Managed Care in the SNF Environment

for clients of:

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Managed Care

POST-TEST

1. Medicare Advantage plans are sometimes referred to as:
   a. Medigap
   b. Part C
   c. Part D
   d. Medicaid

2. Which is NOT a requirement to join a Medicare Advantage Plan?
   a. Entitled to Part A
   b. Limited income and resources
   c. Enrolled in Part B
   d. Live in plan’s service area

3. If you are in a Medicare Advantage Plan
   a. You may have prescription drug coverage
   b. You should buy a Medigap policy
   c. Benefits and cost sharing will always be the same as Original Medicare
   d. You can change your plan at any time

4. Which one is NOT a type of Medicare Advantage Plan?
   a. HMO
   b. PPO
   c. SNP
   d. SNF

5. When beneficiary wants to dis-enroll from the MA plan during a SNF stay the facility must provide notice how?
   a. Written
   b. Orally
   c. Both
6. What type of claim must be submitted to Medicare for a beneficiary with a MA Plan?

7. What type of MDS must be submitted for beneficiaries with a MA plan?

8. Which are acceptable billing methods for MA contracts? (Dependent on Contract type)
   a. PPS
   b. Charge based
   c. Level of care
   d. Contracted daily rate
   e. All of the above

9. If a beneficiary no longer requires skilled care under the MA plan the SNF may discharge the patient using a patient status code 04?
   a. True
   b. False

10. MA residents have the same rights of appeal as do traditional Medicare beneficiaries?
    a. True
    b. False
Managed Care

POST TEST ANSWERS

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   d. **SNF**

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Informational

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OBRA assessments

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Managed Care

Objectives

- Define Medicare Advantage (MA) Plans
- Managed Care Penetrations
- Describe how MA Plans work
- Explain eligibility requirements and enrollment
- MA Plan Types
- Managed Care Trends in the SNF
- Managed Care Contracts
- Managed Care Billing
- MA Notices
Medicare Advantage Plans
Overview

• What are Medicare Advantage Plans?
• Who can join and when?
• How MA Plans work?
• Types of MA Plans?

What IS Managed Care?

• Managed care is a generic term for various health care payment systems that attempt to contain costs by controlling the type and level of services provided.
Managed Care Plans

• Health plan options
  – Approved by Medicare
  – Run by private companies
• Part of the Medicare program
• Sometimes called Part C
• Available across the country
• Provide Medicare-covered benefits
  – May cover extra benefits

THEY ARE NOT SUPPLEMENTAL PLANS

Types of Insurance/Managed Care Plans encountered in SNFs

• Fee For Service
• Health Maintenance Organization (HMO)
  – e.g., Kaiser, Humana, United
• Medicare Advantage Plan
  – BCBS, etc.
  – Same as Medicare? Maybe not
Types of Insurance/Managed Care Plans encountered in SNFs

- Accountable Care Organization
  - Contract
  - In Network vs. Out of Network
- Medicaid Managed Care
  - Risk Based
  - Primary Care Case Management (PCCM)
    - PCP Case Management Fee

Who Owns the Various Plans?

- Insurance Company’s
- Hospitals and Hospital systems
- Preferred Provider Organizations (PPO)
- Provider Sponsored Organization (PSO)
- Religious Fraternal Benefit Plan (RFBP)
- Exclusive Provider Organizations (EPO)
- Individual Practice Associations (IPA)
- Physician/Hospital Organizations (PHO)
  - ALL Must be approved by Medicare
Rules for MA Plan

• Medicare pays a capitated amount (per enrollee) each month to the companies offering Medicare Advantage Plans.
• Medicare makes a separate payment to plans for providing prescription drug benefits under Medicare Part D.
• Companies must follow rules set by Medicare.
• Each Medicare Advantage Plan can charge different out of pocket expense and have different rules.
• These rules can change each year.

Medicaid Managed Care

• The Health and Human Services Commission (HHSC) contracts with managed care organizations (MCO) licensed by the state.
• The HHSC pays each MCO a monthly amount to coordinate health services to Medicaid clients.
• The MCO plans contract directly with doctors and other health care providers to create a provider network for the MCO’s members.
• The health plan provides all Medicaid covered medically necessary services to the member.
Medicaid Managed Care Penetration

Comprehensive Medicaid Managed Care Models in the States, 2014

As of July 1, 2014
- MCO only (24 states including DC)
- MCO and PCO (13 states)
- PCO only (8 states)
- No Comprehensive MMC (3 states)

NOTE: ID's VNSP program, which is a Medicaid, has been reclassified to ODM from a FMAP UC an MCO by CMS but is not counted here as such. CA has a small PCO program operating in LA County for those with HIV.


Marketing MA plans
Medicare Marketing Guidelines (MMG) For Medicare Advantage

- Provide Policy clarifications and operational guidance
- Updated each year
- CMS marketing requirements apply to:
  - Medicare Advantage Plans
  - Medicare Prescription Drug Plans
  - Cost Plans
  - Some other plans

Managed Care Marketing

- Health Care Settings
  - Marketing allowed in common areas
    - Hospital or nursing home cafeterias
    - Community or recreational rooms
    - Conference rooms
  - No marketing in health care setting
    - Waiting rooms
    - Exam rooms and hospital patient rooms
    - Dialysis centers and pharmacy counter areas
Educational Events

- Educational Events
  - No marketing activities at educational events
  - Can not provide meals
  - Can not give gifts over $15.00
  - Plans may distribute
    - Medicare and/or health educational materials
    - Agent/broker business cards
      - Containing no marketing information
How Does Managed Care Work?

- Beneficiary receives services through the plan
  - All Part A and Part B covered services (except Hospice)
  - Some plans may provide additional benefits
- Most plans include prescription drug coverage
- May have to visit network doctors/hospitals
- May differ from Original Medicare
  - Benefits
  - Cost-sharing
How Does Managed Care Work, cont.

• Still in Medicare program
  – Medicare pays the plan every month for care provided
• Still have Medicare rights and protections
• If the plan leaves Medicare
  – can join another Medicare Advantage Plan, or
  – can return to Original Medicare

How Does Managed Care Work, cont.

• Beneficiary still pays the Part B premium
  o A few plans may pay all or part
  o State assistance for some
• May pay plan an additional monthly premium
• Pay deductibles, coinsurance, and copayments
  o Different from Original Medicare
  o Varies from plan to plan
  o Costs may be higher if out-of-network
Who Can Join A Medicare Advantage Plan?

- Eligibility requirements
  - Entitled to Medicare Part A (Hospital Insurance)
  - Enrolled in Medicare Part B (Medical Insurance)
  - Live in plan service area
  - Usually no End Stage Renal Disease (ESRD) at enrollment
- To join, you must also:
  - Provide necessary information to the plan
  - Follow the plan rules
  - Belong to one plan at a time

When Can You Join?

- Initial Enrollment Period (IEP)
  - 7 month period begins 3 months before the month you turn 65
  - Includes the month you turn 65
  - Ends 3 months after the month you turn 65
- Medicare Open Enrollment Period “Open Enrollment”
  - Oct 15 – Dec 7
  - Coverage begins Jan 1
- Plans must be allowing new members to join
When You Can Join or Switch Plans

• Special Enrollment Periods (SEP)
• Move out of your plan’s service area
• Plan leaves Medicare program or reduces its service area
• Leaving or losing employer or union coverage
• **You enter, live at, or leave a long-term care facility**
• You have a continuous SEP if you qualify for Extra Help
• Losing your Extra Help status
• You join or switch to a plan that has a 5-star rating
• Retroactive notice of Medicare Entitlement
• Other exceptional circumstances

Special Enrollment Period Trial Rights

• People who join an MA Plan for the first time
  o When first eligible at 65 or
  o Leave Original Medicare and drop Medigap policy
• Can disenroll during first 12 months
  o Return to Original Medicare
  o Have guaranteed issue rights for Medigap
Dis-enrolling from a Managed Care Plan

• Medicare Advantage Disenrollment Period (MADP)
  – Can only leave a Medicare Advantage and return to Original Medicare plan during the Medicare Advantage Disenrollment Period (MADP). You cannot join or switch MA plans during this time. The MADP is from January 1 - February 14 each year.

Open Enrollment period

• Can switch to another Medicare Advantage Plan or to Original Medicare during the Open Enrollment Period, also known as Annual Enrollment. This period runs from October 15 - December 7 each year, with coverage starting January 1.
Special Enrollment Periods (SEP)

- Move out of your plan’s service area
- Plan leaves Medicare program or reduces its service area
- Leaving or losing employer or union coverage
- You enter, live at, or leave a long-term care facility
- You join or switch to a plan that has a 5-star rating
- Retroactive notice of Medicare Entitlement
- Other exceptional circumstances

CMS Issues Guidance for Beneficiary Disenrollment by Nursing Facilities

- If a beneficiary or their legal representative requests assistance from the LTC facility in changing the beneficiary's health care coverage, the LTC facility must follow certain steps to ensure changes comply with regulations regarding enrollment/disenrollment and resident rights.
CMS Issues Guidance for Beneficiary Disenrollment by Nursing Facilities

- Explain orally and in writing the impact to the beneficiaries if they change to a stand-alone drug plan and Original Medicare.
- Develop written policies and procedures regarding the process of assisting beneficiaries with changing their health care coverage.

Disenrollment by Nursing Facilities cont.

- Any change in a beneficiary's health care coverage must be initiated by the beneficiary or his/her legal representative.
- A clear explanation that the beneficiary would no longer be a member of the MAPD or MMP.
- An explanation that medical services will be billed to original Medicare and/or Medicaid and what this means regarding deductibles and copays and loss or lack of supplemental coverage for the beneficiary.
- The name of the drug plan that will cover the beneficiary’s medications, including the deductible and copays/coinsurances especially related to their current drug therapy.
Disenrollment cont.

– Specific information regarding the beneficiary’s opportunities to change Medicare plans and Medicare prescription drug coverage while in the facility (i.e. every month) and when discharged (i.e. for 2 months following the month of discharge) or by virtue of being eligible for Medicare and Medicaid (i.e. every month).
– An explanation that enrollment in the PDP will be effective the first day of the month following the month of enrollment/disenrollment.

Disenrollment cont.

• An explanation that in some cases the beneficiary may not be able to reenroll into the MA or MAPD plan the beneficiary previously had (or for that matter into any MA or MAPD plan) even if the beneficiary has a valid election period. (e.g. beneficiaries with ESRD that disenroll from an MA plan and return to original Medicare can never re-enroll in an MA plan; such beneficiaries must stay with original Medicare until the beneficiary no longer meets the definition of having ESRD. Employer sponsored MAPDs may not and do not have to accept a beneficiary back into the plan).
Disenrollment cont.

- Develop written policies and procedures regarding the process of assisting beneficiaries with changing their health care coverage that at a minimum include:
  - Under what circumstances the facility can assist a beneficiary with a plan change.
  - The need to obtain a document signed by the beneficiary or representative that acknowledges the specific information regarding the impact of a change in coverage was provided to them orally and in writing and that they understand the information.
  - The need to obtain an attestation signed by the facility staff member that assisted with the change in enrollment attesting that the beneficiary or representative requested the change and that the beneficiary or representative (as applicable) received and understood the minimum required information listed above.
Consequences of Beneficiary Disenrollment by a LTC Facility

- If documentation of a beneficiary’s request to change enrollment cannot be provided by a LTC facility, CMS will consider the enrollment not to be legally valid, cancel the enrollment action and, if necessary and appropriate, reinstate the beneficiary’s MA, MAPD or MMP coverage as if never disenrolled.
- CMS will be reporting these incidents to the Medicare Drug Integrity Contractor (MEDIC) that investigates fraud and abuse incidents.
- Medicare Managed Care Manual, Chapter 2, Sec. 40.6).

Types of MA Plans

- HMO
- PPO
- FFS
- MSA
### Medicare Health Maintenance Organization (HMO) Plans

- Copayment amounts are set by the plan
- Usually must use network doctors and hospitals
- May pay in full for care outside plan’s network
  - Covered if emergency or urgently needed care
  - POS option allows visits to “out-of-network” providers
- May need to choose primary care doctor
  - Usually need a referral to see a specialist
  - Doctors can join or leave
- May include prescription drug coverage

### Medicare Preferred Provider Organization (PPO) Plans

- Can see any doctor or provider that accepts Medicare
  - Does not need referral to see specialist
  - Does not need referral to see out-of-network provider
  - Copayment and coinsurance amounts set by plan
  - Will usually pay more for out-of-network care
- May get Medicare prescription drug coverage
Medicare PPO Plans, cont.

• Regional PPOs
  – Available in most areas of the country
  – Usually serve entire state or a multi-state area
  – Have annual limit on out-of-pocket costs
    • Varies by plan
  – May have higher deductible and/or premium than other PPOs

Medicare Private Fee-for-Service (PFFS) Plans

• Can see any Medicare-approved doctor or hospital that accepts the plan
  – Can get services outside service area
  – Don’t need referral to see a specialist
  – Plan sets copayment amounts

• If offered, can get Medicare prescription drug coverage
  – If not offered, can join a Medicare Prescription Drug Plan
Special Needs Plans (SNPs)

- Designed to provide:
  - Focused care management
  - Limit membership
  - Special expertise of plan’s providers
  - Benefits tailored to enrollee conditions
- Must include prescription drug coverage

Medical Savings (MSA) Plans

**Similar to Health Savings Account Plans**

- Have two parts
  - Medicare Advantage Plan with high deductible
    - Pays covered costs after deductible is met
  - Medical Savings Account
    - Medicare deposits money the person may use to pay health care costs
- Not available in all areas
Managed Care Plans
Trends In the SNF

• The trend is to see more managed care in the SNF environment. The basic idea is that a private insurer manages people's Medicare and/or Medicaid benefits with the goals of increasing efficiency and reducing costs.

• Skilled nursing facilities could lose substantial sums of money unless a facility is on top of exclusions and other contract elements.

Managed Care Plans
Trends In the SNF, cont.

• Certain items can be “excluded” from the per-diem rate. Pricey meds., therapy

• Stay on top of benefit coverage. Ask for the “Evidence of Coverage” form the provider or beneficiary.

• HMOs typically reimburse more slowly than traditional Medicare.

• Consider a Managed Care Coordinator
Managed Care Contracts

Contract Elements

• Medical Necessity
  – A fundamental concept in managed care is that unnecessary services will not be covered.
  – The contract will limit reimbursement to services that are "medically necessary."
  – The key issue is: **who decides medical necessity** -- the provider, or the MA.
Contract Elements

• Payment Options
• How will I get paid?
  – Rate Levels
  – RUG based
  – Percent of Charges
  – Case Rates
  – Capitation

Managed Care Contracts

• Another crucial facet of managed care contracts is exclusions.
• Can the nursing home be reimbursed for these items in addition to receiving the standard daily payment.
• Nursing homes that negotiate smart exclusions will have a greater ability to care for high-acuity patients.
Managed Care Considerations

• A person receiving post-acute skilled care might change levels several times during a stay, as he or she experiences improvements and setbacks.

• Have someone verify that the health plan is approving a patient at the correct level on an ongoing basis.

• KNOW THE CONTRACT TERMS

Items to review

• Request copies of any documents incorporated by reference such as:
  – provider policy and procedure manuals
  – subscriber plan documents (Evidence of Coverage or EOC)
  – utilization and authorization procedures guidelines
  – review these documents prior to signing any contract
Questions to be asked and answered (get answers in writing)

• Medical necessity - who determines medical necessity? Where are the criteria posted?
• What is the contract term? Does it include automatic renewal provisions or annual rate negotiations?
• What are the termination provisions?
• Notification of the covered person should be the responsibility of the plan.

Questions to be asked and answered

• What are the procedures to determine patient eligibility? Web based? Telephone system? Is a transaction number given?
• Does the plan require other data than what is submitted on a clean CMS 1500 or UB-04?
• Is coordination of benefits the plans responsibility or the providers? How do you determine which plan is primary?
• What are the provisions for dispute resolution?
Questions to be asked and answered

• What services can be billed to members? Non-covered services, co pays, deductibles
• What is the time frame for submission of claims and payment of claims?
• What fee schedule is being used?
• Do not accept bundling of charges other than those shown under Medicare guidelines.
• Does the plan require a 3 day hospitalization prior to admission?

Managed Care Admissions
Managed Care Admission Process

- Rushing Medicare Advantage through the admission process can be costly
- Managed Care Contracts are complex.
  - Rates
  - Exclusions
  - Administrative Rules
  - Case Management
  - Claims Filing

  All of these are not easily accessible

MA Admissions

- Patient eligibility/benefit/coverage information must be available at time of admission.
- Managed Care contract database should be established.
- The admission information, contract data base and payer system should all be linked.
- Billing Software must be compatible for MA billing of RUGs.
Important Questions

• Does the BOM/Facility understand the exclusions and how to bill them? Is the correct rate/revenue code being billed?
• Does your BOM have a provider manual from each health plan providing detailed information for billing and appeals? Is there a contact name and contact number for the specific health plan?
• Therapy utilization: Negotiate higher rates when additional therapy is appropriate.
• Utilization Review: Provide clinical updates needed for continued stay.

MA Framework

• Managed Care Process for Admissions
  – Gather demographic information on resident
  – Collect all insurance information
  – Verify Facility has a valid contract with MA Plan
  – Verify coverage details of resident’s MA plan (Evidence of Coverage)
  – Obtain written approval from MA plan for current episode of care.
  – Admit resident, if approved.
MA Framework

• If done prior to admission, then there will be a more successful outcome.
  – Better Care Management
  – Less denials
  – Timely payments

Verifying Medicare Advantage Plan Coverage

• First step to a successful managed care admission:
  – Verify benefits and coverage prior to admission.
  – If a Medicare Advantage plan then information is available about Medicare Part C enrollment on Page 1 of the CWF.
  – If plan is not a Medicare Advantage plan then insurance verification must be done, via internet or phone.
**Medicare Replacement info via DDE CWF**

**Part C information**

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**CWF Fields that display Part C information**

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**Medicare Replacement info via HIQA CWF**

**CWF Fields that display Part C information**

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<th>FULL-NAME</th>
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<td>PER 1 PLAN-TYP</td>
<td>PRIOR ID 00000 OPT 0 ENR 00000 TERM 000000</td>
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<tr>
<td>PRIOR PLAN-TYP</td>
<td>PRIOR ID 00000 OPT 0 ENR 00000 TERM 000000</td>
</tr>
</tbody>
</table>
Part C info via CWF

- EFF DT (DDE) ENR (HIQA) Plan Effective Date
- TERM Plan termination date
- PER 1 PLAN - TYP (Current Plan Year)
- PRIOR PLAN – TYP (Prior Plan coverage if applicable)
- CURR ID / ID CODE Plan identification code
- Medicare Advantage Plan Contract Identification

Insurance Verification

- If the plan is not a Medicare Advantage plan then you may need to call the plan for details.
  - Some plans have a web page that can be accessed for coverage information
  - Various clearinghouse that can be subscribed to can provide insurance information
  - If in doubt CALL the insurance company
Insurance verification

- It is important to record accurate information regarding coverage.
- Use an insurance verification tool to help ensure all needed information is gathered.
- This will also guide admissions to ask the correct questions.

Sample Verification Form

Insurance Questionnaire
Preauthorization of Benefits

1. Facility Name: __________________________ Facility #: __________________________
2. Resident Name: __________________________ Resident #: __________________________
3. Date of Admission: __________________________
4. Insurance: __________________________
5. Policy ID #: __________________________
6. Policy Effective Date: __________________________ Copy of ID Card: ______ YES ______ NO
   If no, please explain why: __________________________
7. Insurance Company Contact: __________________________
8. Insurance Co. Contact Phone #: __________________________ Fax #: __________________________
9. Type of Insurance Plan (circle one): Worker Comp/ No Fault Auto/ Liability Insurance/ EGHPI/ GHP/ PPO/
   MCR NMO/ MCR Supplemental/ LTC Long Term Care Ins.
10. Benefits in a skilled nursing facility available? ______ Yes ______ No If yes, # of days: __________
    What is the maximum amount paid and maximum days covered? __________
    Annual/out of pocket deductible amount: __________, Amount met: __________
11. Is preauthorization required? ______ Yes ______ No (if no, skip to #16) If yes, what is needed by Insurance
    Company for preauthorization? __________________________
    Was it sent? ______ Yes ______ No Date: __________________________ Time: __________________________ Sent by? __________________________
Who to bill?

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Instructions</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Maintenance Organization (HMO)</td>
<td>Call the plan for authorization.</td>
<td>Managed care plan with a provider network. Limited or no out-of-network coverage with the exception of emergency services.</td>
</tr>
<tr>
<td>Preferred Provider Organization (PPO)</td>
<td>You may treat the patient.</td>
<td>Has a network of providers. In return for higher cost sharing, members can go out of network for all plan services, including supplemental benefits.</td>
</tr>
<tr>
<td>Provider of Service(s) System (POS)</td>
<td>You may treat the patient subject to plan rules. Contact the plan for details.</td>
<td>A limited out-of-network option offered by HMO plans. Contact the plan for details.</td>
</tr>
<tr>
<td>Indemnity</td>
<td>You may treat the patient.</td>
<td>If this is a private Fee-for-Service (FFS) plan, you must follow the plan’s terms and conditions of payment. If this is a Medical Savings Account (MSA) plan, the member may pay you directly.</td>
</tr>
<tr>
<td>Fee-for-Service (FFS) Demo</td>
<td>You may treat the patient.</td>
<td>Beneficiaries remain in original Medicare and are entitled to all FFS benefits. There are no changes to Medicare FFS billing instructions or claims processing.</td>
</tr>
</tbody>
</table>

Skilled Services
Daily Skilled Services

- Meets eligibility requirements
- Physician Certification
- Documentation must reflect a daily skilled service
  - Flow sheets
  - Daily summary progress note is best practice
    - Reflects a summary of status, assessment, and plan
- Must require a daily skilled service
  - 5 days a week by therapy
  - 7 days a week by nursing

Daily Nursing Documentation

- Documentation should create a clear picture.
- Documentation must validate the services billed to Medicare.
- Documentation must support skilled interventions.
- Part A services may be required to treat conditions that are unstable or potentially unstable.
  - Medical record must identify unstable/potentially unstable conditions
Nursing Skilled Level of Care

1. Overall Management and Evaluation of care plan
2. Observation and Assessment of resident’s changing condition
3. Patient Education
4. Intravenous or intramuscular injections and intravenous feeding
5. Enteral feeding that comprises at least $\geq 51\%$ of calories or calories $26-50\%$ and fluid $\geq 501\text{cc}$

6. Nasopharyngeal and tracheostomy aspiration;
7. Insertion and sterile irrigation and replacement of suprapubic catheters;
8. Application of dressings involving prescription medications and aseptic techniques;
9. Treatment of extensive decubitus ulcers or other widespread skin disorder; Stage 3 or 4
Nursing Skilled Level of Care

10. Heat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by nurses to adequately evaluate the patient’s progress;

11. Initial phases of a regimen involving administration of medical gases;

12. Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing that are part of active treatment, e.g., the institution and supervision of bowel and bladder training programs.

13. Dialysis – depends if receiving a daily skilled service

14. Chronic conditions are not considered skilled unless with complications
   • Stasis Ulcers

15. Prognosis is not a factor in determination of skilled services
   • Terminal resident may or may not be skilled depending on daily skilled service
Non-skilled Supportive Services

1. Routine medications
2. Maintenance care of colostomy or ileostomy
3. Maintain functioning indwelling catheter
4. Changes of dressings for non-infected post-op or chronic conditions
5. Maintenance of plaster cast
6. Routine care connected to braces or similar devices
7. Restorative maintenance program

Therapy Skilled Services

- **Ongoing assessment of rehabilitation needs and potential:** Services concurrent with the management of a patient care plan, including tests and measurements of range of motion, strength, balance, coordination, endurance, functional ability, activities of daily living, perceptual deficits, speech and language or hearing disorders;
Therapy Skilled Services

Rehabilitation Services – 5 days a week
- Therapeutic exercises or activities
- Gait evaluation and training
- Range of motion
- Maintenance Therapy - to design and establish program
- Speech therapy

Nursing Supports Therapy

- Documentation should reflect collaboration.
- DO NOT document – “Resident is going to therapy for gait training” over and over again.
- Document how the resident is doing since going to therapy.
- Document what happens on the unit as it relates to ADLs, documentation should elaborate on how therapy is helping (or not) to achieve ADL goals.
Nursing Supports Therapy

• What is therapy working on?
  – On ST – Nursing documents resident cries easily when trying to express self, or problems trying to form words, but today started using hand gestures.
  – On OT – Residents ability to use an adaptive device for eating. Status and progress.
  – On PT – Resident expresses “PT makes me feel better, I can even walk a little.”

• Daily Documentation to support therapy
  – Each day is like a chapter in a book.
  – Detailed description of ADL status
  – Details will demonstrate progress
  – Contributors to progress or lack of progress
    • Medical, cognitive, sensory, mental, pain etc.
    • Progress or lack of progress toward goals
## Nursing Supports Therapy

**Weekly Medicare Meeting** – Communication of prior week and plans for next week.
- Review status in therapy – what is therapy working on
- Review status of ADLs on unit related to ADL goals
- Review medical status and skilled nursing services
- Discharge plan

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**Weekly IDT or Nursing Summary Note** is recommended
- Document a weekly summary note if daily documentation is incomplete.
- Includes same information as a daily note but reflects entire week.
- Summarizes the “chapters in the book” for the week.
Example Notes

• For example, instead of charting “monitor response to therapy,” it would be better to indicate they are actually “evaluating and noting” the resident’s response to therapy. Adding simple phrases such as “resident is making improvements in her ADL status this week, as evidenced by transferring today with one assist as opposed to two assist last week” would be beneficial in supporting Medicare claims.

Example Notes

• For example, nursing could include a phrase such as “resident reported moderately decreased pain after receiving e-stim treatment.”
• Nursing documentation could be more supportive of skilled therapy services by making reference to resident’s gait, such as “resident is unable to safely ambulate independently at this time due to unsteady gait.”
Example Notes

- Nursing skilled documentation does not always support therapy skilled services; “One assist with walker” is all that is used to describe progress on unit in response to therapy; not all ADLs that therapy is working on are included.
- Nursing skilled documentation at times, is contradictory to therapy. Example: “Ambulates independently”

Medicare Advantage and MDS

- Which type of contracts
  - Medicare PPS: RUG-IV
    - Does it follow PPS MDS schedule?
  - Contracted rate with exceptions
Contract requires RUGs

- The SNF bills the MA the RUG achieved from PPS MDS.
- The SNF completes all required Medicare MDS to be used for billing MA. However, these MDSs are **NOT** submitted to CMS QIES ASAP system.
  - These PPS MDSs can be used as back-up MDSs if the SNF is notified after discharge that the resident was actually covered under Traditional Medicare.

Contract requires RUGs

- While the PPS MDSs are not submitted to QIES ASAP System; the required OBRA MDS would be submitted.
  - This means the 5 day MDS would need to be completed separate from the OBRA Admission MDS.
SNF Bills MA plan based on levels

• For these types of contracts the SNF bills the MAO the level/rate which applies to level the resident achieved or was authorized by the contract.
  – The **SNF may not be** completing any PPD MDS on these residents as not needed to bill MAO.
  – For SNFs that chose to complete PPS MDS on these residents as “back-up” in case later this resident is determined to be on Traditional Medicare; then the PPS MDS that were created (but not submitted) could also be used to create Information Only claim for submission to CMS as described earlier in this procedures.

CMS HIPPS Requirements

• Effective July 1, 2014, all claims submitted to MAO include a HIPPS code calculated by an OBRA Required Admission (with exceptions).
CMS HIPPS Requirements

MA Stays of More than 14 days:

• Admission MDS completed during this MA covered Stay – Include HIPPS on CMO claim.
• If no, Admission MDS, then any OBRA MDS completed during MA covered stay (quarterly, annual, SCSA)
• If no OBRA MDS was completed during MA covered stay; submit the HIPPS code from most recent MDS that was completed prior to MA covered Stay.
• Admission completed on prior stay, or most recent OBRA completed on long term resident (quarterly, annual, SCSA).

CMS HIPPS Requirements cont.

• MA Stays 14 days or less:
  – Use HIPPS code from any OBRA assessment completed during this short MA covered stay.
  – Submit a default HIPPS code (AAA00) if:
    • (1) the SNF stay was less than 14 days within a spell of illness,
    • (2) the beneficiary has been discharged prior to the completion of the initial OBRA Admission assessment, and
    • (3) no other assessment was completed during the stay
CMS HIPPS Requirements cont.

– To submit a default HIPPS code to the Encounter Data System, use the default Resource Utilization Group (RUG) code of “AAA” and Assessment Indicator “00” on encounter data submissions starting with “from” dates of service July 1, 2014.
– Might use default HIPPS code if billing levels to MA plan
– May not use this default code in other situations.

What Do I Do?

• Known MA resident admitted
  – Complete MDS per RUG-IV requirements if required by MA (Also BEST PRACTICE)
  – Bill according to RUG rules or contract
  – Physician certifications required?
  – Other claim considerations?
What Do I Do?

- SNF thought resident was MA, but later find out should have been traditional Medicare for the entire stay. No Medicare MDS were completed.
  - Still on Part A and still current resident
    - Indicate Original Medicare start date as admit date
    - Use Initial MDS Then go to next due Medicare MDS
  - Discharged already?
    - Use 14-day MDS but modify Medicare start date

MA changes to Traditional Medicare

- On MA then changes to Traditional Medicare during stay.
  - CMS states you do not need to start new Medicare cycle if doing Medicare cycle already.
  - Best practice (MACs too) is to start new Medicare MDS cycle, and first day on Medicare is the Medicare start date on MDS.
    - Continue with number of remaining days for spell of illness
    - Re-start Physician certifications
    - Therapy eval? May get default rate if date prior to Medicare start date
Billing the Medicare Advantage Plan

Common billing errors

- Not recognizing a patient is enrolled in a Medicare Advantage (MA) plan
- Confusing supplemental insurance with MA payer information
- Not getting required preauthorization & subsequent authorizations
- Claims not containing proper authorization numbers & date spans
Common billing errors

• Not being aware that MDS assessments may be required
• Not understanding how a MA payer reimburses
• Not billing claim correctly per contract requirements
• Timely filing requirements

Communication

• Crucial between clinician and business office.
  – Business Office needs to know:
    • When authorizations take place
    • How often authorizations are needed
    • When authorization number changes
Billing Methods

- **PPS** – Follow MDS schedule or does the MA plan have its own schedule
- **Pier Diem** – A daily rate usually with a contracted MA plan
- **Level of Care (LOC)** – Level 1, Level 2 etc.
- **Charge based** – Not as common – reimbursed based on total charges

Billing Differences

- **Diagnosis Codes** – If a particular diagnosis code has been used for authorization ensure that diagnosis is on the claim.
- **Revenue Codes** – Revenue code 120 for room and board typically used for Medicare. Managed Care may use Revenue codes 190, 191 or 192 for level of care
- **Ancillaries** – MA plan may pay separately for ancillaries. Ensure the correct HCPCS or CPT codes are used.
Hospice and MA

• Beneficiary may be covered under a MA plan but require hospice.
• Make sure to inquire with MA plan regarding hospice services.
• If hospice episode is not related to MA episode then a 07 condition code can be added to claim to show hospice and MA episode not related.

Hospice example

• Resident is on hospice for a terminal illness. Resident falls breaks hip, not related to the terminal illness. Facility may bill MA plan for the fractured hip and hospice would continue to bill for terminal illness.
Billing Checklist

- Is correct payer & policy number on claim?
- Are correct authorization numbers on claim for time period being billed?
- Does claim reflect correct occurrence span code for qualifying hospital stay requirement?
- Do diagnosis codes on claim correlate with those authorized?

Billing Checklist

- Does claim include accurate ancillary charges & meet plan requirements for itemization?
- Is 3 day hospitalization meet if not is claim coded correctly?
- Does claim reflect accurate revenue codes for accommodation days?
## Managed Care with RUGs

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<th>RUG Code</th>
<th>Description</th>
<th>Amount</th>
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<tbody>
<tr>
<td>0020</td>
<td>HIPS RATE CODE</td>
<td>200.00</td>
</tr>
<tr>
<td>0120</td>
<td>B &amp; B HUMPIV 2HD (GERI)</td>
<td>640.16</td>
</tr>
<tr>
<td>0420</td>
<td>PHYSICAL THERAPY</td>
<td>640.16</td>
</tr>
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</table>

## Managed Care with Levels

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<th>Description</th>
<th>Amount</th>
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<td>0191</td>
<td>SUBACUTE-LEVEL I</td>
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<tr>
<td>0192</td>
<td>SUBACUTE-LEVEL II</td>
<td>400.00</td>
</tr>
<tr>
<td>0250</td>
<td>PHARMACY</td>
<td>640.16</td>
</tr>
<tr>
<td>0420</td>
<td>PHYSICAL THERAPY</td>
<td>640.16</td>
</tr>
</tbody>
</table>
Medicare Billing Requirements for Beneficiaries Enrolled in MA Plans

- If the SNF is non-participating with the plan, the beneficiary must be notified of his or her status because he/she MAY be private pay in this circumstance, depending upon the type of MA plan in which he/she is enrolled;

- If the SNF is participating with the plan, pre-approve the SNF stay with the plan;

- If the plan denies coverage, appeal to the plan, not to the FI;

- Count the number of days paid by the plan as Part A days used (this IS the beneficiary’s 100 days of Medicare SNF benefits);

- Submit a claim to the intermediary to subtract benefit days from the CWF records, this is called an “informational claim” and is submitted with an 04 condition code.
Medicare Billing Requirements for Beneficiaries Enrolled in MA Plans, cont.

- If a beneficiary no longer requires skilled care under the MA plan the SNF may discharge the patient using a patient status code 04.

- If the beneficiary drops his or her MA plan participation during their SNF stay the beneficiary is entitled to coverage under Medicare FFS for the number of days available that remain out of the 100 days available under the SNF benefit.

Medicare Billing Requirements for Beneficiaries Enrolled in MA Plans

- If the enrollee is in a SNF in December, in an MAO that does not require a prior qualifying 3-day hospital stay and then joined Original Medicare on January 1, the stay continues to be considered a covered stay (if medically required). Use a condition code 58 to waive the three day stay requirement.

- If resident elects hospice during an MAO stay, hospice bills Medicare and the resident remains traditional Medicare until the beginning of the next month.

- Always check the CWF before any billing resumes.
Managed Care Appeals

Managed Care Notices/Appeal Rights

• Plan must say in writing how to appeal if
  – Will not pay for a service
  – Does not allow a service
  – Stops or reduces a course of treatment

• Can ask for fast (expedited) decision
  – Plan must decide within 72 hours

• See plan's membership materials
  – Include instructions on how to file an appeal or grievance
Medicare Advantage Notices

- MA Residents have the overall same rights to appeal
  - Appeal to Medicare Advantage (demand bill)
  - Appeal to QIO for an Expedited Review
- Timing for Determination notices is the same – on or before last covered day.
- Timing for Expedited Review notices is the same – 2 days before last covered day/service.

Medicare Advantage Denial Notices

- MA should ensure a notice is issued when a Part A stay is ending as the resident has a right to appeal.
  - MA may ask SNF to assist with issuing notice
- **Notice of Denial of Medical Coverage:** CMS-10003-NDMC.
  - Follow procedures outlined by MA
  - Right to appeal to MA program
  - Issued on or before last covered day
Medicare Advantage Expedited Review Notice

Expedited Review Notice

• The SNF has responsibility along with the MA to ensure this notice is properly issued.

• Issue **Notice of Medicare Non-Coverage (NOMNC)**
  CMS-10123
  o Issue two days before last covered day or service
  o Follow MA procedures

Medicare Advantage Expedited Review Notice

Expedited Review Notice

• Only issue Detailed Explanation if appeal requested
  - CMS-10124-DENC

• Right to appeal to QIO
  o Expedited Review is best choice for resident and SNF
  o Appeal process overall the same as for non-MA residents
Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the front page of this notice. We also have a consumer assistance program.

Notice of Denial of Medical Coverage
(Replaced by Denial of Medical Coverage with Denial of Payment, if applicable)

Date
Member number

Your request was denied
We have denied your request (criteria used: denied, stopped, reduced, suspended) the (payment of) medical services/items listed below, requested by you or your service provider:

Why did we deny your request?
We denied your request because (criteria used: denied, stopped, reduced, suspended) the (payment of) medical services/items listed above because (Provide specific rationale for decision and include State or Federal law and/or Evidence of Coverage provisions to support decision):

You have the right to appeal our decision
You have the right to ask (your name) to review our decision by asking us for an appeal (Include Medicare information, if applicable). You must ask us for an appeal within 60 calendar days of the date of this notice. We will send you a Notice of Appeal Rights within 30 days of the date of your request. If you do not ask for an appeal within 60 calendar days of the date of this notice, you may not appeal our decision.

Appellant: Ask (your name) to review our decision for an appeal within 60 days (Choose State Medical timeframe, if different) of the date of this notice. We can give you more time if you have a good reason for missing the deadline.

State Fair Hearing: Ask for a State Fair Hearing within 60 days of the date of this notice. You have up to 120 days if you have a good reason for being late.

If we’re denying an essential service, you can keep working. Your service provider will be paid for the services unless you ask for an appeal. If you ask for an appeal, we will delay the service until after the appeal is completed. If you choose to appeal, we will send you an appeal decision within 60 days of the date of your appeal. If you do not appeal, we will provide you with a Notice of Appeal Rights within 30 days of the date of your request. You may ask for an appeal within 60 days of the date of this notice. We will send you a Notice of Appeal Rights within 30 days of the date of your request. If you do not ask for an appeal within 60 days of the date of this notice, you may not appeal our decision.

How to Ask for an Appeal
To ask for an appeal, you may call or write to us. You must call or write within 60 calendar days of the date of this notice.

Appendix: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the front page of this notice. We also have a consumer assistance program.

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(Replaced by Denial of Medical Coverage with Denial of Payment, if applicable)

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How to Ask for an Appeal
To ask for an appeal, you may call or write to us. You must call or write within 60 calendar days of the date of this notice.
Required Notices

- After every:
  - Adverse determination
  - Adverse appeal

- Include:
  - Detailed explanation of why services denied
  - Information on next appeal level
  - Specific instructions
Appeal Levels

- Plan Reconsideration
- Independent Review Entity (IRE)
- Administrative Law Judge (ALJ)
- Medicare Appeals Council (MAC)
- Judicial Review

Fast Track Appeal

- When services are ending too soon
  - Skilled Nursing Facility
  - Home Health Agency
  - Comprehensive Outpatient Rehabilitation Facility
- Will get Notice of Medicare Non-coverage
  - At least 2 days before services end
  - If appealed, will get Detailed Explanation of Non-coverage
- Decision from Quality Improvement Organization (QIO) within 2 days
Common Denials

• Daily skilled service not supported

• Unstable conditions or resident problems not identified

• Minimal descriptions of resident condition; wounds, unstable conditions, nursing interventions, potential complications
How to Avoid the Denials

• QA Oversight!

• Let’s Review.....

Managed Care Compliance Oversight

• Quality Assurance
  – Admission process
  – Oversight daily/weekly charting
  – Continued stay authorizations
  – MA Notices
  – Review at weekly Medicare meeting
  – Triple Check prior to billing
  – Consider a Managed Care Coordinator
That's all Folks!
Summary of CMS Memorandum to Long Term Care Facilities on Disenrollment Issues

On May 26, 2015, the Centers for Medicare and Medicaid Services (CMS) issued a memorandum on beneficiary disenrollment from Medicare Advantage (MA) Plans and dual demos. Specifically, CMS alleges that long term care (LTC) facilities, including nursing centers and skilled nursing facilities are inappropriately encouraging Medicare beneficiaries to dis-enroll from MA plans and dual demonstrations.

In the transmittal, CMS indicates that the Agency has received reports that LTC facilities are disenrolling beneficiaries from Medicare Advantage prescription drug plans (MA-PDs) and enrolling them into stand-alone drug plans (PDPs), and that this practice has occurred without the beneficiary or their representative’s knowledge and/or complete understanding. CMS states that these practices have also been seen among facilities serving dual eligible enrollees participating in or who could participate in a Medicare-Medicaid plan (MMP) as part of the CMS Financial Alignment Initiative. Such practices are noncompliant with current CMS regulatory requirements.

Also in the memo, CMS states any change in a beneficiary’s health care coverage must be initiated by the beneficiary or his/her representative. If a beneficiary or their legal representative requests assistance from the LTC facility in changing the beneficiary’s health coverage, the facility must take the following steps to ensure changes comply with regulations regarding enrollment/disenrollment and resident rights:

1. Explain both orally and in writing the impact to the beneficiaries if they change to a stand-alone drug plan and Original Medicare. Additional information on what to include can be found on CMS’s site, click [here](#).
2. Develop written policies and procedures regarding the process of assisting beneficiaries with changing their health care coverage. Additional information on what to include can be found on CMS’s site, click [here](#).

If documentation of a beneficiary’s request to change enrollment cannot be provided by a LTC facility, **CMS will notify the state survey and certification agency**, consider the request not legally valid, cancel the enrollment action and, if necessary and appropriate, reinstate the beneficiary’s MA, MAPD, or MMP coverage as if never disenrolled. CMS will report these incidents to the Medicare Drug Integrity Contractor (MEDIC) for fraud and abuse investigation.

AHCA is in the process of reviewing the language and has reached out to CMS to initiate a dialogue.
Exhibit 10: Model Disenrollment Form

Referenced in section: 10

If you request disenrollment, you must continue to get all medical care from <plan name> until the effective date of disenrollment. Contact us to verify your disenrollment before you seek medical services outside of <plan name>’s network. We will notify you of your effective date after we get this form from you.

<table>
<thead>
<tr>
<th>Last name:</th>
<th>First Name:</th>
<th>Middle Initial</th>
<th>□ Mr. □ Mrs. □ Miss. □ Ms.</th>
</tr>
</thead>
</table>

Medicare #

<table>
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<tr>
<th>Birth Date:</th>
<th>Sex:</th>
<th>Home Phone Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ M □ F</td>
<td>(      )</td>
</tr>
</tbody>
</table>

Please carefully read and complete the following information before signing and dating this disenrollment form:

If I have enrolled in another Medicare Advantage or Medicare Prescription Drug Plan, I understand Medicare will cancel my current membership in <MA plan name> on the effective date of that new enrollment. I understand that I might not be able to enroll in another plan at this time. I also understand that if I am disenrolling from my Medicare prescription drug coverage and want Medicare prescription drug coverage in the future, I may have to pay a higher premium for this coverage.

Your Signature*: ______________________________          Date: _____________

*Or the signature of the person authorized to act on your behalf under the laws of the State where you live. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this disenrollment and 2) documentation of this authority is available upon request by <plan name> or by Medicare.

If you are the authorized representative, you must provide the following information:

Name : __________________________
Address: __________________________
Phone Number: (___) ___- _____
Relationship to Enrollee __________________________

<Contract#, alpha-numeric identifier, “CMS Approved/File & Use” [date] (as applicable)>
Exhibit 10a: Information to include on or with Disenrollment Form – Attestation of Eligibility for an Election Period

Referenced in section: 30.4

Typically, you may disenroll from a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year or during the Medicare Advantage Disenrollment Period from January 1 through February 14 of each year. There are exceptions that may allow you to disenroll from a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Election Period.

☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.

☐ I get extra help paying for Medicare prescription drug coverage.

☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date) _________________________________.

☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date) ___________________________________________.

☐ I am joining a PACE program on (insert date) _____________________________.

☐ I am joining employer or union coverage on (insert date) _________________.

If none of these statements applies to you or you’re not sure, please contact <plan name> at <phone number> (TTY users should call <TTY number>) to see if you are eligible to disenroll. We are open <insert days and hours of operation>.
SAMPLE MANAGED CARE CONTRACT

PHYSICIAN AGREEMENT

THIS AGREEMENT is entered into by and between ________________, Inc., a __________ corporation, ("Network") and ____________________, M.D. ("Physician").

WHEREAS, the Network is developing a provider network consisting of physicians, institutional facilities, and providers of ancillary health; and

WHEREAS, Physician wishes to be a Participating Physician in Network.

NOW, THEREFORE, in consideration of the mutual promises contained herein, the parties agree as follows:

Make sure the contract clearly describes what product line(s) this contract is for.

When is the contract effective?

Example - This Agreement applies only to Payer's Commercial HMO, but not to Payer's Medicare HMO.

I. DEFINITIONS

1.1 “Benefit Plan” means those health care services which are included as health care benefits pursuant to Member’s Benefit Plan.

Make sure that Benefit Plans are only in those Product lines you have agreed to contract.

Example - Benefit Plans will be limited to Commercial HMO, and not Medicare HMO.

1.2 "Covered Services" means medical and other health care services that are covered under a Health Benefit Plan established by a Payer and which are deemed Medically Necessary by Payer or Network.

Who is the Payer? Look for a definition of Payer.

1.3 "Emergency" means the sudden and unexpected onset of a condition or symptoms requiring medical or surgical care to screen and/or treat the Member, and which is secured immediately after the onset (or as soon thereafter as the care can be made available), and is of such immediate nature that the Member's life or health might be jeopardized if he or she is not treated as soon as possible.

1.4 “Fee Schedule” means the maximum amount which Network will pay for a specific service.

And what exactly is that?

1.5 "Medically Necessary" or "Medical Necessity" means those services or supplies which, under the terms and conditions of this Agreement, are determined to be: appropriate and necessary for the symptoms, diagnosis or treatment of the medical conditions of the Member; provided for the diagnosis or direct care and treatment of the medical condition of the Member; within standards of medical practice within the community; and not primarily for the convenience of the Member, the Member’s physician or another provider.

1.6 "Member" means any person eligible to receive Covered Services and whose Benefit Plan has access to the Network.
Make sure that Member is only in those Product lines you have agreed to contract.

Example - Member will be limited to Commercial HMO, and not Medicare HMO.

1.7 "Participating Hospital" means a duly licensed hospital which has entered into an agreement with Network to provide Covered Services to Members.

1.8 "Participating Physician" means a physician who has entered into an agreement with Network to provide Covered Services to Members.

What Physicians and Hospitals are participating?

1.9 "Payer" means an organization, firm, or governmental entity, including but not limited to a self-insured employer, employer coalition, health insurance purchasing cooperative, insurer, health maintenance organization or preferred provider organization, that has contracted with Network to arrange for the provision of health care services to its members.

The Payer and the Network you are contracting with are not necessarily the same. The Payer may pay the Network to access providers in the Network. In these situations, the Payer is obligated to pay the claim not the Network.

Network warrants that its contracts with Payers require Payers to comply with all Payer requirements and responsibilities described in this Agreement, and that such contracts also require Payers to acknowledge that they will not be allowed to participate in the negotiated rates and other terms of this Agreement if they fail to comply with such requirements.

Network agrees that each agreement with any Payer shall provide for a differential for in-network versus out-of-network coverage for Physician Services of at least 10%. The foregoing discount shall also be applied to the Member’s out-of-pocket costs, i.e. Copayments or Deductibles.

Network agrees to provide a quarterly list of contracted Payers.

1.10 "Primary Care Physician" means a Participating Physician who is designated by the Network as a provider of primary care services, and who is primarily responsible for managing and coordination the overall health care needs of the Member.

1.11 “Physician Manual” means the manual which has been prepared by Network and sets forth all policies and procedures governing Physician’s participation in Network.

Make sure you get a copy of this and read it.

1.12 "Specialty Care Physician" means a Participating Physician who is designated by the Network as a provider of specialty services other than primary care services.

1.13 "Utilization Review/Quality Assurance Plan" or "UR/QA Plan" means the program or programs adopted by the Network, and carried out by Participating Providers with Network which authorizes and monitors the utilization of Providers offered to Members.

Before executing the contract, obtain copies of the Payer’s Provider Handbook/UR/UM Manuals and Protocols. Understand the Appeals, Grievance, UR/QA, and Authorization Processes. Determine which services need preauthorization and notification and who can request authorizations – PCP, SCP or both. Are retro-authorizations considered for medical necessity?
Additional Definitions to include:

- “Clean Claim” means a claim for payment for a Covered Service that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in Payer's claims processing system. It does not include a claim under review for medical necessity.

- “Claim” means a bill submitted by Physician to Network for Physician services provided to a Member using a billing form containing equivalent information.

- “Non-Covered Services” means services, supplies, products and accommodations that Network is not required to provide to Members pursuant to a Group Contract, including but not limited to services which are not authorized by Network as part of the Utilization Review program.

II. PHYSICIAN RESPONSIBILITIES

2.1 Physician agrees to provide to Members those Covered Services to the same extent and availability, and with the same degree of care, as Physician normally provides such services to the general community.

2.2 Physician shall maintain reasonable office hours in a location convenient to Members, and agrees to be accessible to Members either personally or by arranging for coverage by another Participating Physician or by another qualified physician approved by Network. Physician shall assist Network in ensuring that the covering physician complies with the UR/QA plans established by Network and by Payers, and that he complies with the compensation terms of this Agreement.

Make sure you can close practice to one product line and not another.

2.3 If Physician arranges with either a participating or non-participating Physician to cover Members for him/her in his/her absence, it will be the Physician’s responsibility to ascertain that the covering Physician will: (a) accept compensation from Network as full payment for covered services in accordance with the applicable Network compensation schedule (b) not bill the Member directly except for any applicable copayment, coinsurance, or deductibles; (c ) obtain approval as designated by Network, prior to all non-emergency hospitalizations and non-emergency referrals of Members; and (d) comply with all Network rules, protocols, procedures, and programs.

This provision makes it the Physician’s responsibly to educate non-participating covering physicians.

2.4 Physician shall maintain adequate medical records for Members and shall retain and preserve such records for the full period of time required by state and federal law. Physician and Network shall maintain the confidentiality of Members’ medical records in accordance with all applicable laws and regulations. Subject to such requirements, the Physician will make the Member’s medical records readily available to any Participating Physician or other health professional who needs the records in order to treat the Member, and upon reasonable request, shall make the records available for review by Network, Payer, or their designee for quality assurance/utilization purposes or for other reasonable and necessary purposes.

Network will reimburse Physician the cost of preparing, copying, and delivering records.
2.5 Network or its designee shall have the right to inspect and audit, any of the Physician's accounting, administrative, medical records and operations.

![This provision allows the Payer to inspect any of your financial records.]

Any review will be limited to Members and Covered Services. Payer shall contact Physician at least fifteen (15) days in advance of any review to schedule a mutual agreeable time for the review.

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2.6 Physician represents that the information provided in the network application is correct. In addition, Physician warrants that he is (a) licensed to practice medicine or osteopathy in the State(s) of California: (b) has met all qualifications and standards for appointment to the medical staff of at least one Participating; (c) will have and maintain, where appropriate, a current and unrestricted narcotics number issued the Drug Enforcement Administration ("DEA"); (d) has specialized training in the area in which he practices.

![Watch the State location referenced in the contract.]

Physician shall report any reportable occurrences including, but are not limited to, any action, investigation, or proceeding initiated or taken by any professional society or organization, by any facility, by any medical group or practice, by any licensure or certification agency, by any reimbursement entity or managed care organization, or by any similar entity or organization, to revoke, suspend, restrict, or otherwise adversely affect his privileges, license, certification, or professional standing or membership. The Physician agrees to notify the Network immediately of any suspension, reduction, or termination of his liability insurance, or of any lawsuit filed against him alleging malpractice or negligence and requesting damages in excess of $5,000.00.

2.7 Physician shall provide and maintain professional liability insurance, in amounts of $250,000 per claim and $750,000 annual aggregate during this Agreement.

![Do you have this coverage?]

Physician agrees that Network shall not be responsible for any claims, actions, liability or damages arising out of the acts or omissions of Physician or the acts or omissions of any non-participating physician who covers Members for the Physician.

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Network agrees that Physician and Physician's employees, servants, directors, or officers shall not be liable or responsible for any and all acts or omissions of Network relating to (i) any and all determinations by Network of Medical Necessity; (ii) any and all determinations by the Network as to whether or not a treatment, service, or product is a Covered Service; and (iii) any and all determinations by Network as to whether or not any person is, or is not, a Member or Beneficiary. Network shall have the duty to make decisions at least according to industry standards and at least with due and appropriate care and diligence. Network shall indemnify and hold Physician and Physician's employees, servants, directors, and officers harmless against any and all claims, actions, proceedings, demands, settlements, liabilities, expenses, or damages asserted against Physician or Physician's agents, employees, and officers to the extent such things result from or arise out of any act or omission of Network; provided however, this indemnification shall not include any claims or harm resulting from, and to the extent of, any liability arising out of the provision of health care services by Physician or Physician's employees, servants, directors, and officers.

2.10 The Physician agrees to cooperate with marketing programs established or approved by Network, and agrees to allow the Network and Payers to list the Physician's name, specialty, address, telephone number,
willingness to accept additional Members, and other relevant information in Participating Provider directories and similar informational materials.

Network shall distribute identification cards identifying Network to all members; each card shall include a toll-free number that Physician may use during normal business hours to verify eligibility of coverage, to obtain general coverage information and to obtain authorizations. A copy of any card(s) of a design not previously seen by Physician shall be provided to Physician prior to distribution of cards to Members.

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4.1 The Network will establish criteria and goals for establishing and monitoring the Medical Necessity, appropriateness, and quality of services provided by Participating Providers.

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Except for Emergency Services, Physician shall confirm Member status and secure prior authorization before rendering services. Upon the request for Member treatment by a participating physician, Physician shall contact Network to confirm Member status and to verify that the proposed treatment is approved as a Covered Service. Network shall provide the requested verifications within ___ hour(s) of Physician’s initial request, unless Physician failed to provide information needed to make the eligibility determination. Upon such verification, Network shall give to Physician an authorization code indicating approval upon which Physician may conclusively rely for the delivery of authorized services to the Member. If Physician obtains such verification, Network shall not retroactively deny payment if Network later determines that Member is not eligible or that the service authorized and rendered is not a Covered Service.

Network shall provide Physician with at least thirty (30) calendar days prior written notice of any modification or amendment of the Utilization Review program. If Physician objects to such modification or amendment, Physician may terminate this Agreement by providing notice to Network within such thirty (30) day period.

4.3 Physician agrees to refer Members to other Participating Providers when he/she is unable to provide the required services and when consistent with sound medical judgment.

Physician will use his/her best efforts to refer Members to other Participating Providers when he/she is unable to provide the required services and when consistent with sound medical judgment.

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PENALTIES!!

Review the Physicians’ office manual carefully.
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Nothing in this Agreement shall be construed to interfere with or affect in any way the exercise of the independent medical judgment of Physician or Physician’s employees in rendering health care services to Members. Specifically, but not in limitation, the Physician or Physician’s employees shall be permitted to communicate with Members concerning (i) all matters necessary or appropriate for the delivery of health care services, (ii) treatment alternatives regardless of the provisions or limitations of coverage, and (iii) the reimbursement arrangements under which the Physician is compensated.

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Is there an Exhibit A? Does is clearly describe reimbursement by product line?

5.2 Physician agrees to look solely to Network for payment for Covered Services.

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5.5 If Physician bills Network, such bill must be submitted no later than ninety (90) days after the date of service. Network shall not be obligated to pay any such bills submitted after the ninety (90) day period.

Try to remove this provision.
Complete claims that are not paid within thirty days will be paid at Physician’s billed charges.

5.6 Physician agrees to cooperate with Network COB requirements and in the recovery of claims from other insurers and third party payers.

Physician will cooperate with Network in implementing Payer’s coordination of benefits program. Where the Network is primary under applicable coordination of benefit rules, the Network shall pay the reimbursement rates due under this Agreement as provided in Attachment. If such payment does not cover all billed charges, Physician may submit claims to the secondary carrier.

Where the Network is other than primary under coordination of benefit rules referred to above, the Network shall pay those amounts which, when added to amounts owed to the Physician from other sources, pursuant to the applicable coordination of benefit rules, shall not exceed one hundred percent (100%) of the amount billed. However, payment by Network to Physician shall not exceed one hundred percent (100%) of the rates set forth in this Agreement.

If the primary carrier does not pay Physician within forty-five (45) calendar days of Physician’s billing, then Network shall pay Physician at the rates set forth in this Agreement and seek reimbursement from the primary carrier. If Network so pays Physician, Physician shall promptly remit to Network such amount of any payment hereafter received from the primary carrier such that Network shall not have paid to Physician any more than it would have paid under this Agreement.

The Physician should not agree to any provision that would limit its recovery of full charges if members subrogate their rights to the health plan.

Network Member ineligibility determinations shall be limited to (30) thirty days after Member was considered eligible.

If Network disagrees with the level of payment due physician, Network will send written notice to Physician specifying reason for disagreement. Network and Physician will work to resolve disagreement. If disagreement cannot be resolved to Physicians reasonable satisfaction, Physician may terminate this Agreement upon thirty days notice to Network.

VI. TERMS AND TERMINATION

6.1 This Agreement shall be effective as of __________, 199___, and shall continue for a term of three (3) years from that date. Unless otherwise terminated as set forth below, the Agreement shall automatically be renewed for subsequent one-year terms. Renegotiations of Agreement shall only take place ninety days prior to the end of the term of the Agreement.

Watch the term of the contract and when you can renegotiate.

The term of this Agreement shall be ____ years, beginning as of _______ ___ ___ and ending at midnight on ________ ___ ___, subject to earlier termination by Network or Physician as hereafter provided. This term may be extended with the consent of both parties in writing.

6.2. Either party may terminate this Agreement, with or without cause, at any time upon one hundred and eighty (180) days’ prior written notice to the other party.

Carefully review the termination period.

6.3 Either party shall have the right to terminate this Agreement upon thirty (30) days’ prior written notice to the other party if the party to whom such notice is given is in breach of any material provision of this Agreement. Such notice shall set forth the facts underlying the alleged breach. If the breach is cured within the notice period, then the Agreement shall continue in effect for its remaining term, subject to any other provision of this Agreement.

Make sure the time frame for breach is understood.
6.4 In addition, Network may terminate this Agreement immediately upon (i) the revocation, suspension, or
restriction of Physician's license to practice medicine; (ii) the revocation, suspension, or restriction of
Physician's license, certification, registration, permit or approval required for the lawful and reasonable
conduct of his practice and the provision of Covered Services to Members; (iii) Physician's failure to maintain
general and professional liability insurance as required under this Agreement; (iv) revocation, suspension, or
restriction of Physician's medical staff appointment or the necessary clinical privileges required to provide
Covered Services at a Participating Hospital or any other hospital; (v) Network's determination that any
Member would be endangered or impaired by the continuation of this Agreement.

6.5 In the event of any material changes in laws affecting the structure of the Network, or affecting the provision
or reimbursement of health care services similar to those provided hereunder, the parties agree to negotiate in
good faith to amend this Agreement to conform with applicable law. In the event that such changes adversely
affect either party, such party may terminate this Agreement upon sixty (60) days written notice if the parties
are unable to renegotiate the Agreement on mutually agreeable terms within such 60-day period.

6.6 In the event of termination of this Agreement, Network and Physician shall use their best efforts to arrange
for an orderly transition of patient care, consistent with appropriate medical standards, for Members who have
been or are at the time under the care of Physician, to the care of another physician selected by Member or
Payer, but for no longer than (1) one year. Such services shall be provided according to this Agreement.

This provision states that even though you have terminated the Agreement you may still be receiving the
reimbursement for a year.

Upon termination of this Agreement Physician shall continue to provide Covered Services to Members then inpatients of the
Physician and entitled to services pursuant to Health Benefit Plans until such Members are (i) discharged or transferred
consistent with sound medical practice; or (ii) thirty (30) calendar days from the effective date of termination.

Network shall pay Physician in accordance with Attachment for services rendered by Physician to such Members. If at the
request of the Network, Physician provides Covered Services to Member admitted to Physician after the effective date of
termination of this Agreement.

Nothing withstanding any provision of this Agreement to the contrary, Network and Physician shall continue to fulfill their
obligations under this Agreement with respect to: (i) payments due Physician; (ii) records maintenance requirements; (iii)
insurance requirements; and (iv) confidentiality requirements.

VII. MISCELLANEOUS

7.1 All Network business, medical and other records and all information generated by or relating to Network
or its management information systems shall be and remain the sole property of Network. Physician agrees
to keep such information strictly confidential.

7.2 The parties are independent contractors, and neither is or shall represent itself as the employer, employee,
partner, agent, principal, or joint venture of the other. The Physician understands and agrees that in the
provision of medical care services, the Physician acts as an independent entity and that the physician-
patient relationship shall in no way be affected.
7.3 Any notice or communication required, permitted or desired to be given hereunder shall be deemed effectively given or mailed, addressed on the signature page.

Preferred notice sent certifed mail.

7.4 The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach hereof.

7.5 This Agreement shall be governed by and construed in accordance with the laws of the state of California.

This Agreement has been executed and delivered, and shall be interpreted, construed and enforced in accordance with the laws of the State of Florida, without regard to any conflict of law provisions contained therein.

7.6 This Agreement may be amended by Network upon thirty (30) days written notice of such proposed amendment. Failure of Physician to provide written objection to such amendment within the thirty (30) day period shall constitute Physician's approval of such amendment.

This Agreement, including all attachments, may not be amended or changed in any of its provisions except by a subsequent written agreement signed by duly authorized representatives of Network and Hospital.

7.7 The invalidity or unenforceability of any term or condition hereof shall in no way affect the validity or enforceability of any other term or provision.

7.8 Physician may not assign this Agreement without Network’s prior written consent.

This Agreement cannot be assigned without the written consent of the other party.

7.9 Network and Physician agree to submit to binding arbitration any dispute or claim arising out of the interpretation of or performance under this Agreement which cannot be settled by informal means.

The parties shall attempt to resolve any dispute, controversy or claim arising out of or relating to this Agreement or the preparation of this Agreement, including but not limited to the payment or non-payment of a claim, the eligibility of a Member, the determination of Covered Services, or the determination of medically necessary procedures, by mutual cooperation. Nothing in this Agreement shall preclude Network or Physician from exercising, at any time, the right to seek resolution through legal remedies as the law may provide.

If any judicial proceeding is necessary to enforce or interpret the terms of this Agreement, the prevailing party shall be entitled to reasonable attorneys’ fees, costs and expenses from the other party, in addition to any other relief to which such party is entitled. If the parties mutually agree to the use of arbitration, the decision of the arbitrator shall not be binding in a court of law.

This Agreement shall be binding upon, and shall inure to the benefit of, the parties hereto and their successors and permitted assignees.

This Agreement supersedes any prior agreements, promises, negotiations or representations, either oral or written, relating to the subject matter of this Agreement. This Agreement may not be amended except in writing duly executed by both parties.

Notwithstanding any provision of this Agreement to the contrary, the sections of this Agreement relating to payment, confidentiality, insurance, and records requirements shall survive any termination of this Agreement.

The failure of Network or Physician to object to or to take affirmative action with respect to any conduct of the other which is a breach of this Agreement shall not be construed as a waiver of that breach or of any prior or future breaches of this Agreement.
Reimbursement Exhibit

Physician shall bill Network and Network shall pay for Medically necessary Covered Services provided by Physician to Member the lesser of (1) Network’s Physician Fee Schedule minus applicable Copayments, Coinsurance, and Deductibles, or (2) usual and customary charges minus applicable Copayments, Coinsurance, and Deductibles.

✍ The rates provided for in this contract may be renegotiated by either party. If new rates have not been agreed to by the parties within thirty (30) days of the written request form the Physician then an automatic increase of ten percent (10%) or the change in the annual Physician and Medical Services Consumer Price Index, whichever is greater, shall be applied to the current rates.

✍ Strike “usual and customary charges” and replace with “Physician’s Billed Charges.”
SAMPLE MANAGED CARE CONTRACT

PHYSICIAN AGREEMENT

THIS AGREEMENT is entered into by and between ______________, Inc., a __________ corporation, ("Network") and ____________________, M.D. ("Physician").

WHEREAS, the Network is developing a provider network consisting of physicians, institutional facilities, and providers of ancillary health; and

WHEREAS, Physician wishes to be a Participating Physician in Network.

NOW, THEREFORE, in consideration of the mutual promises contained herein, the parties agree as follows:

© Make sure the contract clearly describes what product line(s) this contract is for.
© When is the contract effective?

✍ Example - This Agreement applies only to Payer's Commercial HMO, but not to Payer's Medicare HMO.

I. DEFINITIONS

1.1 “Benefit Plan” means those health care services which are included as health care benefits pursuant to Member’s Benefit Plan.

© Make sure that Benefit Plans are only in those Product lines you have agreed to contract.

✍ Example - Benefit Plans will be limited to Commercial HMO, and not Medicare HMO.

1.2 "Covered Services" means medical and other health care services that are covered under a Health Benefit Plan established by a Payer and which are deemed Medically Necessary by Payer or Network.

✍ Who is the Payer? Look for a definition of Payer.

1.3 "Emergency" means the sudden and unexpected onset of a condition or symptoms requiring medical or surgical care to screen and/or treat the Member, and which is secured immediately after the onset (or as soon thereafter as the care can be made available), and is of such immediate nature that the Member’s life or health might be jeopardized if he or she is not treated as soon as possible.

1.4 “Fee Schedule” means the maximum amount which Network will pay for a specific service.

© And what exactly is that?

1.5 "Medically Necessary" or "Medical Necessity" means those services or supplies which, under the terms and conditions of this Agreement, are determined to be: appropriate and necessary for the symptoms, diagnosis or treatment of the medical conditions of the Member; provided for the diagnosis or direct care and treatment of the medical condition of the Member; within standards of medical practice within the community; and not primarily for the convenience of the Member, the Member’s physician or another provider.

1.6 "Member" means any person eligible to receive Covered Services and whose Benefit Plan has access to the Network.
Make sure that Member is only in those Product lines you have agreed to contract.

Example - Member will be limited to Commercial HMO, and not Medicare HMO.

"Participating Hospital" means a duly licensed hospital which has entered into an agreement with Network to provide Covered Services to Members.

"Participating Physician" means a physician who has entered into an agreement with Network to provide Covered Services to Members.

What Physicians and Hospitals are participating?

"Payer" means an organization, firm, or governmental entity, including but not limited to a self-insured employer, employer coalition, health insurance purchasing cooperative, insurer, health maintenance organization or preferred provider organization, that has contracted with Network to arrange for the provision of health care services to its members.

The Payer and the Network you are contracting with are not necessarily the same. The Payer may pay the Network to access providers in the Network. In these situations, the Payer is obligated to pay the claim not the Network.

Network warrants that its contracts with Payers require Payers to comply with all Payer requirements and responsibilities described in this Agreement, and that such contracts also require Payers to acknowledge that they will not be allowed to participate in the negotiated rates and other terms of this Agreement if they fail to comply with such requirements.

Network agrees that each agreement with any Payer shall provide for a differential for in-network versus out-of-network coverage for Physician Services of at least 10%. The foregoing discount shall also be applied to the Member’s out-of-pocket costs, i.e. Copayments or Deductibles.

Network agrees to provide a quarterly list of contracted Payers.

"Primary Care Physician" means a Participating Physician who is designated by the Network as a provider of primary care services, and who is primarily responsible for managing and coordination the overall health care needs of the Member.

“Physician Manual” means the manual which has been prepared by Network and sets forth all policies and procedures governing Physician’s participation in Network.

Make sure you get a copy of this and read it.

"Specialty Care Physician" means a Participating Physician who is designated by the Network as a provider of specialty services other than primary care services.

"Utilization Review/Quality Assurance Plan" or "UR/QA Plan" means the program or programs adopted by the Network, and carried out by Participating Providers with Network which authorizes and monitors the utilization of Providers offered to Members.

Before executing the contract, obtain copies of the Payer’s Provider Handbook/UR/UM Manuals and Protocols. Understand the Appeals, Grievance, UR/QA, and Authorization Processes. Determine which services need preauthorization and notification and who can request authorizations – PCP, SCP or both. Are retro-authorizations considered for medical necessity?
Additional Definitions to include:

- "Clean Claim" means a claim for payment for a Covered Service that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in Payer’s claims processing system. It does not include a claim under review for medical necessity.
- "Claim" means a bill submitted by Physician to Network for Physician services provided to a Member using a billing form containing equivalent information.
- "Non-Covered Services" means services, supplies, products and accommodations that Network is not required to provide to Members pursuant to a Group Contract, including but not limited to services which are not authorized by Network as part of the Utilization Review program.

II. PHYSICIAN RESPONSIBILITIES

2.1 Physician agrees to provide to Members those Covered Services to the same extent and availability, and with the same degree of care, as Physician normally provides such services to the general community.

2.2 Physician shall maintain reasonable office hours in a location convenient to Members, and agrees to be accessible to Members either personally or by arranging for coverage by another Participating Physician or by another qualified physician approved by Network. Physician shall assist Network in ensuring that the covering physician complies with the UR/QA plans established by Network and by Payers, and that he complies with the compensation terms of this Agreement.

Make sure you can close practice to one product line and not another.

2.3 If Physician arranges with either a participating or non-participating Physician to cover Members for him/her in his/her absence, it will be the Physician’s responsibility to ascertain that the covering Physician will: (a) accept compensation from Network as full payment for covered services in accordance with the applicable Network compensation schedule (b) not bill the Member directly except for any applicable copayment, coinsurance, or deductibles; (c) obtain approval as designated by Network, prior to all non-emergency hospitalizations and non-emergency referrals of Members; and (d) comply with all Network rules, protocols, procedures, and programs.

This provision makes it the Physician’s responsibly to educate non-participating covering physicians.

2.4 Physician shall maintain adequate medical records for Members and shall retain and preserve such records for the full period of time required by state and federal law. Physician and Network shall maintain the confidentiality of Members’ medical records in accordance with all applicable laws and regulations. Subject to such requirements, the Physician will make the Member’s medical records readily available to any Participating Physician or other health professional who needs the records in order to treat the Member, and upon reasonable request, shall make the records available for review by Network, Payer, or their designee for quality assurance/utilization purposes or for other reasonable and necessary purposes.

Network will reimburse Physician the cost of preparing, copying, and delivering records.
2.5 Network or its designee shall have the right to inspect and audit, any of the Physician's accounting, administrative, medical records and operations.

**This provision allows the Payer to inspect any of your financial records.**

- Any review will be limited to Members and Covered Services. Payer shall contact Physician at least fifteen (15) days in advance of any review to schedule a mutual agreeable time for the review.
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Make sure you are provided with up-to-date Provider Directories.

Physician will use his/her best efforts to refer Members to other Participating Providers when he/she is unable to provide the required services and when consistent with sound medical judgment.

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Try to remove this provision.
Complete claims that are not paid within thirty days will be paid at Physician’s billed charges.

5.6 Physician agrees to cooperate with Network COB requirements and in the recovery of claims from other insurers and third party payers.

Physician will cooperate with Network in implementing Payer’s coordination of benefits program. Where the Network is primary under applicable coordination of benefit rules, the Network shall pay the reimbursement rates due under this Agreement as provided in Attachment. If such payment does not cover all billed charges, Physician may submit claims to the secondary carrier.

Where the Network is other than primary under coordination of benefit rules referred to above, the Network shall pay those amounts which, when added to amounts owed to the Physician from other sources, pursuant to the applicable coordination of benefit rules, shall not exceed one hundred percent (100%) of the amount billed. However, payment by Network to Physician shall not exceed one hundred percent (100%) of the rates set forth in this Agreement.

If the primary carrier does not pay Physician within forty-five (45) calendar days of Physician’s billing, then Network shall pay Physician at the rates set forth in this Agreement and seek reimbursement from the primary carrier. If Network so pays Physician, Physician shall promptly remit to Network such amount of any payment hereafter received from the primary carrier such that Network shall not have paid to Physician any more than it would have paid under this Agreement.

The Physician should not agree to any provision that would limit its recovery of full charges if members subrogate their rights to the health plan.

Network Member ineligibility determinations shall be limited to (30) thirty days after Member was considered eligible.

If Network disagrees with the level of payment due physician, Network will send written notice to Physician specifying reason for disagreement. Network and Physician will work to resolve disagreement. If disagreement cannot be resolved to Physicians reasonable satisfaction, Physician may terminate this Agreement upon thirty days notice to Network.

VI. TERM AND TERMINATION

6.1 This Agreement shall be effective as of __________, 199___, and shall continue for a term of three (3) years from that date. Unless otherwise terminated as set forth below, the Agreement shall automatically be renewed for subsequent one-year terms. Renegotiations of Agreement shall only take place ninety days prior to the end of the term of the Agreement.

Watch the term of the contract and when you can renegotiate.

The term of this Agreement shall be ___ years, beginning as of _______ ___ ___ and ending at midnight on _________ ___ ___, subject to earlier termination by Network or Physician as hereafter provided. This term may be extended with the consent of both parties in writing.

6.2. Either party may terminate this Agreement, with or without cause, at any time upon one hundred and eighty (180) days’ prior written notice to the other party.

Carefully review the termination period.

6.3 Either party shall have the right to terminate this Agreement upon thirty (30) days’ prior written notice to the other party if the party to whom such notice is given is in breach of any material provision of this Agreement. Such notice shall set forth the facts underlying the alleged breach. If the breach is cured within the notice period, then the Agreement shall continue in effect for its remaining term, subject to any other provision of this Agreement.

Make sure the time frame for breech is understood.
6.4 In addition, Network may terminate this Agreement immediately upon (i) the revocation, suspension, or restriction of Physician's license to practice medicine; (ii) the revocation, suspension, or restriction of Physician's license, certification, registration, permit or approval required for the lawful and reasonable conduct of his practice and the provision of Covered Services to Members; (iii) Physician's failure to maintain general and professional liability insurance as required under this Agreement; (iv) revocation, suspension, or restriction of Physician's medical staff appointment or the necessary clinical privileges required to provide Covered Services at a Participating Hospital or any other hospital; (v) Network's determination that any Member would be endangered or impaired by the continuation of this Agreement.

6.5 In the event of any material changes in laws affecting the structure of the Network, or affecting the provision or reimbursement of health care services similar to those provided hereunder, the parties agree to negotiate in good faith to amend this Agreement to conform with applicable law. In the event that such changes adversely affect either party, such party may terminate this Agreement upon sixty (60) days written notice if the parties are unable to renegotiate the Agreement on mutually agreeable terms within such 60-day period.

6.6 In the event of termination of this Agreement, Network and Physician shall use their best efforts to arrange for an orderly transition of patient care, consistent with appropriate medical standards, for Members who have been or are at the time under the care of Physician, to the care of another physician selected by Member or Payer, but for no longer than (1) one year. Such services shall be provided according to this Agreement.

This provision states that even though you have terminated the Agreement you may still be receiving the reimbursement for a year.

Upon termination of this Agreement Physician shall continue to provide Covered Services to Members then inpatients of the Physician and entitled to services pursuant to Health Benefit Plans until such Members are (i) discharged or transferred consistent with sound medical practice; or (ii) thirty (30) calendar days from the effective date of termination.

Network shall pay Physician in accordance with Attachment for services rendered by Physician to such Members. If at the request of the Network, Physician provides Covered Services to Member admitted to Physician after the effective date of termination of this Agreement.

Nothing withstanding any provision of this Agreement to the contrary, Network and Physician shall continue to fulfill their obligations under this Agreement with respect to: (i) payments due Physician; (ii) records maintenance requirements; (iii) insurance requirements; and (iv) confidentiality requirements.

VII. MISCELLANEOUS

7.1 All Network business, medical and other records and all information generated by or relating to Network or its management information systems shall be and remain the sole property of Network. Physician agrees to keep such information strictly confidential.

7.2 The parties are independent contractors, and neither is or shall represent itself as the employer, employee, partner, agent, principal, or joint venture of the other. The Physician understands and agrees that in the provision of medical care services, the Physician acts as an independent entity and that the physician-patient relationship shall in no way be affected.
7.3 Any notice or communication required, permitted or desired to be given hereunder shall be deemed effectively
given or mailed, addressed on the signature page.

Preferred notice sent certified mail.

7.4 The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as or
be construed to be a waiver of any subsequent breach hereof.

7.5 This Agreement shall be governed by and construed in accordance with the laws of the state of California.

This Agreement has been executed and delivered, and shall be interpreted, construed and enforced in accordance with the
laws of the State of Florida, without regard to any conflict of law provisions contained therein.

7.6 This Agreement may be amended by Network upon thirty (30) days written notice of such proposed
amendment. Failure of Physician to provide written objection to such amendment within the thirty (30) day
period shall constitute Physician's approval of such amendment.

This Agreement, including all attachments, may not be amended or changed in any of its provisions except by a subsequent
written agreement signed by duly authorized representatives of Network and Hospital.

7.7 The invalidity or unenforceability of any term or condition hereof shall in no way affect the validity or
enforceability of any other term or provision.

7.8 Physician may not assign this Agreement without Network’s prior written consent.

This Agreement cannot be assigned without the written consent of the other party.

7.9 Network and Physician agree to submit to binding arbitration any dispute or claim arising out of the
interpretation of or performance under this Agreement which cannot be settled by informal means.

The parties shall attempt to resolve any dispute, controversy or claim arising out of or relating to this Agreement or the
preparation of this Agreement, including but not limited to the payment or non-payment of a claim, the eligibility of a Member,
the determination of Covered Services, or the determination of medically necessary procedures, by mutual cooperation.
Nothing in this Agreement shall preclude Network or Physician from exercising, at any time, the right to seek resolution through
legal remedies as the law may provide.

If any judicial proceeding is necessary to enforce or interpret the terms of this Agreement, the prevailing party shall be entitled
to reasonable attorneys' fees, costs and expenses from the other party, in addition to any other relief to which such party is
entitled. If the parties mutually agree to the use of arbitration, the decision of the arbitrator shall not be binding in a court of law.

This Agreement shall be binding upon, and shall inure to the benefit of, the parties hereto and their successors and permitted
assignees.

This Agreement supersedes any prior agreements, promises, negotiations or representations, either oral or written, relating to
the subject matter of this Agreement. This Agreement may not be amended except in writing duly executed by both parties.

Notwithstanding any provision of this Agreement to the contrary, the sections of this Agreement relating to payment,
confidentiality, insurance, and records requirements shall survive any termination of this Agreement.

The failure of Network or Physician to object to or to take affirmative action with respect to any conduct of the other which is a
breach of this Agreement shall not be construed as a waiver of that breach or of any prior or future breaches of this Agreement.
Reimbursement Exhibit

Physician shall bill Network and Network shall pay for Medically necessary Covered Services provided by Physician to Member the lesser of (1) Network’s Physician Fee Schedule minus applicable Copayments, Coinsurance, and Deductibles, or (2) usual and customary charges minus applicable Copayments, Coinsurance, and Deductibles.

гер The rates provided for in this contract may be renegotiated by either party. If new rates have not been agreed to by the parties within thirty (30) days of the written request form the Physician then an automatic increase of ten percent (10%) or the change in the annual Physician and Medical Services Consumer Price Index, whichever is greater, shall be applied to the current rates.

гер Strike “usual and customary charges” and replace with “Physician’s Billed Charges.”
Insurance Verification and Pre-admission Process

It is imperative that coverage of the skilled stay is determined prior to admission. Several tools are used to determine coverage and payer, including the hospital face sheet, referral source documents, Medicare Secondary Payer Questionnaire, Insurance verification form and Medicare Common Working File (also known as HIQA of CWF). It is also necessary to obtain copies of the patients Medicare card and front and back of all other insurance cards, including, Medicaid, supplemental and Long Term Care policies.

The Medicare Common Working File is the system most commonly used to verify Medicare eligibility and coverage information as well as to determine the recipients benefit days available. This information can also be obtained by the provider through the Medicare Interactive Voice Response system (IVR).

Interpreting the information obtained from either the Common Working File or the Interactive Voice Response is usually the responsibility of either the Admissions Coordinator or the Business Office Manager. Understanding the Common Working File printout and the information it contains and having a process that includes verifying the information will aid in identifying the pay source for the recipient.

Page 1 of the Common Working File contains the information that pertains to the recipients Medicare coverage selection. A person who is eligible for Medicare Part A coverage has an option to choose between the federally funded Traditional Medicare Part A plan or coverage through a health plan approved by Medicare and offered by private insurance companies. These health plans are referred to as Medicare Part “C” or Medicare Advantage (MA) plans. **Medicare Advantage Plans provide Medicare health coverage and usually Medicare drug coverage. They aren’t supplemental insurance.** Not all Medicare Advantage Plans work the same way, so it is important to verify the coverage prior to admission.

The lines below the recipients FULL NAME in the middle section on page 1 of the common working file reflect the selection of a Medicare Advantage Plan. It is important to review this section of the CWF to determine whether or not the selection is in effect at the time of admission. The effective date of the coverage (ENR DATE), plan type description, contract number of the plan (CURR ID) and termination date of the coverage are all displayed in this section. The CURR ID number on the CWF is the identifier associated with the plan. Medicare has developed a Managed Care Directory, which is quite descriptive, with plan contact information located at: [http://www.cms.hhs.gov/MCRAdvPartDEnrolData/](http://www.cms.hhs.gov/MCRAdvPartDEnrolData/).

A Common Working File that indicates an active Medicare Advantage Plan (Part C) will not have a TERM DATE and will display one of the following five plan type descriptions: HMO, PPO, POS, Indemnity, or FFS Demo. CMS provides the following guidance to the provider community to assist in interpreting the meaning of these plan type descriptions:
<table>
<thead>
<tr>
<th>Plan Type Description</th>
<th>Short Definition</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO</td>
<td>Call plan for authorization.</td>
<td>Managed care plan with a provider network. Limited or no out-of-network coverage with the exception of emergency services.</td>
</tr>
<tr>
<td>PPO</td>
<td>You may treat the patient.</td>
<td>Has a network of providers. In return for higher cost sharing, members can go out of network for all plan services, including supplemental benefits.</td>
</tr>
<tr>
<td>POS</td>
<td>You may treat the patient subject to plan rules. Contact the plan for details.</td>
<td>A limited out-of-network option offered by HMO plans. Contact plan for details.</td>
</tr>
<tr>
<td>Indemnity</td>
<td>You may treat the patient.</td>
<td>If this is a PFFS plan, you must follow the PFFS plans terms &amp; conditions of payment. If this is an MSA plan, the member may pay you directly.</td>
</tr>
<tr>
<td>FFS Demo</td>
<td>You may treat the patient.</td>
<td>Beneficiaries remain in Original Medicare and are entitled to all fee-for-service benefits. There are no changes to Medicare FFS billing instructions or claims processing.</td>
</tr>
</tbody>
</table>

The Common Working File will also indicate whether or not the recipient has other coverage which could create a situation where Medicare would be secondary to the other coverage. Page 2 of the CWF contains information regarding Hospice coverage and an open Hospice period would indicate that the recipient is currently under the care of a Hospice organization and Medicare cannot cover the Skilled Nursing Facility stay until the Hospice period is closed or revoked. The Hospice Organization should be contacted to initiate the revocation prior to admission.

Pages 9, 10 or 11 of the CWF will reflect Employee Group Insurance or Auto and Other Liability coverage which could cover the Skilled Nursing Facility stay and render Medicare as secondary coverage. Any coverage reflected on the CWF that does not have a termination or end date should be reviewed carefully to determine whether that insurance is the primary coverage for the stay. Keep in mind that all Medicare recipients are considered COVERED BY MEDICARE whether or not Medicare is the primary payer and all Medicare guidelines should be followed during their treatment.

After the Common Working File or Interactive Voice Response Information is interpreted a determination can be made about coverage for the Skilled Nursing Facility admission and the process of verifying the coverage can begin. A Insurance verification form should be initiated and utilized to record the information. The document would become a part of the patient’s financial record and the information should be updated as necessary.
The information on the Common Working File print out should be utilized to verify coverage and to determine the appropriate billing method and claims submission procedures. It is important to rely on the Common Working File as the source for obtaining Medicare coverage. Occasionally a resident may present an insurance card that may have been terminated or lapsed. It also is possible for a Medicare recipient to dis-enroll from a Medicare Advantage Plan or enroll in a plan and the information is not reflected in the common working file. The information on the Common Working File is updated monthly and plan options are effective on the first day of the month of either the enrollment or dis-enrollment. It is recommended that the CWF is reviewed monthly for all Medicare recipients to assure that the most current information is obtained.

Medicare Advantage Plans provide all of the resident’s Part A (Hospital Insurance) and Part B (Medical Insurance) coverage. This means they must cover at least all of the services that Original Medicare covers. However, each Medicare Advantage Plan can charge different out-of-pocket costs. These are usually copayments but can also be coinsurance and deductibles. It’s important to call any plan before admission to determine the plan’s rules, amount of coverage, what the resident’s costs will be, and to obtain claims information. Utilize the Insurance Verification form to record the information as it is obtained during the phone call to the insurance company.

Being aware of the MA plan type is crucial, especially for those beneficiaries who are enrolled in Private Fee-For-Service (PFFS) plans. Below are brief descriptions of the various types of Medicare Advantage plans:

**Health Maintenance Organization (HMO) Plans**
- People who join a Medicare HMO may be asked to choose a primary care doctor. Members must see their primary care doctor before they see any other health care provider. They usually need a referral to see a specialist (such as a cardiologist). A referral is a usually required from the primary care doctor for the member to see a specialist or get certain services.
- In Medicare HMOs, the copayment or coinsurance amounts a member pays for services are set by the plan. There are doctors and hospitals that contract with the plan (called the plan’s “network”). People generally must get their care and services from the plan’s network. Call or get a list from the plan to see which doctors, hospitals and skilled nursing facilities are in the plan’s network.
- People who get health care outside of the network may have to pay for those services themselves. In most cases, neither the Medicare HMO nor Original Medicare will pay for those services. The service area is where the plan accepts members and where plan services are provided. Members are covered for emergency or urgently needed out-of-network care. Some Medicare HMOs offer a Point-of-Service option. This allows people to go to other doctors and hospitals who aren’t a part of the plan (“out-of-network”), but they may pay more.

**Preferred Provider Organization (PPO) Plans**
- Medicare PPOs use many of the same rules as Medicare HMOs discussed above. However, people in a PPO generally can see any doctor or provider that accepts Medicare. They don’t need a referral to see a specialist. If they go to doctors, hospitals, or other providers that aren’t part of the plan (“out-of-network” or “non-preferred”), they don’t need a referral, but they will usually pay more.
Every Medicare PPO Plan must pay for all covered services received out-of-network, but every plan is different in what their members must pay.

Regional PPOs are available in most areas of the country. Unlike local PPOs, which serve individual counties, regional PPOs serve an entire region, which may be a single state or multi-state area. This helps bring more plan options to people with Medicare. In a regional PPO, members will have an added protection for Medicare Part A and Part B benefits because regional PPOs limit members’ annual out-of-pocket costs. The annual out-of-pocket limit varies by plan. Regional PPOs may have a higher yearly deductible and/or premium than other PPOs.

Private Fee-for-Service (PFFS) Plans

A Medicare Private Fee-for-Service (PFFS) Plan is a Medicare Advantage Plan offered by a private insurance company under contract Medicare. Some companies offer more than one plan in an area, with different benefits and costs. PFFS Plans may not be available in all areas. The general rules for how Medicare Private Fee-for-Service Plans work include:

- Members can choose which provider they will see, do not need a referral to see a specialist, and can get services outside their service area. However, while they can go to any Medicare-approved doctor or hospital, the provider must accept the terms and conditions of their plan’s payment.
- Members may get extra benefits not covered under Original Medicare, such as extra days in the hospital.
- The private company, rather than the Medicare program, decides what amount members pay for the services they get.
- If a doctor sees a PFFS patient, they become a “deemed” provider and must accept the plans terms and conditions except during emergency care. Providers are “deemed” when they know before providing a service, that you a patient is in a Medicare PFFS Plan; they have reasonable access to the plan’s terms and conditions of payment; and the service is covered by the plan.

Special Needs Plans (SNP)

Medicare Special Needs Plans are only available in some areas. Medicare SNPs must limit all or most of their membership to people with certain chronic or disabling conditions, those eligible for both Medicare and Medicaid, or people in certain institutions (like a nursing home).

Medical Savings Account (MSA) Plans

Medicare Medical Savings Account (MSA) Plans are similar to Health Savings Account Plans available outside of Medicare. They have two parts. The first part is a Medicare Advantage Plan with a high deductible. This health plan won’t begin to pay covered costs until the person has met the annual deductible. The second part is a Medical Savings Account into which Medicare deposits money that the person with Medicare may use to pay health care costs. There is a MSA demonstration program available in some areas that allows preventive services before the deductible is met, and has cost-sharing after the deductible is met, up to a separate out-of-pocket limit. For more information on MSA Plans, visit: www.medicare.gov/Publications/Pubs/pdf/11206.pdf
Private Insurance (Non-Medicare) Admissions

- Prior to accepting a Non-Medicare covered resident for a skilled stay it is still recommended that you obtain a Common File to determine that the Private Insurance is the only coverage.
- Private Insurance coverage should be verified by telephone to determine the policy rules, coverage rate, claims process and pre-certification requirements.
- A method to “cost out” of the patients stay should be established and the appropriate clinical approvals should be obtained.
- Any Letter of Agreement or One Time Contract should be obtained prior to the admission. The rate, level of care and other requirements should be clearly defined in the document.
- Contracted rates and Care levels should be reviewed at least annually by facility administration.
- The resident should be provided with a letter detailing the specifics of the coverage. The document should include any co-pays, deductibles and coverage limitations that they may be responsible to pay. An example letter is attached.

Contacting the Insurance Company by telephone to verify all insurance including Private, Medicare Managed Care, Supplemental, and Worker’s Compensation is essential. Although verification of coverage does not guarantee payment of the claim it will give you the information necessary to make an informed decision about the admission. During the verification phone call you should also obtain the name of the customer service representative that you are speaking to.

Following are examples of the questions that should be included in the verification phone call:

- Does the plan require pre-certification?
- Does the plan cover Skilled Nursing Facility placement? For how long?
- Does the plan require re-authorization? How often?
- Is there a deductible? Co-Pay? Out-of-Pocket maximum?
- Does the plan require case management?
- Does the plan pay an all inclusive daily rate? Or RUGS rate following MDS schedule?
- Where are claims sent?
- Does the Insurance cover Part B therapy in a skilled nursing setting?
- Is this a Medicare replacement plan?
- Is this a Medicare Supplemental Plan?
- Is there any additional information that you require from our facility?
- Does the plan cover ancillary charges? Pharmacy? Therapy? Medical Supplies? DME?
- Are we required to be a CONTRACTED provider?

Any information obtained during the phone call should be recorded and maintained in the financial file. Medical Case Management and re-authorization requirements should be communicated to the designated Clinical staff member for follow up.

The Business Office is responsible for filing the claim for payment for all insurance admissions. Claims filing requirements differ for every insurance company and specific instructions for filing the claims, such as claim form utilized, coding requirements and claims address can be obtained by either calling the insurance company or by visiting its website.
# Insurance Verification

Resident’s Name ___________________________   Date___________

<table>
<thead>
<tr>
<th>Insured Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Number:</td>
<td>Social Security Number:</td>
</tr>
<tr>
<td>Insurance Company/Plan Name:</td>
<td></td>
</tr>
<tr>
<td>Insurance Company Representative:</td>
<td></td>
</tr>
<tr>
<td>Insurance Representatives Telephone Number:</td>
<td></td>
</tr>
<tr>
<td>Policy Number:</td>
<td></td>
</tr>
<tr>
<td>Group Name/Number:</td>
<td></td>
</tr>
<tr>
<td>Effective Date of Policy:</td>
<td></td>
</tr>
<tr>
<td>Claims Address:</td>
<td></td>
</tr>
</tbody>
</table>

**Plan Type:** Medicare Supplement _____ Medicare Advantage ________
Private Insurance ________ Other ________

Does this plan require Pre-Certification? Y or N

If so how often is Pre-Certification needed? ____________________
Authorization #___________________________

Is any information needed prior to delivering services? Y or N

Is there a Co pay that the insured will be responsible for paying? Y or N  Amount $

Is there a Deductible that needs to be met prior to coverage starting?  Y or N   Amount $

When does the first day of coverage start?

How many days are covered in the benefit?

If the plan’s skilled nursing benefit is exhausted (100 days), are there any other benefits that cover custodial care or long term placement? Y or N

If yes:
  - What are the payment terms (how much do they pay and for how long?)
  - What will the facility have to provide in order to receive payment and does it require continued certification? __________________________

Required forms that need to be submitted with the claim to receive full payment?
Check all that apply below:
UB 04 ___ CMS 1500 ___ Medicare EOB ___ Physician Orders ___ Medical Record ___

When the level of care changes, will they need a denial from Medicare? Y or N

Person Completing This Form___________________________  Date________________
Facility Name
Facility Street Address
City, State & Zip code

Date

Resident Name:
Address:
City, State & Zip

Dear (Resident Name):_________________________:

(Name of Facility):_____________________________ has reviewed your
Primary/Secondary/Supplemental Insurance with:

(Name of Insurance Company) - Policy #_________________________________.

They indicate you will be responsible for the following:

__________________Deductible_____________________________________________
__________________Co Insurance per Day effective on day______________________
__________________% of Charges___________________________________________
__________________Other_________________________________________________

We are billing your insurance as a courtesy, if the insurance company does not pay; the resident
or responsible party may be billed and may be responsible for any charges due. If there are any
questions, please call and speak with the Business Office Director at (facility phone number).

Sincerely,

(Business Office Director)

(Responsible Party)

__________________________ Date: __________
VERIFICATION OF INSURANCE COVERAGE

FACILITY NAME: ____________________________________________________________

RESIDENT: ____________________________ DOB ____________________________

Did Medicare Screening show that this resident has Medicare? □ YES □ NO
(If the resident does not have Medicare, they cannot have a Medicare Replacement Policy)

INSURANCE COMPANY: ____________________________
POLICY NUMBER: ____________________________ GROUP #: ____________________________

1. Does the resident have current coverage? □ YES □ NO Effective date: ________________
(If the answer to this question is No, Stop here.)

2. Is this a Medicare Replacement Policy? □ YES □ NO
(Possible Answers: This is Medicare Part C; This is a Medicare Advantage Plan)
(This is a Replacement A or B Policy)

3. Is this a HMO or PPO? □ YES □ NO

4. If YES - What is the reimbursement rate?
   Is there difference between in and out of network coverage? □ YES □ NO
   IF Yes, describe
   (Usually they will tell you if the facility is out of network and what the discounted rate is. If we are not in Network you may have to negotiate a rate.)

5. What skilled nursing services are covered under this policy? ____________________________
   Possible Answers : Room & Board, Therapies, Labs, X rays and Med Supplies (Replacement A coverage or Primary Insurance);
   Days 21 – 100 after Medicare pays or Med A coinsurance (Supplement A coverage); 100% of Med B Therapy (Replacement B);
   Therapy - 20% after Medicare pays (Supplement B); a flat rate for skilled care (this is Flat Rate Insurance).

6. If they cover therapy, which types? PT OT ST

7. What are the maximum benefits? ____________________________

8. Does this insurance pay at a daily rate? □ YES □ NO What amount?_____________________
   (If yes, this is Flat Rate Insurance.)

9. Is there coverage for non skilled custodial care? □ YES □ NO
   (If YES, this is long term care insurance and will be billed by the facility.)

10. If the resident is not skilled will this policy cover Part B Therapy IN FULL, not just coinsurance?
    □ YES □ NO
    (If yes, this is a Med B replacement or Primary Insurance)

11. Are there any special requirements for coverage? □ YES □ NO Describe ____________________________
    (Do they need progress notes, physician orders, precertification, etc.)

12. Is there a timely billing policy? ____________________________
    (Many insurance companies require billing to be submitted within a limited time after the services are rendered.)

13. Will this policy cover Medicare Coinsurance for a Part A stay? □ YES □ NO
    (If yes, this is Supplement A)
VERIFICATION OF INSURANCE COVERAGE

14. Will this policy cover Medicare Coinsurance for Part B services? □ YES □ NO
   (If yes, this is Supplement B)

15. Are there any policy exclusions or pre-existing conditions clauses relating to SNF? ________________
   (Example: they cover PT/OT but not ST)

16. Is there an out of pocket or deductible related to this policy? □ YES □ NO
   If there is a deductible, has all or part of it been paid ______ How much? ________________
   If there is an out of pocket what is the amount? ________________ Daily amount or lump sum
   Has all or part it been paid? __________________________ How much? ________________

17. Is pre-certification required for this insurance coverage? □ YES □ NO
   If Yes, what is required: ____________________________________________________________
   How often: __________________________________________________________________________
   (Generally you will be given specific instructions to obtain preauthorization, often this requires you, a nurse or a
   therapist to call a different number and you may be required to send medical information. This may need to be done
   regularly.)

18. Is this policy set up as an Automatic Medicare Crossover for payment? □ YES □ NO
   (This only applies to Medicare Supplement Policies and means that no paper claim must be sent and the claim will
   automatically be paid after Medicare pays.)

19. What form of billing is required? □ UB-04 □ R.A. □ OTHER ________________
   (Describe) __________________________________________________________________________
   (Without this information, we will not get paid. Other forms of billing are a monthly statement, an itemized bill.)

20. Are RUGS required to be included with the billing? □ YES □ NO

21. Verify correct/current claims mailing address and phone number: (DO NOT RELY ON THE CARD)
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________ Phone Number (Always get this!)

22. Name of insurance representative verifying the information: __________________________

IF PREAUTHORIZATION IS REQUIRED COMPLETE AND CONFIRM

   Number Called ____________________________
   Preauthorization # ____________________________
   Contact Person ____________________________
   Completed by ____________________________
   Date completed ____________________________

What is your conclusion of the payer source? __________________________

Verification completed by: __________________________________________

   Name and Title __________________________ Date __________________________
# EXAMPLE
## Insurance Verification

**Resident’s Name** ___________________________  **Date** ____________

<table>
<thead>
<tr>
<th>Insured Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Number:</td>
<td>Social Security Number:</td>
</tr>
<tr>
<td>Insurance Company/Plan Name:</td>
<td></td>
</tr>
<tr>
<td>Insurance Company Representative:</td>
<td></td>
</tr>
<tr>
<td>Insurance Representatives Telephone Number:</td>
<td></td>
</tr>
<tr>
<td>Policy Number:</td>
<td></td>
</tr>
<tr>
<td>Group Name/Number:</td>
<td></td>
</tr>
<tr>
<td>Effective Date of Policy:</td>
<td></td>
</tr>
</tbody>
</table>

**Claims Address:**

Plan Type:  
- Medicare Supplement____
- Medicare Advantage____
- Private Insurance____
- Other________

Does this plan require Pre-Certification?  Y or N  If so how often is Pre-Certification needed?____________ Authorization #___________________________

Is any information needed prior to delivering services? Y or N

Is there a Co pay that the insured will be responsible for paying? Y or N  Amount $_____

Is there a Deductible that needs to be met prior to coverage starting?  Y or N  Amount $_____

When does the first day of coverage start?

How many days are covered in the benefit?

If the plan’s skilled nursing benefit is exhausted (100 days), are there any other benefits that cover custodial care or long term placement? Y or N  If yes:
  - What are the payment terms (how much do they pay and for how long?)
  - What will the facility have to provide in order to receive payment and does it require continued certification? ______________________

Required forms that need to be submitted with the claim to receive full payment?

Check all that apply below:
- UB 04 _____
- CMS 1500 _____
- Medicare EOB____
- Physician Orders____
- Medical Record____

When the level of care changes, will they need a denial from Medicare? Y or N

---

**Person Completing This Form** ___________________________  **Date** ____________

---
CURR PLAN (current) and PRIR PLAN (previous) indicate the type of managed care plan in which the beneficiary is enrolled. There are five types of managed care plans:

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Instructions</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Maintenance Organization (HMO)</td>
<td>Call the plan for authorization.</td>
<td>Managed care plan with a provider network. Limited or no out-of-network coverage with the exception of emergency services.</td>
</tr>
<tr>
<td>Preferred Provider Organization (PPO)</td>
<td>You may treat the patient.</td>
<td>Has a network of providers. In return for higher cost sharing, members can go out of network for all plan services, including supplemental benefits.</td>
</tr>
<tr>
<td>Provider of Service(s) System (POS)</td>
<td>You may treat the patient subject to plan rules. Contact the plan for details.</td>
<td>A limited out-of-network option offered by HMO plans. Contact the plan for details.</td>
</tr>
<tr>
<td>Indemnity</td>
<td>You may treat the patient.</td>
<td>If this is a private Fee-for-Service (PFFS) plan, you must follow the plan’s terms and conditions of payment. If this is a Medical Savings Account (MSA) plan, the member may pay you directly.</td>
</tr>
<tr>
<td>Fee-for-Service (FFS) Demo</td>
<td>You may treat the patient.</td>
<td>Beneficiaries remain in original Medicare and are entitled to all FFS benefits. There are no changes to Medicare FFS billing instructions or claims processing.</td>
</tr>
</tbody>
</table>

CUR ID (current) and PRI ID (previous) indicate the number assigned to a particular Managed Care Organization (MCO). This number can be used to obtain contact information for the MCO in the MCO Directory, which can be found at:


OPT (option) indicates the option code, which identifies whether services are restricted or unrestricted. The valid values are:
- Unrestricted:
  - 1 – Medicare processes all Part A and Part B provider claims.
  - 2 – MCO processes claims for directly provided service and for services from providers with effective arrangements. Medicare processes all other bills.
- Restricted:
  - A – Medicare processes all Part A and Part B provider claims.
  - B – MCO processes claims only for directly provided services.
  - C – MCO processes all claims.

ENR is the date the beneficiary enrolled in the managed care plan.

TERM is the termination date for coverage by that managed care plan.

**Informational-Only Claim Submission Requirements**

When a patient is enrolled in a managed care plan and receives certain inpatient services, an informational-only claim must be submitted to Medicare for the purpose of tracking the patient’s benefit utilization and, in some cases, for the provider to receive special payments. The chart below describes how these claims are submitted for inpatient acute hospitals, Inpatient Rehabilitation Facilities (IRFs), Long-Term Care Hospitals (LTCHs), Critical Access Hospitals (CAHs) and Skilled Nursing Facilities (SNFs)/Swing Bed (SB) facilities.

<table>
<thead>
<tr>
<th>Non-teaching facility</th>
<th>Acute</th>
<th>IRF</th>
<th>LTCH</th>
<th>CAH</th>
<th>SNF/SB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered claim with condition code 04 for Disproportionate Share Hospital (DSH) payment.</td>
<td>Covered claim with condition code 04 for Electronic Health Record (EHR) incentive payment.</td>
<td>Covered claim with condition code 04 for DSH payment.</td>
<td>Covered claim with condition code 04 for DSH payment.</td>
<td>Submit claim to the managed care plan for payment; submit the same claim to Medicare to track the patient’s benefit utilization.</td>
<td></td>
</tr>
<tr>
<td>Effective October 1, 2011, covered claim with condition code 04 and the Case-Mix Group (CMG) code and assessment date from the IRF Patient Assessment Instrument (PAI) for Low-Income Patient (LIP) payment.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Teaching facility</th>
<th>Acute</th>
<th>IRF</th>
<th>LTCH</th>
<th>CAH</th>
<th>SNF/SB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered claim with condition codes 04 and 69 for DSH and Direct Graduate Medical Education (DGME) payments.</td>
<td>Non-covered claim with condition codes 04 and 69 for LIP and DGME payments.</td>
<td>Non-covered claim with condition codes 04 and 69 for DSH and DGME payments.</td>
<td>Not applicable.</td>
<td>Not applicable.</td>
<td></td>
</tr>
</tbody>
</table>
Note: Managed care informational-only claims are not required for outpatient hospital or Inpatient Psychiatric Facility (IPF) services. If requesting a denial based on coverage by a managed care plan, submit the claim as covered without condition code 04 or 69.


Managed Care Plan for a Portion of the Billing Period

The chart below describes how inpatient claims are submitted when a patient is enrolled in a managed care plan for only a portion of the inpatient stay.

<table>
<thead>
<tr>
<th>IPPS</th>
<th>IPF</th>
<th>IRF</th>
<th>LTCH</th>
<th>CAH</th>
<th>Non-IPPS</th>
<th>SNF/SB</th>
</tr>
</thead>
<tbody>
<tr>
<td>• If Medicare is primary upon admission, bill the entire claim to Medicare.</td>
<td>• Bill the managed care plan for days the patient is enrolled in the managed care plan.</td>
<td>• If the managed care plan is primary upon admission, bill the entire claim to the managed care plan.</td>
<td>• Bill Medicare for the days the patient is not enrolled in the managed care plan.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Reference: IOM Pub. 100-04, Chapter 1, Section 90.

Managed Care Plan and Hospice

When a patient is enrolled in a managed care plan and elects the hospice benefit, all hospice and non-hospice related services beginning on the date of the hospice election are billed to Medicare as follows:

• Hospice services covered under the Medicare hospice benefit are billed by the hospice provider to the Home Health and Hospice (HH&H) Medicare Administrative Contractor (MAC).
• Services provided by the enrollee’s attending physician (if the physician is not employed by or under contract to the enrollee’s hospice) are billed by the physician to the carrier or A/B MAC.
• Services not related to the treatment of the terminal condition are billed by the provider to the intermediary or A/B MAC with condition code 07.
• Services furnished after the revocation or expiration of the enrollee’s hospice election are billed accordingly until the full monthly capitation payments begin again. Monthly capitation payments begin on the first day of the month after the beneficiary revokes the hospice election.

Reference: IOM Pub. 100-04, Chapter 11, Section 30.4.
Medicare Advantage Plan “Plan”: Know the contract terms

1. Medicare Advantage Organizations (MAO) sometimes referred to as Managed Care Organizations (MCO) or Medicare Part C contracts with SNFs for Skilled Part A services. Note: MA plans do not always have a contract with the facility. Any MA plan can be accepted by the facility. Some facilities do have contracts with the MAO.

   a. PPS MDSs are not required for private individual health plans that are not Medicare Advantage plans.

2. CMS Reporting Requirements must be met: General Rules

   a. CMS requires, effective July 1, 2014, all claims submitted by MAO include a HIPPS code calculated by an OBRA Required Admission. However, CMS encourages MAO to use HIPPS codes from PPS MDS if available.
      i. To meet this requirement, SNFs must submit HIPPS codes on their bills to MAO.
   b. SNF is also required to submit an “Information Only No Pay Claim” to CMS. The HIPPS codes would match what was submitted to the MAO.

Know contract terms with Medicare Advantage Plan:

The SNF bills the MAO the RUG achieved from PPS MDS. This is a RUG based contract.

1. For these types of contracts, the SNF completes all required Medicare MDS to be used for billing MAO. However, these MDSs are NOT submitted to CMS QIES ASAP system.
   a. These MDSs will be used for billing the “Plan”. The software will create the needed RUG HIPPS code. However, not all software will produce the claim.
   b. While these PPS MDSs are not submitted to QIES ASAP System; the required OBRA MDS would be submitted.
      i. This means the 5-day MDS would need to be separated by OBRA Admission MDS.
   c. These PPS MDSs can be used as back-up MDSs if the SNF is notified after discharge that the resident was actually covered under Traditional Medicare.

Best Practice:
When completing PPS MDS for MAO billing:

1. Reason for Assessment:
   a. The “Reason for Assessment” A0310B can reflect the PPS MDS type or code as “99” but again these MDS are not submitted to QIES ASAP System.
      i. The benefit of using the actual “Reason for Assessment” in A0310B (5, 14, 30, etc.) is to communicate to the biller the AI (Assessment Indicator) and number of days which correspond with the MDS the claim being submitted to managed care.
      ii. Coding “99” is also acceptable coding, but then the biller needs to determine the appropriate days for each MDS type for the No Pay claim.
    o Later if these MDSs are submitted to Traditional Medicare for billing, the “Reason for Assessment” must be changed to “99,” so ensure your software allows you to change A0310B for these MDSs that were not submitted.
2. CMS states to code A0410 according to the bed certification type.
   a. “3” if the MDS record is for a resident on a Medicare and/or Medicaid certified unit.
   b. “2” if the MDS record is for a resident on a unit that is neither Medicare nor Medicaid certified but the state has the authority to collect MDS information for residents on this unit.
   c. “1” if the MDS record is for a resident on a unit that is neither Medicare nor Medicaid certified, and the state does not have authority to collect MDS information for residents on this unit. This coding is actually never used because an MDS that meets the definition for coding “1” would never be submitted.
   d. Some software will not give a RUG if they don’t code it like a Medicare patient so code it a “3” or “2” if needed to complete MDS in software.
   e. It is best practice to not combine an OBRA required assessment with a PPS Scheduled or Unscheduled MDS completed solely for billing the Medicare Advantage health plan for this reason.

3. The biller will bill the MAO using HIPPS code and Assessment Indicator (AI) for the 5, 14, 30, 60 and 90-day PPS MDS.

4. On all “Medicare Advantage Health Plan” residents, the biller continues to submit Informational Only No Pay claims to Medicare during the “Medicare Advantage Health Plan” stay - covered claim with a condition code 04 and either use the RUG or AAA00 (this claim does not pay but tracks utilization/benefit days only) achieved from the OBRA Required Initial/Admission MDS if that is all that has been completed. If PPS MDS had been completed (but not submitted) per Medicare Advantage Health Plan contract, then use HIPPS codes from those for appropriate days.
   a. The “No Pay” claims which are considered to be “informational only” must now reflect the RUGs even if only the HIPPS code from the Initial/Admission MDS is used; Informational only claims, must be done even if billing Medicare Advantage program a different rate per contract.

When not Completing PPS MDS for MAO Contract:

1. **The SNF bills the MAO based on levels/tiers set in contract.** This is a level/tier based contract. For these types of contract the SNF bills the MAO the level/rate which applies to level the resident achieved or was authorized by the contract.
   Note: For SNFs that chose to complete PPS MDS on these residents as “back-up” in case later this resident is determined to be on Traditional Medicare; then the PPS MDS that were created (but not submitted) could be used to create Information Only claim for submission to CMS as described earlier in this procedures.

2. For these types of contract, the SNF may not be completing any PPD MDS on these residents as not needed to bill MAO.

3. **Meeting Reporting Requirements to CMS:** CMS requires, effective July 1, 2014, all claims submitted to MAO include a HIPPS code calculated by an OBRA Required Admission (with exceptions).
   a. **How to determine which HIPPS code to use on claim to MAO;** In order of selection:
      i. **MA Stays of More than 14 days:**
         o Admission MDS completed during this MA covered Stay – Include HIPPS on CMO claim
         o If no, Admission MDS, then any OBRA MDS completed during MA covered stay (quarterly, annual, SCSA)
If no OBRA MDS was completed during MA covered stay; submit the HIPPS code from most recent MDS that was completed prior to MA covered Stay.

- Admission completed on prior stay, or most recent OBRA completed on long term resident (quarterly, annual, SCSA)

ii. MA Stays 14 days or less:

- Use HIPPS code from any OBRA assessment completed during this short MA covered stay.
- Submit a default HIPPS code if (1) the SNF stay was less than 14 days within a spell of illness, (2) the beneficiary has been discharged prior to the completion of the initial OBRA Admission assessment, and (3) no other assessment was completed during the stay.
  - To submit a default HIPPS code to the Encounter Data System, use the default Resource Utilization Group (RUG) code of “AAA” and Assessment Indicator “00” on encounter data submissions starting with “from” dates of service July 1, 2014.
  - May not use this default code in other situations.

iii. SNF is also required to submit an “Information Only No Pay Claim” to CMS. The HIPPS codes would match what was submitted to the MAO.

### Medicare Advantage Plan Stay and MDS: Best practice

**What to do when SNF notified after discharge that resident was on Traditional Medicare for the entire stay:**

1. Assuming the MDS Coordinator completed the Scheduled PPS MDSs as required; then these MDSs can be used to bill Traditional Medicare.
   - The MDS Coordinator needs to reopen these MDS, the “Reason for Assessment” A0310B must be “99” and change A0410 as “1.” Neither Federal nor State required submission to “3” Federal required submission; then submit to QIES ASAP System.
   - The biller should bill Traditional Medicare with the appropriate HIPPS Code.
   - The biller will also need to cancel the “info only - No Pay” claims previously submitted before billing Medicare to prevent duplication in counting the utilization days/benefit days.

2. If the MDS Coordinator has not completed any PPS MDSs, the Initial/Admission OBRA MDS, (which is already in the QIES ASAP System) may be used for billing Medicare the first 30 days (covering billing periods associated with the 5-day and 14-day MDS).

   *The provider may use the OBRA Admission Assessment (the ARD of the OBRA Admission Assessment may be before or during the Medicare stay and does not have to fall within the ARD window of the 5-day or 14-day Assessment) to bill for all days of covered care associated with Medicare required 5-day and 14-day Assessments, even if the beneficiary is no longer receiving therapy services that were identified under the most recent clinical assessment.*

   - The biller would bill Traditional Medicare with the appropriate HIPPS code, but use Assessment Indicator code “60” for the claim.
b. The biller would also have to cancel the “info only- No Pay” claims previously submitted before billing Medicare to prevent duplication in counting the utilization days/benefit days.

3. Other type of MDSs which could be used for billing in this special situation:

a. When an OBRA Admission Assessment does not exist, the SNF must have a valid OBRA Assessment (except a stand-alone Discharge Assessment) in the QIES ASAP System that falls within the ARD window of the 5-day or the 14-day (including grace days) in order to receive full payment at the RUG category in which the resident grouped for days 1-14 or days 15-30. This assessment may only cover one payment period.

b. When the ARD of a valid OBRA Assessment is set outside the allowed ARD window for the 5-day or 14-day PPS MDS (including grace days), then the SNF must bill the default rate for the applicable payment periods. For covered days associated with the Medicare-required 30-day, 60-day, or 90-day Assessments, the SNF must have a valid MDS. If an ARD of a valid OBRA Assessment is set outside the allowed ARD window for that PPS MDS (including grace days), then the SNF must bill the default rate.

What MDS Assessments to complete if SNF learns during stay that the resident is changing to Traditional Medicare or visa versa.

1. If a resident changes to Traditional Medicare during their SNF stay, the resident is entitled to coverage under Traditional Medicare for the number of days remaining out of the 100 days available in the benefit period.
   a. The MDS Coordinator should complete all required PPS MDS (including OMRAs) with day 1 of the assessment cycle as the first day the resident resumes enrollment under Traditional Medicare. This date is usually the first day of the next month after disenrollment from the Medicare Advantage Plan.
      a. A 5-day PPS MDS completed with an ARD of day 1 - 8 sets the payment for the first 14 days. A Medicare Start Date would be noted, and this MDS would be submitted to QIES ASAP System.
      b. The MDS Coordinator then continues with the usual PPS MDS cycle including OMRAs.
      c. The resident only has the remaining days from the stay.
         i. For example, if the resident used 33 days under the “Plan,” and then converted to Traditional Medicare the first day of the month; that day is the 34th benefit day out of a potential 100 days.
      b. When the “Plan” ends and coverage under traditional Medicare begins, the next claim is submitted to the MAC sequentially beginning with the 5-day PPS MDS on the first Medicare Part A claim.
      c. The biller uses condition code 58 (managed care disenrollment) if the resident did not have a 3-day qualifying hospital stay (many Medicare Advantage Plans do not require that the 3-day qualifying hospital stay to be met).
   2. If the resident changes to MCO from traditional Medicare; begin new Medicare PPS cycle per contract.
90.2 - Medicare Billing Requirements for Beneficiaries Enrolled in MA Plans
(Rev. 1394, Issued: 12-14-07, Effective: 10-01-06, Implementation: 03-17-08)
If a beneficiary chooses an MA plan as his or her form of Medicare, he/she cannot look to traditional “fee for service” Medicare to pay the claim if the MA plan denies coverage.

SNF providers shall apply the following policies to MA beneficiaries who are admitted to a SNF:

- If the SNF is non-participating with the plan, the beneficiary must be notified of his or her status because he/she MAY be private pay in this circumstance, depending upon the type of MA plan in which he/she is enrolled;
- If the SNF is participating with the plan, pre-approve the SNF stay with the plan;
- If the plan denies coverage, appeal to the plan, not to the “fee for service” FI;
- Count the number of days paid by the plan as Part A days used (this IS the beneficiary’s 100 days of Medicare SNF benefits);
- Submit a claim to the “fee for service” intermediary to subtract benefit days from the CWF records. (Note: The plans do not send claims to CWF for SNF stays). Failure to send a claim to the FI will inaccurately show days available.
- If a beneficiary no longer requires skilled care under the MA plan the SNF may discharge the patient using a patient status code 04. No-payment bills are not required for beneficiaries that are receiving non-skilled care and are enrolled in an MA plan. If the beneficiary again requires skilled care after a period of non-skilled care, the provider should begin a new admission claim for Medicare to continue the spell of illness.

Billing Requirements

- Submit covered claims and include a HIPPS code (use default code AAA00 if no assessment was done), room and board charges and condition code 04.

NOTE: If the beneficiary drops his or her MA plan participation during their SNF stay, the beneficiary is entitled to coverage under Medicare FFS for the number of days available that remain out of the 100 days available under the SNF benefit.
period ended prior to the “from” date on the claim. The FI does not need to verify that
the MA plan was the one that terminated.

90.2 - Medicare Billing Requirements for Beneficiaries Enrolled in MA Plans
(Rev. 1394, Issued: 12-14-07, Effective: 10-01-06, Implementation: 03-17-08)

If a beneficiary chooses an MA plan as his or her form of Medicare, he/she cannot look to
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SNF providers shall apply the following policies to MA beneficiaries who are admitted to a SNF:

• If the SNF is non-participating with the plan, the beneficiary must be notified of his
or her status because he/she MAY be private pay in this circumstance, depending upon
the type of MA plan in which he/she is enrolled;

• If the SNF is participating with the plan, pre-approve the SNF stay with the plan;

• If the plan denies coverage, appeal to the plan, not to the “fee for service” FI;

• Count the number of days paid by the plan as Part A days used (this IS the
beneficiary’s 100 days of Medicare SNF benefits);

• Submit a claim to the “fee for service” intermediary to subtract benefit days from the
CWF records. (Note: The plans do not send claims to CWF for SNF stays). Failure to
send a claim to the FI will inaccurately show days available.

• If a beneficiary no longer requires skilled care under the MA plan the SNF may
discharge the patient using a patient status code 04. No- payment bills are not required for
beneficiaries that are receiving non-skilled care and are enrolled in an MA plan. If the
beneficiary again requires skilled care after a period of non-skilled care, the provider
should begin a new admission claim for Medicare to continue the spell of illness.

Billing Requirements

- Submit covered claims and include a HIPPS code (use default code AAA00 if no
assessment was done), room and board charges and condition code 04.

**NOTE:** If the beneficiary drops his or her MA plan participation during their SNF stay,
the beneficiary is entitled to coverage under Medicare FFS for the number of days
available that remain out of the 100 days available under the SNF benefit.

100 – Part A SNF PPS for Hospital Swing Bed Facilities
(Rev. 1, 10-01-03)
PM A-02-016
<table>
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<th>CODE</th>
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<th>AMOUNT</th>
<th>CODE</th>
<th>VALUE CODES</th>
<th>AMOUNT</th>
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<tbody>
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<td></td>
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</tbody>
</table>

**Attending Physician**
- Name: Doe John
- NPI: 123456789A
- Group Name: BCBS
- Insurance Group No.: 123456

**Other Procedure**
- R & B
- 250.00

**X Ray**
- 2
- 120.00

**Physical Therapy**
- 20
- 1800.00

**Occupational Therapy**
- 25
- 1975.00

**Total Charges:** 11,745.00
<table>
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<tr>
<th>31</th>
<th>32</th>
<th>33</th>
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**DESCRIPTION**

- **0191**: Subacute-Level I
- **0192**: Subacute-Level II
- **0250**: Pharmacy
- **0420**: Physical Therapy
- **0424**: Evaluation/Re-Evaluation
- **0430**: Occupational Therapy
- **0434**: Evaluation/Re-Evaluation
- **0440**: Speech Language Pathology
- **0444**: Evaluation/Re-Evaluation

**Details**

- **Code**: 0191
  - **Description**: Subacute-Level I
  - **Units**: 300.00
  - **Revenue**: 60.41
  - **Profit**: 0
  - **Total**: 300.00

- **Code**: 0192
  - **Description**: Subacute-Level II
  - **Units**: 400.00
  - **Revenue**: 60.41
  - **Profit**: 0
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- **Code**: 0250
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  - **Revenue**: 0
  - **Profit**: 0
  - **Total**: 1300.00

- **Code**: 0424
  - **Description**: Evaluation/Re-Evaluation
  - **Units**: 150.00
  - **Revenue**: 0
  - **Profit**: 0
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  - **Description**: Occupational Therapy
  - **Units**: 1300.00
  - **Revenue**: 0
  - **Profit**: 0
  - **Total**: 1300.00

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  - **Description**: Evaluation/Re-Evaluation
  - **Units**: 150.00
  - **Revenue**: 0
  - **Profit**: 0
  - **Total**: 150.00

- **Code**: 0440
  - **Description**: Speech Language Pathology
  - **Units**: 1200.00
  - **Revenue**: 0
  - **Profit**: 0
  - **Total**: 1200.00

- **Code**: 0444
  - **Description**: Evaluation/Re-Evaluation
  - **Units**: 150.00
  - **Revenue**: 0
  - **Profit**: 0
  - **Total**: 150.00

**TOTALS**: 13490.16
**INFORMATIONAL BILL ONLY - SKILLED MEDICARE ADVANTAGE PATIENT**

**DOE, JOHN**

**POLARIS GROUP**
1001 SUNNY LANE
SUNNY HILLS, FLORIDA 75169
(850) 555-0000

**HUMANA**
P O BOX 14601
LEXINGTON, KY 40512-4601

**CREATION DATE**
020311

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</table>

**INFORMATIONAL CLAIM**

**CLAIM EXAMPLE**

**POLARIS GROUP**
1001 SUNNY LANE
SUNNY HILLS, FLORIDA 75169
(850) 555-0000

**HUMANA**
P O BOX 14601
LEXINGTON, KY 40512-4601

**CREATION DATE**
020311

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Form Instructions for the Notice of Denial of Medical Coverage (or Payment)
CMS-10003-NDMCP

A Medicare health plan ("plan") must complete and issue this notice to enrollees when it denies, in whole or in part, a request for a medical service/item or a request for payment of a medical service/item the enrollee has already received. The notice contains text in curly brackets "{   }" to be inserted, as applicable, as explained in these instructions. The notice also contains text in square brackets "[   ]" that is to be inserted, as applicable, if a plan enrollee receives full benefits under a State Medical Assistance (Medicaid) program and the plan denies a service/item that is subject to Medicaid appeal rights. Bracketed text shown in italics must be inserted in the notice as written. Bracketed text that is not italicized provides instruction on text to be inserted in the notice.

The OMB control number must be displayed on the notice. The notice must be provided in 12 point font.

Heading
• Date: Insert the month, day, and year the notice is issued.
• Name: Insert the enrollee’s full name.
• Member number: Insert the enrollee’s plan identification number. The enrollee’s HIC number must not be used.

A plan is permitted to insert additional fields of information in the header section of the notice consistent with applicable State requirements, such as the enrollee’s Medicaid number, provider name, and date of service.

Section Titled: Your request was denied
The plan must insert the appropriate term to describe the action taken; that is, whether the service was denied, stopped, reduced or, in the case of a Medicaid service, suspended (temporarily stopping a service). If the denial involves a payment request, the plan must insert the payment of text shown in brackets. In the free text field, the plan must clearly and specifically list the denied medical services/items.

Section Titled: Why did we deny your request?
The plan must insert the appropriate term to describe the action taken; that is, whether the service was denied, stopped, reduced or, in the case of a Medicaid service, suspended (temporarily stopping a service). In the free text field, the plan must provide a specific and detailed explanation of why the medical services/items were denied and must include the applicable Medicare (or Medicaid) coverage rule or applicable plan policy (e.g., Evidence of Coverage provision) upon which the action was based.
Section Titled: You have the right to appeal our decision
The plan must insert its name in the {health plan name} field.

If the action taken involves Medicaid benefits, insert text shown in the square brackets, as applicable (include the timeframe for requesting an appeal for a Medicaid service, if the State timeframe is more or less than 60 days). If the enrollee is not required to exhaust the plan level appeal before requesting a State Fair Hearing, the notice must inform the enrollee of the right to concurrently request a plan appeal and a State Fair Hearing. The plan must insert applicable timeframes for requesting a State Fair Hearing.

Section Titled: If you want someone else to act for you
The plan must insert the phone and TTY numbers to be used if the enrollee needs information on how to name a representative.

Section Titled: There are 2 kinds of appeals
Standard Appeal - As applicable, the plan must insert the adjudication timeframe for standard Medicaid appeals.

Fast Appeal - No information to insert.

Section Titled: How to ask for an appeal with {health plan name}
In the title to this section, insert the health plan name.

Step 1: If the plan requires the appeal to be in writing, insert the bracketed option of written. If the notice relates to a Medicaid service, insert the italicized text shown in the square brackets.

Step 2: In the spaces provided for Standard and Fast Appeals, the plan must insert the plan’s address, phone and fax number(s). If the plan accepts standard appeal requests by phone, insert the text shown in brackets.

Section Titled: What happens next?
If the denial involves a payment request, insert the payment of text shown in brackets. If the notice relates to Medicaid services, insert additional State-specific rules, as applicable.

Section Titled: How to ask for a Medicaid State Fair Hearing/What happens next?
The optional Medicaid text in brackets must be included if the plan manages both Medicare and Medicaid benefits and the service/item is subject to Medicaid appeal rights. If applicable, insert text shown in square brackets if a Medicaid service was denied, stopped, reduced, or suspended. The plan must insert applicable timeframes for State fair hearings, as well as address, phone and fax numbers. If the denied medical services/items do not involve Medicaid services, the text related to asking for a State Fair Hearing must not be included in the notice.
Section Titled: Get help & more information

In the spaces provided, the plan must insert the plan’s toll free phone and TTY numbers for the enrollee, physician or representative to call if they need information or help. This section must always be included in the notice, whether or not the notice integrates the text from the preceding section containing bracketed language related to Medicaid State Fair Hearings. If the notice involves a Medicaid service, the plan must insert Medicaid/State contact information.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0829. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attention: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under “Get help & more information.”

**Notice of Denial of Medical Coverage**
{Replace Denial of Medical Coverage with Denial of Payment, if applicable}

Date:         Member number:

Name:

[Insert other identifying information, as necessary (e.g., provider name, enrollee’s Medicaid number, service subject to notice, date of service)]

**Your request was denied**
We’ve {Insert appropriate term: denied, stopped, reduced, suspended} the {payment of} medical services/items listed below requested by you or your doctor [provider]:

________________________________________________________________________
________________________________________________________________________

**Why did we deny your request?**
We {Insert appropriate term: denied, stopped, reduced, suspended} the {payment of} medical services/items listed above because {Provide specific rationale for decision and include State or Federal law and/or Evidence of Coverage provisions to support decision}:

________________________________________________________________________
________________________________________________________________________

**You have the right to appeal our decision**
You have the right to ask {health plan name} to review our decision by asking us for an appeal [Insert Medicaid information, if applicable: and/or you can request a State Fair Hearing. You can ask for both types of review at the same time, as long as you meet the deadlines. If you ask us for an appeal first, you may miss the deadline for requesting a State Fair Hearing.]:

Appeal: Ask {health plan name} for an appeal within 60 days [Insert State Medicaid timeframe, if different] of the date of this notice. We can give you more time if you have a good reason for missing the deadline.

**State Fair Hearing:** Ask for a State Fair Hearing within ( ) days of the date of this notice. You have up to ( ) days if you have a good reason for being late.

If we’re stopping or reducing a service, you can keep getting the service while your case is being reviewed. **If you want the service to continue, you must ask for an appeal** (Insert, if applicable: or a State Fair Hearing) within 10 days of the date of this notice or before the service is stopped or reduced, whichever is later. Your provider must agree that you should continue getting the service. If you lose your State Fair Hearing appeal, you may have to pay for these services.
If you want someone else to act for you

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: {number(s)} to learn how to name your representative. TTY users call {number}. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You’ll need to mail or fax this statement to us.

Important Information About Your Appeal Rights

There are 2 kinds of appeals

Standard Appeal – We’ll give you a written decision on a standard appeal within 30 days [Insert timeframe for standard Medicaid appeals, if different] after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We’ll tell you if we’re taking extra time and will explain why more time is needed. If your appeal is for payment of a service you’ve already received, we’ll give you a written decision within 60 days.

Fast Appeal – We’ll give you a decision on a fast appeal within 72 hours after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting up to 30 days for a decision.

We’ll automatically give you a fast appeal if a doctor asks for one for you or supports your request. If you ask for a fast appeal without support from a doctor, we’ll decide if your request requires a fast appeal. If we don’t give you a fast appeal, we’ll give you a decision within 30 days.

How to ask for an appeal with {health plan name}

Step 1: You, your representative, or your doctor [provider] must ask us for an appeal [or State Fair Hearing]. Your {written} request must include:

- Your name
- Address
- Member number
- Reasons for appealing
- Any evidence you want us to review, such as medical records, doctors’ letters, or other information that explains why you need the item or service. Call your doctor if you need this information.

[Insert, if applicable: You can ask to see the medical records and other documents we used to make our decision before or during the appeal. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision.]

Step 2: Mail, fax, or deliver your appeal {or call us}.

For a Standard Appeal: Address: {Phone:} Fax:

{Insert, if applicable: If you ask for a standard appeal by phone, we will send you a letter confirming what you told us.}

For a Fast Appeal: Phone: Fax:
**What happens next?**

If you ask for an appeal and we continue to deny your request for \{payment of\} a service, we’ll send you a written decision and automatically send your case to an independent reviewer. **If the independent reviewer denies your request, the written decision will explain if you have additional appeal rights.**

[Insert additional State-specific Medicaid rules, as applicable.]

---

**How to ask for a Medicaid State Fair Hearing**

[You have the right to ask for a State Fair Hearing without asking us (health plan) to review our decision first.]

**Step 1:** You or your representative must ask for a State Fair Hearing (in writing) within (       ) days of the date of this notice. You have up to (       ) days if you have a good reason for your request being late.

Your \{written\} request must include:

- Your name
- Address
- Member number
- Reasons for appealing
- Any evidence you want us to review, such as medical records, doctors’ letters, or other information that explains why you need the item or service. Call your doctor if you need this information.

**Step 2:** Send your request to:

Address:
Phone:                                    Fax:

---

**What happens next?**

The State will hold a hearing. You may attend the hearing in person or by phone. You’ll be asked to tell the State why you disagree with our decision. You can ask a friend, relative, advocate, provider, or lawyer to help you. You’ll get a written decision within (       ) days. The written decision will explain if you have additional appeal rights.

[A copy of this notice has been sent to:]

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**Get help & more information**

- \{Health Plan Name\} Toll Free: TTY users call:
  {Insert plan hours of operation}
- 1-800-MEDICARE (1-800-633-4227), 24 hours, 7 days a week. TTY users call: 1-877-486-2048
- Medicare Rights Center: 1-888-HMO-9050
- Elder Care Locator: 1-800-677-1116
- [Medicaid/State contact information]
When to Deliver the NOMNC

A Medicare provider or health plan (Medicare Advantage plans and cost plans, collectively referred to as “plans”) must deliver a completed copy of the Notice of Medicare Non-Coverage (NOMNC) to beneficiaries/enrollees receiving covered skilled nursing, home health (including psychiatric home health), comprehensive outpatient rehabilitation facility, and hospice services.

The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily.

Note: The two day advance requirement is not a 48 hour requirement.

This notice fulfills the requirement at 42 CFR 405.1200(b)(1) and (2) and 42 CFR 422.624(b)(1) and (2). Additional guidance for Original Medicare and Medicare Advantage can be found, respectively, at Chapter 4, Section 260 of the Medicare Claims Processing Manual and Chapter 13, Sections 90.2-90.9 of the Medicare Managed Care Manual.

Plans only:
In situations where the decision to terminate covered services is not delegated to a provider by a health plan, but the provider is delivering the notice, the health plan must provide the service termination date to the provider at least two calendar days before Medicare covered services end.

Provider Delivery of the NOMNC

Providers must deliver the NOMNC to all beneficiaries eligible for the expedited determination process per Chapter 4, Section 260 of the Medicare Claims Processing Manual and Chapter 13, Sections 90.2-90.9 of the Medicare Managed Care Manual. A NOMNC must be delivered even if the beneficiary agrees with the termination of services. Medicare providers are responsible for the delivery of the NOMNC. Providers may formally delegate the delivery of the notices to a designated agent such as a courier service; however, all of the requirements of valid notice delivery apply to designated agents.

The provider must ensure that the beneficiary or representative signs and dates the NOMNC to demonstrate that the beneficiary or representative received the notice and understands that the termination decision can be disputed. Use of assistive devices may be used to obtain a signature.
Electronic issuance of NOMNCs is not prohibited. If a provider elects to issue a NOMNC that is viewed on an electronic screen before signing, the beneficiary must be given the option of requesting paper issuance over electronic if that is what is preferred. Regardless of whether a paper or electronic version is issued and regardless of whether the signature is digitally captured or manually penned, the beneficiary must be given a paper copy of the NOMNC, with the required beneficiary-specific information inserted, at the time of electronic notice delivery.

**Notice Delivery to Representatives**

CMS requires that notification of changes in coverage for an institutionalized beneficiary/enrollee who is not competent be made to a representative. Notification to the representative may be problematic because that person may not be available in person to acknowledge receipt of the required notification. Providers are required to develop procedures to use when the beneficiary/enrollee is incapable or incompetent, and the provider cannot obtain the signature of the enrollee’s representative through direct personal contact. If the provider is personally unable to deliver a NOMNC to a person acting on behalf of an enrollee, then the provider should telephone the representative to advise him or her when the enrollee’s services are no longer covered.

The date of the conversation is the date of the receipt of the notice. Confirm the telephone contact by written notice mailed on that same date. When direct phone contact cannot be made, send the notice to the representative by certified mail, return receipt requested. The date that someone at the representative’s address signs (or refuses to sign) the receipt is the date of receipt. Place a dated copy of the notice in the enrollee’s medical file. When notices are returned by the post office with no indication of a refusal date, then the enrollee’s liability starts on the second working day after the provider’s mailing date.

**Exceptions**

The following service terminations, reductions, or changes in care are not eligible for an expedited review. Providers should not deliver a NOMNC in these instances.

- When beneficiaries never received Medicare covered care in one of the covered settings (e.g., an admission to a SNF will not be covered due to the lack of a qualifying hospital stay or a face-to-face visit was not conducted for the initial episode of home health care).
- When services are being reduced (e.g., an HHA providing physical therapy and occupational therapy discontinues the occupational therapy).
- When beneficiaries are moving to a higher level of care (e.g., home health care ends because a beneficiary is admitted to a SNF).
• When beneficiaries exhaust their benefits (e.g., a beneficiary reaches 100 days of coverage in a SNF, thus exhausting their Medicare Part A SNF benefit).

• When beneficiaries end care on their own initiative (e.g., a beneficiary decides to revoke the hospice benefit and return to standard Medicare coverage).

• When a beneficiary transfers to another provider at the same level of care (e.g., a beneficiary transfers from one SNF to another while remaining in a Medicare-covered SNF stay).

• When a provider discontinues care for business reasons (e.g., an HHA refuses to continue care at a home with a dangerous animal or because the beneficiary was receiving physical therapy and the provider’s physical therapist leaves the HHA for another job).

**Plans Only:**

If a member requests coverage in the above situations, the plan must issue the CMS form 10003 - Notice of Denial of Medical Coverage.

**Alterations to the NOMNC**

The NOMNC must remain two pages. The notice can be two sides of one page or one side of two separate pages, but **must not** be condensed to one page.

Providers may include their business logo and contact information on the top of the NOMNC. Text may not be moved from page 1 to page 2 to accommodate large logos, address headers, etc.

Providers may include information in the optional “Additional Information” section relevant to the beneficiary’s situation.

**Note:** Including information normally included in the Detailed Explanation of Non-Coverage (DENC) in the “Additional Information” section does not satisfy the responsibility to deliver the DENC, if otherwise required.
**Contact information:** The name, address and telephone number of the provider that delivers the notice must appear above the title of the form. The provider’s registered logo may be used.

**Member number:** Providers may fill in the beneficiary’s/enrollee’s unique medical record or other identification number. The beneficiary’s/enrollee’s HIC number must not be used.

**THE EFFECTIVE DATE YOUR {INSERT TYPE} SERVICES WILL END:** {Insert Effective Date}: Fill in the type of services ending, {home health, skilled nursing, comprehensive outpatient rehabilitation services, or hospice} and the actual date the service will end. Note that the date should be in no less than 12-point type. If handwritten, notice entries must be at least as large as 12-point type and legible.

**YOUR RIGHT TO APPEAL THIS DECISION**

- Bullet # 1 not applicable
- Bullet # 2 not applicable
- Bullet # 3 not applicable
- Bullet # 4 not applicable
- Bullet # 5 not applicable

**HOW TO ASK FOR AN IMMEDIATE APPEAL**

- Bullet # 1 not applicable
- Bullet # 2 not applicable
- Bullet # 3 not applicable
- Bullet # 4 Insert the name and telephone numbers (including TTY) of the applicable QIO in no less than 12-point type.

**Signature page:**

**Plan contact information (Plans only):** The plan’s name and contact information must be displayed here for the enrollee’s use in case an expedited appeal is requested or in the event the enrollee or QIO seeks the plan’s identification.

**Optional: Additional information.** This section provides space for additional pertinent information that may be useful to the enrollee. It may not be used as a
Detailed Explanation of Non-Coverage, even if facts pertinent to the termination decision are provided.

**Signature line:** The beneficiary/enrollee or the representative must sign this line.

**Date:** The beneficiary/enrollee or the representative must fill in the date that he or she signs the document. If the document is delivered, but the enrollee or the representative refuses to sign on the delivery date, then annotate the case file to indicate the date that the form was delivered.
write to: CMS, 7500 Security Boulevard, Attention: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Notice of Medicare Non-Coverage

Patient name:          Patient number:

The Effective Date Coverage of Your Current {insert type} Services Will End: {insert effective date}

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current {insert type} services after the effective date indicated above.
- You may have to pay for any services you receive after the above date.

Your Right to Appeal This Decision

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above;
  o Neither Medicare nor your plan will pay for these services after that date.
- If you stop services no later than the effective date indicated above, you will avoid financial liability.

How to Ask For an Immediate Appeal

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- Call your QIO at: {insert QIO name and toll-free number of QIO} to appeal, or if you have questions.

See page 2 of this notice for more information.
If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:

• If you haveOriginal Medicare: Call the QIO listed on page 1.

• If you belong to a Medicare health plan: Call your plan at the number given below.

Plan contact information

Additional Information (Optional):

Please sign below to indicate you received and understood this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

Signature of Patient or Representative             Date
Form Instructions for the Detailed Explanation of Non-Coverage (DENC) CMS-10124

A Medicare provider or health plan (Medicare Advantage plans and cost plans, collectively referred to as “plans”) must deliver a completed copy of this notice to beneficiaries/enrollees receiving covered skilled nursing, home health, comprehensive outpatient rehabilitation facility, and hospice services upon notice from the Quality Improvement Organization (QIO) that the beneficiary/enrollee has appealed the termination of services in these settings. The DENC must be provided no later than close of business of the day of the QIO’s notification.

Alterations to the DENC

Providers may include their business logo and contact information on the top of the DENC. Text may not be moved to a second page to accommodate large logos, address headers, etc.

Heading

Insert contact information here: The name, address and telephone number of the provider or plan that delivers the notice must appear above the title of the form. The entity’s registered logo is not required, but may be used.

Date: Fill in the date the notice is generated by the provider or plan.

Patient Name: Fill in the beneficiary’s/enrollee’s first and last name.

Member number: Fill in the beneficiary’s/enrollee’s medical record or identification number. The beneficiary’s/enrollee’s HIC number must not be used.

{Insert type}: Insert the kind of service being terminated, i.e., skilled nursing, home health, comprehensive outpatient rehabilitation service, or hospice.

Bullet # 1 The facts used to make this decision: Fill in the patient specific information that describes the current functioning and progress of the beneficiary/enrollee with respect to the services being provided. Use full sentences, in plain English.

Bullet # 2 The detailed explanation of why the services are no longer covered. Fill in the detailed and specific reasons why services are either no longer reasonable or necessary for the beneficiary/enrollee or are no longer covered according to the
Medicare guidelines. Describe how the beneficiary/enrollee does not meet these guidelines.

**Bullet # 3** (Plans only) The plan policy, provision, or rationale used in the decision if the notice is delivered to a health plan enrollee: Fill in the reasons services are no longer covered according to the plan’s policy guidelines, if applicable. Describe how the enrollee does not meet these guidelines. If the plan relied exclusively on Medicare coverage guidelines, please explain that here.

**If you would like a copy of the policy:** If the plan has not provided the Medicare guidelines or policy used to decide the termination date, inform the beneficiary/enrollee how and where to obtain the policy. Provide a telephone number for beneficiaries/enrollees to get a copy of the relevant documents sent to the QIO.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938–xxxx. The time required to complete this information collection is estimated to average 1.25 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attention: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Detailed Explanation of Non-coverage

Date:

Patient name: Patient number:

This notice gives a detailed explanation of why your Medicare provider and/or health plan has determined Medicare coverage for your current services should end. **This notice is not the decision on your appeal.** The decision on your appeal will come from your Quality Improvement Organization (QIO).

**We have reviewed your case and decided that Medicare coverage of your current {insert type} services should end.**

• The facts used to make this decision:

• Detailed explanation of why your current services are no longer covered, and the specific Medicare coverage rules and policy used to make this decision:

• Plan policy, provision, or rationale used in making the decision (health plans only):

If you would like a copy of the policy or coverage guidelines used to make this decision, or a copy of the documents sent to the QIO, please call us at: {insert provider/plan toll-free telephone number}