MEDICARE ADVANTAGE AND NON-COVERED SERVICES: IT'S NOT WHAT YOU THINK!

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INTRODUCTION - KIM

• New to ophthalmology 01/06/14
  – Attended ASOA – Boston April 2014
• You don’t know what you don’t know
  – Get help!
• How we implemented what I didn’t understand at first
• No financial disclosures

INTRODUCTION - PAUL

• Many years in Eye Care
• Tech, Coder, Admin/Operations, Auditor
• Disclosure: I have a financial interest. I am a Senior Consultant for Corcoran Consulting Group

FINANCIAL DISCLOSURES

Paul Larson is a Senior Consultant with Corcoran Consulting Group. He acknowledges a financial interest in the subject matter of this presentation.

KIM: MY LIGHTBULB MOMENT

• Pre-service determinations (aka pre-donals)
  – What are these?
  – Will this impact business?
  – Should we have been doing this all along?
  – What do we do NOW?
• No standard between advantage plans
  – Each payer had it’s own form
  – HINT: Advantage plans are like a 3 year olds

HOW DID WE GET HERE?

• Found a letter to UHC … but in reality to ALL Part C plans¹:
  – DATE: May 5, 2014
  – TO: Medicare Advantage Organizations, Medicare Health Care Prepayment Plans, and Medicare Cost Plans
  – SUBJECT: Improper Use of Advance Notices of Non-coverage
    “...The Medicare Enrollment & Appeals Group (MEAG) and Medicare Drug & Health Plan Contract Administration Group (MCAG) have received reports of Medicare Advantage organizations (MAOs) issuing notices to enrollees that advise of non-coverage for an item or service that do not comply with the requirements for such notices…”
HOW DID WE GET HERE?

- “... The notices being used... appear to be based on, and similar in purpose and content to, the advanced beneficiary notice of noncoverage (ABN) ... Such notices are not applicable to the Medicare Advantage program, and are not appropriate for use by an MAO with respect to its enrollees. MAOs sending such notices should immediately cease this practice and instead follow the process for issuing a notice of a denial of coverage ...”
  
  (Big "OUCH" for the MA Plans ...)


HOW DID WE GET HERE?

- “... By their own terms, the ABN requirements in the statute and regulations do not apply in the Medicare Advantage context. This is because a Medicare Advantage enrollee has always had the right under the statute and regulations to an advance determination of whether services are covered prior to receiving such services ...”
  
  • NOW it affects your office ...


HOW DID WE GET HERE?

- “... services and referrals a contracted provider gives are considered plan-approved unless "notice is provided to the enrollee that the services will not be covered." MAOs appear to be misinterpreting this statement to mean that providing an advance notice to an enrollee that an item or service is non-covered (i.e., providing a notice outside of the organization determination process) is a permissible means of holding the enrollee financially responsible ...”

  • What do you think now? Need more information ...


HOW DID WE GET HERE?

- “... MAOs are prohibited from circumventing the organization determination process. The use of non-compliant advance notices of non-coverage by MAOs diminishes the enrollee protections that are part of the organization determination process ...”

  • “... In circumstances where there is a question whether or not the plan will cover an item or service, the enrollee has the right to request an organization determination ...”

  - So ... do you really want beneficiaries asking?
  - Or should your office do it?

  • Still need more information ...


HOW DID WE GET HERE?

- “... Unless a plan notifies an enrollee that an item or service will not be covered by issuing standardized denial notice CMS-10003, the MAO has not complied ...”

  • “... the failure to provide a compliant denial to the enrollee means that the enrollee is not liable for services provided by a contracted provider or upon referral from a contracted provider ...”

  • WOW.
  • Back to Kim!


MEDICARE FACTS

- Network Health Plan (local insurance provider) sent us the CMS memo about the Improper Use of Advanced Notices of Non-Coverage
  
  - Pre-service determinations defined

- We understood that Medicare Part A or Part B doesn't ALLOW prior authorizations – this is what you use an ABN for
  
  - How do you manage this with OTHER payers?
**Was This Real?**

- Called other Administrators – Variety of responses
  - Some were doing nothing “nothing will happen”
  - Some were submitting everything and complaining about the staffing they would need, the time constraints etc.
  - Some people were submitting non-billable codes (S codes) which would automatically get kicked out of a lot of payers systems.
  - We realized this was more serious and couldn’t afford to risk a new service line (FS and Premium) that was supposed to be profitable.
    - More research ...

- More research ...
  - We could absolutely be asked to return $$ to pts & payers
  - We targeted our biggest MA payers and tried to figure out how to work with them.
    - They had the same issues we did.
    - They didn’t want to do this anymore than we did.
  - 2 week lead time required for some procedures??
  - Approached our MA plan Provider Relation managers

- Right away - some easy fixes
  - First we needed to come up with our description of the service we were looking to get denied.
    - This needs to be clear and be descriptive about the service and use language that your payer sees as noncovered
  - Network Health sent us a document regarding non-coverage for keratotomy.
    - They said that we should stop submitting charges for Femto (LRIs) as a non-covered service using 66999 because they don’t cover it, won’t cover it and their system is not smart enough to recognize it.
    - GREAT!

- Right away - some problems - UHC
  - No blanket statements of noncoverage
  - Submit for LRIs with 66999 but they approve it (sigh) and won’t give blanket “exemptions”
    - We call – “UHC admits they don’t pay for that”
    - Document the conversations (each and every time)
    - If we do submit, they pay v/small amounts
    - We send back and they accept, which is usually the end
    - Their reps change all the time, so it’s hard
    - UHC just turned this over to WellMed when it’s AARP

**Guidelines**

"The Code is More Like "Guidelines" Rather Than Actual Rules"

Pirates of the Caribbean “Curse of the Black Pearl” 2003

**Medicare Advantage & Toddlers**

- Learning that MA plans don’t like to play with other (MA plans) … sigh
- The “3 year old” analogy:
  - They don’t communicate well
  - They are very temperamental
  - They won’t share
  - Every one responds differently – even to the same question!
**PROBLEMS / CONCERNS / HEADACHES**
- How much work is this going to create?
- Will this change what services we offer?
- How we schedule?
  - Do we really need to schedule 2 weeks out?
- Staffing requirements?
  - Can my current staff handle this potential workload addition?
- What else don’t I know?
- Compliance issues

**WORK LOAD**
- How much work is this going to create?
  - Who will do this?
  - Billing
  - Surgery Scheduler
- What services *really* need this?
  - Are we doing this just for big ticket items?
  - Does the MA plan have an “out” for some services?
  - How much time will it take?
  - Is this going to be like Prior Auths?
  - Track the time, adjust as needed

**SERVICES**
- What needs a pre-determination?
  - Medicare won’t allow a pre-authorization
  - Do MA plans pre-auth?
    - If yes, do that ... for *covered portions*
    - But ... Is a pre-authorization the same as a pre-determination?

**SERVICES**
- Out of Pocket
  - What services will patients truly pay for?
    - Extended refraction
    - Minor surgeries
    - Advanced IOLs
  - Femto...Should we?
    - Will this impact the $$ we think we’re going to make on Femto?

**OPHTHALMOLOGY PATIENT ISSUES**
- Large senior population
  - Patients want it all done in one visit
    - This is fine for Medicare, but not for MA plans
  - May make decisions based on money
    - Patient may decline a service even though it is the best option for their health if more money is involved.
    - Doctor’s decide to ‘give away’ services

**OPHTHALMOLOGY PATIENT ISSUES**
- Large senior population
  - Explanations take forever
    - Trying to help a patient understand what they are financially responsible is painful
    - WHO does these explanations matters!
      - Right temperament, etc
      - Have same person take the follow-up questions!
**FS LASER & PREMIUM IOL ... ANY MA ISSUES?**

- What happens when a payer refuses to comply with Medicare Guidelines and (mistakenly) agrees to COVER the FS laser and/or Premium IOL?
  - UHC
  - Re-work & staff time
    - Patients think you told them the wrong thing!
    - More staff time to explain...
  - Be aware some payers might actually cover
- Can you get a payer to give you a universal denial? (YAY!!)
  - Network Health in Wisconsin

**FS LASER & PREMIUM IOL ... ANY MA ISSUES?**

- What happens when the payer pays in error?
  - Find out if payer paid in error – or do they (sigh) cover it and you had no idea?
  - If actually covered, refund this money to patient
  - Keep track of this payer … this is unusual
  - If they paid by mistake:
    - Attach Medicare explanation of Non-Covered Service
    - Talk to your provider rep
    - Include specific description of service and why it is a non-covered service (specifically refractive and 2nd surgery)
  - SAMPLE INDICATION for payer
  - SAMPLE OP NOTE ADDENDUM for payer

**FS LASER - INDICATION**

**Femtosecond Incisional Laser Refractive Surgery for Corneal Astigmatism**

During the evaluation for cataract surgery, the patient was noted to have regular corneal astigmatism that was unrelated to any prior eye surgery. More extensive refractive testing was performed which confirmed that the amount and type of astigmatism can be fully or partially corrected with the femtosecond (FS) laser performing arcuate keratotomy incisions. The patient wants to see well without correction and the regular astigmatism would otherwise prevent that from being possible – even with cataract surgery. The indication for this FS laser corneal surgery with arcuate keratotomy incisions can be regarded as both cosmetic and refractive since it aims to improve vision without correction (no or minimal glasses correction) as well as correct the residual astigmatic refractive error not otherwise correctable with cataract surgery and standard intraocular lens implantation planned for this eye...

**FS LASER – "SAMPLE” OP NOTE**

**Femtosecond Incisional Laser Refractive Surgery for Corneal Astigmatism**

... In this refractive surgical procedure for astigmatism (which is performed immediately prior to the cataract surgery), the patient’s affected eye is identified and centered under the FS laser. The eye is prepped and draped, and then the laser images the eye. The surgical plan is confirmed and the laser-software is programmed to correct the appropriate location and amount of the regular corneal astigmatism. The FS laser is then turned on and the regular astigmatism correction placed within the cornea. The FS laser is then uncoupled and the process for cataract extraction is begun separately.

**SCHEDULING / STAFFING**

- When we first learned about “pre-determinations”, we freaked out like so many other offices we asked….how do we do this? Who has this much time? How much is this costing us? On and on the questions went.
- Different reactions from different areas
  - Techs, Surgeons, Billing, etc.
- In the end:
  - Turns out, if you take a deep breath and really talk it out, you realize your existing staff can handle this. Just figure out the process that work for you. Decide how to divide up the work.

**PAYER RESPONSES - KIM**

- Payers generally say they will respond to you in “14 days”
  - Many respond right away (while on the phone/next day)
  - Nobody with an MA plan gets on the surgery schedule unless their case will have NO noncovered services
**PAYER RESPONSES - PAUL**

- How should you respond when the payer makes the mistake?
  - Call Provider Services at the plan
    - You might not succeed with the first person on the phone, so “move up the chain”. If still blocked, write a letter.
    - Call the patient. Be proactive and tell them that the insurance paid for something they shouldn’t have and you’ll be back in touch.

- If you have to write one, what should the letter say?
  - Reference the claim number, pt name, DOB, service date, code(s) – patient & service specific information
  - If they have a policy:
    - Reference that you followed their rules
    - Reference the effective date of the policy and match that to your claim date
    - Include their policy in your response
  - Discuss that you knew it was noncovered, should have been denied by them
    - “We are refunding your improper payment”, “We are not entitled to it under the terms of our participation agreement”, etc.

**SOLUTIONS**

- What process works?
  - Every office is unique in what workflow makes sense
  - Ownership (internally) is key

- How do we get paid?
  - Talk to your payers. Be specific and try to get something in writing.
    - Some payers will only confirm on the phone that these services aren’t covered and won’t give you something formal.
    - Some payers want you to call vs. online submission and will verbally give you a “decline” (to cover) with a reference number.
  - Many MA systems seem to be set up to automatically pay (not deny) non-covered service codes
    - Completely counter-intuitive to the notion of “non-covered service”

- There are OTHER noncovered services you should think about too!
  - We have a demographic that benefits from IPL (Intense Pulsed Laser) for dry eye
  - Follow the same process!
  - In the end, making payers agree that the services you want to provide are noncovered is the goal.

- Refractions – also important
  - The answer here isn’t so simple – there might be coverage
  - MA plans often have a vision benefit
  - Staff needs to know at phone and check-in, but also techs/Drs

- Patient issues:
  - If the patient calls their payer and doesn’t understand –
    - We give them our Network Health document (blacked out) so they know we’re right about noncoverage … at least some of the time
    - Patients generally accept this since it is from a payer

- Who gets the calls now?
  - Used to be billing
  - Surgery Schedulers now – and NO STAFFING INCREASE!
  - We allow for lead time so that we can get the answer BEFORE surgery

- It took about two months

**SOLUTIONS**

- Most valuable pieces of advice we can give?
  1) Identify the individual at the MA plan who CAN address your concern
  2) Keep the lines of communication open
  3) Develop a personal relationship with this person at the MA plan
    - What does your MA contact need from you? Ask!
**SOLUTIONS**

- Most valuable pieces of advice we can give?
  4) When plans mistakenly approve, work the "approval" to get the plan to agree this service is noncovered
  - Patients naturally think approval means they won’t have to pay (YOU made the mistake …)
  - Be sure pts understand you aren’t entitled to MA payment for everything …
  5) Follow the MA plan’s instructions
  - Forms and process

**THANK YOU**

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