

MEDICARE SUBVENTION DEMONSTRATION PROJECT (THE TRICARE SENIOR PRIME PROGRAM)

1.0. PURPOSE

1.1. The Department of Defense (DoD) has entered into an agreement with the *Center for Medicare and Medicaid Services (CMS)* for a three-year demonstration project to run from January 1, 1998 through December 31, 2000, under which Medicare will reimburse DoD for care provided to Medicare-eligible beneficiaries of the Military Health System (MHS). The TRICARE Senior Prime program has been extended through December 31, 2001 as provided by the Fiscal Year 2001 National Defense Authorization Act (Public Law No.: 106-398). As part of this agreement, selected Military Treatment Facilities (MTFs) with support from the Managed Care Support (MCS) Contractor, integrated by their Lead Agent, will operate as Medicare+Choice Organizations (M+C Organizations), offering enrollment into TRICARE Prime to dually-eligible beneficiaries (beneficiaries who are eligible for care in the MTF and who are also eligible for Medicare). TRICARE Prime for dually-eligible beneficiaries shall be known as the TRICARE Senior Prime option. The goal of this demonstration is to test a cost-effective alternative for delivering accessible and quality care to dually-eligible beneficiaries that would not increase the total federal cost for either agency. The contractor shall perform all of the requirements for Medicare+Choice as identified in the Balanced Budget Act of 1997. The sites selected for this demonstration are identified in [Figure 23-5-1](#), with the key dates in [Figure 23-5-2](#).

1.2. Enrollees will select a primary care manager (PCM) in the participating MTF. The MTFs will rely on the Managed Care Support Contractor for support in the following areas (as further defined in this modification):

- Health Care Finder (referral for services not available in the MTF),
- Health Care Services (specialty and Medicare covered services not available in the MTF),
- Eligibility and Enrollment,
- Utilization Management (to include case management and discharge planning),
- Claims Processing,
- Reporting Requirements,
- Marketing,
- Beneficiary Services, and
- Medical Peer Review.

1.3. The contractor shall also support the MTF in becoming qualified as an M+C Organization and in preparing for and participating in the *CMS* qualification site visit. At a minimum, the contractor shall perform at least two site visits with each participating MTF (one prior to the *CMS* qualification site visit and one during the *CMS* qualification site visit) wherein the contractor provides expert advice and assistance in Medicare managed care qualifications and operations. Assistance shall include up to 1,000 hours of consultation for

each site, as needed, except for the combined site in Region 6, which shall be up to 2,000 hours of consultation shared by participating Region 6 MTFs. Consultative services shall commence not later than 30 calendar days after the effective date of this contract modification.

2.0. INTERFACE WITH LEAD AGENT/MTF

The contractor shall meet with the Lead Agent and MTF to modify the existing memorandum of understanding (MOU) with the Lead Agent/MTF as appropriate to facilitate the requirements of this section. The MOU shall be executed two weeks prior to the qualification site visit. The contractor, Lead Agents, and MTFs shall use this vehicle to reach agreement adding specificity to requirements for marketing, provider training, utilization management reporting, and other such support as provided for in this section. The contractor shall submit the modification to the MOU in its proposal responding to the requirements in this section. The contractor, in concert with the Lead Agent, shall develop all letters and notices that are required to be sent to applicants, enrollees, and providers.

NOTE: Usual MOU procedures will apply for requirements contained in the contract. Tasks/requirements outside the provisions of the contract will be ordered by the Contracting Officer through issuance of a contract modification.

3.0. MARKETING

3.1. The contractor shall begin marketing activities two months prior to the start of health care delivery. However, the contractor shall issue public announcements of the advent of the TRICARE Senior Prime option at least 15 days prior to the beginning of marketing to include flyers and local installation newspaper articles, to ensure beneficiaries have knowledge of the program and the scheduled educational meetings. Public announcements shall include, at a minimum, publication in local newspapers to cover the entire catchment area and shall be of sufficient presence to attract the attention of potential enrollees. In addition to any other proposed marketing program, the contractor shall advertise at a minimum, a prominent, strategically placed ad in the local newspapers on the Sunday prior to the start of marketing. The specific times, frequency, size, and locations shall be included in the MOU. Using the layouts provided by TMA for the newspaper ads, the contractor shall add local information regarding times, dates, and locations of educational meetings.

3.2. The enrollment form and marketing materials will be developed and printed centrally by DoD and will include: TRICARE Senior Prime posters, informational brochure, the enrollment form, the TRICARE Senior Prime Coverage agreement, and the design for the cover of the network provider directory. The point of contact for replenishing, correcting, and updating these marketing materials is the DoD TMA, Office of Communications and Customer Service. The contractor shall incorporate site-specific information into the generic materials provided. The contractor shall reproduce and mail out all documents associated with the TRICARE Senior Prime Program. This includes any requested and required TSP materials that the Lead Agent forwards to the contractor to ensure compliance with all TMA/*CMS* requirements. Using the cover design provided, the contractor shall develop, print, and provide to each enrollee (and others upon request) a TRICARE Senior Prime Network Provider Directory that identifies all MTF and civilian network providers to whom an enrollee may be referred, including any provider added to the network specifically to support this demonstration, e.g., home health care agencies, skilled nursing facilities, etc. The

contractor shall update the provider directory in accordance with current contract requirements. The contractor shall also provide to TRICARE Senior Prime enrollees all brochures and information available to other TRICARE Prime enrollees on the National Mail Order Pharmacy Benefit. Any other marketing materials that the sites wish to disseminate to beneficiaries shall be submitted to TMA, Special Programs and Demonstrations, for prior approval. Subsequent to initial marketing, approval of site-specific marketing materials shall be forwarded to the Lead Agent for coordination and approval by the Regional **CMS** Office.

3.3. The contractor shall be responsible for the proposal and development of flyers to announce educational meetings including the number of flyers and how they will be distributed. Flyers shall be prepared and submitted to the Lead Agent for approval no later than 45 days prior to the start of marketing. The flyers will be approved and returned to the contractor for printing and distribution no later than 30 days prior to the start of marketing. No later than 15 days prior to marketing, the contractor shall display the flyers and posters in prominent places announcing the advent of marketing.

3.4. The contractor shall support educational meetings starting two months prior to the start of health care delivery and continuing, as needed, through the enrollment period in each demonstration site to fully explain the demonstration, including information about limited enrollment capacity, program benefits, the impact of enrollment on an applicant's eligibility for other Medicare-covered services, "lock-in," implications of dropping Medicare supplemental insurance, and other MHS health care services. Educational meetings shall be concentrated during the first two weeks of the marketing period. The contractor shall propose the number of meetings to be held at each site, considering the number of Medicare-eligible beneficiaries in the area and the enrollment capacity of the MTF. The educational meetings shall be held on the military installations participating in the demonstration program, or at off-site locations mutually agreed upon by the contractor, Lead Agent, and the MTF Commander. In the event that capacity is reached prior to the end of the open enrollment period, the contractor shall widely publicize that capacity has been reached and that applications are no longer being accepted.

3.5. The contractor shall not release enrollment applications until the first day of marketing (two months prior to the start of health care delivery).

3.6. The contractor shall ensure that TSP is included in all on-going marketing requirements under the current contract. The contractor shall propose TSP marketing efforts on an annual basis commensurate with their current contract, and working with the Lead Agent office, will determine which TSP efforts will be implemented during the option period.

4.0. **ELIGIBILITY/ENROLLMENT**

4.1. **Eligibility**

4.1.1. A beneficiary must meet all of the following eligibility requirements. An eligible beneficiary:

- is Medicare eligible, or will be Medicare eligible on the basis of age, on or before the effective date of enrollment (see also [paragraph 4.3.](#) for instructions regarding "aging-in"),

- is eligible for care in the Military Health System,
- is entitled to Medicare Part A,
- is enrolled in Medicare Part B,
- lives within the MTF catchment area, and
- has received services as a dual eligible prior to July 1, 1997, or became eligible for Medicare, Part A on or after July 1, 1997.

EXCEPTION: A beneficiary who has been diagnosed with end stage renal disease (ESRD) or receives routine dialysis treatment, or has received a kidney transplant within the last 36 months, is not eligible to enroll, except as provided under [paragraph 4.3](#). (aging-in). A beneficiary with a diagnosis of ESRD and/or who lives outside the service area of the demonstration site may age in. (A beneficiary who is diagnosed with ESRD while enrolled is eligible to remain in TRICARE Senior Prime.)

4.1.2. The demonstration area is defined as the zip codes that are a part of the official CAD directory. Beneficiaries living outside of the catchment areas are not eligible to enroll, except for those beneficiaries who are eligible to “age-in” to the demonstration as defined in [paragraph 4.3](#). (Beneficiaries shall not be disenrolled if the Postal Service changes their zip code which places them outside of the catchment area.)

4.1.3. Under this demonstration, enrollees are not subject to an enrollment fee, but shall be subject to cost-shares in accordance with the attached matrix of benefits, which conform with the TRICARE Prime benefit package with several exceptions (e.g., skilled nursing facility (SNF) care, respite care). There is no catastrophic cap or deductible collected or credited for care received under this demonstration. Point of Service does not apply; Portability does not apply.

4.2. Enrollment Process

4.2.1. The contractor shall provide a written enrollment plan to the Lead Agent (with a copy to the COR) for approval not later than 45 days prior to the start of enrollment. Feedback will be provided no later than 15 days following submission of the plan. The contractor shall establish an enrollment process that provides a fair and equitable opportunity for beneficiaries to obtain information about the TRICARE Senior Prime option and provides an opportunity for them to submit applications. This process shall include the following activities at a minimum:

4.2.1.1. The contractor shall distribute enrollment packages at sites convenient to eligible beneficiaries, including at the educational meetings, the TRICARE Service Center, the MTF, and other sites as agreed upon by the contractor and MTF Commander/Lead Agent, no earlier than the first day of marketing. The contractor shall also mail enrollment packages to beneficiaries who request them by telephone.

4.2.1.2. The contractor shall provide telephone lines and adequate numbers of trained staff at the TRICARE Service Center to review applications, provide assistance completing applications, provide applications by mail, if requested, schedule appointments and conduct face-to-face interviews, if requested by the beneficiary. The contractor shall meet all established contract requirements and performance standards for the TRICARE Service Center and telephone service unit.

4.2.1.3. The contractor shall provide in the enrollment application package a preaddressed return envelope with the contractor's address. The envelope must have imprinted on the outside in large lettering, "must NOT be postmarked prior to (date to be determined by TMA)" to ensure that applicants clearly see that it should not be mailed early.

4.2.2. The contractor shall conduct an open enrollment season for at least 30 days, beginning in 1999 the minimum enrollment period is the month of November. A 30 day open enrollment season in subsequent years shall be conducted by a subsequent contract modification upon direction from the Lead Agent, based on enrollment capacity at participating sites. However, enrollment status of the Medicare enrollee in TRICARE Senior Prime shall be continuous, with an indefinite end date entered into DEERS. (See [Figure 23-5-4](#)).

4.2.3. Enrollment applications shall be accepted by mail only. The contractor shall date stamp all applications with the date of receipt. Application envelopes postmarked earlier than the start of the open enrollment period (15 days after the start of marketing) shall be returned to the applicant with an appropriate letter of explanation. The contractor shall retain a copy of the application and the postmarked envelope for one year from date of receipt. Applications are for individual enrollment only and shall be processed on a first come, first served basis. However, in households with more than one eligible beneficiary, the applications may be submitted in one envelope and shall be processed together. If both applicants are eligible and there is space for one of the applicants, both shall be enrolled.

4.2.4. The MPC on behalf of the contractor shall, on a daily basis, compile a list of applications processed that day. In order of receipt, the contractor shall verify all information in a face-to-face interview or by telephone contact (Medicare HMO/CMP Manual, 2001.5).

4.2.4.1. The contractor shall make at least two attempts to make telephone contact within the first ten working days after receipt of an application. These attempts will be documented on the MPC system. In the event that telephone contact is not achieved, the contractor shall, within 12 working days of receipt of an application, send a letter requesting that the applicant call to verify information on the enrollment form, allowing three mail days, which would not include Sundays or holidays, but would include Saturday. The letter shall clearly inform the applicant that failure to respond within 30 calendar days will render their application incomplete. This letter will be automatically generated by the MPC system. If the applicant does not respond within 45 calendar days to the automated letter generated by the MPC, the MPC system will automatically render the application incomplete. Forty-five calendar days allows the applicant 30 days to respond and an additional 15 days for the information to be received and processed by the M+CO in accordance with **CMS** OPL 99.100. Once the application is rendered incomplete, the MPC will generate a denial of enrollment letter to the applicant highlighting the appropriate reason for the enrollment denial.

4.2.4.2. Documentation of telephone contact or attempts to contact an applicant shall comply with current contract requirements. The purpose of the telephonic contact is to review the application with the potential enrollee, obtain additional information as necessary to complete the application, determine the applicant's understanding of the program, and educate and inform the applicant as necessary, especially on the lock-in requirements of the TSP program. If requested, an appointment for a face-to-face interview shall be scheduled within a reasonable time to permit the applicant to make a final decision regarding enrollment.

NOTE: Persons who assist beneficiaries in completing forms must sign the form and indicate their relationship to the beneficiary.

4.2.4.3. The contractor shall provide each applicant with a copy of his/her completed, signed, and dated application (Medicare HMO/CMP Manual 2001.6).

4.2.5. The contractor shall verify eligibility as defined in Eligibility/Enrollment (see [paragraph 4.0.](#) of this section), to include those applicants who will be placed on the waiting list, via:

4.2.5.1. An inquiry of the Defense Enrollment Eligibility Reporting System (DEERS) through the Medicare Processing Center as defined in [paragraph 6.0.](#), Interface with **CMS**, to verify eligibility for the MHS, the applicant's age, address, and zip code.

4.2.5.2. Self-declaration on the enrollment form of use of the MTF as a dual-eligible.

4.2.6. An application may be pended for further clarification. Reasons for pending include:

4.2.6.1. The contractor's inability to reach an applicant by telephone as required under [paragraph 4.2.4.](#) above, and

4.2.6.2. A discrepancy between DEERS and an applicant's assertion that he/she is eligible for care in the MHS. In this case, the applicant shall be given an opportunity to correct DEERS.

4.2.7. If the contractor discovers a discrepancy between an applicant's current, verified address on the enrollment form and **CMS**, the contractor shall inform the applicant that the address should be corrected. If there is a discrepancy between the current address and the DEERS address, the contractor shall correct the DEERS address when entering the enrollment in DEERS.

4.2.8. DMDC shall produce the Universal TRICARE Beneficiary Cards.

4.2.9. The contractor shall provide the enrollee with written confirmation of the enrollment effective date, an enrollment card, and applicable enrollment materials as discussed in [paragraph 3.0.](#) and [10.7.](#) Refer to [paragraph 6.0.](#), below, for instructions on enrollment confirmation with **CMS** and procedures for establishing enrollment dates. All enrollment materials shall be mailed to the beneficiary within two working days of notification from **CMS** of their enrollment effective date.

4.2.10. Annual open enrollment periods may be exercised at the option of the Government by subsequent modification. The contractor shall consult with the MTF/Lead Agent 90 days prior to the end of each enrollment year regarding the necessity for an open enrollment period.

4.2.11. Upon reaching enrollment capacity, the MPC will establish a wait list of eligible applicants at the level reflected in [Figure 23-5-1.](#) The MPC will notify the contractor as part of the monthly reporting requirement regarding available spaces. When space is available, the

contractor shall offer applicants on the wait list an opportunity to enroll and shall verify all information on the original enrollment form to ensure its continuing accuracy.

4.2.12. Once capacity is reached, the contractor shall notify all unsuccessful applicants using the appropriate letter developed for that purpose.

4.3. Aging In

4.3.1. During initial open enrollment, any TRICARE Prime enrollee with a PCM at a participating MTF who becomes Medicare eligible on the basis of age, on or after the date health care delivery begins, and who resides within the approved geographic service area covered by the TSP program, shall be offered enrollment on an “aging-in” basis.

NOTE: The residence requirement does not apply to individuals who aged in to TSP prior to January 1, 2001. However, if these individuals move from their current residence, they must move within the TRICARE Senior Prime services area to maintain their enrollment in TRICARE Senior Prime.

4.3.2. Notwithstanding capacity limits, enrollees in TRICARE Prime who are assigned to a primary care manager at a participating MTF, attain age 65, meet other eligibility requirements and, desire to enroll in TRICARE Senior Prime shall be enrolled. TRICARE Prime enrollees who: are assigned to a primary care manager at a participating MTF and meet all eligibility requirements except ESRD and desire to enroll in TRICARE Senior Prime, shall be enrolled during their initial coverage election period as defined by 42 CFR 422.62 and further specified in other **CMS** regulations and policy.

4.3.3. The MTF shall provide information to the contractor on Primary Care Managers with panel openings for selection by the enrollee. As detailed in [paragraph 6.0.](#), the MPC will track TRICARE Prime enrollees, and 150 days prior to the TRICARE Prime enrollee becoming Medicare eligible on the basis of age, will notify the contractor. Medicare eligibility is the first day of the month in which the beneficiary turns 65. If the beneficiary’s birthdate is the first day of the month, eligibility is the first day of the month preceding the birth month. The contractor shall, 120 days prior to the enrollee becoming Medicare eligible on the basis of age, provide information to the enrollee regarding TRICARE Senior Prime and their opportunity to enroll. The beneficiary must return the application to enroll into TRICARE Senior Prime to the contractor no later than 60 days prior to his/her becoming Medicare eligible on the basis of age. If the beneficiary fails to meet the 60 day deadline submission the contractor will attempt to process the beneficiary’s application in time to meet the TSP age-in requirement rule. Enrollment data for a beneficiary aging-in to the TRICARE Senior Prime option must be submitted to **CMS** at least 30 days prior to Medicare eligibility and no later than 30 days from receipt of the election form from the beneficiary.

5.0. HEALTH PROMOTION/CLINICAL PREVENTIVE SERVICES

5.1. The contractor shall provide the Health Evaluation Assessment Review (HEAR) to each enrollee at the time the initial TRICARE Senior Prime identification card is provided (except for TRICARE Prime enrollees aging-in to TRICARE Senior Prime or if the enrollee has completed a HEAR within the past 18 months). An applicant’s failure to return the survey does not affect his or her enrollment in TRICARE Senior Prime. The contractor shall follow up on unanswered surveys within 60 days with at least one written or one telephonic

contact. If follow-up attempts are not successful in obtaining a response, the contractor shall document that instance for the record. Such documentation shall be assessable for monitoring purposes.

5.2. The contractor shall provide enrollee HEAR data survey result reports to the enrollee and the MTF within 15 days of receipt of the HEAR. Reporting of this information is on-going to the extent that surveys continue to be received from enrollees. Enrollees' HEAR data shall be provided to the government in an electronic medium in a form that can be manipulated by the government.

5.3. The contractor shall include TRICARE Senior Prime enrollees in all on-going requirements for HEAR surveys as are specified in the MCS Regional TRICARE Contract.

5.4. The contractor shall also provide each enrollee with an age appropriate self-intervention manual which has been approved by the Lead Agent, and a Health Care Information Line pamphlet, explaining the 24 hour nurse line at the same time (but not necessarily in the same mailing), as the Coverage Agreement, and TRICARE Senior Prime identification card is provided. The contractor shall ensure that the TRICARE Senior Prime enrollees receive all other health promotion materials and have access to activities available to TRICARE Prime enrollees, as detailed in the TRICARE contract.

6.0. INTERFACE WITH **CMS** - MEDICARE PROCESSING CENTER (MPC)

6.1. The MPC is a front end processor that the contractor shall use for all electronic communications with **CMS** (see [Figure 23-5-4](#)). The MPC simplifies communication and improves data quality for all demonstration participants. For **CMS**, the MPC is an experienced processor and user of all required systems. The MPC has the ability with their existing communications infrastructure and access to perform required processes without involving multiple processors. The MPC will gather data from the MCSCs, DEERS, and CEIS; perform data manipulation as necessary and provide a single feed to **CMS**. For DoD, the MPC will feed needed Medicare data to the MCSCs and CEIS. The MPC also processes reconciliations of enrollment and encounter data to insure that **CMS** and DoD are in sync, a requirement for demonstration audit and validation. For the MCSCs the MPC provides a single on-line eligibility verification and enrollment system. [Figure 23-5-5](#) provides charts showing the data flow.

6.2. The contractor shall participate in planning meetings with the government and MPC personnel. These meetings will define details of data exchange, on-line entry, and other issues to support this demonstration. The contractor shall travel to a central site for two meetings of approximately three days duration. The contractor shall pay their own travel and per diem. The meeting support costs will be borne by the MPC.

6.3. The MPC will provide the contractor with training at the contractor designated site. The contractor shall provide the space and workstations sufficient for their personnel to be trained. Training should take approximately three days. Two shifts of two and a half days each will be provided if necessary.

6.4. The contractor shall conduct application processing on the MPC system. The contractor gains access through the MPC provided dial-up access, or through a dedicated line. MPC provides the data line if the contractor is processing applications from a central

site. All equipment at the contractor end is the responsibility of the contractor. The contractor shall contact TMA, Special Programs and Demonstrations, (703) 681-0039 with any systems questions. DEERS access is imbedded into the MPC system. The MPC also maintains the most current Medicare eligibility status data; i.e., ESRD, Part B, MSP Working Aged, Hospice, State Buy-In, etc., on those MHS eligibles identified as residing in the service area. When the contractor conducts the DEERS eligibility check through the MPC, the system populates the enrollment screen with information from DEERS and **CMS** as available, thus simplifying the entry process.

6.5. Applications received and verified by the contractor by the 25th of the month shall be entered into the MPC system by the close of business on the second workday of the following month.

6.6. The MPC will provide the contractor with a monthly transaction report that notifies the contractor of enrollment confirmations and errors. The monthly report will also provide the contractor with all other eligibility and enrollment changes. The contractor shall provide a copy of the monthly transaction report to the Lead Agent within five calendar days of receipt from the MPC.

6.7. Following receipt of the monthly transaction report from the MPC, the contractor shall provide the enrollee with written notification of the enrollment effective date, enrollment card and applicable enrollment materials. All materials shall be mailed to ensure receipt by the beneficiary at a minimum of three working days prior to the enrollment effective date. With the same mailing and where required by their contract, the contractor shall also provide the beneficiary with the Health Evaluation Assessment Record form and the self intervention manual; however, an applicant's failure to return the survey does not affect their enrollment in the demonstration project. The contractor shall not enroll a beneficiary in DEERS until confirmation of the applicant's enrollment in **CMS** has been received. The contractor shall enter the enrollment into their internal system, if necessary.

6.8. The contractor shall enter the alternate care code of "D" into DEERS to identify the beneficiary as a Medicare Demonstration enrollee. The contractor shall verify the enrollment action entered in DEERS is correctly reflected on the system within one working day following the initial entry of the information into DEERS.

6.9. The MPC will provide the contractor with activity, error, and other reports that require the contractor to process changes regarding enrollment data bases (contractor and DEERS) to reflect all changes within 21 calendar days of receipt of the report.

7.0. **RETROACTIVE ENROLLMENT**

A retroactive enrollments shall be processed only when as individual has fulfilled all election and eligibility requirements for a M+C plan, and the M+CO or **CMS** is unable to process the election for the statutorily required effective date. Retroactive enrollments are required when the M+CO has improperly informed an individual on the effective date of coverage, or when enrollment is originally denied due to erroneous indicators in the **CMS** system that result in inaccurate beneficiary information. Such applicants shall be enrolled regardless of capacity limits and shall be entered into DEERS.

8.0. RECORDS RETENTION

8.1. The contractor shall ensure that all enrollment and disenrollment forms are signed and dated. All applications shall be filed by applicant's SSN and segregated between those that were approved and those that were denied. Files for applications that were denied shall contain all supporting documentation regarding the rationale for the denial (including the envelope in which it was received). For all enrollment applications, all associated development, letters to beneficiaries, confirmation or denial notifications from **CMS**, annotations of the mailing date of the enrollment card and associated enrollment materials, etc., shall be maintained with the enrollment application. The contractor shall retain all enrollment applications while the beneficiary is enrolled in TRICARE Senior Prime and for one year after disenrollment. The contractor may retain enrollment/disenrollment forms, and other documentation identified above, either in hard copy, readable microfilm, or electronic media/CD, as long as these versions of storage are readily available for review and the signature and the date on the forms are clearly readable. After one year from disenrollment, the contractor shall follow the records management requirements in [Chapter 2](#).

8.2. The contractor shall retain on active files all reconciliation data received from **CMS** for one year from the date of receipt and then follow the procedures in [Chapter 2](#) for records retention. The contractor shall propose the site at which all documentation will be retained.

9.0. DISENROLLMENT

9.1. An enrollee may be involuntarily disenrolled for:

9.1.1. Failure To Maintain Medicare Part B

Upon notification by **CMS** that an enrollee is no longer eligible for enrollment, the contractor shall disenroll the enrollee on the date specified by **CMS**. The contractor shall notify the enrollee and the MTF Commander within two working days of notification from **CMS**. The contractor shall enter the disenrollment into DEERS.

9.1.2. Failure To Comply With Requirements Of TRICARE Senior Prime, Or For Disruptive Or Abusive Behavior

The contractor shall involuntarily disenroll an enrollee only upon final notification of such a determination by **CMS** (see [Figure 23-5-6](#)). If the disenrollment is for reasons other than death or loss of entitlement to Part A or Part B, the individual must be given a written notice of the disenrollment with explanation why the M+C Organization is planning to disenroll the individual. The notice must be mailed to the individual before submission of the disenrollment notice to **CMS**. The notice must include an explanation of the individual's right to a hearing under the M+C organization grievance procedures. (422.74(c)). The involuntary disenrollment date shall be effective in accordance with **CMS** determination. An enrollee shall NOT be disenrolled for exercising his/or her option to make treatment decisions with which TRICARE Senior Prime disagrees. The contractor shall enter the disenrollment into DEERS.

9.1.3. Moving Outside Of The Approved Service Area For More Than Six Consecutive Months (422.72(d)(4))

In the event that an enrollee is identified as being outside of the service area for more than six consecutive months, the contractor shall notify the MTF Commander/Lead Agent. The contractor shall involuntarily disenroll the enrollee only upon direction of the MTF Commander/Lead Agent. Within two working days of receipt of such notice and in no less than 29 days prior to the disenrollment effective date, the contractor shall notify the affected beneficiary by certified mail of the disenrollment. Involuntary disenrollment shall be effective in accordance with **CMS** determination. (See [Figure 23-5-6](#).) The contractor shall enter the disenrollment into DEERS.

9.2. The MPC and contractor shall process voluntary disenrollments in accordance with the election effective date requirements of the Balanced Budget Refinement Act of 1999 and OPL 113. (See [Figure 23-5-6](#)).

9.3. An enrollee who disenrolls or is disenrolled involuntarily may request reenrollment at the next enrollment period.

10.0. ACCESS TO NETWORK PROVIDERS

10.1. Access To Services

10.1.1. TRICARE Senior Prime must be able to identify members with complex or serious medical conditions; assess those conditions using medical procedures to diagnose and monitor them on an ongoing basis; and establish a treatment plan with an adequate number of direct access visits to specialists (i.e., no prior authorization required) to comply with the treatment plan.

10.1.2. When a contracting physician is terminated from TRICARE Senior Prime, the organization must make a "good faith" effort to provide written notice of the termination to enrolled patients seen on a regular basis by the terminated provider within 15 working days of the termination. The member should be informed of his/her rights to maintain access to the terminated provider's services by disenrolling from TSP and enrolling into another M+C plan that the provider contracts with, or by enrolling in traditional Medicare.

10.1.3. TRICARE Senior Prime is required to provide services in a culturally competent manner to all members, including those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities.

10.2. Access To Providers

The contractor shall, in consultation with the Lead Agent and MTFs, develop a network of providers to augment the health care services available in the MTF. The contractor shall ensure that the network includes a sufficient number and mix of providers that, in conjunction with the MTF providers, assures appropriate services are available for the population enrolled. If the contractor provides documentation of efforts to negotiate rates, and there is no other accessible provider of the needed specialty available, the Lead Agent may approve payment up to the Medicare rate to include disproportionate share

payments, if necessary, to secure a network specialty provider agreement for a needed service. Upon direction of the contracting officer, the contractor shall provide, the following:

- 10.2.1. A list of TRICARE network providers who have agreed to participate in TRICARE Senior Prime;
 - 10.2.2. Service area maps showing the location of the TRICARE Senior Prime network providers;
 - 10.2.3. For each category of providers, specimen copies of agreements between the contractor and the network providers which govern the provider's participation in TRICARE Senior Prime, and
 - 10.2.4. A schedule showing how many agreements have been signed to date and a statement as to the date the remaining agreements will be completed.
- 10.3. The contractor shall ensure that network providers agree to accept referrals for enrollees and to provide clinical feedback to the MTF for care provided to an enrollee consistent with existing practices for TRICARE Prime. At the time of the **CMS** site visit, the contractor shall make available for **CMS** viewing, the signed agreements between the contractor and all TRICARE Senior Prime providers.
- 10.4. The Primary Care Manager (PCM) for enrollees in TRICARE Senior Prime shall always be an MTF provider. For services not available within the MTF, the same referral and authorization process under TRICARE Prime shall be utilized, except that any referrals to non-network providers found to be medically necessary and appropriate shall be referred to the MTF Commander or designee prior to authorization. The MTF Commander or designee will provide a response within one working day.
- 10.5. The contractor shall ensure that referrals are directed to a network provider, if required services are not available in the MTF. If a network provider is not available for referral, authorization must be approved by the MTF Commander or his/her designee. The contractor shall, upon consultation with the Lead Agent regarding non-network provider referral volume, enhance the network as appropriate.
- 10.6. The Medicare benefit includes coverage of manual manipulation of the spine (to treat subluxation demonstrated by x-ray) and is a covered benefit under TRICARE Senior Prime. The contractor shall obtain a network provider capable of delivering this benefit, in accordance with the applicable state laws ([Figure 23-5-7](#)).
- 10.7. Upon direction of the contracting officer, the contractor shall provide to the Lead Agent and TMA, a draft TRICARE Senior Prime Provider Directory that includes a listing of the MTF providers. The contractor shall also provide, under separate cover, a map plotting the locations of network providers. The final TRICARE Senior Prime Provider Directory shall be available for distribution at the time (but not necessarily in the same mailing), as the Coverage Agreement and the TRICARE Senior Prime identification card are provided to enrollees.

11.0. TRAINING OF PROVIDERS

The contractor shall ensure that all MTF and civilian network providers serving TRICARE Senior Prime enrollees receive education prior to the date of the **CMS** site visit, as notified by TMA, for both the TRICARE and Medicare programs. The contractor shall ensure that those providers shall have ongoing access to information about these programs. The training and information provided to both MTF and network providers shall include the process for referrals and the use of the health care finder. The contractor shall develop an addendum to the network provider manual that clearly explains the Medicare benefit and TRICARE Senior Prime and shall ensure that TRICARE Senior Prime is included in all on-going provider training conducted in compliance with training requirements under the current contract. The contractor shall make all such information available to MTF providers.

12.0. BENEFITS

The benefits to be delivered under the demonstration shall include all services and supplies covered by the Medicare Program, to include benefits identified in 42 CFR 422.100, and self-referral (PCM referral or TSP authorization is not required) for pneumococcal vaccines, plus additional services not covered by Medicare as follows: outpatient pharmacy services and preventive services. The TRICARE Prime Program shall be the vehicle for delivery of the benefit package, except that standard Medicare coverage of skilled nursing facility care, home health care, and chiropractic services will apply. The contractor is responsible for determining and applying the Medicare coverage for these benefits, including local/regional policies if applicable. Claims shall not be denied based on TRICARE benefit policy without first reviewing to determine if the service is covered under Medicare policy. The benefit package and cost-share structure as defined in [Figure 23-5-3](#) mirrors the TRICARE Prime benefit, with the following exceptions:

12.1. Enrollment in the TRICARE Senior Prime does not require an enrollment fee.

12.2. Inpatient care in a Medicare-participating skilled nursing facility (SNF) is covered, when the skilled level of care following a hospital stay is needed. The patient must have been an inpatient of a hospital for a medically necessary stay of at least three consecutive calendar days prior to being able to obtain SNF coverage. The three consecutive calendar days may be waived at the discretion of the Lead Agent and the MTF with the knowledge that the number of days not in a hospital will be added to the total number of days covered in an SNF. Transfer to an SNF must be within 30 days of the hospital discharge, unless the patient's condition makes transfer medically inappropriate. The Medicare skilled nursing facility benefit is limited to 100 medically necessary days in a benefit period, with no cost-share. A benefit period begins the day the patient is admitted to the hospital, and ends when he/she has been out of a hospital or SNF for 60 consecutive days, including the day of discharge. It also ends if the beneficiary stays in a SNF, without receiving SNF care for 60 consecutive days. Once a benefit period ends, a new benefit period begins and hospital and SNF benefits are renewed. There is no limit to the number of benefit periods. The contractor shall track the number of beneficiary days in which a TRICARE Senior Prime enrollee is an inpatient in a skilled nursing facility.

12.3. The contractor shall track the number of inpatient mental health days used by an individual enrollee. Such information shall be retained in a form readily accessible for

provision to **CMS** upon an enrollee's disenrollment from TRICARE Senior Prime or the end of the demonstration.

12.4. In addition to tracking inpatient days as described in [paragraph 12.2.](#) and [12.3.](#) above, the contractor shall track the number of beneficiary days in which a TRICARE Senior Prime enrollee is an inpatient in a nursing facility; an intermediate care facility; a psychiatric hospital; a rehabilitation hospital; a long term care hospital; as well as a swing bed hospital. The contractor will also be responsible for contacting the applicable facilities, verifying enrollees that meet the criteria for OPL 54 and then reporting those enrollees' names to their enrollment division on the last day of the month prior to the monthly **CMS** submission. A courtesy copy of those names reported to the enrollment division will be sent to the appropriate Lead Agent designee. OPL 54 applies.

12.5. Manual manipulation of the spine, if subluxation is identified by a Medical Doctor or Doctor of Osteopathy by x-ray, may be performed by a chiropractor, a physician or by non-physician practitioners, such as physical therapists, if allowed under applicable state law.

12.6. The definition for emergency and urgent care shall be that of Medicare, as follows:

12.6.1. Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

12.6.2. "Emergency services" means covered inpatient and outpatient services that are:

- delivered by any MTF or civilian medical facility;
- furnished by a provider qualified to furnish emergency services;
- needed to evaluate or stabilize an emergency medical condition. ([Figure 23-5-8](#)) provides further explanation of emergency services.)

12.6.3. Urgently needed services are covered services provided when an enrollee is temporarily absent from TSP's service area (or, under unusual and extraordinary circumstances, provided when the enrollee is in the service area but the TSP provider network is temporarily unavailable or inaccessible) when such services are medically necessary and immediately required:

- As a result of an unforeseen illness, injury or condition; and
- It was not reasonable given the circumstances to obtain the services through TSP.

12.7. To qualify for home health care, a TRICARE Senior Prime enrollee must be homebound according to the Medicare definition; require intermittent skilled nursing, physical therapy, or speech therapy; and be under the care of a physician. In addition, the services must be furnished under a plan of care that is prescribed and reviewed at least every

62 days by a physician. If these conditions are met, TRICARE Senior Prime will pay for skilled nursing; physical, occupational, and speech therapies; medical social services; home health aide visits; durable medical equipment and medical supplies. As long as the care is reasonable and necessary and meets the above criteria, there are no limits on the number of home health visits or length of coverage.

12.8. Enrollees are entitled to all pharmacy services available to TRICARE Prime enrollees.

12.9. The TRICARE Prime Point of Service Option is not applicable to this demonstration.

13.0. CLAIMS

13.1. General

13.1.1. The contractor shall adjudicate claims for all health care services provided to TRICARE Senior Prime enrollees by both network and non-network providers. The contractor shall not be financially at-risk for payment of these claims, but shall be reimbursed by the TRICARE Management Activity.

13.1.2. All rules applicable to processing claims for TRICARE Prime to include, eligibility verification, health care finder authorization verification, coordination of benefits for the working aged and other categories identified in Pub 75 as applicable, third party liability (TPL), TRICARE ClaimCheck, TRICARE payment/check release, etc., shall apply, except those specifically excluded non-network provider services. Claims shall not be denied based on TRICARE benefit policy without first reviewing to determine if the service is covered under Medicare policy.

13.1.3. Non-Availability Statements (NAS) are not applicable to this demonstration.

13.1.4. The point of service option is not applicable to this demonstration.

13.1.5. No deductibles or catastrophic cap accumulations are applicable to this demonstration.

13.1.6. Prepayment review for care not authorized is applicable to TRICARE Senior Prime, except that, other than emergent or urgent care, non-authorized care is to be denied and the enrollee provided the appropriate letter explaining the denial and the enrollee's appeal rights. Please note that, in conducting prepayment review for emergency services in or out of the service area, and urgent care services when an enrollee is out of the area, approval for payment is dependent on the presenting symptoms and the enrollee's perception of the existence of an emergent or urgent situation, not on the resulting diagnosis. (See [Figure 23-5-8](#) for definitions of emergency and urgent services.) These claims should be paid unless there is evidence to the contrary.

13.1.7. A referral or preauthorization for the care provided must be present on the contractor's system when a claim is being processed for care rendered by a provider outside of the MTF, including preventive care. A referral or preauthorization is not required for:

13.1.7.1. Emergency services, anywhere;

13.1.7.2. Urgently needed services; (see definition)

13.1.7.3. Renal dialysis services provided while temporarily outside the service area;

13.1.7.4. Post-stabilization care for pre-approved (or deemed approved as specified in 42 CFR 422.100(b)(1)(iv)(B)) services from non-network providers;

13.1.7.5. Ancillary tests ordered by a military primary care manager (PCM) or for ancillary services rendered as part of an authorized speciality evaluation or treatment.

13.1.7.6. **P**harmaceutical services, to include both retail and mail order;

13.1.7.7. Access to women's health specialist for routine and preventative health care services provided as a basic benefit;

13.1.7.8. Influenza and pneumococcal vaccinations; and

13.1.7.9. The first eight mental health outpatient visits when provided by a network provider.

NOTE: Paragraphs 13.1.7.1.-13.1.7.6. above, may be received from network or non-network providers, while paragraphs 13.1.7.7.-13.1.7.9., must be received from network providers only.

13.1.8. For each claim processed for services received outside of the MTF, the contractor shall provide the beneficiary and provider with an explanation of benefits (EOB). The information on the reverse side of the EOB shall be blank. On each EOB processed, the contractor shall include the following message: "This is a claim for TRICARE Senior Prime. No deductibles or catastrophic cap accumulations are applicable to this program."

13.1.9. In the event a claim is denied for payment, the contractor shall provide the beneficiary and the provider with a letter in addition to the EOB, explaining the reason for the denial and providing appropriate appeal rights.

13.1.10. The contractor shall create a HCSR for each network and non-network claim processed to completion and submit to the TRICARE Management Activity (TMA) in accordance with current contract requirements for not at risk funds. There are specific reporting data elements for this demonstration to include special processing codes for network and non-network claims, enrollment status code, voucher reporting by branch of service specific to the demonstration and pricing profile code. There are no additional fields which have to accommodate new values for this demonstration.

13.2. Network Claims

13.2.1. The contractor shall follow TRICARE processing requirements, guidelines standards, and reporting requirements for network claims.

13.2.2. The contractor shall reimburse network claims in accordance with existing TRICARE network provider agreements. The out-of-pocket expense (cost share or co-payment) incurred by a TSP enrollee for a network provided benefit service, or a TSP referred

and/or authorized benefit service from a non-network provider, must be uniform across the regional TSP service area. Proposed changes to provider agreements that will increase the financial liability of TSP beneficiaries must be submitted to **CMS** 60 days prior to the effective date and approved by **CMS**. **CMS** will only approve changes which increase the out-of-pocket expenses of beneficiaries for an effective date of January 1. Mid year changes will only be approved by **CMS** when the change(s) are advantageous to the TSP beneficiary. Following **CMS** approval, appropriate notice must be given to all beneficiaries 30 days prior to implementation/effective date of change. For example, to assure that changes are effective 01/01/2000, they must be requested by 11/01/1999. The following references apply, OPL 66, 42 CFR 422.300 and 422.304.

13.3. Non-Network Claims

13.3.1. The contractor shall follow **CMS** processing requirements, guidelines and standards for non-network claims.

13.3.2. The contractor shall apply the clean/non-clean claims definitions in [Figure 23-5-13](#).

13.3.3. The contractor shall pay 95% of all clean non-network claims within 30 calendar days of receipt. The contractor shall pay or deny 100% of non-clean, non-network claims within 60 days.

13.3.4. The contractor shall follow **CMS** requirements concerning interest penalty payments as a result of late claims payments for Medicare patients. Any interest penalties imposed by **CMS** as a result of late claims payment shall be the responsibility of the contractor without reimbursement by the government. A report of all interest penalties shall be furnished to the Lead Agent each quarter.

13.3.5. Failure to pay a clean claim or within 30 days requires the contractor to pay interest on the clean claim as noted in the preceding paragraph. All other claims must be approved or denied within 60 calendar days from the date of receipt. Failure to issue a timely written notice constitutes an adverse organization determination, which the beneficiary or provider may appeal. (See [Figure 23-5-13](#).)

13.3.6. Non-institutional claims shall be reimbursed in accordance with current CMAC rates.

13.3.7. Institutional claims shall be reimbursed using the current Medicare Prospective Payment System.

13.3.8. Emergency and urgent service claims will be paid billed charges.

13.3.9. TRICARE ClaimCheck will not apply to non-network claims.

13.4. Readiness Testing

Prior to the start of health care delivery, the contractor shall demonstrate the ability of its staff and automated claims processing system to accurately process claims in accordance with stated requirements. This shall be accomplished through a government

administered test to be conducted no later than 30 days prior to the start of health care delivery, on a date mutually agreed upon by the government and the contractor. The test shall include all front end processes required including enrollment, loading of needed provider files, issuance of required authorizations and referrals, processing both network and non-network professional and institutional claims for enrolled beneficiaries and imaging of claims. Also required shall be the generation of Health Care Service Records (HCSRs) as well as the data required by the Medicare Processing Center (MPC).

13.5. Reporting

13.5.1. The contractor shall generate and submit a HCSR for all claims processed.

13.5.2. No later than the 15th day of the month following the month in which a claim is paid, the contractor shall submit to the MPC UB-92 or **CMS** 1500 data, as appropriate, for all claims.

13.5.3. The contractor shall provide TRICARE Senior Prime network information on Monthly Workload and Cycle Time Aging Reports in the required format provided in [Chapter 15](#). Separate reports are required for non-network clean and non-network non-clean claims by each MTF in the same format. Telephone inquires, walk-ins, correspondence, appeal and grievance information do not have to be separated and may be provided in one report in the required format provided in [Chapter 15](#). These reports shall arrive by the 15th calendar day of each month reporting for the previous month.

13.6. Audits

All TRICARE Senior Prime claims are excluded from the TMA quarterly audits.

13.7. Quality Control

13.7.1. The contractor shall develop and implement an end-of-processing quality control program for TRICARE Senior Prime claims which assures accurate processing and payments for authorized services received by eligible beneficiaries from certified providers. The reports will be based on calendar year quarters.

13.7.1.1. The contractor shall randomly sample and review a sufficient number of processed TRICARE Senior Prime claims and adjustments to validate the quality of adjudication, processing, and management control. Process review includes examination of the **CMS** 1500/UB-92, data input, explanation of benefits (EOBs), and payment. Claims in the sample shall be selected randomly, or by other acceptable statistical methods in sufficient numbers to yield at least a 90% confidence level with a precision level of 5%. The sample shall be drawn at or near the end of each quarter from claims completed during the review period. The contractor may draw the sample up to 15 calendar days prior to the close of the quarter, but must include claims completed in the period between the date the sample is drawn and the close of the quarter in the next quarterly sample. The contractor's report to TMA shall reflect the inclusive processing dates of the claims in the sample.

13.7.1.2. Documentation of the results shall be completed within 45 calendar days of the close of each contract quarter. Unless notified otherwise, the contractor shall provide the results of the quarterly review to the Chief, Claims Operations Office, TMA-Aurora, and the

Director, Contract Resource Management, by the 45th calendar day following the close of each quarter.

13.7.1.3. The contractor shall correct all erroneously processed claims in accordance with the error correction guidelines and overpayments recovery outlined in [Chapter 11](#).

13.7.2. The contractor shall retain copies of the reviewed claims on-site for a period of no less than four months following submission of the audit results. This does not change the six year requirement for retention of records. TMA staff will review the results and the Government reserves the right to audit a selected sample of the audited/quality review documents, either at the contractor's site or will require the contractor to forward selected work for review at TMA.

13.7.3. In order for Plan Managers/Administrators at each site to meet **CMS** required oversight requirements, visits to the contractor's site may be scheduled. Review of quarterly audited/quality review documents, claims processing policies and procedures for TSP and correspondence files may be part of these on site visits.

14.0. UTILIZATION MANAGEMENT/QUALITY ASSURANCE

14.1. General

Utilization management, including case management and discharge planning, and quality assurance for this demonstration shall be performed in accordance with the current Managed Care Support Contract in the Region and current Medicare+Choice requirements under Part 422 subpart D, unless otherwise specified under separate contract modifications. Enrollees in TRICARE Senior Prime shall access network or non-network provided specialty care only through an approved referral by their MTF PCM, unless otherwise specified in this chapter.

14.2. Peer Review Activities

The contractor shall support the MTF in fulfilling requirements for the provision of medical records for network and non-network care, as requested by the MTF for review by the **CMS** Peer Review Organization (PRO). As a general rule, medical records requested for review shall be provided within 15 days for network providers and within 30 days for non-network providers. [Figure 23-5-9](#) provides information on the PRO process with which the MTF will be required to comply.

15.0. APPEALS

15.1. General Information

For purposes of this demonstration project, the appeals process involves only adverse organization determinations (denial of a claim or service). All other issues and complaints by either providers or beneficiaries shall be considered grievances. Medicare (**CMS**) may be involved in the appeals process but considers the grievance process to be internal to the plan. Grievances are covered in [paragraph 16.0](#). The contractor, MTF, and Lead Agent shall utilize the appeals process at [Figure 23-5-10](#) to develop an appeals process specific to the TRICARE Senior Prime Program for their site. The appeals process shall be

included in the policies and procedures developed to manage the plan and shall be in place prior to the **CMS** Site Survey.

15.2. Organization Determinations

15.2.1. Definition

Organization determinations are defined in 42 CFR 422.556(b). Briefly they are generally determinations regarding the provision of services or payment for services already received, based on the facts, coverage, or medical grounds.

15.2.1.1. The facts include issues of enrollment, lack of authorization (including failure to follow prescribed referral and authorization requirements, unauthorized use of non-network provider, etc.).

15.2.1.2. All benefits are subject to the Medicare appeal process.

15.2.1.3. Medical grounds are based on medical judgement (e.g., non-emergency, non-urgent, not a skilled or not the appropriate level of care, not medically necessary, not the treatment option offered by the Plan, etc.).

15.2.2. Making an Organization Determination

Unless otherwise specified under separate contract, organization determinations described above shall be made in accordance with the current MCS contract and/or as clarified in the LA/MTF/MCS contract memorandum of agreement/understanding.

15.2.3. Issuing an Organization Determination

The issuance of an adverse organization determination letter to beneficiary or provider shall be in accordance with the jointly developed appeals process and shall meet **CMS** requirements. Reference 42 CFR 422.566-422.576.

15.3. Reconsiderations

The appeal of an adverse organization determination shall be conducted in accordance with the policies and procedures developed to manage the plan (see [paragraph 15.1](#)). Reconsiderations which result in a total or partially unfavorable response for the beneficiary shall be referred to the Center for Health Dispute Resolution (CHDR) in accordance with **CMS** requirements. Reference 42 CFR 422.578-422.590.

15.4. Expedited Reconsiderations

Expedited reconsiderations shall be conducted in accordance with the above guidelines and those found in [Figure 23-5-10](#). Reference 42 CFR 422.590(d).

16.0. GRIEVANCE PROCESS

The contractor shall support the plan's resolution of beneficiary grievances relating to care received from a network or non-network provider. (See [Figure 23-5-11](#) for an explanation of "Grievances.") Reference 42 CFR 422.564.

17.0. BENEFICIARY SERVICES

The contractor shall provide the same level of services and responses to telephonic, in-person, and written inquiries with the same standards as applicable to the current MCS contract and **CMS** requirements.

18.0. WORKING AGED ENROLLEES

18.1. The contractor shall identify and administer a **CMS** Working Aged Survey ([Figure 23-5-12](#)) to all aged Medicare beneficiaries upon enrollment in TRICARE Senior Prime and annually thereafter. The contractor shall, through biannual advertisement (newsletters or other means) inform beneficiaries of the requirement to provide notification of changes in working aged status. The contractor shall follow-up on unanswered surveys with at least two telephonic attempts within the first 30 days and one written attempt within the second 30 days, if needed, to obtain a 100% response rate from enrollees ages 65 to 75. The contractor shall, upon request, provide an enrollee with a second copy of the **CMS** Working Aged Survey.

18.2. The contractor shall provide survey data to **CMS** via the MPC in the format as required in [Figure 23-5-13](#), shall verify data received from **CMS** via the MPC, and incorporate a working aged identifier in the coordination of benefits activities.

18.3. The contractor shall provide an initial report to the appropriate MTF on the working aged status of enrollees within 30 days of the open enrollment period and shall provide updates within ten days of a new enrollment or any changes in an enrollee's working aged status.

19.0. PAYMENT FOR CONTRACTOR SERVICES RENDERED

The contractor shall report the TRICARE Senior Prime claims on separate vouchers according to the [ADP Manual, Chapter 2](#). The HCSR data for each claim must reflect the appropriate data element values. To distinguish a TRICARE Senior Prime (Medicare) voucher from a voucher for other TRICARE, the contractor shall utilize the specific Voucher Branch of Service Codes mandated in the ADP Manual for use in reporting such claims. The contractor shall process payments via Letter of Credit on a not-at-risk basis for the health care costs incurred for each TRICARE Senior Prime claim processed to completion, upon acceptance of the vouchers by TMA.

20.0. TRANSITIONS

20.1. Change In Contractor

All transition requirements as defined in [Chapter 1, Section 8](#) apply.

20.2. Termination of Demonstration

DoD and **CMS** will develop procedures for transitioning out of **TRICARE Senior Prime**. These changes will be defined and implemented by contract modification.

20.2.1. Enrollment

Enrollment applications received by August 31, 2001 will be processed for a September 1, 2001 effective date. The last effective date of enrollment in TRICARE Senior Prime is September 1, 2001. Applications for enrollment received on September 1, 2001 or later regardless of the postmark date, must be returned to the applicant with a letter of denial. In addition, regardless of the postmark date, applications received for effective dates beyond September 1, 2001 must also be returned to the applicant with a letter of denial.

20.2.2. Requirements of the MCSC Operations Manual 6010.49-M Chapter 23, Section 5 cease at 12:00 midnight on December 31, 2001 with the following exceptions:

20.2.2.1. Continuation of Care

TRICARE Senior Prime remains responsible for all Part A inpatient hospital services of TSP enrollees that are hospitalized in a prospective payment system (PPS) hospital until the beneficiary is discharged.

NOTE: *Coverage for care in a non-PPS hospital or in a SNF ends on December 31, 2001.*

20.2.2.2. Pending Appeals

42 CFR 422.502(a)(3) requires that all M+C organizations, including TSP, to provide access to benefits for the duration of their contracts. 42 CFR 422.618(b) requires TSP to “pay for, authorize, or provide” the services that the Center for Health Dispute Resolution determines should have been covered by the organization. TSP is obligated to process any appeals for services which, if originally approved, would have been provided or paid while Medicare beneficiaries were enrolled in the plan.

20.2.2.3. Payment of Claims

Claims for services received up through December 31, 2001, as well as claims for services received after December 31, 2001 as described under “Continuation of Care” above must be paid.

20.2.2.4. Records Retention

The record retention requirements described in paragraph 8.0 as well as those described at 42 CFR 422.502(d) and (e) apply.

FIGURE 23-5-1 TRICARE SENIOR DEMONSTRATION SITES AND TIMELINE

TRICARE REGION		ESTIMATED ENROLLMENT CAPACITY	WAIT LIST
1	Dover Air Force Base, Dover, DE	1,500	750
4	Keesler Air Force Base, Biloxi, MS	3,100	900
6	Brooke Army Medical Center, San Antonio, TX	5,000	2,500
	Wilford Hall Medical Center, San Antonio, TX	5,000	2,500
	Sheppard Air Force Base, Wichita Falls, TX	1,300	650
	Fort Sill, Lawton, OK	1,400	700
Central Region	Fort Carson, Colorado Springs, CO	2,000	1,000
	Air Force Academy, Colorado Springs, CO	1,200	600
9	Naval Medical Center San Diego, San Diego, CA	4,000	2,000
11	Madigan Army Medical Center, Fort Lewis, WA	3,300	1,500

“Aging-in” is projected to increase enrollment by 10% each year of the demonstration.

FIGURE 23-5-2 KEY DATES

Timelines and key dates are contained in the TRICARE Senior Prime Project Status Sheet, which is available in Microsoft Excel 97 and Microsoft Excel 5.0/95.

FIGURE 23-5-3 COST-SHARES

Listed below are the applicable charges when an enrollee receives care in the civilian community.	
SERVICE	COST-SHARE
Office visit; medical and surgical care in provider's office, a hospital, or a skilled nursing facility	Office Visit - \$12
Manual manipulation for subluxation of the spine when demonstrated by x-rays	Office Visit - \$12
Second opinion by another network Physician prior to surgery	Office Visit - \$12
Drugs and biologicals which cannot be self-administered, and are furnished as a part of a physician's services	None
Ancillary Services; Effective for care provided on or after March 26, 1998, TSP enrollees shall have no copayments for ancillary services in the categories listed below (normal referral and authorization provisions apply): <ul style="list-style-type: none"> • Diagnostic radiology and ultrasound services included in the CPT code range from 70000 through 76999; • Diagnostic nuclear medicine services included in the CPT code range from 78000 through 78999; • Pathology and laboratory services included in the CPT code range from 80000 through 89399; and • Cardiovascular studies included in the CPT code range from 93000 through 93350. 	No Copay
NOTE: Contractors are not required to search their files for claims for ancillary services which were not processed according to these guidelines. The contractor shall, however, if requested by an appropriate individual, adjust specific claims under these guidelines if the date of service is on or after March 26, 1998.	
Outpatient services received at a participating hospital for diagnosis or treatment of an illness or injury	Office Visit - \$12
Outpatient surgical procedures performed in an ambulatory surgical center	Copay - \$25
Outpatient mental health services	Copay \$25 individual/\$17 group
Independently practicing outpatient physical therapy and occupational therapy services	Copay \$12
Comprehensive outpatient rehabilitation facility services	Copay \$12 per service
Transfusions of blood	No Copay
Medical supplies, such as dressings, splints, and casts	A cost share of 20% of negotiated fee

FIGURE 23-5-3 COST-SHARES (CONTINUED)

SERVICE	COST-SHARE
Renal dialysis	Copay \$12
Ambulance services	Copay \$20
Ostomy supplies and prosthetic devices such as: braces for arm, leg, back and neck, artificial limbs, artificial eyes, contact lenses replacing natural lenses, and breast prostheses after surgery	A cost share of 20% of negotiated fee
Durable medical equipment, such as oxygen equipment, wheelchairs, and other equipment when prescribed by a Plan Physician for use in the home	A cost share of 20% of a negotiated fee
Pneumococcal vaccine and its administration	No Copay
Hepatitis B vaccine for members considered to be at high or intermediate risk of contracting disease	No Copay
Home health care services furnished by a participating home health agency, when authorized	No Copay
Screening pap smear	No Copay
Breast cancer screening (Mammography) - Medicare coverage is at least every other year for women 65 or older	No Copay
Therapeutic shoes for those suffering from severe diabetic foot disease	20% of a negotiated fee
Influenza vaccine	No Copay
Other age-appropriate preventive services included eye exams, immunizations, blood pressure screening, hearing exams, sigmoidoscopy or colonoscopy, serologic screening and certain education and counseling services	No Copay
Retail Pharmacy Network - <i>per 30 day Rx supply, up to a 90 day supply</i>	<i>See Policy Manual, Chapter 13, Section 11.1, Table 1</i>
<i>National Mail Order Pharmacy - up to 90 day supply</i>	<i>See Policy Manual, Chapter 13, Section 11.1, Table 1</i>
<i>Non-network Retail Pharmacy</i>	<i>See Policy Manual, Chapter 13, Section 11.1, Table 1, Standard deductible and cost-shares apply</i>
Emergency services: Emergency and urgently needed care obtained in an emergency room, on an outpatient basis, both network and non-network and in and out of service area	Copay \$30 per visit
Partial hospitalization for substance abuse (alcoholism or drug abuse) treatment. No limit on number of days of treatment.	Copay \$40 per day

FIGURE 23-5-3 COST-SHARES (CONTINUED)

<p>This chart lists the applicable charges when an enrollee receives care as an inpatient. Rates subject to change based on future Medicare benefits determinations.</p>		
INPATIENT HOSPITAL SERVICE	MILITARY HOSPITAL	CIVILIAN HOSPITAL
Acute inpatient admissions	No charge	\$11 per day/ minimum \$25 per admission
Inpatient mental health/substance abuse (inpatient care in a psychiatric hospital is limited to 190 lifetime days per beneficiary)	No charge	Copay \$40 per day
Inpatient care in a Medicare - participating skilled nursing facility (SNF) when the skilled level of care following a hospital stay is needed, the patient must be an inpatient of a hospital for a medically necessary stay of at least 3 consecutive calendar days prior to being able to obtain SNF coverage. Transfer to an SNF must be within 30 days of hospital discharge, unless the patient's condition makes transfer medically inappropriate.		Benefit is limited to 100 days and there is no cost-share.
Home health care - furnished by participating home health agency, when authorized		No charge

FIGURE 23-5-4 INFORMATION MANAGEMENT FUNCTIONAL REQUIREMENTS

INFORMATION MANAGEMENT FUNCTIONAL REQUIREMENTS

TRICARE SENIOR PRIME DEMONSTRATION PROJECT

**Information Management, Technology & Reengineering (IMT&R)
June 11, 1998**

Version 2

- **Clarification of CEIS reporting requirements**

FIGURE 23-5-4 INFORMATION MANAGEMENT FUNCTIONAL REQUIREMENTS (CONTINUED)

DESCRIPTION

The TRICARE Senior Prime functional requirements identify the information system capabilities and interface requirements for the Department of Defense (DoD) Military Health Systems (MHS) in support of the demonstration project.

PURPOSE

The purpose of this document is to define the functional requirements for the DoD systems supporting the TRICARE Senior Prime demonstration project to ensure a successful implementation of the program.

1. SCOPE

1.1 Identification

The Department of Health and Human Services (DHHS), the *Center for Medicare & Medicaid Services (CMS)*, the DoD, and the Office of the Assistant Secretary of Defense (Health Affairs) (OASD(HA)) have agreed to support a demonstration project, entitled TRICARE Senior Prime, through 31 December 2000, under which Medicare will reimburse the DoD for care it provides to Medicare-MHS dual-eligible beneficiaries. The goal of this demonstration is to implement a cost-effective alternative for delivering accessible and quality care to dual-eligible (Medicare and military eligible) beneficiaries while ensuring that the demonstration does not increase the total Federal cost for either agency.

Enrollment into the TRICARE Senior Prime demonstration project is limited to dual-eligible beneficiaries who meet all of the following eligibility requirements:

- Are entitled to Medicare Part A, enrolled in Medicare Part B and are eligible for care in the MHS as described in Section 1074(b) or 1076(b) of Title 10 United States Code, excluding beneficiaries diagnosed with end stage renal disease;
- Are Medicare eligible on the basis of age, or will “age-in” to the demonstration by being enrolled in TRICARE Prime with a PCM in the demonstration MTF and becoming Medicare eligible during the demonstration;
- Are residents of the geographic areas covered by the demonstration and where enrollment in the demonstration is offered; and
- Have received services as a dual eligible prior to July 1, 1997, or became eligible for Medicare, Part A on or after July 1, 1997.

Participation in TRICARE Senior Prime Program is voluntary. Beneficiaries must apply for enrollment in the program. There are capacity limits per demonstration service area. No new MTFs will be built and no existing facilities will be expanded with funds from the demonstration project.

FIGURE 23-5-4 INFORMATION MANAGEMENT FUNCTIONAL REQUIREMENTS (CONTINUED)

Six service areas have been selected by the DHHS and the DoD for participation in the demonstration project. These service areas include the following:

1. Brooke Army Medical Center, San Antonio, Texas, Wilford Hall Medical Center, San Antonio, Texas, Ft. Sill, Lawton, Oklahoma, and Sheppard Air Force Base, Wichita Falls, Texas
2. Madigan Army Medical Center, Fort Lewis, Washington
3. Naval Medical Center San Diego, San Diego, California
4. Keesler Air Force Base, Biloxi, Mississippi
5. Ft. Carson, Colorado Springs, Colorado and US Air Force Academy, Colorado Springs, Colorado
6. Dover Air Force Base, Dover, Delaware

The DoD Information Management/Information Technology (IM/IT) systems supporting the TRICARE Senior Prime demonstration are as follows:

- the Managed Care Support Contract (MCSC) Systems
- the Composite Health Care System (CHCS)
- the Ambulatory Data System (ADS)
- the Defense Enrollment Eligibility Reporting System (DEERS)
- the Corporate Executive Information System (CEIS)
- the IOWA Foundation Medicare Processing Center (MPC)
- the TRICARE Management Activity, Office of Acquisition Management and Support (TMA AM&S)
- Medical Expense and Performance Reporting System (MEPERS)
- Expense Assignment System (EAS)
- National Mail Order Pharmacy (NMOP)

1.2 Project Overview

TRICARE Senior Prime is one of two health care delivery systems defined in the Memorandum of Agreement (MOA) for the Medicare Demonstration of Military Managed Care. Approximately 1.1 million Americans age 65 and older are beneficiaries not only of the MHS, but also of Medicare. These dual-eligible beneficiaries do not have a Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) entitlement, but are eligible for care in a MTF on a space-available basis. TRICARE Senior Prime, a DoD Medicare at-risk HMO program initiative, offers dual-eligible beneficiaries the opportunity to enroll into this demonstration. Enrollment into this demonstration is scheduled to begin July 15, 1998. Multiple AISs, to include the CHCS, ADS, CEIS, and DEERS must ensure data flow between MTFs, the MPC, and the *CMS*. This effort encompasses identification of critical data, transfer of data, data storage, and data standardization.

FIGURE 23-5-4 INFORMATION MANAGEMENT FUNCTIONAL REQUIREMENTS (CONTINUED)**1.3 Document Overview**

This document defines the functional requirements for the enrollment and claims data flow process amongst the systems supporting the TRICARE Senior Prime demonstration project within the DoD. The functional requirements section presents each system's requirements for enrollment, claims, and reporting in the following order:

- 2.1 MCSC
- 2.2 CHCS
- 2.3 DEERS
- 2.4 CEIS
- 2.5 MPC
- 2.6 TMA, AM&S

A graphical representation of the interfaces and data flow processes among the application information systems (AIS) for beneficiary, enrollment, and claims/clinical data can be found in Exhibit 1 and Exhibit 2. General security and privacy IM/IT requirements for TRICARE Senior Prime can be found in Section 4 of this document.

2. FUNCTIONAL REQUIREMENTS**2.1 MCSC**

The MCSCs are responsible for all aspects of enrollment and disenrollment in the TRICARE Senior Prime Program, of the TRICARE Operations Manual 6010.49-M, [Chapter 23](#), February 24, 1998, stipulates the business rules and processes for the MCSCs in managing the TRICARE Senior Prime Program enrollment as follows: 1) health care finder, 2) health care services, 3) eligibility and enrollment, 4) utilization management, 5) claims processing, 6) reporting requirements, 7) marketing, 8) beneficiary services, and 9) medical peer review. Within each demonstration area, the MCSC will communicate and provide statistics to the Lead Agent and MTF Commanders on the TRICARE Senior Prime Program according to the MOA.

Enrollment Data Requirements:

- 2.1.1 The MCSCs shall process TRICARE Senior Prime applications from MHS beneficiaries.
- 2.1.2 The MCSCs shall verify MHS eligibility in DEERS via MPC and Medicare eligibility with **CMS** via MPC.
- 2.1.3 The MCSCs shall enter enrollment, enrollment updates and disenrollment information in the MPC system for **CMS** enrollment processing.
- 2.1.4 The MCSCs shall enroll MHS-eligible, **CMS**-confirmed beneficiaries into DEERS, which automatically transmits to CHCS-MCP.
- 2.1.5 The MCSCs shall produce and send the enrollment confirmation letter, and other enrollment materials to the TRICARE Senior Prime enrollee.

FIGURE 23-5-4 INFORMATION MANAGEMENT FUNCTIONAL REQUIREMENTS (CONTINUED)

2.1.6 The MCSCs shall update enrollment information, to include entry of disenrollments when applicable, into DEERS, which automatically transmits to CHCS-MCP, based on the MPC DEERS/*CMS* reconciliation report.

2.1.7 The MCSCs shall disenroll TRICARE Senior Prime beneficiaries in accordance with current contract requirements

Claims Data Requirements:

2.1.8 The MCSCs shall create and submit a Health Care Service Record (HCSR) to TMA, AM&S for each TRICARE Senior claim in accordance with current contract requirements.

2.1.9 The MCSCs shall create and submit monthly Uniform Billing (UB) 92 and *CMS* 1500 data to the MPC for each claim processed for TRICARE Senior Prime enrollees.

Report Requirements:

All reports required under this section shall be provided in electronic format. The detailed format and data transmission protocols will be specified during detail design.

2.1.10 The MCSCs shall maintain a daily list of TRICARE Senior Prime applications processed via MPC.

2.1.11 The MCSCs shall provide HEAR data results reports to the enrollee and the MTF. The HEAR data shall be provided to the government in an electronic medium in a form that can be manipulated by the government.

2.1.12 The MCSCs shall establish and maintain a wait list of eligible applicants via MPC at the level established by the participating site and monitor enrollment levels.

2.1.13 The MCSCs shall maintain and report enrollment processing information as specified by the current contract.

2.1.14 The MCSCs shall maintain and report enrollee disenrollment rates and reasons, complaint and appeal information as specified by the current contract.

2.1.15 The MCSCs shall maintain and report referral and access information as specified by current contract requirements.

2.1.16 The MCSCs shall maintain and report utilization management/quality assurance information, to include case management and discharge planning, in accordance with the current contract requirements.

2.2 CHCS

The CHCS is a fully integrated, automated health care system developed and maintained by the DoD MHS for use in all MTFs. The CHCS provides the appointment and health care delivery system used by the MTFs for TRICARE Senior Project enrollees. The TRICARE Senior Project enrollee appointments, referrals, clinical, ancillary orders and results, and admissions and dispositions will be performed using the CHCS for care rendered at the MTF.

FIGURE 23-5-4 INFORMATION MANAGEMENT FUNCTIONAL REQUIREMENTS (CONTINUED)

2.3 DEERS

The DEERS is the official DoD system for MHS eligibility and enrollment in the TRICARE Senior Project. The MCSC performs MHS eligibility verification during the enrollment process by accessing the DEERS system via the Government provided desktop enrolment software application. The MCS contractor assigns the beneficiary a TRICARE Senior Project enrollment start date and end date, a Primary Care Location, the network provider type code, and the appropriate health care delivery program designation.

Enrollment Data Requirements:

- 2.3.1 The DEERS shall provide the official DoD system of record for TRICARE Senior Prime enrollment information.
- 2.3.2 The DEERS shall provide MHS eligibility verification for the MPC and for the CHCS.
- 2.3.3 The DEERS shall receive and maintain enrollment transactions from MCS contractors for TRICARE Senior Prime enrollees. DEERS will provide the specific CHCS and MCSC platforms with notification of the enrollment transaction.
- 2.3.4 If the beneficiary's enrollment does not meet the eligibility criteria for TRICARE Senior Prime enrollment, the DEERS shall reject the enrollment and notify the MCS contractor of the rejection. Where *CMS* finds that a potential enrollee does not meet their criteria, *CMS* will notify the MCS contractor.
- 2.3.5 The DEERS shall send a monthly eligibility file to the MPC for the Medicare sites.
- 2.3.6 The DEERS shall send a monthly TRICARE Senior enrollment file to the CEIS and the MPC for the Medicare sites.
- 2.3.7 The DEERS shall send a monthly TRICARE enrollment file to the MPC for the Medicare sites.

Claims Data Requirements:

There are no claims data requirements for the DEERS.

Report Requirements:

There are no reporting requirements for the DEERS.

2.4 CEIS

The CEIS provides the DoD executive information and decision support reporting system for all MHS command levels. CEIS is the primary database for the TRICARE Senior Prime Program. TRICARE Senior Prime will collect data and provide reports consistent with Enrollment Based Capitation (EBC). The CEIS will store and process all SIDR, SADR, and HCSR data.

Enrollment Data Requirements:

- 2.4.1 The CEIS shall receive and maintain monthly TRICARE Senior enrollment and eligibility information from the DEERS.

FIGURE 23-5-4 INFORMATION MANAGEMENT FUNCTIONAL REQUIREMENTS (CONTINUED)

2.4.2 The CEIS shall receive and maintain monthly TRICARE Senior enrollment, eligibility and disenrollment information from the MPC, including the enrollee's unique claim number, (HICN) assigned by *CMS*.

2.4.3 The CEIS shall receive and maintain monthly PCM enrollment information from the CHCS.

Claims Data Requirements:

2.4.4 The CEIS shall receive and process ancillary data and the SIDR from the CHCS.

2.4.5 The CEIS shall receive and process the SADR from the ADS.

2.4.6 The CEIS shall receive and process the HCSR data from the TMA, AM&S.

2.4.7 The CEIS shall provide a data feed to MPC containing *CMS* 1500 and UB 92 data for TRICARE Senior Prime enrollee direct care dispositions and ambulatory visits.

2.4.8 The CEIS shall apply the patient level cost algorithm (PLCA) and the EBC methodology to SIDR and SADR information for TRICARE Senior Prime costing.

Evaluation and Reconciliation Data Requirements:

2.4.9 The CEIS shall maintain TRICARE Senior Prime data and provide ad hoc access to support TRICARE Senior Prime program evaluation by the TMA.

2.4.10 The CEIS shall maintain enrollment, utilization, and financial data for the TMA, Military Services, Intermediate Commands, MTFs and Lead Agents.

2.4.11 The CEIS shall include TRICARE Senior Prime enrollment and purchased care data in EBC reporting.

2.4.12 The CEIS shall report TRICARE Senior Prime performance and receipt of interim payments on a national, site and MTF level.

Report Requirements:

2.4.13 The CEIS shall report the number of MHS beneficiaries age 65 and over by the following categories: TRICARE enrollment status, dual user status, Medicare enrollment site, MTF catchment area, Medicare age range, gender, zip code, county, beneficiary category, Medicare plan (estimated for Part A only, Part B only and Parts A and B), and estimated count of non-enrollees ineligible due to: hospice care, ESRD, institutionalized, and handicap status.

2.4.14 The CEIS shall report the number of TRICARE Prime enrollees eligible to age-in to TRICARE Senior Prime per DEERS by month of eligibility.

2.4.15 The CEIS shall report the number of active enrollments, disenrollments, and new enrollments on a monthly basis for TRICARE Senior Prime enrollees by site by MTF.

2.4.16 The CEIS shall report the actual TRICARE Senior enrollment versus enrollment capacity for the demonstration sites by MTF.

2.4.17 The CEIS shall report inpatient and outpatient utilization and cost for TRICARE Senior Prime enrollees and shall compare the data to other peer and normative data.

FIGURE 23-5-4 INFORMATION MANAGEMENT FUNCTIONAL REQUIREMENTS (CONTINUED)

- 2.4.18 The CEIS shall report the cost of all space-available care provided to non-enrolled Medicare eligible beneficiaries compared to level of effort.
 - 2.4.19 The CEIS shall report the count and cost of ancillary services (laboratory, radiology, and pharmacy) provided to TRICARE Senior Prime enrollees.
 - 2.4.20 The CEIS shall report the count and cost incurred by TRICARE Senior Prime enrollees seen outside the enrollment MTF.
 - 2.4.21 The CEIS shall report preventive service delivery rates for TRICARE Senior Prime enrollees.
 - 2.4.22 The CEIS shall report the count and cost of community-based care (hospice, skilled nursing facility, home health care) provided to TRICARE Senior Prime enrollees.
 - 2.4.23 The CEIS shall compare monthly cost and utilization information for TRICARE Senior Prime enrollees to TRICARE Senior Prime key performance targets.
 - 2.4.24 The CEIS shall report TRICARE Senior Prime performance and receipt of interim payments on a national, site and MTF level.
 - 2.4.25 The CEIS shall report the total number and percentage of TRICARE Senior Prime enrollees with OHI.
 - 2.4.26 The CEIS shall report the number of TRICARE Senior Prime patient visits to their PCM and other providers.
 - 2.4.27 The CEIS shall report the disenrollment by the length of time the beneficiary was in the plan, and indicate the reason for disenrollment.
 - 2.4.28 The CEIS shall report the re-enrollment rates, by the length of time the beneficiary was out of the plan.
 - 2.4.29 The CEIS shall report the total number and rate of TRICARE Senior Prime enrollees requesting a change of PCM and indicate the reason for the change.
 - 2.4.30 The CEIS shall provide an updated EBC Scorecard that reports separately for TRICARE Senior Prime enrollees and Medicare eligible non-enrollees using the EBC costing methodology.
 - 2.4.31 The CEIS shall report the projected and actual interim payments from **CMS** on a national and site level.
 - 2.4.32 The CEIS shall report a monthly and annual reconciliation based on projected and actual interim payments. All calculations will be based on the Medicare site and MTF projected historical level of effort (LOE) and enrollment.
 - 2.4.33 The CEIS shall report the actual MTF and site enrollee expenses priced per the PLCA methodology, for both incremental and full costs, projected for the annual reconciliation by site and DoD.
- 2.5 **MPC**

FIGURE 23-5-4 INFORMATION MANAGEMENT FUNCTIONAL REQUIREMENTS (CONTINUED)

The MPC will provide the system for all electronic communications to **CMS** for enrollment and “claims” reporting. The MCSCs shall use the MPC system to enter enrollment data for **CMS**, in addition to their own systems to enter complete TRICARE Senior enrollments to DEERS. The MPC simplifies communications and improves data quality for all demonstration participants. Under current proposed enrollment data flow processes, the MPC will gather data from MHS systems, e.g., MCSC, DEERS, and CEIS, perform data manipulations as necessary, and provide a single transmission to the **CMS**. The MPC system will transmit Medicare data to the MCSCs, DEERS, and CEIS. The MPC will also reconcile enrollment and encounter data to ensure that the **CMS** and DEERS are synchronized.

Enrollment Data Requirements:

- 2.5.1 The MPC shall provide required enrollment information to the **CMS** for TRICARE Senior Prime.
- 2.5.2 The MPC shall receive enrollment information from the **CMS** for reconciliation. This will include a monthly enrollment, disenrollment, and error report, a transaction and activity report, and a membership report.
- 2.5.3 The MPC shall verify TRICARE Senior Prime enrollment eligibility on-line via DEERS.
- 2.5.4 The MPC shall process and maintain TRICARE Senior Prime enrollments, disenrollment, and beneficiary information.
- 2.5.5 The MPC shall report **CMS** enrollments, disenrollment, updates, and errors to the MCSC.
- 2.5.6 The MPC shall send an enrollment reconciliation report to the MCSC.
- 2.5.7 The MPC shall establish a waiting list of eligible applicants for TRICARE Senior Prime.
- 2.5.8 The MPC shall verify Medicare eligibility against an eligibility file provided by **CMS**.
- 2.5.9 The MPC shall receive monthly eligibility files from DEERS.
- 2.5.10 The MPC shall receive a monthly TRICARE Senior Prime enrollment file from DEERS.
- 2.5.11 The MPC shall receive a monthly TRICARE Prime enrollment file from DEERS, which will be used to predict age-in eligibility.

Claims Data Requirements:

- 2.5.12 The MPC shall receive civilian encounter data in **CMS** 1500 and UB 92 format from the MCSCs.
- 2.5.13 The MPC shall receive direct care encounter data in **CMS** 1500 and UB 92 format from the CEIS.
- 2.5.14 The MPC shall transmit claims data as required by the **CMS**.
- 2.5.15 The MPC shall accept claim error information from the **CMS** and send claim error info back to the MCSC and CEIS.

FIGURE 23-5-4 INFORMATION MANAGEMENT FUNCTIONAL REQUIREMENTS (CONTINUED)

Report Requirements:

- 2.5.16 The MPC shall provide a monthly enrollment capacity report to the MCSCs indicating the current enrollment and number of available enrollment spaces.
- 2.5.17 The MPC shall provide monthly enrollment processing activity and error report to the MCSCs.
- 2.5.18 The MPC shall provide a reconciliation report to the MCSCs.
- 2.5.19 The MPC shall report TRICARE Senior waiting list information by demonstration MTF to the MCSCs and CEIS.
- 2.5.20 The MPC shall provide a report to the MCSCs indicating the number of applications entered per day.
- 2.5.21 The MPC shall provide a daily list to the MCSCs of applications entered or received per day.
- 2.5.22 The MPC shall provide a report to the MCSCs indicating applications with no telephone attempts in the first 10 days.
- 2.5.23 The MPC shall provide a report to the MCSCs of applications inactive for 35 days.
- 2.5.24 The MPC shall provide a monthly enrollment activity and error report to MCSCs resulting from *CMS* processing.
- 2.5.25 The MPC shall provide the MCSCs a pre-edit error report of enrollment activity awaiting transmission to *CMS*.
- 2.5.26 The MPC shall provide the MCSCs a report of *CMS*-accepted enrollments to include all discrepancies between DEERS and the application information entered into MPC.
- 2.5.27 The MPC shall provide the MCSCs a monthly enrollment reconciliation report specifying the discrepancies between DEERS and *CMS* enrollment information.
- 2.5.28 The MPC shall provide a monthly enrollment capacity report to the MCSCs indicating the number of available spaces and the wait list applicants for those enrollment slots.
- 2.5.29 The MPC shall provide the MCSCs a monthly report of TRICARE Senior Prime Enrollees which specifies the discrepancies between DEERS and MPC zip code.
- 2.5.30 The MPC shall provide the MCSCs a monthly report of MCSC-submitted disenrollments by disenrollment reason.
- 2.5.31 The MPC shall provide the MCSCs a report of TRICARE Prime enrollees eligible to age-in to TRICARE Senior Prime per DEERS. Age-in letter and labels can also be provided.
- 2.5.32 The MPC shall provide annual working aged confirmation to the MCSCs with enrollee information pre-printed for mailing.
- 2.5.33 The MPC shall provide the MCSCs a report of enrollees who have not returned the working aged confirmations.

FIGURE 23-5-4 INFORMATION MANAGEMENT FUNCTIONAL REQUIREMENTS (CONTINUED)

2.5.34 The MPC shall provide an application/enrollment file available for downloading by the MTFs.

2.6 TMA, AM&S

The TMA, AM&S office will receive and process the HCSR data from the MCSC. Encounter data is received and processed daily by TMA, AM&S, and then transmitted to the CEIS.

Enrollment Data Requirements:

There are no enrollment data requirements for the TMA, AM&S. (Enrollment DMIS ID shall be provided on the HCSR by the MCSC)

Claims Data Requirements:

2.6.1 The TMA, AM&S shall accept the HCSR data from the MCSCs as specified in the overall contract.

2.6.2 The TMA, AM&S shall send the HCSR and EBC data to the CEIS on a monthly basis.

Report Requirements:

There are no report requirements for TMA, AM&S.

3. INTERFACE IDENTIFICATION

The requirements below define the new interfaces required for the TRICARE Senior Prime demonstration. This section does not define the technical and communication components of the interfaces among the systems. Exhibit 1 provides a graphical representation of the TRICARE Senior Prime system interfaces for the enrollment data flow process. Exhibit 2 provides a graphical representation of the system interfaces for the claims/clinical data flow process for the TRICARE Senior Prime demonstration project.

3.1 New Enrollment Interfaces Required for TRICARE Senior Prime

3.1.1 The MCSCs shall interface with the MPC for Medicare enrollment information and updates.

3.1.2 The MPC shall interface with the DEERS for MHS/Medicare eligibility and enrollment.

3.1.3 The MPC shall interface with *CMS* for Medicare enrollment processing.

3.1.4 The MPC shall interface with the CEIS for Medicare eligibility and entitlement for Senior Prime enrollees.

3.2 New Claims Interfaces:

3.2.1 The MCSCs shall interface with the MPC to transmit UB 92 and *CMS* 1500 records.

3.2.2 The CEIS shall interface with the MPC to transmit *CMS* 1500 and UB 92 records as mutually agreed upon by DoD and *CMS*.

3.2.3 The MPC shall interface with the *CMS* for required encounter data.

4. SECURITY AND PRIVACY REQUIREMENTS

4.1 See [ADP Manual, Chapter 1, Section 1](#).

FIGURE 23-5-5 DATA FLOW CHARTS

1.0. TRICARE SENIOR OPTION - ENROLLMENT DATA FLOW

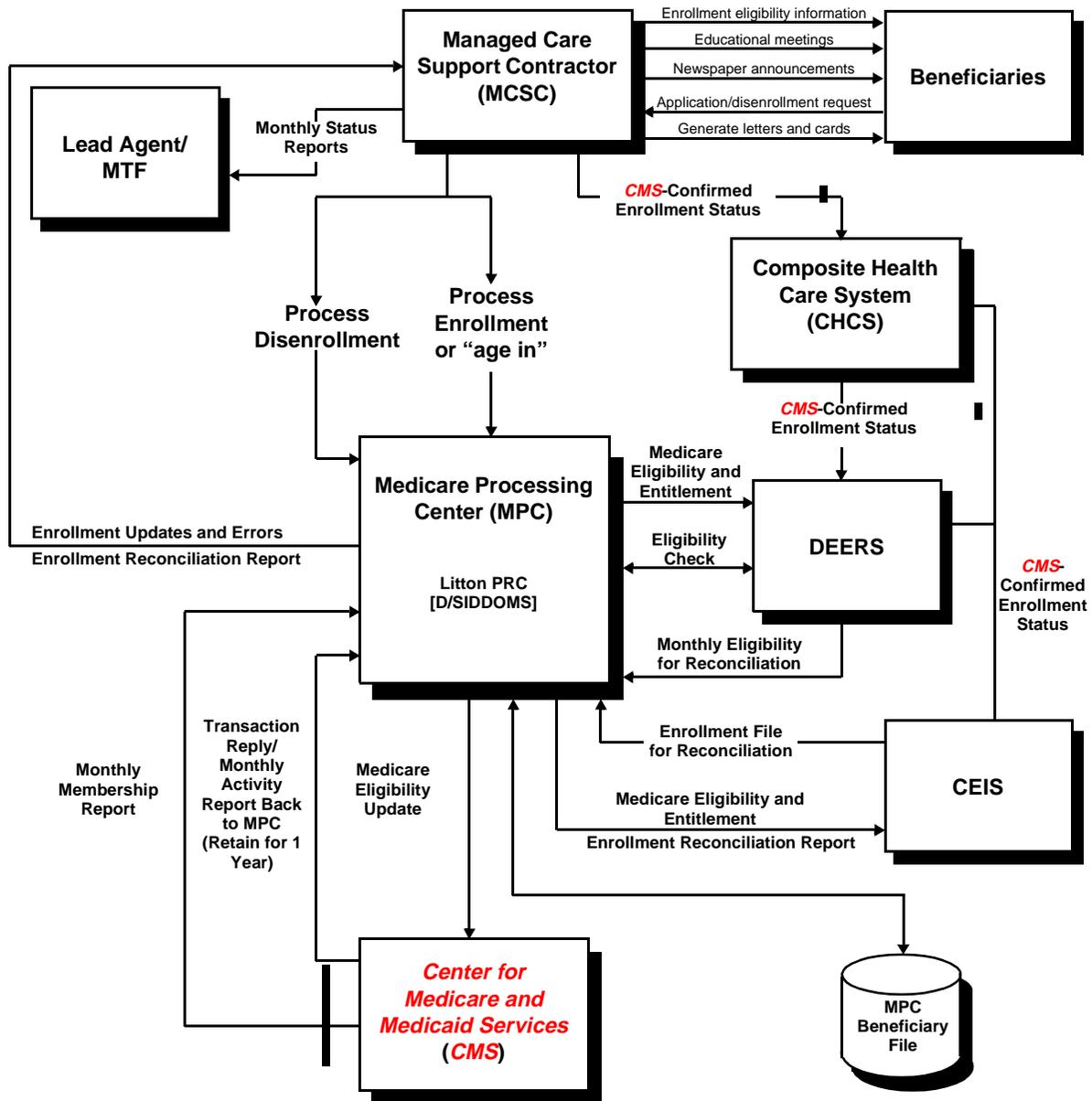


FIGURE 23-5-5 DATA FLOW CHARTS (CONTINUED)

2.0. TRICARE SENIOR OPTION - CLAIMS/CLINICAL DATA FLOW

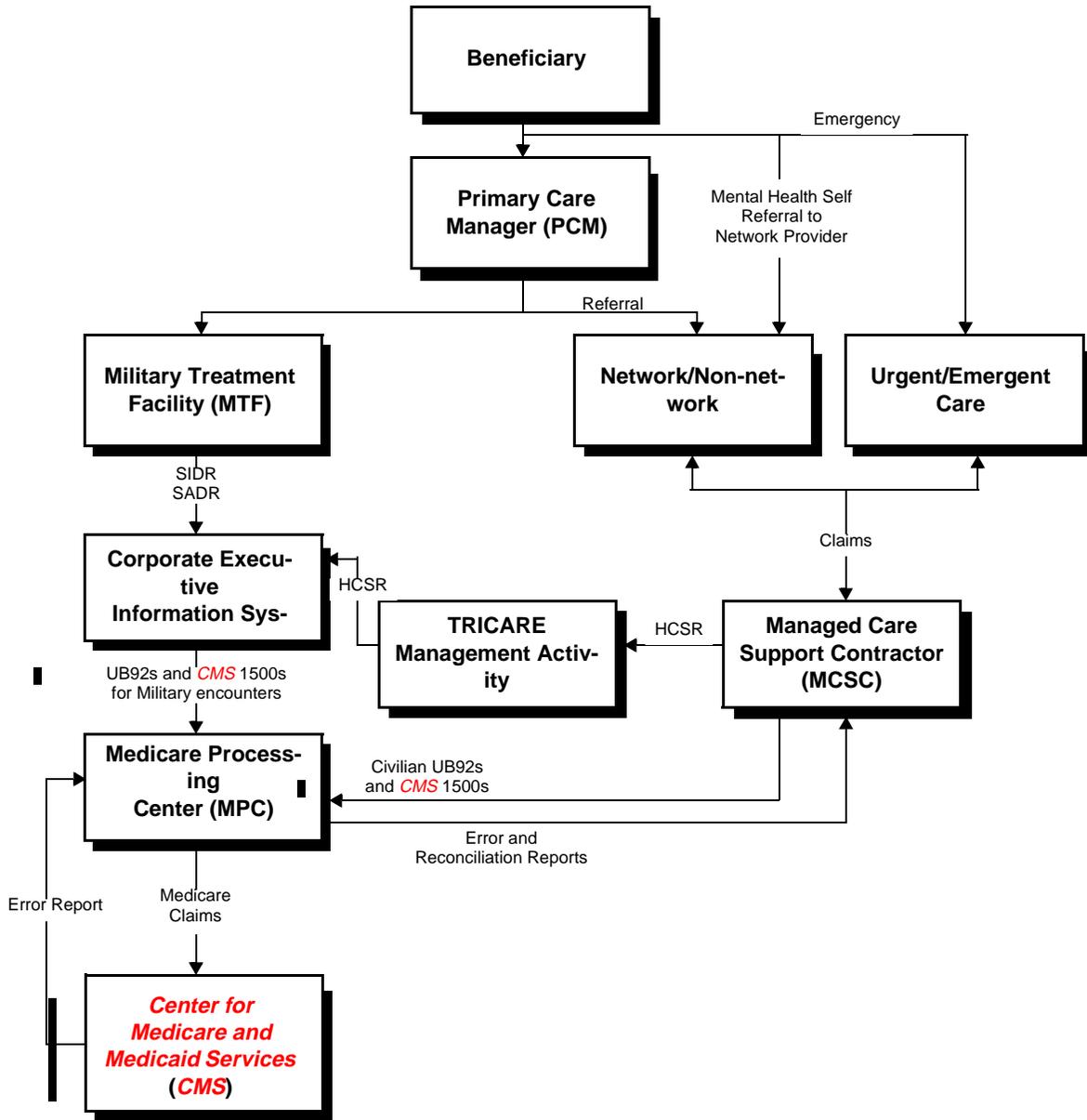


FIGURE 23-5-6 DISENROLLMENT

INVOLUNTARY DISENROLLMENT

In all cases of involuntary disenrollment, the enrollee has twenty-nine (29) days from the date of receipt to respond to the Notice of Intent to be Involuntarily Disenrolled. Medicare permits involuntary disenrollment of an enrollee in an M+C Organization following appropriate due process. Under the TRICARE Senior Prime program, the MTF Commander may apply the Medicare procedures for involuntary disenrollment. The MTF Commander may not propose to terminate an enrollee based upon his/her utilization of services or mental illness unless it has a direct effect upon the ability to deliver services. The MTF Commander may not initiate disenrollment because the beneficiary exercises his/her option to make treatment decisions with which the MTF disagrees; e.g., refuses aggressive treatment for cancer.

A beneficiary may be involuntarily disenrolled for the following reasons:

1. Enrollee moves out of the M+C Organization's geographic area. Upon direction of the MTF Commander/Lead Agent, the M+C Organization will disenroll a Medicare enrollee who moves out of its geographic area and does not voluntarily disenroll if the M+C Organization establishes, on the basis of a written statement from the enrollee or other evidence acceptable to **CMS**, that the enrollee has permanently moved out of its geographic area. Upon approval of the MTF Commander, the contractor must give the beneficiary a written notice of termination of enrollment. The notice must be mailed to the enrollee prior to the submission of the disenrollment notice to **CMS**. The notice to the beneficiary must include an explanation of the enrollee's right to have the disenrollment heard under the grievance procedures established under **CMS** regulations 42 CFR 417.436.
2. Enrollee commits fraud or permits abuse of M+C Organization enrollment card. A Medicare beneficiary may be disenrolled by the M+C Organization if the beneficiary knowingly provides, on the application form, fraudulent information upon which an M+C Organization relies and which materially affects his or her eligibility to enroll in the M+C Organization, or if the beneficiary intentionally permits others to use his or her enrollment card to receive services from the M+C Organization. In either case, the M+C Organization must give the beneficiary a written notice of termination of enrollment. The notice must be mailed to the enrollee prior to the submission of the disenrollment notice to **CMS**. The notice must include an explanation of the enrollee's right to have the disenrollment heard under the grievance procedures established under **CMS** regulations 42 CFR 417.564.
3. Enrollee's entitlement to benefits under the supplementary medical insurance program ends. **CMS's** liability for monthly capitation payments to the M+C Organization on behalf of the beneficiary ends with the month immediately following the last month of entitlement to benefits under Part B of Medicare.
 - a. The M+C Organization must provide the enrollee a written notice of disenrollment if the individual loses entitlement to Part A or Part B benefits. **CMS** will notify the M+C Organization that the disenrollment is effective the first day of the calendar month following the last month of entitlement to Part A or Part B benefits. (422.74)
4. Disenrollment for cause. An M+C Organization may disenroll a Medicare enrollee for cause if the enrollee's behavior is disruptive, unruly, abusive, or uncooperative to the extent that his or her continuing enrollment in the M+C Organization seriously impairs the M+C Organization's ability to furnish services to either the particular enrollee or other enrollees.

FIGURE 23-5-6 DISENROLLMENT (CONTINUED)

- a. Effort to resolve the problem. The M+C Organization must make a serious effort to resolve the problem presented by the enrollee, including the use (or attempted use) of internal grievance procedures.
- b. Consideration of extenuating circumstances. The M+C Organization must ascertain that the enrollee's behavior is not related to the use of medical services or due to diminished mental capacity.
- c. Documentation. The M+C Organization must document the enrollee's behavior, its efforts to resolve problems and any extenuating circumstances. (422.74(d)(2))
- d. **CMS** decides based on a review of the documentation submitted by the M+C Organization, whether disenrollment requirements have been met. **CMS** makes this decision within 20 working days of receipt of the documentation material, and notifies the M+C Organization within 5 working days after making its decision.
- e. Effective date of disenrollment. If **CMS** permits an M+C Organization to disenroll an enrollee for disruptive behavior, the disenrollment takes effect on the first day of the calendar month after the month in which the M+C Organization complies with the notice requirements. (422.74(c))

Before beginning the disenrollment for cause process, the MTF Commander will make a serious effort to resolve the problem presented by the enrollee and inform the enrollee that his/her continued behavior may result in termination of membership in TRICARE Senior Prime. If the problem cannot be resolved, the MTF Commander will give the member written notice of intent to request disenrollment for cause. In this notice, the MTF Commander will include an explanation of the enrollee's rights to a hearing under the organization's grievance procedures.

PROPOSED DISENROLLMENT NOTICE

Once the grievance process has been completed or the member has chosen not to use this process, the MTF Commander will provide documentation to **CMS** for involuntary disenrollment of the enrollee. Documentation will include:

- (1) The reason that the MTF is requesting disenrollment for cause.
- (2) A summary of efforts to explain the issues to the enrollee and the other types of options presented before disenrollment was considered.
- (3) A description of the enrollee's age, diagnosis, mental status, functional status, and social support system; and
- (4) Separate statements from primary providers describing their experience with the enrollee.

VOLUNTARY DISENROLLMENT

A Medicare enrollee may disenroll by giving the M+C Organization a signed, dated request in the form and manner prescribed by the M+C Organization. All complete disenrollment requests received on or before the tenth (10th) day of the month are effective the first day of the first calendar month following the date the election is received, and all complete disenrollment requests received after the tenth (10th) day of each month are effective the first day of the second calendar month after the request has been received.

FIGURE 23-5-6 DISENROLLMENT (CONTINUED)

The contractor shall acknowledge receipt of the disenrollment request and provide the enrollee with a copy of the written request for disenrollment. The contractor must also provide a written statement explaining that the enrollee remains enrolled in the M+C Organization until the effective date of the disenrollment. All health care must be arranged and authorized through TSP up until the effective date of disenrollment. Neither TSP nor **CMS** will pay for services not arranged for by TSP.

Within two (2) working days of receipt of the request, the contractor shall update the MPC system. The MPC submits to **CMS** on a weekly basis any new enrollment/disenrollment requests. The entire disenrollment process, starting with the contractor's receipt of the completed disenrollment form through the submission of the disenrollment notice to **CMS** by the MPC, must be completed within fifteen (15) days.

Upon notification of the **CMS** disenrollment acceptance by the MPC, the contractor shall update designated systems (CHCS/MCP, DEERS, internal systems).

If a request for a specific disenrollment date is received, but the disenrollment date requested is outside the timeframes (as described above), return the request to the beneficiary and indicate the span of dates in which the request should be submitted. For example: If an enrollee submitted a request for disenrollment on May 1 and wanted an effective disenrollment date of August 1, return the request and instruct the enrollee to resubmit their request for disenrollment between June 11 and July 10.

Exceptions to the rule:

Disenrollment requests received between November 1 and November 10 are usually effective December 1. However, since the month of November is also the Annual Election Period for many Managed Care Plans, enrollees may ask for a January 1 effective date.

Requests for retroactive disenrollment:

Requests for retroactive disenrollment are processed by the **CMS** regional offices or their designee.

Disenrollment requests must include the enrollee's:

- name,
- address,
- telephone number,
- sex,
- date of birth,
- Medicare #,
- signature or signature of the enrollee's representative

NOTE: If a representative's signature is provided in the absence of the enrollee's signature, proof of representative status must also be provided.

FIGURE 23-5-7 MANUAL MANIPULATION OF THE SPINE - MEDICARE COVERAGE**Operational Policy Question:**

Which practitioners are authorized by law to perform manual manipulation of the spine as a Medicare covered service?

Answer:

Section 1861(r) of the Social Security Act provides the definition of a physician for Medicare coverage purposes, which includes a chiropractor for treatment of manual manipulation of the spine to correct a subluxation demonstrated by x-ray. The statute specifically references manual manipulation of the spine to correct a subluxation demonstrated by x-ray as a physician service. Thus, managed care plans may use physicians to perform this service.

Managed care plans contracting with Medicare are not required, however, to offer services of chiropractors, but may use other physicians to perform this service. In addition, managed care plans may offer manual manipulation of the spine as performed by non-physician practitioners, such as physical therapists, if allowed under applicable state law.

Please also note that section 2153.1 of the Medicare HMO/CMP manual states that marketing materials of managed care plans must clearly state which physician specialties are authorized by the plan to provide manual manipulation of the spine.

FIGURE 23-5-8 M+C ORGANIZATION 2104. EMERGENCY SERVICES

Assure that medically necessary emergency care is available 24 hours a day, seven days a week. Beneficiaries are not required to receive emergency services at your plan facilities nor are they required to secure prior approval for emergency services provided inside or outside your geographic area. Provide a system to pay claims for emergency services provided out-of-plan and pay for all emergency services provided out-of-plan. (See 2107 for the permissible limits on the amount you must pay.)

2104.1 Definition.--Use the definition provided in 42 CFR 422.2. Specifically, "emergency services" mean covered inpatient and outpatient services that are:

- Furnished by a provider qualified to furnish emergency services; and
- Needed to evaluate or stabilize an emergency medical condition,

EXAMPLE: While visiting her son, a 70 year old woman with a history of cardiac arrhythmias experiences a rapid onset of chest pain, nonproductive hacky cough, and generalized tired feeling. The son calls his own physician, who recommends he bring his mother in to see him right away. After the physician evaluates the patient, the physician diagnosis is a common cold, and he prescribes two over-the-counter medications for treatment.

In this case, the M+C Organization is required to pay for the physician's services because the enrollee's medical condition appeared to require immediate medical services.

There does not need to be a threat to a patient's life. An emergency is determined at the time a service is delivered. Do not require prior authorization. You may request notification within 48 hours of an emergency admission or as soon thereafter as medically reasonable. However, payment may not be denied if notification is not received.

If it is clearly a case of routine illness where the patient's medical condition never was, or never appeared to be, an emergency as defined above, then you are not responsible for payment of claims for the services. Do not retroactively deny a claim because a condition, which appeared to be an emergency, turns out to be non-emergency in nature.

All procedures performed during evaluation and treatment of an emergency condition related to the care of that condition must be covered. An example is a member who is treated in an emergency room for chest pain and the attending physician orders diagnostic pulmonary angiography as part of the evaluation. Upon retrospective review, you cannot decide that the angiography was unnecessary and refuse to cover this service.

If during treatment for an emergency situation, the enrollee receives care for an unrelated problem, you are not responsible for the care provided for this unrelated non-emergency problem. An example is a member who is treated for a fracture and the attending physician also treats a skin lesion. You are not responsible for any costs, such as a biopsy, associated with treatment of this unrelated non-emergency care.

After the emergency, pay the cost of medically necessary follow-up care. (See HMO Manual Section 2105.)

2104.2 Transfers.--If one of your Medicare enrollees receives emergency medical care in a non-plan hospital, you may wish to transfer the patient to your facility (or a facility that you designate) as soon as possible. Pay the transfer costs, such as an ambulance charge, if it is necessary.

FIGURE 23-5-8 M+C ORGANIZATION 2104. EMERGENCY SERVICES (CONTINUED)

Be aware that the transferring hospital is subject to statutory limitations on when, and how, the transfer may be made. Under Section 1876 of the Act, the hospital must first determine whether the patient's condition has stabilized within the meaning of the statute. In general, this means that within reasonable medical probability, no material deterioration of the condition is likely to result from, or occur during, the transfer.

If the patient's condition has not stabilized, the patient may only be transferred if the patient makes an informed, written request for transfer, or the attending physician or appropriate medical authority signs a certification that the risks of the transfer are outweighed by the medical benefits expected from transfer to another medical facility. If these conditions are met, then the transfer may be made, but only if it also meets the definition of an appropriate transfer. (See Section 1876(c)(2) of the Social Security Act.)

In general terms, an appropriate transfer is one in which:

- The transferring hospital:
 1. Provides medical treatment to minimize the risks to the individual,
 2. Forwards all relevant medical records, and
 3. Uses qualified personnel and transportation equipment for the transfer;
- The receiving facility:
 1. Has available space and qualified personnel, and
 2. Except for specialized facilities that under Section 1876(g) of the Act cannot refuse a transfer, agrees to accept the transfer and provide appropriate medical treatment; and
 3. The transfer meets any other requirements the Secretary may find necessary in the interest of health and safety of individuals.

If the transferring hospital fails to meet these requirements, it may lose its Medicare provider agreement or be subject to civil money penalties or a civil action for damages. Physicians involved in an improper transfer may also be subject to civil money penalties and may be excluded from participation in Medicare.

Provide assistance with the above requirements to facilitate an appropriate transfer to one of your facilities or a facility that you designate.

If there is a disagreement over the stability of the patient for transfer to another inpatient facility, the judgment of the attending physician at the transferring facility prevails and is binding on the M+C Organization.

HMO 2105. URGENTLY NEEDED SERVICES

Use the definition provided in 42 CFR 422.2. Specifically, urgently needed services are covered services provided when an enrollee is temporarily absent from the TSP service area (or, under unusual and extraordinary circumstances, provided when the enrollee is in the service area but the TSP provider network is temporarily unavailable or inaccessible) when such services are medically necessary and immediately required as a result of an unforeseen illness, injury or condition; and it was not reasonable given the circumstances to obtain the services through TSP.

FIGURE 23-5-8 M+C ORGANIZATION 2104. EMERGENCY SERVICES (CONTINUED)

Cover these services if:

- The enrollee is temporarily absent from your geographic area, and
- The receipt of health care services cannot be delayed until the enrollee returns to your organization's geographic area. The enrollee is not required to return to the service area because of the urgently needed services.

Urgently needed care pertains only to out-of-area care to treat an unforeseen condition. Prior authorization is not needed in seeking urgently needed services. Your marketing materials must clearly describe the concept of urgently needed services as well as include an explanation of the enrollee's rights in these situations.

EXAMPLE: A 72 year old man had a left femoral bypass graft six weeks ago. He goes on his previously scheduled vacation to his sister's house who lives out of the service area. While there, he begins to notice left leg numbness that is occurring with greater frequency and intensity and is not totally relieved by his medications. His sister takes him to see her physician.

Pay for the physician's services because the enrollee's medical condition appeared to be such that the provision of medical services could not be delayed until the enrollee returned to your service area.

Services that can be foreseen are not considered urgently needed services, and without a prior authorization the plan is not required to pay for these services. For example, you are not required to pay without prior authorization when a member who needs oxygen therapy travels outside your service area for a personal emergency or a vacation. Develop a clear policy on your responsibility and the beneficiary's financial responsibility in these situations. Consider making special arrangements with providers outside your service area or clearly discussing any restrictions on out-of-area coverage with Medicare beneficiaries at the time of application.

Marketing materials must clearly describe the limits of your out-of-area coverage. Assume responsibility for urgently needed services without regard to the length of absence from the geographic area, as long as the enrollee maintains membership in your plan. However, if the enrollee is absent for an extended period (beyond six consecutive months) and you have not been notified and have not arranged for membership to continue, you may assume that the move is a permanent move and begin procedures to disenroll the beneficiary. If you do not disenroll the beneficiary and you know that he/she is absent for up to six consecutive months, then you are liable for all services rendered, including routine care. (See HMO Manual Section 2001ff.)

Cover medically necessary follow-up care to emergency and urgent care situations if that care cannot be delayed without adverse medical effects.

FIGURE 23-5-9 M+C ORGANIZATION PEER REVIEW ORGANIZATION RELATIONSHIP

Assumption of Review: The PRO is to notify all M+C Organizations in its service area of its assumption of review. This notice is to be sent within five working days of the later of the effective date of its M+C Organization review contract or the date **CMS** notifies the PRO of the participation of a risk M+C Organization.

The PRO is to comply with all requirements concerning relationships with M+C Organizations, hospitals and other facilities and providers specified in regulation.

Memorandum of Understanding: Each PRO is to modify or execute **CMS** agreements (pertaining to review of risk M+C Organization care) acceptable to HCFA with the Medicare risk M+C Organizations in its area no later than 45 days after the later of its M+C Organization review contract effective date or **CMS** notification as specified above. The PRO is to notify its project officer if any M+C Organization fails to sign an MOU within 45 days.

The agreement is to identify appropriate contact persons for all required activities (i.e., certification of the list of users/nonusers, certification of the targeted review data, receiving medical records on a flow basis, etc.) and contain the following:

- The party responsible, i.e., the hospital or M+C Organization, for distributing the “Important Message” to enrollees;
- Notification procedures for when an M+C Organization clinic, or other provider, closes and reopens under a different provider name;
- The M+C Organization giving the PRO copies of all policies, protocols, specific to a potential quality concern or a specific area, lists of covered services, lists of participating providers, and quality assurance plans, and providing copies of updates to these on a quarterly basis;
- The selection of all required samples;
- M+C Organization’s responsibility to identify and provide ambulatory and other medical records pertaining to all risk M+C Organization care rendered through the termination date of the M+C Organization contract.
- The PRO’s right to request records for additional care outside of the standard review period whenever the PRO review suggests the need to investigate possible quality concerns.
- Timing and location of PRO review;
- Procedures for obtaining records or copies of records for review (e.g., photocopying) and the amount the PRO is to pay for photocopying and mailing records;
- Cooperation by the PRO with the M+C Organization and physicians/providers prior to issuing a final quality of care decision;
- Focused review requirements;
- Requirements for the M+C Organization to provide records, when necessary to the PRO.
- Provisions for the modification of the agreement by either of the parties and for notification to the **CMS** Regional Office of such modifications.

FIGURE 23-5-9 M+C ORGANIZATION PEER REVIEW ORGANIZATION RELATIONSHIP (CONTINUED)

Where a potential quality concern exists, the PRO is to provide the M+C Organization (and the provider or physician) with an opportunity to discuss the proposed decision. The PRO should specify in its agreement with the M+C Organization which M+C Organization parties are to have authority to discuss the proposed quality concerns.

The PRO is to be evaluated on its success coordinating and cooperating with the M+C Organization and related physicians/provides in order to assure or improve the quality of care provided the Medicare beneficiary.

FIGURE 23-5-10 APPEALS (THIS FIGURE HAS BEEN UPDATED TO REFLECT M+C REQUIREMENTS)**HMO 2402. WRITTEN EXPLANATION OF APPEALS PROCEDURES**

Inform all enrollees in writing of the appeals procedures. Provide members with written descriptions in the following situations:

- Every time a service or payment is denied (42 CFR 422.568(d)(3))
- At initial enrollment as part of the membership materials;
- Each year in the annual rights notice; and
- Upon request by the enrollee or his/her representative.

Clearly distinguish between grievance issues and appeal issues in all written explanations. Describe all steps of the Medicare appeals procedures, from the organization determination by the M+CO to the judicial review rights after exhaustion of administrative appeal rights. Include time limits, amount in controversy requirements and procedures for filing appeals.

In all adverse organization determination notices, include a description of the member's right to a reconsideration as well as a description of the rest of the appeal process. (42 CFR 422.568(d)(3))

HMO 2403. ORGANIZATION DETERMINATIONS

An organization determination is defined at 42 CFR 422.566(b) as any determination made by an M+C organization with respect to any of the following:

- Payment for emergency services, post stabilization care or urgently needed services;
- Payment for any other services furnished by a provider or supplier other than the organization that the enrollee believes are Medicare covered or should have been furnished, arranged for or reimbursed by the organization; or
- The organization's refusal to provide services the enrollee believes the organization is obligated to cover, and the enrollee has not obtained them elsewhere.
- Discontinuation of a service.

Issue a written notice for all adverse organization determinations. Resolve all disputes involving organization determinations through the appeal procedures.

2403.1 Time Limit for Issuing an Organization Determination Notice.--Issue organization determination notices for all "clean" claims within 30 calendar days of receiving the claim. A "clean" claim has no defect, impropriety or particular circumstance requiring special treatment preventing timely payment. Claims that lack any required documentation or authorization numbers are not considered clean.

For non-"clean" claims, issue an organization determination notice to the member within 60 calendar days of receiving the request for payment or services. Send organization determination notices for transferred claims to the member within 60 calendar days of the receipt of the claim from the carrier or intermediary. Do not delay the determination past 60 days, even to wait for medical records or additional information. Failure to issue a written notice within 60 days of your claim constitutes an adverse organization determination, which the member may appeal.

FIGURE 23-5-10 APPEALS (THIS FIGURE HAS BEEN UPDATED TO REFLECT M+C REQUIREMENTS) (CONTINUED)

The M+C organization must pay interest on clean claims that are not paid within 30 days in accordance with section 1816(c)(2)(B) and 1842(c)(2)(b). All other claims must be approved or denied within 60 calendar days from the date of the request.

2403.2 Required Organization Determination Notice.--Issue an organization determination notice when a member requests payment or services as described below:

1. **Reimbursement for Emergency or Urgently Needed Services.**--Issue an organization determination notice whenever a member requests reimbursement for emergency services or urgently needed out-of-area services.
2. **Reimbursement for Services Denied by the Plan that the Member Received Out-of-Plan.**--Issue an organization determination notice for health services received out-of-plan that the enrollee believes:
 - Are covered under Medicare; and
 - You should have furnished, arranged for, or reimbursed.
3. **Transferred Claims.**--Issue an organization determination notice on all claims transferred by carriers or intermediaries.
4. **Service Denials.**--Issue an organization determination notice if you refuse to provide services for which the enrollee believes you are responsible and the enrollee has not received the services out-of-plan. Make this written determination whenever any plan representative denies a service, whether it is a plan-contracted provider or a plan employee or official.
5. Advise physicians and other plan representatives that if they refuse to provide a service for a member, the member may appeal the decision. Educate plan physicians and representatives on beneficiary appeals rights, including how and when a member may file an appeal. If a physician denies an enrollee's request for a service, he/she should ask the enrollee if he/she would like to appeal. The plan must issue a written determination to the member whenever the member disagrees with the physician's decision or wants to appeal a service denial.
6. **Organization Determinations for Supplemental Benefits.**--The Medicare appeal procedures apply to services included in an optional supplemental benefit package, as well as all benefits offered in risk-based plans' basic Medicare package, whether these benefits are funded through Medicare payments or through member premiums. The appeal procedures also apply to Part A benefits (inpatient hospital and skilled nursing facility services) for which "Part B only" Medicare beneficiaries pay a premium.
7. **Organization Determination Concerning Enrollee Rights Regarding Medicare Covered Services You Have Furnished.**--Issue an organization determination notice when you deny rights claimed by an enrollee regarding Medicare covered services you furnished, if the denial produces a dispute with an identifiable dollar value.

FIGURE 23-5-10 APPEALS (THIS FIGURE HAS BEEN UPDATED TO REFLECT M+C REQUIREMENTS) (CONTINUED)

2403.3 Processing Guidelines for Organization Determinations with Incomplete Documentation.--If documentation of a request for service is incomplete, try to obtain all relevant documentation within the 14 day or 72 hour expedited deadline. You may extend the timeframe by up to 14 days if the enrollee requests the extension or if you justify a need for additional information and explain how the delay is in the interest of the enrollee, (e.g. diagnostic test). The extension is not permitted in order to obtain medical records from network providers. When waiting for medical records from a non-network provider the time doesn't begin until the records are received. Document the case file as to when the records were requested. If you cannot obtain relevant documentation before the deadline, make the best decision possible based on the available information. Do not automatically deny the claim due to lack of medical documentation. If the only information available is the beneficiary's description of the situation, base the decision on that description. If you receive further information after making your decision, you may reopen it as described in Section 2409.

2403.4 Notice of Organization Determination. 2403.4 is outdated and replaced here by 42 CFR 422.568.

(a) **Timeframes for requests for service.** When a party has made a request for a service, the M+C organization must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after the date the organization received the request for a standard organization determination. The M+C organization may extend the timeframe by up to 14 calendar days if the enrollee requests the extension or if the organization justified a need for additional information and how the delay is in the interest of the enrollee (for example, the receipt of additional medical evidence from noncontract providers may change an M+C organization's decision to deny). The M+C organization must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than upon expiration of the extension.

(b) **Timeframes for requests of payment.** The M+C organization must process requests for payment according to the "prompt payment" provisions set forth in Section 422.520.

(c) **Written notification for adverse organization denials.** If an M+C organization decides to deny service or payment in whole or part, it must give the enrollee written notice of the determination.

(d) **Content of the notice.** The notice of any denial under paragraph (c) of this section must

- (1) State the specific reasons for the denial in understandable language;
- (2) Inform the enrollee of his or her right to a reconsideration;
- (3) Describe both the standard and expedited reconsideration processes, including the enrollee's right to and conditions for obtaining an expedited reconsideration for service requests, and the rest of the appeal process; and
- (4) Comply with any other requirements specified by *CMS*

DO NOT USE-We have denied your out-of-plan service because it was not emergency care, out-of-area urgently needed care, or authorized by a plan representative.

FIGURE 23-5-10 APPEALS (THIS FIGURE HAS BEEN UPDATED TO REFLECT M+C REQUIREMENTS) (CONTINUED)

(e) **Effect of failure to provide timely notice.** If the M+C organization fails to provide the enrollee with timely notice of an organization determination as specified in this section, this failure itself constitutes an adverse organization determination and may be appealed.

2403.5 Effect of the Organization Determination.--The organization determination is final and binding on all parties unless it is reconsidered or revised under HMO Manual Section 2409.

HMO 2409. REOPENING DETERMINATIONS AND DECISIONS

The entity which makes an organization, reconsidered, or revised determination may reopen the determination.

Reopenings occur after a decision has been made, generally, to correct an error, in response to suspected fraud, or in response to the receipt of information not available or known to exist at the time the claim was initially processed. A reopening is not an appeal right. It is an administrative procedure under which the entity that made a determination re-examines that decision for a specific reason. The decision to reopen a case is at the discretion of the party who made the determination and is not appealable. Any party subject to a determination may request a reopening. The filing of a request for reopening does not relieve you from your obligation to make payment as described in or provide services as described in 42 CFR 422.618.

Typically, reopenings are only requested after the exhaustion of appeal rights. A party may request a reopening even if it still has appeal rights, as long as the guidelines for reopenings are met. For example, if a beneficiary receives an adverse reconsideration determination, but later obtains relevant medical records, he or she may request a reopening rather than a hearing before an ALJ. However, if the beneficiary did not have additional information and just disagreed with the reasoning of the decision, he or she must file for the appeal.

If a party requests a reopening while it still has appeal rights, it also files for the appeal and asks for a continuance until the reopening is decided. If the reopening is denied or the original determination is not revised, the party retains its appeal rights.

2409.1 Guidelines for Reopenings.--Do not reopen a decision unless the request follows these guidelines. Also, follow these guidelines when you are requesting the reopening

- Make the request in writing;
- State the purpose for the reopening. Make clear that you are requesting a reopening. Do not request a reconsideration. M+C Organizations/CMPs do not have a right to reconsideration;
- Do not submit a statement of dissatisfaction. It is not grounds to grant a reopening; and
- Make the request within the time frames permitted by HMO Manual Section 2409.2.

2409.2 Time Limits for Reopenings.--Reopenings must be filed:

1. Within 12 months from the date of the notice of the organization or reconsideration determination, at the discretion of the party who made the determination;

FIGURE 23-5-10 APPEALS (THIS FIGURE HAS BEEN UPDATED TO REFLECT M+C REQUIREMENTS) (CONTINUED)

2. After such 12-month period, but within 4 years after the date of the notice of the organization determination, if there is good cause for reopening the determination or decision; or

At any time to correct a clerical error or an error on the face of the evidence which affects the determination or decision; or When fraud or similar fault affected the determination or decision.

2409.3 Good Cause for Reopening.--Good cause exists where:

- There is new and material evidence, not readily available at the time of the determination, and consideration of this material may result in a different conclusion,
- There is an error on the face of the evidence which affects the determination or decision; or,
- There is a clerical error in the claim file.

2409.4 Definitions--

Meaning of New and Material Evidence.--New and Material Evidence is evidence not considered when making the previous decision. This evidence must show facts not available previously and possibly result in a different decision. The submittal of any additional evidence is not a basis for reopening. New information also includes an interpretation of existing information (e.g., a different interpretation of a benefit).

Meaning of Clerical Error.--A clerical error includes such human and mechanical errors as mathematics or computational mistakes, inaccurate coding, or computer errors.

Meaning of Error on Face of the Evidence.--An error on the face of evidence exists if the determination or decision is clearly incorrect based on all the evidence present in the appeal file, the SSA files, or **CMS** files at the time of determination.

The CHDR Medicare Managed Care Reconsideration Process Manual and revised forms are available on the Center for Health Dispute Resolutions Website which is:

www.healthappeal.com

FIGURE 23-5-10 APPEALS (THIS FIGURE HAS BEEN UPDATED TO REFLECT M+C REQUIREMENTS) (CONTINUED)

**IMPLEMENTATION OF THE EXPEDITED APPEAL REGULATION (REVISED TO REFLECT M+C REQUIREMENTS)
PROGRAM MEMORANDUM**

NOTE TO: All Medicare+Choice Organizations (M+C Organizations),
Competitive Medical Plans (CMPs), and Health Care Prepayment Plans
(HCPPs)

SUBJECT: Implementation of the Expedited Appeal Regulation

A final rule with comment, “Establishment of an Expedited Review Process for Medicare Beneficiaries Enrolled in M+C organizations, CMPs and HCPPs” was published on April 30 in the Federal Register. Medicare contracting M+COs must be in compliance with all requirements of this final rule beginning August 28, 1997.

On June 18, we issued a Program Memorandum to all Medicare contracting M+COs that included a copy of the final rule, informed them of the compliance date, and provided model appeal language. This Program Memorandum provides the following information:

1. Model Language for Expedited Organization Determinations (Attachment A)
2. Flow Charts: Expedited Organization Determination Process and Expedited Appeal Process (Attachment B)
3. Comparison of Standard and Expedited Appeal Processes (Attachment C)
4. Qs and As (Attachment D)
5. Model Appeal Language: Member Materials, Denial Notices, and Notices of Discharge and Medicare Appeal Rights (NODMAR) (Attachment E1)
6. Model Appeal Language for Claim Denials (Attachment E2)

FIGURE 23-5-10 APPEALS (THIS FIGURE HAS BEEN UPDATED TO REFLECT M+C REQUIREMENTS) (CONTINUED)

Attachment E1 and E2 replace the Model Appeal Language provided as Attachment A of the June 18 Program Memorandum.

All Medicare contracting M+COs will be required to report information to the *Center for Medicare and Medicaid Services (CMS)* on all requests for expedited appeals. We are working with The American Association of Health Plans, M+C organizations, and The Center for Health Dispute Resolution (The Center) to develop a standard format for collecting this information.

Inform Medicare Enrollees Of Their Right To Expedited Reviews

You must notify all Medicare beneficiaries enrolled in your M+CO of the expedited 72-hour organization determination and appeal processes and clarify that terminations of health care services are organization determinations which may be appealed. You may notify enrollees through a special letter, an article/insert in a newsletter, or other M+COs publication directed to the Medicare enrollee. Medicare enrollees must receive this notification prior to August 28.

Allow 10 mailing days. As always, your *CMS* regional office (RO) must approve all materials sent to Medicare enrollees.

Use Of Model Appeal Language In All Member Materials

You must modify all member materials (member handbooks, evidence of coverage, denial notices and NODMAR) that describe appeal rights. Use of the attached model language will hasten approval through the *CMS* ROs. We have revised the Model Appeal Language provided in the June 18 Program Memorandum to reflect comments received. (See Attachments E1 and E2.) The primary change is the creation of separate Model Appeal Language for claim denial notices. Additional minor changes were made to improve the flow of the text. Through December 31, Medicare contracting M+COs may use an addendum to inform enrollees of their right to an expedited organization determination and expedited appeal. Beginning January 1, 1998, all M+CO documents which describe member rights must incorporate approved language which describes the expedited organization determination process as well as the expedited appeal process.

The June 18 Program Memorandum did not include language for an expedited organization determination. The Model Expedited Organization Determination Language is provided in Attachment A for use in member materials such as the member handbook and evidence of coverage.

FIGURE 23-5-10 APPEALS (THIS FIGURE HAS BEEN UPDATED TO REFLECT M+C REQUIREMENTS) (CONTINUED)

Process For Expedited Review

Member Requests

A Medicare enrollee or his/her representative may request, either orally or in writing, an expedited organization determination and/or expedited appeal if the enrollee or his/her representative believes the enrollee's health, life, or ability to regain maximum function may be jeopardized by the standard 14-day organization determination process and/or the standard 30-day appeal process.

You cannot require that an enrollee obtain a physician's statement of support for the expedited request. You are responsible for deciding whether the request for an expedited organization determination and/or expedited appeal meets the criteria.

Physician Requests

Any physician may request or provide oral or written support for an enrollee's request for an expedited organization determination and/or appeal. All physician requests (non-plan physicians as well as plan physicians) and enrollee requests with physician support must be expedited. The physician should be clear that he/she believes the situation is time sensitive and/or the review should be conducted within 72 hours or less as medically necessary or appropriate.

If a physician (whether plan or non-plan) is supporting a member's request for expedited determination or appeal, a waiver of payment or appointment of representative form is not required. M+COs may not delay the proceeding to obtain this documentation. A waiver of the provider's right to collect payment from the beneficiary remains required in a retrospective case if a non-plan provider is the appealing party. Non-plan providers do not have appeal rights on their own behalf for preservice cases. However, a beneficiary may appoint anyone, including a non-plan provider, to be his/her representative.

Process For Receiving Requests

You are required to develop a meaningful process for receiving requests for expedited reviews which may include designating an office or department, phone number for oral requests, and FAX machine number to facilitate beneficiary access and M+CO receipt of requests for expedited reviews (organization determinations and appeals). These procedures must be clearly explained in member materials including denial notices and NODMARs. (See the Model Appeal Language in Attachment E.) In addition, M+COs will be accountable for educating staff and provider networks to ensure that requests for expedited review received by medical groups or other M+CO offices are referred immediately to the designated M+CO office or department. The 72-hour period begins when the request is received by the designated office or department.

FIGURE 23-5-10 APPEALS (THIS FIGURE HAS BEEN UPDATED TO REFLECT M+C REQUIREMENTS) (CONTINUED)**Denied Requests**

When a request for expedited organization determination or expedited appeal is denied, you should automatically transfer it to the standard 14-day process for organization determination or 30 day appeal process (or such shorter period as required by state law or M+CO policy). Do not require the enrollee to file a written appeal. The standard time frame begins with the date the request for expedited review is received. When you deny a request for expedited review, you must orally notify the enrollee immediately and follow up with a written letter of explanation within two working days. Include in this letter an explanation that the enrollee's request will be processed within 14-days for organization determinations or 30 days for appeals and that if the enrollee disagrees with the decision to use the standard time frames, the enrollee may file a grievance with the M+CO. Provide instructions and the time frame for your grievance process.

If an enrollee orally requests a standard 30-day appeal, instruct him/her to file a written request and indicate where it should be sent. The standard 30-day appeal process requires that appeals be requested in writing. However, as noted above, if the enrollee requests an expedited 72-hour appeal and you deny the request, you cannot require the enrollee to file a written request before you process the appeal in the standard 30-day process. You are required to document oral requests for expedited appeals in writing.

Immediate PRO Review

The June 18 Program Memorandum indicated that the hospital NODMAR must include notification of the immediate PRO review right as well as notification of the standard and expedited appeal processes. Enrollees who are inpatients at a hospital must use the immediate PRO review process if they disagree with a decision to discharge, rather than the expedited appeal process, provided that they request the review by noon of the first working day following receipt of the NODMAR. Medicare law currently provides an immediate (three working days) PRO review of hospital discharges with financial protection for the beneficiary. If an enrollee misses the noon deadline for filing for immediate PRO review, the enrollee can still request an expedited appeal. Medicare contracting M+COs must not process any requests for expedited appeal when immediate PRO review is being conducted for hospital discharge. **You should revise your NODMAR to clearly explain these rights to enrollees.**

FIGURE 23-5-10 APPEALS (THIS FIGURE HAS BEEN UPDATED TO REFLECT M+C REQUIREMENTS) (CONTINUED)

Submittal Of Cases To The Center

The Center will issue revised forms and instructions for M+CO submittal of **CMS**-level reconsiderations. These revisions will address both expedited and standard reconsiderations. The new forms and instructions will be based upon, and will not substantially modify, the current instructions. The new instructions will modify case processing time frames as required by the regulations. The new forms will add those data elements necessary for monitoring M+CO compliance with expedited appeal processing. One (common) set of forms, based on the current forms, will be used for both types of appeals. The current requirements for the components of the case folder (e.g. medical records, plan contract language, chronologies, etc.) will remain and will apply to both expedited and standard appeals.

M+COs are expected to meet the regulation requirement to send expedited case files to The Center within 24 hours of the M+CO's completion of an expedited appeal. At this time, The Center does not plan to routinely staff on weekends, but will work with major delivery vendors to ensure safe and confirmed receipt of material.

Because of confidentiality and technical quality concerns, The Center is not permitted to accept case files by FAX. Hard copies of expedited cases should be sent to The Center by overnight delivery. The Center will modify the current (letter) process for acknowledgments of receipt of case files. The Center is considering a process whereby M+COs would notify The Center by FAX or E-mail of the impending submission of an expedited case, with The Center confirming receipt via the same media.

The Center's Additional Information Request Policy

For the past several years, The Center has frequently requested additional information from M+COs in order to reach an informed decision.

Effective August 28, in cases where The Center believes that additional information is necessary to reach an informed decision in a reconsideration case, The Center will request this information. M+COs should respond to The Center in accordance with the following timetable:

Expedited appeals	Within 3 days from date of request
Pre-service cases, not expedited	Within 10 days from the date of request
Retrospective cases	Within 15 days from the date of request

The Center reserves the right to deviate from (accelerate) these time frames for individual cases when such action is medically indicated. The Center will FAX all information requests to the M+COs.

FIGURE 23-5-10 APPEALS (THIS FIGURE HAS BEEN UPDATED TO REFLECT M+C REQUIREMENTS) (CONTINUED)

Extensions will not be granted. Second requests for information will no longer be made by The Center. M+COs are reminded that The Center is under no statutory or regulatory requirement to request additional information from the M+COs in any case. Accordingly, M+COs should make every attempt to submit original case files to The Center with complete information.

In the event that a M+CO does not respond to a request for additional information, The Center will decide the case based upon the information contained in the original case file. If the M+CO's documentation does not substantiate its denial of a claim, The Center will overturn the M+CO's denial.

M+COs that obtain additional pertinent information after submitting a case to The Center may, on their own initiative, submit this information within three days of receipt of the appeal case file by The Center. The Center is under no obligation to use this information. Use of the information will depend in part on its relevance to the subject of appeal and the review stage of the case at the time of receipt of the additional information by The Center.

Please direct any comments on submission of appeals case files or additional appeals case information to David Richardson, President, or Judy Feldt, Project Manager, The Center, on (716) 586-1770. If you have comments or questions on the implementation of the Expedited Appeal Regulation you may contact Rae Loen at (410) 786-1104, or by mail at the Center for Health Plans and Providers, Health Plan Purchasing & Administration Group, Division of Program Management & Field Liaison--Team B, S3-18-13, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Bruce Merlin Fried
Director
Center for Health Plans and Providers

Attachments

FIGURE 23-5-10 APPEALS (THIS FIGURE HAS BEEN UPDATED TO REFLECT M+C REQUIREMENTS) (CONTINUED)

ATTACHMENT A

Model Expedited Organization Determination Language for Member Materials

We normally have up to 14 days with an option of a 14 day extension to determine whether your request for a service is a medically appropriate and covered service. In some cases, you have a right to a decision within 72-hours of your request. You can get a fast decision if your health or ability to function could be seriously harmed by waiting 14 days for a standard decision. If you ask for a fast decision, we will decide whether you get a 72-hour/ fast decision. If not, your request for a service will be processed within 14 days with the option of a 14 day extension. If any doctor asks [M+C organization name] to give you a fast decision, we must give it to you.

14 - Day Extension

An extension up to 14 days is permitted beyond the 72-hour period, if the extension of time benefits you; for example, if you need time to provide [M+C organization name] with additional information or if we need to have additional diagnostic tests completed.

Oral and Written Requests

- You may file an oral or written request for a 72-hour decision. Specifically state that “I want an: expedited decision, fast decision or 72-hour decision.” or “I believe that my health could be seriously harmed by waiting 14 days for a standard decision.”
- To file a request orally, call [phone number]. [name of M+C organization] will document the oral request in writing.
- To hand deliver your request, our address is [specific M+C organization address].
- To FAX your request, our number is [FAX number]. If you are in a hospital or a nursing facility, you may request assistance in having your written request for a service transmitted to [name of M+C organization] by use of a FAX machine.
- To mail a written request, our mailing address is: [M+C organization/CMP Appeal Department address] however, the 72-hour review time will not begin until your request for appeal is received.

(M+C organizations with other options for accepting requests for expedited organization determinations should describe them here. For example this might include beneficiary requests for a service while in a physicians office. Also include information here on how the beneficiary may provide additional information.)

We will make a decision on your request for a service and notify you of our decision within 72-hours of receipt of your request.

FIGURE 23-5-10 APPEALS (THIS FIGURE HAS BEEN UPDATED TO REFLECT M+C REQUIREMENTS) (CONTINUED)**NOTE:**

(1) If state law or M+CO policies require the determination be made in fewer than 60 days, the shorter period should be reflected in the notice.

(2) If a medical group is issuing the notice, whenever reference is made to the M+C organization, reference to the medical group should be substituted.

(3) This model language may be used in member materials such as member handbooks and the evidence of coverage.

FIGURE 23-5-10 APPEALS (THIS FIGURE HAS BEEN UPDATED TO REFLECT M+C REQUIREMENTS) (CONTINUED)

ATTACHMENT B

Expedited Review Process
Organization Determination

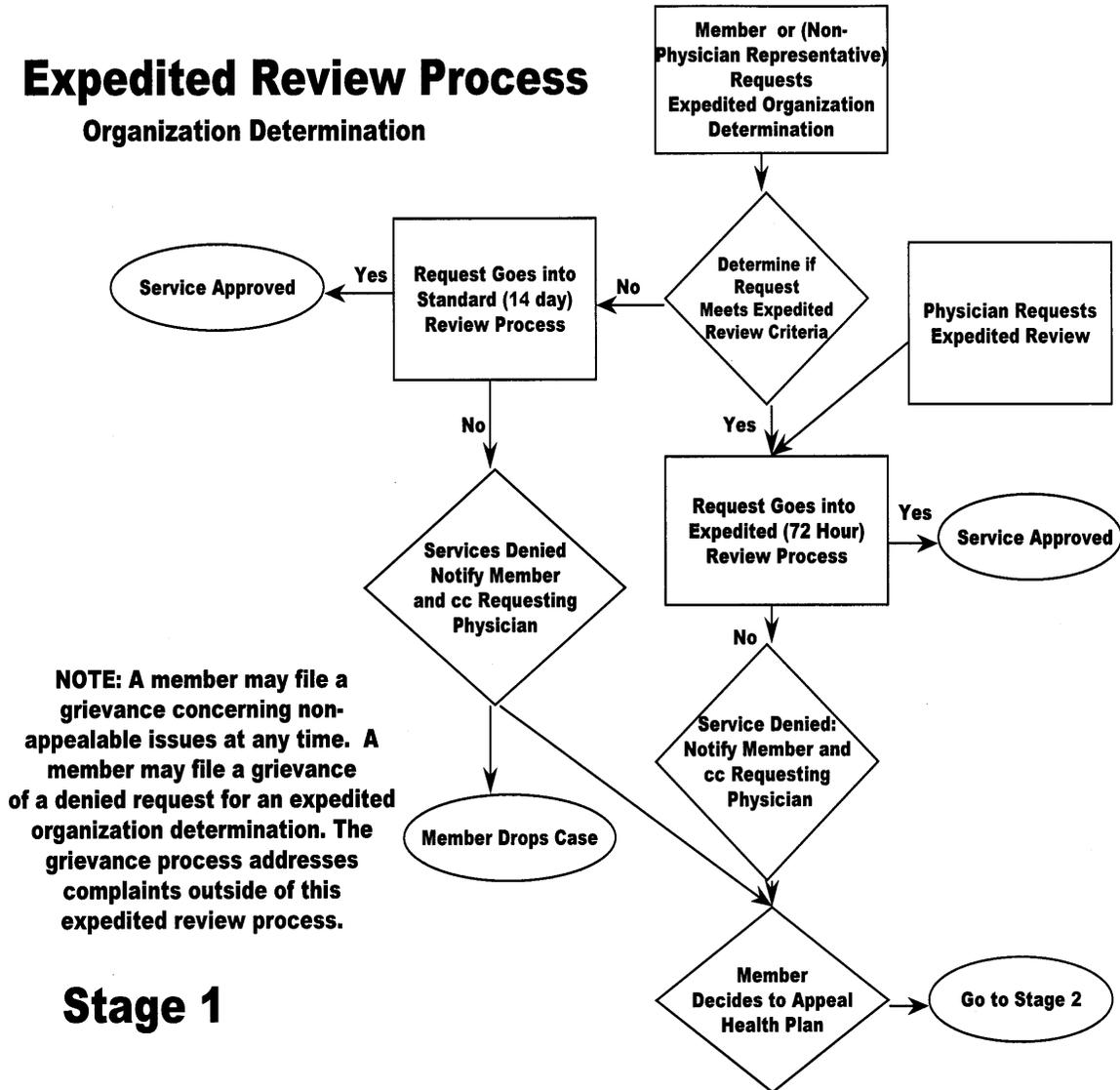


FIGURE 23-5-10 APPEALS (THIS FIGURE HAS BEEN UPDATED TO REFLECT M+C REQUIREMENTS) (CONTINUED)

ATTACHMENT B

Expedited Appeal Process

Reconsideration Decisions

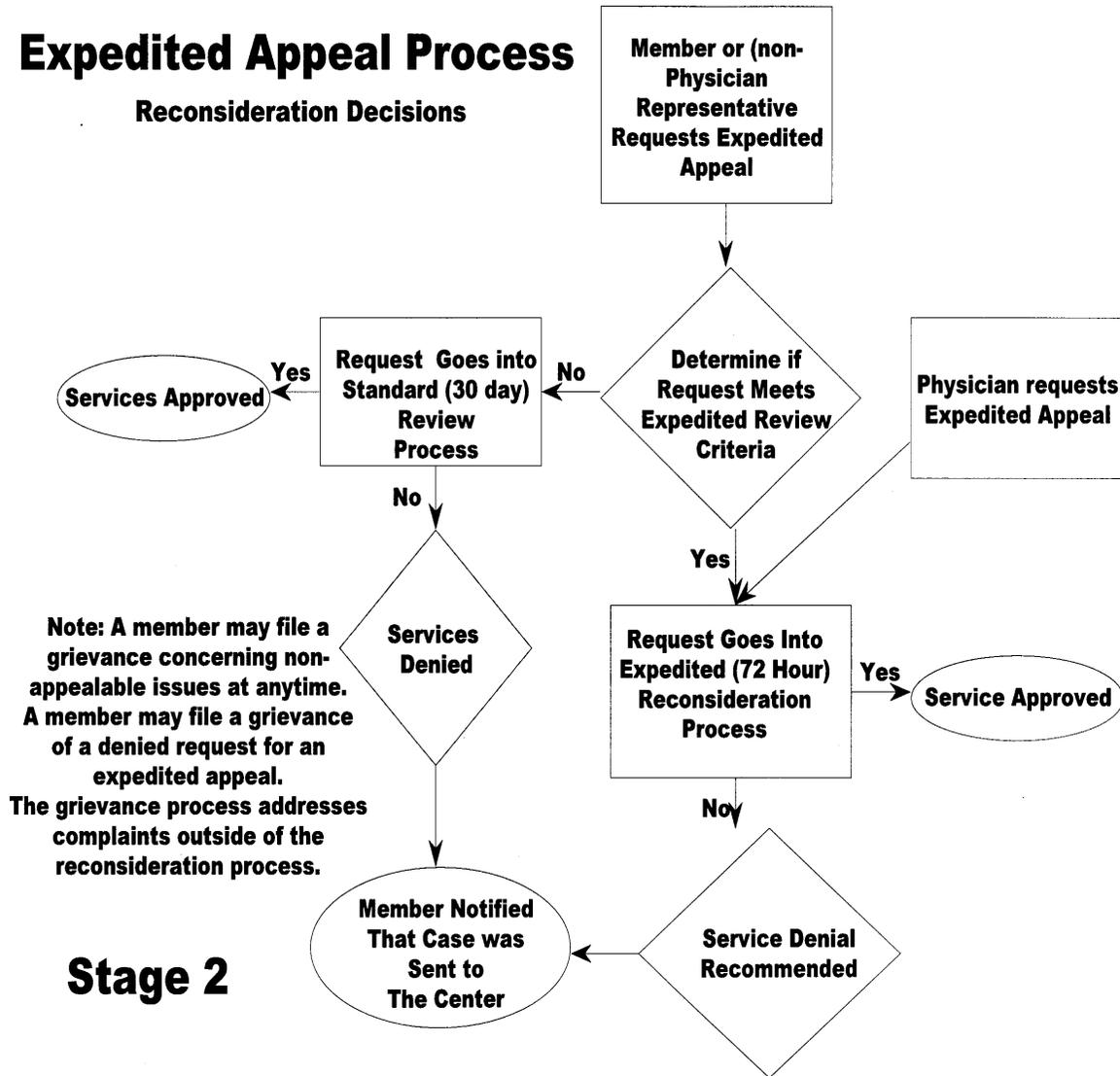


FIGURE 23-5-10 APPEALS (THIS FIGURE HAS BEEN UPDATED TO REFLECT M+C REQUIREMENTS)

ATTACHMENT C

A COMPARISON OF THE FEDERAL APPEAL PROCESSES FOR MEDICARE MANAGED CARE	
STANDARD 30 DAY APPEAL	EXPEDITED 72 HOUR APPEAL
<p><u>Organization Determinations for which the 30 day appeal is available:</u></p> <ol style="list-style-type: none"> 1. Payment for emergency or urgently needed services received 2. Any other health services furnished by a provider or supplier other than the M+CO that the enrollee believes: <ul style="list-style-type: none"> - are covered under Medicare; and - should have been furnished, arranged for, or reimbursed by the M+CO 3. The M+CO's refusal to provide services that the enrollee believes should be furnished or arranged for by the M+CO and the enrollee has not received the services outside the M+CO. 4. Decisions to discontinue services when the enrollee believes there is a continuing need for the service. <p><u>Notice of Adverse Organization Determination</u></p> <p>Must notify enrollee within 14 calendar days of receiving enrollee's request for services.</p> <ul style="list-style-type: none"> - must notify enrollee within 30 days (clean claim) of receiving request for payment - must inform enrollee within 60 days (unclean claim) of receiving an enrollee's request for payment. 	<p><u>Organization Determinations for which the 72-hour appeal is available:</u></p> <ol style="list-style-type: none"> 1. The M+CO's refusal to provide services that the enrollee believes should be furnished or arranged for by the M+CO and the enrollee has not received the services outside the M+CO 2. Decisions to discontinue services when the enrollee believes there is a continuing need for the service. <p><u>Notice of Adverse Organization Determination</u></p> <p>If the expedited review is granted, the M+COs must notify the enrollee within 72 hours of receiving the enrollee's request for services.</p> <ul style="list-style-type: none"> - state reasons for determination - inform enrollee of appeal rights <p>M+CO must grant all physician requests and enrollee requests with physician support for an expedited organization determination.</p> <p>In cases where M+CO must receive medical information from a non-affiliated physician or provider, the time standard begins with receipt of the information.</p>

FIGURE 23-5-10 APPEALS (THIS FIGURE HAS BEEN UPDATED TO REFLECT M+C REQUIREMENTS) (CONTINUED)

ATTACHMENT C

A COMPARISON OF THE FEDERAL APPEAL PROCESSES FOR MEDICARE MANAGED CARE	
STANDARD 30 DAY APPEAL	EXPEDITED 72 HOUR APPEAL
<p><u>Request for Reconsideration</u></p> <p>Requests for reconsideration must be made in writing and filed with the M+CO, SSA or in the case of TRICARE Senior Prime, with the MTF.</p> <p>Requests must be filed within 60 calendar days of the organization determination,</p> <ul style="list-style-type: none"> - exception for good cause <p><u>Opportunity to Submit Evidence</u></p> <p>M+C organization must provide the parties to the reconsideration reasonable opportunity to present evidence and allegations of fact or law related to the issue in dispute. Allow parties to present such evidence in person or in writing and take the evidence into account.</p>	<p><u>Request for Reconsideration</u></p> <p>Requests for expedited reconsideration may be made orally or in writing and filed with the M+C organization, per M+C organization instructions.</p> <p>M+C organization must document oral requests in writing.</p> <p>M+C organization determines if the standard 30 day process could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. Orally notify enrollee that his/her appeal will be processed within 30 days if his/her request is not expedited, and follow-up with a written notice within two working days.</p> <p>M+C organization must grant all physician requests and beneficiary requests with physician support for expedited reconsideration.</p> <p><u>Opportunity to Submit Evidence</u></p> <p>In the case of an expedited reconsideration, the opportunity to present evidence is limited by the short time frames for issuing decisions. M+COs must provide the parties to the reconsideration reasonable opportunity to present evidence and allegations of fact or law related to the issue in dispute. Allow parties to present such evidence in person or in writing and take the evidence into account. M+COs must inform enrollee or representative of the conditions for submitting evidence, in person, via telephone or in writing using FAX or electronic transfer of information.</p>

FIGURE 23-5-10 APPEALS (THIS FIGURE HAS BEEN UPDATED TO REFLECT M+C REQUIREMENTS) (CONTINUED)

ATTACHMENT C

A COMPARISON OF THE FEDERAL APPEAL PROCESSES FOR MEDICARE MANAGED CARE	
STANDARD 30 DAY APPEAL	EXPEDITED 72 HOUR APPEAL
<p>Responsibility for Reconsideration Time Limits</p> <p>a) If M+CO makes a fully favorable decision, issue the reconsideration decision within 30 calendar days from the date of receipt of the request for reconsideration or the expiration of an extension (up to 14 days).</p> <p>b) If M+C organization recommends partial or complete affirmation of its adverse determination - the M+C organization must prepare a written explanation and send the entire case to the CMS contractor within 30 calendar days of the receipt of the request for reconsideration. CMS (The Center) makes the reconsideration determination.</p> <p>For good cause, CMS may allow extensions to the time limit.</p> <p>Failure of the M+C organization to issue a reconsidered determination within the 30 calendar day limit constitutes an adverse determination and the file must be submitted to the HCF. (The Center).</p> <p>M+C organization must concurrently notify beneficiary that his or her case has been forwarded to CMS.</p>	<p>Responsibility for Reconsideration Time Limits</p> <p>a) If M+CO makes a fully favorable decision, issue the reconsideration decision within 72 hours from the date of receipt of the request for reconsideration or expiration of the extension (up to 14 days).</p> <ul style="list-style-type: none"> - an extension of up to 14 days is permitted if the enrollee requests it or if the M+CO finds that additional information is necessary and the delay is in the interest of the enrollee. - if initial notification is given orally, written confirmation must be mailed within two working days. - for cases where the M+CO must receive medical information from a non-affiliated physician or provider, the time standard begins with receipt of the information. <p>b) If M+C organization recommends partial or complete affirmation of its adverse determination - the M+C organization must prepare a written explanation and send the entire case to the CMS contractor within 24 hours of its determination, the expiration of the 72 hour review period or the expiration of an extension.</p> <p>For good cause, CMS may allow extensions to the time limit.</p> <p>Failure of the M+CO to issue a reconsidered determination within the 72 hour limit or expiration of an extension constitutes an adverse determination and the file must be submitted to the CMS contractor.</p> <p>M+C organization must concurrently notify beneficiary that his or her case has been forwarded to CMS.</p>

FIGURE 23-5-10 APPEALS (THIS FIGURE HAS BEEN UPDATED TO REFLECT M+C REQUIREMENTS) (CONTINUED)

ATTACHMENT C

A COMPARISON OF THE FEDERAL APPEAL PROCESSES FOR MEDICARE MANAGED CARE	
STANDARD 30 DAY APPEAL	EXPEDITED 72 HOUR APPEAL
<p><u>CMS Reconsideration Time Limits</u></p> <p>The CMS contractor, The Center for Health Dispute Resolution (The Center) decides cases within 30 working days. Beginning August 28, 1997:</p> <ol style="list-style-type: none"> 1. M+COs will have up to 10 days from the date of The Center’s request to submit additional information for preservice cases which are not expedited and; 2. M+COs will have up to 15 days from The Center’s request to submit additional information for retrospective cases. 	<p><u>CMS Reconsideration Time Limits</u></p> <p>The CMS contractor, The Center for Health Dispute Resolution (The Center) will decide expedited appeals within 10 working days. Beginning August 28, 1997 M+COs will have up to three days from the date of The Center’s request to submit additional information.</p>

FIGURE 23-5-10 APPEALS (THIS FIGURE HAS BEEN UPDATED TO REFLECT M+C REQUIREMENTS)

ATTACHMENT D

Questions and Answers for M+COs Regarding:

The Final Rule With Comment titled:

The Medicare Program: Establishment of an Expedited Review Process for Medicare Beneficiaries Enrolled in M+C organizations, CMPs and HCPPs

1. By what date must M+COs be in compliance with the new expedited review processes?

August 28, 1997.

2. When and how must we inform enrollees of their expedited review rights?

In order to comply with the new regulations M+COs must notify Medicare enrollees of the expedited/72-hour organization determination and appeal processes prior to August 28. You may notify enrollees through a special letter, an article/insert in a news letter or other M+CO publication directed to the Medicare enrollee. **In addition, M+CO documents (such as Evidence of Coverage, Member Handbook, etc.) that provide Medicare beneficiaries with information about their appeal rights must be amended.** Until December 31 or until the next printing--whichever comes first--the current description of appeal rights must be amended by an insert which describes the expedited process for organization determinations and appeals. Beginning January 1, 1998, all M+CO documents must incorporate approved language which describes the expedited organization determination process as well as the expedited reconsideration process. All Notices of Discharge and Medicare Appeal Rights (NODMAR) and all denial notices must be revised **by August 28.**

3. Is Model Appeal language available?

Yes. In order to hasten approval of new M+C organization appeals language through the **CMS** Regional Office and state authorities, we provided Model Appeal Language in the June 18, 1997 Program Memorandum. This language has been revised and is replaced by the separate Model Appeal Language for Claim Denials and Service Denials provided in the July 1997 Program Memorandum. Use of this language will facilitate approval by early August and thus meet **CMS** requirements for having this information in place.

4. Will **CMS provide training for M+CO staff?**

Yes, **CMS** plans to hold training sessions in various parts of the country. These sessions are in San Francisco on August 21, Chicago on August 25, and New York in September (date to be determined).

FIGURE 23-5-10 APPEALS (THIS FIGURE HAS BEEN UPDATED TO REFLECT M+C REQUIREMENTS) (CONTINUED)**5. Who can request an appeal (Standard 30 or Expedited 72-hour)?**

1. An enrollee may file an appeal.
2. If an enrollee wants someone to file the appeal for him or her:
 - a. The enrollee should provide his/her name, Medicare number, and a statement which appoints an individual as his/her representative. (Note: The enrollee may appoint any provider.)

For example: "I [enrollee] appoint [name of representative] to act as my representative in requesting an appeal from [name of M+C organization] and/or the *Center for Medicare and Medicaid Services* regarding [name of M+C organization's (denial of services) or (denial of payment for services)].

NOTE: Denial of payment for services may only be appealed under the Standard 60 day appeal process.

- b. The enrollee must sign and date the statement.
 - c. The enrollee's representative must also sign and date this statement unless he/she is an attorney.
 - d. The enrollee must include this signed statement with his/her appeal.
3. A non-plan provider may file a standard appeal for a denied claim if he/she completes a waiver of beneficiary payment statement which says he/she will not bill the enrollee regardless of the outcome of the appeal.
4. A court appointed guardian or an agent under a health care proxy to the extent provided under state law may file a standard or expedited appeal.

6. What other authority does a representative of a beneficiary have?

On behalf of a beneficiary, a representative may:

- (1) Obtain information about the beneficiary's claim to the same extent that the beneficiary is able to.
- (2) Submit evidence;
- (3) Make statements about facts and law; and
- (4) Make any request or give any notice about the proceedings.

7. Does the expedited appeal regulation extend appeal rights to plan physicians and providers?

No. However, plan physicians and providers may be appointed representatives by beneficiaries or may provide statements in support of a beneficiary's request for an expedited appeal.

FIGURE 23-5-10 APPEALS (THIS FIGURE HAS BEEN UPDATED TO REFLECT M+C REQUIREMENTS) (CONTINUED)

8. Does the expedited appeal regulation change the requirement that requests for standard 30 day appeals be filed in writing?

No. Requests for standard 30-day appeals must be filed in writing. If an enrollee orally requests a standard 30-day appeal, instruct him/her to file a written request and indicate where it should be sent. The standard 30-day appeal process requires that appeals be requested in writing. However, if the enrollee requests an expedited 72-hour appeal and you deny the request, you cannot require the enrollee to file a written request before you process the appeal in the standard 30 day process. You are required to document oral requests for expedited appeals in writing.

9. What is an expedited organization determination?

Normally M+COs have 14 days to process a Medicare enrollee's request for a service. In some cases, enrollees have a right to an expedited/72-hour organization determination. An enrollee can get an expedited organization determination if his/her health, life, or ability to regain maximum function may be jeopardized by the standard 14-day organization determination process.

10. What is an expedited appeal?

Normally M+COs have 30 days to process a Medicare enrollee's appeal. In some cases, enrollees have a right to an expedited/72-hour appeal. An enrollee can get an expedited appeal if his/her health, life, or ability to regain maximum function may be jeopardized by the standard 30-day appeal process.

11. Does an enrollee have to have an expedited organization determination in order to get an expedited appeal?

An expedited determination is not a prerequisite to an expedited appeal. An expedited appeal may be granted even if the organization determination proceeded through the standard 14-day process. A request for an expedited appeal must be considered independently from a request for an expedited organization determination and may be granted even if the request for expedited organization determination is denied.

12. If an enrollee requests an expedited review and supports the request with a letter from a physician noting the urgent need for the services, is the M+CO obligated to process the request in the expedited 72-hour process?

Yes. In this example, the beneficiary has filed the request for expedited review (organization determination/reconsideration (appeal)). Because there is physician support, the expedited review must be conducted. M+COs are not permitted to turn down a physician's request for an expedited review on behalf of an enrollee, or to turn down an enrollee's request for an expedited review when it is supported by a physician.

FIGURE 23-5-10 APPEALS (THIS FIGURE HAS BEEN UPDATED TO REFLECT M+C REQUIREMENTS) (CONTINUED)**13. Under what circumstances may a M+CO turn down a physician's request for an expedited appeal?**

- A) M+COs must not process enrollee and physician requests for an expedited appeal regarding hospital discharge if an immediate PRO review for hospital discharge is being conducted.
- B) M+COs are not required to grant a physician's request for expedited review when the request concerns a denial of payment.

14. What can be appealed?

Medicare enrollees can appeal if they do not agree with [name of M+C organization or name of medical group] decisions about their health care. **They have a right to appeal if they think:**

- [name of M+C organization or name of medical group] has not paid a bill
- [name of M+C organization or name of medical group] has not paid a bill in full
- [name of M+C organization or name of medical group] will not approve or give him/her care that should be covered
- [name of M+C organization or name of medical group] is stopping care that he/she still needs.

NOTE: The 72-hour appeal process does not apply to denials of payment.

15. Is hospital discharge subject to the expedited appeal process?

The June 18 Program Memorandum indicated that the Hospital NODMAR must include the immediate PRO review right as well as the standard and expedited appeal processes. We wish to clarify that enrollees who are inpatients at a hospital must use the immediate PRO review process if they disagree with a discharge decision and are able to file timely. However, if an enrollee misses the noon deadline for filing for immediate PRO review, the enrollee may still request an expedited review. Medicare contracting M+COs should not process any requests for expedited appeal when immediate PRO review is being conducted for hospital discharge.

16. Is a denial based on exhaustion of benefits appealable?

Yes. Exhaustion of a benefit is a termination which is an appealable organization determination. Depending on the circumstances, this appeal may fall under either the standard or expedited appeal process.

FIGURE 23-5-10 APPEALS (THIS FIGURE HAS BEEN UPDATED TO REFLECT M+C REQUIREMENTS) (CONTINUED)

17. Is a physician who orally requests an expedited review on behalf of an enrollee required to obtain a signed statement from the enrollee authorizing the representation?

Yes. M+COs must be able to document that a request for appeal is valid. Therefore, representative statements are required every time a beneficiary appoints someone to act on his/her behalf on appeal. This representative designation is valid throughout all levels of the appeal process for the appeal case. Representative statements must be provided to the M+CO. The M+CO is not obligated to issue a determination prior to receipt of the statement.

18. Is a representative statement required of physicians who support a beneficiary's request for expedited appeal?

No. Physician calls, FAXES etc. in support of a beneficiary's request for expedited review do not require a representative statement. In cases where the physician is supporting a request, the beneficiary is responsible for filing the appeal request by phone, by FAX, in person or by mail. If you have not yet heard from the beneficiary contact the beneficiary to document the beneficiary's appeal.

19. Can a M+CO designate the office or department within its organization where requests for expedited review are to be made?

Yes. M+COs are required to develop a meaningful process for receiving requests for expedited appeals that may include designating an office or department, phone number for oral requests, and FAX machine number to facilitate beneficiary access and M+CO receipt of requests for expedited reviews. These procedures must be clearly explained in member materials including denial notices and NODMARs. In addition, M+COs will be accountable for educating staff and provider networks to ensure that requests for expedited review received by medical groups or other M+CO offices are referred immediately to the designated M+CO office or department.

20. Who makes the decision to expedite?

M+COs have the responsibility for deciding whether or not an enrollee's request for expedited review is granted with the following exception: If a physician files the request as a representative of the enrollee or files a statement orally or in writing in support of a request by a beneficiary, the M+CO must conduct an expedited review.

FIGURE 23-5-10 APPEALS (THIS FIGURE HAS BEEN UPDATED TO REFLECT M+C REQUIREMENTS) (CONTINUED)**21. What happens when we deny a request for expedited organization determination or appeal?**

When a request for expedited organization determination or expedited appeal is denied, the M+CO must automatically transfer it to the standard 14-day organization determination process and 30-day appeal process respectively. The M+CO may not request that the enrollee file a written appeal. The standard time frame begins with the date the M+CO receives the request for expedited review.

22. How and when do we inform the enrollee of the decision to deny an expedited review?

When the M+CO denies a request for expedited review, it must notify the enrollee orally at once and follow-up with a written letter of explanation within two working days. The plan must include in this letter an explanation that the enrollee's request will be processed within 14-days for organization determinations and 30 days for appeals, and that if the enrollee disagrees with the decision to deny an expedited review, the enrollee may file a grievance with the M+CO. The M+CO must provide instructions and the time frame for the grievance process.

23. Does the enrollee have a right to appeal a M+CO decision to deny an expedited review?

No. However, the enrollee may file a grievance with the M+CO. The M+CO must provide instructions to its enrollees regarding this right including the time frame for the grievance process.

24. How can M+COs give enrollees an opportunity to present evidence during the 30-day and the 72-hour expedited review process?

M+COs must give the enrollee an opportunity to present evidence during the standard and expedited review periods. M+COs must inform enrollees of this right when the enrollee makes the request for an appeal. The M+CO must allow the enrollee to present this information in any reasonable manner, including in person, by telephone and by FAX.

25. Are there any circumstances under which the M+CO could request an extension of the 72-hour time frame?

An extension of up to 14 days is permitted if requested by the enrollee or if the M+C organization or CMP finds that additional information is necessary and the delay is in the interest of the enrollee. Examples of reasons for an extension include additional diagnostic testing or consultations with medical specialists or a beneficiary request for the extension in order to provide the M+CO with additional information. M+C organizations are not permitted to use the extension to gather information from contracted providers, M+C organizations must have internal mechanisms for gathering information from contracted providers within the 72-hour timeframe.

FIGURE 23-5-10 APPEALS (THIS FIGURE HAS BEEN UPDATED TO REFLECT M+C REQUIREMENTS) (CONTINUED)

26. How is the 14 day extension obtained?

If the beneficiary needs an extension of up to 14 days, he/she orally informs the M+CO and explains to the M+CO why he/she feels the extension is necessary. M+COs must document beneficiary requests for extensions in writing.

If the M+CO needs an extension of up to 14 days, the M+CO orally informs the beneficiary and explains to the beneficiary why the M+CO feels the extension is necessary, how the extension will benefit the beneficiary and when the decision will be made. M+COs must follow-up with the beneficiary in writing.

27. Are there any circumstances under which the M+CO could request an extension greater than 14 working days.

No. However, in a specific circumstance, the elapsed time period for a plan decision may exceed 14 working days. In this circumstance, if the M+CO has requested information from non-affiliated physicians or other providers, the regulation provides that the plan's decision must be made within 72-hours of receipt of the requested information. As the information might be received on the 14th day, the time period could exceed 14 working days.

NOTE: No extension of time will be permitted if network providers have failed to submit information required by the M+CO.

28. Is there an expedited process for the Administrative Law Judge Level and beyond?

No, the expedited processes only apply to the M+C organization level reconsideration and the **CMS** level reconsideration.

FIGURE 23-5-10 APPEALS (THIS FIGURE HAS BEEN UPDATED TO REFLECT M+C REQUIREMENTS) (CONTINUED)**ATTACHMENT E-1****MODEL APPEAL LANGUAGE FOR MEMBER MATERIALS AND SERVICE DENIALS**

(Must be in 12 point type)

You Have a Right To Appeal

You can appeal if you do not agree with [name of M+C organization or name of medical group] decisions about your medical bills or health care. **You have a right to appeal if you think:**

- [name of M+C organization or name of medical group] has not paid a bill
- [name of M+C organization or name of medical group] has not paid a bill in full
- [name of M+C organization or name of medical group] will not approve or give you care it should cover
- [name of M+C organization or name of medical group] is stopping care you still need.

NOTE: If a medical group is issuing the denial notice with the required Model Appeal Language, whenever the word we is used it should be replaced with the name of the M+C organization.

We normally have 30 days to process your appeal. In some cases, you have a right to a faster, 72-hour appeal. You can get a fast appeal if your health or ability to function could be seriously harmed by waiting 30 days for a standard appeal. If you ask for a fast appeal, we will decide if you get a 72-hour/fast appeal. If not, your appeal will be processed in 30 days. If any doctor asks [M+C organization name] to give you a fast appeal, or supports your request for a fast appeal, we must give it to you.

30 - Day Appeal Process

If you want to file an appeal which will be processed within 30 days do the following:

- File the request in writing with [M+C organization name] at the following address: (____), or with an office of the Social Security Administration, or if you are a railroad annuitant, with the Railroad Retirement Board.
- Mail, FAX, or deliver your request in person. [please provide mailing address, and the address where hand delivered requests are received if different and FAX number]
- File your request within 30 days of the [date of this notice] which is [date].
- See the following sections which apply to both the 30-day appeal and the 72-hour appeal: "Support for Your Appeal, Who May File an Appeal, Help With Your Appeal, and Peer Review Organization Complaint Process."

FIGURE 23-5-10 APPEALS (THIS FIGURE HAS BEEN UPDATED TO REFLECT M+C REQUIREMENTS) (CONTINUED)

Even though you may file your request with the Social Security Administration or Railroad Retirement Board office, that office will transfer your request to [name of M+C organization] for processing. We are responsible for processing your appeal request within 30 days from the date we receive your request. If we do not rule fully in your favor, we will forward your appeal request to the *Center for Medicare and Medicaid Services* contractor (The Center for Health Dispute Resolution) for a decision.

**72-Hour Appeal Process
(Does not apply to denials of payment)**

If you want to file an appeal which will be processed within 72 hours do the following:

- File an oral or written request for a 72-hour appeal. Specifically state that “I want an expedited appeal, fast appeal or 72-hour appeal,” or, “I believe that my health could be seriously harmed by waiting 30 days for a normal appeal.”
- To file a request orally, call [phone number]. [name of M+C organization] will document the oral request in writing.
- To hand deliver your request, our address is [specific M+C organization address].
- To FAX your request, our FAX number is [FAX number]. If you are in a hospital or a nursing facility, you may request assistance in having your written appeal transmitted to [name of M+C organization/CMP] by use of a FAX machine.
- To mail a written request, our address is: [M+C organization/CMP Appeal Department address] however, the 72-hour review time will not begin until your request for appeal is received.
- You must file your request within 30 days of the [date of this notice] which is [date].

(M+C organizations with other options for accepting appeal requests should describe them here. For example delivering appeals requests in person to a member services office. Also include information here on how the beneficiary may provide additional information.)

14 - Day Extension

An extension up to 14 days is permitted for a 72-hour appeal, if the extension of time benefits you; for example, if you need time to provide [M+C organization name] with additional information or if we need to have additional diagnostic tests completed.

We will make a decision on your appeal and notify you of it within 72-hours of receipt of your request. However, if our decision is not fully in your favor, we will automatically forward your appeal request to the *Center for Medicare and Medicaid Services* contractor, (The Center for Health Dispute Resolution (The Center)), for an independent review. The Center will send you a letter with their decision within 14 working days of receipt of your case from [name of M+C organization/CMP].

FIGURE 23-5-10 APPEALS (THIS FIGURE HAS BEEN UPDATED TO REFLECT M+C REQUIREMENTS) (CONTINUED)**THE FOLLOWING INFORMATION APPLIES TO BOTH
30 DAY APPEALS AND 72-HOUR APPEALS****Support for Your Appeal**

You are not required to submit additional information to support your request for services or payment for services already received. [Name of M+C organization] is responsible for gathering all necessary medical information, however, it may be helpful to you to include additional information to clarify or support your position. For example, you may want to include in your appeal request information such as medical records or physician opinions in support of your appeal. To obtain medical records, send a written request to your primary care physician. If your medical records from specialist physicians are not included in your medical record from your primary care physician, you may need to make a separate written request to the specialist physician(s) who provided medical services to you. M+C organizations that have different procedures for members to follow in order to obtain medical records or physician opinions should describe them here. Please describe the process for obtaining medical records or physician opinions for the 72-hour appeal process. [Name of M+C organization] will provide an opportunity for you to provide additional information in person or in writing.

Who May File an Appeal

1. You may file an appeal.
2. If you want someone to file the appeal for you:
 - a. Give us your name, your Medicare number, and a statement which appoints an individual as your representative. (Note: You may appoint any provider.) For example: "I [your name] appoint [name of representative] to act as my representative in requesting an appeal from [name of M+C organization] and/or the *Center for Medicare and Medicaid Services* regarding [name of M+C organization's] (denial of services) or (denial of payment for services).
 - b. You must sign and date the statement.
 - c. Your representative must also sign and date this statement unless he/she is an attorney.
 - d. Include this signed statement with your appeal.
3. A non-plan provider may file a standard appeal of a denied claim if he/she completes a waiver of liability statement which says he/she will not bill you regardless of the outcome of the appeal.
4. A court appointed guardian or an agent under a health care proxy to the extent provided under state law.

FIGURE 23-5-10 APPEALS (THIS FIGURE HAS BEEN UPDATED TO REFLECT M+C REQUIREMENTS) (CONTINUED)

Help With Your Appeal

If you decide to appeal and want help with your appeal, you may have your doctor, a friend, lawyer, or someone else help you. There are several groups that can help you. You may want to contact the Area Agency on Aging at [phone number], the Insurance, Counseling, and Assistance Program at [phone number], the Medicare Rights Center at Toll Free 888-HMO-9050.

NOTE: In addition to the above sources of assistance, the State Ombudsman at [phone number] should be added to all SNF notices of Discharge and Medicare Appeal Rights (NODMAR).

Additional Rights

Administrative Law Judge Hearing

If you are dissatisfied with the reconsidered determination of the independent entity (the Center), you have a right to a hearing before an Administrative Law Judge, if the service in dispute is valued at, at least \$100.00 or the claim in dispute is at least \$100.00. The determination letter from the center explains how to request a hearing.

Departmental Appeals Board

If you are dissatisfied with the decision of the Administrative Law Judge, you may request the Departmental Appeals Board review the Administrative Law Judge's decision or dismissal.

Judicial Review

- a) You may request Judicial review of an Administrative Law Judge's decision if:
 - The Departmental Appeals Board denied your request for review; and
 - The value of the service or claim is \$1000.00 or more.
- b) You may request Judicial review of the Department Appeals Board's decision if:
 - It is the final decision of the *Center for Medicare and Medicaid Services*; and
 - The value of the service or claim is \$1000.00 or more.

FOLLOWING ARE TWO QUALITY COMPLAINT PROCESSES WHICH ARE SEPARATE FROM THE APPEAL PROCESS DESCRIBED ABOVE.

Peer Review Organization Complaint Process

If you are concerned about the quality of the care you have received, you may also file a complaint with the local Peer Review Organization [Name of PRO and phone number]. Peer Review Organizations are groups of doctors and health professionals that monitor the quality of care provided to Medicare beneficiaries. The Peer Review Organization review process is designed to help stop any improper practices.

FIGURE 23-5-10 APPEALS (THIS FIGURE HAS BEEN UPDATED TO REFLECT M+C REQUIREMENTS) (CONTINUED)**[M+C organization name] Quality Complaint Process**

You may also file a written quality complaint with [M+C organization name]. [Please describe your written procedures including time frames for investigating these types of complaints (called grievances).] We will review your complaint and notify you in writing of our conclusion. This process is separate from the appeal process described above. Please call [phone number] for additional information.

FIGURE 23-5-10 APPEALS (THIS FIGURE HAS BEEN UPDATED TO REFLECT M+C REQUIREMENTS) (CONTINUED)

ATTACHMENT E-2

MODEL APPEAL LANGUAGE FOR CLAIM DENIALS

(Must be in 12 point type)

You Have a Right To Appeal

You can appeal if you do not agree with [name of M+C organization or name of medical group] decision about your medical bills or health care. **You have a right to appeal if you think:**

- [name of M+C organization or name of medical group] has not paid a bill
- [name of M+C organization or name of medical group] has not paid a bill in full
- [name of M+C organization or name of medical group] will not approve or give you care it should cover
- [name of M+C organization or name of medical group] is stopping care you still need.

NOTE: If a medical group is issuing the denial notice with the required Model Appeal Language, whenever the word “we” is used it should be replaced with the name of the M+C organization.

30 - Day Appeal Process

If you want to file an appeal which will be processed within 30 days do the following:

- File the request in writing with [M+C organization name] at the following address: (____), or with an office of the Social Security Administration, or if you are a railroad annuitant, with the Railroad Retirement Board.
- Mail, FAX, or deliver your request in person. [please provide mailing address, and the address where hand delivered requests are received if different and FAX number]
- File your request within 60 days of the [date of this notice] which is [date].
- See the following sections which apply to both the 30-day appeal and the 72-hour appeal: “Support for Your Appeal, Who May File an Appeal, Help With Your Appeal, and Peer Review Organization Complaint Process.”

Even though you may file your request with the Social Security Administration or Railroad Retirement Board office, that office will transfer your request to [name of M+C organization] for processing. We are responsible for processing your appeal request within 30 days from the date we receive your request. If we do not rule fully in your favor, we will forward your appeal request to the *Center for Medicare and Medicaid Services* contractor (The Center for Health Dispute Resolution) for a decision.

FIGURE 23-5-10 APPEALS (THIS FIGURE HAS BEEN UPDATED TO REFLECT M+C REQUIREMENTS) (CONTINUED)**Support for Your Appeal**

You are not required to submit additional information to support your request for services or payment for services already received. [Name of M+C organization] is responsible for gathering all necessary medical information, however, it may be helpful to you to include additional information to clarify or support your position. For example, you may want to include in your appeal request information such as medical records or physician opinions in support of your appeal. To obtain medical records, send a written request to your primary care physician. If your medical records from specialist physicians are not included in your medical record from your primary care physician, you may need to make a separate written request to the specialist physician(s) who provided medical services to you. **M+C organizations that have different procedures for members to follow in order to obtain medical records or physician opinions should describe them here.** [Name of M+C organization] will provide an opportunity for you to provide additional information in person or in writing.

Who May File an Appeal

1. You may file an appeal.
2. If you want someone to file the appeal for you:
 - a. Give us your name, your Medicare number, and a statement which appoints an individual as your representative. (Note: You may appoint a non-plan provider.) For example: "I [your name] appoint [name of representative] to act as my representative in requesting an appeal from [name of M+C organization] and/or the *Center for Medicare and Medicaid Services* regarding [name of M+C organization's] (denial of services) or (denial of payment for services)."
 - b. You must sign and date the statement.
 - c. Your representative must also sign and date this statement unless he/she is an attorney.
 - d. Include this signed statement with your appeal.
3. A non-plan providers may file a standard appeal for a denied claim if he/she completes a waiver of liability statement which says he/she will not bill you regardless of the outcome of the appeal.
4. A court appointed guardian or an agent under a health care proxy to the extent provided under state law.

FIGURE 23-5-10 APPEALS (THIS FIGURE HAS BEEN UPDATED TO REFLECT M+C REQUIREMENTS) (CONTINUED)

Help With Your Appeal

If you decide to appeal and want help with your appeal, you may have your doctor, a friend, lawyer, or someone else help you. There are several groups that can help you. You may want to contact the Area Agency on Aging at [phone number], the Insurance, Counseling, and Assistance Program at [phone number], or the Medicare Rights Center at Toll Free 888-HMO-9050.

NOTE: In addition to the above sources of assistance, the State Ombudsman at [phone number] should be added to all SNF notices of Discharge and Medicare Appeal Rights (NODMAR).

FOLLOWING ARE TWO QUALITY COMPLAINT PROCESSES WHICH ARE SEPARATE FROM THE APPEAL PROCESS DESCRIBED ABOVE.

Peer Review Organization Complaint Process

If you are concerned about the quality of the care you have received, you may also file a complaint with the local Peer Review Organization [Name of PRO and phone number]. Peer Review Organizations are groups of doctors and health professionals that monitor the quality of care provided to Medicare beneficiaries. The Peer Review Organization review process is designed to help stop any improper practices.

[M+C organization name] Quality Complaint Process

You may also file a written quality complaint with [M+C organization name]. [Please describe your written procedures including time frames for investigating these types of complaints (called grievances).] We will review your complaint and notify you in writing of our conclusion. This process is separate from the appeal process described above. Please call [phone number] for additional information.

FIGURE 23-5-10 APPEALS (THIS FIGURE HAS BEEN UPDATED TO REFLECT M+C REQUIREMENTS) (CONTINUED)

**SUGGESTED CLINICAL CRITERIA
FOR
AUTOMATIC EXPEDITED REVIEW**

1. All Appealed Rehab Hospital Continued Stay Denials
2. All appealed SNF Continued Stay Denials.
3. All requests/denials for continued home health services.
4. All denials of Physical Therapy within 6 months of a CVA, head injury/surgery, or other acute trauma.
5. All first requests for Physical Therapy within 4 months of a CVA, head injury/surgery, or other acute trauma.
6. All denials for continuing Physical therapy within 6 months of a major joint (i.e., hip, total knee) surgery.
7. All first requests for continuing Physical Therapy within 4 months of major joint surgery.
8. Requests/denials for chemotherapy, radiation therapy or proposed surgical treatment of a known malignancy.
9. Requests/denials of a proposed AIDS therapy in an AIDS patient.
10. Any denial of a proposed "experimental" treatment in a terminal patient. (Use California State Law in defining terminal).
11. Any requests by a physician for urgent determination/recon review.
12. Any call where there is a refusal by the provider to proceed with a scheduled service/test because an authorization was not given on a service that has been scheduled. (e.g., surgery scheduled but no authorization issued on which to proceed.)

*All other pre-service cases would be judged case-by-case as to whether failure to grant an expedited review/denial could mean harm to the member if the standard review process was imposed.

FIGURE 23-5-11 HMO 2400. DISTINGUISHING BETWEEN GRIEVANCES AND APPEAL

There are two types of procedures for resolving enrollee complaints, the Medicare appeals procedures and the plan-internal grievance procedures. Resolve all enrollee complaints through one of these procedures. Use the procedure appropriate to the complaint. Disputes about organization determinations, are resolved only through the Medicare appeals procedure. These are primarily complaints concerning payment for services or denial of services. Use the grievance procedures for all complaints which do not involve an organization determination. Transfer complaints between the two procedures when appropriate.

2400.1 Complaints Which Apply Both to Appeals and Grievances.--The appeals and grievance procedures are mutually exclusive. Process complaints under the appeals procedures or grievance procedures. If an enrollee addresses two issues in one complaint, process each issue separately and simultaneously under the proper procedure. Do not process these complaints first through the grievance procedures, and then through the appeals procedures.

2400.2 Appeals. All organization determinations are subject to the appeals procedures. Complaints sometimes do not appear to involve an organization determination and are misclassified as grievances. This may occur because the plan did not issue the written notice of an adverse determination. (See Section 2403.5.) Common mis-classifications include:

- A. Service Denials.**--Service denials are often mis-identified in cases in which:
- The provider of services made a coverage denial;
 - A notice of adverse organization determination was not issued timely (422.568); and
 - The beneficiary appeals pursuant to Section 2403.1.

Inform providers that they must ensure timely issuance of a written notice of adverse organization determination as described in 2403.5 when coverage is denied. The provider may issue the organization determination notice or he/she may ensure that the medical group or organization issues the notice.

B. Quality of Care.--Complaints concerning the quality of a service a member received are treated as a grievance. However, quality of care complaints are occasionally complaints of a denial of services. For example, a member complains of poor medical care because his doctor did not authorize a surgery or other medical service. This complaint involves a denial of service. Process it through the appeals procedures. Peer Review Organizations (PROs) also review beneficiary quality of care complaints. (See 2305.1F.)

C. Accessibility.--Complaints concerning timely receipt for services already provided are treated as grievances. If the member complains that he has not been able to obtain a service, treat it as an appeal. If the member complains that he had to wait so long for a service that he went out-of-plan, treat it as an appeal for payment for the out-of-plan services.

D. Non-Medicare Covered Services.--The Medicare appeals procedures apply to all benefits offered under a risk-based contractor's basic benefit package. They also apply to Part A benefits which "Part B only" members buy from the plan. Non-Medicare benefits in a cost-reimbursed contractor's basic benefit package are not subject to the appeals procedures.

FIGURE 23-5-11 HMO 2400. DISTINGUISHING BETWEEN GRIEVANCES AND APPEAL (CONTINUED)

2400.3 Claims Processed by Carriers and Intermediaries.--Carriers or intermediaries receiving claims for members of risk-based plans transfer the claims to the plan for processing. Carriers and intermediaries sometimes correctly process claims for members of cost-reimbursed plans (i.e., when enrollees see a non-plan physician). Enrollees file for appeal with the entity that made the determination. For example:

A. Claims Denied by the Carrier or Intermediary.--The enrollee files an appeal with that carrier or intermediary.

B. Claims Paid by the Carrier or Intermediary, but the Enrollee Disagrees with Payment Amount.--The enrollee files the claim with the carrier or intermediary. For example, a member submits a claim for a motorized wheelchair. The carrier decides the motorized wheelchair was not medically necessary and reimburses the member at the rate approved for a non-motorized wheelchair. If the enrollee believes the motorized wheelchair was medically necessary, he/she appeals through the carrier.

C. Claims Paid by the Carrier or Intermediary and the Enrollee Wants Reimbursement for Coinsurance or Deductibles.--Enrollees file appeals with the M+C organization/CMP if they agree with the carrier's or intermediary's decision, but disagree with the plan's reimbursement for the Medicare deductible and coinsurance. For example, the carrier processes a claim for a motorized wheelchair and pays 80% of the allowable charge. However, the plan issues an organization determination denying the deductible and coinsurance because the member purchased the wheelchair from a non-plan provider. The enrollee appeals to the HMO/CP for reimbursement. Process appeals on carrier or intermediary claims only in this situation.

2400.4 Grievances.--The following items are not subject to the appeals procedures. Process them under the grievance procedures outlined in Section 2410:

- Disputes that do not meet the definition of an organization determination.
- Examples of grievances include:
 - Complaints about waiting times, physician demeanor and behavior, adequacy of facilities; or
 - Involuntary disenrollment issues.
- Disputes about items or services that you have furnished, either directly or under arrangement, for which the enrollee has no further liability for payment (i.e. services rendered without charge or for which the responsibility for payment does not rest with the Medicare beneficiary). However, services for which Medicaid has paid or could pay are subject to appeal.

HMO 2410. SCOPE OF GRIEVANCES

Process all member complaints which are not organization determinations through the grievance procedures. This includes complaints about coverage under an optional benefit package, waiting times, physician behavior and involuntary disenrollment concerns. Handle all disputes about organization determinations under the appeals procedures.

FIGURE 23-5-11 HMO 2400. DISTINGUISHING BETWEEN GRIEVANCES AND APPEAL (CONTINUED)

HMO 2411. PROCEDURES

Maintain internal grievance procedures. Provide the following procedures:

- Transmit timely grievances and complaints to appropriate decision making levels in the plan;
- Take prompt, appropriate action, including a full investigation if necessary; and
- Notify concerned parties of investigation results.

FIGURE 23-5-12 **CMS WORKING AGED SURVEY**

CMS WORKING AGED SURVEY

Name: _____ Social Security # _____
 Address: _____ Phone # _____
 City, State, Zip: _____

1. Please indicate your employment status (Check only one):
 WORKING FULL TIME WORKING PART TIME SELF EMPLOYED
 ACTIVE DUTY RETIRED NOT EMPLOYED

2. Do you have health insurance through your employer or your spouse's employer?
 NO (If NO, go to step 3 to sign and date this survey)
 YES, THROUGH MY EMPOLYER YES, THROUGH MY SPOUSE'S EMPLOYER

If YES, please tell us about your health insurance:

Insurance Company Name: _____
 Insurance Company Address: _____
 Insurance Company City, State, Zip: _____
 Subscriber Name: _____
 Policy Number: _____
 Effective Date: _____ Termination Date: _____

If YES, please tell us about the employer providing his health insurance coverage:

Employer Name: _____
 Employer Address: _____
 Employer City, State, Zip: _____
 Employee Id: _____
 Group Number: _____ Group Plan: _____

3. Signed: _____ Date: _____

Please contact your health plan if these answers change.

FIGURE 23-5-13 DATA ELEMENT REQUIREMENTS - WORKING AGED INFORMATION*

FIELD	DESCRIPTION
Claim Number	HIC Number
Last Name	Beneficiary Last Name
First Initial	Beneficiary First Name Initial
Sex	Beneficiary Sex Code
Date of Birth	Beneficiary Birth Date; format includes century
Contract Number	GHP Contract Number
MSP Coverage Indicator	Yes or No
Prior Commercial	Number of months a beneficiary was enrolled in Plan on a commercial basis prior to Medicare contract, if applicable
Transaction Type	Add or Change MSP Data Transaction, or Delete MSP Data Transaction
Insurer's Name	Primary Insurer's Name
Insurer's Address	Primary Insurer's Address
Policy Number	Primary Insurer's policy number of insured if available
MSP Effective Date	Effective date of MSP coverage
MSP Termination Date	Termination of MSP coverage
Patient Relationship	Relation of patient to insured (Patient is insured or Spouse)

* These are the data elements required, unless otherwise stated, to update the Working Aged information