PURPOSE:

EXPLANATION:

The Centers for Medicare and Medicaid Services (CMS) has established policies for Medicare Advantage (MA) level organization determinations, reconsiderations and appeals. The Kaiser Foundation Health Plan of Washington MA level reconsideration process is one step in a larger multi-level Medicare Managed Care appeal process.

This document outlines the Kaiser Foundation Health Plan of Washington Medicare Advantage (MA) policy related to standard and expedited reconsiderations of adverse organization determinations. An adverse organization determination is defined as: a decision by a health plan to deny, modify, reduce, or terminate payment, coverage, authorization or provision of health care services or benefits including the admission to or continued stay in a facility.

Kaiser Foundation Health Plan of Washington will subject complaints about co-payments to the appeals process when a member believes that Kaiser Foundation Health Plan of Washington has required the member to pay an amount for a health service that should be the health plan’s responsibility.

POLICY:

This policy was established to address the requirements defined in Chapter 13 of the Medicare Managed Care Manual guidelines for member reconsiderations/appeals of adverse organizational determinations. (Section 70, 80, 90 and 100)

DESCRIPTION:

Kaiser Foundation Health Plan of Washington follows Chapter 13 Medicare Managed Care Manual guidelines for reconsiderations of adverse organizational determinations, in responding to and documenting all requests from Medicare Advantage (MA) members. Expedited reconsiderations/appeals (Section 80) are available in medically urgent situations when requested and the treating or reviewing physician, with knowledge of the member’s medical condition, determines that the member’s life, health, or ability to regain maximum function could be jeopardized, or that severe pain would be prolonged. Details of the Kaiser Foundation Health Plan of Washington appeals process and right to an expedited review are sent to members at initial enrollment, upon denial of an member request or an organization determination, upon member request and annually thereafter.
The independent review entity (IRE) must conduct the reconsideration as expeditiously as the member’s health condition requires and should observe the same time frames as required for Medicare health plans (Section 90).

PROCEDURES:

RECONSIDERATIONS (POST SERVICE)

1. If Kaiser Foundation Health Plan of Washington makes a reconsidered determination on a request for payment that is completely favorable to the member, written notice of its reconsidered determination is sent to the member and the claim is paid no later than 60 calendar days after receiving the reconsideration request. (RC-01) (70.7.3)

2. If Kaiser Foundation Health Plan of Washington affirms, in whole or in part, its adverse organization determination, or fails to provide the member with a reconsideration determination within 60 days of receipt of the request (which constitutes an affirmation of its adverse organization determination), the case is forwarded to CMS’ independent review entity no later than 60 calendar days after receiving the reconsideration request. Kaiser Foundation Health Plan of Washington concurrently notifies the member that the case has been forwarded the case to the IRE. (RC-02) (70.7.3)

3. If Kaiser Foundation Health Plan of Washington’s determination is reversed in whole or in part by the independent review entity, Kaiser Foundation Health Plan of Washington pays for the service no later than 30 calendar days from the date it receives the notice reversing the organization determination. Kaiser Foundation Health Plan of Washington must also inform the independent review entity that the organization has effectuated the decision. (140.2.3)

4. If Kaiser Foundation Health Plan of Washington’s determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, Kaiser Foundation Health Plan of Washington will authorize or provide the service under dispute as expeditiously as the member’s health requires, but no later than 60 days from the date it received notice of the reversal. (RC-03)

5. If Kaiser Foundation Health Plan of Washington requests MAC review of an ALJ decision, the organization may await the outcome of the review before paying for, authorizing or providing the service under dispute. If Kaiser Foundation Health Plan of Washington files an appeal with the MAC a copy of the appeal request and any accompanying documents are sent to the enrollee, and the IRE is notified that a MAC review has been requested. Whenever Kaiser Foundation Health Plan of Washington effectuates a decision the independent review entity is notified. (140.4)

6. Kaiser Foundation Health Plan of Washington accepts reconsideration requests from the member or their legal representative within 60 days of the formal written initial adverse organization determination unless ‘good cause’ is established and documented according to CMS requirements. If a member has additional or associated commercial coverage (PEBB, FEHB or other commercial plans) the timeframe for submission of the request follows whatever their coverage policy and plan rules allow.

RECONSIDERATIONS (PRE-SERVICE)
1. If Kaiser Foundation Health Plan of Washington makes a reconsideration of an adverse organization determination, on a standard pre-service request a decision is issued to the member (made and placed in the mail), as expeditiously as the member’s health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified, i.e. requested by the member or if Kaiser Foundation Health Plan of Washington justifies a need for additional information and documents how the delay is in the interest of the member). (RP-01) (70.7.1)

2. If upon reconsideration, Kaiser Foundation Health Plan of Washington overturns its adverse organization determination denying the member’s request for payment, Kaiser Foundation Health Plan of Washington issues its reconsidered determination and sends payment for the service to the member. This is mailed no later than 60 calendar days from the date the request for a standard reconsideration was received. (70.7.3)

3. If Kaiser Foundation Health Plan of Washington makes a reconsidered determination that affirms in whole or in part, its adverse organization determination, a written explanation is prepared and the complete case file documenting the service request is sent to the independent review entity contracted by CMS as expeditiously as the member’s health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). Kaiser Foundation Health Plan of Washington also concurrently notifies the member of this action. (RP-02) (80.4)

4. For requests for payment, the Medicare health plan must forward the member’s case file to the independent review entity no later than 60 calendar days from the date it receives the request for a standard reconsideration (80.4). If Kaiser Foundation Health Plan of Washington’s determination is reversed in whole or in part by the independent review entity, Kaiser Foundation Health Plan of Washington authorizes the service within 72 hours from the date the notice reversing the determination is received. The service is provided as quickly as the member’s health requires (but no later than 14 calendar days from that date). Kaiser Foundation Health Plan of Washington also informs the independent review entity that the decision has been effectuated. (RP-03) (140.2.1)

5. If Kaiser Foundation Health Plan of Washington’s determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, Kaiser Foundation Health Plan of Washington authorizes or provides the service under dispute as expeditiously as the member’s health requires, but no later than 60 days from the date it received notice of the reversal. (RP-03) (140.2)

EXPEDITED RECONSIDERATIONS (PRE-SERVICE)

1. Kaiser Foundation Health Plan of Washington documents all oral requests for expedited reconsiderations in writing, and maintains the documentation in a case file. Processes are in place to ensure that members have efficient and convenient means to submit oral or written requests for expedited reconsiderations. (RP-04) (80.1)

2. Kaiser Foundation Health Plan of Washington makes decisions about whether to expedite a reconsideration based on regulatory requirements quickly. If Kaiser Foundation Health Plan of Washington decides not to expedite a reconsideration, the request is automatically transferred to the standard reconsideration process timeframe. The determination is made as expeditiously
as the member’s health condition requires, but no later than within 30 calendar days from the date that the request for the expedited reconsideration was received. Prompt oral notice is provided to the member of the decision not to expedite, and written notice including explanation of the member’s rights is provided within 3 calendar days of the oral notice. (80.1) If Kaiser Foundation Health Plan of Washington expedites the reconsideration, the determination is made and the member notified as expeditiously as the member’s health requires, but no later than 72 hours from the time the request for reconsideration was received (or an additional 14 calendar days if an extension is justified). (80.1) Although CMS allows plans to notify the member or the physician orally or in writing, the member must be notified within the 72 hour time frame. Mailing the notice within 72 hours is insufficient. (80.1) If Kaiser Foundation Health Plan of Washington notifies the member of its fully favorable expedited determination orally, written confirmation is mailed to the member within 3 calendar days of the oral notification. (80.1) If Kaiser Foundation Health Plan of Washington affirms, in whole or in part, its adverse expedited organization determination, the case is forwarded to CMS’ independent review entity as expeditiously as the member’s health requires, but not later than 24 hours after the decision. (80.4) If Kaiser Foundation Health Plan of Washington fails to provide the member with the results of its reconsideration within the timeframes specified above (as expeditiously as the member’s health condition requires or within 72 hours), this failure constitutes an adverse reconsideration determination, and Kaiser Foundation Health Plan of Washington submits the file to CMS’ independent review entity within 24 hours. Kaiser Foundation Health Plan of Washington concurrently notifies the member in writing that it has forwarded the case file to CMS’ independent review entity. (RP-05) (80.2)

3. If Kaiser Foundation Health Plan of Washington decides not to expedite a reconsideration, the written notice of the decision not to expedite (that follows the oral notice) informs the member of the following:
   a. That the request will be processed using the standard timeframe of 30 days.
   b. That the member has the right to file an expedited grievance if he or she disagrees with the decision not to expedite.
   c. That the member has the right to resubmit a request for an expedited reconsideration and that with any physician’s support indicating that applying the standard time frame for making a determination could seriously jeopardize the member’s life, health or ability to regain maximum function, the request will be expedited automatically.
   d. Instructions about the Kaiser Foundation Health Plan of Washington grievance process and its timeframes (RP-06) (80.1)

4. If Kaiser Foundation Health Plan of Washington’s determination is reversed in whole or in part by the independent review entity, Kaiser Foundation Health Plan of Washington will authorize or provide the service under dispute as expeditiously as the member’s health requires but no later than 72 hours after the date that the notice reversing the determination is received. Kaiser Foundation Health Plan of Washington also informs the independent review entity that the decision has been effectuated. (140.2.2)

5. If Kaiser Foundation Health Plan of Washington’s determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, Kaiser Foundation Health Plan of Washington authorizes or provides the service under dispute as expeditiously as the member’s health requires, but no later than 60 days from the date notice of the reversal was received. Kaiser Foundation Health Plan of Washington also informs the independent outside entity that the decision has been effectuated. (140.3) (RP-07)
6. If Kaiser Foundation Health Plan of Washington grants an extension on a reconsideration, the written notice to the member includes the reasons for the delay, and informs the member of the right to file an expedited grievance if he or she disagrees with the decision to grant an extension. (RP-08) (70.7.1)

**Member Appeals Coordinator Responsibility**

- All reconsiderations are reviewed by a person(s) not involved in the initial determination, and not a subordinate of the initial reviewer.
- Collects, documents and analyzes all information relevant to the member’s request.
- Conducts a thorough investigation and documents findings.
- Assists the member with the reconsideration process as needed-access is ensured for members who have limited English, literacy problems or who have physical or mental disabilities that may impede their ability to file an appeal.
- Determines and documents coverage criteria using the member’s Evidence of coverage and Medicare rules that reference the benefit provision, guideline, protocol or other similar criterion on which the appeal decision is based.
- Ensure continued coverage is provided under the member’s medical benefit for concurrent care decisions for ongoing course of treatment pending the outcome of the appeal.
- Notifies the member of the decision using approved communication documents and future appeal rights.
- If a members request is granted, in part or in full, the Coordinator is responsible for assuring and coordinating the implementation of the decision.
- The member or legal representative will be provided, upon request and at no cost, access to and copies of all documents, records, and other information relevant to their reconsideration request.
- The member or their legal representative may submit written comments, documents, or other information relating to the appeal. Members are informed of this right, as well as the submission process, in the initial adverse organizational determination notification.

**Clinical Reviewer**

- All reconsiderations that require clinical expertise will be reviewed by a clinician(s) not involved in the initial determination, and not a subordinate of the initial reviewer.
- The clinical reviewer determines and documents medical criteria using Medicare rules and healthplan criteria and policy.
- The reconsideration is reviewed by a clinician who has appropriate expertise (same or similar specialty) in the field of medicine that encompasses the member’s condition or disease.
- The case notes include the title and credentials of the clinical reviewer when an adverse determination is upheld.

**Party(ies) to a Reconsideration**

- Kaiser Foundation Health Plan of Washington Medicare Advantage members or their authorized representative must submit a written request for a reconsideration of an adverse organization within 60 days of the issuance of the determination.
If a member has assigned a legal representative or other party to act on their behalf or another party has DPOA or other appropriate legal documentation they may file a reconsideration request on behalf of the member. If a representative does not have appropriate legal documentation in effect, the coordinator informs them of the requirements before a reconsideration can be documented and investigated.

APPLICABILITY:

This policy applies to standard and expedited member reconsiderations and organization determinations for Kaiser Foundation Health Plan of Washington Medicare Advantage (H5050) and Kaiser Foundation Health Plan of Washington Options PPO Medicare Advantage plan (H2810).

SCOPE:

This policy applies to the handling of a member's, or his/her representative (including the referring or referred-to physician), request to modify a previous organizational determination made by the health plan. When an adverse organizational determination is upheld at the Kaiser Foundation Health Plan of Washington Medicare Advantage reconsideration level, the reconsideration case file is automatically forwarded by the Kaiser Foundation Health Plan of Washington Reconsiderations Coordinator to CMS's contracted Independent Review Entity for the next level of review.

RESPONSIBILITIES:

TRAINING:

A comprehensive training presentation will be offered to staff involved in coverage decisions, appeals and grievances and customer service representatives yearly and upon hire. Participation in this training will be a requirement.

AUDIT:

Management will assure an internal audit of Medicare Member Appeals cases.

Health Plan Operations Compliance is responsible for implementation and oversight of this procedure and process.

DEFINITIONS:

Reconsideration: Any of the procedures that deal with the review of adverse organization determinations on the health care services a member (enrollee) 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 member(enrollee)), or on any amounts the member(enrollee) must pay for a service as defined in 42 CFR 422.566(b). These procedures include reconsideration by the Medicare health plan and if necessary, an independent review entity, hearings before Administrative Law Judges (ALJs), review by the Medicare Reconsiderations Council (MAC), and judicial review.

Complaint: Any expression of dissatisfaction to a Medicare health plan, provider, facility or Quality Improvement Organization (QIO) by a member (enrollee) made orally or in writing. This can include concerns about the operations of providers or Medicare health plans such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, the respect paid to members (enrollees), the claims regarding the right of the member (enrollee) to receive services
or receive payment for services previously rendered. It also includes a plan’s refusal to provide services to which the member (enrollee) believes he or she is entitled. A complaint could be either a grievance or a reconsideration, or a single complaint could include elements of both. Every complaint must be handled under the appropriate grievance and/or reconsideration process.

**Effectuation:** Compliance with a reversal of the Medicare health plan’s original adverse organization determination. Compliance may entail payment of a claim, authorization for a service, or provision of services.

**Member:** A member is a Medicare Advantage or Medicare Advantage Part D enrollee who has elected a Medicare Advantage or Medicare Advantage Part D plan offered by an MA or MA-PD organization, or a Medicare Advantage or Medicare Advantage Part D enrollee who has elected a cost plan or HCPP.

**Grievance:** Any complaint or dispute, other than one involving an organization determination, expressing dissatisfaction with the manner in which a Medicare health plan or delegated entity provides health care services, regardless of whether any remedial action can be taken. A member (enrollee) or their representative may make the complaint or dispute, either orally or in writing, to a Medicare health plan, provider, or facility. An expedited grievance may also include a complaint that a Medicare health plan refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration time frame. In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.

**Independent Review Entity:** An independent entity contracted by CMS to review Medicare health plans’ adverse reconsiderations of organization determinations.

**Medicare Advantage Plan:** A plan as defined at 42 CFR. 422.2 and described at 422.4.

**Medicare Health Plan:** Collective reference to Medicare Advantage Plans, Cost Plans, and Health Care Prepayment Plans (HCPPs).

**Organization Determination:** Any adverse benefit determination made by a Medicare health plan with respect to any of the following:

- Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services,
- Payment for any other health services furnished by a provider other than the Medicare health plan that the member believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by the Medicare health plan,
- The Medicare health plan’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 the Medicare health plan,
- Discontinuation of a service if the member believes that continuation of the services is medically necessary, or
- Failure of the Medicare health plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the member with timely notice of an adverse determination, such that a delay would adversely affect the health of the member.
REFERENCES:

- Medicare Managed Care Manual Chapter 13

Medicare Advantage Part C - Standard Reconsiderations of an Adverse Decision

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Related Policies, Documents and References:

Medicare Advantage Part C - Standard Reconsiderations of an Adverse Decision

Documents which refer to this document:

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