

PROGRAM MEMORANDUM

DATE: July 22, 1997

NOTE All Medicare Contracting Health Maintenance
TO: Organizations (HMOs),
Competitive Medical Plans (CMPs), and Health Care
Prepayment Plans (HCPPs)

SUBJECT: Implementation of the Expedited Appeal Regulation

A final rule with comment, "Establishment of an Expedited Review Process for Medicare Beneficiaries Enrolled in HMOs, CMPs and HCPPs" was published on April 30 in the Federal Register. Medicare contracting health plans must be in compliance with all requirements of this final rule beginning August 28.

On June 18, we issued a Program Memorandum to all Medicare contracting health plans that included a copy of the final rule, informed them of the compliance date, and provided model appeal language. This Program Memorandum provides the following information:

1. Model Language for Expedited Organization Determinations (**Attachment A**)
2. Flow Charts: Expedited Organization Determination Process and Expedited Appeal Process (**Attachment B**) **downloadable .pdf file** (22kb)
3. Comparison of Standard and Expedited Appeal Processes (**Attachment C**)
4. Qs and As (**Attachment D**)
5. Model Appeal Language: Member Materials, Denial Notices, and Notices of Non-Coverage (NONC) (**Attachment E1**)
6. Model Appeal Language for Claim Denials (**Attachment E2**)

Attachment E1 and E2 replace the Model Appeal Language provided as Attachment A of the June 18 Program Memorandum.

All Medicare contracting health plans will be required to report information to the Health Care Financing Administration (HCFA) on all requests for expedited appeals. We are working with The American Association of Health Plans, HMOs, and The Center for Health Dispute Resolution (The Center) to develop a standard format for collecting this information.

Inform Medicare Enrollees of Their Right to Expedited Reviews

You must notify all Medicare beneficiaries enrolled in your health plan of the expedited 72-hour organization determination and appeal processes and clarify that terminations of health care services are organization determinations which may be appealed. You may notify enrollees through a special letter, an article/insert in a newsletter, or other health plan publication directed to the Medicare enrollee. Medicare enrollees must receive this notification prior to August 28. Allow 10 mailing days. As always, your HCFA regional office (RO) must approve all materials sent to Medicare enrollees.

Use of Model Appeal Language in all Medicare Materials

You must modify all member materials (member handbooks, evidence of coverage, denial notices and NONC) that describe appeal rights. Use of the attached model language will hasten approval through the HCFA ROs. We have revised the Model Appeal Language provided in the June 18 Program Memorandum to reflect comments received. (See Attachments E1 and E2.) The primary change is the creation of separate Model Appeal Language for claim denial notices. Additional minor changes were made to improve the flow of the text. Through December 31, Medicare contracting health plans may use an addendum to inform enrollees of their right to an expedited organization determination and expedited appeal. Beginning January 1, 1998, all health plan documents which describe member rights must incorporate approved language which describes the expedited organization determination process as well as the expedited appeal process.

The June 18 Program Memorandum did not include language for an expedited organization determination. The Model Expedited Organization Determination Language is provided in Attachment A for use in member materials such as the member handbook and evidence of coverage.

Process for Expedited Review

Member Requests

A Medicare enrollee or his/her representative may request, either orally or in writing, an expedited organization determination and/or expedited appeal if the enrollee or his/her representative believes the enrollee's health, life, or ability to regain maximum function may be jeopardized by the standard 60-day organization determination process and/or the standard 60-day appeal process.

You cannot require that an enrollee obtain a physician's statement of support for the expedited request. You are responsible for deciding whether the request for an expedited organization determination and/or expedited appeal meets the criteria.

Physician Requests

Any physician may request or provide oral or written support for an enrollee's request for an expedited organization determination and/or appeal. All physician requests (non-plan physicians as well as plan physicians) and enrollee requests with physician support must be expedited. The physician should be clear that he/she believes the situation is time sensitive and/or the review should be conducted within 72 hours or less as medically necessary or appropriate.

If a physician (whether plan or non-plan) is supporting a **member's** request for expedited determination or appeal, a waiver of payment or appointment of representative form is not required. Health plans may not delay the proceeding to obtain this documentation. A waiver of the provider's right to collect payment from the beneficiary remains required in a retrospective case if a non-plan provider is the appealing party. Non-plan providers do not have appeal rights on their own behalf for preservice cases. However, a beneficiary may appoint anyone, including a non-plan provider, to be his/her representative.

Process for Receiving Requests

You are required to develop a meaningful process for receiving requests for expedited reviews which may include designating an office or department, phone number for oral requests, and FAX machine number to facilitate beneficiary access and health plan receipt of requests for expedited reviews (organization determinations and appeals). These procedures must be clearly explained in member materials including denial notices and NONCs. (See the [Model Appeal Language](#) in Attachments E1 and E2.) In addition, health plans will be accountable for educating staff and provider networks to ensure that requests for expedited review received by medical groups or other health plan offices are referred immediately to the designated health plan office or department. The 72-hour period begins when the request is received by the designated office or department.

Denied Requests

When a request for expedited organization determination or expedited appeal is denied, you should automatically transfer it to the standard 60-day process for review (or such shorter period as required by state law or health plan policy). Do not require the enrollee to file a written appeal. The standard time frame begins with the date the request for expedited review is received. When you deny a request for expedited review, you must orally notify the enrollee immediately and follow up with a written letter of explanation within 2 working days. Include in this letter an explanation that the enrollee's request will be processed within 60-days and that if the enrollee disagrees with the decision to process the appeal in the standard 60-day time frame, the enrollee may file a grievance with the health plan. Provide instructions and the time frame for your grievance process.

If an enrollee **orally** requests a standard 60-day appeal, instruct him/her to file a **written** request and indicate where it should be sent. The standard 60-day appeal process requires that appeals be requested in writing. However, as noted above, if the enrollee requests an expedited 72-hour appeal and you deny the request, you cannot require the enrollee to file a written request before you process the appeal in

the standard 60-day process. You are required to document oral requests for expedited appeals in writing.

Immediate PRO Review

The June 18 Program Memorandum indicated that the hospital NONC must include notification of the immediate PRO review right as well as notification of the standard and expedited appeal processes. Enrollees who are inpatients at a hospital would be well advised to use the immediate PRO review process if they disagree with a decision to discharge, rather than the expedited appeal process, provided that they request the review by noon of the first working day following receipt of the NONC. Medicare law currently provides an immediate (3 working days) PRO review of hospital discharges with financial protection for the beneficiary. Thus, from a beneficiary protection perspective, the beneficiary should choose this option. If an enrollee misses the noon deadline for filing for immediate PRO review, the enrollee can still request an expedited appeal. Medicare contracting health plans must not process any requests for expedited appeal when immediate PRO review is being conducted for hospital discharge. **You should revise your NONC to clearly explain these rights to enrollees .**

Submittal of Cases to The Center

The Center will issue revised forms and instructions for health plan submittal of HCFA-level reconsiderations. These revisions will address both expedited and standard reconsiderations. The new forms and instructions will be based upon, and will not substantially modify, the current instructions. The new instructions will modify case processing time frames as required by the regulations. The new forms will add those data elements necessary for monitoring health plan compliance with expedited appeal processing. One (common) set of forms, based on the current forms, will be used for both types of appeals. The current requirements for the components of the case folder (e.g. medical records, plan contract language, chronologies, etc.) will remain and will apply to both expedited and standard appeals.

Health plans are expected to meet the regulation requirement to send expedited case files to The Center within 24 hours of the health plan's completion of an expedited appeal. At this time, The Center does not plan to routinely staff on weekends, but will work with major delivery vendors to ensure safe and confirmed receipt of material.

Because of confidentiality and technical quality concerns, The Center is not permitted to accept case files by FAX. Hard copies of expedited cases should be sent to The Center by overnight delivery. The Center will modify the current (letter) process for acknowledgments of receipt of case files. The Center is considering a process whereby health plans would notify The Center by FAX or E-mail of the impending submission of an expedited case, with The Center confirming receipt via the same media.

The Center's Additional Information Request Policy

For the past several years, The Center has frequently requested additional information from health plans in order to reach an informed decision.

Effective August 28, in cases where The Center believes that additional information is necessary to reach an informed decision in a reconsideration case, The Center will request this information. Health plans should respond to The Center in accordance with the following timetable:

Expedited Appeals	Within 3 days from the date of request
Pre-service cases, not expedited	Within 10 days from the date of request
Retrospective cases	Within 15 days from the date of request

The Center reserves the right to deviate from (accelerate) these time frames for individual cases when such action is medically indicated. The Center will FAX all information requests to the health plans.

Extensions will not be granted. Second requests for information will no longer be made by The Center. Health plans are reminded that The Center is under no statutory or regulatory requirement to request additional information from the health plans in any case. Accordingly, health plans should make every attempt to submit original case files to The Center with complete information.

In the event that a health plan does not respond to a request for additional information, The Center will decide the case based upon the information contained in the original case file. If the health plan's documentation does not substantiate its denial of a claim, The Center will overturn the health plan's denial.

Health plans that obtain additional pertinent information after submitting a case to The Center may, on their own initiative, submit this information within 3 days of receipt of the appeal case file by The Center. The Center is under no obligation to use this information. Use of the information will depend in part on its relevance to the subject of appeal and the review stage of the case at the time of receipt of the additional information by The Center.

Please direct any comments on submission of appeals case files or additional appeals case information to David Richardson, President, or Judy Feldt, Project Manager, The Center, on (716) 586-1770. If you have comments or questions on the implementation of the Expedited Appeal Regulation you may contact Anne Breslin at (410) 786-1117 or Rae Loen at (410) 786-1104, or by mail at the Center for Health Plans and Providers, Health Plan Purchasing & Administration Group, Division of Program Management & Field Liaison--Team B, S3-18-13, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

/s/

Bruce Merlin Fried
Director
Center for Health Plans and Providers
Attachments

Attachment A

Model Expedited Organization Determination Language for Member Materials

We normally have up to 60 days to determine whether your request for a service is a medically appropriate and covered service. In some cases, you have a right to a decision within 72-hours of your request. You can get a fast decision if your health or ability to function could be seriously harmed by waiting 60 days for a standard decision. If you ask for a fast decision, we will decide whether you get a 72-hour/ fast decision. If not, your request for a service will be processed within 60 days. If any doctor asks **[HMO name]** to give you a fast decision, we must give it to you.

10 - Day Extension

An extension up to 10 working days is permitted beyond the 72-hour period, if the extension of time benefits you; for example, if you need time to provide **[HMO name]** with additional information or if we need to have additional diagnostic tests completed.

Oral and Written Requests

- You may file an oral or written request for a 72-hour decision. Specifically state that "I want an: expedited decision, fast decision or 72-hour decision." or "I believe that my health could be seriously harmed by waiting 60 days for a standard decision."
- To file a request orally, call **[phone number]**. **[name of HMO]** will document the oral request in writing.
- To hand deliver your request our address is **[specific HMO address]** .
- To FAX your request, our number is **[FAX number]** . If you are in a hospital or a nursing facility, you may request assistance in having your written

request for a service transmitted to **[name of HMO]** by use of a FAX machine.

- To mail a written request, our mailing address is: **[HMO/CMP Appeal Department address]**, however, the 72-hour review time will not begin until your request for appeal is received.

(HMOs with other options for accepting requests for expedited organization determinations should describe them here. For example this might include beneficiary requests for a service while in a physicians office. Also include information here on how the beneficiary may provide additional information.)

We will make a decision on your request for a service and notify you of our decision within 72-hours of receipt of your request.

NOTE:

- 1.
2. **If state law or health plan policies require the determination be made in fewer than 60 days, the shorter period should be reflected in the notice.**
3. **If a medical group is issuing the notice, whenever reference is made to the HMO, reference to the medical group should be substituted.**
4. **This model language may be used in member materials such as member handbooks and the evidence of coverage.**

Attachment C

A COMPARISON OF THE FEDERAL APPEAL PROCESSES FOR MEDICARE MANAGED CARE

STANDARD 60 DAY APPEAL	EXPEDITED 72 HOUR APPEAL
Organization Determinations for which the 60 day appeal is available: <ol style="list-style-type: none">1. Payment for emergency or urgently needed services received2. Any other health services furnished by a provider or supplier other than the health plan that the	Organization Determinations for which the 72-hour appeal is available: <ol style="list-style-type: none">1. The health plan's refusal to provide services that the enrollee believes should be furnished or arranged for by the health plan and the enrollee has not received

<p>enrollee believes:</p> <ul style="list-style-type: none"> ○ are covered under Medicare; and ○ should have been furnished, arranged for, or reimbursed by the health plan <p>3. The health plan's refusal to provider services that the enrollee believes should be furnished or arranged for by the health plan and the enrollee has not received the services outside the health plan.</p> <p>4. Decisions to discontinue services when the enrollee believes there is a continuing need for the service.</p>	<p>the services outside the health plan.</p> <p>2. Decisions to discontinue services when the enrollee believes there is a continuing need for the service.</p>
<p>Notice of Adverse Organization Determinations</p> <p>Must notify enrollee within 60 calendar days of receiving enrollee's request for payment or services.</p> <ul style="list-style-type: none"> • state reasons for determinations • inform enrollee of appeal rights 	<p>Notice of Adverse Organization Determination</p> <p>If the expedited appeal is granted, the health plans must notify the enrollee within 72 hours of receiving the enrollee's request for services.</p> <ul style="list-style-type: none"> • state reasons for determination • inform enrollee of appeal rights <p>Health plan must grant all physician requests and enrollee requests with physician support for an expedited organization determination.</p> <p>In cases where health plan must receive medical information from a non-affiliated physician or provider, the time standard begins with receipt of the information</p>
<p>Request for Reconsideration</p> <p>Requests for reconsideration must be made in writing and filed with the health plan, SSA, or the RRB.</p> <p>Requests must be filed within 60 calendar days of the organization determination</p> <ul style="list-style-type: none"> • exception for good cause 	<p>Request for Reconsideration</p> <p>Requests for expedited reconsideration may be made orally or in writing and filed with the health plan, per health plan instructions.</p> <p>Health plan must document oral requests in writing.</p> <p>Health plan determines if the standard 60 day process could seriously jeopardize the</p>

	<p>life or health of the enrollee or the enrollee's ability to regain maximum function. Orally notify enrollee that his/her appeal will be processed within 60 days if his/her request is not expedited, and follow-up with a written notice within 2 working days.</p> <p>Health plan must grant all physician requests and beneficiary requests with physician support for expedited reconsideration.</p>
<p>Opportunity to Submit Evidence</p> <p>Health plan must provide the parties to the reconsideration reasonable opportunity to present evidence and allegations of fact or law related to the issues in dispute. Allow parties to present such evidence in person or in writing and take the evidence into account.</p>	<p>Opportunity to Submit Evidence</p> <p>In the case of an expedited reconsideration, the opportunity to present evidence is limited by the short time frames for issuing decisions. Health plans must provide the parties to the reconsideration reasonable opportunity to present evidence and allegations of fact or law related to the issue in dispute. Allow parties to present such evidence in person or in writing and take the evidence into account. Health plans must inform enrollee or representative of the conditions for submitting evidence, in person, via telephone or in writing using FAX or electronic transfer of information.</p>
<p>Responsibility for Reconsideration Time Limits</p> <ul style="list-style-type: none"> a. If health plan makes a fully favorable decision, issue the reconsideration decision within 60 calendar days from the date of receipt of the request for reconsideration. b. If health plan recommends partial or complete affirmation of its adverse determination - the health plan must prepare a written explanation and send the entire case to the HCFA contractor within 60 calendar days of the receipt of the request for reconsideration. HCFA makes the reconsideration determination. 	<p>Responsibility for Reconsideration Time Limits</p> <ul style="list-style-type: none"> a. if health plans makes a favorable decision, issue the reconsideration decision within 72 hours from the date of receipt for reconsideration. <ul style="list-style-type: none"> o an extension of up to ten working days is permitted if the enrollee requests it or if the health plan finds that additional information is necessary and the delay is in the interest of the enrollee. o if initial notification is given orally, written confirmation must be mailed within 2 working days.

<p>For good cause, HCFA may allow extensions to the time limit.</p> <p>Failure of the health plan to issue a reconsidered determination within the 60 calendar day limit constitutes an adverse determination and the file must be submitted to the HCFA contractor.</p> <p>Health plan must concurrently notify beneficiary that his or her case has been forwarded to the HCFA contractor.</p>	<ul style="list-style-type: none"> o for cases where the health plan must receive medical information from a non-affiliated physician or provider, the time standard begins with receipt of the information <p>b. If health plan recommends partial or complete affirmation of its adverse determination - the health plan must prepare a written explanation and send the entire case to the HCFA contractor within 24 hours of its determination, the expiration of the 72 hour review period or the expiration of an extension.</p> <p>For good cause, HCFA may allow extensions to the time limit.</p> <p>Faulure of the health plan to issue a reconsidered dtermination within the 72 hour limit or expiration of an extension constitutes an adverse determination and the file must be submitted to the HCFA contractor.</p> <p>Health plan must concurrently notify beneficiary that his or her case has been forwarded to the HCFA contractor.</p>
<p>HCFA Reconsideration Time Limits</p> <p>The HCFA contractor, The Center for Health Dispute Resolution (The Center), decides cases within 30 working days. Beginning August 28, 1997:</p> <ol style="list-style-type: none"> 1. Health plans will have up to 10 days from the date of The Center's request to submit additional information for preservice cases which are not expedited and; 2. Health plans will have up to 15 days from The Center's request to submit additional information for retrospective cases. 	<p>HCFA Reconsideration Time Limits</p> <p>The HCFA contractor, The Center for Health Dispute Resolution (The Center), will decide expedited appeals within 10 working days. Beginning August 28, 1997, health plans will have up to 3 days from the date of The Center's request to submit additional information.</p>

**Questions and Answers for Health Plans Regarding
The Final Rule with Comment Titled
The Medicare Program: Establishment of an Expedited Review
Process
for Medicare Beneficiaries Enrolled in HMOs, CMPs and HCPPs**

1. **By what date must health plans be in compliance with the new expedited review processes?**

August 28, 1997.

2. **When and how must we inform enrollees of their expedited review rights?**

In order to comply with the new regulations health plans must notify Medicare enrollees of the expedited/72-hour organization determination and appeal processes prior to August 28. You may notify enrollees through a special letter, an article/insert in a news letter or other health plan publication directed to the Medicare enrollee. **In addition, health plan documents (such as Evidence of Coverage, Member Handbook, etc.) that provide Medicare beneficiaries with information about their appeal rights must be amended.** Until December 31 or until the next printing--whichever comes first--the current description of appeal rights must be amended by an insert which describes the expedited process for organization determinations and appeals. Beginning January 1, 1998, all health plan documents must incorporate approved language which describes the expedited organization determination process as well as the expedited reconsideration process. All Notices of Noncoverage (NONC) and all denial notices must be revised by **August 28** .

3. **Is Model Appeal language available?**

Yes. In order to hasten approval of new HMO appeals language through the HCFA Regional Office and state authorities, we provided Model Appeal Language in the June 18, 1997 Program Memorandum. This language has been revised and is replaced by the separate Model Appeal Language for Claim Denials and Service Denials provided in the July 1997 Program Memorandum. Use of this language will facilitate approval by early August and thus meet HCFA requirements for having this information in place.

4. **Will HCFA provide training for health plan staff?**

Yes, HCFA plans to hold training sessions in various parts of the country. These sessions are in San Francisco on August 21, Chicago on August 25, and New York in September (date to be determined).

5. **Who can request an appeal (Standard 60-day or Expedited 72-hour)?**

1. An enrollee may file an appeal.
2. If an enrollee wants someone to file the appeal for him or her:
 - a. The enrollee should provide his/her name, Medicare number, and a statement which appoints an individual as his/her representative.

(Note: The enrollee may appoint any provider.)

For example: "I **[enrollee]** appoint **[name of representative]** to act as my representative in requesting an appeal from **[name of HMO]** and/or the Health Care Financing Administration regarding **[name of HMO]** 's (denial of services) or (denial of payment for services).

NOTE: Denial of payment for services may only be appealed under the Standard 60 day appeal process.

- b. The enrollee must sign and date the statement.
 - c. The enrollee's representative must also sign and date this statement unless he/she is an attorney.
 - d. The enrollee must include this signed statement with his/her appeal.
3. A non-plan provider may file a standard appeal for a denied claim if he/she completes a waiver of beneficiary payment statement which says he/she will not bill the enrollee regardless of the outcome of the appeal.
4. A court appointed guardian or an agent under a health care proxy to the extent provided under state law may file a standard or expedited appeal.

6. **What other authority does a representative of a beneficiary have?**

On behalf of a beneficiary, a representative may:

1. Obtain information about the beneficiary's claim to the same extent that the beneficiary is able to;
2. Submit evidence;

3. Make statements about facts and law; and
4. Make any request or give any notice about the proceedings.

7. **Does the expedited appeal regulation extend appeal rights to plan physicians and providers?**

No. However, plan physicians and providers may be appointed representatives by beneficiaries or may provide statements in support of a beneficiary's request for an expedited appeal.

8. **Does the expedited appeal regulation change the requirement that requests for standard 60 day appeals be filed in writing?**

No. Requests for standard 60-day appeals must be filed in writing. If an enrollee **orally** requests a standard 60-day appeal, instruct him/her to file a **written** request and indicate where it should be sent. The standard 60-day appeal process requires that appeals be requested in writing. However, if the enrollee requests an expedited 72-hour appeal and you deny the request, you cannot require the enrollee to file a written request before you process the appeal in the standard 60 day process. You are required to document oral requests for expedited appeals in writing.

9. **What is an expedited organization determination?**

Normally health plans have 60 days to process a Medicare enrollee's request for a service. In some cases, enrollees have a right to an expedited/72-hour organization determination. An enrollee can get an expedited organization determination if his/her health, life, or ability to regain maximum function may be jeopardized by the standard 60-day organization determination process.

10. **What is an expedited appeal?**

Normally health plans have 60 days to process a Medicare enrollee's appeal. In some cases, enrollees have a right to an expedited/72-hour appeal. An enrollee can get an expedited appeal if his/her health, life, or ability to regain maximum function may be jeopardized by the standard 60-day appeal process.

11. Does an enrollee have to have an expedited organization determination in order to get an expedited appeal?

An expedited determination is not a prerequisite to an expedited appeal. An expedited appeal may be granted even if the organization determination proceeded through the standard 60-day process. A request for an expedited appeal must be considered independently from a request for an expedited organization determination and may be granted even if the request for expedited organization determination is denied.

12. If an enrollee requests an expedited review and supports the request with a letter from a physician noting the urgent need for the services, is the health plan obligated to process the request in the expedited 72-hour process?

Yes. In this example, the beneficiary has filed the request for expedited review (organization determination / reconsideration (appeal)). Because there is physician support, the expedited review must be conducted. Health plans are not permitted to turn down a physician's request for an expedited review on behalf of an enrollee, or to turn down an enrollee's request for an expedited review when it is supported by a physician.

13. Under what circumstances may a health plan turn down a physician's request for an expedited appeal?

- A. Health plans must not process enrollee and physician requests for an expedited appeal regarding hospital discharge if an immediate PRO review for hospital discharge is being conducted.
- B. Health plans are not required to grant a physician's request for expedited review when the request concerns a denial of payment.

14. What can be appealed?

Medicare enrollees can appeal if they do not agree with **[name of HMO or name of medical group]** decisions about their health care. **They have a right to appeal if they think:**

- o **[name of HMO or medical group]** has not paid a bill
- o **[name of HMO or medical group]** has not paid a bill in full
- o **[name of HMO or medical group]** will not approve or give him/her care that should be covered
- o **[name of HMO or medical group]** is stopping care that he/she still needs.

NOTE: The 72-hour appeal process does not apply to denials of payment.

15. Is hospital discharge subject to the expedited appeal process?

The June 18 Program Memorandum indicated that the Hospital NONC must include the immediate PRO review right as well as the standard and expedited appeal processes. We wish to clarify that enrollees who are inpatients at a hospital would be well advised to use the immediate PRO review process if they disagree with a discharge decision. However, if an enrollee misses the noon deadline for filing for immediate PRO review, the enrollee may still request an expedited review. Medicare contracting health plans should not process any requests for expedited appeal when immediate PRO review is being conducted for hospital discharge.

16. Is a denial based on exhaustion of benefits appealable?

Yes. Exhaustion of a benefit is a termination which is an appealable organization determination. Depending on the circumstances, this appeal may fall under either the standard or expedited appeal process.

17. Is a physician who orally requests an expedited review on behalf of an enrollee required to obtain a signed statement from the enrollee authorizing the representation?

Yes. Health plans must be able to document that a request for appeal is valid. Therefore, representative statements are required every time a beneficiary appoints someone to act on his/her behalf on appeal. This representative designation is valid throughout all levels of the appeal process for the appeal case. Representative statements must be provided to the health plan. The health plan is expected to commence its review prior to receipt of the statements. However, the health plan is not obligated to issue a determination prior to receipt of the statement.

18. Is a representative statement required of physicians who support a beneficiary's request for expedited appeal?

No. Physician calls, FAXES etc. in support of a beneficiary's request for expedited review do not require a representative statement. In cases where the physician is supporting a request, the beneficiary is responsible for filing the appeal request by phone, by FAX, in person or by mail. If you have not yet heard from the beneficiary contact the beneficiary to document the beneficiary's appeal.

19. Can a health plan designate the office or department within its organization where requests for expedited review are to be made?

Yes. Health plans are required to develop a meaningful process for receiving requests for expedited appeals that may include designating an office or department, phone number for oral requests, and FAX machine number to facilitate beneficiary access and health plan receipt of requests for expedited reviews. These procedures must be clearly explained in member materials including denial notices and NONCs. In addition, health plans will be accountable for educating staff and provider networks to ensure that requests for expedited review received by medical groups or other health plan offices are referred immediately to the designated health plan office or department.

20. Who makes the decision to expedite?

Health plans have the responsibility for deciding whether or not an enrollee's request for expedited review is granted with the following exception: If a physician files the request as a representative of the enrollee or files a statement orally or in writing in support of a request by a beneficiary, the health plan must conduct an expedited review.

21. What happens when we deny a request for expedited organization determination or appeal?

When a request for expedited organization determination or expedited appeal is denied, the health plan must automatically transfer it to the standard 60-day process for review. The health plan may not request that the enrollee file a written appeal. The standard time frame begins with the date the health plan receives the request for expedited review.

22. How and when do we inform the enrollee of the decision to deny an expedited review?

When the health plan denies a request for expedited review, it must notify the enrollee orally at once and follow-up with a written letter of explanation within 2 working days. The plan must include in this letter an explanation that the enrollee's request will be processed within 60-days and that if the enrollee disagrees with the decision to deny an expedited review, the enrollee may file a grievance with the health plan. The health plan must provide instructions and the time frame for the grievance process.

23. Does the enrollee have a right to appeal a health plan decision to deny an expedited review?

No. However, the enrollee may file a grievance with the health plan. The health plan must provide instructions to its enrollees regarding this right including the time frame for the grievance process.

24. How can health plans give enrollees an opportunity to present evidence during the 60-day and the 72-hour expedited review process?

Health plans must give the enrollee an opportunity to present evidence during the standard and expedited review periods. Health plans must inform enrollees of this right when the enrollee makes the request for an appeal. The health plan must allow the enrollee to present this information in any reasonable manner, including in person, by telephone and by FAX.

25. Are there any circumstances under which the health plan could request an extension of the 72-hour time frame?

An extension of up to 10 working days is permitted if requested by the enrollee or if the HMO or CMP finds that additional information is necessary and the delay is in the interest of the enrollee. Examples of reasons for an extension include additional diagnostic testing or consultations with medical specialists or a beneficiary request for the extension in order to provide the health plan with additional information. HMOs are not permitted to use the extension to gather information from contracted providers, HMOs must have internal mechanisms for gathering information from contracted providers within the 72-hour timeframe.

26. How is the 10 day extension obtained?

If the beneficiary needs an extension of up to 10 days, he/she orally informs the health plan and explains to the health plan why he/she feels the extension is necessary. Health plans must document beneficiary requests for extensions in writing.

If the health plan needs an extension of up to 10 days, the health plan orally informs the beneficiary and explains to the beneficiary why the health plan feels the extension is necessary, how the extension will benefit the beneficiary and when the decision will be made. Health plans must follow-up with the beneficiary in writing.

27. Are there any circumstances under which the health plan could request an extension greater than 10 working days.

No. However, in a specific circumstance, the elapsed time period for a plan decision may exceed 10 working days. In this circumstance, if the health plan has requested information from non-affiliated physicians or other providers, the regulation provides that the plan's decision must be made within 72-hours of receipt of the requested information. As the information might be received on the 10th day, the time period could exceed 10 working days.

Note: No extension of time will be permitted if network providers have failed to submit information required by the health plan.

28. Is there an expedited process for the Administrative Law Judge Level and beyond?

No, the expedited processes only apply to the HMO level reconsideration and the HCFA level reconsideration.

Attachment E1

**MODEL APPEAL LANGUAGE
FOR MEMBER MATERIALS AND SERVICE DENIALS**

**(Must be in 12 point type)
You Have a Right to Appeal**

You can appeal if you do not agree with **[name of HMO or name of medical group]** decisions about your medical bills or health care. **You have a right to appeal if you think:**

- **[name of HMO or name of medical group]** has not paid a bill
- **[name of HMO or name of medical group]** has not paid a bill in full
- **[name of HMO or name of medical group]** will not approve or give you care it should cover
- **[name of HMO or name of medical group]** is stopping care you still need.

NOTE: If a medical group is issuing the denial notice with the required Model Appeal Language, whenever the word "we" is used, it should be replaced with the name of the HMO.

We normally have 60 days to process your appeal. In some cases, you have a right to a faster, 72-hour appeal. You can get a fast appeal if your health or ability to

function could be seriously harmed by waiting 60 days for a standard appeal. If you ask for a fast appeal, we will decide if you get a 72-hour/ fast appeal. If not, your appeal will be processed in 60 days. If any doctor asks **[HMO name]** to give you a fast appeal, or supports your request for a fast appeal, we must give it to you.

60-Day Appeal Process

If you want to file an appeal which will be processed within 60 days, do the following:

- File the request in writing with **[HMO name]** at the following address: (-----), or with an office of the Social Security Administration, of ir you are a railroad annuitant, with the Railroad Retirement Board.
- Mail, FAX, or deliver your request in person. **[Please provide mailing address, and the address where hand delivered requests are received if different and FAX number.]**
- File your request within 60 days of the **[date of this notice]** which is **[date]**.
- See the following sections which apply to both the 60-day appeal and the 72-hour appeal: **"Support for Your Appeal, Who May File an Appeal, Help With Your Appeal, and Peer Review Organization Complaint Process"**

Even though you may file your request with the Social Security Administration or Railroad Retirement Board office, that office will transfer your request to **[name of HMO]** for processing. We are responsible for processing your appeal request within 60 days from the date we receive your request. If we do not rule fully in your favor, we will forward your appeal request to the Health Care Financing Administration's contractor (The Center for Health Dispute Resolution) for a decision.

72-Hour Appeal Process

(Does not apply to denials of payment)

If you want to file an appeal which will be processed within 72 hours, do the following:

- File an oral or written request for a 72-hour appeal. Specifically state that "I want an: expedited appeal, fast appeal or 72-hour appeal." or "I believe that my health could be seriously harmed by waiting 60 days for a normal appeal."

- To file a request orally, call **[phone number]**. **[name of HMO]** will document the oral request in writing.
- To hand deliver your request, our address is **[specific HMO address]** .
- To FAX your request, our FAX number is **[FAX number]**. If you are in a hospital or a nursing facility, you may request assistance in having your written appeal transmitted to **[name of HMO/CMP]** by use of a FAX machine.
- To mail a written request, our address is: **[HMO/CMP Appeal Department address]** however, the 72-hour review time will not begin until your request for appeal is received.
- You must file your request within 60 days of the **[date of this notice]** which is **[date]** .

(HMOs with other options for accepting appeal requests should describe them here. For example delivering appeals requests in person to a member services office. Also include information here on how the beneficiary may provide additional information.)

10-Day Extension

An extension up to 10 working days is permitted for a 72-hour appeal, if the extension of time benefits you; for example, if you need time to provide [HMO name] with additional information or if we need to have additional diagnostic tests completed.

We will make a decision on your appeal and notify you of it within 72-hours of receipt of your request. However, if our decision is not fully in your favor, we will automatically forward your appeal request to the Health Care Financing Administration's contractor, (The Center for Health Dispute Resolution (The Center)), for an independent review. The Center will send you a letter with their decision within 10 working days of receipt of your case from [name of HMO/CMP] .

THE FOLLOWING INFORMATION APPLIES TO BOTH 60-DAY APPEALS AND 72-HOUR APPEALS Support for Your Appeal

You are not required to submit additional information to support your request for services or payment for services already received. [Name of HMO] HMOs that have different procedures for members to follow in order to obtain medical records or physician opinions should describe them here. Please describe the process for obtaining medical records or physician opinions for the 72-hour appeal process. [Name of HMO] will provide an opportunity for you to provide additional information in person or in writing.

Who May File an Appeal

1. You may file an appeal.
2. If you want someone to file the appeal for you:
 - a. Give us your name, your Medicare number, and a statement which appoints an individual as your representative. (Note: You may appoint any provider.)

For example: "I [your name] appoint [name of representative] to act as my representative in requesting an appeal from [name of HMO] and/or the Health Care Financing Administration regarding [name of HMO]'s (denial of services) or (denial of payment for services).

- b. You must sign and date the statement.
 - c. Your representative must also sign and date the statement unless he/she is an attorney.
 - d. Include this signed statement with your appeal.
3. A non-plan provider may file a standard appeal of a denied claim if he/she completes a waiver of liability statement which says he/she will not bill you regardless of the outcome of the appeal.
4. A court appointed guardian or an agent under a health care proxy to the extent provided under state law.

Help With Your Appeal

If you decide to appeal and want help with your appeal, you may have your doctor, a friend, lawyer, or someone else help you. There are several groups that can help you. You may want to contact the Area Agency on Aging at [phone number], the Insurance, Counseling, and Assistance Program at [phone number], the Medicare Rights Center at Toll Free 888-HMO-9050.

NOTE: In addition to the above sources of assistance, the State Ombudsman at [phone number] should be added to all SNF notices of noncoverage.

FOLLOWING ARE TWO QUALITY COMPLAINT PROCESSES WHICH ARE SEPARATE FROM THE APPEAL PROCESS DESCRIBED ABOVE
Peer Review Organization Complain Process

If you are concerned about the quality of the care you have received, you may also file a complaint with the local Peer Review Organization [Name of PRO and phone number] . Peer Review Organizations are groups of doctors and health professionals that monitor the quality of care provided to Medicare beneficiaries. The Peer Review Organization review process is designed to help stop any improper practices.

[HMO name] Quality Complaint Process

You may also file a written quality complaint with [HMO name]. [Please describe your written procedures including time frames for investigating these types of complaints (called grievances).] We will review your complaint and notify you in writing of our conclusion. This process is separate from the appeal process described above. Please call [phone number] for additional information.

Attachment E2

MODEL APPEAL LANGUAGE FOR CLAIMS DENIALS

(Must be in 12 point type)

You Have a Right to Appeal

You can appeal if you do not agree with [name of HMO or name of medical group] decisions about your medical bills or health care. **You have a right to appeal if you think:**

- [name of HMO or name of medical group] has not paid a bill
- [name of HMO or name of medical group] has not paid a bill in full
- [name of HMO or name of medical group] will not approve or give you care it should cover
- [name of HMO or name of medical group] is stopping care you still need.

NOTE: If a medical group is issuing the denial notice with the required Model Appeal Language, whenever the word "we" is used, it should be replaced with the name of the HMO.

60-Day Appeal Process

If you want to file an appeal which will be processed within 60 days, do the following:

- File the request in writing with **[HMO name]** at the following address: (-----), or with an office of the Social Security Administration, of ir you are a railroad annuitant, with the Railroad Retirement Board.
- Mail, FAX, or deliver your request in person. **[Please provide mailing address, and the address where hand delivered requests are received if different and FAX number.]**
- File your request within 60 days of the **[date of this notice]** which is **[date]**.
- See the following sections which apply to both the 60-day appeal and the 72-hour appeal: **"Support for Your Appeal, Who May File an Appeal, Help With Your Appeal, and Peer Review Organization Complaint Process"**

Even though you may file your request with the Social Security Administration or Railroad Retirement Board office, that office will transfer your request to **[name of HMO]** for processing. We are responsible for processing your appeal request within 60 days from the date we receive your request. If we do not rule fully in your favor, we will forward your appeal request to the Health Care Financing Administration's contractor (The Center for Health Dispute Resolution) for a decision.

Support for Your Appeal

You are not required to submit additional information to support your request for services or payment for services already received. **[Name of HMO]** is responsible for gathering all necessary medical information, however, it may be helpful to you to include additional information to clarify or support your position. For example, you may want to include in your appeal request information such as medical records or physician opinions in support of your appeal. To obtain medical records, send a written request to your primary care physician. If your medical records from specialist physicians are not included in your medical record from your primary care physician, you may need to make a separate written request to the specialist physician(s) who provided medical services to you. **HMOs that have different procedures for members to follow in order to obtain medical records or physician opinions should describe them here.** **[Name of HMO]** will provide an opportunity for you to provide additional information in person or in writing.

Who May File an Appeal

1. You may file an appeal.
2. If you want someone to file the appeal for you:

- a. Give us your name, your Medicare number, and a statement which appoints an individual as your representative. (Note: You may appoint any provider.)

For example: "I **[your name]** appoint **[name of representative]** to act as my representative in requesting an appeal from **[name of HMO]** and/or the Health Care Financing Administration regarding **[name of HMO]**'s (denial of services) or (denial of payment for services).

- b. You must sign and date the statement.
 - c. Your representative must also sign and date the statement unless he/she is an attorney.
 - d. Include this signed statement with your appeal.
3. A non-plan provider may file a standard appeal of a denied claim if he/she completes a waiver of liability statement which says he/she will not bill you regardless of the outcome of the appeal.
 4. A court appointed guardian or an agent under a health care proxy to the extent provided under state law.

Help With Your Appeal

If you decide to appeal and want help with your appeal, you may have your doctor, a friend, lawyer, or someone else help you. There are several groups that can help you. You may want to contact the Area Agency on Aging at **[phone number]**, the Insurance, Counseling, and Assistance Program at **[phone number]**, the Medicare Rights Center at Toll Free 888-HMO-9050.

NOTE: In addition to the above sources of assistance, the State Ombudsman at [phone number] should be added to all SNF notices of noncoverage.

FOLLOWING ARE TWO QUALITY COMPLAINT PROCESSES WHICH ARE SEPARATE FROM THE APPEAL PROCESS DESCRIBED ABOVE

Peer Review Organization Complain Process

If you are concerned about the quality of the care you have received, you may also file a complaint with the local Peer Review Organization **[Name of PRO and phone number]**. Peer Review Organizations are groups of doctors and health professionals that monitor the quality of care provided to Medicare beneficiaries. The Peer Review Organization review process is designed to help stop any improper practices.

[HMO name] Quality Complaint Process

You may also file a written quality complaint with **[HMO name]**. **[Please describe your written procedures including time frames for investigating these types of complaints (called grievances).]** We will review your complaint and notify you in writing of our conclusion. This process is separate from the appeal process described above. Please call **[phone number]** for additional information.