Success with Medicare Advantage Plans

Marjorie Mantione, PT
Clinical Appeals Supervisor
Clinical Implementation Specialist
Uniform Data System for Medical Rehabilitation
Objectives

- Understand MCR Advantage plans and beneficiaries general rights under part C
- Identify strategies for increasing the likelihood of a successful IRF pre-certification
- Discuss fighting post-discharge denials
- Identify strategies for marketing/advocating your IRF’s services over those of a SNF
Overview

• Medicare Advantage plans (Medicare Part C plans) are offered by private insurance companies on behalf of Medicare to manage a beneficiary’s benefits
• Medicare pays a set amount of money each month to the private insurance company to provide healthcare coverage
• Enrollment in these plans continues to increase across the country
• In 2014, Medicare Advantage plan enrollment represented approximately 30% of total Medicare enrollment, up from 25% in 2010
Access to Services

- Medicare Advantage plans must cover all medically necessary services covered by Medicare Part A and Part B services and must adhere to Medicare-established criteria for services rendered.
- The plans are not required to provide the same access to providers as the original Medicare plan.
- Medicare Advantage plans can use a network of providers under HMO- or PPO-type plans.
- Some plans cover non-network providers, but the cost to the enrollee varies.
Access to Services

• Medicare Advantage plans will contract with providers to cover the spectrum of services beneficiaries would receive under normal Medicare.

“An MA plan may specify the providers through whom the enrollees may obtain services if it ensures that all original Medicare covered services . . . are available and accessible . . .”

—Medicare Managed Care Manual, Ch. 4, §110.1
Access to Services

• Each Medicare Advantage plan’s internal medical necessity policies must include coverage criteria no more restrictive than the original Medicare criteria.

• A plan may offer additional coverage as a supplemental benefit but may not limit the original Medicare coverage.
Access to Services

• Need to verify the patient’s benefits and level of coverage under the specific plan
• Costs to patient (copays) can vary, depending on the plan and the provider
Access to Services

“Plans may not implement utilization management protocols that create inappropriate barriers to needed care.”

—Medicare Managed Care Manual, Ch. 4, §110.1.1
Organization Determinations

• An organization determination is any decision made by a Medicare Advantage organization regarding payment or benefits to which an enrollee believes he is entitled.

• These determinations may involve decisions about whether to provide or pay for a benefit or service the enrollee believes may be covered by the plan.

• Organization determination requests can be made by the enrollee, the enrollee’s representative, or the physician.

• The enrollee can appoint a representative to act on his behalf in requesting a determination and to represent the enrollee in the appeal process (requires a representative form).
Organization Determinations

• Includes:
  • Advance coverage determinations (also known as pre-certifications/pre-authorizations/pre-service decisions)
  • Post-service payment decisions
Organization Determinations

• Advance coverage determinations can be performed to determine whether the service is deemed medically necessary and covered

• The enrollee or a physician may request an expedited pre-service determination

• An expedited pre-service reconsideration may be pursued if an advance coverage decision is adverse
Organization Determinations: Pre-service Request Time Frames

• The plan must make a decision as “expeditiously as the enrollee's health condition requires”
  • Expedited requests: Within seventy-two hours of the request
  • Standard requests: Within fourteen days of the request
• Both determination time frames may be extended up to fourteen calendar days if the enrollee requests an extension or if the plan documents that an extension is in the enrollee’s best interests (such as waiting for medical records)
Organization Determinations: Pre-service Request Time Frames

- An expedited determination can be requested when waiting for a decision under standard time frames “could place the enrollee’s . . . ability to regain maximum function in serious jeopardy” (*Medicare Managed Care Manual*, Ch. 13, §50)
- The enrollee or any physician can request an expedited determination
- Expedited requests can be made orally or in writing
Medical Exigency Standard

• Requires the review entity to make decisions “as expeditiously as the enrollee’s health condition requires”

• Plans must treat every case in a manner that is appropriate to its medical particulars or urgency

• Plans should not systematically take the maximum time permitted for service-related decisions
Organization Determinations

“[W]hen a member complains that he or she has been unable to obtain a service that he or she is entitled to receive (such that a delay adversely effects the health of the enrollee), it should be addressed as an organization determination, which can be appealed.”

—Medicare Managed Care Manual, Ch. 13, §30.1.2
Organization Determinations

“[I]f 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 . . .”

—Medicare Managed Care Manual, Ch. 4, §10.16
Organization Determinations

- If the plan expects to issue an adverse decision based on a lack of medical necessity, the determination must be reviewed by a physician or an appropriate licensed healthcare professional before the plan issues the decision.
- This healthcare professional must have sufficient expertise, including knowledge of Medicare coverage criteria.
Organization Determinations

• The denial rationale must include the following:
  • The specific reason for the denial
  • The right to a standard reconsideration or an expedited reconsideration (appeal rights)
  • Time frames
  • The right to appoint a representative
  • The right to submit additional evidence
Strategies for a Successful Organization Determination

- Pre-admission authorization
  - Have the referring physician specify the need for IRF services, not just “rehab”
  - Submit a thorough pre-admission screening with specific requirements for inpatient medical care and intensive rehabilitation
  - Have the physician request an expedited decision as waiting for a decision could place the enrollee’s ability to regain maximum function in serious jeopardy
Strategies for a Successful Organization Determination

• If the initial determination is adverse:
  • Request a physician-to-physician phone conference to discuss the case
  • Cite MCR’s IRF criteria for a reasonable and necessary admission, and explain why and how the patient meets this criteria
  • Have the patient file a complaint regarding failure to receive services the patient is entitled to
  • Have the patient, the physician, or a representative file an expedited request for reconsideration (appeal)
Five Levels of Medicare Advantage Appeals

- **Level 1:** Reconsideration
  - Reconsiderations by Medicare Advantage plan
- **Level 2:** IRE reconsideration
  - Reconsiderations by independent review entity
- **Level 3:** ALJ Hearing
  - Administrative law judge hearings
- **Level 4:** MAC review
  - Review by the Medicare Appeals Council
- **Level 5:** Judicial review
  - Judicial review by a federal district court
# Time Frames for Appeals and Decisions

<table>
<thead>
<tr>
<th>Organization Determination</th>
<th>Level 1 Health Plan Reconsideration</th>
<th>Level 2 IRE Reconsideration</th>
<th>Level 3 ALJ Hearing</th>
<th>Level 4 MAC Review</th>
<th>Level 5 Judicial Review</th>
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<td>Time to file: 60 days</td>
<td>Time to file: Automatic forwarding to IRE if plan upholds denial</td>
<td>Time to file: 60 days</td>
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**Standard process:**
- Pre-service: 14 days
- Payment: 60 days

**Expedited process:**
- Pre-service: 72 hours
- Payment: Cannot be expedited

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Level 1: Reconsideration

- Case is presented back to the plan for determination
- A medical director other than the one who made the initial organization determination reviews the case
- Sixty-day file time from date of adverse organization determination for standard appeal
- A physician, the enrollee, or the enrollee’s representative can request an expedited reconsideration if the standard time frame could jeopardize the enrollee’s ability to regain maximum function
- For an expedited reconsideration, a decision must be made “expeditiously” but no later than seventy-two hours from the time of the request
Level 2: IRE Reconsideration

- If the plan upholds the denial at level 1, the case is automatically forwarded to the IRE
- Time frames to forward a case to the IRE:
  - For standard requests: No later than thirty calendar days from receipt of original request for reconsideration
  - For expedited requests: No later than twenty-four hours from the affirmation of adverse expedited organization determination
  - For requests for payment: No later than sixty calendar days from receipt of original request
- Notification is provided by the plan, and the enrollee/representative is allowed to submit additional information to the IRE
Level 2: IRE Reconsideration

- Expedited requests must be decided within seventy-two hours
- Standard pre-service requests must be decided within thirty days
- Standard payment requests are decided within sixty days
Request for ALJ Hearing

• A party must file a request for an ALJ hearing within sixty days of the date of the notice of an adverse IRE determination

• The Medicare Advantage plan does not have the right to request an ALJ hearing but must be made a party to it
Additional Considerations for Medicare Advantage Plans
Do IRF Documentation Requirements Apply to Medicare Advantage Patients?

- 42 Code of Federal Regulations §412.622(4) says that the new documentation requirements apply to any patient for whom the IRF seeks payment directly from fee-for-service or traditional Medicare.

- Because Medicare Advantage companies reimburse IRFs for treatment of Medicare Advantage patients, the documentation requirements do not apply to Medicare Advantage patients unless the Medicare Advantage companies adopt the same policies.

—IRF PPS Coverage Requirements, November 2009 National Call—Follow-up, Series 4
In-Network Providers

• Know your agreement
  • Does it require pre-certification?
  • Who is the plan’s medical director?
  • Are the terms consistent with CMS’s criteria for IRFs?
  • Does the plan require standard MCR IRF documentation requirements?
  • Do you have appeal rights?
• For admissions, verify the coverage amounts and any contractual exclusions or “carve outs” to maximize reimbursement
Out-of-Network Providers

- For admissions, verify the coverage amounts and the costs to the enrollee
- Consider a “letter of agreement”—a one-time agreement that admits an enrollee with specific terms and a specific pay rate
Advocating IRF over SNF

- Not all Medicare Advantage plans are familiar with the differences between IRFs and SNFs when performing pre-authorization of services
  - Thus, you must present your case for an IRF level of care
- Even though sections in the *Medicare Managed Care Manual* affirm DME and SNF coverage, it does not explicitly mention IRF services
Advocating IRF over SNF

“Under the new requirements, a patient meeting all of their required criteria for admission to an IRF would be appropriate for IRF care whether or not he or she could have been treated in a skilled nursing facility.”

—CMS guidance from the IRF PPS Coverage Requirements National Call, November 2009
Advocating an IRF over a SNF

• Educate the decision makers at the plan
  • Identify the individual at the plan who is making post-acute care decisions
  • Set up a face-to-face meeting and/or provide facility tours if local
• Develop positive relationships with case managers
• Provide patient status updates
• Provide patient-specific outcome data following an enrollee’s discharge
  • Use the Patient Profile Report
Advocating an IRF over a SNF

• Provide facility-specific outcome data
  • Profile reports by CMG, including:
    • Functional gains
    • Discharge disposition
    • Length of stay
  • Readmission data
  • Hospital-acquired infection data
  • Patient satisfaction data
• Provide comparative SNF outcome data
  • Nursing home compare
  • Dobson/DaVanzo: AMRPA-commissioned report on IRF vs. SNF outcomes
Advocating an IRF over a SNF

• Track plan admissions and patients “lost” to SNFs
• If you identify a consistent pattern of admission denials for IRF-appropriate patients, consider discussing the plan’s utilization protocols with the plan’s leadership
• According to CMS’s policy, the plan’s protocols must not create barriers to needed care, including IRF services
Additional Resources

- CMS’s MA State/County Penetration Report
  - Shows the percentage of eligible Medicare beneficiaries who have enrolled in a Medicare Advantage plan by county
- CMS’s MA Contract Services Area by State/County Report
  - Shows specific plan coverage by county
Questions?

Marjorie Mantione, PT, Clinical Appeals Supervisor, Clinical Implementation Specialist:
• 716-817-7891
• mmantione@udsmr.org

Appeals at UDSMR:
• 716-817-7824
• appeals@udsmr.org