Medicare Advantage

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Basics:

- Medicare Advantage Organizations (MAOs) are private health plans that administer the Medicare benefit.
- MAOs are different than supplements – they cover both the Medicare portion of the claim and all or part of the member cost sharing.
- Must cover all Part A and Part B benefits
- Must comply with the relevant LCDs and NCDs

The Basics - Flexibility

- May impose utilization review features, such as referral requirements or prior authorization, not required by original Medicare.
- The can review medical necessity in instances in which Medicare FFS automatically makes payment.
- Are not required to pay contracting providers in the same amount or manner as original Medicare
- Can choose to cover benefits beyond Part A and Part B.

Basics

- A Medicare Advantage organization must generally be organized and licensed under state law as a risk bearing entity.
- States may regulate solvency and licensure of Medicare Advantage plans
- Other state laws regulating the plans are preempted. For example, laws regulating prompt payment laws, recoupment, or external appeals laws.

Types of MA Plans

- Coordinated Care Plans
  - HMO with or with POS benefit
  - Local PPO
  - Regional PPO
- Other Plans
  - MSAs
  - PFFS plans

Types of plans -- Special Needs Plans (SNPs)

- Coordinated care plans that limit enrollment to either dual eligibles, individuals in institutions, or those with certain chronic conditions (e.g., diabetes, asthma, congestive heart failure…)
- Must file and follow a model of care

Types of MA plans

- Extremely important to know they type to understand the plan’s obligations and your rights.
- Every membership card indicates the type of MA plan.

Types of Participation Status

- In-network
- Out-of-network
- Deemed provider
  - Providers who furnish non-emergency services to PFFS members who do not have a written agreement with the plan

Sources of Rights and Responsibilities

- Contracted providers – Law and written contract
- Non-contracted providers – Law
- Deemed providers – Law and plan's "terms and conditions."

Examples of Why Plan Type and Participation Status are Important

- HMOs must cover emergency and urgent care services furnished by non-contract providers without prior authorization.
- PPOs must allow beneficiaries to receive covered services from any Medicare eligible provider without prior authorization.
- MAOs must pay non-contract providers what they would have received under Medicare FFS.
- Non-contract providers are prohibited from balance billing MAO members.
- There are regulatory prompt payment timelines for non-contract providers.

Questions and Answers

- Background: Care Improvement Plus

Question and Answers

- Coverage of items and services covered by FFS Medicare
  - Every Medicare Advantage Organization is obligated to maintain its summary of benefits online
  - Benefits are approved by CMS

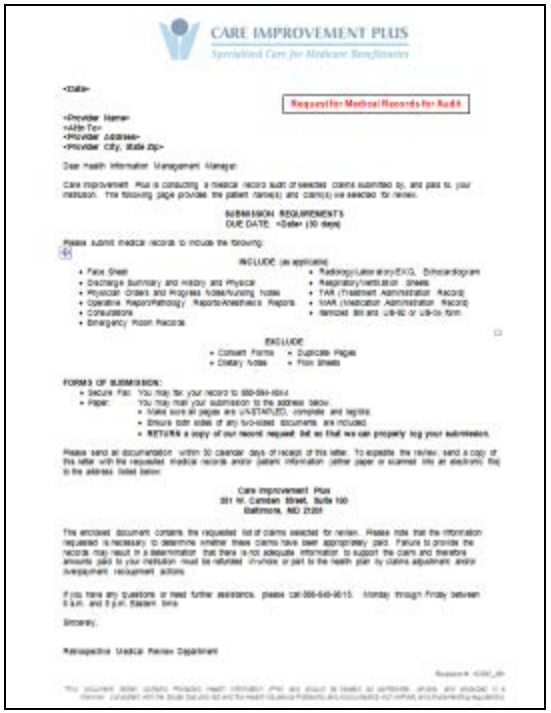
Questions and Answers

- Medical Record Requests

Medical Record Requests

- Medicare Advantage plans are required to review medical records for various reasons:
  - Risk Adjustment
  - Quality Improvement
  - STARs
  - Fraud, Waste and Abuse

- For the claims selected for audit, Care Improvement Plus will review the chart on-hand in order to cut down on duplicate requests.


CARE IMPROVEMENT PLUS

Specialized Care for Medicare Beneficiaries

<Date>

Request for Medical Records for Audit

<Provider Name>
<Attn To>
<Provider Address>
<Provider City, State Zip>

Dear Health Information Management Manager:

Care Improvement Plus is conducting a medical record audit of selected claims submitted by, and paid to, your institution. The following page provides the patient name(s) and claim(s) we selected for review.

SUBMISSION REQUIREMENTS
DUE DATE: <Date> (30 days)

Please submit medical records to include the following:

INCLUDE (as applicable)

- Face Sheet
- Discharge Summary and History and Physical
- Physician Orders and Progress Notes/Nursing Notes
- Operative Report/Pathology Reports/Anesthesia Reports
- Consultations
- Emergency Room Records
- Radiology/Laboratory/EKG, Echocardiogram
- Respiratory/ventilator sheets
- TAR (Treatment Administration Records)
- MAR (Medication Administration Records)
- Itemized bill and UB-92 or UB-04 form

EXCLUDE

- Consent Forms
- Dietary Notes
- Duplicate Pages
- Fax sheets

FORMS OF SUBMISSION:

- Secure Fax: You may fax your record to 888-594-1614
- Paper: You may mail your submission to the address below
  - Make sure all pages are LEGIBLE, complete and legible
  - Ensure both sides of any two-sided documents are included
  - RETURN a copy of our record request list so that we can properly log your submission.

Please send all documentation within 30 calendar days of receipt of this letter. To expedite the review, send a copy of this letter with the requested medical records and/or patients information (either paper or scanned into an electronic file) to the address listed below:

Care Improvement Plus
351 W. Camden Street, Suite 100
Baltimore, MD 21201

The enclosed document contains the requested list of claims selected for review. Please note that the information requested is necessary to determine whether these claims have been appropriately paid. Failure to provide the records may result in a determination that there is not adequate information to support the claim and therefore amounts paid to your institution must be refunded (invoice or part to the health plan by claims adjustment and/or overpayment recoupment actions.

If you have any questions or need further assistance, please call 866-649-9615, Monday through Friday between 8 a.m. and 5 p.m. Eastern time.

Sincerely,

Retrospective Medical Review Department

Submission Options

Mail

- Manual Indexing required
- Include original request to streamline process.
- Bar Code technology being implemented this year.

Fax

- 100% dedicated fax line allows for expedited requests and a zero complaint volume!

Today's Preferred Method

CDs

- Provide password separate from CD – HIPAA compliant

3rd Party Vendor

- Care Improvement Plus collaborates with third-party copy vendors to set up automated processes to fulfill medical record requests on behalf of facilities but implementation may take some time to ensure each facility is notified of the audit requests separately from the risk adjustment program

Electronic Records

- Upload medical records directly to the provider portal – Going live Q2 2013!

Future Enhanced Method

The audit process moves faster and with less likelihood of delays if the ORIGINAL letter is included with the record!

Record Request Process

Initial Medical Record Request

Allows 30 days for submission

Reminder Medical Record Request

Sent at day 15 after Initial Medical Record Request

Insufficient Documentation Letter

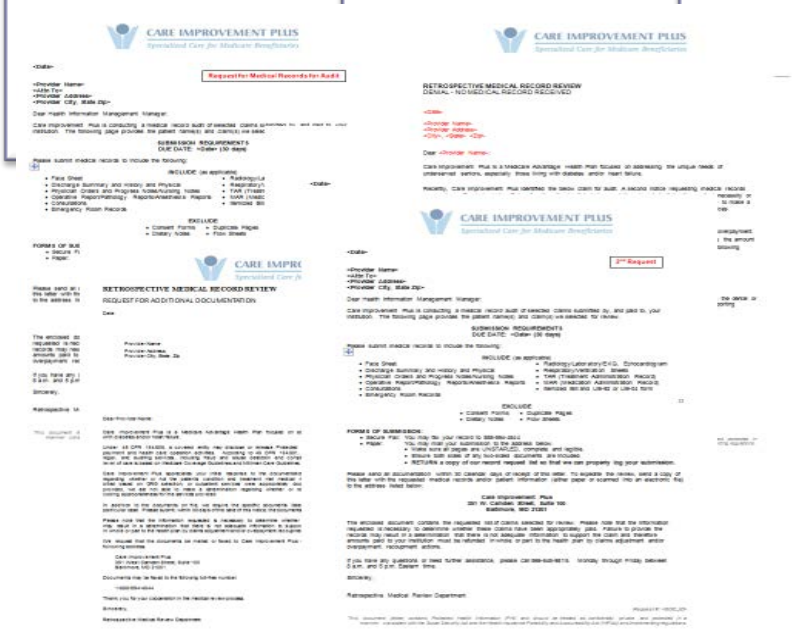
Allows 30 days to submit additional documentation

Failure to Submit Medical Record Demand Letter

If complete Medical Record is not received after 45 days, this demand letter is sent and a claim retraction is issued

Claim Reconsideration

No timeframe is enforced at this time. If the medical record is submitted, the record will be reviewed



Payment For Records

- Care Improvement Plus pays the rates published in the Federal Register.
- Process for obtaining payment:

Request for Payment

Medical Records

Requestor Information (please print information)

Provider Name

Provider Tax Identification Number (TIN)

Provider Address (Check will be mailed to this address)

Contact Name

Contact Phone

Payment Details (Care Improvement Plus will pay $0.12/page or a maximum fee of $25.00 per medical record)

Member Name	Member Subscriber ID	Date(s) of Service	Number of Page(s)	Total Claim (not to exceed $25.00)

Please use this form to request payment for the medical records. Please print all information in the above fields and fax it back to Care Improvement Plus at 1-888-479-5512.

Upon implementation of the Electronic Medical Record portal, invoices can be generated automatically upon confirmation of upload!

Post-Payment Review

Review Timeframe

The review is performed within 60 days of receiving the record, utilizing Milliman guidelines, Medicare Coverage Guidelines, LCD/NCD, Inpatient Only procedure list.

Who Performs the Audit

Medical records are reviewed holistically for appropriateness of the service and the accuracy of the billing utilizing various resources:

- Certified coders (billing accuracy)
- Nurses/physicians (appropriateness of service)

Audit Results

A determination letter is sent including a comprehensive rationale for the adverse determination.

- Reason for re-opening
- Rationale
- Time frame to submit voluntary refund – 45 days
- Appeal rights

Question and Answers

- Payment
  - Non-network – paid the same amount and manner, recognizing same codes as Medicare FFS
  - Network – paid according to contract.

Question and Answer

- Fee Discrimination

Question and Answer

- Network terminations
  - Wellpoint, Humana, Anthem, etc…
  - Trend toward smaller networks as cost savings measure.
  - Laws re: Provider Networks and Terminations
    - Adequacy standards – CMS has checked and plans still meet standards.
    - Members notified 30 days in advance
    - Providers notified 60 days for w/o cause

Network terminations (cont'd)

- Notice of termination must include:
  - Reason for termination (e.g., without cause)
  - If relevant to reason for termination, standards and profiling data used to evaluate, numbers and mix of physicians needed by the MAO
- Physician has a right to appeal
  - Majority of hearing panel must be peers of the affected physician.
  - No right to appear in person.

Question and Answers

- Best Practices in appealing a Medicare Advantage plan decision.
  - Different appeals process for in-network and out-of-network.
  - Appeal process information included on denial letter and on website.
  - Coverage issue – include a blinded FFS remittance for same service showing coverage.

AppealProcess

- Care Improvement Plus follows the appeal and reconsideration guidelines as outlined in the PCUG manual.
- MAPD plans are audited to ensure the process is followed.

Adverse Determination letter sent (appeal information provided)

Provider can appeal within 60 days of Determination Letter

Plan processes appeal within 60 Days (decision made by 2nd level Medical Director review)

Additional levels of appeals available depending on the contracting status of provider


CARE IMPROVEMENT PLUS
Specialized Care for Medicare Beneficiaries

RETROSPECTIVE MEDICAL RECORD REVIEW
ADVERSE DETERMINATION

Per Medicare definition, 1st & 2nd Level Reviews must be conducted by separate individuals

The ALJ has a 70-75% overturn rate on RAC reviews. Care Improvement Plus has a much lower overturn rate with the ALJ.

Appeal Timeframes

	Appeal Timeframe From Determination (Provider) ***	Appeal Completion Timeframe (Care Improvement Plus) ***	Recoupment Timeframe***
Full Denial based on Org Determination	60 Days	60 Days	Starts on day 41 unless appeal received prior to day 41
Payment Dispute/Reconsideration	60 Days	60 Days	Starts on day 41

***Timeframes may differ for contracted providers depending on the contract.

Question and Answer

- Resolving Problems with MAOs.
  - What type of plan? Membership cards tell you.
  - Contract or non-contract providers?
  - Appealable issue? Use available process.

Your Questions