# HOLDING MEDICARE ADVANTAGE PLANS ACCOUTABLE

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Revenue Cycle an Equalize RCM Company


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Westin Dallas Fort Worth Airport

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TRILOGY REVENUE CYCLE

# Accelerating Revenue, Empowering Healthcare

## Comprehensive Solutions for Hospitals, Clinics, and Practices — From Coding to Collections & Automation to Advisory

| Who We Serve | Business Processes | Consulting/Advisory | Automation |
|---|---|---|---|
| Critical Access Hospitals | Coding | Coding | BillSmart – reduces rejections and denials |
| Short Term Acute Hospitals (PPS) | Billing | CDI | AVID –discovers unidentified insurance coverage |
| Rural Community Hospitals | AR Follow Up | Patient Registration | CSA – quickly status claims for improved cash collections and claim resolution |
| Rural Health Clinics | Denial Management | Business Office | AMP – automates payment posting, improving timeliness and accuracy |
| Multi and Single Specialty Practices | Payment Posting | Managed Care Strategy | |
| Urgent Care Providers | Credentialing | Billing System Optimization | |
| | KPI Reporting and Analytics | | |
| | Troubled/Aged AR work down | | |
| | EHR Conversion/ Legacy AR work down | | |
| | Appointment Setting | | |
| | Call Center | | |

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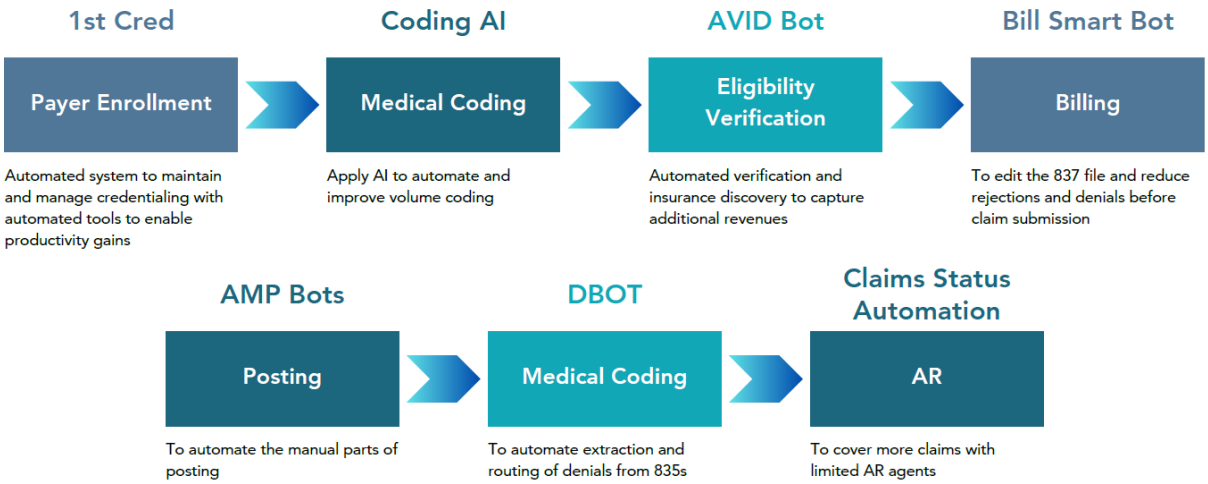
# Technology Touchpoints in Our Process



# Agenda

- Holding Medicare Advantage Payors Accountable
  - 42 C.F.R. key regulations
  - Review of Medicare Advantage Appeals and Grievance Process
  - Provider Complaint Tracking Database
- Get Organized and Know Your Agreements
  - Managed Care Grids
  - Share drive for contracts
- Products other than Contracted MA plans
  - Non-Contracted – They owe you “your” Medicare rate.
  - Commercial Plans
  - Other Plans – VA CCN, CHIP, Inmate, etc.

# I. Holding Medicare Advantage Payors Accountable

## A. 42 C.F.R. key regulations

### 1. How to Reference

42 C.F.R. § 260.11(a)(1)

| 42 C.F.R. | § 260 | .11 | (a)(1) |
|---|---|---|---|
| Title | Part | Section | Paragraph |

B. Inquiry vs. Appeal – Definitions 42 C.F.R. § 422.561

1. Inquiry – a written or verbal request for information that ***does NOT express dissatisfaction*** such as request for benefits.

2. Appeal – "any of the procedures that deal with the review of adverse organization determinations…procedures include reconsiderations by the MA organization…" 42 C.F.R. § 422.561. Also, any written or verbal expression of dissatisfaction with an ***adverse benefit determination***. As long as there is an ***expression of dissatisfaction***, it is still an appeal regardless of the payor's nomenclature such as reconsideration, redetermination, refilling, appeal, etc. An appeal is claim specific.

C. Grievance – any expression of dissatisfaction other than a specific claim - 42 C.F.R. § 422.564

1. Definition of Grievance: "Any complaint or dispute, other than one that constitutes an organization determination, expressing dissatisfaction with any aspect of an MA organization's or provider's operations, activities, or behavior, regardless of whether remedial action is requested" 42 C.F.R. § 422.561(2). A grievance is often procedural such as not following the manual, regulations, not answering the phone timely, etc.

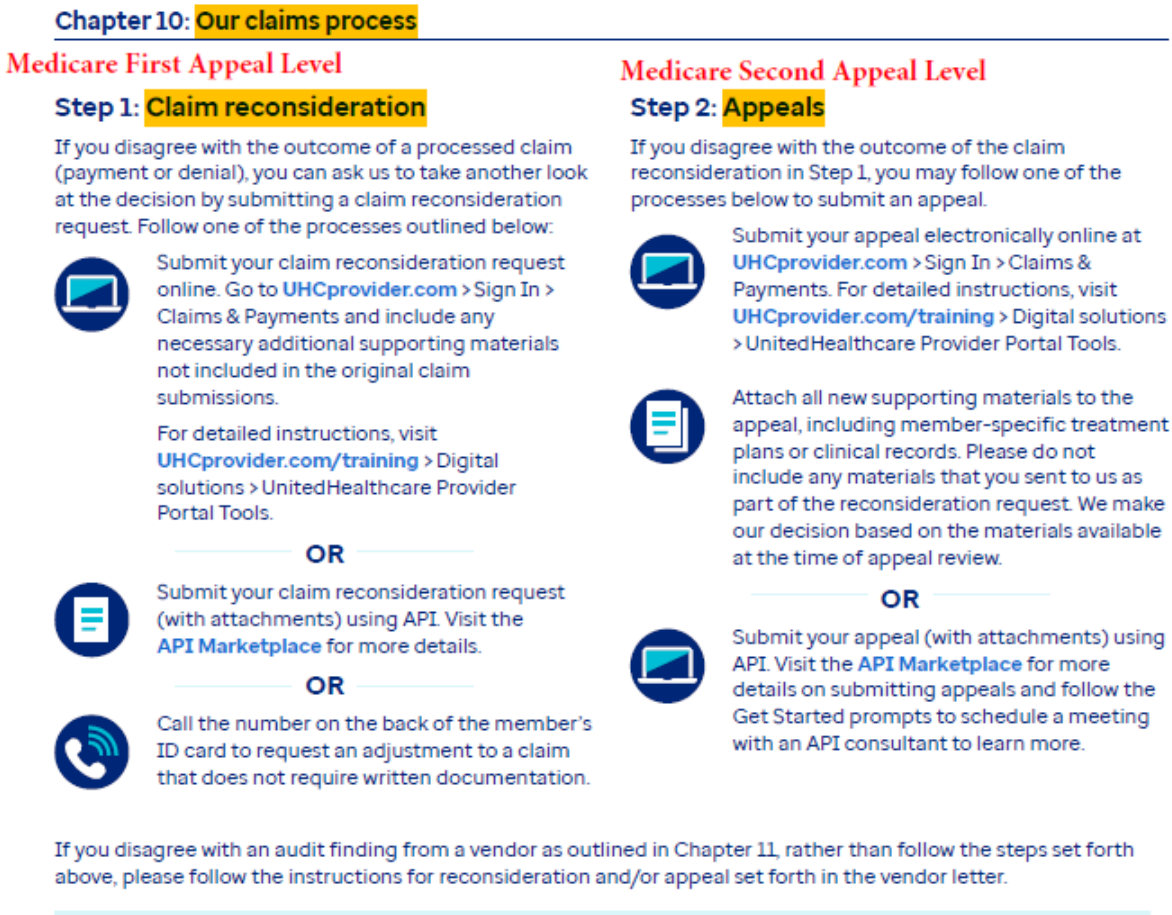
2. Provider Manual – Plans are required to list the Grievance process in their provider manual. Follow the process in the manual **exactly** regardless of what the plan tells you unless they provide it in writing.

3. Resources

    a. 42 C.F.R.: https://www.ecfr.gov/current/title-42
    b. Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance: https://www.cms.gov/medicare/appeals-and-grievances/mmcag/downloads/parts-c-and-d-enrollee-grievances-organization-coverage-determinations-and-appeals-guidance.pdf

# D. Medicare Advantage Appeals and Grievance Process

1. Plans try to insert steps before a “Level 1 Appeal” to confuse providers and to provide more opportunities for the provider to miss regulatory deadlines.



**Chapter 10: Our claims process**

## Medicare First Appeal Level

### Step 1: Claim reconsideration

If you disagree with the outcome of a processed claim (payment or denial), you can ask us to take another look at the decision by submitting a claim reconsideration request. Follow one of the processes outlined below:

Submit your claim reconsideration request online. Go to **UHCprovider.com** > Sign In > Claims & Payments and include any necessary additional supporting materials not included in the original claim submissions.

For detailed instructions, visit **UHCprovider.com/training** > Digital solutions > UnitedHealthcare Provider Portal Tools.

**OR**

Submit your claim reconsideration request (with attachments) using API. Visit the **API Marketplace** for more details.

**OR**

Call the number on the back of the member's ID card to request an adjustment to a claim that does not require written documentation.

## Medicare Second Appeal Level

### Step 2: Appeals

If you disagree with the outcome of the claim reconsideration in Step 1, you may follow one of the processes below to submit an appeal.

Submit your appeal electronically online at **UHCprovider.com** > Sign In > Claims & Payments. For detailed instructions, visit **UHCprovider.com/training** > Digital solutions > UnitedHealthcare Provider Portal Tools.

Attach all new supporting materials to the appeal, including member-specific treatment plans or clinical records. Please do not include any materials that you sent to us as part of the reconsideration request. We make our decision based on the materials available at the time of appeal review.

**OR**

Submit your appeal (with attachments) using API. Visit the **API Marketplace** for more details on submitting appeals and follow the Get Started prompts to schedule a meeting with an API consultant to learn more.

If you disagree with an audit finding from a vendor as outlined in Chapter 11, rather than follow the steps set forth above, please follow the instructions for reconsideration and/or appeal set forth in the vendor letter.

# 2. When is a Grievance or Appeal Considered Received?

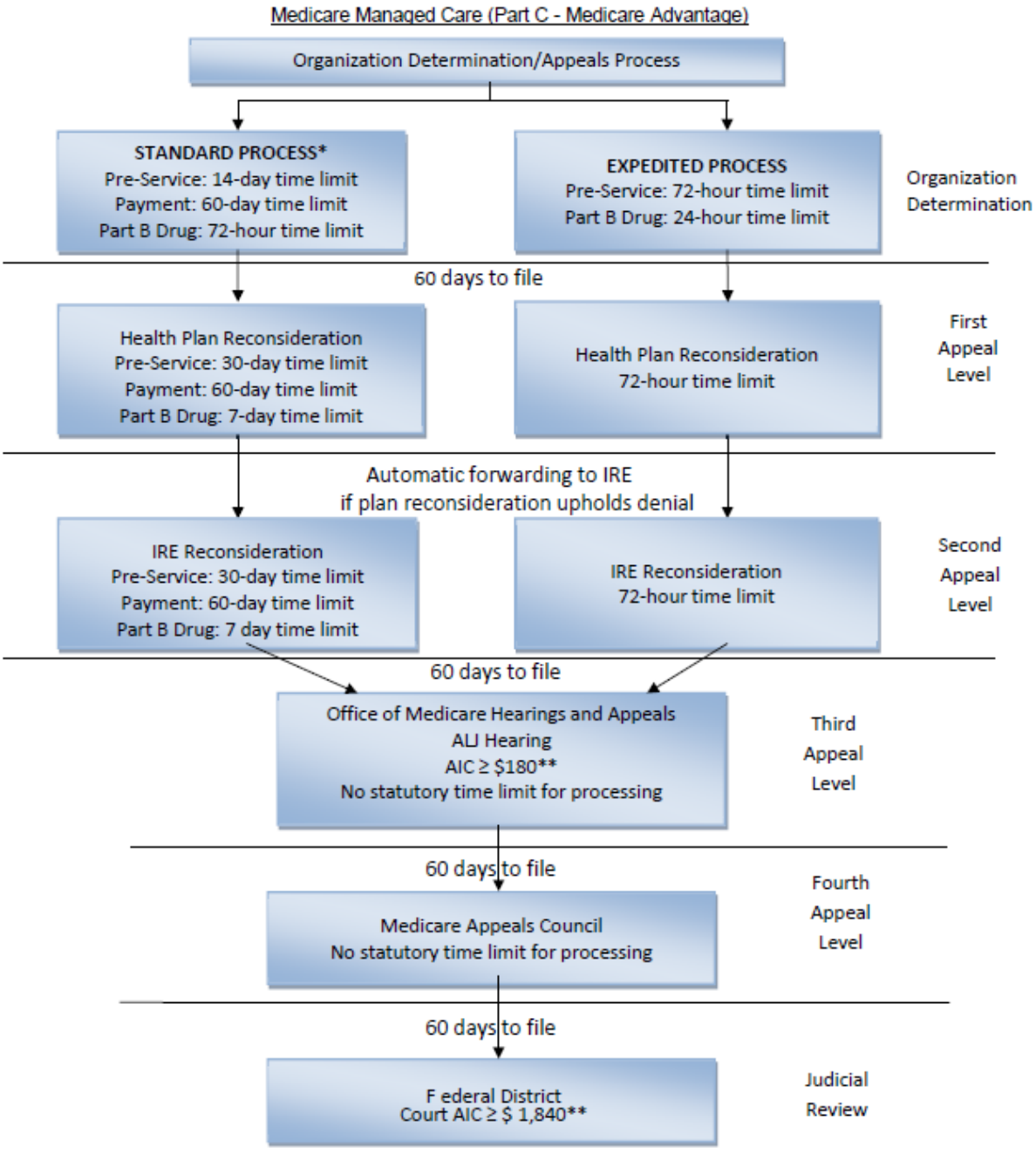
### 10.5.2 – When a Request is Considered Received by the Plan

Plans must have processes in place to accept requests (grievance, coverage, and appeal requests) 24 hours a day, 7 days a week (including holidays). Requests (and for Part D, prescriber supporting statements for exception requests) are deemed "received" on the date and time:

- The plan initially stamps a document received by regular mail (i.e., U.S. Postal Service);
- A delivery service that has the ability to track when a shipment is delivered (e.g., U.S. Postal Service, UPS, FedEx, or DHL) delivers the document;
- A faxed document is successfully transmitted to the plan, as indicated on the fax transmission report;
- A verbal request is made by telephone with a customer service representative;
- A message is left on the plan's voicemail system if the plan utilizes a voicemail system to accept requests or supporting statements after normal business hours; or
- A request is received through the plan's website, provided the website and/or portal meets all applicable regulatory requirements.

**Note:** For standard requests, the processing timeframe begins when the plan, any unit in the plan, or a delegated entity (including a delegated entity that is not responsible for processing) receives a request. For expedited requests, the processing timeframe begins when the appropriate department receives the request. Plan material should clearly state where pre- and post-service requests should be sent, thus ensuring requests are received at the correct location and giving the plan the greatest amount of time to process the request. Plan policy and procedures should clearly indicate how to route requests that are received in an incorrect location to the correct location as expeditiously as possible.

# 3. Appeals Process




AIC = Amount in Controversy / ALJ = Administrative Law Judge / IRE = Independent Review Entity
*Plans must process 95% of all clean claims from out of network providers within 30 days. All other claims must be processed within 60 days.
**The AIC requirement for an ALJ hearing and Federal District Court is adjusted annually in accordance with the medical care component of the consumer price index. The chart reflects the amounts for calendar year (CY) 2024.

# E. Provider Complaint Tracking Database

## 1. New Process so complaints can be tracked

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

**DATE:** December 22, 2025

**TO:** All Medicare Advantage Organizations

**FROM:** Vanessa S. Duran, Director
Medicare Drug Benefit and C&D Data Group

**SUBJECT:** Health Plan Management System (HPMS) Complaints Tracking Module Updates for Managing Provider Complaints

On December 22, 2025, CMS will implement an online form on cms.gov for providers that need to report a complaint about a Medicare Advantage plan. Upon submission, these complaints will be sent to the HPMS Complaints Tracking Module (CTM). The process will flow as described below:

- Providers will access the online complaint using the following steps:
  - Go to https://www.cms.gov.
  - Select "Medicare" from the top left dropdown menu.
  - Select "Health & drug plans" from the left-hand navigation.
  - Select "Report a provider complaint about an MA plan."
- The online form will capture basic information about the complainant, beneficiary, provider, and Medicare Advantage plan, a complaint summary, and optional fields for date(s) of service and claim number.
- Given these data will be captured by an online form, MA plans will no longer receive an attachment of the original provider complaint form.
- Provider complaints will be placed into a queue in the CTM, where CMS will review and triage prior to assigning a contract number.

Please contact Kristy Holtje (Kristy.Holtje@cms.hhs.gov) for questions about this memo.

## 2. Not a substitute for invoking Medicare Member's Appeals or Grievance rights.

## II. Get Organized and Know Your Agreements

A. Review your contracts to make sure they are complete and fully executed

# B. Standardize Files and Naming Conventions

| Payor Name | Entity Type | Entity (mnemonic) | Document Type | Additional Descriptor such as Product, Clinic location, Amendment description, Other | Start Date | Termination Date |
|---|---|---|---|---|---|---|
| United | Facility | | Agreement | Clinic mnemonic | YYYYMMDD | YYYYMMDD |
| BCBS | Professional | | Amend | CHIP | | |
| AHS | Global | | Notice | Language | | |
| Medicaid | Ancillary | | Communication | Rates | | |
| Medicare | | | | Rate Letter | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | Examples | | | |
| Aetna | Facility | | Agreement | | 20100101 | |
| Aetna | Facility | | Amend | Rates | 20110101 | |
| Aetna | Facility | | Notice | *description* | 20180101 | |
| Aetna | Professional | | Agreement | | 20100101 | |
| Aetna | Professional | | Amend | Language | 20120101 | |
| Aetna | Professional | | Notice | Rate Letter | 20181001 | |

Aetna Facility Agreement 20181201
Aetna Facility Amend Rates 20210101
Aetna Facility Amend Language 20220101
Aetna Facility Amend MA 20240101
Aetna Facility Notice Medicare Rate 20250401
Aetna Professional Agreement 20230701
Aetna Professional Amend MA 20240101
Aetna Facility Notice Medicare Rate 20250401
BCBSTX Facility Agreement 20240101
BCBSTX Facility Amend 20250101
BCBSTX Facility Notice Medicare Rate 20240401
BCBSTX Facility Notice Medicare Rate 20250401
BCBSTX Professional Agreement 20231101
BCBSTX Professional Notice Medicare Rate 20240401
BCBSTX Professional Notice Medicare Rate 20250401
Cigna Global Agreement 20090201
Cigna Global Amend Rates 20150712
Cigna Global Communication MA 20230101

C. Store on shared drive for needed individuals / departments in Revenue Cycle

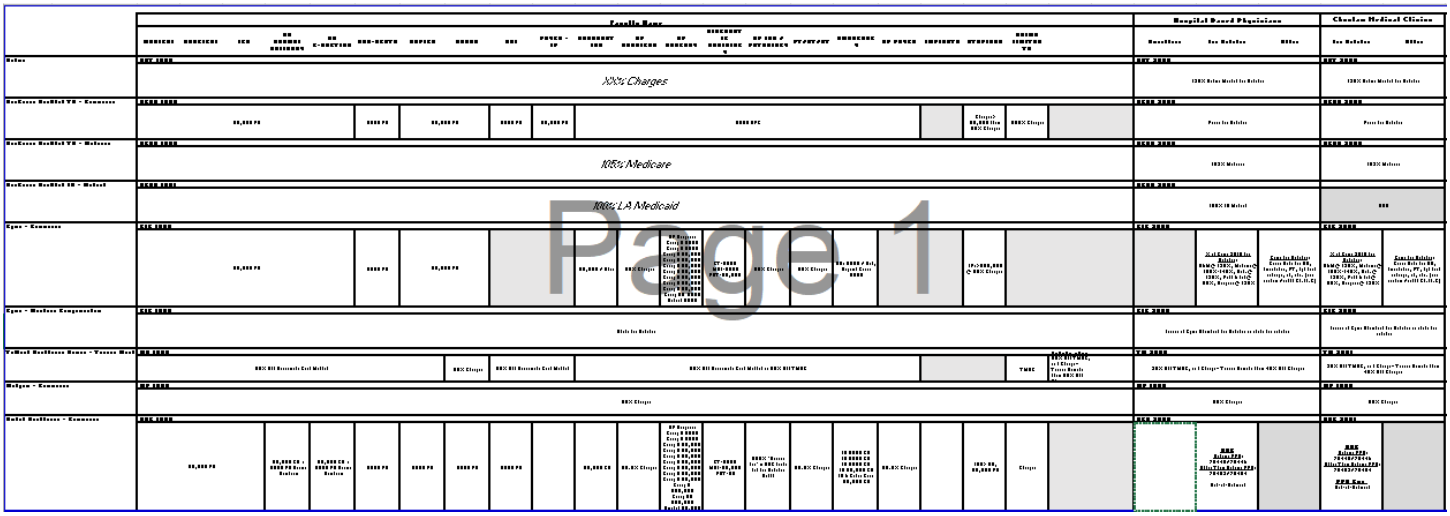
D. Contract Summary Grids – email Ed.Casteel@trilogyrcs.com for full electronic templates for grids

1. Contracts By Entity - Grid by payor, by product to know which agreements go with which entities. Can be used to identify inconsistencies and/or holes in what is contracted verses what is out-of-network

**Contracts by Entity Summary**

| | | Name | Legal Name #1 | Legal Name #2 | Legal Name #3 | Legal Name #4 | Legal Name #5 | | |
|---|---|---|---|---|---|---|---|---|---|
| | | dba | Hospital #1 | Ancillary #1 | Hospital Based Physicians #1 | Clinic #1 | Clininc #2 (RHC) | STATUS | NOTES |
| | | TIN | xx-xxxxxxx | xx-xxxxxxx | xx-xxxxxxx | xx-xxxxxxx | xx-xxxxxxx | | |
| **Payor** | **Contract ID** | **Description** | | | | | | | |
| Aetna | AET 1000 | Facility (Comm, WC) | AET 1000 | AET 1000 | AET 1000 | | | Active | 8/15/09 - __/__/__ |
| Aetna | AET 2000 | Prof (Comm, WC) | | | | AET 2000 | AET 2000 | Active | 4/1/10 - __/__/__ |
| BCBSTX | BCBS 1000 | Facility (Comm, WC) | BCBS 1000 | BCBS 1000 | BCBS 1000 | | | Active | 1/1/12 - __/__/__ |
| BCBSTX | BCBS 1000 | Facility (Medicare) | BCBS 1000 | BCBS 1000 | BCBS 1000 | | | Active | 1/1/19 - __/__/__ |
| BCBSTX | BCBS 2000 | Prof (Comm, WC) | | | | BCBS 2000 | BCBS 2000 | Active | 11/15/15 - __/__/__ |
| BCBSTX | BCBS 2000 | Prof (Medicare) | | | | BCBS 2000 | BCBS 2000 | Active | 1/1/19 - __/__/__ |
| BCBSLA | BCBS 1001 | Facility (Medicaid) | BCBS 1001 | BCBS 1001 | BCBS 1001 | OON | OON | Active | 1/1/21 - __/__/__ |
| TriWest Healthcare Alliance (Tricare West) | TW 1000 | Facility (Tricare) | TW 1000 | TW 1000 | | | | Active | 12/22/21 - __/__/__ |
| TriWest Healthcare Alliance (Tricare West) | TW 2000 | Facility (Tricare) | | | TW 2000 | | | Active | 1/1/22 - __/__/__ |
| TriWest Healthcare Alliance (Tricare West) | TW 2001 | Facility (Tricare) | | | | TW 2001 | TW 2001 | Active | 1/1/22 - __/__/__ |

# 2. Contract Rate Summary



# 3. Contract Provision Summary - Contract terms that your Revenue Cycle staff need to know

a. Revenue Cycle

i. Timely Filing – how long to file the first claim

ii. Appeal Time Frame
   a. How long to file
   b. Time to file based off
   c. Date of service
   d. Date of discharge
   e. Date of first denial
   f. Date of last denial
   g. Timely Filing and Appeal time frames are not the same

iii. Overpayments, Offsets, Recoupments
   a. Is there a requirement of formal Notice
   b. Can the provider object to the recoupment
   c. Does the payor have the right to offset

iv. Billing of Members
   a. Allowed
   b. Prior notice of specific services

v. Clean Claims Payment
   a. Is there a penalty
   b. Start date
   c. Interest rate
   d. Loss of discount

vi. Medical Records

a. Unlimited copies
b. Reimbursement

vii. Eligibility Verification
a. Is the plan responsible for providing accurate eligibility
b. What happens if eligibility is wrong or there is retroactive eligibility
c. Is retroactive eligibility limited or open-ended

viii. UM Requirements
a. Notices
b. Pre-Certs
c. Authorizations
d. Time frames

ix. Emergency
a. Prudent Layperson
b. Notice Requirements
c. Definition of Emergency
d. Evaluate and Stabilize ONLY
e. Does it include TREATMENT

x. Medical Necessity
a. Criteria
d. Medicare
e. MCG vs. InterQual
f. Clinical without definition
b. Exceptions

b. Contract Administration
iii. Amendments

iv. Acquisitions
v. Assignment
vi. Rate Negotiations & Increases
vii. Notice Address
viii. Termination without Cause
ix. Renewal Date
x. Effective Date
xi. Charge Master Notice

## Contract Provision Summary

| Payor | Timely Filing | Appeal Time Frame | Overpayment Offsets, Refunds & Recoupments | Billing Members | Clean Claim Payment | Medical Records | Eligibility Verification | COB/TPL | UM Requirements | Silent PPO | Emergency | Medical Necessity | Plan Policy and Procedure |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Payor #1 | (4.1.1) Primary payor 180 days from DOS. Secondary payor - 180 days from Primary's EOB. Worker's Comp: (AWCA Addendum, VI) 90 days. | (4.1.1) 180 days | (4.1.2) 2 years after payment. 30 day notice w/ right of offset. | (4.3.1) Member must agree in writing to be liable for Non-covered service. Waived if member failed to identify themselves as a member of plan. (4.3.2) Member Held Harmless. | | | | (see section 4.2) | (4.1.4) Provider shall abide by. | (2.10) Non-health benefit products require 90 day notice w/ facility able to reject. | (1.14) Prudent Layperson | (1.23) Clinical but doesn't define UM Criteria. Allows for denials based on lowest cost setting. | (5.1) Dynamic and mg change from time to time. Includes . Includes newsletters, e-mail and letter. 90 notice including newsletter or e-mail w/ 30 days to object. |
| Payor #2 | (2.2.2.3) 180 days w/ best efforts in 30 days. | | (2.2.7) Recovery allowed. | (2.2.3.1) Can't bill Members for services provided not in compliance with UM programs and policies. Member must agree in writing to be liable for Non-covered/Non-medically necessary service. | (4.3) Best efforts in 30 days. | (2.4.3) No charge. | (3.5) Not responsible for incorrect/retroactive information submitted by Group. | (2.2.5) See agreement. | | | | (1.9) Clinical but doesn't define UM Criteria. | (2.2.2.2) agrees to comply. (3.6) BCBSNC will notify Provider of changes. |
| Payor #2 | (2.2.2.3) 180 days | | (2.2.7) 30 day notice w/ right of offset. | (2.2.3) Member Held Harmless. Member must agree in writing to be liable for specific Non-covered/Non-medically necessary service. | (3.3) Reasonable efforts in 30 days. | (2.4.3) No charge. | (3.5) Not responsible for incorrect/retroactive information submitted by Group. | (2.2.5) see agreement for limits on reimbursement and billing of members. | | | | (E1.1.9) Clinical but doesn't define UM Criteria. | (2.2.2.2 & 2.6.1) agrees to comply. (3.6) BCBSNC will notify Provider of changes w/ reasonable time to comply. |
| Payor #2 | (4.2.2) 180 days. | | | (4.5.1 & 4.5.6) Member Held Harmless. Member must agree in writing to be liable for specific Non-covered/Non-medically necessary service. | (3.3) Reasonable efforts in 30 days. | (6.1.1. & 6.1.2) No charge. | (4.6) Best Efforts to make adjustments w/in 90 days. | (4.7) | | | (1.9) Prudent Layperson | (1.17) Clinical but doesn't define UM Criteria. | (2.3.1 & 3.2.5) Shall comply. Changes require 60 prior notice. |

## III. Products other than Contracted MA plans

D. Non-Contracted MA Plans – They owe you "your" Medicare rate

3. CAH & RHC – Medicare Rate Letter
4. CAH Method II Billing – Optional billing method where professional services are billed on a UB04. Paid at 115% of Medicare PPS Fee Schedule for your locality.

5. PPS

   a. Hospital Inpatient – Use IPPS Pricer with HMO flag set to “Yes” (https://www.cms.gov/ipps-webpricer)

   b. Physician – Fee Schedule from CMS website adjusted for locality. Use file *yy*LOCCO to get locality to look up correct Geographic Practice Cost Indices (GPCIs) in file GPCI*yyyy*. Us the GPCIs to adjust rates in National Physician Fee Schedule Relative Value File (PPRRVU*yy_month*) for your locality.

**COUNTIES INCLUDED IN 2025 LOCALITIES. (ALPHABETICALLY BY STATE AND LOCALITY NAME WITHIN STATE)**

| Medicare Adminstrative Contractor | Locality Number | State | Fee Schedule Area | Counties |
|---|---|---|---|---|
| 04412 | 31 | TEXAS | AUSTIN | TRAVIS |
| 04412 | 20 | | BEAUMONT | JEFFERSON |
| 04412 | 09 | | BRAZORIA | BRAZORIA |
| 04412 | 11 | | DALLAS | DALLAS |
| 04412 | 28 | | FORT WORTH | TARRANT |
| 04412 | 15 | | GALVESTON | GALVESTON |
| 04412 | 18 | | HOUSTON | HARRIS |
| 04412 | 99 | | REST OF STATE | ALL OTHER COUNTIES |

E. Commercial Plans – Based on “your” Medicare rate

F. Tricare Community Care Network

    3. West Region - TriWest Healthcare Alliance (Texas)

    4. East Region – Humana Military

G. Other Plans – Based on “your” Medicare rates

    3. CHIP

    4. Inmate

    5. Contract billing

# Underpayments Keeping You Up at Night?


## Managed Care Services – What we do:

We start the process by building a managed care infrastructure to optimize cash collections. This is accomplished by:

1. Auditing your agreements.
2. Providing robust tools and training to ensure that your staff understands each contract, with the end goal of preventing underpayments and fighting current underpayments.
3. Coaching staff on writing effective appeals to enforce agreement terms, and identification of operational/technical problem areas.
4. We empower your revenue cycle team with agreement terms to avoid operational breakdowns, which can result in unnecessary denials.
5. Archiving your agreements so you always have them to support:

- Auditors
- No Surprises Act
- Patient estimates
- Payment verification/contract modeling
- Budgeting

After building the infrastructure, we verify opportunities to improve collections with existing agreements, re-negotiated agreements, and new agreements. This includes identifying current payments/missing documents and assisting your organization with obtaining missing documentation from payors. If a payment verification system is not available, we assist with the development of alternative approaches, including:

- Service Line Reporting
- Percentage of charges
- Sample Audits

The last step is installing a sustainable managed care support system to coach your payor negotiator. We support your managed care negotiator with the following:

- Time-tested techniques, tactics, and strategies for successful negotiating
- Redlining contract language, issue identification, and resolution
- Summarization of available market and financial data

601-405-4641 trilogy-health.com

2.

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# Questions?

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