

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2711	Date: May 24, 2013
	Change Request 7903

SUBJECT: Expedited Determinations for Provider Service Terminations

I. SUMMARY OF CHANGES: This change request provides new information to the the manual in accordance with CMS-4004-FC (69 FR 69252, November 26, 2004), effective July 1, 2005. The manual addition ensures consistency with provisions of the final rule and clarifies operating instructions.

EFFECTIVE DATE: August 26, 2013

IMPLEMENTATION DATE: August 26, 2013

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	30 / Table of Contents
N	30/260/260.1/Statutory Authority
N	30/260/260.2/Scope
N	30/260/260.2.1/Exceptions
N	30/260/260.3/Notice of Medicare Non-Coverage
N	30/260/260.3.1/Alterations to the NOMNC
N	30/260/260.3.2/Completing the NOMNC
N	30/260/260.3.3/Provider Delivery of the NOMNC
N	30/260/260.3.4/Required Delivery Timeframes
N	30/260/260.3.5/Refusal to Sign the NOMNC
N	30/260/260.3.6/Financial Liability for Failure to Deliver a Valid NOMNC
N	30/260/260.3.7/Amending the Date of the NOMNC
N	30/260/260.3.8/NOMNC Delivery to Representatives
N	30/260/260.3.9/Notice Retention for the NOMNC
N	30/260/260.3.10/Hours of NOMNC Delivery
N	30/260/260.4/Expedited Determination Process
N	30/260/260.4.1/Beneficiary Responsibilities
N	30/260/260.4.1.1/Timeframe for Requesting an Expedited Determination
N	30/260/260.4.1.2/Provide Information to QIO
N	30/260/260.4.1.3/Obtain Physician Certification of Risk (Home Health and CORF services only)
N	30/260/260.4.2/Beneficiary Liability During QIO Review
N	30/260/260.4.3/Untimely Requests for Review
N	30/260/260.4.4/Provider Responsibilities
N	30/260/260.4.5/The Detailed Explanation of Non-Coverage
N	30/260/260.5/QIO Responsibilities
N	30/260/260.5.1/Receive Beneficiary Requests for Expedited Review
N	30/260/260.5.2/Notify Providers and Allow Explanation of Why Covered Services Should End
N	30/260/260.5.3/Validate Delivery of the NOMNC
N	30/260/260.5.4/Solicit the Views of the Beneficiary
N	30/260/260.5.5/Solicit the Views of the Provider

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N	30/260/260.5.6/Make Determination and Notify Required Parties
N	30/260/260.6/Effect of a QIO Expedited Determination
N	30/260/260.6.1/Right to Pursue an Expedited Reconsideration
N	30/260/260.6.2/Effect of QIO Determination on Continuation of Care
N	30/260/260.6.3/Right to Pursue the Standard Claims Appeal Process
N	30/260/260.6.4/Expedited Determination Notice Association with Advance Beneficiary Notices
N	30/261 – Expedited Determination Notice Association with Advance Beneficiary Notices

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:

No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2711	Date: May 24, 2013	Change Request: 7903
--------------------	--------------------------	---------------------------	-----------------------------

SUBJECT: Expedited Determinations for Provider Service Terminations

EFFECTIVE DATE: August 26, 2013

IMPLEMENTATION DATE: August 26, 2013

I. GENERAL INFORMATION

A. Background: This change request provides new information to the 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.

B. Policy: Under the procedures listed in 42 CFR Part 405 Subpart J, Section 521 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106 554), Medicare beneficiaries can appeal their provider service terminations to a Quality Improvement Organization (QIO).

The Medicare claim appeals process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) and section 940 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2004 (MMA).

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility											
		A/B MAC			D M E M A C	F I R E	C A R E R	R H I	Shared- System Maintainers				O t h e r
		A	B	H H H					F I S S	M C S	V M S	C W F	
7903.1	Contractors shall be aware of the new policy in chapter 30, sections 260 through 261.												P r o v i d e r s

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility
--------	-------------	----------------

		A/B MAC			D M E M A C	F I M A C	C A R R I E R	R H H I	Other
		A	B	H H H					
7903.2	MLN Article : A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X			X	X	X	

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Janet Miller, 404-562-1799 or janet.miller@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:

No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

Section B: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically

authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Claims Processing Manual

Chapter 30 - Financial Liability Protections

Table of Contents

(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

- 260 – *Expedited Determinations of Provider Service Terminations*
 - 260.1 – *Statutory Authority*
 - 260.2 - *Scope*
 - 260.2.1 – *Exceptions*
 - 260.3 – *Notice of Medicare Non-Coverage*
 - 260.3.1 - *Alterations to the NOMNC*
 - 260.3.2 - *Completing the NOMNC*
 - 260.3.3 – *Provider Delivery of the NOMNC*
 - 260.3.4 – *Required Delivery Timeframes*
 - 260.3.5 - *Refusal to Sign the NOMNC*
 - 260.3.6 - *Financial Liability for Failure to Deliver a Valid NOMNC*
 - 260.3.7 - *Amending the Date of the NOMNC*
 - 260.3.8 – *NOMNC Delivery to Representatives*
 - 260.3.9 - *Notice Retention for the NOMNC*
 - 260.3.10- *Hours of NOMNC delivery*
 - 260.4 - *Expedited Determination Process*
 - 260.4.1 – *Beneficiary Responsibilities*
 - 260.4.1.1—*Timeframe for Requesting an Expedited Determination*
 - 260.4.1.2 – *Provide Information to QIO*
 - 260.4.1.3 – *Obtain Physician Certification of Risk (Home Health and CORF services only)*
 - 260.4.2 – *Beneficiary Liability During QIO Review*
 - 260.4.3 - *Untimely Requests for Review*
 - 260.4.4 - *Provider Responsibilities*
 - 260.4.5 - *The Detailed Explanation of Non-Coverage*
 - 260.5 – *QIO Responsibilities*
 - 260.5.1 - *Receive Beneficiary Requests for Expedited Review*
 - 260.5.2 - *Notify Providers and Allow Explanation of Why Covered Services Should End*
 - 260.5.3 – *Validate Delivery of NOMNC*
 - 260.5.4 - *Solicit the Views of the Beneficiary*
 - 260.5.5 - *Solicit the Views of the Provider*
 - 260.5.6 – *Make Determination and Notify Required Parties*
 - 260.6 - *Effect of a QIO Expedited Determination*
 - 260.6.1 - *Right to Pursue an Expedited Reconsideration*
 - 260.6.2 - *Effect of QIO Determination on Continuation of Care*
 - 260.6.3 - *Right to Pursue the Standard Claims Appeal Process*
- 261 – *Expedited Determination Notice Association with Advance Beneficiary Notices*

260 – Expedited Determinations of Provider Service Terminations (Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

260.1 – Statutory Authority

(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

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) (Pub. L. 106-554) granted beneficiaries in Original Medicare the right to an expedited determination process to dispute the end of their Medicare covered care in certain provider settings.

This process was implemented through a final rule with comment period, CMS-4004-FC (69 FR 69252, November 26, 2004), effective July 1, 2005. The resulting regulations are located at 42 CFR Part 405, §§405.1200 - 405.1204. There is a parallel process for beneficiaries enrolled in Medicare health plans. (See §§90.2-90.8 in Chapter 13 of the Medicare Managed Care Manual (CMS Pub. 100-16)

260.2 – Scope

(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

The expedited determination process is available to beneficiaries in Original Medicare whose Medicare covered services are being terminated in the following settings. All beneficiaries receiving services in these settings must receive a Notice of Medicare Non-Coverage (NOMNC) before their services end: For purposes of this instruction, the term “beneficiary” means either beneficiary or representative, when a representative is acting for a beneficiary.

- *Home Health Agencies (HHAs)*
- *Comprehensive Outpatient Rehabilitation Services (CORFs)*
- *Hospice*
- *Skilled Nursing Facilities (SNFs)-- Includes 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). A NOMNC must be delivered by the SNF at the end of a Part A stay or when all of Part B therapies are ending. For example, a beneficiary exhausts the SNF Part A 100-day benefit, but remains in the facility under a private pay stay and receives physical and occupational therapy covered under Medicare Part B. A NOMNC must be delivered by the SNF when both Part B therapies are ending.*

Skilled Nursing Facilities includes beneficiaries receiving Part A and B services in Swing Beds.

260.2.1 – Exceptions

(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

The following service terminations, reductions, or changes in care are not eligible for an expedited review. Providers should not deliver a NOMNC in these instances.

- *When beneficiaries never received Medicare covered care in one of the covered settings (e.g., 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 (e.g., an HHA providing physical therapy and occupational therapy discontinues the occupational therapy).*
- *When beneficiaries are moving to a higher level of care (e.g., home health care ends because a beneficiary is admitted to a SNF).*
- *When beneficiaries exhaust their benefits (e.g., 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 (e.g., a beneficiary decides to revoke the hospice benefit and return to standard Medicare coverage).
- When a beneficiary transfers to another provider at the same level of care (e.g., a beneficiary transfers from one SNF to another while remaining in a Medicare-covered SNF stay).
- When a provider discontinues care for business reasons (e.g., 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).

260.3 – Notice of Medicare Non-Coverage

(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

The notice 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 NOMNC. The notice and accompanying instructions may be found online at <http://www.cms.gov/Medicare/Medicare-General-Information/BNI>

260.3.1 - Alterations to the NOMNC

(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

The NOMNC must remain two pages. The notice can be two sides of one page or one side of two separate pages, but **must not** be condensed to one page.

Providers may include their business logo and contact information on the top of the NOMNC. Text may not be shifted from page 1 to page 2 to accommodate large logos, address headers, etc.

Providers may include information in the optional "Additional Information" section relevant to the beneficiary's situation.

Note: Including information normally included in the Detailed Explanation of Non-Coverage (DENC) in the "Additional Information" section does not satisfy a provider's responsibility to deliver the DENC, if otherwise required.

260.3.2 - Completing the NOMNC

(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

Providers must use the OMB-approved NOMNC (CMS-10123). Providers must type or write the following information in the corresponding blanks of the NOMNC:

- Patient name
- Medicare patient number
- Type of coverage (SNF, Home Health, CORF, or Hospice)
- Effective date (last day of coverage)

Note: The effective date is always the last day beneficiaries will receive coverage for their services. 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.

260.3.3 – Provider Delivery of the NOMNC

(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

Providers must deliver the NOMNC to all beneficiaries eligible for the expedited determination process per §260.2. A NOMNC must be delivered even if the beneficiary agrees with the termination of services.

Medicare providers are responsible for the delivery of the NOMNC. Providers may formally delegate the delivery of the notices to a designated agent such as a courier service; however, all of the requirements of valid notice delivery apply to designated agents.

The provider must ensure that the beneficiary or representative signs and dates the NOMNC to demonstrate that the beneficiary or representative received the notice and understands that the termination decision can be disputed. Use of assistive devices may be used to obtain a signature.

Electronic issuance of NOMNCs is not prohibited. If a provider elects to issue a NOMNC that is viewed on an electronic screen before signing, the beneficiary must be given the option of requesting paper issuance over electronic if that is what is preferred. Regardless of whether a paper or electronic version is issued and regardless of whether the signature is digitally captured or manually penned, the beneficiary must be given a paper copy of the NOMNC, with the required beneficiary-specific information inserted, at the time of notice delivery.

260.3.4 –Required Delivery Timeframes

(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

The NOMNC should be delivered to the beneficiary at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily. For example, if the last day of covered SNF care is a Friday, the NOMNC should be delivered no later than the preceding Wednesday.

Note: *The two day advance requirement is NOT a 48 hour requirement. For example, if a patient's last covered home health service is at 10AM on Wednesday and the notice is delivered at 4PM on the prior Monday, it is considered timely.*

If home health services are being provided less frequently than daily, the notice must be delivered no later than the next to last visit before Medicare covered services end. For example, if home health care is provided on Tuesdays and Thursdays, and Tuesday is the last day of Medicare covered services, the notice must be delivered no later than the preceding Thursday.

The NOMNC may be delivered earlier than two days preceding the end of covered services. However, delivery of the notice should be closely tied to the impending end of coverage so a beneficiary will more likely understand and retain the information regarding the right to an expedited determination.

The notice may not be routinely given at the time services begin. An exception is when the services are expected to last fewer than two days. In these instances, the notice may be given by the provider when services begin.

There is an accepted circumstance when the NOMNC may be delivered sooner than two days or the next to last visit before coverage ends. This exception is limited to cases where a beneficiary receiving home health services is found to no longer be homebound, and thus ineligible for covered home health care. In this circumstance, the NOMNC should be immediately delivered to the beneficiary upon discovery of the loss of homebound status. We expect that in the vast majority of cases, in all settings, the decision of a physician to end care will be based on medical necessity, and thus, foreseeable by the provider within the required time frames for notice delivery.

260.3.5 - Refusal to Sign the NOMNC

(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

If the beneficiary refuses to sign the NOMNC the provider 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. Beneficiaries who refuse to sign the NOMNC remain entitled to an expedited determination.

260.3.6 - Financial Liability for Failure to Deliver a Valid NOMNC
(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

If a Qualified Independent Contractor (QIO) determines that a provider did not deliver a valid NOMNC to a beneficiary, the provider is financially liable for continued services until two days after the beneficiary receives valid notice, or until the effective date of the valid notice, whichever is later.

260.3.7 - Amending the Date of the NOMNC
(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

If the initial NOMNC was delivered to a beneficiary and the effective date was changed, the provider may amend the notice to reflect the new date. The newer effective date may not be earlier than the effective date of the original notice except in those cases involving the abrupt end of services, as discussed in §260.3.4.

The beneficiary must be verbally notified as soon as possible after the provider is aware of the change. The amended NOMNC must be delivered or mailed to the beneficiary and a copy retained in the beneficiary's file.

If an expedited determination is already in progress, the provider must immediately notify the QIO of the change and provide an amended notice to the QIO.

260.3.8 – NOMNC Delivery to Representatives
(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

The NOMNC may be delivered to a beneficiary's appointed or authorized representative. Appointed representatives are individuals designated by beneficiaries 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. <http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf> See Chapter 29 of the Medicare claims processing manual, section 270.1, for more information on appointed representatives.

CMS usually requires that notification to a beneficiary who has been deemed legally incompetent be made to an authorized representative of the beneficiary. Generally, an authorized representative is an individual who, under State or other applicable law, may make health care decisions on a beneficiary's behalf (e.g., the beneficiary's legal guardian, or someone appointed in accordance with a properly executed durable medical power of attorney).

However, if a beneficiary is temporarily incapacitated a person (typically, a family member or close friend) whom the provider has determined could reasonable represent the beneficiary, but who has not been named in any legally binding document, may be a representative for the purpose of receiving the notices described in this section. Such a representative should have the beneficiary's best interests at heart and must act in a manner that is protective of the beneficiary and the beneficiary's rights. Therefore, a representative should have no relevant conflict of interest with the beneficiary.

In these instances of delivering a notice to an unnamed representative, the provider should annotate the NOMNC with the name of the staff person initiating the contact, the name of the person contacted, and the date, time, and method (in person or telephone) of the contact. A copy of the NOMNC with this information should be retained in the beneficiary's record.

Note - Exceptions to in person notice delivery. *If the NOMNC must be delivered to a representative not living with the beneficiary, the provider is not required to make off-site in- person notice delivery to the representative. The provider must complete the NOMNC as required and telephone the representative at least two days prior to the end of covered services. The provider should inform the representative of the beneficiary's right to appeal a coverage termination decision.*

The information provided should include the following:

- *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.*
- *The telephone number of the QIO to request the appeal.*

The date the provider communicates this information to the representative, whether by telephone or in writing, is considered the receipt date of the NOMNC.

The NOMNC must be annotated with the following information on the day that the provider makes telephone contact:

Reflect that all of the information indicated above was communicated to the representative; Note 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.

A copy of the annotated NOMNC should be mailed to the representative the day telephone contact is made and a dated copy should be placed in the beneficiary's medical file.

If the provider chooses 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) The burden is on the provider 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.

*If both the provider and the representative agree, providers may send the notice by fax or e-mail, however, providers fax and e-mail systems must meet the **The Health Insurance Portability and Accountability Act of 1996 (HIPAA)** privacy and security requirements.*

260.3.9 - Notice Retention for the NOMNC

(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

The provider must retain the original signed NOMNC in the beneficiary's file. The beneficiary should receive a paper copy of the NOMNC that includes all of the required information such as the effective date and covered service at issue. Electronic notice retention is permitted if the NOMNC was delivered electronically.

260. 3.10 - Hours of NOMNC Delivery

(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

Notice delivery should occur within the normal operating hours of the provider. Providers are not expected to extend their hours or days of business solely to meet the requirements of the expedited determination process. However, it is expected that all notices be provided as timely as possible within these constraints.

260.4 - Expedited Determination Process

(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

260.4.1 – Beneficiary Responsibilities

(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

260.4.1.1—Timeframe for Requesting an Expedited Determination

(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

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 by noon of the day before the effective date on the NOMNC. The beneficiary may contact the QIO by telephone or in writing. 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.

260.4.1.2– Provide Information to QIO

(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

The beneficiary must be available to answer questions or supply information requested by the QIO. The beneficiary may, but is not required to, supply additional information to the QIO that he or she believes is pertinent to the case.

260.4.1.3 – Obtain Physician Certification of Risk (Home Health and CORF services only)

(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

A beneficiary must obtain a physician certification stating that failure to continue home health or CORF services is likely to place the beneficiary's health at significant risk. Without such a certification statement a QIO may not make a determination for service terminations in these settings.

The physician certification is a written statement from any licensed physician contacted by a beneficiary. This is a special certification required only in this expedited determination process for expedited determinations in home health and CORF settings.

A 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.

260.4.2 – Beneficiary Liability During QIO Review

(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

A provider may not bill a beneficiary who has timely filed an expedited determination for disputed services until the review process, including a reconsideration by a Qualified Independent Contractor (QIC), if applicable, is complete.

260.4.3 - Untimely Requests for Review

(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

If the beneficiary makes an untimely request to the QIO, the QIO will accept the request for review, but is not required to complete the review within its usual 72-hour deadline. The QIO will make a determination as soon as possible upon receipt of the request.

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.

The coverage protections discussed in 260.4.2 do not apply to a beneficiary who makes an untimely request to the QIO.

260.4.4 - Provider Responsibilities

(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

When a provider is notified by a QIO of a beneficiary request for an expedited determination, the provider must--

- Deliver the beneficiary a DENC (see §260.4.5) 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;*
- Supply all information, including medical records, requested by the QIO. The QIO may allow this required information to be supplied via phone, writing, or electronically. If supplied via phone, the provider must keep a written record of the information it provides within the patient record; and*
- Furnish the beneficiary, at their request, with access to or copies of any documentation it provides to the QIO. The provider may charge the beneficiary a reasonable amount to cover the costs of duplicating and delivering the documentation. This documentation must be provided to the beneficiary by close of business of the first day after the material is requested.*

260.4.5 - The Detailed Explanation of Non-Coverage

(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

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 notice and accompanying instructions may be found online at <http://www.cms.gov/Medicare/Medicare-General-Information/BNI> Medicare providers are responsible for the delivery of the DENC to beneficiaries who request an expedited determination by the QIO.

The DENC must contain the following information:

- The facts specific to the beneficiary's discharge and provider's determination that coverage should end.*
- 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.*

The provider 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 the provider that the beneficiary has requested an expedited determination. A provider may also choose to deliver the DENC with the NOMNC.

The DENC does not require a signature but should be annotated in the event of a beneficiary's refusal to accept the notice upon delivery.

Note: *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 with 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.*

DENC delivery to representatives, DENC hours of delivery, and DENC retention requirements are the same as the NOMNC requirements outlined in §260.3.

Expedited Determination Scenario in a Skilled Nursing Facility - Example

On June 2nd, the SNF delivers a NOMNC to Bob Mills notifying him that his Medicare covered stay will end on June 4th. Bob decides to request an expedited determination.

<i>June 2nd</i>	<i>June 3rd</i>	<i>June 4th</i>	<i>June 5th</i>	<i>June 6th</i>
<i>NOMNC Delivered</i> <i>Bob receives a NOMNC indicating that his coverage is ending June 4th.</i>	<i>Bob must request an expedited determination by noon today.</i>	<i>NOMNC Effective Date</i> <i>This is the last day of coverage, as stated on the NOMNC.</i>	<i>If Bob made his request on June 2nd:</i> <i>The QIO makes its decision and notifies Bob and the SNF by COB.</i>	<i>If Bob made his request on June 3rd:</i> <i>The QIO makes its decision and notifies Bob and the SNF by COB.</i>
	<i>The QIO must notify the SNF of Bob's request for an expedited determination.</i> <i>The SNF must deliver the DENC to Bob by COB today.</i> <i>The SNF must provide relevant medical records to the QIO by COB today.</i>	<i>The beneficiary has no liability for this day as this is the last day of coverage in the SNF.</i>	<i>If QIO decision is unfavorable:</i> <i>Beginning today Bob is liable for his stay if he does not leave the SNF.</i>	.

260.5 – QIO Responsibilities

(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

260.5.1 - Receive Beneficiary Requests for Expedited Review

(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

QIOs must be available to receive beneficiary requests for review 24 hours a day, 7 days a week.

260.5.2 - Notify Providers and Allow Explanation of Why Covered Services Should End

(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

When the QIO receives a request from a beneficiary, the QIO must immediately notify the provider of services that a request for an expedited determination was made. If the request is received after normal working hours, the QIO should notify the provider as soon as possible on the morning after the request was made.

260.5.3 – Validate Delivery of NOMNC

(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

The QIO must validate that the NOMNC included the required elements outlined below:

- *Date that coverage of services ends.*
- *Date that beneficiary's financial liability begins.*
- *Description of right to an expedited determination (and how to request an expedited determination) and the right to submit relevant information to the QIO.*
- *Right to detailed information on why the provider believes Medicare will no longer cover services.*
- *Contact information for QIO in the state where services were delivered.*

The QIO should determine that NOMNC delivery was valid if all of the following criteria are met:

- *All elements stated above are included.*
- *The beneficiary signed and dated the notice. If the NOMNC was annotated because the beneficiary refused to sign the notice upon delivery, the QIO may still conduct an expedited determination in these instances*
- *Notice was delivered at least two days before services terminate. For a non-residential provider, the notice may be delivered at the next to last visit before services terminate.*

Invalidating a NOMNC should be a rare occurrence. The only reasons to invalidate are the lack of one of the criteria stated above or a pattern of minor errors as established by the provider.

If a QIO invalidates a NOMNC, a new NOMNC must be issued to the beneficiary with an effective date at least two days after the beneficiary receives valid notice. If the beneficiary again disagrees with the termination of care, a new request to the QIO must be made.

260.5.4 - Solicit the Views of the Beneficiary

(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

The QIO must solicit the views of the beneficiary who requested the expedited determination.

260.5.5 - Solicit the Views of the Provider

Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

The QIO must afford the provider an opportunity to explain why the discharge is appropriate.

260.5.6 – Make Determination and Notify Required Parties

Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

No later than 72 hours after receipt of the request for an expedited determination, the QIO must make its determination on whether the discharge is appropriate based on medical necessity or other Medicare coverage policies.

Note: *If the QIO does not receive supporting information from the provider, it may make its determination based on the evidence at hand, or defer a decision until it receives the necessary information. If this delay results in continued services for the beneficiary, the provider may be held financially liable for these services as determined by the QIO.*

The QIO must notify the beneficiary, the beneficiary's physician, and the provider of services of its determination. This notification must include the rationale for the determination and an explanation of Medicare payment consequences and beneficiary liability. QIOs must also inform the beneficiary of the right to an expedited reconsideration by the Qualified Independent Contractor (QIC) and how to request a timely expedited reconsideration. The QIO will make its initial notification via telephone and will follow up with a written determination letter.

260.6 - Effect of a QIO Expedited Determination

(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

The QIO determination is binding unless the beneficiary pursues an expedited reconsideration per section 270 of this chapter.

260.6.1 - Right to Pursue an Expedited Reconsideration

(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

If dissatisfied with the expedited determination, the beneficiary may request an expedited reconsideration according to the procedures described in section 270 of this chapter.

260.6.2 - Effect of QIO Determination on Continuation of Care

(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

If the QIO decision extends coverage to a period where a physician's orders do not exist, 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 if that care is later terminated, per the requirements of this section. If the beneficiary again disagrees with the termination of care, a new request to the QIO must be made.

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

Example: If covered home health care continues following a favorable QIO decision for the beneficiary, the HHA would resume issuance of Home Health Advanced Beneficiary Notices (HHABNs) 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 must be issued to the beneficiary since this would be an initiation of non-covered care.

Example: If covered Skilled Nursing Facility (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 SNFABN must be issued to the beneficiary.

260.6.3 - Right to Pursue the Standard Claims Appeal Process **(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)**

If a beneficiary receives services of the type at issue in the expedited determination after the coverage end date, and coverage is denied, the beneficiary may appeal the denial within the standard claims appeal process (See Chapter 29 of this manual.)

261 – Expedited Determination Notice Association with Advance Beneficiary Notices **(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)**

Delivery of the NOMNC does not replace the required delivery of other mandatory notices, including ABNs. Notice delivery must be determined by the individual NOMNC requirements per this section and ABN delivery requirements per §1879 of the Act and per guidance in this chapter. Both the NOMNC and an ABN may be required in certain instances.

Only one notice may be required when Medicare covered care is ending.

Example: A beneficiary is receiving 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 continue the CORF services, an ABN should not be issued.

Some situations may require two notices at the end of Medicare covered care.

Example: A beneficiary's Part A stay is ending because skilled level care is no longer medically necessary and the beneficiary wishes to remain in the SNF receiving custodial care. The beneficiary must receive the NOMNC two days prior to the end of coverage. A SNFABN must also be delivered before custodial care begins.

It is also possible that no notice is required when Medicare coverage is ending.

Example: A beneficiary exhausts the 100 day benefit in a SNF. In this instance, the NOMNC should not be delivered. The SNFABN is not required in this situation. However, it can be issued voluntarily, as a courtesy to the beneficiary.