



Washington & West, LLC

Denial and Underpayment Recovery Experts

Medicare (Dis)Advantage?

*How Medicare Advantage Is Supposed to Work and
What Hospitals Can Do to Make It Work for Them*

South Carolina HFMA Annual Institute

May 28, 2014

Medicare Advantage: Presentation Objectives

- ▶ What is Medicare Advantage? How is it different than original Medicare?
- ▶ How can we minimize denials and maximize appeal successes?
- ▶ What can we do to deal with an uncooperative plan?
- ▶ What are the keys to success in increasing proper net reimbursement for services for Medicare Advantage patients?



6/9/2014

2

By The Numbers

- ▶ Nationwide, about half of hospital visits are for Medicare enrollees.
- ▶ In 2013, 28% of Medicare enrollees were in a Medicare Advantage plan. Roughly 1-in-6 hospital visits.
 - ▶ In South Carolina, 20%, up from 17% (Minnesota 49%, Alaska < 1%)
- ▶ In 2013, 14.4 million people were Medicare Advantage enrollees.
 - ▶ In South Carolina, 167,292, a 17% increase over 2012
- ▶ Big business: Humana \$1.2B, Aetna \$1.9B, United Healthcare \$5.6B

6/9/2014

3

Who's Who

- ▶ In South Carolina, three firms combine for 86% of the market.
 - ▶ United Group 43% (includes Care Improvement Plus)
 - ▶ Humana 35%
 - ▶ BCBS 8%
- ▶ Care Improvement Plus has 80,560 SC enrollees.
 - ▶ “CIP-ville” would be SC’s fourth largest city.

What's What

- ▶ Created in 1997 as “Medicare+Choice”
 - ▶ Regs. in 42 CFR 422 (some parts of 42 CFR 405, original Medicare)
- ▶ Renamed “Medicare Advantage” in 2003
- ▶ Plans stand in place of Medicare Part A (inpatient hospital) and Part B (outpatient) benefits

What's What

- ▶ Stated Congressional Purposes:
 - ▶ Give beneficiaries “a wide array of private health plan choices”
 - ▶ Cost containment
- ▶ Most plans are HMOs, PPOs, or Private Fee-for-Service.
 - ▶ 65% enrolled in HMOs, 29% in PPOs

Funding Basics

- ▶ Plans bid against “benchmarks,” theoretically Medicare’s costs.
 - ▶ Benchmarks are usually inflated. In 2014, benchmarks average 112% of Medicare payments
- ▶ Originally, this was a deliberate incentive to get insurers into the market.
 - ▶ ACA instituted phased reduction
 - ▶ How will plans offset that lost revenue?
- ▶ In 2009, 13.4% of payments to Medicare Advantage plans went to administrative costs and profit margin.

6/9/2014

7

Profit Center?

Keep the Change

Whatever portion of its rate a plan doesn't spend on actual services or administrative costs is the plan's to keep.

Denials = Rate not spent

Overpayment changes?

- ▶ CMS issued a final rule on 5/23/14 that includes a requirement for MA plans to repay overpayments. 79 Fed. Reg. 29843.
- ▶ These are excess amounts in Medicare's payment to the plans—e.g. paying for too many enrollees—NOT overpayments to providers.

What's in it for seniors?

Basic Rule:

“[A]n MA organization . . . must provide enrollees in that plan with coverage of the basic benefits described in paragraph (c).”

42 C.F.R. § 100(a)

“Basic benefits are all Medicare-covered services, except hospice services.”

42 C.F.R. § 100(c)(1)

Emergency Services



Plans **MUST** pay for emergency services.

- ▶ MA plans **must** pay for any services needed to evaluate or stabilize an emergency medical condition, regardless of network or authorization
 - ▶ Prudent layperson definition: “[A] medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in [serious jeopardy to health, impairment to bodily functions, or dysfunction of any part.]”

Payment for Emergency Services



Stabilization decision
is binding.

- ▶ The plan must pay for all emergency services until the patient is stabilized.
 - ▶ “The physician treating the enrollee must decide when the enrollee may be considered stabilized for transfer or discharge, and that decision is binding on the MA organization.”
- ▶ The plan is required to pay for post-stabilization services if: the plan authorizes; the services are rendered within one hour of a request for authorization; or the plan does not respond within an hour or have a physician available for consultation.

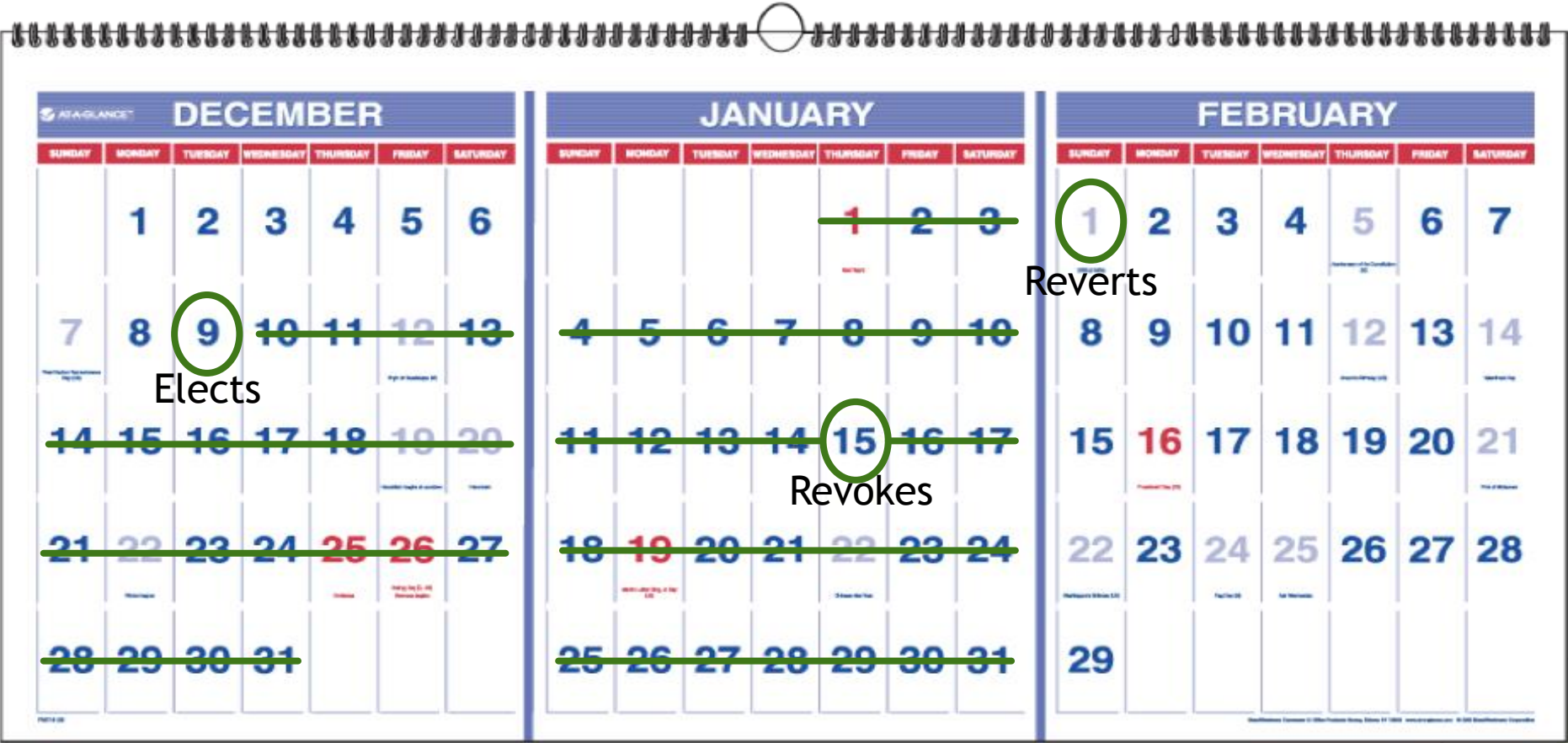
Benefits - Hospice



Remember not to bill MA plans for Hospice patients.

- ▶ “except Hospice”: Medicare Advantage DOES NOT cover Hospice.
- ▶ Hospice election reverts patient to original Medicare for all payments until the month AFTER revocation.
- ▶ Medicare Payment Advisory Commission March 2014 Report to the Congress recommends adding Hospice to Medicare Advantage benefits to streamline payments and care.

Benefits - Hospice



Medicare Advantage is Stateless

- ▶ Medicare Advantage expressly preempts state managed care laws.
- ▶ State protections are replaced by federal laws & regulations, but how much?

Preemption at Work - Retrospective Review

▶ South Carolina Law:

- ▶ “An insurer may not initiate overpayment recovery efforts more than eighteen months after the initial payment was received by the provider [except for fraud, required by a self-insured plan, or required by a state or federal government program].” SC Code, Title 38, Ch. 59, § 250(B).

▶ How does this law apply to claims paid by Medicare Advantage plans?



Use contract terms to limit the look-back.

▶ It doesn't.

- ▶ Plans limited only by “reopening” period of original Medicare.

Provider Payments in Theory

Basic Rule:

“[E]ach MA organization must . . . provide coverage of, by furnishing, arranging for, or making payment for, all services that are covered by [Medicare].”

42 C.F.R. § 101(a)

Provider Payments in Reality

- ▶ Lots of opportunity for plans to refuse to pay, such as:
 - ▶ Subjective determinations like medical necessity;
 - ▶ Procedural requirements like authorization; and
 - ▶ Billing requirements like claim filing deadlines.

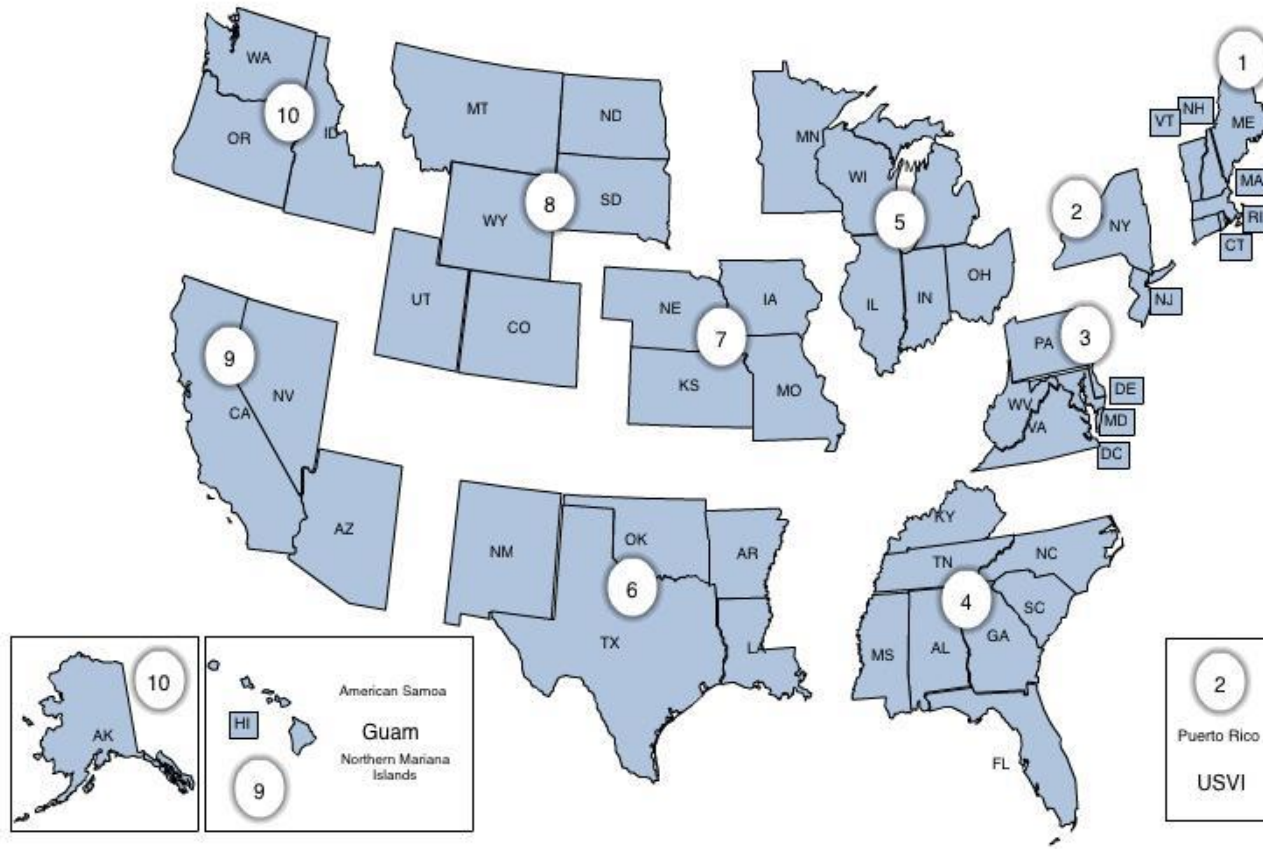
Provider Payment Resolution

- ▶ What can providers do to resolve denials or other problems?
 - ▶ Appeal - What this means depends on whether contracted or not
 - ▶ Use dispute resolution tools in contracts
 - ▶ Ask for help from CMS

Who's Watching?

- ▶ Medicare Advantage is regulated by CMS.
- ▶ CMS point-of-contact for Medicare Advantage problems is the Regional Office for the MA plan, not the provider.
 - ▶ Humana is headquartered in Kentucky
 - ▶ The Kansas City RO regulates Medicare in Kentucky
 - ▶ If you have a Humana issue, talk to Kansas City
- ▶ When CMS talks, plans do listen.

CMS Regional Offices



1. Boston
2. New York
3. Philadelphia
4. Atlanta (BCBS of SC)
5. Chicago
6. Dallas
7. Kansas City (Humana)
8. Denver
9. San Francisco (Care Imp. Plus)
10. Seattle

CMS Policies in Medicare Advantage

- ▶ Medicare Advantage Plans are bound by National Coverage Determinations.



Use NCDs/LCDs in appeals.

- ▶ Medicare Advantage Plans are bound by relevant MAC's Local Coverage Determinations. Where a plan operates in multiple jurisdictions, it can apply each separately or adopt the LCD that is most beneficial to enrollees.
 - ▶ Services rendered by a provider outside the plan's area are governed by policies issued by that provider's MAC.
- ▶ Where there is no applicable CMS policy, Plans may adopt their own.

CMS Policies in Medicare Advantage

- ▶ Two-Midnight Rule:
 - ▶ No explicit statement from CMS re: application to Medicare Advantage.
 - ▶ MA plans are bound by CMS coverage policies AND must provide the same benefits available in Parts A & B, so it should apply.
 - ▶ Contracts can resolve ambiguity.
- ▶ Rebilling: (for inpt. admissions denied for medical necessity)
 - ▶ “The [rebilling] rules do not apply in the MA context.” FY14 IPPS Final Rule
 - ▶ MA plans “free to apply the same principles . . . Regarding payment of Part B services to a hospital where a stay is not covered under Part A.”

Rebilling at Plan's Discretion

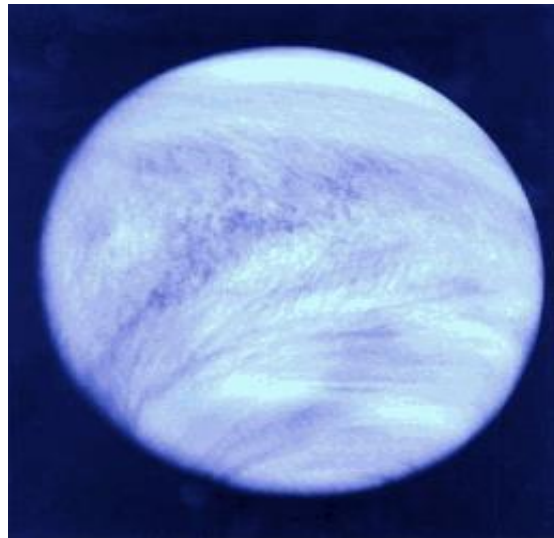
- ▶ Care Improvement Plus, 8/31/13: “[CIP] allows providers up to 180 days from the date of the adverse determination letter or an adverse appeal decision.”
 - ▶ Use condition code W2 to attest no pending Part A claim or appeal
- ▶ Humana: ???
 - ▶ The only published policy pre-dates the rebilling Interim Ruling and Final Rule, contemplates only the “ancillary” services that were payable previously.
 - ▶ However, for post-payment reviews, rebilling has typically been successful.



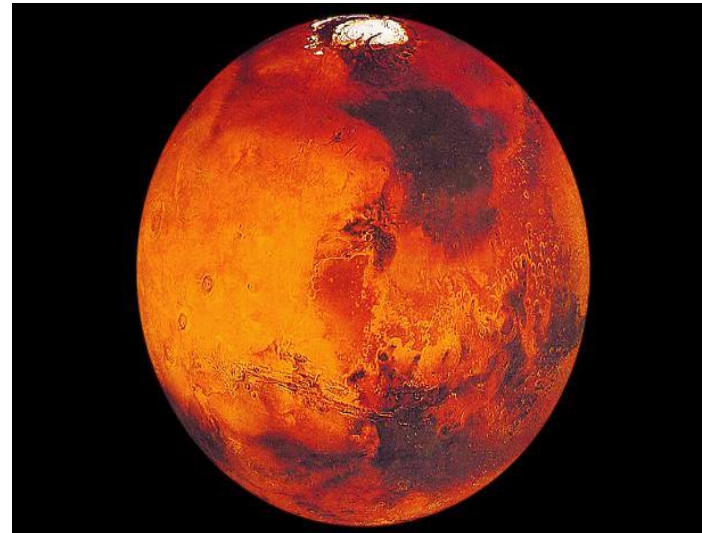
Get rebilling in your contract.

Two Worlds

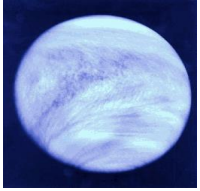
Contracted
Providers
are from Mars



Non-Contracted
Providers
are from Venus

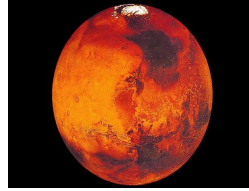


Two Worlds



Non-Contracted

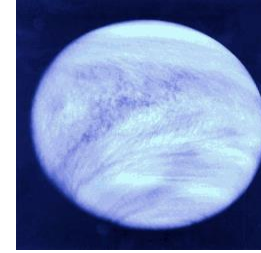
- ▶ Must pay Medicare rates.
- ▶ Entitled to internal appeal.
- ▶ Entitled to independent review.
 - ▶ Maximus
 - ▶ ALJ
 - ▶ MAC/Court



Contracted

- ▶ Can pay below Medicare rates.
- ▶ No appeal rights.
- ▶ No independent review.

Non-Contracted Providers

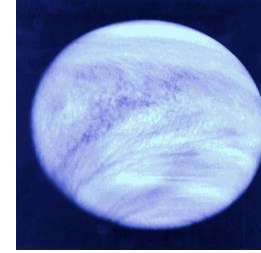


- ▶ Regulations govern *almost* everything
- ▶ Plans can still set their own billing and payment policies (claim timeliness, electronic claims, etc.).
 - ▶ Rates are Medicare rates, and providers from accepting more.
- ▶ Providers have independent appeal rights.



Non-contracted providers can get to an ALJ.

Non-Contracted Provider Denials



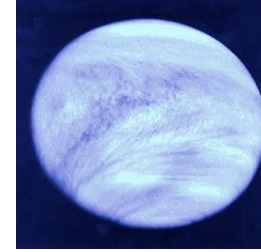
- ▶ Denials can come pre-service, pre-payment, or post-payment.
 - ▶ Some plans using RAC program contractors for retro reviews.

The Certified Coder completed the 3rd level appeal review, which included the submitted medical records for the below referenced patient. Based on the submitted documentation, the appeal is Upheld.

Insurance Company:	Humana
Review Conducted by:	CGI

- ▶ Appeals process is clearly defined and resembles original Medicare process.

Non-Contracted Provider Appeals



- ▶ Independent review is the central theme of the appeal process.
 - ▶ Maximus (2012: upheld 81% of inpatient hospital denials)
- ▶ Very little in the process is at the plan's discretion.
 - ▶ “Good cause” for untimely filing (as of 1/1/14 no automatic forward)
 - ▶ Reopening

Appeals Process

Organization Determination

Appeal to Plan
Standard or
Expedited (pre-service appeals only)

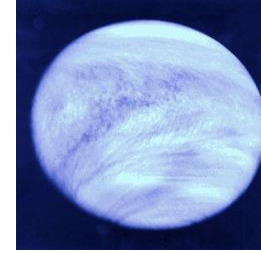
Independent Review by Maximus
(plan must send the appeal)

Administrative Law Judge

Medicare Appeals Council

Federal Court

Non-Contracted Provider Appeals



▶ First step: Plan’s “Organization Determination”

Organization Determination

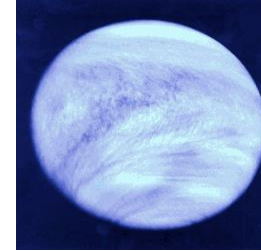
- ▶ Authorization denial
- ▶ Claim denial
- ▶ Retrospective denial
- ▶ Must give written notice and notify of appeal rights, requirements

▶ Second step: Provider or Patient Requests Reconsidered Determination

Appeal to Plan

- ▶ Due 60 days from initial determination
- ▶ MUST include Waiver of Liability (WOL)

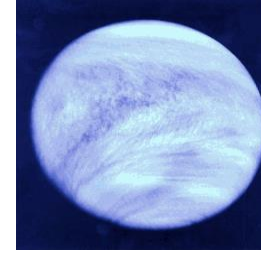
Non-Contracted Provider Appeals



Appeal to Plan

- ▶ Third Step: Reconsidered Determination (plan's obligations)
 - ▶ If the WOL is not included, plan must make reasonable efforts to obtain, but can dismiss in 60 days.
 - ▶ Must decide within 60 days after request
 - ▶ If unfavorable, must forward to Maximus (not if dismissed)
 - ▶ If no decision within 60 days, must forward to Maximus
 - ▶ “If CMS determines that the Medicare health plan has a pattern of not making a reasonable and diligent effort to gather and forward information to the independent review entity, the Medicare health plan **will be considered to be in breach of its Medicare contract.**” (Managed Care Manual)

Non-Contracted Provider Appeals

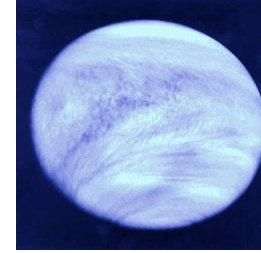


- ▶ Since the plan forwards the appeal to Maximus, the appeal to the plan is also the appeal to Maximus.
 - ▶ You can supplement at Maximus, but shouldn't rely on that.
- ▶ As in original Medicare appeals, all evidence should be submitted before Maximus' decision.
- ▶ Your first appeal needs to be as strong as it can be.



Your first appeal is really your first two.

Non-Contracted Provider Appeals



▶ Fourth Step: Independent Review Entity - Maximus Part C

- ▶ Must decide within 60 days of receipt
- ▶ Maximus sends written acknowledgement of receipt
- ▶ If unfavorable, must notify appellant (no automatic forward)

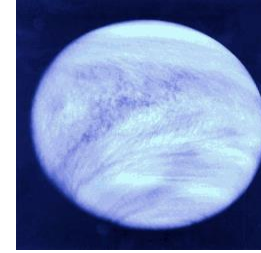
Maximus

▶ Fifth Step: Administrative Law Judge

- ▶ Due 60 days from “date of notice”
- ▶ Must meet amount-in-controversy (\$140.00 for CY14)
- ▶ Plan can’t request

ALJ

Non-Contracted Provider Appeals



▶ Medicare Appeals Council

- ▶ Due 60 days from receipt of ALJ decision (presumed 5 days)
- ▶ Plan CAN request

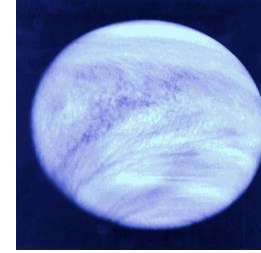
Appeals Council

▶ District court

- ▶ Due 60 days from receipt of MAC decision
- ▶ Must meet amount-in-controversy (\$1430.00 for CY14)
- ▶ Plan CAN request

Federal Court

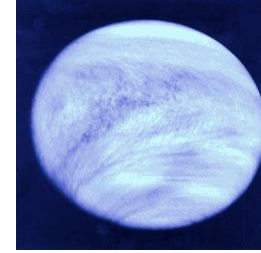
Non-Contracted Provider Concerns



- ▶ Plans don't always follow the rules.
 - ▶ Insufficient notice
 - ▶ Inaccurate appeal information
 - ▶ Improper timing (especially audits)
 - ▶ Slow response
 - ▶ Not realizing there's a difference

- ▶ Providers may have to follow up repeatedly to get IRE forwards.
 - ▶ CMS can be helpful

Non-Contracted Non-Compliance?

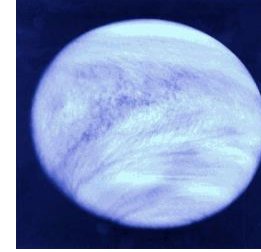


- ▶ One plan has a three-level internal appeals process for all providers.
- ▶ How does this interface with CMS-mandated process?
 - ▶ “If the MA organization affirms . . . it must . . . send the case file to [Maximus] no later than 60 calendar days from the date it receives the request.”
- ▶ Obtaining full compliance (still a work in progress) requires constant contact, readiness to ask for CMS help.



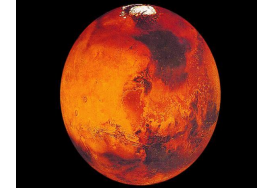
For common problems, consider acting through groups

Non-Contracted Non-Compliance?



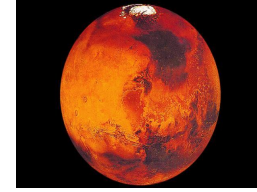
- ▶ Remember the basic rule:
Pay any claim Medicare would pay.
- ▶ Can plans rely on InterQual/Milliman to deny claims and appeals?
 - ▶ CMS: IQ/MCG “may assist,” but CMS-published criteria are what matters.
 - ▶ If CMS doesn’t rely on IQ/MCG, should plans be able to?

Contracted Providers



- ▶ The contract governs almost everything.
- ▶ Rates are usually Medicare rates, but don't have to be.
 - ▶ CMS prohibited by law from compelling contracts or dictating prices
- ▶ Plan sets billing & payment procedures and requirements.
- ▶ Appeals: “Contract providers do not have appeal rights.”
 - ▶ “CMS considers a contracted plan provider an agent of the MAO offering the plan.”
 - ▶ Patients can appeal denied services

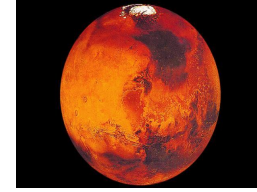
Patient Appeals



You can help your patients get services.

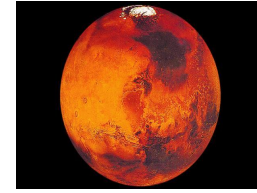
- ▶ Patients have clear appeal rights for *services*.
 - ▶ If a plan denies authorization for an elective service, the patient can ask the plan to reconsider.
 - ▶ If the plan still denies, the patient has automatic rights to independent review.
 - ▶ The patient can appoint a representative to pursue the appeal, including a provider.

Transferred Appeal Rights



- ▶ Can a contracted provider use a patient's rights to appeal denial of *payment*?
- ▶ No, in principle.
 - ▶ If enrollee has no financial risk, CMS says there ARE no appeal rights.
 - ▶ All provider/plan contracts must have “hold harmless” provisions.
- ▶ But there are some good legal and policy arguments.

Contracted Provider Appeals

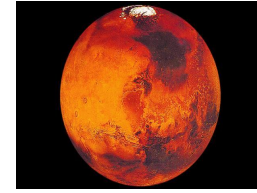


- ▶ Contracted providers *do* have appeal rights *if* appeals are in their contracts.
- ▶ Absent that, contracted providers have no rights to any independent judgment.
- ▶ Without contractual protections, denials can be blank checks.
 - ▶ Demand third-party review, levels of appeal, arbitration, definitions, etc.



Put indep. review or arbitration rights in your contract.

Medicare Advantage



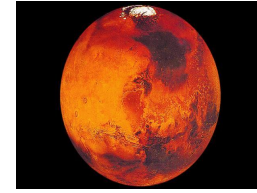
6 Essential Contract Considerations

6/9/2014

43

Essential Contract Considerations

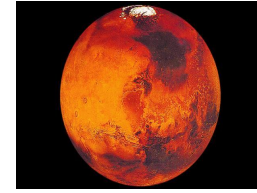
#1: Should We Contract?



- ▶ Think carefully about the decision to contract with a plan, even if market forces don't leave you much of a choice.
- ▶ Simply being *in* a contract changes your rights fundamentally.
 - ▶ Remember: No state law. Limited federal protection.
 - ▶ You only have the appeal rights you bargain for.
- ▶ Understand what rights you're giving up by contracting and negotiate for protections in return. Look at more than just rates.

Essential Contract Considerations

#2: Definitions Matter



Actual Contract Language:

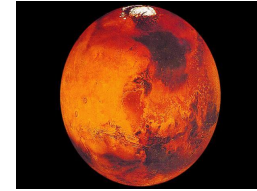
“Medical Necessity. For purposes of determinations of Medical Necessity, PAYER will apply the following definition:

Medically Necessary means services that are determined by PAYER to be:

- (1) Rendered for the treatment or diagnosis of an injury or illness; and*
- (2) Appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with scientific evidence and recognized standards; and*
- (3) Not furnished primarily for the convenience of the Member or the attending physician.”*

Essential Contract Considerations

#3: Dispute Resolution



► Appeals

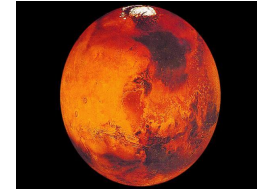
Actual Contract Language: *“Hospital may appeal any decision by Payer to deny payment. Such appeal shall be made in writing to the Appeals Department and submitted with the relevant medical record within sixty (60) days after Hospital’s receipt of the denial.”*

► Beyond Appeals - Arbitration/Litigation (watch for carve-outs)

Actual Contract Language: *“In the event of a dispute between Payer and Hospital which cannot be settled by mutual agreement, such dispute shall be resolved by binding arbitration. Differences of opinion as respects medical necessity shall be resolved, after Payer’s medical necessity procedures have been utilized, by a third party reviewer.”*

Essential Contract Considerations

#4: Authorization



Actual Contract Language: *“Hospital shall comply with Payer’s prior authorization and notification policies, including:*

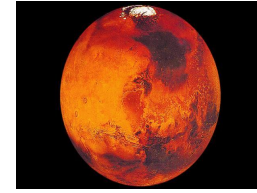
Obtain prior authorization from Payer for outpatient services, elective inpatient admissions, and ambulatory surgery; AND

In the event of an admission for emergency care or a non-scheduled overnight admission, notify Payer within three (3) hours of the admission.”

Failure to meet any such requirements may result in loss of payment.”

Essential Contract Considerations

#5: Look-Back Limits



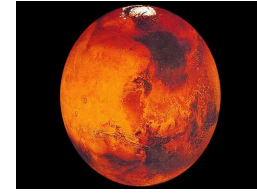
Actual Contract Language: *“Hospital agrees that Payer may recover any overpayment made to Hospital by offsetting such amounts from later payments. Payer may make retroactive adjustments to payments within eighteen (18) months from original payment date.”*



Use state law as baseline. SC limits to 18 months from claim payment.

Essential Contract Considerations

#6: Provider Manuals



Actual Contract Language: “Hospital will abide by provisions of Payer’s Provider Manual. Payer may change the Provider Manual from time to time and will use reasonable efforts to inform Hospital at least thirty days in advance of any material change to the Provider Manual. If a Provider Manual change is noticed only via Payer’s website, Hospital will have a 30-day grace period for any denied claims from the effective date of the change.”



Put manual change notice requirements in contracts.

Denials and How to Approach Them

- ▶ If you have a significant Medicare Advantage population, you probably have significant Medicare Advantage denials. Is your facility identifying all of them?
 - ▶ Look for “hidden denials” like “contractual adjustments”
- ▶ “Keep the change” payment structure creates incentive to deny.
- ▶ Plans’ aggressiveness varies, so keep track of denials by payer.
 - ▶ Keep “Payer Report Cards”

Medicare Advantage

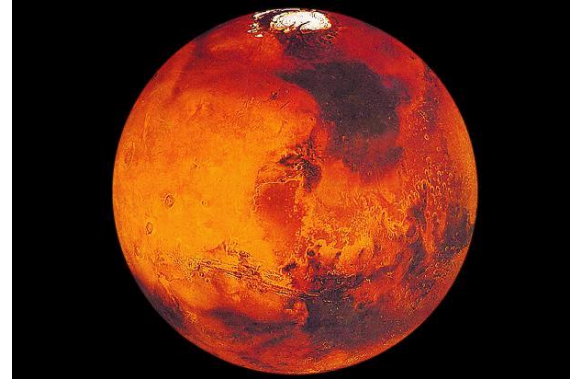
Medicare Advantage plan X has
denied your claim.

What now?

6/9/2014

51

Remember What World You're In



- ▶ What an appeal gets you depends on whether or not you're contracted.
- ▶ Arguments change, too:
 - ▶ If you're non-contracted, lean on CMS rules.
 - ▶ If you're contracted, enforce your contract.

Is This Appealable?

- ▶ 76-year old male presents to the ED via EMS. Complaints include severe chest pain and sweating. Patient has substantial cardiac history. ED physician documents need to rule out an MI.
- ▶ Provider is not contracted with patient's Medicare Advantage plan and did not seek authorization. Plan denies provider's claim for ED and related services.

Is This Appealable? Yes!

- ▶ This likely meets the “prudent layperson” definition of emergency services. As such, the plan is liable:
 - ▶ Regardless of network status; AND
 - ▶ Regardless of authorization.

Is This Appealable?

- ▶ 83-year old woman presents for a scheduled, elective total knee replacement, an inpatient-only procedure. Anesthesiology clears her for surgery with no concerns, there are no complications during the procedure, and afterward she experiences an unremarkable post-operative course and is discharged. The plan denies payment for her inpatient admission, arguing that there was no increased risk or need for intense services.

Is This Appealable? Yes!

- ▶ CMS has designated this procedure as inpatient-only. Medicare Advantage plans are bound by CMS coverage decisions, must provide at least the same level of benefits as Medicare, and must pay any claim Medicare would pay.

Is This Appealable?

- ▶ 93-year old man with metastatic lung cancer and a prognosis of weeks has elected Hospice. During his Hospice stay, he experiences symptoms of a stroke and is treated in the provider's ED. The provider bills his Medicare Advantage plan, which pays the claim. 14 months later, the plan retracts, indicating original Medicare should have paid because of the Hospice election.

Is This Appealable? Maybe.

- ▶ Yes, but.....
 - ▶ Contracted: Look to apply a contractual provision regarding retraction or provider's reliance on plan determinations.
 - ▶ Non-Contracted is tougher.
 - ▶ CMS: Provider responsible for knowing the rules, and plan payment/retraction is not good cause for untimely Medicare claim.

Is This Appealable?

- ▶ Non-contracted hospital admitted an MA enrollee and provided that the hospital believes were reasonable and necessary. The plan believes the services could have been outpatient and denies the claim.
- ▶ The provider appeals, but the plan still doesn't think the admission was necessary and sends a letter indicating the appeal is denied and no further appeals exist.

Is This Appealable? Yes!

▶ Yes!

- ▶ Non-contracted provider is entitled to independent review, including ALJ.
- ▶ Remember, **plan** has to forward the appeal to Maximus. If plan doesn't, provider will need to follow up (maybe repeatedly) and may need to talk to CMS.

Appeals Checklist

- ▶ First question: Are we contracted?
 - ▶ If not, we need a Waiver of Liability.
- ▶ Second question: How long do we have to appeal?
 - ▶ If non-contracted, at least 60 days.
 - ▶ If contracted, look to the contract.
- ▶ Third question: How many levels of appeal do we have?
 - ▶ If non-contracted, five, but the first appeal covers two levels.
 - ▶ If contracted, look to the contract. Some have only one!

Appeals Strategies

- ▶ Be timely!
- ▶ Get it all out there.
 - ▶ Legal arguments
 - ▶ Clinical arguments
 - ▶ Documentation
- ▶ Spot trump cards
 - ▶ Inpatient-only procedures
 - ▶ Emergency services
 - ▶ Post-stabilization care
 - ▶ Contractual provisions

Medicare Advantage Recommendations

- ▶ When thinking about contracting, remember that the terms are essential.
 - ▶ Demand fair terms.
 - ▶ Have those experienced in denial management review proposed contract for fairness & denial prevention opportunities.
- ▶ Exercise your rights to appeal.
 - ▶ **Advocate** based upon facts, law, and clinical evidence. Don't just send the medical records.
 - ▶ Consider outsourcing for overflow, second opinions, or tough issues
- ▶ Track denials by payer and type: “Payer Report Cards”
 - ▶ Utilize Cards in negotiations
 - ▶ Consider utilizing Cards for complaints to CMS

Thank you for your attention!

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