



CMS 2010 MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLAN SPRING CONFERENCE
Sheraton Baltimore City Hotel, April 20-21, 2010
Verbatim Transcript
Part C Regulatory Changes: Overview of CMS-4085 Changes

GOOD AFTERNOON.
MY NAME IS TIM ROE,

AND I WORK
ON THE PART "C"

APPEALS LAW
AND POLICY

IN THE DIVISION
OF APPEALS POLICY

WITHIN THE MEDICARE
ENROLLMENT AND APPEALS GROUP,

AND I'M JUST GONNA SPEND
THE NEXT FEW MINUTES

DISCUSSING PART "C" APPEALS,
REGULATORY CHANGES

DUE TO FINAL RULE 4085.

APPLICATION OF GRIJALVA NOTICE

AND APPEAL REQUIREMENTS
TO HCPPs.

SINCE HEALTH CARE
PREPAYMENT PLANS PROVIDE

ONLY PART "B" SERVICES,
WHEN APPLYING PART "C"

APPEALS REGULATIONS
TO PART "E" PLANS--

PART "E" PLANS BEING
COST PLANS--AND HCPPs,

IN THE JANUARY 28, 2005,
FINAL RULE,

WE EXCLUDED INPATIENT HOSPITAL
AND SNF, CORF,

AND HOME HEALTH APPEAL RIGHTS,

THINKING THAT THESE WERE
PART "A" SERVICES

OR SETTINGS THAT WERE NOT
APPLICABLE TO HCPPs.

AND THEN WE LATER REALIZED
THAT SINCE CORF SERVICES FALL

UNDER PART "B," THAT PORTION
OF THE GRIJALVA RULES

SHOULD APPLY TO HCPPs.

THE NEXT SLIDE IS
ACCEPTING ORAL ORGANIZATION

DETERMINATION REQUESTS.

BECAUSE OUR REGULATIONS HAVE
BEEN SILENT ON THE MANNER

IN WHICH AN ENROLLEE
MUST REQUEST

A STANDARD ORGANIZATION
DETERMINATION

BUT HAVE EXPLICITLY ALLOWED
ORAL EXPEDITED

ORGANIZATION DETERMINATIONS

AND THE FACT THAT MEDICARE
HEALTH PLANS HAVE BEEN

ACCEPTING STANDARD ORGANIZATION
DETERMINATION REQUESTS

BY PHONE AND OTHER METHODS
FOR MANY YEARS,

CMS DECIDED TO CLEARLY ALLOW
BOTH ORAL AND WRITTEN

STANDARD PRESERVICE REQUESTS
FROM ENROLLEES.

HOWEVER, HEALTH PLANS CONTINUE

TO HAVE DISCRETION

ON HOW TO ACCEPT
PAYMENT REQUESTS.

THE NEXT SLIDE IS
REQUIREMENTS FOR PROVIDING

A NOTICE OF APPEAL RIGHTS.

PREVIOUSLY, THE REGULATION
REQUIRED THE ENROLLEE

TO DISAGREE WITH
THE TERMINATION OR REDUCTION

OF A PREVIOUSLY AUTHORIZED
COURSE OF TREATMENT.

HOWEVER, PREAMBLE DISCUSSIONS
INVOLVING THIS RULE,

BOTH PRE- AND POST-GRIJALVA,
INDICATED THAT THIS WAS

AN AREA THAT REMAINED
A BIT UNSETTLED.

FOR VARIOUS REASONS,
INCLUDING BECAUSE THE ENROLLEE

IN EFFECT ALREADY RECEIVED
A FAVORABLE

ORGANIZATION DETERMINATION
INVOLVING A COURSE OF TREATMENT,

WE DECIDED TO NO LONGER REQUIRE
ENROLLEE DISAGREEMENT

IN ORDER TO TRIGGER NOTICE
AND APPEAL RIGHTS

WHEN ENDING OR REDUCING
A DOCUMENTED, PLANNED COURSE OF TREATMENT

IN ANY SETTING.

HOWEVER, UNLIKE SERVICES
OR THE STAY ENDING

IN INPATIENT HOSPITAL SNF, CORF,
OR HOME HEALTH SETTINGS,

ONCE THE DOCUMENTED COURSE OF
TREATMENT HAS ENDED AS PLANNED

IN ANY OTHER SETTING,
ANY FURTHER REQUEST

OF THOSE SERVICES ARE TREATED

AS NEW ORGANIZATION
DETERMINATIONS.

THE NEXT SLIDE IS ABOUT
ENROLLEE REPRESENTATIVES

FILING GRIEVANCES.

BECAUSE OF EXPLICIT AUTHORITY
UNDER SECTION 1852(F) AND (G)

OF THE SOCIAL SECURITY ACT,

ENROLLEE REPRESENTATIVES
HAVE ALWAYS HAD

THE SAME RIGHTS
AND RESPONSIBILITIES

WHEN FILING A GRIEVANCE
AS THEY DO WITH AN APPEAL.

THIS IS A TECHNICAL REVISION
IN ORDER TO CLEARLY IMPLEMENT

THE ACT AND BE CONSISTENT
WITH THE PART "B" REPRESENTATIVE

REGULATORY LANGUAGE.

DELIVERY OF THE GENERIC NOTICE.

THIS CHANGE WAS PURELY
A TECHNICAL CORRECTION

TO PRIOR REGULATORY GUIDANCE.

WE INADVERTENTLY DIRECTED
THE MEDICARE HEALTH PLAN

TO DELIVER THE NOTICE
OF MEDICARE NONCOVERAGE

IN A SNF, CORF,
OR HOME HEALTH SETTING

AND THE IMPORTANT MESSAGE
FOR MEDICARE

IN THE INPATIENT
HOSPITAL SETTING

AFTER A SUCCESSFUL
ENROLLEE APPEAL.

HOWEVER, ALL OTHER AUTHORITIES,
BEING THE ACT,

LAWSUIT SETTLEMENTS,

OTHER SECTIONS
OF THE REGULATIONS, ET CETERA,

MAKE IT CLEAR THAT THE PROVIDER
RATHER THAN THE HEALTH PLAN

IS ALWAYS RESPONSIBLE
FOR DELIVERING

THESE GENERIC NOTICES REGARDLESS
OF THE ENROLLEE'S STATUS.

THE NEXT SLIDE INVOLVES REMOVAL
OF THE WORD "AUTHORIZED"

NEXT TO "REPRESENTATIVE"
IN THE REGULATION.

THIS CHANGE IS ALSO
A TECHNICAL CORRECTION

IN ORDER TO BE CONSISTENT
THROUGHOUT THE APPEALS SECTION

AND TO ALSO ENSURE THAT READERS
UNDERSTAND THAT OUR INTENTION

IS NOT TO LIMIT WHAT WE MEAN
BY A REPRESENTATIVE.

THE TERM "AUTHORIZED"
USUALLY MEANS

STATE-APPOINTED REPRESENTATIVES,

PERHAPS DUE TO ISSUES
OF COMPETENCY,

WHILE THE TERM APPOINTED
MEANS SOMEONE

AN ENROLLEE CONSCIOUSLY CHOOSES
TO REPRESENT HIM OR HER

DURING AN APPEAL.

WE NEVER INTENDED TO
DISTINGUISH THE TWO

OR TREAT THEM DIFFERENTLY,

AND THEREFORE, WE ONLY USE
THE TERM "REPRESENTED"--

"REPRESENTATIVE" THROUGHOUT
SUBPART "M".

AND I'M GONNA PASS
THE MICROPHONE TO BEVERLY SGROI

TO DISCUSS EFFECTUATION ISSUES
AND OTHER TOPICS.

THANK YOU.

GOOD AFTERNOON,
EVERYONE.

I'M JUST GOING TO GO
OVER A FEW REMINDERS

FOR THE HEALTH PLANS.

THE FIRST IS...

THE EFFECTUATION REQUIREMENTS,

AND THESE ARE
THE REFERENCE AREAS

WHERE YOU CAN FIND
THE INFORMATION

CONCERNING STANDARD
RECONSIDERATION

DETERMINATIONS OR DECISIONS,

AND THAT CAN BE FOUND
IN THE REGULATION

AT 42 CFR, SECTION 422.618,

AND FOR EXPEDITED

REDETERMINATIONS

IN SECTION 422.619,

AND ALSO,
THE EFFECTUATION REQUIREMENTS

ARE COVERED IN OUR
"MEDICARE MANAGED CARE MANUAL,"

CHAPTER 13, SECTION 140.

THIS SLIDE SHOWS
THE EFFECTUATION DETERMINATIONS

WHEN THE DECISION IS REVERSED
BY THE HEALTH PLAN,

AND SO WHEREUPON
RECONSIDERATION REVERSES

ITS ADVERSE
ORGANIZATION DETERMINATION,

THESE ARE THE TIME FRAMES
FOR EFFECTUATING

THAT REVERSED DECISION.

HERE ARE THE EFFECTUATION
TIME FRAMES

WHEN THE HEALTH PLAN'S
DETERMINATION IS REVERSED

IN WHOLE OR IN PART
BY OUR INDEPENDENT REVIEW ENTITY

MAXIMUS FEDERAL SERVICES.

OF PARTICULAR IMPORTANCE
IS THE HEALTH PLAN'S

RESPONSIBILITY
TO NOTIFY MAXIMUS

WHEN THE EFFECTUATION
DOES OCCUR,

AND THESE ARE
THE EFFECTUATION REQUIREMENTS

REGARDING REVERSALS
FROM EITHER

AN ADMINISTRATIVE
LAW JUDGE HEARING

OR A MEDICARE
APPEALS COUNCIL REVIEW.

AND YOU WILL NOTE THAT
THE ONLY EXCEPTION

TO THE EFFECTUATION REQUIREMENTS
OCCUR WHEN A HEALTH PLAN

HAS REQUESTED A MEDICARE
APPEALS COUNCIL REVIEW

OF AN ALJ HEARING DECISION.

AND AGAIN, HEALTH PLANS MUST
INFORM MAXIMUS

WHEN THAT EFFECTUATION
HAS OCCURRED.

AND FINALLY, HEALTH PLANS
ARE STRONGLY ENCOURAGED

TO USE THE STATEMENT
OF COMPLIANCE FORM

THAT HAS BEEN DEVELOPED
BY MAXIMUS

WHEN SUBMITTING THEIR
EFFECTUATION NOTIFICATIONS.

AND I'VE INCLUDED ON THIS SLIDE
THE WEB ADDRESS FOR MAXIMUS,

WHERE YOU CAN FIND
THEIR "RECONSIDERATION PROCESS MANUAL,"

AS WELL AS OTHER
USEFUL INFORMATION.

SECOND REMINDER TOPIC
CONCERNS STANDARD ORAL

RECONSIDERATION REQUESTS.

IF A HEALTH PLAN DECIDES
TO ACCEPT

STANDARD ORAL

RECONSIDERATION REQUESTS,

THE HEALTH PLAN MUST FOLLOW
THE GUIDELINES ESTABLISHED

IN THE MANUAL AT SECTION 70.2,

WHICH INCLUDES SENDING
AND RECEIVING BACK

FROM THE ENROLLEE
A SIGNED ACKNOWLEDGEMENT

OF THE APPEAL ISSUE.

AND THE FINAL REMINDER TOPIC
CONCERNS APPEALS

FROM NON-CONTRACT PROVIDERS,

SPECIFICALLY
THE "MANAGED CARE MANUAL,"

SECTION 40.2.3, ADDRESSES
THE NOTICE REQUIREMENTS

WHEN A HEALTH PLAN
DENIES PAYMENT

OF A NON-CONTRACT
PROVIDER'S CLAIM.

CMS WILL BE UPDATING
THIS MANUAL SECTION

TO CLARIFY THAT A NDP,
THE NOTICE OF DENIAL OF PAYMENT,

IS TO BE USED TO CONVEY
THE PAYMENT DENIAL.

AND FINALLY,
MANUAL SECTION 60.1.4

PROVIDES THE GENERAL
REQUIREMENTS CONCERNING

NON-CONTRACT PROVIDER APPEALS,
INCLUDING THE REQUIREMENTS

CONCERNING THE WAIVER
OF LIABILITY FORM.

AND NOW I'LL TURN IT OVER

TO PAUL FOSTER,

WHO WILL DISCUSS THE PAYMENT
RESOLUTION DISPUTE PROCESS.

THANK YOU, BEVERLY.

AS SHE SAID,
I'M PAUL FOSTER

FROM THE MEDICARE DRUG
AND HEALTH PLAN

CONTRACT ADMINISTRATION GROUP.

LET ME BEGIN BY THANKING
THE MEDICARE ENROLLMENT AND APPEALS GROUP

FOR THIS OPPORTUNITY
TO DISCUSS VERY BRIEFLY

THE NON-CONTRACTED PROVIDER
PAYMENT DISPUTE PROGRAM.

AS YOU MAY KNOW,
THERE ARE IMPORTANT DIFFERENCES

BETWEEN THE TWO PROGRAMS.

ONE DEALS PRIMARILY
WITH BENEFICIARY APPEALS

WHEN SERVICES ARE DENIED
AND NO PAYMENT HAS BEEN MADE

WHILE THE OTHER DEALS
EXCLUSIVELY

WITH NON-CONTRACTED PROVIDERS
DISPUTING A PAYMENT AMOUNT

WHEN SOME AMOUNT OF PAYMENT
HAS BEEN MADE.

I'M GOING TO DISCUSS
THE LATTER PROGRAM,

INVOLVING THE NON-CONTRACTED
PROVIDER PAYMENT DISPUTES.

MANY OF YOU KNOW
WE FIRST CONTRACTED

WITH FIRST COAST SERVICE OPTIONS

TO HANDLE DISPUTES

BETWEEN PRIVATE
FEE-FOR-SERVICE PLANS

AND DEEMED
OR NON-CONTRACTED PROVIDERS

ON JANUARY 1, 2009.

ON JANUARY 1, 2010,
WE EXPANDED OUR CONTRACT

TO INCLUDE ALL MA PLANS,
COST PLANS, DEMONSTRATIONS,

PATIENT ORGANIZATIONS,
EVERYBODY ACTUALLY.

NOW I NOTE THAT
ON OUR FIRST SLIDE

IT SAYS THAT THIS
IS NEW FOR 2010.

NOW IN FAIRNESS,
WHAT IS NEW

IS THAT FOR THE FIRST TIME
WE HAVE DELEGATED

THIS RESPONSIBILITY
TO A CONTRACTOR

EXPERIENCED AND QUALIFIED
TO DETERMINE THE AMOUNT

A NON-CONTRACTED PROVIDER IS DUE
UNDER ORIGINAL MEDICARE.

TO BE SURE, IT HAS ALWAYS
BEEN THE CASE THAT MA PLANS

SHOULD BE REIMBURSING
NON-CONTRACTED PROVIDERS

NO LESS THAN THEY WOULD RECEIVE
UNDER ORIGINAL MEDICARE,

BUT WHAT WE LACKED WAS
A FORMAL DISPUTE PROGRAM

TO RESOLVE DISPUTES
WHEN MA PLANS

AND NON-CONTRACTED PROVIDERS
DISAGREE ON THE PAYMENT AMOUNT.

THIS FORMAL PROCESS
IS WHAT WE'LL ACHIEVE

WITH FIRST COAST OPTIONS,
INCORPORATED.

AND...

AS WE SAID, WE EXPANDED IT
IN JANUARY 1, 2010.

LET ME JUST GO OVER SOME
OF THE HIGHLIGHTS BRIEFLY.

ONE ISSUE THAT WE ALWAYS HAVE
OR THAT IS NEW

IS THE NON-CONTRACTED PROVIDERS
MAY SUBMIT WHAT WE CALL

DOWN-CODED CLAIMS FOR REVIEW

BASED ON DISPUTES INVOLVING
MEDICAL NECESSITY.

NOW GENERALLY,
FIRST COAST JUST LOOKS

AT WHEN THERE'S
A PAYMENT DISPUTE.

NOW WE CONSIDER IF A PLAN
IS DOWN-CODING

THAT IN THAT SITUATION
SOME PAYMENT HAS BEEN MADE.

SO IN A SITUATION WHERE YOU
MAY LOWER THE CODE OR SOMETHING

AND A PAYMENT WAS MADE,
FIRST COAST COULD HANDLE THAT.

THEY WOULDN'T HANDLE IT
IF SERVICE WAS DENIED.

SO FOR THAT LIMITED
NUMBER OF CASES

THEY WOULD HANDLE THAT

IF A PAYMENT WAS MADE

AND THE PAYMENT WAS BUNDLED
OR SOMETHING LIKE THAT.

THAT IS SOMETHING
THEY WOULD HANDLE.

AGAIN, IT'S ONLY AVAILABLE
FOR SITUATIONS

WHERE THE MA PLAN HAS ACTUALLY
MADE SOME TYPE OF PAYMENT.

IF NO PAYMENT WAS MADE,
THEN IT WOULD BE SOMETHING

THAT WOULD GO TO MAXIMUS.

AND MY NEXT SENTENCE SAYS THAT.

FOR FULL DENIALS,
NON-CONTRACTED PROVIDERS

CONTINUE TO SIGN THE WAIVER
OF LIABILITY FORM

AND UTILIZE THE SUBPART "M"
APPEALS PROCESS.

NOW WHAT WE REQUIRE
OF THE PROVIDERS IS THAT

THEY MUST FIRST ATTEMPT
TO RESOLVE THE DISPUTE

THROUGH THE INTERNAL
PLAN PROCESS.

SO AS THE MA PLAN--
ONCE YOU MAKE A PAYMENT

TO A PROVIDER, THEY MUST
FIRST COME TO YOU

AND SAY--WELL,
IF THEY DISAGREE,

THEY MUST FIRST USE
YOUR PROCESS

BEFORE THEY CAN GO
TO FIRST COAST.

NOW UNLIKE THE SUBPART "M"
APPEAL PROCESS,

THE FIRST COAST DECISION
IS A BINDING DECISION

ON THE PLAN,

AND WHAT WE'RE DOING,
WE'RE TRACKING IT

TO MAKE SURE THAT IF THERE
WAS AN UNDERPAYMENT

THAT THE PLAN ACTUALLY
MAKES THAT PAYMENT

TO THE PROVIDER.

AND THAT'S BASICALLY ALL
THAT I'M GONNA PRESENT TODAY

ABOUT THE PROCESS.

WE DID SEND OUT A HPMS MEMO
THAT I'M SURE THE PLANS GOT,

AND HOPEFULLY, YOU'VE BEEN--

WELL, HOPEFULLY, YOU HAVEN'T
BEEN DEALING WITH FIRST COAST.

MAYBE YOU'VE BEEN MAKING
ALL THE PAYMENTS CORRECTLY,

BUT IF YOU HAVE,
HOPEFULLY THE PROCESS

HAS BEEN GOING SMOOTHLY.
THANK YOU.