



**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]