blue california
Promise Health Plan

POLICY & PROCEDURE
Medical Services

Policy Title: CMS Part C and D Reporting – Organization Determinations and Reconsiderations		
Policy No: 50.2.80	**Original Date: 02/11**	
Effective Date: 12/18	**Revision Date: 12/18**	**Revision No: 1**
Department Head: Date:	**Medical Services/P&T Committee: Date:**	
P&P Committee: Date:	**Department(s):** **UM**	

PURPOSE:

To establish procedures for accurate and timely submission of CMS' Part C and Part D Reporting Requirements, in Particular, reporting associated with the "Part C Organization Determinations and Reconsiderations" measure.

DEFINITIONS:
Refer to CMS' Technical Specifications Manual and Reporting Requirements.

POLICY:

It is Blue Shield Promise policy to ensure that the Part C and Part D Reporting Requirements are accurate and submitted in a timely manner (refer to Medicare Ops P&P 50.23.5)

1. Data will be based on the reporting periods of 1/1 through 3/31, 4/1 through 6/30, 7/1 through 9/30, and 10/1 through 12/31.

2. Data will correspond to the applicable CMS contract

3. Blue Shield Promise will meet the CMS Deadline for quarterly reporting for this measure. The report is due to CMS on 5/31 (1/1 through 3/31 data), 8/31 (4/1 through 6/30 data), 11/30 (7/1 through 9/30 data) and 2/28 (10/1 through 12/31 data).

4. Blue Shield Promise defines the term "Organization Determination" in accordance with 42 CFR §422.566 and the Medicare Managed Care Manual Chapter 13, Sections 10.1 and 20.2

5. Calculation of the total number of organization determinations **includes**:

a. All organization determinations (Part C only) with a date of member notification of the final decision that occurs during the reporting period, regardless of when the request for organization determination was received.
b. All claims submitted for payment including those that pass through the adjudication system that may not require determination by the staff of the organization or its delegated entity.
c. Decisions made on behalf of the organization by a delegated entity.
d. Only organization determinations that are filed directly with the organization or its delegated entities (e.g., excludes all organization determinations that are only forwarded to the organization from the CMS Complaint Tracking Module (CTM) and not filed directly with the organization or delegated entity).
e. All methods of organization determination request receipt (e.g., telephone, letter, fax, in-person).
f. All organization determinations regardless of who filled the request.

6. Calculation of the total number of organization determinations excludes:
    a. All organization determinations that involve services provided to Medicaid-only members
    b. Dismissals or withdrawals
    c. Quality Improvement Organization (QIO) reviews of a member's request to continue Medicare – covered services (e.g., a SNF stay).
    d. Duplicate claim submissions (e.g., a duplicate request for payment concerning the same service or item)
    e. Claims returned to a provider/supplier in which a substantive decision (Fully Favorable, Partially Favorable or Adverse) has not yet been made due to error (e.g., claim submissions or forms that are incomplete, invalid or do not meet the requirements for a Medicare claim).

7. Calculation of the number of fully favorable organization determinations includes:
    a. All fully favorable pre-service organization determinations for contract and non-contract providers/suppliers
    b. All fully favorable payment (claim) organization determinations for contract and non-contract providers/suppliers
    c. For instances when a request for payment is submitted to an organization concerning an item or service, and the organization has already made a favorable organization determination (i.e., issued a fully favorable pre-service decision), includes the request for payment for the same item or service as another, separate, fully favorable organization determination.

8. Calculation of the number of partially favorable organization determinations includes:
    a. All partially favorable pre-service organization determination for contract and non-contracted providers/suppliers

9. Calculation of the number of partially favorable organization determinations, excludes:
    a. All partially favorable payment organization determinations fro contract and non-contract providers/suppliers.

10. Calculation of the number of adverse organization determinations, includes:
    a. All adverse pre-service organization determinations for contract and non-contract providers/suppliers
    b. All adverse payment (claim) organization determinations that result in zero payment being made to non-contract providers.
    c.
11. Calculation of the number of adverse organization determinations, excludes:
    a. All adverse payment (claim) organization determinations that result in zero payment being made to contract providers.

12. Blue Shield Promise defines the term "Reconsideration" in accordance with the Medicare Managed Care Manual Chapter 13, Sections 10.1 and 70.

13. Calculation of the total number of reconsiderations includes:
    a. All reconsiderations (Part C only) with a date of member notification of the final decision that occurs during the reporting period, regardless of when the request for reconsideration was received.
    b. Decisions made on behalf of the organization by a delegated entity
    c. All methods of reconsideration request receipt (e.g., telephone, letter, fax, in-person).
    d. All reconsiderations regardless of who filed the request. For example, if a non-contracted provider signs a waiver of liability and submits a reconsideration request, a plan is to report this reconsideration in the same manner it would report a member-filled reconsideration.
    e. Only reconsiderations that are filed directly with the organization or its delegated entities (e.g., excludes all reconsiderations that are only forwarded to the organization from the CMS Complaint Tracking Module (CTM) and not filed directly with the organization or delegated entity).

14. Calculation of the total number of reconsiderations excludes:
    a. All reconsiderations that involve services provided to Medicaid-only members
    b. Dismissals or withdrawals
    c. QIO reviews of a member's request to continue Medicare-covered services (e.g., a SNF stay).
    d. Duplicate claim submissions (e.g., a duplicate request for payment concerning the same service or item).

e. Requests for reconsideration returned to a provider/supplier in which a substantive decision (Fully Favorable, Partially Favorable or Adverse) has not yet been made due to error – e.g., claim submissions or forms that are incomplete, invalid or do not meet the requirements for a Medicare claim.

15. Calculation of the number of fully favorable reconsideration determinations, includes:
    a. All fully favorable pre-service reconsideration determinations for contract and non-contract providers/suppliers
    b. All fully favorable payment (claim) reconsideration determinations for contract and non-contract providers/suppliers

16. Calculation of the number of partially favorable reconsideration determinations includes:
    a. All partially favorable pre-service reconsideration determination for contract and non-contract providers/suppliers

17. Calculation of the number of partially favorable reconsideration determinations excludes:
    a. All partially favorable payment reconsideration determinations for contract and non-contract provider/suppliers

18. Calculation of the number of adverse reconsideration determinations includes:
    a. All adverse pre-service reconsideration determinations for contract and non-contract providers/suppliers
    b. All adverse payment (claim) reconsideration determinations that result in zero payment being made to non-contracted providers

19. Calculation of the number of adverse reconsideration determinations excludes:
    a. All adverse payment (claim) reconsideration determinations that result in zero payment being made to contract providers.

PROCEDURE:

Data Preparation, Review, and Submission

1. The Utilization Management and Claims Department is the business owner for Part C Organization Determinations and Reconsiderations CMS Reporting. It is responsible for ensuring that the data submitted is accurate. This includes a comparison to prior reporting periods.
2. The Utilization Management and Claims Department receives the data from the Informatics Department.
    a. The data is reviewed using established source code. Source code is based on corresponding Part C and Part D Technical Specifications. Source code logic is documented by the Informatics team and updated as necessary based on changes to the reporting requirements.

3. The Utilization Management and Claims Department reviews the data produced by Informatics (in collaboration with Medicare Operations Department) and confirms the accuracy of the data by email notification to Medicare Ops.

Responding to Potential Data Discrepancy Notifications

1. If there are notices received from Medicare Ops related to the accuracy of the data submitted, the Utilization Management and Claims Department performs another quality review and addresses any discrepancies or corrections to the Medicare Ops Department.
2. The Utilization Management and Claims Department provides the Medicare Ops Department the final data/statistics to be submitted to CMS.
    a. An email confirmation showing the final data to be submitted is received from the Medicare Ops Department

REFERENCES/AUTHORITIES:

42 CFR §422.516(a)
CMS Data Validation Procedure Manual Appendix B: Data Validation Standard
Part C Reporting Requirements Technical Specifications

ATTACHMENTS:
H5928 Part C Organization Determinations and Reconsiderations Source Code