

M+C organizations. Instead, we have largely maintained the existing standard. That is, an M+C organization must have an established process to track and maintain records on all grievances received both orally and in writing, including, at a minimum, the date of receipt, final disposition of the grievance, and the date that the M+C organization notified the enrollee of the disposition. We have specified that an M+C organization must respond to an enrollee's grievance within 24 hours if the complaint involves an M+C organization's refusal to grant an enrollee's request for an expedited organization determination or an M+C organization's decision to invoke an extension on an appeal request. M+C organizations must routinely respond to such grievances, and although the 24-hour time frame represents a new requirement, it does not affect the information collection burden. (Note that M+C organizations already document their case files or notify enrollees when they process requests for expedited reviews under §§ 422.570 and 422.584, and invoke extensions to the organization determination and reconsideration times frames under §§ 422.568, 422.572, and 422.590.) Thus, while the new requirement is subject to the PRA, the burden associated with this requirement is captured by the requirements in §§ 422.568, 422.572 and 422.590, approved under OMB number 0938-0829.

*Section 422.620—How M+C Enrollees Must Be Notified of Noncoverage of Inpatient Hospital Care*

When an M+C organization has authorized coverage of the inpatient admission of an enrollee, either directly or by delegation (or the admission constitutes emergency or urgently needed care, as described in sections 422.2 and 422.113), the M+C organization (or hospital that has been delegated the authority to make the discharge decision) must provide a written notice of noncoverage when the beneficiary disagrees with the discharge decision.

Based on the 2002 CMS Data Compendium, (CMS Publication Number 03437), there are approximately 11.8 million Medicare beneficiaries discharged from hospitals each year. We extrapolate that approximately 1.8 million of these are M+C discharges. As discussed in section II.C of this preamble, based on previous inpatient hospital appeals data from the QIO's Standard Data Processing System, we estimate that about 0.1 to 0.2 percent (1,800 to 3,600) of M+C enrollees'

hospital discharges will be disputed. We project that it would take M+C organizations (or hospitals that have been delegated the authority to make the discharge decision) approximately 30 minutes to prepare and furnish the notice required in these cases. Thus, the total annual burden associated with providing notices to M+C enrollees is approximately 900 to 1800 hours. (Note that issuance of these notices will not take effect until a separate PRA statement has been published.)

*Section 422.626—Fast-Track Appeals of Service Terminations to the IRE*

An enrollee who desires a fast-track appeal must submit a request for an appeal to the IRE, in writing or by telephone, by noon of the first calendar day after receipt of the written termination notice. If the IRE is closed on the day the enrollee requests a fast-track appeal, the enrollee must file a request by noon of the next day that the IRE is open for business.

In 1999, the Center for Health Dispute Resolution (CHDR), the entity with whom CMS now contracts to conduct appeals of M+C reconsiderations, reviewed approximately 3,000 cases involving services provided by SNFs, HHAs, and CORFs. (Note that we have no way of knowing the proportion of these cases that involved service terminations, but for purposes of this analysis, we will make the assumption that all of these 3,000 cases involve service terminations.) Based on the General Accounting Office's 1999 Report to the Special Committee on Aging, "Greater Oversight Needed to Protect Beneficiary Rights," managed care organizations reverse their original adverse organization determinations in approximately 75 percent of appealed cases. Therefore, we believe that the 3,000 cases that went to CHDR likely represent about 25 percent of all appeals (i.e., "reconsiderations") involving affected providers that are now conducted by M+C organizations. Thus, we estimate that the number of provider appeals that would likely be heard by an IRE would be 12,000 cases. This constitutes approximately 2 percent of the 616,500 M+C enrollees that we estimate will receive termination notices, which we believe is a reasonable estimate of the maximum number of enrollees that are likely to file appeals with the IRE. It is estimated that it will take 12,000 enrollees 15 minutes to file an appeal on an annual basis. The total annual burden associated with this requirement is 3,000 hours.

The enrollee may submit evidence to be considered by the IRE in making its

decision and may be required by the IRE to authorize access to his or her medical records in order to pursue the appeal. It is likely that no more than 10 percent of the 12,000 enrollees who file appeals will also submit additional evidence. It is estimated that it will take 1,200 enrollees 60 minutes to submit evidence on an annual basis. That is, since enrollees may not be functioning at their maximum capacity, they may need to contact family members, friends, or their personal physicians who might provide assistance in gathering additional evidence. The total annual burden associated with this requirement is 1,200 hours.

Upon notification by the IRE of a fast-track appeal, the M+C organization must supply any and all information, including a copy of the notice sent to the enrollee, no later than by close of business of the following day. It is estimated that it will take M+C organizations 60–90 minutes to gather and prepare a case file to send to the IRE. Since we have estimated that approximately 12,000 enrollees would request appeals, the total annual burden associated with this requirement is 12,000–18,000 hours.

Upon an enrollee's request, the M+C organization must provide a copy of, or access to, any documentation sent to the IRE no later than close of business of the first day after the day the material is requested. We estimate that 20% of the 12,000 enrollees who file an appeal will request copies of information forwarded to the IRE. It is estimated that it will take M+C organizations 15 minutes to provide a copy of all of the information provided to the IRE, to 2,400 enrollees. The total annual burden associated with this requirement is 600 hours.

If the IRE upholds an M+C organization's termination decision in whole or in part, the enrollee may appeal by requesting that the IRE reconsider its decision. It is estimated that 50 percent of the 12,000 appeals will result in the IRE upholding the M+C organization's termination decision. Of those 6,000 cases, we estimate that 20 percent of the enrollees will request a reconsideration by the IRE. It is estimated that it will take 1,200 enrollees 30 minutes to file a request for reconsideration on an annual basis. The total annual burden associated with this requirement is 600 hours.

*Section 489.27—Beneficiary Notice of Discharge Rights*

A hospital that participates in the Medicare program must furnish each Medicare beneficiary, or an individual acting on his or her behalf, the notice of discharge rights required under section