MAXIMUS Federal Medicare Health Plan Reconsideration Process Manual

Medicare Managed Care Reconsideration Project

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Customer Service: 585-348-3300

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Case Information Fax: 585-425-5292
(Please submit only case-specific information, such as responses to Requests for Information – do not submit confidential case specific information by email)

Project Web Site:

www.medicareappeal.com

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MAXIMUS Federal

MEDICARE HEALTH PLAN RECONSIDERATION PROCESS MANUAL

MEDICARE MANAGED CARE RECONSIDERATION PROJECT

Effective October 2019

1. INTRODUCTION

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

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

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

- 42 CFR §422
- Medicare Managed Care Manual
- Program Memoranda and Transmittals

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

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

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2. DEFINITIONS

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

2.1 ADJUDICATOR

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

2.2 APPEAL

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

2.3 APPEAL PROCESS

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

2.4 AUTHORIZED REPRESENTATIVE

An individual appointed by an enrollee to represent him/her in filing an appeal. See Section 4.2.1 for additional information. Also known as Appointed Representative.

2.5 DE NOVO REVIEW

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

2.6 ENROLLEE

A Medicare beneficiary who has enrolled in a Medicare Health Plan. An enrollee may also be known as a member.

2.7 EVIDENCE OF COVERAGE

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

2.8 EXPEDITED RECONSIDERATION

A de novo review of an adverse organization determination that must be processed quickly to avoid endangering the life or health of the enrollee or the enrollee's ability to regain or maintain maximum function. Generally, expedited reconsiderations must be completed as soon as is medically indicated, but not longer than 72 hours, with a possible extension of up to 14 calendar days if the delay is in the enrollee's interest (See 42 CFR §422.590). Examples of cases that should be expedited include pre-service skilled nursing facility cases, pre-service acute inpatient care cases and cases in which a physician indicates that applying the standard timeframe for making a determination could seriously affect the life or health of the enrollee or the enrollee's ability to regain maximum function.

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

2.9 INDEPENDENT REVIEW ENTITY (IRE)

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

2.10 LOCAL COVERAGE DECISION (LCD)

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

2.11 MEDICARE ADVANTAGE ORGANIZATION

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

2.12 MEDICARE APPEAL SYSTEM (MAS)

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

2.13 MEDICARE HEALTH PLAN

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

2.14 ORGANIZATION DETERMINATION

A decision of the Medicare Health Plan, or a person acting on its behalf, to approve or deny a payment for a health care service or a request for provision of health care service made by, or on behalf of, a Medicare Health Plan enrollee. An organization determination concerns benefits an enrollee is entitled to receive under the Medicare Health Plan, including basic benefits; mandatory and optional supplemental benefits; and cost-sharing (deductible, coinsurance, and/or copayment). An organization determination is the Medicare Health Plan's initial coverage determination. Medicare Health Plans must have procedures for making standard determinations and expedited determinations. Expedited determinations apply to cases in which applying standard determination procedures could seriously jeopardize the enrollee's life, health or ability to regain maximum function (See 42 CFR §§422.566-422.572).

2.15 RECONSIDERATION

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

2.16 RECONSIDERATION DETERMINATION NOTICE

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

2.17 REOPENING

A review of a completed IRE reconsideration determination undertaken at the sole discretion of the IRE for the purpose of addressing new information received or a potential error in the determination (See42 CFR §422.616).

2.18 REQUEST FOR INFORMATION (RI)

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

2.19 STANDARD CLAIM RECONSIDERATION

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

2.20 STANDARD SERVICE RECONSIDERATION

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

2.21 STANDARD SERVICE PART B DRUG RECONSIDERATION (Effective 1/1/2020)

Reconsideration of denials of authorization for Medicare Part B coverable drugs, including continuation of usage of a Part B drug, which do not meet criteria for an expedited reconsideration. Standard Service Part B Drug Reconsiderations must be completed within 7 calendar days of the request receipt. These requests are not subject to any extensions and may also be referred to as pre-service Part B drug appeals.

3. WORKING WITH MAXIMUS FEDERAL

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

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

3.1 SOURCES OF INFORMATION ABOUT MAXIMUS FEDERAL IRE RECONSIDERATION

Medicare Managed Care and PACE Reconsideration Project Process Manuals

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

Medicare Managed Care & PACE Reconsideration Project Web Site

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

- Links to CMS web sites for statute, regulation and manuals related to Medicare Managed Care Reconsideration
- Project newsletter, *Recon Notes*
- Updated Project organization and contact information
- National, Regional and Medicare Health Plan level Reconsideration data
- Case Status Information

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

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

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

Project Newsletter ("Recon Notes")

When directed to do so by CMS, MAXIMUS Federal publishes a newsletter, "Recon Notes," which addresses commonly observed situations in the reconsideration process and updates MAXIMUS Federal policies and procedures as needed. This newsletter is available to Medicare Health Plans and the public through our web site: www.medicareappeal.com.

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

An entity that has established a new Medicare Advantage contract with CMS is encouraged to contact MAXIMUS Federal prior to its first enrollment effective date. Email or write to MAXIMUS Federal at medicareappeal@maximus.com. MAXIMUS Federal will arrange to provide the new Medicare Health Plan a telephonic briefing on the IRE project.

3.3 IDENTIFYING AND CHANGING MEDICARE HEALTH PLAN POINT OF CONTACT

3.3.1 MEDICARE HEALTH PLAN KEY ORGANIZATION CONTACT

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

3.3.2 MEDICARE HEALTH PLAN INDIVIDUAL RECONSIDERATION CASE CONTACTS

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

3.4 SEEKING INFORMATION ABOUT CASES

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

In addition, you may call us at 585-348-3300. MAXIMUS Federal maintains a staffed switchboard Monday to Friday from 8 AM to 5:30 PM and Saturday from 9 AM to 2 PM, Eastern Time. For calls made after normal business hours, you may choose to leave a message that will be returned the next business day or you may contact us via email at medicareappeal@maximus.com.

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

MAXIMUS Federal employs a staff of Adjudicators who manage individual reconsideration case files. Specific questions about a case under review may be directed to medicareappeal@maximus.com. Information that is to be made part of the case file and used in the final determination must be submitted in writing.

Medicare Health Plans are responsible for supporting their enrollees in the reconsideration process. Plans should not direct members to MAXIMUS Federal for routine case status inquiries.

Medicare managed care enrollees may be referred to 1-800-MEDICARE for general information regarding the Medicare managed care appeals process and to locate resources for assistance in the appeals process.

3.5 SUGGESTIONS AND COMPLAINTS

MAXIMUS Federal is an ISO 9001:2008 certified Independent Review Entity. As such, management requires a formal process for identification of opportunities for corrective and preventive action, or continuous improvement. Please freely provide any suggestions or complaints to any MAXIMUS Federal staff member who is interacting with you, or to the Project Director. If you are not completely satisfied, the MAXIMUS Federal QIC Program Manager would appreciate the opportunity to address your concern.

3.6 HOLIDAYS

MAXIMUS Federal offices will be closed in observance of the following Federal holidays:

- New Year's Day
- Martin Luther King, Jr. Day
- Presidents' Day
- Memorial Day
- Independence Day
- Labor Day
- Columbus Day
- Veterans Day
- Thanksgiving Day
- Christmas Day

MAXIMUS Federal will accept delivery of case files on those days through the QIC Appeals Portal or secure file transfer with the following business day being used as the date of receipt. If you intend to submit a case for receipt by MAXIMUS Federal on one of the above-listed days, you must contact MAXIMUS Federal via telephone (585-348-3300) at least 24 hours in advance to arrange for that case file delivery.

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

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

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

4.1 Medicare Health Plan's Organization Determination Notice Requirements
4.2 Medicare Health Plan Validation of Party, Representative, and Eligible Appeal
4.3 Non-Medicare Plan Services
4.4 Reconsideration Priority
4.5 Medicare Health Plan Responsibility to Conduct a Full Medicare Health Plan Reconsideration
4.6 Medicare Health Plan Reconsideration with Incomplete Evidence

4.1 MEDICARE HEALTH PLAN'S ORGANIZATION DETERMINATION NOTICE REQUIREMENTS

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

MAXIMUS Federal closely reviews the organization determination to define the denied service or claim subject to IRE reconsideration. In addition, we compare the type, format, and content of the notice to CMS requirements and report "notice deficiencies" to CMS. Finally, MAXIMUS Federal abstracts and reports to CMS the dates of the initial request for service (or payment) versus organization determination, for purposes of monitoring Medicare Health Plan timeliness. The organization determination date is the date on which a decision was communicated to the enrollee or appellant, whether orally or in the form of a decision letter.

CMS has developed standardized denial notices, which are described in the subsections following.

4.1.1 NOTICE OF DENIAL OF MEDICAL COVERAGE (NDMC)

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

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

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

CMS has issued a standard form for the NDMC. Medicare Health Plans may not deviate from the language of the CMS form. Please note that the OMB control number must be displayed on the notice. A copy of the completed NDMC must be included in the Medicare Health Plan reconsideration case file.

4.1.2 NOTICE OF DENIAL OF PAYMENT (NDP)

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

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

4.1.3 NOTICE OF MEDICARE NON-COVERAGE (NOMNC)

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

Telephone delivery of the notice is permitted only in limited circumstances, and there are specific requirements with regard to the documentation of the telephone call (See CMS Medicare Managed Care Manual, Chapter 13 for full details). A copy of the completed NOMNC must be included in the Medicare Health Plan reconsideration case file.

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

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

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

- An enrollee (including his or her representative)
- An assignee of the enrollee (that is, a non-contract physician or other non-contract provider who has furnished a service to the enrollee and formally agrees to waive any right to payment from the enrollee for that service)
- The legal representative of a deceased enrollee's estate
- Any other provider or entity (other than the Medicare Health Plan) determined to have an appealable interest in the proceeding (See 42 CFR §§422.574 and 422.578)

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

4.2.1 Representative Documentation
4.2.2 Provider-as-Party Documentation
4.2.3 Provider as Person "Supporting" the Enrollee Appeal
4.2.4 Representative of a Deceased Enrollee’s Estate
4.2.5 Processing Reconsiderations with an Invalid Appeal Requestor

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

4.2.1 REPRESENTATIVE DOCUMENTATION

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

An enrollee may designate any person as his or her representative. CMS in general requires that Medicare Health Plans document proof of the validity of the enrollee's representative. Special rules apply to two circumstances:

1. Enrollees who are incapacitated
2. Providers as representatives.

General Requirements

If the party requesting the reconsideration is **not** the enrollee, and the special circumstances discussed below do not apply, it is the responsibility of the Medicare Health Plan to determine and document that the requesting party is an appropriate representative of the enrollee (See CMS Medicare Managed Care Manual, Chapter 13). Appropriate documentation may include, but is not limited to, a durable power of attorney, a health care proxy, an appointment of guardianship, an Appointment of Representative form (CMS-1696), or other legally recognized forms of appointment. In the event the Medicare Health Plan does not have access to these documents, an Appointment of Representative form accepted by MAXIMUS Federal for this purpose is included in the *Appendix* of the Medicare Managed Care Manual Chapter 13. Representative documentation is required even if the representative is an attorney, family member, or medical provider (See Special Condition 2, below). Representative documentation must be included in the case file submitted to MAXIMUS Federal for IRE Reconsideration.

It is also the Medicare Health Plan's obligation to attempt to obtain the needed representative documentation. Plans must make, and document, their attempts to obtain this documentation. If a Medicare Health Plan does not receive the representative documentation at the end of the appeal timeframe, PLUS EXTENSION, the Medicare Health Plan must dismiss the request and issue a *Notice of Dismissal of Appeal Request.* Appellants have the right to request review of this dismissal. These dismissal reviews are discussed in more detail in Section 8 below.

Please note, this means that Medicare Health Plans must allow the full timeframe, plus any extensions allowable, for the requestor to submit the representative documentation. Plans should not issue a *Notice of Dismissal of Appeal Request* until the full timeframe, plus extension (if applicable), has expired (See the Medicare Managed Care Manual, Chapter 13, §10.4).

Special Condition 1: Enrollee Who Is Incapacitated or Incompetent

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

The Appointment of Representative form (CMS-1696) can be found in Chapter 13 of the Medicare Managed Care Manual.

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

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

Federal regulations state that a physician must notify the enrollee of the standard service appeal request. For purposes of processing the appeal, it is the Medicare Health Plan's responsibility to assess whether the enrollee has received proper notice. If the Medicare Health Plan processes the appeal request, MAXIMUS Federal accepts that the Medicare Health Plan has sufficient proof that the enrollee was properly noticed.

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

4.2.1.1 Dismissal for lack of Proper Documentation

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

4.2.2 PROVIDER-AS-PARTY DOCUMENTATION

4.2.2.1 Non-Contract Providers

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

Managed Care Manual Chapter 13, §60.1.1 states that Medicare Health Plans must make, and document, their attempts to obtain the Waiver of Liability. If the Medicare Health Plan does not receive the Waiver of Liability by the conclusion of the appeal timeframe, the Medicare Health Plan must dismiss the request and issue a *Notice of Dismissal of Appeal Request*. Non- Contract provider appellants have the right to request review of this dismissal. These dismissal reviews are discussed in more detail in Section 8 below.

Please note that this means that Medicare Health Plans should not issue a *Notice of Dismissal of Appeal Request* for lack of a Waiver of Liability until the appeal timeframe has concluded.

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

4.2.2.2 Contract Providers

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

4.2.3 PROVIDER AS PERSON "SUPPORTING" THE ENROLLEE APPEAL

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

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

4.2.4 REPRESENTATIVE OF DECEASED ENROLLEE'S ESTATE

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

4.2.5 PROCESSING RECONSIDERATIONS WITH AN INVALID APPEAL REQUESTOR

If the Medicare Health Plan receives a reconsideration request without the required executed representative or waiver of liability document (or in which the required document is incomplete or erroneous), the Medicare Health Plan level reconsideration review should not begin. However, the Medicare Health Plan must make reasonable attempts to inform the requestor of the inadequacy and obtain the representative or waiver of liability documents (See *Chapter 13 of the Medicare Managed Care Manual*). If the Medicare Health Plan does not get the appropriate documentation, then the Medicare Health Plan must dismiss the request per Chapter 13 of the Managed Care Manual. Appellants may request review of this dismissal under the process described in Section 8 of this manual.

4.3 NON-MEDICARE PLAN SERVICES

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

4.4 RECONSIDERATION PRIORITY

Effective January 1, 2020, there are four levels of reconsideration priority:

1. Standard service reconsideration;
2. Standard service Part B Drug request reconsideration;
3. Standard claim payment reconsideration; and
4. Expedited reconsideration.

These four levels are defined in *Section 2*. Definitions. Refer also to 42 CFR §422 Subpart M for a complete definition and explanation of the differing requirements for these reconsiderations.

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

4.5 MEDICARE HEALTH PLAN RESPONSIBILITY TO CONDUCT A FULL RECONSIDERATION

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

MAXIMUS Federal may, at its discretion, utilize the "request for additional information" process (See Section 6.6) to direct Medicare Health Plans to remedy a case in which a complete Medicare Health Plan level reconsideration has not occurred or has not been documented.

MAXIMUS Federal will notify CMS if a Medicare Health Plan displays a pattern of failure to complete and document a thorough Medicare Health Plan level reconsideration.

4.6 MEDICARE HEALTH PLAN RECONSIDERATION WITH INCOMPLETE EVIDENCE

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

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

5. SUBMITTING RECONSIDERATION CASE FILES TO MAXIMUS FEDERAL

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

5.1 CASES THAT MUST BE SUBMITTED TO MAXIMUS FEDERAL FOR RECONSIDERATION

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

5.2 TIME STANDARDS FOR SUBMISSION OF CASES TO MAXIMUS FEDERAL

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

5.2.1 TIMELINESS OF SUBMISSION OF EXPEDITED RECONSIDERATIONS

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

For expedited cases only, the regulations (42 CFR §422.590(d)(4)) also define an additional interval for "submission" of the case file to MAXIMUS Federal. Submission is to occur within 24 hours of the Medicare Health Plan's completion of its reconsidered determination. The 24-hour period permitted for submission is thus in addition to the time permitted for the Medicare Health Plan reconsideration.

The Medicare Health Plan must submit expedited reconsideration case files to MAXIMUS Federal via overnight/next day delivery rather than by standard mail. Expedited reconsideration case files may also be submitted to MAXIMUS Federal through the QIC Appeals Portal.

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

5.2.2 MAXIMUS BUSINESS HOURS AND QIC APPEALS PORTAL AVAILABILITY

MAXIMUS Federal offices are open to receive case file submissions Monday through Saturday. The QIC Appeals Portal is open 24 hours a day, seven days a week. Please note, however, that MAXIMUS Federal will use the system receipt date as the date the documentation was received when the file is received during normal business hours. Normal business hours are Monday through Friday until 7p.m. and Saturday until 2:00p.m. If the system receipt date is outside of the MAXIMUS Federal normal business hours, the following business day shall be used as the receipt date. MAXIMUS Federal will pull files at least every four hours during business hours daily; the final pull of each business day will occur between the hours of 6:00 pm and 7:00 pm (Eastern Time) daily.

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

Exhibit 5-1
EXPEDITED CASE SUBMISSION TIMETABLE

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

*Some delivery vendors require senders to specify "Saturday Delivery" on the envelope/package to be delivered. MAXIMUS Federal is open to receive cases on Saturday from 9:00 am to 2:00 pm (Eastern Time).

5.2.2 TIME STANDARD FOR SUBMISSION OF STANDARD SERVICE RECONSIDERATIONS

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

- As expeditiously as the enrollee's health condition requires, or
- Not later than 30 calendar days after the receipt of a valid reconsideration request, subject to an additional 14-calendar day extension, if taken in the enrollee's interest, as per 42 CFR §422.590(e).

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

5.2.3 TIME STANDARD FOR SUBMISSION OF STANDARD SERVICE PART B DRUG RECONSIDERATIONS

Effective January 1, 2020, Medicare rules require Medicare Health Plans to complete standard service Part B Drug reconsiderations no later than 7 calendar days after the receipt of a valid reconsideration request. Standard service Part B Drug reconsiderations are not entitled to the 5-calendar day interval for mailing noted above for regular standard service reconsiderations.

For standard service Part B drug appeals, submission is to occur within 24 hours of the Medicare Health Plan's completion of its reconsidered determination. The 24-hour period permitted for submission is thus in addition to the time permitted for the Medicare Health Plan reconsideration.

The Medicare Health Plan must submit standard per-service Part B drug appeal reconsideration case files to MAXIMUS Federal via overnight/next day delivery rather than by standard mail. These reconsideration case files may also be submitted to MAXIMUS Federal through the QIC Appeals Portal.

As a practical matter, MAXIMUS Federal assumes that Medicare Health Plan reconsideration decisions occur as of the close of the business day on which the decision is rendered. Therefore, the Medicare Health Plan meets the 24-hour standard if it submits the case to a commercial delivery service by that delivery vendor's close of business on the day after the Medicare Health Plan makes its reconsideration determination.[3] The case would then be delivered to MAXIMUS Federal on the next day that falls within the vendor's customary schedule.

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

5.2.4 TIME STANDARD FOR SUBMISSION OF STANDARD CLAIM RECONSIDERATIONS

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

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

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

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

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

Please note that the data entry required for submission of a case file through QIC Appeals Portal is equivalent to the *Medicare Managed Care Reconsideration Background Data Form*; no separate form needs to be submitted for case files sent via the QIC Appeals Portal. For all cases, including those submitted via the QIC Appeals Portal, a structured Case Narrative report is required.

5.3.1 INITIATION OF EXPEDITED CASES

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

5.3.2 ORGANIZATION OF THE NEW CASE FILE PACKAGE

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

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

When submitting paper case files, the Medicare Health Plan may include more than one new case in the package submitted to MAXIMUS Federal, but it is imperative to clearly separate individual case files from one another to prevent issues with intermingling enrollee information.

The MAXIMUS Federal offices are open to receive case file submissions Monday through Saturday. The QIC Appeals Portal is open 24 hours a day, seven days a week. Please note, however, that MAXIMUS Federal will use the system receipt date as the date the documentation was received when the file is received during normal business hours. Normal business hours are Monday through Friday until 7:00 pm and Saturday until 2:00 pm. If the system receipt date is outside of the MAXIMUS Federal normal business hours, the following business day shall be used as the receipt date. MAXIMUS Federal will pull files at least every four hours during business hours daily; the final pull of each business day will occur between the hours of 6:00 pm and 7:00 pm (Eastern Time) daily.

When submitting electronic case files using the QIC Appeals Portal, the Medicare Health Plan may include only one new case in each package submitted to MAXIMUS Federal.

For all case file submissions:

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

5.3.3 ORGANIZATION OF INDIVIDUAL NEW CASE FILES

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

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

Exhibit 5-2
EXPLANATION OF "CASE MATERIAL"

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

• Notices
o Appointment of Representative (if applicable)
o Non-Contract Provider Waiver of Liability (if applicable)
o Notice of Medicare Health Plan Adverse Organization Determination
o Notice of Medicare Health Plan Reconsideration Determination
o Notice of Denial of Expedited Appeal Request (if applicable)
o Notice of Extension to timeframe taken in enrollee interest (if applicable)
• Record of Adverse Determination and Medicare Health Plan Reconsideration
o Prior authorization or claim denial documents
o Medical Director or consultant determinations
o Documentation of arguments of enrollee, enrollee's provider or representative
o Any provider letters of support or consultations supporting the enrollee's position
o Any relevant call logs or system reports
o Any other records kept by the Medicare Health Plan of its initial determination or reconsideration proceeding
• Medicare Health Plan Decision Making Criteria
o Complete copy of subscriber agreement, preferably on CD-ROM
o Full citation for any CMS policy references, or copy of text[4]
o Other Information
o Complete copy of any referenced internal medical policy, utilization review criteria, technology assessment, or other cited medical criteria
• Medical Records (See *Section 5.3.4*)

[4] "Full citation" refers to the designation of section and paragraph of the Social Security Act or CFR, CMS Manual Section/Page; a copy is not required for these citations. For Local Coverage Decisions, a copy must be included unless an active and complete citation is provided via direction to a web address. Do not cite to secondary sources (for example, MCG/Milliman, InterQual, or proprietary internal policies) unless complete text is provided.

5.3.4 GUIDANCE ON SELECTION AND INCLUSION OF MEDICAL RECORDS

For denials that are based, in whole or part, on medical necessity, the Medicare Health Plan is burdened with the requirement to provide a "peer defensible" rationale for the denial. Medical records that relate to the case issues must be included. Medical records that do not relate to the case should not be included.

If the Medicare Health Plan has made one or more unsuccessful attempts to obtain records, such attempts should be documented. For example, the Medicare Health Plan may include a statement within the Case Narrative (Section IV (B) Justification) detailing the attempts made to obtain the records and the basis of why the Medicare Health Plan arrived at its decision without these records.

Medicare allows MA plans to use step therapy for Medicare Part B drugs to manage its formulary. This is the process of beginning drug therapy for a medical condition with "preferred" (or more cost-effective) on-formulary drug alternative(s) and progressing to other drug therapies only as necessary. A plan must grant an exception to its step therapy coverage rules for Medicare Part B drugs if it determines that the requested drug is medically necessary, consistent with the prescriber's statement and the medical records. The physician statement and the medical records must show that the step therapy drugs:

1. have been ineffective in treating the enrollee; or
2. are likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or
3. are likely to cause an adverse reaction or other harm to the enrollee.

The documentation required in the case file from the plan is as follows:

- Plan specific plan Step Therapy rules
- Enrollee physician statement regarding trial and failure of specific medications Enrollee medical records regarding previous treatments
- Entire Evidence of Coverage /Plan Formulary and any addendums regarding Medicare Part B Drugs.

Exhibit 5-3: Suggested Medical Records for Inpatient and Long-term Care Denials and *Exhibit 5-4: Suggested Medical Records for Other Common Types of Denials* are offered by MAXIMUS Federal to reduce the need for requests for additional information to the Medicare Health Plan. The Medicare Health Plan should regard *Exhibits 5-3* and *5-4* as a general guide. Requirements for a given case may vary. MAXIMUS Federal reserves the right to request records in addition to those listed in *Exhibit 5-3* and/or *5-4* should the situation warrant the request.

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

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

***** Records may be from an acute care hospital, a SNF, or an inpatient rehabilitation facility depending on the case types and basis for denial.

Exhibit 5-4

SUGGESTED MEDICAL RECORDS FOR OTHER COMMON TYPES OF DENIALS

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

5.3.5 CONFIRMATION OF MAXIMUS FEDERAL CASE RECEIPT

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

Standard Service and Claim Cases

MAXIMUS Federal sends the Medicare Health Plan and appealing party an acknowledgement letter by regular first class mail within two (2) business days of our receipt of the case file. Allowing for time for delivery of the Medicare Health Plan case to MAXIMUS Federal, the Medicare Health Plan should contact MAXIMUS Federal if it has not received the acknowledgement letter within 10 business days of its case submission.

Dismissal Review Cases

MAXIMUS Federal does not send an acknowledgement letter for these types of cases. When the request for a review of the Medicare Health Plan's dismissal is received, MAXIMUS Federal will request the case file from the Medicare Health Plan. Our receipt of the file is confirmed by the appealing party's and Medicare Health Plan's receipt of our reconsideration determination notice (See Section 8).

Cases submitted via the QIC Appeals Portal (all priorities and case types)

When a case file is submitted to MAXIMUS Federal via the QIC Appeals Portal, the Medicare Health Plan will receive immediate on-screen acknowledgement that the documents have been received by MAXIMUS Federal, as well as a follow-up e-mail confirmation of receipt. Confirmation will include a tracking number.

6. MAXIMUS FEDERAL RECONSIDERATION PROCESS

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

6.1 MAXIMUS FEDERAL CASE PROCESSING TIME STANDARDS

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

CASE CLASS	TIME STANDARD
Expedited	72 hours, plus 14 calendar day extension if in enrollee's interest, or sooner if warranted by enrollee's medical condition
Standard Service	30 calendar days, plus 14 calendar day extension if in enrollee's interest, or sooner if warranted by enrollee's medical condition
Standard Service Part B Drug	7 calendar days- no extensions are permitted for these case types (effective January 1, 2020)
Standard Claim	60 calendar days

In expedited and standard service appeals, MAXIMUS Federal may extend the decision timeframe by up to 14 calendar days if it is in the enrollee's interest. This 14-day extension is not permitted for standard service Part B drug appeals. MAXIMUS Federal will notify the enrollee and Medicare Health Plan of the extension in writing.

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

6.2 ADMINISTRATIVE CASE INTAKE

The steps in MAXIMUS Federal administrative case intake are:

- Mail Opening and sorting of new case files
- Inquiry on CMS systems to verify beneficiary enrollment in Medicare Health Plan
- Medicare Appeal System assignment of a random "reconsideration case number"
- Generation of acknowledgement letters (standard service and claim only)
- Assignment of the case to a MAXIMUS Federal Adjudicator

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

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

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

6.3.1 ALL EVIDENCE MUST BE IN WRITING

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

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

6.3.2 COMMUNICATIONS REGARDING THE POTENTIAL IRE DETERMINATION ARE NOT PERMITTED

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

6.3.3 ENROLLEE SUBMISSION OF ADDITIONAL INFORMATION TO THE IRE CASE FILE

The MAXIMUS Federal acknowledgement letter that is sent to the enrollee or valid representative, advises the enrollee of their ability to submit information or arguments directly to MAXIMUS Federal. The acknowledgement letter is not used for expedited cases or standard service Part B Drug cases. For standard service and standard claim reconsiderations (not standard service Part B drug cases), the enrollee is given 10 days to submit information to MAXIMUS Federal.

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

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

6.4 ADJUDICATOR CASE REVIEW

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

6.5 PHYSICIAN REVIEW

Pursuant to 42 CFR §422.590(h)(2), determinations of medical necessity must be made by a physician, where physician is defined to include doctors of chiropractic and osteopathy. MAXIMUS Federal maintains a panel of over 800 medical consultants who are fully credentialed to the standards of our accrediting body, URAC. These medical consultants are located throughout the United States and include a mix of physicians who predominately practice in community rather than academic settings.

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

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

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

6.6 REQUESTS TO MEDICARE HEALTH PLAN FOR ADDITIONAL INFORMATION

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

6.6.1 REQUEST FOR ADDITIONAL INFORMATION IS AT MAXIMUS FEDERAL DISCRETION

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

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

6.6.2 REQUEST FOR INFORMATION PROCESS

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

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

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

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

- If hard copy delivery is used for an RI response, the Medicare Health Plan must place the *Request for Information Response Cover Sheet* (see *Appendix*) on top of the response documents.
- If the Medicare Health Plan places more than one RI response in a package, separate each RI response with the *Request for Information Response Cover Sheet.*

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

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

Expedited reconsiderations	within 3 calendar days from date of request
Standard Service reconsiderations	within 5 calendar days from date of request
Standard Service Part B Drug reconsiderations	within 24 hours from date of request
Standard Claim reconsiderations	within 10 calendar days from date of request

The above timeframe deadline is for the date of Medicare Health Plan submission (mailing or fax) of the material to MAXIMUS Federal. Expedited RI responses and Standard Service Part B Drug Reconsideration RI responses must be submitted by fax (if material does not contain confidential information), portal, or by overnight delivery.

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

6.7 RECONSIDERATION DETERMINATION NOTICES

6.7.1 ISSUING A RECONSIDERATION DETERMINATION

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

6.7.2 GENERAL CHARACTERISTICS OF MAXIMUS FEDERAL DETERMINATION NOTICES

All MAXIMUS Federal reconsideration determination notices that are not fully in the enrollee's favor contain an explanation of the enrollee's right to request further appeal by the Office of Medicare Hearings & Appeals (OMHA). This review can include a Hearing with an Administrative Law Judge (ALJ) or an on-the-record review by an Attorney Adjudicator. A Hearing is a meeting with you and the ALJ so that you can talk about your appeal. An on-the- record review is a review based on the administrative record. Enrollees can ask for the kind of review that they prefer.

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

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

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

6.7.3 TRANSLATION OF CORRESPONDENCE

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

6.7.4 PROVISION OF COMMUNICATION IN ALTERNATE FORMATS

MAXIMUS Federal is required by CMS to arrange to provide communication in alternate formats, if needed. The Medicare Health Plan notifies MAXIMUS Federal of the need for alternate formats on the *Reconsideration Background Data Form* (See *Appendix*).

6.8 ENROLLEE REQUESTS FOR CASE FILES

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

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

7. POST RECONSIDERATION DETERMINATION PROCESSING

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

7.1 MAXIMUS Federal Monitoring of Medicare Health Plan Compliance with Overturned Determinations
7.2 IRE Reopening Process
7.3 Administrative Law Judge (ALJ) Process
7.4 Medicare Appeals Council (MAC) Process

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

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

7.1.1 MEDICARE HEALTH PLAN EFFECTUATION TIMEFRAMES

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

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

If you have questions regarding a MAXIMUS Federal determination, please send your request to the Plan Liaison at medicareappeal@maximus.com .Please note MAXIMUS Federal is not authorized to waive compliance with any final determination. If you feel that you cannot comply with the MAXIMUS Federal reconsideration determination notice, you must notify your Account Manager at the CMS Regional Office.

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

7.1.2 MAXIMUS FEDERAL RECONSIDERATION COMPLIANCE MONITORING

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

1. MAXIMUS Federal issues the Medicare Health Plan a copy of the reconsideration determination notice. Included with this copy is a *Notice to Comply with IRE Part C Reconsideration Determination,* that details the Medicare Health Plan's responsibilities, including the timeframe by which a compliance notice must be received by MAXIMUS Federal
2. The Medicare Health Plan is required to submit a statement attesting to compliance (effectuation) to MAXIMUS Federal. The Statement must be submitted to MAXIMUS Federal in accordance with timeframes noted within the *Notice to Comply with IRE Part C Reconsideration Determination.*
3. MAXIMUS Federal provides 5 days from the due date of submission for mailing time.
4. If MAXIMUS Federal does not receive the Medicare Health Plan statement of compliance within 30 days, MAXIMUS Federal reports the Medicare Health Plan's failure to comply to CMS. The Medicare Health Plan is not copied on this report to CMS.

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

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

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

7.2 IRE REOPENING PROCESS

An IRE Reopening is an administrative procedure in which the IRE re-evaluates its reconsideration determination for the purpose of addressing an error, fraud, or information not available at the time of IRE initial determination. A reopening is not an appeal right.

MAXIMUS Federal may accept or reject a request for a reopening at its sole discretion. Within 30 calendar days of receipt of a request for reopening, MAXIMUS Federal will make a determination as to whether or not it shall reopen a case and inform the appellant and the plan of that determination.

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

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

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

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

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

MAXIMUS Federal's contract with CMS allows 120 days for the processing of Reopening cases. In many cases, especially those requiring physician review, the full timeframe may be required. However, MAXIMUS Federal endeavors to process Reopenings within the same time

standards that are applied to reconsiderations whenever possible. Special consideration is given to Reopenings of Expedited cases.

7.3 OFFICE OF MEDICARE HEARINGS AND APPEALS (OMHA) PROCESS

The appellant (enrollee, his/her representative, or the non-contract provider) may request an appeal of the MAXIMUS Federal reconsideration determination before an Administrative Law Judge (ALJ) or Attorney Adjudicator (AA) with the Office of Medicare Hearings and Appeals. MAXIMUS Federal does not determine an enrollee's right to a hearing, nor does it schedule, conduct, or administer hearings.

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

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

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

MAXIMUS Federal forwards the reconsideration case file to the appropriate Office of Medicare Hearings and Appeals. MAXIMUS Federal does not communicate directly with Medicare Health Plans or parties during the OMHA review process. MAXIMUS Federal's role is limited to providing complete case files to the OMHA office.

7.3.2 TRACKING AND CONDUCT OF ALJ OR AA HEARING

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

7.3.3 ALJ OR AADETERMINATION PROCESSING

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

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

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

7.3.4 EFFECT OF MEDICARE APPEALS COUNCIL REQUEST ON ALJ DECISION EFFECTUATION

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

7.4 MEDICARE APPEALS COUNCIL PROCESS

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

7.4.1 TRACKING AND CONDUCT OF MEDICARE APPEALS COUNCIL HEARING

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

7.4.2 MEDICARE APPEALS COUNCIL DETERMINATION PROCESSING

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

8. HEALTH PLAN DISMISSAL PROCESSING AND APPEALS

Effective January 1, 2014, Medicare Health Plans are not required to automatically forward dismissed reconsideration requests to MAXIMUS Federal. Rather, Medicare Health Plans are required, when dismissing an appellant's reconsideration request, to inform the appellant about the right to request IRE review of the dismissal. CMS guidance explicitly states that Medicare Health Plans should use the model *Notice of Dismissal of Appeal Request* to advise appellants when their request is being dismissed. Appellants will then have the right to request a review of the Medicare Health Plan's dismissal determination directly to MAXIMUS Federal. Plans should include the model dismissal appeal request form with all dismissals. This form is intended to standardize incoming dismissal appeal requests and to provide MAXIMUS Federal with the information necessary to initiate the appeal request and case file request from the plan. Additional information is provided in 8.1. Topics discussed in this section are:

8.1 NOTICE OF DISMISSAL OF APPEAL REQUEST

The Notice of Dismissal of Appeal Request provides MAXIMUS Federal with sufficient information to begin processing an appellant's dismissal review request. MAXIMUS Federal recommends that Medicare Health Plans include either the Medicare Health Plan appeal case number or the date of services on the Notice of Dismissal of Appeal Request.

Appellants should either fax or mail a copy of this Notice of Dismissal of Appeal Request, along with any supporting documentation relevant to the review request, directly to MAXIMUS Federal.

Plans should include the model dismissal appeal request form with dismissals. If the plan has the ability to populate information in this form (e.g., names, dates of service), MAXIMUS Federal recommends that plans do so. Plans should customize this form to include their Plan information and a fax number for MAXIMUS Federal to utilize to request a case file. The model form is included in Appendix A.

8.2 DISMISSAL CASE FILE REQUESTS

Once MAXIMUS Federal receives a dismissal review request from the appellant, MAXIMUS Federal will contact, via fax, the individual or department that the Medicare Health Plan has listed on the Notice of Dismissal of Appeal Request as the party responsible for providing

a copy of the case file to MAXIMUS Federal. Per CMS guidance, Medicare Health Plans will have 24 hours from receipt of the case file request to forward the requested case file to MAXIMUS Federal. CMS permits a 5-day mailing window for receipt of case files.

8.3 MAXIMUS FEDERAL REVIEW OF DISMISSAL DECISION

Once MAXIMUS Federal has received the case file from the Medicare Health Plan, MAXIMUS Federal will review the contents of the file and the *Notice of Dismissal of Appeal Request*, along with any supplemental information submitted by the appellant. After this review, MAXIMUS Federal will determine if the Medicare Health Plan's dismissal was appropriate. If MAXIMUS Federal agrees that the dismissal was appropriate, MAXIMUS Federal will affirm the Medicare Health Plan's dismissal. If MAXIMUS Federal finds that the Medicare Health Plan's dismissal was NOT appropriate (or new information has been discovered since the time of the Medicare Health Plan's dismissal making the appeal request valid), MAXIMUS Federal will overturn the Medicare Health Plan's dismissal and advise the Medicare Health Plan that it needs to perform a substantive reconsideration.

8.3.1 FACTORS THAT MAY RESULT IN AN OVERTURN OF A PLAN'S DECISION TO DISMISS

- The appellant has shown good cause for filing their appeal outside of the 60-day appeal window and the reason for the Medicare Health Plan's dismissal is untimely filing of the appeal.
- The Medicare Health Plan has not provided proof that it made attempts to secure representative or Waiver of Liability documentation in accordance with Chapter 13 of the Medicare Managed Care Manual.

If MAXIMUS Federal decides that the Medicare Health Plan's dismissal should be overturned, then the Medicare Health Plan is responsible for rendering a full, substantive reconsideration of the issue at appeal. If, at the end of this reconsideration, the Medicare Health Plan denies coverage of or payment for the item or service in dispute, in whole or in part, the Medicare Health Plan should follow the appropriate steps for forwarding the case for independent review to MAXIMUS Federal as per the instructions in this Manual.

Please note: when Medicare Health Plans send these cases to MAXIMUS Federal for substantive reconsideration review, Medicare Health Plans should include in the case file a copy of the MAXIMUS Federal overturn decision from the dismissal review. The date of the overturn decision will serve as the date of the reconsideration request for purposes of completing the Reconsideration Background Data Form.

8.4 DISMISSAL CASE FILE DOCUMENTATION

For dismissal review case files being submitted by the Medicare Health Plan at MAXIMUS Federal request, Medicare Health Plans should send an abbreviated case file. The case file should include:

- The *Medicare Managed Care Dismissal Case File Data Form*
- A Dismissal Case File Narrative
- The organization determination documents
- The appeal request documents
- A copy of the *Notice of Dismissal of Appeal Request*
- Documentation of attempts made by the Medicare Health Plan to have the appealing party correct any appeal request deficiency

8.4.1 THE MEDICARE MANAGED CARE DISMISSAL CASE FILE DATA FORM

Every request from MAXIMUS Federal to a Medicare Health Plan for a dismissal case file needs to be accompanied by the *Medicare Managed Care Dismissal Case File Data Form*. While similar to the *Reconsideration Background Data Form*, this form contains fewer and different data elements. The Medicare Health Plan must designate a contact person on the *Medicare Managed Care Dismissal Case File Data Form*. Medicare Health Plans **must** also include the MAXIMUS Federal Appeal Number on this form. This Appeal Number will be provided to the Medicare Health Plan on the faxed case file request form.

8.4.2 ACKNOWLEDGMENT LETTERS

MAXIMUS Federal will not issue acknowledgment letters to either the appellant or the Medicare Health Plan regarding dismissal review requests.

8.5 TIMEFRAMES FOR MAXIMUS FEDERAL REVIEW

All dismissal review requests will be reviewed by MAXIMUS Federal in accordance with the timeframes applicable to the priority of the appeal. This means that for expedited dismissal reviews, MAXIMUS Federal will render its dismissal decision within 72 hours of receipt of the case file from the Medicare Health Plan. For standard service (pre-service) dismissal review requests, decisions will be made within 30 days of receipt of the case file from the Medicare Health Plan. For standard service Part B drug dismissal review requests, decisions will be made within 7 days of receipt of the case file from the Medicare Health Plan. For standard claim (payment) dismissal review requests, decisions will be made within 60 days of receipt of the case file from the Medicare Health Plan. If MAXIMUS Federal needs to request additional information from the Medicare Health Plan in order to process the dismissal review, an extension of 14 days is permitted for

expedited and standard service (pre-service) cases. No extensions are permitted for standard service Part B drug and standard claim (payment) dismissal reviews.

8.6 DISMISSAL REVIEW DECISIONS ARE BINDING

As per CMS guidance, MAXIMUS Federal decisions regarding dismissal reviews are binding. No parties to the dismissal will have further appeal rights of the dismissal decision.

9. RECONSIDERATION DATA

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

The topics addressed are:

9.1 MEDICARE APPEALS SYSTEM

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

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

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

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

9.2 MEDICARE HEALTH PLAN MONITORING REPORTS

MAXIMUS Federal reports information to CMS related to:

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

It is important to note that MAXIMUS Federal provides the above reports to CMS Central and Regional Offices to advise those offices of *potential* non-compliance. CMS personnel determine how such reports should be used in discharge of their Medicare Health Plan monitoring function. Typically, CMS personnel will contact the Medicare Health Plan if a significant issue (for

example, outlier) or pattern appears to exist, and will provide the Medicare Health Plan the opportunity to research the case(s) more thoroughly.

However, as will be explained below, the source of the reported compliance data is primarily the Medicare Health Plan itself—specifically entries made to the *Reconsideration Background Data Form* by the Medicare Health Plan. It is vital that the Medicare Health Plan carefully and accurately complete the form.

Proper Use of CMS Prescribed Adverse Determination Notices

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

Timeliness of Medicare Health Plan - Organization Determination and Reconsideration

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

- Classify the case by priority (expedited, standard service, standard service Part B drug, standard claim)
- Enter "date of receipt" and "date of completion" of the organization determination and Medicare Health Plan reconsideration
- Enter requests for expedited processing and related Medicare Health Plan decision
- Indicate if a 14-day extension was taken "in the enrollee's interest" (this extension is not applicable to standard claim and standard service Part B drug appeals).

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

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

Timeliness of Effectuation Compliance

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

9.3 USING THE MAXIMUS FEDERAL WEBSITE TO TRACK TIMELINESS AND EFFECTUATION

MAXIMUS Federal is responsible for providing CMS with data for certain STAR rating measures and for data in support of Regional Office (RO) Medicare Health Plan oversight activity. Specifically, MAXIMUS Federal provides CMS with timeliness data for STAR metric C32 and with overturn rates for metric C33. In addition, MAXIMUS Federal provides reports indicating cases where MAXIMUS Federal has not been notified of overturned cases requiring compliance effectuation.

In order to allow Medicare Health Plans to proactively monitor the cases that they have sent to MAXIMUS Federal for processing, we have developed a website that allows Medicare Health Plans to access timeliness and compliance data in real time: www.medicareappeal.com. This website is updated daily and is current as of the close of business on the previous business day.

It is important that Medicare Health Plans continuously review their underlying measure data that are the basis for the Part C Star Ratings. CMS expects Medicare Health Plans to routinely monitor these data. Medicare Health Plans that notice discrepancies or have questions about the data should bring these issues to the attention of MAXIMUS Federal as they arise. Medicare Health Plans are encouraged to submit any questions they may have about the data to the email box linked under the 'Contact Us' tab on the MAXIMUS Federal Part C appeals website or on the Contact Information page in the Medicare Advantage Reconsideration Process Manual. Medicare Health Plans that wait to raise issues with their data until CMS' plan preview periods may find there is inadequate time to investigate and resolve them within the production schedule for the release of the Star Ratings. Any issues or problems should be raised well in advance of CMS' plan preview periods.

The following sections will review the resources that are available on the website so that Medicare Health Plans can use the information throughout the year to monitor their own cases as well as report any discrepancies well in advance of STAR data being reported.

9.3.1 PLAN TIMELINESS DATA

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

decision. Once the limiting information is entered into this search box, a list of results data will appear.

MAXIMUS Federal provides two different data elements to CMS to calculate timeliness.

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

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

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

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

Effective January 1, 2020, for standard Part B drug cases, Medicare Health Plans have 7 days to render their reconsideration. Due to the nature of these appeals, only one business day is

allowed for mailing. Medicare Health Plans are expected to submit standard Part B drug cases to MAXIMUS Federal via overnight mail or the QIC Appeals Portal. Because Sundays and Federal holidays are not considered business days, for appeals where the mailing day would fall on a Sunday or a Federal holiday, one extra day is permitted for those cases to arrive.

In 2019, MAXIMUS added a column to the website to represent plan timeliness at CMS' request. All cases found to be timely using the above described formula, will be indicated as "Yes" timely. All cases found to be untimely will be indicated as "No".

9.3.2 PLAN EFFECTUATION DATA

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

This data listing advises Medicare Health Plans what the MAXIMUS Federal decision was and if notice of their compliance with that decision has been received. Medicare Health Plans may wish to check this data daily if they are waiting to see if MAXIMUS Federal has received compliance information. In addition, Medicare Health Plans can monitor those cases where MAXIMUS Federal has not noted a compliance was received. MAXIMUS strongly encourages Medicare Health Plans to review effectuation data on our website and address any outdated effectuations.

9.3.3 DATA DISCREPANCIES

If a Medicare Health Plan notices that there is no compliance data entered for a case where they have sent compliance information to MAXIMUS Federal, or that timeliness data listed on the website appears to be inaccurate, MAXIMUS Federal can investigate that discrepancy. With either the timeliness or effectuation data, if a Medicare Health Plan has a question about a data element or wants to report a discrepancy, they can send an email to the email box linked under the "Contact Us" tab in the upper right hand corner of the website. This email box is continuously monitored and questions are answered promptly.

Appendix A- Model Appellant Dismissal Form

Dismissal Appeal Request Form

Directions: If you wish to appeal this dismissal, please fill out the information on this form and send it to MAXIMUS Federal Services at the address shown below. **Please note, please include a copy of the Notice of Dismissal with your request if you are able to.**

1. Name of beneficiary:
2. Medicare Number:
3. Person appealing: ☐Beneficiary ☐Provider of Service ☐Representative
4. Name of person appealing:
5. Address of the person appealing:

   _____

6. Item or service you wish to appeal:
7. Provider name:
8. Date of the service: From _____ To _____☐NA
9. Why do you disagree with the health plan's reason for dismissal? (Attach additional pages, if necessary.)

10. You may also include any supporting material to assist your appeal. Examples of supporting materials may include, but are not limited to:

☐ Mail or fax proof of timely filing ☐ Good cause reason for filing your appeal late to the plan ☐ Good cause reason for filing your appeal late to MAXIMUS ☐Remittance Advice or Explanation of Benefits ☐ Mail or fax proof of submission of documents to the plan

NOTE: For appeals about your Notice of Dismissal, it is NOT necessary for you to send medical records to MAXIMUS. We will only be making a decision about the plan's reason for dismissal.

12. Signature of Person Appealing: Date:

Mail to:

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

[Plan Insert Plan Name & Fax Number]
[Plan Case or Control #]
[Plan Claim Number if applicable]1