MAXIMUS Federal Services

MEDICARE MANAGED CARE RECONSIDERATION BACKGROUND DATA FORM

1. CASE PRIORITY:

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

2-a. AMOUNT IN CONTROVERSY: $ _____

2-b. DATE(S) OF SERVICE IN QUESTION: _____

2-c. DOES THIS CASE INVOLVE A COST SHARING ISSUE?

☐ **Yes** ☐ **No**

3. ENROLLEE DATA

Enrollee Name: _____ **HIC:** _____

Enrollee Street: _____ **Enrollee Phone:** _____

Enrollee City: _____ **State:** _____ **Zip:** _____

Is the Enrollee Deceased? ☐ **No** ☐ **Yes-** Date of Death ___/___/___

Is the Enrollee in Hospice? ☐ **No** ☐ **Yes-** Date of Election ___/___/___ (election form must be provided)

Does the Enrollee require the final Determination Notice in a language other than English?

☐ No ☐ Yes _____ (specify language)

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

☐ No ☐ Yes _____ (specify type of format below)

☐ Large Print (if other than 18 point font, indicate size below) ☐ Audio CD ☐ Braille ☐ Qualified Reader

☐ Other _____ (specify type of format or font)

4. APPEAL REQUESTOR DATA (check one)

☐ **Enrollee is Requestor**
☐ Enrollee's treating physician (no AOR required for Expedited or Standard Service cases)

☐ Enrollee's Estate	Is Estate Documentation in File?	☐ Yes	☐ No
☐ Non-Contract Provider (payment cases only)	Is a Waiver of Liability in File?	☐ Yes	☐ No
☐ Representative	Is an AOR or Power of Attorney in File?	☐ Yes	☐ No
☐ Surrogate acting in accordance with State Law		☐ Yes	☐ No

Name of Requestor: _____ Phone: _____

Company Name: _____

Street: _____

City: _____ State: _____ Zip: _____

5. MEDICARE HEALTH PLAN (MHP) DATA

CMS Contract # (REQUIRED): _____

Plan Name: _____

Plan Type: ☐HMO ☐MSA ☐HCPP ☐Cost ☐PSO ☐Local PPO ☐Regional PPO ☐Demo ☐PFFS ☐SNP ☐PACE ☐ MMP ☐ MMP-NY FIDA

Address for Appeal Correspondence:
Street: _____
City: _____
State: _____ Zip: _____

6. MHP CONTACT PERSON FOR THIS RECONSIDERATION

Contact Person Name:_____ **Email:**_____
Phone:_____
RI Fax Number:_____ **Decision Letter Fax Number:**_____
Alternate Contact Person or Supervisor Name:_____ **Phone:**_____

7. MHP ORGANIZATION DETERMINATION (Complete for all cases)

a.	**Date of Initial Authorization request or claim submission**	__/__/__
b.	**Date of Plan's initial Denial (Organization Determination)**	__/__/__
c.	**Was an Expedited request made?**	☐ Yes ☐ No
d.	**Was the expedited request granted?**	☐ Yes ☐ No
e.	**Did the plan take an extension? (If so, please provide notice in file)**	☐ Yes ☐ No

8. MHP RECONSIDERATION (Complete for all cases)

a.	**Date of Reconsideration Request**	__/__/__
b.	**Date of Plan's Reconsideration Determination**	__/__/__
c.	**Was an Expedited request made?**	☐ Yes ☐ No
d.	**Was the expedited request granted?**	☐ Yes ☐ No
e.	**Did the plan take an extension? (If so, please provide notice in file)**	☐ Yes ☐ No

9. PROVIDER IDENTIFICATION DATA- Please List All Providers applicable to this appeal, including referring providers

Provider Name(s)	**Specialty**	**Records Requested?**	**Records Provided?**	**Contract Provider?**
1. _____	_____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. _____	_____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. _____	_____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. _____	_____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Services received/requested outside of the MHP's geographic service area?	☐ **Yes**	☐ **No**	
Services received/requested outside of MHP's network of providers?	☐ **Yes**	☐ **No**	
Services received/requested outside of Enrollee's medical group?	☐ **Yes**	☐ **No**	☐ **N/A**

10. DEFINITION OF DENIED SERVICES OR CLAIMS

Item/service in dispute _____

Enrollee's ICD-9/10 diagnosis code(s) applicable to the issues in this case: _____
_____
_____

HCPCS/CPT codes representing the items/services in dispute _____
(Please do not substitute revenue codes for outpatient hospital services) _____
_____
_____

CASE NARRATIVE OUTLINE (Attach to file as a document separate from the Background Data Form)

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

1. **CASE SUMMARY** (Please make sure to include the following: Enrollee name, age, sex, specific plan (i.e., Value plan vs. Deluxe Plan) and information about any supplemental riders that the enrollee may have, in addition to a description of the item/service in dispute)

2. **CHRONOLOGY OF CARE** (This should be a brief overview of the timeline of events in this case. Please refer to claim numbers for dates of service as appropriate)

3. **APPELLANT'S ARGUMENTS FOR COVERAGE**

4. **MHP RATIONALE FOR DENIAL**

5. **JUSTIFICATION (i.e. citations to rules upon which plan denied coverage)**

6. **Please indicate if the Following Documents are included in the file**

a. Organization Determination Notice <u>with appeal rights</u>	☐ **Yes**	☐ **No**
b. Notice of Appeal Status/Closure letter	☐ **Yes**	☐ **No**
c. Appeal Letter (or phone records if expedited request was made)	☐ **Yes**	☐ **No**
d. *Evidence of Coverage	☐ **Yes**	☐ **No**
e. Criteria used to reach decision	☐ **Yes**	☐ **No**
f. Medical Records (legible)	☐ **Yes**	☐ **No**
g. Original X-rays, Digital X-ray prints, Photographs	☐ **Yes**	☐ **No**

***Please note: we encourage MHPs to submit these types of files in an electronic format on a CD. Please note: .PDF format is preferable.**