

**PersonalCare
Quality Improvement
Policy and Procedure**

Policy: Maximus Federal Services, Inc. Format **Number:** MA100.10

Date Effective: 11/14/08 **Page** 1 of 7

Approved By:

| Medical Director | Date | Director, Quality Improvement | Date |
|---------------------------------|-------------|--------------------------------------|-------------|
| Policy Review: (date) | | | |
| 12/14/07 | | | |
| Policy Revisions: (date) | | | |
| 11/14/08 | | | |

| Item | Description |
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| Purpose | The following information must be submitted with each Maximus Reconsideration Case file. The information is necessary for case administration and processing and provides Maximus information for a fair evaluation of the Reconsideration, tracking of cases, CMS compliance or policy considerations. The information is required. It is not recommended or optional, unless expressly noted as such. |
| Policy | <p>All sections of the Reconsideration Background Data Form (attached) are mandatory, as is each applicable element within a section, per the instructions below. Do not leave a mandatory section or data element blank if you are uncertain how to code it. Contact Maximus prior to completing the form.</p> <p>The form completion instructions, per Section and data element, are as follows:</p> <p>I. CASE CLASS Put an X in front of the appropriate case class. Note that some cases have 2 or more class components (e.g., both a standard service and standard claim component). Mark each case class that applies. Maximus will process the case at the “highest” class assigned by the MA.</p> <p>II. AMOUNT IN CONTROVERSY The amount in controversy is the actual or estimated liability to the appellant (enrollee, estate or non-contract provider who has executed a waiver of liability) if the MA’s adverse determination is upheld at IRE Reconsideration. This field is mandatory. Enter the amount in whole dollars only.</p> <p>III. ENROLLEE, PARTY AND REPRESENTATIVE DATA <u>Enrollee Name, Medicare Number and Telephone Number</u> Format name as Last, First, Middle. The Medicare number (“HIC number”) is</p> |

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| | <p>critical to Maximus administration. <u>Maximus is unable to initiate the case without the correct HIC number and therefore, will not recognize receipt of the case until the MA provides the correct HIC number. Provide enrollee telephone number, including area code, if available.</u></p> <p><u>Other/Supplemental Insurance Coverage</u> CMS has requested collection of this data.</p> <p><u>Enrollee Address</u> Provide the last known address even if the enrollee is deceased. Indicate whether the enrollee is living or deceased.</p> <p><i>The enrollee information is required even if the reconsideration is submitted by a non-contract provider or other authorized representative.</i></p> <p><u>Party</u> One category must be checked and only one category can apply. If a representative is appealing on behalf of an enrollee, the enrollee is still the party appealing.</p> <p>Check enrollee unless one of the following categories applies:</p> <ul style="list-style-type: none"> • <i>Estate of Enrollee</i> An authorized representative of an enrollee’s estate may request a reconsideration. • <i>Provider</i> A non-contract provider who is appealing in its own interest not that of the enrollee. To gain standing as an appellant, such a provider must complete a Waiver of Liability document that must be included in the case file. Consult the <i>Medicare Advantage Organization Medicare Managed Care Reconsideration Manual</i> for an example of a Waiver of Liability document. <p><u>Representative</u> Another person may represent an enrollee. Indicate whether there is a representative and the relationship of the representative to the party. Provide the representative’s address, to enable Maximus to send correspondence to that individual.</p> <p><u>Authorization for Representative or Party</u> If the enrollee is not the party, the MA must include appropriate authorization documentation (“appointment of representative”). An example of an appointment of representative form is contained in the <i>Medicare Managed Care Reconsideration Manual</i>.</p> <p><i>If the MA has attempted to obtain a representative authorization and has been unable to do so, the MA should indicate that the case is submitted for dismissal by</i></p> |

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| | <p><i>Maximus, by placing an X in the box indicating request for dismissal.</i></p> <p>If the enrollee is not competent to execute an appointment of representation, the MA is responsible for determining if the representative is authorized to act for the enrollee under State law. <i>If so, a person so authorized by the MA must complete the attestation under Item 2.</i></p> <p><u><i>Translation Request</i></u> Maximus will provide determination letters in languages other than English. If the enrollee requires the Maximus Reconsideration Determination Notice in a language other than English, please notify Maximus through the Reconsideration Background Data Form. The language in which the document must be translated must be included in the form.</p> <p>IV. MANAGED CARE ORGANIZATION DATA <u>MA Name and Identifying Data</u> Enter the name of the MA, the relevant product name, CMS Contract Number and identify the type of organization.</p> <p>Enter the exact address to which Maximus should send correspondence for this particular case (i.e., the Case Contact address). This may, or may not, be the address used by the MA to correspond with CMS for other purposes.</p> <p>V. CONTACT PERSON FOR THIS RECONSIDERATION The MA may designate any authorized individual to act as the liaison with Maximus for the submitted case. The MA may use different authorized individuals for different cases.</p> <p>Enter the name, title and contact information for the person acting as the point of contact for this particular case.</p> <p>VI. MANAGED CARE ORGANIZATION APPEAL CASE PROCESSING COMPLIANCE DATA The data entered in this section, including blank or missing data, is abstracted by Maximus exactly as provided and is then entered into a computer system used for reporting MA compliance to CMS. This reporting includes calculation of MA appeal processing timeliness, in comparison to timeliness standards set for in 42 CFR § 422.590.</p> <p>VI(A). ORGANIZATION DETERMINATION Include a copy of the Organization Determination Notice in the case file, in the location specified in the <i>Maximus Medicare Advantage Organization Medicare Managed Care Reconsideration Manual</i>. If the MA did not issue an Organization Determination Notice, provide an explanation in the same location. For Medicare Advantage Organizations, the Organization Determination Notice may be in one</p> |

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| | <p>of four CMS approved formats, depending upon the nature of the case:</p> <ul style="list-style-type: none"> • NODMAR • NONC • Notice of Denial of Payment (NDP) • Notice of Denial of Medical Coverage (NDMC) <p><u>Date of Request for Organization Determination</u> The MA should determine the “date of request” on the basis of the history and facts of the case and applying CMS regulations (42 CFR §422.566) that define such a request.</p> <p>Enter the date in MM/DD/YY format.</p> <p><u>Date of Organization Determination</u> Enter the date the Organization Determination was issued or, for NODMAR or SNF NONC, delivered to the enrollee. Use MM/DD/YY format.</p> <p><u>Did Enrollee Or Provider Make and Expedited Request for the Organization Determination?</u> Check “yes” or “no.” This response relates to the organization determination, not the subsequent request for an expedited reconsideration.</p> <p><u>Was the Expedited Request Granted?</u> Check “yes” if the MA expedited the case, <i>whether or not</i> the enrollee asked for the case to be expedited. “Yes” must be checked if the MA indicated the case class is “Expedited.” If “yes” is checked and/or the case class is expedited, Maximus will apply the timeframes for expedited case processing in reporting compliance to CMS.</p> <p>Check “no” if a request for expedited determination was not granted.</p> <p><u>Did the MA take a 14-day Extension?</u> CMS regulations (42 CFR §§422.568 and 422.572) permit the MA to take up to a 14-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 authorization determinations.</p> <p>Check “yes” if the MA purposefully took such an extension. Do not check “yes” if the MA was late in case processing for reasons other than an extension in the enrollee’s interest. If the MA checks “yes” Maximus will add 14 days in its calculation of MA timeliness. If “yes” is checked, the MA is obligated to issue a notice of extension to the enrollee, and this notice should be included in the case</p> |

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| | <p>file (See <i>Maximus Medicare Advantage Organization Managed Care Reconsideration Manual</i>).</p> <p>Check “no” if the MA did not purposefully take an extension. Check “NA” if the case class is Standard Claim Denial. (An extension is not available for this case class).</p> <p><u>Justification for Late Organization Determination</u> If the MA Organization Determination did not occur by the date, including any valid extension, established in 42 CFR §§422.568 and 422.572, the MA may enter an explanation for the delay.</p> <p><u>Did the Organization Determination Involve a Medical Necessity Determination?</u> Check “yes” or “no”. The purpose of this field is to indicate whether, based upon 42 CFR §422.590, a review by a physician was required.</p> <p><u>Name of the MD Making the Organization Determination</u> Write or print legibly the full name, or leave blank if an MD determination was not obtained or required. Maximus and CMS are not tracking the identify of MA decision makers. The purpose of this field is to permit comparison with the physician used at the MA Reconsideration level, to ascertain if the requirement for a different decision maker (42 CFR §422.590(g)) was met.</p> <p><u>Specialty of the MD Making the Organization Determination</u> Enter the specialty in which the medical decision maker is board certified or board eligible. Use of the American Board of Medical Specialty categories is recommended, but not required.</p> <p>VI(B). MA LEVEL RECONSIDERATION The data elements contained in this section parallel those sought for the Organization Determination. Apply the same instructions given for Organization Determination.</p> <p>VII. PROVIDER IDENTIFICATION DATA The purpose of this section is to assist Maximus in identifying <i>each</i> provider that is referenced in the MA's case file. MAs 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. MAs need not identify providers who are merely a part of the member's general utilization history (i.e., history unrelated to the denied services).</p> <p>Each provider is recorded in this section <i>only once</i>. If there are more than 5 providers, expand the table or attach a second sheet.</p> |

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| | <p>Complete the “Type”, “Specialty”, “Relationship to MA”, and “Medical Records” fields using the codes provided on the form for each of these fields. Indicate whether the provider is located in or out of the service area of the MA by use of a Yes or No in the “In Area” field. Indicate in the “Dates Covered by Records” field the first and last dates of service addressed in the medical records.</p> <p>The purpose of the Medical Records field is for Maximus to easily determine if records are found in the case file and, if not, whether the MA has attempted to obtain charts. If issues exist regarding sufficiency or availability of medical records, these issues should be discussed in the case narrative.</p> <p>VIII. DEFINITION OF DENIED SERVICES OR CLAIMS</p> <p>The purpose of this section is to provide Maximus with a succinct definition of the one, or more, denied claims or services addressed in the case file.</p> <p>A separate line should be completed for each discrete, or different, service that is contested in the Reconsideration. A service is “different” if it is sought from or rendered by a different provider, or consists of a different type of care, unrelated procedure, or item. It is not necessary to use a separate line to define multiple occurrences of the same service (e.g., different dates of physical therapy or days within an inpatient stay).</p> <p>Diagnosis and particularly procedure codes will assist Maximus to ensure that it is appropriately recognizing the contested treatment or item. However, these codes are not mandatory.</p> <p>The <u>brief description of denied item</u> should be a succinct definition of the service or item, which is contested. You need only define the denied item itself (e.g., “motorized wheel chair”). Do not attempt to provide background or explain arguments of the MA or the enrollee.</p> <p>The <u>service type code</u> is a new and important data element that will assist Maximus to assign the case. Note that the case should be assigned to the “first” code that applies. If the disputed service is “out of area” it should be coded to item 1, even if the content of the service matches a later code. Likewise, if the disputed service occurs in an in-area emergency episode, it should be coded 2. All other services are coded to the appropriate category.</p> <p>IX. ATTESTATION</p> <p>The attestation is now required as a means of MA certification that the information provided on the Medicare Managed Care Reconsideration Background Data Form and included within the case file is complete and accurate, to the best of the MAs knowledge.</p> |

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| | Completion of the Attestation is mandatory. |
| Responsibility | PersonalCare Appeals Department & Quality Improvement Director |
| References | Medicare Managed Care Manual; Chapter 13 |
| Attachments | Medicare Managed Care Reconsideration Background Data Form: |
| Flowcharts | N/A |