Medicare Part C: Organization Determinations, Appeals & Grievances (ODAG)

ODAG Common Findings, Process Reminders and Best Practices

Kristi Sugarman-Coats
Account Manager
Division of Medicare Health Plans Operations
Centers for Medicare & Medicaid Services

December 5, 2016
ICE 2016 Annual Conference
San Francisco, CA

Overview

- Review of Common Findings
- ODAG Processes and Best Practices
- Job Aids and Outreach Guidance Memos
- ODAG Resources

Review of Common Findings

Program Audit Findings

- Insufficient outreach for additional information
- Inadequate/incorrect/incomplete denial rationales
- Inappropriate denials
- Failure to properly oversee delegated entities
- Grievances: Incomplete investigations, not addressing all issues, failure to recognize quality of care concerns

Review of Common Findings

- Enrollee notification required for organization determinations and reconsiderations even if request came from provider
- Document date notice entered mail stream
- Provide proof of mail date and copy of notification
- AOR good for one year after date of enrollee and representative signature
  - Copy submitted with each subsequent request
  - Valid for duration of complaint/request

ODAG Processes and Best Practices

- Pre-service organization determinations and reconsiderations
  – Ensure appropriate review of expedited cases requiring outreach for additional information
  – Provider's second submission for same coverage request is an appeal
  – Confirm dental, vision and transportation benefits provided are consistent with enrollee's EOC

ODAG Processes and Best Practices

- Post Service
  - Claims
    - Check for prior authorization on file if not submitted with claim
    - EOB messaging to member and provider is understandable
  - Direct Member Reimbursement
    - Any request for reimbursement from a member
    - Payment may go to member or provider
  - Payment Reconsiderations
    - Must have process in place for non-contract provider payment reconsiderations
      - WOL required prior to starting timeframe

ODAG Processes and Best Practices

- Grievances
  - Consistent process for grievance handling
  - Address and respond to all issues in grievance
  - Quality of Care (QOC) is the enrollee's perception of the care received
  - Verbal grievances must have good notes in system so that anyone can understand the issue, research completed and the final resolution
- Dismissals
  - Send Notice of Dismissal of Appeal Request and include right to request IRE review of dismissal
  - Include reason for dismissal (untimely appeal, no WOL or AOR, obtained requested pre-service treatment)

Job Aids HPMS Memo

- HPMS memo “Job Aids Replace the Common Conditions, Best Practice Audit Memos” released April 20, 2016
  - Included three ODAG and three CDAG job aids for plans to use: Classification, Outreach & Denials
    - Classification of complaint
      - OD/reconsideration: Need for service
      - Grievance: Complaint about provider, quality, service
      - Inquiry: General question about plan policies or providers

Job Aids HPMS Memo (cont.)

- Outreach
  - Make three attempts
  - Use different types of outreach (phone, fax, email, mail)
  - Thorough documentation of outreach attempts
- Denials
  - Criteria for making denial (EOC, LCD, NCD, etc.)
  - Information needed to approve service
  - Ensure information is correct
  - Understandable and in language requested by enrollee

Guidance on Outreach HPMS Memo

- HPMS memo "Guidance on Outreach for Information to Support Coverage Decisions" released October 18, 2016
  - Minimum of three (3) attempts
  - During normal business hours in provider's time zone
  - Use different contact methods (phone, fax, email, mail)
  - Document all attempts made
  - Contracted providers must respond within timeframe requested by plan/delegated entity
  - Extension of timeframe at enrollee's request or information needed from non-contract provider

Guidance on Outreach HPMS Memo

- Standard
  - Organization determinations make first attempt within two (2) calendar days of coverage request
  - Reconsiderations make first attempt within four (4) calendar days of receipt of appeal request
  - Subsequent attempts timed appropriately
- Expedited
  - First attempt upon receipt of coverage request
  - Subsequent attempts timed appropriately

ODAG Resources

- Medicare Managed Care Manual, Chapter 13
- HPMS Memos
  - Job Aids Replace the Common Conditions, Best Practice Audit Memos (4/20/2016)
  - Guidance on Outreach for Information to Support Coverage Decisions (10/18/2016)
- MAXIMUS Reconsideration Process Manual http://www.medicareappeals.com/Portals/3/PDF/Recon%20Manual%2012-19-12.pdf
- 42 CFR Part 422, Subpart M
- Part C Appeals & Grievances Mailbox: Part_C_Appeals@cms.hhs.gov

Medicare Part D: Organization Determinations, Appeals & Grievances (CDAG)

CDAG Common Findings, Process Reminders and Best Practices

Lucy Saldaña, Pharm.D.

Region IX Pharmacist Consultant

Division of Medicare Health Plans Operations

Centers for Medicare & Medicaid Services

December 5, 2016

ICE 2016 Annual Conference

San Francisco, CA

Overview

- Review of Common Findings
- Job Aids and Outreach Guidance Memos
- CDAG Resources

Review of Common Findings

Program Audit Findings

Failure to:

- Auto-forward coverage determinations and/or redeterminations (standard or expedited) to the Independent Review Entity (IRE) for review and disposition
- Effectuate determinations within 24 hours of receipt of expedited coverage determination requests
- Notify beneficiaries of its payment decisions within 14 days of receipt of coverage determination request

Review of Common Findings

<u>Program Audit Findings</u>

- Insufficient outreach for additional information
- Failure to have procedures in place for requesting additional information
- Inadequate/incorrect/incomplete denial rationales
- Reviewer did not adhere to the PA criteria as approved by CMS, resulting in inappropriate denials
- Failure to ensure redeterminations were made by appropriate physicians when initial denials were based on lack of medical necessity

Review of Common Findings

<u>Program Audit Findings</u>

- Misclassified coverage determination or redetermination requests as grievances and/or customer service inquiries.
- Failed to identify and process beneficiary complaints and disputes as grievances.
- Failed to keep essential recordkeeping documentations
- Failure to properly oversee delegated entities

Job Aids and Outreach Guidance Memos

How to classify an incoming call:

- Coverage determination/redetermination, did the enrollee:
  - Run out of a drug and are in need of it?
  - Complain about a drug not covered?
  - Pay out of pocket for a covered drug?
  - Ask how to get a drug covered?
  - Indicate an excluded drug should be covered?

Job Aids and Outreach Guidance Memos

-- Grievance: did the enrollee complain about:

- Customer service?
- The quality of care received?
- Mail delay?
- Not receiving their ID card/EOB/ANOC in the mail?
- A drug is not on formulary?
- General complaint about the plan?
- A pharmacist?

Job Aids and Outreach Guidance Memos

- Inquiry, did the enrollee ask:
  - A general question?
  - How the formulary is developed?
  - For coverage of a non-Part D drug?
  - A general question about a plan policy or in-network pharmacies?

Job Aids and Outreach Guidance Memos

- Denial Notice Rationale
  - Know the drug, dose, and administration
  - Review your case system for the denial reason
  - Review approved formulary criteria for the drug
  - Make sure you are using the correct notice template

- Writing the Denial Rationale
  - Use OMB-approved specific language for Part B vs. Part D denials
  - Explain requirement for enrollee to try and fail specific drugs
  - Rationale should match the case notes on why the request was denied

- Final Hints
  - Is the information that would be needed to approve coverage for the drug included?

Job Aids and Outreach Guidance Memos

- Reasonable Outreach
  - Prior to initial attempt, determine:
    - If an expedited or standard decision is needed
    - What information is missing
  - Initial outreach attempt
    - Within a few hours of receiving the request
    - Make outreach attempts only during business hours
    - Leave at least a few hours between attempts for the prescriber to respond
  - Two additional attempts
    - Leave at least a few hours from your final outreach attempt prior to issuing a decision.
  - Final Hints
    - Did you make at least 3 outreach attempts?
    - Did you try different methods of outreach (e.g., phone, fax)?

CDAG Resources

- Medicare Prescription Drug Benefit Manual, Ch.18
- HPMS Memos
  - Job Aids Replace the Common Conditions, Best Practice Audit Memos (4/20/2016)
  - Guidance on Outreach for Information to Support Coverage Decisions (10/18/2016)
- MAXIMUS Reconsideration Process Manual http://www.medicareappeals.com/Portals/3/PDF/Recon%20Manual%2012-19-12.pdf
- 42 CFR Part 422, Subpart M
- Part D Appeals & Grievances Mailbox:

  PartD_Appeals@cms.hhs.gov

Questions & Answers

Jullin Kwok
Account Manager
Division of Medicare Health Plans Operations
Centers for Medicare & Medicaid Services

December 5th , 2016

ICE 2016 Annual Conference

San Francisco, CA