Medicare Managed Care Manual

Chapter 13 - Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals Applicable to Medicare Advantage Plans, Cost Plans, and Health Care Prepayment Plans (HCPPs), (collectively referred to as Medicare Health Plans)

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10 - Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

This chapter addresses organization determinations and appeals for beneficiaries enrolled in a plan provided by a Medicare Advantage (MA) organization, or a Medicare cost plan or a health care prepayment plan (HCPP), and with any other complaints the enrollee may have with any of these plans. Beginning January 1, 2006, references to Medicare health plans should be read to include MA organizations, cost plans, and HCPPs unless other instruction is provided specific to those plan types. Nothing in this manual should be construed to alter the contractual obligations between cost plans or HCPPs and CMS except that cost plans and HCPPs must now conform to the regulatory requirements at 42 CFR Part 422, Subpart M.

Non-contracted providers may also have appeal rights in limited circumstances. For more information, please read §60.1.4.

Additional information related to Appeals and Grievances may also be found at:

http://www.cms.hhs.gov/MMCAG

Medicare health plans are encouraged to view CMS Web site FAQs regularly for additions and clarifications to existing policy at: http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=1ats8JXh

Please note that this manual chapter does not address or provide guidance for appeals and grievances concerning Part D drug benefits. Medicare health plans offering MA-PD organizations should consult Chapter 18 of the Prescription Drug Benefit Manual for information about Part D appeals and grievances.

10.1 - Definition of Terms*/Grievance*

(Rev. 88; Issued: 09-21-07; Effective/Implementation Dates: 09-21-07)

Unless otherwise stated in this Chapter, the following definitions apply:

Appeal: Any of the procedures that deal with the review of adverse organization determinations on the health care services an enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service as defined in 42 CFR 422.566(b). These procedures include reconsideration by the *Medicare health plan* and if necessary, an independent review entity, hearings before Administrative Law Judges (ALJs), review by the Medicare Appeals Council (MAC), and judicial review.

Disputes involving optional supplemental benefits offered by cost plans and HCPPs will be treated as appeals no later than January 1, 2006, (earlier at the cost plan's or HCPP's discretion). Prior to this rule change for 2006, they have been treated as grievances. Cost plans and HCPPs need to educate enrollees about this procedural change.

Assignee: A non-contracted physician or other non-contracted provider who has furnished a service to the enrollee and formally agrees to waive any right to payment from the enrollee for that service.

Complaint: Any expression of dissatisfaction to a Medicare health plan, provider, facility or Quality Improvement Organization (QIO) by an enrollee made orally or in writing. This can include concerns about the operations of providers or Medicare health plans such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, the respect paid to enrollees, the claims regarding the right of the enrollee to receive services or receive payment for services previously rendered. It also includes a plan's refusal to provide services to which the enrollee believes he or she is entitled. A complaint could be either a grievance or an appeal, or a single complaint could include elements of both. Every complaint must be handled under the appropriate grievance and/or appeal process.

Effectuation: Compliance with a reversal of the Medicare health plan's original adverse organization determination. Compliance may entail payment of a claim, authorization for a service, or provision of services.

Enrollee: A Medicare Advantage eligible individual who has elected a Medicare Advantage plan offered by an MA organization, or a Medicare eligible individual who has elected a cost plan or HCPP.

Grievance: Any complaint or dispute, other than one involving an organization determination, expressing dissatisfaction with the manner in which a Medicare health plan or delegated entity provides health care services, regardless of whether any remedial action can be taken. An enrollee *or their representative* may make the complaint or dispute, either orally or in writing, to a Medicare health plan, provider, or facility. An expedited grievance may also include a complaint that a Medicare health plan refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration time frame.

In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.

Independent Review Entity: An independent entity contracted by CMS to review Medicare health plans' adverse reconsiderations of organization determinations.

Inquiry: Any oral or written request to a Medicare health plan, provider, or facility, without an expression of dissatisfaction, e.g., a request for information or action by an enrollee.

Medicare Advantage Plan: A plan as defined at 42 CFR. 422.2 and described at 422.4.

***Medicare Health Plan**: Collective reference to Medicare Advantage Plans, Cost Plans, and Health Care Prepayment Plans (HCPPs).*

Organization Determination: Any determination made by a Medicare health plan with respect to any of the following:

- Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services,

- Payment for any other health services furnished by a provider other than the Medicare health plan that the enrollee believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by the Medicare health plan,

- The Medicare health plan's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the Medicare health plan,

- Discontinuation of a service if the enrollee believes that continuation of the services is medically necessary, or

- Failure of the Medicare health plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.

Quality Improvement Organization (QIO): Organizations comprised of practicing doctors and other health care experts under contract to the Federal government to monitor and improve the care given to Medicare enrollees. QIOs review complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare health plans, and ambulatory surgical centers. The QIOs also review continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs and CORFs.

Quality of Care Issue: A quality of care complaint may be filed through the Medicare health plan's grievance process and/or a QIO. A QIO must determine whether the quality of services (including both inpatient and outpatient services) provided by a Medicare health plan meets professionally recognized standards of health care, including whether appropriate health care services have been provided and whether services have been provided in appropriate settings.

Reconsideration: An enrollee's first step in the appeal process after an adverse organization determination; a Medicare health plan or independent review entity may re-evaluate an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.

Representative: An individual appointed by an enrollee or other party, or authorized under State or other applicable law, to act on behalf of an enrollee or other party involved in *an* appeal *or grievance*. Unless otherwise stated, the representative will have all of the rights and responsibilities of an enrollee or party in obtaining an organization determination, *filing a grievance, or* in dealing with any of the levels of the appeals process, subject to the applicable rules described at 42 CFR Part 405.

10.2 - Responsibilities of the Medicare Health Plan

(Rev. 88; Issued: 09-21-07; Effective/Implementation Dates: 09-21-07)

Each Medicare health plan, including any Medicare Advantage plan that it may offer, must establish and maintain procedures for:

- Standard and expedited organization determinations;

- Standard and expedited appeals; and

- Standard and expedited grievances.

Medicare health plans also must provide written information to enrollees *or their representatives* about the grievance and appeal procedures that are available to them through the Medicare health plan, at the following times:

- Grievance procedure - at initial enrollment, upon involuntary disenrollment initiated by the Medicare health plan, upon denial of an enrollee's request for expedited review *of an organization determination or appeal,* upon an enrollee's request, and annually thereafter;

- Appeals procedure, including the right to an expedited review - at initial enrollment, upon notification of an adverse organization determination, upon notification of a service or coverage termination (e.g., hospital, CORF, HHA or SNF settings), and annually thereafter; and

- Quality of care complaint process available under QIO process as described in §1154(a)(14) of the Social Security Act (the Act) - at initial enrollment, and annually thereafter.

As with all contractual responsibilities in the Medicare Advantage program, the health plan may delegate any of its grievances, organization determinations, and/or appeals responsibilities to another entity or individual that provides or arranges health care services. In cases of delegation, the Medicare health plan remains responsible and must therefore ensure that requirements are met completely by its delegated entity and/or individual.

10.3 - Rights of Managed Care Enrollees

(Rev. 34, 10-03-03)

Relative to grievances, organization determinations, and appeals, the rights of managed care enrollees include, but are not limited to the following sections:

10.3.1 - Grievances

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

- The right to have grievances heard and resolved in accordance with the guidelines that are described in this chapter of the manual; and

- The right to request quality of care grievance data from Medicare health plans.

10.3.2 - Organization Determinations

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

- The right to a timely organization determination;

- The right to request an expedited organization determination, or an extension, as described in this chapter; and, if the request is denied, the right to receive a written notice that explains the enrollee's right to file an expedited grievance.

- The right to a written notice from a Medicare health plan of its own decision to take an extension on a request for an organization determination that explains the reasons for the delay and explains the enrollee's right to file an expedited grievance if he or she disagrees with the extension.

- The right to receive information from a Medicare health plan regarding the enrollee's ability to obtain a detailed written notice from the Medicare health plan regarding the enrollee's services; and

- The right to a detailed written notice of a Medicare health plan's decision to deny, terminate or reduce a payment or service in whole or in part, or to reduce the level of care in an ongoing course of treatment which includes the enrollee's appeal rights.

10.3.3 - Appeals

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

- The right to request an expedited reconsideration as provided in this chapter;

- The right to request and receive appeal data from Medicare health plans;

- The right to receive notice when an appeal is forwarded to the Independent Review Entity (IRE);

- The right to automatic reconsideration by an IRE contracted by CMS, when the Medicare health plan upholds its original adverse determination in whole or in part;

- The right to an Administrative Law Judge (ALJ) hearing if the independent review entity upholds the original adverse determination in whole or in part and the remaining amount in controversy meets the appropriate threshold requirement, as set forth in section 100.2;

- The right to request Medicare Appeals Council (MAC) review if the ALJ hearing decision is unfavorable to the enrollee in whole or in part;

- The right to judicial review of the hearing decision if the ALJ hearing and/or MAC review is unfavorable to the enrollee, in whole or in part, and the amount remaining in controversy meets the appropriate threshold requirement, as set forth in section120;

- The right to file a quality of care grievance with a QIO;

- The right to request a QIO review of a termination of coverage of inpatient hospital care. If an enrollee receives immediate QIO review of a determination of non-coverage of inpatient hospital care, the above rights are limited. In this case, the enrollee is not entitled to the additional review of the issue by the Medicare health plan. The QIO review decision is subject to an ALJ hearing if the amount in controversy meets the appropriate threshold, and review of an ALJ hearing decision or dismissal by the MAC. Enrollees may submit requests for QIO review of determinations of non-coverage of inpatient hospital care in accordance with the procedures set forth in section 160;

- The right to request a QIO review of a termination of services in skilled nursing facilities, home health agencies and comprehensive outpatient rehabilitation facilities. If an enrollee receives QIO review of a SNF, HHA or CORF service termination, the enrollee is not entitled to the additional review of the issue by the Medicare health plan. Enrollees may submit requests for QIO review of provider settings in accordance with the procedures set forth in section 90.2;

- The right to request and be given timely access to the enrollee's case file and a copy of that case subject to federal and state law regarding confidentiality of patient information. The Medicare health plan shall have the right to charge the enrollee a reasonable amount, for example, the costs of mailing and/or an amount comparable to the charges established by a QIO for duplicating the case file material. At the time the request for case file material is made, the Medicare health plan should inform the enrollee of the per page duplicating cost. Based on the extent of the case file material requested, the Medicare health plan should provide an estimate of the total duplicating cost for which the enrollee will be responsible. The Medicare health plan may also charge the enrollee the cost of mailing the material to the address specified. If enrollee case files are stored off-site, then the Medicare health plan may not charge the enrollee an additional cost for courier delivery to a plan location that would be over and above the cost of mailing the material to the enrollee; and

- The right to challenge local and national coverage determinations. Under §1869(f)(5) of the Act, as added by §522 of the Benefits Improvement and Protection Act (BIPA), certain individuals ("aggrieved parties") may file a complaint to initiate a review of National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs). Challenges concerning NCDs are to be reviewed by the DAB of the Department of Health and Human Services. Challenges concerning LCDs are to be reviewed by ALJs. The new coverage challenge process is available to both beneficiaries with original Medicare and those enrolled in Medicare health plans.

20 - Complaints

(Rev. 22, 05-09-03)

20.1 - Complaints That Contain Elements of Both Appeals and Grievances

(Rev. 22, 05-09-03)

Complaints may include both grievances and appeals. Complaints can be processed under the appeal procedures, under the grievance procedures, or both depending on the extent to which the issues wholly or partially contain elements that are organization determinations. One complaint letter may contain a grievable issue and an appealable issue. If an enrollee addresses two or more issues in one complaint, then each issue should be processed separately and simultaneously (to the extent possible) under the proper procedure.

20.2 - Distinguishing Between Appeals and Grievances

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

Appeal procedures must be used for complaints or disputes involving organization determinations. Grievance procedures are separate and distinct from organization determination and appeal procedures. Determine whether the issues in an enrollee's complaint meet the definition of a grievance, an appeal, or both. The Medicare health plan then must resolve all enrollee's complaints or disputes through the appropriate procedure to address the particular type of complaint.

For example, Medicare health plans must determine how to categorize complaints about co-payments on a case-by-case basis. Medicare health plans must subject complaints about co-payments to the appeals process when an enrollee believes that an Medicare health plan has required the enrollee to pay an amount for a health service that should be the Medicare health plan's responsibility. If an enrollee expresses general dissatisfaction about a co-payment amount, then a Medicare health plan should process the enrollee's complaint as a grievance.

Complaints concerning an enrollee's involuntary disenrollment initiated by the Medicare health plan must also be processed through the grievance procedures. Other types of complaints that might fall into the grievance category include, but are not limited to: a change in premiums or cost sharing arrangements from one contract year to the next, difficulty getting through on the telephone, the quality of care of services provided, interpersonal aspects of care, such as rudeness by a provider or staff member, or failure to respect an enrollee's rights. The facts surrounding a complaint will determine whether the appeals or grievance process should be initiated. The following are offered as examples of when each process should begin:

- An enrollee who currently uses a particular heart specialist is dismayed to find out that the specialist he/she uses will no longer be a contracted provider with the Medicare health plan. The enrollee calls the health plan and complains. The

enrollee states that he/she has tried other specialists before, was not satisfied, and therefore wants the health plan to continue coverage of the heart specialist. This complaint should be treated as a request for an organization determination, subject to the appeals process, on the basis that the enrollee believes that continued care with the particular heart specialist is required for his/her well-being.

- An enrollee who currently does not use a particular heart specialist reads in his provider manual that the heart specialist is no longer in the plan's network. The enrollee calls the plan to complain, even though it does not directly affect him at the current time because the enrollee does not currently see a heart specialist. In this instance, the complaint cannot be interpreted as a request for an organization determination. The complaint should therefore be handled as a grievance.

Complaints concerning the quality of medical care received under Medicare may be acted upon by the Medicare health plan, but also may be addressed through the QIO complaint process under §1154(a)(14) of the Act. (See also the QIO Manual chapter regarding the Beneficiary Complaint Process.) This process is separate and distinct from the Medicare health plan's grievance process. For example, if an enrollee believes his/her physician misdiagnosed the enrollee's condition, then the enrollee may file a complaint with the QIO in addition or in lieu of a complaint filed under the Medicare health plan's grievance process. All grievances regarding quality of care, regardless of whether they are filed orally or in writing must be responded to in writing. When the Medicare health plan responds to an enrollee's grievance in writing, it must include a description of the enrollee's right to file the grievance with the QIO. For any grievance filed with the QIO, the Medicare health plan must cooperate with the QIO in resolving the grievance.

Complaints concerning organization determinations are resolved through appeal procedures. Organization determinations primarily include complaints concerning the benefits to which an enrollee is, or believes he/she is, entitled, i.e., payment or provision of services. Additionally, an appeal might arise from a complaint when an enrollee disputes the calculation of his/her co-payment amount.

At times Medicare health plans will need to process complaints using the Medicare health plan's grievance procedures as well as its appeal procedures. For example, an enrollee might complain that because he/she had to wait so long to obtain a referral, he/she received services out of network. The enrollee's complaint contains both an appealable request for payment as well as a grievance about the timeliness of services. Therefore, complaints must be reviewed on a case-by-case basis. Complaints that are grievances must be resolved as expeditiously as the enrollee's case requires, based on the enrollee's health status, but no later than 30 days after the date the organization receives the oral or written grievance. Grievances filed orally, may be responded to orally unless the enrollee requests a written response or the grievance concerns quality of care. Grievances filed in writing must be responded to in writing.

20.3 - Procedures for Handling a Grievance

(Rev. 88; Issued: 09-21-07; Effective/Implementation Dates: 09-21-07)

Each Medicare health plan, and any managed care plan it offers, must provide meaningful procedures for timely hearing and resolving both standard and expedited grievances between enrollees and the Medicare health plan or any other entity or individual through which the Medicare health plan provides health care services.

The Medicare health plan must include the following requirements in its grievance procedures:

- Ability to accept any information or evidence concerning the grievance orally or in writing not later than 60 *calendar* days after the event;

- Ability to respond within 24 hours to an enrollee's expedited grievance whenever:

  - *A* Medicare health plan extends the time frame to make an organization determination or reconsideration; or

  - *A* Medicare health plan refuses to grant a request for an expedited organization determination or reconsideration;

- Use a model notice, or regional office approved variation of the model notice, to notify enrollees of their right to file an expedited grievance (see Appendix 5);

- Prompt, appropriate action, including a full investigation of the grievance as expeditiously as the enrollee's case requires, based on the enrollee's health status, but no later than 30 *calendar* days from *the date* the oral or written request *is received*, unless extended as permitted under 42 CFR 422.564(e)(2);

- Timely transmission of grievances to appropriate decision-making levels in the organization;

- Notification of investigation results *provided* to all concerned parties, as expeditiously as the enrollee's case requires based on the enrollee's health status, but not later than 30 *calendar* days *from the date the grievance is filed with the health plan;*

- Prompt notification to the enrollee *or their representative* using an approved notice regarding an organization's plan to take up to a 14 calendar day extension on a grievance case, (see Appendix 5);

- Documentation of the need for any extension taken (other than one requested by the enrollee) that explains how the extension is in the best interest of the enrollee; and

- Procedures for tracking and maintaining records about the receipt and disposition of grievances. Consistent with §170 of this chapter, Medicare health plans must disclose grievance data to Medicare beneficiaries upon request. Medicare health

plans must be able to log or capture enrollees' grievances in a centralized location that is readily accessible.

20.3.1 - Procedures for Handling Misclassified Grievances

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

Should a Medicare health plan misclassify a grievance as an appeal and issue a denial notice and if the independent review entity determines that the complaint was misclassified as an appeal, then the independent review entity must dismiss the appeal and return the complaint to the Medicare health plan for proper processing. The Medicare health plan must notify the enrollee in writing that the complaint was misclassified and will be handled through the Medicare health plan grievance process. Medicare health plans are expected to audit their own appeals and grievance systems for the presence of errors, and institute appropriate quality improvement projects as needed.

EXAMPLE 1

A Medicare health plan enrollee has a contractual benefit that covers one pair of eyeglasses every 24 months with a maximum Medicare health plan contribution of $70.00. The enrollee ordered glasses as prescribed by a Medicare health plan optometrist and was covered for $70.00 of the bill. The enrollee returned to the optometrist, asserting that the glasses were no good and the prescription was wrong. The enrollee requested Medicare health plan coverage for another pair of glasses. Where an enrollee complains that contractually covered and previously rendered services are inadequate or substandard in quality, this type of complaint (i.e., request for another pair of glasses) should be classified as a grievance (quality of care complaint) as opposed to an appeal.

EXAMPLE 2

Over an enrollee's objections, a Medicare health plan determines that it requires additional medical records from a health provider to decide on a request for an organization determination. The enrollee's objection to the extension that the Medicare health plan granted to allow it to wait for the medical records should be classified as an expedited grievance and processed within 24 hours.

20.4 - Written Explanation of Grievance Procedures

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

The Medicare health plan must provide all members with written grievance procedures upon initial enrollment, involuntary disenrollment (i.e., initiated by the Medicare health plan), annually, and upon request. Medicare health plans are also required to provide all members with written notice about their right to file an expedited grievance upon denial of the enrollee's request for an expedited appeal, a request for an expedited organization determination, or whenever the Medicare health plan decides to take an extension on a request for an organization determination or appeal. CMS has developed a model notice

Medicare health plans can use to notify enrollees whenever these actions occur, (see Appendix 5). Note that substantive changes to the model notice language must be approved in accordance with regional office marketing procedures.

Any time a written grievance notification is required, Medicare health plans must include at least the following information:

- How and where to file a grievance; and
- The differences between appeals and grievances.

30 - Organization Determinations

(Rev. 88; Issued: 09-21-07; Effective/Implementation Dates: 09-21-07)

An organization determination is any determination (i.e., an approval or denial) made by the Medicare health plan, or its delegated entity with respect to the following:

- Payment for temporarily out of the area renal dialysis services;
- Payment for emergency services, post-stabilization care, or urgently needed services;
- Payment for any other health services furnished by a provider (other than the Medicare health plan), that the enrollee believes:
    - Are covered under Medicare, or
    - If not covered under Medicare, should have been furnished, arranged for, or reimbursed by the Medicare health plan.
- Refusal to authorize, provide, or pay for services, in whole or in part, including the type or level of services, which the enrollee believes should be furnished or arranged by the organization;
- Discontinuation or reduction of a service that the enrollee believes should be continued because they believe the service to be medically necessary, in accordance with this chapter; and
- Failure of the Medicare health plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay adversely affects the health of the enrollee.

Each Medicare health plan must establish procedures for making timely organization determinations regarding the benefits an enrollee is entitled to receive under a managed care plan. It includes basic benefits, mandatory and optional supplemental benefits and the amount, if any, that the enrollee is required to pay for a health service.

Once an organization determination has occurred, the appeals process may be triggered if an enrollee believes the Medicare health plan's decision is unfavorable. If a managed care enrollee disputes an organization determination, the case must be handled using the federally mandated appeals process. If an enrollee complains about any other aspect of the Medicare health plan (e.g. the manner in which care was provided), the Medicare health plan must address the issue through the separate grievance process.

When the Medicare health plan decides not to provide or pay for a requested service, in whole or in part, *or if it discontinues or reduces a service,* this decision constitutes an adverse organization determination. In the event of any adverse organization determination, a Medicare health plan must provide the enrollee with a written denial notice with appeal rights. (See Appendix 1.)

Medicare health plans must ensure issuance of written notices of adverse organization determinations whenever coverage is denied in whole or in part. Enrollees and providers must be educated that a request for a denial notice must be submitted to the Medicare health plan if the enrollee believes that service or payment is being denied. Once the determination is made, the Medicare health plan must issue the denial notice (also see §§ 40.2.1 and 40.2.2).

30.1 - Procedures for Handling Misclassified Organization Determinations

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

All organization determinations are subject to appeal procedures. Sometimes complaints do not appear to involve organization determinations and are misclassified as grievances exclusively. This may occur because the organization did not issue the written notice of an adverse organization determination (i.e., a denial notice). Upon discovery of such an error, the Medicare health plan must notify the enrollee in writing that the complaint was misclassified and will be handled through the appeals process. The time frame for processing the complaint begins on the date the complaint is received by the Medicare health plan, as opposed to the date the Medicare health plan discovers its error. Medicare health plans are expected to audit their own appeals and grievance systems for the presence of errors and institute appropriate quality improvement projects as needed.

30.1.1 - Quality of Care

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

A complaint received by a Medicare health plan concerning the quality of service a member received is generally treated as a grievance. However, quality of care complaints are occasionally complaints of a denial of services. For example, a member complains of poor medical care because his/her doctor did not authorize a surgery or other medical service. This complaint involves a denial of service that should simultaneously be processed through the appeal procedures of the plan. In this case, the

Medicare health plan is responsible for directing the complaint to the appeal process and the grievance process.

Complaints about quality of care issues may also be received and acted upon by the QIO. In situations in which the enrollee has gone both to the QIO and to the Medicare health plan, Medicare health plans must recognize the authority of the QIO with respect to timely submission of requested information/documentation.

30.1.2 - Service Accessibility

(Rev. 22, 05-09-03)

Complaints concerning the timely receipt of services that have already been provided may be treated as grievances. However, when a member complains that he or she has been unable to obtain a service that he or she is entitled to receive (such that a delay adversely affects the health of the enrollee), it should be addressed as an organization determination, which can be appealed.

When the member complains that he/she had to wait so long for a service that he/she went out-of-plan, the complaint should be treated as an appeal for payment for the out-of-plan services as well as a grievance about the timeliness of the service.

30.1.3 - Employer-Sponsored Benefits

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

Managed care appeal procedures apply to all benefits offered under a Medicare health plan - including optional supplemental benefits. However, determinations on items or services purchased by an employer, over and above the Medicare approved benefit package provided by the Medicare health plan, such as payments of premiums or beneficiary cost sharing provided by the employer, are not subject to these managed care requirements.

30.2 - Jurisdiction for Claims Processed on Behalf of Managed Care Enrollees Through the Original Medicare-Fee-For-Service System

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

Claims received by Medicare fee-for-service (FFS) carriers for enrollees of Medicare health plans will be denied, and the supplier, physician or practitioner will be notified through the appropriate claim level remittance advice reason code message that the services should be billed to the patient’s managed care plan.

Claims received by Medicare FFS fiscal intermediaries for enrollees of Medicare health plans will be transferred to the member’s Medicare health plan for processing. This transfer is not considered a denial on the part of the fiscal intermediary. As a result, the managed care member has no appeal rights under the Medicare FFS program. If the

Medicare health plan denies the claim, the Medicare health plan must issue its member a denial notice with appeal rights. The Medicare health plan has jurisdiction for this claim.

30.3 - Special Jurisdictional Rules for Claims Processing and Appeals for Medicare Cost Plans and HCPPs

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

It is often appropriate for carriers to process claims for enrollees in cost plans (except as specified otherwise, these rules affecting cost plans also apply to HCPPs) as regular Part B claims (e.g., when enrollees see an out-of-network physician without plan authorization or for certain services such as physical therapy [see Chapter 17(B), Section 300 of the Cost Plan Manual]). It may also be appropriate for fiscal intermediaries to process Part B emergency or urgently needed services (under 42 CFR 417.558, this depends on whether the cost plan is paying for the services).

Similarly, it may be appropriate for a fiscal intermediary to process claims for cost plan enrollees as regular Part A claims (e.g., when enrollees use an out-of-network facility or for certain services such as home health or hospice services [see Chapter 17(B), Section 300 of the Cost Plan Manual]). Also, if a cost plan with a contract under Section 1876 of the Social Security Act elects "billing option 1" (i.e., chooses to have CMS pay for all hospital and SNF services – see 42 CFR 417.532(c)), the fiscal intermediary would process any claims received (including Part B hospital outpatient claims).

However, regardless of who pays Part A or Part B claims, if an enrollee has received services through the cost plan's network, or out-of-network at the direction of the cost plan/network provider (e.g. referral), or because of an emergency inpatient admission, appeals concerning a denial of payment of such services would fall under the rules that apply to cost plan services contained in 42 CFR Part 422, Subpart M. (In the case of an HCPP, this would only involve Part B services. Part A services are not covered under the HCPP agreement, and would always be processed under the 42 CFR Part 405 appeals rules.) Furthermore, the enrollee cannot be held liable for a Part A or Part B service just because a carrier or fiscal intermediary denied the claim under these circumstances. This is true even though the cost plan has no influence on the carrier's or fiscal intermediary's decision. The 42 CFR Part 405 fee-for-service appeals rules apply only in a case in which the enrollee self-referred out of the cost plan's provider network or hospital /SNF network without the cost plan's involvement (including outpatient emergency services at an out-of-network hospital). Any disputes involving applicable cost-sharing would fall under the rules that apply to cost plan services contained in 42 CFR Part 422, Subpart M.

If an enrollee files an appeal with the cost plan when the appeal should have been filed with the carrier or fiscal intermediary, the cost plan must inform the enrollee that the appeal should be filed with the carrier or fiscal intermediary that denied the payment. The cost plan should direct the enrollee to the Medicare Summary Notice (MSN) for an explanation of the 42 CFR Part 405 fee-for-service appeals process. The cost plan must inform the enrollee in the Evidence of Coverage (EOC) that the cost plan's appeals process is only for disputes relating to organization determinations made by the plan or

certain emergency admissions. The cost plan may illustrate the dual appeals process by providing examples in the EOC. CMS will release guidance to the IRE to ensure that the IRE does not inappropriately process appeals that should have been filed with the carrier or fiscal intermediary.

40 - Standard Organization Determinations

40.1 - Standard Time Frames for Organization Determinations

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

When an enrollee has made a request for a service, the Medicare health plan must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after the date the organization receives the request for a standard organization determination.

The Medicare health plan may extend the time frame up to 14 calendar days. This extension is allowed to occur if the enrollee requests the extension or if the organization justifies a need for additional information and documents how the delay is in the interest of the enrollee (for example, the receipt of additional medical evidence from non-contracted providers may change a Medicare health plan's decision to deny). When the Medicare health plan grants itself an extension to the deadline, it must notify the enrollee, in writing, of the reasons for the delay, and inform the enrollee of the right to file a grievance if he or she disagrees with the Medicare health plan's decision to grant an extension. The Medicare health plan must notify the enrollee, in writing, of its determination as expeditiously as the enrollee's health condition requires, but no later than the expiration of any extension that occurs, in accordance with this chapter.

The Medicare health plan must pay 95 percent of clean claims from non-contracted providers within 30 calendar days of the request. All other claims must be paid or denied within 60 calendar days from the date of the request.

40.2 - Notice Requirements for Standard Organization Determinations

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

40.2.1 - Written Explanation by a Medicare Health Plan of a Practitioner's Decision

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

The Medicare health plan must educate enrollees and practitioners that when there is a disagreement with a practitioner's decision to deny a service or a course of treatment, in whole or in part, the enrollee has a right to request and receive from the Medicare health plan a detailed written notice regarding the practitioner's decision.

40.2.2 - Written Notification by Medicare Health Plan of Its Own Decision

(Rev. 88; Issued: 09-21-07; Effective/Implementation Dates: 09-21-07)

If the Medicare health plan decides to deny, discontinue, or reduce services or payments, in whole or in part, *and the enrollee believes that services should be covered,* then it must give the enrollee a written notice of its determination. *The Medicare health plan must provide notice using the most efficient manner of delivery to ensure the enrollee receives the notice in time to act (e.g., via fax, hand delivery, or mail).* If the enrollee has a representative, the representative must be *given* a copy of the notice. *The written notice of determination may be a separate different document from any plan generated claims statement to the enrollee or provider. Such plan-generated statements may include explanation of benefits (EOBs), detailing what the plan has paid on the enrollee's behalf, and/or the enrollee's liability for payment.*

The Medicare health plan must use approved notice language in Appendix 1 (see Notice of Denial of Medical Coverage (NDMC) and Notice of Denial of Payment (NDP)). *If a* Medicare health plan uses *its existing* system-generated notification *(i.e., EOB)* regarding payment denials *as its written notice of determination, the plan* must ensure that the *EOB* contains the OMB-approved language of the NDP *verbatim and* in its entirety, and meets the content requirements listed in the NDP's form instructions (see Appendix 1).

The standardized denial notice forms have been written in a manner that is understandable to the enrollee and must provide:

- The specific reason for the denial that takes into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any;

- Information regarding the enrollee's right to a standard or expedited reconsideration and the right to appoint a representative to file an appeal on the enrollee's behalf (as mandated by 42 CFR 422.570 and 422.566(b)(3);

- For service denials, (see NDMC, Appendix 1), a description of both the standard and expedited reconsideration processes and time frames, including conditions for obtaining an expedited reconsideration, and the other elements of the appeals process;

- For payment denials, (see NDP, Appendix 1) a description of the standard reconsideration process and time frames, and the rest of the appeals process; and

- The beneficiary's right to submit additional evidence in writing or in person.

Example of language that is not acceptable in section 40.2.2, list item 1, above (because it is not specific enough or provides the background necessary to indicate why rehabilitation services are no longer necessary):

You required skilled rehabilitation services - Physical therapy for mobility + gait, including ADL's, swallowing evaluation and speech therapy - from 6/5/2005. These services are no longer needed on a daily basis.

The denial rationale must be specific to each individual case and written in a manner that an enrollee can understand.

Examples of language that is acceptable (because it provides detail sufficient to guide the enrollee on any further action, if necessary):

- The case file indicated that while Jane Doe was making progress in her therapy programs, her condition had stabilized and further daily skilled services were no longer indicated. The physical therapy notes indicate that she reached her maximum potential in therapy. She had progressed to minimum assistance for bed mobility, moderate assistance with transfers, and was ambulating to 100 feet with a walker. The speech therapist noted that her speech was much improved by 6/12/2001, and that her private caregiver had been instructed on safe swallowing procedures and will continue with feeding responsibilities.

- Home health care must meet Medicare guidelines, which require that you must be confined to your home. You are not homebound and consequently the home health services requested are not payable by Medicare or the Medicare health plan.

- Golf carts do not qualify as durable medical equipment as defined under Medicare guidelines. Medicare defines durable medical equipment as an item determined to be necessary on the basis of a medical or physical condition, is used in the home or an institutional setting, and meets Medicare's safety requirements. A golf cart does not meet these requirements and is not payable by Medicare or (**name of health plan**).

Plans are free to use any general attachments accompanying such notices, such as a form for its enrollees' voluntary use in filing an appeal. However, this material must go through the regional office's marketing review.

40.2.3 - Notice Requirements for Non-contracted Providers

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

If the Medicare health plan denies a request for payment from a non-contracted provider that is appealing on his or her own behalf, the Medicare health plan must notify the non-contracted provider of the specific reason for the denial and provide a description of the appeals process. The Medicare health plan must also explain that in the event that the non-contracted provider wishes to appeal, the non-contracted provider must sign a waiver of liability statement (see Appendix 6).

40.3 - Effect of Failure to Provide Timely Notice

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

If the Medicare health plan fails to provide the enrollee with timely notice of an organization determination, this failure itself constitutes an adverse organization determination and may be appealed. The Medicare health plan must include in the annual Evidence of Coverage (EOC) information regarding an enrollee's right to appeal when the Medicare health plan fails to provide a timely notice.

50 - Expedited Organization Determinations

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

An enrollee, or any physician (regardless of whether the physician is affiliated with the Medicare health plan), may request that a Medicare health plan expedite an organization determination when the enrollee or his/her physician believes that waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

Expedited organization determinations may not be requested for cases in which the only issue involves a claim for payment for services that the enrollee has already received. However, if a case includes both a payment denial and a pre-service denial, the enrollee has a right to request an expedited appeal for the pre-service denial.

50.1 - Making a Request for an Expedited Organization Determination

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

When asking for an expedited organization determination, the enrollee or a physician must submit either an oral or written request directly to the organization, or if applicable, to the entity responsible for making the determination. A physician may also provide oral or written support for an enrollee's own request for an expedited determination.

- The Medicare health plan must automatically provide an expedited organization determination if a physician indicates, either orally or in writing, that applying the standard time for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function (the physician does not have to use these exact words). The physician need not be the enrollee's representative in order to make the request;

- For a request made by an enrollee, the Medicare health plan must expedite the review of a determination if the plan finds that applying the standard time for making a determination could seriously jeopardize the enrollee's health, life, or ability to regain maximum function;

- If the Medicare health plan decides to expedite the request, it must render a decision as expeditiously as the enrollee's health condition might require, but no later than 72 hours after receiving the enrollee's request; and

- If the Medicare health plan denies the request for an expedited organization determination, the organization follows the requirements specified in section 50.3.

50.2 - How the Medicare Health Plan Processes Requests for Expedited Organization Determinations

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

The Medicare health plan must establish and maintain procedures that:

- Establish efficient and convenient means for enrollees to submit oral/written requests for expedited organization determinations;

- Document all oral requests in writing and maintain the documentation in the case file;

- Promptly decide whether to expedite a determination based on whether applying the standard time frame for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function;

- Provide written notice of denials of requests for expedited determinations and instructions on how to file an expedited grievance when enrollees dispute the managed care denial or extension decision; and

- Develop a meaningful process for receiving requests for expedited reviews. These procedures should include designating an office and/or department to receive both oral or written requests and a telephone number for oral requests, and may include a facsimile number to facilitate receipt of requests for expedited organization determinations. The procedures must be clearly explained in member materials. In addition, Medicare health plans will be accountable for educating staff and provider networks to ensure that requests for expedited review received by medical groups or other health plan offices are referred immediately to the Medicare health plan's designated office or department. The 72-hour period begins when the request is received by the appropriate office or department designated by the Medicare health plan regardless of whether the provider is under contract to the Medicare health plan. If the Medicare health plan requires medical information from non-contracted providers to make a decision, the Medicare health plan must request the necessary information from the non-contracted provider within 24 hours of the initial request for an expedited organization determination. Non-contracted providers must make reasonable and diligent efforts to expeditiously gather and forward all necessary information to assist the Medicare health plan in meeting the required time frame. Regardless of whether the Medicare health plan must request information from non-contracted

providers, the Medicare health plan is responsible for meeting the same time frame and notice requirements as it does with contracting providers.

50.2.1 - Defining the Medical Exigency Standard

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

The medical exigency standard requires a Medicare health plan and CMS' independent review entity to make decisions as "expeditiously as the enrollee's health condition requires." This standard is set forth in regulation at 422.568(a) (standard organization determination), 422.572(a) (expedited organization determination), 422.590(a) (standard reconsideration), 422.590(d)(1) (expedited reconsideration) and 422.592(b) (for reconsidered determination by independent review entity), 422.618(a) (Medicare health plan effectuating standard reconsidered determination), 422.618(b)(1) (effectuation requirements for reversals by the independent review entity), 422.618(c) (effectuation requirements for reversals by the ALJ or higher levels of appeal), 422.619 (effectuation requirements for expedited reconsidered determinations), 422.619(a) (Medicare health plan effectuating expedited reconsidered determinations), 422.619(b) (effectuation requirements for reversals by the independent review entity for expedited reconsidered determinations), 422.619(c) (effectuation requirements for reversals by the ALJ or higher levels of appeal for expedited reconsidered determinations). This standard requires that the Medicare health plan or the independent entity apply, at a minimum, establish accepted standards of medical practice in assessing an individual's medical condition. Evidence of the individual's condition can be demonstrated by indications from the treating provider or from the individual's medical record (including such information as the individual's diagnosis, symptoms, or test results).

The medical exigency standard was established by regulation to ensure that Medicare health plans would develop a system for determining the urgency of both standard and expedited requests for services, triage incoming requests against pre-established criteria, and then give each request priority according to that system. That is, Medicare health plans must treat every case in a manner that is appropriate to its medical particulars or urgency. Medicare health plans should not systematically take the maximum time permitted for service-related decisions.

50.3 - Action Following Denial for Expedited Review

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

If a Medicare health plan denies a request for an expedited organization determination, it must automatically transfer the request to the standard time frame and make a determination within 14 calendar days (the 14-day period starts when the request for an expedited determination is received by the Medicare health plan), give the enrollee prompt oral notice of the denial including the enrollee's rights, and subsequently deliver to the enrollee, within 3 calendar days, a written letter of the enrollee's rights that:

- Explains that the organization will automatically transfer and process the request using the 14-day time frame for standard determinations;

- Informs the enrollee of the right to file an expedited grievance if he or she disagrees with the organization's decision not to expedite the determination;

- Informs the enrollee of the right to resubmit a request for an expedited determination and that if the enrollee gets any physician's support indicating that applying the standard time frame for making determinations could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, the request will be expedited automatically; and

- Provides instructions about the expedited grievance process and its time frames.

CMS has developed a model notice that plans may use to notify enrollees about their expedited grievance rights (see Appendix 5).

50.4 - Action on Accepted Requests for Expedited Determinations

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

If an organization grants a request for an expedited determination, the determination must be made in accordance with the following requirements:

- A Medicare health plan that approves a request for expedited determination must make the determination and notify the enrollee and the physician involved, as appropriate, of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receiving the request. Although the Medicare health plan may notify the enrollee orally or in writing, the enrollee must be notified within the 72 hour time frame. Mailing the determination within 72 hours in and of itself is insufficient. The enrollee must receive the notice in the mail within 72 hours. When the determination is adverse, the Medicare health plan must mail written confirmation of its determination within 3 calendar days after providing oral notification, if applicable; and

- The Medicare health plan will extend the 72-hour time frame by up to 14 calendar days if the enrollee requests the extension. The Medicare health plan also may extend the time frame by up to 14 calendar days if the organization justifies a need for additional information and documents how the delay is in the interest of the enrollee. When the Medicare health plan extends the time frame, it must notify the enrollee in writing of the reasons for the delay, and inform the enrollee of the right to file an expedited grievance if he or she disagrees with the Medicare health plan's decision to grant an extension. The Medicare health plan must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than the expiration of the extension.

50.5 - Notification of the Result of an Adverse Expedited Organization Determination

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

The Medicare health plan must use approved notice language in Appendix 1. The standardized denial notice form has been written in a manner that is understandable to the enrollee and must provide:

- The specific reason for the denial that takes into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any;

- Information regarding the enrollee's right to a standard or expedited reconsideration and the right to appoint a representative to file an appeal on the enrollee's behalf;

- A description of both the standard and expedited reconsideration processes should include conditions for obtaining an expedited reconsideration, and the other elements of the appeals process; and

- The beneficiary's right to submit additional evidence in writing or in person.

If the Medicare health plan first notifies an enrollee of an adverse expedited determination orally, mail written confirmation to the enrollee within 3 calendar days of the oral notification.

60 - Appeals

60.1 - Parties to the Organization Determination for Purposes of an Appeal

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

The parties to an organization determination include:

- The enrollee (including his or her representative);

- An assignee of the enrollee (i.e., a physician or other provider who has furnished a service to the enrollee and formally agrees to waive any right to payment from the enrollee for that service);

- The legal representative of a deceased enrollee's estate; or

- Any other provider or entity (other than the Medicare health plan) determined to have an appealable interest in the proceeding.

Any of these parties can request an appeal, with the exception that only the enrollee (or an enrollee's representative) or a physician can request an expedited organization determination (that does not involve a request for payment of services).

60.1.1 - Representatives Filing Appeals for Enrollees

(Rev. 88; Issued: 09-21-07; Effective/Implementation Dates: 09-21-07)

Individuals who represent enrollees may either be appointed or authorized (for purposes of this chapter [and the definition under 42 CFR Part 422, Subpart M], they are both referred to as "representatives"). An enrollee may appoint any individual (such as a relative, friend, advocate, an attorney, or any physician) to act as his or her representative and file an appeal on his or her behalf. Also, a representative (surrogate) may be authorized by the court or act in accordance with State law to file an appeal for an enrollee. A surrogate could include, but is not limited to, a court appointed guardian, an individual who has Durable Power of Attorney, or a health care proxy, or a person designated under a health care consent statute. To be appointed by an enrollee, both the enrollee making the appointment and the representative accepting the appointment *(including attorneys)* must sign, date, and complete a representative form (for purposes of this section, "representative form" means a Form CMS-1696 Appointment of Representative or other conforming instrument). Due in part to the incapacitated or legally incompetent status of an enrollee, a surrogate is not required to produce a representative form. Instead, he or she must produce other appropriate legal papers supporting his or her status as the enrollee's authorized representative. Medicare health plans with service areas comprising more than one state should develop internal policies to ensure that they are aware of the different State representation requirements in their service areas.

Either the signed representative form for a representative appointed by an enrollee, or other appropriate legal papers supporting an authorized representative's status, must be included with each appeal. Regarding a representative appointed by an enrollee, unless revoked, an appointment is considered valid for one year from the date that the appointment is signed by both the member and the representative. Also, the representation is valid for the duration of the appeal. A photocopy of the signed representative form must be submitted with future appeals on behalf of the enrollee in order to continue representation. However, the photocopied form is only good for one year after the date of the enrollee's signature. Any appeal received with a photocopied representative form that is more than one year old is invalid to appoint that person as a representative and a new form *(the 07/05 edition of the CMS-1696)* must be executed by the enrollee.

Please note that a new OMB-approved Form CMS-1696, Appointment of Representative (AOR) form (see Appendix 4), contains the necessary elements and conforms to the Privacy Act requirements, and is preferred. For purposes of the Medicare health plan disseminating the AOR form, the prior versions of Form CMS-1696 are obsolete. **Please note that only Sections I, II, and III of the new form apply to the Medicare Advantage program**. However, if another representative form is used, it must contain at least the applicable elements included in the AOR form. Medicare health plans may not require appointment standards beyond those included in the CMS form.

For appeals submitted with the previous edition of Form CMS-1696 - With the issuance of the new OMB-approved Form CMS-1696, Medicare health plans are encouraged to continue accepting appeal requests *that are filed* with the previous edition of the AOR form, with the understanding that the Medicare health plan will obtain a *signed copy of the OMB-approved* Form CMS-1696 *or other conforming instrument* from the enrollee before an appeal decision is sent. Medicare health plans *will* develop procedures to ensure that all representative forms received without the *required* privacy statement are updated. *Plans will complete the appeal within the appropriate time frame. However, if the new Form 1696 form is not obtained within the appeal decision-making time frame, plus extension, the plan will notify the purported representative that the completed review (including the decision letter) will be sent to the IRE for dismissal.*

For appeals submitted either without a representative form or with a defective representative form (except as noted above) - It is the Medicare health plan's obligation to inform the enrollee and purported representative, in writing, that the reconsideration request will not be considered until the appropriate documentation is provided. For expedited requests, the Medicare health plan must develop procedures to ensure that expedited requests are not inappropriately delayed. When a request for reconsideration is filed by a person claiming to be a representative, but the representative does not provide appropriate documentation upon the Medicare health plan's request, the Medicare health plan must make, and document, its reasonable efforts to secure the necessary documentation. The Medicare health plan *must* not undertake a review until or unless such documentation is obtained. The time frame for acting on a reconsideration request commences when the documentation is received. However, if the Medicare health plan does not receive the documentation by the conclusion of the appeal time frame, plus extension, the Medicare health plan *must* forward the case to the independent review entity with a request for dismissal. The Medicare health plan must comply with the Independent Review Entity Reconsideration Process Manual section on reconsiderations that fail to meet representative requirements. *Where an appeal initiated by a representative is submitted to the independent review entity, the independent review entity will examine the appeal for compliance with the appointment of representative requirements. The independent review entity may dismiss cases in which a required representative form is absent or defective.* (See note regarding reviews performed by QIOs in §90.10.)

A provider, physician, or supplier may not charge an enrollee for representation in an appeal. Administrative costs incurred by a representative during the appeals process are not reasonable costs for Medicare reimbursement purposes.

60.1.2 - Authority of a Representative

(Rev. 88; Issued: 09-21-07; Effective/Implementation Dates: 09-21-07)

A representative may:

- Obtain information about the enrollee's claim *or grievance* to the extent consistent with current Federal and state law;

- Submit evidence;

- Make statements of fact and law; and

- Make any request, or give or receive any notice about the appeal *or grievance* proceedings.

60.1.3 - Notice Delivery to Representatives

(Rev. 88; Issued: 09-21-07; Effective/Implementation Dates: 09-21-07)

NOTE: *This section applies to a representative receiving written notification of organization determinations or service terminations. Signature requirements discussed below do not apply to organization determination notices.*

The CMS requires that notification of changes in coverage for an enrollee who is not competent be made to a representative of the enrollee. Notification to the representative may be problematic because that person may not be available in person to acknowledge receipt of the required notification. Medicare health plans are required to develop procedures to use when the enrollee is incapable of receiving or incompetent to receive the notice, and the Medicare health plan cannot obtain the signature of the enrollee's representative through direct personal contact.

Regardless of the competency of an enrollee, if the Medicare health plan is unable to personally deliver a notice of non-coverage to a representative, then the Medicare health plan *must* telephone the representative to advise him or her when the enrollee's services will no longer be covered. The Medicare health plan must *identify itself to the representative and provide a contact number for questions about the plan. It must describe the purpose of the call which is to* inform the representative about the right to file an appeal. The information provided *must* at a minimum, include the following:

- The date services end, and when the enrollee's liability begins;

- How to get a copy of a detailed notice describing why the enrollee's services are not being provided;

- A description of the particular appeal right being discussed (e.g., QIO vs expedited);

- When (by what time/date) the appeal must be filed to take advantage of the particular appeal right;

- The entity required to receive the appeal, including any applicable name, address, telephone number, fax number or other method of communication the entity requires in order to receive the appeal in a timely fashion;

- Provide at least one telephone number of an advocacy organization, or 1-800-MEDICARE that can provide additional assistance to the representative in further explaining and filing the appeal; and

- Additional documentation that confirms whether the representative, in the writer's opinion, understood the information provided.

The date the Medicare health plan conveys this information to the representative, whether in writing or by telephone, is the date of receipt of the notice.

Confirm the telephone contact by written notice mailed on that same date. Place a dated copy of the notice in the enrollee's medical file, and document the telephone contact with the member's representative (as listed above) on either the notice itself, or in a separate entry in the enrollee's file or attachment to the notice. The documentation *will* indicate that the staff person told the representative the date the enrollee's financial liability begins, the enrollee's appeal rights, and how and when to initiate an appeal. Also include the name, *organization and contact number* of the staff person initiating the contact, the name of the representative contacted by phone, the date and time of the telephone contact, and the telephone number called.

When direct phone contact cannot be made, send the notice to the representative by certified mail, return receipt requested. The date that someone at the representative's address signs (or refuses to sign) the receipt is the date received. Place a copy of the notice in the enrollee's medical file, and document the attempted telephone contact to the members' representative. The documentation *will* include: the name, *organization and contact number* of the staff person initiating the contact, the name of the representative you attempted to contact, the date and time of the attempted call, and the telephone number called. When the return receipt is returned by the post office with no indication of a refusal date, then the enrollee's liability starts on the second working day after the Medicare health plan's mailing date. The form instructions accompanying a denial notice may also contain pertinent information regarding delivery to enrollees or their representatives. Plans and providers *will* consider such instructions as manual guidance.

NOTE: References to Medicare health plans also apply to delegated entities, as applicable

60.1.4 - Non-Contracted Provider Appeals

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

A non-contracted provider, on his or her own behalf, is permitted to file a standard appeal for a denied claim only if the provider completes a waiver of liability statement, which provides that the provider will not bill the enrollee regardless of the outcome of the appeal. See Appendix 6.

Physicians and suppliers who have executed a waiver of beneficiary liability are not required to complete the CMS-1696, Appointment of Representative, form. In this case,

the physician or supplier is not representing the beneficiary, and thus does not need a written appointment of representation.

When a non-contracted provider files a request for reconsideration of a denied claim but the provider does not submit the waiver of liability documentation upon the Medicare health plan's request, the Medicare health plan must make, and document, its reasonable efforts to secure the necessary waiver of liability form. The Medicare health plan should not undertake a review until or unless such form is obtained. The time frame for acting on a reconsideration request commences when the properly executed waiver of liability form is received. However, if the Medicare health plan does not receive the form by the conclusion of the appeal time frame, the Medicare health plan should forward the case to the independent review entity with a request for dismissal. The Medicare health plan must comply with the IRE's Reconsideration Process Manual section on reconsiderations that fail to meet provider-as-party requirements.

70 - Reconsideration

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

The Medicare health plan's denial notice must inform the enrollee of his/her right to a reconsideration and the right to be represented by an attorney or other representative in the reconsideration process. Instructions on how and where to file a request for reconsideration must also be included. In addition, the member handbook or other materials must include information about free legal services available for qualified individuals. The reconsideration consists of a review of an adverse organization determination or termination of services decision, the evidence and findings upon which it was based, and any other evidence that the parties submit or that is obtained by the Medicare health plan, the QIO, or the independent review entity.

70.1 - Who May Request Reconsideration

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

Any party to an organization determination (including a reopened and revised determination), i.e., an enrollee, an enrollee's representative or a non-contracted physician or provider to the Medicare health plan, or a termination of services decision, may request that the determination be reconsidered. However, contracted providers do not have appeal rights. An enrollee, an enrollee's representative, or physician (regardless of whether the physician is affiliated with the Medicare health plan) on the other hand, are the only parties who may request that an Medicare health plan expedite a reconsideration.

When a non-contracted physician or provider seeks a standard reconsidered determination for purposes of obtaining payment only, then the non-contracted physician or provider must sign a waiver of liability, i.e., the non-contracted physician or provider formally agrees to waive any right to payment from the enrollee for a service.

70.2 - How to Request a Standard Reconsideration

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

A party may request a standard reconsideration by filing a signed, written request with the Medicare health plan. Except in the case of an extension of the filing time frame, a party must file the request for reconsideration within 60 calendar days from the date of the notice of the organization determination. If a Medicare health plan chooses to accept an oral reconsideration, the Medicare health plan should be aware that the timeframe for processing the reconsideration begins with acceptance of the oral request. The following steps should be taken:

- The request should be recorded in the enrollee's own words, repeated back to the member to confirm the accuracy, and placed into a tracking system;

- If a department other than one that responds to appeals receives the request, it should forward the request to the appropriate department handling appeals;

- The department handling appeals should mail an acknowledgement letter to the enrollee to confirm the facts and basis of the appeal, and request that the enrollee sign and return the acknowledgement letter. The letter must explain that until the acknowledgement letter is returned, no final decision can be issued;

- The Medicare health plan should not issue a final decision on the appeal until it receives the signed acknowledgement letter, or other signed document relevant to the appeal request; and

- If the Medicare health plan does not receive a returned, signed acknowledgement by the conclusion of the appeal timeframe, plus extension, the Medicare health plan should forward the case to the independent review entity with a request for dismissal.

70.3 - Good Cause Extension

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

If a party shows good cause, the Medicare health plan may extend the time frame for filing a request for reconsideration. The Medicare health plan should consider the circumstance that kept the enrollee or representative from making the request on time and whether any organizational actions might have misled the enrollee. Examples of circumstances where good cause may exist include (but are not limited to) the following situations:

- The enrollee did not personally receive the adverse organization determination notice, or he/she received it late;

- The enrollee was seriously ill, which prevented a timely appeal;

- There was a death or serious illness in the enrollee's immediate family;
- An accident caused important records to be destroyed;
- Documentation was difficult to locate within the time limits;
- The enrollee had incorrect or incomplete information concerning the reconsideration process; or
- The enrollee lacked capacity to understand the time frame for filing a request for reconsideration.

The party requesting the good-cause extension may file the request with the Medicare health plan in writing, including the reason why the request was not filed timely. If the Medicare health plan denies an enrollee's request for a good cause extension, the enrollee may file a grievance with the Medicare health plan.

70.4 - Withdrawal of Request for Reconsideration

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

The party who files a request for reconsideration may withdraw the request at any time before a decision is mailed by writing to the Medicare health plan.

If a written withdrawal request is received by a Medicare health plan before the organization has made its reconsideration decision, then the organization may withdraw the appeal. However, if the withdrawal request is received after the Medicare health plan has forwarded a reconsideration case to the independent review entity (IRE), then the organization must forward the withdrawal request to the IRE for processing

70.5 - Opportunity to Submit Evidence

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

The Medicare health plan must provide the parties to the reconsideration reasonable opportunity to present evidence and allegations of fact or law related to the issues in dispute. Parties must be allowed to present such evidence in person or in writing. However, the enrollee is not required to submit additional evidence, but may exercise this right if the enrollee chooses.

The Medicare health plans must take the evidence into account when making a decision. In addition, the Medicare health plan must, upon an enrollee's request, provide the enrollee with a copy of the contents of the case file, including but not limited to, a copy of supporting medical records and other pertinent information used to support the decision. The Medicare health plan must abide by all applicable Federal and state laws regarding confidentiality and disclosure for mental health records, medical records, or

other health information. See 45 CFR 164.500 et. seq. (regarding the privacy of individually identifiable health information).

The Medicare health plan must make every reasonable effort to accommodate an enrollee's request for case file material including, but not limited to, allowing the enrollee or authorized representative to obtain the material at a plan location (such as the office of a plan physician or other provider with whom the Medicare health plan has a business relationship) or mailing the material to any address specified by the enrollee or authorized representative. The Medicare health plan shall have the right to charge the enrollee a reasonable amount (e.g., comparable to charges established by a QIO) for duplicating the case file material. At the time the request for case file material is made, the Medicare health plan should inform the enrollee of the per page duplicating cost, and based on the extent of the case file material requested, provide a learned estimate of the total duplicating cost for which the enrollee will be responsible. The Medicare health plan may also charge the enrollee the cost of mailing the material to the address specified. The Medicare health plan may not charge the enrollee an additional cost for courier delivery of the material to a plan location that would be over and above the cost of mailing the material to the enrollee.

In the case of an expedited reconsideration, the opportunity to present evidence is limited by the short time frame for making a decision. Therefore the Medicare health plan must inform the parties of the conditions for submitting the evidence, including reminding the enrollee that a 14 calendar day extension can be given if the enrollee feels he/she will need additional time.

70.6 - Who Must Reconsider an Adverse Organization Determination

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

The Medicare health plan must designate someone other than the person involved in making the initial organization determination when reviewing a reconsideration. If the original denial was based on a lack of medical necessity, then the reconsideration must be performed by a physician with expertise in the field of medicine that is appropriate for the services at issue.

In cases involving emergency services, the Medicare health plan must apply the prudent layperson standard when making the reconsideration determination.

70.6.1 - Meaning of Physician With Expertise in the Field of Medicine

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

The physician need not, in all cases, be of the same specialty or subspecialty as the treating physician. The physician must, however, possess the appropriate level of training and expertise to evaluate the necessity of the service. This does not require that the physician always possess identical specialty training.

For example, there may be situations where only one specialist practices in a rural area, and therefore, it would not be possible for the Medicare health plan to obtain a second reviewer with expertise in the same specialty. In addition, there may be some situations where there are few practitioners in highly specialized fields of medicine. Under these types of circumstances, it may not be possible to get physicians of the same specialty or sub-specialty involved in the review of the adverse organization determination.

70.7. - Time Frames and Responsibilities for Conducting Reconsiderations

70.7.1 - Standard Reconsideration of the Denial of a Request for Service

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

Upon reconsideration of an adverse organization determination, the Medicare health plan must make its reconsidered determination as expeditiously as the enrollee's health condition requires. This must be no later than 30 calendar days from the date the Medicare health plan receives the request for a standard reconsideration. The time frame will be extended by up to 14 calendar days by the Medicare health plan if the enrollee requests the extension or also may be extended by up to 14 calendar days if the organization justifies a need for additional information and documents how the delay is in the interest of the enrollee. When the Medicare health plan extends the time frame, it must notify the enrollee in writing of the reasons for the delay, and inform the enrollee of the right to file an expedited grievance if he or she disagrees with the Medicare health plan's decision to grant itself an extension. When extensions are used, the organization must issue and effectuate its determination as expeditiously as the enrollee's health condition requires, but no later than upon the expiration date of the extension.

Occasionally, the Medicare health plan may not have complete documentation for a reconsideration request. The organization must make reasonable and diligent efforts to obtain all necessary medical records and other pertinent information within the required time limits. If the Medicare health plan cannot obtain all relevant documentation, it must make the decision based on the material available.

70.7.2 - Affirmation of a Standard Adverse Organization Determination

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06))

If the Medicare health plan makes a reconsidered determination that affirms in whole or in part, its adverse organization determination, it must prepare a written explanation and send the complete case file to the independent review entity contracted by CMS. This must be completed as expeditiously as the enrollee's health condition requires, but no later than 30 calendar days from the date the Medicare health plan receives the request for a standard reconsideration, or no later than the end of any extension. The Medicare health plan must make reasonable and diligent efforts to gather and forward all pertinent information to the independent review entity. The Medicare health plan must also notify the enrollee that the case has been forwarded to the independent review entity.

If CMS determines that the Medicare health plan has a pattern of not making a reasonable and diligent effort to gather and forward information to the independent review entity, the Medicare health plan will be considered to be in breach of its Medicare contract.

70.7.3 - Standard Reconsideration of the Denial of a Request for Payment

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

If upon reconsideration the Medicare health plan overturns its adverse organization determination denying an enrollee's request for payment, then the Medicare health plan must issue its reconsidered determination and send payment for the service to the enrollee. This must be mailed no later than 60 calendar days from the date it received the request for a standard reconsideration.

If the Medicare health plan affirms, in whole or in part, its adverse organization determination (i.e., continues to deny payment in whole or in part), it must prepare a written explanation and send the complete case file to the independent review entity contracted by CMS. This must be completed no later than 60 calendar days from the date it receives the request for a standard reconsideration. The Medicare health plan must make reasonable and diligent efforts to gather and forward information to the independent review entity. The Medicare health plan must also notify the enrollee that the case has been forwarded to the independent review entity. If CMS determines that the Medicare health plan has a pattern of not making a reasonable and diligent effort to gather and forward information to the independent review entity, the Medicare health plan will be considered to be in breach of its Medicare contract.

70.7.4 - Effect of Failure to Meet the Time Frame for Standard Reconsideration

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

If the Medicare health plan fails to provide the enrollee with a reconsidered determination within the time frames specified in section 80.4 this failure constitutes an affirmation of the adverse organization determination. In this case, the Medicare health plan must submit the complete file to the independent review entity, according to the procedures set forth in section 80.5. If CMS determines that the Medicare health plan has a pattern of not concluding its standard reconsiderations within the required time frames or not making reasonable and diligent effort to gather and forward information to the independent review entity, then the Medicare health plan will be considered to be in breach of its Medicare contract.

70.7.5 - Dismissal of a Standard Pre-Service Reconsideration

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

If an enrollee has requested a standard pre-service reconsideration but the Medicare health plan becomes aware that the enrollee has obtained the service before the Medicare health plan completes its reconsideration determination, the Medicare health plan should dismiss the pre-service reconsideration request since the provision of the service is now moot. The pre-service reconsideration processing stops, and the organization forwards the appeal case with supporting documentation to the IRE for dismissal. When the bill is submitted for payment to the Medicare health plan, the organization should make its determination on whether to pay for the service. If the Medicare health plan denies payment, it will then issue either an NDP or system generated explanation of enrollee's benefit and applicable appeal rights.

If the Medicare health plan does not become aware that the enrollee has already received the service (after the enrollee submitted the pre-service reconsideration) and the organization continues to deny the pre-service reconsideration and forwards the appeal case to the IRE, if the IRE receives information indicating that the service has already been obtained, the IRE will dismiss the pre-service reconsideration request.

80 - Expediting Certain Reconsiderations

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

General Reconsiderations

An enrollee or any physician (regardless of whether the physician is affiliated with the Medicare health plan) may request that a Medicare health plan expedite a reconsideration of a determination, in situations where applying the standard procedure could seriously jeopardize the enrollees life, health, or ability to regain maximum function, including cases in which the Medicare health plan makes a less than fully favorable decision to the enrollee. In light of the short time frame for deciding expedited reconsiderations, a physician does not need to be an authorized representative to request an expedited reconsideration on behalf of the enrollee. A request for payment of a service already provided to an enrollee is not eligible to be reviewed as an expedited reconsideration.

To ask for an expedited reconsideration, an enrollee or a physician must submit an oral or written request directly to the organization or entity responsible for making the reconsideration. A physician may provide oral or written support for a request made by an enrollee for an expedited reconsideration. The Medicare health plan must provide an expedited determination if a physician indicates (the physician does not have to use the exact words) that applying the standard time frame could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Certain Provider Setting Reconsiderations (SNF, HHA, and CORF)

When an enrollee misses the deadline for filing for an immediate QIO review of a SNF, HHA, or CORF termination decision, the enrollee may request that the Medicare health plan perform an expedited reconsideration. Before accepting a request for an expedited reconsideration, Medicare health plans must distinguish, by determining the appropriate

time frame, between misdirected requests for reviews that should go to the QIO, and those expedited reconsideration requests that are being filed because the window for filing the request to the QIO has elapsed. The Medicare health plans should establish the appropriate time frame for either accepting or forwarding requests for expedited reconsiderations by the following:

- If the Medicare health plan receives the request for expedited reconsideration earlier than noon of the day following the date of the advance termination notice, the Medicare health plan should contact the QIO and inform the QIO that the enrollee wishes to file an immediate QIO review of a termination from a SNF, HHA or CORF. The Medicare health plan must subsequently forward a detailed notice and the case file to the QIO. A copy of the detailed notice should also be sent to the enrollee, or

- If the QIO time frame for considering the appeal has elapsed, the Medicare health plan may consider the request as an expedited reconsideration to be processed by the Medicare health plan. The Medicare health plans should process these requests under the expedited appeal procedures. If the reconsideration request is forwarded to the QIO, then the Medicare health plan should educate the enrollee about his or her appeal rights to a QIO.

80.1 - How the Medicare Health Plan Processes Requests for Expedited Reconsiderations

(Rev. 88; Issued: 09-21-07; Effective/Implementation Dates: 09-21-07)

The *plan* must establish and maintain procedures for expediting reconsiderations. These include establishing an efficient and convenient method for individuals to submit oral or written requests for expedited appeals, documenting oral requests, and maintaining the documentation in the case file. The Medicare health plan must designate an office and/or department to receive both oral or written requests and a telephone number for oral requests, and may include a facsimile number to facilitate receipt of requests for expedited appeals. The Medicare health plan must promptly decide whether to expedite or follow the time frame for standard reconsiderations.

If a Medicare health plan denies a request for an expedited reconsideration, it must automatically transfer the request to the standard reconsideration process and then make its determination as expeditiously as the enrollee's health condition requires, but no later than within 30 calendar days from the date the Medicare health plan received the request for expedited reconsideration. The Medicare health plan must also provide the enrollee with prompt oral notice of the denial of the request for reconsideration and the enrollee's rights, and subsequently mail to the enrollee within 3 calendar days of the oral notification, a written letter that:

- Explains that the Medicare health plan will automatically transfer and process the request using the 30-day time frame for standard reconsiderations;

- Informs the enrollee of the right to file an expedited grievance if he or she disagrees with the organization's decision not to expedite the reconsideration;

- Informs the enrollee of the right to resubmit a request for an expedited reconsideration and that if the enrollee gets any physician's support indicating that applying the standard time frame for making a determination could seriously jeopardize the enrollee's life, health or ability to regain maximum function, the request will be expedited automatically; and

- Provides instructions about the grievance process and its time frames.

If the Medicare health plan approves a request for an expedited reconsideration, then it must complete the expedited reconsideration and give the enrollee (and the physician involved, as appropriate) notice of its reconsideration as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receiving the request. While the Medicare health plan may notify the enrollee orally or in writing, the enrollee must be notified within the 72 hour time frame. Mailing the notice within 72 hours in and of itself is insufficient. The enrollee must receive the notice within 72 hours. *If the plan first notifies the enrollee orally of a completely favorable expedited reconsideration, it must mail written confirmation to the enrollee within 3 calendar days. When the reconsideration is adverse the plan must mail written confirmation of its reconsideration within 3 calendar days after providing oral notification, if applicable.*

If the request is made or supported by a physician, the Medicare health plan must grant the expedited reconsideration request if the physician indicates (the physician does not have to use this exact language in his or her oral or written request or support of the request) that the life or health of the enrollee, or the enrollee's ability to regain maximum function could be seriously jeopardized by applying the standard time frame in the processing of the reconsideration request. For an enrollee request not supported by a physician, the Medicare health plan must determine whether the life or health of the enrollee, or the enrollee's ability to regain maximum function, could be seriously jeopardized by applying the standard time frame in the processing of the reconsideration request.

The 72-hour time frame must be extended by up to 14 calendar days if the enrollee requests the extension. The time frame also may be extended by up to 14 calendar days if the Medicare health plan justifies a need for additional information and documents how the extension is in the interest of the enrollee, e.g., the receipt of additional medical evidence from a non-contracted provider may change a Medicare health plan's decision to deny. When the Medicare health plan extends the time frame, it must notify the enrollee in writing of the reasons for the extension, and inform the enrollee of the right to file an expedited grievance if he or she disagrees with the Medicare health plan's decision to grant an extension. The Medicare health plan must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than the last day of the extension.

If the Medicare health plan requires medical information from non-contracted providers, the Medicare health plan must request the necessary information from the non-contracted

provider within 24 hours of the initial request for an expedited reconsideration. Non-contracted providers must make reasonable and diligent efforts to expeditiously gather and forward all necessary information to assist the Medicare health plan in meeting the required time frame. Regardless of whether the Medicare health plan must request information from non-contracted providers, the Medicare health plan is responsible for meeting the same time frame and notice requirements as it does with contracting providers.

If an enrollee misses the noon deadline to file for immediate QIO review of an inpatient hospital discharge, then the enrollee may request an expedited reconsideration with the Medicare health plan. While a Medicare health plan uses discretion as to whether to expedite a request, the Medicare health plan is encouraged to automatically expedite all requests to appeal inpatient hospital discharges. Additionally, the Medicare health plan is encouraged to automatically expedite all requests to appeal skilled nursing facility (SNF), home health (HHA) and Comprehensive Outpatient Rehabilitation Facility (CORF), and physical therapy reductions, discontinuations and terminations.

80.2 - Effect of Failure to Meet the Time Frame for Expedited Reconsideration

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

If a Medicare health plan does not notify the enrollee within the required time frames set forth in this chapter for expedited reconsideration, this constitutes an adverse decision. In this case the Medicare health plan must submit the complete file to the independent review entity according to the procedures set forth in this chapter. If CMS determines that the Medicare health plan has a pattern of not concluding its expedited reconsiderations within the required time frames or not making reasonable and diligent efforts to gather and forward information to the independent review entity, then the Medicare health plan will be considered to be in breach of its Medicare contract.

80.3 - Forwarding Adverse Reconsiderations to the Independent Review Entity

(Rev. 88; Issued: 09-21-07; Effective/Implementation Dates: 09-21-07)

If a Medicare health plan affirms the adverse organization determination (in whole or in part) it must submit a written explanation with the complete case file to the independent review entity contracted by CMS within the time frames appropriate for standard and expedited cases, as set forth in this chapter. The Medicare health plan must submit a hard copy case file to the independent review entity by mail or overnight delivery service at its designated address. *R*efer to the independent review entity's Reconsideration Process Manual for additional instructions. *See the independent review entity's Web site at www.medicareappeals.com.*

The Medicare health plan must notify the enrollee that it has forwarded the case to the independent entity for review. The notice also must advise the enrollee of his/her right to submit additional evidence that may be pertinent to the enrollee's case, if the enrollee

chooses. The notice must direct the enrollee to submit such evidence to the independent review entity, and must include information on how to contact the independent review entity. CMS has developed a model notice that Medicare health plans can use to notify enrollees whenever cases are forwarded to the independent review entity, (see *Appendix 10*). Note that substantive changes to the model notice language must be approved in accordance with regional office marketing procedures.

80.4 - Time Frames for Forwarding Adverse Reconsiderations to the Independent Review Entity

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

The Medicare health plan must forward the enrollee's case file within the following regulatory time frames:

- For standard requests for service, the Medicare health plan must forward an enrollee's case file to the independent review entity as expeditiously as the enrollee's health condition requires. This must be completed no later than 30 calendar days from the date the Medicare health plan receives the enrollee's request for reconsideration (or no later than upon the expiration of an extension);

- For expedited reconsiderations, the Medicare health plan must forward the enrollee's case file to the independent review entity as expeditiously as the enrollee's health condition requires, but no later than within 24 hours of affirmation of its adverse expedited organization determination; and

- For requests for payment, the Medicare health plan must forward the enrollee's case file to the independent review entity no later than 60 calendar days from the date it receives the request for a standard reconsideration.

80.5 - Preparing the Case File for the Independent Review Entity

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

Give each file a separate folder, labeled with the member's name and Health Insurance Claim (HIC) number.

The actual case file will contain:

- An Appeal Transmittal Cover Sheet on top of the case file, so that the independent review entity can clearly differentiate new cases from other incoming materials;

- Reconsideration Background Data Form, which is a standard data collection document with supplementary narrative description and attachments; and

- Case Narrative.

Medicare health plans should refer to the most current version of the Independent Review Entity's Reconsideration Process Manual for information concerning the Appeal Transmittal Cover Sheet and the Reconsideration Background Data Form. **Medicare health plans are expected to fully complete all appropriate sections of the Reconsideration Background Data Form in support of CMS' appeals data collection activities.**

90 - Reconsiderations by the Independent Review Entity

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

The independent review entity must conduct the reconsideration as expeditiously as the enrollee's health condition requires and should observe the same time frames as required for Medicare health plans. When the independent review entity conducts its reconsideration, the parties to the reconsideration are the parties listed in section 60.1 of this chapter as well as the Medicare health plan.

When the independent review entity completes its reconsidered determination, it is responsible for notifying all the parties of the reconsidered determination, and for sending a copy of the reconsidered determination to the appropriate CMS Regional Office.

The determination notice of the independent review entity must be stated in understandable language and in a culturally competent manner taking into account the enrollees presenting medical condition, disabilities, and special language requirements, if any, and:

- Include specific reasons for the entity's decisions;

- Inform parties, other than the Medicare health plan of their right to an ALJ hearing if the amount in controversy meets the appropriate threshold requirement, and if the decision is adverse (i.e., does not completely reverse the organization's adverse determination); and

- Describe procedures that the parties must follow to obtain an ALJ hearing.

90.1 - Storage of Appeal Case Files by the Independent Review Entity

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

The CMS' independent review entity stores the appeal case files for a period of seven years from the end of the calendar year in which final action is taken. The inventory of case files include the reconsideration case files forwarded from the Medicare health plan and processed by the independent review entity which are not appealed further, as well as ALJ hearing case files returned to the independent review entity.

90.2 - QIO Expedited Reviews of Coverage Terminations in Certain Provider Settings (SNF, HHA, and CORF)

(Rev. 88; Issued: 09-21-07; Effective/Implementation Dates: 09-21-07)

NOTE: Unlike cost plans, HCPPs are not regulated by the rules contained in 42 CFR 422.624-626, §§90.2-90.*10*. The HCPP enrollees follow the original Medicare expedited review process contained in *42 CFR Part 405*.

Enrollees have the right to an expedited review by a Quality Improvement Organization (QIO) when they disagree with their Medicare health plan's decision that Medicare coverage of their services from a skilled nursing facility (SNF), home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF) should end. When a Medicare health plan has approved coverage (which includes a plan or plan provider directing an enrollee to seek care from a non-contracted provider/facility) of an enrollee's admission to a SNF, or coverage of HHA or CORF services, the enrollee must receive a Notice of Medicare Non-Coverage (NOMNC) at least 2 days in advance of the services ending. *Note that where a representative has been appointed, or assumes responsibility for decision-making on the enrollee's behalf, health plans must ensure that the representative receives all required notifications. Plans also may provide an additional copy of such communications to the enrollee.*

Additionally, for services provided in a facility or by a provider that is part of the Medicare health plan's contracted network, an enrollee must receive a NOMNC 2 days in advance of the services ending. The right to expedited review stems from the Grijalva lawsuit, and was established in regulations in a Final Rule published on April 4, 2003, (68 FR 16,652). If the enrollee does not agree that covered services should end, the enrollee may appeal by requesting an expedited review of the case by the QIO in the State where the services are being provided. The enrollee's Medicare health plan must then furnish a Detailed Explanation of Non-coverage (DENC) explaining why services are no longer necessary or covered on the day the QIO notifies the plan of the appeal. The review process generally will be completed within less than 48 hours of the enrollee's request for a review. The notification and appeal procedures distribute responsibilities among four parties:

- The Medicare health plan generally is responsible for determining the discharge date and providing, upon request, a detailed explanation of termination of services. Medicare health plans must coordinate with SNFs, HHAs, or CORFs by providing the termination date as early in the day as possible to allow for timely delivery of the NOMNC. (Medicare health plans may choose to delegate these responsibilities to their contracted providers, or make arrangements with non-contracted providers if the Medicare health plan is responsible for the enrollee utilizing the non-contracted provider, understanding that the Medicare health plan is ultimately responsible/liable for the provider's decisions);

- The provider is responsible for delivering the NOMNC on behalf of a Medicare health plan no later than 2 days before an enrollee's covered services end;

- The patient/managed care enrollee (or representative) is responsible for acknowledging receipt of the NOMNC and contacting the QIO (within the specified timelines) if he or she wishes to obtain an expedited review;

- The QIO is responsible for immediately contacting the Medicare health plan and the provider if an enrollee requests an expedited review and for making a decision on the case by no later than close of business the day after the QIO receives the information necessary to make the decision; and

- A QIO, when acting as an independent review entity, for purposes of the expedited review process, may receive and review records from a provider or Medicare health plan. Medicare health plans must comply with such requests for *information by the QIO.*

Please note that since QIOs must be available both to receive and respond to an enrollee's appeal request at all times, plans may need to make arrangements to provide a response to QIO requests for records as well as a detailed notice (DENC) to the enrollee. However, plans that receive a request for records due to an early appeal request from an enrollee (i.e., prior to 2 days before services end) have until close of business the day before the effective date that Medicare coverage ends to provide the records to the QIO.

90.3 - Notice of Medicare Non-Coverage (NOMNC)

(Rev. 88; Issued: 09-21-07; Effective/Implementation Dates: 09-21-07)

The NOMNC is an OMB-approved standardized notice (see Appendix 7). The NOMNC is a written notice designed to inform Medicare enrollees that their covered SNF, HHA, or CORF care is ending. (See Appendix 7.) The NOMNC meets the notice requirements set forth at 42 CFR 422.624(b)(2).

All enrollees receiving covered SNF, HHA or CORF services must receive a NOMNC upon termination of services, even if they agree that services should end. The notice may be delivered earlier, but must be delivered no later than 2 days prior to the proposed termination of services. Although Medicare health plans are responsible for either making or delegating the decision to end services, SNFs, HHAs, and CORFs are responsible for delivering the notices to enrollees. A provider may formally delegate to an agent the delivery of the NOMNC under the following conditions:

- The agent must agree in writing that it will deliver the notice on behalf of the provider;

- The agent must adhere to all preparation, timing and valid delivery requirements for the notice as described in §§90.4 and 90.5 of this chapter *as applicable;* and.

- The provider remains ultimately responsible for the valid delivery of the NOMNC. (See §90.4.)

Providers (or agents) that deliver the NOMNC must insert the following patient-specific information:

- The enrollee's name;
- The date that coverage of services ends.

The notice *must* also identify and provide the telephone number of the appropriate QIO. All other required elements of the notice are included in the standardized material on the notice. The provider also has the option to include (or an agent to include) additional information in the space provided on the notice. Note that completion of this section of the standardized notice is optional, and does not substitute for delivery of a Detailed Explanation of Non-Coverage (DENC) which is required when an enrollee invokes his or her appeal rights.

The NOMNC *is* not *to* be used when a Medicare health plan determines that an enrollee's services should end based on the exhaustion of Medicare benefits (such as the 100-day SNF limit), *when a single service that does not end the skilled stay ends, and the enrollee disagrees with that determination,* or when an admission to SNF, home health or CORF services is not covered. Instead, Medicare health plans must issue the Notice of Denial of Medical Coverage (NDMC) in these cases (see Appendix 1).

The following examples illustrate typical Fast-Track appeal scenarios.

FAST-TRACK APPEAL SCENARIOS

Scenario 1

On May 25th Mary Jane Anderson is admitted to a SNF for an infection after surgery. On June 2nd, the Medicare health plan contacts the SNF that Anderson no longer needs care and notifies the SNF to deliver an advance notice to Anderson that she will be discharged on June 4th. Anderson decides to appeal.

May 25th	***June 2nd***	***June 3rd***	***June 4th***	***June 5th***
Anderson is admitted to the SNF.	***Advance Notice Distribution Date*** *Anderson receives advance notice that her coverage is ending June 4th.*	*Anderson must file an appeal with the QIO by noon.*	***Advance Notice Effective Date*** *If Anderson appealed, she should receive a decision from the QIO by COB.*	*If Anderson lost the appeal, and continued getting care, she is liable for care starting today.*
	The provider delivers a Notice of Medicare Non-Coverage (NOMNC).	***If Anderson appeals, the QIO notifies the Medicare health plan to provide medical information and the detailed notice to the QIO by COB. The provider may be asked to provide a copy of the signed NOMNC. The provider may also be asked to provide medical records.***	***The QIO makes its decision by COB or one day after it has received the information it needs to decide the case. The decision will either overturn, uphold, or determine a new discharge date. If Anderson is discharged on the 4th, she will likely incur no additional liability.***	***If Anderson won her appeal, the Medicare health plan is liable, and would have to issue a new advance notice, or abide by the discharge date stipulated by the QIO.***

Scenario 2

On May 25th, Mary Jane Anderson is preauthorized to receive care from an HHA. On June 2nd, the Medicare health plan decides that Anderson is well enough to stop receiving services. The Medicare health plan notifies the HHA to deliver an advance notice to Anderson that she will be terminated from services on June 4th. Anderson decides to appeal.

May 25th	***June 2nd***	***June 3rd***	***June 4th***	***June 5th***
Anderson is beginning a preauthorized course of care.	***Advance Notice Distribution Date*** *Anderson receives advance notice of termination.* ***The effective date on the notice she has been given is June 4th.***	*Anderson must file an appeal with the QIO by noon.*	***Advance Notice Effective Date*** *If Anderson appealed, she should receive a decision from the QIO by COB*	*If Anderson lost the appeal, and continued getting care, she is liable for care starting today.*
	The provider delivers a Notice of Medicare Non-Coverage (NOMNC)	***If Anderson appeals, the QIO notifies the Medicare health plan to provide medical information and the detailed notice to the QIO by COB. The provider may be asked to provide a copy of the signed NOMNC. The provider may also be asked to provide medical records.***	***The QIO makes its decision by COB or one day after it has received the information it needs to decide the case. The decision will either overturn, uphold or determine a new termination date. If Anderson receives no services after this date, she has no liability.***	***If Anderson won her appeal, the Medicare health plan is liable, and would have to issue a new advance notice, or abide by the discharge date stipulated by the QIO.***

This scenario can apply to either an HHA or CORF.

90.4 - Meaning of Valid Delivery

(Rev. 88; Issued: 09-21-07; Effective/Implementation Dates: 09-21-07)

Valid delivery generally means that the enrollee must be able to sign the NOMNC to acknowledge receipt of the form. The enrollee must be able to understand that he or she may appeal the termination decision. Valid delivery does not preclude the use of assistive devices, witnesses, or interpreters for notice delivery. Thus, if an enrollee is able to comprehend the notice, but either is physically unable to sign it, or needs the assistance of an interpreter to translate it or an assistive device to read or sign it, valid delivery may be achieved by documenting the use of such assistance. Furthermore, if the enrollee refuses to sign the notice, the notice is still valid as long as the provider documents that the notice was given, but the enrollee refused to sign.

Except in rare circumstances, CMS believes valid delivery is best accomplished by face-to-face contact with the enrollee. However, if the enrollee is not able to comprehend the contents of the notice, it must be delivered to and signed by the enrollee's representative. If a representative is not available to receive and sign the notice in person, the procedures set forth in §60.1.3 are applicable. Occasionally, circumstances may prevent physical delivery of the NOMNC to an enrollee or the representative by a *Medicare health* plan or provider, creating the need to use an alternate delivery method. In these cases, the Medicare health plan or provider must document the reason for employing this alternative. QIOs will review the documentation provided to assess whether delivery was appropriate.

Valid delivery also requires delivery of an OMB approved notice consistent with either the standardized OMB-approved original notice format, or a regional office approved variation of the OMB approved format. Details regarding what constitutes an approved variation of an OMB approved format are included in the form instructions, in FAQs (see Appendix 9), these plan manual instructions, and the appendices.

In general, notices are valid when all patient specific information required by the notice is included, and any non-conformance is minor i.e., it does not change the meaning of the notice or the ability to request an appeal. For example, misspelling the word "health" is a minor non-conformance of the notice that would not invalidate the notice. However, a transposed phone number on the notice would not be considered a minor non-conformance since the enrollee would not be able to contact the QIO and/or the health plan to file an appeal. Such errors are to be reported to the regional office plan manager. The plan manager may assist the plan in correcting the error, determine what corrective action may be required, and re-approve any subsequent variations of the NOMNC or DENC.

90.5 - When to Issue the Notice of Medicare Non-Coverage (NOMNC)

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

Consistent with 42 CFR 422.624(b)(1), providers must distribute the NOMNC at least 2 days prior to the enrollee's SNF, CORF or HHA services ending. To correctly count the 2 days, consider the examples provided as part of the FAQs referenced in Appendix 9.

If the enrollee's services are expected to be fewer than two days in duration, the SNF, HHA or CORF must provide the NOMNC to the enrollee at the time of admission to the provider. If, in a non-residential setting, and the span of time between services exceeds two days, the provider may deliver the notice at the next to last time that services are furnished. This will prevent a non-residential provider from having to make an additional trip to deliver the notice to the enrollee.

Although the regulations do not require action until 2 days before the planned termination of covered services, a provider may deliver the notice earlier if the date that coverage will end (that is, the "effective date" of the notice) can be identified. Medicare health plans and providers are encouraged to work together so that the NOMNC can be delivered as soon as the service termination date is known. Delivery of the NOMNC by the provider as soon as it knows when the Medicare health plan will terminate coverage will allow the enrollee more time to determine whether he or she wishes to appeal, and may permit more time for providers and Medicare health plans to furnish any needed records. Coordination between the Medicare health plan and provider that results in earlier notice delivery can minimize potential liability for either the enrollee or the Medicare health plan, depending on the QIO's decision.

In some cases, permitting flexibility in the timing of notice delivery may result in an early, and possibly premature, enrollee request for a QIO review. In these situations, the QIO must immediately notify the Medicare health plan of the appeal request, but all parties will need to exercise judgment in determining when it makes sense for the Medicare health plan and/or provider to furnish any needed medical records or other documentation to the QIO. Although a Medicare health plan should provide the enrollee (and the QIO) with a detailed notice as soon as it learns of the appeal request, it may be appropriate to delay providing the enrollee's medical records until shortly before the planned coverage termination, when the record is presumably complete enough to permit an informed QIO determination. Nevertheless, the overall deadline for record provision remains close of business of the day before the planned termination.

90.6 - Detailed Explanation of Non-Coverage (DENC)

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

The DENC is a standardized written notice that provides specific, and detailed information to Medicare enrollees concerning why their SNF, HHA, or CORF services are ending (see Appendix 8). The DENC meets the notice requirements set forth in 42 CFR 422.626(e)(1). The Medicare health plan (or the provider by delegation) must issue the DENC to the enrollee (with a copy provided to the QIO) whenever an enrollee appeals a termination decision about their SNF, HHA or CORF services.

The DENC must include the following:

- A specific and detailed explanation why services are either no longer reasonable and necessary or otherwise no longer covered;

- A description of any applicable Medicare coverage rule, instruction or other Medicare policy, including citations to the applicable Medicare policy rules or information about how the enrollee may obtain a copy of the Medicare policy from the Medicare health plan;

- Any applicable Medicare health plan policy, contract provision, or rationale upon which the termination decision was based; and

- Facts specific to the enrollee and relevant to the coverage determination that are sufficient to advise the enrollee of the applicability of the coverage rule or policy to the enrollee's case.

90.7 - When to Issue the Detailed Explanation of Non-Coverage

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

Medicare health plans (or providers by delegation) must issue the DENC to enrollees and provide a copy to the QIO no later than close of business (typically 4:30 P.M.) the day of the QIO's notification that the enrollee requested an appeal, or the day before coverage ends, whichever is later.

The intent of the requirement that the enrollee receive the DENC is to make sure that enrollees who choose to contest a service termination or discharge are made aware of the reasoning for the coverage termination and have an opportunity to present their views to the QIO. Additionally, QIOs rely on the DENC to obtain the rationale for the termination decision, and any accompanying information regarding managed care coverage policies or Medicare rules that informed the managed care determination. Thus, the Medicare health plan should deliver the DENC to the enrollee and QIO expeditiously.

To ensure that the delivery of the DENC is timely, the Medicare health plan may use, but is not limited to, personal delivery or a courier service. If an enrollee is receiving non-residential services and requests that the Medicare health plan provide the DENC through e-mail or facsimile, then the Medicare health plan should document and accommodate the request. The Medicare health plan should also work with the QIO on how best to transmit the DENC, but generally may deliver the DENC to the QIO via personal delivery, courier service, e-mail or facsimile. Using this information, the QIO can make sure that the enrollee is aware of the rationale for the coverage termination decision, and has an opportunity to dispute the decision, in the course of soliciting the enrollee's views.

The regulations and accompanying CMS instructions for the Fast-Track appeals process do not prohibit distribution of a NOMNC by the provider and Medicare health plan earlier than 2 days before the planned termination of covered services. Thus, a Medicare health plan and its providers may choose to deliver the advance termination notice to enrollees, upon admission in some cases, or as soon as it is determined that coverage will be terminated.

The flexibility accommodating early notice delivery, however, could result in an early, and possibly premature, enrollee request for a QIO review. Although the Medicare health plan must still issue the DENC by close of business (COB) of the QIO's notice about the appeal, the Medicare health plan and/or provider may choose the following procedure in these infrequent instances:

- The Medicare health plan and/or provider may determine that it is more appropriate to delay providing the enrollee's medical records until the medical record is presumably complete enough to permit an informed QIO determination. Keep in mind that the deadline for record provision remains close of business of the day before the planned termination.

We strongly encourage providers to structure their notice delivery and discharge patterns to make the new process work as smoothly as possible. For example, SNF providers may want to consider how they can assist enrollees who wish to be discharged in the evening or on weekends in the event they lose their appeal and do not want to incur financial liability. Tasks such as ensuring that arrangements for follow-up care are in place, scheduling equipment to be delivered (if needed), and writing orders or instructions can be done in advance, facilitating a faster, simpler discharge.

90.8 - Enrollee Procedures to Request Fast-Track Review of Provider Service Terminations

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

An enrollee receiving services in a SNF, HHA, or CORF, who wishes to obtain an independent appeal of the Medicare health plan's termination decision that such care is no longer medically necessary must submit a timely request for a fast-track review to the QIO that has an agreement with the provider. A timely request is one in which an enrollee requests an appeal from the QIO either by noon of the day following receipt of the NOMNC; or, where an enrollee receives the NOMNC more than two days prior to the date coverage is expected to end, an enrollee requests an appeal with the QIO no later than noon of the day before coverage ends (that is, the "effective date" of the notice).

An enrollee should not incur financial liability if the QIO reverses the Medicare health plan's termination decision, or if the enrollee stops receiving care no later than the effective date inserted on the enrollee's NOMNC.

90.9 - Handling Misdirected Records

(Rev. 62, 09-10-04)

The fast-track review process complements the existing independent review process for other types of appeals. Therefore, Medicare health plans and providers must be prepared to re-submit materials if they are inadvertently sent to the wrong review entity. If a QIO or the independent review entity (IRE) that processes reconsiderations receives a request for a fast-track review after the review deadline, it must notify the Medicare health plan

by telephone, so that the applicable appeals process can continue expeditiously. Neither QIOs nor the IRE will be responsible for forwarding misdirected records to the appropriate office, so Medicare health plans must be prepared to resubmit the requested information to the correct office, and/or contact the enrollee to initiate an expedited appeal if the enrollee is filing an untimely fast-track appeal.

An enrollee who fails to request an immediate fast-track QIO review in accordance with these requirements may still file a request for an expedited reconsideration with the Medicare health plan under the provisions in §80 of this chapter. The Medicare health plan is encouraged to accommodate such requests for an expedited reconsideration.

90.10 - Authority of a QIO to Request Enrollee Records

(Rev. 88; Issued: 09-21-07; Effective/Implementation Dates: 09-21-07)

On occasion, an individual who claims to be an enrollee's representative requests an expedited review lacking proper representative documentation. In that case, a QIO, when operating as an independent review entity under contract with CMS, must be allowed, as permitted under the payment definition in HIPAA (see 45 CFR 164.501), to receive, and review an enrollee's records from a provider or Medicare health plan regardless of whether the records include a representative's form or statement to the Medicare health plan. However, *plans and* QIOs may only release protected health information to individuals in accordance with applicable HIPAA requirements, such as to representatives who have provided the proper representation documents.

100 - Administrative Law Judge (ALJ) Hearings

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

If the amount remaining in controversy meets the appropriate threshold requirement set forth in §100.2, any party to the reconsideration (with the exception of the Medicare health plan) who is dissatisfied with the reconsidered determination has a right to a hearing before an ALJ.

The amount remaining in controversy can include any combination of Part A and B services. Other services for which an enrollee is entitled under a plan's benefit package may be used to reach the threshold amount. See 42 CFR 422.100 for a description of the types of services covered by Medicare health plans.

If the basis for the appeal is the Medicare health plan's refusal to provide services, the projected value of those services is used to compute the amount remaining in controversy. If the basis for the appeal is the Medicare health plan's refusal to cover optional or supplemental benefits, the projected value of those benefits is used to compute the amount remaining in controversy.

100.1 - Request for an ALJ Hearing

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

A request for an ALJ hearing must be in writing and must be filed with the entity specified in the IRE's reconsideration notice. If the Medicare health plan receives a written request for an ALJ hearing from the enrollee, the Medicare health plan must immediately forward the enrollee's request to the IRE. The independent review entity is responsible for compiling the reconsideration file and forwarding it to the appropriate ALJ hearing office.

Except when an ALJ extends the time frame as provided in 42 CFR Part 405, a party must file a request for an ALJ hearing, within 60 days of the date of the notice of a reconsidered determination. Any request for a "good cause" extension must be in writing and state the reasons why the request was late. If the party shows good cause for missing the deadline, the ALJ may grant an extension.

The parties to an ALJ hearing are the same as those for the reconsideration, and also include the Medicare health plan and any other person or entity whose rights with respect to the reconsideration may be affected by the hearing, as determined by the ALJ. Although the Medicare health plan does not have a right to request an ALJ hearing, it must be made a party to the hearing. Fees for services provided by the Medicare health plan representative are not subject to regulations at 42 CFR Part 405, which govern appointment of representatives and payment of fees to representatives at the ALJ hearing level of appeal.

100.2 - Determination of Amount in Controversy

(Rev. 88; Issued: 09-21-07; Effective/Implementation Dates: 09-21-07)

Beginning in January 2005, the amount in controversy (AIC) requirement for an ALJ hearing will increase by the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved. Any amount that is not a multiple of $10 will be rounded to the nearest multiple of $10.

For 2007, the AIC threshold for an ALJ hearing is $110.*

**This amount is established by October of the current year. Thus, revisions will be posted in the manual updates following establishment of the AIC.*

The ALJ determines whether the amount remaining in controversy (for both Part A and Part B services) meets the appropriate threshold. For cases involving denied services, the projected value of the services is used to determine whether the amount in controversy is met. For cases involving optional or supplemental benefits, but not employer-sponsored benefits limited to employer group members, the projected value of those benefits is used to determine whether the amount in controversy is met. The Medicare health plan is expected to cooperate with the ALJ and assist in the computation of the amount in controversy. The hearing may be conducted on more than one claim at a time; i.e., the enrollee may have several claims involving several issues. The enrollee may combine claims to meet the threshold requirement, if the following elements are met:

- The claims must belong to the same beneficiary;
- The claims must each have received a determination through the independent review entity reconsideration process;
- The 60-day filing time limit must be met for all claims involved; and
- The hearing request must identify all claims.

The ALJ dismisses cases where the appropriate amount in controversy is not met. If, after a hearing is initiated, the ALJ finds that the amount in controversy is not met, he/she discontinues the hearing and does not rule on the substantive issues raised in the appeal. Any party may request review of the dismissal of a hearing through the Medicare Appeals Council (MAC) review.

110 - Medicare Appeals Council (MAC) Review

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

Any party dissatisfied with the ALJ hearing decision (including the Medicare health plan) may request that the MAC review the ALJ's decision or dismissal. Regulations located at 42 CFR Part 405 regarding Appeals Council Review apply to MAC review for matters addressed in this chapter, to the extent they are appropriate.

The MAC may grant or deny the request for review. If it grants the request, it may either issue a final decision or dismissal, or remand the case to the ALJ with instructions on how to proceed with the case.

110.1 - Filing a Request for MAC Review

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

A request for a MAC review must be filed by writing a letter to the MAC. A request should be submitted directly to the MAC at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6127
Medicare Appeals Council
330 Independence Avenue, S.W.
Cohen Building, Room G-644
Washington, DC 20201

If a Medicare health plan decides to request a MAC review, the organization must concurrently notify the enrollee of this action by sending a copy of the request, as well as accompanying documents, that the organization submits to the MAC.

110.2 - Time Limit for Filing a Request for MAC Review

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

The request for a MAC review must be filed within 60 days of the date of receipt of the ALJ hearing decision or dismissal. The MAC assumes the ALJ decision was received within 5 days of the date of the decision, unless evidence indicates otherwise. The MAC may grant an extension of the request for a review if the party can show "good cause" for missing the deadline. (See 42 CFR Part 405 for the standards applicable for determining "good cause.")

110.3 - MAC Initiation of Review

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

The MAC may initiate a review on its own motion within 60 days after the date of an ALJ hearing decision or dismissal. If the MAC initiates a review, it mails notice of this action to all parties at their last address of record.

110.4 - MAC Review Procedures

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

The MAC will review a case if:

- There appears to be an abuse of discretion by the ALJ;
- There is an error of law;
- The action, findings or conclusions of the ALJ are not supported by substantial evidence; or
- There is a broad policy or procedural issue that may affect the general public interest.

If new and material evidence is submitted, the MAC shall consider the additional evidence only where it relates to the period on or before the date of the ALJ hearing decision. The MAC shall evaluate the entire record, including the new and material evidence submitted if it relates to the period on or before the date of the ALJ hearing decision. It will then review the case if it finds that the ALJ's action, findings, or conclusions is contrary to the weight of the evidence currently of record.

A copy of the **MAC's** decision will be mailed to the parties at their last known address.

120 - Judicial Review

(Rev. 88; Issued: 09-21-07; Effective/Implementation Dates: 09-21-07)

Any party, including the Medicare health plan (upon notifying all the other parties), may request judicial review of an ALJ's decision if:

- The MAC denied the parties request for review; and
- The amount in controversy meets the appropriate threshold.

In addition, any party, including the Medicare health plan (upon notifying all the other parties), may request judicial review of a MAC decision if:

- The MAC denied the parties request for review; or
- It is the final decision of CMS; and
- The amount in controversy is met.

For 200*7*, the AIC threshold required for judicial review is $*1,130*.

The enrollee may combine claims to meet the amount in controversy requirement. To meet the requirement:

- All claims must belong to the same enrollee;
- The MAC must have acted on all the claims;
- The enrollee must meet the 60-day filing time limit for all claims; and
- The requests must identify all claims.

A party may not obtain judicial review unless the MAC has acted on the case - either in response to a request for review or on its own motion.

120.1 - Requesting Judicial Review

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

A party must file a civil action in a district court of the United States in accordance with procedures outlined in 42 CFR Part 405. The action should be initiated in the judicial district in which the enrollee lives or where the Medicare health plan has its principal place of business. If neither the organization nor the member is in such judicial district, the action should be filed in the United States district court for the District of Columbia.

130 - Reopening and Revising Determinations and Decisions

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

A reopening is a remedial action taken to change a final determination or decision even though the determination or decision was correct based on the evidence of record. That action may be taken by:

- A Medicare health plan to revise the organization determination or reconsideration;
- An IRE to revise the reconsidered determination;
- An ALJ to revise the hearing decision; or
- The MAC to revise the hearing or review decision.

If a Medicare health plan issues an adverse organization determination because it did not receive requested documentation and the party subsequently requests a reconsideration with the requested documentation, the organization must process the request as a reopening.

Additionally, a Medicare health plan must process clerical errors (which include minor errors and omissions) as reopenings, instead of reconsiderations. If the organization receives a request for reopening and disagrees that the issue is a clerical error, the organization must dismiss the reopening request and advise the party of any appeal rights, provided the time frame to request an appeal on the original denial has not expired. For purposes of this section, clerical error includes human and mechanical errors on the part of the party or the Medicare health plan, such as:

- Mathematical or computational mistakes;
- Inaccurate data entry; or
- Denials of claims as duplicates.

When a party has filed a valid request for an appeal of an organization determination, reconsideration, ALJ hearing, or MAC review, no adjudicator has jurisdiction to reopen an issue until all appeal rights are exhausted (except for clerical errors, as described above). Once the appeal rights have been exhausted, the Medicare health plan, IRE, ALJ, or MAC may reopen as set forth in this section.

The Medicare health plan's, IRE's, ALJ's, or MAC's decision on whether to reopen is final and not subject to appeal. Also, the filing of a request for a reopening with the IRE, ALJ, or MAC, does not relieve the Medicare health plan of its obligation to make payment for, authorize, or provide services as specified in this chapter.

130.1 - Guidelines for a Reopening

(Rev. 22, 05-09-03)

The following are guidelines for a reopening request:

- The request must be made in writing;
- The request for a reopening must be clearly stated;
- The request must include the specific reason for requesting the reopening (a statement of dissatisfaction is not grounds for a reopening, and should not be submitted); and
- The request should be made within the time frames permitted for reopening (as set forth in section 130.2).

130.2 - Time Frames and Requirements for Reopening

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

Reopenings of organization determinations and reconsiderations initiated by a Medicare health plan:

- Within 1 year from the date of the organization determination or reconsideration for any reason;
- Within 4 years from the date of the organization determination or reconsideration for good cause as defined in §130.3;
- At any time if there exists reliable evidence (i.e., relevant, credible, and material) that the organization determination was procured by fraud or similar fault;
- At any time if the organization determination is unfavorable, in whole or in part, to the party thereto, but only for the purpose of correcting a clerical error on which that determination was based; or
- At any time to effectuate a decision issued under the coverage (National Coverage Determination (NCD)) appeals process.

Reopening of organization determinations and reconsiderations requested by a party:

- A party may request that a Medicare health plan reopen its organization determination or reconsideration within 1 year from the date of the organization determination or reconsideration for any reason;
- A party may request that a Medicare health plan reopen its organization determination or reconsideration within 4 years from the date of the organization determination or reconsideration for good cause in accordance with section 130.3; or

- A party may request that a Medicare health plan reopen its organization determination at any time if the organization determination is unfavorable, in whole or in part, to the party thereto, but only for the purpose of correcting a clerical error on which that determination was based.

Reopening reconsiderations, hearing decisions and reviews initiated by an IRE, ALJ, or the MAC:

- An IRE may reopen its reconsideration on its own motion within 180 days from the date of the reconsideration for good cause in accordance with §130.3. If the IRE's reconsideration was procured by fraud or similar fault, then the IRE may reopen at any time;

- An ALJ may reopen his or her hearing decision on his or her own motion within 180 days from the date of the decision for good cause in accordance with §130.3. If the ALJ's decision was procured by fraud or similar fault, then the ALJ may reopen at any time; or

- The MAC may reopen its review decision on its own motion within 180 days from the date of the review decision for good cause in accordance with §130.3. If the MAC's decision was procured by fraud or similar fault, then the MAC may reopen at any time.

Reopening IRE reconsiderations, hearing decisions, and reviews requested by a party:

- A party to a reconsideration may request that an IRE reopen its reconsideration;

- Within 180 days from the date of the reconsideration for good cause in accordance with §130.3;

- A party to a hearing may request that an ALJ reopen his or her decision within 180 days from the date of the hearing decision for good cause in accordance with §130.3; or

- A party to a review may request that the MAC reopen its decision within 180 days from the date of the review decision for good cause in accordance with §130.3.

130.3 - Good Cause for Reopening

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

Good cause may be established when:

- There is new and material evidence that was not available or known at the time of the determination or decision, and may result in a different conclusion; or

- The evidence that was considered in making the determination or decision clearly shows on its face that an obvious error was made at the time of the determination or decision.

A change of legal interpretation or policy by CMS in a regulation, CMS ruling, or CMS general instruction, whether made in response to judicial precedent or otherwise, is not a basis for reopening a determination or hearing decision under this section. This provision does not preclude organizations from conducting reopenings to effectuate coverage (NCD) decisions.

130.4 - Notice of a Revised Determination or Decision

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

Reopenings Initiated by the Medicare Health Plan, IRE, ALJ, or the MAC

When any determination or decision is reopened and revised as provided in §130, the Medicare health plan, IRE, ALJ, or the MAC must mail its revised determination or decision to the parties to that determination or decision at their last known address. An adverse revised determination or decision must state the rationale and basis for the reopening and revision and any right to appeal and must also be provided to the enrollee at his/her last known address.

Reopenings Initiated at the Request of a Party

The Medicare health plan, IRE, ALJ, or the MAC must mail its revised determination or decision to the parties to that determination or decision at their last known address. An adverse revised determination or decision must state the rationale and basis for the reopening and revision and any right to appeal.

If the enrollee is the party which initiated the reopening, the adverse revised determination or decision must also be provided at his/her last known address.

130.5 - Definition of Terms in the Reopening Process

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

130.5.1 - Meaning of New and Material Evidence

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

The submittal of any additional evidence is not a basis for reopening in and of itself. “New and material evidence” is evidence that had not been considered when making the original decision. This evidence must show facts not previously available, which could

possibly result in a different decision. New information also includes an interpretation of existing information that the adjudicator deems to be credible (e.g., a different interpretation of a benefit).

130.5.2 - Meaning of Clerical Error

(Rev. 22, 05-09-03)

A clerical error includes such human and mechanical errors as mathematical or computational mistakes, inaccurate coding, and computer errors.

130.5.3 - Meaning of Error on the Face of the Evidence

(Rev. 22, 05-09-03)

An error on the face of the evidence exists if the determination or decision is clearly incorrect based on all the evidence present in the appeal file. For example, a piece of evidence could have been contained in the file, but misinterpreted or overlooked by the person making the determination.

140 - Effectuating Reconsidered Determinations or Decisions

140.1 - Effectuating Determinations Reversed by the Medicare Health Plan

(Rev. 27, 07-25-03)

140.1.1 - Standard Service Requests

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

If the Medicare health plan completely reverses the initial adverse organization determination (i.e., initial service denial), the organization must authorize or provide the service under dispute as expeditiously as the enrollee health condition requires. However, service must be authorized or provided no later than 30 calendar days (or no later than upon expiration of an extension) from the date the request for reconsideration is received by the Medicare health plan.

140.1.2 - Expedited Service Requests

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)
If on reconsideration of an expedited request for service the Medicare health plan completely reverses the initial organization determination, the Medicare health plan must authorize or provide the service under dispute as expeditiously as the enrollee's health condition requires, but not later than 72 hours after the date the Medicare health plan receives the request for reconsideration (or no later than upon expiration of an extension).

140.1.3 - Payment Requests

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

If the Medicare health plan completely reverses the initial adverse organization determination (i.e., initial claim denial), the organization must pay for the service no later than 60 calendar days after the date it receives the request for reconsideration.

140.2 - Effectuating Determinations Reversed by the Independent Review Entity

(Rev. 22, 05-09-03)

140.2.1 - Standard Service Requests

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

If the Medicare health plan's decision is reversed in whole or in part by the independent review entity, the Medicare health plan must provide the services under dispute as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days from the date it receives notice that the independent review entity reversed the determination. If it is not appropriate for the Medicare health plan to provide the service within 14 calendar days, e.g., because of the enrollee's medical condition or the enrollee is outside of the service area, then the Medicare health plan must authorize the services within 72 hours from the date it receives notice that the independent review entity reversed the determination. The Medicare health plan must inform the independent review entity that the Medicare health plan has effectuated the decision.

140.2.2 - Expedited Service Requests

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

If the Medicare health plan's determination is reversed in whole or in part by the independent review entity, the Medicare health plan must authorize or provide the service under dispute as expeditiously as the enrollee's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination. The Medicare health plan must inform the independent review entity that the Medicare health plan has effectuated the decision.

140.2.3 - Payment Requests

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

The Medicare health plan must pay for the service no later than 30 calendar days from the date it receives notice of the reversal. The Medicare health plan must inform the independent review entity that the Medicare health plan has effectuated the decision.

The reconsidered determination of the independent review entity is final and binding on all parties unless an appropriate party requests an ALJ hearing or the case is revised. Medicare health plans do not have the right to request an ALJ hearing.

140.3 - Effectuating Decisions by All Other Review Entities

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

If the organization determination is reversed in whole or in part by an ALJ, the MAC, or judicial review, the Medicare health plan must pay for, authorize, or provide the service under dispute as expeditiously as the enrollee's health condition requires, but no later than 60 calendar days from the date it receives notice reversing the initial organization determination. However, when a Medicare health plan requests MAC review of an ALJ decision, the organization may await the outcome of the review before paying for, authorizing or providing the service under dispute. A Medicare health plan that files an appeal with the MAC must concurrently send a copy of the appeal request and any accompanying documents to the enrollee, and must notify the IRE that it has requested a MAC review. Whenever the Medicare health plan effectuates a decision it must inform the independent review entity.

140.4 - Independent Review Entity Monitoring of Effectuation Requirements

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

The CMS requires its independent review entity to monitor a Medicare health plan's compliance with determinations or decisions that fully or partially reverse an original Medicare health plan determination (denial). The process is as follows:

- The independent review entity issues to the Medicare health plan a copy of the reconsidered determination. Included with this copy is a Notice of Requirement to Comply;

- Pursuant to the compliance notice, the Medicare health plan is required to mail to the independent review entity a statement attesting to compliance with the independent review entity's decision. This documentation is to confirm when and how compliance occurred (e.g., service authorization, payment made, etc.). Notification to the IRE that the Medicare health plan plans to pay for or plans to provide the service **will not** be considered appropriate compliance with the effectuation requirements. The Medicare health plan must provide the IRE with affirmative notice of effectuation. The Medicare health plan's notice of compliance should be forwarded to the independent review entity concurrent with the Medicare health plan's effectuation;

- If the independent review entity does not obtain the compliance notice, it mails the Medicare health plan a reminder notice; and

- If the independent review entity does not receive the Medicare health plan's compliance report within 30 days of the reminder notice, the independent review entity reports the Medicare health plan's failure to comply to CMS. The Medicare health plan is not copied on the notice to CMS.

140.5 - Effectuation Requirements for Former Medicare Health Plan Enrollees

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

A Medicare health plan is legally responsible under its contract and the regulations to authorize, provide, or pay for all Medicare covered services that are denied and upon appeal are found to be services the Medicare health plan should have authorized, provided, or paid for its enrollees. CMS policy is that a beneficiary is entitled to receive a service and/or payment of a service from a Medicare health plan from which the beneficiary either voluntarily or involuntarily disenrolled prior to a final decision on appeal. The guidance that follows is provided with respect to individual disenrollment, contract termination/service area reduction, and Medicare health plan bankruptcy. The guidance in the following sections will provide a Medicare health plan with its obligations to effectuate favorable appeal decisions of former members after the relationship between a member and the Medicare health plan ends.

140.5.1 - Effectuation Requirements When an Individual Has Disenrolled from a Medicare Health Plan

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

Type of Reconsideration	Situation (prior to receipt of appeal decision)	MHP Effectuation (after receipt of appeal decision favorable to enrollee)
Payment	Reconsideration initially filed on a payment denial.	MHP obligated to pay. (422.100(b)(1)(v)). If the former enrollee has paid for the service, the MHP needs to reimburse the former enrollee. If payment to the provider is outstanding, the MHP is responsible for payment. The MHP will provide payment in an amount the provider would have received under original Medicare (including balance billing permitted under Medicare Part A and Part B). (422.100(b)(2)). The MHP

Type of Reconsideration	Situation (prior to receipt of appeal decision)	MHP Effectuation (after receipt of appeal decision favorable to enrollee)
		will indemnify the former enrollee for other than cost-sharing amounts in effect at the time the beneficiary was an enrollee. (422.502(g)(1)(ii).
Pre Service	Enrollee **has not received** service from a provider pending the appeal determination. [**NOTE**: Does not matter if enrollee disenrolled before or after filing the appeal, as long as appeal was filed within the appropriate time frame]	MHP is responsible to provide services. (422.100(a)). At the time of the appeal decision: 1). If the former enrollee remains in the service area – then MHP meets its obligation by either offering to provide service through its network under the cost-sharing terms in effect at the time of the improper denial, or paying for the service it allows the former enrollee to obtain from another provider. The MHP will develop a policy that clearly delineates the MHP's offer. The policy will be relayed through enrollee materials. [NOTE: If the MHP offers to provide the service and the enrollee declines to receive the service through the MHP's network, then the MHP does not have to pay for the service.] 2). If former enrollee is outside of service area – then MHP will pay for the service. (422.100(b)(1)(v)). The MHP will provide payment in an amount the provider would have received under original Medicare (including balance billing permitted

Type of Reconsideration	**Situation (prior to receipt of appeal decision)**	**MHP Effectuation (after receipt of appeal decision favorable to enrollee)**
		under Medicare Part A and Part B). (422.100(b)(2). The MHP will indemnify the beneficiary for other than cost-sharing amounts in effect at the time the beneficiary was an enrollee. (422.502(g)(1)(ii)).
Pre Service	Enrollee **has received** service from a non-contracting provider pending the appeal determination. [NOTE: Does not matter if enrollee disenrolled before or after filing the appeal, as long as appeal was filed within the appropriate Time frame]	MHP is responsible to pay for services. (422.100(b)(1)(v)). The MHP will provide payment in an amount the provider would have received under original Medicare (including balance billing permitted under Medicare Part A and Part B). (422.100(b)(2)). The MHP will indemnify the beneficiary for other than cost-sharing amounts in effect at the time the beneficiary was an enrollee. (422.502(g)(1)(ii)). When the former enrollee receives the service through original Medicare, the MHP will reimburse the Medicare Trust Fund. The MAO will indemnify the beneficiary for other than cost-sharing amounts in effect at the time of the adverse organization determination. When the former enrollee receives the service from a new MHP, the former MHP will reimburse the new MHP at the rate described above and the beneficiary the amount that is over the plan cost-sharing amount in effect at the time of the adverse organization

Type of Reconsideration	Situation (prior to receipt of appeal decision)	MHP Effectuation (after receipt of appeal decision favorable to enrollee)
		determination.

140.5.2 - Effectuation Requirements When a Medicare health plan Contract Ends

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

Type of Reconsideration	Situation (prior to receipt of appeal decision)	MHP Effectuation (after receipt of appeal decision favorable to enrollee)
Payment or Pre Service	MAO contract terminated/non-renewed and enrollee either has or has not received service from a new provider pending the appeal determination.	MHP is responsible to pay for services. (422.100(b)(1)(v)). The MHP will provide payment in an amount the provider would have received under original Medicare (including balance billing permitted under Medicare Part A and Part B). (422.100(b)(2)) The MHP will indemnify the beneficiary for other than cost-sharing amounts in effect at the time the beneficiary was an enrollee. (422.502(g)(1)(ii))

140.5.3 - Effectuation Requirements for a Medicare Health Plan Bankruptcy

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

Type of Reconsideration	Situation	MHP Effectuation
	Chapter 7 - MHP generally closes and a court-appointed trustee accumulates the assets of the debtor and sells them, and distributes the money to the creditors. Chapter 11 - Reorganize the debtor and submit a Plan of Reorganization. MHP is still operational.	MHP will follow Federal Bankruptcy Court decision regarding the provision of medical services, reimbursement of claims, and/or closure of the organization. MHP will work with CMS Regional Office and Central Office staff to determine the

	MHP under State Receivership/Conservatorship- Attempt by the State to preserve the MHP's assets in order to reorganize, to sell the organization, or to shut down operations and pay its creditors.	organization's financial responsibility for appeals effectuation. State Insurance Law governs payment of services. In some cases, pre-service decisions may continue to be processed by the MHP. Since each MHP Bankruptcy and State Receivership/Conservatorship action is unique, CMS staff must review to determine whether the organization has the resources to effectuate appeal overturns.

150 - Notification to Enrollees of Non-Coverage of Inpatient Hospital Care

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

NOTE: Because HCPPs are not regulated by the rules contained in 42 CFR 422.620-622, §§150-160.1 are not applicable to HCPPs. Those enrollees follow the original Medicare immediate review process contained in Part 405.

Where a Medicare health plan has authorized coverage of the inpatient hospital admission of an enrollee, either directly or by delegation (or the admission constitutes emergency or urgently needed care), the Medicare health plan is required to issue the enrollee a written notice of non-coverage only under the circumstances described in section 150.2.

150.1 - Notice of Discharge and Medicare Appeal Rights (NODMAR)

(Rev. 88; Issued: 09-21-07; Effective/Implementation Dates: 09-21-07)

NOTE: *If the Medicare health plan denies coverage of the admission, this section (issuing the NODMAR and a QIO review) does not apply. Instead, the plan must deliver either the NDMC or the NDP. Appeals of this type of determination would follow the standard appeals process.*

*(**NOTE**: Due to a final rule affecting inpatient hospital notices being implemented on July 1, 2007, CMS is revising notices through the Office of Management and Budget's Paperwork Reduction Act process. After 7/1/07, the NODMAR will no longer be used.)*

The model NODMAR is a written notice that is designed to inform Medicare enrollees that their covered inpatient hospital care is ending. The NODMAR must include the following:

1. The specific reason why inpatient hospital care is no longer needed or covered;

2. The effective date and time of the enrollee's liability for continued inpatient care;

3. The enrollee's appeal rights;

4. If applicable, the new lower level of care being covered in the hospital setting; and

5. Any additional information specified by CMS.

The model NODMAR (see Appendix 3) meets the notice requirements set forth in 42 CFR 422.620(c). We encourage Medicare health plans to use this model form, but they are allowed to develop their own. All NODMARs *(including forms developed by the plans)* must be approved by the Medicare health plan's Regional Office Plan Manager until such time that CMS issues a standardized form.

Before the Medicare health plan can provide an enrollee with a NODMAR, the physician who is responsible for the enrollee's inpatient hospital care must concur with the decision to discharge the enrollee or lower the enrollee's level of care within the same hospital facility.

150.2 - When to Issue a NODMAR

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

Consistent with 42 CFR 422.620, Medicare health plans (and hospitals that have been delegated responsibility by a Medicare health plan to make the discharge/non-coverage decision) will distribute the NODMAR only when:

- The enrollee expresses dissatisfaction with his or her impending discharge; or

- The Medicare health plan (or the hospital that has been delegated the responsibility) is not discharging the individual but no longer intends to continue coverage of the inpatient hospital stay. In other words, the Medicare health plan intends to lower the enrollee's level of care from inpatient acute to, for example, skilled nursing, within the same hospital facility (a change that could be transparent to the enrollee if no notice were provided). This does not mean that the Medicare health plan distributes a NODMAR without attending physician concurrence to discharge or transfer the enrollee (concurrence is required

The Medicare health plan (or hospital that has been delegated the responsibility) is not required to issue the NODMAR if the enrollee dies while in an inpatient hospital setting.

In determining whether continued inpatient hospital care is medically necessary, consider the level of care required by the enrollee and the availability and appropriateness of other facilities and services. For example, if the enrollee no longer requires acute care in an inpatient hospital, and could receive proper treatment at a skilled nursing facility (SNF), but a Medicare-certified SNF bed is not available, further care at the hospital may be medically necessary to permit the needed skilled services to continue.

A Medicare health plan should deliver the NODMAR as soon as possible after learning of an enrollee's dissatisfaction with the discharge decision, but no later than 6:00 p.m. of the day before discharge. If the enrollee is incompetent or otherwise incapable of receiving the notice, the notice must be delivered to the enrollee's representative. (Note that this person would also likely be the individual who expressed dissatisfaction.)

160 - Requesting Immediate Quality Improvement Organization (QIO) Review of Inpatient Hospital Care

(Rev. 88; Issued: 09-21-07; Effective/Implementation Dates: 09-21-07)

***(NOTE:** Due to a final rule affecting inpatient hospital discharges being implemented on July 1, 2007, CMS is in the process of drafting manual instructions to reflect those changes to existing requirements.)*

An enrollee remaining in the hospital that wishes to appeal the Medicare health plan's discharge decision that inpatient care is no longer necessary must request immediate QIO review of the determination in accordance with this section's requirements. An enrollee will not incur any additional financial liability if:

- The enrollee remains in the hospital as an inpatient;
- The enrollee submits the request for immediate review to the QIO that has an agreement with the hospital;
- The request is made either in writing, by telephone or fax; and
- The request is received by noon of the first working day after the enrollee receives written notice of the Medicare health plan's determination that the hospital stay is no longer necessary.
- The following rules apply to the immediate QIO review process:
- On the date that the QIO receives the enrollee's request, the QIO must notify the Medicare health plan that the enrollee has filed a request for immediate review;
- The Medicare health plan and/or hospital must supply any information that the QIO requires to conduct its review. This must be made available by phone, fax, or in writing, by the close of business of the first full working day immediately following the day the enrollee submits the request for review;

- In response to a request from the Medicare health plan, the hospital must submit medical records and other pertinent information to the QIO by close of business of the first full working day immediately following the day the Medicare health plan makes its request;

- The QIO must solicit the views of the enrollee who requested the immediate QIO review; and

- The QIO must make an official determination of whether continued hospitalization is medically necessary, and notify the enrollee, the hospital, and the Medicare health plan by close of business of the first working day after it receives all necessary information from the hospital, the Medicare health plan, or both.

An enrollee who fails to request an immediate QIO review in accordance with these requirements may file a request for an expedited reconsideration with the Medicare health plan. The Medicare health plan should expedite the request for an expedited reconsideration. Likewise, if the QIO receives a request for immediate QIO review beyond the noon filing deadline and forwards that request to the Medicare health plan, the Medicare health plan should expedite that request. Thus, the Medicare health plan would generally make another decision about the services within 72 hours. However, the financial liability rules governing immediate QIO review do not apply in an expedited review situation.

160.1 - Liability for Hospital Costs

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

The presence of a timely appeal for an immediate QIO review filed by the enrollee in accordance with this section entitles the enrollee to automatic financial protection by the Medicare health plan. This means that if the Medicare health plan authorizes coverage of the inpatient hospital admission directly or by delegation, or this admission constitutes emergency or urgently needed care, the Medicare health plan continues to be financially responsible for the costs of the hospital stay until noon of the calendar day following the day the QIO notifies the enrollee of its review determination.

170 - Data

(Rev. 88; Issued: 09-21-07; Effective/Implementation Dates: 09-21-07)

NOTE: *Data requirements do not apply to cost plans or HCPPs.*

Medicare *Advantage organizations* are expected to disclose grievance and appeals data*, upon request,* to individuals *eligible to elect an MA organization.* For purposes of this section, by appeals data we mean all appeals filed with the M*A organization* that are accepted for review or withdrawn upon the enrollee's request, but exclud*ing* appeals that the organization forwards to the IRE for dismissal. The *MA organizations* should not

send out a subset or partial list of the data, even if only a subset of the data is requested. For example, if a beneficiary requests data on the number of appeals received by the *MA organization*, then the *MA organization must* send the beneficiary a complete report of both its appeal and grievance data for the reporting period.

The MA organizations must report to beneficiaries the number of appeal and grievance requests per 1000 enrollees. The purpose of this calculation is to normalize reporting among larger and smaller *MA organizations* for comparison purposes. Since larger organizations would reasonably be expected to receive more appeals and grievances relative to smaller organizations, simply reporting raw data could be misleading.

The rate is calculated by multiplying the total number of requests for [an appeal or grievance] by 1,000, and dividing that number by the average number of members enrolled during the data collection period. *The calculation* does not require that the *MA organization* have a minimal enrollment of 1000 members.

The following are examples of how the rates get normalized across small and large plans:

EXAMPLE 1

MA organization average membership = 500

# of appeals received during the data collection period = 4

4 x 1000/500 = 8

# of Appeals per 1000 members = 8

EXAMPLE 2

MA organization average membership = 5000

# of appeals received during the data collection period = 40

40 x 1000/5000 = 8

# of Appeals per 1000 members = 8

170.1 - Reporting Unit for Appeal and Grievance Data Collection Requirements

(Rev. 88; Issued: 09-21-07; Effective/Implementation Dates: 09-21-07)

The reporting unit for appeal and grievance data sent to beneficiaries is to be consistent with *(generally the same as)* the reporting unit for the Health Plan Employer Data and Information Set (HEDIS), the Medicare Consumer Assessment of Health Plans Study (CAHPS), and the Medicare Health Outcomes Survey (HOS). *T*herefore, *MA organizations* must make changes to the reporting unit for appeals and grievances

concurrently. However, CMS retains the flexibility to grant special exceptions to the general reporting unit to allow for case-by-case exceptions for good cause.

170.2 - Data Collection and Reporting Periods

(Rev. 88; Issued: 09-21-07; Effective/Implementation Dates: 09-21-07)

In order for *MA organizations* to report appeal and grievance data consistently, data collection and reporting periods have been established.

- The data collection period is the time frame in which the data were collected. Data collection periods will be based on an ongoing 12-month period. By ongoing, we mean that the prior 6 months of data are added to the next 6 months of data in order to come up with a 12-month data collection period;

- The reporting period refers to the time frame during which organizations will be expected to report the data. The reporting period begins 3 months after the data collection period ends. Reporting periods are 6 months in duration; and

- Organizations are expected to report out appeal and grievance data to beneficiaries, upon request, beginning 3 months after the end of each data collection period. For example, if the data collection period ends September 30, 2005, the organization *will* begin reporting data to the beneficiary January 1, 2006. The 3-month lag between the end of the data collection period and the beginning of the report period allows the *MA organization* to resolve appeals received during the data collection period and ensure quality control over the data reported.

Below is a chart detailing the *sample* yearly collection and reporting cycles.

Sample **Yearly Collection and Reporting Cycles**

6-month Data Collection	3-month Reconciliation	What kind of data?
4/1/0*6* - 9/30/0*6*	10/1/0*6* - 12/31/0*6*	last 6 months
10/1/0*6* - 3/31/0*7*	4/1/0*7* - 6/30/0*7*	last 12 months
4/1/0*7* - 9/30/0*7*	10/1/0*7* - 12/31/0*7*	last 12 months, etc.

170.3 - New Reporting Periods Start Every 6 Months

(Rev. 88; Issued: 09-21-07; Effective/Implementation Dates: 09-21-07)

The MA organizations are expected to report out new data every 6 months. The new data that get reported will include the two most recent data collection periods. For example, the data collection period would begin each year starting on April 1 and ending on September 30, thus the reporting period would run from January 1 through June 30. The next reporting period begins July 1 and runs through December 31. This report included appeal and grievance data collected beginning April 1 through March 31 (or the two

latest 6 month data collection periods). As an example, beneficiary requests for appeal and grievance data beginning January 1, 2007, through June 30, 2007, would be based on appeals received by the organization from October 1, 2005, through September 30, 2006, and so on.

The standardized language in Appendix 2 provides both contextual information and, where possible, offers an explanation about what the data provided by an MA organization might suggest to a beneficiary. By doing so, MA organizations will help beneficiaries make a connection between the processing and disposition of appeals.

On page 4 of Appendix 2, the report provides background regarding independent reviews. For example, one sentence states that an independent review provides an opportunity for a new, fresh look at the appeal outside of the organization. Also, in an effort to explain why the IRE might disagree with XYZ organization, the report offers that the IRE may have had more information about the appeal.

The MA organizations will meet the disclosure requirements set forth in the regulations at 42 C.F.R 422.111(c)(3) by utilizing the report found at Appendix 2.

170.4 - Maintaining Data

(Rev. 88; Issued: 09-21-07; Effective/Implementation Dates: 09-21-07)

The CMS expects *MA organizations* to maintain a health information system that collects, analyzes, and integrates the data necessary to implement disclosure requirements.

170.5 - Appeal and Grievance Data Collection Requirements

(Rev. 88; Issued: 09-21-07; Effective/Implementation Dates: 09-21-07)

The following describes the appeal *and grievance* data *MA organizations* are expected to record and report. This format should be used by the *MA organization* in recording the data internally and is the required format for reporting the information to beneficiaries. Reports should be readable and understandable to the recipient of the information. The material also should be typed in at least a 12-point font. *If the MA organization provides any of its own materials or discussion to supplement CMS' standardized format, as with all member materials, prior approval by the Regional Office is required.*

The MA organizations should provide informational copies *of appeal and grievance data sent to beneficiaries to the appropriate Regional Office (RO). MA organizations only need to send the RO one copy of the data sent during a single period. Plans do not need to send multiple copies of the same report to the RO.*

170.5.1 - Appeal Data

(Rev. 88; Issued: 09-21-07; Effective/Implementation Dates: 09-21-07)

Line 1. Time Period Covered: **[*Sample* Reporting Period lasts from 01/01/07 through 06/30/07, which includes data collected from 10/01/05 through 09/30/0*6*, *and 07/01/07 through 12/31/07, which includes data collected from 04/01/06 through 03/31/07*.]**

Line 2. Total Number of Requests for an Appeal Received by **[Organization Name]*:* [insert # here]**.

Instructions: This line includes all requests for reconsideration, including Pre-Service {standard & expedited} and Claims (Payment) Appeals, *but excludes appeals requests that the organization forwards to CMS' independent review entity for dismissal*.

Line 3. Average Number of Enrollees in **[Organization Name]: [insert # here]**.

Instructions: To calculate the number of enrollees, count the number of enrollees at the end of each month of the data collection period. Divide that total by 12 (the total number of months in the data collection period).

Line 4. Total Number of Appeal Requests per 1,000 enrollees: **[insert # here]**

Instructions: This number is calculated by multiplying the total number of requests for an appeal (line #2) by (1,000) and dividing by the total number of enrollees as of the last date of the data collection period (line #3).

Line 5. Of the Appeal Requests Received by **[Organization Name]** between **[*sample 12-month period*: 04/01/06** through **03/31/07], [Organization Name] completed [insert # here]**.

Instructions: This number should be equal to or less than the number in line #2. Organizations are reporting cases received in the period indicated in line #1, but completed at the *MA organization* level within 60 days following the last date in line #1. For example, a withdrawal would be reflected in line #2 as a case received; but since a decision is not rendered for a withdrawn case, a withdrawal would not be reflected in this line item.

A "completed" appeal means one that has been resolved by the *MA organization* or has left the *MA organization* level. If there were no withdrawals, we anticipate that the number of completed appeals will be the same as the number of requests for reconsideration, provided the *MA organization* has met its deadlines.

Therefore, the organization is accounting for all appeals that it has completed within 60 days after the last date in line #1.

The 60-day time frame is based on the maximum time frame in 422.590(b), which allows an *MA organization* 60 days to resolve a dispute involving a claim or payment either by deciding an enrollee should receive payment or by forwarding the case to the independent review entity. Cases involving requests for services have a shorter time frame.

Of those cases:

NOTE: Partial denials should be recorded as not decided fully in favor of the enrollees.

Line 6. **[Insert # here]** or **[insert % here]** of the appeals were decided fully in favor of the enrollee.

Line 7. **[Insert # here]** or **[insert % here]** of the appeals were not decided fully in favor of the enrollee.

Line 8. **[Insert # here]** or **[insert % here]** were withdrawn by the enrollee.

[**NOTE:** When the decision is not fully in favor of the enrollee, or when the decision is not completed within the required time, as specified in 42 CFR 422.590, the case is automatically sent to the independent review entity.]

Line 9. For all appeals received by **[Organization Name]** between **[*sample 12-month period:* 04/01/0*6* through *0*3/31/0*7*], [insert # here]** cases were sent to the independent review entity for review.

Instructions: This number should be the same as the number in line #7, provided that all case files were forwarded to *CMS' IRE in a* timely *manner*.

Of those cases:

[**NOTE:** Partial denials should be recorded as not decided fully in favor of the beneficiary.]

Line 10. **[Insert # here]** or **[insert % here]** of **[Organization's Name]** cases reviewed by the independent review entity were decided fully in favor of the enrollee.

Line 11. **[Insert # here]** or **[insert % here]** of **[Organization's Name]** cases reviewed by the independent review entity were not decided fully in favor of the enrollee.

Line 12. **[Insert # here]** or **[insert % here]** were withdrawn by the enrollee.

Line 13. **[Insert # here]** or **[insert % here]** are still awaiting a decision by the independent review entity.

In certain situations, the *MA organization* is required to process an appeal faster because delay in making a decision could cause serious harm to enrollees. This is called an expedited appeal. In many cases, it is the *MA organization* that decides whether or not to expedite the appeal.

Instructions: The following measurements are meant to reveal how often the *MA organization* granted requests for the expedited processing of an appeal. (Expedited organization determinations are not covered by this measure.

Line 14. Between **[*sample 12-month period*: 04/01/0*6* through 03/31/0*7*][Organization Name]** received **[insert # here]** requests for expedited processing for appeals.

Of those cases:

Line 15. **[Insert # here]** or **[insert % here]** of the requests for expedited processing of the appeal were granted.

Instructions: This line includes cases where the decision was to expedite.

170.5.2 - Quality of Care Grievance Data

(Rev. 88; Issued: 09-21-07; Effective/Implementation Dates: 09-21-07)

Line 1. Time Period Covered: **[*Sample* Reporting Period lasts from *01/01/07* through *06/30/07*, which includes data collected from *10/01/05* through *09/30/06*, *and* *07/01/07* *through* *12/31/07 which includes data collected from 04/01/06 through 03/31/07*].**

Line 2. Total number of Quality of Care Grievances Received by **[Organization's name: insert # here].**

Instructions: This line should only include grievances that involve quality of care complaints received during the data collection period.

Line 3. Average Number of Enrollees in **[Organization's name]: [insert # here].**

Instructions: To calculate the number of enrollees, count the number of enrollees at the end of each month of the data collection period. Divide that total by 12 (the total number of months in the data collection period).

Line 4. Total Number of Quality of Care Grievances received per 1,000 enrollees **[insert # here].**

Instructions: This number is calculated by multiplying the total number of grievances by (line #2) by (1,000) and dividing by the total number of enrollees as of the last date of the reporting period (line #3).

Instructions: This line should only include grievances that involve quality of care complaints received during the data collection period.

In addition to reporting raw data to beneficiaries, *MA organizations* also must explain what the numbers mean in a separate report. See Appendix 2 for standardized language.

Appendices

Appendix 1 - Notice of Denial of Medical Coverage and Notice of Denial of Payment

(Rev. 22, 05-09-03)

The form, Notice of Denial of Medical Coverage - Form CMS-10003-NDMC - can be found at: http://www.cms.hhs.gov/MMCAG/Downloads/NDMC.pdf

Instructions for Form CMS-10003-NDMC can be found at:
http://www.cms.hhs.gov/MMCAG/Downloads/NDMCInstructions.pdf

The form, Notice of Denial of Payment - Form CMS-10003-NDP - can be found at:
http://www.cms.hhs.gov/MMCAG/Downloads/NDP.pdf

Instructions for Form CMS-10003-NDP can be found at:
http://www.cms.hhs.gov/MMCAG/Downloads/NDPInstructions.pdf

OMB Approval No. 0938-0778

Appendix 2 - Beneficiary Appeals and Quality of Care Grievances Explanatory Data Report

SAMPLE REPORT

(Rev. 88; Issued: 09-21-07; Effective/Implementation Dates: 09-21-07)

MEDICARE APPEALS AND
QUALITY OF CARE GRIEVANCES
XYZ ORGANIZATION
April 1, 2006 to March 31, 2007

What kind of information is this?

When you ask for it, the government requires (**XYZ Organization**) to provide you with reports that describe **what happened** to formal complaints that (**XYZ Organization**) received from their Medicare members. There are two types of formal complaints: **Appeals and Grievances.**

Medicare members have the right to file an appeal or grievance with their *MA organizations*. The next few pages contain information about the appeals and quality of care grievances that (**XYZ Organization**) received between April 1, 2006, and March 31, 2007.

Each *MA organization* will have different numbers of appeals and quality of care grievances, and these numbers can mean different things. For example, a *MA organization* might have a small number of appeals and quality of care grievances because the plan talks with members about their concerns and agrees to find solutions. Or a*n MA organization* might have a small number of appeals and quality of care grievances because its members are not aware of their right to file an appeal or grievance.

How big is (XYZ Organization)?

(**XYZ Organization**) has about 88,000 Medicare members.

(line 3 on the attached report)

Page 1

Appeals Information beginning on Page 2 Quality of Care Grievance Information on Page 6

INFORMATION ON MEDICARE APPEALS

April 1, 200*6* To March 31, 200*7*

What is an appeal?	An appeal is a formal complaint about (**XYZ Organization**)'s decision not to pay for, not to provide, or to stop an item or service that a Medicare member believes s*he*/he needs. If a member cannot get an item or service that the member feels she/he needs, or if the *MA organization* has denied payment of a claim for a service the member has already received, the member can appeal. For example, a member might appeal (**XYZ Organization**)'s decision to stop physical therapy, to deny a visit to a specialist, or to deny payment of a claim.
How many appeals did (XYZ Organization) receive?	(**XYZ Organization**) received 174 appeals from its Medicare members. About 2 out of every 1,000 Medicare members appealed (**XYZ Organization**)'s decision not to pay for or provide, or to stop a service that they believed they needed. (lines 2 and 4 on the attached report)
How many appeals did (XYZ Organization) review?	(**XYZ Organization**) reviewed 157 appeals during this time period. (lines 5 through 8 on the attached report)
What happened?	From the **174** appeals it received from its members: (XYZ Organization) decided to pay for or to provide all services that the member asked for 41% of the time. (**XYZ Organization**) decided **not** to pay for or to provide the services that the member asked for **49%** of the time. Medicare members withdrew their request before (**XYZ Organization**) could decide 10% of the time.

INFORMATION ON EXPEDITED OR "FAST" APPEALS
April 1, 200*6* to March 31, 200*7*

What is a "fast" or expedited appeal?	A Medicare member can request that (**XYZ Organization**) review the member's appeal quickly if the member believes that his health could be seriously harmed by waiting for a decision about a service. This is called a request for an **expedited** or **"fast" appeal**. (**XYZ Organization**) looks at each request and decides whether a "fast" appeal is necessary. By law, (**XYZ Organization**) must consider an appeal as quickly as a member's health requires. If (**XYZ Organization**) determines that a "fast" appeal is necessary, it must notify the Medicare member as quickly as the member's health requires but no later than 72 hours.
How many "fast" appeals did XYZ Organization receive?	(**XYZ Organization**) received **20** requests for "fast" appeal from its Medicare members. (lines 14 through 16 on the attached report)
What happened?	When a member requested a "fast" review, (**XYZ Organization**) agreed that a "fast" review was needed **75%** of the time. (**XYZ Organization**) did not agree to a "fast" review **25%** of the time. This number may include requests by members for whom the *MA organization* may not have believed were in danger or serious harm.

INFORMATION ON INDEPENDENT REVIEW
April 1, 200*6* to March 31, 200*7*

What is Independent Review of an appeal?

After a member has sent an appeal to (**XYZ Organization**), if the organization continues to decide that it should not pay for or provide all services that the member asked for, (**XYZ Organization**) must send all of the information about the appeal to an **independent review *entity (IRE)*** that contracts with Medicare, not with (**XYZ Organization**).

An independent review provides an opportunity for a new, fresh look at the appeal outside of the *MA organization*. *The CMS' IRE* goes over all of the information from (**XYZ Organization**) and can consider any new information.

If the *IRE* does not agree with (**XYZ Organization**)'s decision, (**XYZ Organization**) must provide or pay for the services that the Medicare member requested.

There may be several reasons why the *IRE* decides to agree with either the Medicare member or (**XYZ Organization**). For example, the *IRE* may disagree with (**XYZ Organization**) because the *IRE* may have had more information about the appeal.

Independent Review Continued on Page 5

INFORMATION ON INDEPENDENT REVIEW
April 1, 2006 to March 31, 2007

How many appeals did the *IRE* consider?

The *IRE* considered **86** appeals from (**XYZ Organization**).

(lines 9 through 13 on the attached report)

What happened?

The *IRE* agreed with the Medicare member's appeal **19%** of the time. This means that in **19%** of these cases, (**XYZ Organization**) ended up paying for or providing all services that these members asked for.

The *IRE* disagreed with the Medicare member's appeal **70%** of the time. This means that in **70%** of these cases, (**XYZ Organization**) ended up **not** paying for or providing all services that these members asked for.

Medicare members withdrew their request for independent review **9%** of the time.

By June 01, 2007, **2%** of appeals were still waiting to be reviewed by the *IRE*.

Note that these percentages may not add to 100% because sometimes the *IRE* dismisses an appeal.

INFORMATION ON QUALITY OF CARE GRIEVANCES
April 1, 200*6* to March 31, 200*7*

What is a quality of care grievance?	A grievance is a complaint that a Medicare member makes about the way (**XYZ Organization**) provides care (other than complaints about requests for service or payment). A **grievance** about the **quality of care** is one kind of grievance. For example, a member can file a grievance about the quality of care when the member believes that the service the member received was not timely or correct, when the member had problems getting a service because of long waiting times or long travel distances, or when the wrong kind of doctor or hospital provided the service.
How many quality of care grievances did (**XYZ Organization**) receive?	(**XYZ Organization**) received **20** grievances about the quality of care. About **less than 1 out of every 1,000** Medicare members filed a grievance about the quality of care they received from (**XYZ Organization**) doctors and hospitals. (lines 2 and 4 under "Quality of Care Grievance Data" on the attached report)
Where can I get more information?	If you are a member of (**XYZ Organization**), you have the right to file an appeal or grievance. You can contact (**XYZ Organization**) at (###) ###-#### to resolve a concern you may have or to get more information on how to file an appeal or grievance. (Be sure to include a phone number for the hearing impaired and your hours of operation.) You may also refer to your Evidence of Coverage for a complete explanation of your rights. You also can contact a group of independent doctors in **STATE**, called a Quality Improvement Organization, at (###) ###-#### for more information about quality of care grievances or to file a quality of care grievance.

Form No. CMS-R-0282

Exp. Date *04/30/2010*

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0778. The time required to prepare this information collection is 2 hours per Medicare health plan. The time to select the prepared form and deliver it to the enrollee is 5 minutes per form. If you have any comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Appendix 3 - Notice of Discharge and Medicare Appeal Rights

(Rev. 22, 05-09-03)

NOTICE OF DISCHARGE & MEDICARE APPEAL RIGHTS

Enrollee's Name:	Date of Notice:
Health Insurance Claim (HIC) Number:	Admission Date:
Attending Physician:	Discharge Date:
Hospital:	Health Plan:

YOUR IMMEDIATE ATTENTION IS REQUIRED

Your doctor has reviewed your medical condition and has determined that you can be discharged from the Hospital because: [check one]

_____You no longer require inpatient hospital care.

_____You can safely get any medical care you need in another setting.

_____Other_____.

[Fill in details.]

This also means that, if you stay in the hospital, it is likely that your hospital charges for [**specify date of first non-covered day**], and thereafter will not be covered by your Health Plan.

The Hospital has developed a discharge plan which explains any follow-up care or medications you need. If you have questions about this follow-up care, you should discuss them with your doctor. If you have not received a discharge plan and wish to do so, please contact your nurse, social worker or doctor.

If you agree with your doctor's discharge decision, you can either read further to learn more about your appeal rights, or you can skip to the end of this notice and sign to show that you have received this notice.

However, if you disagree with your Doctor's discharge decision, Medicare gives you the right to appeal. In that case, please continue reading to learn how to appeal a discharge decision, what happens when you appeal, and how much money you may owe.

IF YOU THINK YOU'RE BEING ASKED TO LEAVE THE HOSPITAL TOO SOON, REQUEST AN IMMEDIATE REVIEW

HOW DO YOU GET AN IMMEDIATE REVIEW?

1. The [**Name of QIO**] is the name of the Quality Improvement Organization - sometimes called a QIO - authorized by Medicare to review the Hospital care provided to Medicare patients. You or your authorized representative, attorney, or court appointed guardian must contact the QIO by telephone or in writing: [**Name, address, telephone and fax number of the QIO**]. If you file a written request, please write, "I want an immediate review".

2. Your request must be made no later than noon of the first working day after you receive this notice.

3. The QIO will make a decision within one full working day after it receives your request, your medical records, and any other information it needs to make a decision.

4. While you remain in the Hospital, your Health Plan will continue to be responsible for paying the costs of your stay until noon of the calendar day following the day the QIO notifies you of its official Medicare coverage decision.

WHAT IF THE QIO AGREES WITH YOUR DOCTOR'S DISCHARGE DECISION?

If the QIO agrees, you will be responsible for paying the cost of your Hospital stay beginning at noon of the calendar day following the day the QIO notifies you of its Medicare coverage decision.

WHAT IF THE QIO DISAGREES WITH YOUR DOCTOR'S DISCHARGE DECISION?

You will not be responsible for paying the cost of your additional Hospital days, except for certain convenience services or items not covered by your Health Plan.

WHAT IF YOU DON'T REQUEST AN IMMEDIATE REVIEW?

If you remain in the Hospital and do not request an immediate review by the QIO, you may be financially responsible for the cost of many of the services you receive beginning [specify date of first non-covered day].

If you leave before [specify date of first non-covered day], you will not be responsible for the cost of care. As with all hospitalizations, you may have to pay for certain convenience services or items not covered by your Health Plan.

WHAT IF YOU ARE LATE OR MISS THE DEADLINE TO FILE FOR AN IMMEDIATE REVIEW?

If you are late or miss the noon deadline to file for an immediate review by your QIO, you may still request an expedited (fast) appeal from your Health Plan. A "fast" appeal means your Health Plan will have to review your request within 72 hours. However, you will not have automatic financial protection during the course of your appeal. This means you could be responsible for paying the costs of your Hospital stay beginning [specify date of first non-covered day].

HOW DO YOU REQUEST A FAST APPEAL?

You may call or fax your request to your Health Plan:

Stamp or Print Here
Name of Health Plan
Address
Phone # and Fax #

If you filed a request for immediate QIO review but were late in filing the request, the QIO will forward your request to your Health Plan as a request for a fast appeal.

If you're filing a written request, please write, "I want a fast appeal."

If you or any doctor asks your Health Plan to give you a fast appeal, your Health Plan must process your appeal within 72 hours of your request.

Your Health Plan may take up to 14 extra calendar days to make a decision if you request an extension or if your Health Plan can justify how the extra days will benefit you. For example, you should request an extension if you believe that you or your Health Plan need more time to gather additional medical information. Keep in mind that you may end up paying for this extended hospital stay.

Please sign to let us know you have received this notice of discharge and appeal rights. By signing this notice, you do not give up your right to appeal this discharge.

_____

Signature of Medicare Enrollee or Authorized Representative Date

cc: [**Health Plan**]

Appendix 4 - Appointment of Representative - Form CMS-1696

(Rev. 88; Issued: 09-21-07; Effective/Implementation Dates: 09-21-07)

The form, Appointment of Representative - Form CMS-1696 - can be found at: http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf

Appendix 5 - Notice of Right to an Expedited Grievance

(Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

MODEL NOTICE

Date:
Enrollee Name: Enrollee ID Number:

NOTICE OF RIGHT TO AN EXPEDITED GRIEVANCE

This notice informs you about your right to file an expedited grievance

_____You are receiving this notice because we are denying your request for a fast (expedited) decision about your request for a service.

_____You are receiving this notice because we are denying your request for a fast (expedited) appeal for a service.

Your request has been transferred to our regular processing time frame.

You can file an expedited grievance whenever we do not provide a fast decision about your initial request for a service, or your request to appeal our denial of a service.

This notice informs you about your right to file an expedited grievance

_____You are receiving this notice because we need to take extra days (take an extension) to decide on your request for a service.

_____You are receiving this notice because we need to take extra days (take an extension) to consider your appeal for a service.

An extension allows us up to 14 additional calendar days to make our decision about your request.

What happens during an expedited grievance?

We must decide within 24 hours if our decision to deny or delay making an expedited decision in your case puts your life or health at risk.

If we determine that we should have expedited your request we will do so immediately and notify you of our decision.

Please call us at {insert phone number of health plan contact} if you want to file an expedited grievance, or want more information.

You can also call 1-800-MEDICARE for more information about the expedited grievance process.

Appendix 6 - Waiver of Liability Statement

(Rev. 22, 05-09-03)

WAIVER OF LIABILITY STATEMENT

_____
Medicare/HIC Number

_____
Enrollee's Name

_____ _____
Provider Dates of Service

_____
Health Plan

I hereby waive any right to collect payment from the above-mentioned enrollee for the aforementioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR 422.600.

_____ _____
Signature Date

Appendix 7 - Notice of Medicare Non-Coverage (NOMNC)

(Rev. 62, 09-10-04)

The form, Notice of Medicare Non-Coverage - Form No. CMS-10095 - can be found at: http://www.cms.hhs.gov/MMCAG/Downloads/NOMNC.pdf

The instructions for the Notice of Medicare Non-Coverage can be found at: http://www.cms.hhs.gov/MMCAG/downloads/NOMNCInstructions.pdf

Appendix 8 - Detailed Explanation of Non-Coverage (DENC)

(Rev. 62, 09-10-04)

The form, Detailed Explanation of Non-Coverage - Form No. CMS-10095 - can be found at: http://www.cms.hhs.gov/MMCAG/Downloads/DENC.pdf

The instructions for the Detailed Explanation of Non-Coverage can be found at: http://www.cms.hhs.gov/MMCAG/Downloads/DENCInstructions.pdf

Appendix 9 - FAQs on the Notice and Appeals Process

(Rev. 88; Issued: 09-21-07; Effective/Implementation Dates: 09-21-07)

CMS FAQs on the Notice and Appeals Process can be searched at:
http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=1ats8JXh

NOTE: *To locate FAQs on the notice and appeals process, type in a search term (e.g., "NOMNC" or "DENC") in the "Enter a Search Term" field and select "Phrases" in the "Search by" field.*

Appendix 10 - Model Notice of Appeal Status

(Rev. 88; Issued: 09-21-07; Effective/Implementation Dates: 09-21-07)

NOTICE OF APPEAL STATUS

Date:

Enrollee's name: Enrollee ID Number:

This notice tells you about the appeal request you sent to _____ [health plan]. After looking at the facts in your case, we think that our first decision to deny coverage and/or payment for the service was right.

WHAT HAPPENS NEXT?

Medicare requires us to send all cases where we have not changed our decision to an independent review entity. MAXIMUS *Federal Services, Inc.* is the independent review entity that Medicare uses to review cases to make sure that we made the right decision.

Your appeal is being sent to MAXIMUS *Federal Services, Inc.* You have the right to submit additional information that may be important to the review of your appeal. MAXIMUS *Federal Services, Inc.* will contact you soon to let you know where to send any additional information and about other rights that you may have.

You also have the right to get a copy of the case file that we are sending to MAXIMUS *Federal Services, Inc.* Please call us at (___)_____ if you want to get a copy of your case file. There may be a small fee to copy your file and send it to you.

NEED MORE HELP?

Call 1-800-MEDICARE (1-800-633-4227) *24 hours a day, including weekends,* for help or more information about the appeals process. *TTY* users should call 1-877-486-2048.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R88MCM	09/21/2007	Revisions to Chapter 13, Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals Applicable to Medicare Advantage Plans, Cost Plans, and Health Care Prepayment Plans (HCPPs), (collectively referred to as Medicare health plans)	09/21/2007	N/A
R80MCM	03/03/2006	Revisions to Chapter 13, Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals Applicable to Medicare Advantage Plans, Cost Plans, and Health Care Prepayment Plans (HCPPs), (collectively referred to as Medicare health plans)	N/A	N/A
R64MCM	12/03/2004	Surveys, Contracting Strategy, Grievances and Appeals	N/A	N/A
R62MCM	09/10/2004	Medicare+Choice Beneficiary Grievances, Organization Determinations and Appeals	N/A	N/A
R48MCM	04/02/2004	Deletion of §§90.2 - 90.8 and Appendices 8 and 9	N/A	N/A
R45MCM	02/13/2004	Miscellaneous Changes	N/A	N/A
R34MCM	10/03/2003	Miscellaneous Changes	10/01/2003	N/A
R27MCM	07/25/2003	Chapter Reorganization	N/A	N/A
R22MCM	05/09/2003	Initial Issuance of Chapter	N/A	N/A