Medicare Part C: Organization Determinations, Appeals & Grievanc(es) (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)
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
• 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
• 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
• 42 CFR Part 422, Subpart M
• Part C Appeals & Grievances Mailbox: Part_C_Appeals@cms.hhs.gov
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

Program Audit Findings

• 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

Program Audit Findings

• 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
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?
-- 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?
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
• 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