CMS Manual System

Pub. 100-16 Medicare Managed Care

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

Transmittal 88 **Date: SEPTEMBER 21, 2007**

SUBJECT: 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).

I. SUMMARY OF CHANGES: This transmittal includes the following changes: Addition of definition for 'Medicare Health Plan,' clarifying language to the definition of 'Grievance' and 'Representative'; clarifications to procedures for handling a grievance; clarifications regarding written notification by Medicare health plan of its own decision; clarifications regarding representatives filing appeals for enrollees; clarifications regarding expedited review of coverage terminations in certain provider settings; updates to amounts in controversy; clarifications regarding a new final rule implemented on July 1, 2007, updates regarding collection and reporting cycle dates for data; and updates to several chapter Appendices.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: September 21, 2007
IMPLEMENTATION DATE: September 21, 2007

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	13/Table of Contents
R	13/10.1/Definition of Terms/Grievance
R	13/10.2/Responsibilities of the Medicare Health Plan
R	13/20.3/Procedures for Handling a Grievance
R	13/30/Organization Determinations
R	13/40.2.2/Written Notification by Medicare Health Plan of Its Own Decision
R	13/60.1.1/Representatives Filing Appeals for Enrollees
R	13/60.1.2/Authority of a Representative
R	13/60.1.3/Notice Delivery to Representatives
R	13/80.1/How the Medicare Health Plan Processes Requests for Expedited Reconsiderations

R	13/80.3/Forwarding Adverse Reconsiderations to the Independent Review Entity
R	13/90.2/QIO Expedited Reviews of Coverage Terminations in Certain Provider Settings (SNF, HHA, and CORF)
R	13/90.3/Notice of Medicare Non-Coverage (NOMNC)
R	13/90.4/Meaning of Valid Delivery
R	13/90.10/Authority of a QIO to Request Enrollee Records
R	13/100.2/Determination of Amount in Controversy
R	13/120/Judicial Review
R	13/150.1/Notice of Discharge and Medicare Appeal Rights (NODMAR)
R	13/160/Requesting Immediate Quality Improvement Organization (QIO) Review of Inpatient Hospital Care
R	13/170/Data
R	13/170.1/Reporting Unit for Appeal and Grievance Data Collection Requirements
R	13/170.2/Data Collection and Reporting Periods
R	13/170.3/New Reporting Periods Start Every 6 Months
R	13/170.4/Maintaining Data
R	13/170.5/Appeal and Grievance Data Collection Requirements
R	13/170.5.1/Appeal Data
R	13/170.5.2/Quality of Care Grievance Data
R	13/Appendix 2/Beneficiary Appeals and Quality of Care Grievances Explanatory Data Report
R	13/Appendix 4/Appointment of Representative – Form CMS-1696
R	13/Appendix 9/FAQs on the Notice and Appeals Process
R	13/Appendix 10/Model Notice of Appeal Status

III. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

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)

(Last Updated - Rev. 88, 09-21-07)

Table of Contents

10.1 - Definition of Terms

(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.

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.

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).

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 use*s 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.

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.

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.

80.3 - 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.

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.

90.10 - 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.

100.2 - 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 200*7*, 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.

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.

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.

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.

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, 200*7*, through June 30, 200*7*, would be based on appeals received by the organization from October 1, 200*5*, through September 30, 200*6*, 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.

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, 200*6* to March 31, 200*7*

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, 200*6*, and March 31, 200*7*. 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)

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, 2006 to March 31, 2007

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, 2006 to March 31, 2007

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 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 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.