



POLARIS PULSE

A Bi-monthly Informational Bulletin Brought To You By Polaris Group

New Independent, Expedited Review Process for SNF Notices of Non-Coverage

New Regulation

Beginning July 1, 2005, Medicare beneficiaries receiving Skilled Nursing Facility (SNF), Home Health Agency (HHA), Comprehensive Outpatient Rehabilitation Facility (CORF) or Hospice Part A services will have access to a fast-tracked review process when notified that the Medicare services will be discontinued during a Part A stay.

The CMS Final Rule of November 2004 requires the provider issue a “Notice of Medicare Provider Non-Coverage” No later than two days before the effective date of the end of Medicare coverage.

Called the “Generic Notice”, the new Notice of Medicare Provider Non-Coverage replaces the SNF Advanced Beneficiary Notice for the purpose of conveying to beneficiaries that Part A coverage is being terminated. The notice also describes what the beneficiary needs to do if an expedited review is desired. This new “Generic Notice” is not required at time of Admission or at time of Exhaustion of Benefits.

The beneficiary requests an independent expedited review of the termination decision from the State Quality Improvement Organization (QIO). The request must be made to the QIO no later than noon the day before services are scheduled to end. The QIO is responsible for immediately contacting the provider.

When notified of a request for review, the SNF must provide the QIO and the beneficiary with a detailed explanation of why coverage is ending via a “Detailed Notice”. The “Detailed Notice” must be delivered to the QIO and the beneficiary by the close of business on the day the beneficiary requests the review. The Detailed Notice may be delivered to the QIO via personal delivery, a courier service that can deliver the package on the same day, e-mail or facsimile. The SNF may need to present additional

information to the QIO for use in making a decision.

Based on the timeframes associated with the expedited review process, the QIO’s review is to be completed within 72 hours of the beneficiary’s request for review. QIO’s will be available on weekends to both receive a request for an expedited determination and to conduct reviews.

Valid Delivery of the Notice

The “Generic Notice” includes 4 fields the SNF must complete:

- Patient name
- Medicare number
- Last date of coverage
- State Quality Improvement Organization’s name and contact number

To ensure “valid delivery” of the “Generic Notice”, the provider must issue the completed notice to the beneficiary or authorized representative (AR). The notice should be signed and dated by the beneficiary or AR. If the beneficiary/AR refuses to sign the notice, the provider must make a notation on the Generic Notice that the beneficiary was provided the notice, but did not sign. An authorized representative may be notified by telephone if personal delivery is not immediately available. The authorized representative must be informed of the notice content. The provider must document the call and mail the notice to the representative. The provider must place the original Generic Notice in the beneficiary’s case file and give a copy to the beneficiary. A copy of the Generic Notice must also be provided to the QIO if there is a request for expedited review.

If a Detailed Notice is issued, the provider does not need to obtain the beneficiary/AR signature on the Detailed Notice.

Importance of Timing

If the SNF fails to issue a timely notice (at least 2 days

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prior to planned termination of Medicare A coverage), the SNF is financially liable for continued services until 2 days after the beneficiary receives a valid Notice or until the service termination date specified on the notice, whichever is later.

Although the regulations and accompanying instructions do not require action until 2 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 whether to pursue an expedited review of the decision. Earlier notice will also allow more time for the review process to occur while Medicare coverage is still in place. If services are expected to last fewer than 2 days, the “Generic Notice” should be delivered upon admission.

If the QIO’s determination upholds the termination date established by the provider, the beneficiary is responsible for services received after the effective date indicated on the termination notice. CMS suggests SNFs consider earlier notice in order to assist residents who wish to be discharged in the evening or on weekends in the event they receive an unfavorable decision from the QIO and want to minimize additional liability.

Tasks such as ensuring arrangements for follow-up care are in place, scheduling equipment to be delivered and writing orders or instructions can be done in advance to facilitate a more efficient discharge. *“We (CMS) strongly encourage providers to structure their notice delivery and discharge patterns to make the new process work as smoothly as possible.”* (Source Medlearn Matters SE0538)

Contact the Polaris Solution Center for additional information.

Revisions to Medicare Appeals Process for Claims Submitted to Fiscal Intermediaries

Revisions to the Medicare Part A and Part B appeals process, include a new level of appeal for redeterminations issued by FIs on or after May 1, 2005. Beginning January 1, 2006, appeals of redeterminations carried out by Medicare carriers (Part B appeals, involving physician services and durable medical equipment items, for example) will be subject to QIC reconsiderations.

The new level of appeal is called a **reconsideration**. “Reconsiderations” will be processed by Qualified Independent Contractors (QIC’s). The QIC replaces the

current “fair hearing” process for Medicare Part B claims. There are 2 QIC’s to handle reconsideration requests — Maximums and First Coast Service Options. A Fiscal Intermediary must include the address for the appropriate QIC on all redetermination notices.

Parties to Part A and Part B redeterminations issued by FIs on or after May 1, 2005 will have the right to appeal to a QIC. All redeterminations issued before May 1, 2005 will have appeal rights to the Administrative Law Judge (ALJ) for Part A claims and to the Hearing Officer (HO) for Part B claims.

A number of additional changes affecting the appeals process went into effect on May 1, 2005. The key changes include:

1. There is no longer a minimum amount in controversy required to move to the next level of appeal (QIC).
2. The Medicare Redetermination Notice (MRN) must inform providers that should they disagree with the decision they have 180 days to appeal to a QIC in writing.
3. The MRN will include a form to use in requesting the reconsideration by the QIC. The form is not required, however, if not used all information included on the form must appear in the letter requesting the appeal.
4. All evidence must be presented before the reconsideration is issued. If a provider does not submit all evidence at this stage, they will not be able to submit any new evidence in subsequent appeal levels unless they demonstrate good cause.
5. The revised process requires FIs to issue an MRN on ALL redeterminations, favorable and unfavorable. Previously, some FIs elected to notify providers of fully favorable decisions through a Remittance Advise (RA) instead of issuing an MRN.
6. Should a provider submit additional evidence after filing the request for redetermination, the FIs 60 day decision making time frame may be extended by 14 calendar days.
7. In the case of minor errors or omissions, providers must be given the opportunity to correct such errors / omissions without the need to initiate an appeal. Consistent with the Medicare Modernization Act, Section 937, CMS requires FIs to conduct re-openings rather than redeterminations to correct such errors and omissions. The re-opening requests may be made over the telephone.
8. Providers do not need to specify the date of the initial determination on a request for redetermination..
9. If more than 1 party files a redetermination request on the same claim before the FI makes a decision on

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- the first request, the FI will consolidate the requests into one proceeding and issue one redetermination.
10. Only the QIC has the authority to dismiss a request for reconsideration.
 11. If the QIC decision is favorable to the appellant and specifies an amount to be paid, the FI must take action to issue payment within 30 calendar days of the QIC's decision. If the QIC decision is favorable to the appellant, but the contractor must compute the amount, the FI must take action to issue payment within 30 days after it computes the amount to be paid (no later than 30 days after the receipt of the QIC's decision).
 12. Providers who submit claims to FIs have the same right as the beneficiary to appeal initial determinations.
 13. Redetermination will be the first level of appeal for both Part A and Part B revised initial determinations.
 14. Parties to a redetermination will have the right to appeal to the QIC within 60 days of an FI's dismissal of a redetermination request.
 15. FIs must handle incomplete redetermination requests as dismissals. Parties to the redetermination have the option to re-file the request if any time remains in the filing period.
 16. The QIC will be responsible for accepting ALJ hearing requests and for preparing case files for the hearing.
 17. FIs must take action on an ALJ decision within the same time frames as described in # 11 above.

The Final Rule also includes the transfer of the ALJ function to the Department of Health and Human Services. The ALJs are required to be organizationally and functionally independent from CMS. This transfer will take place no earlier than July 1, 2005, but no later than October 1, 2005.

SOLUTION CENTER Q&A
"Where No Question Goes Unanswered"

- Q:** If a Part A resident went out to the hospital for 6 hours including midnight, but was not admitted, should the MDS cycle restart with a 5-day MDS?
- A:** No, when the resident goes to the hospital for less than 24 hours, but is gone at midnight, the Medicare assessment "clock" is merely adjusted by skipping that day for calculating when the next Medicare assessment is due.

TELECONFERENCE TRAININGS

Polaris Group is pleased to
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Live Teleconference Trainings

<u>Topic</u>	<u>Date</u>
Quality Indicator Review New & Old	6/16
New SNF Proposed RUG System	6/21
Master ADL Coding	6/23
New Urinary Continence & Catheters Survey Protocol	6/28
Pressure Ulcer Program and Protocol	7/14
New Process for SNF Denial Letters	7/19
Fall Prevention and Management	7/21
Revised Medicare Appeals Process	7/26
New Urinary Continence & Catheters Survey Protocol	7/28

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 seminars, please contact the
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