blue california
Promise Health Plan

Policy Title: Medicare Beneficiary Denial Notices		POLICY #: 50.2.31 Line of business: Medicare Adv	
Department Name: Utilization Management	**Original Date** 7/13	**Effective Date** 5/19	**Revision Date** 12/18
Department Head: Sr. Director, UM		**Date: 3/21**	
Medical Services/P&T Committee: (If Applicable)		**Date: 3/21**	

PURPOSE

To establish procedures for ensuring appropriate notification letters are sent to enrollees for adverse or partially adverse organization determination.

POLICY

Blue Shield of California Promise Health Plan (Blue Shield Promise) complies with the CMS requirements in the processing of adverse or partially adverse organization determination. (Refer to UM P&Ps 50.2.20, Expedited Organization determination and 50.2.22, Standard Organization determination).

Blue Shield Promise Health Plan's Utilization Management Department uses CMS-approved notification letters for all determinations for requests for medical services.

PROCEDURE

Only licensed physicians can make partially or fully adverse decision on the initial review of the request. The physician has a current and unrestricted license, has sufficient expertise in the scope of practice of his or her profession, and has adequate knowledge of Medicare's local and national coverage criteria for making determination.

Blue Shield Promise Health Plan utilizes CMS-approved standardized notice forms, which include the following:

- The specific reason for the denial that takes into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any;
- Information regarding the enrollee's right to a standard and expedited reconsideration and the right to appoint a representative to file an appeal on the enrollee's behalf;
- For service denials, a description of both the standard and expedited reconsideration processes and time frames, including conditions for obtaining an expedited reconsideration, and the other elements of the appeals process;
- For payment denials, a description of the standard reconsideration process and time frames, and the rest of the appeals process; and
- The beneficiary's rights to submit additional evidence in writing or in person.

Delegated Activities to the Hospitals:
Blue Shield Promise Health Plan delegates the hospitals to perform these 2 activities:

- Important Message from Medicare (IMM) about Your Rights

This notice is issued by the hospital if the patient no longer meets the criteria for acute, inpatient hospital stay.

- Detailed Notice of Discharge (DND)

This notice is used by the patient to express dissatisfaction with the discharge decision by the hospital. This is triggered by the IMM.

- Oversight of the Delivery of DND:

Blue Shield Promise Health Plan ensures that the Detailed Notice of Discharge forms are properly and promptly executed. When Blue Shield Promise is alerted by a call from the QIO regarding the delay or improper execution of DNDs, the respective hospital is notified and informed of Blue Shield Promise's responsibility to ensure compliance with the timeliness and accuracy of the DND letters, in accordance with the Chapter 13 of the CMS' Medicare Managed Care Manual.

DEFINITIONS:
Adverse Organization Determination
Decision of the Medicare plan not to provide for nor pay for a requested service, in whole or in part.

REFERENCES

- 42 CFR 422.570, 422.566(b)(3)
- Chapter 13, Medicare Managed Care Manual

Care1st - Medicare Advantage
Member Notification Templates, Descriptions and Timeframes

Notice Type	When is it used?	Timeframe
Integrated Denial Notice (IDN)	To inform member when coverage of requested service or payment is being denied, in whole or in part. Provides member with the right to an appeal.	Issue NDMC within 14 calendar days (standard) or within 72 hours (expedited) after receipt of request.
Informational Letter to Beneficiary and/or Provider/Physician Carve-Out Letter	To inform member when a service is provided by an entity other than the provider group and how to arrange for the requested service. Not a denial of service; does not inform member of appeals process.	Issue Informational Letter within 14 calendar days after receipt of request.
Notice of Medicare Non-Coverage [NOMNC]	To notify member when SNF, HH, or CORF services are ending. Provides member the opportunity to request expedited review from QIO.	Issue no later than 2 calendar days or 2 visits prior to proposed termination of services. If expected LOS is 2 days or less, give notice on admission.
Detailed Explanation of Coverage [DENC]	When the QIO review is requested. Provides member detailed explanation why Medicare coverage should end. Serves as a confirmation (indirectly from QIO) that member appealed the decision. Triggered by NOMNC letter. Issued by the organization that issued the NOMNC letter.	Issue to QIO **and** member on the same day the delegate was notified of the appeal.
Notice of Reinstatement of Coverage	To notify member when a denial has been reversed and coverage of SNF, HH, or CORF services will be continued. Optional form	
MA-Extension - Standard	Used to notify the member and provider when the timeframe for making a decision cannot be met.	**Standard** - give notice **in writing,** within 14 calendar days of receipt of request. (Maximum extension is **14+14** calendar days from initial date of receipt of request).

Care1st - Medicare Advantage
Member Notification Templates, Descriptions and Timeframes

Notice Type	When is it used?	Timeframe
MA-Extension - Expedited	Provides information regarding expedited oral or written grievance process with Care1st.	**Expedited**: Give notice in writing, within 72 hours of receipt of request (Maximum extension is **72 hours + 14 calendar days** from the date the request is received.
MA-Expedited Criteria Not Met	When a request for expedited review does not meet criteria for expedited review. Informs member that the request will be processed no later than 14 calendar days after the date of receipt of request. Informs member of the right to resubmit a request for an expedited determination. Informs about member's right to file an expedited oral or written grievance with Care1st regarding the decision not to expedite the review.	Give oral notice to member within 72 hours followed by written notice within 3 calendar days of oral notice.
Important Message from Medicare [IMM]	Hospital admission notice Given to alert all Original Medicare & MA beneficiaries of their appeal rights at discharge from a hospital stay.	Issue within 2 calendar days of admission or not more than 2 calendar days prior to discharge.
Detailed Notice of Discharge [DND]	When a hospital inpatient expresses dissatisfaction with the discharge decision or the organization no longer intends to cover services at the inpatient hospital level of care. Triggered by Important Message from Medicare letter (IMM) Issued by either the hospital or health plan/full risk organization. Serves as a confirmation (indirectly from QIO) that member appealed termination of services. Provides detailed explanation why the hospital services are either no longer reasonable and necessary or are no longer covered.	Issue to both QIO and member as soon as possible but no later than noon of the day after notification by the QIO.
	Provides description of any applicable Medicare coverage rules, instructions, or other Medicare policy Provides information about how the member may obtain a copy of the Medicare policy from the MA organization.	

Notice Type	When is it used?	Timeframe
	Provides any applicable Medicare health plan policy, contract provision, or rationale upon which the discharge determination was based. Includes facts specific to the member and relevant to the coverage determination sufficient to advise the member of the applicability of the coverage rule or policy to the member's case.	
	Note: May be used by Care1st Health Plan or full-risk groups.	