

Expedited Determinations
Home Health / CORF

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Objectives

- Explain the history of the ED process and how this process affects the provider and the beneficiary.
- Determine when it is appropriate to give the notice.
- Demonstrate how to complete the generic notice with all the documentation required by CMS.
- Demonstrate how to complete the detailed notice with all the documentation required by CMS.
- Explain the reconsideration process and how the process affects the provider and the patient.
- Explain the barriers to effective delivery of the notice.

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How It All Began

- 1993: Lawsuit—Grijalva v. Shalala
- First Medicare Advantage appeal—
January 1, 2004
- Extended to FFS—July 1, 2005
- Under the Balanced Budget Act



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Why It All Began

- Beneficiaries wanted due process rights
- Protect beneficiary rights
- Provide financial protections



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How EDs Affect You

- CMS can audit your facility.
- Invalid notices can cost money.
- Invalid notices waste time and can confuse patients.
- Laws pertaining to EDs are federal regulations.



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How The Process Works

- The Medicare Advantage Plan or Provider issues the Notice.
- The patient or family member calls if they want an appeal.
- At time of appeal, physician certification—usually in the record—is required to proceed.
- Patient has 60 days to send in completed certification.
- HSAG requests the record.
- The physician reviews the record.
- The patient and facility are notified of the decision.



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When To Issue A Notice

When it is determined that *all* skilled services are no longer required

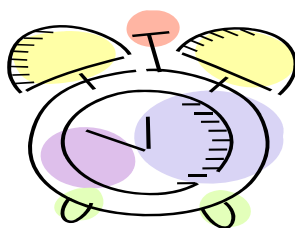


GENERIC NOTICE is issued whether the patient agrees or disagrees with the discharge!

Timing Requirements

Providers

- Notice issued on the next to the last visit



Patient

- Must call by noon of the day before the effective date if appeal is desired

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The Details of the Process



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Provider Responsibility

- Fax a copy of the Generic Notice, Face Sheet, and Detailed Notice.
- If the patient is a Medicare Advantage patient, the MA issues the Detailed Notice.



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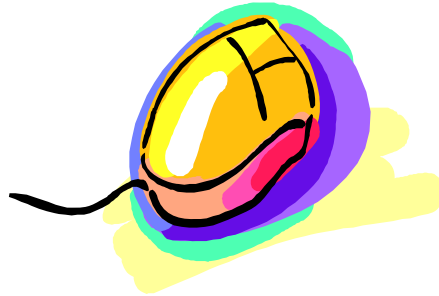
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Where to get the Notices

<http://www.cms.hhs.gov/BNI>



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A screenshot of a Windows Internet Explorer browser window displaying the CMS website. The address bar shows <http://www.cms.hhs.gov/BNI/>. The page title is "Overview Beneficiary Notices Initiative (BNI)". The CMS logo is visible at the top, along with the tagline "Improving the health, safety and well-being of America". The main content area is titled "Beneficiary Notices Initiative (BNI) Overview" and includes a "Please Note" section and a list of financial liability notices. The navigation menu at the top includes links for Home, Medicare, Medicaid, SCHIP, About CMS, Regulations & Guidance, Research, Statistics, Data & Systems, Outreach & Education, and Tools. The taskbar at the bottom shows the start button and several open applications, including Internet Explorer and Paint. The HSAG logo is visible in the bottom right corner of the slide.

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FFS ED Notices

As of July 1, 2005, Home Health Agencies (HHAs), Skilled Nursing Facilities (SNFs), Comprehensive Outpatient Rehabilitation Facilities (CORFs) and Hospices with beneficiaries in Fee-For-Service Medicare are required to notify beneficiaries of their right to a new expedited review process when these providers anticipate that Medicare coverage of their services will end.

HHAs, SNF, Hospice, CORF, and swing beds (under instruction) are required to provide a Generic Notice to beneficiaries to alert them that Medicare covered item(s) and/or service(s) are ending and give beneficiaries the opportunity to request an expedited determination from a QIO. A Detailed Notice is given when the QIO review is requested in order to provide more explanation on why coverage is ending.

Effective October 1, 2005, HHA, SNF, Hospice, CORF, and swing beds must use approved versions of the Expedited Determination notices.

August 20, 2008- Download current **CMS Forms 10123 and 10124**

*The renewed, OMB-approved Notice of Medicare Provider Noncoverage (CMS-10123) and Detailed Explanation of Noncoverage (CMS-10124) are now available for download and immediate use. The expiration date for the renewed forms is 07/31/20011. CMS will allow a 60-day transition period for use of the new forms. Mandatory use of the renewed forms will begin on **November 1, 2008**.*

To download the FFS Expedited Determination Notices and Instructions, please click on the appropriate link below.

MA ED Notices

Under the Medicare Advantage program, HHA, SNF, CORF are required to provide a Generic Notice to beneficiaries to alert them that Medicare covered item(s) and/or service(s) are ending and give enrollees the opportunity to request an expedited determination from a QIO. A Detailed Notice is given when the QIO review is requested in order to provide more explanation on why coverage is ending.

To download the notices and instructions, please click on the appropriate link below.

Downloads

- [Notice of Medicare Non-Coverage \(NOMNC\) \[pdf, 23KB\]](#)
- [Instructions for NOMNC \[pdf, 26KB\]](#)
- [Detailed Explanation of Non-Coverage \(DENC\) \[pdf, 25KB\]](#)
- [Instructions for DENC \[pdf, 15KB\]](#)

Related Links Inside CMS

There are no Related Links Inside CMS

Related Links Outside CMS

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Tips for Success

- Standard notice for all situations
- Copy for the patient, copy for the chart
- Educate your staff, especially weekend staff
- Develop a process and “stick” to it
- Short, concise delivery

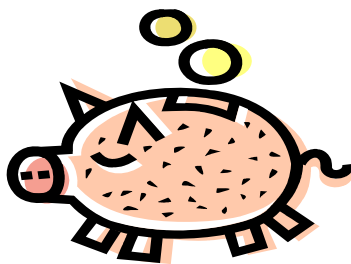


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Delays

- Failure to submit the information in the time frame can result in a delay in the review.
- Any costs associated with the delay are NOT the responsibility of the beneficiary.



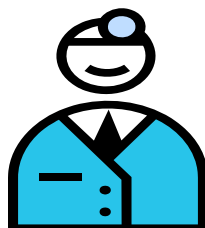
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The HSAG Physician

- Has the option to contact the patient's physician prior to making a decision.
- May agree or disagree that the beneficiary is ready to be discharged from skilled services.



Notification

HSAG will notify the beneficiary and the HHA, CORF, or Medicare Advantage Organization by close of business the day after we receive all information necessary to make a decision.



Reconsiderations

- The beneficiary has a right to ask for a reconsideration of HSAG's decision.
- The beneficiary does not have the same financial protections during this process.



More Reconsiderations

- FFS patients—Maximus (the Qualified Independent Contractor) completes the review
- Medicare Advantage patients—HSAG completes the review
- Another physician not involved with the original decision reviews the chart

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The Next Step

If the reconsideration does not go in the beneficiary's favor, he or she can appeal to the Administrative Law Judge (ALJ)—only for financial issues.



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Beneficiary Request for Documents

Upon request, the HHA, CORF, or Medicare Advantage Organization must provide the beneficiary the documentation sent to HSAG.

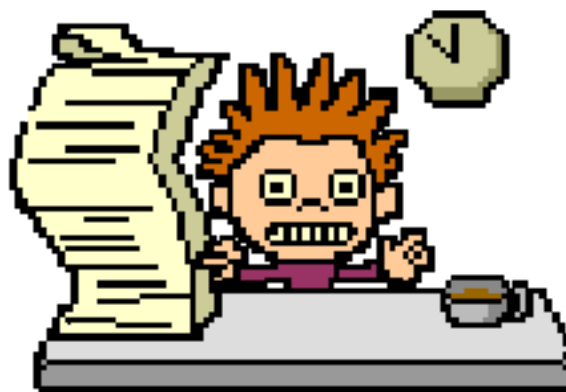


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Complications



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Invalid Notices

- Wrong form
- Doesn't meet CMS guidelines
- Missing documentation
- Wrong time frames
- Wrong dates
- Wrong QIO phone number



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Representatives

- Legal types
- Deferring to state law
- No representative on record and patient unable to sign
- Patients that require assistive devices



Exceptions

- Therapy caps (Part B)
- Admission to higher level of care
- Unsafe environment
- Move out of the area
- Signed up for hospice



Weekend Staff

Need to:

- Know who HSAG is and its role in processing these appeals.
- Be familiar with the notices.
- Be able to locate the notice.
- Know how to re-issue the notice.
- Know they can give out PHI to HSAG.
- Know how to fax notices and records.

Delivery Issues

- Excuses
- Patient won't sign
- Patient is not competent
- Representative won't acknowledge



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ED Phone Number

1-800-841-1602



Call with any questions: 8:00 a.m.–4:30 p.m. PST
7 days a week, 365 days a year

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Over 1 million drug-related injuries occur every year in health care settings. The Institute of Medicine estimates that at least a quarter of these injuries are preventable.

To find out how to prevent medication errors, go to
http://www.hsag.com/ca_drugsafety/.



www.hsag.com

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