HEALTH PLAN
HHA
EXPEDITED APPEALS
(FAST TRACK)

PROCESSING MANUAL

August 2008

MASSPRO
Making an Impact.

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HEALTH PLAN HHA EXPEDITED APPEALS (FAST TRACK) PROCESSING MANUAL

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This material was prepared by Masspro, the Medicare Quality Improvement Organization for Massachusetts, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily represent CMS policy. 8sow-ma-3a-08-05 HHA_FastTrackAppealsMan-may

Introduction

This manual is designed to provide basic information regarding the appeals process for Health Plans' and home health agency (HHA) providers' determinations to terminate services for Health Plan enrollees (also called beneficiaries).

This manual follows the process chronologically.

IMPORTANT! This manual identifies what Masspro needs in order to complete the review of the appeal, as required by statute and regulation. On those pages where HHA processes are described, Masspro is not requiring how tasks should be accomplished. This manual should not be considered prescriptive. Facilities may feel free to incorporate this information into their own policies and procedures.

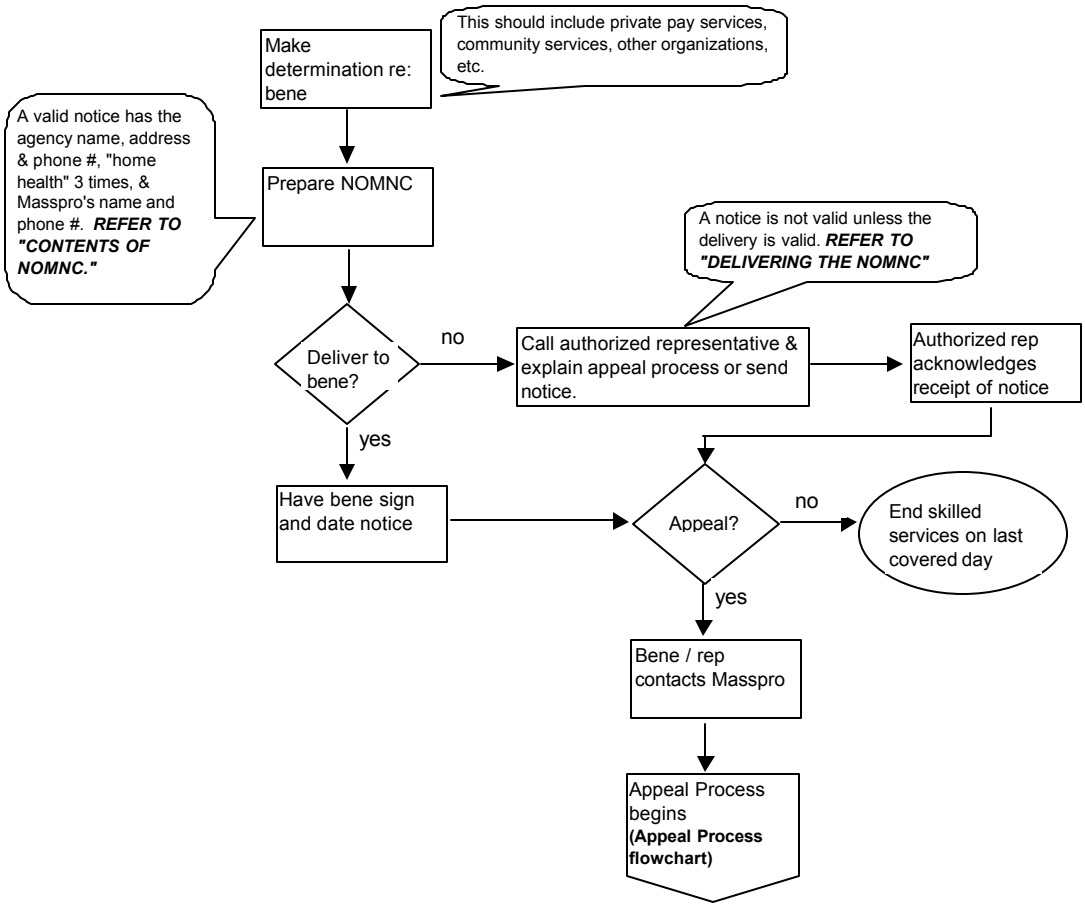
Pre-Discharge

This section describes what occurs prior to the appeal. Your agency may have procedures different from these.

This section includes

- a workflow of the process prior to discharge, and
- a discussion of how to prepare the beneficiary and/or family about the discharge.

Workflow of the Pre-Discharge Process



Preparing the Beneficiary / Family for Eventual Discharge

Discharge planning is an important part of your treatment plan. Well in advance of the actual end of services, discuss with the beneficiary and his/her family, such things as what services are available as private pay, what community services are available or other organizations the beneficiary or family may wish to contact.

As part of that conversation, discuss and/or share the *Notice of Medicare Non-coverage* that you will be giving. You should also discuss appeal rights at that time.

Important! Masspro recommends that you do not issue the notice prematurely. Here is why:

Remember, the appeal process begins the moment the beneficiary or authorized representative contacts Masspro! If you give the notice at a discharge planning meeting well in advance of the two-day requirement, and the beneficiary appeals immediately, Masspro will review the medical record, which at that time, will probably **not** support that services are no longer medically necessary.

Preparing the Notice of Medicare Non-coverage

When to Issue the Notice of Medicare Non-coverage

As specified in 42 CFR§422.624(1)(2), "a termination of service is the discharge of an enrollee from covered provider services, or discontinuation of covered provider services, when the enrollee has been authorized by the MA organization, either directly or by delegation, to receive an ongoing course of treatment from that provider. Termination includes cessation of coverage at the end of a course of treatment preauthorized in a discrete increment, regardless of whether the enrollee agrees that such services should end."

A notice does not need to be issued

- for patient-initiated discharges, or
- if the visiting nurse feels threatened or unsafe.

Contents of the Notice of Medicare Non-coverage

The Notice of Medicare Non-coverage (NOMNC) is a standard CMS form (10095) onto which you must enter the information appropriate for your agency and for each client.

Reference: Refer to page 9 for a sample of a perfectly completed NOMNC.

The Perfect NOMNC – Standard Information

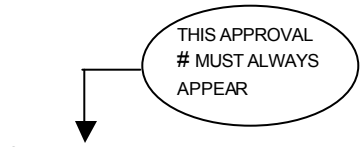
A perfect NOMNC:

- Is the correct form – CMS-10095
- Has all the parts of the correct form
  - Displays OMB Approval No. 0938-0910 in the upper right corner
  - Describes the appeal process, including how to contact Masspro at its 24-hour toll-free number (1-800-252-5533)
  - Includes the CMS form number, expiration date 8/31/2010, and the CMS language at the bottom of page 2

Note: The annotations on the sample pages shown on the next page are provided to you by Masspro for quick reference only. For detailed instructions, refer to the CMS website.

Note: The sample is in 10-point font. The font size for your notices must be at least 12 points.

[STANDARD INFORMATION]



OMB Approval No. 0938-0910

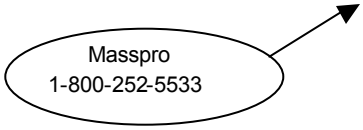
{Insert logo here}

NOTICE OF MEDICARE NON-COVERAGE

. . .
. . .
. . .

HOW TO ASK FOR AN IMMEDIATE APPEAL

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally by no later than two days after the effective date of this notice.
- **Call your QIO at: {insert name and number of QIO} to appeal, or if you have questions.**



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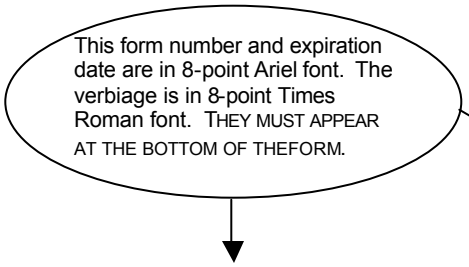


Form No. CMS-10095 (NOMNC) Exp Date: 8/31/2010

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938- 0910. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

The Perfect NOMNC – Customized Information

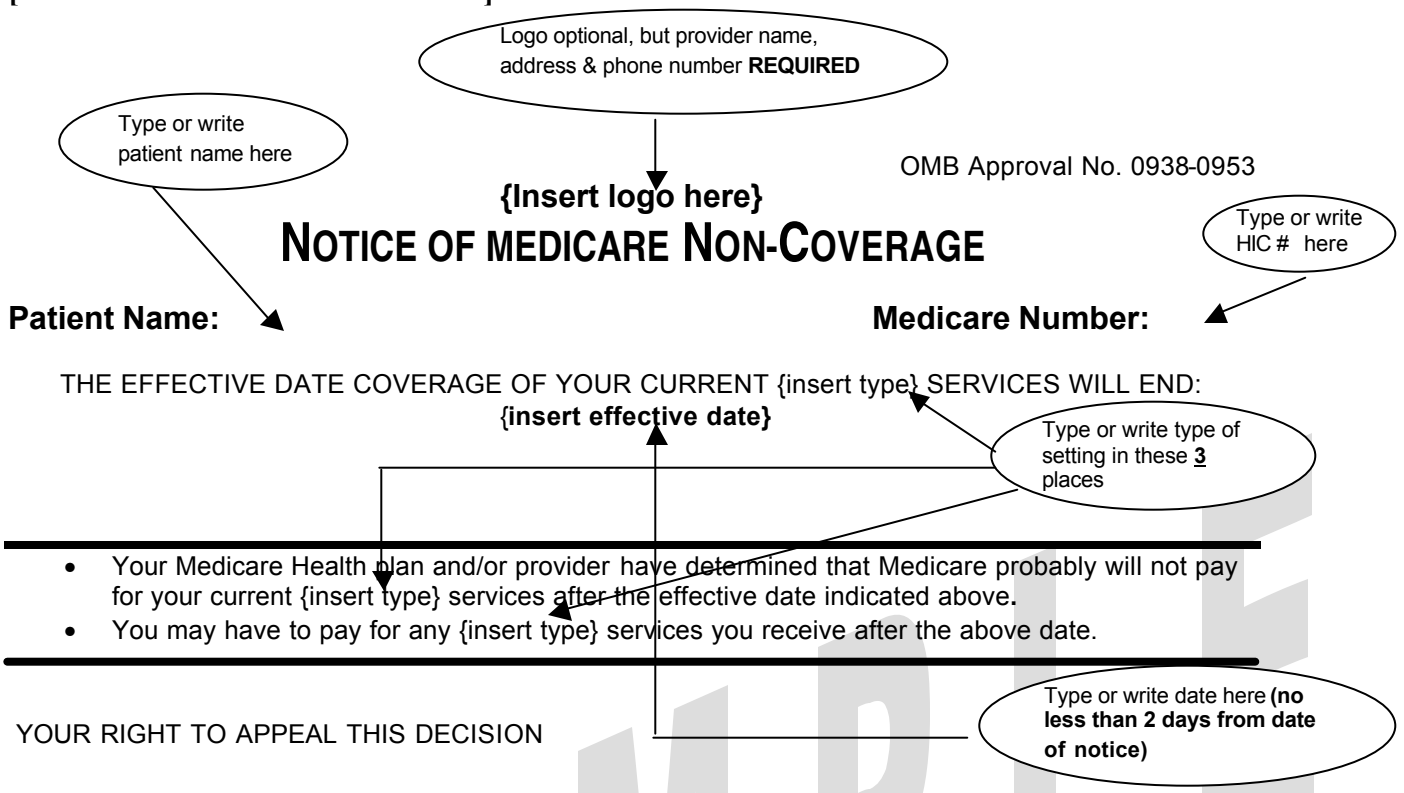
The perfect NOMNC

- Is customized correctly for your agency
  - Uses at least a 12-point font
  - Correctly displays agency name, address and phone number. Logo is optional.
  - Identifies the **setting** in which services that are being terminated in the three appropriate locations on the form
    Note: "HOME HEALTH" IS THE CORRECT LANGUAGE for the end of these services because CMS regulations specify the NOMNC refers to **setting**, not services.
- Is filled out correctly for each patient
  - Includes the beneficiary's name and identifying number
  - Is signed by the beneficiary/ authorized representative or includes notation that beneficiary/ authorized representative refused to sign or was unable to sign
  - Is dated
- Accurately "counts" from date of notice to the effective date. According to CMS regulations, the instructions for the completion of the form state that effective date is
  - the last covered day
  - the day before the beneficiary becomes liable

Note: The annotations on the sample page shown on the next page are provided to you by Masspro for quick reference only. For detailed instructions, refer to the CMS website.

Note: The sample is in 10-point font. The font size for your notices must be at least 12 points.

[CUSTOMIZED INFORMATION]



Sample Completed NOMNC

Refer to the NOMNC on the next two pages to see how a completed one should look.

OMB Approval No. 0938-0910

Healthy Home Health Agency
111 Main St.
Anywhere, MA 01111
800-555-5555

NOTICE OF MEDICARE NON-COVERAGE

Patient Name: I. M Pashunt **Patient ID Number:** 111111

THE EFFECTIVE DATE COVERAGE OF YOUR CURRENT home health SERVICES WILL END: May 6, 2008

- Your Medicare Health plan and/or provider have determined that Medicare probably will not pay for your current home health services after the effective date indicated above.
- You may have to pay for any home health services you receive after the above date.

YOUR RIGHT TO APPEAL THIS DECISION

- You have the right to an immediate, independent medical review (appeal), while your services continue, of the decision to end Medicare coverage of these services.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer will also look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees that services should no longer be covered after the effective date indicated above, neither Medicare nor your plan will pay for these services after that date.
- If you stop services no later than the effective date indicated above, you will avoid financial liability.

HOW TO ASK FOR AN IMMEDIATE APPEAL

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally by no later than the effective date of this notice.
- **Call your QIO at:** Masspro 1-800-252-5533 **to appeal, or if you have questions.**

See the back of this notice for more information.

OTHER APPEAL RIGHTS:

- If you miss the deadline for requesting an immediate appeal with the QIO, you still may request an expedited appeal from your Medicare Health plan. If your request does not meet the criteria for an expedited review, your plan will review the decision under its rules for standard appeals. Please see your Evidence of Coverage for more information.
- Contact your plan or 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048 for more information about the appeals process.

ADDITIONAL INFORMATION (OPTIONAL)

Please sign below to indicate that you have received this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

Signature of Patient or Representative **Date**

Form No. CMS-10095 (NOMNC) Exp Date: 8/31/2010

Delivering the NOMNC

42 CFR§422.624 (b) and (c) specify that a notice is acceptable only if the delivery of the notice is valid.

Delivering a Notice to the Beneficiary

If the beneficiary has the capacity to sign the notice, here is an example of what steps might occur.
Note: Your agency's procedures may differ.

1. Deliver it directly to him/her.
2. Explain the contents of the notice, specifically
   - when the last covered day will be,
   - what appeal rights he/she has,
   - Masspro's telephone number, and
   - that to appeal, he/she must call Masspro by noon the day prior to the last covered day.
3. Have him/her sign and date the notice at the right place on the notice.
4. Put a copy of the **signed** notice in the medical record.

Documenting When The Beneficiary Refuses to Sign the Notice

If the beneficiary refuses to sign the notice, you must document what you reviewed in the notice and the beneficiary's refusal to sign.

Note: The date of refusal is considered the date of receipt of the notice.

Document and sign the form, including the

- name of beneficiary,
- date and time of contact,
- that you explained appeal rights, Masspro's telephone number and by what time Masspro must be called, and
- that he/she refused to sign.

Hint: You may create a template with the essential information (and blank lines ready to be filled in with the specifics for the specific patient) for everyone to use so that no information is missed. This may also help staff remember to include the important points in the notification.

On the next page is a sample of the perfect documentation when the beneficiary or representative refuses to sign the notice. **Note:** This is page two of the NOMNC, except the form is shown in 10-point font. Yours must be at least 12.

OTHER APPEAL RIGHTS:

- If you miss the deadline for requesting an immediate appeal with the QIO, you still may request an expedited appeal from your Medicare Health plan. If your request does not meet the criteria for an expedited review, your plan will review the decision under its rules for standard appeals. Please see your Evidence of Coverage for more information.
- Contact your plan or 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048 for more information about the appeals process.

ADDITIONAL INFORMATION (OPTIONAL)

I delivered this notice to _____ [Bene's name] at _____ [time] [A.M./P.M.] on _____ [date]. I told _____[him/her] that the last covered day would be _____ [date of last covered day]. I explained appeal rights and gave Masspro's toll free # (1-800-252-5533). I explained that in order to request a fast appeal, Masspro must be called before noon on _____ [date by when Masspro must be called]. _____ [He/She] refused to sign.

Hand Delivering a Notice to a Representative

If the beneficiary does not have the capacity to sign the notice, and the representative is at the beneficiary's home, you should hand deliver the notice to the representative. If he/she refuses to sign the notice, document that refusal as you would if the beneficiary refuses to sign.

Delivering a Notice Telephonically

You may need to deliver a notice by telephone if

- the beneficiary does not have the capacity to sign the notice, and
- you cannot hand deliver the notice to the representative.

The regulations regarding valid delivery of the notice are very specific. Therefore, you must be careful to follow the guidelines and document your attempts.

Follow these steps:

1. Make **direct** telephonic contact with the representative.
   Important! The telephone contact must be direct. A message left on an answering machine does **NOT** qualify as valid telephonic delivery.
2. Identify the following components of the notice:
   - What services are ending
   - When the last covered day is
   - How he/she can request an appeal

  - That he/she must request the appeal to Masspro by noon the day prior to the last covered day
  - Masspro's telephone number
3. Document on the notice the name of the person you spoke to and the information provided. Be sure to sign the documentation. A sample is shown on the next page.
4. Send the notice to the representative by regular or certified mail.

Documenting When You Have Delivered the Notice Telephonically

Document and sign the form, including the

- name of the representative,
- name of beneficiary,
- date and time of contact, and
- that you explained appeal rights, Masspro's telephone number and by what time Masspro must be called.

Hint: You may create a template with the essential information (and blank lines ready to be filled in with the specifics for the specific patient) for everyone to use so that no information is missed. This may also help staff remember to include the important points in the notification.

Below is a sample of the perfect documentation when you deliver the notice telephonically. **Note:** This is page two of the NOMNC, except the form is shown in 10-point font. Yours must be at least 12.

OTHER APPEAL RIGHTS:

- If you miss the deadline for requesting an immediate appeal with the QIO, you still may request an expedited appeal from your Medicare Health plan. If your request does not meet the criteria for an expedited review, your plan will review the decision under its rules for standard appeals. Please see your Evidence of Coverage for more information.
- Contact your plan or 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048 for more information about the appeals process.

ADDITIONAL INFORMATION (OPTIONAL)

I delivered this notice telephonically to _____ [rep's name], authorized representative for _____ [beneficiary's name] on _____ [date] at _____ [time] [A.M./P.M.] I explained that the last covered day will be _____ [date of last covered day]. I explained that if she disagrees with this notice, she can appeal this decision. I told her that Masspro is the review organization that handles these appeals and Masspro's toll free # is 800-252-5533. I explained that in order to request a fast appeal, Masspro must be called before noon on [date].

Delivering the Notice when the Representative Cannot Be Reached by Telephone

You may need to deliver a notice by mail if

- the beneficiary does not have the capacity to sign the notice,
- you cannot hand deliver the notice to the representative, and
- your repeated attempts (at least three ***documented*** calls through a reasonable time period) to make **direct** telephonic contact with the representative have not been successful.

The regulations regarding valid delivery of the notice are very specific. Therefore, you must be careful to follow the guidelines and document your attempts.

Follow these steps:

1. Prepare the notice for mailing. Do not change anything, including the last covered day that is listed on the notice.
2. Make a copy of the notice for your records and file it in the medical record.
3. Mail the NOMNC by a "trackable" mail service, such as certified mail or FedEx.
   Note: Although CMS requirements do not specify how the notice must be sent, they do place the burden on the provider to demonstrate that the notice has been validly delivered or that reasonable effort has been made to deliver the notice. Certified mail or FedEx are the most efficient ways to do this.

Documenting When You Have Delivered the Notice by Mail

Document and sign the form, including the

- dates and times of attempts to call the representative,
- date you mailed the notice,
- last covered day, and
- any other information related to the receipt or return of the mailing information.

Hint: You may create a template with the essential information (and blank lines ready to be filled in with the specifics for the specific patient) for everyone to use so that no information is missed. This may also help staff remember to include the important points in the notification.

On the next page is a sample of the perfect documentation when you deliver the notice by mail.
Note: This is page two of the NOMNC, except the form is shown in 10-point font. Yours must be at least 12.

OTHER APPEAL RIGHTS:

- If you miss the deadline for requesting an immediate appeal with the QIO, you still may request an expedited appeal from your Medicare Health plan. If your request does not meet the criteria for an expedited review, your plan will review the decision under its rules for standard appeals. Please see your Evidence of Coverage for more information.
- Contact your plan or 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048 for more information about the appeals process.

ADDITIONAL INFORMATION (OPTIONAL)

6/5/06 9:05 called; left message on machine to call
6/5/06 12:35 called, left message on machine to call
6/5/06 4:30 called, left message on machine to call
Signed, Clara Barton, Case Manager

After 3 telephone attempts to reach representative, I mailed this notice on Monday 6/5/06. (Last covered day 6/7/06)
Notice received back unsigned from Post Office today, 6/9/06.
Patient's liability began 6/8/06.
Signed, Clara Barton, Case Manager

Delivering a NOMNC when Coverage Ends Abruptly

"Abrupt end" is defined by CMS as "unanticipated and immediate."

- According to CMS, this should be a rare occurrence.
- You must still give a notice, using the same notification process.
- Effective date is the date of the notice.
- Beneficiary has 24 hours to appeal.
- Masspro will verify that the medical record supports the appropriateness of the abrupt discharge.

The Appeal Process

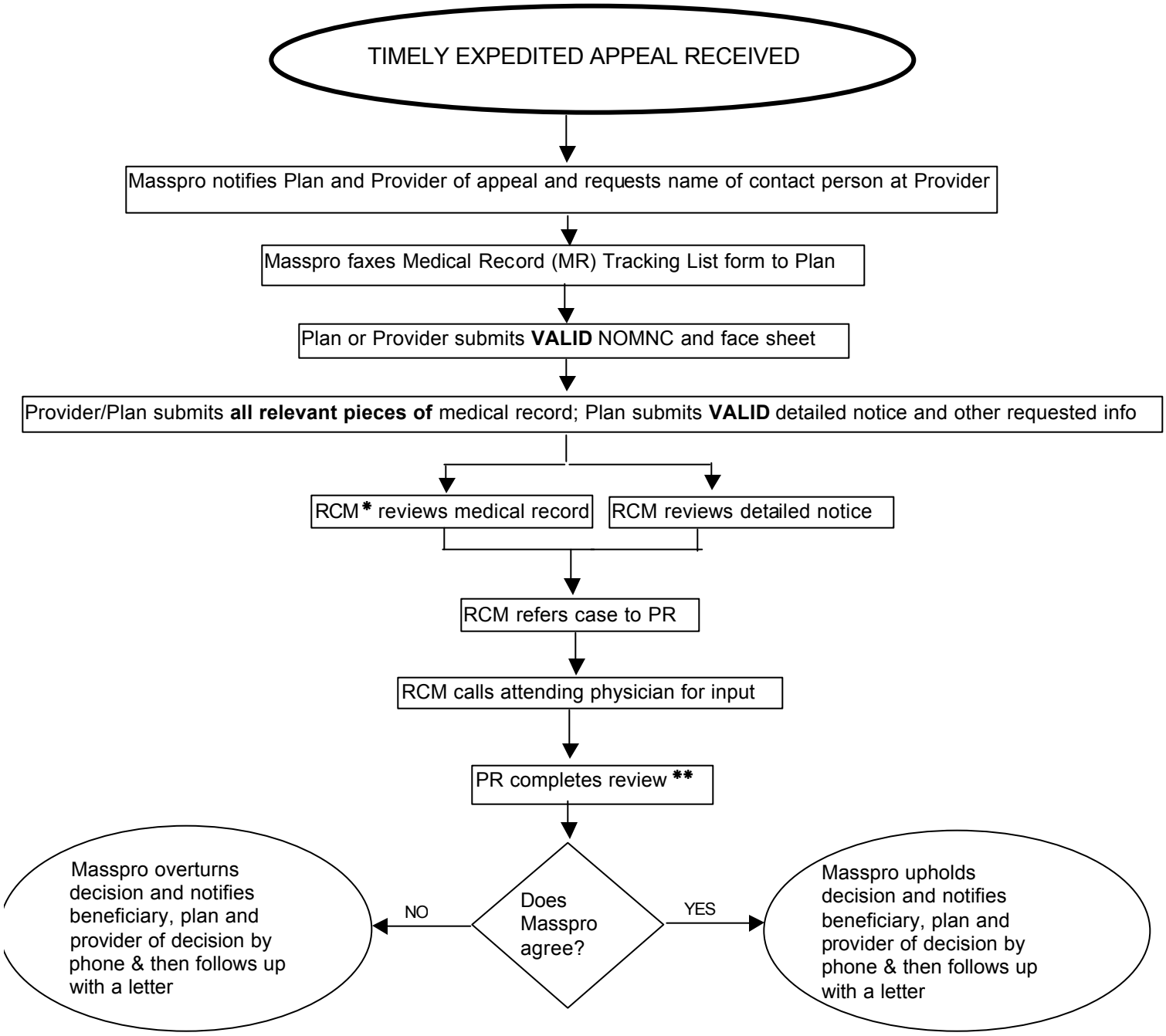
Overview

It is often advantageous to put the individual tasks we do into the perspective of the entire process.

This section provides that overview, including the following:

- Appeal process (flowchart) as it would be if every task were completed perfectly
- Appeal process (flowchart) as it usually occurs
- Appeal process and timeframes (table)

Appeal Process Flowchart – Perfect



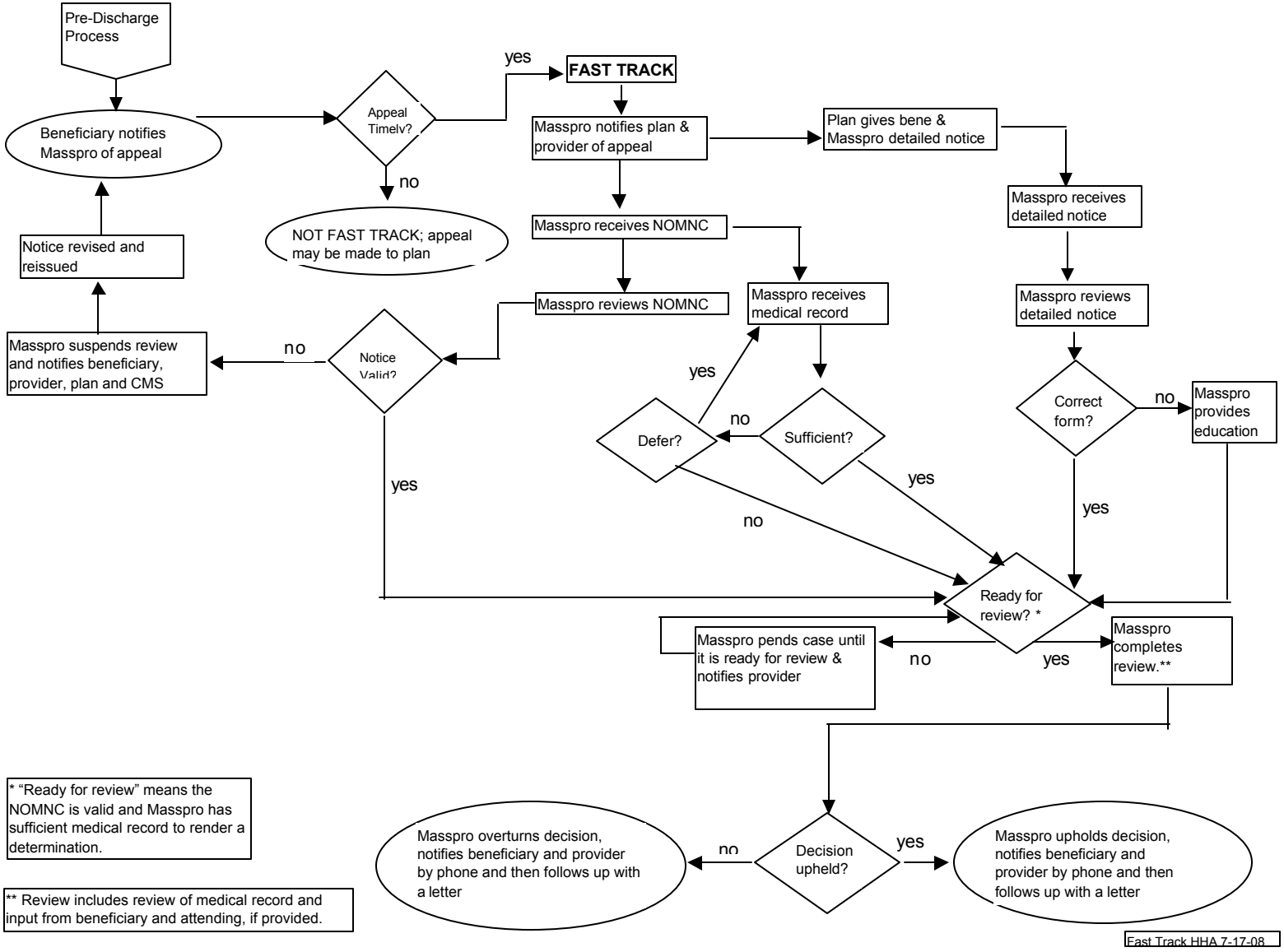
***** RCM = Review Case Manager

****** Review includes review of medical record and input from beneficiary and attending, if provided.

Appeal Process Flowchart – Imperfect

The workflow for the appeal process is shown on the next page. As this flowchart illustrates, the appeal process has many possible loops and issues, if everything is not perfect.

The Appeal Process



Appeal Process and Timeframes

	Procedure	Description / Comments	Example: Timeline
Initial Stages	The HHA gives the beneficiary a **Notice of Medicare Non-Coverage** (NOMNC) prior to terminating coverage.	Notice must be given no later than 2 days before the effective date.	Monday, June 5, stating that effective date is Wednesday, June 7
	The beneficiary/authorized representative contacts Masspro by phone, fax or mail to request a fast track appeal.	Call must be made *no later than noon of the day before the effective date that Medicare coverage ends.*	Tuesday, June 6
	Masspro solicits views from the beneficiary / authorized representative.		Tuesday, June 6
	Masspro RCM contacts the Medicare Health Plan to • notify of the appeal, • request the NOMNC, • remind the plan that it must prepare and deliver a detailed notice, and • request necessary information for review	This request is followed up with a fax requesting medical records	Tuesday, June 6
	Masspro RCM contacts provider to notify of the appeal and request contact information.		Tuesday, June 6
	Masspro calls attending to ask if he has any information to add.		Tuesday, June 6
	Plan / Provider submits requested information.	Submission must include copies of: • NOMNC • Detailed notice • Medical record (or appropriate portions)	Tuesday, June 6 (COB)
Post-Initial Stages	Masspro RCM reviews NOMNC.		Tuesday, June 6 or Wednesday, June 7
	Masspro RCM refers to PR.		Wednesday, June 7
	Masspro PR performs the review, using the medical record, information from beneficiary / authorized representative and attending, and any other provided information.		Wednesday, June 7
	PR renders the decision to uphold or overturn the notice.		Wednesday, June 7 (COB)
	RCM notifies all parties, including the beneficiary / authorized representative, plan, and provider.	Initial notification by phone, followed by letter	Wednesday, June 7 (COB)

Important Elements During the Initial Stages of the Appeal Process

As described in both the flowcharts and the table in the "Overview" section of "The Appeal Process," there are many steps that must occur at the beginning of the appeal process. Because of the regulatory time requirements, the process must move very quickly. Collaboration between the provider, the plan and Masspro ensures an efficient process that resolves the appeal appropriately.

The purpose of this section is to identify the ways to ensure that the steps taken during the initial stages of the appeal process move the process forward.

Ensuring Communication with Masspro

The most important elements of ensuring communication with Masspro are

- identifying the appropriate contact, and
- communicating with Masspro using the Home Health Medical Record Tracking List form.

IDENTIFYING THE APPROPRIATE CONTACT

Throughout the short but intensive appeal process, Masspro must be able to communicate with your agency and therefore needs a contact person.

Select the person at the agency who can

- provide Masspro with the NOMNC and patient's face sheet immediately after notification of the appeal,
- be responsible for the gathering, organizing and submitting of the required portions of the medical record,
- answer questions about this patient and this period of service,
- respond if the faxed information is unreadable, incomplete or incorrect, and
- provide other or additional information.

Important! The selected person should understand the process thoroughly, in particular be able to locate all relevant portions of the medical record submission.

COMMUNICATING WITH MASSPRO USING THE HOME HEALTH MEDICAL RECORD TRACKING LIST FORM

Masspro's primary means of communicating is the Home Health Medical Record Tracking List form. This form will be faxed to the plan as soon as the beneficiary appeals the NOMNC. Whether or not you receive a similar form from the plan, you may want to refer to it for the information it provides.

HOME HEALTH
MEDICAL RECORD TRACKING LIST

#1 FAX IMMEDIATELY
Fax these 2 items AND THIS FORM *immediately* when you are notified that there is an appeal.

[✓] Notice of Non-Coverage
[✓] Face Sheet with patient's demographic information

Please provide the name and phone number (extension) of the person Masspro should contact about this appeal: _____

#2 SECOND FAX
Fax ALL these items AND THIS FORM before the close of business today.

→ Please include patient's name on *all* documents. ←
→ Please include a fax cover sheet for *all* faxes. ←

What we need ↓	Check what's included ↓	
✓		Detailed Notice
✓		Facility Discharge summary, Emergency Department Record or Facility Referral
✓		Comprehensive Admission Assessment
✓		Oasis (SOC/ROC, 60 day f/u, SCIC, Transfer, Discharge)
✓		Discipline-Specific Admission Assessment
✓		All Discharge Summaries
✓		Progress Notes (RN, PT, OT, Speech, MSW)
✓		Home Health Aide Care Plans
✓		Physicians Orders (485 & telephone orders)
✓		Current Medication List
✓		Lab Results

→ Please include patient name on all documents.

Masspro Helpline #: 1-800-252-5533
Masspro Appeal Fax #: 1-781-419-2509

Masspro needs the following information, as specified on this form:

- The contact's name (or contacts' names)
- The NOMNC
  Note: The NOMNC is called the Notice of Non-Coverage on the Home Health Medical Record List form.
- The patient's face sheet.

Fax the Home Health Medical Record List, NOMNC and face sheet to Masspro at 781-419-2509.
Reminder: If the NOMNC is two-sided, both sides must be faxed.

Recovering from a Not-So-Perfect (Invalid) NOMNC

CMS requires Masspro to evaluate the NOMNC and specifies what happens if a notice is invalid. The plan has responsibility to issue the valid NOMNC and notify the beneficiary of any changes in liability or time frames.

The beneficiary must contact Masspro again to appeal the NOMNC.

Preparing the Medical Record

The determination as to whether Masspro will uphold or overturn the decision to terminate the beneficiary's services depends on the information from the medical record submitted to Masspro.

Reference: For information and important suggestions about faxing the medical record, refer to page 25.

COMPONENTS

To make an appropriate decision, Masspro must know the status of the patient upon admission (baseline) plus the patient's current status. ***We do not need the entire medical record.***

Here are the components of the medical record that Masspro must have:

- Facility discharge summary, Emergency Department record or facility referral
- Comprehensive admission assessment
- Oasis (SOC/ROC, 60 day f/u, SCIC, Transfer, Discharge) – Initial plus most recent
- Discipline-Specific Admission Assessment
- All discharge summaries
- Progress notes (RN, PT, OT, Speech, Case Management/Social Service) – Most recent 5 visits
- Current Home Health Aide Care Plan
- Physicians orders (485 written & phone), including discharge orders and/or orders to discontinue service
- Current medication list
- Current lab results
- Detailed Notice of Non-Coverage (**Note:** The plan provides this to Masspro)

Does your agency store some of these items somewhere other than in the medical record? If so, do not forget to obtain them from wherever they are stored and submit them to Masspro.

Here are the components that Masspro does not need:

- MDS
- RAP sheet
- Consent forms
- Permission slips

Important! Please ensure the information you fax to Masspro includes ***baseline information*** and documentation regarding the ***last month*** (only) of visits.

Faxing the Medical Record to Masspro (Faxing Realities)

IMPORTANT THINGS TO REMEMBER

- The Masspro RCM and PR cannot review the record if they cannot read it!
- Your fax may not be the only one coming into Masspro at the time you send it.
- Regulations require you to issue a notice before discharging a patient. Therefore, if Masspro overturns your decision because the documentation does not support it (even for the reason that the documentation Masspro received was insufficient), you will need to issue another notice and start the process again before discharging the patient.

SUGGESTIONS AND GUIDELINES

- Make sure the pages are legible. The reviewers are nurses and physicians, but if the handwriting is not legible, they cannot review the records and complete the review.
- Make sure that the copies created by your fax machine are readable.
  Important! Although Masspro understands the financial constraints of equipment, if your agency's fax machine cannot provide what is needed for a review, Masspro cannot perform the review.
- Help Masspro identify that your agency is the source of the records. Every fax machine has the capability to be set up to print each page with the information listed below. Masspro's ability to review your records will be improved if you set up your fax machine to include the
  - ➢ date and time,
  - ➢ page number, and
  - ➢ telephone number of sender.
- Make sure the patient's name is on each sheet.
- Make sure Masspro can read every page. For example, physician orders (especially telephone orders) that are "cascaded" on top of each other may be perfectly readable as originals, but when they are faxed, only the top edge of the pages behind the top page shows. Separate the pages before faxing them to Masspro.
- Sort the pages by category (for example, all med sheets together, all labs together).
- If sending a large number of pages, sort them into parts (packets).
  - ➢ Send a cover sheet identifying the name and phone number of the contact person and the total number of parts (packets) to follow.
  - ➢ For each part (packet), put a cover sheet on top identifying
    - – which part (packet) this is (for example, part 3 of 6),
    - – how many pages in this part (packet), and
    - – the total number of pages being faxed.
- **IMPORTANT!** If you are faxing on the weekend, be sure to call Masspro (1-800-252-5533) to notify us of the incoming fax.

Here is the way cascaded orders come through the fax machine:

Dr. Smith 5-6-08
Dr. Smith 5-8-08
Dr. Smith 5-12-08 ~~~ ~~~ ~~ ~~~ ~~~ ~~~~ ~~~~~ ~~~ ~~~~~~~ ~~~

Post-Initial Stages of the Appeals Process

Once the NOMNC has been submitted and determined to be valid, and the medical records have been faxed and determined to be sufficient, the review begins.

During this time, it is essential that Masspro be able to reach the contact person.

Ensuring Contact

Contact issues are some of the most problematic. If the Masspro RCM cannot reach the appropriate contact person,

- issues with the medical record cannot be resolved, and
- decisions could be delayed or the NOMNC overturned.

The following recommendations will help expedite the process and ensure a prompt determination:

- Make arrangements to educate everyone in your agency to ensure that anyone answering a telephone knows to whom to direct a call when the caller says, "Masspro calling regarding an appeal (or Notice of Medicare Non-coverage)."
- Include the name and phone number of the person handling the case on the Home Health Medical Record Tracking List.
- If a different person handles a case on weekends, identify that person's name and phone number, as well.

Hint: It is essential that the person answering the telephone when Masspro calls be able to locate a contact person. See Appendix C for a sample form to be placed next to all telephones.

Finalizing the Process

Here is the process for the review:

1. The Review Case Manager (RCM) uses screening criteria from the appropriate manual, such as CMS' *HHA Manual.*
2. The RCM refers the case to a Physician Reviewer (PR).
3. The PR evaluates the case and makes a decision based upon medical judgment.
   Key question to be answered:

   Does the information supplied by the provider and the plan clearly indicate that the treatment that this patient was receiving is no longer medically necessary?

4. The RCM notifies the beneficiary, provider and plan.
   - ➢ If Masspro upholds (agrees with) the decision, we agree that services should terminate.
   - ➢ If Masspro overturns (disagrees with) the decision, the beneficiary cannot be held financially liable.

Reference Information

What The Organization Is Called

- Medicare Health Plan (HP)
- Managed care organization
- "Medicare Advantage" is still used for some existing materials (including legislation) that have not yet been changed.

General Information about Notices of Medicare Noncoverage

- Statutes and regulations give HP enrollees the right to appeal an HHA's determination that he/she no longer needs skilled services.
- HHAs must notify enrollees of the termination of skilled services and of their appeal rights using standardized forms.
- QIOs have the responsibility to respond to enrollees' appeals.
- This is a real benefit to Medicare enrollees who
  - get a fast decision about financial liability, and
  - have a chance to make a real-time decision about their future plans.
- Masspro, as the QIO, has the authority to determine that
  - notices are valid in content and delivery (as specified by CMS), and
  - the information clearly indicates that the skilled services this patient is receiving are no longer medically necessary.

Brief History of Notices of Medicare Noncoverage

- 1993 class action lawsuit (Grijalva v Shalala) challenged the adequacy of the managed care appeals process.
- Settlement agreement (2000) required Centers for Medicare & Medicaid Services (CMS) to introduce a review process to conduct fast-track reviews of appeals of decisions to terminate services.
- Regulations CFR42§422.

Why Time Is So Important

The regulations are very specific about the timing of the process.

- The notice must be delivered no later than two days before the end of services.
- If the beneficiary appeals by noon the day before the effective date (expedited appeal), the process must be complete within 24 hours of Masspro's receipt of a complete medical record.

Basic Terminology

Term	Definition
Review Case Manager (Abbreviated RCM)	The person at Masspro with whom the staff at the HHA interacts. The RCM is a non-physician reviewer who "shepherds" process, performs initial review, makes contact, etc. **Note:** RCMs use screening criteria from CMS' *HHA Manual.*
Physician Reviewer (Abbreviated PR)	Physician who performs review and makes the review determination. **Note:** PRs base their decision on their medical judgment.
Upheld Review Determination	Masspro agrees with (upholds) the decision that skilled services are no longer medically necessary. The beneficiary's liability begins the day ***after*** notification by Masspro of the decision/determination.
Overturned Review Determination	Masspro does not agree with (overturns) the decision that skilled services are no longer medically necessary. The beneficiary cannot be held financially liable.
Effective Date	• Term used in the NOMNC: "The effective date your {specific} services will end:" • Last covered day • Day before beneficiary becomes liable
Termination of Service (42CFR§422.624(a)(2))	• "Discharge of an enrollee from covered provider services" OR • "Discontinuation of covered provider services" • Includes "cessation of coverage at the end of a course of treatment preauthorized in a discrete increment, regardless of whether the enrollee agrees that such services should end." • Does not "include the termination of one type of service by the provider if the beneficiary continues to receive other Medicare-covered services from the provider."
Exhaustion of benefits	• Term applied when the beneficiary's total number of benefit days have been used for treatment, based upon his/her contract with the Medicare Health Plan organization • QIOs do not perform "medical necessity" reviews for appeals resulting from notices based upon exhaustion of benefits
Term of benefits	• Term applied to days of treatment prescribed by the physician for a particular illness or ailment • Example: 5 home visits by a physical therapist • QIOs do perform "medical necessity" reviews for appeals resulting from notices based upon term of benefits

APPENDICES

Appendix A: Resources

Masspro Resources

If you	Contact	At
Have general questions about the Fast Track program	Cheryl Lehane, RN	781-419-2753 or clehane@ maqio.sdps.org
Have specific questions about a Fast Track appeal	Beneficiary Helpline	800-252-5533
Want to fax information (including medical record) related to a Fast Track appeal	Masspro's Fast Track review fax	781-419-2509
Want to give the beneficiary the number to contact Masspro	Beneficiary Helpline	800-252-5533
Need to notify Masspro of a fax you are sending during non-business hours	Beneficiary Helpline	800-252-5533
Have a general question about Masspro	Masspro's switchboard	781-890-0011

CMS Resources

If you	Go to	And
Want the most recent NOMNC and instructions	http://www.cms.hhs.gov/MMCAG/	1. Scroll down to Downloads section. 2. Click on Notices – MS Word. 3. Save the (zip) folder to your computer. 4. Open and save the notice.

Appendix B: Sample Telephone Sign

A sign like this one may be used to assist the staff at your agency in directing calls regarding appeal requests to the appropriate person at your agency.

When **Masspro** calls for **Appeals**

Forward call to:

Weekday: _____

Weekend: _____

Appendix C: Grijalva v Shalala

The Fast-track appeal process came into being through this process:

- 1993 class action lawsuit brought by beneficiaries enrolled in Medicare risk-based managed care organization program.
- Case challenged the adequacy of the managed care appeals process.
- Settlement agreement approved by Arizona District Court, December 4, 2000.
- Under the settlement agreement, the Centers for Medicare & Medicaid Services (CMS) agreed to publish a notice of proposed rulemaking proposing regulations that would establish new notice and appeal procedures when a risk-based managed care organization decides to terminate coverage of provider services to an enrollee.
- Key element is the review process to conduct fast-track reviews of appeals of decisions to terminate services.
- CMS selected the Quality Improvement Organizations (QIOs) like Masspro to perform these reviews.
- Because it has similar responsibilities when Medicare beneficiaries dispute hospital discharge decisions, Masspro has extensive experience with this type of review.

Appendix D: Comparison between Fee-for-Service and Health Plan Expedited Determination Programs

Topic	Health Plan ED (Grijalva)	FFS ED (BIPA)
Affected beneficiary	Enrolled in Medicare risk-based managed care plan (including PPOs, where service is pre-authorized by the plan)	Enrolled in traditional, fee-for-service Medicare
Affected providers	SNF, HHA, CORF	SNF, HHA, CORF, *hospice*
Definition: "termination of service"	Discharge of the enrollee from covered provider services or discontinuation of covered provider services, when the enrollee has been authorized by the HP, either directly or by delegation, to receive an on-going course of treatment from that provider. Termination includes cessation of coverage at the end of a course of treatment preauthorized in a discrete increment, regardless of whether the enrollee agrees that the services should end.	Discharge of a beneficiary from a residential provider of services, or a complete cessation of coverage at the end of a course of treatment prescribed in a discrete increment, regardless of whether the beneficiary agrees that the services should end.
Notice – Also called	**NOMNC; formerly called Advance Notice**	**Generic Notice**
Notice – Form number	CMS-10095	CMS-10123
Notice – Form name	Notice of Medicare Non-Coverage	Notice of Medicare ***Provider*** Non-Coverage
Notice – Issuance	Termination of ***all*** services. (Complete – not service reduction or exhaustion of benefits.)	
Notice – Timing	No later than two days before proposed end of services. If services expected to be fewer than two days in duration, delivered at the time of admission. If span between services exceeds two days, given no later than the next-to-last time services are furnished.	
Appeal rights – SNF	Any beneficiary (or legal representative) disagreeing with termination of service may appeal.	
Appeal rights – Hospice	Not Applicable – regulations do not apply to MA hospice	Any beneficiary (or legal representative) disagreeing with termination of service may appeal.
Appeal rights – HHA and CORF	Any beneficiary (or legal representative) disagreeing with termination of service may appeal.	A physician must certify that failure to continue the provision of the service(s) may place the beneficiary's health at significant risk.
Deadline for appeal (requesting QIO review)	Noon the day prior to the effective date.	
Untimely request	Referred back to plan.	QIO accepts as a non-expedited appeal. This appeal may occur at any time (for example, 1 day or 1 month later)

Topic	Health Plan ED (Grijalva)	FFS ED (BIPA)
Notification of receipt of appeal	QIO notifies plan and provider the day the request received.	QIO notifies provider the day the request received.
QIO's request	Made to plan: • copies of NOMNC and detailed notices • medical record	Made to provider: • name/number of contact person • copies of generic and detailed notices • medical record • for HHAs, physician's certification
Detailed notice	Plan must issue notice the day it is notified of the appeal.	Provider must issue notice the day it is notified of the appeal.
Missing documentation	QIO determines whether to proceed with available information or to request additional information.	
Invalid generic notice	QIO discontinues review and notifies • plan, • provider, • enrollee, and • CMS Project Officer	QIO discontinue reviews and notifies • provider, and • beneficiary
Invalid detailed notice	QIO continues review and notifies • plan, • provider, and • enrollee	QIO continues reviews and notifies • provider, and • beneficiary
Input from attending physician	QIOs are not required to solicit input	QIOs are required to solicit input
Notification of determination	Verbal, followed by written.	
Timeframe for QIO decision	Telephone notice of determination must be made by close of business the day following receipt of sufficient information that the QIO needs to make the determination.	Telephone notice of determination must be made within three days of receipt of the appeal.