

**PersonalCare
Quality Improvement
Policy and Procedure**

Policy: Reconsideration of an Organization Determination, Including Transplants (First Level of Appeal) **Number:** MA100.01

Date Effective: 12/14/07 **Page** 1 of 12

Approved By:

_____ Medical Director	_____ Date	_____ Director, Quality Improvement	_____ Date
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Policy Review: (date)

12/14/07	11/14/08	_____	_____	_____	_____
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Policy Revisions: (date)

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Item	Description
Purpose	<p>To ensure compliance with federal requirements and to provide a process for the reconsideration of an adverse service determination.</p> <p>For MA members with Part D coverage (“MA-PD”), see Policy MA 100.15 (Corporate Policy CVTY/AP/103-D) for a description of redetermination of pharmacy related organization determinations.</p>
Policy	<p>PersonalCare will provide a procedure to address requests for: (1) a standard reconsideration of an adverse service or payment organization determination by any party to an organization determination; and (2) an expedited reconsideration of an adverse service organization determination by a member, his/her representative, or provider acting on behalf of the member.</p> <p>PersonalCare will conduct a thorough and complete review of all requests for Reconsideration and issue a decision in a timely fashion.</p> <p>If PersonalCare delegates any of its responsibilities to another entity or individual through which the organization provides health care services or claim payments, PersonalCare is ultimately responsible for ensuring that entity or individual satisfies these requirements.</p>
Responsibility	PersonalCare Appeals Department & Quality Improvement Director

**PersonalCare
Quality Improvement
Policy and Procedure**

Item	Description
Definitions	<p>Appeal: An appeal means any of the procedures that deal with the review of an adverse organization determination on the health care services the Medicare member believes he or she is entitled to receive, including delay in providing, arranging for or approving the health care services (such that a delay would adversely affect the health of the enrollee), or any amounts the Medicare member must pay for a service, as defined in Federal Regulation 42 C.F.R. § 422.566(b). Appeal procedures include reconsiderations by [CHC], and if necessary, an independent review entity, hearings before Administrative Law Judges ("ALJs"), review by the government's Medicare Appeals Council ("MAC") and judicial review in federal courts.</p> <p>Representative: A representative is an individual appointed by a Medicare member or under State or other applicable law to act on his or her behalf in obtaining an organization determination or in dealing with any of the levels of the appeal process.</p> <p>A representative may:</p> <ul style="list-style-type: none"> • Obtain information about the member's claim to the same extent that the member is able to; • Submit evidence; • Make statements about facts and law; and • Make any request or give any notice about the proceedings. <p>Appointment of Representative (Form CMS-1696) or equivalent documentation must be completed for representatives to act on a member's behalf.</p> <p>Physicians may request expedited reconsiderations for services on a patient's behalf without being appointed as the enrollee's representative. However, if the physician seeks a standard determination for purposes of obtaining payment, the physician must sign a waiver of liability statement.</p> <p>Grievance means any complaint or dispute other than one that constitutes an organization determination, expressing dissatisfaction with any aspect of an MA organization's or provider's operations, activities, or behavior, regardless of whether remedial action is requested, as defined in 42 C.F.R. § 422.561.</p> <p>Independent Review Entity: Federal statutes require the Centers for Medicare and Medicaid Services ("CMS") to contract with an independent, outside entity to review and resolve, in a timely manner, reconsiderations that affirm, in whole or in part, an MA organization's denial of coverage or requirement to pay. Unless an MA organization completely reverses its coverage denial issued to the member during the appeal, the MA organization must prepare a written explanation and refer the member's case to the independent review entity for a new and impartial determination concerning the payment or service at issue. Currently, CMS has contracted with the Maximus Federal Services, Inc., to perform this independent, outside review function.</p> <p>Member: A member is an MA eligible individual who has enrolled in an MA plan</p>

**PersonalCare
Quality Improvement
Policy and Procedure**

Item	Description
	<p>offered by PersonalCare. For purposes of these policies, the term "member" only refers to an individual enrolled in an MA plan offered by PersonalCare.</p> <p>Organization Determination: An organization determination is any determination made by PersonalCare or on behalf of PersonalCare with respect to any of the following:</p> <ol style="list-style-type: none"> (1) Payment for temporary out-of-area renal dialysis services, emergency services, post-stabilization care, or urgently needed services. (2) Payment for any other health services, in whole or in part, furnished by a provider that the member believes— <ol style="list-style-type: none"> (i) Are covered under Medicare; or (ii) If not covered under Medicare, should have been furnished, arranged for, or reimbursed by PersonalCare. (3) PersonalCare’s refusal to provide or pay for services, in whole or in part, including the type or level of services that the member believes should be furnished or arranged for by PersonalCare. (4) Discontinuation or reduction of a service, if the member believes that continuation of the service is medically necessary. (5) PersonalCare’s’s failure to approve, arrange for, furnish or provide payment for health care services in a timely manner, or failure to provide the Medicare member with timely notice of an adverse determination, if such a delay would adversely affect the health of the Medicare member. <p>The following individuals or entities may be a party to an organization determination:</p> <ol style="list-style-type: none"> (a) The member (including his or her representative); (b) An assignee of the member (that is, a physician or other provider who has furnished or intends to furnish a service to the member and formally agrees to waive any right to payment from the member for that service); (c) The legal representative of a deceased member's estate; or (d) Any other provider or entity (other than PersonalCare) determined to have an appealable interest in the proceeding. <p>Physician: The term physician is fully defined by Federal statute, but, in general,</p>

**PersonalCare
Quality Improvement
Policy and Procedure**

Item	Description
	<p>means any of the following practitioners who are legally authorized to practice in the state in which he or she practices:</p> <ul style="list-style-type: none"> • Doctor of medicine or osteopathy; • Doctor of dental surgery or of dental medicine; • Doctor of podiatric medicine; • Doctor of optometry; • Chiropractor <p>Reconsideration: A reconsideration consists of a review of a member's adverse organization determination, the evidence and findings upon which it was based, and any other evidence the parties may submit or PersonalCare or CMS may obtain.</p>
Procedure	<p>A. <u>STANDARD RECONSIDERATION</u> (<i>Requests for services and payment.</i>) (<i>For Expedited Reconsideration, please refer to Section B below.</i>)</p> <ol style="list-style-type: none"> 1. All Standard Reconsiderations are sent or forwarded to the Appeal Coordinator. Upon receipt of a request for standard reconsideration, the Appeal Coordinator will identify whether the reconsideration request is submitted within sixty (60) calendar days from the date of the notice of the organization determination. If PersonalCare failed to issue the notice of organization determination, no time limit applies. If the party requested the reconsideration later than sixty [60] days after the organization determination, the Appeal Coordinator will send a letter to the member requesting good cause for late filing. [CVTY/NATL/A&G 120b] <ol style="list-style-type: none"> 1a. If the party shows good cause, PersonalCare may extend the timeframe for filing a request for reconsideration if the sixty (60)-day period has expired. The party to the organization determination may file a written request for reconsideration and to extend the timeframe with PersonalCare. The written request must state why the request for reconsideration was not filed on time. 1b. The timeframe within which the organization must conduct its review begins when it receives the request. 2. The party who files a request for reconsideration may withdraw the request by filing a written request for withdrawal with PersonalCare. 3. If a non-contracted provider files an appeal, the waiver of liability form must be included with the appeal. If the completed form is not received by conclusion of the appeal timeframe the case will be forwarded to Maximus Federal Services for dismissal. 4. Upon receiving a written request to consider an adverse organization determination, the Appeal Coordinator will enter appropriate documentation

**PersonalCare
Quality Improvement
Policy and Procedure**

Item	Description
	<p>into the Appeal tracking system under a “pending” status. The AC investigates the case and works with appropriate customer service organization, and/or PersonalCare staff to obtain the necessary information to prepare the reconsideration.</p> <p>5. The Appeal Coordinator will send written notification of the receipt of the request for reconsideration to the member. [Letter CVTY/NATL/A&G/011a or M0003_08MAPD_PFFS_602 ReqForRecon] The CMS approved letter must include, at a minimum:</p> <ul style="list-style-type: none"> • An invitation to submit in person or in writing supporting information including evidence and allegations of facts or law regarding the request; • A statement explaining the steps PersonalCare will follow to investigate the request, including verification of the facts, review of PersonalCare policies and Evidence of Coverage, and evaluation of the request; and • The date by which a decision will be made. <p>6. Upon receipt of a request to reconsider, if medical records are needed, the Appeal Coordinator will send a request to the provider. If medical records are not received after appropriate follow-up, the appeal will proceed based on information available.</p> <p>7. The Appeal Coordinator shall request all information regarding the initial organization determination from the relevant areas (i.e., Health Services, CSO, etc.). The contact person for the area from which information was requested shall submit the initial organization determination, supporting documentation, or any other documentation an area may have related to the reconsideration, to the Appeal Coordinator in sufficient time to allow an internal reconsideration hearing, if necessary, and</p> <ul style="list-style-type: none"> • to ensure a reconsideration decision is made as expeditiously as the member’s health requires, not to exceed thirty (30) days of the member’s request. for reconsideration of a service denial. • to ensure a reconsideration decision is made within sixty (60) days of the member’s request for reconsideration of a claim payment denial • <i>The Appeal Coordinator may refer the reconsideration request to designated contact persons within other departments as necessary or appropriate to fully investigate the circumstances of that case (e.g., to a Claims Service Associate for claim related issues or to a medical reviewer for medical issues).</i> • <i>The Appeal Coordinator will gather all related evidence regarding the</i>

**PersonalCare
Quality Improvement
Policy and Procedure**

Item	Description
	<p style="text-align: center;"><i>organization determination that will be required to make a reconsidered decision, including all necessary clinical information that will be provided by the Health Services contact.</i></p> <p>8. For Service Reconsiderations: PersonalCare may extend the timeframe by up to fourteen (14) calendar days if the member requests the extension or if with organization justification of a need for additional information and how the delay is in the interest of the member. For extensions, PersonalCare must issue and effectuate its determination as expeditiously as the member’s health condition requires, but no later than upon expiration of the extension. The notice of extension letter must inform the member of the right to an expedited grievance if he or she disagrees with the extension. [Letter CVTY/NATL/ A&G/001b]</p> <p>9. <u>Reconsideration Committee</u>. The Reconsideration Committee consists of:</p> <ul style="list-style-type: none"> • For reconsiderations that do not involve organization determinations that a service is or was not medically necessary: one (1) to three (3) PersonalCare managers who were not involved in making the initial organization determination nor be a subordinate of the individual who made the initial organization determination, must conduct the reconsideration and review all appropriate information; • For reconsiderations of organization determinations that a service is or was not medically necessary, a PersonalCare or other Coventry health plan medical director with expertise in the field of medicine that is appropriate for the services at issue and who was not involved in making the initial decision, nor be a subordinate of the individual who made the initial organization determination, must conduct the reconsideration and review all appropriate information. If there is no other Coventry health plan medical director available with expertise in the field of medicine that is appropriate for the services at issue, PersonalCare will utilize an outside physician as appropriate. Note: A physician involved in the reconsideration process need not in all cases be of the exact same specialty or sub-specialty as the treating physician. • For reconsiderations of organization determinations involving transplant services (except transplant facility exception requests as described in the next bullet point), the Reconsideration Committee must consist of one to three members and include a Coventry VP Medical Director or the Coventry Chief Medical Officer with expertise in the field of medicine that is appropriate for the services at issue. If a Coventry VP Medical Director or the Coventry Chief Medical Officer do not have expertise in the field of medicine that is appropriate for the services at issue, PersonalCare will utilize an outside physician as appropriate. Note: A physician involved in the reconsideration process need not in all cases

**PersonalCare
Quality Improvement
Policy and Procedure**

Item	Description
	<p><i>be of the exact same specialty or sub-specialty as the treating physician.</i> In addition, the committee members cannot have been involved in the initial organization determination, nor be a subordinate of the individual who made the initial organization determination and must include consultation with a health care professional(s) who has appropriate training and experience in the field of medicine involved in the medical judgment. Three clinical peer review consultation reports are requested for Bone Marrow Transplant and Stem Cell Transplant Reconsiderations. One clinical peer review is requested for all other transplant reconsiderations.</p> <ul style="list-style-type: none"> • For reconsiderations involving a request for approval of a transplant at a non-network transplant facility, the Reconsideration Committee must be comprised of: <ul style="list-style-type: none"> i) a Coventry VP Medical Director, or the Coventry Chief Medical Officer. The Coventry VP Medical Director or the Coventry Chief Medical Officer cannot have been involved in the initial organization determination, nor be a subordinate of the individual who made the initial organization determination; ii) if neither the Coventry VP Medical Director, nor the Coventry Chief Medical Officer are available, then the Committee must include a Coventry Plan CEO or Regional Vice President. The Coventry Plan CEO or Regional Vice President cannot have been involved in the initial organization determination, nor be a subordinate of the individual who made the initial organization determination. <p>10. If the member initiated the reconsideration, and PersonalCare makes a reconsidered determination that is completely favorable to the member, the Appeal Coordinator will send a written notice to the member or the member's representative. [Letter M0003_08MAPD_PFFS_596 ReconServ, or M0003_08MAPD_PFFS_597 ReconPayFav]. If a provider initiated the reconsideration and the reconsideration determination is completely favorable to the member/provider, the Appeal Coordinator will notify the provider and member in writing using [Letter M0003_08MAPD_PFFS_596 ReconServ, or M0003_08MAPD_PFFS_597 ReconPayFav].</p> <p>11. If the claim involves a service that requires preauthorization, an appropriate authorization will be entered into the computer system within the 30 day required time frame. If PersonalCare makes a reconsidered determination on a request for payment that is in whole or in part favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request</p>

**PersonalCare
Quality Improvement
Policy and Procedure**

Item	Description
	<p>12. If PersonalCare makes a reconsideration determination that affirms, in whole or in part, the adverse organization determination, it must prepare a written explanation and send the case file to the independent review entity within the required timeframes. (Refer to policy MA 100.10 or corporate policy CVTY/AP-104). PersonalCare must make reasonable and diligent efforts to assist in gathering and forwarding information to the independent review entity. [CHC] must notify the member that the case has been forwarded to an independent review entity. [Letter CVTY/NATL/A&G/010c, M0003_08MAPD_PFFS_599 ReconServDenied]</p> <p>13. <i>If PersonalCare fails to provide the member with a reconsideration determination within the specified timeframes, this failure constitutes an affirmation of its adverse organization determination and PersonalCare must submit the file to the independent review entity.</i></p> <p>14. If a member has requested a standard pre-service reconsideration, but PersonalCare becomes aware that the member has obtained the service before PersonalCare completes its reconsideration determination, PersonalCare will dismiss the pre-service appeal. The pre-service reconsideration processing stops, and the Appeal Coordinator will forward the appeal case to the Independent Review Entity for dismissal.</p> <p>15. The Appeal Coordinator organizes all documentation relevant to the reconsideration request in the appeal case file and documents the results in the Appeal tracking system.</p> <p>16. The Appeal Coordinator will provide to the member, upon request, copies of documents relevant to their reconsideration.</p> <p><u>B. EXPEDITED RECONSIDERATION REQUEST (SERVICES):</u></p> <p>1. A member, a representative of the member, or a provider acting on behalf of the member must submit an oral or written request directly to PersonalCare or, if applicable, to the entity responsible for making the reconsideration as directed by PersonalCare if the member believes that applying the standard time frame for reviewing a reconsideration would seriously jeopardize his or her life or health or ability to regain maximum function.</p> <p>2. Once PersonalCare’s Appeal Coordinator receives the expedited reconsideration request, the request, including the date and time of receipt of the oral or written request, is immediately documented in the member’s case file and in the Appeal tracking system. [Form CVTY/NATL/A&G/016]</p>

**PersonalCare
Quality Improvement
Policy and Procedure**

Item	Description
	<p>3. The Appeal Coordinator identifies whether the request for reconsideration was submitted more than sixty (60) calendar days from the date the member received an adverse organization determination. If so, the Appeal Coordinator sends a letter to the member or his/her authorized representative requesting good cause for late filing. [Letter M0003_08MAPD_PFFS_600 LateFileLtr]</p> <p>4. If a physician indicates that the standard timeframe for making a reconsideration could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, the reconsideration will be expedited. A physician may provide oral or written support for a request for an expedited reconsideration.</p> <p>5. If the member submits the request for expedited reconsideration without any physician support for the request, the Appeal Coordinator will review the case with a Coventry Medical Director (who was not involved in the initial decision). The Medical Director will determine whether the requested reconsideration meets the expedited reconsideration criteria. If the request meets expedited reconsideration criteria proceed to section D below. If the request does not meet expedited reconsideration criteria, refer to Section C below.</p> <p><u>C. DENIAL OF EXPEDITED RECONSIDERATION REQUEST:</u></p> <p>1. If the request for an expedited reconsideration is denied, PersonalCare automatically transfers a request to the standard timeframe (see Section A above) and makes the determination within the thirty (30) calendar day timeframe established in the standard reconsideration policy.</p> <p>2. The thirty (30) day standard reconsideration period begins with the day PersonalCare receives a request for the expedited reconsideration.</p> <p>3. PersonalCare gives the member oral notice, within 24 hours of receipt of the expedited request, of the decision that the request for reconsideration does not meet expedited reconsideration criteria. PersonalCare will advise the member in writing within three (3) calendar days of receipt of request with a letter that includes the following: [Letter CVTY/NATL/A&G/004a with CVTY/NATL/A&G/020b].</p> <ul style="list-style-type: none"> • Explains that PersonalCare will process the request using the thirty (30) day timeframe for standard reconsiderations; • Provides instructions about the grievance process and its timeframes, including the right to file an expedited grievance if the member disagrees with the decision not to expedite; and

**PersonalCare
Quality Improvement
Policy and Procedure**

Item	Description
	<ul style="list-style-type: none"> • Informs the member of the right to resubmit the request with physician’s support. <p><u>D. EXPEDITED SERVICE DETERMINATION:</u></p> <ol style="list-style-type: none"> 1. If PersonalCare approves a request for expedited reconsideration, PersonalCare notifies the member (and the provider involved as appropriate) of its decision, whether adverse or favorable, as expeditiously as the member’s health condition requires, but no later than seventy-two (72) hours after receiving the request. 2. PersonalCare may extend the seventy-two (72)- hour deadline by up to fourteen (14) calendar days if the member requests the extension or if the organization justifies a need for additional information and how the delay is in the interest of the member (for example, the receipt of additional medical evidence from noncontract providers may result in PersonalCare overturning its decision to deny). PersonalCare will notify the member in writing of the reasons for an extension and inform the member of the right to file an expedited grievance if he or she disagrees with PersonalCare’s decision to grant an extension. For extensions, PersonalCare must issue and effectuate its determination as expeditiously as the member’s health condition requires, but no later than upon expiration of the extension. 3. If PersonalCare must request necessary information from providers, it must do so within twenty-four (24) hours of the initial request for expedited reconsideration. Providers must make reasonable and diligent efforts to expeditiously gather and forward all necessary information. 4. PersonalCare’s Appeal Coordinator will advise the member of the member’s opportunity to submit evidence, in person or in writing, in support of their request. 5. The Appeal Coordinator compiles all necessary information for review by the Reconsideration Committee, including all information regarding the initial organization determination from the relevant areas (i.e., Health Services, CSO, etc.). The Reconsideration Committee must conduct the reconsideration. 6. PersonalCare must notify the member of its determination as expeditiously as the member’s health condition requires, but no later than 72 hours after receipt of the request with oral notification. Written notification will follow within 3 calendar days. In cases where an extension was granted, notification will be given orally and sent to the member no later than upon expiration of the extension. [Letter CVTY/NATL/A&G/001b]

**PersonalCare
Quality Improvement
Policy and Procedure**

Item	Description
	<p>7. If PersonalCare makes a reconsideration that is completely favorable and:</p> <p style="padding-left: 40px;">a) the reconsideration was initiated by a PersonalCare member or representative, if necessary, an appropriate authorization will be entered into the computer system and notification will be given to the member in writing and orally of PersonalCare’s reconsideration determination; or</p> <p style="padding-left: 40px;">b) the reconsideration was initiated by a provider, appropriate authorization will be entered into the computer system and notification will be given to the provider orally and the provider and member in writing utilizing [Letter M0003_08MAPD_PFFS_596 ReconServ].</p> <p>8. If, as a result of the reconsideration, PersonalCare affirms, in whole or in part, the adverse organization determination, the Appeal Coordinator must submit a written explanation and the case file to the independent review entity as expeditiously as the member’s health condition requires, but no later than within twenty-four (24) hours of its affirmation. PersonalCare must make reasonable and diligent efforts to assist in gathering and forwarding information to the independent review entity. [Letters: CVTY/NATL/A&G/010c, or M0003_08MAPD_PFFS_599 ReconServDenied]</p> <p>9. If PersonalCare refers the matter to the independent review entity, it must concurrently notify the member of that action. [Letters: CVTY/NATL/A&G/010c, or M0003_08MAPD_PFFS_599 ReconServDenied]</p> <p>10. <i>If PersonalCare fails to provide the member with a reconsidered determination within the timeframes, this failure will constitute an affirmation of its adverse reconsidered organization determination and PersonalCare must submit the file to the independent review entity within twenty-four (24) hours of the expiration of the timeframe.</i></p> <p>11. The Appeal Coordinator organizes all documentation relevant to the reconsideration request in the reconsideration case file as outlined in the independent review entity (Maximus Federal services, Inc.) Manual and documents in the Appeal tracking system.</p>
References	Medicare Managed Care Manual; Chapter 13
Attachments	<u>Letters:</u> M0003_08MAPD_PFFS_600 LateFileLtr,

**PersonalCare
Quality Improvement
Policy and Procedure**

Item	Description
	CVTY/NATL/A&G/004a, CVTY/NATL/A&G/001b, CVTY/NATL/A&G/011a (Letter 011a references CVTY/NATL/MBR/125a— replaced by cms1696), M0003_08MAPD_PFFS_596 ReconServ, CVTY/NATL/016, M0003_08MAPD_PFFS_597 ReconPayFav, CVTY/NATL/A&G/020b, M0003_08MAPD_PFFS_599 ReconServDenied, M0003_08MAPD_PFFS_602 ReqForRecon CVTY/NATL/A&G/010c
Flowcharts	Reconsideration Workflow

PersonalCare Quality Improvement Policy and Procedure

Attachments:



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