# CMS Manual System

## Pub. 100-16 Medicare Managed Care

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

**Transmittal: 45** | **Date: February 13, 2004**


**I. SUMMARY OF CHANGES:**

**CLARIFICATION – EFFECTIVE: Not Applicable.**

**Section 40.2.2 - Written Notification by M+C Organizations** - Added link to Appendix 1, which will link in the Internet-Only-Manual version. (Because Appendix 1 was not changed and is not included in the revision, a working link cannot be inserted into the revision file.)

**Section 70.4 - Withdrawal of Request for Reconsideration -** Added language regarding the process for withdrawing a reconsideration request by a party depends on whether the request was received by an M+C organization before the organization makes a reconsideration decision or after.

**Section 110.1 - Filing a Request for DAB Review** - The address to directly submit a DAB review is updated.

**Section 140.1.1 - Standard Service Requests** - Added the words "authorized or" to the last sentence.

**Section 140.3 - Effectuating Decisions by All Other Review Entities** - Added language allowing an M+C organization to await the outcome of the review before paying for, authorizing or providing the service under dispute when it requested the DAB review of and ALJ decision.

**Section 140.4 - Independent Review Entity Monitoring of Effectuation Requirements -** Added language to list item 2 regarding effectuation requirements.

**Section 170 - Data** - Added language to carefully define "appeals data."

***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 | Chapter 13 / Section 40.2.2 / Written Notification by M+C Organizations |
| R | Chapter 13 / Section 70.4 - Withdrawal of Request for Reconsideration |
| R | Chapter 13 / Section 110.1 - Filing a Request for DAB Review |
| R | Chapter 13 / Section 140.1.1 - Standard Service Requests |
| R | Chapter 13 / Section 140.3 - Effectuating Decisions by All Other Review Entities |
| R | Chapter 13 / Section 140.4 - Independent Review Entity Monitoring of Effectuation Requirements |
| R | Chapter 13 / Section 170 - Data |

## III. ATTACHMENTS:

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

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## 40.2.2 - Written Notification by M+C Organizations

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

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). 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**).

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## 70.4 - Withdrawal of Request for Reconsideration

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

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

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

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## 110.1 - Filing a Request for DAB Review

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

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

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

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

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## 140.1.1 - Standard Service Requests

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

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

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## 140.3 - Effectuating Decisions by All Other Review Entities

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

If the organization determination is reversed in whole or in part by an ALJ, the DAB, or judicial review, the M+C organization must pay for, authorize, or provide the service under dispute as expeditiously as the enrollee's health condition requires, but no later than 60 calendar days from the date it receives notice reversing the initial organization determination. *However, when an M+C organization requests DAB review of an ALJ decision, the organization may await the outcome of the review before paying for,*

*authorizing or providing the service under dispute. An M+C organization that files an appeal with the DAB must concurrently send a copy of the appeal request and any accompanying documents to the enrollee, and must notify the IRE that it has requested a DAB review. Whenever the* M+C organization *effectuates a decision it* must inform the independent review entity.

## 140.4 - Independent Review Entity Monitoring of Effectuation Requirements

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

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

1. The independent review entity issues to the M+C organization a copy of the reconsidered determination. Included with this copy is a Notice of Requirement to Comply.

2. Pursuant to the compliance notice, the M+C organization is required to mail to the independent review entity a statement attesting to compliance with the independent review entity's decision. This documentation is to confirm when and how compliance occurred (e.g., service authorization, payment made, etc.). *Notification to the IRE that the M+C organization plans to pay for or plans to provide the service* ***will not*** *be considered appropriate compliance with the effectuation requirements. The M+C organization must provide the IRE with affirmative notice of effectuation.* The M+C organization's notice of compliance should be forwarded to the independent review entity concurrent with the M+C organization's effectuation.

3. If the independent review entity does not obtain the compliance notice, it mails the M+C organization a reminder notice.

4. If the independent review entity does not receive the M+C organization's compliance report within 30 days of the reminder notice, the independent review entity reports the M+C organization's failure to comply to CMS. The M+C organization is not copied on the notice to CMS.

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## 170 - Data

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

M+C organizations are expected to disclose grievance and appeals data to eligible Medicare individuals upon request. *For purposes of this section, by appeals data we mean all appeals filed with the M+C organization that are accepted for review or withdrawn upon the enrollee's request, but excludes appeals that the organization forwards to the IRE for dismissal.* M+C organizations should not send out a subset or partial list of the data, even if only a subset of the data is requested. For example, if a beneficiary requests data on the number of appeals received by the M+C organization, then the M+C organization would send the beneficiary a complete report of both its appeal and grievance data for the reporting period.

M+C organizations must report to beneficiaries the number of appeal and grievance requests per 1000 enrollees. The purpose of this calculation is to normalize reporting among larger and smaller M+C organizations for comparison purposes. Since larger organizations would reasonably be expected to receive more appeals and grievances relative to smaller organizations, simply reporting raw data could be misleading.

The rate is calculated by multiplying the total number of requests for [an appeal or grievance] by 1,000, and dividing that number by the average number of members enrolled during the data collection period. It does not require that the M+C organization have a minimal enrollment of 1000 members.

The following are examples of how the rates get normalized across small and large plans:

**EXAMPLE 1**

M+C organization average membership = 500

# of appeals received during the data collection period = 4

4 x 1000/500 = 8

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

**EXAMPLE 2**

M+C organization average membership = 5000

# of appeals received during the data collection period = 40

40 x 1000/5000 = 8

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