

MEDICARE PART C COMPLIANCE

Quality Review

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QUALITY REVIEW



Chapter 4

E
Benefits & Beneficiary
Protections



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Chapter 5

Quality Improvement

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Chapter 6

Provider Relations

Gretchen
Kane

Chapter 11

Provider Contracts

Ernie Tai

Chapter 13

Organization Determinations

Patty
Hokenson



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QUALITY REVIEW

Resources to Prepare for the CMS Audit

- Medicare Managed Care Manual
<http://www.cms.hhs.gov/Manuals/IOM>
- Monitoring Guide Version 5 w/o worksheets
 - HPMS – Monitoring – Audit Reports
 - Resource Guide



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QUALITY REVIEW

CMS Site Visit Letter with Enclosure I Request for a MAO narrative and supporting documentation for each element

- Chapters 4, 5, 6, 11 & 13
 - Narrative & supporting documentation - (Chapters 4 & 5) + HSD Tables 1-4
 - Narrative & supporting documentation + Worksheet Samples - (Chapters 6, 11 & 13)



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Chapter 4 Benefits & Beneficiary Protections

AA01-AA05	Access and Accessibility
HA01	Health Assessment
CC01-CC04	Coordination of Care
CF01	Confidentiality
AD01	Anti-discrimination
DG01	Delegation



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Access and Accessibility

- AA01 – Adequate & Appropriate Provider Network
- AA02 – Adequate & Appropriate Provider Access to Care
- AA03 - PCP Panel Established and Maintained
- AA04 – Necessary Specialty Care Provided
- AA05 – Services Provided with Cultural Competence



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Health Assessment

HA01 - Initial Health Assessment

- Good Faith effort to conduct a health assessment for new members within 90 days of effective date of enrollment
- Follow-up on unsuccessful attempts to contact an enrollee & thoroughly documents
- Provider Contracts and/or P & Ps inform first tier and down stream entities of this requirement



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Coordination of Care

- CC01 – Continuity of Care Through Community Arrangements
- CC02 – Timely Communication of Clinical Information
- CC03 – Standards for Member Input into Treatment Plan/Advance Directives
- CC04 – Member Health Record Uses Established Standards



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Confidentiality

CF01 – Confidentiality of Member Information

- P & Ps on confidentiality of medical records or other health information
- P & Ps protect against unauthorized or inadvertent disclosure of information
- P & Ps release original medical records only in accordance with Federal and State Laws, court orders, or subpoenas & member request



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Anti-Discrimination

AD01 - No member discrimination in delivery of health care

- P & Ps MAO does not deny or limit coverage or furnishing of benefits to individuals eligible to enroll in a plan on basis of health status (ex. ESRD)
- Participating providers have practice policies that demonstrate they accept for treatment any member in need of health care services they provide
- Does not disenroll members when they develop ESRD while enrolled



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Delegation

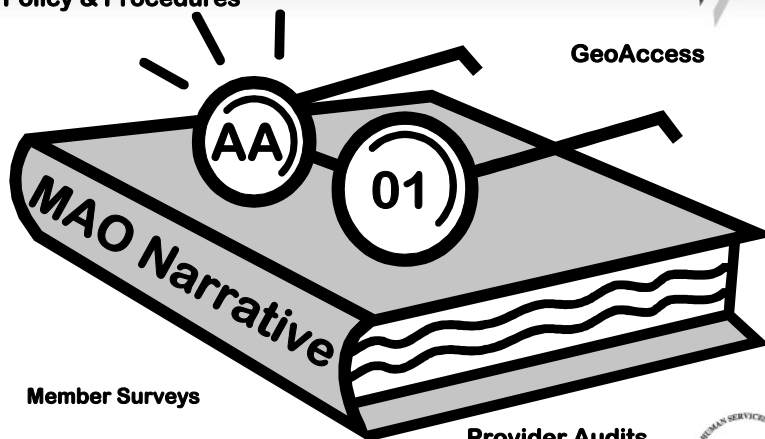
DG01 Oversight of Delegated Entities with Chapter 4 Responsibilities

- Written agreement
 - Specifies delegated activities
 - Reporting responsibilities
 - Revocation of delegated activities
- MAO performs pre-delegation audit
- Ongoing monitoring / conduct annual review

Adequate & Appropriate Network

Policy & Procedures

GeoAccess



Member Surveys

Provider Audits

MEDICARE PART C COMPLIANCE

Questions?



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MEDICARE PART C COMPLIANCE

Chapter 5 Quality Improvement

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Chapter 5 Quality Improvement

- QY01-Quality Improvement Program That Is Evaluated Annually
- QY02-Adequate Health Information System
- QY03-Appropriate Utilization Management Program
- QY05-Significant Problems Corrected



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Chapter 5 Quality Improvement

- QY07-Oversight of Delegated Entities with Chapter 5 Responsibilities
- QY08-Chronic Care Improvement Program
- QY09-Quality Improvement Projects



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Quality Improvement QY01

- The MAO must have an ongoing quality improvement (QI) program that is formally evaluated at least annually.



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Quality Improvement QY01

MAO Response

- The MAO has a QI program that incorporates information from customer, appeals and grievances, medical management, credentialing, provider relations, claims, sales, and marketing.
- MAO designates a senior official responsible for QI administration.
- The MAO has a QI program that has a policy making body that evaluates the effectiveness of the QI program.
- MAO has an annual evaluation of its QI program which assesses progress in implementation of QI strategies, activities, and recommendations.
- MAO Encourages its providers to participate in CMS and HHS quality improvement initiatives.



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Quality Improvement QY01

Supporting Documentation

- QI minutes
- QI program and evaluation
- Board minutes
- Organizational charts
- QI work plan



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Quality Improvement QY08 and QY09

- QY08-Chronic Care Improvement Program
- QY09-Quality Improvement Projects



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Quality Improvement QY08

MAO Response

- The MAO describes CCIP criteria that include methods for identifying MA enrollees with multiple or sufficiently severe chronic conditions who would benefit from participating in a CCIP.
- The MAO provides mechanisms for monitoring MA enrollees that are participating in a CCIP.



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Quality Improvement QY08

Supporting Documentation

- Policies and procedures
- CCIP program criteria and evaluation
- Overview of CCIP data collection and system documentation
- Committee minutes where reports are reviewed
- Analysis of CCIP participating enrollee surveys results
- List of diagnoses considered to be severe or chronic conditions
- MIS reports
- Records of completed health assessments
- Provider manual
- List of patients identified with severe chronic medical conditions



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Quality Improvement QY09

MAO must successfully complete annual QI projects that focus on both clinical and non-clinical areas and submit the project reports to the evaluation entity.



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Quality Improvement QY09

MAO Response

- The MAO describes QI projects (1) focus on both clinical and non-clinical areas; (2) follows the current quality improvement process; (3) measures performance; (4) focus on improving performance for the Medicare population; and (5) involves systematic and periodic follow-up on the effect of the interventions.



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Quality Improvement QY09

Supporting Documentation

- Project completion reports
- Project review report
- Quality Indicator data, measured repeated, that demonstrates significant change relative to baseline measurement
- QI Project communication records and processes
- QI Project corrective action plans
- Sampling methodology
- Interventions and associated indicators



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Quality Improvement QY08 and QY09

• Review Entity

- MAQRO- Medicare Advantage Quality Review Organization
- Three Quality Improvement Organizations (QIOs) have CMS MAQRO contract
 - Delmarva
 - IPRO
 - Lumetra



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MEDICARE PART C COMPLIANCE

Questions?



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MEDICARE PART C COMPLIANCE

CHAPTER 6 Provider Relations

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Provider Relations

Audit Elements

- **PR01**-Participation and Termination Procedures
- **PR02**-Consultation with Physicians and Subcontracted Physician Groups (re:PR01)
- **PR03**-Credentialing Requirements for Physicians and Other Health Care Professionals
- **PR04**-Process for Consultation with Health Care Professionals regarding credentialing



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Provider Relations

Audit Elements

- **PR05**-Credentialing Requirements for Facilities
- **PR06**-Discrimination Against Health Care Professionals Prohibition
- **PR07**-No Prohibition on Health Care Professionals Advice to Patients.



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Provider Relations

Participation and Termination Procedures-PR01

- The MAO must have written policies and procedures and a process for rules of physician participation and adverse participation decisions.



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Provider Relations

MAO Response-PR01

- The MAO describes how it provides for participation and the management of physician members and physician groups by (1) following written notice of rules of participation including termination of payment, credentialing, and other rules directly related to participation decisions and (2) identifies and submits documentation illustrating how it meets this requirement.



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Provider Relations

PR01-Ask the ?s

- What are our written rules of participation that directly relate to participation decisions?
- Do we give written notice, before the rules are put into effect, of material rule changes?
- Do we ensure that physicians receive a notice of adverse participation decisions? How?
- What is our process for appealing adverse participation decisions?
- Do we notify contracting physicians of the timeframe of (within 60 days) terminating the contract without cause?



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Provider Relations

Ask the ?s-PR01

- Is our hearing panel composed of a majority of peers of the affected physician?
- Do we notify the proper authorities when a provider is suspended or terminated?
- Do we have P & Ps to determine if a provider has opted out of Medicare?
- Do we ensure that all of the above applies equally to physicians in subcontracting groups? How?



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Provider Relations

Examples of Supporting Documentation-PR01

- Policies and procedures for credentialing/recredentialing
- Credentialing committee minutes
- Model termination/suspension notice
- Provider manual-provider responsibilities
- Selection and retention criteria
- List of terminated or suspended providers and case files
- Hearing panel minutes



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Provider Relations

Consultation with Physicians and Subcontracted Physician Groups-PR02

- The MAO must establish a formal mechanism to consult with the physicians and subcontracted groups that have agreed to provide services regarding the organization's medical policy, quality improvement programs, and medical management procedures



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Provider Relations

MAO Response-PR02

- The MAO describes (1) that it has a formal mechanism to consult with contracted providers regarding medical policy, quality improvement programs and medical management procedures and (2) identifies and submits the supporting documentation illustrating how it meets this requirement.



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Provider Relations

Ask the ?s-PR02

- How do we adopt practice guidelines?
- Do we approve and periodically review clinical criteria based on scientific advances or changes in customary practice? How?
- How do we make clinical criteria for specific procedure available upon provider request?
- What is our formal mechanism for consulting affiliated physicians as it periodically reevaluates guidelines?



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Provider Relations

Ask the ?s-PR02

- Do we disseminate practice guidelines to physicians? Selected relevant guidelines (prevention, self care) to members? How?
- Do we consult with affiliated physicians and outside experts and communicate coverage decisions to providers? How?
- Have we adopted coverage policies consistent with national Medicare coverage determinations?



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Provider Relations

Ask the ?s-PR02

- What is our process for communicating practice guidelines, upon request, to all providers and enrollees, including discharge criteria, continued stay, and admission practice guidelines?



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Provider Relations

Examples of Supporting Documentation-PR02

- Provider manuals and newsletters
- Documentation of conducting consultations with affiliated physicians and outside experts
- Coverage decision process for communicating the info to physicians
- Examples of the MAO's clinical practice guidelines
- Medical Services Policy and Procedure Pharmacy and Therapeutics Committee minutes
- QA minutes



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Provider Relations

Credentialing Requirements for Physicians and Other Health Care Providers-PR03

- The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing



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Provider Relations

MAO Response-PR03

- The MAO describes (1) its process in place to credential and recredential its providers, (2) identifies and submits supporting documentation of that process illustrating how it meets this requirement and (3) will have a selected sample of credentialing files available on site.



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Provider Relations

Ask the ?s- PRO3

- Do we have policies and procedures for the process?
- Are we obtaining the necessary information within the required timeframes?
- How do we provide oversight for credentialing?



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Provider Relations

Examples of Supporting Documentation- PR03

- Policies and procedures for Initial Credentialing
- Policies and procedures for Recredentialing
- Initial Credentialing Application-sample
- Recredentialing Application-sample



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Provider Relations

Sample-PR03

- HSD-2 Table with MDs, ODs and Chiropractors. The Reviewer selects a sample. The following is a checklist the reviewer will use while reviewing the files:
 - ✓ Completed Application
 - ✓ Documentation of verification of license
 - ✓ Documentation of verification of board certification, if applicable
 - ✓ Documentation of how the board verifies information for education and training, if applicable
 - ✓ Documentation of education



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Provider Relations

Sample-PR03

- ✓ Documentation of clinical privileges, if applicable
- ✓ Documentation of verification of malpractice insurance
- ✓ Documentation of DEA or CDS certification, if applicable
- ✓ Documentation that the MAO checked the National Practitioner Data Bank
- ✓ Documentation that quality of care information was considered in recredentialing process



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Provider Relations

Sample-PR03

- ✓ Documentation that the MAO reviews the most recently issued Sanction Report
- ✓ Documentation that the MAO reviews the most recently issued Medicare opt out list
- ✓ All supporting documentation pertinent to the credentialing cycle must be dated and within six (6) months of the Credentialing Committee decision date.



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Provider Relations

Lessons Learned-PR03

The Medicaid providers were not credentialed for Medicare-ensure the sanction and opt out requirements are met (OIG website).

The MAO **always** retains credentialing responsibility even if it delegates the function to a contracted entity.

Neither the MAO nor the delegated entity was performing the credentialing/recredentialing process according to Medicare requirements-provide oversight to ensure that credentialing meets the Medicare requirements.



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Provider Relations

Credentialing Files Review

- The better the organization of the file, the easier the review-including at the delegated entities.
- Tab/highlight the individual documents and dates of completion-must be completed with 6 months of committee determination.



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Provider Relations

Credentialing Files Review

- When it's a recredential (at least every 3 years), make sure the initial credential information is in the file with tabs/highlights as above for both.
- Prepare the file according to the checklist so the MAO can easily ascertain a reviewer will find the needed information.



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Provider Relations

Process for Consultation with Health Care Professionals Regarding Credentialing-PR04

- The MAO must have a process for health care professionals' input in the credentialing process



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Provider Relations

MAO Response-PR04

- The MAO narrative describes (1) the composition of the credentialing committee, how often it meets, that it discusses relevant credentialing issues and provides feedback to the MAO regarding its policies and procedures and (2) identifies and submits supporting documentation illustrating how it meets this requirement.



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Provider Relations

PR04-Ask the ?s

- How do we receive advice from contracting health care professionals with respect to criteria for credentialing and recredentialing of individual health care professionals?
- Do we have policies and procedures for the process?



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Provider Relations

Examples of Supporting Documentation

- Initial credentialing policies and procedures
- Recredentialing policies and procedures
- Credentialing committee policies and procedures
- Credentialing committee minutes for on site review



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Provider Relations

Credentialing Requirements for Facilities-PR05

- The MAO must have written policies and procedures for selection and evaluation of providers and follow a documented process for facilities regarding initial credentialing and recredentialing.



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Provider Relations

MAO Response-PR05

- The MAO describes (1) how it determines and re-determines at specified intervals that each facility is licensed to operate in the State, is in compliance with any applicable State or Federal requirements including Medicare certification and is reviewed and approved by accrediting body or meets the standards established by the MAO itself and (2) identifies and submits documentation illustrating how it meets this requirement.



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Provider Relations

PR05-Ask the ?s

- How do we determine our network facilities are (1) licensed to operate in the State, (2) in compliance with any applicable State or Federal requirements-including Medicare certification, and (3) reviewed and approved by an accrediting body or meets the standards we have established for facility providers?
- What's our policy for re-determining this and how often do we do it?



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Provider Relations

Examples of Supporting Documentation- PR05

- Policies and procedures for credentialing and recredentialing of contracting facilities
- State licensure information
- Accrediting information
- Medicare provider number documentation
- Credentialing committee minutes (on site)
- Files the MAO maintains on its contracting facilities (on site)



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Provider Relations

Discrimination Against Health Care Professional Prohibited-PR06

- An MAO may not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of his/her license.



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Provider Relations

MAO Response-PR06

- The MAO describes (1) that it does not discriminate against any health care professional, any providers serving high risk populations or specialize in the treatment of costly conditions and (2) identifies and submits supporting documentation illustrating how it meets this requirement.



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Provider Relations

PR06-Ask the ?s

- How do we ensure we're not discriminating against health care professionals for participation, reimbursement, or indemnification?
- How do we ensure we're not discriminating against professionals who serve high risk populations or who specialize in the treatment of costly conditions?
- What written notice is sent to providers declining to accept them in our network? Does it include the reason for declining?



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Provider Relations

Examples of Supporting Documentation- PR06

- Provider anti-discrimination policies and procedures
- Documentation of any complaint against the MAO that was filed with CMS
- Written notice to the provider



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Provider Relations

No Prohibition on Health Care Professionals Advice to Patients-PR07

- An MAO may not prohibit a health care professional from advising or advocating on behalf of a patient.



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Provider Relations

MAO Response-PR07

- The MAO describes that (1) it allows the health care providers to give information about the member's health status, medical care or treatment options including the risks, benefits, and consequences of treatment and non-treatment and the opportunity for the member to refuse treatment and to express preferences about future treatment and (2) identifies and submits supporting documentation illustrating how it meets this requirement.



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Provider Relations

PR07-Ask the ?s

- How do we encourage health care providers to give information about the member's health status, medical care or treatment options (including alternative treatments that may be self administered) to the individual and provide an opportunity to decide among all relevant treatment options?
- How do we encourage health care providers to give information about the risks, benefits and consequences of treatment or non-treatment?
- How do we encourage health care professionals to provide the opportunity for the member to refuse treatment and to express preferences about future treatment decisions?



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Provider Relations

Examples of Supporting Documentation-PR07

- Policies and procedures for advising and advocating for Members
- Policies and procedures for Independent Contractor Relationship
- Provider Manual
- Provider newsletters
- Member newsletters
- Documentation from the MAO for any complaint received by CMS



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MEDICARE PART C COMPLIANCE

Questions?



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MEDICARE PART C COMPLIANCE

CHAPTER 11 Provider Contracts

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Provider Contracts

Medicare Managed Care Manual

Chapter 11 – Medicare Advantage
Application Procedures and Contract
Requirements (Rev. 83, 04-25-2007)

<<http://www.cms.hhs.gov/manuals/downloads/mc86c11.pdf>>

Section 100.4 – Provider and Supplier
Contract Requirements



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Provider Contracts

Letter Confirming Audit to be Conducted Onsite

Enclosure I – Minimum Documentation Requirements For Sample Case Files

Chapter 11 – Contracts (pages 4-5)

WS-CN1 – Provider Contracts

Current contract(s) including all amendments and delegation agreements.

Tab the location of each required provision in each of the contracts.



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Provider Contracts

- For delegated entities chosen in the sample, provide a signed copy of the contract between the MAO and the delegated entity.



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Provider Contracts

- For all other contracts chosen in the sample, provide a signed copy of the contract actually signed by the provider or representative of the provider chosen in the sample. For example, if the listed provider is a member of an IPA or PHO, provide the subcontract between the provider and the IPA or PHO, not the contract between the IPA or PHO and the MAO. However, if the listed provider is an employee of a subcontracting entity (e.g. medical group), please indicate this and provide proof of the employment relationship between the subcontracting entity and the provider. CMS contracting requirements do not apply to employment agreements.



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Provider Contracts

Medicare Advantage Audit Review Guide, Version 5

Chapter 11 Contracts (pages 59-61)
<HPMS / Monitoring / MMC Auditing / Auditing
Guides / MA Audit Review Guide, Version 5>

Elements CN01-CN09



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Provider Contracts

Medicare Advantage Audit Review Guide, Version 5

Element CN01

Privacy and Confidentiality



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Provider Contracts

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Element CN02

Prompt Payment



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Provider Contracts

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Element CN03

Hold Harmless



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Provider Contracts

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Element CN04

Abide by Federal Requirements



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Provider Contracts

Medicare Advantage Audit Review Guide, Version 5

Element CN06

Compliance with MAO's Policies and Procedures



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Provider Contracts

Medicare Advantage Audit Review Guide, Version 5

Element CN07

Deemable Activities - Delegation Requirements



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Provider Contracts

Medicare Advantage Audit Review Guide, Version 5

Element CN08

Non-Deemable Activities – Delegation Requirements



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Provider Contracts

Additionally, the Policies and Procedures distributed to the providers and suppliers must include 30 additional provisions, including –

- Services available 24 hours/day, 7 days/week
- Adhere to CMS marketing provisions
- Ensure services are provided in a culturally competent manner
- Submission of data, medical records and certify completeness and truthfulness
- Comply with medical policy, QI and MM.

MMCM, Ch. 11, Section 100.4.



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Provider Contracts

Medicare Advantage Audit Review Guide, Version 5

Element CN09

Adequate Compliance Plan



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Provider Contracts

Adequate Compliance Plan

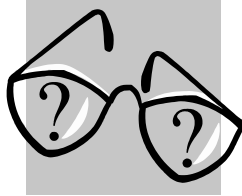
- Policies and procedures
- Written compliance plan
- Compliance plan training materials
- Description of communication mechanism
- Disciplinary guidelines
- Internal monitoring and auditing reports
- Required corrective actions



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Questions?



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MEDICARE PART C COMPLIANCE

CHAPTER 13 Organization Determinations

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Organization Determinations

Chapter 13 Organization Determinations 4 Worksheets

**WS-OP1 Adverse Standard Pre-Service
Organization Determinations**

**WS-OP2 Requests for Expedited
Organization Determinations**



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Organization Determinations

Chapter 13 Organization Determinations 4 Worksheets

**WS-OP4 Terminations of Services-Skilled Nursing
Facility (SNF), Home Health Agency (HHA),
Comprehensive Outpatient Rehab Facility (CORF)**

**WS-OP5 QIO Review of Termination of Services-
SNF, HHA, CORF Services**



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Organization Determinations

WORKSHEET: WS-OP1

**Adverse Standard Pre-Service
Organization Determinations**

- **Timeliness (14 calendar days)**
- **Notice of Denial of Medical Coverage (NDMC) compliance**
- **Resource: ICE UM Timeliness Standards for CMS**



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Organization Determinations

**Audit Review Elements
Associated with WS-OP1**



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Organization Determinations

Review Element OP01: Adverse Standard Pre-Service Organization Determinations (Timeliness)

If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).



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Organization Determinations

Review Element OP02: Adverse Standard Pre-Service Organization Determinations (Notice Content)

If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and the specific denial reason. The notice must also inform the enrollee of his or her right to a standard or expedited reconsideration, including the rights to, and conditions for, obtaining an expedited reconsideration, as well as describe the appeal process.



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Organization Determinations

WORKSHEET: WS-OP2

Requests for Expedited Organization Determinations

- Timeliness (72 hours)
- Resource: ICE UM Timeliness Standards for CMS



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Organization Determinations

WORKSHEET: WS-OP2

Requests for Expedited Organization Determinations

- Appropriate Notices
 - Notice of decision not to expedite
 - Notice of extension
 - Verbal notice of approval decision
 - Written notice of denial decision



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Organization Determinations

Audit Review Elements Associated with WS-OP2



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Organization Determinations

Review Element OP03: Receipt and Documentation of Expedited Organization Determination Requests

The MAO must establish an efficient and convenient means for individuals (including members, their applicable representatives, or their physicians) to submit oral or written requests for expedited organization determinations, document all oral requests in writing, and maintain the documentation in a case file.



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Organization Determinations

Review Element OP04: Requests for Expedited Organization Determinations (Timeliness)

The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, promptly provide oral notice to the member of the decision not to expedite, and provide written notice within 3 calendar days of the oral notice.

If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.



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Organization Determinations

Review Element OP05: Adverse Expedited Organization Determinations (Notice Content)

If the MAO makes an adverse expedited organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and the specific denial reason. The notice must also inform the enrollee of his or her right to a standard or expedited reconsideration, including the rights to, and conditions for, obtaining an expedited reconsideration, as well as describe the appeal process.



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Organization Determinations

Review Element OP06: Organization Determination Extensions (Notice Content)

If an extension is granted for an organization determination, the written notice to the member must include the reasons for the delay, and inform the member of the right to file an expedited grievance if he or she disagrees with the decision to grant an extension.



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Organization Determinations

Review Element OP07: Decision Not to Expedite an Organization Determination (Notice Content)

If the MAO decides not to expedite an organization determination, the notice to the member of the decision not to expedite must explain that the MAO will process the request using the 14-day standard timeframe, inform the member of the right to file an expedited grievance if he or she disagrees with the decision not to expedite, inform the member of the right to resubmit a request for an expedited determination with any physician's support, and provide instructions about the MAO grievance process and its timeframes.



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Organization Determinations

Review Element OP08: Correctly Distinguishes Between Organization Determinations and Reconsiderations

The MAO must correctly distinguish between organization determinations and reconsiderations.



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Organization Determinations

WORKSHEET: WS-OP4

Terminations of Services-Skilled Nursing Facility (SNF), Home Health Agency (HHA), Comprehensive Outpatient Rehab Facility (CORF)

- **Timeliness (2 days)**
- **Notice Compliance**
- **Resource: ICE UM Timeliness Standards for CMS**



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Organization Determinations

Audit Review Elements Associated with WS-OP4



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Organization Determinations

Review Element OP10: Termination of Provider Services: Notice of Medicare Non-Coverage of SNF, HHA, or CORF Services (Timeliness)

The MAO must provide the notice of Medicare Non-Coverage through the provider (SNF, HHA, or CORF) to enrollees of its decision to terminate provider services no later than two days before the proposed end of the services.



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Organization Determinations

Review Element OP11: Termination of Provider Services: Notice of Termination of SNF, HHA, or CORF Services (Notice Content)

The MAO's notice of termination of SNF, HHA, or CORF services must use the Notice of Medicare Non-Coverage (CMS-10095-A), must include the date that the coverage of services ends; the date the enrollee's financial liability for continued services begins; a description of the enrollee's right to a fast-track appeal via the QIO; information about how to contact the QIO; the enrollee's right to submit evidence to the QIO; and alternative appeal mechanisms if the enrollee fails to meet the deadline for a fast-track appeal.



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Organization Determinations

WORKSHEET: WS-OP5

QIO Review of Termination of Services-SNF, HHA, CORF Services

- **Timeliness (2 days)**
- **Appropriate notices**
- **Proof of effectuation if indicated**
- **Resource: ICE UM Timeliness Standards for CMS**



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Organization Determinations

Audit Review Elements Associated with WS-OP5



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Organization Determinations

Review Element OP12: Detailed Explanation of Non-Coverage (Timeliness)

The MAO, upon notification by the QIO that an enrollee has filed a request for a fast-track appeal, must send the written CMS-10095-B (Detailed Explanation of Non-Coverage) to the enrollee by the close of business on the day the QIO notification is received.



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Organization Determinations

Review Element OP13: Detailed Explanation of Non-Coverage (Notice Content)

The MAO must include in the Detailed Explanation of Non-Coverage of Provider Services (CMS-10095-B) an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction, or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.



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Organization Determinations

Review Element OP14: Effectuation of QIO Decision Reversals

If a QIO reverses an MAO organization determination decision to terminate SNF, HHA, or CORF services, the MAO must provide the enrollee with a new notice consistent with §422.624(b).



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Organization Determinations

OP15: Detailed Notice of Discharge of Inpatient Hospital Care

- Policies and procedures
- Detailed notice templates
- Complaint/grievance logs



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Organization Determinations

Review Element OP15: Detailed Notice of Discharge of Inpatient Hospital Care

Prior to discharging the individual or lowering the level of care within the hospital setting, the MAO must secure concurrence from the physician responsible for the Enrollee's inpatient care. When the QIO has notified an MAO that an enrollee has requested an immediate review of an MAO or hospital's determination that inpatient care is no longer necessary, the MAO must, directly or by delegation, provide the Detailed Notice of Discharge to the enrollee as soon as possible but no later than noon of the day after the QIO's notification.



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Organization Determinations

Review Element OP15: Detailed Notice of Discharge of Inpatient Hospital Care (con't)

The detailed notice must include a detailed explanation of why services are either no longer reasonable and necessary or are no longer covered in an inpatient hospital setting; a description of any applicable Medicare coverage rule, instruction, or other Medicare policy used in this determination, including information about how the enrollee may obtain a copy of the Medicare policy; any applicable MA organization policy, contract provision, or rationale upon which the discharge determination was based; and facts



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Organization Determinations

Review Element OP15: Detailed Notice of Discharge of Inpatient Hospital Care (con't)

specific to the enrollee and relevant to the coverage determination sufficient to advise the enrollee of the applicability of the coverage rule or policy to the enrollee's case. During the review process, the plan ensures that all information the QIO needs to make its determination is provided, either directly (with hospital cooperation) or by delegation, no later than noon of the day after the QIO notifies the MAO that a request or an immediate review has been received from the enrollee.



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Organization Determinations

Tools Utilized to Ensure CMS Compliance



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Organization Determinations

Medicare Managed Care Manual

Chapter 13 – Medicare Advantage
Beneficiary Grievances, Organization
Determinations and Appeals (Rev. 88, 09-21-
2007)

[www.cms.hhs.gov/manuals/downloads/mc86
c13.pdf](http://www.cms.hhs.gov/manuals/downloads/mc86c13.pdf)

Sections 30, 40, 50, & 90



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Organization Determinations

Medicare Advantage Audit Guide Version 5

- HPMS
- Monitoring
- Audit Guides
- MA Audit Review Guide, Version 5
- Pages 67-73



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Organization Determinations

Medicare Advantage Appeals Notices www.cms.hhs.gov/MMCAG

- Notice of Denial of Medical Coverage (NDMC) & Instructions
- Notice of Denial of Payment (NDP) & Instructions



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Organization Determinations

Medicare Advantage Appeals Notices
www.cms.hhs.gov/MMCAG/

- Notice of Medicare Non-Coverage (NOMNC) & Instructions
- Detailed Explanation of Non-Coverage (DENC) & Instructions



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Organization Determinations

Industry Collaboration Effort (ICE) Pre-Service Denial Reason Matrix
www.iceforhealth.org

- Approved Documents
- UM Templates & Tools (Medicare Advantage)
- ICE CMS MA Pre-Service Denial Matrix
04-16-07



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Organization Determinations

Industry Collaboration Effort (ICE) 2006 UM
Workshop Questions and Answers
www.iceforhealth.org

- Past Training Workshops and Materials
- 2006 Utilization Management Workshop Information/Materials
- Workshop Materials
- 2006 ICE UM Workshop Participant Questions



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MEDICARE PART C COMPLIANCE

Questions?



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