

# **EXPEDITED DETERMINATION (ED) PROCESS FOR ORIGINAL MEDICARE Questions and Answers (Q&As)**

## **INTRODUCTION**

For an overview of the expedited review process, please click [here](#). These Q&As replace all previous guidance on the expedited review process.

*Note that new Q&As have been added to the previously existing list in March 2006. The new Q&As are #11 in Group 2, #9 in Group 4, #11 in Group 5, #13 in Group 6 ( subgroup “Delivery of the Generic Notice”) and #14 in Group 7 (subgroup Skilled Nursing Facilities (SNFs)).*

The Q&As are grouped as follows:

**1. General Scope of ED Process in Original Medicare – 8 Q&As**

*Includes:* Information on differences in the similar ED processes for Medicare managed care and Original Medicare; Medicare Secondary Payer; Dual Eligibles; differences for providers submitting claims to Medicare carriers and intermediaries.

**2. General Policy on the ED Process – 10 Q&As**

*Includes:* Authorized Representatives; Payment Liability; Reduction of Services; Wholly or Partially Noncovered Services; Higher Level of Care, Hospitalization; Similar Level of Care, Different Providers; Residential to Non-Residential Care; Change of Providers; and Instructions.

**3. Physician Orders/Certification of Risk – 8 Q&As**

*Includes:* what settings require certification statement, the QIO role in these processes, physician orders to continue care

**4. QIO/QIC Information – 8 Q&As**

*Includes:* information on access to QIOs, the QIO role in the process, timely and untimely reviews, QIC reconsideration timeframes.

**5. Overlap with Other Current Processes – 10 Q&As**

*Includes:* overlaps with ABNs, and demand billing.

**6. Notification Process – 37 Q&As**

*Includes:* completing and delivering the generic and detailed ED notices

**7. Individual Benefits Subject to the ED Process– 13 Q&As**

*Includes:* information specific to Home health, CORF, Hospice, Swing bed, SNF

## **Group 1: General Scope of ED Process in Original Medicare – 8 Q&As**

### **Managed Care**

- Q1. How does the new expedited determination process that was effective July 1, 2005 affect the existing process for Medicare managed care (i.e., Medicare Advantage, M+Cs)?
- A1. This guidance addresses only the expedited review process for Original Medicare, also known as the Medicare Fee-For-Service Program. CMS is not implementing any changes in the ED process for Medicare managed care enrollees.
- Q2. Can I use the original Medicare and Medicare Advantage ED notices interchangeably or can I combine the notices?
- A2. Although ED procedures for Original Medicare beneficiaries are largely similar to the procedures for managed care enrollees, there are some differences between the two processes. These differences include the timeframes for decisions and filing late appeals, and plan involvement in the appeal process for managed care enrollees. Thus, CMS created different notices for each process and the appropriate notice(s) must be used according to the type of Medicare that was chosen by the beneficiary.

### **Medicare Secondary Payer**

- Q3. Do expedited determination notices have to be given when the beneficiary has Original Medicare as the secondary, instead of primary, payer?
- A3. Yes, the generic notice is given whenever all Medicare covered services end, no matter where in the sequence of payers Medicare falls.

### **Beneficiaries Dually Eligible for Medicare and Medicaid**

- Q4. Is there any difference in the expedited process if a beneficiary is entitled to both Medicare and Medicaid, not just Medicare?
- A4. No, the notification requirements and the review process are the same.

## **Intermediary-Administered Benefits**

- Q5. What providers and services are affected by the expedited determination process?
- A5. The regulation applies to the end of any period of covered care provided by any “non-hospital” provider listed in section 1861(u) of the Social Security Act under Original Medicare (fee-for-service payment). Swing beds of hospitals are affected, however, since covered services in these beds are comparable to those provided by SNFs. In total, the affected provider types are swing beds, SNFs, hospices, HHAs and CORFs.

In refining the application of this new right to these providers, CMS ultimately recognizes seven affected service types listed in the chart below. Expedited notice would be required every time all covered services end in each of these service types, EXCEPT in cases where benefits are exhausted. **Separating PPS and non-PPS services into distinct categories, particularly in SNFs where this distinction also coincides with the difference of payment under Part A and Part B, is a change from previous policy on the expedited process, effective with the release of these Q and As.** CMS will update all applicable instruction accordingly at a later point in time.

**Summary of Notification Requirements for FFS Expedited Determinations for Each Affected Provider Type**

<b>Provider Type Subject to Expedited Determination</b>	<b>Medicare Payment Source for Covered Services</b>	<b>Affected Types of Bill (TOBs)</b>	<b>Triggers for Expedited Notice</b>	<b>Usual Service/Terminations Cases Not Triggering Expedited Notice* in Benefit**</b>
Swing Bed	Part A	18x	<b>End of Part-A covered level of care with benefit days remaining</b>	<ul style="list-style-type: none"> <li>▪ No notice given when benefit days expire/have expired</li> <li>▪ No notice given for transfers to comparable providers, including SNFs</li> <li>▪ No notice given for leave of absence</li> </ul>
SNF Prospective Payment System (PPS)	Part A	21x	<b>End of Part-A covered level of care with benefit days remaining</b>	<ul style="list-style-type: none"> <li>▪ No notice given when benefit days expire/have expired</li> <li>▪ No notice given for transfer to comparable provider</li> <li>▪ No notice given for leave of absence</li> </ul>
Other SNF	Part B	22x, 23x	<b>End of <u>all</u> Part B services on plan of care</b>	<ul style="list-style-type: none"> <li>▪ No notice given if care in question is one-time or intermittent in nature, such as services available to all Part B beneficiaries independent of the setting of care/residence-- see list in Group 7, question 10.</li> </ul>
Hospice	Part A	81x, 82x	Provider discharge from hospice benefit for coverage reasons	<ul style="list-style-type: none"> <li>▪ No notice given when beneficiary revokes the benefit</li> <li>▪ No notice given for transfer to other hospice</li> </ul>
Home Health PPS	Part A and/or B	32x, 33x	Provider discharge from home health benefit for coverage reasons	<ul style="list-style-type: none"> <li>▪ No notice given for transfer to other home health agency (HHA)</li> <li>▪ No notice given for mid-episode hospitalization whether HHA discharges or not</li> </ul>
Other Home Health	Part B	34x	End of <u>all</u> Part B services on plan of care, i.e., therapy plan of care	<ul style="list-style-type: none"> <li>▪ No notice given if care in question is one-time or intermittent in nature, such as services available to all Part B beneficiaries independent of the setting of care/residence; Examples: <ul style="list-style-type: none"> <li>+ DME provided when HHA is acting like an independent supplier</li> <li>+ Roster billing of vaccines</li> </ul> </li> </ul>
CORF	Part B	75x	End of all Part B services on plans of care	<ul style="list-style-type: none"> <li>▪ No notice given if care in question is one-time or intermittent in nature, such as services available to all Part B beneficiaries independent of the setting of care/residence</li> </ul>

\*"Notice" only means expedited determination process requirements, NOT other notice requirements, such as for SNFs with the delivery of SNFABNs, denial or "cut" letters.

\*\*Expedited Notice is not given in any benefit when termination of covered services is: (1) the result of a beneficiary, not a provider, deciding to end coverage; (2) when termination is for reasons other than medical necessity under Medicare coverage policy; and (3) when the beneficiary requires treatment at a higher level of care, such as transfer to an acute-care hospital.

**NOTE: "Bolding"**, other than titles, represents significant change from current instructions.

Q6. What are the residential and non-residential providers discussed in the expedited determination regulation?

A6. Under the expedited determination regulation, the residential providers are swing beds, SNFs and hospices. The non-residential providers are HHAs and CORFs.

### **Carrier-Administered Benefits**

Q7. I'm an independent professional who submits claims for therapy services directly to a Medicare carrier. Do I have to give out expedited determination notices?

A7. No. The expedited determination process for original Medicare that became effective July 1, 2005 only applies to specific fee-for-service institutional providers listed in section 1861(u) of the Social Security Act, namely HHAs, SNFs, swing beds, CORFs and hospices. Even if the professional is an independent therapist providing services comparable to a CORF, these therapists would not be subject to the expedited process.

Q8. Does the expedited determination process apply to DME suppliers?

A8. No, the expedited determination process does not apply to DME suppliers.

### **Group 2: General Policy – 11 Q&As**

#### **Authorized Representatives**

Q1. Who can act on behalf of an incompetent beneficiary? For example, what is the process for delivering a generic notice if the beneficiary is not capable of receiving a notice?

A1. In general, State law dictates who may act as the authorized representative of the beneficiary. State laws differ from one jurisdiction to another with respect to what is required to legally represent an incompetent beneficiary. For example, some States have health care consent statutes providing for health care decision-making by surrogates on behalf of patients who lack advance directives and guardians. Other States have laws that grant authority to individuals with durable powers of attorney.

In an emergency, a disinterested third party, such as a public guardianship agency, may be an authorized representative, e.g., where the beneficiary's inability to act has arisen suddenly (e.g., a medical emergency, a traumatic accident, an emotionally traumatic incident, disabling drug interaction, stroke, etc.). Such parties are used when there is no one who genuinely can be considered as the beneficiary's choice as his or her authorized representative. Thus, a provider should deliver the generic notice to the individual authorized under State law to make health care decisions on behalf of the beneficiary when the beneficiary cannot act alone.

## **Payment Liability**

- Q2. If a beneficiary decides to request an expedited determination of a discharge decision and requests that services continue pending the outcome of the review, who is financially responsible for the additional days of service?
- A2. The QIO's decision will determine whether the beneficiary or Medicare is financially responsible for the disputed days. Section 405.1202(e)(8)(ii) of the expedited determination regulation states that the QIO's initial notification will include an explanation of the Medicare payment consequences of the determination and the date a beneficiary becomes fully liable for services. To the extent that the coverage end date on the generic notice given by the provider is upheld, the beneficiary is responsible for services received after that effective date.
- Q3. When would providers become liable under the expedited determination process?
- A3. The regulation gives only two examples where providers may become liable under the new expedited process. One is if the provider fails to give a valid notice; for instance, the provider fails to give the notice 2 days in advance when applicable. The other is if the provider fails to provide the reviewing QIO with requested information in a timely fashion. Otherwise, the QIO is deciding whether coverage will continue and the Medicare program will pay, or if the beneficiary will be liable for care if delivered beyond the coverage end date on the generic notice.

## **Reduction of Services**

- Q4. Suppose that a beneficiary is receiving physical therapy, wound care, and an "IV" in a facility. If the facility only discontinues the IV, is it required to deliver a generic notice to the beneficiary 2 days prior to the IV ending?
- A4. When one set of services ends, but other Medicare-covered services continue, a provider is not required to deliver the generic notice. The generic notice should be given only when the beneficiary will no longer receive any Medicare-covered services from the provider.

## **Wholly or Partially Noncovered Services**

- Q5. If a physician has ordered home health services, some of which are covered and some that are not, should an HHABN and an expedited determination notice be given at the initiation of these services?
- A5. Expedited determination notices are only given when all Medicare covered care ends—they are not required as a result of the initiation of services. When an initiation of non-covered care, or reduction of some covered care, occurs, only an ABN notice, such as the HHABN, would be required.

### **Higher Level of Care; Hospitalization**

- Q6. If a beneficiary is in a facility, gets pneumonia and subsequently needs to go to an acute hospital setting, should the beneficiary receive the generic notice?
- A6. No. The generic notice is not intended or required for situations where an individual moves to a more intensive level of care, even if the facility ultimately discharges the beneficiary while still in the hospital.

### **Similar Level of Care; Different Providers**

- Q7. A beneficiary is in a hospice and is no longer considered to be terminally ill. The hospice tells the beneficiary that Medicare coverage of hospice services will be ending and that he can continue his care under a HHA. Should the beneficiary receive a generic notice?
- A7. Yes. The generic notice would be given at the end of the hospice period of covered care, since the beneficiary may want to dispute the discharge from the hospice. Though some aspects of care under those benefits may be similar, there are differences that could result in the beneficiary facing liability for payment for specific services Medicare covers under hospice but not under home health.

### **Residential to Non-Residential Care**

- Q8. Please verify if the generic notice must be issued if the beneficiary no longer requires skilled services in a facility, but a physician authorized home health services subsequent to the discharge. Would the beneficiary also need to receive a notice at the end of the home health episode?
- A8. Yes, the beneficiary must receive a generic notice before the conclusion of the stay in the facility. This would qualify as an end to a distinct level of care. The beneficiary has the right to request an expedited determination regarding his or her discharge from the facility to home. The beneficiary then too should receive a generic notice at the end of Medicare covered home health as a separate episode of care.

## Change of Providers

Q9. Could CMS summarize some common situations where an expedited notice is and is not required when beneficiaries are changing providers/care settings?

A9. Yes. CMS agrees this is a good idea, and below has adapted an effort by a QIO to highlight some common situations:

<b>PROVIDER 1: Discharging Beneficiary</b>	<b>PROVIDER 2: Receiving Beneficiary</b>	<b>PROVIDER 1: Issue Generic Notice?</b>	<b>Rationale</b>
SNF Part A or Part B, or skilled swing bed	[Another] SNF	No	Transfers among providers of the same type do not require expedited notice.
SNF Part A or B, or skilled swing bed	HHA	Yes	Beneficiary has right to review of the loss of residential care and/or the change in level/frequency of services.
SNF Part A or B, or skilled swing bed	NF, non-skilled DPU or non-skilled swing bed	Yes	Beneficiary has right to review of the change in the level of services to noncovered care.
HHA	Hospice	No	Beneficiary's choice to elect the hospice benefit; could continue home health/other care instead even if terminally ill.
HHA	SNF	No	Notification is not required when the beneficiary condition necessitates a higher/more intensive level of care.
Any FFS provider required to give expedited notice	Acute stay hospital	No	Notification is not required when the beneficiary condition necessitates a higher/more intensive level of care.
Any FFS provider required to give expedited notice	<b>NOT to a Medicare provider type;</b> home settings including assisted living	Yes	Basic right to review of discharge/termination of covered care.



## Instructions on ED

Q10. Where can I find information on the new expedited review process?

A10. In addition to these Qs&As, you can find the following information on the BNI webpage ([www.cms.hhs.gov/medicare/bni](http://www.cms.hhs.gov/medicare/bni)):

- OMB Approved Generic Notice (English and Spanish) (CMS-10123) [Word] [PDF]
- OMB Approved Detailed Notice (English and Spanish) (CMS-10124) [Word] [PDF]
- Instructions for Using the Generic Notices
- Instructions for Using the Detailed Notices
- General Information Regarding The Expedited Review Process
- A Medlearn Matters Article (SE0538) entitled “New Expedited Review Process for Disputed Terminations of Medicare Covered Services in SNFs, HHAs, CORFs and Hospices” can be found at: <http://www.cms.hhs.gov/medlearn/matters>
- Intermediary instructions in 2005 CMS transmittals, Transmittal 577 (re-issued as 594 without a change in content) on the CMS Manuals webpage: [www.cms.hhs.gov/manuals/](http://www.cms.hhs.gov/manuals/).

## Therapy Caps

Q11. When the annual dollar limit or “cap” for therapy services recently implemented by CMS is exceeded, can a beneficiary who does not qualify for one of the allowed exceptions request an expedited determination?

A11. No, exceeding the therapy cap does not trigger the expedited right. This is true because the cap is set in law and once it is exceeded, QIOs cannot contradict or reinterpret the law. Exceeding the therapy cap is similar to exhaustion of other benefits, such as when a beneficiary exceeds the limit of 100 days of coverage in a SNF Part A stay. Providers never issue generic notices based solely because benefits exhaust.

If reaching the cap, however, coincides with the end of other Medicare covered care offered by the provider, the generic notice should be given to allow the beneficiary to receive a QIO opinion on the **other** services being terminated. However, if the cap has been reached and therapy is the only remaining covered service, the generic notice is not given because the QIO cannot overturn the statutory limit, as stated above.

If the cap has not been reached and therapy is the only remaining covered service, the provider should give the generic notice when these therapy services are ending. This is because the statutory limit for the benefit has not been reached, and the provider is making a medical necessity decision to terminate covered therapy services thus making it appropriate for a QIO to review at the beneficiary’s request.

### Group 3: Physician Certifications/Orders – 8 Q&As

- Q1. In what settings do beneficiaries need a physician's certification that failure to continue services may place the beneficiary's health at significant risk ?
- A1. The expedited determination regulations require the physician certification for expedited review requests involving service terminations by non-residential providers if they want to seek a QIO review. CMS has defined non-residential providers in instructions as HHAs and CORFs. This certification can be provided by any licensed physician.
- Q2. Does the attending physician have to provide the certification statement? Can a QIO physician provide it?
- A2. Although we indicated previously that a QIO physician could provide the required certification statement for beneficiaries, **we have reevaluated this issue, and determined that it is not appropriate for a QIO both to provide the physician certification statement required in order to request a review and to conduct the review itself.**
- Instead, when a beneficiary requests an expedited review, but does not have the necessary certification, the QIO will instruct the beneficiary to call his or her attending physician to request such a statement or to obtain the required statement from any other physician of the beneficiary's choice. CMS will make this change clear in subsequent instructions to intermediaries.
- Q3. The expedited determination regulation states beneficiaries being served by non-residential providers must obtain the physician certification of risk. Does this physician certification authorize delivery of care like other physician certifications?
- A3. No, the physician certification of risk does not authorize delivery of any care not previously ordered by a physician. For expedited determinations, the physician certification is merely a written statement from a physician that failure to continue services may place the beneficiary's health at significant risk. Without such a statement, a QIO may not make a determination on a beneficiary's ED request. It may be the physician who ordered the previous care who gives the certification, or it may be any other licensed physician the beneficiary contacts.
- Q4. Are new physician's orders needed to continue care if a patient requests an expedited review?
- A4. Most often, because the generic notice is intended to be given before coverage ends, there may be standing orders for care through the coverage end date on the notice, which may or may not call for provision of services in the remaining period of time. Coverage may also end unexpectedly, so that previously received orders could authorize delivery of additional services that would then become noncovered. However, if previous physician orders for care have either lapsed or been terminated, **existing requirements that orders**

**be in place are not changed by the expedited determination process. Therefore, care must always be delivered according to the physician order when such orders are required.**

- Q5. What if Medicare coverage is ending, but physician's orders continue beyond the coverage end date on the generic notice?
- A5. The generic expedited determination notice is required whenever the provider believes that Medicare coverage will end, regardless of whether other noncovered services will continue. [See Group 5 Q&A section on "Current Process Overlap" for related ABN considerations.]
- Q6. What if the beneficiary has trouble finding a physician to give a certification statement?
- A6. As long as the beneficiary initiates the expedited process properly, either timely or untimely, the QIO should process the review. If a physician certification has not been obtained by the beneficiary when making the request for review, the QIO will allow 60 days for the beneficiary to receive the physician certification and proceed with the review process as requested (timely or untimely). If a certification has not been obtained within the 60 day timeframe, the QIO will not proceed with the review.
- Q7. When a physician has written admission orders, but none of the services are considered to be covered by Medicare, is the expedited determination notice required?
- A7. No, if there is no coverage at admission, expedited notices are not given.
- Q8. Why should the non-residential provider be required to deliver a detailed notice if the physician does not certify a significant health risk? It seems unproductive for a provider to deliver this notice until after the QIO has reviewed the generic notice for validity.
- A8. Normally, the provider would not give the detailed notice until after the generic notice was given, a physician certification was obtained by the beneficiary, and the provider had been contacted by a QIO because a review had been requested. The physician certification is not sequentially related to the detailed notice. Neither the QIO nor the provider will always be able to ascertain when the certification statement will arrive. The certification constitutes beneficiary evidence; the detailed notice constitutes provider evidence. The information required in the detailed notice should represent the underlying rationale in any discharge or service termination, so that, in the very small minority of disputed discharges/terminations, the rationale should be clear to the QIO.

#### **Group 4: QIO/QIC Information – 9 Q&As**

- Q1. How do providers find out what organization is their QIO and set up arrangements for exchanging medical records and other tasks that are involved in the expedited review process?

A1. QIOs are assigned to cover specific States. CMS maintains a directory of State QIOs at [www.cms.hhs.gov/qio/](http://www.cms.hhs.gov/qio/). When actual expedited review requests are received, QIOs are responsible for contacting the involved providers, and issues like the exchange of medical records can be resolved in the context of individual cases. However, QIOs may contact providers in advance of any actual requests in order to facilitate the process. Note the regulations allow QIOs discretion to accept initial information from providers by phone in order to provide some leeway in the timing of the exchange of written materials.

Q2. Why does the QIO need a copy of the detailed notice? How long does the provider have to get the detailed notice to the QIO and how should the notice be delivered?

A2. The regulations require that the provider send a copy of the detailed notice to the QIO. The QIO should, in the course of soliciting the beneficiary's views, ensure that the beneficiary is aware of and understands the provider's rationale for the coverage termination decision on the detailed notice and has an opportunity to dispute the decision.

Generally, the provider must ensure that the QIO has the detailed notice by close of business of the same day as the QIO's notification that the beneficiary requested an expedited determination. The provider may deliver the detailed notice to the QIO via personal delivery, or through a courier service that can deliver the package on the same day. Facsimile or phone contact can also be made, as long as it is followed-up by written materials in the mail. HIPAA regulations do not allow beneficiary specific information to be sent via email, such as the Medicare or HIC number on the generic notice.

Q3. Will QIOs and QICs issue determinations with coverage for specified periods of time? Can QIOs order care? If QIOs cannot order care, must providers deliver services just because of a QIO decision that coverage should continue implies more care is needed?

A3. The experience to date with Medicare managed care has been that usually the QIO decision affirms only whether or not discharge is appropriate, and that decision is relative to the date given at the top of the generic notice as the coverage end date. In managed care, QIOs have only very occasionally specified that coverage/a specific treatment should continue for specific period of time beyond the coverage end date.

In any case where a QIO determines that care should be continued and there are no physician's orders, providers with questions can contact the QIO about the decision. However, since QIOs are not prescribing or treating entities in their own right, they cannot order care.

Q4. Is there any provision that requires QIOs to notify the provider by a certain time that a beneficiary has requested an expedited determination from a QIO?

A4. Section 405.1202(e)(1) of the regulations requires the QIO to "immediately" notify the provider about the beneficiary's request for an expedited determination on the date the QIO received the request. Therefore, the QIO must contact the provider without delay, working within the established business hours of both the QIO and provider.

- Q5. Will QIOs be conducting reviews on weekends?
- A5. Yes, QIOs will be available both to receive a beneficiary's request for an expedited determination and to conduct reviews on weekends, if necessary. CMS believes this policy will serve to minimize possible liability for the beneficiary. For example, if a beneficiary requests an expedited review by noon Friday, and the provider furnishes the necessary documentation that day as expected, the QIO should be able to provide its determination by Monday.
- Q6. What if a beneficiary misses a deadline for filing a request for an expedited determination? Is there an "untimely" expedited review that provides the same options to beneficiaries?
- A6. Yes, there is a "non-expedited" review process. Under 42 CFR 405.1202(b)(4), QIOs are still obligated to accept requests for review from beneficiaries after the noon deadline associated with the timely expedited review process. In this situation, however, the 72 hour deadline for the QIO's decision and the liability protection afforded under the normal process do not apply.
- Q7. When a covered period of care has ended, and a beneficiary or authorized representative requests a review beyond the timely request requirement, how will the QIO proceed?
- A7. A beneficiary must file a timely review with a QIO by noon of the calendar day after the generic notice was received or the day before coverage ends. Under instructions, CMS clarified this should also be considered as up to 24 hours after coverage ends in cases where there is an abrupt end, since the regulation focuses on cases where there is time to give notice in advance.

Regulations also require QIOs to honor untimely requests for expedited reviews. Currently QIOs allow the beneficiary 60 calendar days from the coverage ends date on the generic notice to make a request, which essentially allows a beneficiary who had been receiving services from a non-residential provider to obtain a risk certification on or within 60 calendar days of the coverage ends date. When this deadline is met, the QIO will be able to accept the request and make a determination on the case.

Like the process for QIO review of hospital inpatient care, QIOs will differ their handling of untimely requests depending on whether the beneficiary is still receiving disputed services. If this is the case, the QIO must make a determination and verbally notify all parties within 7 calendar days of receipt of the request. When the beneficiary is no longer receiving services, the QIO must make a determination within 30 calendar days of receipt of the request.

- Q8. Regarding reconsiderations, what does the "not to exceed 14 days" reference in the regulation mean? Is it that the beneficiary has 14 days to appeal or 14 days of continued coverage?

- A8. This time frame is an extension of up to 14 days that the beneficiary can request before the QIC renders an expedited reconsideration decision. It does not imply continued coverage during the period.
- Q9. Can QICs invalidate a notice a QIO has already found valid?
- A9. No. As an initial step, QIOs are charged with determining whether the generic notice is valid or invalid under the expedited determination process. QIC are charged with determining whether coverage should end based on medical necessity or other Medicare coverage policies subsequent to QIO decisions on coverage.

### **Group 5: Overlap with Current Processes - 10 - Q&As**

- Q1. Please explain which notices you are referring to when you use the term “ABN”?
- A1. An ABN, which stands for advance beneficiary notice, is a notice that a provider gives before the delivery of potentially noncovered care, so that beneficiaries can make informed choices on both receiving the item(s) or service(s) in question and on accepting responsibility for payment. Specific notices in the ABN family are:
- a. HHABN: Home-Health Advance Beneficiary Notice, for use by HHAs.
  - b. SNFABN: Skilled Nursing Facility Advance Beneficiary Notice, for use by SNFs.
  - c. SNF Denial Letters: Model letters used as alternatives to the SNFABN.
  - d. ABN – L: An ABN adapted for laboratories or when billing only lab services.
  - e. ABN – G: The “General Use” ABN used by most Medicare providers/suppliers.
  - f. HINN – Hospital Issued Notice of Noncoverage (used for inpatient hospital services).
- Q2. Please explain the difference between the expedited determination notices and ABNs.
- A2. Expedited determination notices are given to alert beneficiaries, **before a discharge or termination of Medicare covered services**, of their right to obtain an independent, immediate QIO review because Medicare coverage of their care is ending. ABNs are given **before the delivery of potentially non-covered care**, and inform beneficiaries that they may be required to pay for care providers believe Medicare will not cover.
- Q3. The expedited determination notices seem to overlap with the current instructions related to ABNs. Will CMS be modifying the ABN instructions?
- A3. Yes. CMS is reviewing the instructions applicable to ABNs to make any necessary changes. **Until new instructions are finalized and released, providers should continue to follow currently published ABN instructions, and provide the expedited determination notices when required by the separate instructions on this process.**

Q4. Are there any circumstances where a provider would need to issue both the expedited review notice and an ABN?

A4. Generally, there is no need to issue both notices at the same time. The only time both types of notices would be necessary is when all Medicare-covered services are ending, but the provider intends to deliver non-covered care. In this situation, the provider must issue the generic notice to the beneficiary in order to advise him/her that Medicare coverage is ending, and also give the beneficiary an ABN prior to the delivery of non-covered care, so that the beneficiary can make an informed choice as to whether to pay for these non-covered services.

Q5. If a beneficiary requested an expedited review of a discharge, can a claim including the days for which the QIO made a coverage decision still be filed? If filed and the days were denied based on the QIO decision, can such claims ever be appealed?

A5. Yes, claims can still be billed that include these days, although the intermediary is expected to deny such a claim. Standard claim appeal rights still exist even when the expedited process is used. Providers are required to wait to bill until the expedited review process is complete, so that a fiscal intermediary's initial determination is informed by the results of the QIO review. However, any initial determination can be appealed.

Q6. What happens if an ABN is given specifying noncoverage, and it turns out the QIO says coverage continues? What if a claim is filed before an expedited review is completed? What process takes priority?

A6. If a QIO under the expedited process finds that covered services should continue for a period for which an ABN was given, the ABN just becomes moot for that period. Providers are advised to annotate the copies of the ABN they have retained if this circumstance occurs. Providers should not bill Medicare until the expedited review process is complete. Since those determinations are binding, and the timely review process unfolds over a matter of days, waiting for these decisions to bill is usually efficient for all involved parties.

In the case of the expedited review process that is requested untimely, the same general rules apply. At most, if a provider filed a claim unaware a beneficiary had or would request an expedited review, nothing more would occur than the provider needing to cancel and re-bill the claim, and that action would be needed **only if** the QIO/QIC decision failed to affirm coverage already reflected on the claim for the period in question. Because they are considering the same coverage policy affecting medical necessity determinations, QIOs decisions resulting from expedited review will often affirm provider determinations on coverage.

Q7. If a beneficiary or his/her family decides a month after discharge they want to dispute noncoverage with an untimely expedited review request, and the beneficiary continued to

receive noncovered care after coverage ended, who would perform the review, the QIO or the intermediary?

- A7. Only the QIOs perform expedited reviews. Usually, expedited reviews will be timely or close to the timely deadlines, because few beneficiaries will want prolonged risk of liability for noncovered periods, and therefore will seek decisions during or as close to the end of coverage as possible. If a beneficiary requests an expedited review well after discharge, but within the limits for untimely review, either the QIO or the provider can discuss with the beneficiary what recourse is really being sought. Both QIOs and providers can point out that the standard claims appeal process may be more appropriate. Whenever a claim is filed an intermediary performs the review of the claim.
- Q8. How does the expedited determination process affect the demand billing process?
- A8. According to existing Medicare policy, it is always the beneficiary's right to have a demand bill filed when items or services are received. Demand billing is a special process involving a human reviewer that can take about three times as long as automated processing (or about 90 days) to complete. The actual process of demand billing is not changed by the new expedited process, so that if demand billing occurs, routine steps of this process must still be followed, such as the need for providers to respond to intermediary ADRs. Intermediaries are aware of the new expedited process, and consequently will not waste resources attempting to change coverage resulting from binding QIO decisions.
- Q9. Does billing related to expedited determinations have to be demand billing?
- A9. There is no specific need to use demand billing instead of routine billing in situations where an expedited review could be or was requested. The review that would be performed by intermediary medical reviewers with demand bills cannot change or overturn a decision made by a QIO on coverage. Therefore, beneficiaries would be expected to request either an expedited review OR demand billing of a discharge/billing related to a discharge. Generally there would be no need for demand billing in the typical situation where the precise end date for covered services is in dispute, and the QIO can provide a fast decision through the expedited process in contrast to the more lengthy intermediary demand bill process.
- Q10. Is the Notice of Exclusion from Medicare Benefits (NEMB) used for expedited determinations?
- A10. No, the NEMB is never used as part of the expedited review process.
- Q11. CMS instructed QIOs to process expedited determination requests from beneficiaries receiving services from HHAs or CORFs as timely as long as they receive the required physician's certification statement within 60 days of the date the generic notice is issued. However, providers have been instructed that for timely requests, billing should be held



until the QIO decision is received. Do providers really have to wait 60 days to bill in these situations?

- A11. No. CMS recognizes the need to balance beneficiary interests-- such as by allowing 60 days to obtain the certification in unusual cases-- with those of providers. Therefore, CMS is refining its policy as follows:

If a HHA or CORF is aware that a request for an expedited review has been made, that provider should wait 72 hours before proceeding with billing, discharge paperwork or related processes. (This represents the maximum amount of time it takes a QIO to render a decision when all parts of a request for review are received.) If the provider does not hear from the QIO either with a request for the beneficiary's records or that the beneficiary review is otherwise proceeding in that 72 hour period, the provider may proceed with billing and other related processes.

Note that if the QIO subsequently informs the provider that the QIO has received the certification and a timely review is proceeding, the provider should suspend billing and related activities until a QIO decision is made. Providers are advised to bill after noon of the calendar day following notification of the QIO decision, since this is the deadline for a beneficiary to request a QIC reconsideration. If a QIC reconsideration is requested, a provider must wait until the QIC decision is received before billing.

## **Group 6: Notification Process – 38 Q&As**

### **Completion of Both Expedited Notices - 7 Q&As**

- Q1. I've heard CMS is going to require use of the "final" versions of the expedited determination notices on the BNI webpage on the CMS website as of October 1.
- A1. Yes. Effective October 1, 2005, providers must use the OMB approved version of the expedited notices located on the BNI webpage and providers should be aware that the OMB approved versions include some different language from the originally published version. The final version posted on the website will have the OMB approval number in the upper right hand corner of the form.
- Q2. Where can copies of the expedited determination notices be obtained?
- A2. The expedited determination notices and instructions for completing them are available online at: <https://cms.hhs.gov/medicare/bni> .
- Q3. Will CMS make the generic and detailed notices available in Microsoft Word through the CMS website?

- A3. In order to help providers, CMS has added a Word version of the notices to the BNI webpage (<https://cms.hhs.gov/medicare/bni> ). However, to ensure that the hard-copy notices are deemed valid by a QIO upon review, providers must ensure that all replications of the notice mirror the notice posted on the BNI website, including structure, wording, and font size.
- Q4. Can providers add additional information to the blank or white areas on the notices? Are providers allowed to make changes to the notices?
- A4. No, providers are not permitted to add additional information to the white areas on the notices they deliver to beneficiaries, other than those already discussed in the form instructions, such as the insertion of the provider logo. Providers may also insert information into the “Additional Information” section of the generic notice. Otherwise, they may not make any other changes to the notices, including condensing the notice into one page. Instructions for how the form should be completed can be found at: <http://www.cms.hhs.gov/medicare/bni/>, along with the notices.
- Q5. Can information be handwritten into the generic and detailed notices?
- A5. Yes, handwriting is permitted, so long as it is legible and approximately as large as 12-point font.
- Q6. Is the provider required to obtain a beneficiary’s signature on the generic notice or detailed notice?
- A6. The provider must obtain the beneficiary’s or authorized representative’s signature on the generic notice, which is evidence that the beneficiary received the notice, and annotate the notice in cases where the beneficiary refuses to sign. The provider does not need to obtain the beneficiary’s or authorized representative’s signature on the detailed notice.
- Q7. How should a provider maintain the expedited determination notices after delivery to the beneficiary or authorized representative? Who receives copies?
- A7. The provider must retain the original signed generic notice, as well as the detailed notice if the beneficiary requests an expedited review, in the beneficiary’s file. Copies of both notices are given to the beneficiary. In the event of a request for an expedited determination, the QIO would also receive copies of both notices.

### **Delivery of Both Notices - 9 Q&As**

- Q1. Please confirm whether the generic notice and the detailed notice may be issued at the same time.
- A1. The expedited determination process requires delivery only of the generic notice, unless the beneficiary requests a QIO expedited determination of the service termination. However, a provider certainly may choose to issue a detailed notice at the same time if,

for example, it is clear the beneficiary wants to request an expedited determination, or if the beneficiary specifically requests the detailed notice or if the provider is not expecting subsequent face-to-face contact in the covered period.

- Q2. CMS instructions say beneficiaries may request a detailed notice even if the QIO has not been contacted. Why is that?
- A2. Although this is not mandatory for providers, giving the detailed notice at this time may help a beneficiary decide not to pursue an expedited determination before additional provider or QIO resources are put into the review effort.
- Q3. Can I use the “Additional Information” section on the generic notice to include detailed facts as to why Medicare coverage is ending so that I don’t have to issue a detailed notice?
- A3. A provider may choose to include additional information, such as the reason for the discharge, in the additional space provided on the generic notice to help the beneficiary understand the situation. However, if this is done, a detailed notice would still be required if the beneficiary requests a QIO review.
- Q4. Can providers charge both a copying and a delivery fee if a beneficiary requests copies of documentation that the provider sent to the QIO?
- A4. Yes. When CMS instructions refer to a copying fee in this instance, that also includes related delivery costs as stated in the expedited determination regulation. Such costs should be in line with routine copying and delivery fees charged in other instances.
- Q5. My business is not a 24-hour a day operation. Must I keep special hours if an expedited determination notification is pending?
- A5. In general, the expedited determination process was not intended to force providers to change their established hours of operation. All notices should be provided as timely as possible within those constraints.
- QIOs however are 7-day a week operations. Even if a QIO was not available on a specific day, or after a certain time of day, expedited determination regulations state that beneficiaries have until noon of the next day the QIO is available, so that their access to the expedited process is not compromised.
- Q6. Are the SNF, swing bed, HHA, CORF and hospice providers the only entities that can issue the expedited notices, or can a delegated entity issue them?
- A6. The SNF, swing bed, HHA, CORF and hospice providers are responsible for delivery of the expedited notices. However, a provider may formally delegate the delivery of the notices to an agent, such as a subcontractor giving care under arrangement, under the following conditions:

1. The agent agrees in writing that it will deliver the notices on behalf of the provider.
2. The agent adheres to all requirements for the effective delivery of the notices.

Q7. Does a provider need to make a special trip to see a patient for the sole purpose of delivering an expedited notice? For instance, in the situation where a beneficiary receiving home health services visits her doctor, and the doctor unexpectedly advises her that she no longer needs home health care, must the HHA visit the beneficiary just to deliver the notice?

A7. No. Rather than visiting the beneficiary for the sole purpose of delivering the notice, the provider may contact the beneficiary by phone to advise her that her home health services are being terminated. The provider then must follow up the phone call by immediately mailing copies of the generic notice to the beneficiary, one of which the beneficiary should sign and return to the provider. If a review is then requested, delivery of the detailed notice can be handled in a similar manner. Since no signature is required on this notice, the beneficiary does not have to mail anything back.

Q8. In the instances when notices may be mailed, must I use certified mail?

A8. No, any mailing/delivery method may be used. However, the burden rests on the provider to demonstrate that the notice has been validly delivered or that reasonable effort has been made to deliver the notice.

Q9. Is there a process to report SNF, swing bed, HHA, CORF, and hospice providers refusing to deliver the required notices to their patients?

A9. Case-specific complaints should be directed to the CMS RO in the provider's area.

### **Completion of the Generic Notice - 7 Q&As**

Q1. What beneficiary-specific information should the provider insert on the generic notice?

A1. Providers must insert the following patient-specific information when they deliver the generic notice to beneficiaries:

- The beneficiary's name
- The beneficiary's Medicare number (i.e., HIC Number, HICN)
- The date Medicare coverage of the beneficiary's services ends

Q2. Can each side of the two-page generic notice be produced as a separate page to allow use of multiple page carbonless paper (i.e., NCR), which would reduce the number of times beneficiaries have to sign copies?

- A2. Yes. A provider may use a two page form to be separately reproduced to accommodate this type of paper.
- Q3. What should a provider do if the patient refuses to sign the generic notice?
- A3. If the patient refuses to sign the generic notice, the provider must annotate the notice with the refusal, and place the date of refusal in the final date blank. Additionally, the provider may choose to have the refusal witnessed, indicating the circumstances and persons involved.
- Q4. Can a patient who refuses to sign the generic notice still obtain an expedited determination?
- A4. Yes. A beneficiary who refuses to sign the generic notice is still entitled to an expedited determination. The beneficiary must still contact the QIO according to the directions on the generic notice.
- Q5. Must the copy of the generic notice that the beneficiary keeps be signed?
- A5. The copy of the notice kept by the beneficiary does not have to be signed. However, the notice kept by the beneficiary must have the effective date filled in, specify the type of covered services ending and have the logo or contact information for the provider at the top of the notice.
- Q6. Does the beneficiary have to fill out any type of form to indicate that he/she will not pursue the expedited determination process after receiving the generic notice?
- A6. No form is required in this situation. The beneficiary retains the right to file an untimely request for up to 60 days from the coverage end date.
- Q7. How should a provider amend a generic notice, if necessary?
- A7. If the provider decides to provide extra visits or days of care, or shortens the time frame to decrease the number of visits or days of care in the covered period, and the initial generic notice has already been validly delivered with a different coverage end date, the provider may amend the generic notice by performing the following actions:
1. Inform the beneficiary of the new date as soon as possible;
  2. Draw a single line through the coverage end date and write the new termination date above or beside the deleted date;
  3. Write the words "Notice Amended" on the generic notice;
  4. Date and sign the entry;
  5. Verbally notify the beneficiary that the generic notice termination date has been amended;
  6. Provide or mail a copy of the amended notice to the beneficiary;

7. Place a copy of the amended notice in the beneficiary's file;
8. If the beneficiary has requested an expedited review, the provider must immediately notify the QIO that the original generic notice has been amended, and send a copy of the amended notice to the QIO as soon as possible. If a beneficiary has not requested an expedited review, the provider does not need to send the amended notice to the QIO.

### **Delivery of the Generic Notice - 12 Q&As**

- Q1. Please clarify how to calculate the appropriate delivery date for the generic notice. Also, what date should be inserted on the generic notice as the date coverage ends. CMS' education material sometimes uses the terms "discharge date" and "last covered day" interchangeably.
- A1. CMS recognizes that the terminology regarding the end of coverage can be confusing, particularly in the SNF setting where the day of discharge often is not a "billed" day. However, regardless of how days are billed, or if services are provided on each day of a covered period, Medicare coverage continues until the moment of discharge or the apparent end of all covered care. Thus, the "day of discharge", the "last covered day", and the "effective date" of the service termination are the same--the terms refer to the last day in the covered period of care.

Unless coverage ends unexpectedly or abruptly, the generic notice should be delivered no later than 2 days before the date of end of coverage. Thus, if the last day in the covered period of care is a Friday, the notice should be delivered no later than the preceding Wednesday. Keep in mind that a provider may deliver the notice earlier than the required deadline, and CMS encourages providers to do so as soon as they can reasonably predict the last day of coverage. The following example illustrates the calculation of 2-day advance delivery of the generic notice:

*On May 25<sup>th</sup>, Mary Jane Anderson is admitted to a SNF after surgery. On June 2<sup>nd</sup>, the SNF delivers a generic notice to Anderson advising that she will be discharged on June 4<sup>th</sup>.*

May 25 <sup>th</sup>	June 2 <sup>nd</sup>	June 3 <sup>rd</sup>	June 4 <sup>th</sup>	June 5 <sup>th</sup>	June 6 <sup>th</sup>
<p>+ Anderson is admitted to the SNF.</p>	<p>+ SNF delivers <b>Generic Notice</b> to Anderson that her coverage is ending effective June 4<sup>th</sup>.</p>	<p>+ Anderson must call the QIO by noon to request an expedited determination.</p> <p>+ QIO's 72-hour window to render a decision begins.</p> <p>+ QIO must notify SNF of Anderson's request.</p> <p>+ The SNF must issue the <b>Detailed Notice</b> to Anderson (and to the QIO) by COB this day.</p> <p>+ The QIO may also ask the SNF to provide Anderson's medical records.</p>	<p>+ <b>This is the Effective Date of Discharge</b> included on the Generic Notice, i.e., the last day of covered care.</p> <p>+ If Anderson is discharged on the 4<sup>th</sup>, she will likely incur no additional liability.</p>	<p>+ If Anderson loses the appeal, she may be liable for any continued care starting today.</p> <p>+ If Anderson won her appeal, Medicare would pay for continued services, and the SNF would have to issue a new generic notice or abide by the discharge date stipulated by the QIO.</p>	<p>+ The QIO issues its decision no later than noon.</p> <p>+ The QIO's decision may overturn, uphold, or in rare cases determine a new discharge date.</p>

Q2. If I mail the generic notice, how do I fill out the coverage end date?

A2. **The coverage end date on the generic notice should always be the actual date Medicare coverage ends.** This is true even in cases where coverage ends abruptly, and therefore notice cannot be given two days before the end of coverage, and/or when the notice is mailed. That is, providers should never fill in the date coverage ends as two days after coverage actually ends, just to satisfy the timing requirements for delivery of

the expedited notice. Providers also should not add the time anticipated for a mailed notice to be received after coverage has ended to what they write as the date coverage ends.

- Q3. If a beneficiary agrees that services should end on the service termination date, is the provider still required to deliver the generic notice?
- A3. Yes, the provider must deliver the generic notice in all applicable situations, regardless of whether the beneficiary agrees that services should end.
- Q4. If a beneficiary chooses to terminate services, does a notice need to be delivered?
- A4. No, the provider does not need to deliver a notice in this situation.
- Q5. Does the expedited determination process apply when discharge is not related to coverage? For example, is the notice required in cases when a provider ends services because it is not considered safe to enter a beneficiary home, or because the provider lost the services of a therapist and can no longer offer related services?
- A5. No, the provider does not need to deliver a generic notice in these situations. There is no dispute over coverage, and the end of coverage is the sole focus of the expedited process.
- Q6. If a beneficiary meets his or her treatment goals earlier than anticipated, e.g., for the specific purpose of rehabilitation, does the provider need to deliver the generic notice?
- A6. Yes, whenever Medicare coverage of services ends, the generic notice must be delivered.
- Q7. If a provider is discontinuing a previously authorized period of covered services, e.g., the provider authorized 12 skilled nursing visits by a HHA nurse, is the provider required to issue a generic notice given that the provider is planning to discharge the patient as scheduled on the last visit?
- A7. Yes. The provider must deliver the generic notice no later than the next-to-last visit in this example. Providing a notice to the beneficiary not only conveys when the services are going to end, but also informs the beneficiary of the right to an expedited determination if the beneficiary disagrees with the termination of covered care.
- Q8. If a beneficiary receives a generic notice more than 2 days before the effective date that Medicare coverage ends, is the beneficiary required to request an expedited determination by noon of the day following receipt of the generic notice?
- A8. No. Although the regulation says that a beneficiary is required to submit a request for an expedited determination by noon of the first day after receipt of the generic notice, this deadline is premised on the generic notice being delivered on the last permissible day. If the notice is delivered earlier, the beneficiary's request is still considered timely as long as the QIO receives the request for an expedited determination no later than noon the day



before the effective date that Medicare coverage ends. This ensures that a beneficiary has the maximum amount of time needed to decide whether to seek QIO review.

Q9. What if a beneficiary's coverage ends abruptly? For example, a home health agency goes to a beneficiary's home for a regularly scheduled visit, and can immediately see the beneficiary is no longer homebound, which is a requirement for coverage of the Medicare home health benefit. How can an expedited determination notice be delivered 2 days prior to the end of Medicare coverage if the provider didn't know that coverage would end?

A9. In such cases, the provider would give the generic notice immediately since coverage has ended, putting that day as the date on the generic notice. The beneficiary would still have the option of pursuing an expedited determination.

While the regulation anticipates that notice will be given in person during an encounter at which covered care is being provided, it was always recognized not all situations would conform to this expectation. The goal was to provide meaningful notice of discharge while coverage is still continuing. This should reduce provider burden by building delivery of the notice into encounters that would have occurred anyway, and also should limit the period of potential beneficiary liability if a QIO decision is sought. However, even when this goal cannot be met, such as when coverage ends abruptly, beneficiaries need to receive the generic notice as timely as possible to assure access to their right to QIO review.

Q10. If the generic notice has to be delivered at least two days before the last covered service, must the beneficiary receive a covered service on at least one of the two remaining days?

A10. No, services do not have to be provided in the period in between delivering the generic notice and the actual end of coverage, which is usually two days. This period has never meant that additional services had to be provided just because the generic notice was given and an expedited determination could be requested. If no other services were on the plan of care for the remaining covered period, no additional services need to be provided. **Basic Medicare requirements that services must be medically necessary to be covered are not waived because a generic notice has been given.**

Q11. Are providers precluded from having a policy to deliver the generic notice on admission of all beneficiaries?

A11. Providers may not routinely give the generic notice to all beneficiaries upon admission. The intent of the requirement that the notice be delivered no later than 2 days before discharge is that notice of the beneficiary's ability to obtain QIO review of the provider's decision to discharge be meaningful. Routinely delivering the notice far in advance of discharge decreases the likelihood that the beneficiary will understand and retain the information about these important rights, as some covered stays/periods can last months.

Q12. What standard will be used to measure how far in advance the expedited determination notice can be given?

A12. Because there can be so much individual variability and because the expedited determination process is applied to several different care settings, CMS does not believe it is in the public interest to set any strict deadline. However, if the duration of covered care is anticipated to be relatively brief and the beneficiary comprehends that the point of discharge is already imminent, notice can be given at any time after the precise discharge date can be established.

Q13. What happens when a QIO decides a generic notice is invalid? What do providers have to do?

A13. When a QIO determines that a generic notice is invalid, that QIO sends a letter to the beneficiary relaying its finding. The QIO also informs the provider that notice is invalid. The provider must then prepare and issue a new generic notice to the beneficiary by taking the following steps:

- Correct the prior notice based on feedback from the QIO
- Assure the coverage end date on Page 1 is still valid as first listed on the notice-- it will not change unless conditions impacting the coverage end date have changed
- Place an asterisk next to the coverage end date
- In the “Additional Information (Optional)” space on Page 2, insert the following message:

\* We are giving you another notice because the QIO decided the previous notice we gave you on [*fill in date the prior generic notice was given*] was invalid. You will not have to pay for any care you receive until two days after you receive this notice. You must call the QIO again after receiving this new notice if you still want the QIO to review the decision to end your Medicare coverage.

- When issuing the new notice, the provider must explain to the beneficiary why another notice is being issued and review the insertion above
- If the beneficiary again contacts the QIO to initiate an expedited review, the provider must issue another detailed notice to the beneficiary even if one had been issued previously

These steps repeated if necessary until valid notice is delivered. It is not anticipated they will have to be repeated, since when asked, QIOs will work with providers to assure they provide valid notice when asked. If a provider fails to correct an invalid notice, the provider may be held liable for subsequent noncovered care. Note that QIOs will not address whether coverage should end or continue until beneficiaries receive valid notice.

## **Completion and Delivery Detailed Notice - 2 Q&As**

- Q1. Regarding the detailed notice, so far CMS has given only minimal guidance in Transmittal 577 (re-printed as Transmittal 594) why services are no longer covered and facts specific to the beneficiary relevant to the coverage determination. Can providers give more information? This example also gives a citation from law. Must the law be referenced?
- A1. The example is modeled on text sometimes used in HINNs when hospital inpatients request QIO review of their discharges. However, the particular circumstances of each case must be considered. Providers should always give as much information as they believe necessary to assist the beneficiary in understanding applicable Medicare coverage policy.

Citations stipulating the policy at issue do not need to be made directly from law. They can also cite any authorized source of Medicare coverage policy: regulations, manuals, intermediary on-line and hardcopy newsletters, etc.

- Q2. When the provider sends the detailed notice to the QIO and beneficiary, does the provider need to send it by close of business on the day that the QIO notified the provider that the beneficiary requested an expedited determination?
- A2. Yes, the provider should send the detailed notice to the beneficiary by no later than close of business on the day the QIO notifies the provider that the beneficiary has requested an expedited determination. The intent of the requirement that the beneficiary receive the detailed notice is to make sure that beneficiaries who choose to contest a termination of covered services are made aware of the reasoning behind the coverage termination, and have time to consider these reasons as part of presenting their views to the QIO.

Thus, providers should always attempt to deliver the detailed notice in the most expeditious manner to accomplish this goal, but can do so within existing hours of operation. If the QIO notification comes at the end of the business day, the provider can give the detailed notice as soon as possible the next day instead of extending business hours.

## **Group 7: Scope of Individual Benefits (questions that are specific to certain types of providers) - 14 Q&As**

### **Home Health**

- Q1. Where can copies of the revised HHABN and the instructions be obtained? Should I be using this new version of the form?
- A1. Although CMS is reevaluating the existing HHABN, it has not yet been revised. HHAs should continue using the current HHABN until further notice. The current HHABN is available on the BNI webpage at: [www.cms.hhs.gov/medicare/bni/](http://www.cms.hhs.gov/medicare/bni/). On May 26, 2005,

CMS published for comment in the Federal Register the revised HHABN as required by the Paperwork Reduction Act. The comment period for the revised HHABN closed on June 6, 2005. CMS is still in the process of considering these comments and obtaining required approvals before the new form and instructions can be finalized.

- Q2. When HHAs provide outpatient therapy under Part B, instead of the home health benefit, to beneficiaries who are not homebound, does the expedited determination process apply?
- A2. Yes, the expedited determination process would apply in this situation. The regulation applies to the end of any period of covered care provided by specific providers listed in 1861(u) of the Social Security Act, and does not specify what benefits or services must be given. However, it would not apply in general for one-time or intermittent Part B services. Examples include a preventive service like a flu vaccination, or DME provided by an HHA as if an independent supplier, not under the home health benefit (i.e., on a 34x type of bill).
- Q3. Can you please clarify whether the expedited determination process also applies to psychiatric home health services?
- A3. Yes, the expedited determination process applies to all Medicare covered services provided by home health agencies for some duration/under a plan of care, and this would include psychiatric home health services.

### **Comprehensive Outpatient Rehabilitation Facilities (CORFs)**

- Q4. Are institutional providers like CORFs, such as ORFs and hospital OPDs, which perform similar and sometimes identical services, subject to the new expedited determination process?
- A4. No. The new process applies only to providers of care listed in section 1861(u) of the Social Security Act. This section of the law does include CORFs, but not similar outpatient providers.
- Q5. As a CORF, all our services are provided under a physician's order/a plan of treatment. Does that mean conceivably every patient will have to receive a generic notice when covered care under a plan ends?
- A5. Yes, except for conditions not in the provider's control, such as when patients discontinue care without notice and cannot be subsequently contacted.

### **Hospice**

- Q6. The expedited determination process requires notice when covered care is terminated, including hospice care. A revocation is a beneficiary-initiated termination of covered care that fits this general description. Must notice be given when beneficiaries revoke?

- A6. No. Revocations cannot trigger expedited determinations since in this case it is the beneficiary's, not the provider's decision to discontinue services. The expedited determination process will apply in hospice only when the provider is discharging for medical necessity reasons, most likely in cases where a remission has lasted long enough that the beneficiary can no longer be certified as having a life expectancy of 6 months or less.

Note that the terminal diagnosis decision should not be a last minute one at the time of recertification, and that patients should be advised in advance when there may be a potential for the provider to discharge, so that alternative arrangements can be made for those still ill and in need of care. The exception would be an unlikely case where it was clear the patient was neither terminally ill nor in need of subsequent care, in which case coverage might end abruptly.

### **Swing Beds**

- Q7. What notice should hospitals issue when covered skilled nursing services of a beneficiary in a swing bed are being terminated?
- A7. In this situation, the hospital must issue the generic notice since skilled nursing care is being terminated. The HINN will no longer be used for terminations of Medicare covered services for beneficiaries in swing beds.
- Q8. What about noncovered admissions? Are expedited determination notices used in any way?
- A8. No, the new expedited determination process only applies to swing beds under original Medicare when a covered level of care comparable to that provided in a SNF is ending completely. If there was never a covered level of care, as with noncovered admissions, or if covered care ended some time back before the new process was effective, this process would not apply.

When this new process does not apply, the applicable hospital notice, the HINN, would be required, since the setting, not level, of care is the determining factor. Updated instructions reflecting all the liability-related beneficiary notices delivered by fee for service swing bed providers, the expedited notices and the HINNs, are found in CMS preliminary instructions on the expedited determination process to Medicare intermediaries (2005 Transmittal 577 updated as Transmittal 594).

- Q9. Are swing beds in CAHs subject to this new process?
- A9. Yes. The type of Medicare payment system, such as prospective payment or cost, or other type of classification of the base hospital does not make a difference. All swing beds under Original Medicare are subject to the new process.

## **Skilled Nursing Facilities (SNFs)**

- Q10. Can CMS better define the cases when expedited notification is required where a beneficiary is a resident in a SNF or a NF (nursing facility) and is receiving services under Medicare Part B?
- A10. The following two lists clarify when expedited notice is and is not required in a SNF when payment is made by Part B:

### **SNF SERVICES UNDER PART B WHERE EXPEDITED NOTICE IS REQUIRED:**

When a beneficiary is receiving one of the services listed below under Medicare Part B, the expedited notice must be given at the time the service is terminated. If the beneficiary is receiving more than one of these services at the same time, and one service is discontinued and the other service(s) continue, the SNF is not required to give the expedited notice until all services provided under Part B on the list below are terminated:

1. Beneficiary receives x-ray, radium, and radioactive isotope, therapy including materials and services of technicians either directly or under arrangement.
2. Beneficiary receives surgical dressings limited to primary dressings i.e., therapeutic and protective coverings applied directly to lesions either on the skin or opening to the skin required as a result of a surgical procedure performed by a physician. (Items such as ace bandages, elastic stockings and support hose, Spenco boots and other foot coverings, leotards, knee supports, surgical leggings, gauntlets and pressure garments for the arms and hands are generally used as secondary coverings and therefore would not be covered as surgical dressings.) Surgical dressings are usually applied first by a physician but may be reapplied by others including the patient or a member of his family either directly or under arrangement. Dressings required for purposes other than a surgical lesion, e.g., bedsores, are not covered.
3. Beneficiary receives prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue), or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repair of such devices either directly or under arrangement.
4. Beneficiary receives total parenteral nutrition and enteral nutrition either directly or under arrangement.

5. Beneficiary receives outpatient physical therapy, outpatient occupational therapy, or outpatient speech pathology services either directly or under arrangement.
6. Beneficiary receives hemophilia clotting factors either directly or under arrangement.

**SNF SERVICES UNDER PART B WHERE EXPEDITED NOTICE IS NOT REQUIRED:**

Notice is not required when Part B will not cover any services. Additionally, the expedited process is not used for the following services that are usually provided once or not for any prolonged duration. If one or any combination of services on the list below are the only covered services provided, expedited notice will not be required when coverage of these services ends:

1. SNF provides diagnostic x-ray tests (including portable x-ray), diagnostic laboratory tests, and other diagnostic tests either directly or under arrangement.
2. SNF provides vaccinations or inoculations either directly or under arrangement.
3. SNF provides leg, arm, back, and neck braces, trusses and, artificial legs, arms, and eyes, including adjustment, repairs, and replacement required because of breakage, wear, loss, or a change in the patient's physical condition either directly or under arrangement.
4. SNF provides ambulance services either directly or under arrangement.
5. SNF provides splints, casts, and other devices used for the reduction of fractures and dislocations either directly or under arrangement.
6. SNF bills for rental or purchase of durable medical equipment for use in the patient's home or place considered to be his residence either directly or under arrangement.

Q11. Would the expedited determination right apply to beneficiaries in a "NF", nursing home or non-skilled part of the facility? What if all beds in the facility are dually certified, but a beneficiary is only receiving a NF or custodial level of care?

A11. All residents of a Medicare-certified SNF whether Medicare, Medicaid or Private Pay who are receiving benefits under Medicare Part B that are provided by the SNF are affected by the expedited notification provision regardless of how the facility participates in the Program (i.e., distinct part, fully participating, dually participating). In a case where the beneficiary is receiving care from other than the SNF while a resident of the

facility, the expedited process applies to the provider of service such as the HHA, CORF acting as a therapist or Hospice actually providing the service. However, services received from provider types not subject to the expedited process are not subject to the notification requirement, such as independent therapists billing Medicare carriers.

Q12. When are expedited notices required for SNF Part A care?

A12. The following two lists clarify when expedited notice is and is not required in a SNF when payment is made by Part A:

SNF SERVICES UNDER PART A WHERE EXPEDITED NOTICE IS REQUIRED:

When expedited notice is required, covered care must end for coverage reasons, such as medical necessity reasons that are appropriate for QIO review, which could include a point comparable to that in billing when SNFs are required to report Occurrence Code 22 for the date active care ended. Note in some instances, a beneficiary must receive more than one notice during a Part A covered stay where coverage under Part A is terminated and then restarted again at a later date.

1. The SNF must provide an expedited notice when all covered services provided under Part A are terminated **where the beneficiary has remaining SNF days available** and the beneficiary continues to reside in the facility.
2. The SNF must provide an expedited notice when all covered services provided under Part A are terminated **where the beneficiary has remaining SNF days available** and the beneficiary continues to reside in the facility and the beneficiary begins receiving services under Part B of Medicare.
3. The SNF must provide an expedited notice when a beneficiary simultaneously ends coverage under Part A and is discharged from the facility.

SNF SERVICES UNDER PART A WHERE EXPEDITED NOTICE IS NOT REQUIRED:

Part A services terminated with the cessation of only some covered services or a reduction in the frequency of such services (which may or may not result in a change in the RUG group assigned to the beneficiary for payment purposes), whether called for on the plan of care or not, does not trigger this new right when payment under Part A continues. Notification is also not required when the 100 days of Part A covered for a benefit period end, since this is a benefit limit set in law and not a medical necessity decision. In summary, cases under Part A where notice is not required are:

1. When a SNF benefit period has ended, i.e., the beneficiary has not been an inpatient of hospital or SNF for a period of 60 consecutive days.



2. Upon admission to the SNF, the beneficiary does not meet the technical eligibility requirement of a three-day inpatient hospital stay (notification could be required under Part B if covered services paid under Part B followed).
3. Upon admission to the SNF, the beneficiary does not require covered care.
4. When a beneficiary is transferred/discharged to a hospital due to acute illness.
5. When a beneficiary chooses to transfer to another SNF (e.g., one that is closer to his home) and will continue to receive covered services under Medicare Part A.
6. **When a beneficiary has exhausted his/her 100-day benefit and remains in the facility.**

Q13. I'm still using SNF denial letters to inform beneficiaries of liability for noncovered care, whether because of a lack of medical necessity or the exhaustion of benefits. I know other SNFs are using the SNFABN. Do I need to change anything in my current procedures for using these notices at this time?

A13. No, and SNFs are still free to use either the denial letters and/or the SNFABN. CMS is still working to revise current instructions for these notices. When these revisions are done, they will take into account the new expedited determination process.

Q14. A QIO has decided we should continue coverage for a patient we had planned to discontinue, and will not tell us what MDS (Minimum Data Set, the patient assessment) or RUG (resource utilization group, a payment group) applies? How do I bill the additional SNF Part A coverage?

A14. QIOs do not consider patient assessment for payment or billing as part of making a determination on coverage. SNFs should follow existing MDS and claims instructions when determining how to bill subsequent to a decision by a QIO or QIC to extend coverage. MDS information is found in the Long-term Care Facility Resident Assessment Instrument User's Manual, primarily Chapter 2, and claim instructions are found in Chapter 6 of the on-line Medicare Claims Processing Manual. When there is not a valid Medicare required MDS for the time in question, payment is at the default rate.

## **NEW EXPEDITED DETERMINATION PROCESS OVERVIEW**

Certain providers (swing beds, SNFs, hospices, HHAs and CORFs) must alert eligible beneficiaries of their right to an expedited review under Original Medicare. Through this expedited determination process, beneficiaries may obtain a QIO review a provider's decision to discharge them, or end all their covered care, for medical necessity reasons.

The expedited determination regulations lay out a review process involving beneficiaries, providers, QIOs and other entities. Usually, providers must give a "generic" notice to beneficiaries no later than two days before the end of all covered care is foreseen, even if the beneficiary agrees with the discharge. The notice used is an OMB-approved CMS notice, completed by the provider and signed by the beneficiary, that assures the beneficiary knows that covered care is ending and has a right to contest this decision. If the beneficiary accepts the provider's determination, no additional action is required.

However, if the beneficiary disagrees, the beneficiary contacts a QIO to request an expedited review—the generic notice gives the contact information. The provider must then give a second more "detailed" notice explaining the reason for the generic notice on the end of covered care. The detailed notice is also an OMB-approved CMS notice.

The QIO is responsible for establishing contact with the provider, so that the beneficiary's medical records can be used in making a determination, although QIOs can still make such decisions even if records are not available. The QIOs should also be given copies of both notices by the provider. Using these records, the QIO makes a decision on coverage and informs the involved parties. The review generally takes 72 hours. An "untimely" process also exists.

A beneficiary may request a reconsideration of the QIO decisions by a QIC under a similar process. When the QIO/QIC makes a decision at the end of the review, providers can then bill for the period that was reviewed in accordance with the QIO/QIC decision on coverage for that period. Standard claim appeal rights still apply to these claims.

