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CHAPTERS	REVISED SECTIONS	NEW SECTIONS	DELETED SECTIONS
13	Table of Contents	60.1.4	
	10.3	90.2	
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	20.3	90.4	
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	80.1	Appendix 8	
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Red italicized font identifies new material

NEW/REVISED MATERIAL - EFFECTIVE DATE: October 1, 2003

IMPLEMENTATION DATE: October 1, 2003

Table of Contents - Line items added for new sections and appendices: 60.1.4, 90.2 through 90.8, Appendix 8, and Appendix 9.

Section 10.3 – Rights of M+C Enrollees - The words "organization determinations" are added to the paragraph.

Section 10.3.3 - Appeals - List Items 9 and 10 are added, and the remaining list is renumbered.

Section 20.3 – Procedures for Handling a Grievance - Initial phrase of first sentence in the second paragraph is deleted. Also, list items 2, 3, and 6 are added, and list items are renumbered.

Section 50.3 – Action Following Denial for Expedited Review - In list item 2, the words "an expedited" are added.

Section 60.1.4 – Notice Delivery to Incompetent Enrollees in an Institutionalized Setting - A new section regarding a requirement to notify an authorized representative for an incompetent institutionalized enrollee is added.

Section 70 – Reconsideration - The words "or termination of services decision" are added as a part of the reconsideration review, and "the QIO" is added to the last sentence as a party that my submit evidence for a reconsideration.

Section 70.1 – Who May Request Reconsideration - The words "or a termination of services decision" is added to identify when a party may request that a determination be reconsidered.

Section 80 – Expediting Certain Reconsiderations - Existing text is placed under a new unnumbered subheading, " General Reconsiderations." A second unnumbered subheading, "Certain Provider Setting Reconsiderations (SNF, HHA, and CORF)" is created and contains new material.

Section 80.1 – How the M+C Organization Processes Requests for Expedited Reconsideration - List item number 2 is added regarding the right to file an expedited grievance, and subsequent items are renumbered. Language is added to encourage all requests for SNF, HHA, and CORF appeals to be expedited.

Section 90.2 – Special Procedures for Expediting Reconsiderations Involving Certain Provider Settings (SNF, HHA, and CORF) - A new section is added to explain new appeal procedures.

Section 90.3 – Meaning of Valid Delivery - A new section is added to explain new appeal procedures.

Section 90.4 – Important Medicare Message of Non-Coverage (Advance Termination Notice) - A new section is added to explain new appeal procedures.

Section 90.5 – Detailed Explanation of Non-Coverage - A new section is added to explain new appeal procedures.

Section 90.6 – When to Issue the Important Medicare Message of Non-Coverage - A new section is added to explain new appeal procedures.

Section 90.7 – When to Issue the Detailed Explanation of Non-Coverage - A new section is added to explain new appeal procedures.

Section 90.8 - Requesting Immediate Quality Improvement Organization (QIO) Review of Provider Service Terminations - A new section is added to explain new appeal procedures.

Section 170.4 - Maintaining Data - Language is added regarding new grievance requirements.

Appendix 8 – Sample Notice Important Medicare Message of Non-Coverage- A model of this notification is added as this new section.

Appendix 9 – Detailed Explanation of Non-Coverage - A model of this notification is added as this new section.

Medicare Managed Care Manual

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

This Chapter Last Updated - **(Rev. 34, October 3, 2003)**

Table of Contents

10.3 – Rights of M+C Enrollees

(Rev. 34, 10-03-03)

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

10.3.3. – Appeals

(Rev. 34, 10-03-03)

1. The right to request an expedited reconsideration as provided in this chapter;
2. The right to request and receive appeal data from M+C organizations;
3. The right to receive notice when an appeal is forwarded to the Independent Review Entity (IRE);
4. The right to automatic reconsideration by an IRE contracted by CMS, when the M+C organization upholds its original adverse determination in whole or in part;
5. The right to an Administrative Law Judge (ALJ) hearing if the independent review entity upholds the original adverse determination in whole or in part and the remaining amount in controversy is $100 or more;
6. The right to request Departmental Appeals Board (DAB) review if the ALJ hearing decision is unfavorable to the enrollee in whole or in part;
7. The right to judicial review of the hearing decision if the ALJ hearing and/or DAB review is unfavorable to the enrollee in whole or in part and the amount remaining in controversy is $1,000 or more;
8. The right to make a quality of care complaint under the QIO process;
9. *The right to request a QIO review of a determination of noncoverage of inpatient hospital care. If an enrollee receives immediate QIO review of a determination of noncoverage of inpatient hospital care, the above rights are limited. In this case, the enrollee is not entitled to the additional review of the issue by the M+C organization. The QIO review decision is subject to an ALJ hearing if the amount in controversy is at least $100.00 and review of an ALJ hearing decision or dismissal from the Departmental Appeals Board if $1,000.00 or more is in controversy. Enrollees may submit requests for QIO review of determinations of noncoverage of inpatient hospital care in accordance with the procedures set forth in §160;*
10. *The right to request a QIO review of a determination of noncoverage in skilled nursing facilities, home health agencies and comprehensive outpatient rehabilitation facilities. If an enrollee receives QIO review of a determination of noncoverage, the enrollee is not entitled to the additional review of the issue by the M+C organization. Enrollees may submit requests for QIO review of provider settings in accordance with the procedures set forth in §90.1;*
11. *T*he right to request and be given timely access to the enrollee's case file and a copy of that case subject to federal and state law regarding confidentiality of patient information. The M+C organization shall have the right to charge the enrollee a reasonable amount, for example, the costs of mailing and/or an amount comparable to the charges established by a QIO for duplicating the case file material. At the time the request for case file material is made, the M+C organization should inform the enrollee of the per page duplicating cost. Based

on the extent of the case file material requested, the M+C organization should provide an estimate of the total duplicating cost for which the enrollee will be responsible. The M+C organization may also charge the enrollee the cost of mailing the material to the address specified. If enrollee case files are stored offsite, then the M+C organization may not charge the enrollee an additional cost for courier delivery to a plan location that would be over and above the cost of mailing the material to the enrollee; and

12. The right to challenge local and national coverage determinations. Under §1869(f)(5) of the Act, as added by §522 of the Benefits Improvement and Protection Act (BIPA), certain individuals ("aggrieved parties") may file a complaint to initiate a review of National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs). Challenges concerning NCDs are to be reviewed by the DAB of the Department of Health and Human Services. Challenges concerning LCDs are to be reviewed by ALJs. The new coverage challenge process will be available to both beneficiaries with original Medicare and those enrolled in Medicare managed care plans.

20.3 - Procedures for Handling a Grievance

(Rev. 34, 10-03-03)

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

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

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

50.3 - Action Following Denial for Expedited Review

(Rev. 34, 10-03-03)

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

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

60.1.4 – Notice Delivery to Incompetent Enrollees in an Institutionalized Setting

(Rev. 34, 10-03-03)

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, 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 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. 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 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 person contacted by phone, the date and time of the telephone contact, and the telephone number called. When notices are 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.

70 - Reconsideration

(Rev. 34, 10-03-03)

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

70.1 - Who May Request Reconsideration

(Rev. 34, 10-03-03)

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

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

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80 - Expediting Certain Reconsiderations

(Rev. 34, 10-03-03)

General Reconsiderations

An enrollee or any physician (regardless of whether the physician is affiliated with the M+C organization) may request that an M+C organization expedite a reconsideration of a determination, in situations where applying the standard procedure could seriously jeopardize the enrollees life, health, or ability to regain maximum function, including cases in which the M+C organization makes a less than fully favorable decision to the

enrollee. In light of the short time frame for deciding expedited reconsiderations, a physician does not need to be an authorized representative to request an expedited reconsideration on behalf of the enrollee. A request for payment of a service already provided to an enrollee is not eligible to be reviewed as an expedited reconsideration.

To ask for an expedited reconsideration, an enrollee or a physician must submit an oral or written request directly to the organization or entity responsible for making the reconsideration. A physician may provide oral or written support for a request made by an enrollee for an expedited reconsideration. The M+C organization must provide an expedited determination if a physician indicates that applying the standard time frame could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

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

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

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

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

(Rev. 34, 10-03-03)

The organization must establish and maintain procedures for expediting reconsiderations. These include establishing an efficient and convenient method for individuals to submit oral or written requests for expedited appeals, documenting oral requests, and maintaining the documentation in the case file. The M+C organization must designate an office and/or department to receive both oral or written requests and a telephone number for oral requests, and may include a facsimile number to facilitate receipt of requests for

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

If an M+C organization denies a request for an expedited reconsideration, it must automatically transfer the request to the standard reconsideration process and then make its determination as expeditiously as the enrollee's health condition requires. This should be done no later than within 30 calendar days from the date the M+C organization received the request for expedited reconsideration. The M+C organization must also provide the enrollee with prompt oral notice of the denial of the request for reconsideration and the enrollee's rights, and subsequently *mail* to the enrollee within 3 calendar days of the oral notification, a written letter that:

1. Explains that the M+C organization will automatically transfer and process the request using the 30-day time frame for standard reconsiderations;
2. *Informs the enrollee of the right to file an expedited grievance if he or she disagrees with the organization's decision not to expedite the reconsideration;*
3. Informs the enrollee of the right to resubmit a request for an expedited reconsideration and that if the enrollee gets any physician's support indicating that applying the standard time frame for making a determination could seriously jeopardize the enrollee's life, health or ability to regain maximum function, the request will be expedited automatically; and
4. Provides instructions about the grievance process and its time frames.

If the M+C organization approves a request for an expedited reconsideration, then it must complete the expedited reconsideration and give the enrollee (and the physician involved, as appropriate) notice of its decision as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receiving the request. If the request is made or supported by a physician, the M+C organization must grant the expedited reconsideration request when the physician indicates that the life or health of the enrollee, or the enrollee's ability to regain maximum function could be jeopardized by applying the standard time frame in the processing of the reconsideration request.

The 72-hour time frame must be extended by up to 14 calendar days if the enrollee requests the extension. The time frame also may be extended by up to 14 calendar days if the M+C organization justifies a need for additional information and documents how the extension is in the interest of the enrollee, e.g., the receipt of additional medical evidence from a noncontract provider may change an M+C organization decision to deny. When the M+C organization extends the time frame, it must notify the enrollee in writing of the reasons for the extension, and inform the enrollee of the right to file a grievance if he or she disagrees with the M+C organization's decision to grant an extension. The M+C organization must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than the last day of the extension.

If the M+C organization requires medical information from noncontract providers, the M+C organization must request the necessary information from the noncontract provider within 24 hours of the initial request for an expedited reconsideration. Noncontract providers must make reasonable and diligent efforts to expeditiously gather and forward all necessary information to assist the M+C organization in meeting the required time

frame. Regardless of whether the M+C organization must request information from noncontract providers, the M+C organization is responsible for meeting the same time frame and notice requirements as it does with contracting providers.

If an enrollee misses the noon deadline to file for immediate QIO review of an inpatient hospital discharge, then the enrollee may request an expedited appeal with the M+C organization. While an M+C organization uses discretion as to whether to expedite a request, the M+C organization is encouraged to automatically expedite all requests to appeal inpatient hospital discharges. Additionally, the M+C organization is encouraged to automatically expedite all requests to *appeal skilled nursing facility (SNF), home health (HHA) and Comprehensive Outpatient Rehabilitation Facility (CORF), and physical therapy discontinuations and terminations.*

90.2 – Special Procedures for Expediting Reconsiderations Involving Certain Provider Settings (SNF, HHA, and CORF)

(Rev. 34, 10-03-03)

There are special procedures for reconsidering termination decisions in skilled nursing facilities (SNFs), home health agencies (HHAs), and comprehensive outpatient rehabilitation facilities (CORFs). Where an M+C organization has authorized coverage of an enrollee's admission to a SNF, or coverage of HHA or CORF services, then the enrollee must receive a written notice two days in advance of the services ending. The M+C organization must coordinate with the SNF, HHA, or CORF so that they can deliver the notice timely. The CMS will standardize the notice that SNFs, HHA,s and CORFs must provide.

90.3 – Meaning of Valid Delivery

(Rev. 34, 10-03-03)

Valid delivery means that the enrollee must be able to understand the purpose and contents of the notice in order to sign for receipt of it. The enrollee must able to understand that he or she may appeal the termination decision. If the enrollee is not able to comprehend the contents of the notice, it must be delivered to and signed by an authorized representative.

Valid delivery does not preclude the use of assistive devices, witnesses, or interpreters for notice delivery. Thus, if an enrollee is not able to physically sign the notice to indicate receipt, then delivery may be proven valid by other means. See §60.1.3 of this chapter.

90.4 – Important Medicare Message of Non-Coverage (Advance Termination Notice)

(Rev. 34, 10-03-03)

The model Important Medicare Message of Non-Coverage is a written notice that is designed to inform Medicare enrollees that their covered SNF, HHA, or CORF care is ending. 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. The Important Medicare Message of Non-Coverage must include the following:

1. *The date that coverage of services ends;*
2. *The date that the enrollee's financial liability for continued services begins;*
3. *A description of the enrollee's right to an expedited appeal to a QIO;*
4. *Information about how to contact the QIO;*
5. *The enrollee's right to submit evidence to the QIO;*
6. *The enrollee's right to receive a detailed notice from the M+C organization;*
7. *The enrollee's right to access or receive a copy of the case file; and*
8. *The enrollee's right to request an appeal to the M+C organization if the enrollee misses the deadline to file with the QIO.*

*The model Important Medicare Message of Non-Coverage (see Appendix 8) meets the notice requirements set forth in 42 CFR 422.624(b)(2). We encourage M+C organizations to use this model form, but they are allowed to develop their own. (**NOTE:** The CMS is in the process of implementing a standardized notice through the Office of Management and Budget's Paperwork Reduction Act process.) All Important Medicare Messages of Non-Coverage must be approved by the M+C organization's Regional Office Plan Manager until such time that CMS issues a standardized form.*

90.5 - Detailed Explanation of Non-Coverage

(Rev. 34, 10-03-03)

The model Detailed Explanation of Non-Coverage is a written notice that is designed to provide specific information to Medicare enrollees as to why their SNF, HHA, or CORF care is ending. The M+C organizations are responsible for either issuing, or delegating the responsibility to issue, the notices to enrollees. The Detailed Explanation of Non-Coverage must include the following:

1. *A specific and detailed explanation why services are either no longer reasonable and necessary or otherwise no longer covered;*
2. *A description of any applicable Medicare coverage rule, instruction or other Medicare policy including citations, to the applicable Medicare policy rules, or the information about how the enrollee may obtain a copy of the Medicare policy from the M+C organization;*
3. *Any applicable M+C organization policy, contract provision, or rationale upon which the termination decision was based; and*
4. *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.*

The model Detailed Explanation of Non-Coverage (see Appendix 9) meets the notice requirements set forth at 42 CFR 422.626(e)(1). We encourage M+C organizations to use this model form, but they are allowed to develop their own. (NOTE: The CMS is in

the process of implementing a standardized notice through the Office of Management and Budget's Paperwork Reduction Act process.) All Detailed Explanations of Non-Coverage must be approved by the M+C organization's Regional Office Plan Manager until such time that CMS issues a standardized form.

90.6 – When to Issue the Important Medicare Message of Non-Coverage

(Rev. 34, 10-03-03)

Consistent with 42 CFR 422.624(b)(1), SNFs, HHAs, and CORFs will distribute the Important Medicare Message of Non-Coverage two days prior to the enrollee's services ending. If the enrollee's services are expected to be fewer than 2 days in duration, the SNF, HHA or CORF should notify the enrollee at the time of admission to the provider. If, in a non-institutional setting, the span of time between services exceeds two days, the provider should deliver the notice no later than the next to last time that services are furnished.

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

(Rev. 34, 10-03-03)

Consistent with 42 CFR 422.626(e)(1), when the QIO notifies an M+C organization that an enrollee has requested an appeal, the M+C organization must issue a Detailed Explanation of Non-Coverage to both the QIO and the enrollee no later than close of business. The M+C organization is also responsible for providing any pertinent medical records used to make the termination decision to the QIO, although the QIO will seek pertinent records from both the provider and the M+C organization.

90.8 - Requesting Immediate Quality Improvement Organization (QIO) Review of Provider Service Terminations

(Rev. 34, 10-03-03)

An enrollee receiving provider services in a SNF, HHA, or CORF that wishes to appeal the M+C organization's termination decision that such care is no longer necessary must request immediate QIO review of the determination in accordance with this section's requirements. An enrollee should not incur financial liability if, upon receipt of the Important Medicare Message of Non-Coverage:

1. *The enrollee submits a timely request for immediate review to the QIO that has an agreement with the provider;*
2. *The request is made either in writing, by telephone or fax, by noon of the next day after receiving the notice;*
3. *The M+C organization meets its time frame to deliver medical information and a Detailed Explanation of Non-Coverage to the QIO; and*
4. *The QIO either reverses the M+C organization's termination decision, or the enrollee stops receiving care no later than the date that the enrollee receives the QIOs' decision.*

The enrollee will incur 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 QIO's decision. This should be the same date as the M+C organization's initial decision to terminate services.

The following rules apply to the immediate QIO review process in SNFs, HHAs, and CORF settings:

1. *On the date that the QIO receives the enrollee's request, the QIO must notify the M+C organization and the provider that the enrollee has filed a request for immediate review;*
2. *The SNF/HHA/CORF must supply a copy of the Important Medicare Message from Medicare and any information that the QIO requires to conduct its review. The information must be made available by phone, fax, or in writing, by the close of business of the day of the appeal request;*
3. *The M+C organization must supply a copy of the Important Medicare Message of Non-Coverage, Detailed Explanation of Non-Coverage and any medical information that the QIO requires to conduct its review. The information must be made available by phone, fax, or in writing, by the close of business of the day that the QIO notifies the M+C organization of an appeal. If an enrollee requests an appeal on the same day the enrollee receives the Important Medicare Message of Non-Coverage, then the M+C organization has until close of business of the following day to submit the case file;*
4. *The QIO must solicit the views of the enrollee who requested the immediate QIO review;*
5. *The QIO must make an official determination of whether continued provider services is medically necessary, and notify the enrollee, the provider, and the M+C organization by close of business of the day after it receives all necessary information from the SNF/HHA/CORF, the M+C organization, or both. If the IRE does not receive the information it needs to sustain an M+C organization's decision to terminate services, then the QIO may make a decision based on the information at hand, or it may defer its decision until it receives the necessary information. If the IRE defers its decision, then coverage of the services by the M+C organization continue; and*
6. *The QIO will refer violations of notice delivery to the CMS regional office.*

An enrollee who fails to request an immediate QIO review in accordance with these requirements may file a request for an expedited reconsideration with the M+C organization. The M+C organization is encouraged to expedite the request for an expedited reconsideration. Likewise, if the QIO receives a request for immediate QIO review beyond the noon filing deadline and forwards that request to the M+C organization, the M+C organization should expedite that request. Thus, the M+C organization would generally make another decision about the services within 72 hours. Financial liability applies in both the immediate QIO review and the M+C organization expedited review situations.

170.4 - Maintaining Data

(Rev. 34, 10-03-03)

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

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

Appendix 8 - Sample Notice - Important Medicare Message of Non-Coverage

(Rev. 34, 10-03-03)

IMPORTANT MEDICARE MESSAGE OF NON-COVERAGE

YOUR {insert type} SERVICES WILL END: {insert date}

- *This notice is to inform you that your health plan's doctor believes that you will no longer need {insert type} services after this discharge date. You may have to pay for any {insert type} services you receive after the above date.*

YOUR RIGHT TO APPEAL THIS DECISION

- *You have the right to an immediate, independent medical review (appeal) of the decision to end your {insert type} services.*
- *If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer will also look at your medical records. You do not have to prepare anything in writing, but you have the right to do so if you wish.*
- *If you choose to appeal, you and the independent reviewer will receive a copy of the detailed explanation about why your services should not continue. You will not receive this form until after you request an appeal.*
- *If you choose to appeal, and the independent reviewer agrees with your health plan, neither Medicare nor your health plan will pay for your {insert type} services after the date indicated on this form,* ***even if you are waiting for your appeal decision.***
- *If you stop services no later than the date indicated on this form, you will avoid financial liability.*

HOW DO YOU GET AN IMMEDIATE APPEAL?

- *Your request for an immediate appeal must be made no later than noon of the day after you receive this notice.*
- *You should make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end your {insert type} services.*
- *The QIO will obtain the needed information from your doctor or providers within one day of receiving your appeal request.*
- *You should get a decision by the QIO no later than one day after you request your appeal.*
- *Call your QIO at: (insert name and number of QIO) to file your appeal.*

See the backside of this form for more information.

OMB Approval No. 0938-xxxx. Form No. CMS-10095

OTHER APPEAL RIGHTS:

- *If you miss the deadline for filing an immediate appeal, you may still request an expedited appeal from your health plan.*

- *Contact your health plan or 1-800-MEDICARE (1-800-633-4227), or TTY/TDD: 1-877-486-2048 for more information about filing appeals.*

SIGNATURE

I have been notified that my {insert type} will end in two days. I understand that I may appeal this decision by contacting the QIO no later than noon tomorrow.

_____ _____

Signature *Date*

_____

Print Name

Appendix 9 -Detailed Explanation of Non-Coverage

(Rev. 34, 10-03-03)

DETAILED EXPLANATION OF NON-COVERAGE

Date:

Patient Name: *Member ID Number:*

Because you requested an appeal, you are receiving this detailed explanation of why {insert health plan} believes you no longer need {insert type} services. ***This notice is not the decision about your appeal.*** *Your appeal decision will come from your Quality Improvement Organization (QIO).*

- *A doctor has reviewed your medical condition and decided that your {insert type services} should end.*
- *The facts of your medical situation used to make this decision:*

{Insert relevant text}

- *Detailed explanation of why you no longer need services, and the Medicare coverage rules and policy used to make this decision:*

{Insert relevant text}

- *{Insert healthplan} policy, provision, or rationale used in making the decision:*

{Insert relevant text}

If you would like a copy of the policy or coverage guidelines used to make this decision, please call us at {insert health plan or provider telephone number}:
