Going to the Source:

Using Medicare's Manuals in SMP and SHIP Work

SHIP & SMP National Meeting

Milwaukee, Wisconsin

The SHIP National Technical Assistance Center

ship NATIONAL NETWORK state health insurance assistance programs

Workshop Objectives

- Describe relationship between CMS Manuals and other sources of policy
- Demonstrate how to find and use CMS manuals for responses to technical questions
- Demonstrate use of CMS manuals in appeals process

Medicare's Manuals

- CMS Internet Only Manual (IOM) System
  - 22 Internet Only Manuals (IOMs)
  - Examples: Medicare Benefit Policy Manual, Medicare Managed Care Manual, Claims Processing Manual, National Coverage Determinations (NCD)
- Expands on statute and Code of Federal Regulations (CFR); interprets, gives more detail
- Incorporates CMS guidance and transmittals
- Binding on CMS payment contractors and MA plans
  - Not binding on Administrative Law Judges (ALJs) and courts

Case 1: Durable Medical Equipment

Mrs. D is 86 years old and suffers from kyphosis, a spinal condition. Her daughter called to ask for help with an MA plan's denied a prior authorization request for a hospital bed. The doctor prescribed it to take pressure off Mrs. D's spine when she's lying down, and thereby reduce the pain. Mrs. D's daughter reports that her mother awakens every two or three hours at night screaming with pain. The family is exhausted. Mrs. D can walk about 15 feet at a time, but only with a walker. The MA plan determined that the hospital bed is not "medically necessary."

Case 1: Durable Medical Equipment

- What is the next step?
  - Request for Reconsideration
- Which Medicare Manual applies?
  - Medicare Benefit Policy Manual (100-02)
    - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending
- Which chapter contains the key guidance?
  - Chapter 15, §110

Question 2a: Hospice

Can a hospice certify a beneficiary as terminally ill and provide services to him without first consulting the individual's attending physician?

Case 2a: Hospice

- Which Medicare Manual applies?
  - Medicare Benefit Policy Manual (100-02)
    - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending
- Which chapter contains the key guidance?
  - Chapter 9, §20

Case 2a: Hospice

***Medicare Benefit Policy Manual,* Hospice Election, Chapter 9, §20.2.1**

- Each hospice designs and prints its election statement. The election statement must include the following items of information:
  - The individual's designated attending physician (if any). Information identifying the attending physician recorded on the election statement should provide enough detail so that it is clear which physician or Nurse Practitioner (NP) was designated as the attending physician. This information should include, but is not limited to, the attending physician's full name, office address, etc.

Case 2a: Hospice

***Medicare Benefit Policy Manual*, Hospice Election, Chapter 9, §20.1**

- For the first 90-day period of hospice coverage, the hospice must obtain, no later than 2 calendar days after hospice care is initiated, (that is, by the end of the third day), oral or written certification of the terminal illness by the medical director of the hospice or the physician member of the hospice IDG, and the individual's attending physician if the individual has an attending physician.

Question 2b: Hospice Certification

Does Medicare require a doctor to meet face-to-face with a patient to determine if she qualifies for the hospice benefit?

Question 2b: Hospice

- Which Medicare Manual applies?
  - Medicare Benefit Policy Manual (100-02)
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending
- Which chapter contains the key guidance?
  - Chapter 9, §20

Question 2b: Hospice Certification

- ***Medicare Benefit Policy Manual*, Hospice Coverage, Ch. 9 §20.1**

  5. face-to-face encounter. For recertifications on or after January 1, 2011, a hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice patient prior to the beginning of the patient's third benefit period, and prior to each subsequent benefit period. Failure to meet the … requirements … results in a failure … to meet the patient's recertification of terminal illness eligibility requirement. The patient would cease to be eligible for the benefit.

Question 3: Oral Health in a Long-term Care Facility

A LTC ombudsman asked if a nursing home's failure to provide dental care to its residents might be considered Medicare or Medicaid fraud. She found that some residents' oral health problems were contributing to costly Medicare-covered hospital stays to treat infections and related symptoms.

Question 3: Oral Health in a Long-term Care Facility

- Which Medicare Manual applies?
  - State Operations Manual (100-07)
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending
- Which chapter contains the key guidance?
  - Appendix PP

Question 3: Oral Health in a Long-term Care Facility

A facility-- (1) Must provide or obtain from an outside resource routine and emergency dental services to meet the needs of each resident….

"Routine dental services" means an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning, fillings (new and repairs), minor dental plate adjustments, smoothing of broken teeth, and limited prosthodontic procedures, e.g., taking impressions for dentures and fitting dentures.

Case 4: Part D Drug Denial

Mr. G was experiencing high levels of pain associated with carpal tunnel syndrome. His doctor instructed him to take 500 mg of naproxin, an over-the-counter pain medication, to relieve the pain. Mr. G used naproxin for two weeks as instructed, yet the pain persisted and at times seemed to intensify. The doctor prescribed Lidoderm® 5% patches for Mr. G to use, in addition to naproxin. Mr. G's drug plan used a prior authorization edit to deny coverage. The plan explained that carpal tunnel syndrome is not a medically-accepted indication for Medicare coverage purposes.

Case 4: Drug Denial

- What is the next step?
  - Request for Reconsideration
- Which Medicare Manual applies?
  - Medicare Prescription Drug Benefit Manuals
  - https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovcontra/partdmanuals.html
- Which chapter contains the key guidance?
  - Chapter 6, §10.6

Case 4: Part D Drug Denial

[T]he Act defines "medically-accepted indication" to any use of a covered Part D drug which is approved under the Federal Food, Drug, and Cosmetic Act, or the use of which is supported by one or more citations included or approved for inclusion in any of the compendia…. The recognized compendia are:

- American Hospital Formulary Service Drug Information;
- DRUGDEX® Information System

Questions?

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