DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTER FOR MEDICARE

DATE: April 25, 2012

TO: Medicare Advantage Organizations, Medicare Health Care Prepayment Plans, and Medicare Cost Plans

FROM: Arrah Tabe-Bedward
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SUBJECT: Issuance of Update to Chapter 13 ("Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals") of the *Medicare Managed Care Manual*

The Centers for Medicare & Medicaid Services has issued the final, updated version of Chapter 13 ("Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals") of the *Medicare Managed Care Manual.* Significant changes to the guidance include the following:

- Section 10.2 has been updated based on 42 CFR §422.562, to require plans to employ a medical director to ensure the clinical accuracy of all organization determinations and reconsiderations involving medical necessity.
- Section 40.1.1 has been updated based on 42 CFR §422.566, to require health care professionals to review organization determinations involving medical necessity.
- Section 70.1 has been updated based on 42 CFR §422.578, to clarify that treating physicians, upon providing notice to an enrollee and acting on the enrollee's behalf, may request a pre-service reconsideration without being the enrollee's representative.
- Sections 150 through 160 have been revised in accordance with revised 42 CFR §§422.620 and 422.622, as well as Chapter 30 of the *Claims Processing Manual.*
- Two model notices located in Appendices 6 and 10 have been updated. The updated notices become effective 90 days after the effective date of this chapter.

The updated version of Chapter 13 and the attached summary document will be posted at: http://www.cms.gov/MMCAG/. In addition, the chapter, which is part of Publication 100-16, is accessible online with the other chapters of the *Medicare Managed Care Manual* at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c13.pdf

The version of Chapter 13, posted on April 23, 2012, at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c13.pdf, **supersedes previous versions of this guidance and is effective March 23, 2012.**

Any questions concerning this guidance should be directed to your CMS account manager.

Summary of Changes for MMCM Chapter 13
Substantive Changes
2012 Update

Section 10.1 – Definition of Terms

- Updated the definition of an Organization Determination, per 42 CFR §422.566(b)(4), including MSA actions which are considered organization determinations.
- Conforming changes made to pages 23-25, Section 30 – Organization Determinations.
- Updated definition of inquiry for consistency with Chapter 18.

Section 10.2 – Responsibilities of the Medicare Health Plan

- Updated Section 10.2, based on 42 CFR §422.562, requiring plans to employ a medical director.

Section 10.4 – Representatives (including subsections)

- Added language to clarify the role of representatives and provider interaction with representatives.

Section 40.1.1 – Who Must review an Organization Determination

- Based on 42 CFR §422.566, added requirement that health care professionals review medical necessity organization determinations.

Section 40.2.3 - Notice Requirements for Non-contract Providers

- Based on audit experience and improper denial notice delivery, clarified health plan requirements concerning non-contract provider reconsideration rights.

Section 70.1 – Who May Request Reconsideration

- Based on 42 CFR §422.578, clarified that a treating physician, upon providing notice to an enrollee and acting on the enrollee's behalf, may request a pre-service reconsideration without being the enrollee's representative.

Section 70.1.1 – Medicare Health Plan Procedures for Accepting Standard Pre-service Reconsiderations from Physicians

- Described the procedures Medicare health plans are to use in determining whether to accept standard pre-service reconsiderations from physicians, without a completed representative form.

Section 70.2 – How to Request a Standard Reconsideration

- Added additional instructions regarding who can request a reconsideration (as described in 42 CFR §422.578), as well as plan handling of requests received beyond the filing timeframe (for consistency with the Maximus reconsideration manual).

Section 80.5 - Preparing the Case File for the Independent Review Entity

- Added language for consistency with the Maximus reconsideration manual.

Section 90.1 – Storage of Appeal Case Files by the Independent Review Entity

- Added clarifying language regarding storage of appeal case files to be consistent with CMS' Record Management Program.

Section 90.2 – QIO Expedited Review of Coverage Terminations in Certain Provider Settings (SNF, HHA, and CORF)

- Revised language to clarify CMS requirements and to reflect regulations at 42 C.F.R. § 422.624(b) – e.g., replaced "expedited review" references with "fast-track appeals."

Section 90.3 – Notice of Medicare Non-Coverage (NOMNC)

- Added language to provide NOMNC delivery timeframe flexibility under rare circumstances for HHAs.
- Due to confusion over coverage requirements based on NOMNC language stating – "*The Effective Date Coverage of Your Current Services Will End*:", we clarified in the SNF example that the date on the NOMNC is a full covered day, and that the discharge date is the day **after** the effective date coverage is ending.

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

- Based on industry comments, updated language to reflect amending and/or reissuing the NOMNC upon a change in a member's condition.

Section 90.8.1 – Effect of a QIO Fast-Track Determination

- Based on longstanding 42 CFR §422.626(g), added language describing an enrollee's right to pursue a reconsideration and right to pursue a Medicare health plan appeal.

Section 90.9 – Fast-Track Reconsiderations for Medicare Health Plan Enrollees (including subsections)

- Based on longstanding 42 CFR §422.626(g), added language to reflect an enrollee's right to file a QIO reconsideration.

Section 110 – Medicare Appeals Council (MAC) Review (including subsections)

- Updated to reflect current processes in accordance with the current regulation at 42 CFR §§405.1100, et seq.

Section 120 – Judicial Review (including subsections)

- Updated to reflect current processes in accordance with the current regulations at 42 CFR §405.1136.

Section 130 - Reopening and Revising Determinations and Decisions

- Clarified that consistent with 42 CFR §422.616, a party cannot have a reopening and an appeal occurring simultaneously (which references the reopening rules under Part 405, including §405.980(a)(4)).

Section 150 – Immediate Review Process for Hospital Inpatients in Medicare Health Plans

- Removed all language from previous section 150 and replaced it primarily with the information contained in revised 42 CFR §§422.620 and 422.622 as well as Chapter 30 of the *Medicare Claims Processing Manual*.

Section 155 – Hospital Requested Expedited Review

- Added language contained in Chapter 30 of the *Medicare Claims Processing Manual* describing the Hospital Requested Expedited Review process. The authority for both manual provisions is contained in Section 1154(e)(2) of the Social Security Act.

Section 160 – Immediate Reconsiderations

- Removed all language from previous section 160 and replaced it primarily with the information contained in revised 42 CFR §§422.620 and 422.622 as well as Chapter 30 of the *Medicare Claims Processing Manual*.