

Part C Claims, Appeals, and Grievances

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AGENDA

1. Introduction to compliance
2. Claims
3. Appeals
4. Grievances



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Introduction

- What is the most important reason for you, the health plan, to

BE IN COMPLIANCE?



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Intro (cont.)

Because CMS says we have to be and they may sanction us if we aren't?

No.



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Intro (cont.)

Because a compliant plan indicates a well-run and smoothly operating plan, which makes members happy, which makes them want to stay in the plan?

YES!



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Intro (cont.)

- Motivation: Fear of CMS.
 - Result: You'll only look at your operations before a CMS audit.
- Motivation: Excellent health plan.
 - Result: You'll continually monitor your operations and be ready at any time for an audit.



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Intro (cont.)

Five Key Tools for Compliance

1. Information Systems
2. Operations Library
3. Human Capital
4. Documentation
5. Internal Auditing



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Information Systems

- Do your internal tracking systems allow you to monitor your compliance?

Example: Can your claims timeliness reports separate contracted from non-contracted claims?

What about clean vs. non-clean claims?



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Information Systems (cont.)

- Can your system separate Part C appeals from Part D redeterminations? What about Part C and Part D grievances?
- Can your system capture dates and times of actions taken by your plan? Can it produce this information for an audit?



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Operations Library

What should be in your operations library?

1. Policies and procedures.
2. CMS-approved notices.
3. CMS manuals and regulations.
4. Information from HPMS, CMS website.



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Operations Library (cont.)

Policies and procedures:

- For every operational activity.
- Cover all requirements in CMS manuals and regs.
- Update as CMS releases new information.
- Ongoing training of staff on changes.



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Operations Library (cont.)

Standard Notices to members:

- Are they approved by CMS?
- Are they the most recent versions?
- Do staff know how to access them and when to use them?



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Human Capital

- Do you have enough staff?
- Are they adequately trained?
- Do you provide ongoing training?
- Do they understand their role in the process?
- Do they have the tools they need?
- Is it feasible to have dedicated Medicare staff?



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Documentation

- CMS audits are all about providing the right documentation.
- Include enough documentation to demonstrate compliance;
- Do not include irrelevant documentation.



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Documentation (cont.)

1. Written documentation:

- claim forms;
- correspondence to member/provider;
- medical records;
- Prior authorization forms;
- Transmittal forms to Maximus/CHDR
- Etc.



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Documentation (cont.)

2. Documentation of non-written actions:

- Internal systems notes of discussions with members/providers;
- Receipt of verbal appeals/grievances;
- Dates of verbal notification to member.

Example: For an expedited appeal, can you provide documentation that you notified the member of your decision within 72 hours of receipt?



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Internal Auditing

- Are you doing self-audits?
- If not, start. Why?

How else will you know if you are in compliance?



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Internal Audits (cont.)

- Do you have buy-in from management and operational departments?
- Are you auditing for all audit guide elements?
- Is audit staff adequately trained?
- How frequently are you auditing?
- What are you doing with the results?



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Part C Claims

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Introduction

- 1) Universes
- 2) Sample Documentation
- 3) Paid Claims Sample
- 4) Denied Claims Sample
- 5) Resources



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Universes

Non-contracted Provider Paid Claims Universe- All non-contracted claims paid during the audit period.

Denied Claims Universe- All claims denied during the audit period which are: non-contracted provider claims denied for the following reasons: non-emergent, non-urgent out of area care, not a covered service, and unauthorized services.



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Universes

Common Problems

- Not separating contracting & non-contracting provider claims
- Not separating out commercial claims



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Universes

Common Problems (continued)

- Sampling by line item instead of the entire claim (if one line item is denied, the entire claim belongs to the denied claims universe)
- Not excluding duplicate claims, adjustments to claims and eligibility denials.



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Universes

Best Practices

- 1) Ensure that the proper systems are in place that meet CMS requirements.
- 2) Proper Staff Training



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Sample Documentation

For both the Non-Contracted Provider Paid Claims Files and the Denied Claims Files-

Files should contain all the information needed to Provide a complete auditable history of the claim for all line items, including all pertinent computer screen printouts. *Please refer to the Claims Check sheets in your packet for more details.*



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Paid Claims Sample

Common Problems

- Clean claims not processed in 30 days
- Claims bouncing between health plan and delegated entity
- Claims not paid accurately or appropriately



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Paid Claims Sample

Best Practices-

- Establish internal audit process to analyze reasons for late payments
- Establish control mechanisms to monitor timeliness



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Paid Claims Sample

Best Practices (continued)-

- Establish goals for training and corrective action implementation
- Identify Medicare claims at time of receipt
- Identify non-contracting claims at time of receipt



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Paid Claims Sample

Common Problems-

- No interest paid on required claims
- Interest isn't correctly computed



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Paid Claim Sample

Best Practices-

- Pay interest on non-contracted provider clean claims paid in 31 days or more
- Compute interest from day 31 through date paid
- Use Julian Date Calendar



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Paid Claims Sample

Common Problems-

- Non-clean claims are not processed in 60 days
- Waiting more than 60 days for requested documentation



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Paid Claims Sample

Best Practices-

- Establish an internal audit process to analyze reasons for late payments
- Establish control mechanisms to monitor timeliness (i.e., if requested documentations not received within 60 days, deny claim).



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Paid Claims Sample

Best Practices (continued)-

- Establish goals for training and corrective action implementation
- Establish a process to immediately log in requested medical evidence and associate it with all related claims.



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Denied Claims Sample

COMMON PROBLEMS

- Denying claims for services that are clearly emergent
- Denying claims for no prior authorization when this authorization was available
- Denying claims without attempting to obtain medical evidence if needed



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Denied Claims Sample

Common Problems (continued)

- Improper denial of Post Stabilization care
- Denying claim as non-emergent without considering that it could have been for urgent out-of-area services.
- Delegated entities denying claims not within their purview



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Denied Claims Sample

Common Problems (continued)-

- Denying out of area claims as unauthorized without applying urgent out of area **and** emergent criteria.
- Denying claims for ancillary services related to authorized services.
- Denying out-of-area dialysis claims as unauthorized
- Denying services from a non-contracted provider that was referred by a contracted provider



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Denied Claims Sample

Best Practices

- Establish a list of claim codes that automatically meet emergent criteria
- Ensure that prior authorization information is checked
- Establish criteria for claims that require medical review



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Denied Claims Sample

Best Practices (continued)

- Ensure requested additional information is recorded in the claims systems and cross referenced to the appropriate claim
- Train delegated entities to ensure that any claims not within their purview need to be forwarded to the correct entity for further review ASAP.



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Denied Claims Sample

Best Practices (continued)

- Establish criteria for identifying Urgent-out-of-area Claims



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Denied Claims Sample

Common Problems

- No written denial notice issued
- Denial reasons were incorrect or incomplete
- Descriptions of denied services are not clear
- OMB mandated appeals language not used



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Denied Claims Sample

Best Practices

- Issue a written denial notice for all claim denials (in cases where members have liability)
- Denial notices must include denial language that explains emergent/urgent criteria instead of denying for “not authorized”
- Denial reason must clearly state why the claim was denied. Can't say “not covered” but must explain why the service is not covered



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Denied Claims Sample

Best Practices (continued)

- Description of services must be clear and should not include code or abbreviations
- OMB Notice of Denial of Payment Form and Instructions were recently updated. Please refer to the 11/14/07 Anthony Culotta HPMS memo regarding the Release of Medicare Advantage Appeals Notices for more information.



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Resources

New Notice of Denial Payment Form

<http://www.cms.hhs.gov/MMCAG/>

Claims Denial Matrix Language (ICE)

http://www.iceforhealth.org/library/documents/ICE_Claims_Medicare_Advantage_Denial_Reason_Guide_112305.pdf

MA Payment Guide

<http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/downloads/oon-payments.pdf>



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Resources (cont.)

Federal Interest Rates

http://www.treasurydirect.gov/govt/rates/tcir/tcir_opdprmt2.htm

Julian Date Calendar

<http://www.fs.fed.us/raws/book/julian.shtml>



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Part C Appeals

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Part C Appeals: Presentation Outline

- Definitions of Terms with Examples
- Appeals Process for Part C
- Common Problems /Best Practices
- Resources



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Part C Appeals: Terminology Under Part C

- Complaint – General description of expression of dis-satisfaction that could be an organization determination, appeal, grievance or combination.



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Part C appeals: Complaint

- My doctor is incompetent and the nurse was rude. He misdiagnosed me twice already and I've gotten worse. I don't want to wait any longer for good care - I want the plan to pay for services that I received at XYZ Medical Center.



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Part C Appeals: Terminology

- Organization Determination – Plan’s decision whether or not to provide or continue (pre-service) a service, or pay for (post-service) a service already received
- Examples of adverse org. determination
 - Plan discontinues physical therapy services
 - Plan denies payment for XYZ Medical Center



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Part C Appeals: Terminology

- Appeal – Pertains to provision of (pre-service) or payment for (post-service) medical services (organization determines)
- Examples of scenarios qualifying for appeal
 - Plan denies request for power wheel chair
 - Plan refuses to pay for out-of-network heart specialist services that was not pre-approved.
 - Member thinks that she should not have to pay a co-payment for an office visit



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Part C Appeals: Terminology

- Grievance – Complaint or dispute that is NOT pertaining to an organization determination



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Part C appeals: Complaint

- My doctor is incompetent and the nurse was rude. He misdiagnosed me twice already and I've gotten worse. I don't want to wait any longer for good care - I want the plan to pay for services that I received at XYZ Medical Center.



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Part C Appeals Process: Overview

- Five step process
 - Plan Review (reconsideration)
 - Independent Review Entity (IRE) (reconsideration)
 - Administrative Law Judge (ALJ)
 - Medicare Appeals Council (MAC)
 - Federal Court



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Part C Appeals Process: Overview

- Timeframes
 - Standard
 - Expedited
 - wait time could jeopardize a member's health
 - not used for payment issues



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Part C Appeals Process: Overview

- Plan is responsible for:
 - Organization determination
 - initial reconsideration
 - forwarding adverse decisions to IRE
 - working with third party reviewers
 - effectuating the decision timely



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Part C Appeals Process: Step 0

- Member, appointed representative or physician requests service or payment
- Plan provides member with organization determination within 72 hours/14 days/30days/60days* of request

*72 hours expedited, 14 days standard,
30 days for clean claims, 60 days for non-clean claims



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Part C Appeals Process: Step 1

- Member, appointed representative or non-contracting physician requests reconsideration
 - in writing within 60 days of the organization determination for a standard reconsideration
 - can choose oral reconsideration
 - must follow steps in section 70.2 of Chapter 13
 - » send written acknowledgement letter
 - » receive signed letter from member
 - either orally or in writing for an expedited reconsideration



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Part C Appeals Process: Step 1 (Plan)

- Plan provides written results of reconsideration to member within 72 hours/30 days/60 days* of request

*72 hours for expedited,
30 days for pre-service,
60 days for payment



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Part C Appeals Process: Step 1-2

- If any portion of reconsideration is adverse to member, plan must forward case file to IRE within

- * 24 hours of decision - expedited
- 30 days of receipt - standard
- 60 days of receipt - for payment



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Part C Appeals Process: Step 2 (IRE)

- IRE reviews case and responds in writing to all parties within CMS specified time-frames

- * 72 hours for expedited
- 30 days for pre-service
- 60 days for payment



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Part C Appeals Process: Step 2-3

- Enrollee or authorized representative may request hearing before ALJ by sending IRE a written request within 60 days of IRE decision
- Contested \$\$ must meet amount in controversy (AIC)* threshold

* 2008 threshold \$120



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Part C Appeals Process: Step 3 (ALJ)

- ALJ Hearing in person or via teleconference
- No regulatory time frames around scheduling/holding a hearing



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Part C Appeals Process: Step 3-4

- Member may request review by Medicare Appeals Council within 60 days of ALJ's decision (or dismissal)



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Part C Appeals Process: Step 4 (MAC)

- MAC may accept or deny request to review case
- MAC will respond in writing directly to all parties



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Part C Appeals Process: Step 5 (Court)

- Any party involved may request Judicial review by filing civil action in district court
- Contested \$\$ must meet amount in controversy (AIC)* threshold

*2008 AIC is \$1,180.00



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Medicare Part C Appeals

Defining the Medicare Part C Appeals Players

- Beneficiary/ members
- Plan staff/ Delegated staff
- CMS contractors (IRE, QIO)
- CMS audit reviewers (ROIX, CO, contractors)



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Medicare Part C Appeals

Overview

- Audit elements
- Common Problems / Best Practices
- Keys to Compliance
- Resources



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Medicare Part C Appeals

Part C Audit Review Guide

- 13 Audit Elements/ Requirements
- Elements categorized as
 - General
 - Claim Payment Appeals
 - Pre-service Appeals
- Element type
 - Sample elements (review of actual cases)
 - Onsite elements (interviews, review of P&Ps, other documents during audit)
 - Ongoing elements (ongoing review throughout year)



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Medicare Part C Appeals

- Common Problems / Best Practices
 - Universes
 - Case categorization
 - Notices
 - Transfer of Cases to IRE
 - Effectuations
 - Documentation
 - Other Process Issues
 - Policies and Procedures



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Medicare Part C Appeals

Common Problems: **Universes**

- Partial plan upholds are incorrectly included in Favorable Reconsideration Universe
- Expedited appeal requests that plan transfers to standard process are incorrectly included in Standard Pre-Service Appeal Universe
- Part D Appeals are incorrectly included in Part C Universes



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Medicare Part C Appeals

Best Practices: **Universes**

Tracking system that captures partial plan uphold decisions as unfavorable decisions and that can extract all expedited appeal requests, whether processed as expedited or transferred to standard process.

Separate Tracking systems for Part C and Part D Appeals

Training / Internal Monitoring to ensure that staff categorize and enter appeals into plan tracking system correctly



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Medicare Part C Appeals

Common Problems:

Case Categorization

- Organization Determinations incorrectly classified as reconsiderations (plan has made no initial determination)
- Pre-service appeal incorrectly classified as claims appeal
- Grievance incorrectly classified as Appeal
- Mixed-case



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Medicare Part C Appeals

Best Practices:

Case Categorization

- Training/Internal Monitoring to ensure cases are categorized and entered into appeal tracking system correctly



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Medicare Part C Appeals

Common Problems: **Notices**

- Unapproved notice(s)
- Out-dated notice(s)
- Inappropriate notice(s)
- Failure to provide oral and/or written notice, when required



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Medicare Part C Appeals

Best Practices: **Notices**

- Use only CMS approved notices (or accepted, if eligible for F/U certification)
- Discard and replace out-dated notices
- Train/monitor staff to use appropriate notices
- Establish internal systems/controls to ensure notices are issued and documented in internal systems



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Medicare Part C Appeals

Common Problems:

Transfer of Cases to IRE

- Failure to forward cases to IRE when unable to fully reverse its own decision
- Failure to forward cases to IRE timely
- Failure to forward cases to IRE for dismissal, when plan unable to obtain AOR / other documentation of representation
- Failure to forward claim reconsiderations filed by non-contracted providers to IRE for dismissal, when plan unable to obtain waiver of liability



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Medicare Part C Appeals

Best Practices:

Transfer of Cases to IRE

- **Tracking System/Internal Reports** – Use to identify cases for transfer to IRE on time
- **Training/Internal Monitoring** - Train staff and monitor ongoing compliance through audits and spot checks
- **Regional Office MAO Letters, Reconsideration Data** – Analyze to determine causes for delay(s) and take corrective action



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Medicare Part C Appeals

Common Problems: **Effectuations**

- Failure to effectuate plan decisions timely
- Failure to effectuate third party (IRE, ALJ, MAC) decision, timely
- Failure to effectuate decisions



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Medicare Part C Appeals

Best Practices: **Effectuations**

- **Tracking System/Reports** Include data elements to track both plan and third party effectuations and other third party decisions (differing time-frames for plan decisions, IRE decisions, MAC, Federal Court)
- **Monitor** functions crossing operational units to ensure payments are issued, services authorized and/or provided, and appeal files documented
- **Use IRE Data from Regional Office** – Analyze cases to determine why IRE overturns not effectuated timely. Use to improve process.



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Medicare Part C Appeals

Common Problems: **Missing Documentation**

- Initial Denial Notice
- Overnight mailing/shipping receipt for cases sent to IRE
- Time/date in system notes/records
- Signed appeal acknowledgement for plans with oral standard appeal process
- Effectuation documentation
- Extension notification, if applicable



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Medicare Part C Appeals

Best Practices:

Missing Documentation

- **Train Staff** – everyone knows entire process and their respective role in processing appeals, and how to document their actions
- **Internal monitoring / corrective action** when needed
- **Use checklists** for internal monitoring



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Medicare Part C Appeals

Common Problems:

Other Process Issues

Failure to Request and/or Obtain (before Processing):

- AOR (or other evidence of representation)
- Waiver of Liability Statement (non-contracted provider payment appeal)
- Good Cause Extension documentation (late appeal)



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Medicare Part C Appeals

Best Practices:

Other Process Issues

- Training / Internal Monitoring - to ensure staff understand requirements



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Medicare Part C Appeals

Common Problems:

Policies/Procedures

- Inaccurate and/or incomplete policies, procedures, desk-references



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Medicare Part C Appeals

Best Practices:

Policies/Procedures

- Review CMS manual chapter to ensure P&Ps capture all CMS requirements
- Review and update policies, procedures, desk references at regularly scheduled intervals and whenever CMS issues revised manual chapters or other guidance



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Medicare Part C Appeals

Good Performance Counts!

CMS can determine plan to be compliant on up to 5 sample elements based IRE data.

- If MAO transfers all unfavorable appeal cases to IRE within required timeframes
- If MAO effectuates all decisions within CMS specified time-frames and notifies IRE



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Medicare Part C Appeals

Keys to Part C Appeals Compliance

1. Understand appeals process (expedited/ standard pre-service appeals, claims)
2. Review P&Ps to ensure all provisions are included (Ch 13)
3. Train new staff and provide frequent training for all other staff on changes as they occur
4. Use model notices (where ever possible), submit notices to CMS for approval, destroy out-dated/ invalid notices
5. Perform regular internal audits to identify weaknesses (staff and process) and take appropriate action to correct, as necessary
6. Ask questions, when not sure



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Medicare Part C Appeals Resources

- Chapter 13 – Medicare Managed Care Manual:
<http://www.cms.hhs.gov/manuals/downloads/mc86c13.pdf>
- Appeals Regulation, 42 CFR 422, subpart M
- Information from HPMS (frequent memos), CMS website
- Maximus Federal Services website:
www.medicareappeals.com
- Appeal checklists (in presentation materials)



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Part C Grievances

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Part C Grievances: Presentation Outline

- Definition
- Grievance Process for Part C
- Common Problems
- Keys to Compliance
- Resources



Part C Grievances: Definition

- Grievance – Complaint or dispute that is NOT pertaining to an organization determination



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Part C Grievances: Definition Issues

- Other (non-CMS) entities may have different names for what CMS calls a “grievance,” and may divide “grievances” into sub-categories based on the issue raised, or on how the member contacted the plan
 - Complaints
 - “Informal” grievances
 - “Formal” grievances



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Part C Grievances: Definition Issues – Bottom Line

- Regardless of what anyone else calls them, they are all **grievances** to CMS.



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Part C Grievances: Process

- Member files written or oral grievance within 60 calendar days from event
- Plan notifies member of decision within 24 hours for expedited and 30 calendar days for standard grievances unless extension is needed
- Plan must notify members of their right to file an expedited grievance
- Plan must notify members if an extension of up to 14 calendar days is needed



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Part C Grievances: Process

- All quality of care grievances that are filed orally or in writing must be responded to in writing and include enrollee's right to file with the Quality Improvement Organization, QIO

Do you know who your QIO is?



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Part C Grievances: Process - Documentation

- It is important to Document
 - Time and date the grievance was received
 - Categorization
 - Resolution date
 - Correspondence to the member
 - Notification to the member of the resolution
 - Response from the facility or provider whom the grievance was made
 - Quality of care grievances should include documentation that the issue was sent to the quality management department and any actions they took



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Part C Grievances: Examples - \$\$\$

- Issues involving money may be grievances, such as requests for reimbursement for lost or damaged items
 - Someone threw away my dentures while I was in the hospital.



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Part C Grievances: Examples –Service & Access

- Member Service
 - I spent 15 minutes on hold trying to get through to Member Services.
 - Your staff are rude!
- Access
 - My doctor's office is only open on Mondays and Wednesdays.
 - The hospital is too far away.



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Part C Grievances: Examples – Quality of Care

- Quality of Care complaints are a *type of grievance*
 - Nobody checked my mother’s IV for 10 hours while she was hospitalized.
 - My doctor prescribed the wrong drug and I got worse.
- Upon request, plan’s must provide information about the number of “Quality of Care Grievances” they received



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Part C Grievances: Examples – Mixed Issues

- Often, members present *both* a grievance *and* a request for an organization determination or appeal at the same time:
- My doctor is incompetent and the nurse was rude. He misdiagnosed me twice already and I’ve gotten worse. I don’t want to wait any longer for good care - I want the plan to pay for services that I received at XYZ Medical Center.



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Part C Grievance: Common Problems

- Mis-classification
- Delay or no notification of resolution
- Incorrect member notice



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Part C Grievance: Common Problems

- Mis-classification
- Part D complaint processed as a Part C grievance
 - Part D grievance included as Part C grievance sample to be reviewed



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Part C Grievance: Common Problems

Delay or no documentation of resolution

- No documentation of grievance
- Notification of decision processed over 30 days
- No documentation of notification
- No documentation of date and time notification was sent to member



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Part C Grievance: Common Problem

Incorrect Member Notice

- Did not use model notice or RO approved notice to notify enrollees of their right to file an expedited grievance
- Did not contain specific grievance disposition
- For quality of care issues, did not inform of QIO



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Part C Grievance: Keys to Compliance

- Review Chapter 13 of the Medicare Managed Care Manual
- Provide training to staff including member services or central points of contact
- Use current revisions of model notices and recycle old notices



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Part C Grievance: Keys to Compliance

- Document all relevant contacts with members
- Develop a tracking system to ensure grievances are processed and notices sent timely
- Develop internal check list to ensure that all grievances meet the compliance standards for grievances



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Part C Grievances: Resources

- Chapter 13 – Medicare Managed Care Manual:
<http://www.cms.hhs.gov/manuals/downloads/mc86c13.pdf>
- Grievance Checklist
- QIO List
- MA Grievances Webpage:
<http://www.cms.hhs.gov/MMCAG/>

