DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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MEDICARE ENROLLMENT & APPEALS GROUP

DATE: September 10, 2013

TO: Medicare Advantage Organizations, Medicare Health Care Prepayment Plans, and Medicare Cost Plans

FROM: Arrah Tabe-Bedward
Director, Medicare Enrollment & Appeals Group

SUBJECT: Change in Part C Reconsideration Dismissal Procedures

CMS is revising the current process requiring Medicare Advantage (MA) organizations and other Medicare health plans (collectively referred to as "plans") to automatically forward all reconsideration requests that the plans believe should be dismissed to the Part C independent review entity (IRE). Effective January 1, 2014, in addition to being responsible for dismissing reconsideration requests when appropriate and providing timely notification of dismissals to enrollees or another party, plans will also be responsible for informing enrollees and other parties about the right to request IRE review of the dismissal. Plans will no longer automatically forward such reconsideration cases to the IRE for review. CMS will issue revised manual provisions that correspond to the process changes outlined in this memo and will develop a model Notice of Dismissal for plans to use when notifying appellants that their reconsideration request is being dismissed. Until Chapter 13 of the Medicare Managed Care Manual is updated, effective January 1, 2014, the revised procedures in this memorandum supersede the current guidance regarding Part C dismissals.

Under the existing manual procedures related to dismissal of a reconsideration request, a dismissal is considered an adverse decision that must be forwarded to the IRE. However, in the case of a dismissal, the plan never performs a substantive review regarding coverage, because the procedural requirements for a valid request for plan reconsideration were not met. Therefore, we believe that a more appropriate interpretation and application of 42 CFR § 422.592 is that adverse decisions subject to auto-forwarding to the IRE should be limited to substantive decisions made on the merits of the case (a denial of coverage) and not include procedural actions such as dismissals. Thus, under the revised procedure described below, a dismissal of a reconsideration request by the plan does not constitute an adverse decision for purposes of applying 42 CFR § 422.592.

We believe this process improvement will be a more efficient use of both plan and IRE resources, while preserving an enrollee's or other party's right to have a dismissal of a reconsideration request reviewed by the IRE. We also believe the improved efficiencies of this revised process will result in reduced costs and operational burden for plans. Currently, the IRE affirms plans' determinations that a case should be dismissed in approximately 98 percent of the

dismissals forwarded by plans. The most common reasons for upholding the plans' dismissals are:

- Failure of the enrollee or other party to file a timely appeal request;
- No waiver of liability submitted with an appeal filed by a non-contract provider;
- Lack of proper appointment of representative documentation; or
- Failure to exhaust the prior level of adjudication.

Our expectation is that plans will redirect the resources currently used to automatically forward dismissals to other critical areas in the processing of plan level appeals, such as conducting timely outreach to providers to obtain clinical documentation necessary to approve coverage and ensuring that enrollees receive timely decision notices.

Revised Dismissal Procedures

Reasons for Dismissing a Request. Plans shall dismiss reconsideration requests under any of the following circumstances:

(1) An individual requests a reconsideration on behalf of an enrollee, but a properly executed appointment of representative form has not been filed and there is no other documentation to show that the individual is legally authorized to act on the enrollee's behalf per the guidance set forth in section 10.4.1 of Chapter 13. This does not relieve the plan of its obligation to make attempts to secure the missing documentation per section 10.4.1 prior to dismissal.

(2) A non-contract provider requests a reconsideration of a denied claim but fails to provide a waiver of liability statement indicating that the non-contract provider will not bill the enrollee regardless of the outcome of the appeal. See section 60.1.1 of Chapter 13. This does not relieve the plan of its obligation to make attempts to secure the missing documentation per section 60.1.1 prior to dismissal.

(3) The enrollee or other party fails to file the reconsideration request within the established timeframes and good cause for late filing has not been established. See section 70.2 and 70.3 of Chapter 13.

(4) A request for a standard pre-service reconsideration is made but the plan becomes aware that the enrollee has obtained the service before the plan completes its determination. See section 70.7.5 of Chapter 13.

(5) Any other circumstance where the plan lacks jurisdiction to review the case.

Notice of dismissal. If a plan dismisses a reconsideration request, the plan must send a written notice of the dismissal to the parties at their last known addresses within the applicable adjudication timeframe pursuant to the requirements of 42 CFR Part 422, Subpart M. The dismissal notice must state the reason for the dismissal and explain the right to request IRE review of the dismissal within 60 calendar days after receipt of the written notice of the plan's dismissal. Requests for IRE review of a plan's dismissal will be filed with the IRE. The

dismissal notice must explain that the request for review of the plan's dismissal should be filed with the IRE at the following address:

MAXIMUS Federal Services, Inc.
Medicare Managed Care & PACE Reconsideration Project
3750 Monroe Avenue, Suite 702
Pittsford, NY 14534-1302
Fax: 585-425-5292

Upon receipt of such request, the IRE will contact the appropriate plan to obtain the case file. Plans must assemble and forward the case file to the IRE within 24 hours of receiving the IRE's case file request.

Effect of Dismissal. The dismissal of a request for reconsideration is binding unless the enrollee or other party requests IRE review.

IRE review of MA organization dismissal. An enrollee or other party has a right to have a plan's dismissal of a reconsideration request reviewed by the IRE if the enrollee or other party files a request for an IRE review within 60 calendar days after receipt of the written notice of the plan's dismissal. If the IRE determines that the plan's dismissal was in error, the IRE vacates the dismissal and remands the case to the plan for reconsideration. The IRE's decision regarding a plan's dismissal is binding and not subject to further review.

The changes set forth in this memorandum must be implemented beginning January 1, 2014. The changes set forth in this memorandum apply exclusively to appeals processed in accordance with 42 CFR Part 422, Subpart M. Please send questions regarding this memorandum to Part_C_Appeals@cms.hhs.gov.