
CMS Manual System

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Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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CHAPTERS	REVISED SECTIONS	NEW SECTIONS	DELETED SECTIONS
7		Table of Contents	
7		7000 - 7580	
7 - Exhibit		Exhibits 7-20 - 7-74	

NEW/REVISED MATERIAL - EFFECTIVE DATE: July 18, 2003

Throughout Chapter 7, all references to Health Care Financing Administration (HCFA) are changed to Centers for Medicare & Medicaid Services (CMS), and all references to Peer Review Organization (PRO) are changed to Quality Improvement Organization (QIO). All references to 42 CFR 462 are changed to 42 CFR 475, and all references to 42 CFR 466 are changed to 42 CFR 476. All references to 42 CFR 473 are changed to 42 CFR 478, and all references to 42 CFR 476 are changed to 42 CFR 480.

Section 7015 - Beneficiary Request for Review of Hospital-Issued Notice of Non-coverage by a Quality Improvement Organization (QIO) is revised to clarify that the QIO completes the review within 30 calendar days from receipt of the medical record and not from the receipt of request. In addition, we added subsection C (Continued-stay HINN Rescinded), which explains your review responsibilities when handling this type of situation.

Section 7025 - Monitoring of Hospital-Issued Notice of Non-coverage is revised to clarify the type of HINN cases selected for your retrospective review.

Section 7055 - Medicare Enrollee Request for Quality Improvement Organization (QIO) Immediate Review includes additional subsection G (NODMAR Rescinded), which explains your review responsibilities when handling this type of situation.

Workload and Costs: These instructions do not represent an increase in workloads or costs.

NOTE: Normally red, italic font identifies new material. However, because this release is a new manual, normal text font is used for the initial release.

Quality Improvement Organization Manual

Chapter 7 - Denials, Reconsiderations, Appeals

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7000 - Hospital-Issued Notice of Non-coverage (HINN) Citations and Authority - (Rev. 4, 07-18-03)

The statutory authorities applicable to your review of a Hospital-Issued Notice of Non-coverage (HINN) are found at §1154(e), §1154(a), and §1879 of the Social Security Act (the Act). The regulatory authorities for issuing a HINN are found at 42 CFR 489.34, 42 CFR 411.404, and 42 CFR 412.42(c).

Hospitals (including ones with swing beds) have the authority to issue notices of non-coverage to beneficiaries or their representatives if the hospital determines that the care the beneficiary is receiving, or is about to receive, is not covered because it is not medically necessary, not delivered in the most appropriate setting, or custodial in nature.

A HINN may be given prior to admission, at admission, or at any point during the inpatient stay (HINNs are discussed in detail in the Hospital Manual, §§414.3-414.10, and model hospital HINNs are contained in §414.11).

NOTE: The hospital is not required to issue a HINN when it does not plan to bill the beneficiary or his/her representative.

§1154(e) of the Act requires you to review all hospital continued-stay notices of non-coverage upon a request by a Medicare beneficiary, his/her representative, or a hospital. This statutory provision does not apply to Quality Improvement Organization (QIO) review involving Skilled Nursing Facility (SNF) swing bed services.

7005 - Issuance of Hospital-Issued Notice of Non-coverage – (Rev. 4, 07-18-03)

A. Preadmission/Admission HINN -- The hospital issues a notice of non-coverage when it determines that the admission is not medically necessary, inappropriate, or custodial in nature. The hospital is not required to obtain concurrence from you or the attending physician prior to issuing the preadmission or admission notice of non-coverage. This also applies to HINNs related to direct admissions to swing beds (i.e., beneficiary is admitted to the swing bed after he/she was discharged from another hospital) and when the hospital determines that the beneficiary does not need SNF services.

B. Continued-stay HINN -- A hospital may issue a continued-stay notice of non-coverage when it determines that a beneficiary no longer requires continued inpatient care and either the attending physician or you concur. Before a hospital can issue a continued-stay notice of non-coverage, it must consider the admission to be covered.

- **Attending Physician Concurs** -- If the attending physician concurs in writing (e.g., written discharge order) with the hospital's determination that the beneficiary no longer requires inpatient care, the hospital may issue a notice of non-coverage to the beneficiary.

- **Attending Physician Does Not Concur** -- The hospital is required to give a notice to the beneficiary or his/her representative when the beneficiary's physician disagrees with the hospital's proposed notice of non-coverage and you are requested to review the case (See Hospital Manual §414.11, Exhibit 10). The hospital may use its own letterhead, but it may not alter or change the language. The notice must be given to the beneficiary or his/her representative concurrently when the hospital requests your review. Develop procedures to monitor issuance of that notice to beneficiaries or their representatives. For example, at the time you solicit the beneficiary's views, ask the beneficiary or his/her representative if he/she received the notice. The hospital may request, either by phone or in writing, that you review the case immediately. Complete your review within 2 working days of either the hospital's request or receipt of any additional information you requested (such as copies of medical records). Determine, on a case-by-case basis, whether a medical record is needed to make the determination as to the medical necessity and appropriateness of the admission and days of care. If you concur with the hospital's decision, notify the hospital that it may issue its HINN and issue your denial notice.

NOTE: In cases where the beneficiary requires a SNF level of care, the hospital cannot issue a notice of non-coverage if a SNF bed is not available. Medicare pays hospitals for days awaiting placement until a SNF bed is available, and the medical record documentation indicates that SNF placement is actively being sought.

- **Advance Continued-stay HINN** -- The hospital could project and determine when acute care furnished to a beneficiary would end and issue a continued-stay notice of non-coverage (with concurrence from you or the attending physician). If a hospital is able to determine in advance that the beneficiary will not require acute inpatient hospital care as of a certain date, it may give the notice of non-coverage in advance of that date (but ordinarily no earlier than 3 days before the first non-covered day).

EXAMPLE: The beneficiary had hip surgery, and he/she requires rehabilitative services but not at an acute hospital level of care. The hospital determines that the most appropriate setting for those services would be a SNF, and it makes arrangements to transfer the beneficiary (within 3 days) because a SNF bed will be available.

EXAMPLE: The beneficiary is recovering from an uneventful post-surgical period after a cholecystectomy. The hospital can predict that within 2 days the beneficiary will no longer require injections for pain control and will tolerate a regular diet and ambulation.

The advance notice does not relieve the hospital or the attending physician of the responsibility for monitoring the beneficiary's condition/level of care changes or for making appropriate discharge planning. If the beneficiary's condition/level of care changes after the notice is issued and further acute care is required (or the SNF bed is no longer available), then the hospital must rescind its notice of non-coverage.

C. Combined Notices in Swing Bed Situations -- The "combined notice" applies to situations where the beneficiary is in an acute care hospital that has beds certified as swing beds, and he/she no longer requires an acute level of care.

The discharge from the acute care bed and admission to the SNF or Nursing Facility (NF) swing bed is essentially a paper transaction with no physical movement of the beneficiary. The purpose of the combined notice is to notify the beneficiary or his/her representative that neither the acute nor SNF care is medically necessary or that the beneficiary no longer requires acute care hospital services but will begin to receive SNF swing bed services. The combined notice also notifies the beneficiary or his/her representative that if he/she disagrees with the hospital's decision an immediate QIO review may be requested (See §7015.B.1.b).

The hospital must issue the combined notice of non-coverage with either the attending physician's or your concurrence. The two post-discharge planning days applicable to Prospective Payment System (PPS) hospital cases (See 42 CFR 412.42(c)) would not apply to this situation. The beneficiary's or his/her representative's liability for payment begins the day following the date of receipt of the notice. The beneficiary may request your immediate review; however, the beneficiary's liability remains the same as specified in the HINN.

D. Continued-stay HINN in Swing Beds Treated as SNF Beds -- The hospital does not need the attending physician's or your concurrence to issue a continued-stay HINN to a beneficiary when SNF swing bed services are no longer needed. The immediate review provisions in §1154(e) of the Act do not apply to stays in SNF swing beds.

7010 - Content of Hospital-Issued Notice of Non-coverage – (Rev. 4, 07-18-03)

You are required to monitor the content of the HINN to determine whether the information is accurate/appropriate. The HINN to the beneficiary or his/her representative must conform to the content (but need not be a duplicate) of the model letters contained in Exhibits 1 through 10 of §414.11 of the Hospital Manual (See §414.5 for instructions concerning the content of hospital HINNs).

7015 - Beneficiary Request for Review of Hospital-Issued Notice of Non-coverage by a QIO - (Rev. 4, 07-18-03)

A. Preadmission/Admission HINN -- When a beneficiary or his/her representative requests review of a preadmission or admission HINN, review any records pertaining to health care services furnished. Include records pertaining to any inpatient hospital services provided or proposed to be provided to the Medicare beneficiary whether or not, in the hospital's view, the services are covered (See 42 CFR 476.88(a) and §§1154 and 1156 of the Act).

- Immediate Review -- If the beneficiary or his/her representative disagrees with the hospital preadmission notice, he/she may request your review, by telephone or in writing, within 3 calendar days of receipt of the HINN. If admitted, the beneficiary or his/her representative may request your review at any point during the stay. In either situation review the case within 2 working days following the beneficiary's or his/her representative's request, and issue either a denial notice or a notice explaining that the care would be, or is, covered.
- Review After Discharge or When Beneficiary Was Not Admitted to Hospital -- The beneficiary or his/her representative may request review within 30 calendar days after receipt of the notice. Complete this review within the timeframe specified for any retrospective review (See §4540). Once your review is completed issue either a denial notice or a notice explaining that the care is covered.

B. Continued-stay HINN -- The beneficiary or his/her representative may request your review, as described below, when the hospital issues a continued-stay notice of non-coverage with the concurrence of the attending physician (See §7005.B.1). If the hospital issues a continued-stay notice of non-coverage with your concurrence, the beneficiary may request a reconsideration of your determination (See §7040).

- Beneficiary Request for QIO Immediate Review of a HINN -- If the beneficiary or his/her representative disagrees with the HINN and remains in the hospital, he/she may request (not later than noon of the first working day after the day the notice was received) an immediate review by you. This request for review may be made by telephone or in writing.
 - The hospital must provide the medical records you require by close of business of the first working day after the date that the beneficiary receives the notice. Develop a procedure with the hospital that will ensure timely receipt of records (e.g., express mail service).
 - When a beneficiary or his/her representative requests your review, perform the review regardless of whether or not the hospital charges for continued-stay, or the beneficiary is liable for such care.
 - Prior to rendering a determination, solicit the views of the beneficiary or his/her representative, hospital, and attending physician (See §7020).
 - Complete the requested review and notify the beneficiary or his/her representative, the attending physician, and the hospital of your determination (whether adverse or favorable) within one full working day after the date of receiving the request and the required medical records.

- Make your notification initially by telephone and follow up with a written notification either:
 - Disagreeing with the hospital's decision (i.e., notifying the beneficiary that he/she requires covered care); or
 - Agreeing with the hospital's determination (i.e., issuing your initial denial notice). In addition, the beneficiary will also receive the HINN.
 - Document the telephone notification (e.g., time of call, information presented, and names of parties contacted). Retain this documentation in your case files.
- Other Review While the Beneficiary Is In the Hospital -- If the beneficiary or his/her representative does not request your review by noon of the first working day after receipt of the HINN and remains in the hospital, he/she may still request your review at any point during the stay. The request may be made by telephone or in writing. Review the case within 2 working days following the beneficiary's or his/her representative's request, and issue either a denial notice or a notice explaining that the care is covered.
 - Review After Discharge -- If the beneficiary is discharged from the hospital, he/she or his/her representative may still request review within 30 calendar days after receipt of the HINN or at any time, for good cause. Complete this review within 30 calendar days of receipt of the medical records, and issue either a denial notice or a notice explaining that the care is covered.

NOTE: After a beneficiary has exhausted all of his/her hospital benefit days (and the length of stay has passed the day outlier threshold), you are not obligated to review the hospital's decision regarding the beneficiary's need for continued hospital care for those days. Any advisory determination you make related to these exhausted benefit days is not subject to your reconsideration process (and further appeal rights) as it is not an initial determination. Your initial determination pertaining to inpatient days prior to exhausting benefit days or within the outlier threshold is binding on all parties (i.e., you can approve or deny Medicare payment, but it is still subject to appeal by the beneficiary).

C. Continued-stay HINN Rescinded -- If the hospital notifies you that the HINN has been rescinded after requesting the medical records:

- Instruct the hospital to submit the medical records (including a copy of the notice rescinding the HINN);
- Review the medical record and determine whether or not the hospital acted appropriately in rescinding the notice;

- Notify the beneficiary that the HINN was rescinded if you agree with the hospital's action and that he or she should have received a written notification from the hospital; and
- Issue your written initial determination (including a determination of the beneficiary's liability for payment under §1869 of the Act) if you disagree with the hospital's rescinded HINN.

7020 - Solicitation of Views Regarding Hospital-Issued Notice of Non-coverage - (Rev. 4, 07-18-03)

A. Beneficiary's Views -- When you conduct a review either because the beneficiary or his/her representative requests one (See §7015.B.1) or the hospital requests your review because the attending physician does not agree with its decision to issue a notice of non-coverage (See §7005.B.2), solicit the views of the beneficiary or his/her representative. This may be done by telephone. Present information solicited to the physician reviewer for use in the review. Also, make the information part of your case file. Solicit the views of the beneficiary or his/her representative at the same time as his/her telephone request for review to minimize the burden on the beneficiary.

Make every attempt to contact the beneficiary or his/her representative within the timeframe allotted for review completion. If the beneficiary or his/her representative cannot be contacted by the end of the first full working day after the request for review and receipt of the medical record, make your review determination without the beneficiary's or his/her representative's views. Retain documentation of your attempts to contact the beneficiary/representative.

B. Discussion With the Hospital and Attending Physician -- Give the attending physician and provider the opportunity to discuss the case prior to your determination, whether it will be adverse or favorable. Make every attempt to contact the hospital and attending physician before you make a determination.

7025 - Monitoring of Hospital-Issued Notice of Non-coverage – (Rev. 4, 07-18-03)

A. Purpose -- Monitor the content of the HINN and the accuracy of the hospital's determination (See Hospital Manual, §414.5).

- Upon a beneficiary's or a hospital's request for review, determine whether the HINN is appropriate and accurate (See §§7005 and 7020).
- For HINNs (e.g., admission) that are issued and no request for review is made, ensure no less than every 6 months a year that:
 - The hospital followed the appropriate process;

- The content of the notice is accurate/appropriate; and
 - The hospital's decision to issue the notice is correct.
- Monitor the hospital to ensure that it is issuing the Hospital Notice to Beneficiary of QIO Review of Need for Continued Hospitalization timely to the beneficiary when your review is requested (See Hospital Manual, §414.11, Exhibit 10).

B. Ongoing Monitoring

- Case Selection -- Conduct review of cases as follows:
- Cases selected monthly by CMS from the processed claims data where the hospital has issued a HINN and there is beneficiary's liability for payment.
 - Cases you have selected (no more than 6 months basis) by using the copy of the (preadmission, admission, or continued-stay) HINN submitted to you by the facility within 3 working days of the HINN issuance.

NOTE: Hospitals are required to submit a bill for all inpatient stays, including those for which no payment can be made. Although no monies are involved with "No-pay bills," a claim is required because hospitalization could extend a Medicare beneficiary's benefit period (See Hospital Manual, §411).

- Timing of Review -- For all cases selected for review, request medical records and complete review according to the timeframes for retrospective review. Reconcile the CMS selected claims data with copies of the HINN you received to ensure that the hospital is notifying you of all notices issued.

If you identify a hospital's failure to submit no-pay claims to the intermediary, work with the intermediary to establish a procedure to address/resolve the hospital's billing problem. The procedure should specify that if after a reasonable period of time (e.g., 6 months or longer) you are unable to reconcile the information between submission of the HINN and the claim data, you notify the intermediary and the hospital of the problem. The procedure must delineate the party (you or the intermediary) who is responsible for sending the hospital formal notification of noncompliance with the billing instructions (See Hospital Manual, §411). If the hospital does not submit a claim to the intermediary (after the specified period of time), notify the respective CMS Regional Office (RO) to take necessary action under its authority to bring the hospital into compliance with program requirements.

- Review Process -- For cases involving preadmission, admission, and continued-stay notices, review:
- All notices received to determine whether the language content of the HINN met the requirements (See Hospital Manual, §414.5);

- HINN cases selected by you (from “all notices“ received) to determine the appropriateness of the notice (i.e., the care was not covered from the point determined by the hospital and the content of the notice met the requirements of §414.5 of the Hospital Manual);
- All cases selected by CMS where the beneficiary is liable for charges for services furnished after notification (See §4230.D). Review these cases to ensure that the beneficiary is not held liable for charges covered by Medicare as specified at §7025;
- All cases involving admission and continued-stay notices identified from processed claims data where the hospital failed to send you a copy. Examine these cases to ensure that abuse is not involved (e.g., a hospital is withholding copies of inaccurate notices to avoid QIO review);
- All cases where the medical information you used for approval was received by telephone and the HINN issued significantly differs from the claim submitted to the intermediary, or where the past history of the facility indicates poor compliance; and
- All cases where you received a beneficiary complaint that was unrelated to the issuance of a hospital notice. However, if during your review evidence is found that a HINN was issued, you should review the HINN as well as the complaint issue (e.g., cases received under Hospital Payment Monitoring Program (HPMP)).

NOTE: For all continued-stay cases, determine the medical necessity and appropriateness of the admission (See §7005.B.2).

- HINN in the Outpatient Setting -- Review notices issued to Medicare outpatients undergoing surgery if the notice relates to denial of admission to the hospital. Review these notices if the beneficiary or his/her representative bring the issue to your attention or if the case is already under review.
- HINN Related to Exclusion and Coverage Issues -- The intermediary is responsible for medical review of claims that involve general exclusion and coverage issues, and review of HINNs associated with those denials. If the intermediary refers a coverage issue case (e.g., dental or cosmetic surgery) to you because a medical necessity review/determination is needed, then review the case and the HINN, if applicable.

C. Notification of QIO Determination -- Upon completion of notice review, take the following actions:

- Admission/Preadmission Notice of Non-coverage

- Issue a notice to all affected parties indicating either that the admission was non-covered (i.e., the hospital was correct in issuing the notice) or that the Medicare program would have covered the admission (i.e., the hospital notice was not issued correctly).
 - If Medicare should have covered the admission and the beneficiary was admitted after receipt of notice, notify the hospital, attending physician, beneficiary, and intermediary that the notice is invalid. Instruct the hospital to refund any monies collected from the beneficiary except for the applicable coinsurance and deductible amounts, personal convenience services, and items not covered by Medicare. The hospital may then submit a claim for Medicare payment, if appropriate.
- Continued-stay HINN
- For PPS cases, if there is a Diagnosis Related Group (DRG) change as a result of DRG validation, issue the notice;
 - If you concur with the hospital that continued inpatient hospital care was not necessary from the point determined by the hospital, issue the denial notice and inform the affected parties that you concur with the hospital's decision (See §§7100-7115);
 - If you determine that the hospital level of care ended earlier than determined by the hospital and additional days of care or costs are denied (non-PPS cases or PPS outlier cases), issue the denial notice (See §§7100-7115);
 - If you determine that the admission was not medically necessary or appropriate, issue an admission denial and determine which party is liable; or
 - If you determine that the hospital's finding is invalid (i.e., the beneficiary required continued inpatient care) and the beneficiary received services for which he/she could be charged, notify the hospital, attending physician, intermediary, and beneficiary. These HINNs are considered inappropriate (See subsection D). Specify in your notice that the charges were invalid and, to the extent collected, must be refunded by the hospital to the beneficiary. The hospital may submit the claim for Medicare payment.

NOTE: Except for those cases reviewed at the beneficiary's or hospital's request, you do not have to issue a denial notice in cases where you agree with the HINN and the beneficiary was not liable for the charges.

D. Inappropriate HINN -- An inappropriately issued HINN would be any case where:

- The hospital's finding is invalid (e.g., where the admission was covered (See subsection C.1), and where continued acute care was medically necessary (See subsection C.2));
- The content of the notice is not in compliance with §414.5 of the Hospital Manual;
- The patient was charged for hospital services without a notice;
- The patient requires SNF care and there was no available SNF bed (See §7005);
- A continued-stay HINN is issued without your concurrence or the concurrence of the attending physician (except in cases where the level of care changes from SNF swing bed services to NF); and
- The beneficiary did not receive written notice when discharged from acute care and admitted to SNF or NF swing bed services.

NOTE: In cases involving an admission HINN where you determine that the beneficiary's condition changed from non-acute to acute, assign a deemed date of admission. Because you agree that the HINN was not issued in error, do not count the case against the hospital as long as the hospital did not charge the beneficiary for the covered acute inpatient services.

E. Corrective Action -- Take corrective action immediately. If, during the course of your review, you detect that a particular hospital has issued an inappropriate notice, determine whether:

- The hospital issued a notice of non-coverage that could result in inappropriate collection of monies from a beneficiary. For example:
 - In a beneficiary request for an immediate review of a HINN with attending physician concurrence, a hospital notice indicates that if you review the case and deny the care, the beneficiary will be liable beginning the third day after receipt of the notice; or
 - A beneficiary complained that the hospital advised him/her that the care was non-covered, but a written notice was never issued.
- The hospital issued a notice that the admission or continued inpatient hospital care was non-covered, but a copy was not submitted to you and the case was identified from the processed claim data (See §7025.B.1); or
- The notices are improper but do not transfer liability for payment to the beneficiary (e.g., the HINN states that Medicare made the decision), and the

hospital refuses to change its notices to bring them into conformance with requirements.

Advise the hospital that issuing invalid notices that result in an improper collection of monies from beneficiaries is a violation of the hospital's Medicare provider agreement. The hospital must make immediate restitution except for the applicable deductible and coinsurance amounts, and if applicable, report the refund (proof of payment) to you and the intermediary.

The hospital's failure to correct its notices and bring them into conformance with the requirements will lead to referral of the hospital to the regional Office of Investigations, Office of Inspector General, Health & Human Services, for enforcement under §1886(f)(2)(B) of the Act.

Other examples of inappropriate notices and corrective actions include, but are not limited to:

- Cases, in which you initially concurred with the hospital on the issuance of the notices but upon reconsideration or retrospective validation review (See §7005.B.2) it is determined that in two or more cases the notices should not have been given (e.g., pertinent information on the cases was not provided), perform the notice review of cases where the attending physician and hospital do not concur by requiring medical records on every request for review; and
- Cases, in which a pattern of abuse is identified (e.g., where you determine that inpatient care was medically necessary but a notice of non-coverage was given) that meets the definition of a substantial violation in a substantial number of cases or a gross and flagrant violation, develop a sanction recommendation in accordance with §§9000-9070.

7030 - Beneficiary Liability Related to Review of Hospital-Issued Notice of Non-coverage - (Rev. 4, 07-18-03)

For beneficiary liability determination instructions, see §4230.D.

7035 - Provider Liability - (Rev. 4, 07-18-03)

A provider is considered to have knowledge as of the date of notice that furnished (or proposed) services were non-covered if it issued a notice of non-coverage to the beneficiary (See 42 CFR 411.406(d)).

7040 - Right to Reconsideration - (Rev. 4, 07-18-03)

A. You Disagree With the Hospital's Determination -- If you disagree with the hospital's determination of non-coverage (i.e., you determine that the care was covered), your

decision is not subject to reconsideration as this is neither a denial determination nor a QIO determination under §1154 of the Act.

B. You Agree With the Hospital's Determination -- If you agree with the hospital's determination either prior to or after issuance of the hospital's notice, issue a denial notice. Your determination is subject to reconsideration in accordance with 42 CFR Part 478 and instructions found in §§7100-7115.

7045 - Notice of Discharge and Medicare Appeal Rights Citations and Authority - (Rev. 4, 07-18-03)

§4001 of the Balanced Budget Act of 1997 (BBA) (Public Law 105-33) enacted August 5, 1997, added §§1851 through 1859 to the Social Security Act (the Act) to establish a new Part C of the Medicare program known as the Medicare + Choice (M+C) Program. Medicare Part C establishes a new authority permitting contracts between CMS and a variety of different managed care and fee-for-service entities (e.g., coordinated care plans). Regulations require that each M+C enrollee must receive a Notice of Non-coverage (NONC) before being released from the hospital once it is determined that inpatient hospital care is no longer necessary (See 42 CFR 422.620). The NONC is now referred to as the Notice of Discharge and Medicare Appeal Rights (NODMAR). The enrollee remains entitled to inpatient hospital care until he/she receives the NONC of that care. An enrollee or his/her representative that disagree with the hospital or M+C determination may only obtain QIO review of the NODMAR by requesting an immediate QIO review (See 42 CFR 422.622).

Until January 1, 2003, existing cost-based contracts established under §1876 of the Act are governed by regulatory provisions in 42 CFR Part 417 (See §1876(h)(5)(B)). Included in that Part are two protections available to managed care enrollees who believe they are being discharged prematurely from a hospital: immediate QIO review as provided by 42 CFR 417.605 or expedited internal review by the HMO or CMP (See 42 CFR 417.609). The regulatory authority for these organizations to issue NODMARs is found at 42 CFR 417.440(f).

7050 - Notice of Discharge and Medicare Appeal Rights – (Rev. 4, 07-18-03)

The Medicare + Choice Organization (M+CO) or the hospital (as delegated) issues the NODMAR with the physician's concurrence to the M+C enrollee. The physician's concurrence acknowledges agreement that inpatient hospital care is no longer necessary.

A. When the M+CO Issues the NODMAR -- The M+CO issues the NODMAR to the M+C enrollee once the required concurrence of the physician who is responsible for the enrollee's hospital care has been obtained (See 42 CFR 422.620(b)).

B. When Hospital Accepts Delegation -- If the M+CO allows the hospital to make the non-coverage/discharge determination (delegation), the hospital must obtain concurrence

from the contracting physician responsible for the enrollee's hospital care or of another physician as authorized by the M+CO (See 42 CFR 422.620(d)).

C. Content of NODMAR -- The NODMAR must include the following information:

- The reason why inpatient hospital care is no longer needed;
- The effective date of the enrollee's liability for continued inpatient care; and
- The enrollee's appeal rights.

D. QIO Responsibility -- You are not required to review or educate the plans regarding the content of the NODMAR. However, if you find an inappropriate NODMAR (e.g., the liability date is missing) during the course of your review, you are expected to report such findings to the CMS RO plan manager through your Project Officer.

7055 - Medicare Enrollee Request for Quality Improvement Organization (QIO) Immediate Review - (Rev. 4, 07-18-03)

A. Enrollee Request -- If the Medicare enrollee or his/her representative disagree with the NODMAR and the Medicare enrollee remains in the hospital, he/she may request (no later than noon of the first working day after the day the notice was received) an immediate review by you. This request for review may be made by telephone or in writing (See 42 CFR 422.622).

NOTE: In cases involving a M+CO located outside the QIO review area, the request for immediate QIO review must be made to and reviewed by the QIO that has the agreement (under 42 CFR 476.78) with the hospital treating the enrollee, not the QIO with the agreement with the M+CO. This means regardless of whether the determination was made by a M+CO or a hospital, the QIO that has the agreement with the M+CO is not involved (See Chapter 3 for the Memorandum of Agreement requirement related to NODMAR).

B. M+C Notification -- On the day that you receive the enrollee's request for an immediate review, you must notify the M+CO.

C. QIO Request for Medical Information -- The M+CO must take the following actions once an enrollee's request for an immediate review is confirmed:

- The M+CO must supply any information that you require to conduct your review. This information must be made available to you, by telephone or in writing, by close of business of the first full working day immediately following the day the enrollee submits the request for review.

- The M+CO must contact the hospital and request that the enrollee's medical records and other pertinent information be sent to you by close of business of the first full working day immediately following the organization's request.

D. QIO Immediate Review

- Solicitation of Views -- You must solicit the view of the enrollee or his/her representative that requested the immediate review (See §7020).
- QIO Review Determination -- Once you have received all the necessary information from the hospital or the organization or both (e.g., medical records), review the case and notify the enrollee, the hospital, and the M+CO of your determination by close of business of the first working day following receipt of all pertinent information. Make your notification initially by telephone and follow up with a written notification (See §7015.B.1).

E. Enrollee Liability Protection -- If the M+CO authorized coverage of the inpatient admission directly or by delegation (or the admission constitutes emergency or urgently needed services as described in 42 CFR 422.2 and 422.112(c)), the organization continues to be financially responsible for the costs of the hospital stay when a timely appeal is filed until noon of the calendar day following the day you notify the enrollee of your decision.

NOTE: The hospital may not charge the M+CO (or the enrollee) if it was the hospital (acting on behalf of the enrollee) that filed the request for immediate QIO review and the QIO upholds the non-coverage determination made by the M+CO.

F. Untimely Request for QIO Immediate Review -- If the request for an immediate review is not filed timely by the Medicare enrollee or his/her representative, do not review the case.

Instructions found at 42 CFR 422.622(a)(2) provide an enrollee who fails to make a timely request for QIO review the fall-back option of requesting an expedited reconsideration from the M+CO. You must notify the beneficiary that his/her case is being referred to the M+CO for an expedited reconsideration (72 hour fast review).

NOTE: The beneficiary is not entitled to subsequent review by the M+CO under the regulations at 42 CFR 422.582 and 42 CFR 422.584 once a QIO review is requested. Instead, the beneficiary has further appeal rights under 42 CFR 478.

G. NODMAR Rescinded -- If the M+CO notifies you that the NODMAR has been rescinded after requesting the medical records, you should:

- Instruct the hospital to submit the medical records (including a copy of the notice rescinding the NODMAR);

- Review the medical record and determine whether or not the hospital acted appropriately in rescinding the notice;
- Notify the beneficiary that the NODMAR was rescinded if you agree with the hospital's action and that he/she should have received a written notification from the hospital; and
- Issue your written initial determination (including a determination of the beneficiary's liability for payment under §1869 of the Act) if you disagree with the hospital's rescinded NODMAR.

Because you do not monitor the issuance of the NODMAR, you are to refer to the Project Officer any single case where a NODMAR has been rescinded.

7100 - Authority - (Rev. 4, 07-18-03)

Deny claims in accordance with 42 CFR 476.83 when you determine that health care services furnished or proposed to be furnished to a beneficiary are non-covered because they are not medically necessary and reasonable (§1862(a)(1) of the Act) or constitute custodial care (§1862(a)(9) of the Act). In addition, QIOs may deny Part A claims when a hospital circumvents the Prospective Payment System (PPS) through unnecessary admissions or readmissions in accordance with §1886(f)(2) of the Act (Deny claims only as specified in §4255). If, as a result of DRG validation, you determine that the diagnosis and/or procedures billed by the hospital should be changed and the DRG is affected, change the DRG assignment in accordance with 42 CFR Part 476. Provide written notification of initial denial determinations and DRG assignment changes to all affected parties as specified in 42 CFR 476.94.

7101 - Types of Denial Determinations - (Rev. 4, 07-18-03)

Initial and technical denials apply to services/items furnished in acute/specialty hospitals (including swing beds) and hospital outpatient/ambulatory surgical centers, hereafter referred to as providers.

A. Initial Denials -- Initial denial determinations are subject to reconsideration and further appeals. These types of denials include:

- Preadmissions;
- Admission;
- Continued-stay;
- Circumvention of PPS;
- Services/procedures; and

- Cost outliers (and day outliers, if applicable).

NOTE: Render an initial denial determination only after you have afforded the provider/practitioner an opportunity for discussion.

B. Technical Denials -- Technical denial determinations are not subject to reconsideration and further appeals, but may be subject to re-review/reopening (See §7102.B). These types of denials include:

- Medical record not submitted timely (42 CFR 476.90(b)); and
- Billing errors (including cost outlier denials due to duplicative billing for services or for services not actually furnished or not ordered by the physician).

NOTE: Opportunity for discussion does not apply to technical denials.

C. DRG Assignment Changes -- DRG assignment changes may result from your correction of technical coding errors or your correction of diagnostic, procedure, or discharge status information and the related codes. Changes to the DRG coding information are not subject to reconsideration and further appeals. These changes are, however, subject to re-review/reopening when they result in a revised DRG assignment and lower payment (See 42 CFR 478.15 and 478.48).

NOTE: Render DRG assignment changes only after you have afforded the provider/practitioner an opportunity for discussion.

7102 - Denial and Reopening Timeframes - (Rev. 4, 07-18-03)

A. Initial Denial Determinations and DRG Assignment Changes -- Render an initial denial determination or DRG assignment change within one year of the payment date of the claim containing the service(s) in question (See 42 CFR 476.96(a)(1)).

If the RO approves the action in writing, you may render an initial denial determination or DRG assignment change after one year but within four years of the payment date of the claim containing the service(s) in question (See 42 CFR 476.96(b)(1)).

NOTE: These timeframes also apply to technical denial determinations.

Issue notices to all appropriate parties as specified in §§7105-7115. Process reconsideration requests as specified in §§7400-7440.

B. Reopening of Initial Denial Determinations and DRG Assignment Changes -- Conduct reopening as specified below. Issue notices to all appropriate parties if the reopening results in a change in your initial denial determination or a change in DRG assignment (See §§7105-7115).

- Reopening Within One Year -- You may reopen an initial denial determination or DRG assignment change within one year of the date of your decision (See 42 CFR 476.96(a)(2)).

NOTE: You may reopen a technical denial determination within one year of the date of your decision when you deny the claim for lack of medical record information and the information is subsequently provided (Do not reopen any other types of technical denial determinations).

- Reopening After One Year But Within Four Years -- You may reopen an initial denial determination or DRG assignment change after one year but within 4 years of the date of your decision if (See 42 CFR 476.96(b)(2)):
 - You receive additional information on the patient's condition that affects the basis of the prior decision;

NOTE: The additional information is generally part of the medical record for the stay in question. There may be exceptions such as additional information related to other hospital stays, physician notes, etc. Addendum orders (i.e., where the physician did not order a service/procedure and retroactively writes such an order) are not considered "additional information."

- Reviewer error occurred in interpretation or application of Medicare coverage policy or review guidelines;
- There is an error apparent on the face of the evidence upon which the initial denial or DRG assignment change was based; or
- There is a clerical error in the statement of the initial denial determination or DRG assignment change.

NOTE: You may reopen a technical denial determination after one year but within four years of the date of your decision when you deny the claim for lack of medical record information and the information is subsequently provided (Do not reopen any other types of technical denial determinations).

7105 - Notification of Denial - (Rev. 4, 07-18-03)

Provide written notification of initial denials, technical denials, and DRG assignment changes to all affected parties, as appropriate (See Exhibits 7-22 through 7-34).

A. Parties to be Notified -- Provide written notice to:

- The beneficiary or his/her representative. Do not notify the beneficiary or his/her representative of DRG assignment changes or denials based on circumvention of PPS or billing errors;
- The attending physician or other attending health care practitioner. Do not notify the individual of circumvention of PPS denials. You are only required to notify the individual of changes to DRG coding information when the changes revise the DRG assignment;
- The provider (if known, include in preadmission/pre-procedure cases). You and the provider are to specify in your memorandum of agreement who will receive your notices for the provider. You are only required to notify the provider of changes to DRG coding information when the changes revise the DRG assignment; and
- The intermediary/carrier. If you notify the intermediary/carrier electronically of the denial determination (including limitation of liability determinations, if applicable), you need not provide a hardcopy of the notice. Notify the intermediary of DRG assignment changes. Do not notify the intermediary of coding changes that do not affect the DRG assignment.

B. Issuance of Notice -- Issue notices on a case-by-case basis as follows:

- One notice addressed to the beneficiary or his/her representative with copies to the provider, attending physician, and intermediary/carrier; or
- One notice addressed to the provider (when the beneficiary or his/her representative is not notified) with copies to the attending physician and intermediary/carrier (Do not send a copy to the attending physician for circumvention of PPS denials).

If a case is selected for retrospective review and you find that a HINN was issued, do not issue a denial notice if you agree with the provider's decision and the beneficiary was not liable for charges (Issue a notice for all HINN cases reviewed at the beneficiary's or provider's request).

C. Determination of Beneficiary Address -- Ensure that denial notices mailed to beneficiaries who are no longer in the facility are sent to the correct address. To assist you in determining the beneficiary's correct address, CMS can provide you with copies of the Carrier Alphabetic State File (CASF) on microfilm or the Beneficiary Eligibility Status Tapes (BEST) on magnetic tape. Use of these files is optional. To obtain copies on an ongoing basis, send a written request to your RO Project Officer. There is no charge to you for these files.

7110 - Timing of Denial Notice - (Rev. 4, 07-18-03)

Notify all affected parties within the mandatory timeframes for review completion (See 42 CFR 466.94) as follows (These timeframes do not apply to denials involving HINNs):

- For preadmission denials, issue the notice before admission to the facility. If the patient is admitted before your medical review is completed, issue the notice by the first working day after the denial determination. At a minimum, maintain a detailed log that clearly indicates when denial notices are issued and to whom (complete patient identification).
- For pre-procedure denials, regardless of whether the patient has been admitted, issue the notice before the procedure is performed.
- For continued-stay denials, issue the notice by the first working day after the denial determination if the beneficiary is still in the facility.

Deliver the notice to beneficiaries in the facility or mail the notice to those no longer in the facility. In addition, issue all notices simultaneously to all affected parties on a case-by-case basis as review determinations are made. Do not hold notices pending completion of a review cycle for notification to a provider, physician, or intermediary/carrier. Document if the denial notice is subsequently returned as undeliverable or receipt refused. Include the returned envelope and notice in the case file.

7115 - Content of Denial Notice - (Rev. 4, 07-18-03)

A. Format of Notice -- Make your denial notices understandable and write the notices in "plain English." In addition, make sure that the beneficiary notice:

- Is in letter format;
- Is addressed to the beneficiary or his/her representative, if applicable (Where the beneficiary is deceased, address the notice to the beneficiary's representative or estate);
- Has a personalized salutation line (e.g., "Dear Mr. Smith" instead of "Dear beneficiary" or "Dear representative"); and
- Includes all pertinent information in the body of the notice (i.e., attachments or enclosures are not acceptable if they are in lieu of required information).

B. Identifying Information -- The heading of the notice must include:

- The date of notice;

- The beneficiary's name;
- The beneficiary's Medicare Health Insurance Claim (HIC) Number;
- The beneficiary's address, his/her representative's address, or address of the person handling the beneficiary's estate if beneficiary is deceased;
- The provider's name;
- The provider's Medicare number (not necessary if you transfer notices to the intermediary electronically);
- The medical record number (if known);
- The admission date (for denials related to "deemed" admission date cases, use the actual admission date); and
- The attending physician's name (for the services in question).

C. Specificity of Notice -- The body of the notice must include:

- Identification of QIO -- Include a brief statement concerning your duties and functions under the Act.
- Reason for Admission -- Specify the reason for the admission. For partial denials (i.e., part of the stay is covered), include a statement specifying that the admission was medically necessary and appropriate (Do not include this statement in "deemed" admission date denial notices).
- Opportunity for Discussion -- Reference your discussions with the attending physician and provider. This requirement is met if your notice states that the involved physician and hospital were provided with an opportunity to discuss the case.

This applies to initial denial determinations and DRG assignment changes. When the DRG assignment is changed (either higher or lower), provide the hospital and physician an opportunity to discuss the DRG change.

- Solicitation of Views -- Reference your solicitation of the beneficiary's or his/her representative's views. Include the date of your discussion (This provision applies only when your review is based on a beneficiary's, his/her representative's, or provider's request for review of a continued-stay HINN).
- Reason for Denial -- Include the relevant facts explaining the reason(s) for the denial determination. The discussion in the beneficiary notice should be in layman's terms, and include all the information necessary to support the denial

determination. The discussion must be specific to the individual case (i.e., it is unacceptable to state only that the services were medically unnecessary, inappropriate, or constituted custodial care).

- For procedure denials, specify either that the patient requires the procedure but the services could be performed on an outpatient basis or that the patient did not require the surgery and, therefore, the procedure was not medically necessary (See Exhibit 7-28).
- For deemed admission denials, continued-stay denials, day outlier denials, and partial admission denials (for non-PPS providers), specify the date(s)/period(s) for the stay or services that are not approved as being medically necessary or appropriate (A partial denial includes services/items that Medicare determined to be covered). In addition, for day outlier and partial admission denials (non-PPS providers), specify the total number of denied days (See Exhibits 7-26, 7-27, and 7-29).
- For continued-stay denials (related to HINNs) involving "deemed" admission situations, modify the notice to include the applicable language (e.g., reason for denial, periods approved and denied, liability determination) (See Exhibits 7-26 and 7-27).
- For cost outlier denials, specify the dates, charges, and specific services/items that will not be approved as being medically necessary or appropriate (See Exhibit 7-30).
- For day outlier denials, distinguish between those days that were not medically necessary and those where the beneficiary could have safely and effectively received the services on an outpatient basis.
- For changes to DRG coding information that affect the DRG assignment (either higher or lower), include a listing of the ICD-9-CM codes and a narrative description as submitted by the provider and as changed by you along with the reason for the changes. Be as specific as possible in explaining the reason(s) for the changes (See Exhibit 7-31). Do not notify the hospital of changes to DRG coding information when the changes do not revise the DRG assignment.
- For billing errors, explain that the error precludes you from completing review of the case. Instruct the provider to submit an adjusted claim to the intermediary (in accordance with your agreements with the intermediary and provider) (See Exhibit 7-24).
- For circumvention of PPS denials, specify that you are denying the second admission. Explain whether the denial is based on services that should have been furnished during the first admission, on an inappropriate

transfer from a PPS unit to a PPS-excluded unit, or on an inappropriate transfer from a PPS-excluded unit to a PPS unit. Cite the provision of the law that authorizes QIOs to deny payment for circumvention of PPS (See Exhibit 7-34).

- Liability Determination for the Beneficiary and Provider -- Include a statement of the beneficiary's or his/her representative's and the provider's liability determinations (under §1879 of the Act), including a detailed rationale for the decision (This applies only to initial medical necessity/custodial care denial determinations) (See Exhibit 7-20).
 - For denials based on circumvention of PPS, explain that the limitation on liability provisions under §1879 do not apply, that the hospital is liable for the denied charges, and that the beneficiary or his/her representative is only responsible for payment of any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare (See Exhibit 7-34).
 - If the beneficiary or his/her representative is found liable, specify the date of the prior notice. Include a copy of the notice. Do not include a copy of the beneficiary's prior notice with the provider/physician notice unless the notice was issued by that provider.
 - If the provider is found liable, specify the dates of liability (if applicable) and the source: brochures, prior notices (including dates), manual references, criteria, etc. Reference must be specific to individual case. Give the provider a copy of the source material referenced by you (See Exhibit 7-20, Conditions II, III, V, IX and X).
 - For denials based on a beneficiary's or his/her representative's request for review of a continued-stay HINN or a provider's request for review of a proposed continued-stay HINN, include the date of your phone notification to the beneficiary or his/her representative (See Exhibit 7-20, Conditions VI and VII).
 - For denials involving review of a HINN, do not approve payment for additional days under §1879 of the Act for purposes of post-discharge planning (i.e., grace days). A provider who issued a HINN has demonstrated knowledge that Medicare will not cover the services and, therefore, §1154(a)(2)(b) is not applicable (See Exhibit 7-20, Conditions VI and VII).
 - For denials based on concurrent review not involving a HINN, you may approve payment for up to two additional days under §1879 of the Act for purposes of post-discharge planning (i.e., grace days) (See Exhibit 7-20, Condition VIII).

NOTE: When you deny a case that involves non-covered services such as routine foot or dental care, do not apply the provisions of §1879.

- Liability Determination for the Physician -- Include a statement of the payment liability determination related to denied physician services (Under §§1842(l) and 1879 of the Act). Include a detailed rationale for the decision (Applies to hospital inpatient and ambulatory/outpatient surgical procedures/services and cost outlier(s) with physician component denials that are determined to be medically unnecessary).
 - For denials involving claims for services billed on an assigned basis (whether furnished by Medicare participating or nonparticipating physicians), make your liability determination in accordance with the provisions of §1879 of the Act.
 - For denials involving services billed on an unassigned basis (by nonparticipating physicians), make your liability determination in accordance with the provisions of §1842(l) of the Act.

NOTE: The determination as to whether the physician is protected from payment liability (when the physician accepts assignment) under §1879 of the Act or from making a refund to the beneficiary or his/her representative (when the physician does not accept assignment) under §1842(l) of the Act is made when the initial denial decision is furnished. In both situations make a determination of the physician's and the beneficiary's knowledge of the non-covered services. Unless there is evidence to the contrary (e.g., the physician annotated in the medical record that he/she has given the beneficiary a written advance notice), presume that the beneficiary or his/her representative had no knowledge that Medicare would not pay for the denied items or services furnished by the physician. On a case-by-case basis, the physician may challenge this presumption when you offer the physician an opportunity to discuss the case. At the same time, ask the physician if he/she accepted assignment (if you were unable to determine this information from your review of the documents in the medical record). The physician should be able to provide you with the information you need as well as a copy of the written advance notice that he/she gave the beneficiary or his/her representative.

- Beneficiary Indemnification for Provider Services -- Include a statement related to the indemnification of the beneficiary or his/her representative when the provider has been found liable for the denied services.

Include the name, address, and telephone number of the Fiscal Intermediary (FI) or the carrier where the beneficiary or his/her representative can file a request for indemnification.

Inform the beneficiary that the following documents must be provided to the FI or carrier:

- A copy of the denial notice;
- A copy of the bill for the services; and
- A copy of the payment receipt from the provider or any other evidence showing that the beneficiary paid the provider.

Instruct the beneficiary that the request must be filed within 6 months of the date of your denial notice (See 42 CFR 411.402(a)(4)).

Specify that if the beneficiary or his/her representative and the provider are not held liable §§1879(a)(1) and (2) conditions are met, he/she is responsible only for payment of any deductible, coinsurance, and convenience services and items normally not covered by Medicare that are furnished during the admission (See Exhibit 7-20, Condition I).

In addition, specify that if the beneficiary or his/her representative is not held liable but the provider is held liable, he/she is responsible only for payment of any convenience services and items normally not covered by Medicare for the denied period. In this situation, the beneficiary or his/her representative is not responsible for the denied services including any applicable deductible and coinsurance (See Exhibit 7-20, Condition II).

- Beneficiary Indemnification for Physician Services -- Include a statement related to the indemnification of the beneficiary or his/her representative for denied physician's services (e.g., inpatient procedure, cost outlier with a physician component, and ambulatory/outpatient surgical denials).

Include the name, address, and telephone number of the carrier where the beneficiary or his/her representative can file a request for indemnification.

Inform the beneficiary that the following documents must be provided to the carrier:

- A copy of the denial notice;
- A copy of the bill for the services; and
- A copy of the payment receipt from the physician or any other evidence showing the beneficiary paid the physician.

Instruct the beneficiary that the request must be filed within 6 months of the date of your denial notice (See 42 CFR 411.402(a)(4)).

For denials involving services billed on an assigned basis by a Medicare participating or nonparticipating physician, specify that the beneficiary or his/her representative should contact the carrier for any refund (See Exhibit 7-20, Conditions III, XI, and XII).

For denials involving services billed on an unassigned basis by a nonparticipating physician, specify that the beneficiary or his/her representative should contact the physician for any refund (See Exhibit 7-20, Condition IIIA).

- Beneficiary's Future Payment Liability -- Include a statement related to the liability for payment of denied services occurring in the future that involve the same, or reasonably comparable, conditions.

This applies only to initial medical necessity/custodial (level of) care denial determinations.

Do not include such a statement if the denial is for a procedure that cannot be repeated (e.g., total removal of an organ).

- Reconsideration Rights -- Include a statement of the reconsideration rights (including expedited reconsideration, if applicable) of the beneficiary or his/her representative, provider, and attending physician (See Exhibit 7-21). This applies only to initial denial determinations.

The statement must specify:

- The places that the beneficiary or his/her representative may file a reconsideration (i.e., Social Security Administration (SSA) Office, Railroad Retirement Office, if applicable, or at your office);
 - The time requirements to file a request; and
 - The possible outcomes of your review as a result of a request for reconsideration.
- Beneficiary Right To Legal Representation -- Include a statement informing the beneficiary or his/her representative of the options for obtaining attorney representation at any step of the appeal process, of the availability of free legal services organizations, and to contact the local social security office for additional information, if needed (See §206(c) of the Act). This requirement is applicable to QIOs involved in the Medicare program by 42 USC 1395(ii). This applies only to initial medical necessity/custodial (level of) care denial determinations.

Insert the following statement, which shall not be altered, after the reconsideration rights paragraph in all initial denials where the beneficiary or his/her representative receives your notification:

- "If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer

referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify."

- Beneficiary Right to Review the Medical Record -- Include a statement informing the beneficiary or his/her representative of the right to examine his/her complete medical record and to receive a copy of that record. This applies only to initial medical necessity/custodial (level of) care denial determinations.

Insert the following statement, which cannot be altered, after the beneficiary right to legal representation paragraph in all initial denials where the beneficiary or his/her representative receives your notification:

- "You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making this denial determination. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information."

If the beneficiary or his/her representative requests the record, redact any QIO deliberations and the names of any QIO review coordinators, physician advisors, or consultants from the material before its release. All practitioner-specific information must be released. Disclose the names of all practitioners who were involved in the patient's treatment and whose names appear in the medical record or other pertinent information.

NOTE: Do not make notations on pages of the medical record in order to minimize the amount of redacting required.

Provide the record at a reasonable cost. The cost is limited to the cost of copying, redacting, and mailing the information.

- Re-review Rights Related to DRG Assignment Changes -- Include a statement of the re-review or reopening rights of the provider and physician. Re-review or reopening rights do not apply when the DRG assignment does not change.

Specify the place to file a review (i.e., QIO).

Specify the time requirements for filing such a request.

NOTE: The re-review or reopening rights do not apply to coding changes that do not affect DRG assignment.

- Signature -- For denial notices include the signature, including title, of the QIO Medical Director or the signature of the QIO physician to whom the Medical Director has delegated this authority. If you delegate this authority to your physician reviewers, do so in accordance with the confidentiality regulations, which specify that the identity of the reviewer cannot be disclosed unless the individual gives his/her consent (See 42 CFR 476.101(b) and 133(a)(2)(iii)). The Billing Error Denial Notice (Exhibit 7-24) may also be signed by the QIO Chief Executive Officer (CEO) or appropriate designee. DRG assignment changes that do not involve medical judgment may also be signed by the Accredited Record Technician or Registered Record Administrator.

7200 - Introduction - (Rev. 4, 07-18-03)

Under your contract with CMS, you are required to conduct medical case review to determine whether the quality of the services provided meets professionally recognized standards of care (See 42 CFR 476.71(a)(2)).

7210 - Notification Requirements - (Rev. 4, 07-18-03)

When you identify a potential quality concern, issue a written notice to the provider and to any physicians apparently involved in the concern. Advise them of your concern, and offer them an opportunity to discuss the potential concern.

Send notices only to the physicians involved in a concern who can provide you with information necessary for you to make a quality determination (See Exhibit 7-74). Much of the information in notices sent to the involved physicians may be identical. However, preserve the confidential nature of the communication to each physician. Tailor each notice to elicit each physician's unique perspective on the concern in question. Inform each physician only of his/her involvement in the potential concern. Do not advise a physician of another physician's involvement.

Do not needlessly proliferate notices to physicians. Send only those notices necessary for resolution of the potential concern. If, after the opportunity to discuss, you believe that an additional physician(s) should be contacted, issue an additional preliminary notice(s), as appropriate.

Once you have completed your review of the potential quality concern (after the opportunity to discuss has been offered), issue a written final notice to each party to whom you sent an initial notice, advising them of your favorable or unfavorable quality determination. If you conduct a re-review of a confirmed quality concern, issue a written notice to the provider and any physicians affected by your re-review determination, advising them of your favorable or unfavorable quality determination.

Issue separate, original notices in all cases. Issuing copies to the provider or physician is not acceptable.

NOTE: Your agreement with the provider may specify where to send your provider notices. It is expected that the designated contact(s) would represent both the administrative and medical staffs (e.g., Chair of the Quality Assurance Committee).

7220 - Basic Elements for Quality Concern Notices - (Rev. 4, 07-18-03)

Your quality concern notices must be clear, informative, and non-threatening (e.g., do not quote at length from QIO regulations). In addition, all notices must contain the following basic elements:

A. Heading -- The heading of the notice must include:

- Your letterhead;
- The date of the notice;
- The name and address of the addressee; and
- Case-identifying information. Specify the patient's name, patient's health insurance claim number, provider name, provider number, date of admission/service, and medical record number (if known).

B. Body -- The body of the notice must contain:

- A salutation;
- A brief statement concerning your duties and functions under the Act;
- A brief statement explaining the purpose of your quality review activities and acknowledging the importance of the provider's/physician's cooperation;
- A brief summary of the background of the case. Specify the name of the patient, the name of the provider, the procedure, treatment, condition, and/or services involved, as appropriate; and
- A confidentiality and re-disclosure statement.

C. Signature -- The notice must be signed by the medical director or the QIO physician to whom the medical director has delegated this authority. Include a title with the signature.

7230 - Potential Quality Concern Notices - (Rev. 4, 07-18-03)

In addition to the basic elements listed in §7220, the body of all potential quality concern notices must contain the following elements:

- A statement that a QIO physician reviewer has reviewed the medical record;
- A summary of the case findings and concerns from the Preliminary Decision portion of the Physician Reviewer Assessment Format (PRAF) (Attaching a copy of the PRAF and referring to the attachment is not acceptable). Although you may reference the PRAF categories for classifying your concerns, do not use the PRAF numbering scheme (e.g., A.1, B.3, C.40, D.99) in your notice. Include sufficient detail so that the parties addressed will clearly understand the identified potential concern;
- A statement that the identified concern is a potential concern;
- A statement offering an opportunity to discuss the case. Specify the method (either by telephone or in writing is acceptable), the timeframe (20 calendar days), and that your determination will be made on the basis of the medical record alone if no response is received within the stated timeframe. Include the name of a QIO contact person, your address, and telephone number;
- For physician notices, a statement that the provider is also being notified of the potential quality concern and given an opportunity to discuss the case. Specify the name of the provider. Do not specify the name of any other physician(s) you may be notifying;
- For provider notices, a statement that the involved physician(s) is also being notified of the potential quality concern and given an opportunity to discuss the case. Specify the name of the physician(s); and
- A statement encouraging the provider and physician to coordinate their responses to you.

7240 - Final Quality Concern Determination Notices - (Rev. 4, 07-18-03)

A. Confirmed Quality Concern Determination -- In addition to the basic elements listed in §7220, the body of these notices must contain the following elements:

- A statement that a QIO physician reviewer has reviewed the medical record and any additional information provided during the opportunity for discussion;
- A summary of the case findings and concerns, including a preferred course of action which would have improved care, from the Initial/Final Decision portion of the PRAF (Attaching a copy of the PRAF and referring to the attachment is not

acceptable). Although you may reference the categories for classifying your concerns, do not use the numbering scheme (e.g., A.1, B.3, C.40, D.99) in your notice;

- A brief statement of your action to be taken. Explain that the results of your review will be entered into your database for pattern analysis and used for related analysis activities. Explain that the physician and provider will have ample opportunity to discuss any patterns involving confirmed quality concerns;
- For physician notices, a statement that the provider is also being notified of the confirmed quality concern. Specify the name of the provider. Do not specify the name of any other physician(s) you may be notifying;
- For provider notices, a statement that the involved physician(s) is also being notified of the confirmed quality concern. Specify the name of the physician(s); and
- A statement of re-review rights. Specify the method of request (in writing), the timeframe for the request (30 calendar days), and that the request should include the reason for disagreement with the determination and any additional information to be considered in making a re-review determination. Include the name of a QIO contact person, your address, and telephone number.

B. Favorable Quality Review Determination -- In addition to the basic elements listed in §7220, the body of these notices must contain the following elements:

- A statement that a QIO physician reviewer has reviewed the medical record and any additional information provided during the opportunity for discussion;
- A summary of the case findings and concerns, including the basis for your favorable determination, from the Initial/Final Decision portion of the PRAF (Attaching a copy of the PRAF and referring to the attachment is not acceptable). Although you may reference the categories for classifying your concerns, do not use the numbering scheme (e.g., A.1, B.3, C.40, D.99) in your notice;
- A brief statement of your action to be taken. Explain that the results of your review will be entered into your database for pattern analysis and used for related analysis activities;
- For physician notices, a statement that the provider is also being notified of your final determination. Do not specify the name of any other physician(s) you may be notifying; and
- For provider notices, a statement that the involved physician(s) is also being notified of your final determination. Specify the name of the physician(s).

7250 - Re-review Quality Concern Notices - (Rev. 4, 07-18-03)

A. Confirmed Quality Concern Upheld -- In addition to the basic elements listed in §7220, the body of these notices must contain the following elements:

- The date of the re-review request;
- An explanation that the physician reviewer who conducted the re-review was not involved in the original quality concern determination;
- A statement that the QIO physician reviewer has re-examined the medical record and any additional information provided by the provider and/or physician;
- A summary of the case findings and concerns, including a preferred course of action which would have improved care, from the Reconsideration/Re-review Decision portion of the PRAF (Attaching a copy of the PRAF and referring to the attachment is not acceptable). Although you may reference the categories for classifying your concerns, do not use the numbering scheme (e.g., A.1, B.3, C.40, D.99) in your notice;
- A brief statement of the action to be taken. Explain that the results of your review will be entered into your database for pattern analysis, used for your related pattern analysis activities, and that the physician and provider will have ample opportunity to discuss any patterns involving quality concerns;
- A statement that the re-review determination is final (i.e., no further appeals apply);
- For physician notices, a statement that the provider is also being notified of your re-review determination. Specify the name of the provider. Do not specify the name of any other physician(s) you may be notifying; and
- For provider notices, a statement that the affected physician(s) is also being notified of your re-review determination. Specify the name of the physician(s).

B. Confirmed Quality Concern Reversed -- In addition to the basic elements listed in §7220, the body of these notices must contain the following elements:

- The date of the re-review request;
- An explanation that the physician reviewer who conducted the re-review was not involved in the original quality concern determination;
- A statement that the QIO physician reviewer has re-examined the medical record and any additional information provided by the provider and/or physician;

- A summary of the case findings and concerns, including the basis for your favorable determination, from the Reconsideration/Re-review Decision portion of the PRAF (Attaching a copy of the PRAF and referring to the attachment is not acceptable). Although you may reference the categories for classifying your concerns, do not use the numbering scheme (e.g., A.1, B.3, C.40, D.99) in your notice;
- A brief statement of the action to be taken. Explain that the results of your review will be entered into your database for pattern analysis and your pattern analysis activities;
- For physician notices, a statement that the provider is also being notified of your re-review determination. Specify the name of the provider. Do not specify the name of any other physician(s) you may be notifying; and
- For provider notices, a statement that the affected physician(s) is also being notified of your re-review determination. Specify the name of the physician(s).

7300 – Diagnosis Related Groups (DRG) Validation Re-reviews – (Rev. 4, 07-18-03)

You are responsible for conducting DRG validation re-reviews. The authority for reviewing changes in diagnostic and procedural coding information is found in 42 CFR 478.10(c).

A. Applicability -- Although there are no reconsideration or appeal rights available for changes resulting from DRG validation, the same process used for making a reconsideration determination is used for DRG re-reviews (See §7430). A provider or practitioner dissatisfied with your change to the diagnostic or procedural coding information is entitled to a review of that change if it caused an assignment of a different DRG and resulted in a lower payment (See 42 CFR 478.15(a)(1)). A beneficiary or his/her representative dissatisfied with your change of the diagnostic or procedural coding information is also entitled to a review of that change if it caused an initial denial of a furnished service (See 42 CFR 478.15(a)(2)). Review each case in its entirety.

B. How to Request a Re-review -- The party must file a written request within 60 calendar days after the date of receipt of the notice of change to the diagnostic or procedural coding information. A party may also file such a request after 60 days for good cause (See §7410.C).

C. Qualifications of a Reviewer -- The individual who reviews changes in DRG procedural or diagnostic information must be a physician who meets the requirements in §7420.A. The individual who reviews changes in DRG coding must be qualified through training and experience with ICD-9-CM coding. The reviewer (physician or non-physician) cannot be the person who made the initial determination (A Registered

Records Administrator or Accredited Records Technician must have responsibility for the overall DRG validation process).

D. Timing of Re-review -- Complete your re-review and send a written notice to all parties within 30 working days of receipt of the request for a re-review.

E. Notices to Parties -- Notify all parties (in writing) of your re-review determination. Be specific in explaining the reason(s) for the changes (See Exhibit 7-47) (Do not send this notice to the beneficiary). Notices of re-review must contain the following elements:

- A brief statement concerning your duties and functions under the Act, including your responsibility to perform DRG validation;
- A listing of the ICD-9-CM code(s) and narrative description as submitted by the provider and as originally changed by you, along with the reason for the changes;
- A brief statement explaining that the provider and practitioner were given an opportunity to provide additional information;
- The rationale used in upholding or reversing the initial DRG determination, including the code(s) you finally determined to be correct upon re-review;
- A statement that the re-review determination is final (i.e., no further appeals apply); and
- The signature, including title, of the medical director or designated physician if the change(s) involve DRG procedural or diagnostic information (i.e., medical judgment). If the change(s) involve(s) DRG coding errors, the re-review notice may be signed by the medical director, designated physician, Chief Executive Officer, Accredited Record Technician, or Registered Record Administrator (See §7115.C.15).

7310 - Re-review of Quality Concerns - (Rev. 4, 07-18-03)

A. Applicability -- Although no reconsideration rights are available for final quality concern determinations, a physician or provider dissatisfied with your confirmed quality concern determination is entitled to a review of that determination. The physician or provider does not need to submit new information to be entitled to a re-review. This is an administrative appeal not required by statute or regulation. No additional review or appeal beyond this re-review is available for a confirmed quality concern determination.

B. Request for a Re-review -- The physician or provider must file a written request for a re-review within 30 calendar days after the date of the receipt of a notice of a confirmed quality concern determination (Assume the date of receipt to be within 5 days of the date of the confirmed quality concern notice if absent proof to the contrary). In the case of

late filing, determine whether the physician or provider has good cause for not requesting a re-review timely (See §7420.C).

- Maintain a system for documenting your receipt of re-review requests. The receipt date, unless otherwise proven, is the date recorded in your documentation system.

C. Qualifications of Physician Reviewers Who Render Quality Re-review Determinations -- Physician reviewers conducting re-reviews must meet the requirements for physician reviewers. Use a physician reviewer who was not involved in the determination of the confirmed quality concern to perform the re-review.

D. Duties of Physician Reviewers Who Render Quality Re-review Determinations -- Duties of physician reviewers include:

- Re-reviewing the original final determination about the quality concern, utilizing the medical record, the PRAF 1, the PRAF 2, and any additional information furnished by the physician or provider;
- Making a final determination regarding the quality concern(s) and the source(s) of the quality concern(s); and
- Completing the PRAF for re-review (PRAF 3).

E. Timing of Re-review -- Complete your review and send a written notice within 30 calendar days after you receive the request for a re-review.

F. Notices to Parties -- Issue a notice of a re-review determination for every case where a re-review is requested. Send the re-review notice to the provider and to the physician(s) affected by your re-review determination.

G. Update of Data System -- (e.g., for pattern analysis, internal quality control) when notices of re-review determinations are sent out.

7400 - Statutory and Regulatory Requirements - (Rev. 4, 07-18-03)

§§1862 and 1155 of the Social Security Act (the Act) and 42 CFR Part 478 set forth the appeals requirements applicable to your Part A and Part B initial denial determinations by providing that a beneficiary, practitioner, or provider dissatisfied with your initial denial determination involving medical necessity, reasonableness of services, or appropriateness of setting is entitled to a reconsideration. A provider dissatisfied with your initial denial determination involving circumvention of PPS (§1886(f)(2) of the Act) is also entitled to a reconsideration.

§1879 of the Act (Limitation on Liability) and 42 CFR Part 405 Subpart G provide that the beneficiary who has been found liable may obtain a reconsideration and appeal of a

Part A QIO determination. §1879(a) of the Act and 42 CFR Part 405 Subpart H provide that the beneficiary who has been found liable may obtain a reconsideration and appeal of a Part B QIO determination. If the provider or practitioner has been found liable and the beneficiary has been found not liable, or if the beneficiary has been found liable and does not pursue a reconsideration on the issue of knowledge, the provider or practitioner may obtain a reconsideration on the issue that they did not know and could not be expected to have known the services denied were not covered under Medicare Part A and/or B. The criteria for determining beneficiary and provider/practitioner knowledge are found in 42 CFR 411.404 and 411.406.

7410 - Requests for Reconsideration - (Rev. 4, 07-18-03)

A. Right to Request Reconsideration -- A beneficiary, provider, or practitioner (including a practitioner who does not accept assignment) may request a reconsideration regardless of whether there is a dollar amount in controversy (e.g., a party may request a reconsideration when a case is paid under the limitation on liability provision) (See 42 CFR 478.16).

NOTE: The term "party" is used throughout this chapter to mean a person (or group) involved in a legal proceeding, usually the beneficiary, provider, and practitioner.

A beneficiary, provider, or practitioner dissatisfied with your denial determination may obtain a reconsideration of the following issues:

- Reasonableness, medical necessity (including the need for using assistants at cataract surgery), and appropriateness of the services furnished or proposed to be furnished (e.g., whether treatment was appropriate for the condition) (See §1862(a)(1) or (9) and §1154(a)(1)(A) of the Act);
- Appropriateness of the setting in which the services were, or are proposed, to be furnished (See §1154(a)(1)(c) of the Act); and
- Whether financially liable under §1879 of the Act (Limitation on Liability):
 - If the beneficiary (or the provider or practitioner) has been found liable by you, the beneficiary may obtain a reconsideration of the liability determination;
 - If the provider or practitioner has been found liable, or the beneficiary has been found liable but does not pursue a reconsideration on the issue of knowledge, the provider or practitioner may obtain a reconsideration of the liability determination; and
 - If the practitioner has been found liable and the beneficiary has been found not liable, or the beneficiary has been found liable but does not pursue a reconsideration on the issue of knowledge, the practitioner may ask for a

reconsideration on the issue that neither the beneficiary nor the practitioner knew and could not have known that the services denied were not covered under Medicare Part B.

NOTE: When a reconsideration is conducted, make a determination on the issue of knowledge. Providers/practitioners can only appeal the limitation on liability determination, not the medical necessity determination, beyond the reconsideration.

A provider dissatisfied with your denial determination may obtain a reconsideration of a Part A denial for circumvention of PPS as specified in §7440.

B. Timeframes To Request Reconsiderations

- Reconsiderations of Retrospective Initial Denials -- A beneficiary who is dissatisfied with your initial denial determination may request a reconsideration by writing to you, a SSA District Office, or a Railroad Retirement Board Office (if the party is a railroad retirement beneficiary). A provider or practitioner may request a reconsideration by writing to you. Reconsider an initial denial determination if the beneficiary, provider, or practitioner files a timely written request:
 - Within 60 calendar days after receipt of the initial denial notice (except for a request for expedited reconsideration under 42 CFR 478.18(c)). Receipt of the notice is assumed to be within 5 days of the date of the initial notice if absent proof to the contrary (See 42 CFR 478); or
 - After 60 days, for good cause (See §7410.C).
- Expedited Reconsiderations of Preadmission/Pre-procedure (Including Assistant at Cataract Surgery) Initial Denials -- A beneficiary, provider, or practitioner who is dissatisfied with your initial denial determination may request an expedited reconsideration by writing or telephoning you. Reconsider an initial denial determination if the beneficiary, provider, or practitioner files a timely written or telephone-expedited request within 3 calendar days after the date of receipt of the notice of a preadmission/pre-procedure (including an assistant at cataract surgery) denial. If an expedited reconsideration is not filed timely, a non-expedited reconsideration may still be requested (See §7410.B.1).
- Expedited Reconsiderations of Concurrent Initial Denials -- A beneficiary, provider, or practitioner who is dissatisfied with your initial denial determination may request an expedited reconsideration through the hospital or by writing or telephoning you. Reconsider an initial denial determination if the beneficiary, provider, or practitioner files a timely expedited request at any time while the beneficiary remains in the hospital. If an expedited reconsideration is not filed timely, a non-expedited reconsideration may still be requested (See §7410.B.1).

C. Good Cause for Late Filing of a Request for a Reconsideration -- In determining whether a party has shown that it had good cause for not filing a timely request for reconsideration, consider, but do not limit your consideration to:

- The circumstances that kept a party from making the request on time;
- Whether your action(s) misled a party; and
- Whether a party did not understand the requirements for filing a timely request.

Examples of circumstances for which you may find good cause include:

- A party was seriously ill and was prevented from requesting a reconsideration;
- There was a death or serious illness in a party's immediate family;
- Important records were accidentally destroyed or damaged;
- A party made a diligent effort, but could not find or obtain the necessary relevant information to support approval of the medical services before the deadline for requesting reconsideration;
- A party requested within the applicable time limit additional information from you explaining the action, and requested reconsideration within 60 calendar days of receiving that information;
- The party was given incorrect or incomplete information by you about when and how to request a reconsideration;
- A party sent the request within the time limit in good faith to another Government agency, but the request did not reach the authorized office until after the time period had expired; or
- Other unusual or unavoidable circumstances that show that a party could not have known of the need to file timely or that prevented the party from filing timely.

7420 - QIO Reconsiderations - (Rev. 4, 07-18-03)

A. Qualifications of a QIO Reconsideration Reviewer -- A QIO reconsideration reviewer must meet the qualifications required of a QIO physician who makes an initial denial determination (See 42 CFR 478.28 and 42 CFR 476.98 for the eligibility requirements for and responsibilities of physician reviewers, including the obligation to consult with peers).

The physician reviewer must also be a board-certified or board-eligible specialist in the same specialty as the physician whose services are being reviewed, and must be

practicing in a setting similar to that of the physician whose services are under review, except:

- If use of a like specialist in a similar setting is impractical for a particular case, use, if possible, a like specialist who practices in another setting.
- If it is impractical for you to meet the conditions listed above, use a board-certified specialist (or board candidate) in the specialty that matches the services under review and who practices in a setting similar to that of the physician whose services are under review. If this is impractical, use a physician reviewer whose practice includes the services under review and whose practice is located in a setting similar to that of the physician whose services are under review. When this is not possible, document the reason(s) in the case file. Also, document the physician reviewer's qualifications in the case file (See §7430.F).

The physician reviewer must not:

- Be the reviewer who made the initial denial determination;
- Have participated in developing or executing the beneficiary's treatment plan;
- Be in practice with any physician involved in the care of the beneficiary;
- Be a member of the beneficiary's family;
- Be a governing body member, officer, partner, 5 percent or more owner, or managing employee in the health care facility where the services were or are to be furnished; or
- Be a member of a reviewer's family, a spouse (other than one who is legally separated under a decree of divorce or separate maintenance), a child (including a legally adopted child), grandchild, parent, grandparent, or sibling.

NOTE: A beneficiary's attending physician may not request a specific reviewer to conduct the reconsideration.

B. Finality of a Reconsidered Determination -- Your reconsidered determination is final and binding upon all parties unless:

- Reopened and revised by you, either on your own motion or at the request of any party within 1 year from the date of the reconsidered determination;
- Reopened and revised by you after 1 year, but within 4 years, because:
 - You receive new and material evidence;

- There is a clerical error in the statement of your reconsidered determination;
 - You erred in interpretation or application of Medicare coverage policy; or
 - There is an error apparent on the face of the evidence upon which your reconsidered determination was based.
- Reopened and revised by you at any time if the reconsidered determination was obtained through fraud or an abusive practice (e.g., describing services in such a way that a wrong conclusion is reached); or
 - Reversed after appeals filed in accordance with §7440. The Administrative Law Judge (ALJ) or the Appeals Council, whichever made the final decision, may reopen and revise its decision in accordance with the procedures set forth in 42 CFR 405.750(b)(1) and (2) which covers reopening and re-reviews under subpart G of Part 405.

A reconsidered determination, a review of a DRG change, or a decision of an ALJ or the Appeals Council may be reopened and reviewed at any time if the reconsideration determination, review, or decision was obtained through fraud or a similar abusive practice that does not support a formal finding of fraud.

7430 - Reconsideration Process - (Rev. 4, 07-18-03)

A. Provision of Information to Parties -- Prior to the reconsideration, give all parties, upon request, an opportunity to examine or obtain a copy of all the material upon which the initial denial determination was based, including the complete medical record and summary of your findings and conclusions in making the initial denial determination. Inform the requester that he may have to pay a reasonable fee for the redaction of, reproduction of, and postage for, the material requested (If patient information would be harmful to the beneficiary, provide it to the beneficiary's designated representative upon receiving the request in writing pursuant to 42 CFR 480.132(c)).

In accordance with regulations governing disclosure of confidential QIO information and regulations at 42 CFR 478.24(a), do not give a party access to:

- Your deliberations; and
- The identity of your review coordinators, physician advisors, or consultants that assisted in reviewing the case (unless they have consented to release of their names).

Establish and implement procedures to segregate your deliberations and identifiers from the medical records when redacting.

No document or other information produced by you in connection with your deliberations in making reconsiderations under Title XI of the Act shall be subject to subpoena or discovery in any administrative or civil proceeding, except that you shall provide, upon request of a practitioner or other person adversely affected by such a determination, a summary of the organization's findings and conclusions in making the determination (See §1160(d) of the Act).

B. Provision For Submittal of Additional Information from Parties -- Give all parties the opportunity to present additional documentary materials (e.g., new evidence) for consideration.

C. The Reconsideration Proceedings -- Conduct the reconsideration proceedings as spelled out in your contract with CMS. Conduct a medical records review at your office with no party being present, or conduct proceedings similar to an evidentiary hearing. In either case, give the party advance notice of the date of the reconsideration to allow sufficient time for submission of evidence. Reschedule a reconsideration if a party submits a written request presenting reasonable justification for rescheduling.

If your contract calls for an evidentiary hearing:

- Give any party the opportunity to ask reasonable questions (e.g., to clarify information presented) of you or of any person who gives testimony; and
- Do not deny any involved party access to the hearing either while you present information or while another party (or a witness) presents information.

You are not required to have your legal counsel attend even if legal counsel for a party attends. In addition, you are not required to make a transcript of the reconsideration proceedings. A summary of the proceedings is adequate.

D. Evidence at Reconsideration -- Consider all information in the medical record, the basis for the initial determination, and any additional evidence submitted by a party.

E. Areas of Consideration -- Make a determination on medical necessity, reasonableness and appropriateness of setting, and whether the beneficiary/physician/provider knew or should have known that the care in question was not covered.

F. Timing of the Reconsidered Determination -- Complete your reconsidered determination and send written notice within the timeframes that follow:

- For Preadmission or Pre-procedure or Assistant at Cataract Surgery Reviews, within 3 working days after you receive the reconsideration request. Apply this timeframe if the initial denial determination was made before the beneficiary was admitted to the institution or before surgery was performed and a timely expedited reconsideration request was made (See §7410.B.2).

- When the Beneficiary is a Hospital Inpatient, within 3 working days after you receive the reconsideration request. Apply this timeframe if the initial denial determination was made while the beneficiary was still in the hospital and a timely expedited reconsideration request was made (See §7410.B.3).
- When the Beneficiary is an Inpatient in a SNF or Receiving Home Health Agency (HHA) Services, within 10 working days after you receive the reconsideration request. Apply this timeframe if the beneficiary is still an inpatient in a SNF for the stay in question or is receiving home health services for the stay in question when you receive the request.
- When the Beneficiary is Receiving Non-institutional Services, is No Longer an Inpatient, or Does Not File a Timely Expedited Request, within 30 working days after you receive the reconsideration request. Apply this timeframe if the initial denial determination concerns ambulatory or non-institutional services (except pre-procedure reviews), the beneficiary is no longer an inpatient in a hospital or SNF and is not receiving home health services for the stay in question, or the party does not file a timely request for expedited reconsideration (See §§7410.B.1 and 2).

Maintain a system, such as a log, for documenting your receipt of the request for reconsideration. Receipt, unless otherwise proven, means the day that you have in your records documentation that a notice was received. A party may request additional information to further explain the determination within 30 working days, and may request a reconsideration within 60 days of receiving the explanation (or within 30 days for an Appeals Council hearing).

G. Notices of a Reconsideration Determination

Notices to Parties -- Notify all parties in writing of your reconsidered determination. Discuss in detail the reasons for the initial and reconsidered determinations. Ensure that the appellant understands the reason(s) for your determination and provide support for your determination should the case be heard by an ALJ.

NOTE: Do not send beneficiaries or physicians reconsideration notices for circumvention of PPS (See §7440 for further instructions for processing circumvention of PPS reconsiderations).

All reconsideration notices must contain the following elements unless otherwise specified (See Exhibits 7-40 through 7-50):

- A brief statement concerning your duties and functions under the Act (Cite the regulatory basis for your review authority);
- The date that the reconsideration was requested and the party who requested it;

- The date of the admission or procedure, the name of the provider, and the reason for the admission or the name of the procedure furnished;
- A detailed explanation of the reason for the initial denial determination. A statement that the care was not medically necessary is not an adequate explanation (See §7115.C.5);
- The qualifications of the physician(s) who reviewed the case at the reconsideration level in a manner consistent with your disclosure requirements;
- A brief statement explaining that the provider and practitioner were given an opportunity to provide additional information;
- A clear explanation of the reasons for the reconsidered determination, including a narrative description of the medical facts and a detailed rationale for the determination. Provide the appropriate statutory and regulatory citations. Include an evaluation of any new points raised as part of the reconsideration request. If no new points are raised, state this in your notice;
- A statement about each party's liability for payment. State the initial liability determination for each party, including the rationale for each liability determination. State the reconsidered determination for each party. Provide a clear discussion of the Medicare payment consequences of the reconsidered determination for the beneficiary, provider, and/or physician, including the rationale for the liability determination;
- Fully document your determination that the beneficiary/provider/practitioner knew or should have known that the care in question was not covered. The following are examples of rationales that would support your liability determination (See 42 CFR 411.406, §§7115.C.6 and 7):
 - The beneficiary received written notice from you, the Fiscal Intermediary (FI), carrier, utilization review committee, provider, or physician that the services were not covered or that similar or reasonably comparable services were not covered. Include a copy of the written notice in the reconsideration notice; and
 - The provider and/or physician had prior knowledge that the services furnished were not covered or that similar or reasonably comparable services were not covered based on experience, actual notice, or constructive notice. This knowledge is based upon the provider's receipt of CMS/QIO/FI/carrier notices (such as manual issuances, bulletins, or other written guides or directives), medical review screening criteria specific to the condition of the beneficiary for whom the furnished services are at issue, or the provider's knowledge of what are considered acceptable standards of practice by the local medical community. Provide

specific references and dates in the provider's and physician's rationale (e.g., Bulletin #200, issued September 30, 1990).

- For denials based on circumvention of PPS, explain that the limitation on liability provisions under §1879 do not apply, that the hospital is liable for the denied charges, and that the beneficiary or his/her representative is only responsible for payment of any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare (See Exhibit 7-50);
- A statement regarding the indemnification of the beneficiary for provider and/or physician services when the beneficiary has been found not liable (See §§7115C.8 and 9) (Include only if the initial denial is upheld or partially reversed. Do not include in circumvention of PPS denials);
- If the beneficiary, provider, and/or physician has been found not liable, specify that the beneficiary is responsible only for payment of any deductible, coinsurance, and convenience services and items normally not covered by Medicare for the denied period;
- If the provider and/or physician has been found liable and the beneficiary has been found not liable, specify that the beneficiary is responsible only for payment of any convenience services and items normally not covered by Medicare for the denied period;
- Include the name, address, and telephone number of the FI and/or carrier where the beneficiary can file a request for indemnification;
- Inform the beneficiary that if a request for indemnification is filed, a copy of the denial notice, a copy of the bill for services, and a copy of the payment receipt from the provider or any other evidence showing that the beneficiary paid the provider must be provided to the FI or carrier;
- A statement regarding future liability (See §7115.C.10) (Include only if the initial denial is upheld or partially reversed. Do not include in circumvention of PPS denials);
- A complete discussion about further appeal rights of all parties (i.e., right to request a hearing before an ALJ) (Include only if the initial denial is upheld or partially reversed);
- Make it clear that beneficiaries may appeal the reasonableness, medical necessity, or appropriateness of services furnished or proposed to be furnished, the appropriateness of the setting in which the services were or are proposed to be furnished, or whether they are liable for payment under §1879 of the Act (Limitation on Liability). The provider and physician may only request a hearing

on the issue of knowledge under §1879. Providers may request a hearing on the issue of circumvention of PPS (See §7410.A);

- State the minimum amount that must be in controversy to appeal your reconsideration determination (See §7500);
- State that a written request for appeals (ALJ hearings) must be filed within 60 calendar days after receipt of a reconsideration determination;
- State that the request should include: the beneficiary's name, Medicare health insurance claim number, where and when the services were received, the reason for dissatisfaction with your determination, any additional evidence the beneficiary, provider or physician wishes to submit, and a copy of the reconsideration notice;
- State that a beneficiary may send an ALJ hearing request to you, any SSA District Office, any Office of Hearings and Appeals (OHA), or a Railroad Retirement Board Office (if eligible) and that a provider or practitioner may send an ALJ hearing request to you or OHA (Do not include in circumvention of PPS denials);
- A statement regarding the beneficiary's or his/her representative's right to legal representation (Include only if the initial denial is upheld or partially reversed. Do not include in circumvention of PPS denials). Use the following language without alteration:
 - "If you want help with your appeal of this denial determination, you can have a friend, lawyer or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify."
- A statement regarding the beneficiary's or his/her representative's right to examine or receive a copy of the complete medical/clinical record (Include only if the initial denial is upheld or partially reversed. Do not include in circumvention of PPS denials). Use the following language without alteration:
 - "You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making this denial determination. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will,

however, charge you a reasonable fee for photocopying and mailing this information."

- The signature of the medical director or designated physician (See §7115.C.15).

Notice to Payers -- Provide prompt written or electronic notification to the appropriate Medicare FI or carrier of a reconsidered determination when the initial denial and/or liability determination is partially or totally reversed. Include the name of the beneficiary, the health insurance claim number, the name of the provider and physician, date of admission, and dates of services, if any, for which Medicare payment will not be made.

H. Record of the Reconsideration -- Maintain the record (i.e., file) of your reconsideration until the later of 4 years after the date on the notice of your determination or completion of litigation and the passage of the time period for filing all appeals.

The record (file) must include:

- The initial denial determination and its basis (i.e., all documents associated with the determination);
- A copy of the initial denial notice;
- Documentation of the date of the receipt of the parties' request for reconsideration;
- Evidence submitted by the parties in support of the reconsideration request;
- The basis for the reconsidered determination;
- A copy of the reconsideration notice; and
- Documentation of when the initial denial and reconsideration notices were given/mailed out to the parties (This may be written in a separately kept log).

7440 - Circumvention of Prospective Payment System (PPS) – (Rev. 4, 07-18-03)

Circumvention of Prospective Payment System (PPS) is a hospital action that results in the unnecessary admission or multiple admissions of an individual entitled to benefits under Medicare Part A. §1886(f)(2) of the Act provides that the Secretary determines, although based upon information supplied by the QIO, the prohibited actions have taken place, and the Secretary denies payment. Therefore, the provisions of §1869 of the Act and 42 CFR 405, which deal with appeals from non-QIO payment denials, are applicable and provide for ALJ, Appeals Council, and judicial review.

Under the Medicare program, circumvention of PPS denials are considered to be initial denial determinations that give further reconsideration and appeal rights to hospitals. Therefore, a hospital dissatisfied with your initial denial determination for circumvention of PPS may request a reconsideration regardless of the amount in controversy (See 42 CFR 405.710(b)). Do not notify the beneficiary or physician of your reconsideration determination (See §7430.G.1 for reconsideration notice requirements) (See Exhibit 7-50).

§1886(f)(2) of the Act is directed only to hospitals that are reimbursed under PPS. Because physicians are not paid for services under PPS, a physician does not have an independent right to appeal an adverse determination under this section. The appeal right belongs to the hospital. The hospital may appoint the physician to act as its representative for an appeal or may call a physician as a witness if the appeal goes to a hearing before an ALJ. Although the physician(s) who provided the services during the denied Part A stay do not receive a copy of your denial notice, they do receive notice when the associated Part B payments are denied. Then he/she may separately appeal the denial of Part B services related to the Part A denial if he or she has accepted assignment of the claim from the beneficiary.

Limitation on liability under §1879 of the Act does not apply to Part A denials for circumvention of PPS. If, however, the Part B services associated with the Part A denial are also denied, limitation on liability may apply.

A. Listing of Documentation Required for Hearing -- Obtain the following documentation before you forward the file to OHA. If any of the evidence deemed necessary is not in existence, or is otherwise unobtainable, fully document this and explain.

- Medical Records -- The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medication and services (See 42 CFR 482.24(c)). If possible, send a copy of the entire medical record. Generally, the medical record contains the following documents:
 - Consent to treatment statement;
 - Consultations, if any;
 - Demographics sheet (e.g., face sheet);
 - Discharge summary;
 - Discharge/transfer instructions;
 - Emergency department records, if any;

- Graphic sheets;
- History and physical;
- Intake/output sheets;
- IV flow sheets, if any;
- Laboratory results (e.g., blood work, urine tests);
- Medication records;
- Nursing assessments;
- Operative/procedural consent to treatment statement, if any;
- Operative reports, if any;
- Physician attestation statement;
- Physician's orders;
- Problem list, if any;
- Progress notes (e.g., physician, nurse, other multi-disciplined practitioners);
- Rehabilitation reports, if any; and
- Test results (e.g., X-rays, MRIs, EKGs, CAT scans), if any.

➤ QIO Documents -- Include the following documents from your files:

- Notice of initial denial determination, including a determination on limitation on liability (See §7115 for denial notice content);
- Request for reconsideration (See §7430.G.1 for reconsideration notice content);
- Request for hearing; and
- Reconsideration determination notice including a determination on limitation on liability. To support your reconsideration determination, include the following information:

- The professional qualifications and experience of the physician reconsideration reviewer. Explain that in accordance with regulations governing disclosure of confidential QIO information you may not reveal the identity of the reviewer unless he/she gives his/her consent (See 42 CFR 480 and §7430); and
- Rationale supporting the determination with the corresponding statute/regulation. Provide your rationale in your reconsideration letter so that it may be taken into consideration by OHA. It is not sufficient to add an explanation to the hearing file.

To request a hearing, the beneficiary or his/her representative (whose appointment has been properly documented) may send a letter or submit OHA's Form CMS-5011-U6, Request for Hearing (See Exhibit 7-62). If a beneficiary submits a letter requesting a hearing without Form CMS-5011-U6, fill out Form CMS-5011-U6 and attach the incoming letter and the form to a letter to OHA that includes the following statement: "See attached letter dated." Staple the letter and the postmarked envelope in which it arrived to the hearing request form. You are not responsible for completing Form SSA-1696-U4, Appointment of Representative. Instead, check the appropriate blank under Item 19A on Form CMS-384, QIO Case Summary, indicating whether a completed beneficiary representative form is on file.

NOTE: Upon receipt of a request for hearing, it is imperative that you date-stamp the request. A request is considered filed on the date it is postmarked (See 42 CFR 478.42(b)(3)). Also, retain a copy of the envelope in which the request for hearing was received in order to have a record of the exact date a request was filed.

- Other Pertinent Documents -- Include the following pertinent documents in your file:
 - Hospital denial notice, preadmission/pre-procedure denial notice and the physician's response to the pre-denial notice. These documents may be the only records in the file if the beneficiary was never subsequently admitted to the hospital or the procedure was never performed following a preadmission/pre-procedure denial;
 - Copies of prior denial notices that involve the same or reasonably comparable conditions. These are especially important for appeals made under the limitation on liability provision;
 - Copies of the laws and regulations not otherwise referenced in your determination on which you relied;
 - Copies of relevant review criteria with a statement explaining that you developed the review criteria with the assistance of specialty physicians from your State and that they are medically recognized indicators of care

that reflect local standards of medical practice. Also, include a copy of CMS' generic quality screens that have been applied to the case, if appropriate;

- Copies of the actual document/bulletin/Memorandum of Understanding (MOU) containing the information given to the provider community. Reference actual documents sent to the hospitals, which may include relevant pages of the QIO Manual; and
- All appropriate billing forms and current benefit data from the claim history. If billing forms and benefit data are not available in the file, request that the Fiscal Intermediary (FI) send this information to the appropriate hearing office (See Exhibits 7-63 and 7-64). Do not hold the hearing folder if you only need FI data. Forward the folder directly to OHA.

NOTE: These documents support your determination. ALJs rule based on preponderance of evidence. The parties to the appeal can bring medical specialists and lawyers to the hearing to establish evidence on their behalf (Party is legally defined as "a person or group involved in a legal proceeding"). However, because neither CMS nor the QIO is a party, ensure that the file forwarded to OHA is as complete as possible.

B. Assembling the Hearing Claim File -- Place all hearing requests in folders before you send them to the hearing office. Each folder must contain the beneficiary's Health Insurance Claim Number (HICN) (i.e., Medicare number) on one line followed directly underneath by the surname, first name, and middle initial (if known). All claims material that pertains to services in question, including the envelope in which the request for hearing was received, must be profiled in this folder in chronological order by type of evidence (e.g., nurse's notes, physician's orders) with the most current material on top.

To provide the ALJ with a concise overview of your determination, add a sheet with the qualifications and experience of the physician reconsideration reviewer and his/her rationale supporting the determination with the corresponding statute/regulation.

Include documents to support your limitation on liability determination.

7500 - Background - (Rev. 4, 07-18-03)

The Office of Hearings and Appeals (OHA) of the Social Security Administration (SSA) conducts hearings. Beneficiaries may appeal any medical necessity or appropriateness of setting determination made by you to an Administrative Law Judge (ALJ) where there is at least \$200 or more at issue (See 42 CFR 478.40). Beneficiaries also may appeal your limitation on liability determination (Title XVIII, §1879 of the Act) where \$100 or more is at issue. Providers and practitioners may only appeal to an ALJ your waiver on liability determination where \$100 or more is at issue (if the beneficiary does not request an ALJ hearing on that same issue). That is, they can only appeal the issue of whether

they knew or should have known that care or services were covered by Medicare. Providers and practitioners cannot request an appeal about the issue of medical necessity or appropriateness of setting under Title XI, §1155 of the Act. Providers can appeal your circumvention of PPS denial determinations under §1886(f)(2) of the Act where \$100 or more is at issue (See §1869(b)(2)(A) of the Act and 42 CFR 405.720(d)). There are no appeal rights to DRG changes beyond DRG re-review.

NOTE: Once a request for hearing is filed (even if the above rules do not appear to be met), only OHA can dismiss the case. Therefore, process and forward every request for hearing to OHA within 30 calendar days from the date of receipt of the request.

7510 - Preparing the Acknowledgment Letter - (Rev. 4, 07-18-03)

Prepare and mail the acknowledgment letter to the party requesting a hearing (See Exhibit 7-60). This letter informs the party to which hearing office his/her request for hearing is being mailed. Place a copy in the file.

NOTE: Because the hearing is generally held at the hearing office closest to the requester's address, you need to know the requester's complete address to locate the hearing office (See instructions in Exhibit 7-61 on "How to Locate the Correct Hearing Office").

7520 - Assembling the Hearing Claim File - (Rev. 4, 07-18-03)

Complete documentation is vital. It is the foundation upon which to make and sustain determinations. Inadequate documentation leads to improper and inconsistent determinations, delays in the appeals process, and reversals at higher appellate levels. Therefore, when assembling the case file, make sure you include all pertinent material.

Files furnished for ALJ hearings must provide specific rationale supporting your determination (Cite applicable sections of the statute and regulations and/or published precedents). The statute, regulations, CMS rulings, and national coverage determinations are binding on ALJs. It is important to cite appropriate regulations because these coincide with the ALJ frame of reference. CMS manual instructions are not binding on ALJs unless the statute or regulations specifically incorporates them.

National coverage determinations are found in the Coverage Issues Manual.

CMS Rulings contain precedent case dispositions, statements of policy, and interpretations of the law and regulations, which you are to follow. CMS Rulings are binding on all CMS components, the Provider Reimbursement Review Board, and ALJs who hear Medicare appeals. These decisions promote consistency in interpretation of policy and adjudication of disputes.

A. Listing of Documentation Required for Hearing -- Obtain the following documentation before you forward the file to OHA. If any of the evidence deemed

necessary is not in existence, or is otherwise unobtainable, fully document this and explain.

➤ Medical Records -- The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medication and services (See 42 CFR 482.24(c)). If possible, send a copy of the entire medical record. Generally, the medical record contains the following documents:

- Consent to treatment statement;
- Consultations, if any;
- Demographics sheet (e.g., face sheet);
- Discharge summary;
- Discharge/transfer instructions;
- Emergency department records, if any;
- Graphic sheets;
- History and physical;
- Intake/output sheets;
- IV flow sheets, if any;
- Laboratory results (e.g., blood work, urine tests);
- Medication records;
- Nursing assessments;
- Operative/procedural consent to treatment statement, if any;
- Operative reports, if any;
- Physician attestation statement;
- Physician's orders;
- Problem list, if any;

- Progress notes (e.g., physician, nurse, other multi-disciplined practitioners);
 - Rehabilitation reports, if any; and
 - Test results (e.g., X-rays, MRIs, EKGs, CAT scans), if any.
- QIO Documents -- Include the following documents from your files:
- Notice of initial denial determination, including a determination on limitation on liability (See §7115 for denial notice content);
 - Request for reconsideration (See §7430.G.1 for reconsideration notice content);
 - Request for hearing; and
 - Reconsideration determination notice including a determination on limitation on liability. To support your reconsideration determination, include the following information:
 - The professional qualifications and experience of the physician reconsideration reviewer. Explain that in accordance with regulations governing disclosure of confidential QIO information you may not reveal the identity of the reviewer unless he/she gives his/her consent (See 42 CFR 480 and §7430); and
 - Rationale supporting the determination with the corresponding statute/regulation. Provide your rationale in your reconsideration letter so that it may be taken into consideration by OHA. It is not sufficient to add an explanation to the hearing file.

To request a hearing, the beneficiary or his/her representative (whose appointment has been properly documented) may send a letter or submit OHA's Form CMS-5011-U6, Request for Hearing (See Exhibit 7-62). If a beneficiary submits a letter requesting a hearing without Form CMS-5011-U6, fill out Form CMS-5011-U6 and attach the incoming letter and the form to a letter to OHA that includes the following statement: "See attached letter dated." Staple the letter and the postmarked envelope in which it arrived to the hearing request form. You are not responsible for completing Form SSA-1696-U4, Appointment of Representative. Instead, check the appropriate blank under Item 19A on Form CMS-384, QIO Case Summary, indicating whether a completed beneficiary representative form is on file.

NOTE: Upon receipt of a request for hearing, it is imperative that you date-stamp the request. A request is considered filed on the date it is postmarked (See 42 CFR

8.42(b)(3)). Also, retain a copy of the envelope in which the request for hearing was received in order to have a record of the exact date a request was filed.

- Other Pertinent Documents -- Include the following pertinent documents in your file:
- Hospital denial notice, preadmission/pre-procedure denial notice and the physician's response to the pre-denial notice. These documents may be the only records in the file if the beneficiary was never subsequently admitted to the hospital or the procedure was never performed following a preadmission/pre-procedure denial;
 - Copies of prior denial notices that involve the same or reasonably comparable conditions. These are especially important for appeals made under the limitation on liability provision;
 - Copies of the laws and regulations not otherwise referenced in your determination on which you relied;
 - Copies of relevant review criteria with a statement explaining that you developed the review criteria with the assistance of specialty physicians from your State and that they are medically recognized indicators of care that reflect local standards of medical practice. Also, include a copy of CMS' generic quality screens that have been applied to the case, if appropriate;
 - Copies of the actual document/bulletin/MOU containing the information given to the provider community. Reference actual documents sent to the hospitals, which may include relevant pages of the QIO Manual; and
 - All appropriate billing forms and current benefit data from the claim history. If billing forms and benefit data are not available in the file, request that the Fiscal Intermediary (FI) send this information to the appropriate hearing office (See Exhibits 7-63 and 7-64). Do not hold the hearing folder if you only need FI data. Forward the folder directly to OHA.

NOTE: These documents support your determination. ALJs rule based on preponderance of evidence. The parties to the appeal can bring medical specialists and lawyers to the hearing to establish evidence on their behalf (Party is legally defined as "a person or group involved in a legal proceeding"). However, because neither CMS nor the QIO is a party, ensure that the file forwarded to OHA is as complete as possible.

B. Assembling the Hearing Claim File -- Place all hearing requests in folders before you send them to the hearing office. Each folder must contain the beneficiary's Health Insurance Claim Number (HICN) (i.e., Medicare number) on one line followed directly

underneath by the surname, first name, and middle initial (if known). All claims material that pertains to services in question, including the envelope in which the request for hearing was received, must be profiled in this folder in chronological order by type of evidence (e.g., nurse's notes, physician's orders) with the most current material on top.

To provide the ALJ with a concise overview of your determination, add a sheet with qualifications and experience of the physician reconsideration reviewer and his/her rationale supporting the determination with the corresponding statute/regulation.

Include documents to support your limitation on liability determination.

7530 - Pre-hearing Case Review - (Rev. 4, 07-18-03)

Do not perform pre-hearing case reviews. Once the party has requested an ALJ hearing, the ALJ has jurisdiction. Immediately assemble and transmit the file to the ALJ.

A. Examining the Hearing Claim File -- Examine each file before sending it to the hearing office to ensure that it contains all the pertinent documents.

B. Completing the QIO Case Summary Form (CMS-384) -- Complete the QIO Case Summary Form (See Exhibit 7-65) on all cases you forward to OHA. This form reflects the pertinent facts concerning the beneficiary, the history of the claim, and the evidence in file. Include a copy of this form in the hearing folder. Retain a copy for your records.

C. Completing the Transmittal Notice - Hearing Case Form (CMS-636) -- Complete the Transmittal Notice - Hearing Case Form (See Exhibit 7-66), checking the appropriate block(s). Place the original CMS-636 in the hearing folder on top of the Request for Hearing Form (CMS-5011-U6). Retain a copy for your records.

7540 - Routing the Hearing Claim File to Office of Hearings & Appeals (OHA) - (Rev. 4, 07-18-03)

Follow instructions found in Exhibit 7-61 on "How to Locate the Correct Hearing Office." Prior to forwarding the claim file to the hearing office, attach the CMS-3509, Health Insurance Appeal Case Form, to the front of the folder (See Exhibit 7-67). This form provides the routing instructions for the hearing office after it completes its action on the request. It is important to place this form on all folders sent to OHA and to check the correct return address block.

NOTE: This form is printed on yellow heavy stock paper. Do not photocopy the form.

7550 - Reporting Requirements - (Rev. 4, 07-18-03)

Collect and report data on all requests you receive and process for hearings in accordance with QIO reporting requirements.

7560 - Hearings by an Administrative Law Judge - (Rev. 4, 07-18-03)

A. Beneficiary Representatives at Hearings -- A Medicare beneficiary may appoint any person to represent him/her who meets the requirements of regulations in 20 CFR 404.1705(b), including a provider/practitioner who furnished the services at issue in the appeal.

The representative must:

- Be generally known to have a good character and reputation;
- Be capable of giving valuable help to the beneficiary in connection with the claim;
- Not be disqualified or suspended from acting as a representative in dealings with OHA; and
- Not be prohibited by any law from acting as a representative.

The beneficiary appoints a provider/practitioner by signing an "Appointment of Representative" form (CMS-1696-U4) (See Exhibit 7-68).

B. Your Participation in the Hearing Process -- Neither you nor CMS have the right to appear or participate in the hearing process because you are not designated as parties in the Social Security Act (See 20 CFR 404.932). However, in order to conduct full and fair hearings, ALJs may call your staff to appear as witnesses and to explain your procedures and determinations.

C. Disclosure of Information for Administrative Hearings -- When a Medicare beneficiary, physician, or provider, who is filing for a hearing by an ALJ, requests you to provide information on your reconsideration determination, disclose the information in accordance with the limitations specified in the regulations at 42 CFR 480.139(b)(2). These regulations require you to disclose detailed facts, findings, and conclusions. Your deliberations, however, are not disclosable, either in written form or through oral testimony. Before disclosing information remove any identification of practitioners, reviewers, or other patients unless each individual gives consent to the disclosure.

D. Retention of Appeals Files After ALJ Hearings -- Fiscal Intermediaries maintain appeal files when the appeal is completed. Maintain your copy of the record (i.e., file) of the appeal until the later of:

- Four years after the date on the notice of your reconsideration determination; or
- Completion of litigation and the passage of the time period for filing all appeals (See §7430.H).

NOTE: ALJ decisions are sent to the CMS respective Regional Office (RO).

7570 - Appeals Council (AC) Review - (Rev. 4, 07-18-03)

If the appellant is dissatisfied with an ALJ's decision, the party may request the Appeals Council (AC) to review the decision. The AC may, on its own motion, review an ALJ decision. The circumstances under which the AC will review an ALJ's hearing decision or dismissal are specified in 42 CFR 404.967. You are not considered a party. However, if you believe that an ALJ decision is in conflict with a statute/regulation, contact the RO by telephone and explain why you believe the decision is in error. If the RO agrees that the case should be referred to the AC, provide the RO with documentation, as quickly as possible (e.g., fax), that should be included in its protest to the AC. Work with the intermediaries in your State to ensure the immediate forwarding of the appropriate case files to the RO when it protests an inappropriate ALJ decision. The timeframe for submitting protests to the AC is very short because the AC has 60 days from the date of the ALJ decision/dismissal to issue notice of its intent to take jurisdiction in the case. The AC has requested that the ROs submit protests within 45 days of the date of the decision or dismissal to allow the AC adequate time for preparation, typing, and issuance of the notice once it has determined that its jurisdiction is appropriate.

The AC may request information by telephone. You may send the records with no breach of confidentiality because they are being sent to another organization that is part of the Department of Health and Human Services. Honor all AC requests, and send the records as soon as possible (See 42 CFR 480.130 and 480.130(b)).

7580 - Judicial Review - (Rev. 4, 07-18-03)

A party may obtain judicial review of the Appeals Council's decision or a decision of an ALJ (when the request for review by the Appeals Council is denied) by filing a civil action under the Federal Rules of Civil Procedure within 60 calendar days after the date the party received notice of the ALJ's or Appeals Council's decision (See 42 CFR 405.730). If dissatisfied after ALJ or Appeals Council review:

- A beneficiary can request judicial review on the issue of medical necessity/appropriateness of setting if the amount of the denied services is \$2,000 or more;
- A beneficiary, provider, or practitioner can request judicial review on the issue of knowledge (i.e., limitation on liability) if the amount of liability is \$1,000 or more; or
- A provider can request judicial review on the issue of circumvention of PPS (§1886(f)(2) of the Act) if the amount of the denied services is \$1,000 or more (See §1869(b)(2)(A) of the Act and 42 CFR 405.730).

Exhibit 7-20 - Limitation of Liability Model Paragraphs –

(Rev. 4, 07-18-03)

Summary of Limitation of Liability Conditions I-XIII:

Identify the applicable limitation of liability condition (§1879 of the Act) and use the appropriate model paragraph. These paragraphs are not all-inclusive but are to be used as a guide in developing the appropriate language.

Condition I: Use when beneficiary and provider are not liable under the limitation of liability provision of the law.

Condition II: Use when beneficiary is not liable, and the provider is liable under the limitation of liability provision of the law. Use for all denials for custodial or medically unnecessary services/(level of) care.

Condition III: Use when beneficiary is not liable, and the provider and the Medicare participating physician (or nonparticipating physician who furnished services on an assigned basis) are liable under the limitation of liability provision of the law. Beneficiary is not responsible for payment of deductible/coinsurance. Use for medically unnecessary procedure(s) and cost outlier(s) with physician component denials (See Exhibits 7-28 and 7-30).

Condition IIIA: Use when beneficiary is not liable, but the provider is liable under the limitation of liability provision of the law, and the nonparticipating physician who furnished services on an unassigned basis is liable (for a refund of any amount paid) under §1842(l) of the Act. Use for medically unnecessary procedure(s) and cost outlier(s) with physician component denials (See Exhibits 7-28 and 7-30).

Condition IV: Use when beneficiary is liable, and the provider is not liable under the limitation of liability provision of the law (e.g., beneficiary had received prior notice for non-covered services proposed/furnished by a provider, and the patient received, from a different provider, the denied services which involve the same or reasonably comparable conditions).

Condition V: Use when beneficiary and provider are liable under the limitation of liability provision of the law (e.g., provider and beneficiary had received prior notice for the same or reasonably comparable non-covered services).

Condition VI: Use when beneficiary is not liable (until date specified by you), and the provider is liable under the limitation of liability provision of the law. Use for denials based on a provider's request for review of a proposed continued-stay HINN (See Exhibit 7-27, Condition I), or a beneficiary's request for non-immediate review of a continued-stay HINN, or a beneficiary's request for review of a SNF swing bed continued-stay HINN (See Exhibit 7-27, Condition II). This applies to both PPS and non-PPS hospitals.

Condition VII: Use when beneficiary is not liable (until noon of the day specified by you), and the provider is liable under the limitation of liability provision of the law. Use for denials based on a beneficiary's request for an immediate review of a continued-stay HINN (See Exhibit 7-27, Condition II). This applies to both PPS and non-PPS hospitals (It does not apply to SNF swing bed continued-stay denials. See Condition VI).

Condition VIII: Use when beneficiary and provider are not liable under the limitation of liability provision of the law. Use for concurrent review of continued-stay denials not involving a HINN where you are approving payment for additional days for purposes of post-discharge planning (i.e., grace days) (See Exhibit 7-27, Condition VII). This applies to both PPS and non-PPS hospitals.

Condition IX: Use when beneficiary and provider are both not liable for part of the denied period and liable for part of the denied period. Use when the beneficiary is responsible for payment of any deductible, coinsurance, and convenience services and items furnished during the covered admission.

Condition X: Use when beneficiary is not liable for a part of the denied period and liable for a part of the denied period, and the provider is liable for the entire denied period. Use when the beneficiary is not responsible for payment of the denied services, including any deductible and coinsurance, for part of the denied period and is responsible for payment for the denied services, including any deductible and coinsurance, for another part of the denied period.

Condition XI: Use when beneficiary, provider, and Medicare participating physician (or nonparticipating physician who furnished services on an assigned basis) are not liable under the limitation of liability provision of the law. Use for outpatient/ambulatory surgical denials (See Exhibit 7-32, Condition II). For denials involving nonparticipating physicians who furnished services on an unassigned basis, see language under Condition IIIA.

Condition XII: Use when beneficiary is not liable. The provider and the Medicare participating physician (or nonparticipating physician who furnished services on an assigned basis) are liable under the limitation of liability provision of the law. Use for outpatient/ambulatory surgical denials (See Exhibit 7-32, Condition II). For denials involving nonparticipating physicians who furnished services on an unassigned basis, see language under Condition IIIA.

Condition XIII: Use when beneficiary, provider, and Medicare participating physician (or nonparticipating physician who furnished services on an assigned basis) are liable under the limitation of liability provision of the law. Use for outpatient/ambulatory surgical denials (See Exhibit 7-32, Condition II). For denials involving nonparticipating physicians who furnished services on an unassigned basis, see language under Condition IIIA.

NOTE: For denials of inpatient hospital services furnished on or after January 1, 1989, through December 31, 1989, delete reference to the beneficiary's responsibility for coinsurance payment for Conditions I, II (partial denials), III (partial denials), VI, VII, VIII, IX, and X (partial denials) (Does not apply to services/items furnished in SNF swing beds).

For denials of SNF swing bed services/items, do not make reference to deductibles, as deductibles do not apply to SNF swing bed denials.

Limitation of Liability Model Paragraphs:

Condition I: Use when beneficiary and provider are not liable under the limitation of liability provision of the law:

We have also determined that neither you nor the hospital knew that the denied services were not covered under Medicare. Medicare will, therefore, pay the hospital for the services under a provision of the Social Security Act.

You are responsible only for payment of any amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare furnished during this admission. If you have paid the hospital for any denied services other than those amounts already mentioned, arrangements can be made to pay you back. Please contact the Fiscal Intermediary (FI) at:

FI Name
Address
Telephone Number

You must make your written request for payment within 6 months of the date of this notice and provide the FI with the following documents:

- A copy of this notice;
- The bill you received for the services; and
- The payment receipt or any other evidence (e.g., canceled check) showing that you have paid for the denied services.

Upon receipt of this notice, you will continue to be responsible for payment for denied services occurring in the future which involve the same or reasonably comparable conditions. However, Medicare will pay for all medically necessary and appropriate hospital care you may require in the future. Should the need arise, we encourage you to discuss arrangements for your health care with your physician.

Condition II: Use when beneficiary is not liable, and the provider is liable under the limitation of liability provision of the law. Use for all denials for custodial or medically unnecessary services/(level of) care:

We have also determined that you did not know that the denied services were not covered under Medicare. Medicare will not pay the hospital for the denied services because the hospital knew or should have known that the services were not covered under Medicare based on (specify: brochures, prior notices (including dates), manual references, criteria, etc.).

If you have paid the hospital for any denied services other than those amounts already mentioned, arrangements can be made to pay you back. Please contact the Fiscal Intermediary (FI) at:

FI Name

Address

Telephone Number

You must make your written request for payment within 6 months of the date of this notice and provide the FI with the following documents:

- A copy of this notice;
- The bill you received for the services; and
- The payment receipt or any other evidence (e.g., canceled check) showing that you have paid for the denied services.

Upon receipt of this notice, you will continue to be responsible for payment for denied services occurring in the future which involve the same or reasonably comparable conditions. However, Medicare will pay for all medically necessary and appropriate hospital care you may require in the future. Should the need arise, we encourage you to discuss arrangements for your health care with your physician.

For total denials, insert: "You are not responsible for payment for the denied services, including any applicable deductible and coinsurance, except for any amounts for convenience services and items normally not covered by Medicare."

For partial denials, insert: "You are not responsible for payment for the services which were denied, except for any applicable amounts for deductible and coinsurance related to the services found covered, plus any amounts for convenience services and items normally not covered by Medicare."

Condition III: Use when beneficiary is not liable, and the provider and the Medicare participating physician (or nonparticipating physician who furnished services on an assigned basis) are liable under the limitation of liability provision of the law. Beneficiary is not responsible for payment of deductible/coinsurance. Use for medically unnecessary procedure(s) and cost outlier(s) with physician component denials (See Exhibits 7-28 and 7-30):

We have also determined that you did not know that the denied services were not covered under Medicare. Medicare will not pay the hospital for the denied services because the

hospital knew or should have known that the denied services were not covered under Medicare based on (specify: brochures, prior notices (including dates), manual references, criteria, etc.). In addition, Medicare will not pay for any of your physician's services related to this denial because your physician knew or should have known that the denied services were not covered under Medicare based on (specify: brochures, prior notices (including dates), manual references, criteria, etc.).

If you have paid the hospital or your physician for any denied services other than those amounts already mentioned, arrangements can be made to pay you back.

For refund of payment related to hospital services, please contact the Fiscal Intermediary (FI). For refund of payment related to physician services, please contact the carrier at:

FI or Carrier Name

Address

Telephone Number

You must make your written request for payment within 6 months of the date of this notice and provide the FI or carrier with the following documents:

- A copy of this notice;
- The bill you received for the services; and
- The payment receipt or any other evidence (e.g., canceled check) showing that you have paid for the denied services.

Upon receipt of this notice, you will continue to be responsible for payment for denied services occurring in the future which involve the same or reasonably comparable conditions. However, Medicare will pay for all medically necessary and appropriate hospital care you may require in the future. Should the need arise, we encourage you to discuss arrangements for your health care with your physician.

For total denials, insert: "You are not responsible for payment for the denied services, including any applicable deductible and coinsurance, except for any amounts for convenience services and items normally not covered by Medicare."

For partial denials, insert: "You are not responsible for payment for the services which were denied, except for any applicable amounts for deductible and coinsurance related to the services found covered, plus any amounts for convenience services and items normally not covered by Medicare."

Condition IIIA: Use when beneficiary is not liable, but the provider is liable under the limitation of liability provision of the law, and the nonparticipating physician who furnished services on an unassigned basis is liable (for a refund of any amount paid) under §1842(l) of the Act. Use for medically unnecessary procedure(s) and cost outlier(s) with physician component denials (See Exhibits 7-28 and 7-30):

We have also determined that you did not know that the denied services were not covered under Medicare. Medicare will not pay the hospital for the denied services because the hospital knew or should have known that the denied services were not covered under Medicare based on (specify: brochures, prior notices (including dates), manual references, criteria, etc.).

If you have paid the hospital for any of the denied services other than those amounts already mentioned, arrangements can be made to pay you back. Please contact the Fiscal Intermediary (FI) at:

FI Name
Address
Telephone Number

In addition, we determined that your physician knew or should have known that the denied services were not covered under Medicare based on (specify: brochures, prior notices (including dates), manual references, criteria, etc.). Therefore, Medicare will not pay you for any of your physician's services related to this denial.

However, you are not responsible for payment for your physician's services because your physician did not notify you, in writing, that his/her services would not be covered under Medicare. You are entitled to a refund if you have paid your physician for any of the denied services. You should contact your physician for any refund. If you have difficulty obtaining this refund, you should contact the carrier at:

Carrier Name
Address
Telephone Number

For total denials, insert: "You are not responsible for payment for the denied services, including any applicable deductible and coinsurance, except for any amounts for convenience services and items normally not covered by Medicare."

For partial denials, insert: "You are not responsible for payment for the services which were denied, except for any applicable amounts for deductible and coinsurance related to the services found covered, plus any amounts for convenience services and items normally not covered by Medicare."

You must make your written request for payment within 6 months of the date of this notice and provide the FI or carrier with the following documents:

- A copy of this notice;
- The bill you received for the services; and
- The payment receipt or any other evidence (e.g., canceled check) showing that you have paid for the denied services.

Upon receipt of this notice, you will continue to be responsible for payment for denied services occurring in the future which involve the same or reasonably comparable conditions. However, Medicare will pay for all medically necessary and appropriate hospital care you may require in the future. Should the need arise, we encourage you to discuss arrangements for your health care with your physician.

NOTE: When you determine that the nonparticipating physician did not know that the denied services would not be covered under Medicare, or if the nonparticipating physician gives the beneficiary or his/her representative a written notice explaining that the services will not be covered under Medicare, the beneficiary is responsible for payment for the denied physician services (i.e., the beneficiary is not entitled to a refund. In these instances, use the following language as applicable:

➤ "We have determined that your physician did not know that the services denied would not be covered under Medicare. Since your physician does not accept Medicare assignment, Medicare cannot pay you for any of your physician's services related to this denial. Therefore, you are responsible for payment for his/her services."

• OR

➤ "We have determined that you knew that your physician's services would not be covered under Medicare based on the written notification he/she gave to you on (date of written notice), a copy of which is enclosed. Medicare will not pay you for any of your physician's services related to this denial. Therefore, you are responsible for payment for his/her services."

Condition IV: Use when beneficiary is liable, and the provider is not liable under the limitation of liability provision of the law (e.g., beneficiary had received prior notice for non-covered services proposed/furnished by a provider, and received, from a different provider, the denied services which involve the same or reasonably comparable conditions):

We have also determined that you knew or should have known that the denied services were not covered under Medicare based on prior notification sent to you on (date of prior notice), a copy of which is enclosed. Therefore, Medicare will not pay the hospital for the denied services even though we have determined that the hospital did not know that these services are not covered. You are responsible for payment of all costs for the denied hospital services you received except for those covered services which can be paid for by Medicare Part B.

Upon receipt of this notice, you will continue to be responsible for payment for denied services occurring in the future which involve the same or reasonably comparable conditions. However, Medicare will pay for all medically necessary and appropriate hospital care you may require in the future. Should the need arise, we encourage you to discuss arrangements for your health care with your physician.

Condition V: Use when beneficiary and provider are liable under the limitation of liability provision of the law (e.g., provider and beneficiary had received prior notice for the same or reasonably comparable non-covered services):

We have also determined that you knew or should have known that the denied services were not covered under Medicare based on prior notification sent to you on (date of prior notice), a copy of which is enclosed. The hospital knew or should have known based on (specify: brochures, prior notices (including dates), manual references, criteria, etc.). Therefore, Medicare will not pay the hospital for the denied services. You are responsible for payment of all costs for the denied hospital services you received except for those covered services which can be paid for by Medicare Part B.

Upon receipt of this notice, you will continue to be responsible for payment for denied services occurring in the future which involve the same or reasonably comparable conditions. However, Medicare will pay for all medically necessary and appropriate hospital care you may require in the future. Should the need arise, we encourage you to discuss arrangements for your health care with your physician.

For partial denials, insert: "In addition, you are responsible for payment of any amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare furnished during this admission."

Condition VI: Use when beneficiary is not liable (until date specified by you), and the provider is liable under the limitation of liability provision of the law. Use for denials based on a provider's request for review of a proposed continued-stay HINN (See Exhibit 7-27, Condition I), a beneficiary's request for non-immediate review of a continued-stay HINN, or a beneficiary's request for review of a SNF swing bed continued-stay HINN (See Exhibit 7-27, Condition II). This applies to both PPS and non-PPS hospitals:

We notified you by telephone on (date of telephone notification) of our determination that the services you are receiving are not covered by Medicare and that if you decided to remain in the hospital, beginning on (date), you would be responsible for payment of all costs for hospital services you receive except for those covered services which can be paid for by Medicare Part B. If you decide to leave the hospital prior to (date), you will be responsible only for payment of any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare.

We are also advising your physician and the hospital of this denial. You should discuss with your physician other arrangements for any further health care you may now require.

Upon receipt of this notice, you will continue to be responsible for payment for denied services occurring in the future which involve the same or reasonably comparable conditions. However, Medicare will pay for all medically necessary and appropriate hospital care you may require in the future.

For PPS hospitals or hospitals participating in State payment control systems or demonstration projects, insert the date of the third day following the date of receipt of the HINN.

For non-PPS hospitals, PPS exempt units, and SNF swing beds, insert the date of the day following the date of receipt of the HINN.

Condition VII: Use when beneficiary is not liable (until noon of the day specified by you), and the provider is liable under the limitation of liability provision of the law. Use for denials based on a beneficiary's request for an immediate review of a continued-stay HINN (See Exhibit 7-27, Condition II). This applies to both PPS and non-PPS hospitals. It does not apply to SNF swing bed continued-stay denials (See Condition VI):

We notified you by telephone on (date of telephone notification) of our determination that the services you are receiving are not covered by Medicare and that if you decided to remain in the hospital after 12 noon on (day following date of your telephone notification), you would be responsible for payment of all costs of hospital services you receive after that time except for those covered services which can be paid for by Medicare Part B. If you decide to leave the hospital prior to 12 Noon on (day following date of your telephone notification), you will be responsible only for payment of any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare.

We are also advising your physician and hospital of this denial. You should discuss other arrangements for any further health care you may now require with your physician.

Upon receipt of this notice, you will continue to be responsible for payment for denied services occurring in the future which involve the same or reasonably comparable conditions. However, Medicare will pay for all medically necessary and appropriate hospital care you may require in the future.

Condition VIII: Use when beneficiary and provider are not liable under the limitation of liability provision of the law. Use for concurrent review of continued-stay denials not involving a HINN where you are approving payment for additional days for the purpose of post-discharge planning (i.e., grace days) (See Exhibit 7-27, Condition VII). This applies to both PPS and non-PPS hospitals:

We have also determined that neither you nor the hospital knew that the denied services would no longer be covered under Medicare beginning (date of first non-covered day). Therefore, under a provision of the Social Security Act, Medicare will pay for (select number of days up to 2) additional day(s) from the date of this notice to arrange for your post-discharge care. If you decide to remain in the hospital beginning on (2nd or 3rd day from date of notice), you will be responsible for payment of all costs of hospital services you receive except for those covered services which can be paid for by Medicare Part B. If you decide to leave the hospital prior to (2nd or 3rd day from date of notice), you will

be responsible only for payment of any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare.

We are also advising your physician and hospital of this denial. You should discuss other arrangements for any further health care you may now require with your physician.

Upon receipt of this notice, you will continue to be responsible for payment for denied services occurring in the future which involve the same or reasonably comparable conditions. Please be aware that Medicare will pay for all medically necessary and appropriate hospital care you may require in the future.

Condition IX: Use when beneficiary and provider are both not liable for part of the denied period and liable for part of the denied period. Use when the beneficiary is responsible for payment of any deductible, coinsurance, and convenience services and items applicable to the covered admission:

We have determined that neither you nor the hospital knew that the denied services from (specify the date(s) not liable) were not covered under Medicare. Medicare will, therefore, pay the hospital for the denied services for this period under a provision of the Social Security Act.

We have also determined that you and the hospital knew or should have known that the denied services from (specify the date(s) liable) were not covered under Medicare. You knew or should have known based on a prior notification sent to you on (date of prior notice), a copy of which is enclosed. The hospital knew or should have known based on (specify: brochures, prior notices (including dates), manual references, criteria, etc.). Medicare will not pay the hospital for the denied services for this period. You are responsible for payment of all costs of the denied hospital services you received from (specify the date(s) liable) except for those covered services which can be paid for by Medicare Part B. In addition, you are responsible for payment of any amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare which are applicable to this admission.

If you have paid the hospital for any of the denied services from (specify the date(s) not liable), other than any applicable amounts for deductible, coinsurance, and convenience services and items, arrangements can be made to pay you back. Please contact the Fiscal Intermediary (FI) at:

FI Name
Address
Telephone Number

You must make your written request for payment within 6 months of the date of this notice and provide the FI with the following documents:

- A copy of this notice;

- The bill you received for the services; and
- The payment receipt or any other evidence (e.g., canceled check) showing that you have paid for the denied services.

Upon receipt of this notice, you will continue to be responsible for payment for denied services occurring in the future which involve the same or reasonably comparable conditions. However, Medicare will pay for all medically necessary and appropriate hospital care you may require in the future. Should the need arise, we encourage you to discuss arrangements for your health care with your physician.

Condition X: Use when beneficiary is not liable for a part of the denied period and liable for a part of the denied period, and the provider is liable for the entire denied period. Use when the beneficiary is not responsible for payment for the denied services, including any deductible and coinsurance, for part of the denied period and is responsible for payment of the denied services, including any deductible and coinsurance, for another part of the denied period:

We have determined that you did not know that the denied services from (specify the date(s) not liable) were not covered under Medicare. We have also determined that you knew or should have known that the denied services from (specify the date(s) liable) were not covered under Medicare based on a prior notification sent to you on (date of prior notice), a copy of which is enclosed. The hospital knew or should have known that the denied services from (specify the date(s) denied) were not covered under Medicare based on (specify: brochures, prior notices (including dates), manual references, criteria, etc.). Therefore, Medicare will not pay the hospital for the denied services.

You are not responsible for payment of the denied services from (specify the date(s) not liable) except for any amounts for convenience services and items normally not covered by Medicare. You are responsible for payment of all costs for the denied hospital services you received from (specify the date(s) liable) except for those covered services which can be paid for by Medicare Part B.

If you have paid the hospital for any of the denied services from (specify the date(s) not liable) other than any amounts for convenience services and items, arrangements can be made to pay you back. Please contact the Fiscal Intermediary (FI) at:

FI Name
Address
Telephone Number

You must make your written request for payment within 6 months of the date of this notice and provide the FI with the following documents:

- A copy of this notice;
- The bill you received for the services; and

- The payment receipt or any other evidence (e.g., canceled check) showing that you have paid for the denied services.

Upon receipt of this notice, you will continue to be responsible for payment for denied services occurring in the future which involve the same or reasonably comparable conditions. However, Medicare will pay for all medically necessary and appropriate hospital care you may require in the future. Should the need arise, we encourage you to discuss arrangements for your health care with your physician.

Condition XI: Use when beneficiary, provider, and Medicare participating physician (or nonparticipating physician who furnished services on an assigned basis) are not liable under the limitation of liability provision of the law. Use for outpatient/ambulatory surgical denials (See Exhibit 7-32, Condition II) (For denials involving nonparticipating physicians who furnished services on an unassigned basis, see language under Condition IIIA):

We have also determined that you, the provider, and your physician did not know that the denied services were not covered under Medicare. Medicare will, therefore, pay the provider and your physician for the denied services under a provision of the Social Security Act.

You are responsible only for payment of any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare (e.g., telephone and television charges). If you have paid the provider or your physician for any of the denied services other than those amounts already mentioned, arrangements can be made to pay you back. You must make your written request for payment within 6 months of the date of this notice and provide the FI and/or carrier with the following documents:

- A copy of this notice;
- The bill you received for the services; and
- The payment receipt or any other evidence (e.g., canceled check) showing that you have paid for the denied services.

Upon receipt of this notice, you will continue to be responsible for payment for denied services occurring in the future which involve the same or reasonably comparable conditions. However, Medicare will pay for all medically necessary and appropriate care you may require in the future. Should the need arise, we encourage you to discuss arrangements for your health care with your physician.

For ambulatory surgical center settings insert: "Please contact the carrier at:"

Carrier Name
Address
Telephone Number

For hospital outpatient settings insert: “For refund of payment related to hospital services, please contact the Fiscal Intermediary (FI) at:”

FI Name
Address
Telephone Number

For hospital outpatient settings insert: “For refund of payment related to physician services, please contact the carrier at:”

Carrier Name
Address
Telephone Number

Condition XII: Use when beneficiary is not liable. The provider and the Medicare participating physician (or nonparticipating physician who furnished services on an assigned basis) are liable under the limitation of liability provision of the law. Use for outpatient/ambulatory surgical denials (See Exhibit 7-32, Condition II) (For denials involving nonparticipating physicians who furnished services on an unassigned basis, see language under Condition IIIA):

We have also determined that you did not know that the denied services were not covered under Medicare. Medicare will not pay the provider for the denied services because the provider knew or should have known that the denied services were not covered under Medicare based on (specify: brochures, prior notices (including dates), manual references, criteria, etc.). In addition, Medicare will not pay for any of the physician's services related to this denial because your physician knew or should have known that the denied services were not covered under Medicare based on (specify: brochures, prior notices (including dates), manual references, criteria, etc.).

You are not responsible for payment for the denied services except for any amounts for convenience services and items normally not covered by Medicare (e.g., telephone and television charges). If you have paid the provider or your physician for any of the denied services other than those amounts already mentioned, arrangements can be made to pay you back.

You must make your written request for payment within 6 months of the date of this notice and provide the FI and/or carrier with the following documents:

- A copy of this notice;
- The bill you received for the services; and
- The payment receipt or any other evidence (e.g., canceled check) showing that you have paid for the denied services.

Upon receipt of this notice, you will continue to be responsible for payment for denied services occurring in the future which involve the same or reasonably comparable

conditions. However, Medicare will pay for all medically necessary and appropriate care you may require in the future. Should the need arise, we encourage you to discuss arrangements for your health care with your physician.

For ambulatory surgical center settings insert: "Please contact the carrier at:"

Carrier Name
Address
Telephone Number

For hospital outpatient settings insert: "For refund of payment related to hospital services, please contact the Fiscal Intermediary (FI) at:"

FI Name
Address
Telephone Number

For hospital outpatient settings insert: "For refund of payment related to physician services, please contact the carrier at:"

Carrier Name
Address
Telephone Number

Condition XIII: Use when beneficiary, provider, and Medicare participating physician (or nonparticipating physician who furnished services on an assigned basis) are liable under the limitation of liability provision of the law. Use for outpatient/ambulatory surgical denials (See Exhibit 7-32, Condition II) (For denials involving nonparticipating physicians who furnished services on an unassigned basis, see language under Condition IIIA):

We have also determined that you knew or should have known that the denied services were not covered under Medicare based on a prior notification sent to you on (date of prior denial notice from any QIG, FI/carrier, physician, or provider), a copy of which is enclosed. The provider knew or should have known that the denied services were not covered under Medicare based on (specify: brochures, prior notices (including dates), manual references, criteria, etc.). Your physician knew or should have known that the services were not covered under Medicare based on (specify: brochures, prior notices (including dates), manual references, criteria, etc.). Therefore, Medicare will not pay the provider or your physician for the denied services. You are responsible for payment of all costs for the denied services you received including any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare (e.g., telephone and television charges).

Upon receipt of this notice, you will continue to be responsible for payment for denied services occurring in the future which involve the same or reasonably comparable

conditions. However, Medicare will pay for all medically necessary and appropriate care you may require in the future. Should the need arise, we encourage you to discuss arrangements for your health care with your physician.

Exhibit 7-21 - Reconsideration Model Paragraphs - (Rev. 4, 07-18-03)

Summary of Reconsideration Conditions I-III:

Identify the applicable reconsideration condition, and use that model paragraph.

Condition I: Use for preadmission denials (i.e., the patient is not yet admitted to the hospital).

Condition II: Use for concurrent denials (i.e., the patient is still in the hospital).

Condition III: Use for retrospective denials (i.e., the patient has been discharged from the hospital).

Reconsideration Model Paragraphs:

Condition I: Use for preadmission denials (i.e., the patient is not yet admitted to the hospital):

If you, your physician, or hospital disagrees with our determination, you may appeal this denial decision by requesting an expedited reconsideration by telephone or in writing. You must make your request for an expedited reconsideration within 3 calendar days from the date of this notice directly to us at:

QIO Name
Address
Telephone Number

We will complete our expedited reconsideration and send a written notice to you within 3 working days.

However, if you do not wish an expedited reconsideration, you, your physician, or hospital are still entitled to a reconsideration. You must submit your request in writing within 60 calendar days from the receipt of this notice to us at the above address.

You may also make your request to any Social Security Office or Railroad Retirement Office (if you are a Railroad Retirement beneficiary). Your request will be forwarded to us.

As a result of our review, we may reaffirm or reverse our prior denial determination. If we reaffirm the denial determination, you will continue to be responsible for payment of services furnished as specified above. If we reverse the denial determination, you will be

refunded any amount collected by the hospital except for payment of deductible, coinsurance, or any convenience services or items normally not covered by Medicare.

Condition II: Use for concurrent denials (i.e., the patient is still in the hospital):

If you disagree with our determination and you decide to remain in the hospital, you, your physician, or hospital may appeal this denial decision while you are still in the hospital by requesting an expedited reconsideration through the hospital or by telephoning or writing us at:

QIO Name
Address
Telephone Number

We will complete our expedited reconsideration and send a written notice to you within 3 working days.

However, if you do not remain in the hospital after (date liability begins), or if you remain in the hospital and do not request an expedited reconsideration, you, your physician, or hospital are still entitled to a reconsideration. You must submit your request in writing within 60 calendar days from receipt of this notice to us at the above address.

You may also make your request to any Social Security Office or Railroad Retirement Office (if you are a Railroad Retirement beneficiary). Your request will be forwarded to us.

As a result of our review, we may reaffirm or reverse our prior denial determination. If we reaffirm the denial determination, you will continue to be responsible for payment of services furnished as specified above. If we reverse the denial determination, you will be refunded any amount collected by the hospital except for payment of deductible, coinsurance, or any convenience services or items normally not covered by Medicare.

Condition III: Use for retrospective denials (i.e., the patient has been discharged from the hospital):

If you, your physician, or hospital disagrees with our determination, you may appeal this denial decision by requesting a reconsideration. You must submit your request in writing within 60 calendar days from receipt of this notice directly to us at:

QIO Name
Address
Telephone Number

You may also make your request to any Social Security Office or Railroad Retirement Office (if you are a Railroad Retirement beneficiary). Your request will be forwarded to us.

As a result of our review, we may reaffirm or reverse our prior denial determination. If we reaffirm the denial determination, you will continue to be responsible for payment of services furnished as specified above. If we reverse the denial determination, you will be refunded any amount collected by the hospital except for payment of deductible, coinsurance, or any convenience services or items normally not covered by Medicare.

**Exhibit 7-23 - Record Not Submitted Timely Denial Model Notice -
(Rev. 4, 07-18-03)**

Use for retrospective admission denials when the medical record (or itemized bill for cost outliers) is not submitted timely by the hospital.

- Opportunity for discussion does not apply.
- Limitation of liability (§1879 of the Act) does not apply.
- Reconsideration does not apply.

NOTE: For inpatient hospital services furnished on or after January 1, 1989, through December 31, 1989, delete reference to the beneficiary's:

- Responsibility for payment of the coinsurance; and
- Utilization of the benefit period.

Record Not Submitted Timely Denial Model Notice:

YOUR LETTERHEAD

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Health Insurance Claim (HIC) Number
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of _____. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

We have denied Medicare payment for your admission of (date) to (provider name) for (specify the procedure/treatment or condition/services). This denial is due solely to the hospital's failure to submit your (select: medical record; or itemized bill; or medical record and itemized bill) as requested by us. This information is necessary for us to complete review of this claim.

Medicare will not pay the hospital for this admission. However, you are not responsible for payment of the denied services except for any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare. If you have paid the hospital for any of the denied services other than those amounts just mentioned, arrangements can be made to pay you back. Please contact the Fiscal Intermediary (FI) at:

FI Name
Address
Telephone Number

You must make your written request for payment within 6 months of the date of this notice and provide the FI with the following documents:

- A copy of this notice;
- The bill you received for the services; and
- The payment receipt or any other evidence (e.g., canceled check) showing that you have paid for the denied services.

Please be aware that the days you spent as an inpatient will be subtracted from the total number of days available to you in this benefit period. Your case can be reopened when the necessary information is submitted by the hospital. You will be notified of the decision resulting from this review.

Sincerely,

Medical Director (or designated physician)

ccs:
Hospital

Physician
FI
Carrier

Exhibit 7-24 - Billing Error Denial Model Notice - (Rev. 4, 07-18-03)

Use for retrospective admission denials when review cannot be completed due to a provider billing error (e.g., incorrectly billed an uninterrupted stay as two separate admissions). Use this notice if you are responsible for notification of billing errors as a result of your agreements with the FI(s) and provider.

- Opportunity for discussion does not apply.
- Limitation of liability (§1879 of the Act) does not apply.
- Reconsideration does not apply.
- Do not notify the beneficiary.

NOTE: For inpatient hospital services furnished on or after January 1, 1989, through December 31, 1989, delete reference to the beneficiary's responsibility for payment of the coinsurance.

Billing Error Denial Model Notice:

YOUR LETTERHEAD

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Health Insurance Claim (HIC) Number
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of _____. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

We have denied Medicare payment for the above admission of (date) for (specify the procedure/treatment or condition/services). In reviewing this admission, an error in billing was discovered which precludes us from completing review of this claim. Our determination is based on the following: (Relate discussion to specific billing error).

Medicare will not pay the hospital for this admission. The beneficiary or his/her representative is only responsible for payment for any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare.

This case can be reopened when a corrected bill is submitted by the hospital to the Fiscal Intermediary (FI), at which time the FI will resubmit the case to us to complete review.

Sincerely,

Medical Director (or designated physician)
Chief Executive Officer, etc., as appropriate

ccs:
Hospital
Physician
FI
Carrier

Exhibit 7-25 - Preadmission Denial Model Notice - (Rev. 4, 07-18-03)

Use only for denials of services furnished prior to admission to the facility.

- Opportunity for discussion applies.
- Limitation of liability (§1879 of the Act) does not apply.
- Reconsideration applies (See Exhibit 7-21).

Preadmission Denial Model Notice:

YOUR LETTERHEAD

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Health Insurance Claim (HIC) Number
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of _____. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Our physician reviewers have denied Medicare payment for your proposed admission of (date) (specify, if known: "to" (name of provider)) for (specify the procedure/treatment or condition/services).

Prior to reaching this decision, we gave your physician (if known: and the hospital) an opportunity to discuss your case.

After a review of your medical record and any additional information provided, we determined that (give a full discussion of the specific reason(s) for denial).

Medicare will not pay for your proposed admission if you and your physician decide you should be admitted to the hospital. We are also advising your physician (if known: and the hospital) of this denial. You should discuss with your physician other arrangements for any further health care you may now require.

NOTE: For denials of provider services only, insert: "Therefore, you will be responsible for payment of all costs for the hospital services you receive except for those covered services which can be paid for by Medicare Part B."

NOTE: For denials of provider and related physician services, insert: "Therefore, you will be responsible for payment of all costs for the hospital and related physician services you receive except for those covered services which can be paid for by Medicare Part B."

Upon receipt of this notice, you will continue to be responsible for payment of denied services occurring in the future which involve the same or reasonably comparable conditions. However, Medicare will pay for all medically necessary and appropriate hospital care you may require in the future.

Use reconsideration paragraph under Condition I.

If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making this denial determination. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information.

Sincerely,

Medical Director (or designated physician)

ccs:
Hospital
Physician
FI
Carrier

Exhibit 7-26 - Admission Denial Model Notices - (Rev. 4, 07-18-03)

Identify the denial condition, and use the appropriate model notice.

Condition I: Use for retrospective admission denials (PPS and non-PPS hospitals) based on inappropriate setting, medically unnecessary, or custodial care. Revise accordingly for denials involving direct admission for NF swing bed services with or without an admission HINN.

Condition II: Use for retrospective denials based on inappropriate setting, medically unnecessary, or custodial care involving "deemed" admission date cases.

For both conditions:

- Opportunity for discussion applies.
- Limitation of liability (§1879 of the Act) applies (See Exhibit 7-20).

➤ Reconsideration applies (See Exhibit 7-21).

Admission Denial Model Notices:

Condition I: Use for retrospective admission denials (PPS and non-PPS hospitals) based on inappropriate setting, medically unnecessary, or custodial care. Revise accordingly for denials involving direct admission for swing bed services with or without an admission HINN.

YOUR LETTERHEAD

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Health Insurance Claim (HIC) Number
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of _____. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Our physician reviewers have denied Medicare payment for your admission of (date) to (name of provider) for (specify the procedure/treatment or condition/services).

Prior to reaching this decision, we gave your physician and the hospital an opportunity to discuss your case.

After a review of your medical record and any additional information provided, we determined that (give a complete, fact-specific discussion of why admitted, care received, reason Medicare is denying, etc.).

Select appropriate limitation of liability paragraph in Exhibit 7-20 under Condition I, II, III, IV, V, IX, or X.

Use reconsideration paragraph in Exhibit 7-21 under Condition III.

If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making this denial determination. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information.

Sincerely,

Medical Director (or designated physician)

ccs:

Hospital
Physician
FI
Carrier

Condition II: Use for retrospective denials based on inappropriate setting, medically unnecessary, or custodial care involving "deemed" admission date cases.

YOUR LETTERHEAD

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Health Insurance Claim (HIC) Number
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of _____ . By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Our physicians have reviewed your admission of (date) to (name of provider) for (specify the procedure/treatment or condition/services). We have determined that the services you received from (date) through (date) are denied for Medicare payment. We have also determined that the services you received for (specify the procedure/treatment or condition/services) beginning (date) were medically necessary and appropriate. Therefore, Medicare will pay for hospital services from (date) through (date).

Prior to reaching this decision, we gave your physician and the hospital an opportunity to discuss your case.

After a review of your medical record and any additional information provided, we determined that (give a complete, fact-specific discussion of why admitted, care received, reason Medicare is denying, etc.).

Select appropriate limitation of liability paragraph in Exhibit 7-20 under Condition I, II, III, IV, V, IX, or X.

Use reconsideration paragraph in Exhibit 7-21 under Condition III.

If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making this denial determination. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information.

Sincerely,

Medical Director (or designated physician)

ccs:

Hospital

Physician

FI

Carrier

Exhibit 7-27 - Continued-stay Denial Notices - (Rev. 4, 07-18-03)

Summary of Continued-stay Denial Notices Conditions I-VIII:

Identify the denial condition, and use the appropriate model notice.

Condition I: Use for concurrent denials when the provider requests review of a proposed continued-stay HINN.

Condition II: Use for concurrent denials when the beneficiary requests an immediate or non-immediate review of a continued-stay HINN (includes SNF swing bed continued-stay denials).

Condition III: Use for concurrent denials when the provider requests review of a proposed combined HINN (i.e., acute care continued-stay denial involving NF swing bed services).

Condition IV: Use for concurrent denials when the provider requests review of a proposed combined HINN (i.e., acute care continued-stay denial involving SNF swing bed services).

Condition V: Use for concurrent denials when the beneficiary requests an immediate or non-immediate review of a combined HINN (i.e., acute care continued-stay denial involving NF swing bed services).

Condition VI: Use for concurrent denials when the beneficiary requests an immediate or non-immediate review of a combined HINN (i.e., acute care continued-stay denial involving SNF swing bed services).

Condition VII: Use for concurrent denials not involving a continued-stay HINN.

Condition VIII: Use for retrospective denials with or without a continued-stay HINN (For PPS cases without a continued-stay HINN, this condition only applies to denials involving the day outlier period of the stay).

For all conditions:

- Opportunity for discussion applies.

- Limitation of liability (§1879 of the Act) applies (See Exhibit 7-20).
- Reconsideration applies (See Exhibit 7-21).

Continued-stay Denial Model Notices:

Condition I: Use for concurrent denials when the provider requests review of a proposed continued-stay HINN.

YOUR LETTERHEAD

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Health Insurance Claim (HIC) Number
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of _____ . By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Based on (name of provider)'s request, our physicians have reviewed your admission on (date) for (specify the procedure/treatment or condition/services). We have determined that your admission was medically necessary and appropriate. However, the services you are currently receiving are not covered by Medicare. Therefore, any inpatient hospital services you receive beginning (date) will not be paid by Medicare.

Prior to reaching this decision, we considered the information provided through a telephone discussion with (insert either "you" or the name of the representative to whom you spoke) on (date of solicitation of views), and any comments received from your physician and the hospital.

After a review of your medical record and any additional information provided, we determined that (give a complete, fact-specific discussion of why admitted, care received, reason Medicare is denying, etc.).

Use limitation of liability paragraph in Exhibit 7-20 under Condition VI.

Use reconsideration paragraph in Exhibit 7-21 under Condition II.

If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making this denial determination. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information.

Sincerely,

Medical Director (or designated physician)

ccs:

Hospital
Physician
FI
Carrier

Condition II: Use for concurrent denials when the beneficiary requests an immediate or non-immediate review of a continued-stay HINN (includes SNF swing bed continued-stay denials).

YOUR LETTERHEAD

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Health Insurance Claim (HIC) Number
Provider Name

Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of _____ . By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

On (date of request for review of HINN), you requested that we review your case because you received, with your physician's concurrence, a notice of non-coverage from (name of provider) on (date). Our physicians have reviewed your admission of (date) to (name of provider) for (specify the procedure/treatment or condition/services). We have determined that your admission was medically necessary and appropriate. We agree, however, with your physician and the hospital that for the reasons specified below, as of (date specified by QIO under Condition VI or VII of limitation of liability paragraph), the services you are currently receiving are not covered by Medicare because (reason for denial). Therefore, any inpatient hospital services you receive beginning (date specified by QIO under Condition VI or VII of limitation of liability paragraph) will not be paid by Medicare.

Prior to reaching this decision, we considered the information provided through telephone discussions with (insert either "you" or the name of the representative to whom you spoke) on (date of solicitation of views), and any comments received from your physician and the hospital.

After a review of your medical record and the information provided, we determined that (give a complete, fact-specific discussion of why admitted, care received, reason Medicare is denying, etc.).

Select limitation of liability paragraph in Exhibit 7-20 under Condition VI or VII.

Use reconsideration paragraph in Exhibit 7-21 under Condition II.

If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making this denial determination. Although the

hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information.

Sincerely,

Medical Director (or designated physician)

ccs:

Hospital
Physician
FI
Carrier

Condition III: Use for concurrent denials when the provider requests review of a proposed combined HINN (i.e., acute care continued-stay denial involving NF swing bed services).

YOUR LETTERHEAD

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Health Insurance Claim (HIC) Number
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of _____ . By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Based on (name of provider)'s request, our physicians have reviewed your admission for acute care services on (date) for (specify the procedure/treatment or condition/services). We have determined that your admission for acute care services was medically necessary and appropriate but that you no longer require acute care services beginning (date of first non-covered acute care day). The care that you need now is not covered by Medicare. Therefore, any inpatient hospital services you receive beginning (date) will not be paid by Medicare.

Prior to reaching this decision, we considered the information provided through a telephone discussion with (insert either "you" or the name of the representative to whom you spoke) on (date of solicitation of views), and any comments received from your physician and the hospital.

After a review of your medical record and the information provided, we determined that (give a complete, fact-specific discussion of why admitted, care received, reason Medicare is denying, etc.).

We notified you on (date of (telephone) notification) that beginning on (date of the day following the date of receipt of the QIO notification) you would be responsible for payment of all costs for hospital services you receive except for those covered services which can be paid for by Medicare Part B. If you decide to leave the hospital prior to (date of the day following the date of receipt of the QIO notification), you will be responsible only for payment of any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare.

We are also advising your physician and hospital of this denial. You should discuss with your physician other arrangements for any further health care you may now require. Upon receipt of this notice, you will continue to be responsible for payment for denied acute care services occurring in the future which involve the same or reasonably comparable conditions. However, Medicare will pay for all medically necessary and appropriate acute hospital care you may require in the future.

Use reconsideration paragraph in Exhibit 7-21 under Condition II.

If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making this denial determination. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record

and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information.

Sincerely,

Medical Director (or designated physician)

ccs:

Hospital
Physician
FI
Carrier

Condition IV: Use for concurrent denials when the provider requests review of a proposed combined HINN (i.e., acute care continued-stay denial involving SNF swing bed services).

YOUR LETTERHEAD

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Health Insurance Claim (HIC) Number
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of _____. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Based on (name of provider)'s request, our physicians have reviewed your admission on (date) for (specify the procedure/treatment or condition/services). We have determined that your admission for acute care services was medically necessary and appropriate, but that you no longer require acute care services beginning (date of first non-covered acute

care day). However, we have determined that you still require the type of hospital services which are furnished in a Skilled Nursing Facility (SNF) beginning (specify date of first SNF swing bed day). These services are known as SNF swing bed services. Medicare will pay for your SNF swing bed services if you have not used up all your SNF benefit days.

Prior to reaching this decision, we considered the information provided through a telephone discussion with (insert either "you" or the name of the representative to whom you spoke) on (date of solicitation of views), and any comments received from your physician and the hospital.

After a review of your medical record and the information provided, we determined that (give a complete, fact-specific discussion of why admitted, care received, reason Medicare is denying, etc.).

We notified you on (date of (telephone) notification) of our determination that you no longer required acute care services, but that you do still require SNF services. Therefore, you are responsible only for payment of any amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare applicable to the acute care and SNF services received during your entire hospital stay.

We are also advising your physician and hospital of this determination.

Upon receipt of this notice, you will be responsible for payment for denied acute care services occurring in the future which involve the same or reasonably comparable conditions. However, Medicare will pay for all medically necessary and appropriate acute hospital care you may require in the future. Should the need arise for further acute care, we encourage you to discuss arrangements for your health care with your physician.

Use reconsideration paragraph in Exhibit 7-21 under Condition II.

If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making this denial determination. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information.

Sincerely,

Medical Director (or designated physician)

ccs:

Hospital
Physician
FI
Carrier

Condition V: Use for concurrent denials when the beneficiary requests an immediate or non-immediate review of a combined HINN (i.e., acute care continued-stay denial involving NF swing bed services).

YOUR LETTERHEAD

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Health Insurance Claim (HIC) Number
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of _____. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

On (date of request for review of HINN), you requested that we review your case because you received a notice of non-coverage from (name of provider) on (date), and you believe you still require acute care services. Our physicians have reviewed your admission of (date of acute care admission) for (specify the procedure/treatment or condition/services). We have determined that your admission for acute care services was medically necessary and appropriate but that you no longer require acute care services beginning (date of first non-covered acute care day). The care that you need now is not covered by Medicare.

Therefore, any inpatient hospital services you receive beginning (date) will not be paid by Medicare.

Prior to reaching this decision, we considered the information provided through a telephone discussion with (insert either "you" or the name of the representative to whom you spoke) on (date of solicitation of views), and any comments received from your physician and the hospital.

After a review of your medical record and the information provided, we determined that (give a complete, fact-specific discussion of why admitted, care received, reason Medicare is denying, etc.).

We notified you on (date of (telephone) notification) that beginning on (date of the day following the date of receipt of the HINN) you would be responsible for payment of all costs for hospital services you receive except for those covered services which can be paid for by Medicare Part B. If you decide to leave the hospital prior to (date of the day following the date of receipt of the HINN), you will be responsible only for payment of any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare.

We are also advising your physician and hospital of this denial. You should discuss with your physician other arrangements for any further health care you may now require.

Upon receipt of this notice, you will continue to be responsible for payment of denied acute care services occurring in the future which involve the same or reasonably comparable conditions. However, Medicare will pay for all medically necessary and appropriate acute hospital care you may require in the future.

Use reconsideration paragraph in Exhibit 7-21 under Condition II.

If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making this denial determination. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information.

Sincerely,

Medical Director (or designated physician)

ccs:

Hospital
Physician
FI
Carrier

Condition VI: Use for concurrent denials when the beneficiary requests an immediate or non-immediate review of a combined HINN (i.e., acute care continued-stay denial involving SNF swing bed services).

YOUR LETTERHEAD

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Health Insurance Claim (HIC) Number
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of _____. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

On (date of request for review of HINN), you requested that we review your case because you received a notice of non-coverage from (name of provider) on (date), and you believe you still require acute care services. Our physicians have reviewed your admission of (date of acute care admission) for (specify the acute care procedure/treatment or condition/services). We have determined that your admission for acute care services was medically necessary and appropriate, but that you no longer required acute care services beginning (date of first non-covered acute care day). However, we have determined that you still require the type of hospital services which are furnished in a Skilled Nursing

Facility (SNF) beginning (specify date of first SNF swing bed day). These services are known as SNF swing bed services. Medicare will pay for your SNF swing bed services if you have not used up all your SNF benefit days.

Prior to reaching this decision, we considered the information provided through a telephone discussion with (insert either "you" or the name of the representative to whom you spoke) on (date of solicitation of views), and any comments received from your physician and the hospital.

After a review of your medical record and the information provided, we determined that (give a complete, fact-specific discussion of why admitted, care received, reason Medicare is denying, etc.).

We notified you on (date of (telephone) notification) of our determination that you no longer require acute care services, but that you do still require SNF services. Therefore, you are responsible only for payment of any amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare applicable to the acute care and SNF services received during your entire hospital stay.

We are also advising your physician and hospital of this determination.

Upon receipt of this notice, you will be responsible for payment for denied acute care services occurring in the future which involve the same or reasonably comparable conditions. However, Medicare will pay for all medically necessary and appropriate acute hospital care you may require in the future. Should the need arise for further acute care, we encourage you to discuss arrangements for your health care with your physician.

Use reconsideration paragraph in Exhibit 7-21 under Condition II.

If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making this denial determination. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information.

Sincerely,

Medical Director (or designated physician)

ccs:

Hospital
Physician
FI
Carrier

Condition VII: Use for concurrent denials not involving a continued-stay HINN.

YOUR LETTERHEAD

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Health Insurance Claim (HIC) Number
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of _____. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Our physicians have reviewed your admission of (date) to (name of provider) for (specify the procedure/treatment or condition/services). We have determined that your admission was medically necessary and appropriate. However, the services you are currently receiving are not covered by Medicare. Therefore, any inpatient hospital services you receive beginning (date) will not be paid by Medicare.

Prior to reaching this decision, we gave your physician and the hospital an opportunity to discuss your case.

After a review of your medical record and any additional information provided, we determined that (give a complete, fact-specific discussion of why admitted, care received, reason Medicare is denying, etc.).

Use limitation of liability paragraph in Exhibit 7-20 under Condition VIII.

Use reconsideration paragraph in Exhibit 7-21 under Condition II.

If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making this denial determination. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information.

Sincerely,

Medical Director (or designated physician)

ccs:

Hospital
Physician
FI
Carrier

Condition VIII: Use for retrospective denials with or without a continued-stay HINN (For PPS cases without a continued-stay HINN, this condition only applies to denials involving the day outlier period of the stay).

YOUR LETTERHEAD

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Health Insurance Claim (HIC) Number
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of _____. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Our physicians have reviewed your admission of (date) to (name of provider) for (specify the procedure/treatment or condition/services). We have determined that your admission was medically necessary and appropriate. However, the inpatient hospital services you received beginning (specify denied date(s)) are denied for Medicare payment.

Prior to reaching this decision, we gave your physician and the hospital an opportunity to discuss your case.

After a review of your medical record and any additional information provided, we determined that (give a complete, fact-specific discussion of why admitted, care received, reason Medicare is denying, etc.).

Select appropriate limitation of liability paragraph in Exhibit 7-20 under Condition I, II, III, IV, V, IX, or X.

Use reconsideration paragraph in Exhibit 7-21 under Condition III.

If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making this denial determination. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record

and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information.

Sincerely,

Medical Director (or designated physician)

ccs:

Hospital

Physician

FI

Carrier

Exhibit 7-28 - Procedure Denial Model Notices - (Rev. 4, 07-18-03)

Identify the denial condition, and use the appropriate model notice.

Condition I: Use for retrospective procedure denials.

If the beneficiary required hospital inpatient services but the procedure is not medically necessary, then only the procedure is denied. Use the procedure denial model notice.

- Opportunity for discussion applies.
- Limitation of liability (§1879 of the Act) applies (See Exhibit 7-20).
- Reconsideration applies (See Exhibit 7-21).

Condition II: Use for preadmission denials.

If the proposed procedure is non-covered and is the only reason for the admission, then the admission is denied. Use the preadmission denial model notice (See Exhibit 7-25).

Condition III: Use for retrospective admission denials.

If the procedure is non-covered and is the only reason for the admission, then the admission is denied. Use the admission denial model notice (See Exhibit 7-26, Condition I).

Condition IV: Use for concurrent or retrospective continued-stay denials.

If the beneficiary required admission initially, but remain(s/ed) in the facility for the proposed procedure only, then the continued-stay is non-covered and is denied. Use the appropriate continued-stay denial model notice (See Exhibit 7-27).

NOTE: For any of the above conditions, if the denial is for a procedure that cannot be repeated (e.g., total removal of an organ), do not use the future liability paragraph: "Upon receipt..."

Procedure Denial Model Notices:

Condition I: Use for retrospective procedure denials.

YOUR LETTERHEAD

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Health Insurance Claim (HIC) Number
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of _____. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Our physicians have reviewed your admission of (date) to (name of provider) for (specify the procedure/treatment or condition/services). We determined that your admission was medically necessary and appropriate. However, the (name of procedure) that was performed on (date) is denied for Medicare payment.

Prior to reaching this decision, we gave your physician and the hospital an opportunity to discuss your case.

After a review of your medical record and any additional information provided, we determined that (give a complete, fact-specific discussion of why admitted, care received, reason Medicare is denying, etc.).

Select appropriate limitation of liability paragraph in Exhibit 7-20 under condition I, III, IV, V, IX, or X.

Use reconsideration paragraph in Exhibit 7-21 under Condition III.

If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making this denial determination. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information.

Sincerely,

Medical Director (or designated physician)

ccs:

Hospital
Physician
FI
Carrier

Exhibit 29 - Day Outlier Denial Model Notice - (Rev. 4, 07-18-03)

Use for retrospective day outlier denials (PPS hospitals) and retrospective partial admission denials (non-PPS hospitals) based on inappropriate setting, medically unnecessary, or custodial care. This applies to those cases where days are carved-out from the outlier period of a PPS admission or from a non-PPS admission. In those cases where the denial is for an uninterrupted period (i.e., beginning at a specified date through discharge), use the appropriate continued-stay denial model notice (See Exhibit 7-27).

- Opportunity for discussion applies.
- Limitation of liability (§1879 of the Act) applies (See Exhibit 7-20).

- Reconsideration applies (See Exhibit 7-21).

Day Outlier Denial Model Notice:

YOUR LETTERHEAD

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Health Insurance Claim (HIC) Number
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of _____. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Our physicians have reviewed your admission of (date) to (name of provider) for (specify the procedure/treatment or condition/services). We determined that your admission was medically necessary and appropriate. However, the inpatient hospital services you received (specify denied date(s)) for a total of (number) day(s) are denied for Medicare payment.

Prior to reaching this decision, we gave your physician and the hospital an opportunity to discuss your case.

After a review of your medical record and any additional information provided, we determined that (give a complete, fact-specific discussion of why admitted, care received, reason Medicare is denying, etc.).

Select appropriate limitation of liability paragraph in Exhibit 7-20 under Condition I, II, IV, V, IX, or X.

Use reconsideration paragraph in Exhibit 7-21 under Condition III.

If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your

appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making this denial determination. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information.

Sincerely,

Medical Director (or designated physician)

ccs:

Hospital
Physician
FI
Carrier

Exhibit 7-30 - Cost Outlier Denial Model Notices - (Rev. 4, 07-18-03)

Identify the denial condition, and use the appropriate model notice.

Condition I: Use for retrospective denials of services or items based on inappropriate setting or medically unnecessary.

- Opportunity for discussion applies.
- Limitation of liability (§1879 of the Act) applies (See Exhibit 7-20).
- Reconsideration applies (See Exhibit 7-21).

Condition II: Use for retrospective denials of services or items based on duplicative billing, or for services not actually furnished or not ordered by the physician.

- Opportunity for discussion does not apply.
- Limitation of liability (§1879 of the Act) does not apply.

- Reconsideration does not apply.
- Do not notify the beneficiary.
- For inpatient hospital services furnished on or after January 1, 1989, through December 31, 1989, delete reference to the beneficiary's responsibility for the coinsurance payment.

Cost Outlier Denial Model Notices:

Condition I: Use for retrospective denials of services or items based on inappropriate setting or medically unnecessary.

YOUR LETTERHEAD

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Health Insurance Claim (HIC) Number
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of _____. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Our physicians have reviewed your admission of (date) to (name of provider) for (specify the procedure/treatment or condition/services). We determined that your admission was medically necessary and appropriate. However, certain inpatient hospital service(s) and item(s) you received are denied for Medicare payment.

Prior to reaching this decision, we gave your physician and the hospital an opportunity to discuss your case.

The specific service/item(s) are as follows:

Specific Service/Item

Date of Service/Item
Charges

After a review of your medical record and any additional information provided, we determined that (give a complete, fact-specific discussion of why admitted, care received, reason Medicare is denying, etc.).

Select appropriate limitation of liability paragraph in Exhibit 7-20 under Condition I, II (cost outlier without a physician component denials based on inappropriate setting or medically unnecessary), III (cost outlier with a physician component denials based on medically unnecessary), IV, or V.

Use reconsideration paragraph in Exhibit 7-21 under Condition III.

If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making this denial determination. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information.

Sincerely,

Medical Director (or designated physician)

ccs:
Hospital
Physician
FI
Carrier

Condition II: Use for retrospective denial of services or items based on duplicative billing, or for services not actually furnished or not ordered by the physician.

YOUR LETTERHEAD

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Health Insurance Claim (HIC) Number
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of _____. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Our physicians have reviewed the above admission of (date) for (specify the procedure/treatment or condition/services). We have determined that the admission was medically necessary and appropriate. However, certain inpatient hospital service/item(s) are denied for Medicare payment.

The specific services/items are as follows:

Specific Service/Item
Date of Service/Item
Charges

After a review of the medical record, we determined that (relate discussion to the specific reason for denial).

- Duplicative billing occurred;
- Services/items not actually furnished; or
- Services/items were not ordered by the physician.

Medicare will not pay the hospital for the denied services. The beneficiary or his/her representative is only responsible for payment of any applicable amounts for deductible and coinsurance related to covered services and any amounts for convenience services and items normally not covered by Medicare.

Sincerely,

Medical Director (or designated physician)

ccs:

Hospital
Physician
FI
Carrier

Exhibit 7-31 - DRG Changes as a Result of DRG Validation Model Notice - (Rev. 4, 07-18-03)

Use when retrospective review results in changes that affect the DRG assignment.

- Opportunity for discussion applies.
- Re-review applies (Reconsideration does not apply).
- Do not notify the beneficiary.

DRG Changes as a Result of DRG Validation Model Notice:

YOUR LETTERHEAD

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Health Insurance Claim (HIC) Number
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of _____ . By law, we review Medicare cases to determine if

the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

We are also required to perform Diagnostic Related Group (DRG) validation on all cases selected for review to ensure that the diagnostic and procedural codes reported by the provider and resulting in the DRG assignment by the Fiscal Intermediary (FI) match both the documentation in the medical record and the physician's attestation.

We have reviewed the above admission of (date) for (specify the procedure/treatment or condition/services). An opportunity to discuss this case was given to the provider and the physician.

We have determined that the admission was medically necessary and appropriate. However, based on a review of the medical record and any other information available, we have changed the following code(s):

- Hospital submitted code(s) and narrative description
- QIO coding change(s) and narrative description

This has resulted in a change in the DRG assignment from (_____) to (_____).

After a review of the medical record and any additional information provided, we determined that (relate discussion to the specific reason for the change(s)).

If the provider or physician disagrees with our determination, either party may request a re-review. You must submit your request for a re-review in writing within 60 days from receipt of this notice directly to us at:

QIO Name
Address
Telephone Number

This information is being reported to the FI for a payment adjustment.

Sincerely,

Medical Director (or designated physician)
Chief Executive Officer, RRA, or ART, as appropriate

ccs:
Physician
FI

Carrier

Exhibit 7-32 - Outpatient/Ambulatory Surgery Denial Model Notices - (Rev. 4, 07-18-03)

Identify the denial condition, and use the appropriate model notice. This applies to hospital outpatient settings and ambulatory surgical centers.

Condition I: Use for pre-procedure denials.

- Opportunity for discussion applies.
- Limitation of liability (§1879 of the Act) does not apply.
- Reconsideration applies (See Exhibit 7-21).

Condition II: Use for post-procedure denials (either prepayment or post-payment). Use this model letter if the procedure performed is non-covered as not medically necessary.

- Opportunity for discussion applies.
- Limitation of liability (§1879 of the Act) applies (See Exhibit 7-20).
- Reconsideration applies (See Exhibit 7-21).

Outpatient/Ambulatory Surgery Denial Model Notices:

Condition I: Use for pre-procedure denials.

YOUR LETTERHEAD

Date of Notice

Name of Patient

Address

City, State, and Zip Code

Health Insurance Claim (HIC) Number

Provider Name

Provider Number

Medical Record Number (if known)

Admission Date

Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review outpatient/ambulatory surgical services provided to Medicare patients in the State of _____. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Our physician reviewers have denied Medicare payment for your proposed surgery of (date) (specify, if known: at (name of provider)) for (specify the surgical procedure).

Prior to reaching this decision, we gave your physician (if known, add: and the provider) an opportunity to discuss your case.

After a review of your medical record and any additional information provided, we determined that (Relate discussion to the specific reason(s) for denial).

Medicare will not pay for your proposed surgery if you and your physician decide you should proceed with the surgery. Therefore, you will be responsible for payment of all costs for the services you receive.

We are also advising your physician (if known, add: and the provider) of this denial. You should discuss with your physician other arrangements for any further health care you may now require.

Upon receipt of this notice, you will continue to be responsible for payment for denied services occurring in the future which involve the same or reasonably comparable conditions. However, Medicare will pay for all medically necessary and appropriate care you may require in the future.

Use reconsideration paragraph in Exhibit 7-21 under Condition I.

If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making this denial determination. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information.

Sincerely,

Medical Director (or designated physician)

ccs:

Hospital
Physician
FI
Carrier

Condition II: Use for post-procedure denials (either prepayment or post-payment).

YOUR LETTERHEAD

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Health Insurance Claim (HIC) Number
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review outpatient/ambulatory surgical services provided to Medicare patients in the State of _____. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Our physician reviewers have denied Medicare payment for your surgery of (date) at (facility name) for (specify the surgical procedure).

Prior to reaching this decision, we gave your physician and the provider an opportunity to discuss your case.

After a review of your medical record and any additional information provided, we determined that (Relate discussion to the specific reason(s) for denial).

Select appropriate limitation of liability paragraph in Exhibit 7-20 under condition XI, XII, or XIII.

Use reconsideration paragraph in Exhibit 7-21 under Condition III.

If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making this denial determination. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information.

Sincerely,

Medical Director (or designated physician)

ccs:

Hospital
Physician
FI
Carrier

**Exhibit 7-33 - Continued-stay Denial Completed Notice –
(Rev. 4, 07-18-03)**

YOUR LETTERHEAD:

Peer System, Inc.
1000 Pine Drive
Baltimore, Maryland 12345
410-555-5555

Date of Notice: August 12, 1990
Name of Patient: John Doe
Address: 200 Cherry Drive
City, State, and Zip Code: Somewhere, MD 00000

Health Insurance Claim (HIC) Number: 000-00-0000 A
Provider Name: Nowhere Hospital
Provider Number: 21-0000
Medical Record Number (if known): 2222
Admission Date: August 1, 1990
Physician Name: John Smith, M.D.

Dear Mr. Doe:

The Peer System, Inc., is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of Maryland. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

On August 11, you requested that we review your case because you received, with your physician's concurrence, a notice of non-coverage from Nowhere Hospital on August 10. Our physicians have reviewed your admission of August 1 to Nowhere Hospital for medical and surgical treatment related to gallstones. We have determined that your admission was medically necessary and appropriate. We agree, however, with your physician and the hospital that for the reasons specified below, as of August 13, the services you are currently receiving are not covered by Medicare because they are no longer medically necessary in the hospital inpatient setting and they can be given safely and effectively outside of a hospital. Therefore, any inpatient hospital services you receive beginning after noon, August 13, will not be paid by Medicare.

Prior to reaching this decision, we considered the information provided through telephone discussions with you on August 12, and any comments received from your physician and the hospital.

After a review of your medical record and the information provided, we determined that you no longer require acute care in a hospital setting. The medical records show that you were admitted on August 1 with complaints of nausea and vomiting of several days duration. After receiving intravenous fluid replacement, a decision was made to remove your gall bladder, which was accomplished on August 3. By August 7, you were no longer taking injections for pain control and were tolerating a regular diet. By August 8, you were up and about in your room and the hall. On August 9, your physician removed your stitches and noted that your incision was well healed with no drainage. By August 10, you were receiving only your oral diuretic, the dosage being the same as when you were admitted. Thus, by the time the hospital gave you the notice of non-coverage, you required only the administration of an oral medication.

We notified you by telephone on August 12, of our determination that the services you are receiving are not covered by Medicare and that if you decided to remain in the hospital after 12 noon on August 13, you would be responsible for payment of all costs of

hospital services you receive after that time except for those covered services which can be paid for by Medicare Part B. If you decide to leave the hospital prior to 12 Noon on August 13, you will be responsible only for payment of any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare.

We are also advising your physician and the hospital of this denial. You should discuss with your physician other arrangements for any further health care you may now require.

Upon receipt of this notice, you will continue to be responsible for payment for denied services occurring in the future which involve the same or reasonably comparable conditions. However, Medicare will pay for all medically necessary and appropriate hospital care you may require in the future.

If you disagree with our determination and you decide to remain in the hospital, you, your physician, or hospital may appeal this denial decision, while you are still in the hospital, by requesting an expedited reconsideration through the hospital by telephoning or by writing us at:

Peer System, Inc.
1000 Pine Drive
Baltimore, Maryland 12345
410-555-5555

We will complete our expedited reconsideration and send a written notice to you within three working days.

However, if you don't remain in the hospital after 12 Noon on August 13 or if you remain in the hospital and do not request an expedited reconsideration, you, your physician, or hospital are still entitled to a reconsideration. You must submit your request in writing within 60 days from the receipt of this notice to us at the above address.

You may also make your request to any Social Security Office or Railroad Retirement Office (if you are a Railroad Retirement beneficiary). Your request will be forwarded to us.

As a result of our review, we may reaffirm or reverse our prior denial determination. If we reaffirm the denial determination, you will continue to be responsible for payment of services furnished as specified above. If we reverse the denial determination, you will be refunded any amount collected by the hospital except for payment of deductible, coinsurance, or any convenience services or items normally not covered by Medicare.

If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a

lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making this denial determination. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information.

Sincerely,

Medical Director

ccs:

Hospital
Physician
FI
Carrier

**Exhibit 7-34 - Circumvention of Prospective Payment System (PPS)
Denial Model Notice - (Rev. 4, 07-18-03)**

Use for retrospective Part A denials involving PPS and PPS-excluded admissions and readmissions within the same PPS hospital based on your determination that the services should have been furnished during the first admission or that the discharge and subsequent admission were inappropriate. This also applies to discharges from PPS and PPS-excluded units and subsequent admissions to hospital-based Skilled Nursing Facility (SNF) and SNF swing beds.

- Opportunity for discussion applies.
- Limitation on liability (§1879 of the Act) does not apply.
- Reconsideration applies (See Exhibit 7-50).
- Do not notify the beneficiary or physician.

Circumvention of PPS Denial Model Notice:

(Do not notify the beneficiary or physician).

LETTERHEAD OF THE QIO

Date of Notice
Name of Provider
Address of Provider
City, State, and Zip Code

Patient Name
Health Insurance Claim (HIC) Number
Medical Record Number (if known)
First Admission Date
Readmission/Transfer Date
PPS Provider Number
PPS-excluded Provider Number (if known)
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of _____. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Select paragraph A, B, or C below:

A: Services Should Have Been Furnished During the First Admission

Our physicians have reviewed the acute care admission of (date) for (specify the procedure/treatment or condition/services) and subsequent acute care readmission of (date) for (specify the procedure/treatment or condition/services). We have determined that the services furnished were medically necessary and appropriate. However, the services should have been furnished during the first admission. This action is considered to be a circumvention of the prospective payment system because each admission triggered payment for an entire episode of hospital care. Thus, when the hospital admitted the patient on (date) and again on (date), the hospital received two Medicare payments instead of one. Therefore, we are denying Medicare payment for the readmission of (date of 2nd admission).

B: Inappropriate Transfer From a PPS Unit to a PPS-Excluded Unit (This also applies to similar transfers from a PPS unit to a hospital-based SNF or SNF swing bed).

Our physicians have reviewed the acute care admission of (date) for (specify the procedure/treatment or condition/services) and subsequent admission of (date) to the (select: psychiatric unit, rehabilitation unit, hospital-based Skilled Nursing Facility

(SNF), or SNF swing bed) for (specify the procedure/treatment or condition/services). We have determined that the patient was admitted to the acute care hospital even though the medical record shows that the patient only required care in the (select: psychiatric unit, rehabilitation unit, hospital-based SNF, or SNF swing-bed) and a bed was available at the time of the acute care admission. This action is considered to be a circumvention of the prospective payment system because each admission triggered payment for an entire episode of hospital care. Thus, when the hospital discharged the patient on (date) and subsequently admitted the patient on (date), the hospital received two Medicare payments instead of one. Therefore, we are denying Medicare payment for the admission of (date of 2nd admission).

C: Inappropriate Transfer From a PPS-Excluded Unit to a PPS Unit (This also applies to similar transfers from a PPS-excluded unit to a hospital-based SNF or SNF swing bed).

Our physicians have reviewed the admission of (date) to the (select: psychiatric or rehabilitation) unit for (specify the procedure/treatment or condition/services) and subsequent admission of (date) to the (select: acute care hospital, hospital-based SNF, SNF swing bed) for (specify the procedure/treatment or condition/services). We have determined that the admission to the (select: psychiatric or rehabilitation) unit was medically necessary and appropriate and that the patient continued to require (select: psychiatric or rehabilitation) care/services when transferred to the (select: acute care hospital, hospital-based SNF, or SNF swing-bed). This action is considered to be a circumvention of the prospective payment system because each admission triggered payment for an entire episode of hospital care. Thus, when the hospital discharged the patient on (date) and subsequently admitted the patient on (date), the hospital received two Medicare payments instead of one. Therefore, we are denying Medicare payment for the admission of (date of 2nd admission).

This denial determination is made under §1886(f)(2) of the Social Security Act. This section authorizes a denial of payment under Part A when the Secretary determines, based on information provided by a QIO that a hospital has taken an action, in order to circumvent PPS, which results in unnecessary admissions, multiple admissions of the same individual, or other inappropriate practices.

Prior to reaching this decision, we gave you an opportunity to discuss this case.

After a review of the medical record and any additional information provided, we determined that (Give a complete, fact-specific discussion related to the reason for denial under paragraph A, B, or C).

The limitation on liability provision of §1879 of the Act does not apply to Part A denials issued under §1886(f)(2) of the Act. Therefore, the hospital is liable for the charges of the denied services. The beneficiary or his/her representative is only responsible for payment of any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare. If the beneficiary or his/her representative

has paid the hospital for any of the denied services other than those amounts already mentioned, the hospital is to refund such payment.

If you disagree with our determination, you may appeal this denial decision by requesting a reconsideration. You must submit your request in writing within 60 days from receipt of this notice directly to us at:

QIO Name
Address
Telephone Number

Sincerely,

Medical Director (or designated physician)

ccs:
FI
Carrier

Exhibit 7-40 - Reconsideration Notices -- Hearings Model Paragraphs - (Rev. 4, 07-18-03)

Condition I: Use in your reconsideration notice when you affirm or partially reverse an initial denial determination that was based on medical necessity or appropriateness of setting, or when you affirm your liability determination that the beneficiary knew that the denied services would not be covered by Medicare.

If you disagree with our reconsideration determination, you may request a formal hearing before an Administrative Law Judge (ALJ) of the Social Security Administration's (SSA's) Office of Hearings and Appeals (OHA) under the following conditions:

- If Medicare has denied payment of \$200 or more for services determined to be either not medically necessary or not provided at an appropriate level of care; or
- If you do not appeal the denial of Medicare payment on the medical issues listed above and have been found liable for payment of at least \$100 of the denied services, and you disagree with our liability determination that you knew or should have known that the denied services were not covered.

If you do not request an ALJ hearing regarding the liability determination, a dissatisfied provider or practitioner may request an ALJ hearing of that liability determination if they are liable for services of \$100 or more.

If you wish to have an ALJ hearing, you must submit a written request within 60 calendar days of receipt of this notice. Your written request should include: your name, Medicare health insurance claim number, where and when services were received, the reason for your dissatisfaction with our determination, any additional evidence you might wish to submit, and a copy of this notice.

You may send your written request to:

- Any social security office;
- An office of SSA's OHA;
- An office of the Railroad Retirement Board, if you are eligible; or
- To us at the following address:

QIO Name

Address (including zip code)

Telephone Number

(A provider or practitioner may only send a written request to us or OHA.)

If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making our initial denial and reconsideration determinations. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information.

If you request a hearing, OHA will notify you of the date and place of the hearing. Hearings are held close to the address given on requests; therefore, if you request a hearing, please include the name of the county in which you reside along with your complete address and zip code. If you wish the hearing to be held somewhere other than close to your residence, please note that on the hearing request.

Condition II: Attach this paragraph to the provider/physician copy of the beneficiary reconsideration notice, as appropriate.

According to §1879(d) of the Social Security Act, if the amount in controversy is at least \$100.00, a beneficiary who is dissatisfied with the limitation on liability reconsideration determination may obtain an administrative hearing conducted by an ALJ of the OHA of

SSA. If the beneficiary chooses not to exercise his or her appeal rights regarding the limitation on liability determination, you (a dissatisfied provider or a dissatisfied practitioner) are entitled to an administrative hearing conducted by an ALJ only addressing the issue of whether you knew or should have known that services would not be covered.

If you wish to have an ALJ hearing regarding the limitation on liability reconsideration determination, you must submit a written request within 60 calendar days of receipt of this notice (unless time is extended for good cause). Your written request should include: beneficiary's name, Medicare health insurance claim number, where and when services were provided, the reason for your dissatisfaction with our determination, any additional evidence you might wish to submit, and a copy of this notice.

You may send your written request to:

- An office of SSA's OHA; or
- To us at the following address:

QIO Name
Address (including zip code)
Telephone Number

If you request a hearing, OHA will notify you of the date and place of the hearing. Hearings are held close to the address given on requests; therefore, if you request a hearing, please include the name of the county in which you are located along with your complete address and zip code. If you wish the hearing to be held somewhere other than close to your place of business, please note that on the hearing request.

**Exhibit 7-41 - Reconsideration Model Notice -- Preadmission Denial -
(Rev. 4, 07-18-03)**

LETTERHEAD OF THE QIO

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Health Insurance Claim (HIC) Number
Provider Name (if known)
Provider Number (if known)
Medical Record Number (if known)
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of _____. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

As a result of (insert either "your" or the name of the physician or provider) (date), request for (insert either "an expedited reconsideration" or "a reconsideration"), we have conducted a complete review of your medical record to determine whether our original denial determination was correct.

A QIO physician reviewer denied Medicare payment for your proposed admission of (date), to (name of provider) for (specify the procedure/treatment or condition/services) because (use the medical information and rationale contained in the initial denial notice).

When we notified you on (date of denial notice) of this denial determination, you were advised that if you and your physician decided that you should be admitted to the hospital, you would be responsible for payment of all costs for the denied services you received except for those covered services which could be paid for by Medicare Part B.

Prior to our reconsideration of this denial determination, we gave your physician, (name), and (name of provider) an opportunity to provide additional information, if they wished.

The reconsideration was performed by a board-certified physician reviewer who specializes in (indicate the specialty of the physician). The physician reviewer, who was not involved in the original denial determination, performed a thorough re-examination of all the information contained in your medical record and considered any additional information provided by your physician and/or the hospital.

The physician reviewer (insert either "reversed" or "upheld") the original denial determination because (Provide the facts and rationale for upholding/reversing the original denial determination for all parties. Include the appropriate statutory and regulatory citations). Therefore, we have determined that Medicare (select either "will" or "will not") pay for your proposed admission if you and your physician decide that you should be admitted to the hospital.

NOTE: If you reverse your initial denial determination, insert: "If admitted, you will only be responsible for payment of any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare."

NOTE: If you uphold your initial denial determination, insert: "If admitted, you will be responsible for payment of all costs of the denied services you receive except for those covered services which can be paid for by Medicare Part B."

We are also advising your physician and the hospital of this reconsideration determination, which affirms our original denial determination. You should discuss with your physician other arrangements for any further health care you may now require.

NOTE: Include the above paragraph only if you uphold your initial denial determination.

Upon receipt of this notice, you will continue to be responsible for payment of denied services occurring in the future which involve the same or reasonably comparable conditions. However, Medicare will pay for all medically necessary and appropriate hospital care you may require in the future.

NOTE: If you reverse your initial denial determination, insert: "If admitted, you will only be responsible for payment of any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare."

NOTE: If you uphold your initial denial determination, insert: "If admitted, you will be responsible for payment of all costs of the denied services you receive except for those covered services which can be paid for by Medicare Part B."

Use Model Hearings Paragraph Exhibit 7-40, Condition I (and Condition II, if appropriate).

NOTE: Include the above paragraph only if you uphold your initial denial determination.

Sincerely,

Medical Director (or designated physician)

ccs:

Provider

Physician

FI/ carrier (if original denial/liability determination changes)

**Exhibit 7-42 - Reconsideration Model Notice -- Admission Denial –
(Rev. 4, 07-18-03)**

LETTERHEAD OF THE QIO

Date of Notice

Name of Patient

Address

City, State, and Zip Code

Health Insurance Claim (HIC) Number
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of _____. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

As a result of (insert either "your" or the name of the physician or provider) (date), request for a reconsideration, we have conducted a complete review of your medical record to determine whether our original denial determination was correct.

A QIO physician reviewer denied Medicare payment for your admission of (date), to (name of provider) for (specify the procedure/treatment or condition/services) because (use medical information and rationale contained in the initial denial notice).

When we notified you on (date of denial notice) of this denial determination, you were advised that (use the limitation on liability determination and rationale for the beneficiary, provider, and/or practitioner contained in the initial denial notice).

Prior to our reconsideration of this denial determination, we gave your physician, (name), and (name of provider) an opportunity to provide additional information, if they wished.

The reconsideration was performed by a board-certified physician reviewer who specializes in (indicate the specialty of the physician). The physician reviewer, who was not involved in the original denial determination, performed a thorough re-examination of all the information contained in your medical record and considered any additional information provided by your physician and/or the hospital.

The physician reviewer (select either "reversed" or "upheld") the original denial determination because (Provide the facts and rationale for upholding/reversing the original denial determination for all parties. Include the appropriate statutory and regulatory citations). Therefore, we have determined that Medicare (select either "will" or "will not") pay for your admission.

NOTE: If you reverse your initial denial determination, insert: "You will only be responsible for payment of any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare."

The physician reviewer also reconsidered the original liability determination that (insert the liable parties, i.e., "you" and/or the name of the provider and/or physician) knew that the denied services were not covered by Medicare. The physician reviewer determined that (Provide the facts and rationale for upholding/reversing the original liability determination for all parties. Include the appropriate statutory and regulatory citations. If your liability determination remains unchanged, tailor the liability language to the limitation on liability information contained in the initial denial notice. If your liability determination changes, tailor the liability language to the appropriate limitation on liability condition found in Exhibit 7-1. Include future liability language).

NOTE: Include the above paragraph only if you uphold your initial denial determination.

Use Model Hearings paragraph Exhibit 7-40, Condition I (and Condition II, if appropriate).

NOTE: Include the above paragraph only if you uphold your initial denial determination.

Sincerely,

Medical Director (or designated physician)

ccs:

Provider

Physician

FI/carrier (if original denial/liability determination changes)

**Exhibit 7-43 - Reconsideration Model Notice -- Continued-stay Denial -
(Rev. 4, 07-18-03)**

**(Expedited Reconsideration Within Three Working Days)
(Physician Agrees with HINN)**

LETTERHEAD OF THE QIO

Date of Notice

Name of Patient

Address

City, State, and Zip Code

Health Insurance Claim (HIC) Number

Provider Name

Provider Number

Medical Record Number (if known)

Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of _____. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

As a result of (insert either "your" or the name of the physician or provider) (date), request for an expedited reconsideration, we conducted a complete review of your medical record to determine whether our original denial determination was correct.

You received, with your physician's concurrence, a notice of non-coverage from (name of provider) on (date), and requested that we review your hospital stay. A QIO physician reviewer determined that your admission of (date), to (name of provider) for (specify the procedure/treatment or condition/services) was medically necessary and appropriate. However, the physician reviewer agreed with your physician and the hospital that beginning (date of first non-covered acute care day), you no longer required acute care in a hospital setting because (use medical information and rationale contained in the initial denial notice).

On (date of notification), we notified you that we agreed with (name of provider)'s notice of non-coverage, and issued a denial determination. You were advised that if you decided to remain in the hospital, beginning (insert date given in denial notice), you would be responsible for payment of all costs of denied services you received, except for those covered services which could be paid for by Medicare Part B.

Prior to our reconsideration of this denial determination, we gave your physician, (name), and (name of provider) an opportunity to provide additional information, if they wished.

The reconsideration was performed by a board-certified physician reviewer who specializes in (indicate the specialty of the physician). The physician reviewer, who was not involved in the original denial determination, performed a thorough re-examination of all the information contained in your medical record and considered any additional information provided by your physician and/or hospital.

The physician reviewer (select either "reversed" or "upheld") the original denial determination because (Provide the facts and rationale for upholding/reversing the original denial determination for all parties. Include the appropriate statutory and regulatory citations). Therefore, we have determined that Medicare (select either "will pay the hospital for the inpatient services you are receiving" or "will not pay the hospital for the inpatient services provided (except for those covered services which can be paid for by Medicare Part B) beginning (date)").

NOTE: If you reverse your initial denial determination, insert: "You will only be responsible for payment of any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare."

NOTE: If you uphold your initial denial determination, insert: "Also, the hospital may send you a bill for services provided to you beginning (date)."

The physician reviewer also reconsidered the original liability determination that (insert the liable parties, i.e., "you" and/or the name of the provider and/or physician) knew that the denied services were not covered by Medicare. The physician reviewer determined that (Provide the facts and rationale for upholding/reversing the original liability determination for all parties. Include the appropriate statutory and regulatory citations. If your liability determination remains unchanged, tailor the liability language to the limitation on liability information contained in the initial denial notice. If your liability determination changes, tailor the liability language to the appropriate limitation on liability condition found in Exhibit 7-1).

NOTE: Include the above paragraph only if you uphold your initial denial determination.

We are also advising your physician and the hospital of this reconsideration determination, which affirms our original denial determination. You should discuss with your physician other arrangements for any further health care you may now require.

NOTE: Include the above paragraph only if you uphold your initial denial determination.

Upon receipt of this notice, you will continue to be responsible for payment of denied services occurring in the future which involve the same or reasonably comparable conditions. However, Medicare will pay for all medically necessary and appropriate hospital care you may require in the future.

NOTE: Include the above paragraph only if you uphold your initial denial determination.

Use Model Hearings paragraph Exhibit 7-40, Condition I (and Condition II, if appropriate).

NOTE: Include the above paragraph only if you uphold your initial denial determination.

Sincerely,

Medical Director (or designated physician)

ccs:

Provider
Physician
FI/carrier (if original denial/liability determination changes)

**Exhibit 7-44 - Reconsideration Model Notice -- Procedure Denial –
(Rev. 4, 07-18-03)**

LETTERHEAD OF THE QIO

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Health Insurance Claim (HIC) Number
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of _____. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

As a result of (insert either "your" or the name of the physician or provider) (date), request for reconsideration, we have conducted a complete review of your medical record to determine whether our original denial determination was correct.

A QIO physician reviewer determined that your admission of (date), to (name of provider) for (specify the treatment, condition, or services) was medically necessary and appropriate. However, the physician reviewer denied Medicare payment for the (name of procedure) that was performed on (date) because (use the medical information and rationale contained in the initial denial notice).

When we notified you on (date of denial notice) of this denial determination, you were advised that (use the limitation on liability determination and rationale for the beneficiary, provider, and/or practitioner contained in the initial denial notice).

Prior to our reconsideration of this denial determination, we gave your physician, (name), and (name of provider) an opportunity to provide additional information, if they wished.

The reconsideration was performed by a board-certified physician reviewer who specializes in (indicate the specialty of the physician). The physician reviewer, who was not involved in the original denial determination, performed a thorough re-examination of all the information contained in your medical record and considered any additional information provided by your physician and/or the hospital.

The physician reviewer (insert either "reversed" or "upheld") the original denial determination because (Provide the facts and rationale for upholding/reversing the original denial determination for all parties. Cite the appropriate statutory and regulatory citations. Give a complete fact-specific discussion of why the patient was admitted, the care received, and the reason Medicare is denying or paying for the procedure). Therefore, we have determined that Medicare (select either "will" or "will not") pay for the (name of procedure) provided on (date), for (amount of dollars). Medicare will pay for the medically necessary care and services you received on admission to (name of provider) from (date of admission) to (date of discharge).

NOTE: If you reverse your initial denial determination, insert: "You will only be responsible for payment of any applicable amounts for deductible, coinsurance, and convenience services and items not normally covered by Medicare."

The physician reviewer also reconsidered the original liability determination that (insert the liable parties, i.e., "you" and/or the name of the provider and/or physician) knew that the denied services were not covered by Medicare. The physician reviewer determined that (Provide the facts and rationale for upholding/reversing the original liability determination for all parties. Include the appropriate statutory and regulatory citations. If your liability determination remains unchanged, tailor the liability language to the limitation on liability information contained in the initial denial notice. If your liability determination changes, tailor the liability language to the appropriate limitation on liability condition found in Exhibit 7-1. Include future liability language).

NOTE: Include the above paragraph only if you uphold your initial denial determination.

Use Model Hearings paragraph Exhibit 7-40, Condition I (and Condition II, if appropriate).

NOTE: Include the above paragraph only if you uphold your initial denial determination.

Sincerely,

Medical Director (or designated physician)

ccs:
Provider

Physician
FI/carrier (if original denial/liability determination changes)

**Exhibit 7-45 - Reconsideration Model Notice -- Day Outlier Denial -
(Rev. 4, 07-18-03)**

LETTERHEAD OF THE QIO

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Health Insurance Claim (HIC) Number
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of _____. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

As a result of (insert either "your" or the name of the physician or provider) (date), request for reconsideration, we have conducted a complete review of your medical record to determine whether our original denial determination was correct.

A QIO physician reviewer determined that your admission of (date), to (name of provider) for (specify the procedure/treatment or condition/services) was medically necessary and appropriate. However, the physician reviewer denied Medicare payment for the inpatient hospital services you received (specify denied date(s)) for a total of (number) day(s) because (use medical information and rationale contained in the initial denial notice).

When we notified you on (date of denial notice) of this denial determination, you were advised that (use the limitation on liability determination and rationale for the beneficiary, provider, and/or practitioner contained in the initial denial notice).

Prior to our reconsideration of this denial determination, we gave your physician, (name), and (name of provider) an opportunity to provide additional information, if they wished.

The reconsideration was performed by a board-certified physician reviewer who specializes in (indicate the specialty of the physician). The physician reviewer, who was not involved in the original denial determination, performed a thorough re-examination of all the information contained in your medical record and considered any additional information provided by your physician and/or the hospital.

The physician reviewer (insert either "reversed" or "upheld") the original denial determination because (Provide the facts and rationale for upholding/reversing the original denial determination for all parties. Include the appropriate statutory and regulatory citations). Therefore, we have determined that Medicare (select either "will" or "will not") pay for the inpatient hospital services you received (specify denied date(s)) for a total of (number) day(s).

NOTE: If you reverse your initial denial determination, insert: "You will only be responsible for payment of any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare."

The physician reviewer also reconsidered the original liability determination that (insert the liable parties, i.e., "you" and/or the name of the provider and/or physician) knew that the denied services were not covered by Medicare. The physician reviewer determined that (Provide the facts and rationale for upholding/reversing the original liability determination for all parties. Include the appropriate statutory and regulatory citations. If your liability determination remains unchanged, tailor the liability language to the limitation on liability information contained in the initial denial notice. If your liability determination changes, tailor the liability language to the appropriate limitation on liability condition found in Exhibit 7-1. Include future liability language).

NOTE: Include the above paragraph only if you uphold your initial denial determination.

Use Model Hearings paragraph Exhibit 7-40, Condition I (and Condition II, if appropriate).

NOTE: Include the above paragraph only if you uphold your initial denial determination.

Sincerely,

Medical Director (or designated physician)

ccs:

Provider

Physician

FI/carrier (if original denial/liability determination changes)

**Exhibit 7-46 - Reconsideration Model Notice -- Cost Outlier Denial -
(Rev. 4, 07-18-03)**

LETTERHEAD OF THE QIO

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Health Insurance Claim (HIC) Number
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of _____. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

As a result of (insert either "your" or the name of the physician or provider) (date), request for reconsideration, we have conducted a complete review of your medical record to determine whether our original denial determination was correct.

A QIO physician reviewer determined that your admission of (date), to (name of provider) for (specify the procedure/treatment or condition/services) was medically necessary and appropriate. However, the physician reviewer denied Medicare payment for the inpatient hospital service(s) and/or item(s) that you received as follows:

Specific Service/Item
Date Service/Item
Charges

Payment was denied because (use medical information and rationale contained in the initial denial notice).

When we notified you on (date of denial notice) of this denial determination, you were advised that (use the limitation on liability determination and rationale for the beneficiary, provider, and/or practitioner contained in the initial denial notice).

Prior to our reconsideration of this denial determination, we gave your physician, (name), and (name of provider) an opportunity to provide additional information, if they wished.

The reconsideration was performed by a board-certified physician reviewer who specializes in (indicate the specialty of the physician). The physician reviewer, who was not involved in the original denial determination, performed a thorough re-examination of all the information contained in your medical record and considered any additional information provided by your physician and/or hospital.

The physician reviewer (insert either "reversed" or "upheld") the original denial determination because (Provide the facts and rationale for upholding/reversing the original denial determination for all parties. Include the appropriate statutory and regulatory citations). Therefore, we have determined that Medicare (select either "will" or "will not") pay for the inpatient hospital service(s) and/or item(s) previously specified.

NOTE: If you reverse your initial denial determination, insert: "You will only be responsible for payment of any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare."

The physician reviewer also reconsidered the original liability determination that (insert the liable parties, i.e., "you" and/or the name of the provider and/or physician) knew that the denied services were not covered by Medicare. The physician reviewer determined that (Provide the facts and rationale for upholding/reversing the original liability determination for all parties. Include the appropriate statutory and regulatory citations. If your liability determination remains unchanged, tailor the liability language to the limitation on liability information contained in the initial denial notice. If your liability determination changes, tailor the liability language to the appropriate limitation on liability condition found in Exhibit 7-1. Include future liability language).

NOTE: Include the above paragraph only if you uphold your initial denial determination.

Use Model Hearings paragraph Exhibit 7-40, Condition I (and Condition II, if appropriate).

NOTE: Include the above paragraph only if you uphold your initial denial determination.

Sincerely,

Medical Director (or designated physician)

ccs:

Provider

Physician

FI/carrier (if original denial/liability determination changes)

Exhibit 7-47 - Re-review Model Notice -- DRG Changes as a Result of DRG Validation - (Rev. 4, 07-18-03)

(To provider - do not notify the beneficiary)

LETTERHEAD OF THE QIO

Date of Notice

Name of Patient

Address

City, State, and Zip Code

Health Insurance Claim (HIC) Number

Provider Name

Provider Number

Medical Record Number (if known)

Admission Date

Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of _____. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

We also are required to perform Diagnostic Related Group (DRG) validation on all cases selected for review to ensure that the diagnostic and procedural codes reported by the provider and resulting in the DRG assignment by the Fiscal Intermediary (FI) matches both the documentation in the medical record and the physician's attestation.

As a result of (insert either the name of the provider or physician) (date) request for a re-review, we have conducted a complete review of the medical record to determine whether our original DRG assignment determination was correct.

A reviewer determined that the admission of (date), for (specify the procedure/treatment or condition/services) was medically necessary and appropriate. However, the reviewer changed the following code(s):

Hospital Submitted Code(s) and Narrative Description

QIO Coding Change(s)

This resulted in a change in the DRG assignment from (_____) to (_____).

The codes were changed because (use the reason for change contained in the DRG Validation notice).

Prior to our re-review of the DRG assignment, we gave the physician, (name), and you an opportunity to provide additional information, if you wished.

Based on a thorough re-examination of all the information contained in the medical record and consideration of any additional information provided by the physician and by you, the reviewer determined that the change in the DRG assignment (insert either "was" or "was not") correct because (include a brief statement of the facts of the case and the rationale used in upholding or reversing the initial DRG change).

Therefore, the final results of the DRG re-review are as follows:

QIO Determined Codes and Narrative Description:

Final Determination: DRG _____

The Social Security Act does not provide for further appeal of this determination.

NOTE: Include the above paragraph only if you uphold your initial DRG change determination.

If you have any further questions, please contact _____.

Sincerely,

Medical Director (or designated physician,
Chief Executive Officer, RRA, or ART, as appropriate)

ccs:
Physician
FI/carrier (if final DRG determination changes)

**Exhibit 7-48 - Reconsideration Model Notice -- Outpatient/Ambulatory
Surgery Denial - (Rev. 4, 07-18-03)**

Condition I: Use for pre-procedure denials.

LETTERHEAD OF THE QIO

Date of Notice

Name of Patient
Address of Patient
City, State, and Zip Code

Health Insurance Claim (HIC) Number
Facility Name (if known)
Facility Provider Number (if known)
Medical Record Number (if known)
Proposed Surgery Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization authorized by the Medicare program to review outpatient/ambulatory surgical services provided to Medicare patients in the State of _____. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

As a result of (insert either "your" or the name of the physician or provider) (date), request for (insert either "an expedited reconsideration" or "a reconsideration"), we have conducted a complete review of your medical record to determine whether our original denial determination was correct.

A QIO physician reviewer denied Medicare payment for your proposed surgery of (date), at (name of provider) for (specify the surgical procedure) because (use the medical information and rationale contained in the initial denial notice).

When we notified you on (date of denial notice) of this denial determination, you were advised that if you and your physician decided that you should proceed with the surgery, you would be responsible for payment of all costs for the denied services you receive except for those covered services which could be paid for by Medicare Part B.

Prior to our reconsideration of this denial determination, we gave your physician, (name), and (name of provider) an opportunity to provide additional information, if they wished.

The reconsideration was performed by a board-certified physician reviewer who specializes in (indicate the specialty of the physician). The physician reviewer, who was not involved in the original denial determination, performed a thorough re-examination of all the information contained in your medical record and considered any additional information provided by your physician and/or the provider.

The physician reviewer (insert either "reversed" or "upheld") the original denial determination because (Provide the facts and rationale for upholding/reversing the original denial determination for all parties. Include the appropriate statutory and

regulatory citations). Therefore, we have determined that Medicare (select either "will" or "will not") pay for your proposed surgery if you and your physician decide to proceed.

NOTE: If you reverse your initial denial determination, insert: "You will only be responsible for payment of any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare."

NOTE: If you uphold your initial denial determination, insert: "You will be responsible for payment of all costs of the denied services you receive."

We also are advising your physician and provider of this reconsideration determination, which affirms our original denial determination. You should discuss with your physician other arrangements for any further health care you may now require.

NOTE: Include the above paragraph only if you uphold your initial denial determination.

Upon receipt of this notice, you will continue to be responsible for payment of denied services occurring in the future which involve the same or reasonably comparable conditions. However, Medicare will pay for all medically necessary and appropriate care you may require in the future.

NOTE: Include the above paragraph only if you uphold your initial denial determination.

Use Model Hearings Paragraph Exhibit 7-40, Condition I (and Condition II, if appropriate).

NOTE: Include the above paragraph only if you uphold your initial denial determination.

Sincerely,

Medical Director (or designated physician)

ccs:

Provider

Physician

FI/carrier (if original denial/liability determination changes)

Condition II: Use for post-procedure denials (either prepayment or post-payment).

LETTERHEAD OF THE QIO

Date of Notice

Name of Patient

Address of Patient
City, State, and Zip Code

Health Insurance Claim (HIC) Number
Facility Name
Facility Provider Number
Medical Record Number (if known)
Surgery Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review outpatient/ambulatory surgical services provided to Medicare patients in the State of _____. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

As a result of (insert either "your" or the name of the physician or provider) (date), request for a reconsideration, we have conducted a complete review of your medical record to determine whether our original denial determination was correct.

A QIO physician reviewer denied Medicare payment for your surgery of (date), at (name of provider) for (specify the surgical procedure) because (use the medical information and rationale contained in the initial denial notice).

When we notified you on (date of denial notice) of this denial determination, you were advised that (use the limitation on liability determination and rationale for the beneficiary, provider, and/or practitioner contained in the initial denial notice).

Prior to our reconsideration of this denial determination, we gave your physician, (name), and (name of provider) an opportunity to provide additional information, if they wished.

The reconsideration was performed by a board-certified physician reviewer who specializes in (indicate the specialty of the physician). The physician reviewer, who was not involved in the original denial determination, performed a thorough re-examination of all the information contained in your medical record and considered any additional information provided by your physician and/or the provider.

The physician reviewer (select either "reversed" or "upheld") the original denial determination because (Provide the facts and rationale for upholding/reversing the original denial determination for all parties. Include the appropriate statutory and regulatory citations). Therefore, we have determined that Medicare (select either "will" or "will not") pay for your surgery.

NOTE: If you reverse your initial denial determination, insert: "You will only be responsible for payment of any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare."

The physician reviewer also reconsidered the original liability determination that (insert the liable parties, i.e., "you" and/or the name of the provider and/or physician) knew that the denied services were not covered by Medicare. The physician reviewer determined that (Provide the facts and rationale for upholding/reversing the original liability determination for all parties. Include the appropriate statutory and regulatory citations. If your liability determination remains unchanged, tailor the liability language to the limitation on liability information contained in the initial denial notice. If your liability determination changes, tailor the liability language to the appropriate limitation on liability condition found in Exhibit 7-1. Include future liability language).

NOTE: Include the above paragraph only if you uphold your initial denial determination.

Use Model Hearings paragraph Exhibit 7-40, Condition I (and Condition II, if appropriate).

NOTE: Include the above paragraph only if you uphold your initial denial determination.

Sincerely,

Medical Director (or designated physician)

ccs:

Provider

Physician

FI/carrier (if original denial/liability determination changes)

Exhibit 7-49 - Reconsideration Completed Notice -- Continued-stay Denial - (Rev. 4, 07-18-03)

**(Expedited Reconsideration Within Three Working Days)
(Physician Agrees with HINN)**

YOUR LETTERHEAD:

Peer System, Inc.

1000 Pine Drive

Baltimore, Maryland 12345

410-555-5555

Date of Notice: August 12, 1990

Name of Patient: John Doe
Address: 200 Cherry Drive
City, State, and Zip Code: Somewhere, MD 00000

Health Insurance Claim (HIC) Number: 000-00-0000 A
Provider Name: Nowhere Hospital
Provider Number: 21-0000
Medical Record Number (if known): 2222
Admission Date: August 1, 1990
Physician Name: John Smith, M.D.

Dear Mr. Doe:

The Peer System, Inc., is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of Maryland. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

As a result of your August 13, request for an expedited reconsideration, we conducted a complete review of your medical record to determine whether our original denial determination was correct.

You received, with your physician's concurrence, a notice of non-coverage from Nowhere Hospital on August 10, 1990, and requested that we review your hospital stay. A QIO physician reviewer determined that your admission of August 1, 1990, to Nowhere Hospital for medical and surgical treatment of gallstones was medically necessary and appropriate. However, the physician reviewer agreed with your physician and the hospital that beginning August 10, you no longer required acute care in a hospital setting since you were receiving only a medication by mouth. That service, which can be safely provided outside of a hospital, does not constitute a hospital level of care and, therefore, is not covered by Medicare.

On August 12, we notified you that we agreed with Nowhere Hospital's notice of non-coverage and issued a denial determination. You were advised that if you decided to remain in the hospital, beginning 12 noon on August 13, you would be responsible for payment of all costs of the denied services you received, except for those covered services which could be paid for by Medicare Part B.

Prior to our reconsideration of this denial determination, we gave your physician, Dr. Smith, and Nowhere Hospital an opportunity to provide additional information, if they wished.

The reconsideration was performed by a board-certified physician reviewer who specializes in abdominal surgery. The physician reviewer, who was not involved in the original denial determination, performed a thorough re-examination of all the information

contained in your medical record and considered any additional information provided by your physician and/or hospital.

The physician reviewer upheld the original denial determination because services you received beginning August 10 could be given safely and effectively outside of a hospital. The medical records indicate that by that time you were up and about with no assistance, tolerating regular food, required no medication for pain control, and were taking only an oral diuretic in a maintenance dosage. Also, your stitches had been removed, and your incision was well healed and dry. Our authority for denying payment is specified in the Code of Federal Regulations, 42 CFR 473.14(a)(3). Therefore, we have determined that Medicare will not pay the hospital for the inpatient services provided (except for those covered services which can be paid for by Medicare Part B) beginning August 10. Also, the hospital may send you a bill for services provided to you beginning August 10.

The physician reviewer also reconsidered the original liability determination that you are responsible for payment of services you received in the hospital after 12 Noon on August 13, because you knew that the services were not covered by Medicare. The physician reviewer determined that you received adequate notice when you received the August 10 notice of non-coverage from the hospital and our telephone and written notice of August 12. Thus, your liability for the cost of the non-covered services received after 12 Noon on August 13 cannot be waived. Your liability for payment is specified in §1879 of the Social Security Act, and in the Code of Federal Regulations, 42 CFR Part 405.

This reconsideration determination notifies you that the services denied are not covered under Medicare. As you were notified in our August 12 denial notice, beginning 12 Noon on August 13, you became responsible for payment of all costs of services you receive in the hospital except for those covered services which can be paid for by Medicare Part B. For hospital services received prior to 12 Noon on August 13, you are responsible only for payment of any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare.

We are also advising your physician and the hospital of this reconsideration determination, which affirms our original denial determination. You should discuss with your physician other arrangements for any further health care you may now require.

Upon receipt of this notice, you will continue to be responsible for payment of denied services occurring in the future which involve the same or reasonably comparable conditions. However, Medicare will pay for all medically necessary and appropriate hospital care you may require in the future.

If you disagree with our reconsideration determination, you may request a formal hearing before an Administrative Law Judge (ALJ) of the Social Security Administration's (SSA's) Office of Hearings and Appeals (OHA) under the following conditions:

- If Medicare has denied payment of \$200 or more for services determined to be either not medically necessary or not provided at an appropriate level of care; or

- If you do not appeal the denial of Medicare payment on the medical issues listed above and have been found liable for payment of at least \$100 of the denied services, and you disagree with our liability determination that you knew or should have known that the denied services were not covered.

If you do not request an ALJ hearing regarding the liability determination, a dissatisfied provider or practitioner may request an ALJ hearing of that liability determination if they are liable for services of \$100 or more.

If you wish to have an ALJ hearing, you must submit a written request within 60 calendar days of receipt of this notice. Your written request should include: your name, Medicare health insurance claim number, where and when services were received, the reason for your dissatisfaction with our determination, any additional evidence you might wish to submit, and a copy of this notice.

You may send your written request to:

- Any social security office;
- An office of SSA's OHA;
- An office of the Railroad Retirement Board, if you are eligible; or
- To us at the following address:

Peer System, Inc.
1000 Pine Drive
Baltimore, Maryland 12345
410-555-5555

(A provider or practitioner may only send a written request to us or OHA.)

If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making our initial denial and reconsideration determinations. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information.

If you request a hearing, OHA will notify you of the date and place of the hearing. Hearings are held close to the address given on requests; therefore, if you request a hearing, please include the name of the county in which you reside along with your complete address and zip code. If you wish the hearing to be held somewhere other than close to your residence, please note that on the hearing request.

Sincerely,

Medical Director

ccs:

Nowhere Hospital
John Smith, M.D.

Exhibit 7-50 - Reconsideration Model Notice -- Circumvention of Prospective Payment System (PPS) - (Rev. 4, 07-18-03)

(Do not notify the beneficiary or physician)

LETTERHEAD OF THE QIO

Date of Notice
Name of Provider
Address of Provider
City, State, and Zip Code

Patient Name
Health Insurance Claim (HIC) Number
Medical Record Number (if known)
First Admission Date
Readmission/Transfer Date
PPS Provider Number
PPS-excluded Provider Number (if applicable)
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of _____. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

As a result of your (date) request for a reconsideration, we have conducted a complete review of the medical record to determine whether our original denial determination was correct.

Select paragraph A, B, or C below:

A: Services Should Have Been Furnished During the First Admission

Our physicians previously reviewed the acute care admission of (date) for (specify the procedure/treatment or condition/services) and subsequent acute care readmission of (date) for (specify the procedure/treatment or condition/services). We determined that the services furnished were medically necessary and appropriate. However, the services should have been furnished during the first admission. This action was considered to be a circumvention of the PPS because each admission triggered payment for an entire episode of hospital care. Thus, when the hospital admitted the patient on (date) and again on (date), the hospital received two Medicare payments instead of one. Therefore, we denied Medicare payment for the readmission of (date of 2nd admission).

B: Inappropriate Transfer From a PPS Unit to a PPS-excluded Unit

NOTE: This also applies to similar transfers from a PPS unit to a hospital-based SNF or SNF swing bed.

Our physicians previously reviewed the acute care admission of (date) for (specify the procedure/treatment or condition/services) and subsequent admission of (date) to the (select: psychiatric unit, rehabilitation unit, hospital-based Skilled Nursing Facility (SNF), or SNF swing bed) for (specify the procedure/treatment or condition/services). We determined that the patient was admitted to the acute care hospital even though the medical record shows that the patient only required care in the (select: psychiatric unit, rehabilitation unit, hospital-based SNF, or SNF swing bed) and a bed was available at the time of the acute care admission. This action was considered to be a circumvention of the prospective payment system because each admission triggered payment for an entire episode of hospital care. Thus, when the hospital discharged the patient on (date), the hospital received two Medicare payments instead of one. Therefore, we denied Medicare payment for the admission of (date of 2nd admission).

C: Inappropriate Transfer From a PPS-excluded Unit to a PPS Unit

NOTE: This also applies to similar transfers from a PPS-excluded unit to a hospital-based SNF or SNF swing bed.

Our physicians previously reviewed the admission of (date) to the (select: psychiatric or rehabilitation) unit for (specify the procedure/treatment or condition/services) and subsequent admission of (date) to the (select: acute care hospital, hospital-based SNF, or SNF swing bed) for (specify the procedure/treatment or condition/services). We determined that the admission to the (select: psychiatric or rehabilitation) unit was

medically necessary and appropriate and that the patient continued to require (select: psychiatric or rehabilitation) care/services when transferred to the (select: acute care hospital, hospital-based SNF, or SNF swing bed). This action was considered to be a circumvention of the PPS because each admission triggered payment for an entire episode of hospital care. Thus, when the hospital discharged the patient on (date) and subsequently admitted the patient on (date), the hospital received two Medicare payments instead of one. Therefore, we denied Medicare payment for the admission of (date of 2nd admission).

This denial determination was based on (use the medical information and rationale contained in the initial denial notice).

Prior to reaching our reconsideration determination, we gave you an opportunity to provide additional information, if you wished.

The reconsideration was performed by a board-certified physician reviewer who specializes in (indicate the specialty of the physician). The physician reviewer, who was not involved in the original denial determination, performed a thorough re-examination of all the information contained in the medical record and considered any additional information provided by the hospital.

The physician reviewer (select either "reversed" or "upheld") the original denial determination because (Provide the facts and rationale for upholding/reversing the original denial determination for all parties. Include the appropriate statutory and regulatory citations.) Therefore, we have determined that Medicare (select either "will" or "will not") pay for the (insert either "readmission" or "admission") of (date of second admission).

This denial determination is made under §1886(f)(2) of the Social Security Act. This section authorizes a denial of payment under Part A when the Secretary determines, based on information provided by a QIO, that a hospital has taken an action, in order to circumvent PPS, which results in unnecessary admissions, multiple admissions of the same individual, or other inappropriate practices.

NOTE: Include the above paragraph only if you uphold your initial denial determination.

The limitation on liability provision of §1879 of the Act does not apply to Part A denials issued under §1886(f)(2) of the Act. Therefore, the hospital is liable for the charges of the denied services. The beneficiary or his/her representative is only responsible for payment of any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare. If the beneficiary or his/her representative has paid the hospital for any of the denied services other than those amounts just mentioned, the hospital is to refund such payment.

NOTE: Include the above paragraph only if you uphold your initial denial determination.

If payment for services is denied due to alleged circumvention of the prospective payment system, you have a right to obtain a hearing conducted by an Administrative Law Judge of the Social Security Administration's (SSA's) Office of Hearings and Appeals (OHA) if the amount in controversy is \$100 or more. To do so, submit a written request within 60 calendar days of receipt of this notice. Your written request should include: beneficiary's name, Medicare health insurance claim number, where and when services were provided, the reason for your dissatisfaction with our determination, any additional evidence you may wish to submit, and a copy of this notice.

NOTE: Include the above paragraph only if you uphold your initial denial determination.

The request for a hearing may be sent to:

- An office of SSA's OHA; or
- To us at the following address:

QIO Name
Address
Telephone Number

NOTE: Include the above paragraph only if you uphold your initial denial determination.

If you request a hearing, OHA will notify you of the date and place of the hearing. Hearings are held close to the address given on requests; therefore, if you request a hearing, please include the name of the county in which you are located along with your complete address and zip code. If you wish the hearing to be held somewhere other than close to your place of business, please note that on the hearing request.

NOTE: Include the above paragraph only if you uphold your initial denial determination.

Sincerely,

Medical Director (or designated physician)

ccs:
FI/carrier (if original denial determination changes)

**Exhibit 7-60 - Sample Acknowledgment Letter to Beneficiary/
Representative When Request Is Sent to the Hearing Office –
(Rev. 4, 07-18-03)**

H.I. Claim Number: _____

Dear _____:

This is in reply to your request for a hearing before an Administrative Law Judge. We have forwarded the file to:

Office of Hearings and Appeals (OHA)

OHA will notify you as to the time and place of the hearing. If you have any further questions regarding this matter, OHA will be glad to assist you.

If you want help with your appeal of this reconsideration determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making our initial denial and reconsideration determinations. Although the hospital is the official repository of medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed below:

QIO Name
Address (including zip code)
Telephone Number

There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information.

Sincerely yours,

cc:
File Folder

Exhibit 7-61 - How to Locate the Correct Hearing Office – (Rev. 4, 07-18-03)

The Administrative Law Judge Hearing Offices (HO) serve particular Social Security District Offices (DO). Therefore, to locate the correct HO to which you must send the hearing folder, you need to know the DO that services the beneficiary. If the requestor is not the beneficiary, use the DO closest to the requestor's address to determine the HO to which the hearing folder is sent.

Since the SSA DOs serve specific counties within the State, it is also necessary for you to determine in which county the beneficiary/requestor resides before you can locate the DO. For these reasons use the following directories:

- U.S. Postal Service Directory of Post Offices;
- DHHS/SSA Service Area Directory (SAD); and
- OHA Field Office Directory.

Using the U.S. Postal Service Directory of Post Offices -- You need this directory to locate the county in which the beneficiary/requestor resides. Once you determine the city, State, and zip code on the request for hearing, locate that city under the "State Listing" in the Postal Service Directory. The county in which that city is located is listed either next to, or below, the city's name.

Using the DHHS/SSA SAD -- Once you have determined the county where the beneficiary/requestor resides, you need to know which SSA DO services that county. This directory is divided into several headings. Use columns marked County, Post Office, and Servicing Office. The counties are listed alphabetically under each State. Find the name of the county under the County heading. The name of the city appears under the Post Office heading. The name of the SSA DO is listed under the Servicing Office. The city may be broken down further into zip code areas. Therefore, it may be necessary for you to determine the correct zip code before you can determine the Servicing Office or SSA DO. At this point, call the DO and request the address of the specific local HO. Also, request the DO to provide you with addresses of all the HOs in its area for future use.

The SSA SAD can be retrieved electronically by using the SSA National Bulletin Board Service (SSANBBS). SSANBBS contains both directory and monthly update SAD files.

Directory SAD files contain the complete directory updated through a specified month. A directory file can be identified by a "D" in the file name. For example, SAD_DSEP.EXE would be the complete directory including updates through September while SAD_DOCT.EXE would be the complete directory including updates through October. Usually, SSANBBS contains the current and prior month directory files. Directory files are very large and very time consuming to download.

Monthly update SAD files contain only the changes for that month. They do not contain the entire directory. A monthly update file can be identified by a "U" in the file name. For example, SAD_USEP.EXE would be the monthly update for September while SAD_UOCT.EXE would be the monthly update for October. Usually, SSANBBS contains the current and prior month update files. Update files are much smaller and much less time consuming to download.

Bear in mind that the monthly update files contain only the changes for that month. Therefore, download them consistently or your directory will not be up-to-date. If you choose not to download the monthly updates, you may want to periodically download the complete directory.

To access SSANBBS, use any PC communication package such as PROCOMM or PCTALK that provides for the XMODEM protocol. Then enter the following information into the dial area of your communication software:

SSANBBS Phone Number: 1-410-965-5780
Baud Rate: 1200/2400
Data Bits: 8
Parity: NONE
Stop Bits: 1
Duplex Mode: Full

Once you have accessed SSANBBS, download the complete directory or monthly update files by entering the following information:

- At the Logo screen, hit enter and key in your name and password.
- At the Main Menu screen, select D (Download Facility).
- At the File Directories Menu screen, select 40 (Electronic Publications).
- At the Electronic Publications Menu screen, select the desired SAD file.
- At the message "Starting to Download Begin Receiving Using XMODEM Protocol," depress the page down (PROCOMM) key or the key that is appropriate to begin downloading for your software.

- Select XMODEM Protocol and download as the file name on the SSANBBS or change it to suit your needs.

If you experience any problems accessing SSANBBS or downloading SAD files, call the Help Desk on 1-410-965-6171.

The following example shows you how the above directories are used in locating the HO to which the hearing folder is sent for a beneficiary residing in Tampa, Florida 33630.

Using the Postal Service Directory, the county in which Tampa is located is Hillsborough.

Using the SSA Service Area Directory (State Listing), locate Hillsborough under the County heading. Under the Post Office heading, note that the city of Tampa is broken out by zip codes. Zip code 33630 is serviced by the Wellwood DO. If the Tampa zip code did not match any of those listed, use "Tampa Other Zips" and Tampa DO.

Exhibit 7-71 - Potential Quality Concern Model Notice – (Rev. 4, 07-18-03)

YOUR LETTERHEAD

Date of Notice
Name of Addressee
Address
City, State, and Zip Code

Patient Name
Health Insurance Claim (HIC) Number
Provider Name
Provider Number
Date of Admission/Service
Medical Record Number (if known)

Dear:

The (QIO name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review medical services provided to Medicare patients in the State of _____. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Our primary purpose is to identify areas where care can be improved and to feed back information to physicians and providers. This peer review is intended to be a collegial interaction with the goal of improving patient care. We appreciate the time and effort involved in your cooperation with our review activities.

A QIO physician reviewer has initially reviewed the care provided to (name of patient) at (name of provider) for (specify the procedure, treatment, condition, and/or services). Based on a careful review of the information contained in the medical record, the physician reviewer has raised some concerns regarding the care provided.

(Summarize the case findings and concerns from the preliminary decision portion of the PRAF.)

This is a potential concern only. We recognize that the medical record may not give a complete clinical picture. Therefore, we are providing you an opportunity to discuss the concerns we have raised prior to rendering our final determination. Your response can be in writing or by telephone. We must receive your response within 20 days from the date of this notice in order for information provided by you to be considered in our final determination. Please direct your response to:

Name of QIO Contact Person
Address
Telephone Number

If you have any questions concerning this notice or would like to make arrangements to discuss this case with a QIO physician reviewer, you may also contact (name of QIO contact person) within 20 days.

We are also notifying (name (See NOTES below)) of our concerns and offering an opportunity to discuss the concerns we have raised. While the physician and the representative for the provider may respond separately to the opportunity for discussion, we strongly encourage coordination of the responses.

NOTE: If the notice is addressed to the provider, insert the name of the physician(s) also notified.

NOTE: If the notice is addressed to the physician, insert the name of the provider. Do not specify other physicians you may be notifying.

If we do not receive your response by (date), a QIO physician reviewer will make a final determination based on the information contained in the medical record alone.

The information in this notice is confidential and may be re-disclosed only in accordance with Federal regulations found in 42 CFR 476.107 and 108.

Sincerely,

Medical Director (or designated physician)
(Include title)

**Exhibit 7-72 - Confirmed Quality Concern Model Notice –
(Rev. 4, 07-18-03)**

YOUR LETTERHEAD

Date of Notice
Name of Addressee
Address
City, State, and Zip Code

Patient Name
Health Insurance Claim (HIC) Number
Provider Name
Provider Number
Date of Admission/Service
Medical Record Number (if known)

Dear:

The (QIO name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review medical services provided to Medicare patients in the State of _____. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Our primary purpose is to identify areas where care can be improved and to feed back information to physicians and providers. This peer review is intended to be a collegial interaction with the goal of improving patient care. We appreciate the time and effort involved in your cooperation with our review activities.

A QIO physician reviewer has completed review of the care provided to (name of patient) at (name of provider) for (specify the procedure, treatment, condition, and/or services). Based on a careful review of the information contained in the medical record and any additional information provided during the opportunity for discussion, the physician reviewer has reached the following determination.

(Summarize the case findings and concerns, including your preferred course of action, from the initial/final review decision portion of the PRAF.)

We are entering this information into our database for pattern analysis. On an ongoing basis we analyze patterns of care involving quality concerns or positive outcomes that may have significance beyond a single episode. Be assured that if a pattern involving a

quality concern is identified, we will provide both you and (name (See NOTES below)) ample opportunity to discuss the concern with us.

NOTE: If the notice is addressed to the provider, insert the name of the physician(s).

NOTE: If the notice is addressed to the physician, insert the name of the provider. Do not specify any other physicians you may also be notifying.

We are also notifying (name (See NOTES above)) of our final determination. If you or (name (See NOTES above)) disagree with our quality of care concern determination, either party may request a re-review. To request a re-review, you must submit your request in writing within 30 days from receipt of this notice. Therefore, we must receive your request by (date). Your written request should include the reason for your dissatisfaction with our determination and any additional information you might wish to submit. Send your written request to:

QIO Name
Address
Telephone Number

The information in this notice is confidential and may be re-disclosed only in accordance with Federal regulations found in 42 CFR 476.107 and 108.

Sincerely,

Medical Director (or designated physician)
(Include title)

**Exhibit 7-73 - Re-review Upheld Quality Concern Model Notice –
(Rev. 4, 07-18-03)**

YOUR LETTERHEAD

Date of Notice
Name of Addressee
Address
City, State, and Zip Code

Patient Name
Health Insurance Claim (HIC) Number
Provider Name
Provider Number
Date of Admission/Service

Medical Record Number (if known)

Dear:

The (QIO name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review medical services provided to Medicare patients in the State of _____. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Our primary purpose is to identify areas where care can be improved and to feed back information to physicians and providers. This peer review is intended to be a collegial interaction with the goal of improving patient care. We appreciate the time and effort involved in your cooperation with our review activities.

As a result of a (date) request for a re-review, we have conducted a complete review of the care provided to (name of patient) at (name of provider) for (specify the procedure, treatment, condition, and/or services) to determine whether our original confirmed quality of care concern determination was correct. This re-review was performed by a QIO physician reviewer who was not involved in the original quality concern determination.

Based on a thorough re-examination of all the information contained in the medical record and consideration of any additional information provided by you and the (insert either "provider" or "physician"), the physician reviewer has reached the following determination.

Summarize the case findings and concerns, including your preferred course of action, from the reconsideration/re-review portion of the PRAF (PRAF 3).

We are entering this information into our database for pattern analysis. On an ongoing basis we analyze patterns of care involving quality concerns or positive outcomes that may have significance beyond a single episode. Be assured that if a pattern involving a quality concern is identified, we will provide both you and (name (See NOTES below)) ample opportunity to discuss the concern with us.

NOTE: If the notice is addressed to the provider, insert the name of the physician(s).

NOTE: If the notice is addressed to the physician, insert the name of the provider. Do not specify any other physicians you may also be notifying.

The Social Security Act does not provide for further appeal of this determination.

We are also notifying (name (See NOTES below)) of our re-review determination.

NOTE: If the notice is addressed to the provider, insert the name of the physician(s).

NOTE: If the notice is addressed to the physician, insert the name of the provider. Do not specify any other physicians you may also be notifying.

The information in this notice is confidential and may be re-disclosed only in accordance with Federal regulations found in 42 CFR 476.107 and 108.

Sincerely,

Medical Director (or designated physician)
(Include title)

Exhibit 7-74 - Examples of Potential Quality Concern Scenarios – (Rev. 4, 07-18-03)

The QIO must make a determination as to which physicians will receive preliminary notices depending on the unique circumstances of each case. Examples of possible scenarios follow:

Scenario 1:

- The attending physician admits and follows the patient.
- The admission is medically necessary.
- At some point during the hospitalization, a surgeon performs a procedure.
- There is a question as to the medical necessity of the procedure.

Notices go to:

- The provider;
- The attending physician; and
- The surgeon.

Scenario 2:

- The attending physician admits and follows the patient.
- At some point during the hospitalization, a surgeon performs a procedure.
- The patient was admitted solely for the performance of the procedure.
- There is a question as to the medical necessity of the procedure.

Notices go to:

- The provider;
- The attending physician; and
- The surgeon.

Scenario 3:

- The attending physician admits and follows the patient.
- At some point during the hospitalization, a surgeon performs a procedure.
- There is a technical error during the procedure with no apparent complications.

Notices go to:

- The provider; and
- The surgeon.

Scenario 4:

- The attending physician admits and follows the patient.
- At some point during the hospitalization, a surgeon performs a procedure.
- There is a technical error during the procedure with apparent complications.

Notices go to:

- The provider; and
- The surgeon.

Scenario 5:

- The attending physician admits and follows the patient.
- At some point during the hospitalization, a surgeon performs a procedure.
- The patient apparently suffers a cerebral vascular accident (CVA) during the procedure.
- An hour's worth of vital signs were apparently not taken during the procedure.

Notices go to:

- The provider;
- The surgeon;
- The anesthesiologist; and
- The physician who medically cleared the patient for surgery, if the QIO identified a concern with the medical clearance.

Scenario 6:

- The attending physician is an internist.
- During the course of the hospitalization, a cardiologist and a pulmonologist are also following.
- The patient experiences an episode of severe respiratory distress.
- All three physicians are called and respond.

- The orders to treat the episode are apparently inadequate and are signed by the internist.

Notices go to:

- The provider;
- The attending physician; and
- The pulmonologist and/or the cardiologist, only if the QIO believes that they can materially contribute to the resolution of the potential quality concern.

Scenario 7:

- The attending physician is an internist.
- During the course of the hospitalization, a cardiologist and a pulmonologist are also following.
- The patient experiences an episode of severe respiratory distress.
- All three physicians are called and respond.
- The orders to treat the episode are apparently inadequate and are signed by the pulmonologist.

Notices go to:

- The provider;
- The pulmonologist; and
- The attending physician.

Scenario 8:

- The attending physician is an internist.
- During the course of the hospitalization, a cardiologist and a pulmonologist are also following.
- The patient experiences an episode of severe respiratory distress.
- The internist responds.
- The orders to treat the episode are apparently inadequate and are signed by the internist.

Notices go to:

- The provider; and
- The attending physician.

Scenario 9:

- The attending physician is an internist.
- During the course of the hospitalization, a cardiologist and a pulmonologist are also following.

- The patient experiences an episode of severe respiratory distress.
- The pulmonologist responds.
- The orders to treat the episode are apparently inadequate and are signed by the pulmonologist.

Notices go to:

- The provider;
- The pulmonologist; and
- The attending physician, if, in the QIO's judgment, he/she can materially contribute to the resolution of the potential quality concern (e.g., if the attending physician saw the patient very soon after the episode and failed to countermand the orders in question).