Topic	Description	Summary of Medicaid Requirements	Summary of Medicare Requirements
Appeals -- Continuation of benefits pending appeal	Medicare and Medicaid differ in terms of whether benefits continue to be provided while a coverage appeal is in process.	Medicaid benefits generally continue and are covered pending a timely appeal (FFP is available for these costs), when the appeal is requested within a certain timeframe. States also may reinstate benefits if requested within 10 days of the date of action (although States may vary). §431.231. The basis of this rule is both regulatory and constitutional (due process clause), as interpreted by Supreme Court in Goldberg v. Kelly and its progeny. Section 1902(a)(3) of the Act; §431.205; §438.420 (managed care). The State may seek recovery against the beneficiary if he or she loses the appeal.	Benefits generally do not continue during the entire pendency of a Medicare appeal involving reduction or termination of services.
Appeals -- Document notifying beneficiaries of appeal rights	Medicare and Medicaid differ in the way in which documents provide notification of appeal rights.	Various documents may be used to notify beneficiaries of their appeal rights depending upon the State. Regulations require that information about appeals be included at the time of application, with a notice of adverse action on a claim, at the time of transfer or discharge from a SNF. §431.206. Also there are requirements of providing notice to beneficiaries enrolled in managed care organizations during terminations, suspensions, reductions in service, denial of payment, among others. §438.404.	Medicare Parts A and B: For standard appeals -- "Medicare Summary Notice" is sent to beneficiaries to notify them of their appeal rights. For expedited appeals -- Medicare Notice of Non-Coverage or important message from Medicare notifies beneficiaries of their appeals rights. Medicare Part C: A notice of non-coverage is delivered to beneficiaries to notify them of their appeal rights. Medicare Part D: A notice Denial of Medicare Prescription Drug Coverage is delivered to beneficiaries to notify them of their appeal rights.

Topic	Description	Summary of Medicaid Requirements	Summary of Medicare Requirements
Appeals -- Timeframes for resolution of an appeal related to benefits	Medicare and Medicaid vary in the time that a payer has to make a decision once an appeal is received.	FFS: Rules vary by State. Generally within 90 days of date of filing the appeal. §431.244. Managed Care: Standard appeals must generally be handled within 45 days, with extensions available in certain circumstances. Expedited appeals are to be handled within 3 working days, with extensions up to 14 calendar days in certain circumstances. §438.402, and §438.408.	Parts A and B: For standard, non-expedited appeals, different periods of time apply depending upon the stage of the review process. At the early stages, contractors generally have 60 days for review. At the ALJ/MAC Stage the review period is 90 days, and failure to meet the required time frame allows the party to escalate the appeal to the next higher level. Section 1869 of the Act; §405.1000 et seq. For timely filed expedited appeals, the time periods at the initial stages are more abbreviated (and generally not longer than 72 hours). Section 1869 of the Act; §405.1202, §405.1204, and §405.1206. Parts C and D: Standard plan reconsiderations must be resolved within 7 days (Part D) or 30 days (Part C). Expedited reviews are to be conducted within 72 hours.

[FR Doc. 2011–11848 Filed 5–11–11; 11:15 am]

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DEPARTMENT OF TRANSPORTATION

Federal Motor Carrier Safety Administration

49 CFR Parts 385, 386, 390, and 395

[Docket No. FMCSA–2004–19608]

RIN 2126–AB26

Hours of Service of Drivers

AGENCY: Federal Motor Carrier Safety Administration (FMCSA), DOT.

ACTION: Notice; availability of supplemental documents; reopening of comment period; correction.

SUMMARY: This document corrects the docket number referenced in the Addresses and Instructions paragraphs to a proposed rule's notice of availability of supplemental documents published in the **Federal Register** of May 9, 2011, regarding Hours of Service of Drivers. This correction replaces an incorrect docket number with the correct docket number for the public to

submit comments to the reopened docket about the four additional documents and FMCSA's possible consideration of the studies' findings in the development of the final rule.

FOR FURTHER INFORMATION CONTACT: Mr. Thomas Yager, Chief, Driver and Carrier Operations Division, Federal Motor Carrier Safety Administration, U.S. Department of Transportation, 1200 New Jersey Avenue, SE., Washington, DC 20590, (202) 366–4325.

Correction

In the notice, FR Doc. 2011–11150, beginning on page 26681 in the issue of May 9, 2011, make the following corrections, in both the **ADDRESSES** and Instructions paragraphs. On page 26681 in the 3rd column in both places it appears, replace docket number "FMCSA–2011–0039" with docket number "FMCSA–2004–19608."

Issued on: May 11, 2011.

Larry W. Minor,

Associate Administrator for Policy.

[FR Doc. 2011–11933 Filed 5–13–11; 8:45 am]

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