



The Medicare Quality Improvement Organization for Florida

Introduction

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This is our second newsletter. In 2007, we will continue to offer healthcare provider education regarding the Expedited Determination process. The ED team is available from 8-4:30, 7 days a week to answer any questions. Upon request, we will be happy to send you copies of the Managed Care and FFS Notices of Non-Coverage via email. These are documents that you may use to develop templates for your staff. This will shorten the time required to give the notice.

At www.fmqai.com, you will find a document titled "How to Complete the Notice of Non-Coverage" which gives instructions on how to complete the notice correctly. There is a document for FFS and one for Medicare Advantage. Click [here](#) for FFS and [here](#) for Medicare Advantage.



Ask Ed and Edna

Just a reminder that if you have any questions for Ed and Edna, please send an e-mail to edandedna@flqio.sdps.org.

Question: With the FFS notice, if a second notice is submitted, a second detail notice should be submitted. Does this also apply with the managed care notice?

Ed: Yes, a second detail notice must be submitted even if a patient is a Medicare Advantage plan beneficiary.

Question: What information should be recorded when the notice is given verbally?

Edna: Good question. When the notice is given by phone, documentation on the notice should include the following: who the healthcare provider spoke with, phone number called, effective date of notice, time frame to appeal, and the QIO phone number.

Question: How far ahead can the notice be given from the planned discharge?

Ed: The notice must be given no later than two days prior to the planned discharge date. The notice should be given close to the planned discharge. FMQAI must request the record the day the patient appeals. If the provider gives the notice too far in advance, FMQAI would not be able to assess the patient's medical status just prior to the planned discharge.

Edna: More good questions this month. Our next column will be in April so be thinking of all the information you want to know about the expedited determination process. Send your questions to edandedna@flqio.sdps.org.



The Reconsideration Process

All patients who request an appeal are entitled to reconsideration when the result of the appeal is unfavorable to the patient. Each patient is advised of his or her reconsideration rights at the time an unfavorable determination is given. The reconsideration process differs between Medicare traditional policies (FFS) and Medicare Advantage (MA) plans.

Traditional (FFS) Medicare patients:

Upon request for reconsideration, the beneficiary is given the telephone number for the qualified independent contractor (QIC) who has a contract with the Medicare program to perform reconsideration reviews. In Florida, the QIC is a company named Maximus. The beneficiary is instructed to call Maximus by noon of the following day for a timely appeal. Maximus will notify the healthcare provider of the reconsideration request and explain their rights to submit additional information to supplement the medical record faxed by FMQAI. The “turn around time” for the reconsideration review is approximately 72 hours. Maximus will notify the beneficiary, healthcare provider, and FMQAI of the reconsideration review results initially by telephone with follow up written correspondence. If Maximus overturns the initial denial, the beneficiary continues to receive treatment and such treatment will be covered or paid for by Medicare. The attending physician will need to assess the beneficiary's response to treatment, establish a new discharge date and issue a new notice at least two (2) days prior to the anticipated discharge, at which time the beneficiary may or may not elect to request an appeal. Should Maximus agree with the initial denial, the beneficiary would be financially responsible for all charges beyond the effective date.

Medicare Advantage (MA) patients:

Upon request for a reconsideration, FMQAI will have a physician, not previously associated with the case, review the medical record and determine if the provided services should continue or not. While Federal regulations give FMQAI 14 days to complete the reconsideration review, FMQAI recognizes that each day represents financial responsibility to either the MA enrollee or MA plan and strives to complete the reconsideration review as quickly as possible. If FMQAI's physician overturns the initial denial, the MA enrollee continues to receive treatment and such treatment will be covered or paid for by the MA plan. The attending physician and/or MA plan will need to assess the enrollee's response to treatment, establish a new discharge date and issue a new notice at least two (2) days prior to the anticipated discharge date, at which time the enrollee may or may not elect to request an appeal. Should FMQAI's physician agree with the initial denial, the enrollee would be financially responsible for all charges beyond the effective date.

Additional Appeal Processes:

All Medicare beneficiaries, traditional and MA enrollees, are entitled to a third level of appeal known as Administrative Law Judge. Instructions for requesting this appeal are included in written correspondence sent to the Medicare beneficiary upholding the initial denial of services.

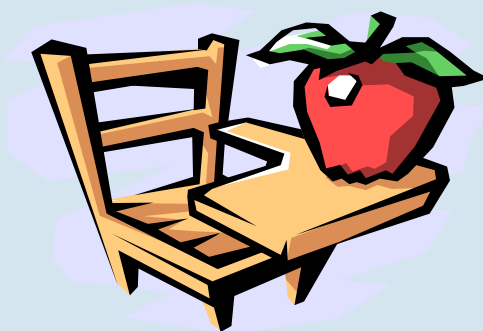
Web-based Educational Opportunities!

FMQAI is committed to assisting providers and their staff to assure they are familiar with the CMS requirements for issuing the Notices of Medicare Non-Coverage and the Notices of Medicare Provider Non-Coverage. You may register for these programs at <https://ifmcevents.webex.com>. Look for FL - Expedited Determinations (Appeals Process) and select a convenient date and time. The following is the schedule of upcoming programs:

February 6, 2007 -10:00 am - SNF/Hospice
February 20, 2007 - 10:00 am - Home Health/CORF

March 6, 2007 -10:00 am - SNF/Hospice
March 20, 2007 - 10:00 am - Home Health/CORF

The handouts are at our website at www.fmqai.com.

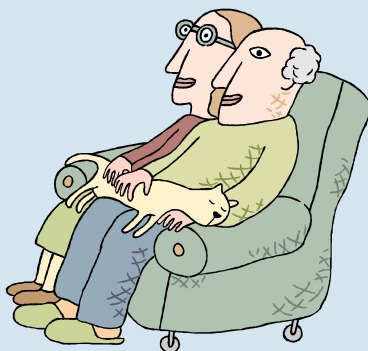


Workshops - Coming soon!

FMQAI is planning regional workshops for spring and summer 2007. Tentatively, the ED team is scheduled to be in Miami, Deerfield Beach, Tampa, Orlando, Pensacola and Fort Myers. The workshops will be a half-day and setting specific. These workshops will be offered at no cost to you and CEUs will be available for nurses and nursing home administrators. Look for more general and registration information as these dates approach.

Posters

FMQAI still has free posters available for healthcare providers which outlines the appeal process. If you and your organization would like copies of this poster, please e-mail your request to mmunsch@flqio.sdps.org.



Important Update for Generic Notice

Please add the following contact information to the last bullet on the first page of your organization's generic notices -

- Call your QIO: FMQAI at:1-866-800-8768 (TTY/TTD 1-866-800-8753)

Therapy Caps—2007

We are happy to report that President Bush signed H.R. 6111, the Tax Relief and Health Care Act of 2006, into law. Among other things, the Act provides a one-year extension of the therapy cap exception process for physical, speech language pathology, and occupational therapy services.



Provider Financial Liability

This is a very important concern! The regulation gives only two examples where providers may become liable under the new expedited process for patients with traditional Medicare (FFS). One is if the providers fails to give a valid notice; for instance, the provider fails to give the notice 2 days in advance when applicable. The other is if the provider fails to provide a reviewing QIO with requested information in a timely manner and the review extends beyond the effective date. Otherwise, the QIO is deciding whether coverage will continue and the Medicare program will pay, or if the beneficiary will be liable for care if delivered beyond the coverage end date on the generic notice. For patients who have Medicare Advantage coverage, the Plan becomes liable when it fails to give the patient notice 2 days in advance or fails to provide a reviewing QIO with requested information in a timely manner and the review extends beyond the effective date.



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