DEPARTMENT OF HEALTH AND HUMAN SERVICES

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- "ICD-10-CM/PCS Myths and Facts," Fact Sheet, ICN 902143, Downloadable only.

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Expedited Determinations for Provider Service Terminations

Note: This article was revised on July 1, 2013, to correct a reference in the first sentence of the "NOMNC Preparation and Delivery" section on page 3 to state Medicare patient number, instead of Medicare provider number. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for Home Health Agencies (HHAs), Comprehensive Outpatient Rehabilitation Facilities (CORFs), Hospices, and Skilled Nursing Facilities (SNFs) providing services to Medicare beneficiaries.

What You Need to Know

Medicare beneficiaries, or a representative acting for a beneficiary, can appeal their provider service terminations to a Quality Improvement Organization (QIO) through the Expedited Determinations process. You have provider responsibilities in this process which, if not completed correctly, could impact your reimbursement. CR 7903, from which this article is taken, provides new information to the Medicare Claims Processing Manual; in accordance with the 42 Code of Federal Regulations (CFR), Part 405 Medicare Program, Expedited Determination Procedures for Provider Service Terminations: Final Rule (Final Rule), published November 26, 2004. The manual addition ensures consistency with provisions of the final rule and clarifies operating instructions.

Background

Excerpts from these manual changes are summarized below.

Health Care Settings in Which the Expedited Determination Process is Available to Beneficiaries

This expedited determination process is available to beneficiaries in Original Medicare whose Medicare covered services are being terminated in the following settings:

- Home Health Agencies (HHA)
- Comprehensive Outpatient Rehabilitation Facilities (CORF)
- Hospice

Skilled Nursing Facilities (SNF), including services covered under a Part A stay, as well as Part B services provided under consolidated billing (i.e. physical therapy, occupational therapy, and speech therapy). For example, a beneficiary exhausts their SNF Part A 100 day benefit, but remains in the facility under a private pay stay and receives covered physical and occupational therapy under Medicare Part B. A Notice of Medicare Non-Coverage (NOMNC) must be delivered by the SNF at the end of a Part A stay or when all of the Part B therapies are ending.

Note: Skilled Nursing Facilities includes beneficiaries receiving Part A and B Services in Swing Beds.

Care Settings in which NOMNC Delivery Does Not Apply

The following care settings do not qualify for NOMNC delivery for termination of services:

- When beneficiary never received Medicare covered care in one of the covered settings (for example, an admission to a SNF will not be covered due to the lack of a qualifying hospital stay, or a face-to-face visit was not conducted for the initial episode of home health care);
- When services are being reduced (for example, an HHA providing physical therapy and occupational therapy discontinues the occupational therapy);
- When beneficiaries are moving to a higher level of care (for example, home health care ends because a beneficiary is admitted to a SNF);
- When beneficiaries exhaust their benefits (for example, a beneficiary reaches 100 days of coverage in a SNF, thus exhausting their Medicare Part A SNF benefit);
- When beneficiaries end care on their own initiative (for example, a beneficiary decides to revoke their Hospice benefit and return to standard Medicare coverage);
- When a beneficiary transfers to another provider at the same level of care (for example, a beneficiary transfers from one SNF to another while remaining in a Medicare-covered SNF stay); or
- When a provider discontinues care for business reasons (for example, an HHA refuses to continue care at a home with a dangerous animal or because the beneficiary was receiving physical therapy and the provider's physical therapist leaves the HHA for another job).

Notice of Medicare Non-Coverage (NOMNC)

Medicare providers are responsible for the delivery of the NOMNC. You must deliver a NOMNC to all beneficiaries eligible for the expedited determination process, even if they agree with the termination of services.

The NOMNC is two page document, subject to the Paperwork Reduction Act Process and approval by the Office of Management and Budget (OMB). As such, it can only be modified according to its accompanying instructions, as unapproved modifications may invalidate it.

Further, while you may include your business logo and contact information at the top of the notice, this cannot cause a shift in text – the NOMNC must remain two pages. You can also include information in the optional "Additional Information" section relevant to the beneficiary's situation. Please note that including information in this section that would normally be found in the Detailed Explanation of Non-Coverage (DENC), does not satisfy your responsibility to deliver the DENC, if otherwise required. You can find the notices and accompanying instructions online at http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html on the CMS website.

NOMNC Preparation and Delivery

When you prepare the NOMNC, you must use the OMB approved form (CMS-10123), and type or write in the appropriate fields: 1) The patient's name; 2) the Medicare patient number; 3) The type of coverage ((SNF, Home Health, CORF, or Hospice); and 4) The effective date (last day of coverage), which is always the last day beneficiaries will receive coverage for their services.

While you may formally delegate the delivery of the notices to a designated agent such as a courier service, you should remember that all of the requirements of valid notice delivery apply to designated agents. It should be delivered to the beneficiary at least two days before Medicare covered services end, or the second to last day of service if care is not being provided daily, or no later than the next to last visit before Medicare covered services end for home health services that are being provided less frequently than daily.

Note: Beneficiaries have no liability for services received on this date, but may face charges for services received the day following the effective date of the NOMNC for home health, hospice, and CORF services. Because SNFs cannot bill the beneficiary for services furnished on the day of (but before the actual moment of) discharge, beneficiaries may leave a SNF the day after the effective date and not face liability for such services.

There are some exceptions to these required delivery timeframes:

1. You may deliver the NOMNC earlier than two days preceding the end of covered services; however, its delivery should be closely tied to the impending end of coverage;
2. You should not routinely give the notice at the time services begin, unless the services are expected to last fewer than two days; and

3. You should deliver the NOMNC sooner than two days or the next to last visit before coverage ends when a beneficiary receiving home health services is unexpectedly found to no longer be homebound, and thus ineligible for covered home health care.

Finally, you must ensure that the beneficiary or representative signs and dates the NOMNC to demonstrate that they received the notice and understand that the termination decision can be disputed. If the beneficiary refuses to sign the NOMNC, you should annotate the notice to that effect, and indicate the date of refusal on the notice. The date of refusal is considered to be the date of notice receipt. Please note that beneficiaries who refuse to sign the NOMNC still remain entitled to an expedited determination.

You may deliver NOMNC to representatives whom the beneficiary has authorized and appointed to act on their behalf during the appeal process. A beneficiary may designate an appointed representative via the "Appointment of Representative" form, the CMS-1696 which can be found at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf on the CMS website. You should inform the representative of the beneficiary's right to appeal a coverage termination decision, and include the following information:

- The beneficiary's last day of covered services, and the date when the beneficiary's liability is expected to begin;
- The beneficiary's right to appeal a coverage termination decision;
- A description of how to request an appeal by a QIO;
- The deadline to request a review as well as what to do if the deadline is missed; and
- The telephone number of the QIO to request the appeal.

If you choose to contact the representative by telephone, the date you communicate the information is considered the NOMNC's receipt date. You should annotate the NOMNC to document the telephone contact with the beneficiary on the day that you make telephone contact, reflecting that all of the information indicated above was included in the communication. The annotated NOMNC should also include the name of the staff person initiating the contact, the name of the representative contacted by phone, the date and time of the telephone contact, and the telephone number called. You must place a dated copy of the annotated NOMNC in the beneficiary's medical file, and mail a NOMNC to the representative the day the telephone contact is made.

If you choose to communicate the information in writing, a hard copy of the NOMNC must be sent to the representative by certified mail, return receipt requested, or any other delivery method that can provide signed verification of delivery (e.g. FedEx, UPS). You should keep in mind that the burden is on you to demonstrate that timely contact was attempted with the representative and that the notice was delivered. The date that someone at the representative's address signs (or refuses to sign) the receipt is considered the date received. Place a copy of the annotated NOMNC in the beneficiary's medical file.

As an alternative to both telephone or hardcopy contact, if both you and the representative agree, you may send the notice by fax or e-mail; however your fax and e-mail systems must meet the HIPAA privacy and security requirements.

Finally, in all cases of delivering the NOMNC, you must retain the original signed document in the beneficiary's file; and send the beneficiary copies of all notices that include all of the required information such as the effective date and covered service at issue.

Amending the NOMNC Date

If you have already delivered the initial NOMNC to a beneficiary and the effective date has changed, you should amend the notice to reflect the new date; and verbally notify the beneficiary, and deliver the amended NOMNC to the beneficiary (retaining a copy in their file). Further, if an expedited determination is already in progress, you must immediately notify the QIO of the change and also provide them an amended notice.

Beneficiary Responsibilities

A beneficiary who receives a NOMNC, and disagrees with the termination of services, may request an expedited determination by the appropriate QIO for the state where the services were provided. The beneficiary must contact the QIO (either by telephone or in writing) by noon of the day before the NOMNC's effective date. (If the QIO is unable to accept the request, the beneficiary must submit the request by noon of the next day the QIO is available).

The beneficiary: 1) Must be available to answer questions or supply information requested by the QIO; 2) May (but is not required to) supply additional information to the QIO that he or she believes is pertinent to the case; and 3) Must obtain a physician certification stating that failure to continue (home health or CORF services only) is likely to place his or her health at significant risk.

Without such a certification statement a QIO may not make a determination for service terminations in these settings, although the beneficiary may request an expedited determination from a QIO before obtaining this certification of risk. Once the QIO is aware of a review request, it will instruct the beneficiary on how to obtain the necessary certification from a physician.

Note: You may not bill a beneficiary who has timely filed an expedited determination for disputed services until the review process (including a reconsideration by a QIO, if applicable) is complete.

If the beneficiary makes an untimely request (by not meeting the timeliness requirements described above), the QIO will accept the request for review, but is not required to complete the review within its usual 72-hour deadline. Beneficiaries have up to 60 days from the effective date of the NOMNC to make an untimely request to a QIO. When the beneficiary is still receiving services, the QIO must make a determination and notify the parties within 7 days of receipt of the request. When the beneficiary is no longer receiving services, the QIO will make a determination within 30 days of the request.

You should also be aware that the coverage protections discussed above will not apply to a beneficiary who makes an untimely request to the QIO.

Provider Responsibilities

When a QIO notifies you of a beneficiary request for an expedited determination, you must deliver the beneficiary a DENC by close of business the day they are notified, supply the QIO with copies of the NOMNC and DENCs by close of business of the day of the QIO notification, and also supply (by telephone, in writing, or electronically) all information, including medical records, that the QIO requests. If you do this by telephone, you must place a written record of the information you that you provided into the patient record.

In addition, you must (at their request) furnish the beneficiary with access to, or copies of, any documentation you provide to the QIO. You may charge the beneficiary a reasonable amount to cover the costs of duplicating and delivering the documentation, which must be provided to the beneficiary by close of business of the first day after the material is requested.

The DENC is subject to the Paperwork Reduction Act Process and approval by the Office of Management and Budget. OMB-approved notices may only be modified as per their accompanying instructions. Unapproved modifications may invalidate the DENC. The DENC must contain the following information:

- A specific and detailed explanation of why services are either no longer reasonable and necessary or no longer covered;
- A description of, and citations to, the Medicare coverage rule, instruction, or other policies applicable to the review; and
- The facts specific to the beneficiary's discharge and provider's determination that coverage should end.

You should make insertions on the notice in Spanish, if necessary. If this is impossible, additional steps should be taken to ensure that the beneficiary comprehends the content of the notice. Providers may resource CMS multilingual services provided through the 1-800-MEDICARE help line if needed.

The delivery must occur in person by close of business of the day the QIO notifies you that the beneficiary has requested an expedited determination. You may also choose to deliver the DENC with the NOMNC. It does not require a signature, but should be annotated in the event of a beneficiary's refusal to sign upon delivery.

Please note that an HHA is not required to make a separate trip to the beneficiary's residence solely to deliver a DENC. Upon notification from the QIO of a beneficiary's request for an expedited determination, an HHA may telephone the beneficiary to provide the information contained on the DENC, annotate the DENC with the date and time of telephone contact, and file it in the beneficiary's records. A hard copy of the DENC should be sent to the beneficiary via tracked mail or other personal courier method by close of business of the day the QIO notifies the provider that the beneficiary has requested an expedited determination. The burden is on the provider to demonstrate that timely contact was attempted with the beneficiary and that the notice was delivered.

Effect of QIO Determination on Continuation of Care

If the QIO decision extends coverage beyond a point covered by the physician's orders (either because of the duration of the expedited determination process, or because the physician has already concurred with the termination of care) providers cannot deliver care. In the event of a QIO decision favorable to a beneficiary without physician orders, the ordering physician should be made aware the QIO has ruled coverage should continue, and be given the opportunity to reinstate orders. The beneficiary may also seek other personal physicians to write orders for care as well as find another service provider. The expedited determination process does not override regulatory or State requirements that physician orders are required for a provider to deliver care.

If a QIO decision is favorable to the beneficiary and the beneficiary resumes covered services, a new NOMNC should be delivered for the new course of care per the usual requirements described above. If the beneficiary again disagrees with the termination of care, a new request to the QIO must be made.

The QIO decision will also affect the necessity of subsequent Advance Beneficiary Notice (ABN) deliveries.

> Example 1: If covered home health care continues following a favorable QIO decision for the beneficiary, the HHA would resume issuance of Home Health Advance Beneficiary Notices (HHABN) as warranted for the remainder of this home health episode. If the QIO decides that Medicare covered care should end and the patient wishes to continue receiving care from the HHA even though Medicare will not pay, an HHABN with Option Box 1(use when item (s) and/or services (s) may be provided that will not be paid for by Medicare) must be issued to the beneficiary since this would be an initiation of non-covered care.
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> Example 2: If covered SNF care continues, following a favorable QIO decision for the beneficiary, but later ends due to the end of Medicare coverage; and the patient wishes to continue receiving uncovered care at the SNF, a Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) must be issued to the beneficiary.

Please keep in mind that delivery of the NOMNC does not replace the required delivery of other mandatory notices, including ABNs. Notice of delivery must be determined by the individual NOMNC requirements (per cite) and ABN delivery requirements per Section 1879 of the Social Security Act and guidance found in the Medicare Claims Processing Manual, Chapter 30 (Financial Liability Protections). In certain instances, both the NOMNC and an ABN may be required, whereas in others, one, two, or even no notices may be required.

> Example When One Notice is Required: The following is an example of an instance in which only one notice may be required when Medicare covered care is ending: A beneficiary is receiving Comprehensive Outpatient Rehabilitation Facility (CORF) services, and all covered CORF care is ending. A NOMNC must be delivered at least two days, or two visits, prior to the end of coverage. If the beneficiary does not wish to continue the CORF services, an ABN should not be given.
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> Example When Two Notices are Required: The following is an example of an instance in which two notices may be required when Medicare covered care is ending: A beneficiary's Part A stay is ending because a skilled level of care is no longer medically necessary and the beneficiary wishes

to remain in the SNF receiving custodial-level care. The beneficiary must receive the NOMNC two days prior to the end of coverage, and a SNFABN must also be delivered before custodial level care begins.

Example When No Notice is Required: As mentioned above, it is also possible that no notice is required when Medicare coverage is ending. The following is an example of such an instance: A beneficiary exhausts the 100 day benefit in a SNF. In this instance, neither the NOMNC nor the SNFABN should be delivered, although the latter can be issued voluntarily, as a courtesy to the beneficiary.

Finally, please keep in mind that a beneficiary for whom coverage is denied, continues to receive services of the type at issue in the expedited determination after the coverage end date, may appeal the denial within the standard claims appeal process (See the Medicare Claims Processing Manual, Chapter 29 Appeals of Claims Decisions), which you can find at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html on the CMS website.

Additional Information

You can find more information about Expedited Determinations for Provider Service Terminations by going to CR 7903, located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2711CP.pdf on the CMS website. You will find the updated Medicare Claims Processing Manual, Chapter 30, as an attachment to that CR.

If you have any questions, please contact your FI or A/B MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.