



Revised Quality of Care Guidance at F309

The Centers for Medicare & Medicaid Services (CMS) has revised the Guidance to Surveyors at Tag F309, Quality of Care in Appendix PP of the State Operations Manual. An Advance Copy of the revisions were posted in Survey & Certification (S&C) Letter 09-22 dated January 23, 2009.

Below is a summary of the revisions:

- Revised guidance for long-term care surveyors at F309, Quality of Care, including a new general investigative protocol and new pain management guidance and investigative protocol will be effective March 31, 2009;
- Removed hospice and dialysis survey protocol language from Appendix P and inserted into F309;
- Removed weight loss investigative protocol from Appendix P due to the June 2008 issuance of F325 investigative protocol;
- Deleted guidance requiring paper copy storage of Minimum Data Set (MDS) in homes with electronic records at Tag F286, 483.20(d);
- Removed demand billing survey process at Appendix P, Part VII and inserted new procedure at Task 5C.

As part of this issuance, CMS is making the following additional changes:

- Deleting the investigative protocol for unintended weight loss (currently under Appendix P, II.B. The Traditional Standard Survey, Sub-Task 5C) due to the June 2008 issuance of the revised guidance at F325 Nutrition;
- Revising portions of the Appendix P Table of Contents to reflect the deletions listed above;
- Removing a sentence under F286 Use [of the Resident Assessment] that had mandated the storage of paper copies of the MDS for homes that have all-electronic clinical records. The retention of paper copies is no longer required for these homes;
- Renumbering Part M of Sub-Task 5C, Review of Influenza and Pneumococcal Immunizations as section K due to removal of current K and L sections; and;

- Removing the outdated demand bill survey procedure in Appendix P, Part VII and replacing it with new procedural language at Sub-Task 5C Resident Review, as new part L, Liability Notices and Beneficiary Appeal Rights.

The interpretive guidelines for F309 were revised to clarify areas such as assessment, care planning, and interventions. The investigative protocols explain objectives and procedures surveyors will need for their investigation. Deficiency categorization provides severity guidance for the determination of the correct level of severity of outcome to residents for deficiencies at Tag F309.

The additional revisions and deletions to Appendices P and PP will become effective on March 1, 2009. At that time, a final copy of this new guidance will be available in a CMS Transmittal and ultimately will be incorporated into Appendix PP of the State Operations Manual on the CMS Web site. An exception is the demand bill change which became effective with S&C Letter 09-20 dated January 9, 2009. See below for an overview of S&C Letter 09-20. The full text of S&C Letters 09-20 and 09-22 can be viewed at www.polaris-group.com/news_releases.asp

Overview of S&C Letter 09-20 Issues Related to Liability Notices and Beneficiary Appeal Rights in Nursing Homes

Denial Letters have been the standard liability notification forms issued to Medicare beneficiaries by SNF providers. In response to requests by SNF providers to consolidate the five Denial Letters, CMS released in 2002 an alternative notice called a Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN). Both the Denial Letters and the SNFABN inform the beneficiary of potential liability for the non-covered services and of their right to file a standard claim appeal if the related claim submitted by the



facility at the beneficiary's request is denied.

S&C Letter 09-20 reviews:

- A Skilled Nursing Facility (SNF) provider's obligations to issue Medicare beneficiary liability notices;
- A Medicare beneficiary's rights related to standard claim and expedited appeals;
- The surveyor's responsibility to determine compliance with Medicare notice and billing requirements for determinations of non-coverage;
- The SNF provider must inform the beneficiary of potential liability for payment for non-covered services when limitation of liability applies;
- The SNF must provide a written notice to the Medicare beneficiary explaining his/her right to file an expedited appeal upon termination of all Medicare covered services;
- Appendix P of the SOM, Survey Protocol for Long Term Care Facilities, Part VII will be deleted. The information in this memo will be moved to Sub-Task 5C and a new section on Liability Notices and Beneficiary Appeal Rights will be created;
- This memo does not apply to beneficiaries with Medicare Advantage.

This letter includes 2 Attachments:

- Attachment 1 reviews the Current SNF Notice Structure with examples for what notice(s) to issue at:
 - Initiation – start of noncovered extended care items / services
 - Reduction – decrease in individual items / services provided under Part B
 - Termination – end of covered care
- Attachment 2 updates Survey Protocol for Compliance with Liability Notices and Beneficiary Appeal Rights.

Recovery Audit Contractor Part 2 The RAC Collection Process

The collection process will be the same as for the affiliated contractor's identified overpayments except the demand letter will come from the RAC while the provider's contractor (Fiscal Intermediary, Medicare Administrative Contractor or Carrier) will issue a remittance advice (RA) with remark code N432

indicating an adjustment was made based on a recovery (RAC) audit. Recoupment takes place by contractor offset unless a provider has submitted a check or initiates a valid appeal prior to day 30. The demand letter will provide information about the amount of money owed and detail the provider appeal rights. Interest begins to accrue on the date of the demand letter.

Medicare Appeals Process for RACs

RAC determination may be appealed in essentially the same manner as any Medicare appeal. The RAC initial determination is appealed to the Medicare contractor that initially paid the claim rather than the RAC that made the initial determination.

• First Level of Appeal – Redetermination

Provider must request redetermination in writing within 120 days of initial determination. If the Provider files the notice of appeal within 30 days of initial determination, recoupment is deferred during the first two appeal levels. Overpayment withholding otherwise starts on day 41. Interest continues to accrue on overpayment during the deferral period. The provider cannot expedite the appeal at this level.

• Second Level of Appeal - Reconsideration

Provider must request a reconsideration by a Qualified Independent Contractor (QIC) in writing. If a provider appeals to QIC recoupment again is deferred. The QIC must process the request for reconsideration within 60 days. If the QIC cannot complete its decision timely the appellant has the right to move the case to an administrative law judge. Evidence not submitted at the reconsideration level prior to QIC decision may be excluded from consideration at later levels.

• Third Level of Appeal – Administrative Law Judge (ALJ) Hearing

Provider may request a hearing before an ALJ by filing the request in writing within 60 days of receipt of the QIC's reconsideration notice. The minimum amount in controversy for calendar year 2009 is \$120. The ALJ may only review evidence previously presented at the Second Level of Appeal, absent a finding of good cause. If the ALJ cannot issue a decision within 90 days it will notify the



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appellant of the right to move the case to the Medicare Appeals Counsel (MAC). The ALJ decision is binding unless it is modified or reversed by the MAC or a federal court.

• **Fourth Level of Appeal – Medicare Administrative Council (MAC) Review**

Provider may file a request for review with the MAC within 60 days of receipt of the ALJ's decision. The request must be in writing and must specify the issues and findings that are being contested. The MAC may review the ALJ's decision on its own motion or at the request of CMS. The appeal is limited to the record made before the ALJ. The MAC must issue a determination within 90 days of the review, either modifying, reversing, or remanding the ALJ decision. If the MAC cannot complete its decision within 90 days it will inform the appellant of the right to move the case to the federal district for judicial review.

• **Fifth Level of Appeal – Federal District Court**

Provider has a final option to file suit in federal district court within 60 days of receipt of the MAC decision. The minimum amount in controversy for 2008 is \$1180 and for 2009 is \$1220. The evidence presented at the federal district court level is limited to the administrative record.

CMS imposed an automatic stay on the work of the RAC program as a result of protests filed with the Government Accountability Office (GAO) by two unsuccessful bidders for RAC awards. The automatic stay stopped all work for all four RAC regional awards until a determination is made by GAO. The GAO has 100 days to issue its decision, which means a decision would be due for these protests in early February.

Q & A

“Where No Question Goes Unanswered!”

Q. Some organizations are suggesting that the MDS 3.0 will not be implemented in October 2009, has CMS made any changes to the implementation timeline?

A. CMS confirmed their ongoing intent for an October 2009 implementation of the MDS 3.0 during the January 2009 Skilled Nursing Facility SNF Open Door Forum call.

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<u>Topic</u>	<u>Date</u>
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ADR Part I—The What, When, How & Why	2/5
MDS for Administrators	2/10
Survey Process, Preparation and Management	2/11
ADR Part II— Survive a Medicare Chart Review	2/12
Implementing QI/QA Program	2/17
Writing a Plan of Correction	2/18
ADR Part III— The Medicare Appeals Process	2/19
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MDS 3.0	2/24
Understanding Your 5 Stars	2/25
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