

**PersonalCare  
Quality Improvement  
Policy and Procedure**

**Policy:** Reconsideration by an Independent Entity      **Number:** MA100.05

**Date Effective:** 12/14/07      **Page** 1 of 5

**Approved By:**

Medical Director	Date	Director, Quality Improvement	Date
<b>Policy Review: (date)</b>			
12/14/07	11/14/08		
<b>Policy Revisions: (date)</b>			

Item	Description
<b>Purpose</b>	To ensure compliance with federal requirements and to provide a process to refer affirmed, in whole or in part, adverse organization determinations to the independent outside entity that contracts with the Centers for Medicare and Medicaid Services (CMS), Maximus Federal Services, Inc.
<b>Policy</b>	To maintain a mechanism that ensures issues that remain in dispute between [CHC] and the member after reconsideration are referred to Maximus.
<b>Responsibility</b>	PersonalCare Appeals Department & Quality Improvement Director
<b>Definitions</b>	<p><b>Appeal:</b> 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 PersonalCare, 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><b>Independent Review Entity:</b> 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</p>

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	<p>case to the independent review entity for a new and impartial determination concerning the payment or service at issue. Currently, CMS has contracted Maximus Federal Services, to perform this independent, outside review function.</p> <p><b>Member:</b> A member is an MA eligible individual who has enrolled in an MA plan 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><b>Organization Determination:</b> 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"> <li>(1) Payment for temporary out-of-area Renal Dialysis, emergency services, post-stabilization care, or urgently needed services.</li> <li>(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"> <li>(i) Are covered under Medicare; or</li> <li>(ii) If not covered under Medicare, should have been furnished, arranged for, or reimbursed by PersonalCare.</li> </ol> </li> <li>(3) PersonalCare’s refusal to provide or pay for services, in whole or in part, that the member believes should be furnished or arranged for by PersonalCare when the member has not received the services outside PersonalCare.</li> <li>(4) Discontinuation or reduction of a service, if the member believes that continuation of the service is medically necessary.</li> <li>(5) PersonalCare’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.</li> </ol> <p>The following individuals or entities may be a party to an organization determination:</p> <ol style="list-style-type: none"> <li>(a) The member (including his or her representative);</li> <li>(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);</li> <li>(c) The legal representative of a deceased member's estate; or</li> <li>(d) Any other provider or entity (other than PersonalCare) determined to have an appealable interest in the proceeding.</li> </ol>

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	<p><b>Reconsideration:</b> 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>
<b>Procedure</b>	<ol style="list-style-type: none"> <li>1. Where PersonalCare affirms its initial adverse organization determination, in whole or in part, PersonalCare automatically forwards the case file to Maximus so that it may make a final reconsideration determination.</li> <li>2. The Appeal Coordinator prepares a written explanation of an adverse organization determination using the format designated by Maximus and refers the adverse organization determination to Maximus.</li> <li>3. Maximus conducts the review as expeditiously as the member’s health condition requires not to exceed thirty (30) calendar days from receipt of the request for review for denials of service (or an additional fourteen (14) calendar days for extension is justified), or sixty (60) calendar days from receipt of request for review for denials of payment or within seventy-two (72) hours of PersonalCare’s request for reconsideration determination review for expedited cases.</li> <li>4. The Appeal Coordinator will concurrently notify the member of this action (Letter CVTY/ NATL/A&amp;G/ 010c).</li> <li>5. When Maximus makes the reconsidered determination, CMS’s independent review entity mails a notice of its reconsidered determination to the parties and sends a copy to CMS. This notice must: <ul style="list-style-type: none"> <li>• State the specific reasons for CMS’ independent review entity’s decisions;</li> <li>• If the reconsidered determination is adverse (that is, does not completely reverse PersonalCare’s adverse organization determination), inform the parties of their right to an Administrative Law Judge (ALJ) hearing if the amount in controversy meets the threshold requirement established annually by the Secretary;</li> <li>• Describe the procedures that the parties must follow to obtain an ALJ hearing; and</li> <li>• Comply with any other requirements specified by CMS.</li> <li>• Be written in understandable language.</li> </ul> </li> <li>6. If Maximus reverses PersonalCare’s organization determination in whole or in part, PersonalCare must authorize services under dispute within seventy-two (72) hours from the date it receives notice reversing the determinations, or provide the service</li> </ol>

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	<p>under dispute as expeditiously as the enrollee’s health condition requires, but not later than fourteen (14) calendar days from the date of receipt of the date it received notice reversing the organization determination.</p> <p>7. If Maximus reverses PersonalCare’s organization determination in whole or in part for a payment decision, the timeframe for payment effectuation is no later than thirty (30) calendar days from the date it receives notice reversing the determination.</p> <p>8. If Maximus overturns the plan’s organizational decision the Appeal Coordinator is responsible for ensuring that a referral authorization is entered into the information system or that any claims already received are reprocessed according to Maximus’ decision. The Appeal Coordinator makes the request to the appropriate department (UM or CSO) and receives verification when the referral and/or claims have been completed. The referral authorization or claim referral verification is documented in the case file.</p> <p>9. The Appeal Coordinator must also inform Maximus, in writing, that PersonalCare has effectuated the decision (Letter M0003_08MAPD_PFFS_604 ConfirmLtr).</p> <p>A reconsidered determination is final and binding on all parties. However, PersonalCare may request reopening of the case in accordance with Medicare regulations.</p> <p>10. The Appeal Coordinator enters the Maximus determination into the appeals database for record keeping.</p> <p>11. PersonalCare must include with the case file all discoverable documentation including the following:</p> <ul style="list-style-type: none"> <li>a. The initial PersonalCare determination notice.</li> <li>b. The member’s written request for appeal.</li> <li>c. If the request for appeal was late, address issue of good cause for later filing.</li> <li>d. All contested claims, bills or request for services, marked with date of receipt.</li> <li>e. All pertinent medical records, including, but not limited to, physician’s notes, nursing notes, progress reports, therapist notes, and discharge summaries. Include medical record if the issue involves emergency or urgently need care, level of care determination, medical necessity, etc.</li> <li>f. Copies of the evidence of coverage or other description of benefits if relevant.</li> <li>g. Copies of relevant passages from the Medicare Managed Care Manual or Medicare Regulations.</li> </ul>

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	<p style="text-align: center;">h. All correspondence between PersonalCare and the member and vice versa, relevant to the appeal request.</p> <p>12. Should the appeal case be referred to an ALJ for review, the health plan’s legal counsel, as appropriate, will represent PersonalCare in the appeal. The Appeal Coordinator should work directly with counsel to prepare the case.</p> <p>13. If Maximus’ determination is reversed in whole or in part by the ALJ, or at a higher level of appeal, PersonalCare must pay for, authorize, or provide the service under dispute as expeditiously as the member’s health condition requires, but no later than sixty (60) calendar days from the date it receives the notice reversing the organization determination.</p> <p>Appeal Coordinator must inform the independent outside entity that the organization has effectuated the decisions.</p>
<b>References</b>	CMS Medicare Managed Care Manual, Chapter 13
<b>Attachments</b>	CVTY/NATL/A&G/010c M0003_08MAPD_PFFS_604 ConfirmLtr
<b>Flowcharts</b>	N/A

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**Attachments:**



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consideration Upheld-



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