When Not to Contract – What to Consider

CMS Guidance: What If You Are Not Contracted With a MA Plan and Alternative Appeal Strategies

R. Phillip Baker, MD

Decision to Contract or Not

- Is there an overwhelming market reason
- Can you get favorable terms in the contract to outweigh the backside loses
- Can you track and justify the additional costs to being contracted
- Does your facility really understand the implications of the contract on revenue cycle
- Does the contract actually provide a profit margin
- Does the plan have network adequacy in your area

Regulations 42 C.F.R. § 422.214

§ 422.214 Special rules for services furnished by noncontract providers.

a) Services furnished by non-section 1861(u) providers.
   1) Any provider (other than a provider of services as defined in section 1861(u) of the Act) that does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA coordinated care plan, an MSA plan, or an MA private fee-for-service plan must accept, as payment in full, the amounts that the provider could collect if the beneficiary were enrolled in original Medicare.
   2) Any statutory provisions (including penalty provisions) that apply to payment for services furnished to a beneficiary not enrolled in an MA plan also apply to the payment described in paragraph (a)(1) of this section.

b) Services furnished by section 1861(u) providers of service. Any provider of services as defined in section 1861(u) of the Act that does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA coordinated care plan, an MSA plan, or an MA private fee-for-service plan must accept, as payment in full, the amounts (less any payments under §§ 412.105(g) and 413.76 of this chapter) that it could collect if the beneficiary were enrolled in original Medicare. (Section 412.105(g) concerns indirect medical education payment to hospitals for managed care enrollees. Section 413.76 concerns calculating payment for direct medical education costs.)

Understand You Rights if You are Not Contracted

- MA Plans have to follow original Medicare Regulations and Guidance for non-contracted facilities
- The "Two Midnight Rule" [technically 42 CFR 412.3(d)] applies to status determinations
  - Includes following the Inpatient Only List
- Must follow Original Medicare rules for readmission denials
- Non-contract providers can bill MA enrollees for denied services, unless a "waiver of liability" is signed by the provider
- Non-contract providers may access the 5 level appeal process on their own behalf, but must sign a "waiver of liability" if doing so
- The issue of access to SNF benefits after a qualifying 3 day inpatient stay is yet to be resolved with CMS as they are treating that as a contract issue between the beneficiary and payer

Escalation of Complaints Against the MA Plans to CMS

- Effective option particularly for non-contracted facilities
- This process was worked out after months of effort with Senior Analyst at the CMS Medicare Advantage Group and communicated by email
- CMS is primarily concerned about the beneficiary
- Facility must attempt one level of appeal with the payer to allow them to correct the issue prior to escalation
- If a non-contracted facility is not allowed to follow Original Medicare Guidelines and has appealed the situation to the plan then escalate this to CMS as a complaint.
- Do not send privileged information in the complaint
- Contracted facility if you can demonstrate that a beneficiary is being potentially harmed or denied services they should be entitled to by a payer's practice this can be escalated as well (not allowing post-acute care, denying medically necessary services)

Example Escalation

I am reaching out again to see if we can get help on issues related to XYZ. XYZ outsources clinical validation audits to Cotiviti and requires that we continue to appeal up to three times to Cotiviti without any further appeals to United Directly. As a non-contracted facility are we not supposed to have the right to appeal directly to XYZ on these matters and even if we initially have to appeal to Cotiviti are we not then supposed to have the right to appeal to an Independent Review Entity. We are being denied the normal levels of appeal we would have under original Medicare which is what we should be allowed as a non-contracted facility.

When I spoke to a Medical Director at Cotiviti about a RAC review he acknowledged that CMS does not allow them to even do clinical validation for Medicare and since per previous directions regarding the Medicare Advantage Plans that if we are non-contracted they have to follow original Medicare guidelines does this also preclude them from even doing these audits. Many of the definitions they are using do not follow current medical definitions and they often quote references that support the inclusion of the diagnosis they are attempting to deny but only use one specific item from said definition and not the entirety of the language in the citation. The often refer to Official Coding Clinic Guidelines then ignore them when it is pointed out that they actually support the coding as billed.

Continued

One example would be acute kidney injury or acute kidney failure either of which is coded to N17.9 and I have attached my appeal without any of the PHI so you can see what I am talking about in that the fail to follow their own citations or use outdated definitions. There are the same issues with other terms like NSTEMI when they insist on having things not included in the Third Universal Definition of Myocardial Infarct which is the current standard of care. If you need them I can provide other examples.

Any help in this would be greatly appreciated and I know you have put many hours into these issues with previous complaints. If they are not allowed to do this at all since CMS has not allowed these reviews for original Medicare that makes this a simple solution but if they are allowed to continue these reviews then they must agree to allow current definitions and for non-contracted facilities not be allowed to hold us to their arbitrary definitions for terms. We all know they only look to deny single CC's or MCC's so that the payment for the claim is significantly affected and I would be very interested to know if they then report these denials to CMS to remove the diagnoses which are often HCC's and have significant impact on the companies risk adjustment scores and the payment from CMS to the MA Plan based on that score.

CMS Contacts for Specific Plans and General Contact

- **Humana MED C Contact at Medicare:**
- Uvonda Meinholdt
  Health Insurance Specialist
  Kansas City Regional Office
  Phone: 816-426-6544
  FAX: 443-380-6020
  Uvonda.Meinholdt@cms.hhs.gov

- **UHC MED C Contact at Medicare:**
- Nicole Edwards
- Phone: 415-744-3672
- Nicole.edwards@cms.hhs.gov

- **Coventry Health Care Med C/Aetna Med C**
- Donald Marik
- Health Insurance Specialist
- Denver Regional Office
- Phone: 303-844-2646
- Donald.Marik@cms.hhs.gov

- **Blue Cross Blue Shield Anthem Med C:**
- Anne McMillan
- Health Insurance Specialist
- Chicago Regional Office
- Phone: 312-353-1668
- Anne.McMillan@cms.hhs.gov

General CMS Contact:
Melanie Xiao
Health Insurance Specialist
Medicare Advantage Branch
Division of Medicare Health Plans Operations
Centers for Medicare & Medicaid Services
CMS San Francisco Regional Office
90 7th Street, 5-300 (5W)
San Francisco, CA 94103-6708
Phone: 415-744-3613
FAX: 443-380-6371
melanie.xiao@cms.hhs.gov

MA Appeals Process – Definitions

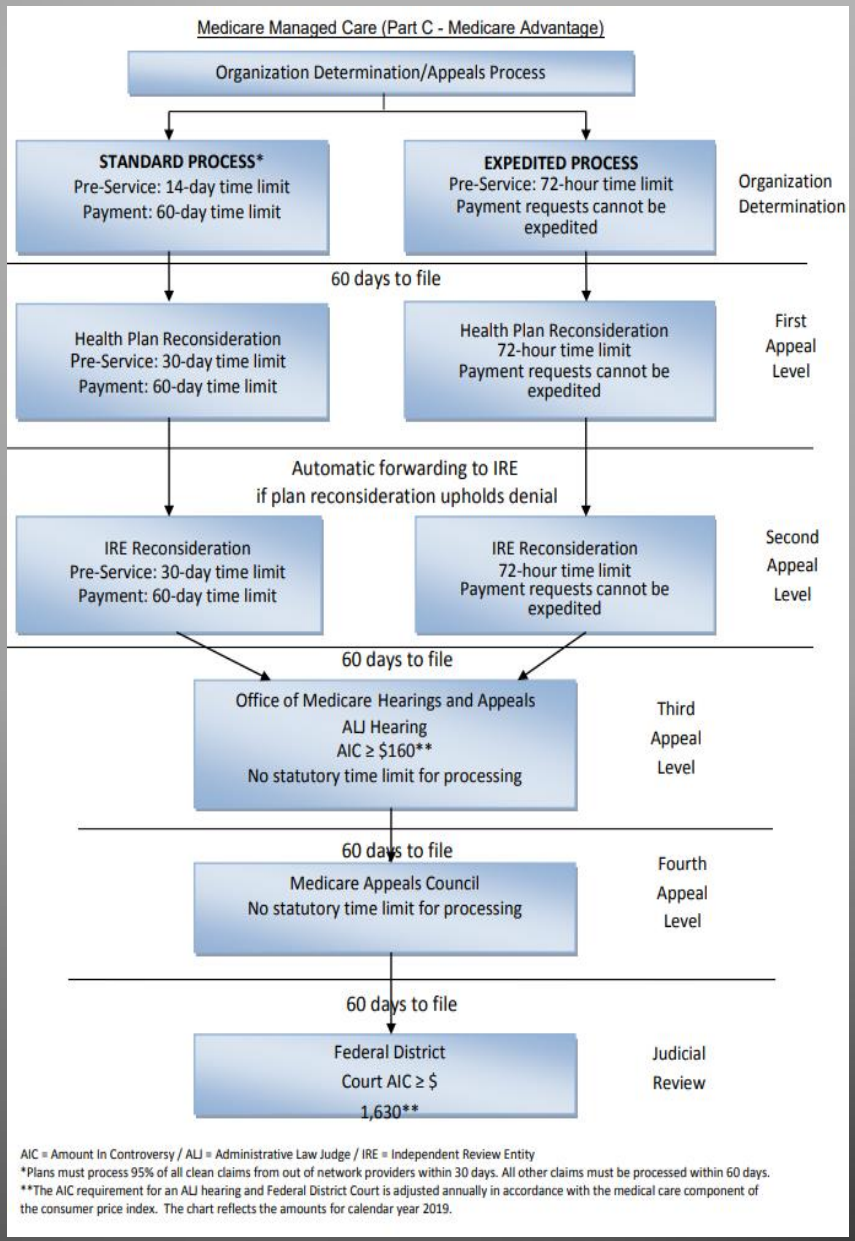
- **Organization Determination** – A decision of the Medicare Health Plan, or person acting on its behalf, to approve or deny a payment for a health care service or a request for provision of health care service made by, or on behalf of, a Medicare Health Plan enrollee.
- **Reconsideration** – the first level in the appeals process which involves review of an adverse organization determination by an MA plan, the evidence and findings upon which it was based, and any other evidence submitted by a party to the organization determination, the MA plan or CMS. Also refers to the second level of appeal in which an independent review entity reviews an adverse plan decision.
- **Grievance** – An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken.

Additional Appeal Strategies

- Denial after concurrent review and authorization for inpatient status should not be allowed as per the Medicare Managed Care Manual, Chapter 4, Section 10.16, Medical necessity it states “If the plan approved the furnishing of a service through an advance determination of coverage, it may not deny coverage later on the basis of a lack of medical necessity.”
- If a plan persists in denial after appeal in this circumstance even for contracted facilities you can appeal to CMS as a violation of CMS policy

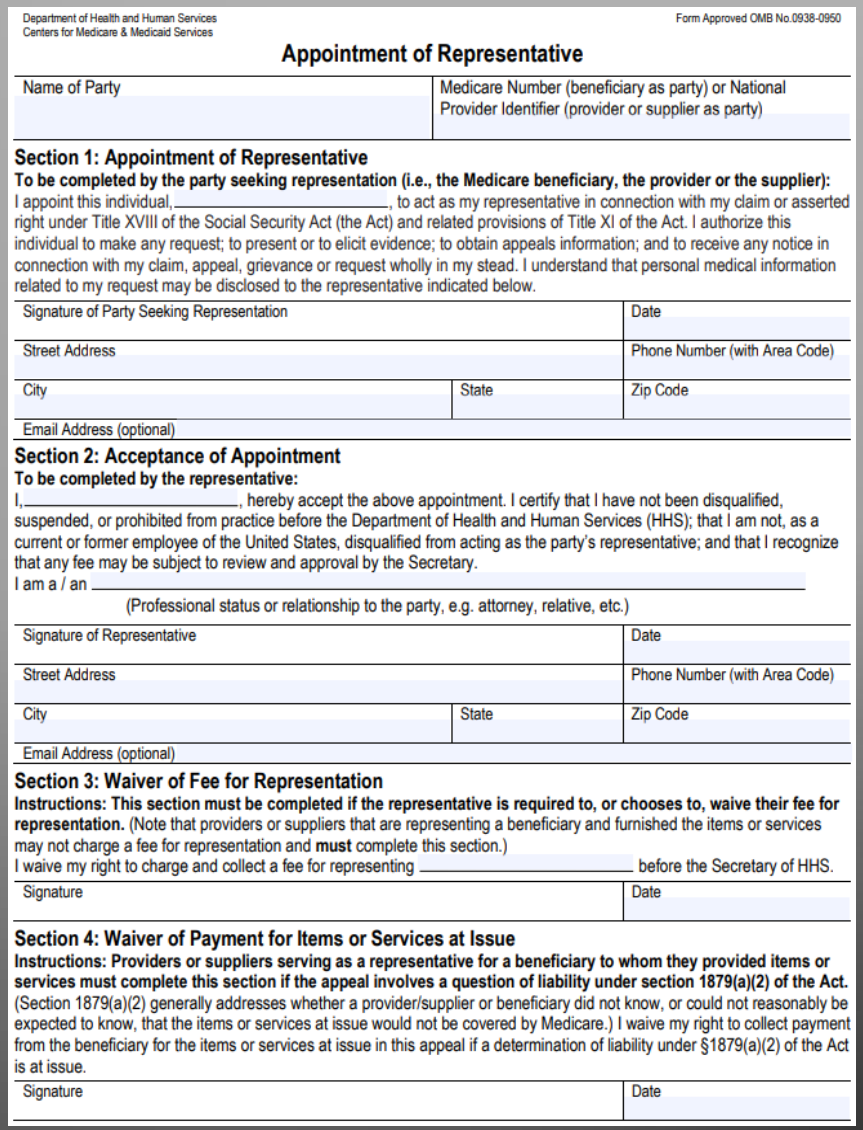
MA Appeals Process

- Enrollee (beneficiary) appeal rights shown
- Non-contract providers may access standard payment appeal pathway if waiver of liability completed
- Anyone with formal representative authority can access full enrollee appeal rights without waiver of liability
- Note automatic forwarding to IRE if first level reconsideration upheld



CMS Form 1696 – formal representative

- Must be accepted by all Medicare Advantage plans – cannot require a different form
- Sections 4 not applicable to Medicare Advantage because the Plan's Evidence of Coverage dictates any cost-sharing responsibility, unchanged by this form
- Providers cannot charge a fee for representing enrollee
- Valid for 1 year, and for life of an appeal



Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved OMB No.0938-0950

Appointment of Representative

Name of Party	Medicare Number (beneficiary as party) or National Provider Identifier (provider or supplier as party)

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

I appoint this individual, _____, to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the Act) and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my claim, appeal, grievance or request wholly in my stead. I understand that personal medical information related to my request may be disclosed to the representative indicated below.

Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)		

Section 2: Acceptance of Appointment

To be completed by the representative:

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____

(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)		

Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to, waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of HHS.

Signature	Date

Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.) I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature	Date

Contact Information

R. Phillip Baker, MD
Medical Director Case Management and Physician Advisor
Self Regional Healthcare
Greenwood, SC

Office – 864-725-5589
Cell – 864-993-6863
Email – Roy.Baker@selfregional.org