Part C Qualified Independent Contractor (QIC)

Medicare Health Plan Reconsideration Procedures Manual

C2C Innovative Solutions, Inc.

Effective May 1, 2026

Part C QIC
C2C Innovative Solutions, Inc. (C2C) Contact Information

Part C QIC Website: https://partcappeals.c2cinc.com/

Part C QIC Secure Appeals Portal Accessible At: https://partcappeals.c2cinc.com/

Part C QIC Plan Liaison Contact Information	
Email: PartC-Plan_Liaison@c2cinc.com	Telephone: 1-866-439-0863

Expedited Reconsideration Appeal Requests	
Preferred Method: Completion of Reconsideration Background Data Form and Upload of Related Case File Narrative and Other Case Documentation Online via the Part C QIC Appeals Portal	https://partcappeals.c2cinc.com/
Alternative Method: **UPS / FedEx Only** C2C Innovative Solutions, Inc. - QIC Part C **Attn: QIC Part C - Expedited** 301 W. Bay St., Suite 1110 Jacksonville, FL 32202	
Telephone for Part C Plans	1-866-439-0863
Telephone for Part C Enrollees	1-866-320-0963
Telephone for Providers	1-866-320-0963
Fax Number for Plan, Provider/Supplier, or Enrollee Submission of Additional Documentation in Response to IRE Request for Information (RFI) related to a pending **Expedited Appeal**	904-539-4075

All Other Reconsideration Appeal Requests	
Preferred Method: Completion of Reconsideration Background Data Form and Upload of Related Case File Narrative and Other Case Documentation Online via the Part C QIC Appeals Portal	https://partcappeals.c2cinc.com/
Alternative Method*: **United States Postal Service (USPS)** C2C Innovative Solutions, Inc. - QIC Part C **Attn: QIC Part C – New Appeals** P.O. Box 1949 Jacksonville, FL 32231-0053	**Alternative Method:** **UPS / FedEx Only** C2C Innovative Solutions, Inc. - QIC Part C **Attn: QIC Part C – New Appeals** 301 W. Bay St., Suite 1110 Jacksonville, FL 32202
USPS Address for All Other Correspondence Not Related to a New Appeal Request: C2C Innovative Solutions, Inc. - QIC Part C **Attn: QIC Part C – Correspondence** P.O. Box 1949 Jacksonville, FL 32231-0053	**UPS / FedEx Only Address for All Other Correspondence Not Related to a New Appeal Request:** C2C Innovative Solutions, Inc. - QIC Part C **Attn: QIC Part C – Correspondence** 301 W. Bay St., Suite 1110 Jacksonville, FL 32202
Telephone for Part C Plans	1-866-439-0863
Telephone for Part C Enrollees	1-866-320-0963
Telephone for Providers	1-866-320-0963
Fax for Plan, Provider/Supplier or Enrollee Submission of Additional Documentation in Response to IRE RFI on a **Part B Drug Appeal**	904-539-4076
Fax for Plan, Provider/Supplier, or Enrollee Submission of Additional Documentation in Response to IRE RFI **on Any Other Appeal Type**	904-539-4078

***USPS method of new case submission is not applicable for Standard Part B Drug appeals given the compressed timeframes. These appeals should only be sent to the IRE via the QIC Appeals Portal or UPS/FedEx.**

Appellant Request for IRE Review of a Plan Dismissal	
United States Postal Service (USPS) C2C Innovative Solutions, Inc. - QIC Part C **Attn: QIC Part C – New Plan Dismissal Appeal** P.O. Box 1949 Jacksonville, FL 32231-0053	**UPS / FedEx Only** C2C Innovative Solutions, Inc. - QIC Part C **Attn: QIC Part C – New Plan Dismissal Appeal** 301 W. Bay St., Suite 1110 Jacksonville, FL 32202
Fax for Parties to Submit New Request for IRE Review of Plan Dismissal	**904-539-4080**
Telephone for Part C Plans	1-866-439-0863
Telephone for Part C Enrollees	1-866-320-0963
Telephone for Providers	1-866-320-0963
Plan Submission of Dismissal Case File Data Form, Dismissal Case Narrative, and Other Documentation to the IRE	
Preferred Method: Completion of Dismissal Case File Data Form and Upload of Related Dismissal Case File Narrative and Other Case Documentation Online via the Part C QIC Appeals Portal	https://partcappeals.c2cinc.com/
Alternative Method:** **United States Postal Service (USPS)** C2C Innovative Solutions, Inc. - QIC Part C **Attn: QIC Part C – Plan Dismissal Case File or Correspondence** P.O. Box 1949 Jacksonville, FL 32231-0053	**Alternative Method:** **UPS / FedEx Only** C2C Innovative Solutions, Inc. - QIC Part C **Attn: QIC Part C – Plan Dismissal Case File or Correspondence** 301 W. Bay St., Suite 1110 Jacksonville, FL 32202
Fax Number for Plan, Provider/Supplier, or Enrollee Submission of Additional Documentation in Response to IRE Request for Information (RFI) related to an **IRE Review of a Plan Dismissal**	Expedited Appeal: 904-539-4075 Standard Part B Drug: 904-539-4076 Any Other Appeal Type: 904-539-4078

***USPS method of submission of dismissal case files is not applicable for Expedited appeals or Standard Part B Drug appeals given the compressed timeframes. These appeals should be sent to the IRE via the QIC Appeals Portal or UPS/FedEx Only.**

Options for Plans to Submit Statements of Effectuation Compliance to IRE	
Preferred Method: Completion of Statement of Compliance Form Online in Part C QIC Appeals Portal	https://partcappeals.c2cinc.com/
Alternative Method: Fax Number for Plans to Submit Statement of Compliance Form	904-539-4096
Alternative Method: **United States Postal Service (USPS)** C2C Innovative Solutions, Inc. - QIC Part C **Attn: QIC Part C – Effectuation Compliance** P.O. Box 1949 Jacksonville, FL 32231-0053	**Alternative Method:** **UPS / FedEx Only** C2C Innovative Solutions, Inc. - QIC Part C **Attn: QIC Part C – Effectuation Compliance** 301 W. Bay St., Suite 1110 Jacksonville, FL 32202

Plan Requests for IRE Reopening	
Preferred Method: Completion of Reopening Request Form in Part C QIC Appeals Portal	https://partcappeals.c2cinc.com/
Alternative Method: **United States Postal Service (USPS)** C2C Innovative Solutions, Inc. - QIC Part C **Attn: QIC Part C – Reopening** P.O. Box 1949 Jacksonville, FL 32231-0053	**Alternative Method:** **UPS / FedEx Only** C2C Innovative Solutions, Inc. - QIC Part C **Attn: QIC Part C - Reopening** 301 W. Bay St., Suite 1110 Jacksonville, FL 32202

Plan 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	
Preferred Method: Completion of Online Plan Authorization of Coverage or Payment Request Form in Part C QIC Appeals Portal	https://partcappeals.c2cinc.com/
Alternative Method: Fax Number for Plan to Submit Additional Information Indicating Plan Authorization of 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. **Please use the Fax Number as Denoted by the Appeal Type.**	Expedited Appeal: 904-539-4075 Standard Part B Drug: 904-539-4076 Any Other Appeal Type: 904-539-4078

Table of Contents

1. INTRODUCTION

The Balanced Budget Act of 1997, as amended by Title II of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), requires the federal government to contract with an Independent Review Entity (IRE) to review and resolve coverage disputes between Medicare Advantage Organizations, Cost Plans, Health Care Prepayment Plans, HCPPs, and any CMS approved Medicare managed care demonstrations where the Medicare requirements for appeals and independent review have not been waived, collectively referred to as Health Plans, and Medicare managed care enrollees. The Centers for Medicare & Medicaid Services (CMS) has contracted with C2C Innovative Solutions, Inc. (C2C) to serve as the IRE, also referred to as the Part C Qualified Independent Contractor (Part C QIC).

This Manual contains the procedures for the coordination of Health Plans with C2C in the processing of reconsiderations and related reconsideration activities. The IRE reconsideration step is part of a multi-level Medicare appeal process.

This Manual provides guidelines by which Health Plans and C2C shall follow for the IRE reconsideration level of appeal. For example, Medicare Health Plans are required to adhere to the CMS policies for initial organization determinations and Medicare Health Plan level reconsiderations steps that occur prior to the submission of a case file to C2C. The focus of this manual is on the processes by which Medicare Health Plans and C2C interrelate for the IRE level reconsideration. This Manual is not intended to serve as a review of CMS policy governing Medicare Health Plan obligations for the Medicare appeal process. This Manual presumes that the reader has a command of the relevant Part C Medicare rules and policies as set forth in:

- 42 CFR Part 422
- CMS IOM Pub. 100-16, Medicare Managed Care Manual
- CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance
- CMS Program Memoranda and Transmittals
- HPMS issuances

Insofar as operational policies and procedures relevant to working with the IRE are concerned, some of the policies and procedures addressed in this Manual are mandatory and complete compliance by the Medicare Health Plan is required. For such requirements, the term "must" or "mandatory" is used. Some policies and procedures provide the Medicare Health Plan with flexibility but offer suggestions for working with the IRE that may result in more efficient and seamless appeals processing for plans, enrollees and other stakeholders. In these areas, the term "recommended,", "suggested" or "optional" is used.

2. DEFINITIONS

The following definitions are provided only for use in this Manual. These definitions do not address all the terms referenced in 42 CFR Part 422, and in some instances

paraphrase or summarize regulatory text. In the event of any discrepancies or inconsistencies, the language in the Part 422 regulations prevail.

2.1 ADJUDICATOR

An appeal professional employed by C2C to manage reconsideration case files. Adjudicators make coverage determinations. Adjudicators do not make medical necessity determinations. Medical necessity determinations are made by C2C's fully credentialed board- certified physicians.

2.2 APPEAL

A review of a Health Plan's adverse organization determination that is contested by the enrollee or another authorized party. The term appeal applies to such procedures at any level of the Medicare appeal process.

2.3 APPEAL PROCESS

The multi-level Medicare process for addressing enrollee challenges to a Medicare managed care adverse organization determination. The IRE reconsideration process is one of the levels in this Medicare managed care appeal process.

2.4 AUTHORIZED REPRESENTATIVE

An individual appointed by an enrollee to represent him/her in filing an appeal.

2.5 DE NOVO REVIEW

A review of by a new and impartial reviewer. The new and impartial reviewer does not give preference to any previous determinations made.

2.6 ENROLLEE

A Medicare beneficiary who has enrolled in a Medicare Health Plan. An enrollee may also be referred to as a member.

2.7 EVIDENCE OF COVERAGE

This term describes the Health Plan document that sets forth the terms of coverage for the Medicare Health Plan enrollees and sometimes is referred to as a Subscriber Contract or Subscriber Agreement.

2.8 EXPEDITED RECONSIDERATION

A de novo review of an adverse organization determination that is processed quickly to avoid endangering the life or health of the enrollee or the enrollee's ability to regain or maintain maximum function. Generally, expedited reconsiderations must be completed as soon as is medically indicated, but not longer than 72 hours after receipt, with a possible extension of up to 14 calendar days for items and services if the delay is in the enrollee's interest (See 42 CFR §422.590). Examples of cases that should be expedited include coverage determinations for items or services in which a physician indicates that applying the standard timeframe for making a decision could seriously affect the life or health of the enrollee or the enrollee's ability to regain maximum function. Requests for Medicare Part B drugs can also be expedited appeals; these types of appeals are not eligible for extensions and must be adjudicated no later than 72 hours from receipt.

The Health Plan has an obligation to determine if an appeal should be expedited, including responding to an enrollee or provider request for an expedited determination. However, C2C, as the IRE, also has the authority to expedite processing of an IRE reconsideration that was not expedited by the Health Plan..

2.9 INDEPENDENT REVIEW ENTITY (IRE)

The entity under contract with CMS to perform reconsideration of denials upheld at the lower appeal level. C2C is the Independent Review Entity. C2C may also be referred to as the Part C QIC.

2.10 LOCAL COVERAGE DECISION (LCD)

A policy document that is published by a Medicare fee-for-service (FFS) contractor with jurisdiction over fee-for-service claims in a defined area that specifies coverage or clinical criteria for claim reimbursement.

2.11 MEDICARE ADVANTAGE ORGANIZATION

An entity that is under contract with CMS to provide Medicare benefits to Medicare beneficiaries. Medicare Advantage Organizations offer Medicare Advantage Plans such as HMOs, PSOs, PPOs, SNPs MSAs, private FFS plans and other programs and projects. The determination of whether an entity is subject to the Medicare Advantage appeal requirements is made by CMS.

2.12 MEDICARE APPEAL SYSTEM (MAS)

The CMS system of record that C2C uses to populate specific data elements from reconsideration cases and to generate required reports for CMS.

2.13 MEDICARE HEALTH PLAN

A term used in this Manual and in C2C correspondence to refer to a Medicare Advantage Plan, Cost Plan, Dual Eligible Plans, and/or HCPP.

2.14 ORGANIZATION DETERMINATION

A decision of the Health Plan, or a person acting on its behalf, to approve or deny a payment for a health care service or a request for provision of health care service made by, or on behalf of, a Medicare Health Plan enrollee. An organization determination concerns benefits an enrollee is entitled to receive under the Medicare Health Plan, including basic benefits; mandatory and optional supplemental benefits; and cost-sharing (deductible, coinsurance, and/or copayment). An organization determination is the Medicare Health Plan's initial coverage determination.

Medicare Health Plans must have procedures for making standard determinations and expedited determinations. Expedited determinations apply to cases in which applying standard determination procedures could seriously jeopardize the enrollee's life, health, or ability to regain maximum function (See 42 CFR §§422.566-422.572).

2.15 RECONSIDERATION

A review of an adverse organization determination. This term applies to both the Medicare Health Plan and to the IRE appeal level.

2.16 RECONSIDERATION DETERMINATION NOTICE

The letter used to communicate the final decision in a reconsideration.

2.17 REOPENING

A review of a completed IRE reconsideration determination undertaken at the sole discretion of the IRE for the purpose of addressing new information received or a potential error in the determination (See 42 CFR §422.616).

2.18 REQUEST FOR INFORMATION (RFI)

A document submitted by the IRE to the Health Plan or Party to the appeal, requesting additional information for adjudication. The IRE may issue a request for information and extend the adjudication timeframe in expedited and standard item or service cases by up to 14 calendar days if requested by the enrollee or needed to address deficiencies in the case file (with notice to the enrollee).

2.19 STANDARD PAYMENT (CLAIM) RECONSIDERATION

Reconsiderations related to a denial of claim payment or reimbursement. Standard payment (claim) reconsiderations must be completed within 60 days of request receipt, may not be expedited, and are not subject to any extensions. A standard payment reconsideration may also be referred to as a retrospective appeal.

2.20 STANDARD ITEM or SERVICE RECONSIDERATION

Reconsiderations of denials of authorization for items or services, including continuing services, that do not meet the criteria for an expedited reconsideration. Standard item or service reconsiderations must be completed within 30 calendar days of the request receipt, subject to a possible 14-calendar day extension if a request for information is issued.

2.21 STANDARD PART B DRUG RECONSIDERATION

Reconsideration of denials of authorization for Medicare Part B coverable drugs, including continuation of usage of a Part B drug, which do not meet criteria for an expedited reconsideration. Standard Part B drug reconsiderations must be completed within 7 calendar days of the request's receipt. These requests are not subject to any extensions.

3. WORKING WITH C2C

This section explains the processes for communicating with C2C, including:

- 3.1 Sources of Information about IRE Reconsiderations
- 3.2 Set-up of New Managed Care Organizations
- 3.3 Identifying and Changing Medicare Health Plan Points of Contact
- 3.4 Seeking Information about Current/Active Cases
- 3.5 Suggestions and Complaints
- 3.6 Holidays

Note: C2C is not authorized to guide or instruct Medicare Health Plans on interpretation of CMS coverage policies or matters related to Medicare Health Plan compliance with CMS' appeals process requirements.

3.1 SOURCES OF INFORMATION ABOUT IRE RECONSIDERATIONS

- *C2C Medicare Health Plan Reconsideration Procedures Manual:* C2C makes this Manual available to Plans to provide information about IRE appeals processing. This Manual is available on the C2C website and is applicable for Medicare Advantage Plans. C2C also provides a Manual for PACE Organizations that is available on the C2C website. Health Plans may download these Manuals from C2C's website.

- *C2C website:* The C2C Part C QIC website (https://partcappeals.c2cinc.com/) contains information such as:
    - Links to CMS websites of the statutes, regulations and policies in CMS manuals that pertain to Medicare Managed Care Reconsiderations
    - C2C contact information
    - Effectuation Information for Part C QIC Reconsiderations
    - Appeal Status Information for Part C QIC Appeals
        - *Note:* Case status information on the website is limited to protect enrollee and Medicare Health Plan confidentiality. A case can only be accessed by the reconsideration case number that is assigned by the Medicare Appeal System when a case file is received from a Health Plan. A reconsideration case number has no logical ties to a Social Security Number, Medicare Number, or any other confidential information. The information that can be obtained by entering the reconsideration case number is limited to the following:
            - IRE Case Number (i.e., the MAS Appeal Number)
            - IRE Request Received Date
            - IRE Appeal Priority
            - Plan Reported Reconsideration Receipt Date (from the Medicare Managed Care Reconsideration Background Data Form)
            - IRE Corrected Recon Receipt Date (if different than the Plan Reported Recon Receipt Date)
            - Plan Timeliness of Appeal Processing
            - Plan Extension (Y/N)
            - IRE Reconsideration Deadline
            - IRE Reconsideration Decision
            - IRE Reopen Decision (if applicable)
            - ALJ Decision (if applicable)
            - Last Decision Date
            - Plan Organization
            - Reconsideration Data from this website can be exported into either an Excel or .csv format

- *Part C QIC Newsletter*: When directed by CMS, C2C publishes a newsletter. This newsletter addresses commonly observed situations in the IRE reconsideration process and provides updates to C2C's policies and procedures. Newsletters that are published will be available to Health Plans through C2C's website.

3.2 SET-UP OF NEW MANAGED CARE ORGANIZATIONS WITH C2C

An entity that has established a new Medicare Advantage contract with CMS should contact C2C prior to its first enrollment effective date. C2C provides an online contact form for Health Plans to provide C2C with key contact information. This form is available via the Reconsideration Procedures Manual Appendix available on the Plan page within the Part C QIC website at https://partcappeals.c2cinc.com/.

3.3 IDENTIFYING AND CHANGING MEDICARE HEALTH PLAN POINT OF CONTACT

MEDICARE HEALTH PLAN KEY ORGANIZATION CONTACT: Each Health Plan must designate and maintain one or two key organizational contacts. Health Plans operating under multiple CMS contract numbers must designate a key contact person for each contract; however, the same individual(s) may serve as the contact for multiple contracts if appropriate. These individuals serve as the primary point of contact for C2C and will receive important communications, as well as outreach if an issue arises with a specific case.

As part of the IRE transition, Plans were required to provide C2C with their key organization contact information through the online form on the C2C Part C QIC website. Plans that did not submit the required information prior to the May 1, 2026, cutover—or Plans that wish to update their information after the cutover—may continue to access this online form to provide new organization contacts or to review and update their Plan-specific key organization contact information as needed. In lieu of completing online, please download the form from the Appendix and return to the Plan Liaison: PartC-Plan_Liaison@c2cinc.com.

MEDICARE HEALTH PLAN INDIVIDUAL RECONSIDERATION CASE CONTACTS: A Health Plan must also list a case specific contact person when submitting a reconsideration case request on the *Medicare Managed Care Reconsiderations Background Data Form*. A Health Plan may, but is not required to, use its key contact as the designated case specific contact. A Health Plan may vary the case specific contact person from case to case. Note: IRE decision notices, and as applicable, the Notice to Comply with a respective IRE, Administrative Law Judge, or Medicare Appeals Council decision, will be faxed from the IRE to the number provided in the case specific contact section of the Reconsiderations Background Data Form.

3.4 SEEKING INFORMATION ABOUT SPECIFIC CASES

A Health Plan can obtain basic information concerning the status of active and decided cases via C2C's Part C QIC website: https://partcappeals.c2cinc.com/. In addition, you may call us at 1-866-439-0863.

For inquiries about the processing status of a specific case file, or group of cases, please visit our Part C QIC website: https://partcappeals.c2cinc.com/.

Specific inquiries from a Plan regarding a case under review may be directed to the Plan Liaison at PartC-Plan_Liaison@c2cinc.com. Any information intended for inclusion in the case file, or that may be used as documentation for the final determination, must be submitted in writing through the appropriate submission process. **Such information must not be sent to this email inbox. Note: Plans must not transmit protected health information (PHI) to this email address.**

Health Plans are responsible for supporting their enrollees in the reconsideration process. Plans should not direct members to C2C for routine case status inquiries.

Medicare Managed Care enrollees should be referred to 1-800-MEDICARE for general information regarding the Medicare Managed Care appeals process and to locate resources for assistance in the appeals process.

3.5 SUGGESTIONS AND COMPLAINTS

Please provide any suggestions or complaints to any C2C staff member who is interacting with you or to the Plan Liaison via email at PartC-Plan_Liaison@c2cinc.com or via telephone at 1-866-439-0863.

3.6 HOLIDAYS

C2C's offices are closed in observance of the following Federal and Corporate holidays:

- New Year's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Friday following Thanksgiving
- Christmas Eve
- Christmas Day

If a holiday falls on a Saturday, it is observed the preceding Friday; if it falls on a Sunday, it is observed the following Monday.

4. BACKGROUND - IMPORTANT CONSIDERATIONS PRIOR TO DEVELOPING THE RECONSIDERATION CASE FILE FOR SUBMISSION

The responsibilities of the Health Plan related to adverse organization determination ("denials") and the Medicare Health Plan level reconsideration are defined by CMS in 42 CFR Part 422, Subpart M, and the CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance. This Reconsideration Procedures Manual is based on the presumption that the Medicare Health Plan understands and complies with these CMS policies.

This Chapter highlights certain aspects of Medicare Health Plan's organization determination and reconsideration processing that directly impacts the subsequent IRE reconsideration. The topics addressed are:

4.1 Medicare Health Plan's Organization Determination Notice Requirements
4.2 Medicare Health Plan Validation of Party, Representative, and Eligible Appeal
4.3 Non-Medicare Plan Services
4.4 Reconsideration Priority
4.5 Medicare Health Plan Responsibility to Conduct a Full Health Plan Reconsideration
4.6 Medicare Health Plan Reconsideration with Incomplete Evidence

4.1 MEDICARE HEALTH PLAN'S ORGANIZATION DETERMINATION NOTICE REQUIREMENTS

The Health Plan is required, in most instances, to provide a written organization determination ("denial") notice to the enrollee or the enrollee's representative. If a denial is subsequently appealed to C2C for reconsideration, a copy of the denial notice and dates pertaining to the Health Plan organization's determination must be included within the case file.

C2C reviews the organization determination to define the denied service or claim subject to IRE reconsideration. In addition, we compare the type, format, and content of the notice to CMS requirements and report "notice deficiencies" to CMS. C2C also abstracts and reports to CMS the dates of the initial request for item or service (or payment) versus organization determination for purposes of monitoring Health Plan timeliness. The organization determination date is the date on which a decision was communicated to the enrollee or appellant, whether orally or in the form of a decision letter.

CMS has developed standardized denial notices, which are described in the subsections following.

4.1.1 NOTICE OF DENIAL OF MEDICAL COVERAGE or Payment (Form CMS-10003-NDMCP)

This OMB-approved notice applies to prior authorization denials, adverse organization determinations including termination of medical services (excepting Inpatient discharge denials).

The Medicare Health Plan must issue an NDMC when it receives a request for an item, service, or Part B drug and the Medicare Health Plan denies the request, in whole or part. However, CMS policy recognizes that some "denials" may occur in the context of provider discussions with enrollees about patient care options, and that in such discussions it may be difficult to ascertain whether the enrollee believes a denial has occurred at that instant. For example, if an enrollee is discussing two treatment options with a physician, the physician might recommend the second option. Whether such a recommendation is a "denial" of the first option depends upon the enrollee's response (that is, acceptance or rejection of the physician's recommendation). Further, the enrollee might not contest the physician's recommendation during the visit but could contest it later.

Due to these unavoidable complications, CMS policy does not obligate Medicare Health Plan providers to issue an NDMC but does obligate providers to inform enrollees of their right to obtain an NDMC from the Medicare Health Plan. The Medicare Health Plan must issue the NDMC if requested by the enrollee. If the Medicare Health Plan makes the denial (for example, in response to a provider's request for prior authorization), the Medicare Health Plan must issue the NDMC.

In summary, in many instances the circumstances of an initial organization determination will necessitate issuance of an NDMC by the Medicare Health Plan. If so, the NDMC must be included in a case file submitted for IRE reconsideration. If a valid exception to the NDMC issuance requirement exists, the Medicare Health Plan should document the exception in the IRE casefile.

A Medicare Health Plan completes and issues a Notice of Denial of Payment (via the CMS 10003-NDMCP) when it denies a request for payment of an item, service, or Part

B drug that was already received by the enrollee. CMS also permits Medicare Health Plans to use the Medicare Health Plan's existing electronic formats that generate Explanation of Benefits forms, as long as the back or a separate attachment contains the CMS 10003-NDMCP information about appeal rights.

CMS has issued a standard form for the NDMCP. Medicare Health Plans may not deviate from the language of the CMS form. Please note that the OMB control number must be displayed on the notice. A copy of the completed NDMCP must be included in the Medicare Health Plan reconsideration case file.

4.1.2 NOTICE OF MEDICARE NON-COVERAGE (NOMNC)

This OMB-approved notice should be issued when the Medicare Health Plan discontinues coverage for Skilled Nursing Facility (SNF) stays, Home Health services, or CORF services. CMS has specific requirements regarding the time and manner of delivery of this notice (See 42 CFR §422.624 and CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance).

Telephone delivery of the notice is permitted only in limited circumstances, and there are specific requirements with regards to the documentation of the telephone call (See CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for full details). A copy of the completed NOMNC must be included in the Medicare Health Plan reconsideration case file.

It is important to note that reduction of a service within the SNF, Home Health, or CORF setting that does not result in termination of skilled coverage does not require the use of the NOMNC. Medicare Health Plans should use the NDMC for this purpose. Also, please note that CMS does not require use of the NOMNC in denials based on exhaustion of benefits. For terminations based on the exhaustion of Medicare benefits, Medicare Health Plans should use the NDMC.

4.2 MEDICARE HEALTH PLAN VALIDATION OF PARTY, REPRESENTATIVE AND ELIGIBLE APPEAL

Federal regulations provide that the following parties may request a reconsideration of an organization determination:

- An enrollee (including his or her representative)
- An assignee of the enrollee (that is, a non-contract physician or other non-contract provider who has furnished a service to the enrollee and formally agrees to waive any right to payment from the enrollee for that service)
- The legal representative of a deceased enrollee's estate
- Any other provider or entity (other than the Medicare Health Plan) determined to have an appealable interest in the proceeding (See 42 CFR §§422.574 and 422.578)

It is a straightforward validation of the appealing party when the enrollee initiates the reconsideration request. It is not as straightforward to validate the appealing party when the Reconsideration request is made by a person other than the enrollee. Special considerations with respect to reconsideration requests made by persons other than the enrollee are discussed under the following sub-headings:

Medicare Health Plans should carefully note that until an authorized representative or provider-as-party is formally validated and documented, the appeal process, including the Medicare Health Plan reconsideration, should not begin. In other words, if the Medicare Health Plan receives an appeal request from a representative who is not validated, the Medicare Health Plan should not initiate the Medicare Health Plan reconsideration process. The procedures in this Manual instruct the Medicare Health Plan on proper technique for addressing Medicare Health Plan reconsideration requests submitted by non-validated representatives or providers-as-party.

4.2.1 REPRESENTATIVE DOCUMENTATION

It is the responsibility of the Medicare Health Plan to correctly identify and apply the laws and procedures related to representation. An enrollee may designate any person as his or her representative. CMS in general requires that Medicare Health Plans document proof of the validity of the enrollee's representative. Special rules apply to three circumstances:

1. Enrollees who are incapacitated
2. Providers as representatives
3. Non-contracted provider uses a billing company or third party to request appeals on their behalf

General Requirements:

If the party requesting the reconsideration is not the enrollee, and the special circumstances discussed below do not apply, it is the responsibility of the Medicare Health Plan to determine and document that the requesting party is an appropriate representative of the enrollee (See Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance). Appropriate documentation may include, but is not limited to, a durable power of attorney, a health care proxy, an appointment of guardianship, an Appointment of Representative form (CMS-1696), or other legally recognized forms of appointment. Representative documentation is required even if the representative is an attorney, family member, or medical provider (*See Special Condition 2, below*). Representative documentation must be included in the case file submitted to C2C for IRE Reconsideration.

It is also the Medicare Health Plan's obligation to attempt to obtain the needed representative documentation. Plans must make, and document, their attempts to obtain this documentation. If a Medicare Health Plan does not receive the representative documentation at the end of the appeal timeframe, PLUS EXTENSION, the Medicare Health Plan must dismiss the request and issue a Notice of Dismissal of Appeal Request. Appellants have the right to request review of this dismissal. These dismissal reviews are discussed in more detail below.

Please note, this means that Medicare Health Plans should allow the full timeframe, plus any extensions allowable, for the requestor to submit the representative documentation. However, Plans must issue an applicable Notice of Dismissal of Appeal Request within the regulatory adjudication timeframe requirements, plus extension (if applicable). (*See the CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance*). For example, if the plan does not timely receive the Waiver of Liability (WOL), the plan must issue a dismissal notice by the end of the adjudication timeframe, per the dismissal procedures set forth in Section 50.1 of the above-mentioned guidance. The plan must mail or otherwise transmit the written notice of the dismissal to the parties at their last known address no later than the conclusion of the applicable adjudication timeframe (please see Section 50.9 of the guidance.)

Special Condition 1: Enrollee Who Is Incapacitated or Incompetent:

If a member is incapacitated or incompetent and cannot sign an appointment of representative document, the Medicare Health Plan must apply state laws regarding legal representation of incapacitated or incompetent persons. If these laws require documentation, such documentation should be obtained by the Medicare Health Plan. The Medicare Health Plan's appeal staff should consult with the Medicare Health Plan's legal counsel to follow the applicable laws. C2C does not require documentation in the IRE case file to substantiate that the Medicare Health Plan has properly applied State law. However, the M*edicare Managed Care Reconsideration Background Data Form* and the QIC Appeals Portal do include a checkbox (under Section 4) that must be selected for C2C to accept the representative as valid (See Appendix).

The CMS Appointment of Representative form (CMS-1696) can be found here: https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf

Special Condition 2: Providers as Representatives

A Physician may initiate Expedited or Standard Pre-Item, Service, or Part B Drug Reconsiderations without Appointment of Representation or Without Being the Provider-as- Party. To determine if a requestor is a “physician” please refer to Social Security Act §1861(r) and Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, section 50.1.

A treating physician may make a reconsideration request on behalf of an enrollee to the Medicare Health Plan to initiate an expedited reconsideration. A treating physician may, upon providing notice to the enrollee, make a request for a standard pre-item, service, or Part B Drug reconsideration on the enrollee’s behalf.

These physicians are not required to obtain an Appointment of Representative document from the enrollee, nor are these physicians required to execute a Waiver of Liability (WOL). Consequently, no Appointment of Representative form is required in a case file submitted to C2C. The Medicare Health Plan must, however, document the physician request in the case file. Please note, however, that appeals requested by non-physician providers require an Appointment of Representation.

Federal regulations state that a physician must notify the enrollee of the standard item, service, or Part B drug appeal request. For purposes of processing the appeal, it is the Medicare Health Plan's responsibility to assess whether the enrollee has received proper notice. If the Medicare Health Plan processes the appeal request, C2C accepts that the Medicare Health Plan has sufficient proof that the enrollee was properly noticed.

4.2.1.1 DISMISSAL FOR LACK OF PROPER DOCUMENTATION

If a reconsideration case file is submitted to C2C that was initiated by a representative, C2C will examine the file for compliance with the representation requirements. C2C will dismiss cases in which a required fully executed Appointment of Representative form or other required documentation is absent (See Section 4.2.5).

4.2.2 PROVIDER-AS-PARTY DOCUMENTATION

Non-Contract Providers:

A non-contract provider may itself become the party to an appeal if that non-contract provider has executed a Waiver of Liability (WOL) form. The purpose of this form is to ensure that the enrollee will not be held financially liable if the provider loses the appeal. The executed WOL document must be included in the case file submitted to C2C (See Section 4.2.5).

Medicare Health Plans must make, and document, their attempts to obtain the WOL. If the Medicare Health Plan does not receive the WOL by the conclusion of the appeal timeframe, the Medicare Health Plan must dismiss the request and issue a Notice of Dismissal of Appeal Request. Non- Contract provider appellants have the right to request review of this dismissal. These dismissal reviews are discussed in more detail in Section 8 below.

Please note that if a Medicare Health Plan dismisses an appeal request from a non-contract provider for no WOL, the Plan should issue a Notice of Dismissal of Appeal Request at the conclusion of the adjudication timeframe, but not after this timeframe has expired. For dismissals, Plans still must comply with the timeframes applicable for appeal adjudication, and failure to timely issue the required Notice of Dismissal of Appeal Request will result in the case needing to be auto forwarded to the IRE. Also, if a plan dismisses a level 1 appeal request, the plan must mail or otherwise transmit a written notice of the dismissal to the parties at their last known address at the conclusion of the applicable adjudication timeframe (please see section 50.9 of the guidance.)

A model WOL statement form can be found at https://www.cms.gov/medicare/appeals-grievances/managed-care/notices-forms.

Special condition 3: A non-contracted provider uses a billing company or third party to request appeals on their behalf

A third-party billing company that is appealing on behalf of a provider must show they are authorized to bring an appeal on behalf of the provider and authorized to sign the WOL for the provider (if applicable). A billing company representative cannot give

him/herself authorization to pursue an appeal; the authorization must be given by the provider directly.

A third-party billing company representing a non-contract provider in a retrospective appeal must provide either:

- A valid AOR authorizing the third party to act on behalf of the provider
- Evidence of a business agreement between the third party and the provider, or
- Confirmation from the provider that the third party is legally permitted to act as an Agent of the provider

Contract Providers:

Contract or "in-plan" providers of the Medicare Health Plan do not have rights to act as the party in an appeal. Payment disputes between a contract provider and the Medicare Health Plan, for which the enrollee has no liability, should be resolved through a forum outside of the Medicare managed care appeal process. These payment disputes are contractual in nature and should be addressed in accordance with the dispute-resolution provisions contained in the applicable provider-plan agreement. Such disputes are not subject to the Medicare Managed Care appeals procedures established in 42 CFR Part 422, Subpart M.

4.2.3 PROVIDER AS PERSON "SUPPORTING" THE ENROLLEE APPEAL

Any person, including a provider, may "support" the enrollee appeal by providing written or oral testimony at the Medicare Health Plan level reconsideration or written testimony at the IRE level reconsideration. There is no requirement for execution of an AOR or WOL if the role of the person is simply providing testimony in support of an enrollee's appeal.

The distinction between representation and support includes any of the following elements:(1) *the person supporting the appeal has no standing to request the appeal proceeding, whereas the representative does*, (2) *the person supporting the appeal does not receive mandatory notices otherwise sent to the enrollee, whereas the representative does*, (3) *the person supporting the appeal cannot make decisions (for example, withdrawing the appeal), whereas the representative may do so*, (4) *the person supporting the appeal does not otherwise "manage" the enrollee's participation in the appeal, whereas the representative may*.

A physician may also, without being a representative, support a request for an appeal to be classified as an expedited reconsideration. The physician may make his/her statement of support in either written or oral form. The effect of such a statement is to mandate expedited status for the appeal if the physician's statement indicates that the application of a standard decision timeframe to the reconsideration could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

4.2.4 REPRESENTATIVE OF DECEASED ENROLLEE'S ESTATE

The Medicare Health Plan has the responsibility to ensure that such representatives are legitimate. The Medicare Health Plan must indicate on the *Medicare Managed Care Reconsideration Background Data Form* (by selecting the appropriate checkbox in

section 4) or in the QIC Appeals Portal if the appeal request initiated by an estate representative is valid. C2C cannot rule on whether estate representation documentation is legitimate. The Medicare Health Plan should consult its legal advisor for assistance in determining the appropriate estate representative.

4.2.5 PROCESSING RECONSIDERATIONS WITH AN INVALID APPEAL REQUESTOR

If the Medicare Health Plan receives a reconsideration request without the required executed representative or WOL document (or in which the required document is incomplete or erroneous), the Medicare Health Plan level reconsideration review should not begin. However, the Medicare Health Plan must make reasonable attempts to inform the requester of the inadequacy and obtain the representative or WOL documents (See CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance). If the Medicare Health Plan does not get the appropriate documentation, then the Medicare Health Plan must dismiss the request per the CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance. Appellants may request review of this dismissal under the process described in Section 8 of this manual.

4.2.6 APPELLANTS DESIGNATED AS HAVING AN 'APPEALABLE INTEREST'

CMS has indicated that any other provider or entity (other than the MA plan) determined to have an appealable interest in the proceeding may request an appeal. However, this '*appealable interest*' designation must be made by the health plan and clearly documented in the case file submitted to C2C for review. The sole authority to grant '*appealable interest*' lies with the health plan and C2C cannot grant this status to a requestor unless the plan has designated the requestor has this interest. Plans should include a full explanation of how and why this appealable interest was granted in their case narrative included in their case file submission to C2C.

4.3 NON-MEDICARE PLAN SERVICES

The Medicare Managed Care appeal process applies only to basic and mandatory or optional supplemental benefits (42 CFR §422.566). Some enrollees have additional benefits, outside the scope of the CMS approved benefit plan, provided separately by their employer or union. Denial of these benefits is not subject to Medicare reconsideration, and such cases should not be submitted to C2C. However, if any portion of the denial overlaps Medicare basic benefits or the Medicare Health Plan mandatory or optional supplemental benefits, the case does qualify for Medicare reconsideration. Likewise, if the enrollee (or non-contract provider party) argues that the denied service should be covered under the Medicare benefits, as opposed to the employer provided benefits, the case should be reviewed as a Medicare reconsideration.

4.4 RECONSIDERATION PRIORITY

There are four levels of reconsideration priority:

1. Standard item or service reconsideration;
2. Standard Part B Drug reconsideration;
3. Standard payment (claim) reconsideration; and
4. Expedited reconsideration.

These four levels are defined in Section 2. Definitions. Refer also to 42 CFR Part 422 Subpart M for a complete definition and explanation of the differing requirements for these reconsiderations.

The classification of a reconsideration as either an expedited or standard reconsideration is the responsibility of the Medicare Health Plan. The Medicare Health Plan should not ask C2C to determine whether a given request for expedited reconsideration should be granted.

C2C will process the appeal in accordance with the priority type conducted by the Plan. If, upon receipt of the case file, C2C determines the case was misclassified on the *Medicare Managed Care Reconsideration Background Data Form*, for example, if a Medicare Health Plan submits a standard claim payment case but incorrectly identifies it as an expedited, C2C will change the classification from expedited to standard claim payment and process the case in accordance with the required timeframe.

4.5 HEALTH PLAN RESPONSIBILITY TO CONDUCT A FULL RECONSIDERATION

Medicare Health Plans are required to conduct a thorough Medicare Health Plan level reconsideration, prior to submitting a case to C2C for IRE level reconsideration. Consult 42 CFR §422.590 and CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for a definition of the Medicare Health Plan's obligations in conducting its reconsideration. In addition, the C2C requirements, and suggestions for IRE level case file preparation (See Section 5.3) will be difficult to meet if the Medicare Health Plan has not previously undertaken and documented a full Medicare Health Plan level reconsideration.

C2C may, at its discretion, utilize the "request for additional information" (RFI) process (See Section 6.6) to direct Medicare Health Plans to remedy a case in which a complete Medicare Health Plan level reconsideration has not occurred or has not been documented.

C2C will notify CMS if a Medicare Health Plan displays a pattern of failure to complete and document a thorough Plan level reconsideration.

4.6 HEALTH PLAN RECONSIDERATION WITH INCOMPLETE EVIDENCE

The Medicare Health Plan should gather all pertinent evidence or information before rendering its organization determination and completing the Plan level reconsideration. CMS policy dictates that a Medicare Health Plan should not automatically deny the enrollee's organization determination request due to a lack of documentation. Therefore, if the only available information is the enrollee's description, the Medicare Health Plan's decision must be based on that description.

The basis of the Medicare Appeals Process is the Constitutional protection of the enrollee's right to federal benefits to which that enrollee is entitled. The burden is therefore generally on the Medicare Health Plan to demonstrate that the enrollee is not entitled to the denied service or claim. Absence of evidence, and most notably relevant medical records, would generally undermine the Medicare Health Plan's arguments that it had demonstrated a legitimate process and basis for its denial. Possible exceptions would include non-emergent or -urgent enrollee "self-referred" out-of-plan services,

without prior related health care access request to the Medicare Health Plan, where the enrollee and non-contract provider will not cooperate in the provision of records.

5. SUBMITTING RECONSIDERATION CASE FILES TO C2C

This Chapter defines the requirements for Medicare Health Plan preparation and submission of case files to C2C for IRE level reconsideration under the following headings:

5.1 Cases That Must Be Submitted to C2C for Reconsideration
5.2 Time Standards for Submission of Cases to C2C
5.3 Preparation and Submission of the New Case File to C2C

5.1 CASES THAT MUST BE SUBMITTED TO C2C FOR RECONSIDERATION

Federal Regulation 42 CFR §§422.590-422.592 and the CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance define cases that must be submitted for IRE reconsideration. The Medicare Health Plan must submit any case for which it is responsible for a Medicare Health Plan level reconsideration unless the Medicare Health Plan has wholly reversed its initial adverse organization determination or dismissed the request for reconsideration. Federal regulations define a case in which the Medicare Health Plan has failed to make a reconsideration determination by the applicable due date, as an affirmation of the adverse organization determination. Therefore, cases in which the Medicare Health Plan has not made a decision, as of the expiration of the decision timeframe, also must be submitted to C2C. If the Medicare Health Plan subsequently obtains or develops additional information on any case (including an incomplete case), it must submit that information to C2C. However, C2C will not delay its review and makes no guarantee that such late, additional information will be taken into account prior to the C2C determination.

5.2 TIME STANDARDS FOR SUBMISSION OF CASES TO C2C

The following sub-sections define time standards for case submission for each reconsideration priority (expedited, standard item or service, standard Part B drug, and standard claim payment). Please note that all references to the "enrollee's request" for a reconsideration should be interpreted as a valid reconsideration request from any permissible appealing party, including representatives and noncontract providers. However, such a request does not become valid until and unless the documentation standards for parties and representatives are met (See Section 4.2).

5.2.1 TIMELINESS OF SUBMISSION OF EXPEDITED RECONSIDERATIONS

Federal regulations (42 CFR §422.590(d) and (e)) require the Medicare Health Plan to complete expedited cases within 72 hours of receipt of the request, or sooner if the enrollee's health condition requires. For expedited item or service cases, the Medicare Health Plan may take an extension of up to 14 calendar days if such extension is in the enrollee's interest.

For expedited cases only, the regulations (42 CFR §422.590(g)) also define an additional interval for "submission" of the case file to C2C. Submission is to occur within 24 hours of the Medicare Health Plan's completion of its reconsidered determination.

The 24-hour period permitted for submission is thus in addition to the time permitted for the Medicare Health Plan reconsideration. The Medicare Health Plan must be submitted using the fastest means possible. This means that Plans should submit expedited appeals via the QIC Appeal Portal.

Plans that do not have the capability to submit electronically and must submit appeals via paper means must submit expedited reconsideration case files to C2C via overnight/next day delivery rather than by standard mail.

For Plans that do not use the QIC Appeals Portal, the Medicare Health Plan meets the 24-hour standard if it submits the case to a commercial delivery service by that delivery vendor's close of business on the day after the Medicare Health Plan makes its reconsideration determination.[1] The case would then be delivered to C2C on the next day that falls within the vendor's customary schedule. *Exhibit 5-1: Expedited Case Submission Timetable* contains a table illustrating how these rules apply to submission of expedited cases.

5.2.2 C2C BUSINESS HOURS AND QIC APPEALS PORTAL AVAILABILITY

Telephone Contact: The IRE will respond to telephone inquiries and return calls during customer service business hours, Monday through Friday from 8:00 AM to 7:00 PM EST. Messages received outside of these hours will be returned by the customer service team within 24 business hours.

Case and Case File Submission from Plan to QIC: The QIC Appeals Portal is open 24 hours a day, seven days a week[2]. The portal submission date will be used as the receipt date of the case file for purposes of calculating health plan timeliness.

Exhibit 5-1: EXPEDITED CASE HARD COPY SUBMISSION TIMETABLE:

Day of the Week of the Medicare Health Plan Determination	*Day of the Week of the Medicare Health Plan Case Submission to Overnight Delivery Vendor*	*Day of the Week of C2C's Receipt*
Monday	Tuesday	Wednesday
Tuesday	Wednesday	Thursday
Wednesday	Thursday	Friday
Thursday	Friday	Saturday*
Friday	Saturday*	Monday
Saturday	Monday	Tuesday

*Some delivery vendors require senders to specify "Saturday Delivery" on the envelope/package to be delivered. C2C is open to receive cases on Saturday and Sunday from 10:00 am to 3:00 PM EST.

[1] As noted in Section 5.1, the failure of the Medicare Health Plan to make its reconsideration determination by the deadline is regarded as an adverse determination that triggers the requirement for case submission to C2C.
[2] With the exception of routine scheduled maintenance or emergency maintenance to fix user issues, the portal will be available.

5.2.3 TIME STANDARD FOR SUBMISSION OF STANDARD SERVICE OR ITEM RECONSIDERATIONS

Regulations at 42 CFR §422.590(a)(2) require the Medicare Health Plan to submit a standard item or service reconsideration to C2C:

- As expeditiously as the enrollee's health condition requires, or
- Not later than 30 calendar days after the receipt of a valid reconsideration request, subject to an additional 14-calendar day extension, if taken in the enrollee's interest, as per 42 CFR §422.590(e).

Note: Most health plans submit cases to C2C via immediate, electronic means (i.e., the QIC Appeal Portal). However, on the rare occasion that a Plan submits a case file to C2C via mail, the Centers for Medicare & Medicaid Services (CMS) will allow the addition of a 5-calendar day mailing window beyond the standard 30/44 day timeframe permitted for standard item or service reconsiderations.

5.2.4 TIME STANDARD FOR SUBMISSION OF STANDARD PART B DRUG RECONSIDERATIONS

Regulations at 42 CFR §422.590(c)(2) require that the Medicare Health Plan to send a standard Part B Drug reconsideration to C2C no later than 7 calendar days after the receipt of a valid reconsideration request.

The Medicare Health Plan must submit standard Part B drug appeal reconsideration case files to C2C via the QIC Appeals Portal or overnight/next day delivery rather than by standard mail.

For Plans that do not use the QIC Appeals Portal, C2C assumes that Medicare Health Plan reconsideration decisions occur as of the close of the business day on which the decision is rendered. Therefore, the Medicare Health Plan meets the 7-calendar day adjudication standard if it submits the case to a commercial delivery service by that delivery vendor's close of business on the day after the Medicare Health Plan makes its reconsideration determination.[3] The case would then be delivered to C2C on the next day that falls within the vendor's customary schedule.

5.2.5 TIME STANDARD FOR SUBMISSION OF STANDARD PAYMENT (CLAIM) RECONSIDERATIONS

Regulations at 42 CFR §422.590(b)(2) require the Medicare Health Plan to submit a standard payment (claim) reconsideration to C2C within 60 calendar days from the date of the enrollee's request for reconsideration. The Medicare Health Plan may submit cases by standard mail; however, plans are strongly encouraged to submit cases via the QIC Appeals Portal. As with standard item or service appeals noted in section 5.2.2, on the rare occasion that a Plan submits a case file to C2C via mail, the CMS will allow the addition of a 5-calendar day mailing window beyond the standard 60-day timeframe permitted for standard payment (claim) reconsiderations. The failure of the Medicare Health Plan to make its reconsideration determination by the deadline is regarded as an adverse determination that triggers the requirement for case submission to C2C.

[3] As noted in Section 5.1, the failure of the Medicare Health Plan to make its reconsideration determination by the deadline is regarded as an adverse determination that triggers the requirement for case submission to C2C.

5.3 PREPARATION AND SUBMISSION OF THE NEW CASE FILE TO C2C

Addressed below are instructions for the Medicare Health Plan on the required methods for physical construction of a case file submitted to C2C for IRE reconsideration. The topics are addressed under the following subheadings:

5.3.1 Initiation of Expedited Cases
5.3.2 Organization of the New Case File Package
5.3.3 Organization of Individual New Case Files
5.3.4 Guidance on Selection and Inclusion of Medical Records
5.3.5 Confirmation of C2C Case Receipt

As explained below, the Medicare Health Plan must include with each case a *Medicare Managed Care Reconsideration Background Data Form* and a structured Case Narrative report. The instructions for this form and report are presented in Appendix and should be thoroughly reviewed since the instructions are integral to an understanding of case preparation and submission requirements.

Please note that the data entry required for submission of a case file through QIC Appeals Portal is equivalent to the *Medicare Managed Care Reconsideration Background Data Form*; no separate form needs to be submitted for case files sent via the QIC Appeals Portal. For all cases, including those submitted via the QIC Appeals Portal, a structured Case Narrative report is required.

5.3.1 INITIATION OF EXPEDITED CASES

Medicare Health Plans are encouraged to submit expedited case files and the ensuing documentation through the QIC Appeals Portal. Health Plans must not fax or email case files to C2C. C2C will not initiate any case that is sent via facsimile until a hard copy or portal-submitted copy of the case file is received. Follow the instructions for case delivery in Section 5.3.2.

5.3.2 ORGANIZATION OF THE NEW CASE FILE PACKAGE

The "New Case File Package" is the envelope or container in which the Medicare Health Plan ships C2C one or more new case files. C2C offices are open to accept case file delivery Monday through Saturday. Address packages using the appropriate address listed in the Contact Information section at the beginning of this Manual.

When submitting paper case files, the Medicare Health Plan may include more than one new case in a package submitted to C2C, but it is imperative to clearly separate individual case files from one another to prevent issues with intermingling enrollee information.

C2C will accept delivery of case files through the QIC Appeals Portal 24 hours a day/7 day a week[4]. The receipt date for purposes of health plan submission timeliness is the actual date/time of portal submission.

[4] With the exception of routine scheduled maintenance or emergency maintenance to fix user issues, the portal will be available.

When submitting electronic case files using the QIC Appeals Portal, the Medicare Health Plan may include only one new case in each package submitted to C2C.

For all hard copy case file submissions submitted to C2C via mail or overnight delivery:

- Complete and place the New Reconsideration Case File Transmittal Cover Sheet form (See Appendix) on top of the case file package.
- Bind each case in the package separately; using clips or other methods that can be removed without special equipment is permissible.
- Do not staple or permanently bind case file material.

5.3.3 ORGANIZATION OF INDIVIDUAL NEW CASE FILES

The organization of the case should be in the following order, "top" of file to "bottom."

- *Medicare Managed Care Reconsideration Background Data Form* (See Appendix)
- Case Narrative (See Appendix)
- Case Material

EXPLANATION OF "CASE MATERIAL":

"Case material" refers to all supporting notices, documentation, medical records, call logs, and so forth. Case material should be placed in a standard order, "top" of file to "bottom," as shown below.

- Notices:
  - Representative Documentation (if applicable)
  - Non-Contract Provider Waiver of Liability (if applicable)
  - Notice of Medicare Health Plan Adverse Organization Determination
  - Notice of Medicare Health Plan Reconsideration Determination
  - Notice of Denial of Expedited Appeal Request (if applicable)
  - Notice of Extension to timeframe taken in enrollee interest (if applicable)

- Record of Adverse Determination and Medicare Health Plan Reconsideration
  - Prior authorization or claim denial documents
  - Medical Director or consultant determinations
  - Documentation of arguments of enrollee, enrollee's provider or representative
  - Any provider letters of support or consultations supporting the enrollee's
  - position
  - Any relevant call logs or system reports
  - Any other records kept by the Medicare Health Plan of its initial determination
  - or reconsideration proceeding

- Medicare Health Plan Decision Making Criteria
  - Complete copy of subscriber agreement, preferably on CD-ROM or USB thumb drive
  - Full citation for any CMS policy references, or copy of text*

  - Other Information
  - Complete copy of any referenced internal medical policy, utilization review
  - criteria, technology assessment, or other cited medical criteria

- Medical Records (See Section 5.3.4)

** Note:* "Full citation" refers to the designation of section and paragraph of the Social Security Act or CFR, and the referenced CMS IOM Manual - Chapter/Section; a copy is not required for these citations. For Local Coverage Decisions, a copy must be included unless an active and complete citation is provided via direction to a web address. Do not cite secondary sources (for example, MCG/Milliman, InterQual, or proprietary internal policies) unless complete text is provided.

5.3.4 GUIDANCE ON SELECTION AND INCLUSION OF MEDICAL RECORDS

For denials that are based, in whole or part, on medical necessity, the Medicare Health Plan must provide a "peer defensible" rationale for the denial. Medical records that relate to the case issues must be included. Medical records that do not relate to the case should not be included.

If the Medicare Health Plan has made one or more unsuccessful attempts to obtain records, such attempts should be documented. For example, the Medicare Health Plan may include a statement within the Case Narrative (Section IV (B) Justification) detailing the attempts made to obtain the records and the basis of why the Medicare Health Plan arrived at its decision without these records.

Medicare allows Medicare Health Plans to use step therapy for Medicare Part B drugs to manage its formulary. This is the process of beginning drug therapy for a medical condition with "preferred" (or more cost-effective) on-formulary drug alternative(s) and progressing to other drug therapies only as necessary. A plan must grant an exception to its step therapy coverage rules for Medicare Part B drugs if it determines that the requested drug is medically necessary, consistent with the prescriber's statement and the medical records. The physician statement and the medical records must show that the step therapy drugs:

1. Have been ineffective in treating the enrollee; or
2. Are likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or
3. Are likely to cause an adverse reaction or other harm to the enrollee.

The documentation required in the case file from the plan is as follows:

- Plan specific Step Therapy edits and rules for the Part B drug
- Enrollee physician statement regarding trial and failure of specific medications
- Enrollee medical records regarding previous treatments
- Entire Evidence of Coverage /Plan Formulary and any addendums regarding Medicare Part B drugs.

Exhibit 5-3: Suggested Medical Records for Inpatient and Long-term Care Denials and Exhibit 5-4: Suggested Medical Records for other Common Types of Denials are offered

by C2C to reduce the need for requests for additional information to the Medicare Health Plan. The Medicare Health Plan should regard these examples as a general guide. Requirements for a given case may vary. C2C reserves the right to request records in addition to those listed in these examples should the situation warrant the request.

Exhibit 5-3: SUGGESTED MEDICAL RECORDS FOR INPATIENT AND LONG-TERM CARE DENIAL

Medical Records	*Acute Hospital Admission Denial*	*Acute Hospital Continued Care Denial*	*SNF Admission Denial*	*SNF Continued Care Denial*	*Inpatient Rehabilitation Admission Denial*	*Inpatient Rehabilitation Denial*
PCP Records	X					
Specialist Records	X					
Treating Physician Support for Denial	X	X	X	X	X	X
Alternate Care Recommendations	X	X	X	X	X	X
Pre-Admission Screening					X	X
Admission Orders*		X	X (hospital)	X (SNF)	X (hospital or SNF)	X (rehab)
Doctor's Orders*		X	X (hospital)	X (SNF)	X (hospital or SNF)	X (rehab)
Admission History and Physical*		X	X (hospital)	X	X (hospital or SNF)	X (rehab)
Discharge Note*		X	X (hospital)	X (hospital)	X (hospital or SNF)	X (hospital, SNF, rehab)
Physician Progress Notes*		X	X (hospital)	X (hospital and SNF)	X (hospital or SNF)	X (rehab)
Nurses Notes*		X	X (hospital)	X (SNF)	X (hospital or SNF)	X (rehab)
Nursing Care Plan*		X		X (SNF)	X (hospital or SNF)	X (rehab)
Medication Record*		X	X (hospital)	X (SNF)	X (hospital or SNF)	X (rehab)
Treatment Records (e.g., wound care)*		X	X (hospital)	X (SNF)	X (hospital or SNF)	X (rehab)
Diagnostic Studies*		X	X (hospital)	X (SNF)	X (hospital or SNF)	X (rehab)
Laboratory Studies*		X	X (hospital	X (SNF)	X (hospital or SNF)	X (rehab)
Physical Therapy Admission and Discharge Notes*				X (SNF)	X (hospital or SNF)	X (rehab)
Physical Therapy Progress Records*		X	X (hospital)	X (hospital and SNF)	X (hospital or SNF)	X (rehab)
Occupational Therapy Admission and Discharge Notes*				X (SNF)	X (hospital or SNF)	X (rehab)

Medical Records	*Acute Hospital Admission Denial*	*Acute Hospital Continued Care Denial*	*SNF Admission Denial*	*SNF Continued Care Denial*	*Inpatient Rehabilitation Admission Denial*	*Inpatient Rehabilitation Denial*
Occupational Therapy Progress Records*		X	X (hospital)	X (hospital & SNF)	X (hospital or SNF)	X (rehab)
Speech Therapy Admission and Discharge Notes*				X (SNF)	X (hospital or SNF)	X (rehab)
Speech Therapy Progress Notes*		X	X (hospital)	X (hospital and SNF)	X (hospital or SNF)	X (rehab)
Nutrition Therapy Notes*		X	X (hospital)	X (SNF)	X (hospital or SNF)	X (rehab)
Discharge Planning Notes*		X	X (hospital)	X (SNF)	X (hospital or SNF)	X (rehab)
Records on prior level of functioning			X	X	X	X

*Records may be from an acute care hospital, a SNF, or an inpatient rehabilitation facility depending on the ease types and basis for denial.

Exhibit 5-4: SUGGESTED MEDICAL RECORDS FOR OTHER COMMON TYPES OF DENIALS

Issue at Appeal	Records Needed
Mobility Aids (PMDs, power wheelchairs, manual wheelchairs, walkers, canes)	PCP records, Physical Therapy records, Orthopedic records, Neurology records (if applicable), face-to-face, in-home DME evaluations
MRIs	PCP records, Orthopedic Records, Neurology Records, Physical Therapy Records
CT scans	PCP records, neurology records, other specialties as needed Cataract surgery
Cataract surgery	PCP records, ophthalmology records
Blepharoplasty	PCP records, ophthalmology records including visual fields (taped and untaped) and photographs
PET scans	PCP records, oncology records
Rehabilitation Therapy	PCP records, physical therapy records, initial assessment and treatment plan
Oxygen Equipment	PCP records, pulmonology records, O2 saturation test results
Chiropractic care	PCP records, orthopedic records (if applicable), neurology records (if applicable), x-rays/x-ray reports
Colonoscopies (including cost sharing cases)	Colonoscopy report, PCP records, gastroenterology records
Foot Care	PCP records, Podiatry records, Endocrinology records (if applicable)
Radiation Therapy/Chemotherapy	PCP records, Oncology records, lab results, surgery records (if applicable)
Bone Growth Stimulators	PCP records, orthopedic records, x-rays/x-ray reports Specialist services
Specialist services (general)	PCP records, records from specialist type at issue
Emergency Room and Ambulance Transport	ER records, ambulance trip reports, nurse's notes, ER triage/intake notes
Mental Health Services	PCP records, Psychiatry records, Psychology/Social Worker notes, Behavioral Health notes

Bariatric Surgery	PCP notes, Bariatric Surgery notes, Nutritionist notes, Endocrinology notes (if applicable)
Dental Services	Dental Records, Oral Surgery Records, Dental x-rays (preferably photo-quality digital prints)
Part B covered drugs	PCP records, requesting physician records
Part B covered drugs/Part B Step Therapy drug	Plan requirements involving step therapy analysis, enrollee physician statement, complete medical records regarding previous treatments, full Evidence of Coverage with Plan Formulary

5.3.5 CONFIRMATION OF C2C CASE RECEIPT

Submission of Reconsideration Cases and Case File Materials

The preferred method for receipt of all cases and case file materials is through the QIC Appeals Portal. When a case file is submitted to C2C via the QIC Appeals Portal, the Medicare Health Plan will receive immediate on-screen confirmation that the documents have been received by C2C. This confirmation will include a tracking number.

Although not preferred, Medicare Health Plans may submit cases and case file materials via hard copy mail or overnight courier (see Contract Information section of this manual for appropriate addresses). C2C does not issue a confirmation of receipt to the Plan for materials submitted through these methods.

C2C will send the appellant a timely acknowledgement letter: within 24 hours of receipt of the case file for expedited appeals and within two (2) business days of our receipt of the case file for standard appeals.

Both the appellant and the Plan will receive the C2C reconsideration determination notice (see Section 6).

IRE Review of Plan Dismissal Cases

When the request for a review of the Medicare Health Plan's dismissal is received, C2C will request the case file from the Medicare Health Plan.

The preferred method for receipt of all case files, related to the Part C QICs review of a Health Plan dismissal, is the QIC Appeals Portal. When a dismissal-related case file is submitted to C2C via the QIC Appeals Portal, the Medicare Health Plan will receive immediate on-screen confirmation of receipt by C2C. This confirmation will include a tracking number.

Although not preferred, plans may submit dismissal case files by hard copy mail or overnight courier (see the Contract Information section of this manual for mailing and courier addresses related to submission of dismissal case files in response to an IRE request). In these instances, C2C does not issue an acknowledgement letter to the appellant. Receipt of the dismissal case file is confirmed by the issuance of the IRE review determination regarding the Plan dismissal, to the appealing party and the Medicare Health Plan (See section 8).

6. C2C RECONSIDERATION PROCESS

The purpose of this Chapter is to provide the Medicare Health Plan with an overview of the procedures and approach that C2C follows in rendering the IRE level reconsideration. The topics addressed are:

6.1 C2C Case Processing Time Standards
6.2 Administrative Case Intake
6.3 Policies on Communication with Medicare Health Plan and Appellant during Case Processing
6.4 Adjudicator Case Review
6.5 Physician Review
6.6 Requests to Medicare Health Plan for Additional Information
6.7 Reconsideration Determination Notices
6.8 Enrollee Requests for Case Files

6.1 C2C CASE PROCESSING TIME STANDARDS

C2C is responsible for completing the IRE reconsideration within the same timeframes and standards that apply to Medicare Health Plans.

CASE CLASS	*TIME STANDARD*
Expedited	72 hours, plus 14 calendar day extension if in enrollee's interest, or sooner if warranted by enrollee's medical condition
Standard Item or Service	30 calendar days, plus 14 calendar day extension if in enrollee's interest, or sooner if warranted by enrollee's medical condition
Standard Part B Drug	7 calendar days- no extensions are permitted for these case types
Standard Payment (Claim), Retrospective	60 calendar days

In expedited and standard item or service appeals, C2C may extend the decision timeframe by up to 14 calendar days if it is in the enrollee's interest. This 14-day extension is not permitted for standard Part B drug appeals or for standard payment (claim) appeals. C2C will notify the enrollee of the extension in writing.

The start of the adjudication time period for IRE reconsideration is the date on which the case file is received at C2C. The end of the time period is the date on which C2C mails its reconsideration determination or review determination notice. Determinations are sent to appellants by standard first-class mail and faxed to Medicare Health Plans to the Decision Letter Fax Number as noted on the *Medicare Managed Care Reconsideration Background Form* for the specific case.

6.2 ADMINISTRATIVE CASE INTAKE

The steps in C2C administrative case intake are:

- Mail Opening and sorting of new case files
- Inquiry on CMS systems to verify beneficiary enrollment in Medicare Health Plan
- Medicare Appeal System assignment of a random "reconsideration case number"

- Generation of acknowledgement letters, when required
- Assignment of the case to a C2C Adjudicator

Note: if the Medicare Health Plan does not provide the enrollee's Medicare number and complete all required fields on the *Medicare Managed Care Reconsideration Background Data Form* (See Appendix), the errors or omissions on the *Reconsideration Background Data Form* will lead to delays in C2C's intake of the case.

6.3 POLICIES ON COMMUNICATION WITH MEDICARE HEALTH PLAN AND APPELLANT DURING CASE PROCESSING

6.3.1 ALL EVIDENCE MUST BE IN WRITING

Federal regulations define the IRE level reconsideration as a de novo determination based upon the documented case file. The IRE level reconsideration does not provide for in-person or telephonic hearings. This means that C2C may consider only such evidence as is submitted and available in the hard copy record.

Any party calling C2C is advised that the information being relayed will not be considered unless it is submitted in writing. A party is advised that he/she should follow up any "telephone testimony" immediately with written documentation.

6.3.2 COMMUNICATIONS REGARDING THE POTENTIAL IRE DETERMINATION ARE NOT PERMITTED

C2C personnel are not permitted to engage in written or phone communication with parties, where the subject of such communication is any discussion or projection of the IRE determination that C2C may make. Discussions are limited to review of the IRE process, including instructions on the procedures for submission of written information to C2C.

6.3.3 ENROLLEE SUBMISSION OF ADDITIONAL INFORMATION TO THE IRE CASE FILE

The C2C acknowledgement letter that is sent to the appellant (e.g., enrollee or valid representative), advises the appellant of their ability to submit additional information directly to C2C.

C2C may provide a Medicare Health Plan information that the Medicare Health Plan has submitted, but C2C may not provide information submitted by the enrollee. If information submitted by the enrollee is not already contained in the case file, and if the information calls into question material submitted by the Medicare Health Plan, C2C may request clarification via a Request for Information (RFI) (See Section 6.6).

Enrollees may be less likely to submit information directly to C2C if the enrollee believes that: (1) the Medicare Health Plan has provided the enrollee the chance to submit evidence to the Medicare Health Plan and (2) the Medicare Health Plan has advised the enrollee that the entire case file has been submitted to C2C.

6.4 ADJUDICATOR CASE REVIEW

An Adjudicator is a professional trained by C2C to: (1) manage the IRE case reconsideration and (2) make coverage determinations. Adjudicators are not permitted

to make medical necessity determinations, which require physician review (See Section 6.5).

6.5 PHYSICIAN REVIEW

Pursuant to 42 CFR §422.590(h)(2), determinations of medical necessity must be made by a physician. Section 1861(r) of Social Security Act defines physicians to include a Doctor of Medicine or Osteopathy, a Doctor of Dental Surgery or of Dental Medicine, a Doctor of Podiatric Medicine, a Doctor of Optometry, and a Chiropractor. See also CMS IOM Pub. 100-01, Medicare General Information, Eligibility and Entitlement Manual, Chapter 5, Section 70 (Physician Defined).

C2C maintains an extensive national health care panel comprised of physicians and other healthcare professionals. Our physician reviewers represent more than 85 of the specialties and subspecialities recognized by the American Board of Medical Specialties (ABMS), along with hundreds of pharmacists and many other clinical experts. Our physician reviewers are located throughout the United States and include a mix of physicians who predominately practice in community rather than academic settings.

Physicians are matched to cases based upon the case clinical issue. Medical necessity decisions issued by the IRE will be made by a physician with expertise in the field of medicine that is appropriate for the disputed item, services, or Part B drug.

The physician reviewer's case file includes a copy of and, where necessary, guidance regarding any applicable Medicare National Coverage Decision (NCD), local coverage decision (LCD) or clinical guidelines. If the Plan's denial decision is based on a Medicare NCD, LCD, or clinical coverage policies in Medicare manuals, Plans do not need to provide the entire manual as part of the case file but rather must identify the specific manual, chapter, and section with the relevant policy to support the Plan's decision. Plans are strongly encouraged to also include a screenshot of the relevant section or other supporting evidence. Where a Medicare Health Plan's medical necessity determination is based upon a Health Plan's specific guideline or policy, such guideline or policy as well as any relevant background evidence from the Medicare Health Plan (including medical literature from peer reviewed publications) will be provided to the IRE's physician reviewer for consideration. Medicare Health Plans must include Plan guidelines and policies for this reason.

The physician reviewer's determination will be subject to quality reviews, including by the C2C Medical Director. Special emphasis is placed on ensuring that the physician reviewer's determination is consistent with any relevant Medicare policies or permissible and medically appropriate Medicare Health Plan policies.

6.6 REQUESTS TO MEDICARE HEALTH PLAN FOR ADDITIONAL INFORMATION

"Request for Additional Information" (RFI) is the formal process by which C2C request and permits the Medicare Health Plan to supply written information to answer a question or remedy a deficiency in the reconsideration case file. The RFI process is discretionary, and C2C has no obligation to request additional information from the Medicare Health Plan.

6.6.1 REQUEST FOR ADDITIONAL INFORMATION IS AT C2C DISCRETION

The C2C reconsideration is designed as an "on the record" review rather than an "in person" proceeding. Therefore, the Medicare Health Plan reconsideration case file must include all relevant evidence and documents used in making the Medicare Health Plan reconsideration determination as well as the documents and records specified in Section 5.3.

The IRE is under no obligation to seek additional information. The Medicare Health Plan bears the burden to show why the denial is appropriate. Therefore, **missing information is reasonably construed to the enrollee's favor.** C2C may decide a case at any time based upon the information available. C2C does not overturn the Medicare Health Plan's denial for case file deficiencies, per se, or on an administrative basis. However, a case file deficiency typically undermines the validity of denial argument of the Medicare Health Plan, hence missing information may result in a determination that is favorable to the appellant.

6.6.2 REQUEST FOR INFORMATION PROCESS

The process used by C2C for Request for Information is as follows:

- The Adjudicator determines the deficiency and double checks the case file to verify the information is, in fact, absent
- The Adjudicator sends a completed Request for Information Form to the fax number provided for the Case Contact on the *Medicare Managed Care Reconsideration Background Data Form*. For expedited cases, the Adjudicator may instead conduct the Plan outreach by phone.
- The Medicare Health Plan Case Contact calls C2C if:
    - Questions exist about the RFI
    - The RFI deadline (See Section 6.6.3) cannot be met
- The Medicare Health Plan develops and submits the RFI Response
- The Adjudicator reviews the RI response to determine if it is sufficient. If not:
    - Minor omissions are resolved by phone
    - Major omissions may lead to a repeat of the RFI process or may lead to C2C determination based on available documents.

6.6.3 MEDICARE HEALTH PLAN SUBMISSION OF THE RESPONSE TO A REQUEST FOR INFORMATION

The Medicare Health Plan must expeditiously submit the requested information to C2C via the QIC Appeals Portal, fax, hard copy mail, or overnight/courier delivery.

- If hard copy delivery or fax delivery is used for an RFI response, the Medicare Health Plan must place the Request for Information Response Cover Sheet (see Appendix) on top of the response documents.
- If the Medicare Health Plan places more than one RFI response in a package, separate each RFI response with the Request for Information Response Cover Sheet.

The following maximum timeframes apply for Medicare Health Plan response to C2C Requests for Information:

Expedited Reconsiderations	Within 24 hours from date of request

Standard Item or Service Reconsiderations	Within 5 calendar days from date of request
Standard Part B Drug Reconsiderations	Within 24 hours from date of request
Standard Payment (claim) Reconsiderations	Within 5 calendar days from date of request

The deadline above is for the date of Medicare Health Plan submission (e.g., QIC Appeals Portal, fax, or mailing) of the requested material to C2C. Expedited RFI responses and Standard Part B Drug Reconsideration RFI responses must be submitted via the QIC Appeals Portal, fax, or by overnight delivery.

C2C may expedite an RFI request if such action is necessary due to the enrollee's health.

6.6.4 MEDICARE HEALTH PLAN SUBMISSION OF ADDITIONAL INFORMATION AUTHORIZING COVERAGE OR PAYMENT FOR AN ITEM, SERVICE, OR PART B DRUG SUBSEQUENT TO PLAN SUBMISSION OF CASE AND CASE FILE TO IRE

In the rare circumstance where a Medicare Health Plan authorizes coverage or issues payment for an item, service, or Part B drug after the Plan has submitted the case and case file documentation to the IRE for reconsideration, the Plan may, as a party to the appeal, take the following action:

- Expeditiously submit the additional information and supporting documentation to the IRE via the QIC Appeals Portal *(preferred)* or via fax, as directed in the applicable form in the Appendix.

Plans should include compelling evidence demonstrating that authorization or payment has been made, such as:

- Evidence of notification to the enrollee that authorization or payment has been issued by the Plan.
- A copy of the related letter sent to the enrollee or other party members.
- A screenshot or other documentation showing the authorization or payment for the item, service, or Part B drug at issue.

If the IRE determines that the information is credible, compelling, and complete, the IRE will issue a favorable decision informing the appellant that the item, service, or drug has been authorized or paid for by the Plan and that no issues remain in dispute.

Note: A Plan may only use this process when it is authorizing or issuing payment for all items, services, or Part B drugs in dispute for the specific case.

6.7 RECONSIDERATION DETERMINATION NOTICES

6.7.1 ISSUING A RECONSIDERATION DETERMINATION

Upon completion of its reconsideration, C2C issues a mailed "reconsideration determination" notice to the appealing party, with a faxed copy to the Medicare Health Plan.

6.7.2 GENERAL CHARACTERISTICS OF C2C DETERMINATION NOTICES

All C2C reconsideration determination notices that are not fully in the enrollee's favor contain an explanation of the enrollee's right to request further appeal by the Office of Medicare Hearings & Appeals (OMHA). The language explains in plain language that the review can include a Hearing with an Administrative Law Judge (ALJ) or an on-the-record review by an Attorney Adjudicator. A Hearing is a meeting with the party (e.g., the enrollee) and the ALJ so that the party can talk about the appeal. An on-the- record review is a review based on the administrative record. Enrollees can ask for the kind of review that they prefer.

A C2C reconsideration determination notice that overturns a Medicare Health Plan determination, in whole or in part, contains an explanation of how the enrollee can obtain the disputed payment or covered service. The enrollee is directed to the Medicare Health Plan to obtain the item or service or claim payment.

Although a C2C reconsideration determination may address or discuss medical care and treatments, the C2C reconsideration determination is not an assessment of quality of care, nor is it medical advice or instruction. A C2C determination is a ruling on the Medicare Health Plan's obligation for coverage (payment or arrangement for a specific benefit, service, or treatment).

For any fully or partially favorable reconsideration determination, C2C also issues the Medicare Health Plan a Notice to Comply with IRE Part C Reconsideration Determination. This document references the favorable determination notice and advises the Medicare Health Plan of its obligation to timely effectuate the favorable decision.

6.7.3 TRANSLATION OF CORRESPONDENCE

Upon request of the enrollee or Medicare Health Plan, C2C is required by CMS to translate its final reconsideration determination notice into the native language of the enrollee. The Medicare Health Plan notifies C2C of the need for translation on the *Medicare Managed Care Reconsideration Background Data Form* (See Appendix).

6.7.4 PROVISION OF COMMUNICATION IN ALTERNATE FORMATS

C2C is required by CMS to arrange to provide communication in alternate formats, if needed. The Medicare Health Plan notifies C2C of the need for alternate formats on the Reconsideration Background Data Form (See Appendix).

6.8 ENROLLEE REQUESTS FOR CASE FILES

The C2C acknowledgement letter advises enrollees of the right to obtain a copy of the reconsideration case file from the Medicare Health Plan and/or C2C. Under instruction from CMS, and subject to the provisions of the Privacy Act and Freedom of Information Act, C2C will release a copy of a reconsideration case file to an enrollee or other authorized individual.

C2C may release to a Medicare Health Plan only copies of documentation the Medicare Health Plan has submitted in the case file.

7. POST RECONSIDERATION DETERMINATION PROCESSING

Several processes may be invoked after C2C issues its reconsideration determination notice. This Chapter provides useful information on these various post determination processes. The topics addressed are:

7.1 C2C Monitoring of Medicare Health Plan Compliance with Favorable Determinations
7.2 IRE Reopening Process
7.3 Administrative Law Judge (ALJ) Process
7.4 Medicare Appeals Council (MAC) Process

7.1 C2C MONITORING OF MEDICARE HEALTH PLAN COMPLIANCE WITH OVERTURNED DETERMINATIONS

Compliance ("effectuation") is defined as the Medicare Health Plan's payment of a claim, or authorization and arrangement for an item or service or continuation of items or services (expedited, standard item or service denial, or standard Part B drug denial), as instructed in the C2C reconsideration determination notice.

7.1.1 MEDICARE HEALTH PLAN EFFECTUATION TIMEFRAMES

The following table summarizes CMS requirements for timeliness of Medicare Health Plan effectuation:

APPEAL PRIORITY	*TIME REQUIREMENT (from receipt of notice)*	*REFERENCE*
Expedited	Authorize or provide within 72 hours, or earlier if enrollee health dictates	42 CFR §422.619(b)(1)
Expedited Part B Drug	Authorize or provide within 24 hours, or earlier if enrollee health dictates	42 CFR §422.619(b)(2)
Standard Item or Service	Authorize within 72 hours, or as expeditiously as enrollee's health requires but no later than 14 calendar days	42 CFR §422.618(b)(1)
Standard Part B Drug	Authorize or provide within 72 hours, or earlier if enrollee health dictates	42 CFR §422.618(b)(3)
Standard Paid Claim	Pay within 30 days	42 CFR §422.618(b)(2)

If you have questions regarding a C2C determination, please send your request to the Plan Liaison at PartC-Plan_Liaison@c2cinc.com. Please note C2C is not authorized to waive compliance with any final determination. If you feel that you cannot comply with the C2C reconsideration determination notice, you must notify your Account Manager at the CMS Regional Office.

A Medicare Health Plan request for a reopening (See Section 7.2), whether granted by C2C or not, does not stay or pend the date of the Medicare Health Plan compliance obligation.

7.1.2 C2C RECONSIDERATION COMPLIANCE MONITORING

CMS requires C2C to monitor Medicare Health Plan compliance with the effectuation process, via the following procedure:

1. C2C issues the Medicare Health Plan a copy of the reconsideration determination notice. Included with this copy is a Notice to Comply with IRE Part C Reconsideration Determination, that details the Medicare Health Plan's responsibilities, including the timeframe by which a compliance notice must be received by C2C
2. The Medicare Health Plan is required to submit a statement attesting to compliance (effectuation) to C2C. The Statement must be submitted to C2C in accordance with timeframes noted within the Notice to Comply with IRE Part C Reconsideration Determination. Medicare Health Plans may submit this information via the QIC Appeals Portal, fax, or mail.
3. C2C provides 5 days from the due date of submission for mailing time.
4. If C2C does not receive the Medicare Health Plan statement of compliance within 30 days, C2C reports the Medicare Health Plan's failure to comply to CMS. The Medicare Health Plan is not copied on this report to CMS.

The Medicare Health Plan statement of compliance may be in a form designed by the Medicare Health Plan but must contain all of the information found on the recommended Medicare Health Plan Statement of Compliance Form contained in the Appendix. Please do not submit unidentified internal computer screen prints as the statement of compliance.

Medicare Health Plan Statements of Compliance should be sent via the QIC Appeals Portal, or via fax or mail as identified in the Contact Information section of this document.

7.2 IRE REOPENING PROCESS

An IRE Reopening is an administrative procedure in which the IRE re-evaluates its reconsideration determination for the purpose of addressing an error, fraud, or information not available at the time of IRE reconsideration determination. A reopening is not an appeal right.

C2C may accept or reject a request for a reopening at its sole discretion. Within 30 calendar days of receipt of a request for reopening, C2C will make a determination as to whether or not it shall reopen a case and inform the appellant and the plan of that determination.

C2C may initiate a reopening on its own initiative. In addition, any of the parties to a reconsideration determination may request a reopening within 180 days of the decision. The reopening request must be in writing and clearly state the basis on which the request is made:

1. Error on the face of the evidence by C2C in its review,
2. Fraud, or
3. New and additional information that was not available at the time C2C made its initial determination in the case.

The process by which C2C administers and adjudicates a reopening request is similar to the reconsideration process:

1. C2C receives and logs the Reopening Request.
2. An acknowledgement letter is sent to the party requesting the reopening and Medicare Health Plan.
3. An Adjudicator not involved in the reconsideration reviews the Reopening.
4. The Adjudicator makes a determination, incorporating a physician review if indicated.
5. A Reopening Determination Notice is issued.
6. If the Reopening Determination reverses a reconsideration (that is, the Reopening finds in fully or partially in favor of the enrollee), a Notice to Comply with IRE Part C Reconsideration Determination is also issued to the Medicare Health Plan. The Medicare Health Plan is then responsible for "effectuation" per the discussion of compliance above.

   A Medicare Health Plan's request for a reopening does not relieve the Medicare Health Plan of the burden of compliance, and reporting of compliance, within the required timeframes (See Section 7.2). The Medicare Health Plan is relieved of this burden if the Medicare Health Plan obtains a Reopening Reversal (of a Favorable reconsideration) prior to the Medicare Health Plan compliance date. The Medicare Health Plan is not relieved of the burden of compliance with the original favorable reconsideration if the Medicare Health Plan receives a Reopening Reversal after the original compliance date.

7. C2C's contract with CMS allows 120 days for the processing of Reopening cases. In many cases, especially those requiring physician review, the full timeframe may be required.

7.3 OFFICE OF MEDICARE HEARINGS AND APPEALS (OMHA) PROCESS

The appellant (enrollee, his/her representative, or the noncontract provider) may request an appeal of the C2C reconsideration determination before an Administrative Law Judge (ALJ) or Attorney Adjudicator (AA) with the Office of Medicare Hearings and Appeals. C2C does not determine an enrollee's right to a hearing, nor does it schedule, conduct, or administer hearings.

The Medicare Health Plan does not have a right to request a review by OMHA. The Medicare Health Plan does have the right to be present at the ALJ hearing and the right to present additional evidence at the hearing.

7.3.1 NOTICE OF RIGHTS TO HEARING AND SUBMISSION OF REQUEST FOR ALJ OR AA HEARING

The right to request an ALJ or AA hearing is explained in the C2C reconsideration determination notice. An enrollee may submit a written request for an ALJ or AA hearing to C2C. If the Medicare Health Plan receives a request for an ALJ or AA hearing, it should immediately forward the request to C2C.

When a party files a request for ALJ hearing, OMHA will then promote the IRE reconsideration case file from the MAS to the OMHA system of record for processing hearings. C2C does not communicate directly with Medicare Health Plans or parties during the OMHA review process. C2C's role is limited to providing complete case files to the OMHA office.

7.3.2 TRACKING AND CONDUCT OF ALJ OR AA HEARING

C2C does not schedule ALJ or AA hearings and does not have direct access to OMHA scheduling information. OMHA is responsible for contacting the requesting party and Medicare Health Plan to schedule the matter before the ALJ. Both parties (that is, the requesting party and the Medicare Health Plan) have a right to be present and present testimony at the ALJ hearing. Any concerns regarding the ALJ hearing should be directed to OMHA.

7.3.3 ALJ OR AA DETERMINATION PROCESSING

The ALJ or AA Determination is mailed directly to the parties (e.g. the enrollee or non-contract provider and Medicare Health Plan). If the ALJ has reversed or modified C2C reconsideration determination and notifies C2C that such a decision has been rendered, C2C sends a copy of the ALJ determination to the Medicare Health Plan with a Notice to Comply with the ALJ Determination. C2C also sends a copy of this notice to the appealing party. The Medicare Health Plan is obligated to effectuate the ALJ's determination. The Medicare Health Plan must report the compliance to C2C in the same manner as a favorable C2C decision.

7.3.4 EFFECT OF MEDICARE APPEALS COUNCIL REQUEST ON ALJ DECISION EFFECTUATION

If the Medicare Health Plan requests Medicare Appeals Council (Appeals Council) review consistent with 42 CFR §422.608, the Medicare Health Plan may await the outcome of the review before it pays for, authorizes, or provides the service under dispute. A Medicare Health Plan that files an appeal with the Appeals Council must concurrently send a copy of its appeal request and any accompanying documents to the enrollee and must notify C2C that it has requested an appeal before the Appeals Council. Medicare Health Plan Statements of Compliance should be sent via the QIC Appeals Portal, or via fax or mail as identified in the Contact Information section of this document.

7.4 MEDICARE APPEALS COUNCIL PROCESS

Federal regulations permit any party to an ALJ hearing to request a further hearing before the Appeals Council (See 42 CFR §422.608). If a hearing before the Appeals Council is requested, C2C is contacted by the Appeals Council to provide a copy of the entire case file in dispute. C2C does not communicate directly with Medicare Health Plans or parties regarding the Appeals Council review process. C2C's role is to provide complete case files to the Appeals Council.

7.4.1 TRACKING AND CONDUCT OF MEDICARE APPEALS COUNCIL HEARING

C2C does not schedule Appeals Council hearings and does not have direct access to Appeals Council scheduling information. Any concerns regarding the Appeals Council hearing process should be directed to the Medicare Appeals Council.

7.4.2 MEDICARE APPEALS COUNCIL DETERMINATION PROCESSING

The Appeals Council Determination is mailed directly to the parties. The Medicare Health Plan is obligated to effectuate the Appeal Council's determination. The Medicare Health Plan must report the compliance to C2C. The Medicare Health Plan Statements of Compliance regarding Council decisions should be sent via the QIC Appeals Portal, or via fax or mail as identified in the Contact Information section of this document.

8. HEALTH PLAN DISMISSAL PROCESSING AND APPEALS

Medicare Health Plans are not required to automatically forward dismissed reconsideration requests to C2C. Rather, Medicare Health Plans are required, when dismissing an appellant's reconsideration request, to inform the appellant about the right to request an IRE review of the Plan dismissal. CMS guidance explicitly states that Medicare Health Plans should use the model Notice of Dismissal of Appeal Request to advise appellants when their request is being dismissed. Appellants will then have the right to request a review of the Medicare Health Plan's dismissal determination directly to C2C. Plans should include the model dismissal appeal request form with all dismissal case files it submits. This form is intended to standardize incoming dismissal appeal requests and to provide C2C with the information necessary to complete the review of the dismissal. Additional information is provided in 8.1. Topics discussed in this section are:

8.1 Notice of Dismissal of Appeal Request
8.2 Dismissal Case File Requests
8.3 C2C Review of Dismissal Decision
8.4 Dismissal Case File Documentation
8.5 Timeframes for C2C Review
8.6 Dismissal Decisions are binding

8.1 NOTICE OF DISMISSAL OF APPEAL REQUEST

The Notice of Dismissal of Appeal Request provides C2C with sufficient information to begin processing an appellant's dismissal review request. C2C recommends that

Medicare Health Plans include either the Medicare Health Plan appeal case number or the date of services on the Notice of Dismissal of Appeal Request.

Appellants should either fax or mail a copy of this Notice of Dismissal of Appeal Request, along with any supporting documentation relevant to the review request, directly to C2C. The address and fax information for the party to file a request for IRE review of a Plan dismissal is identified in the Contact Information section of this manual.

Plans should include the model dismissal appeal request form with Plan dismissals. If the plan can populate information in this form (e.g., names, dates of service), C2C recommends that plans do so. Plans should customize this form to include their Plan information and a fax number for C2C to utilize to request a case file. The CMS model Notice of Dismissal of Appeal Request form is available at: https://www.cms.gov/medicare/appeals-grievances/managed-care/notices-forms.

8.2 DISMISSAL CASE FILE REQUESTS

Once C2C receives a dismissal review request from the appellant, C2C will contact, the individual or department that the Medicare Health Plan has listed on the Notice of Dismissal of Appeal Request as the party responsible for providing a copy of the case file to C2C. Per CMS guidance, Medicare Health Plans will have 24 hours from receipt of the case file request to forward the requested case file to C2C. See section 5.3.5 for case file submission methodology.

8.3 C2C REVIEW OF DISMISSAL DECISION

Once C2C has received the case file from the Medicare Health Plan, C2C will review the contents of the file and the Notice of Dismissal of Appeal Request, along with any supplemental information submitted by the appellant. After this review, C2C will determine if the Medicare Health Plan's dismissal was appropriate. If C2C agrees that the dismissal was appropriate, C2C will affirm the Medicare Health Plan's dismissal. If C2C finds that the Medicare Health Plan's dismissal was NOT appropriate (or new information has been discovered since the time of the Medicare Health Plan's dismissal making the appeal request valid), C2C will overturn the Medicare Health Plan's dismissal and remand the case to the Medicare Health Plan and advise the plan that it needs to perform a substantive reconsideration.

8.3.1 FACTORS THAT MAY RESULT IN AN OVERTURN OF A PLAN'S DECISION TO DISMISS AND SUBSEQUENT REMAND TO PLAN

- The appellant has shown good cause for filing their appeal outside of the 60-day appeal window and the reason for the Medicare Health Plan's dismissal is untimely filing of the appeal.
- The Medicare Health Plan has not provided proof that it made attempts to secure representative or Waiver of Liability documentation in accordance with CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.

If C2C decides that the Medicare Health Plan's dismissal should be overturned, then C2C will remand the case to the Medicare Health Plan. The Medicare Health Plan is then responsible for rendering a full, substantive reconsideration of the issue at appeal. If, at the end of this reconsideration, the Medicare Health Plan denies coverage of or payment for the item or service in dispute, in whole or in part, the Medicare Health Plan should follow the appropriate steps for forwarding the case for independent review to C2C as per the instructions in this Manual.

Note: When Medicare Health Plans send these cases to C2C for substantive reconsideration review, Medicare Health Plans should include in the case file a copy of the C2C remand action from the dismissal review. The date of the remand action will serve as the date of the reconsideration request for purposes of completing the *Medicare Managed Care Reconsideration Background Data Form* or completing the QIC Appeals Portal online submission questions.

8.4 DISMISSAL CASE FILE DOCUMENTATION

For dismissal review case files being submitted by the Medicare Health Plan at C2C request, Medicare Health Plans should send an abbreviated case file. The case file should include:

- The Medicare Managed Care Dismissal Case File Data Form
- A Dismissal Case File Narrative
- The organization determination documents
- The appeal request documents
- A copy of the Notice of Dismissal of Appeal Request
- Documentation of attempts made by the Medicare Health Plan to have the appealing party correct any appeal request deficiency

8.4.1 THE MEDICARE MANAGED CARE DISMISSAL CASE FILE DATA FORM

Every request from C2C to a Medicare Health Plan for a dismissal case file needs to be accompanied by the Medicare Managed Care Dismissal Case File Data Form. While similar to the *Medicare Managed Care Reconsideration Background Data Form*, this form contains fewer and different data elements. The Medicare Health Plan **must** designate a contact person on the *Medicare Managed Care Dismissal Case File Data Form*. Medicare Health Plans must also include the C2C Appeal Number on this form. This Appeal Number will be provided to the Medicare Health Plan on the case file request form.

8.4.2 ACKNOWLEDGMENT LETTERS

C2C will not issue acknowledgment letters to either the appellant or the Medicare Health Plan regarding dismissal review requests.

8.5 TIME FRAMES FOR C2C REVIEW

All dismissal review requests will be reviewed by C2C in accordance with the timeframes applicable to the priority of the appeal. This means that for expedited dismissal reviews, C2C will render its dismissal decision within 72 hours of receipt of the case file from the Medicare Health Plan. For standard item or service dismissal review requests, decisions will be made within 30 days of receipt of the case file from the Medicare Health Plan. For standard Part B drug dismissal review requests, decisions will be made within 7 days of receipt of the case file from the Medicare Health Plan. For standard payment (claim) dismissal review requests, decisions will be made within 60 days of receipt of the case file from the Medicare Health Plan. If C2C needs to request additional information from the Medicare Health Plan in order to process the dismissal review, an extension of 14 days is permitted for expedited and standard item or service (pre- service) cases. No extensions are permitted for dismissal reviews related to standard Part B drug or standard payment (claim) cases.

9. RECONSIDERATION DATA

C2C extracts numerous data elements from submitted reconsideration case files and provides reports to CMS based on the collected data. This Section discusses the related data systems and how the collected information is used within the reports. The topics addressed are:

9.1 Medicare Appeals System (MAS)
9.2 Medicare Health Plan Monitoring Reports
9.3 Using the C2C Website to Track Timeliness and Effectuation

9.1 MEDICARE APPEALS SYSTEM (MAS)

C2C utilizes the Medicare Appeal System (MAS) to support administration of the reconsideration process. Data is obtained and entered into the MAS from the following sources:

- CMS data systems, which provide enrollee and Medicare Health Plan identifying information.
- *Medicare Managed Care Reconsideration Background Data Forms*, from which certain data fields completed by the Medicare Health Plans are entered, as given into the MAS.
- Adjudicator abstraction of information from other reconsideration case file documents.

In addition to providing data to C2C for general program administration, MAS data is relevant to Medicare Health Plans in the following ways:

- CMS obtains reports, based upon MAS data, to monitor certain aspects of Medicare Health Plan compliance with appeal requirements.
- CMS publishes Quarterly Part C Reconsideration Appeals Data Fact Sheets on its website: https://www.cms.gov/medicare/appeals-grievances/managed-care/review-part-c-independent-entitiy.

9.2 MEDICARE HEALTH PLAN MONITORING REPORTS

C2C reports information to CMS related to:

- Timeliness of Medicare Health Plan organization determination and reconsideration determination
- Medicare Health Plan effectuation of IRE, ALJ, or Medicare Appeals Council overturned reconsideration determinations

It is important to note that C2C provides the above reports to CMS Central and Regional Offices to advise those offices of potential non-compliance. CMS personnel determine how such reports should be used in discharge of their Medicare Health Plan monitoring function.

Typically, CMS personnel will contact the Medicare Health Plan if a significant issue (for example, outlier) or pattern appears to exist and will provide the Medicare Health Plan the opportunity to research the case(s) more thoroughly.

However, as will be explained below, the source of the reported compliance data is primarily the Medicare Health Plan itself—specifically entries made to the *Medicare Managed Care Reconsideration Background Data Form* (or via the online form in the QIC Appeals Portal) by the Medicare Health Plan. **It is imperative that the Medicare Health Plan carefully and accurately complete the form.**

Proper Use of CMS Prescribed Adverse Determination Notices

C2C Adjudicators review the case file and ascertain which notice, if any, is contained. The type of notice is compared against the type required for the given appeal. The format and content of the Notice is also compared against related CMS requirements.

Timeliness of Medicare Health Plan - Organization Determination and Reconsideration

The *Medicare Managed Care Reconsideration Background Data Form* (See Appendix) requires the Medicare Health Plan to:

- Classify the case by priority (expedited, standard service, standard service Part B drug, standard claim)
- Enter "date of receipt" and "date of completion" of the organization determination and Medicare Health Plan reconsideration
- Enter requests for expedited processing and related Medicare Health Plan decision
- Indicate if a 14-day extension was taken "in the enrollee's interest" (this extension is not applicable to standard payment (claim) and standard service Part B drug appeals).

This data is used to calculate the time interval within which the organization determination and reconsideration should occur and compares this interval with the actual timeliness reported by the Medicare Health Plan. A variety of reports that measure Medicare Health Plan timeliness are submitted to CMS using these calculations. This set of reports relies upon the information exactly as given by the Medicare Health Plan on the Reconsideration Background Data Form. Consequently, Medicare Health Plan errors or omissions on this form will result in reporting of either missing data or cases outside of timeframe compliance.

In addition, the C2C adjudicators compare the contents of the case file (for example, notices and correspondence) to the data reported by the Medicare Health Plan on the *Medicare Managed Care Reconsideration Background Data Form* (or portal submission). If the Adjudicator determines that an error or omission exists on the Reconsideration Background Data Form, this error or omission is, if possible, corrected and reported separately. C2C uses this information to report "discrepancies" with respect to Medicare Health Plan reported timeliness to CMS.

Timeliness of Effectuation Compliance

Using the Medicare Health Plan's report of effectuation to C2C, we report to CMS listings of cases without compliance notice and statistics on effectuation compliance.

9.3 USING THE C2C WEBSITE TO TRACK TIMELINESS AND EFFECTUATION

C2C is responsible for providing CMS with data for certain STAR rating measures and for data in support of Regional Office (RO) Medicare Health Plan oversight activity. Specifically, C2C provides CMS with timeliness data for STAR metric C32 and with favorable decision rates for metric C33. In addition, C2C provides reports indicating cases where C2C has not been notified of favorable cases requiring compliance effectuation.

In order to allow Medicare Health Plans to proactively monitor the cases that they have sent to C2C for processing, we have developed a website that allows Medicare Health Plans to access timeliness and compliance data in via our Effectuation Status Lookup tool, available on the Part C QIC website: https://partcappeals.c2cinc.com/. This website is updated daily and is current as of the close of business on the previous business day.

It is important that Medicare Health Plans continuously review their underlying measure data that are the basis for the Part C STAR Ratings. CMS expects Medicare Health Plans to routinely monitor these data. Medicare Health Plans that notice discrepancies or have questions about the data should bring these issues to the attention of C2C as they arise. Medicare Health Plans may submit questions about the data to the Part C QIC Plan Liaison at: PartC-Plan_Liaison@c2cinc.com email box. Medicare Health Plans that wait to raise issues with their data until CMS' STAR Rating plan preview periods may find there is inadequate time to investigate and resolve them within the production schedule for the release of the STAR Ratings. Any issues or problems should be raised well in advance of CMS' plan preview periods.

The following sections will review the resources that are available on the website so that Medicare Health Plans can use the information throughout the year to monitor their own cases as well as report any discrepancies well in advance of STAR data being reported.

9.3.1 PLAN TIMELINESS DATA

Plans can access timeliness data from the Part C QIC website (https://partcappeals.c2cinc.com/) via the Appeals Status Lookup. Once selected, this tool gives Medicare Health Plans multiple options for searching for data, for example by a particular contract number or case number. It also allows Medicare Health Plans to limit the search by, for example, the date that C2C receives the case or the date that C2C renders its decision. Once the limiting information is entered into this search box, a list of data results will appear. The resulting data list can be exported into either an Excel or .csv file.

9.3.2 PLAN EFFECTUATION DATA

Plans can access effectuation data from the Part C QIC website (https://partcappeals.c2cinc.com/) via the Effectuation Status Lookup. Once selected this tool gives the Medicare Health Plans the ability to monitor effectuation and compliance. Plans can search the data on the website and monitor which of their cases have been found favorable or partially favorable by the IRE or the ALJ and determine if C2C has received the Medicare Health Plan attestation of compliance with the related effectuation. As with timeliness data, Medicare Health Plans can limit the search by various data points and export the resulting data into MS Excel or a .csv format.

This data provides Medicare Health Plans with decision disposition and information regarding whether the Plan compliance attestation has been received and recorded by C2C. C2C encourages Medicare Health Plans to review effectuation data on our website regularly and address any outdated effectuations.

9.3.3 DATA DISCREPANCIES

If a Medicare Health Plan notices that there is no compliance data entered for a case where they have sent compliance information to C2C, or that timeliness data listed on the website appears to be inaccurate, C2C can investigate that discrepancy. With either the timeliness or effectuation data, if a Medicare Health Plan has a question about a data element or wants to report a discrepancy, they can send an email to the Plan Liaison at PartC-Plan_Liaison@c2cinc.com. -This email box is continuously monitored, and questions are answered promptly.