



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

Boston & New York – Serving Our Beneficiaries Together

Verbatim Transcript

Provider Payment Dispute Resolution for Non-Contracted Providers
Paul Foster and Sheri Souers

>> WE'RE NOW GOING
TO TURN OUR ATTENTION

TO PROVIDER PAYMENT
DISPUTE RESOLUTION

FOR NON-CONTRACTED
PROVIDERS.

WE HAVE PAUL FOSTER AND
SHERI SOUERS WITH US.

PAUL FOSTER HAS WORKED
FOR THE CENTERS FOR MEDICARE

AND MEDICAID SERVICES
SINCE SEPTEMBER, 1994

AS A MANAGED CARE SPECIALIST.

HE'S A SENIOR ANALYST
IN THE DIVISION OF MEDICARE

ADVANTAGE OPERATIONS.

DURING HIS TIME HERE,

HE'S FOCUSED PRIMARILY
ON MANAGED CARE ISSUES.

HE'S LED NUMEROUS CMS CENTRAL
OFFICE AND REGIONAL OFFICE

COMBINED, REVIEW TEAMS IN
ANALYZING AND APPROVING OVER

100 MANAGED CARE ORGANIZATIONS
TO OFFER HEALTH INSURANCE

BENEFITS TO MEDICARE
BENEFICIARIES THROUGHOUT

THE COUNTRY, AS WELL AS IN
PUERTO RICO, THE VIRGIN ISLANDS,

AND HAWAII.

MR. FOSTER SERVES AS
THE GOVERNMENT TASK LEADER

FOR SEVERAL FEDERAL
PROCUREMENT CONTRACTS

THAT WE AWARD.

HE'S BEEN THE CO-LEAD OF A
WORK GROUP IN CENTRAL OFFICE.

THIS PARTICULAR WORK
GROUP IN CENTRAL OFFICE

SINCE ITS INCEPTION IN 2005.

HE LED THE ROCO TRAINING TEAM
FOR 4 YEARS, COORDINATING

MAJOR INTERNAL AND EXTERNAL
TRAINING FOR CMS MANAGED

CARE STAKEHOLDERS.

SO THE PURPOSE OF MY SHARING
THIS INFORMATION WITH YOU

IS TO LET YOU KNOW THE DEPTH
OF HIS EXPERIENCE

AND HIS KNOWLEDGE.

HE HOLDS A B.A.
AND AN M.A. DEGREE

FROM BOWIE STATE UNIVERSITY.

JOINING HIM IS SHERI SOUERS,

WHO IS ALSO FROM
OUR CENTRAL OFFICE.

SHERI CURRENTLY SERVES
AS THE PROGRAM DIRECTOR

FOR THE PAYMENT DISPUTE
RESOLUTION CONTRACTOR,

WHICH WE, AGAIN, HAVE A SET
OF INITIALS FOR--THE PDRC,

WHICH IS ADMINISTERED BY
FIRST COAST SERVICE OPTIONS.

SHERI HAS ACQUIRED
AN EXTENSIVE KNOWLEDGE

OF MEDICARE REIMBURSEMENT,
HAVING MANAGED INTERIM

REIMBURSEMENT AND COST REPORT
SETTLEMENT FOR INSTITUTIONAL

PROVIDERS FOR MORE THAN 20 YEARS
PRIOR TO THE FORMATION

OF THE PDRC WHICH NOW
HAS THAT FUNCTION.

INSTRUMENTAL NOT ONLY IN FIRST
COAST'S EFFECTIVENESS IN ITS

RESPONSIBILITIES
AS A FISCAL INTERMEDIARY,

SHE IS NOW
A LEADER OF THE PDRC.

SHERI HAS SERVED ON NATIONAL
WORK GROUPS RELATED

TO COST REIMBURSEMENT ISSUES.

AND SO THE DEPTH OF HER
EXPERIENCE IS EXTENSIVE AS WELL.

SO PLEASE GREET
PAUL AND SHERI.

[APPLAUSE]

>> GOOD MORNING.

THANKS, EVERYONE, FOR COMING.

IT'S GOOD TO BE HERE.

IT'S GOOD TO BE IN BROOKLYN.

>> YEAH!

HA HA HA.

YES, I'VE ENJOYED MYSELF
THE LAST COUPLE OF DAYS.

YESTERDAY I GOT
TO GO INTO MANHATTAN

AND HANG OUT
WITH DENZEL WASHINGTON.

I GUESS THAT'S THE HOT PLAY
OF THE MOMENT ON WALL STREET--

ON BROADWAY, I'M SORRY.

AS I WAS COMING IN YESTERDAY,
I SAW THE BEAUTIFUL PICTURES

OF PUERTO RICO AND
THE VIRGIN ISLANDS.

I KNOW WE HAVE SOME FRIENDS
OVER THERE FROM PUERTO RICO

THAT I'VE ENJOYED GOING DOWN.

I KNOW NEXT YEAR IF YOU WANT
TO MOVE THE CONFERENCE TO ONE

OF YOUR OUTPOSTS, LIKE PUERTO
RICO OR VIRGIN ISLAND,

JUST TO LET YOU KNOW,
I'M--I'M AVAILABLE.

HA HA HA HA.

IT'S CERTAINLY A PLEASURE
TO HAVE THE OPPORTUNITY

TO DISCUSS THE NON-CONTRACTED

PROVIDER PAYMENT
DISPUTE PROGRAM.

SO THANKS AGAIN TO THE NEW YORK
AND BOSTON REGIONAL

OFFICES FOR THEIR INVITATION.

A LITTLE OVER 2 YEARS AGO,
CMS STARTED THE PROCESS WHICH

WOULD RESULT IN FORMULIZING

A PAYMENT DISPUTE PROGRAM

FOR NON-CONTRACTED AND DEEMED
PROVIDERS WHO DISAGREED

WITH THE PAYMENT FROM
A PRIVATE FEE-FOR-SERVICE PLAN.

NOW PRIOR TO THIS PROGRAM'S
IMPLEMENTATION,

NO FORMAL PROCESS WAS IN PLACE
AT CMS THAT DEALT SPECIFICALLY

WITH THE AMOUNT OF PAYMENT.

THESE TYPES OF DISPUTES
USUALLY GOT HANDLED

ON AN AD HOC BASIS, AND MAY HAVE
REQUIRED A LITTLE ARM TWISTING

ON THE--ON--BY
THE ACCOUNT MANAGER

OR PLAN MANAGER
IN CMS TO ACTUALLY GET

THAT DISPUTE RESOLVED.

OBVIOUSLY, THIS AD HOC PROCESS

WAS NOT GOING TO BE ENOUGH
OVER THE LONG HAUL.

THUS, CMS BEGAN SOLICITING
AND RECEIVING PROPOSALS

BY SEVERAL
TALENTED ORGANIZATIONS

WITH THE EXPERTISE
AND BACKGROUND...

TO COMPUTE ORIGINAL
MEDICARE PAYMENT.

AND WE SELECTED FIRST COAST
SERVICE OPTIONS, INC.--

INCORPORATED.

AND I THINK IN THE INTRODUCTION
YOU'VE HEARD

THAT THEY SERVED AS A PART A
FISCAL INTERMEDIARY,

PART B CARRIER,

PART A WEST QUICK,
AND PART B NORTH QUICK.

AND, OBVIOUSLY,
THEY HAVE THE EXPERTISE

IN THE FEE-FOR-
SERVICE PAYMENT PROGRAM,

PPS PAYMENT, AND THE VARIOUS

GROUPE AND PRICER
PROGRAMS BY CMS.

NOW AS THE FIRST SLIDE
INDICATES,

ON JANUARY 1 FIRST COAST
BEGAN ACCEPTING DISPUTES

FROM PRIVATE FEE-FOR-SERVICE
PLANS ONLY.

NOW, HOW DID WE GET
TO JANUARY 1?

WELL, THE PRIVATE FEE-FOR-
SERVICE PROGRAM,

SPECIFICALLY,
THE TERMS AND CONDITIONS

MANDATED THAT CMS WOULD SELECT

AN INDEPENDENT ENTITY
TO RESOLVE PAYMENT DISPUTES

FOR DEEMED AND
NON-CONTRACTED PROVIDERS.

NOT ONLY DID YOU HAVE
THIS GROWING OUT

OF THE REGULATIONS, BUT
THERE WAS MOUNTING EVIDENCE

THAT PAYMENT PROBLEMS EXISTED.

IT WAS ALSO CLEAR THAT SOME
MANAGED CARE ORGANIZATION

DID NOT HAVE A WELL-DEFINED
DISPUTE PROCESS

FOR NON-CONTRACTED PROVIDERS.

NOT ONLY FOR NON-CONTRACTED
PROVIDERS--OR NOT ONLY WAS

THIS TRUE FOR PRIVATE

FEE-FOR-SERVICE PLANS,

BUT FOR OTHER
MA-TYPE PLANS.

THUS, IN JANUARY 1, CMS BEGAN
CONTRACTING OR REVIEWING

DISPUTES FOR OTHER TYPES OF
MA PLANS, SUCH AS COST PLANS,

PACE ORGANIZATIONS,
THAT SORT OF PLAN.

WE ALSO EXPANDED IT TO
REVIEW ISSUES OF DOWN-CODING

OF CLAIMS AND RELATED MEDICAL
NECESSITY DETERMINATIONS.

SO FOR THE FIRST
YEAR, IN 2009,

WE DEALT EXCLUSIVELY
WITH PRIVATE

FEE-FOR-SERVICE CLAIMS.

JANUARY, 2010, WE MOVED IT

TO ALL OF THE OTHER
TYPE MA-PLANS.

ONE THING YOU SHOULD KNOW
THAT UNDER THE FIRST YEAR

BENEFICIARY APPEALS AND
CONTINUING BENEFICIARY APPEALS

ARE NOT COVERED
UNDER THIS PROCESS,

NOR ARE DENIALS THAT
RESULT IN ZERO PAYMENT.

SO I GUESS ONE OF THE KEY
ELEMENTS OF THE PROGRAM

IS THAT FIRST COAST REVIEWS

DISPUTES WITH NON-CONTRACTED

PROVIDERS WHERE SOME TYPE
OF PAYMENT HAS BEEN MADE

TO THE PLAN.

THIS IS SORT OF DIFFERENT THAN
WHAT WE HEARD ABOUT YESTERDAY,

WHEN CERTAINLY THERE'S FRAUD
AND THERE'S--

ON BEHALF OF SOME PROVIDERS

WHO, YOU KNOW, ARE TRYING
TO FRAUDULENTLY RECEIVE PAYMENT.

I THINK WHAT WE'RE TALKING
ABOUT IS A SITUATION WHERE,

YOU KNOW, THESE PROVIDERS,
MOST OF THEM ARE LEGITIMATE,

THEY'RE NOT TRYING TO DEFRAUD.

IT COULD BE A DISAGREEMENT
OR MISUNDERSTANDING ON THE PART

OF THE PROVIDER OR THE PLAN.

SO THIS PROCESS IS USED TO
HELP RESOLVE THOSE PROBLEMS.

SO, WE GOT THERE BECAUSE
WE DID GET A LOT OF COMPLAINTS

FROM SOME PROVIDERS
THAT THEY WEREN'T RECEIVING

WHAT THEY WOULD RECEIVE
UNDER ORIGINAL MEDICARE.

AND THAT WASN'T A PROBLEM
BECAUSE OUR REGULATIONS STATE

THAT NON-CONTRACTED PROVIDERS
SHALL RECEIVE NO LESS

THAN THEY WOULD RECEIVE

UNDER ORIGINAL MEDICARE.

NOW, I GUESS IN A PERFECT WORLD
ALL OF YOUR BENEFICIARIES

WOULD RECEIVE CARE
FROM CONTRACTOR PROVIDERS

AND IT
WOULDN'T BE A PROBLEM.

YOU WOULD HAVE ALREADY
NEGOTIATED THE TERMS

AND CONDITIONS OF PAYMENT.

BUT WE KNOW THAT IN MANAGED
CARE, AND CONTRACTING,

AND HEALTH SERVICE DELIVERY,
BENEFICIARIES DON'T ALWAYS

ACCESS CARE
AT CONTRACTED PROVIDERS,

ESPECIALLY FOR EMERGENCY
AND URGENTLY NEEDED SERVICES.

SO WE NOW HAVE THIS PROCESS,
YOU KNOW, WHERE THEY CAN--

IN FACT, IF THEY DISPUTE
A PAYMENT, YOU KNOW,

WE CAN GET THAT RESOLVED
BECAUSE WE HAVE EXPERTS

TO BE ABLE TO TELL THEM
WHAT THEY WOULD HAVE GOTTEN

UNDER ORIGINAL MEDICARE.

NOW LET ME JUST GO OVER--

JUST DO AN OVERVIEW OF HOW
THE PROCESS WORKS.

I GUESS THE KEY ELEMENT IS
THAT A NON-CONTRACTED PROVIDER

HAS TO GO THROUGH YOUR
APPEAL PROCESS FIRST,

OR YOUR DISPUTE PROCESS.

WE DON'T LIKE TO CALL IT

APPEAL BECAUSE THAT'S SORT

OF THE PURVIEW OF MAXIMUS,

AND SO WE CALL IT
A DISPUTE PROCESS,

IT'S NOT NECESSARILY AN APPEAL,
BUT A DISPUTE PROCESS.

SO, THE FIRST THING IS THAT YOU
MUST HAVE AN INTERNAL DISPUTE

PROCESS, BECAUSE IF YOU DON'T
HAVE AN INTERNAL DISPUTE

PROCESS FOR NON-CONTRACTED
PROVIDERS,

YOU KNOW, THEY'RE STILL GOING

TO BE ABLE
TO APPLY WITH CMS

TO RENDER A DECISION
IN THAT CASE.

SO YOU MUST HAVE THAT INTERNAL
DISPUTE PAYMENT PROCESS.

THEY MUST, YOU KNOW,
ACCESS THAT.

THEY MUST FILE
THAT DISPUTE WITH YOU.

SO IF THEY CONTINUE
TO DISAGREE AND,

LET'S SAY, YOU SAY,
"WELL, YOU KNOW WHAT?

"WE MADE THE PAYMENT CORRECTLY.

"THIS IS WHAT YOU
SHOULD HAVE BEEN PAID

AND WE'RE GOING TO
STAND BY THAT."

AT THAT POINT THE PROVIDER
CAN, IN FACT, CONTINUE

THIS PROCESS
WITH FIRST COAST, YOU KNOW,

THE INDEPENDENT ENTITY, AND
HAVE THAT PROCESS RESOLVED.

YOU WILL BE NOTIFIED.

FIRST COAST--IF THEY DO
RECEIVE A PAYMENT DISPUTE,

THE MA PLAN IS NOTIFIED.

IT'S NOT THAT YOU
WOULDN'T KNOW ABOUT IT.

NOW THE PROCESS IS DIFFERENT
THAN MAXIMUS IN THAT

OUR APPEAL PROCESS HAS
TO BE BASICALLY INITIATED

BY THE PROVIDER.

THE PLAN DOESN'T HAVE TO SEND
FIRST COAST ANY DOCUMENTATION,

ALTHOUGH YOU ARE CERTAINLY
WELCOME TO DO IT,

AND I ENCOURAGE YOU TO DO IT

IF YOU WANT TO MAKE SURE THAT
ALL THE EVIDENCE IS THERE.

BUT IT'S NOT SOMETHING
THAT IS REQUIRED,

UNLESS FIRST COAST FEELS THERE

IS ADDITIONAL INFORMATION

THAT THEY WOULD NEED.

FIRST COAST HAS
60 DAYS TO COMPLETE

THE PAYMENT DISPUTE DECISION,
AND I'M GLAD TO REPORT

THAT THEY'VE BEEN ABLE
TO DO THAT.

INITIALLY, WHEN THE PROGRAM
FIRST STARTED,

WE DIDN'T REALIZE--OR
WE WERE A LITTLE NERVOUS

ABOUT HOW MANY
REQUESTS WOULD WE GET.

I MEAN,
THERE WAS NO WAY TO TELL

HOW MANY DISPUTE REQUESTS
OR APPEALS--NOT APPEALS,

BUT DISPUTE REQUESTS
THAT YOU GET

FROM NON-CONTRACTED PROVIDERS.

BUT WE SET A THRESHOLD
OF 60 DAYS FROM THE TIME

THEY RECEIVE THAT REQUEST
TO ACTUALLY RENDER A DECISION.

IF THAT DECISION
IS FAVORABLE TO THE PROVIDER,

THEN THE MA PLAN HAS 30 DAYS

IN ORDER TO IMPLEMENT
THAT DECISION...

AND YOU MUST NOTIFY CMS WITHIN
7 DAYS OF MAKING A PAYMENT.

NOW, THIS DECISION IS
BINDING ON BOTH PARTIES.

WE FEEL THAT THE REGULATIONS
GIVE US THE AUTHORITY, YOU KNOW,

DOWN THROUGH THE SECRETARY,

THAT THESE NON-CONTRACTED
PROVIDERS SHOULD RECEIVE

WHAT THEY WOULD RECEIVE
FROM MEDICARE.

SO IT IS A BINDING DECISION

THAT WE MAKE AND WE WILL
TRACK THAT DECISION.

NOW I'M GOING
TO LET SHERI TAKE OVER NOW

AND JUST GIVE
YOU SOME OF THE RESULTS

THAT HAVE OCCURRED SINCE
JANUARY 1, 2009.

>> THANK YOU, PAUL.

I AM SHERI SOUERS.

AND I WANT TO ASSURE YOU

THAT ALTHOUGH I HAVE
A PART A BACKGROUND,

I HAVE PEOPLE ON MY STAFF

WITH EXTENSIVE
PART B BACKGROUNDS.

IN FACT, I HAVE SOMEBODY
THAT HAS 36-PLUS YEARS

OF PART B PRICING,
WE HAVE NURSES.

UH, SO WE HAVE A GOOD TEAM.

AS PAUL SAID, UM...UM...

WE DEAL
WITH NON-CONTRACTED PROVIDERS

AND DEEMED PROVIDERS WHO ARE
SEEKING REIMBURSEMENT

THAT'S NO LESS THAN ORIGINAL
MEDICARE WOULD HAVE ALLOWED.

WE MAKE A DECISION
ON THE TOTAL REIMBURSEMENT,

NOT THE NET PAYMENT,
SO, FOR INSTANCE,

IF THE FEE SCHEDULE SAYS
THE ALLOWABLE AMOUNT IS \$100,

THAT'S OUR DECISION
WITHOUT REGARD TO HOW MUCH

OF THAT \$100 IS PAYABLE
BY THE MEMBER OR THE PLAN.

SO IT'S AT THE TOTAL
REIMBURSEMENT LEVEL.

SO, SO FAR SINCE THE BEGINNING
OF THE PROGRAM, WE'VE ISSUED

DECISIONS ON OVER
1,300 CASES OR CLAIMS.

AND I GUESS ANOTHER WAY
TO THINK OF THAT IS

THAT'S 1,300 INSTANCES
WHERE YOU WERE ABLE TO RELEASE

A VERY PERSISTENT
PROVIDER THAT SAYS

YOU DIDN'T PAY THEM CORRECTLY.

OR THAT'S 1,300 CASES
THAT PAUL DIDN'T HAVE

TO GET INVOLVED WITH.

UM...AND SO FAR 75%
OF OUR DECISIONS HAVE BEEN

THAT THE PROVIDER
HAD BEEN UNDERPAID,

AND THIS IS NEARING
\$1 MILLION IN AGGREGATE.

AND I REALIZE I'M TALKING TO
THE AUDIENCE THAT MAY NOT LIKE

THAT STATISTIC, BUT WE'LL GET
INTO SOME OF THE REASONS

THAT WE THINK WE'RE SEEING
THAT A LITTLE BIT LATER.

AS PAUL SAID, WE ARE ISSUING
DECISIONS WITHIN THE 60 DAYS.

AS OF APRIL, WE WERE
AVERAGING 42 DAYS

TO GET OUR DECISIONS OUT.

AND OUR DECISIONS
ARE BINDING ON THE PARTIES,

BUT EITHER PARTY
CAN REQUEST A DEBRIEF

TO GET A BETTER UNDERSTANDING
OF OUR DECISIONS.

WE TRY TO WRITE
OUR DECISION LETTERS

WITH A LOT OF SUPPORT
FOR OUR RATIONALE.

AND WE'VE ONLY HAD 3--WE'VE ONLY
CONDUCTED 13 DEBRIEFS SO FAR,

SO, YOU KNOW,
WE THINK THE LETTERS

ARE PRETTY SELF-EXPLANATORY
WHEN THEY GET OUT THERE.

AND WE HAVE BEEN GETTING
SOME POSITIVE FEEDBACK

FROM MA PLAN REPRESENTATIVES
AND PROVIDERS.

THEY SEEM TO BE APPRECIATIVE
THAT THERE IS A PROCESS,

THAT, YOU KNOW, AN ESTABLISHED
INDEPENDENT REVIEW PROCESS

THAT THEY CAN USE.

AND I THINK THEY FIND THAT
WE'RE EASY TO DO BUSINESS WITH,

AND OUR DECISION MAKERS
HAVE BEEN VERY GOOD

AT ESTABLISHING,
YOU KNOW, A PROFESSIONAL

WORKING RELATIONSHIP
WITH PROVIDERS

AND PLAN REPRESENTATIVES.

WE SEE DISPUTES ON JUST ABOUT
EVERY REIMBURSEMENT ISSUE

YOU COULD COME UP WITH.

SOME OF THE MOST
COMMON ONES

THAT WE'VE BEEN DEALING
WITH ARE ON THE SLIDE.

LAB PRICING,
INCLUDING PANELING

AND SOME THAT
ARE CARRIER PRICED,

PHYSICIAN CLAMS--
THESE ARE ISSUES

SUCH AS GLOBAL SURGERY,

BUNDLING, OR NCCI ISSUES,

THE USE OF MODIFIERS,
PORTABLE X-RAY.

AND THEN ON THE
INSTITUTIONAL PROVIDERS,

WE HAVE HOSPITAL
INPATIENT, PPS,

AND WE THINK A LOT
OF THOSE ISSUES ARE HAVING

TO DO WITH USING A CORRECT
PROVIDER-SPECIFIC FILE.

SOMETIMES, IT'S RECOGNIZING
THAT A TRANSFER HAD OCCURRED

OR HAD NOT OCCURRED.

OF COURSE,
WE HAVE CASES INVOLVING

HOME HEALTH AGENCIES, AND WE
ALSO HAVE HOSPITAL OUTPATIENT,

WHICH IS PAID UNDER OPPS.

AS FAR
AS LESSONS LEARNED, UM...

I GUESS THIS IS
SOMETHING THAT, YOU KNOW,

WE KNOW GOING INTO IT--

MEDICARE REIMBURSEMENT
IS OFTEN VERY COMPLICATED

AND DIFFICULT TO IMPLEMENT
TIMELY AND CORRECTLY.

UM, BUT, AS WE REVIEW
THESE CASES,

IF WE MAKE A DECISION THAT
IS FAVORABLE TO THE PROVIDER,

OR THAT THE PROVIDER
HAS BEEN UNDERPAID,

WE'RE TRYING TO CAPTURE
A REASON FOR THE ERROR

SO THAT WE CAN REPORT
BACK TO CMS,

AND MAYBE, YOU KNOW, BE ABLE
TO OFFER SOME ASSISTANCE

DOWN THE ROAD TO, YOU KNOW,
WHAT'S CAUSING THESE ERRORS.

NOW, WE CAN'T ALWAYS DETERMINE
WHAT CAUSED THE ERROR.

WE'RE KIND OF GUESSING AS
WE LOOK AT YOUR DOCUMENTATION.

BUT ONE THING THAT WE THINK
WE SEE IS THAT SOMETIMES

THE MA PLANS ARE RELYING
ON A VENDOR SOFTWARE

THAT REALLY CAN'T HANDLE EVERY
REIMBURSEMENT SITUATION,

OR IT HASN'T BEEN
UPDATED TIMELY.

UM...SOMETIMES IT'S
MISINTERPRETATION OF THE RULES

OR AN EFFECTIVE DATE.

SOMETIMES IT'S AS
SIMPLE--WELL, NOT AS SIMPLE--

BUT SOMETIMES IT IS APPLYING
THE WRONG REIMBURSEMENT METHOD

TO THE TYPE OF CLAIM.

YOU KNOW, TRYING
TO PRICE AN ASC CLAIM

ON THE PART B

PHYSICIAN FEE SCHEDULE.

THERE'S, YOU KNOW, MAYBE
A LONG-TERM CARE PROVIDER

THAT HAS--USED TO BE
AN ACUTE CARE PROVIDER

AND NOW IT'S A LONG-TERM CARE,

AND IT'S STILL BEING PRICED
AS IF IT'S UNDER IN-PATIENT PPS.

UM...SOMETIMES THE MODIFIERS
THAT ARE USED

ON A SERVICE LINE
SEEM TO BE IGNORED, YOU KNOW,

THAT COMES IN WITH A MODIFIER
AND IT PROCESSES

AS IF IT DIDN'T HAVE ONE.

UM...SOME OF THE MORE SUBTLE
THINGS THAT WE THINK WE'VE SEEN

IS CMS HAS PC PRICERS THAT
ARE AVAILABLE FOR ALMOST

EVERY TYPE OF INSTITUTIONAL
REIMBURSEMENT.

THOSE ARE THE MORE
COMPLICATED ITEMS.

SO THERE ARE SOME TOOLS
AVAILABLE, AND WE'VE SEEN

CASES WHERE MA PLANS SEEM
TO BE USING THOSE TOOLS

BUT MAYBE NOT USING
THEM PROPERLY.

THERE'S A CERTAIN FIELD THAT
NEEDS TO BE, YOU KNOW,

HAVE A ONE INDICATOR
INSTEAD OF A ZERO,

OR SOMETHING, AND SO THEY'RE
GETTING AN INCORRECT RESULT

BECAUSE THE TOOLS AREN'T
BEING USED PROPERLY,

OR NOT BEING UPDATED TIMELY.

IF YOU'RE USING ANY
OF THOSE PC PRICERS,

OR YOUR VENDOR
IS USING THAT DATA

TO UPDATE THEIR SYSTEMS,

THE PROVIDER'S SPECIFIC FILE
GETS UPDATED QUARTERLY,

SOMETIMES MORE OFTEN,
SOMETIMES THERE'S TWEAKING

TO THE PRICING LOGIC,

SO THOSE HAVE TO BE UPDATED
IN YOUR SYSTEMS AS WELL.

AND THEN WE'VE
SEEN SOME INSTANCES

WHERE THE ORGANIZATION'S
PAYMENT DISPUTE PROCESS

IS NOT CLEARLY DEFINED

OR COMMUNICATED

WITHIN THE ORGANIZATION.

THAT'S PROBABLY SOMETHING THAT
WE'LL DEVELOP AS TIME GOES ON.

WE SAW SOME IMPROVEMENTS
IN THE PFFS PLANS,

AND WE THINK WE'LL SEE
THAT IN OTHER PLANS AS WELL.

BUT SOME PROVIDERS

DON'T EVEN GET A RESPONSE

WHEN THEY ISSUE--YOU KNOW,
THEY DISPUTE A PAYMENT.

WE SEE EVIDENCE OF OVER
AND OVER AND THEY'RE JUST NOT

GETTING A RESPONSE.

I WOULD GUESS THAT'S, UM, YOU
JUST DON'T HAVE A PROCESS

SET UP THAT THAT PERSON TAKING
IN THE DISPUTE UNDERSTANDS

WHAT TO DO WITH IT.

UM...AND THEN THERE ARE CASES
WHERE WE SEE THE PROVIDER

HAS DOCUMENTED A VERY CLEAR
TRAIL OR SET OF DOCUMENTATION

ABOUT WHY THEY SHOULD GET
A DIFFERENT PAYMENT

THAN THEY DO, AND WE
DON'T SEE ANY EVIDENCE

THAT THAT WAS
REALLY CONSIDERED.

WE KIND OF SEE A RUBBER STAMP.

I MEAN, WE DON'T REALLY KNOW
WHAT'S GOING ON AT YOUR SHOPS,

BUT THE PAPER THAT WE SEE--THE
DECISION LETTER LOOKS LIKE

THAT HAS BEEN DISREGARDED

AND IT'S JUST, YOU KNOW,
WE PAID CORRECTLY.

SO, YOU KNOW, SOME OF THOSE,
AS WE GET INTO THE DECISION,

YOU KNOW, THE PROVIDER LAID OUT

THE STORY RIGHT HERE,

AND THEY HAVE DOCUMENTATION OF
HOW ORIGINAL MEDICARE WOULD PAY,

THEY HAVE, YOU KNOW, WHATEVER--
THE FEE SCHEDULE ATTACHED.

AND IT JUST DIDN'T SEEM
TO MAKE IT THROUGH THE SYSTEM.

THIS CHART DEPICTS JUST
THIS YEAR--THE FIRST 4 MONTHS

OF THE YEAR WHERE WE'RE GETTING
OUR REQUESTS FOR DECISIONS.

WE'RE STILL GETTING MOST
OF THEM FROM PRIVATE

FEE-FOR-SERVICE PLANS,
BUT WORD IS STARTING TO GET OUT

AND THE OTHER MA--
DISPUTES REGARDING

OTHER MA PLANS ARE
STARTING TO COME IN.

THE WORD IS GETTING OUT
BECAUSE WE'VE ISSUED--

OR CMS HAS ISSUED SOME ARTICLES

IN A COUPLE
OF DIFFERENT PUBLICATIONS.

CMS HAS A WEB PAGE NOW
UNDER HEALTH PLANS

GENERAL INFORMATION, OVER TO
THE LEFT SIDE THERE'S A LINK

FOR PAYMENT DISPUTES.

WE HAVE IT ON
OUR CORPORATE WEB PAGE.

SO, UM, WORD'S GETTING OUT.

AND, AS PAUL SAID,
WE DON'T REALLY KNOW

WHAT THE UPPER LIMIT
IS OF THIS WORK LOAD.

SO, WE'RE WATCHING IT
STEADILY INCREASE.

ALL RIGHT, THIS CHART--
I REALIZE IT'S HARD FOR YOU

TO DEPICT EVERYTHING
THAT'S UP THERE,

BUT I WANTED TO ILLUSTRATE
SOME OF THE REASONS

FOR OUR DISMISSALS.

I THINK ON MY FIRST SLIDE
I HAD A COMMENT

THAT WE'VE DISMISSED MANY MORE
CASES THAN WE'VE DECIDED.

AND PAUL INDICATED
THAT YOU WOULD KNOW

IF WE RECEIVE
A REQUEST FOR A DECISION.

YOU'D ONLY KNOW ABOUT THOSE THAT
WE HAVE ACCEPTED--YOU KNOW,

ACKNOWLEDGED AS A VALID CASE.

WE GET MANY MORE
THAT WE DISMISS,

AND WE DON'T INVOLVE
YOU IN THAT.

IF IT DOESN'T MAKE IT THROUGH
THE FIRST LEVEL OF OUR REVIEW,

YOU KNOW, ALL THE PIECES
ARE THERE FOR US TO MAKE

A DECISION, WE'LL DISMISS

IT TO THE PROVIDER

AND NEVER EVEN LET
YOU KNOW ABOUT THOSE.

BUT, I GUESS, MOST NOTICEABLE
ON THIS SLIDE IS THE LAST BAR.

THAT'S OUR APRIL DISMISSALS
FOR MISSING INFORMATION.

AND WE'VE CHANGED
OUR PROCESS A LITTLE BIT,

THAT'S WHY YOU
SEE THE SPIKE.

BUT A PROVIDER MUST SUBMIT
A FEW SPECIFIC PIECES

OF DOCUMENTATION IN ORDER
FOR US TO DETERMINE

THAT WE HAVE ENOUGH
INFORMATION TO WORK WITH.

AND THAT'S A DESCRIPTION
OF THE ISSUE,

A COPY OF THE CLAIM
AS IT WAS SUBMITTED

TO THE MA PLAN,
A COPY OF THE REMITTANCE

ADVICE SHOWING WHAT
THE MA PLAN PAID,

AND THEN A COPY
OF THE PLAN'S DECISION

REGARDING THE PAYMENT DISPUTE.

SO, IF WE DON'T HAVE THOSE
BASIC PIECES OF INFORMATION,

WE REALLY CAN'T TELL WHAT'S
GOING ON, AND SO WE'LL EITHER

HAVE TO DEVELOP AND ASK

FOR THAT MISSING INFORMATION,

OR DISMISS. AND WE FOUND

THAT WE WERE SENDING OUT
DEVELOPMENT LETTERS

AND ENDED UP
DISMISSING A HUGE PERCENTAGE

OF THOSE ANYWAY, SO WE KIND
OF CUT OUT THAT STEP.

WE WILL DEVELOP IF IT'S JUST
ONE PIECE OF INFORMATION

THAT WE FEEL CERTAIN
THE PROVIDER HAS,

AND JUST DIDN'T HAPPEN TO
INCLUDE IN THEIR REQUEST,

BUT IF IT'S
SUBSTANTIALLY INCOMPLETE,

WE'RE DISMISSING NOW.

UH...I GUESS WHAT I'D WANT
TO DRAW YOUR ATTENTION TO

ARE THE DARKER-COLORED ITEMS
ON THE SLIDE.

THOSE ARE SOME OF THE
DISMISSALS THAT WE BELIEVE

THE MA PLANS MAY BE ABLE
TO HAVE SOME IMPACT ON.

THESE ARE ISSUES SUCH AS,
IT'S NOT A PAYMENT DISPUTE,

THE CLAIM NEVER MADE IT
THROUGH THE FRONT END EDITS--

YOU KNOW, SOME KIND
OF CLAIMS PROCESSING EDIT

THAT CAUSED IT
TO NOT BE PAID.

AND IN SOME CASES
THE DECISION LETTER,

OR THE RESPONSE BACK
TO THE PROVIDER,

WHEN THEY'RE KIND
OF CHALLENGING THAT,

IS, YOU KNOW,
GO TO FIRST COAST SERVICE

OPTIONS FOR A DECISION.

BUT IF A PAYMENT HASN'T BEEN
MADE, THAT'S NOT SOMETHING

WE WOULD HANDLE,
SO WE WOULD DISMISS THAT

AS NOT A PAYMENT DISPUTE.

SOMETIMES IT'S
JUST A COMPLAINT.

AND WE SAY
THAT'S NOT A PAYMENT DISPUTE.

UM...THERE ARE MEDICAL
NECESSITY OR COVERAGE ISSUES

THAT MAKE THEIR WAY TO US,
AND, AGAIN, WE DISMISS THOSE.

AND SOMETIMES THAT IS--THE
DECISION LETTER FROM THE PLAN

INDICATES THIS
IS NOT A COVERED ITEM,

OR IT'S, YOU KNOW,
A REPLY TO NCD.

"PLEASE GO TO FIRST COAST
SERVICE OPTIONS FOR MORE

GUIDANCE," OR YOU KNOW,
WHATEVER WORDING YOU USE.

BUT--SO, THOSE WE'LL DISMISS.
UM...

AND WHEN WE MAKE
THOSE KIND OF DISMISSALS,

WE INSTRUCT THE PROVIDER
TO GO BACK TO THE PLAN

AND TRY TO WORK IT OUT

AND MAKE THEM ALSO AWARE THAT
THEY MAY HAVE APPEAL RIGHTS

UNDER THE BENEFICIARY
APPEAL PROCESS,

AND THAT THERE'S
AN ACCOUNT MANAGER

THAT MAY BE ABLE
TO ASSIST THEM FURTHER

IF THEY CAN'T RESOLVE
THEIR ISSUES.

SOME OF THE OTHER REASONS
THAT WE MAY DISMISS

IS THAT THE PROVIDER
HASN'T FORMALLY FILED

A PAYMENT DISPUTE WITH
THE PLAN BEFORE COMING TO US,

OR THAT MORE THAN 180 DAYS
HAS PASSED SINCE THE PLAN

HAS ISSUED ITS DECISION.

AND SO NORMALLY THESE TYPES
OF DISMISSALS ARE REALLY

AN INDICATION THAT
THE PROVIDER IS NOT FOLLOWING

THE PROCEDURES, BUT WE THINK,

YOU KNOW, BECAUSE OF SOME
OF THESE CONFUSING LETTERS

THAT ARE GOING OUT, THAT MA
ORGANIZATIONS MAY HAVE SOME

ABILITY TO IMPACT THAT AND
WE'LL GET THIS CLEANED UP,

YOU KNOW, AS THE YEAR GOES ON.

AND SOME OF THE OTHER TYPES OF
DISMISSALS I HAVE UP HERE ARE,

UM, THAT THE PROVIDER
HAS REQUESTED A WITHDRAWAL

AFTER THEY'VE SUBMITTED
THE REQUEST TO US.

AND WE THINK WHAT WE'RE SEEING
HERE IS THAT AFTER WE SEND

OUR ACKNOWLEDGEMENT LETTER TO
THE MA PLAN, THEY'RE LOOKING

AT THE CLAIM AND SAY,
"OH, I SEE THE PROBLEM,"

AND FIXING IT.

SO THE PROVIDER GET THEIR
PAYMENT AND THEN--YOU KNOW,

SOMETIMES, WE FIND THIS OUT
AS WE'RE TRYING TO UNDERSTAND

WHAT HAPPENED WITH THE CLAIM.

WE MIGHT CONTACT
THE MA PLAN REPRESENTATIVE

AND FIND OUT IT
JUST GOT PAID,

AND SO WE'LL CONTACT
THE PROVIDER AND SAY,

"DO YOU WANT TO
JUST WITHDRAW THIS?"

SO WE DO HAVE A PRETTY

FAIR NUMBER OF WITHDRAWALS.

WE HAVE SOME THAT
ARE DISPUTES REGARDING

SOMETHING OTHER THAN
A MEDICARE ADVANTAGE PLAN.

WE'VE, UM...SOME INVOLVE
RECENTLY A MEDICAID HMO PAYMENT,

UM, AND THE PROVIDER
HAS COME TO US.

SOME, UM...YOU KNOW,
IT'S ANOTHER KIND

OF A FEDERAL PROGRAM,

BUT IT'S NOT
A MEDICARE ADVANTAGE.

WE'VE ALSO RECEIVED DISPUTES
FOR CONTRACTED PROVIDERS.

AND WHEN WE SEND OUR
ACKNOWLEDGEMENT LETTER TO YOU

ON A CASE THAT WE HAVE
ACCEPTED AS A VALID CASE,

WE ALERT YOU THAT
THIS IS A DISPUTE

BETWEEN A NON-CONTRACTED
PROVIDER IN THE PLAN,

AND THAT IF YOU KNOW
OTHERWISE, LET US KNOW.

BUT WE SEE SOME UP FRONT
WHERE THEY IDENTIFY THEMSELVES

AS A CONTRACTED PROVIDER,
THEY'VE GOT SOME BEEF WITH YOU,

AND THEY COME TO US,
AND WE DISMISS THAT

AS NOT

IN OUR JURISDICTION.

UM, AND THEN WE'VE RECEIVED
A HANDFUL OF DUPLICATE REQUESTS.

THESE ARE RELENTLESS
PROVIDERS, AS YOU KNOW.

SO...UM...

AND I GUESS I JUST WANT
TO REITERATE THE TYPES OF CASES

THAT YOU SHOULD BE REFERRING
PROVIDERS ONTO US ARE THOSE

WHERE YOU'VE MADE PAYMENT,
OR HAVE CONSIDERED PAYMENT

FOR THAT SERVICE INCLUDED
IN ANOTHER SERVICE--YOU KNOW,

A BUNDLING KIND OF ISSUE--AND
NOT MEDICAL NECESSITY CASES.

UM...SO ANYTIME
A PAYMENT IS MADE,

IT'S A LIKELY CANDIDATE

FOR OUR DISPUTE
RESOLUTION PROCESS.

I THINK WE'RE GOING TO HAVE
SOME TIME FOR QUESTIONS

AFTERWARDS, BUT I'M GOING
TO TURN IT OVER TO PAUL NOW.

>> I DID WANT TO FOLLOW UP
ON ONE THING THAT SHE SAID

AND JUST TO POINT OUT TO YOU,
IT IS TRUE THAT PROVIDERS

MUST FOLLOW YOUR PROCESS,

SO YOU HAVE TO HAVE
A PROCESS IN PLACE.

NOW, OUR REGULATIONS
DON'T DICTATE

WHAT YOUR INTERNAL
DISPUTE PROCESS IS

IN TERMS OF HOW LONG
YOU GIVE THE PROVIDER.

SO, THAT'S SOMETHING THAT YOU
NEED TO THINK ABOUT TO MAKE SURE

IT'S CLEAR, BECAUSE IF YOU
HAVE AN INTERNAL DISPUTE

PROCESS THAT SAYS, "THIS
PROVIDER MUST DISPUTE

THIS PAYMENT WITHIN 60 DAYS,"

AND HE DISPUTES IT WITHIN
90 DAYS AND COMES TO US,

THAT'S SOMETHING
THAT WE WILL DISMISS,

BECAUSE THEY HAVEN'T FOLLOWED
YOUR INTERNAL PROCESS.

SO THE ONUS IS
ON THE PROVIDER.

YOU KNOW, WE TALK ABOUT THE 6
MONTHS WHERE WE CAN ACTUALLY

GO BACK 6 MONTHS,
AND THAT'S TRUE,

BUT THAT'S IF HE'S
FOLLOWED YOUR PROCESS,

OR WITHIN THAT 6 MONTHS
YOU ISSUED A PAYMENT DECISION.

SO THEY HAVE
TO FOLLOW YOUR PROCESS.

NOW IN TERMS OF EFFECTUATION,

I SAID EARLIER THAT

THERE IS A 30-DAY PERIOD

WHERE CMS EXPECTS PLANS
AFTER A DECISION

IS RENDERED BY FIRST COAST,

AND THEY ISSUE
THAT DECISION TO YOU,

YOU SHOULD EFFECT
THAT PAYMENT WITHIN 30 DAYS.

AND WHAT WE'LL DO, WE'LL
CONTINUE TO MONITOR THIS.

AND, AS YOU KNOW, IF YOU'VE
BEEN INVOLVED IN THIS PROCESS,

YOU HAVE TO NOTIFY FIRST COAST
THAT THE PAYMENT WAS MADE,

AND MOST PLANS
HAVE BEEN DOING THAT.

I THINK OVER
THE LAST FEW MONTHS

WE'VE HAD ALMOST 100%
COMPLIANCE WHEN A DECISION

HAS BEEN MADE THAT WAS
UNFAVORABLE TO THE PLAN.

YOU KNOW, YOU HAVE
ISSUED THAT PAYMENT

AND ALSO NOTIFIED
FIRST COAST.

SO CONTINUE TO DO THAT.

THAT IS A PART OF OUR,
YOU KNOW, COMPLIANCE STRATEGY

TO MAKE SURE THAT, YOU KNOW,
NON-CONTRACTED PROVIDERS

DO RECEIVE WHAT THEY WOULD
GET UNDER ORIGINAL MEDICARE.

JUST SOME BACKGROUND
IN TERMS OF HOW WE PROMOTED

THE PROGRAM, THERE WERE HPMS
MEMOS THAT WENT OUT

BACK IN 2008
WHEN WE FIRST STARTED.

THE LAST ONE WAS
IN JANUARY 4, 2010,

AND THAT DISCUSSED HOW
WE EXPANDED THE PROCESS.

CMS ALSO HAS PUT OUT A GUIDE
FOR OUT-OF-NETWORK PAYMENTS

THAT RECENTLY
HAVE BEEN UPDATED,

AND YOU SHOULD CHECK
OUR WEB PAGE.

IT'S NOT SOMETHING THAT COMES
OUT THROUGH OUR DIVISION,

BUT IT IS AT CMS,
AND IT SORT OF EXPLAINS,

YOU KNOW, HOW YOU SHOULD
MAKE THESE PAYMENTS

FOR OUT-OF-NETWORK PROVIDERS.

IT ALSO TALKS
ABOUT OUR PROCESS, TOO,

SO THAT WAS GOOD.

I GUESS IN THE PRIVATE
FEE-FOR-SERVICE PLANS,

IT WAS
IN THEIR TERMS AND CONDITIONS,

SO NON-CONTRACTED PROVIDERS

SORT OF KNEW IF THEY READ

YOUR TERMS AND CONDITIONS

THAT THIS PROCESS
WAS AVAILABLE.

WE DID REACH OUT TO THE
AMERICAN HOSPITAL ASSOCIATION

AND THE AAMA, AS WELL
AS A COUPLE OF OTHER NATIONAL

GROUPS TO LET
THEIR MEMBERS KNOW.

AND WE CONTINUE TO DO
OTHER OUTREACH ARTICLES.

AS SHERI SAID, THERE
WERE SEVERAL PUBLICATIONS

THAT DISCUSSED THIS PROCESS.

ONE OF THE IMPORTANT THINGS
THAT WE HAVE AT CMS SURROUNDING

THIS PROCESS IS OUR
STAKEHOLDER GROUP,

AND WE MEET BIWEEKLY.

BECAUSE, AGAIN,
THIS WAS A PROCESS

THAT WE STARTED FROM SCRATCH.

IT HADN'T BEEN A PART OF CMS,

AND, YOU KNOW,
IT'S A HUGE UNDERTAKING

IN TERMS OF ESTABLISHING,
YOU KNOW, THIS TYPE

OF DISPUTE PROCESS
THAT BOTH PARTIES

WILL RESPECT
AND, YOU KNOW, ABIDE BY.

SO SHERI AND THEM, THEY'VE

ALSO DEVELOPED A MANUAL

THAT'S ON THEIR WEB PAGE,

AND IS ALSO ON OURS
THAT SORT OF DESCRIBES

HOW THE PROCESS WORKS.

AND, AGAIN, WE'RE GOING
TO CONTINUE TO GET REPORTS

FROM THEM THAT, YOU KNOW,
WE'LL BE ABLE TO SHARE

IN TERMS OF TRENDS,
YOU KNOW,

AND FREQUENTLY CLAIMS
THAT ARE UNDERPAID.

I DON'T WANT TO, YOU
KNOW--I KNOW IT SOUNDS SORT

OF PESSIMISTIC,
BUT FOR THE MOST PART,

NON-CONTRACTED PROVIDERS
ARE PAID CORRECTLY.

I MEAN, WHAT WE SEE ARE
THE ONES WHO ARE DISPUTING IT.

WE DON'T SEE
THE HUNDREDS OF THOUSANDS

WHERE THERE IS NO DISPUTE AND
THE PLAN WAS PAID CORRECTLY.

SO, I DON'T WANT TO GIVE
A FALSE IMPRESSION THAT, OH,

ALL CLAIMS ARE NOT
BEING PAID CORRECTLY.

MOST OF THEM ARE.

AND EVEN SOME OF THE ONES
THAT HAVE BEEN DISPUTED

HAVE TURNED OUT THAT
YOU HAVE PAID CORRECTLY.

I THINK THAT'S
ABOUT 35% OF THEM.

UH, I THINK WE'RE VERY PLEASED
THUS FAR, YOU KNOW,

FOR THE 2 YEARS THE PROGRAM
HAS BEEN OPERATING.

SOME OF THE PROVIDERS
HAVE SUPPORTED OUR DECISION

AND THEY'RE GLAD THAT
THIS PROCESS IS IN PLACE,

AS WELL AS SOME OF THE MANAGED
CARE ORGANIZATIONS.

OR MOST OF THEM, YOU KNOW,
HAVE BEEN--YOU KNOW,

WE'VE BEEN PLEASANTLY SURPRISED
THAT THEY'VE BEEN SUPPORTIVE.

AGAIN, THERE IS ENHANCED
TECHNICAL GUIDANCE

AND EDUCATIONAL RELATED THINGS

THAT WE CAN GET FROM THIS
IN TERMS OF THE PROPER PAYMENT

AND HOW YOU CAN MAKE BETTER
PAYMENTS IN THE FUTURE.

AND I THINK IT ALSO
GIVES GREATER CONFIDENCE

IN THE PROGRAM TO KNOW THAT
THIS TYPE OF DISPUTE PROCESS

IS AVAILABLE
TO NON-CONTRACTED PROVIDERS.

AND ONE THING THAT WE DIDN'T
DO OVER THE FIRST 2 YEARS--

YOU KNOW, WE TALKED ABOUT
THE COMPLIANCE PROGRAM IN TERMS
OF EFFECTUATION
OF THE PAYMENT.

THAT'S SOMETHING
THAT'S PRETTY CLEAR-CUT.

IF, YOU KNOW, YOU SAY YOU HAVE
30 DAYS TO MAKE THE PAYMENT

AND IT'S NOT MADE,
THAT'S SOMETHING WE CAN DOCUMENT

AND TAKE ACTION ON
IF THAT PROBLEM CONTINUES.

WE DIDN'T WANT TO USE THIS

AS JUST SOME
GENERAL COMPLIANCE ISSUE

BECAUSE A CERTAIN PLAN RECEIVED
A LOT OF PAYMENT DISPUTES.

THAT WAS REALLY
NOT AN INDICATION

THAT, YOU KNOW, THEY'RE
PAYING A LOT OF CLAIMS WRONG.

IT JUST COULD BE, YOU KNOW,
WE DON'T KNOW HOW MANY CLAIMS

THAT THEY'RE PAYING.

SO WE DIDN'T WANT TO JUST JUMP
TO A CONCLUSION AND USE THAT

IN OUR COMPLIANCE
STRATEGY TO SAY,

"WELL, YOU KNOW,
YOU CAN'T PAY CLAIMS,"

OR THIS SORT OF THING.

THAT'S NOT WHAT
THIS WAS ABOUT.

THERE'S MY CONTACT
INFORMATION AND SHERI'S.

AS I SAID,
IF YOU HAVE QUESTIONS,

FEEL FREE TO ASK THEM.

I WAS HERE A COUPLE
OF MONTHS AGO

WITH THE HOSPITAL ASSOCIATION
AND WE WERE JUST INUNDATED

WITH QUESTIONS
OF THIS PROCESS.

UH...WE SPOKE IN BALTIMORE

AND WE DIDN'T GET ANY
QUESTIONS FROM THE PLANS,

WHICH WAS
SORT OF SURPRISING.

BUT WE CAN TAKE QUESTIONS NOW,

OR WE'LL BE HERE TOMORROW
WHEN YOU CAN SUBMIT THEM.

BUT THANKS FOR YOUR ATTENTION.

[APPLAUSE]

OK, YES?

>> YES,
ON THE MANAGED CARE SIDE,

AS I WAS SAYING,

WE ARE REQUIRED
TO HAVE THE PROVIDERS

SIGN THE WAIVER
OF LIABILITY.

DOES FCSC REQUIRE THAT
DOCUMENTATION AS WELL?

>> OK,
THANK YOU FOR THE QUESTION,

AND THAT'S A QUESTION
THAT I ALWAYS GET.

AND THE SHORT ANSWER IS NO.

THERE'S NO WAIVER
OF LIABILITY NEEDED

FOR THE FIRST COAST PROCESS.

THIS IS A PROCESS THAT'S
STRICTLY A PROVIDER PROCESS.

THE BENEFICIARY IS
REALLY NOT IMPACTED,

SO IN THESE CASES YOU DON'T
NEED A WAIVER OF LIABILITY.

THAT'S ONLY WHEN
THE PAYMENT HAS BEEN DENIED

OUTRIGHT AND THAT CASE
GOES TO MAXIMUS.

SO THAT'S ONE
OF THE DISTINCTIONS.

AND LET ME JUST ADD

WE MADE SURE THAT WE HAD,

UH...BETH SCROY
ON OUR STAKEHOLDER GROUP.

AND SHE'S THE CONTRACT OFFICER
FOR THE MAXIMUS CONTRACT.

SO THERE'S GREAT COMMUNICATION
BETWEEN FIRST COAST

AND MAXIMUS TO MAKE SURE
THAT, YOU KNOW, IF WE GET CASES

THAT BELONG TO THEM, THAT GETS
TO THEM AND VICE VERSA.

IF THEY GET CASES, THEY'LL TRY
TO DIRECT THEM OUR WAY

THAT SHOULD BE GOING
TO FIRST COAST.

SO, NO, THAT'S--NO WAIVER
OF LIABILITY

THAT THE PROVIDER
HAS TO SIGN.

>> DO YOU HAVE PLANS TO SET
UP A CONTACT...[INDISTINCT]

WE'VE ONLY RECEIVED ONE THIS
YEAR...[INDISTINCT]

>> OK, NOW, ARE
YOU SAYING, UH...HPMS?

NOW, THESE REQUESTS
GO TO FIRST COAST

AND THEY COME
FROM THE PROVIDERS. SO...

>> [INDISTINCT DIALOGUE]

>> OH, OK. I'LL LET
SHERI ANSWER THAT ONE.

>> WE STARTED OUT USING--
HIS QUESTION IS,

HOW DO WE DETERMINE
WHO WE'RE GOING TO DIRECT

OUR CORRESPONDENCE TO
AT THE MA PLAN? UM...

WE'RE USING THE CORPORATE--
MEDICARE COMPLIANCE OFFICER

THAT'S LISTED IN HPMS UNLESS
YOU TELL US OTHERWISE.

SO YOU CAN CONTACT US
AT THAT EMAIL ADDRESS.

PDRC AT FCSO.COM,

AND LET US KNOW
WHO THEY SHOULD GO TO.

WE TRY TO FAX OUR DECISIONS

SO THAT YOU
HAVE THEM TIMELY.

SO WE WOULD WANT
THE CONTACT NAME,

AND THE FAX NUMBER,

AND TELEPHONE NUMBER,
EMAIL ADDRESS,

BECAUSE WE WANT TO TRY

TO KEEP THAT
COMMUNICATION OPEN.

AND WE UNDERSTAND THAT THAT
IS SOME OF THE PROBLEM,

THAT OUR DECISION--EVEN OUR
ACKNOWLEDGEMENT LETTER GOES

SOMEWHERE
IN YOUR ORGANIZATION

AND WE WANT TO GET IT
TO THE RIGHT PERSON.

SO DEFINITELY LET US KNOW
IF WE NEED TO CHANGE THAT.

>> YES,
THAT'S A GOOD POINT, SHERI,

THAT THE HPMS CONTACT
SHOULD BE UPDATED

SO WE'LL KNOW EXACTLY
WHO TO DIRECT IT TO.

BUT, AGAIN, YOU KNOW, YOU HAVE
OUR CONTACT INFORMATION

SO YOU CERTAINLY CAN
CONTACT SHERI OR MYSELF

IF YOU HAVE
UPDATED INFORMATION,

AND THEY WILL MAKE
SURE THAT IT GETS

TO THE RIGHT PERSON
IN THE ORGANIZATION.

BECAUSE SOMETIMES
IT COULD BE COMPLIANCE,

IT COULD BE
A CLAIMS PERSON.

YOU NEED TO
LET US KNOW. OK?

THANK YOU AGAIN.

[APPLAUSE]