APPENDIX

V 6.1, October 2019

Appendix: Reconsideration Case Forms and Instructions

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APPENDIX

INSTRUCTIONS FOR RECONSIDERATION BACKGROUND DATA FORM AND CASE NARRATIVE

MEDICARE MANAGED CARE RECONSIDERATION PROJECT

INSTRUCTIONS FOR COMPLETION OF:

MEDICARE MANAGED CARE RECONSIDERATION BACKGROUND DATA FORM AND CASE NARRATIVE

I. GENERAL ORGANIZATION OF SUBMITTED NEW CASE FILE MATERIAL

Consult the appropriate MAXIMUS Federal Services Inc. *Medicare Health Plan Reconsideration Process Manual* for general instructions on IRE Reconsideration case file development. The instructions that follow apply to completion of the mandatory:

- Reconsideration Background Data Form
- Case Narrative

II. INSTRUCTIONS FOR COMPLETION OF THE RECONSIDERATION BACKGROUND DATA FORM

The Medicare Health Plan must submit a completed Reconsideration Background Data Form (RBDF) with each new IRE reconsideration case file. The form provides MAXIMUS Federal Services with information necessary for case processing. In addition, MAXIMUS Federal Services directly reports to CMS certain data entered on the form by the MA plan. MAXIMUS Federal Services will report this data as given by the MA plan on the *Reconsideration Background Data Form* and will not attempt to correct errors or omissions.[1]

Electronic versions of the form are located on the Medicare Managed Care Reconsideration Project Website, maintained by MAXIMUS Federal Services, at www.medicareappeal.com. We recommend that the MA plan type all entries to the *Reconsideration Background Data Form.* If handwritten, the person completing the form should write legibly and print if necessary.

Complete the sections of the *Reconsideration Background Data Form* following the instructions below. If you have questions about any sections, please contact MAXIMUS Federal Services prior to completing the form.

[1] For certain compliance data elements (e.g. dates for MA plan appeal activity,) MAXIMUS Federal Services reports to CMS both the dates provided by the MA plan on the Reconsideration Background Data Form and, separately, any discrepancy noted by MAXIMUS Federal Services based upon other case file material. For example, MAXIMUS Federal Services would report a discrepancy to CMS if the date on a notice document did not correspond to the date entered for that notice on the Reconsideration Background Data Form.

The form completion instructions, by Section and data element, are as follows:

1. CASE PRIORITY

Put an X in front of the appropriate Reconsideration Priority

2a. AMOUNT IN CONTROVERSY

The amount in controversy is the actual or estimated cost of the item or service to the appellant (enrollee, estate, or non-contract provider who has executed a Waiver of Liability) if the Medicare Health Plan's adverse determination is upheld at IRE reconsideration.

Enter the amount in whole dollars only.

2b. DATE(S) OF SERVICE IN QUESTION

Enter the dates of service in dispute if the case is a retrospective appeal.

2c. DOES THIS CASE INVOLCE A COST SHARING ISSUE?

Select the appropriate check box if the case involves a cost sharing (i.e. copayment, coinsurance, or deductible) issue.

2d. IS THIS CASE AN AUTO-FORWARD?

Select the appropriate check box if the case has been auto-forwarded due to missed turn-around time

3. ENROLLEE DATA

The enrollee information is required even if the reconsideration request was submitted by a non-contracted provider or authorized representative.

- Provide the enrollee's full first and last names
- Provide the full HIC number. The Medicare number ("HIC number") is critical to MAXIMUS Federal Services administration. MAXIMUS Federal Services is unable to initiate the case without the correct HIC number and therefore will not recognize receipt of the case until the Medicare Health Plan provides the correct HIC number.
- Provide the last known address even if the enrollee is deceased.
- Indicate whether the enrollee is living or deceased.

- Indicate if the enrollee is enrolled in hospice or was enrolled in hospice on the dates of service at issue.

- MAXIMUS Federal Services will provide determination letters in languages other than English. If the enrollee requires the MAXIMUS Federal Services reconsideration determination notice in a language other than English, notify MAXIMUS Federal Services through the Reconsideration Background Data Form. The language into which the document must be translated must be included in the form.

- MAXIMUS Federal Services will arrange for communication with enrollees in an alternate format if required. If the enrollee requires the MAXIMUS Federal Services correspondence in an alternate format, notify MAXIMUS Federal Services through the Reconsideration Background Data Form. The required alternate format must be included in the form.

4. APPEAL REQUESTOR DATA

- Check one category to identify the requestor - only one category can apply.

    - *Enrollee is Requestor* – use this category unless one of the following categories applies.

    - *Enrollee's treating physician* – use this category only for pre-service and expedited cases. Physicians do not require an Appointment of Representation for these case priorities.

    - *Enrollee's Estate* – An authorized representative of an enrollee's estate may request a reconsideration. The Medicare Health Plan is responsible for determining the validity of the representation documentation. Indicate whether the documentation is provided in the case file.

    - *Non-Contract Provider* – A non-contract provider who is appealing in his or her own interest, and not that of the enrollee. To gain standing as an appellant, the provider must complete a Waiver of Liability document. Indicate whether the Waiver of Liability document is included in the case file. You may find a model Waiver of Liability in the Medicare Managed Care Manual, Chapter 13.

    - *Representative* – An authorized representative of the enrollee. Please note that a treating physician may represent an enrollee without a completed AOR in either an expedited or standard service appeal. A treating physician must, however, have a completed AOR to represent an enrollee in a retrospective (claim payment) appeal. Indicate whether the appropriate representation document is provided in the file.

    - *Surrogate acting in accordance with State Law* – Indicate if the enrollee has a surrogate (e.g. guardianship).

- Enter the following information about the requestor, if not the enrollee: name, telephone number, company/facility/practice name (if applicable), street, city, state, and ZIP.

5. MEDICARE HEALTH PLAN DATA

- Enter the CMS Contract Number (HXXXX or RXXXX) and select the appropriate plan type. Plan types are as follows:

  HMO – Health Maintenance Organization
  MSA – Medicare Savings Account
  HCPP – Health Care Prepayment Plan
  COST – Cost Plan
  PSO – Point of Service Organization
  Local PPO
  Regional PPO
  Demo – CMS Demonstration Plan
  PFFS – Private Fee for Service
  SNP – Special Needs Plan
  PACE – Program for All-inclusive Care for the Elderly
  MMP – Medicare/Medicaid Dual Eligibility Demo Plan
  MMP-NY FIDA – Medicare/Medicaid Fully Integrated Duals Advantage Demo Plan (New York State only)

- Enter the address to which MAXIMUS Federal Services should send correspondence for this particular case (that is, the Case Contact address).

6. MHP CONTACT PERSON FOR THIS RECONSIDERATION

- The Medicare Health Plan may designate any authorized individual to act as the liaison with MAXIMUS Federal Services for the submitted case. The Medicare Health Plan may use different authorized individuals for different cases.

- Enter the name, phone number, email address, and fax numbers for the person acting as the point of contact for this particular case. In addition, provide contact information for an alternate person if the contact person is unavailable.

7. MEDICARE HEALTH PLAN ORGANIZATION DETERMINATION

- *Date of Initial authorization request or claim submission* – The Medicare Health Plan should determine the date of request based on the history and facts of the case and applying CMS regulations (42 CFR §422.566) that define such a request. Enter the date in MM/DD/YY format.

- *Date of Plan's Initial Denial (Organization Determination)* – Enter the date the organization determination was issued or, for NOMNC or inpatient hospital discharge notice, signed by the enrollee. Use MM/DD/YY format.

- *Was an Expedited request made?* – Indicate if the Enrollee or Provider made a request for an Expedited Organization Determination. This question relates to the organization determination, not the subsequent request for an expedited reconsideration.

- *Was the Expedited request granted?* – Check "yes" if the Medicare Health Plan expedited the determination. Check "no" if a request for expedited determination was not granted. Do not answer if no expedited request was made.

- *Did the plan take an extension? (If so, provide notice in file)* – CMS regulations (42 CFR §§422.568 and 422.572) permit the Medicare Health Plan to take up to a 14 calendar day extension in making the organization determination if the extension is taken in the enrollee's interest. The extension applies only to expedited and standard service determinations. If the Medicare Health Plan indicates that it took an extension, the Medicare Health Plan is obligated to issue a notice of extension to the enrollee, and this notice should be included in the case file.

8. MEDICARE HEALTH PLAN RECONSIDERATION

The data entered in this section, including blank or missing data, is abstracted by MAXIMUS Federal Services exactly as provided and is then entered into a computer system used for reporting Medicare Health Plan compliance to CMS. This reporting includes calculation of Medicare Health Plan appeal processing timeliness, in comparison to timeliness standards set forth in the Federal regulation.

- *Date of Reconsideration Request* – The Medicare Health Plan should determine the date of request on the basis of the history and facts of the case and applying CMS regulations (42 CFR §422.582) that define such a request. Enter the date in MM/DD/YY format. Plans should enter the date that they received the VALID appeal request (e.g. if the plan received an appeal request from the enrollee's estate on 11/1/14 but did not receive estate documentation until 11/13/14, the plan should enter 11/13/14 as the appeal request date.)

- *Date of MHP Reconsideration Determination* – Enter the date the reconsideration determination was made by the Medicare Health Plan or, if no determination was made, the date the Medicare Health Plan forwarded the case to the IRE. Use MM/DD/YY format.

- *Was an Expedited request made?* – Check "yes" or "no." This response relates to the reconsideration determination, not the prior request for an expedited organization determination.

- *Was the Expedited request granted?* – Check "yes" if the Medicare Health Plan expedited the reconsideration, *whether or not* the enrollee asked for the case to be expedited. Check "no" if a request for expedited reconsideration was not granted.

- *Did the plan take an extension? (If so, please provide notice in file)* – CMS regulations (42 CFR §422.590) permit the Medicare Health Plan to take up to a 14 calendar day extension in making the reconsideration determination if the extension is taken "in the enrollee's interest." The extension applies only to the expedited and standard service reconsideration determinations. Check "yes" if the Medicare Health Plan purposefully took such an extension. If "yes" is checked, the Medicare Health Plan is obligated to issue a notice of extension to the enrollee, and this notice should be included in the Medicare Health Plan's case file. Check "no" if the Medicare Health Plan did not purposefully take an extension.

9. PROVIDER IDENTIFICATION DATA

The purpose of this section is to assist MAXIMUS Federal Services in identifying each provider that is referenced in the Medicare Health Plan's case file. Medicare Health Plans should include the provider(s) of denied, or unauthorized, services, as well as any other provider who plays a significant role in the sequence of events surrounding the denial of services or payment. Medicare Health Plans need not identify providers who are merely a part of the member's general utilization history (that is, history unrelated to the denied services).

- Each provider is recorded in this section *only once*. If there are more than four (4) providers, attach a second sheet.

- Complete the "Provider Name" and "Specialty" fields using the space provided on the form for each of these fields. Indicate if medical records were requested, if the records were provided, and if the provider is a contract provider with the plan.

- Indicate if the services at issue were, or are requested to be, performed outside of the service area

- Indicate if the services at issue were, or are requested to be, performed outside of the plan's network

- Indicate if the services at issue were, or are requested to be, performed outside of the enrollee's medical group. If your plan does not utilize medical groups/referral circles, select "N/A."

10. DEFINITION OF DENIED SERVICES OR CLAIMS

The purpose of this section is to provide MAXIMUS Federal Services with a succinct definition of the denied items or services addressed in the case file. Diagnosis and particularly procedure codes will assist MAXIMUS Federal Services to appropriately recognize and address the contested treatment or item.

- *Item/Service in dispute* – provide a brief description of the denied item(s) or service(s)

- *Enrollee's condition related to the Item/Service in dispute* – provide a brief description of the Enrollee's condition related to the item/service in dispute. Please do not provide diagnosis codes in this field.

- *Enrollee's ICD-9/10 diagnosis codes applicable to issues in the case* – provide the diagnosis code(s) on the denied claim or the diagnosis codes from the authorization request

- *HCPCS/CPT Codes representing the items/services in dispute* – provide the appropriate procedure codes from the denied claim or the codes from the authorization request. Do not substitute revenue codes for HCPCS/CPT codes for outpatient hospital services.

III. CASE NARRATIVE

The outline for the required Case Narrative is contained on page 4 of the Reconsideration Background Data Form for reference only. The Medicare Health Plan should supply Case Narrative as a document separate from the Reconsideration Background Data Form. The Case Narrative must be typed. The mandatory sections of the Case Narrative are:

- Case Summary
- Chronology of Care
- Appellant's Arguments for Coverage
- Health Plan Reason for Denial

CASE SUMARY

The purpose of the summary is to orient the MAXIMUS Federal Services reviewers and condense the information provided in the following sections. The summary should not exceed a paragraph or two.

- Provide the enrollee's name, age, sex, specific plan, and information about any supplemental benefits or riders that the enrollee may have.

- Briefly describe the relevant medical history and current condition, including significant changes in status, of the enrollee. Explain how the appellant came to request the service(s) that the Medicare Health Plan denied.

- Provide an exact description of the item(s) or service(s) requested by the appellant and denied by the Medicare Health Plan that are contested in the appeal. Include any relevant technical definition of the denied item/service that facilitates research regarding CMS coverage policies. If the Medicare Health Plan has offered to provide alternative or partial care, and this is important to understanding the context of the denial, explain.

- Please note: if the reason for coverage denial is that covered services must be given by **a contract provider who is associated with a specific PCP group/network**, it is important that you **include that information in the case file narrative.**

CHRONOLOGY OF CARE

- Define those events that are relevant to an understanding of the enrollee's needs or demands, and how the Medicare Health Plan has attempted to respond. Emphasize meaningful communication, not length. It is not necessary that the chronology repeat appeal processing dates, which are provided on the Reconsideration Background Data Form. The chronology should be presented in a Date/Event format, e.g. "04/15/15 enrollee's medical records receive from PCP."
  Examples of events that a well-written Chronology might contain are:
  - Onset of enrollee's illness or condition (as related to the appeal);

- Episodes of care, or care seeking behavior, prior to but related to the appeal itself;
- Consultations by which the enrollee becomes aware of, or requests, the denied service;
- How the Medicare Health Plan responded to the enrollee's request.

APPELLANT'S ARGUMENTS FOR COVERAGE

- MAXIMUS Federal Services assumes the Medicare Health Plan has provided the appellant with an opportunity to provide input in person, in writing, or by phone. In addition, the enrollee may have a formal representative, or may have obtained letters or other evidence of support from plan, or non-plan providers.

- "Provider support" is deemed to include a provider's prior authorization request, unless there is clear documentation that the provider who filed the request did not support it. A provider might submit a prior authorization request only to satisfy the demand of an enrollee. The Medicare Health Plan would have to provide actual documentation of the provider's lack of endorsement (e.g. a letter from that provider). A general statement, such as "the provider did not support the request," is not sufficient.

- The Medicare Health Plan must provide a faithful summary of each argument advanced by the enrollee and, separately, each argument advanced by a representative or other person supporting the appellant's case. Reference and attach each document in which such an argument is advanced.

- Note that if MAXIMUS Federal Services identifies a valid argument made by an enrollee or supporting person, and that argument is not acknowledged by the Medicare Health Plan, MAXIMUS Federal Services may overturn the Medicare Health Plan denial without seeking clarification (that is, without a Request for Additional Information).

MHP RATIONALE FOR DENIAL

Provide a one or two sentence statement of the Medicare Health Plan's primary reason(s) for denial. Do not list every conceivable reason for the denial, (e.g. "not covered," "not emergent," "not urgent," "not medically necessary," and "not authorized.") List only those reasons applicable to the current case. MAXIMUS Federal Services has found that the following terminology for denial reasons is useful for plans. However, plans may indicate their reasons for denial in any terms the plan chooses.

- *Not Enrolled* – The Medicare Health Plan's records indicate the member was not enrolled on the date(s) that would obligate the Medicare Health Plan to cover the disputed service.

- *Not a Covered Benefit* – The service or item in question is not covered under the member's contract under any normal circumstances (e.g. acupuncture).

- *Exceeded Coverage* – The service is a covered benefit, but the enrollee has exceeded limits set in the subscriber agreement (e.g. covered days, visits, or a dollar maximum).

- *Not an Emergency* – The service is "in area" and the Medicare Health Plan disputes the member's argument that the care met the "prudent layperson" standard for an emergency. This reason is not applicable to out-of-area care that, by definition, need only qualify as "urgent" care (42 CFR §422.113).

- *Not Urgent* – The service was obtained or sought out of the service area and the Medicare Health Plan determines it does not meet the definition of urgent care (42 CFR §422.113).

- *Not Unforeseen* – The service was obtained or sought out of the service area and the Medicare Health Plan determines that it does not meet this qualifying condition for urgent care (42 CFR §422.113).

- *Not Justified by Medicare Health Plan Delay or Withholding of Care* – The service was obtained by the enrollee without authorization or out of network on the argument that the Medicare Health Plan delayed or withheld medically necessary care. The Medicare Health Plan disputes this argument.

- *Not the Treatment Option (or Provider) Approved by Medicare Health Plan* – Applies to a case in which the enrollee seeks (pre-service) or sought (claim denial) a form of treatment that the Medicare Health Plan might recognize as medically appropriate, but the Medicare Health Plan seeks to limit coverage to an alternative appropriate treatment (or provider).

- *Not Skilled Care* – The basis for denial when care is deemed custodial, or fails to meet other Medicare qualifying criteria.

- *Not Authorized* - Care not approved in compliance with the Medicare Health Plan's authorization procedures. Usually, this reason is secondary or complementary to a reason above (e.g. "the visit to the Emergency Department was not emergent and was not authorized").

- *Not Medically Necessary* – A service which is covered by the Medicare Health Plan, but which the Medicare Health Plan determines fails to meet the definition of reasonable and necessary (42 CFR §411.15).

- *Not a Medicare Health Plan Provider* – The service sought or obtained by the member was or will be rendered by a provider who is not under contract with the Medicare Health Plan.

JUSTIFICATION

The contents of the Medicare Health Plan's justification will vary based upon its primary reason for denial. However, it is important the Medicare Health Plan justification not only state the Medicare Health Plan's position, but also offer a specific rebuttal to each argument advanced by the enrollee, representative, or supporting provider.

- *Denials on Issues of Coverage* – If the Medicare Health Plan denies on the basis of coverage, the Medicare Health Plan must justify its denial by review and interpretation of the applicable Medicare regulations, guidelines, policies, or Medicare Health Plan subscriber agreement. The Medicare Health Plan must include a copy of the applicable Medicare regulation, guideline policy, or provide the exact citation. The citation must be made directly to the applicable Federal policy text (e.g. 42 CFR §XXX.XX). Do not make citations to secondary sources (e.g. CCH. St. Anthony's Medicare Guide, et all).

- *Disputes on Matters of Fact* – In some cases, the appealing party and Medicare Health Plan may disagree on matters of fact (e.g. whether or not the member called for prior authorization on a given date). If the appellant has raised a factual dispute, the Medicare Health Plan must directly address the issue raised by the appellant, and provide any (contrary) evidence that may be available.

- *Denial of Medical Necessity* – If the Medicare Health Plan's denial is based upon a medical judgment (e.g. not emergent, not urgent, not skilled level, not medically necessary), the Medicare Health Plan is required to utilize a physician with appropriate expertise to conduct the medical review (42 CFR §422.590). A different physician must be used to make the Medicare Health Plan reconsideration determination.

  The written decisions of these physicians are the most critical components of the Medicare Health Plan's justification, although a nurse or other staff of the Medicare Health Plan may attempt to further document or explain the determinations in the case file. If there is any conflict or difference between the written opinion of the physician's determination and other arguments made in the case file, MAXIMUS Federal Services may defer to the physician's determination.

  The Medicare Health Plan may use a format of its choice for documenting the denial of medical necessity. However, the topics the clinical determinations should address are:

  - Clinical Summary – A statement of the relevant medical history and conditions of the enrollee, including any status changes that relate to the appropriateness of the denied treatment or care.

- Medicare Health Plan Medical Criteria - Identification and description (copy) of any criteria used by the Medicare Health Plan physicians in their adverse determinations. This could include applicable National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Health Plan internal criteria, purchased proprietary criteria, practice guidelines, recognized medical literature, and technology assessments. Copies of these documents should also be included.

- Medicare Health Plan Authorized or Recommended Care – An explanation of care or treatment offered or provided by the Medicare Health Plan, if any, in lieu of the (denied) care sought by the enrollee. *The Medicare Health Plan must indicate whether this care has actually been offered and authorized, and whether it has been accepted or rejected by the enrollee.* In most instances, it is not sufficient for the Medicare Health Plan to indicate that it is "willing" to provide alternative care. The Medicare Health Plan should document that such care has been explained and offered to the enrollee and the enrollee's response.

- *Justification for Denial* – If the Medicare Health Plan has cited and provided Medicare or Medicare Health Plan medical guidelines, the Medicare Health Plan should confirm with the reference to pertinent medical evidence (records) that the patient meets, or fails to meet, all criteria within those guidelines. If there is an argument that the patient has unique needs and should be exempt from the guidelines, that argument should be addressed.

INDICATE IF THE FOLLOWING DOCUMENTS ARE INCLUDED IN THE FILE

Plans should indicate what documents are being provided in the case file submitted.

Please note that each case file not submitted for dismissal should include a complete copy of the Evidence of Coverage or Subscriber Agreement. We encourage Medicare Health Plans to submit the Evidence of Coverage or Subscriber Agreement in an electronic format (preferably .PDF) on a CD.

APPENDIX

RECONSIDERATION BACKGROUND DATA FORM

MAXIMUS Federal Services

MEDICARE MANAGED CARE RECONSIDERATION BACKGROUND DATA FORM

[FOR MEDICARE HEALTH PLAN USE ONLY]

http://www.medicareappeals.com/Medicare-Advantage-2

APPENDIX

INSTRUCTIONS FOR DISMISSAL CASE FILE DATA FORM

MEDICARE MANAGED CARE RECONSIDERATION PROJECT

INSTRUCTIONS FOR COMPLETION OF:

MEDICARE MANAGED CARE DISMISSAL CASE FILE DATA FORM AND CASE NARRATIVE

I. GENERAL ORGANIZATION OF SUBMITTED DISMISSAL CASE FILE MATERIAL

Consult the appropriate MAXIMUS Federal Services, Inc. *Medicare Health Plan Reconsideration Process Manual* for general instructions on dismissal case file development. The instructions that follow apply to completion of the mandatory:

- Medicare Managed Care Dismissal Case File Data Form
- Case Narrative

II. INSTRUCTIONS FOR COMPLETION OF MEDICARE MANAGED CARE DISMISSAL CASE FILE DATA FORM

The Medicare Health Plan must submit a completed Medicare Managed Care Dismissal Case File Data Form with each new dismissal case file. The form provides MAXIMUS Federal Services with information necessary for review of the Medicare Health Plan's dismissal action. In addition, MAXIMUS Federal Services directly reports to CMS certain data entered on the form by the MA plan.

Electronic versions of the form are located on the Medicare Manage Care Reconsideration Project Website, maintained by MAXIMUS Federal Services at www.medicareappeal.com. We recommend that the Medicare Health Plan type all entries to the Medicare Managed Care Dismissal Case File Data Form. If handwritten, the person completing the form should write legibly and print if necessary.

Complete the sections of the Medicare Managed Care Dismissal Case File Data Form, following the instructions below. Do not leave a required section or data element blank if you are uncertain how to code it. If you have questions about any sections, please contact MAXIMUS Federal Services prior to completing the form.

The form completion instructions, by Section and data element, are as follows:

MAXIMUS CASE NUMBER:

Enter the case number that was provided on the Dismissal Case File Request fax.

1. CASE PRIORITY

Put an X in front of the appropriate priority.

2. DATE(S) OF SERVICE IN QUESTION

Enter the dates of service in dispute if the case is a dismissal review of a standard claim.

3. DISMISSAL REASON

Indicate the reason that the Medicare Health Plan dismissed the appeal request.

4a. ENROLLEE DATA

The enrollee information is required even if the reconsideration is submitted by a non-contract provider or authorized representative.

- Provide the enrollee's full first and last name.
- The Medicare number ("HIC Number") is critical to MAXIMUS Federal Services administration. MAXIMUS Federal Services is unable to initiate the case without the correct HIC number and therefore will not recognize receipt of the case file until the Health Plan provides the correct HIC number.
- Provide the last known address even if the enrollee is deceased.
- MAXIMUS Federal Services will provide determination letters in languages other than English. If the enrollee requires the MAXIMUS Federal Services determination notice in a language other than English, notify MAXIMUS Federal Services through the Medicare Managed Care Dismissal Case File Data Form. The language into which the document must be translated must be included in the form.
- MAXIMUS Federal Services will communicate with enrollees in an alternate format if required. If the enrollee requires the MAXIMUS Federal Services correspondence in an alternate format, notify MAXIMUS Federal Services through the Dismissal Case File Data Form. The required alternate format must be included in the form.

4b. REQUESTOR DATA

- Check one category to identify the requestor; only one category can apply.
    - *Enrollee is Requestor* – Use this category unless one of the following categories applies.
    - *Enrollee's treating physician* – Use this category only for pre-service and expedited cases. Physicians do not require an Appointment of Representation for these case priorities.

- *Enrollee's Estate* – An authorized representative of an enrollee's estate may request a reconsideration. The Medicare Health Plan is responsible for determining the validity of the representation documentation. Indicate whether the documentation is provided in the case file.

- *Non-Contract Provider* – A non-contract provider who is appealing in his or her own interest, and not that of the enrollee. To gain standing as an appellant, the provider must complete a Waiver of Liability document. Indicate whether the Waiver of Liability document is included in the case file. You may find a model Waiver of Liability in the Medicare Managed Care Manual, Chapter 13

- *Representative* – An authorized representative of the enrollee. Please note that a treating physician may represent an enrollee without a completed AOR in either an expedited or standard service appeal. A treating physician must, however, have a completed AOR to represent an enrollee in a retrospective (claim payment) appeal. Indicate whether the appropriate representation documentation is provided in the file.

- *Surrogate acting in accordance with State Law* – Indicate if the enrollee has a surrogate (e.g. guardianship).

- Enter the following information about the requestor, if not the enrollee: name, telephone number, company/facility/practice name (if applicable), street, city, state, and ZIP.

5. MEDICARE HEALTH PLAN (MHP) DATA

- Enter the CMS Contract umber (HXXXX or RXXXX)

- Enter the address to which MAXIMUS Federal Services should send correspondence for this particular case (that is, the Case Contact address).

6. MHP CONTACT PERSON FOR THIS DISMISSAL REVIEW

- The Medicare Health Plan may designate any authorized individual to act as the liaison with MAXIMUS Federal Services for the submitted case. The Medicare Health Plan may use different authorized individuals for different cases.

- Enter the name, phone number, email address, and fax numbers for the person acting as the point of contact for this particular case. In addition, provide contact information for an alternative person if the contact person is unavailable.

DISMISSAL CASE FILE NARRATIVE

The outline for the required Dismissal Case File Narrative is contained on page 2 of the Medicare Managed Care Dismissal Case File Data Form for reference only. The Medicare Health Plan should supply a Dismissal Case File Narrative as a document separate from the Medicare Managed Care Dismissal Case File Data Form. The Dismissal Case File Narrative must be typed.

The mandatory sections of the Dismissal Case File Narrative are:

- Dismissal Case Summary
- Dismissal Chronology
- Health Plan Dismissal Rationale
- Justification

1. DISMISSAL CASE SUMMARY

Briefly describe the Medicare Health Plan's dismissal case. Explain how the appellant came to request the service(s) that the Medicare Health Plan denied. The purpose of the summary is to orient the MAXIMUS Federal Services reviewers and condense the information provided in the following sections. The summary should not exceed a paragraph.

2. DISMISSAL CHRONOLOGY

Define those events that are relevant to the plan's dismissal of the appellant's request. This chronology should include dates of initial authorization request/denial, date of plan organization determination, date of the appellant's invalid appeal request, dates of attempts to secure representative documentation, Waiver of Liability, or good cause, as applicable, and the date that the plan issued its Notice of Dismissal. The Chronology should be presented in a Date/Event format.

3. MHP DISMISSAL RATIONALE

Provide a one or two sentence statement of the Medicare Health Plan's reason or dismissing the appellant's request.

4. JUSTIFICATION

The contents of the Medicare Health Plan's justification will vary based upon its reason for dismissal. Plans should cite to the rule relied upon to dismiss the appellant's request. The plan should also address any denials of good cause or rejections of submitted representative documentation.

5. INDICATE IF THE FOLLOWING DOCUMENTS ARE INCLUDED IN THE FILE

Plans should indicate what documents are being provided in the dismissal case file submitted. Please note that each dismissal case file submitted should include a copy of the Notice of Dismissal issued by the plan, as well as the other supporting documentation listed.

APPENDIX

DISMISSAL CASE FILE DATA FORM

MAXIMUS Federal Services

MEDICARE MANAGED CARE DISMISSAL CASE FILE DATA FORM

http://www.medicareappeals.com/Medicare-Advantage-2

APPENDIX

NEW RECONSIDERATION CASE FILE TRANSMITTAL COVER SHEET

MAXIMUS Federal Services

MEDICARE MANAGED CARE RECONSIDERATION PROJECT

NEW RECONSIDERATION CASE FILE TRANSMITTAL COVER SHEET

For use to submit a new Medicare Managed Care Reconsideration Project case file for review by MAXIMUS Federal Services. MAXIMUS Federal Services will not accept a new case file submitted via facsimile. MAXIMUS Federal Services will not initiate new cases submitted via facsimile until the hard copy is received.

Expedited Case File Materials? YES_____ NO_____

Member Name: _____

Member HIC Number: _____

Document	**Check if submitted**
Reconsideration Background Data Form **Case will not be initiated until the completed Reconsideration Background Data Form is received by MAXIMUS Federal Services*	☐
Case Narrative	☐
Organization Determination and Reconsideration Process Notices	☐
Records of Adverse Determination	☐
Medicare Health Plan Decision Making Criteria	☐
Medical Records (if applicable)	☐

APPENDIX

REQUEST FOR INFORMATION RESPONSE COVER SHEET

MAXIMUS Federal Services

MEDICARE MANAGED CARE RECONSIDERATION PROJECT

REQUEST FOR INFORMATION RESPONSE COVER SHEET

For use to submit case file specific information in response to a MAXIMUS Federal Services Request for Information. Do not send documents containing confidential information via facsimile.

Expedited Case File Materials? YES_____ NO_____

Member Name: _____

MAXIMUS Federal Services Case Number: _____

APPENDIX

STATEMENT OF COMPLIANCE FORM

MAXIMUS Federal Services

Medicare
Managed Care & PACE
Reconsideration
Project

Reviewing
Medicare Appeals

MAXIMUS Federal Services
Medicare Part C QIC
3750 Monroe Ave, Suite 702
Pittsford, NY 14534-1302
Tel: 585-348-3300
Fax: 585-425-5292
www.medicareappeal.com

Who We Are

We are MAXIMUS Federal Services. We are experts on appeals. Medicare hired us to review the file and decide if the health plan made the correct decision. ***We work for Medicare.*** *We do not work for the health plan.*

Office of the Project Director
Medicare Managed Care & PACE Reconsideration Project

NOTICE TO COMPLY WITH IRE Part C RECONSIDERATION DETERMINATION

Federal regulations require your organization to effectuate the attached IRE Part C Reconsideration Determination within a specific time period. These time periods are:

Appeal Priority	*Effectuation Due (from receipt of Decision)*
Expedited	Authorize or Provide service within 72 hours*
Standard Service (Pre-service)	Authorize service within 72 hours **or** Provide service within 14 calendar days*
Standard Claim (Retrospective)	Pay for service within 30 calendar days (Check number required for proof of payment)

* Or as expeditiously as the enrollee's health condition requires

An IRE Part C Reconsideration Determination is final and binding. The determination may only be revised through a Reopening Determination. A Request for Reopening does not extend your organization's compliance date. You are relieved of the compliance responsibility only if you receive a favorable Reopening Determination notice from MAXIMUS Federal Services prior to the compliance due date.

Your organization has no appeal right to an Administrative Law Judge.

Please provide a written notice of compliance to MAXIMUS Federal Services within fourteen (14) calendar days from the date of the effectuation of payment, authorization or provision of services and/or supplies.

In order to ensure proper handling, please use the attached form to notify MAXIMUS Federal Services of compliance.

MAXIMUS Federal Services

MEDICARE MANAGED CARE & PACE RECONSIDERATION PROJECT

PART C

STATEMENT OF COMPLIANCE FORM

Enrollee Name (First initial, last name)		
Health Plan Contact		
MAXIMUS Federal Services Case #		
Health Plan Name		
Health Plan Contract # (H# or R#)		
Authorization # and Date Required for pre-service and expedited cases	#	Date
Check # or EFT# and Date Required for retrospective cases	#	Date

Important information:

- MAXIMUS Federal Services cannot waive compliance with a Reconsideration Determination.
- If you cannot comply with the Reconsideration Determination, you must notify your Account Manager at the CMS Regional Office.
- Compliance notice for Standard Claim (retrospective) cases that do not contain a check number or EFT number will be rejected and referred to the CMS Regional Office Account Manager for review.

Please mail or fax this form to:

MAXIMUS Federal Services
Medicare Part C QIC
3750 Monroe Avenue, Suite 702
Pittsford, NY 14534-1302
Fax: (585) 425-5292

APPENDIX

REOPENING REQUEST FORM

MAXIMUS Federal Services

MEDICARE MANAGED CARE RECONSIDERATION PROJECT

REOPENING REQUEST FORM

Enrollee Name: _____

MAXIMUS Federal Services Reconsideration Case Number: _____

Dates of Service: _____

Medicare Health Plan Name: _____

Medicare Health Plan Contact: _____

Contact Title: _____

Street Address: _____

Mail Stop: _____

City/State/Zip: _____

Telephone Number: _____ Ext: _____

Fax Number: _____ Date of Request: _____

Basis of Reopening Request:

☐ Error on the face of the evidence

☐ New and material evidence

☐ Fraud

Explain briefly:

APPENDIX

STATEMENT OF COMPLIANCE FORM - ALJ

MAXIMUS Federal Services

Medicare
Managed Care & PACE
Reconsideration
Project

Reviewing Medicare Appeals

MAXIMUS Federal Services
Medicare Part C QIC
3750 Monroe Ave, Suite 702
Pittsford, NY 14534-1302
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Office of the Project Director
Medicare Managed Care & PACE Reconsideration Project

MAXIMUS Federal Services

NOTICE TO COMPLY WITH ADMINISTRATIVE LAW JUDGE DETERMINATION

Federal regulations require your organization to effectuate the attached Administrative Law Judge Determination within the specific time period stated below.

Appeal Priority	*Effectuation Due (from receipt of Decision)*
Expedited or Standard Service (Pre-service)	Authorize or provide service as expeditiously as the enrollee's health condition requires but no later than 60 calendar days.*
Standard Claim (Retrospective)	Pay for service no later than 60 calendar days.*

* If the MA organization makes a valid request for Medicare Appeals Council (MAC) review, the MA organization may await the outcome of the review before it pays for, authorizes, or provides the service under dispute.

In order to ensure proper reporting, the MA Organization should notify MAXIMUS Federal Services that it has requested a MAC appeal **at the time the MAC review request is made**.

In order to ensure proper handling, please use the attached form to notify MAXIMUS Federal Services that you have either requested MAC review or that you have complied with effectuation.

MAXIMUS Federal Services

MEDICARE MANAGED CARE & PACE RECONSIDERATION PROJECT

ADMINISTRATIVE LAW JUDGE DECISION

STATEMENT OF COMPLIANCE FORM

Enrollee Name (First initial, last name)		
Health Plan Contact		
MAXIMUS Federal Services Case #		
ALJ Case #		
Health Plan Name		
Health Plan Contract # (H# or R#)		
Request has been made for MAC review.	Date:	
Authorization # and Date Required for pre-service and expedited cases	#	Date
Check # or EFT# and Date Required for retrospective cases	#	Date

Important information:

- You may send the completed Statement of Compliance Form via fax to: 585-425-5292
- Send completed form no later than 14 days after the effectuation date.
- If you cannot comply with the Reconsideration Determination, you must notify your Account Manager at the CMS Regional Office.
- Compliance notice for Standard Claim (retrospective) cases that do not contain a check number or EFT number will be rejected and referred to CMS Regional Office Account Manager for review.

MAXIMUS Federal Services Admin. Use Only

Log _____ *File* _____