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FDR Compliance Newsletter

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Training changes

Effective 1/1/2016, Centers for Medicare & Medicaid Services (CMS) requires that FDRs use CMS's training courses to meet the FDR training requirements.

Two ways to complete

Your employees and Downstream Entities assigned to provide administrative and/or health care services for our Medicare plans can access CMS's trainings in one of two ways:

1. **Complete the modules on the Medicare Learning network (MLN) website.** The general compliance course is called *Medicare Parts C and D General Compliance Training*, and the FWA training is called *Combating Medicare Parts C and D Fraud, Waste and Abuse (FWA) Training*. They can both be completed on the MLN, after registration.
2. **Download or print CMS's general compliance training and FWA training and incorporate them into your training materials/system.** You can't change the content of the CMS training modules to ensure the integrity and completeness of the training.

Regardless of the method used, training must be completed:

- Within 90 days of hire or the effective date of contracting
- At least annually thereafter

In this issue

Quick links

- **Aetna's FDR Guide** (updated 2/2016)
- **Medicare Managed Care Manual**
- **Medicare Prescription Drug Benefit Manual**
- **Aetna's Code of Conduct** (updated 10/2015)
- **CMS's General Compliance Training**
- **CMS's FWA Training**
- **Exclusion Lists:**
  - **OIG's List of Excluded Individuals and Entities (LEIE)**
  - **GSA's System for Award Management(SAM)**

*Aetna maintains a comprehensive Medicare Compliance Program. It includes communication with Aetna Medicare FDRs. Dedicated to Aetna's Medicare Compliance Program is John Wells, Medicare Compliance Officer. He's based in Maryland. You can send questions or concerns for John and/or his Medicare compliance subject matter experts to **MedicareFDR@aetna.com**.*

Keep records

We confirm your compliance with these requirements as part of our annual attestation process. But you should also maintain evidence of training completion. Evidence of completion may be in the form of certificates from the MLN, attestations, or training logs. If you use training logs or reports as evidence of completion, they must include:

- Employee names
- Dates of employment
- Dates of completion
- Passing scores (if captured)

FWA Training exception

The only exception to this training requirement is if you are "deemed" to have met the FWA certification requirements through enrollment into Medicare Parts A or B of the Medicare program or though accreditation as a supplier of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS). Those parties deemed to have met the FWA training through enrollment into the CMS Medicare Program must still complete general compliance training.

CMS's audit protocol updates

CMS performs regular program audits on plan sponsors, like Aetna, that offer Medicare Part C and D plans. These audits ensure that we deliver benefits according to the terms of our contract. They also confirm that we evaluate compliance with core program requirements.

On October 19, CMS released their 2015 and 2016 audit protocols. This release was followed by a clarification document issued on January 19.

Major universe changes

Below is a summary of the major changes between the 2015 and 2015/2016 universes. This list is not complete. You can refer to the 2015/2016 Audit Protocol documents and CMS Audit Protocol Announcement, and CMS Audit Protocol Addendum Memo for a full description of changes.

All universes

What is an FDR

First Tiers, Downstream and Related Entities

First Tier Entity is any party that enters into a written arrangement, acceptable to CMS, with a Medicare Advantage Organization or Part D plan sponsor or applicant to provide administrative services or healthcare services to a Medicare eligible individual under the Medicare Advantage program or Part D program.

Downstream Entity is any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit or Part D benefit, below the level of the arrangement between a Medicare Advantage Organization or applicant or a Part D plan sponsor or applicant and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Related Entity means any entity that is related to a Medicare Advantage Organization or Part D sponsor by common ownership or control and:

Performs some of the Medicare Advantage Organization or Part D plan sponsor's management functions under contract or delegation; or

Furnishes services to Medicare enrollees under an oral or written agreement; or

Leases real property or sells materials to the Medicare Advantage Organization or Part D plan sponsor at a cost of more than $2,500 during a contract period.

CMS now requires that all universes be submitted in .xlsx or .csv format. Additionally, the date and time formatting has changed.

Organization Determination Appeals and Grievances (ODAG) universes

Many fields were added or removed from tables 1,2,5-10, and 3. In addition, the following changes should be noted:

- The Health Insurance Claim Number (HICN) has been removed from all tables.
- International Classification of Diseases (ICD) codes are requested for all diagnosis fields.

- 'Person who made the request' has been added to many of the tables.

Coverage Determinations Appeals and Grievances universes

Many fields were added and removed from tables 3,5-7, and 11-13. In addition, the following changes should be noted for the ODAG universes:

- New universe pull instructions were provided as part of the CDAG 2015/2016 Audit Protocol document introduction.
- Dismissed, Withdrawn, and N/A have been added as acceptable responses to the 'Request Disposition' field.
- N/A has been listed as an acceptable response to the 'NDC_11' field.

Other universes

Many fields were added and removed from the Compliance Program Effectiveness (CPE) universe tables. There were also multiple additions and removals to the Formulary Administration Table 3.

Review the protocols

There have been many changes made to the universe tables. Become familiar with them by reviewing the individual tables.

You can refer to the 2015/2016 Audit Protocol documents, CMS Audit Protocol Announcement, and the memo released January 19, titled "Addendum to the 2015/2016 Program Audit Protocols" for more information.

Prior to hire screenings

FDRs must complete exclusion list screenings prior to hire and monthly thereafter for all employees and downstream entities.

Upon hire

Many FDRs confuse "upon hire" with "prior to hire," but they are not the same. CMS requires the screening be conducted prior to hire. When we audit your screening process, we will look for evidence that the screening occurred before the hire date.

Screening at the same time or "upon hire" does not meet the requirement. We often see FDRs that try to do screening on an employee's first day, but that does not satisfy the requirement. You must ensure that you know whether an employee or downstream entity is excluded before they are hired or contracted to provide Medicare services

Let us know if you have any questions. Just send an email to MedicareFDR@aetna.com.

Ban of Advanced Beneficiary Notices (ABN) for Medicare Advantage (MA)

Provider organizations should be aware that an Advanced Beneficiary Notice of Non-Coverage (ABN) is not a valid form of denial notification for an MA member. ABNs, sometimes referred to as "waivers," are used in the original Medicare program. However, you can't use them for patients enrolled in Aetna's MA plans as CMS prohibits use of ABNs.

As a provider who has elected to participate in the Medicare program, you need to understand which services are covered by original Medicare and which are not. Aetna's Medicare Advantage plans are required to cover everything that original Medicare covers, and in some instances may provide coverage that is more generous or otherwise goes beyond what is covered under original Medicare.

As an Aetna Medicare contracted provider, you are expected to understand what is covered under Aetna's Medicare Advantage plans. CMS mandates that providers who are contracted with a Medicare Advantage plan, such as Aetna, are not permitted to hold a Medicare Advantage member financially responsible for payment of a service not covered under the member's Medicare Advantage plan unless that member has received a pre-service Organization Determination (OD) notice of denial from Aetna **before such services are rendered.** If the member does not have a pre-service

organization determination notice of denial from Aetna on file, you must hold the member harmless for the non-covered services and cannot charge the member any amount beyond the normal cost-sharing amounts (i.e., copayments, coinsurance, and/or deductibles).

However, where a service is never covered under original Medicare or is listed as a clear exclusion in the member's Evidence of Coverage (EOC) or other similar plan document, a pre-service organization determination is not required in order for you to hold the member financially liable for such non-covered Services. Please note, services or supplies that are not medically necessary or are otherwise determined to be not covered based on clinical criteria do not constitute "clear exclusions" under the member's plan, as the member is not likely to be able to ascertain on the face of the EOC that such services will not be covered.

ODs can be initiated by you as the provider, or the member in order to determine if the requested/ordered service is covered prior to a member receiving it, or prior to scheduling a service such as a lab test diagnostic test, or procedure.

Holding members responsible

Remember, unless a service or supply is never covered under original Medicare, you will only be able to hold an Aetna Medicare member financially responsible for a non-covered service if the member has received a pre-service OD denial from Aetna and decides to proceed with the service knowing they will be financially liable.

Questions and answers

Below are answers to some of the frequently asked questions we get on the topic of ABNs.

Q: All my patients sign an ABN stating they will be financially responsible for anything their insurance does not cover. Can I still use this process?
A: No, ABNs are for original Medicare and are not permitted for MA members. An ABN does not allow you to hold an MA member financially responsible for services that Aetna won't cover. To hold an MA member financially responsible for a service, the MA member must be notified through Aetna's OD process that the item or service will not be covered by Aetna. This OD must be completed prior to providing the item or service.

Q: An item or service is sometimes covered based on medical necessity. I'm not sure if my patient qualifies, what should I do?
A: If you aren't absolutely sure the service is covered, you or the MA member should request an OD from Aetna. This OD should be completed prior to the service being provided. Aetna will make a decision after reviewing the request and any relevant medical records. ODs can be standard (14 days or less) or an OD can be expedited (72 hours or less) if the physician believes that delay would place the member's life, health or ability to regain maximum functioning in serious jeopardy.

Remember, unless the service or supply is never covered under original Medicare, you will not be able to hold the MA member financially responsible for the non-covered service unless the member has a pre-service OD denial from Aetna and decides to proceed thereafter.

Q: What should I do if an item or service is excluded from coverage and is explicitly listed as an exclusion in the Evidence of Coverage (EOC)?
A: If the EOC clearly indicates that the service is not covered under any circumstance, members and providers do not need to go through the OD process. Providers can hold the MA member financially liable for these services. However, you should educate the member that the service is NOT covered by Medicare and they will be held responsible.

Q: Can a member be held financially responsible for a non-covered service if he or she was advised to request an OD but did not?
A: It depends. If the service is never covered by original Medicare or is listed as a clear exclusion in the member's EOC, then the member can be held financially responsible without an OD. However, if this exception does not apply, and the member was advised to obtain an OD but does not, then you will not be able to bill the member for the non-covered service. It is for this reason that many providers choose to initiate the OD process on behalf of their members.

Q: Is it really my responsibility to make sure that my patient has an OD from Aetna?
A: Aetna does not require providers to obtain ODs on behalf of their patients. However, a provider can request an OD for the member or ask the member to request an OD from Aetna. No matter what, if an OD is not obtained and a non-covered service is provided, the member cannot be held financially responsible unless the service is never covered under original Medicare or is listed as a clear exclusion in the member's EOC.

Q: Do I need to get the member's permission before requesting an OD on the member's behalf?
A: No permission or proof is needed for a provider to request an OD on behalf of a patient. Providers can, and often do, request ODs on behalf of their patients.

Get more information

Information about the OD process and the probation of ABNs can be found in Chapter 4, section 170, of the *Medicare Managed Care Manual* or the *Code of Federal Regulations* in section 42 CFR §§ 422.568 and 422.572. You can also reference the HPMS memo titled "*Improper Use of Advance Notices of Non-coverage*" issued on May 5, 2014.

Of course, you can always let us know if you have questions by emailing MedicareFDR@aetna.com.

Report to Aetna actual or potential fraud, waste and abuse OR non-compliance:

FDRs can have their own internal processes in place for reporting, however, instances which impact Aetna's Medicare business should be reported back to us by using one of the methods below:

By phone:
1-888-891-8910
(7 days a week, 24 hours a day)

Over the internet:
https://aetna.alertline.com

By mail:
Corporate Compliance
P.O. Box 370205
West Hartford, CT 06137-0205