Medicare Diabetes Prevention Program (MDPP)

Medicare Advantage (MA) Appeals Process

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This document describes the Centers for Medicare & Medicaid Services (CMS) MA appeals process and outlines important information about MA appeals that MDPP suppliers should be aware of when offering MDPP services to MA enrollees. MDPP suppliers should refer to the MDPP Medicare Advantage Fact Sheet for recommended practices when offering MDPP services to MA enrollees and for important general information about working with Medicare Advantage Organizations (MAOs).

Medicare Advantage Overview

What is MA?

There are two ways for beneficiaries to receive Medicare coverage: original Medicare (Part A and Part B benefits) and MA (Part C). MA is a Medicare health plan offered by a private company that contracts with Medicare to provide, at a minimum, Part A and Part B benefits. MA plans may also offer coverage of supplemental health benefits that are not covered by Medicare Part A or Part B.

Who provides MA?

MA plans are provided by MAOs. An MAO is the legal entity that has a contract with the Medicare program to provide coverage for health care services. An MA plan is the package of Medicare benefits offered by the MAO to a Medicare beneficiary. An MAO may offer multiple MA plans from which beneficiaries can choose the one that best meets their health care needs.

Important Definitions

Enrollee:	An enrollee is a Medicare Part C-eligible individual who elected, or enrolled in, a Part C plan offered by an MAO.
Organizational Determination:	An organizational determination is a decision made by, or on behalf of, an MA plan about authorization or payment for a health care item or service, the portion of an item or service payment that a health plan requires the enrollee to pay, or a limit on the quantity of items or services.
Reconsideration:	A reconsideration involves an MA plan reviewing an adverse organizational determination, its supporting findings, and other evidence. A reconsideration is the first level of the appeals process.
Independent Review Entity (IRE):	A Part C IRE is an organization that CMS contracts with to review Medicare Part C plan denials. If an MA plan makes an adverse reconsideration decision (e.g., upholds its initial adverse organizational determination) in whole or in part, the MA plan must automatically submit the case file and its decision for review by the Part C IRE. A review by the Part C IRE is the second level of the appeals process.
Waiver of Liability:	A document in which the health care supplier declares that they will not bill an MA enrollee regardless of the outcome of a standard appeal for a denied claim. The Waiver of Liability statement asserts that the MA enrollee is not financially responsible for a denied claim. The Waiver of Liability protects beneficiaries from medical expenses not covered by their MA plan.

Payment for Furnishing MDPP Services to MA Enrollees

MDPP suppliers request payment for MDPP services furnished to MA enrollees from the enrollee's MA plan, not Medicare. MDPP suppliers should always seek guidance directly from MAOs on the procedure for requesting payment for services furnished to an MA plan's eligible enrollees. Check with the MA plan for information on eligibility, coverage, and payment prior to furnishing services. MA plans may have different patient out-of-pocket costs and specific rules for billing for services. For example, MA plans can impose beneficiary cost-sharing for MDPP services, but cost-sharing is only allowed if the MDPP supplier is out of network and there is another in-network MDPP supplier. You must follow the MA plan's terms and conditions for payment.

Important Information:

The payment amount that an MDPP supplier is entitled to receive from an MA plan for furnishing MDPP services to eligible enrollees depends on whether the MDPP supplier has a contract to provide MDPP services with the enrollee's MA plan and the terms of that contract.

FAQs

What information should an MDPP supplier expect to receive if an MA plan denies their claim?
An MDPP supplier should expect to receive a remittance advice/notice or similar notification with a specific reason for the denial and a description of the appeals process.

Can MA plans develop their own eligibility criteria that MA enrollees must meet to access MDPP services?
No. MA plans may not modify the eligibility requirements established by federal regulation, which determine an enrollee's eligibility to receive MDPP services. However, plans may provide MDPP services as a supplemental benefit to MA enrollees who do not meet the eligibility requirements for MDPP services.

What steps should an MDPP supplier take if they do not understand the reason code or explanation provided for a claim denial by an MA plan?
MDPP suppliers who receive claim denials with unclear reason codes or explanations should first contact the MA plan for additional clarification before considering an appeal of the claim denial.

Key Distinction: In-network and Out-of-network Suppliers

MDPP suppliers must have a contract with an MA plan to be considered in-network suppliers. In-network suppliers have agreed to offer services to the MA plan's enrollees at a pre-specified rate. An MDPP supplier that is not contracted with an MA plan is considered out of network.

Appeals Overview for Determinations by MA Plans

Reconsideration

If an MA plan denies an MDPP supplier's or enrollee's request for a pre-service approval or payment (i.e., the MA plan issues an adverse organizational determination) for an MDPP service, in whole or in part, the supplier or enrollee may appeal the decision to the MA plan by requesting a reconsideration. The MA plan must provide written instructions on how to appeal.

The following parties may request reconsiderations:

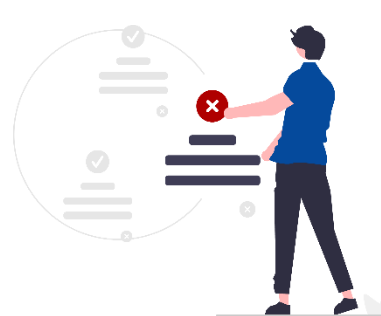
- The enrollee or their appointed representative[i]
- An assignee of the enrollee (i.e., a physician, MDPP supplier, or other provider who has furnished a service to the enrollee and formally agrees to waive any right to payment from the enrollee for that service), including staff working under the direction of the provider
- An MDPP supplier, other provider, or entity (other than the MA plan) determined to have an appealable interest
- A legal representative of the deceased enrollee's estate

Reconsideration requests must be filed with the MA plan within 60 calendar days from the date of the notice of the organizational determination. Reconsideration requests must be made in writing unless the MA plan accepts verbal requests. An MDPP supplier or enrollee should call the MA plan or check the MA plan's Evidence of Coverage (EOC) to determine whether the plan accepts verbal reconsideration requests. An MA plan's EOC should be available on their website.

Reconsideration requests should include, at a minimum, the following:

- Name of the enrollee
- Information identifying which denial is being appealed
- Contact information for the MDPP supplier, enrollee, or other person filing the reconsideration request

Notification Requirements for Non-Contracted MDPP Suppliers



If an MA plan denies a non-contracted MDPP supplier's request for pre-service approval or payment, the MA plan must notify the non-contracted MDPP supplier of the reason for the denial and describe the appeals process. The notice must specify the:

- Right to request reconsideration within **60 days of notification**
- Requirement to submit a Waiver of Liability form with any reconsideration request, which states that the MDPP supplier will not bill the enrollee regardless of the outcome of the appeal
- Address for reconsideration request submission

A non-contracted supplier may file a standard appeal for a denied claim only if the supplier submits a Waiver of Liability.

> ***Related Resources:*** *Go to the CMS Notices and Forms web page for Managed Care appeals & grievances to find a model Waiver of Liability form.*

[i] Any individual appointed by the enrollee (e.g., relative, advocate, attorney) using the CMS-1696 form or an equivalent written notice.

MA Plan Processing of Reconsideration Requests

MA plans must have processes in place for receipt and documentation of initial reconsideration requests, as described below:

- For reconsideration requests submitted verbally, the MA plan must:
  - Establish and maintain a process for categorizing and documenting verbal requests
  - Retain documentation of a verbal request in the case file
  - Explain the procedures that the MDPP supplier or enrollee must follow to file a written request, if the plan does not accept verbal reconsideration requests
- For reconsideration requests submitted in writing, the MA plan must:
  - Accept the request
  - Not require the written reconsideration request to be on a specific form
    - The MA plan or other entity may develop a pre-service, benefit, and/or payment request form (for optional use)
  - Retain documentation of a written request in the case file

Once the MA plan receives the reconsideration request, it must make its decision and notify the MDPP supplier or enrollee within **30 calendar days** of receipt of a pre-service request or within **60 calendar days** of receipt of a payment request. If the decision is unfavorable, in whole or in part, the MA plan must submit the case file and its decision for automatic review by the Part C IRE.

MA Appeals Process: First and Second Appeals Levels

Organizational Determination	First Appeal Level	Second Appeal Level
Standard Process [ii] *Pre-Service:* The MA plan must respond within **14 days** of receipt of pre-service approval request *Payment:* The MA plan must respond within **60 days** of receipt of payment approval request	**Health Plan Reconsideration** *Pre-Service:* The MA plan must respond within **30 days** of receipt of reconsideration request for pre-service organizational determination *Payment:* The MA plan must respond within **60 days** of receipt of reconsideration request for payment organizational determination	**IRE Reconsideration** *Pre-Service:* The IRE must respond within **30 days** of notice of MA plan upholding of pre-service organizational determination *Payment:* The IRE must respond within **60 days** of notice of MA plan upholding of payment organizational determination

60 days for MDPP supplier to file a reconsideration following an unfavorable organizational determination

The MA plan should automatically forward the reconsideration to the IRE if the plan upholds denial

Related Resources: *For more information on the timing of reconsideration requests the Managed Care Appeals Flow Chart can be found on the CMS Managed Care appeals & grievances web page.*

[ii] Plans must process 95% of all clean claims from out of network suppliers within 30 days. All other claims must be processed within 60 days

Helpful Resources

If your organization needs information or guidance with MDPP payment policy or the MA billing process (such as appeals and determinations), you can submit questions by going to the MDPP Supplier Support Center web page and clicking the Start New Inquiry button.

Resource	Resource Content
MDPP Medicare Advantage Fact Sheet	PDF document with best practices for furnishing MDPP services to MA enrollees and for important general information about working with MAOs
MDPP Medicare Advantage FAQs	Frequently asked questions about MA coverage of MDPP
Guidance for Medicare Advantage Plans from the 2018 Physician Fee Schedule	PDF document with MA-related extracts on MDPP from the 2018 Physician Fee Schedule final rule
Reconsideration by the Medicare Advantage (Part C) Health Plan	CMS Managed Care appeals & grievances web page with a summary of the reconsideration request process by MA plans
Parts C & D Enrollee Grievances, Organizational/Coverage Determinations, and Appeals Guidance	PDF document with guidance on grievances, organizational/coverage determinations, and appeals for beneficiaries enrolled in a plan provided by an MAO
Medicare Advantage Plan Directory	CSV file with plan directory for MA, Cost, PACE, and Demo Organizations