.

YOU NEED TO PROVIDE THE COMPLETE
CASE FILE TO MAXIMUS.

THIS INCLUDES ALL INFORMATION
THAT YOU USED

IN MAKING YOUR DECISION.

THE LIST IN THIS SLIDE
PROVIDES THE BASICS

OF WHAT WE WOULD EXPECT TO SEE
IN A CASE FILE.

YOU MAY HAVE
ADDITIONAL INFORMATION

THAT YOU WOULD LIKE TO INCLUDE
BEYOND THIS.

SO WHAT HAPPENS AFTER MAXIMUS
RECEIVES THE CASE?

WE ENTER THE CASE INTO THE CMS
MEDICARE APPEALS SYSTEM.

WE ASSIGN THE APPEAL
TO A QUALIFIED

APPEALS STAFF MEMBER,

AND THEN
THIS INDIVIDUAL CONFIRMS

THAT THE APPEAL IS VALID,

IDENTIFIES THE ISSUE IN APPEAL,

DETERMINES THE COVERAGE RULE,

RESOLVES DISCREPANCIES
IN KEY INFORMATION

BY REQUESTING
ADDITIONAL INFORMATION.

IF THE DISPUTE RESOLVES--
EXCUSE ME,

REVOLVES AROUND A MEDICAL
NECESSITY ISSUE,

WE WILL OBTAIN
A PHYSICIAN'S OPINION

FROM ONE OF OUR
INDEPENDENT CONSULTANTS

FOR THE MEDICAL NECESSITY
DETERMINATION,

AND THEN THE APPEAL PROFESSIONAL
TAKES ALL OF THIS INFORMATION

AND RENDERS A DECISION.

THIS DECISION IS THEN
MAILED TO THE ENROLLEE

AND AT THE SAME TIME, WE FAX IT
TO THE HEALTH PLAN.

IF THE DECISION IS IN FAVOR
OF THE HEALTH PLAN,

THE ENROLLEE WILL
RECEIVE INFORMATION

REGARDING REQUESTING
AN ADMINISTRATIVE

LAW JUDGE HEARING.

IF THE DECISION IS AN OVERTURN
OR A PARTIAL OVERTURN,

MEANING THAT WE FOUND IN FAVOR
OF THE ENROLLEE,

THE ENROLLEE RECEIVES GUIDANCE
TO CONTACT THE HEALTH PLAN

TO GET THE SERVICE OR PAYMENT,

AND THE HEALTH PLAN RECEIVES
A COMPLIANCES STATEMENT

ALONG WITH THE DECISION.

AND THAT MOVES US
INTO EFFECTUATION.

AS I JUST STATED,

THE COMPLIANCE STATEMENT

IS INCLUDED IN
THE HEALTH PLAN'S COPY

OF THE OVERTURNED
DECISION LETTER.

FEDERAL REGULATIONS REQUIRE
THE HEALTH PLAN

TO EFFECTUATE
AN OVERTURNED DECISION

WITHIN A SPECIFIC TIME FRAME

AND TO NOTIFY THE I.R.E.

THE MODEL STATEMENT--
COMPLIANCE STATEMENT,

INCLUDED WITH
THE DECISION LETTER,

SERVES AS THIS NOTIFICATION.

THE DOCUMENT SHOULD BE COMPLETED
AND RETURNED TO MAXIMUS

WITHIN 14 DAYS OF
THE HEALTH PLAN'S EFFECTUATION.

THIS SLIDE CONTAINS A LIST
OF SOME OF THE BEST PRACTICES.

WHEN COMPLETING THIS FORM,
PLEASE USE THE APPEAL NUMBER

AT THE--FOR THE APPEAL--
EXCUSE ME, LEVEL

AT WHICH THE COMPLIANCE
IS REQUIRED.

FOR EXAMPLE, IF THE OVERTURN
OCCURS AT THE REOPENING LEVEL,

PLEASE INCLUDE
THE REOPENING NUMBER

ON THE COMPLIANCE NOTICE.

ALSO, IF THE CASE
IS A PAYMENT CASE,

YOU NEED TO INCLUDE
A CHECK NUMBER

OR AN ELECTRONIC FUNDS
TRANSFER NUMBER.

ANY OTHER INFORMATION,
WE WOULD NOT BE ABLE TO ACCEPT

AND WE'RE GOING TO NEED
TO GO OUT TO THE CMS

REGION--PLAN REGIONAL MANAGER

TO GET VERIFICATION
OR TO GET ACCEPTANCE.

AND THEN FINALLY,
STARTING IN MAY 2010,

YOU SHOULD'VE RECEIVED--
BEGIN SEEING

A REMINDER NOTICE
THAT WILL COME TO YOU

AT THE BEGINNING OF EACH MONTH.

THIS REMINDER NOTICE
FROM MAXIMUS

PROVIDES YOU
WITH A LIST OF CASES

THAT ARE MISSING
AN EFFECTUATION NOTICE

AND ARE ABOUT TO BE
REPORTED TO CMS.

AND THE NEXT SLIDE SHOWS
AN EXAMPLE OF THE LIST

INCLUDED IN THE REMINDER NOTICE.

HOPEFULLY, YOU CAN SEE--
SEE THE DETAILS ON THIS.

I JUST WANT TO POINT OUT

A FEW THINGS

ABOUT THE REMINDER REPORT LIST.

WE INCLUDE INFORMATION
ON THE ENROLLEE

TO ASSIST YOU IN THE IDENTIFI--
IN ADDITION TO OUR APPEAL NUMBER

TO ASSIST YOU IN THE
IDENTIFICATION OF THE ENROLLEE

AND THE SPECIFIC APPEAL.

IN THIS PARTICULAR SLIDE,
I WANTED TO HIGHLIGHT

THE LAST ENTRY
FOR ENROLLEE "J.S."

AS YOU CAN SEE,
THERE ARE 2 LEVELS OF APPEAL

FOR ENROLLEE "J.S."

FIRST, THERE WAS
A RECONSIDERATION

IN WHICH MAXIMUS FOUND IN FAVOR
OF THE HEALTH PLAN

OR CONSIDERED AN UPHOLD,

AND FROM THE INFORMATION,
WE CAN SURMISE,

SINCE THERE'S AN A.L.J. LEVEL,

THAT "J.S." REQUESTED
AN A.L.J. HEARING

AND THE A.L.J. FOUND PARTIALLY
FAVORABLE FOR THE ENROLLEE.

LOOKING AT THE FIRST ENTRY
FOR "J.S.,"

YOU CAN SEE THE MAXIMUS DECISION
AND THE DATE OF THE DECISION.

THERE IS NO DATE IN THE COLUMN

TITLED "EFFECTUATION DUE DATE,"

OBVIOUSLY BECAUSE
THERE IS NO EFFECTUATION

REQUIRED AT OUR LEVEL.

WE FOUND IN FAVOR
OF THE HEALTH PLAN,

AND SO IT WAS
CONSIDERED AN UPHOLD.

THE REASON THAT THIS APPEARS
ON THIS REPORT

IS BECAUSE WE ARE LOOKING
FOR AN EFFECTUATION

FOR THE A.L.J. DECISION,

AND JUST REITERATING THE POINT
ON THE PRIOR SLIDE,

WHEN SENDING IN
THE EFFECTUATION NOTICE,

YOU SHOULD REFERENCE
THE APPEAL NUMBER

THAT--THAT REQUIRES
THE EFFECTUATION.

SO IN THIS CASE,
THE HEALTH PLAN WOULD REFERENCE

THE--THE A.L.J. NUMBER,
WHICH WOULD BE 1-210 360 054

ON THE STATEMENT
OF COMPLIANCE FORM.

SO ONE OF THE MANY QUESTIONS
WE RECEIVE IS,

WHY IS THIS CASE
STILL ON THE REPORT?

ONCE A MONTH,
MAXIMUS SENDS A REPORT

TO THE RESPECTIVE

CMS REGIONAL OFFICES

IDENTIFYING THOSE CASES MISSING

A STATEMENT OF
COMPLIANCE NOTICE.

OFTEN, THE REGIONAL OFFICES WILL
THEN CONTACT THE HEALTH PLANS

TO FOLLOW UP ON
ANY MISSING NOTICES.

THERE MAY BE INSTANCES
WHERE THE HEALTH PLAN

HAS SUBMITTED INFORMATION,

BUT FOR A VARIETY OF REASONS,

THE CASE STILL APPEARS
ON THE REPORT.

THESE REASONS ARE: FIRST OF ALL,
INCOMPLETE INFORMATION.

THE STATEMENT
OF COMPLIANCE NOTICES

THAT DO NOT CONTAIN
APPROPRIATE INFORMATION

WILL BE FORWARDED TO THE CMS
REGIONAL OFFICE PLAN MANAGER

FOR REVIEW.

YOU WILL RECEIVE A FORM LETTER

INDICATING THAT THE INFORMATION
WAS SENT FOR REVIEW.

IN ADDITION, WE IDENTIFY
THOSE CASES

THAT ARE CURRENTLY
AT CMS FOR REVIEW

ON THE EFFECTUATION
NOTICE REPORT,

AND WE'LL PUT A SINGLE DAGGER

NEXT TO THOSE CASES

SO THAT HOPEFULLY EVERYONE
WILL BE AWARE THAT

YES, WE'VE RECEIVED
SOME INFORMATION.

WE COULDN'T ACCEPT IT
AT THIS TIME

AND THAT WE ARE TRYING
TO RECONCILE THAT INFORMATION.

THE NEXT POSSIBLE REASON
WOULD BE THAT

THERE'S A POTENTIAL DECISION
OR EFFECTUATION CONFLICT.

SOMETIMES, THE DECISION
AT 2 LEVELS

IS A PARTIAL OVERTURN,

SO THERE MAY BE
A PARTIAL OVERTURN

AT THE...RECONSIDERATION LEVEL

AND A PARTIAL OVERTURN
AT THE REOPENING LEVEL.

RESEARCH IS REQUIRED TO CONFIRM

WHETHER THE EFFECTUATION
WE RECEIVED IS COMPLETE.

DOES IT--DOES IT TAKE CARE
OF BOTH LEVELS?

WHILE WE STRIVE TO HAVE
THESE ISSUES RESOLVED

PRIOR TO RUNNING
ALL OF THE REPORTS,

THERE ARE INSTANCES IN WHICH
THE EFFECTUATION NOTICES

ARE RECEIVED SO CLOSE
TO THE RUN DATE

THAT WE ARE UNABLE
TO RESOLVE THEM

PRIOR TO THE REPORT RUN.

AGAIN, IN THESE INSTANCES,
WE PLACE A SPECIAL MARK

IDENTIFYING THAT
A COMPLIANCE STATEMENT

HAS BEEN RECEIVED;

HOWEVER, THESE CASES
ARE UNDER REVIEW.

AND FINALLY, ONE OF
THE MOST COMMON REASONS

FOR A CASE TO APPEAR
ON MULTIPLE REPORTS

IS JUST THE REPORT TIMING LAG.

COMPLIANCE STATEMENTS
MAY BE RECEIVED

AFTER THE SECOND REPORT IS RUN,

SO YOU'VE RECEIVED--
WE'VE RUN REPORT NUMBER ONE.

IT GOES TO THE CMS
REGIONAL OFFICE.

THE REGIONAL OFFICE COMES TO YOU
FOR A FOLLOW-UP.

BY THE TIME YOU GET US THE--US
THE EFFECTUATION INFORMATION,

THE SECOND REPORT
MAY HAVE ALREADY RUN.

THEREFORE, THOSE COMPLIANCE
STATEMENTS THAT ARE RECEIVED

AFTER THAT SECOND REPORT RUN,

THE CASE IS STILL
GOING TO BE THERE.

WE WILL CATCH IT
FOR THE THIRD RUN,

BUT AGAIN, IT'S THAT
COMPLIANCE REPORT RUNNING LAG.

IT'S THAT REPORT TIMING LAG.

WE ARE WORKING TO TRY
AND ELIMINATE THAT LAG,

BUT I DO WANT TO MAKE EVERYONE
AWARE OF THAT.

OK, AND THIS SLIDE CONTAINS
IMPORTANT INFORMATION

ON HOW YOU CAN SUBMIT
THE COMPLIANCE STATEMENTS

AND WHO TO CONTACT IF YOU HAVE
QUESTIONS OR CONCERNS.

ONE WORD OF CAUTION
I DO WANT TO SAY--

WHEN--WHEN
SENDING US INFORMATION,

PLEASE DO NOT
E-MAIL OR FAX A P.H.I.

BUT AGAIN, YOU CAN SUBMIT
THE STATEMENT OF COMPLIANCE

BY MAILING IT TO US,
BY FAXING TO US,

OR YOU CAN EVEN SCAN AND E-MAIL
THE INFORMATION TO US.

SO THAT TAKES CARE
OF THE OPERATIONAL ISSUES

OF WORKING WITH MAXIMUS.

THE NEXT ITEM
I'D LIKE TO ADDRESS

IS WHAT CONSTITUTES
A VALID APPEAL REQUEST.

THERE ARE 3 QUESTIONS
ONE MUST ASK

WHEN DECIDING IF A VALID--
APPEAL IS VALID.

IS THE REQUESTOR
A VALID REQUESTOR?

IS THE ISSUE ONE
THAT CAN BE APPEALED?

WAS THE REQUEST MADE
IN THE PROPER MANNER?

OFTENTIMES, THE ANSWERS
TO THESE QUESTIONS

ARE INTERDEPENDENT,

MEANING WHO THE REQUESTOR IS

OFTEN DETERMINES HOW AND WHAT
ISSUE CAN BE APPEALED.

FOR EXAMPLE, A CONTRACT PROVIDER

CANNOT MAKE A WRITTEN
APPEAL REQUEST

FOR PAYMENT FOR A SERVICE

WHEN THERE IS NO
ENROLLEE LIABILITY.

THAT DISPUTE IS
A CONTRACTUAL MATTER

TO BE RESOLVED TO THE TERMS
OF THE CONTRACT

BETWEEN THE HEALTH PLAN
AND ITS CONTRACT PROVIDER.

IN THAT CASE, THE ISSUE
IS CONSIDERED INVALID.

HOWEVER, A CONTRACT PROVIDER
CAN MAKE

A WRITTEN PAYMENT APPEAL REQUEST

ON BEHALF OF THE ENROLLEE

ASSUMING, PERHAPS,
THE ENROLLEE HAS GONE OUT

AND PAID FOR A WHEELCHAIR
AND IS SEEKING REIMBURSEMENT.

THE--WITH THE PROPER
DOCUMENTATION, THE A.O.R.,

THE CONTRACT PROVIDER, COULD BE

THE REPRESENTATIVE FOR THE
ENROLLEE IN THAT CIRCUMSTANCE.

SO WHO ARE VALID REQUESTORS?

WE HAVE ENROLLEES,
WE HAVE NON-CONTRACT PROVIDERS

WITH THE WAIVER,

WE HAVE AN ENROLLEE ESTATE,

A VALID REPRESENTATIVE OF
ANY OF THE 4 I JUST MENTIONED--

3 I JUST MENTIONED, EXCUSE ME--
AND THE TREATING PHYSICIAN.

IN THE PRIOR SLIDE,
SOME OF THE VALID REQUESTORS

CAN ONLY BE CONSIDERED VALID

WHEN THEY HAVE
THE REQUIRED DOCUMENTATION.

FOR EXAMPLE, A REPRESENTATIVE

WOULD NEED SOME FORM
OF DOCUMENTATION

GIVING THEM THE AUTHORITY TO ACT

AS THE REPRESENTATIVE
FOR THE ENROLLEE.

THAT COULD BE THE APPOINTMENT
OF REPRESENTATIVE FORM

ON THE CMS FORM 1696.

IT CAN BE THE EQUIVALENT
OF THE CMS FORM 1696

IN ORDER FOR
AN EQUIVALENT OF 1696,

THERE ARE 4
PIECES OF INFORMATION,

4 KEY PIECES
OF REQUIRED INFORMATION,

AND THAT IS
SUFFICIENT INFORMATION

TO IDENTIFY THE ENROLLEE;

ACKNOWLEDGMENT THAT THE PERSONAL
MEDICAL INFORMATION

WILL BE SHARED;

ACCEPTANCE OF PAYMENT--
EXCUSE ME,

ACCEPTANCE OF APPOINTMENT,
EXCUSE ME;

AND WAIVER OF THE FEE.

ESTATE DOCUMENTATION,
IF IT'S THE ENROLLEE'S ESTATE

THAT IS APPEALING
FOR A PAYMENT CONCERN,

WE LOOK TO THE HEALTH PLAN
TO VERIFY

THAT THE DOCUMENTATION IS VALID,

SO IN A NUTSHELL, IF YOU
ACCEPT IT, WE WILL ACCEPT IT.

AND FINALLY,
THE NON-CONTRACT PROVIDER.

IN THOSE INSTANCES WHERE
THE NON-CONTRACT PROVIDER

IS LOOKING FOR PAYMENT,

AND YOU HAVE--YOU HAVE DENIED IT
BECAUSE IT IS A COVERAGE ISSUE,

THE NON-CONTRACT PROVIDER
MUST HAVE A WAIVER OF LIABILITY

IN ORDER TO GO THROUGH
THE APPEALS PROCESS.

AND AGAIN, JUST A REMINDER,
IF THAT'S MISSING,

IT IS THE PLAN'S RESPONSIBILITY
TO ATTEMPT TO OBTAIN

THAT WAIVER OF LIABILITY.

WHAT CAN BE APPEALED?

FIRST OF ALL, THERE MUST BE
ENROLLEE LIABILITY,

AND AS WE TOUCHED UPON EARLIER,

IF THERE IS A DISPUTE REGARDING
PAYMENT TO A CONTRACT PROVIDER

AND THERE IS NO
ENROLLEE LIABILITY,

THE PROPER FORM FOR RESOLUTION
OF THE CONCERN

IS DETERMINED BY YOUR CONTRACT
WITH THE CONTRACT PROVIDER.

YOU ALSO WOULD NEED
TO HAVE A PLAN-LEVEL

ORGANIZATION DETERMINATION
COMPLETED.

THE ISSUE MUST BE ONE
OF WHETHER THE HEALTH PLAN

MUST COVER THE SERVICE
OR ITEM IN APPEAL.

AGAIN, IT HAS TO BE
A COVERAGE ISSUE,

WHICH WOULD BE
SLIGHTLY DIFFERENT,

AND I KNOW YOU JUST HEARD
FROM THE PAYMENT DISPUTE

RESOLUTION CONTRACTOR,

SO THERE WILL BE
CERTAIN INSTANCES WHERE

CERTAIN DISPUTES
SHOULD BE RESOLVED

OUTSIDE THE MEDICARE
MANAGED CARE APPEALS FORM.

AND THE REQUEST MUST HAVE
BEEN MADE TIMELY,

SO THE REQUEST MUST HAVE
BEEN MADE WITHIN

60 DAYS OF
THE ORGANIZATION DETERMINATION

WITH, OF COURSE, THE CAVEAT FOR
REVIEW FOR GOOD CAUSE.

AND I APOLOGIZE--THAT LAST
BULLET SHOULD NOT BE THERE.

THE NEXT TOPIC FOR DISCUSSION
IS THE REQUEST METHODS

THAT CAN BE USED
AND FOR WHAT CASE TYPE.

FOR STANDARD CLAIM CASES,

ALSO REFERRED TO AS RESPECTIVE--
RETROSPECTIVE CASES,

WRITTEN APPEAL REQUESTS
ARE NECESSARY,

SO IF THE HEALTH PLAN RECEIVES
A REQUEST VIA TELEPHONE,

THE PLAN MUST DOCUMENT
AND VERIFY THE APPEAL REQUEST

WITH THE ENROLLEE.

YOU'RE GONNA HEAR MORE ABOUT
THAT IN JUST A FEW MINUTES.

FOR A STANDARD SERVICE REQUEST,

ALSO RESERVED--REFERRED TO
AS A PRE-SERVICE REQUEST,

AGAIN, WRITTEN REQUESTS
ARE NECESSARY.

SO AGAIN, IF THE HEALTH PLAN

RECEIVES A REQUEST
VIA TELEPHONE,

THE PLAN MUST
DOCUMENT AND VERIFY

THE APPEAL REQUEST
WITH THE ENROLLEE.

THESE APPEALS CAN COME,
OBVIOUSLY, FROM THE ENROLLEE,

A VALID REP OF THE ENROLLEE,
OR THE TREATING PHYSICIAN.

AND AGAIN, AS YOU KNOW,
THE TREATING PHYSICIAN

IN THIS PARTICULAR CIRCUMSTANCE
WOULD NOT

ACTUALLY REQUIRE AN A.O.R.

AND THEN FINALLY, WE HAVE
THE EXPEDITED APPEAL REQUESTS.

EXPEDITED APPEAL REQUESTS
MAY COME

EITHER AS A WRITTEN REQUEST
OR AN ORAL REQUEST.

UNLIKE THE STANDARD REQUEST,

AN ORAL REQUEST DOES NOT
NEED TO BE VERIFIED.

AND FINALLY TO NOTE,
YOU CANNOT HAVE

AN EXPEDITED CLAIMS PAYMENT
APPEAL REQUEST.

UNDER NO CIRCUMSTANCES.
IF YOU SEND US

AN EXPEDITED
CLAIMS PAYMENT REQUEST,

WE WILL DOWNGRADE THAT
TO A RETROSPECTIVE CASE.

SO JUST TO WRAP UP ON MY END
SOME KEY POINTS.

AGAIN, WHEN YOU'RE SUBMITTING
THE CASE FILE,

PLEASE REMEMBER TO SUBMIT
THE COMPLETE CASE FILE,

AND THAT WOULD INCLUDE
THE E.O.C. WHEN NECESSARY.

AGAIN, TYPICALLY,
A COMPLETE CASE FILE

INCLUDES THE RECONSIDERATION
BACKGROUND DATA FORM,

THE CASE NARRATIVE, AND ALL
THE SUPPORTING DOCUMENTATION

AND ALL THE DOCUMENTATION
THAT YOU USE

TO MAKE YOUR FINAL DECISION.

WE STRONGLY RECOMMEND
THAT YOU USE

THE MODEL COMPLIANCE STATEMENT
THAT'S PROVIDED TO YOU

WITH THE--ANY OVERTURN
OR PARTIAL OVERTURN

DECISION LETTER.

THAT STATEMENT OF COMPLIANCE
IS ALSO AVAILABLE

ON OUR WEB SITE.

AND JUST ENSURE THAT YOU HAVE
A VALID APPEAL REQUEST,

MEANING THAT YOU'VE HAD
THE RIGHT REQUESTOR

ASKING THE RIGHT ISSUE
AND USING THE RIGHT METHOD.

IF YOU HAVE ANY
QUESTIONS OR CONCERNS,

I DO INVITE YOU TO CONTACT US.

YOU CAN CONTACT US AT
MEDICAREAPPEAL@MAXIMUS.COM.

THIS E-MAIL ADDRESS
IS MONITORED DAILY.

THANK YOU.

AND NOW--
[APPLAUSE]

>> AS I BEGAN EARLIER,

THERE WAS JUST A FEW REMINDERS

THAT I WANTED TO POINT OUT
TO THE PLANS.

ONE DEALING WITH
THE NON-CONTRACT PROVIDERS

AS THE APPELLANT UNDER THE
[INDISTINCT] APPEALS PROCESS.

PROCESSING--FOR
THE PROCESS, EXCUSE ME--

FOR ACCEPTING ORAL STANDARD
RECONSIDERATION REQUESTS.

AND FINALLY, THE PART C
EFFECTUATION REQUIREMENTS.

OK. SO TO BEGIN, I'D LIKE
TO HIGHLIGHT THE REQUIREMENTS.

WHEN A NON-CONTRACT PROVIDER--
EXCUSE ME,

NON-CONTRACT PROVIDER
CLAIM IS DENIED

AND THE PROVIDER REQUESTS
A RECONSIDERATION

OF THAT DENIED CLAIM,

SPECIFICALLY, SECTION 40.2.3
OF THE MANAGED CARE MANUAL

ADDRESSES THE HEALTH PLAN'S
NOTICE REQUIREMENTS

WHEN A NON-CONTRACT PROVIDER'S
REQUEST FOR PAYMENT

IS DENIED.

THAT IS, WHEN ZERO PAYMENT
IS BEING MADE ON THAT CLAIM.

AND AS YOU HEARD PREVIOUSLY
FROM PAUL FOSTER

AND, I GUESS, SHERRY SAUERS,

ANYTIME SOME LEVEL
OF PAYMENT IS MADE,

THAT'S WHEN THAT DISPUTE
NO LONGER FALLS UNDER

THE SUBPART M
APPEALS REQUIREMENTS.

SO FOR EXAMPLE,
THE NOTIFICATION OF DENIAL

MUST INCLUDE THE SPECIFIC
REASONS FOR THE DENIAL

AND PROVIDE A DESCRIPTION
OF THE APPEALS PROCESS.

THIS INFORMATION
COULD BE INCLUDED

IN THE HEALTH PLAN'S
REMITTANCE NOTICE

OR REMITTANCE ADVICE,
WHATEVER YOU CALL IT,

THAT'S SENT TO YOUR
NON-CONTRACT PROVIDER

WHERE IT COULD BE CONVEYED
IN SOME OTHER NOTIFICATION.

CMS WILL BE UPDATING
THIS PARTICULAR MANUAL SECTION

TO FURTHER CLARIFY
THE NOTICE REQUIREMENTS

FOR THE HEALTH PLANS.

ADDITIONALLY, THE MANUAL
SECTION 60.1.4

PROVIDES THE GENERAL
REQUIREMENTS CONCERNING

NON-CONTRACT PROVIDER APPEALS,

INCLUDING THE REQUIREMENTS
CONCERNING

THE WAIVER OF LIABILITY FORM.

OK? MY SECOND REMINDER TOPIC

CONCERNS ORAL STANDARD
RECONSIDERATION REQUESTS.

GENERALLY, THE STANDARD
RECONSIDERATION REQUEST

IS SUBMITTED IN WRITING
BY THE PARTY

THAT RECEIVED THE ADVERSE
ORGANIZATION DETERMINATION.

IF A HEALTH PLAN
CHOOSES TO ACCEPT

ORAL STANDARD
RECONSIDERATION REQUESTS,

THE HEALTH PLAN
MUST FOLLOW THE GUIDELINES

ESTABLISHED IN THE MANUAL
AT SECTION 70.2,

WHICH INCLUDES SENDING
AND RECEIVING BACK

FROM GENERALLY THE ENROLLEE
A SIGNED ACKNOWLEDGMENT

OF THE APPEAL ISSUE.

THE ESTABLISHED GUIDELINES
ARE NOT OPTIONAL

BUT MUST BE FOLLOWED
WITH RESPECT TO ORAL REQUESTS.

AND MY FINAL
REMINDER TOPIC CONCERNS

THE EFFECTUATION REQUIREMENTS.

I'D LIKE TO HIGHLIGHT
THAT THE REQUIREMENTS

FOR STANDARD RECONSIDERATION
DETERMINATIONS OR DECISIONS

CAN BE FOUND IN THE REGULATION
AT 42 CFR SECTION 422.618

AND FOR EXPEDITED
RECONSIDERED DETERMINATIONS

IN SECTION 422.619.

AND ALSO THE EFFECTUATION
REQUIREMENTS ARE COVERED

IN THE CHAPTER 13
OF THE MANAGED CARE MANUAL

AT SECTION 140.

SO HERE ARE

THE EFFECTUATION TIMEFRAMES

WHEN, UPON RECONSIDERATION,
THE HEALTH PLAN REVERSES

ITS ADVERSE
ORGANIZATION DETERMINATION.

SO YOU SEE FOR
STANDARD SERVICE REQUESTS,

YOU'RE TO AUTHORIZE OR PROVIDE

AS EXPEDITIOUSLY
AS THE ENROLLEE'S

HEALTH CONDITION REQUIRES,

BUT NO LATER THAN
30 CALENDAR DAYS

FROM RECEIPT OF
THE RECONSIDERATION REQUEST.

FOR EXPEDITED REQUESTS,
YOU'RE TO AUTHORIZE OR PROVIDE

AS EXPEDITIOUSLY
AS THE ENROLLEE'S

HEALTH CONDITION REQUIRES,

BUT NO LATER THAN 72 HOURS
FROM RECEIPT OF THE REQUEST,

AND FOR PAYMENT REQUESTS,
YOU'RE TO PAY

NO LATER THAN 60 CALENDAR DAYS,

AGAIN FROM RECEIPT OF
THE RECONSIDERATION REQUEST.

OK? THIS SLIDE SHOWS
THE EFFECTUATION TIMEFRAMES

WHEN THE HEALTH PLAN'S
DETERMINATION IS REVERSED

IN WHOLE OR IN PART

BY THE INDEPENDENT

REVIEW ENTITY,

OF COURSE WHICH IS MAXIMUS
FEDERAL SERVICES.

FOR STANDARD REQUESTS,
YOU'RE TO AUTHORIZE SERVICE

WITHIN 72 HOURS FROM RECEIPT
OF THE MAXIMUS DECISION

OR PROVIDE AS EXPEDITIOUSLY

AS THE ENROLLEE'S
HEALTH CONDITION REQUIRES

BUT NO LATER THAN
14 CALENDAR DAYS.

EXPEDITED REQUESTS REQUIRE YOU
TO AUTHORIZE OR PROVIDE SERVICE,

AGAIN, AS EXPEDITIOUSLY

AS THE ENROLLEE'S
HEALTH CONDITION REQUIRES

BUT NO LATER THAN
72 HOURS FROM RECEIPT

OF MAXIMUS' DECISION.

AND FINALLY, THE PAYMENT--
FOR PAYMENT REQUESTS,

YOU'RE TO PAY NO LATER
THAN 30 CALENDAR DAYS

FROM RECEIPT OF THE DECISION.

OF PARTICULAR IMPORTANCE IS
THE HEALTH PLAN'S RESPONSIBILITY

TO NOTIFY MAXIMUS WHEN
THE EFFECTUATION OCCURS,

THAT IS, WHEN
THE HEALTH PLAN'S NOTIFICATION

TO MA--EXCUSE ME.

THE HEALTH PLAN'S NOTIFICATION

TO MAXIMUS

SHOULD OCCUR WITHIN
14 CALENDAR DAYS OF PAYMENT

OR AUTHORIZATION OR PROVISION
OF THE SERVICE.

AND PLEASE NOTE
THAT HEALTH PLANS

CANNOT APPEAL
A MAXIMUS DECISION,

SO HEALTH PLANS,
THEN, ARE EXPECTED

TO COMPLY WITH
THE EFFECTUATION TIMEFRAMES.

EVEN IF--I DO
WANT TO POINT OUT--

EVEN IF A HEALTH PLAN
WOULD REQUEST REOPENING

OF MAXIMUS' DECISION,

YOUR REOPENING REQUEST
DOES NOT PEND

THE EFFECTUATION REQUIREMENT.

AND HERE WE HAVE
THE EFFECTUATION REQUIREMENTS

REGARDING FAVORABLE DECISIONS

FROM EITHER AN ADMINISTRATIVE
LAW JUDGE HEARING

OR A MEDICARE
APPEALS COUNCIL REVIEW.

YOU ARE TO PAY FOR, AUTHORIZE,
OR PROVIDE SERVICE

AS EXPEDITIOUSLY
AS THE ENROLLEE'S

HEALTH CONDITION REQUIRES

BUT NO LATER THAN
60 CALENDAR DAYS

FROM RECEIPT OF THE ALJ
OR THE MAC'S DECISION.

YOU'LL NOTE THAT
THE ONLY EXCEPTION

TO THE EFFECTUATION REQUIREMENT

IS WHEN THE HEALTH PLAN REQUESTS

A MEDI--THE MEDICARE
APPEALS COUNCIL REVIEW

OF AN ALJ HEARING DECISION.

AND ONCE AGAIN, THE HEALTH PLAN
MUST INFORM MAXIMUS

WHEN EFFECTUATION HAS OCCURRED

OR THAT MEDICARE
APPEALS COUNCIL REVIEW

HAS BEEN REQUESTED.

AND NOTIFICATION TO MAXIMUS
SHOULD OCCUR

WITHIN 14 DAYS OF
EITHER OF THESE EVENTS.

AND FINALLY, PLANS ARE
STRONGLY ENCOURAGED

TO USE THE STATEMENT
OF COMPLIANCE FORM

THAT'S BEEN DEVELOPED BY MAXIMUS

WHEN SUBMITTING YOUR
EFFECTUATION NOTIFICATION.

AS JANICE DID,
I'VE INCLUDED ON THIS SLIDE

THE WEB ADDRESS FOR MAXIMUS,

WHERE YOU CAN FIND MAXIMUS'S
MEDICARE HEALTH PLAN

RECONSIDERATION PROCESS MANUAL

AND OTHER USEFUL
PROGRAM INFORMATION,

AND I ENCOURAGE ALL THE PLANS

TO REGULARLY CHECK
MAXIMUS'S WEB SITE

FOR PROGRAM UPDATES
AND ANY NEW INFORMATION

THAT MIGHT BE ADDED.

AND I THANK YOU FOR YOUR
ATTENTION THIS MORNING.

[APPLAUSE]

>> OK. IF ANYONE HAS ANY
QUESTIONS THEY'D LIKE TO ASK.

HI. MY QUESTION'S
FOR JANICE, ACTUALLY.

YOU WERE TALKING ABOUT
THE ALTERNATIVE

TO THE 1696 U FORM,

AND YOU WENT THROUGH
THE 4 REQUIRED ELEMENTS,

AND I DIDN'T
GET ALL THOSE...

OH, OK. SURE.

THE REQUIRED ELEMENTS
WOULD BE

SUFFICIENT INFORMATION
TO IDENTIFY THE ENROLLEE;

ACKNOWLEDGEMENT THAT
PERSONAL MEDICAL INFORMATION

WILL BE SHARED;

THE FACT THAT

THE REPRESENTATIVE

ACCEPTS THE APPOINTMENT;

AND A WAIVER OF FEE.

SO YOU CAN'T CHARGE
YOUR MOM FOR BEING HER REP.

THANK YOU.

HI. I ACTUALLY
HAVE 2 QUESTIONS.

THE FIRST ONE IS
REGARDING ALJ OVERTURNS.

ARE YOU SAYING
THAT WE SHOULD

EFFECTUATE THAT
VIA MAXIMUS

USING THE MAXIMUS
EFFECTUATION FORM?

FOR THE QIC PART C, THE--
WE--WE--WHEN--EXCUSE ME.

YOU RECEIVE AN OVERTURN
FROM THE ALJ.

HOPEFULLY, THE ALJ
HAS ALSO FORWARDED

THAT CASE
BACK TO OUR OFFICE.

WHEN WE RECEIVE
AN OVERTURN DECISION,

WE WILL SEND YOU A COPY
WITH A--A LETTER

THAT HAS A STATEMENT OF
COMPLIANCE ATTACHED TO IT

SAYING ESSENTIALLY
THAT THE ALJ

OVERTURNED THE HEALTH PLAN,

AND THERE NEEDS
TO BE COMPLIANCE

WITHIN THE REQUIRED
TIMEFRAME.

OK, BECAUSE WE--
I'VE NEVER RECEIVED

AN EFFECTUATION FORM
FROM YOU GUYS

WHEN ALJ HAS
OVERTURNED, SO...

WE'VE NEVER--

YEAH, THANK YOU
FOR LETTING ME KNOW.

MAYBE WE CAN
TOUCH BASE LATER

AND WE CAN FIND OUT
WHAT CASE THAT WAS,

BUT YOU SHOULD
BE RECEIVING

A COMPLIANCE NOTICE
FROM US.

OK. AND THE OTHER
QUESTION IS,

IS REGARDING
THE REIMBURSEMENT DISPUTE.

IS--WHEN A CLAIM
IS SUBMITTED

AND THERE ARE MULTIPLE
CPT CODES ON IT

AND...PAYMENT WAS MADE
TO PARTICULAR CPT CODES

AND YET ON A CPT CODE,
THERE WAS NO PAYMENT.

IS THAT CONSIDERED...
TO GO TO MAXIMUS

OR TO
THE DISPUTE RESOLUTION

WHEN THEY COME BACK
TO APPEAL

THAT CPT CODE
THAT WAS DENIED?

SO I THINK WE CAN--
WE CAN RESOLVE THAT

BY SAYING
IF YOU'VE DENIED THAT

BECAUSE IT WASN'T
A MEDICALLY NECESSARY--

WOULD THAT BE
FAIR TO SAY, BEVERLY,

THAT YOU'RE NOT
COVERING IT BECAUSE

MAYBE, FOR EXAMPLE, IT'S NOT
A MEDICARE-COVERED SERVICE

THAT WOULD COME TO MAXIMUS?

YES, BUT SOMETIMES--

UNFORTUNATELY, OR
MAYBE FORTUNATELY,

I'M NOT A PAYMENT SPECIALIST,
SO IT'S A LITTLE OUT OF MY AREA,

BUT IF THE CODE IS BUNDLED
WITHIN PERHAPS ANOTHER CODE

THAT'S BEEN PAID,

THEN THAT WOULD
NOT BE AN ISSUE

THAT WOULD FALL UNDER
THE SUBPART M PROCESS.

SO...IT CAN BE VERY TRICKY.

I KNOW IT'S A FINE LINE HERE

IN DETERMINING WHICH CASES

SHOULD GO TO FIRST COAST

AND WHICH CASES LEGITIMATELY

CONTINUE TO FALL UNDER
THE SUBPART M PROCESS.

I JUST WANT
TO REITERATE, TOO,

I KNOW PAUL AND SHERRY
BOTH SAID

THAT THEY ARE IN CONTACT.

WE ARE VERY MUCH
IN CONTACT WITH ONE ANOTHER.

THIS IS A NEW APPEALS
PROCESS THAT JUST STARTED

IN JANUARY OF THIS YEAR.

WHILE I THINK PROBABLY

95% OF THE ISSUES
ARE WORKED OUT,

I'M SURE THERE'S STILL
A COUPLE THAT--

THAT, YOU KNOW,
WE'RE GONNA NEED

TO GO BACK AND FORTH ON.

BUT WHEN WE DO
HAVE QUESTIONS,

WE DO BRING IT UP TO CMS

OR, YOU KNOW, WE'LL BE IN
CONTACT WITH SHERRY'S GROUP

TO SAY WE'VE--EITHER
WE THINK THIS IS OURS

OR WE THINK THIS IS THEIRS.

BUT CLEARLY,

IF IT WAS A CODE

THAT, IF YOU WILL,
STAND--STANDS ON ITS OWN,

IT'S, YOU KNOW, AND SOME
LEVEL OF PAYMENT IS MADE,

THEN THERE--ONCE--
ONCE PAYMENT IS MADE

THEN THERE'S NO LONGER
BENEFICIARY LIABILITY

WITH RESPECT
TO THAT CLAIM,

AND THAT'S THE--
THAT'S THE REASON

THAT IT CAN
NO LONGER FALL

UNDER THE SUBPART M
APPEALS PROCESS,

BECAUSE ONCE
MEMBER LIABILITY

IS TAKEN OUT OF
THE PICTURE,

SUBPART M
NO LONGER APPLIES.

BUT WHERE--
IT'S A FULL DENIAL,

NO AMOUNT OF MONEY
AT ALL HAS BEEN PAID,

THEN OF COURSE IT CAN BE
MEMBER LIABILITY

AND IT CONTINUES TO FALL
UNDER THE SUBPART M PROCESS.