

# Medicare Managed Care Manual

## Chapter 13 - Medicare+Choice Beneficiary Grievances, Organization Determinations, and Appeals

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## **10 - Medicare+Choice (M+C) Beneficiary Grievances, Organization Determinations, and Appeals**

**(Rev. 62, 09-10-04)**

This chapter deals with organization determinations and appeals for beneficiaries enrolled in a plan provided by a Medicare+Choice (M+C) organization and with any other complaints the enrollee may have with the M+C organization and any of the plans it offers. Noncontracted providers may have appeal rights in limited circumstances. For current Medicare plans that are converting to M+C organizations, these instructions supersede previous related instructions concerning appeal procedures for Medicare contracting health plans. Managed care organizations that are not converting to M+C organizations should continue to follow instructions previously set forth in the HMO/CMP Manual. *Additional information related to Appeals and Grievances may also be found at <http://www.cms.hhs.gov/healthplans/appeals>. M+C organizations are encouraged to view the website Q&As regularly for additions and clarifications to existing policy.*

### **10.1 - Definition of Terms**

**(Rev. 22, 05-09-03)**

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 M+C organization and if necessary, an independent review entity, hearings before Administrative Law Judges (ALJs), review by the Departmental Appeals Board (DAB), and judicial review.

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

**Authorized Representative:** Any individual authorized by an enrollee, or a surrogate who is acting in accordance with state law on behalf of the enrollee, in order to obtain an organization determination or deal with any level of the appeals process. Representatives are subject to the rules described in [20 CFR Part 404, Subpart R](#), unless otherwise stated in this chapter of the manual.

**Complaint:** Any expression of dissatisfaction to an M+C organization, provider, facility or Quality Improvement Organization (QIO) by an enrollee made orally or in writing. This can include concerns about the operations of providers, insurers, or M+C organizations 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 the organizations' refusal to provide services the enrollee believes he or she is entitled. A complaint could be either a grievance or an appeal, or a single complaint could include both. Every complaint must be handled under the appropriate grievance or appeal process.

**Effectuation:** Compliance with a reversal of the M+C organizations' original adverse organization determination. Compliance may entail payment of a claim, authorization for a service, or provision of services.

**Enrollee:** An M+C eligible individual who has elected an M+C plan offered by an M+C organization, or his/her authorized representative.

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

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 M+C organizations' denial of coverage determinations.

**Inquiry:** Any oral or written request to an M+C organization, provider, or facility, without an expression of dissatisfaction, e.g., a request for information or action by an enrollee.

**Organization Determination:** Any decision made by or on behalf of a M+C organization regarding payment or services to which an enrollee believes he or she is entitled.

**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. They 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 managed care plans, and ambulatory surgical centers. The QIOs also review continued stay denials in acute inpatient hospital facilities.

**Quality of Care Issue:** A quality of care issue may be filed through the M+C organization's grievance process and/or a QIO. A QIO must determine whether the quality of services (including both inpatient and outpatient services) provided by an M+C organization meets professionally recognized standards of health care, including whether appropriate health care services have not been provided or have been provided in inappropriate settings.

**Reconsideration:** An enrollee's first step in the appeal process; an M+C organization or independent review entity may reevaluate an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.

## **10.2 - Responsibilities of the M+C Organization**

**(Rev. 22, 05-09-03)**

Each M+C organization and each M+C plan that it offers must establish and maintain procedures for:

1. Standard and expedited organization determinations;
2. Standard and expedited appeals; and
3. Grievances.

M+C organizations also must provide written information to enrollees about the grievance and appeal procedures that are available to them through the M+C organization, at the following times:

1. Grievance procedure - at initial enrollment, upon involuntary disenrollment initiated by the M+C organization, upon denial of an enrollees' request for expedited review, upon an enrollees request, and annually thereafter;
2. Appeal procedure, including the right to expedited review - at initial enrollment, upon notification of an adverse organization determination or denial, and annually thereafter.
3. 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 M+C program, the organization 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 M+C organization remains responsible and must therefore ensure that requirements are met completely by its delegated entity and/or individual.

### **10.3 – Rights of M+C Enrollees**

**(Rev. 34, 10-03-03)**

Relative to grievances, *organization determinations*, and appeals, the rights of M+C enrollees include, but are not limited to, the following:

#### **10.3.1 - Grievances**

**(Rev. 22, 05-09-03)**

1. The right to have grievances heard and resolved in accordance with the guidelines that are described in this chapter of the manual; and
2. The right to request quality of care grievance data from M+C organizations.

#### **10.3.2 - Organization Determinations**

**(Rev. 22, 05-09-03)**

1. The right to a timely organization determination;

2. The right to request an expedited organization determination as described in this chapter;
3. The right to receive information from a practitioner regarding the enrollee's ability to obtain a detailed written notice from the M+C organization regarding the enrollee's services; and
4. The right to a detailed written notice of an M+C organization's decision to deny, terminate or reduce a service in whole or in part, which includes the enrollee's appeal rights.

### **10.3.3 - Appeals**

**(Rev. 34, 10-03-03)**

1. The right to request an expedited reconsideration as provided in this chapter;
2. The right to request and receive appeal data from M+C organizations;
3. The right to receive notice when an appeal is forwarded to the Independent Review Entity (IRE);
4. The right to automatic reconsideration by an IRE contracted by CMS, when the M+C organization upholds its original adverse determination in whole or in part;
5. The right to an Administrative Law Judge (ALJ) hearing if the independent review entity upholds the original adverse determination in whole or in part and the remaining amount in controversy is \$100 or more;
6. The right to request Departmental Appeals Board (DAB) review if the ALJ hearing decision is unfavorable to the enrollee in whole or in part;
8. The right to judicial review of the hearing decision if the ALJ hearing and/or DAB review is unfavorable to the enrollee in whole or in part and the amount remaining in controversy is \$1,000 or more;
9. The right to make a quality of care complaint under the QIO process;
10. *The right to request a QIO review of a determination of noncoverage of inpatient hospital care. If an enrollee receives immediate QIO review of a determination of noncoverage of inpatient hospital care, the above rights are limited. In this case, the enrollee is not entitled to the additional review of the issue by the M+C organization. The QIO review decision is subject to an ALJ hearing if the amount in controversy is at least \$100.00 and review of an ALJ hearing decision or dismissal from the Departmental Appeals Board if \$1,000.00 or more is in controversy. Enrollees may submit requests for QIO review of determinations of*

*noncoverage of inpatient hospital care in accordance with the procedures set forth in [§160](#);*

- 11. The right to request a QIO review of a determination of noncoverage in skilled nursing facilities, home health agencies and comprehensive outpatient rehabilitation facilities. If an enrollee receives QIO review of a determination of noncoverage, the enrollee is not entitled to the additional review of the issue by the M+C organization. Enrollees may submit requests for QIO review of provider settings in accordance with the procedures set forth in [§90.1](#);*
12. The right to request and be given timely access to the enrollee's case file and a copy of that case subject to federal and state law regarding confidentiality of patient information. The M+C organization shall have the right to charge the enrollee a reasonable amount, for example, the costs of mailing and/or an amount comparable to the charges established by a QIO for duplicating the case file material. At the time the request for case file material is made, the M+C organization should inform the enrollee of the per page duplicating cost. Based on the extent of the case file material requested, the M+C organization should provide an estimate of the total duplicating cost for which the enrollee will be responsible. The M+C organization may also charge the enrollee the cost of mailing the material to the address specified. If enrollee case files are stored offsite, then the M+C organization may not charge the enrollee an additional cost for courier delivery to a plan location that would be over and above the cost of mailing the material to the enrollee; and
13. The right to challenge local and national coverage determinations. Under [§1869\(f\)\(5\)](#) of the Act, as added by §522 of the Benefits Improvement and Protection Act (BIPA), certain individuals ("aggrieved parties") may file a complaint to initiate a review of National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs). Challenges concerning NCDs are to be reviewed by the DAB of the Department of Health and Human Services. Challenges concerning LCDs are to be reviewed by ALJs. The new coverage challenge process will be available to both beneficiaries with original Medicare and those enrolled in Medicare managed care plans.

## **20 - Complaints**

**(Rev. 22, 05-09-03)**

### **20.1 - Complaints That Apply to Both Appeals and Grievances**

**(Rev. 22, 05-09-03)**

Complaints may include both grievances and appeals. Complaints can be processed under the appeal procedures, under the grievance procedures, or both depending on the

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

## **20.2 - Distinguishing Between Appeals and Grievances**

**(Rev. 22, 05-09-03)**

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

For example, M+C organizations must determine whether to categorize complaints about copayments on a case-by-case basis. M+C organizations must subject complaints about copayments to the appeals process when an enrollee believes that an M+C organization has required the enrollee to pay an amount for a health service that should be the M+C organization's responsibility. If an enrollee expresses general dissatisfaction about a copayment amount, then an M+C organization should process the enrollee's complaint as a grievance.

Complaints concerning an enrollee's involuntary disenrollment initiated by the M+C organization must also be processed through the grievance procedures. Other types of complaints that might fall into the grievance category include, but are not limited to: A change in premiums or cost sharing arrangements from one contract year to the next, Difficulty getting through on the telephone, The quality of care or services provided, Interpersonal aspects of care, such as rudeness by a provider or staff member, or failure to respect an enrollee's rights.

The facts surrounding a complaint will determine whether the appeals or grievance process should be initiated. The following are offered as examples of when each process should begin:

- An enrollee who currently takes a particular brand-name drug is dismayed to find out that the plan has made a formulary change and will no longer cover the drug used by the enrollee. The enrollee calls the plan and complains. The enrollee states that he/she has tried the generic equivalent before and it was not effective, and therefore wants the plan to continue coverage of the brand-name drug. This complaint should be treated as a request for an organization determination, subject to the appeals process, on continuation of coverage for the brand-name drug.

- An enrollee who currently does not take any prescription medications reads in his annual notice of change that the plan will no longer be covering any brand-name drugs. The enrollee calls the plan to complain about this reduction in benefits, even though it does not directly affect them at the current time. Because the enrollee does not take any prescription medications, the complaint cannot be interpreted as a request for an organization determination. The complaint should therefore be handled as a grievance.

Complaints concerning the quality of medical care received under Medicare may be acted upon by the M+C organization, but also may be addressed through the QIO complaint process under [§1154\(a\)\(14\)](#) of the Act. (See also the QIO Manual chapter regarding the Beneficiary Complaint Process.) This process is separate and distinct from the M+C organization's grievance process. For example, if an enrollee believes his/her physician misdiagnosed the enrollee's condition, then the enrollee may file a complaint with the QIO in addition or in lieu of a complaint filed under the M+C organizations' grievance process.

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

At times M+C organizations will need to process complaints using the M+C organization's grievance procedures as well as its appeal procedures. For example, an enrollee might complain that because he/she had to wait so long to obtain a referral, he/she received services out of network. The enrollee's complaint contains both an appealable request for payment as well as a grievance about the timeliness of services. Therefore, complaints must be reviewed on a case-by-case basis.

### **20.3 - Procedures for Handling a Grievance**

**(Rev. 34, 10-03-03)**

Each M+C organization, under any M+C plan that it offers, must provide meaningful procedures for timely hearing and resolving grievances between enrollees and the M+C organization or any other entity or individual through which the M+C organization provides health care services.

The M+C organization must include the following requirements in its grievance procedures:

1. Ability to accept any information or evidence concerning the grievance;

2. *Ability to respond within 24 hours to an enrollee's grievance that an M+C organization extended the time frame to make an organization determination or reconsideration, or refused to grant a request for an expedited organization determination or reconsideration;*
3. *Timely transmission of grievances to appropriate decision-making levels in the organization;*
4. Prompt, appropriate action, including a full investigation of the complaint if necessary;
5. Notification of investigation results to all concerned parties, consistent with state law; *and*
6. *Procedures for tracking and maintaining records about the receipt and disposition of grievances. Consistent with §170 of this chapter, M+C organizations must disclose grievance data to Medicare beneficiaries upon request. The M+C organizations must be able to log or capture enrollees' grievances in a centralized location that may be readily accessed.*

### **20.3.1 - Procedures for Handling Misclassified Grievances**

**(Rev. 22, 05-09-03)**

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

#### **EXAMPLE**

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

## **20.4 - Written Explanation of Grievance Procedures**

**(Rev. 22, 05-09-03)**

The M+C organization must provide all members with written grievance procedures upon initial enrollment, involuntary disenrollment (i.e., initiated by the M+C organization), upon denial of an enrollee's request for expedited review, annually, and upon request. The Evidence of Coverage (EOC) must clearly explain the grievance procedures. Additionally, the M+C organization must notify enrollees about any changes to its grievance procedures 30 days in advance of the effective date of the change. The notice must include at least the following information:

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

## **30 - Organization Determinations**

**(Rev. 22, 05-09-03)**

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

1. Payment for temporarily out of the area renal dialysis services;
2. Payment for emergency services, post-stabilization care, or urgently needed services;
3. Payment for any other health services furnished by a provider (other than the M+C organization), that the enrollee believes:
  - i. Are covered under Medicare, or
  - ii. If not covered under Medicare, should have been furnished, arranged for, or reimbursed by the M+C organization;
4. 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;
5. Discontinuation 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

6. Failure of the M+C organization 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.

Each M+C organization must establish procedures for making timely organization determinations regarding the benefits an enrollee is entitled to receive under an M+C 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 M+C organization’s decision is unfavorable. If an M+C 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 M+C organization (e.g. the manner in which care was provided), the M+C organization must address the issue through the separate grievance process.

When the M+C organization decides not to provide or pay for a requested service, in whole or in part, this decision constitutes an adverse organization determination. In the presence of any adverse organization determination, an M+C organization must provide the enrollee with a written denial notice with appeal rights. See [Appendix 1](#).

M+C organizations must ensure issuance of written notices of adverse organization determinations whenever coverage is denied. Providers must be educated that they must inform enrollees that a request for a denial notice must be submitted to the M+C organization if the enrollee believes that the enrollee is being denied a service. Once the determination is made, the M+C organization must issue the denial notice (see also [§40.2.1](#)).

## **30.1 - Procedures for Handling Misclassified Organization Determinations**

**(Rev. 22, 05-09-03)**

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

### **30.1.1 - Quality of Care**

**(Rev. 22, 05-09-03)**

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

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

### **30.1.2 - Service Accessibility**

**(Rev. 22, 05-09-03)**

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

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

### **30.1.3 - Employer-Sponsored Benefits**

**(Rev. 22, 05-09-03)**

M+C appeal procedures apply to all benefits offered under an M+C organization - including optional supplemental benefits. However, determinations on items or services purchased by an employer, over and above the Medicare approved benefit package provided by the M+C organization, such as payments of premiums or beneficiary cost sharing provided by the employer, are not subject to these M+C guidelines.

## **30.2 - Jurisdiction for Claims Processed on Behalf of M+C Enrollees Through the Original Medicare-Fee-For-Service (FFS) System**

**(Rev. 22, 05-09-03)**

Claims received by Medicare fee-for-service (FFS) carriers for enrollees of M+C organizations will be denied, and the supplier, physician or practitioner will be notified through the claim level remittance advice reason code message 109 that the services should be billed to the patient's managed care plan.

Claims received by Medicare FFS fiscal intermediaries (FIs) for enrollees of M+C organizations will be transferred to the member's M+C organization for processing. This transfer is not considered a denial on the part of the FI. As a result, the M+C member has no appeal rights under the Medicare FFS program. If the M+C organization denies the claim, the M+C organization must issue its member a denial notice with appeal rights. The M+C organization has jurisdiction for this claim.

## **40 - Standard Organization Determinations**

**(Rev. 22, 05-09-03)**

### **40.1 - Standard Time Frames for Organization Determinations**

**(Rev. 22, 05-09-03)**

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

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

The M+C organization must pay 95 percent of clean claims from noncontracted providers within 30 calendar days of the request. All other claims must be paid or denied within 60 calendar days from the date of the request.

## **40.2 - Notice Requirements for Standard Organization Determinations**

**(Rev. 22, 05-09-03)**

### **40.2.1 - Written Notification by Practitioners**

**(Rev. 22, 05-09-03)**

The M+C organization must educate practitioners that there may be situations where an enrollee disagrees with a practitioner's decision about a request for a service or a course of treatment. Thus, at each patient encounter with an M+C enrollee, a practitioner must notify the enrollee of his or her right to receive, upon request, a detailed written notice from the M+C organization regarding the enrollee's services. The practitioner's notification must provide the enrollee with information about how to contact the M+C organization. Given that practitioners may contract with one or more M+C organizations, M+C organizations are encouraged to allow their practitioners discretion for how best to incorporate such notification into their existing practices.

### **40.2.2 - Written Notification by M+C Organizations**

**(Rev. 62, 09-10-04)**

If an enrollee requests an M+C organization to provide a detailed notice of a practitioner's decision to deny a service, in whole or in part, or if the M+C organization decides to deny, in whole or in part, the services or payments then it must give the enrollee a written notice of its determination. If the beneficiary has a representative, the representative must be sent a copy of the notice.

The M+C organization must use approved notice language in [Appendix 1](#). As an alternative, M+C organizations that use electronic EOBs may continue to use the EOB with the standard appeals language on the back in lieu of the standardized Notice of Denial of Payment (NDP). *An M+C organization that chooses to use the EOB instead of the NDP must ensure that the EOB contains the requirements listed in the NDP's form instructions.* The standardized denial notice forms have been written in a manner that is understandable to the enrollee and provides:

1. The specific reason for the denial that takes into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any;
2. 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\(b\)\(3\)](#));

3. For service denials, 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;
4. For payment denials, a description of the standard reconsideration process and time frames, and the rest of the appeals process; and
5. The beneficiary's right to submit additional evidence in writing or in person.

Example of language that is not acceptable in §40.2.2, list item 1, above (because it is not specific enough or understandable):

You required skilled rehabilitation services-P.T. eval. for mobility + gait-eval. for ADL's, speech eval. swallowing - from 6/5/2001, and 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 calculated for an enrollee to understand.

Examples of language that is acceptable (because it is specific to the individual's case):

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 M+C organization.

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)**.

### **40.2.3 - Notice Requirements for Noncontracted Providers**

**(Rev. 22, 05-09-03)**

If the M+C organization denies a request for payment from a noncontracted provider, the M+C organization must notify the noncontracted provider of the specific reason for the denial and provide a description of the appeals process. The M+C organization must also explain that in the event that the noncontracted provider wishes to appeal, the noncontracted provider must sign a waiver of liability statement. See [Appendix 6](#).

### **40.3 - Effect of Failure to Provide Timely Notice**

**(Rev. 22, 05-09-03)**

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

## **50 - Expedited Organization Determinations**

**(Rev. 22, 05-09-03)**

An enrollee, or any physician (regardless of whether the physician is affiliated with the M+C organization), may request that an M+C organization expedite an organization determination when:

1. The enrollee or his/her physician believes that waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy; and
2. The enrollee believes the M+C organization should furnish directly or arrange for services to be provided (when the enrollee has not already received the services outside the M+C organization).

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

## **50.1 - Making a Request for an Expedited Organization Determination**

**(Rev. 22, 05-09-03)**

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

1. The M+C organization must automatically provide an expedited organization determination to any request made or supported by a physician. The physician must indicate, either orally or in writing, that applying the standard time for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. The physician need not be appointed as the enrollee's authorized representative in order to make the request.
2. For a request made by an enrollee, the M+C organization must expedite the review of a determination if the organization finds that the enrollee's health, life, or ability to regain maximum function may be jeopardized by waiting for a standard organization determination.
3. If the M+C organization decides to expedite the request, it must render a decision as expeditiously as the enrollee's health condition might require, but no later than 72 hours after receiving the enrollee's request.
4. If the M+C organization denies the request for an expedited organization determination, the organization follows the requirements specified in [§50.3](#).

## **50.2 - How the M+C Organization Processes Requests for Expedited Organization Determinations**

**(Rev. 22, 05-09-03)**

The M+C organization must establish and maintain procedures that:

1. Establish efficient and convenient means for enrollees to submit oral/written requests;
2. Document all oral requests in writing and maintain the documentation in the case file;
3. Promptly decide whether to expedite a determination based on whether applying the standard time frame for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function; and

4. Develop a meaningful process for receiving requests for expedited reviews. These procedures should include designating an office and/or department to receive both oral or written requests and a telephone number for oral requests, and may include a facsimile number to facilitate receipt of requests for expedited organization determinations. The procedures must be clearly explained in member materials. In addition, M+C organizations 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 M+C organization's designated office or department. The 72-hour period begins when the request is received by the appropriate office or department designated by the M+C organization regardless of whether the provider is under contract to the M+C organization. If the M+C organization requires medical information from noncontract providers to make a decision, the M+C organization must request the necessary information from the noncontract provider within 24 hours of the initial request for an expedited organization determination. Noncontract providers must make reasonable and diligent efforts to expeditiously gather and forward all necessary information to assist the M+C organization in meeting the required time frame. Regardless of whether the M+C organization must request information from noncontract providers, the M+C organization is responsible for meeting the same time frame and notice requirements as it does with contracting providers.

## **50.2.1 - Defining the Medical Exigency Standard**

**(Rev. 22, 05-09-03)**

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

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

### **50.3 - Action Following Denial for Expedited Review**

**(Rev. 34, 10-03-03)**

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

1. Explains that the organization will automatically transfer and process the request using the 14-day time frame for standard determinations;
2. Informs the enrollee of the right to file *an expedited* grievance if he or she disagrees with the organization's decision not to expedite the determination;
3. Informs the enrollee of the right to resubmit a request for an expedited determination and that if the enrollee gets any physician's support indicating that applying the standard time frame for making determinations could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, the request will be expedited automatically; and
4. Provides instructions about the expedited grievance process and its time frames.

### **50.4 - Action on Accepted Requests for Expedited Determinations**

**(Rev. 22, 05-09-03)**

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

1. An M+C organization that approves a request for expedited determination must make the determination and notify the enrollee and the physician involved, as appropriate, of its decision. Whether the decision is adverse or favorable, the

M+C organization must make its decision as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receiving the request.

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

If the M+C organization first notifies the enrollee of its expedited determination orally, it then must mail written confirmation to the enrollee within 3 calendar days of the oral notification.

## **50.5 - Notification of the Result of an Expedited Organization Determination**

**(Rev. 22, 05-09-03)**

The M+C organization must use approved notice language in [Appendix 1](#). The standardized denial notice form has been written in a manner that is understandable to the enrollee and provides:

1. The specific reason for the denial that takes into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any;
2. 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;
3. A description of both the standard and expedited reconsideration processes should include conditions for obtaining an expedited reconsideration, and the other elements of the appeals process; and
4. The beneficiary's right to submit additional evidence in writing or in person.

## **60 - Appeals**

(Rev. 22, 05-09-03)

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

(Rev. 22, 05-09-03)

The parties to an organization determination include:

1. The enrollee (including his or her authorized representative);
2. An assignee of the enrollee (i.e., a physician or other provider who has furnished a service to the enrollee and formally agrees to waive any right to payment from the enrollee for that service);
3. The legal representative of a deceased enrollee's estate; or
4. Any other provider or entity (other than the M+C organization) determined to have an appealable interest in the proceeding.

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

#### **60.1.1 - Representative Filing on Behalf of the Enrollee**

(Rev. 62, 09-10-04)

An enrollee may appoint any individual (such as a relative, friend, advocate, an attorney, or any physician) to act as his or her representative. A representative who is appointed by the court or who is acting in accordance with State law may also file an appeal for an enrollee. *M+C organizations 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.* With the exception of incapacitated or legally incompetent enrollees where appropriate legal papers, or other legal authority, support this representation, both the enrollee making the appointment and the representative accepting the appointment must sign, date, and complete an appointment of representative form or similar written statement. If the appointed representative is an attorney, only the enrollee needs to sign the appointment of representative form or similar statement.

The representative statement must include the enrollee's name and Medicare number. The enrollee may use Form CMS-1696-U4 or SSA-1696-U4 ([Appendix 4](#) and

[Appendix 5](#) respectively), Appointment of Representative (available at Social Security offices), although it is not required. The enrollee may also use the appointment of representative statement provided in the IRE Reconsideration Processing Manual.

A signed form or statement must be included with the enrollee's appeal. A separate appointment of representative form or statement is required for each appeal.

Except in the case of incapacitated or incompetent enrollees, a request for reconsideration from a representative is not valid until supported with an executed appointment of representative form. It is the M+C organization'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.

If a case file is initiated by a representative and submitted to the independent review entity, the independent review entity will examine the file for compliance with the appointment requirements. The independent review entity may dismiss cases in which a required appointment of representative form is absent.

When a request for reconsideration is filed by a person claiming to be a representative, but the party does not provide appropriate documentation upon the M+C organization's request, the M+C organization must make, and document, its reasonable efforts to secure the necessary appointment forms. The M+C organization should not undertake a review until or unless such forms are obtained. The time frame for acting on a reconsideration request does not commence until the properly executed appointment form is received. However, if the M+C organization does not receive the form or statement at the conclusion of the appeal time frame, plus extension, the M+C organization should forward the case to the independent review entity with a request for dismissal. The M+C organization must comply with the IRE Reconsideration Process Manual section on reconsiderations that fail to meet representative requirements.

A provider, physician, or supplier may not charge an enrollee for representation in an appeal.

Costs associated with the appeal are not reasonable costs for Medicare reimbursement purposes.

A representative who is a surrogate acting in accordance with State law may file an appeal. 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.

## 60.1.2 - Authority of a Representative

(Rev. 22, 05-09-03)

On behalf of an enrollee, a representative may:

1. Obtain information about the enrollee's claim to the extent consistent with current Federal and state law;
2. Submit evidence;
3. Make statements about facts and law; and
4. Make any request or give any notice about the proceedings.

## 60.1.3 - Notice Delivery to *Authorized Representatives*

(Rev. 62, 09-10-04)

The CMS requires that notification of changes in coverage for an institutionalized enrollee who is not competent be made to an authorized representative acting on behalf of the enrollee. Notification to the authorized representative may be problematic because that person may not be available in person to acknowledge receipt of the required notification. The M+C organizations are required to develop procedures to use when the enrollee is incapable or incompetent *of receiving the notice*, and the M+C organization cannot obtain the signature of the enrollee's representative through direct personal contact. If the M+C organization is unable to personally deliver a notice of noncoverage to a person *legally* acting on behalf of an enrollee, then the M+C organization should telephone the representative to advise him or her when the enrollee's services are no longer covered. The M+C organization must also inform the representative about the right to file an appeal, when and how to file an appeal, and the date that financial liability begins. The date of the conversation is the date of the 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 to the members' representative. The documentation should include: the name 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 of receipt. Place a copy of the notice in the enrollee's medical file, and document the attempted telephone contact to the members' representative. The documentation should include: the name 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 M+C organization's mailing date.

**NOTE:** *References to M+C organizations also apply to delegated entities, as applicable.*

#### **60.1.4 - Noncontracted Provider Appeals**

**(Rev. 62, 09-10-04)**

A noncontracted provider is permitted to file a standard appeal for a denied claim only if the provider completes a waiver of liability statement, which provides that the provider will not bill the enrollee regardless of the outcome of the appeal. See [Appendix 6](#).

Physicians and suppliers who have executed a waiver of beneficiary liability are not required to complete the representative form. In this case, the physician or supplier is not representing the beneficiary, and thus does not need a written appointment of representation.

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

#### **70 - Reconsideration**

**(Rev. 34, 10-03-03)**

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

## **70.1 - Who May Request Reconsideration**

**(Rev. 34, 10-03-03)**

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

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

## **70.2 - How to Request a Standard Reconsideration**

**(Rev. 22, 05-09-03)**

A party may request a standard reconsideration by filing a signed written request with the M+C organization, SSA office, or, in the case of a qualified Railroad Retirement Board (RRB) beneficiary, an RRB office. Except in the case of an extension of the filing time frame, a party must file the request for reconsideration within 60 calendar days from the date of the notice of the organization determination. Requests made at an office of the SSA or RRB will be forwarded to the M+C organization for reconsideration; however, the time frame for review does not begin until the M+C organization receives the request for reconsideration.

If an M+C organization chooses to accept an oral appeal request, the M+C organization should process the request as follows:

1. The request should be recorded in the enrollee's own words, repeated back to the member to confirm the accuracy, and placed into a tracking system;
2. If a department other than one that responds to appeals receives the request, it should forward the request to the appropriate department handling appeals;
3. The department handling appeals should mail an acknowledgement letter to the enrollee to confirm the facts and basis of the appeal, and request that the enrollee sign and return the acknowledgement letter; and

4. The M+C organization should not issue a final decision on the appeal until it receives the signed acknowledgement letter, or other signed document relevant to the appeal request.

### **70.3 - Good Cause Extension**

**(Rev. 22, 05-09-03)**

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

1. The enrollee did not personally receive the adverse organization determination notice, or he/she received it late;
2. The enrollee was seriously ill, which prevented a timely appeal;
3. There was a death or serious illness in the enrollee's immediate family;
4. An accident caused important records to be destroyed;
5. Documentation was difficult to locate within the time limits;
6. The enrollee had incorrect or incomplete information concerning the reconsideration process; or
7. The enrollee lacked capacity to understand the time frame for filing a request for reconsideration.

The party requesting the good-cause extension may file the request with the M+C organization, the SSA office, or RRB office in writing, including the reason why the request was not filed timely. If the M+C organization denies an enrollee's request for a good cause extension, the enrollee may file a grievance with the M+C organization.

### **70.4 - Withdrawal of Request for Reconsideration**

**(Rev. 45, 02-13-04)**

The party who files a request for reconsideration may withdraw the request at any time before a decision is mailed by writing to the M+C organization, SSA office, or RRB office.

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

## **70.5 - Opportunity to Submit Evidence**

**(Rev. 22, 05-09-03)**

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

The M+C organizations must take the evidence into account when making a decision. In addition, the M+C organization must, upon an enrollee's request, provide the enrollee with a copy of the contents of the case file, including but not limited to, a copy of supporting medical records and other pertinent information used to support the decision. The M+C organization must abide by all Federal and state laws regarding confidentiality and disclosure for mental health records, medical records, or other health information. See [45 CFR 164.500](#) et. seq. (regarding the privacy of individually identifiable health information).

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

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

## **70.6 - Who Must Reconsider an Adverse Organization Determination**

**(Rev. 22, 05-09-03)**

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

In cases involving emergency services, the M+C organization must apply the prudent layperson standard when making the reconsideration determination.

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

**(Rev. 22, 05-09-03)**

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

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

## **70.7. - Time Frames and Responsibilities for Conducting Reconsiderations**

**(Rev. 22, 05-09-03)**

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

**(Rev. 22, 05-09-03)**

Upon reconsideration of an adverse organization determination, the M+C Organization must make its reconsidered determination as expeditiously as the enrollee's health condition requires. This must be no later than 30 calendar days from the date the M+C organization receives the request for a standard reconsideration. The time frame will be extended by up to 14 calendar days by the M+C organization if the enrollee requests the

extension or also may be extended by up to 14 calendar days if the organization justifies a need for additional information and documents how the delay is in the interest of the enrollee. When the M+C organization extends the time frame, it must notify the enrollee in writing of the reasons for the delay, and inform the enrollee of the right to file a grievance if he or she disagrees with the M+C organization's decision to grant itself an extension. When extensions are used, the organization must issue and effectuate its determination as expeditiously as the enrollee's health condition requires, but no later than upon the expiration date of the extension.

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

### **70.7.2 - Affirmation of a Standard Adverse Organization Determination**

**(Rev. 22, 05-09-03)**

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

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

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

**(Rev. 22, 05-09-03)**

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

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

### **70.7.4 - Effect of Failure to Meet the Timeframe for Standard Reconsideration**

**(Rev. 22, 05-09-03)**

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

### **80 - Expediting Certain Reconsiderations**

**(Rev. 34, 10-03-03)**

#### ***General Reconsiderations***

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

To ask for an expedited reconsideration, an enrollee or a physician must submit an oral or written request directly to the organization or entity responsible for making the reconsideration. A physician may provide oral or written support for a request made by

an enrollee for an expedited reconsideration. The M+C organization must provide an expedited determination if a physician indicates that applying the standard time frame could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

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

*When an enrollee misses the deadline for filing an immediate QIO review of a SNF, HHA, or CORF termination decision, the enrollee may request that the M+C organization perform an expedited reconsideration. Before accepting a request for an expedited reconsideration, M+C organizations must distinguish, by determining the appropriate time frame, between misdirected requests for reviews that should go to the QIO, and those expedited reconsideration requests that are being filed because the window for filing the request to the QIO has elapsed. The M+C organizations should establish the appropriate time frame for either accepting or forwarding requests for expedited reconsiderations by the following:*

- 1. If the M+C organization receives the request for expedited reconsideration earlier than noon of the day following the date of the advance termination notice, the M+C organization should contact the QIO and inform the QIO that the enrollee wishes to file an immediate QIO review of a termination from a SNF, HHA or CORF. The M+C organization must subsequently forward a detailed notice and the case file to the QIO. A copy of the detailed notice should also be sent to the enrollee.*
- 2. If the QIO time frame for considering the appeal has elapsed, the M+C organization may consider the request as an expedited reconsideration to be processed by the M+C organization. The M+C organizations are strongly encouraged to process these requests under the expedited appeal procedures. If the reconsideration request is forwarded to the QIO, then the M+C organization should educate the enrollee about his or her appeal rights to a QIO.*

## **80.1 - How the M+C Organization Processes Requests for Expedited Reconsideration**

**(Rev. 34, 10-03-03)**

The organization 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 M+C organization 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 M+C organization must promptly decide whether to expedite or follow the time frame for standard reconsiderations.

If an M+C organization 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. This should be done no later than within 30 calendar days from the date the M+C organization received the request for expedited reconsideration. The M+C organization 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:

1. Explains that the M+C organization will automatically transfer and process the request using the 30-day time frame for standard reconsiderations;
2. *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;*
3. 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
4. Provides instructions about the grievance process and its time frames.

If the M+C organization 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 decision as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receiving the request. If the request is made or supported by a physician, the M+C organization must grant the expedited reconsideration request when the physician indicates that the life or health of the enrollee, or the enrollee's ability to regain maximum function could be 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 M+C organization 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 noncontract provider may change an M+C organization decision to deny. When the M+C organization 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 a grievance if he or she disagrees with the M+C organization's decision to grant an extension. The M+C organization 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 M+C organization requires medical information from noncontract providers, the M+C organization must request the necessary information from the noncontract provider

within 24 hours of the initial request for an expedited reconsideration. Noncontract providers must make reasonable and diligent efforts to expeditiously gather and forward all necessary information to assist the M+C organization in meeting the required time frame. Regardless of whether the M+C organization must request information from noncontract providers, the M+C organization 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 appeal with the M+C organization. While an M+C organization uses discretion as to whether to expedite a request, the M+C organization is encouraged to automatically expedite all requests to appeal inpatient hospital discharges. Additionally, the M+C organization 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 discontinuations and terminations.*

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

**(Rev. 22, 05-09-03)**

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

## **80.3 - Forwarding Adverse Reconsiderations to the Independent Review Entity**

**(Rev. 22, 05-09-03)**

If an M+C organization 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 M+C organization must submit a hard copy case file to the independent review entity by mail or overnight delivery service at its designated address. The M+C organization should refer to the independent review entity's Reconsideration Process Manual for additional instructions.

The M+C organization 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.

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

**(Rev. 22, 05-09-03)**

The M+C organization must forward the enrollee's case file within the following regulatory time frames:

1. For standard requests for service, the M+C organization must forward an enrollee's case file to the independent review entity as expeditiously as the enrollee's health condition requires. This must be completed no later than 30 calendar days from the date the M+C organization receives the enrollee's request for reconsideration (or no later than upon the expiration of an extension).
2. For expedited reconsiderations, the M+C organization must forward the enrollee's case file to the independent review entity as expeditiously as the enrollee's health condition requires, but no later than within 24 hours of affirmation of its adverse expedited organization determination.
3. For requests for payment, the M+C organization must forward the enrollee's case file to the independent review entity no later than 60 calendar days from the date it receives the request for a standard reconsideration.

## **80.5 - Preparing the Case File for the Independent Review Entity**

**(Rev. 22, 05-09-03)**

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

The actual case file will contain:

1. An Appeal Transmittal Cover Sheet on top of the case file, so that the independent review entity can clearly differentiate new cases from other incoming materials;
2. Reconsideration Background Data Form, which is a standard data collection document with supplementary narrative description and attachments; and
3. Case Narrative.

M+C organizations should refer to the most current version of the Independent Review Entity's Reconsideration Process Manual for information concerning the Appeal Transmittal Cover Sheet and the Reconsideration Background Data Form.

## **90 - Reconsiderations by the Independent Review Entity**

**(Rev. 22, 05-09-03)**

The independent review entity must conduct the reconsideration as expeditiously as the enrollee's health condition requires and should observe the same time frames as required for M+C organizations. When the independent review entity conducts its reconsideration, the parties to the reconsideration are the parties listed in [§60.1](#) of this chapter as well as the M+C organization.

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

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

1. Include specific reasons for the entity's decisions;
2. Inform parties, other than M+C organization of their right to an ALJ hearing if the amount in controversy is \$100 or more, and if the decision is adverse (i.e., does not completely reverse the organization's adverse determination); and
3. Describe procedures that the parties must follow to obtain an ALJ hearing.

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

**(Rev. 27, 07-25-03)**

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

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

***(Rev. 62, 09-10-04)***

*As of January 1, 2004, enrollees have the right to an expedited review by a Quality Improvement Organization (QIO) when they disagree with their M+C organization'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 an M+C organization has approved coverage 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 calendar days in advance of the services ending. This right stems from the Grijalva lawsuit, and was established in regulations in a final rule published on April 4, 2003 (68 FR 16,652). It is similar to the longstanding right of a Medicare beneficiary to request a QIO review of a discharge from an inpatient hospital.*

*If the enrollee does not agree that covered services should end, the enrollee may request an expedited review of the case by the QIO in the State where the services are being provided. The enrollee's M+C organization must furnish a detailed notice explaining why services are no longer necessary or covered. 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:*

- 1. The M+C organization generally is responsible for determining the discharge date and providing, upon request, a detailed explanation of termination of services. M+C organizations 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 notice. (M+C organizations may choose to delegate these responsibilities to their contracting providers.)*
- 2. The provider is responsible for delivering the Notice of Medicare Non-Coverage (NOMNC) on behalf of M+C organizations to all enrollees no later than 2 days before their covered services end.*
- 3. The patient/MA enrollee (or authorized representative) is responsible for acknowledging receipt of the NOMNC and contacting the QIO (within the specified timelines) if they wish to obtain an expedited review.*
- 4. The QIO is responsible for immediately contacting the M+C organization and the provider if an enrollee requests an expedited review and making a decision on the case by no later than the day Medicare coverage is predicted to end.*

### ***90.3 - Notice of Medicare Non-Coverage (NOMNC)***

***(Rev. 62, 09-10-04)***

*The NOMNC is an OMB approved standardized notice. The NOMNC is a written notice designed to inform Medicare enrollees that their covered SNF, HHA, or CORF care is ending. The NOMNC meets the notice requirements set forth in 42 CFR 422.624(b)(2). As of August 1, 2004, M+C organizations must use the standardized notice. (See Appendix 7). Before that date, M+C organizations may use the model NOMNC, or any RO-approved variation.*

*All enrollees must receive an NOMNC, even if they agree that services should end. The notice must be delivered no later than 2 days prior to the proposed termination of services. Although M+C organizations 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:*

- 1. The agent must agree in writing that it will deliver the notice on behalf of the provider.*
- 2. The agent must adhere to all preparation, timing and valid delivery requirements for the notice as described in sections 90.4 and 90.5 of this chapter.*
- 3. The provider remains ultimately responsible for the valid delivery of the NOMNC.*

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

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

*The notice should also identify 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.*

*The NOMNC should not be used when M+C organizations determine that an enrollee's services should end based on the exhaustion of Medicare benefits (such as the 100-day SNF limit). Instead, M+C organizations must issue the Notice of Denial of Medical Coverage (NDMC). (See Appendix 1)*

## **90.4 – Meaning of Valid Delivery**

**(Rev. 62, 09-10-04)**

*Valid delivery generally means that the enrollee must be able 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. Except in rare circumstances, CMS believes valid delivery is best accomplished by a face-to-face contact with the enrollee. If the enrollee is not able to comprehend the contents of the notice, it must be delivered to and signed by the enrollee’s legally authorized representative.*

*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.*

*Occasionally, circumstances may prevent physical delivery of the NOMNC to an enrollee or the authorized representative by an M+C organization or provider, creating the need to use an alternate delivery method. In those cases, the M+C organization or provider must document the reason for employing an alternative. QIOs will review the documentation provided to assess whether valid delivery occurred. (See the information regarding notice delivery to authorized representatives in [§60.1.3](#) of this chapter.)*

## **90.5 – When to Issue the Notice of Medicare Non-Coverage**

**(Rev. 62, 09-10-04)**

*Consistent with [42 CFR 422.624\(b\)\(1\)](#), providers must distribute the NOMNC at least 2 calendar days prior to the enrollee’s services ending. To correctly count the 2 calendar days, consider the examples provided as part of the FAQs in [Appendix 9](#).*

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

*Although the regulations do not require action by any of the four responsible parties until 2 days before the planned termination of covered services, a provider may deliver the notice earlier if the date that coverage will end (that is, the “effective date” of the notice) can be identified. M+C organizations and providers are encouraged to work together so that the NOMNC can be delivered as soon as the service termination date is*

*known. Delivery of the NOMNC by the provider as soon as it knows when the M+C organization will terminate coverage will allow the patient more time to determine if they wish to appeal and may permit more time for providers and M+C organizations to furnish any needed records. Coordination between the M+C organization and provider that results in earlier notice delivery can minimize potential liability for either the enrollee or the M+C organization, depending on the QIO's decision.*

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

## **90.6 - Detailed Explanation of Non-Coverage (DENC)**

**(Rev. 62, 09-10-04)**

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

*The DENC must include the following:*

- A specific and detailed explanation why services are either no longer reasonable and necessary or otherwise no longer covered;*
- A description of any applicable Medicare coverage rule, instruction or other Medicare policy, including citations to the applicable Medicare policy rules or information about how the enrollee may obtain a copy of the Medicare policy from the M+C organization;*
- Any applicable M+C organization policy, contract provision, or rationale upon which the termination decision was based; and*
- Facts specific to the enrollee and relevant to the coverage determination that are sufficient to advise the enrollee of the applicability of the coverage rule or policy to the enrollee's case.*

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

***(Rev. 62, 09-10-04)***

*M+C organizations (or their providers by delegation) must issue the DENC to enrollees and provide a copy to the QIO no later than close of business (typically 4:30 P.M.) of the day of the QIO's notification that the enrollee requested an appeal, or the day before the effective date coverage ends, whichever is later. Because the QIO needs the DENC in order to conduct its review, the M+C organization must ensure that the QIO has the DENC timely.*

*The intent of the requirement that the enrollee receive the DENC is to make sure that enrollees who choose to contest a service termination or discharge are made aware of the reasoning for the coverage termination and have an opportunity to present their views to the QIO. Thus, the M+C organization should deliver the DENC to the enrollee in the most expeditious available manner to accomplish this goal. To ensure that the delivery is timely, the M+C organization may use personal delivery or a courier service to get the notice to the enrollee. If an enrollee is receiving non-residential services and requests that the M+C organization provide the DENC through e-mail or facsimile, then the M+C organization should document and accommodate the request.*

*The M+C organization should work with the QIO on how best to transmit the DENC, but generally may deliver the DENC to the QIO via personal delivery, courier service, e-mail or facsimile. Using this information, the QIO can make sure that the enrollee is aware of the rationale for the coverage termination decision, and has an opportunity to dispute the decision, in the course of soliciting the enrollee's views.*

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

***(Rev. 62, 09-10-04)***

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

*An enrollee should not incur financial liability if the QIO reverses the M+C organization's termination decision, or if the enrollee stops receiving care no later than the effective date inserted on the enrollee's NOMNC.*

*The enrollee likely will incur at least one day of financial liability if the QIO upholds the M+C organization's termination decision, and the enrollee continues to receive services until the day after the effective date inserted on the NOMNC. For example, although the QIO's decision should generally be made on the same date as the effective date coverage is expected to end, an enrollee likely would not leave a SNF until the following day. Thus, in this instance, the enrollee would incur one day of financial liability if the QIO upholds the M+C organization's termination decision. For HHA or CORF services, the enrollee would incur financial liability only if the enrollee continued to receive services beyond the effective date on the NOMNC, and the QIO upheld the M+C organization's termination decision.*

## **90.9 - Handling Misdirected Records**

**(Rev. 62, 09-10-04)**

*The fast-track review process complements the existing independent review process for other types of appeals. Therefore, M+C organizations and providers must be prepared to resubmit materials if they are inadvertently sent to the wrong reviewing entity. If a QIO or the independent review entity (IRE) that processes reconsiderations receives a request for a fast-track review after the review deadline, it must notify the M+C organization by telephone, so that the applicable appeals process can continue expeditiously. Neither QIOs nor the IRE will be responsible for forwarding misdirected records to the appropriate office, so M+C organizations must be prepared to resubmit the requested information to the correct office, and/or contact the enrollee to initiate an expedited appeal if the time frame for requesting the fast-track appeal review has expired.*

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

## **100 - Administrative Law Judge (ALJ) Hearings**

**(Rev. 22, 05-09-03)**

If the amount remaining in controversy is \$100 or more, any party to the reconsideration (with the exception of the M+C organization) who is dissatisfied with the reconsidered determination has a right to a hearing before an ALJ.

The amount remaining in controversy, which can include any combination of Part A and B services, is computed in accordance with [42 CFR 405.740](#) for Part A services and [42 CFR 405.817](#) for Part B services. Other services for which an enrollee is entitled under a plan's benefit package may be used to reach the threshold amount. See [42 CFR 422.100](#) for a description of the types of services covered by M+C organizations.

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

## **100.1 - Request for an ALJ Hearing**

**(Rev. 22, 05-09-03)**

A request for an ALJ hearing must be in writing and can be filed with the M+C organization, an SSA office, an RRB office, or with CMS' independent review entity. If the M+C organization receives a written request for an ALJ hearing from the enrollee, the M+C organization must immediately forward the enrollee's request to the IRE. The independent review entity is responsible for compiling the reconsideration file and forwarding it to the appropriate ALJ hearing office.

Except when an ALJ extends the time frame as provided in [20 CFR 404.933\(c\)](#), a party must file a request for an ALJ hearing, within 60 days of the date of the notice of a reconsidered determination. Any request for a "good cause" extension must be in writing and state the reasons why the request was late. If the party shows good cause for missing the deadline, the ALJ may grant an extension. (See [20 CFR 404.911](#) for the ALJ standards for "good cause.")

The parties to an ALJ hearing are the same as those for the reconsideration, and also include the M+C organization and any other person or entity whose rights with respect to the reconsideration may be affected by the hearing, as determined by the ALJ. Although the M+C organization does not have a right to request an ALJ hearing, it must be made a party to the hearing. Fees for services provided by the M+C organization representative are not subject to regulations at [20 CFR 404.1720](#), which govern appointment of representatives and payment of fees to representatives at the ALJ hearing level of appeal.

## **100.2 - Determination of Amount in Controversy**

**(Rev. 22, 05-09-03)**

The ALJ determines whether the amount remaining in controversy (for both Part A and Part B services) is \$100 or more. For cases involving denied services, the projected value of the services is used to determine whether the amount in controversy is \$100 or more. 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 \$100 or more. The M+C organization 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 \$100 limitation, if the following requirements are met:

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

The ALJ dismisses cases involving less than \$100. If, after a hearing is initiated, the ALJ finds that the amount in controversy is less than \$100, 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 Departmental Appeals Board (DAB) review.

## **110 - Departmental Appeals Board (DAB) Review**

**(Rev. 22, 05-09-03)**

Any party dissatisfied with the ALJ hearing decision (including the M+C organization) may request that the DAB review the ALJ's decision or dismissal. Regulations located at [20 CFR 404.967](#) through [404.984](#) regarding Appeals Council Review apply to DAB review for matters addressed in this chapter.

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

### **110.1 - Filing a Request for DAB Review**

**(Rev. 45, 02-13-04)**

A request for a DAB review must be filed by writing a letter to the DAB. A request may be submitted to an office of the Railroad Retirement Board (for railroad retirees) or directly to the DAB at the following address:

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

If an M+C organization decides to request a DAB review, the organization must concurrently notify the enrollee of this action by sending a copy of the request, as well as accompanying documents, that the organization submits to the DAB.

## **110.2 - Time Limit for Filing a Request for DAB Review**

**(Rev. 22, 05-09-03)**

The request for a DAB review must be filed within 60 days of the date of receipt of the ALJ hearing decision or dismissal. The DAB assumes the ALJ decision was received within 5 days of the date of the decision, unless evidence indicates otherwise. The DAB may grant an extension of the request for a review if the party can show “good cause” for missing the deadline. (See [20 CFR 404.911](#) for the standards applicable for determining “good cause.”)

## **110.3 - DAB Initiation of Review**

**(Rev. 22, 05-09-03)**

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

## **110.4 - DAB Review Procedures**

**(Rev. 22, 05-09-03)**

The DAB will review a case if:

1. There appears to be an abuse of discretion by the ALJ;
2. There is an error of law;
3. The action, findings or conclusions of the ALJ are not supported by substantial evidence; or

4. There is a broad policy or procedural issue that may affect the general public interest.

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

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

## **120 - Judicial Review**

**(Rev. 22, 05-09-03)**

Any party, including the M+C organization (upon notifying all the other parties), may request judicial review of an ALJ's decision if:

1. The DAB denied the parties request for review; and
2. The amount in controversy is \$1,000 or more.

In addition, any party, including the M+C organization (upon notifying all the other parties), may request judicial review of a DAB decision if:

1. The DAB denied the parties request for review; or
2. It is the final decision of CMS; and
3. The amount in controversy is \$1,000 or more.

The enrollee may combine claims to meet the \$1,000 amount in controversy requirement. To meet the requirement:

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

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

## **120.1 - Requesting Judicial Review**

**(Rev. 22, 05-09-03)**

A party must file a civil action in a district court of the United States in accordance with [§205\(g\)](#) of the Act (see [20 CFR 422.210](#) for a description of the procedures to follow in requesting judicial review). The action should be initiated in the judicial district in which the enrollee lives or where the M+C organization has its principal place of business. If neither the organization nor the member is in such judicial district, the action should be filed in the United States district court for the District of Columbia.

## **130 - Reopening and Revising Determinations and Decisions**

**(Rev. 22, 05-09-03)**

An organization or reconsideration determination made by an M+C organization, a reconsidered determination made by the independent review entity, or the decision of the ALJ or DAB that is otherwise final and binding, may be reopened and revised only by the entity that made the determination or decision. A reopening may be initiated by any of the aforementioned parties to the determination or decision as described in this chapter.

Reopening occurs after a decision has been made, generally to correct an error, in response to suspected fraud, or in response to the receipt of information not available or known to exist at the time the complaint was initially processed. A reopening is not an appeal right. It is an administrative procedure under which the entity that made a determination re-examines that decision for a specific reason. The decision to reopen a case is at the discretion of the entity that made the determination. The entity's decision on whether to grant a reopening is not appealable.

Typically, the reopening is only requested after the exhaustion of appeal rights. However, a party may request a reopening even if it still has appeal rights, as long as the guidelines for reopening are met. For example, if an enrollee receives an adverse reconsidered determination, but later obtains relevant medical records, he or she may request a reopening rather than a hearing before an ALJ. However, if the enrollee did not have additional information and just disagreed with the reasoning of the decision, he or she must file for the appeal.

If a party requests a reopening while it still has appeal rights, it also files for the appeal and asks for a continuance until a reopening is decided. If the reopening is denied or the original determination is not revised, the party retains its appeal rights.

The filing of a request for a reopening does not relieve the M+C organization of its obligation to make payment for, authorize, or provide services as specified in this chapter. Once a revised determination or decision is issued, any party may appeal the new determination or decision.

## **130.1 - Guidelines for a Reopening**

**(Rev. 22, 05-09-03)**

The following are guidelines for a reopening request:

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

## **130.2 - Time Limits for a Reopening**

**(Rev. 22, 05-09-03)**

A reopening may be filed:

1. Within 12 months of the date of the initial M+C organization determination or the reconsideration determination, for any reason;
2. After such 12-month period, but within 4 years of the date of the initial M+C organization determination or the reconsideration determination, for good cause as defined in §130.3; or
3. At any time when fraud or similar fault affected the M+C organization determination or the reconsideration determination.

## **130.3 - “Good Cause” for Reopening**

**(Rev. 22, 05-09-03)**

“Good cause” exists where:

1. There is new and material evidence, not readily available at the time of the determination or decision, and consideration of this material may result in a different conclusion;
2. There is a clerical error in the file; or

3. There is an error on the face of the evidence, which affects the determination or decision.

## **130.4 - Definition of Terms in the Reopening Process**

**(Rev. 22, 05-09-03)**

### **130.4.1 - Meaning of New and Material Evidence**

**(Rev. 22, 05-09-03)**

The submittal of any additional evidence is not a basis for reopening in and of itself. “New and material evidence” is evidence not considered when making the previous decision. This evidence must show facts not previously available, which could possibly result in a different decision. New information also includes an interpretation of existing information (e.g., a different interpretation of a benefit).

### **130.4.2 - Meaning of Clerical Error**

**(Rev. 22, 05-09-03)**

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

### **130.4.3 - Meaning of Error on the Face of the Evidence**

**(Rev. 22, 05-09-03)**

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

## **140 - Effectuating Reconsidered Determinations or Decisions**

**(Rev. 22, 05-09-03)**

### **140.1 - Effectuating Determinations Reversed by the M+C Organization**

**(Rev. 27, 07-25-03)**

### **140.1.1 - Standard Service Requests**

**(Rev. 45, 02-13-04)**

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

### **140.1.2 - Expedited Service Requests**

**(Rev. 22, 05-09-03)**

If on reconsideration of an expedited request for service the M+C organization completely reverses the initial organization determination, the M+C organization must authorize or provide the service under dispute as expeditiously as the enrollee's health condition requires, but not later than 72 hours after the date the M+C organization receives the request for reconsideration (or no later than upon expiration of an extension).

### **140.1.3 - Payment Requests**

**(Rev. 22, 05-09-03)**

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

## **140.2 - Effectuating Determinations Reversed by the Independent Review Entity**

**(Rev. 22, 05-09-03)**

### **140.2.1 - Standard Service Requests**

**(Rev. 22, 05-09-03)**

If the M+C organization's decision is reversed in whole or in part by the independent review entity, the M+C organization must provide the services under dispute as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days from the date it receives notice that the independent review entity reversed the determination. If it is not appropriate for the M+C organization to provide the service within 14 calendar days, e.g., because of the enrollee's medical condition or the enrollee

is outside of the service area, then the M+C organization must authorize the services within 72 hours from the date it receives notice that the independent review entity reversed the determination. The M+C organization must inform the independent review entity that the M+C organization has effectuated the decision.

### **140.2.2 - Expedited Service Requests**

**(Rev. 22, 05-09-03)**

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

### **140.2.3 - Payment Requests**

**(Rev. 22, 05-09-03)**

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

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

## **140.3 - Effectuating Decisions by All Other Review Entities**

**(Rev. 45, 02-13-04)**

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

## **140.4 - Independent Review Entity Monitoring of Effectuation Requirements**

**(Rev. 45, 02-13-04)**

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

1. The independent review entity issues to the M+C organization a copy of the reconsidered determination. Included with this copy is a Notice of Requirement to Comply.
2. Pursuant to the compliance notice, the M+C organization is required to mail to the independent review entity a statement attesting to compliance with the independent review entity's decision. This documentation is to confirm when and how compliance occurred (e.g., service authorization, payment made, etc.).  
*Notification to the IRE that the M+C organization plans to pay for or plans to provide the service **will not** be considered appropriate compliance with the effectuation requirements. The M+C organization must provide the IRE with affirmative notice of effectuation.* The M+C organization's notice of compliance should be forwarded to the independent review entity concurrent with the M+C organization's effectuation.
3. If the independent review entity does not obtain the compliance notice, it mails the M+C organization a reminder notice.
4. If the independent review entity does not receive the M+C organization's compliance report within 30 days of the reminder notice, the independent review entity reports the M+C organization's failure to comply to CMS. The M+C organization is not copied on the notice to CMS.

## **140.5 - Effectuation Requirements When an M+C Organization Non-Renews Its Contract**

**(Rev. 22, 05-09-03)**

If an M+C organization terminates its contract with CMS, appeals that are pending with the independent review entity (IRE) after such termination must be effectuated if the IRE overturns the M+C organization's adverse organization determination. Since the M+C contract and the regulations at [42 CFR 422.502\(a\)\(3\)](#) require M+C organizations to provide access to benefits for the duration of their contract, M+C organizations are obligated to process and effectuate any appeals from organization determinations (in connection with both services and/or payment of services) which are determined to be covered, and which should have been provided or paid for while Medicare beneficiaries

were enrolled in the plan. Thus, the terminating M+C organization is responsible for claims payments arising from decisions on pending appeals that are issued following termination of the contract.

## **150 - Notification to Enrollees of Noncoverage of Inpatient Hospital Care**

**(Rev. 22, 05-09-03)**

Where an M+C organization has authorized coverage of the inpatient hospital admission of an enrollee, either directly or by delegation (or the admission constitutes emergency or urgently needed care), the M+C organization is required to issue the enrollee a written notice of noncoverage only under the circumstances described in [§150.2](#).

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

**(Rev. 22, 05-09-03)**

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

1. The specific reason why inpatient hospital care is no longer needed;
2. The prospective effective date of the enrollee's financial liability for continued inpatient care; and
3. The enrollee's appeal rights.

The model NODMAR (see [Appendix 3](#)) meets the notice requirements set forth in [42 CFR 422.620\(c\)](#). We encourage M+C organizations to use this model form, but they are allowed to develop their own. (**NOTE:** The CMS is in the process of implementing a revised notice of noncoverage form through the Office of Management and Budget's Paperwork Reduction Act process.) All NODMARs must be approved by the M+C organization's Regional Office Plan Manager until such time that CMS issues a standardized form.

Before the M+C organization gives a NODMAR, the physician who is responsible for the enrollee's inpatient hospital care must concur with the decision to discharge the enrollee.

## **150.2 - When to Issue a NODMAR**

**(Rev. 62, 09-10-04)**

Consistent with [42 CFR 422.620](#), M+C organizations (and hospitals that have been delegated responsibility by an M+C organization to make the discharge/noncoverage decision) will distribute the NODMAR only when:

1. The enrollee expresses dissatisfaction with his or her impending discharge; or
2. The M+C organization (or the hospital that has been delegated the responsibility) is not discharging the individual, but no longer intends to continue coverage of the inpatient stay.

The M+C organization (or hospital that has been delegated the responsibility) is not required to issue the NODMAR if the enrollee dies while in an inpatient hospital setting.

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

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

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

**(Rev. 22, 05-09-03)**

An enrollee remaining in the hospital that wishes to appeal the M+C organization'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:

1. The enrollee remains in the hospital as an inpatient;
2. The enrollee submits the request for immediate review to the QIO that has an agreement with the hospital;

3. The request is made either in writing, by telephone or fax; and
4. The request is received by noon of the first working day after the enrollee receives written notice of the M+C organization's determination that the hospital stay is no longer necessary.

The following rules apply to the immediate QIO review process:

1. On the date that the QIO receives the enrollee's request, the QIO must notify the M+C organization that the enrollee has filed a request for immediate review;
2. The M+C organization 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;
3. In response to a request from the M+C organization, 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 M+C organization makes its request;
4. The QIO must solicit the views of the enrollee who requested the immediate QIO review; and
5. The QIO must make an official determination of whether continued hospitalization is medically necessary, and notify the enrollee, the hospital, and the M+C organization by close of business of the first working day after it receives all necessary information from the hospital, the M+C organization, 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 M+C organization. The M+C organization is encouraged to 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 M+C organization, the M+C organization should expedite that request. Thus, the M+C organization would generally make another decision about the services within 72 hours. However, the financial liability rules governing immediate QIO review do not apply in an expedited review situation.

## **160.1 - Liability for Hospital Costs**

**(Rev. 22, 05-09-03)**

The presence of a timely appeal for an immediate QIO review as filed by the enrollee in accordance with this section entitles the enrollee to automatic financial protection by the M+C organization. This means that if the M+C organization authorizes coverage of the

inpatient hospital admission directly or by delegation, or this admission constitutes emergency or urgently needed care, the M+C organization continues to be financially responsible for the costs of the hospital stay until noon of the calendar day following the day the QIO notifies the enrollee of its review determination.

## **170 - Data**

**(Rev. 45, 02-13-04)**

M+C organizations are expected to disclose grievance and appeals data to eligible Medicare individuals upon request. *For purposes of this section, by appeals data we mean all appeals filed with the M+C organization that are accepted for review or withdrawn upon the enrollee's request, but excludes appeals that the organization forwards to the IRE for dismissal.* M+C 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 M+C organization, then the M+C organization would send the beneficiary a complete report of both its appeal and grievance data for the reporting period.

M+C 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 M+C 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. It does not require that the M+C 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**

M+C organization average membership = 500

# of appeals received during the data collection period = 4

$4 \times 1000/500 = 8$

**# of Appeals per 1000 members = 8**

### **EXAMPLE 2**

M+C organization average membership = 5000

# of appeals received during the data collection period = 40

$40 \times 1000/5000 = 8$

**# of Appeals per 1000 members = 8**

## **170.1 - Reporting Unit for Appeal and Grievance Data Collection Requirements**

**(Rev. 22, 05-09-03)**

The reporting unit for appeal and grievance data sent to beneficiaries is to be consistent with 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). Generally, the reporting unit for appeal and grievance data is to be the same as for HEDIS, CAHPS and HOS; therefore, M+C 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. 22, 05-09-03)**

In order for M+C organizations to report appeal and grievance data consistently, data collection and reporting periods have been established.

1. 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.
2. 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.
3. 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 9/30/02, the organization will begin reporting data to the beneficiary 1/1/2003. The 3-month lag between the end of the data collection period and the beginning of the report period allows the M+C organization to resolve appeals received during the data collection period and ensure quality control over the data reported.

Below is a chart detailing the yearly collection and reporting cycles for 2002 - 2003.

### Yearly Collection and Reporting Cycles for 2002 - 2003

6-month Data Collection	3-month Reconciliation	What kind of data?
4/1/02 - 9/30/02	10/1/02 - 12/31/02	last 6 months
10/1/02 - 3/31/03	4/1/03 - 6/30/03	last 12 months
4/1/03 - 9/30/03	10/1/03 - 12/31/03	last 12 months, etc.

## 170.3 - New Reporting Periods Start Every Six Months

(Rev. 22, 05-09-03)

M+C 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, 2003, through June 30, 2003, would be based on appeals received by the organization from October 1, 2001, through September 30, 2002, and so on.

## 170.4 - Maintaining Data

(Rev. 34, 10-03-03)

The CMS expects M+C organizations to maintain a health information system that collects, analyzes, and integrates the data necessary to implement disclosure requirements. *At a minimum, M+C organizations keep information on the following grievance elements:*

- *The date that the M+C organization received the complaint,*
- *The date that the M+C organization disposed of the complaint, and*
- *If appropriate, the date that the M+C organization notified the enrollee of the grievance disposition.*

## 170.5 - Appeal and Grievance Data Collection Requirements

(Rev. 62, 09-10-04)

The following describes the appeal data M+C organizations are expected to record and report. This format should be used by the M+C 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. The M+C organizations should provide informational copies to the appropriate Regional Office. If the M+C organization provides any of its own materials or discussion to supplement CMS' *OMB approved* format, as with all member materials, prior approval by the Regional Office is required

### 170.5.1 - Appeal Data

(Rev. 22, 05-09-03)

Line 1 Time Period Covered: **[Reporting Period lasts from 7/01/03 through 12/31/03, which includes data collected from 4/01/02 through 3/31/03.]**

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.

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 **[04/01/02 through 03/31/03]**, **[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 M+C 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.

Line 5. A “completed” appeal means one that has been resolved by the M+C organization or has left the M+C 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 M+C 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 M+C 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 **[04/01/02 through 3/31/03]**, **[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 CHDR timely.

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 M+C 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 M+C organization that decides whether or not to expedite the appeal.

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

Line 14. Between **[04/01/02 through 03/31/03]** **[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. 62, 09-10-04)

Line 1. Time Period Covered: **[Reporting Period lasts from 7/01/03 through 12/31/03, which includes data collected from 4/01/02 through 3/31/03].**

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, M+C organizations also must explain what the numbers mean in a separate report. See [Appendix 2](#) for *standardized* language.

## Appendices

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

**(Rev. 22, 05-09-03)**

The form, [Notice of Denial of Medical Coverage - Form CMS-10003-NDMC](#), and [Instructions for Form CMS-10003-NDMC](#) can be found on CMS' Forms Page.

The form, [Notice of Denial of Payment - Form CMS-10003-NDP](#), and [Instructions for Form CMS-10003-NDP](#) can be found on CMS' Forms Page.

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

(Rev. 62, 09-10-04)

### MEDICARE APPEALS AND QUALITY OF CARE GRIEVANCES

#### XYZ ORGANIZATION

**April 1, 2002 to March 31, 2003**

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 Medicare health plans**. The next few pages contain information about the appeals and quality of care grievances that **(XYZ Organization)** received between April 1, 2002, and March 31, 2003.

Each Medicare health plan will have different numbers of appeals and quality of care grievances, and these numbers can mean different things. For example, a Medicare health plan 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 Medicare health plan might have a small number of appeals and quality of care grievances because its members are not aware of their right to file an appeal or grievance.

How big is (XYZ Organization)?

**(XYZ Organization)** has about 88,000 Medicare members.  
(line 3 on the attached report)

Page 1

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

## INFORMATION ON MEDICARE APPEALS

### April 1, 2002 To March 31, 2003

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 needs.

If a member cannot get an item or service that the member feels she/he needs, or if the health plan 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, 2002 to March 31, 2003

- 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 health plan may not have believed were in danger or serious harm.

## INFORMATION ON INDEPENDENT REVIEW

**April 1, 2002 to March 31, 2003**

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 organization** that contracts with Medicare, not for **(XYZ Organization)**.

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

If the independent review organization 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 independent review organization decides to agree with either the Medicare member or **(XYZ Organization)**. For example, the independent review organization may disagree with **(XYZ Organization)** because the independent review organization may have had more information about the appeal.

## INFORMATION ON INDEPENDENT REVIEW

### April 1, 2002 to March 31, 2003

How many appeals did the independent review organization consider?

The independent review organization considered **86** appeals from **(XYZ Organization)**.

(lines 9 through 13 on the attached report)

What happened?

The independent review organization 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 independent review organization 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, 2003, **2%** of appeals were still waiting to be reviewed by the independent review organization.

Note that these percentages may not add to 100% because sometimes the independent review organization dismisses an appeal.

## INFORMATION ON QUALITY OF CARE GRIEVANCES

**April 1, 2002 to March 31, 2003**

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.

**Page 6**

Form No. CMS-R-0282

Exp. Date 01/31/2007

*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 M+C organization. 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.*

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## Appendix 3 - Notice of Discharge and Medicare Appeal Rights

(Rev. 22, 05-09-03)

### NOTICE OF DISCHARGE & MEDICARE APPEAL RIGHTS

Enrollee's Name:

Date of Notice:

Health Insurance Claim (HIC) Number:

Admission Date:

Attending Physician:

Discharge Date:

Hospital:

Health Plan:

#### YOUR IMMEDIATE ATTENTION IS REQUIRED

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

\_\_\_\_\_ You no longer require inpatient hospital care.

\_\_\_\_\_ You can safely get any medical care you need in another setting.

\_\_\_\_\_ Other \_\_\_\_\_.

[Fill in details.]

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

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

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

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

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

### **HOW DO YOU GET AN IMMEDIATE REVIEW?**

1. The [**Name of QIO**] is the name of the Quality Improvement Organization - sometimes called a QIO - authorized by Medicare to review the Hospital care provided to Medicare patients. You or your authorized representative, attorney, or court appointed guardian must contact the QIO by telephone or in writing: [**Name, address, telephone and fax number of the QIO**]. If you file a written request, please write, "I want an immediate review".
2. Your request must be made no later than noon of the first working day after you receive this notice.
3. The QIO will make a decision within one full working day after it receives your request, your medical records, and any other information it needs to make a decision.
4. While you remain in the Hospital, your Health Plan will continue to be responsible for paying the costs of your stay until noon of the calendar day following the day the QIO notifies you of its official Medicare coverage decision.

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

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

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

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

### **WHAT IF YOU DON'T REQUEST AN IMMEDIATE REVIEW?**

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

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

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

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

**HOW DO YOU REQUEST A FAST APPEAL?**

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

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

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

If you’re filing a written request, please write, “I want a fast appeal.”

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

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

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

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Signature of Medicare Enrollee or Authorized Representative

Date

cc: [Health Plan]

# Appendix 4 - Appointment of Representative - Form CMS-1696-U4

(Rev. 22, 05-09-03)

DEPARTMENT OF  
HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME (Print or Type)	PLI CLAIM NUMBER
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## SECTION I APPOINTMENT OF REPRESENTATIVE

I appoint this individual: \_\_\_\_\_  
(Print or type name and address of individual you want to represent you.)

to act as my representative in connection with my claim or asserted right under Titles XI, or XVIII of the Social Security Act. I authorize this individual to make or give any request or notice; to present or to elicit evidence; to obtain information; and to receive any notice in connection with my claim wholly in my stead.

SIGNATURE (Beneficiary)	ADDRESS
TELEPHONE NUMBER	DATE
(Area Code)	

## SECTION II ACCEPTANCE OF APPOINTMENT

I, \_\_\_\_\_, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration or the Centers for Medicare & Medicaid Services; that I am not, as a current or former officer or employee of the United States, disqualified from acting as the claimant's representative; and that I will not charge or receive any fee for the representation unless it has been authorized in accordance with the laws and regulations referred to on the reverse side hereof. In the event that I decide not to charge or collect a fee for the representation I will notify the Social Security Administration and the Centers for Medicare & Medicaid Services (completion of Section III (optional) satisfies this requirement).

I am a / an \_\_\_\_\_  
(Attorney, union representative, relative, law student, etc.)

SIGNATURE (Representative)	ADDRESS
TELEPHONE NUMBER	DATE
(Area Code)	

## SECTION III (Optional) WAIVER OF FEE OR DIRECT PAYMENT

(Note to Representative: You may use this portion of the form to waive a fee or to waive direct payment of the fee from withheld past-due benefits.)

I waive my right to charge and collect a fee for representing \_\_\_\_\_  
\_\_\_\_\_ before the Social Security Administration or the Centers for Medicare & Medicaid Services.

SIGNATURE	DATE
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(See important information on reverse)  
FORM CMS-1696-U4 (10-84)

# Appendix 5 - Appointment of Representative - Form SSA-1696-U4

(Rev. 22, 05-09-03)

Social Security Administration

Form Approved  
OMB No. 0960-0527

Please read the back of the last copy before you complete this form.

Name (Claimant) (Print or Type)	Social Security Number
Wage Earner (If Different)	Social Security Number

## Part I APPOINTMENT OF REPRESENTATIVE

I appoint this person, \_\_\_\_\_  
(Name and Address)

to act as my representative in connection with my claim(s) or asserted right(s) under:

Title II (RSDI)     
  Title XVI (SSI)     
  Title IV FMSHA (Black Lung)     
  Title XVIII (Medicare Coverage)

This person may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

I am appointing, or I now have, more than one representative. My main representative is \_\_\_\_\_  
(Name of Principal Representative)

Signature (Claimant)	Address
Telephone Number (with Area Code) ( )	Date

## Part II ACCEPTANCE OF APPOINTMENT

I, \_\_\_\_\_, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part III satisfies this requirement.)

I am an attorney.     
  I am not an attorney.     
 (Check one.)

Signature (Representative)	Address
Telephone Number (with Area Code) ( )	Date

## Part III (Optional) WAIVER OF FEE

I waive my right to charge and collect a fee under sections 206 and 1631(d)(2) of the Social Security Act. I release my client (the claimant) from any obligations, contractual or otherwise, which may be owed to me for services I have provided in connection with my client's claim(s) or asserted right(s).

Signature (Representative)	Date
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## Part IV (Optional) ATTORNEY'S WAIVER OF DIRECT PAYMENT

I waive only my right to direct payment of a fee from the withheld past-due retirement, survivors, disability insurance or black lung benefits of my client (the claimant). I do not waive my right to request fee approval and to collect a fee directly from my client or a third party.

Signature (Attorney Representative)	Date
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## Appendix 6 - Waiver of Liability Statement

(Rev. 22, 05-09-03)

### WAIVER OF LIABILITY STATEMENT

\_\_\_\_\_  
Medicare/HIC Number

\_\_\_\_\_  
Enrollee's Name

\_\_\_\_\_  
Provider

\_\_\_\_\_  
Dates of Service

\_\_\_\_\_  
Health Plan

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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

*(Rev. 62, 09-10-04)*

*The form, Notice of Medicare Non-Coverage – Form No. CMS-10095, can be found at <http://www.cms.hhs.gov/healthplans/appeals/NOMNC0938-0910.pdf>.*

*The instructions for the Notice of Medicare Non-Coverage can be found at [http://www.cms.hhs.gov/healthplans/appeals/CMS10095A\\_FormInstrrevised428.pdf](http://www.cms.hhs.gov/healthplans/appeals/CMS10095A_FormInstrrevised428.pdf).*

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

***(Rev. 62, 09-10-04)***

The form, “Detailed Explanation of Non-Coverage”– Form No. CMS-10095, can be found at <http://www.cms.hhs.gov/healthplans/appeals/DENC4-28fnl.pdf>.

The instructions for the Detailed Explanation of Non-Coverage can be found at <http://www.cms.hhs.gov/healthplans/appeals/Denc%20FormInstrfnl428.pdf>.

*Appendix 9 – FAQs on the Grijalva Fast-Track Appeals Process*

*(Rev. 62, 09-10-04)*

*The FAQs on the Grijalva Fast-Track Appeals Process can be found at  
[http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std\\_alp.php?p\\_cat\\_lvl2=88](http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_cat_lvl2=88)*