15.2 SNF/HHA/CORF Provider Service Terminations – Medicare

Grijalva Decision

For Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) providers, Healthfirst would like to advise you of some important changes that have taken place with respect to the appeals process and delivery of the notification of termination of covered services.

As part of a settlement agreement between CMS and Medicare beneficiaries, the federal rules governing Medicare appeals were recently revised. Specifically, pursuant to 42 CFR Section 422.624, the provider of services is responsible for delivering the Notice of Medicare Non-Coverage (NOMNC) to Medicare managed care members prior to the cessation of services for medical necessity determinations. For denials of SNF 100 day Benefit Exhaustion, admission to SNF, Home Care or CORF that is Not Covered, or when single service ends but skilled stay continues, the Notice of Denial of Medical Coverage (NDMC) will be issued. The delivery must be made to the managed care member two (2) days prior to the termination of the covered services and will not be considered valid until the member signs and dates the notice. If the member is incompetent or otherwise incapable of receiving the notice, the notice must be delivered to the member's legally authorized representative. If no authorized representative has been appointed, then the facility should seek the requested signature from the caregiver on record (i.e., the family member involved in the plan of treatment). If the member has no legally authorized representative or caregiver on record, then the facility should annotate the notice and sign on behalf of the member.

The Notice of Medicare Non-Coverage will be faxed to you, along with every preauthorization and concurrent authorization approval letter issued on behalf of Healthfirst members. It is imperative that you keep this form on file until it is time to present it two (2) days prior to discharge or within the last two sessions of home health services or therapy/rehabilitation. In addition, it is important that you understand that Healthfirst will not be responsible for any charges that extend past the authorized amount due to the failure of a provider/facility to deliver the notice and secure a member's signature.

Request of Immediate Quality Improvement Organization (QIO) Review (QIO Appeal) of SNF/HHA/CORF

Provider Service Terminations

A member receiving skilled provider services in a SNF, HHA, or CORF who wishes to appeal a Healthfirst decision to terminate such services because care is no longer medically necessary must request an immediate QIO review of the determination, in accordance with CMS requirements.

When to Issue Detailed Explanation of Non-Coverage

Once the QIO receives an appeal, it must issue a notice to Healthfirst that a member appealed the termination of services in SNF/HHA/CORF settings. Upon receipt of this notice, Healthfirst is responsible for issuing the Detailed Explanation of Non-Coverage – a written notice that is designed to provide specific information to Medicare members regarding the end of their SNF, HHA, or CORF care. (See Appendix XIII).

Healthfirst must issue a Detailed Explanation of Non-Coverage (DENC) to both the QIO and the member no later than the close of business when the QIO notifies Healthfirst that a member has requested an appeal.

Healthfirst is also responsible for providing any pertinent medical records used to make the termination decision to the QIO, although the QIO will seek pertinent records from both the provider and Healthfirst.

Immediate QIO Review Process of SNF/HHA/CORF Provider Service Terminations

On the date that the QIO receives the member's request, the QIO must notify Healthfirst and the provider that the member has filed a request for immediate review. The SNF/HHA/CORF must supply a copy of the Notice of Medicare Non-Coverage and any other information that the QIO requires to conduct its review. The information must be made available by phone, by fax, or in writing by the close of the business day of the

appeal request date.

Healthfirst must supply a copy of the Notice of Medicare Non-Coverage, Detailed Explanation of Non-Coverage, and any medical information that the QIO requires to conduct its review. The information must be made available by phone, by fax, or in writing by the close of the business day that the QIO notifies Healthfirst of an appeal. If a member requests an appeal on the same day the member receives the Notice of Medicare Non-Coverage, then Healthfirst has until close of business the following day to submit the case file.

The QIO must solicit the views of the member who requested the immediate QIO review. The QIO must make an official determination of whether continued provider services are medically necessary and notify the member, the provider, and Healthfirst by the close of the business day after it receives all necessary information from the SNF/HHA/CORF, Healthfirst, or both. If the QIO does not receive the information it needs to sustain the Healthfirst decision to terminate services, then the QIO may make a decision based on the information at hand or it may defer its decision until it receives additional required information. If the QIO defers its decision, then coverage of the services by Healthfirst will continue and the QIO will refer violations of notice delivery to the CMS regional office.

A member should not incur financial liability if, upon receipt of the Notice of Medicare Non-Coverage:

the member submits a timely request for immediate review to the QIO that has an agreement with the provider;

the request is made either in writing, by telephone, or by fax by noon (12pm) of the next day after receiving the notice;

Healthfirst meets its time-frame obligations to deliver medical information and a Detailed Explanation of Non-Coverage to the QIO; and

the QIO either reverses the Healthfirst termination decision or the member stops receiving care no later than the date that the member receives the QIO's decision.

The member will incur **one (1) day** of financial liability if the QIO upholds the Healthfirst termination decision and the member continues to receive services until the day after the QIO's decision. This should be the same date as the Healthfirst initial decision to terminate services.

A member who fails to request an immediate QIO review in accordance with these requirements may file a request for an expedited appeal with Healthfirst. Healthfirst will expedite the request for an expedited appeal if the QIO receives a request for an immediate QIO review beyond the noon (12pm) filing deadline and forwards that request to Healthfirst. Healthfirst would generally make an expedited decision about the services within seventy-two (72) hours. Financial liability applies in both the immediate QIO review and Healthfirst expedited review situations.

If an appeal occurs during a weekend, a Healthfirst Care Manager will contact the nursing office or SNF/HHA/CORF administrator on duty to facilitate the delivery of the Detailed Explanation of Non-Coverage.