



Information for Healthcare Improvement



Expedited Appeal Connection

January 2010
Volume 2, Issue 1

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 the provider's 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 days prior to the anticipated discharge, at which time the beneficiary may or may not decide to request an appeal. Should Maximus agree with the initial denial, the beneficiary would be financially responsible for all charges beyond the effective date.



The Reconsideration Process (cont.)

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 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.

Provider Financial Liability

There are only two examples where providers may become liable for patients with traditional (FFS) Medicare. One is if the provider fails to give a valid notice; for instance, the provider fails to give the notice two days in advance when applicable. The other is if the provider fails to provide a reviewing Quality Improvement Organization (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 MA coverage, the plan becomes liable when it fails to give the patient notice two 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.

FAQs

Q. In what settings do beneficiaries need a physician's certification that failure to continue services may place the beneficiary's health at significant risk?

A. The expedited determination regulations require the physician certification for expedited review request involving service terminations by non-residential providers if they want to seek a QIO review. CMS has defined non-residential providers in instructions as home health agencies and comprehensive outpatient rehabilitation facilities. This certification can be provided by any licensed physician.

Q. What if the beneficiary has trouble finding a physician to give a certification statement?

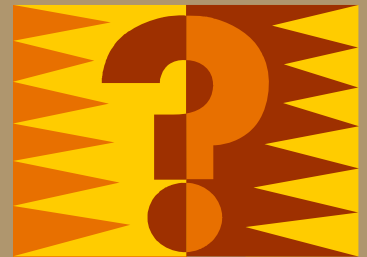
A. As long as the beneficiary initiates the expedited process properly, the QIO should process the review. If a physician certification has not been obtained by the beneficiary when making the request for review, the QIO will allow 60 days for the beneficiary to receive the physician certification and proceed with the review process as requested. If a certification has not been obtained within the 60 day timeframe, the QIO will not proceed with the review.

Q. Should a beneficiary receive a Notice of Non-coverage if he/she has exhausted his/her benefits?

A. No. Medicare will not pay after exhaustion of benefits, so there is need to appeal.

Q. If a patient is violent towards staff or other patients and the facility wishes to discharge him/her, is the Notice of Non-coverage necessary?

A. A Notice of Non-coverage does not need to be given under these circumstances.



*For more information about this newsletter or
for questions about the appeal process, contact:*

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*Remember the educational trainings are still available
at <http://edu.flqio.org>. There is one Continuing
Education (CE) credit available for taking the course.*

This material was prepared by FMQAI, the Medicare Quality Improvement Organization for Florida, 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. FL2010FONR1811584