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## **CMS ISSUES PRELIMINARY INSTRUCTIONS FOR EXPEDITED REVIEW OF CERTAIN CLAIMS**

Effective July 1, 2005, the Centers for Medicare & Medicaid Services (CMS) has issued preliminary instructions for its expedited review process. The new CMS instructions implement the expedited review process mandated by §521 of the Benefits Improvement and Protection Act of 2000 (BIPA), and modified by the Medicare Modernization Act of 2003 (MMA). These statutory requirements amend 42 U.S.C. §1395ff of the Medicare Act to provide home health, hospice, Comprehensive Outpatient Rehabilitation Facility (CORF), and skilled nursing facility (SNF) and swing bed beneficiaries the right to appeal pending discharge from a period of covered care.

The appeal is to a state's Quality Improvement Organization (QIO), and is similar to that provided by the QIO for inpatient hospital discharges under Medicare's managed care program, Medicare Advantage. Disputes about payment are to be reviewed under the standard appeals process available for the adjudication of payment disputes.

Under the process, the provider of a covered home health, hospice, CORF, SNF or swing bed service is required to give a beneficiary a generic notice of termination no later than 2 days before the proposed end of the covered service. If the services are less than 2 day's duration, the notice is to be given at the time of admission, or for non-residential providers, at the next to the last time the services are furnished. If the provider fails to give notice as required, the beneficiary's coverage continues until 2 days after valid notice is provided.

The beneficiary may then make a timely request to a QIO for an expedited determination. The request is timely if made no later than noon of the calendar date following receipt of the generic notice. Once the beneficiary requests the review process, billing cannot occur until the QIO determines if coverage can continue. If review is not requested timely, the beneficiary does not have financial liability protection.

Upon receipt of the beneficiary's request, the QIO is to notify the provider of the beneficiary's request for an expedited determination. The provider, by close of business of the same day it receives notice from the QIO, is to provide the beneficiary with a detailed notice that explains why the service at issue is to be terminated. Providers must also supply beneficiaries with copies of documentation sent to the QIO, if requested, by close of business after the first day after the request, but may charge a copying fee.

The QIO is to make its determination within 72 hours of receipt of the request for the expedited determination. Notification may initially be by telephone but must be followed by a written notice, including information on reconsideration options. The QIO may make its decision even if not all requested information has been received.

The burden of proof is on the provider to support its coverage termination decision. Providers are to meet QIO requests for information, and must supply copies of generic and detailed notices as requested. The QIO is to allow the provider to explain its termination decisions.

For details on the preliminary instructions, see CMS Pub-100-04, Medicare Claims Processing, Transmittal, 577. The instructions provide useful, although confusing, detail about CMS' rules for the expedited review process, the circumstances for extensions, obtaining additional evidence, and information about further review steps, including when the expedited notice is to be given - distinct from its liability notice, the Advanced Beneficiary Notice (ABN).

Please check CMS' beneficiary notice initiative page for copies of current notices. See, [www.cms.hhs.gov/medicare/bni/](http://www.cms.hhs.gov/medicare/bni/) . We will address at another time recent changes in notices, including the elimination of certain notices of non-coverage. This complicated notice process has many aspects yet to be resolved by CMS.

*For a discussion of expedited review and notice issues, please contact attorney Alfred Chiplin ([achiplin@medicareadvocacy.org](mailto:achiplin@medicareadvocacy.org)) or attorney Vicki Gottlich ([vgottlich@medicareadvocacy.org](mailto:vgottlich@medicareadvocacy.org)) in the Center for Medicare Advocacy's Washington, DC office at (202) 216-0028, or consulting attorney Sally Hart ( [shart@acdl.com](mailto:shart@acdl.com)) in Tucson, AZ at (520) 327-9547.*