# CMS Manual System

## Pub. 100-16 Medicare Managed Care

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

**Transmittal 62**

**Date: September 10,2004**


**I. SUMMARY OF CHANGES:**

**NEW/REVISED MATERIAL - EFFECTIVE DATE: September 10, 2004**

**Table of Contents -** Revised for new sections 90.2 - 90.9 and Appendices 8 and 9 as well as changes to section titles 60.1.3 and 60.1.4 and Appendix 7.

**Section 10 - Medicare + Choice (M+C) Beneficiary Grievances, Organization Determinations, and Appeals -** Added last sentence referring reader to CMS' website on appeals and grievances.

**Section 40.2.2 - Written Notification by M+C Organizations -** In second paragraph, added sentence regarding requirements for an M+C organization to use an EOB in place of the NDP.

**Section 60.1.1 - Representative Filing on Behalf of the Enrollee -** Added sentence to first paragraph regarding an M+C organization's responsibility to develop internal policies regarding an enrollee's State representation requirements in their service area.

**Section 90.2 - Expedited Reviews of Coverage Terminations in Certain Provider Settings (SNF, HHA, and CORF) -** Added section to explain Fast-track Appeals Procedures.

**Section 90.3 - Notice of Medicare Non-Coverage (NOMNC) -** Added section to describe advance notice of non-coverage.

**Section 90.4 - Meaning of Valid Delivery** - Added section to explain valid delivery.

**Section 90.5 - When to Issue the Notice of Medicare Non-Coverage -** Added section to explain the timeframe for delivery of NOMNC.

**Section 90.6 - Detailed Explanation of Non-Coverage (DENC) -** Added section to explain requirements for completion of detailed notice.

**Section 90.7 - When to Issue the Detailed Explanation of Non-Coverage** - Added section to describe delivery of the DENC.

**Section 90.8 - Enrollee Procedures to Request Fast-track Review of Provider Service Terminations** - Added section to explain how enrollees request Fast-Track Appeals.

**Section 90.9 - Handling Misdirected Records** - Added section to explain procedures and responsibility regarding resubmission of misdirected records.

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

The previous Appendix 7, "Enroll Rights," has been deleted. The material has been incorporated into current Chapter 13.

The new Appendix 7, "Notice of Medicare Non-Coverage (NOMNC)," provides links to CMS' website for the "Notice of Medicare Non-Coverage" and its instructions.

**Appendix 8 – Detailed Explanation of Non-Coverage (DENC)** - Links are provided to CMS' website for the notice and its instructions.

**Appendix 9 – FAQs on the Grijalva Fast-Track Appeals Process** - Links are provided to CMS' website for Frequently Asked Questions on this topic.

**CLARIFICATION – EFFECTIVE: Not Applicable.**

**Section 60.1.3 - Notice Delivery to Authorized Representative -** Renumbered section 60.1.4 as section 60.1.3. In addition:

Changed to title to current section 60.1.3.

Added the phrase "of receiving the notice" and "legally" in the first paragraph.

Added text to last paragraph regarding instructions on sending notices to an enrollee's representative.

**Section 60.1.4 - Noncontracted Provider Appeals -** Renumbered section 60.1.3 as section 60.1.4 and changed to title to current section 60.1.4.

**Section 150.2 - When to Issue a NODMAR** - Deleted last sentence of third paragraph regarding issuance of a NODMAR when a SNF bed becomes available. This information is incorrect.

**Section 170.5 - Appeal and Grievance Data Collection Requirements** - Revised language to reflect that data reporting is in a required reporting format.

**Section 170.5.2 – Quality of Care Grievance Data** - Changed final sentence in this section to reflect that Appendix 2 is now standardized language.

**Section 170.6 – Explaining Appeal and Quality of Care Grievance Data Reports** - Changed the word "model" to "standardized." In last paragraph, deleted sentences

regarding instructions for an M+C organization to develop its own Appeals and Grievances notice. The notice provided in Appendix 2 is now standard notice.

**Appendix 2 – Beneficiary Appeals and Quality of Care Grievances Explanatory Data Report** - Added OMB approval number to this now standard notice.

***Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged.***

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

| R/N/D | CHAPTER/SECTION/SUBSECTION/TITLE |
|---|---|
| R | Table of Contents |
| R | Chapter 13 / Section 10 / Medicare + Choice (M+C) Beneficiary Grievances, Organization Determinations, and Appeals |
| R | Chapter 13 / Section 40 / Subsection 2.2 / Written Notification by M+C Organizations |
| R | Chapter 13 / Section 60 / Subsection 1.1 / Representative Filing on Behalf of the Enrollee |
| R | Chapter 13 / Section 60 / Subsection 1.3 / Notice Delivery to Authorized Representative |
| R | Chapter 13 / Section 60 / Subsection 1.4 / Noncontracted Provider Appeals |
| N | Chapter 13 / Section 90 / Subsection 2 / Expedited Reviews of Coverage Terminations in Certain Provider Settings (SNF, HHA, and CORF) |
| N | Chapter 13 / Section 90 / Subsection 3 / Notice of Medicare Non-Coverage (NOMNC) |
| N | Chapter 13 / Section 90 / Subsection 4 / Meaning of Valid Delivery |
| N | Chapter 13 / Section 90 / Subsection 5 / When to Issue the Notice of Medicare Non/Coverage |
| N | Chapter 13 / Section 90 / Subsection 6 / Detailed Explanation of Non-Coverage (DENC) |
| N | Chapter 13 / Section 90 / Subsection 7 / When to Issue the Detailed Explanation of Non-Coverage |
| N | Chapter 13 / Section 90 / Subsection 8 / Enrollee Procedures to Request Fast-Track Review of Provider Service Terminations |
| N | Chapter 13 / Section 90 / Subsection 9 / Handling Misdirected Records |
| R | Chapter 13 / Section 150 / Subsection 2 / When to Issue a NODMAR |
| R | Chapter 13 / Section 170 / Subsection 5 / Appeal and Grievance Data Collection Requirements |
| R | Chapter 13 / Section 170 / Subsection 5.2 / Quality of Care Grievance Data |
| R | Chapter 13 / Section 170 / Subsection 6 / Explaining Appeal and Quality of Care Grievance Data Reports |

| R/N/D | CHAPTER/SECTION/SUBSECTION/TITLE |
|---|---|
| R | Chapter 13 / Appendix 2 / Beneficiary Appeals and Quality of Care Grievances Explanatory Data Report |
| N | Chapter 13 / Appendix 7 / Notice of Medicare Non-Coverage (NOMNC) |
| N | Chapter 13 / Appendix 8 / Detailed Explanation of Non-Coverage (DENC) |
| N | Chapter 13 / Appendix 9 / FAQs on the Grijalva Fast-Track Appeals Process |

**III. ATTACHMENTS:**

| | |
|---|---|
| | **Business Requirements** |
| **X** | **Manual Instruction** |
| | **Confidential Requirements** |
| | **One-Time Special Notification** |

# Medicare Managed Care Manual

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

Last Updated - Rev. 62

September 10, 2004

---

Table of Contents

---

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

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

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

---

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

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

If an enrollee requests an M+C organization to provide a detailed notice of a practitioner's decision to deny a service, in whole or in part, or if the M+C organization

decides to deny, in whole or in part, the services or payments then it must give the enrollee a written notice of its determination. If the beneficiary has a representative, the representative must be sent a copy of the notice.

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

1. The specific reason for the denial that takes into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any;

2. Information regarding the enrollee's right to a standard or expedited reconsideration and the right to appoint a representative to file an appeal on the enrollee's behalf (as mandated by 42 CFR 422.570 and 422.566(b)(3);

3. For service denials, a description of both the standard and expedited reconsideration processes and time frames, including conditions for obtaining an expedited reconsideration, and the other elements of the appeals process;

4. For payment denials, a description of the standard reconsideration process and time frames, and the rest of the appeals process; and

5. The beneficiary's right to submit additional evidence in writing or in person.

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

> You required skilled rehabilitation services-P.T. eval. for mobility + gait-eval. for ADL's, speech eval. swallowing - from 6/5/2001, and these services are no longer needed on a daily basis.

The denial rationale must be specific to each individual case and written in a manner calculated for an enrollee to understand.

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

> The case file indicated that while Jane Doe was making progress in her therapy programs, her condition had stabilized and further daily skilled services were no longer indicated. The physical therapy notes indicate that she reached her maximum potential in therapy. She had progressed to minimum assistance for bed mobility, moderate assistance with transfers,

and was ambulating to 100 feet with a walker. The speech therapist noted that her speech was much improved by 6/12/2001, and that her private caregiver had been instructed on safe swallowing procedures and will continue with feeding responsibilities.

Home health care must meet Medicare guidelines, which require that you must be confined to your home. You are not homebound and consequently the home health services requested are not payable by Medicare or the M+C organization.

Golf carts do not qualify as durable medical equipment as defined under Medicare guidelines. Medicare defines durable medical equipment as an item determined to be necessary on the basis of a medical or physical condition, is used in the home or an institutional setting, and meets Medicare's safety requirements. A golf cart does not meet these requirements and is not payable by Medicare or (**name of health plan**).

---

## 60.1.1 - Representative Filing on Behalf of the Enrollee

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

An enrollee may appoint any individual (such as a relative, friend, advocate, an attorney, or any physician) to act as his or her representative. A representative who is appointed by the court or who is acting in accordance with *S*tate law may also file an appeal for an enrollee. *M+C organizations with service areas comprising more than one state should develop internal policies to ensure that they are aware of the different State representation requirements in their service areas.* With the exception of incapacitated or legally incompetent enrollees where appropriate legal papers, or other legal authority, support this representation, both the enrollee making the appointment and the representative accepting the appointment must sign, date, and complete an appointment of representative form or similar written statement. If the appointed representative is an attorney, only the enrollee needs to sign the appointment of representative form or similar statement.

The representative statement must include the enrollee's name and Medicare number. The enrollee may use Form CMS-1696-U4 or SSA-1696-U4 (Appendix 4 and Appendix 5 respectively), Appointment of Representative (available at Social Security offices), although it is not required. The enrollee may also use the appointment of representative statement provided in the IRE Reconsideration Processing Manual.

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

Except in the case of incapacitated or incompetent enrollees, a request for reconsideration from a representative is not valid until supported with an executed appointment of representative form. It is the M+C organization's obligation to inform the enrollee and purported representative, in writing, that the reconsideration request will not be considered until the appropriate documentation is provided.

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

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

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

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

A representative who is a surrogate acting in accordance with State law may file an appeal. A surrogate could include, but is not limited to, a court appointed guardian, an individual who has Durable Power of Attorney, or a health care proxy, or a person designated under a health care consent statute.

---

## 60.1.*3* – Notice Delivery to *Authorized Representatives*

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

The CMS requires that notification of changes in coverage for an institutionalized enrollee who is not competent be made to an authorized representative acting on behalf of the enrollee. Notification to the authorized representative may be problematic because that person may not be available in person to acknowledge receipt of the required notification. The M+C organizations are required to develop procedures to use when the enrollee is incapable or incompetent *of receiving the notice,* and the M+C organization

cannot obtain the signature of the enrollee's representative through direct personal contact. If the M+C organization is unable to personally deliver a notice of noncoverage to a person *legally* acting on behalf of an enrollee, then the M+C organization should telephone the representative to advise him or her when the enrollee's services are no longer covered. The M+C organization must also inform the representative about the right to file an appeal, when and how to file an appeal, and the date that financial liability begins. The date of the conversation is the date of the receipt of the notice. Confirm the telephone contact by written notice mailed on that same date. Place a dated copy of the notice in the enrollee's medical file, and document the telephone contact to the members' representative. The documentation should include: the name of the staff person initiating the contact, the name of the *representative* contacted by phone, the date and time of the telephone contact, and the telephone number called.

*When direct phone contact cannot be made, send the notice to the representative by certified mail, return receipt requested. The date that someone at the representative's address signs (or refuses to sign) the receipt is the date of receipt. Place a copy of the notice in the enrollee's medical file, and document the attempted telephone contact to the members' representative. The documentation should include: the name of the staff person initiating the contact, the name of the representative you attempted to contact, the date and time of the attempted call, and the telephone number called.* When *the return receipt is* returned by the post office, with no indication of a refusal date, then the enrollee's liability starts on the second working day after the M+C organization's mailing date.

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

## 60.1.4 – Noncontracted Provider Appeals

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

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

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

When a noncontracted provider files a request for reconsideration of a denied claim but the provider does not submit the waiver of liability documentation upon the M+C organization's request, the M+C organization must make, and document, its reasonable efforts to secure the necessary waiver of liability form. The M+C organization should not undertake a review until or unless such form is obtained. The time frame for acting on a reconsideration request does not commence until the properly executed waiver of liability form is received. However, if the M+C organization does not receive the form at

the conclusion of the appeal time frame, the M+C organization should forward the case to the independent review entity with a request for dismissal. The M+C organization must comply with the IRE's Reconsideration Process Manual section on reconsiderations that fail to meet provider-as-party requirements.

---

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

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

*As of January 1, 2004, enrollees have the right to an expedited review by a Quality Improvement Organization (QIO) when they disagree with their M+C organization's decision that Medicare coverage of their services from a skilled nursing facility (SNF), home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF) should end. When an M+C organization has approved coverage of an enrollee's admission to a SNF, or coverage of HHA or CORF services, the enrollee must receive a Notice of Medicare Non-Coverage (NOMNC) at least 2 calendar days in advance of the services ending. This right stems from the Grijalva lawsuit, and was established in regulations in a final rule published on April 4, 2003 (68 FR 16,652). It is similar to the longstanding right of a Medicare beneficiary to request a QIO review of a discharge from an inpatient hospital.*

*If the enrollee does not agree that covered services should end, the enrollee may request an expedited review of the case by the QIO in the State where the services are being provided. The enrollee's M+C organization must furnish a detailed notice explaining why services are no longer necessary or covered. The review process generally will be completed within less than 48 hours of the enrollee's request for a review. The notification and appeal procedures distribute responsibilities among four parties:*

1. *The M+C organization generally is responsible for determining the discharge date and providing, upon request, a detailed explanation of termination of services. M+C organizations must coordinate with SNFs, HHAs, or CORFs by providing the termination date as early in the day as possible to allow for timely delivery of the notice. (M+C organizations may choose to delegate these responsibilities to their contracting providers.)*

2. *The provider is responsible for delivering the Notice of Medicare Non-Coverage (NOMNC) on behalf of M+C organizations to all enrollees no later than 2 days before their covered services end.*

3. *The patient/MA enrollee (or authorized representative) is responsible for acknowledging receipt of the NOMNC and contacting the QIO (within the specified timelines) if they wish to obtain an expedited review.*

4. *The QIO is responsible for immediately contacting the M+C organization and the provider if an enrollee requests an expedited review and making a decision on the case by no later than the day Medicare coverage is predicted to end.*

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

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

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

*All enrollees must receive an NOMNC, even if they agree that services should end. The notice must be delivered no later than 2 days prior to the proposed termination of services. Although M+C organizations are responsible for either making or delegating the decision to end services, SNFs, HHAs, and CORFs are responsible for delivering the notices to enrollees. A provider may formally delegate to an agent the delivery of the NOMNC under the following conditions:*

1. *The agent must agree in writing that it will deliver the notice on behalf of the provider.*

2. *The agent must adhere to all preparation, timing and valid delivery requirements for the notice as described in sections 90.4 and 90.5 of this chapter.*

3. *The provider remains ultimately responsible for the valid delivery of the NOMNC.*

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

1. *The enrollee's name;*

2. *The date that coverage of services ends.*

*The notice should also identify the appropriate QIO. All other required elements of the notice are included in the standardized material on the notice. The provider also has the option to include (or an agent to include) additional information in the space provided on the notice.*

*The NOMNC should not be used when M+C organizations determine that an enrollee's services should end based on the exhaustion of Medicare benefits (such as the 100-day*

*SNF limit). Instead, M+C organizations must issue the Notice of Denial of Medical Coverage (NDMC). (See Appendix 1)*

## *90.4 – Meaning of Valid Delivery*

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

*Valid delivery generally means that the enrollee must be able sign the NOMNC to acknowledge receipt of the form. The enrollee must be able to understand that he or she may appeal the termination decision. Except in rare circumstances, CMS believes valid delivery is best accomplished by a face-to-face contact with the enrollee. If the enrollee is not able to comprehend the contents of the notice, it must be delivered to and signed by the enrollee's legally authorized representative.*

*Valid delivery does not preclude the use of assistive devices, witnesses, or interpreters for notice delivery. Thus, if an enrollee is able to comprehend the notice, but either is physically unable to sign it, or needs the assistance of an interpreter to translate it or an assistive device to read or sign it, valid delivery may be achieved by documenting the use of such assistance. Furthermore, if the enrollee refuses to sign the notice, the notice is still valid as long as the provider documents that the notice was given, but the enrollee refused to sign.*

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

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

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

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

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

*Although the regulations do not require action by any of the four responsible parties until 2 days before the planned termination of covered services, a provider may deliver the*

*notice earlier if the date that coverage will end (that is, the "effective date" of the notice) can be identified. M+C organizations and providers are encouraged to work together so that the NOMNC can be delivered as soon as the service termination date is known. Delivery of the NOMNC by the provider as soon as it knows when the M+C organization will terminate coverage will allow the patient more time to determine if they wish to appeal and may permit more time for providers and M+C organizations to furnish any needed records. Coordination between the M+C organization and provider that results in earlier notice delivery can minimize potential liability for either the enrollee or the M+C organization, depending on the QIO's decision.*

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

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

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

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

*The DENC must include the following:*

- *A specific and detailed explanation why services are either no longer reasonable and necessary or otherwise no longer covered;*

- *A description of any applicable Medicare coverage rule, instruction or other Medicare policy, including citations to the applicable Medicare policy rules or information about how the enrollee may obtain a copy of the Medicare policy from the M+C organization;*

- *Any applicable M+C organization policy, contract provision, or rationale upon which the termination decision was based; and*

- *Facts specific to the enrollee and relevant to the coverage determination that are sufficient to advise the enrollee of the applicability of the coverage rule or policy to the enrollee's case.*

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

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

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

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

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

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

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

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

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

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

## *90.9—Handling Misdirected Records*

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

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

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

---

## 150.2 - When to Issue a NODMAR

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

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

1. The enrollee expresses dissatisfaction with his or her impending discharge; or

2. The M+C organization (or the hospital that has been delegated the responsibility) is not discharging the individual, but no longer intends to continue coverage of the inpatient stay.

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

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

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

---

## 170.5 - Appeal and Grievance Data Collection Requirements

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

The following describes the appeal data M+C organizations are expected to record and report. This format should be used by the M+C organization in recording the data internally and is the *required* format for reporting the information to beneficiaries. Reports should be readable and understandable to the recipient of the information. The material also should be typed in at least a 12-point font. The M+C organizations should provide informational copies to the appropriate Regional Office. If the M+C organization provides any of its own materials or discussion to supplement CMS' *OMB approved* format, as with all member materials, prior approval by the Regional Office is required

---

## 170.5.2 - Quality of Care Grievance Data

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

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

Line 2. Total number of Quality of Care Grievances Received by **[Organization's name: insert # here].**

Instructions: This line should only include grievances that involve quality of care complaints received during the data collection period.

Line 3. Average Number of Enrollees in **[Organization's name]: [insert # here].**

Instructions: To calculate the number of enrollees, count the number of enrollees at the end of each month of the data collection period. Divide that total by 12 (the total number of months in the data collection period).

Line 4. Total Number of Quality of Care Grievances received per 1,000 enrollees **[insert # here].**

Instructions: This number is calculated by multiplying the total number of grievances by (line #2) by (1,000) and dividing by the total number of enrollees as of the last date of the reporting period (line #3).

Instructions: This line should only include grievances that involve quality of care complaints received during the data collection period.

In addition to reporting raw data to beneficiaries, M+C organizations also must explain what the numbers mean in a separate report. See Appendix 2 for *standardized* language.

## 170.6 - Explaining Appeal and Quality of Care Grievance Data Reports

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

The *standardized* language included in Appendix 2 provides both contextual information and, where possible, offers an explanation about what the data provided by an M+C organization might suggest to a beneficiary. By doing so, the M+C organizations will help beneficiaries to make a connection between the processing and disposition of appeals.

Line 10 of the appeal data report (see above) requires M+C organizations to report the number or percentage of cases reviewed by the independent review entity, that were decided fully in favor of an enrollee.

The report shows that of the 86 appeal cases that XYZ Organization forwarded to the independent review entity for review (see line 9), 16 or 19 percent were decided fully in favor of an enrollee. On page 4 of Appendix 2, the report provides background regarding independent reviews. For example, one sentence states that an independent review provides an opportunity for a new, fresh look at the appeal outside of the plan. Also, in an effort to explain why the independent review entity might disagree with XYZ organization, the report offers that the independent review entity may have had more information about the appeal.

*When* M+C organizations format their reports according to Appendix 2, M+C organizations will meet the disclosure requirements set forth in the M+C regulations at 42 CFR 422.111(c)(3). *Any additions to the* report must be approved by your CMS Regional Office (RO) plan manager. National plan's language will be approved by the lead RO in accordance with CMS' marketing guidelines. While the CMS RO approves the content of the report, the M+C organization is solely responsible for the validity of the data included in the report.

---

*OMB Approval No. 0938-0778*

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

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

## MEDICARE APPEALS AND

## QUALITY OF CARE GRIEVANCES

## XYZ ORGANIZATION

## April 1, 2002 to March 31, 2003

What kind of information is this?

When you ask for it, the government requires (**XYZ Organization**) to provide you with reports that describe **what happened** to formal complaints that (**XYZ Organization**) received from their Medicare members. There are two types of formal complaints: **Appeals and Grievances. Medicare members have the right to file an appeal or grievance with their Medicare health plans**. The next few pages contain information about the appeals and quality of care grievances that (**XYZ Organization**) received between April 1, 2002, and March 31, 2003.

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

How big is (XYZ Organization)?

(**XYZ Organization**) has about 88,000 Medicare members.

(line 3 on the attached report)



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

# INFORMATION ON MEDICARE APPEALS

## April 1, 2002 To March 31, 2003

**What is an appeal?**

An appeal is a formal complaint about (**XYZ Organization**)'s decision not to pay for, not to provide, or to stop an item or service that a Medicare member believes s/he needs.

If a member cannot get an item or service that the member feels she/he needs, or if the health plan has denied payment of a claim for a service the member has already received, the member can appeal. For example, a member might appeal (**XYZ Organization**)'s decision to stop physical therapy, to deny a visit to a specialist, or to deny payment of a claim

**How many appeals did (XYZ Organization) receive?**

(**XYZ Organization**) received 174 appeals from its Medicare members. About 2 out of every 1,000 Medicare members appealed (**XYZ Organization**)'s decision not to pay for or provide, or to stop a service that they believed they needed.

(lines 2 and 4 on the attached report)

**How many appeals did (XYZ Organization) review?**

(**XYZ Organization**) reviewed 157 appeals during this time period.

(lines 5 through 8 on the attached report)

**What happened?**

From the **174** appeals it received from its members:

(**XYZ Organization**) decided to pay for or to provide all services that the member asked for **41%** of the time.

(**XYZ Organization**) decided **not** to pay for or to provide the services that the member asked for **49%** of the time.

Medicare members withdrew their request before (**XYZ Organization**) could decide **10%** of the time.



**Expedited or "Fast" Appeals Information on Page 3**

## INFORMATION ON EXPEDITED OR "FAST" APPEALS

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

| | |
|---|---|
| What is a "fast" or expedited appeal? | A Medicare member can request that (**XYZ Organization)** review the member's appeal quickly if the member believes that his health could be seriously harmed by waiting for a decision about a service. This is called a request for an **expedited** or **"fast" appeal.** |
| | (**XYZ Organization**) looks at each request and decides whether a "fast" appeal is necessary. By law, (**XYZ Organization**) must consider an appeal as quickly as a member's health requires. If (**XYZ Organization**) determines that a "fast" appeal is necessary, it must notify the Medicare member as quickly as the member's health requires but no later than 72 hours |
| How many "fast" appeals did XYZ Organization receive? | (**XYZ Organization**) received **20** requests for "fast" appeal from its Medicare members. |
| | (lines 14 through 16 on the attached report) |
| What happened? | When a member requested a "fast" review, (**XYZ Organization**) agreed that a "fast" review was needed **75%** of the time. |
| | (**XYZ Organization**) did not agree to a "fast" review **25%** of the time. This number may include requests by members for whom the health plan may not have believed were in danger or serious harm. |

## INFORMATION ON INDEPENDENT REVIEW

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

What is Independent Review of an appeal?

After a member has sent an appeal to (**XYZ Organization**), if the organization continues to decide that it should not pay for or provide all services that the member asked for, (**XYZ Organization**) must send all of the information about the appeal to an **independent review organization** that contracts with Medicare, not for (**XYZ Organization**).

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

If the independent review organization does not agree with (**XYZ Organization**)'s decision, (**XYZ Organization**) must provide or pay for the services that the Medicare member requested.

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


**Independent Review Continued on Page 5**

## INFORMATION ON INDEPENDENT REVIEW

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

How many appeals did the independent review organization consider?

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

(lines 9 through 13 on the attached report)

What happened?

The independent review organization agreed with the Medicare member's appeal **19%** of the time. This means that in **19%** of these cases, (**XYZ Organization**) ended up paying for or providing all services that these members asked for.

The independent review organization disagreed with the Medicare member's appeal **70%** of the time. This means that in **70%** of these cases, (**XYZ Organization**) ended up **not** paying for or providing all services that these members asked for.

Medicare members withdrew their request for independent review **9%** of the time.

By June 01, 2003, **2%** of appeals were still waiting to be reviewed by the independent review organization.

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

# INFORMATION ON QUALITY OF CARE GRIEVANCES

## April 1, 2002 to March 31, 2003

**What is a quality of care grievance?**

A grievance is a complaint that a Medicare member makes about the way (**XYZ Organization**) provides care (other than complaints about requests for service or payment). A **grievance** about the **quality of care** is one kind of grievance. For example, a member can file a grievance about the quality of care when the member believes that the service the member received was not timely or correct, when the member had problems getting a service because of long waiting times or long travel distances, or when the wrong kind of doctor or hospital provided the service.

**How many quality of care grievances did (XYZ Organization) receive?**

(**XYZ Organization**) received **20** grievances about the quality of care. About **less than 1 out of every 1,000** Medicare members filed a grievance about the quality of care they received from (**XYZ Organization**) doctors and hospitals.

(lines 2 and 4 under "Quality of Care Grievance Data" on the attached report)

**Where can I get more information?**

If you are a member of (**XYZ Organization**), you have the right to file an appeal or grievance.

You can contact (**XYZ Organization**) at (###) ###-#### to resolve a concern you may have or to get more information on how to file an appeal or grievance. (Be sure to include a phone number for the hearing impaired and your hours of operation.) You may also refer to your Evidence of Coverage for a complete explanation of your rights.

You also can contact a group of independent doctors in **STATE**, called a Quality Improvement Organization, at (###) ###-#### for more information about quality of care grievances or to file a quality of care grievance.



*Form No. CMS-R-0282* *Exp. Date 01/31/2007*



---

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

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

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

*The instructions for the Notice of Medicare Non-Coverage can be found at http://www.cms.hhs.gov/healthplans/appeals/CMS10095A_FormInstrrevised428.pdf.*

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

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

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

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

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

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

*The FAQs on the Grijalva Fast-Track Appeals Process can be found at http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_cat_lvl2=88*