Operational Policy Letter #46

Department of Health & Human Services

Health Care Financing Administration

Medicare Managed Care

December 19, 1996

MANAGED CARE COVERAGE

Issue:

1. General coverage requirements

What are the coverage requirements for beneficiaries in Medicare contracting managed care plans?

Medicare contracting managed care plans are required to provide their Medicare enrollees those services that are covered under Medicare and available to other fee-for-service Medicare beneficiaries residing in the geographic area covered by the plan. This means that contracting HMO/CMPs (both risk and cost plans) must abide by HCFA national coverage decisions. They must also abide by specific written policies made by the Medicare carrier or intermediary with jurisdiction for claims in the geographic area served by the plan. (These policies are sometimes called "local medical review determinations".) In cases where the plan overlaps the jurisdictions of more than one contractor, and the contractors have different medical review policies, the plan must apply the medical review policies of the contractor in the area where the beneficiary lives.

2. Coverage issues manual

Where can I get information regarding national coverage decisions?

Newly contracted HMO/CMPs are put onto the distribution list for the Coverage Issues Manual, HCFA Publication 6 which describes national coverage policies, including lists of procedures and a discussion of the circumstances under which they are covered. This distribution list includes regular updates. Medicare HMO/CMPs are expected to become familiar with this material and how to research coverage issues.

3. Medicare's local medical review policies

Where can I get information regarding local medical review policies made by the Medicare contractors in my state?

The HMO should contact the carrier medical director's office in its state and request to be placed onto the distribution list for any contractor specific policies and related information. Also, in each state where there are Medicare contracted HMOs and CMPs we have requested that HMO representatives be put onto the Carrier Advisory Committee that deals with coverage issues. The HMO representatives are expected to act as a point of contact and information among all of the managed care organizations in the state and the carrier. The name of the HMO representative will be available from the HMO state association.

For issues regarding durable medical equipment, national coverage policies are published in the coverage issues manual. In addition, there are four Durable Medical Equipment Regional Carriers (DMERCs), each which publishes coverage guidelines for its regions in quarterly bulletins. Contact the DMERC for your region to obtain these guidelines.

4. Definition of local medical review policies

If the local carrier or intermediary has no written policy regarding coverage for a certain service, should the HMO rely on evidence that claims have been paid by the Medicare contractors for the service as evidence that the service is covered?

Carriers and intermediaries process and pay extremely large volumes of claims, and despite extensive computer screening and editing, the contractors cannot completely ensure that payment is not made for noncovered services. Thus, the fact that a claim for a service has been paid is not reliable evidence that the service is covered due to a contractor specific coverage determination by the carrier. Managed care plans should rely on written notices from the Medicare contractor as evidence of coverage decisions.

5. Process for making a coverage decision

When there is no national or contractor specific policy regarding coverage of a service, how should the HMO/CMP make a coverage determination?

HMO/CMPs are required to make coverage determinations when there is no national policy or contractor specific policy on the service. They may, but are not required to use the coverage policies of other HMO/CMPs in their service area. They should make coverage determinations using an objective, evidence based process. Conclusionary statements about

coverage, such as "it is our policy to deny coverage for service X," are not acceptable substitutes for a careful process based on authoritative evidence.

Examples of evidence that are useful in this process include use of studies from government agencies such as the Agency for Health Care Policy and Research (including the Center for Health Care Technology) and the Food and Drug Administration. Evaluations performed by independent technology assessment groups such as ECRI and the Blue Cross/Blue Shield Association (BCBSA) also provide useful background. The HMO/CMP or its parent organization may perform its own analysis of the issue, giving weight to a literature search for well designed controlled clinical studies of the technology that have appeared in a peer reviewed journals. Noncontrolled case studies and anecdotal information are far less persuasive in supporting coverage decisions. In the absence of authoritative evidence or medical consensus that a service is reasonable and necessary for patients, the HMO/CMP is justified in denying coverage for the service.

6. Medical necessity.

Does a decision that a service is "covered" mean that any patient who desires the service should receive it?

There is a distinction between the decision that a health care service, as a general rule, can be reimbursed by Medicare and the decision, made in the resolution of care for an individual patient, that the service is appropriate for that patient. This decision regarding appropriate care for the individual patient is usually referred to as a medical necessity decision. Thus, it may be true that a service that is "covered" in general is found not to be "reasonable and necessary" for an individual beneficiary because of the medical condition of the beneficiary or the availability of more effective alternate treatments.

The judgments regarding medical necessity made by the HMO/CMP may not always be identical to those made by providers in the fee for service sector and allowed by the carriers. This is permissible as long as the judgments of the HMO/CMPs remain within the range of high quality medical practice and are in the best interest of the patient.

7. Restrictions on physician's advice regarding diagnostic and treatment options.

Are Medicare contracting managed care plans permitted to use contract clauses or other restrictions that prevent medical providers from fully discussing all of the appropriate diagnostic or treatment options for a disease or condition with a beneficiary?

No. Clauses in HMO contracts or similar restrictions that prevent physicians or other providers from fully discussing all diagnostic or treatment options with a patient are not allowed. Among the benefits to which Medicare beneficiaries are entitled is advice from their physicians on medically necessary treatment options that may be appropriate for their condition or disease. Beneficiaries in managed care plans are entitled to all of the benefits of other Medicare beneficiaries, and are entitled to advice on appropriate diagnostic and treatment options from their physician. Since a gag clause would have the practical effect of prohibiting a physician from giving a patient the full range of advice and counsel that is clinically appropriate, it would result in the HMO not providing all covered Medicare services to its enrollees, in violation of the HMO's responsibilities. Thus, they are prohibited. Assuring the availability of this benefit to Medicare beneficiaries will be part of HCFA's routine oversight of contracting managed care organizations. HCFA has issued OPL96.044 to explain this issue.

LEGAL AND REGULATORY BASIS FOR COVERAGE POLICIES

What is the legal and regulatory basis for the coverage requirements?

A. Statutory requirements from the Social Security Act:

Section 1862(a)(1)(A) excludes payment for items which "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

Section 1876(c)(2)(A) of the Social Security Act requires contracting plans to provide enrollees with the services covered under Part A and Part B.

Section 1876(I)(6) states that the Secretary can terminate a contract with, or apply other remedies to an entity if that contracting entity "fails substantially to provide medically necessary items and services that are required . . . to be provided to an individual covered under the contract, if the failure has affected . . . the individual (beneficiary)."

B. Regulations from Part 42 of the Code of Federal Regulations

42CFR417.414(b) states that (except for hospice care) "an HMO or CMP must furnish to its Medicare enrollees (directly or through arrangements with others) all the Medicare services to which those enrollees are entitled to the extent that they are available to Medicare beneficiaries who reside

in the HMO's or CMP's geographic area but are not enrolled in the HMO or CMP."

C. Office of Managed Care Manual Policy

Section 2101 states "All Medicare beneficiaries enrolled in your HMO/CMP (whether risk based or cost-reimbursed) are entitled to receive at least the services that are covered by fee-for-service Medicare in your geographic area. You must provide, or arrange to provide, all services covered by Part A and Part B of Medicare . . . For detailed descriptions of coverage under fee-for-service Medicare, refer to the Medicare Carrier's Manual, Medicare Intermediary Manual, and Coverage Issues Manual . . . ." Section 2150 states ". . . organize your service delivery system in the most efficient manner possible. If more than one type of practitioner or provider is qualified to perform a service, you have the option of choosing which practitioner or provider (as allowed by state law) you use to furnish a specific service as long as all Medicare-covered services are available and accessible and services are of high quality."

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