October 28, 2020

Webinar Transcript: Post-Acute Appeals

Good morning everybody. This is Cheryl Cook. I'm with Kepro, and we are going to start our discussion here in just a few seconds. I do want to remind everybody that we are recording this call and would kindly ask that you place your lines on mute. We can protect the clarity of the call. OK, well welcome everybody to Kepro's Post-acute Appeals. Before we get started, if you would just allow me a few minutes to go over some housekeeping items, I'd greatly appreciate it. As I mentioned, in order to protect the integrity of the call, all participants are muted. We would ask that you also make sure that you remain muted on your side, and please do not place us on hold, as we will all hear your facility's hold music, and that may be disruptive to others. We are going to record this call, so that other team members and facilities have the opportunity to view it and listen to it at their convenience. We want to make sure that everybody does have the opportunity to learn from us. Lastly, we will ask if you have questions that you please hold them until the end, so that we can be able to unmute lines, and we would also then ask if you would like to please submit them through the chat feature. We will read them and will provide as much information back to you as humanly possible. So, with that, let's get going.

During the course of today's discussion, we're going to provide some information about the overall appeal process, the provider, the QIO responsibilities, how to fill out the Medicare Notice of Non-Coverage form, and then, how you submit it to Kepro. We're also going to share with you some of the lessons we have learned over these nearly 16 to 17 years of performing these types of beneficiary-requested appeals.

My name is Cheryl Cook. I'm the Program Director for the Beneficiary and Family Centered Care Quality Improvement Organization or the BFCC-QIO, which is a mouthful to say in all one word or in one sentence. But basically, it is the contractor who is responsible for doing the review work, the mandatory reviews, in your particular state or area. I personally have been with the QIO program since 2001 and have been involved in every aspect of the appeal process, from its inception, when the proposed rules were published through the implementation, and then through them along with any updates that have transpired since that time. My personal background is that of a clinical nurse, and I have held every position from a graduate to a Chief Nursing Officer in facilities. I come from a for-profit environment, having worked with HCA for 25 plus years. During that time frame, my nursing career has been primarily in critical care from the emergency department to open heart recovery and anything and everything in between.

Publication No. R146810-127-10/2020. This material was prepared by Kepro a Medicare Quality Improvement Organization 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 reflect CMS policy.

Just a little fun fact for me. You'll see on the slide here after about five years of clinical practice, I felt that I needed a break from the fast-paced hospital environment. I dearly love to cruise, and at the time, which was many, many years ago, I took a position on Carnival Cruise Lines working as a ship's nurse. This was back in 1983, and I thought it would be just like The Love Boat for those of us old enough to remember that series. Needless to say, that 2 1/2 years of working on board ship was the hardest and yet the best nursing position I ever had. You might have to ask me about that sometime, and I'll be more than happy to share it with you. Also on the call is Rose Hartnett, who is our operations director. She is an individual who is deeply involved with the appeal process, and after, she may jump on and provide some additional information as we go through. As you can see, her fun fact is noted there, that after becoming empty nesters, her and her husband have traveled a lot, traveled to 37 states and have stayed in 21 national parks. That's a pretty interesting gig there.

So, you might be asking who we are? Who is Kepro? We're a company with multiple state and federal contracts, and our corporate office is located in Harrisburg, PA. We have offices and satellite offices throughout the United States, from coast to coast and from north to south. Our mission is to improve lives through healthcare quality and clinical expertise. We do work on behalf of the government, both state and federal, and also some private healthcare payers to maximize health quality and improve accuracy and increase efficiencies. We really drive change in the healthcare system that allows healthcare dollars to reach more people, by ensuring the right care is delivered at the right time. So, with this slide, I've given you a little bit more information about who we are.

Kepro is the BFCC-QIO contractor for 29 states, and we are responsible for handling the statutory required reviews. With the largest volume of those reviews being appeals, we also do quality of care complaints, reviews initiated by the beneficiary. We do quality of care reviews that are initiated by other contractors or by CMS itself. We also provide Immediate Advocacy as a tool or an option for resolving some of those patient complaints that really aren't of a quality nature; the facility room was cold; the food was bad; the physician staff wasn't helpful. Those are some of the things which can really be best resolved through the use of Immediate Advocacy.

At this point in time, we're just going to move into the appeals section of our program, which will provide you with some information about the history of those appeals, the processing, the differences between the appeals, and also some of the provider and QIO responsibilities. There are three major appeals that Kepro performs. There are others, but they're really small in volume, and they're not utilized much by either the Medicare beneficiary or the provider when you're comparing it to, say, a hospital discharge appeal or in the post-acute setting. Post-acute appeals related to the health plan member, we refer to

those as Grijalvas because that was the result of a class action lawsuit that was titled Grijalva versus Shalala, which was started back in 1993 by an Arizona Medicare beneficiary, Mr. or Mrs. Grijalva against the Department of Health and Human Services Secretary, which was Dr. Shalala at the time. The primary concern from that Medicare health plan member was that their skilled services were being terminated without any advance warning and really without an appeal in place.

There was a hospital appeal process in place at that time but not really one for the post-acute setting. This particular lawsuit traveled through the court system. A settlement was reached in the early 2000s, and on January of 24, 2001, a proposed rule was published, kind of outlining what the parties agreed to in that lawsuit. In 2003, the final rule was published to the community with an implementation date of January 2004, and the rest, as we say, is history. Grijalva started.

It was followed closely by what we call BIPA, which is a similar appeal process; however, this was tagged in regulations as part of Section 521 of the Medicare and Medicaid and SCHIP Benefits Improvement and Protection Act of 2000, commonly referred to as BIPA, and that final rule was published in early 2005 with implementation beginning on July 1, 2005. Basically, BIPA mirrors what is over in the post-acute setting appeals that are related to the Medicare health plans. The only difference is that the processing time is slightly different. Timelines give you just a tad bit more time, but overall, it still provides that beneficiary with an opportunity to question or to disagree with the termination of skilled services as well as an appeal process. Generally speaking, for BIPA, there are different processes depending upon the location where skilled services are being provided.
For example, for those residential settings, such as in a SNF or in hospice, there is a defined time frame for the completion of those reviews.

However, for a non-residential setting, such as a home health agency or comprehensive outpatient rehab facilities, the BFCC-QIO is required to receive a physician certification of harm before an appeal can be completed. So, for example, if a Fee for Service traditional Medicare beneficiary requested an appeal from a skilled nursing facility, we would take that appeal request. We would process it according to the time frames. However, if a request came from a Medicare beneficiary involved in home health services, we are required to receive a certification of harm before we can complete that review. So likely what you'll hear from us is to request a copy of the notice of Medicare Non-Coverage, so that we can then validate that. The appeal process really tells the beneficiaries and/or the reps of the impending discontinuation of skilled services. It establishes a time frame for that person or for someone other than Medicare to be financially responsible, should skilled care continue, and it also gives a Medicare beneficiary or health plan member the right to disagree with that decision and to have an independent review organization, such as

Kepro, review and determine if the provider's decision is supported by the medical record documentation.

At the 50,000-foot view, the process flows like this. The plan or the provider gives that Medicare beneficiary a Notice of Medicare Non-Coverage or what is commonly referred to in the industry as the NOMNC. That beneficiary or rep will call the BFCC-QIO in your state, that would be Kepro, and request an appeal. We're going to gather a whole lot of information on that call, and then, we're going to verbally notify the provider and the plan, if it's appropriate, of the beneficiary's request for an appeal. Then we will send you a medical record request and ask for specific components of that patient's medical record to be sent to us for review. Again, looking at very high level, medical record due dates and times were established by federal rules and regulations and not the BFCC-QIO or not by Kepro.

Once that record is received, it's going to be prepared by a nurse. That nurse is going to look for certain elements that are in there. If those elements are not there, he or she may determine that there's not enough information for processing. We will notify folks if that record is prepped, and there is sufficient information. We're going to send that medical record to an independent physician reviewer. These are not Kepro employees. They are Kepro subcontractors, and they have to meet regulations to be a subcontractor for either BFCC-QIO. Basically, those are that they are licensed in a state and that they perform on average 20 hours a week doing patient care. We do require that they are board certified in whatever specialty they have. And then, lastly, once that review comes back from the physician reviewer, we're going to notify all involved parties, and we're going to start with the beneficiary since it is their appeal request.

I'm not sure how many in the audience know that on September 18 of this year, CMS published the fiscal 2021 IPPS and LTAC Final Rule. Within this rule, CMS is now requiring that all providers submit requested medical records through an electronic means. CMS also provided information as to the amount of reimbursement it will pay for electronic submission of these requested medical records. Kepro knows that this was a very short notice to the provider community regarding this requirement, and as such, we have continued to keep our fax lines and fax servers operational. We will accept fax transmissions; however, without a signed and approved waiver from Kepro, the provider will not be reimbursed for the submission of that faxed medical record.

Additional information has been provided on our website, and you can see the links down below on this slide. We've also sent information out via the Kepro newsletter, an email, and fax blast, and we've also incorporated this in all of our outreach activities. So basically, this was again not our rule. It was a CMS rule. They published it on the 18th of September with an implementation date of October 1. We will work with providers as needed and as

requested, to assist with this electronic submission of requested medical records. You'll see that on our forms that go out now, there's an actual web link for you to use, and as noted, we also still do have our fax number on that request for medical information.

Should the provider need to continue to submit your medical records via fax, whether or not you have a signed waiver, we ask that you please put the barcode cover sheet as the first page of your fax transmission. The reason we do this is that the barcode allows for our system to connect the submitted information to the right appeal. Auto attach. It moves that appeal into the next phase, which is the nurse reviewer aspect. This action saves a number of hand offs on our handing of documents. I think all of us can appreciate that when we hand things off, sometimes things can get misplaced or lost or whatever. We're just trying to be as efficient as possible, so if we can reduce the number of handoffs, we can also then reduce the time that's required to process an appeal. That's our ultimate goal is to make the appeal process efficient and streamlined, so that the Medicare beneficiary gets their requested appeal done, as quickly as possible, as correctly as possible, and then also so that the healthcare providers and the plans can get their information as well. We want to reduce any potential delays in that manner. So again, we're just going to ask that you please, please put that bar code on as the first page coming in.

So, we have talked a bit about a lot of different aspects, but we do want to go in and talk a little bit more about what the provider responsibilities are in regard to the appeals. The beneficiary obviously has responsibility to ask for the appeal. The provider has specific responsibilities that are outlined in the Claims Processing manual and Chapter 30 as well as by transmittals that have been sent in in the early days of this process. The QIO also has responsibilities here. So, for providers, the providers are required to issue the NOMNC when all or the last skilled services are being discontinued. For example, if your resident is receiving physical, occupational, and speech therapies as well as skilled nursing aspects, the NOMNC is given when the very last skilled service is stopped, not when you drop PT, and you continue with OT, then nursing. But when you drop everything, and there's only one last remaining skilled service, that is when the notice is to be given for residential settings such as the skilled nursing facility.

In hospice, the NOMNC has to be given within two calendar days of the effective date. I use the term effective date because that's what you're going to see on the NOMNC. You're not going to see the last covered day; the title is effective date. It is commonly referred to as last covered day, but I just want the audience to realize that's not how it's labeled on the Notice of Medicare Non-Coverage. It is noted as an effective date. Between the effective date and the signature date, there has to be two calendar days, not 48 hours, but two calendar days. For example, if today is October 14, if you're going to issue a notice and give it to a beneficiary, your effective date can't be any earlier than October 16, which would be Friday. For home health services, it is given on the next to the last visit for that purpose.

Not all home health patients receive skilled services every single day. They don't want the home health agencies or anyone having to make an unnecessary trip to deliver that notice.

So, for that reason, for those non-residential settings, you give it on the next to the last day. According to Medicare's Claims Processing manual, the notice should be given in person unless there are extenuating circumstances, and we'll talk a little bit about those later in this program. The notice would not be required to be given when your patient or your resident is moving from skilled care to say hospital care. You would not have to do that if you're in an unsafe environment, such as recently in the state of Louisiana, where they've had storms that have come in. If you have to move your patients, to move them from an unsafe environment to a safe environment, you're not required to issue those notices. Should the beneficiary elect and sign for hospice services, then the notice is not required, and if the beneficiary has exhausted all skilled days or the benefit, used skilled days for the Fee for Service, then you would not be required to give it. So, for example, if they have reached their hundred days for that Fee for Service patient or resident, you would not be required to issue a Notice of Medicare Non-Coverage.

CMS also required the SNF ABN when Part A services are being stopped. The ABN is not under review by the QIO, but we have heard from skilled providers that when they have survey agencies that come in, they do look for that ABN. We just want you to know that it is a requirement, but we, as a contractor, do not have to have that notice nor do we have any appeal responsibilities for that notice. We've given you a web link here, so that you can go and look for more information in regard to the SNF ABN.

When the Medicare beneficiary or the health plan member calls a QIO, as I mentioned, they're going to be asked for specific information. We're going to gather information, so that we can process their appeal request. We're going to ask the beneficiary or their rep things like, basically, you know your name, your address, how can we contact you. What's a good address for us to send a letter to? And then, we're going to solicit their viewpoint. Why do you think you're not ready for this service to be discontinued? And that's important because that is federally required of us to ask or solicit their viewpoints. We're going to solicit the provider’s viewpoint and the attending’s viewpoint through the medical record documentation. But for the beneficiary, we want to know what his or her opinion is, and why they don't feel they're ready for the next level.

When we conclude that call, we're going to then notify the healthcare provider, and if this is a health plan member, we're going to notify the plan of the appeal request. We're going to send you a faxed medical documentation request asking for specific components of the medical record along with copies of the Notice of Medicare Non-Coverage. If by chance, you happen to have the Detailed Explanation of Non-Coverage or what people like to call the DENC, if you have that, that would be greatly appreciated if you can submit it. I will say

to you that it is not a requirement for us to get the DENC. It is nice to have, and if you can provide it, we would greatly appreciate it, as we will also include that in the information that we send to our physician reviewers.

Our request is also going to include information as to how to submit the information, specifically how to electronically submit the information, and then again, as I mentioned before, the fax servers do remain open. You can submit it via fax. If we have a signed waiver on board, we will reimburse you the appropriate amount of money. If not, we will not reimburse you, but we will accept it. For those beneficiaries requesting an appeal for a home health or a CORF termination of service, we're going to ask the provider for a copy of the Notice of Medicare Non-Coverage and the face sheet.

Just a reminder, the QIO has to have a physician certification of harm before it can do the review. We will assist the beneficiary with getting such a document from his or her physician. Once we have their request and verbal consent from them, we will fax a certification to their primary physician and ask that it be completed and returned to us, so hopefully we can reduce the amount of time that the beneficiary takes when they're trying to get that certification of harm. Just a tidbit in here for those home health settings, the beneficiary has up to 60 calendar days to get that certification of harm to the QIO. Until we receive that certification of harm, we, by law, cannot complete that review. This is not a Kepro decision. This is a federal requirement, so this is the reason why we have tried to assist that beneficiary and reaching out to their provider, to their primary physician, so that we can get that information directly and reduce the number of days on that appeal.

Upon receipt of the Notice of Medicare Non-Coverage, we are charged by CMS to validate the notice. That is the first step in this review process; we have to look at it. We will be looking for such items as are you using the current form. It's a CMS OMB form. There's a CMS OMB number, the approval date. There isn't an expiration date. I think the approval date is 2011, so it's still in place. We're going to look at the number of days between the effective date and the signature date. We're going to look for the telephone number of the QIO for that patient to call and request an appeal. I think you can imagine if there's a wrong number on that document, then the beneficiary has no way of activating his or her appeal process, and so we're going to look to ensure that that number is correct. If the notice is delivered to a representative by telephone, is there appropriate documentation either on the NOMNC itself or within the medical record regarding this notification? And again, it's really critical because we receive telephone calls from representatives that say the skilled facility never told me this. They didn't call me, they didn't provide me with this information, and if we can't find the documentation in the medical record that indicates that the rep was called on a day and it was within that two days, it's highly likely we'll disagree with that notice and make it an invalid notice.

By federal regulations, in the post-acute setting, the medical record is due to the BFCC-QIO by close of business on the day of the appeal request notification. If Susie Smith called and asked for an appeal at 4:45 Eastern Standard Time, and the provider is in the Eastern Standard Time zone, we are going to call you and notify you of that appeal and technically, by federal regulations, that medical record would be due by 5:00 pm. Now we understand that, and this is applicable for all of our time zones that we operate in, which is currently six, we understand that if that beneficiary calls us late in the day in any time zone, it is going to be very hard, if not impossible, to get the requested medical records by 5:00 pm. That said, our portal is an electronic portal. In fact, servers are open, and they're available 24 hours a day, seven days a week, 365 days a year. We do have some internal processes that are used for late notifications and submissions, and we try to work with providers the best way we can, but at the end of the day, it is the provider's responsibility to get the medical records to us as quickly as possible.

If that medical record documentation isn't received timely, we are required to do one of two things. We can either make a decision with what we have on hand, which isn't much of anything, or we can wait for the documentation to arrive. Due to the fact that there is potential financial liability on the part of the beneficiaries, we are going to make a decision on what we have at hand, which isn't much. It's going to likely result in an administrative denial, due to an untimely submission of the medical record. We understand, and we will work with you. We will do whatever we can. As I mentioned, we have some internal thresholds that we have put in place, so that we don't arbitrarily make a decision at 5:01 pm in any time zone to deny a medical record. It's just makes rework for everybody. So please hear me when I say that we're going to work with everybody that we humanly can.

And then the other thing I just want to mention here is that within the federal rules and regs is also the provider's responsibility to give to the Medicare beneficiary or the representative a copy of documentation that was sent to QIO at no cost. Many times, we will have individuals call us and say can you send me what was sent to you for review, and we will do that. But we are also going to charge that person money for that information. We will refer them back to the provider community and let them know that the providers are required to provide them with a copy of what was sent to Kepro at no cost. But at the end of the day, they may still come back to us and ask us for that, and we will oblige that request. I'm going to just leave this slide here for just a few seconds and just provide a little bit of information on the Notice the Medicare Non-Coverage, then the Detailed Explanation of Non-Coverage.

These are not Kepro’s forms. These are CMS forms, and they are provided and reviewed and approved by the Office of Management and Budget (OMB) on this website right here, which is what we commonly refer to as the BNI website. You are going to find almost every notice that could be given to a Medicare beneficiary, and on the left-hand side of that

screen, you're going to see them. These are all hyperlinks, and you can click on them, and they will take you directly to any and all of these notices. Also, the website is going to provide you with some details. So for example, since we're talking about post-acute; if I were to click on the Fee for Service, Expedited Determination Notices, that would take me to a page that is going to list some high level discussion up here, and it's also going to provide, at the bottom, things that are called downloads. That is where you can find the notices. You can find the instructions on how to complete the notice if you need that. We're going to go over that in just a bit, but this is the official repository, and I would just highly recommend to the audience that you bookmark this page. It's going to be very valuable to you and to your team as you go through this process.

OK, so again, we've talked a little bit about the bene's responsibility. We talked about the process itself. We talked about provider responsibilities, so if you'll just allow me to take just a few minutes to talk to you about what does Kepro have to do, what are they going to do here? By contract, the BFCC-QIO is available from 9:00 am to 5:00 pm local time, Monday through Fridays, and from 11:00 am to 3:00 pm local time on weekends and designated holidays. We typically adhere to the identified federal holidays with the exception of Columbus and Veteran's Day. Other times, we are right there with the federal holidays during business hours. If there are times when we're busy or during the off hours, there is a voicemail that is available and can be used to leave messages. Any and all messages that are left on the voicemail will be returned by close of business on the next calendar day. So, we do operate a seven-day a week, 365-day office environment; although it is remote right now, we are doing these appeals every single day. I do have people that are in the office before 11:00 am and after 3:00 pm, but this is when our telephone lines are open and available. After those times, you're going to get our after-hours office, but you may still be contacted by us after that time frame, and those are our business hours. Those are defined by our contract with CMS, and we must adhere to that. Overall, our process is to review the submitted material to prep it for the physician reviewer and then send it out to that reviewer, get it back from that reviewer, and then notify all parties of the outcome, starting with the beneficiary and/or their representative.

As I previously mentioned, the QIO receives documentation; we validate the NOMNC. We're going to ensure the completeness of the received medical information; anything that's inaccurate or maybe inconsistent may result in a negative outcome for the provider and the plan. You may think well what do you mean by inconsistent documentation? We have had medical records received where the attending physician or the facility physician is saying that Mary Smith can walk 150 feet with a rolling walker without any assistance. And yet when we get to the PT notes or the therapy notes, we see that Mary Smith can walk 10 feet, and she needs assistance to be able to walk with that rolling walker. That's inconsistent documentation. We don't get to see the patient. We are not physically in your facility, so we make our decision based upon what is charted in the medical record, and so

if there's inconsistent documentation, physicians are very inclined to make a decision in favor of the beneficiary. So, I mentioned, we prep, and we send all of this information out to those independent physicians. Again, they're actively practicing physicians. They are not employees of Kepro. They must actively practice at least 20 hours a week, and they're going to use their best medical judgment as well as the knowledge of the Jimmo settlement to be able to make a decision.

Jimmo is a lawsuit that was settled, and information has been provided to all the providers as well as to the review contractors as to how you are to make decisions, and it's not based upon the plateau verbiage. It's really very distinct information as to whether or not skilled facilities should continue care to either continue the progression of that patient or to decrease the opportunity for that patient to decline, so again, our physicians are going to make that decision based upon their best medical judgment and their knowledge of Jimmo. And then lastly, we're going to notify everybody by the close of business on the day after receipt of all the requested information because the decisions have negative financial impact to anyone, whether it's a provider or to the plan.

There are many levels of appeals. If that patient disagrees with us, they can ask for a reconsideration review for the traditional Fee for Service beneficiary. There's a different contractor that does that reconsideration review. They're called the qualified independent contractor or the QIC. It is either going to be C2C, or it's going to be Maximus Federal Services, depending upon where you are located in the country. For the health plan members, the QIO will do the reconsideration review, and we will do that using a different physician who was not involved in the first level review at all. Even after the reconsideration review is completed. If the beneficiary is still not happy with the outcome, he or she can ask for an Administrative Law Judge review. That's the next level. That's their right. And that right is given to them. If the ALJ or Administrative Law Judge agrees with the initial decision, that beneficiary can take it to what is called the Department Appeals Board or the DAB; you might know it as the Medicare review board. And they will also look at all the information, and they will render a decision. And if by some chance that beneficiary is still not happy with the DAB outcome, he or she could take it to federal district court.

Now I will also need to say that in order for the Administrative Law Judge to be activated, it is going to require that that beneficiary and or family member have paid $200 or more out of pocket. That is the threshold before the ALJ will hear a case from the beneficiary and/or the rep. One of the most important steps in this appeal process is the completion of the Notice of Medicare Non-Coverage or the NOMNC. And as I've mentioned before, several times, the document has to be validated before the QIO can do its review.

I want to just take a few minutes to talk about completing the Notice of Medicare Non-Coverage. This is essentially what the notice looks like. You can see up here that it says the

effective date; I typically am going to refer to the effective date, so that you will understand that this is the area which we're looking at on this particular notice. It also is broken up into sections. Each of these sections have some points that are looking for it, and we've got to make sure that you use the right form. As I mentioned, there is an OMB CMS form number. On there, it was approved on December 31 of 2011, and then you also have the OMB number on the other side. You can find detailed instructions on how to complete this notice on the BNI website, but here's a few that we wanted to share with you. At the top, add the provider information. It can be your name, or it could be your logo. You can insert that at the top of the Notice of Medicare Non-Coverage, but you need to be cautious with that to make sure that your font size doesn't stretch this notice to more than two pages long. The provider name must be in the correct spot on the form along with provider number. CMS stated that the provider number cannot be the Medicare number, so you should not be using that. The number should not be the health insurance claim number, or what we commonly call the HIC number; it should not be placed on that form, to protect the patient's personal identifiable information.

The next level of information is for the provider to insert the type of services that are being stopped. Remember, this is the last service being stopped. You need to enter the effective date. This means that should the beneficiary receive the above skilled services after the effective date, someone other than Medicare will be financially responsible for the payment of such services. Again, looking at the effective date is two days after it is given. So, if you're giving that patient the notice today on October 14, the effective date cannot be any earlier than October 16. Insert the BFCC-QIO telephone number that the beneficiary is to call when making an appeal. If this number is not correct, we may have to consider this to be an invalid notice as a beneficiary did not have the information on who to call and ask for an appeal. Make sure right here that you're putting the name and Kepro's toll-free number. That would be the toll-free number for your region. There are five regions, and each of them have distinct numbers, so you need to put that number that is applicable to your particular region.

If this is a health plan member, the provider must include the plan contact information. This is for should the member call the QIO untimely, which is after 12:00 pm on the day before the effective date. So, if you gave the notice today, the effective date is the 16th. If that member called us at 12:15 pm tomorrow, it would be considered an untimely request. We would still validate the notice, will still ask for the notice and validate it, but if that notice is valid, then that beneficiary is going to be returned back to the plan, so that the plan can activate the appeal process.

Then there's a section on the notice that's called the Additional Information, and it says it's optional, and it is. This is a field that can be used to provide additional information to the beneficiary. If you want to put in here the reason why you're making that decision, it's an

optional field. You can do that. You could use it to document if the beneficiary refused to sign the form. That's fine; he or she can refuse to sign it, and you could use this section to do that documentation. It could also be used to document the verbal or telephonic notification of the representative. I'm going to show you here. This is just sample language. You might recall that I mentioned that in the Medicare Claims Processing manual it stated that the notification had to be in person, but we all know that there are many situations where an in-person notification can't be made. In this situation of COVID pandemic is an example where you know a face-to- face in-person notification may not have been made, could not have been made safely. So, in that case, telephonic notification is made.
If you're going to do the telephonic notification, you need to provide documentation of what actions you took to give proper notification. This can be documented in the Additional Information section of the Notice of Medicare Non-Coverage, or if you want to put it on a separate piece of paper, that is fine, but you have to make sure that you send us that separate piece of paper. You can't keep those telephone notifications in the case management or the social worker's office. We really need to do that because if that rep calls us and says ABC sent me this by mail. They never called me about this. I have no ability to activate an appeal process, and we have no documentation that says you did. Then it's very difficult to be able to continue on. We would likely make that notice a non-valid or in an invalid notice.

So, this is just an example; you could use it. You could throw it out. You can make your own, but there is specific information that has to be completed. So, you want to make sure that you basically do the who, what, when, where. You need to document the date and the time of your call. Who did you speak to? What telephone number did you call? What did you explain? How was the representative made aware of the effective date? Do they know when the liability date is? Do they know when to call in for the appeal? Do they know the telephone number of that to call in? Did you explain that you're going to be sending them a copy of the notice? You know, I can either mail it to you, I can fax it to you, but I will send you a copy of this notice.

Then there's some contact information there. If you want to put contact information, you have to confirm that the representative understood all of the information that was explained, and then there's a signature of the facility caller, the title of that caller. You need to say the name, what telephone number you know, so on and so forth. This is just an example. You can write your own. If you have copies of this type of stuff that you've used in the past that contains all of these elements, that is perfectly fine to continue using, but just make sure that all of those elements are there. CMS published a Medicare Learning Network several years ago, explaining all of that. If by some chance you don't have that, or you would like to have that, you can reach out to us, and we'll be able to provide that to you.

And then the last section of the form is for signatures and the date, the signature of the patient or the representative and the date. Again, remember that signature date needs to be two days before the effective date, so that they clearly understand that the notice is critical. It cannot go beyond two pages. You could put it on front and back if you so choose, but it cannot go beyond two pages, and I would really hate to make a notice invalid because it is a 2 1/2 page notice, and that's been driven by the logo that's on the front page. Just be mindful of that please.

And so, at this point in time, we want to just share a few lessons with the community that we've learned in these many years that we have done this. We certainly have entered some unique situations over our years, and we've learned from them; we've learned with our providers, stakeholders, and with the plans. And we really understand that there are sometimes delivery issues. I think the biggest concern that we see is who's a rep? Who can I give this notice to? We get that question often. You know we need to know who to call, what numbers to use, and then if we have to reach back out to the weekend staff, we need to know who they are.

We know that the delivery of the notice can be trying at times for the beneficiary, they might want a specific person involved in this process. They might want their wife, their husband, their son, their daughter, their next-door neighbor, somebody specific that helps them. So, they'll tell you, I'm not going to do that until so and so can help me, or we know that they often refuse to sign the document. That is their option. They can refuse to sign it. Signing the document doesn't mean that you agree with it. It just means that you have been given it. And there are times when the beneficiary themselves or they're really not able to sign the document, due to some cognitive or some health reasons. We understand that, and that's when you might have to reach back out and connect with a representative. I'm sure that no one on the call has ever had a representative refuse to meet with the team. It's probably only with me, but I've had them where they've actually avoided case managers and social workers literally. In hospitals. I realize this doesn't deal with the hospital, but it's a similar delivery process. I've actually had them avoid us by walking, turning around, and walking away from us.

We know that many reps are not in the same area, town, or even the same state, times when they simply won't answer their telephones. Those are all problems that people have encountered. We understand that, and so we do try to work with them. So, if you're working with a representative, really determine who is a rep first and foremost. CMS is going to tell you to follow the state law. Whatever your state law is for representation is what you should be following. You might ask what happens if there's no representative on record and the beneficiary is unable to sign for treatment. I would go back and ask you what is your policy for that? What is it? What is your facility policy when you have a case where you have a situation where the resident has suddenly not been able to speak for

him or herself, how do you handle that? We know that under the state laws, we know that there are some legal types of representation such as power of attorney's, healthcare surrogates, next of kin. But what we'd also say to you is to look at what your facility's processes. What is your policy and procedure? CMS will actually take it down to a non-relative individual who has the best interest of the patient at heart. So, you need to understand how that can stair step down in regard to that.

So, for a representative, how does the facility notify them? This is going to be somewhat redundant from information we shared before, but in the Claims Processing manual it does say that typically, generally this is an in-person delivery. You're not required to make offsite in-person notices. You're not required to drive to the bene's house and give it to them or to the representative's house to give it to them, but generally in what I'd like to call normal situations in normal times, it would be delivered in person.

However, if you have to do it by telephone, there are specific steps that need to be in place and also need to be documented. The staff would complete the notice as required. You call that representative, and you give him at least two days prior to the end of skilled services. Please make sure you cover the who, what, when, where, and the beneficiary's last covered day of skilled service. What the effective date is? When does liability begin? They need to know that they have a right to appeal. This decision can be appealed to the QIO. They need to know the deadline for the appeal to request it and what to do if that deadline is missed. Telephone numbers for the QIO to request an appeal, and they also need to know the date the above is communicated is considered to be the receipt date of the Notice of Medicare Non-Coverage, even if it's done by telephone. This is the receipt date.

As I mentioned, the Notice of Medicare Non-Coverage needs to be documented and annotated with all of that previous information of that call that you made. You need to also make sure that the staff person's names there as well as the representative's name that you called, the date time of the call, telephone number called, etc. Again, all of this is just to make sure that you all have documented that a proper notification has been made. A copy of the notice must be mailed to the rep on the day of the telephone contact. You also must retain a copy of the Notice of Medicare Non-Coverage wherever you documented that information; you have to do that.

Also on this last bullet point, I really would like to stress a little bit about CMS directions to the QIO community. I believe, also in the final rules for these appeals, there's a statement that says the burden is on the provider, to demonstrate timely contact was attempted, a notice was delivered, so the burden of proof resides on the provider to ensure two things; number one, that the decision to discontinue services is appropriate, and second of all, to make sure that you've done a timely delivery of that notice. Again, this is kind of repetitive. Please accept my apologies for that, but I just think it's very important to give you some

tools that you might find useful in your day-to-day interactions, especially when it comes to telephonic notifications.

And then as far as contact information to ensure that we notify the provider community of an appeal request. It is just critical for us to know who to call at the facilities; we really need to know who to call during normal business hours, Monday through Friday 9:00 am to 5:00 pm local time. That's 9:00 am to 5:00 pm in the Eastern Time zone, the same in the Central, Mountain Pacific, and we actually cover the Hawaiian time zone for Alaska, so we need to know that, so that we can make sure that everybody has adequate notification and is able to provide us with that. So normal business hours, Monday through Friday. We need to know after hours, weekends, and holidays, who to call? Your holiday number. Working hours are 11:00 am to 3:00 pm local time again through all the time zones. Again. Who to call? What telephone number to call? What fax number, so that we can send you the faxed documentation request and then the form itself? If you need to make changes to your contacts or perhaps you don't know if we have your contact information, that form is actually on our website, and you can use it, and you could submit it to us. We will take it and will update our provider contact list that we have, and we will send you documentation that that change has been made. So again, it is critical for us to be able to connect with the right people and to reduce any potential delays.

One of the things that we've also learned is for the weekend staff. There are times when we do a lot of appeals on a Saturday. This is because we typically get a lot of requests on Fridays. I will give you an example of that. On this past Friday, which was October 9, we initiated 410 appeals on that one day alone. So that means there's going to be some contact with weekend staff; so, it's really important for that identified staff member to know who we are and what our role is with processing appeals, just to be familiar with the notice itself and where to locate it. If it's not on the chart, if by some chance, it's in an office somewhere, to know how to reissue a notice if the original was deemed invalid, if we made a decision on Saturday that the notice was invalid. If your weekend staff knows how to complete that form, they could turn around and reissue that notice with the appropriate changes made and give that notice back out to the beneficiary and/or the rep. Also, they need to understand that they can release the PHI and the PII to us in order to process an appeal. Again, as I mentioned, on Friday, 410 appeals were started. We would have notified people if by some chance we're missing a record, and we want to call and make sure that we can get it before making a negative decision for the provider. The weekend staff needs to know that they can release that information to us, that it is appropriate to do so.

And again, just a few things to just kind of bring it all to conclusion. We understand that the appeal process can be confusing to many people, despite the fact that these have been in place since 2004; there's still times where it's confusing to people; so just some important tips to know. Make sure that the NOMNC you're using is current. It is the form number that

you see on the screen. It was approved on December 31 of 2011, and it does have an OMB approved number that you see there. Develop an internal process for your facility and stick to it. Just make sure your team members know the process, they understand it, a copy of the notice for the beneficiary and a copy for the medical file. It's important for us to get that notice.

You can develop a really short, concise delivery process for the Notice of Medicare Non-Coverage. It does not need to take you 30 minutes to deliver that. But just internally develop that delivery process, and the one thing I do want to just to stress is that we are a partner in this process; we're not an adversary. We want to make sure that we do the appeals timely and correctly. We do not like making administrative denials because a notice is invalid, the records didn't get to us until two days after they were due. We just want to make sure that that the beneficiary's rights are protected and that we do the review correctly, quickly, accurately, and that all parties are notified of the decision, so that anyone can reach out for their next steps.

So, with that, I am going to stop talking. Now I'm going to ask my team if there are any chat questions. Please let us know what the chat questions might be, and then we'll open the lines. Just a few minutes for any questions. So, Marie or Shannon, do we have any questions in the chat box? There is one. Is there any documentation as to how late in the day a Medicare Advantage plan can issue a notice? There isn't any documentation that the QIO is aware of. We are not privy to what happens on the health plan side of the house if they are. If there is a particular plan that's giving a notice at 4:00 pm in the afternoon, and you're having to deliver it, and then the beneficiary calls us at 4:50 pm, I think you can see where there might be some delays that would be encountered, but there's nothing in writing that says that the plan has to deliver their notices by X, whatever X time it is.

OK, any other questions in the chat Marie? Next question, will you be sharing a copy of this presentation? We can send that out by email after the presentation. Super. OK, let's see.

We have one. Is there any financial responsibility while the patient remains in the facility if appeal goes to the ALJ? There is financial responsibility. First and foremost, the ALJ is not a quick process. It's going to take weeks, if not months, before that beneficiary gets an ALJ hearing. There is no financial protection in the reconsideration process. So, if you recall, I mentioned that if the beneficiary doesn't like the initial decision, they can do a reconsideration review. If it's a Fee for Service beneficiary, that reconsideration is done by the QIC. If it's a health plan member, the QIO does the reconsideration. When we give out those reconsideration rights, we inform the beneficiary and/or representative that there is no financial protection during the reconsideration review process. The QIC has their own time frame for completing the recons. We, as a QIO, have our own time frame for completing those while we try to do it as quickly as we can. I think you can appreciate that

the expedited appeals have a higher priority. Recons have to be completed in the post-acute setting within 14 calendar days, and during those 14 calendar days, there is no guarantee of financial protection. Now, if the recon physician reviewer overturns the initial decision, then yes, the beneficiary would be would not have any financial obligations for that reconsideration time frame. However, if the recon physician agrees with that initial decision, then that financial responsibility remains from the liability date that we gave the beneficiary and the provider.

Any more questions? Sometimes we do not receive the bar code. What do we do when trying to meet the deadline, and we do not have the bar code? Ideally, you should receive it; if you do not, you can continue to fax your documents to us. It just means that we have to manually attach those records to the right appeal request. It's just a potential delay in getting those attached and getting those processed as we have to locate that appeal. We can do that, and so please if you have that bar code, we ask that you use it. If you do not, you cannot electronically submit that record. Then please go ahead and fax it normally. That is all the questions that I am seeing at this time. Are there any more questions? I'm not seeing any more Cheryl. Well, thank you everyone for joining us today. We hope that this information has been helpful to you. We are here to assist as needed and don't hesitate to reach out to us, so have a great day everybody. Goodbye.