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New Expedited Review Process for Disputed Terminations of Medicare-Covered Services in SNFs, HHAs, CORFs, and Hospices

Note: This article was revised on June 6, 2005, to contain a more descriptive title. All other information remains the same.

Provider Types Affected

Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs), Comprehensive Outpatient Rehabilitation Facilities (CORFs), and hospices treating Medicare patients

Provider Action Needed

Be sure staff is aware of the new requirements regarding notification of Medicare patients about the cessation of Medicare coverage of their services. The new rules are effective on July 1, 2005.

Background

Beginning July 1, 2005, beneficiaries in original Medicare will have access to a new fast-track, expedited review process when Medicare coverage of their SNF, HHA, CORF, or hospice services is about to end. The requirement for these expedited reviews stems from section 1869(b)(1)(F) of the Social Security Act (the Act), as amended by section 521 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), Public Law 106--554. The Centers for Medicare & Medicaid Services (CMS) published the final regulations needed to implement the new process on November 26, 2004 (69 *FR* 69252). The regulation may be viewed at: http://a257.g.akamaitech.net/7/257/2422/06jun20041800/edocket.access.gpo.gov/2004/04-26133.htm. As a result of the new regulations, the review process for Medicare beneficiaries in the original Medicare will essentially parallel the expedited review process that has been in effect for Medicare managed-care enrollees since January 1, 2004.

New Regulations

Based on the provisions of the November 2004 final rule, SNFs, HHAs, CORFs, and hospices must provide the Notice of Medicare Provider Non-Coverage (Generic Notice) to Medicare beneficiaries no later than two days before the effective date of the end of the coverage that their Medicare coverage will be ending. If the beneficiary does not agree that coverage should end, the beneficiary may request an expedited review of the termination decision by the Quality Improvement Organization (QIO) in that State. The provider then must furnish the Detailed Explanation of Non-Coverage (Detailed Notice) to the beneficiary explaining why

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services are no longer covered. Generally, the QIO's review will be completed within 72 hours of the QIO's receipt of the beneficiary's request for a review.

The new SNF, HHA, CORF, and hospice notification and review requirements distribute responsibilities under the new process among three parties:

1) The provider is responsible for delivering the Generic Notice to all beneficiaries no later than 2 days before their covered services end and for delivering the Detailed Notice to the QIO and the beneficiary by close of business of the day the beneficiary requests a review.
2) The beneficiary (or authorized representative) is responsible for acknowledging receipt of the Generic Notice and for contacting the QIO within the specified timeframes if he/she wishes to pursue an expedited review.
3) The QIO is responsible for immediately contacting the provider if a beneficiary requests an expedited review and then making a decision no later than 72 hours after receipt of the beneficiary's request.

What Do the New SNF, HHA, and CORF Notification Requirements Mean for Providers?

Notice of Medicare Provider Non-Coverage (Generic Notice)

The Generic Notice is a short and straightforward notice that simply informs the beneficiary of the date that coverage of services is going to end and describes what should be done if the beneficiary wants the decision to be reviewed or if the beneficiary needs more information about the decision. CMS has designed the Generic Notice so that its delivery is as simple and burden-free as possible for the provider. The Generic Notice includes only three variable fields (patient name, Medicare number, and last date of coverage) that the provider will have to fill in before delivering it to the beneficiary. There is also space for the provider to enter additional inform if desired.

When to Deliver the Generic Notice

Generally, the provider is responsible for delivering the Generic Notice no later than two days before covered services will end. If services are expected to last fewer than two days, the Generic notice should be delivered upon admission. If there is more than a two-day span between services (e.g., in the home health setting), the Generic Notice should be issued the next to last time services are furnished.

How to Deliver the Generic Notice

To ensure "valid delivery" of the Generic Notice, the provider must provide the completed notice to the beneficiary (or authorized representative) so that the beneficiary can sign and date the notice. If the beneficiary refuses to sign the notice, the provider must make a notation on the Generic Notice that the beneficiary was provided with the notice but did not sign it. An authorized representative may be notified by telephone if personal delivery is not immediately available. In this case, the authorized representative must be informed of the content of the notice, and the provider must document the call and then mail the notice to the representative.

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Providers that deliver the Generic Notice must insert the following patient-specific information:

- The beneficiary's name and Medicare number, and
- The date that coverage of services ends.

The Generic Notice also should identify the appropriate QIO. It also includes space for additional information as necessary or required.

Expedited Review Process and the Detailed Notice

If the beneficiary decides to appeal the provider's decision that Medicare coverage should end, he/she must contact the QIO by no later than noon of the day before services are to end (as indicated in the Generic Notice) to request a review. The QIO will inform the provider of the request for a review. The provider is responsible for providing the QIO and the beneficiary with a detailed explanation of why coverage is ending. The provider may need to present additional information to the QIO for the QIO to use in making a decision. Based on the timeframes associated with the expedited review process, the QIO decision should take place 72 hours after receipt of the beneficiary's request for a review.

Importance of Timing/Need for Flexibility

Although the regulations and accompanying instructions do not require action until two days before the planned termination of covered services, the Generic Notice may be given as soon as the provider can reasonably determine the discharge date. This will provide beneficiaries with more time to consider their options, including whether to pursue an expedited review of the decision. This also would allow more time for the review process to occur while Medicare coverage is still in place. Similarly, SNF providers may want to consider how they can assist patients who wish to be discharged in the evening or on weekends in the event that they receive an unfavorable decision from the QIO review process and want to minimize any additional liability. Tasks such as ensuring that arrangements for follow-up care are in place, scheduling equipment to be delivered (if needed), and writing orders or instructions can be done in advance to facilitate a more efficient discharge. We strongly encourage providers to structure their notice delivery and discharge patterns to make the new process work as smoothly as possible.

CMS intends to continue to work together with all involved parties to identify problems, publicize best practices, and implement needed refinements to these procedures; thus we welcome all suggestions for fine-tuning the expedited review process.

Additional Information

Further information on the new expedited review process, including the Generic Notice, Detailed Notice, and related instructions, can be found on CMS' Beneficiary Notices Initiative web page at:

http://www.cms.hhs.gov/medicare/bni. The BNI web page includes a link to Frequently Asked Questions about the expedited review process. CMS is also in the process of incorporating these procedures into Chapter 30 of the CMS Medicare Claims Processing Manual.

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