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CENTERS FOR MEDICARE & MEDICAID SERVICES

BFCC-QIO FAQ

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KEPRO is the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for 33 states and the District of Columbia. KEPRO provides medical record reviews as well as Immediate Advocacy for Medicare beneficiaries. Below are frequently asked questions related to KEPRO's services.

1. What is the difference between a Grijalva review and a BIPA review?

Home health agencies, skilled nursing facilities, hospices, and comprehensive outpatient rehabilitation facilities are required to provide a Notice of Medicare Non-Coverage (NOMNC) to beneficiaries when their Medicare covered service(s) are ending. The NOMNC provides information for beneficiaries on how to request an expedited appeal.

Both the Grijalva review and BIPA review allow the beneficiary to request a post-acute appeal. However, the Grijalva review is for managed care patients and the BIPA review is for Medicare Fee-for-Service patients. One major difference is that the BFCC-QIO cannot review a Grijalva case if the beneficiary does not call by the deadline. It must then be reviewed by the managed care company. Another difference is that the reconsideration (which is a second review after the first determination) for a BIPA review is done by another contractor, not the BFCC-QIO.

2. What is a Weichardt review?

A Weichardt review is a hospital discharge appeal review. It is named Weichardt after the defendant in a lawsuit. This review requires the Medicare hospital patient to be given a notice called the Important Message from Medicare. This notice provides all the information necessary for the Medicare patient to appeal his/her discharge from the hospital. There are mandated requirements regarding the delivery of this notice, to make sure that the beneficiary is properly informed of all his/her appeal rights.

3. What are the HINN types, and how are they different?

HINN 10, also known as the Notice of Hospital Requested Review (HRR), should be issued by hospitals to beneficiaries in Original Medicare whenever a hospital requests QIO review of a discharge decision without physician concurrence.

HINN 11, which is used for non-covered items or services provided during an otherwise covered stay, and its instructions have not yet been incorporated into Chapter 30 of the Online Claims Processing Manual.

HINN 12 should be used in association with the Hospital Discharge Appeal Notices to inform beneficiaries of their potential liability for a non-covered continued stay.

The Preadmission/Admission HINN, used prior to an entirely non-covered stay, is also known as HINN 1 and replaces HINNs 1 and 9.

4. How does Immediate Advocacy work?

Immediate Advocacy is an informal process used by the QIO to resolve a complaint quickly. This process begins when the Medicare beneficiary or representative gives verbal consent to proceed with the complaint. Once the beneficiary or representative agrees to the process and gives consent, the QIO contacts the provider or practitioner on behalf of the beneficiary. A beneficiary may discontinue Immediate Advocacy at any time. Immediate Advocacy is not appropriate for situations when the beneficiary does not want his or her identity disclosed to the provider or practitioner.

5. What is a Two-Midnight Short-Stay review?

The Two-Midnight rule is a rule that specifically identifies the minimum length of a hospital stay for Medicare beneficiaries to qualify as an inpatient stay. The Centers for Medicare & Medicaid Services (CMS) recently decided to use BFCC-QIOs, rather than Medicare Administrative Contractors (MACs) or Recovery Auditors, to conduct the first line medical reviews of providers who submit claims for inpatient admissions. The BFCC-QIO will review for the appropriateness of an inpatient admission.

6. How does the BFCC-QIO review HWDRGs?

Hospitals may submit requests for Higher Weighted Diagnosis-Related Group (DRG) assignments directly to their MAC for processing and payment. All such requests granted by the MAC are subsequently selected by CMS for BFCC-QIO review on a post-payment basis. BFCC-QIOs review hospital-requested Higher Weighted DRG assignments for medical necessity, quality, and DRG validation.

7. What is the difference between a beneficiary complaint and a general Quality of Care review?

A beneficiary complaint is a review that is submitted by either a beneficiary or his/her representative. At the end of the review, disclosure is made to the person who initiated the complaint. There is also an opportunity for discussion provided to the provider/practitioner as well as a reconsideration opportunity if a possible quality of care concern is identified.

The general Quality of Care review usually begins as a referral or as a review initiated by another BFCC-QIO review, such as an appeal or a HWDRG review. In this process, there is no opportunity for discussion for the provider/practitioner, just a reconsideration opportunity. There is also no disclosure to the beneficiary or representative.

8. How does the BFCC-QIO Sanction process work?

When the BFCC-QIO reviews a quality of care complaint, the review is sent out to a physician reviewer. The physician reviewer can determine that the concern was Gross & Flagrant or that there was a Substantial Number of Substantial Violations. Once that determination is made, the case is sent out to two more physician reviewers. If two of the three concur that the case is a potential Sanction case, then the provider is notified and may request to submit additional information in

writing or may request a face-to face meeting with the BFCC-QIO. A Sanction panel, comprised of physicians, is convened, and they assist with the determination regarding the potential Sanction issue.

If it is determined that there is no violation, the case proceeds as a normal Quality of Care review. If there is a violation, then the provider will be placed on a Corrective Action Plan (CAP). This may involve submitting data to the BFCC-QIO for a period of time, usually a year. Once the CAP has been successfully completed, the case is closed. If the CAP is not completed to the satisfaction of the BFCC-QIO, the case may be referred to the Office of the Inspector General (OIG) for a potential Sanction.

9. How does the EMTALA process work?

KEPRO conducts a five-day Medical Advisory review upon request from the appropriate CMS regional office. KEPRO's physician conducts a medical assessment of a potential Emergency Medical Treatment and Labor Act (EMTALA) violation case. The five-day review is not mandated by the federal statute and regulations. However, the regional office may use this review as a resource in making a compliance determination, rather than simply determining the merits of the complaint.

Under sections 1867(d)(3) of the Act and 42 CFR §489.24(g), KEPRO is required to conduct a 60-day review upon receipt of a completed EMTALA case sent to the OIG for possible civil monetary penalty or exclusion sanction.

10. What is an Assistant at Cataract review?

Per Section 1862(a)(15) of the Social Security Act, Medicare will not pay for the use of an assistant at cataract-related procedures unless its local BFCC-QIO has approved the use of an assistant due to complicating medical factors. The provider must request a pre-approval review prior to the procedure in order to bill for an assistant. This review is not commonly requested from the BFCC-QIO.

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