A Message to

Business Office Managers

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MEMORANDUM

TO: Administrators of AmeriHealth Participating Home Health Agencies

FROM: Kathleen Mariano
Manger, Provider Relations

DATE: January 5, 2004

SUBJECT: FINAL RULE ON MEDICARE+CHOICE APPEAL AND GRIEVANCE PROCEDURES

You may have already received from Centers for Medicare and Medicaid Services (CMS) a Provider Bulletin that details home health agencies' and Medicare+Choice Organizations' (M+CO) responsibilities to implement the new requirements under the Grijalva regulations which is effective January 1, 2004.

This purpose of this bulletin from AmeriHealth is to provide you with the requirements along with operational guidance to ensure compliance with the new regulations. The Final Rule (65 Federal Register 16652), which becomes effective January 1, 2004, establishes:

- New notice and appeal procedures for members when their M+CO, such as AmeriHealth, decides to terminate coverage of home care services; and
- Addresses the obligations of Medicare participating home health agencies to issue discharge or termination of coverage notices to Medicare+Choice (AmeriHealth 65) members.

1. Termination of Coverage Notification

Under the Final Rule, the home health agency is required to:

- Deliver to the Medicare+Choice member a written notice prior to discontinuance of home care services;
- Use the standardized notice developed by CMS to notify the member of the discontinuation of services;
- Deliver the notice to the member or the member's authorized representative with a minimum of 2 days notice or the next to the last visit that services are furnished if the span of time between services exceeds 2 days;
- Ensure that the member or the member's authorized representative signs and dates the notice to indicate both receipt of the notice and understanding of its contents; and
- Fax the signed notice to: **Lynn Collins, Manager, Medicare Appeals Units (MAU) at (215) 238-7970 the same day given to the member.**

2. Fast-Track Appeals Process

The final rule provides members with a fast-track appeal process, enabling them to appeal the decision to discontinue home care services. To initiate a fast-track appeal, the member must submit an appeal request in writing or by telephone to QIO by noon of the first day after the **receipt** of the discontinuation of services notice is issued. QIO is required to notify AmeriHealth of the member's request for a fast-track appeal on the date they receive the request.

- **Medicare+Choice Organization's Responsibilities:**

  - I AmeriHealth must send a detailed notice to the member by the close of business of the day of QIO notification; and
  - AmeriHealth must provide QIO with all required documentation that QIO needs to make a decision. The documentation must be provided to QIO **no later than the close of business of the day that QIO notifies the M+CO of the appeal.**
    Coverage of home care services that are the subject of a fast-track appeal continues until the date and time designated in the discontinuation notice, unless QIO reverses I AmeriHealth's decision.

- **Home Health Agency's Responsibilities:**

- As noted in Section 1 above, the home health agency must deliver to the Medicare+Choice member, 2 days prior to any termination or the next to the last visit that services are furnished if the span of time between services exceeds 2 days, a written notice of discontinuation of services using the standard CMS form.
- Fax the signed notice to: **Lynn Collins, Manager, Medicare Appeals Units (MAU) at (215) 238-7970 the same day given to the member.**
- Fax a complete copy of the Medical Records upon member appeal request to MAU **at (215) 238-7970**
- Provide the name and telephone number of a contact at your facility for the Medicare Member Appeal Department's use.

We understand that implementing some of the regulations may be challenging for you as well as for AmeriHealth. However, it is our goal to work together and keep an open dialogue for any problems or issues that you encounter. QIO has also indicated their willingness to work with AmeriHealth and our participating home health agencies to help with this process.

If you have any questions regarding the appeal and grievance procedures outlined in this bulletin, please contact Lynn Collins at 215-241-3593, Catherine Cutair at 215-241-7264, or Andrea Williams at 215-241-7264.

Attachments

NEW ENROLLEE RIGHTS, NEW PROVIDER RESPONSIBILITIES IN THE M+C PROGRAM

Introduction

Beginning on January 1, 2004, enrollees of Medicare+Choice (M+C) plans will have the right to an expedited review by a Quality Improvement Organization (QIO) when they disagree with their M+C plan's decision that Medicare coverage of their services from a skilled nursing facility (SNF), home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF) should end. This new right stems originally from the Grijalva lawsuit and was established in regulations in a final rule published on April 4, 2003 (68 FR 16652). It is similar to the longstanding right of a Medicare beneficiary to request a QIO review of a discharge from an inpatient hospital.

What is "Grijalva"?

"Grijalva" is Grijalva v. Shalala – a class action lawsuit that challenged the adequacy of the Medicare managed care appeals process. The plaintiffs claimed that beneficiaries in Medicare managed care plans were not given adequate notice and appeal rights when coverage of their health care services was denied, reduced or terminated. Following extended legal negotiations -- and significant changes to appeals procedures that resolved many issues -- CMS reached a settlement agreement with plaintiffs and published a proposed rule based on that agreement in January 2001, and the final rule in April 2003.

New Regulations

Based on the provisions of the April 2003 final rule, SNFs, HHAs, and CORFs must provide an advance notice of Medicare coverage termination to M+C enrollees no later than 2 days before coverage of their services will end. If the patient does not agree that covered services should end, the enrollee may request an expedited review of the case by the QIO in that State and the enrollee's M+C plan must furnish a detailed notice explaining why services are no longer necessary or covered. The review process generally will be completed within less than 48 hours of the enrollee's request for a review.

The new SNF, HHA, and CORF notification and appeal requirements distribute responsibilities under the new procedures among four parties:

1) The *M+C organization* generally is responsible for determining the discharge date and providing, upon request, a detailed explanation of termination of services. (In some cases, M+C organizations may choose to delegate these responsibilities to their contracting providers.)
2) The *provider* is responsible for delivering the Notice of Medicare Non-Coverage (NOMNC) to all enrollees no later than 2 days before their covered services end.
3) The *patient/M+C enrollee* (or authorized representative) is responsible for acknowledging receipt of the NOMNC and contacting the QIO (within the specified timelines) if they wish to obtain an expedited review.
4) The *QIO* is responsible for immediately contacting the M+C organization and the provider if an enrollee requests an expedited review and making a decision on the case by no later than the day Medicare coverage is predicted to end.

Again, these new notice and appeal procedures go into effect on January 1, 2004. You should be aware that the Medicare law (section 1869(b)(1)(F) of the Social Security Act) establishes a parallel right to an expedited review for "fee-for-service" Medicare beneficiaries, and we expect to implement similar procedures for these beneficiaries later in 2004.

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

Notice of Medicare Non-Coverage (NOMNC)

The NOMNC (formerly referred to as the Important Medicare Message of Non-Coverage) is a short, straightforward notice that simply informs the patient of the date that coverage of services is going to end and describes what should be done if the patient wishes to appeal the decision or needs more information. CMS is developing a single, standardized NOMNC that is designed to make notice delivery as simple and burden-free as possible for the provider. The NOMNC essentially includes only two variable fields (i.e., patient name and last day of coverage) that the provider will have to fill in.

When to Deliver the NOMNC

Based on the M+C organization's determination of when services should end, the provider is responsible for delivering the NOMNC no later than two days before the end of coverage. If services are expected to be fewer than two days, the NOMNC should be delivered upon admission. If there is more than a 2-day span between services (e.g., in the home health setting), the NOMNC should be issued on the next to last time services are furnished. We encourage providers to work with M+C organizations so that these notices can be delivered as soon as the service termination date is known. A provider need not agree with the decision that covered services should end, but it still has a responsibility under its Medicare provider agreement to carry out this function.

How to Deliver the NOMNC

The provider must carry out "valid delivery" of the NOMNC. This means that the member (or authorized representative) must sign and date the notice to acknowledge receipt. Authorized representatives may be notified by telephone if personal delivery is not immediately available. In this case, the authorized representative must be informed of the contents of the notice, the call must be documented, and the notice must be mailed to the representative.

Expedited Review Process

If the enrollee decides to appeal the end of coverage, he or she must contact the QIO by no later than noon of the day before services are to end (as indicated in the NOMNC) to request a review. The QIO will inform the M+C organization and the provider of the request for a review and the M+C organization is responsible for providing the QIO and enrollee with a detailed explanation of why coverage is ending. The M+C organization may need to present additional information needed for the QIO to make a decision. Providers should cooperate with M+C organization requests for assistance in getting needed information. Based on the expedited timeframes, the QIO decision should take place by close of business of the day coverage is to end.

Importance of Timing/Need for Flexibility

Although the regulations and accompanying CMS instructions do not require action by any of the four responsible parties until 2 days before the planned termination of covered services, we want to emphasize that whenever possible, it's in everyone's best interest for an M+C organization and its providers to work together to make sure that the advance termination notice is given to enrollees as early as possible. Delivery of the NOMNC by the provider as soon as it knows when the M+C organization will terminate coverage will allow the patient more time to determine if they wish to appeal. The sooner a patient contacts the QIO to ask for a review, the more time the QIO has to decide the case, meaning that a provider or M+C organization may have more time to provide required information.

We understand the challenges presented by this new process and have tried to develop a process that can accommodate the practical realities associated with these appeals. With respect to weekends, for example, many QIOs are closed on weekends (except for purposes of receiving expedited review requests), as are the administrative offices of M+C organizations and providers. Thus, to the extent possible, providers should try to deliver termination notices early enough in the week to minimize the possibility of extended liability for weekend services for either M+C enrollees or M+C organizations, depending on the QIO's decision.

Similarly, SNF providers may want to consider how they can assist patients that wish to be discharged in the evening or on weekends in the event they lose their appeal and do not want to accumulate 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 and, thus, facilitate a faster and more simple discharge. We strongly encourage providers to structure their notice delivery and discharge patterns to make the new process work as smoothly as possible.

We recognize that these new requirements will be a challenge--at least at first – and that there may be unforeseen complications that will need to be resolved as the process evolves. We intend to work together with all involved parties to identify problems, publicize best practices, and implement needed changes.

More Information

Further information on this process, including the NOMNC and related instructions can be found on the CMS website at www.cms.hhs.gov/healthplans/appeals. (Also, the regulations are at 42 CFR 422.624, 422.626, and 489.27 and Chapter 13 of the M+C Manual includes information on the process.)

Questions and Answers Regarding the Fast-Track Appeal Process

Example Scenario:

Mrs. S is admitted to ABC Skilled Nursing Facility (SNF) following an acute hospital admission. The initial length of stay assigned upon admission on 1/5/04 is seven days, with a next review date with AmeriHealth set for 1/12/04. On 1/12, it is determined that Mrs. S is receiving skilled services and is making progress. A next review date with AmeriHealth is set for 1/19/04. Upon review on 1/19, it appears that Mrs. S has met her therapy goals and she will be moving to a custodial level. At this point AmeriHealth will request the full medical record for the last **seven** days, from 1/12 through 1/19, in order to have the necessary information to make a determination.

Q: How long will the SNF have to provide the requested portion of the medical record to AmeriHealth?
A: If the request is made before 12 pm, the SNF will have until *12 pm on* 1/20. If the request is made after 12 pm, the SNF will have until *24 hours from the time of the request*.

On 1/20 the medical record is reviewed by an AmeriHealth medical director, and it is determined that skilled care is no longer being provided or is no longer necessary. On 1/20, AmeriHealth will notify the SNF that coverage of skilled care will be terminated on 1/22, with an expected discharge on 1/23**.**

Q: What is the SNF's responsibility at this point?
A: **1.** Deliver the advanced termination notice to the patient (enrollee) by the end of day notifying him/her of AmeriHealth's intent to terminate coverage on 1/22 by end of the day, and obtain the member's or responsible party's signature. CMS has stated that it is in everyone's best interest for an M+CO and its providers to work together to make sure that the advance notice is given to members as early as possible. Therefore, we will make every attempt to provide you with as much advance notice as possible.

2. Fax a copy of the termination notice, the same day it is given to the member, to:

Lynn Collins, Manager
Medicare Member Appeals
215-238-7970

Q: What if the SNF fails to deliver the notice to the enrollee that same day?
A: Once AmeriHealth notifies you that 1/22 is the last covered day because no skilled services are being provided after that date, it is considered a non-covered service and the member is held harmless.

Q: How long does the member have to initiate a "fast-track" appeal to the QIO?
A: The member has until noon on the day following receipt of the termination notice to initiate the fast-track appeal.

Mrs. S and her family disagree with the determination to discharge her on 1/23 and file an appeal with the QIO before noon. The QIO notifies AmeriHealth immediately upon receipt of the enrollee's request for a fast-track appeal.

Q: What is AmeriHealth's responsibility?
A:
1. Send detailed denial notice to member.
2. Request complete medical record from the SNF.
3. Have Medical Director review complete medical record.
4. Prepare package with all medical records, AmeriHealth notes, a copy of the detailed denial notice and the termination notice issued by SNF and submit it to the QIO by the end of day of the notification.

Q. What is the SNF's responsibility should the member initiate a fast-track appeal?
A. While we understand the difficulty in obtaining the medical records in such a short timeframe, we asked the QIO exactly what they expected from the SNFs. **The QIO's response was that they required the full set of records from the SNF. Therefore, the SNF is required by the QIO to provide AmeriHealth with a complete copy of the medical record on the same day it is requested.** The QIO noted that they would be monitoring SNFs for compliance. The Medicare Member Appeals Department will coordinate the receipt of the medical records. The records can be faxed to the Medicare Member Appeals Department at 215-238-7970.

Q: How long does the QIO have to render a determination upon receipt of all information from AmeriHealth?
A: The QIO is required to render its decision by close of business the day after it receives the necessary information.

Q: Does this process continue during the weekend?
A: Yes, this process applies every day of the week.