



NEW MEDICARE EXPEDITED APPEAL RIGHTS: WHAT DO BENEFICIARIES GAIN?

Starting in July 2005, beneficiaries in the traditional Medicare program may seek expedited review of a skilled nursing facility, home health, hospice or comprehensive outpatient rehabilitation facility (CORF) services discharge or termination. The Centers for Medicare & Medicaid Services (CMS) published an interim final rule to implement the expedited appeals procedures on the Friday after Thanksgiving. 69 Fed Reg 69252 (Nov. 26, 2004).

The procedures parallel the expedited appeals process for Medicare Advantage (i.e., HMOs, PPOs, private fee-for-service) plans which resulted from a settlement in the [Grijalva v. Shalala](#) lawsuit originally brought by Center for Medicare Advocacy Attorneys in 1993. The provider must give the beneficiary a general, standardized notice at least two days in advance of the proposed end of the service. If the service is fewer than two days, or if the time between services is more than two days, then notice must be given by the next to last service. The notice describes the service, the date coverage ends, the beneficiary's financial liability for continued services, and how to file an appeal.

A beneficiary must request expedited review, orally or in writing, by noon of the next calendar day after receiving notice. At that time, the beneficiary is given a more specific notice that includes a detailed explanation of why services are being terminated, a description of any applicable Medicare coverage rules and information on how to obtain them, and other facts specific to the beneficiary's case. The beneficiary is not financially liable for the continued services until the later of two days after receiving the notice or the termination date specified on the notice.

The grounds for requesting expedited review are more limited than for Medicare Advantage plans, however, because of restrictions included in the underlying statute. Expedited review is available in cases involving a discharge from the provider of services, or a termination of services where "a physician certifies that failure to continue the provision of such services is likely to place the individual's health at significant risk." 42 U.S.C. § 1395ff(b)(1)(F). Under the regulations, services furnished by a residential provider or a hospice are discharges for which a doctor's certificate is not required. Services furnished by a "non-residential provider," such as home health services, are treated as a termination of services for which a doctor's certificate of significant health risk must be provided. 42 C.F.R. § 405.1202(a). CMS further states that a reduction in

service does not count as a termination or discharge and therefore does not trigger the right to the expedited determination process.

Expedited review will be conducted by the Quality Improvement Organization (QIO), which has 72 hours in which to make a decision. When the QIO receives the request for review, it must contact the provider, which then must supply the QIO with information supporting its determination, including the notice, by the close of the same business day. The provider may make the information available by telephone or in writing. The beneficiary may request a copy of materials submitted by the provider, and may submit his or her own additional information. The QIO must solicit the views of the beneficiary when making its decision. The QIO must also look at the notice to determine if it meets CMS requirements and can grant the appeal if the notice is deficient. The beneficiary does not incur liability if the QIO decision is delayed because the provider did not get the necessary information to the reviewer in a timely manner.

If the QIO sustains the decision to terminate/discharge services, the beneficiary may request expedited reconsideration, orally or in writing, by noon of the calendar day following initial notification. Expedited reconsiderations are to be conducted by the “appropriate” Qualified Independent Contractor, or QIC, a new contractual entity that will eventually conduct reconsideration reviews of all fee-for-service claims. CMS says that if the QICs are not up and running by July 1, 2005, when these expedited appeals provisions go into effect, the QIOs will do the reconsiderations until the QICs are available. The QIC must issue a decision within 72 hours of the request, unless the beneficiary asks for an extension. If the QIC does not comply with the time frame, the beneficiary may escalate the case to the administrative law judge hearing level.

The new regulations, at 42 C.F.R. §405.1206, incorporate the process for requesting review of a hospital discharge where the hospital and the physician concur in the discharge. Beneficiaries may request an appeal of a hospital discharge by noon of the next *working* day instead of noon of the next calendar day as for other services, based on the statutory language establishing the hospital discharge right to appeal. The regulations also require the QICs to conduct the reconsideration of a denied expedited hospital appeal instead of the QIOs, who conduct reconsiderations under the current process.

Under current regulations, 42 CFR 412.42(c), a beneficiary who gets a notice of noncoverage and who files an appeal with the QIO is not liable for the cost of the hospital stay until noon of the day after receiving the QIO decision. However, the new regulations implement an amendment made to 42 U.S.C. § 1154(e), the underlying statute, by the Benefits Improvement and Protection Act of 2000 allowing for waiver of liability until the Immediate Review is issued. Thus, the new regulations add that, to avoid financial liability for this time period, the beneficiary must be someone who “meets the conditions of 1879(a)(2) of the Social Security Act (that is, the individual did not know, and could not reasonably have been expected to know, that payment would not be made for such items or services under part A or part B)...” 42 C.F.R. §§ 405.1206(a), (f). As a result, if the notice of noncoverage informs a beneficiary of potential liability if the QIO finds in

favor of the hospital, the beneficiary may be deemed to know that payment would not be made and may be responsible for payment.

In all settings, including the hospital setting, the beneficiary or an authorized representative must sign the notice of noncoverage to acknowledge receipt. If the beneficiary refuses to sign the notice, the provider may note the date of refusal in the record, and that date is considered the date of receipt of the notice. This raises concerns for individuals who may not have the capacity to act and who may have no one to act for them.

Beneficiaries retain the right to utilize the standard appeals process rather than the new expedited process. A QIO may review an appeals request from a beneficiary whose request is not filed in a timely manner, but the QIO does not have to adhere to the time frame for issuing its decision, and the limitation on liability does not apply.

The Center for Medicare Advocacy will prepare comments on the interim final regulations, which are due on January 25, 2005. Contact Vicki Gottlich in the Washington, D.C. office at (202) 216-0028, or vgottlich@medicareadvocacy.org if you have questions or concerns, or if you are interested in signing on to the comments.