

Parts C and D Appeals Updates

Part C Regulatory Changes: Overview of CMS-4085 Changes

Application of Grijalva Notice & Appeal Requirements to HCPPs

Health Care Prepayment Plans (HCPP) must follow “Grijalva” notice and appeal requirements when enrollee services end in an in-network Comprehensive Outpatient Rehabilitation Facility (CORF)

Accepting Oral Organization Determination Requests

- Medicare health plans may accept standard organization determinations orally and in writing
- However, payment requests must be submitted in writing (unless a plan allows enrollees to submit payment requests orally)

Requirements for Providing a Notice of Appeal Rights

A Medicare health plan must automatically provide an enrollee written notice of appeal rights if it reduces or prematurely discontinues a previously authorized course of treatment

Enrollee Representatives

Enrollee representatives have the same rights and responsibilities when filing either grievances or appeals

Delivery of the Generic Notice

Providers, rather than plans, deliver the generic notices after a successful enrollee “Grijalva” or “Weichardt” appeal

Removal of the Word “Authorized”

Removed the word “authorized” as a description for representatives throughout Subpart M of Part 422

Reminders for MA plans

References

- 42 CFR 422.618 and 422.619
- MMCM Chapter 3, section 140

Effectuation Requirements

- Effectuating Determinations Reversed by the Health Plan
 - Standard Service Requests – authorize or provide NLT 30 calendar days
 - Expedited Service Requests – authorize or provide NLT 72 hours
 - Payment Requests – pay NLT 60 calendar days

Effectuation Requirements (Continued)

- Effectuating Determinations Reversed by the IRE
 - Standard Service Requests – authorize within 72 hours; provide NLT 14 calendar days
 - Expedited Service Requests – authorize or provide NLT 72 hours
 - Payment Requests – pay NLT 30 calendar days
 - Health Plan must inform IRE of effectuation – 14 calendar days from date of payment or authorization/provision of service

Effectuation Requirements (Continued)

- Effectuating Decisions by other Review Entities (ALJ or MAC)
 - Pay for, authorize, or provide NLT 60 calendar days
 - Exception – MAC review of ALJ decision
 - Health Plan must inform IRE of effectuation – 14 calendar days from date of payment or authorization/provision of service

Effectuation Requirements (Continued)

- IRE developed Statement of Compliance form
- Reconsideration Process Manual for IRE (MAXIMUS Federal Services, Inc.) www.medicareappeal.com

Process for Accepting Standard Oral Reconsideration Requests

- Chapter 13, § 70.2
- Must obtain a signed acknowledgement from the enrollee
 - sets forth the facts and basis of the oral appeal request

Non-Contract Providers as Appellants

- Medicare Managed Care Manual Chapter 13, sections 40.2.3 and 60.1.4; IRE Reconsideration process Manual, section 4.2.2.1
- Notice Requirements
- Waiver of Liability

Overview of the Payment Dispute Resolution Program (PDRP)

Non-Contract Providers – Payment Dispute Process

- New for 2010
 - Expanded the Private Fee-For-Service payment dispute resolution process to cover all MA plan types
- Non-contract providers may submit down-coded claims for review based on disputes involving medical necessity, coding, etc.

Non-Contract Providers – Payment Dispute Process (Continued)

- The PDRP is available only for claims where some payment was made
- For full denials, non-contract providers continue to sign the waiver of liability and utilize the Subpart M appeals process (Part C IRE, Maximus)

Non-Contract Providers – Payment Dispute Process (Continued)

- Non-contract providers must attempt to resolve the dispute through the internal plan process first
 - If the non-contract provider is not satisfied with the plan's decision or the plan doesn't attempt to resolve it in a timely manner, the non-contract provider can submit the claim to FCSO
- Unlike the Subpart M appeals process, FCSO's decision is final and binding on both the health plan and non-contract provider

Contact Information

- For further information about the PDRP, please contact Paul Foster at: paul.foster@cms.hhs.gov.
- See also First Coast Service Options, Inc. information at www.fcso.com.

Part D

Part D Regulatory Changes: Overview of CMS-4085 Changes

Standard Coverage Determination Requests

- Plan sponsors must accept standard coverage determination requests orally and in writing
- However, standard requests for payment must be submitted in writing (unless a plan sponsor allows enrollees to submit payment requests orally)

Requests for Reimbursement

- Plan sponsor must notify the requestor of the decision within 14 calendar days after receiving the request
- If the decision is favorable, the plan sponsor must also provide payment within 14 calendar days after receiving the request

Standard Coverage Determination Decisions

- Plan sponsors must provide written notice of favorable and unfavorable standard coverage determination decisions
- Initial notice of a favorable decision may be provided verbally,
- So long as the written notice is mailed within three calendar days after providing the verbal notice
- Added form and content requirements for approval notices

Expedited Coverage Determination Decisions

- Plan sponsors must provide written notice of favorable and unfavorable expedited coverage determination decisions
- Initial notice of a decision may be provided verbally,
- So long as written notice is mailed within three calendar days after providing the verbal notice
- Added form and content requirements for approval notices

Expedited Redetermination Decisions

- Plan sponsors must provide written notice of favorable and unfavorable expedited redetermination decisions
- Initial notice of a decision may be provided verbally, so long as written notice is mailed within three calendar days after providing the verbal notice
- Added form and content requirements for approval notices

Part D Regulatory Changes: Overview of CMS-4127 Changes

Reopening and Revising Decisions

- 42 CFR §§ 423.1978 - 423.1986
- A plan sponsor may revise a coverage determination or redetermination decision on its own motion or at the request of an enrollee
- A plan sponsor cannot reopen and revise a decision once an appeal has been requested

Reopening and Revising Decisions

(Continued)

- A plan sponsor may reopen and revise a decision it makes within one year from the date of the decision for any reason, or within four years from the date of the decision for good cause as defined in § 423.1986
- A plan sponsor may reopen and revise a decision it makes at any time if reliable evidence of fraud or similar fault exists, as defined in § 405.902

Reopening and Revising Decisions

(Continued)

- An enrollee may ask a plan sponsor to reopen and revise a decision it makes:
 - Within one year for any reason
 - Within four for good cause, as defined in §423.1986
- A decision not to reopen is not subject to review
- The filing of a reopening request does not relieve the plan sponsor from its obligation to provide benefits or make payment

Reminders for Part D Plan sponsors

Submitting Reconsideration Cases and Contact Changes

- PDPs should send auto-forwarded Part D benefit reconsideration cases to the **Fairport, NY office** (not King of Prussia, PA office)
- Part D plan contact changes should be e-mailed to **Part D QIC/Maximus** plan liaison

Accuracy of Prescriber Information

- Part D QIC continues to receive inaccurate prescriber information from plans
 - Check the accuracy of this information to prevent possible PHI breaches
- Draft revisions to Chapter 18 of the Prescription Drug Benefit Manual