MAXIMUS Federal Services Medicare Health Plan Reconsideration Process Manual
Medicare Managed Care Reconsideration Project

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Project Web Site: www.medicareappeal.com

* Do not submit confidential case specific information by email.

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MEDICARE HEALTH PLAN RECONSIDERATION PROCESS MANUAL

MEDICARE MANAGED CARE RECONSIDERATION PROJECT

Effective January 2003
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1. INTRODUCTION

The Balanced Budget Act of 1997, as amended by Title II of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), requires the federal government to contract with an Independent Review Entity (IRE) to review and resolve coverage disputes between Medicare Advantage Organizations, Cost Plans and HCPPs (collectively referred to as Medicare Health Plans), and Medicare managed care enrollees. The Centers for Medicare & Medicaid Services (CMS) has contracted with the MAXIMUS Federal Services to serve as this independent entity.

This manual contains the procedures for the coordination of Medicare Health Plans with MAXIMUS Federal Services in the processing of IRE level reconsiderations, and related post reconsideration activities.

The IRE level reconsideration is one step in a larger multi-level Medicare Managed Care appeal process. For example, Medicare Health Plans are required to adhere to CMS policies for initial organization determinations and Medicare Health Plan level reconsiderations—steps that occur well prior to the submission of a case file to MAXIMUS Federal Services. The focus of this manual is on the processes by which Medicare Health Plans and MAXIMUS Federal Services interrelate for the IRE level reconsideration. This manual is not intended to serve as a review of CMS policy governing Medicare Health Plan obligations for the appeal process overall. This manual presumes that the reader has a command of relevant Medicare policies such as:

- 42 CFR Part 422
- Medicare Managed Care Manual
- Program Memorandum and Transmittals

Certain policies, procedures and operational documents discussed in this manual are mandatory, and complete compliance by the Medicare Health Plan is expected. For such requirements, the term "must" or "mandatory" is used. In other areas we have attempted to provide the Medicare Health Plan with flexibility, but may have offered suggestions for work methods that we believe will enhance the working relationship between Medicare Health Plans and MAXIMUS Federal Services. In these areas, the term "recommended" or "suggested" or "optional" is used.

Our hope is that the Medicare Health Plan user finds this manual clear and helpful. If you have suggestions or comments, please submit to:

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2. DEFINITIONS

The following definitions are provided solely for use in this Manual. These definitions do not address all the significant terms used in 42 CFR Part 422, and in some instances paraphrase or summarize regulatory text. In the event of any discrepancy or inconsistency, the language of 42 CFR Part 422 supersedes these definitions.

2.1 ADJUDICATOR

An appeal professional employed by MAXIMUS Federal Services to manage individual reconsideration case files. MAXIMUS Federal Services Adjudicators make coverage determinations. Adjudicators do not make medical necessity determinations. Medical necessity determinations are made by fully credentialed board certified physicians under contract with MAXIMUS Federal Services.

2.2 APPEAL

A procedure to review a Medicare Health Plan's adverse organization determination that is contested by the enrollee or another authorized party. The term appeal applies to such procedures at any level of the multi-step Medicare Managed Care appeal process (for example , Medicare Health Plan reconsideration, IRE level reconsideration, ALJ hearing, and so on).

2.3 APPEAL PROCESS

The entire multi-level Medicare managed care complaint process for addressing enrollee challenges to a Medicare managed care adverse organization determination. The IRE reconsideration process is one level in the broader Medicare managed care appeal process.

2.4 DE NOVO REVIEW

A review of an individual dispute by a new and impartial reviewer. The new and impartial reviewer does not give preference to any previous determinations made on the individual dispute.

2.5 EVIDENCE OF COVERAGE

This term describes the Medicare Health Plan document that sets forth the terms of coverage for the Medicare Health Plan enrollees. This document is sometimes called a Subscriber Contract or Subscriber Agreement.

2.6 EXPEDITED RECONSIDERATION

A de novo review of an adverse organization determination that must be processed quickly to avoid endangering the life or health of the enrollee or the enrollee's ability to regain maximum function. Generally, expedited reconsiderations must be completed as soon as is medically indicated, but not longer than 72 hours, with a possible extension of up to 14 calendar

days if the delay is in the enrollee's interest. (See 42 CFR §422.584). Examples of cases that should be expedited include pre-service skilled nursing facility cases, pre-service acute inpatient care cases and cases in which a physician indicates that applying the standard timeframe for making a determination could seriously affect the life or health of the enrollee or the enrollee's ability to regain maximum function.

The Medicare Health Plan has an obligation to determine if an appeal should be expedited, including responding to an enrollee or provider request for expedited determination. However, MAXIMUS Federal Services has the authority to expedite processing of an IRE reconsideration that was not expedited by the Medicare Health Plan.

2.7 INDEPENDENT REVIEW ENTITY (IRE)

The entity under contract with CMS to perform reconsideration of denials upheld at the Medicare Health Plan level reconsideration. MAXIMUS Federal Services is the Independent Review Entity.

2.8 LOCAL COVERAGE DECISION (LCD)

A document, identified as an LCD, published by a Medicare fee for service contractor with jurisdiction over fee for service claims in a defined area that specifies coverage or clinical criteria for fee for service claim reimbursement.

2.9 MEDICARE ADVANTAGE ORGANIZATION

An entity that is under contract with CMS to provide Medicare benefits to Medicare beneficiaries. Medicare Advantage Organizations offer Medicare Advantage Plans such as HMOs, PSOs, PPOs, SNPs MSAs and private FFS plans and certain other programs and demonstration projects. The determination of whether an entity is subject to the MA appeals requirements is made by CMS, not MAXIMUS Federal Services.

2.10 MEDICARE APPEAL SYSTEM (MAS)

Data system used by MAXIMUS Federal Services for collecting specific data elements from reconsideration cases and for creating specific reports for CMS.

2.11 MEDICARE HEALTH PLAN

Term used in this Manual and in MAXIMUS Federal Services correspondence to refer to a MA Plan, Cost Plan and/or HCPP.

2.12 ORGANIZATION DETERMINATION

A decision of the Medicare Health Plan, or a person acting on its behalf, to approve or deny a payment for a health care service or a request for provision of health care service made by, or on behalf of, a Medicare Health Plan enrollee. An organization determination concerns

benefits an enrollee is entitled to receive under the Medicare Health Plan, including: i) basic benefits; ii) mandatory and optional supplemental benefits; and iii) co-payments. An organization determination is the Medicare Health Plan's initial coverage determination. Medicare Health Plans must have procedures for making standard determinations and expedited determinations. Expedited determinations apply to cases in which applying standard determination procedures could seriously jeopardize the enrollee's life, health or ability to regain maximum function. (See 42 CFR §422.566-422.572).

2.13 RECONSIDERATION

A review of an adverse organization determination. This term applies both to the Medicare Health Plan and IRE level appeal proceeding.

2.14 RECONSIDERATION DETERMINATION NOTICE

Letter used to communicate MAXIMUS Federal Services' final decision in a reconsideration.

2.15 REOPENING

A review of a completed IRE reconsideration determination undertaken at the sole discretion of the IRE for the purpose of addressing a potential error in the determination. (See 42 CFR §422.616).

2.16 REQUEST FOR INFORMATION (RI)

A MAXIMUS Federal Services document submitted to the Medicare Health Plan requesting information from the Medicare Health Plan to correct a case file deficiency.

2.17 STANDARD CLAIM RECONSIDERATION

Reconsiderations related solely to a denial of claim payment or reimbursement. Claim reconsiderations must be completed within 60 days of request receipt. Claim reconsiderations may not be expedited. May also be referred to as a retrospective appeal.

2.18 STANDARD SERVICE RECONSIDERATION

Reconsiderations of denials of authorization for service(s) including continuing services, which do not meet the criteria for an expedited reconsideration. Standard service reconsiderations must be completed within 30 calendar days of the request receipt, subject to a possible 14-calendar day extension if in the enrollee's interest. May also be referred to as a pre-service appeal.

3. WORKING WITH MAXIMUS FEDERAL SERVICES

This Chapter explains the basic processes for communicating with MAXIMUS Federal Services, under the following headings:

Please note that MAXIMUS Federal Services is not authorized by CMS to guide or instruct Medicare Health Plans on interpretation of CMS coverage policies, or matters related to Medicare Health Plan compliance with CMS appeals process requirements. For example, we are not able to offer Medicare Health Plans advice on how a hypothetical case would be decided if presented to us. Policy inquires of this type should be directed by the Medicare Health Plan to its designated CMS Regional Office Account Manager.

3.1 SOURCES OF INFORMATION ABOUT MAXIMUS FEDERAL SERVICES IRE RECONSIDERATION

Medicare Managed Care & PACE Reconsideration Project Process Manuals

MAXIMUS Federal Services makes available process manuals for the *Medicare Managed Care & PACE Reconsideration Project* as the primary print source for information about the IRE program. MAXIMUS Federal Services makes available on its web site two manuals: one manual for Medicare Advantage plans and one manual for PACE Organizations. Each Manual contains process information specific to the Health Plan type. Health plans are welcome to download the applicable manual from the Project web site, www.medicareappeal.com.

Medicare Managed Care & PACE Reconsideration Project Web Site

In addition to the process manuals, the Project web site, www.medicareappeal.com (See *Exhibit 3-1*) contains the following information:

- Links to CMS web sites for statute, regulation and manuals related to Medicare Managed Care Reconsideration
- Current and past versions of the Project newsletter, *Recon Notes*
- Updated Project Organization and Contact information
- National, Regional and Medicare Health Plan level Reconsideration data
- Case Status Information

Exhibit 3-1
Medicare Managed Care & PACE Reconsideration Project Web Site

Case status information on the Project web site is purposefully limited to protect enrollee and Medicare Health Plan confidentiality. The case can only be accessed by the "reconsideration case number" that is assigned by the Medicare Appeal System upon receipt of a case file from the Medicare Health Plan. A reconsideration case number has no logical relationship to Social Security Number, Medicare Number, or any other confidential information. The information that can be obtained by reconsideration case number is limited to:

- IRE Request received date
- IRE Appeal Priority (Expedited, Standard Service, Standard Claim)
- Plan Reported Recon Receipt Date (from the *Reconsideration Background Data Form*)
- IRE Corrected Recon Receipt Date (if different than the Plan Reported Recon Receipt Date)
- Plan Extension
- IRE Recon Decision (Uphold, Overturn, Partial Overturn, Withdrawn, Dismissed, or Pending)
- IRE Reopen Decision (if applicable)
- ALJ Decision (if applicable)
- Last Decision Date

Project Newsletter ("Recon Notes")

MAXIMUS Federal Services publishes a newsletter, "Reconsideration Notes," which addresses commonly observed situations in the reconsideration process and updates

MAXIMUS Federal Services policies and procedures as needed. This newsletter is available to health plans and the public through our web site: www.medicareappeal.com.

3.2 SET-UP OF NEW MANAGED CARE ORGANIZATIONS WITH MAXIMUS FEDERAL SERVICES

An entity that has established a new Medicare Advantage contract with CMS is encouraged to contact MAXIMUS Federal Services prior to its first enrollment effective date. Call or write the MAXIMUS Federal Services Project Director (See Manual Page ii, MAXIMUS Federal Services Contact Information). MAXIMUS Federal Services will arrange to provide the new Medicare Health Plan a telephonic briefing on the IRE project.

3.3 IDENTIFYING AND CHANGING MEDICARE HEALTH PLAN POINT OF CONTACT

3.3.1 MEDICARE HEALTH PLAN KEY ORGANIZATION CONTACT

As part of new Medicare Health Plan project set-up, MAXIMUS Federal Services requests that each Medicare Health Plan designate and maintain one key organization contact. Medicare Health Plans that operate under multiple CMS contract numbers must designate and maintain a Key Contact for each CMS contract. The Medicare Health Plan may use the same, or different, personnel as the Key Contact for each contract. This individual will be the official management contact with MAXIMUS Federal Services. MAXIMUS Federal Services will send the Key Contact all important materials. We will also contact this individual if we encounter a general issue working with the Medicare Health Plan, or an unusual and significant case-specific problem. The Medicare Health Plan should use the Key Contact to initiate contact with MAXIMUS Federal Services to resolve problems perceived by the Medicare Health Plan. To identify or change this individual, submit the Notice of Change in Key Organization Contact (located in *Appendix*) to MAXIMUS Federal Services via our project email box at medicareappeal@maximus.com.

3.3.2 MEDICARE HEALTH PLAN INDIVIDUAL RECONSIDERATION CASE CONTACTS

The Medicare Health Plan must designate a contact person on a Reconsideration Background Data Form submitted with each reconsideration case (See *Appendix*). The Medicare Health Plan may, but is not required to, use its Key Contact as the designated case specific contact. The Medicare Health Plan may vary the Case Contact from case to case.

3.4 SEEKING INFORMATION ABOUT CASES

As discussed above, the Medicare Health Plan can obtain basic information concerning the status of active and decided cases via the Project web site, www.medicareappeal.com.

In addition, MAXIMUS Federal Services maintains a staffed switchboard Monday to Friday, from 8 AM to 5:30 PM and Saturday from 9 AM to 2 PM, Eastern Time (585-348-

3300). For calls made after normal business hours, you may choose to leave a message that will be returned the next business day or you can contact us via email at medicareappeal@maximus.com.

For inquiries simply about the processing status of a specific case file, or group of cases, please visit our website www.medicareappeal.com.

MAXIMUS Federal Services employs a staff of "Adjudicators" who manage individual reconsideration case files. Specific questions about a case under review should be directed to the individual Adjudicator assigned to the case in question. Consult MAXIMUS Federal Services case documentation, or ask the MAXIMUS Federal Services operator, to identify the Adjudicator assigned to the case. Information that is to be made part of the case file and used in the final determination must be submitted in writing.

Medicare Health Plans are responsible for supporting its enrollees in the reconsideration process. Plans should not direct members to MAXIMUS Federal Services for routine case status inquiries. Medicare managed care enrollees may be referred to 1-800-MEDICARE for general information regarding the Medicare managed care appeals process and to locate resources for assistance in the appeals process.

3.5 SUGGESTIONS AND COMPLAINTS

MAXIMUS Federal Services is an ISO 9001:2000 certified Independent Review Entity. As such, management requires a formal process for identification of opportunities for corrective and preventive action, or continuous improvement. Please freely provide any suggestions or complaints to any MAXIMUS Federal Services staff member who is interacting with you, or to the Project Director. If you are not completely satisfied, the MAXIMUS Federal Services QIC Lead would appreciate the opportunity to address your concern.

3.6 HOLIDAYS

MAXIMUS Federal Services offices will be closed for the following holidays:

- Thanksgiving Day
- Christmas Day
- New Year's Day

MAXIMUS Federal Services will still accept delivery of case files on those days. If you intend to submit a case for receipt by MAXIMUS Federal Services on one of the above-listed days, you must contact MAXIMUS Federal Services via telephone (585-348-3300) at least 24 hours in advance to arrange for case file delivery.

4. BACKGROUND—IMPORTANT CONSIDERATIONS PRIOR TO DEVELOPING THE RECONSIDERATION CASE FILE FOR SUBMISSION TO MAXIMUS FEDERAL SERVICES

The responsibilities of the Medicare Health Plan related to adverse organization determination ("denials") and the Medicare Health Plan level reconsideration are defined by CMS in 42 CFR Part 422, Subpart M and Chapter 13 of the CMS Medicare Managed Care Manual. This MAXIMUS Federal Services Medicare Health Plan Reconsideration Process Manual is based on the presumption that the Medicare Health Plan understands and complies with these CMS policies, and is not an instruction guide for them.

The purpose of this Chapter is to highlight certain aspects of Medicare Health Plan's organization determination and reconsideration processing that directly impact subsequent IRE reconsideration. The topics addressed are:

4.1 MEDICARE HEALTH PLAN'S ORGANIZATION DETERMINATION NOTICE REQUIREMENTS

The Medicare Health Plan is required, in most instances, to provide a written organization determination ("denial") notice to the enrollee or the enrollee's representative (See *Section 4.2*). If a denial is subsequently appealed to MAXIMUS Federal Services for IRE reconsideration, a copy of the denial notice and dates pertaining to Medicare Health Plan organization determination processing must be included within the case file.

MAXIMUS Federal Services closely reviews the organization determination to define the denied service or claim subject to IRE reconsideration. In addition, we compare the type, format and content of the notice to CMS requirements and report "notice deficiencies" to CMS. Finally, MAXIMUS Federal Services abstracts and reports to CMS the dates of the initial request for service (or payment) versus organization determination, for purposes of monitoring Medicare Health Plan timeliness.

CMS has developed the following standardized denial notices:

4.1.1 NOTICE OF DENIAL OF MEDICAL COVERAGE (NDMC)

This OMB-approved notice applies to prior authorization denials, adverse organization determinations including termination of medical services (excepting Inpatient discharge denials).

The Medicare Health Plan must issue a NDMC when it receives a request for a service and the Medicare Health Plan denies the request, in whole or part. However, CMS policy recognizes that some "denials" may occur in the context of provider discussions with enrollees about patient care options, and that in such discussions it may be difficult to ascertain whether or not the enrollee believes a denial has occurred at that instant. For example, if an enrollee is discussing two treatment options with a physician, the physician might recommend the second option. Whether such a recommendation is a "denial" of the first option depends upon the enrollee's response (that is, acceptance or rejection of the physician's recommendation). Further, the enrollee might not contest the physician's recommendation during the visit, but could contest it at a later date.

Due to these unavoidable complications, CMS policy does not obligate Medicare Health Plan providers to issue an NDMC, but does obligate providers to inform enrollees of their right to obtain an NDMC from the Medicare Health Plan. The Medicare Health Plan must issue the NDMC if so requested by the enrollee. If the Medicare Health Plan makes the denial (for example, in response to a provider's request for prior authorization), the Medicare Health Plan must issue the NDMC.

In summary, in many instances the circumstances of an initial organization determination will necessitate issuance of an NDMC by the Medicare Health Plan. If so, the NDMC must be included in a case file submitted for IRE reconsideration. If a valid exception to the NDMC issuance requirement exists, the Medicare Health Plan should document the exception in the IRE case file.

CMS has issued a standard form for the NDMC. Medicare Health Plans may not deviate from the language of the CMS form. Please note that the OMB control number must be displayed on the notice.

4.1.2 NOTICE OF DENIAL OF PAYMENT (NDP)

A Medicare Health Plan completes and issues this notice when it denies a request for payment of a service that was already received by the enrollee. While CMS does have an OMB-approved notice, CMS also permits Medicare Health Plans to use the Medicare Health Plan's existing electronic formats that generate Explanation of Benefits, as long as the back or a separate attachment contains the NDP information about appeal rights.

A copy of the completed NDP must be included in the Medicare Health Plan reconsideration case file.

4.1.3 NOTICE OF MEDICARE NON-COVERAGE (NOMNC)

This OMB-approved notice should be issued when the plan discontinues coverage for Skilled Nursing Facility (SNF) stays, Home Health services or CORF services. CMS has specific requirements with regard to time and manner of delivery of this notice.
(See 42 CFR 422.624 and CMS Medicare Managed Care Manual, Chapter 13). Telephone delivery of the notice is only permitted in limited circumstances, and there are specific

requirements with regard to the documentation of the telephone call. See CMS Medicare Managed Care Manual, Chapter 13.

It is important to note that reduction of a service within the SNF, Home Health, or CORF setting that does not result in termination of skilled coverage does not require the use of the NOMNC. Medicare Health Plans should use the NDMC for this purpose. Also, please note that CMS does not require use of the NOMNC in denials based on exhaustion of benefits. For terminations based on the exhaustion of Medicare benefits, Medicare Health Plans should use the NDMC.

4.2 MEDICARE HEALTH PLAN VALIDATION OF PARTY, REPRESENTATIVE AND ELIGIBLE APPEAL

Federal regulations provide that the following parties may request a reconsideration of an organization determination:

- An enrollee (including his or her representative)
- An assignee of the enrollee (that is, a non-contract physician or other non-contract provider who has furnished a service to the enrollee and formally agrees to waive any right to payment from the enrollee for that service)
- The legal representative of a deceased enrollee's estate
- Any other provider or entity (other than the Medicare Health Plan) determined to have an appealable interest in the proceeding. (See 42 CFR §422.578)

It is a straightforward validation of the appealing party when the enrollee initiates the reconsideration request. It is not as straightforward to validate the appealing party when the Reconsideration request is made by a person other than the enrollee. Special considerations with respect to reconsideration requests made by persons other than the enrollee are discussed under the following sub-headings:

Medicare Health Plans should carefully note that until an "authorized" representative or provider-as-party is formally validated and documented, the appeal process, including the Medicare Health Plan reconsideration, should not begin. In other words, if the Medicare Health Plan receives an appeal request from a representative who is not validated (See *Section 4.2.1*) the Medicare Health Plan should not initiate the Medicare Health Plan reconsideration process. The procedures in *Section 4.2.5* below instruct the Medicare Health Plan on proper technique for addressing Medicare Health Plan reconsideration requests submitted by non validated representatives or providers-as-party.

4.2.1 REPRESENTATIVE DOCUMENTATION

It is the responsibility of the Medicare Health Plan, not MAXIMUS Federal Services to correctly identify and apply the laws and procedures related to representation.

An enrollee may designate any person as their representative. CMS in general requires that Medicare Health Plans document proof of the validity of the enrollee's representative. Special rules apply to two circumstances: (1) enrollees who are incapacitated and (2) providers as representatives.

General Requirements

If the party requesting the reconsideration is **not** the enrollee, and the special circumstances discussed below do not apply, it is the responsibility of the Medicare Health Plan to determine and document that the requesting party is an appropriate representative of the enrollee. (See CMS Medicare Managed Care Manual, Chapter 13). Appropriate documentation may include, but is not limited to, a durable power of attorney, a health care proxy, an appointment of guardianship or other legally recognized forms of appointment. In the event the Medicare Health Plan does not have access to these documents, an Appointment of Representative form accepted by MAXIMUS Federal Services for this purpose is included in the *Appendix* of the Medicare Managed Care Manual Chapter 13. Representative documentation is required even if the representative is an attorney, family member or medical provider (See Special Condition 2, below). Representative documentation must be included in the case file submitted to MAXIMUS Federal Services for IRE Reconsideration.

It is also the health plan's obligation to attempt to obtain the needed representative documentation. Plans must make, and document, their attempts to obtain this documentation. If a plan does not receive the representative documentation at the end of the appeal timeframe, PLUS EXTENSION, the plan must submit the case to MAXIMUS Federal Services for dismissal. This means that plans must allow the full timeframe, plus any extensions allowable, for the requestor to submit the representative documentation. Plans should not submit cases to MAXIMUS Federal Services for dismissal until the full timeframe, plus extension (if applicable), has expired. See Medicare Managed Care Manual Ch. 13, §10.4.

Special Condition 1: Enrollee Who Is Incapacitated or Incompetent

If a member is incapacitated or incompetent and cannot sign an appointment of representative document, the Medicare Health Plan must apply state laws regarding legal representation of incapacitated or incompetent persons. If these laws require documentation, such documentation should be obtained by the Medicare Health Plan. The Medicare Health Plan's appeal staff should consult with the Medicare Health Plan's legal counsel to follow the applicable laws. MAXIMUS Federal Services does not require documentation in the IRE case file to substantiate that the Medicare Health Plan has properly applied State law. However, the *Medicare Managed Care Reconsideration Background Data Form* does include a checkbox (under section 4-b) that must be selected in order for MAXIMUS Federal Services to accept the representative as valid. (See *Appendix*).

The Appointment of Representative form can be found in Chapter 13 of the Medicare Managed Care Manual.

Special Condition 2: A Physician May Initiate Expedited or Standard Pre-Service Reconsiderations without Appointment of Representation or Without Being the Provider-as Party. To determine if a requestor is a "physician" please refer to Social Security Act §1861(r).

Any physician may make a reconsideration request on behalf of an enrollee to the Medicare Health Plan to initiate an expedited reconsideration. A treating physician may, upon providing notice to the enrollee, make a request for a standard pre-service reconsideration on the enrollee's behalf. These physicians are not required to obtain an appointment of representative document from the enrollee, nor are these physicians required to execute a waiver of enrollee liability. Consequently, no appointment of representative form is required in a case file submitted to MAXIMUS Federal Services. The Medicare Health Plan must, however, document the physician request in the case file. Please note, however, that appeals requested by non-physician providers require an Appointment of Representation.

Federal regulations state that a physician must notify the enrollee of the standard service appeal request. For purposes of processing the appeal, it is the health plans responsibility to assess whether the enrollee has received proper notice. If the health plan processes the appeal request, MAXIMUS Federal Services assumes that the health plan has sufficient proof that the enrollee was properly noticed.

Note that an appointment of representative requirement does apply to a provider who attempts to represent an enrollee in a standard claim reconsideration case.

4.2.1.1 Dismissal for lack of Proper Documentation

If a reconsideration case file is submitted to MAXIMUS Federal Services that was initiated by a representative, MAXIMUS Federal Services will examine the file for compliance with the appointment requirements. MAXIMUS Federal Services will dismiss cases in which a required fully executed appointment of representative form is absent. (See *Section 4.2.5*).

4.2.2 PROVIDER-AS-PARTY DOCUMENTATION

4.2.2.1 Non-Contract Providers

A non-contract provider may itself become the party to an appeal if that non-contract provider has executed a *Waiver of Liability* form. The purpose of this form is to ensure that the enrollee will not be held financially liable if the provider loses the appeal. The executed *Waiver of Liability* document must be included in the case file submitted to MAXIMUS Federal Services. MAXIMUS Federal Services will dismiss cases in which a fully executed *Waiver of Liability* form is absent. (See *Section 4.2.5*).

Managed Care Manual Ch. 13, §60.1.1 states that plans must make, and document, their attempts to obtain the Waiver of Liability. If the plan does not receive the Waiver of Liability by the conclusion of the appeal timeframe, the plan should forward the case to MAXIMUS Federal Services for dismissal. Please note that this means that plans should not submit cases to MAXIMUS Federal Services for dismissal for no Waiver of Liability until the appeal timeframe has concluded.

A model Waiver of Liability form can be found in Chapter 13 of the Medicare Managed Care Manual.

4.2.2.2 Contract Providers

Contract or "in-plan" providers of the Medicare Health Plan do not have rights to act as the party in an appeal. Payment disputes between a contract provider and the health plan, for which the enrollee has no liability, should be resolved through a forum outside of the Medicare managed care appeal process.

4.2.3 PROVIDER AS PERSON "SUPPORTING" THE ENROLLEE APPEAL

Any person, including a provider, may "support" the enrollee appeal by providing written or oral testimony at the Medicare Health Plan level reconsideration or written testimony at the IRE level reconsideration. There is no requirement for execution of an appointment of representative or waiver of liability if the role of the person is simply providing testimony in support of an enrollee's appeal. The distinction between representation and support includes any of the following elements:(1) the person supporting the appeal has no standing to request the appeal proceeding, whereas the representative does, (2) the person supporting the appeal does not receive mandatory notices otherwise sent to the enrollee, whereas the representative does, (3) the person supporting the appeal cannot make decisions (for example, withdrawing the appeal), whereas the representative may do so, (4) the person supporting the appeal does not otherwise "manage" the enrollee's participation in the appeal, whereas the representative may.

A physician may also, without being a representative, support a request for an appeal to be classified as an expedited reconsideration. The physician may make his/her statement of support in either written or oral form. The effect of such a statement is to mandate expedited status for the appeal if the physician's statement indicates that the application of a standard decision timeframe to the reconsideration could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

4.2.4 REPRESENTATIVE OF DECEASED ENROLLEE'S ESTATE

The Medicare Health Plan has the responsibility to ensure that such representatives are legitimate. The Medicare Health Plan must indicate on the *Reconsideration Background Data Form* (by selecting the appropriate checkbox in section 4-b) if the appeal request initiated by an estate representative is valid. MAXIMUS Federal Services cannot rule on whether estate representation documentation is legitimate. The Medicare Health Plan should consult its legal advisor for assistance in determining the appropriate estate representative.

4.2.5 PROCESSING RECONSIDERATIONS WITH AN INVALID APPEAL REQUESTOR

If the Medicare Health Plan receives a reconsideration request without the required executed representative or waiver of liability document (or in which the required document is incomplete or erroneous), the Medicare Health Plan level reconsideration review should not begin. However, the Medicare Health Plan must make reasonable attempts to inform the requestor of the inadequacy and obtain the representative or waiver of liability documents (See *Ch. 13 of the Medicare Managed Care Manual*). If the Medicare Health Plan does not get the appropriate documentation, then the plan must still submit a "case file" to MAXIMUS Federal Services for IRE level resolution. We will review documentation showing the Medicare Health Plan's compliance with CMS notice requirements and the efforts to obtain the missing documentation. Section 4.7 below provides more information on case file requirements and important distinctions between cases dismissed for untimely filing and those dismissed for invalid documentation. MAXIMUS Federal Services may refer cases with incomplete or unsatisfactory documentation to the Medicare Health Plan's CMS Account Manager.

4.3 NON-MEDICARE PLAN SERVICES

The Medicare Managed Care appeal process applies only to basic and mandatory or optional supplemental benefits (42 CFR §422.566). Some enrollees have additional benefits, outside the scope of the CMS approved benefit plan, provided separately by their employer or union. Denial of these benefits is not subject to Medicare reconsideration, and such cases should not be submitted to MAXIMUS Federal Services. However, if any portion of the denial overlaps Medicare basic benefits or the Medicare Health Plan mandatory or optional supplemental benefits, the case does qualify for Medicare reconsideration. Likewise, if the enrollee (or non-contract provider party) argues that the denied service should be covered under the Medicare benefits, as opposed to the employer provided benefits, the case should be reviewed as a Medicare reconsideration.

4.4 RECONSIDERATION PRIORITY

There are three levels of reconsideration priority: (1) standard services request reconsideration; (2) standard claim payment reconsideration; and (3) expedited reconsideration. These three levels are defined in *Section 2.* Definitions. Refer also to 42 CFR Part 422 Subpart M for a complete definition and explanation of the differing requirements for these reconsiderations.

The classification of a reconsideration as either an expedited or standard reconsideration is the responsibility of the Medicare Health Plan. The Medicare Health Plan should not ask MAXIMUS Federal Services to determine whether a given request for expedited reconsideration should be granted. However, MAXIMUS Federal Services has the right to change a classification, if upon receipt, MAXIMUS Federal Services determines the case was misclassified. For example, if a Medicare Health Plan submits a standard claim payment case as

expedited, MAXIMUS Federal Services may change the classification from expedited to standard claim.

4.5 MEDICARE HEALTH PLAN RESPONSIBILITY TO CONDUCT A FULL RECONSIDERATION

Medicare Health Plans are required to conduct a thorough Medicare Health Plan level reconsideration, prior to submitting a case to MAXIMUS Federal Services for IRE level reconsideration. Consult 42 CFR §422.590 and the CMS Medicare Managed Care Manual for a definition of the Medicare Health Plans obligations in conducting its reconsideration. In addition, the MAXIMUS Federal Services requirements and suggestions for IRE level case file preparation (See *Section 5.3*) will be difficult to meet if the Medicare Health Plan has not previously undertaken and documented a full Medicare Health Plan level reconsideration.

MAXIMUS Federal Services may, at its discretion, utilize the "request for additional information" process (See *Section 6.6*), to direct Medicare Health Plans to remedy a case in which a complete Medicare Health Plan level reconsideration has not occurred or has not been documented. MAXIMUS Federal Services will notify CMS if a Medicare Health Plan displays a pattern of failure to complete and document a thorough Medicare Health Plan level reconsideration.

4.6 MEDICARE HEALTH PLAN RECONSIDERATION WITH INCOMPLETE EVIDENCE

The Medicare Health Plan should gather all pertinent evidence or information before rendering its organization determination and completing the Medicare Health Plan level reconsideration. CMS policy dictates that a Medicare Health Plan should not automatically deny the enrollee's organization determination request due to a lack of documentation. Therefore, if the only available information is the enrollee's description, the Medicare Health Plan's decision must be based on that description.[1]

Insufficient medical records are the primary example of incomplete evidence in Medicare Health Plan determinations. Medical necessity can almost never be ascertained by review of administrative (for example claim) data, but rather requires primary medical record documentation. As the CMS policies outlined above suggest, the burden of proof in a medical necessity denial is usually on the Medicare Health Plan, and absence of appropriate medical records is likely to lead to the conclusion on IRE review that the Medicare Health Plan has not substantiated its denial.

Certain CMS Medicare National Coverage Decisions (NCD) or Local Coverage Decisions (LCD) dictate that coverage or denial of an item or service be based upon specified

[1] The basis of the Medicare Appeals Process is the Constitutional protection of the enrollee's right to federal benefits to which that enrollee is entitled. The burden is therefore generally on the MA Organization to demonstrate that the enrollee is not entitled to the denied service or claim. Absence of evidence, and most notably relevant medical records, would generally undermine the MA Organizations arguments that it had demonstrated a legitimate process and basis for its denial. Possible exceptions would include non emergent or urgent enrollee "self referred" out-of plan services, without prior related health care access request to the MA Organization, where the enrollee and non-contracted provider will not cooperate in the provision of records.

medical evaluations and findings. For example, if the enrollee is requesting a wheelchair, the Medicare Health Plan should utilize reliable medical evidence to ascertain whether the enrollee is bed or chair confined. It is the Medicare Health Plans obligation to obtain such medical evidence before the IRE level reconsideration.

Before submitting a case for reconsideration, the Medicare Health Plan should exhaust all reasonable efforts to obtain the required evidence and records. If the Medicare Health Plan is submitting a case file with incomplete evidence, the Medicare Health Plan should document these efforts in the case file. (See *Section 5.3.4*).

4.7 SUBMITTING CASES FOR DISMISSAL

4.7.1 CASE FILE DOCUMENTATION

In certain circumstances, a Medicare Health Plan should not complete a full reconsideration, but rather forward the case file to MAXIMUS Federal Services for dismissal. These circumstances include, but are not limited to:

- Invalid appeal requestor (discussed above in *Section 4.2.5*)
- Untimely filing of appeal request

In these instances, the health plan should send an abbreviated case file. The case file should include:

- The Reconsideration Background Data Form
- If dismissal is based on invalid representative, please complete the appropriate portion of Section 4b.
- In all dismissal cases, Section 8 must be completed even though the case is being submitted for dismissal. This is a **NEW REQUIREMENT that began in 2011.** Dismissal cases will be held to the CMS mandated timeliness standard.
- The organization determination documents
- The appeal request documents
- Documentation of attempts made by the health plan to have appealing party correct appeal request deficiency

4.7.2 DISTINCTION BETWEEN UNTIMELY FILING AND INVALID APPEAL REQUESTOR

At times, an appeal request may be both untimely and the appeal requestor is invalid. In such instances, the case should be reviewed first to determine if the appeal was filed timely, then it should be evaluated to determine if the appeal requestor is valid. If the request is not filed timely, please submit the case file for dismissal.

If the appeal is timely filed, but the requestor is invalid, the Medicare Health Plan should attempt to obtain the missing documentation. If the missing documentation is not received, the case should be submitted for dismissal as an invalid appeal request. Please make sure to include

documentation of the attempts to obtain the missing information.

Example Chart:

Appellant Type	**Number of days appeal request filed <u>after</u> denial notice date**	**Standing documents required and received**	**Next Steps***	**Resolution**
Non-contract provider	60 days or less	WOL required, WOL received		Process Reconsideration
Non-contract provider	60 days or less	WOL required, WOL not received	Ask for WOL (provide form) and document the request	If no WOL received, forward for dismissal. If WOL received, process reconsideration
Non-contract provider	61 days or more	WOL required, WOL received		If no good cause exists, forward for dismissal. If good cause exists, process reconsideration
Non-contract provider	61 days or more	WOL required, WOL not received	If there is "good cause" for late reconsideration request filing, ask for WOL (include form) and document the request	If no WOL received, forward for dismissal. If WOL received, process reconsideration if there is good cause. If there is no good cause, forward for dismissal

* Assumes, when appropriate, MHP will review late reconsideration request filings for "good cause" as defined in the Medicare Managed Care Manual, Chapter 13. If the MHP finds good cause, it should then consider the reconsideration request as received timely.

4.7.3 MAILING TIMEFRAMES FOR DISMISSAL REQUESTS

The same mailing timeframes allowed for non-dismissal requests (i.e., reconsideration) apply to cases submitted for dismissal (see Section 5.2). That means for standard retrospective and pre-service dismissal requests, five calendar days are allowed for mailing. For expedited dismissal requests, the 24-hour submission period noted in Section 5.2.1 applies.

5. SUBMITTING VALID RECONSIDERATION CASE FILES TO MAXIMUS FEDERAL SERVICES

This Chapter defines the requirements for Medicare Health Plan preparation and submission of case files to MAXIMUS Federal Services for IRE level reconsideration under the following headings:

5.1 CASES THAT MUST BE SUBMITTED TO MAXIMUS FEDERAL SERVICES FOR RECONSIDERATION

Federal Regulation 42 CFR §§422.590-422.592 and the CMS Medicare Managed Care Manual, Chapter 13 define cases that must be submitted for IRE reconsideration. The Medicare Health Plan must submit any case for which it is responsible for a Medicare Health Plan level reconsideration, unless the Medicare Health Plan has wholly reversed its initial adverse organization determination. Federal regulations define a case in which the Medicare Health Plan has failed to make a reconsideration determination by the applicable due date, as an affirmation of the adverse organization determination. Therefore, cases in which the Medicare Health Plan has not made a decision as of the expiration of the decision timeframe also must be submitted to MAXIMUS Federal Services. If the Medicare Health Plan subsequently obtains or develops additional information on any case (including an incomplete case), it must submit that information to MAXIMUS Federal Services. However, MAXIMUS Federal Services will not delay its review and makes no guarantee that such late, additional information can be taken into account prior to the MAXIMUS Federal Services determination.

5.2 TIME STANDARDS FOR SUBMISSION OF CASES TO MAXIMUS FEDERAL SERVICES

The following sub-sections define time standards for case submission for each reconsideration priority (expedited, standard service and standard claim). Please note that all references to the "enrollee's request" for a reconsideration should be interpreted as a *valid* reconsideration request from any permissible appealing party, including representatives and noncontract providers. However, such a request does not become valid until and unless the documentation standards for parties and representatives are met (See *Section 4.2*).

5.2.1 TIMELINESS OF SUBMISSION OF EXPEDITED RECONSIDERATIONS

Federal regulations (42 CFR §422.590(d)) require the Medicare Health Plan to complete expedited cases within 72 hours of the enrollee (or enrollee's provider's) request, or sooner if the enrollee's health condition requires. The Medicare Health Plan may take an extension of up to 14 calendar days, if such extension is in the enrollee's interest.

For expedited cases only, the regulations (42 CFR §422.590(d)(5)) also define an additional interval for "submission" of the case file to MAXIMUS Federal Services. Submission is to occur within 24 hours of the Medicare Health Plan's completion of its reconsidered determination. The 24-hour period permitted for submission is thus in addition to the time permitted for the Medicare Health Plan reconsideration.

The Medicare Health Plan must submit expedited reconsideration case files to MAXIMUS Federal Services via overnight/next day delivery rather than by standard mail. As a practical matter, MAXIMUS Federal Services assumes that Medicare Health Plan reconsideration decisions occur as of the close of the business day on which the decision is rendered. Therefore, the Medicare Health Plan meets the 24-hour standard if it submits the case to a commercial delivery service by that delivery vendor's close of business on the day after the Medicare Health Plan makes its reconsideration determination.[2] The case would then be delivered to MAXIMUS Federal Services on the next day that falls within the vendor's customary schedule. *Exhibit 5-1*: *Expedited Case Submission Timetable*, contains a table illustrating how these rules apply to submission of expedited cases.

MAXIMUS Federal Services' offices are open to receive case file submissions Monday through Saturday.

Exhibit 5-1
EXPEDITED CASE SUBMISSION TIMETABLE

Day of Medicare Health Plan Determination	Day of Medicare Health Plan Case Submission to Overnight Delivery Vendor	Day of MAXIMUS Federal Services Receipt
Monday	Tuesday	Wednesday
Tuesday	Wednesday	Thursday
Wednesday	Thursday	Friday
Thursday	Friday	Saturday*
Friday	Saturday*	Monday
Saturday	Monday	Tuesday

* Some delivery vendors require senders to specify "Saturday Delivery" on the envelope/package to be delivered. MAXIMUS Federal Services is open to receive cases on Saturday from 9 AM to 2 PM Eastern Time.

5.2.2 TIME STANDARD FOR SUBMISSION OF STANDARD SERVICE RECONSIDERATIONS

Regulations at 42 CFR §422.590(a)(2) require the Medicare Health Plan to submit a standard service reconsideration to the MAXIMUS Federal Services:

2 As noted in Section 5.1, the failure of the MA Plan to make its reconsideration determination by the deadline is regarded as an adverse determination that triggers the requirement for case submission to MAXIMUS Federal Services

- As expeditiously as the enrollee's health condition requires
- Not later than 30 calendar days after the receipt of a valid reconsideration request, subject to
- An additional 14-calendar day extension, if taken in the enrollee's interest

The regulations do not provide any additional time period for submission. Also, MAXIMUS Federal Services does not require the Medicare Health Plan to use overnight delivery for these cases. Consequently, for purposes of defining and calculating timeliness, MAXIMUS Federal Services adds five calendar days to the intervals listed above. For example, MAXIMUS Federal Services would consider a standard service case, without an extension, to be submitted timely if it is received within 35 calendar days of the enrollee's valid request for reconsideration.

5.2.3 TIME STANDARD FOR SUBMISSION OF STANDARD CLAIM RECONSIDERATIONS

Regulations at 42 CFR §422.590(b)(2) require the Medicare Health Plan to submit a standard claim reconsideration to MAXIMUS Federal Services within 60 calendar days from the date of the enrollee's request for reconsideration. The Medicare Health Plan may submit cases by standard mail. For calculations of timeliness, MAXIMUS Federal Services adds 5 calendar days to the 60 days. For example, MAXIMUS Federal Services would consider a standard claim case to be submitted timely if it is received within 65 calendar days of the enrollee's valid request for reconsideration.

5.3 PREPARATION AND SUBMISSION OF THE NEW CASE FILE TO MAXIMUS FEDERAL SERVICES

Addressed below are instructions for the Medicare Health Plan on the required methods for physical construction of a case file submitted to MAXIMUS Federal Services for IRE reconsideration. The topics are addressed under the following subheadings:

5.3.1 Initiation of Expedited Cases
5.3.2 Organization of the New Case File Package
5.3.3 Organization of Individual New Case Files
5.3.4 Guidance on Selection and Inclusion of Medical Records
5.3.5 Confirmation of MAXIMUS Federal Services Case Receipt

As explained below, the Medicare Health Plan must include with each case a *Medicare Managed Care Reconsideration Background Data Form* and a structured *Case Narrative* report. The instructions for this form and report are presented in *Appendix*, and should be thoroughly reviewed since the instructions are integral to an understanding of case preparation and submission requirements.

5.3.1 INITIATION OF EXPEDITED CASES

To initiate submission of an expedited case, the Medicare Health Plan must fax or email MAXIMUS Federal Services a "*Notice of Intent to Submit Expedited Reconsideration"* form. (See *Appendix*).[3] We require this form to enable work planning for these short turnaround cases, and also to alert the Medicare Health Plan if a planned case delivery does not occur.

To protect enrollee confidentiality, Medicare Health Plans must not fax or email the actual expedited case file itself. MAXIMUS Federal Services will not initiate any case that is sent via facsimile until a hard copy of the case file is received. Follow the instructions for case delivery in *Section 5.3.2*.

Note that because of the short turn-around time for expedited cases, MAXIMUS Federal Services does not send the appellant or Medicare Health Plan an acknowledgement letter for such cases.

5.3.2 ORGANIZATION OF THE NEW CASE FILE PACKAGE

The "New Case File Package" is the envelope or container in which the Medicare Health Plan ships MAXIMUS Federal Services one or more new case files. MAXIMUS Federal Services offices are open to accept case file delivery Monday through Saturday and most holidays. Address packages to:

MAXIMUS Federal Services
Medicare Managed Care Reconsideration Project
3750 Monroe Ave. Ste. 702
Pittsford, New York 14534-1302

The Medicare Health Plan may include more than one new case in the package submitted to MAXIMUS Federal Services

- Complete and place the form, *New Reconsideration Case File Transmittal Cover Sheet (See Appendix)* on top of the case file package.
- Please bind each case in the package separately; using clips or other method that can be removed without special equipment is permissible.
- Do not staple or permanently bind case file material.

5.3.3 ORGANIZATION OF INDIVIDUAL NEW CASE FILES

The organization of the case will be in the following order, "top" of file to "bottom."

- *Medicare Managed Care Reconsideration Background Data Form (See Appendix)*
- *Case Narrative* (*See Appendix*)
- *Case Material (See Exhibit 5-2)*

[3] See also page 1 of this Manual, *Contacting MAXIMUS Federal Services*, for fax and email instructions.

Exhibit 5-2
EXPLANATION OF "CASE MATERIAL"

"Case material" refers to all supporting notices, documentation, medical records, call logs and so forth. Case material should be placed in a standard order, "top" of file to "bottom," as follows:

- Notices
  - Appointment of Representative (if applicable)
  - Provider Waiver of Liability (if applicable)
  - Notice of Medicare Health Plan Reconsideration Determination
  - Notice of Medicare Health Plan Adverse Organization Determination
  - Notice of Denial of Expedited Appeal Request (if applicable)
  - Notice of Extension to timeframe taken in enrollee interest (if applicable)

- Record of Adverse Determination and Medicare Health Plan Reconsideration
  - Prior authorization or claim denial documents
  - Medical Director or consultant determinations
  - Documentation of arguments of Enrollee, Enrollee's provider or Representative
  - Any provider letters of support or consultations supporting the enrollee's position
  - Any relevant call logs or system reports
  - Any other records kept by the Medicare Health Plan of its initial determination or reconsideration proceeding

- Medicare Health Plan Decision Making Criteria
  - Complete copy of subscriber agreement, preferably on CD-ROM
  - Full citation for any CMS policy references, or copy of text[4]
  - Other Information
  - Complete copy of any referenced internal medical policy, utilization review criteria, technology assessment, or other cited medical criteria

- Medical Records (See *Section 5.3.4*)

[4] "Full citation" refers to the designation of section and paragraph of the Social Security Act or CFR, CMS Manual Section/Page. For Local Coverage Decisions, a copy must be included unless an active and complete citation is provided to a web address. **Do not** cite to secondary sources (for example, Milliman, Hayes, Commerce Clearing House) unless complete text is provided.

5.3.4 GUIDANCE ON SELECTION AND INCLUSION OF MEDICAL RECORDS

For denials that are based, in whole or part, on medical necessity, the Medicare Health Plan is burdened with the requirement to provide a "peer defensible" rationale for the denial. Medical records that relate to the case issues must be included. Medical records that do not relate to the case should not be included. If the Medicare Health Plan has made an unsuccessful attempt to obtain records, such attempts should be documented. For example, the Medicare Health Plan may include a statement within the Case Narrative (Section IV(B) Justification) detailing the attempts made to obtain the records and the basis of why the Medicare Health Plan arrived at its decision without these records.

Exhibit 5-3: Suggested Components of Medical Records, is offered by MAXIMUS Federal Services to reduce the need for "requests for additional information" to the Medicare Health Plan. The Medicare Health Plan should regard *Exhibit 5-3* as a general guide. Requirements for a given case may vary. MAXIMUS Federal Services reserves the right to request records in addition to those listed in *Exhibit 5-3* should the situation warrant the request.

Exhibit 5-3
SUGGESTED MEDICAL RECORDS FOR INPATIENT AND LONG-TERM CARE DENIAL

Medical Records	*Acute Hospital Admission Denial*	*Acute Hospital Continued Care Denial*	*SNF Admission Denial*	*SNF Continued Care Denial*	*Inpatient Rehabilitation Admission Denial*	*Inpatient Rehabilitation Continued Care Denial*
PCP Records	X					
Specialist Records	X					
Treating Physician Support For Denial	X	X	X	X	X	X
Alternate Care Recommendations	X	X	X	X	X	X
Pre-Admission Screening					X	X
Admission Orders*		X	X (hospital)	X (SNF)	X (hospital or SNF)	X (rehab)
Doctor's Orders*		X	X (hospital)	X (SNF)	X (hospital or SNF)	X (rehab)
Admission History and Physical*		X	X (hospital)	X	X (hospital or SNF)	X (rehab)
Discharge Note*		X	X (hospital)	X (hospital)	X (hospital or SNF)	X (hospital, SNF, rehab)
Physician Progress Notes*		X	X (hospital)	X (hospital and SNF)	X (hospital or SNF)	X (rehab)
Nurses Notes*		X	X (hospital)	X (SNF)	X (hospital or SNF)	X (rehab)
Nursing Care Plan*		X		X (SNF)	X (hospital or SNF)	X (rehab)
Medication Record*		X	X (hospital)	X (SNF)	X (hospital or SNF)	X (rehab)
Treatment Records (e.g., wound care) *		X	X (hospital)	X (SNF)	X (hospital or SNF)	X (rehab)
Diagnostic Studies*		X	X (hospital)	X (SNF)	X (hospital or SNF)	X (rehab)
Laboratory Studies*		X	X (hospital)	X (SNF)	X (hospital or SNF)	X (rehab)
Physical Therapy Admission and Discharge Notes*				X (SNF)	X (hospital or SNF)	X (rehab)
Physical Therapy Progress Records*		X	X (hospital)	X (hospital and SNF)	X (hospital or SNF)	X (rehab)
Occupational Therapy Admission and Discharge Notes*				X (SNF)	X (hospital or SNF)	X (rehab)
Occupational Therapy Progress Records*		X	X (hospital)	X (hospital and SNF)	X (hospital or SNF)	X (rehab)
Speech Therapy Admission and Discharge Notes*				X (SNF)	X (hospital or SNF)	X (rehab)
Speech Therapy Progress Notes*		X	X (hospital)	X (hospital and SNF)	X (hospital or SNF)	X (rehab)
Nutrition Therapy Notes*		X	X (hospital)	X (SNF)	X (hospital or SNF)	X (rehab)
Discharge Planning Notes*		X	X (hospital)	X (SNF)	X (hospital or SNF)	X (rehab)
Records on prior level of functioning			X	X	X	X

***** Records may be from acute hospital, SNF or inpatient rehab depending on the case types and basis for denial.

Exhibit 5-4

SUGGESTED MEDICAL RECORDS FOR OTHER COMMON TYPES OF DENIALS

Issue at Appeal	**Records needed**
Mobility Aids (PMDs, power wheelchairs, manual wheelchairs, walkers, canes)	PCP records, Physical Therapy records, Orthopedic records, Neurology records (if applicable), face-to-face, in-home DME evaluations
MRIs	PCP records, Orthopedic Records, Neurology Records, Physical Therapy Records
CT Scans	PCP records, neurology records, other specialties as needed
Cataract surgery	PCP records, ophthalmology records
Blepharoplasty	PCP records, ophthalmology records including visual fields (taped and untaped) and photographs
PET scans	PCP records, oncology records
Rehabilitation Therapy	PCP records, physical therapy records, initial assessment and treatment plan
Oxygen Equipment	PCP records, pulmonology records, O2 saturation test results
Chiropractic care	PCP records, orthopedic records (if applicable), neurology records (if applicable), x-rays
Colonoscopies (including cost sharing cases)	Colonoscopy report, PCP records, gastroenterology records
Foot Care	PCP records, Podiatry records , Endocrinology records (if applicable)
Radiation Therapy/Chemotherapy	PCP records, Oncology records, lab results, surgery records (if applicable)
Bone Growth Stimulators	PCP records, orthopedic records, x-rays
Specialist services (general)	PCP records, records from specialist type at issue
Emergency Room and Ambulance Transport	ER records, ambulance trip reports, nurse's notes, ER triage/intake notes
Mental Health Services	PCP records, Psychiatry records, Psychology/Social Worker notes, Behavioral Health notes
Bariatric Surgery	PCP notes, Bariatric Surgery notes, Nutritionist notes, Endocrinology notes (if applicable)
Dental Services	Dental Records, Oral Surgery Records, Dental x-rays (including digital prints)
Part B covered drugs	PCP records, requesting physician records

5.3.5 CONFIRMATION OF MAXIMUS FEDERAL SERVICES CASE RECEIPT

MAXIMUS Federal Services does not accept responsibility for loss or delay of case files caused by the US Mail or other delivery services. We do attempt to notify Medicare Health Plans and the other party to the appeal of receipt of case files, as follows:

Expedited Cases

If the Medicare Health Plan submits a *Notice of Intent to Submit an Expedited Reconsideration Form,* MAXIMUS Federal Services will contact the Medicare Health Plan if the file does not arrive on the date identified in the form. MAXIMUS Federal Services does not send an acknowledgement letter, due to the short time available for case processing. Our receipt of the file is confirmed by the Medicare Health Plan and other party's receipt of our reconsideration determination notice. (See *Section 6.6*).

Standard Service and Claim Cases

MAXIMUS Federal Services sends the Medicare Health Plan and appealing party an acknowledgement letter by regular first class mail within 48 hours of our receipt of the case file. Allowing for time for delivery of the Medicare Health Plan case to MAXIMUS Federal Services, the Medicare Health Plan should contact MAXIMUS Federal Services if it has not received the acknowledgement letter within 10 business days of its case submission.

6. MAXIMUS FEDERAL SERVICES RECONSIDERATION PROCESS

The purpose of this Chapter is to provide the Medicare Health Plan with an overview of the procedures and approach that MAXIMUS Federal Services follows in rendering the IRE level reconsideration. Although the focus is on MAXIMUS Federal Services procedures, implications for the Medicare Health Plan are highlighted in text contained in shaded boxes. The topics addressed are:

6.1 MAXIMUS FEDERAL SERVICES CASE PROCESSING TIME STANDARDS

MAXIMUS Federal Services is responsible for completing the IRE reconsideration within the same timeframes and standards that apply to Medicare Health Plans.

CASE CLASS	TIME STANDARD
Expedited	72 hours, plus 14 calendar day extension if in enrollee's interest, or sooner if warranted by enrollee's medical condition
Standard Service	30 calendar days, plus 14 calendar day extension if in enrollee's interest, or sooner if warranted by enrollee's medical condition
Standard Claim	60 calendar days

In expedited and standard service appeals, MAXIMUS Federal Services may extend the decision timeframe by up to 14 calendar days if it is in the enrollee's interest. MAXIMUS Federal Services will notify the enrollee and Medicare Health Plan of the extension in writing.

The start of the time period for IRE reconsideration is the date on which the case is received at MAXIMUS Federal Services. The end of the time period is the date on which MAXIMUS Federal Services mails its reconsideration determination notice. Determinations are sent to appellants by standard first class mail and faxed to health plans.

6.2 ADMINISTRATIVE CASE INTAKE

The steps in MAXIMUS Federal Services administrative case intake are:

- Mail Opening and sorting of new case files
- Matching of expedited cases to Medicare Health Plan *Notice of Intent to Submit Expedited Case*.
- Inquiry on CMS systems to verify beneficiary enrollment in Medicare Health Plan.
- Medicare Appeal System assignment of a random "reconsideration case number".
- Generation of acknowledgement letters (standard service and claim only).
- Assignment of the case to a MAXIMUS Federal Services Adjudicator

See *Section 5.3.5* for the discussion of acknowledgement letters and response the Medicare Health Plan should take if a letter is not received.

Note that our ability to accomplish case intake is compromised if the Medicare Health Plan does not provide the enrollee's Medicare number and all other required fields on the *Reconsideration Background Data Form (See Appendix).* Errors or omissions on the *Reconsideration Background Data Form* will lead to delays in MAXIMUS Federal Services intake of the case.

6.3 POLICIES ON COMMUNICATION WITH MEDICARE HEALTH PLAN AND APPELLANT DURING CASE PROCESSING

6.3.1 ALL EVIDENCE MUST BE IN WRITING

Federal regulations define the IRE level reconsideration as a De novo determination based upon the documented case file. The IRE level reconsideration does not provide for in-person or telephonic hearings. This means that MAXIMUS Federal Services may consider only such evidence as is submitted and available in the hard copy record.

If any party calls MAXIMUS Federal Services, they are advised that the information they relay will not be considered unless it is submitted in writing. A party should follow up any "telephone testimony" immediately with written documentation

6.3.2 COMMUNICATIONS REGARDING THE POTENTIAL IRE DETERMINATION ARE NOT PERMITTED

MAXIMUS Federal Services personnel are not permitted to engage in written or phone communication with parties, where the subject of such communication is any discussion or projection of the IRE determination that MAXIMUS Federal Services may make. Discussions are limited to review of the IRE process, including instructions on the procedures for submission of written information to MAXIMUS Federal Services.

6.3.3 ENROLLEE SUBMISSION OF ADDITIONAL INFORMATION TO THE IRE CASE FILE

The MAXIMUS Federal Services acknowledgement letter that is sent to the enrollee or valid representative, advises the enrollee of their ability to submit information or arguments directly to MAXIMUS Federal Services. The acknowledgement letter is not used for expedited cases. For standard reconsiderations, the enrollee is given 10 days to submit information to MAXIMUS Federal Services.

MAXIMUS Federal Services may provide a Medicare Health Plan information that the Medicare Health Plan has submitted, but MAXIMUS Federal Services may not provide information submitted by the enrollee. If information submitted by the enrollee is not already contained in the case file, and if the information calls into question material submitted by the Medicare Health Plan, MAXIMUS Federal Services may request clarification via a Request for Information (See *Section 6.6*).

Enrollees may be less likely to submit information directly to MAXIMUS Federal Services if the enrollee believes that: (1) the Medicare Health Plan has provided the enrollee the chance to submit evidence to the Medicare Health Plan and (2) the Medicare Health Plan has advised the enrollee that the entire case file has been submitted to MAXIMUS Federal Services.

6.4 ADJUDICATOR CASE REVIEW

An "Adjudicator" is a professional trained by MAXIMUS Federal Services to: (1) manage the IRE case reconsideration and (2) make coverage determinations. Adjudicators are not permitted to make medical necessity determinations, which require physician review (See *Section 6.5*).

6.5 PHYSICIAN REVIEW

Pursuant to 42 CFR § 422.590(g)(2), determinations of medical necessity must be made by a physician, where physician is defined to include doctors of chiropractic and osteopaths. MAXIMUS Federal Services maintains a panel of over 400 medical consultants who are fully credentialed to the standards of our accrediting body, URAC (American Accreditation HealthCare Commission). These medical consultants are located throughout the United States, are in active practice and include a mix of physicians who predominately practice in community versus academic settings.

The MAXIMUS Federal Services medical consultants cover all specialties and all relevant sub-specialties recognized by the American Board of Medical Specialties (ABMS). Physicians are matched to cases based upon the case clinical issue. For most cases, this means that the specialty of the MAXIMUS Federal Services reviewer is the same as the specialty of the physician who would render the contested service. In cases in which the issue is the appropriateness of a referral from one specialist to another (for example, internal medicine to

dermatology), MAXIMUS Federal Services may choose to use the specialty of the referring physician.

The Adjudicator referral to the physician includes a copy and, where necessary, guidance regarding any applicable Medicare National Coverage Decision (NCD), local coverage decision (LCD) or clinical guidelines. Where the Medicare Health Plan medical necessity determination is based upon a Plan guideline, such guideline and any relevant background from the Medicare Health Plan (including literature from recognized medical publications) will be emphasized to the MAXIMUS Federal Services reviewer. Medicare Health Plans must include Plan guidelines for this reason.

The physician consultant's report is reviewed by the Adjudicator and, if need be, the MAXIMUS Federal Services Medical Director. Special emphasis is placed on ensuring that the consultant's determination is consistent with any relevant Medicare policies, or permissible and medically appropriate plan policies.

6.6 REQUESTS TO MEDICARE HEALTH PLAN FOR ADDITIONAL INFORMATION

"Request for Additional Information" (RI) is the formal process by which MAXIMUS Federal Services permits the Medicare Health Plan to supply written information to remedy a question or deficiency in the reconsideration case file.

6.6.1 REQUEST FOR ADDITIONAL INFORMATION IS AT MAXIMUS FEDERAL SERVICES DISCRETION

The MAXIMUS Federal Services reconsideration is designed as an "on the record" review rather than an "in person" proceeding. Therefore, the Medicare Health Plan reconsideration case file must include all materials submitted and used in making the Medicare Health Plan reconsideration determination and all such material as is specified in *Section 5.3.*

The IRE is under no obligation to seek additional information. The Medicare Health Plan bears the burden to show why the denial is appropriate. Therefore, **missing information is reasonably construed to the enrollee's favor.** MAXIMUS Federal Services may decide a case at any time based upon the information available. MAXIMUS Federal Services does not overturn the Medicare Health Plan for case file deficiencies, per se, or on an administrative basis. However, a case file deficiency typically undermines the validity of denial argument of the Medicare Health Plan, hence missing information may result in an IRE overturn.

6.6.2 REQUEST FOR INFORMATION PROCESS

The process used by MAXIMUS Federal Services for Request for Information is as follows:

- The Adjudicator determines the deficiency and double checks the case file to verify the information is, in fact, absent
- The Adjudicator sends a completed Request for Information Form to the fax number or email address provided for the Case Contact on the *Reconsideration Background Data Form*
- The Medicare Health Plan Case Contact calls MAXIMUS Federal Services if:
    - Questions exist about the RI
    - The RI deadline (See *Section 6.6.3*) cannot be met
- The Medicare Health Plan develops and submits the RI Response
- The Adjudicator reviews the RI response to determine if it is sufficient. If not:
    - Minor omissions are resolved by phone
    - Major omissions may lead to a repeat of the RI process or may lead to MAXIMUS Federal Services determination based on available documents.

6.6.3 MEDICARE HEALTH PLAN SUBMISSION OF THE RESPONSE TO A REQUEST FOR INFORMATION

To protect patient confidentiality in accordance with federal standards, the Medicare Health Plan must not transmit confidential information to MAXIMUS Federal Services by email or fax.[5] All confidential information must be submitted to MAXIMUS Federal Services by hard copy mail or delivery. For purposes of this discussion, the MAXIMUS Federal Services assigned reconsideration number is not considered confidential information.

- If hard copy delivery is used for an RI response, the Medicare Health Plan must place the Request for Information Response Cover Sheet (see Appendix) on top of the response documents.

- If the Medicare Health Plan places more than one RI response in a package, separate each RI response with the *Request for Information Response Cover Sheet.*

The Medicare Health Plan may respond to a Request for Information by fax if the Medicare Health Plan can fully address the RI requirements without use of confidential identifiers, or by redacting such identifiers.

The following maximum timeframes apply for Medicare Health Plan response to MAXIMUS Federal Services Requests for Information:

Expedited reconsiderations	Within 3 calendar days from date of request
Standard Service reconsiderations	Within 5 working days from date of request
Standard Claims reconsiderations	Within 10 working days from date of request

[5] The use of secure email for transmittal of Reconsideration material is under investigation.

The above timeframe deadline is for the date of Medicare Health Plan submission (mailing or fax) of the material to MAXIMUS Federal Services. Expedited RI responses must be submitted by fax (if material does not contain confidential information) or by overnight delivery.

MAXIMUS Federal Services may expedite an RI request if such action is necessary due to the enrollee's health.

6.7 RECONSIDERATION DETERMINATION NOTICES

6.7.1 ISSUING A RECONSIDERATION DETERMINATION

Upon completion of its reconsideration, MAXIMUS Federal Services issues a "reconsideration determination" notice to the appealing party, with a copy to the Medicare Health Plan and CMS Regional Office.[6]

6.7.2 GENERAL CHARACTERISTICS OF MAXIMUS FEDERAL SERVICES DETERMINATION NOTICES

All MAXIMUS Federal Services reconsideration determination notices that are not fully in the enrollee's favor contain an explanation of the enrollee's right to request further appeal before an Administrative Law Judge.

A MAXIMUS Federal Services reconsideration determination notice that overturns a Medicare Health Plan determination, in whole or in part, contains an explanation of how the enrollee can obtain the disputed payment or covered service. The enrollee is directed to the Medicare Health Plan to obtain the service or claim payment.

Although a MAXIMUS Federal Services reconsideration determination may address or discuss medical care and treatments, the MAXIMUS Federal Services reconsideration determination is not an assessment of quality of care, nor is it medical advice or instruction. A MAXIMUS Federal Services determination is a ruling on the Medicare Health Plan's obligation for coverage (payment or arrangement for a specific benefit, service or treatment).

For any full or partial overturn determination, MAXIMUS Federal Services also issues to the Medicare Health Plan a *Notice to Comply with IRE Part C Reconsideration Determination*. This form document references the overturn determination notice and advises the Medicare Health Plan of its obligation to effectuate the overturn decision.

[6] The CMS Regional Office receives a copy of Overturn, Partial Overturn, Withdrawal and Dismissal decisions only. The CMS Regional Office does not receive a copy of an Uphold decision.

6.7.3 TRANSLATION OF DETERMINATION NOTICES

Upon request of the enrollee or Medicare Health Plan, MAXIMUS Federal Services is required by CMS to translate its final reconsideration determination notice into the native language of the enrollee. The Medicare Health Plan notifies MAXIMUS Federal Services of the need for translation on the *Reconsideration Background Data Form* (See *Appendix*).

6.8 ENROLLEE REQUESTS FOR CASE FILES

The MAXIMUS Federal Services acknowledgement letter and brochure advise enrollees of the right to obtain a copy of the reconsideration case file from the Medicare Health Plan and/or MAXIMUS Federal Services. Under instruction from CMS, and subject to the provisions of the Privacy Act and Freedom of Information Act, MAXIMUS Federal Services will release a copy of a reconsideration case file to an enrollee, or other authorized individual.

MAXIMUS Federal Services may only release to a Medicare Health Plan copies of documentation the Medicare Health Plan has submitted in the case file.

7. POST RECONSIDERATION DETERMINATION PROCESSING

A number of processes may be invoked after MAXIMUS Federal Services issues its reconsideration determination notice. This Chapter provides useful information on these various post determination processes. The topics addressed are:

7.1 MAXIMUS FEDERAL SERVICES MONITORING OF MEDICARE HEALTH PLAN COMPLIANCE WITH OVERTURNED DETERMINATIONS

Compliance ("effectuation") is defined as the Medicare Health Plan's payment of a claim (overturned standard claim denial), or authorization and arrangement for a service or continuation of services (overturned expedited or standard service denial), as instructed in the MAXIMUS Federal Services reconsideration determination notice.

7.1.1 MEDICARE HEALTH PLAN EFFECTUATION TIMEFRAMES

The following table summarizes CMS requirements for timeliness of Medicare Health Plan effectuation:

APPEAL PRIORITY	TIME REQUIREMENT (from receipt of notice)	REFERENCE
Expedited	Authorize or provide within 72 hours, or earlier if enrollee health dictates	42 CFR §422.619(b)
Standard Service	Authorize within 72 hours, or provide within 14 days, or earlier if enrollee health dictates	42 CFR §422.618(b)(1)
Standard Claim	Pay within 30 days	42 CFR §422.618(b)(2)

If you have questions regarding a MAXIMUS Federal Services determination, please contact the MAXIMUS Federal Services Project Director of the Medicare Managed Care Reconsideration Project. Please note MAXIMUS Federal Services is not authorized to waive compliance with any final determination. If you feel that you cannot comply with the MAXIMUS Federal Services reconsideration determination notice, you must notify your Account Manager at the CMS Regional Office.

A Medicare Health Plan request for a reopening (See *Section 7.2*), whether granted by MAXIMUS Federal Services or not, does not stay or pend the date of the Medicare Health Plan compliance obligation.

7.1.2 MAXIMUS FEDERAL SERVICES RECONSIDERATION COMPLIANCE MONITORING

CMS requires MAXIMUS Federal Services to monitor Medicare Health Plan compliance with the effectuation process, via the following procedure:

1. MAXIMUS Federal Services issues the Medicare Health Plan a copy of the reconsideration determination notice. Included with this copy is a *Notice to Comply with IRE Part C Reconsideration Determination,* that details the Medicare Health Plan's responsibilities, including the timeframe by which a compliance notice must be received by MAXIMUS Federal Services

2. The Medicare Health Plan is required to submit a statement attesting to compliance (effectuation) to MAXIMUS Federal Services. The Statement must be submitted to MAXIMUS Federal Services in accordance with timeframes noted within the *Notice to Comply with IRE Part C Reconsideration Determination.*

3. MAXIMUS Federal Services provides 5 days from the due date of submission for mail time.

4. If MAXIMUS Federal Services does not receive the Medicare Health Plan statement of compliance within the required timeframe, MAXIMUS Federal Services will send to the Medicare Health Plan a reminder notice.

5. If MAXIMUS Federal Services still does not receive the Medicare Health Plan statement of compliance within the timeframe indicated in the reminder notice, MAXIMUS Federal Services reports the Medicare Health Plan's deficiency to CMS. The Medicare Health Plan is not copied on this report to CMS.

The Medicare Health Plan statement of compliance may be in a form designed by the Medicare Health Plan, but must contain all of the information found on the recommended *Medicare Health Plan Statement of Compliance Form* contained in *Appendix*. Please do not submit unidentified internal computer screen prints as the statement of compliance.

Medicare Health Plan *Statements of Compliance* should be sent to the attention of:

MAXIMUS Federal Services
Medicare Managed Care Reconsideration Project
Attn: Compliance
3750 Monroe Ave. Ste. 702
Pittsford, NY 14534-1302

7.2 IRE REOPENING PROCESS

An IRE Reopening is an administrative procedure in which the IRE re-evaluates its reconsideration determination for the purpose of addressing an error, fraud, or information not available at the time of IRE initial determination. A reopening is not an appeal right. MAXIMUS Federal Services may accept or reject a request for a reopening at its sole discretion.

MAXIMUS Federal Services may initiate a reopening on its own initiative. In addition, either of the parties to a reconsideration determination may request a reopening. The reopening request must be in writing and clearly state the basis on which the request is made:

1. Error on the face of the evidence by MAXIMUS Federal Services in its review
2. Fraud
3. New and additional information that was not available at the time MAXIMUS Federal Services made its initial determination in the case

The process by which MAXIMUS Federal Services administers and adjudicates a reopening request is similar to the reconsideration process:

1. MAXIMUS Federal Services receives and logs the Reopening Request.
2. An acknowledgement letter is sent to the party and Medicare Health Plan.
3. An Adjudicator not involved in the reconsideration reviews the Reopening.
4. The Adjudicator makes a determination, using a physician review if indicated.
5. A Reopening Determination Notice is issued.
6. If the Reopening Determination reverses a reconsideration Uphold (that is, the Reopening finds in favor of the enrollee), a *Notice to Comply with IRE Part C Reconsideration Determination* is also issued to the Medicare Health Plan. The Medicare Health Plan is then responsible for "effectuation" per the discussion of compliance in *Section 7.2* above.

A Medicare Health Plan's request for a reopening does not relieve the Medicare Health Plan of the burden of compliance, and reporting of compliance, within the required timeframes (See 7.2). The Medicare Health Plan is relieved of this burden if the Medicare Health Plan obtains a Reopening Reversal (of a reconsideration Overturn), prior to the Medicare Health Plan compliance date. The Medicare Health Plan is not relieved of the burden of compliance with the original reconsideration overturn if the Medicare Health Plan receives a Reopening Reversal after the original compliance date.

MAXIMUS Federal Services attempts to process Reopenings within the same time standards that are applied to reconsiderations.

7.3 ADMINISTRATIVE LAW JUDGE (ALJ) PROCESS

The appellant (enrollee, his/her representative, or the non-contract provider) may request an appeal of the MAXIMUS Federal Services reconsideration determination before an Administrative Law Judge (ALJ) with the Office of Medicare Hearings and Appeals.

MAXIMUS Federal Services does not determine an enrollee's right to a hearing, nor does it schedule, conduct or administer hearings.

The Medicare Health Plan does not have a right to request an ALJ hearing. The Medicare Health Plan does have the right to be present at the ALJ hearing and the right to present additional evidence at the hearing.

7.3.1 NOTICE OF RIGHTS TO HEARING AND SUBMISSION OF REQUEST FOR ALJ HEARING

The right to request an ALJ hearing is explained in the MAXIMUS Federal Services reconsideration determination notice and brochure. An enrollee may submit a written request for an ALJ hearing to MAXIMUS Federal Services. If the Medicare Health Plan receives a request for an ALJ hearing, it should immediately forward the request to MAXIMUS Federal Services.

MAXIMUS Federal Services forwards the reconsideration case file to the appropriate Office of Medicare Hearings and Appeals. MAXIMUS Federal Services does not communicate directly with Medicare Health Plans or parties during the Administrative Law Judge hearing process. MAXIMUS Federal Services' role is limited to providing complete case files to the ALJ field office.

7.3.2 TRACKING AND CONDUCT OF ALJ HEARING

MAXIMUS Federal Services does not schedule ALJ hearings and does not have direct access to ALJ scheduling information. The Office of Medicare Hearings and Appeals is responsible for contacting the requesting party and Medicare Health Plan to schedule the matter before the ALJ. Both parties (that is, requesting party and the Medicare Health Plan) have a right to be present and present testimony at the ALJ hearing. Any concerns regarding the ALJ hearing should be directed to the Office of Medicare Hearings and Appeals.

7.3.3 ALJ DETERMINATION PROCESSING

The ALJ Determination is mailed directly to both parties (enrollee and Medicare Health Plan). The Office of Medicare Hearings and Appeals returns a copy of the ALJ decision and the complete case file to MAXIMUS Federal Services. MAXIMUS Federal Services reviews the ALJ determination for two purposes:

1. MAXIMUS Federal Services determines whether the Medicare Health Plan was given the opportunity to appear at the ALJ Hearing. If not, MAXIMUS Federal Services informs the Medicare Health Plan.
2. If the ALJ has reversed or modified MAXIMUS Federal Services' reconsideration determination, MAXIMUS Federal Services sends a copy of the ALJ determination to the Medicare Health Plan with a *Notice to Comply* with the Administrative Law Judge Determination. MAXIMUS Federal Services also sends a copy of this notice to the appealing party.

The Medicare Health Plan is obligated to effectuate the ALJ's determination as expeditiously as the enrollee's health condition requires, but no later than 60 calendar days from the date it receives notice reversing the organization determination. The Medicare Health Plan must report the compliance to MAXIMUS Federal Services in the same manner as for a MAXIMUS Federal Services reconsideration reversal.

7.3.4 EFFECT OF MEDICARE APPEALS COUNCIL (APPEALS COUNCIL) REQUEST ON ALJ DECISION EFFECTUATION

If the Medicare Health Plan requests Medicare Appeals Council (AC) review consistent with 42 CFR §422.608, the Medicare Health Plan may await the outcome of the review before it pays for, authorizes, or provides the service under dispute. A Medicare Health Plan that files an appeal with the AC must concurrently send a copy of its appeal request and any accompanying documents to the enrollee and must notify the MAXIMUS Federal Services that it has requested an appeal before the AC.

7.4 MEDICARE APPEALS COUNCIL PROCESS

Federal regulations permit either party to an ALJ hearing to request a further hearing before the AC. See 42 CFR §422.608. If a hearing before the AC is requested, MAXIMUS Federal Services is contacted by the AC to provide a copy of the entire case file in dispute. MAXIMUS Federal Services does not communicate directly with Medicare Health Plans or parties regarding the AC review process. MAXIMUS Federal Services' role is to provide complete case files to the AC.

7.4.1 TRACKING AND CONDUCT OF MEDICARE APPEALS COUNCIL HEARING

MAXIMUS Federal Services does not schedule AC hearings and does not have direct access to AC scheduling information. Any concerns regarding the AC hearing process should be directed to the Medicare Appeals Council.

7.4.2 MEDICARE APPEALS COUNCIL DETERMINATION PROCESSING

The AC Determination is mailed directly to both parties (enrollee and Medicare Health Plan). The Medicare Health Plan is obligated to effectuate the AC's determination as expeditiously as the enrollee's health condition requires, but no later than 60 calendar days from the date it receives notice reversing the organization determination. The Medicare Health Plan must report the compliance to MAXIMUS Federal Services in the same manner as for a MAXIMUS Federal Services reconsideration reversal.

8. RECONSIDERATION DATA

MAXIMUS Federal Services extracts numerous data elements from submitted reconsideration case files and provides reports to CMS based on the collected data. This Section discusses the related data systems and how the collected information is used within the reports. The topics addressed are:

8.1 Medicare Appeals System
8.2 Medicare Health Plan Monitoring Reports

8.1 MEDICARE APPEALS SYSTEM

MAXIMUS Federal Services utilizes the Medicare Appeal System (MAS) to support administration of the reconsideration process. Data is obtained and entered to MAS from the following sources:

- CMS data systems, which provide enrollee and plan identifying information
- *Reconsideration Background Data Form,* from which certain data fields completed by the Medicare Health Plan are entered, as given, to MAS.
- Adjudicator abstraction of information from other reconsideration case file documents.

In addition to providing data to MAXIMUS Federal Services for general program administration, MAS data is relevant to Medicare Health Plans in the following ways:

- CMS obtains reports, based upon MAS data, to monitor certain aspects of Medicare Health Plan compliance with appeal requirements.
- MAXIMUS Federal Services publishes Reconsideration Statistical Reports on the Project web site www.medicareapppeal.com.

8.2 MEDICARE HEALTH PLAN MONITORING REPORTS

MAXIMUS Federal Services reports information to CMS related to:

- Timeliness of Medicare Health Plan organization determination and reconsideration determination
- Medicare Health Plan effectuation of IRE, ALJ, or Medicare Appeals Council overturned reconsideration determinations

It is important to note that MAXIMUS Federal Services provides the above reports to CMS Central and Regional Offices to advise those offices of *potential* non-compliance. CMS personnel determine how such reports should be used in discharge of their Medicare Health Plan monitoring function. Typically, CMS personnel will contact the Medicare Health Plan if a significant issue (for example, outlier) or pattern appears to exist, and will provide the Medicare Health Plan the opportunity to research the case(s) more thoroughly.

However, as will be explained below, the source of the reported compliance data is

primarily the Medicare Health Plan itself—specifically entries made to the *Reconsideration Background Data Form* by the Medicare Health Plan. It is vital that the Medicare Health Plan carefully and accurately complete this form.

Proper Use of CMS Prescribed Adverse Determination Notices

MAXIMUS Federal Services Adjudicators review the case file and ascertain which notice, if any, is contained. The type of notice is compared against the type required for the given appeal. The format and content of the Notice is also compared against related CMS requirements.

Timeliness of Medicare Health Plan - Organization Determination and Reconsideration

The *Reconsideration Background Data Form* (See *Appendix*) requires the Medicare Health Plan to:

- Classify the case by reconsideration priority (expedited, standard service, standard claim)
- Enter "date of receipt" and "date of completion" of the organization determination and Medicare Health Plan reconsideration for all cases, including dismissals
- Enter requests for expedited processing and related Medicare Health Plan decision
- Indicate if a 14-day extension was taken "in the enrollee's interest"

This data is used to calculate the time interval within which the organization determination and reconsideration should occur, and compares this interval with the actual timeliness reported by the Medicare Health Plan. A variety of reports that measure Medicare Health Plan timeliness are submitted to CMS using these calculations. *This set of reports relies upon the information exactly as given by the Medicare Health Plan on the Reconsideration Background Data Form.* Consequently, Medicare Health Plan errors or omissions on this form will result in reporting of either missing data or cases outside of timeframe compliance.

In addition, the MAXIMUS Federal Services Adjudicators compare the contents of the case file (for example, notices and correspondence) to the data reported by the Medicare Health Plan on the *Reconsideration Background Data Form.* If the Adjudicator determines that an error or omission exists on the *Reconsideration Background Data Form,* this error or omission is, if possible, corrected and reported separately. MAXIMUS Federal Services uses this information to report "discrepancies" with respect to Medicare Health Plan reported timeliness to CMS.

Timeliness of Effectuation Compliance

Using the Medicare Health Plan's report of effectuation to MAXIMUS Federal Services, we report to CMS listings of cases without compliance notice and statistics on effectuation compliance.

8.3 USING THE MAXIMUS FEDERAL SERVICES WEBSITE TO TRACK TIMELINESS AND EFFECTUATION

MAXIMUS Federal Services is responsible for providing CMS with data for certain STAR rating measures and for data in support of Regional Office (RO) health plan oversight activity. Specifically, MAXIMUS Federal Services provides CMS with timeliness data for STAR metric C34 and with overturn rates for metric C35. In addition, MAXIMUS Federal Services provides reports indicating cases where MAXIMUS Federal Services has not been notified of overturned cases requiring compliance effectuation. In order to allow health plans to proactively monitor the cases that they have sent to MAXIMUS Federal Services for processing, we have developed a website that allows health plans to access timeliness and compliance data in real time. The website is www.medicareappeal.com. The following sections will review the resources that are available on the website so that plans can use the information throughout the year to monitor their own cases as well as report any discrepancies well in advance of STAR data being reported.

8.3.1 PLAN TIMELINESS DATA

Plans can access timeliness data from the www.medicareappeal.com website by hovering over the 'Health Plans' tab at the top of the main interface page of the site. The drop-down menu that appears there will have a selection option called 'Search for Your Appeals Case'. Once selected, this tab gives plans the option of searching for data for a particular contract number or case number. It also allows plans to limit the search by either the date that MAXIMUS Federal Services receives the case or the date that MAXIMUS Federal Services renders its decision. Once the limiting information is entered into this search box, a list of results data will appear.

MAXIMUS Federal Services provides two different data elements to CMS to calculate timeliness. As mentioned above, after performing a search, a list of results data will appear. These case search results are divided into columns. The data columns used to report timeliness data to CMS are columns 2 (IRE Request Received Date), column 4 (Plan Reported Recon Receipt Date), and column 5 (IRE Corrected Recon Receipt Date). Column 2 represents the date that MAXIMUS Federal Services receives the case file from the health plan. Column 4 represents the date that the health plan reports to MAXIMUS Federal Services on the Reconsideration Background Data Form that they received the valid appeal request from the appellant. Column 5, if filled in, is the date that, after going through the documentation in the case file, MAXIMUS Federal Services has determined is the actual appeal start date. Timeliness is based on the number of days between columns 2 and 4. If there is a date in column 5, then timeliness is based on the number of days between columns 2 and 5.

For example, for retrospective (i.e., payment) cases, plans have 60 days to render their reconsiderations. In addition, for purposes of calculating timeliness, this Manual allows 5 days for mailing of standard pre-service and retrospective cases (see Section 5.2). Therefore, if columns 2 and 4 are more than 65 days apart, the case will be considered late. If there is a date in column 5, the case will be considered late if there are more than 65 days between columns 2 and 5.

The calculation works in exactly the same manner for expedited and standard pre-service cases with the exception of the timeframes allowed. For standard pre-service cases, plans have 30 days to render their reconsideration. Once again, MAXIMUS Federal Services allows 5 days for mailing. Therefore, standard pre-service cases received more than 35 days beyond the date in column 4 will be considered late. Of course, for standard pre-service cases, extensions are allowed for health plans to gather additional information. If the health plan has alerted MAXIMUS Federal Services via the *Reconsideration Background Data* Form that they have taken an extension, it will be noted in column 6. A 'Y' finding in this column will allow for an additional 14 days for standard pre-service cases. Therefore, for standard pre-service cases where there was an extension taken, there should be no more than 49 days between columns 2 and 4.

For expedited cases, the standard timeframe is 72 hours (or 3 days). However, due to the nature of expedited appeals, only one business day is allowed for mailing. Plans are expected to submit expedited cases to MAXIMUS Federal Services via overnight mail. Please note because Sundays are not considered business days, for appeals where the mailing day would fall on a Sunday, extra day is permitted for those cases to arrive. The same caveat for extensions for standard pre-service cases applies to expedited cases as well.

8.3.2 PLAN EFFECTUATION DATA

The www.medicareappeal.com website can also be used by health plans to monitor effectuation and compliance. The method of performing a search for this data on the website is very similar to the method used for seeing timeliness data. From the main interface page of the website, plans can hover over the 'Health Plans' tab at the top of the page. A drop down menu will appear, with a selection entitled 'Search Effectuation Data.' This selection allows plans to monitor which of their cases have been overturned or partially overturned and they can determine if MAXIMUS Federal Services has received plan compliance information. As with timeliness data, plans can limit the search by contract number, case number or date. Once search criteria are entered, a results data list will appear.

This data listing advises plans what the MAXIMUS Federal Services decision was and if notice of their compliance with that decision has been received. Plans can check this data daily (it is updated daily) if they are waiting to see if MAXIMUS Federal Services has received compliance information. In addition, plans can monitor those cases where MAXIMUS Federal Services has not noted a compliance was received.

8.3.2 DATA DISCREPANCIES

If a plan notices that there is no compliance data entered for a case where they have sent compliance information to MAXIMUS Federal Services, or that timeliness data listed on the website appears to be inaccurate, MAXIMUS Federal Services can investigate that discrepancy. With either the timeliness or effectuation data, if a health plan has a question about a data

element or wants to report a discrepancy, they can send an email to the email box linked under the ‘Contact Us’ tab in the upper right hand corner of the website. This email box is continuously monitored and questions are answered promptly.