

APPENDIX: PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) ORGANIZATION RECONSIDERATION PROCEDURES MANUAL FORMS & INSTRUCTIONS

MAY 2026, VERSION 1.0

Forms & Instructions Included in this Appendix:

1. *Instructions for PACE Reconsideration Background Data Form and Case Narrative*
2. *PACE Reconsideration Background Data Form*
3. *Appointment of Representative Statement*
4. *New Case File Transmittal Cover Sheets for PACE Participant Reconsideration Requests to the IRE*
5. *PACE Organization Response to IRE Request for Additional Documentation Transmittal Cover Sheet*
6. *Statement of Compliance Form-IRE Reconsideration Decision*
7. *PACE Organization Reopening Request Form*
8. *PACE Organization Submission of Additional Information Authorizing Coverage or Payment for an Item, Service, or Part B Drug Subsequent to the PACE Organization Submission of the Case and Case File to the IRE for Processing of the IRE Reconsideration*
9. *Key PACE Organizational Contact Form*

SECTION 1:

INSTRUCTIONS FOR THE PACE RECONSIDERATION BACKGROUND DATA FORM AND CASE NARRATIVE

INSTRUCTIONS FOR COMPLETION OF: PACE RECONSIDERATION BACKGROUND DATA FORM AND CASE NARRATIVE

1.0 General Organization of Submitted New Case File Material

Consult the appropriate C2C PACE Organization (PO) Reconsideration Process Manual for general instructions on Reconsideration case file development. The instructions that follow apply to completion of the mandatory:

- Reconsideration Background Data Form
- Case Narrative

2.0 Instructions for Completion of Reconsideration Background Data Form

The PO must submit a completed Reconsideration Background Data Form with each new IRE Reconsideration case file. The form provides C2C with information necessary for case administration and processing. In addition, C2C directly reports to CMS certain data entered on the form by the PO. C2C will report this data as given by the PO on the Reconsideration Background Data Form and will not attempt to correct errors or omissions.¹

POs may develop their own “local” version of the Reconsideration Background Data Form, for example to modify spacing or accommodate electronic completion. Prior to implementation, the PO should submit any proposed local version to C2C the C2C Plan Liaison for review: PartC-Plan_Liaison@c2cinc.com.

We recommend that the PO type all entries into the Reconsideration Background Data Form. If not, the person completing the form should write legibly and print if necessary.

The required format for all “date” entries is MM/DD/YY.

All sections of the Reconsideration Background Data Form are mandatory, as is each applicable element within a section, according to the instructions below. Do not leave a mandatory section or data element blank if you are uncertain how to code it. If you have questions about any sections, please contact C2C’s Plan Liaison prior to completing the form: PartC-Plan_Liaison@c2cinc.com.

¹ For certain compliance data elements (e.g. dates for PO appeal activity), C2C reports to CMS both the dates provided by the PO on the Reconsideration Background Data Form and, separately, any discrepancy noted by C2C based upon other case file material. For example, C2C would report a discrepancy to CMS if the date on a notice document did not correspond to the date entered for that notice on the Background Data Form.

The form completion instructions, per Section and data element, are as follows.

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. C2C will process the case at the “highest” class assigned by the PO.

II. ENROLLEE AND REPRESENTATIVE DATA

Enrollee Name, Medicare Number and Telephone Number

- Format name as Last, First, Middle.
- Provide the full HIC or MBI number. The Medicare number (“HIC/MBI number”) is critical to C2C administration. C2C is unable to initiate the case without the correct HIC or MBI number and therefore will not recognize receipt of the case until the PO provides the correct HIC or MBI number.
- Provide enrollee telephone number, including area code, if available.

Enrollee Address

- Provide the last known address even if the enrollee is deceased. Indicate whether the enrollee is living or deceased.
- The enrollee information is required even if the reconsideration is submitted by an authorized representative.

Representative

- Another person may represent an enrollee. The PACE Organization is responsible to verify that the representative is the appropriate designated represented for the enrollee. Provide the representative’s address, to enable C2C to send correspondence to that individual.

Translation and Alternate Format Requests

- C2C will provide determination letters in languages other than English. If the enrollee requires the C2C Reconsideration Determination Notice in a language other than English, please notify C2C through the Reconsideration Background Data Form. The language in which the document must be translated must be included in the form.
- C2C will arrange for communication with enrollees in an alternate format if required. If the enrollee requires the C2C correspondence in an alternate format, notify C2C through the Reconsideration Background Data Form. The required alternate format must be included in the form.

III. PACE ORGANIZATION DATA

PO Name and Identifying Data

- Enter the name of the PO and the CMS Contract Number. Enter the exact address to which C2C should send correspondence for this particular case (i.e., the Case Contact address). This may, or may not, be the address used by the PO to correspond with CMS for other purposes.

Contact Person for This Reconsideration

- The PO shall designate an authorized individual to act as the liaison with C2C for the specific submitted case. The PO may use different authorized individuals for different cases.
- Enter the name, title and contact information for the person acting as the point of contact for this particular case.

IV. PACE ORGANIZATION PROCESSING DATES

IV(A). Organization Determination

Date of Request for Service Determination

- The PO should determine the “date of Service Determination request” on the basis of the history and facts of the case.
- Enter the date in MM/DD/YY format.

Did the PO take a 5-day Extension?

- CMS regulations (42 CFR §460) permit the PO to take up to a 5-day extension in making the service determination at the participants request or if the extension is taken “in the enrollee’s interest.”
- Check “yes” if the PO purposefully took such an extension. Do not check “yes” if the PO was late in case processing for reasons other than an extension in the enrollee’s interest. If the PO checks “yes” C2C will add 5 days in its calculation of PO timeliness.
- Check “no” if the PO did not purposefully take an extension.

Date of Service Determination

- Enter the date the Service Determination was issued using the MM/DD/YY format.

VI(B). PO Appeal Determination

Date of Request for PO Appeal

- The PO should determine the “date of PO Appeal request” on the basis of the history and facts of the case.
- Enter the date in MM/DD/YY format.

Did Enrollee or Provider Make an Expedited Request for an Expedited PO Appeal?

- Check “yes” or “no.”

Was the Expedited Request Granted?

- Check “yes” if the PO expedited the case, whether or not the enrollee asked for the case to be expedited. “Yes” must be checked if the PO indicated the case class is “Expedited.” If “yes” is checked and/or the case class is expedited, C2C will apply the timeframes for expedited case processing in reporting compliance to CMS.
- Check “no” if a request for expedited determination was not granted.

Did the PO take a 14-day Extension?

- CMS regulation (42 CFR §460.124) permit the PO to take up to a 14-day extension in making the expedited Appeal Determination if the extension is taken “in the enrollee’s interest.”
- Check “yes” if the PO purposefully took such an extension. Do not check “yes” if the PO was late in case processing for reasons other than an extension in the enrollee’s interest. If the PO checks “yes” C2C will add 14 days in its calculation of PO timeliness.
- Check “no” if the PO did not purposefully take an extension.

Date of PO Appeal Determination

- Enter the date the PO Appeal Determination was issued using the MM/DD/YY format.

IV(C). REQUEST FOR IRE REVIEW

Date of Request for IRE Review

- The PO should provide the date on which the enrollee requested IRE review of the appeal based on the history and facts of the case.
- Enter the date in MM/DD/YY format.

Did Enrollee or Provider Make an Expedited Request for an Expedited IRE Review?

- Check “yes” or “no.”

Date PO Case File sent for IRE Review

- The PO should provide the date on which the PO reconsideration case file was prepared and sent to the IRE for an independent review of the appeal.
- Enter the date in MM/DD/YY format.

V. DESCRIPTION OF ITEM OR SERVICE IN DISPUTE

V(A). DEFINITION OF DENIED ITEMS

Description of Item or Service in Dispute

- The purpose of this section is to provide C2C with a succinct definition of the one, or more, denied claims or services addressed in the case file.
- 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).
- The brief description of denied item should be a succinct definition of the service or item, which is contested. You need only define the denied item itself (e.g., “motorized wheelchair”). Do not attempt to provide background or explain arguments of the PO or the enrollee.

Estimated Dollar Amount in Dispute

- Enter the dollar amount in dispute. If the actual dollar amount is unknown, please provide a best estimate.

Dates of Service

- For disputes regarding services not yet provided, leave blank. For disputes regarding payment for services already received, list date(s) on which the service was provided.

V(B). PROVIDER IDENTIFICATION

- The purpose of this section is to assist C2C in identifying each provider that is referenced in the PO’s case file. POs 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. POs need not identify providers who are merely a part of the member’s general utilization history (i.e., history unrelated to the services denied).
- Each provider is recorded in this section only once. If there are more than 5 providers, expand the table or attach a second sheet.
- Complete the “Type”, “Specialty”, “Relationship to PO”, 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 PO by use of a Yes or No in the “In Area” field.

- The purpose of the Medical Records field is for C2C to easily determine if records are found in the case file and, if not, whether the PO has attempted to obtain charts. If issues exist regarding sufficiency or availability of medical records, these issues should be discussed in the case narrative.

VI. ATTESTATION

- The attestation is required as a means of PO certification that the information provided on the PACE Organization Reconsideration Background Data Form and included within the case file is complete and accurate, to the best of the PO's knowledge.
- Completion of the Attestation is mandatory.

3.0 CASE NARRATIVE

The outline for the required Case Narrative is contained on page 4 of the Reconsideration Background Data Form for reference only. The PO should supply Case Narrative as a document separate from (not attached to) the Reconsideration Background Data Form. The Case Narrative must be typed.

The mandatory sections of the Case Narrative are:

- Case Summary
- Chronology of Care
- Enrollee's Arguments for Coverage
- PO Reason for Service or Claim Denial

I. CASE SUMMARY

- Briefly describe the relevant medical history and current condition, including significant changes in status, of the enrollee. Explain how the enrollee came to request the service(s) that the PO denied.
- Provide an exact description of the item(s) requested by the enrollee and denied by the PO that are contested in the appeal. Include any relevant technical definition of the denied item that facilitates research regarding CMS coverage policies. If the PO has offered to provide alternative or partial care, and this is important to understand the context of the denial, explain.
- The purpose of the summary is to orient the C2C reviewers and condense the information provided in the following sections. The summary should not exceed a paragraph or two.

II. CHRONOLOGY OF CARE

- Define those events that are relevant to an understanding of the enrollee's needs or demands, and how the PO has attempted to respond. Emphasize meaningful

communication, not length. It is not necessary that the Chronology repeat appeal processing dates, which are provided on the Reconsideration Background Data form.

- The Chronology should be presented in a Date/Event format:

DATE	EVENT

- Examples of events that a well-written Chronology might contain are:
 - Onset of enrollee’s illness or condition (as related to the appeal).
 - Episodes of care, or care seeking behavior, prior to but related to the appeal itself
 - Consultations by which the enrollee becomes aware of, or requests, the denied service
 - How the PO responded to the enrollee’s request
 - Episodes of care, or care seeking behavior, of the enrollee related to the appeal, but subsequent to the PO denial or reconsideration

III. ENROLLEE’S ARGUMENTS FOR COVERAGE

- C2C assumes the PO has provided the enrollee, (or non-contract provider if such provider is the party), with an opportunity to provide input in person, in writing or by phone. In addition, the enrollee may have a formal representative or may have obtained letters or other evidence of support from PO, or non-PO, providers. “Provider support” is deemed to include a provider’s prior authorization request, unless there is clear documentation that the provider who filed the request did not support it.²
- The PO must provide a faithful summary of each argument advanced by the enrollee and, separately, each argument advanced by a representative or other person supporting the appellant’s case. Reference and attach each document in which such an argument is advanced.
- Note that if C2C identifies a valid argument made by an enrollee or supporting person, and that argument is not acknowledged by the PO, C2C may overturn the PO denial without seeking clarification (i.e., without a Request for Additional Information).

IV. PO RATIONALE FOR SERVICE OR CLAIM DENIAL

² A provider might submit a prior authorization request to satisfy the demand of an enrollee, but without that provider’s endorsement. The PO would have to provide actual documentation of the provider’s lack of endorsement (e.g. a letter from that provider). A general statement, “the provider did not support the request” is not sufficient.

IV(A). SUMMARY STATEMENT OF REASON FOR DENIAL

Provide a one or two sentence statement of the PO's primary reason(s) for denial. Do not list every conceivable reason for the denial (e.g., "not covered", "not emergent" "not urgent" "not medically necessary" and "not authorized"). List only those reasons applicable to the current case. C2C has found that the following terminology for denial reasons is useful for POs. However, POs may indicate their reasons for denial in any terms the PO chooses.

- **Not Enrolled:** The PO's records indicate the member was not enrolled on the date(s) that would obligate the PO to cover the disputed service.
- **Not a Covered Benefit:** The service or item in question is not covered under the member's contract under any normal circumstances (e.g. acupuncture).
- **Exceeded Coverage:** The service is a covered benefit, but the enrollee has exceeded limits set in the subscriber agreement (e.g., covered days, visits or a dollar cap).
- **Not Justified by PO Delay or Withholding of Care:** The service was obtained by the enrollee without authorization or out of network on the argument that the PO delayed or withheld medically necessary care. The PO disputes this argument.
- **Not The Treatment Option (Or Provider) Approved by PO:** Applies to a case in which the enrollee seeks (pre-service) or sought (claim denial) a form of treatment that the PO might recognize as medically appropriate, but the PO seeks to limit coverage to an alternative appropriate treatment (or provider).
- **Not Skilled Care:** The basis for denial when care is deemed custodial or fails to meet other Medicare qualifying criteria.
- **Not Authorized:** Care not approved in compliance with the PO's authorization procedures. Usually, this reason is secondary or complementary to an above reason.
- **Not Medically Necessary:** A service which is covered by the PO, but which the PO determines fails to meet the definition of reasonable and necessary (42 CFR §411.15).
- **Not A PO Provider:** The service sought or obtained by the member was or will be rendered by a provider who is not under contract with the PO or who is not a provider within a defined network available to that member.

IV(B). JUSTIFICATION

The contents of the PO's justification will vary based upon its primary reason for denial. However, it is important that the PO justification not only states the PO's position but also offer a specific rebuttal to each argument advanced by the enrollee, representative, or supporting provider.

DENIALS ON ISSUES OF COVERAGE

- If the PO denies based on coverage, the PO must justify its denial by review and interpretation of the applicable Medicare regulations, guidelines, policies or PO subscriber agreement. The PO must include a copy of the applicable Medicare regulation, guideline policy or provide the exact citation. The citation must be made directly to the applicable federal policy text (e.g., 42 CFR §XXXXX). Do not make citations to secondary sources (e.g., CCH, St. Anthony's Medicare Guide, etc.).

- If the PO cites its *evidence of coverage*, it must provide a complete copy of that subscriber agreement.

Disputes On Matters of Fact

In some cases, the appealing party and PO may disagree on matters of fact (e.g., whether the member called for prior authorization on a given date). If the appellant has raised a factual dispute, the PO must directly address the issue raised by the appellant and provide any (contrary) evidence that may be available.

Denial of Medical Necessity

If the organization determination is based upon a medical judgment (e.g. not emergent, not urgent, not skilled level, not medically necessary), the PO should obtain the opinion of a physician with appropriate expertise.

The written decisions of these physicians are the most critical components of the PO's justification, although a nurse or other staff of the PO may attempt to further document or explain the determinations in the case file. If there is any conflict or difference between the written opinion of the physician's determination vs. other arguments made in the case file, C2C may defer to the physician's determination.

The PO may use a format of its choice for documenting the denial of medical necessity. However, the topics the clinical determinations should address are:

- Clinical Summary — A statement of the relevant medical history and condition of the enrollee, including any status changes that relate to the appropriateness of the denied treatment or care.
- PO Medical Criteria — Identification and description (copy) of any criteria used by the PO physicians in their adverse determinations. This could include purchased proprietary criteria, PO developed criteria, practice guidelines, recognized medical literature and technology assessments. The PO should determine if there are applicable national Medicare coverage guidelines, or Local Medical Review Policies (LMRPs). These should also be included.
- PO Authorized or Recommended Care — An explanation of care or treatment offered or provided by the PO, if any, in lieu of the (denied) care sought by the enrollee. The PO must indicate whether this care has actually been offered and authorized, and whether it has been accepted or rejected by the enrollee.³

Justification for Denial

- If the PO has cited and provided Medicare or PO medical guidelines, the PO should confirm with reference to pertinent medical evidence (records) that the patient meets, or fails to meet, all criteria within those guidelines. If there is an argument that the patient has unique needs and should be exempt from the guidelines, that argument should be addressed.
- If the PO cannot obtain the pertinent medical evidence (records), the PO should document its attempts to obtain the material. In addition, the PO should explain the basis for its uphold in the absence of the medical records. Note that in general, a PO should not

³ In most instances, it is not sufficient for the PO to indicate that it is "willing" to provide alternative care. The PO should document that such care has been explained and offered to the enrollee and the enrollee's response.

automatically deny an enrollee's Reconsideration request solely due to the lack of medical documentation to substantiate medical necessity. See C2C PACE Organization Reconsideration Procedures Manual Section 4.6.

- If the PO determination is based solely on its reviewing physician(s) clinical opinion, that opinion should be explained with reference to the pertinent medical evidence (records). If the denied care has been recommended or supported by a medical professional, it is particularly important that the "justification" include a rebuttal to such recommendation.

SECTION 2:

PACE RECONSIDERATION BACKGROUND DATA FORM

PACE ORGANIZATION RECONSIDERATION BACKGROUND DATA FORM

I. Case Class:

- Expedited
- Standard Service (Pre-authorization)
- Standard Claim (Reimbursement)

II. Identifying Data — Enrollee

Enrollee Name: _____
Medicare (HIC)#: _____ / Medicare (MBI) #: _____
Mailing Address: _____
Telephone #: _____ ZIP: _____
City: _____ State: _____
Is Enrollee Deceased? Yes No
Does the Enrollee require the final decision in a language other than English? Yes No
If Yes, please indicate required language: _____

Does the Enrollee require communication be made in any alternate format?

No Yes (specify type of format) _____
Large Print (if other than 18-point font, indicate size below) Audio CD Braille Qualified Reader
Other (specify type of format or font) _____

Designated Representative Information (Complete if Enrollee has a Designated Representative for Reconsideration)

Name: _____ Telephone #: _____
Mailing Address: _____
City: _____ State: _____ ZIP: _____

III. PACE Organization Information

PO Name: _____ CMS Contract #: _____
Mailing Address: _____ Plan Type: PACE
Organization
City: _____ State: _____ Zip: _____
Plan Contact: _____
Phone: _____ FAX: _____
Best time to contact (Eastern Time): _____ Email: _____

IV. PACE Organization Processing Data

IV(A). Organization Determination

- 1) Date Request for Service Determination made: _____
- 2) Did the PO take the up to a 5-day extension? Yes No
- 3) Date Service Determination made: _____

IV(B). PO Appeal Decision

- 1) Date Request for PO Appeal made: _____
- 2) Was the request for an Expedited PO Appeal? Yes No
- 2) If request was for an expedited decision, did the PO take the up to a 14-day extension? Yes No
- 3) Date PO Appeal Decision made: _____

IV(C). Request for IRE Review

- 1) Date Request for IRE Review made: _____
- 2) Was the request for an Expedited IRE Reconsideration? Yes No
- 3) Date PO Case File prepared and sent: _____

V. Description of Item or Service in Dispute

V(A). Definition of Denied Items

Item No.	Description of Item or Service in Dispute	Estimated \$ Amount in Dispute	Denied Dates of Service
1			
2			
3			

V(B). Provider Identification

Complete a line for each provider described in case. Do not limit to denied service if a provider is referenced for other purposes, such as role in referral or claim denial process.

Provider	Specialty	Type	Relation to PO	Medical Records
1				
2				
3				

Codes:	Type	Relation to PO	Medical Records
	1. Hospital 2. SNF 3. Other Facility 4. Freestanding Clinic 5. Home Health Agency 6. Practitioner/Professional	A. PCP/Enrollee's Primary Care Center B. Other PO Provider, in Network C. Non Plan Provider, but under Referral from PO D. No Relationship to PO	1. Included 2. Not Applicable 3. Not Requested 4. Requested/Refused

VI. Attestation

I certify on behalf of the PACE Organization defined in Section III, above, that the information on this form and submitted with this case is to the best of the organization's knowledge the true, accurate and complete record of the appeal available to the organization at this time.

Signed: _____

Print Name: _____

Date: _____

PACE Reconsideration Case Narrative Outline

Attach to file as a document separate from the Background Data Form.

Please note, if the reason for coverage denial is that covered services must be given by a contracted provider who is associated with a specific PCP group/network it is important that you include that information in the case file narrative.

1.	Case Summary
2.	Chronology of Care
3.	Enrollee's (or other party's) Arguments for Coverage
4.	PO Reason for Denial

SECTION 3:

APPOINTMENT OF REPRESENTATIVE STATEMENT

APPOINTMENT OF REPRESENTATIVE STATEMENT

Please include a signed copy with the reconsideration case file submitted to the IRE, where applicable.

Enrollee Name *Medicare HIC or MBI Number*

Provider *Dates of Service*

PACE Organization: _____

I hereby swear that I am the above-mentioned enrollee or have the legal authority to appoint a representative for the above-mentioned enrollee. I appoint the following individual _____ to act as my representative in requesting a reconsideration from the above-referenced PACE Organization and/or C2C, as designated external appeal agent of the Centers for Medicare & Medicaid Services.

Signature *Date*

I, _____ hereby accept the above appointment.
(Appointed Representative)

Signature of Appointed Representative *Date*

SECTION 4

NEW PACE RECONSIDERATION CASE FILE TRANSMITTAL COVER SHEET FOR RECONSIDERATION

NEW RECONSIDERATION CASE FILE TRANSMITTAL COVER SHEET

This transmittal sheet is required whenever a PACE Organization submits a case and corresponding case file (including the case file narrative and all supporting documentation) to C2C.

To ensure proper handling, the Plan must include this transmittal sheet for each case submitted to the IRE via mail or overnight courier.

The C2C mailing address and courier address, by appeal type, is denoted in the Contact Information section of the Reconsiderations Procedures Manual.

Does this case involve an Expedited Appeal? YES NO

Member Name: _____

Member HIC/MBI Number: _____

Document	Check if Submitted
Reconsideration Background Data Form *Case will not be initiated until the completed Reconsideration Background Data Form is received by C2C	<input type="checkbox"/>
Case Narrative	<input type="checkbox"/>
Service Determination and PO Appeal Process Notices	<input type="checkbox"/>
Records of Adverse Determination	<input type="checkbox"/>
PO Decision Making Criteria	<input type="checkbox"/>
Legible Medical Records (if applicable)	<input type="checkbox"/>
Participant Coverage Information (PACE Participant Coverage Document or Equivalent)	<input type="checkbox"/>
Other Documentation (if applicable)	<input type="checkbox"/>

SECTION 5

PACE ORGANIZATION RESPONSE TO IRE REQUEST FOR ADDITIONAL DOCUMENTATION TRANSMITTAL COVER SHEET

SECTION 6

STATEMENT OF COMPLIANCE FORM-IRE DECISION

NOTICE TO COMPLY WITH IRE/Part C QIC RECONSIDERATION DETERMINATION

C2C Innovative Solutions, Inc.

Medicare Part C QIC
 P.O. Box 1949
 Jacksonville, FL
 32231-0053

Fax Number for Attestations:
 904-539-4096

Plan Liaison Telephone Number:
 1-866-439-0863

Federal regulations require your organization to effectuate the attached IRE Part C Reconsideration Determination within a specific time period.

These time periods are:

<i>Appeal Priority</i>	<i>Effectuation Due (from receipt of Decision)</i>
Expedited Part B Drug	Authorize or Provide service within 24 hours*
Expedited Item or Service	Authorize or Provide service within 72 hours*
Standard Item or Service (Pre-service)	Authorize service within 72 hours or Provide service within 14 calendar days*
Standard Claim (Retrospective)	Pay for service within 30 calendar days (Check number required for proof of payment)

* Or as expeditiously as the enrollee's health condition requires

An IRE Part C Reconsideration Determination is final and binding. The determination may only be revised through a Reopening Determination. A request for reopening does not extend your organization's compliance date. Compliance requirements are only relieved if your organization receives a favorable Reopening Determination notice from C2C before the compliance due date.

Please provide written notice of compliance to C2C through the fax number listed in the banner or by mail within fourteen (14) calendar days from the date the payment, authorization, or provision of services and/or supplies is effectuated.

To ensure proper handling, please use the attached form when notifying C2C of compliance.

**IRE/PART C QIC DECISION
PLAN STATEMENT OF COMPLIANCE FORM**

Enrollee Name (First initial, last name)		
PACE Organization Contact		
C2C Reconsideration Case #		
PACE Organization Name		
PACE Organization Contract #		
Authorization # and Date	#	Date:
Check # or EFT# and Date Required for retrospective cases	#	Date:

Important information:

- Please note C2C cannot waive compliance with a C2C Reconsideration Determination.
- If you feel that you cannot comply with the C2C Reconsideration Determination, you must notify your CMS Regional Office point of contact.
- If you have questions regarding a C2C Reconsideration Determination, please contact the C2C Plan Liaison at PartC-Plan_Liaison@c2cinc.com.

Please return this form to us via fax or mail:

Fax: 904-539-4096

Mail: C2C Innovative Solutions, Inc. - QIC Part C
Attn: QIC Part C – Effectuation Compliance
P.O. Box 1949
Jacksonville, FL 32231-0053

SECTION 7

REOPENING REQUEST FORM



IRE/Part C QIC: PACE ORGANIZATION REOPENING REQUEST FORM

Please return this form via mail:

**Mail: C2C Innovative Solutions, Inc. - QIC Part C
Attn: QIC Part C - Reopening
P.O. Box 1949
Jacksonville, FL 32231-0053**

Enrollee Name: _____

C2C Reconsideration Case Number: _____

Dates of Service: _____

PACE Organization Name: _____

PACE Organization Contact: _____

Contact Title: _____

Street Address: _____

Mail Stop: _____

City/State/Zip: _____

Telephone Number: _____ Ext: _____

Fax Number: _____ Date of Request: _____

Basis of Reopening Request:

- Error on the face of the evidence
- New and material evidence
- Fraud

Explain briefly:

SECTION 8

PACE ORGANIZATION SUBMISSION OF ADDITIONAL INFORMATION AUTHORIZING COVERAGE OR PAYMENT FOR AN ITEM, SERVICE, OR PART B DRUG SUBSEQUENT TO THE PACE ORGANIZATION SUBMISSION OF THE CASE AND CASE FILE TO THE IRE FOR PROCESSING OF THE IRE RECONSIDERATION

**PACE ORGANIZATION SUBMISSION OF ADDITIONAL INFORMATION AUTHORIZING
COVERAGE OR PAYMENT FOR AN ITEM, SERVICE, OR PART B DRUG SUBSEQUENT
TO THE PLAN SUBMISSION OF THE CASE AND CASE FILE TO THE IRE FOR
PROCESSING OF THE IRE RECONSIDERATION**

This form is to be used by the PACE Organization to provide the IRE with additional information for consideration when the Organization has authorized or made payment for the item, service, or Part B drug in dispute **after** the case file has already been submitted to C2C for processing. PACE Organizations should complete the information below and submit it to

C2C as soon as the approval decision has been made to help prevent the issuance of a substantive appeal decision by C2C. Please attach any documentation supporting the PACE

Organization's approval. Examples include authorization notices, screen prints reflecting approval issuance, or documentation showing that the claim was paid (e.g., EFT confirmation, check number).

Upon validation of the information provided, if C2C has not already adjudicated the case, C2C will issue a favorable decision to the party indicating that the item, service, or Part B drug was authorized or paid for on the specified date and that no issues remain in dispute.

Please Fax the Completed Form to C2C at:
Expedited Appeals: 904-539-4075
Standard Part B Drug Appeal: 904-539-4076
All Other Appeal Types: 904-539-4078

Enrollee First & Last Name: _____

C2C Reconsideration Case Number: _____

QIC Portal Confirmation Number (if applicable): _____

Dates(s) of Service or Item/Service at Appeal: _____

PACE Organization Name: _____

PACE Organization Contract Number: _____

PACE Organization Contact Name: _____

Contact Email Address: _____

Contact Fax Number: _____

Telephone Number: _____ Ext: _____

Date of Authorization or Payment for Item, Service or Part B Drug: _____

Explain briefly the actions taken. Clearly identify the specific item, service, or Part B drug the PACE Organization has authorized or paid for and attach documentation supporting the authorization or payment for the date(s) of service at issue.

SECTION 9

MEDICARE PART C QIC RECONSIDERATIONS KEY PLAN ORGANIZATION CONTACT FORM

Medicare Part C QIC Reconsiderations Key Plan Organization Contact Form

This contact form is for Medicare Advantage (MA) Organizations, Medicare Cost Plans, Health Care Prepayment Plans (HCPPs) and Program of All-Inclusive Care for the Elderly (PACE) Organizations providing Medicare Part C items, services or Medicare Part B drugs.

Each plan must complete the form below to designate one or two key organizational contact(s) for general appeal-related communications and escalated case-specific concerns. **Plans are strongly encouraged to complete this form directly online via the C2C Part C QIC Website:** <https://www.c2cinc.com/QIC-Part-C>.

Note: For routine case-specific activities, C2C Innovative Solutions, Inc. will communicate with the contact identified in the Part C Reconsideration Background Form for the respective appeal.

If not completed online, please email the completed form to:
PartC-Plan_Liaison@c2cinc.com

PLAN CONTACT INFORMATION	
Contract Number	
Contract Name	
Contract Type	
Mailing Address	
Mail Stop/Suite Number	
City	
State	
Zip Code	
Primary Contact Name	
Primary Contract Phone #, ext.	
Primary Contact Email	
Alternate Contact Name	
Alternate Contact Phone #, ext.	
Alternate Contact Email	
Effective Date of Change (if applicable)	

Submitted by: _____

Date: _____