I still have some questions regarding the Medicare notice requirements:

1. If the person is receiving therapy services and is only being covered under Medicare Part B and services are ending, do they still need a Generic Notice of Noncoverage?

2. If the person is receiving services under their Medicare Part A benefit and services are ending, do they need the Advance Beneficiary Notice and the Generic Notice of Noncoverage?

1. This is one of the questions we are still awaiting a final decision from CMS on. At this point it appears that yes we still give the notice for those Part B services.

2. If the resident is to remain in the facility then both notices would be given. If the resident is being discharged only the Generic Notice needs to be provided.

My question is who is the QIO for the state of Alabama? Your help would be greatly appreciated. I enjoyed your audioconference, it was very informative.

Alabama QIO: Alabama Quality Assurance Foundation - 205-970-1600. NOTE: This may not be the phone number you need to put on the Generic Notice. You should contact your QIO and ask them what phone number beneficiaries should call if they want to appeal.

If a resident is picked up on Part B therapy, has it for a few weeks, then therapy decides that he did what he could do and discharges from Part B on such and such a date, do we give a generic notice for Part B residents only. This resident was never on Part A?

This is still an unanswered question. CMS has released contradicting statements in their documents in this case and we are awaiting final clarification.

We agree that CMS has released conflicting information. We are still awaiting final clarification from CMS on this issue. In the meantime, the Generic Notice should be given in situations where all Medicare covered services end. In your example, that would be the discharge from therapy, and the Generic Notice should be given no later than 2 days before the last day of therapy.

I am confused. Slide 55 and 56 states about her last covered day will be the 15th and her notice given on the 13th. She is discharged from the facility on the 15th. In the Q&A it was stated that when they are discharged from the facility and going home they don't need a generic form. So if she was going home, she wouldn't need a form. Does she or doesn't she? The last covered day is not the day of discharge with
Medicare. When billing we put in the last covered day with a code of 22 and TOB of 213 if staying in the facility. If leaving the facility a TOB of 214 is used and the day they leave the facility is put in the "to date". We do not get paid for the last day. The only time services would be given on the discharge date is if they unexpectedly went to the hospital. Please clarify all of this.

In the example you give, the Generic Notice does need to be given: slide 55 and 56 are correct. The Generic Notice must be given at least 2 days before Medicare-covered services end, even if the resident is being discharged home at the end of the covered stay. The only time the Generic Notice does not have to be given is if the resident initiates the discharge home. In that case, the discharge is not related to the end of the Medicare covered services, and no Generic Notice is necessary. It may help to keep in mind that the purpose of the Generic Notice is to give the resident an opportunity to appeal the provider's decision to end Medicare coverage of the services. If the resident decides on her own that she is ready to go home, and there is no provider’s decision to end the coverage, then no Generic Notice is needed, because there is no termination of coverage to appeal. (See also question # 18 on the CMS Q & A document).

I do not recall anyone stated that the Generic Notice is not required when a resident is discharged home. If this is the case, we apologize for this error. According to the CMS open door forum on this topic, when the nursing facility terminates all Medicare coverage, the generic form must be given, even if the plan is for the resident to be discharged home.

Regarding the last covered day, this is per the Medicare Q & A, issued 7/1/05:

Q10. Please clarify how to calculate the appropriate delivery date for the GENERIC NOTICE. We have had mixed messages regarding the date that should be inserted on the GENERIC NOTICE. CMS’ education material sometimes uses the terms "discharge date" and "last covered day" interchangeably.

A10. We recognize that the terminology can be confusing particularly in the SNF setting where the day of discharge often is not a "billed" day. However, regardless of how days are billed, "Medicare-covered services" continue until the moment of discharge. Thus, the "day of discharge", the "last covered day", and the "effective date" of the service termination are the same, i.e., the terms refer to the last day in the covered period of care. Usually, in all settings, the GENERIC NOTICE must be delivered no later than 2 days before this date. Thus, if the last day in the covered period of care is a Friday, the notice should be delivered no later than the preceding Wednesday. Keep in mind that a provider may deliver the notice before the required deadline, and we encourage providers to do so as soon as they can identify the last day of covered services. The following example illustrates the calculation of the two-day GENERIC notice:

A date is established for termination of Medicare covered services to a snf patient. A generic notice is delivered and signed. The patient's condition then changes and it is
determined that the patient qualifies for additional skilled services. When a discharge date is again established should the original generic notice be amended with the new date according to the guidelines discussed for this same scenario for home care, or should a second notice be issued?

You can either issue a new notice or just amend the previous notice. We included a sample amended notice in the handouts.

From CMS Q & A document (7/1/0), Question # 13:

Q13. If a provider delivers a GENERIC NOTICE to the beneficiary, but the provider subsequently determines that services should continue beyond the original effective date, does the provider have to deliver a new GENERIC NOTICE?

A13. In the above situation, the provider must inform the beneficiary of the new effective date that coverage will end, either through delivery of a new GENERIC NOTICE, delivery of an amended GENERIC NOTICE, or through a mail or telephone contact. If the provider contacts the beneficiary other than in person to deliver this information, the provider should annotate the original GENERIC NOTICE to reflect the revised effective date that coverage will end, the date and time that the provider contacted the beneficiary, and the name of the person who initiated the contact. The annotated GENERIC NOTICE should be placed in the beneficiary's medical file.

Also, see Question #15, which addresses how to amend the Generic Notice in more detail.

I am the RN that does the Medicare determination, MDS's, chart audits, notifying family r/t MedA and "cuts", skilled vs custodial care, etc. With the new Notice of Medicare Provider Non-Coverage letter I will have to send out in the event I do make a "cut" from MedA, my question is:

What is the name and number of the QIO in New York State for an appeal?

New York QIO: IPRO 516-326-7767. NOTE: this may not be the phone number you need to put on the Generic Notice. You should contact your QIO and ask them what phone number beneficiaries should call if they want to appeal.

Thank you for your presentation on that issue. Your company did a much better job than our intermediary in presenting and explaining this topic. Since we have a short term rehab unit, we deal with Medicare covered stays in which people are discharged back to the community all the time. We also do outpatient therapy. We need additional clarification on the people that are discharged home and those outpatient Med B people whose therapy comes to an end and are discontinued. From your presentation, I understood that all these people would need a generic Notice of Noncoverage two days to being discharged home or two days prior for outpatient therapy being discontinued. Is that correct? Please advise.
1. Yes, the generic notice must be given to those residents who will be discharged home, if the discharge is due to their Medicare covered stay ending.

2. The Expedited review process does not currently pertain to residents who receive therapy services on an outpatient basis (ie., come from home daily to receive therapy).

My question is in regards to QIO. Is QIO an internal selected group of individuals within our SNF to review the decisions or is QIO stationed out of Medicare Intermediary? If stationed externally, what is their telephone number and do we, the SNF facility initiate the appeal or does the patient and or Patient Rep initiate the appeal?

The QIO is an independent review organization that is contracted with CMS. The QIO is separate from the SNF and the Intermediary. Each State has its own QIO. Since I do not know which State you are in, you can find the name and phone # of your QIO at the following site:

http://www.medqic.org/dcs/ContentServer?pagename=Medqic/MQGeneralPage/GeneralPageTemplate&name=QIO%20Listings

I work in a short term, hospital based sub-acute unit that's primary focus is rehab. Our Licensure is long term care. Because our length of stay for patients is short, we find that there is a certain number of patients that require longer skilled nursing time for recovery than we are able to provide them. These patients are dismissed from our unit and admitted to other long term care facilities under continued Medicare coverage. Is this the correct? Are we to issue patients in this situation a Medicare notice of noncoverage?

At this time we do not believe that it is necessary to give the notice if the resident is being transferred to another SNF and will continue to receive Medicare covered services. We are awaiting CMS clarification on this.

The question relates to Part A SNF benefits.

The resident is admitted with pressure ulcers and being covered for a stage 3 or 4 or multiple stage 2’s, etc. On monitoring the ulcers it appears they may heal soon. When this happens the resident will no longer qualify for coverage (for example, a single stage 3 goes to a stage 2). BUT, it is impossible to know when a wound will heal in advance. If we are supposed to use the ED how can we give 2 days notice? Even if we monitor daily and yesterday it was a stage 3 and today when I look it is a stage 2 I still am not giving 2 days notice.
The same situation can occur for a person on therapy who is starting to refuse. We don’t necessarily know in advance how many days they will refuse or why. We would start working with them and the family to get them to participate (or do an assessment to find out if there is a medical reason). So, if on the 3rd day the person refuses and we realize they will not continue on program, again how can we give 2 days notice of ending services? It appears that we would be covering for someone not getting services for 2 more days.

You ask a very interesting question. It is my understanding that the SNF should issue the generic notice at as soon as they believe that Medicare covered services would be coming to an end. An amended notice can always be given if it is later decided that the resident would still qualify for Medicare covered services.

In the case of the resident who refuses, it would appear that the resident would be allowed an additional 2 days of coverage once the notice is provided.

We have a short term SNF at our hospital. I understand that we need to give a generic ABN when every Medicare patient is dismissed from the SNF and no further Medicare services will be provided. The one scenario that was not discussed was when we dismiss a patient home with HH services - do we give the notice to that patient or not?

Yes, you must still give the Generic Notice even though they will be receiving other Medicare covered services from HH. The Generic form you give is informing them that their SNF services are coming to an end.

From CMS Q & A document (7/1/05):

Q30. Please verify if the GENERIC NOTICE must be issued if the beneficiary no longer requires skilled services in a SNF but the provider authorized the beneficiary to receive home health services subsequent to the discharge.

A30. Yes, the beneficiary must receive a GENERIC NOTICE before the conclusion of the SNF stay. This would qualify as an end to the SNF episode of care. The beneficiary has the right to request an expedited determination regarding his or her discharge from the SNF to home. The beneficiary must then receive a GENERIC NOTICE at the end of the home health care, which is treated as a separate episode of care.

I just listened to the audio conference and found it very helpful. Can you tell me where can I access the “Notice of Medicare Provider Non-coverage” forms and the detailed notice forms?

http://www.cms.hhs.gov/medicare/bni/
My background is with a hospice program. Can you tell me when this will be implemented for hospice services and website information specific to hospice guidelines for Medicare Notice of Noncoverage? How much of the home health presentation is applicable to hospices?

The expedited review process initiated 7/1/05 is for Home Health, SNFs, CORFs and Hospices. The hospice is required to follow the same procedures as outlined for the other providers. You can find information regarding this process at: www.cms.hhs.gov/medicare/bni

I am so confused as when I need to issue a Generic notice and a ABN I have not been doing both since July 1. I have only been issuing the Generic Notice. I have not been issuing anything with the Medicare part B residents. I will deal with that. On the Detailed notice: What if you can't reach the POA on the day you get contacted of the appeal? Do you just write on the Detailed notice that you attempted to call them and send it on, and mail it certified to the POA? So many of our residents are incompetent and their POA live out of town.

You’re not the only one confused at this time, there remain many unanswered questions. I hope we were able to clear some of them up for you.

Regarding the POA question, document who you attempted to call, date, time, phone # and then issue the letter return receipt/certified mail. The signature and date on the receipt will be the date the individual was considered to be notified.